MINISTRY OF HEALTH
Republic of Liberia

DCP3 Disease Control Priorities
Country Translation Phase

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

Collaboration between the Ministry of Health, Liberia and the Disease Control Priorities 3 Country Translation Project

REPORT ON DEVELOPING THE LIBERIA UNIVERSAL HEALTH COVERAGE ESSENTIAL PACKAGE OF HEALTH SERVICES

International Centre for Migration, Health and Development

UCL

Radboudumc

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Abbreviations

CHE	Current health expenditure
DALYs	Disability-adjusted life years
DCP3	Disease Control Priorities 3rd edition
EPHS	Essential Package of Health Services
EPR	Emergency preparedness and response
EUHC	Essential Universal Health Coverage
FRP	Financial risk protection
FY	Fiscal year
GDP	Gross domestic product
GoL	Government of Liberia
HCC	Health Coordination Committee
HIPTool	Health Interventions and Prioritisation Tool
HPP	Highest-priority package
HSCC	Health System Coordination Committee
IMF	International Monetary Fund
LHEF	Liberia Health Equity Fund
LLMICs	Low- and lower middle-income countries
LSHTM	London School of Hygiene and Tropical Medicine
MoH	Ministry of Health
MoFDP	Ministry of Finance and Development Planning
NCDs	Non-communicable diseases
NHSSP	National Health Sector Strategic Plan
OOP	Out-of-pocket
PHC	Primary health care
RDF	Revolving Drugs Fund
RMNCAH	Reproductive, maternal, newborn, child, and adolescent health
SDGs	Sustainable Development Goals
TWG	Technical working group
UHC	Universal health coverage
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
WHO	World Health Organization
WB	World Bank

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- Mr. Ernest M. Gonyon, Director Health Financing
- Mr. G. Martin Dumoe, Director Policy & Planning
- Mrs. Diana T. Sarteh, Chief Nursing Officer
- Mr. J. Mike Mulbah, Director Monitoring & Evaluation
- Mrs Christine Brooks-Jarret, Policy Advisor to the Minister of Health
- Mr. Carlton Kpahn, Assistant Planning Director
- Mrs Linda Jasper Kokolo, Administrative Assistant, Health Services

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DCP3 Team (alphabetical order)

- Prof. Ala Alwan, Professor, Global Health and Principal Investigator, DCP3 Country Translation Project, London School of Hygiene & Tropical Medicine
- Prof. Rob Baltussen, Professor Global Health Economics, Radboud University Medical Centre
- Dr. Manuel Carballo, Executive Director, International Centre for Migration, Health and Development
- Mr. AJ Climpson-Stewart, Project Manager, DCP3 Country Translation Project
- Ms. Ina Gudumac, Project Assistant, DCP3 Country Translation Project
- Dr. Hassan Haghparast-Bidgoli, Associate Professor of Economics, University College London
- Dr. Gerard Joseph Abou Jaoude, Research Fellow, University College London
- Dr. Ngashi Ngongo, Health System Specialist, International Center for Health System Strengthening
- Prof. Jolene Skordis, Professor of Economics, University College London

Advisers

- Prof. Anna Vassal, Professor of Health Economics, London School of Hygiene & Tropical Medicine
- Dr. Abdul Ghaffar, Executive Director, Alliance for Health Policy and Systems Research (also facilitating the Ministerial Retreat held in Monrovia on 18 August 2022)
- Prof. Sameen Siddiqi, Head, Department of Community Health, Aga Khan University

The role of the members of the Technical Working Groups was central in all stages of the project.

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Foreword

This report outlines the activities and outcomes of the collaboration established in 2021 between the Ministry of Health – Government of Liberia (GOL) and the Diseases Control Priorities 3 (DCP3) Country Translation project, hosted at the London School of Hygiene and Tropical Medicine and supported by the Bill & Melinda Gates Foundation.

The collaboration aimed to support the GOL's ongoing initiatives to accelerate progress towards universal health coverage (UHC), with a special focus on updating and prioritising the essential package of health services (EPHS). By improving access to essential health services, particularly for the poor and vulnerable, Liberia will reinforce efforts to meet its commitment to the Sustainable Development Goals (SDGs) and the United Nations General Assembly Political Declaration on UHC.

The report provides an overview of the intensive work undertaken by the Ministry of Health as part of this collaboration. All the milestones of the operational plan endorsed by the Ministry have now been achieved. The report also offers a snapshot of the health and health financing situation in Liberia, the process undertaken to design the current version of the EPHS for UHC, the scenarios proposed for discussion with high-level policymakers, as well as the high-level decisions taken by the Ministry on the contents and financing of the EPHS.

We hope that this report will contribute to consultations with all stakeholders, including the Ministry of Finance and Development Planning, Liberia Revenue Authority, development partners, and civil society organisations, focusing on high-level policy decisions leading to the implementation of the updated EPHS.

Ala Alwan, MD, FRCP, FFPH
Professor, Global Health and PI, DCP3 Country Translation Project
London School of Hygiene & Tropical Medicine

Executive Summary

The Disease Control Priorities 3 (DCP3) Country Translation project is supporting selected low- and middle-income countries in setting priorities for essential packages of health services (EPHS), on the pathway to universal health coverage (UHC). In 2021, DCP3 initiated collaboration with the Liberia Ministry of Health (MoH) to provide technical assistance in updating the national EPHS and build capacity in priority setting and decision making on resource allocation for package implementation. The review of the 2011-2021 EPHS comes at a crucial time for the country, when a number of other national health policies are also being updated, including the National Health Sector Strategic Plan (NHSSP) and the National Health Financing Strategy.

Following initial discussions with the MoH in 2021 and the endorsement of the operational plan by the MoH and partners during the inception workshop in January 2022, intensive work was conducted on several work streams. This work included collecting evidence, analysing the fiscal space, mapping existing services, training on resource optimisation analyses to inform health intervention prioritisation, setting decision criteria for the prioritisation of interventions, conducting a prioritisation workshop for the Technical Working Groups (TWGs), conducting a preliminary costing, and developing and discussing funding scenarios.

Analysis of the fiscal space shows the challenges Liberia faces in funding its health system, and the difficult decisions the government must take when determining which services should be prioritised for inclusion in a UHC package. The estimated GoL budget allocations to health for 2021 were US$16 per capita, and the budget was executed at an 84% rate. A decision was reached to develop the components of the UHC package using a level of US$12-14 in government financing.

The UHC EPHS prioritisation process led to the initial shortlisting of 132 high-priority interventions, using decision criteria that included cost-effectiveness of interventions, disease burden targeted, disability-adjusted life years (DALYs) averted, budget impact, financial risk protection, equity (targeting vulnerable population groups), and feasibility of implementation. The high priority interventions are delivered across six platforms: population level, community services, health clinics, health centres, district and county hospitals, and tertiary care hospitals.

Further refinement of the list based on consultations with MoH technical experts led to a shorter set of 128 highest-priority interventions, which served as the basis for recommending several financing scenarios for consideration by the government. The scenarios provided options for core sub-packages of interventions that the government can publicly finance and make accessible to all citizens free at the point of use. The government is already establishing a cost-sharing (cost recovery) programme and the scenarios therefore provided options for complementary sub-

packages of health services, funded with co-payments to supplement government contributions.

The EPHS scenarios were reviewed in a high-level Ministry of Health retreat led by H.E. Dr. Jallah, Minister of Health on 18 August 2022. Scenario 4, containing a primary health care focused package[1], was considered by the high-level officials as the most realistic and affordable option for the health system in Liberia at this stage.

Consistent with the key principles of UHC, the package will use public resources to provide, to all people, the highest impact interventions at the primary health care level; it covers 78 core interventions provided free at point of service use, and 50 complementary interventions financed through the MoH cost-sharing programme. The core and complementary sub-packages are estimated to cost the government US$12.28 per capita, which is well within the fiscal space range agreed for government financing of the package of US$12-14. An estimated 1.2 million DALYs will be averted by implementing the interventions in this package.

Scenario 4 package by platform

Delivery Platforms	# Interventions	Total cost per capita	Cost per capita covered by partner funding	Cost Sharing	Total cost per capita to government	DALYs averted
Core	**78**	**14.18**	**7.25**	-	**6.93**	**874,359**
Population-Based	10	0.27	0.08	-	0.19	6,551
Community	18	1.80	0.54	-	1.26	147,402
Clinic	48	12.01	6.6	-	5.41	705,895
Health Centre	2	0.10	0.03	-	0.07	14,510
Complementary	**50**	**13.82**	**3.12**	**5.35**	**5.35**	**297,910**
Health Centre	14	3.68	1.00	1.34	1.34	73,387
District & County Hospitals	27	9.70	2.1	3.80	3.80	213,260
Tertiary Hospitals	9	0.44	0.01	0.21	0.21	11,264
Total	**128**	**28.00**	**10.37**	**5.35**	**12.28**	**1,172,269**

The MoH now has the data, technical capacity, and the tools to adjust this package to address additional considerations that may emerge in the transition to implementation and also to respond to future policy and fiscal changes.

The retreat agreed on the next steps to implement the package.

[1] The primary health care structure in the Liberian health system covers services provided at the population, community and health clinic levels.

→ A more robust costing of the core and complementary sub-packages will be conducted by the MoH in collaboration with development partners who have already committed to support this task. This process is needed to ensure a more reliable costing that is linked to budgeting. Further prioritisation and adjustment of the two sub-packages in the EPHS may also be required following costing.

→ The health system gaps will need to be thoroughly reviewed based on the National Health Policy.[22] An operational plan will be prepared by the MoH and partners to tackle these gaps and to reinforce the health service delivery system, with special focus on primary health care platforms and referral mechanisms.

→ The UHC package will not be implemented unless the cost-sharing programme and the Liberia Health Equity Fund (LHEF) are finalised and endorsed by the government. The form and level of co-payments involved in the complementary package will need to be discussed, with special focus on measures to reduce its potentially negative impact on service access and to lower the financial risk. The ministerial retreat emphasised the critical need to expedite action in this area to ensure that the package is rolled out in 2023.

→ The MoH plans to launch the UHC package in a meeting of stakeholders as soon as the above-mentioned next steps are completed. In the meantime, an advocacy and engagement plan will be developed.

1. Introduction

The Government of Liberia is committed to achieving UHC as part of the Sustainable Development Goals. Target 3.8 requires all countries to achieve UHC by 2030. As a signatory to the 2019 United Nations Political Declaration on UHC, Liberia aims to scale up efforts to achieve SDGs target 3.8 and implement evidence-informed, high impact interventions to meet the needs of its population, in particular the most vulnerable. This commitment is reflected in the National Policy and Strategic Plan (2011–2021)[(1)]. By improving access to essential health services, particularly for the poor and vulnerable, the government recognises that UHC is also fundamental to achieving other SDG targets related to poverty alleviation, promoting quality education, achieving gender equality and women's empowerment, and increasing economic growth.

As part of the UHC agenda, the government is reviewing the challenges facing the health sector and revising the 2011–2021 Essential Package of Health Services[(2)] with a view to improving access to quality essential health services, medicines, and vaccines. Updating the EPHS is part of the National Health Sector Strategic Plan (UHC roadmap), and the National Health Financing Strategy, which are also being updated in 2022.

To achieve UHC, countries must advance along three important dimensions: expanding health service coverage to include all population groups, providing access to a wider range of priority services, and protecting against financial risk by reducing out-of-pocket (OOP) expenditure. Addressing the gaps in the three UHC dimensions is essential to reaching this goal. In this regard, the Ministry established a collaboration with the DCP3 Country Translation Project in 2021, with a special focus on updating the EPHS using the DCP3 evidence and generic UHC packages.

This report provides an overview of the work undertaken in Liberia as part of this collaboration. Section 2 offers a snapshot of the health and health financing situation in Liberia and information on DCP3 and its model packages. Section 3 details the process undertaken in Liberia for arriving at the EPHS adopted to accelerate progress towards UHC, while Section 4 provides several scenarios on the scope, contents, and financing of the package and options for increasing the fiscal space for health. Section 5 presents the package adopted during the ministerial retreat and next steps.

2. Background

2.1 Liberia context

Liberia is a low-income country, where years of conflict and health emergencies have severely weakened its economic, social and health systems. Almost half (44.4%) of its population of 5.2 million lives below the international poverty line of US$ 1.9 per day[3]. In 2019, Liberia was ranked 175th out of 189 countries on the Human Development Index[4] — a measure that combines life expectancy, educational attainment, and per capita income indicators.

Over the past few decades, Liberia has made steady strides in improving key health indicators. Between 2013 and 2019/2020, maternal mortality dropped from 1,072 to 742 per 100,000 live births. Despite the decline, Liberia remains one of the countries with the highest maternal mortality. Among the leading causes of maternal deaths reported by the Liberia 2020 Maternal and Neonatal Death Surveillance and Review are haemorrhage (42%), sepsis (20%), and eclampsia (17%).[5] Infant mortality has been reported to have increased from 54 to 63 deaths per 1,000 live births. Estimates suggest that about 1.98 million DALYs were lost in 2019, 61% of which were due to communicable, maternal, child, and nutritional conditions, 33% to non-communicable diseases (NCDs), and 5.6% to injuries.[6]

Liberia's health system is facing major constraints affecting most of its building blocks. Some of the main challenges include shortages and poor distribution of health workers; critical gaps in health infrastructure; ineffective procurement and supply chain management systems; and insufficient financing of the health sector.[7] The UHC service coverage index, which measures the coverage of 14 tracer indicators of essential health services, was 42 in 2019[8](Table 1), lower than the regional average of 46. Overall, service availability and readiness of the health facilities to provide general health services are suboptimal. The average general service readiness of 701 health facilities in Liberia was estimated at 59% in 2018, with lower scores for availability of essential medicines (44%) and diagnostics (42%).[9-10]

Table 1: Selected key indicators

UHC Service Coverage Index	42.0	(2019) *
Current health expenditure (CHE) per capita (US$)	53	(2019) †
Government health spending % total health expenditure	16	(2019) ₸
Out-of-pocket expenditure as % of current health expenditure	53.0	(2019) ₸
Incidence of catastrophic health expenditure at 10% of household total consumption or income (%)	6.7	(2016) ‡
Skilled health workers per 10,000 population	12.8	(2021) **

* WHO Global Health Observatory https://www.who.int/data/gho;
† Global Health Expenditure Database https://apps.who.int/nha/database;
₸ MoH Liberia National Health Account, 2018/19;
‡ WHO & WB Global Monitoring Report on Financial Protection in Health, 2021;
** National Health Observatory Report, September 2021

The number of people incurring impoverishing health spending remains high. In 2016, OOP expenses for health pushed 2% of the Liberian population below the extreme poverty line, with an additional 37% pushed further into poverty.[11] This highlights a critical need for the Liberian government to mobilise additional public funding for health services, improve the efficiency of health spending, reduce OOP expenditures and lower the risk of impoverishment and avoidable ill health or death that catastrophic spending causes.

2.2 Disease Control Priorities 3

DCP3 presents the critical evidence needed for strategic health policymaking and lays out an approach to support countries in expanding coverage of quality health services.[12-13] It provides a comprehensive review of the efficacy and cost-effectiveness of priority health interventions across 21 health areas, through systematic appraisal of evidence, economic evaluation and expert judgement to support decision-making in resource constrained contexts.

DCP3 presents two model essential packages of health services, which serve as a guide and a starting point for the development or revision of an EPHS on the pathway to achieving UHC in low- and lower middle-income countries (LLMICs). The first – Essential UHC Package (EUHC) – includes 218 high-priority health services designed for lower middle-income countries. The second – Highest-Priority Package (HPP) – includes 108 interventions and is proposed for low-income countries where EUHC is not affordable. The DCP3 model packages offer guidance or a set of interventions that can be adapted by countries to develop their UHC EPHS based on their disease burden, health needs, health system capacity, and available financing.

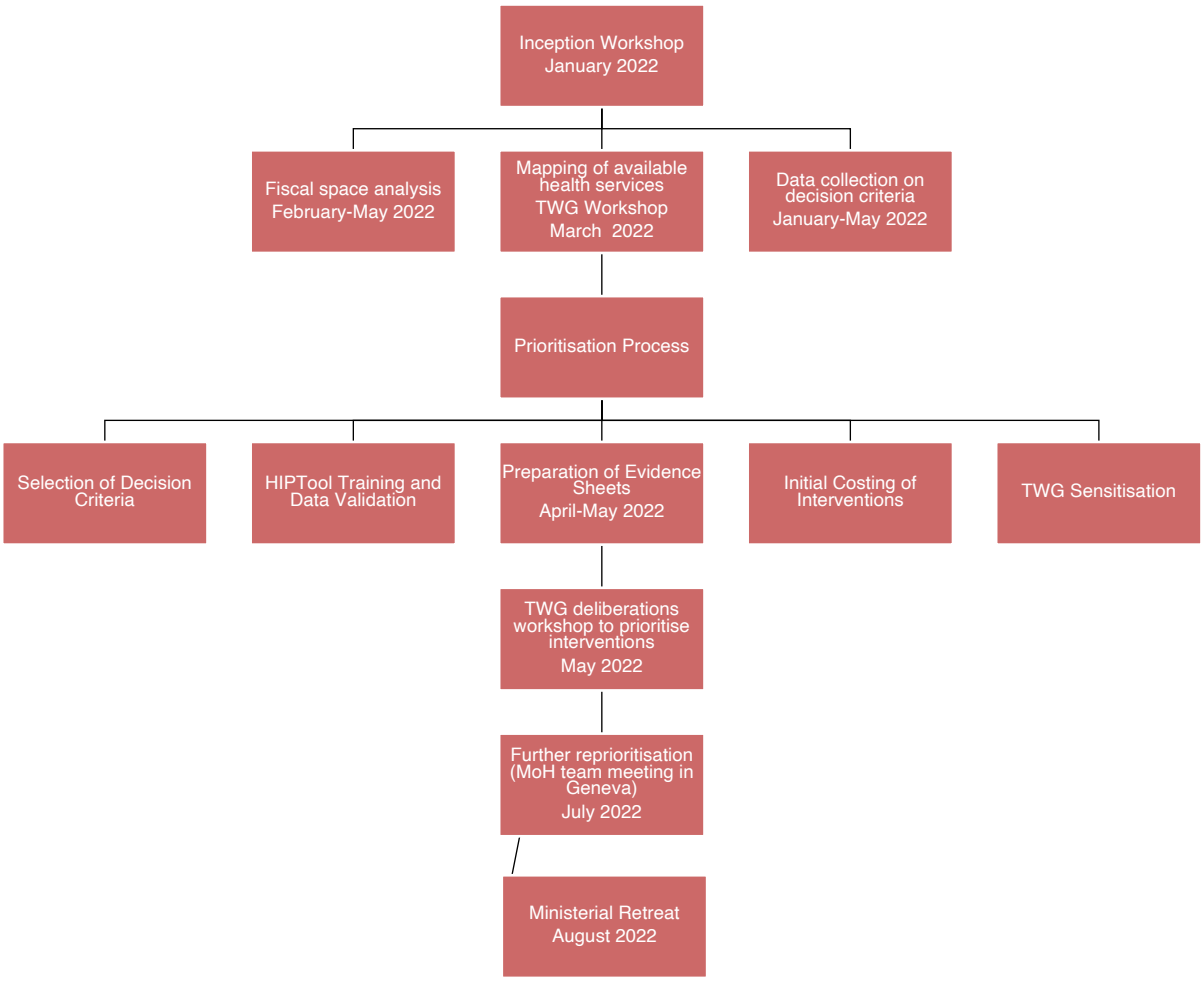
The DCP3 approach recommends that any essential package of health services is financed publicly without co-payments and is implemented to achieve UHC in a stepwise manner, through a progressive universalism approach. By publicly financing the highest priority and most cost-effective health services, the DCP3 approach seeks to cover all three key dimensions of UHC, namely increasing population coverage, reducing financial risk, and expanding the range of essential health services.

Since 2018, the DCP3 Country Translation Project, based at the London School of Hygiene and Tropical Medicine (LSHTM), has supported several countries in designing or revising their national UHC EPHS using DCP3 evidence.

3. Process of updating the Liberia EPHS

The process of updating the Liberia EPHS was built on earlier work done by the MoH and partners in 2021 and on the experience of other countries where the DCP3 evidence and model packages were implemented. The timeline of the work in Liberia is presented below (Fig.1). The activities undertaken in the course of this collaboration tried to strike a balance between scientific rigor and the need to update the EPHS within a relatively short time frame.

Figure 1: Timeline of the work in Liberia



3.1 Initial engagement

At the beginning of 2021, DCP3 engaged with the Liberia MoH to discuss potential collaboration to support priority setting and UHC-related policies, including the updating of the EPHS with a focus on evidence-informed processes. A virtual meeting was organised on 8 June 2021 with H.E. Dr. Wilhelmina Jallah, Minister of Health and ministry officials to discuss potential collaboration. During this meeting, H.E. the Minister and team highlighted the critical timing of this work in Liberia's efforts to meet the health needs of the population. It was agreed that further discussions should take place in the

country, with a DCP3 team travelling to Liberia from September 20-23, 2021. The DCP3 country visit was organised during the National Health Policy Dialogue & Strategic Planning Workshop in Buchanan City. The team participated in the discussions and presented the DCP3 work to MoH staff, the National Public Health Institute of Liberia, UN agencies, development partners, and other stakeholders. A special meeting was held between the DCP3 team and Mr. A. Vaifee Tulay, Deputy Minister for Policy, Planning and Monitoring and Evaluation, and team to discuss the current status of the 2011-2021 EPHS (called EPHS I)[2] implementation and possibilities for collaboration.

A draft document on the potential DCP3 collaboration with Liberia was prepared and discussed with H.E the Minister, the Chief Medical Officer & Deputy Minister for Health Services, and other senior MoH staff. It included priorities of reviewing and updating the EPHS and capacity building in the MoH and other national partners in the areas of health economics, priority setting, and development of UHC packages. This document formed the basis for discussions regarding collaboration, and it was further agreed to draft an operational plan that covered the priorities proposed for collaboration.

The draft operational plan was officially presented and discussed on 17-18 November 2021, during Minister Jallah and MoH team's visit to Geneva, Switzerland. Following detailed discussions on Liberia's health system, EPHS I process and costing, and current work on updating the EPHS, the operational plan was further revised (Annex 1) and later endorsed by H.E. in a formal letter (Annex 2) on 26 November 2021.

Based on the operational plan and building on the work already done by the Ministry and development partners, intensive work began in Liberia to revise the EPHS based on the DCP3 evidence and packages. The Policy and Planning Division was assigned as a focal point for the initiative. Weekly meetings between the MoH, DCP3, and partners were set up to advance the work and ensure a comprehensive and engaged process, with additional connection on specific issues as needed.

3.2 Planning meetings and inception workshop

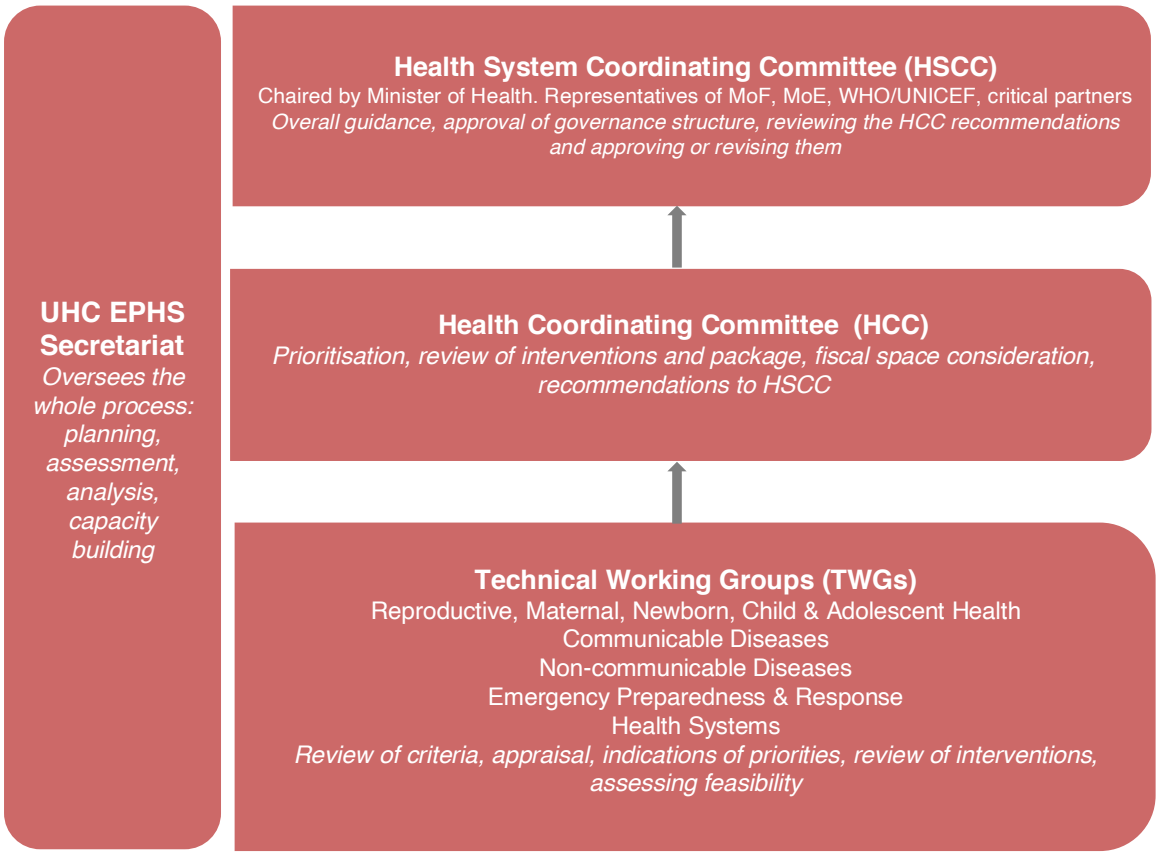
On 16-21 January 2022, the DCP3 team and the MoH organised a series of planning meetings in Monrovia, followed by an inception workshop. The week included preparatory work with the Ministry's senior management team and a series of meetings with the MoH and key partners on the draft National Health Policy and Health Financing Strategy 2022-2031 and the draft EPHS II process and contents. Prior to the inception workshop, remote discussions were conducted with several development partners that were actively engaged in health strengthening in Liberia.

The inception workshop was held on 20 January 2022 and was attended by 85 participants from across the Liberian health system and partners, including UN agencies. It focused on sensitising and building consensus among various stakeholders on UHC and a roadmap to update the EPHS, building partnerships for the revision and implementation of the EPHS, and developing joint plans for the prioritisation process.

The workshop was inaugurated by H.E. Dr. Jallah, who emphasised the importance of evidence-informed decision-making to update the EPHS, and in prioritising health services in a way that ensures affordability and feasibility of implementation.

Following presentations from WHO, UNICEF, USAID, MoH, and DCP3, discussions were held on the various components of the prioritisation process, including the development of an operational plan for updating the EPHS. Key steps, including a timeline and roles, were agreed, and adopted by the MoH and partners during the workshop. The plan included (a) installing a Secretariat and a governance structure (Fig. 2); (b) assessing the fiscal space for health; (c) mapping existing health services for prioritisation; (d) reviewing the available cost data, identifying gaps and conducting additional cost analysis, if necessary; and (e) prioritising of health services and updating the EPHS. The meeting concluded with participants highlighting the need to expedite action and conducting the prioritisation process as soon as possible, to meet the timeline set by the government.

Figure 2: UHC EPHS Governance Structure



Following the inception workshop, the governance structure (Fig. 2) and institutional arrangements were put in place by instituting a UHC EPHS Secretariat within the MoH, with technical support from DCP3. The decision-making forums were built on existing structures and included (a) five technical working groups (TWGs) on reproductive, maternal, newborn, child and adolescent health (RMNCAH), communicable diseases, NCDs, health services, and emergency preparedness and response (EPR), with

membership representing a wide range of public health, health system, and clinical professions; (b) the Health Coordination Committee (HCC), and (c) the Health System Coordination Committee (HSCC). The governance structure and composition of the TWGs were formally endorsed by the MoH on 11 March 2022.

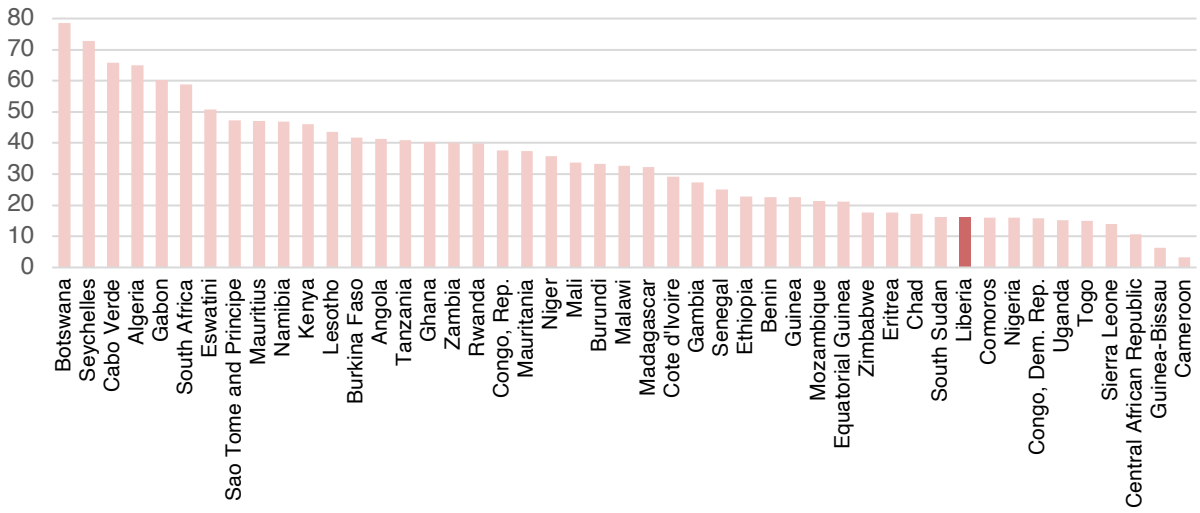
3.3 Fiscal space assessment

An assessment of the fiscal space for health was conducted between February and May 2022 to better understand the feasible levels of government spending for UHC and the potential for expanding public expenditure on health. The International Monetary Fund 2021 World Economic Outlook Database was used as a main source of data for economic growth projections. The Liberian MoH and Ministry of Finance and Development Planning (MoFDP) data have been used for this exercise, noting that some of the estimates differ from those published by the WHO Global Health Expenditure Database. Annex 3 presents the full fiscal space analysis report.

The gross domestic product (GDP) in Liberia grew rapidly between 2010 and 2013, with annual increases of 6-9%, before stabilising at around US$3 billion from 2014 to 2020. In 2021, Liberia's GDP rose by 3.6% and is expected to continue growing by 5% on average over the next 5 years.

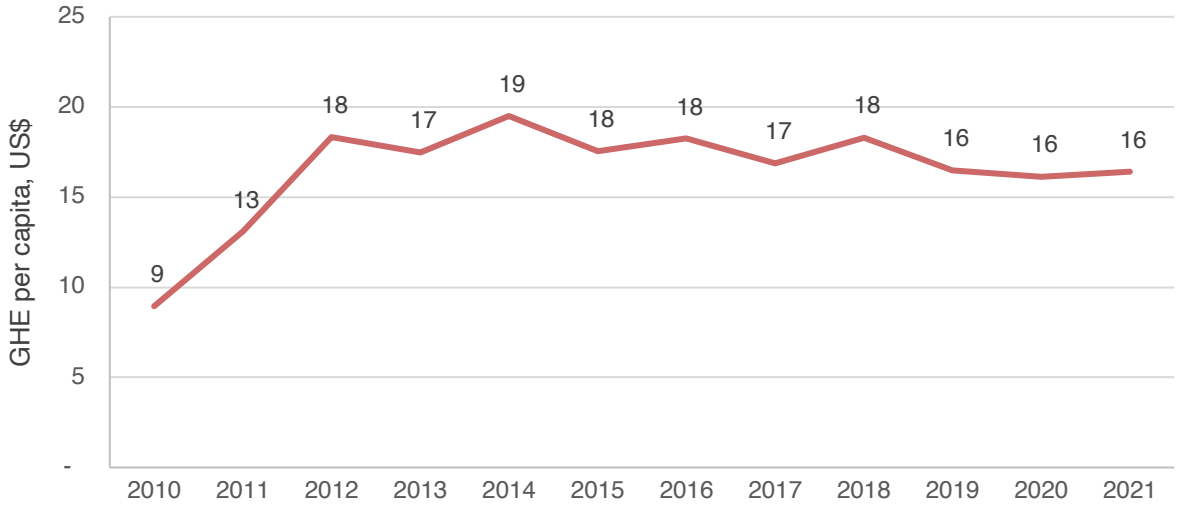
The percentage of the government budget allocated to health has increased steadily from 9% in 2010 to 14% in 2021 and has plateaued since then. However, looking at the domestic government health expenditure as a percentage of the current health expenditure (Fig. 3), the GoL is providing less than 20% of the total health budget. Funding for health must increase to enable OOP expenditure to decrease and for UHC to be achieved.

Figure 3: Domestic general government health expenditure as a % of current health expenditure [14]



The government health spending per capita increased from US$ 9 in 2010 to US$ 18 in 2018, but has decreased since then to US$16 in 2021 (Fig.4).

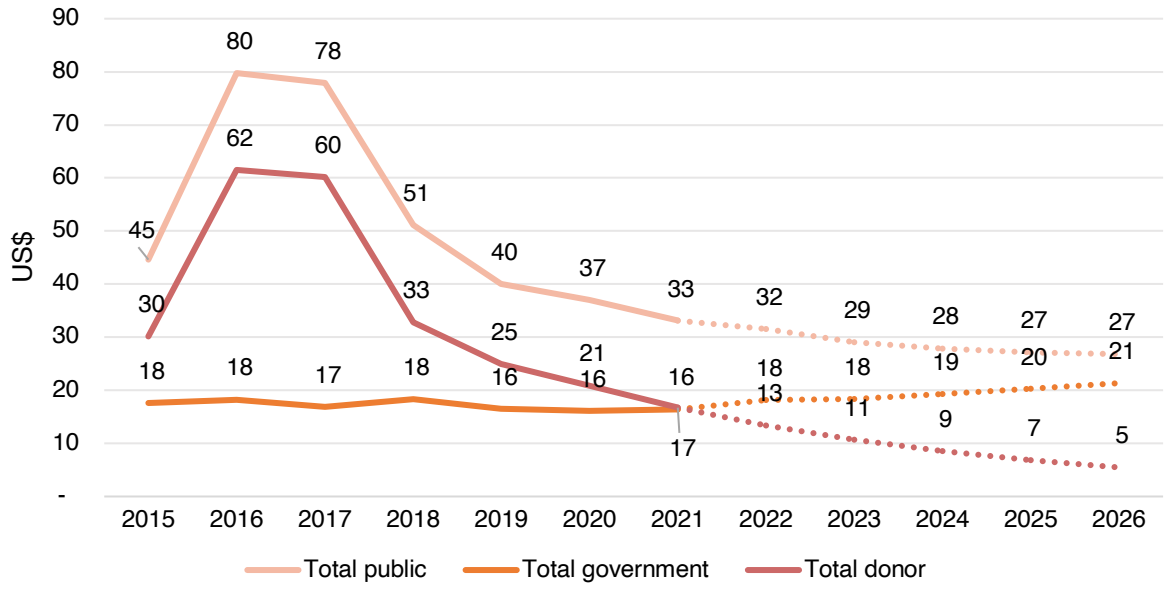
Figure 4: Government health expenditure per capita (2010-2021)



Source: MoH and MoFDP data

However, the International Monetary Fund (IMF) projections estimate an increase in the per capita government health budget from the current level of US$16 to US$21 in 2026, while donor funding will decrease significantly, from US$21 in 2020 to US$5 in 2026. Total public funding, which is the sum of per capita government and partner/donor funding, is therefore projected to decrease from US$37 per capita in 2020 to US$27 per capita in 2026. Figure 5 shows the projected amounts of government and donor spending per capita.

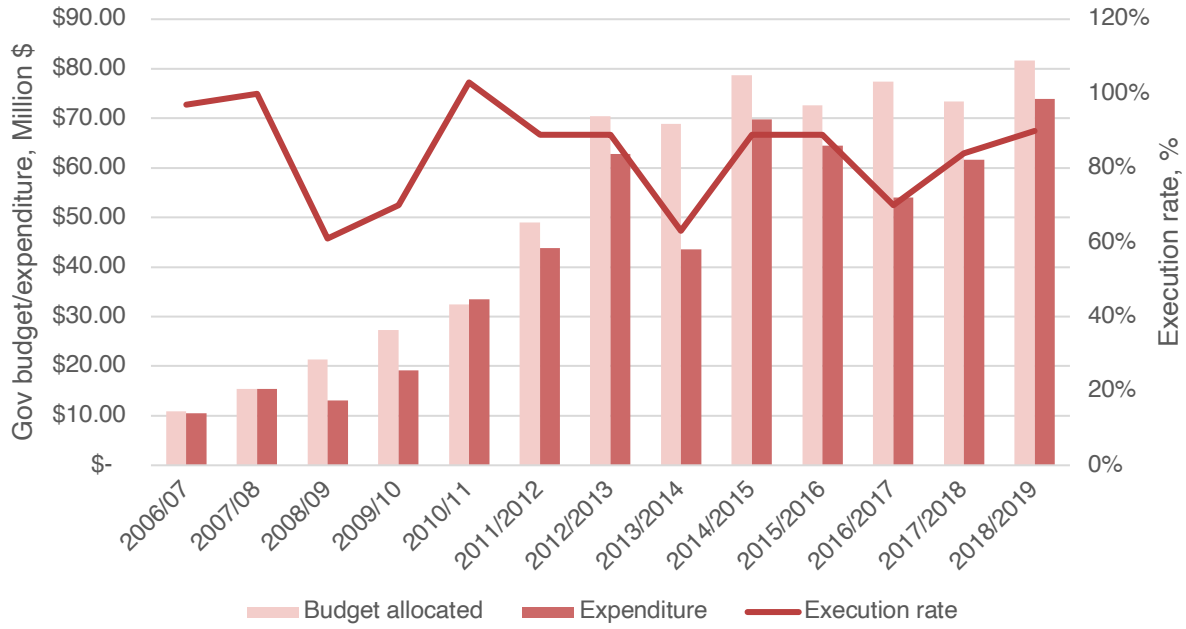
Figure 5: Projected per capita government and donor funding



Source: IMF, World Economic Outlook Database, MoH and MoFDP data

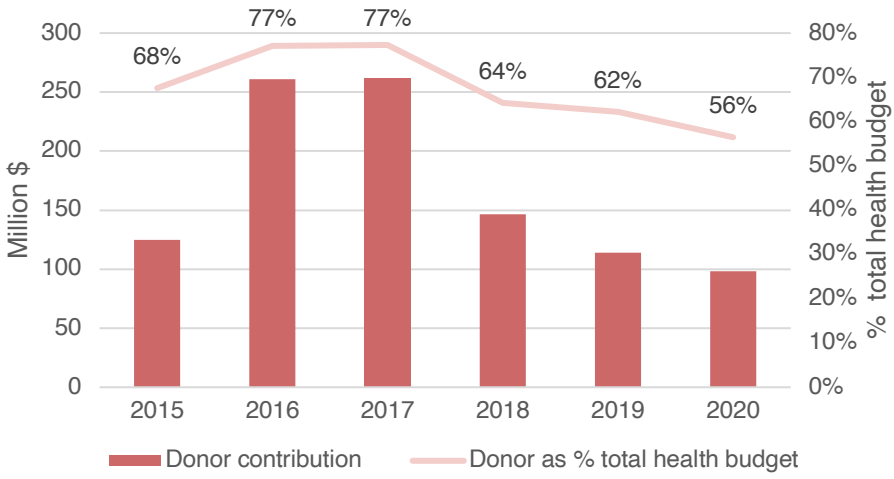
In planning to publicly finance the UHC package of health services, it is important to know that the government health allocation is not necessarily consistent with actual disbursements. Since 2006, the average execution rate of the budget is 84% (Fig. 6), which translates into a loss of US$2-3 of per capita spending. The gaps in implementing the allocated budget are mainly due to challenges in the current Public Financial Management, which cause delays in approval and disbursement of funds. Additionally, Liberia implements a cash-based budget and disburses based on revenue raised. When revenue falls short of the budget, this also impacts disbursement rates.

Figure 6: Actual disbursements of health budget (2006-2019)



Partner and donor funding have been a major contributor to Liberia's health budget, estimated at an average of 67% of the overall health budget since 2015. However, this funding has decreased substantially since 2017 (Fig. 7) and is predicted to continue to decline. This progressively decreasing trend may also be seen in Figure 5 above.

Figure 7: Donor contribution as % of total health budget (2015 – 2020)



Based on the fiscal space analysis and considering the strategic vision of the government on UHC, the per capita government spending on health is estimated at around US$16. However, allocating all government funds to package implementation is unrealistic. When designing the contents and implementation scenarios of the UHC EPHS, it was recommended to use a level of US$12-14 in government funding, taking into account management support requirements and other critical health system priorities, as well as the average budget execution rate of 84%. Additional funding is currently provided by development partners, who are already covering the major costs of certain interventions, such as routine immunisation and special programmes. These funding contributions are accounted for explicitly in the scenarios presented later in this report, although some partners are now asking the government to take on full financing of some of these interventions.

3.4 Mapping and assessment of existing health services

On 28-29 March 2022, the DCP3 team led a mapping workshop in Monrovia to identify the health services currently provided by the Liberian health system, as well as define which of the 218 DCP3 EUHC interventions were most relevant to the Liberian context. Over 70 representatives of the TWGs, partner agencies, and service providers from different levels of the health system attended the session.

During the two-day workshop, the TWGs were asked to respond to the following two questions:

- which DCP3 EUHC package interventions are relevant to the healthcare needs of Liberia and should be included in the prioritisation process?
- what is the estimated population coverage for the DCP3 EUHC interventions that are already provided by the different levels of the health system in Liberia?

An analysis of the workshop results showed that 67 (31%) out of the 218 DCP3 EUHC package interventions were considered by the TWGs as not currently provided in Liberia (Fig.8).

Figure 8: Availability of the 218 DCP3 Interventions

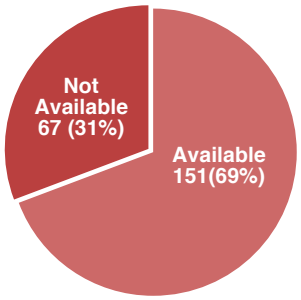
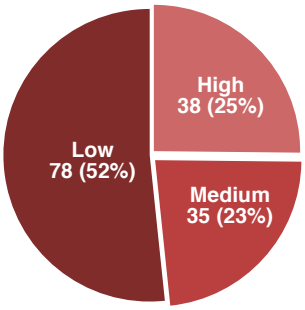


Figure 9: Estimated coverage of the 151 available DCP3 interventions



Out of the 151 available interventions, it was estimated that 52% were provided at low coverage (1-50%), 23% at medium coverage (51-75%), and 25% at high coverage (75%-100%)(Fig. 9). Only a small percentage of the DCP3 EUHC package interventions were estimated to be provided at full or almost full coverage.

As shown in Table 2, the mapping also demonstrated significant gaps in the service coverage levels at the community level, with low coverage being observed for 60% of community level DCP3 interventions. In addition, most of the available RMNCAH interventions are provided at low coverage (Table 3). Although the assessment of coverage of basic health services during the mapping process was conducted based on the views and experience of members of the TWGs, it still provides, in the absence of more real-time survey data, important information on the current implementation of critical health services.

Table 2: Availability of DCP3 interventions in the Liberia health system by platform

Platform (see note below)	# Available Interventions	1-50% Population having access	51 - 75% Population having access	75-100% Population having access
Population-based	10	3 (30%)	4 (40%)	3 (30%)
Community	35	21 (60%)	5 (14%)	9 (26%)
Health Centre	52	25 (48%)	15 (29%)	12 (23%)
First Level Hospital	39	18 (46%)	8 (21%)	13 (33%)
Specialty & Referral Hospitals	15	11 (73%)	3 (20%)	1 (7%)
Total	**151**	**78 (52%)**	**35 (23%)**	**38 (25%)**

Note: The table above uses the five DCP3 platforms, which were later changed to fit the structure of the Liberia health system. Liberia has six platform levels: Population-Based, Community, Clinic, Health Centre, District & County Hospitals, and Tertiary Care Hospitals. In the subsequent prioritisation process, the clinic platform was added, with interventions reallocated here from other platforms following review by TWG members and MoH staff.

Table 3: Availability of DCP3 interventions in the Liberia health system by cluster

Cluster (see note below)	# Available Interventions	1-50% Population having access	51 - 75% Population having access	75-100% Population having access
RMNCAH	51	31 (61%)	9 (18%)	11 (22%)
Communicable Diseases	40	15 (38%)	10 (25%)	15 (38%)
NCDs & Injuries	30	20 (67%)	6 (20%)	4 (13%)
Health System	30	12 (40%)	10 (33%)	8 (27%)
Total	**151**	**78 (52%)**	**35 (23%)**	**38 (25%)**

Note: The table uses the four DCP3 clusters. During the prioritisation process, a fifth cluster – Emergency Preparedness and Response – was added to correspond to the governance structure adopted for the purpose of updating the EPHS.

Following the mapping process, 200 of the 218 DCP3 EUHC interventions reviewed at the workshop were considered by the TWGs as high priority for inclusion in the next

prioritisation phase. In addition, two new interventions on EPR were created and added to the list for further prioritisation.

A review was also conducted of the interventions already included in the draft EPHS II, which had been proposed by a group of MoH experts and consultants before the DCP3 collaboration. A detailed analysis showed that 38 draft EPHS II interventions were not covered by the DCP3 model package; these interventions were thus added to the existing list of interventions for prioritisation. This resulted in an initial shortlist of 240 interventions considered as high priority by the TWGs and recommended for prioritisation. A detailed report of the mapping process, including the list of 240 interventions, is attached as Annexes 4 and 5.

3.5 HIPTool training

As a preparatory step in the lead up to prioritisation deliberations, the DCP3 team organised a training workshop in Buchanan City on 25-27 April 2022. The three-day workshop was attended by 12 senior technical personnel from the MoH and partner organisations, including two assistant ministers. Annex 6 contains the agenda and the list of participants.

The training aimed to build capacity within the MoH on resource optimisation analyses, how these can inform priority setting, and specifically on the use of the Health Interventions and Prioritisation Tool (HIPtool) – a resource optimisation tool. During the training, MoH and partner staff developed a better understanding of cost-effectiveness, resource optimisation, HIPtool, data needs and linkages.

The workshop participants reviewed the 240 interventions identified during the mapping exercises, existing data and additional data needs, and defined populations in need for each intervention. Based on this information, participants ran a preliminary analysis and generated a ranking/league table of interventions based on cost-effectiveness. The results of the preliminary HIPtool analysis were discussed at the prioritisation workshop.

3.6 Prioritisation workshop

On 28 April 2022, the MoH and DCP3 hosted the prioritisation workshop in Monrovia for members of the TWGs and partners. The objective of the workshop was to review the current status in updating the EPHS, reach consensus on the decision criteria for prioritising interventions, discuss the results of the HIPtool optimisation, and reach consensus on the prioritisation process to assess the list of 240 interventions mentioned above. These interventions were subsequently validated and assessed by the TWGs during the prioritisation process.

Prior to this workshop, the MoH and DCP3 team reviewed key documents on Liberia's national health policies and strategies, and identified a number of key values that are considered important. These were then translated into a set of eight decision criteria and discussed at the workshop. A brief survey was conducted during the workshop to

rank the criteria that would be adopted to facilitate prioritisation. All eight criteria were regarded as important in the context of Liberia, and it was agreed that they would be used in the prioritisation process. Figure 10 shows the ranking given by the TWGs from highest to lowest priority.

Figure 10: Ranking of decision criteria by the TWGs

3.7 Data collection and generation

In preparation for the deliberation workshop, evidence on the decision criteria for the 240 interventions was collated and validated with the MoH. Individual evidence sheets were developed for each intervention, incorporating colour-coded evidence on six of the eight criteria agreed upon by the TWGs in April (burden of disease, quality of evidence, cost-effectiveness, financial risk protection, budget impact, effectiveness). For two criteria (targeting vulnerable groups and feasibility), no evidence was systematically available. Annex 7 contains an example of the evidence sheets used during the TWG deliberations.

Data required to inform evidence sheets used in the prioritisation deliberations were collated from local, regional, and global secondary sources. Local expert opinion was used where data was not available.

1. Burden of disease: All burden of disease data (DALYS, mortality, incidence and prevalence) were sourced from the Institute for Health Metrics and Evaluation (IHME) Global Burden of Disease 2019 online results tool.[6]
2. Intervention coverage levels: Intervention coverage estimates were collated from the Liberia/MoH health information system, national surveys such as the Demographic and Health Survey, UN estimates for Liberia such as from UNAIDS or WHO, and peer-reviewed literature.
3. Intervention unit cost: USAID activity-based costing estimates were used to inform the unit cost of 46 services. The remainder were informed by adjusting DCP3 LMIC unit cost estimates based on health-worker salaries in Liberia.
4. Intervention cost-effectiveness: Cost-effectiveness estimates (US$/DALY averted) were sourced primarily from DCP3 Annexes 7A[15] and 3F[16] as well as from local, regional, and global peer-reviewed literature.

5. Intervention financial risk protection score: All financial risk protection scores were based on data from DCP3 Annex 3F [16].

The full list of data sources, estimates and assumptions used to inform the intervention data can be found in Annex 8.

3.8 Prioritisation deliberations

A meeting with the TWGs was held on 16 May 2022 to go over the prioritisation process, review the evidence sheets, clarify cut off points for each decision criteria and share instructions with TWG chairs and rapporteurs on the voting system and procedures during the deliberations workshop (Annex 9).

The deliberation workshop was held on 18-19 May 2022 in Monrovia, with participation of over 60 members of the TWGs and technical experts. It aimed to produce an evidence-informed list of high priority interventions by utilising local and international data and local expert judgement. The workshop focused on the TWG voting on the priority level of the 240 interventions, using the evidence on cost-effectiveness, burden of disease, budget impact, effectiveness, and financial risk protection, and the TWG's expert opinion on the criteria for which no evidence was available (targeting vulnerable groups and feasibility of implementation). Following two days of extensive deliberations, each TWG presented their voting on each intervention as high, medium, or low priority. The TWGs also provided corrections to intervention titles, health system platforms, current coverage, population in need, and additional information on vulnerable groups, feasibility of implementation, and coverage targets for 2030.

Out of 240 interventions, 132 were assessed by the TWGs as 'high priority', 54 as 'medium priority', 44 as 'low priority', and 10 were eliminated after further consideration. Annex 10 shows the 240 interventions by their priority level. The final evidence-informed shortlist of 132 high priority interventions produced by the TWGs was recommended for further assessment and appraisal. During the deliberations, an additional delivery platform (clinic) was introduced, which had not been previously included in the list of DCP3 service delivery platforms.

The preliminary results of the TWGs deliberations were presented to a meeting of senior Ministry of Health officials on 20 May 2022. The meeting was chaired by Dr. Francis Kateh, Deputy Minister of Health and Chief Medical Officer. The meeting concluded with decisions to refine some of the interventions and further prioritise the high priority interventions to fit within the Liberia fiscal space.

3.9 Second round of deliberations

The cost of the preliminary set of 132 high priority interventions exceeded the estimated fiscal space for public expenditure on health (US$16). It was therefore essential to undergo a second round of prioritisation to review the high priority interventions and develop more affordable scenarios for UHC package design. The second round of

deliberations focused on what might be more feasible to publicly finance and implement in the short term, until the health budget is progressively expanded along the UHC timeline to meet the cost of the full list of high priority interventions.

In this regard, an intensive five-day meeting with seven senior MoH officials, including the Assistant Minister for Health Services and Assistant Minister of Planning, was organised in Geneva, Switzerland on 11-14 July 2022. The meeting aimed to discuss the MoH's vision, positions, and plans on UHC, including options for EPHS costing and financing, review the preliminary outcome of the TWGs deliberations, conduct an in-depth review of the fiscal space analysis, reach consensus on the level of public spending allocated for EPHS financing, and discuss scenario options for financing a prioritised EPHS.

The final shortlist of 132 high priority interventions prioritised by the TWGs went through another round of review, with a specific emphasis on validating the initial figures/assumptions on the estimated target population and coverage. Changes were made to the data on 'population in need' and 'current coverage' of some interventions, which in turn modified the associated interventions' total spending, cost per capita, and DALYs averted. Data for some interventions, such as EPR, are not currently available. If these were to be added, they could produce further alterations to costs and health outcomes. This review and further technical consultation with MoH technical experts resulted in a refined and harmonised list of 128 interventions.

Tables 4 and 5 show the breakdown of the revised high-priority 128 interventions by delivery platform and cluster, indicating the cost per capita and DALYs averted. The 128 interventions were costed at US$28.00 per capita and were projected to avert close to 1.2 million DALYs. This set of high priority interventions served as a basis for further appraisal and discussion of funding.

Table 4: Cost per capita and DALYs averted of 128 interventions by platform

Platform	# Interventions	Cost Per Capita (US$)	DALYs averted
Population-Based	10	0.27	6,551
Community	18	1.80	147,402
Clinic	48	12.01	705,895
Health Centre	16	3.78	87,897
District & County Hospitals	27	9.70	213,260
Tertiary Hospitals	9	0.44	11,264
Total	**128**	**28.00**	**1,172,269**

Table 5: Cost per capita and DALYs averted of the 128 interventions by cluster

Cluster	# Interventions	Cost Per Capita (US$)	DALYs averted
RMNCAH	45	17.96	780,740
Communicable Diseases	36	7.28	273,564
NCDs	20	1.67	41,939
Health System	20	1.10	76,025
EPR	7	-	-
Total	**128**	**28.00**	**1,172,269**

4. Liberia EPHS and scenarios for financing

Based on the list of health interventions prioritised by the TWGs, four scenarios were developed to inform decision-making on EPHS content and financing.

Scenario development involved extensive consultations with MoH officials, using the data revised during the second round of deliberations and the criteria agreed during the process of this collaboration. The process considered the available government funding for EPHS package implementation as well as the feasibility of implementation. These scenarios were presented and discussed during the ministerial retreat on policy harmonisation and alignment with UHC EPHS package and financing mechanisms.

4.1. Assumptions in developing the EPHS scenarios

A number of assumptions and considerations were taken into account in developing the four scenarios for implementation:

- **Data.** The assumptions were based on the data on population in need, current coverage and cost gathered during the prioritisation process (see Section 3.7). This data was validated with the MoH during the second round of deliberations and the Geneva meeting. Data for interventions related to emergency or pandemic preparedness and response are not available and should be part of a special initiative to update the Joint External Evaluation and EPR action plan.

- **Available funding.** It is assumed that a fiscal space between US$12 and US$14 per capita is currently available for EPHS implementation. The reduction of available fiscal space for package financing from US$16 to US$12-14 is meant to cover other necessary expenditures outside the EPHS, and also to account for the incomplete budget execution rate of around 84%.

- **Partner/donor funding.** Although the forecast on donor funding suggests a declining trend, it was assumed that it will continue at the same rate for the next 5 years for the interventions that are currently being partially or fully financed. Within the list of 128 high priority interventions, it was estimated that four interventions on child immunisation and prevention of mother-to-child transmission of HIV[2] were entirely funded by partners at a total cost of US$ 4.35 per capita; 78 interventions were considered by the MoH as being partially funded (39 RMNCAH interventions; 30 communicable diseases; 7 NCDs; 1 health systems; 1 EPR). For partially funded interventions, it was assumed that partner/donor contribution amounted to 30% of the total cost of the interventions. In calculating the total cost to the government of the packages in each scenario,

[2] HC8: PMTCT of HIV (Option B+) and syphilis; C11: Pneumococcus vaccination; C12: Rotavirus vaccination; C16: Childhood vaccination series (diphtheria, pertussis, tetanus, polio, BCG, measles, hepatitis B, Hib, rubella)

the full and partial contributions from partners/donors have been taken into account.

- **Cost-sharing programme**: it is assumed that the MoH-developed cost-sharing programme, which is currently planned to include minimum user fees at the point of use, will be finalised and implemented this year. For the purpose of the UHC EPHS scenarios, it was assumed that cost sharing is set at 50% of costs. This percentage was used to calculate the total cost to the government of the complementary interventions in Scenarios 2-4. However, the level of co-payment will be decided by the government when the cost-sharing programme is finalised; costing estimates will be adjusted if a lower level is set[3].

It is important to note that the scenarios below are based on cost estimates appropriate for priority setting, not for implementation and budgeting. While the resulting prioritised core sub-packages suggested in this work are more likely to be in line with the estimated fiscal space for package rollout, a more stringent costing process is recommended for all interventions. A comprehensive micro-costing will provide more accurate cost information for each intervention and for the total package, particularly for implementation and management costs. A more robust costing could also improve the low disbursement rates in Liberia by increasing spending predictability over time, by service. It would also inform budgeting, planning, service purchasing and contracting out, medicine and supplies procurement, and assessing resource gaps for funders, among other benefits.

4.2 Scenarios

Four scenarios are presented below, based on the list of 128 interventions. The complete list of interventions under each scenario is available in Annex 11. Table 6 at the end of this section presents the cost to the government of the packages in each scenario.

In view of the decision made by the MoH to introduce a cost-sharing programme, Scenarios 2-4 are each composed of two sub-packages:

- a ‘core sub-package’ – defined as critical high-priority services by the TWGs and MoH that should be provided free at point of use, using public financing to ensure full access and sustainability of critical programmes and their capacity to continue to achieve health gains;

- a ‘complementary sub-package’ – composed of the next highest priority interventions, determined by the MoH, that need to be covered through other financing mechanisms, like cost-sharing or co-payments. In calculating the total

[3] Estimates were also made based on 30% co-payment.

cost of complementary sub-packages to the government, the contribution of partners/donors and 50% cost-sharing were taken into account.

The risks of cost-sharing and user fees should, however, be noted. Cost sharing (user fees) can reduce access to, and use of, services that are considered high priority in Liberia. Catastrophic health spending and impoverishment may result from the use of critical services that are not fully funded, particularly for the poorest. If cost sharing cannot be avoided entirely in the short term for these high-priority services, the government is urged to expand government health spending to fund these services and remove user fees as soon as possible.

An overview of all four scenarios is presented below:

Table 6: Overview of Scenarios 1-4

	# Interven-tions	Delivery platforms	Total cost per capita	Cost per capita covered by partners	Cost Sharing	Cost per capita to government	DALYS averted
Scenario 1	**128**	**6 P/Co/C/ H/DC/T**	**28.00**	**10.37**	**-**	**17.63**	**1,172,269**
Scenario 2	**128**		**28.00**	**10.37**	**1.115**	**16.52**	**1,172,269**
Core	101	6 P/Co/C/H/ DC/T	25.73	10.33	-	15.40	1,072,750
Complem.	27	4 C/H/DC/T	2.27	0.04	1.115	1.115	99,519
Scenario 3	**128**		**28.00**	**10.37**	**4.015**	**13.61**	**1,172,269**
Core	92	4 P/Co/C/H	17.86	8.26	-	9.60	947,745
Complem.	36	2 DC/T	10.14	2.11	4.015	4.015	224,524
Scenario 4	**128**		**28.00**	**10.37**	**5.35**	**12.28**	**1,172,269**
Core	78	4 P/Co/C/H	14.18	7.25	-	6.93	874,359
Complem.	50	3 H/DC/T	13.82	3.12	5.35	5.35	297,910

Note: P=Population-based; Co=Community; C=Clinic; H=Health Centre; DC=District & County Hospitals; T=Tertiary Hospitals.
The cost per capita to the government is calculated by (1) removing from the total cost per capita of the core sub-package the cost of fully funded and 30% of the cost of the interventions that are currently partially funded by partners and donors, and (2) excluding from the complementary sub-package the cost covered by partners/donors and 50% co-payment.

Scenario 1

Scenario 1 Is an aspirational package that includes the 128 interventions that were deemed as 'highest priority' by the TWGs, delivered through all six platforms. The interventions were determined by cost-effectiveness and other decision criteria adopted by the TWGs. The package is free at point of use and is estimated to have a total cost of US$28.00 or US$17.63 if partner funding is taken into account (see Table 6 above). Implementation of the full package is estimated to avert almost 1.2 million DALYs. Since this package far exceeds the available government spending, it could be used for advocacy and resource mobilisation or for implementation when health resource allocations are increased across the UHC timeline.

Scenario 2

Scenario 2 (Table 6) is based on Scenario 1 interventions, covered in two sub-packages:

→ **core sub-package,** which includes 101 interventions delivered through all six platforms at a cost of US$25.73 per capita or a cost to the government of US$15.40 after removing the cost of partner/donor funding for some interventions. These interventions are free at point of use.

→ **complementary sub-package**, which includes 27 interventions delivered through 4 platforms (clinic, health centre, district and county hospitals, tertiary hospitals). The total cost of the complementary package is US$2.27 per capita, while the total cost to the government is US$1.115.

The total cost to the government (US$ 16.52) of the core and complementary packages exceeds the currently available government spending for the EPHS.

Scenario 3

Scenario 3 (see Table 6) is an extended primary health care-based option, covering population, community, clinic, health centre interventions in the core sub-package and county, district, and tertiary hospitals in the complementary sub-package.

→ The **core sub-package** includes 92 interventions delivered through 4 platforms (population level, community, clinic, and health centre). The total cost per capita is US$17.86 or a net cost to the government of US$9.60 when partner funding is excluded.

→ The **complementary sub-package** has 36 interventions delivered through district, county and tertiary care hospitals. The total cost of the complementary sub-package is US$10.14, with a net cost to the government of US$4.015.

The total cost per capita to the government of both sub-packages is US$13.61, which meets the currently available government funding for EPHS implementation.

Scenario 4

Scenario 4 focuses on primary health care, as defined by the Liberia health system, covering population, community and health clinic platforms. The scenario is divided into core and complementary sub-packages (see Table 6):

→ The **core sub-package** includes 78 interventions delivered through population level, community, and clinic platforms. Two health centre interventions were also added as they were either part of a clinic intervention requiring patient stabilisation at the health centre level or were already supported by development partners and concerned conditions directly related to poverty. The total cost of the core package is US$14.18, while the total cost to the government is US$6.93.

→ The **complementary sub-package** includes 50 interventions delivered at health centres, district and county hospitals, and tertiary hospitals. The total cost of the complementary package is US$13.82 per capita, while the total cost to the government is US$5.35.

The total cost to the government of the Scenario 4 package (US$12.28) meets the currently available government funding for EPHS implementation.

4.3 Cost-sharing programme and co-payments

The Ministry of Health is currently designing a cost-sharing programme to recover part of the costs of health services, which can be used to improve quality or increase the range of services included in the complementary sub-package. However, the complementary sub-packages in Scenarios 2-4 include high priority interventions that avert a significant disease burden in Liberia. As such, it is important to note again that co-payments can reduce use of critical health interventions.[17-18] As the poorest in Liberia have the greatest health need, they risk being the most adversely affected. Besides, individual exemptions to user fees may prove complex to implement at the point of care. Finally, adopting one package that is fully funded and another that is partly funded but offered by the same provider could easily constitute a communications challenge for both patients and health service providers. Significant investment in training and signage would be required to explain which services are contained in which packages and what co-payments are expected.

While it is accepted that a limited budget will constrain the number of services that can be fully funded by government spending, it is important that the Liberian government consider strategic approaches to expand public spending on essential health care, as a

prerequisite for achieving UHC and as a necessary investment in human capital for Liberia's future prosperity.

4.4 Options for increasing the fiscal space for health

Key principles in setting the EPHS are affordability and feasibility of implementation. Aspirational packages that do not meet these two criteria are difficult to implement and result in implicit health resource prioritisation. The package should therefore have sustainable sources of funding along the UHC 2030 timeline, linked to robust financing mechanisms.

Since public spending on essential health services is central to UHC, it is critical to explore options to implement the package in a way that is consistent with current fiscal realities. At the same time, it is important to consider increasing the resources necessary for a progressive increase in coverage of interventions over the next 7-8 years of the SDG cycle, while taking into account fiscal space projections. It is projected that per capita government budget for health will increase from US$16 in 2021 to US$21 in 2026, while donor funding will decrease from US$21 in 2020 to US$5 in 2026. Total per capita public funding will decrease from US$37 in 2020 to US$27 in 2026.
Options to increase health resource allocation include:

- Ensuring that macroeconomic growth translates into expanding fiscal space for health
- Reinforcing efficient use of existing health expenditure
- Generating new health sector specific resources through earmarked taxation
- Increasing health allocation by further prioritising health in the government budget
- Growing development assistance and donor funding.

In Liberia, the first three are the most promising options. First, as mentioned before, IMF projections indicate that prospects for macroeconomic growth are positive. GDP grew rapidly between 2010 and 2013, with annual increases of 6-9%, before stabilising around US$3 billion until 2020. In the last year, national GDP has grown by 3.6% and is predicted to continue growing by 5% on average over the next 5 years.

Second, additional resources could be generated through increased taxation and earmarking for health. There is potential to increase goods and services tax or value-added tax in Liberia, which is currently 10%, and generate a substantial tax revenue in the country. Another potential source is excise taxes on alcohol, tobacco, sugar, and luxury goods, which currently constitute a small proportion of Liberia tax revenue. Excise taxes on tobacco, alcohol and sugar taxes are well documented to increase government revenue.[19-20] However, their sustainability and long-term predictability of revenue is a challenge.

Third, additional resources could be generated through efficiency gains, partly by implementing the UHC EPHS and focusing on the highest-impact investments,

reinforcing strategic purchasing and strengthening public financial management and budget planning to execution.

The other two options, namely of reprioritising government budget and increased development assistance, seem to be less promising at present. The Abuja declaration challenges governments to spend at least 15% of their annual budget on health, but the Liberian government already allocates around 14% of the total government budget to health. Similarly, current projections indicate that partner/donor funding is declining. While per capita government budget is estimated to increase from US$16 in 2021 to US$21 in 2026, donor funding is projected to decrease from US$21 in 2020 to US$5 in 2026. It would still be essential to have an in-depth assessment of new opportunities for development assistance and possibilities for slowing down the decline of existing support. There are options to strengthen the engagement of key development partners operating in Liberia who are not yet providing significant assistance for the health area.

5. Ministerial review of the UHC EPHS and outcome of the collaboration

5.1 Objectives of the ministerial retreat and UHC EPHS Scenarios

A ministerial retreat was held on 18 August 2022. The objectives were to review the outcome of collaboration, including the scenarios proposed for the UHC EPHS, reach consensus on policy decisions on the UHC EPHS, and harmonise and align these with the 2022-2026 NHSSP and National Health Financing Strategy and the next steps for accelerating progress to UHC. Annex 12 contains the list of participants and the agenda of the retreat.

The updated NHSSP was reviewed, and key strategic priority actions were identified.

The DCP3 team provided an overview of the MoH/DCP3 collaboration, covering all EPHS design processes since the inception workshop in January 2022 and presented four scenarios on the design, contents, and preliminary costing of the UHC EPHS.

As detailed in Section 4.2, while Scenarios 1 and 2 are unaffordable at present given the currently limited public funding, the initial costs to the government of Scenarios 3 and 4 do fall within the recommended fiscal space range ($12-14 per capita) for EPHS financing. Both scenarios include a core sub-package which is publicly financed and a complementary sub-package financed by other mechanisms, including the MoH cost-sharing programme. However, following a detailed review of all options and alignment with the NHSSP, the senior health officials at the ministerial retreat reached consensus on endorsing Scenario 4. They considered it as the most appropriate and realistic, given the currently available fiscal space for health, the further anticipated rise of costs as a result of progressively increasing coverage of interventions along the 2030 UHC

timeline, and taking into account current financing plans, including the ongoing development of the cost-sharing programme.

The risk of the impact of co-payment for some complementary interventions on service access, health equity and health outcomes has been voiced during the retreat. In this respect, the package design allows an assessment of such risk and provides the possibility of adjusting the level of co-payment to match available resources, until more public funding becomes available to cover the full cost of the complementary sub-package.

It is worth noting that according to MoH data, four of the interventions in the Scenario 4 core sub-package are fully funded by partners/donors. In addition, partners are partially covering the cost of 59 interventions in the core sub-package and 19 in the complementary sub-package. These interventions are marked in Annex 11.

As stated above, the total cost of the core and complementary sub-packages to the government is $12.28, which fits within the level of funding currently available for UHC package implementation. Most of the costs in the core sub-package is at the clinic level, which also includes the highest number of interventions.

Table 8: Breakdown of Scenario 4 interventions by platform and cluster

Platforms	# Interventions	Total cost per capita	Cost per capita covered by partner funding	Cost sharing*	Total cost per capita to government	DALYS averted
Core	**78**	**14.18**	**7.25**	-	**6.93**	**874,359**
Population-Based	10	0.27	0.08	-	0.19	6,551
Community	18	1.80	0.54	-	1.26	147,402
Clinic	48	12.01	6.6	-	5.41	705,895
Health Centre	2	0.10	0.03	-	0.07	14,510
Complementary	**50**	**13.82**	**3.12**	**5.35**	**5.35**	**297,910**
Health Centre	14	3.68	1.00	1.34	1.34	73,387
District and County Hospitals	27	9.70	2.1	3.80	3.80	213,260
Tertiary Hospitals	9	0.44	0.01	0.21	0.21	11,264
Total	**128**	**28.00**	**10.37**	**5.35**	**12.28**	**1,172,269**

Clusters	# Interventions	Total cost per capita	Cost per capita covered by partner funding	Cost sharing	Total cost per capita to government	DALYS averted
Core	**78**	**14.18**	**7.25**	-	**6.93**	**874,359**
RMNCAH	33	9.17	5.79	-	3.38	632,736
Communicable	27	4.29	1.27	-	3.02	221,553
NCDs	9	0.62	0.18	-	0.44	18,094
Health System	2	0.09	-	-	0.09	1,977
EPR	7	-	-	-	-	-
Complementary	**50**	**13.82**	**3.12**	**5.35**	**5.35**	**297,910**
RMNCAH	12	8.78	2.26	3.26	3.26	148,004
Communicable	9	2.99	0.85	1.07	1.07	52,012
NCDs	11	1.05	-	0.525	0.525	23,845
Health System	18	1.00	0.01	0.495	0.495	74,049
Total	**128**	**28.00**	**10.37**	**5.35**	**12.28**	**1,172,269**

5.2 Next steps

The Ministerial retreat discussed the next steps. The following are key actions agreed:

- **Conducting a more robust costing**. The preliminary costing estimates made during the prioritisation of interventions must be followed by a more reliable costing process, which is necessary for budgeting and financial planning and management. It is also important for effective communication with other policy makers, especially finance, and for resource mobilisation. USAID has already conducted a detailed costing of a significant number of primary health services that are part of the UHC EPHS,[21] and UNICEF has already committed to support the costing of the full package. The outcome of the detailed costing will result in further adjustments of the core and complementary sub-packages.

- **Developing an operational plan for health system strengthening**. A prerequisite for a successful transition from package design to rollout is to address the key health system gaps that currently impede implementation. The NHSSP identifies important health system constraints and a wide range of recommendations. However, a comprehensive action to respond to these recommendations will require considerable time, efforts and resources, that cannot be met within the short timeframe required to initiate EPHS implementation. For this reason, it will be important to identify those top priority constraints that require action by the MoH and partners through a feasibly executed short- and medium-term operational plan.

- **Reviewing existing health financing mechanisms and public financing management**. A key area of health financing functions and health system reform is on package financing and budgeting. Reviewing existing health financing mechanisms and public financing management will thus be critical for package rollout. For an effective outcome of the review, the MoH must ensure full engagement of the Ministry of Finance and Development Planning, Liberia Revenue Authority, key relevant development partners, and Parliament.

- **Finalising the cost-sharing programme and the Liberia Health Equity Fund with special emphasis on instituting measures to reduce the potential risks of co-payments on access to services.** A major prerequisite for EPHS rollout is finalisation and government endorsement of the cost-sharing programme and the LHEF. Ongoing work on these initiatives needs to be accelerated and given higher priority. As stated before, the assumption made in constructing the overall cost of the package is a co-payment for the interventions in the complementary sub-package. The form and level of co-payment involved in the complementary sub-package will need to be discussed with special focus on measures to reduce potentially negative impact on service access and lower the financial risk to users.

- **Reinforcing partnerships for package rollout**. Key partners were involved in the different stages of the development of the UHC package. The scenarios, developed as an outcome of the package design process, will need to be presented and discussed with development partners and other stakeholders. Participants at the retreat recommended holding a special meeting for this purpose. The meeting will provide an opportunity for the stakeholders to understand, and have a dialogue on, the interventions included in the two sub-packages. The meeting will also be an integral next step to ensure the buy-in and support of development partners and donors, including continued contribution in funding the interventions they are currently supporting.

- **Developing a multi-year operational plan to implement the EPHS** for UHC and aligning partner resources within the package.

- **Preparing an advocacy and engagement plan.** An advocacy and engagement plan needs to be drafted and discussed in consultation with stakeholders and development partners. The retreat also highlighted the need to develop a communication strategy for the launch and dissemination of the UHC EPHS and the updated NHSSP.

6. References

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Annexes

Annex 1 Operational plan

Available here: https://drive.google.com/drive/folders/1ZDydyqhaG2qswe7Q1otg5ASBJ3qANnq4?usp=sharing

Annex 2 Letter of endorsement

Available here: https://drive.google.com/drive/folders/1I-m4KiyuvZPDIpPYEI9aHhpnaSxywhuZ?usp=sharing

Annex 3 Fiscal space analysis

Available here:

https://drive.google.com/drive/folders/1EBFYAYYVST_12ijLGsLcQ1eQJUJ0FyEk?usp=sharing

Annex 4 Mapping workshop report

Available here: https://drive.google.com/drive/folders/1QqawSYkj6rTL_G7TV9WLkbhVc7a_2_XU?usp=sharing

Annex 5 Full list of interventions for prioritisation

Available here: https://drive.google.com/drive/folders/1xNTwynTMwARg4kD3oLMI0GUNG39J9fyz?usp=sharing

Annex 6 HIPTool training agenda and participant list

Available here: https://drive.google.com/drive/folders/1sI56z6MEFVA86E2PL_1RzHyy4b5k5lEn?usp=sharing

Annex 7 Evidence sheets

Available here: https://drive.google.com/drive/folders/1rR44Eimn0TcJIcAmkShAgcRGg-GSxMad?usp=sharing

Annex 8 Data sources, estimates and assumptions

Available here:
https://drive.google.com/drive/folders/1i7OVC8E4YMuKCWmc6Bu3ki8sP_XTFQfv?usp=sharing

Annex 9 Explanation of decision criteria and colour coding

Available here:
https://drive.google.com/drive/folders/1u5KCJZUHOeCgkrv2YNn10p-pPw7-XDC-?usp=sharing

Annex 10 List of TWG prioritised interventions

Available here:
https://drive.google.com/drive/folders/1wPblhFYR_ZNeegJLviHpA8reMJvWthu1?usp=sharing

Annex 11 List of interventions under each scenario

Code	Intervention Title	Service delivery Platform	Cluster	Partner/Donor funding	Cost per capita	Scenario 1	Scenario 2	Scenario 3	Scenario 4
EPHS11	IEC/BCC on immunization	Population-Based	Communicable Disease	Partial	0.1	Core	Core	Core	Core
EPHS20	IEC/BCC on preventing malaria transmission	Population-Based	Communicable Disease	Partial	0.07	Core	Core	Core	Core
EPHS25	IEC/BCC on spread of filariasis, symptoms and case management	Population-Based	Communicable Disease	Partial	0.1	Core	Core	Core	Core
P2	Mass media messages concerning healthy eating and exercise	Population-Based	NCD	Partial	0.01	Core	Core	Core	Core
P3	Mass media messages concerning substance abuse	Population-Based	NCD	Partial	0.003	Core	Core	Core	Core
P7	Conduct a comprehensive assessment of International Health Regulations (IHR) competencies using the Joint External Evaluation tool and develop, cost, finance and implement an action plan to address gaps in preparedness and response	Population-Based	EPR	No	-	Core	Core	Core	Core

P8	Conduct simulation exercises and health worker training for outbreak events including outbreak investigation, contact tracing and emergency response	Population-Based	EPR	No	-	Core	Core	Core	Core
P9	Decentralize stocks of anti viral medications in order to reach at-risk groups and disadvantaged populations	Population-Based	EPR	No	-	Core	Core	Core	Core
P10	Develop and implement a plan to ensure surge capacity in hospital beds, stockpiles of disinfectants, equipment for supportive care, and personal protective equipment	Population-Based	EPR	No	-	Core	Core	Core	Core
P11	Develop plans and legal standards for curtailing interactions between infected persons and uninfected population and implement and evaluate infection control measures in health facilities	Population-Based	EPR	No	-	Core	Core	Core	Core
C4	Promotion of exclusive breastfeeding and complementary feeding by community health workers	Community	RMNCAH	Partial	0.01	Core	Core	Core	Core
C8	Detection of malnourished children and referral to appropriate level of care	Community	RMNCAH	Partial	0.06	Core	Core	Core	Core

C9	Detection and treatment of childhood infections (iCCM), including referral of danger signs	Community	RMNCAH	Partial	0.57	Core	Core	Core	Core
C10	Education on handwashing and safe disposal of stools	Community	RMNCAH	Partial	0.01	Core	Core	Core	Core
C14	Provision of vitamin A and zinc supplementation to children according to WHO guidelines	Community	RMNCAH	Partial	0.04	Core	Core	Core	Core
EPHS8	Deworming of children	Community	RMNCAH	Partial	0.04	Core	Core	Core	Core
C20	School based HPV vaccination for girls	Community	RMNCAH	Partial	0.11	Core	Core	Core	Core
C21	Mass drug administration for lymphatic filariasis, onchocerciasis, schistosomiasis, soil-transmitted helminthiases, yaws, trachoma, and foodborne trematode infections	Community	Communicable Disease	Partial	0.46	Core	Core	Core	Core
C25	Education campaigns for the prevention of gender-based violence	Community	RMNCAH	Partial	0.19	Core	Core	Core	Core
C30	Provision of condoms to key populations, including sex workers, men who have sex with men, people who inject drugs, transgender populations, and prisoners	Community	Communicable Disease	Partial	0.22	Core	Core	Core	Core

C32	Routine contact tracing to identify individuals exposed to TB and link them to care	Community	Communicable Disease	Partial	0.04	Core	Core	Core	Core
EPHS17	DOTS and defaulters tracing	Community	Communicable Disease	Partial	-	Core	Core	Core	Core
EPHS38	Mass drug distribution, administration for NTDs	Community	Communicable Disease	Partial	0.04	Core	Core	Core	Core
C43	Early detection and treatment of human African trypanosomiasis and leprosy	Community	Communicable Disease	Partial	0.02	Core	Core	Core	Core
C44	Total treatment for yaws	Community	Communicable Disease	Partial	0.001	Core	Core	Core	Core
C45	Identify and refer patients with high risk including pregnant women, young children, and those with underlying medical conditions	Community	Communicable Disease	No	-	Core	Core	Core	Core
C46	In the context of an emerging infectious outbreak, provide advice and guidance on how to recognize early symptoms and signs and when to seek medical attention	Community	EPR	No	-	Core	Core	Core	Core
EPHS39	Focused use of vaccines for epidemic infections, such as COVID-19, meningococcus, Lassa fever, and others	Community	EPR	Partial	-	Core	Core	Core	Core
C1	Antenatal and postpartum education on family planning	Clinic	RMNCAH	Partial	0.02	Core	Core	Core	Core

EPHS3	Encouraging 8 or more ANC contacts at the facility with support from the community	Clinic	RMNCAH	Partial	0.02	Core	Core	Core	Core
HC2	Management of miscarriage or incomplete abortion and post abortion care	Clinic	RMNCAH	Partial	0.0001	Core	Core	Core	Core
EPHS2	Management of anemia before and during pregnancy	Clinic	RMNCAH	Partial	0.02	Core	Core	Core	Core
HC9	Screening and management of hypertensive disorders in pregnancy	Clinic	RMNCAH	Partial	0.01	Core	Core	Core	Core
HC10	Screening and management of diabetes in pregnancy (gestational diabetes or pre-existing type II diabetes)	Clinic	RMNCAH	Partial	0.02	Core	Core	Core	Core
FLH1	Detection and management of fetal growth restriction	Clinic	RMNCAH	Partial	0.25	Core	Core	Core	Core
HC3	Management of preterm premature rupture of membranes, including administration of antibiotics	Clinic	RMNCAH	Partial	0.02	Core	Core	Core	Core
HC11	Management of labor and delivery in low-risk women (BEmNOC), including initial treatment of obstetric or delivery complications prior to transfer	Clinic	RMNCAH	Partial	0.48	Core	Core	Core	Core

C2	Counseling of mothers on providing thermal care for preterm newborns (delayed bath and skin-to-skin contact)	Clinic	RMNCAH	Partial	0.01	Core	Core	Core	Core
C3	Management of labor and delivery in low-risk women by skilled attendants, including basic neonatal resuscitation following delivery	Clinic	RMNCAH	Partial	0.28	Core	Core	Core	Core
EPHS5	Provision of vitamin A supplementation to postpartum women	Clinic	RMNCAH	Partial	0.05	Core	Core	Core	Core
C6	HIV education and counseling for pregnant women, sex workers, people who inject drugs, men who have sex with men, and transgender individuals, and PLHIV and their partners	Clinic	Communicable Disease	Partial	0.01	Core	Core	Core	Core
HC8	PMTCT of HIV (Option B+) and syphilis	Clinic	RMNCAH	Full	0.22	Core	Core	Core	Core
C7	In high malaria transmission settings, intermittent preventive treatment in pregnancy	Clinic	Communicable Disease	Partial	0.03	Core	Core	Core	Core
HC32	Provision of insecticide-treated nets to children and pregnant women attending health centers	Clinic	Communicable Disease	Partial	0.18	Core	Core	Core	Core

FLH19	Management of severe malaria, including early detection and provision of rectal artesunate in community settings followed by parenteral artesunate and full-course of ACT	Clinic	Communicable Disease	Partial	0.76	Core	Core	Core	Core
C11	Pneumococcus vaccination	Clinic	RMNCAH	Full	1.33	Core	Core	Core	Core
C12	Rotavirus vaccination	Clinic	RMNCAH	Full	0.78	Core	Core	Core	Core
C13	Provision of cotrimoxazole to children born to HIV-positive mothers	Clinic	Communicable Disease	Partial	0.07	Core	Core	Core	Core
EPHS6	Treatment of skin pustules or cord infection	Clinic	RMNCAH	Partial	0.0034	Core	Core	Core	Core
HC1	Early detection and treatment of neonatal pneumonia with oral antibiotics	Clinic	RMNCAH	Partial	0.00018	Core	Core	Core	Core
EPHS7	Treatment of neonatal tetanus	Clinic	RMNCAH	Partial	0.00003	Core	Core	Core	Core
FLH3	Jaundice management with phototherapy	Clinic	RMNCAH	No	0.001	Core	Core	Core	Core
C16	Childhood vaccination series (diphtheria, pertussis, tetanus, polio, BCG, measles, hepatitis B, Hib, rubella)	Clinic	RMNCAH	Full	2.03	Core	Core	Core	Core
HC12	Detection and treatment of childhood infections with danger signs (IMCI)	Clinic	RMNCAH	Partial	1.07	Core	Core	Core	Core

C35	In all malaria-endemic countries, diagnosis with rapid test or microscopy (including speciation) followed by treatment with ACTs (or current first-line combination)	Clinic	Communicable Disease	Partial	0.15	Core	Core	Core	Core
EPHS22	Early detection and response for yellow fever	Clinic	Communicable Disease	Partial	0.0003	Core	Core	Core	Core
HC30	Evaluation and management of fever in clinically stable individuals using WHO IMAI guidelines, with referral of unstable individuals to first-level hospital care	Clinic	Communicable Disease	Partial	0.93	Core	Core	Core	Core
EPHS21	Diagnosis and treatment of typhoid	Clinic	Communicable Disease	No	0.02	Core	Core	Core	Core
C42	Management of lymphedema	Clinic	Communicable Disease	Partial	0.79	Core	Core	Core	Core
EPHS29	Case reporting and management of bites and rabies	Clinic	Communicable Disease	Partial	0.1	Core	Core	Core	Core
HC16	Post gender-based violence care, including counseling, provision of emergency contraception, and rape-response referral (medical, psychosocial and judicial)	Clinic	RMNCAH	Partial	1.04	Core	Core	Core	Core

HC17	Syndromic management of common sexual and reproductive tract infections (for example urethral discharge, genital ulcer, and others) according to WHO guidelines	Clinic	RMNCAH	Partial	0.4	Core	Core	Core	Core
HC21	Partner notification and expedited treatment for common STIs, including HIV	Clinic	Communicable Disease	Partial	0.02	Core	Core	Core	Core
HC22	PrEP for discordant couples and others at high risk of infection such as commercial sex workers (in high prevalence settings)	Clinic	Communicable Disease	Partial	0.16	Core	Compl.	Core	Core
HC28	Screening for HIV in all individuals with a diagnosis of active TB; if HIV infection is present, start (or refer for) ARV treatment and HIV care	Clinic	Communicable Disease	Partial	0.001	Core	Core	Core	Core
HC38	Provision of aspirin for all cases of suspected acute myocardial infarction	Clinic	NCD	No	0.0001	Core	Core	Core	Core
HC40	Screening and management of diabetes among at-risk adults, including glycemic control, management of blood pressure and lipids, and consistent foot care	Clinic	NCD	Partial	0.3	Core	Core	Core	Core

HC42	Treatment of acute pharyngitis in children to prevent rheumatic fever	Clinic	NCD	No	0.0001	Core	Core	Core	Core
HC45	Opportunistic screening for hypertension for all adults and initiation of treatment among individuals with severe hypertension and/or multiple risk factors	Clinic	NCD	Partial	0.001	Core	Core	Core	Core
HC50	Management of depression and anxiety disorders with psychological and generic antidepressant therapy	Clinic	NCD	Partial	0.28	Core	Core	Core	Core
HC51	Management of epilepsy, including acute stabilization and long-term management with generic anti-epileptics	Clinic	NCD	No	0.03	Core	Core	Core	Core
HC61	Resuscitation with basic life support measures	Clinic	Health System	No	0.04	Core	Core	Core	Core
HC62	Suturing laceration	Clinic	Health System	No	0.05	Core	Core	Core	Core
EPHS34	Early detection and treatment of eye infection	Clinic	Communicable Disease	Partial	0.02	Core	Core	Core	Core
EPHS36	First aid management of eye injury	Clinic	NCD	Partial	0.001	Core	Core	Core	Core
EPHS13	Management of ear infection	Clinic	Communicable Disease	No	0.02	Core	Compl.	Core	Core
FLH12	Management of severe acute malnutrition	Health Centre	RMNCAH	Partial	0.06	Core	Core	Core	Core

FLH4	Management of eclampsia with magnesium sulfate, including initial stabilization at Health Center	Health Centre	RMNCAH	Partial	0.03	Core	Core	Core	Core
FLH5	Management of maternal sepsis, including early detection at Health Center	Health Centre	RMNCAH	Partial	0.05	Core	Core	Core	Compl.
FLH7	Management of preterm labor with corticosteroids, including early detection at health centers	Health Centre	RMNCAH	Partial	0.21	Core	Core	Core	Compl.
HC6	Management of neonatal sepsis, pneumonia, and meningitis using injectable and oral antibiotics	Health Centre	RMNCAH	Partial	0.004	Core	Core	Core	Compl.
EPHS12	Surveillance and case reporting of immunizable diseases	Health Centre	Communicable Disease	Partial	-	Core	Core	Core	Compl.
HC13	Among all individuals who are known to be HIV positive, immediate ART initiation with regular monitoring of viral load for adherence and development of resistance	Health Centre	RMNCAH	Partial	1.59	Core	Core	Core	Compl.

HC26	For PLHIV and children under five who are close contacts or household members of individuals with active TB, perform symptom screening and chest radiograph; if there is no active TB, provide isoniazid preventive therapy according to current WHO guidelines	Health Centre	Communicable Disease	Partial	0.19	Core	Core	Core	Compl.
HC27	Diagnosis of TB, including assessment of rifampicin resistance using rapid molecular diagnostics (UltraXpert), and initiation of first-line treatment per current WHO guidelines for drug-susceptible TB; referral for confirmation, further assessment of drug resistance, and treatment of drug-resistant TB	Health Centre	Communicable Disease	Partial	0.49	Core	Core	Core	Compl.
HC33	Identify and refer to higher levels of health care patients with signs of progressive illness	Health Centre	Communicable Disease	No	-	Core	Compl.	Core	Compl.
HC37	Low-dose inhaled corticosteroids and bronchodilators for asthma and for selected patients with COPD	Health Centre	NCD	No	0.001	Core	Core	Core	Compl.

HC14	Psychological treatment for mood, anxiety, ADHD, and disruptive behavior disorders in adolescents	Health Centre	RMNCAH	Partial	0.83	Core	Core	Core	Compl.
HC52	Management of schizophrenia using generic anti-psychotic medications and psychosocial treatment	Health Centre	NCD	No	0.04	Core	Core	Core	Compl.
HC57	Dental extraction	Health Centre	Health System	No	0.19	Core	Compl.	Core	Compl.
HC60	Management of non-displaced fractures	Health Centre	Health System	No	0.05	Core	Compl.	Core	Compl.
FLH42	Relief of urinary obstruction by catheterization or suprapubic cystostomy	Health Centre	Health System	No	0.04	Core	Compl.	Core	Compl.
FLH9	Surgery for ectopic pregnancy	District & County Hospital	RMNCAH	Partial	0.003	Core	Core	Compl.	Compl.
EPHS4	Management of antepartum hemorrhage	District & County Hospital	RMNCAH	Partial	1.49	Core	Core	Compl.	Compl.
FLH8	Management of complications of labor, including operative delivery (CEmNOC)	District & County Hospital	RMNCAH	Partial	0.85	Core	Core	Compl.	Compl.
FLH6	Management of newborn complications, neonatal meningitis, and other very serious infections requiring continuous supportive care (IV fluids, oxygen, etc.)	District & County Hospital	RMNCAH	Partial	0.01	Core	Core	Compl.	Compl.

RH1	Full supportive care for severe preterm newborns	District & County Hospital	RMNCAH	Partial	0.01	Core	Core	Compl.	Compl.
FLH11	Full supportive care for severe childhood infections with danger signs	District & County Hospital	RMNCAH	Partial	2.51	Core	Core	Compl.	Compl.
FLH13	Early detection and treatment of early-stage cervical cancer	District & County Hospital	RMNCAH	No	1.23	Core	Core	Compl.	Compl.
HC47	Essential palliative care and pain control measures, including oral immediate release morphine and medicines for associated symptoms	District & County Hospital	NCD	No	-	Core	Compl.	Compl.	Compl.
HC67	Expanded palliative care and pain control measures, including prevention and relief of all physical and psychological symptoms of suffering	District & County Hospital	Health System	No	0.004	Core	Compl.	Compl.	Compl.
FLH17	Referral of cases of treatment failure for drug susceptibility testing; enrollment of those with MDR-TB for treatment per WHO guidelines (either short or long regimen)	District & County Hospital	Communicable Disease	Partial	0.05	Core	Core	Compl.	Compl.

FLH18	Evaluation and management of fever in clinically unstable individuals using WHO IMAI guidelines, including empiric parenteral antimicrobials and antimalarials and resuscitative measures for septic shock	District & County Hospital	Communicable Disease	Partial	2.09	Core	Core	Compl.	Compl.
EPHS23	Management of hemorrhagic fevers	District & County Hospital	Communicable Disease	No	0.001	Core	Core	Compl.	Compl.
FLH23	Medical management of acute heart failure	District & County Hospital	NCD	No	0.05	Core	Compl.	Compl.	Compl.
HC43	Long term management of ischemic heart disease, stroke, and peripheral vascular disease with aspirin, beta blockers, ACEi, and statins (as indicated) to reduce risk of further events	District & County Hospital	NCD	No	0.71	Core	Compl.	Compl.	Compl.
FLH24	Management of bowel obstruction	District & County Hospital	NCD	No	0.004	Core	Compl.	Compl.	Compl.
EPHS30	Management of head injury	District & County Hospital	Health System	No	0.04	Core	Compl.	Compl.	Compl.
FLH31	Appendectomy	District & County Hospital	Health System	No	0.002	Core	Compl.	Compl.	Compl.

FLH36	Fracture reduction and placement of external fixator and use of traction for fractures	District & County Hospital	Health System	No	0.05	Core	Compl.	Compl.	Compl.
FLH37	Hernia repair including emergency surgery	District & County Hospital	Health System	No	0.03	Core	Compl.	Compl.	Compl.
FLH39	Irrigation and debridement of open fractures	District & County Hospital	Health System	No	0.05	Core	Compl.	Compl.	Compl.
FLH44	Repair of perforations (for example, perforated peptic ulcer, typhoid ileal perforation)	District & County Hospital	Health System	No	0.05	Core	Compl.	Compl.	Compl.
FLH45	Resuscitation with advanced life support measures, including surgical airway	District & County Hospital	Health System	No	0.02	Core	Core	Compl.	Compl.
FLH47	Surgery for filarial hydrocele	District & County Hospital	Health System	No	0.01	Core	Compl.	Compl.	Compl.
FLH48	Trauma laparotomy	District & County Hospital	Health System	No	0.11	Core	Compl.	Compl.	Compl.
FLH49	Trauma-related amputations	District & County Hospital	Health System	No	0.1	Core	Compl.	Compl.	Compl.
FLH50	Tube thoracostomy	District & County Hospital	Health System	No	0.03	Core	Compl.	Compl.	Compl.

FLH55	Initial assessment, and prescription, and provision of individualized interventions for musculoskeletal, cardiopulmonary, neurological, speech and communication, and cognitive deficits, including training in preparation for discharge	District & County Hospital	Health System	No	0.21	Core	Compl.	Compl.	Compl.
EPHS35	Management of pneumothorax and hemothorax	Tertiary Hospital	NCD	No	0.11	Core	Compl.	Compl.	Compl.
RH2	Specialized TB services, including management of MDR- and XDR-TB treatment failure and surgery for TB	Tertiary Hospital	Communicable Disease	Partial	0.01	Core	Core	Compl.	Compl.
RH3	Management of refractory febrile illness including etiologic diagnosis at reference microbiological laboratory	Tertiary Hospital	Communicable Disease	No	0.16	Core	Compl.	Compl.	Compl.
RH7	Treatment of early-stage breast cancer with appropriate multimodal approaches (including generic chemotherapy), with curative intent, for cases that are detected by clinical examination at health center	Tertiary Hospital	NCD	Partial	0.004	Core	Core	Compl.	Compl.

RH9	Treatment of early-stage childhood cancers (such as Burkitt and Hodgkin lymphoma, acute lymphoblastic leukemia, retinoblastoma, and Wilms tumor) with curative intent in pediatric cancer units or hospitals	Tertiary Hospital	NCD	No	0.02	Core	Core	Compl.	Compl.
RH11	Urgent, definitive surgical management of orthopedic injuries (for example, by open reduction and internal fixation)	Tertiary Hospital	NCD	No	0.06	Core	Compl.	Compl.	Compl.
RH13	Repair of club foot	Tertiary Hospital	NCD	No	0.04	Core	Compl.	Compl.	Compl.
RH14	Cataract extraction and insertion of intraocular lens	Tertiary Hospital	Health System	Partial	0.04	Core	Core	Compl.	Compl.
FLH57	Prevention and relief of refractory suffering and of acute pain related to surgery, serious injury, or other serious, complex or life-limiting health problems	Tertiary Hospital	Health System	No	0.0002	Core	Compl.	Compl.	Compl.

Annex 12 Agenda and list of participants for Ministerial Retreat

Available here: https://drive.google.com/drive/folders/1-9sBAwuoJWVX5WYKXM5lUTu7sdflLgt1?usp=sharing