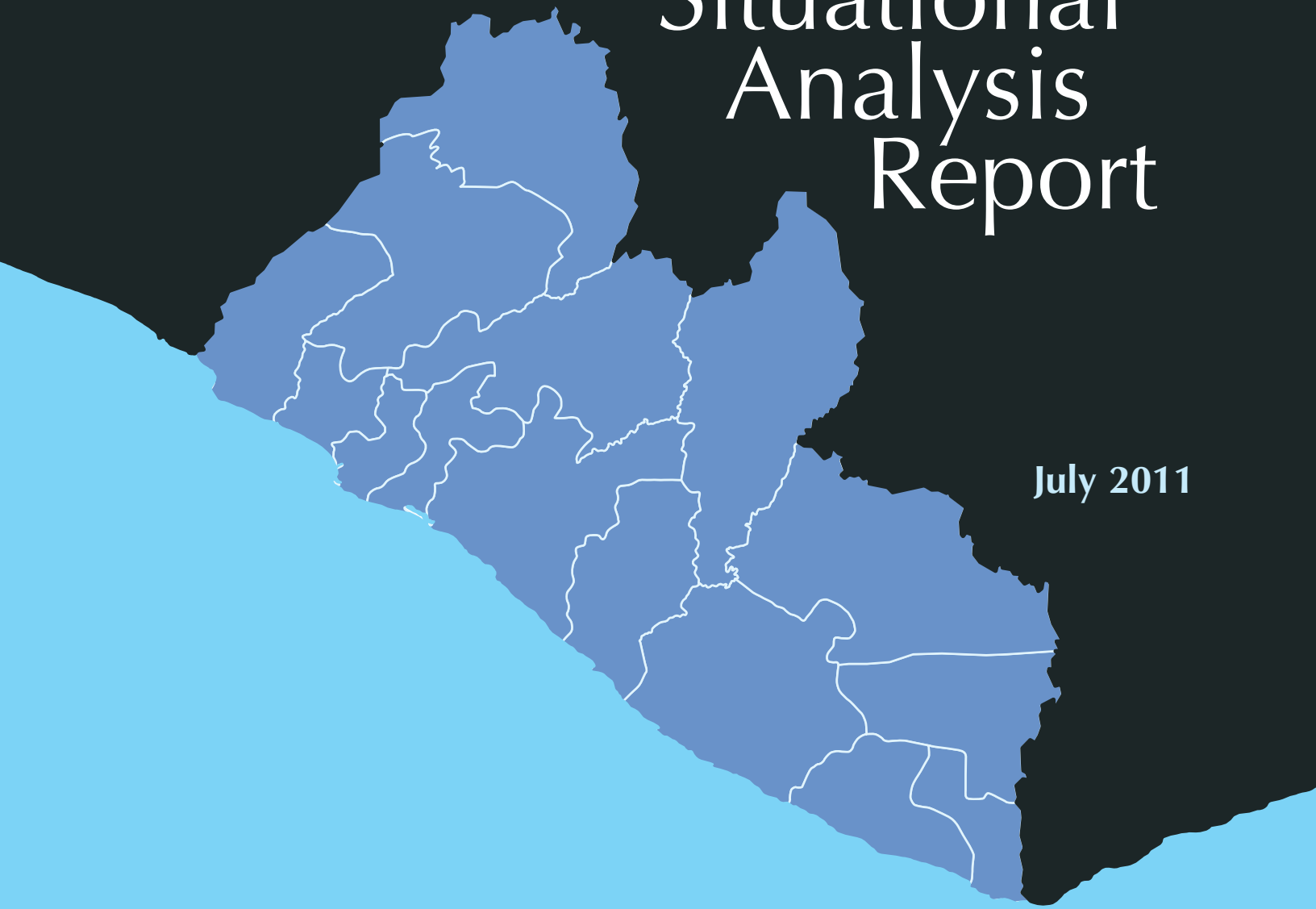
Republic of Liberia

Ministry of Health and Social Welfare

Country Situational Analysis Report



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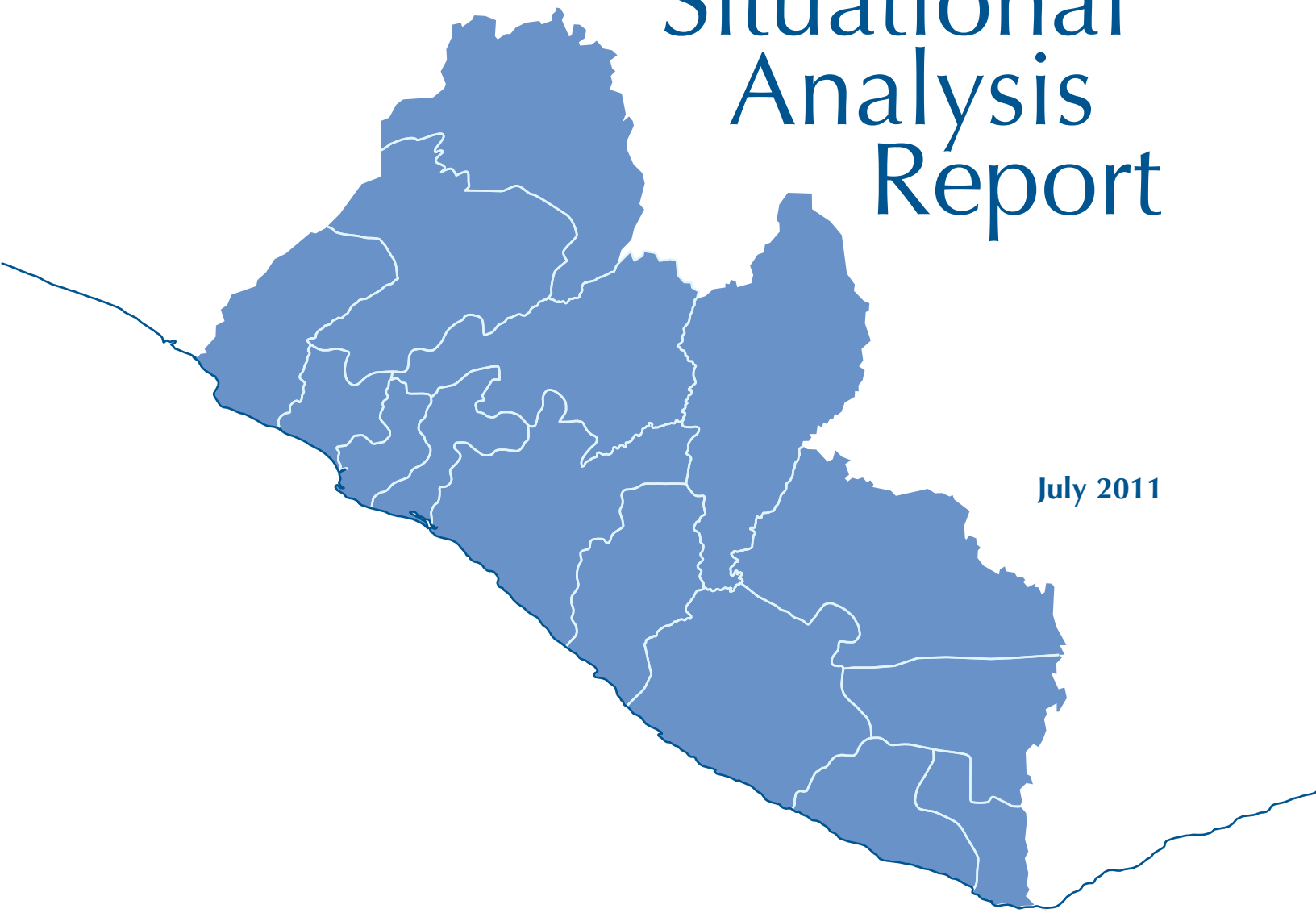

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Foreword

In 2006, Liberia embarked upon a journey towards a secure, prosperous and healthier future, and the Government of Liberia committed itself to leading the way. To guide our efforts, we developed our Poverty Reduction Strategy with concrete actions to build peace and security, revitalize our economy, strengthen governance and the rule of law and deliver basic services. As its contribution to the Poverty Reduction Strategy, the Ministry of Health and Social Welfare carried out a participatory policy and planning process to develop a National Health and Social Welfare Policy and Plan.

People and organizations from across government, civil society, the private sector and the general public selflessly contributed their efforts to the implementation of that policy and plan and remarkable progress has been made. We have reopened training institutions and expanded the workforce, invested in our health facilities and successfully rolled out the Basic Package of Health Services. As a result, access to basic services has increased, the prevalence of major killers like malaria and diarrhea have been reduced, and fewer children are needlessly dying than at any time in decades.

As that plan approaches its intended completion, Liberia has established a national vision of becoming a middle-income country by 2030, and the health and social welfare of the population are critically important to reach that vision. Therefore, the Ministry has embarked upon a process of reviewing and analyzing implementation of the National Health Plan to determine what worked, what didn't and why.

The intent of this situational analysis is to document the experience and inform development of a long-term vision, policy and plan framework explicitly aimed at guiding decision-makers through the next ten years. Many individuals and organizations generously contributed their time and resources to the analysis process and all contributions are gratefully acknowledged.

This situational analysis benefits from substantially more information than was available in 2007, as well as from additional policy guidance on decentralization and other relevant issues. Thus, while ongoing analytical capacity will continue to be crucial to understanding the changing environment and introducing appropriate adjustments to the system, the Ministry of Health and Social Welfare is confident that the 2011 National Health and Social Welfare Policy and Plan are based on an analysis of the best information available at the time they were developed.

S. Tornorlah Varpilah
Deputy Minister for Planning
Ministry of Health and Social Welfare

Abbreviations

AFRR	Accreditation Final Results Report
AIDS	Acquired Immune Deficiency Syndrome
ARI	Acute Respiratory Infection
ART	Anti-Retroviral Therapy
BLSS	Basic Life Saving Skills
BPHS	Basic Package of Health Services
CA	County Administration
CHO	County Health Officer
CHSWT	County Health and Social Welfare Team
CHV	Community Health Volunteer
CLA	County Legislative Assembly
CM	Certified Midwife
DHS	Demographic and Health Survey
ECOWAS	Economic Community of West African States
EDL	Essential Drug List
EHRP	Emergency Human Resources Plan
EmOC	Emergency Obstetric Care
EmONC	Emergency Obstetric and Neonatal Care
EPHS	Essential Package of Health Services
EPI	Expanded Program on Immunization
FBO	Faith-Based Organization
GAVI	Global Alliance Vaccines Initiative
GC	Governance Commission
GDP	Gross Domestic Product
GFATM	Global Fund for AIDS, Tuberculosis and Malaria
GOL	Government of Liberia
GRC	Governance Reform Commission
HIPC	Heavily Indebted Poor Country
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HRCR	Human Resources Census Report
HRIS	Human Resources Information System
HSPF	Health Sector Pool Fund
ICT	Information Communication Technology
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IMNCI	Integrated Management of Neonatal and Childhood Illnesses
INGO	International Non-Governmental Organization
IPT	Intermittent Preventive Treatment
JFKMC	John F. Kennedy Medical Center
LDHS	Liberia Demographic and Health Survey
LIBR	Liberia Institute for Biomedical Research
LISGIS	Liberia Institute for Statistics and Geo-Information Services
LMHRA	Liberia Medicines and Health Products Regulatory Authority

LMIS	Liberia Malaria Indicator Survey
LNGO	Local Non-Governmental Organization
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MD	Medical Doctor
MOE	Ministry of Education
MOF	Ministry of Finance
MOGD	Ministry of Gender and Development
MOHSW	Ministry of Health and Social Welfare
MOJ	Ministry of Justice
MOU	Memorandum of Undertanding
MOPEA	Ministry of Planning and Economic Affairs
MYS	Ministry of Youth and Sports
NDP	National Decentralization Policy
NDP	National Drug Policy
NDS	National Drug Service
NFP	Not-for-Profit
NGO	Non Governmental Organization
NHA	National Health Account
NHPP	National Health Policy and Plan
NMCP	National Malaria Control Program
NPHC	National Population and Housing Census
NRL	National Reference Laboratory
NTD	Neglected Tropical Diseases
OFM	Office of Financial Management
OGC	Office of General Council
OOP	Out-of-Pocket
PA	Physician Assistant
PBC	Performance-Based Contract
PCT	Program Coordination Team
PCU	Program Coordination Unit
PFP	Private-for-Profit
PHC	Primary Health Care
PMI	President's Malaria Initiative
PRS	Poverty Reduction Strategy
RBHS	Rebuilding Basic Health Services
RN	Registered Nurse
SCMP	Supply Chain Master Plan
SCMU	Supply Chain Management Unit
SDP	Service Delivery Point
TB	Tuberculosis
TTM	Trained Traditional Midwife
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Program
UNICEF	United Nations Children Fund
US$	United States Dollar
USAID	United States Agency for International Development
VCT	Volunteering Counseling and Testing
WAHO	West African Health Organization
WHO	World Health Organization

Summary

Context. After a 14-year conflict that destroyed most of the national infrastructure, tore apart the social fabric and cost at least 200,000 lives, Liberia is gradually recovering. Gross domestic product (GDP) growth has rebounded to almost 7 percent and completion of the Heavily Indebted Poor Country (HIPC) process in June 2010 eliminated US$4.6 billion in national debt. Sustaining economic growth will require increasing investment in reconstruction of infrastructure (ports, roads, bridges and public utilities) as well as increasing investments in other sectors, such as education, agriculture and security.

In this context, the Government of Liberia developed the Poverty Reduction Strategy (PRS) in 2008 as the framework for national development and the National Health and Social Welfare Policies to increase access to effective basic services. As the PRS period comes to a close in 2011, the challenge for the Ministry of Health and Social Welfare is to develop a unified vision and a plan for continuing to improve the health and social welfare of people in Liberia that will be become an integral part of national development plan.

Financing. In 2008, total health and social welfare expenditure reached over US$100 million (or US$29 per person), or 15 percent of GDP.[1] This was an unprecedented level of expenditure for Liberia and in line with the West and Central Africa Region average in 2006 (US$28 per person (WHO)). External donors and households largely accounted for the high levels of expenditure (47 and 35 percent respectively), while government spending accounted for 15 percent. Government spending has remained stable as a percentage of the national budget (between 7 and 8 percent), but it nearly doubled in absolute terms. Donor funds are predominantly used to support service delivery at the primary care level, while referral hospitals consume the largest portion of government expenditure. The alarmingly high level of household expenditure was largely spent on private goods and services.

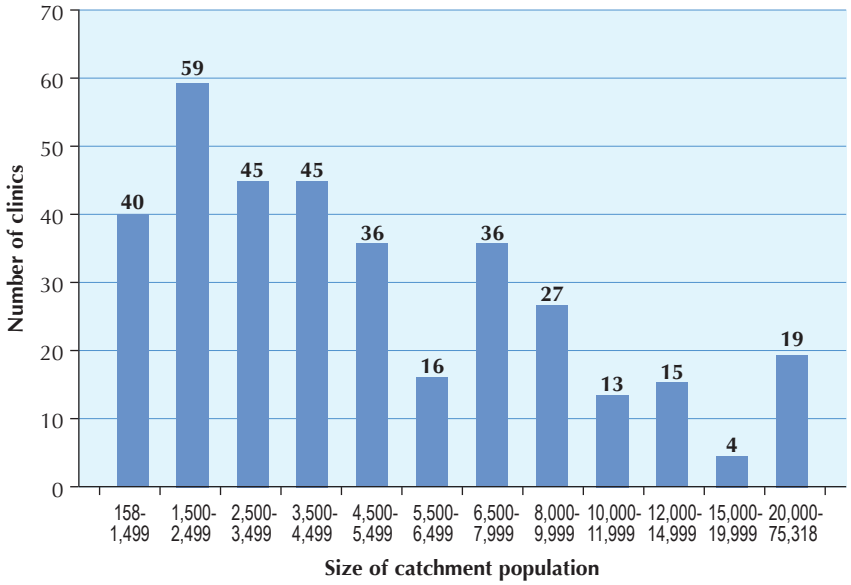
As the economy continues to grow and the national budget increases, public expenditure must continue to increase by at least the same amount at which donors are expected to reduce their funding if health and social welfare spending is to remain at current levels. Effort should also be made to put in place financial safety nets for households, in the form of risk pooling or social insurance, as a means of ensuring social protection. And the already high levels of inputs must be used more efficiently to increase the overall effectiveness of the service delivery system.

Infrastructure. The Basic Package of Health Services (BPHS) designates a clinic to serve a primary catchment population of between 3,500 to 12,000 and health centers to serve primary catchment populations of between 25,000 to 40,000. In addition, health centers also serve as points for secondary referral from neighboring clinics. Hospitals are expected to serve as secondary referral facility for a population of up to 200,000 people. Figure 1 depicts functioning health facilities and their actual catchment populations. It shows that almost one third (144) of functioning Government facilities are serving populations well below the minimum threshold (3,500) for a clinic established by the BPHS, while others are serving populations much larger than anticipated.

Moreover, the 2008 Population and Housing Census reports that 40 percent of all households must travel one hour or more to reach the nearest health facility, confirm-

1. *Liberia National Health Account 2009*.

Figure 1. Number of clinics per catchment population



ing that the existing health facility network is not accessible to a large portion of the population. The sector must ensure that appropriately resourced facilities are effectively distributed according to the size, density and utilization rates of the population. Optimization in this area would significantly improve the efficiency of the system.

Human Resources. In 2009, the National Census of Human Resources for Health and Social Welfare identified 9,196 people in the health and social welfare workforce. Sixty-two percent (5,989) were clinical workers while 38 percent (3,207) were non-clinical, including central ministry staffs, county administration, drivers, etc. However, only 33 percent of the entire workforce was found to be skilled health service providers; the other 67 percent were unskilled workers (cooks, cleaners, nurse aides) who occupy the majority of the paid positions.

Progress has been made in expanding the number and quality of pre-service training institutions in order to increase the capacity to produced more skilled workers. However, since 2006, there has been higher production of some cadres of professional workers (especially registered nurses) than was planned, while shortages persist for other critical cadres (especially physicians, physician assistants and midwives).

Distribution of the workforce followed the general trend of distribution of health facilities. Application of rigid staffing criteria at facilities, in the absence of reliable catchment population and utilization data that indicate workload, has resulted in sub-optimal distribution of the workforce. Deployment has been difficult because of the inflexibility of the BPHS salary scale and the inadequate incentives to retain professionals in rural areas. Thus, there is a need to improve the coherence between retaining essential workers from the existing workforce, producing additional workers with the right skills mix, population-based allocation of human resources, and effective motivation and retention schemes, especially for remote rural areas.

Health Services. With the end of the prolonged conflict, the health status of people in Liberia is improving. While still high, the under-5 child mortality rate has declined from 220 per 1,000 live births in 1986 to 110 per 1,000 live births in 2007. Malaria prevalence in children has also declined from 64 to 32 percent and access to prompt and effective treatment for malaria has increased. However, the maternal mortality rate remains very high (994 per 100,000), full immunization coverage remains inadequate (51 percent) and the HIV prevalence (1.5 percent) poses a potential threat to the population (3,476,608), of which 52 percent are 19 years of age or younger and 47 percent live in urban areas.

In 2007, the Basic Package of Health Services was developed in order to expand equitable access to consistent health services by requiring standardized delivery of several high-impact public health interventions. It prioritizes services that were perceived as the most critically needed at the time to improve the health status of the Liberian population with the resources that were available. At that time, priorities such as control of non-communicable diseases, occupational health, dental and eye health were considered to be beyond Liberia's resource capacity.

Initial implementation of the BPHS to date is considered to have been successful in achieving an agreed package of services. However, at the community level, implementation of the BPHS has been challenging because of the difficulty in getting unpaid and poorly supervised community health volunteers and trained traditional midwives to deliver an increasing package of services. Given the large percentage of the rural population reliant upon community services, due to travel distances to the nearest facility, improving community-based service delivery remains a high priority.

Moving forward, the challenge will be to expand the variety of services provided to better respond to the needs of the local population and increase the flexibility of service delivery strategies to better serve Liberia's dense urban populations as well as its less dense, but vast, rural population. Resource allocation must be optimized according to the size of the population and actual utilization in order to achieve a more efficient delivery system so that all levels provide the necessary services, with attention to equity.

Social Welfare. The Ministry of Health and Social Welfare completed the process of developing a National Social Welfare Policy in 2009. Due to the breadth of the social welfare issues, the policy has three goals: (1) A strengthened enabling environment for social welfare, protection and enhancement; (2) relevant social services provided to populations in need in a cost-effective manner, based on systems that support effective demand; and (3) improved and enhanced social capital systems that increase choice, reduce risk and protect the most vulnerable. The immediate challenges facing the social welfare aspect of the sector are to complete the reform of the Social Welfare Department in the Ministry of Health and Social Welfare, to establish the essential social welfare needs at each level of the system and to integrate them with the ten-year health policy and plan development process currently underway.

Pharmaceuticals. The 2010 Liberian Medicines and Health Products Regulatory Authority Act (LMHRA) established the legal framework for pharmaceuticals in Liberia; however, the LMHRA Act did not establish pharmaceutical regulations to accompany the authority. The 2001 National Drug Policy, 2007 Essential Drug List (EDL) and the National Formulary all require revision, while the Standard Treatment Guidelines have been partially revised. A ten-year Supply Chain Master Plan (SCMP) was developed in 2010, but it does not include a financial component to the plan. Funding for drugs is fragmented: the Government pays for drugs at facilities that it is supporting exclusively; bilateral donors pay for drugs at facilities supported through NGOs; some faith-based hospitals manage their own importation of drugs; and vertical program donors (PMI, GFATM, GAVI) pay for drugs that are provided free to all facilities. Although the SCMP envisages that eventually the National Drug Service (NDS) will be the predominant drug procurement mechanism, currently each source of funds uses its own procurement channel.

Support Systems. The Government of Liberia demonstrated its commitment to decentralization by developing the National Decentralization Policy in 2009; however, key aspects of the legal and administrative framework at the national and county level remain to be resolved. The National Health Policy and Plan's approach to decentralization is to commit the central MOHSW to progressively assigning responsibilities to the counties as they are equipped to assume them. This approach is based on designating responsibility for managing the support functions at the county level to the County Health and Social Welfare Teams (CHSWTs).

Progress has been made in delegating responsibility to the county level and coupling that responsibility with the capacity to deliver. In addition to county planning, guidelines for decentralization of the support systems and standard procedures have been developed for several key responsibilities. Financial policies, procedures and tools have been

disseminated and human resource officers have been assigned to each county (as have HMIS and M&E officers); gradually the functioning of the support systems is improving at all levels. Building upon the progress already made, the challenge before the Ministry of Health and Social Welfare is to reconcile the integrated National Health and Social Welfare Policy with National Decentralization Policy. An administrative framework, based on a legal mandate, must gradually align the health and social sector support systems with national vision for local governance.

1. Country Context

Table 1: Country at a Glance, April 2011

Topic	Status
Geographic size	111,369 square kilometers
Annual rainfall	4,000 mm (one of the highest in the world)
Natural resources	Iron ore, rubber, timber, diamonds, gold
Founded	July 26, 1847
Executive	President: Ellen Johnson-Sirleaf (2006)
Legislature	Bicameral (Senate and House of Representatives)
Per-capita gross domestic product	US$247 (2010 estimate)
Gross domestic product growth rate	1.8% (2001–2010 estimate), 5.9% (2010 estimate)
Population living on less than $1 per day	76.2%
Population	3,476,608 (32% in Monrovia; 2008 census)
Population growth rate	2.1% (2008 census)
Life expectancy	59.1 years (2010 UNDP)
Under-5 mortality rate	114/1000 live births (2007 DHS)
Maternal mortality rate	994/100,000 live births (2007 DHS)
Access to improved drinking water	75% (93% urban, 58% rural) (2009 LMIS)
Access to adequate sanitation	44% (63% urban, 27% rural) (2009 LMIS)
HIV seroprevalence	1.5% (1.8% female, 1.2% male) (2007)
Supervised childbirth	46% (2007 DHS)
Institutional deliveries	37% (2007 DHS)
Vaccination coverage (full)	51% (2010)
Net enrollment primary school	74% male, 58% female (2000–2006 average)
Net enrollment secondary school	37% male, 27% female (2000–2006 average)

Source: *Demographic and Health Survey* (2007), *UNDP Human Development Report* (2010), *Liberia Malaria Indicator Survey* (2009), *United Nations Developmental Assistance Framework* (2008), *Liberia Poverty Reduction Strategy* (2008), *Core Welfare Indicator Questionnaire* (2007), World Bank and IMF *Economic Outlook* (April 2010).

1.1 Map of the 15 counties in Liberia

Liberia covers an area of 111,369 square kilometers and is bordered by the Atlantic Ocean to the south, Côte d'Ivoire to the east, Sierra Leone to the northwest and Guinea to the northeast. Administratively, it is divided into 15 counties and had a total population of 3,476,608 million in 2008.[2]

1.2 History and demography

1.2.1 History and Background

Founded on July 26, 1847, Liberia is the oldest republic in Africa. However, between 1847 and 1980, a small minority governed the country by oppressing the large indigenous majority. Over many years that system of minority rule and an inequitable distribution of resources eventually lead to the 1980 coup and, ultimately, to the civil conflict that lasted from 1989 to 2003.

After the end of conflict, an interim government presided over Liberia until the current government of national unity, led by President Ellen Johnson-Sirleaf, assumed office in 2006. Following completion of an initial 100-day plan and then an Interim Poverty Reduction Strategy (PRS), Liberia launched its first full Poverty Reduction Strategy in 2008 based on four pillars:

1. Consolidating Peace and Security;
2. Revitalizing the Economy;
3. Strengthening Governance and the Rule of Law; and
4. Rehabilitating Infrastructure and Delivering Basic Services.

Implementation of the PRS got off to a slow start, but by November 2010, 86 percent of priority deliverables had been accomplished.[3]

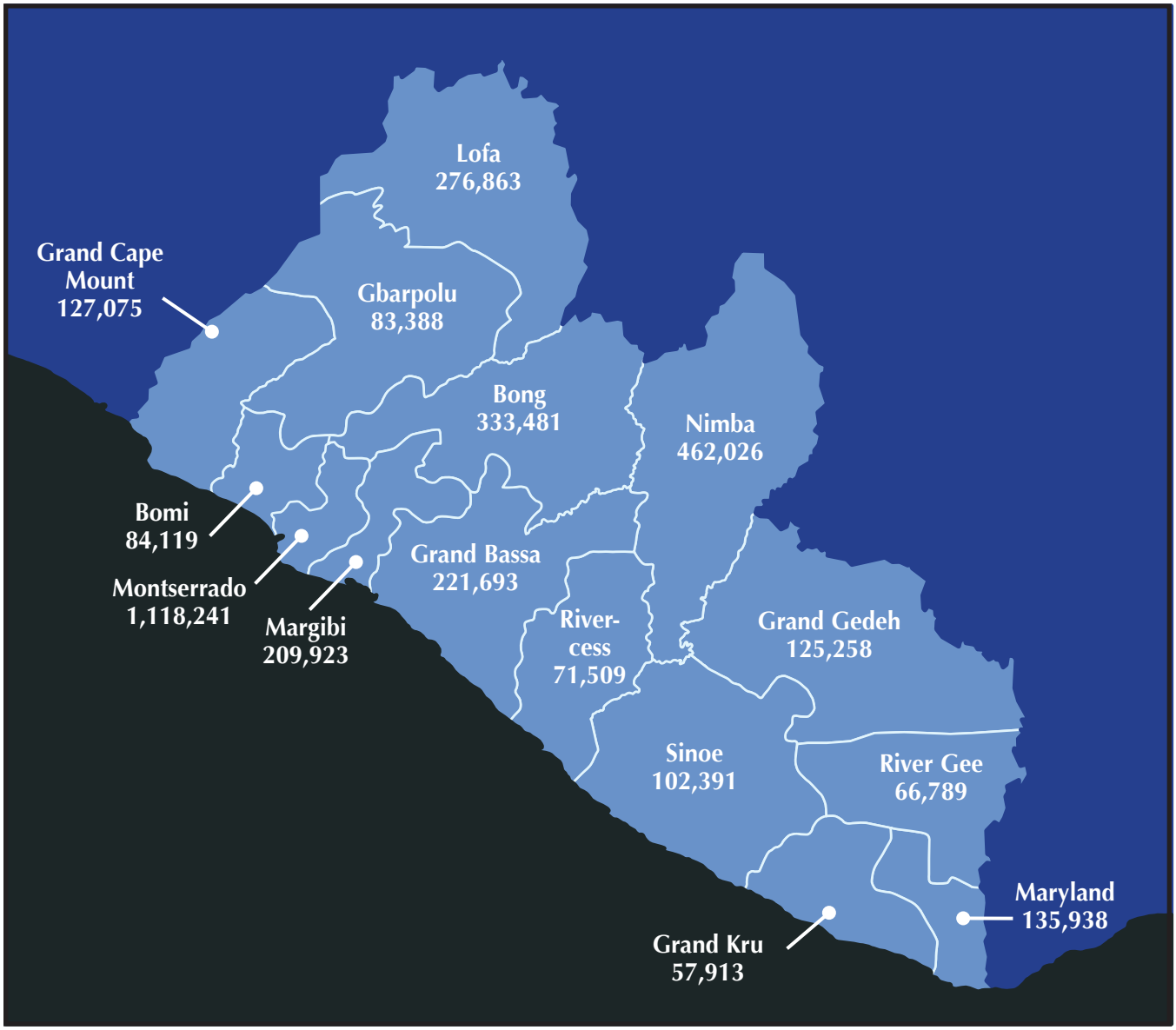
The Health and Social Welfare sector falls under Pillar 4 and the priority deliverables were largely derived from the 2007 National Health Policy and Plan (NHPP), including: basic services, human resources, infrastructure, support systems, and financing. The current PRS and NHPP continue until mid-2011; the Ministry of Health and Social Welfare is preparing for policy and plan continuation from 2011 onward.[4] National elections are constitutionally required to be held in October 2011 and a new government will be sworn in in January 2012.

1.2.2 Demography

The 2008 Population and Housing Census Final Results reported 17 major ethnic affiliations. Most Liberians (85.6 percent) identified themselves as Christian, while Muslims made up 12.2 percent and "Other" 2.2 percent. Of the 15 administrative counties, the "big six" (Montserrado, Nimba, Bong, Lofa, Grand Bassa and Margibi) accounted for 75.4 percent of the total population. The census identified a total population of 3,476,608, an increase of 65 percent from the 1984 census (2,101,628). The population of Montserrado County more than doubled since 1984 (from 491,078 to 1,118,241).

2. *Liberia National Population and Housing Census* (2008).
3. Ministry of Planning and Economic Affairs, November 2010.
4. *Roadmap for Development of a Ten-Year National Health and Social Welfare Policy and Plan*, November 2010.

Figure 2: Distribution of population by county



One-third of all Liberians live in Monrovia and, nationally, 47 percent of the population now lives in urban areas. However, while the urban population has grown, the census reported that 40 percent of all households travel more than one hour to the nearest health facility—over two-thirds of households in rural areas.

The census results also identified a "Special Population" of 51,367 people, especially children, who were either institutionalized or whose status was "floating" at the time of the census, indicating the extent to which social resiliency and social capacity (or social capital) to cope has deteriorated as a result of the conflict and changing demography.[5] Over 40 percent (832,030) of the population was displaced during the civil conflict and over 10 percent (95,657) had not yet resettled by 2008.[6] The weakened social capital

5. Including approximately 1,500 persons in prison, 85 percent of whom are pre-trial detainees. Except for Monrovia Central Prison, none of Liberia's other prisons have an on-site clinic with a qualified clinician.

6. *Population and Housing Census Final Results*, LIGIS, 2008, respondents 14 years of age and older.

also supports the 110,260 people who were identified as disabled, including those affected by the conflict, the elderly, and those disabled from birth.

1.3 Socio-economic situation

In 2010, Liberia ranked 162nd out of the 169 countries included in the UNDP's Human Development Report. Average life expectancy was 59 years, the adult literacy rate was 58 percent, and the combined gross school enrollment was 57 percent. Progress is being made on the Millennium Development Goals (access to improved drinking water and school enrollment are both improving) but the impact of the conflict will make it difficult for Liberia to achieve most of the goals. The serious economic challenges that usually accompany chronic conflict were also experienced in Liberia, where an estimated 63.8 percent of the population now lives in poverty.[7] Historically, poverty is higher in rural areas of Liberia, especially in south central and northwestern parts of the country; however, the urban population migration is increasing the poverty in urban areas.

From 1987 to 1995 Liberia's Gross Domestic Product (GDP) fell by almost 90 percent and it has not yet recovered. According to the World Bank and IMF's Economic Outlook, Liberia's 2010 estimated per capita GDP was US$247. This figure is down US$970 from its peak of US$1,217 in 1980. The recent global economic downturn has contributed to the slow economic recovery and will stunt future economic growth for some time to come. However, due in part to the very low economic baselines, Liberia has un-mistakenly made economic progress in recent years. Figure 3 shows the resilient rate of Gross Domestic Product (GDP) growth from the peak of the conflict, through the current global economic downturn and projected until 2030.[8]

Caution should be exercised when projecting future public sector revenues for health and social welfare because the projected growth rate of 15 percent does not reflect the historic GDP growth. Nevertheless, Liberia recently benefitted tremendously from completion of the Heavily Indebted Poor Countries (HIPC) process, and a total external debt burden of US$4.6 billion, equivalent to 800 percent of GDP, was cancelled by June 2010. Debt relief will enable Liberia to finance reconstruction of vital infrastructure that will underpin future economic growth.

1.4 Structural organization and decentralization

1.4.1 Organization of the health and social welfare sector

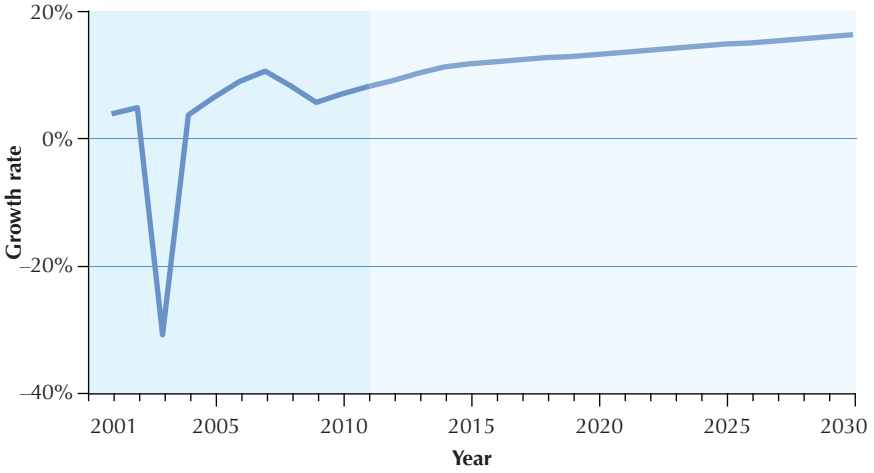
In principle, the health and social welfare sector has three distinct levels of service delivery, the primary level, secondary level, and tertiary level. At the primary level, clinics are to serve a population between 3,500 to 12,000 people with services that include promotional health, basic mental health services and the management of common conditions for children and adults, including basic emergency obstetrics care at the health center. Within the clinic catchment area, community-based outreach services are either provided by an outreach team from the clinic or by a community-based Community Health Volunteer (CHV) to increase access to high-impact health interventions. In reality, as shown previously in Figure 1 (page 2), many clinics are serving catchment popula-

7. Ministry of Planning and Economic Affairs, 2008.
8. World Bank and IMF *Economic Outlook* (2010).

tions of less than 3,500, outreach from clinics into communities is very limited, and CHVs are poorly supervised.

The secondary level health centers and "county" hospitals provide a wide range of curative and preventive services, including common surgical conditions and comprehensive 24/7 emergency and inpatient care. In reality, during the conflict and post-conflict period, some health centers have been performing as "clinics" and are only now in the process of becoming fully functional health centers. The tertiary level exists at John F. Kennedy Medical Center in Monrovia and includes specialist services not provided at the secondary level of care.

Figure 3: Actual and Projected Gross Domestic Product Growh Rate, 2001–2030



In practice, most rural households rely on preventive outreach services provided at the community level, such as vaccination campaigns, or they walk to the nearest facility for curative care if they believe the condition is serious and they are able to walk. Meanwhile urban households rely on facility-based services since they are generally within easier geographic reach. Some clinics at the primary level provide limited secondary level services, such as emergency obstetrics care, because of the distance to a secondary level facility. Similar to clinics, secondary level facilities serve vastly different size catchment populations and provide primary level care to their local community.

1.4.2 Organization of the Ministry of Health and Social Welfare

The Ministry of Health and Social Welfare exists at the central ministry level in Monrovia and at the operational level in all 15 administrative counties. The central ministry is comprised of four departments: Health Services, Planning and Vital Statistics, Social Welfare, and Administration. Under the Minister for Health and Social Welfare, four Deputy Ministers and seven Assistant Ministers manage the four departments and numerous bureaus.[9] In 2009, the Governance Reform Commission recommended that the number of departments in all ministries, including the Ministry of Health and Social Welfare, be consolidated. The commission also recommended reducing the number of Deputy Ministers, eliminating the position of Assistant Minister altogether and instituting the position of Permanent Secretary in each ministry. The Governance Reform Commission's recommendations have not yet been implemented.

At the operational level, a County Health and Social Welfare Officer heads the County Health and Social Welfare Team (CHSWT), a District Health Officer (usually an Officer In Charge (OIC) at one of the health facilities) coordinates services in their district, and an OIC manages health and social welfare services at the facility level. Primary level care facilities are intended to supervise community level services in their catchment communities, but this has proved extremely difficult due to the long distances to reach many of the communities served by the facility. All health and social welfare professional employees (either contracted or civil servants) from the facility level, district, county, and central ministry are currently considered staffs of the Ministry of Health and Social Welfare.

9. See Annex I: Organization of the MOHSW, p. 62.

1.4.3 Decentralization

The 2007 National Health Policy and Plan's approach to decentralization is to commit the central ministry to progressively assigning responsibilities to the County Health and Social Welfare Teams as they are equipped to assume them. The CHSWT in turn is responsible for progressively assigning responsibility for aspects of the support system functions to the district, facility and community level.

The Government of Liberia developed the National Decentralization Policy in 2009. Over the course of the next ten years (from the date the policy is enacted into law), this decentralization policy will gradually eliminate the organizational structure of the Ministry of Health and Social Welfare at the operational level. According to the National Decentralization Policy, the Ministry of Health and Social Welfare will exist only at the national level, carrying out the following principal functions: policy formulation, promulgation of regulations, resource mobilization and allocation, national planning, broad sector programming, and monitoring and evaluation.

At the county level, the decentralization policy provides that health and social welfare will become an administrative department of county administration. The county administrations will be responsible for planning and administering the functions of government within each county. The county health and social welfare department will be headed by a director, appointed by the county superintendant from a list of qualified, national candidates provided by the Ministry. The health and social welfare department director will manage county health and social welfare activities and facilitate implementation of national programs. At the district level, a district health officer will form part of district administration. All health and social welfare workers in every county will be employed and paid by the county administration under guidelines established by the Civil Service Agency.

There are important divergences between the Ministry of Health and Social Welfare's approach to decentralization and the National Decentralization Policy. Chief among these divergences is that the National Health and Social Welfare Policy and Plan do not recognize and incorporate the role of the county administration at the operational level. For example and in contrast to the decentralization policy, currently the CHSWT and all health and social welfare workers are considered MOHSW staffs, essentially forming part of a nationwide organization that extends from the central ministry to the community level in each county. Health infrastructure renovation and construction is managed centrally from Monrovia. The national drug supply chain is viewed from the perspective of central level direct inputs into a national system. And health financing as a whole is viewed from a national policy perspective rather than as a county financing issue for the county administration. These divergences are primarily due to Health and Social Welfare subsector policies developed prior to the 2009 National Decentralization Policy.

While ongoing efforts by the central ministry to build county capacity, standardize and promote a cohesive health system have not been counterproductive thus far and should be continued, caution should be exercised in the future to ensure that the health and social welfare sector does not diverge further from the national decentralization strategy. In fact, given the resources and advancing capacity of the teams at the county level, the health and social welfare sector is perhaps better positioned than any other sector to play a major, complementary role with the Ministries of Finance and Internal Affairs for incremental rollout of the national decentralization process.

1.5 Legal framework

The 1976 Public Health Law requires revision in order to reflect the National Decentralization Policy, as well as to effectively govern a decentralized health and social welfare service delivery system. The legal framework must encapsulate the mandate of a non-operational, central-level ministry, the authority to establish and enforce policy, and the authority to formulate resource distribution criteria and to regulate all related health institutions and activities.

In the absence of a revised public health law, the new Office of General Counsel, within the Ministry of Health and Social Welfare, developed a policy and process for promulgation of regulations related to health and social welfare. With the exception of child adoption, very few other regulations have been adopted since the new regulation process was put in place. For example, a pharmaceuticals and medicines authority act was passed by the legislature in 2010, but pharmaceuticals and medicines regulations have not been developed. Regulations also remain to be developed for technical standards of service delivery, licensure of both public and private service delivery and training institutions, as well as for ethics and research purposes.

The Office of General Counsel and the regulations promulgation policy are evidence of an important legal capacity that did not previously exist within the ministry. With the support of partners, the OGC will lead the process of revising the Public Health Law in 2011 to reflect the decentralized and integrated health and social welfare system.

1.6 Policy implications of the current country context

1.6.1 Changing demography

Because of internal migration and the elevated population growth rate, more Liberians than ever, especially children, are now living in urban areas. As a result of the weakened social capital in rural and urban areas, the proportion of vulnerable people, especially children, has also increased. Therefore Health and Social Welfare service delivery strategies should adapt to the changing demography and reflect the needs of the population. Particular emphasis should be placed on how to most efficiently and effectively deliver basic services in high-density urban populations, thereby creating efficiencies that will enable the delivery of appropriate services to low-density, rural areas.

1.6.2 Economic forecasting

In estimating potential future revenues to the health and social welfare sector from all sources, especially from household incomes and public spending, the historic economic volatility and actual economic growth should guide development of realistic revenue forecasts. Overestimating potential resources will undercut planning, resource allocation and beneficiary expectations.

1.6.3 Decentralization

Health and social welfare sector strategies should begin to move away from central ministry management of resources, implementation and, to some extent, support systems. An administrative decentralization policy is required that interprets the national decentralization policy into implementation terms for the health and social welfare sector.

1.6.4 Legal framework

Revision of the 1976 Public Health Law in 2011 should articulate a legal framework for a decentralized health and social welfare system, for the National Health and Social Welfare Policy and Plan, for all subsector policies (e.g., financing and human resources), as well as for the regulatory authority and mechanisms required to effectively govern the health and social welfare system.

Reference documents for this chapter

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- *Economic Outlook*, World Bank and IMF, 2010.
- *Governance Reform Commission Report*, GOL, 2008.
- *Human Development Report*, UNDP, 2010.
- *Liberia Malaria Indicator Survey*, MOHSW, 2009.
- *Liberia Poverty Reduction Strategy*, GOL, 2008.
- *National Decentralization Policy*, GOL, 2009.
- *National Health Policy and Plan*, MOHSW, 2007.
- *National Social Welfare Policy*, MOHSW, 2009.
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- *United Nations Development Assistance Framework*, 2008.

2. Health and Social Welfare Financing

2.1 Overview

The 2007 National Health Policy commits the Government of Liberia to financing health care at the highest level possible, taking into consideration its revenues and competing priorities. The policy commits the government to progressively increasing the share of its budget apportioned to the health sector, while a mixture of other financing strategies (user fees, health insurance, and other forms of pre-payment) will also be explored. However, the policy states that "In light of crushing levels of poverty, the Ministry has decided to suspend the administration of user fees at the primary health care level . . . 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 2007 National Health Plan assumed that funding for health and social welfare would come from the Government of Liberia, special budgets for vertical programs and other sources. The plan included a detailed, multi-year budget by activity area, based on anticipated, available resources. Table 2 presents the estimated sources of funding for the National Health Plan in U.S. dollars.

Table 2: 2007 Anticipated Financing of the Health and Social Welfare (in US$ millions)

Source of Funding	2007	2008	2009	2010	Total	%
MOHSW (increasing to 15% of the GOL budet)	$10	$18	$28	$33	$89	32%
Donor funding (program, humanitarian and development)	$40	$40	$40	$40	$160	56%
Other sources (out-of-pocket and private)	$4	$7	$8	$15	$34	12%
Total	**$54**	**$65**	**$76**	**$88**	**$283**	**100%**

Source: Table 11, National Health Plan (2007).

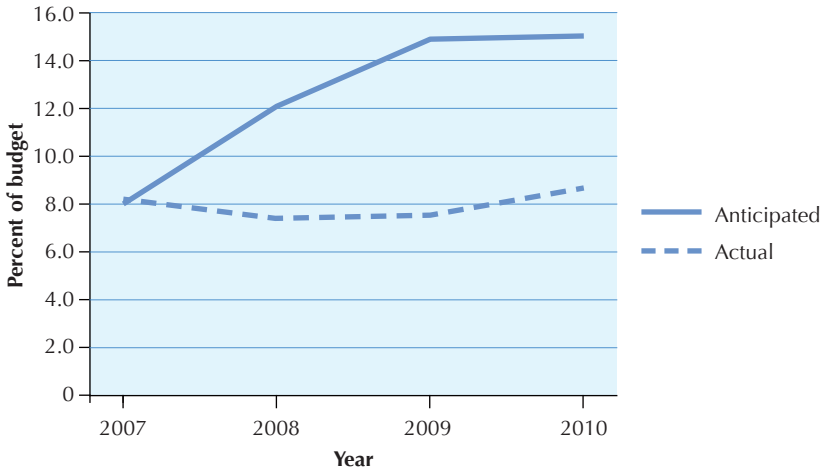
The financing plan anticipated that 32 percent of the total funding required to implement the NHP would come from the national budget, while 56 percent would come from donors and 12 percent from other sources of funding. Social welfare financing was included in the 2007 estimate along with the BPHS, infrastructure, human resources and support systems.

Table 3: Government of Liberia Health Budget, FYs 2006–2009, in US$

Fiscal Year	2007–2008	2008–2009	2009–2010	2010–2011
A. Total GoL budget	$208,819,357	$298,087,792	$347,035,687	$369,379,000
B. Total health budget	$18,705,242	$22,906,608	$25,767,030	$32,480,992
C. Anticipated health budget	$10,000,000	$18,000,000	$28,000,000	$33,000,000
D. Anticipated % of total	8.00%	12.00%	15.00%	15.00%
E. Actual percent of total	8.96%	7.68%	7.42%	8.79%

Source: Financial statements for the years ended June 30, 2008 (audited), 2009 (unaudited) and 2010 (unaudited), Office of Financial Management, Ministry of Health and Social Welfare.

Figure 4: Anticipated versus Actual GOL Budget Allocations for Health and Social Welfare, by percent



2.2 Sources of Funding

2.2.1 Government

Table 3 presents the Government of Liberia legislatively approved budgets from FY 2007 to FY 2010, the approved allocation for health and social welfare, the NHP anticipated allocations and the approved and anticipated allocations as a percent of the total government budget.

In absolute terms, the health and social welfare approved national budget allocations (B) were in line with the NHP anticipated allocations (C) each fiscal year from 2007 to 2010. The NHP assumed that the anticipated budget would be achieved by Liberia gradually fulfilling its Abuja commitment to allocate 15 percent of the national budget to health (D). However, the percent of the national budget allocated to health generaly remained stable (E) and growth in the overall size of the national budget enabled the absolute increases in health spending. This is an example of the potential to overestimate available resources raised in section 1.6.2 (see Figure 4).

2.2.2 Donor

The National Health Plan anticipated that donor health and social welfare funding would remain stable in absolute terms between FY 2007 and 2010 at US$40 million per year, declining from 74 percent of total funds in FY 2007 to 45 percent in FY 2010. The picture of actual donor expenditure during the period is not complete. It is expected that the ongoing process of developing the health financing policy will include a comprehensive update of donor expenditures. However, the 2009 National Health Accounts (NHA) report (for FY 2007–2008) identified that donor funding amounted to 47 percent of all funds in the sector. In the absence of a complete, multi-year picture, Table 4 presents the anticipated donor, government and other sources of funding as well as the actual funding identified by the NHAs as an *indicator* of anticipated versus actual funds for the four-year period.

The information in Table 4 indicates that, as was the case in many other areas,

health and social welfare funding data was grossly lacking in 2007. People were paying substantially more money for health and social welfare services than was known at the time the National Health Plan was developed. This information undoubtedly would also have had an impact on service delivery polices, priorities and strategies. It also indicates that 2007 donor-funding estimates significantly overstated the actual proportion of donor funds in the sector.

Table 4: 2007–2008 Anticipated Versus Actual Funds (US$ millions)

Source	Anticipated	Actual
Government	10	16.9
Donor	40	48.6
Other Sources	4	37.9
Total	**54**	**103.4**

Source: 2009 National Health Accounts Report (p. 59) and 2007 National Health Plan (p. 27).

2.2.3 Other sources

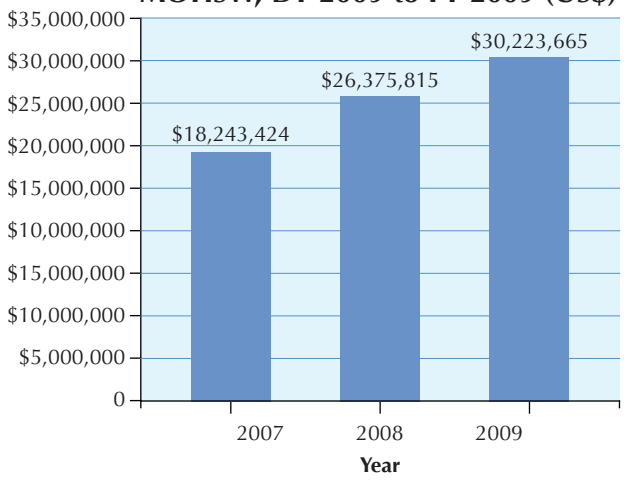
Of the US$37.9 million from Other Sources, 93 percent of those funds came from out-of-pocket (or household) funds, which are spent overwhelmingly (85 percent) on private providers. The National Health Accounts reported that household funds comprised 35 percent of the total funds in the sector. If donor funds were excluded from the equation, household funds would in fact represent two-thirds of all domestic sources of funds used for health and social welfare. The significance of this proportion and where it was being spent (and why) would have potentially had a major impact on development of the 2007 plan.

2.3 Areas of expenditure by source

2.3.1 Government

In 2008, the establishment of the Office of Financial Management within the Ministry of Health and Social Welfare enabled a substantial increase in both government and donor funds managed by the ministry. Figure 5 depicts the increase in funds managed by the MOHSW between FY 2007 and FY 2009.

Figure 5: Total Funds Managed by the MOHSW, DY 2009 to FY 2009 (US$)



However, even with the increase in funds managed over the last three fiscal years, the MOHSW still spent over 90 percent of the funds it managed on recurrent costs. The cost of human resources nearly doubled during the three-year period, from US$4.5 million in 2007 to US$8.6 million in 2009. The amount spent on capital expenditure was just US$1.7 million in FY 2009, representing only 6 percent of all funds managed by the MOHSW. This could be explained by an overall increase in activity and supplies at existing facilities, as well as by the cost of making functional the additional facilities described in section 3.3.1 of this report.

The National Health Accounts also reported that 67 percent of government funds spent for health and social welfare were consumed at the operational level by government hospitals, health centers, clinics and community level activities; whereas national programs and central administration consumed 33 percent of government funds.

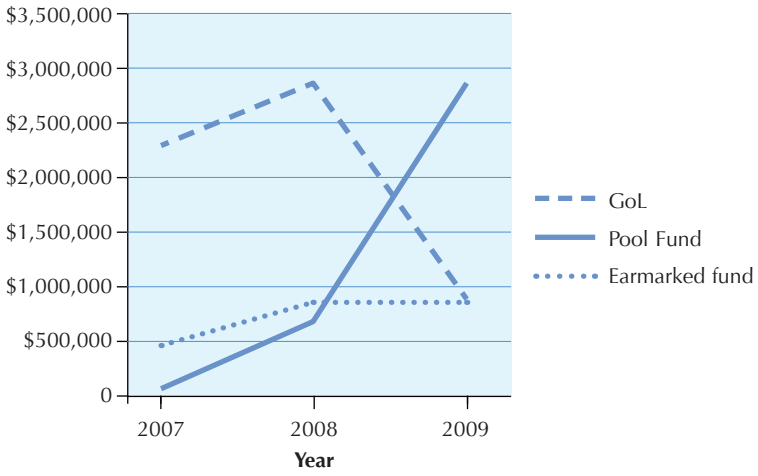
While two-thirds of government funds were consumed by activities in the counties, the pattern of funds transfer to the counties during the period from FY 2007 to FY 2009

Table 5: Transfers to Counties by Source from FY 2007 to FY 2009 (US$)

Source	2007	%	2008	%	2009	%
GoL	2,261,000	81%	2,835,507	65%	721,732	17%
Pool fund	47,450	2%	743,577	17%	2,864,834	65%
Earmarked funds	478,034	17%	797,119	18%	769,122	18%
Total	2,786,484	100%	4,376,203	100%	4,355,688	100%

Source: Unaudited Financial Statements for the years ended June 30, 2008, 2009 and 2010.

Figure 6: County Allocations by Source (US$)



indicates that government funds were increasingly being retained at the national level. Table 5 presents the transfer of funds to counties by source between FY 2007 and FY 2009.

The reduction in government fund transfers to the counties shown in Table 5 was offset by the increase in transfer of Health Sector Pool Funds to the county level. Figure 6 presents this shift from government to pool funded transfers to the counties.

However, although the MOHSW is transferring pool funds to the county level, at this time only one county (Bomi County) is directly receiving pool funds. Several other counties (Gbarpolu, Grand Gedeh, Lofa, Margibi, Maryland and River Cess) receive pool funds through NGO contracts, but the net effect is that government transfers to the counties are decreasing and offsets by the pool fund are largely being received by only one county or being managed by NGOs.

No national formula exists for determining the level of resource allocations to counties and no central database is in place to capture which resources (GOL, pool, donor) are being channeled where and based on what criteria (population, access or otherwise). While resource allocations generally follow the existence of government health and social welfare facilities, lack of a clear and transparent resource allocation policy could have catastrophic effects on the system: inequitable resource allocation will undermine decentralization and potentially even the political stability; quality of care will deteriorate; and the number of facilities could grow until the system financially collapses.

2.3.2 Donors

Figure 7 depicts the management of donor funds by agent. Of the US$48,644,951 in donor funds identified by the 2009 National Health Accounts (for FY 2007–2008), 59 percent were managed by NGOs, 34.7 percent were managed by the central Ministry of Health and Social Welfare, 0.7 percent by JFK Hospital, and the combined 15 County Health and Social Welfare Teams managed just 0.6 percent, or US$318,458.[10]

Although this information is from FY 2007–2008 and the MOHSW has taken steps to build county capacity, this disparity in the management of resources between the central MOHSW and CHSWT stands in stark contrast to the National Decentralization Policy described above in section 1.4.3. Moreover, the more recent reduction in transfers

10. The remaining 5 percent is managed by parastatal organizations and expended on health-related activities.

of government funds to counties described in section 2.3.1 should cause concern as to whether the government allocations are in fact diverging away from the national policy on decentralization. More enquiry is required to better understand the reasons why government transfers to the counties have reduced so significantly.

Of the donor funds managed by NGOs, 73 percent are used at the operational level by hospitals, health centers and clinics, and community level activities (20, 42 and 11 percent respectively). Twenty-seven percent of donor funds managed by NGOs are used for implementation of national programs and administration. Based on the 2007 National Health Policy and Plan and the National Health Policy on Contracting (2008–2011), service delivery contracting is being used as a mechanism to finance and ensure continuity of service delivery during the transition period from relief to development. A mixture of approaches is being used that includes "contracting-in," when one level of government contracts with another, and "management contracting," when a partner organization (NGO or FBO) is contracted to provide management support to a government facility.

Figure 7: Management of Donor Funds, by Agent, (NHA, FY 2007–2008)

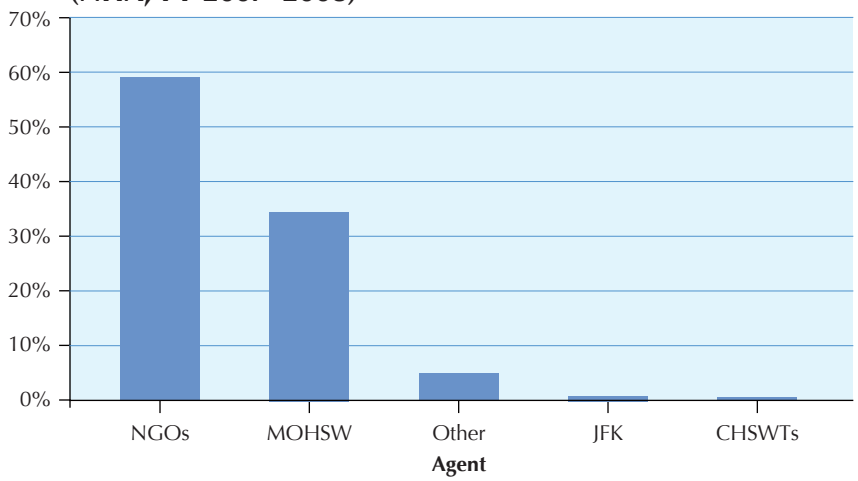
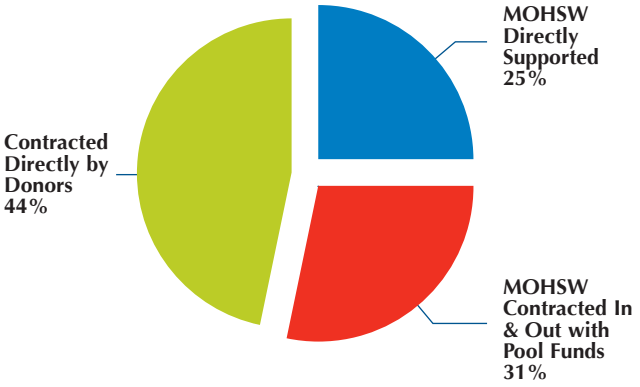


Figure 8: Distribution of Facility Support by Source and Mechanism



A performance incentive is used with some contracts in the hopes of improving performance in desired areas, promoting the motivation and retention of staff and, ultimately, improving health outcomes. As of October 2010, of the 292 health and social welfare facilities supported through contracts, 232 are performance-based. Figure 8 depicts the distribution of support to facilities by source and mechanism. All contracting support for facilities (in and out) is paid for with donor funds (either through the pool fund or directly by donors).

The Health Sector Pool Fund was established by the Ministry of Health and Social Welfare in 2008 to help finance unfunded priorities from the National Health Plan, to increase the leadership of the MOHSW in allocating resources, and to reduce the transaction costs associated with managing multiple different donor funds. As of June 30, 2010, the pool fund had four contributing donors. Total commitments to the pool fund exceeded US$35 million, while over US$20 million had been received and US$11 million had been spent.[11]

Over two-thirds of all commitments to the pool fund has been allocated to directly funding service delivery at government facilities, thus contributing continuity of service delivery during the transition from relief to development. However, most of the donor commitments to the pool fund have been made on an annual basis, making it difficult for government to depend on the pool fund as a reliable mechanism for long-term funding. Therefore, the certainty of continuity of service delivery is unknown at pool fund supported facilities (approximately one-third of all operate as government facilities). Several

11. *Second Annual Report on the Health Sector Pool Fund*, MOHSW, 2010.

of the main health donors in Liberia do not intend to contribute to the pool fund due to their own administrative policies, indicating that the pool fund will remain only one of several ways in which services are funded.

2.3.3 Other sources

Of the US$37.9 million funds from other sources identified by the 2009 National Health Accounts (for FY 2007–2008), 93 percent are household funds. This high level of household expenditure was unforeseen at the time financial estimates were developed for the 2007 National Health Plan. Data from the 2008 Community Health Seeking Behavior Survey indicated that although a majority of households (63.8 percent) live below the poverty line, each household spent about US$10 per person, per year on health. The survey data also shows that the poorest 20 percent of the population actually spend as much as 17 percent of their annual income on health.

Eighty-five percent of this comparatively high household expenditure, by a generally poor population, was for private services, including private hospitals and clinics (primarily faith-based), private pharmacies and traditional medicine. Only 15 percent of household expenditure was spent on government services. There are many potential explanations for this, but respondents reported lack of drugs in public facilities as a cause for expenditure at private pharmacies. In any case, this amount of household spending on health is very high, especially when compared to the US$4.8 per capita spent by government and compared to the overall per capita health expenditure in Liberia of US$29 per year.[12]

2.4 Policy implications of current health and social welfare financing

2.4.1 Risk pooling

Despite the policy of free services within the framework of the BPHS, the high level of household spending and the catastrophic potential it has for poor households provides ample evidence of the need for financial safety nets. The National Health and Social Welfare Financing Policy and Strategic Plan must explore existing means of solidarity and potential risk-pooling mechanisms such as social insurance as way of enhancing social protection.

2.4.2 Evidence-based financial policy

Relying solely on one three-year-old set of national health accounts data when developing a national health financing policy in a quickly evolving health system gives cause for concern, especially considering the previous experience of policy and planning in the absence of reliable financial data. More recent data is required about actual and projected resources in order to establish and implement a financing policy that is meaningful and will maximize the systematic potential to improve health and welfare of the population.

12. According to the WHO, per-capita total health expenditure in the West and Central Africa Region in 2006 was $28.

2.4.3 Sustainability

As Liberia moves further along the development continuum, the National Health and Social Welfare Financing Policy must anticipate that foreign assistance will decline over time. Therefore, sustained government spending on health and social welfare, as a proportion of the national budget, should increase in proportion to offset the declining donor funds.

2.4.4 Realistic financial planning

In the context of low economic productivity and in the face of numerous national budget priorities, the health and social welfare financial plan (and therefore activities) should rely on resource estimates that are based on past experience and are realistic, not lofty, global commitments by either government or donors.

Despite Liberia's Abuja commitment to allocate 15 percent of the national budget for health and social welfare, experience financing the current National Health Plan has shown that this is not a realistic budgetary expectation on which to base resource projections. Moreover, in the absence of actual evidence for the amount of total resources to anticipate, conservative estimates should be used to ensure that the expansion of the health system described below in section 3.3.1 is accompanied the resources necessary to sustain it.

2.4.5 Efficiency

At US$ 29 per capita, health spending in Liberia is already comparatively high in the West and Central Africa region and the resource envelope is not likely to increase significantly. Service delivery prioritization, accessibility, staffing, infrastructure and resource allocation in general must all be optimized to increase efficiency and maximize the potential impact on both the quantity and the quality of services.

2.4.6 Resource allocation

The intent of the National Decentralization Policy is *at least* to deconcentrate resource management to the county level. The County Health and Social Welfare Teams currently manage less than 1 percent of the financial resources in the sector, and allocation of resources to the counties is not based upon a transparent, equitable formula. The future health and social welfare policy should therefore establish an evidence-based, equitable and transparent formula for allocating resources to the 15 counties. The ten-year plan should articulate how resources will increasingly be distributed and managed at the county level. Revision of the public health law, described in section 1.5, should provide the legal framework within which reside the authority and obligation for the MOHSW to deconcentrate resources.

Reference documents for this chapter

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3. Infrastructure

3.1 Overview

The 2007 National Health Policy approaches infrastructure from the perspective of distribution of facilities in relation to population density, utilization and geographic access. The intent was for the national level to set the distribution ceilings based upon objective planning criteria.

The National Health Plan relies on the 2006 MOHSW Rapid Assessment in which county health officers reported needing to increase the number of facilities from 354 to 550 in order to achieve the number that existed before the war. However, the size of the facility network envisaged in the NHP is not based on evidence of actual affordability and accessibility. Instead, the plan simply projected that minor or major rehabilitation of 110 existing facilities would be required, 30 facilities would need to be reconstructed and 30 new health clinics would need to be constructed in underserved areas.

The plan also asserts that the first two years of implementation would concentrate on the consolidation of health work in existing health facilities, pending a long-term assessment of rehabilitation and construction needs based on utilization, population, geographic access, cost and other socio-economic factors. At the time the National Health Policy and Plan was developed, the Ministry of Health and Social Welfare did not anticipate that it would need to construct many new health facilities in order to meet the service delivery needs of the population.

3.2 Infrastructure policy

3.2.1 Linkages to service delivery

The Basic Package of Health Services provides a detailed description of the types of services, staffing, drugs and equipment that are required at the different levels of the health system for delivery of the BPHS. However, the BPHS does not establish standards for the physical structure (the infrastructure) in which the services should be provided. For example, the need for secure space for patient records, safe storage of essential drugs, patient privacy, infection control requirements and so on are not articulated by the BPHS. Instead, the BPHS provides extensive matrices that list the services to be provided, categorized by "room" (e.g., the "Women's Reproductive Health Room"), for purposes of indicating what medical or non-medical equipment should be available. Confusion was created by the lack of explicit requirements for the physical structure, references to numerous "rooms," and even by some ambiguity in the BPHS service delivery requirements.

In 2008, when the health and social welfare sector began working towards reaching the target number of renovations and new constructions established by the National Health Plan, NGOs in particular began asking what are the minimum spatial requirements for a clinic to meet the BPHS service requirements? According to the BPHS,

"midwives working in rural clinics may be able to do some deliveries, but should concentrate on supporting and supervising the Trained Traditional Midwives." Access to emergency obstetric care for the five main complications of pregnancy is to be accessed at the health center or hospital level of care.[13] The standard for service delivery was left open-ended as to the whether deliveries should be taking place at the clinic level, and by implication whether clinics should include safe, private space for women to deliver. If deliveries will take place, would limited inpatient capacity be required? Would lighting be required for nighttime deliveries?

3.2.2 Absence of infrastructure standards

To resolve these ambiguities related to the physical structures where services are to be provided, in 2008 the Ministry of Health and Social Welfare developed and disseminated a prototype clinic that was to become the approved standard for primary health care service delivery. Figure 9 is a computer-generated depiction of the 2008 clinic prototype. It was proposed that the clinic prototype could be built in stages, depending upon whether maternity services were to be provided, which according to the BPHS essentially depended upon the existence and experience of a midwife. If an experienced midwife was to be recruited, then presumably the full clinic prototype should be built.

The prototype clinic—the lowest level structure in the health and social welfare system—includes 18 separate rooms to accommodate service delivery. The average cost for constructing this facility is $124,415.[14] In the absence of standards for renovation and maintenance, the Ministry of Health and Social Welfare required that not only all new clinic constructions but also all renovations should adhere to the facility space implied by the prototype. But a prototype is an inflexible solution to apply to the variations in service delivery requirements based on actual size of catchment populations and service uptake and is an inflexible solution to renovation needs.

In 2009, when the BPHS accreditation process began to penalize facility accred-

13. *Basic Package of Health Services*, June 2008, p. 18.

14. Based upon ten clinic construction contracts in ten counties (one per county) awarded by the MOHSW in 2009.

Figure 9: Primary Health Clinic Prototype

itation scores based on the physical space available, many NGOs found themselves in a dilemma of potentially being required to invest high levels of inputs into physical structures that did not necessarily link to service delivery requirements and patient utilization. Nevertheless, as of October 2010, 131 renovation or new construction projects were approved by the MOHSW and 82 have been completed since 2008. The long-term assessment of rehabilitation and construction needs based on utilization, population, geographic access, cost and other socio-economic factors envisaged in the National Health Plan was never carried out.

3.3 Infrastructure planning

3.3.1 Expansion of the facility network

The MOHSW Rapid Assessment in 2006 identified 354 functioning health facilities in Liberia, including 306 public and 48 private (mostly faith-based) facilities. In reality while 354 facilities were deemed to be "functional" in 2006, there were more than 550 facilities listed in the Humanitarian Information Center (HIC) database. The MOHSW has built on the HIC database to establish the Infrastructure Development Information System (IDIS) for planning purposes. Over time IDIS has been extensively updated to remove duplication, add missing facilities, and add information regarding facility ownership, donor assistance, facility accreditation scores and primary catchment populations.

Figure 10: Increase in Government, Private, and Total Functional Health Facilities, 2006 to 2010

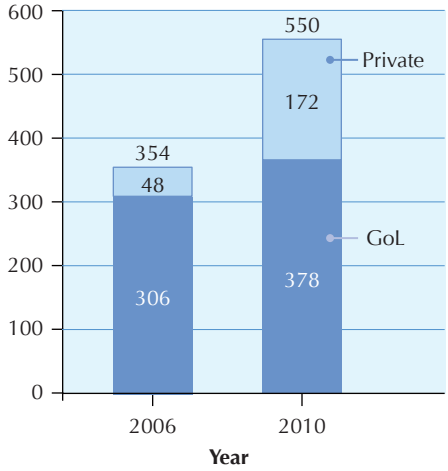


Figure 10 depicts the growth of the functional facility network over the four-year period. In 2010, the number of functioning health facilities equaled the National Health Plan target of 550 (378 public and 172 private). The dramatic increase in functional facilities cannot, however, be fully attributed to improved services. This increase was a combination of improvements in existing public facilities, the opening of approximately 50 new facilities, the addition of previously existing not-for-profit facilities to the database and the inclusion of previously existing private-for-profit facilities (primarily in Montserrado). No analysis has been done of the correlation between intended facility locations and actual locations of newly identified facilities. This comparative analysis should form part of the upcoming ten-year county-planning exercises.

In 2010, 80 percent of the total number (378) of functioning government facilities achieved the minimum score (75 percent) required by the BPHS accreditation process, exceeding the HIPC and PRS target (70 percent). In comparison, only 31 percent of private facilities met minimum facility accreditation criteria (44 percent for not-for-profit (NFP) facilities and 22 percent for private-for-profit (PFP) facilities). The poorer performance of private facilities is due in part to the fact that most of their facilities did not receive donor-funded assistance. Ownership of health facilities is shown in Table 6 (next page). Of 618 health facilities currently listed in the IDIS database, 396 are government-owned, 73 are NFP facilities that are overwhelmingly owned by faith-based organizations (FBO) and 98 are PFP facilities, including company-owned facilities. Most of the PFP-owned clinics, including a number whose ownership has not yet been verified, are located in Montserrado County. Distribution of facilities by ownership and facility type is shown in Table 7.

Table 6: Distribution of Health Facilities by Ownership

County	GOL	NFP	PFP	NA	Total
Bomi	20	2	2		24
Bong	32	5	1		38
Gbarpolu	14				14
Grand Bassa	21	7	2		30
Grand Cape Mount	32				32
Grand Gedeh	17	1			18
Grand Kru	17				17
Lofa	53	3			56
Margibi	18	2	14		34
Maryland	20	4			24
Montserrado	47	34	75	49	205
Nimba	42	12	4	2	60
Rivercess	16	1			17
River Gee	16	1			17
Sinoe	31	1			32
Grand Total	**396**	**73**	**98**	**51**	**618**

Table 7: Summary of Facility Type by Ownership

Owner	Clinic	HC	Hosp	NA	Total
GOL	333	40	23		396
Not for Profit	56	7	10		73
Private for Profit	90	4	4		98
NA				51	51
Grand Total	**479**	**51**	**37**	**51**	**618**

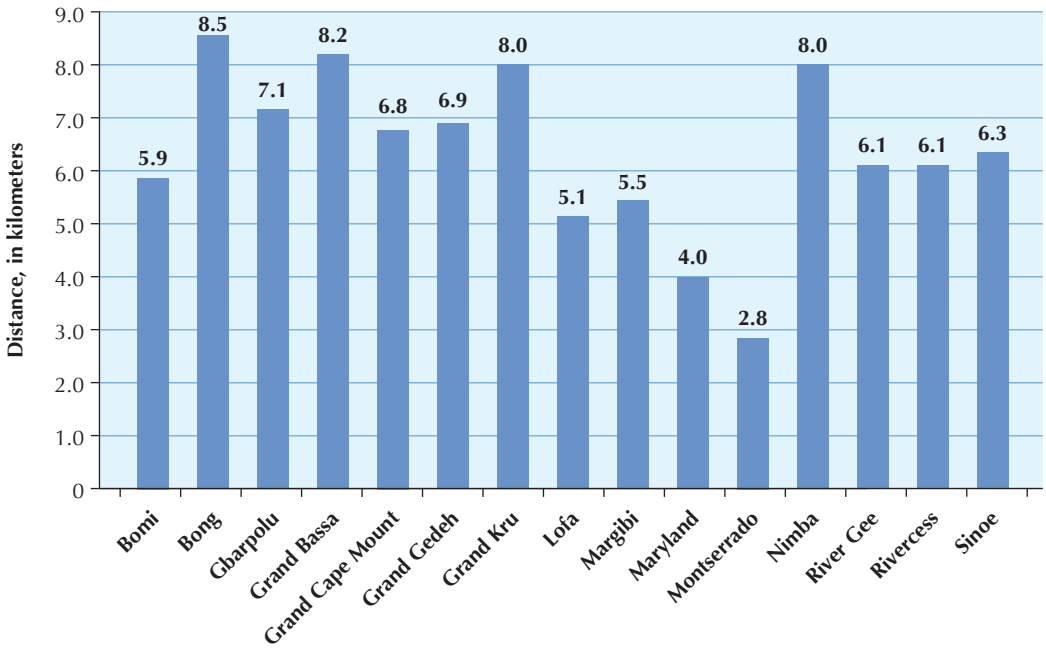
It is noteworthy that ownership of a health facility by a private sector partner and assistance provided to a health facility by an implementing partner are not the same thing. An FBO-owned clinic may (or may not) be receiving assistance from a donor-funded NGO partner. The confusion between NGO implementing partners and facility ownership is an issue requiring clarification in the revised policy and plan in order to better manage sustainable, long-term partnerships.

3.3.2 Geographic access

Health and social welfare service delivery is fundamentally linked to geographic distribution of the population and population density. At the time the 2007 National Health Plan was developed, it had been 23 years since the previous population census, a period during which the country experienced a prolonged civil conflict and significant

population displacement. County and national authorities could not have had an evidence-based grasp of the density and geographic access of the population in relation to health and social health facilities when the 2006 MOHSW Rapid Assessment was carried out. By including rapid assessment targets for renovation, reconstruction or construction of health facilities in the National Health Plan and Poverty Reduction Strategy before having done a thorough study of population distribution, utilization, cost, etc., significant amount of capacity and resources were committed to target results that were neither evidence-based nor supported by recurrent cost projections. Once the sector was committed to the targets, there was little incentive to carry out the thorough study of facility needs based on utilization and population, so it was never done.

Figure 11. Average Distance from Communities to Facilities, by County



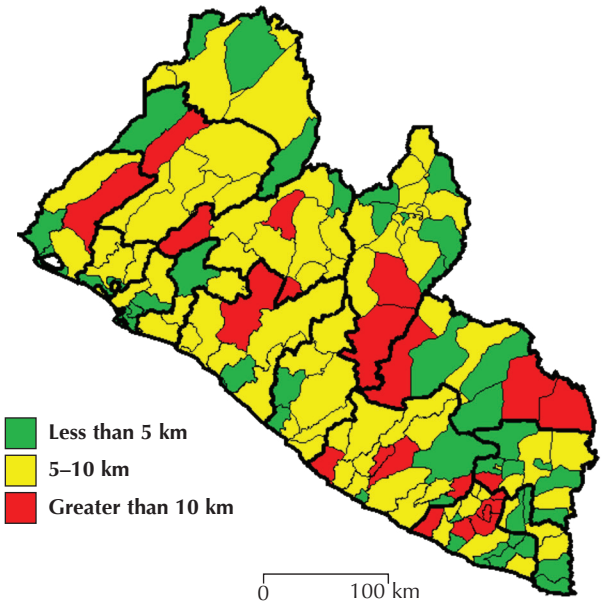
The rapid assessment findings were included in county planning activities; therefore county plans were also not evidence-based in relation to special distribution and population density. It is not clear the extent to which county facility planning was actually implemented. A comparative analysis in this area should form a precursor to future county planning processes. The effective catchment population radius for a clinic established by the BPHS is up to one hour of travel time. The 2008 Population and Housing Census Final Results found 40 percent of all households travel one hour or more (31 percent more than 80 minutes) to the nearest health facility. These findings are supported by a recent survey in Nimba County in which over 1,400 respondents reported having to travel 136 minutes *on average* to reach the nearest facility. Figure 11 presents the average distance from communities to their nearest health facility by county.[15] With the average distances to the nearest facility in most counties well beyond the effective 5-kilometer radius (one hour) established by the BPHS, it is clear that despite the perceived rapid expansion of the network of facilities presented in section 3.3.1, a greater number of optimally sized service delivery points are required in most counties, especially in Nimba, Bong and Grand Bassa Counties.

3.3.3 Population density

The Basic Package of Health Services designates a clinic as a facility serving a catchment population of between 3,500 and 12,000; health centers a population of between 25,000 and 40,000; and hospitals a population of around 200,000 people. Figure 12 (next page) shows the number of functioning government clinics and the size of the

15. Figures 11, 12 and 13 are based on the *RBHS Geographic and Demographic Distribution of Health Facilities in Liberia Report*, November 2010.

Figure 12. Liberia Districts, Distance of Communities from Facilities



catchment population they serve. As indicated, two-fifths of the clinics in Liberia (144 clinics, or 40 percent) are serving catchment populations below the minimum threshold established by the BPHS, while 10 percent of clinics are serving populations that actually warrant a health center.

Figure 13 shows the average size facility catchment population by county. It indicates that in several counties, clinics are serving much larger catchment populations on average, especially Bong, Nimba, Margibi, and Montserrado. Standardizing the quantity of human and material resources provided to facilities according to the BPHS has resulted in clinics in some counties having greater shortages of drugs and a much higher workload than clinics in other counties.

3.4 Policy implications of the infrastructure situation

3.4.1 Evidence-based planning

Effective planning for the provision of health and social welfare infrastructure requires reliable information on the spatial density of the population that will use the facilities, as well as on the service delivery priorities. Recently available population density data, along with geographic distance analysis, service delivery priorities and staffing availability, should form the basis for the county and national planning processes. A comparative analysis of planned versus actual progress in existing county plans should also be a precursor to future county planning in order to increase the likelihood of realistic, future planning.

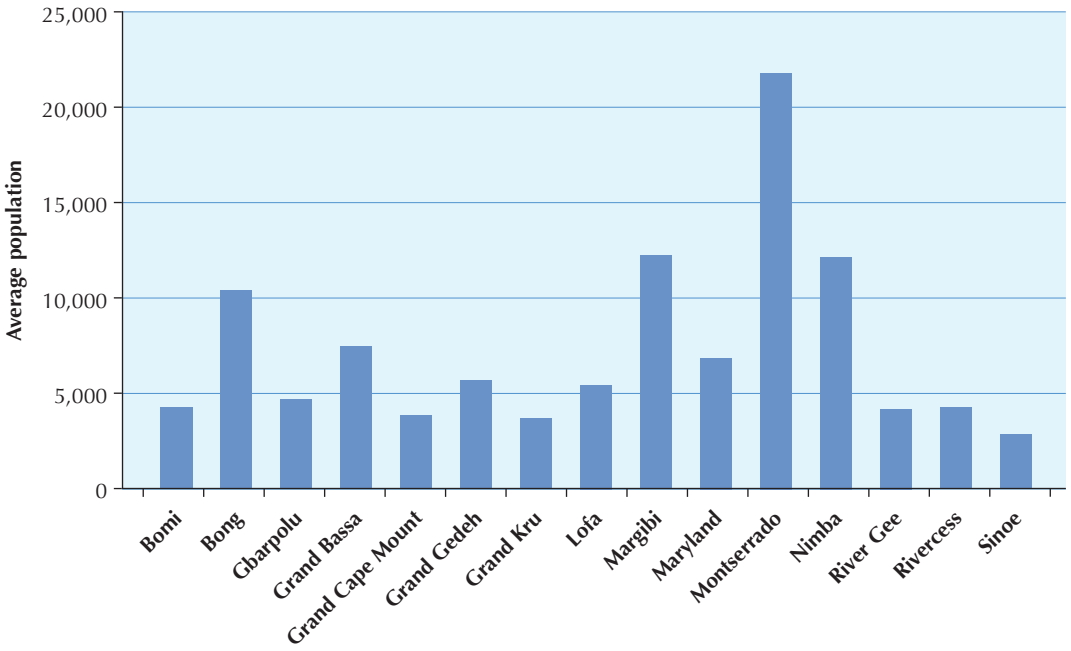
3.4.2 Population-based facility distribution

Based on delivery priorities, the size and density of a catchment population and service uptake should be the principal factors used to determine the number and type of facilities that will serve the area The BPHS effective community catchment population one-hour radius (five kilometers) remains valid, but the facility catchment population criteria should be revised to reflect the wide variations in the size of catchment populations. Additional facility classifications should be established to allow more efficient, incremental increases in resource allocation from smaller to large catchment populations.

In order to predict and control overall costs in the health and social welfare system as a whole, and based on revised facility classifications, policies should be established for national and county planning ceilings that result in more efficient allocation of resources and more optimal distribution of facilities. In urban areas with high population densities, fewer large facilities should serve large catchment populations, which would increase efficiency and take advantage of economies of scale. In low-density rural areas, distribu-

tion of multiple small service-delivery points with appropriate staffing will minimize the distance people have to travel to reach care and will optimize the resource distribution to communities.

Figure 13. Average Size of Facility Catchment Populations, by County (2010)



3.4.3 Standards-based infrastructure

The physical structures for the provision of health and social welfare services should be standards-based, rather than one-size-fits-all prototypes. The type and size of the structures should be closely linked to the services that will be provided and to the catchment populations they are expected to serve. Facility standards allow for greater flexibility and more responsive physical structures, thereby enhancing overall optimization and efficiency. Standards also indicate less-costly renovation and maintenance requirements rather than exclusively relying on expensive new construction. Consistent application of standards would benefit from clear project delivery processes that must be followed for renovation or construction of publicly owned facilities.

Reference documents for this chapter

- *Annual Report*, MOHSW, 2009.
- Kruk et al. (2010). "Availability of Essential Health Services in Post-conflict Liberia," *Bulletin of the World Health Organization, 88*:527–34 .
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- *Second Annual Report on the Health Sector Pool Fund*, MOHSW, 2010.

4. Human Resources

4.1 Overview and objectives

When the National Health Policy and Plan were developed in 2007, the health and social welfare workforce was characterized by scarcity of qualified professionals, gross imbalance in favor of urban areas and low productivity across all cadres of workers. There were wide disparities in workforce remuneration, inconsistent staffing patterns in the facilities, incomplete and fragmented workforce information and no workforce planning and management capacity at all levels. Pre-service training was in a desperate situation and almost non-existent outside of Monrovia.

It was in this context that the Ministry of Health and Social Welfare put in place a strategy to meet immediate human resource needs while improving the overall management, gender balance, appropriate skills mix and equitable distribution of the workforce over time. The four main objectives for human resources that were identified in the National Health Plan are:

1. Ensure a coordinated approach to human resource planning;
2. Enhance worker performance, productivity and retention;
3. Increase the number of trained workers and their equitable distribution; and
4. Ensure gender equity in employment especially in management positions.

Much has been done in less than four years to increase the size of the workforce, to increase the number of qualified professionals and to encourage their equitable distribution across all levels of the system. However, critical workforce issues remain unresolved in terms of planning and management, improving retention, especially in rural areas, ensuring appropriate skills mix, and optimizing staffing levels to improve the workforce efficiency.

4.2 Coordinated planning

Unlike other ministries in the Government of Liberia, in 2008, the Ministry of Health and Social Welfare established a Human Resources Unit to coordinate planning, development and management of the health and social welfare workforce. A human resources director was hired in the central ministry and a county human resource officer has been assigned to each County Health and Social Welfare Team. At the central level, the HR unit is responsible for collecting and disseminating human resource information and at the county level the HR officers are responsible for recruitment and deployment of workers.

With funding from the Health Sector Pool Fund, a human resources information and payroll system has been installed at the central level. A few central ministry staffs have been trained, but the system is not yet being used to its potential. County human resource officers have not been yet trained on it. A draft human resources policy has been developed, but it is not complete and it lacks an accompanying strategic plan.

As was described in section 3.3.3, although the BPHS assigned standards for the number of people to be served by a given type of facility, health facility distribution (or classification) did not strictly reflect the size of the catchment population. Therefore, facility staffing often did not reflect the population, uptake and workload. Because of the perceived need for health authorities to be firm in requiring adherence to BPHS staffing norms, those norms became rigid. Even when it was obvious that some clinics were overstaffed in relation to the catchment population and service uptake, the BPHS minimum staffing was required. As shown in Figure 12 (in section 3.3.3 above), 40 facilities serve catchment populations of less than 1,500 people each and 144 facilities serve populations less than the minimum BPHS threshold for a clinic (3,500), and yet elsewhere, staffs with the same number of personnel serve much larger catchment populations.

In 2008, the BPHS accreditation process began penalizing facilities for staffing gaps without taking into account utilization and underserved areas (the absence of a needed facility). Therefore, as long as there were resources available (as section 2.2 demonstrates was the case), it was in the interest of all stakeholders, from the local community to the national government, to fully staff all facilities according to the BPHS standard, not according to catchment population and utilization. The goal was to attain the highest possible national BPHS accreditation score, which was linked to PRS deliverables and the HIPC debt-relief process.

The sub-optimal human resource allocation reflected a wider trend that had significant repercussions: communities that did not already have an existing government facility when the BPHS was rolled out were less likely to get a new facility because the performance incentive (higher scoring) under the accreditation process was to increase resource allocation to existing service delivery points rather than establish additional ones.

The catchment population information that has recently been added to the IDIS database is based on community-to-facility distances and 2008 census data. This provides the necessary tools to begin to redistribute and reclassify facilities based on population density. If the BPHS staffing norms can respond to these actual, less dense catchment populations, as well as to large, denser populations, the workforce and service delivery could be made significantly more equitable, optimal and efficient.

4.3 Performance and retention

Improving workforce performance requires clarity of roles and responsibilities at all levels and provides appropriate incentives (monetary and non-monetary) on a timely basis. In 2007, establishment of the BPHS salary scale went a long way towards putting an end to the geographic and organizational migration of workers and it was an early step in improving workforce performance. Later steps included developing standard job descriptions for all cadres of the BPHS, establishing standardized facility supervision tools and making resources available for supervision. However, much more could still be done, particularly in underserved rural areas, to improve workforce deployment, retention and performance.

For example, a recent survey was carried out to test how nurses and midwives would respond to some other policies, in addition to provision of the BPHS salary, that are being considered by the MOHSW.[16] The results of the survey were used to estimate, under different schemes, the proportion of nurses and midwives who would accept a job in

16. *Policy Options to Retain Nurses in Rural Liberia: Evidence from a Discrete Choice Experiment.* Ministry of Health and Social Welfare and The World Bank, 2010.

rural areas. Several important recommendations were made that could be very useful for improving rural workforce deployment, performance and retention, including recruiting students for pre-service training from rural areas and increasing salary or allowances for deployment to rural areas.

Recently, new and innovative efforts have also been made in some counties to improve performance at the facility level by providing performance-based incentives. This development has the potential to impact workforce behavior in significant ways, including potentially improving workforce performance. Issues surrounding implementation of performance-based incentives should be closely observed for effectiveness over time, as well as for any unintended effects it may have on workforce migration and service mix.

One area that remains to be explored is the way in which the workforce is a retained, in particular the unskilled worker. The Ministry of Finance made a policy decision in 2010 to cease paying incentives to government volunteers—all necessary government workers should be on the civil service payroll. Line ministries are in the process of implementing this policy. The 2009 National Census of Health and Social Welfare Workers in Liberia reports that of the 8,553 public sector workers, 3,207 are non-clinical, including 707 cleaners, 515 security guards and 457 registrars.[17]

As 'slots' on the civil service payroll are freed up by natural attrition of older members of the workforce and by removal of residual 'ghost workers,' some consideration and prioritization should be made regarding which cadres of workers are eligible to become professional civil servants.[18] In the absence of clear policy guidance on retention, in the future, guards and cleaners could occupy scare spaces on the payroll. When highly skilled clinical workers graduate from pre-service institutions, the government could be unable to hire them. One suggestion, in line with the intent of decentralization, would be for lower level cadres of non-clinical workers such as guards, cleaners, registrars and nurse aides to be paid by the CHSWTs or county administration through the county budget, while highly trained clinical and professional workers could be retained by the civil service, enabling them to be redeployed as required.

4.4 Production and distribution

The National Health Policy and Plan intended that training institutions be assessed to identify their capacities and the relevance of their curricula. The objective was to increase the number and quality of institutions and improve the intake to better reflect both the national demographic as well as the needs of the workforce. An initial rapid assessment of health training intuitions in Liberia was later followed by a more comprehensive review of Monrovia-based institutions and subsequently a national pre-investment survey of pre-service institutions in all parts of the country, which is still going on.[19]

Some of the progress that has already been made in terms of quantity and distribution of pre-service training includes reopening of the Martha Tubman School of Midwifery in Grand Gedeh County, reopening of the Esther Bacon School of Nursing and Midwifery in Lofa County and renovation of the Tubman National Institute of Medical Arts in

17. See Annex II, Breakdown of the Public Sector Health and Social Welfare Workforce, p. 63, for more information.

18. Recently, the Ministry of Finance increased the number of payroll positions for the MOHSW to 4,000.

19. *Assessment of Health Training Institutions in Liberia*, April 2007, MOHSW and the *Comprehensive Assessment of Peri-Monrovia Health Education*, MOHSW Massachusetts General Hospital Center for Global Health, 2008.

Monrovia. A number of activities have also taken place to improve the quality of pre-service training, including revision of the curricula for mid-level health workers, introducing standards of care, improving teaching skills of instructors and clinical preceptors, and updating the skill levels and status of some workers, such as certified midwives, through the National In-service Education Strategy. This strategic intervention resulted in an increase in health workers with competency in Integrated Management of Neonatal and Childhood Illnesses (IMNCI) from 40 in 2006 to 524 in 2010.

The Basic Package for Mental Health Care Services calls for a significant expansion of mental health competency-based trained mid-level providers at the clinic, health center, county hospital wellness units, and tertiary facilities. Consistent with this package, the MOHSW is developing a job classification for the mental health clinician, an intensively trained and credentialed mid-level primary care provider.

At the time of the 2006 MOHSW Rapid Assessment, the sector had 3,966 full-time health and social welfare workers. The emergency human resources plan estimated that Liberia would require a total of 6,000–8,000 health and social welfare workers to meet its workforce needs. In 2009, the National Health and Social Welfare Workforce Census recorded 9,196 health and social welfare workers, an increase of 5,230 workers. Ironically, now that the paid workforce exceeds 9,000 workers, the total workforce gap for clinical workers is less than 10%, just 817 (mostly MDs, PAs and CMs), according to the population-based EHRP targets. However, many of the clinical workers in the census are under-qualified; for example, 44 percent of nurses lack the level of education required by their professional association. Of these 8,553 workers, 62 percent (5,346) are clinical workers and 38 percent (3,207) are non-clinical workers. The increase is largely attributable to the inclusion of non-clinical workers in the 2009 census that were not included in the 2006 rapid assessment; however, other cadres of workers also increased dramatically.

In 2006, there were 453 registered nurses (RNs). Based on the anticipated production capacity, the population-based Emergency Human Resources Plan (EHRP) projected the number of RNs would increase to 609 by 2011. But by the time of the census in 2009, there were already 1,327 RNs in the workforce, triple the number that existed in 2006. At the same time, the number of certified midwives in 2009 had barely reached half the targeted number, and physician assistants (PAs) continue to be in scarce supply. This is significant because using physician assistants is the interim solution for the shortage of physicians, especially at health centers, as well as part of the permanent solution in low-density population settings where a high-cost medical doctor is not practical.

The evidence suggests that workforce needs were not communicated and coordinated well enough by the Ministry of Health and Social Welfare with the pre-service training institutions, and also that the BPHS salary scale may have been an important factor that influenced workforce production. In the BPHS salary scale, registered nurses are paid more than certified midwives, and RNs are more likely to be the officer in charge (OIC) of a clinic. OICs are paid US$75 more per month than a certified midwife. The BSc degree in nursing also offers better career advancement opportunities than does a certification, and nursing trainers are readily available to support increased production.

As the BPHS accreditation process reinforced the requirement to fully staff facilities, registered nurses were hired as fast as they could be produced in order to fill OIC positions at the clinic level. In fact, the 2010 accreditation process identified no staffing gaps for registered nurses in public facilities, although anecdotally hospitals report being unable to adequately staff three shifts per day.

4.5 Gender equity in employment

In terms of ensuring gender equity in employment, no gender policy has yet been developed to guide health and social welfare workforce recruitment. The 2009 human resource census identified that 61.9 percent of the total workforce is male and 38.1 percent female; however, female workers make up 48.7 percent of the clinical cadres. The disproportionate number of male workers is in the non-clinical cadre, where they make up 80 percent. Because non-clinical cadres (3,207) constitute the majority of newly hired workers (5,230) in the scale-up of the workforce, the implication is that overall gender equity actually worsened—a smaller proportion of female, non-clinical health workers were hired during the period and the total workforce now has a smaller proportion of female workers.

4.6 Policy implications of the human resources situation

4.6.1 Workforce planning

Flexible staffing norms, or more variations of standard norms, should be developed that reflect variations in catchment population density, service delivery priorities and actual workload. In facilities where the workload is lighter, multi-tasking should be required (e.g., patient registration, dispensing medicines, and even cleaning could be done by one unskilled worker with a high school level of education). Evidence-based workforce planning provides a major opportunity to increase equitable access, improve optimization and increase efficiency in the health and social welfare service delivery system.

4.6.2 Performance and retention

Improved performance and retention also provides an opportunity to increase more equitable, optimal and efficient service delivery.

Existing options to improve workforce performance by linking recruitment, career development and remuneration to service distribution and service delivery priorities should be incorporated in the human resource policy and plan. Specifically, the BPHS salary scale should be revised to reflect priority workforce production targets and include more variation to reflect distribution and deployment priorities.

In line with the National Decentralization Policy, the human resources policy and plan should establish eligibility for the civil service and mechanisms to support county-level employment of unskilled cadres of workers.

4.6.3 Production and distribution

As a function of the human resources policy and plan, workforce production by pre-service institutions should be coordinated by the Human Resources Unit at the Ministry of Health and Social Welfare according to planning and service delivery priorities.

Tuition subsidies (both institutional and individual) should also reflect planning and service delivery priorities, especially in underserved, rural areas.

Professional boards should be strengthened to verify and better regulate their members' practices. Additional cadres of clinic workers should be created and courses offered to registered nurses to enable them to become physician assistants or nurse practitioners.

Workforce distribution should be closely linked to performance and retention strategies that reflect population density.

Along with more flexible, population-based staffing, coordination, production, distribution and retention should converge on closing the workforce gap for priority clinical cadres, especially PAs and CMs in rural areas, as quickly and efficiently as possible.

Reference documents for this chapter

- *Assessment of Health Training Institutions in Liberia*, MOHSW, 2007.
- *Basic Package of Health Services*, MOHSW, 2007.
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- *Policy Options to Retain Nurses in Rural Liberia: Evidence from a Discrete Choice Experiment*, MOHSW and The World Bank, 2010.
- *Rapid Assessment Report*, MOHSW, 2006.
- *RBHS Geographic and Demographic Distribution of Health Facilities in Liberia Report*, November 2010.

5. Basic Package of Health Services

5.1 Overview

In 2007, the Ministry of Health and Social Welfare sought to establish a consistent package of evidenced-based, essential health services that it could commit to providing to the entire population.[20] Therefore, the Basic Package of Health Services (BPHS) was developed in order to ensure equitable access to health services by increasing the overall efficiency and effectiveness of the health system at all levels. The BPHS prioritizes services that were perceived as the most critically needed at the time to improve the health status of the Liberian population with the resources that were available, including the following six service areas:

1. Maternal and Newborn Health;
2. Child Health;
3. Reproductive and Adolescent Health;
4. Communicable Disease Control;
5. Mental Health; and
6. Emergency Care.

According to the National Health Policy and Plan, the BPHS is intended to be available at every level of the health system and in every publicly-owned health facility in Liberia, as well as in privately owned facilities receiving government subsidy. In 2008, actual provision of the BPHS at public facilities therefore became a core indicator of the government's commitment to restoring basic services.

Since 2008, in part to measure progress against this core indicator, an annual Basic Package of Health Services accreditation survey has been carried out initially at all government facilities, but starting in 2010, at every known health facility in Liberia, including private faith-based and for-profit facilities. According to the January 2010 BPHS Accreditation Final Results Report, 80 percent of publicly owned facilities provide the Basic Package of Health Services to their clients, and Liberia has therefore achieved one of its most ambitious development targets.

However, there are indications that equitable access to efficient, effective health services at all levels remains to be achieved. This section will review the purpose of the BPHS, progress toward its objectives, and issues surrounding its actual implementation that have policy implications for future service delivery. References for additional health data are provided at the end of the section.

20. *National Health Policy* (2007), MOHSW.

5.2 Purpose of the BPHS

The Basic Package of Health Services was established for two over-arching purposes. First, it was established to define a standardized pack of services and, second, to enable resources to be redistributed to allow for universal access to the standardized package.[21]

5.2.1 Standardizing a package of services

Standardizing a basic package of health services essentially means prioritizing which services will be provided and using those priorities to establish criteria and operational plans across the whole spectrum of health service related activities. In 2007, the rationale was that it would create efficiencies in production and procurement that would allow services to be provided more efficiently and, therefore, to a potentially greater number of people.

Establishing service delivery priorities implied that some services would be consciously left out. The BPHS states that although they were high priorities, other program areas such as non-communicable diseases (e.g., diabetes, fibroids, and hypertension), occupational health, complementary medicine and neglected tropical diseases were not included because of resources constraints and sustainability issues.[22]

The intent of creating a standardized package of services was to implement the BPHS as an "indivisible set of services and activities in all health facilities, i.e., a health facility cannot be deemed 'fully functional' until it is capable of providing the entire BPHS to its target population."[23] There were advantages and disadvantages to this standardized packaging approach.

In terms of financing the BPHS, 47 percent of funds for health come from donor sources (see section 2, above). Having a consistent, measurable package of services has enabled facilities, either individually or by groups, to be funded by different donors without inconsistencies in the services being provided. A standard package allowed a competitive bidding process to take place, which might have created additional efficiency and accommodated procurement requirements associated with funding from some donors.

A disadvantage of a fixed package approach was that it encouraged rigid application of criteria and guidelines in the planning process in terms of distribution of facilities, staffing levels and provision of drugs. It also didn't take into account that people would still present at the facility for treatment of illnesses that weren't included in the basic package, thereby becoming an unplanned—and oddly unrecorded—burden on the facility's resources. In this way, a large portion of health care went off-radar but continued to consume important resources. This partial blindness was largely self-inflicted.

5.2.2 Promote redistribution to enable universal access

As presented in section 1.2.2, the population of Liberia is now almost evenly split between urban and rural areas. Roughly one-third of the people live in densely populated Monrovia, while another one-third live in low-density rural areas 80 minutes or more away from the closest health facility.[24] Even if the actual demographic characteristics

21. *BPHS*, Part Two, Purpose of the BPHS, p. 3.
22. *BPHS*, Part Three, Criteria for Inclusion of Health Activities, p. 5.
23. *BPHS*, Part Four, Program Areas and Components, p. 7.
24. *Population and Housing Census Final Results*, 2008

Table 8: Policies and Plans Associated with Rollout of the BPHS

Policies	Strategic Plans
• National Strategy and Policy for Community Health Services (Oct. 2008) • National Mental Health Policy (Jun. 2009) • Sexual and Reproductive Health Policy (May 2009) • National Nutrition Policy (Oct. 2008) • National Policy on Health Service Contracting • Environmental and Social Management Framework (Nov. 2009) • Health Promotion Policy (2009) • HMIS Policy (Jun. 2009) • National M&E Framework and Plan (Jan. 2009)	• National Strategy for Child Survival in Liberia (2008–2011) • Basic Package for Mental Health Services (Jan. 2010) • MMR Road Map: MOHSW (Nov. 2007) • National Malaria Strategic Plan 2010–2015 (Jan. 2010) • National HIV/AIDS Strategic Framework II 2010–2014 • Integrated Guidelines for HIV–AIDS Testing, Care, Treatment • National TB Strategic Plan (Jun. 2009) • Emergency Human Resources Report and Plan (2007–2011) • National In-Service Education Strategy (Dec. 2008) • Policy Options to Retain Nurses in Rural Liberia: Evidence from a Discrete Choice Experiment (Jun. 2010)

had been known in 2007, achieving universal access through a strategy of resource redistribution to such a disparate population would prove to be extremely difficult. It involves striking a balance between reducing per-capita investments in high-density urban areas and consequently achieving economies of scale with larger facilities, in order to invest higher per-capita resources in inefficient, low-density rural areas. And it requires accurate, detailed data about the demographic and the flexibility to allocate resources according to variations in size, density and distance of the population in relation to the services provided. Imprecision in the resource distribution formula and assumptions based on inaccurate or incomplete data could have significant, unintended consequences.

As funding was channeled into contracting provisions of the BPHS at 292 health facilities across the country (see section 2.3.2), the scale of potential inefficiency resulting from imprecise facility distribution and rigid guidelines becomes significant (see Figure 12 for the breakdown of facilities versus their actual catchment population). Given that all contracting of the BPHS is done with donor funds and that donor funding is almost twice as likely to be spent on clinics and health centers (35 percent) than on hospitals (20 percent), inequities in resource redistribution related to BPHS contracting have generally been in favor of primary health care at the expense of secondary care.

According to recently released detailed census data, catchment populations in Liberia are significantly less dense than was assumed in many rural areas and, conversely, they are much denser than assumed in urban areas, especially in Monrovia. There are service delivery implications for extreme variances in the demographic and in urban versus rural health that also make rigid application of guidelines (HR, infrastructure, etc.) and 'indivisible' bundling of priority services less likely to be effective.

5.3 Rollout

One common misconception is that the Basic Package of Health Services was rolled out quickly across all levels of the health system. To the contrary, before actually delivering the indivisible set of services and activities an enormous amount of preparatory activity was required. Policies, strategic plans, treatment guidelines and protocols had to be developed for all of the priority interventions in the BPHS. Training packages had to be designed and delivered and processes for measuring progress had to be established. Table 8 presents an indicative list of national polices and strategic plans that were developed to accompany delivery of the BPHS, while others remain to be developed such as a national strategy for delivery of emergency obstetrics and neonatal care.

Developing these policies and strategic plans facilitates service delivery regardless of the existence of the BPHS, so they should not be seen as obstacles to the rollout process or a waste of scare resources. But with such a large number of policies and plans involved in establishing the standards and criteria for delivery of the BPHS, the rollout not surprisingly took considerable time and dedication. Moreover, changes to the BPHS will necessitate revision of a good deal of the accompanying policies, plans, guidelines and protocols.

5.4 Health status

According to the National Health Plan, the following areas were to be tracked during the implementation of the BPHS:

- Improved maternal health;
- Improved child health;
- Increased equitable access to quality health care services (the BPHS);
- Improved prevention, control and management of major communicable diseases; and
- Improved nutrition status.

This section provides a snapshot of the current status of these areas, as well as for mental health. Increased access to the BPHS was covered above in section 3.3.2.

5.4.1 Maternal health

The 2007 Demographic and Household Survey (DHS) identified that the maternal mortality rate increased over the preceding seven years from 578 deaths per 100,000 live births in 2000 to 994 deaths per 100,000 live births in 2007. The total fertility rate was 5.9 and the contraceptive prevalence rate was just 11 percent. The DHS also reported that a professional health worker assists only 46 percent of women during birth and only 37 percent of deliveries take place in a health facility. The 2009 Liberia Malaria Indicator Survey (LMIS) augments the 2007 DHS findings by reporting that the proportion of women who have already given birth or become pregnant by the age of 19 increased from 29 percent in 2000 to 38 percent in 2009. The Roadmap for the Reduction of Maternal and Child Mortality was developed in line with MDG target 5 in order to reverse the alarming trends identified in the DHS and LMIS.

5.4.2 Child health

The 2007 DHS also reported that the infant mortality rate declined from 144 deaths per 1,000 live births in 1986 to 71 deaths per 1,000 live births in 2007, in line with Millennium Development Goal 4. The under-5 mortality rate followed the same trend, declining from 220 deaths per 1,000 live births in 1986 to 110 deaths per 1,000 lives births in 2007. The 2007 DHS findings for infant and child mortality rates in Liberia were below the sub-Saharan Africa averages of 102 and 171 deaths per 1,000 live births, respectively. The evidence indicates a gradual decline in infant and child mortality in Liberia that began as far back as the mid-1980s. However, despite the progress that has been made, many health problems persist. The full vaccination coverage rate remains low (51 percent) and malaria, acute respiratory infections (ARI), diarrheal diseases, and malnutrition remain the main causes of under-5 deaths. To address these persistent challenges, the 2009 Community Health Strategy was developed, which includes a community-level strategy for Integrated Management of Childhood Illness.

5.4.3 Communicable disease

- *HIV:* According to the Liberia Health and Demographic Survey (LDHS), the prevalence of HIV in the country was 1.5 percent in the general population, ages 15–49 years. According to an antenatal sentinel surveillance survey conducted in 2008, the prevalence of HIV among pregnant women attending antenatal clinics in Liberia was 4 percent. The MOHSW has scaled up HIV and AIDS service delivery points to 162 HIV counseling and testing (HCT) sites, 142 prevention of mother-to-child transmission (PMTCT) sites, and 24 HIV care and treatment sites. The anti-retroviral therapy (ART) coverage in the general population has increased to 34 percent as of June 2010.
- *Malaria:* Malaria is the leading cause of morbidity and mortality with 38 percent of out patient attendance and 42 percent of in-patient deaths attributable to malaria.[25] The major achievements in malaria control include: 47 percent of households have at least one insecticide treated bed-net (up from 18 percent); 45 percent of women are receiving two or more intermittent, preventative treatments (IPT) during their most recent pregnancy (up from 4.5 percent); 17 percent of children under 5 are receiving prompt and effective treatment for malaria within 24 hours of the onset of fever (up from 5 percent). Overall, the malaria prevalence has reduced and access to prompt and effective treatment has expanded.
- *Tuberculosis:* The Ministry of Health and Social Welfare has struggled to scale up TB and leprosy services at the same time as malaria and HIV. While 5,964 patients were placed on TB treatment regimes in 2009, only 232 (4 percent) were treated through a community-based treatment program. The vast majority of patients continue to rely on facility-based treatment, with its known associations to stigmatization and increased cost to the patient.

5.4.4 Nutrition

The 2010 Comprehensive Food Security and National Survey (CFSNS) found that nationally 42 percent of Liberian children under 5 were stunted, increasing their risk of

25. Liberia Malaria Indicator Survey, MOHSW, 2009

dying from normal childhood illness and risk of chronic illness later in life. Rural areas have more cases of stunting that than urban areas, and Montserrado has the lowest prevalence at 31 percent, while nine other counties exceed 40 percent. The National Nutritional Policy was developed in 2009 to improve the nutritional status of the population, especially children. The national food security and nutrition strategy is multi-sector and oriented toward communities, households and individuals to reduce the high levels of food insecurity and malnutrition.

5.4.5 Mental health

Epidemiological studies indicate high rates of mental illness, as well as high rates of exposure to sexual violence, post-traumatic stress disorder and substance abuse. However, there is only one practicing psychiatrist in the country and only a handful of trained mental health nurses, and clinical mental health services remain centralized. There are no outpatient or inpatient treatment options available at health clinics or health centers; only Grant Hospital maintains an in-patient psychiatric ward. To begin to address these issues, the National Mental Health Policy was established in 2009. The policy mandates a decentralized approach to integrate mental health and neuropsychiatric care into the primary health care system. It provides for increasing the clinical capacity of mental health professionals and the primary health care workforce to meet the mental health needs of the population, as well as for basic epidemiological research to inform training, policy and practice in a culturally appropriate context.

5.5 Levels of delivering the BPHS

Universal access to the prioritized services in the BPHS included providing a limited package of services at each level of the health system, from the community to referral level hospital care. Table 9 (on pages 40–41) presents an abridged summary of the BPHS in the left column and in the columns on the right the availability and level of resources allocated to them, based on the catchment population.

Community level. Additional services (marked with "*" in the table above) have been added to original BPHS community-level services provided by the gCHV/TTM (General Community Health Volunteer/Trained Traditional Midwives), according to the 2008 Community Health Services Policy and Strategy (especially in support of EPI activities). The striking aspect of Table 9 is the similarity of services expected to be provided at the community level by unpaid, poorly managed gCHVs/TTMs and the services provided at the clinic level by a complete team of professional, paid employees.

Moreover, given that 40 percent of households live one hour or more away from the nearest health facility (and therefore outside of the BPHS effective catchment population radius), there are few services exclusive to the clinic level that would encourage people to make the journey. By rigidly applying resource allocation criteria such as the minimum catchment population for establishing a new clinic, unskilled, volunteer health workers are expected to provide a majority of basic services for a substantial portion of the rural population.[26] Not surprisingly, implementation of the community health strategy has experienced significant delays and likely contributes to difficulties in implementing high-impact interventions such as EPI and district-level micro-planning.

Primary level. At the primary level, in addition to serving the immediate catchment

26. *Population and Housing Census Final Results*, LIGIS, 2008.

Table 9: Abridged Summary of the BPHS, Levels of Resources and Catchment Populations

Catchment Population / Interventions and Services	1 to 2,000	3,500 to 12,000	Up to 40,000	Up to 200,000
	gCHV or TTM	Clinic	Health Center	Hospital
1.0 Maternal & Newborn Care				
1.1. Antenatal care				
Diagnosis of high-risk pregnancy	Yes	Yes	Yes	Yes
IPT with SP, iron supplementation, ITNs	Yes	Yes	Yes	Yes
Treatment of malaria	*	Yes	Yes	Yes
1.2. Labor and delivery care				
Identify fetal malpositions	Refer	Refer	Yes	Yes
Normal vaginal delivery	Yes	Yes	Yes	Yes
Emergency obstetric care	Refer	Refer	Yes & Refer	Yes
PMTCT Package	Yes	Yes	Yes	Yes
1.3. Post-partum Care				
Prevention and detection of puerperal infection	Yes	Yes	Yes	Yes
Detection and treatment of anemia	Yes	Yes	Yes	Yes
Counseling on birth spacing and FP service	Yes	Yes	Yes	Yes
1.4. Care of the newborn				
Emergency neonatal care	Refer	Yes	Yes	Yes
Manage neonatal infections and sepsis	Yes & Refer	Yes & Refer	Yes	Yes
HIV care/replacement feeding, Immunizations	-	Yes	Yes	Yes
2.0. Child Health				
Vaccine security/cold chain	-	Yes	Yes	Yes
EPI, BF, GM, Vitamin A, deworming, ITNs, ORT	Yes	Yes	Yes	Yes
Management of pneumonia, fever and malaria	Yes	Yes	Yes	Yes
Identify and manage dehydration/severe diarrhea	Yes & Refer	Yes & Refer	Yes	Yes
3.0 Adolescent, sexual, and reproductive health				
3.1 Family planning				

Table continues →

population, a facility should receive referrals from gCHVs and TTMs in surrounding communities, especially for complicated deliveries. Although evidence indicates that institutional deliveries are gradually increasing, according to the 2010 BPHS accreditation report only one in three clinics is providing basic emergency obstetrics care because these services are not required under the BPHS at a clinic. In the absence of basic EmOC at the clinic level, as indicated in Table 8, emergency obstetrics referral is from the community gCHV/TTM to the nearest 24-hour facility (either a health center or hospital). More analysis is required to determine the average distance (and travel cost)

Catchment Population / Interventions and Services	1 to 2,000	3,500 to 12,000	Up to 40,000	Up to 200,000
	gCHV or TTM	Clinic	Health Center	Hospital
Distribute oral contraceptives and condoms	Yes	Yes	Yes	Yes
DMPA injection	-	Yes	Yes	Yes
Intrauterine devices	-	-	Yes	Yes
3.2 Adolescent health				
Substance abuse prevention, family life education	Yes	Yes	Yes	Yes
Oral contraceptives and condom distribution	Yes	Yes	Yes	Yes
4.0 Disease Prevention, Control & Management				
4.1 HIV/AIDS				
ABC promotion and condom distribution	Yes	Yes	Yes	Yes
Home-based care	Yes	-	-	-
Treatment of opportunistic infections	-	-	Yes	Yes
VCT, PMTCT	-	Yes	Yes	Yes
Blood screening and antiretroviral therapy	-	-	-	Yes
4.2 Control of malaria				
Clinical diagnosis	Refer	Yes	Yes	Yes
RDT/microscopy, treating uncomplicated cases	*	Yes	Yes	Yes
Distribution of ITNs and IPT	Yes	Yes	Yes	Yes
4.2 Control of tuberculosis				
Case detection–sputum smear	Refer	Refer	Yes	Yes
DOTS and active case-finding in community/ OPD	Yes	Yes	Yes	Yes
BCG vaccination	*	Yes	Yes	Yes
5.0 Essential Emergency Treatment				
Shock, injuries, poisoning	Yes & Refer	Yes & Refer	Yes & Refer	Yes
6.0 Mental Health				
Diagnosis and treatment	Refer	Refer	Yes	Yes

of households to the nearest 24-hour facility to better understand the implications on access to emergency obstetrics care.

Referral level. In the absence of a national assessment on the status of secondary health care, the BPHS accreditation process is the only national measure of secondary health services.[27] According to the 2010 BPHS accreditation report, 23 of 30 health

27. A national survey on the availability of Comprehensive Emergency Obstetrics and Neonatal Care will be completed in early 2011.

centers and 17 of 18 hospitals were accredited for provision of the BPHS. But the overall accreditation results do not reflect the poor condition of hospitals and the generally low quality of secondary health care. The accreditation report found that of the 15 county hospitals intended to be providing comprehensive EmONC services, only 10 were providing all the required comprehensive services. The same report found that only 15 health centers were providing all of the required basic services for basic EmONC. It appears that the general preference to fund the BPHS at the primary health care level and the inefficiencies in sub-optimal resource distribution across the entire health system have indirectly resulted in substandard secondary care.

5.6 Implications of the BPHS

5.6.1 Efficiency and effectiveness

Although the priority interventions included in the Basic Package of Health Services are evidence-based and each stands on its own merits, bundling an "indivisible" set of limited services and establishing strict criteria and standards for their implementation has resulted in unresponsive service delivery and inaccurate resource commitments. Continuing to 'go-to-scale' with this formula without the flexibility to optimize has created an inefficient and ineffective service delivery system based on high levels of donor inputs.

In response to trends in funding for the BPHS and reflecting actual population density in urban and rural areas, generally these inefficiencies have occurred to the advantage of the primary health care level and come at the expense of the secondary level of service delivery. However, given the poor geographic access of rural communities, any potential excess capacity at the primary health care level will be called upon to deliver primary care closer to rural populations. More analysis is needed to determine what resources are required at the referral level and how best to incrementally optimize between the smallest health center and the largest hospital, avoiding the same inflexible resource allocation strategy that has become apparent at the primary healthcare level.

5.6.2 Opportunities for revision

While there have been trade-offs between creating built-in flexibility in what and how the services are provided and creating a package of services that is easier to plan, fund, procure and monitor, the trade-offs are tractable. By expanding the types of services planned and provided, and by making service delivery modalities more flexible, accompanied by optimal planning, the efficiency and effectiveness of service delivery can still be improved.

Using reliable data that was not available in 2007, a variety of services could be provided at government facilities that are responsive to the health needs of the local population. In addition to the existing limited package of services currently provided, over the course of the next decade other priorities could be included, such as non-communicable and neglected tropical diseases, environmental and occupational health, and eye and even dental health. A functional referral system would ensure efficient patient access to the variety of services available through the appropriate levels of the health system, from the community to the clinic, to secondary and tertiary levels of care. Additional services, including basic mental health and basic social welfare services, could be gradually incorporated at service delivery points at all levels in the system.

In low-density catchment areas where 40 percent of Liberians reside, multiple smaller service delivery points, staffed by skilled health professionals, could respond to community-level needs, and these smaller service delivery points could rely upon referrals to an accessible next level of care, especially for basic, life-saving emergency services. In densely populated urban areas, the particular service delivery needs and priorities of urban health would be addressed by having a small number of large facilities that can handle a high volume of patients. In all cases, evidence-based planning for service delivery can now be done at the district, county and national levels to reflect the disease burden and demographic characteristics of the whole population.

Reference documents for this chapter

- *Annual Report*, MOHSW, 2009.
- *Basic Package of Health Services*, MOHSW, 2007.
- *Basic Package of Health Services Accreditation Final Results Report,* MOHSW, 2010.
- *Basic Package for Mental Health Services*, MOHSW, 2010.
- *Community Health Services Policy and Strategy*, MOHSW, 2008.
- *Comprehensive Food Security and Nutritional Survey, 2010.*
- *Demographic and Health Survey*, LIGIS, 2007.
- *Liberia Malaria Indicator Survey*, MOHSW, 2009.
- *National Health Policy and Plan*, MOHSW, 2007.
- *National Mental Health Policy and Strategic Plan*, MOHSW, 2009.
- *National Nutrition Policy*, 2009.
- *Population and Housing Census Final Results*, LIGIS, 2008.
- *Rapid Assessment Report*, MOHSW, 2006.

6. Social Welfare

6.1 Overview

In the situation Liberia finds itself in today, almost half of the population live in chronic poverty, 16 percent are disabled, 7.2 percent of all children are orphaned, there are over 100,000 demobilized former soldiers, over 12,000 demobilized children, and an unknown number subject to human trafficking. There are an estimated 1,500 persons in the prison system, of which 85 percent are pre-trial detainees, living in deplorable conditions and without access to basic medical care. Of the vulnerable populations, there are those who are especially vulnerable, including children in trouble with the law, children living outside of appropriate care, elderly persons living alone, elderly-headed households, households without any labor resources, and adults and children subject to human trafficking. Understanding vulnerable groups is, therefore, critical to a situational analysis of social welfare. Vulnerability is defined in the National Social Welfare Policy as the susceptibility to harm due to forces outside of one's control. Not all persons and households are vulnerable, and not all of those who are vulnerable are vulnerable in the same manner.

As a conceptual tool, it is useful to consider vulnerability in terms of the resilience of society in ordinary and extraordinary times, the strength of livelihood strategies to cope with short-term and long-term crises, and the quality and quantity of resources that can be drawn upon to minimize the impacts of vulnerability. The most serious impact of instability, war, and misrule is the collapse of the system that brings people together for purposes of mutual protection and development. This system of 'social capital'—the extent to which people can rely on each other in times of need, and the extent to which people organize locally to attain shared objectives—has been severely weakened in Liberia, with particularly negative implications for the most vulnerable.

At this point in time, Liberia has a daunting task to respond to the problem of vulnerability. The government lacks sufficient resources, an institutional framework, laws and regulations to respond to the needs of the vulnerable. Equally important, Liberia lacks the orientation to enable a community-based response to build a demand-driven approach that strengthens the voice and influence of vulnerable groups themselves. The social welfare practitioners in Liberia lack an agreed definition of the populations which they are responsible for, the advocacy skills and experience needed to influence others, procedures to prioritize those most in need and the coordination infrastructure necessary to guide a coherent response.

6.2 Progress

In the face of this situation, the Ministry of Health and Social Welfare completed the process of developing a National Social Welfare Policy in 2009. The participatory process included national and international nongovernmental and faith-based organizations (NGOs and FBOs), bilateral and multilateral partners, other government ministries,

departments and agencies, but the overall leadership was provided by the Ministry of Health and Social Welfare. Due to the breadth of the social welfare issues, the policy has three policy goals:

1. A strengthened enabling environment for social welfare, protection and enhancement;
2. Relevant social services provided to populations in need in a cost effective manner, based on systems that support effective demand; and
3. Improve and enhance social capital systems that increase choice, reduce risk and protect the most vulnerable.

The three policy goals have a total of eight objectives that provide direction for accomplishing the goals.

Goal 1: Enabling Environment

i. To enhance institutional capacity in Government, partner organizations, and decentralized institutions;
ii. To strengthen the Government regulatory system;
iii. To improve the policy, planning and strategic environment.

Goal 2: Social Services

iv. To design and implement a multi-pronged, multi-sector social welfare system that targets those most in need with priority social welfare services, and that supports the attainment of basic needs services such as education, health, water and sanitation among all vulnerable groups;
v. To design and implement improved systems of financing and accountability for the provision of social welfare services.

Goal 3: Social Capital

vi. To consultatively design and implement effective programs to enhance community capacity, taking care to ensure the inclusion of the rights-holding disenfranchised;
vii. To focus attention at the community and sub-community levels aimed at strengthening the influence and social organization of the most vulnerable;
viii. To strengthen local systems of governance in communities and build the capacity of community groups to overcome negative coping strategies associated with, among others, violence, alcohol and drug abuse, discrimination, ethnicity, beliefs, or health status.

Two priorities were outlined in the Policy: (1) sector strengthening, and (2) protecting Liberia's most vulnerable. These two priorities guide the actions elaborated in the Draft National Social Welfare Plan of Action 2009–2016, which was designed in two stages, 2009–2011 and 2012–2016.

Stage One. Only preparatory actions were proposed for 2009–2011 that would set the groundwork for the five-year period to follow, including:

- Beginning a process that will yield three Regional Social Welfare Action Plans during the 2011/12–2015/16 Plan period.

- Holdtng discussions with service providers to prepare proposals for innovative community outreach programs.
- Holdtng discussions with the Ministry of Internal Affairs to determine how it can engage in the design of the National Emergency Plan and National Emergency Strategy.
- Supporttng a process of curriculum review and development and in-service training opportunities for social workers, and seektng financing for substance abuse programs and a behavioral change communications investigation.
- Worktng closely with the Ministry of Justice with regard to juvenile justice procedures.
- Conducting a child protection needs assessment. If warranted, an action plan for a rapid response initiative for child protection will be developed.

Initial progress on the proposed two-year phase has been to develop a plan to de-institutionalize 5,000 children in welfare institutions. The De-institutionalization Plan of Children in Welfare Institutions implementation process calls for an Independent Accreditation Committee (IAC) to monitor, evaluate and recommend approval or closure for welfare institutions. The IAC committee, chaired by the Ministry of Justice, has been established and regulations and tools for residential childcare institutions have been developed. UNICEF, Save the Children, Don Bosco Homes, MYS, MOJ, MIA, MOE, MOGD, and the Liberia Repatriation, Resettlement, Refugees Commission (LRRRC) are all key stakeholders who are members IAC. A Technical Working Group has also been established to oversee the plan implementation.

In terms of juvenile justice, the Ministry of Justice is responsible for the prosecution of juveniles. The Women and Children Unit ensures that children's rights are protected when they come in contact or conflict with the justice system; however, none of Liberia's prisons has a functioning clinic, cells are overcrowded and unhygienic, and no resources are provided for healthcare. The Women and Children Unit collaborates with the Juvenile Division at Ministry of Health and Social Welfare while the Judiciary adjudicates their cases. The Ministry of Education ensures that children are provided free primary education, the Ministry of Labor makes sure that juveniles are not subjected to hard labor, and the Ministry of Gender ensures that children are not abused. Don Bosco Homes and the Child Fund are responsible to provide safe home protection services and for juveniles referred from the Ministry of Health and Social Welfare. UNICEF is the lead funding partner for the national child justice program. The MOHSW has increased its collaboration with other relevant line ministries, especially the Ministry of Justice, and other partners in carrying out the National Child Justice Program being supported by UNICEF.

To strengthen human resources, the National Social Work Association Board of Liberia has been established and is working with the National Association of Liberia Social Workers to address the social worker issues in Liberia, including curriculum review and development, pre-service and in-service training, accreditation and deployment of social workers.

Stage Two. During the five-year phase (2012–2016) of the National Social Welfare Plan, the critical activity for sector strengthening is the participatory development of a National Strategic Framework for Social Welfare, requiring the extensive involvement of state and non-state actors. This work is not yet underway, but the main elements of the Strategic Framework would at a minimum require the following:

1. Purpose: casting the social welfare response in terms of national development (policy, plans, national policies, poverty, development planning, etc.) and detailing the reform and reorientation that is central to the success of the policy and plans;
2. Human resource framework (hiring, pre-service training, in-service training, placement), including consideration of skills profile (case work, coordination and facilitation skills, development planning), resource availability, and cost estimates;
3. Specific consideration of support to a cadre of development workers able to assist with community-based social service delivery, and coordinate the community-level response with district level developmental social workers;
4. Institutional and management framework (including a clear definition and elaboration of roles for various Government ministries, parastatals, and non-state actors);
5. Financial framework (disbursement, monitoring and audits, financial absorption capacity and constraints, procurement and procurement management);
6. Monitoring and evaluation framework (systems, information management, subnational and national monitoring, progress reporting, evaluation, research, and integration with ministerial and national M&E systems and information needs).

Although not yet under way, during the same five-year phase and in order to protect Liberia's most vulnerable people, the critical activity should be:

1. The 2009/10–2010/11 Plan of Action period will focus on the development of guidelines on reunification for social workers using a case management approach; consideration of community-based strategies will be elaborated during the 2011/12–2015/16 plan period.
2. Conduct feasibility study of places of safety for women and children, including the pending one in Monrovia
3. Create a Joint Team across the Ministry of Justice and the Ministry of Health and Social Welfare to review the situation of children in conflict with the law.
4. Employ the Joint Team from the Ministry of Justice and the Ministry of Health and Social Welfare to review the issue of children seeking legal assistance.
5. The Ministry of Health and Social Welfare will commission a consultancy to conduct a situation analysis of the most vulnerable children living outside of family care, the aged, and trafficking of women and children.
6. Ministry of Health and Social Welfare will hold discussions with service providers to prepare proposals for innovative community outreach programs and pilot a community-based initiative for a demand-driven approach to the provision of social welfare services.
7. Ministry of Health and Social Welfare will support a process of curriculum review and development and in-service training opportunities for social workers, and will seek financing for substance abuse programs and a behavioral change communications investigation.

Finally, to support effective plan implementation and as a matter of urgency, a full-time Plan Coordinator should be appointed for two years, supported by an Assistant Plan Coordinator. These two officers would be based in the Ministry, but much of their time would be focused on working with other ministries and non-state actors.

6.3 Lessons learned

Although the implementation of the National Social Welfare Policy is perhaps too fresh to discern lessons about reducing vulnerability, nonetheless, some process-oriented lessons can be learned from the recent implementation. On the constructive side, the importance of working collaboratively within multi-sector coalitions was evident in the development of high-level committees for important issues such as adoption and welfare institutions. However, while a number of important activities were initiated during Stage One in the areas of juvenile justice and child protection, failure to finalize the Draft Social Welfare Action Plan resulted in divergences or delays of other important activities. For example, developing innovative community outreach pilot programs to increase social capital was not prioritized. This will impede the planning of specific activities for Stage Two and will make it difficult to integrate community-based social welfare with community-based health activities.

Another lesson learned at this point is that Stage Two (2012–2016) social welfare sector-strengthening priorities (from the Strategic Framework) align closely with components of the National Health and Social Welfare Plan, including human resources, financing, governance and decentralization, service delivery (including at the community level), monitoring and evaluation. With the development of an integrated health and social welfare policy, these components of the strategic framework need not be developed in isolation.

6.4 Policy recommendations

1. The concept of a social welfare strategic framework should be de-emphasized. Social welfare stakeholders should rely on the health and social welfare policy and plan process in order to resolve workforce needs, financing issues, infrastructure requirements and support system needs.
2. The Stage Two social welfare plan of activities for 2012–2016 should be developed as part of the National Health and Social Welfare Policy ten-year planning process.
3. Incomplete stage one (2009–2011) preparatory activities should form part of the first-year implementation plan for the Health and Social Welfare Ten-Year Plan.
4. A set of social welfare services and activities for each level of the system should be developed as a priority in order to be incorporated into the National Health and Social Welfare Ten-Year Plan being developed.

Reference documents for this chapter

- *National Health Policy and Plan*, MOHSW, 2007.
- *National Social Welfare Policy*, MOHSW, 2009.
- *National Mental Health Policy and Strategic Plan*, MOHSW, 2009.
- *Population and Housing Census Final Results*, LIGIS, 2008.
- *Rapid Assessment Report*, MOHSW, 2006.

7. Pharmaceuticals and Health Commodities

7.1 Overview

The overall goal for the pharmaceutical subsector established in the National Health Policy is to increase access to efficacious, high-quality, safe and affordable medicines for people in Liberia. The policy makes a series of statements about the purpose of the subsector in relation to policy and regulation, availability, rationale use, strengthening the professional associations and good management practices. The National Health Plan includes lists of activities related to the policy statements. While important information is provided in the plan, it is not presented in a clear actionable way to accomplish priorities. Therefore, this section presents a situational analysis of the main policy and regulatory issues established by the National Health Policy. What has been done? What is still planned? And what are the policy implications for the National Health and Social Welfare Policy and Plan process currently under way?

7.2 Policy and regulation

7.2.1 Policy

The National Public Health Law assigns responsibility for the pharmaceutical subsector to the Ministry of Health and Social Welfare. The MOHSW developed the Liberian National Drug Policy in 2001, which describes in very broad terms the components of the pharmaceutical subsector to be established, strengthened or restructured. The NDP is a broad document, combining both policy and strategy, but it lacks requisite and contemporary detail, and it has neither been implemented nor revised since that time.

The existing Essential Drug List (EDL) was revised in 2007 to correspond with the Basic Package of Health Services; however, some drugs listed on it are obsolete and the revisions are incomplete. Standard Treatment Guidelines have been revised for those services provided by mid-level health professionals, but a complete revision for all services associated with the BPHS has not been completed. Building on the foundations of a revised National Drug Policy, revised and complete Essential Drug List and complete Standard Treatment Guidelines, the National Formulary needs to be revised to become the standard therapeutic instrument used in the Liberian health sector. Other related policies that have recently been developed or are pending include:

- The National Mental Health Policy and Basic Package of Mental Health Services, which include psychotropic drug requirements;
- The pending Human Resource Policy and Plan, which governs planning, production, deployment and retention of pharmacists;
- The pending National Health and Social Welfare Financing Policy and Plan,

which will provide the financing framework for the National Drug Policy and strategic implementation plan;
- The recently developed National Supply Chain Master Plan;
- Integrated Guidelines for HIV–AIDS Testing, Care, and Treatment; and
- The National In-Service Education Strategy (December 2008).

7.2.2 Regulation

Currently there are no formal regulations governing the import-export and transit of medicines and health products in Liberia and therefore no legal means for the government of Liberia to stem the importation of counterfeit commodities. An act to create the Liberian Medicines and Health Product Regulatory Authority (LMHRA) was passed by the legislature in 2010 to address this situation; guidelines and regulations will be established by the LMHRA. The MOHSW's Office of General Counsel has established legally a compliant process for the promulgation of regulations and will support the LMHRA in the development of such regulations in 2011. The National Drug Technical Committee described in the National Health Policy does not yet exist, although the MOHSW intends to develop guidelines and establish this committee soon. Also, there are no standard drug donation and disposal guidelines in place.

The Pharmacy Board licenses retail pharmacies and drugstores and is responsible for their monitoring and inspection. Although there is an existing Listed Medicines Handbook of all medicines sold in Liberia, at present there is no functioning system of drug registration. There is a quality control laboratory but it is not functioning adequately. Under the new legislation, the laboratory is expected to become part of the LMHRA. In the future, the LMHRA is expected to take on the role of inspection of all manufacturers, importers, wholesalers, and distributors, and receive the income currently generated by licensing of wholesale medicine premises.

7.2.3 Professional associations

There are currently 42 registered pharmacists in Liberia, and a registered pharmacist has been appointed to each county by the MOHSW. The Pharmacy Board registers pharmacists upon completion of the pharmacy degree. The Ministry of Health and Social Welfare and the University of Liberia School of Pharmacy recently revised the existing BSc pharmacy degree curriculum. The enrollment in the School of Pharmacy is expected to continue to increase; however, there are neither full-time pharmacy lecturers nor functioning pharmacy laboratories.

Graduates from the School of Pharmacy undertake a one-year internship prior to registration with the Pharmacy Board. There is no published curriculum to guide the internship year. There is no specific post-graduate pharmacist education in Liberia. The Pharmaceutical Association of Liberia does not currently provide any continuing education. However, the Pharmacy Board in conjunction with the Pharmaceutical Association has again commenced a course to train dispensers. There is an additional organization known as the Pharmacy Business Association, which is made up mainly of non-pharmacist entrepreneurs, especially Indian nationals, but it has no stated goals or functions.

7.3 Supply chain and drug use

7.3.1 Supply Chain Management Unit

In 2010, a Logistics and Supply Chain Management Unit (SCMU) was established in the MOHSW. With the support of partners, the SCMU developed a National Supply Chain Master Plan in 2010. The SCMP covers product selection, quantification, procurement, storage and distribution. Developing the SCMP was a 'condition precedent' (or requirement) for the MOHSW to become the Principal Recipient (PR) of Global Funds in Liberia for HIV (a function previously held by the UNDP). As the MOHSW strengthens its own SCMU, the Global Fund procurement facility in Geneva procures HIV drugs on behalf of Liberia.[28] In addition to the SCMP, the National Standard Operation Procedures for health commodity management has been developed and used to monitor the consumption of these commodities. The Supply Chain Master Plan makes it very clear that ultimately the importation, storage and distribution of vertical program and NGO medicines will become the responsibility of National Drug Service.

7.3.2 The National Drug Service

The National Drug Service (NDS) is a semi-autonomous not-for-profit organization that procures and distributes essential medicines to the counties. Originally, NDS was part of the MOHSW. During the war, NDS was made semi-autonomous as a way of enabling donors to fund drug supply that was not immediately subject to confiscation by whichever faction exercised executive authority (held on a rotating basis) over the country. Currently, NDS receives funds directly from the Government of Liberia, as well as support from donors (particularly the GFATM as part of a capacity building process) and applies a cost-recovery formula to the drugs it procures on behalf of the MOHSW. There has been an ongoing dispute between the MOHSW and NDS about the cost recovery formula and monies NDS feels it is owed by the MOHSW.

National drug orders are prepared by the MOHSW for procurement by NDS. County health officers place drug requests directly with NDS and they are filled as inventory permits. NDS does not transport drugs to the county level. CHSWTs (potentially with assistance from partner NGOs) collect their own supplies; occasionally, some larger hospitals also order and collect their own supplies. The turn-around time is approximately two to three weeks if the drugs are in stock.

Many NGOs also buy drugs from NDS, when drugs are available. Some NGOs have reported being able to source drugs on the international market from the International Development Association (IDA) and other sources for a small fraction of what they cost at NDS because they are able to use globally negotiated frame procurement agreements. All drugs paid for or provided by USAID also use a parallel supply chain management system. All Health Sector Pool Funded facilities, as well as those funded by the EU, have the option of procuring from NDS but may procure elsewhere if drugs are not available. Consequently, a large proportion of the 292 facilities supported by NGOs rely on other sources than NDS to supply government health facilities.

28. It has not yet been determined whether the GF procurement facility in Geneva will also procure malaria and TB drugs when the MOHSW takes on the PR function for those funds in 2011.

7.4 Implications for the health and social welfare policy

The National Drug Policy, Essential Drug List, Standard Treatment Guidelines and National Formulary should be revised to conform with revisions to the BPHS and adopted as part of the ten-year health and social welfare policy and plan process. Providing drugs to facilities should be based on population density and utilization formulas that reflect actual patient need.

The Liberian Medicines and Health Product Regulatory Authority should be supported by the MOHSW as part of the ten-year policy and plan implementation process in order to establish appropriate regulations for the pharmaceutical subsector, including enforcement of effective quality control of drugs entering Liberia and guidelines for the donation and disposal of drugs. The existing criminal law should be enforced to stop the incipient theft and resale of drugs from public facilities.

In order to facilitate the rational use of drugs, sound prescribing guidelines and good dispensing practices should be provided to trained prescribers and dispensers. Professional associations and institutions should be strengthened to ensure compliance with internationally accepted standards.

Further, in order to reduce waste and ensure the safety and timely availability of drugs and other health commodities, the ongoing efforts to strengthen supply chain should continue in earnest.

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8. Other Support Systems

8.1 Overview

The support systems pillar is the foundation on which the entire health system rests. It provides the means and strategies for de-concentrating planning and budgeting, Health Management Information System (HMIS), research, monitoring and evaluation, technology and communication, vehicle maintenance, and logistics management functions to the county to deliver basic health services. The importance of support systems was recognized in the Ouagadougou Declaration of 2008 and the Algiers Declaration of 2009 as a conduit for strengthening primary health care and health systems and improving quality of care in Africa.[29] The National Health Plan states that "the priority and primary objective of the support systems component will be to develop the capacity of County Health Teams (CHSWT) 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." In support of this objective, the National Decentralized Management Support Systems Implementations Strategy and Plan was developed in 2008. It contains proposals and recommendations for establishing a program within the Ministry of Health and Social Welfare to roll out decentralized management support systems to the county level in Liberia with appropriate training for CHSWT staffs.

8.2 Planning and budgeting

Financial management (FM) at the county level is a critical, enabling support system required to make other support systems operational. The current financial management implementation needs require each county to operate a simple system of banking and cash management of subsidies granted to them by the central Ministry. The efforts need to focus on getting the basics right, rather than introducing sophisticated reforms or systems that may absorb a large share of the government's scarce resources and human capacity. As of June 2010, all 15 county health teams have been assigned an accountant and have been trained in basic financial management. Staffs at 18 referral health facilities across the country have also been trained. A manual financial management system was put in place, standardizing all books and records across the counties. Government reforms, funding arrangements, banking arrangements, management arrangements, essential procurement arrangements, accounting arrangements and reporting arrangements have all been put in place. The central Ministry's Office of Financial Management has installed a schedule of supportive supervision, where each county receives at least two supportive visits per year from OFM accountants. An annual one-week refresher workshop is held by the OFM for all hospital and CHSWT accountants. A package of technical assistance in financial management for the OFM itself is linked to management of the Health Sector Pool Fund.

29. *Ouagadougou Declaration on Primary Health Care and Health Systems in Africa*, 2008

8.3 Health Management Information Systems (HMIS)

The 2007–2011 National Health Policy asserted that HMIS will be strengthened in order to better collect, organize and maintain relevant data in a timely fashion. 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. In response to this policy statement, the Ministry embarked on a vigorous campaign to improve the health information system through capacity development and policy formulation. These efforts began in August 2007 with the establishment of a consensus to create an HMIS that would be a "comprehensive interlinking network of informational datasets." Initially, an effort was made to create a customized District Health Information System (DHIS) to improve reporting of health services data from facility to county and national levels. This lead quickly to additional related developments for HIMS:

- The HMIS Unit was made functional by staff recruitment and training at central and county levels;
- Information Communication Technology (ICT) equipment valued at nearly US$1 million was procured and distributed at national and county levels;
- Multiple, fragmented and uncoordinated reporting tools were revised into a harmonized instrument with coordinated reporting procedures; and
- The elaboration and promulgation of a HMIS policy and strategy was completed in 2009.

The combination of the above efforts boosted data generation, analysis and dissemination for evidence-based planning and policy decision-making. As a result, the reporting of health services quickly evolved from calculators and typewriters to laptops, servers and printers. By 2010, monthly reporting improved from erratic to an average of 76 percent of facilities reporting (see Figure 14) using the DHIS standard reporting and analysis software. This substantial progress has translated into gradual improvement in the Ministry's annual reports of 2007, 2008 and 2009 and led to initiating an HMIS quarterly bulletin and to the production of morbidity data.

In the context of the ten-year development policy and plan, the HMIS will continue to create a National Health Information System (NHIS) that includes a set of interrelated components and procedures organized with the objective of generating health information and intelligence to monitor the health status and health services of the nation, and to improve public health leadership and management at all levels. The objective of an HMIS is to increase the availability of up-to-date, reliable information at all levels of the health system. Therefore, there is a need to develop a simple, timely HMIS that can monitor progress, inform decision-making and assure quality in the delivery of health services.

8.4 Research

In recent years (2006–2010), the Ministry has used policy-related studies to provide the needed evidence for the elaboration of policies and strategies, such as those that affect the human resources for health, health financing, nutrition and decentralization. Although, there have been numerous studies, the MOHSW has not involved the Research Unit in these studies and has not invested in making the unit functional. Therefore, the Research Unit has not developed formal guidelines or policy for general use on conducting research. The Liberia Institute for Bio-medical Research (LIBR) is

now ready to play the role for which it was established, but it is faced with seri-ous challenges.

8.5 Partnerships and coordination

Since 2006, the MOHSW sought strong, structured partnerships around shared objectives and approaches, within and outside the health sector, required to improve the health and social welfare status of the Liberian people.[30] Under the National Health Plan the responsibility for coordination of partners and stakeholders will be decentralized:

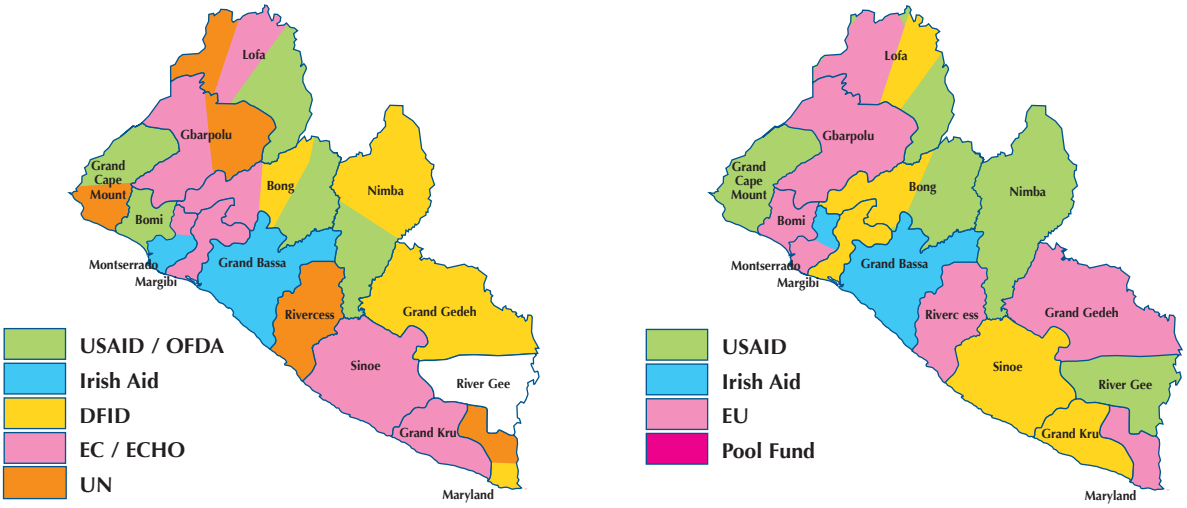
1. Coordination by the MOHSW of donors;
2. Coordination by county health teams of partners operating programs within their county;
3. Coordination with partners who own private or support public health facilities; and
4. Coordination with community-based structures, e.g., community development committees and community health volunteers.

8.5.1 Coordination of Donors

Historically, donors have been coordinated according to health facility or activity (e.g., immunization, malaria, nutrition). During the war years, donor coordination was driven by proposals developed by NGOs seeking humanitarian funding for health facilities, which they had selected to assist. This coordination by health facility successfully avoided duplication of assistance to the same health facility. However, it did create a situation where three, four, or even five NGOs might be working within the same county. Multiple health NGOs working in the same county typically results in duplication of management functions, fragmentation, reduced economies of scale, and competition for human resources, and it requires increased effort to coordinate by the CHSWT. An objective of the current National Health Plan has been to improve donor coordination, and thus NGO activity, across the fifteen counties. In addition to donor willingness to consolidate their programming, the establishment of the pool fund has helped to build countywide support from one partner in a majority of counties (see the maps in Figure 15 for 2008 and 2011). This has reduced fragmentation, increased overall efficiency, and provided for one principal partner to work with the CHSWT.

30. *National Health Policy and Plan*, MOHSW, 2007.

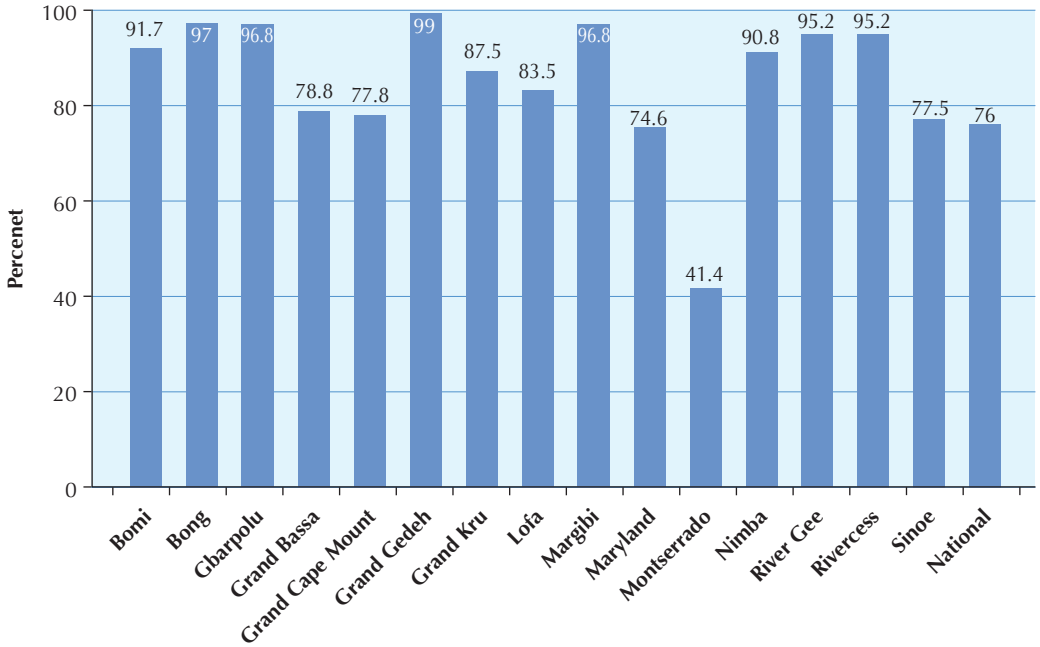
Figure 15: Donor Coordination in 2008 Versus 2011



A contemporary issue is coordinating the donor funds directly managed by the MOHSW. In 2007, the Ministry established a Program Coordination Team (PCT) in order to involve all of the Ministry's departments, bureaus and units in implementation of the National Health Plan. The intent was to use national systems (procurement, M&E, planning and financial management) whenever possible, thereby strengthening organizational capacity in the process. However, several special implementation units, dedicated to managing funds from a single donor, have emerged within the framework of an integrated implementation strategy.

The World Bank–funded Health System Reconstruction Project (HSRP), the Pool Fund Secretariat and the Global Fund for AIDS, Tuberculosis and Malaria (GFATM) Program Coordination Unit (PCU) have each been established to manage earmarked funds from their respective donors. They each require dedicated space, administrative processes

Figure 14: Health Management Information System Reporting, by County, 2010



and special attention to achieve their discrete objectives. Moreover, they do not closely coordinate with each other and they interact sporadically with the PCT. Only the GAVI Health System Strengthening grant has been managed by the PCT itself. Therefore, in 2009, the Ministry decided to establish one Program Management Unit that would incorporate the functions of various special implementation units (HRSP, PCU, pool fund) within the Ministry. The intent was to increase efficiency, strengthen coordination and improve integration of donor project funds. However, due to the perceived need to maintain a strong and dedicated management for Global Funds, implementation of this decision has been delayed.

8.5.2 Partners and program coordination by county health teams

It is noteworthy that donor coordination also exists by program, e.g., HIV/AIDS, malaria, and EPI. The MOHSW recognizes the need for specialized national programs of this nature and the inevitability that donor funding by program will continue into the future. At the same time, however, the MOHSW recognizes the need for program integration at the local level to make a more efficient use of resources. It is in this regard and in line with the National Decentralization Policy that the capacity building of CHSWTs for coordination of local partners and vertical programs is necessary. To this end the MOHSW has concentrated considerable effort and resources in the capacity building of CHSWTs. Improving the capacity of CHSWTs in managing partnerships is shifting the paradigm from humanitarian and vertical approaches to a horizontal, integrated health development.

8.5.3 Partners for health service delivery

The Liberian health system developed a foundation of public-private partnerships. For example, the creation of the Christian Health Association of Liberia in 1975 recognized the key role that the faith-based community played at that time in the provision of health services, at the clinic, health center and hospital levels. Similarly, a number of private-for-profit clinics and hospitals, e.g., Firestone, not only operated health facilities for their employees but also provided services to the surrounding community. At that time it was estimated that approximately 25 percent of Liberia's health facilities were owned and operated by private-sector partners with funding assistance from external sources (missions), company income, user fees, and/or MOHSW funding.

Charities, faith-based organizations, nongovernmental organizations and private providers are major contributors to the health delivery system. Ways to strengthen coordination between the government and providers will be identified at national and county levels. The Ministry and its 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; and
- 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.

8.5.4 Policy implications

The MOHSW and CHSWTs have made strides in partnering and coordination during the implementation of the five-year National Health Plan. The MOHSW will use the following partnership frameworks to engage its partners in the development of its ten-year Policy and Plan.

1. Clarify partnership terminology, especially for FBOs, LNGOs and CBOs, by reference to three groups of partners, i.e., government of Liberia (GOL), Not-for-Profit (NFP) and Private-for-Profit (PFP) providers.
2. Negotiate health services delivery agreements selectively with partners in the NFP and PFP sector. This might, for example, include FBO, LNGO and CBO-owned health facilities taking on the responsibility to provide the new health package for an assigned health catchment area.
3. Partnerships with implementing partners to carry out of the county health plan. This framework will have the CHSWTs play key role in coordinating all of the local partners, including INGOs, LNGOs, FBOs, CBOs and PFP health facilities.
4. Partnerships with communities and community-based volunteers. The community health services policy addresses the issue of which technical areas of the BPHS should be implemented at the facility, outreach or community level. That would come under the BPHS pillar. However, the management of the relationship between health facilities and communities will be discussed in the partnership chapter.
5. Partnerships with bilateral and multilateral donors. This is where the concept of coordination with donors to mobilize assistance by county will come in. This framework will deal with the rationalization of donor assistance and support to geographic areas of the country.

Reference documents for this chapter

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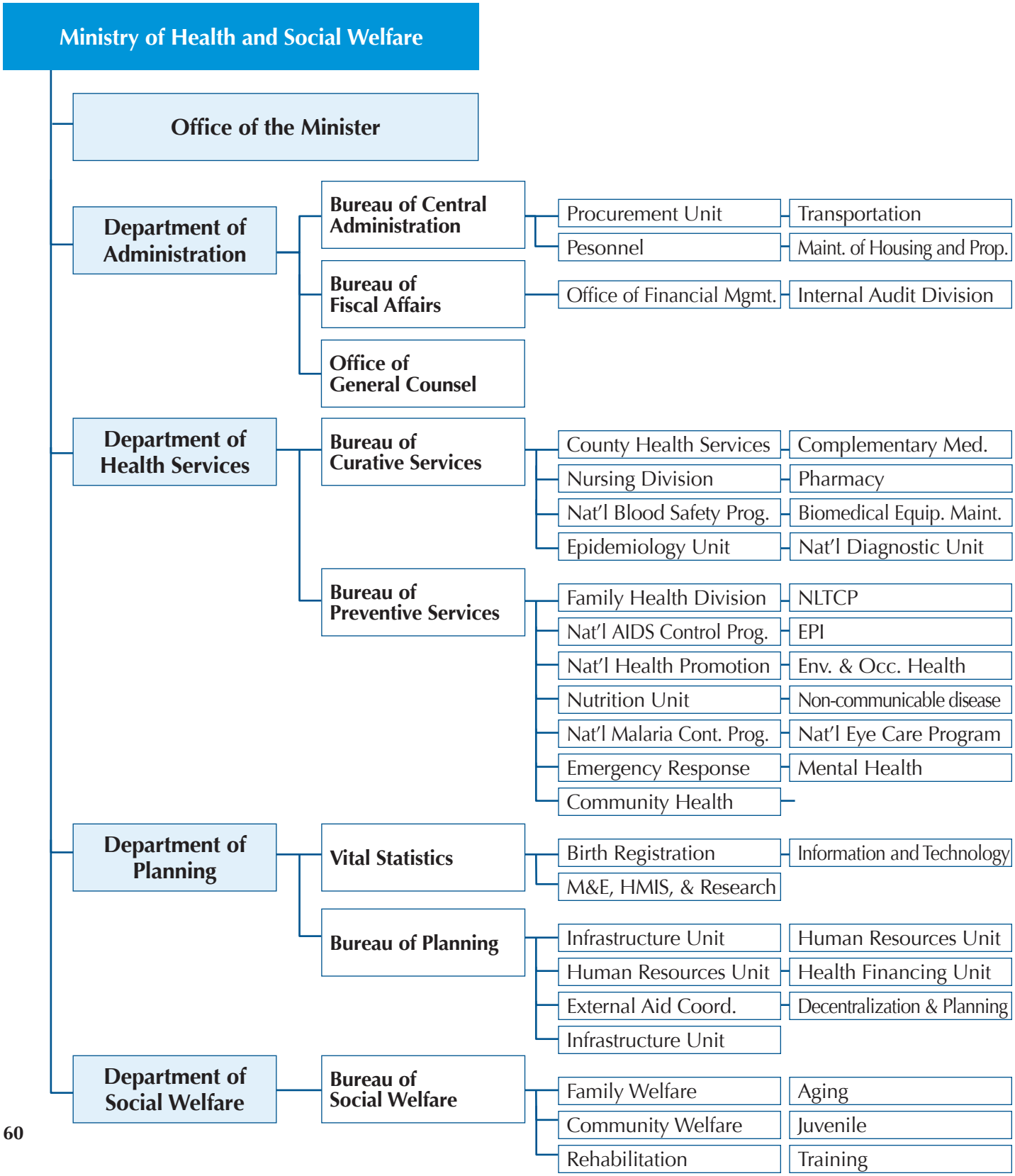
- *National Health and Social Welfare Review Conference Report*, MOHSW, 2010.
- *National Health Policy and Plan*, MOHSW, 2007.
- *National Health Management Information System Strategy and Plan*, MOHSW, 2009.

Annexes

Annex I: Organization of the MOHSW



Annex II: Breakdown of the Public Sector Health and Social Welfare Workforce

Cadre (Group and individual)		Number	%
Clinical Health Workers		**5,346**	**62.5%**
Physician		**90**	**1.1%**
	Physician	67	0.8%
	Surgeon	23	0.3%
Nurse		**1,393**	**16.3%**
	Graduated nurse	129	1.5%
	Licensed practical nurse (LPN)	255	3.0%
	Nurse anesthetist	55	0.6%
	Nurse midwife	66	0.8%
	Registered nurse	824	9.6%
	Scrub nurse	64	0.7%
Certified midwife		**412**	**4.8%**
Physician assistant		**286**	**3.3%**
Nurse aide		**1,589**	**18.6%**
Traditional midwife		**243**	**2.8%**
	Traditional midwife	50	0.6%
	Trained Traditional Midwife	193	2.3%
Dentist		**23**	**0.3%**
	Dental surgeon	8	0.1%
	Dentist	15	0.2%
Environmental health technician		**173**	**2.0%**
	Environmental health technician	119	1.4%
	Health inspector	54	0.6%
Lab technician /assistant		**376**	**4.4%**
	Lab aide/assistant	239	2.8%
	Lab technician	137	1.6%

Table continues →

Cadre (Group and individual)		Number	%
X-ray technician		22	0.3%
Pharmacist		46	0.5%
Other		693	8.1%
	Physiotherapist	6	0.1%
	Social worker	182	2.1%
	Dispenser	505	5.9%
Non-Clinical Health Workers		**3,207**	**37.5%**
Accountant		88	1.0%
Cleaner		707	8.3%
Field worker		127	1.5%
Non-clinical professional		1,285	15.0%
Registrar		457	5.3%
Security		515	6.0%
Surveillance		28	0.3%
Total		**8,553**	**100.0%**

Annex III: Reference Documents

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Republic of Liberia

Ministry of Health and Social Welfare

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