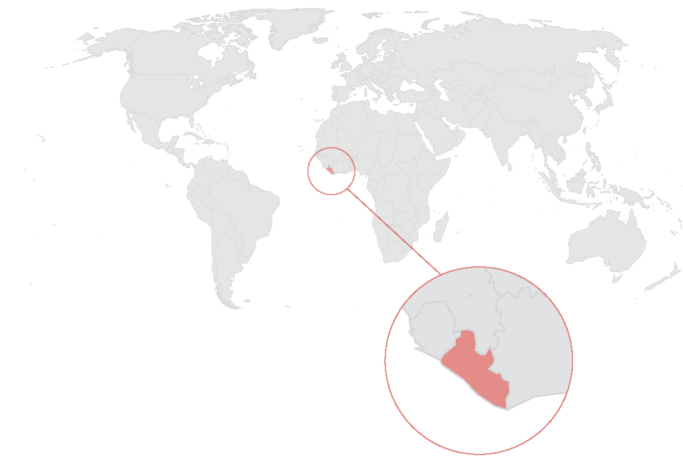


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Social Policy Country Briefs

Liberia



Udhayashankar Kanagasabai

The Health Care System in Liberia



Global Dynamics
of Social Policy CRC 1342



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No. 46

THE HEALTH CARE SYSTEM IN LIBERIA

Udhayashankar Kanagasabai*

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1. COUNTRY OVERVIEW (LATEST DATA AVAILABLE)



Source: <https://ontheworldmap.com/liberia/> (Accessed July 9, 2024)

- » Sub-Region: Western Africa
- » Capital: Monrovia
- » Official Language: English
- » Population size: 5.5 million (UN 2024)
- » Share of rural population: 47% (World Bank 2022)
- » GDP: 4 billion US\$ (World Bank 2022)
- » Income group: Low Income
- » Gini Index: 35.3 (World Bank 2016)
- » Colonial period and independence: In the early 19th century, members of the “American Colonization Society” (founded in 1816) worked with U. S. government officials to resettle formerly enslaved people in Africa. An agreement was reached with local chiefs in 1821, and a year later the first group of emancipated slaves and members of the American Colonization Society landed at Cape Mesurado, near present-day Monrovia. The independent Republic of Liberia was proclaimed in 1847.

2. SELECTED HEALTH INDICATORS

Indicator	Country	Global Average
Male life expectancy	63.2 (WHO 2021)	70 (World Bank 2022)
Female life expectancy	65 (WHO 2021)	75 (World Bank 2022)
Under-5 mortality rate (per 1000 live births)	76 (WHO 2023)	37 (World Bank 2022)
Maternal mortality rate	661 (WHO 2021)	223 (World Bank 2020)
HIV prevalence	1.5% (WHO 2021)	0.7% World Bank (2020)
Tuberculosis prevalence (cases per 100,000)	308 (WHO 2023)	133 (World Bank 2022)
	Only incidence data available	

3. LEGAL BEGINNING OF THE SYSTEM

Name and type of legal act	Public Health and Safety Laws Title 31 of the Liberian Code of Laws of 1956
Date the law was passed	1956
Date of <i>de jure</i> implementation	1956
Brief summary of content	With international assistance in 1945, the government of Liberia established what was then called the National Public Health Services, and in 1956 the Public Health and Safety Laws of Liberia was formulated (Liberian Codification Project 1975; Ministry of Health and Social Welfare 2010; Kanagasabai and Ballah 2022). The policy stipulated that there was to be annual examination of all school children; there was to be premarital serology and medical examination with free treatment for those found positive: there was to be free treatment to all students and indigents in government clinics and hospitals (Kanagasabai and Ballah 2022; HPSOL 2022; Njoh 2018).
Socio-political context of introduction	The history of Liberia begins in the United States of America. In 1816, a group made up primarily of Quakers and slaveholders in Washington D.C. formed the American Colonization Society (ACS) (Anjali Mitter Duva 2002; Njoh 2018). The goal of the ACS was to repatriate free born Blacks and former slaves back to Africa. In 1822, the first 86 voluntary Black emigrants landed on Cape Montserrado, on what was then known as the Grain Coast. The land, however, was inhabited by the Mel and Kwas speaking peoples (Ciment 2013). The land that was to be Liberia was partly purchased, and sometimes obtained more forcefully from the indigenous population (Ciment 2013; Anjali Mitter Duva 2002). The settlers then proceeded to reconstruct American society, erecting structures reminiscent of Southern plantations and establishing churches while maintaining English as their language. They engaged in intricate interactions with indigenous communities—sometimes intermarrying, at other times discriminating—while persistently endeavouring to “civilize” them and impose Western values on their traditional way of life (Ciment 2013; Anjali Mitter Duva 2002). Liberia would eventually declare its independence on July 26, 1847. As Liberia’s territory expanded, a government comprised mainly of repatriates concentrated along the coast sought to exert authority over an increasingly populous native population dwelling predominantly in the interior regions. In the ensuing decades, mounting economic challenges gradually eroded the state’s control over the indigenous communities along the coast. With diminished support from the financially strained ACS, Liberia struggled to modernize its primarily agricultural economy, facing a stark imbalance between the high costs of imports and the revenue generated from exports of coffee, rice, palm oil, sugarcane, and timber. Between 1847 till the early 1900s, Liberia’s health system consisted largely of disjointed health facilities run by various Christian missionary led organizations and settlers from the United States of America. In 1946, Dr. Joseph Nagbe Togba, M.D., returned home from the United States after completing his formal training and internship at Meharry Medical College (Njoh 2018). He was the first Liberian born physician to practice medicine in Liberia, where others prior to him were either white Americans or freed slaves who had settled in Liberia (Njoh 2018).

4. CHARACTERISTICS OF THE SYSTEM AT INTRODUCTION

a. Organisational structure

In the early 1940s, President Tubman requested for American assistance to tackle the many health problems that the country confronted. In response, the U.S. State Department, in November 1944, directed the United States Public Health Service (USPHS) to send a small team of African American health workers to Liberia (Njoh 2018; West 1948; Kanagasabai and Ballah 2022). In 1945, the bureau of Public Health and Sanitation was established in Monrovia, Liberia. The first policies on disease control and on health interventions for the fledgling country would emanate from this office (Njoh 2018). In 1946, Dr. Togba returned to Liberia and started working at the Liberia Government Hospital in Monrovia, as the only Liberian Doctor and one of twelve physicians in the country. Upon arrival he wrote about his observations of the health care system and public health in the country, *“public health as practiced in Liberia simply applied to Monrovia and its environs. The work of public health was a matter of going along the streets to the homes of prominent officials in the cabinet, legislature, and judiciary. The grass and dirt around their homes were to be cleared. Garbage and dirt were not to be seen in certain places in Monrovia or else the Public Health team was to be taken to task”* (Njoh 2018).

In 1946, shortly after Dr. Togba’s return home, the legislature passed the first ACT meant to impact the health of the public, which stipulated the following: there was to be an annual examination of all school children; there was to be premarital serology and medical examination with free treatment for those found positive; there was to be free treatment to all students and indigents in government clinics and hospitals. One of the earliest descriptions of the health system at the time was provided by Dr. John B. West who led the USPHS team. Dr. John B. West, wrote of his initial impression in the Public Health Reports, *“we found that to the best of our knowledge there were six physicians, two dentists and an indeterminate number of nurses practicing in Liberia, which has a population estimated at two million”* (West 1948).

Between the 1940s to the early 1960s, the number of governments run health facilities had progressively increases to constitute almost half of all health facilities in the country. The remaining health facilities were operated either by Christian missions or mining concession health facilities.

» Coverage (principal health insurance)

Percentage of population covered by government schemes	Some share
Percentage of population covered by social insurance schemes	Negligible
Percentage of population covered by private schemes	Some share
Percentage of population uncovered	Majority

b. Coverage

In the late 1940s, the government of Liberia proposed a health plan with six major goals, that was finally passed in 1956 and was meant to improve the country’s health. It consisted of:

- (a) Annual physical examination for all school children
- (b) Premarital testing and free treatment for venereal disease cases
- (c) Free treatment for students and tribal people treated in government hospitals and clinics.
- (d) Broader employment of foreign doctors
- (e) Increase in clinics and hospital construction throughout the nation, and
- (f) Local institutions for medical training

With the passing of the 1956, Title 31 Public Health Safety Laws, this plan was officially implemented as the government’s policy on health.

c. Provision

By 1950, the Liberian government had under contract 18 doctors. Among them 2 were dentist, 1 eye specialist, 1 ear, nose and throat specialist, 1 accident surgery specialist and 1 laboratory technician. Of the 18 doctors only 2 were Liberian nationals.

Following, the 1956 Public Health Safety Law, the government of Liberia started to go beyond preventive services to expanding curative services based on the needs of the people. A focus was placed on building training institutions such as the Tubman National Institute of Medical Arts and the building of hospitals and clinics to offer more curative services to the Liberian people.

By the 1960s, there was at least one public hospital constructed or under construction in each county. In addition, there were 9 mission built and run hospitals, and 5 hospitals run by the mining concessions and 1 by the Fire Stone Rubber cooperation.

Name	Year	Location	Beds
Christian Missionary Built			
St Marks hospital	1859	Harper	-
St Timothy hospital	1917	Cape Mount	25
The Holy Cross hospital	1924	Bolahun	-
Curan Lutheran hospital	1924	Zorzor	50
Ganta methodist hospital	1926	Ganta	50
Baptist Carrie V Dyer hospital	1926-1957	Monrovia	26
Eternal love winning hospital	1951	Monrovia	50
Phebe Lutheran hospital	1965	Gbarnga	75
St joseph's catholic hospital	1967	Monrovia	
Corporation Built Hospitals			
Firestone hospital	1926	Harbel	50
Liberia mining company hospital	1950	Bomi hills	50
Liberia Swedish Mineral Mining Company hospital	1953	Yekepa	50
German Liberian Mining Company hospital	1958	Bong County	50
National Iron Ore Company	1960	Bomi hills	50
Liberia Swedish Mineral Mining Company hospital	1964	Buchanan	100
Government Built			
Maternity hospital	1926	Monrovia	120
Liberian government hospital	1926	Monrovia	180
James Jenkin Memorial Hospital	1950	Harper	
Sanniquellie government hospital	1955	Sanniquelle	
Tellewonyan memorial hospital	1957	Voinjama	75
Francis Grant hospital	1950s	Greenville	50
2 clinics	1946	Monrovia	
1 clinic	1946	Tapita	
1 clinic	1946	Vonjama	
1 clinic	1946	Marshall	
1 clinic	1946	Sinoe	
7 clinics	1946	Tchien, Voinjama, kolahun, lower Buchanan, Greenville, Robertsport, Harper	
5 clinics	1947	Marshall, Salala, Webbo, Rivercess, and Bopolu	

Name	Year	Location	Beds
2 clinics	1948	Sasstown and Plebo	
6 clinics	1949	Johnsonville, Suehn, Caresburg, ClayAshland, Arthington, Grandcess	
2 clinics	1950	Tewor and Barclayville	

In the mid-1960s, it was recognized that there were negative consequences for the country's economic and social development tied to the health care status of the country. In a speech President William Tubman stated *"the high incidence rates for many chronic debilitating diseases and infections are directly responsible for much absenteeism and lack of stamina and vitality, as well as inability of so many of our people to perform their daily task and responsibilities adequately and consistently"*. The solution to these issues was to make available adequate preventive and curative services for every country, district and village in Liberia.

Services at hospitals included both inpatient and outpatient services while clinics provided outpatient services. Despite a lack of human resources, such as dentist and other specialized care, where trained personnel were available services were accessible.

d. Financing

In the 1940s the Liberian government proceeded to invest significantly in their health sector. In 1944, the government allocated \$72,000 to public health and medical care. This rose annually to \$400,00 in 1947. By 1950, Liberia's budget appropriation for Public Health and Sanitation was 12% of its annual revenues, which at the time was one of the highest in the world.

During this period the majority of the health sector financing was distributed between the government of Liberia, Christian Missions, and the private Mining Concessions that ran the various health facilities. Privately owned and operated health facilities were negligible and out of pocket expenses was minimal.

e. Regulation

When President Tubman was sworn in 1944 as the 19th president of Liberia, he promised to make health and education a priority for his government. Recognizing the limited resources of the country he appealed to the United States for assistance shortly after taking office. The U.S. State Department responded by directing the US public Health Services to send a small team of African American Health Workers to Liberia to help address the health problems in the country. This led to the establishment of a new department within the Liberian government called the Bureau of Public Health and Sanitation, in 1945, that was headquartered in Monrovia. This would be the foundation of the national health care system in Liberia. It was the first attempt to have a central location from where clear and decisive policies could be made and disseminated across the country as related to health. The new government unlike its predecessors was thinking of a unified, well-organized approach to national public health matters

In 1948, the National Public Health Service was established to lead the fight against diseases and promote health nationwide.

As early as 1927 the Liberian Medical Board was responsible for the licensing of medical practitioners in the country. This entity would eventually be housed in the future ministry of health and later become its own independent entity.

The very first services and benefits package was made by presidential proclamation following advise from the US Public Health Service Mission and Dr. Togba, who was the director of the Bureau of Public Health and Sanitation.

5. SUBSEQUENT HISTORICAL DEVELOPMENT OF PUBLIC POLICY ON HEALTH CARE

a. Major reform I

Name and type of legal act	Public Health and Safety Laws of Liberia Title 33: Public Health Law																																								
Date the law was passed	Revised in 1976																																								
Date of <i>de jure</i> implementation	1976																																								
Brief summary of content	<p>In 1972, the Government of Liberia reviewed the health sector, which consequently led to eliminating the National Public Health Services and establishment of the Ministry of Health and Social Welfare. This change was accompanied with a shift from enforcement of public health laws, through prosecution and penalties to health education for a positive, and sustained behavioural change.</p> <p>The 1976 revised Public Health Law focussed on curative services (Njoh 2018) and medical education:</p> <ul style="list-style-type: none"> » August 1, 1968, opening of the Monrovia Torino Medical College (would become the A. M. Doglioti College of Medicine) » On June 18, 1971, the John F. Kennedy Medical Center was dedicated. This institution was mandated to increase the number of well-trained paramedical personnel for the health facilities in Liberia » To provide through the facilities of a 300-bed general teaching hospital, the best in modern medical diagnosis and treatment <p>To serve as the nucleus for the training of medical students at the University of Liberia</p>																																								
Population coverage	<p>The new law included provisions for: control of acute communicable diseases and condition; environmental sanitation; health standards of public and private institutions; regulation of drugs; vital statistics (disposal of human remains); regulation and supervision of medical and allied health professions.</p> <p>Health services were available to all citizens and residents of the country. However, accessibility of healthcare delivery in rural parts of the country was still a challenge.</p> <p style="text-align: center;">Hospital bed distribution in 1978</p> <table border="1"> <thead> <tr> <th>County</th> <th>Beds</th> <th>Population</th> <th>Ratio (population/beds)</th> </tr> </thead> <tbody> <tr> <td>Bassa</td> <td>179</td> <td>172,155</td> <td>962</td> </tr> <tr> <td>Bong</td> <td>193</td> <td>221,178</td> <td>1,146</td> </tr> <tr> <td>Cape mount</td> <td>99</td> <td>64,469</td> <td>665</td> </tr> <tr> <td>Grand Gedeh</td> <td>50</td> <td>81,806</td> <td>1,636</td> </tr> <tr> <td>Lofa</td> <td>159</td> <td>205,559</td> <td>1,295</td> </tr> <tr> <td>Maryland</td> <td>208</td> <td>104,330</td> <td>502</td> </tr> <tr> <td>Montsearrdo</td> <td>1,304</td> <td>501,150</td> <td>384</td> </tr> <tr> <td>Nimba</td> <td>196</td> <td>284,399</td> <td>384</td> </tr> <tr> <td>Sinoe</td> <td>80</td> <td>76,990</td> <td>962</td> </tr> </tbody> </table>	County	Beds	Population	Ratio (population/beds)	Bassa	179	172,155	962	Bong	193	221,178	1,146	Cape mount	99	64,469	665	Grand Gedeh	50	81,806	1,636	Lofa	159	205,559	1,295	Maryland	208	104,330	502	Montsearrdo	1,304	501,150	384	Nimba	196	284,399	384	Sinoe	80	76,990	962
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Type of benefits	Health services available included: inpatient, outpatient, specialized services (dental, ophthalmology, ear, nose and throat), internal medicine, paediatrics, surgery, obstetrics, gynaecology, psychiatry, pathology, radiology, physiotherapy, and rehabilitative services.																																								
Socio-political context of introduction	In 1944, three weeks after his inauguration, President William Tubman abandoned Liberia's position on neutrality in World War II and declared war against Germany and the Axis powers. In return, the United States was willing to provide the Liberian government with assistance. President Tubman prioritized technical support for the health sector. Post-World War Two Liberia's economy continued to expand slowly but did not have the resources to execute all of the governments' plans. However, President Tubman was determined to prioritize the health sector as he saw improved health services as way to protect and preserve Liberia's "Human Capital," those he hoped could be trained and used by foreign investors and projects. An early understanding of the connection between a healthy population with access to preventive and curative services and that of productive economy drove the health system revolution that occurred in Liberia between the late 1960s to the early 1980s.																																								

b. Major reform II

Name and type of legal act	National Health Policy and Plan Basic Package of Health Services (BPHS) Act Establishing the National Public Health Institute of Liberia The New Public Health Law as Revised (2019)
Date the law was passed	National Health Policy and Plan (2007-2011) Basic Package of Health Services (2008) Act Establishing the National Public Health Institute of Liberia (2016) The New Public Health Law as Revised (2019)
Date of <i>de jure</i> implementation	2007-2011, 2016, 2019
Brief summary of content	<p>The National Health Policy and Plan are designed around four strategic orientations of Primary Health Care, Decentralization, Community Empowerment and Partnerships for Health. The operational and integrated framework for implementing the National Health Policy and Plan is based on four key components - 1) Basic Package of Health Services; 2) Human Resources for Health; 3) Infrastructure Development; and 4) Support Systems (Ministry of Health & Social Welfare (MoHSW) Republic of Liberia 2007; Ministry of Health and Social Welfare 2012).</p> <p>The BPHS is the cornerstone of Liberia's national health care delivery strategy. Two distinct ideas have guided the development of the BPHS. First, the health system must be based on the principles of primary health care. Second, the management of services should be progressively decentralized (Liberian Ministry of Health and Social Welfare 2008; Ministry of Health & Social Welfare (MoHSW) Republic of Liberia 2007).</p> <p>The National Public Health Institute of Liberia (NPHIL) was established by the NPHI Act of 2016, which was signed into law by the president in January 2017 ("Critical Aspects of the NPHI Act to Establish NPHIL CASE STUDY Case Series on Providing a Legal Framework for a National Public Health Institute: The Liberia Experience," n.d.).</p> <p>The National Public Health Law was revised in 2019 in an effort to harmonize the functions of the Ministry of Health and the newly established NPHIL (MOFA 2019).</p>
Population coverage	<p>The 2007-2011 Health Policy Plan articulated the following principles for health coverage: Equity, social justice and good governance are essential for health and social improvements. Every Liberian shall have access to health services, irrespective of socio-economic status, origin, gender, and geographic location. The pro-poor commitment of the Government will be demonstrated by concrete measures, taken at all levels of health care provision. Recognition shall be given to the special needs of the most vulnerable. User-friendly services shall be equally accessible to everyone regardless of their gender. Government will ensure that health care services are delivered on an equitable and affordable basis to all communities and persons, especially to the poor and vulnerable members of the community and to women and children. The BPHS was developed with two clearly articulated strategies: First, that the health system should be fundamentally based on the principles of primary health care, with an emphasis on making services available at the peripheral levels of the health system; and Second that the management of health services should be progressively decentralized, so that the responsibility for implementing them rests at the County level, rather than in the national capital. The BPHS involves an integrated provision of primary and secondary care. Primary care, including both outpatient curative and preventive care as well as outreach services, is provided at all health facilities for their primary catchment area. This applies equally to hospitals, health centers and clinics. The effective catchment area is thought to be an area with a diameter of about ten kilometres round the facility. Depending on the population density, those populations vary between about 3,500 and 12,000.</p> <p>The overall objective of NPHIL is to improve the health status of the population of Liberia in collaboration with relevant agencies and institutions of government. The specific objectives are as follows:</p> <ol style="list-style-type: none"> (a) Contribute to the development and sustainability of public health workforce (b) Develop, enhance, and expand the surveillance and response platforms (c) Develop and strengthen the laboratory system and public health diagnostics (d) Develop, enhance, and expand processes and structures to protect environmental and occupational health (e) Expand, conduct, and coordinate public health and medical research to inform Liberian public health policies

Population coverage(continued)	<p>The Public Health Law Revised (2019) defines that the mission of the public health system is to promote and contribute to the highest attainable standard of public health for the people of Liberia by: preventing health risks and diseases; identifying and reducing health risks in the communities; preventing, detecting, investigating, and responding to the spread of diseases; promoting healthy lifestyles; promoting a safe and healthy environment; promoting the availability, affordability, and accessibility of quality healthcare services through the private and public sectors; and providing quality healthcare services when not otherwise available.</p>
Available benefits	<p>Because the BPHS emphasizes primary health care, it focuses attention on those services that are provided to and used by the population of the immediate catchment area of health facilities. The Basic Package of Health Services for Liberia consists of the following:</p> <p>Maternal and Newborn Health</p> <ul style="list-style-type: none"> » Antenatal care » Labor and delivery care » Emergency obstetric care » Postpartum care » Newborn care » Family Planning <p>Child Health</p> <ul style="list-style-type: none"> » Expanded Program on Immunization » Integrated management of childhood illnesses » Infant and young child feeding » Reproductive and Adolescent Health » Family planning » Sexually transmitted infections <p>Adolescent Health</p> <ul style="list-style-type: none"> » Communicable Disease Control » Control of STI/HIV/AIDS » Control of tuberculosis » Control of malaria » Control and management of other diseases with epidemic potential <p>Mental Health</p> <p>Emergency</p>
Socio-political context of introduction	<p>The 1990-2003, civil war had led to a significant decline in the economy and increasing poverty. The 14 year civil conflict had taken a country that achieved food security and middle income status in the 1970s, to one of the poorest countries in the early 2000s. Per capita Gross Domestic Product (GDP) in 2004 prices had declined from US\$1,269 in 1980 to US\$ 167 in 2005, a decline of 87 percent.</p> <p>By the time Liberia emerged from civil war in 2003, fourteen years of brutal conflict had ruined Liberia's economy, infrastructure, health system, and the health and education of its people. Of Liberia's 550 pre-war health facilities, only 354 facilities (12 public hospitals, 32 public health centers, 189 public clinics, 10 private health centers, and 111 private clinics) were functioning by the end of 2003. Eighty percent of these were managed by non-governmental organizations (NGOs) and faith-based organizations (FBOs).</p> <p>The establishment of the NPHIL was in response to the devastating 2014-2016 Ebola Virus Epidemic that left over 4000 Liberians dead. The EVD outbreak of 2014-2016 necessitated the establishment of a structure to work in collaboration with the Ministry of Health to concentrate on strengthening national and subnational public health capacities to institutionalize and implement infection prevention and control practices, improve surveillance and diagnostics, and build public health capacity to prevent the future outbreak of such diseases and other events of public health concern in Liberia.</p> <p>The Title 33 Public Health Law was revised in 2019 as the original law adopted on July 16, 1976, had existed for over 40 years and no longer reflected the current realities and needs of the country. The following justifications were given for the revision:</p> <ol style="list-style-type: none"> (a) Title 33 provides for fines and fees that do not reflect current day economic realities, (b) the 1976 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

Socio-political context of introduction
(continued)

- (c) As a result, recent legislative enactments have been made to either amend or repeal certain provisions of Title 33 and the said enactments, while a part of the Public Health Law, are in separate documents; and the Liberia Medicines and Health Products Regulatory Act of 2010 removes the regulation of drugs from the Ministry of Health and the Liberia Pharmacy Board and gives same to the Liberia Medicines and Health Products Regulatory Agency (LMHRA);
 - (d) Part IX, Section 1 of the said LMHRA Act repeals certain provisions of Title 33 and regulations made thereunder without specifically naming the repealed provisions and regulations;
 - (e) The Act creating the Ministry of Gender and Children Protection removes the social welfare component of the functions of the Ministry of Health;
 - (f) it is imperative to collate and integrate the separate laws governing the public health system, with the realization that a unified public health system is necessary in ensuring that all citizens and residents of the Republic have equal access to health services;
 - (g) the mission of the public health system is to promote and contribute to the highest attainable standard of public health for the people of Liberia by: preventing health risks and diseases; identifying and reducing health risks in the communities; preventing, detecting, investigating, and responding to the spread of diseases; promoting healthy lifestyles; promoting a safe and healthy environment; promoting the availability, affordability, and accessibility of quality healthcare services through the private and public sectors; and providing quality healthcare services when not otherwise available.
-

6. DESCRIPTION OF CURRENT HEALTH CARE SYSTEM

a. Organisational structure

The 2007-2011 NHP reflected the government of Liberia's commitment to decentralization (Ministry of Health and Social Welfare 2011; Ministry of Health and Social Welfare 2012). The Liberian health sector is structured in a tiered system. At the central level is the Ministry of Health and Social Welfare, who is responsible for:

- » Proposing and monitoring of health legislation and law enforcement
- » policy formulation, revision and enforcement
- » resource mobilization and allocation, national and long-term planning
- » broad health sector programming
- » monitoring and evaluation
- » technical oversight of service delivery, regulation, major research and development initiatives.

At the county level the County Health and Social Welfare Service Administration Teams (CH&SWT) is the operational management structure. The CH&SWT has the authority to manage country health facilities, including hospitals.

The health system itself is based on three main levels of care (primary, secondary and tertiary).

The Primary Level of Care includes basic health care services delivered through clinics and small health centers. The health clinic is a small facility with not more than five beds, providing basic preventive and curative care. The package at this level includes promotional health, basic mental health services and the management of common conditions of children and adults.

The Secondary Level of Care encompasses large health centers and county hospitals. The health center is a primary care and referral facility with up to 40 beds, providing a wide range of curative and preventive services, supported by a small laboratory. Basic emergency and inpatient care is included. The county referral hospital has more than 50 beds and permanent capacity to manage common surgical conditions, including basic intensive care.

The Tertiary Level of Care is represented by the John Fitzgerald Kennedy Medical Center (JFKMC), which shall continue to be autonomous and managed by its Hospital Administration Department under the supervision of a Board of Directors.

The CH&SWTs are responsible for county planning, resource allocation, financial management and implementation of national priorities, facility management, maintenance and supervision, management of personnel, collection and analysis of HMIS-generated data, coordination with local and international partners at this level,

and collaboration with the County Health and Social Welfare Board, and all other relevant stakeholders (Ministry of Health and Social Welfare 2012).

Liberia has both a national health system and a private health system. Post war, it has seen a proliferation in privately owned and operated health clinics, health centers, and hospitals. Most of these facilities are covered through a combination of private health insurance or out of pocket expenditures. In addition, Liberia still maintains its history of health facilities that are supported and operated by Faith Based Organizations (Christian Connections for International Health 2021).

» Coverage

Percentage of population covered by government schemes	Negligible
Percentage of population covered by social insurance schemes	15%
Percentage of population covered by private schemes	Some share
Percentage of population uncovered	Majority

b. Coverage

No definitive quantitative data are available on the percentage of the population covered by the government and private schemes. It is estimated that about 15% of the population, within the formal sector is covered by some form of insurance (JSI 2014; Lee et al. 2011; Garnet and Thompson 2018; Republic of Liberia 2015).

The 1975 Social Security Act of Liberia, revised February 2017, established the National Social Security & Welfare Corporation (NASSCORP). The National Social Security & Welfare Corporation (NASSCORP) is an autonomous public institution charged with implementing three schemes designed to provide social protections to eligible persons (NASSCORP 2017; JSI 2014). These schemes are:

- » Employment Injury Scheme (or EIS) was launched February 1, 1980;
- » National Pension Scheme (or NPS) was launched September 1, 1988; and
- » Welfare Scheme (or WS) is yet to be launched.

These three schemes constitute the Social Security program in Liberia. The EIS is a Social Security program available to all persons working for a registered employer. It is designed to provide cash and material benefits to take care of employees who sustain injuries or become disabled as a result of job-related accidents or occupational diseases. Formal sector employees are covered by the employment injury scheme, which is part of the government-run social security scheme, or medical insurance from private health insurers or employer managed health facilities. Contributions from both employers and employees pay for pensions and other social security benefits, including the employment injury scheme that pays for healthcare services to treat workplace related injuries.

Formal sector populations can also obtain medical insurance from private health insurers. Many employers and/or employees' associations require their employees and/or members to pay monthly deductible premiums from their salary, for life, accident and medical insurance coverage (Ministry of Health and Social Welfare 2011; Ministry of Health and Social Welfare 2012; JSI 2014).

The medical insurance usually covers the employee and dependents (one spouse and up to four children), and pays for outpatient and inpatient services (31 days maximum) and some surgical procedures delivered mostly by non-profit private healthcare providers (JSI 2014).

Formal sector employees in the concessionaire sector, covering rubber, palm oil, and mining and forestry, in some cases, receive healthcare from employermanaged health facilities governed by the concessionaire's agreement with the government (JSI 2014).

c. Provision

In 2009, a national human resources census recorded 8,553 public sector health and social welfare workers (Dahn et al. 2021; Montserrado County Background," n.d.; Government of Liberia 2016).

Of those who reported their cadre, 62 percent (5,346) were clinical and 38 percent (3,207) were non-clinical (including security guards, registrars and cleaners). However, only 48 percent (2,568) of the clinical workers were skilled providers (e.g., physicians, physician assistants, nurses, midwives, pharmacists, lab technicians) and almost 70% of the total workforce was wither non-clinical or unskilled.

In the 2010 Basic Package of Health Services Accreditation Final Results Report, the MOHSW reported 550 open health facilities (378 public and 172 private) (Liberian Ministry of Health and Social Welfare 2008).

Most rural households are more than one hour's walk away from the nearest health facility. Health facilities and clinics provide basic preventive and curative care, including immunization and maternal and child health-care. Skilled delivery attendance is only available if a clinician (midwife, physician or nurse) is assigned to the clinic. Emergency care usually requires referral from the clinic to the nearest secondary-level care facility. Many patients self-refer and enter the health system at the wrong level, creating an unnecessary burden on the secondary level of care. Most counties have only one government hospital and one or two health centers providing 24-hour care for conditions requiring hospitalization, emergency services and diagnostic services.

Two distinct packages of services will be cornerstones of the national strategy to improve the health and social welfare of all people in Liberia: the gender-sensitive Essential Package of Health Services (EPHS) and a planned Essential Package of Social Services (EPSS) (Ministry of Health Republic of Liberia 2011). The two packages will list in detail the services that the MOHSW assures will be available throughout the public system.

The EPHS prioritizes the services that reflect the prevailing disease burden and health conditions affecting the population. It includes all elements of the Basic Package of Health Services (maternal, child and newborn health, communicable diseases, reproductive and adolescent health, mental health and emergency care) as well as a phased-expansion to include non-communicable diseases, essential child nutrition, neglected tropical diseases, environmental and occupation health, school health, eye health and prison health.

d. Financing

- » Health expenditure was 14% of GDP in 2009 (Ministry of Health and Social Welfare and Health Systems 20/20 Project 2011).
- » The 2009 National Health Accounts Report (NHA) for fiscal year 2007-2008 reported a total health and social welfare expenditure of US\$ 103, 496, 421, or \$29 per person in Liberia.
- » Donors and out of pocket financing accounted for most of the expenditures (45% and 25%, respectively). Government spending according to the NHA has remained stable as percentage of the national budget (between 7-8%) over a four-year period.

e. Regulation of dominant system

The **Ministry of Health and Social Welfare** is responsible for regulating the healthcare system according to the Public Health Law. The core responsibilities of the MOHSW are to promote, preserve and maintain a comprehensive, functional, and sustainable public health system in Liberia for the purpose of preventing and controlling communicable diseases and other conditions of public health importance. The Minister has the following authority:

- (a) Oversee administrative review of any administrative decision made under the provisions of this Title as set forth in Chapter 4.
- (b) Appoint and oversee County Health Administration as set forth by the provisions of this Title.
- (c) Collect information regarding events of public health importance including reports required by Section 7.3. Any events that may constitute a public health emergency shall be reported in compliance with the International Health Regulations (2005).
- (d) Make and Promulgate regulations.
- (e) Take all lawful and reasonable measures necessary to prevent the occurrence of or deal with any epidemic or communicable disease.
- (f) Exercise any other powers or perform any other duties in respect of the public health as set forth in this Title or in any other written law.

National Public Health Institute (2016): Has the authority to promulgate and issue regulations governing NPHIL in the field of public health research in Liberia (Sirleaf 2017).

Liberia Medicine and Health Products Regulatory Authority: Responsible for the regulation of importing and exporting of all drugs used in the country.

Liberian Medical and Dental Council (2010): Responsible for the licensing of medical health practitioners.

- » Liberian Medical and Dental Council: The LMDC (Liberia Medical and Dental Council) was established by an Act of the National Legislator and signed into law by Her Excellency, President Ellen Johnson Sirleaf of Liberia on March 25, 2010, to monitor and regulate all Health Workers and health institutions in the country (Njoh 2018). Prior to 2010 the Council was a Board under the direct guidance of the Honorable Minister of Health and Social Welfare of Liberia. Unlike her predecessor, the Liberia Medical Board, the present Council is autonomous and has the power given to it by the Act to examine and issue licenses to all who qualify to practice the Medical profession in Liberia.
 - » Mandate to examine, regulate and monitor both health professional and facilities
 - » The Council registers all Physicians, Surgeons, Dental Surgeons, and allied medical professionals practicing within the Republic of Liberia.
 - » set procedures, guidelines, and standards for the accreditation of medical services and health training institutions.
- » Liberian Board of Nursing and Midwifery: Formal nursing and midwifery education began in Liberia around 1922 (Kpangaala-Flomo et al. 2021). Established in 1949, the Liberian Board for Nursing and Midwifery (LBNM) is the legal power and authority in regulating and monitoring the nursing and midwifery profession in Liberia and ensures professional excellence in nursing and midwifery education and practices.
- » Liberia Medicines and Health Products Regulatory Authority was established in 2010 and mandates with the responsibility to ensure the safe, effective and good quality medicines are available to the Liberian public (LMHRA 2010). Including the following:
 - » To protect the Liberian public from harmful effects of substandard medicines and health products
 - » To ensure fair trade practices in medicines and health products
 - » To promulgate regulations to fight illegal trade in medicines, including counterfeit and adulterated medicines and health products.
 - » To conduct or facilitate necessary research and development, promote pharmacovigilance and disseminate timely drug information
- » The services available in the benefit package are decided by the Ministry of Health and Social Welfare in collaboration with relevant regulatory authorities, professional bodies and foreign actors and donors.

7. ROLE OF GLOBAL ACTORS

- » Since the civil war donor funding has been the primary source of healthcare spending. In 2009/2010, donor funding made up 82% of the health system funding (Garnet and Thompson 2018; Ministry of Health and Social Welfare and Health Systems 20/20 Project 2011). This dependence on donor funding has left the health system vulnerable to fluctuations. The Government of Liberia allocates around 14.6% of its overall budget to the health sector, nearly achieving the 15% target set by the Abuja Declaration. However, the overall government budget is relatively small (Ministry of Health and Social Welfare and Health Systems 20/20 Project 2011).
- » While donor funds are expected to gradually decrease over the next ten years, 59 percent of current donor funds (either directly or through the health pool fund) are spent on contracts with NGOs to support 292 health facilities, representing 75 percent of the functioning government facilities in 2010, of which funding for 232 are performance-based (Ministry of Health and Social Welfare 2007; Ministry of Health & Social Welfare (MoHSW) Republic of Liberia 2007). The diverse group of partners, including international donors, Non-Governmental and Faith-Based Organizations and Private for Profit providers working in the health sector are motivated by a range of different mandates, interests, resources and ways of working.
- » The United States is Liberia's single largest bilateral donor. The US provided 22% of the Liberian health budget in 2009 (Downie 2012). Additionally, Global Fund to Fight AIDS, Tuberculosis and Malaria (Global Fund) is one of the largest contributors supporting the health sector in Liberia (World Health Organization et al. 2015; Downie 2012). Other major contributors include the United Nations, USAID, and the Bill and Melinda Gates Foundation.

- » Historically, Liberia has a long history with faith-based organizations since the founding of its oldest hospitals by evangelical missions. In 2016, it was estimated that 100 out of the 753 health facilities in the country were faith-based facilities. Faith-based health facilities are spread in both rural and urban populated counties. It is estimated that based on their strategic locations, faith-based facilities are providing healthcare services to about 13.28% of the total population in Liberia (Christian Connections for International Health 2021).

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