
# Annual Report of the Health Sector Pool Fund

July 1, 2013, through June 30, 2014

Republic of Liberia

Ministry of Health
and Social Welfare

Jointly prepared by the
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# Abbreviations and Acronyms

| | |
|---|---|
| AFD | French Development Agency |
| AHA | Africa Humanitarian Action |
| BCHSWT | Bomi County Health Team |
| CHSWT | County Health and Social Welfare Team |
| DFID | Department for International Development |
| EPHS | Essential Package of Health Services |
| FY | Fiscal Year |
| GFATM | Global Fund for Aids, Tuberculosis, and Malaria |
| GoL | Government of Liberia |
| HMIS | Health Management Information Systems |
| M&E | Monitoring and Evaluation |
| IP | Implementing Partner |
| MDGs | Millennium Development Goals |
| MOHSW | Ministry of Health and Social Welfare |
| NDS | National Drug Service |
| NHP | National Health and Social Welfare Plan |
| NGO | Non-Governmental Organization |
| OFM | Office of Financial Management |
| OPD | Out-Patient Department |
| PBC | Performance-Based Contracting |
| PFMF | Pool Fund Manager Firm |
| PFSC | Pool Fund Steering Committee |
| QA | Quality Assurance |
| SBA | Skilled Birth Attendant |
| SDC | Swiss Agency for Development and Cooperation |
| TOR | Terms of Reference |
| UNICEF | United Nations Children's Fund |

# Contents


HAWA MASSAQUOI
COMMUNITY CHILD
CARE CENTER
UNIFICATION TOWN
LOWER MARGIBI CO. LIBERIA
Motto: Proverbs 22:6
in the way he should
01835/ 0886518659

# 1. Overview

This report covers the Government of Liberia's (GoL) fiscal year (FY) 2013–2014, from July 1, 2013, through June 30, 2014. It is based on data and information from the national Health Management Information System (HMIS), the Ministry of Health and Social Welfare's (MOHSW) Monitoring and Evaluation Unit, county health and social welfare teams (CHSWTs), and the Pool Fund Secretariat. A brief overview of the background and objectives of the pool fund, the main contributors, and design characteristics of the fund are covered in Section 1. The main funding areas and highlights of activities conducted during this reporting period are described in Section 2. Progress in the fund's performance monitoring framework is also summarized in Section 2, along with data on key health indicators. Section 3 gives the financial position of the fund since its establishment and the financial position at the end of this reporting period.

## 1.1 Background of the pool fund

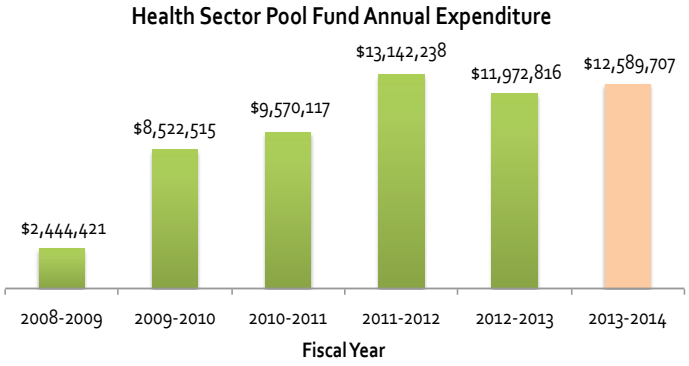
The Health Sector Pool Fund was established in April 2008 by the GoL because the large number of health actors presented a major challenge to achieving alignment behind the National Health and Social Welfare Plan (NHP), which translated into excessive transaction costs for the government. The objectives of the pool fund are three-fold:

i. To help finance priority unfunded needs within the NHP;

ii. To increase the leadership of MOHSW in the allocation of sector resources;

iii. To reduce the transaction costs associated with managing multiple projects from different donors.

The United Kingdom's Department for International Development, Irish Aid, the Swiss Agency for Development and Cooperation, the French Development Agency, and the United Nations Children's Fund (UNICEF) currently use the pool fund to provide financial support for health.




Since its establishment in 2008, the pool fund has received over $64 million in contributions, of which 98 percent has been committed to unfunded NHP priorities and 91 percent has been spent. The fund's annual expenditures from its inception through this reporting period are shown in the chart below (see Section 3 for more information). Due to the continued commitment by donors to using this mechanism, the GoL has identified the pool fund as a key feature of the National Health and Social Welfare Financing Policy and Plan.

## 1.2 Organization of the fund

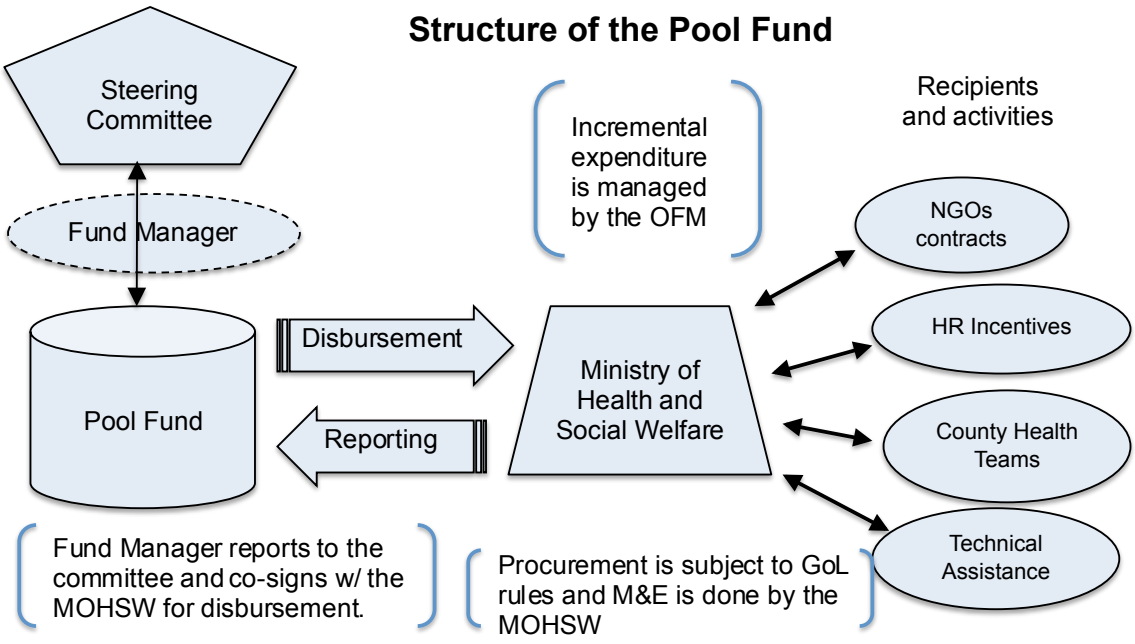
The pool fund is managed within the Ministry of Health and Social Welfare by a Pool Fund Management Firm (PFMF) that is contracted by UNICEF and paid for by the fund. The two primary areas of responsibility for the PFMF are the management of the pool fund mechanism and control of fiduciary risk associated with use of the fund. The PFMF also supports the MOHSW to develop funding proposals for pool fund allocations. A Pool Fund Steering Committee reviews these

funding proposals and is the decision-making body for the fund.

The steering committee was set up by the MOHSW when the fund was established to ensure transparency, reinforce coordination, and provide a forum for dialogue. It is chaired by the Ministry of Health and Social Welfare and co-chaired by a lead donor (currently UNICEF). The committee is comprised of contributing donors to the fund, other GoL ministries, and invited representatives from major organizations active in the health sector (e.g., USAID and WHO). This allows the committee to serve as a coordinating entity between contributing donors and other partners by virtue of its membership's wide representation.

A Pool Fund Secretariat is also managed by the Pool Fund Management Firm and supports the functioning of the steering committee. The secretariat is charged with organizing the activities and retaining the records of the steering committee and of the pool fund. It ensures annual independent audit and risk assessment are conducted and it produces reports, steering committee briefing papers, and meeting minutes and resolutions.

During implementation, the pool fund uses national systems for financial management, procurement, internal audit, planning, monitoring, and evaluation in accordance with best practice and the principles of the New Deal for Engagement with Fragile States. To reinforce this approach, over the last several years pool funds have been flexibly allocated to strengthen several of these national system areas to increase their effectiveness.



## 2. Planned and Actual Activities

The Health Sector Pool Fund exists to support unfunded priorities from the National Health and Social Welfare Policy and Plan. The priority funding areas in fiscal year (FY) 2013–2014 included providing direct support for Sthe Essential Package of Health Services (EPHS) through a range of funding modalities. Priority areas also included the procurement of essential drugs and medical supplies, investing in the support systems of MOHSW's central administration, supporting the MOHSW's risk management strategy, and the costs associated with pool fund administration. Table 2.1 (below) presents the allocation categories for FY 2013–2014 and the total expenditure for each category. See Section 3 for more information on expenditure.

**Table 2.1 Pool Fund Expenditure in FY 2013–2014 by Category (US$)**

| Allocation Category | Maximum Allocation[1] (US$) | Total Expenditure (US$) | Percent Spent | Percent of Total |
|---|---|---|---|---|
| Direct support for provision of the Essential Package of Health Services (EPHS) | 14,281,409 | 10,265,061 | 72% | 82% |
| Essential drugs & medical supplies[2] | 194,353 | 194,353 | 100% | 2% |
| Central MOHSW support systems | 827,313 | 531,489 | 64% | 4% |
| MOHSW risk management strategy | 795,448 | 476,280 | 60% | 4% |
| Pool fund administration[3] | 1,126,743 | 1,122,524 | 100% | 8% |
| **Total** | **17,225,266** | **12,589,707** | **73%** | **100%** |

[1] Includes the unpaid balance of the commitment from FY 2012–2013 and the FY 2013–2014 commitment.
[2] This allocation was originally from August 2012 through July 2013. It is included in this report because final payments were made during this reporting period and because stocks were still being received and distributed.
[3] Pool fund administration includes Ecobank charges, wire transfer fees, UNICEF's 1% pass-through fee, and the cost of pool fund management from March 2014 until March 2015.

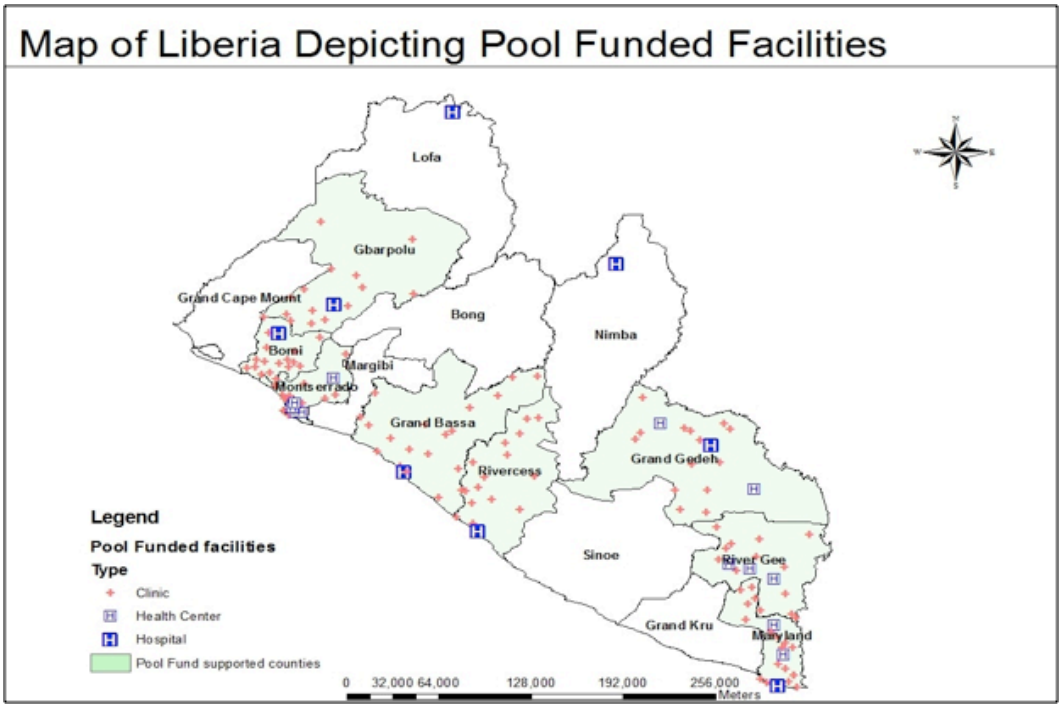
## 2.1 Planned activities

### 2.1.1 Direct support for service delivery

The EPHS places emphasis on all maternal and child health services, including child nutrition, adolescent health services, emergency services and communicable disease control. Using a contracting-in modality with CHSWTs and a contracting-out modality with non-governmental organizations (NGOs), the pool fund supported provision of the EPHS in 10 counties during FY 2013–2014 (see Table 2.2 and the map below it). All contracts were scheduled to come to an end on June 30, 2014. However, the Pool Fund Steering Committee approved a no-cost extension until September 30, 2014, for all FY 2013–2014 allocations in order to provide sufficient time to complete capital projects and other approved expenditures.

**Table 2.2: Active Service Delivery Allocations FY 2013–2014**

| Nb | Ref | County | Amount (US$) | Partner | Total Facilities | Clinic | Health Center | Hosp. | Catchment Population |
|---|---|---|---|---|---|---|---|---|---|
| 1 | FJ | Montserrado | 1,587,963 | AHA | 17 | 12 | 5 | 0 | 220,692 |
| 2 | FK | River Gee | 1,046,330 | MERCI | 16 | 13 | 3 | 0 | 75,659 |
| 3 | FL | Bomi | 1,276,919 | CHSWT | 20 | 19 | 0 | 1 | 89,176 |
| 4 | FP | Gbarpolu | 969,261 | CHSWT | 14 | 13 | 0 | 1 | 94,461 |
| 5 | FR | Grand Bassa | 1,075,631 | CHSWT | 20 | 19 | 0 | 1 | 213,155 |
| 6 | FN | Grand Gedeh | 2,136,528 | CHSWT | 17 | 14 | 2 | 1 | 131,389 |
| 7 | FM | Maryland | 1,690,055 | CHSWT | 21 | 18 | 2 | 1 | 144,594 |
| 8 | FO | Rivercess | 1,063,416 | CHSWT | 17 | 16 | 0 | 1 | 81,005 |
| 9 | F7 | Lofa | 950,282 | CHSWT | 1 | 0 | 0 | 1 | 23,026 |
| 10 | FQ | Nimba | 579,986 | CHSWT | 1 | 0 | 0 | 1 | 22,994 |
| | | | **12,376,371** | **Total** | **144** | **123** | **13** | **8** | **1,096,151** |



### 2.1.2 Contracting-out to NGOs

Two NGOs funded by the pool fund, MERCI and AHA, were contracted-out in FY 2013–2014 to implement projects in River Gee and part of Montserrado Counties respectively. In close collaboration with the CHSWTs, these NGOs provided direct support for the delivery of the EPHS Primary Level. This traditional form of NGO support included planning and monitoring, logistics support, health worker training, and provision of salaries and incentives where necessary, among other activities.

### 2.1.3 Countywide CHSWT contracting-in

There were six CHSWTs contracted-in to provide countywide support of the EPHS Primary and Secondary Levels, according to the type of facility, at all government-owned health facilities in their respective counties. The pool fund was used to fill funding gaps in the county operational plans. All county plan budgeting and pool fund allocations under this approach were comprehensive and included GoL allocations made to the counties as well as contributions from other sources (Global Fund, UNICEF, etc.) for purposes of transparency. To gain economies of scale and minimize fiduciary risk, most health worker salary payments and the purchase of drugs and medical supplies were conducted at the central MOHSW level through electronic back transfer on behalf of the contracted-in counties.

### 2.1.4 Hospital CHSWT contracting-in

Two CHSWTs were contracted-in exclusively to provide EPHS Secondary Level support to their respective county referral hospitals (G.W. Harley Hospital in Nimba County and Tellewoyan Hospital in Lofa County). This approach is the same as the contracting-in approach described above but is limited to the country referral hospitals because other government facilities in these counties are supported by another source of donor funds (USAID).

### 2.1.5 Essential medicines and medical supplies

The allocation for essential drugs and medical supplies was intended to finance procurement of essential medicines and medical supplies to support two CHSWTs (Bomi and Grand Bassa) and the two NGO partners (AHA and MERCI) for 12 months, from August 2012 through July 2013, but was subsequently expanded by the Pool Fund Steering Committee to include other counties. This activity also supports partial implementation of the National Supply Chain Master Plan, for example, documented systems to guide national quantification of health commodities, a Logistic Management Information System, and a service agreement system between the NGOs and the National Drug Service (NDS).

### 2.1.6 Support systems

Another funding priority for the pool fund in FY 2013–2014 was strengthening the central MOHSW's service delivery support systems for planning, monitoring and evaluation, donor aid coordination, financial management, and internal audit, among others. Investing in these priority areas allowed the pool fund to use the MOHSW's central systems to manage and monitor much of the implementation of pool-funded activities. An additional benefit of this allocation has been the improved capacity of these systems to manage and monitor implementation of activities funded by other sources of funds, including the GoL, GAVI, GFATM, UNICEF, USAID, and other funds that rely on national systems.

### 2.1.7 Risk management

This allocation's overall objective was to mitigate the priority financial and programmatic risks that affect allocations from the fund. Activities were geared toward strengthening management systems at the decentralized level, expanding internal and external audits to include Implementing Partners (NGOs) and CHSWTs, and assessing and monitoring the fiduciary risk environment in which the pool fund operates.

### 2.1.8 Pool fund administration

Pool fund administration was an inherent cost of operating the fund and includes bank encasement charges and fees, UNICEF's pass-through fee, and the cost of pool fund management (paid in advance until March 2015). A pool fund management firm, contracted by UNICEF and paid for by the fund, managed the pool fund and conducted the day-to-day activities of the Pool Fund Secretariat. The secretariat has nine staff members including a pool fund manager, two fund management advisors, two project accountants, an administrator, an operations officer, and drivers. The secretariat team worked closely with MOHSW counterparts and other donor-funded programs to support implementation and monitoring of pool-funded activities and to control the fiduciary risk associated with use of the pool fund, including at the county level. The secretariat also retained the records of the pool fund and the steering committee, including proposals, reports, steering committee briefing papers, resolutions, and meeting minutes.

## 2.2 Actual activities

FY 2013–2014 started off with the implementation of activities at the county and central MOHSW levels based on the approved allocations by the Pool Fund Steering Committee. The counties continued the contracting-in modality that began in January 2013 and reinforces the MOHSW's decentralization policy. Funds received by the CHSWTs from the GoL budget and from the pool fund were their main sources of direct funding for FY 2013–2014.

### 2.2.1 Direct support for service delivery

This fiscal year was marked with two major events that interrupted the provision of essential health care services for periods within the year and led to delays in some activities being implemented. First, two major health worker strikes occurred (July 2013 and February 2014) with health workers protesting against the GoL's failure to adequately respond to their demands for better benefits and working conditions. Second, the outbreak of Ebola Virus Disease (EVD) had a nationwide impact on the availability of health services.

#### 2.2.1.1 Health Worker Strikes (July 2013 and February 2014)

In July 2013 and February 2014, there were major nationwide health worker strikes lasting a period of one week each. In the first instance, health workers returned back to work after the first strike action and a grievance committee was set up by the MOHSW to explore the issues raised by health workers. Prior to the committee's report, the second health worker strike occurred from February 17 to 21, 2014. It was led by the leadership of the National Health Workers Association of Liberia (NHWAL), which is based in Monrovia with representatives in each county Reports from the CHSWTs confirmed that the strike action took place continuously during this period in the counties, interrupting the provision of essential health and social welfare services. The southeastern counties were hit hardest by the strike and a high proportion of health workers did not go to work, resulting in very limited numbers of staffs present in the health facilities. Throughout the strike, CHSWTs maintained minimum emergency, obstetric, and surgical services where possible. Moreover, teams of health workers from the central MOHSW and Tubman National Institute of Medical Arts (TNIMA) graduating students were deployed to support the CHSWTs in providing health services. The demand made by the health workers included: placing all health workers on GoL payroll, increasing the current salary, and improving the working conditions, including accommodation in hard to reach areas. Within a few weeks after the health workers strike, the first case of EVD was reported in Liberia. This meant that health workers had to be on the frontline to provide the required services.

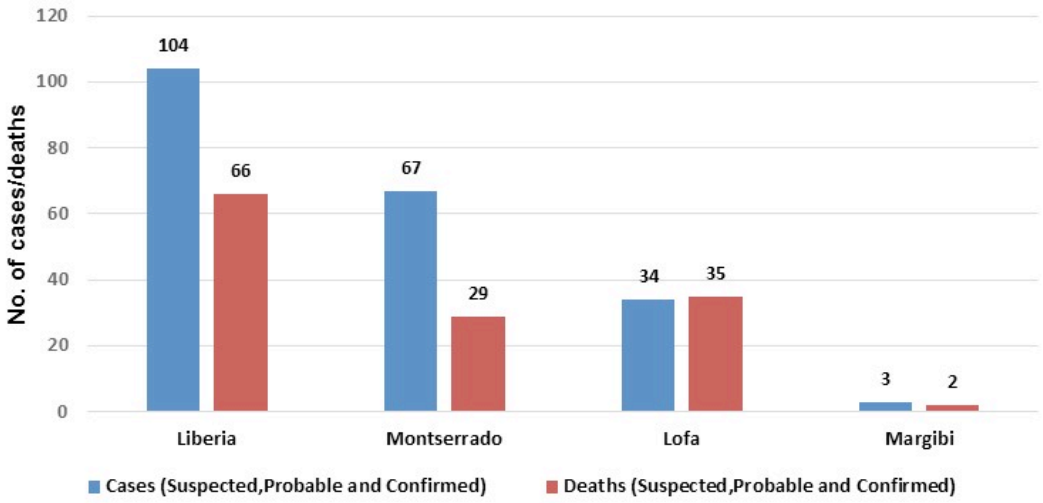
#### 2.2.1.2 Ebola outbreak and response in Liberia as of June 2014

The Ebola outbreak started in Liberia in March 2014, when the index case was reported from Lofa, and has continued up to present. This is the first time such an outbreak has hit West Africa, including Liberia. The first wave of EVD ended in late April 2014, but then a second wave of the epidemic started in May 2014 and has affected 9 of 15 counties. This EVD outbreak has been the largest outbreak ever recorded and has been declared by the World Health Organization as a Public Health Emergency, calling on the global community to join the fight against the deadly disease in West Africa. The current outbreak is the first time that Ebola has hit a densely populated urban area such a Monrovia. Liberia is the country in the West Africa region most affected by the disease. As of June 30, 2014, the cumulative number of cases of EVD was 104 (suspected, probable, and confirmed), which included 66 deaths (suspected, probable, and confirmed). There were 48 confirmed out of the total cases, 10 cases of EVD reported were health care workers, with 8 deaths recorded. Only two Ebola treatment unit (ETUs) were set up as of June 2014, one in Lofa County and one at JFK Hospital in Montserrado County with a capacity of approximately 80 beds.

At the start of the outbreak, Liberia had no capacity for laboratory testing for EVD. Testing of patients admitted at the ETU in Lofa was done by collecting specimens and safely transporting them for testing to Guekedu, Guinea. By the start of June 2014, the only testing facility in Liberia equipped for EVD was at the Liberia Institute for Bio-Medical Research in Margibi County. The average number of test conducted per week was 27, with 106 total tests completed in June. Of the tests that were made, about 45% were positive for EVD, and the most affected counties were Montserrado, Lofa, and Margibi.

These events led to a major impact on the overall health care delivery system of Liberia, which was striving to improve key health indicators despite the challenges of limited human resources for health, periodic stock-out of essential medicines and supplies, weak referral systems, and poor quality of care services, including infection prevention and control. Because of a lack of staffs, material, and equipment, most health facilities were forced to turn away patients who exhibited EVD signs and symptoms, with almost no referral facility to address their conditions. Additionally, patients have been afraid to seek care for fear of contracting EVD at a health facility. Health workers also fear

**Figure 1: Ebola Virus (EVD) Cases and Deaths in Liberia in May and June, 2014**



providing care due to the number of health workers who died and due also to the fear of encountering suspected EVD cases. By the end of the 2013–2014 fiscal year, the number of reported new EVD cases was continuing to increase and the potential impact on the health system and population posed an extremely serious threat.

### 2.2.2 Countywide CHSWT contracting-in

**General experiences**: Despite the continued support to the counties by the pool fund, the two events described above were reported by the CHSWTs as the most difficult periods during this fiscal year and led to them being too overwhelmed to manage these events. The Pool Fund Secretariat conducted quarterly calls with the CHSWTs to understand the experience of each county during the period, and phone interviews and face-to-face discussions during monitoring visits that were conducted with each of the relevant CHSWTs for this report. See Annex 1 for a complete list of findings and recommendations from Pool Fund Secretariat visits to pool funded counties. Data collected through the Health Management Information System (HMIS) was used as another means to gather information. Due to the delay in the submission of the integrated quarterly narrative reports from the counties for most of the period, not much information on the community-based activities was reported.

**Experiences by county:** Six CHSWTs were contracted-in to provide countywide support for the delivery of the EPHS Primary and Secondary Levels at all government-owned health facilities in the county. Highlights from these counties are described below.

- **Bomi County:** Routine activities were ongoing within the county. However, toward the end of the quarter suspected cases of EVD were reported from other counties; consequently, there was fear among health care workers and the general population. Implementation of activities for the fiscal year was on course with not much left to be completed as per the county's annual operational plan. However, the Bomi County team reported delays in receiving their GoL budgetary allotment.
- **Gbarpolu County**: The Gbarpolu CHSWT reported that activities were implemented during the period but logistical challenges persisted. Staffs were recruited to fill the gaps that existed, especially the accountant position at the CHSWT level. This allowed them to start addressing the backlog of administrative liquidation of funding received. Health workers returned to work and the situation was be-

ing monitored. The county continued to follow-up with central level on the investigation of the potential theft incident involving the county accountant (a police report is also pending on this matter).

- **Grand Bassa County:** The CHSWT continued the implementation of their county plan during this period with focus on integrated supervision at the clinics. Most of the activities were implemented within the period based on allotments received from the pool fund. The county received all of their quarterly allotments from GoL and this was attributed to having administratively liquidated funds after they were received. The county received some capital items, such as computers funded under the pool fund risk management allocation, which improved CHSWT and district health office reporting ability. Despite some logistical challenges, supportive supervision was conducted in hard-to-reach areas.
- **Grand Gedeh County:** The processes for the procurement of capital items was delayed; however, many activities were implemented at the county level and health facilities remained opened during this period. Some GoL funding was received but not for all quarters during the fiscal year. Drugs and medical supplies were received, including supplies from UNICEF. The health worker strike affected the provision of services.
- **Maryland County:** Planned activities were implemented in Maryland County, however the GoL allotment was not received for all quarters. The pool fund allotment was received despite some delays, but the bonus payments were also delayed, due to the time required to verify performance data, which demotivated staffs. Recruitment of additional staff for health facilities was completed in order to fill gaps in the health workforce, and drugs and medical supplies were received during this period.
- **Rivercess:** The County Health Officer reported that the pool fund support continued to be the major source of funding they received during the reporting period, and only a small portion of the allotted GoL funding was received. Most of the PF allotment was used for the upkeep of the hospital for patient feeding, fuel, and basic supplies, and the drug and medical supply situation has greatly improved. There were also gaps in staffing (financial assistant and logistician and other health facility staffs) which were recruited in this quarter. Supportive supervision was conducted at the health facilities by the CHSWT.

### 2.2.3 Contracting-out to NGOs

**Montserrado:** Subsequent to the MOHSW providing notice of the end contract, NGOs for this period focused on preparing to hand over their activities to the CHSWT. Meetings were held with the MOHSW to review the contractual agreement and key activities to be completed by June 30, 2014. AHA reported receiving funding from the pool fund for the quarter and reports were submitted on time. Drugs and medical supplies were received from NDS and distributed to the counties. AHA conducted their annual audit as per the contractual agreement with the MOHSW. In Montserrado, cases of Ebola were reported to be increasing during this period.

**River Gee:** The implementation of activities by MERCI continued during this period with the development of the transitional plan with the CHSWTs. A meeting was held with the MOHSW and the pool fund manager to review the contractual agreement and subsequently a letter of notice was provided by the MOHSW. Drugs and medical supplies were provided by NDS and transported to the counties for distribution. Reports were submitted on time and funds were disbursed.

### 2.2.4 Hospital CHSWT contracting-in

**Lofa (Tellewoyan Memorial Hospital):** Construction worked continued during this period for staffs accommodation although

not funded by the pool fund. The hospital remained on the alert for suspected Ebola cases. Staffs were afraid that they would encounter suspected cases. Pool funded drugs and medical supplies were requested and received by the hospital, and staffs received pool-funded salaries and incentives for the period. Health services continued to be provided.

**Nimba (G.W. Harley Hospital):** The hospital continued to provide services during this period and the staffing gap (physician assistants, seven registered nurses, ten certified midwives, and one laboratory technician) was addressed. The hospital is still in need of another medical doctor with advanced surgical skills to train and support the medical director and team.

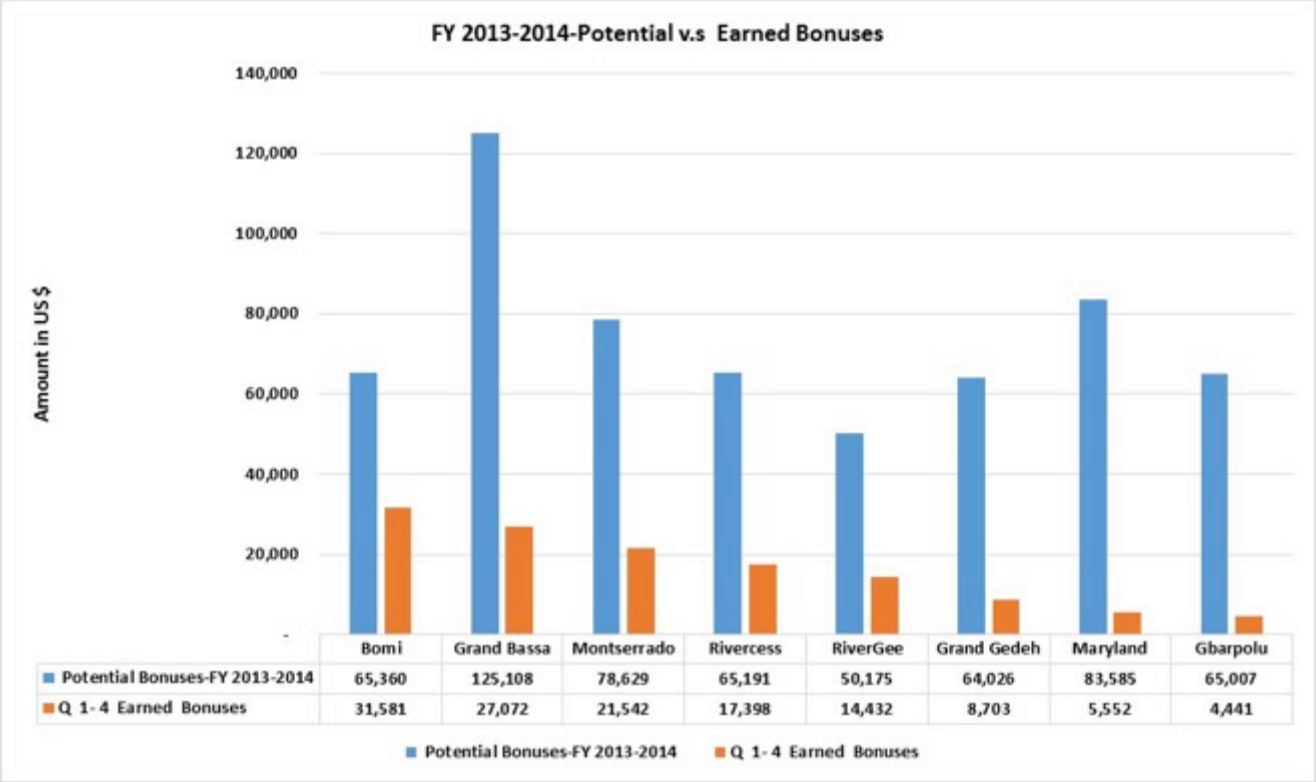
### 2.2.5 Performance component

The performance-based financing (PBF) approach was adopted by the Ministry of Health and Social Welfare in July 2011. This strategy is intended to improve health services by incentivizing indicators mostly relating to the MDGs. The MOHSW started the implementation in 7 counties and then subsequently rolled it out to 11 counties, namely: Lofa, Bong, Nimba, Gbarpolu, Bomi, Grand Gedeh, Maryland, Rivercess, Grand Bassa, Montserrado, and River Gee, covering 251 (45%) out of the 559 primary health care facilities in Liberia. Out of this number, 136 (54%) are covered through Pool Fund for PBF Bonuses. This strategy, which has been supported by the pool fund, is guided by the Contracting-In Guidelines and the PBF Operational Manual.

The fundamental purpose for performance contracts is to improve performance of the Liberian health system. The PBF component is supported by the USAID Fixed Amount Reimbursement Agreement (FARA) and the Health Sector Pool Fund (HSPF) for primary health care facilities. The World Bank is providing support to the MOHSW for PBF implementation at the secondary level (hospitals) in five hospitals (Redemption in Montserrado County, Jackson F. Doe Memorial Hospital in Nimba County, Phebe Hospital in Bong County, Tellewoyan Hospital in Lofa County, and J. J. Dossen Hospital in Maryland County). Bonuses allocated to county health and social welfare teams constitute 10% of the county's total budget. Of the 10% allocated to counties, 80% is allocated for service delivery indicators (HFs) and 20% for administrative indicators (IPs). At the primary level, bonuses are earned based on targets reached.

Despite the purpose of the PBF component supported through the PF, PBF bonus payments have generally been held up for the last 12 months of FY2013–2014 due to delays in data verification by the MOHSW and late submission of payment requests to the Pool Fund Secretariat. The staffs in the counties continue to be demotivated because of these delays. PBF has made some gains in the improvement of service delivery indicators. However, following field visits, discussions were held with health facility staffs and at the central Ministry of Health and Social Welfare. Issues raised included the importance of conducting an evaluation of the PBF scheme, the scheme's sustainability due to the fact that all PBF payments are made with donor funding (the GoL does not pay bonuses), consideration of semiannual PBF counter verification instead of quarterly, and the appropriate timing for the submission of request for payment. These PBF issues have been raised with the senior management of the MOHSW, which is deliberating how to proceed.

In FY 2013–2014, a total amount of US $597,082 was allocated for PBF across 8 of 10 counties supported by the pool fund. Out of this amount, US $130,721 (22%) was actually earned by counties. Bonuses were paid for all quarters in the year. Bomi and River Gee–MERCI earned more than 50% of their potential bonuses, while Montserrado, Rivercess, and Grand Bassa counties received only about 20% of their potential bonuses. The PBF bonuses not earned are not paid. In Q4, no counter-verification (April–June 2014) was conducted due to the EVD outbreak because




| | Bomi | Grand Bassa | Montserrado | Rivercess | RiverGee | Grand Gedeh | Maryland | Gbarpolu |
|---|---|---|---|---|---|---|---|---|
| Potential Bonuses-FY 2013-2014 | 65,360 | 125,108 | 78,629 | 65,191 | 50,175 | 64,026 | 83,585 | 65,007 |
| Q 1- 4 Earned Bonuses | 31,581 | 27,072 | 21,542 | 17,398 | 14,432 | 8,703 | 5,552 | 4,441 |

verification teams could not go to the field. However it was agreed by the senior management that indicators not captured in the HMIS be averaged so that health workers received their bonus in a timely manner and data in the HMIS be used for calculation of achievement against targets. The decrease in the amount of bonuses earned by the counties can be attributed to the following reasons: delays in the implementation of activities, delays in the allocation funds approved by the pool fund based on funding availability from fund donors, delays in the liquidation of funds by the counties and subsequent delays in disbursement of county operational funds. The pool funds disbursed were used by most of the counties as the primary funds for the period due to delays in receiving GoL allocations.

Reports from the counties show that PBF bonuses allocated to the health facilities varied in terms of the activities carried out and use of the bonus funds, but in many cases the bonus was used to pay for routine operational costs such as minor repairs to the facilities, purchase of land for construction of mini-offices to be used by the district health officers, repair of hand pumps, fencing of health facilities, community meetings, local construction of EPI facilities, food items for traditional midwives, maternal waiting homes, and mobile phones for requesting ambulance referral. Experienced has shown that there is also a need to carefully monitor the activities and bonuses spent at the county level. The PBF team has been having discussions on the next approach to PBF implementation due to sustainability of funding issue. Plans are ongoing for PBF to be implemented in 3 to 5 of 12 counties that are currently implementing PBF for primary health care services, as a means to carefully implement the scheme. An additional component has been added to the scheme to look at perceived satisfaction of clients at the community level. However, considering the much bigger issue about the sustainability of paying of bonuses and what they are spent on, there is a need for the MOHSW to consider evaluating the PBF scheme and the sustainability of the funding currently used to pay for the verification exercise and the actual bonus payment.

**Table 2.3: Number of Staffs Paid by the Service Delivery Allocation in Q4**

| County | Health Facility Staffs | CHSWT staffs | Total |
|---|---|---|---|
| Bomi | 380 | 40 | 420 |
| Gbarpolu | 192 | 0 | 192 |
| Grand Bassa | 56 | 21 | 77 |
| Grand Gedeh | 488 | 21 | 509 |
| Lofa | 191 | 0 | 191 |
| Maryland | 383 | 11 | 394 |
| Nimba | 129 | 3 | 132 |
| Rivercess | 222 | 4 | 226 |
| River Gee | 222 | 0 | 222 |
| Montserrado | 346 | 0 | 346 |
| **Total** | **2,609** | **100** | **2,709** |

Moreover, it is advisable to consider the wisdom of providing or withholding routine operational funds, in the form of bonuses to health facilities according to performance, given the potential for performance to worsen if basic operational funds are withheld.

### 2.2.6 Human resources

**Incentive payment:** The pool fund continued to support incentive and salary payments for health workers, CHSWT staff and facility staff, as well as support staff at the central MOHSW level. The total of number of health workers routinely paid a monthly salary or incentive with pool funds was 2709. Recruitment took place mainly in Maryland, Nimba (G.W. Harley Hospital), Gbarpolu, Grand Gedeh, and River-cess counties to fill in the gaps in staffing. The number of staffs paid incentives represents approximately 26% of the estimated 10,340 staffs in the health workforce.

### 2.2.7 Essential drugs and medical supplies

The pool fund continued to support service delivery in all 15 counties through the provision of essential medicines and medical supplies purchased through the National Drug Service (NDS). During the 2013–2014 fiscal year, most of the pool-funded medicines provided to the counties were from the previous fiscal year under the F8 allocation because most of that supply remained in stock at the end of the previous fiscal year due to the time required for procurement and delivery of drugs on the international market. The distribution of pool-funded drugs was coordinated by the Pool Fund Secretariat, Supply Chain Management Unit (SCMU), and the NDS. A total of US $1,345,634 in drugs and medical supplies was distributed in the first ($639,064) and second ($706,570) rounds of distribution to the counties, based on invoices and reports submitted to the Pool Fund Secretariat following the drug distributions. The two rounds of distribution occurred in December 2013 and May 2014. From these distributions, a net balance of US $844,598 of drugs and medical supplies paid for by the pool fund remained in stock at NDS at the end of the fiscal year while the EVD outbreak was unfolding. Most of the remaining stock consists of essential supplies; only a limited amount is essential drugs, and therefore it is not under high risk of drug expiration. A comprehensive inventory was conducted in June 2014 as part

**Table 2.4: Summary of Pool Funded Drug Distribution in FY 2013–2014**

| Category | Amount (US $) |
|---|---|
| PF drugs and medical supplies received | 2,197,390 |
| Reported expired drugs (February 3, 2014) | 7,158 |
| **PF drugs and medical supplies, balance** | **2,190,232** |
| **Round I distribution, December 2013** | |
| Pool Fund supported counties (distribution per invoice) | 335,953 |
| Non–Pool Fund supported counties (distribution per invoice) | 303,111 |
| **Sub-total** | **639,064** |
| **Round II distribution, May 2014** | |
| Pool Fund supported counties (distribution per invoice) | 439,636 |
| Non–Pool Fund supported counties (distribution per invoice) | 266,934 |
| **Sub-total** | **706,570** |
| **Total Distribution (NDS invoices)** | **1,345,634** |
| NDS reported balance, based on invoices as of June 2014 | 844,598 |
| NDS reported balance (NDS stock status report) as of June 2014 | 798,822 |
| **Variance** | **45,777** |

of the annual independent audit of the pool fund and the results will be included in the audit report. Meanwhile the procurement process for the US $1.8 million allocated for drugs and medical supplies in FY 2013–2014 continues into the new fiscal year. This will complement MOHSW's current essential drug program stock in the pipeline and will be received and distributed during FY 2014–2015.

### 2.2.8 Support Systems

The funding to strengthen the central MOHSW's service delivery support systems, such as planning, monitoring and evaluation, donor aid coordination, financial management, and internal audit, continued as planned during this reporting period.

**Office of Financial Management (OFM):** The OFM continued to manage funds from bilateral and multilateral donors, as well as from the GoL and in collaboration with the Pool Fund Secretariat team for pool funds. The financial management activities included ensuring compliance with the GoL's Public Financial Management Act, capacity building, and providing supervision and support to the CHSWTs. In addition to performance of its routine tasks, six staffs from OFM attended a three-week training in South Africa on the proficient use of Sage 300 ERP software (the Ministry's accounting system). Since their return, they have worked closely with various project accountants to ensure financial statements are prepared using the accounting system. The OFM has also undertaken a massive effort to reconcile the accounting system information with Excel spreadsheets that were run alongside the system by some projects over the years. The OFM team participated in the Annual Pool Fund Audit (November 2012–June 2013) and Fiduciary Risk Assessment (FRA) conducted by the international accountancy firms of Baker Tilly Virchow Krause LLP and More Stephens International, Ltd., respectively. OFM also worked closely with the Pool Fund Secretariat

to prepare, for audit purposes, various pool fund financial statements for the eight months ended June 30, 2013.

**Monitoring and Evaluation (M&E) Unit:** The M&E Unit monitors implementation of the National Health and Social Welfare Plan; in addition, with the Pool Fund Secretariat, it jointly monitors pool-funded activities. However, during the final quarter of the fiscal year, the M&E team did not conduct routine monitoring visit due to their involvement in the Ebola response activities, specifically in the areas of epidemiology, surveillance, training, and data management. Over the entire fiscal year, however, the M&E Unit did report some key achievements:

- Development and finalization of the National M&E policy and guideline
- Development and finalization of HMIS and M&E standard operating procedures for national, county and facility levels
- Integration of vertical monitoring activities such as routine pool fund monitoring, PBF contract monitoring, and program specific data validations
- Conducting Lot Quality Assurance Sampling (LQAS) outcome monitoring surveys in Sinoe and Rivercess counties
- Implementation of a two-week national M&E training retreat in Bomi County
- Reactivation of the national M&E coordination forums

**External Aid and Coordination Unit (EACU):** In the reporting period the EACU continued to liaise with partners and visitors to the Ministry of Health and Social Welfare and organize the Health Sector Coordination Committee (HSCC) meetings.

**Infrastructure Unit**: In this reporting period, the Infrastructure Unit team joined the teams working on Ebola Treatment Units construction and other assessments for the establishment of EVD diagnostic testing laboratories.

**County Health Services:** In the final quarter of the fiscal year, the County Health Services Unit focused on the Ebola response activities with desk officers and the Contracting-in Coordinator serving as technical assistants to the affected counties. The Contracting-in Coordinator worked closely with the Lofa CHSWT to support the response in one of the hardest hit areas of the country.

### 2.2.9 Risk management

The Risk Management allocation was based on a requirement in the bilateral agreement between the MOHSW and Irish Aid that 10 percent of their contribution be used for risk management purposes within the 2013–2014 fiscal year. As the fiscal year was already underway at the time the requirement was established, the risk management allocation was for a nine-month period from October 1, 2013, to June 30, 2014.

The implementing units for the allocation were the Office of Financial Management's Internal Audit, Compliance, and County Health Services units. An allocation was proposed to support the implementation of the Ministry of Health and Social Welfare's Risk Management Plan, including strengthening management systems at the decentralized level, expanding internal and external audit to include Implementing Partners (CHSWTs and NGOs) at the county level, and assessing the overall fiduciary risk environment for the pool fund.

**Allocation Goal**: To ensure that pool fund support for implementation of the National Health and Social Welfare plan is used effectively for its intended purpose of helping to improve the health social welfare status of all people in Liberia. The specific objectives were:

1) To mitigate the priority financial risks that affect allocations from the Pool Fund;

2) To mitigate the priority programmatic risks that affect allocations from the Pool Fund.

The following subsection summarizes the progress made on the implementation of the Risk Management Project:

**Objective 1. To mitigate the priority financial risks**

**Internal Audit and Compliance:** This unit focused on the strengthening of the internal audit and compliance processes. The following key activities were achieved:

- **Internal Audit Review:** The unit continued their review of the liquidations reports from the counties and central level and NGOs in preparation for disbursements. Reports provided by the auditors linked to issues of compliance.
- **Recruitment and Deployment of Regional Auditors:** Four regional auditors were hired in December 2013 and underwent training at the central level facilitated by OFM and Internal Audit unit, followed by a week of work at the central MOHSW as a means of orientation prior to deployment. These auditors were deployed to their respective regions as follows: Region 1 (Nimba, Margibi, Bong, and Lofa), Region 2 (Gbarpolu, Bomi, and Grand Cape Mount), Region 3 (Sinoe, Rivercess, and Grand Bassa) and Region 4 (Grand Kru, River Gee, Maryland, and Grand Gedeh). Reports and discussion held with the regional auditors show that they all underwent seven days of training in preparation for deployment. Issues identified by the regional auditors were: absence of key staffs (accountants and CHOs) during pre-audit, assets management, registry and coding of materials, warehouse management and records, adherence to procurement regulations, lack of supplier business registration, absence of delivery notes on most transactions, low capacity in some areas of financial management, payroll (verification, records and files), communication from central MOHSW to CHSWTs on internal auditors' roles and responsibilities.
- **Field Audits (Internal):** Field audits conducted in the counties showed that there are issues with the CHSWT completing bank reconciliations, missing payment vouchers, vendors lacking current business registration and valid tax clearance, re-

cording and tracking stock in the stores, maintenance of fixed asset registers with all items properly coded, filing of documents, compliance with the PPCC procedures/regulations, lack of supporting documents on payment vouchers, and limited oversight of human resources in the counties. These issues were reported across all counties. The internal audits also included the implementing partners, MERCI and AHA. The internal audit team visited Gbarpolu County as a follow-up to the Pool Fund Manager's visit to explore the minor theft incident involving the accountant. This issue is still under police investigation.

- **Training:** Training was completed for 10 internal audit staffs for November 11–14 and December 10–14,2014. The training was done in two phases conducted by Symantec Consulting, in Yaba, Nigeria. The training focused on risk mitigation and management, detecting fraud and error, and sound internal control management, effective risk reduction implementation strategies.

- **Risk Management and Mitigation TOT:** MOHSW held a Training-of-Trainers (TOT) Risk Management and Mitigation Workshop in Buchanan, Grand Bassa County from June 4 to 6, 2014. The Pool Fund Management participated in the TOT. A total of 46 staffs—Central Level (28), CHOs/CHSA (12) from 6 counties (Montserrado, Margibi, Grand Bassa, Lofa, Nimba, and Bong)—were trained. The objective of the training was to build the capacities of these central- and county-level staffs as trainers so that they can return and roll out the risk mitigation plans, strategies, and actions already taken at the central level to the counties. The importance of sound and practical procurement practices was emphasized. Also included on the agenda were: Regional Support Team orientation, an overview of Risk Management and Mitigation, the Risk Management Decentralization Strategy, MOHSW Internal Communication Strategy, and Code of Conduct and Civil Service Standing Orders. The conference also focused on how risk management and mitigation strategies provide an overall guidance for policy and procedure development and implementation. The Compliance Officer of the MOHSW led this workshop, with support from the pool fund. Trainers from the Civil Service Agency (CSA), the Public Procurement and Concessions Commission (PPCC), the Governance Commission (GC), the National Drug Service (NDS), and the Liberia Medicines and Health Products Regulatory Authority (LMHRA) made presentations. This provided an opportunity for under-standing the policies, laws, and regulations around these risks areas and for strengthening and ensuring an effective environment for implementation.

- MOHSW has mitigated 65 of the 99 risks identified in the USAID Stage 2 Risk Assessment report. However, some have not fully been cleared, but communications and monitoring strategies are in place to continuously make improvements where necessary. Risks still awaiting mitigation are mainly related to the areas of human resources and procurement management. The MOHSW Public Financial Management and Risk mitigation plan will be updated with the support of the USAID–GEMS team.

- **Follow-up on Audit Recommendations:** Follow-up on audit recommendations was completed by the compliance officer to three counties (Grand Gedeh, River Gee, and Grand Kru). Financial reporting had improved due to the training provided by the OFM and the introduction of the electronic system. Procurement continues to be a challenge in the southeast counties because the competition is low. There are not many vendors with similar products, business registration and tax clearance are not rigidly enforced, and vendors are not

willing to issue statements consistently without receiving purchase orders. Obtaining three quotes from vendors also remains difficult.

**Procurement Activities Review:** The Pool Fund Management Firm in the fourth quarter continued the site visits and reviews of county and hospital procurement activities. The onsite appraisals followed the plan established by the MOHSW Procurement Unit and approved by the Deputy Minister for Administration. The two most significant reviews by the Pool Fund Management Firm and MOHSW Contracting-In Coordinator from the Ministry's Health Services Department were conducted with two hospital projects. These projects are in counties where the major funding support for the county health and social welfare teams come from a different donor. The principal purpose of the visit was to observe the hospital's continuing improvement of healthcare by evaluating the healthcare facilities and encouraging the staff and management team to excel in providing safe and effective care of the highest quality and value. The focus of the exercise was on the hospital's system and procedures and included a review of procurement and administrative activities. The site visit further confirmed earlier observations that procurement activities by the CHSWT and hospitals occur but there were extreme compliance challenges, and strict compliance with Public Procurement & Concessions Act and MOHSW procurement policies was not evident during the site visits. The formal written GoL and MOHSW procurement policies and guidance were principally designed for central office operations and not for county activities, where there are limited administrative staff and local vendors. The organizations visited attempted to follow the general procurement guidelines but struggled to meet the specific directives and requirements. The site reviews found the following problematic issues:

- The procurement committee had no records of meetings or minutes of activities.
- The procurement officers had multiple assignments not directly related to procurement.
- The organizations' procurement officers and administrators had little or no contact with MOHSW Procurement Unit (ProU).
- The organizations did not have copies of the Public Procurement & Concessions Act or related documents to use as a reference.
- No written procurement plan and budget had been developed or used.
- Contracts with venders to provide goods and services were sometimes written, but there was no evidence that competitive bidding was used in establishing the contracts.
- No vendor lists and no formal process to obtain bids were used.
- Procurement or purchase order logs were not used. The drug and medical supplies purchased locally lacked full procurement documentation.
- Procurement of items of greater value than the approving officer authority level was evident.
- Procurement documents appeared to be all dated on the same date.
- There was little or poor documentation of procurement transactions.

To address some of the gaps found in the site visits, the Pool Fund Management Firm prepared and distributed to the CHSWTs a procurement reference notebook containing Procurement at County Level, MOHSW Procurement SOP, MOHSW Procurement Standard Operating Procedure (Version 3.0), the Public Procurement & Concessions Act of 2005, Amendment & Restatement Regulations 1–80 (October 2010), Public Procurement & Concessions Act of 2005 Implementa-

tion Manual, and the Public Procurement & Concessions Act Frequently Asked Questions. These reference materials are intended to address many CHSWT questions and inquiries.

**Office of Financial Management:** OFM activities focused on strengthening the MOHSW financial management system at the central and county levels. The pool fund support provided to manage the risk associated with use of pool fund resources continued as planned during this reporting period. The OFM was involved in the training (ACCPAC and super users' orientation) and in working with Modular Resources & Services Ltd., of Ghana, on the use of the SAGE EPR ACCPAC system for financial management services at MOHSW, which has been in use since 2008. The Pool Fund Management Firm supported this technical assistance to the MOHSW. Key activities implemented as per the project's objectives were:

- **County eFinSys:** In October 2013, OFM finalized the new electronic financial management system (County eFinSys), which features unique workbooks for budgeting, accounting, reporting, procurement planning and management, and a set of registers for assets, stock management, and for tracking commitments.
- **System validation and TOT**: The system was completed after the validation and after the Training of Trainers workshop held in November 2013 with 10 staffs (Compliance, 2, Internal Audit, 3, Pool Fund, 3, and OFM, 2) trained as system users.
- **Training on the eFinSys:** OFM conducted two training sessions on the electronic financial management system (county eFinSys). **December 2–6, 2013,** first group of 76 staffs trained (CHOs, medical directors, administrators, procurement/logistic officers, accountants, internal audi-tors (regional) from Bomi, Bong, Grand Cape Mount, Grand Bassa, Gbarpolu, Rivercess and Montserrado counties; **December 9–13, 2013,** second group of 62 staffs in the same categories.
- **Procurement of ICT supplies and logistic support:** The OFM received and distributed ICT equipment intended for all CHSWTs as well as two vehicles for monitoring and supervision visits to the counties. The procurement of the capital items for the counties greatly boosted the OFM's efforts to migrate the counties from manual to electronic accounting and financial reporting.
- **County progress on the use of the system**: Up to 75% of the institutions submitted accurate financial reports. Despite this success in terms of financial reporting, procurement and warehousing are still challenging because logistics and procurement officers are still slow in procurement planning and warehouse management.
- Counties are now recording financial transactions using the new electronic system, generating more accurate and reliable reports (though not in a timely manner), and preparing consolidated (entity-wide) financial reports across various funding sources
- **Monitoring visit:** The OFM made one round of visits to the counties as a follow up to the trainings indicated above. Twelve out of the fifteen counties were visited during the fourth quarter. In spite of the achievement made to date, counties still lag behind in the following areas, which need to be accelerated, and the use of the existing system reinforced and closely monitored. The areas that need improvement are: use of appropriate forms designed to facilitate adherence to the procurement process; maintenance and regular updating of Fixed Assets register; maintaining stock records and the commitments register.

**Pool Fund Annual Audit (November 2012 to June 2013) and Fiduciary Risk Assessment (FRA)**

The procurement process for the annual audit and FRA was completed in May 2014, following a proper tendering process led by the MOHSW in collaboration with the PFM. The names of the selected firms (Baker Tilly Liberia for the Pool Fund Annual Audit and Moore Stephens LLP for the Fiduciary Risk Assessment) were provided to pool fund steering committee members for approval via email voting along with the minutes of the MOHSW procurement committee meeting. The procurement process for the annual audit followed the provisions of the Amendment and Restatement of the Public Procurement and Concessions Act, 2005, and the MOHSW Procurement Standard Operating Procedure Manual.

**Independent audit:** The Joint Financing Arrangement for the Health Sector Pool Fund includes provisions for annual independent audit. The contract start and end dates for the audit were June 2 through July 7, 2014. The audit followed four phases, namely: Scoping & Planning, Testing and Validation (which covered the field work conducted to the counties and IPs), Exit meeting and discussion, and Reporting. The audit also involved a comprehensive physical inventory at NDS. The initial plan was interrupted because the fieldwork coincided with the county planning exercise; however, the team was able to complete the fieldwork prior to the increased Ebola response activities. This annual audit covered implementing partners (NGOs) in accordance with the terms of their contract with the MOHSW, the National Drug Service (NDS), central MOHSW departments and units, and CHSWTs as the implementers of contracting-in supported by the pool fund. The audit period was for eight months of FY 2012–2013 beginning November 1, 2012, and ending June 30, 2013. The report for the audit will be submitted to the Pool Fund Steering Committee after review by the MOHSW and the Pool Fund Secretariat.

**Fiduciary Risk Assessment:** The fiduciary risk assessment (FRA) was started in May 2014 by Moore Stephens LLP, an international firm working along with its local partner, Parker & Associates. The primary objective of the FRA was to better understand the fiduciary risk environment in which the pool fund operates in order to manage the associated risks. The FRA was also expected to provide guidance on mitigating any significant risks to the proper use of funds and outline a suitable process for monitoring performance. The international team began work on June 9, 2014, as per the plan, and stayed until June 13, 2014. During this period discussions with the relevant departments and MOHSW and the Pool Fund Team and document reviews were carried out. Parker & Associates (the local partner) conducted the field visits. The Moore Stephens team informed the Pool Fund Manager via email on June 14, 2014, that, after careful consideration of the update provided on Ebola outbreak and in view of the subsequent instruction provided by the firm, they had decided to leave Liberia for a while. The FRA team was unable to return to complete the fieldwork but continued working remotely with the MOHSW and Pool Fund Secretariat and other relevant parties on interviews and document review. The report for the FRA will be submitted to the Pool Fund Steering committee after submission and review by the MOHSW and Pool Fund Management Firm.

**Objective 2: To mitigate the priority programmatic risks**

The County Health Services Department implemented Objective 2 of the risk management allocation. The key achievements for the period were:

**Assessment of Baseline Capacity:** Working with the relevant departments, the OFM team conducted the baseline assessment for six counties (Grand Cape Mount, Margibi, Rivercess, Bomi, Gbarpolu, Grand Bassa), using different processes of the readiness review for contracting-in guidelines, including prequalification, county self-assessments based on

set criteria, and on-site verification of the county self-assessments. A three-day feedback meeting was held after the assessment to validate findings from the assessment. Prior to conducting the assessment, a one-day orientation meeting was organized with the MOHSW Contracting-in Technical Review Committee to discuss the counties' self-assessed results and identify specific areas for support. Preliminary results from the pre-qualification scores and the verified self-assessment visit were summarized into a draft comprehensive capacity-building plan. This plan will be reviewed and validated by the respective counties. The assessment took into account non-pool fund supported counties for comparison purposes. Bomi County was selected to monitor progress of the contracting-in strategy. The recommended minimum score for contracting-in was set at 70%, consistent with the threshold set for accreditation. The pre-qualification scores indicated that Bomi (76%), Grand Cape Mount (74%), and Margibi (71%) exceeded the 70% threshold, while Grand Bassa (61%), Rivercess (62%), and Gbarpolu (63%) fell slightly below the threshold.

**Development of the capacity building plan:** After the baseline assessment was conducted, the team identified strategic issues linked to capacity gaps at the county level. This led to the development of a draft comprehensive capacity building plan that was validated with the counties. The plan contains specific functional areas and subcategories within each area for improvement and strengthening, such as resources, technical support and technical assistance, advisors available for each functional area, funding sources for capacity-building, timeline for provision of capacity-building, responsible MOHSW office and partners for ensuring capacity-building is provided, and monitoring and evaluation of capacity-building activities.

The intention was for the capacity building team to provide to the senior level MOHSW salient analysis on the implementation of the capacity building plan for review and endorsement, including challenges, lesson learned, and recommendations that would be key to informing future plans and strategies. However, because this risk allocation was developed during the fiscal year, there was insufficient time to implement the capacity building plan before the outbreak of Ebola in March 2014 and again in June 2014 and the dual crisis of responding to Ebola while trying to restore health care services after the collapse of the health system. In the context of strengthening the health system's ability to withstand future shocks, such as the one caused by Ebola, the relevance of the capacity building plan and its implementation will be considered after the Ebola epidemic is brought under control and health care services have been restored.

### 2.2.10 Pool fund administration

Pool Fund Secretariat team worked closely with MOHSW counterparts and other donor-funded programs to support implementation and monitoring of pool-funded activities and to control the fiduciary risk associated with use of the pool fund. Routine activities such as banking-related activities, processing of payment requests from the counties and central level, liquidation reviews, reporting, budget planning, procurement monitoring (including at the county level), and coordination and other administrative activities continued during this period. The secretariat team worked closely with the OFM and other relevant departments on the Pool Fund Annual Audit and Fiduciary Risk Assessment. The Pool Fund Management Firm also conducted joint monitoring visits with MOHSW counterparts to two counties (Tellewoyan Hospital in Lofa and G.W. Harley Hospital in Nimba). Working with the National Drug Service, the procurement process for the drugs and medical supplies for FY 2013–2014 was also started. A banking assessment was completed but analysis could not be made due to the competing priorities during the fourth quarter.

Three monthly pool fund financial updates (April, May, and June 2014) were submitted to

the steering committee along with the FY 2013–2014 Q3 draft report for steering committee review. The Secretariat also retained all records of the Pool Fund Steering Committee, including proposals, reports, contracts, steering committee briefing papers, resolutions, and meeting minutes. During the fourth quarter, the Pool Fund Steering Committee meeting planned for June 6, 2014, was postponed due to the absence of the Chairperson, who was conducting other official duties. The Pool Fund Manager provided support to the Ebola response where necessary during this period and attended numerous EVD coordination meetings.

### 2.3 Challenges

There were many challenges reported by the counties as well as those seen during field visits and experienced on a day-to-day basis by the Pool Fund Secretariat. These were as follows:

(1) **Ebola outbreak:** The identification of the first case of Ebola in Foya led to a change of focus from routine services and other issues to the need to tackle this threat. Given that it was a first experience for Liberia, many activities were interrupted in getting the response started. The counties began to focus on the response activities, especially for those hardest hit. This continued up to the end of the fourth quarter with an increasing trend in new cases.

(2) **Nationwide health workers strike:** The strike interrupted the provision of routine essential health and social welfare services. The CHSWTs struggled to maintain surgical, obstetric, and emergency services during the strike period due to the limited number of health workers on duty. Some staff had to work overtime to maintain services. Dealing with the demands of the health workers, the county authorities, and the population in need of services was challenging. Linked to the strike was the issue of GoL payroll staff. Counties reported having many staff working in the health facilities who were not on GoL payroll but were only paid pool fund incentives.

(3) **Accommodation:** The lack of staff accommodation and poor living conditions in hard-to-reach areas was reflected in some counties' reports. This also contributed to staff attrition due to the cost to them to rent accommodations.

(4) **Supervision, monitoring and logistics:** Some counties continued to report broken vehicles and ambulances, which impeded supportive supervision, distribution of drugs and medical supplies, and referral of patients. This was attributed to the delayed in procurement process for capital items as funding was not available at the start of the year.

**Stock-out of essential drugs and medical supplies.** Although the interim approach was implemented for most of the year, counties still reported stock-out for essential drugs at the health facility levels.

(5) **The use of the pool fund allocations to meet shortfalls in GoL allocations:** Most counties reported not receiving their government budget allocation and for those who received funds, it was not in the right amount.

(6) **Potential theft:** The Gbarpolu theft issue is still pending resolution by the MOHSW, and this has caused further interruption of activities implemented in Gbarpolu County because the county accountant was dismissed and funding is being withheld until the backlog of liquidations is completed.

(7) **Counties still have unliquidated funds**: The pool fund team is working closely with internal auditors and OFM in ensure liquidation is completed during the next period.

(8) **PBF bonuses:** Bonuses have not been paid on time due to delayed verification

exercise and delayed submission of request to the Pool Fund Secretariat for payment, which demotivated staffs.

### 2.4 Success story

The delivery of baby Miatta—our little Pool Fund Manager—occurred about 6 days before the first cases of Ebola were identified in Liberia. The real Pool Fund Manager wore gloves for the delivery but there was limited water and soap for cleaning. Reflecting on the current Ebola outbreak points to an essential component of the response activities. At the health facility level, there could be suspected cases presenting and requiring care. The risk of such encounter is high but with proper adherence to universal precautions and triaging, we would be able to provide non-Ebola related services. If baby Miatta was born in the wake of the Ebola outbreak, the mother, baby, and caregivers might have contracted Ebola given the delivery situation. There is always an urge to save lives but health worker self-protection is important.

**The Follow-Up:** Compared to many other babies, baby Miatta was fortunate to have taken all of her vaccines before access to health care service became challenging. She continued with exclusive breast-feeding and turned 3 months in May 2014 and will be monitored closely.

**Key Messages:**

- There is a need to maintain routine health care services with a focus on infection prevention and control even during an Ebola outbreak.
- Appropriate and timely health care, especially immunization, provided to children less than 1 year will help them to survive and live to have many more birthdays.

## 2.5 Ten-Year National Health Plan Monitoring Framework

The National Health and Social Welfare Plan, 2011–2021 includes a monitoring framework with 19 indicators to monitor progress against the goals and objectives of the plan that the pool fund exists to help achieve. At the time the plan was developed, baselines were established for each indicator as well as targets to be achieved by 2021. The monitoring framework includes impact indicators, such the maternal mortality ratio and child mortality rate, which are also health-related MDG indicators. Other indicators reflect the wider health system goals of equitable access, responsiveness, and financial protection. The remaining indicators, most of which can be computed at the county level, monitor system performance, service provision, the functioning of the systemic components, and sector coordination. The table below presents progress on the NHP monitoring framework for counties supported by the pool fund during the Government of Liberia's FY 2013–2014, which began July 1, 2013 and continued through June 30, 2014, with comparisons made to the national achievements.

| Goal/Objective | Indicator | Baseline | Year | Source | Target 2021 | Progress to Date* |
|---|---|---|---|---|---|---|
| **Indicators monitoring Liberia's overall goal of improved health status (these indicators are not exclusive of the health sector and should be measured every 5 years)** | | | | | | |
| Healthier population | Maternal mortality (per 100,000 live births) | 994 | 2007 | LDHS | 497 | 1,072 |
| | Under-5 mortality rate (per 1,000 live births) | 114 | 2009 | LMIS | 57 | 94 |
| | Life expectancy at birth (years) | 59 | 2010 | UNDP | TBD | 59 |
| **Indicators monitoring health system's goals (to be monitored every 1–3 years, and are specific for the health system)** | | | | | | |
| Increased access and utilization of health services | Percent of the population living within 5 km of the nearest health facility | 69% | 2010 | RBHS | 85% | 72% |
| Responsiveness to users' expectations through decentralization, ensuring a fair degree of equity | Equity index: ratio of contacts (head count/head) in the 25% of population with highest consumption over 25% population with lowest consumption | 2.39 | 2010 | HMIS | 1.5 | 2.28 |
| Financial protection | Public expenditure in health and social welfare as % of total public expenditure | 7.80% | 2010 | MOF/OFM | >10% | 10.60% |

* Please note that the indicators reported in this report are only those monitored on quarterly basis.

| | | | Base-line | Target 2021 | Pool Fund FY 2013 Target | National FY 2013 Target | Pool FY 2013 – Q4 | National FY 2013 – Q4 | Pool FY 2013-14 | National FY 2013-14 |
|---|---|---|---|---|---|---|---|---|---|---|
| **Indicators monitoring Health System performance (these mostly annual indicators focus on the system's components and their performance)** | | | | | | | | | | |
| Service provision | Maternal health | % of deliveries that are facility-based with a skilled birth attendant | 22% | 80% | 43% | 50% | 47% | 56% | 41% | 52% |
| | Family planning | Couple-years protection with family planning methods | 45,798 | TBD | 34,509 | 72,029 | 9,141 | 35,437 | 36,269 | 141,953 |
| | Child health/EPI | % of children under 1 year who received pentavalent-3 vaccination | 74% | 90% | 100% | 90% | 80% | 83% | 82% | 86% |
| | Service consumption | OPD consultations per inhabitant per year | 0.9 | 2 | 0.94 | 1.04 | 0.78 | .95 | 0.90 | .93 |
| | Malaria | % of pregnant women provided with 2nd dose of IPT for malaria | 29% | 80% | 49.90% | 45% | 48% | 46% | 45% | 47% |
| | HIV/AIDS | Number of pregnant women testing HIV+ and initiated on ARV prophylaxis. | 1,613 | TBD | 307 | 2,987 | 57 | 141 | 293 | 798 |
| | Tuberculosis | Number of smear positive TB cases notified per 100,000 population | 103 | 127 | 11 | 3 | 104 | 665 | 816 | 3,321 |
| | Human resources | Number of skilled birth attendants (physicians, nurses, midwives and physician assistants)/10,000 population | 5.7 | 14 | 13 | 7.4 | Reported annually[4] | | | |
| | Drugs | % of facilities with no stock-out of tracer drugs during the period | TBD | 95% | 59.60% | 70% | Pending[5] | | | |
| Systemic components | HMIS | % of timely and complete HMIS reports submitted to the MOHSW during the year | 76% | 90% | 83%<br>98% | 60%<br>80% | 69%<br>97% | 60%<br>78% | 67%<br>97% | 41%<br>82% |
| | Financing | % of execution of annual allocation of GoL budget for health | 64% | 95% | | 92% | Reported annually | | | |
| | Quality | % of facilities reaching two-star level in accreditation survey including clinical standards (public network facilities). | 9.30% | 90% | 0% | 0% | Reported annually | | | |
| Sector coordination | | Percent of aid that is untied | TBD | 50% | | Pending National Health Accounts survey results | | | | |

[4] Please note that the indicators reported in this report are only those monitored on quarterly basis.

[5] The description, calculation, and source data for stock-out indicator are still being analyzed by the MOHSW's HMIS Unit.

## 2.6 Indicator performance

Key performance indicators are monitored to assess the performance and progress made against targets set in the NHSWP Monitoring Framework. Support continues to be provided for service delivery focusing on the EPHS at all levels (community, primary, secondary, and tertiary). The data presented below represents an overall reporting rate of 97%, with timely reports at 67% nationally. Over the quarters, the reporting rates have remained relatively constant, however, timely reports still remains an issue to be address. Currently only the health facility level data is being monitored through the District Health Information System. Community-based interventions are reported in county quarterly narrative reports to the MOHSW. Counties are not provided feedback by the respective MOHSW teams when narrative reports are submitted, and thus it is difficult for the Pool Fund Secretariat to ascertain reasons for some changing trends in indicators monitored.

### 2.6.1 Maternal and newborn health

Essential primary healthcare services are provided at the health facility and community levels. During this reporting period, national skilled delivery coverage increased from 52% in Q3 to 57% in Q4. Skilled delivery coverage has shown an increasing trend over the fiscal year. The recent Liberia Demographic Health Survey, published in 2013, identified the Maternal Mortality Rate had increased from 994 to 1,072 (per 100,000 live births). The table below presents the skilled delivery coverage in pool-funded and all counties during the current and previous reporting periods (see annex 2 for absolute figures).

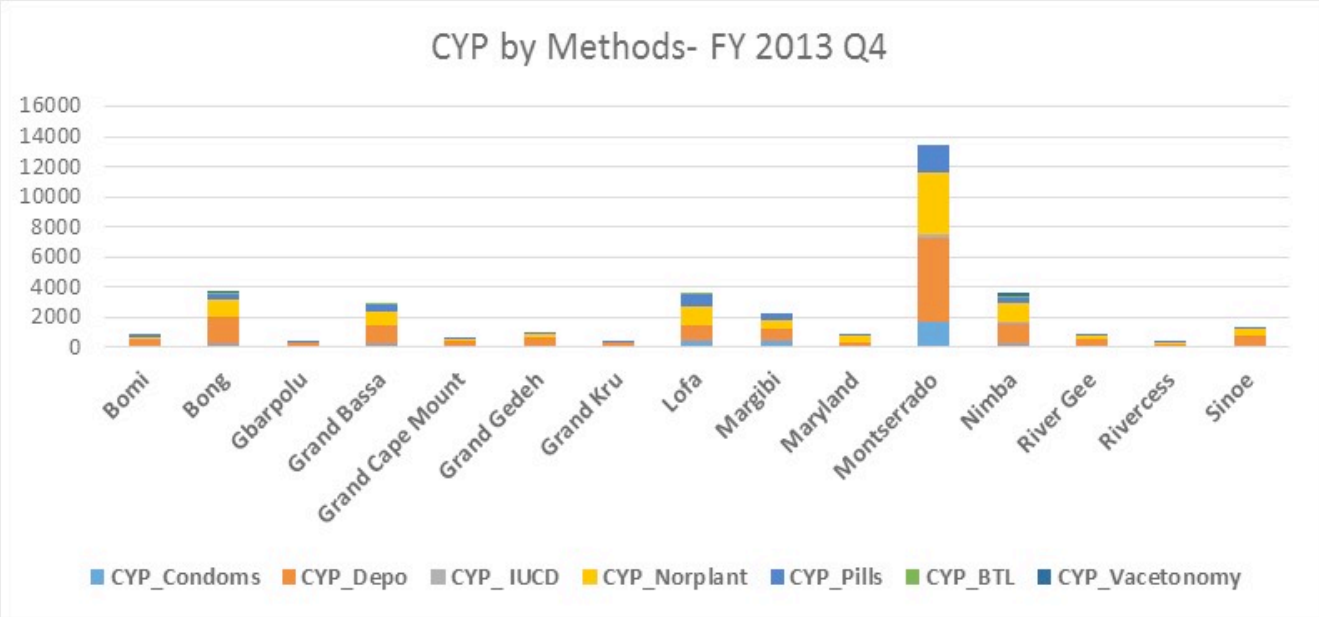
**Skilled Delivery Coverage in Pool Fund Counties (red) vs. National (white)**

| County | Overall Population | Pool Fund population | Jul–Sep | Oct–Dec | Jan–Mar | Apr–Jun | FY 2013 |
|---|---|---|---|---|---|---|---|
| Bomi | 95,290 | 89,176 | 66% | 69% | 73% | 84% | 72% |
| Bong | 377,767 | | 43% | 73% | 80% | 92% | 75% |
| Gbarpolu | 94,461 | 94,461 | 27% | 17% | 30% | 33% | 27% |
| Grand Bassa | 247,055 | 213,155 | 32% | 36% | 34% | 44% | 37% |
| G.C. Mount | 143,949 | | 33% | 39% | 40% | 39% | 37% |
| Grand Gedeh | 141,893 | 131,389 | 39% | 43% | 45% | 53% | 45% |
| Grand Kru | 62,726 | | 19% | 30% | 25% | 32% | 30% |
| Lofa | 313,629 | 23,026 | 37% | 60% | 70% | 71% | 66% |
| Margibi | 237,803 | | 46% | 45% | 49% | 57% | 48% |
| Maryland | 144,594 | 144,594 | 38% | 30% | 40% | 47% | 39% |
| Montserrado | 1,164,147 | 220,692 | 46% | 43% | 41% | 41% | 43% |
| Nimba | 523,386 | 22,994 | 27% | 72% | 68% | 79% | 71% |
| River Gee | 75,659 | 75,659 | 48% | 46% | 45% | 54% | 48% |
| Rivercess | 81,005 | 81,005 | 41% | 47% | 43% | 45% | 43% |
| Sinoe | 115,484 | | 25% | 44% | 58% | 58% | 50% |
| **Liberia** | **3,818,848** | **1,096,151** | **39%** | **50%** | **52%** | **56%** | **52%** |

### 2.6.2 Family planning

Couple-years of protection (CYP) is a key indicator used by MOHSW to monitor the performance of family planning programming. CYP is the estimated protection provided by family planning services during a one-year period, based upon the volume of all contraceptives provided to clients during that period. The chart below presents the CYP by commodity/method for all counties in Liberia, including pool-funded counties for the year.

Montserrado continues to have the highest utilization of family planning services due to the number of health facilities that provide services and access to commodities. Depo and Norplant are the two methods most frequently used across the counties. Gbarpolu, Grand Kru, Maryland, and Rivercess counties still show a much lower uptake for family planning services. FP commodities usage is being promoted through health education and community outreach services.




### 2.6.3 Child Health / EPI

The EPHS emphasizes the importance of the Expanded Program on Immunization. Five different antigens (BGC, polio, pentavalent, measles, and yellow fever) are administered to children under age 1 to protect them from childhood illness and boost the immune system as part of EPI. The table below presents the percentage of children under age 1 who received pentavalent-3 vaccination in pool fund supported counties (see Annex 2 for absolute figures).

Across the counties, coverage rates have been maintained during the year and have shown upward trends. The coverage for Penta 3 decreased in Q3 to 79% but increased to 83% in Q4. The overall coverage is 86.4%. This is one of the service provision indicators that has showed marked improvement and is consistent with the overall trends of immunization coverage highlighted by Liberia's achievement of the MDGs 4.

**Penta 3 Coverage – Pool Fund Counties (red) vs. National (white)**

| County | Overall Population | Pool Fund population | Jul–Sep | Oct–Dec | Jan–Mar | Apr–Jun | FY 2013 |
|---|---|---|---|---|---|---|---|
| Bomi | 95,290 | 89,176 | 87% | 86% | 88% | 100% | 89% |
| Bong | 377,767 | | 84% | 115% | 103% | 117% | 107% |
| Gbarpolu | 94,461 | 94,461 | 83% | 73% | 74% | 90% | 80% |
| Grand Bassa | 247,055 | 213,155 | 79% | 82% | 72% | 101% | 84% |
| G.C. Mount | 143,949 | | 80% | 92% | 75% | 76% | 79% |
| Grand Gedeh | 141,893 | 131,389 | 75% | 84% | 56% | 55% | 67% |
| Grand Kru | 62,726 | | 63% | 88% | 83% | 68% | 83% |
| Lofa | 313,629 | 23,026 | 57% | 85% | 79% | 85% | 85% |
| Margibi | 237,803 | | 72% | 72% | 81% | 79% | 75% |
| Maryland | 144,594 | 144,594 | 108% | 108% | 86% | 96% | 101% |
| Montserrado | 1,164,147 | 220,692 | 100% | 97% | 76% | 68% | 85% |
| Nimba | 523,386 | 22,994 | 39% | 91% | 78% | 84% | 87% |
| River Gee | 75,659 | 75,659 | 93% | 76% | 47% | 63% | 69% |
| Rivercess | 81,005 | 81,005 | 85% | 92% | 68% | 87% | 83% |
| Sinoe | 115,484 | | 74% | 96% | 100% | 117% | 101% |
| **Liberia** | **3,818,848** | **1,096,151** | **80%** | **93%** | **79%** | **83%** | **86%** |

### 2.6.4 Service Delivery

A key indicator for measuring progress on health service delivery for the entire population is the consumption of services, as indicated by the utilization rate (the number of curative consultations per capita). The table below presents the utilization rate in all counties (pool fund shaded in red) in Q4 and for FY 2013–2014. The utilization rate across all counties ranged from 0.6 to 1.5 overall for the year, with Bomi County having the highest utilization rate and Gbarpolu County the lowest. The differences can be attributed to accessibility to health facilities within these two counties. Gbarpolu County health facilities are quite scattered, with long distances and bad road a challenge. In Bomi most of the health facilities are accessible, except for a few days during the rainy season.

**Utilization Rate – Pool Fund Counties (red) vs. National (white)**

| County | Overall Population | Pool Fund population | Jul–Sep | Oct–Dec | Jan–Mar | Apr–Jun | FY 2013 |
|---|---|---|---|---|---|---|---|
| Bomi | 95,290 | 89,176 | 1.5 | 1.4 | 1.5 | 1.8 | 1.5 |
| Bong | 377,767 | | 0.7 | 0.8 | 0.7 | 0.91 | 0.77 |
| Gbarpolu | 94,461 | 94,461 | 0.6 | 0.3 | 0.4 | 0.6 | 0.48 |
| Grand Bassa | 247,055 | 213,155 | 1.9 | 0.9 | 0.7 | 0.91 | 1.1 |
| G.C. Mount | 143,949 | | 0.9 | 0.9 | 0.8 | 0.8 | 0.83 |
| Grand Gedeh | 141,893 | 131,389 | 0.6 | 0.7 | 0.5 | 0.67 | 0.62 |
| Grand Kru | 62,726 | | 1.2 | 1.2 | 1.0 | 1.1 | 1.1 |
| Lofa | 313,629 | 23,026 | 0.9 | 0.9 | 0.9 | 1 | 0.97 |
| Margibi | 237,803 | | 1 | 0.9 | 0.9 | 0.94 | 0.92 |
| Maryland | 144,594 | 144,594 | 0.8 | 0.8 | 0.8 | 0.8 | 0.8 |
| Montserrado | 1,164,147 | 220,692 | 1.1 | 1 | **0.7**[6] | 0.88 | 1.48 |
| Nimba | 523,386 | 22,994 | 0.6 | 0.9 | 0.9 | 1.1 | 0.93 |
| River Gee | 75,659 | 75,659 | 1.1 | 1.2 | 1.0 | 1.2 | 1.1 |
| Rivercess | 81,005 | 81,005 | 0.8 | 0.6 | 0.2 | 0.8 | 0.61 |
| Sinoe | 115,484 | | 0.7 | 0.7 | 0.7 | 0.8 | 0.72 |
| **Liberia** | **3,818,848** | **1,096,151** | **1.5** | **1.4** | **1.5** | **0.95** | **0.93** |

### 2.6.5 Malaria

Pregnant women are provided the second dose of Intermittent Preventative Treatment (IPT2) for malaria during pregnancy. The uptake of IPT2 is expected to increase with the use of antenatal care services by pregnant women. The table below presents the IPT2 coverage for FY 2013–2014 (see Annex 2 for absolute figures). IPT2 coverage in Q 3 was at 51% and decreased slightly in Q4 to 47%, making the average for the year less than 50%.

[6] The data is being further validated for Montserrado county.

**IPT2 Coverage – Pool Fund Counties (red) vs. National (white)**

| County | Overall Population | Pool Fund population | Jul–Sep | Oct–Dec | Jan–Mar | Apr–Jun | FY 2013 |
|---|---|---|---|---|---|---|---|
| Bomi | 95,290 | 89,176 | 47% | 46% | 68% | 63% | 55% |
| Bong | 377,767 | | 47% | 63% | 88% | 81% | 70% |
| Gbarpolu | 94,461 | 94,461 | 31% | 16% | 29% | 28% | 26% |
| Grand Bassa | 247,055 | 213,155 | 48% | 44% | 48% | 48% | 48% |
| G.C. Mount | 143,949 | | 46% | 46% | 52% | 43% | 46% |
| Grand Gedeh | 141,893 | 131,389 | 29% | 36% | 43% | 41% | 37% |
| Grand Kru | 62,726 | | 17% | 29% | 30% | 22% | 27% |
| Lofa | 313,629 | 23,026 | 34% | 49% | 55% | 52% | 52% |
| Margibi | 237,803 | | 29% | 32% | 40% | 33% | 33% |
| Maryland | 144,594 | 144,594 | 45% | 41% | 47% | 69% | 51% |
| Montserrado | 1,164,147 | 220,692 | 44% | 37% | 40% | 29% | 37% |
| Nimba | 523,386 | 22,994 | 22% | 62% | 63% | 61% | 60% |
| River Gee | 75,659 | 75,659 | 45% | 42% | 40% | 45% | 43% |
| Rivercess | 81,005 | 81,005 | 43% | 36% | 46% | 44% | 42% |
| Sinoe | 115,484 | | 25% | 50% | 59% | 53% | 47% |
| **Liberia** | **3,818,848** | **1,096,151** | **38%** | **45%** | **51%** | **46%** | **47%** |

### 2.6.6 HIV/AIDS

HIV and AIDS prevention and control is critical for disrupting the spread and reducing the burden of HIV/AIDS in Liberia. One of the preventive strategies used is the provision of voluntary testing and counseling services and ARV prophylaxis to prevent mother-to-child transmission. The number of pregnant women who tested HIV-positive and started ARVs increased from 141 in Q4 to 293 for FY 2013–2014 in PF supported counties, with an overall achievement of 798 nationally for the year. The promotion of testing for HIV during antenatal care is likely to facilitate the identification of HIV-positive pregnant women and subsequently their timely placement on ARVs.

### 2.6.7 Tuberculosis

Tuberculosis remains a major public health problem in Liberia. The notification and treatment of TB are critical intervention strategies, while tracking the number of new TB cases and providing treatment are key indicators. The number of smear-positive TB cases notified per 100,000 population was 104 in Q4 and 816 for FY 2013–2014 in PF supported counties, with an overall achievement of 3,321 cases nationally for the year.

**Reporting Rate by County (FY 2013–2014), Pool-Funded Facilities Only**

| Name | # of facilities | Actual Reports | Expected Reports | Reporting Rate | Reports On Time | Percent On Time |
|---|---|---|---|---|---|---|
| Bomi | 20 | 60 | 60 | 100% | 43 | 72% |
| Gbarpolu | 14 | 42 | 42 | 100% | 38 | 90% |
| Grand Bassa | 20 | 60 | 60 | 100% | 56 | 93% |
| Grand Gedeh | 17 | 51 | 51 | 100% | 43 | 84% |
| Lofa | 1 | 3 | 3 | 100% | 0 | 0% |
| Maryland | 21 | 61 | 63 | 97% | 4 | 6% |
| Montserrado | 17 | 42 | 54 | 78% | 30 | 56% |
| Nimba | 1 | 3 | 3 | 100% | 3 | 100% |
| River Gee | 16 | 48 | 48 | 100% | 33 | 69% |
| Rivercess | 17 | 51 | 51 | 100% | 51 | 100% |
| **Liberia** | 144 | 421 | 435 | 97% | 301 | 67% |

### 2.6.8 HMIS

The overall rate of reporting has remained constant throughout the quarters. Timely reporting has been the major issue over the period. Exploring this issue with the HMIS unit, they have noted issue of delayed collection of HMIS reports from the health facilities by the district health officers due to logistical constraints such is broken motorcycles, bad road condition, and poor Internet communications for some counties. These issues are being addressed at the county level to ensure reports are gathered on time.

# 3. Financial Position[7]

## 3.1 Lifetime financial position from April 1, 2008, to June 30, 2014

| | Notes[8] | US$ |
|---|---|---|
| **Pool fund inflows** | | |
| Cash contributions by donors to date | A | 64,314,698 |
| Bank interest and other income | B | 387,213 |
| Total pool funds received | | 64,701,911 |
| | | |
| **Pool fund outflows** | | |
| Payments for projects and activities | | 57,684,990 |
| Bank fees, charges and tax on credit interest | C | 461,957 |
| Total cash payments | D | 58,146,947 |
| | | |
| ***Net balance of inflows less outflows*** | | 6,554,964 |
| | | |
| **Represented by:** | | |
| Book balance of pool fund account | | 5,841,009 |
| Book balance of disbursement account | | 713,955 |
| Total pool fund bank account book balances | E | 6,554,964 |
| | | |
| Total pool funds received | | 64,701,911 |
| Total commitments | F | 63,356,725 |
| Uncommitted balance of pool fund received | | 1,345,186 |
| | | |
| Unpaid balance of pool fund commitments | G | 5,209,778 |
| Pool fund balance as at June 30, 2014 | | 6,544,964 |

[7] All figures are in United States Dollars.
[8] See Section 3.3 (below) for all notes.

## 3.2 Financial position for FY 2013–2014

| | Q1 July 1– September 30, 2013 US$ | Q2 October 1– December 31, 2013 US$ | Q3 January 1– March 31, 2014 US$ | Q4 April 1– June 30, 2014 US$ | Note | Year-End June 30, 2014 US$ |
|---|---|---|---|---|---|---|
| **Opening Balances** | | | | | | |
| Main Account | 7,844,970 | 14,361,296 | 10,743,833 | 8,913,443 | | 7,844,970 |
| Disbursement Account | 528,516 | 99,796 | 507,364 | 768,814 | | 528,516 |
| Opening Balance | 8,373,486 | 14,461,092 | 11,251,197 | 9,682,257 | | 8,373,486 |
| Prior Period Adjustment | | | | | H | (159,238) |
| **Total Opening Balance** | **8,373,486** | **14,461,092** | **11,251,197** | **9,682,257** | | **8,214,248** |
| Contributions Received | 9,337,962 | 0 | 1,500,000 | | | 10,837,962 |
| Bank Interest | 16,405 | 5,000 | 32,944 | 38,111 | | 92,461 |
| **Total Receipts** | **9,354,367** | **5,000** | **1,532,944** | **38,111** | | **10,930,423** |
| **Total Funds Available** | **17,727,853** | **14,466,092** | **12,784,141** | **9,720,368** | | **19,144,671** |
| Payments | 3,266,763 | 3,214,895 | 3,101,884 | 3,169,468 | | 12,753,009 |
| Prior Period Adjustment | | | | | I | (163,302) |
| **Total Payments** | | | | | | **12,589,707** |
| **Closing Balances** | | | | | | |
| Main Account | 14,361,296 | 10,743,833 | 8,913,443 | 5,841,009 | | 5,841,009 |
| Disbursement Account | 99,795 | 507,365 | 768,814 | 709,891 | | 713,955 |
| **Fund Balance** | **14,461,091** | **11,251,198** | **9,682,257** | **6,550,900** | | **6,554,964** |
| Unpaid Commitments | 12,846,350 | 11,171,410 | 8,375,185 | 5,205,714 | | 5,209,778 |
| Uncommitted Funds | 1,614,741 | 79,788 | 1,307,072 | 1,345,186 | | 1,345,186 |

## 3.3 Notes to the financial position

**Note A: Contributions (April 1, 2008 to June 30, 2014)**

| Donor | Pledges to date | Contributions received to date (base currency) | Contributions received to date | Outstanding pledge (base currency) |
|---|---|---|---|---|
| AFD | € 3,942,701 | € 1,577,080 | US $2,000,000 | € 2,365,620 |
| DFID | £19,945,000 | £19,945,000 | US $31,569,660 | £0 |
| Irish Aid | € 18,000,000 | € 18,000,000 | US $24,286,491 | € 0 |
| SDC | US $2,038,547 | US $2,038,547 | US $2,038,547 | $0 |
| UNICEF | US $4,000,000 | US $4,000,000 | US $4,000,000 | $0 |
| UNHCR | US $420,000 | US $420,000 | US $420,000 | $0 |
| **Total** | | | **USD 64,314,698** | |

**Note B: Bank Interest and Other Income (April 1, 2008 to June 30, 2014)**

| | Pool fund main bank account | Disbursement bank account | Total |
|---|---|---|---|
| Interest on timed deposit | US $ 353,314 | US $33,599 | US $386,913 |
| Bid documents sale | | US $300 | US $300 |
| **Total** | **US $353,314** | **US $33,899** | **US $387,213** |

Effective November 1, 2013, the MOHSW has negotiated a timed deposit interest of 2.0% per annum on the Pool Fund Main Bank Account with Eco bank on timed deposits of 30 days and longer. The last negotiated rate was 1.8% per annum on timed deposits placed per quarter.

**Note C: Bank Fees, Charges, and Tax on Credit Interest (April 1, 2008 to June 30, 2014)**

| | Main Account | Disbursement Account | Total |
|---|---|---|---|
| Ecobank fees | US $333,389 | US $7,829 | US $341,218 |
| Ecobank charges | US $74,215 | US $12,727 | US $86,942 |
| Tax on credit interest | US $30,561 | US $3,234 | US $33,795 |
| **Total** | **US $438,164** | **US $23,790** | **US $461,955** |

**Note D (Total Cash Payments):** Refer to Table 3.1 below.

**Note E (Pool Fund Bank Account & Book Balances):** The pool fund main bank account balance includes all outstanding transfers (made against the main account, but not yet deposited in the disbursement account), and the disbursement bank account balance includes all the outstanding transfers and all outstanding checks (made against the disbursement account, but not yet deposited by the recipient) as of June 30, 2014. These transactions are summarized in the following tables:

**Reconciliation of Book Balances to Bank Balances**

| Item | Main Account | Disbursement Account |
|---|---|---|
| Book Balance | 5,841,009 | 713,955 |
| Outstanding Transfers | 544,732 | (544,732) |
| Outstanding Checks | - | 696,637 |
| Timed Deposit | - | - |
| Bank Balance | 6,385,741 | 865,860 |

**Outstanding Transfers and Checks**

| Allocation Code | Allocation | Total Outstanding Transfers from Main Account to Disbursement Account | Total Outstanding Checks: Disbursement Account |
|---|---|---|---|
| F7 | Tellewoyan Mem. Hosp. | - | $ 24,877.26 |
| FD | Grand Gedeh CHSWT | - | $4,250.23 |
| FI | Support Systems, Contracting- In | - | $ 9,158.06 |
| FN | Grand Gedeh CHSWT | | $ 59,711.94 |
| FS | Risk Management | - | $ 29,153.57 |
| FJ | AHA Montserrado | $69,805 | $69,805.42 |
| FK | MERCI (3)/River Gee | $350,674 | $350,674.00 |
| FL | Bomi CHSWT | $124,252 | $124,252.29 |
| FM | Maryland CHSWT | | $28,479.22 |
| FP | Gbarpolu CHSWT | | $525.00 |
| | **Total** | **544,732** | **$696,637** |

**Note F (Total Commitments):** At the June 6, 2013 meeting, the Pool Fund Steering Committee approved a ceiling of $11,166,565 as commitment for three previous Implementing Partners' contracts (FJ, FK, FL) and contracting-in of six counties (FM, FN, FO, FP, FQ, FR) for the period July 1, 2013 through June 30, 2014 (refer to Table 3.1 below for the related allocation amounts). Due to cash availability constraints, the Steering Committee authorized the Pool Fund Manager to make commitments to the intended recipients according to cash availability and against the approved ceiling. As of January 1, 2014, all commitments were funded up to June 30, 2014. For more information, refer to Table 3.1 below.

**Note G (Unpaid Balances of Commitments):** Refer to Table 3.1 below.

**Note H (Prior Period Adjustment):** The opening balance brought forward from June 30, 2013 was stated as $8,373,486 on the basis of cash in bank in the Disbursement Account as at June 30, 2013 and therefore included cash for outstanding checks as well as bank errors at June 30, 2013. Subsequently, the Pool fund has instituted a complete 'cash-basis of accounting treatment' as a change of accounting procedure that checks & transactions written and forwarded in a period, whether cashed or not, be treated as executed and expensed for that period. The prior year adjustment is the deduction of outstanding checks and the addition of the bank error against the balance brought forward from June 30, 2013, totaling a net adjustment of $159,238.

**Note I (Prior Period Adjustment):** As per note H (above) and the change in accounting procedure, the outstanding checks as at June 30, 2013 were treated as expensed in the 2012–2013 fiscal year and therefore deducted from the payments in FY 2013–2014. Refer to Table 3.1 (below) for a detailed breakdown of total payments.

| Table 3.1: Notes D, F, G, I: Total Commitments, Payments, and Unpaid Balance of Commitments | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| | Project Activities | Original Commitment | Total Commitments (Note F) | Total Payments Current Quarter (Note: I) | Total Payments Year to Date (Note: I) | Total Payments (Note: D) | Unpaid Balance of Commitments (Note: G) | Status/Completion Date |
| PØ | Curran Midwifery School | 211,504 | 211,504 | 0 | 0 | 211,504 | 0 | closed |
| P1 | National Reference Laboratory (LIBR) | 683,049 | 683,049 | 0 | 0 | 683,049 | 0 | closed |
| P2 | Partner Service Provision Phase I – AHA (1) | 445,569 | 445,569 | 0 | 0 | 445,569 | 0 | closed |
| P2 | Partner Service Provision Phase II | 1,128,753 | 1,070,831 | 0 | 0 | 1,070,831 | 0 | closed |
| P2 | Partner Service Provision Phase III | 953,334 | 914,110 | 0 | 0 | 914,110 | 0 | closed |
| P3 | Social Welfare Policy | 63,226 | 63,276 | 0 | 0 | 63,276 | 0 | closed |
| P4 | Medical Doctors Program | 230,700 | 221,328 | 0 | 0 | 221,328 | 0 | closed |
| P5 | Bank fees, charges, tax on interest cr., & others | 450,506 | 450,506 | 0 | 56,743 | 450,506 | 0 | - |
| P6 | CemONC/C.B. Dunbar | 662,552 | 662,552 | 0 | 0 | 662,552 | 0 | closed |
| P7 | PHC Clinics Construction | 1,523,346 | 1,027,586 | 0 | 0 | 1,027,586 | 0 | closed |
| P8 | HR - Incentive, Policy, & Payroll Syst. | 954,263 | 837,329 | 0 | 0 | 837,329 | 0 | closed |
| P9 | PMU (3) | 2,068,882 | 2,014,119 | 0 | 0 | 2,014,119 | 0 | closed |
| PA | Pool Fund Audit 2008/2009 | 70,225 | 70,225 | 0 | 0 | 70,225 | 0 | closed |
| PB | CHT – Bomi (1) | 2,118,489 | 2,068,819 | 0 | 0 | 2,068,819 | 0 | closed |
| PC | MERCI (1) | 213,646 | 157,383 | 0 | 0 | 157,383 | 0 | closed |
| PD | AHA (4) | 623,403 | 580,747 | 0 | 0 | 580,747 | 0 | closed |
| PE | M & E Support | 414,042 | 372,157 | 0 | -9,075 | 372,157 | 0 | closed |
| PF | Merlin-Maryland | 4,335,965 | 4,304,568 | 129,000 | 754,753 | 4,304,568 | 0 | closed |
| PG | Merlin-Grand Gedeh | 4,384,330 | 4,351,651 | 77,000 | 113,842 | 4,351,651 | 0 | closed |
| PH | AHA-RiverCess | 2,628,488 | 2,624,331 | 0 | 0 | 2,624,331 | 0 | closed |
| PI | AHA-Gbarpolu | 2,326,021 | 2,319,929 | 0 | 0 | 2,319,929 | 0 | closed |
| PJ | International Rescue Committee –Nimba | 1,520,660 | 1,520,660 | 0 | 263,881 | 1,520,660 | 0 | closed |
| PK | Save the Children UK-Montserrado | 1,268,632 | 1,265,029 | 0 | 0 | 1,265,029 | 0 | closed |
| PL | Pool Fund Management/unicef | 2,846,146 | 2,846,146 | 0 | 0 | 2,846,146 | 0 | closed |
| PM | Pool Fund Audit 2009/2010 | 118,184 | 118,184 | 0 | 0 | 118,184 | 0 | closed |
| PN | OFM Support | 1,374,780 | 1,368,037 | 0 | 0 | 1,368,037 | 0 | closed |
| PP | Key Staff Support | 170,289 | 170,289 | 0 | 0 | 170,289 | 0 | closed |
| PQ | Pool Fund Audit 2010/2011 | 22,075 | 22,075 | 0 | 0 | 22,075 | 0 | closed |
| PR | Marshall Health Center | 100,000 | 82,674 | 0 | 0 | 82,674 | 0 | closed |
| PS | National Health Plan | 271,500 | 271,457 | 0 | 0 | 271,457 | 0 | closed |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| PT | Bomi CHT (2) | 800,000 | 648,893 | 0 | 0 | 648,893 | 0 | closed |
| PU | PMU (4) | 700,000 | 696,855 | 0 | 0 | 696,855 | 0 | closed |
| PV | Merlin Grand Bassa | 257,985 | 257,985 | 0 | 0 | 257,985 | 0 | closed |
| PW | Merlin Montserrado | 114,615 | 114,615 | 0 | 0 | 114,615 | 0 | closed |
| PX | MERCI (2)/River Gee | 130,000 | 130,000 | 0 | 0 | 130,000 | 0 | closed |
| PY | BCHT (3) | 240,769 | 240,769 | 0 | 0 | 240,769 | 0 | closed |
| PZ | Others/Undistributed Transfer | 0 | 0 | 0 | 0 | 0 | 0 | |
| FØ | AHA Montserrado | 1,841,943 | 1,696,462 | 0 | 28,555 | 1,696,462 | 0 | closed |
| F1 | MERCI (3)/River Gee | 1,240,359 | 1,172,907 | 0 | 20,410 | 1,172,907 | 0 | closed |
| F2 | BCHT (4) | 1,482,307 | 1,375,277 | 0 | 34,914 | 1,375,277 | 0 | closed |
| F3 | Merlin-Maryland (2) | 1,158,841 | 1,139,061 | 0 | 182,769 | 1,139,061 | 0 | closed |
| F4 | Merlin-Grand Gedeh (2) | 1,258,292 | 1,233,053 | 0 | 191,391 | 1,233,053 | 0 | closed |
| F5 | AHA-RiverCess (2) | 620,878 | 614,818 | 0 | 0 | 614,818 | 0 | closed |
| F6 | AHA-Gbarpolu (2) | 600,033 | 594,404 | 0 | 0 | 594,404 | 0 | closed |
| F7 | Telowoyan Memorial Hosp. | 950,282 | 950,282 | 99,252 | 375,853 | 551,156 | 399,127 | Sep-14 |
| F8 | NDS- Drugs (RFP3) | 2,310,525 | 2,310,525 | 0 | 194,353 | 2,306,712 | 3,812 | Jul-13 |
| F9 | IRC/Nimba | 448,073 | 448,073 | 0 | 0 | 373,394 | 74,679 | Dec-12 |
| FA | Pool Fund Audit 2011/2012 | 50,000 | 44,080 | 0 | 0 | 44,080 | 0 | closed |
| FB | HW Incentives- Jan. 2013 | 250,000 | 150,333 | 0 | 2,598 | 150,333 | 0 | closed |
| FC | Maryland CHT (2) | 685,722 | 606,987 | -189 | 102,729 | 469,571 | 137,417 | Jun-13 |
| FD | Grand Gedeh CHT (2) | 734,864 | 567,913 | -4,329 | 206,031 | 563,584 | 4,329 | Jun-13 |
| FE | River Cess CHT (2) | 424,391 | 323,791 | 0 | 151,142 | 272,201 | 51,590 | Jun-13 |
| FF | Gbarpolu CHT (2) | 361,906 | 361,906 | 0 | 71,918 | 288,749 | 73,157 | Jun-13 |
| FG | Nimba CHT (GW Harley) (2) | 194,800 | 194,800 | 0 | 17,394 | 60,807 | 133,993 | Jun-13 |
| FH | Grand Bassa CHT (1) | 247,965 | 247,965 | 0 | 182,112 | 228,547 | 19,418 | Jun-13 |
| FI | Support Systems-Contracting- In | 827,313 | 827,313 | 135,341 | 540,564 | 699,760 | 127,553 | Jun-14 |
| FJ | AHA Montserrado | 1,473,555 | 1,587,963 | 351,374 | 1,533,291 | 1,533,291 | 54,673 | Jun-14 |
| FK | MERCI (3)/River Gee | 992,288 | 1,046,330 | 501,295 | 1,000,393 | 1,000,393 | 45,937 | Jun-14 |
| FL | BCHT (4) | 1,185,845 | 1,276,919 | 296,952 | 1,225,386 | 1,225,386 | 51,533 | Jun-14 |
| FM | Maryland CHT (3) | 1,690,055 | 1,690,055 | 400,151 | 1,223,874 | 1,223,874 | 466,181 | Jun-14 |
| FN | Grand Gedeh CHT (3) | 2,136,528 | 2,136,528 | 375,334 | 1,026,995 | 1,026,995 | 1,109,533 | Jun-14 |
| FO | River Cess CHT (3) | 1,063,416 | 1,063,416 | 127,290 | 427,695 | 427,695 | 635,721 | Jun-14 |
| FP | Gbarpolu CHT (3) | 969,261 | 969,261 | 132,202 | 325,585 | 325,585 | 643,676 | Jun-14 |
| FQ | Nimba CHT (GW Harley) (3) | 579,986 | 579,986 | 97,523 | 268,150 | 268,150 | 311,836 | Jun-14 |
| FR | Grand Bassa CHT (2) | 1,075,631 | 1,075,631 | 150,425 | 533,402 | 533,402 | 542,229 | Jun-14 |
| FS | Risk Management Support | 795,448 | 795,448 | 298,331 | 476,280 | 476,280 | 319,168 | Jun-14 |
| FT | Pool Fund Administration/unicef | 988,550 | 1,058,550 | 0 | 1,054,332 | 1,054,332 | 4,218 | Mar-15 |
| FT | Pool Fund Administration/unicef- Bank Charges | 11,450 | 11,450 | 2,517 | 11,450 | 11,450 | 0 | Mar-15 |
| | **Total** | **65,076,434** | **63,356,725** | **3,169,466** | **12,589,707** | **58,146,946** | **5,209,777** | |

# Annexes

## Annex 1: Summary of field monitoring visits

The M&E Unit has been heavily involved in the data generation and management of the EVD response; therefore no routine service delivery monitoring visits were conducted during this period due to the Ebola outbreak response. However, the M&E team spent time reviewing their monitoring and supervision tools as well as participation in the ongoing National Health Policy and Plan evaluation. Overall, throughout this fiscal year the M&E Unit along with other department staffs visited the counties every quarter. The Pool Fund Secretariat team conducted monitoring visits with the Contracting-In coordinator from the County Health Services Unit during Q4. For the entire fiscal year, only Rivercess County was not visited by the Pool Fund Secretariat team due to the Ebola situation in Q4 (April–June 2014). Overall, the secretariat team visited 9 out of 10 pool fund supported counties during the fiscal year. See below a summary of dates visits that were conducted and key participants. A total of 48 out of 144 (33%) pool fund supported health facilities were visited by the secretariat along with other participants from the MOHSW.

| | Counties | Dates Visited | Team | Facilities Visited |
|---|---|---|---|---|
| 1 | Gbarpolu | Oct 28–30 , 2013 | PF Secretariat , CHS and Internal Audit | 7 |
| 2 | Bomi | Oct 30–Nov 1, 2013 | PF Secretariat , CHS and Internal Audit | 9 |
| 3 | Grand Bassa | Dec 3–7, 2013, March 14–15, 2014, April 2, 2014 , June 2014 | PF Secretariat , CHS, DFID, Irish Aid, Procurement, Internal Audit | 10 |
| 4 | Montserrado | Nov 15, Dec 3,Dec 20, 2013, Jan 21, Feb 5, 2014, June 2014 | PF Secretariat, SCMU, NDS, MOHSW, AFD, DFID | 9 |
| 5 | Grand Gedeh | March 18–20 ,2014 | PF Secretariat | 4 |
| 6 | River Gee | March 20–23, 2014 | PF Secretariat | 2 |
| 7 | Maryland | March 23–26,2014 | PF Secretariat | 5 |
| 8 | Nimba, G.W. Harley Hospital | June 9–10, 2014 | PF Secretariat and CHS | 1 |
| 9 | Lofa, Tellewoyan Hospital | June 10–12,2014 | PF Secretariat and CHS | 1 |

Generally, based on visits to 9 of 10 pool fund supported counties, the pattern of issues was very similar across the counties. Therefore, there is a real need for the MOHSW to think through what the pool fund support to the counties should be annually. Capacity issues related to management and oversight exist in the areas of planning, monitoring, financial management, and procurement which could lead to a mismanagement of funds in counties with low achievements and to an overall loss of funding from donors. It was clear that

MOHSW monitoring visits have largely focused on service delivery and less on monitoring the support system. Our general findings are presented in the table below in line with the Health System Building Blocks.

**SUMMARY FINDINGS & RECOMMENDATIONS**

1. **LEADERSHIP, GOVERNANCE AND COORDINATION**

- Overall oversight and management of the county health system by the CHSWT is still weak and needs strengthening in the area of planning, financial management, and monitoring.
- There appear to be two parallel management systems maintained in the county—CHSWT and hospital management—with both not properly linking up together in some counties.
- Periodic supervision is carried out but not much action has been taken, based on findings from the visits.
- The counties are concerned about the timing for starting the county planning process.
- County board meetings are held and there is linkage with partners working in the counties

2. **SERVICE DELIVERY**

- Access to some health facilities is still challenging, especially during the rainy season, for both patients and CHSWT
- Most components of the EPHS are being implemented. However, a focus on quality of services delivered should be prioritized. There were quality of care issues noted (e.g., sterilization, environment in which care is provided, and drugs and supplies management).
- Some health facilities were poorly managed, which indicates issues in the quality of care provided to patients.
- Community health services (ICCM) is being implemented within the counties at various levels.
- Laboratory services operate at the minimum level in the facilities visited.
- Mental health clinicians were seen in some facilities; however, there were issues of the availability of drugs to the health facilities, which raised concerns about the management of these drugs
- There are basic facility infection prevention control measures in place but much needs to be improved, beginning with maintenance of proper handwashing facilities at various point in and out of the health facilities, e.g., latrines, delivery rooms, OPD. Incinerators and placenta pits are being used. Some latrines are poorly maintained and require proper rehabilitation, and overall waste management needs to be improved.
- Water is available at most of the health facilities or from a nearby source. However, there is a need for periodic chlorination and rehabilitation of hand pumps.
- The ambulance was seen transferring patients from the PHCs to the hospital; however, proper monitoring and analysis of the fuel consumption and patient load is essential for planning.

**3. FINANCIAL MANAGEMENT AND PROCUREMENT**

- Periodic reviews of county budgets are not being conducted. Such reviews are necessary to allow for planning and prioritization of key activities, although discussions take place at the CHSWT Level
- Work plans are available but there appears to be some disconnect with the actual implementation, based on the funding available.
- Counties reported delays in receiving operational funds and incentive, both GoL allotments and pool funds. Pool fund allotments were forthcoming, while that of GoL was not. As such the CHSWT have turned to creditors within the counties. Once funds are received, the CHSWT then embarks on payments with most of the paperwork for those payments not conforming with the procurement processes.
- The pharmacy staffs travel at least 2 or more times per quarter for drugs supplies and procurement-related issues.
- There was limited adherence to the PPCC guidelines observed at the county level.

**4. HUMAN RESOURCES**

- Availability of qualified workers at various levels is still a challenge. Therefore, major gaps still exist in staffing at the CHT and health facility levels. Gaps exist for PA, CMs, nurses, lab technician and nurse anesthetist.
- Most professional staffs seen at the health facilities are not originally from the county.
- Staffs have worked within the counties for at least 5 years or more.
- Each health facility visited had at least 3 or 4 professional staffs (PA, RN, CM, lab technician/aide)
- The number of staffs on GoL payroll at the facilities varies (1 or 2 up to a maximum of 3)
- Staffs were not paid PBF bonuses for the last 3 quarters. Staffs are not aware of why bonuses are paid and some even leave before receiving their bonuses due to delays. Allocations of PBF bonuses for the facilities are used to carry out small projects, such as construction of community health unit and others. However, little information was reported on the use of the funds.

**5. HEALTH INFRASTRUCTURE**

- Staff accommodation is available at some health facilities. However, due to the size, qualified staffs have to share rooms to be able to accommodate each other, which makes the places congested. The latrine and bathrooms are outside the accommodations, which poses some security risk to staffs, especially at night in remote areas. Staffs accommodations are being constructed in some counties using GoL allotment.
- Infrastructure maintenance is poor at some health and accommodation facilities.
- The CHT is paying for staff accommodation at some facility areas where no accommodation exists.
- It was observed that some facilities and accommodation ceilings were leaking.
- Several robberies occurred in Maryland County due to the vulnerable nature of the hospital premises.

**6. HEALTH INFORMATION**

- Health data is collected through the DHIS. Data is collected by the DHOs from the health facilities. However it is sometimes delayed due to logistical constraints and problems accessing the Internet in some counties.
- At some county level health facilities, data on key indicators are displayed on the walls.
- The data is not being used at the county level for decision-making.

**7. DRUGS AND MEDICAL SUPPLIES**

- Some equipment in the hospitals and health facilities are completely worn out and require replacement.
- There were expired drugs seen at some health facilities. Large number of drugs with close expiry dates (i.e., MERLIN's remaining drugs and medical supplies in the Southeast) were seen in the depot.
- Drugs storage is available at the county level, but maintenance of proper storage as per the required standards is still weak.
- There were reported stock-outs of essential drugs and medical supplies at the county depot and health facilities. Although it was reported that drugs were delivered to the counties through the interim approach, stock-outs were experienced within a few weeks of distribution, which indicates that the quantity of drugs supplied did not match the consumption pattern.
- There was documented evidence of monthly inventories completed in the drugs depots, but these inventories were absent from most of the health facilities.

**8. MONITORING AND SUPERVISION VISITS**

- The M&E visits conducted were more focused on service delivery and less on monitoring the support systems.
- Several counties seemed to receive multiple visits at a given time. This poses problems for the actual implementation of activities. There were many activities ongoing at the time of our visit: supportive supervision, PBF verification, training, UNICEF distribution of ICCM supplies, etc. There is a need to critically think through how some of these visits can be merged and frequency minimized to achieve better outputs and cost savings.
- Electronic records (database) for HR, M&E, drugs, and medical supplies are being maintained. However some of these are not periodically backed up nor is anti-virus software updated on the computers.
- Internet access is limited in some counties. This poses challenges for timely reporting. The mobile telephone network is not available at all locations, requiring staffs to find suitable outside locations to be able to call the ambulance for referrals.
- Some M&E tools are lacking at the county and health facility levels

**RECOMMEDATIONS: COUNTIES**

- Given the challenges faced at the county level with the availability of essential drugs and medical supplies and the fact that NDS usually does not have all the drugs and supplies required, funds should be made available to the counties to purchase drugs and medical supplies while international procurement is ongoing.
- Based on the recent strike action, health workers spoken to made the following recommendations:
- Place staffs on GoL payroll

- Provide staffs accommodation with basic facilities in remote areas
- For staffs with long-term services, provide scholarship opportunities for career development
- Provide transportation facilities for staffs at the health facilities
- A threshold of funding from the pool fund should be provided to the counties for county planning. Periodic support should be provided by on financial management and procurement related issues.
- For county operational funds, there is a need for the central Ministry of Health and Social Welfare to support the counties in the purchase of good and services not readily available at the county level.

**RECOMMEDATIONS: POOL FUND SECRETARIAT**

1. **MANAGEMENT OVERSIGHT, MONITORING AND SUPERVISION**

- MOHSW should reinforce the oversight role of the CHO with reference to proper management of the county health activities (service delivery and support systems, human resources, procurement, M&E, and financial management) and emphasize the issue of **accountability for resources** invested into the counties.
- MOHSW should reemphasize to the CHSWTs the need to conduct quarterly reviews of their operational plan achievements compared to their budget goals so that the CHSWTs will be able to prioritize their activities.
- MOHSW should reinforce the monitoring of the use of GoL funding and reporting at the county level.

2. **FINANCIAL MANAGEMENT**

- MOHSW should review the policy of giving **cash allotments** to the counties that have demonstrated financial management related issues. MOHSW should focus on providing material goods to the counties and limit the amount of cash available at the CHSWT level.
- The secretariat should review liquidation practices in the counties and reinforce supervision and monitoring by OFM staffs.
- Approvals should be used for payment voucher.
- The use of eFinSys should be increased.

3. **SUPPLY CHAIN AND PROCUREMENT**

- Investment in the drugs and supply management system at the county and health facility level is essential to maintain the supply chain process. Focus on set-up of county depots to avoid frequent travel to Monrovia, which requires DSA and fuel but also leads to wear and tear of the vehicles. A warehouse can be set-up with essential non-medical items procured from Monrovia on a quarterly basis to avoid frequent travel and thus to save cost.
- Essential equipment and laboratory supplies should be included in the procurement of drugs and medical supplies for the counties.

4. **HEALTH INFRASTRUCTURE**

- The MOHSW should focus on periodic maintenance of the existing health infrastructure and staff accommodation. Consideration could be

given to enlarging some health facilities to create adequate space.

**5. COUNTY PLANNING**

- Proper analysis of the following should be carried out by CHSWTs in preparation for the support from central level and justifications should be provided for activities prioritized by the counties for FY 2014–2015
    1. Actual HR needs for the county, considering recruitment, attrition, and retention issues
    2. Fuel consumption for utility vehicles, ambulances, generators, and motorcycles
    3. Rehabilitation and maintenance of staff accommodation, health facilities, and other infrastructure
    4. Drugs and medical supplies, equipment, and laboratory supplies
    5. Hospital admission and patient feeding

**6. PERFORMANCE-BASED FINANCING**

- MOHSW should evaluate the impact of the PBF mechanism, review assessment timing (at least semiannual), and include issues of sustainability when considering funding issues. Achievement of PBF targets is tied to multiple factors, which needs to be recognized.

**7. HUMAN RESOURCES**

- For addressing some of the HR issues, disseminating information about MOHSW processes is essential. The following could be consider for the placement of staffs on GoL payroll:
    1. Ensure that every county is included when slots for placement on GoL payroll are determined.
    2. Target professional staffs first, then move to support staffs. Have a mix of support staffs and professional staffs for each county
    3. Target hard to reach and difficult counties.
    4. Target long serving staffs, for example, those with more than 3 years of service.
    5. The nursing and medical boards should send representatives to the county periodically for the renewal of staff licenses.
    6. Provide periodic communications to the counties on the progress MOHSW is making to address HR issues
- A focus on accommodation for health workers in remote area could be a motivating factor for staff retention.
- MOHSW should address this question: "What health workforce profile does the MOHSW wants to build in the next four years, taking into consideration a cadre of staff, professional development, skills-mix, numbers, recruitment, deployment, retention, and other topics.

## Annex 2: HMIS data

**Table A1: Number of Skilled Deliveries, Pool-Funded Counties vs National**

| County | Overall Population | Pool Fund population | Q1 | Q2 | Q3 | Q4 | FY 2013 |
|---|---|---|---|---|---|---|---|
| Bomi | 95,290 | 89,176 | 691 | 734 | 768 | 894 | 3,087 |
| Bong | 377,767 | | 1,809 | 3,058 | 3,345 | 3,883 | 12,095 |
| Gbarpolu | 94,461 | 94,461 | 271 | 176 | 310 | 345 | 1,102 |
| Grand Bassa | 247,055 | 213,155 | 882 | 976 | 917 | 1,211 | 3,986 |
| G.C. Mount | 143,949 | | 523 | 620 | 634 | 629 | 2,406 |
| Grand Gedeh | 141,893 | 131,389 | 614 | 680 | 703 | 849 | 2,846 |
| Grand Kru | 62,726 | | 132 | 210 | 177 | 228 | 747 |
| Lofa | 313,629 | 23,026 | 1,272 | 2,097 | 2,437 | 2,498 | 8,304 |
| Margibi | 237,803 | | 1,193 | 1,189 | 1,284 | 1,511 | 5,177 |
| Maryland | 144,594 | 144,594 | 611 | 482 | 641 | 764 | 2,498 |
| Montserrado | 1,164,147 | 220,692 | 5,841 | 5,508 | 5,324 | 5,348 | 22,021 |
| Nimba | 523,386 | 22,994 | 1,543 | 4,200 | 3,966 | 4,642 | 14,351 |
| River Gee | 75,659 | 75,659 | 404 | 384 | 375 | 459 | 1,622 |
| Rivercess | 81,005 | 81,005 | 367 | 419 | 387 | 410 | 1,583 |
| Sinoe | 115,484 | | 313 | 567 | 743 | 756 | 2,379 |
| **Liberia** | 3,818,848 | **1,096,151** | **16,466** | **21,300** | **22,011** | **24,427** | **84,204** |

**Table A2: Penta 3 Uptake - Pool-Funded Counties vs. National**

| County | Overall Population | Pool Fund population | Q1 | Q2 | Q3 | Q4 | FY 2013 |
|---|---|---|---|---|---|---|---|
| Bomi | 95,290 | 89,176 | 809 | 811 | 824 | 948 | 3,392 |
| Bong | 377,767 | | 3,110 | 4,292 | 3,824 | 4,392 | 15,618 |
| Gbarpolu | 94,461 | 94,461 | 752 | 664 | 692 | 844 | 2,952 |
| Grand Bassa | 247,055 | 213,155 | 1,918 | 1,993 | 1,744 | 2,476 | 8,131 |
| G.C. Mount | 143,949 | | 1,129 | 1,314 | 1,071 | 1,096 | 4,610 |
| Grand Gedeh | 141,893 | 131,389 | 10,43 | 1,180 | 785 | 775 | 3,783 |
| Grand Kru | 62,726 | | 390 | 542 | 514 | 426 | 1,872 |
| Lofa | 313,629 | 23,026 | 1,745 | 2631 | 2,432 | 2,655 | 9,463 |
| Margibi | 237,803 | | 1,684 | 1,686 | 1,896 | 1,876 | 7,142 |
| Maryland | 144,594 | 144,594 | 1,534 | 1,537 | 1,232 | 1,381 | 5,684 |
| Montserrado | 1,164,147 | 220,692 | 1,1391 | 11,103 | 8,670 | 7,850 | 39,014 |
| Nimba | 523,386 | 22,994 | 2,012 | 4,692 | 4,029 | 4,404 | 15,137 |
| River Gee | 75,659 | 75,659 | 692 | 564 | 351 | 474 | 2,081 |
| Rivercess | 81,005 | 81,005 | 677 | 739 | 546 | 704 | 2,666 |
| Sinoe | 115,484 | | 841 | 1,098 | 1,138 | 1,352 | 4,429 |
| **Liberia** | 3,818,848 | **1,096,151** | **29,727** | **34,846** | **29,748** | **31,653** | **125,974** |

**Table A3: IPT2 Uptake—Pool-Funded Counties vs. National**

| County | Overall Population | Pool Fund population | Q1 | Q2 | Q3 | Q4 | FY 2013 |
|---|---|---|---|---|---|---|---|
| Bomi | 95,290 | 89,176 | 551 | 542 | 795 | 748 | 2,636 |
| Bong | 377,767 | | 2,167 | 2,913 | 4,110 | 3,813 | 13,003 |
| Gbarpolu | 94,461 | 94,461 | 355 | 179 | 334 | 333 | 1,201 |
| Grand Bassa | 247,055 | 213,155 | 1,460 | 1,326 | 1,472 | 1,477 | 5,735 |
| G.C. Mount | 143,949 | | 804 | 813 | 925 | 766 | 3,308 |
| Grand Gedeh | 141,893 | 131,389 | 503 | 631 | 745 | 721 | 2,600 |
| Grand Kru | 62,726 | | 131 | 228 | 231 | 169 | 759 |
| Lofa | 313,629 | 23,026 | 1,287 | 1,898 | 2,114 | 2,034 | 7,333 |
| Margibi | 237,803 | | 850 | 947 | 1,166 | 975 | 3,938 |
| Maryland | 144,594 | 144,594 | 793 | 727 | 829 | 1,249 | 3,598 |
| Montserrado | 1,164,147 | 220,692 | 6,253 | 5,375 | 5,679 | 4,156 | 21,463 |
| Nimba | 523,386 | 22,994 | 1,438 | 3,970 | 4,036 | 3,974 | 13,418 |
| River Gee | 75,659 | 75,659 | 421 | 393 | 375 | 421 | 1,610 |
| Rivercess | 81,005 | 81,005 | 424 | 361 | 459 | 442 | 1,686 |
| Sinoe | 115,484 | | 356 | 712 | 836 | 765 | 2,669 |
| **Liberia** | 3,818,848 | **1,096,151** | **17,793** | **21,015** | **24,106** | **22,043** | **84,957** |