

# *Liberia CTAP II - Country Specific Health Sector Accountability Report*

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# *List of Abbreviations*

<b>CTAP:</b>	COVID 19 Transparency and Accountability in African Project
<b>EPHS:</b>	Essential Package of Health Services
<b>GDP:</b>	Gross Domestic Product
<b>LDHS:</b>	Liberia Demographic and Health Survey
<b>MoH:</b>	Ministry of Health
<b>OHCP:</b>	One Health Coordination Platform
<b>PAPD:</b>	Pro Poor Agenda for Prosperity and Development
<b>PHL:</b>	Public Health Law
<b>RBHS:</b>	Rebuilding Basic Health Services
<b>RMNCAH:</b>	Reproductive, Maternal, Newborn, Child, and Adolescent Health
<b>USAID:</b>	United States Agency for International Development

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# *Executive Summary*

Since the cessation of the Liberian civil war and the transition to democratic governance, Liberia has made significant progress in the health sector, especially in terms of reproductive, maternal, newborn, child, and adolescent health (RMNCAH) performance. Indicators show significant gains as RMNCAH services are now available across the 15 counties. Despite this, recent reports put the life expectancy rate in the country at 62.5 years (F 66/M 63 years) and an infant mortality rate of 63/1000 live births. Under 5 mortality is estimated at 93/1000 births; the neonatal mortality rate was 37 deaths per 1,000 live births; the post-neonatal mortality rate was 25 deaths per 1,000, and maternal mortality is reported at 661/100,000 births. Malaria, diarrheal diseases, neonatal disorders, lower respiratory infections, ischemic heart disease, HIV/AIDS, stroke, tuberculosis, cirrhosis and other chronic liver diseases, and maternal disorders are the leading causes of death in Liberia, the core governance structure of the Liberian health system.

The ministry is responsible for the formulation, implementation, monitoring and evaluation of health policies, plans, and standards; delivering and coordinating the delivery of decentralized medical care in public facilities; developing health manpower; and undertaking preventive and promoting health services, including specific health interventions. In addition to the government, other key actors in the health sector play vital roles in the delivery of health care. These actors include those in the private sector who are either non-profit or for-profit. The non-profit sub-sector constitutes a larger proportion of the private actors and is better organized than the for-profit sector. It is estimated that the combined non-profit subsector provides approximately 47% of the health care in the country, while the private for-profit sector provides less than 30%.

The latest World Health Organization (WHO) 2018 data indicates that there are 0.5 nurses and midwives per 1,000 people in Liberia.

WHO estimates that at least 2.5 medical staff (physicians, nurses, and midwives) per 1,000 people are needed to provide adequate coverage for primary care interventions. The number of doctors in the country is 298. This puts the ratio of doctors to patients at 1:15,000, whereas the WHO recommends the ratio at 1:1000. Low pay and incentives for nurses and doctors have led to almost yearly strike actions staged by the National Health Workers Association of Liberia. The most recent strike was called because of decreases in salaries caused by the government's salary harmonization policy, which affects all public sector workers in the country. Health workers called on the government to address salary disparities, constant deduction salaries, and low or no salaries for healthcare workers. They claimed that nurses with the diploma, AA, BSc Degree, physician assistants and other healthcare staff are making less than US\$250 as take-home salaries, while they work 24 hours a day due to the limited number of staff.

The government of Liberia recognizes that access to basic health care throughout the life cycle of all Liberians is a critical contributor to economic productivity and is a function of a healthy and thriving citizenry. It is well articulated in Liberia's National Vision and successive medium-term development plans such as the Pro-Poor Agenda for Prosperity and Development (PAPD) that to earn a substantial demographic dividend, the country's largely youthful population must live long, healthy, and productive lives to reach their economic potential. Hence, it is understood that access to basic health care will be a fundamental contributor to the evolution of human capital that will drive our socio-economic development agenda. Despite this recognition in national policy, programs, citizen engagement, and funding continue to lag behind projected needs. The government's financing of the health sector falls below expectations as far as its commitment made along with other African governments in 2001 when African leaders

converged in Abuja, Nigeria and agreed to allocate a minimum of 15% of GDP towards health sector strengthening. Only once since 2006 has budgetary allocation reached 15%. The decline in the preceding years of 2020 and 2022 could be due to the COVID-19 global pandemic, resulting in a shortfall of major revenue sources such as revenue from exports and a decline in donor support as western nations looked to combat their COVID-19 scourges.

Amidst low funding by the national government to the health sector, reports of corruption in the health sector persist. Much more recently, the Office of the Inspector General of the Global Fund found procurement fraud, concealed payments, and wasted or misused resources as fraudulent practices within the National Aids Control Program overseen by the Ministry of Health of Liberia. Other forms of corruption that have been found in the Liberian health system include absenteeism due to nurses and doctors working two or more jobs; diversion of patients from public health centres to public health centres where public health practitioners have some pecuniary interest in the public health centre; bribery to access healthcare services; theft and diversion of drugs from public health centres to private health centres; and placement of ghost workers on the Ministry's payroll.

Like most constitutional democracies, the Legislature has oversight over executive branch functionaries such as the Ministry of Health. The Legislature, from time to time, will exercise this authority by inviting responsible officers within the ministry for reports on national health emergencies and other emerging national issues in the health sector, such as worker strikes. This oversight can extend to calling on Finance Ministry authorities to explain payments to health workers and the like. Observers of legislative oversight in the country have said that the legislature has failed to demand regular statutory reports on the health sector from



*Public expenditure on health was reported at 8.5% of GDP in 2019. As a share of current health expenditure, public expenditure on health has stayed consistently below 20%. In 2019, it was reported at 16.1% of total current health expenditure.*

the ministry and has also failed to enforce the implementation of outcome-based and gender-responsive budgets.

Public expenditure on health was reported at 8.5% of GDP in 2019. As a share of current health expenditure, public expenditure on health has stayed consistently below 20%. In 2019, it was reported at 16.1% of total current health expenditure. In 2022, the total appropriation for health is US \$78,368,300.00, of which the US \$61,367,357.00 is allocated to salaries and goods and services, representing 78% of the total budget.

What needs to be enforced is strong political will from the executive in terms of funding to the health sector to at least meet the Abuja

Declaration's benchmark of 15% of total fiscal budget expenditure each year and strong legislative oversight that focuses on the outcome and project-based budgeting with a gender responsive focus. Donor funding and private sector goodwill also need to be harnessed to yield good results for the citizenry that provide increased access to community and county healthcare systems, take into account the needs of people with disabilities and provide good training for staff in combination with robust monitoring and evaluation mechanisms to ensure that service delivery reaches those it is intended for. The government also needs to make a strong effort to increase the pay of healthcare workers to acceptable standards and provide adequate equipment for more than basic service delivery at the community level.

# *Methodology*

The research adopted an extensive literature review approach of past and present documents. The documents reviewed were reports from the government of Liberia, especially the Ministry of Health, non-governmental organizations, and inter-governmental organizations working within the health sector. The reviews were intended to discover trends in Liberia's poor socio-economic performance and poor health outcomes. Moreover, the desk review considered the governance architecture of Liberia's healthcare governance and how

political decisions are made on critical health infrastructure. The study reviewed budgetary allocations to the Ministry of Health at the national and sub-national levels; basic information on health facilities in Liberia; and proxied fatality figures to measure performance.

The study adopted a purposive sampling approach in selecting the three focal counties for analysis, considering the five (5) regions of Liberia. These counties include Nimba, Margibi, and Grand Bassa counties.

## *Study Objectives:*

Through a nationally representative survey of 100 individuals. This study aims to:

- Understand citizens' access to healthcare and their perception of quality healthcare as a public good.
- Understanding health sector financing/general level of public health expenditure, including private sector donations and financing at both national and sub-national levels.
- Understand and quantify transparency and accountability in the health sector.

Transparency here refers to relevant, contextual, accessible, timely, understandable, and accurate disclosure of information on actions, rules, plans, and processes, while accountability is defined in terms of an overall accountability system, where actors are held answerable and face consequences both within the government and from outside of the government. Relatively little work has explored the knowledge, perceptions, and practices of ordinary citizens concerning the issue. By working to fill these gaps in knowledge, the findings of the survey will serve two principal uses. First, the data and analysis will provide a robust evidence base for policymakers and practitioners looking to deepen their understanding of citizens' perceptions of and attitudes toward public health accountability and transparency in Liberia. This knowledge, in turn, can help inform policies and programs to increase public healthcare accountability and transparency. The results of this survey will additionally stimulate debates and inform discussions on the topic. health sector accountability.

### ***Research Method***

To pursue the objectives of this research, a mixed-methods approach will be used. putting together plans for collecting both qualitative and quantitative data and putting together analyses of primary and secondary data.

- 1 A desk review of data and information will be conducted to provide background on which to contextualize the research activities and inform research goals.
- 2 A nationally representative survey of 100 Liberian citizens to quantify KAP surrounding public healthcare accountability and transparency

### ***Sampling design***

This study will have a population aged 18 or older, which will include an equal representation of males and females in four (four) selected counties in Liberia. Nimba, Grand Bassa, and Margibi counties. A quantitative component of the study will be conducted with a nationally representative sample of 100 Liberian citizens that explores KAP towards public healthcare accountability and transparency. To achieve nationally this representation, a one-stage stratified method is employed to achieve the representation. Primary sampling units will be identified before the start of the data collection process. Primary sampling units are where the community is clustered and 100 respondents will be selected from households. For these purposes, a household is defined as a group of people who presently eat together from the same pot. By this definition, a household does not include people who are currently living elsewhere for purposes of studies or work, but it does include domestic workers or temporary visitors. In multi-household dwelling structures (like blocks of flats or backyard dwellings for renters, relatives, or household workers), each household will be treated as a separate sampling unit. the sampling will randomly choose households.

An equal probability method will be used to randomly select one household member for participation using a household member list and Kish grid. This will be used to achieve gender representation in the study.

### ***Qualitative Respondent Selection***

In the qualitative part of the study, key informant interviews will be done with stakeholders and selected care providers in health facilities that are spread out across the study areas in a proportional way.

## Research Questions

**01**

*What are Liberia's health sector performance, governance structures and tiers of responsibility (management, funding and policy making) and universal healthcare coverage dynamics at the national and sub-national levels, including the role of stakeholders?*

**02**

*What are the features and extent of reforms in Liberia's health sector including politico-economy analysis, as well as the nature and extent of corruption?*

**03**

*What are the role and impact of oversight institutions on health sector systemic efficiency?*

**04**

*In what ways has healthcare financing and fiscal management at national and sub-national levels evolved including the existing financing patterns, forms of expenditure, gaps and issues of citizen participation and accountability?*

**05**

*What are citizens' perceptions and visions on healthcare access and of quality of service of healthcare as a public good?*

## Study Limitations

Selecting to study 3 out of the 15 counties in the country encapsulated in the views of 100 citizens therefrom might not represent the full perception of the rest of the country, thus presenting a skewed picture of what citizens currently think of the healthcare sector in general. Access to healthcare statistics is heavily reliant on the Liberia Demographics and Health Survey (DHS), compiled by the Liberian Institute for Statistics and Geo-Information Services (LIGIS). Budgetary appropriations (as low as they may be) may be misleading, as most times, fiscal outturn falls far below-appropriated amounts, thus hindering actual spending on national health care.



## *Sector Two:*

# *Health Sector Overview, Governance and Stakeholders*

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Liberia's health system has evolved over time from its inception in the 1950s to what it is now in 2022. Over the last 17 years, which mark the cessation of the civil war and the transition to democratic governance, Liberia has made significant progress in the health sector. Performance indicators for Reproductive, Maternal, Newborn, Child, and Adolescent Health (RMNCAH) show that RMNCAH services are now available in all 15 counties, which is a big step forward.

Most recent reports put the country's population at just under 5 million, with a per capita income of US \$1,250, an average life

expectancy rate of 62.5 years (F 66/M 63 years), and an infant mortality rate of 63/1000 live births. Under 5 mortality is estimated at 93/1000 births, the neonatal mortality rate was 37 deaths per 1,000 live births, and the post-neonatal mortality rate was 25 deaths per 1,000. Maternal mortality is reported at 661 per 100,000 births. Malaria, diarrheal diseases, neonatal disorders, lower respiratory infections, ischemic heart disease, HIV/AIDS, stroke, tuberculosis, cirrhosis and other chronic liver diseases, and maternal disorders are the leading causes of death in Liberia.

Relative to maternal care, the 2019 Liberia Democratic and Health Survey further reveals the following:

### ***Prenatal care:***

*87% of women aged 15–49 who had a birth in the 5 years before the survey had four or more prenatal care visits, and 71% received prenatal care during the first trimester of their most recent pregnancy.*

### ***Protection against neonatal tetanus:***

*83% of women's most recent live births were protected against neonatal tetanus, a decline from 88% in 2013.*

### ***Delivery:***

*80% of births in the 5 years before the survey were delivered in a health facility, and 84% were delivered with the assistance of a skilled provider.*

### ***Postnatal care:***

*80% of women with a birth in the 2 years before the survey and 76% of their newborns received a postnatal check within 2 days of delivery.*

### ***Cord care:***

*6% of births in the 2 years before the survey had chlorhexidine applied to the stump of the umbilical cord.*

### ***Problems in accessing health care:***

*45% of women aged 15–49 have at least one problem accessing health care; getting money for treatment is the most common.*

At the core of the Liberian health system is the Ministry of Health (formerly the Ministry of Health and Social Welfare). The Ministry of Health, according to the Act establishing the Ministry in 2015, is responsible for the formulation, implementation, monitoring and evaluation of health policies, plans, and

standards; delivering and coordinating the delivery of decentralized medical care in public facilities; developing health manpower; and undertaking preventive and promoting health services, including specific health interventions.

### The Ministry's core functions according to the Act include the following:

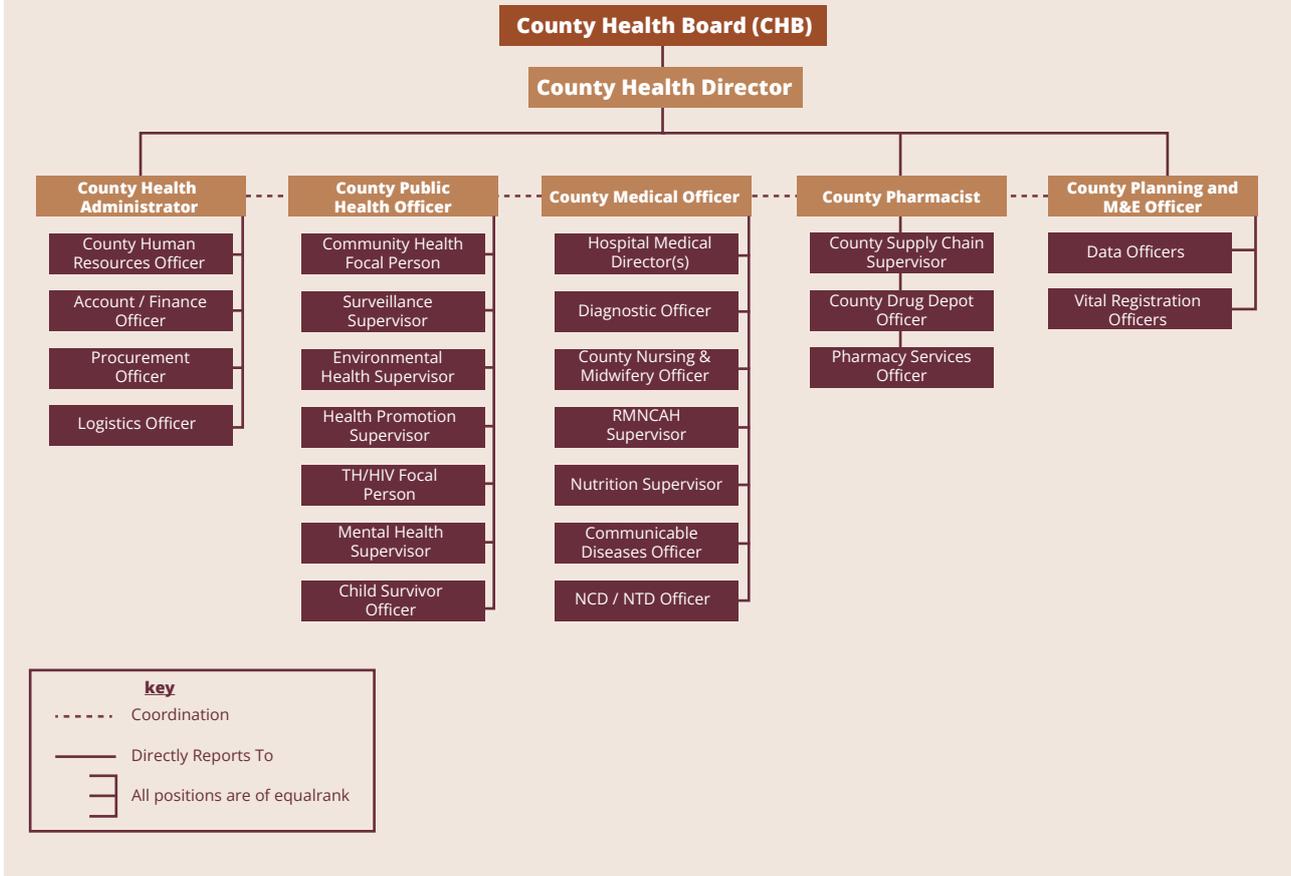
- Develop and coordinate the development of sector policies, plans, standards and regulations;
- Maintain a national health management information system which includes data relating to birth, death, and burials;
- Coordinate and promote the conducting of health and health-related research;
- Provide medical care and treatment through public health facilities, as well as decentralize such care and treatment;
- Provide preventive care and promote family, environmental, and occupational health;
- To coordinate with healthcare institutions, stakeholders, and/or the donor community to formulate and support healthcare interventions;
- Pursue health sector decentralization within the framework of the National Decentralization Agenda, and promote preventive, family, environmental, and occupational health services.
- Carry out fiscal management and improve health-care support systems; and
- Administer the Public Health Law as well as perform other powers and functions as may be provided by law.

As a unitary state, all healthcare execution functions are overseen by the executive branch of government, with the Legislature responsible for budgetary appropriations as advised by the Ministry of Health. The Ministry is structured into divisions, sections, and units in line with its core functions. It is headed by a minister of health who is supported by three deputy ministers in charge of three departments, namely: administration, policy planning and M&E, and health services. Five (5) assistant ministers assist the deputy ministers and the minister.

The assistant minister functions are labelled: curative services, preventive services, planning and policy, vital statistics, and administration. This presents the first level of healthcare management in the country.

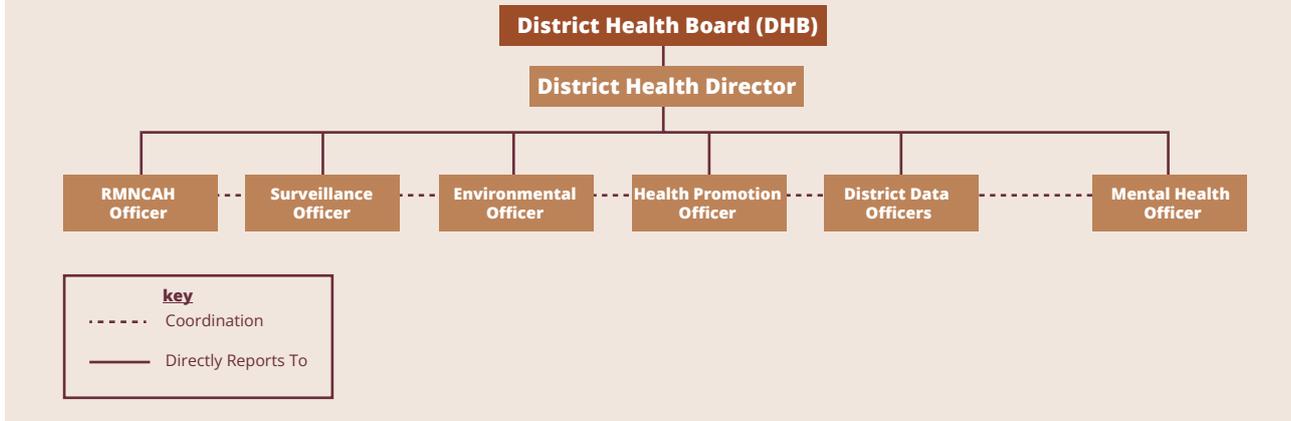
The second-tier management delivery level consists of decentralized operational and management health systems at county level operations entrusted to the county health teams (CHTs). Health facilities in the counties are overseen and managed by the various CHTs; 15 in total for each county.

Figure 1: County Health Teams Diagram



The system is then decentralized further at the district level with District Health Boards responsible for administering community-level health to the public, including public clinics and health centres, and ensuring that community-level private clinics and drug stores are duly accredited and have qualified staff on a case-by-case basis.

Figure 2: District Health Structure in Liberia

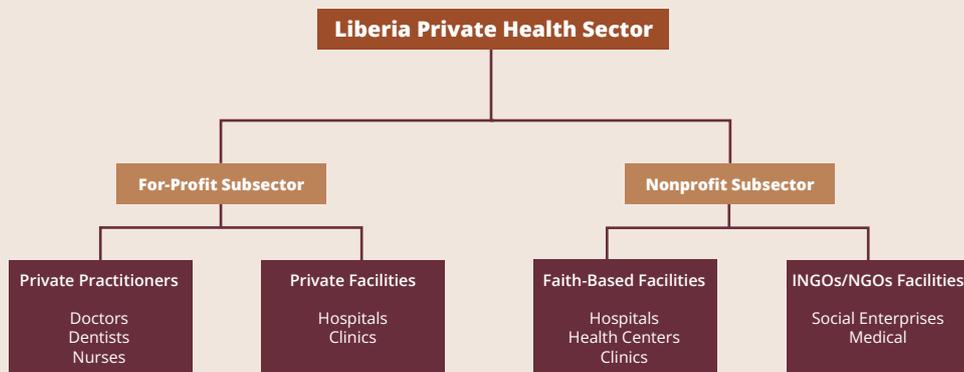


All counties in the country have at least one publicly owned secondary level hospital where critically ill patients from the districts are referred. These secondary county health structures will, however, have a very minimum number of doctors and adequately qualified nurses. Some companies operating in the country have established health facilities for the treatment of their workers and affected community members. The largest referral hospital in the country is the John F. Kennedy Medical Center, located in Monrovia and operated by the national government. Other tertiary level hospitals include the Duside Hospital, located in middle Liberia and operated by the Firestone Rubber Company, and the Jackson F. Doe Hospital, located in northern Liberia, Nimba County, operated by the national government. However, because of limited medical equipment and specialized doctors, most critically ill patients should seek medical advice and treatment outside the country.

### *Private Sector*

In addition to the government, other key actors in the health sector play vital roles in the delivery of health care. These actors include those in the private sector who are either non-profit or for-profit. The non-profit sub-sector constitutes a larger proportion of the private actors and is better organized than the for-profit sector. In addition to the government, other key actors in the health sector play vital roles in the delivery of health care. These actors include those in the private sector who are either non-profit or for-profit. The non-profit sub-sector constitutes a larger proportion of the private actors and is better organized than the for-profit sector. It is estimated that the combined non-profit subsector provides approximately 47% of the health care in the country, while the private for-profit sector provides less than 30%

**Figure 3: Private Sector Structure**



### *Healthcare access*

Liberia's health sector, like many other sectors, suffered huge setbacks because of the civil crisis. The government's efforts are reviving the sector that evolved through the country's post-war recovery and development processes. With support from the United States Agency for International Development (USAID) and other partners, the Government of Liberia 2007 introduced the "Basic Package of Health Services" (BPHS) aimed at ensuring equitable access to health services. This effort sought to rebuild the health care delivery system of the country. USAID, through its Rebuilding Basic Health Services (RBHS) Project, supported 103 health facilities across the country. This intervention yielded results according to the MOH Accreditation surveys of the supported RBHS facilities in 2010, which indicated an 88% average score of improved access. Continued efforts at improving access while at the same time ensuring quality standards witnessed the introduction of the Essential Package of Health Services (EPHS), which built upon the BPHS. The EPHS, in its first phase (2011–2013), placed increased emphasis on maternal and child health services, adolescent health services, emergency services, and communicable disease control.

The number of trained medical practitioners in the country hovers far below recommended and acceptable standards. The latest World Health Organization (WHO) 2018 data indicates that there are 0.5 nurses and midwives per 1,000 people in Liberia. WHO estimates that at least 2.5 medical staff (physicians, nurses, and midwives) per 1,000 people are needed to provide adequate

coverage with primary care interventions (WHO, World Health Report 2006). The latest reports put the number of doctors in the country at 298. The number of trained medical practitioners in the country hovers far below recommended and acceptable standards. The latest World Health Organization (WHO) 2018 data indicates that there are 0.5 nurses and midwives per 1,000 people in Liberia. WHO estimates that at least 2.5 medical staff (physicians, nurses, and midwives) per 1,000 people are needed to provide adequate coverage with primary care interventions (WHO, World Health Report 2006). The latest reports put the number of doctors in the country at 298. WHO recommends a 1:1,000 doctor-to-patient ratio for adequate healthcare service. This puts the ratio of doctors to patients at 1:15,000 whereas the WHO recommends the ratio at 1:1000.

Low pay and incentives for nurses and doctors have led to almost yearly strike actions staged by the National Health Workers Association of Liberia, the organization that heads public health workers in the country. The most recent strike was called because of decreases in salaries caused by the government's salary harmonization policy that affected all public sector workers in the country. Health workers called on the government to address salary disparities, constant deduction of salaries, and low or no salaries for healthcare workers. They claimed that nurses with diplomas, AA, BSc degrees, physician assistants, and other healthcare staff are making less than \$250 as take-home salaries while they work 24 hours a day due to the limited number of staff.

6. Candace Eastman and Franklin Dolo (2016). *Liberia Health Sector Scan*

7. Wright, J., *Health Finance & Governance Project, July 2015. Essential Package of Health Services Country Snapshot: Liberia*. Bethesda, MD: Health Finance & Governance Project, Abt Associates Inc.

8. *Liberia Medical and Dental Council, 2016*



## *Sector Three:*

# *Political Economy of the Health Sector*

A plethora of literature has established the existence of a strong relationship between healthcare and the economy. The Government of Liberia recognizes that access to basic health care throughout the life cycle of all Liberians is a critical contributor to economic productivity and is a function of a healthy and thriving citizenry. This relationship is highly interdependent. Whether in the formal or informal sectors of the economy, a healthy workforce is critical to the success of the country's development goals and objectives. For example, it is well articulated in Liberia's National Vision and

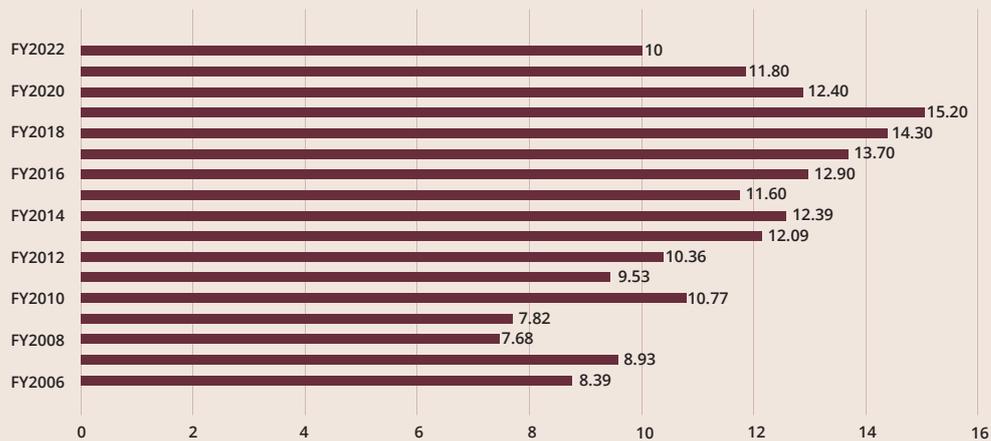
successive medium-term development plans such as the Pro-Poor Agenda for Prosperity and Development (PAPD) that to earn a substantial demographic dividend, the country's largely youthful population must live long, healthy, and productive lives to reach their economic potential. Hence, it is understood that access to basic health care will be a fundamental contributor to the evolution of human capital that will drive our socio-economic development agenda. Despite this recognition in national policy, programs, citizen engagement, and funding continue to lag behind projected needs.

## 1. Investment in the Health Sector

Health financing is a critical challenge in Liberia. There is low investment in health, a lack of comprehensive health financing policies and strategic plans, extensive out-of-pocket payments, weak financial management, inefficient resource use, and weak mechanisms for coordinating partner support. Affordable and equitable access to health care throughout the country lags. Investment in the health sector leans largely

toward donors (multilateral and bilateral). The government's financing of the health sector falls below expectations as far as its commitment made along with other African governments in 2001 when African leaders converged in Abuja, Nigeria and agreed to allocate a minimum of 15% of GDP towards health sector strengthening. Only once since 2006 has budgetary allocation reached 15%. Figure 4 shows investment in terms of allocations to health in the national budget.

**Fig. 4. Percentage National Budget Allocated to Health**



Source: Author

## 2. Corruption

Amidst low funding by the national government to the health sector, reports of corruption in the health sector persist. Much more recently, the Office of the Inspector General of the Global Fund found procurement fraud, concealed payments, and wasted or misused resources as fraudulent practices within the National Aids Control Program overseen by the Ministry of Health of Liberia. Other forms of corruption that have been found in the Liberian health system include absenteeism due to nurses

and doctors working two or more jobs; diversion of patients from public health centres to public health centres where public health practitioners have some pecuniary interest in the public health centre; bribery to access healthcare services; theft and diversion of drugs from public health centres to private health centres; and placement of ghost workers on the Ministry's payroll.

The causes of corruption were found to be a lack of work incentives, patients believe that it is important to “know” the health worker to access good care, According to Vian, (2008), major incentives that encourage diversion of resources from the public sector by health workers include poor documentation, lack of public awareness regarding healthcare processes, and inadequacies in monitoring and evaluation.

### ***3. The “Haves” Versus the “Have Nots” as a Determinant of Access to Healthcare***

The most recent Gini coefficient of inequality puts Liberia at 35.3 showing the measure of income and expenditure inequality among the population. Whilst this number might be hovering around the world’s average of 38.8, in Liberia, the question of who has and who does not have is largely answered by who has proximity to government and influence over governmental processes. According to World Bank data, ***“in 2016, more than 2.2 million Liberians were unable to meet their basic food needs, of which almost 1.5 million (68%) resided in rural areas, 1.6 million were below the food-poverty line, and 670,000 lived in extreme poverty.”*** The Ebola and COVID-19 pandemics only heightened the level of poverty in the country.

Assessing the level of poverty in the country is an important element of any analysis because of poverty’s impact on the kind of

health care citizens can access when in need. Public health facilities are getting more expensive by the day as the government decreases real spending in the public health sector year on year since 2019. ***The WHO reports that total expenditure on health per capita is less than \$100/year (compared to neighbouring Sierra Leone at \$224/year). As a result, a typical visit to a medical centre can cost the average Liberian between US \$25 and the US \$50.00. That amount will typically come with a test for malaria and typhoid only and exclude other more incisive tests. More penetrating tests can cost much more. As a result, for much of the population living under US \$2.00 a day, a one-day trip to the clinic can mean cutting down on essential nutrition for the family for months.*** A Liberian facing such a decision can easily go see a “praying mother” for divine intervention rather than spend what he/she does not have on healthcare.

Another scenario that is presented is the ability of medium-to high-level officials in the government to travel abroad to access basic health care services. That can be seen in the increase in medical trips to Ghana and India. It is not a surprising sight to even see very poor Liberians facing deadly medical conditions begging for help on the radio and in newspapers to raise funds to be flown abroad.

12. [Corruption-in-the-health-sector-in-Anglophone-W-Africa\\_ACE-Working-Paper-005.pdf](#) (soas.ac.uk)

13. Vian, 2008; Stakeholder Democracy Network, 2013

14. Gini index - Liberia | Data (worldbank.org)

15. Liberia Overview: Development news, research, data | World Bank

16. <https://2016.export.gov/industry/health/healthcareresourceguide/eg>

17. Healthcare Cost Continues to Rise in Liberia. What is Being Done About It? - Liberia Business Journal



## *Sector Four*

# *Legislative Oversight*

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Like most institutions of government, the Ministry of Health's principal leadership (i.e., Minister, Deputy, and Assistant Ministers) are appointed by the President of the Republic of Liberia. These appointments are subject to confirmation by the Liberian Senate. Within the tenants of coordination among the three branches of government (Legislative, Executive, and Judiciary), the Legislature exercises oversight responsibility of the

various government parastatals; the Ministry of Health is no exception. In the Liberian Senate and House of Representatives, both the Senate and House have committees on health. These committees are headed by chairpersons and their fundamental functions are to provide guidance on health care and ensure appropriations made in the national budget are executed to meet the health needs of the citizenry.

**Table 1 Critical Public Health Laws in Liberia**

S/N	Legislation	Critical provisions	Impact
1	Ministry of Health Act, 2015	<p>Section 39.3: Vested the Ministry for the formulation, implementation, monitoring, and evaluation of health policies, plans and standards; deliver, coordinate the delivery of decentralized medical care in public facilities; develop health manpower; undertake preventive and promote health services including specific health interventions</p> <p>Section 39.4 It specifies the core functions of the Ministry as follows:</p> <p>Create and coordinate the creation of sector policies, plans, standards, and regulations; maintain a national health management information system that includes birth, death, and burial data;</p> <p>Coordination and promotion of health and health-related research</p> <p>Provide medical care and treatment through public health facilities, as well as decentralize such care and treatment;</p> <p>Preventive services and promotion of family, environmental, and occupational health; collaboration with healthcare facilities, stakeholders, and/or the donor community to develop and support healthcare interventions;</p> <p>Pursue health sector decentralization within the framework of the National Decentralization Agenda, and promote preventive, family, environmental, and occupational health services. Conduct fiscal management and improve the health sector's support systems. and administer this chapter of the Public Health Law, as well as perform such other powers and functions as may be provided by law.</p>	<p>1. ensure independent monitoring and the implementation of healthcare projects</p> <p>2. Provide expert duties for the Ministry free of bias</p>
2	Public Health Law as amended, 2019	<p>Section 26.11 (1) mandates health institutions to attend to a user without any form of discrimination including disability. Discrimination occurs when people are treated less fairly than others.</p> <p>Section 52.8 establishes a fund to be known as the One Health Coordination Platform. The platform shall establish a fund to be known as the "One Health Coordination Platform Fund." The Fund shall consist of appropriations by the Legislature for that purpose, grants, donations, and bilateral and/or multilateral arrangements. Section 53.2 provides the Minister of Health with a report of public health events.</p> <p>Section 52.4 establishes a multi-sectoral body to be known as the One Health Coordination Platform (OHCP), which shall be comprised of ministries and agencies; civil society and non-governmental organizations; higher learning institutions; and international partners.</p> <p>Subchapter B, Section 51.2 establishes the Clinical Trials Technical Advisory Committee</p> <p>Section 49.3: gives a person with a mental disability the rights to exercise all civil, political, economic, social, and cultural rights as recognized in Liberian law and international treaties ratified by the Republic of Liberia.</p>	<p>The 1976 Public Health Law does not address new and emerging public health challenges such as emergency treatment, discrimination, mental health, nutrition, regulation of marketing of products for infants and young children, zoonotic diseases, non-communicable diseases, antimicrobial resistance, clinical trials and complementary and alternative medicine.</p>

Source: Author

The Liberian Legislature is a bicameral one, with a House of Senate and a House of Representatives. All revenue bills originate in the House of Representatives but must be concurred with by the Senate. Both Houses together pass on the national budget in which health allocations are estimated for the fiscal year. The Joint Public Accounts Committee will hold public hearings for discussions on health budget proposals. High-level officers within the Ministry of Health are invited to the hearings. At the hearings, they will outline their health targets for the people and justify their allocations. Based on the Committee's uptake of the discussions, it will make recommendations to the plenary for the passage of the proposed budget. The Committee may accept the proposal, recommending the exact amounts allocated by the executive, or it may make

recommendations for increases or decreases in health budget allocations.

As depicted in Table 2 below, the Legislature has found it difficult to meet the continental obligation as set out in the Abuja Declaration commitment of ensuring 15% of the annual budgetary allocation to health. Notably, leading up to the outbreak of the Ebola virus disease pandemic in 2014, the national budget progressively increased up to a 15.2% allocation in 2019, slightly exceeding the benchmark of 15%. The decline in the preceding years of 2020 and 2022 could be due to the COVID-19 global pandemic, resulting in a shortfall of major revenue sources such as revenue from exports and a decline in donor support as western nations looked to combat their own COVID-19 scourges.

**Table 2 Percentage of National Budget Allocated to the Ministry of Health, 2013-2022**

Year	Percentage
2013	12.09
2014	12.39
2015	11.60
2016	12.90
2017	13.70
2018	14.30
2019	15.20
2020	12.40
2021	11.80
2022	10.00

Source: Human Resource Information and Monitoring System (FRIMS)

Like most constitutional democracies, the Legislature has oversight over executive branch functionaries such as the Ministry of Health. The Legislature, from time to time, will exercise this authority by inviting responsible officers with the ministry for reports on national health emergencies and other emerging national issues in the health sector, such as workers' strikes. This oversight can

extend to calling on Finance Ministry authorities to explain payments to health workers and the like. Observers of legislative oversight in the country have said that the legislature has failed to demand regular statutory reports on the health sector from the ministry and has also failed to enforce the implementation of outcome-based and gender-responsive budgets.

## *Sector Five:*

# *Financing and Fiscal Management*

### *1. General Overview*

Financing of the Liberian healthcare sector reflects contributions from the national government, private sector donations (especially during the pandemic), expenditures by ordinary citizens,

development partners, and donor agencies. The Ministry of Health coordinates all public health spending, including direct budgetary support from development partners and donors.

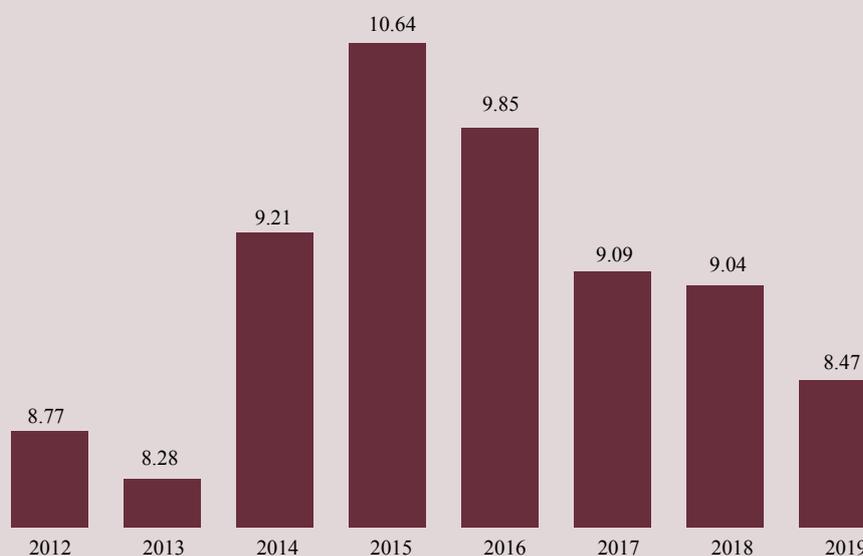
**Table 3: Public Health Expenditure Statistics (2021)**

No.	Indicator	Expenditure
1.	Health expenditure per capita	53 US dollars
2.	Health expenditure per capita based on PPP	126 international dollars
3.	General government expenditure on health as a share of general government expenditure	4.1%
4.	Out of pockets expenditure as a share of current health expenditure	54.4%
5.	Expenditure on health	219 million
6.	Real expenditure on health	219 million
7.	Voluntary health insurance as a share of current expenditure on health	6.9%
8.	Government expenditure on health per capita	11 US dollars
9.	Government expenditure on health based on PPP	3,181
10.	Private expenditure on health as a share of total health expenditure	59.2%

Public expenditure on health was reported at 8.5% of GDP in 2019. As a share of current health expenditure, public expenditure on health has stayed consistently below 20%. In 2019, it was reported at 16.1% of total current health expenditure. The country at least reached the Abuja Declaration target of 15% of fiscal budget appropriation for one year in 2019 when it recorded a record 15.2% appropriation of the national budget to the

health sector. Nonetheless, recurrent expenditures such as salaries and purchases of goods and services consume a large portion of budgetary appropriations. In 2022, the total appropriation for health is US \$78,368,300.00 of which the US \$61,367,357.00 is allocated to salaries and goods and services representing 78% of the total budget.

Figure: 5. Public Health Expenditure as a Percentage of GDP 2012-2019



Source: The World Bank

International organizations such as the World Bank, the IMF, and the European Union provide loans and grants to the Liberian health sector. The Global Fund largely funds the country's malaria and HIV/AIDS programs. The Japanese government, through JICA, provides funding to maternal health

programs and USAID funds several international and local non-governmental organizations' programs to support the Liberian health sector. The Center of Disease Control, through its PREVAIL program, funds elaborate research on communicable diseases such as COVID-19.

Table: 4. Funds from Development Partners to Support COVID-19 initiatives

Organization	Amount (USD)	Purpose/Description of Funding
World Bank	17 Million	World Bank off-budget support reallocates funds from existing projects to healthcare workers, medical supplies and logistics with ongoing discussions on FY2021 support.
European Union	15 Million	EU to provide almost \$15 million from both pre-COVID-19 budget support and reallocations.
International Monetary Fund	49 Million	IMF to provide debt relief under their Catastrophe Containment and Relief Trust with ongoing negotiations for further support in FY2021
African Development Bank	20 Million	AfDB off-budget support goes towards food security and nutritional program with additional support being negotiated for FY2021
United States Aid for International Development	2 Million	USAID off-budget support will go towards contract trace, case management, logistics and supplies, public awareness and agricultural interventions and additional support is being negotiated for FY2021

Source: Author

In the private sector, corporate bodies such as concessionaires finance their hospitals and clinics to support healthcare delivery for their employees and adjacent communities. Banks, other private organizations, and individuals will readily make donations in times of national health emergencies. For example, during the Ebola and COVID-19 pandemics, private entities made donations of ambulances, drugs, and personal protective equipment to the health sector.

The out-of-pocket financing in Liberia is huge because of the low health insurance coverage within the population. Some workers' unions and employee groups are covered under workers' insurance schemes at a minimum value. Individuals will frequently make direct payments to medical centres to obtain healthcare. Once in a while, you will find individuals making a plea for public support to fund expensive treatments abroad.

## ***2. Financial Management***

The MOH, in its most recent Joint Financial Management Assessment Report, noted the existence of the Office of Financial Management responsible for preparing annual budget estimates, managing payroll, responsible for training staff and providing quality assurance and guidance at the county level. The report indicated strongly that health sector budgeting could benefit from the introduction of more a "structured and participatory process" that helps to reflect healthcare priorities and needs. It also notes that delays in the budget approval process can translate into delays by the finance ministry to release funds to the health sector which in turn, causes uncertainty for planning for budget execution and low spending averages on the healthcare budget which has

a "deleterious impact on service delivery."

Each department in the MoH and the country's health team units have an internal audit structure. There also exists the larger administrative level, Internal Audit Governance Board Secretariat (IAGBS) and Audit Committee. These two bodies are responsible for routine internal audit controls. There are also external auditors from the Internal Audit Agency (IAA) and the General Audit Commission (GAC). However, all of these auditing frameworks are said to be weak because of low budgetary funding from the national government and the political will to prosecute persons found to be associated with financial malpractices in the auditors' reports.

## ***3. Audits***

In Liberia, the General Auditing Commission (GAC) is responsible for the audit of all public sector funds, including those contributed by donors and other partners. Statutorily, it should audit all agencies of government at least once a year, but due to low funding and the low capacity of its staff, the GAC has a heavy backlog of audits to do in the health sector. In its most recent audit on public funding in the health sector, the MOH's performance on procurement and distribution of medical supplies and drugs in Liberia for the fiscal years June 30, 2017 to June 30, 2019, found that the procurement and distribution of medical supplies and drugs by the MOH was "inadequate to meet the medical needs of Liberia." The audit also showed that the healthcare system is run on limited and expired drugs.

26. Liberia\_Health\_Sector\_JFMA\_Report11\_08092016.pdf (uhc2030.org)

27. id

28. GAC's Procurement, Distribution Audit Reveals How Liberia's Health System Runs on Limited, Expired Drugs - FrontPageAfrica (frontpageafricaonline.com)



## *Sector Six:*

# *Citizens' Voices*

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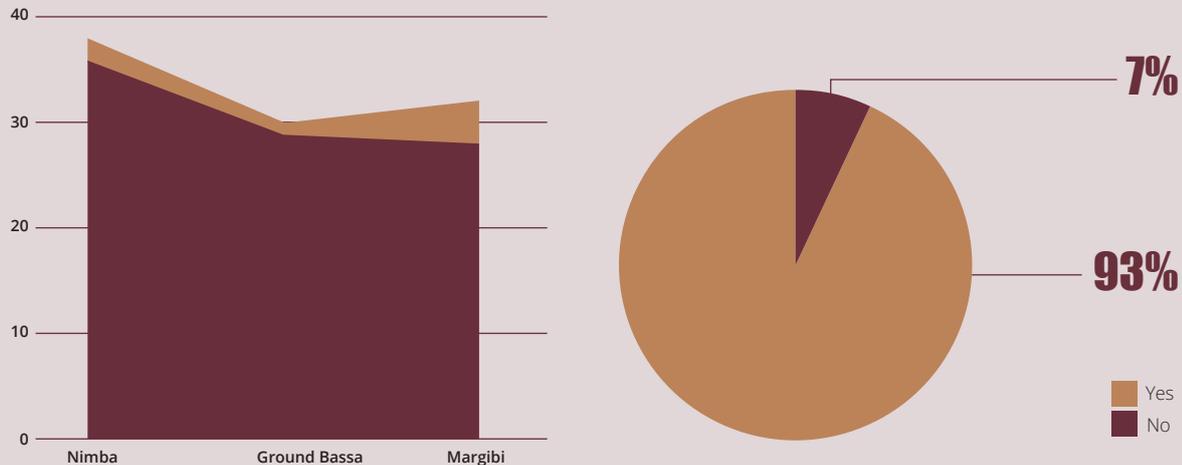
### *1. Health A Right*

Based on the findings from 6 KIs and 3 FGDs combined with the responses of 100 respondents, the following can be generalized to fit the narrative of the health sector above. Respondents generally believe that healthcare is a right. The central theme brought out in the focus group discussions was the widely held belief that healthcare is a right and Liberians, in general, are not enjoying it optimally. One participant noted how it seems ***“just enough for the government to build a clinic and put one or two physician assistants and nurses in there with no equipment or drugs.”*** The thing is, the money is our money. When they come and put a small mud hut in our communities

and have large dedication ceremonies, take pictures and leave the place empty.” ***“When government realizes health as a right and respects its obligations to the people, our health system will be able to work for us,”*** another participant in Grand Bassa stressed. When the views of participants were posed to a key informant at the MOH, he stated that the government of Liberia does recognize health as a right but a very tight resource base and competing priorities in other sectors mean already limited resources have to be distributed efficiently against all other pressing needs in the country.

Fig. 6. Healthcare as a Right

## HEALTHCARE AS A RIGHT?



Source: Author

## 2. Community Health Facilities

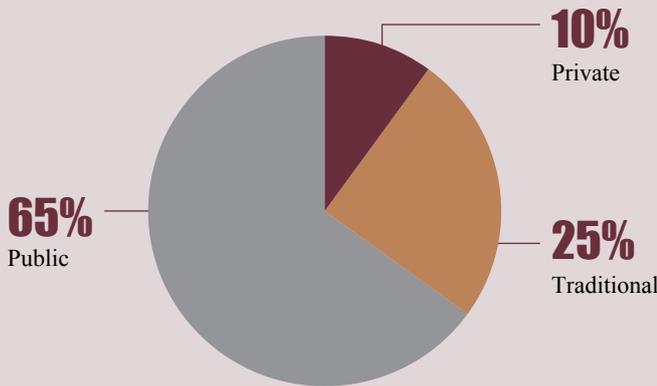
Respondents generally agreed to have some form of health facility in their community, mostly public health facilities. They, however, unsurprisingly, prefer to go to a private health facility instead of a public health facility or a traditional medicine practitioner. Participants indicated that service at private health facilities is better than at public health facilities, although more expensive. ***“Why go to the public health facility when sometimes you will only get one tablet to take right there and nothing else?”*** a participant in

Margibi County noted. ***“The private people are better equipped than the government health centres,”*** a participant in Grand Bassa County stated. Almost all the people in the focus group discussions stated they would only resort to traditional medicine as a last recourse. Mostly when they feel they have the underlying problem of witchcraft associated with their ill health.

Fig. 7. Health Facility and Type

**Health Facility and Type**

*Health facility in your community?*



Source: Author

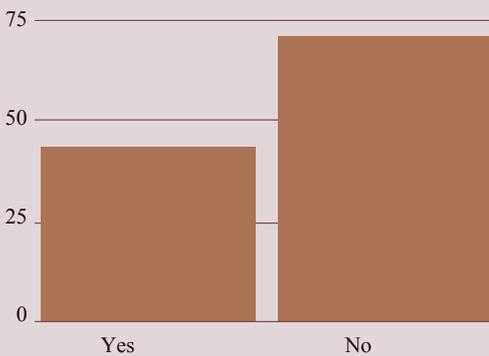
**3. Accessibility**

Most respondents say that health facilities are not accessible in terms of cost to respondents, particularly the few referral hospitals in the country. *“When you are sick, you have to spend between two hundred and*

*three hundred dollars just to be checked.”* Many say they cannot afford this, so they stay home and pray for healing or go to some traditional herbalist and hope to get a cure for whatever ailment they have.

Fig. 8. Accessibility/ General

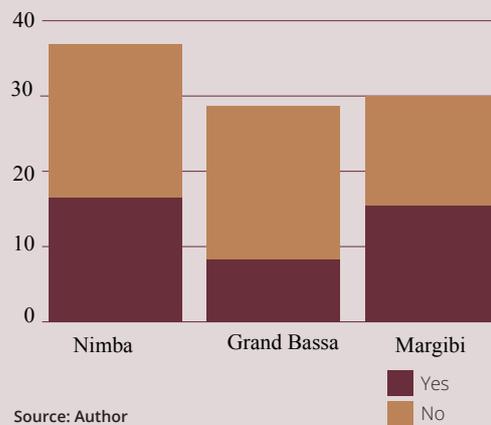
**Are health facilities accessible?**



Source: Author

Fig. 9. Accessibility / County Level

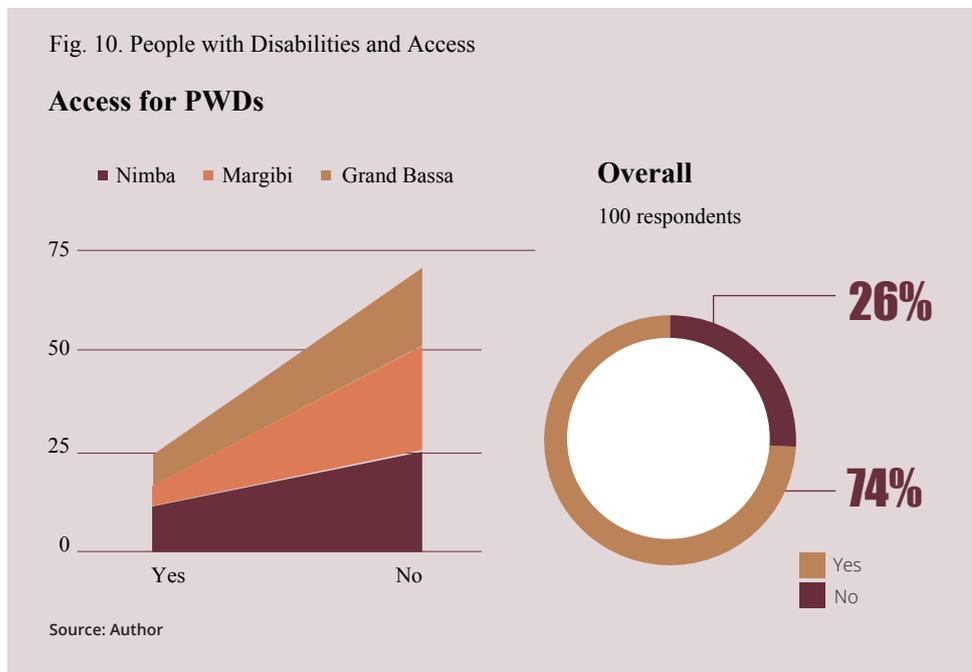
**Are health facilities accessible?**



Source: Author

Respondents say healthcare centre securities using the ticketing system will usually keep lower numbers for people who can pay to be seen first and the services provided are mostly limited to simple treatments for malaria and typhoid with most having to buy prescribed medication from private drug stores or people peddling drugs in buckets. Several persons in the FGDs reported that a visit to a public health centre would usually last more than ten hours before they see a medical practitioner and be treated. Discussants also complained that nurses who interact with them have limited interpersonal skills and can be very loud and abusive.

The study also finds access for people with disabilities wanting. Over three-quarters of respondents report that healthcare access for people with disabilities is often marginalized and not included in healthcare planning and simple design or procurement of health infrastructure in the country. For example, one visually impaired person in an FGD said, "Every time I go to the clinic, I will be presented with papers to fill out even though the nurse can see that I am carrying a cane." They make no effort to be inclusive in that clinic. I would have to go outside to find someone to help me fill out the form. When I get back, I am now at the tail end of the line."



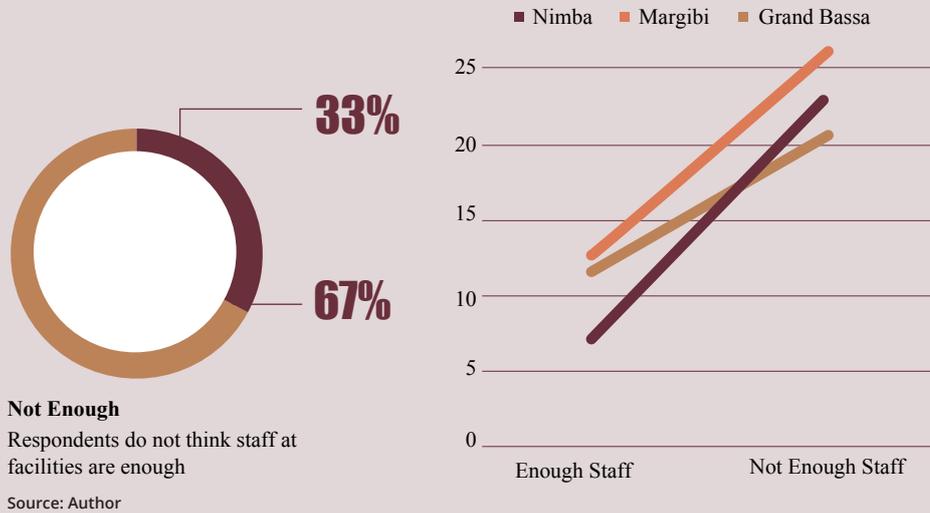
Key Informants report that healthcare workers are simply not prepared to address different needs of people with disabilities as these are not currently part of training protocols and PWDs issues are not highlighted in Ministry of Health bulletins.

On whether there is enough staff in health facilities to care for patients, respondents

report that there is simply not enough staff per patient. Many FGDs discussants said that even in some health centres where the Ministry of Health has assigned an adequate number of staff, some health workers take on second jobs in private centres to compensate for low wages in the public sector. They said that, for this reason, staff are always short in public health facilities.

Fig. 11. Health Workers per Citizens

**Do health facilities have enough staff?**



Key informants agree with the findings of the report and say that low funding for above basic curative services, infrequent supply of drugs, and lack of monitoring and evaluation systems contribute to challenges in the

delivery of healthcare services at the district level in the country. They also indicated that the government could do well to arrange more in-service training for medical practitioners at the community level.

Fig. 12. Demographics of Respondents

**Gender Report**

Percentage, age and sex of respondents



Respondents in this study are represented in figure 12. 42% of participants were male, while females represented 58% of the sample. In terms of county representation in the sample, no one county dominated the sample, as shown in figure 13. In the view of

the author, Nimba county had 32% respondents, Grand Bassa had 30%, and Margibi county had 32% representation of respondents' views, which in the view of the author is representative of the sample.

Fig. 13. County Representation of Respondents

### County Representation of Respondents





## *Conclusion and Recommendations*

The discussion and findings reflect the state of Liberia's healthcare sector, which is most in need of national revamping. In terms of policies and laws, the country is not found wanting. What needs to be enforced is strong political will from the executive in terms of funding to the health sector to at least meet the Abuja Declaration's benchmark of 15% of total fiscal budget expenditure each year and strong legislative oversight that focuses on the outcome and project-based budgeting with a gender responsive focus. Donor funding and private sector goodwill also need

to be harnessed to yield good results for the citizenry that provide increased access to community and county healthcare systems, take into account the needs of people with disabilities and provide good training for staff in combination with robust monitoring and evaluation mechanisms to ensure that service delivery reaches those it is intended for. The government also needs to make a strong effort to increase the pay of healthcare workers to acceptable standards and provide adequate equipment for more than basic service delivery at the community level.

The following specific recommendations are proffered:

### ***Government***

#### ***Focus on Budgeting for Success:***

The government needs to revamp the health sector investment plan with a specific focus on addressing issues in the Liberia Demographic and Health Survey. With health authorities admitting that the office of financial management needs to be more inclusive when developing budget annual budget proposals to target priority needs, it can be said that budget planning and priority spending needs are not aligned, and therefore already scarce resources are not effectively addressing areas where the needs are greatest.

#### ***Introduce Compulsory Health Insurance for at least Public Sector Workers:***

The government should gradually introduce a national health insurance scheme by starting with public-sector workers and their families. Although most needed by all in the country to counteract the growing prohibitive cost of health care, the government can first focus on a sector that can be easily regulated but also can pay small monthly amounts into the scheme. As it is currently, public sector workers can decide at the ministry and agency level whether they want to be insured. Most of the existing insurance schemes are so low that workers have to tap into their pockets to cover other costs beyond registration and testing for malaria and typhoid.

#### ***Improve Health Service Delivery in the Country:***

To avoid the problem of medical tourism by high-level officials and denial of the poor access to adequate healthcare, which is a right, the government needs to provide funds to hospitals to procure first-class medical equipment and train local practitioners on how to use it. This will engender local confidence in the medical centre's ability to

deliver critical medical care and reduce capital flight that comes about when much-needed resources are taken out of the country because people are forced to seek better care outside of the country. This also includes improving how drugs are procured in the public sector.

#### ***Fight Public Health Corruption:***

The government not only needs to invest in investigating health sector waste and abuse through adequate budgetary support to the GAC and the IAA, but the government also needs to support the Ministry of Justice to prosecute the accused. Most of the time, when people are accused in audit reports, they get to remain in the position whilst defending themselves sternly in the media against a "witch-hunt." The executive needs to muster the political will to clamp down hard on health sector corruption to ensure that already scarce resources are effectively utilized. The Legislature also needs to improve on the exercise of its oversight authority on executive functionaries. The Legislature must appropriate adequate relevant budgets and demand periodic reports on budgetary implementation. The Legislature also needs to work closely with audit agencies to ensure that their findings are taken seriously by the Ministry of Justice for prosecution.

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authority on executive functionaries. The Legislature must appropriate adequate relevant budgets and demand periodic reports on budgetary implementation. The Legislature also needs to work closely with audit agencies to ensure that their findings are taken seriously by the Ministry of Justice for prosecution.

***Civil Society and Citizens:***

***Keep Health as a Right at the Center of Public***

***Discourse:*** Liberia can utilize its robust civil society and publicly engaged citizens to bring the government's attention to addressing healthcare as a right of all citizens, thereby ensuring that health budgeting and planning receive the priority attention it deserves. Civil society should become abreast of all international and local instruments for advocacy on healthcare reform to hold the government accountable for the delivery of its obligations.

***Focus on Budget and other Advocacy in the Health Sector:*** Civil society can yell as much as they want about how deplorable and in

need of revamping the health sector is. But if the sector is not adequately funded through budgetary allocations and appropriations, very little improvement can be realized in the sector. It is critical for civil society organizations and citizen groups to focus on budget cycle advocacy to achieve real positive results in the country's health outcomes. Civil society and other citizen groups must also focus on funding to audit institutions and the Ministry of Justice's prosecution proposes.

***Private Sector:***

***Mobilization of Private Resources:***

The private sector can contribute its support to healthcare in the country through the mobilization of private resources to invest in the health sector. Given the infancy nature of Liberia's healthcare system, investing in modern medicine and delivery could yield high profits for the private sector and lead to more money staying in the country that would otherwise have been used outside the country in pursuit of medical care.



COVID-19 TRANSPARENCY &  
ACCOUNTABILITY IN AFRICA

