

Republic of Liberia



Ministry of  
Health and  
Social Welfare

National  
Human Resources  
Policy and Plan  
for Health and  
Social Welfare  
2011–2021



## Foreword

It is my honor to present the 2011 National Human Resources Policy and Plan for Health and Social Welfare. This policy and plan represent our collective commitment to implement the National Health and Social Welfare Policy and Plan, 2011–2021, which we developed just a few short months ago.



Under the very strong leadership of President Ellen Johnson-Sirleaf, we, the people of Liberia, continue the process of transforming our country into a more secured, more prosperous and healthier nation. To guide our efforts, the Government has developed the Medium-Term Social and Economic Development and Growth Strategy, which sets the stage for Liberia becoming a middle-income country by 2030.

Recognizing that health and social protection are key determinants of human development and that human resources are our greatest national assets, the Ministry of Health and Social Welfare conducted a participatory process to develop this human resources policy and plan in order to accelerate progress towards the national vision for social and economic development. Many individuals and organizations, from across the country and outside Liberia, have generously contributed to its development and we gratefully acknowledge all their contributions.

The goal for human resources is to efficiently staff and effectively manage our facilities with the right mix of qualified workers, in order to provide services according to the people's needs and according to highest professional and ethical standards. Our strategy is to expand the coverage of essential services by improving the balance between strengthening the existing workforce, producing additional workers with the necessary mix of skills and deploying skilled, motivated workers where they are needed most.

In order to attain our goal over the next 10 years, the network of functioning facilities must be expanded and the size of the skilled workforce to operate the network must be increased. This will require the sustained commitment of all stakeholders to wisely use every available resource in a participatory and transparent manner, with strong Government leadership throughout the process.

With this human resource policy and plan in place, built on a foundation of partnership and collaboration, we pledge to continue the march towards our ultimate goal of a healthy Liberia with social protection for all our citizens.

Walter T. Gwenigale, MD  
Minister  
Ministry of Health and Social Welfare

## Abbreviations

|        |  |
|--------|--|
| BPHS   | Basic Package of Health Services                   |
| CHSWT  | County Health and Social Welfare Team              |
| CHV    | Community Health Volunteer                         |
| CM     | Certified Midwife                                  |
| CSA    | Civil Service Agency                               |
| EHRP   | Emergency Human Resources Plan                     |
| EPHS   | Essential Package of Health Services               |
| EPSS   | Essential Package of Social Services               |
| FBO    | Faith-Based Organization                           |
| FMIS   | Financial Management Information System            |
| GOL    | Government of Liberia                              |
| HMIS   | Health Management Information System               |
| HR     | Human Resources                                    |
| HRCR   | Human Resources Census Report                      |
| HRIS   | Human Resources Information System                 |
| HRTC   | Human Resources Technical Committee                |
| JFKMC  | John F. Kennedy Medical Center                     |
| LDHS   | Liberia Demographic and Health Survey              |
| LPN    | Licensed Practical Nurse                           |
| M&E    | Monitoring and Evaluation                          |
| MBA    | Merit-Based Appointment                            |
| MD     | Medical Doctor                                     |
| MOE    | Ministry of Education                              |
| MOF    | Ministry of Finance                                |
| MOHSW  | Ministry of Health and Social Welfare              |
| NFP    | Not-for-Profit                                     |
| NGO    | Non-Governmental Organization                      |
| NHSWPP | National Health and Social Welfare Policy and Plan |
| OGC    | Office of General Counsel                          |
| PA     | Physician Assistant                                |
| PCT    | Program Coordination Team                          |
| PFP    | Private-for-Profit                                 |
| PHC    | Primary Health Care                                |
| PRS    | Poverty Reduction Strategy                         |
| RN     | Registered Nurse                                   |
| SDP    | Service Delivery Point                             |
| SOPs   | Standard Operating Procedures                      |
| TNIMA  | Tubman National Institute for Medical Arts         |
| TTM    | Trained Traditional Midwives                       |
| UNICEF | United Nations Children’s Fund                     |
| USAID  | United States Agency for International Development |
| WB     | World Bank   |
| WHO    | World Health Organization                          |

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## Summary

This first-ever National Human Resources Policy and Plan for Health and Social Welfare is in full alignment with the goal, vision, objectives and guiding principles of the National Health and Social Welfare Policy and Plan, 2011–2021. The policy and plan development processes were participatory and included analyzing the workforce and the experience of implementing the 2007 National Health Plan (see Annex 1: Expanded Situational Analysis).

The situational analysis determined that much has been done in 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 issues remain unresolved in terms of planning and management of the workforce, improving retention, especially in rural areas, ensuring appropriate skills mix and optimizing staffing levels to improve the workforce efficiency.

Therefore, the overarching goal of this policy and plan is to efficiently staff and effectively manage the network of facilities with the right mix of qualified workers in order to provide services according to the people's needs and according to the highest professional and ethical standards. In accordance with the NHSWPP, the principles guiding this human resources policy and plan are equity, efficiency, quality, sustainability, decentralization and partnership.

To achieve the policy's overarching goal, this human resources plan will concentrate on four interdependent objectives: (1) Increasing the number of equitably distributed, qualified and high-performing workers at all levels; (2) increasing number of high-performing facilities and institutions that promote continuous learning and assure quality; (3) strengthening the workforce to be people-centered, gender-sensitive and service-oriented; and (4) increasing number of safe and enabling learning and working environments equipped with the "tools of the trade."

The strategies to achieve these objectives are based on improving HR planning, development and management. The MOHSW will also invest in the enabling environment by strengthening the legal framework, regulation, standards setting, and enforcement. To oversee implementation, the Human Resources Technical Committee will be expanded, supported by a strengthened Human Resources Unit, and the Human Resources Information System will be institutionalized to ensure evidence-based planning and management.

Based on the projected population size in 2021 and the coverage target (85%), the public facility network will increase by 70% and the total number of workers necessary to operate the facility network will exceed 15,000, of whom 55% will be professionals and about one-half will be positioned at hospitals. Most of the professionals will fall into three categories: nurses, midwives and physician assistants. In absolute terms, nurse aides will be the largest category, and the number of physicians will also increase significantly.

Implementing this human resources policy and plan will cost an estimated US\$ 3.70 per capita in 2011, increasing to US\$ 8.60 by 2021 when factoring for the larger workforce and inflation. At these costs, human resources will represent about 20% of the total cost of implementing the NHSWPP, 2011–2021.

# 1. Introduction

## 1.1 Policy Context

This National Human Resources Policy and Plan for Health and Social Welfare (HRPP) was formulated during a defining period in the national development process. Through the Ministry of Planning and Economic Affairs, the Government has developed the Medium-Term Social and Economic Development and Growth Strategy to set the stage for Liberia becoming a middle-income country by 2030. Recognizing that health and social welfare are key determinants of human development, and in the context of this national vision, the Ministry of Health and Social Welfare (MOHSW) recently lead the development of one holistic National Health and Social Welfare Policy and Plan (NHSWPP), 2011–2021 that will substantially improve the health and social welfare of the population today and in the future.

Based on the NHSWPP and its guiding principles and strategic approaches, the MOHSW has developed this HRPP with sufficient detail to meet the long-term human resource requirements for health and social welfare over the next ten years. This HRPP builds on the 2007 version of the National Health Plan and draws upon the knowledge attained by implementation as well as from numerous sources of new data about the status of the population and the health and social welfare workforce, including: the 2009 National Census of Health and Social Welfare Workers in Liberia,<sup>1</sup> the 2010 Discrete Choice Experiment<sup>2</sup> and the 2010 Workforce Optimization Analysis.<sup>3</sup> Thus, the MOHSW is confident that this HRPP is evidence-based and reflects the best information and guidance available at the time it was developed.

The human resources policy and plan development process has been consultative and participatory throughout. Representatives from communities, civil society and religious groups, as well as district, county and national government officials discussed and deliberated on its content and orientation. At the outset, a multi-stakeholder technical working group was constituted to guide the HRPP formulation process and regular meetings were held with public and private organizations and with other major stakeholders and development partners. By maintaining a robust analytical capacity to understand the changing environment, this HRPP will be updated and enriched as experience is gained and knowledge accumulates

## 1.2 Scope and Purpose

This HRPP is relevant to all workers within the sector working in public, private-for-profit (PFP), and private not-for-profit (NFP) training institutions and facilities, including those owned by non-governmental and faith-based organizations (NGOs and FBOs). It has been developed

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<sup>1</sup> *National Census of Health and Social Welfare Workers in Liberia*, Ministry of Health and Social Welfare and Liberia Institute for Geo-Information Services, 2010.

<sup>2</sup> Vujicic, M., Alfano, M., Ryan, M., Wesseh, C. S., and Brown-Annan, J., *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.

<sup>3</sup> *Workforce Optimization Analysis: Optimal Health Worker Allocation for Healthcare Facilities across the Republic of Liberia*, Ministry of Health and Social Welfare and Clinton Health Access Initiative, 2010

to provide a vision for addressing the human resources (HR) problems in the sector and ensuring that every person in every community has equitable and affordable access to qualified, motivated, productive and fairly paid health and social welfare workers, who are working in safe, supported and enabling environments and who are using the right “tools of the trade.”

In light of multiple national priorities and demands on limited resources, establishing an equitable health and social welfare system requires a sustained commitment by all stakeholders to use every available resource wisely and to do so in an inclusive, participatory manner. Therefore this Human Resources Policy and Plan focuses upon nationally set priorities on which all concerned partners are asked to concentrate their efforts in order to develop the accessible, responsive system necessary to substantially improve the health and social welfare of the population.

## **2. Situational Analysis**

### **2.1 Demographic Status**

With an annual growth rate of 2.1 percent, Liberia's population of 3,476,608 will reach 4.5 million by 2021. A large proportion (47%) of the population lives in poverty and is concentrated in densely populated urban areas, while a majority remains in sparsely populated rural areas. Despite the success of the 2007 NHPP, Liberia continues to suffer from poor health indicators, especially among women and children, particularly in rural areas. The maternal mortality ratio is an extremely high 994 deaths per 100,000 live births and only one-third (37%) of deliveries take place in a health facility (26% in rural areas). While the under-5 mortality rate (U5M) and childhood malaria prevalence (32%) have both improved, malaria remains the leading cause of morbidity, and mortality and the U5M (110 per 1,000 live births) remains high.

### **2.2 Overview of Human Resources Development**

When the NHPP was 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 (see Annex 1: Expanded Situational Analysis). There were wide disparities in workforce remuneration, inconsistent staffing patterns in the facilities, incomplete and fragmented workforce information and little workforce planning and management capacity. Pre-service training was in a desperate situation and almost non-existent outside of Monrovia.

Much has been done in 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 issues remain unresolved in planning and management of the workforce, improving retention, especially in rural areas, ensuring appropriate skills mix, and optimizing staffing levels to improve the workforce efficiency.

### **2.3 Characteristics of the Workforce**

The 2009 National Census of Health and Social Welfare Workers in Liberia recorded 9,196 health and social welfare workers. This number includes the 3,207 (35%) non-clinical workers and consists of, among others, cleaners, drivers, and administrative and security staff. The census also recorded 5,989 clinical workers, which includes nurse aides, nurses, certified midwives, physician assistants, physicians and social welfare workers. Despite the size of the workforce, almost 70 percent was either non-clinical or unskilled. Liberia had only 2,181 skilled birth attendants (physicians, PAs, nurses and midwives) for a population of 3,476,608, a ratio of 1.58 skilled birth attendants per 1,000 population, well below the WHO threshold of 2.28 per 1,000.

### **2.4 Workforce Development**

Progress has been made toward increasing the number and quality of pre-service training institutions; however, there has been higher production of some cadres than was planned (espe-



cially nurses), while shortages persist for other critical cadres (physicians, physician assistants and certified midwives). Some of the progress made in the 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 renovating of the Tubman National Institute of Medical Arts in Monrovia. Other improvements to the quality of pre-service training include revising the curricula for mid-level health workers, introducing standards of care, improving teaching skills of instructors and clinical preceptors, and updating the skills levels and status of some workers, such as certified midwives, through the National In-service Education Strategy.

## **2.5 Facility Staffing**

The Government of Liberia is the largest employer of the health and social welfare workers in the country. However, almost half of government-employed workers are based in Monrovia and over half of all skilled workers have less than four years of practical experience. According to the 2011 BPHS Health Facility Accreditation Report, many workers also lack the "tools of the trade," such as essential drugs and medical equipment. Reflecting the variations in size of catchment populations, one-size-fits-all staffing patterns have resulted in under- and over-staffing at facilities, and thus produced significant variations in workload. Deployment to rural areas has been difficult because of the inflexibility of the salary scale and generally inadequate incentives to retain skilled providers in remote areas. Thus, in addition to establishing flexible staffing criteria that respond to local conditions, there is a need to improve the coherence between strengthening the existing workforce, producing additional workers with the right skills mix and effectively deploying and retaining the workforce where it is needed.

## 3. Policy Orientations

### 3.1 Policy Foundations

The Human Resources for Health and Social Welfare Policy and Plan (HRPP) is based on and is essential for the implementation of the National Health and Social Welfare Policy and Plan, 2011–2021 (NHSWPP) and should be read in conjunction with the rules and regulations established by the Civil Service Act and the Labor Laws of Liberia.

The mission, vision and goal of the NHSWPP, which the HRPP serves to implement, may be articulated as follows:

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

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

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

The overarching goal of this HRPP is for facilities and institutions to be managed effectively and efficiently and equipped with the right skills mix of qualified workers who provide quality services that meet the highest professional and ethical standards and sector's needs. In accordance with the NHSWPP, the principles guiding this human resources policy are equity, efficiency, quality, sustainability, decentralization and partnership.

**Equity:** The government's pro-poor commitment to gender equity will be demonstrated by concrete measures taken at all levels to ensure that all people in Liberia have equitable access to professionally trained, motivated and supported health and social welfare workers operating in a well managed, safe and effective health and social welfare system.

**Efficiency:** The greatest potential gains will be realized from the inputs of all stakeholders in order to maximize efficiency. Allocation of human resources among counties and distribution to facilities and communities will be made according to population size, utilization and workload.

**Quality:** Concerted efforts will be made to improve the quality of care by increasing the degree to which services improve the likelihood of desired outcomes. Decision-making will be predicated on doing the right thing, in the right way, at the right time and making the best use of the resources available in order to satisfy patients.

**Sustainability:** This principle emphasizes the development of appropriate solutions that are locally manageable and sustainable and that build local and systemic capacity. Sustainable plans will be designed within affordable cost ceilings in the projected fiscal framework.

**Decentralization:** In accordance with the National Decentralization Policy, officials at the

county level shall become increasingly responsible for service delivery and partner oversight, while the central level will focus on establishing policies and standards, resource mobilization, aggregate planning, monitoring and evaluation and research.

**Partnership:** In order to enable participation and ensure that actions are in accordance with the principles of this HRPP, the Government will continue to guide partnerships for human resources in order to create long-term, sustainable working relationships. The MOHSW will ensure that the actions of all partners are efficient, effective and consistent with the overall sector and sub-sector policies.

### 3.2 Policy Objectives

Sustained leadership, stakeholder commitment, resources and effort are needed to achieve the vision and goal of the NHSWPP by accomplishing the following overall health and social welfare objectives:

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

The Human Resources Policy and Plan has four policy objectives that contribute to achieving the NHSWPP objectives:

1. Increase in the number of equitably distributed, qualified and high-performing workers at all levels;
2. Increase in the number of high-performing facilities and institutions that promote continuous learning and assure quality;
3. Strengthening of the workforce to be people-centered, gender-sensitive and service-oriented;
4. Increase in the number of safe and enabling learning and working environments equipped with the tools of the trade.

The overall strategies to achieve these human resources objectives are based on increasing efficiency and effectiveness of human resources planning, development and management.

### **3.3 Enabling Environment**

The MOHSW will invest in the enabling environment for human resources through the legal framework, legislation, regulation and enforcement.

#### ***3.3.1 Legal Framework***

The health and social welfare workforce, whether in the public or the private sector, is governed by the Public Health Law and Title 18, known as the “Labor Law,” of the Liberian Code of Laws Revised, as may be amended or revised from time to time. Employees of the Government of Liberia must further abide by the Civil Service Act and Civil Service Standing Order (known collectively as the “Civil Service Act”), as amended from time to time, and other rules and regulations based on the Civil Service Act. Contracted employees of the Government must also abide by the Civil Service Act and other rules and regulations governing the Government’s contractual employees.

#### ***3.3.2 Legislation***

The MOHSW and the independent agencies shall each, in accordance with their mandates, review, amend and reinforce human resource legislation, accreditation and licensing as necessary and shall recommend legislative reforms. When necessary or desirable, the MOHSW and the independent agencies shall collaborate in furtherance of such mandates.

#### ***3.3.3 Regulation***

The MOHSW will strengthen the Liberia Medical and Dental Council, and other independent agencies may be created (as mandated and, if necessary or desirable, in collaboration with national judicial, regulatory and enforcement authorities) to promote the monitoring and reinforcement of Title 33, also known as the “Public Health Law,” of the Liberian Code of Laws Revised, as the same may be amended or revised from time to time, in the following areas, including but not limited to: professional public, private and autonomous healthcare training institutions, departments, programs and facilities.

The MOHSW, the Liberia Medical and Dental Council, and other independent agencies that may be created, shall institute mechanisms to ensure that the workforce complies with existing legislation, regulation, standard operating procedures, work protocols, guidelines and professional codes of conduct. Particular care will be given to separating regulatory responsibilities from the MOHSW’s service delivery duties in order to avoid conflicts of interest.

#### ***3.3.4 Enforcement***

In conjunction with the judicial and regulatory enforcement authorities, the MOHSW and professional boards, including the Medical and Dental Council, will promote the monitoring and enforcement of the labor laws of Liberia, the Public Health Law, the Civil Service Standing Order and other rules and regulations based on the Standing Order.

Mechanisms will be established to ensure compliance with existing and new human resources legislation, regulation, standard operating procedures, work protocols, guidelines and professional codes of ethics and conduct. Pre- and in-service professional training programs will re-

inforce these compliance mechanisms as well as the study of the legal aspects of health and social welfare service provision. The Ministry will develop a public awareness program to inform the public about health and social welfare–related practices that are allowed by law and those that are forbidden, and how to proceed when legal infringements are suspected.

### **3.4 Planning, Development and Management**

As articulated in the NSWPP and section 3.2, a prerequisite for expanding the coverage of priority services is improving the coordination between strengthening the existing professional workforce, producing additional workers with the right skills mix, establishing evidence-based health worker (re)distribution, and supporting effective management, motivation and retention schemes. In order to accomplish this, systems for human resource planning, development and management must be put in place.

#### ***3.4.1 Human Resource Planning***

**Plans:** All human resource plans will be evidence-based, time- and cost-indicative, and made in accordance with relevant and sub-sector policies, including Civil Service Agency rules and regulations. All human resource plans will be user-friendly, with clearly spelled-out activities and timelines, and widely disseminated to all stakeholders.

The MOHSW will adopt a participatory framework and consult relevant partners and stakeholders to develop and validate human resource plans, such as human resource strategic plans, workforce development plans, human resource operational and rolling plans, and staffs training plans. County health and social welfare teams will also consult relevant stakeholders when developing human resource annual plans, which will form an integral part of the county planning.

**Staffing:** The MOHSW will formulate optimal staffing criteria with multiple increments according to the services to be delivered and workloads, in order to guide human resource planning, prevent over- and understaffing, and increase the number of facilities and access to essential services. Redundant workers, particularly unskilled and low-skilled ones, will be progressively retrenched or transferred to the county payroll in order to free up slots in the Civil Service Agency payroll for hiring skilled workers who can be (re)deployed where needed.

**Financing:** The MOHSW will provide a framework for ensuring sustainable financing for recurrent costs, capital investments and other costs associated with improving the training, and development, recruitment, deployment, retention and management of the workforce. The MOHSW will also ensure that the financial accounting system can track all human resource expenditures and establishes human resources as a sub-account in National Health Accounts surveys.

**Research:** The MOHSW will support human resource research to inform policy formulation and rationalization of workforce functions. Priority research areas include workload studies to rationalize redistribution of the workforce, impact studies of interventions to attract and retain qualified workers in remote areas, and studies of the cost-effectiveness of the scholarship program.

**Monitoring and Evaluation:** The National Monitoring and Evaluation Policy and Strategy for health and social welfare will guide the monitoring and evaluation framework for this human resource policy and strategic plan. The MOHSW will monitor the performance of human resources against the overall progress of the sector in implementing the NSWPP 10-year plan. Unintended effects will be measured alongside the intended ones and adjustments will be made when necessary. The MOHSW will monitor workforce performance using a comprehensive Human Resource Information System (HRIS) and a Human Resources Observatory that will be linked to the Health Management Information System (HMIS).

### ***3.4.2 Human Resource Development***

**Training and Development:** The MOHSW will put a system in place to strengthen health and social welfare training institutions and rationalize the production, training and development of the sector's workforce. The MOHSW will coordinate higher education and pre-service training institutions by developing an accreditation and investment program to increase their capacity and improve the effectiveness of workforce production. Quality of care will constitute a cross-cutting component of all training modules. Pre- and in-service training curricula will include professional codes of ethics and conduct as well as non-clinical subjects, such as food security and nutrition.

The Ministry will assess the need for changing existing professional profiles or creating new categories of health and social welfare workers to accomplish the priorities established by the NSWPP, in particular for these multi-purpose, skilled providers who may work independently or as part of small teams in remote areas. Because of the uneven rate of improvement in competencies for social welfare, special attention will be devoted to social welfare staffing.

Vertical in-service training activities will be progressively absorbed into a comprehensive in-service training program under the Ministry's Training Unit. In order to improve the performance of active workers, program managers and supervisors will be consulted to determine training priorities according to documented service delivery needs. In the face of severe shortages of critical cadres, strategies for shifting tasks to mid-level health professionals will be used to close the workforce gap in priority clinical skills as quickly and efficiently as possible.

**Scholarships:** The MOHSW will promote career advancement, strengthen the scholarship program and enhance training opportunities for the workforce. It will strengthen the effectiveness, transparency and accountability of the Scholarship Committee and actively collaborate with funding agencies and relevant national and international training institutions and programs to secure funds to increase scholarship opportunities.

The Scholarship Committee will ensure that all scholarships contribute to meeting high-priority, critical human resource needs for the health and social welfare sector. Workforce applicants who wish to make career shifts that do not contribute to meeting the sector's priority human resource needs may do so, but they will not be eligible for a government scholarship for health or social welfare training. The MOHSW will facilitate the deployment of the new graduates after successful completion of the sponsored course.

**Quality Assurance:** In collaboration with regulatory bodies, training institutions and partners, the MOHSW will strive to assure the quality of all training and provide working and learning environments that are conducive, safe, and enabling and, according to pre-determined stan-

dards and up-to-date tools of the trade. Concerted effort will be made to improve the degree to which workforce training improves the likelihood of desired service delivery outcomes and results in decision-making predicated on doing the right thing, in the right way, at the right time in order to satisfy patients.

### **3.4.3 Human Resource Management**

**Leadership, Management and Ethics:** The MOHSW will put in place a system at the central, county and facility levels to strengthen leadership and management capacity, especially of directors, managers and officers-in-charge. Professionals serving in leadership and management positions will be accountable for effectively supervising their staffs and improving performance where necessary through formal appraisals based on clear job descriptions.

The leadership and management strengthening system will emphasize delegation of management responsibilities where prudent by developing administrative regulations for acting-staff (in conjunction with the OGC and the CSA), and will ensure continuity of control during a manager's prolonged absence. Qualified women will be encouraged to take on increased leadership and management positions.

Professional boards, pre-service training institutions and the MOHSW Training Unit will be charged with increasing awareness of and adherence to codes of professional ethics and conduct, particularly with regards to management practices and patient care. Senior managers will provide leadership at the central and county levels to ensure timely implementation of this system, monitoring and making adjustments when necessary.

**Recruitment, Deployment and Retention:** The MOHSW will establish staffing criteria for all types of service delivery points (SDPs) according to their level in the health system, the services provided, the geographic location of the catchment population and workload. SDPs may be either permanent or nonpermanent locations where skilled providers offer services on a regular basis. In some cases, multi-purpose skilled providers may work independently or as part of small teams in remote areas.

The MOHSW will recruit and deploy the workforce to SDPs with the intent of preventing over- and understaffing and increasing the population's geographic access to essential services. Recruitment, deployment and retention benefit and remuneration packages will be established by the Ministry to increase motivation, gender balance and retention of skilled providers in rural areas, including accommodation allowances where necessary. The MOHSW will also introduce measures to improve workforce performance by linking recruitment, career development, remuneration and hardship incentives to service delivery and health management priorities.

## 4. Strategic Plan

### Overview of plan goal, objectives and activities

As National Health and Social Welfare Plan, 2011–2021 is the instrument dedicated to implementing the 2011 National Health and Social Welfare Policy, so too is this 5-year strategic plan the principal instrument for implementing the HRPP.<sup>4</sup> Therefore, the human resources policy and strategic plan serve the same **overarching goal**: Facilities and institutions shall be effectively and efficiently managed and equipped with the right skills mix of qualified workers who provide quality services that meet the highest professional and ethical standards and sector's needs.

Attainment of the goal shall be guided by the same **principles** of equity, efficiency, quality, sustainability, decentralization and partnership, as well as by the same four objectives that contribute to implementing the NHSWPP. Building upon the strategies outlined in the human resources policy (planning, development and management), the following is an overview of the main **activities by objective** in the human resources strategic plan.

1. Increase the number of equitably distributed, qualified and high-performing workers at all levels by:
  - Promoting equitable distribution of the workforce
  - Improving performance of students and workers
2. Increase the number of high-performing facilities and institutions that promote continuous learning and assure quality through:
  - Strengthening the planning, management and coordination functions of the HR Unit within the MOHSW
  - Strengthening the management performance of facilities and institutions
  - Strengthening the quality of pre-service training
  - Strengthening the capacities of regulatory and professional bodies
  - Strengthening the quality of in-service training
  - Promoting continuous learning of the workforce
  - Fostering effective collaboration among sectors, partners and stakeholders
3. Strengthen the workforce to be people-centered, gender-sensitive and service-oriented by:
  - Promoting a gender-sensitive workforce
  - Promoting a workforce that is service-oriented and people-centered
4. Increase the number of safe and conducive working and learning environments equipped with the “tools of the trade” through:
  - Improving safety in working and learning environments
  - Increasing the number of learning and working environments with the “tools of the trade.”

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<sup>4</sup> After five years of implementing the human resource policy (FY 2011–2015), this strategic plan will be revised according to the implementation priorities for the subsequent five years (FY 2016–2020).



## 4.1 Objective 1: Increasing the number of high-quality workers

The first objective of this HR Strategic plan is to increase the number of equitably distributed, qualified and high-performing workers at all levels.

### The first strategy (1.1) is to promote equitable distribution of the workforce

**Rationale:** As the situational analysis indicates, the health and social welfare workforce lacks adequate numbers of qualified, experienced and supported workers. The workforce, especially skilled birth attendants, is inequitably distributed in favor of urban areas and hospitals, resulting in wrong skills mix at most facilities, especially in rural areas. Clinics are the most short-staffed in every cadre. Rural counties like Nimba, Grand Gedeh, Gbarpolu and Maryland have the lowest ratios for skilled birth attendants per 1,000 population.

Attraction and retention of a skilled and experienced workforce in hard-to-reach areas is problematic. Nurses with experience in rural areas value working in urban areas the least. Willingness to work in rural areas is influenced by a host of factors, including age, sex, previous and current work experience. A majority of the respondents in the Discrete Choice Experiment survey indicated that they would be willing to exchange their current urban location for one in a rural area for a period of up to three years if they were given (in order of priority): a motorbike, free housing or adequate equipment. A normal workload was the least valued, proposed incentive. Therefore, the following activities will be carried out in order to implement strategy 1.1:<sup>5</sup>

- A. 1.1.1 Review and update staffing norms for each type of facility in line with the service delivery priorities, population-based workload and targets. Counties will be given a ceiling of professional staff positions with budgetary coverage to be reviewed every 2 years. The ceilings will be set in accordance with payroll funding availability. [2012–2014]
- A. 1.1.2 Redeploy cadres from central level, hospital facilities and urban facilities, where they are in surplus, to clinics and health centers and to areas that lack critical cadres, to improve the skills mix of those facilities. [2011–2013]
- A. 1.1.3 Institute a 1-year compulsory rural service scheme after graduation from government-owned training institutions. [2011–2013]
- A. 1.1.4 Develop and implement deployment benefit packages geared to hard-to-reach remote areas, including moving, transport, and/or housing allowances. [2011–2013]

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<sup>5</sup> The time period for implementing the proposed activities is shown in brackets after each activity and the activities have been numbered for easy reference when referring to the costing of these activities and to the HR Operational Plan (2011–2013).

## The second strategy (1.2) is to improve performance of students and workforce

**Rationale:** The health and social welfare workforce is inadequately remunerated. Almost half of the workforce receives a monthly income between US\$ 50 and US\$ 100. More than 6 out of 10 workers report a monthly income of less than US\$ 100. In 2008, an incentive scheme for critical cadres in each of the three regional zones was introduced by the MOHSW. The incentives for zone 3 (hard-to-reach areas) are inadequate to attract and retain qualified and experienced workers. On average, medical doctors in this scheme earn US\$ 1,114 a month while physician assistants earn US\$ 225 and nurses earn US\$ 202. However, the scheme is not based on performance and the workforce is inadequately managed and lacks the “tools of the trade.” These factors make it difficult to recruit and retain workers and manage their motivation and performance. Therefore, the following activities will be carried out in order to implement strategy 1.2:

- A. 1.2.1 Reinforce standardized recruitment procedures that are timely, needs-based, gender-sensitive, non-discriminatory, transparent and in line with Civil Service Agency’s Merit Base Appointment (MBA) process. [2011–2013]
- A. 1.2.2 Implement appointment of workers in line with MBA guidelines and Standardized Operational Procedures to ensure that newly appointed workers are provided with an appointment letter, clear job description, and induction program and have access to a copy of the Employee Handbook and the Professional and Ethical Codes of Conduct. [2011–2013]
- A. 1.2.3 Increase the number of professional health and social welfare workers on the Civil Service Agency payroll, while improving the gender balance and disability representation. Decrease the number of unskilled workers on the CSA payroll by contracting out non-professional services (cleaning, laundry, security, etc.). [2012 and onwards]
- A. 1.2.4 Reinforce a system in which an employee serving in an acting position receives fair remuneration upon assuming an acting responsibility and will not serve in an acting capacity for longer than 2 years. [Ongoing]
- A. 1.2.5 Conduct performance evaluations to improve individual worker performance and development using standardized performance management tools. [Ongoing]
- A. 1.2.6 Establish and implement a public reward system, linked to performance appraisals, so that all facilities and institutions recognize outstanding performance of workers and students. The reward system should serve to highlight model professional and ethical patient care and inspire improvement in pre-service and in-service practice. [Ongoing]
- A. 1.2.7 Develop and implement promotion procedures for each cadre according to performance and qualifications, in line with MBA guidelines. [2012–2014]
- A. 1.2.8 Develop and implement a comprehensive, performance-based remuneration scheme for each cadre. [2011 and ongoing]
- A. 1.2.9 Develop and implement career progression schemes for each cadre and support career counseling, mentoring and coaching for students. [2014–2016]

- A. 1.2.10 Provide and promote equal—yet gender- and disability-sensitive—career advancement opportunities to develop the skills mix of the existing workforce, especially for qualified lower cadres, to advance their careers. [Ongoing]
- A. 1.2.11 Develop and implement a training program in leadership and management for managers of facilities, institutions, divisions, units; programs to build capacity for initiating and leading effective change; and performance management systems and processes for making evidence-based decisions. [Ongoing; to review in 2015]
- A. 1.2.12 Offer fellowship programs for critical teaching staff (e.g. laboratory, pharmacy, psychiatry, radiology and anesthesia). [2011–2014]
- A. 1.2.13 Conduct annual staff satisfaction surveys. [Ongoing]
- A. 1.2.14 Renovate, upgrade and build new accommodations for teaching and clinical staff, especially in rural areas, that are accessible to persons with disabilities. [Ongoing through 2014]

## 4.2 Objective 2: Increasing the number of high-performing facilities and institutions

The second objective of this human resources strategic plan is to increase the number of high-performing facilities and institutions that promote continuous learning and assure quality.

These facilities include all health and social welfare clinical facilities, all departments within the MOHSW, relevant academic and research institutions, and health and social welfare training schools.

**The first strategy of Objective 2 (2.1) is to strengthen the planning, management and coordination functions of the HR Unit within the MOHSW**

**Rationale:** The human resources situational analysis provides some evidence that most facilities and institutions are underperforming. However, although three human resource policy studies have been carried out (the 2009 HR census, the 2010 Discrete Choice Experiment and the 2010 Workforce Optimization Analysis), there is no system in place nor any institutional capacity to systematically determine information needs, synthesize results and utilize the data and information for evidence-based decision making.

The Human Resource Unit within the MOHSW also underperforms due to the difficulty of coordinating with multiple units, each reporting to different assistant ministers, as well as to the large number of human resource-related responsibilities assigned to only a few dedicated staffs and a lack of funding for the unit.

The Human Resources Unit is responsible for formulating human resource policies and developing evidence-based human resource plans. Other responsibilities include planning for and coordinating recruitment, (re)deployment, training and development, collaborating with stakeholders and supporting the decentralization process of major human resource functions to the county level. In the 2008 PRS, 11 out of 37 deliverables for the MOHSW were HR-related

and the responsibility of the Human Resources Unit.

The following activities will therefore be carried out in order to implement strategy 2.1:

- A. 2.1.1 Upgrade the Human Resources Unit, restructure and expand it, consolidating all HR functions in the Ministry within the unit and recruit the necessary staffs to fulfill its functions. [2011–2013]
- A. 2.1.2 Develop and implement a capacity strengthening plan to enable the staffs of the Human Resource Unit and Human Resource Officers based in the counties to effectively carry out all major human resource functions. [2011; ongoing]
- A. 2.1.3 Expand, maintain and decentralize a comprehensive Human Resource Information System, linked it to the Ministry's HMIS system, and use the HRIS for evidence based decision-making in human resource planning, development and management. [2011; ongoing]
- A. 2.1.4 Establish and use a Human Resources Observatory. [2016]
- A. 2.1.5 Review and update the Human Resource Policy. [2016]
- A. 2.1.6 Establish a multi-sector Human Resource Technical Committee. [2011]
- A. 2.1.7 Develop workload indicators as well as acceptable minimum and maximum productivity of staff by categories to be used for human resource planning and management; redeploy staffs according to facility workloads; retrench staffs with consistently sub-optimal performance. [Every two years beginning in 2012]
- A. 2.1.8 Develop and implement realistic, gender-sensitive, needs-based, time- and cost-indicative (re)deployment plan, in line with national laws, policies and guidelines, to rationalize workforce deployment and enhance the skills mix in all facilities and institutions. [2011–2013]
- A. 2.1.9 Establish and support a national Training Coordination Committee. [2013]
- A. 2.1.10 Develop and implement an 10-year national training plan. [2012–2013]
- A. 2.1.11 Develop and implement succession plans. [2014]
- A. 2.1.12 Review and update the HR Strategic Plan every 2 years. [Ongoing through 2013]
- A. 2.1.13 Develop, implement, review and update cost-indicative annual human resource operational plans at the national and county levels. [2011; ongoing]
- A. 2.1.14 Produce and disseminate annual human resource reports to increase information flow and transparency with other bodies of Government, communities, beneficiaries and development partners. [2011; ongoing]
- A. 2.1.15 Determine the feasibility of contracting out training programs for managers at central, institutional, CHSWT and facility levels in leadership and management competencies, planning, M & E and report writing. [Ongoing]
- A. 2.1.16 If feasible, contract out the actual training in leadership and management of managers, officers in charge (OICs) and human resource professionals of all facilities and institutions at all levels. [2015–2018]

- A. 2.1.17 Develop and implement SOPs for human resource functions to be gathered in a human resource manual. [2011; to be reviewed every 2 years].
- A. 2.1.18 Every two years, organize human resource forums with managers of regulatory bodies, professional associations, health training institutions and CHSWT Human Resource Officers to discuss relevant issues in human resource planning, development and management. [2012; every 2 years thereafter]
- A. 2.1.19 Develop and use interactive information infrastructure (potentially Web-based) to respond to human resource inquiries, to provide information about career development and scholarship opportunities, and facilitate communication within and across levels. [2016]

**The second strategy (2.2) is to strengthen the management performance of facilities and institutions**

**Rationale:** Other facilities and institutions feel equally challenged because of ineffective organizational structures, multiple systemic inefficiencies and lack of leadership and management competences to effectively and efficiently manage the facilities and produce the desired targets and quality. Therefore, the following activities will be carried out in order to implement strategy 2.2:

- A. 2.2.1 Establish effective organizational structures at all facilities and institutions, in line with their mandates, promote teamwork and multidisciplinary collaboration and delegate responsibilities and authority to act to the next senior level. [Ongoing]
- A. 2.2.2 Promote effective management at all levels by training managers in results-based management. [Ongoing]
- A. 2.2.3 Recruit workers according to need and increase the minimum qualifications (e.g. high school diploma) for non-clinical and low skilled cadres. [2011–2013]
- A. 2.2.4 Retain recruitment records for a period of two years to allow for monitoring and professional scrutiny. [Ongoing]
- A. 2.2.5 Train and supervise critical staff in task-shifting (especially from medical doctors to physician’s assistants) as an interim solution until workforce production targets have been met. [Ongoing]
- A. 2.2.6 Review and reinforce performance through quarterly integrated supervision of all facilities to ensure implementation of professional and ethical standards, job descriptions, annual performance evaluations, protocols and guidelines. [Ongoing]
- A. 2.2.7 In collaboration with the professional boards and associations, establish and monitor a system for making confidential reports and for dealing with violations of ethical codes and standards occurring at facilities and institutions. [2011–2013]

### The third strategy (2.3) is to strengthen the quality of pre-service training

**Rationale:** The number of training institutions, programs, qualified teachers and professors are inadequate and the working and learning environments in most cases are not conducive. The situation is further compounded by a poor preparation of students enrolled in those institutions, which adversely affects their academic performance and leads to substandard faculty development and a weak monitoring of training institutions by regulatory bodies and Government.

Although curricula for several cadres programs were reviewed in 2009, their contents insufficiently prepare students for assuming leadership and management positions in facilities and effectively communicating with their patients, clients and communities. The following activities will thus be carried out in order to implement strategy 2.3:

- A. 2.3.1 Update and use the pre-service database and up-to-date technology for effective human resource planning and management. [Ongoing]
- A. 2.3.2 Develop transparent criteria and procedures to assess training institutions, in conjunction with professional boards and associations, such as the Medical and Dental Council, and the MOE. [2011; ongoing]
- A. 2.3.3 Review and update standardized curricula for each clinical cadre every 2 years to ensure that curricula integrate new knowledge, skills and “good practice,” meet the service needs, and consist of a significant part of non-clinical subjects.<sup>6</sup> [2012; ongoing]
- A. 2.3.4 Review, restructure and implement standardized internship plans for each cadre and include an exposure to rural working conditions in the curricula to nurture familiarity with rural service at an early career stage. [2013–2015]
- A. 2.3.5 Recruit teachers and academics, in line with the evidence-based workforce plan, and offer competitive benefits to attract and retain them. [2014–2015]
- A. 2.3.6 Conduct short-term courses for teaching staff at all levels based on needs in technical areas and in teaching competencies. [2011; ongoing]
- A. 2.3.7 Upgrade all diploma training programs to BSc level. [2014]
- A. 2.3.8 Upgrade and expand existing training institutions to increase the output of training of key cadres in line with this strategic plan.<sup>7</sup> [Ongoing through 2016]
- A. 2.3.9 Establish a regional faculty exchange programs. [2016–2017]

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<sup>6</sup> Non-clinical subjects include leadership and management, HMIS, strategic and operational planning, integrated supervision, report and proposal writing, patient and customer care, teamwork and multidisciplinary collaboration, communication skills, social and cultural aspects of health and ill health, integrated supportive supervision, community engagement and professional and ethical codes of conduct that promote transparency and trust in and accountability of their work.

<sup>7</sup> Decisions to establish new training institutions will be made after considering long-term projections of needs of existing institutions (in quality and quantity). Strengthening of existing institutions will take priority over expansion.

- A. 2.3.10 Establish linkages/associations with "sister" universities, colleges and schools outside of Liberia. [2016–2017]

**The fourth strategy (2.4) is to strengthen the capacities  
of regulatory and professional bodies**

**Rationale:** Regulatory and professional bodies (councils, boards and associations), such as the Medical and Dental Council, already exist and their membership consists of qualified professionals, but they do not have the resources to fulfill their mandates. They lack the resources to monitor all training institutions, conduct spot-checks on qualifications and professional and ethical performance of the clinical workforce and prepare plans and reports. As a result, the reinforcement of regulations is weak, which affects the quality of the training and service delivery. The regulatory and professional bodies should be audited on annual basis by an independent body contracted by the MOHSW. This Strategic Plan gives much importance and urgency to making the regulatory and professional bodies highly functional and thus prioritizes the following activities to implement strategy 2.4:

- A. 2.4.1 Review, refine and update the functions, mandates and responsibilities of regulatory and professional bodies. [2011–2013]
- A. 2.4.2 Provide the regulatory and professional bodies, such as the Medical and Dental Council, with gradually increasing resources to enable them to incrementally fulfill their mandates [2011–2013], including:
- A. 2.4.3 Conduct biannual assessments of all training curricula at all public, private and private-for-profit training institutions and clinical sites, and monitor the implementation of and adherence to training curricula. [2011–2013]
- A. 2.4.4 Provide the necessary regulatory and curricula clarity for training institutions to comply and qualify for certification every two years. [2011–2013; ongoing]
- A. 2.4.5 Develop and implement regulations regarding registration and certification procedures for training institutions. [2011–2013; ongoing]
- A. 2.4.6 Develop, update and use the database of licensed workers and accredited institutions and service facilities. [2011; ongoing]
- A. 2.4.7 Develop and implement a system to link pre-service training, in-service training, continuing professional development, career development and registration, certification and licensing. [2013–2016]
- A. 2.4.8 Present annual plans, budgets and reports to the MOHSW's Human Resources Unit and present findings and recommendations the Annual NHSWPP Review Conference. [2011; ongoing]
- A. 2.4.9 Review legislative acts concerning accreditation, licensing and certification in line with the mandate of the MOHSW and make recommendations for adjustments when needed. [2011–2013]
- A. 2.4.10 Conduct an independent annual audit of the regulatory and professional boards on their performance. [2011; ongoing]

### The fifth strategy (2.5) is to strengthen the quality of in-service training.

**Rationale:** The Human Resources Unit has a Training Section responsible for rationalizing, planning, coordinating and assuring quality of all in-service training within the sector. However, the few workers available for the section are heavily involved in conducting training themselves, which takes them away from their office and their core business.

Although several training modules have been developed to improve service delivery, these modules have been narrowly defined and address merely the pure clinical aspects of the service delivery, neglecting other important aspects of service delivery such as effective communication, maintaining and using HMIS, planning, report writing and meeting management. Allowances are often attached to attending in-service training, which is often regarded as a form of income and thus making it highly competitive to attend. Training is often fragmented and offered on an ad hoc basis, and its positive impact on the quality of service delivery is not always evident. Therefore, the following activities have been planned to improve the quality of in-service training through strategy 2.5:

- A. 2.5.1 Review existing methods of and modules for all in-service training and develop new methods of in-service training that reduce the time that workers spend away from their job, for example through on-site training and mentoring, integrated supportive supervision and e-learning. [2011–2013]
- A. 2.5.2 Develop and implement a coordinated and competency-based in-service training program, in line with CSA guidelines, for each cadre, standardize the curricula aligned with good practice and up-to-date technology. [2014–2015]
- A. 2.5.3 Train and support community volunteers in line with the national policy on community volunteers. [2011; ongoing]
- A. 2.5.4 Develop and use transparent criteria for in-service training eligibility and workshop participation. Communicate the criteria to the workforce. [Ongoing]

### The sixth strategy (2.6) is to promote continuous learning of the workforce

**Rationale:** The Ministry's workforce is adequate in numbers but has the wrong skills mix and inadequately qualified and experienced workers. In this context, the MOHSW strategy is to support all workers to climb their career ladders, to offer them continuous professional training, in line with the requirements for the sector, and to enhance continuous learning for their personal and professional growth. The following activities will thus be carried out in order to implement strategy 2.6:

- A. 2.6.1 Collaborate with training institutions to widen entrance opportunities for critical professions and offer remedial training courses for applicants lacking the admittance requirements, in order to increase the number of qualified applicants for critical training programs. [2013–2016]
- A. 2.6.2 Create opportunities for workers to study through participation in distance programs, evening and weekend courses, e-learning and training using modern means of information, communication and technology. [2014 –2015; ongoing]
- A. 2.6.3 Develop and implement procedures to make the Scholarship Committee more effective, transparent and accountable for their work and include representation of training institutions and other relevant stakeholders, [2011; ongoing]



- A. 2.6.4 Provide subsidy to train the underrepresented cadres *only* until the optimum number of each cadre for implementing the PHC concept (with strong secondary and tertiary referral facilities) has been achieved. Provide free professional education in public universities only until there are adequate numbers of priority cadres, including medical doctors, certified midwives, PAs, opticians, lab technicians, anesthetists, dentists, physiotherapists, psychiatrists, psychiatric nursing, social workers. [2011; ongoing]
- A. 2.6.5 Review, update and implement the Scholarship Policy. Ensure that the scholarships are awarded in a manner that follows the basic principles: they are needs-based, cost-effective, gender-sensitive, and encourage service in hard-to-reach areas. Enhance long- and short-term training opportunities for the workforce and increase the spectrum of relevant national and international training opportunities.<sup>8</sup> [2011; ongoing]
- A. 2.6.6 Create opportunities for members of professional and regulatory bodies and human resource managers to participate in sub-regional, regional and global exchanges and forums that promote good practices and innovative actions and solve human resource problems, while giving prominence to national relevance and needs. [2013; ongoing]
- A. 2.6.7 Establish accessible libraries in major institutions, including at central level of the MOHSW and at all CHSWTs, and provide Internet connection to major referral facilities to support personal and professional development. [2014–2015]
- A. 2.6.8 Organize a “National Health and Social Welfare Career Counseling Week” at all levels and create opportunities for career counseling during the annual review conference. [2014–2015]

**The last strategy of the Objective 2 (2.7) is to foster effective collaboration among sectors, partners and stakeholders**

**Rationale:** The health and social welfare sector depends heavily on other sectors, its partners and stakeholders for implementing and monitoring of its policies and plans and for the attraction, motivation, performance and retention of its workforce. In support of the decentralization process, local governments and communities are important stakeholders. To oversee, plan and coordinate the complex human resource arena, it is vital to institute a high-level body with senior representatives of all relevant ministries and development partners. The following activities will thus be carried out in order to implement strategy 2.7:

- A. 2.7.1 Support the high-level national Human Resource Technical Committee to coordinate the implementation and monitoring of the National Human Resource for Health and Social Welfare Policy and Plan<sup>9</sup> [Ongoing]

<sup>8</sup> All scholarships should contribute to the applicants’ career advancement while addressing the needs of the sector. Deployment will occur immediately after successful completion of the sponsored course. Applicants for scholarships who wish to make career shifts that do not contribute to their career advancement and to their skill and professional concentration can do so *but will not be eligible* for a government scholarship.

<sup>9</sup> The HR Technical Committee oversees the HR Working Group and sub-committees, including the Scholarship Committee. The HR Unit acts as the secretariat to the HR Technical Committee.

- A. 2.7.2 Collaborate with relevant Government bodies, including the Ministries of Education, Finance, Public Works and Transport, to establish and maintain primary and secondary schools in the vicinity of health and social welfare facilities, to build adequate housing and to expand and maintain the road network, especially in rural areas. [Ongoing]
- A. 2.7.3 Collaborate with partners and national and international pre-service institutions to secure financial and technical assistance for producing the required numbers of each cadre, according to workforce needs and priorities. [Ongoing]
- A. 2.7.4 Establish and maintain effective partnerships with communities, in particular community development committees, community volunteers, complementary medical practitioners, traditional midwives, clinic committees and county health and social welfare boards, to involve and empower them, to promote transparency and accountability of service providers and to increase demand for and coverage of services. [2011; ongoing]
- A. 2.7.5 Develop human resource research priorities and collaborate with the MOHSW Research Unit, research institutions, and stakeholders to study aspects of human resource interventions, determine lessons learned, and disseminate and use research findings for evidence-based policy formulation. [2016; ongoing]

### **4.3 Objective 3: To develop a gender-sensitive, people-centered workforce**

The third objective of this HR Strategic Plan is to develop a gender-sensitive, service oriented and people-centered workforce.

#### **The first strategy of Objective 3 (3.1) is to promote a gender-sensitive workforce**

**Rationale:** The gender make-up of the health and social welfare workforce has not yet met the guidelines of the National Gender Policy. According to the 2009 human resource census, 61.9% of the total HR workforce is male and 38.1% female. The greatest disparity occurs in the non-clinical cadre. Some 80% of this cadre are men and include drivers and security guards. Of all clinical workers, 48.7% are women, yet they are predominantly nurses and midwives. Medical doctors and physician assistants are overwhelmingly men; men also dominate the senior management positions. Therefore, the following activity will receive high priority throughout the implementation of this plan:

- A. 3.1.1 Implement the National Gender Policy in all aspects of training, development, recruitment, deployment and promotion of the health and social welfare workforce. [2011; ongoing]

#### **The second strategy (3.2) is to promote a workforce that is service-oriented and people-centered**

**The Rationale:** The sector faces problems with the availability, attitude and performance of its workers. This affects the quality and coverage of service delivery and access to health care and social welfare services.

Absenteeism among workers is widespread. In addition to anecdotal reports, two human resource studies conducted in 2010 explicitly mention that absenteeism among the workforce issues disrupted their proposed research. The human resource census also reported the absence of 428 workers, almost 5% of the total workforce.

No professional and ethical codes of conduct (or Employee Handbook) exist to guide workers and hold them accountable for their behaviors. Consequently, unprofessional and unethical conduct occurs with impunity and those affected by negative behaviors are often not aware of their rights. Therefore, this strategic plan will embark on the following activities to implement strategy 3.2:

- A. 3.2.1 Develop, print and distribute an Employee Handbook and enforce professional and ethical codes of conduct. [2012–2013]
- A. 3.2.2 Facilitate management teams at all permanent service delivery points and institutions, including CHSW boards and community development committees, to monitor professional and ethical conduct of the workforce and create ombudsman positions where one can report unprofessional and unethical behaviors. [2013; ongoing]
- A. 3.2.3 Develop, implement and enforce a written policy that full-time public sector employees will not work in private practice during official working hours (2011)
- A. 3.2.4 In collaboration with the Departments of Health Services and Social Welfare Services and the M&E Unit, review and update supportive supervision manuals that include the importance of effective leadership, professional and ethical service delivery, patient/client care, transparency and trust in and accountability of their work, availability of job descriptions and consistent implementation of annual performance evaluations. [2012-2013]
- A. 3.2.5 Print and distribute the supervision manuals and organize in-service training on integrated comprehensive supportive supervision. [2012–2013]
- A. 3.2.6 Provide easy access to and adequate sitting arrangements in all facilities and institutions for the pregnant and physically challenged workers, the elderly and sick. [2011; ongoing]
- A. 3.2.7 Develop and implement client satisfaction programs at all facilities and institutions and at all levels. [2011; ongoing]

#### **4.4 Objective 4: To increase the number of safe and enabling working environments**

The fourth objective is to increase the number of safe and enabling working and learning environments equipped with the tools of the trade.

**The first strategy of Objective 4 (4.1) is to improve safety, security and well-being of students and workers at learning and working environments**

**Rationale:** So far, the sector has not given much attention to the well-being, safety and security of its students and workers. They tend to operate in learning and working environments without having adequate information on occupational health and safety threats, on measures to mitigate these risks, and on the use of protective tools, clothing and post-infection prophylaxis. The following activities will implement strategy 4.1:

- A. 4.1.1 Assess health and social welfare working and learning environments for the prevalence and use of safety and security measures, including appropriate infrastructure, protective environments, clothing, post-infection treatment and guidelines. [2016–2017]
- A. 4.1.2 Develop and implement a policy and program on occupational health, safety, security and risk reduction at all health and social welfare institutions and facilities, including: (a) maintaining records of work-related injuries, illness, accidents and fatalities to help assess and mitigate future risks; and (b) training and supervising workers in the maintenance and use of equipment and supplies to prevent accidents and reduce risks and vulnerabilities. [2015–2017]
- A. 4.1.3 Conduct annual briefings and meetings in the workplace to enhance information sharing and effective communication on issues regarding physical and emotional well-being, teamwork, stress-management, work-life balance. [2011; ongoing]
- A. 4.1.4 Protect students and workers against harassment (sexual or other forms) in accordance with the laws of Liberia and CSA guidelines and establish regional administrative hearing committees. The committees will be made up of focal persons from major facilities and institutions in the regions, and other members, in accordance with guidance from the MOHSW. The regional committees will forward recommended decisions and courses of action to the central MOHSW. [2011; ongoing]
- A. 4.1.5 Enforce the Government policy on working hours in all facilities and institutions. This excludes periods when the catchment population is experiencing emergencies and epidemics. [2014]
- A. 4.1.6 Facilitate reliable transport to and from home to workers on night shifts to enhance their safety. [2011; ongoing]

**The second strategy (4.2) is to increase the number of learning and working environments with the tools of the trade.**

**Rationale:** Students and workers lack the “tools of the trade.” A 2007 assessment of training institutions found that only two (Mother Pattern College of Health Sciences and the Rural Training Institute at Phebe Hospital) had appropriate learning environments. Generally, at other institutions, the facility and furniture are in a state of disrepair. Communication technology is not readily available or is absent altogether. The limited number of full-time faculty has resulted in employing or contracting part-time teachers. The faculty-to-student ratio is unacceptably high, with typically 1 faculty for more than 40 students. According to the BPHS Ac-

creditation Report (January 2011), scores for the availability of required drugs, medical equipment, including laboratory equipment, vary considerably and dip as low as 24%. Therefore, the following activities have been planned to implement strategy 4.2:

- A. 4.2.1 Assess all learning and working environments on availability and quality of the required equipment and materials during annual accreditation. [2012; ongoing]
- A. 4.2.2 Create and maintain enabling learning and working environments, equipped with adequate and up-to-date “tools of the trade” to be able to assure quality of training and services and increase motivation of students and workers. [2012–2016]

## 5. Implementation Arrangements

### 5.1 Human Resource Technical Committee

Leveraging the expertise and resources of the many stakeholders active in health and social welfare, the MOHSW will established a Human Resources Technical Committee (HRTC) to coordinate the financing, implementation and monitoring of the National Human Resource Policy and Plan and related human resource plans. The Human Resources Unit will act as the secretariat for HRTC and carry out the required coordination and facilitation. The Deputy Minister for Planning, Research and Development (or his/her designee) will chair the HRTC and report on proceedings to the Minister for Health and Social Welfare. The CHSWTs will replicate this HRTC at the county level, with the CHSWT Human Resource Officers being the focal point for coordination and facilitation.

At the national level, the HRTC will bring together all stakeholders working in human resources. Its membership consists of senior representatives from the Ministries of Health, Finance, Education, Public Works, Labor, and Internal Affairs and the Civil Service Agency, Liberia Institute for Public Administration (LIPA), professional and regulatory bodies, training institutions, civil society (NGOs and FBOs), and private sector and other development partners (e.g., interested donors). At the county level, the HRTC will consist of members of the CHSW boards and have representatives from the same relevant sectors and partners present at the national level.

The Terms of Reference for the Human Resource Technical Committees include the following:

1. Provide technical assistance to the HR functions of the MOHSW and CHSWTs;
2. Ensure that HR priorities are identified and established as essential components of the health system;
3. Ensure frequent dialogue and information-sharing on developments in HR with all concerned partners;
4. Ensure the availability of robust comprehensive and decentralized HRIS to be used for evidence-based planning and management of the workforce;
5. Develop a unified HR monitoring and evaluation framework of indicators, including target-setting, to be used by all partners and stakeholders;
6. Review the human resource policy every 10 years;
7. Review and adjust when necessary the human resource strategic and operational plans;
8. Develop and review cost- and time-indicative annual human resource plans;
9. Advocate for adequate resources for health and social welfare;
10. Develop and/or endorse proposals for funding HR interventions;
11. Ensure that linkages are established with all public-sector departments and private and civil society institutions that are involved in HR;
12. Support negotiations and coordination with different partners on matters relating to HR;

13. Ensure that good practices on HR development and management are documented;
14. Ensure that annual reviews of the status of HR in the country are organized; oversee the publication of annual reports on the results of the review.

## **5.2 Monitoring and Evaluation**

In accordance with the National Monitoring and Evaluation Policy and Strategic Plan, the MOHSW's Human Resources Unit will use the comprehensive decentralized HRIS to establish a baseline, set realistic annual targets for the major human functions at all levels, and facilitate the monitoring of the implementation of the plans.

The activities in Section 4 (above) provide for several monitoring increments that are to be carried out by different stakeholders, including:

- The national-level Human Resource Technical Committee will meet at least quarterly to monitor the implementation of operational plans and adjust the plans as necessary. For the technical committee to accomplish this function, the Human Resource Unit will provide committee members with copies of various monitoring reports, including comprehensive quarterly supervisory and annual accreditation reports;
- As the unit responsible for monitoring the NHSWPP, the M&E Unit of the MOHSW will monitor the performance of the national Human Resource Technical Committee;
- Supervision teams for each of the counties will conduct at least quarterly supportive supervision of all the facilities and institutions within the county, using a standardized supervisory manual that will include staffs performance and other HR factors;
- The annual accreditation team will expand its scope to include key human resource related issues, thereby contributing to monitoring the four objectives of this Plan;
- The professional and regulatory bodies will review the licensing requirements for all cadres every two years;
- County human resource officers will ensure annual performance evaluations of each worker are carried out. Results will be used for evidence-based decision-making;
- An independent company, selected by an open procurement process and paid for by the MOHSW, will conduct annual performance audits of the regulatory and professional bodies to assess their performance against their respective mandates. The contracted company will provide the annual audit reports to the MOHSW, which will make the findings available to the public before the end of each GOL fiscal year.

The MOHSW Human Resource Unit will make regular presentations to the MOHSW's Program Coordination Team, MOHSW senior staffs, the Human Resource Technical Committee, as well as at the NHSWPP Review Conferences on progress made implementing this policy and plan.

## **5.3 Operation Plans**

Operational plans will be important to facilitate the financing, implementation, monitoring and review of the strategic plan and will be fully aligned with the goals and objectives of the human resource policy and NHSWPP. The first operational plans will cover a period of two years from July 1, 2011, to June 30, 2013. In 2012, based on the first annual review of the imple-

mentation this HRPP, a revised annual plan will be developed for the period July 1, 2012, to June 30, 2013. In 2013, an annual plan will be developed after the previous has been reviewed, and so on.

All operational and annual plans will be time- and cost-indicative. Time-indicative plans will facilitate the development of quarterly, monthly and weekly plans and budgets, enable assessment of the percentage of planned activities successfully implemented within the planned period, and help to determine how effectively the Human Resource Unit is in reviewing and developing realistic plans. Plans will be cost-indicative in order to project the costs involved for each strategic action and thus assess its cost-efficiency, rationalize and prioritize human resource planning and solicit funds when necessary.

In addition to reviewing and developing time and cost plans, the Human Resource Unit will also develop other plans, such as needs-based workforce deployment plans (short- to medium-term planning), training plans (long-term planning), career ladder plans for each cadre of health and social welfare worker, and succession plans.

All national-level time- and cost-indicative plans will be approved by the HRTC prior to dissemination to all relevant institutions, organizations, programs, CHSWTs and facilities to ensure that their plans will be aligned with the national ones and are realistic and achievable.

## 5.4 Workforce Estimate

The size and cost of the workforce will evolve over the lifespan of this 10-year policy, in accordance with population growth and the overall policy objective of increasing accessibility of services established by the NSWPP. By first determining the number and type of facilities required in 2021, the size and cost of the workforce can then be projected.

According to the 2.1 population growth rate (2.1), Liberia's population will exceed 4.5 million people by 2021. Based on the national target (85%) for increasing the population's geographic accessibility to services, and detailed county-planning processes of assigning service delivery points to under-served populations, table 1 (below) presents the projected GOL health facility network in 2021. To achieve the target level of coverage for the population, the network of functioning public facilities must increase from 399 in 2011 to 543 by 2021.

To determine the number of workers required to operate the 2021 network of facilities, staffing norms by facility type must be multiplied by the number of facilities in each category (clinic, health center, etc.). Table 2 presents the staffing pattern for each type of facility and the number of facilities projected by 2021. Average team size by type of facility must be read as indicators of resource allocation, which may be reallocated as needed, as actual team sizes will vary on the basis of workload.

For new facilities, the initial team size will likely be kept to a minimum because most newly opened facilities in remote areas will serve small populations. Teams serving small populations will be comprised of just two or three workers, one of whom will be a multipurpose professional (nurse, PA or midwife).

Based on the population, facility and coverage factors, the total number of workers will exceed 15,000 by 2021, 55% of whom will be professionals. Most of the professionals fall into three categories: nurses, midwives and PAs. In absolute terms, nurse aides are the biggest category.



The number of physicians will rise significantly by 2021, and about one-half of all personnel will be positioned at county hospitals.

**Table 1. Network of Government of Liberia Health Facilities by County, 2011–2021**

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

CH = County Hospital, DH = District Hospital, HC = Health Center, NH = National Hospital, RH = Regional Hospital

**Table 2. Workforce for the 2021 Network of Government of Liberia Facilities**

| Cadre                       | Facility No. 2021 |            |           |             |            |              |            |              |            |              |
|-----------------------------|-------------------|------------|-----------|-------------|------------|--------------|------------|--------------|------------|--------------|
|                             | Clinic            | 419        | HC        | 98          | C.H.       | 21           | RH         | 4            | JFKMC      | 2021         |
| Physician                   |                   |            |           |             | 8          | 178          | 15         | 60           | 115        | 353          |
| Hospital Admin.             |                   |            |           |             | 1          | 21           | 1          | 4            | 1          | 26           |
| Nursing Director            |                   |            |           |             | 1          | 21           | 1          | 4            | 1          | 26           |
| Physician's Assistant       | 1                 | 419        | 2         | 196         | 12         | 252          | 24         | 96           | 24         | 987          |
| Registered Nurse            |                   |            | 2         | 196         | 42         | 882          | 99         | 396          | 144        | 1,618        |
| Certified Midwife           | 1                 | 419        | 4         | 392         | 46         | 966          | 99         | 396          | 143        | 2,316        |
| Nurse Midwife               |                   |            |           |             | 20         | 420          | 120        | 480          | 120        | 1,020        |
| Pharmacist                  |                   |            |           |             | 3          | 63           | 4          | 16           | 4          | 83           |
| Anesthetist                 |                   |            |           |             | 10         | 220          | 15         | 60           | 28         | 308          |
| O.R. Technician             |                   |            |           |             | 10         | 220          | 16         | 64           | 24         | 308          |
| Lab Technician              |                   |            | 1         | 98          | 3          | 63           | 5          | 20           | 9          | 190          |
| Lab Assistant               |                   |            |           | 0           | 10         | 220          | 12         | 48           | 20         | 288          |
| Environ. Health. Technician |                   |            | 1         | 98          | 3          | 63           | 4          | 16           | 6          | 183          |
| Social Worker               |                   |            | 1         | 98          | 6          | 126          | 8          | 32           | 8          | 494          |
| X-ray Technician            |                   |            |           |             | 3          | 63           | 4          | 16           | 8          | 87           |
| Administrative Assist.      |                   |            |           |             | 7          | 147          | 8          | 32           | 12         | 191          |
| Radiologist                 |                   |            |           |             | 3          | 63           | 4          | 16           | 8          | 87           |
| Nutrition                   |                   |            |           |             | 3          | 63           | 5          | 20           | 5          | 88           |
| Physiotherapist             |                   |            |           |             | 3          | 63           | 4          | 16           | 8          | 87           |
| <b>Professional Staff</b>   | <b>2</b>          | <b>838</b> | <b>11</b> | <b>1078</b> | <b>196</b> | <b>4,116</b> | <b>448</b> | <b>1,792</b> | <b>688</b> | <b>8,742</b> |

| Cadre                     | Facility No. 2021 |              | Facility No. 2021 |              | Facility No. 2021 |              | Facility No. 2021 |              | Facility    |               |
|---------------------------|-------------------|--------------|-------------------|--------------|-------------------|--------------|-------------------|--------------|-------------|---------------|
|                           | Clinic            | 419          | HC                | 98           | C.H.              | 21           | RH                | 4            | JFKMC       | 2021          |
| Nurse Aide                | 1                 | 419          | 1                 | 98           | 90                | 1,890        | 160               | 640          | 160         | 3,207         |
| Dispenser                 | 1                 | 419          | 1                 | 98           | 10                | 220          | 12                | 48           | 20          | 805           |
| Lab Aide                  |                   |              |                   |              | 15                | 315          | 20                | 80           | 20          | 415           |
| Recorder                  | 1                 | 419          | 1                 | 98           | 3                 | 63           | 4                 | 16           | 4           | 600           |
| <b>Skilled, Non-Prof.</b> | <b>3</b>          | <b>1,257</b> | <b>3</b>          | <b>294</b>   | <b>118</b>        | <b>2,488</b> | <b>196</b>        | <b>784</b>   | <b>204</b>  | <b>5,027</b>  |
| <b>Non-Skilled</b>        | <b>1</b>          | <b>419</b>   |                   |              | <b>41</b>         | <b>861</b>   | <b>103</b>        | <b>412</b>   | <b>165</b>  | <b>1,857</b>  |
| <b>Total</b>              | <b>6</b>          | <b>2,514</b> | <b>14</b>         | <b>1,372</b> | <b>355</b>        | <b>7465</b>  | <b>747</b>        | <b>2,988</b> | <b>1057</b> | <b>15,626</b> |

## 5.5 Cost Estimate

Having determined the number of workers necessary to operate each type of public facility and when they will be required (according to county plans), the estimated cost of service delivery can be calculated by: (1) using the EPHS salary scale; (2) adding an additional fixed proportion for CHSWT and MOHSW management costs (15%); and (3) applying a projected annual rate of inflation (5%).

$$\text{Annual cost of service delivery} = \text{No. of workers} \times \text{salary scale} \times 1.15 \times 1.05$$

By including the annual average cost of the human resources strategic plan activities (see Annex 2 for the budget narrative), the total estimated cost of implementing the HRPP can be determined by year. Table 3 presents the cost for service delivery, management personnel and strategic plan activities by year from 2011 to 2021.<sup>10</sup>

**Table 3. Human Resource Policy Implementation Cost by Year, 2011–2021 (US\$)**

| Fiscal Year | Service Delivery Personnel | Management Personnel | Investment and Operational Costs | Total      |
|-------------|----------------------------|----------------------|----------------------------------|------------|
| 2011–2012   | 10,289,453                 | 1,543,418            | 1,913,385                        | 13,746,256 |
| 2012–2013   | 12,717,779                 | 1,907,667            | 1,913,385                        | 16,538,831 |
| 2013–2014   | 15,146,104                 | 2,271,916            | 1,913,385                        | 19,331,405 |
| 2014–2015   | 17,574,430                 | 2,636,164            | 1,913,385                        | 22,123,979 |

<sup>10</sup> Human resource strategic plan activities are classified as Investment and Operational Costs in Table 3.

| Fiscal Year        | Service Delivery Personnel | Management Personnel | Investment and Operational Costs | Total              |
|--------------------|----------------------------|----------------------|----------------------------------|--------------------|
| 2015–2016          | 20,002,755                 | 3,000,413            | 1,913,385                        | 24,916,553         |
| 2016–2017          | 22,431,080                 | 3,364,662            | 1,913,385                        | 27,709,127         |
| 2017–2018          | 24,859,406                 | 3,728,911            | 1,913,385                        | 30,501,702         |
| 2018–2019          | 27,287,731                 | 4,093,160            | 1,913,385                        | 33,294,276         |
| 2019–2020          | 29,716,057                 | 4,457,408            | 1,913,385                        | 36,086,850         |
| 2020–2021          | 32,144,382                 | 4,821,657            | 1,913,385                        | 38,879,424         |
| <b>Total</b>       | <b>212,169,177</b>         | <b>31,825,376</b>    | <b>19,133,850</b>                | <b>263,128,403</b> |
| Average Proportion | 81%                        | 12%                  | 7%                               | 100%               |

As indicated in Table 3, the total cost of implementing the National Human Resources Policy and Plan for Health and Social Welfare, 2011–2021 is US\$ 263,128,403.

The cost of service delivery represents 81% of implementing the HRPP, whereas investments in areas such as in-service training and supportive supervision cost just 7%. Management and support costs for the central MOHSW and CHSWTs represent 12% of total estimated costs.

**Table 4: HRRP and NHSWPP Cost per capita, 2011 and 2021 (US\$)**

| Year | NHSWPP per capita (US\$) | HRRP per capita (US\$) | HRRP % of NHSWPP |
|------|--------------------------|------------------------|------------------|
| 2011 | 18                       | 3.7                    | 20.5             |
| 2021 | 44                       | 8.6                    | 19.5             |

In terms of per capita costs of the HRPP, implementation will cost an estimated US\$ 3.7 per capita in 2011. The estimated per capita cost will increase to US\$ 8.6 by 2021, factoring for inflation and an increased population. Each year, from 2011 to 2021, human resources represent about 20% of the total cost of implementing the NHSWPP, 2011–2021.<sup>11</sup>

## 5.6 Risks and Assumptions

Among the many risk factors that may affect the NHSWPP and the implementation of the HRPP are:

<sup>11</sup> *National Health and Social Welfare Policy and Plan, 2011–2021*, “Section 7: Broad Plan Cost Estimate,” p. 81, Ministry of Health and Social Welfare.

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

This HRPP has been formulated on basis of a number of assumptions:

- The country will enjoy political stability and economic growth.
- The GOL will improve the national infrastructure, particularly in hard-to-reach areas.
- The GOL will increase annually its financial allocation to the MOHSW, of which a greater proportion will be allocated to strengthen major human resource functions.
- The GOL will continue to raise the visibility of the human resource crisis at all forums where health and social welfare is an agenda item.
- Development partners will provide generous and sustained financial and technical support to the implementation and monitoring of the HRPP.
- The MOHSW will be committed to:
  - Make the HRTC work and will provide direction to and close monitoring of the committee;
  - Develop, implement and monitor the sector budget for health and social welfare, in collaboration with relevant partners;
  - Develop and maintain a functional HRIS, HMIS and HR Observatory that provide the necessary information that will be used to rationalize functions and priorities.

# Annex 1: Expanded Situational Analysis

## 1. Background

Since the restoration of peace and stability in the country and with the support of the reform-minded government, the MOHSW has made significant efforts to reform the sector, create a relevant and sustainable decentralized health system, strengthen the planning and management functions of the County Health and Social Welfare Teams (CHSWTs), deploy HR directors for each of the 15 CHSWTs, regard health and social welfare as basic human rights, and increase access to improved quality of health and social welfare services by implementing and monitoring the Basic Package of Health Services (BPHS) in all 15 counties.

The MOHSW acknowledges that “HR is the most valuable asset of the health sector” (MOHSW 2007a: 15). In the Poverty Reduction Strategy (PRS) for the period 2007–2011, 11 of the 37 PRS deliverables for the MOHSW were HR-related (Republic of Liberia 2008a: 120).

## 2. Overview of Sector’s Workforce and Facilities

In 2009, the HR Census team recorded 9,196 health and social welfare workers.<sup>12</sup> This number includes 3,207 non-clinical workers (35%) and consists of, among others, cleaners, drivers, and administrative and security staff, resulting in a clinical workforce of 5,989 workers. Nurse aides (1,589) and (all categories of) nurses (1,393) constitute 17.3% and 15.2%, respectively, of the total, making them the next biggest groups in the sector’s workforce. Certified midwives (412), physician assistants (PAs) (286), and social welfare workers (182) count for 4.5%, 3% and 2% of the total workforce, respectively (World Bank 2010a: 6). In 2006, the Rapid Assessment team recorded a workforce of 4,970 full-time and part-time health and social welfare workers (MOHSW 2006). A comparison with 2009 is not straightforward because the 2006 Assessment excluded traditional midwives and non-clinical workers.

**Table 1. Total workforce in numbers per cadre/category for 2006 and 2009**

| Cadre/Category                  | 2006 HR Rapid Assessment | 2009 HR Census | HR Difference <sup>13</sup> |
|---------------------------------|--------------------------|----------------|-----------------------------|
| Physician/Doctor                | 169                      | 67             | -102                        |
| Surgeon                         |                          | 23             | +23                         |
| Physician Assistant             | 273                      | 286            | +13                         |
| Registered Nurse (RN)           | 453                      | 1327           | +874                        |
| RN/Certified Midwife (CM)       | 18                       | 66             | +48                         |
| Certified Midwife               | 355                      | 412            | +57                         |
| Nurse Aide                      | 1091                     | 1589           | +498                        |
| Environmental Health Officer    | 55                       | –              | –                           |
| Environmental Health Technician | –                        | 119            | –                           |

<sup>12</sup> This number includes the 428 workers who were absent from work at the time of the survey. These workers have not been included in the further analysis of the workforce. The figure 9,196 includes trained and untrained traditional midwives but excludes other traditional and alternative health practitioners, full-time staff working in training institutions and community health volunteers.

<sup>13</sup> These numbers do not tell anything about the attraction and retention levels for each cadre, though.

| Cadre/Category                       | 2006 HR Rapid Assessment | 2009 HR Census | HR Difference <sup>13</sup> |
|--------------------------------------|--------------------------|----------------|-----------------------------|
| Health Inspector                     | –                        | 54             | –                           |
| Lab technician                       | 149                      | 137            | –12                         |
| Lab Assistant/Aide                   | 156                      | 239            | +83                         |
| X-ray Technician                     | 25                       | 22             | -3                          |
| Pharmacist                           | 29                       | 46             | +17                         |
| Dispenser                            | 427                      | 505            | +78                         |
| Dentist                              | 13                       | 15             | +2                          |
| Dental Surgeon                       |                          | 8              |                             |
| Social welfare worker                | 100                      | 182            | 82                          |
| Formally trained traditional midwife |                          | 193            |                             |
| Traditional midwife                  |                          | 50             |                             |
| Non-clinical worker                  | –                        | 3207           | –                           |

Sources: MOHSW 2006, MOHSW and World Bank 2010a.

The sector lacks adequate numbers of qualified, experienced and supported health and social welfare workers. According to the HR Census, Liberia has 2,181 skilled birth attendants (physicians, PAs, nurses and midwives) for a population of 3,476,608, resulting in a national ratio of 1.58 skilled birth attendants per 1,000 population. This is still far below the WHO threshold of 2.28 per 1000 population, used as a proxy indicator required to meet 80% coverage of deliveries by skilled workers.

The Government of Liberia is the largest employer of the sector's 2009 workforce (29.7%). Almost half of these workers are based in Monrovia. Some 22.7% of the workforce is on contract, 16.4% are private-for-profit employees, and 22.7% are classified as volunteers. (This percentage excludes the numerous community health volunteers). The biggest groups of volunteers are among the nurse aides and the non-clinical workforce (World Bank 2010a: 20). Nurse aides, however, are overstaffed in all facilities and in all counties (MOHSW/CHAI 2010: 14, 27). The Census report does not have a category for workers employed or contracted by private not-for-profit organizations and volunteers working for NGOs.

The country has had a significant increase in facilities since 2006. In that year, Liberia had 286 functional clinics, 50 health centers and 18 hospitals (MOHSW 2007a: 5). The 2009 Census reports 600 functional facilities, including 423 clinics, 42 health centers, 31 hospitals and 104 pharmacies/dispensaries (World Bank 2010a: 3).<sup>14</sup>

<sup>14</sup> The survey team did not visit 143 facilities, the bulk of which were clinics. It is unclear from the Census report whether this number is included or excluded in the 603 facilities. (World Bank 2010a: 5). The survey covered 603 facilities, including public, private not-for-profit and private for-profit health care facilities and 104 pharmacies/dispensaries but excluded all training institutions (World Bank 2010a: 3).

### **3. HR Challenges**

Despite remarkable increase in the workforce and functional facilities, a host of push-and-pull factors severely hamper the current HR situation. The sector continues to face major HR challenges, in particular in the areas of planning, development and management.

#### **3.1 Planning**

##### **3.1.1 Emergency Human Resources Health Plan 2007–2011**

In 2007, the MOHSW drafted the Emergency Human Resources for Health Plan 2007–2011 to scale up the production and recruitment of staff (MOHSW 2007c). In that same year, the HR Unit within the Ministry was established and an HR director appointed. Although a Strategic Human Resource Development Plan was developed for the period 2008–2010, it has never been approved and implemented (MOHSW 2008e). Both plans were not time- and cost-indicative.

##### **3.1.2. Workforce Not Well-Experienced**

The sector's total workforce is not well-experienced. Nearly one-third (30.8 %) have had two years or less of work experience; more than half (51.6%) of the workforce have four years or less of work experience. Just less than one in five people (19.3%) has 10 years of working experience. Male workers are, on average, slightly more experienced than female workers (World Bank 2010a: 17-18). The report did not analyze working experience in relation to cadres, and the cadre of social welfare workers has not been analyzed at all. Furthermore, the sector's clinical workforce is relatively old. Six out of every ten workers (60.9%) are aged 40 or older (World Bank 2010a: 16).

##### **3.1.3. Gender Imbalance**

A gender imbalance exists within the sector's workers. The majority of them (61.9%) are male, but this percentage is skewed due to the high proportion of men among the non-clinical workers (78.3%) (World Bank 2010a: 15). Clinical cadres follow strong traditional and stereotypical gender lines. More than four out of every five PAs (84.6%), physicians (84.4%), and lab technicians and lab assistants (84.3%) are men. For pharmacists, this percentage is slightly lower: 78.3%. Yet women make up the biggest part of the nurses and certified midwives, with 57.4% and 98.3%, respectively, resulting in a slight gender imbalance among clinical cadres: 51.3% are men and 48.7% are women (World Bank 2010a: 15).

##### **3.1.4. Health Sector Spending**

For the fiscal year 2007–2008, 7.73% of Liberia's national annual budget was allocated to the public health sector (MOHSW 2009i). However, for the fiscal year 2009–2010, the health sector budget was 7.35% of the annual national budget (Republic of Liberia 2009). To meet the Millennium Development Goals (MDGs), the UN stipulates that, for a country like Liberia, health care spending should be US\$ 34.00 per capita. In 2008, the MOHSW estimated it to be US\$ 4.80. However, when international and private assistance was included, the amount was US\$ 18.75 (Lamm and Chapman 2008: 4). However, it is unclear how this amount was calculated and whether it includes training and development of the required cadres, physical infrastructure development and technical assistance. The 2009 National Health Accounts Report for the fiscal year of 2007–2008 reported a total health and social welfare expenditure of US\$



29 per capita. This is high compared to other countries in the West and Central African region (having an average of US\$ 28 per person in 2006). Donations and out-of-pocket payments accounted for the most expenditure (47% and 35% respectively) while government spending is 15%.

### **3.1.5. No comprehensive and effective Human Resources Information System**

The MOHSW is in the process of establishing an Human Resources Information System (HRIS) but does not yet have an effective and comprehensive sector-wide decentralized HRIS in place to rationalize all decision making related to the major HR functions. Also, the payroll is not yet completely clean and still contains employees who are wrongly paid (e.g., drivers paid as nurses and midwives as cleaners).

During 2009–2010, three HR policy studies were conducted as a foundation of the HR Policy and to provide evidence for strategic and operational priorities and actions for the HR plans.

## **3.2. Development**

### **3.2.1. Development of Staff Is Inadequate**

The development of the workforce is grossly inadequate and of low caliber. In 2007 and 2008, health training institutions were assessed, including the state of the training programs and accreditation status, HR (faculty and staff), students, curriculum, infrastructure, funding and formal linkages between selected public and private training institutions. The assessment served to inform strategic directions in line with the BPHS (MOHSW/USAID 2007; Lamm and Chapman 2008). All institutions have had an influx of students for paramedical training programs. In 2007, 1,600 applicants applied for 200 positions in the Tubman National Institute of Medical Arts (TNIMA). The school has 450–500 students (MOHSW/USAID 2007: 12).

### **3.2.2. Admission to Training Not Geared to Address Gender Gaps or to Give Priority to Students from Hard-To-Reach Areas**

Students are predominantly female between the ages of 19 and 40. For example, at TNIMA, the midwifery program is 100% female, the nursing program is 98%, the physician assistant (PA) program 40%, but the environmental health program is 10% female (MOHSW/USAID 2007: 12). Training programs do not give priority to students from rural or hard-to-reach areas (MOHSW/USAID 2007: 7).

### **3.2.3. Not Sufficient Full-Time Qualified Faculty Staff**

Institutions lack adequate numbers of full-time qualified faculty staff (FTE). The majority of teachers/instructors are male and do not have the appropriate Master's or Ph.D. degree qualifications. In 2008, the A.M. Dogliotti College of Medicine lacked instructors for histopathology, biochemistry, pediatrics and psychiatry. Medical students could not go for rotation in hospitals due to a lack of transport and supervisors (Lamm and Chapman 2008: 8, 10). In addition, all schools have an unacceptably high student-to-faculty ratio,<sup>15</sup> overcrowded classrooms and inadequate text books.

### **3.2.4. Curricula do not meet the requirements**

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<sup>15</sup> With 1 FTE faculty for more than 30 students (MOHSW/USAID 2007: 1).

Further, facilities use outmoded curricula, which have not been revised by the different licensing boards since the mid-1980s. Curricula do not meet the needs of the population or the requirements of the BPHS. Also, updated WHO guidelines on key programs are unavailable. Affiliated teaching hospitals and clinical training sites are overwhelmed by the number of students and the lack of adequate clinical supervisors and sound learning environments (MOHSW/USAID 2007: 7-8; Lamm and Chapman 2008: 9-47). The Medical Board has put the Dogliotti College of Medicine on probation.

### **3.2.5. Infrastructure of the schools and dormitories inadequate**

The infrastructure of the schools and dormitories is grossly inadequate. Classrooms and furniture are in "extensive disrepair," with the exception of Mother Patern and Phebe, which "appear to have a good and conducive learning environment." Communication technology and computers are not readily available or are totally absent. Most students live off-campus (MOHSW/USAID 2007: 8).

### **3.2.6. Limited Resources for Pre-Service Training**

All institutions and programs have inadequate funds. Funding sources and institutional linkages are diverse. For the operational costs, training institutions predominantly rely on students' tuition fees. TNIMA and Phebe also receive some government subsidies and attract students with government or non-governmental organizations (NGO) scholarships. Phebe and Mother Patern also receive funds through international faith-based organizations (FBO) to support their rehabilitation efforts and in-kind donations such as refurbished equipment and medical supplies (MOHSW/USAID 2007: 8-9). The funding for the College of Medicine comes from the GOL through the Ministry of Education to the University. Its funds are appropriated by the Board of Trustees of the University. Although a budget is presented, the College has no direct say in decisions related to its distribution. Since 2007 donations for the College can be "earmarked" for certain purposes. Nonetheless, there seem to be no financial reporting requirements (Lamm and Chapman 2008: 7, 9-10).

### **3.2.7. Sector Facilities and Training Institutions Not Equitably Distributed**

The sector's facilities and training institutions are also not equitably distributed

### **3.2.8. Lack of Continuing Education and System to Ensure Re-certification and Re-licensing**

All cadres lack continuing education. Professional boards lack a system to ensure annual procedures for re-certification and re-licensing of the workforce in the various cadres (Lamm and Chapman 2008: 7).

## **3.3 Management**

### **3.3.1 Salaries Are Inadequate to Live On**

The sector faces major problems with HR management issues. First, the workforce is inadequately remunerated. In 2008, the Ministry and its partners introduced an incentive scheme for critical cadre. Almost half of the workforce reports receiving a monthly income between US\$ 50.00 and US\$ 100.00.<sup>16</sup> More than 6 out of every 10 workers (63.6%) report a monthly income of US\$ 100.00 or less (World Bank 2010a: 21). On average, physicians and PAs working within Monrovia report earning more than those working outside the capital. Certified mid-

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<sup>16</sup> This income includes salary plus financial incentives (World Bank 2010a: 21).

wives, however, report earning more outside Monrovia. For nurses, reported incomes are roughly the same within and outside Monrovia (World Bank 2010a: 23). In addition, GOL employees report a higher income than workers in other employment categories within the sector (World Bank 2010a: 22).

### 3.3.2. Remuneration Gaps between Cadres and by Gender

More men (1,675) than women (1,433) have a reported income of US\$ 100.00 or above. Physicians are the highest earners, followed by pharmacists and dentists. The gap between the reported incomes of physicians and those of nurses is huge. On average, medical doctors report earning US\$ 1,114.19 a month while nurses report US\$ 202.26. Overall, the reported income of nurses is higher than that of certified midwives (US\$ 170.19) but lower than that of PAs (US\$ 225.15) (World Bank 2010a: 21). Further, the pay system for the public sector workforce is fragmented, varying according to employment status, cadre and location (World Bank 2010b: 7).<sup>17</sup>

**Table 2. Monthly Zonal Pay Rates in US\$ for Selected Cadres of MOHSW Contract Workers**

| Cadre                   | Monrovia Zone | Outside Monrovia Zone | South East Zone |
|-------------------------|---------------|-----------------------|-----------------|
| Medical Doctor          | US\$ 900      | US\$1000              | US\$1,200       |
| PA                      | 175           | 213                   | 250             |
| Nurse (RN, Grad Nurse)  | 125           | 163                   | 200             |
| Nurse Anesthetist       | 175           | 213                   | 225             |
| Nurse Midwife           | 150           | 175                   | 200             |
| Nurse Aide              | 80            | 80                    | 80              |
| License Practical Nurse | 100           | 125                   | 150             |
| Certified Midwife       | 110           | 143                   | 175             |

Source: MOHSW Nov. 2007

### 3.3.4. Not Sufficient “Tools of the Trade” to Provide Quality Health Services

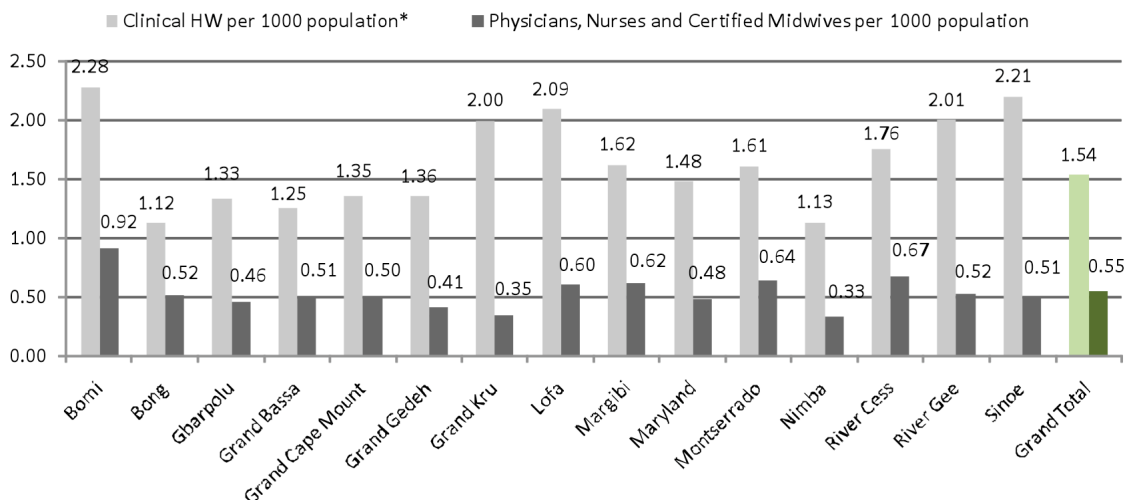
The workforce lacks the adequate “tools of the trade.” According to the BPHS Accreditation Report of 2011, scores for the availability of required drugs, medical equipment (including laboratory equipment) vary considerably and dip as low as 24% (World Bank 2010b: 7).

### 3.3.5. Staff Not Equitably Distributed

Next, the sector’s workforce, including skilled birth attendants, is not equitably distributed between counties to the disadvantage of remote rural counties. Nimba (0.33), Grand Kru (0.35), Grand Gedeh (0.41), Gbarpolu (0.46) and Maryland (0.48) have the lowest ratios for skilled birth attendants per 1,000 population. However, these ratios are slightly higher because they include PAs (see Figure 1).

<sup>17</sup> Staff on GOL payroll are paid a salary that is based on their cadre without considering such factors as location, professional training and years of experience. Specific GOL cadres receive a “top-up,” which is determined by location (World Bank 2010b: 7). Contract workers within the counties receive a contract fee or incentive (which is equivalent to the GOL salary) plus a “top-up” in line with the GOL “top-up” per cadre and location (in one of the three identified zones). Volunteers are either not paid or paid only on an irregular basis.

**Figure 1. Ratio of Physicians, Nurses and Certified Midwives, per 1000 Population per County**



The workforce is inequitably deployed in favor of urban areas and hospitals. The inequitable distribution of workers also exists within counties between facilities to the disadvantage of clinics, especially those located in sparsely populated areas and areas with few amenities such as schools, transport networks and banks (World Bank 2010b: 7). Clinics are the most short-staffed in every cadre (MOHSW/CHAI 2010: 19).

Overall, facilities have the wrong skills mix and therefore are insufficiently staffed to deliver the BPHS and meet the national health and demographic targets. Montserrado County, with the largest population (32%) and the country's academic hospital, has 33% of the national workforce. Yet, a number of cadres are disproportionately concentrated: Montserrado has 53% of the country's 67 physicians, 59% of its 15 dentists and 91% of its 22 X-ray technicians (World Bank 2010a: 7-8). Lofa county has the highest proportion of (trained and untrained) traditional midwives (23.5%) against 7.4% in Montserrado. Nimba, with 13.3% of the national population, has 6.3% of the certified midwives (World Bank 2010a: 8, 10).

In line with the BPHS, the minimum nursing staffing level within clinics should be two nurses (assuming the in-charge is a nurse). According to the HR census, the average is only 1.3 nurses per clinic. For health centers, the minimum nursing staffing level is six nurses (assuming that the in-charge is a nurse) or five nurses (assuming that the in-charge is a PA). In 2010, the average was 4.3 nurses per health center (World Bank 2010b: 1). Yet, according to the Workforce Optimization Analysis report, the greatest relative need is for PAs, followed by doctors, midwives, dispensers and only then nurses (MOHSW/CHAI 2010: 13).

Redeployment of existing staff from hospitals to health centers and clinics will save the GOL money and remove the need for additional staff in certain areas and facilities (MOHSW/CHAI 2010: 18). Nurses surveyed report that attracting them to rural areas for a three-year period could be enhanced by providing them with: adequate equipment (46%), housing (52%), transportation (53%), or a US\$ 50.00 bonus (49%). If a US\$ 100.00 bonus were paid, then 64% of

the nurses would be willing to work in rural areas; 69% would be willing to do so if both housing and motorbikes were provided; and 66% if both housing and a US\$ 50.00 bonus were in the package (World Bank 2010b: 15-16).<sup>18</sup>

### **3.3.6. Difficult to Attract and Retain Staff in Remote Areas**

Attraction and retention of a skilled and experienced workforce in remote areas is problematic. Overall, working in urban areas is highly desirable. In particular, nurses aged 35 and above and female nurses highly value working in an urban location (World Bank 2010b: 13). Nurses with exposure to rural areas, either by birth or through their professional training or on-the-job experience, value working in urban areas the least (World Bank 2010b: 13). Research conducted elsewhere supports the above and shows evidence that willingness to work in rural areas is influenced by a host of factors, including age, sex, previous and current work experience in rural areas, having been born in a rural area, having been professionally trained in rural areas and/or having had practicals/internships in rural areas (Lagarde and Blaauw 2009; Dolea *et al.*, 2010; Serneels *et al.*, 2010).

### **3.3.7. Inadequate Housing and Lack of Transport**

Nurse respondents in the Discrete Choice Experiment (DCE) were likely to exchange their current urban location for one in a rural area and work there for a period of three years if they were offered (in order of priority) a motorbike, free housing or adequate equipment. A normal workload was the least appreciated proposed incentive (World Bank 2010b: 12-13).

Adequate housing could serve as a motivating factor to attract and retain qualified and experienced cadres in rural areas. Although overall, nurses in the DCE rated free housing as the second most valuable incentive to induce them to move to a rural area for a three-year period, female nurses, older nurses and nurses with exposure to rural areas valued free housing the most (World Bank 2010b: 12; 14).

Housing conditions leave much to be desired. Less than one-third of the workforce (30.2%) reports having an "intact" residence. Another third (34.3%) lives in "damaged" accommodation. Of this group, 10% live in housing with "major damage." The remaining workforce live in newly built (23.4%) or renovated accommodation (12.1%) (World Bank 2010a: 29).

Housing conditions show large disparities between counties. In Lofa, 58.2% of the workers live in "newly built" accommodation compared to 8.1% in Grand Kru. In Maryland some 47.5% of the workforce have intact accommodation but in Lofa only 10% do. This result is confusing, because in Lofa 58% of workers live in newly built houses, yet only 10% live in intact accommodation. Some 28.5% of the workers in Bomi live in renovated houses, compared to 4.3% in River Cess (World Bank 2010a: 29). In Montserrado, almost all workers report living in a house with a cement, wood or tile floor (95.5%), and that their houses have a zinc, asbestos, cement or tile roof (98%). Of all the counties, houses in Grand Kru are the worst: only 35.9% have adequate floors and 39.7% have adequate roofs. Overall, Nimba, Gbarpolu, Lofa, Grand Gedeh, Sinoe, River Cess, River Gee and Grand Kru (listed in descending order) have the highest percentages of workers residing in accommodation with sub-optimal floors, walls and roofs combined (World Bank 2010a: 28).

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<sup>18</sup> According to the DCE study, a bonus of US\$ 25.00 would have only a very small effect.

Transportation is essential. This includes transportation during work as well as to and from work and outside of working hours (World Bank 2010b: 8). Although nurse respondents who participated in the DCE valued free transportation the most overall, this preference was strongest among male nurses, older nurses and nurses with prior exposure to rural areas (World Bank 2010b: 12). Transportation is problematic, especially in rural areas (World bank 2010b: 14).

The main means of transportation to work is walking or biking (56.1%), followed by taking public transport (36.9%). Only a few own a motorbike or car (5.1%). It is unclear from the Census whether those are privately-owned cars and motorbikes or are provided by the employer/contractor because of seniority or as incentive (2010a: page 27) or can use a family-owned motorbike or car (1.9%). Again, there is a strong rural–urban divide. Some 17.7% of the workforce outside the capital relies on public transport and 76.5% walks or bikes to and from work, while in Monrovia 81.2% of the workers use public transport and only 9.1% walk or bike (World Bank 2010a: 26-27).

The workload is influenced by, among other things, the location and functions (level) of the facility, working hours, staffing levels, levels of absenteeism among workers, and (creating) patient demand. Although nurses overall value a “normal” workload the least, female nurses, older nurses and those who have worked in a rural setting value a normal workload the most (World Bank 2010b: 12; 15).

#### **3.3.8. Absenteeism from Work**

There appears to be considerable absenteeism among workers. In addition to anecdotal reports, two HR studies explicitly mentioned that absenteeism among the workforce disrupted their proposed research work. The HR Census reported the absence of 428 workers, almost 5% of the total workforce (World Bank 2010a: 6). Using the DCE methodology, the study reported that “the true absence rate of nurses at facilities was much higher than what was estimated to construct the target sample.” (World Bank 2010b: 10)

#### **3.3.9. Not All Clinical Staff Have Required Certificates or Licenses**

Last, not all nurses and physicians have the relevant certificates or are adequately licensed. Some 14.6% of the nurses and 13.3% of physicians reported not having the obligatory documents (World Bank 2010a: 25). This percentage could be underestimated since the survey team did not ask the relevant cadres to show them copies of their required papers.

## Annex 2: Budget Narrative for Activities

While 81% of the cost of implementing the HRPP is for service delivery workers, this section describes the assumptions made and information used for costing the activities of the HRPP (the 7% allocated to Investments and Operations Costs, shown in Table 3 in Section 5). The activities listed below are those that have been costed. Activities are referred to by number, e.g. , A.1.1.4, so that more details on the specific activity can be read.

### **Benefit packages for workforce in hard-to-reach areas (A.1)**

- A monthly bonus of US\$ 62 (or US\$ 744 annually), to be provided to the workforce in hard-to-reach areas.

### **Public reward systems (A.1.2.6)**

- An annual reward of US\$ 100, given to the best-performing student or worker in each institution and facility. According to the 2011 Accreditation Report, there are 378 facilities. This number has been rounded to 400 to cover training institutions and MOHSW departments as well.

### **Leadership and management training (A.1.2.11)**

- Managers of facilities, institutions, divisions and programs will be trained in leadership and management competencies. Starting in 2012–2013, an annual budget item of US\$ 30,000 will be included for leadership and management training, which usually lasts 3–5 days. There are no specifics on the number of managers in the total workforce, but it is assumed that this budget allocation will allow training of at least 20 managers per year.

### **Fellowship programs for critical teaching staff (A.1.2.12)**

- For the first four years of the Strategic Plan, three fellowships (at a value of US\$ 15,000 each) will be offered to critical teaching staff.

### **Conduct annual staff satisfaction surveys (A.1.2.13)**

- Fifteen integrated supervisors will receive training in how to conduct staff satisfaction surveys. The two-day training will be conducted by the Research Unit of the MOHSW. The unit cost of US\$ 100 per person per day covers the daily subsistence allowance of US\$ 50, transport, catering, rent of training site, stationery and printing costs.
- An extra lump-sum budget for stationery and fuel (US\$ 2,000 per year) to conduct the annual staff satisfaction surveys has been included as well.

### **Renovate, upgrade and build new accommodation for teaching and clinical staff (A.1.2.14)**

- A twofold policy will be applied here: (1) houses will be built and renovated for teaching and clinical staff in region 1 and (2) a housing allowance will be given to staff in regions 2 and 3.
- Construction and upgrading of houses: Starting in 2014–2015, 25 new houses will be built per year at an estimated cost of US\$ 25,000 per house. This amount should cover upgrading and renovation of existing houses in the region.

### **HR unit (A.2.1.1)**

- A budget to cover operational costs, apart from salaries and incentives for the HR staff (which are included in the workforce budget explained in Section 10.1).
- Annual lump-sum budgets for stationery and office supplies (US\$ 2,500), communication and information campaigns (US\$ 5,000), travel and subsistence (US\$ 7,500), fuel (1,500 US\$), and workshops (US\$ 10,000).

#### **Human Resources Information System (HRIS) (A.2.1.3)**

- HMIS and FMIS systems are available at the MOHSW, and the HRIS will be linked to these systems. An international consultant will be hired for 35 days to assist the MOHSW to make a comprehensive HRIS, to decentralize HRIS to all counties, and to train CHSWTs in updating and using HRIS for making evidence-based decisions. The cost of US\$ 1,800 per day covers the consultancy fees and the costs of international and national transport, visa, communication and printing.
- The cost of purchasing the HRIS software is estimated at US\$ 200 per employee (total of 2,566 employees) and covers license fees, technology, installation and implementation, training and maintenance.
- Fifteen CHSWTs will receive a one-day HRIS training in 2011–2012. The cost of US\$ 100 per person per day covers the daily subsistence allowance of US\$ 50, transport, catering, rent of training site, stationery and printing costs. It is assumed that these CHSWTs will train their staff in use of the HRIS if needed.

#### **National 10-year sector training plan (A.2.1.10)**

- Technical assistance is planned to elaborate the national sector training plan after the national sector workforce plan is available. An international consultant will be hired for 20 days in 2012–2013. The cost of US\$ 1,800 per day for the international consultant covers the consultancy fee and the costs of international and national transport, visa, communication and printing.

#### **Standard operations procedures development and compilation in a Human Resources manual (A.2.17)**

- Printing costs estimated to be US\$ 1,000.

#### **HR forums (A.2.1.18)**

- A lump sum amount of US\$ 3,500 per forum is included to organize an HR forum every two years. The first forum is planned for 2012.

#### **Recruitment of teachers and academics (A.2.3.5)**

- Ten extra teachers and academics will be recruited in 2014–2015 and in 2015–2016 at a monthly salary of US\$ 1,000.

#### **Short-term courses for teaching staff (A.2.3.6)**

- A lump-sum amount of US\$ 10,000 per year to provide short-term courses for teaching staff.



### **Pre-service training programs (A.2.3.8)**

- Based on the 2010 Optimization Analysis,<sup>19</sup> the number of additional workers needed is: 56 doctors, 20 nurses, 121 midwives, 329 physician assistants and 71 dispensers. Pre-service training costs have been calculated by using the training cost per cadre category, as found in the Emergency HR Plan 2007–2011 (in US\$, per year per student) and the number of pre-service training years needed. The total cost of providing pre-service training to the additional number of cadres is US\$ 4,373,100. This amount has been spread over 5 years (which covers the period of the longest pre-service training) starting in fiscal year 2011–2012, so that by 2016 the required number of cadres will have been trained and can be deployed.

### **Upgrading and expansion of training institutions (A.2.3.8)**

- Because the detailed plans of the required upgrade and expansion of the existing training institutions are not available yet, an estimated average budget of US\$ 150,000 per existing institution to renovate, expand and upgrade them to the required standards and needs has been included.

### **Construction of four training institutions (A.2.3.10)**

- The construction of four new training institutions is planned to begin in 2014–2015 and continue through 2018 at a cost of US\$ 1,500,000 per institution. This amount is based on the recent construction of the midwifery school, and it has been increased to include extra facilities for nurses and laboratory technicians. The cost includes teaching rooms, housing for teaching staff, dormitories, a restaurant and a laboratory.

### **Budget for regulatory and professional bodies (A.2.4.2)**

1. A secretariat of 5 FTE will support the regulatory and professional bodies at an annual salary of US\$ 1,000 per person.
- An annual lump-sum amount of US\$ 3,500 per regulatory and professional board to support their functioning. Initially three bodies will be supported; beginning in 2013–2014, seven bodies will receive support.
  - Seating allowances of US\$ 100 per board member have been proposed in the budget. It is assumed that each body will appoint 5 members and that they will meet four times per year on average.

### **Independent audits of the regulatory and professional boards (A.2.4.10)**

- Annual independent audits of all regulatory and professional boards (at US\$ 1,000 per board per year) will begin in fiscal year 2012–2013.

### **In-service training program (A.2.5.2)**

- Since no workforce training plan is yet available, some preliminary estimates have been made. The in-service training programs for each cadre will start in fiscal year 2014–2015.
- A lump-sum amount of US\$ 30,000 per year has been proposed to cover the in-service training programs (fees, rent of training space, catering) and the daily subsistence allowances of the cadres. It is assumed that minimal 100 workers per year would receive (short-term) in-service training.

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<sup>19</sup> MOHSW and CHAI (2010), *Workforce Optimization Analysis: Optimal Health Worker Allocation for Healthcare Facilities across the Republic of Liberia*.

- A lump-sum amount of US\$ 2,000 per year for procuring and distributing training materials has been included.

**Training of community volunteers (A.2.5.3)**

- A lump-sum amount of US\$ 7,500 per year has been proposed to cover a one-day training of community volunteers (fees, rent of training space, catering, materials). It is assumed that a minimum of 100 gCHV per year will attend the training.

**Support to Scholarship Committee (A.2.6.3)**

- A lump-sum amount of US\$ 1,000 per year has been proposed to support the Scholarship Committee. This amount covers printing (e.g., the Standard Operating Procedures), communication and information costs.

**Employee Handbook (A.3.2.1)**

- Starting in 2012–2013, a lump-sum amount of US\$ 1750 per year is included to print and distribute the Employee Handbook.

**Supervision manual (A.3.2.5)**

- An annual lump sum amount of US\$ 5000 per year is included to print and distribute the supervision manual.

**Client satisfaction programs (A.3.2.7)**

- A budget item of US\$ 50,000 in fiscal year 2014–2015, to implement a client satisfaction program. A workers' survey will be conducted (and can be contracted out to an academic institution or survey research organization).

**Occupational health, safety, security and risk reduction program (A.4.1.2)**

2. A lump sum amount of US\$ 10,000 has been budgeted in the fiscal year 2016–2017 to provide training to the workforce in occupational health, safety, security and risk reduction and for purchasing safety equipment, protective gear, etc.

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