Table of Contents

<table>
<thead>
<tr>
<th>Section #</th>
<th>Section Description</th>
<th>Page Number</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Table of Contents</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Acronyms</td>
<td>3</td>
</tr>
<tr>
<td>1</td>
<td>Introduction and Background</td>
<td>4</td>
</tr>
<tr>
<td>2</td>
<td>County Health Planning Process</td>
<td>9</td>
</tr>
<tr>
<td>3</td>
<td>Situational and Gap Analysis</td>
<td>10</td>
</tr>
<tr>
<td>4</td>
<td>Description of Objectives, Targets, Strategies, Intended Beneficiaries and Activities</td>
<td>23</td>
</tr>
<tr>
<td>5</td>
<td>Supervision, Monitoring and Evaluation</td>
<td>23</td>
</tr>
<tr>
<td>6</td>
<td>Implementation Challenges and Solutions</td>
<td>24</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>Details on HR and Infrastructure</td>
<td>25</td>
</tr>
<tr>
<td>Attachment 2</td>
<td>County Health Technical Plan:</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- County Objectives and Targets</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- County Facility Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- County Implementation Plan</td>
<td></td>
</tr>
<tr>
<td></td>
<td>- County Health Team Budget</td>
<td></td>
</tr>
</tbody>
</table>
## Acronyms

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>AHA</td>
<td>African Humanitarian Action</td>
</tr>
<tr>
<td>INGO</td>
<td>International non-governmental organization</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired immuno-deficiency syndrome</td>
</tr>
<tr>
<td>ANC</td>
<td>Antenatal clinic</td>
</tr>
<tr>
<td>ARV</td>
<td>Anti-retroviral</td>
</tr>
<tr>
<td>BCC</td>
<td>Behavior Change Communication</td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based Organization</td>
</tr>
<tr>
<td>CBSP</td>
<td>Community-based Service Provider</td>
</tr>
<tr>
<td>CDC</td>
<td>Community Development Committee</td>
</tr>
<tr>
<td>CHT</td>
<td>County Health Team</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>CM</td>
<td>Certified Midwife</td>
</tr>
<tr>
<td>DOTS</td>
<td>Directly Observed Treatment-Short Course</td>
</tr>
<tr>
<td>EPI</td>
<td>Expanded Program on Immunization</td>
</tr>
<tr>
<td>FBO</td>
<td>Faith-based Organization</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>GOL</td>
<td>Government of Liberia</td>
</tr>
<tr>
<td>HBLSS</td>
<td>Home-based Life Saving Skills</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immuno-deficiency Virus</td>
</tr>
<tr>
<td>HFs</td>
<td>Health Facility (ies)</td>
</tr>
<tr>
<td>HWs</td>
<td>Health Worker(s)</td>
</tr>
<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
</tr>
<tr>
<td>HS</td>
<td>Health Service</td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
</tr>
<tr>
<td>BPHS</td>
<td>Basic Package of Health Services</td>
</tr>
<tr>
<td>IEC</td>
<td>Information Education Communication</td>
</tr>
<tr>
<td>IMCI</td>
<td>Integrated Management of Childhood Illnesses</td>
</tr>
<tr>
<td>IPT</td>
<td>Intermittent Preventive Treatment</td>
</tr>
<tr>
<td>IRC</td>
<td>International Rescue Committee</td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine device</td>
</tr>
<tr>
<td>HS</td>
<td>Health Service</td>
</tr>
<tr>
<td>LSS</td>
<td>Life Saving Skill</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MEDIC</td>
<td>Medical Emergency Relief and Corporative International</td>
</tr>
<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother to Child Transmission</td>
</tr>
<tr>
<td>MSF</td>
<td>Medceins San Frontieres</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-governmental Organization</td>
</tr>
<tr>
<td>PA</td>
<td>Physician Assistant</td>
</tr>
<tr>
<td>RN</td>
<td>Registered Nurse</td>
</tr>
<tr>
<td>SCF/UK</td>
<td>Save the Children Fund/United Kingdom</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
</tr>
<tr>
<td>TT</td>
<td>Tetanus Toxoid</td>
</tr>
<tr>
<td>TM</td>
<td>Traditional midwife</td>
</tr>
<tr>
<td>VPD</td>
<td>Vaccines-preventable diseases</td>
</tr>
<tr>
<td>TTM</td>
<td>Trained Traditional Midwives</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counseling and Testing (Center)</td>
</tr>
<tr>
<td>MTI</td>
<td>Medical Teams International</td>
</tr>
<tr>
<td>IMC</td>
<td></td>
</tr>
</tbody>
</table>
1.0 Introduction and Background

1.1 County population, geography and administrative structure

Grand Cape Mount County is one of the five oldest counties in Liberia. Situated in the southwestern most corner of Liberia it is bounded on the east by Bomi County, on the west by the Republic of Sierra Leone, on the north and northeast by Gbarpolu County and on the south by the Atlantic Ocean. Cape Mount County has five major ethnic groups, namely: – Vai, Mende, Gola, Kpelleh and Mandingo.

The county is sub-divided into four districts: 1. Gola Konneh, 2) Garwula, 3) Porkpa, and 4) Tewor; there is one Commonwealth-Tombey Chiefdom in Tallah Township. The estimated population of Cape Mount County is 191,102. Robertsport city, the capital of Cape Mount County houses the administrative seat of the county with the county administrative building and City Corporation.

1.2 Administrative Structure of Grand Cape Mount County in organization Chart

The county superintendent represents the President of Liberia in the county. She has oversight responsibility of the county and is assisted by a core of officials including an assistant superintendent for development, who is responsible for the coordination of development activities, including the formulation of a county development agenda, a five-year county plan. A superintendent’s council, headed by the superintendent, serves as an advisory council in the county.

The organogram below shows the administrative structure of Cape Mount County. The administrative structure is basically the same for all 15 counties of Liberia. Minor variations may exist in some counties due to the size of the county and/or the availability of human resource for the various posts.

Demographic indicators

- Total population 100% 191,102
- Under one population 4% 7,644
- Under five population 15% 28,665
- Women of childbearing age 25% 47,776
- Pregnant women 5% 9,555
1.3 Summary: Current Status of Basic Package for Health Services in Grand Cape Mount County

- **Health Status:**
  - Maternal and Newborn Care
    - 58% of pregnant women are receiving two doses TT vaccinations
    - 42% of TT2 vaccination recipients are non pregnant women
  - Child Health
    - DPT3 coverage in children under one year of age is 28%
    - Total malaria episodes treated June 2006-June 2007 is 110,456
  - Disease Control
    - HIV/AIDS: total tested 35, positives 7, negatives 28
    - TB: total cases 21, total positive 10, total negative 11 and EP 1

- **County Health Team:** 9 persons

1.4 Description of current county health system

- Thirty two functional health facilities out of total of 33 (97%)
- One Hospital; 1 Health Centre; 29 Clinics (GOL), 1 private
- Twenty four (75%) are being supported by NGOs (MTI, AHA, IMC, CCF)
### 4.1 County Health Team

#### 1.4.1.1 Current Cape Mount County Health Team

<table>
<thead>
<tr>
<th>No.</th>
<th>Name</th>
<th>Position</th>
<th>Cell #</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Dr. Raymond Kromah</td>
<td>County Health Officer</td>
<td>06518530</td>
</tr>
<tr>
<td>2.</td>
<td>Theresa Alpha</td>
<td>County Heath Service Administrator</td>
<td>06527211</td>
</tr>
<tr>
<td>3.</td>
<td>Momodu Sombai</td>
<td>Community Health Department Director</td>
<td>06539471</td>
</tr>
<tr>
<td>4.</td>
<td>Peter Borbor</td>
<td>Clinical Supervisor</td>
<td>06661815</td>
</tr>
<tr>
<td>5.</td>
<td>Kpakama Kromah</td>
<td>County Pharmacist</td>
<td>06550230</td>
</tr>
<tr>
<td>6.</td>
<td>Matthew Paasawe</td>
<td>EPI Supervisor</td>
<td>06601127</td>
</tr>
<tr>
<td>7.</td>
<td>Aaron B. Massalay</td>
<td>Hospital Administrator</td>
<td>06939896</td>
</tr>
<tr>
<td>8.</td>
<td>Cyrus B. Sneh</td>
<td>County Surveillance Officer</td>
<td>06552505</td>
</tr>
<tr>
<td>9.</td>
<td>Evans Lablah</td>
<td>Nursing Director</td>
<td>06840918</td>
</tr>
</tbody>
</table>
1.4.1.2 Grand Cape Mount County Health Team **Proposed** Organogram

**Grand Cape Mount County Health Team Organogram – Proposed Per Plan**

- **County Health Officer**
  - **County Health Board**
    - **Hospital Medical Director**
      - **Hospital Administrator**
        - **Community Health Department Director**
          - **Pharmacist**
            - **Nursing Service Director**
              - **County Health Services Administration**
                - **HR management Unit Head**
                  - **Finance Officer**
                    - **HMIS/Data Manage/County Registrar**
                      - **Assistant HMIS/Data Manager – M&E Focal Person**
                        - **3 Registrar 1 Data Clerk**
                          - **Logistician**
                            - **Assistant Logistician**
                              - Mechanic, plumber, electrician & carpenter
                - **Assistant Logistician**
                  - **Logistician**
                    - **Assistant Logistician**
                      - **3 Registrar 1 Data Clerk**
                        - **Logistician**
                          - **Assistant Logistician**
                            - Mechanic, plumber, electrician & carpenter
          - **Clinic Coordinator**
            - **Clinical Supervisor**
              - **Social Welfare Supervisor**
                - **Environmental Health Officer**
                  - **Public Health Inspector**
                    - **County Surveillance Officer**
                      - **Reproductive Health Supervisor**
                        - **IEC/BCC Focal Person**
                          - **Proposed Additional CHT members**
                            - 3 Registrar 1 Data Clerk
1.4.2 Partnerships (NGOs, private sector)

The major health sector partners in Cape Mount County are AHA, MTI, IMC and CCF.

1.4.3 Financial resources (including Governments, NGOs and UN agencies)

For the fiscal year 2007-2008, the budgetary allocation to the Grand Cape Mount CHT is USD 60,000 for the county hospital and USD 55,000 for health systems. Drugs, medical supplies and staff salaries are supported directly by the MOHSW. The MOHSW also provides a monthly fuel allowance of USD 1,675.50 for 500 gallons of gas of which the county hospital gets 300 gallons while the county health team gets 200 gallons.

Additional resources for infrastructure, training and other activities required to implement the BPHS will be supported by the MOHSW through the GOL budget and partners (multilateral donors, INGOs, etc) contributions. It is expected that the CHT will be provided some support to contract health staff to support the implementation of the BPHS where necessary.

2.0 County Health Planning Process

The Grand Cape Mount County Interim Health Plan (2007-2008) was elaborated at a time when challenges presented by decades of civil war were compounded by the sudden departure of NGOs support to health facilities. The revitalization of the Cape Mount County health sector therefore requires a comprehensive and robust plan that will serve as a road map for effective delivery of the health care services, especially the Basic Package for Health Services, BPHS.

The County Health Plan is formulated in consonance with the National Health Plan which provides the strategy for implementation of the National Health Policy. The Cape Mount County health plan is therefore an effort to implement the Basic Package for Health Services which forms the cornerstone of the National Health Plan. The plan is also linked to Pillar Four (Infrastructure and Basic Social Services) of the Interim Poverty Reduction Strategy (iPRS) of the Liberian Government, and the UN Millennium Development Goals of 2015.

Formulation of the Cape Mount County health plan consisted two phases:

- Phase one was the training of county health teams of five counties - Bomi, Grand Cape Mount, Grand Gedeh, Lofa and Nimba - in June 2007 to give them orientation on the BPHS and the development of their respective county plans within the context of the basic package.

- Phase two was a 4-day Grand Cape Mount County Health Planning Workshop (September 5-8, 2007) organized by the Grand Cape Mount County Health Team with facilitators from the central Ministry. The planning workshop brought together key stakeholders in the county and had over 30 participants. The participants included the County Health Team, District Health
Officers, NGO partners, members of the Superintendent’s office and other local authorities, including Chiefs. Others were representatives from the UNMIL Civil Affairs Office and the mass media.

The participants developed the health plan by building consensus following extensive discussions in plenary and during small group working sessions. The groups were based on the four key components of the National Health Plan, namely: BPHS, HR, Infrastructure and Support Systems. Group work was followed by review at plenary during which time the document under review was finalized. The entire body participated in the selection of **16 health facilities for BPHS implementation.** The selection of facilities was guided by a set of criteria, which among others includes the equitable distribution of facilities/services.

The participants also prioritized major objectives and targets, as well as activities to be implemented during the planned period. At the end of the entire process a one-year plan was adopted and endorsed by all the workshop participants.

### 3.0 Situational/Gap Analysis of the Grand Cape Mount County Health System

A situational analysis puts into perspective the strengths and weaknesses of the Grand Cape Mount County health system and defines the gaps that need to be filled for equity in health service in the county. The major findings include:

**I. Basic Package for Health Services**

**A. All Program Areas**

**1. Community Level**

**Strengths**
- Existence of 40 TTM out 112 TMs

**Underlying factors/causes**
- LSS training conducted by CHT and FHD/MOH

**Weaknesses**
- LSS training for TMs was limited to only a few communities
- Absence of health education activities at the community level
Underlying factors/causes
- No support to extend LSS training for TMs to more communities
- CHWs lack skills in health education
- Insufficient/limited health education materials

2. Health Facility Level
Strengths:
- Availability of approximately 70% of required staff in all functional health facilities
- Satisfactory level of health education going on at HFs for all services being provided
- Thirty two out of total 33 HFs functional in the county

The underlying factors
- Good incentives and motivation by GOL and NGO partners
- Health education training was conducted for HWs
- Good NGO and GOL support facilitated revitalization and operation of HFs

Weaknesses/gaps/unmet needs:
- Lack of CMs for some HFs
- Poor access of some communities to HFs
- Inadequate health education materials (in both quality and quantity)

The underlying factors
- Lack of motivation for CMs
- HFs are located in isolated (hard-to-reach) communities
- Lack of financial support for reproduction of health education materials

B. Maternal and Newborn Care

Community level
Strengths
- TTM take pregnant women for routine ANC
- TTM take newborns delivered at home for routine vaccinations
- TTM take timely referrals of pregnant women in labor
The underlying factors/causes
- LSS training received by TTM; the training was conducted by the CHT in collaboration with FHD/MOH and NGO partners in Cape Mount County
- Health education received by TTM on the importance of EPI services

Weaknesses/gaps/unmet needs:
- Not all communities have TTM to promote use of ANC services
- 90% of deliveries are done at home

Underlying factors/causes
- Inadequate number of TTM; training of traditional midwives needs to be extended to more communities
- Long distance of communities from HF,
- Cultural/religious beliefs: communities are predominantly Moslems; Moslem women tend to prefer delivering in the hands of women/females; HF are seen as having male HWs who may have to attend to all patients including women in labor
- Limited knowledge of the benefits of health service due to inadequate health education

Facility Level
Strengths
- Availability of EPI services at 90% of functional HF
- Availability of CMs in 69% of functional HF
- ANC services available in all (100%) functional HF
- Some basic services provided by all HF

The underlying factors
- Good storage facilities for vaccines; trained personnel to provide immunizations
- Proximity of Cape Mount to Monrovia allows for HWs from Monrovia to easily work there; Support/incentives provided by NGOs
- Availability of trained HWs to provide service

Weaknesses/gaps/unmet needs:
- Inadequate number of CMs for HF
- Non-NGO supported HF lack adequate human resource
- Lack of some essential medical supplies in 60% of HF

Underlying factors
- Lack of motivation for CMs
- Lack of motivation for HWs at non-NGO supported HF
- Budgetary constraints of GOL
C. Child Health:

Community Level:
Strengths:
• One thousand fifty six (1056) health promoters selected from communities to undergo training in IMCI

Underlying factors:
• Need identified by CHT and NGO partner MTI
• Training done by MOH to support CHT

Weaknesses/gaps/unmet needs:
• Some communities not included in selection of health promoters
• Referral is slow/weak

The underlying factors/causes
• Several communities are geographically hard to reach
• Funding for training of hygiene promoters is limited
• CHW not sensitized to need for prompt referrals

Health Facility Level
Strengths
• 95% of HF providing RI
• 80% of HFs have EPI refrigerators
• 80% of under ones utilizing EPI services
• 80% of HF conducting outreach EPI activities

The underlying factors/causes
• Good support from partners
• Logistical support from EPI/MOH and UNICEF
• Sensitization of communities

Weaknesses/gaps/unmet needs:
• Outreach EPI services not regular
• 20% of HFs lack EPI refrigerators
• 20% of HFs not conducting outreach EPI services
The underlying factors/causes
- Inadequate logistics for outreach EPI services; also roads are inaccessible some of the time
- Limited logistics provided by EPI/MOH for EPI;

D. Reproductive and Adolescent Health
1. Community level
There are no reproductive health activities going on at the community level in Cape Mount County

2. Health Facility
Strengths
- Availability FP services at HFs though not always
- Syndromic management of STIs at some HFs

Underlying factors
- Support provided by FHD/MOHSW
- Availability of drugs provided by NDS

Weaknesses
- FP services intermittent, not regular
- Lack of adolescent reproductive health program
- Approximately 22% of HFs do not have services for syndromic management of STIs
- No PMTCT program in Cape Mount County

Underlying factors
- Inadequate and irregular supply of commodities from the central level
- No organized (adolescent reproductive health) program at the national level
- Lack of trained HWs,

E. Disease Control – HIV/AIDS
1. Community Level
Strengths
- CHW involved in condom distribution
- Good awareness activities involving drama group and CHWs
Underlying factors
- Availability of condoms at community level,
- Training provided community members by NACP

Weaknesses
- High incidence of unsafe sex
- Condom distribution and public awareness not in all communities

Underlying factors
- Myths that condoms cause impotency
- Limited number of trained CHWs

2. Facility Level
Strengths
- Availability of VCT services at two of 32 (6) HFs

Underlying factors
- Availability of trained personnel and supplies provided by NACP

Weaknesses
- Majority (94%) of HF lack VCT services
- Lack of health education at most facilities

Underlying factors
- Lack of support to increase/expand VCT services
- Lack of trained HW

E. Disease Control – TB
1. Community Level:
- There is no TB program at the community level; there is limited support from the central level for the TB program in Cape Mount County

2. Facility Level
Strengths
- Availability of four TB treatment centers in Cape Mount County

Underlying factor:
- Support from the national program and GFATM
Weaknesses
• Inadequate amount of TB treatment centers
• Irregular supply of drugs to TB treatment centers

Underlying factor/causes
• Lack of support from the central level
• Irregular supply of drugs by the national program

E. Disease Control – Malaria

Community level
Strengths:
• Public awareness of malaria ongoing with involvement of CHWs
• ITNs distributed by community health care providers

Underlying factors:
• Training and other support provided by the NMCP
• Availability of ITNs provided by partners including MTI

Weaknesses:
• NONE

2. Facility Level
Strengths:
• Most HWs trained in malaria case management

Underlying factors/causes
• Training conducted by NMCP and partners including Mentor Initiative

Weaknesses
• Irregular supply of drugs/supplies
• ITNs not distributed at ANC

Underlying factors/causes
• ITNs not supplied by the national program but by NGOs

F. Mental Health:
• There is no Mental Health Program in Grand Cape Mount County; MOHSW has no organized program at the national level
G. Essential Emergency Treatment:
• There is no Essential Emergency Program in Grand Cape Mount County;

II. Human Resource
Strengths
• Good interpersonal relations (unity, togetherness) among CHT
• 7 of 25 CHT post filled (28%)
• Organized CHT with records of HWs in county
• Availability of some trained and committed staff despite low salaries

Underlying factors
• Support of MOHSW
• Refresher training provided by CHT with support of NGO partners

Weaknesses
• 72% of CHT positions not filled
• Lack of district level health staff
• Lack of trained HWs (CMs, Pas, RNs) in majority of districts
• Low capacity and educational level of some service providers
• Lack of community involvement in health activities
• Lack of job descriptions
• Salary structure not always reflective of skills and knowledge of staff
• Lack of motivation/benefits for HW e.g. housing, transportation allowance, retirement package
• No involvement of CHT in HR recruitment
• Constant absence of county level HW from county
• Poor job security,

Underlying factors
• National problem of insufficient HWs in the country
• No local training institution for professional HW
• Systems not developed at the national level
• Constant for county level staff to be away at workshops, etc
• NGO major employer and their departure usually abrupt
III. Infrastructure

Strengths
• Existence of 32 functional HFs out of 33 total in the county
• Most HFs are easily accessible

Underlying factors
• GOL, NGO and community support
• Small county with fairly good road network

Weaknesses
• Many HFs in poor physical condition
• Some HFs lack electricity, water
• County hospital is inaccessible to majority of the population

Underlying factors
• Poor maintenance, some HF also poorly built and small
• Inadequate budgetary allocation
• Political interference in selection of site for county hospital

IV. Support System

1. Policy formulation and implementation

Strengths
• Policy information shared with partners at coordination meetings
• Partners implementing policy under CHT guidance
• Existence of a structure (CST meeting) for discussion of policy issues

Underlying factors
• Good leadership of the county health team

Weaknesses
• None

2. Planning and Budgeting

Strengths
• Availability of manpower for planning and budgeting; county has of a finance officer
Underlying factors
  • MOH/GOL support/deployment
  • Staff commitment and motivation

Weaknesses
  • Planning and budgeting not decentralized

3. Human Resource Management and in-service training

Strengths
  • NGO providing salary incentives for HWs in 24 of 32 HFs
  • Regular in-service training of HWs by CHT with support of NGO partners
  • Regular training of TTM

Underlying factors
  • Support provided by MOH/GOL and its partners

Weaknesses
  • Limited trained human resource
  • Many HWs not on GOL payroll
  • HWs in GOL-run HFs receive no incentives
  • No human resource unit or officer
  • Salaries are low

Underlying factors
  • Low GOL budget

4. Health Management Information System

Strengths
  • Trained and computer literate county registrar
  • Computer identified by MOH for county registrar

Underlying factors:
  • Implementation of MOH decentralization policy
  • Training and deployment of personnel by MOH
Weaknesses
- HMIS unit functioning poorly

Underlying factors
- HMIS functions not clearly defined or known to officer

5. Drugs and Medical Supplies
Strengths
- Availability of drugs and medical supplies from GOL and partners including NGOs and GFATM
- Availability of a county pharmacist

Underlying factors:
- Successful resource mobilization by GOL
- Staff recruitment and deployment by MOH

Weaknesses
- Frequent stock out of essential drugs at HF

Underlying factors
- Delay in quarterly replenishment of supplies by NDS
- Bad road condition

6. Facility and Equipment maintenance
Strengths
- Availability of one maintenance staff (a carpenter) at the county hospital, St. Timothy Hospital

Underlying factors
- Dedication of staff to county hospital

Weaknesses
- Inadequate maintenance team (no mechanic, plumber, electrician)
- Lack of organized maintenance department
- Inadequate and irregular supply of fuel

Underlying factors
- Maintenance system of MOH not fully decentralized
7. **Logistics and Communication**

**Strengths**
- Availability of a county logistician
- The following logistical support are in the county and functional:
  - one ambulance (belongs to NGO partner)
  - six motorbikes
  - one vehicle

**Underlying factors:**
- GOL and partner support

**Weaknesses**
- There is no IEC/BCC focal point
- No adequate transportation for drugs and medical supplies
- The following logistical and communication support are in the county **but non-functional:**
  - One vehicle
  - 9 motorbikes,
  - 2 VHF radios.

**Underlying factors**
- Low GOL budget

8. **Supervision, Monitoring and Evaluation, Research**

**Strengths**
- Responsible officer (clinical supervisor) available
- Some degree of supervision taking place
- Availability of computer for M&E
- Data clerk identified/available

**Underlying factors**
- Designation of responsibility by CHT
- Committed CHT executing responsibility in spite of limited capacity

**Weaknesses**
- No joint supervision taking place
- Lack of logistical support from partners for supervision
- Data clerk is non-functional
- Reporting system is weak
Underlying factors/causes
• Lack of proper coordination between partners
• Non-involvement of CHT in NGO contracting process thus has little or no control/say in their activities
• Data clerk not available for use by the CHT
• Limited central level support

9. Stakeholder Coordination and Community Participation

Strengths
• Existence of mechanism (regular meeting) for coordination of partners activities
• Most communities have CDCs
• Some HF's have CHWs
• CHT regularly explores avenues for partnership and social mobilization for health. For example discussions are currently underway for rehabilitation of two health facilities by a mining company (Bangorma) and the community (Zarway)

Underlying factors
• Good leadership by CHT
• Some degree of community participation in health

Weaknesses
• Poor coordination; meetings are irregular
• Lack of cooperation from some NGO partners
• CHWs not very functional,
• Poor commitment from some communities

Underlying factors
• Citations to meetings are sent late
• Poor follow up to meetings; decisions are neither disseminated nor implemented
• Communities are not motivated

4.0 Description of County Health Objectives, Targets, Activities and Budget Allocation

4.1 County Health Technical Plan

Please refer to the County Health Technical Plan (Attachment 1) for:

1. Objectives and Targets
2. County Facility Plan (HR, Infrastructure and Services Needs for selected BPHS and non BPHS facilities)
3. Implementation Plan (Activities, Responsibilities and Timelines)
4. County Health Team Budget Allocation

Each of these have been structured by the major components and sub components of the National Health Plan

5.0 Supervision, Monitoring and Evaluation

In order to ensure an effective and reliable monitoring and evaluation system for impact measurement, a one year M&E Plan will be developed based on the County Health Plan. Based on the one year M&E Plan, routine recording and reporting systems of the Grand Cape Mount County Health Team will be strengthened to closely monitor program implementation in the 16 selected BPHS facilities as well as in non-BPHS facilities.

An HMIS/M&E Unit will be established to coordinate all reports relating to implementation of the BPHS strategy. Standardized checklists for supervision, and reporting forms for monitoring purposes will also be developed. CHWs will be strengthened to collect data at the community level using standardized reporting forms. Data collected at health facilities (including private ones) from all levels of the health system will be collated and analysed at the county health team level and reported to the central level. Regular monitoring will be conducted at all levels on a quarterly basis. A bi-annual review of implementation of activities will be conducted to evaluate progress of program activities.

Monitoring and Evaluation will be done at three levels, namely:
   1. County Health Team level,
   2. County Health Advisory Board level,
   3. Ministry of Health and Social Welfare level

6.0 Implementation Challenges

There are numerous challenges that will attempt to impede the successful implementation of the Grand Cape Mount County Health Plan (2007-2008). These include the following:
   • Lack of commitment from local authority
   • Limited capacity of the Grand Cape Mount County Health Team to implement the plan
   • Inadequate mobilization of needed resources
   • Limited motivation/incentive for staff
• Rapid turnover of health workers
• Unavailability of trained human resources in the country
• Bad road conditions

**Strategies to address challenges to BPHS implementation**

It is necessary to develop appropriate strategies to address these challenges in order to achieve the objectives contained in the County Health Plan. The following actions are therefore recommended:

• Ensure a Grand Cape Mount County Health & Social Welfare Board (CHSWB) is set up immediately and the terms of reference/guidelines developed for its operation,
• Engage the CHSWB to facilitate the mobilization of additional resources,
• Solicit countywide commitment towards the implementation of the county health plan through the holding of a mass meeting under he leadership of the superintendent’s office, with all stakeholders including sectoral partners,
• Continuously monitor progress towards achievement of set targets of the County Health Plan
• Ensure continuous monitoring of the implementation of activity plans, as per the monitoring and evaluation activities outlined in the health plan
## Appendix 1: Details on HR and Infrastructure

### A. HR

<table>
<thead>
<tr>
<th>Staff categories</th>
<th>BPHS Standards</th>
<th>County hospital: planned</th>
<th>Current staff: total</th>
<th>Planned staff: total</th>
<th>Staffing gap</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinic (28)</td>
<td>Health center (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical doctor</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Physician assistant</td>
<td></td>
<td>3</td>
<td>14</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>1</td>
<td>6</td>
<td>22</td>
<td>25</td>
<td>3</td>
</tr>
<tr>
<td>B.Sc Nurse</td>
<td></td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>-2</td>
</tr>
<tr>
<td>Licensed practical nurse</td>
<td></td>
<td>3</td>
<td>15</td>
<td>3</td>
<td>-12</td>
</tr>
<tr>
<td>Nurse aide</td>
<td>1</td>
<td>5</td>
<td>13</td>
<td>33</td>
<td>20</td>
</tr>
<tr>
<td>Certified midwife</td>
<td>1</td>
<td>4</td>
<td>21</td>
<td>39</td>
<td>18</td>
</tr>
<tr>
<td>Trained traditional midwife</td>
<td></td>
<td>2</td>
<td>31</td>
<td>2</td>
<td>-29</td>
</tr>
<tr>
<td>Laboratory Technician</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Laboratory Aide</td>
<td></td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>-2</td>
</tr>
<tr>
<td>Dispenser</td>
<td>1</td>
<td>2</td>
<td>34</td>
<td>32</td>
<td>-2</td>
</tr>
<tr>
<td>Environmental technician</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Social worker</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Recorder</td>
<td>1</td>
<td>3</td>
<td>33</td>
<td>33</td>
<td>0</td>
</tr>
<tr>
<td>Cleaner</td>
<td></td>
<td>4</td>
<td>7</td>
<td>4</td>
<td>-3</td>
</tr>
<tr>
<td>Security</td>
<td>1</td>
<td>4</td>
<td>37</td>
<td>34</td>
<td>-1</td>
</tr>
</tbody>
</table>
## County Human Resources Planning Summary

<table>
<thead>
<tr>
<th>Staff categories</th>
<th>BPHS Standards</th>
<th>County</th>
<th>Current staff total</th>
<th>Planned staff total</th>
<th>Staffing gap</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Clinic (No. =28)</td>
<td>hospital (planned)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical doctor</td>
<td></td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacist</td>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Physician assistant</td>
<td>1</td>
<td>3</td>
<td>14</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>2</td>
<td>6</td>
<td>22</td>
<td>25</td>
<td>3</td>
</tr>
<tr>
<td>B.Sc Nurse</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>-2</td>
</tr>
<tr>
<td>Licensed practical nurse</td>
<td></td>
<td>3</td>
<td>15</td>
<td>3</td>
<td>-12</td>
</tr>
<tr>
<td>Nurse aide</td>
<td>1</td>
<td>5</td>
<td>13</td>
<td>33</td>
<td>20</td>
</tr>
<tr>
<td>Certified midwife</td>
<td>1</td>
<td>3</td>
<td>21</td>
<td>39</td>
<td>18</td>
</tr>
<tr>
<td>Trained traditional midwife</td>
<td></td>
<td>2</td>
<td>31</td>
<td>2</td>
<td>-29</td>
</tr>
<tr>
<td>Laboratory Technician</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>Laboratory Aide</td>
<td></td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>-2</td>
</tr>
<tr>
<td>Dispenser</td>
<td>1</td>
<td>2</td>
<td>34</td>
<td>32</td>
<td>-2</td>
</tr>
<tr>
<td>Environmental technician</td>
<td></td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Social worker</td>
<td></td>
<td>1</td>
<td>0</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Recorder</td>
<td>1</td>
<td>3</td>
<td>33</td>
<td>33</td>
<td>0</td>
</tr>
<tr>
<td>Cleaner</td>
<td></td>
<td>4</td>
<td>7</td>
<td>4</td>
<td>-3</td>
</tr>
<tr>
<td>Security</td>
<td></td>
<td>4</td>
<td>35</td>
<td>34</td>
<td>-1</td>
</tr>
</tbody>
</table>
Staffing
Others non medical staff under the Hospital (St. Timothy) is as follows:

<table>
<thead>
<tr>
<th>Type of Personnel</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Plumber</td>
<td>1</td>
</tr>
<tr>
<td>Electrician</td>
<td>1</td>
</tr>
<tr>
<td>County Health Administrator</td>
<td>1</td>
</tr>
<tr>
<td>Driver</td>
<td>2</td>
</tr>
<tr>
<td>Radio operator</td>
<td>1</td>
</tr>
<tr>
<td>Carpenter</td>
<td>1</td>
</tr>
<tr>
<td>Laundryman</td>
<td>2</td>
</tr>
<tr>
<td>Cook</td>
<td>3</td>
</tr>
<tr>
<td>Vaccinator</td>
<td>2</td>
</tr>
<tr>
<td>Ward clerk</td>
<td>1</td>
</tr>
<tr>
<td>CHO special assistant</td>
<td>1</td>
</tr>
<tr>
<td>Mason</td>
<td>1</td>
</tr>
<tr>
<td>Hospital Administrator</td>
<td>1</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>18</strong></td>
</tr>
</tbody>
</table>

Others Staff under the Health Center (Sinje)

<table>
<thead>
<tr>
<th>Type of Personnel</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cook</td>
<td>3</td>
</tr>
<tr>
<td>Electrician</td>
<td>1</td>
</tr>
<tr>
<td>Driver</td>
<td>1</td>
</tr>
<tr>
<td>Counselors</td>
<td>2</td>
</tr>
<tr>
<td>Vaccinator</td>
<td>2</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>9</strong></td>
</tr>
</tbody>
</table>

Clinics
Some clinics have seven instead of the six staff members as per the staffing pattern recommended by the Basic Package; this is due to the presence of a vaccinator in such health facilities. Nurses with B.Sc who are serving as OICs will be redeployed to the hospital and PA/RNs will be recruited to replace them as OICs at the selected BPHS clinics. Licensed practical nurses (LPNs) will be recommended for scholarship to further their education to become registered nurses, and if not possible, they will be recommended for
retirement. Laboratory aides and nurse aides will also be recommended to further their education to become laboratory technicians and registered nurses respectively.

**Training**

All the staff in the BPHS clinics and selected staff in the BPHS hospital will receive in-service training in the period Sept 07 to June 08 to help them implement the BPHS. For Grand Cape Mount County, training is required in IMCI, (72); HIV/AIDS,(72); PMTC, (2); Rational Use of Drugs,(12); Syndromic Management,(72); Malaria Case Management,(72); HMIS (64), VCT (10), CHWs (40 new recruited and trained) and in-service training for 76 CHWs.

**B. Infrastructure**

Grand Cape Mount County Infrastructure Plan Summary

<table>
<thead>
<tr>
<th>Facilities</th>
<th>County plan:</th>
<th>Rehabilitation</th>
<th>Build new</th>
<th>Utilities installation</th>
<th>Equipment required</th>
</tr>
</thead>
<tbody>
<tr>
<td>Government facilities:</td>
<td>June 07</td>
<td>June 08</td>
<td>Minor</td>
<td>Major</td>
<td>Upgrade</td>
</tr>
<tr>
<td>BPHS priority, June 2008</td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td></td>
</tr>
<tr>
<td>• Hospitals</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health centers</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clinics</td>
<td>14</td>
<td>13</td>
<td>11</td>
<td>2</td>
<td>1*</td>
</tr>
<tr>
<td>Total</td>
<td>16</td>
<td>16</td>
<td>12</td>
<td>3</td>
<td>1</td>
</tr>
<tr>
<td>BPHS priority after June 2008</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Hospitals</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Health centers</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Clinics</td>
<td>15</td>
<td>16</td>
<td>7</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Total</td>
<td>15</td>
<td>16</td>
<td>7</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Private</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total facilities in county</td>
<td>32</td>
<td>32</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

* Infrastructure is adequate for health center, but requires minor rehabilitation
**BPHS Facilities**

**List of 3 facilities that need major rehabilitation**
1. St. Timothy Government Hospital
2. Kongo Clinic
3. Lofa Bridge Clinic

**List of BPHS selected facilities needing minor rehabilitation:**
1. Sinje Health Center
2. Tallah Clinic
3. Kawillahum Clinic
4. Dambala Clinic
5. Kpeneji Clinic
6. Diah Clinic
7. Kulankor Clinic
8. Than Mafa Clinic
9. Jenewode Clinic
10. Varguaye Clinic

**Definition of Major and Minor Rehabilitation**

**a) Major Rehabilitation includes: (St. Timothy Hospital)**
- Complete replacement of doors
- Complete replacement of windows
- Complete replacement of damaged ceilings
- Complete replacement of damaged roofing sheets
- Complete rehabilitation of water system
- Complete rehabilitation of sewage system
-- Complete painting of hospital
-- Complete rehabilitation of the Kitchen
- Complete rehabilitation of laundry
Minor Rehabilitation includes:
- Replacement of some damaged items such as:
- Windows, doors, door locks, light bulbs, painting,
- potty, ceiling, roofing sheets, shelves, benches, chairs

Upgrading
The Dambala clinic has been selected for upgrading to health center. The upgrading of Dambala Clinic to health center is very important and urgent. This clinic is ideally located in Porkpa District and there are absolutely no referral facilities in adjacent communities. Secondly, the upgrade would reduce the time and long distance patients have to walk to reach the nearest health center.

NON-BPHS FACILITIES
There are 16 non BPHS facilities categorized as follows:
Major rehabilitation
1. Fahnja
2. Bangoma

Minor rehabilitation
1. Simbehum
2. Fanti Town
3. Madina
4. Jundu
5. Bendu
6. Kanga
7. Bendaja