

A REPORT OF THE CSIS  
GLOBAL HEALTH POLICY CENTER

# The Road to Recovery

REBUILDING LIBERIA'S HEALTH SYSTEM

*Author*

Richard Downie

August 2012



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# CONTENTS

<b>Overview</b>	<b>1</b>
<b>Introduction</b>	<b>3</b>
<b>The Situation Today</b>	<b>4</b>
<b>The U.S. Contribution to Liberia's Recovery</b>	<b>6</b>
<b>Barriers to Success</b>	<b>9</b>
Addressing Current and Emerging Health Priorities	9
Human Resources	10
Sustainability and Funding	12
Strengthening Health Systems	13
Decentralization	13
Integrating the Health System with Other Development Sectors	14
<b>Recommendations for U.S. Policy</b>	<b>15</b>





# THE ROAD TO RECOVERY

## REBUILDING LIBERIA'S HEALTH SYSTEM

Richard Downie<sup>1</sup>

### Overview

The process of rebuilding Liberia's shattered health system is entering a crucial and potentially destabilizing phase. With the assistance of the United States, Liberia has made steady progress in delivering basic health services to its citizens since the end of the civil war in 2003. Efforts have focused on dealing with the most urgent public health priorities: communicable diseases like malaria, tuberculosis, and HIV/AIDS; maternal and newborn health; and childhood disease. An ambitious policy of decentralization has sought to address the chronic shortage of health services in rural communities. During this period, international donors, nongovernmental organizations (NGOs), and faith-based groups have provided the bulk of the services, but this situation has slowly begun to change, with the Liberian government and local NGOs assuming a larger responsibility.

At the same time, Liberia's Ministry of Health and Social Welfare (MoHSW) has begun to make the longer-term investments needed to build a sustainable health system. Increasingly, funding is directed toward establishing financial systems, setting up monitoring and evaluation programs, and improving planning capacity within the health sector. Liberia is fortunate to have a credible, experienced health leadership that is committed to the government's ambitious agenda of turning Liberia from a failed state into a healthy, secure, middle-income country by the year 2030.

Unfortunately, vision and dedication alone are insufficient to help Liberia achieve this objective. Liberia's health system is beset with serious capacity problems. It is chronically short of human resources, equipment, and drugs. The decentralization policy faces serious challenges, not least of which is the difficulty of finding professional health workers willing to deploy to far-flung areas. Furthermore, as Liberia moves further out of conflict, the donor assistance upon which it still heavily depends is starting to waver. The domestic budgetary pressures faced by some of Liberia's most consistent supporters exacerbate the process. The MoHSW is warning of a financial shortfall, and, at the time of writing, the minister of health is lobbying to persuade his president to exempt the health sector from a government-wide spending freeze on new staff and buildings. In this moment of uncertainty, Liberia's hard-won gains in public health could easily unravel.

The United States has been Liberia's most steadfast partner during this reconstruction effort and remains publicly committed to playing a leading role. As a statement of its commitment to Liberia and as part of an effort to move toward a more sustainable development model, the U.S. Agency for International Development (USAID) has begun channeling funds directly through the MoHSW, rather than through third-party contractors. This new approach, if successful, will

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1. Richard Downie is deputy director and fellow with the Africa Program at the Center for Strategic and International Studies.

give an important boost to the ministry's stated effort to begin the long transition away from donor dependency.

The United States can do several specific things to sustain the momentum on public health in Liberia:

- Be patient. "Quick wins" on health will become harder to achieve in Liberia, as the country's health system moves from an emergency response phase to a period of consolidation. Even with the best interventions, indicators for maternal mortality and other key health challenges will take years to bring down. The United States should maintain its commitment even when quantifiable improvements are slow to occur, provided its efforts are matched by its Liberian partners.
- Prioritize strengthening the health system. Investments in Liberia's health systems and supporting structures are the best way to build a sustainable health service in the long run. Boosting capacity at the MoHSW should remain a priority. USAID should consider slowly increasing the amount of funding directed through the MoHSW over time, provided that accountability is not compromised.
- Increase support for human resources. The United States should consider offering more scholarships for medical training to entice Liberians into careers in the health sector. It should come up with innovative strategies to encourage Liberian health professionals living in the United States to take up work placements in their country of origin.



Source: United Nations, Department of Peacekeeping Operations, Cartographic Section, October 2010.



## Introduction

Liberia has come a long way in the nine years since the end of its civil war. In 2003, the country lay in ruins after 14 years of conflict. Few Liberians were untouched by the violence. Out of a population of 3.5 million, an estimated 270,000 people lost their lives, and more than 800,000 were displaced.<sup>2</sup> Many sought refuge in neighboring countries, while others fled to the capital, Monrovia, which saw its population double to more than 1 million. Women suffered horrific violence; a postwar survey in one county found that 90 percent of interviewees had suffered physical or sexual abuse.<sup>3</sup> Young people were traumatized by the war, in which many children enlisted as soldiers in the various rebel groups that marauded their way up and down the country.<sup>4</sup> Liberia's infrastructure was shattered, with roads and bridges destroyed and water and power supplies cut. The health system was not spared. Hospitals and clinics were looted, emptied of medicines, and burned down or vandalized. By the end of the war, only 354 health facilities remained operational, out of a prewar total of 550.<sup>5</sup> The vast majority of them were run by NGOs. The headquarters of Liberia's health ministry, meanwhile, had become a temporary residence for refugees. Nine out of ten doctors had fled the country, and the medical training system had collapsed. Just 168 physicians remained, mostly in Monrovia.

The war had a catastrophic impact on Liberia's health and development indicators (see table on next page). The statistics for maternal and child health were particularly stark. The 2007 Demographic and Health Survey, which covered the period 2002–2006, recorded an infant mortality rate of 71 deaths per 1,000 live births. Only 39 percent of children under the age of two had received their recommended vaccinations. At the time the survey was conducted, 31 percent of children under five were suffering symptoms commonly associated with malaria, and 20 percent had diarrhea. One in every nine children died before his or her fifth birthday.<sup>6</sup> The survey found that Liberia was one of the most dangerous countries for expectant mothers. Less than two-fifths of women gave birth in a health facility, and only 46 percent had a skilled birth attendant with them at the time of delivery. The maternal mortality rate for the seven years up to 2007 was 994 deaths per 100,000 live births.<sup>7</sup> This statistic was even more sobering when combined with survey data on total fertility rates, which showed that Liberian women have an average of 5.2 children.<sup>8</sup>

The figures on communicable disease also underline the scale of Liberia's health challenge. Malaria is the leading cause of death in Liberia, accounting for more than 40 percent of deaths in

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2. Republic of Liberia Ministry of Health and Social Welfare, *Country Situational Analysis Report* (Monrovia, Liberia: Ministry of Health and Social Welfare, 2011), 7.

3. Basia Tomczyk et al., "Women's Reproductive Health in Liberia, Lofa County Reproductive Health Survey," January–February 2007, 4.

4. According to the National Commission on Disarmament, Demobilization, Rehabilitation and Reintegration, more than 11,000 children registered with the United Nations as combatants in the aftermath of the war.

5. Patrick T. Lee et al., "An Analysis of Liberia's 2007 National Health Policy: Lessons for Health Systems Strengthening and Chronic Disease Care in Poor, Post-Conflict Countries, Globalization and Health 2011," 3, <http://www.globalizationandhealth.com/content/7/1/37>.

6. Liberia Institute of Statistics and Geo-Information Services, the Ministry of Health and Social Welfare, and the National AIDS Control Program, *Liberia Demographic and Health Survey 2007* (Monrovia, Liberia: Liberia Institute of Statistics and Geo-Information Services), 8.

7. Ibid., 11.

8. Ibid., 3.

hospital.<sup>9</sup> Approximately 1.5 percent of the 15–49 age group had tested positive for HIV by 2007.<sup>10</sup> Tuberculosis rates are 518 per 100,000, according to the World Health Organization.<sup>11</sup>

### Selected Data for Liberia

Population (millions, 2008 census)	3.47
Population growth rate (% 2008 census)	2.1
Life expectancy at birth	56
Per capita gross domestic product (\$US)	360
Population living below international poverty line (% \$1.25 per day)	84
Adult literacy rate (% aged 15 and above)	59
Access to adequate sanitation (% <i>Liberia Malaria Indicator Survey 2009</i> )	44
UN Human Development Index rating (out of 187)	182

Sources: Data from United Nations Development Programme, *Human Development Report 2011: Sustainability and Equity* (New York: Palgrave Macmillan, 2011), and from other sources as indicated.

## The Situation Today

Fast forward to 2012, and signs of progress are everywhere. Training facilities for nurses, midwives, and physicians are up and running. The number of operational health facilities is back up to prewar levels, and most buildings have been refurbished or rebuilt. Staff from the MoHSW have just completed their move into a new, Chinese-built headquarters on the outskirts of Monrovia. The resumption of basic health services has begun to have a positive impact on health outcomes. Sixty-four percent of children under the age of two have been immunized against diphtheria, pertussis (whooping cough), and tetanus, compared with 35 percent in 2003.<sup>12</sup> Overall life expectancy was 56 years in 2010, up from 53 years when the war ended in 2003.

All these improvements have been built upon a solid policy framework. A National Health Policy (NHP), published in 2007, was integrated with the government's Poverty Reduction Strategy, a blueprint for adding impetus to Liberia's postwar recovery from 2008 to 2011. The centerpiece of the NHP was a plan to deliver a basic package of health services (BPHS), free of charge, to Liberian citizens. These services included communicable disease control, emergency care, mater-

9. Republic of Liberia, Ministry of Health and Social Welfare, *Liberia National Health and Social Welfare Policy, 2011–21*, 6, <http://www.moh.gov.lr/doc/Final-NHSWPP.pdf>.

10. *Liberia Demographic and Health Survey*, 14.

11. See <http://www.who.int/gho/countries/lbr.pdf>.

12. World Bank, World Development Indicators, <http://data.worldbank.org/indicator/SP.DYN.IMRT.IN/countries?page=1>.

nal and newborn health, and mental health care (see box 1). The emphasis was on ensuring that health facilities across the country provided a standard, measurable set of services regardless of



Ministry of Health and  
Social Welfare.  
Photo by Richard Downie.

whether they were run by the government, local or international NGOs, faith-based organizations, or private companies. An accreditation process found that by 2011 the BPHS was available at 82 percent of government facilities.<sup>13</sup> Building on this policy foundation, the MoHSW broadened its scope, launching an essential package of health services (EPHS) in 2011. The EPHS widens the number of services the government commits to providing to include treatment for noncommunicable diseases, child nutrition, dental and eye care, and neglected tropical diseases. The EPHS also aims to strengthen the referral system, formalizing a tiered structure of primary, secondary, and tertiary facilities with the objective of rationalizing services and making the system more efficient. The EPHS is the central element of a new national health plan for the country, drawn up in 2011 following almost a year of consultations with both domestic and international partners. Its end product is the Liberia National Health and Social Welfare Policy and Plan, a document that sets out the health priorities for the MoHSW for the next 10 years.

Government spending on health, while still modest, has risen dramatically from its postwar nadir, when national revenue was just \$85 million. Liberia's economic recovery was given a huge boost when it fulfilled World Bank requirements for debt relief in 2010, allowing virtually all of its \$4.9 billion national debt to be forgiven. By 2012, the national budget was a healthier-looking \$500 million, allowing a greater share to be allocated to health. In spite of this improving picture, the government's contribution to total health spending remained small. Preliminary data from the National Health Accounts, compiled by the MoHSW, showed that government expenditure made

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13. Jacob Hughes, Amanda Glassman, and Walter Gwenigale, "Innovative Financing in Early Recovery: The Liberia Health Sector Pool Fund" (working paper 288, Center for Global Development, Washington, DC, 2012), 2.

up just \$19 million of the \$179 million spent on health in 2009. By far the largest share—\$122 million—was spent by donors, while households took on a large burden, spending \$35 million.<sup>14</sup>

Overall, Liberia's health system shows some positive features despite the almost overwhelming public health challenges it faces. There is strong political will on the Liberian side and a desire to transition from donor-recipient status to locally led ownership of the health system. The government is taking on a larger share of front-end health service delivery from international NGOs, which helps strengthen its legitimacy in the eyes of the public. At the same time, the MoHSW and its international partners have tried to strike a balance between the immediate need to deliver services and the importance of making long-term investments in establishing sustainable systems and structures. Although there is still a long way to go, policy makers have put increasing emphasis on getting the right health systems in place, from procurement and human resources to monitoring and evaluation mechanisms and health management information structures. Planning functions are improving, and the move toward medium-term financial planning is a welcome development. The Ministry of Health has some capable leaders who can draw on the experience gained during long careers in the health sector. The minister of health and social welfare, Walter Gwenigale, and other senior officials are committed, professional, and consultative. The government has a well-formulated policy for improving the health system. Documents such as the 10-year health plan, while highly aspirational in tone, offer a compelling vision for moving forward.

The challenges, however, remain immense, and many mistakes have been made along the way. In assessment of health services, for example, too much emphasis was placed through the BPHS on measuring the quantity of inputs rather than the quality of service provided. The overall standard of services remains low, with long waits for patients, few available drugs, and poor health outcomes. The large role that donor contributions and out-of-pocket payments play in health expenditure leads to basic access issues, particularly for the least well off. The poorest fifth of the population spends up to 17 percent of its annual income on health, according to one estimate.<sup>15</sup>

## The U.S. Contribution to Liberia's Recovery

As Liberia's single-largest bilateral donor, the United States has played a vital role in helping the country get back on its feet. The United States provided 22 percent of the Liberian health budget in 2009, the largest single share of any country, including Liberia itself.<sup>16</sup> In reality, its financial commitment is even larger when one takes into account additional contributions to initiatives like the Global Fund to Fight AIDS, Tuberculosis, and Malaria and the GAVI Alliance, which have large programs in Liberia. Liberians have viewed and continue to view the United States as their preferred partner in the rebuilding effort. USAID is the lead agency of the U.S. government engaged in helping Liberia rebuild its health sector. Current focus areas include family planning and reproductive health, maternal and child health, HIV/AIDS, and malaria. For service delivery, the set-piece initiative has been the USAID-funded Rebuilding Basic Health Services (RBHS), a \$62 million, four-year program running through 2013 in which performance-based contracts have been established with NGOs to provide health services at more than 100 government clinics. Increasing emphasis has also been placed on building strong institutions within the ministry. The

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14. Ibid., 15.

15. Lee et al., "Analysis of Liberia's 2007 National Health Policy," 4.

16. Ibid., 6.

### Box 1: Mental Health in Liberia

A glance at the mental health system in Liberia helps illuminate the challenges facing the health sector as a whole. The mental health burden is enormous. A survey of 1,600 adults conducted in 2008 sheds light on the scale of the problem and the extent to which it can be linked to wartime trauma.<sup>1</sup> Forty-four percent of interviewees showed signs of suffering from posttraumatic stress disorder, and just over 10 percent said they had contemplated suicide. Anecdotal evidence suggests a major problem with substance abuse among former child combatants. In addition, Liberians suffer from a high number of what mental health expert Janice Cooper describes as the “regular, run-of-the-mill mental health problems,” such as depression.<sup>2</sup> Dr. Cooper, one of the few professionals working on mental health in Liberia, runs programs for the Carter Center, a charitable organization set up by former President Jimmy Carter to advance peace and health worldwide. She notes that mental health is a neglected area in the United States, where she worked for many years, but the problems are compounded in Liberia, where so many other priorities jostle for attention. In addition, social stigma is high. “Stigma is acute here because many people believe in witchcraft and think it’s a cause of mental illness,” explains Dr. Cooper. “There’s also a widely held belief that mental illness is contagious or that it is retribution for misdeeds committed during the war.”

Rodney Presley, director of Grant Mental Health Hospital, the only in-patient referral facility for mental health in the country, says that patients arrive in a terrible condition. “I have seen families turn up with a family member in the back of a pick-up truck, bound and in one case, gagged,” he noted. “Because of this, one of the first things I do when I admit patients is look at their wrists and ankles because they often have wounds or scars from being tied up.”

The Ministry of Health is aware of the mental health challenge; indeed, Minister Gwenigale lobbied hard to include mental health in the BPHS. Although Liberia has passed good policies, including the National Mental Health Policy in 2009, the resources are not available to translate policy into effective service delivery. Shortages of trained professionals and medicines are the biggest challenges. Only one Liberian psychiatrist serves the whole country. Previously, no psychotropic drugs appeared on the national approved list of medicines, and there was recently a six-month-long stockout of the main antiseizure drug.

Liberians have been making efforts to address the problems. The counties are setting up wellness units, which will have small numbers of beds available for medium-stay mental health patients. The first one opened in early 2012 in Bong County. The Carter Center is implementing a government project to train up to 150 midlevel clinicians to become mental health assistants,



Dr. Janice Cooper, Carter Center.  
Photo by Richard Downie.

1. K. Johnson et al., “Association of Combatant Status and Sexual Violence with Health and Mental Health Outcomes in Postconflict Liberia,” *Journal of the American Medical Association* 300 (2008): 676–90.

2. Interview conducted by the author in Monrovia, March 29, 2012.



### Box 1 (continued)

with responsibility for diagnosing mental conditions and prescribing the drugs to treat them, when they are available. To date, 38 mental health assistants have graduated from the six-month program. Efforts are under way to reach out to vulnerable groups such as young people, young mothers, and prisoners. A weekly mental health clinic was set up in Monrovia Central Prison. Mental health practitioners are also beginning to integrate mental health into other areas of the health system. Talks are in progress to train HIV counselors to offer posttest counseling following a spate of suicide attempts among people newly diagnosed with the virus. Although these are all positive steps, Liberia has a long way to go before it begins to make serious inroads into the problem.

Health Systems 20/20 project has focused on strengthening financial management and planning functions within the MoHSW.

Tracing the path of U.S. assistance to Liberia since 2003 reveals an interesting shift in priorities and approaches. Initial engagement in the postwar period took the form of emergency relief administered by USAID through its Office of Foreign Disaster Assistance (OFDA). But lack of foresight and bureaucratic inertia meant that the transition from this emergency response phase to a more development-focused approach was slow and halting. The United States did not shift gears until Ellen Johnson Sirleaf was elected president of Liberia in 2007. Even then, the pace of change was slow, leading to frustration on the Liberian side. USAID did not begin awarding contracts for its RBHS program until 2009, four years after initial discussions had begun on how to transition from humanitarian to development assistance. President Johnson Sirleaf commented on the slow pace of change during a visit to Washington in 2011. Asked to identify one area where U.S. support could be strengthened, the president said: “Reduce the time from commitment to cash, especially in a post-conflict environment.”<sup>17</sup>

While the United States pondered its approach in Liberia, it missed several chances to integrate its activities more fully with other international partners and with the MoHSW itself. While the RBHS project was still in the planning stage, the MoHSW set up a pool-fund mechanism to streamline donor support for the health sector. The U.K. Department for International Development (DFID), Ireland’s development arm Irish Aid, the United Nations Children’s Fund (UNICEF), and the United Nations High Commissioner for Refugees (UNHCR) eventually joined the fund, but the United States did not. The pool fund helped coordinate financial support on agreed-upon priorities, consolidate funding streams, and, by making use of national Liberian structures, helped strengthen institutions in the process. The RBHS project eventually got under way but bucked the growing trend toward working through local partner institutions, choosing instead to implement the program through a U.S.-based contractor. According to observers, this decision was due in part to personality clashes between USAID’s former health team lead and Liberia’s minister of health. The result was a vertical program that missed an opportunity to strengthen Liberian institutions.

In the past two years, USAID has shifted toward a more sustainable, flexible approach and an increased willingness to transfer more responsibility to Liberia’s health officials and institutions.

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17. See <http://allafrica.com/stories/201106270340.html>.

This shift reflects new priorities at USAID, as the organization tries to put the USAID FORWARD agenda into effect, as well as personnel changes at the USAID mission in Monrovia.<sup>18</sup> In late 2011, USAID signaled a new approach by committing to spend \$42 million over four years to address a set of health priorities agreed upon with the government of Liberia. USAID chose a fixed-amount reimbursement agreement (FARA) as its mechanism for channeling the funds to the Liberians. Under the arrangement, the MoHSW will pay the up-front costs of meeting these joint priorities but will be refunded for its work when it delivers its targets to the satisfaction of USAID. USAID will therefore work directly through the ministry rather than through its own contracting partner, and U.S. funds will be paid directly into Liberia's central bank. The new arrangement essentially amounts to earmarked funding for Liberia's health sector, something that has been warmly welcomed by Liberian officials, who view the move as proof of U.S. delivery on its commitment to encouraging local ownership in development. By choosing to reimburse the Liberians for services delivered rather than pay for them up front, the United States minimizes its financial risk. But by placing increased responsibility on the MoHSW to deliver health benefits, USAID faces reputational risk if services fail to improve or even deteriorate. USAID officials believe the opportunities outweigh the risks and that a progressive approach that places faith in Liberian personnel and institutions will ultimately pay off. Liberia is in many ways a testing ground for this new approach, with variations of the FARA arrangement being introduced in just a handful of other countries, including Rwanda and Afghanistan.

## Barriers to Success

While Liberia has made good progress in rebuilding its health sector since 2003, big challenges remain. The Ministry of Health and Social Welfare has entered a critical phase as it seeks to consolidate the gains and lay the foundation for future improvements. But funding issues cloud the horizon, and there is a strong sense that the progress made so far can be easily undone. The following section looks at some of the main roadblocks to success.

## Addressing Current and Emerging Health Priorities

Liberia faces the twin challenge of dealing with existing basic health care priorities while setting up the resources and systems to deal with an expanded set of health needs down the line. For the time being, tackling chronic diseases like malaria and HIV/AIDS and addressing maternal and child health issues take priority over the treatment of noncommunicable diseases. Reducing the stubbornly high maternal mortality rate is perhaps the biggest challenge. Indeed, the recorded rate of 994 deaths per 100,000 births is actually higher than it was at the end of the war, although improved data collection may account for the rise. The MoHSW has set a target of cutting maternal mortality to 497 deaths per 100,000 by 2021, and efforts are under way to integrate this priority into the training system with a plan to increase by 50 percent the number of skilled birth attendants.<sup>19</sup> Midwifery schools have reopened in Grand Gedeh and Lofa counties. As part of the strategy, doctors are sent for an additional six-month course in obstetrics and gynecology upon

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18. The USAID FORWARD agenda seeks to reorient the organization toward a more results-focused approach, based on working through host-country partners.

19. Republic of Liberia, Ministry of Health and Social Welfare, *Liberia National Health and Social Welfare Policy, 2011–21*, 48, <http://www.moh.gov.lr/doc/Final-NHSWPP.pdf>.

completion of their basic training. Traditional birth attendants—who, although untrained, are commonly relied upon in rural areas—are given small cash incentives to accompany expectant mothers to a health facility when they are ready to give birth, rather than help deliver the baby at home. This initiative highlights the fact that dealing with persistent health challenges is not only about offering treatment but also about changing public attitudes and behavior. Given the fact that changing social norms and behavior takes time, bringing down maternal mortality rates will not happen overnight.

As Liberia attempts to cope with these basic priority challenges, other neglected health issues could become health crises, creating what has been described as a “double burden” for the health sector.<sup>20</sup> These include noncommunicable diseases like hypertension and diabetes, referred to by one official as an “epidemic,” which currently receive no donor support. Chronic diseases like tuberculosis also fall into the neglected category. Although they receive funding, notably through the Global Fund, the resources devoted to tackling the disease do not match the scale of the problem.<sup>21</sup> Mental health is another area of enormous unmet need, so too are dental and eye health and the entire category of preventive medicine. A careful balance will have to be struck between anticipating and mitigating these new health risks while tackling the priority challenges, all without overwhelming the health system.

## Human Resources

Liberia faces a chronic shortage of health workers, particularly in jobs that demand specialized skills. Liberians are quick to point out that more Liberian physicians are working in the United States than in their country of origin. The lack of specialists is particularly alarming: Liberia currently has no pathologists or anesthesiologists, one psychiatrist, one internist, two pediatricians, and three obstetricians.<sup>22</sup> The statistics for the overall health workforce are almost as stark. According to a 2011 assessment, the total health workforce stands at 8,553. Of this number, 3,207 are in nonclinical roles such as accountants, cleaners, and security guards. The remaining 5,346 front-line workers include 90 physicians, 1,393 nurses, and 412 midwives.<sup>23</sup> These figures represent a big increase from 2003, thanks to the resumption of training programs for nurses and midwives, but numbers alone do not tell the whole story. While the shortage of physicians and surgeons is acute, a recruitment drive has led to an excess of nurses in some areas and created unnecessary strains on the health budget. However, the distribution of the workforce across the country is uneven, and the skills mix in individual health facilities is often inappropriate. For this reason, the MoHSW advocates task shifting to plug the gaps and make the health workforce as flexible as possible. This approach has already resulted in some successes in the treatment of HIV/AIDS, where community health workers and junior health staff are trained to provide some of the day-to-day care and follow-up support for patients receiving antiretroviral therapy.

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20. A. Boutayeb, “The Double Burden of Communicable and Non-Communicable Diseases in Developing Countries,” *Transactions of the Royal Society of Tropical Medicine and Hygiene* (March 2006), 191–99.

21. Tuberculosis constitutes the smallest part of the Global Fund portfolio in Liberia, with \$15.8 million disbursed to date out of a total of \$102.1 million (figures current as of April 2012), <http://portfolio.theglobalfund.org/en/Country/Index/LBR>.

22. Interview conducted by author at MoHSW with Moses Massaquoi, Clinton Health Access Initiative, March 28, 2012.

23. Ministry of Health and Social Welfare, *Country Situational Analysis Report*, 61.



## Box 2: Sustainability in Practice: The Work of Merci

Merci is one of the most successful examples of domestic leadership in Liberia's health sector. Originally set up by the international NGO, Médecins Sans Frontières, it is now a wholly Liberian-run organization operating primary health care facilities in three Liberian counties on behalf of the government. It has plans to expand into the secondary care system, running a newly built hospital in River Gee County, close to the border with Côte d'Ivoire. Merci has been one of the beneficiaries of the Ministry of Health's attempts to decentralize the health system. It has built sufficient local capacity to bid for, win, and manage performance-based contracts on behalf of the MoHSW.

The executive director of Merci, Titi Brooks, began working at the organization as a shelter doctor in 1999. During that time, she says she has accumulated a wealth of experience in implementing programs on behalf of international NGOs and multilateral organizations: "With each project we have learned more, have built up our capacity and professionalism so that now we are self-sustainable. We have become sharper on the management side, the financial side of things."<sup>1</sup>

There are sizable challenges of running an NGO in Liberia, particularly one that operates in two of its poorest and most remote counties, River Gee and Maryland, in the far southeast of the country. "There are lots of logistics issues," explains Dr. Brooks. "These are places you can't just decide to go...one day and show up the next. Getting equipment and materials there is difficult. The roads are bad so our cars get worn out so quickly."

Attracting suitably qualified staff is also a problem, particularly those with technical and administrative skills. "We always try to hire locally because it helps to retain staff," says Dr. Brooks. "But for accountants and other positions, we can only find them in Monrovia."

Looking ahead, Dr. Brooks is confident that Liberians will ultimately be able to take full ownership of their health system. But in the near term, more help is needed: "To the United States, I would say we still need support," she says. "We need...hand holding for a while until we are ready. If we are left alone suddenly, all our gains could be lost. We want to do it ourselves but it's important to remember that it is still so soon after the war. Only when the next government comes in will we be able to judge the true progress this country has made."



Dr. Titi Brooks, Merci.  
Photo by Richard Downie.

1. Interview conducted by author in Paynesville, Liberia, March 29, 2012.

## Sustainability and Funding

Liberian officials are genuine in their desire that the health sector make the transition from donor dependence to self-sufficiency. At the same time, they are deeply anxious to control the speed of the process and concerned that the sustainability of the health system might be put at risk if external assistance tapers off too quickly. Bilateral donors such as the United States have recently championed types of support that build local capacity, looking to work through institutions within the MoHSW rather than international NGOs and contractors. The FARA arrangement is intended to build capacity within the ministry, which takes control of funding, contracts out health services through its own providers, and audits and monitors those contracts to ensure that performance standards are met. But there is a sense that Liberia is in a race against time to build sufficient domestic capacity before donors wind down their activities in the country (see box 2). If the donors depart too soon, nascent health institutions could buckle under the strain. Liberia has already had to manage a tricky transition from the emergency relief phase of its recovery to a greater focus on development. This period saw the departure of many international NGOs and a destabilizing handover within international development organizations such as USAID, where OFDA gave up day-to-day leadership of operations. The next transition, from externally led to internally led ownership of the health system, promises to be even more difficult to manage.

The MoHSW has been proactively trying to anticipate an emerging funding gap and plan accordingly. A first step was to measure the size of the problem by gathering reliable data on health expenditure. The country's first National Health Accounts were published in 2009. They show in stark terms the continued dependence of the health sector on outside funding, with more than 65 percent of Liberia's health expenditure coming from donors and a large burden falling on households. Given the dominant role played by external donors, small reductions in support can have a disproportionately large effect on budgets. Gaps are starting to appear in donor funding, and Liberia's health sector faces a looming budget crunch that threatens to stall or even reverse some of the progress made so far. The health sector pool fund is running low, with neither DFID nor Irish Aid able to make long-term financial commitments. The decision by the Global Fund not to accept any new grant requests until 2014 was another blow. Funding uncertainty has already started to have an impact, slowing down implementation of the new 10-year health policy and complicating efforts to decentralize health service delivery. Delays in the payment of donor-financed bonuses to Liberian health staff in Bomi County led to threatened strike action. Officials in the Ministry of Health express concern that budget reductions will soon begin to affect health outcomes, for example, by reversing gains made in the treatment and prevention of malaria.

The tail-off in donor support has raised a question about Liberia's ability to continue providing free health services to its citizens. User fees were suspended in the country's public health facilities in 2006 to kick-start its health recovery. Health officials argue that free health care was never a sustainable policy and was introduced under donor pressure. But the restoration of fees is a sensitive issue given the precarious state of public health. Out-of-pocket expenditure on health is already high, and the government is reluctant to place an increased burden on the poor. However, it realizes that a crunch point is approaching and has identified 2013 as the year when the concept of free health care will be revisited. Different options are being examined that would help bridge the financial shortfall while cushioning the impact on health consumers. They include health insurance, raising revenue through "sin taxes" on alcohol, tobacco, and other unhealthy products, phasing in charges, and waiving fees for the most needy or for the most important frontline services.

The anticipated reduction in funding also makes the government's stated objective of meeting the 2001 Abuja Declaration commitment by African leaders to spend 15 percent of total expenditure on health by 2015 look even more unattainable. The current commitment to health in the national budget is approximately half that figure. Officials privately concede that the Abuja objective will have to be abandoned and a more realistic target will have to be set that meets Liberia's essential health needs without bankrupting the state. A medium-term expenditure framework is being drawn up, in consultation with donors, to help determine the future course. While no amount of planning can resolve a large budget shortfall, it may at least help soften the blow.

## Strengthening Health Systems

Given the scale of Liberia's public health needs, since the end of conflict in 2003 efforts have focused on the delivery of essential services. While quick-impact activities have been important in making a dent in some of Liberia's most pressing health challenges, they do not provide a platform for building a sustainable health system in the long run. As a result, attention has shifted over time to an emphasis on building health institutions. Significant progress has been made. The MoHSW is widely regarded as one of the best-run ministries in the Liberian government. Its Office of Financial Management, set up by PricewaterhouseCoopers, is seen as a model for other departments to follow. A human resources unit within the ministry is also highly regarded. The ministry is establishing a health management information system to coordinate data collection and to monitor and evaluate health services in the counties. But the process is incomplete, and dysfunctional systems continue to cause inefficiencies and hamper Liberia's ability to deliver adequate health services. Supply chain management and drug procurement are particular problems. Drug shortages and stockouts are a recurring issue, particularly in rural clinics. Bad roads, inadequate warehousing and cold storage facilities, and poor organization all contribute to the problem. Despite the 10-year supply chain master plan established in 2010 to help rationalize the system, confusion persists, partly because funding for drugs comes from a variety of sources, including the government, NGOs, and the pool fund and the Global Fund, each of which uses its own procurement system. The government has been slow to compile and publish a list of approved drugs, and, in the absence of leadership from the center, unregulated pharmacies have flourished, often providing substandard or even harmful drugs.

Another area of weakness is data collection, particularly in the counties. The absence of reliable information on the availability and quality of health services makes it very difficult to formulate strategy. Plans for a health records database remain a far-off dream. In the meantime, data are recorded on paper and often lost or poorly disseminated. Efforts to strengthen data collection systems continue. The president has taken a personal interest in reviewing data on particular health priorities, demanding to see monthly figures on the number of women who die in childbirth. But a culture of record keeping has yet to take hold, particularly in the counties. A senior official at the MoHSW expressed concern that some county officials continued to make up or "guesstimate" health data.

## Decentralization

The Liberian government is committed to a policy of decentralization. The thinking behind this is sound: the war led to mass migration out of the countryside and into Monrovia, which is now home to more than one-third of the population. Now that peace has been restored, encouraging

people to settle back in rural areas will assist in the delivery of public services and take pressure off the overcrowded capital. More important, the move toward decentralization is an attempt to reverse Liberia's history of poor governance, which was based on highly centralized rule by wealthy elites. Within the health sector, the disparities between urban and rural communities appear to justify the policy. The 2008 Population Census found that 41 percent of Liberian households live more than an hour's walk from the nearest health facility.<sup>24</sup> But for the rural households, the figure was 66 percent, compared with 15 percent for those in urban areas.

The process of decentralizing governance structures and services is, however, a monumental challenge for a government with limited resources and weak capacity. In the health sector, the effort goes on, with powers gradually devolving from the MoHSW to county health and social welfare teams in each of Liberia's 15 counties. These teams will ultimately have responsibility for drawing up their own health strategies and budgets, contracting out health services, and evaluating the standard of care patients receive.

The task of positioning health resources in the right areas is enormous. The MoHSW finds it difficult to recruit enough suitably qualified health professionals who are willing to work in hard-to-reach rural counties, where conditions are basic, infrastructure is poor, and public services are often nonexistent. Retention is a big problem as well, and health officials have to offer higher salaries and travel benefits to persuade medical staff to work in the remote southeast of the country. For the time being, a large share of the responsibility for local health care rests with community health workers, who are unpaid and essentially untrained volunteers. To improve the standard of service they provide, Liberia needs to integrate these workers more fully into the formal health system and motivate them with the offer of training programs and small stipends.

Establishing an even service across Liberia's 15 counties is another challenge. The legacy of the immediate postwar period—when services were rolled out in a haphazard, uncoordinated way without a thorough needs assessment—means that supply and demand are often mismatched. Currently, 40 percent of Liberia's health facilities are actually underused, while 10 percent serve a far greater catchment area than they were designed for, placing an unsustainable burden on staff and resources.<sup>25</sup> The essential package of services was designed to iron out these inconsistencies, paving the way for a more equitable distribution of services and facilities across the country. But it will be hard to close the quality gap between rural and urban health services without major budget increases. Because these are unlikely, health officials are searching for ways to reposition and optimize the resources that are already available. One such method is implementation of a referral mechanism, which would take pressure off primary care facilities by ensuring that patients with more serious or specialized health problems enter the system at the right level. Turning the referral system from concept to reality will be a challenge, not least because it requires educating the public on the correct procedures to follow.

## Integrating the Health System with Other Development Sectors

Many of Liberia's health challenges are multidimensional and will not be resolved without interventions in the broader development arena. Liberia's health minister, Dr. Gwenigale, points to the importance of road building as a critical way of improving health outcomes, speculating on the

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24. Liberia Institute of Statistics and Geo-Informational Services, "Republic of Liberia 2008 National Population and Housing Census Final Results," [http://www.emansion.gov.lr/doc/Population\\_by\\_County.pdf](http://www.emansion.gov.lr/doc/Population_by_County.pdf).

25. Ministry of Health and Social Welfare, *Country Situational Analysis Report*, 26.

number of women who die from complications related to childbirth because they are unable to reach a health facility in time. Education also plays an important role in improving health awareness and disease prevention. Providing employment has significant health implications in a country where households spend significant amounts of money on health care. Perhaps most important, maintaining security and consolidating the peace are prerequisites for advancing the nation's health. In short, the health system cannot be looked at in isolation from the national development agenda, and all institutions must be built up together if sustainable progress is to be made.

## Recommendations for U.S. Policy

1. *Sustain the commitment.* Liberia is at a critical juncture in the development of its health sector. It has ridden out the immediate postwar emergency relief phase, delivering basic health services to its population with the assistance of international donors. It has now begun to build the supporting structures that will underpin a sustainable health system over the long run. Significant progress has been made. Now is not the time to scale back support. Liberian health officials express high anxiety that a looming funding gap places fragile gains at risk. Hard-won advances in reducing child mortality, bringing down the prevalence of malaria, and diagnosing and treating HIV/AIDS could be quickly reversed if donor support fades. Given the shared history of Liberia and the United States, Liberians view the United States as their preferred partner and greatly value U.S. assistance. In turn, the Liberian leadership within the MoHSW has proven itself capable, willing, and sincere in its commitment to build a health service that will one day sustain itself without outside assistance. The United States has made critical, long-standing investments in Liberia that have been instrumental in helping the country move out of conflict. Thanks in part to these efforts, Liberia has the potential to become a fully functioning, peaceful, and prosperous nation, a success story in a region blighted by conflict and instability. For all these reasons, the United States should maintain support for Liberia's health sector at its current levels and work closely with the MoHSW to devise a financial strategy that will help bridge the medium-term funding gap.
2. *Be patient.* Liberia's health system is entering a period of consolidation. The outpouring of emergency relief and basic health services in the aftermath of 2003 brought about a series of quick wins. But cracking some of Liberia's entrenched structural health challenges will take much longer. The effort to cut maternal mortality rates, for example, will require long-term shifts in behavior. Educating the population to take a more preventive view toward health and to seek out professional medical assistance and curative services when they are sick will also take time. For this reason, it may not be possible to observe a big improvement in health outcomes in the next few years to match the outward progress made in the immediate postwar period. This apparent lack of progress should not cause the United States to despair or to doubt the value of its investment in Liberia's health system. Members of Congress should resist pressure from constituents to cease funding programs that do not appear to produce immediate results.
3. *Focus on building strong health systems and institutions.* The increased focus of U.S. activities on strengthening the support systems of Liberia's health sector—capacity building in the ministry, financial and strategic planning, procurement, monitoring and evaluation, and data management—is welcome and should be continued. It might not be the sort of headline-grabbing activity that attracts the plaudits at home, but it helps Liberia deliver more efficient, better-quality

services at lower cost. The decision to channel more assistance through the MoHSW through the FARA mechanism is welcome. It gives meaning to USAID's commitment to support host-country ownership of the development agenda. This approach is not without risks, however. It places the onus for health service delivery firmly in the hands of a ministry that is still in its early stages of development. But if the ultimate aim is to phase out U.S. assistance, leaving robust health structures behind, then a policy that seeks to strengthen host-country institutions without sacrificing transparency and accountability must be the best way to proceed.

4. *Invest in human resources.* Liberia's health system remains desperately short of skilled medical personnel. The war prompted many of its most qualified professionals to flee the country, and few have been enticed back. Although the United States is investing in training a new cadre of health professionals in Liberia, it could do more to encourage Liberians to consider careers in the health sector by providing more scholarships for medical students. These scholarships should be for training in Liberia rather than overseas, where education is more expensive and where the graduates may be tempted to stay and not return home at the end of their studies. The U.S. government should also make a concerted outreach effort to members of the Liberian diaspora working in the U.S. health system. It should offer them incentives to accept short-term work placements in Liberia, with the ultimate aim of encouraging them to consider a permanent move back home.
5. *Engage the private sector more effectively.* The United States should come up with creative ways of involving the private sector more fully in Liberia's health system. Although one of the core principles of the U.S. Global Health Initiative is to promote private sector engagement in health, the country strategy for Liberia makes little mention of how to achieve this objective.<sup>26</sup> The private for-profit health care sector is growing in Liberia and should be harnessed. USAID is in the early stages of engaging with this sector, for example, by using private companies to deliver artemisinin-based combination therapy treatments for malaria patients. Efforts should be made to evaluate the success of this approach and to look for other opportunities for collaboration.
6. *Seek more opportunities to coordinate with other donors.* Donor coordination has improved over time. External actors have consolidated their activities, and now just three donors are providing the main funding in Liberia's 15 counties: USAID, the pool fund, and the European Union. Organizations like the Global Fund and the Clinton Health Access Initiative have staff permanently housed within the Ministry of Health. The Health Sector Pool Fund has eased Liberia's burden of dealing with multiple donors, all with separate funding streams, priorities, and reporting mechanisms. But the financial uncertainty currently facing the pool fund may undermine efforts toward better coordination, causing funding streams to diversify once more. While USAID is not part of the pool fund, it approached its members about making FARA reimbursements through the pool. This proposal was rejected because the other members felt they were being asked to underwrite the risk for USAID. Other chances for closer coordination have also been missed. The United States should be constantly open to any opportunity that helps reduce the workload on the host-country government by consolidating its health activities with other international donors.

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26. See <http://www.ghi.gov/documents/organization/175132.pdf>.







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