



BUDGET GAP ANALYSIS · JUNE 2025

Budget Gap Analysis for Primary Health Care (PHC) and Immunization in Liberia (2020–2024)

An Evidence-Based Budget Analysis Supporting Health Financing Advocacy





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Budget Gap Analysis Series · Empowering Communities to Save Lives

EXECUTIVE SUMMARY

Key findings at a glance

This Budget Gap Analysis examines the Government of Liberia's (GOL) budgetary commitments to Primary Health Care (PHC) and immunization over the five-year period 2020–2024. Using a mixed-methods approach drawing on official national budget data, MFD expenditure reports, Ministry of Health operational records, the Global Health Expenditure Database, and GAVI co-financing projections, the analysis identifies critical financing shortfalls, budget execution failures, and structural vulnerabilities that threaten Liberia's health system sustainability.



Health Sector	PHC Financing	Immunization
Total 5-yr appropriations: \$384.88M . Actual disbursements: \$328.09M — a gap of \$56.79M (15%). Best year 2024: 92%. Worst 2020: 75%. Consistently below Abuja 15% target.	Of \$79.36M approved for PHC, only \$28.21M disbursed (35.5%) . Lowest: 2020 at 6%. Best: 2022 at 95%. PHC = 9.6% of actual health spending vs WHO benchmark of 40%.	GAVI covered \$13.36M (85%) ; GOL contributed only \$2.33M (15%) — below GAVI's 20% threshold. World Bank exits vaccine financing from 2026.

Key Conclusion: Liberia's health system is characterized by chronic under-execution of health budgets, inadequate PHC investment (9.6% vs WHO's 40%), dangerous donor dependency (67% donor-sourced), and an immunization program at structural risk as World Bank financing ends in 2026. Meeting the Abuja Declaration's 15% target requires an additional \$40–50M annually; closing the PHC gap requires +\$10–15M/year.

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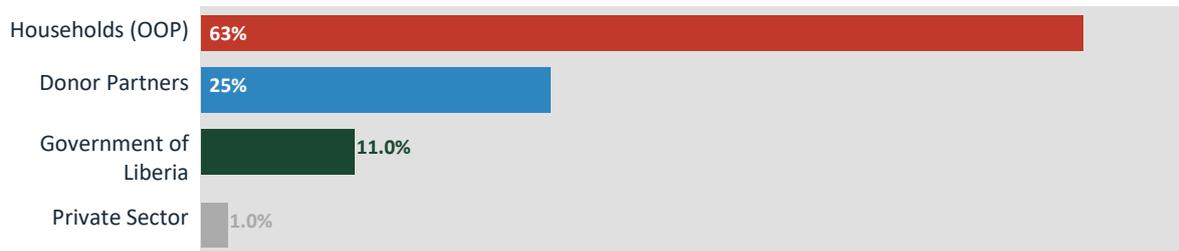
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Section 1

Introduction*Background, financing landscape, objectives, scope and methods*

Target 3.8 of the Sustainable Development Goals (SDGs) calls for the attainment of Universal Health Coverage (UHC) by 2030. For resource-constrained countries like Liberia, achieving UHC requires structured, phased strategies — beginning with strengthening Primary Health Care (PHC) and progressively expanding coverage. According to the World Health Organization (WHO), PHC is the most inclusive, equitable, and cost-effective pathway to UHC. Despite its crucial role, financing PHC in developing countries remains a persistent challenge, hindered by limited government budgets, heavy donor reliance, and inefficient resource allocation.

This Budget Gap Analysis contributes to improving PHC and immunization outcomes in Liberia by identifying funding shortfalls, inefficiencies, and misallocations in government financing of PHC. It is part of a broader evidence-based study supporting the health financing advocacy work of the Public Health Initiative of Liberia (PHIL).

1.1 Liberia's PHC and Immunization Financing Landscape*Figure 1: Health Expenditure Financing by Source (%)*

Liberia's health sector relies heavily on external and household financing. According to the 2023 Health Sector Resource Mapping Report, the total anticipated health resource envelope was US\$221.9 million, with 67% from donor partners and 33% from the Government. Key donors include USAID (US\$54.7M, 37%), the Global Fund (US\$29.8M, 20%), and the World Bank (US\$25M, 17%). Approximately 77% of external funds are managed off-budget by implementing partners, limiting government oversight and planning capacity.

GOL's health budget represented about 9.5% of its total national budget, allocated primarily to wages (77% of sector allocation), leaving minimal funding for operational costs, medicines, or service delivery inputs.

1.2 Objectives of the Budget Gap Analysis

The primary objective is to assess GOL's commitment to PHC and immunization financing for 2020–2024. This includes: (1) a detailed review of national budget allocations — appropriation, allotment, and disbursement trends; (2) evaluation of how government allocations align with the estimated cost of delivering essential PHC services; and (3) assessment of Liberia's co-financing obligations under the GAVI initiative, identifying outstanding payments, delays, or fulfilment challenges.

1.3 Scope of Work

Table 3: Scope of Work and Task Descriptions

#	Task	Description
1	Review of National Budget Documents	Analyze annual health sector budgets 2020–2024, focusing on PHC and immunization line items — appropriations, allotments, and disbursements.
2	GAVI Co-Financing Analysis	Examine GOL's historical and current co-financing commitments to GAVI; compare required contributions against payments; identify shortfalls.
3	Stakeholder Consultations	Engage with MOH, MFDP, GAVI focal points, and USAID to validate budget figures and gather contextual information.
4	Budget Gap Estimation	Calculate the difference between required PHC/immunization funding and available resources; project future gaps.
5	Reporting and Recommendations	Produce a comprehensive report with findings, implications, and actionable recommendations.

1.4 Methods and Approaches

A mixed-methods approach combining qualitative and quantitative techniques was adopted. The quantitative component analyses budget data including appropriations, allotments, and actual disbursements. This is complemented by qualitative insights from document reviews and stakeholder consultations. Data were drawn from official sources (MFDP national budget and performance reports, MOH expenditure records), GAVI, the Global Health Expenditure Database, and World Development Indicators. Analysis employed spreadsheet-based tools to compile, compute, and visualize budget trends and financing gaps.

Section 2

National Budget Allocations for PHC and Immunization (2020–2024)

Appropriations, allotments, and actual disbursements

2.1 Analysis of Total Health Sector Budgetary Allocations

Assessment of GOL's health sector allocation reveals consistent disparity between appropriations, allotments, and actual disbursements. While the average annual appropriation stood at US\$76.98 million, the corresponding average disbursement was only US\$65.47 million — approximately 85% of what was originally approved by the Legislature. The year 2020 records the largest execution gap (25%), while 2024 performed best at 92%.

Table 4: GOL Health Sector Allocations (2020–2024, USD Million)

Year	Appropriation	Allotment	Disbursement	Exec Rate (%)
2020	72.80	86.45	54.81	75.3%
2021	74.51	61.07	64.35	86.4%
2022	83.19	72.06	70.08	84.2%
2023	74.27	65.68	64.57	87.0%
2024	80.10	78.03	74.28	92.7%
Period Average	76.98	72.66	65.62	85.2%
Period Total	384.87	363.29	328.09	—

2.1.1 Appropriations by Spending Entities

Among spending entities, the Ministry of Health consistently received the largest share — approximately 77–78% of total sector allocations. In FY2024, MOH was appropriated US\$62.31M of the total US\$80.10M. John F. Kennedy Medical Center was the second-largest beneficiary (US\$7.17M in 2024), followed by NPHIL (US\$3.15M). The total health sector budget grew from US\$72.80M in 2020 to US\$80.10M in 2024.

Table 5: Health Sector Approved Budget by Spending Entities (2020–2024, USD Million)

Spending Entity	2020	2021	2022	2023	2024
Ministry of Health	55.50	57.93	66.05	55.90	62.31
JFK Medical Center	6.36	5.64	6.05	7.16	7.17
Phebe Hospital	1.75	1.57	1.68	1.68	1.14
NPHIL	2.76	2.50	2.67	2.92	3.15
Jackson F. Doe Hospital	2.58	2.24	2.50	2.50	2.48
Liberia College of Physicians	1.46	2.28	1.41	1.39	1.34
Other Institutions	2.39	2.35	2.83	2.72	2.61
Total	72.80	74.51	83.19	74.27	80.10

Table 6: Health Sector Approved Budget by Economic Classification (2020–2024, USD Million)

Economic Classification	2020	2021	2022	2023	2024
Compensation of Employees	51.08	51.65	54.30	57.11	58.51
Use of Goods and Services	7.34	11.28	7.07	8.24	11.02
Subsidy	0.45	0.10	0.42	0.76	0.73
Grants	8.06	6.25	6.06	7.37	8.43
Non-Financial Assets	5.88	15.35	0.00	0.80	1.41
Total	72.80	83.19	67.86	74.27	80.10

2.1.2 Allotments by Spending Entities

Persistent gaps between appropriations and actual allotments undermine health financing predictability. In 2024, US\$80.10M was appropriated but only US\$78.03M allotted (97%). However, 2022 saw US\$83.19M appropriated with only US\$72.06M allotted (86.6%). Compensation of employees consistently received the highest allotment rates; funding for goods and services and capital investment was erratic.

Table 7: Health Sector Allotments by Spending Entities (2020–2024, USD Million)

Spending Entity	2020	2021	2022	2023	2024
Ministry of Health	65.91	47.49	57.21	49.43	60.71
JFK Medical Center	7.55	4.62	5.24	6.33	6.99
Phebe Hospital	2.08	1.29	1.46	1.49	1.11
NPHIL	3.28	2.05	2.31	2.58	3.07
Jackson F. Doe Hospital	3.06	1.84	2.17	2.21	2.42
Other Institutions	4.57	3.78	3.67	3.64	3.73
Total Health Sector	86.45	61.07	72.06	65.68	78.03

2.1.3 Disbursements by Spending Entities and Economic Classification

Actual disbursements lagged behind both appropriations and allotments. In 2024, US\$74.28M was disbursed of the US\$80.10M appropriated — a 92.7% execution rate, the best in the period. Compensation of employees consistently received the highest disbursement rates; goods and services, grants, and capital investments were erratic and underwhelming.

Table 9: Health Sector Disbursements by Spending Entities (2020–2024, USD Million)

Spending Entity	2020	2021	2022	2023	2024
Ministry of Health	43.56	49.91	53.07	47.65	56.11
JFK Medical Center	3.29	5.18	6.29	6.79	6.15
Phebe Hospital	0.93	1.33	1.50	1.35	1.15
NPHIL	2.06	2.33	3.19	2.93	3.41
Jackson F. Doe Hospital	1.77	2.37	2.27	2.17	2.74

Spending Entity	2020	2021	2022	2023	2024
Other Institutions	3.20	3.23	3.76	3.68	4.72
Total Health Sector	54.81	64.35	70.08	64.57	74.28

2.2 Analysis of PHC and Immunization Financing

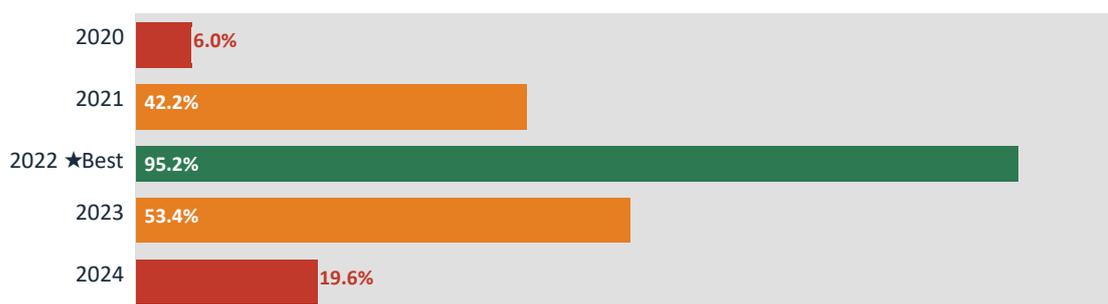
PHC is assessed using a hybrid approach combining allocations to PHC-designated facilities with budget lines reflecting core PHC services per the WHO functional definition — specifically budget lines 2218 (specialized materials and services: drugs, vaccines, family planning), 2500 (subsidies to community clinics and facilities), and 2600 (grants to hospitals and health facilities).

KEY FINDING: Of the US\$79.36M appropriated for PHC over five years, only US\$28.21M was actually disbursed — a disbursement rate of 35.5%. PHC disbursements represented just 9.6% of total health sector spending, against the WHO-recommended benchmark of 40%.

Table 11: GOL's Total Allocations to PHC (2020–2024, USD Million)

Year	Appropriation	Allotment	Disbursement	Exec Rate (%)
2020	24.37	6.76	1.46	6.0%
2021	17.27	13.17	7.28	42.2%
2022	12.16	13.12	11.57	95.2%
2023	8.58	5.59	4.58	53.4%
2024	16.97	5.29	3.33	19.6%
Period Average	15.87	8.79	5.64	35.5%
Period Total	79.36	43.94	28.21	—

Figure 3: PHC Budget Execution Rate by Year (%)



The trend shows a steep decline in PHC performance after 2022's exceptional 95.2% execution rate. In 2020, only 6 cents of every approved PHC dollar reached a health facility. The peak of 2022 was not sustained — by 2024, execution collapsed to 19.6% despite a relatively high US\$16.97M appropriation. When PHC disbursements are compared to the total health sector, PHC receives only 9.6% of actual disbursements — far below WHO's 40% benchmark.

2.2.1 PHC Appropriations by Spending Entities and Economic Classification

MOH is the principal driver, accounting for over 90% of total PHC appropriations annually. In 2024, MOH received US\$15.81M of US\$16.97M total. Grants consistently accounted for the largest share (avg US\$9.86M annually), followed by specialized materials and services, then subsidies.

Table 12: PHC Appropriation by Spending Entities (2020–2024, USD Million)

Spending Entity	2020	2021	2022	2023	2024
Ministry of Health	22.66	15.11	10.52	7.21	15.81
JFK Medical Center	0.42	0.37	0.61	0.41	0.30
Phebe Hospital	0.50	0.41	0.44	0.38	0.18
Jackson F. Doe Hospital	0.43	0.74	0.39	0.39	0.28
NPHIL	0.37	0.64	0.21	0.20	0.40
Other Entities	0.00	0.00	0.00	0.00	0.00
Total	24.37	17.27	12.16	8.58	16.97

Table 13: PHC Appropriation by Economic Classification (2020–2024, USD Million)

Economic Classification	Code	2020	2021	2022	2023	2024
Specialized materials & services	2218	6.08	7.56	4.73	3.52	7.81
Subsidies	2500	0.52	0.33	0.42	0.35	0.73
Grants	2600	17.78	9.38	7.01	4.71	8.43
Total	—	24.37	17.27	12.16	8.58	16.97

2.2.2 PHC Allotments by Spending Entities and Economic Classification

PHC allotment performance is severely below appropriated levels. In 2024, only US\$5.29M was allotted against US\$16.97M appropriated — 31% execution at allotment stage. MOH was allotted only US\$4.55M of its US\$15.81M appropriation. While 2021 and 2022 saw higher allotments (US\$13.17M and US\$13.12M respectively), these were exceptions.

Table 14: PHC Allotment by Spending Entities (2020–2024, USD Million)

Spending Entity	2020	2021	2022	2023	2024
Ministry of Health	6.21	11.52	11.21	4.51	4.55
JFK Medical Center	0.24	0.28	0.57	0.35	0.15
Phebe Hospital	0.24	0.23	0.38	0.38	0.09
Jackson F. Doe Hospital	0.08	0.62	0.36	0.24	0.21
NPHIL	0.00	0.53	0.59	0.11	0.29
Total	6.76	13.17	13.12	5.59	5.29

Table 15: PHC Allotment by Economic Classification (2020–2024, USD Million)

Economic Classification	Code	2020	2021	2022	2023	2024
Specialized materials & services	2218	2.25	3.55	3.63	2.47	1.38

Economic Classification	Code	2020	2021	2022	2023	2024
Subsidies	2500	0.49	0.35	0.87	0.21	0.15
Grants	2600	4.02	9.27	8.62	2.92	3.76
Total	—	6.76	13.17	13.12	5.59	5.29

2.2.3 PHC Disbursements by Spending Entities and Economic Classification

MOH accounts for over 80% of all PHC disbursements annually. In 2024, the Ministry received only US\$2.78M — 17.6% of its PHC appropriation of US\$15.81M. This compares poorly to 2022, when US\$9.76M was disbursed (93% of appropriation). Several institutions received zero PHC disbursements throughout the five-year period.

Table 16: PHC Disbursement by Spending Entities (2020–2024, USD Million)

Spending Entity	2020	2021	2022	2023	2024
Ministry of Health	1.25	5.91	9.76	3.58	2.78
JFK Medical Center	0.03	0.25	0.55	0.35	0.08
Phebe Hospital	0.08	0.13	0.38	0.29	0.09
Jackson F. Doe Hospital	0.10	0.57	0.28	0.24	0.21
NPHIL	0.00	0.43	0.59	0.11	0.18
Total	1.46	7.28	11.57	4.58	3.33

Table 17: PHC Disbursement by Economic Classification (2020–2024, USD Million)

Economic Classification	Code	2020	2021	2022	2023	2024
Specialised materials & services	2218	0.19	3.15	3.44	2.37	1.19
Subsidies	2500	0.10	0.17	0.64	0.05	0.05
Grants	2600	1.17	3.96	7.48	2.15	2.09
Total	—	1.46	7.28	11.57	4.58	3.33

2.3 GOL–GAVI Immunization Co-Financing Payments

Under the GAVI co-financing arrangement, GOL is obligated to finance 20% of total vaccine costs. In addition, traditional vaccines (including measles) have historically been financed by the World Bank. The Bank has notified GOL of its intention to pass on this financing responsibility — meaning from 2026, GOL must absorb an estimated average annual cost of US\$1.06M for these vaccines.

CRITICAL ALERT: The World Bank will stop financing traditional vaccines from 2026. GOL must plan immediately to absorb an estimated US\$1.06M per year — on top of rising GAVI co-financing obligations that require progressive increases through 2029.

2.3.1 GAVI Contributions

Over the five years, GAVI contributed US\$13.36M in actual disbursements — reflecting a high execution rate and strong donor commitment. Contributions peaked in 2020 at US\$6.98M (influenced by COVID-19 responses), dropped sharply in 2021 (US\$0.71M), and recovered to US\$2.53M in 2024.

Table 18: GAVI Co-Financing Contributions (2020–2024, USD Million)

Year	GAVI Budget	GAVI Utilised	GOL Co-Financing	Total Imm. Cost
2020	6.25	6.98	0.43	7.41
2021	0.76	0.71	0.66 *	1.37
2022	2.25	2.20	0.46	2.66
2023	0.94	0.94	0.34 *	1.28
2024	3.03	2.53	0.44 *	2.97
Period Average	2.65	2.67	0.47	3.14
Period Total	13.24	13.36	2.33	15.69

* Paid by World Bank loan — not genuine domestic financing.

2.3.2 GOL Contributions

GOL's cumulative co-financing 2020–2024 was US\$2.33M — about 15% of total immunization costs, below the required 20%. In 2021, 2023, and 2024, contributions were financed through World Bank loans rather than genuine domestic fiscal resources. Separately, budget code 221814 (vaccines outside GAVI) recorded only US\$1.12M in disbursements — 42% of appropriations, with zero disbursements in 2021 and 2023.

Table 19: GOL Co-Financing (2020–2024, USD Million)

Year	Co-Financing Due	Amount Paid	Balance Due	Paid By
2020	0.43	0.43	0.00	GOL
2021	0.66	0.66	0.00	World Bank (loan)
2022	0.46	0.46	0.00	GOL
2023	0.34	0.34	0.00	World Bank (loan)
2024	0.44	0.44	0.00	World Bank (loan)
2025 (proj.)	0.45	0.35	0.10	GOL (partial)
Average	0.46	0.45	0.02	—
Total	2.78	2.68	0.10	—

Table 20: GOL Allocations to Vaccines Outside GAVI Arrangement (2020–2024, USD Million)

Year	Appropriation	Allotment	Actual Disbursement	Exec Rate (%)
2020	0.60	0.42	0.42	70.0%
2021	0.67	0.14	0.00	0.0%
2022	0.35	0.58	0.58	166.0% *
2023	0.60	0.00	0.00	0.0%

Year	Appropriation	Allotment	Actual Disbursement	Exec Rate (%)
2024	0.47	0.12	0.12	25.5%
Average	0.54	0.25	0.22	42.3%
Total	2.69	1.26	1.12	—

* Supplemental allotment in FY2022 exceeded original appropriation.

2.3.3 GAVI Immunization Cost Projections

According to GAVI's co-financing projections, GOL's required contribution will progressively increase from 7.4% of total vaccine costs in 2024 to approximately 14.8% by 2029, as GAVI's share declines from 92.6% to 85.2%. This gradual transition reflects GAVI's broader policy of encouraging countries to move toward self-sufficiency.

Table 21: GOL Co-Financing Projections (2024–2029, USD Million)

Year	GOL Required	GOL Share (%)	GAVI Share (%)	Total Vaccine Cost
2024	0.39	7.4%	92.6%	4.87
2025	0.39	9.2%	90.8%	3.87
2026	0.46	13.5%	86.5%	2.95
2027	0.69	16.3%	83.7%	3.55
2028	0.62	14.8%	85.2%	3.58
2029	0.63	14.8%	85.2%	3.62

Note: Projected costs for traditional vaccines (World Bank exit from 2026, est. US\$1.06M/year) are not included above but must be factored into GOL's immunization budget planning.

Section 3

Identification and Estimation of the Budget Gaps

Overall health sector, PHC, and immunization financing gaps

Building on the preceding analyses, this section provides a comprehensive quantification of the financing gaps affecting Liberia's health sector, PHC, and immunization services. The identification of these gaps is critical for understanding the extent to which government resources fall short of service delivery needs — particularly as donor commitments shift and the imperative for domestic financing increases.

3.1 Overall Health Sector Financing Gaps

Two critical dimensions of the budget gap are identified: the Execution Gap (discrepancies between approved budgets and actual disbursements) and the Abuja Target Gap (the shortfall between Liberia's health budget and the internationally agreed target of 15% of national expenditure allocated to health).

A. Execution Gap

From FY2020 to FY2024, cumulative health sector appropriations totalled US\$384.88M while actual disbursements reached US\$328.09M — a financing gap of US\$56.79M (approximately 15%). 2020 recorded the worst performance with 25% undisbursed. 2024 showed the strongest improvement at 92% execution.

B. Abuja Declaration Gap

Liberia consistently underperforms against the Abuja Declaration target of 15% of national budget for health. Health sector spending averaged only 9–10% across the review period — 5–6 percentage points below the benchmark. Meeting the Abuja target would require an annual increase of US\$40–50 million.



3.2 PHC Financing Gaps

PHC financing gaps are assessed through a three-tier comparison (appropriation vs allotment vs disbursement) and benchmarked against: (a) the WHO recommendation that PHC receive at least 40% of health sector disbursements; and (b) peer-country per-capita PHC spending from the Global Health Expenditure Database.

Key Finding Area	Details
Execution Gap	Only US\$28.21M of US\$79.36M appropriated for PHC was disbursed (35.5%). The five-year undisbursed total: US\$51.15M.
WHO Benchmark	PHC disbursements represented only 9.6% of total health sector spending — against WHO's recommended threshold of 40%.

Key Finding Area	Details
Funding Gap Needed	Bridging the WHO gap requires an additional US\$10–15M annually in PHC disbursements above current levels.
Per-Capita Gap	GOL PHC spending: US\$3.94 per person. Household out-of-pocket: US\$40.16 per person. A 10:1 burden ratio.
Regional Context	Côte d'Ivoire: US\$32.37; Ghana: US\$30.13 government PHC per person. Liberia: US\$3.94.

Table 24: PHC Benchmarked Indicators — Global Health Expenditure Database

Country	PHC Govt Spending Per Capita (USD)	OOP Spending Per Capita (USD)
Sao Tome & Principe	\$48.06	n/a
Côte d'Ivoire	\$32.37	n/a
Ghana	\$30.13	n/a
Kenya	\$17.45	n/a
Senegal	\$9.67	n/a
Zimbabwe	\$8.19	n/a
LIBERIA ◀	\$3.94	\$40.16
WHO PHC Benchmark	≥ 40% of health sector spending	—

3.3 Immunization Financing Gap

A. Heavy Reliance on External Financing

Between 2020 and 2024, GAVI contributed US\$13.36M (85% of immunization costs), while GOL contributed only US\$2.33M (15%) — below the 20% GAVI threshold. GOL's genuine domestic contribution is even lower: in 2021, 2023, and 2024, it was financed through World Bank loans that must eventually be repaid.

B. Budget Execution Challenges

Disbursements for vaccines outside the GAVI arrangement totaled only US\$1.12M over five years — 42% of appropriations. Zero disbursements were recorded in 2021 and 2023, indicating systematic failures in vaccine budget execution beyond the GAVI arrangement.

Figure 6: GOL vs GAVI Immunization Financing Contributions (2020–2024, USD Million)

Year	GOL Contribution	GAVI Contribution	Total Immunization Cost	GOL Share (%)
2020	0.43	6.98	7.41	5.8%
2021	0.66 *	0.71	1.37	48.2%
2022	0.46	2.20	2.66	17.3%
2023	0.34 *	0.94	1.28	26.6%
2024	0.44 *	2.53	2.97	14.8%
Average	0.47	2.67	3.14	15.0%
Total	2.33	13.36	15.69	14.9%

* Paid by World Bank loan — not genuine domestic financing.

C. Projected Gaps Widening

GAVI co-financing projections require GOL's contribution to rise from US\$3.87M in 2025 to approximately US\$3.62M by 2029 as GAVI's share declines to 85.18%. Additionally, the World Bank will cease financing traditional vaccines from 2026, adding US\$1.06M/year to GOL's fiscal obligation. If current trends continue, Liberia risks accumulating significant arrears or immunization programme disruption.

3.4 Implications of Financing Gaps on Coverage and Health Outcomes

Implication	Detail
Interrupted Vaccine Supply	Irregular disbursements and donor dependency cause vaccine stock-outs, delayed campaigns, and weakened cold chain operations — especially in hard-to-reach communities.
Erosion of Immunization Coverage	Financing gaps contribute to declining coverage for key antigens (DTP3, measles), with substantial subnational disparities. Areas of low PHC investment mirror regions of lower immunization uptake.
Increased Household Burden	As government funding falls short, out-of-pocket costs for transportation and service fees create significant barriers to health access, particularly in rural areas.
Risk of Disease Outbreaks	Inadequate immunization financing weakens disease surveillance and rapid response capacity, raising outbreak risk for measles, polio, yellow fever, and other vaccine-preventable diseases.
Donor Dependency and Transition Risk	With the World Bank exiting and GAVI increasing co-financing expectations, failure to build domestic fiscal capacity poses a major threat to long-term immunization sustainability.
Weak Institutional Ownership	Underfunding limits MOH's ability to lead long-term immunization planning, budget for new vaccine introductions, and scale integrated PHC delivery.

Section 4

Conclusion and Recommendations

Summary of findings and priority actions for Liberia's health financing

4.1 Conclusion

This budget gap analysis reveals significant and persistent financing gaps in Liberia's health sector, particularly in PHC and immunization. Key conclusions:

1. Between 2020 and 2024, cumulative health sector execution amounted to only US\$328.09M of US\$384.88M appropriated — a shortfall of **US\$56.79M (14.75%)**. Execution has improved, with 2024 reaching 92% of appropriated levels.
2. Liberia consistently underperforms against the Abuja Declaration target of 15% national budget for health. On average, the sector received only **9–10%** — requiring an annual increase of **US\$40–50M** to meet the target.
3. PHC financing is acutely deficient. Only **US\$28.21M of US\$79.36M** appropriated for PHC over five years was disbursed (35.5%). PHC represented only **9.6%** of health sector spending against WHO's benchmark of 40%. Bridging the gap requires **+ \$10–15M/year**.
4. Immunization financing reflects heavy donor dependency. GOL contributed only **US\$2.33M (15%)** of total immunization costs 2020–2024, against GAVI's required 20%. Much of this was financed through repayable World Bank loans.
5. The World Bank will cease financing traditional vaccines from 2026, adding **US\$1.06M/year** to GOL's fiscal obligation — on top of rising GAVI co-financing requirements through 2029.

4.2 Recommendations

1

1. Develop a Domestic Resource Mobilization (DRM) Strategy

GOL, in collaboration with partners and civil society, should develop and implement a DRM strategy for sustainable PHC and immunization financing. This should identify innovative fiscal instruments, improve tax efficiency, and explore earmarked revenue streams including health levies and social insurance contributions.

2

2. Strengthen Budget Execution Systems

Improving budget credibility and execution is critical. Measures include enhanced cash planning, timely quarterly allotments, and systematic monitoring of fund flow bottlenecks to ensure appropriated resources are fully and predictably disbursed to frontline PHC facilities and immunization program.

3

3. Increase Budgetary Allocation to Health and PHC

GOL should progressively raise health sector spending toward the Abuja 15% target and increase PHC's share of health expenditures to at least 40% as per WHO recommendations. Legislative advocacy and Cabinet-level prioritization of PHC are essential.

4

4. Institutionalise GAVI Co-Financing in the National Budget

GOL should fully integrate GAVI co-financing obligations into annual budget planning and execution frameworks, ensuring commitments are not reliant on ad hoc external support. This includes planning for full assumption of World Bank-financed vaccines beginning in 2026.

5

5. Improve Transparency and Reporting in PHC and Immunization Financing

PHC and immunization budget lines should be clearly identifiable at national and subnational levels. Routine publication of budget execution reports and program-level disbursement tracking will strengthen accountability and policy responsiveness.

6

6. Enhance Donor Coordination and Transition Planning

Given the anticipated tapering of external support, GOL should engage with donors on a structured transition plan promoting joint accountability, gradual cost-sharing, and domestic capacity development for immunization and essential PHC services. This plan should be finalized before the World Bank exit in 2026.

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IMPLEMENTING PARTNER

Public Health Initiative Liberia (PHIL)

A local non-governmental organisation working to strengthen health systems, improve health financing, and advocate for sustainable domestic investment in Primary Health Care and immunization in Liberia.

GLOBAL CSO PARTNER

Global Health Advocacy Incubator (GHAI)

A global civil society partner to GAVI, working across 10 countries to support advocacy for sustainable domestic financing for immunization and Primary Health Care. GHAI builds the capacity of local CSOs to drive evidence-based health financing advocacy.

About GHAI’s Global Immunization and Financing Program

The Global Health Advocacy Incubator (GHAI) works in partnership with GAVI, the Vaccine Alliance, to strengthen domestic financing for immunization and essential Primary Health Care services. GHAI operates across **10 countries**, building the capacity of civil society organizations to advocate for increased government investment, improved budget execution, and sustainable national ownership of immunization and PHC programs.

The views expressed in this report are those of the authors and do not necessarily reflect the positions of GHAI, GAVI, or any other partner organisation.

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