Quarterly Report of the Health Sector Pool Fund

October 1, 2014, through
December 31, 2014

Republic of Liberia

Ministry of Health
and Social Welfare

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Abbreviations and Acronyms

AFD	French Development Agency
CHT	County Health and Social Welfare Team
DFID	Department for International Development
EPHS	Essential Package of Health Services
FY	Fiscal Year
GOL	Government of Liberia
HMIS	Health Management Information Systems
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MOH	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
PBF	Performance-Based Financing
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
USAID	United States Agency for International Development
WHO	World Health Organization

Contents

1. Overview

1.1 Background of the pool fund

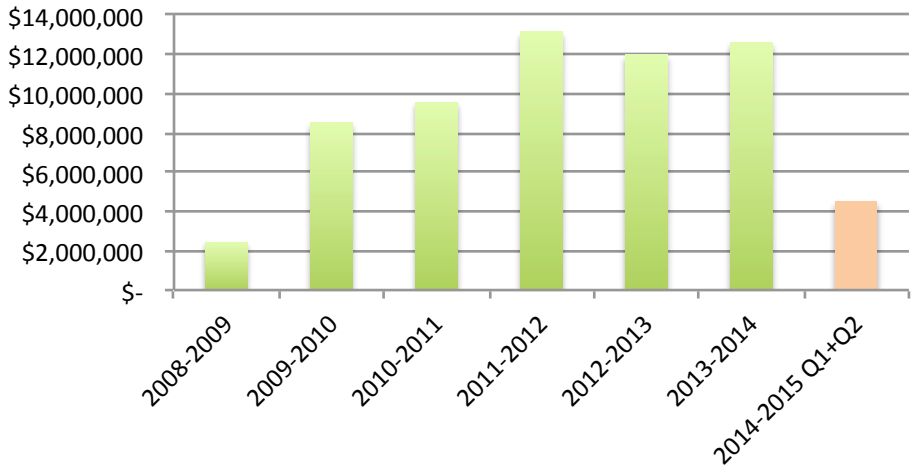
This report covers the second quarter of the Government of Liberia's (GOL) fiscal year (FY) 2014–2015, from October 1 to December 31, 2014. It is based on data and information from the national Health Management Information System (HMIS), the Ministry of Health and Social Welfare's (MOH) Monitoring and Evaluation Unit, county health and social welfare teams (CHTs), 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 highlights of activities conducted during this reporting period are described in Section 2. Progress in the pool fund's performance monitoring framework is summarized in Section 3, along with data on key health indicators. Section 4 gives the financial position of the fund since its establishment and the financial position at the end of this reporting period.

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 threefold: (1) To help finance priority unfunded needs within the NHP; (2) to increase the leadership of MOH in the allocation of sector resources; and (3) to reduce the transaction costs associated with managing multiple projects from different donors.

The United Kingdom's Department for International Development (DFID), Irish Aid, the Swiss Agency for Development and Cooperation (SDC), the French Development Agency (AFD), and UNICEF currently use the pool fund to provide financial support for the health sector in Liberia. 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. The fund's annual expenditures from its inception through this reporting period are shown in the chart below (see Section 4 for more information).

Since its establishment in 2008, the pool fund has received over $70 million in contributions, of which 99 percent has been committed to unfunded priorities and 89 percent has been spent.

Health Sector Pool Fund Annual Expenditure

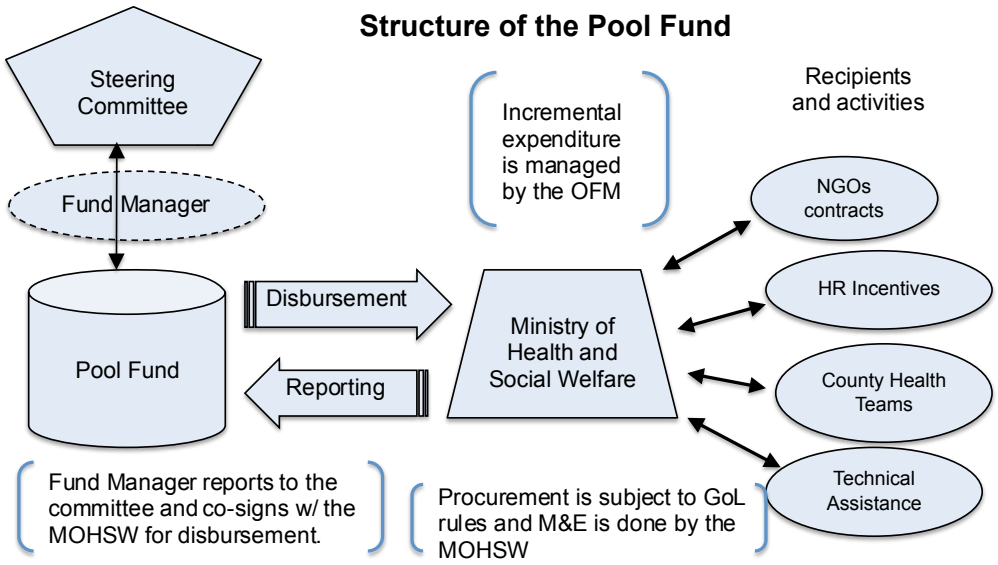


1.2 Organization of the fund

The pool fund is managed within the Ministry of Health and Social Welfare (MOH) 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 MOH 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 MOH when the fund was established to ensure transparency, reinforce coordination, and provide a forum for dialogue. It is chaired by the MOH 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 the wide representation of its membership.

A Pool Fund Secretariat is 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 pool fund. It ensures that an annual independent audit and periodic risk assessment are conducted (with annual review) and it produces regular performance 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 (M&E) in accordance with best practices 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 within the MOH to increase their effectiveness.



2. Planned and Actual Activities

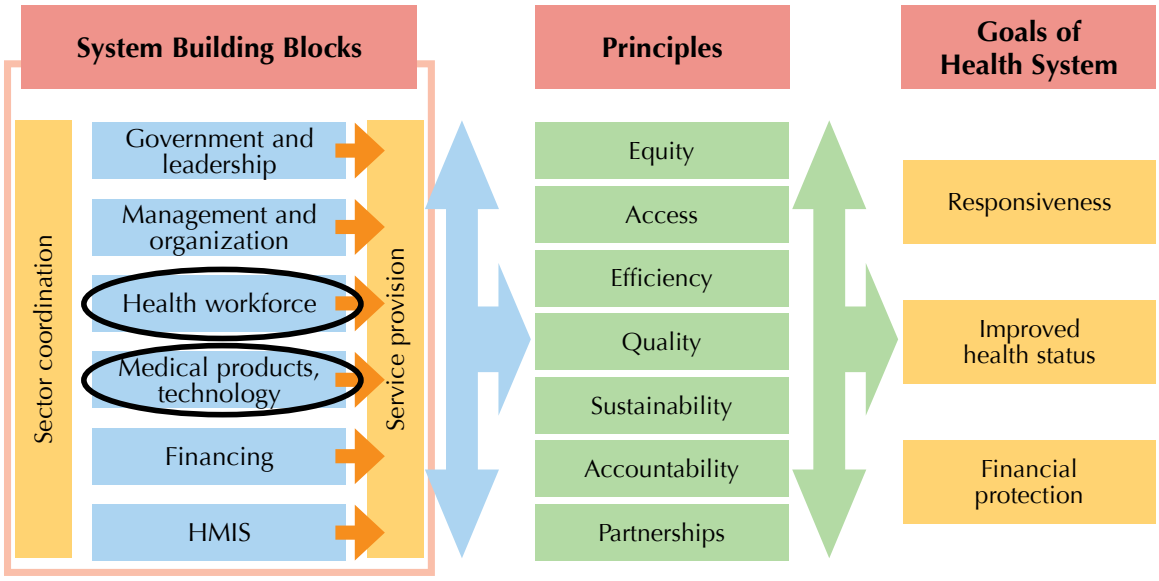
While the Health Sector Pool Fund exists to fund the unfunded priorities from the National Health and Social Welfare Plan (NHP), the specific objectives of the NHP include:

1. Increasing access to and utilization of a comprehensive package of quality health and social welfare services of proven effectiveness, delivered close to the community, endowed with the necessary resources and supported by effective systems;
2. Making health and social welfare services more responsive to people's needs, demands, and expectations by transferring management and decision-making to lower administration levels, thereby ensuring a fair degree of equity; and
3. Making health care and social protection available to all Liberians, regardless of their position in society, at a cost that is affordable to the country.

The priority areas approved by the steering committee for pool fund support in FY 2014–2015 reinforce a sector approach and are directly linked to the "Health workforce" and "Medical products and technology" health system building blocks detailed in the NHP, as shown in Figure 1 below. These building blocks, underpinned by the NHP's guiding principles, are the foundation of the health system.

The pool fund's 2014–2015 funding priorities are described in an annual plan that was approved at the beginning of the fiscal year by the Pool Fund Steering Committee. *The overall goal of the pool fund's FY 2014–2015 annual plan of strategic funding priorities is to improve access to quality health care services through the provision of essential medicines and supplies and retention of qualified health workers for service delivery*. The specific objectives are:

Figure 2. **Health System Framework (adapted from WHO)**



Objective 1. To retain and motivate health workers and support staff for the delivery of quality health care services and management of support systems;

Objective 2. To improve the availability of and access to essential medicines and supplies at the health facility level;

Objective 3. To mitigate the priority fiduciary and programmatic risks that affect allocations from the pool fund; and

Objective 4. To efficiently and effectively manage the pool fund mechanism and control the fiduciary risk associated with use of the fund.

Budgeted Allocations by Objective, FY 2014–2015

Objective	Allocation Amount (US$)
Objective 1: Human Resources	5,570,000
Objective 2: Essential Medicines	2,600,000
Objective 3: Risk Management	638,500
Objective 4: Administration[1]	60,000
Total	**8,868,500**

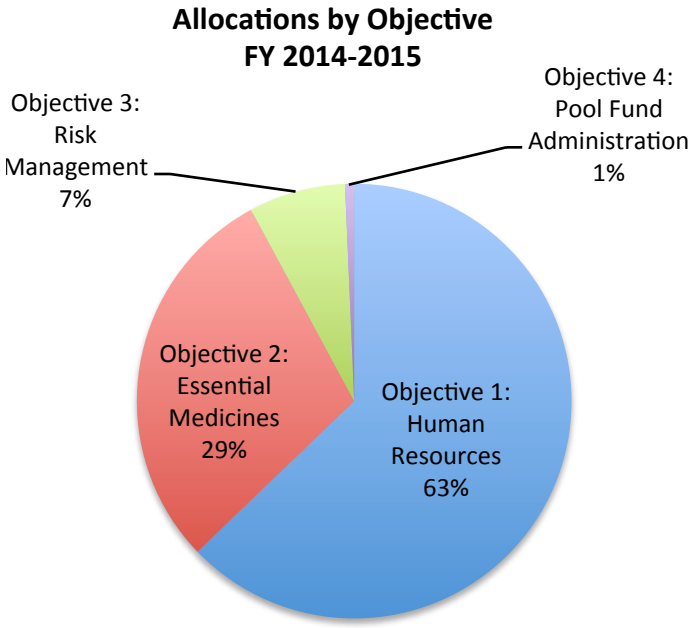
1. Pool fund administration includes Ecobank charges, wire transfer fees, and UNICEF's contract administration fee. The cost of pool fund management was prepaid in FY 2013–2014 until March 2015 and no additional funds have been allocated for this purpose.

The corresponding funding allocations for these four objectives are presented in the table below (see Section 4 for detailed information on expenditure during the reporting period). Complimenting these allocations from the pool fund, GOL budgetary allocations to the central MOH and CHTs are expected to cover health system operational costs such as vehicle and facility maintenance and repairs.

The original budget accompanying the annual plan was US $8.3 million allocated across four objectives. Based upon a recommendation by the Pool Fund Steering Committee to increase the proportion of the annual pool fund budget allocated to risk management, the MOH submitted a revised budget, in the amount of US $8.8 million, that was approved by the steering committee in October 2014. At the start of the fiscal year, although the pool fund's annual budget was approved, commitments made by donors had not yet been received into the fund. Unspent funds from the previous year were used until additional funding was received from pool fund donors in December 2014, nearly 6 months into the current fiscal year. Based on the funds received in December 2014, the annual plan is now fully funded; however, expenditure was lower than projected due to delayed receipt of contributions and delayed implementation of planned activities caused by the Ebola crisis.

As the chart (at right) indicates, nearly two-thirds of all pool fund allocations in FY 2014–2015 are allocated to human resources for health, while most of the remainder is allocated to essential medicines and supplies. The sections below describe the expected outcomes, programmatic indicators, targets, and activities for each of these objectives (see Annex 1 for the overall FY 2014–2015 performance measurement framework). In addition, the pool fund will continue to utilize the NHP Monitoring Framework, with its 19 indicators, to monitor progress against the goal and objectives of the NHP (see Section 3 for more information).

Figure 1. **Health System Framework (from WHO)**



2.1 Ebola response and restoration of essential health services

2.1.1 Ebola response

The MOH's Monitoring and Evaluation and HMIS Units continued to produce maps, presentations and daily situation reports that were circulated to a wide range of stakeholders during the reporting period. This has been a key focus of the MOH team as they lead the Surveillance Pillar of the Ebola response, requiring a substantial amount of time away from the teams' regular activities to be able to produce the daily sit rep. Data reported in this section is taken from the Sit. Rep. 230 with reference made to other sit. reps. within this period.

The period from October through December 2014 was the critical period of the Ebola response, and Liberia gradually began to show signs of real improvement by mid-December 2014. In this period, Lofa County, the initial epicenter of the disease, achieved zero new cases (more than 42 days without a new case), as occurred in other counties such as Grand Gedeh, Maryland, RiverGee, and Grand Kru. There were "hotspots" in Rivercess, Sinoe, and Grand Bassa counties, with clusters of cases seen in remote areas. The CHTs and partners responded to the outbreaks and were able to control the spread of the virus. By the close of the reporting period, the last laboratory confirmed case was seen in Margibi County on December 30th, 2014 and only 3 confirmed cases were reported in the country.

As of December 31, 2014 (Sit. Rep. 230), the cumulative number of cases of Ebola was 8,119 (up from 3,834 as of September 30, 2014). This included 3,198 suspected cases, 1,805 probable cases, and 3,116 confirmed cases, which resulted in 3,471 deaths among all suspected, probable, and confirmed cases. There were 370 cases of health care workers being infected by Ebola and 178 deaths recorded. By December 31, 2014, the average confirmed case per day was 1, as compared to 50–60 confirmed cases in September and October 2014.

The average number of confirmed cases seen per day during the peak of the outbreak was 60. Montserrado has active transmission ongoing and increases in the number of cases compared to the rest of the country. The projection from the MOH team is that if the curve stays pointed sharply downward with enhanced interventions, the light at the end of the tunnel might be in sight. The following are summary updates on several thematic aspects of the Ebola response:

Figure 2: **Number of confirmed cases per day up to December 31, 2014 (Sit. Rep. 230)**

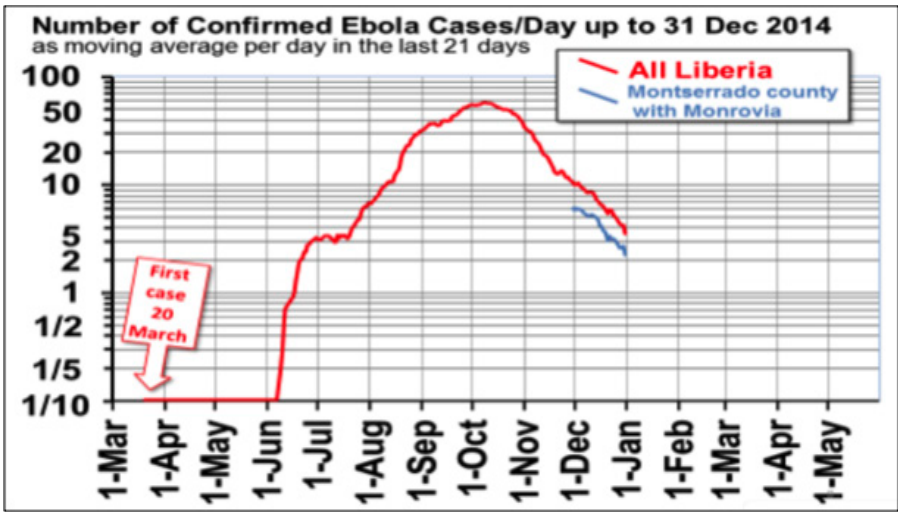
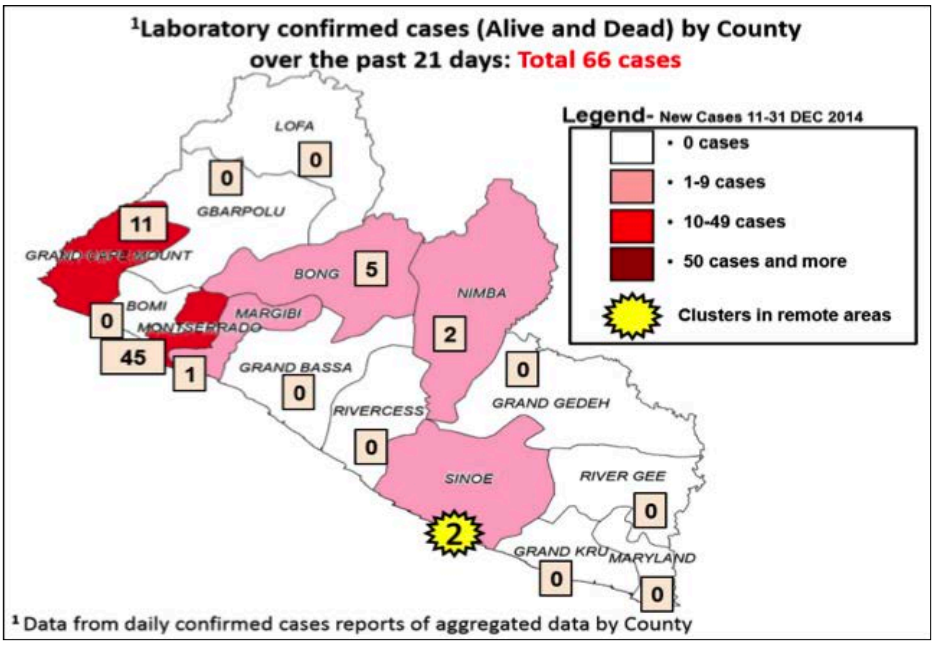


Figure 3: **Laboratory confirmed cases (alive and dead) by county over the past 21 days (December 11–31, 2014) (Sit. Rep. 230)**



- **Psychosocial Support:** There were 1,400 recorded survivors of Ebola in Liberia. A coordination meeting is being held with the survivors, and a survivor network has been established with prospects for establishing chapters in the counties. Survivors are 53% female and 47% male. The age group most affected is 0-40 years, with most being of reproductive years. The highest number of survivors was reported in Montserrado (52.2%), Margibi (14.6%), Lofa (9.5%), and Bong (7.9%). Interim care centers have also been set up to provide care to children of affected families while their parents are in treatment or awaiting reunification and reintegration with relatives, in the event of a

family member(s) dying from Ebola. Ongoing psychosocial support is required for survivors, affected families, and responders.

- **Epidemiology and surveillance:** The team continues to track cases, but with a greater focus on new cases per day and on ensuring that those cases are listed on the contact list. There are issues of counties not reporting suspected or probable cases, but daily calls are made to the counties to make sure this is done.
- **Case management:** In this quarter, the team continued to focus on the construction by partners of Ebola Treatment Units (ETUs) in strategic locations and on ensuring that health care workers were trained in how to protect themselves from Ebola. Hot and cold Ebola training (real and simulated) was provided to health care workers, covering theoretical aspects along with the actual ETU experience.
- U.S. and Liberian health authorities have given provisional approval for Ebola vaccine trials. The PREVAIL (Partnership for Research on Ebola Vaccine Study in Liberia) is a large clinical study led by the Liberia–U.S. clinical research partnership and sponsored by the U.S. National Institute of Allergy and Infectious Diseases (NIAID), which is part of the U.S. National Institutes of Health. There are two Ebola vaccines being tested: Chad3-EBO-Z (GlaxoSmithKline) and rVSV-ZEBOZ (Merck and New Link).
- **Safe and dignified burial:** A new Ebola cemetery was opened in December 2014 on the Roberts Field Highway (Disco Hill area), which lead to the smooth transition from cremation to culturally appropriate safe and dignified burial. Engagement is now being made with funeral homes to facilitate the process of safe burial working along with the Ebola burial teams. The burial teams have kept themselves safe throughout the Ebola response, with no burial team member becoming infected.
- **Diagnosis:** Testing capacity increased with the opening of 8 laboratories for the testing of suspect Ebola cases in Bong, Nimba, Grand Gedeh, Montserrado and Cape Mount counties. Mouth swabs are also being used to test dead bodies.
- **Social mobilization:** A knowledge, attitude, and practice survey is being conducted and results will be included in the next quarterly report. There is still some level of resistance in some areas to behavioral change. Social mobilizers and training teams have reached 83 of 88 districts in Liberia, targeting various groups via door-to-door interpersonal communication.

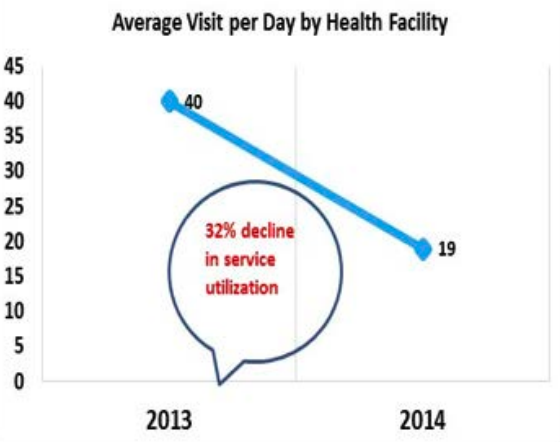
- **Contact tracing:** Active case tracing is ongoing in the communities by active cases finders and contact tracers. Some contacts are being missed from the contact list while other are moving to new locations, especially in Montserrado County, and exporting cases to the other counties.
- **Partnership:** The response continues to benefit from the strong leadership of the MOH through the Incident Management System, which has benefited from partnership with donors, INGO, NGOs, government agencies, and communities.
- **Finance:** The World Bank trust fund for Ebola response is being implemented by the GOL and its partners, especially UN agencies. The current World Bank grant ends in September 2015 and is expected to support the Ebola response and restoration of essential services with a focus on strengthening the health system. The MOH also received funds and material support from other sources to support the fight against Ebola, as well as funds from the Government of Liberia's National Ebola Trust Fund.
- **Payment of health care workers:** ETUs, Ebola response teams, and routine health service workers continue to receive hazard pay based on the rates approved by the Ministry of Finance and Development Planning (MOFDP), in consultation with the MOH.
- **Logistics:** A main logistics hub (located at SKD stadium) and five forward logistics bases have been established with improved access to overland, sea, and air transport for the response personnel and cargo used for the response. Utility vehicles, ambulance, and motorcycles have also been procured to support the response.
- **Emergency operations centers (EOCs):** Preparation of a national EOC site is being concluded and renovation work for county EOCs is ongoing at seven of the county nine EOCs sites. The national EOC site (across the street from the MOH) is expected to be completed by May 2015.
- **Phase I and II Strategy – Ebola Response:** Phase 1 of the Government of Liberia's EVD response strategy has been praised for its effectiveness in bringing the epidemic under control, and a Phase 2 strategy has set a course for getting to zero cases as quickly as possible. The Phase 2 strategy includes continuation of several activities proven to be effective in controlling EVD, such as contact tracing, rapid isolation and treatment, and safe and dignified burials, as well as new areas of emphasis. These include, among others, increased active case finding and referral, restoration of essential healthcare services that adhere to Infection Prevention Control (IPC) standards, strengthening community social mobilization to restore confidence and increase the demand for and utilization of health services, and increasing the psychosocial support services for survivors.

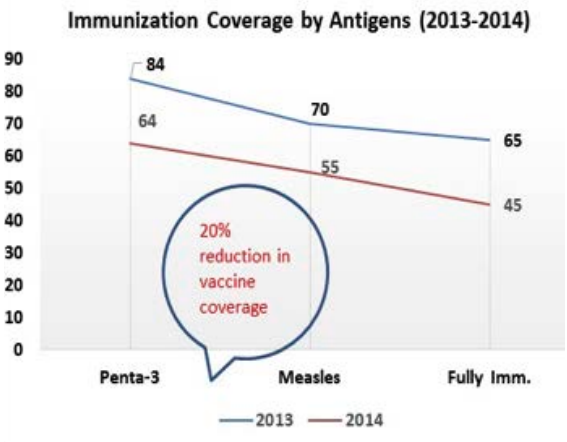
2.1.2 Restoration of essential health services

Fear of Ebola and a lack of resources to protect themselves drove many health workers away from health facilities and resulted in what the WHO termed a secondary health crisis in which mortality caused by a lack of health services could surpass mortality caused by the epidemic. The graphs below provide a snapshot of the impact of Ebola on health service delivery.

Restoring essential health services is now a top priority in the health sector and a restoration of health services plan has been developed by the MOH. Phase one of the restoration plan is moving ahead with the support of the GOL through the finance ministry. The finance ministry has provided US $6 million in funding from the World Bank's Ebola Trust Fund to support restoration of health care services along with other funding sources to support diagnostics services, fleet management, drugs and medical supplies, and hazard pay for routine health care workers.

As part of the restoration plan, the MOH is implementing a strategy of awarding performance contracts for managerial functions at key health facilities, contracting-out management of services to selected NGOs (based on past experience and presence in the county), and establishing MOUs with private and





faith-based institutions. The awarding of contracts started with 51 health care facilities (23 public, 28 private) designated to receive US $6 million. In all, 14 hospitals, 13 health centers, and 21 clinics (a mix of private and public facilities) will use the World Bank funding from January 1 to June 30, 2015.

A high-level meeting was held in Geneva on December 10 and 11, 2014 to set the agenda for building resilient systems in Ebola affected countries. The participants agreed on certain core principles to guide an "Agenda for Action" and to identify opportunities and partnerships for restoring and rebuilding people-centered services in a more resilient and responsive health system. In Liberia, a medium-term, post–Ebola plan is being developed, led by the MOH's Department for Planning, Research and Development. The post-Ebola planning process will include a health system asse ssment using a comprehensive and integrated approach (pre-Ebola performance), evidence of the impact of Ebola crisis on the health sector, recommendations to build a resilient health system, development of an investment plan (2015–2021), stakeholder consultation at all levels, and amendment to the 10-year National Health Plan.

2.2 Human resources

2.2.1 Planned activities

Objective 1	To retain and motivate health workers and support staff for the delivery of quality health services and management of support systems;
Key Activities	• Monthly processing of incentive payment • Incentive payroll monitoring
Expected Outcome	• Staff are retained and motivated to provide quality health services.
Indicator	• Number and cadre of health workers, CHSWT, and support system staff paid to provide quality health care services
Target	• No more than 2,669 MOH staff (25% of total health workforce) will be paid an incentive by the pool fund during FY 2014–2015.

The overarching goal in the National Health Plan for human resources is to "efficiently staff and effectively manage the network of facilities with the right mix of qualified workers in order to provide services according to the people's needs and according to the highest professional and ethical standards." In order to achieve this goal the MOH has actively been pursuing the following objectives:

1. Increasing the number of equitably distributed, qualified, and high-performing workers at all levels;
2. Increasing the number of high-performing facilities and institutions that promote continuous learning and assure quality;
3. Strengthening the workforce to be people-centered, gender-sensitive, and service-oriented; and
4. Increasing the number of safe and enabling environments for learning and working equipped with the "tools of the trade."

The human resources challenge is to ensure there are enough qualified, motivated staff performing well enough to meet management and service delivery needs. To accomplish this, and to reduce health worker migration among facilities, counties, and NGOs, a health worker salary scale was created in 2007 that is intended to standardize the health salaries.

The salary scale sets the amount of salary health workers are to be paid. They are paid a portion or all of their salary as an "incentive" (or salary "top-up") according to what (if any) they received as base pay on the government payroll. Depending upon the county, donor funds (e.g., pool funds) or government funds are used to pay incentives in order to top-up civil service salary payments (if any) to meet the health worker salary scale commitment. Under this objective all payments to health workers with pool funds are consolidated and paid by the MOH through the Personnel Department and the MOH's Office of Financial Management (OFM).

The role of the county health teams is to assign staff to facilities according to MOH health facility staffing norms and to verify monthly staffing lists to be paid by the central MOH. The OFM and Pool Fund Secretariat carry out the processing of payment requests and tracking the payment of incentives. They also liaise with the counties to ensure that the pool fund incentive list is managed and monitored properly. County staffing-lists are spot-checked at the facility level during county monitoring visits described under Objective 3 related to risk management.

2.2.2 Actual activities

The progress made on the implementation of activities for this quarter was gathered through interviews and daily interaction with the CHSWTs, the support systems team, and the HMIS system. The following activities were implemented under Objective 1 for this reporting period.

Monthly processing of incentive payment: The staff payrolls during the quarter were generated by the OFM (Payroll Accountant), reviewed of by the Personnel Director, and signed by the MOH's Deputy Minister of Administration. The Pool Fund Accountant supported the processing of the payroll by electronic bank transfer via Ecobank directly into the individual health worker bank accounts. Eight of 10 counties reported that their staffs received their incentives on time during the period, either through direct bank deposits or cash payment. Gbarpolu's county health and social welfare team (CHT) reported a delay in receiving incentive pay due to internal management issues related to authority for finances caused by the theft incident, which led to mistrust among the Gbarpolu CHT. River Gee County does not have a bank. Therefore, funds are withdrawn in Monrovia and visits are made to clinics to pay salaries, which introduces logistical changes and delays in payment.

The GOL mandates the use of bank transfers for the payment of salaries and incentives, but access to banking institutions poses challenges to staffs in counties without banks. Health workers without bank accounts have begun to open accounts as a result of the GOL requirement to receive Ebola hazard pay, which requires a bank account as condition for payment. An analysis of the pool fund supported payroll found that an increasing number of

staffs are opening bank accounts, and this is expected to improve over the coming quarters except in counties without banks.

Incentive payroll monitoring: The payment of incentives continued during this period for 10 counties where health worker incentives are supported in part with pool funds. Upon the consolidation of the county payroll and central-level support system payroll, they were analyzed to compare incentive rates between the counties previously managed by NGOs and those managed through the MOH system. The analysis showed that the rates for some of the counties (e.g., Bomi, which was managed by the CHT) is slightly different from rates in other counties. It also showed that some staffs are below the minimum wage of US $125 approved by the Civil Service Agency. The necessary adjustments were not feasible during this quarter, given the current Ebola situation, while health workers remained dissatisfied with payment issues. However, health workers need to be prepared for potential future changes to the amount of incentive they receive.

The number of health workers supported by the pool fund for this quarter remained relatively stable. The total number of persons paid did not exceed 2,709 for the quarter, including both support systems and facility-based staffs. No new or additional recruitment took place during this quarter; however, information gathered from the counties showed that some staffs were replaced to fill gaps in staffing from attrition. The two tables (at right) present the total number of health workers and CHT staffs receiving pool-funded incentives.

Health Workers and CHT Incentives Paid in Q1 FY 2014-2015

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

Central MOHSW Support Staffs Paid Incentives in Q1 FY 2014–2015

Department	Units	No. of staffs
Administration	OFM	22
	Internal Audit/Compliance	10
	Infrastructure	7
Planning	M&E	3
	External Aid	2
Health services	CHS/CMO Office and SCMU	2
Total		**46**

Note: The number of persons paid fluctuated slightly during each month.

2.3 Medicines and supplies

2.3.1 Planned activities

Objective 2	To improve the availability and access to essential medicines and supplies at the health facility level;
Key activities	• Procurement, clearance, and storage of essential medicines and medical supplies. • Distribution, reception, and verification of essential medicines and medical supplies at the county and health facility levels. • Conducting of a quarterly inventory of the Essential Drug Program, with reports on distribution and stock status submitted to the PFSC.
Expected outcome	• Improved access to essential medicines and supplies at the health facilities for patients
Indicator	• Inventory accuracy rate: compare stock levels recorded in the MOH records to actual stock levels on the warehouse floor
Targets	• Four physical inventories conducted by NDS per year

The MOH's goal for essential medicines is to "ensure continuous supply and access to efficacious, high-quality, safe and affordable medicines for all people in Liberia," according to the NHSWP. Drug and medical supply purchasing is the second largest cost in the health sector after personnel. The National Drug Service (NDS) is the purchasing agent for the MOH's essential drugs. NDS also provides warehousing and distribution services for a fee of a fixed percentage of the cost of the drugs purchased.

Each year, the MOH's Supply Chain Management Unit (SCMU) is in charge of the quantification of needed drugs, including forecasting national drug requirements, and in creating a procurement plan. The SCMU is also in charge of calculating the total amount of resources required to finance this plan, taking into account GOL and county budgets and donor commitments.

NDS is the entity that actually purchases the drugs and medical supplies by identifying suppliers, evaluating bids, negotiating contracts, and making payments for essential drugs and medical supplies procured for the MOH. However, drugs paid for by the pool fund are paid directly from the Pool Fund Disbursement Account to the supplier in Europe.

In FY 2014–2015, the MOH allocated pool funds for the procurement of essential medicines and supplies that form a part the MOH Essential Drug Program (EDP). The drugs procured are available to all MOH supported facilities anywhere in the country, not just counties previously supported by the pool fund through NGOs. This is to ensure equitable access to essential drugs by all people in Liberia as well as to reduce the fragmentation of the supply chain, where previously only certain drugs have been available to certain counties due to different sources of funds.

As was the case in FY2013–2014, the pool fund covers the costs of NDS administrative and logistics fees for the procurement, storage, distribution, monitoring, and reporting on stock procured with pool funds. As the focal point for pool fund drug procurement, in coordination with the Pool Fund Secretariat, the SCMU works closely with NDS to ensure drugs and supplies are procured in a timely fashion and progress updates are provided on a periodic basis.

Counties access essential medicines and supplies through the MOH distribution model. The activities for MOH teams include "coordinating the distribution of commodities in the counties, distributing commodities according to the Interim Arrangement standard quantities,

conducting a physical count at all of the county depots at the end of the distribution to ascertain stock status, ensuring that facilities and the county depot update reporting tools as the commodities are distributed, and assisting the county depot staff to reconcile store records and produce their inventory report."[2] As part of this objective, the NDS is now required to conduct quarterly inventories and provide them to the Pool Fund Secretariat. NDS will also be audited annually, as it was in 2014 as part of the pool fund annual audit, which will include an audit of records as well as physical stock. This is intended to limit discrepancies between NDS-reported drug stock levels and actual stock levels on the warehouse floor.

2.3.2 Actual activities

The drug order placed with Mission Pharma by NDS, in accordance with the GOL's Public Procurement and Concessions Commission (PPCC) procedures, began to be delivered during this quarter. The initial consignment arrived by air and included laboratory reagents and supplies for blood grouping, rapid test kits and the other drugs and medical supplies. The first shipment arrived on November 26, 2014, and the second on December 15, 2014. The value of the drugs received was US $126,496 (13% of the total order). Mission Pharma scheduled staggered drug deliveries to avoid receiving large quantities of drugs that exceed NDS's available warehouse space. Essential drugs and medical supplies have also been procured by UNICEF and WHO with funds from the World Bank Ebola Trust Fund. The Pool Fund Secretariat will work closely with the Health Services Department and the SCMU to ensure that the next drug and supplies order funded by the pool fund for FY 2014–2015 takes into account all of the supplies in the pipeline.

In December 2014, NDS conducted physical inventory of the stock funded by the pool fund in order to close out the F8 stock (paid for in FY 2012–2013). The inventory process was supervised by an internal auditor from the MOH. Upon completion of the inventory, the results showed that limited stock was remaining of the F8 drug procurement and therefore the remaining supplies were combined into the MOH's essential drug program for onwards distribution to health facilities.

NDS continues to have the following issues that affect its operations: limited warehouse space, staffs not on GOL payroll, transportation and maintenance support, and electricity (payment of bills and fuel for the generator). The Pool Fund Secretariat is processing the payment of logistic and administrative fees to NDS for the procurement of the FY 2013–2014 US $1.8 million drug and medical supplies order. The secretariat will work with the MOH and NDS to ensure that this amount has a clear plan for utilization. Recruitment by the MOH of an additional supply chain officer is in progress but has been placed on hold pending the arrival of the drugs and medical supplies. Recruitment will be completed in the next quarter. Drugs and medical supplies were distributed through the MOH's Interim Approach and other distribution was done through the logistics cluster for the Ebola Response. However some counties still reported not having some of the drugs and materials needed, especially for surgery. A strategy will need to be put in place whereby a minimum allocation of funds is set aside for emergency supply orders by the counties so they can be procured faster locally but which follow all the requisite government procurement processes.

Summary of Pool-funded Drug Distribution, Q2 FY 2014–2015

Category	Amount (US $)
PF drugs and medical supplies received	2,197,390
Reported expired drugs (Feb 3, 2014) report	7,158
PF drugs and medical supplies, balance	2,190,232
Round I distribution, Dec. 2013	639,064
Round II distribution, May 2014	706,570
Round II distribution, Aug. 2014*	34,825
Subtotal	1,380,459
NDS reported balance based on invoices as of September 2014	809,773

Note: The pool-funded drugs still being distributed are from the F8 drugs stock funded in FY 2012–2013.

2. Refer to the "Interim Approach. Supply Chain Management Unit. 2013."

2.4 Risk management

2.4.1 Planned activities

Objective 3	To mitigate the priority financial and programmatic risks that affect allocations from the pool fund.
Key Activities	• Conduct integrated supervision and monitoring visits to project sites with reports submitted to the PFSC. • Conduct independent evaluation of at least three projects at the end of 12 months. • Conduct the annual pool fund audit, with final reports provided to the PFSC.
Expected Outcome	• Improved integrated supervision and monitoring of pool fund supported projects, focusing on service delivery and support systems, risk management, and mitigation.
Indicator	• Number of pool fund audits • Number of integrated monitoring visits • Number of project evaluations
Targets	• One pool fund audit per year • Four integrated monitoring visits • One program evaluation, inclusive of three projects

Risks associated with the pool fund are managed through two different approaches. First, the Pool Fund Management Firm (PFMF) has a responsibility to manage and control the fiduciary risk associated with the pool fund mechanism. This responsibility includes ensuring regular reconciliation of pool fund bank accounts, conducting spot checks and verification visits of pool-funded activities, and ensuring that the independent audits and risk assessments are carried out and the recommendations are followed up. The second approach is via a risk management allocation from the pool fund to the MOH for unfunded activities from the MOH's fiduciary risk management plan. For FY 2014–2015, the MOH proposed the following risk management activities to be funded by the pool fund:

1. Conducting integrated supervision and monitoring visits to project sites, with reports submitted to the PFSC;
2. Conducting an independent evaluation of at least three projects completed by CHSWTs and NGOs in FY 2013–2014; and
3. Completing the annual pool fund audit with final reports provided to the PFSC.

Integrated supervision and monitoring visits will incorporate the activities of relevant departments into one site visit. The integration is expected to include a focus on data verification and coaching, monitoring of service delivery activities, financial and HR management, procurement, internal audit, follow-up on audit recommendations, and compliance-related issues. In the past, these activities were conducted independently instead of using the proposed one visit / one team strategy. There are three advantages to the new approach: (1) costs are reduced, (2) the impact on normal health service delivery operations is lessened by reducing the total number of central MOH visits, and (3) a more integrated approach to service delivery and support system monitoring can be achieved.

In order to determine the programmatic

efficacy of pool fund expenditures, independent evaluations of at least three service delivery contracts from FY 2013–2014 will be conducted. To cover the scope of the scenarios currently funded, these could include an evaluation of Bomi County, which has been an initial pilot of the contracting-in model for 27 months, and Merci in River Gee Country, because it is one of the last NGOs fully implementing the contracting-out model, and one of the two hospital projects. This will allow the pool fund to create specific case studies highlighting the pros and cons of the different models used.

The Joint Financing Arrangement for the pool fund includes provision for an annual independent audit. To date, these annual audits have generally been limited to the central MOH departments and units, in particular the OFM and Pool Fund Secretariat; however, going forward these audits will also include NDS. The period to be audited will be for FY 2013–2014 beginning July 1, 2013, and ending June 30, 2014. The selection of the audit firm will follow the provisions of the Amendment and Restatement of the Public Procurement and Concessions Act, 2005 and the MOH's Procurement Procedures.

2.4.2 Actual activities

Most of the people normally involved with field visits associated with risk management were heavily involved in the Ebola response activities and they multitasked to support the restoration of health care service activities and post-Ebola planning. The Pool Fund Secretariat, represented by the Pool Fund Manager, is also serving as the Deputy Manager of the Incident Management System, supporting the Ebola response activities as well as the restoration of health care services. This resulted in shifting some workload to other staffs in the secretariat. Moreover, the Pool Fund Secretariat, OFM, and Internal Audit and Compliance teams heavily focused on reviewing and responding to the Annual Audit and Fiduciary Risk Assessment, while working along with the auditors (see Annex 2, Fiduciary Risk Improvement Plan, Management Responses, and Status Update). The draft reports were reviewed and prepared for the PFSC meetings held in October and December 2014. With the support of the Pool Fund Secretariat, the MOH will reconsider the feasibility of going ahead with the planned independent evaluation of the previous contracting-in allocations to CHTs, depending on how things continue to unfold with the Ebola epidemic, post-Ebola planning, and the availability of MOH personnel to undertake such a process at this time.

The Pool Fund Secretariat conducted three joint monitoring visits by teams from various MOH departments to Gbarpolu and Lofa during the period. A field visit was also conducted by the Pool Fund Secretariat and an MOH procurement officer to Gbarpolu to assess the issues of basic utilities for the hospital, focusing on electricity, water supply, fuel, and maintenance related issues. The visit to Gbarpolu was a crucial follow-up visit by the OFM and the pool fund, given the theft incident reported in October 2013. Recommendations from the field visit have been developed by the joint monitoring teams for MOH senior management for action.

The MOH's Internal Audit Unit conducted a risk assessment of NDS in December 2014. The purpose of the assessment was to identify areas of risk affecting the operations of the National Drug service and to appraise the NDS's board of directors and the senior management of MOH on the updated risk profile of NDS. The full report is available in the MOH's Internal Audit Unit. A meeting of the MOH's regional auditors was convened in August 2014 and a debriefing meeting held with the pool fund manager, the internal audit director and the regional auditors. The purpose of this meeting was to review their activities over the previous period and develop a strategy for supporting the counties. In December, a strategy for rotation of the auditors, timelines for reporting and reviewed TOR was agreed. Training was conducted in December 2014 and the auditors were re-deployed to different regions. The counties requiring more support were identified as the resident county for the auditors. This strategy is intended to support the CHT with their financial and procurement related transactions. The counties confirmed

that the auditors had arrived in their resident counties and were settling in. The teams were deployed to the following regions:

1. River Gee, Grand Bassa, and Sinoe County
2. Margibi, Bong, Lofa, Nimba County
3. Gbarpolu, Bomi, and Grand Cape Mount county
4. Maryland, Grand Gedeh, River Gee, and Grand Kru.

The following weak areas were highlighted by the auditors and continue to be issues highlighted from field visits by the teams:

- Poor assets management
- Inaccurate recording and coding of materials and supplies
- Lack of warehouse management and records
- Procurement regulations not adhered to
- Business registration for small business not available
- Absence of delivery notes on most transactions
- Capacity building needed for some staffs in the field
- Payroll gaps (verification, records, and files)
- Financial management issues
- Liquidation reports delayed and not properly compiled
- Availability of staff during pre-audit
- Lack of approval and signatory of vouchers

General constraints highlighted by the counties were:

- Limited staffing in some areas, however no new staffs can be hired. Those available have to multitask to compensate for this problem.
- Operational support to the county is needed for fuel, stationeries, communication cards and cost for repair and maintenance of vehicles and motorcycles.
- GOL funding is still not being disbursed on time

2.5 Administration

2.5.1 Planned activities

Objective 4	To efficiently and effectively manage the pool fund mechanism and control of fiduciary risk associated with the fund.
Key Activities	• Management of the pool fund mechanism, including support to the steering committee and the day-to-day operations of the secretariat. • Management and control of the fiduciary risk associated with use of the fund.
Expected Outcome	• Effective management of the pool fund mechanism and control of fiduciary risk.
Indicator	• Performance review conducted of the fund management firm and the results presented to the steering committee.
Targets	• Twice per calendar year

Administration is an inherent cost for the pool fund and includes bank encasement charges and fees, fund transfer fees, the fee charged by UNICEF for costs associated with handling the Pool Fund Management Firm's (PFMF) contract, as well as the actual cost of pool fund management, which includes the cost of the Pool Fund Secretariat and field activity monitoring.

The pool fund is currently managed by a Pool Fund Management Firm (PFMF) that has two principal responsibilities: (1) management of the pool fund mechanism, and (2) management and control of the fiduciary risk associated with use of the pool fund. Fund management includes the responsibility and cost of running the Pool Fund Secretariat and conducting field monitoring and spot checks of pool-funded activities. The secretariat team works closely with MOH 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 retains the records of the pool fund and the steering committee, including proposals, reports, contracts, steering committee briefing papers, resolutions, and meeting minutes.

In FY 2014–2015, the role and responsibility for the PFMF is to continue to efficiently and effectively manage the pool fund mechanism and control fiduciary risk associated with the fund. The PFMF will work closely with the relevant MOH departments to ensure that the pool fund mechanism's fiduciary risk is managed properly. This includes working with the MOH in the process of planning and budgeting of pool fund allocations and monitoring to ensure that the MOH can adequately manage allocations. The PFMF will also ensure that the PFSC is regularly updated with information relevant to the PFMF and that all procedures are followed. To ensure high-quality pool fund management, the performance of the PFMF will continue to be assessed by a sub-committee of the steering committee and the results of the assessment will be reported to the committee.

2.5.2 Actual activities

Pool Fund Secretariat team worked closely with MOH counterparts and other donor-funded programs to support the 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, and

coordination and other administrative activities continued during this period. The focus for this quarter was working with the relevant MOH teams to review their budgets and develop realistic workplans in the midst of the Ebola response that affected the timing of most activities.

The secretariat worked closely with the Health Services department for the restoration of essential health care services. The Pool fund Manager also supported the Personnel Department to generate staff lists and to process payments for ETUs, routine health care workers, and Ebola response teams in the 15 counties. Visits were conducted to Sinoe, Bomi, Margibi, and Cape Mount counties in November and December 2014, as well as trips to ETUs in Montserrado on special visits for donors. The Pool Fund Management Firm also supported the MOH's incident management system in several ways: the coordination of the EVD response; support to thematic groups for the response; facilitating donors, partners, and special guest visits; special meetings; and liaising with the MFDP team for the World Bank's and African Development Bank's support for Ebola response. The Pool Fund Secretariat also continues to provide support to the Department of Administration supporting the OFM and the Personnel Department to manage human resource issues for the Ebola response and Health Services department for the restoration of health care services. The support during this period also focused on planning for the post-Ebola plan development, which was expected to start in January 2014.

Working with the National Drug Service, the pool fund management team also followed up on the procurement process for drugs and medical supplies for FY 2013–2014 and discussions on the development of a MOU with NDS for the procurement of the drugs and medical supplies. Three monthly pool fund financial updates (October, November, and December 2014) were provided to the steering committee, along with the draft Q1 FY 2014–2015 report, and a supplemental proposal for NDS re-organization using a service provider.

The pool fund team continues to work closely with the OFM to ensure that the financial reporting system was using ACCPAC, the approved MOH financial management software, and to ensure that all the necessary system changes were being implemented as recommended. Plans have been made for a consultancy with Modular Resources to support the MOH in the review of the financial management systems and upgrade of ACCPAC, focusing on license renewal and training as well as on the set-up of a back-up server. The pool fund team will continue to support the MOH on the Ebola response and restoration of health care services and participate in the planning process for post-Ebola.

3. Other Relevant Information

3.1 Ten-Year National Health Plan Monitoring Framework

The NHP 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 FY 2014–2015, which began July 1, 2014 and continues through June 30, 2015, with comparisons made to the national achievements.

Goal/Objective	Indicator	Baseline	Year	Source	Target 2021	Progress to Date[3]
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%	10.6%

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

			Baseline	Target 2021	Pool Fund FY 2013 Actual	National FY 2014 Target	National FY 2014 Q2	National Year to Date
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%	41%	50%	32%	28%
	Family planning	Couple-years protection with family planning methods	45,798	TBD	36,772	72,029	16,302	31,096
	Child health/ EPI	% of children under 1 year who received pentavalent-3 vaccination	74%	90%	82%	90%	48%	
	Service consumption	OPD consultations per inhabitant per year	0.9	2	0.72	1.04	0.44	
	Malaria	% of pregnant women provided with 2nd dose of IPT for malaria	29%	80%	45%	45%	25%	
	HIV/AIDS	Number of pregnant women testing HIV+ and initiated on ARV prophylaxis.	1,613	TBD	293	2,987	74	143
	Tuberculosis	Number of smear positive TB cases notified per 100,000 population	103	127	73	3	116	193
Systemic components	Human resources	Number of skilled birth attendants (physicians, nurses, midwives and physician assistants)/10,000 population	5.7	14	TBD	7.4	Reported annually	N/A
	Drugs	% of facilities with no stock-out of tracer drugs during the period	TBD	95%	TBD	70%	Pending	N/A
	HMIS	% of timely and complete HMIS reports submitted to the MOHSW during the year	76%	90%	67 %	60%	42%	48%
					97%	80%	63%	89%
	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		

3.2 Indicator performance

Key performance indicators are monitored to assess the performance and progress made against targets set in the NHP Monitoring Framework. Support continues to be provided for service delivery, focusing on the EPHS at all levels (primary, secondary, and tertiary).

The data presented below represents an overall county reporting rate of 63%, with timely reports at 42% during the period from October to December 2014. Compared to the previous quarter, there has been gradual improvement in the reporting rates as health facilities re-opened and with services being provided again. The county level teams continue to focus on restoration of health care services and getting key supervision activities back on course as EVD cases decrease. Currently, only data from the health facility level is being monitored through the District Health Information System (DHIS). Community-based interventions are reported in county quarterly narrative reports to the MOH, but not through the DHIS. The figures below illustrate the completeness and timeliness of reporting (see Annex 3 for absolute figures).

Reporting Rate and Timeliness of HMIS Reports by County

Name	Number of facilities	Actual Reports	Expected Reports	Reporting Rate	Reports On Time	Percent On Time
Bomi	24	65	72	90%	25	38%
Bong	39	117	117	100%	113	97%
Gbarpolu	14	32	42	76%	16	50%
Grand Bassa	30	69	90	77%	44	64%
Grand Cape Mount	32	89	96	93%	31	35%
Grand Gedeh	21	54	63	86%	49	91%
Grand Kru	17	51	51	100%	50	98%
Lofa	59	168	177	95%	120	71%
Margibi	30	61	90	68%	30	49%
Maryland	24	70	72	97%	34	49%
Montserrado	241	123	723	17%	27	22%
Nimba	63	178	189	94%	153	86%
River Gee	17	40	51	78%	31	78%
Rivercess	19	51	57	89%	51	100%
Sinoe	34	95	102	93%	52	55%
Liberia	664[4]	1,263	1992	63%	826	42%

4. Total health facilities in counties.

3.2.1 Maternal and Newborn Health

Essential primary healthcare services are provided at the health facility and community levels. During this reporting period, the national skilled delivery coverage increased from 28% in the previous quarter to 32% in Q2. Skilled delivery coverage showed an increasing trend over the last fiscal year, but, with the interruption of services, this indicator has showed a major change in health-seeking behavior by pregnant women. There are reports of pregnant women being denied services because health workers were afraid to provide care, especially for pregnant women in delivery, because of their exposure to body fluid and bleeding. It is clear that the EVD epidemic forced most women to deliver at home, a practice that poses substantial maternal risk. The recent Liberia Demographic Health Survey, published in 2013, determined that the maternal mortality rate was

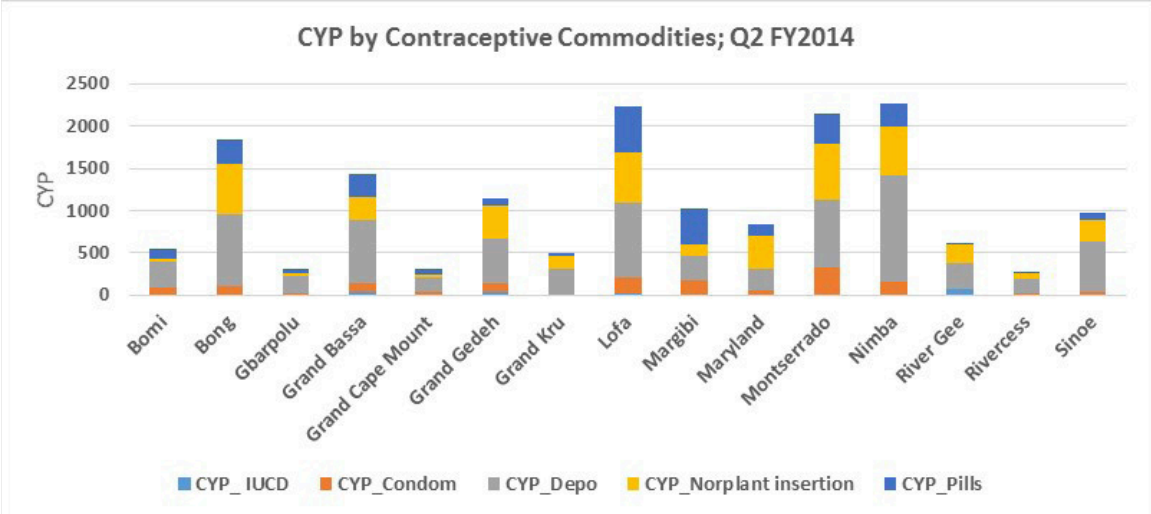
1,072 per 100,000 live births, an increase from 994. The table below presents the skilled delivery coverage in all counties during the current reporting periods (see Annex 3 for absolute figures).

Skilled Deliveries Coverage

County	Overall Population	Total FY 2013	Apr–Jun FY 2013	Jul–Sep FY 2014	Oct–Dec FY 2014
Bomi	95,290	72%	84%	26%	43%
Bong	377,767	75%	92%	45%	60%
Gbarpolu	94,461	27%	33%	26%	25%
Grand Bassa	247,055	37%	44%	24%	23%
G.C. Mount	143,949	37%	39%	9%	13%
Grand Gedeh	141,893	45%	53%	43%	42%
Grand Kru	62,726	30%	32%	33%	26%
Lofa	313,629	66%	71%	42%	50%
Margibi	237,803	48%	57%	1%	12%
Maryland	144,594	39%	47%	37%	29%
Montserrado	1,164,147	43%	41%	11%	14%
Nimba	523,386	71%	79%	53%	55%
River Gee	75,659	48%	54%	24%	22%
Rivercess	81,005	43%	45%	37%	45%
Sinoe	115,484	50%	58%	45%	37%
Liberia	3,818,848	52%	56%	28%	32%

3.2.2 Family planning

Couple-years of protection (CYP) is a key indicator used by MOH 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 graph below presents the CYP by commodity/method for all counties in Liberia. Montserrado, Nimba, Bong, and Lofa have high rates of CYP compared to the other counties. Depo and Norplant are the two methods most frequently used across the counties.



3.2.3 Child health / EPI

The EPHS emphasizes the importance of Integrated Management of Neonatal and Childhood Illnesses (IMNCI), the Expanded Program on Immunization (EPI), malaria control and treatment, and child nutrition programs. 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 shows the percentage of children under age 1 who received pentavalent-3 vaccination.

Penta 3 Coverage

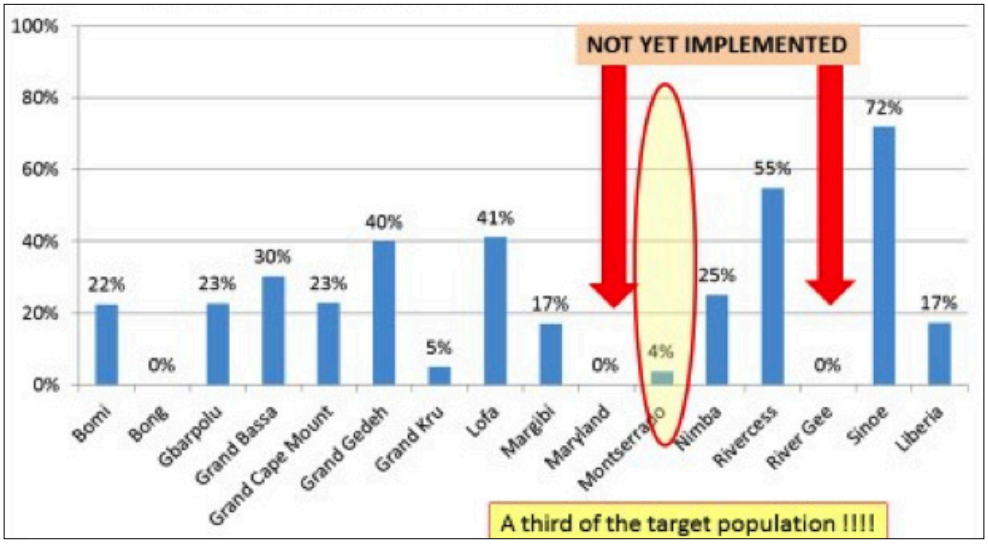
County	Overall Population	Total FY 2013	Apr–Jun FY 2013	Jul–Sep FY 2014	Oct- Dec FY 2014
Bomi	95,290	89%	100%	29%	65%
Bong	377,767	107%	117%	55%	83%
Gbarpolu	94,461	80%	90%	50%	47%
Grand Bassa	247,055	84%	101%	46%	51%
G.C. Mount	143,949	79%	76%	11%	32%
Grand Gedeh	141,893	67%	55%	70%	68%
Grand Kru	62,726	83%	68%	59%	71%
Lofa	313,629	85%	85%	38%	68%
Margibi	237,803	75%	79%	0%[5]	24%
Maryland	144,594	101%	96%	83%	67%
Montserrado	1,164,147	85%	68%	41%	25%
Nimba	523,386	87%	84%	48%	57%
River Gee	75,659	69%	63%	24%	17%
Rivercess	81,005	83%	87%	49%	56%
Sinoe	115,484	101%	117%	72%	66%
Liberia	3,818,848	86%	83%	43%	48%

5. Margibi County was unable to report HMIS data on a timely basis during the peak of the Ebola epidemic between July and September; however, some data was subsequently submitted after the reporting deadline.

The data indicates that, like skilled attendance at birth, there has been a decrease in immunization rates across the country compared to last year. Penta-3 coverage slightly increased during this reporting period but still remains very low, at a rate of 48%.

Due to the low immunization rates, the MOH decided, in consultation with the WHO, to conduct an immunization campaign due to the ongoing measles outbreak. Periodic Intensification of Routine Immunization (PIRI) was introduced. This is a strategy to get targeted groups vaccinated. There are three rounds of PIRI planned, with the first round conducted in December 2014. The target population was children aged 9 to 59 months (551,364 nationwide). A total of 95,540 children in that age group received measles vaccinations as part of the PIRI round 1 activities (December 2014), which represents 17% of total target and 21% of 12 counties covered .

December 2014 round PIRI Coverage: Measles for children aged 9–59 months

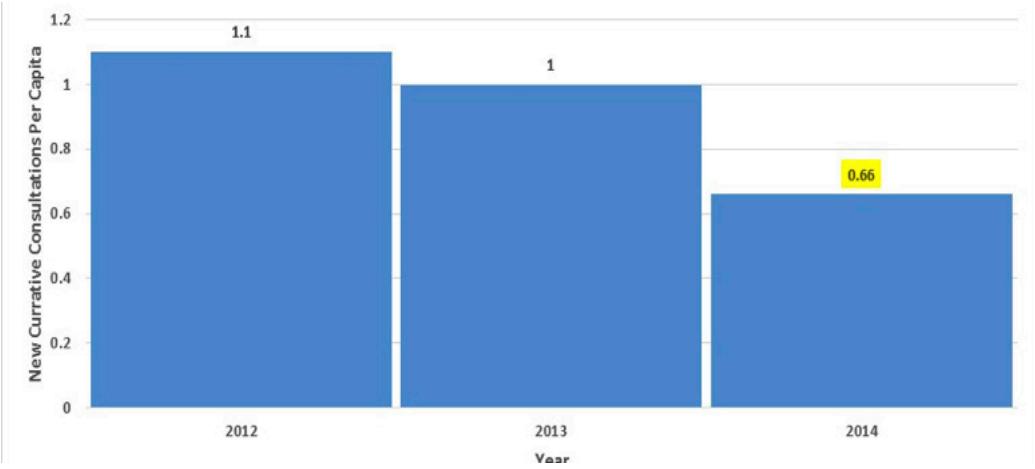


PIRI was not implemented in two counties (Maryland and River Gee) but is being planned in the next round. However Montserrado, with one-third of the country's population, had only 4% coverage for measles immunization. Plans have been made to conduct and additional two rounds of immunization campaign in the next quarter upon the decrease of EVD cases across the country.

3.2.4 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 shows the utilization rate in all counties in Q2 for FY 2014–2015. As the table indicates, the utilization rates have remained significantly low during both quarters. This is attributed to the fact that health services dropped off during the Ebola crisis and have been only gradually restored, with confidence being slowly rebuilt among patients to seek essential health care services and among health care workers to see the patients and provide the services. Delivery of health care services in Montserrado still remains below normal, given the ongoing presence of active transmission compared to the other counties. The utilization rate ranges from 0.2 to 0.8, with Lofa the highest and Cape Mount and Montserrado the lowest, and with no information reported for Margibi County. Annual utilization rates have also dropped (see chart, Annual Trend in Health Service Utilization Rate).

Annual Trend in Health Service Utilization rate in Liberia – 20112-2014



Utilization Rate

County	Overall Population	Total FY 2013	Apr–Jun FY 2013	Jul–Sep FY 2014	Oct–Dec FY 2014
Bomi	95,290	1.5	1.8	0.47	0.78
Bong	377,767	0.77	0.91	0.41	0.46
Gbarpolu	94,461	0.48	0.6	0.47	0.4
Grand Bassa	247,055	1.1	0.91	0.45	0.52
G.C. Mount	143,949	0.83	0.8	0.15	0.33
Grand Gedeh	141,893	0.62	0.67	0.42	0.47
Grand Kru	62,726	1.1	1.1	0.92	0.67
Lofa	313,629	0.97	1	0.61	0.84
Margibi	237,803	0.92	0.94	0[6]	0.34
Maryland	144,594	0.8	0.8	0.52	0.57
Montserrado	1,164,147	1.48	0.88	0.22	0.20
Nimba	523,386	0.93	1.1	0.68	0.60
River Gee	75,659	1.1	1.2	0.55	0.42
Rivercess	81,005	0.61	0.8	0.4	0.43
Sinoe	115,484	0.72	0.8	0.61	0.58
Liberia	3,818,848	0.93	0.95	0.39	0.44

6. Margibi County was unable to report HMIS data on a timely basis during the peak of the Ebola epidemic between July and September; however, some data was subsequently submitted after the reporting deadline.

3.2.5 Malaria

Pregnant women are provided a 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 Q2 (see Annex 3 for absolute figures). IPT2 coverage increased slightly to 25% in the second quarter of FY 2014–2015, up from 22% in the first quarter, but well below the 45% coverage in FY 2013–2014.

IPT2 Coverage

County	Overall Population	Total FY 2013	Apr–Jun FY 2013	Jul–Sep FY 2014	Oct–Dec FY 2014
Bomi	95,290	55%	63%	19%	34%
Bong	377,767	70%	81%	34%	48%
Gbarpolu	94,461	26%	28%	19%	20%
Grand Bassa	247,055	48%	48%	24%	24%
G.C. Mount	143,949	46%	43%	6%	12%
Grand Gedeh	141,893	37%	41%	36%	30%
Grand Kru	62,726	27%	22%	25%	18%
Lofa	313,629	52%	52%	25%	34%
Margibi	237,803	33%	33%	0%	10%
Maryland	144,594	51%	69%	34%	31%
Montserrado	1,164,147	37%	29%	8%	12%
Nimba	523,386	60%	61%	43%	38%
River Gee	75,659	43%	45%	20%	15%
Rivercess	81,005	42%	44%	25%	29%
Sinoe	115,484	47%	53%	37%	32%
Liberia	3,818,848	45%	47%	22%	25%

3.2.6 HIV/AIDS

HIV and AIDS prevention and control is critical for disrupting the spread and reducing the bur-den of HIV/AIDS in Liberia. One of the preventive strategies in use is 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 was 74 in the in Q2. 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.

3.2.7 Tuberculosis

Tuberculosis remains a major public health problem in Liberia. The notification and treatment of TB are critical intervention strategies, while measuring the number of new TB cases and treatment are key indicators. The number of positive TB smear tests per 100,000 was 116 in Q2.

4. Financial Position

4.1 Lifetime financial position, April 1, 2008, to December 31, 2014

Category	Notes[7]	US$
Pool fund inflows		
Cash contributions by donors to date	A	70,202,260
Bank interest and other income	B	391,519
Total pool funds received		70,593,779
Pool fund outflows		
Payments for projects and activities		62,145,825
Bank fees, charges and tax on credit interest	C	498,353
Total payments	D	62,644,178
Net balance of inflows less outflows		7,949,601
Represented by:		
Book balance of pool fund account		7,122,113
Book balance of disbursement account		827,488
Total pool fund bank account book balances	E	7,949,601
Net balance of commitments less payments:		
Total commitments	F	70,242,506
Total payments		62,644,178
Unpaid balance of pool fund commitments	G	7,598,328
Uncommitted fund balance at December 31, 2014		351,273

7. See Section 4.4 (below) for all notes.

4.2 Financial position, April 1, 2008, to December 31, 2014[8]

	Q1 July 1–September 30, 2014 US$	Q2 October 1–December 31, 2014 US$	Q3 January 1–March 31, 2015 US$	Q4 April 1–June 30, 2015 US$	Note	Year to Date US$
Opening balances						
Main account	5,841,009	2,846,179				5,841,009
Disbursement account	713,955	616,357				713,955
Total opening balance	**6,554,964**	**3,462,535**				**6,554,964**
Contributions received	0	5,887,562				5,887,562
Bank interest	4,305	0				4,305
Total receipts	**4,305**	**5,887,562**				**5,891,867**
Total funds available	**6,559,269**	**9,350,097**				**12,446,831**
Total payments YTD	3,096,734	1,400,496			H	4,497,231
Closing book balances						
Main account	2,846,178	2,846,179				7,122,113
Disbursement account	616,357	616,357				827,488
Total closing balance	**3,462,535**	**3,462,535**			E	**7,949,601**
Unpaid Commitments	3,462,535	7,598,328			G	7,598,328
Uncommitted funds	**0**	**351,273**				**351,273**

8. July 1 to September 30, 2014.

4.3 Budgeted versus actual expenditure by quarter

	Approved Budget [October 28, 2014] US$	Q1 July 1–September 30, 2014 US$	Q2 October 1– December 31, 2014 US$	Q3 January 1–March 31, 2015 US$	Q4 April 1– June 30, 2015 US$	Total Expenditure	Unspent Balance US$
Objective 1: **Human Resources**							
Health worker salaries	5,570,000	1,221,847	1,222,364			2,444,211	3,125,789
Subtotal	**5,570,000**	**1,221,847**	**1,222,364**			**2,444,211**	3,125,789
Objective 2: **Drugs**							
Drugs & supplies	2,300,000						2,300,000
NDS fees	300,000						300,000
Subtotal	**2,600,000**						2,600,000
Objective 3: **Risk Management**							
Independent audit	75,000						75,000
Independent evaluation	65,000						65,000
Integrated supervision	182,500						182,500
Regional auditors	82,000		3,937			3,937	78,063
OFM support	138,000		7,751			7,751	130,249
Activity monitoring	96,000						96,000
Subtotal	**638,500**		**11,688**			**11,688**	626,812
Objective 4: **Admininistration**							
Fund management[9]							
Bank fees	60,000	1,916	38,544			40,460	19,540
Subtotal	**60,000**	**1,916**	**38,544**			**40,460**	19,540
Total	**8,868,500**	**1,223,763**	1,272,596			**2,496,359**	6,372,141
FY 2013–2014 project balances brought forward	3,227,059	1,872,971	127,901			2,000,872	1,226,187[10]
Grand Total	**12,095,559**	**3,096,734**	**1,400,497**			**4,497,231**	7,598,328

9. Pool fund administration includes Ecobank charges, wire transfer fees, and UNICEF's contract administration fee. The cost of pool fund management was prepaid in FY 2013–2014 until March 2015 and no additional funds have been allocated for this purpose.

10. The remaining project balance for FY 2013-2014 represent 50% balance of the Pool Fund drug order and administrative/logistic fee for NDS and final payment to IRC.

4.4 Notes to the financial position

Note A: **Contributions (April 1, 2008, to December 31, 2014)**

Donor	Pledges to date	Contributions received to date (base currency)	Contributions received to date	
AFD	€ 3,942,701	€ 2,365,620	US $2,960,402	€ 1,577,080
DFID	£19,945,000	£19,945,000	US $31,569,660	£2,650,000
SDC	US $2,038,547	US $2,038,547	US $2,038,547	US$ 1,578,947
Irish Aid	€ 22,000,000	€ 22,000,000	US $29,213,651	€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			US $ 70,202,260	

Note B: **Bank interest and other income (April 1, 2008 to December 31, 2014)**

	Pool fund main bank account	Disbursement bank account	Total
Interest on timed deposit	US $ 357,620	US $33,599	US $391,219
Bid documents sale		US $300	US $300
Total	US $357,620	US $33,899	US $391,519

Effective November 1, 2013, the MOH has negotiated an interest rate of 2.0% per annum on the pool fund main bank account with Ecobank 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 December 31, 2014)**

	Pool fund main bank account (USD)	Disbursement bank account (USD)	Total (USD)
Ecobank fees	371,753	7,829	379,582
Ecobank charges	74,305	9,991	84,296
Tax on credit interest	31,242	3,234	34,476
Total	477,299	21,054	498,353

Note D: **(Total Payments)**

Refer to table of expenditures, below.

Note E: **(Pool Fund Bank Account and 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 December 31, 2014. These transactions are summarized in the following tables:

Reconciliation of Book Balances to Bank Balances

Item	Main Account	Disbursement Account
Bank Balance	2,622,113	934,686
Bank Errors		(3,755)
Outstanding Transfers		
Outstanding Checks		(103,443)
Timed Deposit	4,500,000	
Book Balance	7,122,113	827,488

Note F: **(Total Commitments)**

See to table of expenditures, below. Upon the closure of the last fiscal year, all uncommitted funds (US$ 1,345,186) were allocated to the personnel budget line (code FV) to ensure health worker salaries could be paid. Allocations to the other 2014–2015 approved budget lines were made based on the funds received from donor commitments in December 2014, which means that the annual plan is fully funded and plans for the additional funds to be received will be developed by the MOH and presented to the steering committee.

Note G: **(Unpaid Balances of Commitments)**

Refer to table of expenditures, below.

Note H: **(Total Payments Current Quarter)**

Refer to table of expenditures, below.

Expenditure on Project Commitments Comparative Report, as of December 31, 2014

Reference	Project Activities	Start Date	Original End Date	Total Commitment	Adjusted Commitment (Note F)	Total Payments Current Quarter	Total Payments Year to Date (Note H)	Total Payments (Note D)	Percentage of Commitment Paid	Unpaid Balance of Commitments (Note G)	Status/ Completion Date
1	Closed pool fund allocations (P0-PZ, F1-F8,FA-FS) Ref to Q 1 FY 2014-2015 disbursement summary sheet)			62,898,200	58,818,190	127,901	1,051,028	58,818,190	100%		Closed
F9	IRC/Nimba	Jul-12	Dec-12	448,073	448,073			373,394	83%	74,679	Pending Internal Audit Clearance in January 2015
FT	Pool fund administration/ UNICEF, bank charges	Jan-13	Mar-15	11,450	60,000	38,544	40,370	46,760	78%	13,240	Jun-15
FU	FY 2013-2014 essential medicines and supplies	Jul-13	Jun-14	2,107,743	2,107,743	0	949,934	949,934	45%	1,157,809	Jun-15
FV	Personnel (health workers support)	Jul-14	Jun-15	1,342,106	5,570,000	1,222,362	2,444,211	2,444,211	44%	3,125,789	Jun-15
FW	Risk management	Jul-14	Jun-15	386,505	638,500	11,689	11,689	11,689	2%	626,812	Jun-15
FX	FY 2014-2015 essential medicines and supplies	Jul-14	Jun-15	2,600,000	2,600,000	0			0%	2,600,000	Jun-15
	Total			69,794,077	70,242,506	1,400,496	4,497,231	62,644,177	89%	7,598,329	

Annexes

Annex 1: Performance measurement framework

Goal: To improve access to quality health care services through the provision of essential medicines and supplies and retention of qualified health workers at health facilities.

Expected Outcomes:

- Staffs are retained and motivated to provide quality health services.
- Improved access to essential medicines and supplies at the health facilities for patients to prevent stock outs.
- Improved integrated supervision and monitoring of pool fund supported projects focusing on service delivery and support systems, risk management, and mitigation.
- Improved management of the pool fund allocations and control of fiduciary risk.

Objectives	Inputs	Outputs	Indicators/Targets	Assumptions and Risks
Obj. 1: To retain and motivate health workers for delivery of quality health care services	**Financial:** $5,000,000 USD **Human resources:** Support system staff	2,669 health workers and support staffs are paid on time and motivated to provide services.	# of health workers, CHSWT, and support system staffs paid to provide quality health care services (EPHS) 2,669 MOH staff are paid incentive during FY2014–2015	**Assumption:** MOH will continue to put health workers on CSA payroll. **Risk:** The incentive payments are not sustainable due to fluctuations in donor funding, and major health worker issues may arise.
Obj. 2: To improve the availability and access to essential medicines and supplies at the health facility level.	**Financial:** $2,600,000 USD value of essential medicines and supplies and administrative and management support **Human resources:** NDS staffs and pool fund secretariat staff.	Improved access to essential medicines and medical supplies in all health facilities across the country to prevent stock outs.	**Inventory accuracy rate:** Compare stock levels recorded by the MOH to actual stock levels on the warehouse floor Essential Medicines and Supplies 4 physical inventories conducted by NDS per yr	**Assumptions:** NDS improves management and monitoring. MOH continues to invest in NDS. **Risk:** Stock outs, expired drugs.

Table continues →

Objectives	Inputs	Outputs	Indicators/Targets	Assumptions and Risks
Obj. 3: To mitigate the priority financial and programmatic risks that affect allocations from the pool fund.	**Financial:** $338,000 USD for the various risk management and mitigation activities **Human Resources:** Pool fund and MOH staffs for integrated monitoring visits. Regional auditor staffs for county audit visits.	Completed pool fund annual audit Four integrated site visits One three-project evaluation	# of pool fund audits # of integrated monitoring visits # of project evaluations # of visits of regional auditor visits 1 pool fund audit per year 4 integrated monitoring visits 1 program evaluation, inclusive of 3 projects	**Assumption:** MOH will invest in the improvements listed as part of the risk management mitigation strategy, put strategies in place based on the recommendations of the assessments that have been done. **Risks:** If there is not adequate investment in risk mitigation activities, there is a risk of losing donor funding.
Obj. 4: To efficiently and effectively manage the pool fund mechanism and control of fiduciary risk associated with the fund.	**Financial:** Investment in fund management and banking costs: $360,000 USD **Human resources:** Pool fund secretariat and management staff	Effective management of the pool fund mechanism and control of fiduciary risk.	Performance review conducted of the fund management firm and the results presented to the steering committee. Twice per calendar year.	**Assumption:** The Fund Management Firm's contract will be extended until the end of FY2014–2015 **Risk:** Failure to assess performance could result in substandard fund management.

Annex 2: Fiduciary Risk Improvement Plan, Management Responses, and Status Update[11]

#	FRA Recommendation	MOH & Pool Fund Management Responses	Responsible	Timeframe	Status
1	Given that the Pool Fund will be using IFMIS in due course, and notwithstanding delays in its implementation due to software issues that have been encountered, processes for classifying projects effectively on the new chart of accounts (CoA) should be assessed and developed as part of the transition to IFMIS. A transition timetable and action plan should be developed setting out how and when the Pool Fund will move over to IFMIS.	The activation and use of the program module of IFMIS (Free balance) is not within the control of MOH, but with MOFDP. Nevertheless, MOH and the Pool Fund Management Firm will engage with the MOFDP to discuss the feasibility of establishing a timetable and action plan for when the Pool Fund can move over to IFMIS.	MOH	June 2014	Ongoing
2	The Ministry and the Pool Fund should keep under review the full use of IFMIS and record transactions using the new CoA. The Ministry of Finance should support this process in order to ensure that there is as much consistency as possible in budgeting and accounting across government.	The GOL chart of accounts is already being used in ACCPAC for all transactions.	MOH	Completed	Completed
3	Data in Excel spreadsheets and information uploaded to ACCPAC should be reviewed periodically. Excel information should be accessible to identified individuals and be backed up regularly.	Any Pool Fund transactions recorded in Excel management spreadsheets for FY 2013–2014 were supplemental to ACCPAC data entries and were reconciled in July 2014 with ACCPAC data for the FY 2013–2014 Pool Fund annual report. Moving forward, the goal is for any necessary reconciliation to be done on at least a quarterly basis.	PFMF	December 2014	Completed
4	The Pool Fund, being a more "manageable" operation, should consider introducing a base budget approach to financial planning and budgeting.	This recommendation will be considered in the context of future Pool Fund annual planning. However, it is noted that base budgeting is better than incremental budgeting, which is currently adopted by the Government. Investment into a very solid training program leading to adoption of base budgeting is welcomed. However, until the wider government adopts a basis other than incremental budgeting, the ministry cannot apply base budgeting to all other programs and government funding.	MOH	Ongoing	Ongoing

Table continues →

#	FRA Recommendation	MOH & Pool Fund Management Responses	Responsible	Timeframe	Status
5	The Pool Fund should maintain its own risk register setting out strategic and operational risks. The MOH'S FRMP should maintain the predictability of donor funding as a permanent strategic risk item. The Pool Fund should carry out periodic reviews of the budget-setting process in order to ensure budgets formulated are reasonable. In particular, the risks around effectively and transparently managing additional support funding regarding the Ebola outbreak should be actively managed by MOH management.	The Pool Fund currently maintains a risk register and updates it at least annually. The MOH accepts the recommendation to maintain the predictability of donor funding as a permanent strategic risk item. Additional funding for Ebola is not channeled through the Pool Fund, which has no mandate to review other donor-funded projects and support. With the current financial management structure around the pool fund, it is unlikely that funds can be diverted without approval from the steering committee.	MOH	June 2015	Partially complete
6	The Pool Fund should retrospectively audit the arrangements at handover to ensure that all unused NGO funds transferred in December 2012 were accurately and completely accounted for. Going forward, any changes in delivery arrangements should be subject to independent review and scrutiny.	The cause of this concern is not self-evident, as those NGOs were obliged to submit copies of all expenditure documentation as part of their contract liquidation and closeout processes. The NGOs involved were also requested by the MOH, in accordance with their contract, to submit independent audit reports for the funds they received. The Pool Fund will explore the feasibility of including verification of balances in the next independent audit of the Pool Fund.	PFMF	June 2015	Ongoing

Table continues →

11. This risk improvement plan and management responses come from the 2014 Fiduciary Risk Assessment of the Health Sector Pool Fund.

#	FRA Recommendation	MOH & Pool Fund Management Responses	Responsible	Timeframe	Status
7	Governance arrangements and underlying systems and processes related to budget setting and implementation should be reviewed and updated accordingly in procedures notes to fully reflect the prevailing arrangements, including the shift away from delegated financial management responsibilities to CHTs (i.e., pool funds are no longer allocated to them). As part of this, a capacity and capability review of all staff involved in budget management should be carried out in order that capability gaps are identified and addressed in a targeted and cost-effective manner (through targeted training for example).	The MOH will consider this recommendation in the as part of the next review of the MOH's financial management policies and procedures. The MOH's Office of Financial Management (OFM) will incorporate the recommendation on budget management capacity into county support visits and capacity building.	MOH	June 2015	Ongoing
8	The Pool Fund and the Ministry should identify delays in government contributions toward projects as a risk and determine how any adverse impact on service delivery in the early stages of the fiscal year can be managed. There should be clear guidelines developed in relation to the monitoring of cash inflows and outflows at the Pool Fund level to ensure that potential shortfalls in available funding are identified as early as possible and the risk of default negated.	This recommendation will be considered in the context of future Pool Fund annual planning and proposed to the Pool Fund Steering Committee as appropriate. The Pool Fund will incorporate guidelines for monitoring cash flow into the Pool Fund Procedures Manual. As the delay in government budget approval and flaws in government budget implementation (bureaucratic processes leading to late receipt of fund and budget cuts) continue to be part of government fiscal management, the core funding of activities that involve the pool fund must be carefully decided.	PFMF	April 2015	Ongoing
9	Annual reports (and other periodic reports) should be enhanced in order to clearly show: key changes in activities and how these changes relate to NHP priorities; analysis of actual expenditures versus budgeted expenditures; and a clear breakdown of fund use by main unfunded rarity headings.	This recommendation will be incorporated into Pool Fund annual and periodic reports to clearly show key changes in activities and how these relate to NHP priorities, budgeted versus actual expenditure, and a breakdown of funds used.	PFMF	December 2014	Completed

Table continues →

#	FRA Recommendation	MOH & Pool Fund Management Responses	Responsible	Timeframe	Status
10	Any separate approvals of drug and medical supply budgets should be carried out and planned for as part of the wider Pool Fund budget-setting process. Budget procedures should be amended accordingly to take on board the requirements for specific Steering Committee approval of drugs and medical supplies.	In the 2014–2015 Pool Fund annual budget, drugs and medical supplies were presented as a separate funding allocation and approved by the Pool Fund Steering Committee.	PFMF	Completed	Completed
11	The Ministry should review its staff capability and capacity to implement the Medium-Term Expenditure Framework (MTEF). Shortfalls and gaps need to be addressed through appropriate measures (e.g., training; greater integration with OFM staff providing support to Pool Fund staff at the Ministry and counties).	The Ministry will review its staff capability and capacity to implement the MTEF. Shortfalls and gaps will be addressed through appropriate measures.	MOH	June 2015	Ongoing
12	The Operational Plan should be refined so that the specific level of detail that is currently contained is summarized into headlines covering key annual objectives, linking these to the 10-year NHP priorities and funding gaps to be filled by the Pool Fund.	This recommendation will be considered in the context of future operational planning, including summarizing specific details in to headlines covering key annual objectives, linking these to the 10 Year NHP priorities and funding gaps.	MOH	June 2015	Ongoing
13	The MOH and Pool Fund should take stock of developments in communications since the FY 2012–2013 Annual Report findings, with a view to confirming whether a Coordinator position will still add value to the wider decentralization bedding in processes.	This position was filled by the MOH in February 2014.	MOH	Completed	Completed
14	The Ministry's Financial Policies and Procedures Manual should be updated to reflect more completely the decentralized processes. For example, more effective monitoring is needed to scrutinize anomalies and reporting issues based on succinct budget outturn analysis in-year and at the end of the year.	The MOH takes into consideration the recommendation that Ministry's Financial Policies and Procedures Manual should reflect decentralized processes. The Financial Management Policies and Procedures Manual has recently been updated and is pending validation and approval. The decentralized financial management processes are adequately addressed in the new manual.	MOH	June 2015	Ongoing

Table continues →

#	FRA Recommendation	MOH & Pool Fund Management Responses	Responsible	Timeframe	Status
15	Periodic and annual Pool Fund reports should set out financial information for actual expenditures to date versus profiled budgets for key expenditures and income lines, both at a consolidated level and by county.	This recommendation will be incorporated into Pool Fund annual and periodic reports to show budgeted versus actual expenditures and a breakdown of funds used.	PFMF	December 2014	Completed
16	The timeliness of budget approvals should be reviewed with a view to ensuring that project start dates and the timing of funding requirements are aligned to actual release of Government monies. The timing of funds should form part of the financial planning process of individual projects.	This recommendation will be considered in the context of future operational planning to ensure that project start dates are aligned to actual release of Government monies. The timing of funds should form part of the financial planning process of individual projects. Consideration should also be given to the fact that government funding is unpredictable and may be considered to be risky in terms of reliability.	MOH	June 2015	Ongoing
17	Systems and processes relating to and supporting in-year expenditure monitoring should be subjected to regular review and assessment. Notably, the reliance upon Excel to monitor expenditure, as opposed to the accounting system, should be addressed as soon as possible, with Excel and ACCPAC being reconciled as minimum in the short term. As part of this, further staff training should be considered.	All Pool Fund transactions recorded in Excel management spreadsheets for FY 2013–2014 were reconciled in July 2014 with ACCPAC data for the FY 2013–2014 Pool Fund annual report. Moving forward, the goal is for this reconciliation to be done on at least a quarterly basis. Three-month Pool Fund staffs training on ACCPAC reconciliation began in October 2014.	PFMF	December 2014	Completed
18	Internal audit work on key financial systems, including the general ledger and expenditure systems, should be carried out as part of a risk-based program of work. (4.7.3) There should be an effective audit plan for the current year and a 3-year rolling plan outlining the review of key financial and operational systems to take place. There should be a fully functioning and effective audit committee present at the Ministry level to review the work of the Ministry's internal audit team and wider assurance related work.	There is an existing internal audit committee, which is headed by the minister. At present the Internal Audit Division is actively part of financial transaction processing, since they are currently engaged in pre-audit of all financial transactions within the ministry.	MOH	June 2015	Ongoing

Table continues →

#	FRA Recommendation	MOH & Pool Fund Management Responses	Responsible	Timeframe	Status
19	The Internal Audit team should focus their work primarily on controls and procedures within the Ministry and Pool Fund.	This recommendation will be considered by the MOH as part of future internal audit planning, including plans for reviewing key financial and operational systems. The mandate of pre-audit by the internal auditors is a policy decision made by the national government. The assignment of auditors is done through the Internal Audit Agency. This auditor reports administratively to the assigned line ministry or agency but functionally to the Internal Audit Agency. The action by the government to support pre-audit was based on poor internal controls in the government. However, the agency plans to do away with this in the long run, given the level of improvement in Internal controls generally. When that happens, internal audits will focus on post-audit issues, as required by the Institute of Internal audit (IIA).	MOH	June 2015	Ongoing
20	Training should be provided to all staffs who will be involved in procurement and contract management on the importance of written documents. This would be expedited with fewer but more concerted guideline documents. To that end, there will be merit in paring down guidelines relatied to contract management and procurement, and compiling one all-encompassing Ministry-wide procurement and contract management manual.	This recommendation will be considered in the context of the MOH's future reviews of procurement and contract management, including the merit of paring down guidelines related to contract management and procurement to establish one all-encompassing Ministry-wide procurement and contract management manual.	MOH	June 2015	Ongoing
21	The MOH should ensure that annual procurement planning is clear, particularly around the roles and responsibilities of all parties, and that sound project management principles are developed and followed. Most notably, a business case, linked to policy priorities, setting out the budget needed for procuring services/supplies and subsequently managing the contract, should underpin all procurement exercises and subsequent management of the projects.	This recommendation will be considered as part of the MOH's future reviews of procurement planning, particularly around the roles and responsibilities of all parties; sound project management principles will be developed and followed.	MOH	June 2015	Ongoing

Table continues →

#	FRA Recommendation	MOH & Pool Fund Management Responses	Responsible	Timeframe	Status
22	Staffs responsible for preparing and reviewing the bank reconciliations should ensure that reviews are competed in a timely manner. All reconciling items should be fully explained and documented.	Bank reconciliation is a necessary first step in producing the Pool Fund monthly financial updates, which have been consistently produced for the last 24 months. The target is to complete bank reconciliation within the first two weeks of the following month. The Office of Financial Management has a dedicated accountant who performs bank reconciliations. The new reconciliation accountant has been give a renewed mandate to follow up on reconciling items.	MOH and PFMF	Completed	Completed
23	Reports to the PFSC about the financial statement should show the budget versus the year-to-date actual position, together with projections for the entire year. These should be compiled to show the key headings as reported in the financial statements.	This recommendation will be incorporated into Pool Fund annual and periodic reports to show budgeted versus actual expenditures and a breakdown of funds used.	PFMF	December 2014	Completed
24	The Ministry and the Pool Fund should seek to encourage its respective auditors to establish a joint working protocol so that each can rely on the other's work.	The recommendation will be considered by MOH and the Pool Fund in future reviews. Also Pool Fund will ask an external auditor or GOL auditing commission to review reports generated by the other in order to have a better understanding of key risks faced by the entity, which will aid the other audit firm in focusing its resources efficiently for an effective audit review	MOH	March 2015	Ongoing
25	Scrutiny and monitoring arrangements, including audit efforts (external and internal), need to be planned and coordinated so that there is sufficient coverage of revised or new arrangements. This will help ensure the adequacy and the integrity of financial information being generated under the revised arrangements.	Although this recommendation is vague, the MOH will consider it in the context of planning and coordinating audit arrangements, including scrutiny and monitoring arrangements, to help ensure the adequacy and the integrity of financial information being generated.	MOH	March 2015	Ongoing

Table continues →

#	FRA Recommendation	MOH & Pool Fund Management Responses	Responsible	Timeframe	Status
26	In accordance with best practice, the Ministry and the Internal Audit Secretariat should initiate periodic reviews of the effectiveness and efficiency of internal audits. As part of this, the internal auditor should collaborate more closely with the external auditor to better understand how work can be planned and conducted in a way that increases the sense of reliance of the external auditor.	This recommendation will be considered by the MOH as part of a future review of the effectiveness and efficiency of internal audits, particularly in relation to the feasibility of more close collaboration with the external auditor to place reliance on the work of internal audit.	MOH	March 2015	Ongoing
27	Internal Audit should periodically review the robustness of arrangements to prevent and detect fraud and corruption.	This recommendation will be considered by the MOH as part of a future review by the Internal Audit Unit of the robustness of arrangements to prevent and detect fraud and corruption, thus initiating fraud risk awareness intended to prevent and detect fraud and corruption.	MOH	June 2015	Ongoing
28	The MOH should put into place key strategic policies followed by fraud awareness initiatives in order to establish proper communication with staffs of the Ministry. Such initiatives should be periodically refreshed and rolled out to staffs so that awareness among them does not diminish.	This recommendation will be strongly considered by the MOH in a future review by the MOH of the strategic policies to prevent and detect fraud and corruption so that awareness among staffs does not diminish.	MOH	June 2015	Ongoing

Annex 3: HMIS Data

Reporting Rate by County

Name	# of facilities	Actual Reports	Expected Reports	Reporting Rate	Reports On Time	Percent On Time
Bomi	24	65	72	90%	25	38%
Bong	39	117	117	100%	113	97%
Gbarpolu	14	32	42	76%	16	50%
Grand Bassa	30	69	90	77%	44	64%
G.C. Mount	32	89	96	93%	31	35%
Grand Gedeh	21	54	63	86%	49	91%
Grand Kru	17	51	51	100%	50	98%
Lofa	59	168	177	95%	120	71%
Margibi	30	61	90	68%	30	49%
Maryland	24	70	72	97%	34	49%
Montserrado	241	123	723	17%	27	22%
Nimba	63	178	189	94%	153	86%
River Gee	17	40	51	78%	31	78%
Rivercess	19	51	57	89%	51	100%
Sinoe	34	95	102	93%	52	55%
Liberia	664[12]	1263	1992	63%	826	42%

12. Total health facilities in counties.

Number of Skilled Deliveries

County	Overall Population	FY 2013	Q4	Q1	Q2
Bomi	95,290	3,087	894	283	463
Bong	377,767	12,095	3,883	1917	2585
Gbarpolu	94,461	1,102	345	283	264
Grand Bassa	247,055	3,986	1,211	680	643
G.C. Mount	143,949	2,406	629	150	218
Grand Gedeh	141,893	2,846	849	687	675
Grand Kru	62,726	747	228	232	185
Lofa	313,629	8,304	2,498	1500	1776
Margibi	237,803	5,177	1,511	17	325
Maryland	144,594	2,498	764	607	470
Montserrado	1,164,147	22,021	5,348	1482	1876
Nimba	523,386	14,351	4,642	3133	3286
River Gee	75,659	1,622	459	205	191
Rivercess	81,005	1,583	410	338	414
Sinoe	115,484	2,379	756	587	488
Liberia	3,818,848	84,204	24,427	12,101	13,859

Penta 3 Uptake

County	Overall Population	FY 2013	Q4	Q1	Q2
Bomi	95,290	3,392	948	281	624
Bong	377,767	15,618	4,392	2,101	3,148
Gbarpolu	94,461	2,952	844	474	449
Grand Bassa	247,055	8,131	2,476	1,156	1,273
G.C. Mount	143,949	4,610	1,096	161	458
Grand Gedeh	141,893	3,783	775	1,001	976
Grand Kru	62,726	1,872	426	372	451
Lofa	313,629	9,463	2,655	1,189	2,161
Margibi	237,803	7,142	1,876	0	568
Maryland	144,594	5,684	1,381	1,214	975
Montserrado	1,164,147	39,014	7,850	4,824	2,924
Nimba	523,386	15,137	4,404	2,528	3,028
River Gee	75,659	2,081	474	183	132
Rivercess	81,005	2,666	704	396	459
Sinoe	115,484	4,429	1,352	838	764
Liberia	3,818,848	125,974	31,653	16,718	18,390

IPT2 Uptake

County	Overall Population	FY 2013	Q4	Q1	Q2
Bomi	95,290	2,636	748	226	411
Bong	377,767	13,003	3,813	1610	2275
Gbarpolu	94,461	1,201	333	231	241
Grand Bassa	247,055	5,735	1,477	761	752
G.C. Mount	143,949	3,308	766	111	220
Grand Gedeh	141,893	2,600	721	651	541
Grand Kru	62,726	759	169	198	145
Lofa	313,629	7,333	2,034	967	1361
Margibi	237,803	3,938	975	6	286
Maryland	144,594	3,598	1,249	618	571
Montserrado	1,164,147	21,463	4,156	1145	1757
Nimba	523,386	13,418	3,974	2850	2504
River Gee	75,659	1,610	421	193	138
Rivercess	81,005	1,686	442	259	292
Sinoe	115,484	2,669	765	533	461
Liberia	3,818,848	84,957	22,043	10,359	11,955