World Health Organization
REGIONAL OFFICE FOR Africa

WHO COUNTRY COOPERATION STRATEGY 2008-2011

LIBERIA

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ABBREVIATIONS

ACT	Artesunate Combination Therapy
AFP	Acute Flaccid Paralysis
AIDS	Acquired Immunodeficiency Syndrome
ARI	Acute Respiratory Infection
ARV	Anti Retro Viral
BCG	Bacillus Chalmette–Guerin
C/TSA	Contractual/Technical Service Agreement
CA(P)	Consolidated Appeal Process
CBI/O	Community-Based Initiative/Operations
CCS	Country Cooperation Strategy (WHO)
CHT	County Health Team
CMH	Commission on Macroeconomics and Health
CSA	Contractual Service Agreement
CSR	Communicable Disease Surveillance
CPC	Communicable Disease Prevention and Control (ONCHO)
DOTS	Directly Observed Treatment, Short-Course
DPC	Disease Prevention and Control
DPT	Diphtheria, Pertussis and Tetanus
EDM	Essential Medicines: Access, Quality and Rational Use
EHA	Emergency and Humanitarian Action (WHO)
EPI	Expanded Programme on Immunization
FAO	Food and Agriculture Organization
FHP	Family Health Programme
FGC/M	Female Genital Cutting/Mutilation
FT	Fixed-Term
GAVI	Global Alliance for Vaccines and Immunization
GBV	Gender-Based Violence
GDP	Gross Domestic Product
GFATM	Global Fund to fight AIDS, Tuberculosis and Malaria
GLRAGPN	German Leprosy Relief AssociationGlobal Private Network
GSM	Global System Management
HAMT	Health Area Management Team
HEC	Health Economic Advisor

HF	High Frequency
HIPC	Heavily-Indebted Poor Country
HIV	Human Immunodeficiency Virus
HQ	Headquarters (WHO)
HSCC	Health Sector Coordinating Committee
HPR	Health Promotion
ITN	Insecticide-Treated Net
IDPs	Internally-Displaced Persons
IDSR	Integrated Disease Surveillance and Response
IMCI	Integrated Management of Childhood Illnesses
IMF	International Monetary Fund
IVD	Immunization and Vaccine Development
LCM	Liberia Coordinating Mechanism
LDHS	Liberian Demographic and Health Survey
MAL	Malaria
MDGs	Millennium Development Goals
MDT	Multi-Drug Therapy
MH&SW	Ministry of Health and Social Welfare
MICS	Multiple Indicators Cluster Survey (UNICEF)
MNH	Mental Health
MOSS	Minimum Operational Security Standards
MPEA	Ministry of Planning and Economic Affairs
M&E	Monitoring and Evaluation Committee
MSF	*Médecins Sans Frontières*
NACP	National AIDS Control Programme
NCD	Noncommunicable Diseases
NEPAD	New Partnership for Africa's Development
NGO	Nongovernmental Organization
NIDs	National Immunization Days
NPO	National Professional Officer
NUT	Nutrition
OPD	Outpatient Department
ORCHC	Office of the United Nations Resident and Humanitarian Coordinator
OSD	Organization of Health Services
PHC	Primary Health Care
PHE	Public Health and Environment
PRS	Poverty Reduction Strategy
REMO	Rapid Epidemiological Mapping of Onchocerciasis

SO	Strategic Objective
ST	Short Term
STP/G/C	Short-Term Professional/General/Consultant
TB	Tuberculosis
TCC	Technical Coordination Committee
ToR	Terms of Reference
UN	United Nations
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCHR	United Nations Commissioner for Human Rights
UNDAF	United Nations Development Assistance Framework
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations Children's Fund
UNMIL	United Nations Mission in Liberia
VSAT	Very Small Aperture Terminal
WB	World Bank
WHO	World Health Organization
WR(O)	World Health Organization Representative (Office)

PREFACE

The WHO Country Cooperation Strategy (CCS) crystallizes the major reforms adopted by the World Health Organization with a view to intensifying its interventions in the countries. It has infused a decisive qualitative orientation into the modalities of our institution's coordination and advocacy interventions in the African Region. Currently well established as a WHO medium-term planning tool at country level, the cooperation strategy aims at achieving greater relevance and focus in the determination of priorities, effective achievement of objectives and greater efficiency in the use of resources allocated for WHO country activities.

The first generation of country cooperation strategy documents was developed through a participatory process that mobilized the three levels of the Organization, the countries and their partners. For the majority of countries, the 2004-2005 biennium was the crucial point of refocusing of WHO's action. It enabled the countries to better plan their interventions, using a results-based approach and an improved management process that enabled the three levels of the Organization to address their actual needs.

Drawing lessons from the implementation of the first generation CCS documents, the second generation documents, in harmony with the 11th General Work Programme of WHO and the Medium-term Strategic Framework, address the country health priorities defined in their health development and poverty reduction sector plans. The CCSs are also in line with the new global health context and integrated the principles of alignment, harmonization, efficiency, as formulated in the Paris Declaration on Aid Effectiveness and in recent initiatives like the "Harmonization for Health in Africa" (HHA) and "International Health Partnership Plus" (IHP+). They also reflect the policy of decentralization implemented and which enhances the decision-making capacity of countries to improve the quality of public health programmes and interventions.

Finally, the second generation CCS documents are synchronized with the United Nations development Assistance Framework (UNDAF) with a view to achieving the Millennium Development Goals.

I commend the efficient and effective leadership role played by the countries in the conduct of this important exercise of developing WHO's Country Cooperation Strategy documents, and request the entire WHO staff, particularly the WHO representatives and divisional directors, to double their efforts to ensure effective implementation of the orientations of the Country Cooperation Strategy for improved health results for the benefit of the African population.

Dr Luis G. Sambo
WHO Regional Director for Africa

EXECUTIVE SUMMARY

The mission of the World Health Organization (WHO) in Liberia is promoting the attainment of the highest possible level of health by all the people of Liberia. To facilitate this process, WHO, working in close collaboration with the Ministry of Health and Social Welfare (MOH&SW), has updated/revised the Country Cooperation Strategy (CCS) covering the period 2008-2011. It is a medium-term, adaptable, country-specific framework for cooperation between the Government of Liberia and the World Health Organization.

The updating/revision of the CCS is most appropriate, realizing that the country is experiencing a transition from a 14-year civil conflict to reconstructing and rebuilding its health system. In updating and revising the CCS, a 12-member WHO/MOH&SW CCS Core Team conducted an in-depth desk review, and prepared the preliminary draft. The draft was reviewed by a small technical working group constituted by the WR and WHO senior staff. Following this review, a one-day review session was hosted, during which the draft CCS document was presented to senior officials of the Ministry of Health and Social Welfare, the UN and other collaborating partners for in-depth discussion and analysis with a view to obtaining country-level endorsement and ownership.

The 8-chapter document analyses: health and development challenges facing the country; the key health policy issues and challenges; the general trends of aid to Liberia; the significant aspects of the WHO current cooperation with the Government of Liberia; the Global and Regional Directions of WHO Corporate Policy Framework; the Strategic Agenda for 2008-2011; implications of the Strategic Agenda for the WHO Secretariat; and Monitoring and Evaluation.

The key health issues and challenges identified during the consultations and from the desk review include:

- rehabilitation/reconstruction of destroyed health infrastructures; acute shortage of human resources; high maternal mortality rate; food insecurity;
- high level of malnutrition; improving access to coverage, quality and operational standards of health care through the Basic Package for Health Services; low access to water, sanitation, education and electricity; revitalizing the system of procurement and management of essential drugs and medicines;
- implementation of the national health policy and plan; low capacity in health management: planning, implementation, monitoring and evaluation; and weak coordination of health actions at different levels.

Accordingly, the current transition from relief to development has resulted in the departure of a number of humanitarian nongovernmental organizations thus creating a challenge for the Government. However, the current enabling environment buttressed by increased budgetary support by the Government and substantial financial support by donors and other partners testify to the acceleration of the restoration of the health sector. Financial requirement for health, nutrition, water and sanitation for 2006/2007 was estimated at US$ 64.1 m. However, the trend of donor support to the health sector from 2006-2007 totalled about US$ 90.1 million.

It is worth noting that this level of donor support, combined with direct government funding of the health sector, will enable Liberia to have a commendable health system during this post-conflict period. Hence, the Government's overall objective of restoring the Liberian health system to the pre-war status is based on the primary health care approach through the Basic Package for Health Services.

The CCS Strategic Agenda for 2008-2011 is, therefore, based on careful reflections and analysis of Liberia's health needs during this post-conflict period, the current socio-economic conditions, the overall objective of the Government for restoring the health sector to the pre-war status, and the global/regional health priorities.

The four Strategic Areas of Intervention selected by the World Health Organization for supporting the Ministry of Health and Social Welfare are:

(i) Emergency Preparedness and Humanitarian Response: Strengthening the capacity of stakeholders in preparedness and timely response to health emergencies in Liberia;

(ii) Strengthening Performance of the Health System: Supporting the MOH&SW in revitalizing the national health system by using the primary health care approach to increase access to essential integrated quality health care; as well as supporting the MOH&SW to reactivate the performance of its stewardship role;

(iii) Disease Prevention and Control: Supporting the MOH&SW to effectively prevent and control communicable and noncommunicable diseases, in order to reduce the resultant mortality and morbidity;

(iv) Improvement of Maternal and Child Health: Supporting the Government's efforts in attaining the Millennium Development Goals for reduction of infant, childhood, newborn and maternal morbidity and mortality.

The four strategic areas of intervention will be addressed by using the overarching approach of promoting and advocating for protection of health, through partnership and intersectoral collaboration for overall improvement of the health status of the people of Liberia. In implementing the Strategic Agenda, special attention will be given to supporting the Government in facilitating the achievement of the health-related Millennium Development Goals.

For effective implementation of the CCS Strategic Agenda, WHO will work with the Ministry of Health and Social Welfare and other relevant national and international partners interested in improving the health status of the people of Liberia. While the CCS document will form the basis of WHO's work in Liberia in developing subsequent Programme Budgets and Biennial Plans of Action, the programme implementation mechanism will be based on working across the three levels of WHO and the various strategic objectives, as well as facilitating pragmatic integration within the national health system for more measurable impact.

SECTION 1

INTRODUCTION

The second generation WHO Country Cooperation Strategy (CCS) for Liberia is an organization-wide, medium-term framework of collaboration with the Government, partners and other stakeholders in the health sector. The framework covering the period 2008-2011 takes into account the period of the first CCS (2005-2010), and also takes due cognizance of the contributions of the other stakeholders, and WHO's comparative advantage to define what WHO will do, how it will do it and with whom. This CCS is in full alignment with national health strategies and priorities and also in harmony with other UN agencies and development partners working in the health sector.

The purpose of the Country Cooperation Strategy (CCS) is to enhance the capacity of WHO in Liberia to support the Government's efforts in achieving prioritized national health objectives. Through the CCS, WHO aims to be more selective, focused and responsive to the priority health needs of the people of Liberia, while taking a measured shift from long-term routine activities towards a more strategic role as adviser, broker and catalyst, maximizing synergies and promoting complementarities with relevant stakeholders, health agencies and development partners in the country.

The update/revision of the CCS document involved extensive desk review and consultations with our key partner, the Ministry of Health and Social Welfare. In addition, consultations were held with 20 other agencies made up of relevant line ministries, national regulatory councils, and national health training institutions, bilateral and multilateral agencies, international organizations and nongovernmental organizations. The CCS review team, led by the WHO Representative for Liberia, consisted of senior policy-makers from the Ministry of Health & Social Welfare and WHO staff.

The World Health Organization fully realizes that the Ministry of Health & Social Welfare and other national stakeholders are the owners, leaders and main implementers of the national health policy and plan. WHO will, in support of the Government of Liberia, initiate strategic interventions in the following areas:

- Emergency Preparedness and Humanitarian Response;
- Strengthening Performance of the Health System;
- Disease Prevention and Control;
- Improvement of Maternal, Newborn and Child Health.

The defined CCS Strategic Agenda was guided by the Liberia Poverty Reduction Strategy Paper, National Health and Social Welfare Policies and Plans (2007-2011), the United Nations Development Assistance Framework (UNDAF) 2008-2012, Humanitarian Reports, the outcomes of extensive consultations, the WHO Corporate Strategy that outlines global priorities for the period 2002-2005, the WHO African Region Strategic Framework 2005-2010 that defines priorities for the Regional Office for Africa, the NEPAD Health Sector Strategy and the Millennium Development Goals (MDGs).

It is pertinent to note that the CCS has been reviewed and updated at a time when Liberia is experiencing a transition from humanitarian relief to recovery, reconstruction and development. The revised and updated CCS will be implemented within a climate of macroeconomic challenges. The CCS document will, therefore, form the basis of WHO's work throughout the organization, influencing the programme budgets and biennial plans of action.

SECTION 2

HEALTH AND DEVELOPMENT CHALLENGES

2.1 COUNTRY PROFILE

2.1.1 Geography

Liberia is located on the West Coast of Africa and shares borders with Côte d'Ivoire, Guinea and Sierra Leone. With a total land area of 111,370 km^2, the country is divided into 15 administrative counties. The climate is tropical.

The 2008 Population and Housing Census preliminary results estimated the population of Liberia at 3.5 million inhabitants. In terms of sex ratio, women account for 51% of the population and men 49%.The results also indicated that the country has a very young population (below 18 years): 63.8% aged 15 plus, 16.2% aged 5-14 years and 15.0% aged 0-4 years. The fertility rate is currently 5.2, indicating a substantial reduction since 1986 from 6.2 in 1999-2000 and 6.6 in 1986.

When the war finally ended in 2003, the economy had been ruined, with over 80% of the population displaced and traumatized, and the country's infrastructure destroyed. During the conflict period, the economy, heavily reliant on agricultural produce and natural resource exports, collapsed. Gross Domestic Product dropped by almost 90% between 1987 and 1995. Per capita GDP in 2006 was US$ 195, down from US$ 1269 in 1980 (Ministry of Planning, 2008).

The country had a huge external and domestic debt burden of US$ 3.7 billion as of mid-2005, representing 80% of GDP and 3000% of export value (Ministry of Health and Social Welfare, 2007). With the inauguration of a democratically-elected government in 2006, there has been marked progress. Economic growth for 2007 was estimated at 9%, and domestic and external direct investment has improved. That notwithstanding, the remaining challenges are enormous, and the country will take years to fully recover.

2.1.2 A country in post-conflict situation

The cessation of the war in 2003 led to the conduct of democratic elections in 2005 that brought to power the first female president in Africa. Though the country is in a state of transition, there are still persistent humanitarian needs to be addressed before real development progress can be attained. Since 2006, the country has made significant progress in consolidating peace, including the establishment of a Truth and Reconciliation Commission, the reintegration of over 103,000 ex-combatants and resettlement of over 200,000 IDPs and refugees, the expansion of community-based reintegration and recovery programmes and restructuring of the security sector. Despite the considerable progress made, formidable reconstruction and development challenges still remain. Fourteen years of protracted war, coupled with a long history of economic mismanagement, have taken a serious toll on the

country and its economy. It is evident that given the tragic history of the conflict and social disintegration, the country, in order to succeed during this post-conflict period, must adopt an inclusive policy framework based on the broadest public participation of all of its citizens.

2.1.3 Security

The Government has made significant progress in expanding peace and security since 2006. The UN security phase has been lower throughout the country. With partner support, the security sector has been restructured, along with the vetting and training of a new core of officers. Also, substantial progress has been made in the resettlement and reintegration of over 300,000 refugees and displaced persons, including 103,000 ex-combatants, a sizeable number being former child soldiers. Despite the training given to the military and police, they (especially the police) are yet to be armed. A number of sub-police stations have been constructed throughout the country, but the unavailability of the needed logistical support continues to constrain the ability of the police to combat the increased crime wave. Most checkpoints installed by UNMIL have been dismantled, and the mission has started reducing its personnel. Though substantial progress is being made in consolidating and maintaining peace and security, the increased crime wave, especially armed robbery, remains a major menace for the Government. Additionally, the fragile security situation in the neighbouring countries of Guinea and Côte d'Ivoire also remains a major security threat for the country.

2.1.4 Human rights and gender issues

Liberia's civil crisis was characterized by gross abuse of human rights and gender-based violence. The Government, during this post conflict period, has initiated a series of measures to improve the human rights and gender situation in the country. An independent human rights commission to monitor the human rights situation of the country has been established, along with a secretariat within the Ministry of Justice. The commission is yet to be functional as its members have not yet been appointed by the Government. As a means of fostering genuine reconciliation, a Truth and Reconciliation Commission has been established and is currently conducting public hearings both within and outside the country. A Governance Commission has also been established and is reviewing existing policies, laws, and institutions to address many of the structural problems that contributed to poor governance in the past. Furthermore, a series of initiatives have been put in place to address issues affecting women. A National Gender-Based Violence Plan of Action has been developed, along with the establishment of a secretariat within the Ministry of Gender and Development. A Rape Law was also passed by the National Legislature in 2007, declaring rape as a criminal act. To ensure protection of the vulnerable groups within the justice system, particularly during detention, including addressing the specific needs of children and young people, women, the elderly and persons with disabilities, the Government has put in place a series of measures. Despite the current efforts of the Government, rape in particular remains a major challenge.

2.1.5 Economy

The Liberian economy, which was ravaged by the war, has since 2006 began to recover, with an estimated GDP reaching US$ 725 million in Fiscal Year 2006/2007. The economy is steadily expanding, with growth rate averaging over 9.5% in 2007. The growth of the economy is attributed to a number of stringent economic policy reforms introduced by the Government to reverse the downward trend of the economy. The economic growth reached an estimated 5.3% in 2005, an estimated 7.8% in 2006, and a further increase to an estimated 9.5% in 2007. The lifting of embargos has spurred an increase in foreign investment. Government revenues, currently estimated at US$ 200 million in 2007/2008 are expected to increase. To

address the current pervasive poverty situation in the country, the Government, with support from partners, buttressed by an inclusive participatory approach, has developed and launched its Poverty Reduction Strategy (PRS) document covering the period 2008-2011. Moreover, the introduction of stringent economic reforms has led to the waiver of a sizable portion of the Government's external debt stock, which stood at US$ 3.5 billion in 2004. Efforts are underway to complete the HIPC debt relief process during the PRS period, thus paving the way for the cancellation of the majority of the country's external debt stock.

2.2 REVIEW OF CCS 2005-2010

The country's first generation CCS 2005-2010 was developed during a very delicate period of the country's existence, as it was emerging from a 14-year catastrophic civil war. As a result, implementation of the first generation CCS was characterized by numerous challenges: shortage of qualified and essential human resources for health, destroyed infrastructure, limited financial resources, weak supportive systems, large-scale humanitarian situation, etc.

Indeed, the years of war and the afore-mentioned problems severely affected the country's health situation. The social consequence of these challenges, compounded by other factors, led to a higher disease burden. As a result, many of the critical issues/challenges across the health sector could not be readily addressed, as the foundations of a functioning health sector were to a large extent weak or non-existent. Additionally, the health sector faced two other equally-important and competing challenges for improving the sector: alleviating poverty and establishing the building blocks of an equitable, efficient, effective, responsive and sustainable health system.

To a large extent, these challenges constrained the implementation of the first generation CCS, and, therefore, made it difficult to attain the desired results as envisaged. Despite some level of progress made to address these challenges, they persist and form the basis for the pursuit of the strategic agenda.

2.3 CURRENT HEALTH PROFILE

One and half decades of civil conflict led to massive and severe disruption of social services, including health care. This impacted negatively on the health status of the population, especially women and children. However, the concerted efforts deployed since 2006 have led to a minimum increase in access and coverage of health care services. It is estimated that 41% of Liberians currently have access to health care.[1]

Liberia's health indicators, though improving, remain unsatisfactory. According to the 2007 Liberian Demographic Survey, childhood mortality has decreased substantially. Infant mortality has declined from 139 per 1000 live births to 71 per 1000 live births; under-five mortality has also declined from 219 to 110 per 1000 live birth, representing 50% reduction of the 1992-1996 infant and under-five mortality rates. Nevertheless, maternal mortality rate in 2007 was 994 deaths per 100,000 live births, representing one of the highest in the world. Life expectancy at birth substantially decreased from 55 years in 1980 to 47.7 years in 2006.

The country's health sector is experiencing a transition from an emergency phase to a development phase. With support from a number of partners, the Ministry of Health and

[1] LDHS – 2007

Social Welfare developed a comprehensive national health policy and a national strategic health plan (2007-2011), as well as a two-year emergency transition plan to prevent a potential crisis that was evolving as a result of the untimely departure of a number of international nongovernmental organizations that provided the greatest share of health services during the conflict period.

The National Strategic Health Plan sets out the priorities of the health sector for the five-year period to include; the Basic Package of Health Services, Human Resources for Health, Infrastructure, and Support Systems. However, while the Basic Package of Health Services and Human Resources for Health are core for reviving the sector, cost implications and financing are major challenges for implementing the plan. The implementation of the plan in 2007 was estimated to cost US$ 283,000,000. Between 2007 and 2008, only 30% of the estimated cost was realized (see Annex IX). While some level of progress has been attained in the health sector, the country's health challenges remain immense.

2.3.1 Communicable diseases

Main Causes of Morbidity

- Malaria
- ARI
- Diarrhea
- Tuberculosis
- Vaccine-Preventable Diseases
- Malnutrition

On account of numerous factors, exacerbated by the war, morbidity and mortality due to communicable diseases worsened.

Malaria: The disease is the leading cause of morbidity and mortality in the country. According to the Liberia Malaria indicator Survey (LMIS 2005), the disease accounts for 38% of outpatient visits and 42.3% of admissions at health facilities. The entire nation's population of 3.5 million is at risk of malaria infection, with serious health and economic implications for the nation, such as cost of treatment, days lost from work and school attendance by those infected with the disease. The National Malaria Control Programme is on track for the control of the disease by pursing the following strategic objectives: (a) review of malaria treatment policy; capacity building to improve skills; improving access to diagnosis and treatment services at health facility and community levels; and strengthening of support systems to implement planned activities.

Acute Respiratory Infections (ARIs), including Pneumonia, is a new, and a growing concern. According to the Liberia Demographic Health Survey (LDHS 2007), 9% of children under five had symptoms of acute respiratory infection (ARI).[2]

Diarrhoeal Diseases: Since 2006, the weekly surveillance reports indicate that diarrhoeal diseases account for 4%-5% of all in-patient and out-patient consultations.[2] A national survey conducted by the Liberia Institute for Geo-services also confirmed that 20% of Liberian children under five had diarrhoea. The survey further indicated that 29% of children under five were among the 6-11 months age group. In addition, epidemics of cholera occur during the rainy season as a result of the deplorable water and sanitary situation, compounded by limited access to pipe-borne water and sanitation services in many parts of the country.

Tuberculosis prevalence is currently estimated at 4 per 1000 as a consequence of the war and the emergence of HIV/AIDS. A comprehensive assessment of the National TB Programme in 2006 revealed that at least 70% of the clinical TB cases were sputum positive. By the end of 2006, over 250 DOTS centres had been established in all counties. The current services being provided are inadequate due to a number of factors, including lack of qualified staff, uncoordinated procurement of drugs, lack of reagents, logistics and an ineffective surveillance system.

HIV/AIDS: The national prevalence rate is estimated at 1.5% according to the 2007 Liberia Demographic and Health Survey while the HIV sentinel surveillance conducted among pregnant women attending antenatal clinics puts the prevalence among this population group at 5.4%. Currently, the country has succeeded in developing and implementing national guidelines for HIV testing and counselling, PMTCT guidelines, national guidelines on ART as well as draft guidelines on blood safety and testing and HIV/TB co-infection guidelines. These tools are being used to train diverse mid-level health professionals, including medical doctors, nurses, physician assistants, etc. To date, there are 1689 patients on ART receiving treatment at 15 centres and 961 PLWHA on prophylaxis at these sites. Additionally, there are 79 HCT sites, 25 PMTCT sites and 15 sentinel sites providing services across the country.

Schistosomiasis (S. heamatobium & S. Mansoni) is prevalent in the most productive agricultural areas of the country. Crude data from a recent (2007-2008) survey conducted by two institutions, the Liberian Institute for Biomedical Research and Cuttington University, in two districts in the central region of the country, indicated that schistosomiasis indeed remains a public health problem in these counties. The survey also found a change in the prevalence rate of the two species in one of the counties, indicating that S. haematobium was more prevalent than S. Mansoni in Lofa County. The reason for the change in prevalence rates for both species is a challenge for the country, especially for the Ministry of Health.

Onchocerciasis is one of the major causes of blindness in Liberia. Pre-war studies among other publications and reports point to the fact that onchocerciasis is prevalent in Liberia. WHO/APOC sponsored a nationwide Rapid Epidemiological Mapping of Onchocerciasis (REMO) from 26 December 1998 to 9 February 1999. A total of 120 villages were selected for this study. Using community nodule rate as indicator of disease endemicity, randomly-chosen resident farmers, aged > 20 years, especially males, were clinically examined. A total of 99 accessible selected villages were examined. The results showed that human onchocerciasis is endemic in Liberia, especially along fertile banks of the major rivers and their tributaries.

In 2008, an outbreak of yellow fever was also reported in Nimba County, where a reactive mass yellow fever vaccination campaign was conducted in seven high risk-districts. A yellow fever risk assessment was jointly conducted by the Ministry of Health and WHO in June 2008, and a preventive yellow fever vaccination campaign is expected to be carried out in January 2009. With Liberia lying in the yellow fever belt of West Africa, this situation can be considered as a sub-regional issue.

Over the years, Lassa fever continues to be reported in the central region of the county; but, the exact magnitude has been difficult to determine. After the cessation of hostilities in 2003, Lassa fever was reported among internally-displaced persons, host population and peacekeepers. For example, in 2005, three cases of Lassa fever were reported among peacekeepers. Factors constraining the containment of the disease include: lack of funding and expertise; inadequate capacity to carry out laboratory investigations; inadequate community mobilization; lack of case management facilities, including drugs such as Ribavirin.

Rabies

Rabies is now re-emerging in some parts of the country, particularly in Lofa, Bong, Montseerado and Nimba Counties. In 2007, at least 30 suspected cases, with 6 deaths, were reported. A national rabies programme is yet to be developed and implemented. Rabies vaccines for post-exposure prophylaxis and prophylaxis in humans are in short supply.

2.3.2 Noncommunicable diseases (NCD)

In the absence of any nationwide reliable data and nationally-representative studies, the exact burden is unknown. There is no focal person for NCD in the MOH, no functional national programme, no national policy and strategies for NCDs. The Oncology Department the only referral hospital in the country is yet to be fully revitalized. The Ministry of Health and Social Welfare has initiated discussions with a number of key partners to develop a resource mobilization plan to support chronic disease risk assessment, using the WHO Stepwise Approach.

Blindness: While the prevalence of blindness in the country is yet to be determined, a unit has been established, and a coordinator appointed by the MOH. A strategic eye-care plan is expected to be developed in 2008. Currently, services are been provided at selected hospitals in five counties. Plans are underway to expand service centres throughout the country in 2009. Available statistics (August 2008) show that a total of 10,345 persons were screened through OPD and outreach, 1141 persons were treated for inmatured cataract, 109 for matured cataract, 562 cataract surgeries, while 1 glaucoma surgery was performed. Mercy Ship is assisting the MOH in the provision of eye care services.

Mental Health and Substance Abuse, and Epilepsy: Liberia has developed a national strategy on alcohol and substance abuse as well as a national policy for the development of a strategic plan on mental health and substance abuse. Through the emergency mental health programme established in 2005, training of nurses and medical students was conducted and regular coordination meetings (mental health task force) held. The Ministry of Health and Social Welfare has included mental health as a priority in the national health plan and the basic package of health services. However, there are serious concerns about the sustainability of these interventions, if additional funding is not available and the priority of mental health is not significantly strengthened at all levels.

Gender-Based Violence (GBV) in all its forms is endemic in Liberia: A study conducted by the Government and supported by partners on sexual gender-based violence/gender-based violence (SGBV/GBV) in ten counties covering all functional regions of the country, indicated that women and girls experienced one of multiple forms of GBV during the Liberian civil crisis, rape being the most common (estimated at 75%). Unfortunately, during this post-conflict period, GBV is still being perpetuated in the country and rape is still the most common form.

Malnutrition: A number of assessments conducted by partners in 2006/2007 indicated high global acute malnutrition rate among children under 5. The 2007 LDHS also indicated that malnutrition, especially acute malnutrition, is quite high in the country. The nutritional status of children under five shows that 39% is stunted, 7% wasted and 19% underweight. In support of the Poverty Reduction Strategy Paper, a national Food Security and Nutrition strategy has been developed and highlights the importance of food security and nutrition. With the current global food crises and the fact that over 69% of food in the country is imported, the malnutrition rate is expected to increase with increased vulnerability of the Liberian population. In this regard, the Government, with support from partners, has developed a food security response programme.

Injuries and disabilities are widespread. However, comprehensive data are lacking and data provided by the National Police limited to road accidents indicate that from January to July 2008, a total of 615 injuries were recorded, 51.2% of which concerned males.

2.3.3 Reproductive health

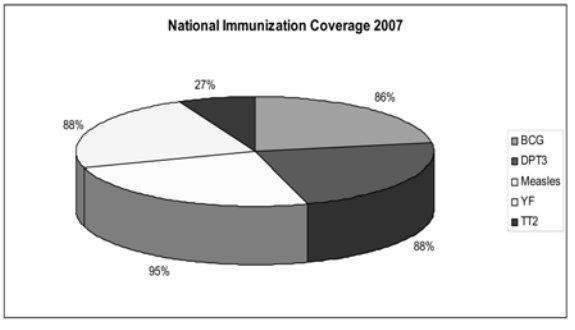
The 2007 Liberia Demographic Health Survey showed that antenatal care attendance was 79%, while facility- based births were estimated at 37%. The study also showed that total fertility rate is on a downward trend, dropping from 6.6 in 1986 to 5.2 in 2007. The rapid health assessment of 2006 estimated TT2+ at more than 85%. Most deliveries in the communities are still done by both trained and untrained traditional birth attendants with no skills for addressing obstetric emergencies.

The LDHS 2007 puts the maternal mortality ratio at 994/100,000 live births; the contraceptive prevalence rate, particularly among married women, at only 11% for all methods, the common ones being the use of oral injectable contraceptives and condoms. A National Road Map for accelerating the reduction of maternal and newborn morbidity and mortality has been developed for identifying priority interventions at community and health facility levels. The lack of adequate data has been a major problem in establishing the prevalence or incidence of fistula in the country.

However, between 2004 and 2005, Mercy Ship successfully operated over 351 patients. Given the magnitude of the situation, an obstetric fistula project was established in 2007, with support from UNFPA, and implemented at the J F K Medical Centre. Through the project, over 409 patients have been operated, along with establishment of ten additional sites in various parts of the country. A rehabilitation/re-integration centre established in Montserrado County, has graduated 65 clients in two batches of 40 and 15 persons, all of whom were given income-generating skills.

2.3.4 Child health and immunization coverage

Although vaccine-preventable diseases are still significant contributors to the high rate of infant and childhood morbidity, mortality and disability in the country, progress has been made to re-establish immunization services and bring these diseases under control. Measles incidence has drastically reduced since the conduct of a catch-up and two follow-up mass immunization campaigns. Liberia has also joined the other countries in the African Region to implement activities that will ultimately lead to the achievement of the global goal of Maternal and Neonatal Tetanus Elimination (MNTE). Because of its sustained efforts at implementing activities under the polio eradication initiative, Liberia is one of the eight countries to present its documentation for polio free status certification this year (2008).



As for routine immunization, there has been a gradual increase in the reported administrative coverage over the past few years. At the end of 2007, coverage rate for some of the antigens is reflected in the chart below. Liberia, like other countries in the sub-region, introduced Pentavalent vaccine (DPT with Hepatitis B and Hemophilus influenza type B) in January 2007. The routine immunization performance, as measured by Pental 3 coverage, has remained very high. This is partly attributed to regular vaccine supply to health facilities; continuing partnership at all levels and, most importantly, supplemented by large outreach

activities at county and national levels. As of December 2008, all of the counties had reached Pental 3 coverage of over 80%. The introduction of the Pentavalent vaccine is expected to lead to the reduction of the incidence of hepatitis and paediatric pneumonia and meningitis. A gradual shift is also underway from use of kerosene to power refrigerators at the peripheral level to solar-powered refrigerators; this is to eliminate the difficulty associated with distribution and rising cost of kerosene.

Dr. Zakari Wambai, far left, received RD Annual award on behalf of WHO Liberia EPI Team

Liberia, which joined the global effort to eradicate polio in 1999, was declared a polio-free country in October 2008. Liberia was also the first of eight countries selected by the African Regional Certification Commission (ARCC) to prepare and present its complete country documentation in 2007. The comprehensive documentation submitted was accepted and endorsed by the ARCC, and the country declared polio free. Throughout the documentation process, extensive technical support was provided by the WHO Intercountry Support Team (IST) for West Africa. On 2 September 2008, at the 58th session of the Regional Committee, the country received the Regional Director's Outstanding Award for excellent services, and for making a difference in WHO's work in the African Region.

2.3.5 Other determinants of health

Availability of Potable Water: Prior to 1990, about 45% of the urban population had access to potable water, compared to 23% for the rural population.[3] The 2007 LDHS shows that only 65% of Liberian households have improved sources of drinking water. The most common source of drinking water is protected dug wells.

Hygiene and Environmental Sanitation: Owing to the war, the sewage systems in the country have long ceased to function, except in Monrovia. The LDHS 2007 shows that 10% of households in the country use improved, unshared toilet facilities. The survey further shows that over 55% of households in Liberia do not have toilet facilities.

Other Wastes (Domestic, Commercial, Clinical and Industrial): Waste collection services have ceased to function in most parts of the urban areas due to shortage of collection vehicles and equipment, thus posing serious health hazard to the population. Most of these were either looted or destroyed. Presently, the only functioning waste collection and disposal system is restricted to Monrovia, the capital.

2.3.6 Health system inputs and functions

The Health System of Liberia continues to operate in partnership with various concession holders, missions/churches and NGOs. The revised national health policy has again adopted decentralization as a core strategy, and is currently strengthening the various support systems. County Health Teams (CHTS) have been reactivated in the fifteen counties. However, the full

[3] LDHS July 2007

constitution of some county teams is yet to be completed. The County Health Teams are responsible for operational planning, implementation and supervision of health activities and services at the county level.

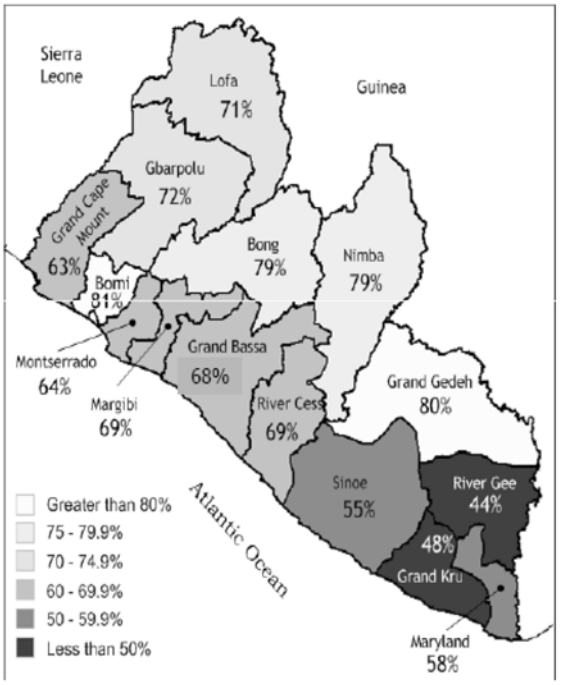
2.3.7 Management system

Central MOH & SW

Government health care services are organized at different levels, generally corresponding to the administrative structure of the country. At the national level is the central Ministry of Health, which is responsible for policy and strategy formulation, planning, organizing, staffing, regulating, coordinating health activities, and supervising the secondary level, as well as financing health care services. In this regard, the Ministry coordinates the activities of various health sector partners. The mechanisms for coordination include the Health Sector Coordinating Committee, which meets on monthly basis, and brings together all partners involved in health care delivery. A number of mechanisms have also been put in place to ensure comprehensive monitoring of the health system. Though a monitoring unit has been established, it is yet to be fully operational. However, joint quarterly supervisory visits are carried out by programmes at the central Ministry.

At the level of the counties are the country health teams, which are responsible for operational planning, management of resources, supervision and implementation of health activities and services at the county level. To date, all the county health teams have been revitalized and restructured, and are headed by physicians. Additionally, county health boards have been established and installed in all the fifteen counties.

In ensuring comprehensive coverage of primary health care services in the country, the Ministry developed the Basic Health Package of Health Services as the cornerstone for the health care delivery. It initiated to address the post-conflict challenge of improved access to primary health care. The Basic Health Package is expected to expand access to quality health services through the provision of an integrated package of health interventions, targeting 70% of health facilities in each county in the first year of implementation. The package was rolled out in the latter part of 2008 by 40% of existing functioning facilities. The major constraint remains the shortage of the required health personnel and limited financial resources. In anticipation of rolling out the basic health package, an in-depth assessment of all the 389 functioning facilities was conducted, and out of these, only 40% met the



Average accreditation scores per county show large variations in the level of services provided. Counties in the south are still facing significant challenges.

requirements for rolling out the basic package. The chart below reflects the regional variation in the provision of health services.

Secondary care services have been extended to a number of counties due to the rehabilitation and reconstruction of a number of hospitals. Seven hospitals have been identified by the Ministry to serve as regional referral hospitals; these facilities are currently being rehabilitated and will be equipped and provided the requisite support to enable them to accomplish their mission. Funding for the reconstruction of hospitals has been provided by the Irish, Chinese, and Swiss Governments. Of the 340 health centres and clinics identified for both major and minor rehabilitation throughout the country, only 40% has been completed and functioning. Construction of additional health centres and clinics has been earmarked for the period 2009-2010, especially in underserved areas.

Regarding tertiary care services, they are still limited to the JFK hospital, the only national referral hospital that has been partially renovated, and four other hospitals as shown in the map below. Of the seven referral hospitals identified, three have been rehabilitated and are functioning; the remaining four, when rehabilitated, are expected to extend referral services to the rural areas. In terms of other specialized tertiary facilities, there exists a small private mental health facility, which is operated by an international nongovernmental organization. The Ministry of Health has recently developed a national mental health policy, and incorporated mental health in the basic package of health services as a core intervention to be provided at all levels of the delivery system.

2.3.8 Health care delivery system

Sixty percent of the international NGOs that provided the greatest share of health services have either left the country or reduced their operations. Twenty percent of the remaining NGOs have informed Government of their intention to leave. As a result, a number of existing arrangements are concluded between the Ministry and NGOs to ensure continuity of services after their departure. In addition, the Ministry of Health, following the conduct of a comprehensive health contracting study, and development of a contracting policy, is currently pilot testing the scheme. To date, a number of bids from various partners, in particular, international nongovernmental organizations have been received and scrutinized with contracts to be awarded in 2008.

2.3.9 Human Resources for Health

The country's overall HRH situation is highly precarious. Nursing aides and traditional midwives continue to constitute a greater proportion of the current workforce with critical shortages in key categories; doctors, nurses, pharmacists, etc. In terms of distribution, the workforce continues to be skewed towards the urban centres. The country's ratios of physicians, nurses, and midwives are extremely low at 0.03, 0.18 and 0.12 per 1000 people. Training institutions that are critical for the development of human resources for health are all in a declining state, exacerbated by the events of the war.

The medium-term Human Resources for Health plan is yet to be fully implemented. The Ministry of Health is currently exploring a number of options to address the shortage of qualified health personnel in the country. One of these is a bilateral agreement with the Cuban Government intended to contract the services of 50 Cuban medical professionals. However, a number of studies have been initiated by the Ministry and partners, which would form the basis for the development of comprehensive human resources for health policy and plan. In addition, two paramedical institutions for training human resources for health have been recently re-opened; while another is under renovation. Also, support has been provided by the World Bank and the Italian Government to the AM Digliotti Medical School, the only medical training institution in the country.

Moreover, the Ministry has suspended payment of tuition fees in all public sector human resources for health training institutions, and, with support from partners, offered scholarships to specialized clinical and managerial health workers, contracted over 1000 health workers through incentive payment, transferred over 300 workers on government contract (despite the freeze on employment), and was expected to recruit, train, and deploy over 2000 community health volunteers. With support from the Clinton Foundation, buttressed by a leadership and management study conducted by WHO, a national management and leadership programme was established and has trained a number of senior staff at the Ministry and 15 county health officers and county health service providers.

2.3.10 Essential drugs and equipment

Registration of drugs for use in the country, in both the public and private sectors, is haphazard and un-coordinated. The National Drug Service (NDS), the agency responsible for the procurement and distribution of drugs and medical supplies, appears to be fairly well structured and capable of handling its current work load, much of which has to do with the handling of supplies procured by the various programmes under the umbrella of the Global Fund and other donor programmes. The Essential Drugs List, the National Formulary and the Standard Therapeutic Guidelines have not been updated for many years. Steps were taken in 2007 to revise the National Essential Drug List. While there are currently only three sub-depots throughout the country, the Ministry, with funding from donors and through the pool, has earmarked the construction of four regional warehouses, and up-grading of drug storage facilities at all the functioning health facilities throughout the country. The transportation, storage capacity and rational use of drugs continue to pose challenges for the health sector.

2.3.11 Laboratory services and blood transfusion

The dearth of diagnostic laboratory opportunities in Liberia, resulting from a total destruction of practically all infrastructural facilities in the country, and the consequential inadvertent health adversity, created a compelling need for proper diagnosis that would inform appropriate therapy.

Hence, a laboratory assessment, conducted in 2007, confirmed that a number of health facilities throughout the country are currently not performing all tests recommended or required for the implementation of the Ministry of Health and Social Welfare's "Basic Package Health Services". This deficiency is particularly noticeable in county hospitals. There are major gaps in blood chemistries at most sites and in haematology at numerous other sites. There is also a lack of microbiology testing. Compounding the situation is the lack of appropriate equipment, infrastructure and qualified personnel.

Against this backdrop, the Ministry of Health and Social Welfare has initiated the establishment of a Laboratory Services Unit within its structure. While efforts to address the long-term needs of a laboratory system, the establishment of a national reference laboratory has been proposed to address the short-term needs of providing advance technical skills and capacity for offering services beyond the scope of the other laboratories in the country. A national blood bank programme has been established, but it is facing numerous challenges. WHO recently seconded a NPO to assist the Government to establish and manage the National Laboratory Programme.

2.3.12 Health information system

The Ministry is yet to carry out a comprehensive assessment of the health management information system and develop a comprehensive health management information system at all levels of the delivery system. However, a series of measures have been initiated to improve performance of the system. All of the different forms of reporting have been standardized, and a unified reporting format for partners introduced. Computers have also been provided to the 15 counties, along with the training of county registrars and county health officers in the use of the specialized data processing software, NEID. Also, a mapping software package has been acquired and installed. The measures instituted have resulted in marked improvement in the collection, compilation, processing, and transmission of data from the peripheral level to the central level. However, there are still a number of challenges to be met, including lack of analytical skills to analyse data, feedback from central level to peripheral level etc.

2.3.13 Health sector financing

From 1993 to 2003, government spending on health declined steadily, averaging as low as 4% of the total national budget. In 2003, the health budget was 8% of the interim budget of US$ 10 m, with actual cash received by the Ministry of Health amounting to LD$ 260,000. Per capita public expenditure on health dropped to an all time low of US$ 3.65 or LD$ 146. Ninety percent (90%) of all funding for the health sector during this period came from donors and UN agencies, and these funds were mainly channelled through international nongovernmental organizations. The funds were mainly devoted to addressing the prevailing acute humanitarian situation.

Since 2006, financing of health services by Government has steadily improved. In 2006/2007, government spending on health care was estimated at US$ 10.1 million, constituting 16.8% of the total health care expenditure (from various sources), and 9% of the national budget. The current fiscal budget (2008/2009) is estimated at US$ 15.3 million, constituting 9% of the national budget of US$ 276 million. To date, per capita public expenditure on health has gradually improved to US$ 4.4, as compared to US$ 1.3 during the war years. The tables below show current government budgetary allocation on health and funds from external sources. As reflected in the table below, donors continue to remain the main source of health financing in the country. There are approximately 10-15 donors financing the health sector.

Table 1: Trend of Government Budgetary Allocation on Health and Social Welfare

Category	2006/07	2007/08
Personnel Expenditure	1 180 248	3 605 207
Goods and Services	2 382 536	2 885 600
Transfers and Subsidies	3 021 572	3 740 572
Capital Expenditure and Equipment	975 241	700 700
Total	**7 559 597**	**10 932 079**

Source: **Ministry of Health and Social Welfare**

Table 2: Sources of Financing and Health Expenditure (2007)

Sources of Health	US$ (million)	US$ per capita Expenditure	% of total Health Expenditure	% Gov. Expenditure
Government	10.1	3.2	16.8	8.4
Private	20.0	6.3	33.3	16.7
Donors	**30.0**	9.4	50.0	25.0
Total	**60.1**	**18.8**	**100.1**	**50.1**

Cost recovery schemes introduced in public facilities prior to and during the war years have all been suspended by the current Government, citing the economic hardship experienced by the population as the major reason. While there are no indications of when the ban will be lifted, it can be assumed that this will depend on improvement in the economy, characterized by a high level of unemployment (estimated at 80%). However, a number of partners including WHO, have assisted the Ministry of Health in conducting several health-financing studies (community health financing, contracting, health expenditure review), which would form the basis for the development of a national health financing policy and plan. Also, the development of a national health account for tracking the inflow and utilization of funds has been initiated with the support of USAID and WHO. A synthesis report of the various studies has been prepared and will form the basis for the hosting a health financing review workshop to explore various options of health care financing for the country.

Private sector financing of the health sector is not quantified, but thought to be considerable. Prior to the war, it was estimated that 64% of the total expenditure on health was incurred in the private sector. This pattern changed drastically during and after the war. Current expenditure in the private health sector is estimated at about 33%. When completed, the on-going NHA study is expected to provide the current expenditure level of the private sector.

To strengthen its financial position, and ensure transparency, the Ministry of Health and Social Welfare, with support from DFID, has established an Office of Financial Management, which is responsible for coordinating the flow of funds from all sources to the Ministry, and the prompt preparation and submission of expenditure reports. The OFM is also responsible for developing and strengthening the capacity of financial units at the level of the central ministry and the counties. The OFM is managed by Price Waterhouse Cooper, an international accounting firm. As a result of the establishment of banking facilities in most counties, and the conduct of a financial management capacity study by the OFM, the Ministry is anticipating establishing appropriate financial management systems in a few counties. Other support systems at the level of the counties, namely logistics, transportation, etc., remain major challenges for the sector.

2.3.14 Key health policy issues and challenges

The following issues and challenges have been identified:

- The resolution of crisis in some neighbouring countries is intimately linked with the country's stability and transition, and development.
- Liberia is vulnerable to a high burden of infectious diseases and epidemics, including; cholera, shigellosis Lassa fever and yellow fever. The steady increase in the prevalence of HIV/AIDS and Tuberculosis demands urgent interventions aimed at reducing the rate of HIV transmission. Laboratory and blood transfusion services need to be rehabilitated; in order to improve the quality of care.
- The high maternal and infant mortality rates in Liberia are major causes of concern, and require the intervention of all stakeholders and partners in order to meet the Millennium Development Goals. Noncommunicable diseases, including mental health and consequences of Gender-Based Violence also need to be addressed.
- The destroyed physical infrastructure for health service delivery will need to be rehabilitated soon. At the moment, poverty continues to suppress the people's demand for services. With the return of peace, health services will need to immediately scale-up their quality and coverage; acute shortage and low quality of human resources for health are urgent issues for Liberia. Issues of human resource development, management and retention also need to be addressed.
- The Health Information System and active Disease Surveillance System need to be strengthened. An active coordination of partners in the health sector should be seen as priority; access to safe drinking water and good excreta disposal facilities is extremely low. Garbage disposal is a key challenge in all towns and cities.

SECTION 3

DEVELOPMENT ASSISTANCE: AID-FLOW, INSTRUMENTS AND COORDINATION

3.1 GENERAL TRENDS OF AID TO LIBERIA

The pattern of development assistance to the health sector has undergone major changes, from relief and humanitarian assistance to rehabilitation and reconstruction. These also include changes in the share contribution by different funding agencies, the method of financial inflow and the nature of programmes funded. Since 2006, aid flow to the health sector has increased tremendously, averaging around US$ 118.00 in 2007 as reflected in Annex III. The increase has been attributed to a series of economic reform measures instituted by the Government. The Government and partners are making efforts to attain a HIPC status, which will no doubt pave the way for an increase in the flow of aid to the country.

The health sector is heavily donor dependent. The Government's health expenditure for 2007/2008 is US$ 15 m or US$ 4 per capita. The country should be spending at least US$ 108.8 million annually on health to meet the MDG spending target of US$ 34 per capita. Compared to the current health expenditure, there is a shortfall of US$ 48.8 million. With an annual growth rate of US$ 7, the Government will not be able to independently fund the health sector without sustained donor support for the next 5-10 years.

3.2 TRENDS OF AID TO THE HEALTH SECTOR

Bilateral and multilateral external aid has been the major sources of funding for the health sector since 2006. These funds have been used to support diversified health activities, including: provision of drugs and medical supplies, rehabilitation/construction of health facilities, provision of equipment, immunization, logistics, financial and technical support, human resource development and capacity building. The programmes funded by external assistance have also been changing; reflecting the evolving needs and shifts in the priority of both donors and the Government of Liberia. In the initial phase (conflict years), assistance was focused on humanitarian and relief aid. Currently, the emphasis has shifted to reconstruction and rehabilitation, as reflected in the table below.

Since 2006, there has been an upsurge and emergence of (funding) agencies that are not public institutions or part of the UN system. Important among these are the Clinton Foundation, Basic (support by USAID), McCall MacBaine, University of Massachusetts, Health Systems 2020, in addition to other Liberian established agencies, which are currently providing a variety of assistance to the Ministry of Health and Social Welfare in a number of areas; technical assistance, donation of equipment and supplies, etc.

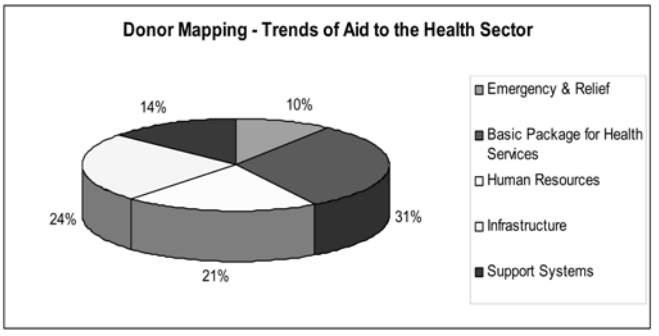
Table 3: Donor Mapping

Donor	Programme Areas				
	Emergency & Relief	Basic Package for Health Services	Human Resources	Infrastructure	Support Systems
Multilateral Institutions					
World Bank			x	x	
ADB					
IMF					
Bilateral Institutions					
USAID	x	x	x	x	x
DFID					
ECHO					
JICA		x	x	x	
GTZ					
IRISH				x	
SWISS				x	x
PRC					
FRENCH					
DUTCH					
SWEDISH					
CUBA					
UN AGENCIES					
WHO	x	x	x		x
UNICEF	x	x		x	
UNDP				x	
UNFPA		x	x		
UNAIDS		x	x		
OTHERS (FOUNDATIONS)					
Clinton Foundation		x			
McBaine		x			x
LERHIS Foundation		x			

As depicted in the chart below, support from donors and other partners to the health sector is mainly concentrated on three of the key pillars of the national health plan, namely Basic Package of Health Services, Infrastructure and Human Resources for Health. Little emphasis is placed on support systems, which constitute a critical element for health services delivery. Further reduction of partner support suggests over-concentration of a number of partners on the same interventions in the various pillars, to the total exclusion of other interventions, leading to gaps in some programme areas, such as human resources for health and support systems.

Given the current efforts by the Government for aid coordination, which is vital for enhancing the productivity of development aid, the fragmented manner in which funds are currently channelled and lack of effective coordination of aid have resulted in duplications and overlap of activities, distortion of aid through conflicting approaches and schemes and gaps identified needs that are not addressed by donors.

As noted, while there seems to be complementarity in partner support to the health sector, there seems to be a number of overlaps, resulting in gaps in some critical programme areas, as indicated above. Though not a traditional WHO programme focus, in full realization of this situation, the WHO recently initiated, through a grant from the Japanese Government (Trust Fund) the renovation and equipping of the maternal and child wards and operating theatres of six hospitals.



The Government, in collaboration with partners, recently developed the Poverty Reduction Strategy Paper, which was launched at a two-day Partners' Forum in Berlin, Germany from 20 to 21 June 2008. Health, incorporated under the fourth pillar (Infrastructure and Basic Social Services), identified four priority areas under the PRS: human resources for health, basic health package, infrastructure, and support systems. The cost of these areas is estimated at US$ 119.7 m. It is anticipated that the sector will receive favourable response in terms of fund commitment.

3.3 MECHANISMS FOR RESOURCE MOBILIZATION

There are currently no institutionalized mechanisms for resource mobilization for the health sector. Hence, support to the health sector is channelled through a multiplicity of mechanisms, including bilateral and multilateral cooperation, technical cooperation programmes, direct support through international nongovernmental organizations, third-party execution, pool fund, submission of proposals for funding and the PRS Partners' Forum. The table below presents the financial requirements for both the PRS and implementation of the national health plan.

Table 4: Financial requirements for implementation of the health component of the PRS and National Health Plan (US$)

Source	Period				
	2007	2008	2009	2010	Total
Poverty Reduction Strategy	- 0 -	39.9	39.9	39.9	119.7
National Health Plan	54.4	65.0	76.1	87.6	283.06
Total	**54.4**	**104.9**	**116.0**	**127.5**	**402.76**

3.4 MECHANISMS AND METHODS OF COORDINATION

Coordination of the health sector is generally at two distinct levels: the Ministry of Health and Social Welfare, and the counties.

At the level of the Ministry is the Health Services Coordinating Committee, which brings together all partners involved in the health sector. The committee is chaired by the Minister of Health and has specific terms of reference; mainly focusing on programme monitoring,

outcomes, funding, challenges, etc. In addition, there are two distinct specialized committees, the Liberia Coordination Mechanisms for the Global Fund and the Inter-agency Coordinating Committee for Immunization, both chaired by the Minister of Health and Social Welfare. Besides, International NGOs have a consortium to coordinate their activities.

At the level of the counties is the County Health Services Coordinating Team, which comprises partners at that level. The coordinating committee is chaired by the County Health Officer. Coordination of partners varies from one county to the other. In some counties, significant coordination is taking place in terms of joint planning and supervision between CHTs and partners; while in other counties there is little or no coordination of partners.

The Ministry of Health and Social Welfare, in collaboration with donors, established in 2007 a Fund Pooling System referred to as "Pool Fund" as a "Budget Support Mechanism". Through this mechanism, financial resources are pooled and used by the Ministry, in line with the national health plan, to undertake projects and programmes approved by a Steering Committee, which comprised donors, UN agencies and the Ministry of Health and Social Welfare.

To date, only three donors, namely the British Department for International Development (DFID) (US$ 8 million), Irish Aid (US$ 1 m) and UNICEF (US$ 0.8 m) have contributed to the fund. All financial transactions of the pool fund are coordinated through the Office of Financial Management. The establishment of the pool fund, though it is yet to receive greater participation, has been hailed and endorsed by the Country Office and other partners as a milestone, and an efficient mechanism for donor coordination and aid alignment. Given the potential benefits of the pool fund, the Government has introduced the concept in other sectors of the country, notably education.

SECTION 4

CURRENT WHO COOPERATION

The WHO Programme of technical cooperation in Liberia has been characterized by mutual partnership between the Government of Liberia and WHO, and is aimed at supporting the Government to improve the health system and well-being of the Liberian population. In this regard, the CCS has been fully aligned with the national health plan and policy, in particular the four essential pillars of the national health plan and the PRS: Basic Package of Health Services, Human Resources for Health, Infrastructure and Support Systems.

WHO achieved in recent times in Liberia an enviable reputation for strong technical skills and commitment to the national health agenda. This has been vividly demonstrated, more importantly since the cessation of the conflict through successful collaboration between the Government, partners and the WCO. The WCO technical support activities hailed by the Government, partners and other UN agencies, include:

- assistance for development of the national mental health policy;
- mobilization of additional resources:
- conduct of a number of health financing studies for development of a national health care financing policy;
- recognition of WCO technical collaboration in programmes such as polio eradication;
- establishment of a reference laboratory;
- malaria control, TB control, scaling-up antiretroviral treatment for people living with HIV/AIDS;
- renovation/rehabilitation of maternal and child wards, including operating theatres in six hospitals;
- technical support in hosting two national health conferences;
- increased liability and trust on WCO by the Government and others, in the light of the Avian Flu and the recent H1NI pandemic;
- collaboration with GAVI and other partners in the strengthening of health systems, joint evaluation and development of the country's second MDGs report, joint development and implementation of the UNDAF, with WCO as the lead agency for the health component of UNDAF;
- development of the PRS, among others.

Ideally, some of the essential elements that have made such notable recognition possible were the tapping of both regional and global experiences, conduct of a number of evidence-based studies, recognition of WCO as a creditable partner by the Government, and its close working relationship with other partners, and the commitment, cooperative attitude, expertise, strong and proactive country team at the WCO.

4.1 WHO COUNTRY OFFICE

WHO's presence in Liberia dates back to 1946, when funding was provided for implementation of a malaria control project in Kpien, Nimba County. Liberia was the first African country to become a member of WHO in March 1947, after which a small office of three staff members was established in Monrovia. The office has, however, grown in size and is currently located in a four-storey building apartment, which it shares with the UN Dispensary. It is modestly equipped and almost MOSS compliant. In 2006, two sub-offices were opened; one in the central region and the other in the south-eastern region of the country, to strengthen the capacity of health partners, assist the Ministry of Health, coordinate health activities and promptly respond to outbreaks.

Logistics and Communication: The WHO Country Office in Liberia presently has one official and six service vehicles for technical activities, while four motorcycles are used by the drivers and messengers. In 2006, the Office was among the last to be connected to the global GPN Network. Efforts are currently underway to make the office fully GSM compliant by November 2008. Also, the Office relies on the use of mobile telephones and VHF/HF radios to facilitate communication.

4.2 STRATEGIC OBJECTIVES

In the current biennium, 2008-2009, the World Health Organization is supporting the following strategic objectives:

Strategic Objective	Acronym
To reduce the health, social and economic burden of communicable diseases	SO 1
To combat HIV/AIDS, malaria and tuberculosis.	SO 2
To prevent and reduce disease, disability and premature death from chronic noncommunicable conditions, mental disorders, violence and injuries	SO 3
To reduce morbidity and mortality and improve health during key stages of life, including pregnancy, childbirth, neonatal period, childhood and adolescence, while improving sexual and reproductive health and promoting active and healthy ageing for all individuals, using a life-course approach and addressing equity gaps	SO 4
To reduce the health consequences of emergencies, disasters, crises and conflicts, and minimize their social and economic impact	SO 5
To promote health and development, prevent and reduce risk factors for health conditions associated with tobacco, alcohol, drugs and other psychoactive substance use, unhealthy diets, physical inactivity and unsafe sex	SO 6
To address the underlying social and economic determinants of health through policies and programmes that enhance health equity and integrate pro-poor, gender-responsive, and human rights-based approaches	SO 7
To promote a healthier environment, intensify primary prevention and influence public policies in all sectors so as to address the root causes of environmental threats to health	SO 8
To improve nutrition, food safety and food security, throughout the life-course, and in support of public health and sustainable development	SO 9
To improve health services through better governance, financing, staffing and management informed by reliable and accessible evidence and research	SO 10
To ensure improved access, quality and use of medical products and technologies	SO 11
To provide leadership, strengthen governance and foster partnership and collaboration in engagement with countries, to fulfil the mandate of WHO in advancing the global health agenda as articulated in the 11th General Programme of Work	SO 12
To develop and sustain WHO as a flexible, learning Organization, in order to enable it to carry out its mandate more efficiently and effectively	SO 13

4.3 FINANCIAL RESOURCE ALLOCATIONS BY AREAS OF ACTIVITY

The WHO Technical Cooperation Programme is based on biennial action plans. It is important to note that the total regular and extrabudgetary allocation by WHO to programme activities in Liberia progressively increased from US$ 5.4 million in 2006/2007 to US$ 7.8 million in 2008/2009; but the trend of financial allocation to individual areas of activity typifies the changing health priorities of the country. Only 5% of the total funds were allocated to Emergency & Humanitarian Action in 2006/2007; but it received 20% of the national budget in 2008/2009. Health Policy & Management received 27% of the budget allocation for 2006/2007, but only 6% in 2008/2009.

4.4 HUMAN RESOURCE MANAGEMENT

The WHO Country Office in Liberia currently has a total of 31 staff members compared to 26 in the previous biennium. The staff is made up of 11 professionals and 20 general service staff. The 11 professionals include 5 international staff and 6 national staff, while all the 20 general service staff are nationals. As for the gender equity, there are two female national professionals and five female GS staff, making a total of 23% of the work force. Ninety percent of the staff is on fixed-term appointment (see Annex XI).

4.5 SUPPORT FROM WHO REGIONAL OFFICE FOR AFRICA AND HEADQUARTERS

As part of the technical cooperation with GOL, the WHO Regional Office for Africa and Headquarters fielded 52 Consultants, who provided technical guidelines during the 2006-2007 biennium to specifically support the Country Office in areas such as Health Systems Development, Emergency & Humanitarian Action, WATSAN, Disease Surveillance, Epidemic Control, Nutrition, Assessment of Gender-Based Violence and incidence of Mental Health. Emergency surgical and basic health kits were also distributed to public, private and NGO health facilities that were responding to emergencies. The beneficiaries include major hospitals in Monrovia and Buchanan. A number of computers and other accessories were also provided to the Ministry of Health and Social Welfare.

4.6 SUB-REGIONAL/INTERCOUNTRY ACTIVITIES

The Country Office staff participated in a number of key sub-regional activities, which are related to disease prevention and control, health systems development, family and child health, and cross-border issues such as control of Lassa fever and immunization in the border areas of Côte d'Ivoire, Guinea and Sierra Leone.

4.7 RESOURCE MOBILIZATION

During 2006 and 2007, the WHO Country Office in consultation with the Ministry of Health & Social Welfare, locally mobilized funds totalling US$ 5 608 405 from a number of sources, including DFID, for revision of the national health policy and development of the plan, USAID, ECHO, CERF, Canadian and Finish Governments for disease surveillance and routine immunization. In addition, UNAIDS and UNHCR provided more than US$ 400,000 for the control of substance abuse and in support of partnership for health. A grant of US$ 116,000, provided by the Irish Government was used mainly to support the two WHO sub-

offices established to assist the Ministry to coordinate health services in the south-eastern and central regions of the country. WHO also mobilized locally US$ 1,300,000 through the Japanese Government for funding reproductive health activities.

4.8 ACHIEVEMENTS

The WHO Technical Cooperation Programme has significantly changed environments for public health action, and influenced policies through allocation of technical and financial resources. Despite the many constraints that characterized the period under review, i.e. state of insecurity and inaccessibility of some parts of the country, some major accomplishments were attained. They included revision of the national health policy, development of a five-year health development plan, development of a road map for reproductive health, establishment of two sub-offices, re-profiling of the WCO, mobilization of over US$ 5.6 million dollars, Emergency Response Teams established in three counties, development of an integrated action plan of avian and human influenza, Drugs, provision of equipment and logistical support for various programmes to MOH&SW, introduction of new pentavalent vaccines, revitalization of the health management information system, development of SGBV plan, conduct of Health and Nutrition assessments and interagency health evaluation, disease outbreaks, development of national guidelines for HIV testing and counselling, PMTCT, ART as well as draft guidelines on blood safety and testing and HIV/TB co-infection, development of a mental health policy and signing of the Framework Convention on Tobacco, etc.

4.9 CONSTRAINTS

The office rental cost is extremely high. Due to the non-availability of a national electricity grid, the high cost of fuel for running the generators also continues to increase the operational costs of the office. Though the national electricity grid has been extended to the area where the office is located, connectivity to the grid remains a major problem.

Personnel: The shortage of some essential staff remains a constraint for the office. While funds have been allocated for the recruitment of some personnel including NPOs (Malaria, HIV/AIDS), they are inadequate for the total additional staff needed, TB, IMCI, MPN. In addition, the office will need additional funds to recruit an NPO for Supply Chain Management to support the Ministry of Health, as well as project drivers, additional drivers, a messenger and a storekeeper for the warehouse.

Cost of Security: Cost of in-country duty travel has decreased, as the entire country has been placed under lower UN security phases. However, staff cost is still high because of the additional expenditure for hazard pay, solar, and rest and recuperation.

Transport Facilities: A number of vehicles were sold because of their old age and prohibitive running and maintenance costs through a public bidding process. Though few new vehicles have been added to the fleet, they are still inadequate to meet the transportation needs of the office.

Communication/Connectivity: The Country Office was finally connected to the global GPN Network in 2006, with the installation of a 128 kbps VSAT. However, the system has intermittently experienced a number of problems due to poor cabling, equipment breakdown, unavailability of spare and replacement parts on the local market, etc. These problems have unfortunately rendered the system inoperative on a number of occasions for periods of up to two months or more, thus affecting both internal and external communication. The system is

currently being overhauled in conformity with GSM requirements. While a centralized archive system for hard or electronic copies in the office is still a major problem, a Librarian Assistant with skills in the area has been recruited and is expected to address the problem.

In sum, there are two major risks impeding the effective implementation of the strategic objectives of the CCS. The first relates to the current challenges facing the health sector at large; the persistent critical shortage of human resources for health, low managerial capacity of the Ministry of Health and Social Welfare, and limited well-equipped infrastructure. The second risk has to deal with potential resource constraints that may inhibit the strengthening of the WCO country presence and its contribution. It is envisaged that sustained resource mobilization would be required in order to alleviate this risk by WCO, AFRO, and HQ. In addition, WCO will partner more with other UN agencies and other partners to ensure complementarity of activities and avoid duplication. Also, the WCO would seek to leverage the capacities and support of the Regional Office and headquarters.

SECTION 5

WHO CORPORATE POLICY FRAMEWORK: GLOBAL AND REGIONAL DIRECTIONS

WHO is undergoing significant changes in the way it operates, with the ultimate aim of performing better in supporting its Member States to address key health and development challenges. This organizational change process has, as its broad frame, the WHO Corporate Strategy.

5.1 WHO MISSION

With its mandate as the lead international health agency, the mission of WHO remains, "the attainment by all peoples, of the highest possible level of health" (Article I of WHO Constitution). The Corporate Strategy and the Policy Framework for Technical Cooperation with Member Countries of the African Region outline key features through which WHO intends to make the greatest possible contribution to health in the world, and indeed in the African Region. The Organization aims at strengthening its technical, intellectual and policy leadership in health matters, as well as its management capacity to address the needs of Member States.

5.2 NEW EMPHASES[4]

The WHO Corporate Strategy emphasizes the following WHO responses to the changing global environment:

- adopting a broader approach to health within the context of human development, humanitarian action and human rights, focusing particularly on the links between health and poverty reduction;
- playing a greater role in establishing wider national and international consensus on health policy, strategies and standards by managing the generation and application of research, knowledge and expertise;
- triggering more effective action to improve health to reduce inequities in health outcomes by carefully negotiating partnerships and catalysing action on the part of others;
- creating an organizational culture that encourages strategic thinking, global influence, prompt action, creative networking and innovation.

[4] Ibidem 1

5.3 STRATEGIC DIRECTIONS[5]

WHO's goals are to build healthy populations and communities and combat ill-health. To achieve these goals, four strategic directions will provide a broad framework for focusing WHO's technical work.

1. reducing excess mortality, morbidity and disability, especially in poor and marginalized populations;
2. promoting healthy lifestyles and reducing risk factors among the population;
3. developing health systems that equitably improve health outcomes, respond to peoples' legitimate demands, and are financially fair;
4. developing an enabling policy and institutional environment in the health sector, and promoting an effective health dimension to social, economic, environmental and development policies.

5.4 CORE FUNCTIONS

The typology of WHO core functions, presented below, is based on the comparative advantage of the Organization at all its levels:

1. articulating consistent, ethical and evidence-based policy and advocacy positions;
2. managing information, assessing trends and comparing performance of health systems; setting the agenda for, and stimulating research and development;
3. catalysing change through technical and policy support in ways that stimulate action and help to build sustainable national capacity in the health sector;
4. negotiating and sustaining national and global partnerships;
5. setting, validating, monitoring and pursuing proper implementation of norms and standards;
6. stimulating the development and testing of new technologies, tools and guidelines for disease control, risk reduction, health care management and service delivery.

5.5 GLOBAL AND REGIONAL PRIORITIES[6]

Given the fact that WHO has to utilize its limited resources efficiently, and in order to be more effective in its interventions, the Organization has selected a limited number of priority issues on which to focus its interventions in the medium term.

The criteria for setting priorities include: (i) potential for significant change in the burden of disease with existing cost-effective interventions; (ii) health problems with major socio-economic impact and a disproportionate impact on the poor; (iii) urgent need for new technologies; (iv) opportunities to reduce health inequalities within and between countries; (v) major demand from Member States and (vi) WHO's comparative advantage. This comparative advantage relates particularly to the provision of public goods, building of consensus around policies, strategies and standards and initiation and management of partnerships.

[5] WHO: General Programme of Work (GPW), 2002-2005.
[6] Idem and The Work of WHO in the African Region, Strategic Framework, 2002-2005.

The global priorities selected on the basis of these criteria include: malaria, HIV/AIDS and TB; maternal health; mental health; tobacco control; noncommunicable diseases; food safety; blood safety; health systems; and health and environment.

The African Region has accordingly prioritized twelve areas to be addressed in the medium term, namely Health Systems Development; Control of Communicable Diseases, including HIV/AIDS, Tuberculosis, Malaria and Blood Safety; Maternal Health; Child Health; Youth and Adolescent Health; Mental Health; Control of Noncommunicable Diseases, including Cardiovascular Diseases, Cancer, Diabetes, and Obstructive Chronic Respiratory Diseases; Health Promotion; Health and Environment; Nutrition; Preparedness for and Response to Emergencies and Epidemics; Poverty and Health and Essential Medicines (including Traditional Medicine).

5.6 MAKING WHO MORE EFFECTIVE AT COUNTRY LEVEL

The expression of WHO corporate strategy at country level will vary from country to country. Taking into consideration country specific health and development challenges, the involvement of other external partners, WHO's current work in and with the country, and the global and regional policy frameworks, WHO will look at balancing the key functions at country level. This means that the Organization will act more as adviser, broker, and catalyst, and will involve itself in routine implementation in case of specific, clearly identified and prioritized initiatives, with a time-limited perspective.

Classification of WHO functions at country level has been developed as follows, based on the broader core functions:

1. supporting limited routine long-term implementation;
2. catalysing adoption and adaptation of technical strategies; overseeing large-scale implementation;
3. supporting research and development; monitoring health sector performance;
4. facilitating sharing of information and knowledge; providing generic policy options, standards and advocacy;
5. providing specific advice; serving as broker; influencing policy action and spending from governments and other partners.

SECTION 6

STRATEGIC AGENDA FOR 2008-2011

6.1 INTRODUCTION

In developing the CCS, the global and regional priorities were taken into account. The Government of Liberia articulated a number of policy and plan documents for the health sector, and the WCO is fully committed to supporting the efforts of the Government in attaining its goals. Hence, the thrust of WCO support for the period 2008-2011, articulated below, was carefully selected, based on their magnitude in the overall health problem in the country.

Consequently, to adequately respond to the various needs and challenges highlighted in sections one (1) to five (5) of the Liberia CCS document, the current WHO Country Cooperation Strategic Agenda selected four specific areas of work based on their impact on the country's burden of disease, the vulnerability of impoverished Liberian people to these diseases, and the availability of cost-effective technologies. Overall, the WCO strategic agenda will focus on the following four strategic directions:

(a) Emergency Preparedness and Humanitarian Response
(b) Strengthening Performance of the Health System
(c) Disease Prevention and Control
(d) Improvement of Maternal, Newborn and Child Health

The above strategic directions and their implementation were chosen in such a way as to reflect the post-conflict transition that the country is currently undergoing. Thus, an emergency preparedness and humanitarian response phase will still be maintained, monitored and reviewed in the short term (up to one year), and as the country advances into politico-socio-economic stability, more development-focused agenda will be pursued and expanded in the medium to long-term.

6.2 EMERGENCY PREPAREDNESS AND HUMANITARIAN RESPONSE

Objective:

Strengthening the capacity of stakeholders in preparedness and timely humanitarian response to health emergencies in Liberia.

Approaches:

During the transition, recovery and development periods, WHO, in collaboration with other relevant sectors and partners, will support MOH&SW in:

- measuring ill-health and assessing needs by county;

- coordinating joint action for health activities;
- filling or ensuring that others fill critical gaps in health response, including gender-based violence;
- revitalizing and building capacity of the health system;
- formulating Emergency Preparedness and Response Plan (EPR);
- developing a national EPR functional plans at the central and county levels;
- monitoring and evaluating emergency response.

6.3 STRENGTHENING PERFORMANCE OF THE HEALTH SYSTEM

The health policy of Liberia draws attention to nationally-agreed priorities, on which the efforts of all concerned partners are to be based during its post-war development era. Given this direction, WHO will contribute technically to capacity building, human resource development, and support the implementation of the Basic Package for Health Services. WHO will also support the Ministry in stewardship through advocacy, policy implementation, priority setting, coordination, and strategic planning and monitoring of the health sector.

In this regard, WHO will support the Ministry of Health and Social Welfare in:

- expanding access to basic health care of acceptable quality;
- establishing the building blocks of an equitable, effective, efficient, responsive, and sustainable health care delivery system.

Approaches:

WHO will strengthen the capacity of the MOH&SW to:

- implement the National Health Policy and Plan;
- support the development and implementation of the human resource and health financing policies and plans; including the development of mental health and social welfare plans;
- strengthen the Health Management Information System at all levels of the health system;
- facilitate increase access to essential medicines and pharmaceutical services;
- improve critical and emergency care services at all levels;
- advocate for health through community initiatives designed to gain political commitment, policy support; social acceptance, and systems support to particular health goal or programme;
- advocate and broker support for rehabilitation and reconstruction of health infrastructures;
- increase accessibility to essential integrated BPHS and improve the quality and safety of services at all levels;
- strengthen managerial capacities of central and county levels of health care delivery;
- support the establishment of an M&E Unit and facilitate the conduct of core operational research;
- promote intersectoral collaboration and partnership coordination for health action;

- support conduct of assessments and strengthening of supply chain management, and other essential support systems.

6.4 DISEASE PREVENTION AND CONTROL

WHO will continue to provide long-term support for selected programmes, address priority and emerging issues, promote healthy lifestyles, and improve the quality of life, with a focus on the most vulnerable and underserved segments of the population through intersectoral collaboration.

Objective:

To support the MOH&SW to effectively prevent and control communicable and noncommunicable diseases in order to reduce the resultant morbidity and mortality.

Approaches:

WHO will strengthen the capacity of the MOH&SW to:

- review policies and implement activities related to prevention and control of the six major causes of mortality: malaria, diarrhoea, malnutrition, ARI, tuberculosis and vaccine preventable diseases;
- review policies and implement activities related to prevention and control of Neglected Tropical Diseases (schistosomiasis, lymphatic filariasis, onchocerciasis, trypanosomiasis). Intensify activities for the prevention and control of malaria, tuberculosis and HIV/AIDS, as part of the implementation of the recommendations of WHO Commission on macro-economy and health through financing from the Global Fund;
- prevent and respond to disease outbreaks (cholera, shigellosis, yellow fever, Lassa fever and probably rabies). Provide people with the relevant information and skills they require to prevent ill-health and maintain healthy lifestyles through intersectoral collaboration;
- establish a structure for a noncommunicable disease programme in the Ministry of Health and Social Welfare;
- prevent and control noncommunicable diseases, including mental health and psycho-social services;
- review/develop policies and guidelines on environmental health; putting emphasis on control of the quality of water, sanitation and occupational health; and promote their implementation;
- set up an integrated system of communicable disease surveillance, including Early Warning System (EWARN).

6.5 IMPROVEMENT OF MATERNAL AND CHILD HEALTH

Maternal and childhood mortality rates in Liberia are among the highest in sub-Saharan Africa. These figures have been exacerbated by the near collapse of the health system and the near absence of antenatal, delivery and postnatal services. Hence, with the availability of a comprehensive RH Road Map, WHO will assist the MOH&SW to increase its capacity to reduce these rates, and will also design and implement programmes that will facilitate reduction in the rate of gender-based violence.

Objective

WHO will support Government efforts in attaining the Millennium Development Goals for the reduction of:

- infant and childhood morbidity and mortality;
- newborn and maternal mortality.

Approaches:

Specifically, WHO will support the MOH&SW to:

- review policies, guidelines, norms and standards, and adapt tools in child and maternal health care services, including IMCI and MPS;
- strengthen capacity for the management of childhood illnesses and MPS;
- advocate and negotiate for increased access to comprehensive maternal and child health services, including essential obstetric care through joint planning, implementation and monitoring with all interested partners.

6.6 WHO FUNCTIONS

Within these four strategic directions, WHO identifies six functions for the Country Office:

- supporting implementation of the health plan with emphasis on the Basic Health Package, adoption and adaptation of strategies, tools and guidelines;
- overseeing large-scale implementation of proven approaches and interventions;
- supporting operational research and development and monitoring health sector performance;
- sharing information on norms and standards, knowledge, and health intelligence, including update on health assessment for decision-making;
- promoting analysis and dialogue, providing policy advice and options, serving as broker;
- advocating for resource mobilization and management; facilitating coordination and partnership for health action.

SECTION 7

IMPLEMENTING THE STRATEGIC AGENDA: IMPLICATIONS FOR WHO SECRETARIAT, FOLLOW-UP AND NEXT STEPS AT EACH LEVEL

The Country Cooperation Strategy for Liberia sets out the strategic directions and medium-term agenda for the work of WHO at all three levels in Liberia, and it will be implemented in phases over the next six years, due to current unpredictable security conditions. To ensure effective implementation, WHO will work with the Ministry of Health & Social Welfare, as well as other relevant sectors and stakeholders, in order to enhance complementarity, maximize synergies and avoid duplication and wastage of the scarce resources available to the health sector.

WHO shall implement the strategy through the normal managerial processes of the Organization, which includes the Programme Budget and Work Plans, funded through the Regular Budget and extra-budgetary sources. However, the implementation of the strategic agenda has implications for the three levels of the Organization.

7.1 WHO COUNTRY OFFICE

The Country Office will be required to provide direct technical support to the country in the six components of the strategic agenda, in line with WHO's core functions.

Even though some of the needed expertise is already available in the Country Office, there will be the need to recruit additional Country Advisers (NPOs or STPs) to address issues such as: Health Systems Development, Malaria, HIV/AIDS, Health Promotion, Mental Health and Disease Surveillance. These would be supplemented by short-term consultants from the Regional Office and HQ. Funding for this additional staff will be sought from both the Regular Budget & extra-budgetary sources. Where this is not possible, efforts to use Associate Professional Officers (APOs) or UN volunteers will be explored. In addition, all levels should try and mobilize additional resources through different channels.

To enhance the operational effectiveness of the Country Office, the existing sub-offices will be strengthened with the recruitment of additional staff and provision of the requisite logistical support.

To effectively implement the strategic agenda, some of the existing NPOs have taken on additional responsibilities, which require new skills such as advocacy, communications, negotiations, resource mobilization and management. Based on the staff development plan, efforts will be deployed to provide these skills to staff in order to enhance their productivity, and to ensure that all WCO staff (technical & administrative) continue to benefit from new developments in their respective areas of work and expertise.

In order to strengthen its administrative capacity to respond effectively to the anticipated increase in workload, two new administrative assistants will be recruited before the end of

the current biennium. In addition, an NPO/IT will also be recruited to strengthen the WCO IT capacity.

Strengthening of the Country Office to enhance its health intelligence role will be done through:

- ensuring direct access of all WCO staff to online journals on health and health-related sciences and databases;
- upgrading of computer capacity in the entire office;
- linking WCO to the GSM;
- building capacity among WCO staff to use the GSM to plan, implement and monitor WHO programmes;
- strengthening the library services with additional computers and access to online services for journals and databases;
- increasing the running costs for the expanded office and ensure an efficient pool of vehicles.

There are budgetary implications to ensure effective operation of the new WCO in Liberia. There will, therefore, be the need to increase budgetary support to meet the new challenges. The WCO will also participate in resource mobilization initiatives such as the CAP, etc. to mobilize additional resources.

7.2 INTERCOUNTRY SUPPORT TEAM (IST)

Given the critical role of assisting the Government during this transitional period, IST will be required to play a more crucial role in assisting the WCO to address these challenges. In particular, technical support will be expected to be provided for full implementation of the strategic agenda in the following areas:

- technical expertise in the adaptation of regional norms, standards and guidelines;
- guidance and supervision of the implementation of WHO resolutions and regional strategies;
- technical and logistical support in emergencies;
- provision of up-to-date technical information and other technical materials;
- research and development;

7.3 WHO REGIONAL OFFICE

The WHO Regional Office for Africa (AFRO) will review and identify the implications of the Liberian CCS on the Regional Office, and disseminate widely the CCS document within the Regional Office. This will ensure a better understanding of the needs of the Liberian health system, and thus improve the scope and quality of technical support provided to the Country Team.

Given the issues and challenges facing the country, AFRO will be expected to increase its resource allocation to the Country Office in order to facilitate and reinforce the implementation of the strategic agenda. Furthermore, AFRO will be expected to use the CCS document to mobilize additional resources for the WCO, through sharing with the key donors and stakeholders.

In addition, continued support for the full implementation of the strategic agenda will be expected from AFRO in the following areas:

- provision of technical expertise for monitoring and supervision of the implementation of health programmes;
- technical expertise in the adaptation of regional norms, standards and guidelines;
- guidance and supervision of the implementation of WHO resolutions and regional strategies;
- technical and logistical support in emergencies;
- provision of up-to-date technical information and adequate WHO publications and other technical materials;
- research and development.

7.4 WHO HEADQUARTERS

WHO headquarters will collaborate with AFRO to mobilize resources, and provide technical support for the full implementation of the CCS of Liberia.

In addition, HQ will be expected to widely disseminate the Liberian CCS document to all clusters and departments in order to ensure that all support from HQ to Liberia is in accordance with the strategic agenda.

Like AFRO, HQ will also be expected to provide up-to-date technical information and adequate WHO publications and other technical materials in order to strengthen the library of the Country Office and enhance its health intelligence role.

Finally, HQ will be required to consistently involve the Country Office in negotiations and transactions with partners concerning the country. This will greatly enhance transparency and accountability across all levels of the Organization and improve our collective visibility.

SECTION 8

MONITORING AND EVALUATION

The WHO Country Cooperation Strategy for Liberia was based on extensive consultations and reviews to reflect the health and development situation as well as challenges prevalent in Liberia in 2006 and 2007. The current CCS will, therefore, form the basis of the biennial plans of action from 2008-2011 and will be subjected to review and evaluation to measure performance and accommodate changes in the health and development situation in the country.

In addition, progress in the implementation of the identified strategic areas of intervention will be periodically measured by using appropriate performance indicators and monitoring mechanism of the WHO managerial process.

ANNEX I: PROCESS OF UPDATING THE WHO COUNTRY COOPERATION STRATEGY IN LIBERIA

The process of developing the WHO Country Cooperation Strategy for Liberia was carried out in conformity with the guidelines provided by AFRO. The following procedures were followed;

Stage one: A meeting of the WCO senior staff was convened by the WR during which the modalities and work plan of updating and revising the CCS was developed. The modalities included a six-stage process that lasted for three months (June - August 2008). A Core Team headed by the WR, was then established.

Stage Two: A meeting was convened by the WR with the Minister of Health and Social Welfare and senior officials of the Ministry. The entire senior staff of the Ministry being new, a power point presentation was done, followed by an in-depth discussion of the genesis, purpose and process of developing and updating the CCS. The cooperation and collaboration of the Ministry was solicited, and a joint core team formed for updating the CCS.

Stage Three: Extensive desk review: a six-week desk review to update the CCS was carried out by the Core Team. A little over sixty documents and reports were reviewed and sourced, followed by consultations with a number of key partners in the health sector. A preliminary draft that evolved was presented to the WR.

Stage Four: The preliminary draft was edited and refined by a small technical team, comprising of senior WCO staff.

Stage Five: A one-day working session was convened at the WCO, during which the document was presented to a cross section of invited participants (partners and MOH) to analyse and provide suggestions to strengthen and improve the CCS document. The document was endorsed at the end of the session, following an in-depth discussion.

Stage Six: The last stage consisted of final editing based on the MDC recommendation and endorsement by the Regional Director and Director General.

ANNEX II: PERSONS CONSULTED (JUNE – AUGUST 2008)

MINISTRY OF HEALTH AND SOCIAL WELFARE

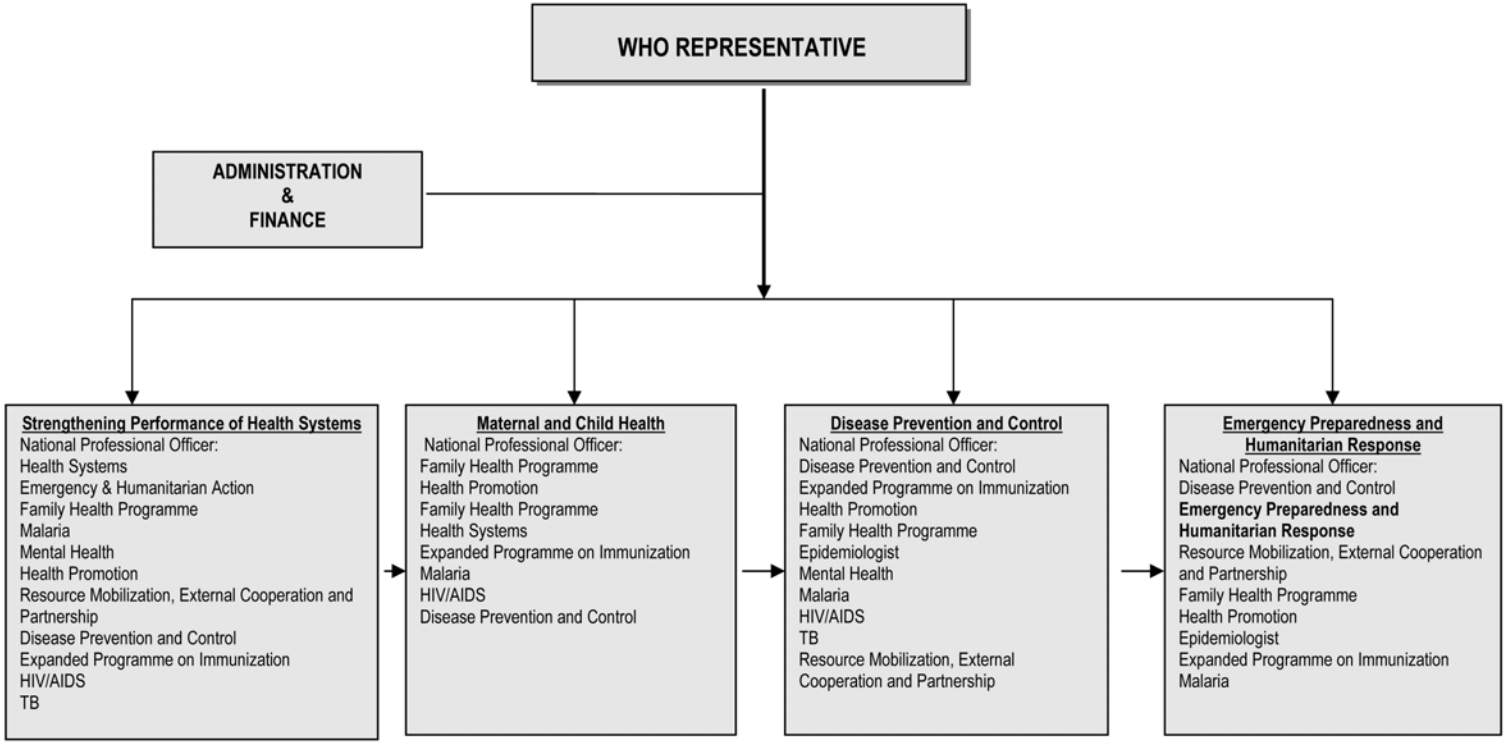
NO.	NAME	POSITION
1	Dr Walter T. Gwenigale	Minister, MOHSW
2	Dr Bernice T. Dahn	Chief Medical Officer, MOHSW
3	Mr Tornorpilah Varpilah	Deputy Minister, Planning & Research, MOHSW
4	Mrs Vivian Cherue	Deputy Minister for Administration, MOHSW
5	Mr Nmah Bropleh	Assistant Minister, MOHSW
6	Mr Jacob Hughes	Manager, Pool Fund, MOHSW
7	Mrs Jessie Duncan	Assistant Minister, MOHSW
8	Mrs Deddeh F. Jones	Chief Nursing Officer, MOHSW
9	Rev Tijli T. Tyee	Chief Pharmacist /RL, MOHSW
10	Mr Malike B. Konneh	Asst. Minister, Vital Statistics, MOHSW
11	Mrs Phyllis Kimba	MOHSW
12	Mrs Chris Dagadu	MOHSW
13	Mr Tolbert Nyensuah	MOHSW
14	Mr Joseph Vayanbah	MOHSW
15	Mr Janjay Jones	NACP/MOHSW
16	Ms Marie-Theresa Kenteng	UNDP
17	Ms Rose Gakuba	UNFPA
18	Ms Rozanne Chorlton	UNICEF
19	Mrs Patricia Sele-Kamara	Ministry of Gender and Development
20	Ms Irene Maasa	MERCI

ANNEX III: TABLE OF TREND OF DONOR SUPPORT TO THE HEALTH SECTOR - 2007– 2008/9

Last Updated 14 March 2008			GoL Fiscal Year, July - June		
GoL Health Budget (Est.)	$ 15.40	$ 15.40	$ 30.80	$ 46.20	$ 77.00
Dept. for Intl. Dev. (DFID)- OFM	$ 0.45	$ 0.60	$ 1.05	$ -	$ 1.05
DFID Pool Fund	$ -	$ 4.00	$ 4.00	$ -	$ 4.00
DFID	$ 4.15	$ 6.20	$ 10.35	$ -	$ 10.35
Dutch Government	$ 0.81	$ -	$ 0.81	$ -	$ 0.81
ECHO	$ 6.30	$ 6.00	$ 12.30	$ -	$ 12.30
European Commission – TA	$ 0.60	$ 0.89	$ 1.49	$ -	$ 1.49
France	$ 0.10	$ 0.13	$ 0.23	$ -	$ 0.23
GAVI - HSS	$ 1.02	$ 1.02	$ 2.04	$ 2.04	$ 4.08
GAVI – INS	$ 0.09	$ -	$ 0.09	$ -	$ 0.09
GAVI – ISS	$ 0.31	$ -	$ 0.31	$ -	$ 0.31
GAVI - New Vaccine Support	$ 0.10	$ 2.10	$ 2.20	$ 1.72	$ 3.92
Global Fund (HIV)	$ 4.95	$ 6.48	$ 11.43	$ 13.70	$ 25.13
Global Fund (TB)	$ -	$ 3.43	$ 3.43	$ 11.10	$ 14.53
Global Fund (Malaria)	$ -	$ 6.35	$ 6.35	$ 31.03	$ 37.38
Irish Aid Pool Fund	$ -	$ 3.00	$ 3.00	$ 3.00	$ 6.00
Irish Aid	$ 7.75	$ 4.50	$ 12.25	$ 4.50	$ 16.75
JICA (Japan)	$ 1.20	$ 2.20	$ 3.40	$ -	$ 3.40
LERHIS Foundation	$ 0.50	$ -	$ 0.50	$ -	$ 0.50
Malaria No More	$ 1.00	$ -	$ 1.00	$ -	$ 1.00
McCall Mac Baine	$ 1.00	$ 1.00	$ 2.00	$ 3.00	$ 5.00
OFDA	$ 1.60	$ -	$ 1.60	$ -	$ 1.60
President's Malaria Initiative	$ 2.00	$ 10.50	$ 12.50	$ 25.00	$ 37.50
USAID	$ 9.78	$ 14.30	$ 24.08	$ -	$ 24.08
US DoD Coop (ODC)	$ 0.50	$ -	$ 0.50	$ -	$ 0.50
Swiss Aid	$ 2.40	$ 2.20	$ 4.60	$ 1.20	$ 5.80
UNICEF	$ 8.60	$ 10.92	$ 19.52	$ -	$ 19.52
CERF (includes CHAP)	$ 3.36	$ -	$ 3.36	$ -	$ 3.36
William J. Clinton Foundation	$ 1.50	$ 1.50	$ 3.00	$ -	$ 3.00
World Health Organization	$ 5.60	$ 7.15	$ 12.75	$ -	$ 12.75
World Bank *UNFPA* *ADB*	$ 2.50	$ 3.00	$ 5.50	$ 3.00	$ 8.50
MSF-B	$ 4.91	$ 5.21	$ 10.12	$ -	$ 10.12
MSF-Esp/CH	$ 2.50	$ -	$ 2.50	$ -	$ 2.50
Total	**$ 90.993**	**$ 118.076**	**$196.449**	**$145.491**	**$341.940**

ORGANIZATIONAL CHART

FUNCTIONAL ORGANIZATIONAL CHART



ANNEX V: INDICATORS OF STRATEGIC DIRECTIONS AND MEANS OF VERIFICATION

1. Emergency Preparedness and Humanitarian Response

Indicators:

- number of counties with Emergency Preparedness and Humanitarian Response Plans;
- number of counties with Early Warning and Response Systems;
- number of Joint Coordination Meetings;
- number of Joint Needs Assessments and Strategic Plans for Emergency Preparedness and Humanitarian Response;
- number of workshops conducted on Emergency Preparedness and Humanitarian Response;
- resources mobilized;
- proportion of emergencies detected and responded to in a timely manner.

2. Strengthening Performance of the Health System

Indicators:

- policy documents, including guidelines, formulated, revised and implemented;
- specific national plans revised, formulated and implemented;
- availability of functional and quality health information database;
- number of functional county health teams;
- % of national budget allocated to health;
- number of government sector ministries/agencies involved in health;
- number of functional pre- and in-service health training institutions;
- coverage of health care delivery with the basic health package of health service at the three different levels;
- quality and cost of available essential drugs in public and private pharmacies.

3. Disease Prevention and Control

Indicators:

- proportion of counties with a functional disease prevention and control programme;
- number of mass media and community-based programmes on health promotion;
- availability of quarterly progress reports from MOH&SW on implementation of the Global Fund programmes for Malaria, Tuberculosis and HIV/AIDS;
- trends of morbidity and mortality for county-specific priority diseases;
- number of counties with a functional integrated disease surveillance system;
- proportion of outbreaks detected, reported and controlled in a timely way.

4. Improvement of Maternal and Child Health

Indicators:

- number of counties with functional comprehensive maternal and child health services, – MOH&SW and Health Partners' Reports;
- trends of country-specific indicators of infant, childhood, newborn and maternal morbidity and mortality – MOH&SW and Health Partners' Reports, including DHS;
- number of Health Facilities providing emergency obstetric care services nationwide. MOHSW & Partners' Reports;
- proportion of communities with functional appropriate technology ambulances. MOHSW & Partners' Reports.

ANNEX VI: SWOT ANALYSIS OF THE CURRENT SITUATION IN THE LIGHT OF FUTURE CHANGES

STRENGTHS

- High level of technical credibility and proficiency
- Access to international expertise and know-how
- Receptivity and cordial working relationship with MOH&SW, health sector NGOs, and development partners
- Dedication, strong commitment and team spirit among staff
- Resilience of staff, especially during emergencies
- Trained NPOs in WCO who have worked with Government and have a good knowledge of the country and culture before joining WHO
- Local communities' willingness to take charge of their own health in the context of PHC, once they are supported and guided

WEAKNESSES

- Lack of adequate funding to address current priority health issues
- Frequent breakdown of internet communication system
- Lack of adequate logistical resources – vehicles
- Limited resources to implement comprehensive programmes

OPPORTUNITIES

- Expansion in economic activities
- Increase budgetary support from government
- Availability of national health policy and plans
- Responsiveness of international community to the restoration of peace
- Availability of some training institutions for health personnel in the country
- Government's commitment and prioritization of health
- Availability of some qualified and dedicated MOH&SW staff
- Commitment of local and international actors in health, with WHO playing technical and leadership role
- New global and other initiatives (GFATM, PRS, ADB, etc.) as potential sources for additional resources to address priority issues
- Current global transformation of WHO, with particular emphasis on strengthening country offices and health action in crisis
- Communities that can be easily motivated
- International community's commitment to help the country with the post-war reconstruction activities

THREATS

- Complete withdrawal of UNMIL
- Fragile state of national security system
- State of sub-regional instability
- Low capacity of MOH&SW
- Inadequate quantity and quality of human resources for health
- Poor road network that makes many communities inaccessible

ANNEX VII: MAIN NATIONAL HEALTH POLICY ORIENTATIONS AND PRIORITIES

The available national health care policies and guidelines include the following:

- Situation Assessment of Liberia's Capacity for Performance-based Contracting (2008);
- National Nutrition Policy for Liberia (2008);
- Draft National Social Welfare Policy (2008);
- Poverty Reduction Strategy Paper (2008);
- National HIV/AIDS Strategic Plan (2008);
- National Child Survival Strategic Plan (2008);
- National Health Development Plan (2007);
- National Health Policy of Liberia (2007);
- National Therapeutic Feeding Guidelines (2007);
- National Road Map for accelerating the reduction of maternal and newborn morbidity and mortality (2007);
- National GBV Plan (2006);
- Supplementary Feeding Programme Guidelines (2004);
- National HIV/AIDS Guidelines (2003);
- National HIV/AIDS Policy (2003);
- National Malaria Policy and Strategic Plan (2003);
- National Plan of Action for Adolescent Health (2002);
- Liberia Therapeutic Guidelines and Essential Drug List (2002);
- Reproductive Health Policy (2001);
- National Drug policy (2001);
- Tuberculosis and Leprosy Policy (2001);
- National Immunization Policy (2000);
- Safe Motherhood Needs Assessment (1999/2000).

ANNEX VIII: WHO BIENNIAL FINANCIAL ALLOCATION BY STRATEGIC OBJECTIVES AND AREA OF WORK 2008-2009 – 2006-2007

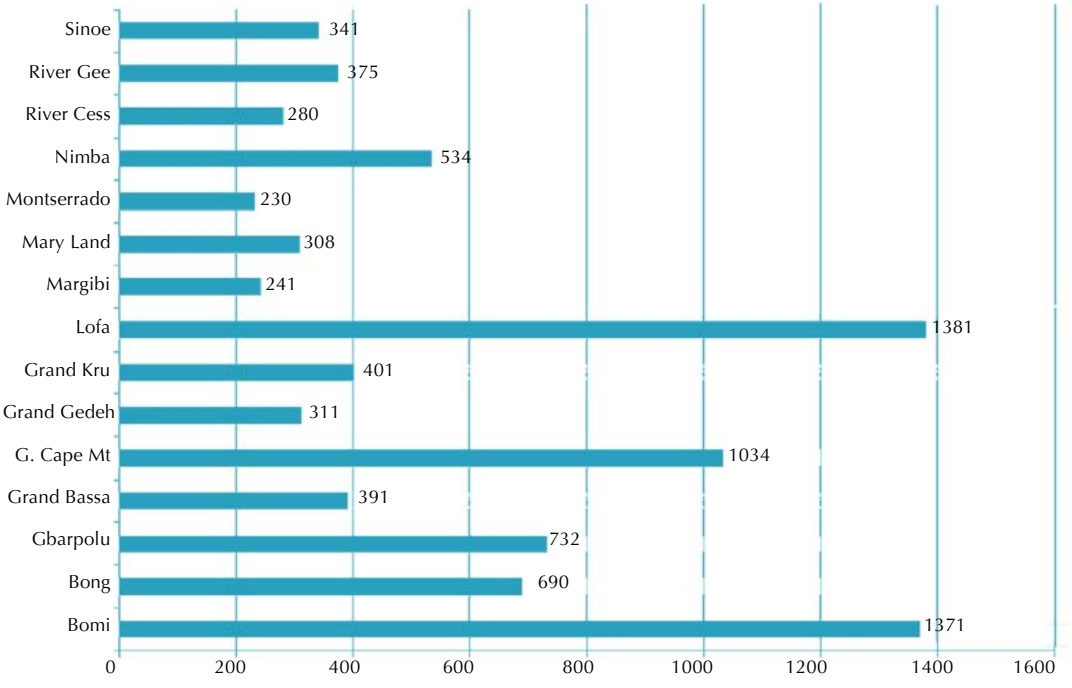
POA 2008-2009 BUDGET				POA 2006-2007 BUDGET			
STRATEGIC OBJECTIVE	**REGULAR BUDGET**	**VOLUNTARY FUNDS**	**TOTAL**	Area of Work	**REGULAR BUDGET**	**VOLUNTARY FUNDS**	**TOTAL**
Strategic Objective one (1)	297 000.00	**1 652 668.00**	**1 940 668.00**	Health Policy and Management	197 000	195 000	392 000
Strategic Objective two (2)	117 000.00	1 010 000.00	1 127 000.00				
Strategic Objective three (3)	124 000.00	44 000.00	168 000.00	Immunization and Vaccine Development	10 000	1 339 000	1 349 000
Strategic Objective four (4)	254 000.00	**459 500.00**	**713 500.00**				
Strategic Objective five (5)	47 000.00	330 000.00	377 000.00	Integrated Disease Prevention and Control	199 000	468 00	667 000
Strategic Objective six (6)	130 000.00	50 000.00	180 000.00				
Strategic Objective seven (7)	75 000.00	11 000.00	86 000.00	Emergency Health Action	24 000	382 000	406 000
Strategic Objective eight (8)	82 000.00	40 000.00	122 000.00				
Strategic Objective nine (9)	64 000.00	109 000.00	173 000.00	Reproductive and Family Health	137 000	321 000	458 000
Strategic Objective ten (10)	275 000.00	518 000.00	793 000.00				
Strategic Objective eleven (11)	71 000.00	72 000.00	143 000.00	Health Promotion	131 000	- 0 -	131 000
Strategic Objective twelve (12)	656 000.00	47 000.00	703 000.00				
Strategic Objective thirteen (13)	702 000.00	71 000.00	773 000.00	Country Office Operation	2 026 000	- 0 -	2 026 000
TOTAL	**$2 894 000.00**	**$4 421 168.00**	**$7 315 168 00**		**2 724 000**	**2 706 000**	**5 430 000**

ANNEX IX: NATIONAL HEALTH DEVELOPMENT PLAN; COSTS FOR IMPLEMENTATION

Proposed Budget for Health and Social Welfare: 2007-2010

Area	INTERVENTIONS	YEAR				
		2007	2008	2009	2010	Total
Human Resources For Health	Conduct HRH needs assessment	0.30	---	-----	---	0.30
	HRH Unit plan database development	1.00	0.15	0.11	0.08	1.34
	Training service provided (scholarships/workshops)	5.00	6.00	6.25	6.25	23.50
	Support training schools (6 schools)	5.00	6.00	6.25	6.25	23.50
	Strengthening county health teams capacity building	1.00	2.50	2.50	2.25	8.25
	Health personnel employed	3.00	4.50	4.50	5.25	17.25
Subtotal: Human Resources for Health		**15.30**	**19.15**	**19.61**	**20.08**	**74.14**
Health Support Systems	Health financing assessment and Trust Fund	0.50	0.50	0.25	0.23	1.48
	Logistics (ambulances, motorcycles, communication)	2.50	3.00	3.50	5.00	14.00
	HMIS Development (national & county levels)	0.80	0.25	0.13	0.13	1.31
	Community-level support systems	0.50	0.50	0.50	1.49	3.00
	County/district support systems (vehicles)	1.00	1.21	1.25	2.50	5.96
	Central-level support (adm. plans, policies, etc)	1.50	1.50	1.50	1.00	6.10
Subtotal Health Support Systems		**6.80**	**6.96**	**7.13**	**10.95**	**31.85**
Basic Health Package (PHC)	Reduce maternal, infant & <5 mortality rates	2.00	1.50	1.50	2.33	7.33
	Routine EPI	1.50	2.00	3.00	3.00	9.50
	Nutrition interventions	0.25	0.50	0.50	0.50	1.75
	Quality PHC services (drugs, equipment, etc)	1.00	1.50	2.00	2.50	7.00
	Malaria treatment, IPT & ITNs (facility & home)	1.00	1.15	2.00	1.00	5.15
	Referral services and treatment	0.50	1.00	0.50	0.50	2.50
	STIs/HIV/AIDS	2.00	3.00	3.00	4.00	12.00
	Scale-up TB & Leprosy control	1.50	1.50	1.50	2.00	6.50
	Strengthen Reproductive Health (safe motherhood)	0.30	1.00	1.50	2.00	4.80
	Selected social welfare services	0.25	0.50	0.17	1.00	2.46
	Emergency Preparedness and Response (EPR)	1.00	1.50	0.40	0.25	3.15
	Essential drugs and medical supplies	4.00	4.00	3.00	1.00	12.00
Subtotal: Basic Health Package (PHC)		**15.30**	**19.15**	**19.61**	**20.08**	**74.14**
Infrastructure	Infrastructure assessment and planning	0.20	---	---	----	0.20
	Rebuild health infrastructure (201 facilities)	0.50	0.50	4.50	6.00	11.50
	Rehabilitate health infrastructure (70% of 354)	0.50	0.50	3.50	5.00	9.50
	Logistical support (vehicles, furniture, etc)	0.20	0.25	0.13	0.75	1.51
	Rehabilitate mental health facilities	0.15	0.25	0.30	0.50	1.20
	Reconstruct, equip and support 3 midwifery schools	0.15	0.24	0.30	0.53	1.22
Subtotal: Infrastructure		**1.70**	**1.74**	**8.91**	**12.78**	**25.13**
Social Welfare	Rehabilitate 3 special rehabilitation facilities	0.75	0.50	0.50	0.50	2.25
	Support 150 orphanages	0.50	0.50	0.50	0.50	2.00
	Logistical support	0.20	0.25	0.28	0.30	1.03
	Social work service, e.g. Mental Health	0.15	0.25	0.25	0.27	0.92
	Capacity building for social workers	0.10	0.24	0.25	0.30	0.89
Subtotal: Social Welfare		**1.70**	**1.74**	**1.78**	**1.87**	**7.08**
Total Excluding Transitional Gap		**40.80**	**48.74**	**57.04**	**65.76**	**212.34**
Transitional Gap		12.00	14.24	17.00	19.00	62.25
Health Planning Implementation Costs		1.60	2.00	2.02	2.86	8.48
Grand Total		**54.40**	**64.99**	**76.06**	**87.62**	**283.06**

ANNEX X: NUMBER OF PERSONS SEEKING HEALTH SERVICES IN LIBERIA, PER 1000 PEOPLE



ANNEX XI

From Incentive Payment to GOL Payroll by County

	County	#OF STAFF 7/01/2009	COUNTY 7/01/2009	# OF STAFF
1	Sinoe	5	Grand Kru	6
2	Rivercess	7	Grand Bassa	6
3	River Gee	18	Grand Gedeh	17
4	Nimba	23	Gbarpolu	6
5	Montserrado	77	Cape Mount	2
6	Maryland	6	Bong	6
7	Margibi	19	Bomi	6
8	Lofa	27		
			TOTALS	**231**