GRAND BASSA COUNTY HEALTH PLAN

2007/2008

MINISTRY OF HEALTH & SOCIAL WELFARE
REPUBLIC OF LIBERIA

Date: September 26, 2007
# 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>11</td>
</tr>
<tr>
<td>3</td>
<td>Situational and Gap Analysis</td>
<td>13</td>
</tr>
<tr>
<td>4</td>
<td>County Health Facility Plan</td>
<td>26</td>
</tr>
<tr>
<td>5</td>
<td>Supervision, Monitoring and Evaluation</td>
<td>29</td>
</tr>
<tr>
<td>6</td>
<td>Implementation Challenges and Solutions</td>
<td>29</td>
</tr>
<tr>
<td>Appendix 1</td>
<td>Details on HR and Infrastructure</td>
<td>31</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>
<tr>
<td>Acronym</td>
<td>Definition</td>
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</tr>
<tr>
<td>AIDS</td>
<td>Acquired immuno-deficiency syndrome</td>
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<tr>
<td>ARV</td>
<td>Anti-retroviral</td>
<td></td>
</tr>
<tr>
<td>CBO</td>
<td>Community-based Organization</td>
<td></td>
</tr>
<tr>
<td>CDC</td>
<td>Community Development Committee</td>
<td></td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
<td></td>
</tr>
<tr>
<td>CST</td>
<td>Community Service Provider</td>
<td></td>
</tr>
<tr>
<td>DPT</td>
<td>Directly Observed Treatment</td>
<td></td>
</tr>
<tr>
<td>FBO</td>
<td>Faith-based Organization</td>
<td></td>
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<tr>
<td>GOL</td>
<td>Government of Liberia</td>
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<tr>
<td>HBLSS</td>
<td>Home-based Life Saving Skills</td>
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<tr>
<td>HFs</td>
<td>Health Facility (ies)</td>
<td></td>
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<tr>
<td>HMIS</td>
<td>Health Management Information System</td>
<td></td>
</tr>
<tr>
<td>HR</td>
<td>Human Resources</td>
<td></td>
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<tr>
<td>IEC</td>
<td>Information Education Communication</td>
<td></td>
</tr>
<tr>
<td>IPT</td>
<td>Intermittent Preventive Treatment</td>
<td></td>
</tr>
<tr>
<td>IUD</td>
<td>Intrauterine device</td>
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<tr>
<td>LFSS</td>
<td>Life Saving Skill</td>
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<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
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<tr>
<td>MOHSW</td>
<td>Ministry of Health and Social Welfare</td>
<td></td>
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<tr>
<td>MSF</td>
<td>Medecins San Frontieres</td>
<td></td>
</tr>
<tr>
<td>PA</td>
<td>Physician Assistant</td>
<td></td>
</tr>
<tr>
<td>SCF/UK</td>
<td>Save the Children Fund/United Kingdom</td>
<td></td>
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<tr>
<td>SP</td>
<td>Sulfadoxine-Pyrimethamine</td>
<td></td>
</tr>
<tr>
<td>TBA</td>
<td>Traditional Birth Attendant</td>
<td></td>
</tr>
<tr>
<td>TM</td>
<td>Traditional midwife</td>
<td></td>
</tr>
<tr>
<td>TTM</td>
<td>Trained Traditional Midwives</td>
<td></td>
</tr>
<tr>
<td>WVL</td>
<td>World Vision Liberia</td>
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</tr>
</tbody>
</table>

**Acronyms**

1. AIDS: Acquired immuno-deficiency syndrome
2. INGO: International non-governmental organization
3. ARV: Anti-retroviral
4. ANC: Antenatal clinic
5. BCC: Behavior Change Communication
6. CBSP: Community-based Service Provider
7. CHT: County Health Team
8. CM: Certified Midwife
9. DOTS: Directly Observed Treatment-Short Course
10. EPI: Expanded Program on Immunization
11. FP: Family Planning
12. HIV: Human Immuno-deficiency Virus
13. HWs: Health Worker(s)
14. HS: Health Service
15. IEC: Information Education Communication
16. IMCI: Integrated Management of Childhood Illnesses
17. IRC: International Rescue Committee
18. UNMIL: United Nations Mission in Liberia
19. M&E: Monitoring and Evaluation
20. M&E: Medical Emergency Relief and Corporative International
21. MOHSW: Ministry of Health and Social Welfare
22. PMTCT: Prevention of Mother to Child Transmission
23. NGO: Non-governmental Organization
24. RN: Registered Nurse
25. SCF/UK: Save the Children Fund/United Kingdom
26. TB: Tuberculosis
27. TT: Tetanus Toxoid
28. TTM: Trained Traditional Midwives
29. VCT: Voluntary Counseling and Testing (Center)
1. Introduction and Background

1.1 County population and geography

Grand Bassa County, established in 1833, is of historical significance and prominence as one of Liberia’s three original counties. The capital city, Buchanan, is the second largest city, in which is located the Port of Buchanan, the second major seaport in Liberia. Grand Bassa is situated in central Liberia and is bounded in the north by Bong County, in the west by Marghibi County, in the northeast by Nimba County, southeast by Rivercess County and the Atlantic Ocean on the southern border. Grand Bassa County is linked to Nimba by a railroad network that has been nonfunctional for over a decade. Grand Bassa also serves as the gateway to southeastern Liberia (Rivercess, Grand Gedeh, Maryland, Grand Kru, Sinoe, and River Gee), and is of great economic potential to these counties and neighboring countries. Therefore, a good road network is vital for inter-county trade and movement.

There are three major ethnic groups in Grand Bassa: Bassa, the majority, comprising 94% of the county’s population; Kpelle (5%), and Kissi (1%). The Kru from neighboring Sinoe County and Fanti fishermen or traders constitute a very small percentage of the population. Languages spoken include Bassa (dominant), Kpelle, Kissi, Kru and Fanti. Grand Bassa County is sub-divided into five political districts: 1) Dian 2) Kpoegbanmain 3) Glarkon, 4) Neekreen and 5) Wee. Like most places in Liberia, the County experienced the perils of war, evidenced by the loss of lives, destruction of properties, social and economic infrastructures such as schools, hospitals, clinics, roads and bridges.

With an estimated population of 200,556, Grand Bassa played host to a multitude of international and national extraction and logging companies prior to the civil war. Its capital city Buchanan, located 89.4 miles from Monrovia, was a thriving commercial/economic hob in pre-war Liberia. However, the protracted period of civil conflict led to near decimation of all commercial and economic infrastructures.

Currently, the Liberia Agriculture Company (LAC), the second largest rubber plantation in Liberia (Firestone rubber plantation being the largest), is located in the County and along with the Liberia Mining Company (LIMINCO), provide employment for a small proportion of the population. The Liberia American Mining Company (LAMCO), processed and exported iron ore from Grand Bassa before the war, providing immense employment opportunities. With the folding and departure of companies during the war years, unemployment skyrocketed, increasing migration towards Monrovia and changes in livelihood patterns.

The health care delivery system in Grand Bassa like elsewhere in Liberia was demolished by the war. The Liberian Government Hospital, located in Buchanan, has been a mainstay in the health system. Nongovernmental organizations (NGOs) and private institutions are currently providing most of the health services in the county’s seven health districts.
1.2 Administrative structure of Grand Bassa County and organization chart

The Superintendent of Grand Bassa County is the representative of the President of Liberia in the county. She has oversight responsibility for the county, and is assisted by an Assistant Superintendent for Development, who is responsible for the coordination of development activities in the county, including the formulation of county development agenda and a five-year county plan. There is a Superintendent Council headed by the Superintendent, which serves as an advisory council. Buchanan houses the administrative seat of the county with the county administrative building and City Corporation. The office of the superintendent, district commissioners and line ministry officials are represented in county officials’ deployment. All five districts of Grand Bassa County have their respective District Development Committee (DDCs).

The organogram below shows the administrative structure of Grand Bassa 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.
1.3 Health Indicators

Information about the health status of the Liberian population is still dependant upon national surveys since the regular reporting system from health facilities has not yet recovered. The most recent data comes from the Liberian Demographic and Health Survey of 2007. Information from that survey and other special studies is presented here.

Mortality rates in children have been improving:

- Neonatal Mortality (under 1 month) 32 /1000
- Infant mortality (under 1 year) 72 /1000  (down from 117 in 1999/2000)
- Under five mortality 111 /1000  (down from 194 in 1999/2000)
There is no recent data on maternal mortality, and the last ratio was 580 / 100,000.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Total Liberia*</th>
<th>Urban*</th>
<th>Rural*</th>
<th>North Central*</th>
<th>Grand Bassa County**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Maternal health</td>
<td></td>
<td></td>
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<tr>
<td>Antenatal care at least once from Skilled Attendant (%)</td>
<td>79.3</td>
<td>94.4</td>
<td>71.6</td>
<td>63.4</td>
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<tr>
<td>Last birth protected from tetanus (%)</td>
<td>77.5</td>
<td>90.4</td>
<td>71.0</td>
<td>74.8</td>
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<tr>
<td>Last birth attended by Skilled Attendant (%)</td>
<td>46.4</td>
<td>78.8</td>
<td>32.2</td>
<td>32.7</td>
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<tr>
<td>Last delivery at a health facility (%)</td>
<td>37.1</td>
<td>63.5</td>
<td>25.5</td>
<td>31.0</td>
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<td>Birth spacing</td>
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<tr>
<td>Women (couples) using a modern contraceptive (%)</td>
<td>10.2</td>
<td>16.3</td>
<td>7.1</td>
<td>7.7</td>
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<tr>
<td>Child health</td>
<td></td>
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<tr>
<td>Percent children 12-23 mo who received:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>• BCG</td>
<td>77.1</td>
<td>91.5</td>
<td>70.2</td>
<td>71.6</td>
<td></td>
</tr>
<tr>
<td>• DPT3</td>
<td>50.3</td>
<td>69.5</td>
<td>41.0</td>
<td>46.1</td>
<td></td>
</tr>
<tr>
<td>• Measles</td>
<td>63.3</td>
<td>76.7</td>
<td>56.8</td>
<td>59.6</td>
<td></td>
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<tr>
<td>% UFC with ARI treated at health facility</td>
<td>69.6</td>
<td>80.7</td>
<td>66.1</td>
<td>73.2</td>
<td></td>
</tr>
<tr>
<td>% UFC with fever treated at health facility</td>
<td>58.2</td>
<td>76.5</td>
<td>50.8</td>
<td>50.7</td>
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<tr>
<td>% children under 5 years: underweight</td>
<td>18.8</td>
<td>17.0</td>
<td>19.6</td>
<td>19.6</td>
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<tr>
<td>% children under 5 years: severely underweight</td>
<td>5.7</td>
<td>5.5</td>
<td>5.9</td>
<td>5.6</td>
<td></td>
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<tr>
<td>Infants exclusively breast-fed for 6 months (%)</td>
<td>28.8</td>
<td></td>
<td></td>
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<tr>
<td>Infants 6-9 months receiving complementary foods (%)</td>
<td>62.4</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>Disease Control</td>
<td></td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Households with at least one mosquito net (%)</td>
<td>30.4</td>
<td>31.3</td>
<td>29.9</td>
<td></td>
<td></td>
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<tr>
<td>Women, 15-49 years who are HIV positive (%)</td>
<td>1.8</td>
<td>2.8</td>
<td>1.1</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Men, 15-49 years who are HIV positive (%)</td>
<td>1.2</td>
<td>2.1</td>
<td>0.6</td>
<td>0.7</td>
<td></td>
</tr>
<tr>
<td>Men &amp; women, 15-49 years: HIV positive (%)</td>
<td>1.5</td>
<td>2.5</td>
<td>0.8</td>
<td>0.6</td>
<td></td>
</tr>
<tr>
<td>Expected annual incidence rate of sputum +ve TB per 1000 population. ***</td>
<td>1.32</td>
<td></td>
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</tbody>
</table>

* North Central: Bong, Nimba, Lofa. ** Data from County Health Office. *** Data from National Tuberculosis Program.
1.4 Description of current county health system

1.4.1. Health Facilities

Number and type of facilities and services provided (public and private)

- There are 31 functional health facilities out of a total 34 (91%)
- There are 3 Hospitals; 1 Health Centre; 20(GOL) clinics, 7 (private) clinics
- 15 HFs (49%) are being supported by NGOs (Merlin)

1.1. Description of health issues and disease burden and existing preventive and control strategies and programs

- Maternal and Newborn Care
  - 103% of pregnant women receiving 2+ TT vaccinations
  - 41% of TT2+ non pregnant

- Child Health
  - DPT3 coverage in under 1 yr old: 91%
  - Total malaria episodes treated June 2006-June 2007: No Information

- Adolescent, Sexual and Reproductive Health No Information

- Disease Control No Information
  - HIV/AIDS: total tested ………., positives ………, negatives ………
  - TB: total cases……..total positive ………., total negative ……. and EP……..
  - Malaria…
### 1.4.2 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. Jerry F. Brown</td>
<td>County Health Officer</td>
<td>06529072</td>
</tr>
<tr>
<td>2.</td>
<td>Isaac W. Duah</td>
<td>County Heath Service Administrator</td>
<td>06527698</td>
</tr>
<tr>
<td>3.</td>
<td>Morris Kessely</td>
<td>Community Health Department Director</td>
<td>06528343</td>
</tr>
<tr>
<td>4.</td>
<td>Thomas Siazia</td>
<td>County Clinical Supervisor</td>
<td>077940471</td>
</tr>
<tr>
<td>5.</td>
<td>James Kollie</td>
<td>County Pharmacist</td>
<td>077066401</td>
</tr>
<tr>
<td>6.</td>
<td>E. Menka Nuah</td>
<td>County EPI Supervisor</td>
<td>06520937</td>
</tr>
<tr>
<td>7.</td>
<td>Stephen B. Wanaah</td>
<td>County Hospital Administrator</td>
<td>077030112</td>
</tr>
<tr>
<td>8.</td>
<td>Matthew Geesay</td>
<td>County Surveillance Officer</td>
<td>077350556</td>
</tr>
<tr>
<td>9.</td>
<td>Joyce W. Garblah</td>
<td>County Nursing Director</td>
<td>06575101</td>
</tr>
</tbody>
</table>
Blue indicates existing structure.; orange is proposed by MOH white required per Plan
1.4.3 Partnerships (NGOs, private sector)

The major health sector partners in Grand Bassa County are African Christian Fellowship International (ACFI), Brenda Kings (Lighthouse Ministries of Jesus Christ), Catholic Health Secretariat, Camphor Mission, Christian Extension Ministries (CEM), Joriam, Liberia Agriculture Company (LAC), Merlin, Mittal Steel, Worldwide Mission

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

For the fiscal year 2007-2008, the budgetary allocation to the Grand Bassa CHT is USD 35,000 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 200 gallons while the county health team gets 300 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

2.1 The National Health Policy and Plan

County health planning is built upon the foundation of the National Health Policy and Plan, and needs to be consistent with them.

The National Health Policy (January 2007) is to: 1) expand access to a basic package of health care by investments in infrastructures, human resources and decentralized management; and 2) establish the building blocks of an equitable, effective, lean, responsive and sustainable decentralized health care delivery system.

The mission of the Ministry of Health and Social Welfare is to reform the sector to effectively deliver quality health and social welfare services to the people of Liberia. The MoH&SW is dedicated to equitable, accessible and sustainable health promotion and protection and the provision of comprehensive and affordable health care and social welfare services. Liberia’s vision is improved health and social welfare status and equity in health; therefore becoming a model of post-conflict recovery in the health field.

The guiding principles and strategic orientations include:

- Health as a Basic Human Right
- Equity, Gender and Poverty Focus
- Efficiency and Sustainability
Objectives of the National Health Plan (February 2007)

a) Basic Package of Health Services
   - Improved child health
   - Improved maternal health
   - Increased equitable access to quality health care services
   - Improved prevention, control and management of major diseases
   - Improved nutrition status

b) Human Resources
   - Ensure a coordinated approach to human resource planning;
   - Enhance health worker performance, productivity and retention;
   - Increase the number of trained health workers and their equitable distribution; and
   - Ensure gender equity in all aspects of employment in health.

c) Infrastructure

Increasing access to PHC is a key objective of the National Health Plan. Since health clinics and health centers make up more than 90% of health facilities, they are the key to increasing access to PHC. The infrastructure plan prioritizes restoring and reforming the capacity of health clinics and health centers to provide the BPHS and increase access to PHC. However, county and referral hospitals will also not be forgotten.

d) Support Systems

The priority and primary objective of the support systems component will be to develop the capacity of County Health Teams (CHT) to take charge of the planning process and resource coordination of development partners to shift from the humanitarian to development model before the end of 2008.
To this end, the support systems capacity-building process will begin with Planning & Budgeting, Health Management Information System, Supervision, Drugs & Medical Supplies and Stakeholder Coordination.

2.2 County Planning Process

The Grand Bassa County Health Interim Plan (2007-2008) was elaborated at a crucial time in the history of the Liberian nation. The decades of the civil conflict have also affected the health sector of the County. The situation is further compounded by the sudden decline of NGOs supported facilities. The revitalization of the 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 BPHS in the county during the interim period.

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 Grand Bassa 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 NHP is also linked to Pillar Four (Infrastructure and Basic Social Services) of the Interim Poverty Reduction Strategy (iPRS) of the Liberian Government, as well as the UN Millennium Development Goals of 2015.

Formulation of the Grand Bassa 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 Bassa County Health Planning Workshop (September 25-28, 2007) was organized by the Grand Bassa 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, members of the House of Representatives, local authorities and the 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 10 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. 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 Bass County Health System

A situational analysis puts into perspective the strengths and weaknesses of the Grand Bass 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**
- Availability of CHWs that are involved in public awareness activities at the community level
- Availability of TTM that are involved in deliveries within the community; also involved in referral of pregnant women to HF
- Existence of the CHCs that act as liaison/link between health services (HF) and communities

**Underlying factors/causes**
- Training of CHW by CHT in collaboration with partners
- Community feels its partner in health service and ensuring ownership for sustainability

**Weaknesses**
- Limited number of CHW

**Underlying factors/causes**
- CHW leaving for jobs that pay - job security

2. Health Facility Level

**Strengths:**
- IEC/BCC daily at all GOL health facilities
- ANC ongoing at all HFs
- OPD operating regularly with no problems
- EPI services at 30 of 31 HFs
- 20 of 21 GOL health facilities conduct outreach EPI activities

**Underlying factors** Availability if HW to provide services
- Support of GOL and partners

**Weaknesses/gaps/unmet needs**
- Inadequate number of HWs in quantity and quality
- Majority of HWs not on GOL payroll
- Drugs supply often irregular – stock out frequent
- HWs threatening to leave hospital for assignment at clinics

**Underlying factors**
- HR shortage due to prolonged years of civil war
- GOL low budget and policy of “hold” on employment
• Delayed replenishment by NDS
• Incentive not uniform for same category of HW in GOL-supported HF and NGO-supported HF; GOL scale higher than that of the NGOs and being paid to clinic-level HWs

B. Maternal and Newborn Care

Community level
Strengths
• About 50% of referrals (of pregnant women with complications) by TTM are timely

Underlying factors/causes
• Refresher training done by CHT and NGO partner, MERLIN
• Monthly TTM meetings
• Daily health education

Weaknesses/gaps/unmet needs:
• About 50% of referrals (of pregnant women with complication) is delayed

Underlying factors/causes
• Bad road condition
• Lack of decision making power by the pregnant woman
• TBAs interference
• Ignorance of signs of complication and determination to perform deliveries at home using cultural practices (e.g. application of herbs and birth/delivery aids such as the cook spoon and the mortar pestle)

Health Facility Level
Strengths
• 85% of maternal and newborn service provided at HF

Underlying factors/causes
• Availability of trained HWs
• GOL and NGO support

Weaknesses/gaps/unmet needs:
• 15% of maternal and newborn service not provided at HF but within the community
• TTM providing maternal and newborn services in 20 of 21 GOL (public) HFs;
• Less than 50% (only 39%) of HFs have CMs
• No ITNs distribution at ANC
The **underlying factors**
- Inadequate amount of HWs (esp. CMs) to provide maternal and newborn service
- Delay at the community level in making referrals;
- ITNs not available

**C. Child Health:**

**Community Level:**

**Strengths:**
- CHWs and hygiene promoters undertaking public awareness on child health including EPI

**Weaknesses/gaps/unmet needs:**
- Decrease in number of CHW who conduct health education
- Late submission of reports by CHWs

The **underlying factors/causes**
- CHW not motivated due to lack of incentives; leaving for greener pastures
- Inadequate number due to high turnover of CHWs; CHWs are moving out in search of job security

**Facility Level**

**Strengths**
- 81% of HF doing growth monitoring
- Coverage of EPI antigens
  - DPT3 = 91%
  - Polio3 = 88%
  - Measles and yellow fever = 103%
  - BCG = 91%
  - TT2 ≥ 90%

The **underlying factors/causes**
- Good GOL and donor support
- Regular health education
- Regular outreach services

**Weaknesses/gaps/unmet needs:**
- 19% of HF not implementing growth monitoring
- No therapeutic feeding for malnutrition at HFs
- Low TT2 coverage for non-pregnant women (41%)
Underlying factors/causes
- Lack of funding/support for growth monitoring in all clinics
- The CHT believes that the low TT2 coverage could be due to missing vaccination card of women

D. Reproductive and Adolescent Health
1. Community level
Strengths
- CHW undertake awareness programs on FP and safe delivery
Underlying factor/causes
- Empowerment of CHW through training by CHT and partners
Weaknesses/gaps/unmet needs:
- Decrease in number of CHW who conduct community awareness
- Irregular/intermittent replenishment of TTM delivery kits
- No gloves for use by TTM
Underlying factors/causes
- Inadequate number due to high turnover of CHWs; CHWs are moving out in search of job security
- FHD/MOH and partners delay in providing TTM working materials
- Gloves not included on supply list - policy

2. Health Facility
Strengths
- Daily health education at HFs
- In-service training conducted for STI awareness at all GOL health facilities
- FP services provided by 17 of 21 GOL facilities
- Syndromic management of STI by all HFs
Underlying factors
- GOL and partners support through CHT
Weaknesses
- Poor condition of delivery beds/equipment/supplies
- Inadequate drug supply
- Lack of trained HW
Underlying factors/causes
- No funds for purchase of new/better quality delivery equipment and supplies
- Delay in supply of drugs by NDS
• Chronic national problem of HR shortage

E. Disease Control – HIV/AIDS

1. Community Level
Strengths
• Active HIV/AIDS awareness activities at the community level by CHWs and hygiene promoters
Underlying factors
• Regular training of CHW and hygiene promoters
Weaknesses
• HIV awareness not covering all communities
Underlying factors
• Limited number of CHWs

2. Health Facility Level
Strengths
• Existence of 8 VCT centers in Grand Bassa County
• ARV drugs available at the county/GOL hospital
• 80% of ANC attendants submitting to voluntary testing for HIV at two hospitals
Underlying factors
• GOL and partners support
• Availability of trained HW in administering ARV
• Intensive awareness undertaken by the CHT
Weaknesses
• Limited health promotion programs being done in communities and through the radio
Underlying factors
• Lack of support
• Inadequate HR and materials for IEC/BCC

F. Disease Control – TB
1. Community Level:
• There is no active TB awareness activities at the community level; there is limited support from the central level/National Leprosy/TB Control program
2. Facility Level

Strengths
- Availability of testing services (sputum) at 5 of 31 functional HFs
- Availability of 6 treatment centers
- Availability of regular supply of drugs

Underlying factor:
- GOL and partners support including GFATM

Weaknesses
- Acute shortage of pediatric drugs
- Limited health promotion programs being done at HF and through the radio

Underlying factor/causes
- Lack of support from the central level
- Inadequate HR and IEC/BCC materials

G. Disease Control – Malaria

Community level

Strengths:
- Community awareness of malaria ongoing by CHW and hygiene promoters

Underlying factors:
- Empowerment of CHW and hygiene promoters through training by CHT and partners

Weaknesses:
- Limited health promotion activities ongoing

Underlying factors:
- Lack of human resource and IEC/BCC materials

2. Facility Level:

Strengths:
- Daily IEC/BCC activities at HFs
- All HF administering ACT
- SP given at ANC

Underlying factors/causes
- Commitment of trained
- Availability of trained HW
Weaknesses

- No distribution of ITNs at ANC
- Supply of SP limited esp. at non-NGO supported HFs
- Regular stock out of ACT

Underlying factors/causes

- No ITNs available for ANC
- Limited supply given by NDS based on quota system and not on need or utilization

F. Mental Health:

- There is no organized Mental Health or Social Welfare program in Grand Bassa County; The Mental Health program is not fully developed at the national level

G. Essential Emergency Treatment:

1. Community Level

   Strengths
   - TTM make timely referrals for about 50% of complicated pregnancies

   Underlying factors/causes
   - Refresher training done by CHT and NGO partner, MERLIN
   - Monthly TTM meetings
   - Daily health education

2. Facility Level

   Strengths
   - Availability of one ambulance
   - Referral guidelines developed and available for distribution

   Underlying factors/causes
   - Support of GOL and partners
   - Initiative of CHT

   Weakness/gap/unmet needs
   - Lack of communication network between and among HFs (in Liberia) to alert and prepare HFs for incoming referrals/emergency cases
   - Lack of trained manpower to handle various categories of health emergencies

   Underlying cause
   - Lack of initiative by CHTs nationwide to use existing VHF radios to establish communication network between health facilities at all levels
   - No system communication established by MOHSW between health facilities
II. Human Resource
Strengths
• Availability of approx. 280 HWs for the Grand Bassa County health system
• Availability of three NGO partners
• Existence of an organized CHT
• Existence of CHW/TTMs/CHCs

Underlying factors
• Support of MOHSW/GOL
• Incentives given by NGOs
• Support of local authorities
• Training provided by CHT with support of NGO partners

Weaknesses
• Uneven distribution of HWs
• Poor quality of HWs; About 75% of HWs not qualified
• High attrition of HWs

Underlying factors
• Lack of human resource plan
• Majority (about 93%) of HWs not on GOL payroll
• No benefits such as housing/accommodation for HWs
• Low salaries

III. Infrastructure
Strengths
• Existence of 31 functional HF out of 34 with:
  - incinerators (90%),
  - safe drinking water (80%),
  - toilets (80%)
  - lights (13%)

Underlying factors
• GOL, NGO, local authorities and community support
Weaknesses
- 16% of HF inaccessible
- Some HFs in poor physical condition: 50% poorly constructed, 10% in makeshift structures
- No staff quarters for all (100%) HFs

Underlying factors
- Bad road condition/no road
- No community participation in HF site selection;
- Poor infrastructure plan

IV. Support System

1. Policy formulation and implementation
   Strengths
   - Policy issues are discussed/shared with partners at monthly coordination meetings
   - Existence of a structure (CST meeting) for discussion of policy issues
   - Policy matters internally discussed by CHT
   Underlying factors
   - Good leadership of the County Health Team
   - Strong, united, committed CHT
   Weaknesses
   - Policy documents lacking in county, only found at the central level
   - Some HFs not fully adhering to policy
   Underlying factors
   - Central level slow distribution/circulation of policy documentation
   - Ignorance, lack of within county training to make HWs aware of policy provisions

2. Planning and Budgeting
   Strengths
   - CHSA trained in budgeting
   - Four members of the CHT trained in Health Systems Management – planning, budgeting, supervision, M&E
   Underlying factors
   - Availability of training opportunities
   Weaknesses
Not all members of the CHT trained in planning and budgeting

**Underlying factors**
- Limited resources

### 3. Human Resource Management and in-service training

**Strengths**
- Availability of qualified HW at 25% of HF
- Regular in-service training provided
- 75% of HWs receive incentives from NGO
- Some HW (20 out of 280 or 7%) on GOL payroll

**Underlying factors**
- MOHSW recruitment/deployment of HW
- Support of GOL and partners

**Weaknesses**
- Majority (93%) of HW not on GOL payroll
- Inadequate amount of HW (both quality and quantity)

**Underlying factors**
- Limited MOH/GOL budget
- Refusal of some qualified HW to work in rural Liberia
- Lack of housing/accommodation for HW

### 4. Health Management Information System

**Strengths**
- Availability of HMIS focal point/staff with the required skills

**Underlying factors:**
- Availability if training opportunity by MOH
- Personal initiative by staff to obtain computer skills

**Weaknesses**
- HMIS unit lacks equipment and supplies (computer, etc)

**Underlying factors**
- Limited financial resources on the part of MOH/GOL
5. Drugs and Medical Supplies

**Strengths**
- Availability of drug depot in county
- Availability of a pharmacist
- Have a drug distribution focal point and a deputy
- Availability of drugs and medical supplies some of the time

**Underlying factors:**
- GOL resource mobilization effort
- Support of MOHSW and partners

**Weaknesses**
- Delayed submission of drug reporting forms
- All MOH/GOL health facilities experience monthly stock out of essential drugs

**Underlying factors**
- Inadequate supply of drugs and medical supply; partners not meeting up with MOU
- Lack of understanding of drug reporting forms
- MOH and NGO poor coordination of drug supply

6. Facility and Equipment maintenance

**Strengths**
- Existence of a maintenance department with some staff (plumber, carpenter, electrician)
- Some maintenance done for HF and equipment

**Underlying factors**
- Some degree of budgetary allocation, although small

**Weaknesses**
- Fuel supply inadequate and delivery late, untimely
- Inadequate maintenance team; some maintenance is done by hired personnel
- Approx. 80% of HF as well as medical equipment not regularly

**Underlying factors**
- Delay in supplying occurs at the central MOHSW
- Limited GOL resources
- Unwillingness of NGOs to share their maintenance staff
7. Logistics and Communication

Strengths
- One logistician (for the county hospital)
- The following logistical and communication support are in Grand Bassa county and functional:
  - one ambulance
  - three vehicles (1 jeep, 2 pick-ups)
  - three motorcycles
  - mobile phone (attached to the county hospital)

Underlying factors:
- GOL resource mobilization efforts
- Staff recruitment/deployment by MOHSW

Weaknesses
- There is no IEC/BCC focal point
- The following logistical and communication support are in the county but non-functional:
  - 9 motorbikes,
  - 1 VHF radios
- There are no bicycles

Underlying factors
- Low/limited GOL budget

8. Supervision, Monitoring and Evaluation, Research

Strengths
- CHT undertakes joint supervision with partners
- Availability of county registrar with some training in data management
- Availability of 7 district surveillance officers
- Data clerk available and currently undergoing training in data entry

Underlying factors
- MOHSW support to CHT

Weaknesses
- Reporting system is weak

Underlying factors/causes
- Limited central level support
9. Stakeholder Coordination and Community Participation

Strengths
- Existence of mechanism (monthly meeting) for coordination of all partners’ activities
- Most communities have Community Health Committees (CHCs); 10% are active

Underlying factors/causes
- Strong CHT leadership

Weaknesses
- Monthly coordination meetings not regular
- Majority of CHCs not active
- CHC members seem not to clearly know their roles/responsibilities

Underlying factors/causes
- Competing priorities

County Health Plan: Facility Plan

Strategic 3-4 year facilities plan
The Grand Bassa County Health Team has considered the needs for health facilities in the county. Equitable distribution of health facilities is desired in order to improve access to primary health and referral care to as many people as possible. A medium term plan for 3 to 4 years proposes the following improvements to the existing network of health facilities in the county.

Eighteen new clinics are proposed to provide services for currently unserved or underserved communities:

<table>
<thead>
<tr>
<th>Location</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kings Town</td>
<td>District 1</td>
</tr>
<tr>
<td>Nathan Page Town</td>
<td>District 1</td>
</tr>
<tr>
<td>Zaye Town</td>
<td>District 1</td>
</tr>
<tr>
<td>Gayegbokon</td>
<td>District 2</td>
</tr>
<tr>
<td>SOS Community</td>
<td>District 2</td>
</tr>
<tr>
<td>Kpu Jimmy</td>
<td>District 2</td>
</tr>
<tr>
<td>Kuenka Town</td>
<td>Campwood</td>
</tr>
<tr>
<td>Garneo Town</td>
<td>Campwood</td>
</tr>
<tr>
<td>Nanglay Town</td>
<td>Campwood</td>
</tr>
<tr>
<td>Seneweh</td>
<td>District 3</td>
</tr>
</tbody>
</table>

26
Referral services for emergency cases (severe and complicated illness) are found in health centers and the hospital. The hospital and health centers are proposed in order to have referral centers in the most easily accessible location for a cluster of clinics and the communities in their catchment areas.

**Five** new health centers or upgrades are proposed in the following locations:

<table>
<thead>
<tr>
<th>Location</th>
<th>District</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bokay Town</td>
<td>Owensgrove</td>
</tr>
<tr>
<td>Compound #2</td>
<td>District #2</td>
</tr>
<tr>
<td>Gardour</td>
<td>District #3</td>
</tr>
<tr>
<td>Nyonbeh Town</td>
<td>District #4</td>
</tr>
<tr>
<td>Senyah</td>
<td>Campwood</td>
</tr>
</tbody>
</table>
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 Bassa 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 facilities) 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, and
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 Bassa County Health Plan (2007-2008). These include the following:

- Difficulty in channeling information for the county at central level
- Difficulties in implementing the decentralization policy at the county level
- Lack of support from local authorities in mobilization of needed resources
- Limited motivation/incentive for staff
- Rapid turnover of health workers
- Unavailability of trained human resources in the country
- Unavailability of training and IEC/BCC materials and difficulty obtaining them from central office in a timely fashion
- Bad road conditions

Strategies to address challenges to BPHS implementation

It is necessary to develop appropriate strategies to address the possible challenges in order to achieve the objectives contained in the County Health Plan. The following solutions are recommended:
• Ensure that a County Health & Social Welfare Board (CHSWB) is set up immediately and terms of references (TORs) and guidelines is developed.
• Engage the CHSWB to facilitate the mobilization of additional resources
• Engage county civil authorities for the mobilization of additional resources for the successful implementation of the County Health Plan
• Obtain the commitment of county civil authorities towards the implementation of the County Health Plan
• Engage other line Ministries (particularly Ministry of Public Works and Utilities) in facilitating the successful delivery of health services and to make them more accessible especially to hard to reach areas (e.g., reconditioning bad road, creating new roads etc.).
• Engage central Ministry constructively, for the timely disbursement of funds and delivery of needed materials for the successful implementation of the Plan.
• Ensure continuous monitoring of progress towards the County Health Plan’s agreed targets and implementation schedule as per the monitoring and evaluation activities outlined in the Plan.
Appendix 1: Details on Human Resources and Infrastructure for Grand Bassa County

A. Human Resources (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 (9)</td>
<td>Health center (2)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical doctor</td>
<td>2</td>
<td></td>
<td>1</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Pharmacist</td>
<td>2</td>
<td></td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Physician assistant</td>
<td>2</td>
<td>3</td>
<td>14</td>
<td>17</td>
<td>3</td>
</tr>
<tr>
<td>Registered Nurse</td>
<td>1</td>
<td>2</td>
<td>22</td>
<td>25</td>
<td>3</td>
</tr>
<tr>
<td>B.Sc Nurse</td>
<td>1</td>
<td>2</td>
<td>7</td>
<td>5</td>
<td>-2</td>
</tr>
<tr>
<td>Licensed practical nurse</td>
<td>1</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>1</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>1</td>
<td>2</td>
<td>4</td>
<td>2</td>
<td>-2</td>
</tr>
<tr>
<td>Dispenser</td>
<td>1</td>
<td>1</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>1</td>
<td>33</td>
<td>33</td>
<td>0</td>
</tr>
<tr>
<td>Cleaner</td>
<td>1</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>

Clinics

Some clinics have seven staff members instead of the six staff members recommended by the Basic Package; this is due to the presence of a vaccinator. Nurses holding B.Sc degrees serving as Officers –in-Charge (OICs) will be redeployed to the hospital, while physicians’ assistants (PA) and registered nurses (RN) will be recruited to replace nurses with B.Sc. degrees as OICs at the BPHS clinics. Licenses practical nurses (LPNs) will be recommended for scholarship to further their education to become registered nurses or if not possible will be recommended for retirement. Laboratory aides and nurses’ aides will also be recommended to further their education to become laboratory technicians and registered nurses respectively.
### Staffing

**Others: non-medical staff under the Hospital (Liberian Government Hospital) is as follows:**

<table>
<thead>
<tr>
<th>Type of Personnel</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>County Health Services Administrator</td>
<td>1</td>
</tr>
<tr>
<td>Hospital Administrator</td>
<td>1</td>
</tr>
<tr>
<td>Assistant Hospital Administrator</td>
<td>2</td>
</tr>
<tr>
<td>CHO special assistant/ secretary</td>
<td>1</td>
</tr>
<tr>
<td>Laundryman</td>
<td>5</td>
</tr>
<tr>
<td>Cook</td>
<td>6</td>
</tr>
<tr>
<td>Vaccinator</td>
<td>0</td>
</tr>
<tr>
<td>Ward clerk</td>
<td>15</td>
</tr>
<tr>
<td>Carpenter</td>
<td>2</td>
</tr>
<tr>
<td>Mason</td>
<td>2</td>
</tr>
<tr>
<td>Driver</td>
<td>4</td>
</tr>
<tr>
<td>Logistician</td>
<td>1</td>
</tr>
<tr>
<td>Radio operator</td>
<td>2</td>
</tr>
<tr>
<td>Electrician</td>
<td>2</td>
</tr>
<tr>
<td>Housekeeping/Cleaners</td>
<td>12</td>
</tr>
<tr>
<td>Plumber</td>
<td>2</td>
</tr>
<tr>
<td>Security</td>
<td>10</td>
</tr>
<tr>
<td>Grounds keepers</td>
<td>3</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>65</strong></td>
</tr>
</tbody>
</table>

**Others: Staff under the Health Center (Catholic private facility not included in the BPHS planning)**

<table>
<thead>
<tr>
<th>Type of Personnel</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Training
All the staff in the BPHS clinics and selected staff in the BPHS hospitals will receive in-service training in the period Sept 07 to June 08 to help them implement the BPHS. In Grand Bassa County, training is required in:
- Integrated management of childhood illnesses (IMCI) (75);
- HIV/AIDS (35);
- Prevention of mother to child transmission (PMTCT) of HIV/AIDS (25);
- Rational Use of Drugs (31);
- Syndromic Management (75);
- Malaria Case Management (75);
- HMIS (4),
- VCT (10),
- CHWs in-service training for 100 CHWs.

B. Infrastructure
Grand Bassa County Infrastructure Plan Summary

<table>
<thead>
<tr>
<th>Government facilities:</th>
<th>Facilities June 07</th>
<th>County plan: June 08</th>
<th>Rehabilitation</th>
<th>Build new</th>
<th>Utilities installation</th>
<th>Equipment required</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td>Minor</td>
<td>Major</td>
<td>Upgrade</td>
<td></td>
</tr>
<tr>
<td>BPHS priority, June 2008</td>
<td>Hospitals</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Health centers</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td>Clinics</td>
<td>9</td>
<td>9</td>
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</tr>
<tr>
<td></td>
<td>Total</td>
<td>10</td>
<td>10</td>
<td>2</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>BPHS priority after June 2008</td>
<td>Hospitals</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>Health centers</td>
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<td>Total</td>
<td>23</td>
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<td>18</td>
<td>23</td>
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</tr>
<tr>
<td>Private</td>
<td>10</td>
<td>10</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total facilities in county</td>
<td>31</td>
<td>31</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

List of (8) facilities that need major rehabilitation

1. Liberian Government Hospital
2. Bokay Town Clinic
3. Compound #2 Clinic
4. Compound #3 Clinic
5. Gardour Clinic
6. Nyonbeh Town (Foster Clinic)
7. Owensgrove Clinic
8. Senyah Clinic

List of BPHS selected facilities needing minor rehabilitation include:

1. Lloydsville
2. Wellbaby

Definition of Major and Minor Rehabilitation

a) Major Rehabilitation includes:

- 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
b) 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

Upgrading five existing clinics to health centers is critical in strategically positioning health facilities to ensure and improve access to basic health services. The following clinics have been selected for upgrading because they are ideally located in areas where no referral facilities exist in proximity to these sites or other adjacent catchment populations. They include: Compound #2 located in District #2, Gourdua in District #3, Nyonbeh Town (Foster Clinic) located in District #4, Bokay Town Clinic located in Owensgrove District and Senyah Clinic in Campwood District. More importantly, their strategic locations would ensure significant reduction in the travel time and long distances patients have to walk to reach to a nearby facility.

**NON-BPHS FACILITIES**

There are 10 non BPHS facilities categorized as follows:

<table>
<thead>
<tr>
<th>Major rehabilitation</th>
<th>Minor rehabilitation</th>
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<tbody>
<tr>
<td>1. Boerglay</td>
<td>1. Barsegiah</td>
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<tr>
<td>2. Compound # 4</td>
<td>2. Edina</td>
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<td>3. Desso</td>
<td>3. Sue town</td>
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<td>4. Jacob Latay</td>
<td>4. Tubmanville</td>
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<td>5. Little Bassa</td>
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<td>6. Little Kola</td>
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<td>7. St. John</td>
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**Nonfunctional clinics**

1. Civil Compound #1
2. Harmonville
3. On Your Own