

NATIONAL SEXUAL & REPRODUCTIVE HEALTH POLICY
MINISTRY OF HEALTH & SOCIAL WELFARE
REPUBLIC OF LIBERIA



FEBRUARY 2010

FOREWORD

Sexual and reproductive health (SRH) concerns the well-being of women, as well as that of their partners and offspring. It has been realized that achievement of Millennium Development Goals (MDGs) in African countries is unlikely without significant improvements in the SRH of its citizens. Consequently, the government of Liberia recognizes that improving SRH is key to the nation's development.

Emerging from nearly two decades of civil conflict that destroyed basic health infrastructures, Liberia is now faced with numerous challenges in the improving the health system. These issues are particularly grave in the area of SRH, as evidenced by the alarming high maternal mortality rate, which has virtually doubled in the past seven years. In addition Liberia has an extremely high adolescent fertility rate, a high unmet need for family planning, and on-going problems with sexual and gender-based violence (SGBV). These indicators highlight the need for an aggressive and comprehensive SRH policy to guide the implementation of evidenced-based interventions that improve the sexual and reproductive health of Liberians. This Policy provides concrete areas of focus as outlined in the Maputo Plan of Action for ensuring that Liberia meets its commitment to women and children as set forth in the MDGs. It addresses reproductive health and rights challenges faced by citizens of Liberia and calls for strengthening the health sector by increasing resource allocation to improve access to SRH services.

This document is designed to be used by policymakers, program managers and planners at all levels in both public and private sectors in SRH. It forms the basis and mandate for all SRH activities, outlining the national strategic direction for improving SRH in Liberia. It will also enable us forge new partnerships - between governments and communities, nongovernmental organizations, development partners and the private sector - that are critical if we are to succeed in the implementation of essential SRH services.

On behalf of the Ministry of Health and Social Welfare, I convey my gratitude to all members of the Reproductive Health Technical Committee (RHTC) for the dedicating their time to finalizing this Policy. The Ministry is also grateful to line ministries, training institutions, health institutions, professional organizations, local and international NGOs, development partners and individuals who participated and contributed to the validation of this National SRH Policy.

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ACRONYMS

ANC	Ante-Natal Care
ARV	Anti-Retrovirals
BLSS	Basic Life-Saving Skills
BCC	Behavior Change Communication
BPHS	Basic Package of Health Services
CDC	Center for Disease Control
CEDAW	Conference for the Elimination of All Forms of Discrimination Against Women
CHT	County Health Team
CHV	Community Health Volunteers
CM	Certified Midwife
CPR	Contraceptive Prevalence Rate
CWIQ	Core Welfare Indicators Questionnaire
EmONC	Emergency Obstetric and Neonatal Care
FGC	Female Genital Cutting
FGM	Female Genital Mutilation
FHD	Family Health Division
GBV/SGBV	Gender-Based Violence/Sexual Gender-Based Violence
gCHV	General Community Health Volunteer
GOL	Government of Liberia
HBLSS	Home-Based Life-Saving Skills
HCT	HIV Counseling and Testing
HDR	Human Development Ratings
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information Systems
ICPD	International Conference on Population and Development
IEC	Information, Education, and Communication
LDHS	Liberia Demographic and Health Survey
LPN	Licensed Practical Nurse
MD	Medical Doctor
MDG	Millennium Development Goal
MIP	Malaria in Pregnancy
MOHSW	Ministry of Health and Social Welfare
MOU	Memorandum of Understanding
NACP	National AIDS and STI Control Program
NGO	Non-Governmental Organization
NHP	National Health Policy
ORS	Oral Rehydration Solution
PA	Physician's Assistant
PEP	Post-Exposure Prophylaxis
PMTCT	Prevention of Mother to Child Transmission
PRS	Poverty Reduction Strategy
RH	Reproductive Health
RHSC	Reproductive Health Steering Committee
RHTC	Reproductive Health Technical Committee
RN	Registered Nurse
RNM	Registered Nurse Midwife
SBA	Skilled Birth Attendant
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TTM	Trained Traditional Midwife
UNDP	United Nations Development Program
UNFPA	United Nations Fund for Population Activities
WHO	World Health Organization
WRA	Women of Reproductive Age

REPRODUCTIVE HEALTH IN LIBERIA

INTRODUCTION

The improvement of sexual and reproductive health (SRH), particularly the reduction of maternal, newborn and child morbidity and mortality, feature among the key challenges for the Government of Liberia (GOL), as stated in the 2007-2011 National Health Policy (NHP). The maternal and child mortality rates in Liberia remain high, estimated at 994 per 100,000 live births and 110 per 1000 live births respectively (LDHS 2007). As a signatory to several guiding international resolutions and conventions that strive to improve SRH, such as the International Convention on Population and Development (ICPD), the Millennium Development Goals (MDGs), and the Convention for the Elimination of All Forms of Violence Against Women (CEDAW), Liberia is committed to fulfilling its commitment to the SRH of its citizens. In an efforts to combat high maternal and child mortality, the GOL developed and adopted the Road Map for Accelerating the Reduction of Maternal and Neonatal Morbidity and Mortality and an Operational Plan based on the Road Map. Complementing these documents are several policies and plans that provide additional details on SRH issues, including the National Policy and Strategy for Community Health and the National Strategy for Child Survival.

Poor SRH indicators in Liberia are by and large due to limited access to health services. The civil war devastated the health sector in Liberia. However, the GOL remains committed to rebuilding the health system in order to improve the health of the Liberian people in pursuit of the country's Poverty Reduction Strategy (PRS). The Ministry of Health and Social Welfare (MOHSW) aims to provide affordable, accessible, equitable, reliable and comprehensive health care to every Liberian through the Basic Package of Health Services (BPHS), which spells out the essential SRH services at all levels of health care service delivery.

The development of this Policy seeks to address the SRH needs of the Liberian population and is consistent with the vision of the GOL through the MOHSW to improve health, social welfare and equity in health.

DEFINITION

The GOL adopts the definition of sexual and reproductive health from the 1994 ICPD in Cairo, Egypt as follows:

SEXUAL AND REPRODUCTIVE HEALTH is the state of complete physical, mental and social well-being, not merely the absence of disease or infirmity, in all matters related to the reproductive system and to its functions and processes.

SITUATION ANALYSIS

Demographic and Health Status

The population of Liberia is relatively young. Recent health statistics indicate that of the total population of 3.5 million, approximately 51% is below the age of 21 years. Liberia's estimated population growth rate is 2.5% (2007 UNDP Human

Development Index). The life expectancy at birth is 41 years for men and 43 years for women. Of women of reproductive age (WRA), 76.3% report at least one obstacle in accessing health care services (LDHS 2007).

The maternal mortality level has worsened. Estimated at 578 deaths per 100,000 live births in 2000, it has increased to 994 deaths per 100,000 live births in 2007. The infant and under-five mortality rates also remain high, estimated at 72 deaths per 1,000 live births and 110 deaths per 1,000 live births respectively. Although most women (80%) have had one or more antenatal care (ANC) visits, only 37% of deliveries occur in health facilities and only 46% of deliveries are attended by a skilled provider (LDHS 2007).

The results of two consecutive Demographic and Health Surveys indicate a relative decline in fertility levels from 6.2 (2000) to 5.2 (2007). However, by the age of 18, 48% of girls have begun childbearing (LDHS 2007). There are geographical disparities: a reproductive health survey undertaken in Lofa County in 2007 revealed a teenage pregnancy rate of over 68% (CDC UNFPA 2007). Post-abortion complications, one of the major causes of maternal mortality, make the situation even more complex.

The uptake of family planning services in Liberia is low, as shown by a national contraceptive prevalence rate (CPR) of 11% and an unmet need of 36% (LDHS 2007). Sexually transmitted infections (STIs), including Human Immunodeficiency Virus (HIV), are prevalent, with one in five women and one in ten men reporting having had STI in 2007 (LDHS). The LDHS estimates the HIV prevalence rate at 1.5% among the general population (2007), while a 2007 National AIDS and STI Control Program (NACP) ANC sentinel survey estimates the rate at 5.4%.

Socio-cultural and Economic Context

Customary laws and practices often deny women and girls their sexual and reproductive rights, especially in rural areas. However, recent legislation, including the rape and inheritance laws, has been enacted to address some of these issues. The high illiteracy rate among women, estimated at 59% (CWIQ 2007), has a negative impact on women's health. The CPR is 7.7% among women without education and 20.6% among women with secondary education. Currently only 1.1% of rural women have completed secondary school (LDHS 2007).

In addition, cultural beliefs about the need for many children are strong, as many parents tend to rely on children for support during old age. Therefore, in the minds of many rural populations, more children equal more socio-economic stability later in life.

During the years of war, acts of sexual violence terrorized Liberians. In a WHO survey, 93% of women interviewed said they were subjected to multiple acts of abuse while 73% of respondents experienced rape, including gang rape (Rapid Assessment of SGBV 2007). Female genital mutilation (FGM), sometimes referred to as female genital cutting (FGC), is embedded in the traditional Sande society of Liberia. The prevalence of the Sande Society (a proxy for women who have

undergone FGM) in rural Liberia is estimated at 72%. Of the women who have undergone FGM or FGC, 45.2% think that the tradition should stop (LDHS 2007).

Health Systems Issues

The health system in Liberia is characterized by a severe shortage of human resources and inequitable distribution; limited infrastructure; inadequate equipment, commodity and drug supply; weak health management information system; poor monitoring and supervision; limited financial resources for reproductive health; and a weak referral system. Currently, 80% of the 437 functioning health facilities operate only with the support of NGOs or faith-based organizations (MOHSW NHP 2007).

There is an acute shortage of certified midwives (CMs), the first line health providers for SRH, with only 325 CMs working in Liberia out of the required number of 1634 (National Health Conference 2008). The production and education of CMs is slowed by the limited number of training institutions. Only four of the eight health training institutions in Liberia run certified midwifery programs. In addition, living conditions in the rural areas and low salaries result in high rates of staff attrition, especially in the counties further from the capital.

In an effort to improve the performance of the available skilled attendants, in-service training in Emergency Obstetric and Newborn Care (EmONC) and Basic Life-Saving skills (BLSS) for health care providers began in 2004.

RATIONALE

In light of the above, there is critical need for Liberia to redouble efforts to improve the SRH of its people, especially that of women, youth, and rural populations. The formulation and subsequent implementation of an SRH policy will ensure a coordinated, integrated, and harmonious delivery of comprehensive SRH services that will improve the overall health of the population.

VISION

That every Liberian citizen enjoys sexual and reproductive health of the highest quality and has the opportunity to fully exercise his or her sexual and reproductive rights.

MISSION

To create an enabling environment for reducing morbidity and mortality related to sexual and reproductive conditions by ensuring universal access to quality sexual and reproductive health services

GUIDING PRINCIPLES

To ensure effective and sustainable implementation of SRH programs the present Policy is underpinned by the following guiding principles:

- **Equity and accessibility:** Recognizing the fundamental right to health and the particular needs of underserved populations, especially those of women, youth and populations in rural and remote areas, in the provision of services;
- **Community participation:** Actively involving beneficiaries in planning, implementation, monitoring and evaluation of programs and activities to ensure ownership;
- **Complementarity:** Building on while not substituting existing national instruments for the provision of health services and health system strengthening;
- **Coordination:** Promoting partnership, collaboration and joint programming among stakeholders as well as a clear definition of roles, recognizing the comparative advantage of key players to avoid duplication and enhance synergies;
- **Stewardship:** Ensuring government-driven leadership for effective interventions that are planned and implemented according to national priorities and the specific needs of the population;
- **Appropriateness:** Building on a clear understanding of local knowledge, practices, perceptions and behaviour in relation to SRH, including gender sensitivity, confidentiality, and responsiveness;
- **Transparency and accountability:** Promoting a sense of responsibility and good governance at all levels in the implementation of the Policy;
- **Sustainability:** Recognizing the need for optimal allocation of resources for appropriate interventions, as well as strengthened managerial capacity to ensure cost-effectiveness and sustainability of SRH programs.

GOAL

To reduce the burden of morbidity and mortality attributed to sexual and reproductive conditions.

OBJECTIVES

1. To provide essential SRH services including EmONC;
2. To increase access to and utilization of SRH services;
3. To improve the quality of SRH services;
4. To ensure sustainable financing and effective management systems for SRH services.

POLICY ORIENTATIONS AND PRIORITIES

The policy orientations are reflected under each of the four objectives in the following sections:

1. Essential SRH Services

Essential SRH services shall be provided at all levels of health service delivery as defined in the BPHS. Its components will include maternal and newborn health, family planning, GBV/SGBV, reproductive tract diseases, and adolescent health with special attention to capacity building of service providers and male involvement.

Policy Objective: To provide essential SRH services.

Maternal and newborn health

To improve maternal and newborn health and reduce pregnancy-related morbidity and mortality, the GOL shall:

- a) Promote the perinatal approach to ensure the integrated delivery of maternal and newborn care services;
- b) Ensure that all maternal and perinatal deaths are notified to the appropriate authorities at all levels of the MOHSW;
- c) Maintain a system for maternal and perinatal death reviews, including maternal and newborn mortality audits in health facilities;
- d) Ensure that all births are notified to the nearest health facility;
- e) Allocate and provide adequate resources for a functional and effective referral system linking all levels of the health service delivery system;
- f) Ensure that all health facilities provide: i) focused ANC including prevention of mother-to-child transmission (PMTCT) and malaria in pregnancy (MIP) prevention and control with a minimum of four visits per normal pregnancy; ii) comprehensive care for normal labor and delivery; iii) comprehensive post-natal care beginning in the first seven days of delivery; iv) basic and comprehensive EmONC in accordance with the BPHS;
- g) Provide essential drugs, medical supplies and equipment for SRH services;
- h) Provide protocols and guidelines on SRH, including EmONC, to all health facilities;
- i) Ensure an adequate number of and appropriate support for health training institutions, especially in the area of SRH;
- j) Strengthen competency-based training of health providers to ensure the availability of skilled attendants;
- k) Strengthen the skills of Community Health Volunteers (CHVs), including general Community Health Volunteers (gCHVs) and Trained Traditional Midwives (TTMs), to carry out their defined roles in the delivery of SRH health service at community level;
- l) Advocate for the integration of nutrition education, essential nutrition actions and food supplementation programs with SRH services and training;
- m) Support the development and delivery of related mental health services, including addressing the issues of pregnancy-related (antenatal and post-partum) psychosis and depression;
- n) Ensure the delivery of comprehensive MNH services and SRH services for disabled and mentally ill women.

Family planning

To improve family planning services and increase the CPR, particularly in an effort to reduce maternal mortality and teenage pregnancy, the GOL shall:

- a) Ensure the availability and provision of a full range of contraceptive methods, including long-term and emergency contraceptive methods, in accordance with the BPHS;
- b) Uphold the principle of informed choice for individual women, men and couples to determine their method of contraception, including long-term methods;
- c) Ensure the provision of emergency contraceptives for the prevention of unintended pregnancy, particularly for rape survivors as part of post-exposure prophylaxis (PEP);
- d) Ensure that family planning counseling emphasizes dual protection against STIs/HIV and unintended pregnancy;
- e) Ensure that the provision of family planning services to adolescents is in line with the BPHS;
- f) Increase access to family planning services by strengthening community-based family planning provision;
- g) Raise the awareness and involvement of men in SRH matters, including family planning;
- h) Advocate for political mobilization around provision of a complete method mix;
- i) Encourage training of service providers and equip facilities to deliver quality comprehensive post-abortion care services, including family planning;
- j) Ensure the integration of services for prevention and management of infertility.

Gender-based violence and sexual gender-based violence (GBV/SGBV)

To provide quality care to survivors of GBV/SGBV, the GOL shall:

- a) Promote advocacy and social mobilization aimed at reducing GBV/SGBV, especially rape and FGM;
- b) Establish a system for reporting sexual violence to facilitate the appropriate management of cases of GBV/SGBV;
- c) Ensure the availability and accessibility of comprehensive services for survivors of GBV/SGBV, including collection of medico-legal evidence, PEP, and emergency contraception;
- d) Strengthen collaboration between the health, social and legal sectors for early reporting, treatment and long-term legal, medical and psychosocial support of survivors and prosecution of offenders;
- e) Support on-going research on the causes and possible preventions of SGBV for decision making;
- f) Encourage schools to incorporate information on SGBV and domestic violence prevention into health education curricula.

Reproductive tract diseases (STIs and HIV/AIDS)

To effectively prevent and manage diseases of the reproductive system, the GOL shall:

- a) Ensure the provision of appropriate prevention, counseling, and management services of reproductive tract cancers and infections, including STIs and HIV;

- b) Promote dissemination of appropriate information, education and communication (IEC) and behavior change communication (BCC) on reproductive tract infections, including STIs and HIV, at all levels of care;
- c) Provide protocols and guidelines for the management of STIs including HIV;
- d) Ensure the availability of essential drugs for reproductive tract cancers and infections, including anti-retrovirals (ARVs), drugs for syndromic management of STIs and opportunistic infections, and diagnostic supplies;
- e) Integration of HIV and STI services for individuals of post-reproductive age.

Adolescent health

To ensure that adolescents have adequate access to the full range of SRH services, the GOL shall:

- a) Ensure the scaling-up of SRH services targeting adolescents and young people;
- b) Institute programs to increase the utilization of SRH services by adolescents;
- c) Promote the integration of adolescent health issues into schools and youth programs;
- d) Ensure the availability of and access to STI and HIV prevention and management including HIV testing and counseling (HCT) and appropriate information for safe sex targeting youth;
- e) Ensure that youth are incorporated in health decision-making, particularly in the area of SRH.

2. Access to and Utilization of SRH Services

The current level of access to SRH services is limited. Access will have to be augmented to address the high maternal and newborn mortality and morbidity rates.

Policy Objective: To increase access to and utilization of SRH services.

In order to ensure that all those in need of SRH services are able to access them, the GOL shall:

- a) Strengthen available health infrastructure and provide additional structures for under-served areas to ensure the equitable distribution of health service delivery facilities throughout the country;
- b) Ensure that all facilities provide SRH services in line with the BPHS;
- c) Provide outreach services and put in place a functional referral system, including transport and communication systems, to bring services closer to populations in rural areas;
- d) Ensure that continuous IEC/BCC interventions are provided to communities, especially young people, to empower populations and create demand for and increase utilization of SRH services, particularly for skilled facility deliveries;
- e) Pursue continuous dialogue with cultural and religious bodies to ensure that cultural and religious practices are in harmony with the GOL's commitment to achievement of SRH goals;
- f) Foster client confidence in the health care delivery system by ensuring the provision of reliable, quality, client-centered services in line with the BPHS.

3. Quality of SRH Services

High-quality services are essential for delivering effective SRH interventions.

Policy Objective: To improve the quality of SRH services.

To achieve SRH services of the highest quality in accordance with the BPHS, the GOL shall:

- a) Ensure that the capacity of service providers at all levels meets the increasing demand for SRH services by providing high-quality pre- and in-service education;
- b) Ensure the development and implementation of human resource strategy to orient and train, deploy and retain health system workers;
- c) Ensure that the performance of service providers meets national standards through regular monitoring, on-the-job supportive supervision and performance appraisal;
- d) Ensure that all facilities are continuously equipped with adequate drugs, commodities and other essential supplies;
- e) Uphold adherence to the accreditation system for the delivery of the BPHS and future health care packages to ensure compliance with national standards of SRH care;
- f) Establish a quality assurance program to continuously monitor and guide further improvements in the quality of SRH services;
- g) Supply service providers with the appropriate tools and guidelines for effective service delivery.

3. Financing and Management of SRH Services

Provision of SRH services requires a significant sustained investment of financial and managerial resources.

Policy Objective: To ensure sustainable financing and effective management systems for SRH services.

To attain uninterrupted provision of SRH services at all levels, the GOL shall:

- a) Increase financial support to SRH programs as part of the national budget;
- b) Explore alternative financing mechanisms for SRH services to alleviate the financial burden from individual households;
- c) Mobilize additional resources from partners and other sources for SRH care services;
- d) Improve the allocative efficiency of available funds for SRH;
- e) Strengthen management support systems, including HMIS, procurement, supply chain management, and logistics, in accordance with the National Health Plan;
- f) Ensure the use of standardized health service management tools and procedures by all implementing partners.

IMPLEMENTATION FRAMEWORK

The MOHSW shall update the Operational Plan to Reduce Maternal and Neonatal Mortality and develop national guidelines, standards, and protocols at the national

and county levels to guide implementation. The MOHSW shall also develop a human resource plan for training, employment, and retention of qualified health workers.

The MOHSW through the Family Health Division (FHD) shall have overall responsibility for monitoring and implementation of the Policy, including the coordination of all agencies, institutions and organizations involved in the provision of SRH services in the country.

For coordinated implementation, the MOHSW will set up a Reproductive Health Steering Committee (RHSC) to provide policy direction and advocate for funding and support of SRH and a Reproductive Health Technical Committee (RHTC) to guide planning and implementation. All activities related to SRH in Memoranda of Understanding (MOUs) between the MOHSW and implementing partners should be in line with the provision of the Policy.

MONITORING AND EVALUATION

Monitoring and evaluation mechanisms, including the HMIS, for timely availability of data for planning, programming and decision-making, will be strengthened, integrated, and streamlined. A set of defined indicators for measuring coverage, utilization, quality, and resources, as well as monitoring output and impact, will be employed.

Evaluation will be done annually, making use of existing tools where appropriate, and will be built into SRH program activities from the planning stage. Midterm and year-end reviews of the implementation of the Policy will be undertaken to inform revision or development of new policies. The Policy calls on the GOL and partners to support operational research on SRH in order to inform policy development and decision making.

CONCLUSION

The development of the SRH Policy is a major step towards ensuring universal access to quality SRH services for all people in Liberia. The SRH Policy calls for an enabling environment through: i) establishment and enforcement of the appropriate legislation that protects the sexual and reproductive rights of individuals; ii) increased coverage of SRH services; iii) development of a critical mass of skilled service providers at all levels of the health system, including the establishment of measures for task shifting and a review of the scope of work of different cadres of health workers, to meet human resources needs; and iv) the availability of necessary infrastructure, essential drugs and supplies, paired with a management systems that can assure their delivery.

The successful development of an SRH implementation strategy based on this Policy will depend greatly on the leadership of the MOHSW in harnessing the inputs of the relevant stakeholders and in ensuring coordination.

Annex 1. Terms of Reference for the Reproductive Health Technical Committee

BACKGROUND

The Sexual and Reproductive Health Policy of Liberia provides a framework for coordinating and monitoring reproductive health activities in Liberia. Coordination is central to a well-designed, comprehensive and focused SRH program.

Currently, SRH interventions are fragmented and poorly monitored and coordinated, making it difficult to determine the quality and effectiveness of these interventions. It is also challenging to readily assess the efficiency of resource use. Strategic partnerships and strengthening the capacity of the MOHSW are integral to improving coordination and monitoring. A more empowered central MOHSW that can support and guide actors at the county level will improve the provision of quality SRH services.

The Reproductive Health Technical Committee (RHTC), appointed by the MOHSW, shall be comprised of medical, public health, and other relevant professionals from both the Government and partner organizations in order to facilitate collaborative planning, implementation, and monitoring at the central level.

OBJECTIVE

The RHTC is a multisectoral, multidisciplinary body that shall provide technical advice and guidance to the Family Health Division (FHD) and its partners on a full range of SRH programming in Liberia. Decisions and recommendations made by the RHTC will apply to all sectors involved in offering SRH services.

RESPONSIBILITIES

The RHTC shall have the following responsibilities:

- To deliberate, analyze, and make recommendations on all SRH service delivery issues;
- To pass decisions and recommendations to MOHSW for consideration, approval and implementation;
- To collaborate with other technical committees in fostering a comprehensive approach to SRH;
- To support information dissemination on SRH, including minutes of meetings, SRH data, annual reports, periodic releases or newsletters, documentaries, etc;
- To provide technical oversight and support in the development and revision of national SRH strategies, programs, policies, standards, procedures, and plans;
- To support the MOHSW in advocacy and mobilization of resources for SRH activities;
- To appoint standing and ad hoc sub-committees to perform specific tasks;
- To recommend modifying membership and hiring additional advisors and consultants as necessary.

The central RHTC will be integral in supporting the establishment of RHTCs at the county level and creating the required linkages and feedback mechanisms. These County Reproductive Health Technical Committees (C-RHTCs) will coordinate decentralized SRH activities and programs at the county levels, including:

- Monitoring and promoting the accessibility of services in terms of location, integration, hours of service, and waiting time;
- Collaborating with other health partners in the county for the effective delivery of SRH services;
- Supporting information dissemination on SRH;
- Facilitating and encouraging the development and implementation of quality assurance mechanisms;
- Organizing and following up on trainings provided in SRH;
- Participating in strategic planning at the county level for service delivery.

TERMS OF EXISTENCE

The RHTC is a perpetually active body unless otherwise decided by the MOHSW. The RHTC shall meet once a month with more meetings and events as needed and decided by the members.

STRUCTURE

The structure of the RHTC is outlined as follows:

Officers:

Chairperson: The Director of the FHD will hold this position permanently. In the absence of the Chairperson, his/her designee will assume the position of Acting Chairperson. The Chairperson shall:

- Serve as executive officer of the RHTC;
- Preside over all meetings;
- Communicate the decisions and recommendations of the RHTC to the MOHSW and stakeholders for further action;
- Ensure the implementation of recommendations made by the RHTC, both at central and county levels
- Appoint Chairpersons of the sub-committees with approval by the members of the RHTC.

Recording Secretary: The Recording Secretary is an elected position determined by the membership of the RHTC. The responsibilities of the Recording Secretary are to:

- Record the minutes of all meetings;
- Prepare and disseminate the minutes of RHTC meetings within seven working days of the sitting of the Committee;
- Keep a simplified and organized record system for RHTC records;
- Work closely with the Administrative Secretary in handling RH records.

Administrative Secretary: The Administrative Secretary is an elected position determined by the membership of the RHTC. The responsibilities of the Administrative Secretary are to:

- In collaboration with the Chairman of the RHTC, prepare the agenda for all meetings;
- Follow up on deliberations of each meeting in collaboration with the other members of the Secretariat;
- Prepare reports in collaboration with the other members of the Secretariat;
- Handle all logistical and administrative matters of the RHTC.

SUB-COMMITTEES

The RHTC shall maintain the following Standing Subcommittees:

Service Delivery Committee: This committee shall be appointed by the Chairperson with the consensus of the RHTC. The Service Delivery Committee shall:

- Recommend a comprehensive package of SRH services to be offered at the various levels of care;
- Develop an updated supervisory tool for SRH service delivery;
- Recommend the provision of appropriate equipment and commodities to SRH service delivery points;
- Update service delivery standards and protocols for SRH as needed;
- Support the expansion of SRH services to the community level;
- Development of relevant job aids for use at all levels of SRH service delivery;
- Design appropriate tracking mechanism for SRH interventions at all levels.

Policy Committee: This committee shall be appointed by the Chairperson with the consensus of the RHTC. This committee shall undertake the following:

- Ensure that SRH policies and guidelines are within the framework of the National Health Policy and other population policies for Liberia as well as within internationally established frameworks for SRH;
- Update, review, and maintain SRH policies and protocols as needed;
- Work closely with the MOHSW in the development of new policies and guidelines.

Education Committee: This committee shall be appointed by the Chairperson with the consensus of the RHTC. This committee shall undertake the following:

- Participate in the review, development and approval of pre- and in-service SRH curricula for all cadres of health workers;
- Help to identify needs for pre- and in-service training in SRH;
- Track SRH training;
- Initiate, support and promote the development and dissemination of SRH information;
- Support SRH BCC.

Advocacy Committee: This committee shall be appointed by the Chairperson with the consensus of the RHTC. This committee shall undertake the following:

- Participate in the review and adapt evidence-based advocacy tools for use by the RHTC

- Prepare advocacy presentation/materials for RH resource mobilization
- Support the MOHSW to collaborate with appropriate institutions for the enactment of appropriate RH laws
- Support and promote advocacy for the improvement of RH programs in the country

The RHTC Chairperson shall approve the chairpersons of all subcommittees with the consensus of members of the RHTC. The RHTC may create or appoint subcommittees, including ad hoc sub-committees, as necessary to carry out specific functions or projects pertaining to service delivery. These committees will report to the RHTC Chairperson or his/her designate.

MEMBERSHIP

The RHTC shall decide on its size and may increase or decrease its membership as it sees fit. Membership will be by appointment of the Chairperson and consensus of the RHTC. Membership will be permanent unless reversed by consensus.

The membership shall be comprised of but not be limited to the below listed (note: these institutions can also become members of the C-RHTCs based on their activities in various counties):

- MOHSW (Family Health Division, National Malaria Control Program, EPI, NACP, etc) and other relevant GOL Ministries (Ministry of Education - School Health Division; Ministry of Gender and Development);
- Health institutions (public and private);
- All accredited health training institutions;
- SRH-related UN-agencies (UNFPA, WHO, UNICEF);
- Donors working in SRH (USAID, EC);
- Community-based organizations, faith-based organizations, and private volunteer organizations involved in SRH;
- National and international non-governmental organizations working in SRH.

Annex 2. Human Resources for Sexual and Reproductive Health

The MOHSW will ensure the presence of a highly-motivated and appropriately trained and skilled personnel to efficiently manage and provide quality SRH services. This shall be done by:

- Determining and incorporating human resource needs for SRH in the Human Resource Development Plan of the MOHSW to ensure equitable deployment of skilled personnel;
- Ensuring that the curricula of all health training institutions include all components of SRH in varying levels of detail;
- Ensuring that personnel providing health services at all levels receive pre- and in-service competency-based training in SRH;
- Taking into account county and district requirements as well as national needs when defining specialized training for staff;
- Linking promotion and in-service training with regular and systematic performance appraisal;
- Developing strategies to increase the number of skilled SRH staff;
- Developing incentive packages to attract and retain skilled and trained staff.

Definitions of Human Resources in SRH

The MOHSW of Liberia has decided encouraging institutional deliveries with skilled birth attendants as a means of improving maternal and neonatal outcomes and SRH in general. A skilled birth attendant (SBA) is a Medical Doctor, Certified Midwife, Physicians Assistant, Registered Nurse, Registered Nurse Midwife, or Licensed Practical Nurse. The skills of an SBA can be enhanced with Basic-Life Saving Skills (BLSS) training. Other SRH personnel include TTMs, counselors, social workers, peer educators, gCHVs, community mobilizers, and advocates.

The following personnel are involved in SRH activities at various levels:

Coordinator: A technical expert in SRH who works at the central level. The Coordinator will have one of the following qualifications: RN, CM, RNM, or MD with gynecological training. The Coordinator has the following responsibilities:

- Plans programs and activities to build the staff capacity;
- Writes proposals to advocate for increased SRH financial and technical resources;
- Makes requisitions to ensure SRH commodities are in country;
- Monitors all SRH activities in collaboration with other partners;
- Establish mechanisms to ensure that all births in the county are registered.

Supervisor: A technical expert in SRH who works at the county level. The Supervisor will have extensive experience in midwifery. The Supervisor has the following responsibilities:

- Supervises SRH programs and activities at the county level;
- Monitors SRH activities in the county;
- Provides technical guidance and support to clinical staff on SRH activities;
- Conducts training and logistical needs assessments;
- Conducts capacity building training for SRH staff;
- Reports to the Coordinator and County Health Team (CHT).

Clinicians: Staff assigned in clinics providing direct SRH services to clients. Clinicians include Physicians, Certified Midwives (CMs), Registered Nurse Midwives (RNM), Registered Nurses (RNs), Physicians Assistants (PAs), Licensed Practical Nurses (LPNs). Clinicians' responsibilities include:

- Provide quality skilled services to pregnant women and mothers, neonates, infants and children under age five, adolescents, women and men of reproductive age, and any other clients seeking SRH care;
- Works at the community level with the SRH team and CHVs to ensure that all community members and mothers, babies and adolescents in particular receive quality and safe care;
- Reports to the SRH Supervisor at the CHT.

Trained Traditional Midwives (TTMs)

While the MOHSW aims to increase institutional deliveries, Trained Traditional Midwives (TTMs) and Traditional Midwives (TMs) still perform more than 60% of deliveries in the country (LDHS 2007). The MOHSW will remain involved with T/TMs, as they constitute a well-respected and enthusiastic resource for community health. However, the MOHSW seeks to redefine the role of T/TMs from that of birth attendant to that of birth supporter. T/TMs are considered members of the cadre of CHV whose roles and responsibilities will be redefined and expanded to focus on mobilizing families and communities to recognize maternal and newborn danger signs and complications for early referral level to save lives. Additional duties in community-based health care will be developed in collaboration with the Community Health Services Division of the MOHSW. In this regard, performance-based affordable motivational packages for TMs who refer pregnant women to the health facility for delivery will be explored and piloted.

The MOHSW has adapted Home-Based Life Saving Skills (HBLSS) training for TMs and TTMs. The HBLSS training places emphasis on early detection and referral at the community level and the importance of prompt management of maternal and newborn complications at the health facility by skilled providers. Trainees will receive an ID card linking them to functional health facilities under the supervision of the health facility's MCH Supervisor, who will conduct monthly meetings with the T/TMS, collect reports, provide feedback, and conduct in-service training. Due to the importance and effectiveness of supportive supervision and follow-up, the MOHSW emphasizes the two weeks in-service training and immediate linkage to the clinic for close monitoring and follow-up for TMs.

The responsibilities of TTMs include:

- Counseling on essential newborn care (warmth, hygiene, immediate breastfeeding), exclusive breastfeeding, maternal and newborn nutrition, and recognition and appropriate actions in the case of danger signs;
- Providing appropriate community-based post-partum and neonatal care;
- Encouraging women to seek SRH care at health facilities (ANC, labor and delivery, and postnatal care, as well as family planning services);
- Recognizing and referring pregnant women with danger signs to health facilities;
- Assisting women, families and communities to develop birth preparedness plans; educating women, families and communities about danger signs in

pregnancy, labor, delivery, and post-partum and the recommended actions to take to save lives;

- Educating and demonstrate desired behaviors at household and community levels using Take Action Cards;
- Identifying all pregnancies, births, and maternal and newborn deaths in their community and reporting to the health facility during monthly meeting.