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# LIBERIA PRIVATE HEALTH SECTOR ASSESSMENT



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## Abbreviations

DHIS2	District Health Information System 2
DHO	District Health Office
ECOWAS	Economic Community of West African States
FARA	fixed-amount reimbursement agreement
FBO	faith-based organization
FY	fiscal year
GOL	Government of Liberia
HIV	human immunodeficiency virus
HMIS	health management information system
HP+	Health Policy Plus
IUCD	intrauterine contraceptive device
LMDA	Liberia Medical and Dental Association
LMDC	Liberia Medical Dental Council
LMHRA	Liberia Medicines and Health Products Regulatory Authority
LNPA	Liberian National Physician Assistants Association
MOH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare
NGO	nongovernmental organization
ROL	Republic of Liberia
SARA	Service Availability and Readiness Assessment
SOP	standard operating procedure
USAID	U.S. Agency for International Development
WHO	World Health Organization

## Executive Summary

The objective of this private sector assessment is to provide an overview of the size, nature, and capacity of the private health sector that delivers family planning and maternal and child health services in Greater Monrovia, as well as to explore the challenges and constraints it faces in providing quality health services to communities. At the time of the assessment, the extent of the private sector’s contribution in Liberia remained largely unknown, with information about the sector highly limited and fragmented.

The Health Policy Plus (HP+) project, funded by the U.S. Agency for International Development (USAID), completed this study of the private health sector in Liberia in July 2019. The study provided a snapshot of a broad range of topics across 30 private facilities in Greater Monrovia (representing 16 percent of all private facilities in Montserrado County). The assessment focused primarily on private providers; however, it also included other stakeholders in the private health sector value chain, including pharmaceutical wholesalers/distributors, diagnostic and laboratory centers, private insurance companies, professional associations, and regulatory bodies. The information contained in this report is intended to spark dialogue between the public and private sector for improved health service delivery.

As part of this assessment, the establishment of a private healthcare federation was also explored. Having a unified voice and a consistent convener of private health stakeholders could help amplify the challenges faced by the private sector, as well as provide a platform for dialogue among private sector stakeholders. Similarly, speaking with “one voice” will enable more effective coordination and dialogue with the public sector and strengthen engagement with the government.

Of the total number of private facilities in Liberia, a very high percentage are located in Montserrado County. This county includes Monrovia, the capital city, which is home to around one-third of the country’s population. This high concentration of people increases the importance of having a well-integrated health system and underpins the focus of this assessment on Greater Monrovia. The availability of private services in the other counties of Liberia is very limited.

Two health areas were prioritized for this study: family planning and maternal and child health. Liberia has one of the highest infant mortality rates in the region, estimated at 53 deaths per 1,000 live births in 2013 (LISGIS et al., 2014). Women ages 10–34 years make up 48 percent of the total female population, and teenage pregnancies (ages 15–19) occur at the significant rate of 33.5 percent (Government of Liberia [GOL], 2018a). Based on the 2008 annual growth projections, the population of Liberia is expected to double by 2041. Considerable gains have been made in recent years to increase the modern contraceptive prevalence rate from 19.5 percent in 2012 to 33.8 percent in 2018. The most accessed method is injectables (60.7 percent) (Track 20, 2018). Similarly, the percentage of births attended by health workers has rapidly increased, from 46.3 percent in 2007 to 61.1 percent in 2013 (World Bank, 2019b).

In 2018, the Ministry of Health (MOH) released its costed implementation plan for family planning. The total cost of the plan from 2018 to 2022 is around US\$46 million, which will increase the number of women using modern contraception from approximately 390,000 in

2018 to 515,000 by 2022 (GOL, 2018a). As outlined in Section 3 of this report, the large number of private sector facilities in urban areas like Monrovia represents an opportunity to scale up family planning services. The last available figures, from the 2013 Demographic and Health Survey, demonstrate the proportion of women accessing family planning services from the private sector to be 30 percent. Section 4 of this report demonstrates that ad hoc access to some family planning commodities has been made available to the private sector, but not the full method mix. A more efficient use of public commodities to decrease stock-outs and extend supply can be explored.

Private service delivery actors face many constraints that hinder their ability to provide quality health services, including the lack of access to in-service trainings, barriers to accessing finance to enhance their businesses, burdensome regulations and nontransparent processes, frequent and lengthy electricity outages, nonpayment or late payment by private insurance companies, and rising costs that impede the delivery of affordable private healthcare due to the steady decline of the Liberian dollar against the US dollar.

The key takeaways of the study are outlined at the end of Chapters 4–8. These findings are explored further as recommendations throughout Chapter 9. Despite constraints, the government of Liberia and donors have the opportunity to efficiently and intentionally create improvements in the health system and better leverage private actors for improved health outcomes. The strengthening of the private health sector in Greater Monrovia represents an opportunity to create a resilient and well-coordinated urban health system, staffed with a qualified, growing health workforce, as well as to expand access to key services through the convenience of private health provision located in the heart of communities.

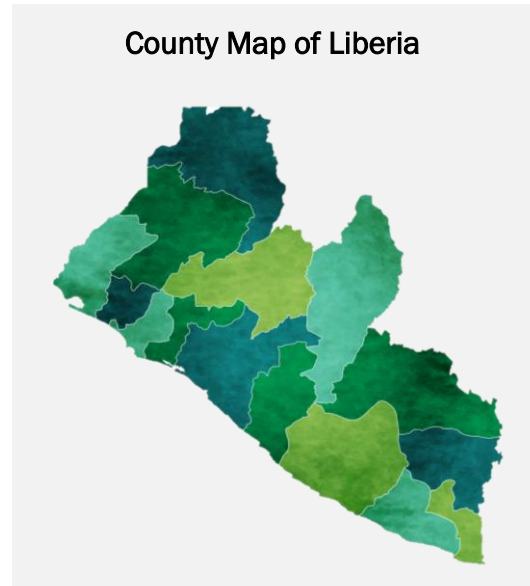


# 1. Background

## 1.1 Liberia

Liberia is a coastal country in West Africa bordered by Guinea, Côte d'Ivoire, and Sierra Leone. It has a total land mass of 110,080 km<sup>2</sup> and a total population estimated at 4.8 million as of 2018 (LISGIS et al., 2014; World Bank, 2018b). Founded by freed American slaves in 1847, the country is Africa's oldest republic. Liberia's history has been marked by significant economic disparities and ethnic and class tensions, which led to civil wars in 1989–2003. The wars caused nationwide deaths, depressed commercial activities, and decimated critical utilities and infrastructure, including water, sewage systems, and roads. Liberia's electricity infrastructure was also heavily destroyed by 15 years of civil conflict. In 2011, the Liberia Electricity Corporation received investment to improve access by low-income households, who were at that time spending nearly 15 percent of their household disposable income on energy (Global Partnership on Output-Based Aid, 2018). Despite this, access to electricity is still unreliable for the private health sector.

Liberia is divided into five regions, which are further divided into 15 counties, 90 districts, and many clans. Liberia's population is evenly split between urban and rural areas, with 48.2 percent of the country's inhabitants residing in urban areas, and a third of the entire population (1,471,477) living in the capital, Monrovia. This high concentration of people in the capital places high importance on the urban health system, where the majority of private facilities are also located. The 2013 Demographic and Health Survey stated that the national fertility rate was 4.7 children per woman in 2013, putting pressure on the country's already struggling healthcare sector (LISGIS et al., 2014). Only 55 percent of Liberian children have received a complete set of vaccinations, 32 percent of children under five are stunted, and the country's maternal and neonatal mortality rates are among the highest in the world (WHO, 2016). The population is also poor; the poverty rate measured at the national poverty line exceeded 50 percent in 2016, with rates ranging from 71.6 percent in rural areas to 31.5 percent in urban centers. Liberia ranks 181 out of 189 countries on the Human Development Index and 174 (out of 190) in ease of doing business (Trading Economics, 2018; UNDP, 2018). Liberia also scores 32 out of 100 on the Corruption Perception Index, which rates countries based on how corrupt their public sector is perceived to be (0 being highly corrupt) (Trading Economics, 2018).



### Box 1. Liberia's Population

- Under the age of 35: 70 percent
- Under the age of 14: 44 percent
- Over the age of 55: 7 percent
- Annual population growth rate: 2.5 percent

## 1.2 Liberia's Economy

The Liberian economy is in a fragile state. The economy contracted at an average rate of 0.8 percent per year from 2014 to 2016, or 3.2 percent per year in per capita terms, providing limited opportunity for growth in the national health budget. It had begun to show little signs of recovery in 2017–2018 (GDP expected to grow from 2.5 percent in 2017 to 3 percent in 2018) despite substantial fiscal and external imbalances (World Bank, 2018). Liberia is a net importer of goods, with exports limited to iron ore and rubber. Between 2009 and 2013, the primary sector—which includes agriculture, forestry, and mining—contributed 4.4 percent to the total 6 percent increase in the real value-added economic sector. However, that contribution declined by 2.2 percent per year in 2014–2016 due to the global decline in commodity prices, which consequently weakened the country's terms of trade (World Bank, 2018).

The 2014–2016 Ebola crisis, coupled with extended declines in global commodity prices, put significant pressure on Liberia's robust post-war recovery and brought the country's renewed expansion to a halt. The country's outlook is still precarious. The U.S. Agency for International Development's (USAID's) Journey to Self-Reliance scorecard rates Liberia low on its capacity indicators but comparatively higher for its indicators related to commitment (USAID, 2018). The growth estimate for 2018 was revised downward from 3.2 percent to 1.2 percent, and for 2019, it is projected to register at an even lower rate of 0.4 percent (World Bank, 2019a). Economic growth remains constrained by several factors, including poor infrastructure, especially energy and road connectivity; low credit access; reliance on the traditional extractive sector with little or no value addition; increasing pressure on the exchange rate; pressure on the country's foreign reserves in the wake of lowered export earnings; high inflationary pressure; and constrained fiscal performance and weak external performance.

Macro-economic challenges continue to plague Liberia's recovery efforts. The major headwinds for 2019 include persistently high inflation and the continued depreciation of the Liberian dollar against the US dollar. As Liberia imports all of its pharmaceutical commodities in US dollars, it has the potential to result in an unpredictable and increasing financial burden on the health sector.

- **Inflation:** Headline inflation reached an all-time high of 28.5 percent by the end of December 2018, fueled by significant depreciation of the Liberian dollar against the US dollar and monetary expansion. By April 2019, year-on-year inflation had declined by 18 percent to 23.3 percent from the December 2018 high. The fall in inflation was attributed to a reduction in prices, primarily of restaurants, hotels, furnishing, household equipment, and routine household maintenance. Inflation is not expected to reach 2018 highs but is rather projected to level out at around 24.4 percent for the remainder of 2019, as the prices of items in the non-food categories continue to reduce (Central Bank of Liberia, 2019a).
- **FX depreciation:** The decline of the Liberian dollar against the US dollar continues to put pressure on an import-dependent Liberian economy. Since the Liberian presidential election in 2017, the rate has dropped from LD\$125.45/US\$1 (as of December 31, 2017) to LD\$204.45/US\$1 (as of August 21, 2019), representing a 63 percent decline. The rate is expected to trade at or around LD\$204/US\$1 during the remainder of 2019 (Central Bank of Liberia, 2019a). In order to curb further declines, export earnings must increase, and fiscal policy interventions must be successfully executed.

## 1.3 Liberia Health Sector Strategy

Supporting the private health sector in Liberia is not only a desirable outcome, it is imperative for achieving the level of resiliency needed for a functioning health market. The private sector is operationally able to navigate and thrive in challenging market forces, providing a needed level of health system resiliency. The government stewardship of health systems is one of the most critical, yet complex, areas of building a resilient health system (WHO, 2007). The government of Liberia's role is to oversee and strengthen the entire health system as it guides the Liberian people to better health. Expanding health coverage is not only a matter of improving public sector systems, but also stewarding a strong private health sector by improving on areas such as effective regulatory policy and establishing public-private contracting and financing mechanisms.

Liberia's 10-year *National Health and Social Welfare Financing Policy and Plan (2011–2021)* is aimed at supporting the government's goal of becoming a middle-income country (Ministry of Health and Social Welfare [MOHSW], 2011). It establishes that the government of Liberia must increase spending on health, while minimizing catastrophic household expenditure for the poorest of the population. In response to the Ebola outbreak, the government of Liberia drafted the *Investment Plan for Building a Resilient Health System (2015–2021)* (MOH, 2015). This document sets out the importance of the government of Liberia in regulating the quality of care in private service delivery, regular monitoring of private facilities, and the need for specialized trainings in Ebola management. These trainings could be delivered through public-private partnerships and functional referral systems between the public and private sector. The *Investment Plan* also cites high compliance of health data reporting by private facilities prior to the Ebola outbreak, with reporting rates at 90 percent in Montserrado County using the District Health Information System 2 (DHIS2).

As a first major step in stewarding the private sector, the government of Liberia undertook a systematic assessment of service provision capacity in public and private health facilities across the country. This Service Availability and Readiness Assessment (SARA) measured a set of tracer indicators of service availability and readiness. The 2017 data were made available to Health Policy Plus (HP+) and the data pertaining to private sector service delivery capacity were later analyzed; the results of that analysis are provided in Section 3 of this report.

### 1.3.1 Health Expenditure

The government of Liberia faces challenges with financing its health sector plan. Despite reaching an allocation of 14.6 percent from the government budget to health, its total budget allocation in fiscal year 2017/18 was still a modest US\$527 million. Since 2008, donor funding for health has declined by 15 percent at the same time that Liberia's economy appears to be stalling (ROL, 2018). The difference between the government of Liberia's health allocation and total health expenditure per capita is illustrated in Table 1.

**Table 1. Per Capita Health Expenditure**

Fiscal Year	2011/ 2012	2015/ 2016
Government of Liberia health expenditure per capita	US\$10	US\$12
Total health expenditure per capita	US\$65	US\$83

Source: ROL, 2018

Liberia's latest *National Health Accounts Fiscal Year 2015/16* in Table 2 demonstrates that the health sector is primarily financed by out-of-pocket expenditure and donor contributions. Given that public sector user fees have been eliminated, one can assume that out-of-pocket expenditures in health go largely to the private sector to acquire services and products. The private sector financing of total health expenditure has grown from 2 percent in fiscal year (FY) 2013/14 to 8 percent in FY 2015/16 (ROL, 2018). High out-of-pocket expenditure is significantly lower than its peak of 76 percent in 2004 and is largely driven by non-prescribed medicines and supplies (ROL, 2018). About 15 percent of people face catastrophic health expenditure, though poorer households with elderly members in urban areas are most likely to be faced with catastrophic expenditure than others, due largely to prescribed medicines, consultation fees, and exams. Liberian people in the wealthiest quintile make up 40 percent of the households that sought care in the private sector. Those that did utilize this sector overwhelmingly reported paying for services out-of-pocket (85 percent) (ROL, 2018).

**Table 2. Total Health Expenditure Overview (FY 2015/16)**

Category	Expenditure (FY 2015/16)
Percentage of the total health expenditure financed by out-of-pocket expenditures	46%
Percentage of total health expenditure financed by donor contributions	32%
Percentage of total health expenditure financed by private sector contribution	2% (FY 2013/14) - 8% (FY 2015/16)
Rate of catastrophic health expenditure	15%

Source: ROL, 2018

Family planning has the second largest share of total health expenditure compared to other diseases or health areas, amounting to 12 percent of total health expenditure. In FY 2017/18, more than 50 percent of the health budget was allocated for employee compensation, while only 10 percent was for goods and services, which include foreign travel, fuel, and telecommunication. With an increasing squeeze due to a volatile currency exchange, this allocation may be smaller in real terms. A remaining 17 percent was distributed directly to various institutions and health facilities, including several private sector providers, as described in Section 4 (ROL, 2019).

In the *National Health Accounts Fiscal Year 2015/16*, 85 percent of people using private clinics reported paying out of pocket (ROL, 2018). Out-of-pocket expenditure is largely driven by medicines and medical supplies, highlighting the need to better segment the market in order to reduce unnecessary out-of-pocket payments for the poorest. Combined with working with the private sector to help support improvements to drive down costs for clients, the public sector can address stock-outs in the public sector to help minimize catastrophic expenditure.

## 2. Study Objectives

### 2.1 Scope of the Private Sector Assessment

USAID/Liberia requested that the USAID-funded HP+ conduct a private sector assessment to determine the current scope of the private sector in Liberia, as well as to identify opportunities to strengthen the Liberian private sector. As part of this assessment, HP+ was asked to support the incubation of a potential private health sector federation in Liberia and to identify priority areas for its membership. There were five objectives:

- Define the size, nature, and capacity of Liberia’s private health sector and its ability to address priority health services, such as family planning and maternal and child health
- Identify the major challenges/constraints for the private health sector, including key policy and regulatory barriers that constrain the private sector’s role in providing priority health services
- Identify opportunities that exist for the growth and progression of the private health sector
- Explore mechanisms to strengthen cooperation, coordination, and networking within the private health sector, and to improve its ability to participate in reform initiatives
- Gauge the interest of the private health sector in joining a network of private providers and becoming a member of the Africa Healthcare Federation.

In summary, the objectives of the assessment were to identify the scale and scope of health services provided by the private health sector, as well as to examine how the enabling environment may be strengthened. Given the large concentration of private providers in the capital, the geographic scope of the study focused on Greater Monrovia. The aim of the assessment was to inform discussions on how the private health sector can best be strengthened.

#### 2.1.1 Definition of the Private Sector

For this assessment, the private sector was defined as all nongovernmental entities, whether operating as for-profit or not-for-profit organizations. In Liberia, the private health sector is composed of for-profit (commercial) entities, as well as nonprofit/not-for-profit/nongovernmental organizations (NGOs) and faith-based organizations (FBOs) (see Box 2). These health providers form the primary part of this assessment. Diagnostic laboratories, pharmaceutical companies, pharmaceutical importers/distributors/wholesalers, and private health insurance companies all participate in supplying inputs to support service delivery and form a secondary part of this assessment.

#### Box 2. Classification of the Private Sector

In Liberia, the private sector consists of a number of different types of actors:

- Private for-profit
- Private not-for-profit
- Faith-based organizations
- Nongovernmental organizations
- Concessions (owned and operated by private companies)

## 2.2 Methodology

After reviewing the private sector assessment scope of work with USAID/Liberia, the HP+ team undertook a comprehensive desk review of all relevant literature to identify the current landscape of the private health sector (see Section 2.2.2. Secondary Analysis) by reviewing and analyzing the Service Availability and Readiness Assessment (SARA) data and Malaria Indicator Survey data.

The assessment itself consisted of qualitative interviews with stakeholders, conducted July 15–26, 2019, in Monrovia, Liberia. The interview team was comprised of two HP+ staff members and two local consultants specializing in private health.

Six qualitative interview guides were prepared in total, one for each category of primary stakeholder:

- Clinics, health centers, hospitals
- Diagnostic laboratories
- Pharmaceutical wholesales/importers/distributors
- Private insurance companies
- Public sector
- Regulatory bodies/associations

### 2.2.1 Sampling

The assessment focused primarily on private health providers. The facilities were selected using a systematic sampling method. To select the sample, a master list of health facilities in Liberia was first created by combining facility master lists from both USAID/Liberia and the Liberian Medical Dental Council (LMDC), both of which had received their lists from the MOH. These lists detailed the name of the facility, address, facility level, and whether it was public or private. They did not provide a categorization for facility type (e.g., NGO, FBO).

Facilities not located in Greater Monrovia or that were beyond a one-hour drive from Monrovia were excluded. The areas included in the assessment were Sinkor, Bushrod Island, Central Monrovia, Congo Town, Paynesville, Somalia Drive, and St. Paul Bridge.

The combined master facility list was further refined by only including facilities that offered the two core health services of interest: family planning and maternal and child health. From the final master list, one-fifth of the final set of facilities was randomly sampled. Facilities that proved challenging to contact or that no longer offered the two core service areas were removed, and the next facility on the list was selected. The number of each facility type whose staff were interviewed as key informants is found in Table 3, and the full list appears in Annex A.

In all, 30 facilities were selected to be interviewed: 63 percent health clinics, 30 percent health centers, and 7 percent hospitals. This is almost 16 percent of the private health market in Montserrado County, which has 189 private health facilities (GOL, 2018b). FBOs in Liberia offer maternal and child health services yet were largely excluded due to not offering family planning services. Only three FBOs, which did offer limited family planning services or hosted family

planning trainings, were included in the final selection. NGOs were not interviewed, as none were selected through the sampling process. Each facility that was selected was mapped using Tableau software along with its registration and delivery prices, to show the areas covered by the interview process and the price range.

In addition to facilities, the assessment included interviews with staff from medical equipment distributors and laboratories, pharmaceutical importers and wholesalers, health associations and regulatory bodies, and insurance companies.

Individuals interviewed from the facilities (i.e., clinics, health centers, and hospitals) were either the business owner, business owner-provider, or provider in charge at the time of the interview (Annex A). In some cases, multiple staff members, such as the facility administrator or head nurse, participated in the interview at the owner's request.

**Table 3. Types and Numbers of Key Informant Interviews**

Interview Type	Interview Subtype	Number Interviewed
Private Health Facilities	Health clinics	19
	Health centers	9
	Hospitals	2
Enabling and Regulatory Bodies	Pharmaceutical wholesalers/retailers	2
	Ministry of Health	5
	Health associations	4
	Insurance companies	2
	Diagnostic/laboratories	3
	Regulatory bodies	2

### *Interview Topics*

The business owners were interviewed to better understand their business, its clients, the challenges faced, and opportunities for improvement and increased effectiveness and efficiency of the business. They were also asked about the service delivery aspects of their business, as well as questions to better understand the business functions of the facility, specifically the ease of obtaining start-up financing, operational financing, and financing for facility expansions. These areas were not generally known by the provider in charge (not the owner of the business), who were therefore not able to answer some questions in full.

### **2.2.2 Secondary Analysis**

A secondary analysis of two existing data sets, the SARA and Malaria Indicator Survey, was carried out prior to the field assessment. An overview of this desk research is provided in Section 3. These data sets were selected because they offered the most recent data available on family planning and maternal and child health services.

1. The SARA provided in-depth information on Liberia’s health sector—specifically, the size of the public and private health sectors in urban and rural Liberia, the private sector in Montserrado County versus other counties, and service readiness scores. The capacity of the private sector was largely unknown until the completion of the SARA in 2017. The Liberian SARA was a systematic survey to generate a set of tracer indicators of service availability and readiness. Quality of care was measured only for a subset of facilities surveyed and was not included in the data made available to the HP+ assessment team. The SARA results established the size of the private sector and its availability and readiness to deliver services. Along with describing the context of private sector service delivery, these data provided a comprehensive overview on how many private facilities offered labor and delivery, antenatal care, and family planning services.
2. The Malaria Indicator Survey was a household survey conducted in 2016 that collected national and regional data to coordinate efforts around malaria prevention. Along with malaria-specific information, the survey provided information on some overarching health areas and the wealth of households surveyed. Survey data also indicated current trends in service provision, specifically around antenatal care, family planning, and labor and delivery. The responses to questions around public and private service delivery were disaggregated based on wealth quintile and urban/rural characteristics.

## 2.3 Overview of the Report

This report is divided into nine sections. Section 1 provides background information on Liberia and its health sector. Section 2 presents the study objectives and methodology. Section 3 provides an overview of private sector health provision in Liberia and, in particular, Montserrado County. Section 4 presents the findings of the private provider interviews, while Section 5 describes the findings from laboratories and diagnostic centers. Section 6 provides an overview of the pharmaceutical product market. Section 7 describes the enabling environment, including private health insurance, access to finance, and licensing requirements. Section 8 covers topics related to public and private sector collaboration. Section 9 provides comprehensive recommendations in relation to the challenges identified as part of the scope of this assessment, along with three recommendations described in more detail.



### 3. Private Health Sector Providers in Liberia

#### 3.1 Composition of the Private Health Sector

In Liberia, the health sector includes three facility levels: health clinics (primary level), health centers (secondary level), and hospitals (tertiary level). Across the country, there were 753 health facilities at the time of the assessment in 2019, 699 of which were classified by the government of Liberia as functional. Non-functional facilities were excluded from this study, as it was unclear whether they were in operation. There were 258 functional private health facilities, compared with 436 public sector facilities (Figure 1). Of the 258 functional private facilities, 189 were located in Montserrado County (Figure 2) (GOL, 2018b). This is further broken down by health facility level for Liberia in Figure 3; for the purposes of this report, health clinics are defined as combined primary levels one and two, health centers are defined as secondary, and hospitals are defined as tertiary.

The 2017 data from the SARA did not include all private facilities operating in Liberia by the time of the private sector assessment. Given the expansion of the private sector’s contribution to health in recent years, new private facilities have come into operation since the SARA was published. The HP+ assessment team noted that several facilities included in the private sector assessment were not surveyed in the SARA. Further, the assessment team received an updated master facility list in October 2019, which included 275 (functional) private health facilities (versus the 258 in operation in 2017). For the purposes of this assessment, the data source is the SARA. In the following sections, some high-level data from the SARA are also presented to situate the private sector in the context of the whole health system.

The private health sector is largely situated in urban and peri-urban areas. Across Liberia, the

Figure 1. Types of (Functional) Health Facilities in Liberia (N=699)\*

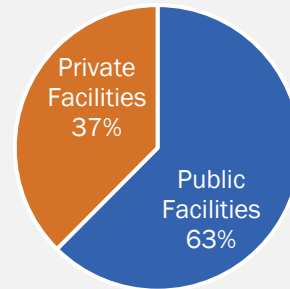
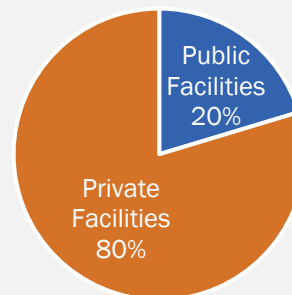
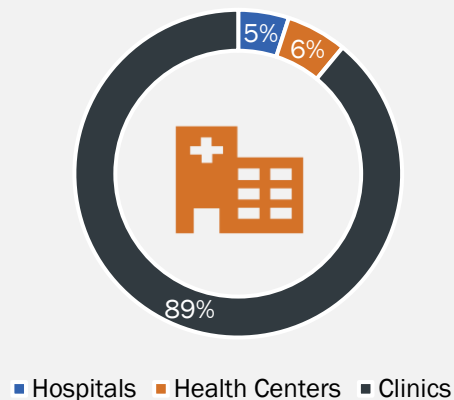


Figure 2. Types of (Functional) Health Facilities in Montserrado County (Urban) (N=236)



\* “Functional” refers to the “functional” and “non-functional” classification in the 2018 SARA. Source: GOL, 2018b

Figure 3. Composition of Private Sector Facilities in Liberia (N=258)



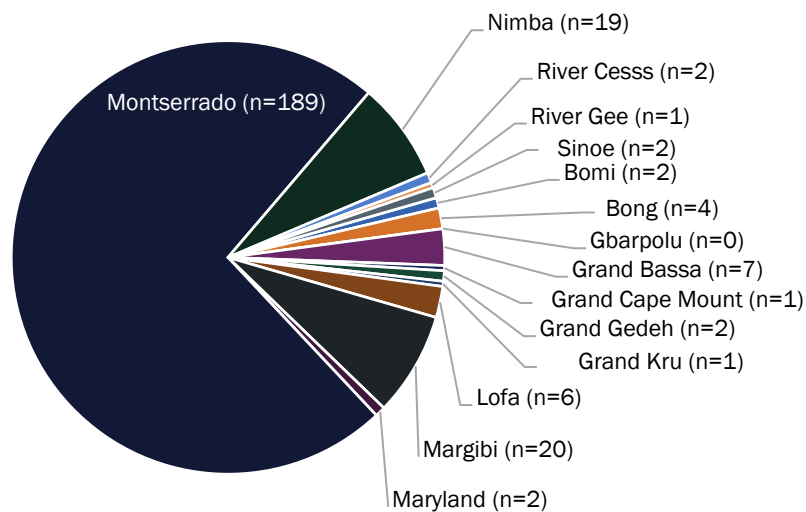
Source: GOL, 2018b

share of the private sector increases significantly from 37 percent nationally to 80 percent in urban areas of Liberia, as shown in Figures 1 and 2. It should be noted that these data represent the *number* of facilities, not the capacity. Some facilities in Montserrado County, such as the J.F. Kennedy Memorial Hospital, which is semi-public, have a large capacity (e.g., 500 beds), whereas strictly private facilities are more limited in capacity.

### 3.2 Size and Scope of the Private Health Service Delivery Sector in Montserrado County

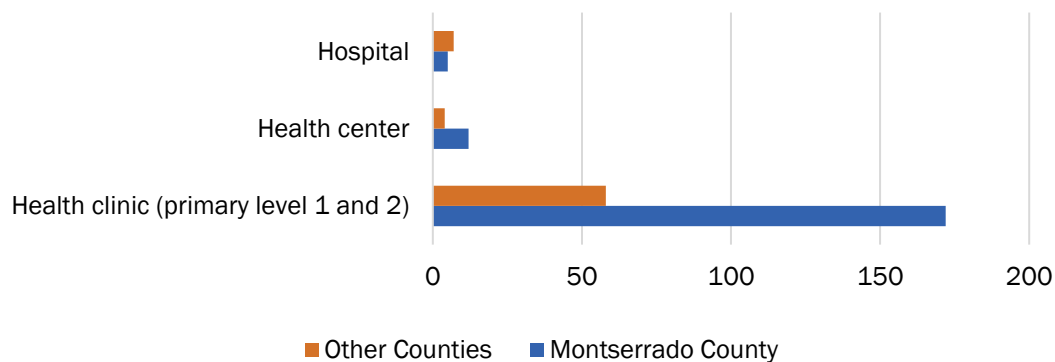
The total number of private facilities in Montserrado County dwarfed the number in other counties. The total number of facilities across every other county was still only a little more than a third of the total number in Montserrado County, as shown in Figure 4. In the private sector, across all counties, there were a total of 230 functional health clinics (88 percent), 16 health centers (7 percent), and 12 hospitals (5 percent) (Figure 3). This is further broken down by the number of facilities per level in Montserrado County and all other counties combined (Figure 5). Across all private facility types, there were 2,986 inpatient beds, 626 of which are dedicated maternity beds. Montserrado County, which is home to approximately one-third of the total population of Liberia and the capital city Monrovia, represents 59 percent of these private inpatient beds (1,776) and over half of the total allocation of maternity beds (335). This represents a private sector density of 12.1 beds per 10,000 population (the World Health Organization [WHO]-recommended target is 30 beds per 10,000 population). In comparison, the public sector in Montserrado County is equipped with 469 inpatient beds, with 168 dedicated maternity beds (GOL, 2018b). Liberia’s premiere semi-public referral hospital, J.F. Kennedy Memorial Hospital, located in Monrovia, is equipped with 500 beds but is not included in the SARA (JFK Memorial Medical Center, 2019). Together with other public facilities, this accounts for a total density of 6.6 beds per 10,000.

Figure 4. Geographic Distribution of (Functional) Private Facilities by County



Source: GOL, 2018b

**Figure 5. Number and Levels of Private (Functional) Health Facilities in Montserrado County versus All Other Counties**



Source: GOL, 2018b

The SARA data focused on the presence and functionality of items deemed crucial for providing quality services within the private sector, namely infrastructure, equipment, amenities, infection control precautions, diagnostic ability, medicines, and commodities (GOL, 2018b). General readiness scores, as classified by SARA, identified mission/faith-based facilities as scoring highest with a 66 percent readiness score, private for-profit with a 58 percent readiness score, public with a score of 56 percent, and NGOs with 55 percent. In the scores related to the availability of basic equipment for diagnosis, FBOs scored the highest at 84 percent, private for-profits had 76 percent, and the public sector scored 80 percent. For access to essential medicines, 34 percent of public facilities had the medicines required, compared with 38 percent of NGOs and private for-profits and 44 percent of FBOs (GOL, 2018b).

In terms of private facilities in Montserrado County that were included in the assessment having access to electricity, 135 private facilities in Montserrado had access to national/community grids, another 54 were connected to generators, and three had solar-powered systems. The remaining 24 had no source of electricity, preventing them from using electronic equipment, having cold chain capabilities, and operating at night. Of the 135 facilities with grid access, 105 had uninterrupted access because of combined Liberia Electricity Corporation and generator use (GOL, 2018b). Of the total 189 private facilities in Montserrado County, only 37 had functional refrigerators for vaccine storage (GOL, 2018b). Data on access to water were limited and therefore not reliable, but around half may have had access to water either within the grounds of the facility or inside the facility.

### 3.3 Human Resources for Health

WHO recommends a health workforce density target of 23 health workers (doctors, nurses, and midwives) per 10,000 population. Liberia's core health worker density within the private and public sector is 11 health workers per 10,000 population. Broken down by county, Montserrado has the overwhelmingly largest availability of health workers: 195 general doctors, 118 specialist doctors, 222 physician assistants, 1,027 nurses, 322 nurse midwives, 71 pharmacists, and 285 pharmacy assistants/dispensers (GOL, 2018b).

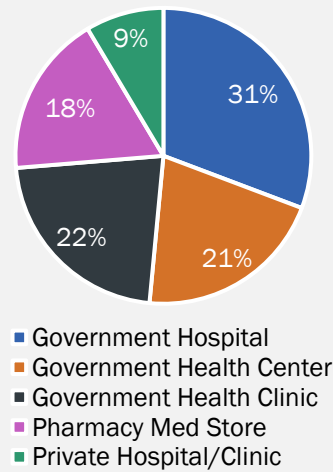
Despite the highest density of the country’s workforce being located in Monrovia, the density of doctors is around 2.1 per 10,000 population (generalists and specialists combined)—far lower than the WHO recommendation of 10 doctors per 10,000 population. Similarly, for nurses, the density is 9.2 per 10,000 population, also lower than the recommended 40 per 10,000 (nurse and nurse midwives combined). The health workforce data in SARA were not disaggregated by sector, so comparison between public and private sector health workforce density was not possible. These figures have remained largely static since 1994, when there were an estimated 2.3 doctors and 10.2 nurses per 10,000 population (Liese et al., 2003).

### 3.4 Health Services

#### 3.4.1 Family Planning

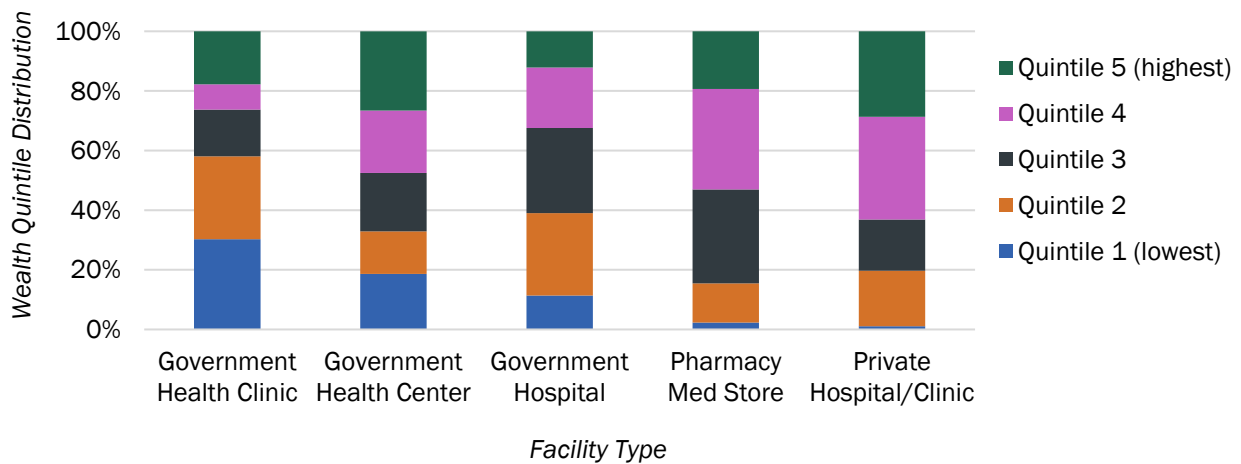
Family planning was one of the two priority services that facilities must offer to participate in this assessment. Family planning services in urban areas are most commonly obtained from the public sector, predominately tertiary-level facilities (Figure 6), and public providers make up more than 75 percent of contraceptive method providers. “Urban” is classified by the Malaria Indicator Survey (2016) as large cities (capital cities and those over 1 million population), small cities (population over 50,000), and towns. Of the 189 private sector facilities in Montserrado County, 105 facilities offered family planning services. Most poorer clients in urban Liberia access family planning services from the public sector, but there is increasing use of family planning services in the private sector among wealthier clients (Figure 7).

Figure 6. Facility Type (Urban) Used for Accessing Current Family Planning Methods (N=491)\*



\* Total percentage is higher than 100 percent due to rounding. Source: NMCP et al., 2017

Figure 7. Source of Current Contraception Method per Wealth Quintile (N=491)



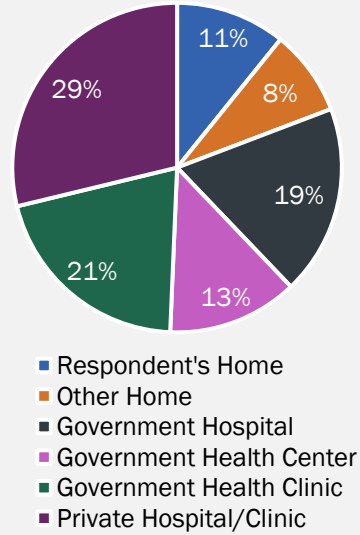
Source: NMCP et al., 2017

### 3.4.2 Maternal and Child Health Services

Maternal and child health services was the second priority health area for the assessment. In Liberia, a total of 567 facilities offered antenatal care services as of 2016 and 561 offered obstetric and newborn services. A similar number of facilities (515) offered immunization services. According to the Malaria Indicator Survey, in 2016, private hospitals and clinics made up 19 percent of all urban facilities used for childbirth (Figure 8).

Similar to family planning services, most poorer clients in urban Liberia deliver in the public sector, although the use of the private sector is increasing for wealthier clients. A large proportion of the middle class use an “other home,” which is typically a private delivery service offered in homes of public sector nurse-midwives, as shown in Figure 9. The utilization across sectors is similar for antenatal care services, with 23 percent of urban clients seeking care from private hospitals and clinics (Figure 10). The middle to wealthiest clients make up the majority of those seeking care from these private facilities (Figure 11).

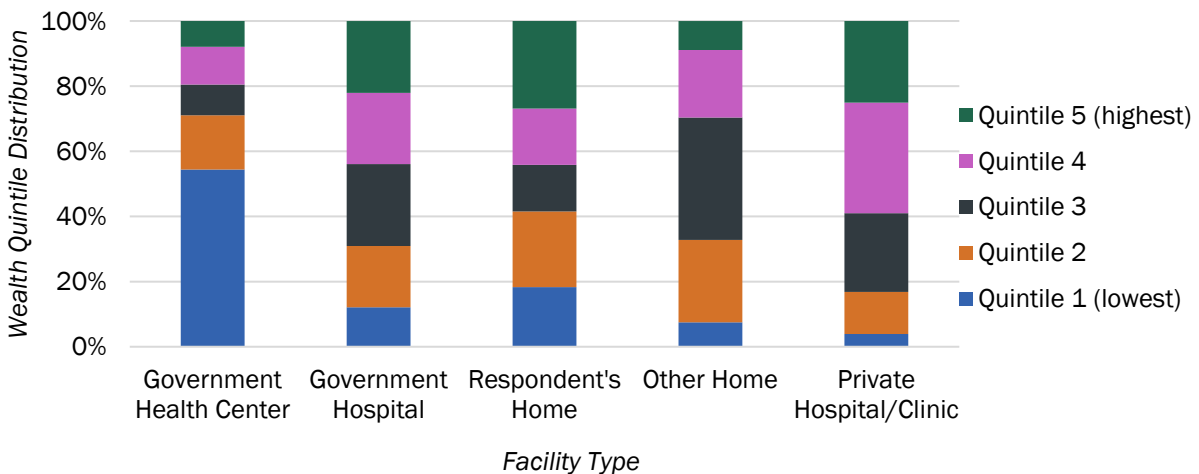
**Figure 8. Facility Type (Urban) Used for Childbirth (N=1,046)\***



\* Total percentage is higher than 100 percent due to rounding. Source: NMCP et al., 2017

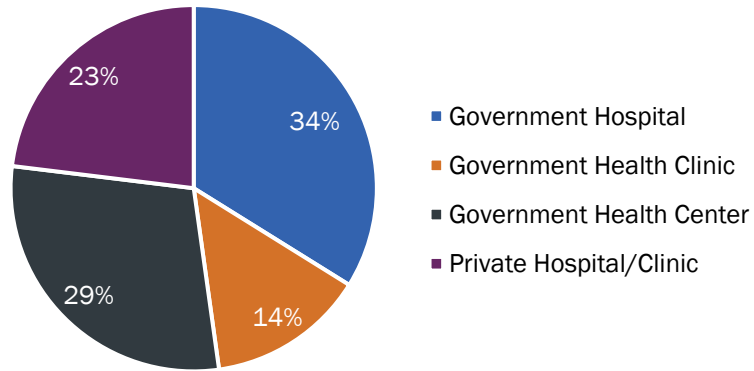
In Montserrado County as of 2016, 114 private facilities offered antenatal care services, and 117 offered obstetric and newborn services. Fewer facilities (84) offered immunization services, while a far greater number of private facilities (160) offered malaria diagnosis and treatment services (GOL, 2018b).

**Figure 9. Facility Type (Urban) Used for Childbirth per Wealth Quintile (N=1,046)**



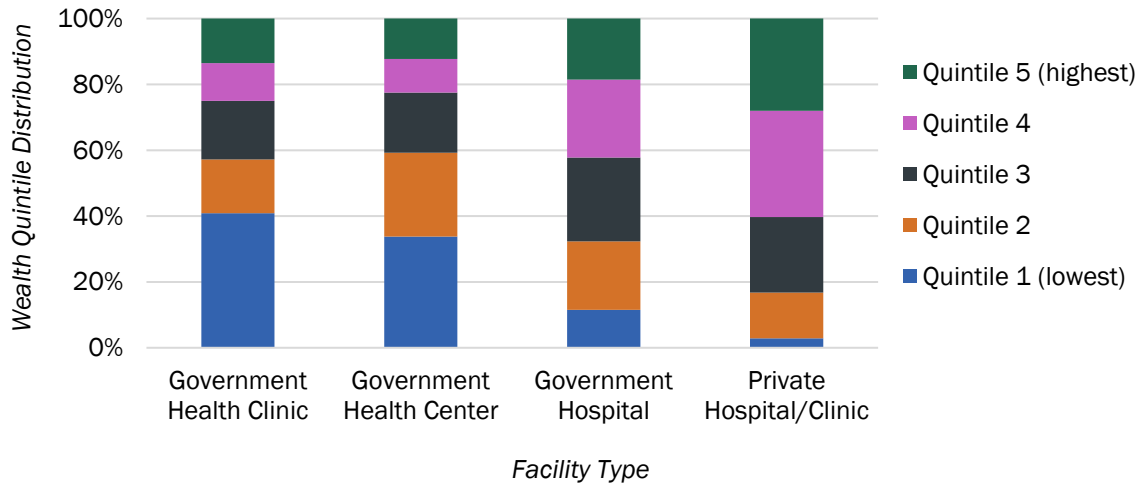
Source: NMCP et al., 2017

Figure 10. Facility Type (Urban) Used for General Antenatal Care (N=1,046)



Source: NMCP et al., 2017

Figure 11. Facility Type (Urban) Used for General Antenatal Care per Wealth Quintile (N=1,046)



Source: NMCP et al., 2017

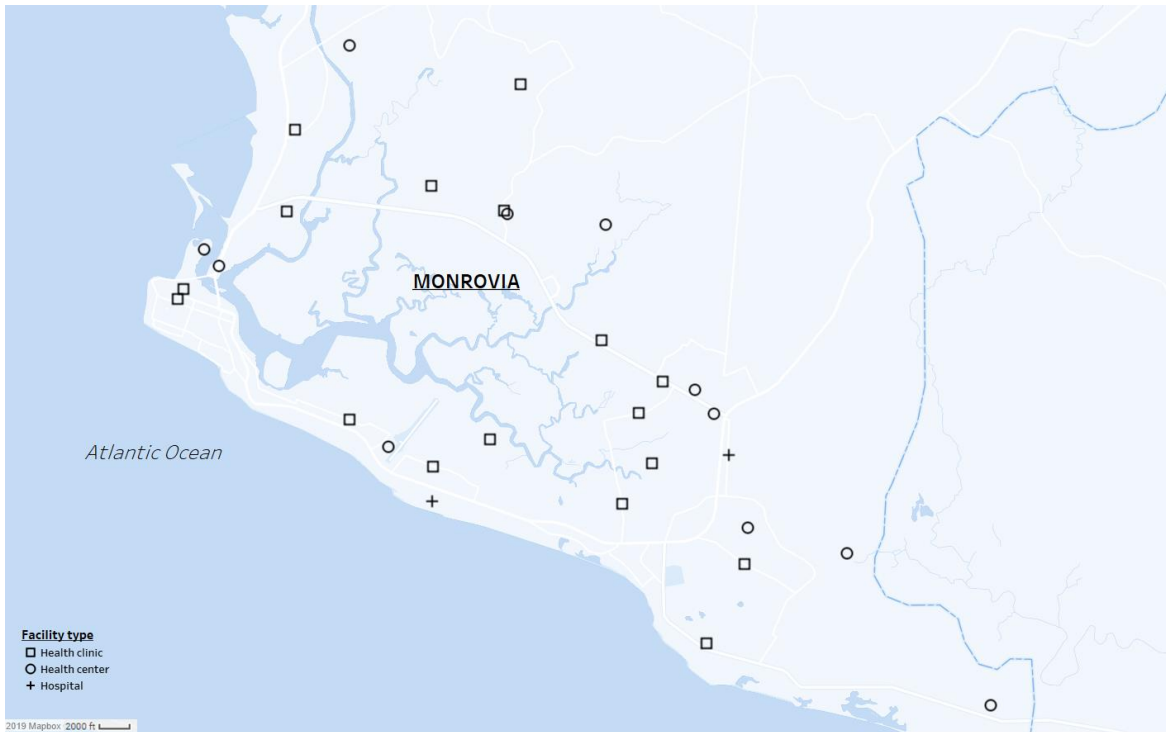
## 4. Private Sector Service Provision

This section presents the findings of the qualitative interviews conducted with health facility key informants in Greater Monrovia, Liberia, in July 2019. The interview questions did not seek information derived from patient registers and did not seek verification of the health data of clients.

### 4.1 Private Health Facilities

The assessment team visited and interviewed stakeholders at 30 health facilities in total (Figure 12). In Montserrado County, there are 189 private facilities, 30 of which were included as part of this assessment. Table 4 represents the percentage of facilities sampled versus the total number of facilities in Montserrado County. The classification of primary, secondary, and tertiary is based on how the facilities are defined by their current health licenses.

**Figure 12. Map of Health Facilities Included in the Assessment**



**Table 4. Ratio of Facility Types in Montserrado County versus Represented in the Assessment**

Facility Type	Percentage of Facilities Sampled for Assessment	Facility Level of All Facilities in Montserrado County
Private Health Clinic	63%	91%
Private Health Center	30%	6%
Private Hospital	7%	3%



## 4.2 Health Facility Infrastructure

In addition to the main characteristics of health facilities presented in Table 5, diagnostic labs which can test and analyze blood samples are an important part of any health system and are essential to provide clients with an accurate diagnosis. All facilities included in the assessment had at least basic in-house diagnostic capability available for their clients. There was often storage available for commodities, and some facilities had a refrigerator, but not necessarily the power needed to keep the refrigerator operating at all times. Of the 30 facilities, all had laboratory technicians on staff, as well as a pharmacy on site and a staffed pharmacy dispenser.

**Table 5. Characteristics of Health Facilities**

Characteristic	Health Clinics (Primary) (n=19)	Health Centers (Secondary) (n=9)	Hospitals (Tertiary) (n=2)
Inpatient and outpatient capability	58%	88%	100%
Outpatient only	42%	12%	N/A
In operation >5 years	83%*	88%*	100% (1 in operation 56 years; 1 in operation 15 years)
Have 1 health facility location	79%	67%	100%
Have >1 health facility location	21%	33%	-
Facility building owned	50%*	78%	100%
Facility building leased	50%*	22%	0
Operation 24 hours a day/7 days a week	57%	100%	100%
Operation Monday–Friday/Saturday (approximately 9 a.m.–5 p.m.)	43%	-	-

\* One facility declined to answer.

### 4.2.1 Access to Electricity

The availability of electricity is essential for private sector health facilities to operate, as they need lighting to perform procedures and power for the proper cold storage of vaccines. Almost all health clinics had access to power from the Liberia Electricity Corporation; however, the flow was inconsistent, so most also had multiple generators on site to support the daily outages. For a one-story clinic, the cost to operate a generator is estimated to be US\$20 per day. Health centers and hospitals reported owning more than one generator, which increased their daily operating expenses. Hospital and health center owners and staff jokingly referred to their multiple generators as “back-ups for back-ups” but recognized that using multiple generators was not sustainable because of rising fuel costs and the expense of maintaining the generators.

*We used to run 24 hours, but the power made us stop. We do not have good LEC [electricity from the Liberia Electricity Corporation], so had to manage through the*



*community current. We raised money through the church and bought a generator. —*  
Health clinic key informant

When respondents were asked to identify the facility’s current major challenge, 30 percent cited the Liberia Electricity Corporation (i.e., access to power) as a major challenge to running their business. Along with rising fuel costs, the frequent trips to buy fuel for the generators and the time and resources needed for repairs placed financial burdens on facilities. One health clinic respondent recalled a time when subsidized solar panels were being considered for the health sector, but they never formally entered the market as a product for sale.

### 4.3 Licensing of Health Facilities

To obtain a health facility license in Liberia, the facility must have a licensed physician on staff. Consequently, it is not unusual to have a physician from the public sector as the licensed physician also associated with a non-physician-owned private facility. The fact that there are more private facilities in Liberia than there are physicians substantiates the frequency of this arrangement. It is assumed that physicians may serve as the operating physician for multiple facilities. Only four private facilities included in the sample were owned by physicians, but this did not mean that these physicians worked exclusively at their own facility.

All health facilities are required to obtain two licenses: a business license (Section 4.3.1) and a health facility license (Section 4.3.2). The exception is FBO-owned facilities, which are not required to have a business license.

#### 4.3.1 Business License

A business license indicates that the facility is a commercial entity liable for paying taxes and following business regulations. The Liberia Business Registry breaks down the annual licensing fees by type of business (e.g., sole proprietor, limited liability company, business corporation; see Annex B) and whether the owner is a Liberian citizen. During the assessment, respondents reported a wide range of fees to the Liberian Revenue Authority for the annual business. The assessment did not ask the facility key informant what type of commercial classification it had, so specific information on the range of fees paid was not available. In general, health clinics and centers reported paying from LD\$2,000–19,200 (approximately US\$10-96). The highest amount reported, LD\$19,200, was almost five times higher than the LD\$4,000 (US\$20) paid annually for Liberian-owned limited liability companies (about LD\$180,000/US\$900 for non-Liberians). Some respondents indicated that the process “is a headache”; other business owners found the process straightforward but time-consuming. It was unclear why the reported business license fees were not in line with the set rates. One respondent cited paying additional fees to expedite the process:

*It is not difficult to get the license, but I had to pay LD\$4,000 to shake things up and get it moving. —*Health clinic key informant

#### 4.3.2 Health Facility License

The health facility license is issued by the LMDC on an annual basis. This license permits a facility to deliver healthcare services to clients. Facilities have a three-month window to apply (January–March), and the license is issued two to three weeks following application and

payment. The health facility licensing fee varies per facility type (clinic, center, hospital) and whether it is Liberian or non-Liberian owned. The fees per category (for-profit, faith-based, concessions, nongovernmental [free], governmental [free]) are outlined in Section 7.3.2. The rates are designed to be applied uniformly to each facility type, no matter their business size. However, some respondents suggested that there should be varied fees per facility based on size, such that smaller facilities which are earning less can pay lower fees. According to the LMDC, private health clinics owned by Liberians are required to pay an annual health licensing fee of US\$100, health center owners pay US\$200, and hospitals pay US\$300. However, the prices paid to the LMDC varied, and respondents reported prices both higher and lower than the required fees. When asked, Liberian-owned health clinics reported paying US\$75–150. Health center respondents reported paying as low as US\$80 for their license, compared to the required fee of US\$200. This was in addition to business license fees, as outlined in Section 4.3.1.

There was little visible evidence within the facilities that facility owners obtained annual health facility licenses. Only one facility included in the assessment had a visible copy of the license displayed on the facility wall. However, it is not mandated that facilities hang their license in a public area for clients to see.

According to respondents, LMDC performs on-the-spot inspections every three to six months to check physicians' licenses, which were also not posted visibly in the facilities. Some respondents suggested that these checks may happen more frequently when the physicians on staff or the facility owners are non-Liberians.

*LMDC can come suddenly. They can come to collect forms, and they check if the doctor has a license.* —Health center key informant

In some cases, LMDC was not inspecting their premises at all nor verifying licensure. Respondents noted that facility visits by a regulatory agency such as the LMDC should be to verify that that submitted information is correct, quality measures are in place, providers are licensed, and health data are being properly reported. It was also noted, however, that some of these responsibilities were currently being performed by the district health teams in some locations. One respondent at a facility commented on the value of these visits:

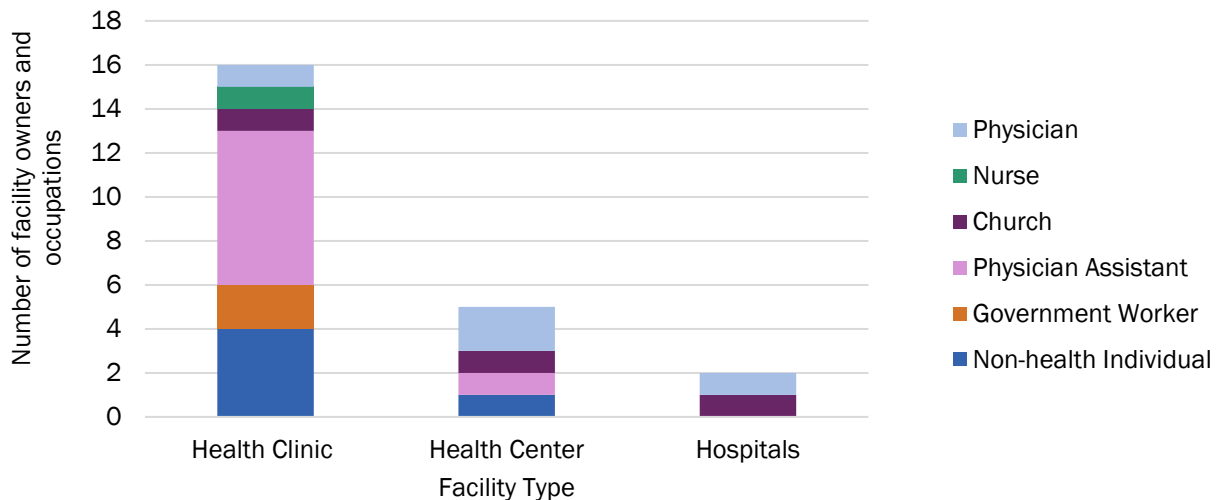
*They're supposed to visit to verify the information on the [license] form, but they don't.* —Health center key informant

#### 4.4 Ownership and Management

Health facilities in Liberia are legally required to have a physician on staff. However, only eight facilities from the assessment were owned and operated by a physician. Of the remaining facilities, four were owned and operated by physician assistants, one by a nurse, five by private individuals (non-health), and two by government workers (Figure 13). Three were owned and operated by FBOs. The ownership of seven facilities was unknown, as respondents declined to answer. Facilities not owned by physicians had licensed physicians on call and scheduled to visit the facility on a rotating basis, manage any complex cases, and provide the licensure needed to register the facility. However, most of these facilities did not receive a visit from the physician more than one to two times per month.

There were cases where a private facility had dual owners (often husband-wife teams), and where one person also worked part time in a public facility or had another part-time job outside the facility. In one case, a co-owner also owned a nurse training institute and was able to make use of the facility for practical trainings. In another case, one co-owner worked for the government, while the other served as a full-time nurse at the facility. Where there were dual owners, the profession of the respondent was recorded (Figure 13).

**Figure 13. Occupation of Facility Owners by Facility Type**



All health centers and hospitals employed a paper-based patient record-keeping system. Most medical records were ordered alphabetically or by patient number and were kept on shelves behind or near the registration desk. The assessment team did not assess how long client records were stored. Many clinics had visible MOH health ledgers for key health areas like vaccination records.

Smaller facilities—especially clinics—had limited capacity to store patient records and adequately preserve them from damage. One clinic had patient records enclosed in plastic covers to prevent damage. Two health centers were using computers to record physicians' notes. At one of those two facilities, the owner explained this as being the first step towards a facility-wide electronic medical records system.

Few facilities have sufficient management and administrative experience to streamline operations and carry out efficient inventory management. Multiple facilities reported the need for managerial and administrative training; one health clinic owner highlighted the need for business strategy expertise:

*Because of the many private clinics around here, since we are all treating the same thing, it also affects the number of people coming to the facility. It's hard to make yourself stand out from a service prospective. —Hospital key informant*

Most health facility premises were owned by the facility owner(s); only 38 percent of facilities leased their premises (with one facility declining to answer) (Figure 14). In general, facility owners were more receptive to making enhancements to their facilities when they owned the

building. Some owners had new construction under way at the time of the assessment. For facilities whose respondents expressed interest in expansion or who had expansion plans underway, 71 percent owned their building. The areas in which facility owners wanted to expand varied from actual structural expansions like a maternity ward or an inpatient unit, to expanding their reach of services, such as mental health or cancer testing. The most commonly cited areas for expansion were tuberculosis services and/or to create an obstetrics ward.

#### 4.5 Staff Composition and Presence

In general, nurses, followed by nurse assistants, were the cadre of providers most commonly found at health clinics. This staffing pattern may reflect the greater need for nurses than other professions at the primary level. Physician assistants were in larger numbers at health centers and hospitals. If a physician assistant was operating in health clinics, he/she most likely owned the facility.

In general, health centers had more staff than clinics, with an average of 40 health and administrative staff members, compared to an average of 16 staff members in clinics. Health centers generally had approximately five more administrative staff than health clinics. Of the 30 facilities included in the assessment, only six had a specialist on staff or on call. Every facility has at least one janitorial staff member. As expected, private hospitals operated with more staff than clinics or health centers, having an average of four physicians, 50 nurses, and 20 nursing assistants on staff. Specialists in the area operated on call for surgery or consultation, as needed.

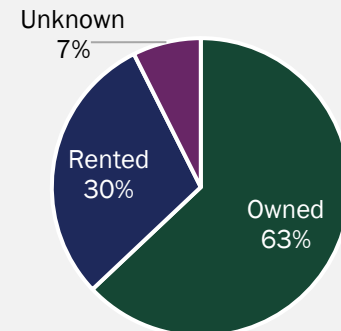
*We have a lot of nurses and physician assistants and not enough doctors and not enough specialists because they are expensive to hire. Health administrative capacity is a problem. A lot of doctors and PAs [physician assistants] are doing the administrative tasks. —Hospital key informant*

Both hospitals included in the assessment had a board of directors, as did eight of the nine health centers. Only 10 percent of health clinics had a board of directors. Facilities with a board had from three to seven directors from various professional areas, including the church, the health sector, and private business. Board members' roles included advising on matters affecting the health business, providing a sounding board for the owners, and advising on major challenges, renovations, or expansion of services.

#### 4.6 Provision of Health Services

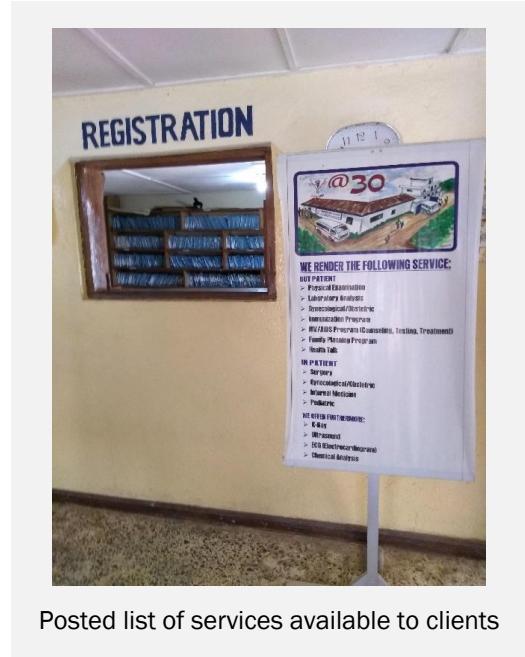
The services offered at the 30 facilities are summarized in Table 6. It was not common for a facility to post available services in a place visible to clients (see photo for example). With regard to training in mental health, one health center was trained by the U.S.-based Carter Center in exchange for offering training space, while staff at another facility received training from the MOH in mental health.

**Figure 14. Health Facility Ownership (N=30)**



**Table 6. Sampled Services Provided at the Facilities Assessed**

Services Offered	Percentage of Facilities (N=30)
Family planning services	93%
Labor and delivery	86%
Malaria treatment	93%
Integrated management of childhood illnesses	93%
HIV counseling and testing	45%
Antiretroviral treatment	31%
Tuberculosis treatment	10%
Mental health counseling	17%



Posted list of services available to clients

**4.6.1 Use of Standard Operating Procedures**

All clinics surveyed reported using standard operating procedures (SOPs) for clinical practice, as issued by the MOH. The assessment did not include verification of whether the SOPs from the MOH were actually being used, and few SOPs were visible in facilities during the assessment. SOPs that were posted on clinic walls included clinical practice guidelines on how to wash hands and SOPs on how to resuscitate a newborn, but these examples were rare. When probed about SOPs and educational materials/updates, some facility owners reported that they had not received health educational materials from the MOH or any other source; a small number of facility owners had guidelines issued by the LMDC and NGOs. Facility owners who said they adhered to SOPs but had not received any information from the MOH or other sources may have been drawing on their experience working in the public sector or taking medical training courses. One owner described the clinical practice procedures that were used to monitor quality as, “I look around and make sure they [staff] are following guidelines.” Others described monthly schedules and staff meetings where procedural quality and past performance were discussed.

One health clinic included in the assessment was currently registered with SafeCare and receiving a business loan from the Medical Credit Fund, two programs operated by PharmAccess, a Dutch NGO. SafeCare was supporting the clinic with quality improvements, including the management of its pharmacy. With no SafeCare team operating in Liberia, a team member from its Ghanaian operations was supporting the improvement process from outside the country, most often by text message. At the clinic, the staff was conducting weekly meetings to review facility data, discuss how to bring about improvements, and analyze progress against the workplan and timeline laid out for them by SafeCare. The clinic was bearing the full cost of the US\$7,000 program over three years.

#### 4.6.2 Pricing and Payment of Services

Identifying the prices of key services within private facilities was a key component of the assessment. Prices for services in several areas were recorded for each facility and are included in this section. All facilities charged a registration fee when a client first visited the facility and needed to be entered into the record system for the first time. If the person was a repeat client, there was a consultation fee. Registration prices were generally fixed, while except for rare emergency cases, all other prices were flexible. If clients could not pay the full amount that day for a prescription, they either bartered and paid a lower fee or, more commonly, the prescription was divided up and clients paid what they could afford. (Clients may also barter when offered a test whose full amount they are unable to pay.) Clients returned later to pay the outstanding bill and were given the rest of the medication. Facilities said that some clients come back and pay, while others do not. How facilities respond in these cases is a gray area and depends entirely on the situation:

*People come and beg for help, we can't say no* —Health clinic key informant

*[We are] flexible on prices because of the economic condition.* —Health clinic key informant

*Patients do not always pay cash. For malaria injections, for example, there are three days' worth of treatment. Have to pay LD\$5,000. They pay the LD\$2,500 first, then pay again for the next injection. Some will pay, others will not. In a day, one or two people come and do not pay.* —Health clinic key informant

*No patient is allowed to leave without being helped, so yes, our prices are flexible.* —Health clinic key informant

However, 60 percent of facilities reported that they only accepted out-of-pocket payments. The remaining 40 percent took payment by means of both out-of-pocket and private insurance. There was no use of mobile money in any of the health facilities. Facilities in the assessment, mainly health centers and hospitals, cited 17 different insurance companies from which they received reimbursements. Only four of the 19 assessed health clinics were found to accept health insurance payments. Half of the facilities accepting insurance said they worked with SAAR Insurance, 40 percent with AUG Insurance, and 30 percent reported working with Omega Insurance. All of these facilities stated that they worked with multiple insurance companies, and two facilities declined to answer.

Facilities accepting clients with private insurance were quick to describe the extended length of time it took to be reimbursed (see Section 7.1.1). As a result, they charged more to private insurance companies for the services provided to their clients as a “penalty” for late payments. One facility owner explained:

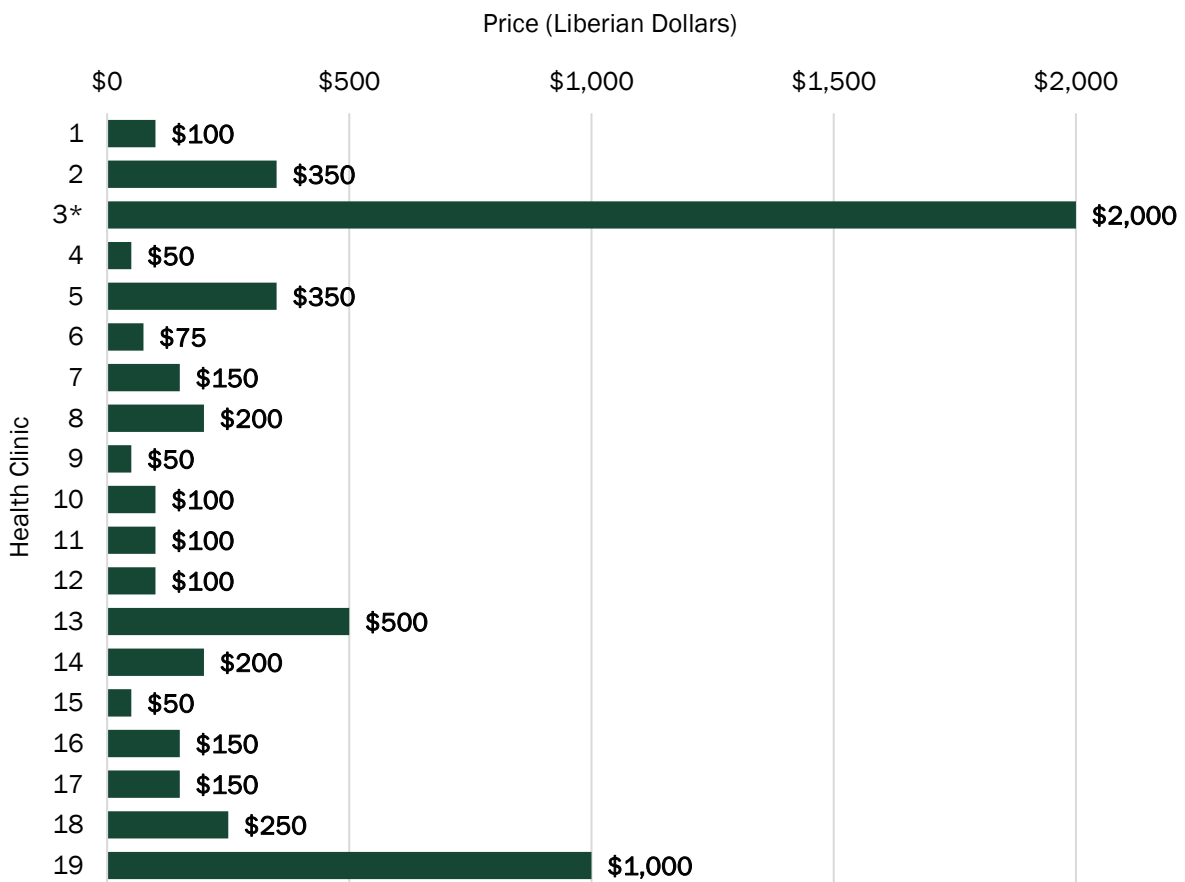
*We charge more to patients using insurance because it takes longer to get the money.* —Health clinic key informant

### 4.6.3 Registration/Consultation Fees

All facilities charged registration (consultation) fees to cover the cost of registering a patient and providing a consultation. This is standard practice for the private health sector. The price paid could cover a one-time visit or multiple visits, depending on the operating practices of the individual facility. Fees ranged from LD\$50 (approximately US\$0.25) to LD\$2,000 (US\$10).

Health clinics showed less variability in the price of registration fees. Sixty-eight percent of the health clinics charged at or below LD\$200 (US\$1). Facility 3 in Figure 15 was an exception in terms of pricing and was providing services to a different clientele, with 75 percent of their clients covered by private insurance (e.g., government employees and expatriates).

Figure 15. Health Clinic Registration Prices



\* Indicates that the price was originally listed in USD and has been converted to LD. The conversion rate is fixed for this report at US\$1 = LD\$200 but is subject to fluctuation in the market.

Health center registration fees varied in a similar manner though were slightly higher, from LD\$20 (US\$0.10) to LD\$5,000 (US\$25), and with 44 percent of the health centers charging at or below LD\$200 (US\$1). The exceptionally low LD\$20 in Figure 16 represents the charitable mission of one particular health center. Health center prices charged at the higher end tended to include a variety of bundled services, such as free additional consultations for a two-week period. Hospitals charged around US\$5–10 (Figure 17).



Payment instructions at cashier desk

No facilities displayed registration fee prices on the wall. Clients were to pay the cashier/registrar (and no one else) the registration fees to ensure that the money reached the proper entity; in some cases, this instruction was posted on the wall (see photo).

Figure 16. Health Center Registration Prices

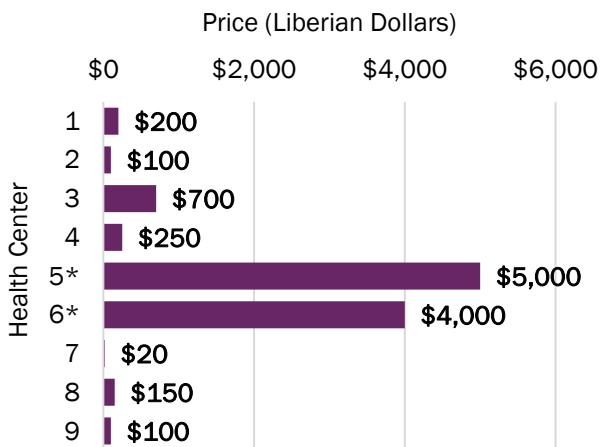
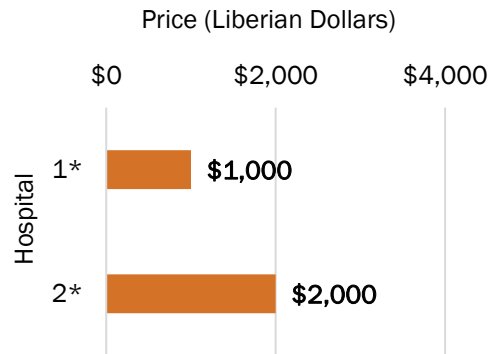


Figure 17. Hospital Registration Prices



\* Indicates that the price was originally listed in USD and has been converted to LD (conversion rate: US\$1 = LD\$200)

#### 4.6.4 Family Planning Services: Implants, Injectables, and IUCDs

To be included in this assessment, facilities had to offer family planning services: service provision, access to commodities (including short-acting methods), or in-service training. Facilities offering family planning generally offered both implants and injectables, and sometimes intrauterine contraceptive devices (IUCDs). Of the 30 facilities in the sample, 22 offered family planning services at the time of the interview because they were being supplied with free family planning commodities (implants, injectables, IUCDs, and condoms) from the MOH. Three facilities were only offering condoms, also provided by the MOH. As part of their arrangement with the MOH, facilities were prohibited from charging a fee (including the registration fee) when providing these services. Three facilities sourced their commodities privately (on an ad hoc basis or continually).



Two facilities included in the assessment did not provide any family planning services. One was a Catholic hospital and therefore had restrictions on providing family planning services beyond natural methods, but it did allow the MOH to host family planning and maternal and child health trainings at the facility. The second facility did not provide family planning services because it had not received free commodities from the MOH in recent times.

Of the facilities that sourced their commodities privately, Facility #1 in Table 7 bought its implants and IUCDs from an NGO, DKT International, which offered free training to facilities that purchased their commodities.

Facility #1 also sold injectables at LD\$100 (US\$0.50) and implants at LD\$1,000 (US\$5). Another clinic that sourced family planning commodities privately sold injectables at LD\$350 (US\$1.75) and implants at LD\$1,000 (US\$5).

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*“FP [family planning] commodities are received for free. We do not charge consultation fees for patients. It is a burden, but we cannot say no to the Ministry, because then they will say that this facility does not offer these services. It is a loss to the facility. Nurses are overworked with FP and HIV services. It is all free, even HIV commodities are free.”*

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*–Hospital key informant*

**Table 7. Cost of Family Planning Commodities**

	Facility #1	Facility #2
Commodity	1 pack of 50 IUCDs	50 units of Depo Provera
Wholesale Price	US\$84 (US\$0.68 each)	US\$20 (US\$0.40 each)
Price to Client	LD\$1000 (US\$5 per unit), includes insertion service	LD\$200 (US\$1)
Markup	Almost 200%*	150%

\* Given that IUCD services are more labor intensive than other methods, net profit is lower than this.

Delivery of products is supposed to occur once a month by the District Health Office (DHO) team, but facilities reported an inconsistent supply of commodities, with deliveries sometimes delayed by three months or more. When they experienced delays, facility owners/providers would personally request the products from the DHO team directly, and they would be delivered shortly thereafter. One facility reported buying injectables privately when the MOH did not provide them on time, and then charging clients for the service, but most facilities simply stopped providing those services until new supplies were received. Of the 22 facilities that sourced their commodities from the MOH, four were charging for services at a wide range of prices. This went against the MOH mandate to provide these services for free, *if* these commodities were sourced from the MOH. Implants in these facilities, for example, were sold anywhere from LD\$100–1,000 (US\$0.50–5.00). The rest of the facilities reported offering their family planning services for free. All three contraceptive methods (IUCDs, injectables, and implants) were not all always offered to clients, as some facilities were only able to source one or two of the commodities from the MOH. Two facilities, for example, did not offer injectables; they also happened to be the two facilities that sourced their commodities privately. Another two facilities did not offer implants but did offer injectables, IUCDs, and condoms. Having providers

trained in inserting and removing IUCDs was not common at the health clinic level—only eight of the 19 health clinic facilities offered IUCDs.

#### 4.6.5 Maternal and Child Health Services: Labor and Delivery, Caesarean Sections, Vaccines

**Labor and delivery.** To be included in the assessment, facilities needed to offer some type of maternal and child health service, but the inclusion criteria did not specify which services must be provided. Of the 30 facilities, 26 offered labor and delivery services (86 percent), while only 73 percent of facilities were operating 24/7 services. Prices for labor and delivery ranged from LD\$1,500 (US\$15) to LD\$4,500 (US\$22.50) in health clinics, LD\$400 (US\$2) to LD\$15,000 (US\$75) in health centers and up to LD\$8,000 (US\$40) in hospitals (Figures 18–20). It was standard for all facilities to have a bundled pricing scheme for their labor and delivery services. The price for antenatal care visits, postnatal care, and some baby supplies could be included in the bundle, but the options varied by facility. In addition, the bundled option was only for registered patients; for emergency deliveries admitted by the facility, the price was typically higher to include the required medical supplies.

*A normal delivery is LD\$3,500 if you have been coming for nine months. If it is an emergency, then it is LD\$5,000. The \$1,500 goes towards baby items, and to prepare for those patients' blood type [that] we do not know. —Health clinic key informant*

Figure 18. (Vaginal) Labor and Delivery Prices at Health Clinics

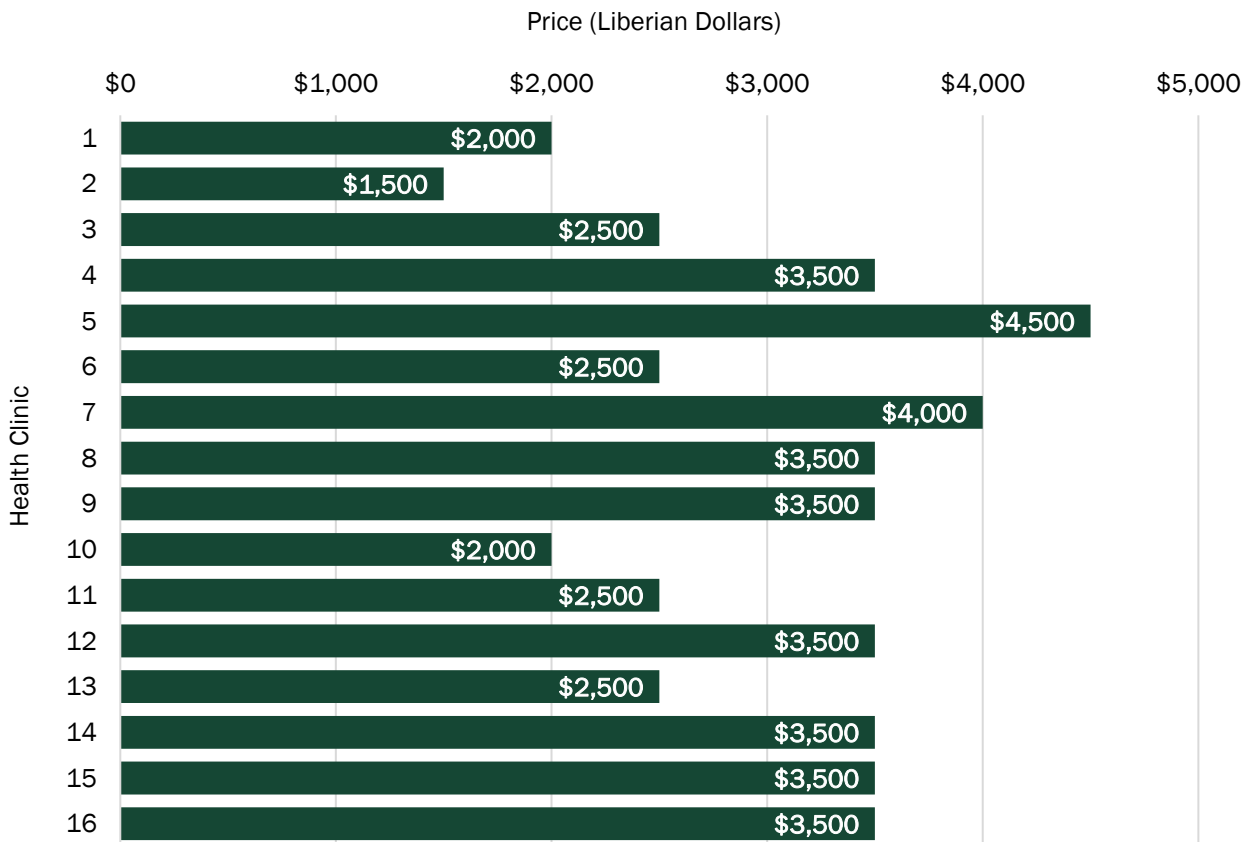


Figure 19. (Vaginal) Labor and Delivery Prices at Health Centers

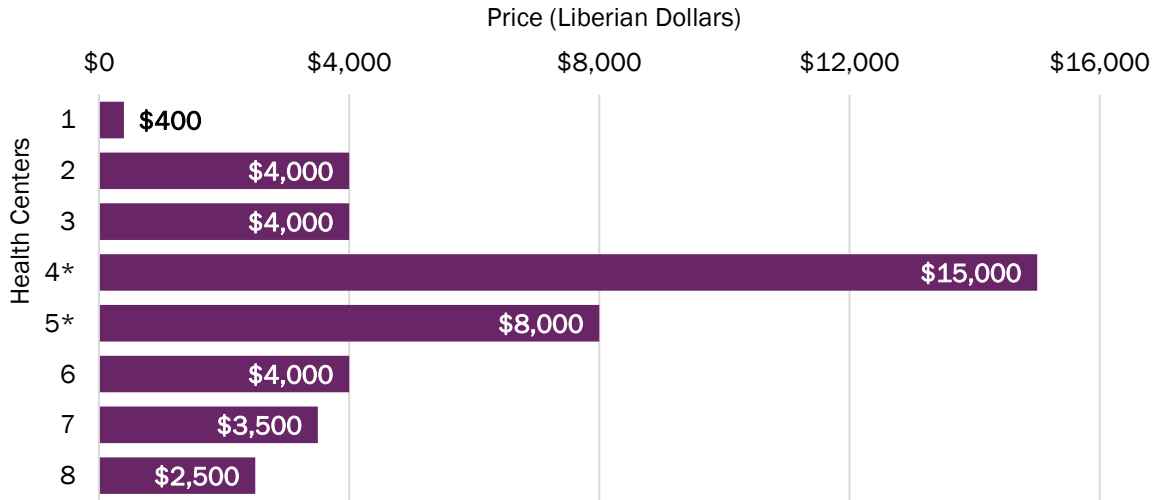
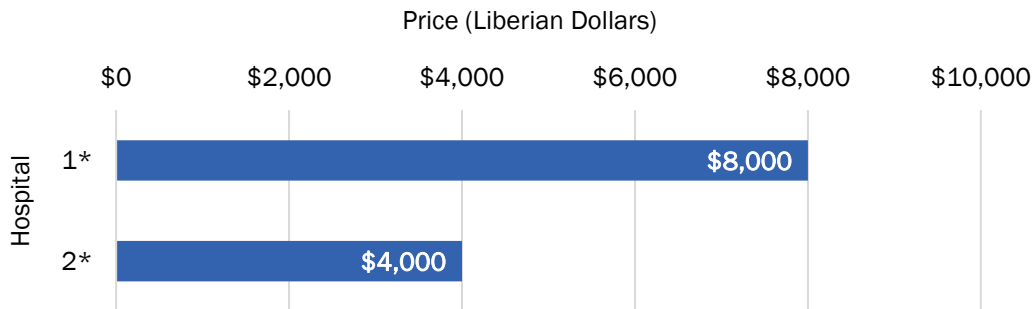


Figure 20. (Vaginal) Labor and Delivery Prices at Hospitals



\* For Figure 19 and 20, indicates that the price was originally listed in USD and has been converted to LD (conversion rate: US\$1 = LD\$200).

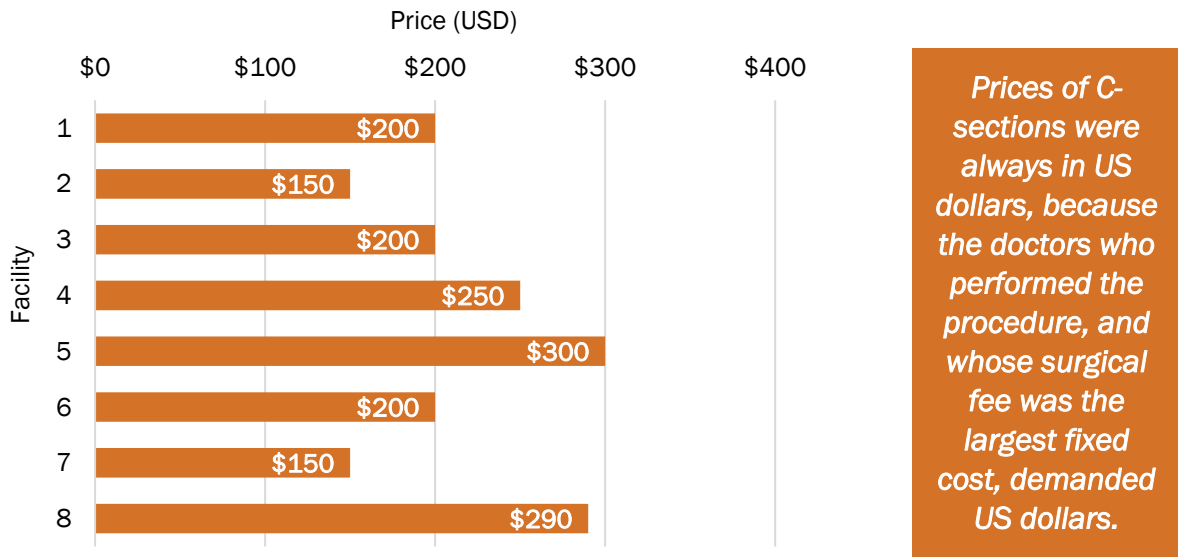
For some facilities, labor and delivery was cited as the most profitable service. One facility with eight beds reported 30–40 deliveries per month in recent times, which they said was lower than their average number. Facilities offering ultrasound services also reported it as one of the most profitable services, with an average cost of around US\$15.

*Other businesses charge US\$25 for ultrasounds, we charge US\$10, so lots of people come here.* —Health center key informant

**Caesarean Sections (C-sections).** C-sections were offered in eight of the 30 facilities. Prices ranged from US\$150 to US\$600 (Figure 21), depending on the patients’ preferred package (e.g., private room, length of stay) and the complications experienced during the procedure. The prices of C-sections were always in US dollars, because the doctors who performed the procedure, and whose surgical fee was the largest fixed cost, demanded US dollars. The equivalent rate in Liberian dollars, which varied depending on the exchange rate, was charged to the client at the time of the procedure.

Across the board, C-section rates were reported to number from 5 percent to 10 percent of deliveries (unverified with client records). Patients in the public sector requiring C-sections were being referred to private sector facilities when the public sector was unable to perform the procedure. This referral process was driving total C-section rates from the normal 10 percent–15 percent up to 75 percent in these facilities (see Section 4.8.3). In private health centers and clinics alike, if a client needed a C-section and the facility could not perform it, the client could choose the facility where she would be referred. This tended to be a choice between the nearest public or private (service-ready) facility.

Figure 21. C-Section Prices (All Facility Types)



**Vaccines.** Where vaccines were available for children, they were offered free of charge. All vaccines were made available to the facilities (either directly or indirectly) by the MOH. However, there was limited capacity to store vaccines in clinics. Those that did not have temperature-controlled refrigerators stored their vaccinations in cold boxes and/or vaccine carriers (see photo) and changed the ice packs at varying times. Some respondents reported changing the ice packs every 24 hours, while another said every two to three days. The assessment team noted that this was not an adequate way to store vaccines beyond transport or for short-term storage. The use of cold boxes as a permanent way to store vaccines is not compliant with WHO cold-chain guidelines for vaccines.

Vaccinations were used as an avenue for community outreach. One clinic explained that they sourced the vaccines from a nearby public community health center and then went door-to-door with a vaccine carrier to vaccinate families. They received no



payment for these services and instead used it as a way to attract clients to the facility for other services. Vaccines that were not used were brought back to the community center at the end of the day. Another health center included in the assessment was offering a comprehensive vaccination program to its clients and was visibly charting progress on the wall.

#### 4.6.6 Medicines

The pricing of medicines was determined by the amount charged by suppliers (see Section 6 for more information on the pharmaceutical supply chain). Facilities reported that to calculate the price for patients, they added 20 percent to the wholesale price paid.

Amounts sold to patients were not based on how much medicine they needed in totality, but how much they could pay for at that moment. For people who could not pay for the full prescription, the remaining medicine was charged separately, and the patients received the rest of their medicine when they returned with the remaining payment owed. All facilities used this installment-based payment system for medicines, which appears to guard against non-payment. Service fees can be flexible, but non-payment of medicines would result in a net loss for the facility. One facility owner reflected on how the facility could increase its supply of drugs if it had access to increased working capital via financial institutions:

*Facilities reported that to calculate the price of medicines for patients, they added 20 percent to the wholesale price.*

*We would buy more drugs so we could pay back the loan. Drugs pay back the loan, because drugs make more money than services. A stock-out on drugs is when the cash is not coming. —Health clinic key informant*

#### 4.6.7 Laboratory Tests

Every facility had a laboratory service in-house and a laboratory technician on staff. Laboratory tests were often cited as the most profitable service at health clinics (versus labor and delivery for health centers and hospitals). Only two of the facilities in the assessment had prices publicly visible, and respondents noted that clients may not understand the names of the tests, which reduces the transparency of providing the pricing information. Similar to the payment schemes outlined in Section 4.6.2, payment for lab services was flexible and, given the lack of transparency on pricing in most facilities, was typically open for negotiation on the part of the client. Annex C includes a sample of lab test prices from three health clinics.

### 4.7 Productivity and Utilization

The client load in clinics was around five to 15 per day (an average of 13), and only a few facilities had a larger client load. Health centers experienced a higher average patient rate, with 37 clients per day. Health clinics had an average of eight beds, while health centers had an average of 23 beds. All clinics allocated their beds to both inpatients and outpatients interchangeably. The increase or decrease in client levels over the previous six months was reported to be mixed. Thirty-six percent of facilities said their client level had increased, mainly because of the rise in malaria cases (due to the rainy season). One facility reported that its new lab was drawing in new patients. Another 46 percent of facilities said that their client load had decreased—about half of such facilities reported that this was due to the slowing economy, while

the other half said it was because people did not want to leave their homes due to the rain. Seventeen percent (five) facilities stated that their patient level had remained the same.

Fourteen of the 19 clinics (73 percent) were open 24/7. Mondays were reported to be the busiest day for all clinics, as well as Wednesdays and Fridays. For clinics open on Saturdays, mornings were often busy. There appeared to be no correlation between the number of clients per day and extended opening hours. Whether operating 24/7 hours or not, there was a consistent average of 13 clients per day.

Client load across the two hospitals varied considerably, from 20–25 clients per day to 120 per day. Both operated 24/7 services and reported experiencing a decrease in client numbers due to the economic climate and the instability of some private insurance companies. Hospitals reported having 90 beds on average that were allocated for both for inpatient and outpatient services. The assessment team noted that no facilities in the assessment were operating near capacity. In general, there was very low utilization of beds when the assessment team visited the facilities. Clinics reported a bed utilization rate of 30 percent to 40 percent. While health centers reported a higher bed utilization rate, the rates varied greatly, with one facility citing 80 percent and one citing 10 percent. The low average bed utilization rate at clinics may also be associated with the fact that only 58 percent of clinics offered inpatient services, compared to 88 percent of centers.

#### **4.7.1 Client Profiles**

Not all facilities had information on or had recorded the breakdown of the sex and age of their clients. For those that did have this information, an average of 75 percent of clients were reported to be female, 65 percent of those women were of reproductive age and older (15–49 years), and 33 percent were adolescents. Around 25 percent were reported to be infants. On average, for all facility types combined, 85 percent of their clientele were reported to be from a poorer background, and about 10 percent were middle class. These responses were based on respondents' best estimates and not on review of the facility registries. As such, the accuracy of this information is uncertain. One health clinic reported not serving any clients from a poor background—instead serving only those from middle or high economic profiles. In general, the occupations of clients from all facilities in the assessment included petty traders, farmers, students, security workers, motorcyclists, expatriates, NGO employees, government workers, businessmen, domestic workers, and the unemployed. The most common occupation of clients cited was petty traders, likely associated with the urban setting of the facilities.

Most facilities had a relatively large catchment area, with 55 percent of facilities serving clients from more than three miles away. Respondents indicated that some patients traveled from as far as 30 miles to reach the facility. One clinic respondent who had clients who traveled long distances said, “They come because we have a reputation of affordable and flexible service.” Most clients traveling to health centers and hospitals used public transportation, including public motorbikes, ka-kas (tuk tuks), or public buses. Of the nine clinics that provided information on client transport, five said that most of their patients walked to their facility, as opposed to using public transport. The third most cited means of transport was private transportation (shared taxis and motorbikes).

## 4.8 Referral Systems

An effective referral system helps ensure a close relationship between all levels of the health system and between public and private providers, resulting in optimal and cost-effective utilization of care at all levels. It also helps ensure that people receive the best possible care closest to home. A well-operating referral system also helps ensure that when resources are insufficient in one facility, assistance is sought from another. As part of this assessment, private facilities were asked to describe their referral system. However, fully understanding the referral system requires involving both public and private health sectors. As the public sector did not form part of this assessment, it was not possible to gain an understanding of how the entire system works.

### 4.8.1 Private-to-Public Sector Referrals

In all health clinics, owners and providers were able to describe the process of referring into the public sector (see photos of sample referral forms). In the case of primary care facilities, the initiating private facility first asks patients which tertiary facility they would like to be referred to. Often, with complex cases the primary facility will encourage the person to be referred to a public hospital; however, it is up to clients or their families. The facility will then call the receiving facility to let them know that a patient is being referred, the support the facility has provided, and the current status of the patient. Clients are often referred to JFK Memorial Hospital (the flagship public hospital, based in Monrovia) and Redemption Hospital. More than half (52 percent) of facilities interviewed reported that one of the hospitals they refer to is JFK, and 24 percent said they refer to Redemption (referral hospitals for five facilities are unknown). In total, there are nine different hospitals to which private facilities refer clients. After the call is complete, the provider prepares an outward referral slip, often stamped/labeled with the private facility name, that details the client's condition and accompanies the client. Assistant nurses or other lower-level staff sometimes accompany the patient to the receiving public facility in either a private car owned by the family, a taxi, or an ambulance, if necessary/possible.

In cases when a patient shows up at the private clinic and it is an emergency case, the facility first stabilizes the patient and initiates the referral process (Annex D). The facility charges for stabilization and admittance from either the patient or the accompanying family members, when possible. Only one facility said it charges US\$10 up front before stabilizing and admitting a patient. In these cases, it was explained that a health provider may accompany the patient if a family member is not available. After the patient has left the facility, the owner/providers claim that the facility is no longer responsible for the patient. If a patient were to become more seriously ill on the way to the receiving facility and the referral slip has been filled out in full, the facility is exempt from any liability because it took all necessary steps.

There were some remarks made that the private sector may refer to the public sector too late in the care process for an effective public sector response and that this behavior may be driven by profit motives. The assessment team found no evidence to back up this assertion, but if it were the case, an effective response would necessitate stewardship from the MOH around clarifying the private sector's role and responsibility within the referral system (see Section 9 for further detail regarding recommendations).

In urban areas, it is common for clients to bypass primary-level services. It is in the interest of the MOH to improve coordination at the primary care level in order to reduce overcrowding of

higher-level public facilities, such as JFK Memorial Hospital. Charging penalty fees to private facilities that refer clients without a referral letter or a phone call is one way to eliminate this practice. Health clinics expressed dissatisfaction that they never receive notification or communication on the process of care following their referral to the public sector.

#### **4.8.2 Private-to-Private Sector Referrals**

Referring clients to a private facility appeared to be more frequent among secondary- or tertiary-level private facilities (including FBOs) when they did not have the capacity to treat the clients. Most health clinics assessed reported referring clients to the nearby public sector hospitals. However, some clients (providers referred to them as “wealthy clients”) choose to seek care *exclusively* from the private sector and express a preference to continue to receive care from this sector when referrals are necessary. Having effective (informal or formal) linkages between private facilities with distinct specialized expertise can be beneficial for all parties, with clients receiving a satisfactory level of care and the private sector utilizing specialized expertise where it exists.

Health clinics tended to refer clients to other private facilities when the client/family had the funds to pay for it. There was also one example of a faith-based hospital referring clients to a private health clinic because this hospital was operating at capacity.

*[We] do refer to private facilities if the patient’s relatives want to go there. [We] base the suggestion on the finance background of the patients. If they are wealthier, then [we] refer to private.* —Health clinic key informant

In some cases, health clinics utilized private laboratory services of other nearby private clinics if their own laboratory services were limited. It is unclear whether clients are sent to the other clinic to have blood drawn, or whether the blood is carried by hand or driven the short distance for analysis.

*Patients do not like to be referred and do not like to go to [public] hospitals, because they feel they will not be looked after well and it is too crowded.* —Health clinic key informant

#### **4.8.3 Public-to-Private Sector Referrals**

It was highlighted during the assessment that the public sector also referred cases to the private sector. This was explained by the private (receiving) facilities as occurring when public facilities ran out of fuel for their generators to power electricity, in which event they referred all complex delivery cases to the private facilities. These complex cases were often emergency labor and delivery clients. Such referrals were reported as happening frequently during the previous two years. The initiating public hospitals were JDJ and Redemption Hospital.

Public-to-private sector referrals were reported as driving up the number of C-section cases in some private secondary and tertiary facilities. For example, the total C-section delivery volume in one health center amounted to 75 percent of all their delivery cases. A private hospital reported that C-section volumes had risen to 50 percent of all their delivery cases. This was also described as placing an undue financial strain on these clients. The price for a C-section at these facilities is US\$150–300, which is likely an unforeseen cost for clients. As such, it is likely



difficult for the facility to charge the full price, and the health center reported that clients most often pay only 50 percent of the bill. The private facilities recognized that it is very challenging to recuperate the full amount of these costs up front, and they offered the patients flexible pay-back periods. In some cases, the bill is eventually paid.

*We get a lot of C-section referrals. [The] nearest public facility is JDJ; we do not refer to them because they have no fuel. —Health center key informant*

#### 4.9 Business Financing (Health Facilities)

All facilities reported self-financing their business. Three facilities (a clinic, center, and hospital) reported using bank loans during recent years to either expand their business or cover fixed costs when the facility was closed (e.g., during the Ebola virus epidemic).

*I took a loan from United Bank for Africa (UBA) for US\$2,500 in 2009 at a 50 percent interest rate to start the business. In 2012, we completed the clinic. We took a loan of [US]\$13,000 from Access Bank for expansion with [US]\$2,000 cash as [one part of the] collateral. Then paid [US]\$1,200 per month for 12 months to pay off. We went to UBA first to look for loan, but they would not finance. —Health clinic key informant*

Accessing formal loans from financial institutions was not a service that any respondents openly welcomed. Taking out a bank loan was described as akin to a “death sentence,” where they could lose their homes or land. The collateral required from banks was reported to be around three times the size of the loan. It was explained that the (lower) interest rates offered up front were never the rate assigned in the loan agreement. Monthly repayments began on day one. Should a facility be a few days late with one payment due to rainy season affecting cash flow, for example, they reported being heavily penalized with late fees.

However, the need for investment in facilities was understood by owners, particularly among those that owned the premises. Facility owners cited wanting to invest in more profitable services like obstetric wards, surgical wards, and expanded labs. Others cited a variety of areas to invest in, such as mobile services, HIV services, tuberculosis screening, cancer treatment, and services for people living with disabilities. These aspirational services were not all necessarily associated with merely increasing profit margins, and it was unclear if these additional services would be the new services prioritized if financing became available to them. One health center described wanting to expand its delivery room after having experienced three deliveries at the same time, which left the delivery team feeling embarrassed about the lack of privacy for the women.

Expansion/construction was mentioned by 30 percent of facilities. Those who were renting the premises all acknowledged that they wanted to speak to their landlords soon about expanding into another part of the building. Enhanced facility construction to improve patient access and flow was not mentioned as a priority for those leasing the buildings. The main priority for all facilities that expressed interest in expansion was to offer more services to draw in higher client volumes. In some cases, small improvements had already been made, but these were limited. For those who owned larger facilities, it was explained that the building had been expanded over several years through self-financing.

## 4.10 Access to Medicines and Commodities

All clinics, centers, and hospitals dispensed medicines to patients. Drugs were commonly cited as the second most profitable service. At the clinic level, in-house pharmacies were rudimentary, with no system in place to track the flow of drugs or monitor expiring drugs. All facilities visited had a lockable cupboard or room to store their drugs. Two facility-based pharmacies were temperature controlled with an air conditioning unit, and one facility spoke of getting an air conditioner installed in their pharmacy as desirable.

Clinics, health centers, and hospitals were accessing their medicines from locally available sources. Local pharmacies were often cited as the most common way to access the medicines they needed for the upcoming one to two months, with 75 percent of facilities sourcing from more than one pharmacy (six facilities opted not to answer). None of the facilities had an exclusive procurement arrangement with any pharmacy, which allowed facilities to procure from any pharmacy. The assessment did not ask about the size of order per pharmacy. Medicines were purchased by facilities through a variety of means, and all facilities stated that they were always searching for the best prices available locally. For most facilities in the assessment, many telephone calls were placed to pharmacies, and those with the best prices were selected for that particular procurement. All facilities obtained medicines over time from at least two to four different sources as prices shifted. The facilities were all highly price sensitive when it came to procurement.

Health facilities were generally offered a one-month credit by pharmacies, but many health clinics were not taking advantage of this:

*Will go sometimes once a week and will buy medicines in bulk. All cash, prices are higher for buying on credit. —Health clinic key informant*

*Pharmacies offer credit options but we do not take it; we do not want to risk going in debt and risk our reputation. —Health clinic key informant*

*Would want to buy the drugs on credit, but don't now because of the [economic] atmosphere. Right now no one wants to trust anyone, and no one can trust anyone. —Health clinic key informant*

The explanation for this was that facility owners did not want to be in debt, nor did they want to risk their reputation by not being able to pay. Due to the poor economic climate (denoted to be the currency crisis) and the non-payment and/or slow reimbursements by some private insurance companies, facilities were waiting to buy medicines until they absolutely needed them, as they did not have a consistent cash flow. They waited until they had obtained a large enough amount of cash from clients to procure enough for one to three months. They then felt secure that they were not going to fall foul by paying on credit. It may be assumed that this was linked to the worsening exchange rate: medicines were purchased by wholesalers/importers in fixed US dollar rates but bought by clients in Liberian dollars. As the exchange rate worsens, prices in Liberian dollars increase and, ultimately, facilities face higher prices to procure the same medicines. There were a number of facilities sourcing medicines from other countries, such as Ghana and European countries, either by way of personal networks or through building relationships with wholesalers abroad. A small number of facility key informants were also

purchasing high quantities of non-prescription drugs and cleaning products from the United States during vacations.

Almost all health clinics, centers, and hospitals in the assessment cited receiving some free commodities and medicines from the MOH, most commonly vaccines and family planning commodities (i.e., implants and injectables).<sup>1</sup> This process operates directly between county/district health teams and individual private facilities. The appropriate forms are completed, the drugs are dropped off directly at the facility free of charge, and services are reported every month. Those that do not comply with reporting stop receiving free commodities. Many facilities recalled that until about two years previously, they used to receive free malaria medication from the MOH.

*Commodities [certain ones] are all free. We go to the county health team, and they give us a form to fill, they ask for patient records, and you enter how much you need. HIV, FP [family planning], IUDs. People who get these services will come back. —Health clinic key informant*

The National Catholic Health Council is currently exploring options to establish a revolving drug fund for the 23 health facilities in its network.

## 4.11 Private Human Resources for Health

As outlined in Section 3.3, Liberia falls short of having the WHO-recommended number of health workers at every level. The shortage of physicians alone places constraints on the growth of the private sector by way of the licensing requirements. The quality of care is also affected by the lack of continuing medical education once health workers exit the public sector.

### 4.11.1 Human Resources

Physicians are more numerous than specialist physicians, but still far short of the WHO-recommended figure. Of the 19 health clinic key informants interviewed, only three had a specialist on call or at their disposal. All cited having a general physician on call due to their licensing requirements. Two of the clinics had an optometrist on call, and one had an obstetrician. Only one health center out of nine had an obstetrician on call. Both hospitals had specialists working either at the facility or on call: one hospital had two surgeons and two obstetricians on call, while the other hospital had a surgeon on call and an obstetrician and pediatrician on staff. Both hospitals also had general physicians on staff, while clinics and health centers generally only had rotating physicians. Some physicians on staff had additional work and were in teaching posts. Physicians had access to regular continuing medical education, which was offered via the LMDC; a mandatory amount of credits is required to maintain the professional license. Only specific cases are exempt from this requirement, such as becoming the Minister of Health, for example.

Physician assistants are nonphysician clinicians who function under the supervision of doctors. Given Liberia's shortage of physicians, there appears to be a limited amount of doctor-led supervision. Physician assistant graduates train for three years in both theoretical and clinical activities and can perform all medical activities with the exception of surgery. They do not have

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<sup>1</sup> Since publishing this report, the supply of free commodities has ended (December 2019).

career progression in Liberia, and there are no specialist or subspecialist programs. The only training is the three-year certificate program (Oliphant, 2015). Almost half of the health clinic owners surveyed were (male) physician assistants.

The nurse workforce is comprised of three groups: nurses, nurse-midwives, and nurse assistants. Although they are the most numerous health workers in Liberia, their numbers are still insufficient according to WHO recommendations. Health clinics in the assessment had an average of 3.6 nurses per facility, centers had an average of 7.4 nurses, and both hospitals had an average of 40.5 nurses per facility; these numbers do not include nurse midwives and nurse assistants. There are currently four nursing programs available in Liberia, and additional programs are under discussion. For example, one physician assistant interviewed was currently in the preparatory phases of developing a new training program. It is unclear whether this would need to be authorized by the MOH.

As part of the assessment, some nurses expressed dissatisfaction at the lack of career progression in the nursing profession. The number of trained nurses entering the market is reported to be increasing at a faster rate than the number of available nursing positions. Moreover, there is limited opportunity for existing and experienced nurses to progress in their career and increase their salary. This saturation in the market may lead to disgruntled nurses, particularly among those who are more experienced. The medical brain drain also affects the nursing human resources available. A 2013 report indicated that 55 percent of Liberian health-workers emigrate (Kollar and Buyx, 2013).

#### **4.11.2 In-service Training**

In-service trainings were desired by all private health facilities to upgrade and maintain staffing capacity. The district health officers are responsible for informing facilities and owners about upcoming public trainings. The trainings appeared to happen only once or twice a year, and facility owners said that they were either not told about them or were told about them at the last minute.

*I would like to see changes in training. Trainings are not inclusive; it is under the table. They never reach out to with trainings or contact us through WhatsApp and such. — Health clinic key informant*

Respondents from half of the interviewed facilities reported receiving a variety of external trainings in the past year. These external trainings were offered by the MOH, the Liberia Medical and Dental Association (LMDA), nursing schools, and NGOs. Eight of the 15 facilities that reported receiving external training received their training from the MOH. Trainings through the MOH are supposed to be publicized via the DHO teams. However, respondents reported being told of them at the last minute and being unable to spare staff members to attend—or they did not hear about the trainings at all. Facilities, including clinics, were sometimes asked to host MOH trainings, and occasionally DHO teams requested other private facilities to send a certain number of staff members to such trainings. Topics included the Expanded Program on Immunization training, HIV, malaria, post-Ebola, and infection prevention and control.

However, other facility owners received notifications of such trainings far in advance. The notification appeared to correlate with how well known they were by the district health officers/county health officers:

*We do attend training with the public facilities, trainings like safe quality health service, and infection prevention and control, and the Ebola treatment and management which was post Ebola crisis and HIV awareness. They are held at the Ministry of Health or at a public hospital. We are notified through the district health officer, ahead of time, usually a week or two prior to event. —Health clinic key informant*

In-house service trainings were offered by 13 of the 30 facilities in the assessment. These in-house trainings were described as staff meetings or training on an individual basis during general rounds, where more experienced staff trained new staff. Training topics mentioned included updated protocols, emergency care, bedside manner/customer service, and immunizations. Facilities stated that these “trainings” happened as often as once every month, or at the very least once per quarter. Major challenges in delivering in-service trainings in-house were the cost of materials, the willingness of the staff to train, documenting minutes, and sharing updated information among all staff.

Facility owners were asked what training needs of any kind had been identified at their facility from which they would benefit. From the 18 facility owners who responded, 13 different areas were cited, including malaria, HIV and tuberculosis (in one facility only), counseling, screening and treatment guidelines, updated SOPs (e.g., for administering vaccines and offering maternal and child health services), human resource management, quality of care, financial management and administration practices, and emergency care. The training areas with the most interest were customer service and quality of care. Access to updated SOPs and emergency care were the second commonly cited training need.

## 4.12 Health Information

Private registered facilities are required to complete the Health Facility Monthly Report the first week of every month. This report collects information on the number of deaths, births, commodities used, and number of infections, among other things (see example in Annex E). The Expanded Programme on Immunization Vaccination Requisition Form that outlines the number of vaccines given is also collected from all facilities on a monthly basis. This report helps the DHO teams calculate the number of vaccinations needed for the subsequent month(s). The DHO teams also inspect in-house pharmacies for those registered to receive free vaccines as part of the Expanded Programme on Immunization.

However, the delivery of vaccines from the MOH was reported to be inconsistent, with delivery delays of up to a year. Facilities were expected to fill out a large ledger at the end of each day with the information required, and once a month the owners/providers transferred the data from the ledger into the report. There were different ledgers for different services, such as obstetrics services and vaccinations. The district health officers were known to check the ledgers when they visited.

District health officers performed general checks of facilities up to three times per month, but this varied depending on the facility. The district health officers’ responsibilities included

speaking with staff, checking whether procedures were being followed, and making suggestions that they expected to be implemented. Facilities indicated that the district health officers did not always do this complete assessment or provide much support:

*They came last week and said we have to tile the facility, but they don't provide support. They said they will be back in two weeks and check.* —Health clinic key informant

For more information on health information reporting, see Section 8.3.

## Key Takeaways

- Limited access to affordable electricity affects the private sector's ability to deliver quality health services, including limiting access to cold chain for vaccine storage. It is also affecting the public sector's ability to deal with complex labor and delivery cases.
- Health licensing requirements could be enhanced through transparent processes, and they could be streamlined to become more efficient; guidelines around visibly displaying licenses at facilities could help build awareness among communities of MOH-authorized private facilities.
- Ownership of health facilities is limited to physicians, which limits the ability for the sector to expand.
- SOPs disseminated to the private sector and inclusion of private providers in MOH trainings may help support improvement of the quality of care in the private sector.
- Almost all services are financed through out-of-pocket payments. The expansion of strategic purchasing schemes could assist with expanding access to poorer segments and decrease the likelihood of catastrophic health expenditure.
- The provision of public commodities is made available in some private facilities. The development of procurement guidelines can strengthen and expand access. Abolishing the rule that the private sector cannot charge a registration/service fee for providing these services, particularly for those who can pay, may encourage more widespread and sustained offering of these services.
- Basic referral systems (referral forms) are in place and could be much improved through effective dialogue between the public and private sector.
- Access to financing to improve and expand health businesses is limited, and businesses are currently self-financed.
- All Liberian medicines are imported and procured in US dollars. The impact of a volatile Liberian dollar against the US dollar is driving increased prices for medicines, as well as higher prices for C-sections.
- Private sector health data are being collected by the public sector. Dialogue between the public and private sector can contribute to building ongoing communication that demonstrates to the private sector how these data are being utilized.

## 5. Laboratories and Diagnostic Centers

Medical laboratories play a crucial role in the detection, diagnosis, and treatment of any illness the patient experiences. There are a small number of advanced laboratory testing and medical imagery services available in Monrovia, and key informants from three laboratory and diagnostic centers were interviewed as part of this assessment. These diagnostic centers also had a clinical practice as a separate business unit, but only their laboratory and diagnostic services were assessed.

The laboratories/diagnostic centers included in the assessment had commenced operations within the last three years and launched parallel clinical services at the same time. As such, these facilities offered a full range of in-house services to clients. However, their laboratory testing and imagery services were also made available to external clients. They offered imaging and diagnostic services not readily available across Liberia. Respondents noted that among the services were those commonly sought abroad by individuals who could afford them. One center stated that 20 percent of their work was lab referrals, another 20 percent was clinical work, and 60 percent was the importation and distribution of medical equipment. It was common for these businesses to have several different arms of operation. If tests could not be processed in-house, the centers sent them abroad. Facility referrals for lab tests were not only going to these specialized centers, but clients were also being referred to health facilities that had invested in a robust in-house laboratory (facility-to-facility referrals). St. Joseph's Hospital, for example, had the largest in-house laboratory among those assessed and could receive referrals from the surrounding area. These facility laboratories did not form part of this assessment.

Of the three diagnostic centers in the assessment, one established in 2019 was fully financed by the National Social Security and Welfare Corporation (NASSCORP) and aimed to generate profit to return to the social security fund. In this case, the board was comprised of both private and public officials. Another center was originally financed with a small loan from a German diagnostic equipment provider. Others were self-financed or financed by their family (as a family business). The diagnostic centers supplying medical equipment were generally an exclusive supplier of one brand of equipment.

### 5.1 Licensing

Similar to health facilities, diagnostic centers are required to pay fees to LMDC, which in turn is required to perform checks at the diagnostic centers to assess the standards. All respondents suggested that LMDC's assessment guidelines needed strengthening, as the centers had been made aware that their standards were higher than the national standards. Two of the three diagnostic centers interviewed were working toward ISO/IEC 17025 and ISO 9001 standards.

All diagnostic centers pay a US\$100 fee to LMDC for their annual license to operate, despite their ability to pay far more than this. All of the health staff employed are required to have up-to-date licensing, which is checked by LMDC. In-service training is commonly offered internally, as none is available externally. Continuing medical education credits can be offered in some cases through partnership with LMDC.



## 5.2 Ownership and Management

Aside from the NASSCORP-initiated center, all were privately owned.

## 5.3 Productivity and Utilization

Private facilities refer their patients to the diagnostic centers for diagnostics that go beyond the standard tests the referring facility is able to offer, such as malaria, hemoglobin, and urinary and stool analysis. For example, as the diagnostic centers in the assessment all had health facilities attached, one cited its most commonly accessed lab test as malaria rapid diagnostic tests. During referrals, samples are transferred in coolers by motorbike, or the clients walk in and samples are taken in person. The diagnostic facilities, which service many referrals, have a courier who collects samples at the same time every morning and then drops off the samples within one day. On average, about 2 percent of the cases cannot be addressed by the center and are referred internationally, often to labs in India or South Africa.

In addition to clinical work and servicing laboratory referrals and requests, some laboratories also import and distribute diagnostic and medical equipment, such as reagents, rapid test kits, and medical equipment such as biochemistry analyzers to both public and private health facilities. The importation process is the same for pharmaceuticals (Section 6.5) and is monitored by the Liberia Medicines and Health Products Regulatory Authority (LMHRA), but there is no sample testing. Imaging devices are purchased directly from the manufacturers. All are charged duties at 2 percent, except the larger equipment like computerized tomography (CT) and magnetic resonance imaging (MRI), which are exempt from duties. Equipment can come in by land or by sea. Given that there is no storage facility at the port, equipment must be picked up at the time of arrival.

All diagnostic centers assessed expressed their interest in new public-private partnerships, and all had the capacity to grow their businesses. None were currently working at capacity, and it may be assumed that they will be largely reliant on the public sector for any significant growth.

## 5.4 Pricing and Payment of Services

Fees for services at diagnostic centers ranged from US\$40–50 per consultation, and these centers mostly served private insurance clients, for example, under CIGNA, Omega, Activa, and SAAR. Opening hours for the lab/diagnostic centers were Monday–Friday or Saturday, 8 a.m.–5 p.m. One center was open 24/7. These centers offered services that were currently largely unavailable in the public and private sector, such as CT and MRI scans.

Pricing varied depending on the mode of referral. For clients being referred by the public sector and FBOs (JFK and Christian Health Association of Liberia), discounts of up to 35 percent were offered for services. However, the majority of their clients were referred from the private sector and either paid out-of-pocket or had access to private health insurance.

## 5.5 Financing

Access to finance is a challenge for this sector. Aside from the NASSCORP initiative, the launch and expansion of these businesses were all self-financed. Some were family-driven businesses.

## 5.6 Access to Human Resources for Health

Staffing for diagnostic centers was sought from within Liberia, and all health staff were required to be licensed. However, all centers in the assessment also employed staff from abroad to fill staffing gaps, and telehealth was used in some complex cases where specialists were needed. One diagnostic center cited foreign companies, such as CT Care and Linen Diagnostics, as companies looking for experienced and qualified laboratory and diagnostic partners in Liberia to expand their range of products and equipment:

*Companies want [their clients] to have a profile. They require [their clients to have] a tech degree, a system for servicing, and a quality control manager and an IT system. —*  
Laboratory and diagnostic center key informant

Historically, Liberia has had training only for laboratory technicians; there has not been any lab technology program. Recently, however, it began a laboratory technologist academic program, and graduates are beginning to enter the marketplace (see Section 7.3). One center trains local personnel in radiography then offers them a position at the facility. Any technologist they train is “bound” to them and must work exclusively for the facility for a fixed period. This bonding is noted to be an operational practice, not a legal requirement.

Along with the importation and selling of equipment comes the responsibility of servicing the equipment. Some equipment manufacturers have no technicians in Liberia to service their equipment, and it has been expensive to fly them in. As such, the facilities in the assessment were beginning to prioritize having service engineers in-country to at least be able to update software and fulfill basic servicing requests. Respondents indicated that the public sector does not fully understand this level of servicing, and they do not take this cost into consideration when purchasing equipment. As a result, pricing of equipment is competitive on the purchasing price only, as there is limited availability for servicing.

### Key Takeaways

- Private (standalone) diagnostic and laboratory centers offer services paid out-of-pocket and through private insurance. The pricing limits the availability of services to wealthier clients.
- Accreditation guidelines and ongoing monitoring for specialized centers could be improved through alignment with and training on international standards.
- Access to qualified, specialized personnel is limited and is addressed through employing staff trained outside of Liberia.
- Access to staff able to service medical equipment is limited.

## 6. Access to Essential Medicines: Pharmaceutical Wholesalers/Retailers

### 6.1 Pharmaceutical Product Market

The pharmaceutical market in Liberia is led by a few private companies that import and operate also as wholesale distributors. Liberia does not have any pharmaceutical manufacturers. The primary companies in the market are BK Pharmacy, Bunty Pharmacy, and Lucky Pharmacy. The assessment team interviewed two of these companies as a part of the non-facility key informant interviews—BK and Lucky Pharmacy. BK Pharmacy made up about 50 percent of the market share nationally and around 60 percent in Monrovia. This was a family-owned business, with 32 years in the Liberian market over two generations. It owned two branches, one in Monrovia, and had a fleet of one truck and two smaller vehicles. Another pharmacy, Lucky, owned a smaller market share. It had a fleet consisting of one large truck and four smaller vehicles but no other retail units. As both pharmacies had their own fleets, they were able to deliver same-day orders made by phone or email. Their fleets were also able to provide cold-chain storage for transportation.

These companies imported from up to 40 different pharmaceutical companies, had 40 employees or more, and had one or more warehouses (around the country). Pharmacy branches employed a few pharmacy technicians, while the pharmacy owners managed the administrative and business aspects.

Pharmacies imported all medicines and commodities, which ranged from malaria test strips, artemisinin-based combination therapy, the emergency contraceptive pill, and occasionally condoms, though these tended to be sourced from Liberian-based NGOs. Pharmacies reported that because the government provides family planning commodities, they therefore did not import these products. Vaccines were provided on demand only, primarily during periods of scarcity, and with a limited amount of stock. Some pharmacies noted that there could be shortages of doxycycline, but they did not report experiencing any other shortages of drugs. Because pharmacists are not allowed to administer injections, intravenous fluids, or perform screenings, these services were not offered. Those sampled reported that in other West African countries such as Sierra Leone and the Gambia, registered pharmacies can administer procedures if a prescription is provided. This appears to be a desirable way of working for Liberian retail pharmacy owners.

### 6.2 Pricing and Discounts

Most pharmaceutical companies in Liberia serve a wide range of clients: private clinics and hospitals, NGO-operated facilities, the United Nations, retail pharmacies (that are registered and have a government-issued identity card), drug shops, and retail outlet(s) where they sell directly to the consumer. In some cases, they sell to the public sector. All prices are fixed and non-negotiable. NGOs are offered wholesale prices, which result in a discount of 2 percent to 5 percent. Similarly, clients who offer a cash down payment are offered a discount of 5 percent. A 30–60-day line of credit is offered as standard, with no minimum order required. Invoices to the private sector and NGOs are generally paid on time. However, orders need to be paid in full

before the entity can order again, to guard against non-payment. Pharmacies reported that government payments are often delayed, sometimes for more than a year. One pharmacy reported that it sells to public sector facilities, but it anticipated never getting paid.

*Right now, customers are taking me as a financier. Hospitals [public] can't pay, but they source all of their drugs from private pharma on credit.* —Pharmaceutical importer/distributor key informant

Pharmacies in the assessment reported adding a 25 percent to 30 percent markup for clients for all but Asian drugs. Around 70 percent of their medicines were generic. Slow-moving products could incur a 35 percent markup, while Asian drugs, which were sourced at a lower cost overall, may have a markup of 50 percent to 60 percent. These markups represented industry standards, as each pharmacy offered very similar prices. Pharmacies assumed that health facilities were adding an additional 20 percent to 25 percent markup.

At the facility level, constrained cash flow and overextended credit create artificial stock-outs. The SARA found that only 44 percent of health facilities had essential medicines in stock for treatment of illnesses (GOL, 2018b). However, all pharmacies interviewed reported having infrequent or rare stock-outs, and health facility key informants confirmed that stock-outs were not a challenge. The challenge of accessing medicines at the service delivery level is likely to be due to the rising price of medicines (imported products are fixed in US dollars) and the overextension of bad credit from pharmacies to facilities and private insurance companies to premium holders.

### 6.3 Access to Business Financing

Accessing financing from financial institutions is not common now, nor was it common when these businesses launched years ago. The market leader was financed from profits taken from a family cotton factory in northern India. Other pharmacies in the assessment were similarly self-financed. All owners interviewed were non-Liberians, which may have limited their access to reasonable rates and certainly resulted in more inspections and overregulation. As for other health stakeholders in Liberia, loans from financial institutions are not easily accessible or desirable. Some respondents described strict financing terms, high transfer charges, and 3 percent to 5 percent in “extra fees.”

*If we went to the bank for finance, we would be bankrupt... Financing is not easy here.* —Pharmaceutical importer/distributor key informant

### 6.4 Regulation

The Liberia Pharmacy Board regulates the retail side of this business. The LMHRA oversees the process for the registration of new drugs. The LMHRA and the Liberia Pharmacy Board perform random inspections of pharmacies. Respondents indicated that inspection occurs one to two times per year, and the pharmacies are given advance notice of their arrival. In Liberia, it was cited that there are more than 200 retail pharmacies and 1,500 medicine stores, all of which are regulated by the LMHRA and the Liberia Pharmacy Board.

LMHRA was created through the Liberian Medicines and Health Products Regulatory Act in 2010. The role of the LMHRA is to issue licenses for the import, export, supply, storage, and

distribution of medicines and health products. Moreover, it is meant to inspect, register, and test medicines, ensure quality control, and regulate clinical studies. The Liberia Pharmacy Board was originally established to inspect pharmacy retailers and issue licenses for the retail distribution of pharmaceuticals, as well as issue licenses for pharmacists and dispensers.

Registering products with the LMHRA can be a laborious process, taking anywhere from six months (known as a “fast-track” procedure) to two years (known as the “regular procedure”) per product. Importers try to move along the process with the LMHRA, which is facilitated by their importing permit only needing to be renewed every three years. Once the products are registered, each distributor receives a certificate per product from the LMHRA, and then all distributors can sell the product.

## 6.5 Pharmaceutical Importing

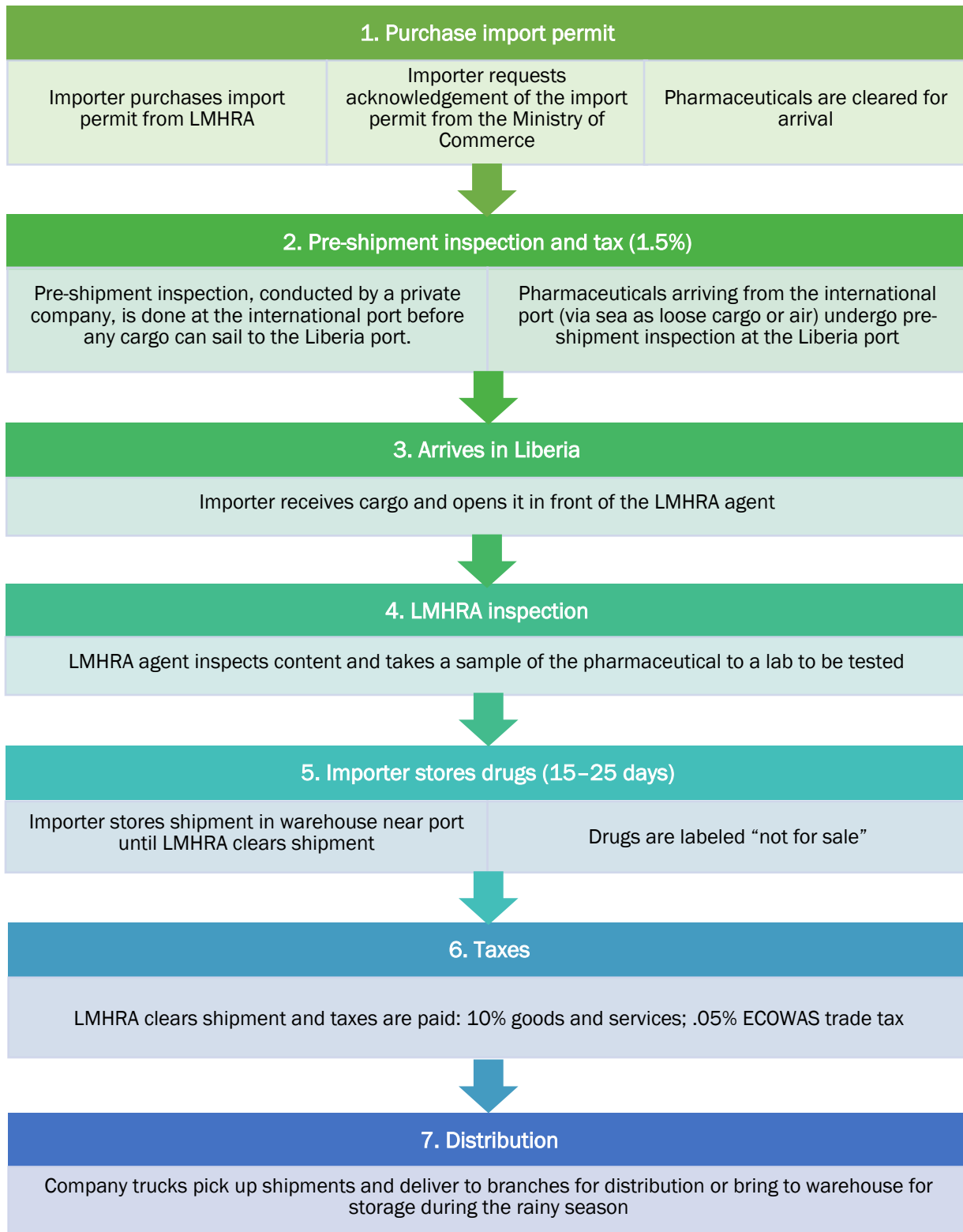
The importation process of pharmaceuticals into Liberia is diagrammed in Figure 22. The process begins when pharmaceutical importers request permission from the Ministry of Commerce and Industry prior to importing specific goods from a particular country or trading zone; the request must include the quantity and quality of the goods to be imported. These written requests accompany the invoice and bill of lading. After receiving the import authorization, the importer purchases an import permit declaration from the LMHRA (formerly the Ministry of Finance and Development Planning). All shipments must go through a pre-shipment inspection either at the point of origin for shipments overseas, or at the point of destination for cargo traveling by air. Pre-shipment is organized by importers through a pre-shipment inspection company like Bureau Veritas, Inspection, Valuation, Association and Control (BIVAC), at a cost of 1.5 percent of the shipment's value. These inspections are required for goods valued at more than US\$3,500. If these pre-shipment inspections are not undertaken, the penalty for importers is around 10 percent to 30 percent of the shipment's value (U.S. Department of Commerce, 2019). When the process is complete, the import permit declaration is issued and the import is approved.

Once the cargo has arrived in Liberia, the importer is responsible for taking possession of the cargo and presenting it to the LMHRA agent, whose job it is to inspect the contents of the cargo and test a sample batch of drugs. The LMHRA follows a sampling schedule for the various pharmaceuticals; some types require larger samples than others. While the cargo is being tested, the importer must store the cargo, sometimes in temperature-specific warehouses, until clearance is given by the LMHRA. This can take 15–25 days. Importers can move this process along and retrieve their shipment sooner, but at a greater cost to them, which is ultimately passed on to the consumer. After customs is complete, importers present costing information to the Ministry of Commerce and Industry for price approval. Some items are exempt from import duties, but pharmaceutical products are not.

During the assessment, there were reports of computer shortages that caused paperwork issues at LMHRA, resulting in indirect fees being paid to solve the containment of their shipments and the issuance of the import permit declaration. One pharmacist described the process at LMHRA as, “It’s a mess over there.”

*In the name of regulation, a lot of bad things are happening.* —Pharmaceutical importer/distributor key informant

Figure 22. Importation Process for Pharmaceuticals Entering Liberia



Once the cargo is cleared by the LMHRA, the Liberian Revenue Authority collects a 10 percent goods and services tax and a 0.5 percent community value-added tax issued by the Economic Community of West African States (ECOWAS). However, retailers selling Liberian-made products do not have to pay this goods and services tax up front and can instead collect it through taxing their customers and submit it to the Liberian Revenue Authority later. At present, there is no pharmaceutical production capability in Liberia.

Drugs are usually brought in via the port. Life-saving medicines and those that require cold chain are brought in via DHL. All medical supplies from syrups to syringes, injections, and latex gloves are imported into Liberia from China, India, and Europe, but not from North America due to higher prices.

## 6.6 Counterfeit Drugs

In Monrovia, there were no reports of counterfeit drugs being distributed, and facilities did not observe any counterfeit peddlers in their areas. However, some respondents mentioned that illegal products are entering the market, particularly in rural areas. Counterfeit drugs using fake brands were cited as entering the market via the porous borders and, as regulatory and importation fees are not being paid, are sold at low prices. It is noted that there were reports of LMHRA seizing non-certified or counterfeit drugs in areas of Monrovia and Montserrado in July 2019 (Front Page Africa [FPA], 2019).

## 6.7 Working in Partnership

Any essential medicines that are classified by the MOH, which include tuberculosis treatment and antiretrovirals, are not allowed to be imported by private companies as mandated by the central procurement agency for Liberia, Central Medicines Store.

*Antiretrovirals should belong to the private sector, but they are limited to the government, so we have no incentive to provide them. —Pharmaceutical importer/distributor key informant*

Artemisinin-based combination therapy for malaria treatment is also provided by the public sector for free, but pharmacies still imported these because they believed the market was large enough to still produce a profit. The government of Liberia sources vaccinations mainly from UNICEF and other NGOs; however, when stock runs low, the government asks pharmacies like BK Pharmacy for help, as private pharmacies are known to be able to source them more quickly. When importing commodities, the private sector has a 20 percent to 22 percent total tax levy, while the government imports commodities tax-free. The private pharmaceutical market reported facing competition from NGOs, which are distributing subsidized family planning products; NGOs such as DKT International are selling family planning commodities in Liberia together with free in-service family planning training. As a result, some private pharmaceutical importers are not importing all family planning products, but only emergency contraceptive pills and condoms. Additionally, there are other NGOs, such as Population Services International, that are subsidizing branded condoms and selling them to pharmacies for retail use.

Partnerships between the government of Liberia and private pharmacies that extend beyond procurement were explored in the past, including a public-private partnership on the storage of

essential medicines in hard-to-reach areas. Lucky Pharmacy, an importer and distributor with storage facilities in 10 counties across Liberia, was approached by the government a few years ago with an offer to buy storage space for DHOs as they deliver commodities to county hospitals. This was to solve the challenge faced by the government in last-mile distribution in areas cut off during the rainy season. Respondents suggested that private pharmacies like Lucky did not suffer from supply-chain issues. There was lengthy dialogue about this in the past, but the public-private partnership was never put into place. More recently, there has been some desire for a public-private partnership on the part of the government of Liberia around last-mile commodity transportation. Allegedly, the MOH struggles to transport all pharmaceuticals securely from the port to its destination; MOH vehicles may be looted while in route, and it has been noted that the private sector does not seem to face the same issue. The government of Liberia may benefit from creating a public-private partnership to leverage private pharmaceutical distribution assets: (cold-chain) storage capabilities and last-mile distribution in hard-to-reach areas.

## Key Takeaways

- Cost-effective stock management and procurement practices are hampered by limited access to working capital, resulting in procurement “as needed.”
- Inefficiencies in importing processes result in increased costs and delays for clients.
- Public-private partnerships to improve areas like last-mile distribution of public commodities could be developed through effective dialogue between the public and private sector.



## 7. Enabling Environment

Health service delivery relies on inputs from various market sources, from pharmaceutical supplies to qualified human resources and formalized access to referral networks, among others. Taking a total market approach means identifying, addressing, and solving health market inefficiencies, using segmenting strategies to focus public funding on those most vulnerable or to expand the market, while strengthening government stewardship of the private sector. The private sector in Liberia has a weak enabling environment, which affects the services delivered; however, there are several inroads to enable the strengthening of *existing* mechanisms to enable a stronger mixed-health-system approach. This section includes an overview of the financing schemes available, access to commodities and capital, and public sector oversight of and collaboration with the private sector, as described by the two key insurance companies, four health associations, and two regulatory bodies whose representatives the assessment team interviewed as key informants.

### 7.1 Financing Private Health Services

In Liberia, formal sector workers are covered by either a government-run social security scheme for employment injury or medical insurance from private insurance companies or concessions (health facilities owned and operated by corporations). For medical insurance, individuals are required to pay monthly premiums from salaries, which are generally matched by the employer. Medical insurance covers the employee and dependents (one adult and up to four children). The 30,000 employees working in the various rubber, palm oil, forestry, and mining sectors in Liberia receive care by way of employer-owned and -managed health facilities on site (concessions). Given the small size of the population, this situation limits the opportunity to have large risk pools if these workers are separate from the general population.

#### 7.1.1 Private Insurance

In Liberia, there are currently a total of 19 private, licensed, for-profit insurance companies, with most offering both life and non-life insurance services (e.g., property and car insurance). Health insurance is offered by 18 of the companies, and it is estimated that claims ratios, or the percentage of claim costs incurred in relation to the premiums earned, are around 65 percent to 70 percent, with a 22 percent gross administrative expense ratio. The sector is licensed and regulated by Liberia's Central Bank, under the Insurance Act of 2013. In 2017 and 2018, claims related to medical insurance schemes were estimated to be around US\$6.3 million. Of all insurance premiums collected in 2018, approximately US\$12.4 million were received from medical and life insurance

#### Box 3. Summary of Liberian Private Health Insurance Market

- 19 total private, licensed companies in Liberia (2019)
- 18 companies offer health insurance (2019)
- Regulated by Liberia's Central Bank
- Medical insurance claims estimated as US\$6.3m (2017 and 2018)
- Of the US\$31 million in premiums collected in 2017, 41 percent were from medical and life insurance
- Penetration rate of private health insurance: 3 percent of the population (2019)

Source: Jackson, unpublished

schemes, representing around 41 percent of industry-wide premiums (Jackson, unpublished) (Box 3). Despite health insurance often being a less profitable line of business for insurance companies, the private sector's contribution as a percentage of total health expenditure grew from 2 percent to 3 percent in FY 2013/14 to 8 percent in FY 2015/16 (ROL, 2018). It is unclear whether the growth of the private sector contribution to total health expenditure is from a growth in private insurance.

The health insurance industry in Liberia is playing a significant role in the delivery of healthcare to formal workers. However, in terms of broader population coverage, there is a long way to go. Only 3 percent of the country's population has access to private health insurance through group medical insurance schemes. For informal workers, the options are highly limited, as no insurance company has products available for individuals. In 2017, a consumer preference market research study was conducted in one-third of Liberia's counties and found that respondents' monthly household health expenditure was between US\$20–60 in households with incomes below US\$150. The study concluded that 82 percent of respondents (n=50) favored some form of insurance and prepayment schemes, and more than two-thirds agreed to contribute between US\$1–2 as a monthly insurance premium (Collaborative Support for Health, 2017).

Of the 18 companies offering health insurance, one company respondent stated that it had the largest market penetration, covering 6,934 primary insured and an additional four dependents per policyholder. This company reported that it was very selective when determining which government agency tenders it bids for, mainly working with those that are semi-autonomous, such as the Liberian Revenue Authority, which has its own source of income. The respondent cited that “most” Liberian ministries do not pay their premiums at present. Their other clients include a select number of private clinics, NGOs, corporations/concessions, and multinational corporations such as Total Oil. Much of their new business is derived from referrals from multinational corporations.

Neither of the two companies included in the assessment made any marketing materials or pricing lists of packages available to the assessment team. Some prices were found displayed for clients in a health facility (Annex C). Online information was also limited. Based on the key informant interviews, there appears to be limited innovation across the sector in pricing; there is generally one fixed package offered, and the premium varies according to the coverage offered. The coverage of packages across the market is broadly consistent and includes inpatient and outpatient services, including surgery, maternity (including prenatal and limited postnatal care), dental, and travel insurance. There are maximum allowances fixed for outpatient visits (see Annex F). No family planning services are included.

Despite the need for an expansion of the sector to cover a broader segment of the population, products are designed only for group insurance. In addition, it was suggested that access to health services through private-insurance-accredited providers is limited by the insurance companies. One insurance company included in the assessment accredited only 30 facilities because “it's less work” and suggested that accrediting 10 facilities would be optimal.

Private insurance companies' accreditation conditions for contracting new facilities are:

1. The facility must already be licensed with LMDC.
2. A physician (medical doctor) must be part of the staff.

3. The facility must have a “clean” environment; the checklist commonly used includes an assessment of access to electricity and waste management procedures.

There is no fixed schedule for monitoring compliance after accreditation (aside from LMDC monitoring visits throughout the year).

One insurance company expressed some challenges, including the pricing of accredited facility services being too high. One suggestion was that prices change daily to respond to currency fluctuations. With the current exchange rate volatility, prices billed in Liberian dollars but charged to insurance companies in US dollars may vary dramatically from one month to the next. Some insurance companies use paper-based systems to track patient claims and detect fraud, limiting both the efficiency and scalability of private health insurance.

Another challenge raised was that the largest employer of formal workers, the government of Liberia, had not paid its premiums in three months because “they don’t have the money.” The Ministry of Finance, which offers a 50 percent contribution to employee premiums, was cited as not having paid its premiums in the preceding six months. One private insurance representative expressed frustration with the current climate and hoped that the future would be different. This seems to be a shared sentiment, and presumably, no company wants to eliminate coverage for those contracts in arrears, as the government of Liberia in totality is a lucrative and potentially large share of their portfolio. The burden of non-payment is being pushed to the health providers, who are still delivering services for privately insured clients (see Section 4.6.2).

In response to experiencing wide disparities between what insurers claimed were due from policyholders and what the policyholders actually owed due to poor recordkeeping, the Central Bank introduced a “no fee, no play” regulation (“No Premium, No Cover” policy) in 2016 (ROL, 2016). Only when at least 50 percent of the premium has been received directly by the insurance company can insurance coverage begin and services be sought by beneficiaries. Despite the challenges with recouping lost revenue from governmental agencies, insurance companies continue to maintain the validity of insurance cards, or, at least, they do not inform the facility that coverage has been invalidated. This is in part because the insurance company anticipates receiving the full amount in arrears at some point in the future, and in part because they compete annually for these large contracts that make up the bulk of their business. However, insurance companies have not always honored the reimbursement of claims from accredited health facilities. This lack of coordination places the burden of non-payment on the private health providers, who are now struggling to maintain their cash flow due to very lengthy reimbursement periods. Providers, in turn, complain that insurance companies are not reimbursing them and so are charging more per service as a premium for delayed or potential non-payment. While the facilities call this a “premium” charged to insurance companies in response to the current uncertainty, the insurance sector describes this higher charge for service as “fraud.” Providers know which insurance companies are slow to reimburse them or have not reimbursed them for several months and have subsequently decided to decline those insurance cards.

*While the facilities call this a “premium” charged to insurance companies in response to the current uncertainty, the insurance sector describes this higher charge for service as “fraud.”*

In 2018, in response to the lack of growing market penetration and the increasing number of insurance companies, the Central Bank issued guidance on capitalization requirements. Capitalization requirements are regulated by the Central Bank and require companies to hold a minimum level of cash in reserve to cover business operating expenses. These requirements discourage riskier investments, reduce the risk of insolvency, and therefore protect consumers from losing their health coverage. Since March 2018, all insurance companies with composite businesses have been required to maintain US\$1,550,625 in reserve and a separation of technical units to manage the businesses separately. The Central Bank strongly encourages the separation of life and non-life insurance and requires a sum of US\$525,000 as required capital resources for operating a life business (Central Bank of Liberia, 2018). One insurance company was undercapitalized and an external administrator was put in place. The process to liquidate and close the company has apparently stalled due to political changes in the government of Liberia, resulting in a lengthy (and costly) administration period.

Though the Central Bank has taken steps to regulate and educate the Liberian insurance market, insurance providers still believe the government of Liberia is not doing its part in maintaining transparency within the insurance market and increasing market penetration. Without the government's help, data from insurance companies are not transparent and partnerships are more difficult to establish. Mistrust and the need for transparency extend beyond the insurance providers and are present at the client level. Without any mandatory patient screening, deductible, or risk-adjusted premium, it is difficult for insurance companies to increase their client pool and to trust that fraud will not occur (Jackson, unpublished).

To circumvent the limited enabling environment and encourage market penetration, Activa (a private insurance company) has begun to work on a microinsurance e-health initiative with the telecommunication company Orange S.A. At the beginning of 2017, there were 1.7 million Orange customers in Liberia, with a 70 percent and growing mobile-penetration rate (Orange, 2017). Activa is hoping to work with Orange to tap into the new pool of Liberians and encourage the purchase of personal accident insurance through a lottery system. Every Orange customer who buys US\$100 worth of credits will be automatically entered in a lottery. Every month, a winner will be announced and receive US\$2,500 worth of personal accident insurance for one year. This partnership is currently in the discussion stage and is awaiting signoff from the Central Bank.

The health insurance sector faces uncertain times, with a declining economy and stagnant pool size. Their clients' limited capacity to pay increasingly expensive premiums is placing a strain on insurers. In addition, a USAID study analyzing out-of-pocket expenditure in four West African countries found that health insurance coverage in Liberia was associated with higher out-of-pocket expenditure (Wang et al., 2016). Any expansion of health insurance coverage to poorer wealth quintiles should result in decreasing the likelihood of out-of-pocket expenditure through increased risk pooling.

### **7.1.2 Public Insurance**

A risk-pooling scheme designed by the government and the Liberia Health Equity Fund, was planned in 2013 but put on hold when the Ebola crisis began. The fund could create a sustainable financial pool that provides equal access to quality healthcare and ensures financial protection to both the formal and informal sector of Liberia. Subsequently, the first plan to cover formal workers was rejected by Parliament. Since then, a revised bill was drafted in 2017 and

has been under consideration. It was anticipated that the resolution would be signed in 2018, but the assessment team learned that no progress has been made since 2017. Given this delay, one of the potential main target groups of the Liberia Health Equity Fund, pregnant women and children under five, remains without any safety net.

An NGO based in Washington, DC, Results for Development, has recently announced a partnership with the MOH in an effort to re-issue a bill around the Liberia Health Equity Fund. They hope to successfully estimate the cost of delivering Liberia's essential package of health services to the public, and they plan on working together on new strategic health reform in light of the fund's future implementation. It is unclear whether the Health Equity Fund is to be extended to include the private provision of services. Given the size and scope of access for women and children in Monrovia, it is recommended that this provision be considered early in the process.

## 7.2 Financial Services

Financial inclusion, the ability of all individuals and businesses to have access to useful and affordable financial products and services, is critical in the fight to reduce poverty and achieve economic growth. For the supply of health, access to financial systems enables business expansion. For the demand of healthcare, targeted savings help minimize unexpected out-of-pocket expenditure. The financial inclusion agenda falls under the remit of the Microfinance and Financial Inclusion Unit of the Central Bank of Liberia. It works with microfinance institutions, credit unions, village savings and loans associations, and grassroots organizations. Representatives from the Central Bank disclosed that none of these organizations is working on products specifically for the health sector.

### 7.2.1 Access to Banking Services and Mobile Money

There are nine commercial banks in Liberia. The banks with the greatest number of branches are Liberia Bank for Development and Investment, EcoBank Liberia Ltd., and GNBank Liberia Ltd., with 18, 11, and 10 branches, respectively, as of 2017 (Central Bank of Liberia, 2019a). The lack of physical infrastructure alone makes it difficult for customers to make transactions, especially outside of Montserrado.

Liberia is a predominately cash-based economy, particularly in the private health sector. However, the total amount of (gross) loans has been rising in 2019, reaching LD\$82.6 billion in April, influenced by increased credit to the private sector. Non-performing loans decreased by 9.3 percent in March–April 2019 (Central Bank of Liberia, 2019b). Despite this, access to loans for the health sector was described as largely a process of overcollateralization, with highly stringent repayment terms (see Section 4.9).

As part of the Central Bank's Maya Declaration, it committed to enhancing mobile money guidelines to ensure that mobile financial services reach at least 50 percent of rural Liberians by the end of 2014, as well as increasing the percentage of the population that participates in formal banking to 30 percent by 2016 (Central Bank of Liberia, 2018). In a 2017 Global Financial Inclusion (GFI) poll of 1,000 Liberians on access to finance, 35.9 percent of respondents reported having a bank account, with only 22.2 percent having a mobile money account (World Bank, 2017). In 2017, the volume of transactions through MTN/Orange mobile money accounted for US\$382,231, with projections to grow to US\$759,652 in 2019 (Central

Bank of Liberia, 2018). In 2016, the Deputy Director of the Regulation and Supervision Department of the Central Bank described the opportunities inherent in mobile money as a “great opportunity for improving financial services delivery, promoting the wider development agenda, and increasing adoption to improve customer adaptation, retention and loyalty to this new technology through various educational and informative programs” (Central Bank of Liberia, 2016).

Accessing financial services in Liberia is challenging, and demand-side psychological factors may hinder some progress in the short term. In terms of health, 25 percent of respondents had resorted to borrowing money for health/medical purposes in the previous 12 months (World Bank, 2017). The private health sector primarily operates with a cash-based system. However, as is seen in other countries like Kenya and Nigeria, once mobile money payments become more commonplace among consumers, health business owners are usually keen to adopt these new practices.

### **7.2.2 Microfinance Institutions**

Microfinance institutions provide a type of financial service directed towards individuals and small businesses that lack access to conventional banking services. Providing loans to smaller market actors can be risky, but allowing capital to flow through all parts of the market allows a more robust and inclusive economy to grow. There are 18 registered microfinance institutions in Liberia, operating predominately in Montserrado County. One microfinance institution, BRAC Microfinance, has extended its outreach to counties outside of Montserrado. The Central Bank describes the private health sector as “undercapitalized,” lacking adequate cash flow to carry on basic business and market operations (Central Bank of Liberia, 2018).

During the assessment, one microfinance fund for the health sector was identified. This was not a traditional microfinance institution, but rather a revolving fund of about US\$1 million. US\$50,000 of this was initially designated for the health sector initiative launched in 2018 by Foundation for Women, in collaboration with Benson Hospital (private hospital), after Foundation for Women experienced success in education sector financing initiatives.

Through this revolving fund, a total of 300+ education partners and 50+ health clinics (primary level) have access to microloans that are structured through a stepwise approach. Each first-time loan is between US\$2,000–5,000 and has been used to fund areas such as upgrading the facility, adding a laboratory, stocking a pharmacy, and other enhancements. The fund has recently granted its second round of loans, up to US\$10,000 per facility, which is funding additional expansion and enhancements.

Repayment rates are 100 percent. It was explained that a few loans were at risk of default in the past, but due to the pressure exerted by the rest of the borrowers who paid their loans on time, the outstanding loans were repaid in full. The group of borrowers has organized themselves into a “Network of Excellence.” Members display the network’s logo in their individual clinics. The members meet monthly with partner Benson Hospital for mutual support, trainings, and discussion. The biggest need to date is finding a way to access affordable and effective drugs, as all drugs imported by the government go to public facilities only.

### **7.2.3 Community Savings Schemes**

Liberians have access to traditional savings and loans practices. One form of savings used is “susu,” which is thought to have come from Nigeria. Susu is a form of saving money where each group member makes a regular standard contribution to a fund that is set up by the group. Each period (e.g., monthly), the total contributions are disbursed to one member of the group. Every member receives one payout during the life of the fund. Funds do not generate any interest for the members but are merely a simple way of safekeeping regular deposits. These practices are widespread across all socioeconomic groups in Liberia.

## **7.3 MOH Accreditation and Licensing Mechanism**

### **7.3.1 Accreditation**

A potential method of fostering sustained facility-level improvements and larger system-level change is the establishment of an accreditation process for health facilities. Although accreditation programs take a variety of forms, accreditation is typically a formal process of assessing the degree to which health facilities meet predetermined standards pertaining to quality and availability of services (Rooney and van Ostenberg, 1999).

In 2007, the process for establishing an accreditation program for Liberian public health facilities was commenced by the MOH, in collaboration with the Clinton HIV/AIDS Initiative. The system was designed to assess the degree to which primary, secondary, and tertiary facilities were meeting the required Basic Package of Health Services (BPHS), rather than tracking quality of care or quality improvements (Cleveland et al., 2011). Assessments were undertaken digitally, resulting in an unparalleled amount of timely and detailed information about health facilities across Liberia. Facilities were branded as bronze, silver, or gold based on the accreditation achieved, providing a way to educate patients about the quality of services available.

Leveraging this accreditation system, in 2009, the MOH piloted performance-based contracting with several NGOs that were operating health facilities. Facilities that received a high score received a bonus. This system was not extended to the for-profit health sector.

### **7.3.2 Licensing: Regulatory Bodies**

#### *Regulation of Health Facilities*

The LMDC is the regulatory agency of all health practitioners and facilities in Liberia and was founded in 2010. Dr. Linda Birch heads the agency. In 2010, the LMDC became an independent agency, separate from the government, and was issued a direct budget of US\$200,000 annually.

The fees charged to facilities are structured into five facility types:

1. For-profit
2. Faith-based
3. Concessions
4. Nongovernmental (free)
5. Governmental (free)

All health facilities must register their facilities with the LMDC. The process for new facilities is lengthier than for renewals, as an in-person assessment of the facility is required before the license is issued. The process for renewals happens annually and can take up to two months to be processed, although two weeks is standard. A form is completed, and a registration fee is paid at the LMDC office. Once LMDC has processed the application, a call is made to the owner to request that they retrieve a hard copy of the license. There are a few cases where an additional fee (US\$40–50) is paid to expedite the process.

The LMDC has drafted a zoning law that, once enacted, will regulate where health facilities can operate. It will stipulate that facilities should be 100 yards or more away from another facility. This stipulation appears to be designed to promote the distribution of its limited workforce and to avoid high penetration in a small number of areas. The LMDC also wants to provide guidance on salary structures for health professionals, as well as regulate fees paid by clients to private sector facilities. They recently received West African Health Organization funding to support the development of a code of conduct for health professionals (Wiakanty, 2019). The LMDC is also currently seeking funding for the development of a patient bill of rights.

Registration fees vary according to the facility type and nationality of the owner (see Annex G for more information on fee structures). The reality of the fee structure is that non-Liberians are paying much higher rates—in some case, three times as high. According to Section 13 of the 1847 Constitution of Liberia, nationality is only eligible on the basis of race. Therefore, anyone born in Liberia not of African descent is also charged a higher licensing fee. Currently, health clinic owners pay US\$100 for facility licenses. For non-Liberian owners, this increases to US\$250. For health centers, licenses are US\$200 (US\$350 for non-Liberians), and hospitals are US\$300 (US\$500 for non-Liberians). It is noted that when asked directly about fees paid, respondents in the assessment cited a lower fee charged for each category. It is unclear whether this was due to a lapse in memory (several months had passed since they had paid the fee) or because fees are negotiable.

Until three years ago, LMDC had 100 staff members and a presence in all counties. In 2019, LMDC is operating with 15 staff, five of whom are clinical inspectors. Currently, the LMDC clinical inspectors only inspect the for-profit sector, and they do not inspect public or nonprofit facilities as in previous years. Over 200 facilities were approved during the inspection period (January–March 2019). Of the facilities included in this assessment, 66 percent had received visits from LMDC in the past year, 23 percent had received a visit more than one year previously, and three facilities declined to answer. LMDC's annual income from fees is around US\$30,000.

LMDC has two types of facility assessments:

- An *assessment* is for new facilities only and takes one full day. This includes following SOPs related to infection prevention and control practices. Licenses are issued after this assessment.
- During *accreditation*, facilities are graded based on infrastructure, patient care, and human resources. LMDC has not performed an accreditation assessment in the last three years.



LMDC was not involved in the fixed-amount reimbursement agreement (FARA) (see Section 8.2). However, LMDC's grading process was leveraged to measure performance. Given the lack of independent funding available to grow LMDC's operations, incentivization could enable it to issue more licenses.

### *Regulation of Health Professionals*

**Liberia Medical and Dental Council.** LMDC is authorized to issue licenses for physicians, as well as to conduct audits of licenses issued by the Liberian National Physician Assistants Association for Physician Assistants. Licenses are issued annually. LMDC provides continuing medical education opportunities for physicians.

For physicians, the process to apply for a license is the same as described above for health facilities. For new physicians there are additional processes and fees. Several of the facilities in the assessment had brought in foreign physicians to work for them due to the limited number of physicians in Liberia. These non-Liberian physicians are charged fees three to four times higher than those charged to Liberian physicians.

**Nursing and Midwives Board.** The Nursing and Midwives Board is authorized to issue licenses for nurses and midwives. This is one of two licensing bodies, both of which issue two-year licenses. The board charges US\$85 for licenses. Included in the membership fee is a US\$10 fee for the Liberian Nurses and Midwives Association. A renewal application form is completed and submitted along with a renewal fee. The old license is presented, and a renewed license is issued within a few days. Nurses are not required to complete any continuing medical education to renew their licenses.

**Liberian National Physician Assistants Board.** While the assessment team anticipated that a separate board to regulate physician assistants would exist, the interviews revealed that this cadre of provider is currently licensed by LMDC, as physicians are, and not by its own separate board.

#### **Liberian Board of Laboratory**

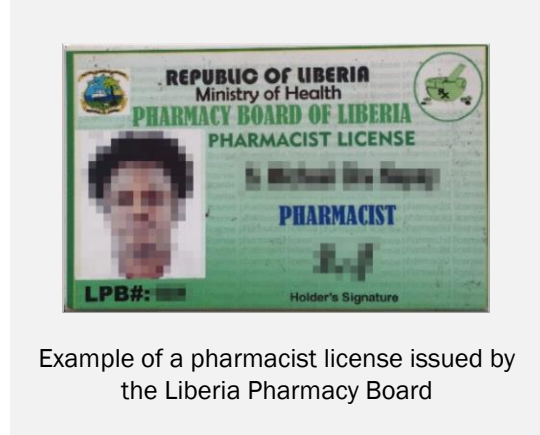
**Technologists.** The Liberian Board of Laboratory Technologists issues two-year licenses. The fee schedule appears in Table 8. There are approximately 250 licensed laboratory professionals in Liberia, but in-service courses or trainings are not being offered.

**Liberia Pharmacy Board.** The Liberia Pharmacy Board charges a US\$50 annual fee for the license. In 2019, the pharmacy board issued licenses to 170 members, the majority of whom work in the public sector. This indicates a ratio of one pharmacist for every 27,650 people (0.4:10,000), which is below the WHO-recommended ratio of 5:10,000 population (WHO, 2019a).

**Table 8. Liberian Board of Laboratory Technologists Two-Year License Fees**

Position	Fee
Lab assistant	\$45
Lab technician (AA degree)	\$55
Lab technologist (BA degree)	\$65
Lab specialist	\$125
Lab scientist	\$150

The Liberia Pharmacy Board was established by an Act in 1966–67 as a specialized body of the Liberia health sector and serves as the directing and coordinating authority for pharmacy practices in Liberia (Liberia Pharmacy Board, 2019). It was set up to ensure that every pharmaceutical entity and pharmacy professional operating in Liberia meets the needed requirements for safe practice, improved productivity, efficiency, and professionalism. It issues professional licenses, the annual license fee for which is US\$100, and has no formal continuing medical education requirements. There are more than 1,500 drugs stores across Liberia, which are also regulated by the Pharmacy Board.



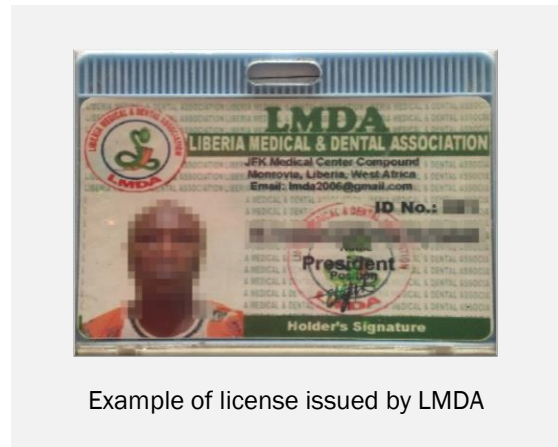
Example of a pharmacist license issued by the Liberia Pharmacy Board

In terms of training programs, the University of Liberia School of Pharmacy was founded in 1986. The West African Postgraduate College of Pharmacists was instrumental in founding the school to develop human resources for the region (Sierra Leone, Liberia, and the Gambia). The pharmacy program in Liberia has a prerequisite of a BSc in either biology or chemistry. After earning the BSc, a student enters a four-year pharmacy program and undertakes a one-year internship before graduating as a pharmacist. Pharmacists can then choose to attend the West African College of Postgraduate for Pharmacists for another four years to become a fellow. The first class of pharmacy technologists graduated in 2014. There are approximately 160–200 retail pharmacists across Liberia.

### 7.3 Professional Associations

#### The Liberia Medical and Dental Association.

LMDA charges a separate annual membership fee to physicians that costs US\$75. It is not mandatory, but it is highly encouraged. The LMDA is authorized to issue continuing medical education credits, and each physician is required to attend LMDA meetings as part of its licensure. In order to attend the LMDA meetings, physicians must be paying members. Meetings are held twice a year in Monrovia. A total of 160 people attended the last meeting, held in 2019. Continuing medical education is also open to non-members and is advertised through its email lists, flyers, and Facebook group. The LMDA also publishes research and organizes medical outreach.



Example of license issued by LMDA

There are currently 300 physicians per year paying for LMDA membership. This makes the national doctor per patient ratio 1:15,700, which is well below the WHO-recommended ratio of 1:1,000 (WHO, 2019b). In Liberia, the public sector currently absorbs around two-thirds of physicians.

**The Liberian Nursing and Midwives Association.** The Liberian Nursing and Midwives Association receives a US\$10 membership contribution per license fee issued to nurses and midwives by the Nursing and Midwives Board. Due to the automatic enrollment upon licensing, the association is comprised of more than 5,000 licensed nurses and midwives. It serves primarily as a body to advocate for better pay and working conditions for its members. It does not offer training or meetings as part of its membership.

**Liberian National Physician Assistants Association.** The physician assistant profession has been in existence in Liberia since 1965. The Liberian National Physician Assistants Association (LNPAA) was established in 1975 and operates as a professional association. It charges an annual membership fee of US\$85. As physician assistants do not have a licensing board, their licensing procedures and processes are governed by LMDC. LNPAA hosts a convention biannually, during which elections for executive/board positions are held. Every year, on the second Saturday in November, LNPAA celebrates National Physician Assistants' Day across the country.

**Liberia Association of Medical Laboratory Technologists.** The Liberia Association of Medical Laboratory Technologists was established in 1978 and is a professional association for laboratory technologists and technicians. It has approximately 200–300 members. This association charges no fees to members and offers no trainings or meetings. It has a designated “Lab Week,” but it does not have any sponsors to support activities.

The terms “lab tech” and “lab technologists” are often used interchangeably in Liberia. However, the laboratory technician has an associate degree, while a laboratory technologist has a bachelor’s degree. Mother Pattern College of Health Sciences is the only recognized institution that is offering the laboratory technologist BSc degree in laboratory science in Liberia. However, it has not yet been internationally accredited. The Tubman Institute of Medical Arts and Mother Pattern College of Health Sciences are the only institutions accredited to issue lab-science-related diplomas for lab technicians.

**Pharmacy Association of Liberia.** Pharmacy Association of Liberia is the professional association for pharmacists and charges an annual membership fee of US\$100. It organizes 12 meetings a year held on the second Saturday of every month. The meetings not only include trainings but are also a time when issues can be raised and resolved. The Pharmacy Association of Liberia also organizes a mandatory retreat sponsored by the government of Liberia in June, which is offered at no charge to members. The organization announces its meetings and retreat through various channels: WhatsApp, Facebook, and an email list. The Liberia Pharmacy Board is connected to the West African Postgraduate College of Pharmacists, from which it receives medical updates.

## Key Takeaways

- Private insurance companies offer packages through group premiums. Only formal workers have access to any form of health insurance. Currently, these premiums are not consistently being paid, leading to pressure on health facilities to underwrite the cost of services.
- Private insurance companies limit access to services by accrediting only a small number of facilities into their network.
- The validity of health facility licenses could be extended beyond one year to improve the efficiency and cost-effectiveness of the process for all parties. Resources could be shifted into monitoring compliance and recommencing accreditation assessments.
- Professional associations offer limited trainings to their membership, while boards offer limited or no continuing medical education credits. Communication systems of professional associations could be enhanced.

## 8. Public-Private Collaboration

The need for more constructive dialogue between public and private health sector actors was raised several times during the assessment. The private sector seeks a forum to raise their issues to discuss with the MOH. There is some level of dissatisfaction among the private sector, particularly at the primary level, that they provide services to their community, often for free or at reduced rates, but their communication with the public sector is limited to submitting data and receiving free public commodities. These data are then never discussed with them in any form. In some ways, it seems that the private health sector may be somewhat nostalgic about the time after the Ebola outbreak, as they received far greater recognition and support for the work they did to support recovery efforts.

In several MOH health policy documents, the private sector is very briefly mentioned, but the policies do not lay out a comprehensive role for the private sector, nor do they mention how the two sectors can work together. During the assessment, a new “private sector team” at the MOH was mentioned as a resource to tap into for further discussions. After further investigation, it appears that this MOH team has not been resourced, as there are no staff working exclusively on private sector topics at the MOH.

### 8.1 MOH Grants and Subsidies

In FY 2017/18 a total of US\$693,210 was allocated as subsidies to various health sector organizations, as well as additional amounts allocated as grants. More than US\$250,000 was allocated to a number of private sector facilities, including Eternal Love Winning Africa (ELWA) hospital and Seventh Day Adventist (SDA) Cooper hospital in Montserrado, but the purpose of the allocations was unclear. In FY 2018/19 this subsidy allocation was increased to US\$1,515,000, and there were allegations raised by members of the House Ways, Means and Finance Committee that the amounts allocated to private facilities (US\$1.2 million) were not the amount approved in the draft budget (FPA, 2018). Furthermore, the criteria for allocating such subsidies and grants remains elusive. A health sector stakeholder interviewed suggested that receipt of these monies may be based on political connections, and that as expenditure is not monitored, it could be spent on international travel, for example. Based on the published draft budget for FY 2019/20, it appears that there is no future allocation planned for private sector facilities.

### 8.2 Public-Private Partnerships: Performance-based Financing

From 2011 to 2015, the government of Liberia implemented a performance-based financing initiative costing up to US\$42 million in three northern counties (excluding Montserrado County), covering a population of approximately 1.4 million people (USAID, 2018). The FARA aimed to improve quality of care for primary care health services, including family planning and maternal and child health services. FARA counties did not perform better overall than non-FARA counties, although FARA facilities performed better over time than non-FARA facilities nationally in all areas measured, apart from couple-years of protection (USAID, 2017). This initiative and its successor (an expansion to six counties: Bong, Nimba, Lofa, Rivergee, Grand Gedeh, and Grand Cape Mount) are mostly limited to the inclusion of public sector facilities (100), with only a few FBOs also included. The MOH is also working with the World Bank to

implement performance-based financing in six secondary and tertiary hospitals (World Bank, 2017). A key goal of all these initiatives is to stimulate MOH learning around contracting based on performance indicators.

### 8.3 Health Information Systems

The Health Management Information Systems (HMIS) department forms part of the Policy and Planning Department in the MOH. This department is the central repository for all health statistics and information analysis on the data received from the 15 county health teams. The county health teams receive this information from the district health officers around the country. There are 90 districts in Liberia. The district health officers collect these data from all facilities via hard copies of a completed form. The district health officers in six counties (Grand Bassa, Lofa, Montserrado, Margibi, Bong, and Nimba) are then able to record the data in the DHIS2 system at their respective district offices. This information is then aggregated at the respective County Health Office through the DHIS2 system. The district health officers in the remaining counties must go to their county's respective health offices to enter the data from the hard copy forms, as DHIS2 has not been rolled out in their districts because of Internet connectivity issues.

Once all the county data have been entered into DHIS2, the HMIS department at the MOH can go into the system and aggregate, analyze, and report the data to the MOH, as well as to development partners. The information also informs the MOH on the effectiveness of its free commodity program, as the DHOs report on commodity disbursement and utilization. The HMIS department only has system access rights to download and review or analyze the data, but it does not have data entry rights.

A public sector stakeholder interviewed reported that it is no longer a challenge to obtain data from most private sector facilities. In July 2017, the HMIS department hosted a workshop for all private facilities to build capacity on how to report their data, inform them of the new reporting requirements, and introduce private facilities to the new reporting template. Since then, HMIS has achieved a 95 percent compliance and completion rate. It was explained that the remaining 5 percent of noncompliant facilities are large private facilities known by the HMIS team. The HMIS team anticipates that donor funds will be provided in late 2019 to host another workshop, further expanding coverage to meet the growing number of private facilities. The HMIS team will roll out an updated reporting template by January 2020. HMIS is also currently working with the Christian Health Association of Liberia to serve as a focal point for all FBOs, and this partnership will assist in achieving 100 percent compliance and completion rates.

### 8.4 Private Healthcare Federation

The private sector in Africa has played a key role in stimulating economic development. Private sector development has therefore received attention both from policymakers in the developing world as well as in the development community. In this context, the creation of an enabling business environment through effective reforms has been acknowledged as an important prerequisite for unleashing a private sector response that leads to dynamic and sustainable growth, increased employment levels, and income generation. Seeking to develop best-practice guidelines based on the experiences of its members, healthcare federations, or aligned groups of non-state health actors, can serve as a forum for information exchange, the identification of

innovative approaches toward better health through enterprise, and private engagement and development in the health industry.

Broadly, the strategic focus for healthcare federations has been clustered in these three areas:

- Conducting high-level advocacy focusing on cross-cutting issues related to law and policy, as well as to ensuring that the country is regionally and globally competitive in doing business and promoting healthcare
- Coordinating the local private health sector through various mechanisms to engage in advocacy that promotes private health sector growth
- Developing members and building the capacity of business membership organizations (also known as federations) so that they grow and represent their subsectors adequately

As a federation gets stronger, its mandate as the voice of the private health sector is fulfilled by:

- Providing a platform for its members to engage in high-level public policy dialogue
- Representing the private health sector in the formulation of policy and law in partnership with the government
- Providing leadership as the unified voice of the private health sector on issues of national importance
- Harmonizing private health sector priorities and ensuring that those priorities are represented in the development of the national health budget

To help advance the private health sector, HP+ brought together stakeholders from all non-state subsectors of the health system to incubate the Healthcare Federation of Liberia. The initial work involved stakeholder scoping to identify potential Healthcare Federation of Liberia members and partners and to identify key issues affecting the private health sector in Liberia through desk research and interviews with stakeholders. During the assessment, the team learned that there were previous attempts in 2004 made by a private health provider to create a private providers network. Unfortunately, this effort was not successful, due in part to a lack of knowledge on how to set up a federation and the lack of an independent facilitator.

Nevertheless, the interest to unify the private sector is still present, and an introductory meeting to obtain buy-in from Liberia's private health sector stakeholders demonstrated how private sector strengthening would benefit the national health ecosystem. The meeting also showed how private health sector unification through a federation would assist with this. It is anticipated that the Healthcare Federation of Liberia will be launched in 2020.

The establishment of the Healthcare Federation of Liberia should enable the private health sector to engage with the MOH through structured engagement channels and processes that will ultimately improve the collaboration between the public and private health sectors. The federation will be linked to the West Africa Private Healthcare Federation for regional activities, as well as the Africa Healthcare Federation, to benefit from continental harmonization of the private health sector.

## Key Takeaways

- Transparent guidelines and processes on the allocation of grants to support private services could help increase efficiencies in health expenditure and target those most in need of this support.
- Health data reporting is currently a one-way process. How to involve the private sector in reviewing aggregated data and providing input into decision-making processes should be considered.
- The private sector in Monrovia is not included in any performance-based financing schemes. Its inclusion should be considered in the design of any future scheme, using a coordinating body like a healthcare federation to act as a unified private sector voice.
- Professional associations offer limited trainings to their membership, while boards offer limited or no continuing medical education credits. Communication systems of professional associations could be enhanced.



## 9. Recommendations

Based on the results of the assessment, several areas were identified as hindering the private health sector’s ability to provide high-quality, high-volume health services to clients. This section outlines these challenges and provides recommendations to address them. They are organized according to the section of the report where they appear. More detail is provided on three of the priority areas in Section 9.2.











### 9.1 Summary Recommendations









Two indicators are used here to provide guidance on how the recommendations scored against predefined criteria: the likely effect on health impact, and the feasibility of operationalizing the recommendation in the short to medium term. This “scoring” is meant only as guidance and was not objectively measured by the assessment team.







- High health impact/feasible in short to medium term
- ◐ Moderate health impact/semi-feasible in short to medium term
- Low health impact/limited feasibility in short to medium term







**Table 9. Recommendations for Service Provision (Section 4)**









Theme (Section in Report)	Challenge	Recommendation	Health Impact	Operational Feasibility
Energy (4.2)	Lack of access to reliable and stable electricity to power services and provide cold storage for vaccines.	Provide access to sustainable sources of energy via solar power (see Section 9.3 for further detail).	● High	◐ Moderate
Licensing of health facilities (4.3)	Physicians on staff are required to obtain health licenses. However, the annual health license requirement is not being fully met, is burdensome for private facilities to comply with, has limited return on health impact if physicians are not actually present, and severely constrains the growth of the private sector due to the small number of physicians in Liberia.	Ease the regulatory burden on non-physician-owned facilities. Revise the legal requirement of having a physician on staff to encompass legal ownership by additional cadres of health workers.  Opening up the availability of licensing to more cadres of health workers provides both increased access for patients and enhanced career opportunities for the different cadres of health workers that are available in higher numbers. For example, a physician assistant could own and operate a clinic when operating only within the boundaries of the physician assistant license.	● High	◐ Moderate





Theme (Section in Report)	Challenge	Recommendation	Health Impact	Operational Feasibility
Health facility licensing (4.3.2)	Clients utilizing private health services cannot visibly check evidence of compliance with licensing requirements.	Recommend that LMDC implement guidelines that require all registered facilities to visibly display their most up-to-date health license. This ensures clients can see when facilities are and are not licensed.	 Moderate	 High
Health facility licensing (4.3.2)	Different licensing prices for Liberian and non-Liberian business owners.	Consider eliminating LMDC's different fee structures based upon the nationality of owners and health workers. This may help stimulate foreign private investment into the Liberian health sector and/or increase the size of the Liberian health workforce and the quality of care offered.	 Low	 Low
Health facility licensing (4.3.2)	No comprehensive (updated) list of private facilities at the MOH. This limits the effectiveness of any regulatory policies enacted. The MOH master list is different from the LMDC list of registered facilities. There are likely many registered and unregistered facilities that are invisible to the MOH and the regulatory bodies.	<ol style="list-style-type: none"> <li>1. Conduct a comprehensive physical mapping of the private health sector in Greater Monrovia to determine the breadth and depth of private services available. A quantitative survey could include an inventory of services available.</li> <li>2. Build capacity at the MOH to maintain a private sector master facility list within DHIS2 or another system as an electronic database.</li> </ol>	 High	 High
Health data (4.4)	Lack of robust patient medical records stored in private facilities.	Build capacity at the facility level to maintain robust patient medical records and appropriate maintenance and storage systems.	 High	 Moderate
Quality of care (4.6.1)	Lack of access to SOPs in the private sector.	<p>Develop SOPs and clinical guidelines for key health areas, aligning with international standards and best practices. These should then be disseminated by the MOH to private health owners via LMDC and the relevant associations/federation.</p> <p>Conduct trainings on key areas, made available via LMDC, professional associations, and/or district health teams.</p>	 High	 Low

Theme (Section in Report)	Challenge	Recommendation	Health Impact	Operational Feasibility
Quality of Care (4.6.1)	Although this assessment did not undertake a comprehensive assessment on the quality of care offered by the private sector, several facilities did not meet a basic level of standard with regards to being clean and tidy. Although this indicator is subjective, it is a basic standard that can be an indication of more serious issues at play around quality of care.	<ol style="list-style-type: none"> <li>1. Reignite the lapsed accreditation guidelines as implemented by LMDC in private sector facilities (which utilize experience gained by the essential package of health services). Use accreditation as a tool to improve quality of care and implement essential training programs in parallel.</li> <li>2. Introduce quality-of-care assessment programs like SafeCare to support facility-wide improvements.</li> </ol>	 High	 Moderate
Regulation (4.3.2)	LMDC does not adequately oversee the quality of health facilities.	<p>To improve service delivery, LMDC needs to be engaged in the accreditation of facilities and could potentially leverage the formerly implemented Liberian accreditation system to properly regulate private facilities.</p> <p>A public display of accreditation is also recommended.</p>	 High	 Moderate
Payment of services (4.6.2)	Facilities do not accept mobile money payments for services.	Early adoption of mobile money by private providers provides a competitive advantage as the numbers increase. The acceptance of mobile money payments also provides a strong foundation for (public and private) health insurance schemes to operate efficiently and transparently.	 Low	 Moderate
Quality of care/ maternal and child health (4.6.3)	Lack of access to basic labor and delivery commodities.	Clean delivery kits can be made available at cost to improve the overall quality of care for normal deliveries. Kits often include commodities such as sterile gloves, plastic sheets, cord ligature, razor blades, tetracycline, cotton, soap, and sanitary pads.	 High	 High



Theme (Section in Report)	Challenge	Recommendation	Health Impact	Operational Feasibility
Client profiles (4.7.1)	This assessment did not measure the socioeconomic background of clients seeking services from the private sector. When asked, respondents stated that their clients were among the poorest.	To fully understand access to private health services for the urban poor, it is recommended that a full socioeconomic survey of clients accessing private health services be conducted. This information will help prioritize intervention areas to stimulate increased access for the urban poor.	 Low	 High
Private-public referrals (4.8.1)	The private sector has limited guidance around emergency care, potentially leading to late diagnosis and/or misunderstandings around the roles and responsibilities of each party.	Support the development of referral guidelines between the public and private sector to clarify the procedures around the admittance and referral of emergency and non-emergency cases to build stronger referral networks. Clarify the roles and responsibilities of each level of facility. Strengthen services, particularly primary care services, to make effective use of health resources. Outline performance expectations, making protocols for care and outward referral forms available. Improve communication, establish a suitable means of communication and transport. Designate a system to fast-track referred emergency cases. Enhance supervision, monitoring outward and back referrals, including completing the loop and providing a back referral or communication to the original facility.	 High	 Moderate
Public-private referrals (4.8.3)	Referral of complex labor and delivery cases from some public hospitals to private health centers/hospitals upon fuel shortages.	Solve the fuel shortages at the few public hospitals to avoid unexpected financial hardship for patients being referred for emergency C-sections at private facilities. Alternatively, underwrite payment of services for these patients.	 High	 Moderate

Theme (Section in Report)	Challenge	Recommendation	Health Impact	Operational Feasibility
Business and management training (4.9)	Lack of business training available in the market for health facility owners, leading to poor management practices.	<p>Increase the capacity of health owners or key providers to do basic bookkeeping, stock management, and human resource management through the introduction of business training.</p> <p>Use local Liberian partners to build a skills-based curriculum targeting health professionals, and use donor funds to buy down the risk for health owners to purchase this training (eliminating the subsidy over a five-year period).</p>	 Moderate	 High
Access to free public commodities and medicines (4.10)	Inconsistencies in access to free public commodities across the private sector. Some have access to some or all free public family planning commodities, while others have access to artemisinin-based combination therapy. Any limitations on free commodities constrain the impact that free program can have on Liberians.	<p>Develop standard, transparent criteria for offering free commodities to facilities. Develop a realistic supply chain pipeline that is communicated to facility owners ahead of time.</p> <p>Communication between DHOs and facilities enables facilities to better plan ahead and purchase private sector commodities when needed.</p>	 High	 High
Access to free public commodities and medicines (4.10)	(see above)	<p>While the provision of free commodities to the private sector may expand coverage of key services to all, the scope is likely constrained by highly limited public subsidies.</p> <p>Segment the market to target unbranded products to those who cannot pay and stimulate the growth of private sector branded products for those who can pay.</p>	 High	 High

Theme (Section in Report)	Challenge	Recommendation	Health Impact	Operational Feasibility
Access to free public commodities and medicines (4.10)	Private facilities prohibited from charging their standard registration fee when using free commodities.	Supporting free family planning delivery to the point of service likely enables better access for poorer clients, although it is not clear if this is the case. The reality is that the private sector is also subsidizing the service, through its free labor, for those who can actually afford to pay something. By freeing up the private sector to charge a fixed registration fee, it enables them to recoup labor costs and supports them in continuing to offer these essential services. It also helps build a more sustainable market for family planning services.	 Low	 Moderate
Access to continuing medical education (4.11)	Lack of access to continuing medical education credit system for physician assistants, despite the profession being regulated by the LMDC.	LMDC currently offers a continuing medical education system for physicians. Expand a similar training and credit system to physician assistants to strengthen their care at the primary level. This supports the enhancement of this profession, which is essential for primary care services. The existing LMDC training programs and structures can be leveraged.	 Moderate	 High
In-service training (general) (4.11.2)	Lack of access to in-service training for any health worker, aside from physicians.	All health workers included as part of this assessment would benefit from quality in-service training programs, made available via their professional associations/boards. The health workforce needs a long-term, well-designed and resourced training plan.	 High	 Moderate
Human Resources (4.11.1)	A growing number of nursing schools opening, without any accreditation or regulations.	The MOH and/or health boards should develop accreditation guidelines for nursing schools (or other private sector educational institutions) to ensure that standards are being met in the development of a new workforce of nurses. Develop guidelines in consultation with the private sector (e.g., via the federation).	 High	 Moderate

Theme (Section in Report)	Challenge	Recommendation	Health Impact	Operational Feasibility
In-service training (4.11.2)	Lack of career progression for the increasing number of nursing graduates entering the job market.	Offer post-graduate nursing training programs to enhance career progression within nursing, leading to more advanced levels of certification.	 Moderate	 Moderate
Data reporting (4.12)	Although the Health Management Information System department recognizes that almost 100 percent of private facilities report their health data to the MOH, facilities receive no feedback or communication from the MOH on their submitted health data.	Consider how, when, and what to feed back to the private sector to encourage long-term data reporting.	 High	 High

**Table 10. Recommendations for Laboratories and Diagnostic Centers (Section 5)**

Theme	Challenge	Recommendation	Health Impact	Operational Feasibility
Regulation (5.1)	Lack of internationally aligned guideline standards for LMDC-led assessments for laboratories/diagnostic centers	Support the advancement of LMDC regulated guidelines, built to international standards, for diagnostic labs and ensure the systematic assessment of private labs/diagnostic centers. Meeting a specific standard will decrease the tainting of specimens and false reads, leading to decreased costs and more rapid treatment.	 High	 High

**Table 11. Recommendations for Access to Essential Medicines (Section 6)**

Theme	Challenge	Recommendation	Health Impact	Operational Feasibility
Access to finance (6.3)	Stock-outs experienced by all facilities, which appears to be largely a cash flow issue around limited receivables financing Banks do offer small medium enterprise financing, but facility owners are afraid to take out loans. Banks request high collateral and just a couple of days of delay in repayments, which means expensive fines and risking losing their homes/land.	Support access to finance initiatives and stimulate the market to introduce financial products targeting the private sector. Stimulate growth in disbursement rates through blended finance approaches (see Section 9.4 for more detail).	● High	● High
Importing regulations (6.4)	Pharmaceutical and medical equipment importers face delays in receiving shipments and additional unforeseen charges due to mismanagement in LMHRA.	Build the capacity of the proposed federation to work with the MOH to align importing policies to practices.	○ Low	○ Low
Counterfeit drugs (6.6)	Illegal and counterfeit drugs reported as available in Liberia.	Build a public-private partnership to combat illegal pharmaceutical markets selling counterfeit drugs. They harm legitimate sales and are potentially detrimental to the health of patients.	● High	○ Low
Public-private partnerships (6.7)	No department in the MOH that is responsible for collaboration with the private sector.	Resource the MOH's private sector team to be able to actively mediate and engage private sector stakeholders in promoting and building understanding around public-private partnerships in health.	○ Low	○ Low
Public-private partnerships (6.7)	The public sector faces challenges in last mile distribution in rural areas, particularly during rainy season. Out-of-pocket expenditures for Liberians are largely driven by medicines and medical supplies.	Develop a public-private partnership between the MOH and a pharmaceutical company with a large geographic presence across northern Liberia to distribute essential public medicines and commodities to public facilities.	◐ Moderate	● High



Table 12. Recommendations for Enabling Environment (Section 7)











Theme	Challenge	Recommendation	Health Impact	Operational Feasibility
Private insurance (7.1.1)	Informal workers have no access to private health insurance, and private insurance companies cannot grow their risk pools.	Develop a microinsurance product for informal workers most at risk of catastrophic payments: women of reproductive age and their infants under five. Using 3–5 insurance companies to expand the risk pool (see Section 9.2 for more information).	 High	 Moderate
Regulation (7.3.2.1)	More licensing checks reported to be in place for non-Liberian-owned businesses.	Understand the causality between increased checks and adherence to higher quality standards.	 Low	 Low
Licensing requirements (7.3.2.1)	Current licenses annual and only granted for a January–December period.	Extend the period of licensure to two or three years to reduce the administrative burden on both LMDC and health facility owners. In addition, explore ways to digitize the process to reduce the time taken to apply and process, and reduce any additional fees. Digitized licensing would aid in cross-checking compliant facilities against a digital master facility list. Consider rolling licenses, instead of fixed January–December licenses, which increase the chance of backlogs and delayed processing times.	 Low	 Low
Professional associations (7.4)	Only some professional associations currently offer trainings to respective members.	Support the development of biannual or annual training programs to be offered as part of professional association membership.  Trainings should be advertised widely through various communication methods to ensure a wide membership reach.	 Moderate	 Moderate

Table 13. Recommendations for Public-Private Collaboration (Section 8)

Theme	Challenge	Recommendation	Health Impact	Operational Feasibility
Grants and subsidies (8.1)	Until this year, the MOH allocated around US\$1 million to private sector facilities with no published guidance on how funds were to be allocated.	<p>Implement a transparent set of guidelines for the private sector to qualify for any public financial support, and create a bi-partisan committee to oversee grants/subsidies awarded.</p> <p>It is recommended that this support be targeted toward priority health areas and limiting the maximum amounts allocated to each facility to encourage wider participation and therefore wider benefit for Liberians.</p> <p>Use current or updated reporting processes driven by the HMIS department to analyze progress. Make this information publicly available to strengthen the transparency of this support.</p>	 High	 High
Performance-based financing (8.2)	There has been limited contracting of the private sector through performance-based financing schemes like FARA. Contracting has been limited to FBO- and NGO-operated facilities.	<p>Consider the involvement of for-profit private facilities in performance-based financing schemes as a way to improve health outcomes in the for-profit private sector. Increase the regularity of monitoring and evaluation activities of contracted for-profit facilities to ensure aligned health impact goals.</p> <p>Any MOH-led programming and contracting experience will help support the effective inclusion of the private sector in the rollout of the Liberia Health Equity Fund.</p>	 High	 Low

Theme	Challenge	Recommendation	Health Impact	Operational Feasibility
Public-private collaboration (8.4)	<p>There is a need to organize the private sector, to involve it in strategic planning and policy development. There is currently no organization in Liberia that consolidates the private health sector for system-wide improvements and system-wide policy development and strategic planning processes.</p>	<p>Launch a private healthcare federation in Liberia that represents the whole private health sector and provides an avenue for health-wide improvements.</p> <p>Use a federation specialized in the private health sector to start a dialogue with the MOH on priority issues for the sector. Use this forum to identify shared challenges among the private sector and find shared solutions.</p> <p>Once this is established, this federation can be used to promote dialogue between the public and private sectors. Identified topics include access to electricity, standardized quality standards and regulations, inclusion of the private sector in quality improvement trainings organized by the public sector, and formalized referral mechanisms.</p> <p>The federation can also bring together the various professional association bodies to discuss quality protocols and build synergies between cadres.</p> <p>The MOH HMIS Department can also use the federation as a resource to further improve and expand reporting coverage to those not included in current master facility lists. This would also improve health system resiliency.</p>	<p style="text-align: center;">● High</p>	<p style="text-align: center;">● High</p>

## 9.2 Microinsurance Product for Informal Workers

Health insurance coverage is typically sparse in low-income countries, particularly for people in the informal sector, contributing to high out-of-pocket expenditure on health. Additionally, family planning is often excluded from health insurance schemes that currently cover mostly formal sector workers. There is an opportunity for micro-health insurance to fill this coverage gap. In low-income country settings, maternal and child healthcare is often a large driver of medical expenses for insurers. Inclusion of family planning in any basic benefits package would help control these costs.

A highly limited number of Liberians have access to health insurance of any form—only formal workers are offered insurance. Those who do have access are not offered family planning services as part of the basic benefits package. Furthermore, out-of-pocket payments continue to be at high levels for Liberians: 46 percent of health expenditures were out-of-pocket as reported in the *National Health Accounts Fiscal Year 2015/16* (ROL, 2018). Until government-backed insurance schemes like the Liberia Health Equity Fund are in more advanced stages, vulnerable groups can be covered for essential health services via microinsurance schemes. Across Africa, 8.4 million people are covered with health microinsurance (Microinsurance Network, 2015). Although microinsurance in health would be new to the Liberian market, Liberia is no stranger to microfinance in other sectors. BRAC has worked across 10 counties in Liberia, offering microloans to women and small business loans to female and male small enterprise owners. In 2016, they introduced mobile money to increase the convenience of transactions. To date, BRAC Liberia has provided small enterprise loans to 1,539 clients, amounting to US\$1.47 million, as well as providing 25,360 microfinance clients with a combined total of US\$3.78 million in loans (BRAC, 2019).

Current private insurance experience in health innovation and reaching different segments of the Liberian market is highly limited. USAID could de-risk investment in micro-health insurance by providing grant funding to crowd in impact investment funds/junior equity to finance a pilot to establish proof of concept. Investors (private insurance companies) would get a return based on the amount of risk to which they subscribe. Current investor risk appetite may not drive the micro-insurer to focus on family planning access, but USAID acting as a first-loss investor would mandate that the start-up prioritize family planning inclusion and impact.

**Table 14. Summary: Microinsurance Product for Women and Families**

<b>Demand-Side Challenges</b>	<p>Liberia has no public health insurance, and informal workers have no access to private insurance.</p> <p>Although normal labor and delivery costs are relatively low (~US\$5–10), C-section costs are high (US\$250–300), and prices are fixed in US dollars.</p>
<b>Supply-Side Challenges</b>	<p>Private insurance companies in Liberia do not offer premiums for individuals.</p>
<b>Solutions</b>	<p>Develop microinsurance to cover a comprehensive primary-care package of care for informal male and female workers of reproductive age and their dependents under the age of five years. The package of care should include maternal and child health services, including labor and delivery and C-sections. Safe delivery kits could be bundled and included for public sector deliveries.</p> <p>Develop a partnership between three to five insurance companies that have an existing large health portfolio and pool premiums to create one risk pool. Insurers would subscribe to a percentage of the risk in return for a percentage of the premium.</p> <p>Payments for services could be provided via mobile money, which is becoming more widespread in Monrovia. This streamlines the payment of premiums from clients and reimbursements to health providers. Enrollment/registration processes could be made available via the mobile payment system and verified by local verification agents to perform necessary checks of the number of dependents, etc.</p>
<b>Public-Private Partnerships</b>	<p>This model would require the cooperation of the Central Bank of Liberia, the Liberia Telecom Cooperation, and the MOH.</p>
<b>Goals</b>	<p>Achieve Sustainable Development Goals 3 and 17: Good health and well-being and partnerships (United Nations, 2018)</p>

### 9.3 Increase Access to Stable, Renewable Energy Sources to Fuel Maternal and Child Health Services

Access to reliable electricity sources are scant in urban Liberia. No one private facility has sustained access to the electricity grid, instead relying on diesel generators to serve as a back-up power source in grid-connected hospitals and clinics. However, these facilities struggle with both high fuel costs and unreliable fuel delivery. Facilities and the interim steering committee of the Healthcare Federation of Liberia have expressed an interest in solar energy.

The installation of solar energy photovoltaic systems should be supported to ensure constant and cost-effective access to electricity to power essential health services. Using solar power also helps facilities save money usually spent on fuel, which can be reinvested into improving health service delivery.

**Table 15. Summary: Increased Access to Energy**

<b>Demand-Side Challenges</b>	Limited access to health services that require power (e.g., C-sections) and properly stored vaccines for newborns.
<b>Supply-Side Challenges</b>	<p>No reliable access to stable electricity to:</p> <ul style="list-style-type: none"> <li>• Provide lighting for 24/7 services, including deliveries and C-sections</li> <li>• Power life-saving equipment like fetal heart monitors and ultrasound machines</li> <li>• Power uninterrupted refrigeration for cold-chain storage of vaccines and medicines</li> <li>• Power information technology systems for stock management and electronic medical records</li> <li>• Power autoclaves for sterilization</li> </ul> <p>In addition, systems do not have properly sized battery banks for time-extended scenarios.</p>
<b>Solutions</b>	<ol style="list-style-type: none"> <li>1. Provide access to a US\$50,000 revolving fund to provide access to basic solar power to health facilities off the grid. We Care Solar provides an obstetric Solar Suitcase including medical-quality lighting, fetal monitors, power for charging cell phones and small devices, and headlamps with rechargeable batteries. A Solar Suitcase with solar panels, LFP battery, two medical LED lights, a charge controller, mounting hardware, and standard accessories cost US\$1,705. All repayments replenish the fund and provide sustainable access to capital.</li> <li>2. Provide access to a US\$100,000 revolving fund to support private facilities in purchasing solar panels to power their maternal and child health services. All repayments replenish the fund and provide sustainable access to capital.</li> </ol> <p>The United Nations Development Programme’s Solar for Health program has identified 19 pre-qualified suppliers for both “plug and play” solar PV units of 5–15 kWh and tailor-made solar photovoltaic installations to power critical departments in larger facilities: surgery, pharmacy, and laboratory.</p>
<b>Goals</b>	Achieve Sustainable Development Goals 3, 7, 13, and 17: Good health and well-being, affordable and clean energy, climate action, and partnerships (United Nations, 2018)

## 9.4 Increase Access to Capital for Private Health Business Owners

Macroeconomic challenges continue to plague Liberia’s recovery efforts. Liberia imports 100 percent of its essential medicines and commodities, and persistently high inflation (23 percent) and the continued depreciation of the Liberian dollar against the US dollar are resulting in increasing prices for imported commodities. This is against the backdrop of the non-payment of private health insurance companies to their accredited service providers for services rendered. These combined factors are placing a great deal of financial stress on health facilities in a time when client volumes are also decreasing.

To support private health entrepreneurs in maintaining consistent access to medicines and commodities (including family planning commodities when MOH supplies are limited), as well as to support the expansion of their businesses to meet community health needs, it is recommended to support access to (working) capital. This can be done by either direct financing methods or by supporting the development of health sector expertise within the existing financial institutions. As a minimum criterion to qualify, family planning services must currently be provided by the facility.

**Table 16. Summary: Improved Access to Capital**

<b>Demand-Side Challenges</b>	Limited access to safe, affordable essential medicines when needed.
<b>Supply-Side Challenges</b>	<p>Private health owners struggle with lack of access to capital from banks due to a lack of credit history and assets to serve as collateral to:</p> <ul style="list-style-type: none"> <li>• Expand their business (offer new health services, improve quality of services, buy equipment, and expand/improve premises)</li> <li>• Access a reliable supply of affordable drugs and commodities for clients</li> </ul>
<b>Solutions</b>	<ol style="list-style-type: none"> <li>1. Create a working capital (revolving) fund to support the expansion of safe, affordable drugs within the private sector. Offer the funds as a loan to private health facilities at competitive rates. Use health-specific loan criteria that offer health businesses the flexibility they need, without being detrimental to the loan portfolio.</li> <li>2. A blended financing mechanism could be structured to de-risk the potential loss to Medical Credit Fund target partner banks to accelerate expansion into the new product segment. Donors could either provide an incentive grant to promote access to finance for the health sector and banks will be rewarded when they meet agreed-upon disbursement targets, or they could provide first-loss capital to de-risk early loans.</li> <li>3. Development Credit Authority in Liberia assumes a share of lending risks to encourage financial institutions to provide loans to actors, sectors, and segments important to development. This “crowding-in” of private capital through the use of guarantees is accomplished at a fraction of the cost of conventional donor support and seeks to permanently replace short-term donor funding with long-term, sustainable, locally generated private capital. Provide health-specific TA to extend the disbursement of loans to the private health sector. (This option could be combined with solution #2.)</li> </ol>
<b>Goals</b>	Achieve Sustainable Development Goals 3, 8, and 17: Good health and well-being, decent work and economic growth, and partnerships (United Nations, 2018)

## Conclusion

This assessment was comprised of three main parts, (1) desk research that informed the Background section to outline the current state of the private sector, (2) findings from key informant interviews with a wide variety of health actors, and (3) a summary of key findings and recommendations. The report outlines the many current challenges faced by the stakeholders in terms of their ability to create a more efficient and effective private health system. As a starting point for further dialogue, the assessment report is intended to aid the government of Liberia, donors, and other key stakeholders in prioritizing support moving forward.

With the establishment of a healthcare federation for the private sector in Liberia, the vision is to enhance public-private engagement to build a resilient and well-coordinated mixed health system that offers affordable and accessible services to the people of Liberia. Only by working together can a health system leverage the full talents and resources of all health actors and expand access to quality, affordable health services to more people.



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## Annex A. Key Informant Interviews

### Facility Key Informant Interviews

Facility Name	Facility Type	Location	Stakeholder Name	Stakeholder Title	Date Interviewed
AFRO-Medical Community Clinic	Clinic	Pipeline, Somalia	Adidi Avweosuo	Owner	7/17/2019
Blessed Clinic	Clinic	Old Road, Central Monrovia	Histine Mulbah	Co-owner	7/25/2019
Divine Joy Community Clinic	Clinic	Caldwell, Bushrod	Moses Toby	Owner	7/26/2019
Forkey Maternity Clinic	Clinic	Barnesville Oldfield, Somalia	James Ballah	Administrator	7/9/2019
Grace A. Reeves Baptist Clinic	Clinic	Old Road, Central Monrovia	Bob Nueita	Administrator	7/25/2019
Graystone Clinic	Clinic	Carey Street, Central Monrovia	Samuel Kromah	Owner	7/24/2019
Helthon Clinic	Clinic	Gardnerville Nyanford Town, Somalia	V. Thomas Johnson	Manager	7/5/2019
Ma Bea Community Clinic	Clinic	SKD Boulevard, Central Monrovia	Kebbeh Pewu	Owner	7/3/2019
Markue Medical Laboratory Clinic	Clinic	Logan Town, Bushrod	K. Mike Tarkue	Co-owner	7/17/2019
Medical Diagnostic Laboratory Clinic	Clinic	GSA Road, Paynesville	Tellewon Jimmie	Owner	7/10/2019
P K Nyansaiye Medical Clinic	Clinic	Ruth Perry Road, Somalia	Paye Konah Nyansaiye	Owner	7/11/2019
Peace Clinic	Clinic	Old Road, Central Monrovia	Dr. Elias Mutatko	Owner	7/24/2019
Safe Zone Community Clinic	Clinic	New Georgia Road, Somalia	Amos Tamba	Clinician	7/3/2019
Siamana Clinic	Clinic	SKD Boulevard, Central Monrovia	Bernard Togbe	Manager	7/26/2019
Snapper Hill Clinic	Clinic	Robert Street, Bushrod	Varsay Sirleaf	Owner	7/25/2019
Sunrise Medical Clinic	Clinic	ELWA Junction, Paynesville	Samuel Kollie	Owner	7/16/2019
The Goodwill Clinic	Clinic	Duport Road, Paynesville	Hannah Ballah	Clinician	7/15/2019

Facility Name	Facility Type	Location	Stakeholder Name	Stakeholder Title	Date Interviewed
TKG Medical and Laboratory Clinic	Clinic	Doe Community, Bushrod	Luseni Kamare	Manger	7/2/2019
Wroto Town Clinic	Clinic	Wroto Town, Central Monrovia	Madame Zarway	Manager	7/26/2019
Agape Health Center	Center	Duport Road, Paynesville	Dyukonjae Paul	Administrator	7/4/2019
Faith Medical and Laboratory Clinic	Center	Red Light, Somalia	Augustine Chieusid	Manager	7/22/2019
Gerlib Clinic	Center	Pipeline, Somalia	Margret Gieraths Nimene	Owner	7/16/2019
J&J Memorial Health Center	Center	ELWA Junction, Paynesville	Jeremiah Sackie	Clinician	7/19/2019
Kingdom Care Medical Clinic	Center	Duport Road, Paynesville	Dr. Henry Fallah	Owner	7/25/2019
Mawah Clinic	Center	Vai Town, Bushrod	Perston Tulay	Manager	7/23/2019
Refuge Place International	Center	Bassa Town, Johnsonville	Fayah Allin	Administrator	7/3/2019
Star of the Sea Health Center	Center	West Point, Central Monrovia	Dr. Diabe Dore	Medical director	7/25/2019
THT Clinic	Center	Barnesville, Somalia	Edwin Vonleh	Accountant	7/11/2019
Benson Hospital	Hospital	Duport Road, Paynesville	Dr. Angela Benson	Co-owner	7/15/2019
St. Joseph's Catholic Hospital	Hospital	Congotown Junction, Central Monrovia	Peter Lansana Dawoh	Administrator	7/23/2019

## Non-Facility Key Informant Interviews

Name	Type	Location	Stakeholder Name	Stakeholder Title
B-Kay Pharmacy	Pharmacy	Broad Street, Central Monrovia	Sanjay BKay	Owner
Lucky Pharmacy	Pharmacy	Duport Road, Paynesville	Sam Jhamnani	Owner
CliniLab	Diagnostic lab	Broad Street, Central Monrovia	John Moussa	Owner
J Singh Medical Laboratory & Clinic	Diagnostic lab	Sinkor, Central Monrovia	Jackie Singh	Owner
Jahmale Medical Solutions	Diagnostic lab	ELWA Junction, Paynesville	Dr. Nicole Cooper	Provider
Activa International Insurance Company	Insurance	Sinkor, Central Monrovia	Saye Gbalazeh	CEO
SAAR Insurance Liberia	Insurance	Broad Street, Central Monrovia	Jean Bernard Fodjo	CEO
Liberia Association of Medical Laboratory Technologists	Health association	Sinkor, Central Monrovia	Sharty Sandy	Acting president
Liberia Medical and Dental Association	Health association	Sinkor, Central Monrovia	Dr. Emmanuel Ekyinbah	President
Liberia Nursing and Midwifery Association	Health association	Carey Street, Central Monrovia	Gloria Stevens	President
Pharmacy Association of Liberia	Health association	Old Road, Central Monrovia	Thomas Kokulo	Secretary general
Health Finance Department	MOH	Congotown Junction, Central Monrovia	Roland Kesselly	Director
Health Management Information Systems	MOH	Congotown Junction, Central Monrovia	Patrick Konwloh	Manager
Human Resources for Health Department	MOH	Congotown Junction, Central Monrovia	Marvin Davis, Sr.	Assistant director
Performance Based Financing Department	MOH	Congotown Junction, Central Monrovia	Vera Mussah	Manager
Central Bank of Liberia	Regulatory body	Ashmun Street, Central Monrovia	Jefferson Kambo	Executive Director, Regulation and Supervision Department
Liberia Medical and Dental Council	Regulatory body	Sinkor, Central Monrovia	Joseph Colmah	Manager

## **Annex B. Snapshot of Liberian Business Registry, Business Licensing Fees**

## LIBERIA BUSINESS REGISTRY

### FEE SCHEDULE FOR NEW ENTERPRISE REGISTRATIONS

The following schedule of fees applies to each of the stated type of legal entity when registering a new enterprise. These are the only fees applied by the Liberia Business Registry when a new enterprise is being registered.

	Types of Business	Fee for Liberian Applicant (LD)	Fee for Non- Liberian Applicant (USD)
1	Sole Proprietors		
	Application Fee	2000	700
2	Limited Liability Companies		
	Application Fee	4000	900
3	Business Corporation		
	Application Fee	4000	900
	Articles of Incorporation filing fee		
	100 Shares	20	20
	500 Shares	100	100
	1000 Shares	200	200
4	Branches of Business Corporation or LLC		
	Application Fee	2000	450
5	Partnerships and Limited Partnership		
	Application Fee	3000	800
6	Not-For-Profit Corporations, Trusts and Foundations		
	Application Fee	3500	400
	Articles of Incorporation (Where applicable)	3500	50
7	Foreign Companies Applying to do business in Liberia		
	Application Fee		500

Other fees applied by the Liberia Business Registry for other purposes (reservation of new name, renewals, amendments, dissolutions and information services, are given in the Registry's web site [lbr.gov.lr](http://lbr.gov.lr), in the "fee tariff" link to that web site.



## Annex C. Sample Laboratory Test Prices from Three Health Clinics

Drug	Price (Facility 1)	Price (Facility 2)	Price (Facility 3)
Blood Type/Blood Grouping	US\$5 (Blood Type)	US\$5 (Blood Grouping)	US\$4 (Blood Type)
FBS	US\$5	US\$5	US\$4
Hepatitis	US\$5	---	US\$30 (Hepatitis B)
Hemoglobin	LD\$275	LD\$100	---
HIV/SPOT	US\$5	LD\$500	US\$3
Malaria	LD\$275	---	---
MTT	LD\$300	LD\$200	US\$4
RBS	US\$5	---	US\$4
RDT	LD\$175	LD\$200 (RDT or M/S)	US\$2
RPR	---	LD\$500	---
SKIN/SNIP(S/S+)	LD\$350	---	US\$3 (Skin Snip)
SSF	---	LD\$400	---
Stool	LD\$375	LD\$400	US\$2
U/A	LD\$275	---	US\$2
Ultra-Sound	US\$20	---	US\$25
Urine Analysis	---	LD\$400	---
VDRL	US\$6	---	---
WBC	LD\$175	LD\$100	US\$2
Widal	LD\$450	LD\$400	US\$5
X-Ray	US\$20	---	US\$25 - 75

Note: table represents transcribed prices from three facility lists: facility 1 “medical clinic laboratory fees,” facility 2 “laboratory test fee(s) 2018/2019, and facility 3 “clinic price list [Q3-2017].”

## **Annex D. Snapshot of Private-Public Sector Referral Tools and Forms**

## Facility A Referral Form

### Referral System Tools

There are two sample tools on the following pages:

- Sample tool 1: Referral form
  - Prepare one copy to send with the client, and keep one copy in the client notes.
- Sample tool 2: Referral register
  - The register has a page for referrals made OUT from a facility and referrals received IN to a facility.
  - Information on back referral of clients referred out from the facility should be made on the same line as information regarding the original referral out. This facilitates follow-up.
  - Please also note, that the two referral registers have a column to indicate whether there is any problem regarding the appropriateness of the referral. Keeping track of this information will help identify if there are problems with referrals from a particular facility, or problems with referral of clients with particular conditions. Knowing this can help focus in-service and continuing education of health workers.

These tools are in Microsoft Word, so that you can adjust them to your particular country situation.

Name of facility:		<b>Referral Form</b>				original / copy	
Referred by:	Name:		Position:				
<b>Initiating Facility Name and Address:</b>					Date of referral:		
Telephone arrangements made:	YES	NO	Facility Tel No.		Fax No.		
<b>Referred to Facility Name and Address:</b>							
Client Name							
Identity Number				Age:	Sex:	M	F
Client address							
Clinical history							
Findings							
Treatment given							
Reason for referral							
Documents accompanying referral							
Print name, sign & date	Name:		Signature:		Date:		
Note to receiving facility: On completion of client management please fill in and detach the referral back slip below and send with patient or send by fax or mail.							

-----✂-----receiving facility - tear off when making **back referral**-----✂-----

<b>Back referral from Facility Name</b>			Tel No.	Fax No.			
Reply from <small>(person completing form)</small>	Name:			Date:			
	Position:		Specialty:				
<b>To Initiating Facility:</b> <i>(enter name and address)</i>							
<b>Client Name</b>							
Identity Number				Age:	Sex:	M	F
Client address							
This client was seen by: <i>(give name and specialty)</i>					on date:		
Patient history							
Special investigations and findings							
Diagnosis							
Treatment / operation							
Medication prescribed							
Please continue with: <i>(meds, Rx, follow-up, care)</i>							
Refer back to:					on date:		
Print name, sign & date	Name:		Signature:		Date:		





### Facility B Referral Form

**Patient Name:** \_\_\_\_\_ **Clinic #:** \_\_\_\_\_

**Sex:** \_\_\_\_\_ **Age:** \_\_\_\_\_

**Complain:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Diagnosis:** \_\_\_\_\_

**Treatment Given:** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Reason for Referral**  
:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Referred To:** \_\_\_\_\_

**Full Name:** \_\_\_\_\_

**Signed:** \_\_\_\_\_

**Title:** \_\_\_\_\_

Facility C Referral Form

Referral Form

Name: \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_

Address: \_\_\_\_\_

Diagnosis:

\_\_\_\_\_

History:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Current Status (general condition, Vital signs)

\_\_\_\_\_

\_\_\_\_\_

Treatment Received (dosage & time)

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

Reason for referral:

\_\_\_\_\_

\_\_\_\_\_

We appreciate your effort and wait for feed-back.

Name, title and signature:

Date: \_\_\_\_\_



# Annex E. Photo of Health Management Information System Monthly Report Form

Health Facility Type: *circle one that applies*

a. Clinic  
 b. Health Center  
 c. Hospital (<= 100 bed capacity)  
 d. Hospital (> 100 bed capacity)

Reporting Period: May 1-31, 2019  
(e.g. Month 1 - 31, Year)

	< 5 years		> 5 years	
	Male	Female	Male	Female
	25	58	71	104
Total head count	Cross-border Patients			
	Male	Female		
	258			

**A) FAMILY PLANNING:** Check here  if service was not provided

Total Counseled for Family Planning								
Methods Used	10 - 14		15 - 19		20 - 24		25+	
	No. of New Acceptors	No. of Continued Users	No. of New Acceptors	No. of Continued Users	No. of New Acceptors	No. of Continued Users	No. of New Acceptors	No. of Continued Users
Condom (male)								
Condom (female)	0	0	0	4	13	0	8	0
Oral Contraceptives								
Depo-provera	0	0	0	29	0	10	18	4
IUCD								
Implant								
Cycle Beads								
Vasectomy								
BTL								

Unit of Distribution	No. of male condom distributed	No. of female condom distributed	monthly cycles distributed	number of injections	number of IUCDs inserted	number of Implant insertions	No of cycle bead distributed	Total Condom distributed for non-family planning purpose
No. Distributed	0	25	0	67	0	0	0	92

## Annex F. Medical Limits for SAAR Insurance Liberia Patients

	Limit for Lab	Limit for X-Ray	Limit for Drugs	Room & Board	Treatment	Surgery	Maternity
Afriland First Bank	\$75	\$100	\$150	\$30/day	\$300	\$400	\$100
BIVAC	\$50	\$30	\$50	\$30/day	\$200	\$275	\$75
Bureau Veritas	\$50	\$30	\$50	\$30/day	\$200	\$275	\$75
US Embassy	90%	90%	90%	-	-	-	-
Ecowas Brown Card	\$40	\$50	\$100	\$30/day	\$250	\$400	\$100
Conservation Interna	\$200	-	-	\$30/day	\$200	\$300	\$100
PUTU	\$45	\$30	\$60	\$20/day	\$200	\$200	\$100
TOTAL Liberia	\$150	\$250	\$100	\$30/day	\$300	\$800	\$500
Clinton Health Access	\$150	\$200	\$150	\$50/day	\$500	\$800	\$200
DAI	\$220			\$30/day	\$250	\$400	\$100
IFRC	\$200	\$500	\$150	\$50/day	\$400	\$1,000	\$200
Save the Children	\$40	\$50	\$60	\$15/day	\$200	\$300	\$75
PSI	\$50	\$30	\$70	\$30/day	\$500	\$500	\$150
LACC (option 1&2)	\$40	\$40	\$60	\$20/day	\$250	\$400	\$75
LACC (option 3&4)	\$50	\$50	\$80	\$50/day	\$400	\$600	\$100
R L J Kendeja	\$20	\$20	\$30	\$10/day	\$100	\$150	\$75
Edu-Care	\$30	\$30	\$50	\$15/day	\$150	\$300	\$100
Internews	\$50	\$50	\$100	\$30/day	\$250	\$400	\$100
Framp	\$50	\$50	\$75	\$30/day	\$300	\$300	\$100
FHI 360	\$50	\$40	\$75	\$20/day	\$250	\$300	\$75
SAAR Insurance	\$50	\$30	\$50	\$30/day	\$200	\$275	\$75
Cheaitou Brother Inc.	\$20	\$20	\$30	\$15/day	\$150	\$250	\$75
Ramiah Enterprise	\$20	\$20	\$30	\$15/day	\$150	\$250	\$75
Ministry of Finance	\$15	\$15	\$30	\$10/day	\$150	\$200	\$75
Give Directly	\$50	\$50	\$60	\$30/day	\$300	\$400	\$100
Mass Group	\$75	\$40	\$100	\$600/private	\$300	\$600	\$150
Landesa	\$150			\$30/day	\$350	\$400	\$100
Solidarity Center	\$75	\$40	\$100	\$600/private	\$300	\$600	\$150
Ireland Embassy	\$50	\$50	\$50	\$400/day	\$350	\$400	\$100

Note: Table transcribed from photo.

## **Annex G. Snapshot of Liberia Medical and Dental Council Licensing Fees**

**LIBERIA MEDICAL & DENTAL COUNCIL**  
**NEW APPROVED DOCTORS AND HEALTH FACILITIES LICENSE FEES**

DATE: \_\_\_\_\_

S/N	DESCRIPTION	CATEGORIES	FEES CHARGED
1	<b>Application</b>		
	<b>GENERAL</b>	All Nationalities	US\$10.00
	<b>DOCTORS:</b>		
2	<b>INTERVIEW FEES</b>	Liberians	US\$50.00
		Non Liberians	US\$150.00
3	<b>GENERAL PRACTITIONERS</b>		
A	<b>INITIAL LICENSE FEES</b>	Liberians	US\$75.00
		Non-Liberians	USD\$200.00
B	<b>RENEWAL LICENSE FEES</b>		
		Liberians	US\$100.00
		Non-Liberians	US\$300.00
4	<b>SPECIALIST / DOCTORS</b>		
A	<b>INITIAL LICENSE FEES</b>	Liberians	US\$150.00
		Non-Liberians	US\$400.00
B	<b>RENEWAL LICENSE FEES</b>		
		Liberians	US\$200.00
		Non-Liberians	US\$450.00
5	<b>PARAMEDICS INTERVIEW FEES</b>		
		Liberians	US\$25.00
		Non-Liberians	US\$75.00
6	<b>PARAMEDICS LICENSE FEES</b>		
A	<b>INITIAL LICENSE FEES</b>	Liberians	US\$50.00
		Non-Liberians	US\$150.00
B	<b>RENEWAL LICENSE FEES</b>	Liberians	US\$75.00
		Non-Liberians	US\$200.00
	<b>COMPLEMENTARY MEDICINE</b>	Liberians	US\$25.00
		Non-Liberians	US\$50.00
7	<b>HEALTH FACILITIES</b>		
I	<b>HOSPITALS</b>		
	<b>FAITH BASED</b>	Liberians	US\$300.00
		Non-Liberians	US\$500.00
	<b>PRIVATE</b>	Liberian	US\$250.00
		Non-Liberians	US\$500.00
	<b>CONCESSION</b>	HOSPITALS	US\$1,500.00
II	<b>HEALTH CENTERS</b>		

	<b>FAITH BASED</b>	Liberians	US\$300.00
		Non-Liberians	US\$500.00
	<b>PRIVATE</b>	Liberians	USD\$200.00
		Non-Liberians	US\$350.00
	<b>CONCESSION</b>		US\$500.00
III	<b>CLINICS</b>		
	<b>PRIVATE</b>	Liberians	US\$100.00
		Non-Liberians	US\$250.00
	<b>FAITH BASED</b>		
		Liberians	US\$100.00
		Non-Liberians	US\$200.00
	<b>CONCESSIONS</b>		Us\$350.00
8	<b>OTHERS: PREOPERATIONAL ASSESSMENT FEES</b>		
	<b>HOSPITALS</b>	Liberians	US\$500.00
		Non-Liberians	US\$1,000.00
	<b>HEALTH CENTERS</b>	Liberians	US\$250.00
		Non-Liberians	US\$500.00
	<b>CLINICS</b>	Liberians	US\$150.00
		Non-Liberians	US\$300.00

Prepared & Submitted by: \_\_\_\_\_

Dr. Nyanquoi K. Kargbo, Jr  
Registrar General – LMDC Secretariat

Approved by: \_\_\_\_\_

Dr. John Mulbah – CHAIRMAN  
LMDC Council

**Proper management internal control system for effective and efficient monitoring and supervision for good governance and transparency in the internal revenues collections of the Council.**

**The policy guidelines stipulate that:**

- 1. All fees charged are to be paid at the designated LMDC bank accounts in the below listed banks as follows:**
  - a. ECOBANK ACCOUNT NUMBER**
    - i. USD ACCOUNT NO. 0011014723314101**
    - ii. LRD ACCOUNT NO. 0010014723314101**
  - b. INTERNAL BANK (IB) LIBERIA, ACCOUNT NUMBER**
    - i. USD ACCOUNT NO. 02-2010-441973-01**
    - ii. LRD ACCOUNT NO. 01-2000-02972-01**
- 2. No money is to be paid to the LMDC finance office by any client.**
- 3. No doctor(s) or health facility owner(s) should solicit any of the LMDC staff to make payment for license on their behalf in the finance department.**
- 4. No LMDC is allowed to receive money from any doctor(s) or visit health facilities for the purpose of collecting license fees on behalf of LMDC**

For more information, contact:

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