WHO

COUNTRY COOPERATION STRATEGY

2018 – 2021

LIBERIA

World Health Organization

REGIONAL OFFICE FOR Africa

LIBERIA


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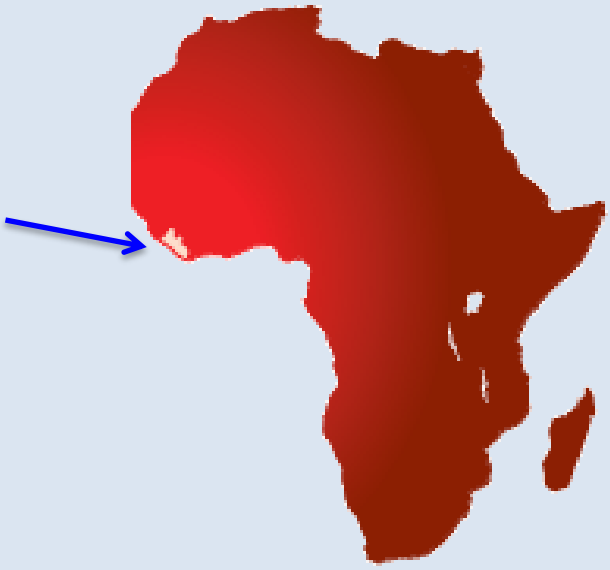


MONROVIA
LIBERIA

Liberia Country Cooperation Strategy 2018—2021

ISBN: 978-929023439-5

Suggested citation. Liberia Country Cooperation Strategy 2018—2021. Brazzaville: WHO Regional Office for Africa; 2019. Licence: CC BY-NC-SA 3.0 IGO.

Cataloguing-in-Publication (CIP) data. CIP data are available at http://apps.who.int/iris.

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Designed and printed in Monrovia, Liberia

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Abbreviations and acronyms

AFRO	WHO Regional Office for Africa
AIDS	acquired immunodeficiency syndrome
ART	antiretroviral therapy
ASRH	Adolescent, sexual, and reproductive health
AU	African Union
CCS	Country Cooperation Strategy
CDC	Centers for Disease Control and Prevention
CPS	Cooperative Partners
CRC	Convention on the Rights of the Child
DFID	Department for International Development
DHIS.2	District Health Information Systems Version 2
DTP3	Diphtheria-Tetanus-Pertussis 3
EPI	Expanded Programme on Immunization
EDV	Ebola virus disease
GDP	Gross Domestic Product
GPW	General Programme of Work
HHA	Harmonization for Health in Africa
HIV	human immunodeficiency virus
HMIS	Health Management Information System
ICT	Information and Communication Technology
IHP+	International Health Partnership
IHR	International Health Regulations
IMR	Infant Mortality Rate
JICA	Japan International Cooperation Agency
LDHS 2013	Liberia Demographic and Health Survey 2013
MCV	measles containing vaccine
MDGs	Millennium Development Goals
MNCAH	Maternal, Newborn, Child and Adolescent Health
MoH	Ministry of Health
MTEF	Medium Term Expenditure Framework
MTR	Mid-term Review
MTSP	Medium Term Strategic Plan
NAPHS	National Action Plan for Health Security
NATF	National Aids Trust Fund
NCDs	Non-communicable diseases
NGO	nongovernmental organization
NHA	National Health Accounts
NHSP	National Health Strategic Plan
NMCP	National Malaria Control Programme

NTDs	Neglected Tropical Diseases
ODA	Official Development Assistance
OOPE	out-of-pocket expenditure
PHC	primary health care
PLHIV	People Living with HIV
PMI	President Malaria Initiative
PMT	Programme Management Team
PMTCT	Prevention of Mother-to-child Transmission
PPP	Public Private Partnership
QOC	Quality of Care
RMNCAH	Reproductive, Maternal, Newborn, Child and Adolescent Health
SARA	Service availability and readiness assessment
SBA	skilled birth attendance
SDGs	Sustainable Development Goals
SIDA	Swedish International Development Agency
SOP	standard operating procedures
SRH	Sexual and Reproductive Health
SWAP	Sector-wide approaches
TB	Tuberculosis
TWG	Technical Working Group
UHC	universal health coverage
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNCT	United Nations Country Team
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNHCR	United Nations High Commission For Refugees
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
WCO	World Health Organization Country Office
WFP	World Food Programme
WHO	World Health Organization

Preface

The WHO Third Generation Country Cooperation Strategy (CCS) crystallizes the major reform agenda adopted by the World Health Assembly with a view to strengthening WHO capacity and making its deliverables more responsive to country needs. It aims at achieving greater relevance of the Organization's technical cooperation with Member States by focusing on identification of priorities and efficiency measures in the implementation of the WHO Programme Budget. It takes into consideration the role of partners, including non-State actors that support governments and communities.

The CCS was formulated within the Global WHO transformation agenda, which focuses on strategic priorities, a strategic shift and organizational reforms, and the four focus areas of the Regional Office for Africa's Transformation Agenda: smart technical focus; pro-results values; responsive strategic operations and effective communications and partnerships.

The new Liberia CCS also draws lessons from: the country's response to the 2014-2015 Ebola virus outbreak; the implementation of the 2013–2017 CCS; the Thirteenth General Programme of Work and its focus on WHO country office strengthening and the United Nations Sustainable Development Partnership Framework.

The CCS is also in line with the global health context and the move towards universal health coverage (UHC). It integrates the principles of alignment, harmonization and effectiveness, as formulated in the Paris Declaration of 2005 and the Busan Agreement of 2011 on Aid Effectiveness. It also incorporates the principles underlying the "Harmonization for Health in Africa" (HHA) and the "International Health Partnership Plus" (IHP+) initiatives, reflecting the policy of decentralization and enhancing the capacity of governments to improve the outcomes of public health programmes.

The document was developed in consultation with key health stakeholders in Liberia. It highlights the expectations of the work of WHO in the country. In line with the renewed country focus strategy, the CCS is to be used to communicate WHO's involvement in Liberia, formulate the WHO programme budget in the country, advocate and mobilize resources, and coordinate with partners and shape the health dimension of the United Nations Sustainable Development Partnership Framework and other health partnerships in the country.

I commend the efficient and effective leadership role played by the Government of Liberia in the conduct of this important exercise of developing the CCS. I also request the entire WHO staff, under the stewardship of the WHO Representative, to facilitate cost-effective implementation of the programmatic orientations of this document for improved health outcomes which will contribute to better health and development in Liberia.

Dr Matshidiso Moeti
WHO Regional Director for Africa

Executive summary

The attainment of the highest possible standard of health for all remains the major commitment of the World Health Organization. This WHO Country Cooperation Strategy for Liberia covers the years 2018–2021 and is aligned to Liberia's National Health Policy and Strategic Plan and the Investment Plan for Building a Resilient Health System (2015–2021). It articulates WHO's role and renewed commitment to collaborating with the Government of Liberia and health partners over the period under review.

The CCS is the outcome of a consultative and inclusive process of systematic analysis of national and international documents, interviews and interactions with multiple stakeholders in health. It takes into consideration WHO's comparative advantage in relation to national health priorities and well as other existing health partners.

The second generation CCS, unfortunately, could not be implemented as was expected, due to daunting challenges such as the Ebola virus outbreak, which led to the near collapse of the health system. The country has since made steady progress in refocusing the health system, with the firm commitment of the Government and its development partners to implementing the investment plan that was aligned with the Ten-Year National Health Policy and Plan.

Furthermore, the country has initiated steps towards achieving universal health coverage through a proposal for the establishment of a Health Equity Fund and the signing of the Health Compact. Despite signs of progress, however, the health system continues to be plagued by significant challenges that have to do with safe and effective service provision, inadequate numbers and poorly motivated health workers, insufficient and non-functional equipment, weak supply chains, poor logistical support, and limited budgetary support.

The CCS III capitalizes on the lessons learned from the implementation of the two previous CCSs and has been aligned with the global health context and the move towards universal health coverage, integrating the principles of alignment, harmonization and effectiveness, as formulated in the Paris Declaration of 2005 and the Busan Agreement of 2011 on Aid Effectiveness and the principles underlying the "Harmonization for Health in Africa" (HHA) and the "International Health Partnership Plus" (IHP+) initiatives, reflecting the policy of decentralization and enhancing capacity of governments to improve the outcomes of public health programmes.

The CCS III, which covers the period 2018–2021, focuses on WHO priority areas, where the Organization's comparative advantage is considered to be most beneficial. The five strategic objectives and priority areas are:

1. Promoting and supporting progress towards universal health coverage, through increased access to and utilization of affordable, efficiently networked and sustainable quality services.

1.1 Develop coherent health sector policies, strategies and integrated plans, assessed and agreed by stakeholders.
1.2 Strengthen health information, analysis and knowledge generation and management of health services with a focus on core services.
1.3 Support and strengthen approaches that remove geographical, social and financial barriers to access to care.

2. Strengthening partnerships and coordination for better health outcomes.

2.1 Strengthen health sector coordination mechanisms and capacities at national and subnational levels, along with sector-wide joint planning, integrated implementation and joint performance reviews.
2.2 Facilitate and undertake structured policy dialogue to enhance stakeholder buy-in and optimize health outcomes.
2.3 Work along and strengthen intersectoral collaboration to address challenges related to social determinants of health.

3. Scaling up reproductive, maternal, newborn, child and adolescent health services.

3.1 Strengthen capacity at all levels (national, county, district, health facility and community) for the provision of high-quality sexual, reproductive, maternal, and newborn health care services.
3.2 Ensure adequate access by adolescents and children under five to the full range of sexual and reproductive health (SRH) and child survival interventions and services.
3.3 Reduce the burden of nutrition-related ill health through planning, implementation and monitoring of nutrition interventions and services, including nutrition surveillance and mitigation of nutritional risk factors.
3.4 Reduce the burden of vaccine preventable diseases (VPD) through planning, implementation, and monitoring of routine and supplementary vaccination activities including VPD, and adverse events following immunization (AEFI) surveillance.

4. Combating communicable diseases, noncommunicable diseases (NCDs) and neglected tropical diseases (NTDs).

4.1 Scale up integrated health services, including community systems for HIV, TB, and malaria, through capacity-building, generation of evidence and information to improve programme management for improved performance.
4.2 Reduce the burden of NTDs by scaling up interventions for prevention, control and elimination.
4.3 Strengthen national capacity to scale up the prevention and control of non-communicable diseases, neglected tropical diseases and their risk factors, including mental health, substance abuse and management of injuries.

5. Health Security.

5.1 Strengthen country health emergency capacity.
5.2 Support country to be adequately protected from emergence of infectious hazards and antimicrobial resistance through effective public health measures.
5.3 Strengthen country capacity to detect, report, investigate and respond to emergencies and disease outbreaks.
5.4 Support polio eradication activities.

The WHO Country Office-Liberia will ensure that the CCS III document is appropriately disseminated to the Ministry of Health, other relevant agencies and various collaborating development partners, to be utilized for advocacy, resource mobilization, and operational planning. The WHO Country Office in Liberia will maintain a harmonious and cordial working relationship with the various technical units in the WHO Regional Office for Africa and WHO headquarters in order to buttress the work of the Organization in Liberia.

The CCS III will be periodically monitored and reviewed, taking into account evolving health and related developments at the national, regional and global levels. Lastly, a mid-term review and an evaluation will be carried out to ascertain lessons learned. These will form the basis for the development of CCS IV.

Chapter 1: Introduction

The Country Cooperation Strategy is a medium-term strategic document that sets out how the WHO Country Office will support implementation of Liberia's national health policy and national health sector strategic plan and investment plan. It is also the main process for harmonizing WHO's collaboration with the United Nations system and health partners in-country; and serves as a reference document for the development of the Country Office's biennial work plans.

The Government of Liberia and the WHO Country Office (WCO) could not adequately implement the second-generation CCS for the period 2013-2017 due to the devastating Ebola virus disease (EVD) outbreak that nearly collapsed the health system. In formulating the new Country Cooperation Strategy, the focus remains on WHO's mission and functions, as well as its role as a neutral broker and policy advisor to Member States. More importantly, the CCS document addresses the health needs of the country as articulated in the national health development agenda.

The WHO third generation Country Cooperation Strategy crystallizes the major reform agenda adopted by the World Health Assembly, with a view to strengthening WHO capacity and making its deliverables more responsive and relevant to the country's needs. It aims at achieving greater relevance of WHO's technical cooperation with Liberia, by focusing on identification of priorities and efficiency measures in the implementation of the WHO programme budget. It takes into consideration the role of partners, including non-State actors that support Government and communities.

This CCS is also aligned with WHO's medium-term vision for health, the Thirteenth General Programme of Work (GPW 13) and the Sustainable Development Goals (SDGs). It focuses on selected priorities for WHO's cooperation in Liberia. It provides a broad framework for building country-level priorities with a bottom-up planning process. It also ensures that WHO's global and regional priorities, as well as national health priorities inform the biennial work plan. The CCS will guide the country-level programme budget and resource allocation. Furthermore, it should help advocate for WHO's priorities in the country, and serve as a tool for mobilizing resources for the health sector.

This CCS complies and dovetails with the WHO/AFRO Transformation Agenda, which marks a commitment to positive change, and is a programme for accelerating implementation of WHO reform within the African Region.[1] In this respect, it is informed by values of the Transformation Agenda, whose four focus areas are: smart technical focus; pro-results values; responsive strategic operations and effective communications and partnerships.

[1] The Transformation Agenda of the WHO Secretariat in the African Region, 2015–2020.

The WHO strategic agenda and the WHO/AFRO Transformation Agenda, as defined in this third generation CCS, is therefore guided by these orientations, and was developed across the three levels of the Organization. The CCS focuses on the main priority areas of the work of the Organization and the strategic approaches to be utilized by WHO to support the prioritized areas. During the period 2018-2021, WHO will focus its efforts in Liberia on the following five broad strategic priorities:

1. Promoting and supporting progress towards universal health coverage through increased access to and utilization of affordable, efficiently networked and sustainable quality services;
2. Strengthening partnerships and coordination for better health outcomes;
3. Scaling up reproductive, maternal, newborn, child and adolescent health services;
4. Combating communicable diseases, non-communicable diseases and neglected tropical diseases;
5. Ensuring health security.

This new CCS is the product of inclusive dialogue and consultation with a wide range of organizations and individuals, including officials from the Ministry of Health and other government agencies, other United Nations system organizations, bilateral and multilateral agencies, civil society and nongovernmental organizations, community groups, academic institutions, and the private sector.

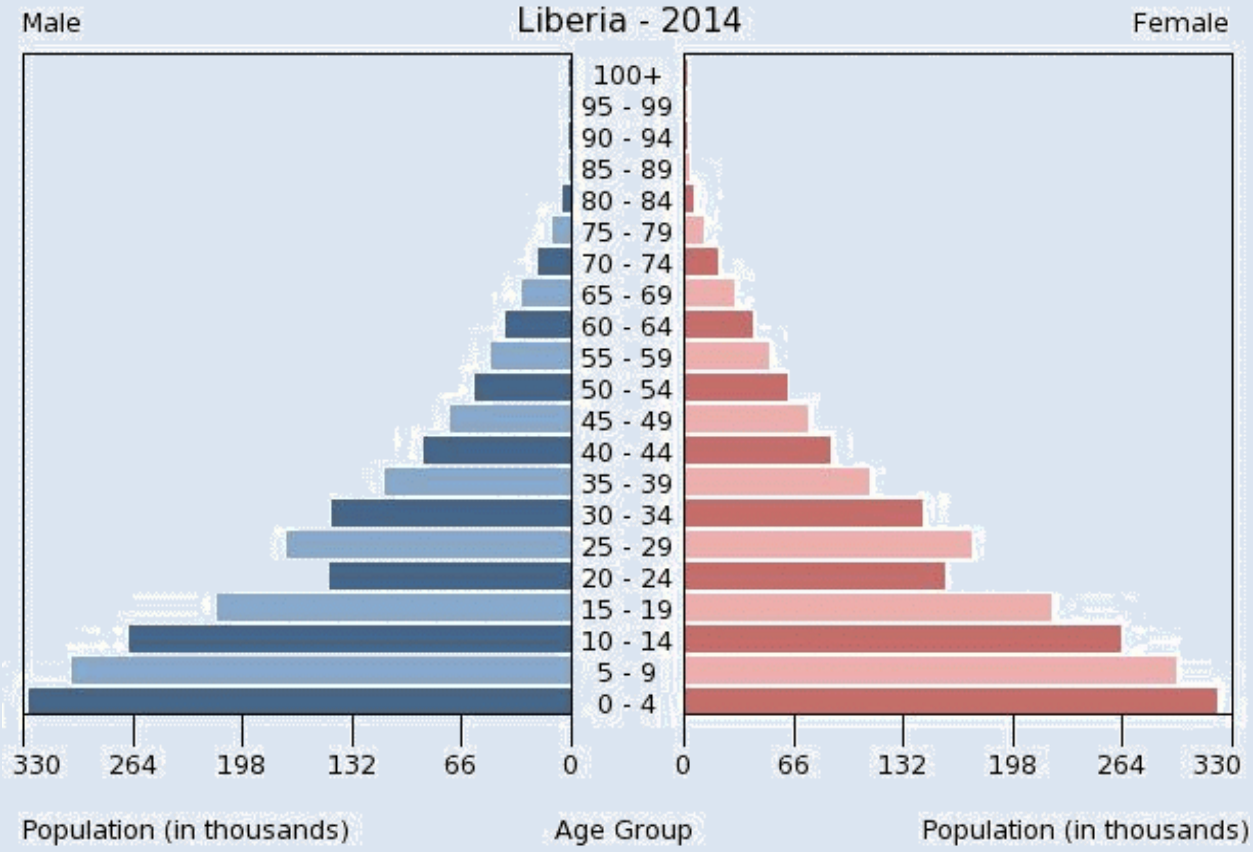
Consultations were also conducted with representatives from socially excluded or disadvantaged subpopulations, and national bodies concerned with human rights. These consultations contributed to ensuring broad support and synergies with partners throughout the CCS process.

Chapter 2: Health and Development Situation

2.1 Political, social and macroeconomic context

Liberia is situated on the west coast of Africa and borders Guinea, Sierra Leone and Côte d'Ivoire. It has a surface area of approximately 111 370 km^2 (43 000 square miles) 96 300 km^2 of which is land and 15 000 km^2, water. Liberia has 15 counties. Monrovia, the capital, is in Montserrado County. Liberia has a predominantly young population (Figure 1). Currently, 47% of the population resides in urban areas, with nearly one third of the population residing in the capital, Monrovia.

Figure 1: Population distribution, by age and sex, Liberia



Liberia ranked 177 out of 188 countries; its Human Development index increased from 0.359 in 2000 to 0.430 in 2014 (HDI 2014). The country's Gross Domestic Product per capita increased from US$ 327 in 2010 to US$ 456 in 2015, and has remained steady over the past two years. According to the 2014 Household Income and Expenditure Survey, about 54% of the population lives below the poverty line.

2.2 Health Status

Child mortality has reduced (achieved MDG 4); under-five mortality rate reduced from 110 in 2009 to 94 per 1000 live births; neonatal mortality rate has also declined from 36 to 26 per 1000 live births**.** Child stunting has declined from 39% to 32% (LDHS 2013).

Figure 2: Mean value, under-five mortality, Liberia, DHS 2013

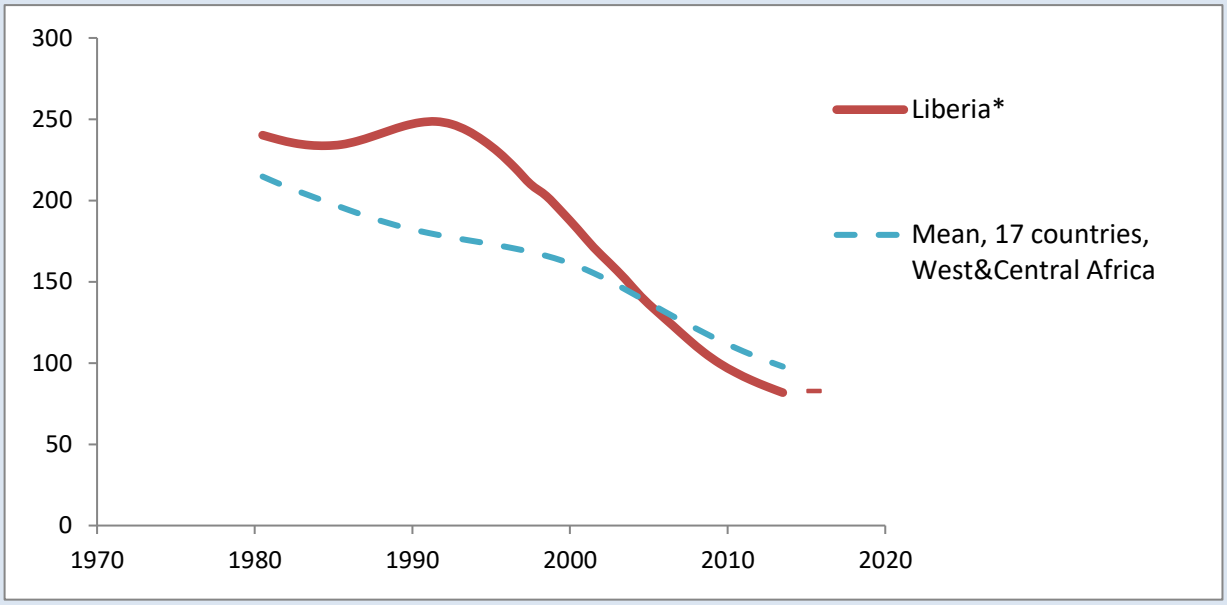
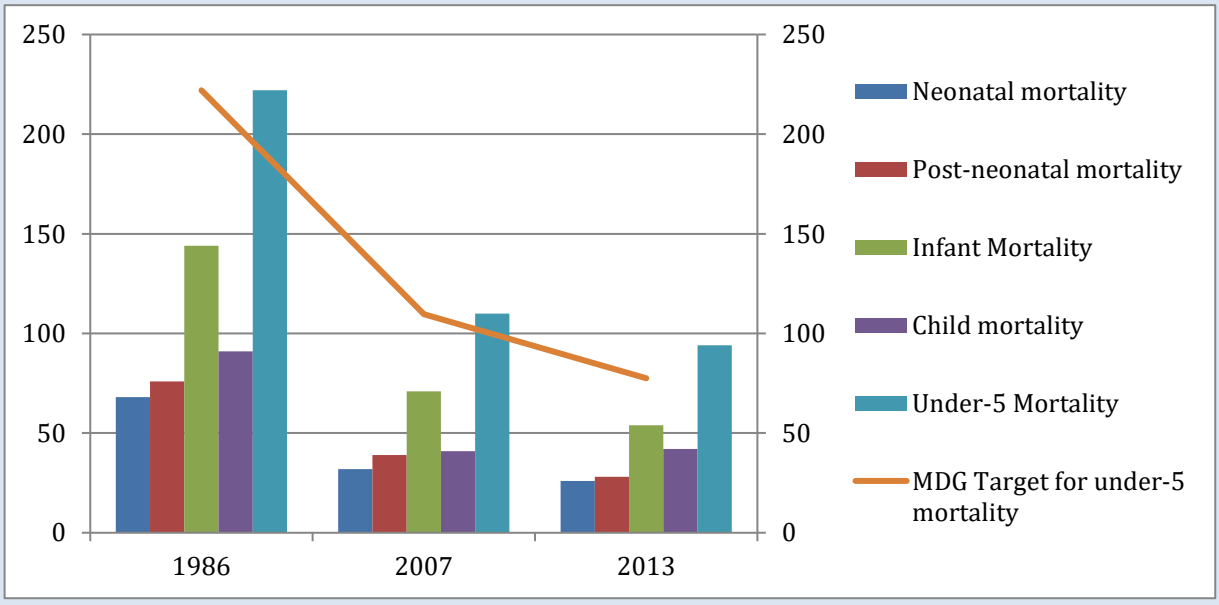
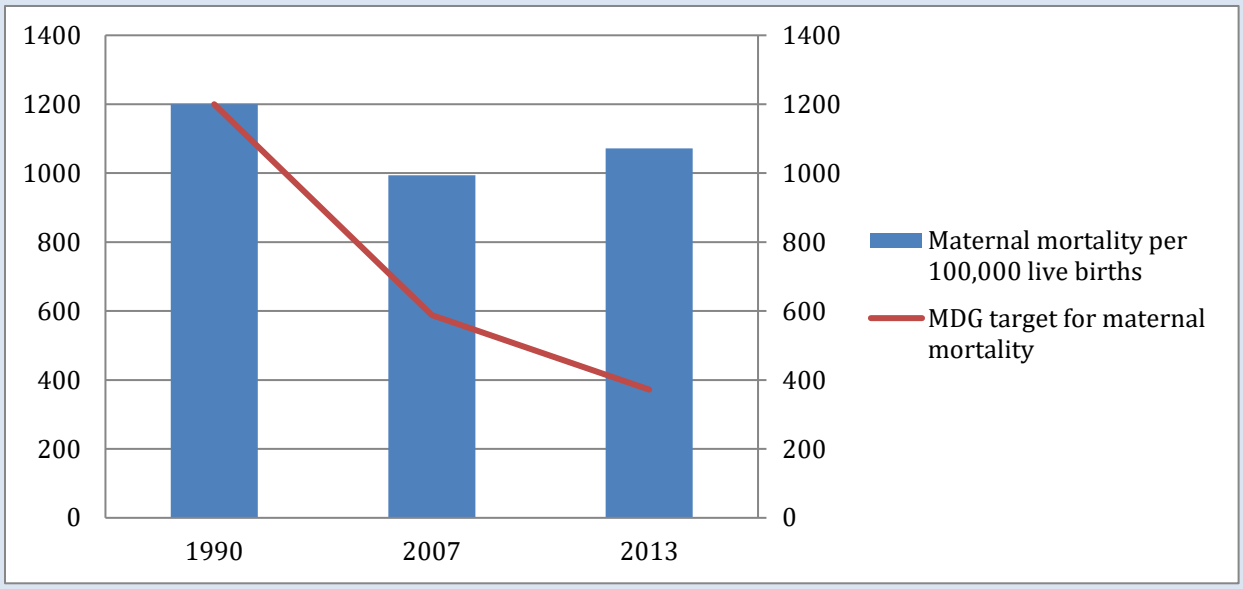


Figure 3: Mortality trend in Liberia (1986–2013)



Maternal mortality in Liberia remains high. More than one third (38%) of adult female (15–49 years) deaths from 2007 to 2013 had maternal causes, accounting for a maternal mortality ratio of 1072 per 100 000 live births (DHS 2013). The levels were almost unchanged from 2000 to 2007, and are among the highest in the African Region.

Figure 4: Trends in maternal mortality, 1990–2013, Liberia



Demographic and health survey 1990–2013

In 2013, HIV prevalence stood at 2.1%; tuberculosis (TB) notifications remained moderately high at 100 per 100 000 population; malaria remained the leading cause of health facility visits (40%) and deaths; under-five mortality was as high as 56% (LDHS 2013). Coverage figures: antiretroviral (ARV) – 21%; TB case detection rate – 63% and 79% treatment success; family planning – 39%; antenatal care – 78%; skilled birth attendance (SBA) – 61%, DTP3 – 71%; insecticide-treated bed net (ITN) use - 38%.

The prevalence of risk factors for non-communicable diseases is high. For instance, in a 2011 NCDs risk factor survey, 31% of adults aged 25-64 years were on medication for, or had hypertension (88% of them were not on treatment); 22% of adults were obese (29% women); 14% of men were smoking and 19% of adults had diabetes or were on medication for it.

Furthermore, Liberia suffers from co-endemicity of onchocerciasis, Lymphatic filariasis, schistosomiasis and soil-transmitted helminths. The burden of leprosy is estimated at 0.8/1000 population. Buruli ulcer and suspected rabies have been reported in all counties. The country was declared free of guinea-worm disease in 2009.

Equity analysis: child mortality - 12% lower in urban areas; coverage of intervention is slightly higher in urban areas. The north western and south eastern regions have a 25% higher mortality rate than the national average (LDHS 2013). The SBA rate ranges from 42% in some counties to

81% in others; DTP3 ranges from 42% to 91%. The poorest 20% of children have lower coverage. Likewise, for stunting, the lowest quintile has 40%.

2.3 Health system challenges and response

A major challenge faced by the health system of Liberia is the increasing expectation and demand for accessible quality health care by its citizens. The country's 14-year civil conflict (1989–2003) left the health system in tatters. In the last decade, with the help of development partners, the health system improved considerably, resulting in modest gains in the health status of the Liberian people. The national health policy and strategic plan (2011–2021) defines the essential package of health services at every level of the three-tier delivery system. The health system functions on the basis of: (a) policy, planning, and resource mobilization and allocation at the national level; and (b) a three-tier decentralized service delivery system at county, district and community levels. In terms of health staff, the total number of health workers increased from 1396 in 1998 to 11 430 in 2016 (Health workforce census, 2016). The number of health facilities increased from 618 in 2010 to 770 in 2017 (Service availability and readiness assessment [SARA+], 2017). In 2016, the country had 35 hospitals, 51 health centres, 618 clinics and 137 pharmacies. Health service provision is pluralistic, with 22% private for-profit providers. Nine out of 10 of these are located in Montserrado and Margibi counties.

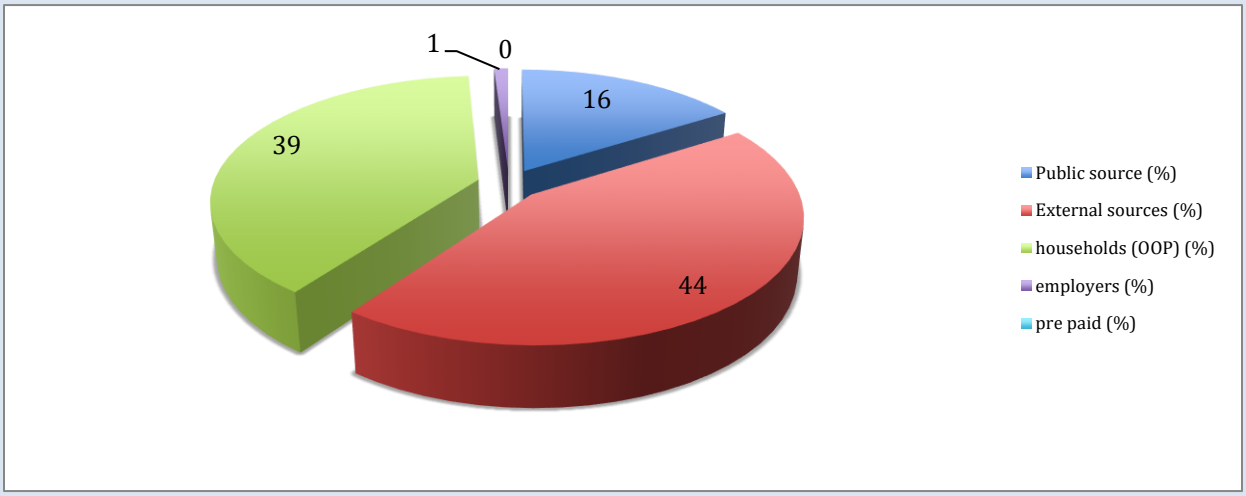
Liberia's health system is fraught with challenges, which were compounded by the eight-month period of the Ebola virus disease outbreak, from August 2014 to March 2015. Currently, the main challenges of the health system, as evidenced by the various country assessments, include shortage and poor distribution of human resources; inadequate number of health infrastructures; ineffective procurement and supply chain management systems that result in frequent stock-out of drugs and supplies; and a weak health management information system that constrains adequate planning and performance monitoring. These challenges are further exacerbated by the insufficient, inefficient and donor-dependent financing of the health sector.

2.3.1 Health financing

At 2.3% of GDP in 2017 (MFDP, 2016), Liberia's health expenditure may not appear to be too small relative to GDP but is actually quite negligible in absolute terms. The low tax base and low 'revenue to GDP ratio' makes it difficult for Government to increase the allocation to health. Only 12.4% of total Government allocation to health comes from Government per se (including external budget support). Donor sources account for 45% of total heath expenditure, and household spending accounts for 34% of the country's total health spending. While private sector spending may be significant relative to the economy, the sector accounts for less than 1% of total health spending.

As shown in Figure 6, pre-paid expenses on health are negligible and mostly (39%) out-of-pocket payments. Although these out-of-pocket payments have shown a declining trend from 51% in 2013, they remain high for excluded and ambulatory care granted under the free health care policy. This has resulted in a situation where those below the poverty line have been exposed to informal fees, with major equity implications.

Figure 6: Health care financing by source, 2017 (NHA 2014/2015)



In this regard, the vulnerable sections of the Liberian population hardly enjoy proper financial protection when they fall sick. Low public expenditure and insufficient health insurance coverage (pre-paid health expenses) hamper effectiveness regarding health gains and equity because of the high risk of catastrophic payment by the population as well as the financial barriers to accessing health care.

Per capita spending as reflected in table 1 now stands at US$ 56 relative to the US$ 86 required to ensure coverage of essential health services to the population. According to the latest national health accounts study (NHA, 2016) and public review (2016) the Liberia health sector lacks financial resources, and is mainly dependent on external donor funding and imbalances in allocation of resources among the different levels of care. For instance, secondary and tertiary hospital care takes 80% of the total allocation, compared to primary health care (health centres and clinics). Resources are more skewed towards vertical programmes.

Table 1: Summary of health system financing, Liberia 2018

Total per capita expenditure on health (US$)	56.00
Percentage of national GDP spent on health (%)	3.5
Out-of-pocket expenses as a percentage of private expenditure on health (%)	85
General Government contribution as a percentage of total medical spending (%)	16

Also, disparities in the geographical distribution of financial resources to the health sector are attributed to the rigid historical facility-based allocation structures, rather than ensuring allocation to those services dealing with the heaviest burden of ill health in the community, for which cost-effective interventions exist. Resources, including donor funding, are not pooled to match priority activities, as stipulated in the annual bottom-up planning process regularly updated by the local health managers.

Public financing, as it stands now, is input- rather than output-based, with few regulatory mechanisms. Gaps have been identified in public financial management capacities in the health sector (JFMA, 2016). Findings recommended specific system-wide reforms, organizational

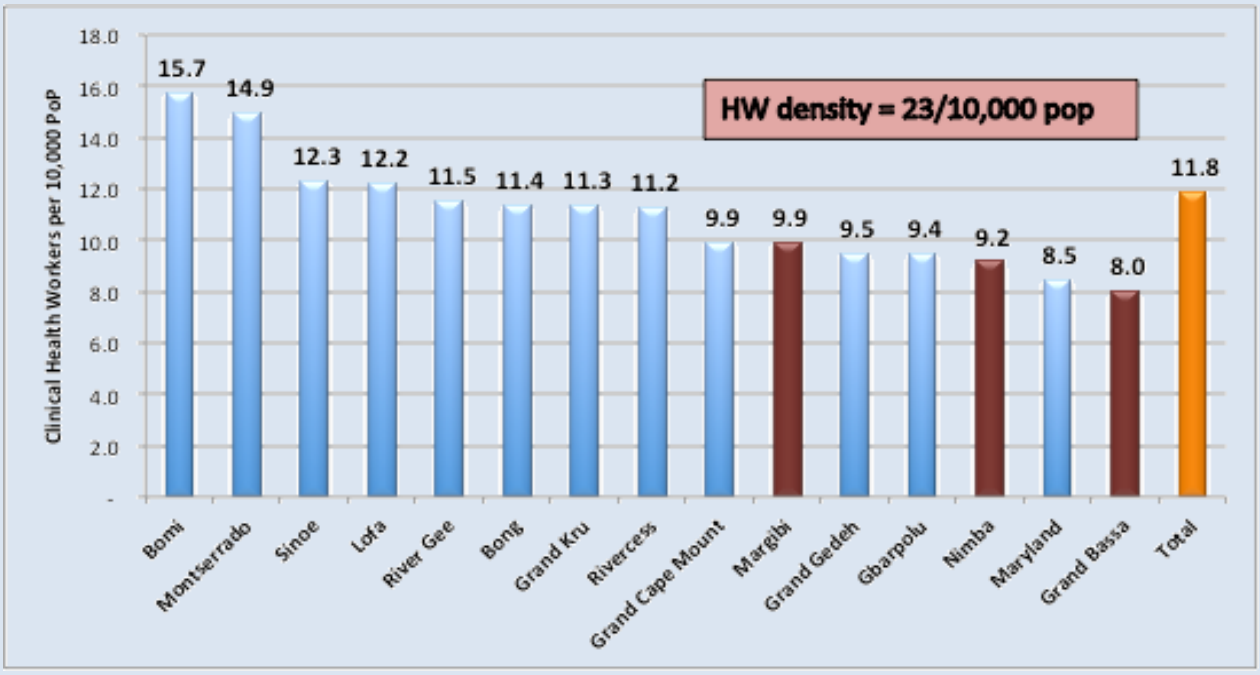
actions to improve financial management, regulatory capacities and personnel-level initiatives that are needed to enhance accountability and performance.

2.3.2 Human resources for health

According to the national health policy and plan (2011–2021), human resources for health ensure that all people have access to skilled, motivated and supportive health workers within a resilient health system. The policy further outlines a set of core objectives: increase the number of equitably distributed, qualified and high performing workers at all levels; increase the number of high performing facilities and institutes that promote continuous learning and assure quality; strengthen the workforce to be people-centred, gender sensitive, and service-oriented; and increase the number of well-equipped safe and enabling working and learning environments. Despite these strategic objectives, the status of human resources for health in the country is very dismal. A 2016 census of the total number and distribution of health workers painted a grim picture. According to the census, the public health workforce had 216 physicians, 407 physician assistants, 3070 nurses (RN/LPN) and 814 midwives, a 58% increase from 2010. There is, however, a core health professional density of only 12 skilled health workers per 10 000 population (Figure 7), well below the WHO recommended target of 23 per 1000 population. The density of health workers ranges from 4.0 in Grand Kru and Nimba to 16 in Bomi, and 15 in Montserrado. This amounts to a gap of 1754 medical doctors and 5889 midwives and nurses in the public sector. Since 2016, the public health sector has been losing a significant number of doctors, nurses and other auxiliary health workers, due to poor working conditions, among other problems, resulting in imbalances between the public and private sectors.

The human resource situation is also challenged by lack of motivation of health workers at all levels of the delivery system, because of low salaries and lack of some basic allowances, such as housing, especially in the counties. There is also a widening gap between the professional categories of staff and support staff, which has complicated the provision of adequate health services. The public health sector workforce in the country is still constrained by limited budgetary support that has inhibited absorption of core health workers on the government payroll. There is an acute shortage of human resources for health training institutions, while those that are available are not well equipped.

Figure 7: Health Workers density per county (*health workforce census, 2016 Liberia)*



2.3.3 Provision of health services

Health service provision is based on a three-tier delivery system (primary, secondary and tertiary), in line with the health sector strategic and annual plans. The service delivery system is pluralistic, with a variety of direct service providers (Government, civil society, including faith-based organizations, local and international nongovernmental organizations and the private sector. Currently, primary health care services do not draw any user charges.

The quality of health care services at all levels of the delivery system is undermined by critical challenges, such as shortage of essential health personnel, limited budgetary support, unavailability of some basic amenities. Compounding the problem is a weak management and coordination framework. Despite the challenges, health facility density has increased from 1.6 per 10 000 population in 2015 to 1.9 in 2017. The percentage of facilities with basic utilities such as water and electricity, improved from 55% in 2015 to 77% in 2016 (SARA+, 2016). Health facility utilization in Liberia is however, at one third the recommended target of five visits per inhabitant (WHO, 2010).

In terms of health service provision, the major weakness is the inequitable distribution of and investment in health infrastructures, and flaws in other general and service-specific readiness factors (limitation and non-availability of guidelines, diagnostics and essential medicines and supplies). Community health services are generally poor and linkages between public and private services are suboptimal. The absence of appropriate referral systems and weak information systems has adversely affected the quality of care.

2.3.4 Health system stewardship

WHO (2010) defines stewardship as a function of government that responds to the needs of the people with transparency and accountability. The main tasks of government include: (a) formulating a health policy that defines norms and directions; (b) exerting influence as an approach to regulation and coordination; and (c) collecting and using intelligence. Tasks (b) and (c) have major capacity gaps. The health management and leadership capacities at every level require strengthening. The country's Constitution endorses the right to health. While a health policy and plan are in place, implementation is constrained. Evidence-based decision-making, timely monitoring and regulatory functions are weak. The 2017 national data quality review indicated challenges in the quality of information systems and the culture of information use.

2.3.5 Reproductive, maternal, newborn, child and adolescent health, and nutrition

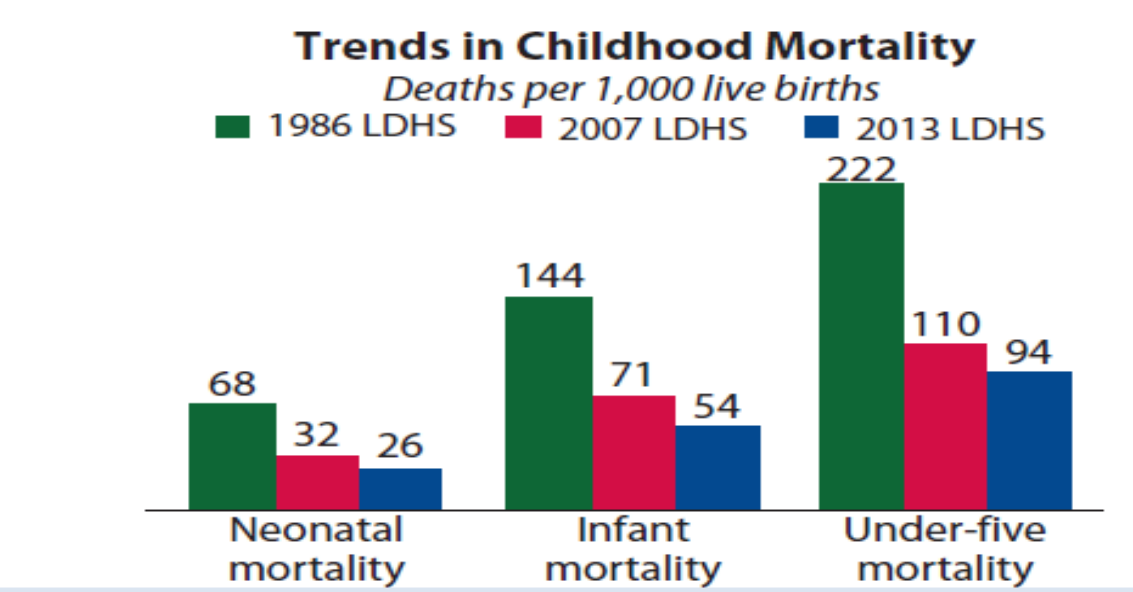
The Government of Liberia has set the Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) agenda as a top priority. The Republic of Liberia is a signatory to Every Woman, Every Child, with a commitment to spend at least 10% of the health sector allotment on RMNCAH. In addition, it is a signatory to the United Nations 2030 Agenda, including the Sustainable Development Goals (SDGs), Family Planning 2020, the African Health Strategy, the Paris Declaration, the Maputo Plan of Action, and the United Nations Secretary General's Global Strategy for Reproductive, Maternal, Newborn and Child Health (RMNCH).

Reproductive, maternal, newborn, child and adolescent health (RMNCAH) and nutrition services remain a top priority for the Government, as enshrined in the Gbarnga Declaration (Vision 2030), which is the overall national development framework that sets the vision and level of development that the Republic of Liberia is striving towards. The health sector aligns RMNCAH with several of its national development policies, plans and strategies, including the National Health Policy and Plan (2011–2021), the Investment Plan for Building a Resilient Health System (2015–2021), and the National Sexual, Reproductive, Maternal, New-Born, Child and Adolescent Health (SRMNCAH) Policy and Plans (July 2015).

Since 2000, Liberia's maternal mortality ratio has ranked among the very highest in the world, at 1072 deaths per 100 000 live births. Maternal and newborn deaths are driven by preventable and treatable complications. The major causes of maternal deaths are haemorrhage (25%), hypertension (16%), unsafe abortion (10%), and sepsis (10%), an indication of the major challenges relating to the quality of the maternal care provided. Low family planning coverage and high teenage pregnancies are also known to be major contributors to maternal mortality. Neonatal deaths account for 35% of under-five deaths, with prematurity, intrapartum-related events and infections as the major causes of death.

There is a high rate of teenage pregnancies, with 31% of women aged 15-19 years having begun childbearing. The overall contraceptive prevalence rate is low, at 20% and an unmet need for contraception of 31%. About 1.9% of the population aged 15-49 years is infected with HIV, all contributing to the high level of maternal mortality.

2.3.6 Immunization



Liberia is committed to universal immunization coverage, through the Global Vaccine Action Plan (GVAP) 2012–2020, to achieve the goal of the Decade of Vaccines. Following a decade-long civil war that decimated the health infrastructure, institutions and the overall economy, the Ministry of Health has made steady efforts to revitalize the health system. The immunization programme was strengthened, as demonstrated by the increase in vaccination coverage across all antigens and counties.

The Ebola virus disease outbreak in 2014 set back an already fragile health system recovering from civil war. As a result, all planned immunization activities, such as outreach, supplementary immunization activities, new vaccine introduction and vaccine supply chain activities were cancelled and rescheduled. This subsequently led to a decline in the coverage of various antigens, Penta-3 immunization coverage decreased by 26%, from 76% in 2013 to 50% in 2014, while measles-containing vaccine (MCV) coverage declined from 74% in 2013 to 58% in 2014. Following the containment of the EVD outbreak, the Investment Plan for Rebuilding a Resilient Health System (2015-2021) and Immunization Recovery Plan for Liberia were developed, with the aim of addressing these gaps and restoring the immunization service delivery and overall health system. Implementation of the investment and immunization recovery plans has led to a steady increase in immunization coverage. For instance, Penta 3 and MCV coverage increased to 50% and 58% in 2014 and further to 86% and 87% in 2017 respectively (WHO and UNICEF Estimates of National Immunization Coverage (WUENIC) 2017).

2.3.7 Nutrition

Nutrition plays an important role in overall mental and physical growth and development of humans. Among the top priorities is improving the nutritional status of children, especially under-fives and women, particularly those of childbearing age. Liberia has joined the global call for scaling up nutrition and the Government is partnering with the United Nations and civil society organizations to accelerate national efforts towards achieving the 2025 World Health Assembly global targets of 40% reduction in the number of children under the age of five years who are stunted; 50% reduction of anaemia in women of reproductive age (pregnant and non-pregnant); 30% reduction in low birth weight; no increase in childhood overweight; increase in the rate of exclusive breastfeeding in the first six months, up to at least 50%; reduce and maintain childhood wasting to less than 5%. Among women aged 15-49 years with a child born in the past five years, 62% received a vitamin A dose postpartum. During the pregnancy leading to their last childbirth, 21% of women took iron tablets for the recommended period of time, and 58% took deworming medication, (LDHS, 2013).

Current available statistics indicate that 32% of Liberian children are stunted, 6% are wasted and 15% are underweight. Almost all children (98%) are breastfed at some point in their life, 55% of infants under 6 months are exclusively breastfed, while 44% of infants 6-8 months old are breastfed along with complementary foods, (Liberia Comprehensive Food Security Survey, 2012).

The causes and main risk factors underlying the poor nutritional status of under-five children include: insufficient or inappropriate care and hygiene practices, poor infant and young child feeding practices, use of unsafe water, inadequacy or absence of sanitation systems and inadequate access to maternal, newborn and child health services.

2.3.8 Communicable disease control

The main communicable diseases with high public health importance in Liberia include HIV and AIDS, viral hepatitis, tuberculosis and malaria. WHO has supported the Ministry of Health to adopt all the global strategies and targets for these diseases. National strategic plans and guidelines are aligned with the global vision enshrined in the Sustainable Development Goals, the WHO Global Strategy on HIV 2016–2021, the WHO End TB Strategy 2016–2035, the Framework for Implementing the End TB Strategy in the African Region 2016–2020, and the WHO Global Technical Strategy for Malaria 2016–2030. These approaches are aligned with the principles of universal health coverage, integrated health services and decentralization, with the aim of "leaving no one behind". The Global Fund, with additional support from PMI/USAID for malaria, is the main funding entity in Liberia.

HIV/AIDS: HIV prevalence among the general population is 2.1% (HIV1 = 1.9%, HIV2 = 0.3%). HIV prevalence among women aged 15–49 years is 2% and men, 1.7%. The prevalence peaks at 3.6% in women aged 25–29 years and in men aged 40–44 years. Among women aged 15–24 years, the prevalence is 1.4% and among men aged 15-24 years, 0.5%. Five successive antenatal care surveys show a declining trend of HIV prevalence among pregnant women conducted in 2006 (5.7%), 2007 (5.4%), 2008 (4.0%), 2011 (2.6%), and 2013 (2.5%). HIV testing service coverage is 49% as at December 2017, up from 26% in 2016.

The country has adopted the test and treat strategy and Option B+ for prevention of mother-to-child transmission (PMTCT), thereby increasing resource needs for testing (first 90), treatment (second 90), and follow-up (third 90). Currently, funds from the Global Fund are complementing a catch-up plan to accelerate the HIV response that primarily targets three high-burden counties (Montserrado, Margin, and Grand Bassa), each with 2.7% HIV prevalence. HIV service scale-up is in progress to achieve the 90-90-90 target. Antiretroviral therapy coverage increased from 20% in December 2016 to 31.2% in December 2017.

Viral hepatitis: Hepatitis B prevalence among voluntary blood donors (2011–2014) is 6.1% and hepatitis C prevalence is 1.8%. The viral hepatitis response is integrated into the national HIV programme, with linkage to RMNCAH, the Expanded Programme on Immunization (EPI), and blood safety. Currently, there is no dedicated funding for the viral hepatitis response, but available resources are leveraged to provide services.

TB: Liberia has become one of 30 high TB-burden countries since 2015; the TB incidence rate increased from 199/100 000 in 1990 to 308/100 000 in 2016; TB case notification (all forms) increased from 6200 in 2015 to 7180 in 2016; treatment coverage was 50% in 2016; treatment success rate that was 68% in 2015 increased to 77% in 2016. The rollout of GeneXpert machines for TB diagnosis in 2015 has improved diagnosis of MDR-TB cases; the number of multidrug-resistant (MDR) TB cases increased from 12 in 2015 to 92 in 2017. The TB funding gap in the Global Fund grant application for 2018-2020 is US$ 6.37 million (including TB case detection, MDR-TB detection and diagnosis; TB-HIV collaborative activities; programme management).

Malaria: Malaria prevalence is 28%. All suspected malaria cases are laboratory confirmed, using rapid diagnostic tests (RDT) or microscopy, before treatment with artemisinin-based combination therapy (ACT). The country is malaria endemic, with the entire population at risk of year-round transmission, which peaks in the rainy season for more than half of the year. The major malaria prevention strategy includes periodic mass distribution of long-lasting insecticide-treated bed nets and intermittent preventive therapy for pregnant women (IPTp). According to the Malaria Indicator Survey 2016, up to 62% of the households in Liberia own at least one ITN. Over 80% of ITNs owned by households were distributed during mass campaigns, and another 4% through antenatal care. The survey also showed that up to 39% of household population, 44% of under-five children, and 40% of pregnant women slept under an ITN the night before the survey. For IPTp, 55% of pregnant women received at least two doses of Fansidar® (Sufadoxine+Pyrimethamine), and 22% received at least three doses.

2.3.9 Non-communicable diseases

Liberia is grappling with the burden of chronic conditions, which is further exacerbated by limited access to health facility-level NCD services; inadequate drugs and medical supplies; insufficient number of qualified technical personnel; weak diagnostic and treatment capacity and poor enforcement of current NCD-related regulations. An NCD-risk factors surveillance survey conducted in 2011 showed that 11.5% of the respondents were tobacco users; 9.9% engaged in smoking tobacco products such as cigarettes, cigars or pipes of tobacco; 34.3% males and females 14% consumed alcohol and 30.7% were hypertensive.

The total prevalence of all cancers is higher in women, 0.4% versus 0.2%[2] in men. This is explained by the high prevalence of breast cancer (0.24%) and cervical cancer (0.12%). Among men, the most prevalent cancers were prostate cancer (0.04%), followed by stomach cancer (0.03%) and non-Hodgkin lymphoma (0.03%). Liver cancer was the cause of 1.1% of total deaths, followed by stomach cancer, with 0.9%.[3] The 2013 LDHS found that among women aged 15–49 years, 7% were underweight, 17.9% were overweight and 8.6% were obese. The burden of injuries is unknown and coordination mechanisms to address them are fragmented.

It is estimated that 400 000[4] people in Liberia suffer from mental health, epilepsy or addiction problems and about 130 000 from a severe form of these conditions. Other factors such as conflict, exposure to sexual violence, poverty, overcrowding and poor housing, low levels of education, lack of employment and meaningful occupation all contribute to significantly higher rates of mental disorder. Following the EVD outbreak, there has been an increase in the number of people reporting mental health and psychosocial distress symptoms. The need for mental health and psychosocial services remains a top priority. Continued support for survivors and affected families is vital.

There are no centres that offer complete standardized treatment for persons with substance use disorders (PSUDs) in Liberia. None of the seven facilities offering some management for PSUDs has specialized staff, infrastructure and resources to offer a comprehensive treatment package of assessment, management and aftercare service.

Key issues relative to NCDs requiring serious consideration and addressing include: operationalization of the NCD multisectoral plan; NCDs data generation and management; NCDs diagnostics, provision of psychotropic drugs for mental health, capacity to implement the mental health plan, infrastructure and management of substance abuse, injuries and support for enforcement of the regulations on NCD prevention and control.

2.3.10 Neglected tropical diseases

Neglected tropical diseases (NTDs) are a major problem in Liberia, contributing to the underlying factors that fuel poverty among the rural population. The multiple burden of different NTDs in Liberia are impediments to socioeconomic development, particularly in poor rural communities. This constitutes a great challenge to achieving the SDGs. NTDs, especially onchocerciasis, Lymphatic filariasis, schistosomiasis and soil-transmitted helminths overlap in nearly all counties. Rapid epidemiological mapping of onchocerciasis conducted in 1999 estimated that the disease affects all 15 counties, with an estimated 1 113 213 people at risk.

A nationwide Lymphatic filariasis mapping exercise conducted in 2010 using immuno-chromatic Test (ICT) cards on individuals aged 15 years and above confirmed the endemicity of Lymphatic filariasis in 13 out of 15 counties in Liberia (with the exception of Gbarpolu and Bomi). Generally, the highest prevalence of infection (>10% by ICT) is manifested in the southeast counties (Grand Grand Bassa, Sinoe, Grand Kru and Maryland). Mass drug administration against onchocerciasis

[2] NCDI commission report 2018
[3] NCDI commission report 2018
[4] Mental health plan 2016-2021

and Lymphatic filariasis continued to be conducted from 2012, with 80% therapeutic coverage across the 13 endemic counties.

Epidemiology mapping of soil-transmitted helminths and schistosomiasis conducted at the end of 2013 in 10 counties showed disparity among the counties, with Bong county having prevalence of 68.9% and Rivercess county with 3.09%. Prevalence of schistosomiasis was high in Bong – 63% for *Schistosoma mansoni* and 56% for *S. haematobium*; In Nimba County, the prevalence was 38% for *S. mansoni* and 20% for *S. haematobium*; in Lofa County, 32% for *S. mansoni* and 10% for *S. haematobium* while Margibi had lower prevalence of 9% and 7% for *S. mansoni* and *S. haematobium* respectively. The remaining counties had schistomiasis prevalence of 0-3%. Among age groups, the distribution of schistosomiasis was 11.6% and 11.2% for *S. haematobium* and S. *mansoni* respectively in children aged 5–8 years. The 9–12 years age group had the highest prevalence of 58% for *S. haematobium* and 57% for *S. mansoni*. This was followed by the 13–15 years age group, with prevalence of 28.2% and 30.6% for *S. haematobium* and *S. mansoni* respectively (schistosomiasis risk mapping 2012/2013).

The national prevalence of leprosy was found to be 0.82 per 10 000 population; however, five counties exceeded the threshold of 1.0/10 000 population. They are Maryland (1.08), Grand Gedeh (1.10), Nimba (3.40), Grand Kru (3.47) and Grand Gedeh (3.79) (Leprosy register review 2015). At the end of 2016, a total of 134 cases of multibacillary leprosy and 68 cases of paucibacillary leprosy were reported (NTDs Annual Review, 2016).

Since 2012, the country has been implementing Buruli ulcer control activities in three counties mainly. These have been limited to passive case detection on clinical basis and treatment with specific antibiotics. In 2016, a total of 103 new cases of Buruli ulcer were reported. Patients with category III lesions constitute more than 47% of all cases, and ulcerative forms, 85%.

Key challenges that require urgent attention include: sustained community participation in MMA to enable the country to attain control status; increased technical capacity to implement the NTD master plan; advocacy for NTDs control; case detection, diagnostics and case management; increased partnership and coordination; and operational research.

2.3.11 Public health security

Lessons learned from the EVD outbreak were used to develop the national health investment plan for building a resilient health system, to complement the National Health Policy and Plan, 2011–2021. The investment plan prioritized, among other pillars, emergency preparedness and response to minimize shocks experienced from the unprecedented EVD outbreak. Also, the investment plan called for the establishment of a National Public Health Institute (NPHIL) which currently serves as the main structure for implementing the International Health Regulations (2005).

Although progress has been made in the area of health security, Liberia remains vulnerable to future disease outbreaks and other natural disasters. The country continues to experience epidemic-prone diseases, including Ebola, Lassa fever, meningitis, cholera, measles and yellow fever. The National Reference Laboratory has improved its capacity to test for epidemic-prone diseases over the last couple of years. It can now test for seven of the epidemic-prone diseases. However, the

regional and county laboratories need strengthening. Prior to the EVD outbreak, the surveillance system was weak, characterized by late and incomplete reporting and delayed confirmation of epidemic-prone diseases, as evidenced by the EVD outbreak in 2014. With the establishment of NPHIL, district surveillance officers and the field epidemiology training programme, the surveillance system has improved, although it is still vulnerable.

In 2016, Liberia was the first country in West Africa to conduct the IHR (2005) Joint External Evaluation (JEE). Nineteen technical areas were assessed for prevention, detection and response. Implementation of the JEE followed the health risk profiling to provide a systematic, transparent and evidence-based approach to identifying and classifying priority risks. This led to the National Action Plan for Health Security (NAPHS). The country has also implemented the Global Health Security Agenda road map, which was crafted post-EVD, to improve the national capacity to detect and respond to public health threats.

Liberia is also vulnerable to natural hazards, including floods, windstorms, fires, sea erosion and landslides. Data on trends and records of previous disasters are limited. The National Disaster Management Agency (NDMA) was recently established as the coordinating body for disasters. A multi-hazard contingency plan has been developed. However, the Government's capacity to address emergencies and humanitarian needs remains very limited with respect to human, logistical and financial resources. Increasing vulnerability is also due to poor access to water, sanitation and hygiene (WASH) facilities, especially by the rural population. Access to improved drinking water was 73% - 56.61% for the rural population and 85.8% for the urban population (LDHS 2013). Similar disparities are noted in access to improved sanitation and hygiene practices.

Key health security challenges to be tackled in the next generation of the CCS include: strengthening IHR (2005) core capacities by sustaining the gains achieved during and post-EVD response, while building capacities in areas with limited capacities through implementation of the NAPHS; developing and implementing a multi-hazard preparedness and response plan; mitigating risks from high-threat infectious hazards; preparing hazard-specific contingency plans; strengthening health emergency information management; supporting emergency operations; and strengthening the coordination mechanism, using the one health platform by ensuring integration with the NDMA.

2.3.12 Polio eradication

The Polio Eradication Initiative (PEI) in Liberia started in 2000, following 12 years of the declaration on polio eradication in Africa in 1988. By 2008, transmission of indigenous wild poliovirus (WPV) had been interrupted in Liberia. However, the country experienced two waves of polio importation from Guinea. The first wave occurred in 2009 with 11 WPV1 cases in six counties and the second with two polio cases in 2010 in two counties. Following these importations, the country conducted multiple nationwide polio vaccination campaigns, and introduced initiatives to improve routine EPI coverage and strengthen acute flaccid paralysis (AFP) surveillance. Liberia has not reported any WPV or cVDPV cases and has remained polio free since 8 September 2010. Although Liberia is no longer a poliovirus-infected country, it remains at high risk of outbreaks. The country maintained certification-level AFP surveillance indicators each year until the Ebola outbreak in 2014–2015. The vaccination coverage in the

country declined significantly during this time, and led to an estimated 50% of children being un-immunized or under-immunized and vulnerable to the polio virus and other vaccine preventable diseases. At the same time, there was a significant drop in the non-polio AFP rate (1.3/100 000) due to a variety of reasons including suspension of shipment of stool specimens to the polio regional laboratory in Abidjan. However, renewed efforts were made to strengthen surveillance and immunization, as part of the recovery process, with a rebound in the non-polio acute flaccid paralysis rate of 3.9/100 000 by end 2017. The aim is to maintain polio-free certification indicators at certification levels, until polio is fully eradicated in the African Region and globally.

2.4 Cross-cutting issues: gender, health equity and human rights

Liberia is currently a signatory to the International Covenant on Civil and Political Rights, the International Covenant on Economic, Social and Cultural Rights, the International Convention on the Elimination of All Forms of Racial Discrimination, the Convention on the Elimination of all Forms of Discrimination against Women, the Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment, the Convention on the Rights of the Child and the Convention on the Rights of Persons with Disabilities.

Despite these positive developments, many preventable deaths from illnesses such as diarrhoea, which is primarily caused by poor hygiene, limited access to safe drinking water, lack of sanitation, malnutrition, and breakdown in food production and delivery infrastructure, are the major contributing factors affecting the population and constitute a major health concern. Many communities in marginalized and hard-to-reach areas, people with disabilities and other excluded communities lack access to basic health services.

Moreover, the country continues to be plagued by a number of human rights problems. The most serious abuses are those linked to deficiencies in the administration of justice, official corruption, and violence against women and children, including rape, domestic violence, and human trafficking. Impunity remains a serious problem, despite intermittent and limited Government attempts to investigate and prosecute officials accused of those abuses.

The National Human Rights Commission, in its action plan (National Human Rights Action Plan 2013-2018), has reiterated the need for increased national commitment and political will to provide adequate support for community health services and improve the effectiveness of services provided by health facilities, and the right to the highest attainable standard of health including other human rights-related issues.

2.4.1 Gender-based violence (GBV) and human rights

The magnitude of gender inequalities varies throughout Liberia in terms of status, region, rural/urban areas, and traditional cultures. Generally, women in Liberia have less access to education, health care, property, and justice than men. Gender inequality and imbalance have led to a diversity of issues such as unequal power relations, lack of access to basic services, economic disempowerment, low participation in decision-making, lack of access to legal and judicial services, HIV and AIDS, and an increased burden of care on women. Despite the prevailing situation, available statistics indicate that access to education has improved for both girls and boys

(15–19 years); with an increase from 31% in 2007 to 41% for girls in 2013, and from 36% in 2007 to 46% for boys in 2013 (LDHS, 2013).

Rape and other acts of sexual violence are prevalent in Liberia. The results from the evaluation report of the Joint Programme on Sexual and Gender-based Violence (SGBV), (Liberia SGBV Joint Programme Evaluation report, 2013) found that rape accounted for 68% of SGBV cases. Domestic violence ranked second to rape, accounting for 26% of all SGBV cases reported. The evaluation also revealed a high level of exposure of young women and girls to sexual exploitation and abuse, with most perpetrators being family members, who are often known by the victims. The report also revealed that 15% of rapes result in pregnancy.

Liberia has made some progress towards addressing these issues. The interventions include a revised National Gender Policy and the Liberia National Action Plan for the Implementation of Security Council Resolution 1325 (on the special needs of girls and women in circumstances caused by armed conflict, including post-conflict reconstruction) and the revised joint statement on the rape law.

However, challenges still abound, especially relating to the implementation and enforcement of gender and human rights-related laws. A coherent and systematic approach to institutionalization of gender mainstreaming, a targeted approach, and a robust monitoring and accountability mechanism are critical to addressing and overcoming gender gaps. Therefore, the right to the highest attainable standard of health, including human rights-related issues requires increased national commitment and political will.

2.5 Development partners' environment

2.5.1 Partnership and development cooperation

The political and economic context has shaped Liberia's partnership and development cooperation landscape. The country is highly dependent on donors and NGOs in the area of health service delivery. Donors contribute more than 75% of total health spending. External assistance funds provide budgetary support through third parties (international and national NGOs) and through direct programme and the pool funding support mechanisms at the Ministry of Health.

Liberia joined the International Health Partnership Plus (IHP+) initiative in April 2016 and in-country partners signed the country compact in November 2017. The development of the country compact took into account the principles and best practices of the global IHP+ (alliance for UHC 2030) and the seven behaviours of effective development cooperation for results. The country's health sector is supported by a number of development partners including:

(a) Bilateral development partners

USAID/CDC, DFID, Irish Aid, European Union, Government of Germany and the Japan International Cooperation Agency (JICA) are the major bilateral partners providing financial support to the health sector in Liberia. The United States provides the largest bilateral grant assistance to Liberia. This assistance is administered by USAID, and targets essential programmes such as maternal and reproductive health, health system strengthening, polio eradication, human resources for health development and malaria control.

The European Commission provides direct budgetary support to the health sector, while the Government of the People's Republic of China provides support for health infrastructure development and emergency management units of the country's Ministry of Health. Support from other bilateral partners (Irish Aid, the United Kingdom and France) is channelled through the 'pooled fund mechanism', an approach that mimics sector-wide funding. JICA and the Government of Sweden also provide funding and direct technical assistance cooperation.

(b) Multilateral development partners

The World Bank, the African Development Bank and the Islamic Development Bank were among the major contributors to the Government for health sector support in 2016 and 2017. The Global Fund and GAVI, the Vaccine Alliance, are the major financiers for HIV, TB, malaria and vaccine preventable diseases.

(c) United Nations System

The main United Nations agencies operating in Liberia include, WHO, UNICEF, UNFPA, UNDP, UN Women, IOM, UNHCR, UNAIDS, FAO, WFP and UNOPS. The United Nations Country Team (UNCT), comprising 18 United Nations agencies was consumed with finalizing implementation of the 2010–2016 United Nation's Development Assistance Framework (UNDAF), which had been extended to 2017. It also dealt with the development of the new 2019–2024 UNDAF, in line with the national development agenda and the SDGs. WHO's contribution to the development of UNDAF is through the United Nations Country Team (UNCT) thematic clusters and working groups on poverty and livelihoods, hunger and malnutrition, education, health, HIV/AIDS, gender-based violence, governance, water and vulnerability reduction.

(d) Other development partners

The Gates Foundation, Zanta International, GAVI, the Vaccine Alliance, and faith-based organizations play an important part in health sector development and service provision in the country. Annex 3 depicts on-budget and off-budget funding by various donors and partners.

2.5.2 Collaboration with the United Nations System at country level

UNDAF 2013–2017, with a costed action plan signed by the United Nations in Liberia, was implemented as a "One Programme". Liberia became a self-starter for the "Delivering as One" initiative in 2012, and established a joint Government and United Nations Steering Committee to oversee implementation of UNDAF. UNDAF 2013–2017 was aligned to essential government documents; the Agenda for Transformation 2030[5] and the Millennium Development Goals (MDGs). UNDAF comprised four pillars: (a) peace, security, rule of law; (b) sustainable economic transformation; (c) human development; and (d) inclusive governance and public institutions. UNDAF focused strategically on the comparative advantages and described the United Nations' collective response to national development priorities.

WHO is, and continues to be actively involved in the UNDAF processes and chairs the human development pillar outcome groups (Health and Nutrition 3.1 and HIV/AIDS 3.6). WHO plays an important role within the United Nations system as lead agency for health, and currently serves as co-chair of the Inter-Agency Programming Team for the UNCT. WHO also participates in United Nations theme groups on joint programmes: H6+ (maternal and child health), the joint programme on sexual and gender-based violence, HIV/AIDS, UN Strategic Communications, monitoring and evaluation. The next generation of UNDAF, expected to be developed in 2018/2019 will be aligned with the current administration's agenda: the Pro-poor Agenda for Development and Prosperity; the SDGs; and CCS III 2018-2021.

2.5.3 Country contributions to the global health agenda: IHR, SDG, UHC, global health security

The Government of Liberia has played a significant role in establishing a peaceful and stabilized political environment that has paved the way for incremental economic and social development. Health and health systems strengthening were at the core of the progressive development and social reform agenda of the Government during the last decade. To that effect, achievements have been documented, including prioritizing health in the public budget allocation and the timely achievement of the MDG4 targets.

The Government has developed and launched a domestic SDG action plan, in line with its Agenda for Transformation, Vision 2030. The country has also initiated steps towards achieving universal health coverage through a proposal for the establishment of a health equity fund and the signing of the Health Compact. As a core activity in the investment plan developed following the Ebola crisis, the Government, in collaboration with development partners, established the National Public Health Institute of Liberia and developed a national plan of action. The purpose of the National Action Plan for Health Security (NAPHS 2018–2022) is to prevent, detect and respond

[5] Government's medium-term plan whose overarching goal is to transform Liberia into a middle-income country by 2030.

to public health threats, prevent international spread of epidemic-prone diseases and promote multisectoral and multidisciplinary coordination and collaboration in the context of one health.

2.5.4 Review of WHO's Cooperation over the past CCS cycle

(i) Level of achievement of the goals in the CCS 2013–2017

Development of the CCS 2013-2017 followed consultation with the Ministry of Health and partners that resulted in the identification of four broad areas (maternal, child and new born health; combating communicable, non-communicable and neglected tropical diseases; health systems strengthening; and health security) aligned with the Ten-year National Health Policy and Plan, the Millennium Development Goals, and the national Agenda for Transformation, Vision 2030, and the plans to enable Liberia to become a middle-income country.

Full implementation of the CCS was not realized due to the unprecedented interruption by the EVD outbreak that grossly impacted the health system of the country. As a result of this development, available resources were allocated to contain the EVD outbreak and strengthen the health system at the expense of services that would improve maternal, child and new born health, as well as address the issue of communicable, non-communicable and neglected tropical diseases. Following the containment of the EVD crisis, WHO and other development partners supported the Government in developing an investment plan for building a resilient health system (2015-2021). Progress to date on the implementation of the investment plan indicates that the health delivery system is on track to recovery, some systemic challenges notwithstanding

(ii) Knowledge and awareness of WCO staff and partners, including MoH, on the CCS and their perception of its relevance

Prior to the development of the CCS, staff members of the county office were reoriented and extensively engaged during its development. Additionally, a half-day retreat was organized by WCO bringing together the senior leadership of the Ministry of Health, health development partners and the United Nations system to discuss the CCS priorities and their alignment to the national health priorities and the MDGs. The CCS priorities were endorsed by all stakeholders, and all were deemed relevant to the national health development agenda. Eventually, the CCS was finalized, printed and distributed to all the stakeholders.

(iii) Challenges encountered during the implementation of the CCS 2013-2017

The CCS was not approved, disseminated and fully implemented. Its implementation coincided with the EVD outbreak, which received more attention to ensure that it was contained. Resources allotted to fund the implementation of CCS II, along with additional financial, human and logistical resources mobilized were rather used for the outbreak. Lessons learned from the implementation of CCS II have formed the basis for the development of CCS III.

(iv) Key actions to be considered by the WCO for the development of the third generation CCS (2018-2021)

The third generation CCS should be approved, launched and widely disseminated to all health development partners, including the private sector. The implementation status of the CCS should be internally reviewed during the development of the biennial programme budgets, the UNDAF reviews and final evaluation in 2021. The CCS will serve as the main advocacy, cooperation and resource mobilization tool for the country office.

Chapter 3: Setting the strategic agenda for WHO cooperation

The strategic agenda and priorities of the CCS III as discussed in this section are in consonance with the prevailing health conditions of the country, as indicated in previous sections of this document, and in line with lessons learned from the implementation of CCS II. This section is also supported by various other analyses and action plans, including the national investment plan for building a resilient health system, the national Ten-year Health Policy and Plan, the performance evaluation of the health sector, and the domesticated health SDG targets.

Additionally, the strategic priorities take into account current Government commitments as described in its Pro-poor Agenda for Development and Prosperity, and the WHO Regional Office for Africa's Transformation Agenda, as well as the current UNDAF. The table below highlights the focus areas within each strategic objective of CCS III and their alignment with the WHO Thirteenth General Programme of Work, and other essential documents.

Table x: CCS III Strategic agenda

3.1 Strategic priority 1 Promoting and supporting progress towards universal health coverage through increased access and utilization of affordable, efficiently networked and sustainable quality services	
Focus area	Strategic approach
1.1 Develop coherent health sector policies, strategies and integrated plans that are assessed and agreed by stakeholders.	• Provide technical support for the development and implementation of policies, strategies and plans for integrated health development. • Support the Government to increase accessibility and availability of integrated health services at all levels of the health system. • Support the Ministry of Health in strengthening managerial capacities at all levels of the health system. • Support and promote intersectoral collaboration and partnership coordination for health actions at all levels of the health system. • Support the implementation of human resources for health and health financing policies and plans. • Support systems and strategies for improved access to affordable and quality-assured essential medicines at all levels of the health system. • Advocate for health through community initiatives designed to gain political commitment, policy support and social acceptance. • Advocate for and support national and local-level policy dialogue for health system strengthening to support UHC.
1.2 Strengthen health information, analysis and knowledge generation, and management of health services, with focus on core services.	• Provide technical support to conduct studies and health facilities surveys to monitor service availability and utilization (SARA). • Strengthening national and county capacity to generate, analyse, manage and utilize health data. • Provide support to strengthen health management information and monitoring and evaluation at all levels of the health system. • Strengthen national and institutional capacity to undertake health reform, utilizing research and evidence-based policy decisions.

	• Support development of policy options and tools to enhance research priorities and ethical issues related to public health. • Provide support for the strengthening of functional human resources for the health information system, and partnership for mobilizing sustainable health workforce resources.
1.3 Support and strengthen approaches that remove geographical, social and financial barriers to access to care	• Provide support to institutionalize and strengthen the NHA for effective tracking of expenditure at national, county and district levels. • Support the Ministry of Health to finalize and roll out the Health Equity Fund to ensure financial risk protection for all Liberians. • Support the Ministry of Health to initiate appropriate dialogue with national legislature and Government financing authorities to increase budgetary support, in line with its commitments to UHC. • Strengthen managerial capacities at all levels of the health system for efficient management and accountability of financial and material resources. • Advocate and support the role of the private sector in health development, and explore domestic alternative means of health financing to attain UHC.

3.2 Strategic priority 2 Strengthening partnership and coordination for better health outcomes	
Focus area	Strategic approach
2.1 Strengthen health sector coordination mechanisms and capacities at national and subnational levels along with sector-wide joint planning, integrated implementation and joint performance review.	• Provide technical support for strengthening health sector organizational structures and coordination mechanisms at all levels of the health system. • Support managerial capacities at all levels of the health system to ensure effective supervision and monitoring of the health system. • Provide technical assistance to develop the technical capacity at the national level for joint planning, monitoring, sector reviews and assessment. • Advocate for support and facilitate an appropriate partnership forum.
2.2 Facilitate and undertake structured policy dialogue to enhance stakeholder buy-in and optimize health outcomes.	• Support MoH to organize and host high-level policy dialogue for members of the national legislature. • Support MoH to organize and host high-level policy dialogue for development partners. • Support MoH to host policy dialogue for private sector providers.
2.3 Work along with and strengthen intersectoral collaboration to address challenges related to social determinants of health.	• Strengthen capacity to ensure intersectoral collaboration at national and subnational levels to address social and economic determinants of health. • Work alongside United Nations agencies and other relevant development partners to implement appropriate policies and interventions on the social determinants of health. • Support institutionalization and strengthening of intersectoral coordination mechanisms and intervention on social determinants of health.

3.3 Strategic priority 3 Scaling up reproductive, maternal, newborn, child and adolescent health services	
Focus area	Strategic approach
3.1 Strengthen capacity at all levels (national, county, district, health facility and community) for the	• Provide technical support, develop policies, guidelines and standards to evaluate quality of maternal and newborn care in health care facilities • Support gradual scale-up of maternal and newborn quality of care standards in health facilities

provision of high-quality sexual, reproductive, maternal, and newborn health care services	• Ensure regular monitoring, supportive supervision and hands-on training of maternal and child health (MCH) focal persons on RMNCAH indicators to assess implementation progress for relevant actions.
3.2 Ensure adequate access by adolescents and under-five children to the full range of SRH and child survival interventions and services.	• Support and implement national FP Plan; FP as an entry point for reduction of maternal and neonatal mortality. • Provide support to policy and guideline development that highlights adolescent specific age and developmental needs. • Support obstetric clinician and neonatal task sharing programmes.
3.3 Reduce the burden of nutritional ill conditions through planning, implementation and monitoring of nutrition interventions and services, including nutrition surveillance and mitigation of nutritional risk factors.	• Support the development and revision of the national nutrition policy and strategy plan of action based on national situation and resources. • Support training of health workers and community health assistants on implementing Infant and Young Child Feeding at health facilities and community level.
3.4 Reduce the burden of vaccine preventable diseases (VPD) through planning, implementation and monitoring of routine and supplemental vaccination activities, including VPD and Adverse Events Following Immunization surveillance.	• Support high-level advocacy to ensure that country and partners make immunization a priority. • Support activities to ensure that individuals and communities understand the value of vaccines and demand immunization as a right and responsibility. • Provide support to ensure equity in immunization service delivery and reach the most vulnerable and underserved population. • Support immunization strengthening activities integrated into overall health system strengthening. • Support activities to ensure sustainable access to predictable funding, quality supplies and innovations. • Support operational research to maximize the reach and benefit of immunization.
3.4 Strategic priority 4 Combat communicable, non-communicable diseases and neglected tropical diseases	
Focus area	Strategic approach
4.1 Scale up integrated health services, including community systems for HIV, TB, and malaria, through capacity building, generation of evidence and information to improve programme management for improved performance.	• Support mobilization of resources to scale up national response to HIV, TB, and malaria. • Provide technical support to scale up improved, equitable and quality services. • Provide technical support to scale up and improve laboratory services. • Provide technical support to generate strategic information to guide decision-making. • Ensure that gender equity and human rights are addressed at all levels of HIV, TB, and malaria services. • Provide technical support to strengthen community engagement, coordination and partnership for national response to HIV, TB, and malaria.
4.2 Reduce the burden of NTDs by scaling up interventions for prevention, control and elimination.	• Support mobilization of resources to scale up national response to NTDs. • Provide technical support to scale up improved, equitable and quality services for prevention, control, and elimination of NTDs. • Ensure that gender, equity, and human rights are addressed at all levels of NTD interventions. • Provide technical support to strengthen community engagement, coordination and partnership for national response to NTDs.

4.3 Reduce the burden of NTDs by scaling up interventions for prevention, control and elimination.	• Support mobilization of resources to scale up national response to NCDs. • Provide technical support to scale up improved, equitable and quality services for prevention, and control of NTDs. • Provide technical support to scale up detection, diagnosis, and treatment of NCDs. • Ensure that gender, equity, and human rights are addressed at all levels of NCD interventions. • Provide technical support to strengthen community engagement, coordination and partnership for national response to NCDs.

3.5 Strategic priority 5 Health security	
Focus area	Strategic approach
5.1 Strengthen country health emergency capacity**.**	• Ensuring that a comprehensive Vulnerability and Risks Assessment Mapping exercise is undertaken. • Strengthening National Disaster Management Agency capacity, including development of a National Multi-Hazard Emergency and Preparedness Plan. • Emergency preparedness policy development. • Simulation exercises required as part of country evaluation and capacity building. • Ensuring emergency supplies and advocating for pre-dispositioning facilities.
5.2 Support county to be adequately protected from emergence of infectious hazards and antimicrobial resistance through effective public health measures.	• Enabling a robust one health systems approach that prevents, detects and responds in time to all infectious hazards. • Advocating for funding for adequate prevention, response and mitigation of emergence of infectious high-threat hazards. • Strengthening laboratory capacity for real-time detection for informed decision and response. • Ensuring increased availability of policies, guidelines and tools on infectious hazards management and control. • Strengthening integrated surveillance capacities, especially at border points of entry. • Reducing risks for antimicrobial resistance.
5.3 Strengthen country capacity to detect, report, investigate and respond to emergencies and disease outbreaks.	• Establish a robust early warning and reporting system through capacity building (including point-of-entry). • Expand laboratory testing capacity. • Capacity-building for frontline responders. • Provision of requisite logistical supplies. • Strengthen referral and transport system for isolation.
5.4 Support polio eradication activities.	• Contribute to global efforts to strengthen polio eradication activities through maintenance of polio eradication certification indicators. • Provide support for heightened Acute Flaccid Paralysis (AFP) surveillance in Liberia. • Support documentation of polio legacy in Liberia.

Chapter 4: Implementing strategic agenda implications for the Secretariat

The implications for the WHO Secretariat involve building capacity for the health system, providing norms and standards and support for implementation of evidence-based interventions, pooling of resources, and application of standard operating procedures for emergencies. Efforts will be made to ensure that the strategic agenda is adequately rooted in an understanding of the country context, paying attention to the socioeconomic challenges and how they affect health development efforts. In particular, attention will be paid to ensuring that implementation of the strategic agenda does not lead to weakening of the State's capacity and/or legitimacy. Likewise, the uneven distribution of technical support should not lead to an unintentional widening of social disparities.

The central focus for the Secretariat will remain strengthening capacity for national health development. To this extent, periodic and systematic risk analyses will be carried out and sustained, to ensure that interventions are not patchy but planned within the overall strategy for health system rebuilding, with a special focus on capacity-building for sustainability. Recognizing the links between political and development objectives, every effort will be made to support integrated whole-of-government approaches and seek the required buy-in across the various relevant sectors through inclusive dialogue and consultations.

Above all, WHO will ensure alignment of the CCS strategic agenda with national health priorities, health-related Sustainable Development Goal targets, monitoring and evaluation, including deepening alignment in strategic agenda implementation through the use of country systems. WHO will also ensure that agreed priorities and focus do not foster fragmentation, but rather seek to promote coordination of partner support for government plans and programmes. The Secretariat will stay engaged, employing a mix of strategic priorities that can meet immediate needs as well as those that assure the country of medium-term predictability of technical support, based on jointly agreed benchmarks.

4.1 Core capacity of WCO

The country office recently completed its functional review, where it proposed an organizational structure that comprises field coordination teams and four technical teams, namely: (a) reproductive, maternal, child, adolescent and nutrition services, (b) health system strengthening, (c) disease prevention and control, and (d), health emergencies. The new structure has considered putting in place a resource mobilization officer, a technical officer for health promotion and another for communications. The technical team has 45 technical officers, supported by five programme assistants, five administrative and finance assistants and 15 drivers at the field level.

4.2 Office space and meeting rooms

The WHO country office in Liberia has a self-contained office space within the United Nations complex in the Sinkor area. The office, as it stands, has one meeting hall for internal use, a library and a store. The WCO, in coordination with the WHO Regional Office, is working to align the office structure with the CCS implementation in the new context.

4.3. WCO information and communication technology needs to implement the CCS

Information and communication technology plays a pivotal role in the implementation of the CCS. This means that no unit can efficaciously deliver without the use of ICT. Hence, to effectively implement the CCS, ICT will need to perform some upgrades on its server room equipment. The server hardware needs to be upgraded, a biometric locking system for the server room door needs to be installed for physical security, and an automatic fire extinguisher system needs to be installed to prevent damages to the equipment in the event of a fire outbreak.

4.4. Interactions with MoH

The WCO has been privileged for years to work hand-in-hand-with the Ministry of Health of the Republic of Liberia, its technical institutions and related line ministries in the country. The WCO has the technical capacity to support the Ministry in implementing the National Health Policy and Investment Plan priorities. The WCO, however, working towards achieving the strategic objectives as stipulated in the GPW and the BWP (2018-2019), and in collaboration with the Ministry of Health and its partners, is cognizant of the need for major adaptations in the way the Office plans and runs its budget, and organizes itself, strengthening the WHO focus areas as stipulated in the Transformation Agenda of the WHO Secretariat in the African Region.

4.5. Support from Intercountry Support Team, WHO/AFRO and WHO/HQ

In implementing this CCS, technical support, guidance and catalytic funding will be expected from the WHO Intercountry Support Team for West Africa, WHO/AFRO and WHO/HQ.

(a) Implications for the WHO Secretariat

The CCS will be implemented within the context of the total withdrawal of the United Nations Mission in Liberia (UNMIL) and increasing responsibilities for the United Nations system, a new development agenda of the new government, domesticated SDGs, Liberia's Vision 2030, UNDAF 2019-2023, the Global Health Security Agenda and concerted efforts to mitigate and ensure readiness to cope with public health threats and disasters.

The CCS's strategic priorities are consistent with the WHO GPW 13, the WHO/AFRO Transformational Agenda 2015-2020 and recommendations on WHO organizational reforms.

The WHO country office will adopt innovative approaches to achieve the desired results, while ensuring synergies, efficiency, effectiveness, transparency and accountability.

(b) Implications for the country office

The country office underwent a functional review and has an approved functional structure that is adequate for implementation of the CCS if fully supported. Optimal human resource capacity is required in strategic areas such as policy dialogue, advocacy and resource

mobilization, to deliver the CCS's strategic priorities. The country office, through increased partnership and joint programmes within the United Nations system, will require additional resources. WHO will continue to fulfil its functions within the United Nations Country Team under the "Delivering as One" framework, while respecting the comparative advantages and synergies among the United Nations agencies.

The country office will have the sole responsibility of implementing the CCS. Technical and financial support will be required from both the WHO Regional Office and headquarters if the needs of the country exceed the capacity of the country office. Also, the country office will apply the principles of equity, gender and human rights, in implementing the CCS in line with the SDGs.

(c) Implications for the WHO Regional Office for Africa

The WHO Regional Office for Africa and the Intercountry Support Team will ensure that the country office has the necessary managerial, technical and operational capacity for implementing the CCS and responding to the needs of the Ministry of Health. WHO/AFRO will delegate authority to the WHO Representative to ensure flexible implementation of the CCS.

WHO/AFRO will help to foster South-South cooperation for knowledge exchange. It will also promote capacity-building for country office staff, and provide the required resources, including surge capacity for emergencies, as required.

(d) Implications for WHO headquarters

WHO headquarters will continue to provide AFRO and the country office with global policy guidance, norms and standards and other emerging initiatives, including on the SDGs, climate change, the High-level Forum on NCDs and the Global Financing Facility. WHO headquarters will work with and complement the efforts of AFRO to provide technical support and mobilize additional resources for implementation of the CCS.

Chapter 5: Monitoring and evaluation of the CCS

This chapter discusses how the Country Cooperative Strategy will be monitored and evaluated during the course of implementation and at the end of its life cycle. It also shows how the lessons learned and recommendations from the final evaluation will be shared within WHO, and with the Government, national stakeholders and development partners.

The CCS will be operationalized through the country biennial and annual plans. Progress will be monitored and evaluated through quarterly reviews, semi-annual monitoring, mid-term reviews, biennial reports and the final evaluation report.

The mid-term review will be conducted at the end of 2019 by the WHO country office. The purpose of the review is to measure progress against each of the focus areas, identify the challenges impeding implementation of the CCS and propose recommendations to improve CCS implementation in the second half of the CCS cycle. The annual and end-of-biennium reports will be used as the basis for the mid-term review. The country office will involve the Ministry of Health in the CCS mid-term review.

The final evaluation of the CCS will take place at the end of 2021 to facilitate and guide development of a new strategy (CCS fourth generation). The evaluation will be conducted in collaboration with the Ministry of Health and partners to measure progress, success factors, challenges, and lessons learned and best practices. Report of the evaluation will be shared with the Ministry of health and partners for strategic engagement, advocacy and resource mobilization, and will also inform the next generation of the CCS.

The final evaluation of the CCS will coincide with the preparation of a new national health development agenda and mid-term review of UNDAF. This will provide the opportunity for better alignment with UNDAF and the new national health agenda.

Annexes

Annex 1: Summary of WHO support to Liberia's health sector during the period 2018–2021

Strategic priorities	Focus area	GPW outcome	National (NHSP) target	SDG targets	UNDAF targets
Promote and support progress towards universal health coverage through increased access to and utilization of affordable, efficiently networked and sustainable quality services.	Develop coherent health sector policies, strategies and integrated plans that are assessed and agreed by stakeholders. Strengthen health information, analysis and knowledge generation and management of health services with focus on operational levels. Support and strengthen approaches that remove geographical, social and financial barriers to access to care.	One billion more people benefitting from universal health coverage (all people and communities have access to, and can use the promotive, preventive, curative, rehabilitative and palliative health services that are appropriate to their needs, and of sufficient quality).		Target 3.8: Achieve universal health coverage, including financial risk protection, access to quality essential health-care services, medicines and vaccines for all. 3.c: Increase health financing and health workforce in developing countries	Pillar 1: Empowering people through improved human development (education and training, health and sanitation, gender equality, youth reorientation and empowerment, physically challenged and senior citizens)
Combat communicable, non-communicable diseases (and neglected tropical diseases)	Reduce the burden of NTDs by scaling up interventions for prevention, control and elimination	One billion more people benefitting from universal health coverage (all people and communities have access to and can use the promotive, preventive, curative, rehabilitative and palliative health services that are appropriate to their needs, and of sufficient quality)	Control neglected tropical diseases	3.3 By 2030, end AIDS, tuberculosis, malaria and neglected tropical diseases epidemics and combat hepatitis, waterborne diseases and other communicable diseases.	Pillar 1: Empowering people through improved human development (education and training, health and sanitation, gender equality, youth reorientation and empowerment, physically challenged and senior citizens)
	Strengthen national capacity to prevent and control non-communicable diseases and their risk factors, including mental health, substance abuse and injury management		Prevent and control non-communicable diseases	3.4 By 2030, reduce by one third, premature mortality from non-communicable diseases, through prevention and treatment and promote mental health and well-being. 3.5 Strengthen the prevention and treatment of substance abuse, including narcotic drug abuse and harmful use of alcohol. 3.6 By 2020, halve the number of global deaths and injuries from road traffic accidents. 3.a Strengthen the implementation of the WHO Framework Convention on Tobacco Control in all countries, as appropriate.	

Strategic priorities	Focus area	GPW outcome	National (NHSP) target	SDG targets	UNDAF targets
Health security	Strengthen country health emergency capacity Support county to be adequately protected from emergence infectious hazards and antimicrobial resistance through effective public health measures Strengthen country capacity to detect, report, investigate and respond to emergencies and disease outbreaks. Support polio eradication activities	One billion more people better protected from health emergencies (populations affected by health emergencies have access to essential life-saving health services and public health interventions; all countries are equipped to mitigate risk from high-threat infectious hazards; and all countries assess and address critical gaps in preparedness for health emergencies, including in core capacities under the International Health Regulations (2005) and in capacities for all-hazard health emergency risk management)	Prevention and Control of other Diseases with Epidemic Potential (NHPP, 2011-2021) Strengthen epidemic preparedness, surveillance and response, including the expansion of the established surveillance and early warning and response system to ensure it is comprehensive enough to detect and respond to future health threats (investment plan 2015-20210)	3.d Strengthen the capacity of all countries, in particular developing countries, for early warning, risk reduction and management of national and global health risks	Pillar 1: Empowering people through improved human development (education and training, health and sanitation, gender equality, youth reorientation and empowerment, physically challenged and senior citizens)

Annex 2: Basic indicators

3.1 Strategic priority 1: Promote and support progress towards universal health coverage through increased access to and utilization of affordable, efficiently networked and sustainable quality services

- Policies, plans and strategies developed and implemented
- Accessibility to health services at all levels increased
- Managerial capacities at all levels strengthened
- Functional intersectoral collaboration at all levels
- Systems and strategies to ensure access to affordable medicines improved
- Well-designed community initiatives for health supported
- Policy dialogue to support UHC established and strengthened
- Capacity to generate, analyse and use health data available
- Health Management Information System (HMIS) and monitoring and evaluation strengthened and functional
- Human Resource Information System strengthened and functional
- NHA institutionalized and functional
- Health equity fund rolled out
- Health budget increased by Government
- Partnership forum for health held
- Capacity for intersectoral collaboration for social and economic determinants strengthened
- Reports on effective supervision and monitoring

3.2. Strategic Priority 2: Strengthening Partnership and Coordination for better health outcomes

- Organizational structures and coordinating mechanisms at all levels strengthened and functional
- Appropriate trainings to strengthen managerial capacities provided
- Number of joint planning, reviews and assessments conducted at national level
- Number of partnership forums held
- Number of intersectoral collaboration sessions organized to address social determinants of health
- Number of interventions jointly implemented with partners on social determinants of health
- Number of policy dialogues hosted for national legislature
- Number of policy dialogues hosted for development partners
- Number of policy dialogues hosted for the private sector

3.3 Strategic priority 3: Scaling up reproductive, maternal, newborn, child and adolescent health services

- Proportion of births attended by skilled health personnel
- Percentage of institutionalized deliveries
- Percentage of antenatal care visits
- Postpartum care coverage for mothers
- Children (0–6) exclusively breastfed
- Number of adolescents (aged 10–19 years) introduced to modern contraceptive methods
- Deaths among pregnant women (aged 10–19 years)
- Number of planned advocacy meetings conducted
- Proportion of planned community meetings conducted
- Proportion of counties with updated reach-every-district/reach-every-child micro plans
- Proportion of supportive supervision visits to subnational levels
- Number of planned operational researches conducted

3.4. Strategic priority 4: Combat communicable, non-communicable diseases and neglected tropical diseases

- Resources mobilized for HIV, tuberculosis and malaria
- Health services scaled up, improved and equitable
- Laboratory services scaled up and improved
- Strategic information generated to guide decision-making
- Gender and human rights issues addressed in ATM services at all levels of the health system
- Community engagement, coordination ad partnership strengthened for ATM programmes
- Resources mobilized to scale up national response for NTDs
- NTDs services scaled up, quality improved and equitable
- Gender and human rights issues addressed in NTDs at all levels of the health system
- Community engagement, coordination ad partnership strengthened for NTDs
- Resources mobilized to scale up NCDs
- NCD services scaled up, quality improved and made equitable
- Gender and human rights issues addressed in NCDs at all levels of the health system
- Community engagement, coordination ad partnership strengthened for NCDs
- Detection, diagnosis and treatment of NCDs scaled up.

3.5 Strategic priority 5: Health security

Indicators 5.1

- WHO country office with a minimum package of operational readiness in place, from 10% to 60%.
  - Demonstrated progress in critical capacities for health emergencies supported by WHO from 30% to 80%.
  - Country core capacities independently evaluated from 20% to 60%.
  - National action plan for strengthening core capacities developed from 0% to 100%.
  - Availability of essential medicines and supplies and other health products from 20% to 60%.

Indicators 5.2

- Proportion of population (women, children and men) affected by infectious hazards, who received risk mitigation interventions according to standards.
- Availability of essential resources, i.e. physical resources, supplies, and competent, motivated personnel to prevent, detect, control and mitigate infectious hazards.
- AFP cases reported; confirmed WPV; NP-AFP rate per 100 000 < 5 years; stool adequacy (100%).
- Demonstrated progress in implementation of transition and post-certification plan
- Certification of polio eradication.
- Technical guidelines, contingency plans, research protocols/research findings on infectious hazard availability.
- Number of strategies, adopted and adapted and implemented on pandemic/epidemic-prone diseases.
- Number of laboratories upgraded to confirm infectious hazards; and number of POEs strengthened to detect and make timely reports of infectious hazards.
- Established surveillance platforms for human and animal health surveillance.
- Improved advocacy and resource mobilization for infectious disease threats and health hazards.

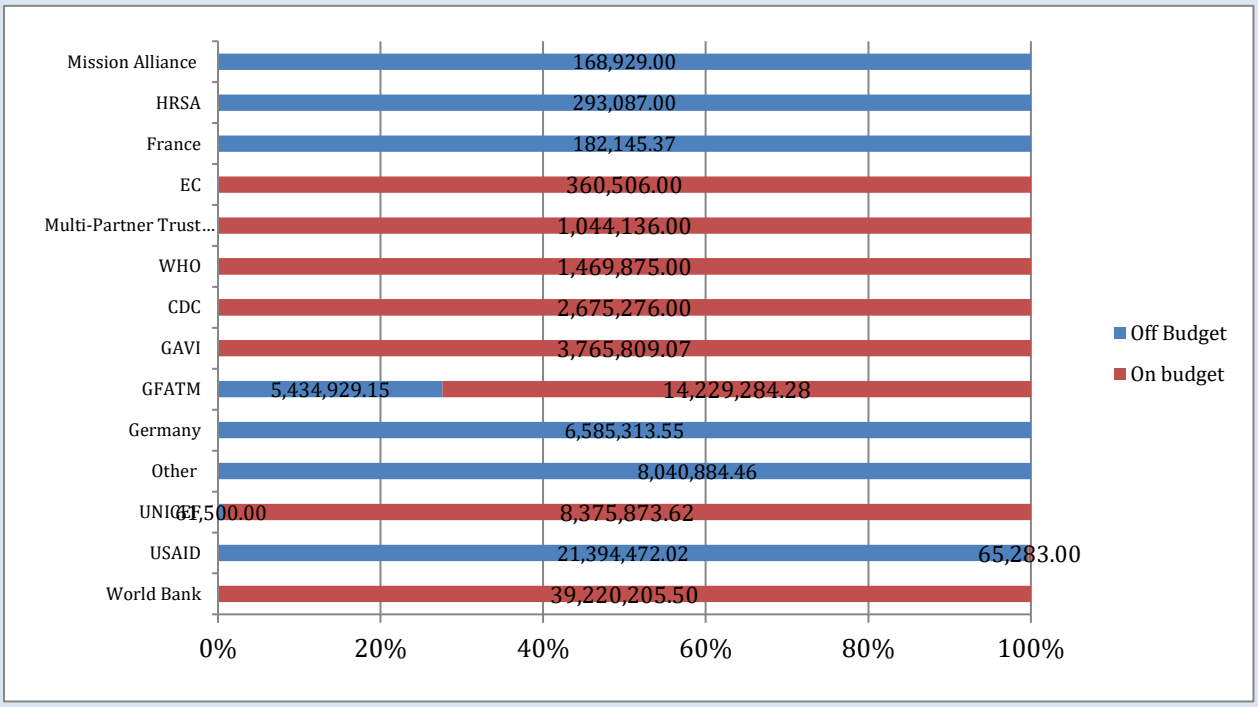
Indicators 5.3

- Percentage of new events rapidly detected, and risks assessed from 60% to 100%.
- Percentage of case notification within 24 hours from 80% to 100%.
- Acute health emergencies and disease outbreaks rapidly responded to within 48 hours from 80% to 100%.
- Number of situation reports for ongoing events.

Indicators 5.4

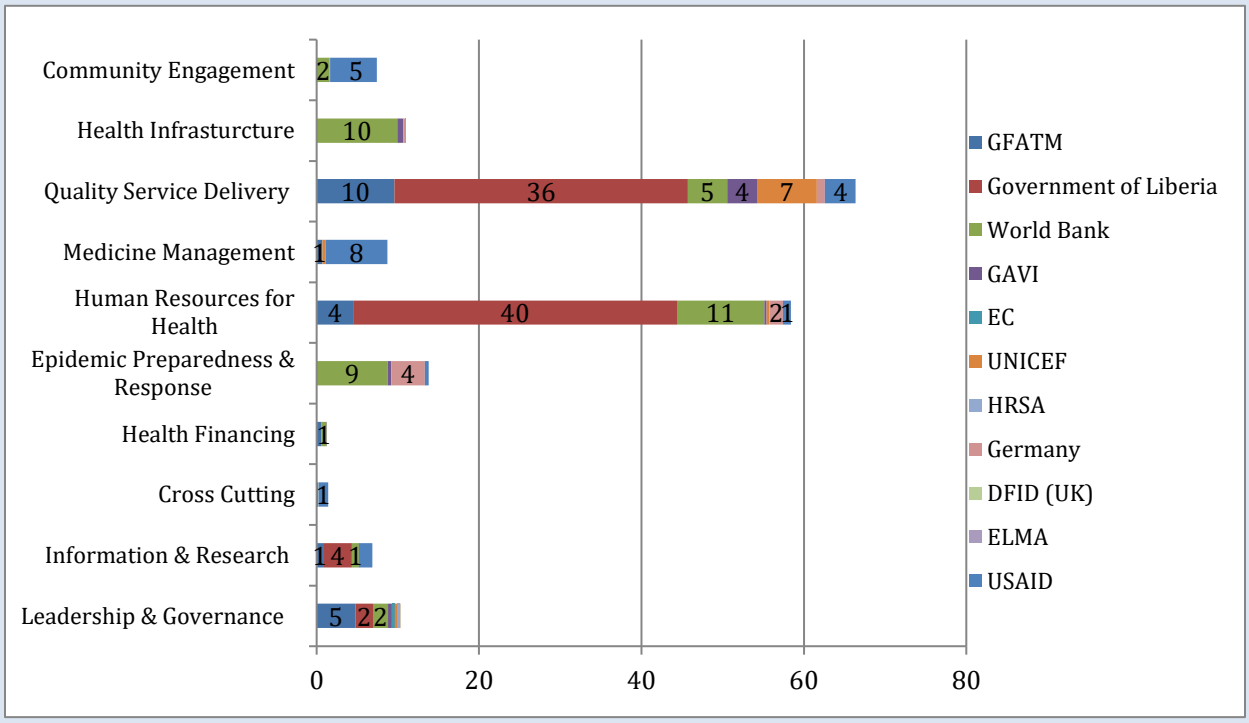
- Proportion of counties with both updated surveillance priority sites and work plans.
- Proportion of planned national polio committee meetings conducted.

Annex 3: Stakeholder mapping off-budget and on-budget funding by donor



Source: Resource mapping report 2018/19: MOH

Donor contributions by investment areas FY18/19



Source: Resource mapping report 2018/19: MOH

Annex 4: Causes of morbidity and mortality 2017 (DHIS)

No.	County	Malaria	Acute respiration infection (new cases)	STI excluding HIV/AIDS	Typhoid (new cases)	Anaemia	Diarrhoea (bloody and watery)	Hypertension (new cases)	Mental Health	Eye Condition	Road Traffic Accidents (car/bike) (new cases)
1	Bomi	44 544	15 474	7982	3985	1116	1116	1116	1116	1116	535
2	Bong	160 518	23 602	25 416	6573	2601	2601	2601	2601	2601	1778
3	Gbarpolu	23 831	11 000	3293	1683	861	861	861	861	861	111
4	Grand Bassa	103 463	23 224	13 494	4724	2 555	2555	555	555	555	1374
5	Grand Cape Mt	41 993	17 759	6018	973	1523	1523	1523	1523	1523	334
6	Grand Gedeh	48 467	9328	6354	2780	461	461	461	461	461	893
7	Grand Kru	38 432	9536	3665	1533	611	611	611	611	611	573
8	Lofa	148 295	49 866	21 275	9343	4570	4570	4570	4570	4570	1156
9	Margibi	84 425	18 821	13 360	6284	3786	3786	3786	3786	3786	1135
10	Maryland	66 945	14 323	4086	1787	662	662	662	662	662	716
11	Montserrado	407 975	81 659	80 861	56 869	22 304	22 304	22 304	22 304	22 304	8124
12	Nimba	263 060	60 756	45 459	16 696	11 661	11 661	11 661	11 661	11 661	2504
13	River Gee	36 003	11 732	2836	1350	524	524	524	524	524	272
14	Rivercess	29 659	4909	3240	649	1205	1205	1205	1205	1205	372
15	Sinoe	920 756	12 495	4936	2073	450	450	450	450	450	632
Total		**2 418 366**	**364 484**	**242 275**	**117 302**	**54 890**	**54 890**	**54 890**	**54 890**	**54 890**	**20 509**

Annex 5: Leading diagnoses for admission, death and disease

	2016 Major Diagnosis			2016 Death			
No.	Disease and condition	Number	%	Diseases (IPD)		Number	%
1	Malaria	56 405	31.5	1	Malaria	1366	29.2
2	Sexually transmitted infections	14 795	8.3	2	Anaemia	446	9.5
3	Anaemia	11 981	6.7	3	Acute respiratory infection	275	5.9
4	Acute respiratory infections	11 573	6.5	4	Diabetes	213	4.6
5	Hypertension	7412	4.1	5	Hypertension	209	4.5
6	Typhoid	6287	3.5	6	All other causes	2162	46.3
7	Maternal complications	5847	3.3	Total		4 671	61.2
8	Injuries	5232	2.9	Diseases (OPD)		Number	%
9	Road traffic accidents (cars/bikes)	4823	2.7	1		1053	31.9
10	Diarrhoea (watery and bloody)	3633	2.0	2		855	25.9
11	Diabetes	2955	1.6	3		751	22.7
12	All other causes	48 337	27.0	4		218	6.6
	Total	**179 280**	100.0	5		428	13.0
				Total		3305	100

No.	Major diagnosis 2017			2017 Deaths			
Disease and condition		Number	%	Diseases (IPD)		Number	%
1	Malaria	45 168	36.8	1	Malaria death	773	24.1
2	Anaemia	8765	7.1	2	Anaemia	392	12.2
3	Sexually Transmitted Infection	8703	7.1	3	Malnutrition	176	5.5
4	Maternal complication	8 075	6.6	4	Hypertension	161	5.0
5	Acute respiratory infections discharge	6515	5.3	5	Acute Respiration Infection	109	3.4
6	Hypertension	4714	3.8	6	Hepatitis	53	1.7
7	Injuries	3650	3.0	7	Diabetes Mellitus	39	1.2
8	Typhoid	3567	2.9	8	Sepsis	28	0.9
9	Road traffic accidents (car/bike)	2941	2.4	9	All other causes	1478	46.1
10	Diarrhoea	2733	2.2	Total		3209	100
11	Diabetes	2495	2.0	Diseases (OPD)			
12	Malnutrition	2310	1.9	1	Hypertension	686	26.1
13	All other causes	23 062	18.8	2	Sexually Transmitted Infections	674	25.6
Total		**122 698**	100.0	3	Malaria death	313	11.9
				4	Maternal complication	303	11.5
				5	All other causes	652	24.8
				Total		2 628	100

Annex 6: Human resources against establishment in the health sector

Numbers of health workers employed or full-time equivalent if available (see definitions below the table)

	Most recent available year in 2016				Most recent available year in 2009				Most recent available year 2007			
	Physicians (including specialists)	Nurses (nurse midwives if no specific midwives)	Midwives	Physicians Assistants (clinical officer, etc.)	Physicians (including specialists)	Nurses (nurse midwives if no specific midwives)	Mid-wives	Physicians Assistants (clinical officer, etc.)	Physicians (including specialists)	Nurses (nurse midwives if no specific midwives)	Midwives	Physicians Assistants (clinical officer, etc.)
National	234	3077	927	518	90	1393	412	286	122	454	297	236
Bomi	6	111	26	10	1	53	23	7	1	11	10	5
Bong	20	281	110	21	5	124	43	10	6	48	28	10
Gbarpolu	3	52	26	10	1	27	10	4	0	2	8	4
Grand Bassa	5	145	35	21	5	89	18	10	2	6	8	10
Grand Cape Mt	4	76	34	32	1	49	14	9	0	20	13	12
Grand Gedeh	3	77	34	23	2	40	9	10	0	10	1	7
Grand Kru	2	38	21	15	1	12	7	4	0	2	2	3
Lofa	9	249	95	37	9	120	37	20	6	3	26	18
Margibi	13	162	42	24	4	90	36	11	5	19	18	11
Maryland	6	80	33	14	6	48	11	17	0	16	4	6
Montserrado	127	1277	322	207	48	512	153	126	97	218	140	106
Nimba	30	329	82	49	5	121	26	33	5	96	30	33
Rivercess	1	50	20	18	1	39	8	8	0	1	2	9
River Gee	3	58	17	15		26	9	11	0	2	5	2
Sinoe	2	92	30	22	1	43	8	6	0	0	2	0

Definitions

Physicians: Include general medical practitioners and specialist medical practitioners.

Nursing personnel: Include nursing professionals and nursing associate professionals.

Midwifery personnel: Include midwifery professionals and midwifery associate professionals.

(Note that for some countries, nurses with midwifery training are considered under nursing)

Annex 7: Ministry of health staff to population ratio 2006, 2009 and 2016

Category	2006			2009			2016		
	Number	%	Cadre/1000 Population	Number	%	Cadre/1000 Population	Number	%	Cadre/1000 Population
Administrators				88	1.1	0.02	1404	8.7	0.34
Administrative Support						0.00	4311	26.8	1.05
Clinical Support/Nurse Aide/Vaccinators				1 589	19.1	0.45	3601	22.4	0.88
Environmental health technicians				173	2.1	0.05	285	1.8	0.07
Dentists				23	0.3	0.01	14	0.1	0.00
Laboratory technicians	126	3.18	0.04	137	1.6	0.04	300	1.9	0.07
Midwifery	297	7.49	0.09	412	5.0	0.12	927	5.8	0.23
Registered Nurses	668	16.84	0.20	1393	16.8	0.39	3077	19.2	0.75
Pharmacists	24	0.61	0.01	46	0.6	0.01	109	0.7	0.03
Dispensers/pharmacy workers	324	8.17	0.10	505	6.1	0.14	962	6.0	0.23
Physicians	122	3.08	0.04	90	1.1	0.03	234	1.5	0.06
Physician assistants	236	5.95	0.07	286	3.4	0.08	518	3.2	0.13
Public health specialists							68	0.4	0.02
Social workers				182	2.2	0.05	254	1.6	0.06
X-Ray technicians				22	0.3	0.01			
Lab aide	135	3.4	0.04	239	2.9	0.07			
Other health cadres	1529	38.6	0.46	6	0.1	0.00			
Non-Clinicians	505	12.7	0.15	3119	37.5	0.88			
Total	3966	100.0	1.19	8310	100.0	2.34	16064	100.0	3.91

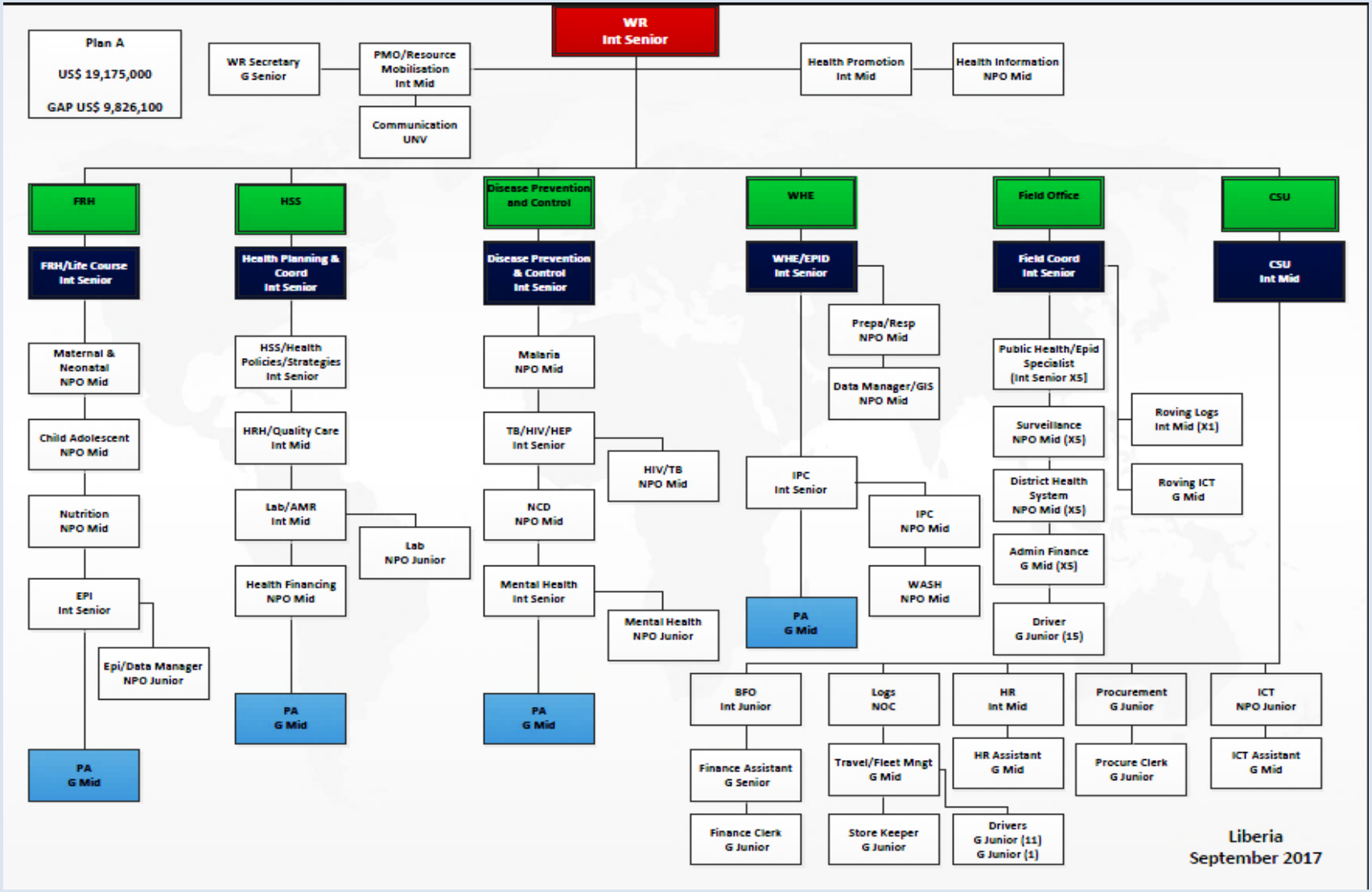
Source: HMIS/Ministry of Health

Population (2016) 4 105 459
Population (2009) 3 549 617
Population (2008) 3 476 608
Population (2006) 3 332 124

Annex 8: WCO Liberia – SWOT Analysis (Country team)

Strengths	Opportunities
1. New CCS, developed after broad consultations 2. Consultative and supportive WR leadership, WCO management team meetings, open door policy 3. Good team spirit and teamwork through cluster meetings 4. Presence of skilled, competent and experienced professional staff covering most of the priority health programmes 5. Availability of guidelines and tools for development and implementation of CCS 6. WHO leadership on providing guidelines and tools to MoH and partners 7. Clear role of WHO in supporting MoH plan of Action 8. Easy access to technical support through IST, AFRO and headquarters ensures quality technical support to MOH 9. Increased administrative efficiency, expanded delegation of authority 10. Timely allocation of funds for activities/allotment notification by AFRO/HQ 11. Functional review: Re-profiling, and posts establishment for most staff	1. Coordination mechanisms for cooperating partners to support the health sector and MoH plan of action 2. High confidence by MoH in WHO, collaboration with counterparts in the MoH is constant 3. Trusted as neutral player of first resort in many instances 4. Presence of other partners and their financial resources, so WHO rides on them for implementation of some programmes 5. New government that has prioritized health 6. Joint United Nations team that works on similar programmes now planning to have more joint activities and share knowledge
Weaknesses	**Threats**
1. CCS not sufficiently used as a planning tool 2. Budget allocation not aligned to CCS 3. Some staff members overloaded having to cover multiple programmes 4. Inadequate staff and finances for programmes like NCDs in the country office	1. Reduced donor funding to government 2. Some “competition” among partners 3. Decentralization of health service not finalized, and HR shortages at county level 4. Inadequate commitment of MoH to WHO operations 5. Outbreak of new disease that disrupts the health systems, for example Ebola

Annex 9: WCO Liberia proposed organogram



Annex 10 List of Participants: CCS Validation

Faith Based Organizations

Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM)

Irish Aid, Embassy of Ireland

Japan International Cooperation Agency (JICA)

Last Mile Health (LMH)

Liberia Health Civil Society Organization

Liberia Health NGO Group

Ministry of Finance Planning and Development

Ministry of Health (MoH)

National Public Health Institute of Liberia (NPHIL)

Partners in Health (PIH)

Private sector representatives

The Department for International Development (DFID)

U.S. Centers for Disease Control and Prevention (US-CDC)

United Nation Population Fund (UNFPA)

United Nations High Commission for Refugees (UNHCR)

United Nations International Children's Emergency Fund (UNICEF)

United Program on HIV and AIDS (UNAIDS)

United States Agency for International Development

UN WOMEN