REPUBLIC OF LIBERIA

MINISTRY OF HEALTH AND SOCIAL WELFARE

JOINT FINANCIAL MANAGEMENT ASSESSMENT REPORT

Final Draft Report

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This report on Joint Financial Management Assessment was prepared by a team of experts from key development partners operating in Liberia's health sector. The assessment was at the request of the Liberia Ministry of Health and Social Welfare (MOH), and was conducted under coordination of the International Health Partnership Initiative (IHP+). The assessment team comprised Maxwell B. Dapaah (Team Leader, World Bank /IHP+) and Kofi Amponsah (Consultant); Saidu Goji (FM Specialist World Bank), Daniel Amponsah (World Bank), Tima Brewah (UNICEF), Kasi Nsubuga (Global Fund), Samir Agbator (USAID); Elena Graomme (Irish Aid); Pia Buller (EU), Sualaho Morris Koon (UNFPA), and Gregg Pavitt (MSH-USAID), Melanie Graeser (MOH), Kerkula Bettee (MOH), Roland Kesselly (MOH) and Nuaker Kweneh (MOH).

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ABBREVIATIONS AND ACRONYMS

AFD	Agence francaise de development
ACC	Audit Committee Charter
AIDS	Acquired Immune Deficiency Syndrome
BCC	Budget Call Circular
BEP	Bid Evaluation Panel
BFP	Budget Framework Paper
BOP	Budget Option Paper
BPN	Budget Policy Note
CFE	Certified Fraud Examiners
CFS	Consolidated Fund Statement
CHT	County Health Team
CHO	County Health Officer
CHDC	Community Health Development Committee
COA	Chart of Accounts
COP	Community Outreach Pharmacy
CPA	Certified Public Accountant
CSA	Civil Service Agency
DBDP	Department of Budget and development Planning
DFID	Department for International Development
EERP	Ebola Emergency Response project
EC	European Commission
EML	Essential Medicine List
EPI	Expanded Program for Immunization
EVD	Ebola Virus Disease
EU	European Union
FAR	Fixed Assets Register
FPPM	Financial Policies and Procedures

FY	Fiscal Year
GAC	General Audit Commission
GAVI	Global Alliance for Vaccines and Immunization
GF	Global Fund
GoL	Government of Liberia
HDI	Hudges Development Incorporated
HFD	Health Financing Division
HFU	Health Financing Unit
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HR	Human Resources
HSPF	Health Sector Pool Fund
HSCC	Health Sector Coordination Committee
IA	Irish Aid
IAA	Internal Audit Agency
ICT	Information, Communication and Technology
IPSAS	International Public Sector Accounting Standard
LACC	Liberia Anti-Corruption Commission
LMDC	Liberia Medical and Dental Council
LMHRA	Liberia Medicines and Health Products Regulatory Authority
LMIS	Logistics Management Information System
IAC	Internal Audit Charter
IAGBS	Internal Audit Governance Board Secretariat
IFMIS	Integrated Financial Management Information System
IHP	International Health Partnership
iNGO	International Non-governmental Organization
IPFMRP	Integrated Public Financial Management Reform Program
JFMA	Joint Financial Management Assessment
KPI	Key Performance Indicator
LBC	Legislative Budget Commission

M&E	Monitoring and Evaluation
MD	Medical Director
MFDP	Ministry of Finance and Development Planning
MOH	Ministry of Health
MTEF	Medium Term expenditure Framework
NDS	National Drug Service
NGO	Non-governmental Organization
NHA	National Health Account
NHPP	National Health Policy and Plan
NHSP	National Health Strategic Plan
NHIP	National Health Investment Plan
NHP	National Health Plan
NTD	Neglected Tropical Disease
OFM	Office of Financial Management
PAAC	Public Accounts and Audit Committee
PAN	Personnel Action Notice
PC	Procurement Committee
PPC	Public Procurement and Concession
PCU	Project Coordination Unit
PAC	Public Accounts Commission
PFM	Public Financial Management
PFS	Pool Fund Secretariat
PPCC	Public Procurement and Concessions Commission
RFQ	Request for Quotations
RMNCAH	Reproductive Maternal Newborn Child and Adolescent Health
SCMP	Supply Chain Master Plan
SCMU	Supply Chain Management Unit
STG	Standard Treatment Guidelines
SWAp	Sector Wide Approach
SDC	Swiss Development Cooperation

TB	Tuberculosis
THE	Total Health Expenditure
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United Started Agency for International Development
USP	United States Parmacopeia
WAEC	West African Examinations Council
WB	World Bank
WHO	World Health Organization

Table of Contents

List of Figures

List of Tables

List of Boxes

EXECUTIVE SUMMARY

Background

The Ebola epidemic, which struck Liberia in March 2014 reversed many of the health sector gains and exposed the underlying weaknesses of the health system that will take years to fully address. The disease infected 372 health workers of which 180 died. The Ebola Virus Disease (EVD) outbreak led to health facility closures, community distrust and fears, and refusal of unprotected health workers to provide routine health services. It disrupted health services provision, highlighting the need to rebuild a resilient health system capable of responding effectively to similar threats.

To transition from the Ebola recovery, Liberia plans to use the Sector Wide Approach (SWAp)[1] to design, implement and evaluate a resilient health system to carry out its health sector strategy. To this end, the Ministry of Health (MOH) joined the International Health Partnership (IHP+) to help improve upon donor coordination, and to jointly work with development partners to strengthen MOH systems, including financial management, monitoring and evaluation (M&E), resource tracking, among others, for implementing the sector program.

This joint financial management systems assessment aims to identify the strengths and underlying weaknesses in the sector FM arrangements and provide a basis for coordinated support to their strengthening and use for implementing the future sector program. The specific objectives of the assessment are therefor to: (i) review the financial management systems of the health sector in Liberia (ii) recommend measures to strengthen the financial management systems that support alignment of all resources with those of MOH and Ministry of Finance and Development Planning (MFDP); and subsequently (iii) improve service delivery and health outcomes for Liberians.

To achieve these objectives, a field data collection comprising a series of face-to-face discussions and interviews with heads of pertinent institutional divisions and units along with a desk review of relevant documents was used to gather information for the assessment.

Main Findings

Budget Formulation and Planning

Existence of PFM structures. The assessment team noted a relatively better planning, budgeting and expenditure management. Planning Department, Health Financing Department (HFD) and Office of Financial Management (OFM) are the three departments involved in health sector resource allocation and expenditure management. The Planning Department assists County Health Teams (CHTs) with the planning of their county health programs and training on how to plan for health activities and programs. HFD focuses on resource mapping and mobilization. OFM prepares the annual budget estimates for input into the National Budget, manages payroll for the entire health sector, trains finance staff at the county level, and provides quality assurance and guidance to county teams on financial accounting and reporting among other financial management functions. The budgeting

[1] SWAp is an approach to international development that brings together a government, donors and other stakeholders within any sector. It is characterized by a set of operating principles rather than a specific package of policies or activities.

process, however, could benefit from a more structured and participatory process that will bring all relevant departments together and help reflect the needs and priorities of the sector.

Availability of key planning and budgeting documents. Liberia has a well-developed and costed Health Sector Investment Plan (2015-2021), National Health Policy Document, Financial Management Policies and Procedures manual. Section 3 of the manual outlines clear guidelines for planning and budgeting of health programs with a focus on adapting MOH budget presentation to the Medium Term Expenditure Framework (MTEF) format, as stated in GoL's MTEF manual. Yet the review showed that MOH does not fulfill the requirement to prepare its budget over a three-year horizon with two outer years. OFM staff lack knowledge, skills and abilities to prepare the budget in line with MTEF format.

Government of Liberia's Chart of Accounts

GoL uses a master Chart of Accounts (COA) that allows for analysis and tracking by MTEF. The assessment found that the COA categorizes expenditures in accordance with the internationally recognized IMF Government Finance Statistics (GFS) standard by functions and expenditure line items. This allows for consistency of comparison across government and to other countries. A challenge facing MOH is that the COA's two-tier reporting is insufficient for the level of disaggregation of activities currently undertaken and also envisaged under a SWAp.

Budget Execution and Reporting

Funds Flow. It was observed that all funds flow through OFM. This allows funds to be well-tracked. Once transfers to county units are approved, it takes two to three business days for transfers to reflect in the accounts. The allotment system makes sure that spending is not above the actual revenue available to support spending. To ensure that quarterly reports are submitted on time, the preceding quarterly report is required to be filed before the next allotment is issued. But the fund flow process is not without shortcomings. In-kind donations to county units are not consistently tracked. It takes an unusually long time to approve the quarterly reports. Moreover, there are delays in the flow of funds from the MFDP due to late approval of the national budget. The continuing resolution provision, which allows MFDP to approve and allow monthly a 1/12th of the prior year's budget has the unintended consequence of delaying the adoption of the budget. Planning for budget execution remains uncertain due to budgetary allocation uncertainties. Low budget execution rates have a deleterious impact on service delivery.

Cash Planning and Forecasting. An all-inclusive process of cash planning and forecasting was found. It involves logistics, procurement, finance, and administration functions. It is done annually ensuring that the forecasts are developed based on projections from current needs and expenditures. However, a number of issues were identified. At the CHT level, implementation does not always follow the forecasts, as allotments received often vary widely from the forecast submitted to MOH. MOH does not provide information on adjusted budget lines and the reasons for the adjustments. Also, there is no budget execution analysis done at the CHT level. This analysis is a key input for the budget preparation process. Due to delays in cash transfers to the county levels, the mission was informed that there are credit balances owed to suppliers in some instances. This has an impact the

reliability of cash balances reported since GoL uses cash accounting. Buying on credit as a result of these challenges puts hospitals at the risk of not getting the necessary supplies.

Management of Petty Cash and Cash Advances. It was realized that MOH issues pre-numbered receipts in sequence for all monies received. However, staffing shortage at the CHT and hospital levels has resulted in inadequate segregation of duties which is an important element of the internal control function. In some cases, the person with custody of the cash does the recording of the transactions as well. This makes petty cash spot checks difficult. There is also no regular independent verification to account for all monies received. No protocol exists to formally hand over the cash box when the person usually responsible for it is unavailable for a period of time.

Non-Salary Expenditure Management and Internal Control. In terms of internal controls, the health minister or deputy ministers approves all payments at the MOH level. At the CHT and hospital levels, the County Health Officer (CHO) or the Medical Director (MD) authorizes all payments. The main types of non-salary expenditure categories are (i) supplies and consumables (goods and services); (ii) transfers and subsidies; and (iii) capital items. Counties, hospitals, and programs receive allotments on a quarterly basis. The counties, hospitals, and programs record allotments as "advances." At the end of each quarter, they are required to send the following expenditure reports to OFM; (i) variance report (budget versus actual) (ii) expenditure plan for following quarter; (iii)bank reconciliation statement; and (iv) copy of bank statement. However, the reports are usually submitted late due to inadequate accounting staff capacity at the CHT levels.

Accounting and financial reporting. AccPac and IFMIS are the two systems used for accounting and financial reporting on cash basis. MOH uses the AccPac accounting system to record and report donor project funds, while IFMIS is used for funds disbursed from the National Budget. Reporting requirements for donors are subject to their own specific rules and procedures using systems not integrated into AccPac. This situation has created multiple reporting in the management of donor fund in MOH. However, internet connectivity related issues often cause several downtimes that impact the timely input of transactions in IFMIS. It is worth noting that AccPac has no activated budget control function. To address this issue, MOH is transitioning to the web-based NetSuite software, which has more advanced functionality. The planned transition from AccPac to NetSuite should take into account internet connectivity and its ability to interface with IFMIS to avoid issues with data migration in the future. County level reporting is on standalone excel-based systems. These excel-based tools pose a high risk of data loss, error and manipulation.

Procurement of Goods and Services

The MOH procurement department has the requisite personnel with expertise in procurement procedures and processes to carry out procurement activities. Implementation of procurement activities is aided by the existence of a Procurement Committee (PC), which is made up of MOH's senior management, a key requirement of the 2005 Public Procurement Act. The committee oversees

activities of the procurement unit, and reviews report of the evaluation panel for contracts above a US$10,000 threshold as well as activities of each step of the procurement cycle. In order to improve the procurement planning process for medical equipment, a quantification committee has been set up at the National Drugs Services (NDS). Notwithstanding these achievements, the counties are not involved in the procurement planning. As a result, their needs are not well-represented in MOH's procurement plan. Procurement plans submitted to the Public Procurement and Concession Commission (PPCC) are not prepared on time causing considerable delays. The staff of the procurement unit are not involved in the budget preparation process leading to lack of proper sequencing of procurement activities. The PC's make-up comprising the Minister and Deputy Ministers causes considerable delays in its meetings since they play both administrative and technical roles. To improve the situation, the Minister has appointed the Deputy Minister for Administration (DMA) to represent her as the chair of the committee. Yet there are also long hours of committee meetings. The excessive length of time precludes members from committing to meetings. As a consequence, there are delays in procurement of goods and services which in turn result in under-utilization of government funds by the end of the year.

Supply Chain Management

Liberia has made some gains in terms of its supply chain management and procurement of drugs. Policy instruments and guidelines are in place for supply chain management. However, the health sector supply chain management is not without challenges. First, roles and responsibilities of the various supply chain actors are not clearly defined. Second, ineffective coordination and management of key supply chain functions is a challenge inhibiting the operations of the three institutions. Essential medicines occasionally expire as a result of lack of storage facilities and an unreliable distribution system. Third, there are fragmentation of activities and high transaction costs for GoL since donor financing on which the supply chain institutions depend, to a large extent, is not predictable. Delays in disbursement of funds has knock on effect on the stock-out of essential medicines at the health facility level. Last, some supply chain personnel are still not on MOH payroll. This adversely affects their motivation and performance.

Human Resource and Payroll Management

The team determined that IFMIS provides adequate automated payroll and human resource management modules. MOH is also well on course with its staffing plan target to employ 15, 000 healthcare workers by 2021. By February 2016, MOH had employed 10,406 healthcare workers. Decentralization of the MOH employment process is currently underway. Nonetheless, the human resource and payroll management systems are scarcely optimal. Due to budget constraints, GoL is unable to absorb over 3,000 healthcare workers on its payroll. Employee turnover at MOH is high. The gap between the number of medical workers and support staff employed by MOH is widening. There is a significant delay in getting new workers on the general payroll. The Internal Audit Agency (IAA) personnel at MOH do not review the payroll on a timely basis, and the payroll is not consolidated. There is no central processing system to reconcile payroll records from MOH, MFDP, and Civil Service Agency (CSA); neither are there established protocols for electronic submittals of payroll, time and attendance sheets, and other payroll related information between independent line operations. County health facilities maintain a parallel payroll to account for essential healthcare workers who are not on the government general payroll. Paying employees on parallel payroll from

health facility allotment strains the already limited allotment for the health facilities to provide adequate quality services. There are delays in processing Personnel Action Notices (PAN) and salary payments as there is no electronic software to connect the facility levels with the center. Inadequate Human Resource (HR) staffing at the county level leads to significant time-lag in updating payroll where necessary. The problem is compounded by the lack of incentives for the professional staff. For example, nurses have no accommodation in many of the facilities in the country, which affects their ability to be on call as circumstances dictate.

Asset Management

A review of MOH's asset management showed that MOH has internal control systems in place for the management of its assets as enshrined in the revised OFM 2015 Financial Policies and Procedures Manual (FPPM). There is also a fixed assets register that enables OFM to track assets, including donations. Despite these strengths, the implementation of the manual remains a challenge as there is ineffective and inefficient monitoring of assets as well as compliance with the manual. There are also weaknesses in tracking movement of assets across MOH, CHTs and the hospitals and health facilities. MOH and the General Services Administration (GSA) are without a mechanism to reconcile the status of MOH's assets.

Auditing

Internal Audit, Compliance and Risk Management. The assessment team noted the existence of key internal audit documents such as the Internal Audit Charter (IAC) and Audit Committee Charter (ACC). There are also established administrative structures like the Internal Audit Governance Board Secretariat (IAGBS) and Audit Committee. Staff from the IIA are assigned to the MoH to conduct routine internal control reviews. However, auditees are unable to timely respond to audit findings. Also the Audit Committee does not meet and discuss issues arising from audits. There is also limited support from the government for the department to perform its audit functions. The Internal Audit Department does not have access to IFMIS to review transactions for compliance.

External Audit. The General Audit Commission (GAC) is the constitutional Supreme Audit Institution (SAI) and auditor of the Republic of Liberia, including MOH. It performs annual audits of GoL's Spending Entities. GAC has made significant strides in reducing the backlog of annual financial audits up to FY2012/13. The FY2014/15 annual financial audit is underway. While GAC has made significant progress in its effort to bring the Consolidated Fund Statement (CFS) audited up- to-date, the auditing of Spending Entities, including MOH are lagging behind. For instance, the auditing of MOH is in a backlog as far back as 2008/09. The auditing of MOH's comprehensive accounts from FY 2008/09 to FY2011/12 which began about two years ago is yet to be completed.

Governance of the Health Sector

General governance. The assessment established that on the governance front, Liberia's health sector has a well-crafted policy framework with a clearly defined strategy to achieve its vision and objectives. The existence of a Health Sector Coordination Committee (HSCC), made up of the Minister of Health (chair), heads of donor and international agencies, and civil society organizations, and private sector is evidence of participatory decision-making. Health officers and representatives of implementing agencies also make decisions at the county level. Despite the foregoing strengths, the

health sector has some governance challenges. In many instances, the dissemination of policy documents at the lower level has been inadequate. Limited availability of printed copies and scarce communication on their content, limit the knowledge and access of the CHTs to strategic documents that they are supposed to implement. HSCC is scheduled to meet quarterly but meetings are irregular. Meetings are usually convened if there is any urgent matter to be approved. Too many competing priorities at the ministry coupled with poor coordination of the process tend to interfere with the regular scheduling of meetings. The team learned that no real programmatic issues are discussed and civil society does not actively participate in sector meetings.

Health Sector Decentralization. The MOH Governance and Decentralization Unit plays a crucial role in GoL's decentralization process. It provides services in some counties. For instance, 2,500 services were delivered through the county service center in Grand Bassa. Nonetheless, the unit has limited human, financial and logistical resources, which limit its ability to regularly supervise the local governance structures.

Donor Mapping and Accounting for Donor Funds

Donor mapping helps MOH to track and project resource commitments from donors and GoL contributions to the sector. However, tracking donor and implementing agencies expenditure is difficult due to the fragmented and uncoordinated nature of health financing in Liberia. There is the need to improve the donor response rate of the survey which informs the donor mapping exercise. This will help to make the exercise more representative of donor engagement in the sector. Only 36 percent of donors responded to FY2015/16 survey for the donor mapping exercise.

POLICY RECOMMENDATIONS

The PFM challenges identified in the assessment present enormous constraints to effective service delivery across the sector. Based on the findings from the assessment, the following are recommend for attention.

Planning and Budgeting Process: (i) broaden participation in planning and budgeting processes to include all the relevant departments and units; and (ii) provide training in MTEF concepts and principles to enhance staff understanding of how to prepare the budget in line with GoL's MTEF guidelines.

Budget Execution and Reporting: (i)employ more finance staff at the county level to address the staffing shortage confronting the counties; (ii) enforce internal control systems and code of conduct; (iii) strengthen financial management capacities of CHTs; (iv) increase allotment for health sector expenditures based on cash needs communicated from the county levels; (v) encourage financial reporting and analysis practices at all levels of the health system; (vi) address delays in receiving allotments by ensuring timely submission of financial reports at both county and central MOH levels; (vii) carry out petty cash spot checks ; (viii) ensure application of a uniform method of petty cash

management at all levels; (ix) ensure independent verification of all monies received and develop formal handover procedures for situations when the person in charge of petty cash is absent; (x) prepare and review bank reconciliation statements on a monthly basis; (xi) maintain control registers for all purchase orders, checks and receipt books issued with emphasis on periodic reviews.

Procurement of Goods and Services: (i) start the procurement planning process earlier so that the procurement plan is completed in June of the current fiscal year. In that way MOH can take advantage of the Framework Agreement set out by the PPCC and decrease delays in procurement; (ii) include CHTs and hospitals in the procurement planning process. This will require building capacity at the county level, (iii) conduct productive meetings based on mutually agreed ground rules in terms of time; (iv) enhance coordination between NDS and donors to facilitate smooth distribution of drugs and pharmaceuticals to health facilities; and (v) Make meeting attendance part of procurement committee members' meetings terms of reference.

Supply Chain Management: (i) set up a strong supply chain coordinating mechanism that will ensure that all supply chain actors, including all development partners strictly adhered to the storage and distribution requirement of Liberia. (ii) simplify OFM financial management and procurement procedures to improve disbursement of funds and ensure effective implementation of critical functions such as distribution of essential medicines. (iii) clarify roles and responsibilities of various supply chain actors operating in the health sector; (iv) conduct a comprehensive assessment of the storage capacity at NDS; and (v) conduct a comprehensive costing of an integrated distribution of essential medicines and supplies and streamline government processes for donors to support an integrated approach.

Human Resources and Payroll Management : (i) review payroll before making payments; (ii) establish a central processing system to cross-verify payroll between the records from MOH, MFDP, and CSA; (iii) accelerate the process of moving MOH employees onto the payroll through MFDP; (iv) employ HR assistants to assist the county HR officers in gathering payroll information in a timely manner and also communicate expeditiously with the central office on key issues such as abandonment of job by employees or death; (v) strengthen the capacities of CHTs and other local structures with clear terms of reference and standardized procedures, training them on basic governance principles and management practices (vi)address the widening gap between medical and non-medical staff by ensuring that the personnel action notice (PAN) contains individuals with different and relevant professional qualifications for migration onto the government payroll.

Assets Management: (i) ensure compliance with the revised OFM manual, including provisions covering fixed assets. (ii) strengthen the capacity of the internal audit unit to enable it to undertake assets verifications at MOH, CHTs and the hospitals and health facilities level; (iii) maintain up-to-date fixed assets register for MOH vehicles, including vehicles received through donations; (iv) submit copy of fixed assets and reconcile same with GSA records at all times; (v) appoint assets manager consistent with the provisions of Article 10.6.1 of the OFM Manual.

Auditing: (a) Internal Audit, Compliance and Risk Management:(i)ensure auditees respond to audit findings and take action as mandated; (ii) management action should be taken against non-

compliance issues and such actions should be documented and widely publicized to serve a deterrent to others; (iii) conduct regular Audit Committee meetings to discuss matters arising from the audits; (iv) begin subsequent audits by checking that there was auditee response and action on previous audit recommendations; (v) carry out regular peer reviews of IA; (vi) include audit reviews of donor funded projects in work plans; (vii) grant auditors access to GoL's financial management systems; (viii) reinforce the IAA by ensuring regular GoL support for audit functions; and (b) **External Audit:** (i) address the causes of the delays in order to bring MOH's audit up-to-date; and (ii) improve GAC's capacity to enable it to conduct audits in a timely manner.

Governance: (i) strengthen the role of HSCC as a strategic decision-making body through regular meetings to discuss the sector program implementation and addressing emerging challenges on a timely basis; (ii) solicit and reinforce civil society participation in policy decisions as well as in monitoring implementation of the sector program, both at central and local levels; and (iii) make adequate resources available to MOH's decentralization unit to enable it to provide better services in the counties.

Donor Mapping and Accounting for Donor Funds: (i) prioritize the data collection exercise aimed at aligning resource mobilization and NHA with the view to holding institutions accountable for their health financing commitment. This will help improve predictability of donor funding.

1. INTRODUCTION

1.1 Background

1. The Ebola epidemic, which struck Liberia in March 2014 reversed many of the health sector gains and exposed the underlying weaknesses of the health system that will take years to fully address. The disease infected 372 health workers of which 180 died. The impact of the EVD on the health system included health facility closures, community distrust and fears, and the fears and refusal of unprotected health workers to provide routine health services. Also, there was disruption in the provision of routine services, negatively affecting the ability to respond to the epidemic. Communities distrusted and had low confidence in the healthcare system to cater to their health needs. The EVD outbreak revealed the need to rebuild the health system in a manner that will make it resilient to effectively respond to similar threats.

2. As Liberia transitions from post-Ebola recovery mode to designing and implementing long-term resilient health systems, it intends to use the SWAp as the new approach for implementing its health sector strategy. To this end, MOH joined IHP+ to help improve upon donor coordination, and to jointly work with development partners to strengthen MOH systems, including financial management, monitoring and evaluation, resource tracking, among others, for implementing the sector program.

3. Since 2008, MOH has implemented a transitional Health Sector Pool Fund (HSPF), a negotiated initiative under which donors agreed to jointly provide financial assistance to implement Liberia's 2007 National Health Plan. The set of principles governing the initiative include coordinated donor support for the national health strategic plan, coordination of resources to fund priorities in the plan, and a common approach for program management and fiduciary arrangement.

4. HSPF is underwritten by 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. Co-chaired by MOH with a rotating lead donor (currently UNICEF), a Steering Committee comprising the aforementioned donors and MOH is the governing and decision-making body for HSPF. The Steering Committee was set up by MOH when the fund was established to ensure transparency, reinforce coordination, and provide a forum for dialogue. Pledges to HSPF to date amount to approximately US$82 million; and, the annual contribution for implementing HSPF activities from 2008 to 2015 constituted 10 percent of support to the national health sector budget. Since 2008 an external management firm (currently J Hughes Development, Incorporated (HDI) has managed the day-to-day operations of the pooled fund through a Pool Fund Secretariat (PFS) housed in MOH.

5. Despite these efforts, a large amount of donor-financed support is off-budget, a situation that has undermined MOH's ability to match such support to national priorities. Moreover, this has caused significant fragmentation and imposed high transaction costs on an already low capacity base of MOH.

Effective processes for transparent financial management, which are critical for implementing the health sector development plan, will be needed to allow donors to channel funds through government systems. It is, however, worth noting that substantial work on broader public financial management has been carried out under the leadership of MFDP. For example, under the Liberia Integrated Financial Management Reform Project (IPFMRP), significant improvements have been made in the areas of planning and budgeting, deployment of IFMIS to line ministries and strengthening of oversight institutions.

6. Taken together, these developments set the context within which this preliminary joint financial management systems assessment is carried out. The assessment is a step towards improved aid coordination and strengthening of sector financial management arrangements in accordance with the aspirations of the IHP+ global compact signed by GoL on April 13, 2016. GoL expects to take advantage of the IHP+ global compact to further maximize the prospects of achieving better health outcomes for the Liberian people. Under the compact, GoL commits to improving the functioning of the country's health systems by better coordinating and managing domestic and external resources. It demonstrates GoL's unwavering commitment to aligning donor support with the priorities of its National Health Strategic Plan (NHSP) with a view to minimizing duplication of funding and parallel implementation arrangements to achieve efficiency gains.

1.2 Purpose and Scope of the Assessment

7. The objectives of the assessment are to (i) review the financial management systems of the health sector in Liberia (ii) recommend measures to strengthen the financial management systems that support alignment of all resources with those of MOH and MFDP; and subsequently (iii) improve service delivery and health outcomes for Liberians.

8. Given that the health sector operates within the broader context of an entire government system, the assessment takes into account both macro level institutions whose actions impact the operations of the health sector, and institutions within the health sector. Institutions covered at the macro level include MFDP, GAC, Internal Audit Agency (IAA), Public Procurement and Concessions Commission (PPCC), Public Accounts Commission (PAC), Legislative Budget Committee (LBC) and Civil Service Agency (CSA). MOH, secondary or county hospitals and CHTs are the health sector and sub-sector institutions assessed.

1.3 Methodology

9. A field data collection made up of a series of face-to-face discussions and interviews with heads of pertinent institutional divisions and units along with a desk review of relevant documents informed this report.

1.3.1 Interviews and Meetings

10. To obtain the perspectives of all those who are involved in the day-to-day management of sector expenditures, senior management of MOH as well as those of macro institutions and agencies involved in the management of GoL's public finances were interviewed. In view of the fact that service delivery is undertaken at the lower level of care (county level), the team conducted specific interviews, which focused primarily on the core functions at the county level. Representatives from CHTs and county hospitals were interviewed. The senior management of seven out of 15 CHTs were interviewed. Finally, the authorities of one secondary hospital (Redemption Hospital) in Monrovia were also interviewed.

1.3.2 Desk Review

11. The assessment team reviewed policy documents and operational reports available at MOH. Quarterly and annual reports produced by the Office of Financial Management (OFM) and their implementing partners constituted specific resources for the assessment. The team also reviewed summary budget estimates and budget execution reports submitted to MFDP. Also, financial management reports from a sample of CHT and secondary hospital submitted to the MOH were extensively reviewed. In addition to specific financial management reports, the team reviewed major policy documents such as the National Health Plan (NHP) and National Health Investment Plan (NHIP). The review involved: (i) a detailed cross-referencing of sources of information and the analysis of data collected; and (ii) documented factual information obtained from frontline staff working on health sector financing and expenditure management.

1.4 Structure of Report

12. The report is structured as follows. Following the introduction is section 2 which focuses on the statutory, legal and regulatory, organizational and institutional framework providing the basis for financial management systems in the health sector in Liberia. Section 3 reviews PFM systems at the macro level, and Section 4 examines budget formulation and planning at national and sector levels. Section 5 presents GoL's Chart of Account. Section 6 looks at budget execution and reporting, which includes fund flow, cash management and planning, management of petty cash and cash advances,

non-salary expenditure management and internal control and financial reporting standards, AccPac financial information system and transition to NetSuite. Section 7 examines procurement of goods and services. Section 8 delves into supply chain management. Section 9 assess human resources for health and payroll management. Section 10 reviews health sector asset management. Section 11 delves into auditing which includes internal audit, compliance and risk management and external audit. Section 12 provides an overview of health sector pool fund currently under implementation. Section 13 presents other relevant areas that support the operational effectiveness of the health sector, and Section 14 provides policy recommendations for government's attention.

2. STATUTORY, LEGAL, REGULATORY, ORGANIZATIONAL AND INSTITUTIONAL FRAMEWORK

2.1 Statutory, Legal and Regulatory Framework

13. Cognizant of the importance of good health as a fundamental driving force for human development, and in the context of the national vision of Liberia becoming a middle-income country by 2030, the MOH developed, in 2011, the National Health Policy and Plan(NHPP) for 2011-2021. The underlying principle of this policy is that health is a state of complete physical, mental and social well-being, and access to quality health and social welfare services is a precondition for individual and societal development. Consistent with World Health Organization's (WHO) health systems framework, this policy is further grounded in the principles of health as a universal human right, equity, efficiency and accountability. The National Health Policy and Plan 2011-2021 sets out the overarching goals of the health sector for "improving the health and social welfare status of the population of Liberia on an equitable basis", and focuses on the following key objectives: (i) increase 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; (ii) make 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; (iii) make healthcare and social protection available to all Liberians, regardless of their position in society, at a cost that is affordable to the country.

14. To achieve NHPP (2011-2021) policy goals of improving the health and social welfare of the population of Liberia, a sound financial management is required. MOH expenditure management with regard to responsibilities for budget preparation, budget execution and reporting are stipulated in the 2009 Public Financial Management Act and Regulations. The Act requires MOH to ensure proper and efficient management of its budget. The relevant provisions of the law and regulations are stated in Box 1 below.

Box 1. Applicable PFM provisions for Financial Management

Section 20:
Sub-section 3. Ministers of individual spending Ministries, and other heads of budgetary institutions and. agencies which are separately identified in the Annual Appropriations Act, are responsible for the proper and efficient execution of their budget in accordance with this Act, the *regulations i*ssued under it, and the instructions and guidelines issued by the Minister. Furthermore, they are fully accountable to the President and the Legislature for their performance in the implementation of their budgets.

Sub-section 4. Ministers and heads of budgetary institutions and agencies may delegate responsibilities for budget execution to designated officials within their ministry/institutions/agencies, consistent with the provisions of sub-section 2. Such delegations, which are subject to *regulations* issued under this Act, do not divest the minister/head of institution/agency of responsibility under this Act.

Source: GoL's 2009 PFM Act

15. With regard to procurement, MOH and other relevant health sector institutions follow the 2005 Public Procurement and Concessions Act and are subject to oversight of the PPCC, which reviews and enforces the procurement rules and regulations in the Act. Underpinning these functions is the 2009 PFM Regulations. Section 24 (1) and (5) of the Regulations provides the compliance provisions for spending entities as shown in Box 2 below.

Box 2. Procurement Provisions in 2009 PFM regulations

Section 24:
Sub-section 1. All purchases of goods and services from suppliers, including capital investments, shall comply with the provisions prescribed in the Public Procurement and Concessions Act of 2005 as amended, and their enabling regulations.

Sub-section 5: All purchases of goods and services from suppliers, including capital investments, shall comply with the provisions prescribed in the Public Procurement and Concessions Act of 2005 as amended, and their enabling regulations.

Source: GOL's 2009 PFM Regulations

2.2 Organizational and Institutional Framework

16. MOH is headed by a Minister who is supported by three Deputy Ministers for Administration, Health Services and Planning and Policy. In addition, four main departments headed by departmental heads constitute the Ministry. They are: (i) Department of Health Services; (ii) Department of Administration; (iii) Department of Policy, Planning and Research; and (iv) Department of Public Health Emergencies.

17. The Department of Health Services comprises five divisions (i) Communicable and non-communicable Disease Division; (ii) Family Health Division; (iii) Diagnostics and Imaging Services Division; (iv) Pharmaceuticals Division; and (v) Institutional Care Division. The Communicable and Non-communicable Disease Division is further divided into mental health unit, communicable disease

prevention and control (HIV/AIDS, TB and Malaria) unit, and non-communicable diseases and neglected tropical diseases (NTDs) unit. The Family Health Division is sub-divided into reproductive, maternal, newborn, child, gender and adolescent health unit, environmental and occupational health unit, expanded program for immunization (EPI) unit, and nutrition unit. Diagnostics and imaging services division consists of radiology and biomedical technology unit, blood safety unit, laboratory unit, and county support services unit. The Pharmaceutical Division consists of supply chain management unit, national drug service unit, and pharmacy unit. The institutional care division consists of medical and dental services unit, nursing and midwifery services, complementary medicines unit, and quality improvement and management unit.

18. The Department of Administration has two main divisions: (i) Office of Financial Management; and (ii) Division of Administration. The Division of Financial Management is sub-divided into accounts unit, budget unit, compliance unit, and warehouse unit. The Department of Planning, Research and Human Development consists of human resource unit, procurement unit, information, communication and technology (ICT) unit, general services unit, infrastructure unit, and transport unit.

19. The Department of Policy Planning and Research comprises Division of Policy and Planning and Division of Vital Health Statistics. The main units under the Division of Policy and Planning are governance and decentralization unit, health financing unit, and external aid coordination unit. The Division of Vital Health Statistics consists of Vital Statistics unit, Monitoring and Evaluation (M&E) unit, research unit, and health management information system unit.

20. The Department of Public Health Emergencies has two divisions: (i) Division of Public Health Institute; and (ii) Division of Disease Prevention and Control. The Division of Public Health Institute consists of bio bank unit, emergency operation center unit, and public health laboratory unit. The Division of Disease Prevention and Control is made up of epidemiological surveillance and epidemic preparedness and response units.

21. Institutionally, MOH operates a three-tier health services delivery system at the county, district and community levels. The delivery of health services in Liberia is structured into primary, secondary and tertiary levels. The primary health care level consists of levels I and II primary health care clinics respectively. The secondary level system consists of health centers and county hospitals situated in the capital city of each county with referral to the tertiary hospitals such as the John F. Kennedy Hospital in Monrovia. The county health system is managed by CHOs, while DHOs manage the district health systems.

3. OVERVIEW OF PFM SYSTEMS AT THE MACRO LEVEL

22. This section reviews PFM systems performance of macro level institutions involved in day-to-day implementation of GoL's PFM reform agenda and relate it to the health sector. As noted in section 1 above, the health sector operates under the umbrella of these institutions and that their operations have direct impact on the sector activities and service delivery.

3.1 Ministry of Finance and Development Planning

23. Significant progress has been made in PFM reforms in Liberia. MFDP has successfully implemented an IFMIS to strengthen financial management processes, with the capacity to progressively capture donor-financed projects. Fifteen donor projects have been migrated to IFMIS and 10 more will be added by the end of the 2016 calendar year. Dedicated staff who work and support the use of IFMIS have been deployed to pilot Spending Entities[2], including MOH. At the county level, however, plans to implement an e-transcript system of expenditure reporting that is linked to IFMIS have yet to be implemented. As a result, accounting and financial reporting activities at the county level remain manual. Also, budget preparation in IFMIS is a challenge. The Department of Budget and Development Planning (DBDP) currently prepares the budget in an access-based system which is interfaced with IFMIS. While there are plans to enhance the IFMIS budget module to allow for budget preparation, it is unclear when this will be completed. In the area of human resources management, there are significant bottlenecks in bringing newly hired staff, especially for the ministries of health and education, onto the government payroll. For example, about 4,000 workers hired by MOH have yet to be regularized on the government payroll due to delays in submitting their required list to MFDP. Further, using IFMIS to prepare timely International Public Sector Accounting Standards (IPSAS) compliant financial statements at the line ministry level remains a challenge due to frequent network downtime, and more broadly weak capacity to generate quality reports at the line ministry level. This may have contributed to line ministries' failure to comply with the requirement of the PFM law and Section 7 of the 2015/16 Budget Act to submit quarterly financial reports to MFPD and the Legislature respectively.

3.2 Legislative Committee on Budget

24. Significant reforms have been made with the merger of the House and Senate Ways, Means and Finance committees to review the National Budget as well as the Public Accounts and Audit Committees (PAAC) of both chambers of the Legislature to review the auditor general's reports. This measure has resulted in faster review and deliberation on the budget than before. However, the momentum gained from holding public hearings for the first cohort of 11 Spending Entities has waned. There was a break in public hearings from August 2015 until April 2016 when they were

[2]Spending Entities are Ministries, Agencies and Commissions who receive and spend GoL's budgetary allocations.

resumed. There is, therefore, considerable scope to further strengthen the demand side of governance and accountability through the national legislature.

3.3 General Audit Commission

25. GAC is responsible for auditing Spending Entities. It has an Auditor General and two deputies. The Commission used to report to the President from 2005 and 2014. Now it reports to the Legislature through PAAC, which reviews its reports and submits recommendations to the President. GAC has also played a key role in the public hearing process when the Legislature considers audit reports. It works collaboratively with PAAC and its secretariat in analyzing audit reports, summarizing findings and advising PAAC during hearings. Besides its annual audit of the final accounts on the Consolidated Fund that is prepared by MFDP, GAC has mostly undertaken compliance audits as most Spending Entities are not able to prepare financial statements. Despite progress made in audit coverage, implementation of its recommendations is a challenge. The fundamental issue is weak enforcement, which remains a challenge across government. Other challenges include overlapping functions with IAA and lack of collaboration from other accountability institutions, including the Liberia Anti-Corruption Commission (LACC) and the Governance Commission. GAC also faces serious staffing constraints, particularly for middle level management positions. This situation has limited its ability to conduct audits across government institutions in a timely manner. It has developed a capacity development plan with European Union (EU) and the World Bank (WB) support but attracting Certified Public Accountants (CPAs) is a major challenge due to competing demands for such scarce skills in the private sector. It also faces budget constraints, which have limited its ability to attract and retain staff.

3.4 Internal Audit Agency

26. The IAA performs asset verifications, compliance reviews, and ensures that Spending Entities, including MOH adhere to internal control procedures. IAA is transitioning from pre-audit to systems audit. As a result, its role as an advisor to the management of line ministries on control of weaknesses and risks is becoming more visible and demanding. It also provides periodic training to help strengthen internal audit capacity in Spending Entities. MOH has been a beneficiary of IAA's onsite support. It has specifically supported MOH to develop assets register, for example, and conducted compliance reviews. IAA's staffing capacity is boosted by three Certified Public Accountants (CPAs), and 70 qualified Certified Fraud Examiners (CFEs). It is however not well-resourced in terms of equipment. It uses the PENTANA,[3] but it is not fully operational. IAA noted that the compliance atmosphere in Ministries, including MOH is weak. Spending Entities do not also incorporate internal audit considerations in their planning and decision-making.

[3] A software for managing audits, inspection, risk, and compliance.

3.5 Public Procurement and Concessions Commission

27. Except for the national security agencies, PPCC performs public procurement functions for all government institutions across the country. It does post-reviews and if tender documents have major issues it asks agencies to retender. To facilitate its work and ensure transparency in the procurement of goods and services, it has established a web-based procurement platform. The Commission is planning to increase its presence in the counties by opening regional offices. It also intends to decentralize government services, but the rollout is delayed due to budgetary constraints. To speed up the procurement processes, it has introduced a framework agreement, which allows the conduct of early procurement activities to address the bottlenecks associated with delays in budget approvals[4]. The framework has been endorsed and approved by Cabinet. It has also been able to put controls in place for all 103 agencies to comply. It is now able to start the procurement process early with 1/12 provision in the 2009 PFM Act. The Commission is constrained with limited budget, lack of staff and space. It has less than 50 staff and has no training facilities.

3.6 Civil Service Agency

28. CSA is the government institution in charge of recruitment and establishment of the government payroll, which captures all employees of the government. The process of putting potential workers on the payroll commences at Spending Entity level, including MOH level. For example, MOH sends PAN to CSA. If the position requires testing, CSA administers tests to the candidate and attach the result to the PAN. An occupational analyst at CSA then reviews the PAN for correct salary, age, photos, properly written justifications, grade and credentials such as university degree, West Africa Examinations Council (WAEC) certificate, etc., and then forwards it to the appropriate officials within CSA for signatures. After obtaining the signatures, the CSA sends the PAN to DBDP at MFDP for budgetary approval. Once approved, the PAN is returned to CSA to be placed on payroll.

29. The JFMA team's investigation showed that the CSA has required number of staff to process PAN as an occupational analyst has been assigned to process each Spending Entity's PAN. However, the CSA has no standard time for processing PAN, although there has been improvement in processing time in recent times. In the past it took a month to process a PAN, but now it only takes between two to three weeks. According to the authorities of CSA, efforts are being made to reduce the processing time to one week. Despite the progress, there are a number of challenges with the filling out and processing of a PAN. The health sector specific challenges are elaborated in section 9.2 below.

[4]Accelerating National Development through Increased Efficiency, Competition, and Value for Money in Public procurement Framework Agreement and Advance Procurement. Public Procurement and Concession Commission. A shot Note. Developed in Partnership with USAID-GEMS.

4. BUDGET FORMULATION AND PLANNING ASSESSMENT

4.1 Overview of GoL's Budget Preparation Process

30. Section 8 of the 2009 PFM Act empowers the Minister of Finance to oversee the budget preparation process. The Act states that: "The Minister shall oversee the preparation of the National Budget in the context of a medium-term fiscal framework for purposes of achieving national objectives over a multi-year period. The fiscal framework for the National Budget should be based on estimates for the fiscal year and for the two subsequent years, which take into account the economic and development policies that are consistent with the Government's declared medium-term economic and fiscal objectives."

31. GoL's budget process is guided by an MTEF manual. The first step of the process is the development of MTFF that captures sources of revenues to ascertain GoL's resource envelope. MFDP sets sector ceilings based on the available resource envelope and according to priorities of the government. Sectors allocate ceilings to their respective Spending Entities. To reinforce the link between government priorities and the budget, and in line with Section 11.3 of the PFM Act, the MTEF provides two phases (a strategic phase and an operational phase) of the budget preparation process.

32. During the first stage of the budget process, the sector ministries are required to develop and submit strategic plans to MFDP. The sector strategic plans provide the basis for MFDP to develop and submit a draft Budget Option Paper (BOP) to the Cabinet for approval. Following the Cabinet's approval, MFDP prepares the Budget Call Circular1 (BCC1), which details the information needed to kick start a consultative process within Spending Entities. During the consultation process, spending entities prepare the Budget Policy Notes (BPN) and submit them to MFDP. MFDP uses the information contained in the BPN to develop the draft Budget Framework Paper (BFP). MFDP submits the BFP to the Cabinet for review and approval. The approved BFP is then submitted to the Legislature for further review and approval. After legislative approval, MFDP develops the BCC2, which details the Spending Entities' ceilings and information for the preparation and submission of their detailed budgets to MFDP. After receiving the budget statements from the spending entities, MFDP finalizes the budget and BFP. This is followed by budget hearings and reviews, and approval by the Cabinet and the Legislature. A major challenge to the process is the delay in getting Cabinet's approval of the BOP. There is also limited participation of Spending Entities in the sector strategic planning process at the sector working group level, which delays the preparation of BPNs; and hence, the draft BFP. The delay in the preparation of the BFP affects the development and issuance of the BCC1. Consequently, only one BCC instead of two BCCs was issued in FY2016/17.

4.2 The Budget Calendar

33. The above process is guided by a budget calendar, which details the key activities to be performed until the budget is submitted to the Legislature. Section 11.1 of the 2009 PFM Act authorizes the President to submit the budget to the Legislature at least two months before the beginning of the fiscal year. Specifically, the Act states that "The President shall submit the Proposed Budget and accompanying documents to the Legislature no later than 2 months before the start of the fiscal year". To follow through on this provision, the Act mandates MFDP to develop and issue the budget calendar as stated in Section 11.2 of the PFM Act: "The preparation of the National Budget shall conform to the process and timetable set forth in Section 11.1 above, which will be further supplemented by a detailed cycle established in a published annual budget calendar in the *regulations* accompanying this Act". *(See annex 2 for the details of the FY2016/17 budget calendar).*

4.3 MOH Planning and Budgeting Process

34. As a public entity, MOH must follow GoL's budget preparation process and cycle as described in section 4.1 above. Section D.1 of the 2009 PFM regulations states that "The budget preparation shall be in accordance with key activities and dates set forth in Section 11 of the Public Finance Management Act 2009, which will be further supplemented by a detailed timetable or a published annual budget calendar to be issued by the Minister". In line with this provision, MOH must prepare and submit its budget estimates within the time frame indicated in the budget calendar. The Ministry, therefore, starts the preparation of its budget as soon as a BCC is issued by MFDP. With this in mind, the assessment team focused on identifying areas where MOH has made significant progress and where it needs further improvement. Key strengths and weaknesses identified include:

❖ **Strengths**

- **Existence of PFM structures**. Remarkable progress has been made in the areas of planning, budgeting and expenditure management**.** There are three departments involved in health sector resource allocation and expenditure management. These departments include Planning Department, Health Financing Division (HFD) and OFM. The planning department focuses mainly on helping CHTs in the planning of their county health programs, including providing them with the requisite training to enhance their understanding of planning of health programs and activities. HFD handles resource mapping and mobilization exercise, and OFM prepares the annual budget estimates for input into the National Budget. In addition, OFM performs financial management functions for the entire health sector. This includes, among others, processing vouchers for payment, payment of salaries of staff on discretionary payroll maintained by MOH, training financial county management staff, providing quality assurance and guidance to county teams on financial accounting and reporting, and providing budget execution and expenditure management functions, and reporting sector expenditure to MFDP.

- **Availability of key planning and budgeting documents.** There is a well-developed and costed Health Sector Investment Plan (2015-2021), National Health Policy Document, and Financial Management Policies and Procedures manual. Section 3 of the manual outlines clear guidelines for planning and budgeting of health programs with a focus on adapting the MOH budget presentation to the MTEF format, as stated in the MTEF manual.

❖ **Weaknesses**

- **Non-existence of participatory budgeting.** The budget has historically been prepared by OFM budget section with no participation by Planning and Health Financing Departments as well as other relevant departments of MOH. Lack of participation presupposes that the budget is prepared based on unrealistic costing of programs and activities. But, for the first time, the three departments came together to prepare this fiscal year's budget. The budget preparation process could benefit from a more structured and participatory process that will help reflect the needs and priorities of the sector.

- **Quality of Budget documentation submitted to MFDP.** In accordance with Section 8(1) of the 2009 PFM Act, MOH must prepare its budget in line with a medium term fiscal framework over a multi-year period. This legal requirement is not strictly adhered to. The budget documentation submitted to MFDP does not conform to Liberia's Medium Term Expenditure Framework manual's guidelines, which require Spending Entities to prepare their budgets over a three-year horizon with two outer years. The team noted that the document only shows figures for the current and previous years but lacks those of the two outer years.

5. GOVERNMENT OF LIBERIA'S CHART OF ACCOUNTS

35. The Chart of Accounts (COA) is used to filter, sort, and subtotal financial activity in a Spending Entity as reflected in IFMIS, and as such is the basic source of information on how expenditures are used by Spending Entity. The more detailed the COA is the more detailed the core revenue and expenditure reports are. This enhances the ability of management to track and focus managerial attention on the needed activity. GoL's COA consists of 9 segments, with 39 total digits. It is compliant with the 2001 Government Finance Statistics (GFS) manual, issued by the IMF.

36. COA segments at the MOH level differs slightly from that of MFDP. This is because MOH has modified several of the segments to help in its expenditure categorization.[5]. As shown in figure 1, the blue shaded segments are the same as the official COA, while the rest are modified (yellow) or used for different purposes (red or white).

[5]The current system, AccPac, cannot accept the full 39 digits of GoL chart of accounts. The MOH is transitioning to a new financial reporting system (scheduled for July, 2016) which may alleviate some or all of these concerns. There are currently no plans to use the IFMIS system as the regular financial management system in MOH. Consolidated information is inputted into IFMIS for reporting purposes.

Figure 1. Comparison of GoL and MOH use of Chart of Accounts

DIAGRAM 1

Comparison of GoL and MoH use of Chart of Accounts

MOH			GoL	
Segment	**Size**		**Segment**	**Size**
Dept./Section	4	-->	MTEF	6
Donor Reporting Class	2			
Fund	6	-->	Fund Type + Fund Source	5
Projects	6	→	Projects	6
Function	4	→	Function	4
Location	4	→	Location	4
Economic Class.	6	→	Economic Class	6
National Health Plan	1	-->	Budget Class	1
Facility/Sub/Recp/Benef/Impl/Agency	4	-->	Agency	7
Total # of digits	**37**		***Total # of digits***	**39**

--> MOH modifies or uses segments for own purposes, could not upload to IFMIS

→ Segments used identically to GoL/MFDP

Source: MOH Coding Sheet

37. Within this structure, MOH uses "projects" segment to track expenditure items for all programs and projects. This segment allows four digits for an actual project plus two to track component and subcomponent activities within a project. This drilldown level of activity is currently sufficient for GoL projects and all donors except Global Fund (GF), which would like to see activity broken down to a "sub-subcomponent" level.

38. The other remaining segments common to the rest of GoL are the classification of individual expenditure items (Economic Class is the individual line item, Function groups the type of expense, Location by County or District). By keeping these items, MOH can prepare consolidated reports that provide the information MFDP needs to compare expenditures across Spending Entities. However, this is done manually by MOH staff retyping data into IFMIS. The data from the segments in white, red, and yellow to some extent are left out of the upload into IFMIS, which means that a user of IFMIS cannot drill down and get that information.

39. CHTs and county hospitals currently report their data via a spreadsheet template. In this template they use the Economic Classification Segment (budget line) by selecting a drop down code. The individual sub-national entity also records the Funding Source and Facility by manually typing in the names of these Funding Sources and Facilities, and then continues to record these items onto the spreadsheet. An officer at MOH then processes these spreadsheets into the AccPac system, adding on the codes for the other segments at that time[6]. AccPac is a parallel system at the MOH level that

[6]OFM is planning on replacing the template system with QuickBooks. Initial work is scheduled to start in June, 2016 with implementation first at CHTs at the larger counties and then gradually extended out. This will be at the same time as the migration to

is used for financial accounting and reporting for all government and donor funds managed by OFM. The system pre-dates the implementation of IFMIS, but has continued to be used because it allows MOH to report on all sources of revenue and expenditure.

40. Expenditures using GoL funds are paid using IFMIS and the GoL version of COA with the entry also being recorded in AccPac using the MOH version of COA. The "location" segment, which has a portion for county and a portion for district, as currently utilized in IFMIS, reports roughly 90 percent [7] of all expenditures as occurring in the county of Montserrado in Monrovia, rather than reflecting the more decentralized purchases of CHTs and county hospitals.

- **Strengths**:

  - GoL's COA categorizes expenditures in an internationally recognized standard expenditure items. This allows for consistency in comparing expenditures across government and countries.
  - GoL's COA allows for analysis and tracking by the MTEF expenditures.

- **Weaknesses:**

  - A challenge facing MOH in using IFMIS would be finding a way to replace the activity information that is currently recorded in the yellow, red, and white highlighted fields in figure 1 above.

  - The projects segment or field is of insufficient size to fully differentiate between projects and track a breakdown of activity within those projects as there can only be two tiers of activity. Currently, the Global Fund requires a third sub-level of activity reporting, which is tracked outside of the COA. This may also pose a challenge under the proposed SWAp.
  - County governments directly record only portions of activities using the COA. OFM staff must upload the transactions into the AccPac system separately, and the additional segment information may be lost at that point.

a new financial management system at the central ministry (NetSuite), which may stretch the resources of OFM to accomplish both items on parallel tracks.

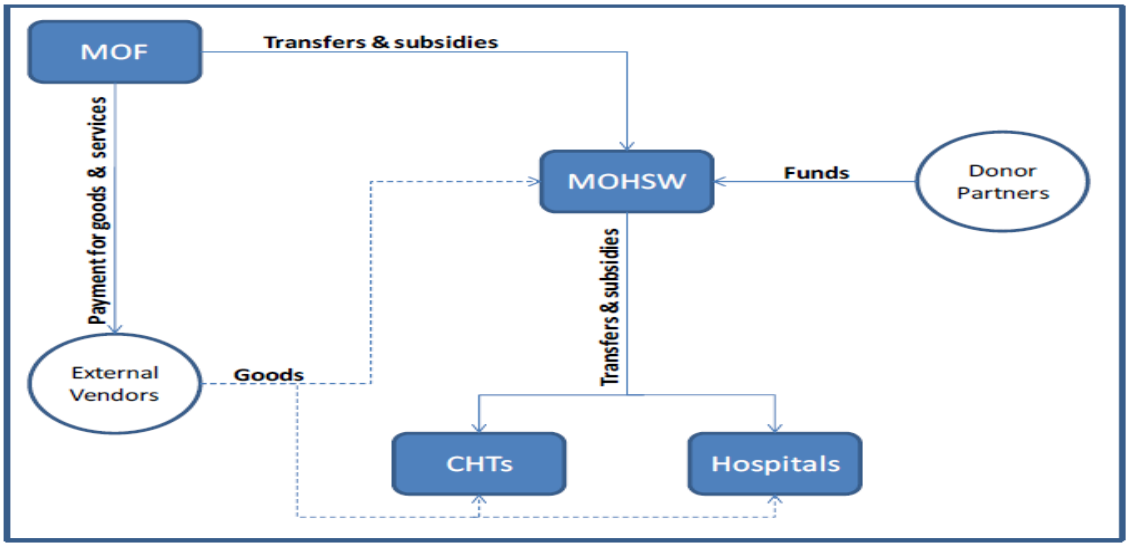
[7] Per OFM. This may reflect that the reports OFM are aware of are not utilizing the COA segment code to report location but rather use items (fields) from the purchasing system such as the seller's location or the location of the purchasing officer (which is often the central procurement office purchasing on behalf of the subnational unit).

6. BUDGET EXECUTION AND REPORTING

6.1 Fund Flow

41. MOH must receive cash transfers and subsidies from MFDP and development partners before disbursement as shown in figure 2 below. Donations in-kind such as equipment and vehicles can be made directly to the CHTs or hospitals. MOH receives funds for CHTs and hospitals and transfers them through OFM to commercial bank accounts of CHTs and hospitals, treating them as expenditures[8]. All donor funds must be channeled through MOH per policy[9], but only USAID's FARA and the HSPF are currently managed through MOH.[10]Yet some donors implement their projects based on their own fiduciary policies and procedures. Others provide funds directly to CHTs and hospitals. In the case of non-GoL recipients, the funds are paid directly into the project's own bank account.

Figure 2. MOH Fund Flow



Source: 2012 MOH Public Financial Management Manual

[8]Ministry of Finance treats the transfer to MOH as an expense, and in turn MOH treats the transfer to CHTs and hospitals as an expense as they are cash based. When the financial statements are consolidated at the end of the year, these transfers are cancelled out as they are internal. Only the amount actually expended (paid out) is treated as an expense in the consolidated report.

[9]Although the team received reports that some donors had made donations to the bank accounts of CHTs and hospitals in contravention of OFM policy.

[10]Pool Fund has its funds in a master (or holding account), and then is transmitted to the MOH disbursement account after approval by the Fund's steering committee.

42. GoL funds are drawn down from MFDP via quarterly allotments once the budget is approved, but the budget is typically approved well after the start of the fiscal year. For example, in the las fiscal year, the budget was approved five months later in November. When the fiscal year starts and the budget has not yet been approved, MFDP has the authority to approve, on a monthly basis, an allotment of up to 1/12th of the prior year budget.

43. Other significant issues remain with the allotment fund flow, even after the budget is passed.

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- Quarterly allotments may decrease if there are revenue or cash flow issues. As a result, Spending Entities cannot count on receiving the full amount of the quarterly allotment. Their procurement plan would push the non-routine expenditures later into the fiscal year to make sure that there is significant allotment to cover the routine expenditures. The procurement process can also take many months to complete.
- Quarterly reports must be submitted before the next allotment is approved. This applies to both MOH and CHTs. While MOH has 45 days to file its quarterly report, CHTs have 15 days to turn in theirs to MOH. Approvals of final reports of CHTs could take time as the report has to be hand delivered and they have to be subjected to several reviews. Approval process is repeated is there is any revisions requested.

❖ **Strengths**

- By having all funds flow through OFM, funds are well tracked. Once transfers to CHTs are approved, it takes two to three days for them to receive funds.
- The allotment system makes sure that spending is not above the actual revenue available to support it.
- Requiring prior quarter reports to be filed before issuing the next allotment is an effective technique to get the quarterly reports submitted.

❖ **Weaknesses**

- In-kind to CHTs and hospitals are not consistently tracked or captured.
- Late budget approval significantly delays the fund flow process.
- The quarterly report approval process can be quite lengthy and time consuming significantly delaying approval. One CHT informed the team they had been waiting two months for their quarterly report to be approved.
- The significant delays in fund flows have a negative impact on budget execution and service delivery. In the last fiscal year, 60 percent of the entire year's allotment was approved in the final quarter.

6.2 Cash Planning and Forecasting

44. MOH prepares cash flow requirements showing how it intends to spend its approved budget and annual revenue forecasts broken down by month. The steps in developing the cash plan are:(i) prepare procurement plan for units; (ii) submit procurement plan to budget officer for review; (iii) submit plan to the Comptroller of OFM for further review; (iv) review procurement plan and prepare weekly cash plan used as a basis for preparing monthly cash plan; (v) submit to Deputy Minister for Administration for review and approval; and (vi) submit approved cash plan to the Deputy Minister for Budget at MFDP.

45. Based on the above steps in developing cash plans and forecasts, the team sought to assess and document any evidence of budget execution performance from expenditure data (i.e. appropriation, allotment, and disbursement) obtained from MFDP. An analysis of the past three expenditure data obtained from MFDP records shows volatility of trends in MOH's budget execution performance (disbursement vs. allotment). In FY 2013/14 MOH fully (100 percent) executed its allotment. However, MOH's budget execution rate significantly plummeted to 62 percent in FY2014/15, but rebounded to 98 percent in FY2015/16. Within the health sector, MOH budget execution performance lagged behind the major health institutions such as John F. Kennedy Medical Center (83 percent); Liberia Medical and Dental Council (85 percent); and Liberia Medical and Health Products Registration (92 percent) in FY2015/16. In FY2015/16, MOH recorded a lower budget execution rate than the Liberia Board of Nursing and Midwifery; Liberia Medical and Dental Council; and Liberia College of Physicians all recording 100 percent budget execution rates respectively. Tables 1, 2, and 3 show trends in MOH's budget execution performance.

Table 1. MOH's Budget Execution Performance (allotment vs. disbursement)-FY2013/14

Institution	Appropriation	Allotment	Disbursement	Over/ underspending	Budget Execution Rate (%)
Ministry of Health	53,227,776	42,260,205	42,260,151	54	100
John F. Kennedy Medical Center	5,969,662	5,968,619	5,968,619	-	100
Phebe Hospital	2,187,341	2,111,030	2,111,030	-	100
Liberia Inst. of Bio-Med. Res.	571,151	567,564	567,564	-	100
Lib Board of Nursing& Midwifery	240,951	237,626	237,626	-	100
Liberia Pharmacy Board	809,995	809,976	809,976	-	100
Liberia Medical & Dental Council	3,239,533	3,150,084	3,150,084	-	100
Lib College of Physicians	-	-	-	-	-
Liberia Med. & Health Products Rag	-	-	-	-	-
National Aids Commission	-	-	-	-	-
Jackson F Doe Hospital	-	-	-	-	-
Total	**66,246,409**	**55,105,104**	**55,105,050**	**54**	**100**

Source: Authors' own calculation with data from MFDP

Table 2. MOH's Budget Execution Performance (allotment vs. disbursement)-FY2014/15

Institution	Appropriation	Allotment	Disbursement	Over/underspending	Budget Execution Rate (%)
Ministry of Health	63,170,439	53,922,182	33,404,154	20,518,028	62
John F. Kennedy Medical Center	6,518,783	5,696,283	4,755,087	941,196	83
Phebe Hospital	2,150,341	1,844,527	1,525,423	319,104	83
Liberia Inst. of Bio-Med. Res.	509,518	499,553	416,420	83,133	83
Lib Board for Nurse & Midwifery	168,944	152,585	105,364	47,221	69
Liberia Pharmacy Board	142,497	133,126	89,127	43,998	67
Liberia Medical & Dental Council	250,000	243,914	206,649	37,265	85
Liberia College of Physicians	1,150,000	1,063,083	891,763	171,320	84
Liberia Med. & Health Products Registration	432,279	473,549	434,748	38,801	92
National Aids Commission	719,858	677,417	575,674	101,743	85
Jackson F Doe Hospital	3,616,095	2,803,583	2,283,952	519,631	81
Total	**78,828,754**	**67,509,801**	**44,688,362**	**22,821,440**	66

Source: Authors' own calculation with data from MFDP

Table 3. MOH's Budget Execution Performance (allotment vs. disbursement)-FY2015/16

Institution	Appropriation	Allotment	Disbursement	Over/under Spending	Budget Execution Rate (%)
Ministry of Health	56,999,469	56,070,590	54,938,117	1,132,474	98
John F. Kennedy Medical Center	6,477,299	6,450,919	6,097,135	353,784	95
Phebe Hospital	2,152,210	2,122,299	2,072,940	49,359	98
Liberia Inst. of Bio-Med. Res.	584,447	584,447	569,633	14,814	97
Lib Board of Nursing& Midwifery	168,943	167,263	166,549	714	100
Liberia Pharmacy Board	142,497	141,713	126,226	15,487	89
Liberia Medical & Dental Council	300,000	298,942	298,439	503	100
Lib College of Physicians	1,150,000	1,129,225	1,128,820	405	100
Liberia Med. & Health Products Registration	517,768	484,890	460,942	23,947	95
National Aids Commission	719,858	681,922	678,472	3,450	99
Jackson F Doe Hospital	3,616,095	3,386,229	3,306,251	79,978	98
Total	**72,828,587**	**71,518,440**	**69,843,524**	**1,674,915**	98

Source: Authors' own calculation with data from MFDP

46. The assessment team was informed by OFM that the main reason for the above expenditure trends was the late release of funds by MFDP to MOH. When the allotments are released towards cut-off date they impact on disbursements as no expenditures will be authorized beyond this date. The team also established that allotments are released after MFDP has reviewed performance for the previous period.

47. At the CHT and hospital levels, the assessment team noted that whereas cash planning and forecasting are done, they are not always followed as the allotment received has huge variances from the initial forecast. Moreover, allotments are received very late in many cases and with no explanation as to which budget category was reduced and for what reason. Forecasts at the county levels may be unreliable as sometimes there are credit balances due to suppliers that are carried over in different reporting periods. Maintenance of the supplies and relationship with suppliers becomes a matter dependent on goodwill. GoL should consistently increase and ensure timely release of its allotment for health expenditures.

❖ **Strengths**

- The process of cash planning and forecasting is inclusive. It involves logistics, procurement, finance, and administration functions. It is done annually ensuring that the forecasts are developed based on projections from current needs and expenditures.

❖ **Weaknesses**

- At the CHT level, implementation does not always follow the forecasts as allotments received often vary widely from the forecast submitted to MOH.
- MOH does not provide information on which budget lines have been adjusted or the reasons for the adjustments. CHTs, therefore, individually and independently re-assess various budget line items.
- There is no budget execution analysis done at the CHT level. This analysis is a key input for the budget preparation process.
- Program targets are not achieved because MOH is unable to disburse the annual allotment.
- Due to delays in cash transfers to the counties there are credit balances due to the suppliers which makes the cash balances reported unreliable. Buying on credit as a result of these arrears puts hospitals at risk of not getting the necessary supplies have impacts on service delivery.

6.3 Management of Petty Cash and Cash Advances

48. CHO, Medical Director (MD), or hospital administrator authorizes all petty cash requests at the county level. Petty cash is kept by the accountant or cashier. Funds drawn for petty cash are meant for the day-to-day running of the counties, districts, and MOH-sponsored institutions and no single item costing more than US$500.00 can be procured from petty cash. Individuals making a claim must submit supporting receipts and invoices to CHT or hospital. However, lack of separation of duties at the county and hospital levels exposes petty cash management to high risk of misappropriation. In some cases, the person with custody of the cash does the recording of the transactions as well. This also impacts the carrying out of petty cash spot checks. The assessment team got mixed responses when the accountants or cashiers were asked whether they have a petty cash float that is replenished when a certain level is reached or if replenishment is done at zero cash balance. MOH should ensure that a uniform method of petty cash management is applied at all levels of the health system, and carry out controls such as petty cash spot checks.

❖ **Strengths**

- Pre-numbered receipts are issued in sequence for all monies received.

❖ **Weaknesses**

- Lack of separation of duties due to shortage of accounting staff at the county level impedes implementation of effective internal control functions. In some cases, the person with custody of the cash does the recording of the transactions as well making petty cash spot checks difficult.
- There is no regular independent verification that all monies received are accounted for.
- There is no established formal handover of cash box when the person usually responsible for the cash box will not be available for a period of time.

6.4 Non-salary Expenditure Management and Internal Control

49. The health minister or deputy ministers approve all payment authorizations at MOH. At the CHT and hospital levels, CHO or MD authorizes all payments. The main types of non-salaries expenditures are: (i) goods and services (supplies and consumables); (ii) transfers and subsidies; and (iii) capital items.

50. GoL funds transferred to the county offices are accounted for as expenditure in the accounts of MOH. Donor funds transferred to programs, CHTs, hospitals, are accounted for as asset – advances. On consolidation of financial reports, expenditures incurred by these entities are offset

against the advances received. MOH's "advances disbursed" accounts are cleared as institutions report their expenditures against the advances they received. Staff receivable accounts are used to manage advances taken by staff for program implementation. Funds disbursed are considered as advances until they are accounted for. Counties, hospitals, and programs receive advance allotments on a quarterly basis. Allotments advanced will be recorded by the counties, hospitals, and programs as "advances." At the end of each quarter, they are required to send the following expenditure reports to OFM: (i)variance report (budget versus actual); (ii) expenditure plan for following quarter; (iii)bank reconciliation; and (iv)copy of bank statement.. These reports are usually submitted late. The assessment team was told that limited staffing capacity is the main reason for late submission of the reports.

6.5 Financial Reporting Standards, AccPac Financial Information System and Transition to NetSuite

51. MOH uses cash basis of accounting and reports using AccPac accounting software. Donor funded projects or programs are generally subjected to specific rules, procedures and reporting requirements. Projects or programs are separately managed from the rest of activities, usually within dedicated Project Coordination Units (PCUs), using specific software not integrated into IFMIS. This leads to situations of operating silos and multiple reporting of donor funds.

52. To address the above issues, MOH plans to roll out the NetSuite software in July 2016. This is expected to provide the opportunity for the alignment of the accounting and reporting requirements across the country. A major reason for the NetSuite rollout is that the software provides an increased number of active modules. Currently county level reporting is on standalone excel-based systems. These excel-based reporting tools pose a high risk of data loss, errors, and manipulation. In addition, the AccPac system used by the OFM has no activated budget control function. As a result, payments may be entered above the budget ceiling on a budget line item. And only manual controls at the point of entry are used to monitor this function. Lack of a countrywide internet connectivity may affect the planned rollout of cloud based NetSuite system, just as IFMIS connectivity continues to be a challenge. Moreover, it will be important to determine upfront if the NetSuite system can be interfaced with IFMIS, at least in the medium term, while full implementation of IFMIS to cover donor-financed project is finalized in the medium to long term. This will help minimize the transaction cost of entering data in the two systems as is currently the case with AccPac.

❖ **Strengths**

- There is a system in place for MOH accounting and financial reporting.
- CHTs have a separate reporting system, which allows them to report their finances to MOH.

❖ **Weaknesses**

- Multiple reporting system at MOH, which have limited functionality and cannot be interfaced with IFMIS.
- CHT reporting systems are prone to data loss, errors and manipulation
- Lack of countrywide internet connectivity hinders MOH's capacity to regularly report to MFDP.

7. PROCUREMENT OF GOODS AND SERVICES

53. MOH's procurement department, currently in the process of decentralizing responsibilities to CHTs, is responsible for procuring expendable and non-expendable items[11] for the central MOH and counties. According to the Public Procurement and Concessions (PPC) Act of 2005, every procuring entity must establish a Procurement Committee (PC). The Committee shall consist of five persons, of which the head of the procuring entity is the chair person. Among others, the functions of the PC are to ensure compliance of the procuring entity with the Public Procurement and Concessions Act of 2005, review the activities of the Procurement Unit, receive the reports and evaluations of a Bid Evaluation Panel (BEP) for contracts above $10,000 and reject the contract award if necessary, confirm the bid price is reasonable for the items to be procured, oversee contract administration, review the activities of each step of the procurement cycle, and give approval to the procurement unit to continue with the procurement process (PPC Act, 2005). At MOH, the Committee consists of all Deputy Ministers, the Comptroller of OFM and the Office of the General Counsel. The 2005 PPC Act states that the Procurement Committee should meet at least every quarter. The procurement committee at MOH meets on average five to six times a year or when there is need for an emergency procurement. Additionally, MOH procurement unit performs its day-to-day procurement functions of the Ministry. Before every PC meeting, the procurement unit evaluates the bids and writes a report containing the recommendations for contract award. The PC then decides whether the selected bidder deserves the award of the contract.

❖ **Strengths**

- The central department is well staffed and trained, and leadership within the department has some of the strongest backgrounds in procurement across all line ministries in Liberia.

[11]Expendable items are item that are designed to be used only once and then abandoned or destroyed. Nonexpendable supplies are items which are not consumed in use and which retain their original identity during the period of use.

- **Establishment of a quantification committee at National Drug Service.** The Supply Chain Management Unit (SCMU) has established a quantification committee at NDS. The committee assesses the country's medical equipment and drug needs on a yearly basis. This is a good step towards improving the procurement planning process for medical items.

❖ **Weaknesses**

- **Procurement planning**. The procurement unit at MOH submits a procurement plan to the PPCC every fiscal year, but the counties are mostly not involved in the planning process. Counties only have work plans and no separate procurement plans. Therefore, the counties' needs for the next fiscal year are not well-represented in the MOH's procurement plan impacting adversely on service delivery. Furthermore, procurement plans to be approved by the PPCC are not prepared in time when the budget is approved, leading to delays in procurement. Staff from the procurement unit are usually excluded in the preparation of the budget; as a result, procurement activities are not properly sequenced.
- **Delays in Procurement Committee meetings.** Although the situation has improved, there are often delays in the PC meetings. One issue is the composition of members of the PC. They are all senior management, at the level of Minister or Deputy Minister. Therefore, it is often difficult to meet as required due to their busy schedules. To mitigate this issue, the Minister of Health has now assigned the Deputy Minister for Administration (DMA) to represent her as the chair of the PC. Similarly, some of the other Deputy Ministers have assigned representatives. These delegations might build in another layer in the procurement process. The delegates may need to report back to the principal before any action will be taken.
- **Long hours of the Committee meetings**. Another issue causing delay is that members hardly get the chance to study the detailed report sent by the procurement unit one week prior to the meeting. This prolongs the meeting time from two to three hours to around five hours as agenda items need to be read out. Due to the prolonged meeting deliberation, members are less likely to commit to a PC meeting. The above issues result in the Procurement Committee meeting less often than would be optimal. Delays in meeting times are one of the reasons why the procurement process is slowed down, which in turn can lead to under-utilization of government funds by the end of the fiscal year. To improve the situation, the need for PC members to attend PC meetings should be part of members' terms of reference and should be regularly followed up by the Minister.
- **Lack of coordination between NDS and donors procuring drugs and medical supplies.** Due to the fragmented nature of procurement of drugs and medical supplies, there are issues of coordination between donors and NDS. Shipments of drugs arrive at the port without NDS' prior knowledge. This causes delays in distribution of the drugs negatively impacting on service delivery at the facility level. The delays in the distribution of the drugs leads to frequent stock-outs in the counties,

and expiration of drugs. Also donors make in-kind donations at the county level without notifying NDS or MOH. This leads to duplication of drugs supplied to counties. It also makes it difficult for NDS to provide effective oversight.

- **Time-consuming procurement process at county level due to inefficiencies and lack of infrastructure leading to counties running on credit with local vendors.** Counties, especially the remote counties in the south eastern region, face delays in procurement. For example, if a county wants to procure items above US$10,000, someone from the CHT has to physically come to Monrovia for approval by the Procurement Committee. The time-consuming procurement process for the already very scarce human resources results in delays in planned activities.
- MOH does not have internal policies and procedures specifically tailored for the Ministry to appropriately plan and consistently apply bidding procedures based on the requirements of the PPCC. Lack of internal policies and procedures meant that threshold requirements are often circumvented in order to allow for use of less cumbersome procurement methods and the criteria for evaluating are inconsistently applied. Moreover, the department does not have a mechanism for collecting and documenting MOHs and counties' needs.

8. SUPPLY CHAIN MANAGEMENT OF DRUGS

8.1 Institutional Arrangements

54. Liberia's supply chain management activities are carried out by three departments of MOH: Pharmacy Division, National Drug Service and the Supply Chain Management Unit (SCMU). The Pharmacy Division provides overall oversight for activities carried out by supply chain actors, pharmaceutical service delivery, including the delivery of essential medicines and other health products at the health facility level. It is also in charge of developing policies and tools as well as managing training programs for dispensers and pharmacists. NDS is responsible for procurement, storage and distribution of drugs and pharmaceuticals. It supplements MOH's efforts by operating four Community Outreach Pharmacies (COP). In carrying out this program, it receives medicines from Mission Pharma and sells them to the population at a reduced cost. NDS has developed key performance indicators (KPI) for monitoring of storage and distribution activities. However, NDS management was dissolved due to operational inefficiencies. As a result, SCMU was appointed to take over its management in addition to its core functions. SCMU, an off-shoot of the Global Fund project coordination unit (PCU), is in charge of overseeing and coordinating key components of the quantification, forecasting, supply planning and distribution of essential medicines. The dual function of SCMU as the NDS interim management poses significant coordination and oversight challenges. These dual functions performed by SCMU affects the effective coordination and oversight of supply chain management activities under its purview. Planning and budgeting for supply chain departments (SCMU, NDS, and Pharmacy Division) are often centralized and only NDS and Pharmacy Division receive MOH allotments. Inefficient coordination and management of essential medicines and

supplies have resulted in the expiration and subsequent destruction of US$9 million worth of essential drugs.

8.2 Policy and Legal Environment

55. Pharmaceutical and drugs supply chain management in Liberia is governed by a number of policy and legal instruments, including the Health Sector Investment Plan, Essential Medicines Policy, 2016 Standard Treatment Guidelines (STG), Essential Medicines List (EML), Supply Chain Master Plan (SCMP), 2010 Liberia Medicines and Health Products Act, National Standard Essential Lists for medical devices, reagents and equipment, and donation guidelines for pharmaceuticals. Following the EVD epidemic, Liberia updated its donation guidelines for pharmaceuticals to incorporate infection prevention and control needs of the country. This presumably suggest that there are two systems in place; and therefore, a uniform national standard essential list for medical devices, regents and equipment would be required to inform procurement decisions of MOH, the donor community and other actors.

8.2 Pharmaceutical Regulation

56. The Liberia Medicines and Health Products Regulatory Authority (LMHRA), was established as a statutory body in 2013 by the 2010 LMHRA Act. LMHRA has a Board, senior management, and staff with undergraduate and graduate degrees. It is an autonomous entity tasked with the responsibility of providing oversight over importation of medicines, registration and marketing authorization, quality assurance, post-marketing surveillance, including pharmacovigilance, and licensing of premises and individuals. It also enforces border control in collaboration with the drug enforcement agency, and conducts inspection and enforcement of standards for pharmaceutical businesses. It releases vaccines for in-country use by reviewing manufacturing records. It operates a Level 2 quality control laboratory, and routinely participates in United States Pharmacopeia (USP) capacity building initiatives. The lab is yet to be WHO prequalified. LMHRA supervises clinical trials, including ethical oversight in relation to protection of subjects taking part in a clinical trial. Yet, the current regulations of LMHRA do not cater to the full scope of the 2010 LMHRA Act.

57. LMHRA reports directly to MFDP and the National Legislature. LMHRA officials interviewed pointed out volatile budgetary allocations and human resource constraints as some of the factors limiting its capacity to adequately decentralize its functions nationwide. For example, in FY2012/13 it received US$750,000. This figure fell to US$230,000 in FY2013/14 and subsequently increased to US$432,000 FY2014/15. In addition, every year it is able to generate an average of US$350,000 internally. In terms of its HR challenges, an existing moratorium on the recruitment of government staff impedes its ability to meet its human resource needs. It also faces transport and accommodation challenges. It has one vehicle and its offices are located within a rented building. As a measure to address these issues, WHO conducted an assessment in 2015. The assessment identified

technical and operational gaps to guide development of a strategic plan which would incorporate key thematic areas of adequate financial resources, human capital development, and effective regulatory processes and customers service. Also, LMHRA should provide quality assurance oversight for all health products procured for use by or on behalf of GoL. But, quality assurance of medicines and medical devices at the port of entry cannot be done as LMHRA has no presence at the port.

58. **Quantification, Forecasting, Selection, and Supply Planning**

59. Quantification, forecasting and supply planning functions are under the purview of SCMU. These activities are conducted with support from USAID (RH, Essential Medicines, and IPC), and Global Fund. Products are selected from the EML and STG. Product selection by procuring agencies, CHTs and international non-governmental organizations (iNGOs) conforms mostly to the specifications of the EML and STG. At the county level, product selection, quantification and availability are often informed by internal requisition processes. However, compliance with EML or STG is unclear. Staff capacity to forecast the need for drugs and supplies is weak. Therefore, CHTs rely on NDS to quantify and assess counties' drugs and medical supplies needs. Pharmacy outlets serve as vendors; however, no clearly documented selection criteria based on LMHRA prequalification can be established. Most procuring partners procure from WHO prequalified vendors based on their own procedures since no national regulatory framework for compliance exist. However, a higher level of quality assurance is maintained until products are handed over to MOH.

60. Forecasting methods are often informed by the availability of consumption data. LMIS data provides the basis for quantification and forecasting of pharmaceutical products. But LMIS data is difficult to obtain in HMIS, Therefore, paper-based LMIS tools are often used and that causes significant delays in obtaining data on stock levels. Consequently, critical medicines' consumption data, which would inform the processes are not readily available. These processes are also mostly donor-driven with external technical assistance. Nonetheless, yearly projections from the forecasting process yield supply plans, which are usually shared with key stakeholders to inform procurement decisions.

8.4 Procurement of Pharmaceuticals

61. Procurement processes for essential medicines and health products are mostly donor-driven and based on SCMU's quantification and supply planning. At the county level, allotment for procurement of essential medicines is received from MOH and procurement processes initiated when internal requisition processes are triggered by departments or facilities. Procurement procedures are in line with MOH procurement requirements. While procurement and health products regulatory requirements for public and private sectors are linked, no such linkage was observed at the county level.

62. There is lack of procurement planning for drugs and medical equipment, particularly at the county level. CHTs and hospitals do not submit a procurement plan to MOH. Therefore, their needs for the succeeding fiscal year are not adequately represented in the budget. There is also lack of coordination between donors and NDS. The SCMP stipulates that the medical procurement by donors and GoL should be fully harmonized. However, only 60 percent is currently harmonized. This means that MOH and NDS are not aware of all the drugs and medical equipment donors are bringing into the country resulting in duplication and misalignment as these donors are not following the NDS' procurement plan. Another issue related to lack of coordination between donors and NDS is that shipment of drugs and medical consumables arrive at the port without prior knowledge of NDS.

8.5 Inventory Management

8.5.1 Storage

63. NDS is fully responsible for the storage and distribution of medicines, medical devices, equipment, reagents, and vaccines. It has seven warehouses which are mostly rented and supported by donor funds. The existing warehouse capacity at NDS caters to finished pharmaceutical products, excipients, reagents, medical devices, diagnostics, vaccines and biological items. NDS at the moment lacks the capacity to store and distribute nutritional products due to their specific temperature requirements. Infrastructural challenges include inadequate storage space to accommodate the delivery of shipment of essential medicines and supplies procured on behalf of MOH partners, UNICEF, UNFPA, and WHO. A comprehensive assessment of storage capacity at NDS and suitability of existing warehouse to minimum good storage practice, including thermal mapping, is yet to be conducted. Additionally, medicines and supplies procured as part of EVD response continue to occupy NDS storage space after having been turned over by MOH implementing partners. Lack of adequate storage space and an increasing demand for storage significantly undermine NDS's performance.

64. NDS warehouses continue to encounter challenges and inconsistent electricity supply for temperature regulation of essential medicines. For instance, during the assessment period, a warehouse located in Monrovia, had power outage. High operational cost due to the over-reliance on power generated from electrical plants and generators pose a serious challenge in maintaining the quality of essential medicines and supplies along the pipeline and to the end-user.

65. In 2015, WHO comprehensively assessed the quality of storage at the county level. The assessment showed that of all the 15 county depots, only two (Margibi and Rivergee) had an acceptable level of storage infrastructure. To increase the country's storage capacity, a Global Fund–USAID joint construction project at an estimated cost of USD 3.4 million is currently in its planning phase with an

additional US$400,000 earmarked for project management expenditures. Construction is expected to last 12-18 months but the contracting is still pending.

8.5.2 Distribution

66. SCMU supports distribution planning and implementation. However, efficiency is undermined by lack of available and timely submission of consumption data by the counties and hospitals and unclear funding commitments and alignment for distribution. Distribution of essential medicines and other health products is mostly donor-driven, but channeled through the OFM at the central MOH.

67. Weak coordination between donor partners in distribution of essential medicines and supplies creates an undue demand for fleet availability that is beyond the capacity of NDS to deliver. Due to the existing challenges with fleet availability and MOH disbursement of funds for movement of essential medicines and health supplies from the central to the county level, significant delays of over one to two months are associated with each distribution activity. Additionally, there is fragmentation of distribution of essential medicines procured through different procuring partners (UNFPA, UNICEF, GLOBAL Fund, WHO), increasing the demand for services that cannot be adequately met by NDS management. A comprehensive costing of an integrated distribution of essential medicines and supplies would need to be conducted and government processes streamlined for donors to support an integrated approach.

68. Parallel distribution channels exist at the central level for vaccines and nutrition products due to the inability of NDS to fully manage and distribute the commodities. In addition, NGOs, including iNGOs at the county level procure and distribute medicines without the full involvement of SCMU. SCMU does not seem to have information on these activities.

69. Notwithstanding the change in management of the NDS, routine inventory activities have supported distribution planning, identification of at-risk items and reduced expiration of essential medicines. NDS serves as the county depot for Montserrat County where stocks for health facilities in Montserrat other counties' depots are maintained. Operational challenges include inadequate transport facilities as NDS currently has only eight trucks. Consequently, it relies on funds from partners for procurement of vehicles to supplement its existing fleet capacity.

8.6 Rational Use of Medicines

70. The Liberian Essential Medicines Policy states the concept of rational medicine use. With support from WHO, the EML and STG were revised in March 2016. These revised documents are yet to be rolled-out nationwide. Additional health systems strengthening approaches in promoting and

enforcing rational medicine use, including the establishment of drugs and therapeutics committees have yet to be implemented.

❖ **Strengths**

- Institutional arrangements exist for the management of supply chain activities in the sector.
- Policy instruments and guidelines for supply chain management are in place

❖ **Weaknesses**

- A key challenge inhibiting the operations of the three departments is ineffective coordination and management between MOH and donors in terms of storage and distribution of essential medicines and supplies. This ineffectiveness occasionally leads to the expiration and subsequent destruction of essential medicines.
- The supply chain functions are mostly donor driven, which leads to unpredictability of assistance, fragmentation of activities and high transaction costs for GoL. Donor support is mainly financed through OFM, but its cumbersome financial and procurement procedures delay disbursement of funds. This situation significantly affects the effective implementation of critical functions such as distribution of essential medicines causing stock-outs at health facility level.
- Roles and responsibilities of the various supply chain actors are not clearly defined. Although key performance indicators have been development for supply chain management, there is ineffective supervision and monitoring of the key supply chain activities.
- The human resources and payroll issues confronting the entire sector also impacts on supply chain activities as a result of delays in migrating MOH personnel onto the payroll. Hospitals, CHTS, NDS, reported maintaining contracts with employees until the lengthy MOH recruitment process is finalized.

9. HUMAN RESOURCES AND PAYROLL MANAGEMENT

9.1 Human Resources for Health

71. As stated in section 2 above, the National Health Policy and Plan 2011-2021 sets out the overarching goals of the health sector for "improving the health and social welfare status of the population of Liberia on an equitable basis", and focuses on the following key objectives: (i) increase 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; (ii) make 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; (iii) make healthcare and social protection available to all Liberians, regardless of their position in society, at a cost that is affordable to the country. Underpinning these objectives is the Human Resource Policy and Plan 2011-2021, which aims "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." The policy further outlines the following specific objectives: (i) increase the number of equitably distributed, qualified and high-performing workers at all levels; (ii) increase the number of high-performing facilities and institutions that promote continuous learning and assure quality; (iii) strengthen the workforce to be people-centered, gender-sensitive and service-oriented; and (iv) increase the number of safe and enabling learning and working environments equipped with the "tools of the trade."

72. Despite the above strategic objectives, the human resources for health situation in Liberia is precarious. There is uneven distribution of health workers by type of occupation and by county. Occupationally, 57 percent of health workers provide preventive and curative services, which constitutes the largest share of the health workforce. The density of health workers varies from county to county with Nimba, Margibi and Grand Bassa having the lowest densities of health workers in all occupational categories, Bomi, Grand Gedeh, Rivercess and Sinoe have the highest densities of general services staff more than double the national average. Table 4 presents occupational categories of health workers by county.

Table 4.MOH Health Workers by County for Selected Health workers

County	Certified Midwife	Registered Midwife	Nurse Aide	Licensed Practical Nurse	Nurse (BSc and RN)	Physician Assistant	Medical Doctor	EHT	Lab Tech	Dispenser	Pharmacist
Bomi	30	7	54	7	123	10	5	5	7	29	3
Bong	75	22	68	24	225	11	14	6	20	29	6
Cape Mount	24	5	47	2	88	28	4	4	5	38	4
Gbarpolu	14	9	33	4	45	12	2	9	3	18	2
Grand Bassa	21	4	94	3	137	15	3	12	8	12	3
Grand Gedeh	21	22	78	5	74	29	1	9	7	30	1
Grand Kru	14	3	57	7	42	19	2	4	3	11	2
Lofa	78	24	119	12	178	36	15	9	10	21	2
Margibi	33	5	53	7	74	21	9	6	13	26	4
Maryland	19	16	60	4	85	19	3	5	8	33	2
Montserrado	208	23	424	47	567	149	66	36	58	70	33
Nimba	40	12	77	13	194	39	21	23	12	14	5
River Gee	16	5	58	4	66	23	2	5	4	26	1
River Cess	22	19	24	9	65	21	3	6	5	24	1
Sinoe	12	8	55	1	80	16	2	5	1	37	1
Total	**627**	**184**	**1301**	**149**	**2043**	**448**	**152**	**144**	**164**	**418**	**70**

Source: Adapted from MOH Health Sector Assessment Report Final 2015-2016

73. The HR situation is aggravated by lack of motivation for staff at the hospital level. For example, non-monetary incentives are nonexistent in most health facilities. In addition, there is no accommodation for nurses in any of the facilities in the country. As a result, nurses who are called upon, especially at night, in the event of emergencies, are reluctant to come to the facility. Further, due to low salaries, there is a high employee turnover of clinicians. There is also a widening gap between the number of medical workers and support staff employed by the MOH. This is because CSA is reluctant to accept non-clinicians on the government payroll. This has further complicated the provision of adequate services.

74. To improve the human resource situation, MOH has set a target of employing 15,000 personnel by 2021. As at February 2016, MOH had employed 10,406 of which 61 percent are clinicians. Table 5 shows the number of health workers by type of worker.

Table 5. Health Workers by Type of Worker

Type of Health Worker	No. of Health Workers	% of Total
Clinicians	6,340	61
Non-clinicians	4,066	39
Total	**10,406**	**100**

Source: MOH, May 9, 2016

9.2 Payroll Management

75. The HR situation as described above, is compounded by the issue of migrating the existing health workers to GoL's payroll. The Government is unable to absorb over 3,000 needed healthcare workers on to the general payroll due to budget constraints. There is no electronic software to process and link local PAN with the central office. The National Budget is passed several months after schedule. This results in delays in processing PANs as well as payment of salaries. There is only one HR officer assigned to a county. As a result, there is significant time-lag in detecting and subsequently deleting from payroll names of staff who have abandoned their jobs or died. The payroll situation by county is shown in Table 6 below.

Table 6.Payroll Status of MOH Health Workers by County

County	Not on Government of Liberia Payroll	On Government of Liberia Payroll	Total	% Not on Government of Liberia Payroll
Bomi	217	311	528	41
Bong	339	415	754	45
Cape Mount	224	228	452	50
Gbarpolu	121	140	261	46
Grand Bassa	243	258	501	49
Grand Gedeh	434	236	670	65
Grand Kru	140	179	319	44
Lofa	449	356	805	56
Margibi	151	225	376	40
Maryland	302	164	466	65

Montserrado	595	2,505	3,100	19
Nimba	204	448	652	31
River Gee	257	128	385	67
River Cess	198	142	340	58
Sinoe	258	185	443	58
Total	4,132	5,920	10,052	41

Source: Adapted from MOH Health Sector Assessment Report Final 2015-2016

9.2.1 Verification of payroll information and payment.

76. The Human Resource Management Information System (HRMIS), a module in IFMIS, is the personnel database that supports the payroll module. While controls around both HRMIS and payroll are automated and effective, there is a significant delay in getting newly hired staff on the general payroll. Moreover, payroll is not reviewed by the Internal Audit Agency (IAA) personnel assigned to MOH before disbursement, a weakness that needs remedy if ensuring timely deletion of ghost names from payroll is to be attained. Payroll is reviewed several months after salaries have been paid. There is no central processing system to cross-verify payroll between the records from MOH on one hand, and MFDP, and CSA on the other hand. This situation leads to multiple payroll records being maintained. Moreover, there is no established protocol for electronic submittals of payroll, time and attendance sheets, and other payroll related information between independent line operations. As a result, CHOs HR Officers travel to MOH to submit monthly payroll lists and payroll related information. Employees who are transferred to the government payroll must travel to Monrovia to receive their first salary checks.

77. At the county level, county health facilities maintain parallel payroll to account for essential healthcare workers who are not on the government general payroll. Employees on the parallel payroll are paid incentives from allotment provided to the health facility. This further strains the already limited allotment for the health facilities to provide adequate and quality services. Like other line ministries, MOH's payroll is not consolidated. The basic salary payroll in Liberian dollars is managed by MFDP and CSA while the general allowance payroll in US dollars is managed by MOH.

9.2.2 Processing of Personnel Action Notice

78. As noted in Section 3 above, getting newly recruited health workers on to GoL's payroll processing is done at two levels. MOH fills out a PAN manually using typewriter and sends it to CSA. CSA personnel use pen to write and sign in their respective columns. This causes major delays in the processing of the PAN.

79. Other factors causing delays in processing the PAN are:

- MOH sometimes submit PANs without adequate supporting documentation, which are returned to be properly resubmitted The back and forth cause delays in the processing of PANs;

- Five CSA officials are required to sign the PAN, hence getting the required signatures takes about two to five weeks;

- PAN received by CSA from MOH are reviewed and signed by appropriate officials and then sent to DBDP at MFDP. It takes a month or two before DBDP returns the PAN to CSA to be placed on payroll.

- While all PANs received by CSA from MOH and other government ministries and agencies are scanned before processing, there are only two scanners at CSA. CSA also prepares, prints and attaches a matrix to the PANs. There is only one printer to print all the matrices CSA attached to the PANs. The inadequacy of office equipment is causing delays in processing PANs.

- Delay in approving the National Budget also causes significant delay in processing the PAN at CSA as processing of PAN depends on budgetary appropriation.

10. ASSET MANAGEMENT

80. The categories of tangible assets managed by GoL include property comprising land and buildings, plant, vehicles, furniture and equipment. GoL also manages intangible capital assets. Under government's cash basis of accounting, purchases of property, plant, furniture and equipment are expensed fully in the year of purchase. However, a memorandum record is maintained in the Fixed Asset Registers (FAR) at historical cost for all non-current assets of the Spending Entities. Unrealized gains or losses arising from changes in the values of property, plant, furniture and equipment are not recognized in the financial statements. Proceeds from disposal of such assets are recognized as non-tax receipt in the period in which they were disposed of.

Strengths

- MOH has internal control systems in place for the management of the Ministry's assets as enshrined in the revised OFM Financial Policies and Procedures Manual 2015. However, actual implementation remains uneven.
- The fixed assets register can enable OFM to track MOH's assets.

❖ **Weaknesses**

- The tracking of asset movements by the internal audit unit at all levels of the health system remains weak.
- Lack of reconciliation by MOH and GSA on the status of MOH's assets.

11. AUDITING

11.1Internal Audit, Compliance and Risk Management

81. The Internal Audit function of MOH is carried out by the Internal Audit Unit headed by a Director. The unit has 19 staff members with various qualifications at different levels. Table 7 provides total number of staff and their qualifications.

Table. Number of Staff by type of qualification.

No.	Position	Number of Staff	Qualification
1.	Director	1	MBA, CFE
2.	Deputy Director	1	MBA
3.	Audit Supervisors	4	BBA
4.	Regional Auditors	4	BBA
5.	Auditors	3	BBA
6.	Junior Auditors	2	BBA & CFE
7.	Audit Assistants	3	BBA
8.	Administrative Assistant	1	-
	Total	**19**	

82. For the purposes of audit, Liberia is divided into four regions each headed by a Regional Auditor. A review of the 2016 Internal Audit summary work plan showed that central office and regional auditors planned pre-audits for disbursements on a continuous basis and periodic audits of other auditable institutions, for instance, hospitals, health centers, NDS warehouses, etc. The Internal Audit Unit is accountable to IAGBS and to the Audit Committee.

83. The mandate and authority of internal audit is established in Part 2 Section 2.2Internal Audit Act, 2012 Audit Committee Charter and Internal Audit Charter. The internal audit charter mandates the committee to:

- Review and approve internal audit plans for the Internal Audit Department.
- Direct management to ensure that the Internal Audit Department has sufficient resources to carry out its mandate.
- Direct employees of the MOH to implement audit recommendations.
- Oversee implementation of the recommendations.

- Inform the Executive Director Internal Audit Governance Board Secretariat (IAGBS) of any critical concerns pertaining to internal controls, financial reporting, audits and compliance.
- Seek any required information from officials or employees of the MOH pertaining to internal controls, financial reporting, audit and compliance.
- Consult with the IAGBS of GoL on matters pertaining to internal controls, financial reporting audit, legal and compliance.

84. The members of the Audit Committee consist of the Minister, Deputy Minister for Administration and a third person designated by the Minister. The Committee also has a Secretary who records the minutes of each meeting and maintains records. The Audit Committee meets four times a year on a quarterly basis and as and when required.

85. The Internal Audit Unit determines whether MOH's risk management, control and governance processes are adequate to ensure: (i)risks are appropriately identified and managed.; (ii)interaction with various governance groups occurs as needed; (iii)financial, managerial and operating information is accurate, reliable and timely; (iv)employees' actions are in compliance with policies, standards, procedures and applicable laws and regulations;(v) resources are acquired economically, used efficiently and adequately protected; (vi) quality and continuous improvement are fostered in the Ministry's control procedures; and (vii) legislative issues impacting the Ministry are recognized and addressed appropriately.

❖ **Strengths**

- There is a framework in place in the form of IAA, Audit Committee Charter, and Internal Audit Charter.
- There are also administrative structures like the Internal Audit Governance Board Secretariat (IAGBS) and Audit Committee.

❖ **Weaknesses**

- Inability of auditees to timely respond to audit findings.
- Inability of the Audit Committee to meet and discuss issues arising from audits.
- Lack of full support from Government for the Department to perform audit functions.
- The Internal Audit Department does not have access to IFMIS to view transactions for compliance.

11.2 External Audit

86. GAC is the constitutional Supreme Audit Institution (SAI) and auditor of all institution in Liberia, including the MOH. GAC has made significant progress in reducing the backlog of annual financial audits from FY2012/13 to FY2014/2015. While GAC has made significant progress in their effort to bring the Consolidated Fund Statement (CFS) audit up-to-date, the audit of Spending Entities, including the MOH are lagging behind. For instance, the auditing of MOH is in backlog as far back as 2008/09 and the last comprehensive audit of the MOH started in FY2007/08 to and ended at the end of the fiscal year. The auditing of MOH comprehensive accounts covering FY2008/09 and 2011/12 began about two years ago, but yet to be completed by GAC.

87. On the other hand, GAC's financial statements for five years up to the year ended June 30, 2015, have been audited by the Kenya National Audit Office Kenya's SAI, first time in the history of the institution. The SAI has demonstrated transparency and accountability by inviting Kenya SAI to audit its five years financial statements. To address the significant delays in auditing MOH, independent audit arrangements have been put in place for auditing donor funded projects, including the Pool Fund reviewed below. GAC was mandated to audit the Ebola Emergency Response Project (EERP). However, it submitted the EERP annual audited financial statements for the year ended June 30, 2016, one month after the submission deadline. This indicates that GAC is weak in delivering Spending Entities audited financial statements on time.

12. HEALTH SECTOR POOL FUND

12.1 Overview of Health Sector Pool Fund

88. The plethora of donors in Liberia's health sector provides significant challenges to implementing health sector programs and ensuring effective service delivery. Historically, every donor that enters the sector comes with its own program and implementation procedures leading to high transaction costs and duplication of programs and activities. To address this issue, GoL established the Health Sector Pool Fund (HSPF) in 2008. HSPF has three main objectives: (i) help finance priority unfunded needs within the NHP; (ii) increase the leadership of MOH in the allocation of sector resources, and (iii) reduce the transaction costs associated with managing multiple projects from different donors.

89. As noted in section 1 above, HSPF's main contributors are DFID, Irish Aid, SDC, AFD and UNICEF. To ensure effective management of the fund, a joint financing agreement (JFA) which commits all participating donors to the HSPF was signed with MOH. The JFA outlines the overall responsibilities of MOH and the participating donors, the governance and fund management arrangements, as well as the functioning of the fund, including audit and reporting requirements. To ensure predictability of donor support, the HSPF agreement requires donors to inform MOH of the

support they intend to provide in each fiscal year. The agreement provides flexibility for other donors to join upon submitting a written request, and a subsequent endorsement and acceptance by the Pool Fund Steering Committee (PFSC), its highest decision-making body. It also stipulates that any donor that intends to terminate its support must provide a three-month written termination notice. As at December 2015, donors had contributed US$82 million, including bank interests into the fund. Of this amount, 96 percent was committed and 85 percent disbursed.

12.2 Institutional and Implementation Arrangements

90. **Pool Fund Steering Committee**: A Pool fund Steering Committee (SC) made up of contributing donors, relevant GoL ministries, and invited representatives from major organizations active in the health sector such as USAID, EU and WHO was set up as the highest decision-making body for the management of the fund. Co-chaired by MOH and a designated lead donor, currently UNICEF, the SC set priorities, reviews and approves all funding proposals, spending plans, disbursements and reports of the Fund. It ensures transparency, encourages coordination and serves as a platform for open dialogue. It also works as a coordinating entity between contributing donors and other partners due to the wide representation of its membership.

91. **Pool Fund Secretariat**: A secretariat housed at MOH, staffed and managed by an international financial management consultancy firm known as the Pool Fund Management Firm (PFMF) supports the running of the SC. PFMF is responsible for its day-to-day management and for supervising the fiduciary risks associated with its use. It ensures that annual independent audits and periodic risk assessments are conducted. It produces and maintains regular performance reports, SC briefing papers, meeting minutes and resolutions. It also supports MOH to develop funding proposals for Pool Fund allocations.

92. **Implementation mechanism.** The utilization and implementation of HSPF is guided by its procedures manual, which is updated as and when required upon approval by PFSC. To receive funds from HSPF, MOH must initiate and develop a proposal that supports the implementation of the NHP. As noted above, the PFSC reviews, discusses and approves each proposal to ensure consistency with the objectives of the NHP.

93. The HSPF uses MOH's existing systems for financial management, procurement, internal audit, and planning. This reduces the administrative burden on MOH and minimizes transaction costs. Moreover, HSPF is only used to cover expenditures within the NHP. MOH presents funding proposals based on a sector approach aligned with the sector priorities in the NHP to the SC for approval. Once approved, those priorities are outlined in an HSPF annual work plan and implemented accordingly.

12.3 HSPF's Areas of Support

94. In support of the implementation of the NHP, HSPF finances activities related to three main areas: (i) health workforce incentives and salaries; (ii) increasing access to availability of medicines and drugs; and (iii) risk mitigation and administration.

12.3.1 Payment of Health Workforce Salaries and Incentives

95. A health sector workforce challenge in Liberia is to ensure there are enough qualified and motivated staff performing well to meet management and service delivery needs. In 2007, a health worker salary scale was created to standardize salaries as a way to achieve the aim of reducing employee turnover by incentivizing health workers to resist moving among facilities, counties, and NGOs. Under the salary scale, some health workers receive from the Pool Fund either a portion of or their entire salaries to motivate and retain them to deliver quality health care services.

96. In FY2014/15, the pool fund supported approximately 2,755 health workers each month at a total annual cost of US $5.57 million. Table 8 below presents the total number of health workers and CHT staff receiving pool funded incentives.

Table 7. Number of Health Workers receiving pool fund incentives

County	Health Facility	CHT	Total
Bomi	380	40	420
Gbarpolu	192	0	192
Grand Bassa	56	21	77
Grand Gedeh	488	21	509
Maryland	383	11	394
Lofa	191	0	191
Montserrado	346	0	346
Nimba	129	3	132
Rivercess	222	4	126
River Gee	222	0	222
Total	**2,609**	**100**	**2,709**

97. In addition to supporting health workers at the county level, the pool fund also pays incentives to 46 support workers at the central MOH. Table 9 provides a number of support workers who received incentives by unit in FY2014/15.

Table 8. Number of MOH staff Receiving Incentives

Department	**Unit**	**Central MOH Support Staff**

Administration	OFM	22
	Internal Audit/Compliance	10
	Infrastructure	7
Planning	M&E	3
	External Aid	2
Health Services	CMO's Office (CHS and SCMU)	2
Total		46

98. A review of the FY 2015/16 second quarter report showed a budgetary allocation of US$ 11.7 million. 48 percent of this amount HSPF was allocated to Human Resources for Health with remaining funds covering essential drugs (40 percent), risk management (5 percent) and HSPF administration (7 percent).

99. In FY2015/16, a target was set to pay part or full salaries of 2, 800 health workers at the central and county levels. As at December 31, 2015, the total number of workers on HSPF incentives was 2,681, including both counties (2,639) and central MOH (42), accounting for 25 percent of the overall health workforce of 10,709. HSPF payments to health workers are consolidated and paid by MOH through the Personnel Unit and OFM. OFM and H S P F Secretariat process payment requests and track the payment of incentives. HSPF accountant supports the processing of the payroll. All counties reported that their staff received their salary or incentives but experienced some delays. There is also an issue of incorrect account numbers, which is a contributing factor for the delays even when payroll is processed on time. Moreover, limited access to banking services in some counties poses a challenge to the payment of the incentives and salaries as the GoL requires the use of bank transfers to effect these payments. Health workers are, therefore, opening bank accounts where possible. Yet not only are some counties without banks, but some health workers need to travel long distance to access their funds, which means time off from work.

100. It is understood that the HSPF incentive and salary payment is a short-term measure. In the long-term, MOH plans to reallocate the funds to non-recurrent health sector costs. MOH, therefore, intends to reduce the number of health workers paid through HSPF and other donors, which will enable the government to set up a comprehensive payroll for future budgeting and forecasting purposes. Nevertheless, it is unclear whether there is a plan in place to manage the transition.

12.3.2 Improving Access to and Availability of Medicines and Medical Supplies

101. NHP objective for essential medicines is to "ensure continuous supply and access to efficacious, high-quality, safe and affordable medicines for all Liberians." In support of this objective,

HSPF allocated US$4.6 million to pay for essential drugs and medical supplies procured. It has carried out an array of activities, including conducting quarterly inventory of pool-funded essential drugs at NDS, procuring and contracting a service provider to overhaul the management of NDS, monitoring the performance of the service provider and strengthening the coordination and linkages between NDS, MOH, and other key stakeholders involved in the supply chain.

102. It is, however, worth noting that HSPF did not allocate any funds for the purchase of essential drugs in FY 2015/16 due to unspent funds from allocations of the two previous years. In FY 2014/15, the MOH proposed to allocate US$ 2.6 million from the Pool Fund for the procurement of essential medicines and supplies that would form a part of MOH's Essential Drug Program (EDP). However, the lack of warehouse space at NDS, the substantial balance from the Pool Fund's FY 2013/14 investment in essential medicines, and the inundation of the health sector with essential medicines and supplies during the response to EVD epidemic, resulted in the anticipated 2014/15 pool fund allocation for drugs remaining unspent at the end of the fiscal year.

103. NDS manages existing balances from the FY 2013/14 US $1.9 million HSPF allocation for essential medicines, while MOH and the HSPF Secretariat monitors it. NDS is required to conduct quarterly inventories, which will be audited annually as part of HSPF annual audit, including the audit of records as well as physical stock. To make sure the unused balance of pool- funded essential medicines held at NDS do not go to waste, a limited amount of not more than US $250,000 were allocated to NDS for operational support. This covered costs of electricity extra labor needed to conduct quarterly inventories.

12.3.3 Risk Mitigation and Administration

104. To mitigate risks affecting allocations from HSFP, the PFMF conducts integrated supervision and field monitoring visits and submits reports to the PFSC. It also oversees the annual independent audit of HSPF. In addition, the PFMF regularly reconciles HSPF bank accounts, conducts spot checks and verification visits of pool-funded activities, and ensures independent audits and risk assessments are regularly carried out and the recommendations are followed up on. In terms of administration, PFMF manages HSPF, the day-to-day operations of its secretariat as well as supporting the SC. The PFMF's performance is reviewed twice every calendar year. In FY 2015/16, the risk management and administrative functions of HSPF Secretariat cost a little over US$1.3 million.

105. While HSPF relies upon national procedures for planning, financial management, and procurement, and therefore makes it easier for MOH to hold donors accountable for their committed funds, the support coming in through this funding mechanism is minor relative to overall donor funds in the health sector.

13. OTHER RELEVANT AREAS

13.1 Governance of the Health Sector

13.1.1 General Governance

106. Of the six building blocks that constitute a health system, according to WHO classification[12], governance is probably the most complex and strategic. It entails both political and technical actions to reconcile competing demands with limited resources, in a challenging environment and changing. According to the Liberia Governance Commission, good governance is "the management of a nation's affairs and resources in a manner that is open and accountable, equitable, transparent, and responsive to the needs of the people under the rule of law"[13]. Liberia's model for governance takes into account the following five core principles:

Figure 3. Liberia's Governance Model

Source: Governance Commission (2013)

107. *Participation:* The principle of participation refers to the existence of mechanisms and structures which guarantee the involvement of citizens in the decision-making process, such as public meetings, surveys, citizen advisory committees and other forms of direct involvement with the public. *Effectiveness and efficiency.* This principle refers to the formulation of clear objectives and the attainment of the desired results, making optimal use of scarce resources. *Equity:* This principle refers to the existence of measures to ensure equal access to the services for all, including the most vulnerable people. *Transparency:* This *principle* refers to the mechanisms put in place by MOH to allow an appropriate level

[12] The six building blocks are: service delivery; health workforce; information; medical products, vaccines and technologies; financing; and leadership and governance (stewardship). WHO (2007). *Strengthening health systems to improve health outcomes. WHO's Framework for Action.*

[13] Governance Commission (2013). *Annual Governance report-2013. Delivering Education and Health Services to the People.*

of scrutiny on its actions and decisions by other parts of the government or civil society. *Rule of Law:* This principle shows the extent to which laws, regulations and codes are enforced in an impartial manner which guarantees that no one, including government, is above the law. *Accountability:* This principle describes the obligation of MOH to justify its actions and decisions to the population. There are three types of accountability: (a) *Political Accountability:* This type of accountability measures the extent to which MOH is accountable to the public and the Legislature, which acts as a horizontal constitutional check on the power of the Executive. The establishment of accountability and integrity institutions like the Liberia Anti-Corruption Commission (LACC) and GAC, among others, supports the attainment of political accountability. *Social Accountability:* This *type of accountability* measures the extent to which MOH is responsive to civic engagement, such as participatory budgeting, social audits, or citizen report cards which allows citizens' involvement and oversight. *Administrative Accountability:* This type of accountability shows the existence of performance measures and internal control systems to ensure that codes of conduct and professional standards are adhered to by employees and contractors.

108. As noted at the outset, in Liberia, the policy guidance in health is ensured by a robust policy framework, with major policies being the *National Health and Social Welfare Plan* (2011-2021) and the *Investment Plan for Building a Resilient Health System in Liberia* (2015-2021) among others. The approach used for their development was reportedly country-led and participatory.

❖ **Strengths**

- Priorities and objectives are clearly stated in the policies, which is an indication of a strong policy guidance and a good step towards the achievement of effectiveness, as defined above.
- Existence of a Health Sector Coordination Committee, (HSCC) chaired by the Minister of Health, which also comprises heads of donors and international agencies, NGOs and civil society organizations, and private sector. HSCC is responsible for taking critical programmatic and financial decisions.
- Existence of some form of health coordination forum at county level, chaired by the CHO with implementing partner representation.

❖ **Weaknesses**

- In many instances, the dissemination of policy documents at the lower level has been inadequate. The limited availability of printed copies and communication on the content of the documents is ineffective. This situation limits CHTs access to strategic policies they are supposed to implement[14].
- HSCC is scheduled to meet quarterly but meetings are very irregular, usually convened if there is any urgent matter to be approved. No real programmatic issues are discussed and civil society is not taking active part. Too many competing priorities, coupled with poor coordination at MOH tend to interfere with the regular scheduling of these meetings.

[14]MoH (2015). *Liberia Health System Assessment.*

109. The above factors demonstrate weaknesses in health sector governance, particularly at the lower level of the health system. Results from the 2013 community score card from five counties (Nimba, Grand Bassa, Montserrado, Rivercess, and Bomi) scored the governance of the health services at 2.45 out of 5, which is below the minimum score of 3. Particularly poor scores were recorded for transparency (1.30) and accountability (1.55), clearly signaling citizens' discontent. Figure 4 illustrates the community score card of the five counties.

Figure 4. Results of Community Score Card in Five Counties

Governance Indicators	Maximum Score	Nimba	Grand Bassa	Montserrado	Rivercess	Bomi	Average Score for Each Category
Effectiveness & Efficiency	5	3.35	3.88	3.34	3.03	2.86	3.29
Transparency &the rule of Law	5	1.79	1.36	.76	1.20	1.40	1.30
Accountability	5	2.04	1.69	1.21	1.27	1.53	1.55
Participation	5	3.23	2.85	2.64	2.55	2.33	2.72
Equity	5	3.61	3.42	3.75	3.26	3.00	3.41
Average Governance Score	5	2.80	2.64	2.34	2.26	2.22	2.45

Source: Governance Commission (2013)

13.1.2 Health Sector decentralization

110. The 2012 National Health Sector Decentralization Policy noted above envisages MOH performing functions related to policy making, emergency preparedness and response on a national scale, setting national standards and guidelines for health workers management and development, procurement of drugs, and setting the investment framework. For CHTs, the policy puts them in charge of county planning, budgeting and implementation following national priorities, facility management, maintenance and supervision, management of personnel, collection and analysis of HMIS-generated data, coordination with local and international partners at that level, and collaboration with the CHBs, among others[15]. Yet in practice, the health management structure still seems top-down, with the central level making most of the policy decisions[16].

111.

112. Nonetheless, the Governance and Decentralization Unit at MOH has played an active role in the GoL general decentralization process, in close collaboration with the Ministry of Internal Affairs and the Inter-Ministerial Committee on decentralization. Decentralized services from MOH are included at the County Service Center already established in Grand Bassa. In six months, MOH delivered over 2,500 services through the County Service Center, especially the issuance of birth certificates. Despite its contributions, the unit has limited resources (human, financial and logistics),

[15] MoH (2011). *National Health and Social Welfare Plan (2011-2021).*

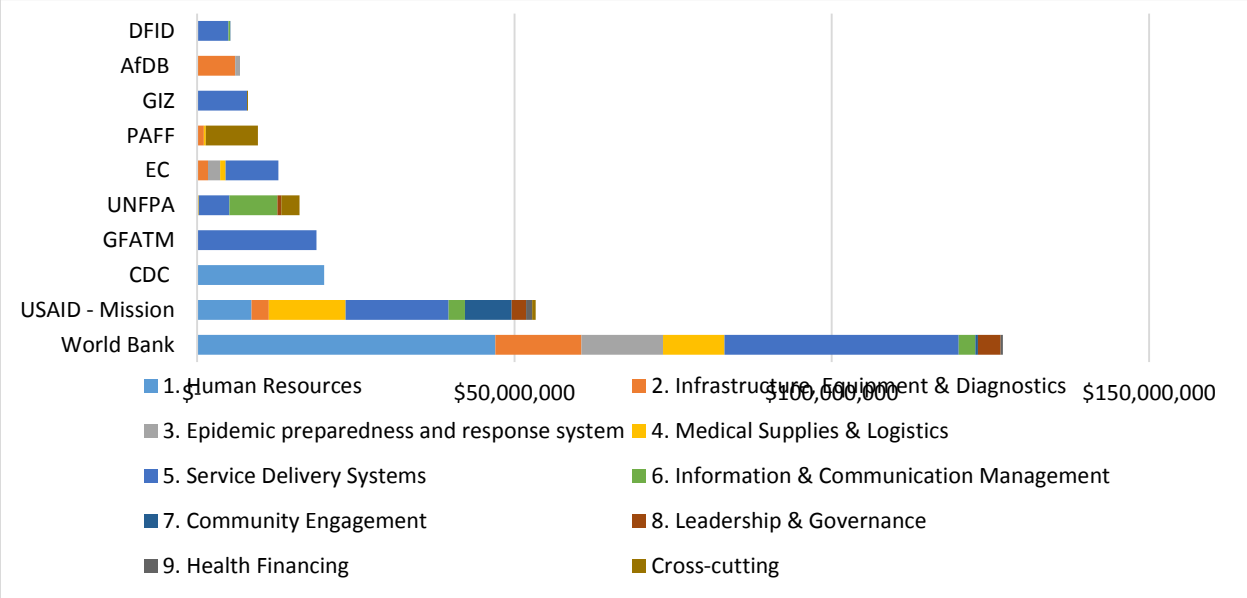
[16] MOH (2015). *Liberia Health System Assessment.*

which affects regular supervision of the local governance structures. At the county level, inadequate leadership and management skills for decision-making as well the lack of budgetary support, inhibit the proper functioning of the local governance structures. Regarding fiscal decentralization, some hospitals and facilities are directly funded by MFDP without going through MOH. As a result, full knowledge of the health budget per county is not known by CHT or MOH. Also, MOH usually signs memoranda of understanding with NGOs to work in the counties without involving them.[17]

13.2 Donor Mapping and Accounting for Donor Funds

113. The health sector has received substantial foreign aid both after the war and again during and after EVD crisis in Liberia. According to the latest National Health Accounts (NHA) for fiscal year 2011/12, donor contributions were 32.4 percent of Total Health Expenditure (THE). Findings from the resource mapping exercise for fiscal year 2013/14 depicted a total of US$179 million committed to the health sector. Of this amount, 73 percent was to come from international donors. Resources mapping exercise undertaken in FY 2015/16 showed that donors contributed 80 percent of the total health sector resource envelope, of which 43 percent was off-budget support. Figure 5 below shows the ten largest donors providing resources by investment area in FY 15/16, with the WB and USAID identified as the largest contributors.

Figure 5. Donor Mapping by Investment Area

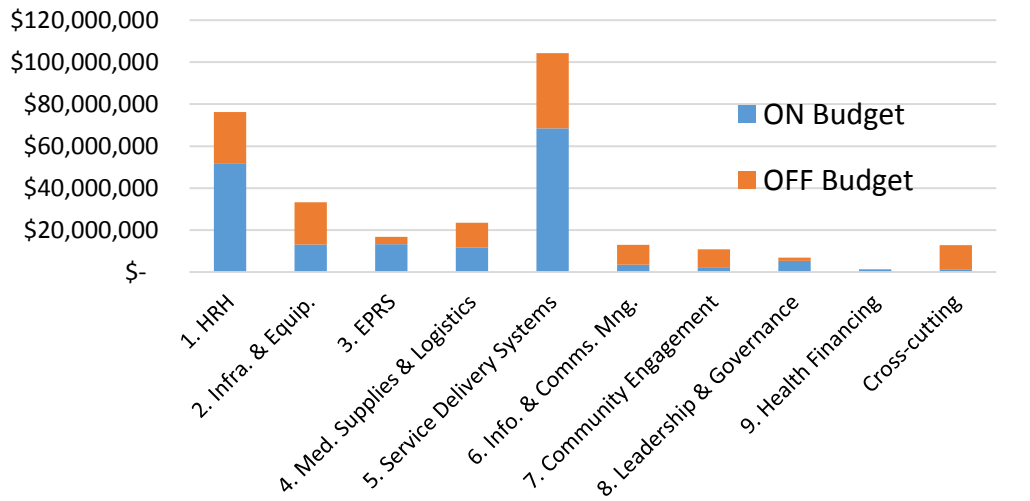


[17] MOH (2015). *Liberia Health System Assessment.*

Source: MOH Resource Mapping Exercise, 2015

114. It is important to note that, a substantial amount of donor funding is off-budget. The National Health Financing Policy and Plan (2011-2021) sets out to develop comprehensive reporting of all external resources, using standards and encouraging pooling and harmonization with the financial management procedures as follows: (a) develop annual operational plan; (b) to the extent possible, use common accounting procedures for resources spent; and (c) at a later stage, integrate funds during the whole accounting process from planning through disbursement and expenditure. Figure 6 shows the percentage of the budget that was on- and off-budget for the FY 15/16, per investment area.

Figure 6. Donor on and off-budget expenditure per investment area, FY15/16



Source: MOH, Resource Mapping Exercise, 2015

13.2.1 Donor Mapping

115. To feed into the planning process of MOH, MOH Health Financing and Planning Units launched a resource mapping exercise in 2013. The purpose of this exercise was to track and project resource commitments from donors and GoL's budget financing for the following fiscal year. The exercise continued in FY2014/15 and FY2015/16, but was disrupted by the Ebola outbreak before it could be completed. For FY 2013/14 projection, GoL and 17 major donors were surveyed to identify planned support towards the health sector. The donors surveyed included USAID, EU/EC/ECHO, UNICEF, the Global Fund, and UNFPA, WHO, GAVI, Irish Aid, DFID and other relevant development partners. For FY2015/16 projection, nine donors (36 percent) and 41 NGOs (52 percent) of the total number of donors surveyed, responded to the survey.

❖ **Strengths**

- The resource mapping exercise provides a relatively comprehensive mapping of donors and their expected support. Having data on partners' support per county

enables MOH to keep oversight and try to improve allocative efficiency and equity in the distribution of resources. Disaggregation per investment area helps inform the planning and budgeting process.

❖ **Weaknesses**

- The resource mapping exercise is not completed in time to inform the planning and budgeting process before the budget is submitted to MFDP. Usually, it is only ready after the budget has been approved and MOH is working on its operational plan for the fiscal year. While still useful at that point in time, to conform to the 2009 PFM regulations on the budget cycle, it should be ready beforehand to advise MOH budget preparation.
- The projections for donors' and implementing partners' resources is only for the following fiscal year. It should map donor contributions for at least three years to conform to MTEF planning.
- The donor and NGO survey response rate is low. Only 36 percent of donors and 52 percent of NGOs present in Liberia responded. Therefore, MOH is not aware of what a large proportion of partners are doing and whether their activities and funding align with its priorities.
- Of the partners that responded to the survey, 43 percent of the support is off-budget. MOH defines off-budget as funds going directly to the implementing partners and that are therefore "off plan" from MOH priorities. Often the level of detail of activities provided is minimal, making it difficult to map out the actual support given by these donors, especially when it comes to analyzing resource gaps for specific programs, such as Reproductive, Maternal, Newborn Child and Adolescent Health (RMNCAH) program.

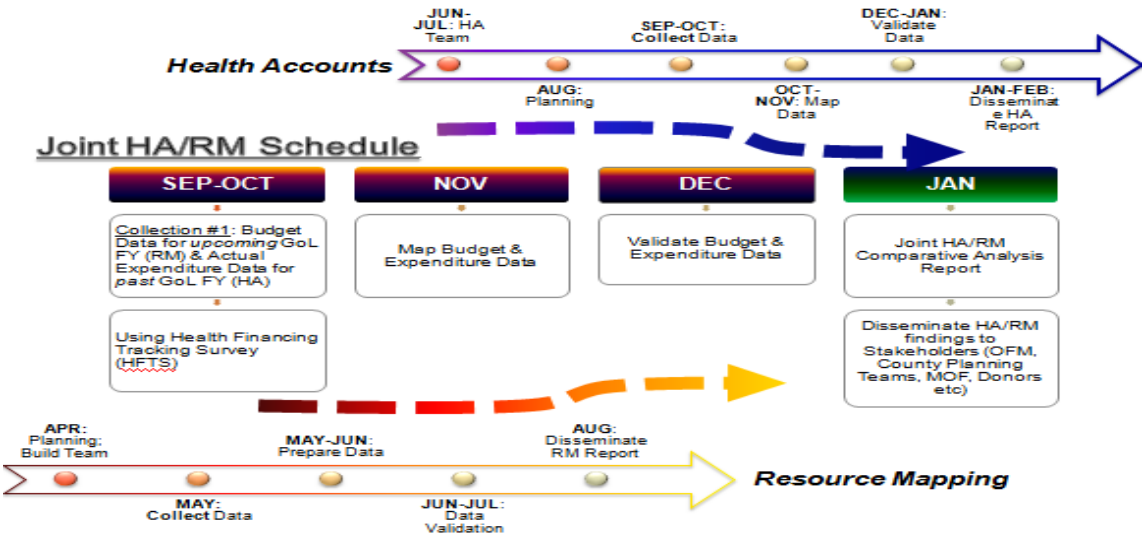
13.2.2 Accounting for Donor Funds

116. The fragmented and uncoordinated nature of health financing in Liberia makes tracking expenditure by donors and implementing agencies difficult. Using focal points for specific partners providing on-budget support through MOH such as HSPF, Global Fund, GAVI, FARA and UNDP among others, OFM works with partner organizations to ensure adherence to specific reporting requirements and execute their planned investments and projects.

117. HFD at MOH conducts National Health Accounts (NHA) exercises which can be used to hold institutions accountable to their financing commitments to the health sector. NHA provides a mechanism to analyze major expenditure patterns from the financing source down to service delivery. However, it is not designed to hold donors and implementing partners accountable for specific commitments and activities as it only gives a high level insight on expenditure flows. Nonetheless, in 2014, HFD commenced the process to develop a data collection mechanism that aligns both resource mobilization and the NHA exercises while institutionalizing these as annual processes. Ultimately, the objectives are to analyze projected funding derived from the resource mapping exercise against the estimated cost of the health sector recovery plan; and to hold institutions accountable to their health

financing commitments by analyzing the expenditure patterns derived from the NHA exercise against those of the resource mapping exercise. The proposed timeline for this exercise is shown in Figure 7 below.

Figure 7. Merged timeline for RM and NHA data collection



Source: MOH, Health Sector Assessment Report, 2015

❖ **Strengths**

- Accounting for certain funds in the health sector through increased use of national systems, particularly MOH's OFM, which manages donor funds from GAVI, GFATM, HSPF, and various project funds.
- HSCC tries to maintain oversight of the major donors in the health sector in order to co-ordinate donor activities with ministry plans and to hold donors accountable.

❖ **Weaknesses**

- There is no formal mechanism in place that accounts for donor funds in a comprehensive way. This is particularly a problem for the large amount of donor funding which is off budget. MOH is not aware of how much these donors are committing to the health sector and whether their commitments actually materialize.

14. POLICY RECOMMENDATIONS

118. The assessment unearthed significant PFM issues, including delays in the release of funds to the counties. These issues present enormous constraints to effective service delivery, especially at the county level. Based on the findings from the assessment, we recommend the following for government's attention.

- **Planning and Budgeting**
  - Broaden participation in planning and budgeting processes to include all the relevant departments and units; and
  - Provide training in MTEF concepts and principles to enhance staff understanding of how to prepare the budget in line with GoL's MTEF guidelines.
- **Budget Execution and Reporting**
  - Employ more finance staff at the county level to address the human resources issues confronting the counties.
  - Allocate adequate funds to the counties.
  - Enforce internal control systems and code of conduct.
  - Strengthen financial management capacities of CHTs.
  - Increase allotment for health sector expenditures based on cash needs communicated from the CHTs.
  - Encourage financial reporting and analysis practices at all levels of the health system.
  - Address delays in receiving allotments by ensuring timely submission of financial reports at both county and MOH levels.
  - Carry out petty cash spot counts
  - Ensure application of a uniform method of petty cash management at all levels.
  - Ensure independent verification of all monies received and develop formal handover procedures for situations when the person in charge of petty cash is absent.
  - Prepare and review bank reconciliation statements on a monthly basis.
  - Maintain control registers for all purchase orders, checks and receipt books issued with emphasis on periodic reviews.

- **Procurement of Goods and Services:**
  - Start the procurement planning process earlier so that the procurement plan is completed in June of the current fiscal year. In that way MOH can take advantage of the Advanced Agreement set out by the PPCC and decrease delays in procurement.
  - Include CHTs and hospitals in the procurement planning process. This will require building capacity at the county level.
  - Conduct productive meetings based on mutually agreed ground rules.
  - Enhance coordination between NDS and donors to facilitate smooth distribution of drugs and pharmaceuticals to health facilities.

- Conduct a comprehensive costing of an integrated distribution of essential medicines and supplies and streamline government processes for donors to support an integrated approach.
- Make meeting attendance part of procurement committee members' meetings terms of reference.

❖ **Supply Chain Management**

- Set up a strong supply chain coordinating mechanism that will ensure that all supply chain actors, including all development partners strictly adhered to the storage and distribution requirement of Liberia.
- Simplify OFM financial management and procurement procedures to improve disbursement of funds and ensure effective implementation of critical functions such as distribution of essential medicines.
- Clarify roles and responsibilities of various supply chain actors operating in the health sector.

❖ **Human Resources and Payroll Management**

- Review payroll before making payments.
- Address the widening gap between medical and non-medical staff.
- Establish a central process system to cross-verify payroll between the records from MOH, MFDP, and CSA.
- Accelerate the processing of moving MOH employees onto the payroll through MFDP.
- Employ HR assistants to assist the county HR officers in gathering payroll information in a timely manner, and also communicate expeditiously with the central office on key issues such as abandonment of job by employees or death.
- Strengthen the capacities of CHTs and other local structures, with clear terms of reference and standardized procedures, training them on basic governance principles and management practices.
- Ensure that the enrollment list contains individuals with different and relevant professional qualifications for migration onto the government payroll.

❖ **Assets Management**

- Ensure compliance with the revised OFM manual, including provisions covering fixed assets.
- Strengthen the capacity of the internal audit unit to enable it to undertake assets verifications at MOH, CHTs and the hospitals and health facilities level.

- Maintain up-to-date fixed assets register for the MOH vehicles, including vehicles received through donations.
- Submit a copy of fixed assets and reconcile same with GSA records at all times.
- Appoint assets manager consistent with the provisions of Article 10.6.1 of the OFM manual.

❖ **Auditing**

➢ **Internal Audit, Compliance and Risk Management**

- Ensure auditees respond to audit findings and take action as mandated.
- Conduct regular Audit Committee meetings to discuss matters arising from the audits.
- Begin subsequent audits by checking that there was auditee response and action on previous audit recommendations.
- Carry out regular peer reviews of IA.
- Include audit reviews of donor funded projects in work plans.
- Grant auditors access to GoL's financial management systems.
- Reinforce the IAA by ensuring regular GoL support for audit functions.

➢ **External Audit**

- Address the causes of the delays in order to bring MOH's audit up to date.
- Improve GAC's capacity to enable it to conduct audits in a timely manner.
- Improve GAC's capacity to enable it to conduct audits in a timely manner.

❖ **Governance**

- Strengthen the role of the HSCC, as a strategic decision-making body.
- Reinforce the linkages with civil society, both at central and local levels.
- Make adequate resources available to MOH's decentralization unit to enable it to provide better services in the counties

❖ **Donor Mapping and Accounting for Donor Funds**

- Prioritize the data collection exercise aimed at aligning resource mobilization and NHA with the view to holding institutions accountable for their health financing commitment. This will ensure predictability of donor funding.

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Annex 1. Policy Implications

No.	Key PFM Area	Policy Implications
1.	**Planning and Budgeting Process**	(i) broaden participation in planning and budgeting processes to include all the relevant departments and units; and (ii) provide training in MTEF concepts and principles to enhance staff understanding of how to prepare the budget in line with GoL's MTEF guidelines.
2.	**Budget Execution and Reporting**	(i)employ more finance staff at the county level to address the staffing shortage confronting the counties; (ii) enforce internal control systems and code of conduct; (iii) strengthen financial management capacities of CHTs; (iv) increase allotment for health sector expenditures based on cash needs communicated from the county levels; (v) encourage financial reporting and analysis practices at all levels of the health system; (vi) address delays in receiving allotments by ensuring timely submission of financial reports at both county and central MOH levels; (vii) carry out petty cash spot checks; (viii) ensure application of a uniform method of petty cash management at all levels; (ix) ensure independent verification of all monies received and develop formal handover procedures for situations when the person in charge of petty cash is absent; (x) prepare and review bank reconciliation statements on a monthly basis; (xi) maintain control registers for all purchase orders, checks and receipt books issued with emphasis on periodic reviews.
3.	**Procurement of Goods and Services**	(i) start the procurement planning process earlier so that the procurement plan is completed in June of the current fiscal year. In that way MOH can take advantage of the Advanced Agreement set out by the PPCC and decrease delays in procurement; (ii) include CHTs and hospitals in the procurement planning process. This will require building capacity at the county level, (iii) conduct productive meetings based on mutually agreed ground rules in terms of time; (iv) enhance coordination between NDS and donors to facilitate smooth distribution of drugs and pharmaceuticals to health facilities; and (v) Make meeting attendance part of procurement committee members' meetings terms of reference.
4.	**Supply Chain Management**	**Supply Chain Management:** (i) set up a strong supply chain coordinating mechanism that will ensure that all supply chain actors, including all development partners strictly adhered to the storage and distribution requirement of Liberia. (ii) simplify OFM financial management and procurement procedures to improve disbursement of funds and ensure effective implementation of critical functions such as distribution of essential medicines. (iii) clarify roles and responsibilities of various supply chain actors operating in the health sector; (iv)

		conduct a comprehensive assessment of the storage capacity at NDS; and (v) conduct a comprehensive costing of an integrated distribution of essential medicines and supplies and streamline government processes for donors to support an integrated approach.
5	**Human Resources and Payroll Management**	(i) review payroll before making payments; (ii) establish a central processing system to cross-verify payroll between the records from MOH, MFDP, and CSA; (iii) accelerate the process of moving MOH employees onto the payroll through MFDP; (iv) employ HR assistants to assist the county HR officers in gathering payroll information in a timely manner and also communicate expeditiously with the central office on key issues such as abandonment of job by employees or death; (v) strengthen the capacities of CHTs and other local structures with clear terms of reference and standardized procedures, training them on basic governance principles and management practices (vi)address the widening gap between medical and non-medical staff by ensuring that the personnel action notice (PAN) contains individuals with different and relevant professional qualifications for migration onto the government payroll.
6.	**Assets Management**	(i) ensure compliance with the revised OFM manual, including provisions covering fixed assets. (ii) strengthen the capacity of the internal audit unit to enable it to undertake assets verifications at MOH, CHTs and the hospitals and health facilities level; (iii) maintain up-to-date fixed assets register for MOH vehicles, including vehicles received through donations; (iv) submit copy of fixed assets and reconcile same with GSA records at all times; (v) appoint assets manager consistent with the provisions of Article 10.6.1 of the OFM Manual.
7.	**Internal Audit, Compliance and Risk Management**	i)ensure auditees respond to audit findings and take action as mandated; (ii) conduct regular Audit Committee meetings to discuss matters arising from the audits; (iii) begin subsequent audits by checking that there was auditee response and action on previous audit recommendations; (iv) carry out regular peer reviews of IA; (v) include audit reviews of donor funded projects in work plans; (vi) grant auditors access to GoL's financial management systems; (vii) reinforce the IAA by ensuring regular GoL support for audit functions.
8.	**External Audit**	(i) address the causes of the delays in order to bring MOH's audit up-to-date; and (ii) improve GAC's capacity to enable it to conduct audits in a timely manner.
9.	**Governance**	(i) strengthen the role of HSCC as a strategic decision-making body; and (ii) reinforce the linkages with civil society, both at central and local levels; and (iii) make adequate resources available to MOH's decentralization unit to enable it to provide better services in the counties.

10.	**Donor Mapping and Accounting for Donor Funds**	(i) prioritize the data collection exercise aimed at aligning resource mobilization and NHA with the view to holding institutions accountable for their health financing commitment. This will ensure predictability of donor funding

Annex 2. Republic of Liberia: FY2016/17 Budget Calendar

No.	Activity	Deadline	Lead
1.	Approval of Calendar	11th September	Finance Minister
2.	Approval of Calendar	18th September	Cabinet
3.	Formal Launch of the FY2016/17	25th September	Finance Minister/Department of Budget & Development
4.	Convene Budget Working Group Meeting	Weekly from 29th September	Dept. of Budget & Development Planning
5.	Review of FY2014/15 Budget performance	16th October	Dept. of Budget and Development Planning
6.	Updating Sector Strategies	13th November	Dept. of Budget & Development Planning
7.	MTFF Finalized	13th November	Dept. of Economic Management/Dept. of Fiscal Affairs
8.	Cabinet Meeting and Approval of the Budget Options Paper Reflecting Sector Strategies	27th November	Finance Minister
9.	Budget Call Circular 1-guidance to Spending Entities on preparing strategic plans for budget submissions	7th December	Dept. of Budget and development Planning
10.	Spending Entities prepare Budget Policy Notes in line with guidance in Budget Call Circular 1	8th January	Spending Entities
11.	Cabinet Approval of the first draft of Budget Framework Paper informed by Budget Policy Notes and Sector Strategies	29th January	Finance Minister/Dept. of Budget and Development Planning

12.	Presentation of Budget Framework Paper to Legislature	5th February	Finance Minister/Dept. Of Budget & Development Planning
13.	Executive/Legislative Dialogue	29th February	Finance Minister/Dept. of Budget & Development Planning
14.	Budget Call Circular 2-guidance to Spending Entities on preparing detailed budget submissions	15th February	Dept. of Budget & Development Planning
15.	Spending Entities detailed budgets in line with Budget Call Circular 2	11th March	Spending Entities
16.	Budget Hearing (Executive)	26th March	Finance Minister/Dept. of Budget & Development Planning/National Budget Committee
17.	Draft Budget Book and Budget Framework Paper based on decisions from Budget hearings	21st April	Dept. of Budget & Development Planning/Dept. of Economic Management
18.	Presentation of the Draft Budget Book and BFP to Cabinet and the President	22nd April	Finance Minister/Dept. of Budget & Development Planning
19.	Presentation of Draft Budget Book and the BFP to the Legislature	29th April	Finance Minister/President

Source: Department of Budget and Development Planning, Ministry of Finance and Development Planning, Monrovia, Liberia