

Innovative Financing in Early Recovery: The Liberia Health Sector Pool Fund

Jacob Hughes, Amanda Glassman, and Walter Gwenigale

Abstract

In post-conflict Liberia, the National Health Plan set out a process for transitioning from emergency to sustainability under government leadership. The Liberia Health Sector Pool Fund, which consists of DfID, Irish Aid, UNICEF, and UNHCR, was established to fund this plan and mitigate this transition by increasing institutional capacity, reducing the transaction costs associated with managing multiple donor projects, and fostering the leadership of the Liberian Health Ministry by allocating funds to national priorities. In this paper, we discuss the design of the health pool fund mechanism, assess its functioning, compare the pooled fund to other aid mechanisms used in Liberia, and look into the enabling conditions, opportunities, and challenges of the pool fund.

JEL Codes: F35, H5, I15

Keywords: Liberia, national health plan, aid effectiveness.

**Innovative Financing in Early Recovery:
The Liberia Health Sector Pool Fund**

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CGD is grateful for contributions from the William and Flora Hewlett Foundation and the UK Department for International Development in support of this work.

Jacob Hughes, Amanda Glassman, and Walter Gwenigale. 2012. "Innovative Financing in Early Recovery: The Liberia Health Sector Pool Fund." CGD Working Paper 288. Washington, D.C.: Center for Global Development.
<http://www.cgdev.org/content/publications/detail/1425944>

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Summary

Making the transition from humanitarian relief to the early-recovery phase and ultimately to a more sustainable, country-driven process has been a continuing challenge in development. In recent years, in settings as diverse as Afghanistan, Haiti and Southern Sudan, donors have directly funded NGOs to provide basic services in early-recovery settings, coordinating with—rather than working through—new governments.¹ While this approach is sometimes successful in improving coverage of basic health services, the strategy for an eventual transition to a government-directed health system has been left undefined.²

In post-conflict Liberia, the government-led, interim National Health Plan (NHP) set out a process for transitioning from the humanitarian phase, through recovery, to sustainable development under government leadership. The plan and its leadership attracted a high level of financial support that was overwhelmingly provided by donors directly to international agencies and non-governmental organizations (NGOs). The government, through its Ministry of Health and Social Welfare (MOHSW), requested technical assistance to build its financial management capacity in order to be eligible for the donor support being provided to the NHP.

The aid that the MOHSW received was predominantly earmarked for specific activities and subject to donor procedures, thus reducing allocative flexibility in proportion to the increases in funding. The MOHSW therefore established a multi-donor pool fund that relied upon national systems and procedures for planning, financial management and procurement and that would increase decision-making space according to the priorities of the NHP. Where systemic bottlenecks arose, the pool fund was used to increase institutional capacity that enabled effective budget execution of both pool as well as other sources of funds, including government funds.

The main features of the pool fund include a steering committee, over US\$ 40 million in total contributions from four donors³, use of national procedures to fund priorities from the NHP and technical assistance for fund management that is paid for out of the pool. All proposals for use of the fund originate with the MOHSW and to date 75% of the contributions have been committed to expanding access to basic health services, while the balance was invested in infrastructure, human resources and support systems.

Although the pool fund was a comparatively small proportion of total donor support, it improved the institutional capacity of the MOHSW, especially in the area of financial manage-

¹ USAID and the World Bank have extensively used performance-based contracting of NGOs to deliver basic services in early recover.

² Hughes, J., Glassman, A., Gwenigale, W., *Liberia Health Pool Fund: Transitioning from Emergency Support to Health System Development*, Center for Global Development, 2011.

³ The four pool fund donors are DFID, Irish Aid, UNICEF and UNHCR.

ment, the coordination of donor funding and increased the stewardship of the MOHSW in delivery of health services.

Use of the pool fund contributed to the expansion of the network of public facilities by 24% and to increasing the percentage of facilities providing the MOHSW's Basic Package of Health Services (BPHS) from 36% in 2008 to 82% by the end of 2010.⁴ Over one-third of public health facilities in Liberia are now pool fund-financed through a combination of contracting-in to local government and management contracting using NGOs. While causality cannot be established given data limitations, increased overall accessibility to the BPHS occurred in the context of a major decline in malaria prevalence in children from 66% in 2005 to 32% in 2009 and to a 50% decline in under-5 mortality from wartime estimates.⁵

The purposes of this paper are (1) to document the design of the health pool fund mechanism, (2) to make quantitative and qualitative assessments of its functioning, (3) to apply aid effectiveness criteria and compare the mechanism to other aid mechanisms used in Liberia, and (4) to draw conclusions about the enabling conditions, opportunities, challenges and recommendations for policy makers.

1. Background

1.1 Socio-political context

Founded in 1847, Liberia is the oldest republic in Africa. Between 1847 and 1980, a small minority governed the country by oppressing the large indigenous majority. Over many years that system of minority rule eventually led to the 1980 coup and ultimately to the civil conflict that lasted from 1989 to 2003. According to the United Nations, the conflict cost over 200,000 lives and displaced 1 million of Liberia's 3.5 million people. It resulted in one of the largest recorded economic collapses, emptied the public coffers and drove up the national debt to a staggering 800% of GDP.⁶ All forms of infrastructure were devastated, including the health system, and the social contract between citizens and government was broken.

After free and fair elections, in 2006 Liberia's President Ellen Johnson-Sirleaf became the first woman elected head of state in Africa. The major priorities for Sirleaf's government were established in the four pillars of Liberia's Poverty Reduction Strategy (PRS):⁷

1. Consolidating Peace and Security;
2. Revitalizing the Economy;

⁴ BPHS Accreditation Final Results Report, MOHSW, 2009, 2010 and 2011.

⁵ Malaria Indicator Survey Report. Ministry of Health and Social Welfare, 2009.

⁶ Country Situational Analysis Report, MOHSW, 2011, p. 8.

⁷ Poverty Reduction Strategy, Government of Liberia, 2008.

3. Strengthening Governance and the Rule of Law; and
4. Rehabilitating Infrastructure and Delivering Basic Services.

When the PRS was developed, the government fulfilled its commitment to devote 55% of the national budget to the strategy; however, government resources alone were not enough to fully fund implementation. The national budget for Fiscal Year (FY) 2008–2009 was just US\$ 298 million, with only 7.6% allocated for health.⁸

Development partners applauded the PRS and pledged their support to its implementation.⁹ They also viewed supporting the reform-minded government as critical to maintaining sub-regional stability amidst tensions in Guinea and Ivory Coast and the post-conflict fragility in Sierra Leone.¹⁰ However, weak public financial management, the high level of public debt and limited absorptive capacity constrained the options available to provide the government direct financial support for health.¹¹

1.2 Overview of the health sector transition

The health sector falls under PRS pillar 4 and the priority areas were derived from the 2007 National Health Plan (NHP), including: health service delivery, human resources, infrastructure and support systems.¹² The cornerstone of the NHP was the Basic Package of Health Services, a set of high-impact interventions designed to address the leading causes of morbidity and mortality.¹³ Liberia's PRS target for the health sector, and the only health sector trigger for the Heavily Indebted Poor Country (HIPC) process, was to deliver the BPHS in 70% of functioning government facilities by 2010; the BPHS baseline in 2008 was 36%.¹⁴

At the time the NHP was developed, Liberia had some of the worst health indicators in the world: the maternal mortality ratio was 994 per 100,000; the under-5 mortality rate was 110 deaths per 1,000 live births; and the population's geographic access to health services was estimated at 41%.¹⁵ Malaria was the leading cause of morbidity and mortality, with 66% of children under 5 testing positive for the prevalence of malaria in 2005.¹⁶ Non-governmental organizations (NGOs) managed three-fourths of government-owned health facilities with

⁸ Country Situational Analysis Report, MOHSW, 2011, p. 14.

⁹ Communiqué: Liberia Poverty Reduction Forum, Berlin, 2008.

¹⁰ *The Health Sector and the Transitional Policy and Funding Gap: A Question of Aid Effectiveness*, Annex 6: Liberia Case Study, p. 65. KIT Study for the Health & Fragile States Network, 2008.

¹¹ Taylor, L., 2005. *Absorptive capacity of health systems*. HLSP/DFID Paper.

¹² National Health Policy and Plan, MOHSW, 2007.

¹³ Basic Package of Health Services, MOHSW, 2007.

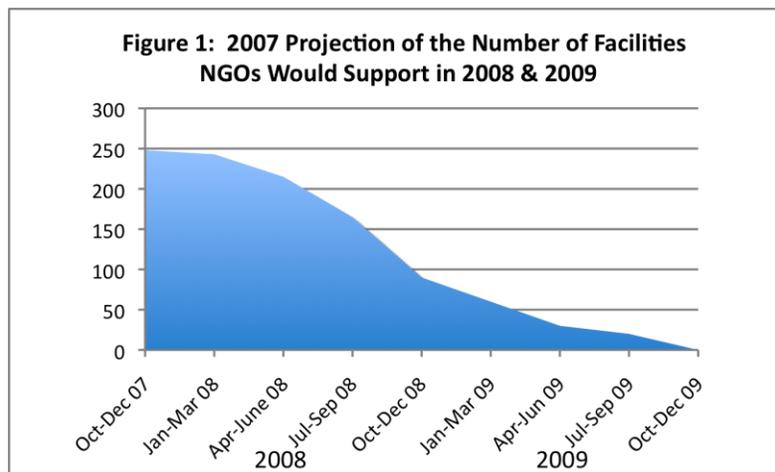
¹⁴ BPHS Accreditation Final Results Report. MOHSW, 2009.

¹⁵ Demographic and Health Survey, Liberia Institute for Statistics and Geo-Information Services, 2007.

¹⁶ Malaria Indicator Survey Report. MOHSW, 2009.

funding from emergency donors, while facilities run by the government lacked staff, drugs and equipment.¹⁷ Services and salaries in NGO-managed facilities were not standardized, contributing to fragmented health services and health worker migration between geographic areas.

Funding for NGO-managed health service delivery was unpredictable and in 2007 most donor support was expected to end by 2009.¹⁸ The government lacked the resources to match reductions in donor support, as discussed above (in section 1.1). With the looming threat of an end to NGO support, not only was continuity of service delivery in jeopardy, so too was completion of the HIPC debt relief process and implementation of the Poverty Reduction Strategy—both critical for national reconstruction and development. Figure 1 depicts the projected reduction in donor support to health facilities through NGOs at the time the NHP was developed.¹⁹



1.3 Aid mechanisms during the transition

Recognizing the potential funding gap between exiting emergency donors and the public budget for health, the Ministry of Health and Social Welfare (MOHSW) appealed to all donors at the 2007 Liberia Partners Forum in Washington, D.C., to continue to support basic services through NGOs: “We don’t want the population to associate peace with lack of services. We need NGOs to continue service delivery” (Walter T. Gwenigale, M.D., Minister of Health and Social Welfare).²⁰ The MOHSW’s appeal precipitated a variety of commitments from donors to support implementation of the NHP. The choice of aid mechanism used by each donor had implications in terms of the level of inherent risk, potential lives saved, the

¹⁷ BPHS Accreditation Final Report. MOHSW, 2009; Country Situational Analysis Report. MOHSW, 2011.

¹⁸ *The Health Sector and the Transitional Policy and Funding Gap: A Question of Aid Effectiveness*, Annex 6: Liberia Case Study, p. 73. KIT Study for the Health & Fragile States Network, 2008.

¹⁹ MOHSW, External Aid Coordination Unit.

²⁰ Liberia Health Sector Partnership Forum Report, Washington D.C., 2007, MOHSW.

impact on the perceived legitimacy of the government and capacity to strengthen national systems. The following is a summary of the funding options that were being considered at the time:²¹

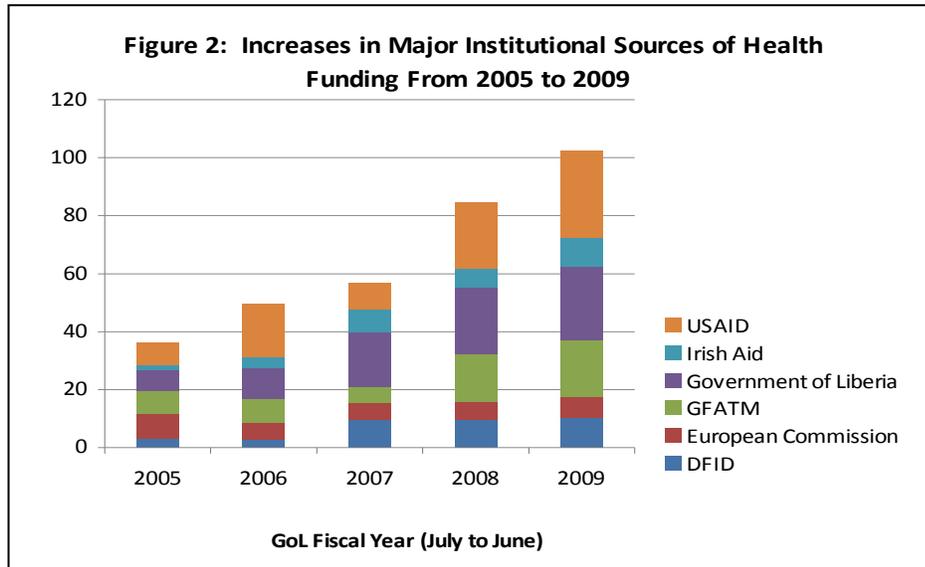
- *Budget support*: funding that is provided directly through the central bank and managed by government in accordance with its own financial systems and procedures.
- *Basket funding*: multi-donor funding that can be used for discrete activities or for national strategies and can be managed independently from or through national systems.
- *Project funding*: funding for discrete interventions typically provided through a special account and managed outside of national systems either by government or by an NGO.
- *Humanitarian funding*: funding tied to discrete, life-saving interventions according to international law and usually through NGO systems.
- *Technical assistance*: A broad range of assistance including the provision of specialist personnel, training and scholarships, grants for research, and associated costs.

The Government of Liberia's preferred way of funding the NHP was through budget support, which has the potential to strengthen national systems and increase the government's allocative decision-making space. Some donors had concerns about government capacity and were inclined to continue under a humanitarian funding mandate rather than to focus on building national systems. In the end, multiple approaches were taken, including extension of humanitarian programs and development of nationwide project approaches, which resulted in avoiding a gap in the availability of health services. No donor agreed to provide budget support for health, but several donors made a commitment to exploring the viability of a basket fund.

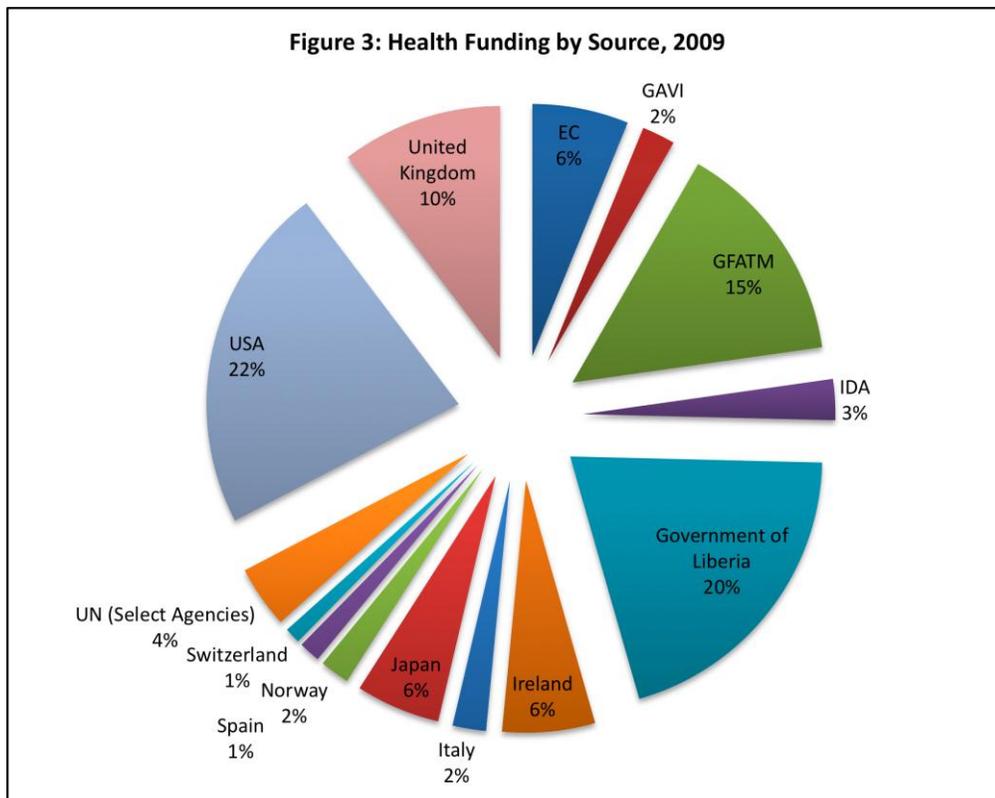
Figure 2 (next page) shows the continuity of major sources of health funding during the transition period from relief to development, as well as the substantial increase that followed the initiation of the 2007 National Health Plan and the MOHSW appeal to partners at the 2007 Liberia Partners Forum. Corresponding to the increased funding, the number of health donors also increased during the period. In 2008, as Figure 3 (next page) shows, the US\$ 60 million of donor funding was comprised of more than 10 health donors.²²

²¹ Leader, N., and Colenso, P., *Aid Instruments in Fragile States*, PRDE Working Paper 5, DFID, 2005.

²² Ministry of Health and Social Welfare, External Aid Coordination Unit.



Multiple donors funded multiple NGOs within a few geographic areas, which resulted in no clear sense of which organization was responsible for providing what services to what population. These arrangements required a huge effort for government to coordinate and align with the NHP. Figure 3 shows the breakdown of health funding by source and the donor fragmentation in 2009 according to partial Organization for Economic Cooperation and Development (OECD - DAC) data.



2. The Health Sector Pool Fund

2.1 Establishment

2.1.1 Role of the Health Sector Coordinating Committee

The establishment of the Health Sector Pool Fund was foreseen in the 2007 National Health Plan (NHP). The NHP envisioned that the pool fund would complement other funding sources, including globally pooled funds, such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (GFATM) and the Global Alliance for Vaccines and Immunization (GAVI), as well as traditional project support for the NHP and the government budget. In order to mobilize and coordinate the different major sources of support for the NHP, the MOHSW established a Health Sector Coordinating Committee (HSCC). The HSCC is chaired by the MOHSW and includes all donors, government and UN agencies active in the health sector.

In accordance with the NHP, the HSCC established a subcommittee in July 2007 to explore the viability of a pool fund.²³ The subcommittee included the WHO, DFID, USAID, EC, UNICEF, an NGO representative and the MOHSW. A technical advisor for improving aid coordination, who was funded DFID at the request of the MOHSW, played a supporting role to the subcommittee and drafting pool fund discussion papers.

The HSCC discussions on the establishment of a pool fund were forward-looking from the outset. UNICEF advised the HSCC that the “structure of the pool fund be light [administratively] and as much like budget support as possible,” while the World Bank cautioned against creating unrealistic expectations because over-reliance on donor funding was “a threat to the sector, obscuring clear planning” and because there was a “need to look at [realistic] medium-term resources and expenditure.”²⁴

After exploring options and with the support of the technical advisor, the subcommittee developed an eight-page proposal for the establishment of a health pool fund, which was later approved by the full HSCC in October 2007. The objectives of the proposed pool fund were threefold:

1. To help finance priority unfunded needs within the NHP;
2. To increase the leadership of the MOHSW in the allocation of resources;
3. And to reduce the transaction costs associated with managing multiple different donor projects.

²³ Health Sector Coordinating Committee Meeting Minutes, July 31, 2007.

²⁴ Health Sector Coordinating Committee Meeting Minutes, October 1, 2007.

The HSCC-approved proposal included arrangements for the design, management and use of potential pool funds, as well as for the control of fiduciary risk, accounting and reporting.²⁵ The role of the HSCC in approving the pool fund was critical to reinforcing MOHSW leadership of the fund as well as to creating sector-wide consensus for its establishment, thereby avoiding perceptions that it was a mechanism being pushed by a single donor.

One key reason why the government approved the pool fund was that both the President of Liberia, Ellen Johnson-Sirleaf, and the Minister of Finance at that time, Antoinette Monsio Sayeh, took a pragmatic view of multi-donor funds, considering them an acceptable alternative to budget support, given that the Public Financial Management Act had not yet been passed by the legislature. The health pool fund was in fact the third of several multi-donor mechanisms established during the period, including the World Bank–managed Liberia Reconstruction Trust Fund and the UNICEF–managed Education Pool Fund.

2.1.2 Initial Donor Participation

When the pool fund proposal was approved by the HSCC, ironically there were no donors publicly prepared to contribute to the fund. Although the conflict in Liberia ended in 2003, most donors were still operating in a humanitarian mode; participating in a pool fund was perceived as a development approach outside the scope of their existing mandate.

USAID continued to work through its Office of Foreign Disaster Assistance until contracts under its development project, Rebuilding Basic Health Services, were awarded in 2009. The European Commission’s Humanitarian Office continued with a humanitarian model until the end of 2010. Although the World Bank was active in discussing the viability of the pool fund, the Bank’s 2007 Health System Reconstruction Project funding had only just been approved by its board of directors and its funding was earmarked for specific project activities; therefore, the World Bank is not a contributing donor to the health pool fund. Similarly, the GFATM funding in Liberia, managed by the United Nation’s Development Program (UNDP), was also earmarked for specific project activities tied to discrete outputs, subject to specific financial reporting and therefore was not channeled through the pool fund.

The pool fund remained a proposal until a management mechanism was put in place and DFID had contributed an initial US\$ 8 million in March 2008²⁶, more than 5 months after the proposal was endorsed by the HSCC. Technically, it did not become a true ‘pool’ of funds until Irish Aid contributed an additional US\$ 3 million in December 2008, 14 months after HSCC endorsement.²⁷ Thereafter, UNICEF became the third contributing donor in January 2009, followed by UNHCR in May 2009. Since 2009, while individual donor contri-

²⁵ *Proposal for the Establishment of a Pool Fund*. Health Sector Coordinating Committee Working Group on Funding Mechanisms, October 2007.

²⁶ The Government of Liberia fiscal year (FY) is from July through June each year. Therefore, the pool fund was established in FY 2007.

²⁷ First Annual Report of the Health Sector Pool Fund, MOHSW, 2009.

butions have been renewed, no new donors have as of yet joined the pool fund, although the Government of France is scheduled to begin contributing to the pool fund by late 2011.

The European Union position on multi-donor mechanisms has recently changed in favor of budget support. Ironically, as they have deemed that budget support for health is not infeasible at this time in Liberia, their aversion to a multilateral approach has driven the EU to adopt a project approach and fund NGOs directly under the 10th European Development Fund mechanism. World Bank funding for health expires in 2011. However, the MOHSW has requested to the World Bank that, if future funds become available for health, they be channeled through the pool fund. USAID is the only new donor committed using national systems and procedures in the future, although not through the pool fund mechanism, as will be described in section 4.1.

2.2 Design of the mechanism

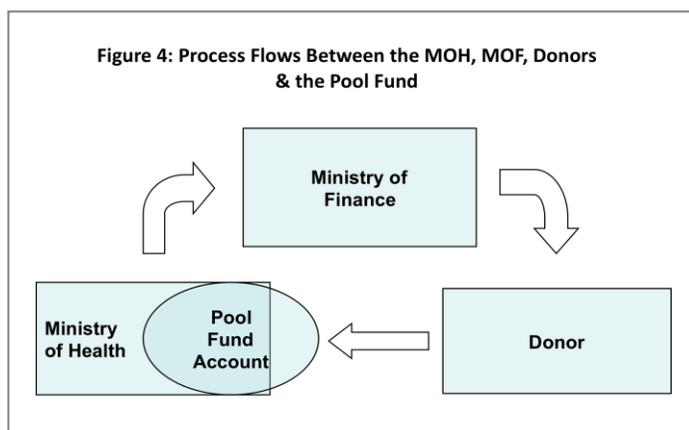
2.2.1 Distinction between a pool and a trust fund

There is often confusion about the distinction between a multi-donor trust fund and a multi-donor pool fund. With the exception of global multi-donor funds, both trust and pool funds are usually country-specific and often have similar features, such as an oversight committee and a mandate for joint programming among contributors. The main distinguishing characteristic between the two is that trust funds are ‘entrusted’ to an independent administrator, usually the World Bank or UNDP, who charges a fee for administering the fund. Trust fund administrators generally rely upon their own systems and procedures for procurement, monitoring and financial management. With pooled funds, the emphasis is on joint programming, and actual fund administration can be positioned closer to or further away from government structures, depending upon the context.”²⁸

2.2.2 Characteristics of the Health Sector Pool Fund

The distinguishing characteristic of the health pool fund was that it was positioned within government in a context of very nascent government capacity. When the pool fund was established in March 2008, Liberia had not yet passed its 2009 Public Financial Management (PFM) Act, and the first post-conflict Public Expenditure Financial Accountability (PEFA) assessment report was not completed until June 2009. The fund was positioned within the MOHSW because an underlying purpose of the fund was to increase government stewardship and capacity rather than solely the mobilization of funds. However, in the absence of the PFM Act and PEFA report, this was considered a high-risk approach, instead of the fund being safely administered from the World Bank or UNDP country office. After establishing a fund management mechanism to mitigate risk, the MOHSW opened a dual-signatory account with a commercial bank, Ecobank Liberia, in which to receive contributions. While the MOHSW owns the commercial account, the Ministry of Finance (MOF)

²⁸ Leader, N., and Colenso, P., *Aid Instruments in Fragile States*, PRDE Working Paper 5, DFID, 2005.



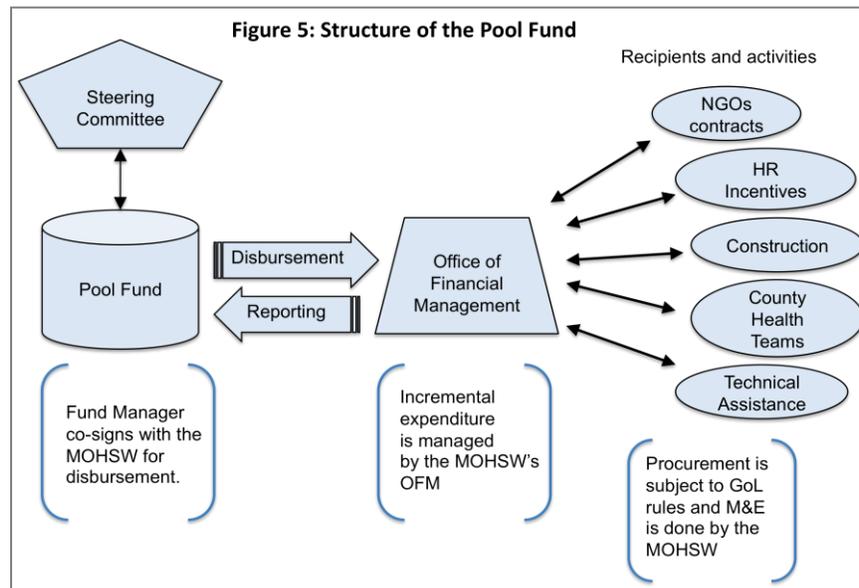
must make requests for funds to contributing donors. In this way, while the MOF is not directly managing the funds, it is fully aware of and exercises control over the flow of funds to government. Figure 4 depicts the process flow between the MOHSW, the MOF and donors.

Each contributing donor has entered into a Joint Financing Arrangement (JFA) with the MOHSW, which governs the use of the funds, the review of fund performance, reporting, and audit provisions. Contributing donors are represented on a Pool Fund Steering Committee (PFSC), which ensures adherence to the JFA.²⁹

Membership of the PFSC is open to any donor who has entered into the JFA and to a group of other representatives, including the WHO, World Bank, the European Union and USAID. The committee also has five permanent members from the Government of Liberia, including representation from the ministries of finance and planning. The Minister of Health and Social Welfare serves as chair and one lead donor serves a co-chair on an annual, rotating basis.

Disbursements from the pool fund are based on a dual-signatory arrangement between the MOHSW and an accounting firm providing technical assistance to the OFM; the accounting firm is known as the Pool Fund Manager. Figure 5 shows the structure of the pool fund, including the steering committee, the fund manager, MOHSW's Office of Financial Management (OFM), and fund sub-recipients.

²⁹ Health Sector Pool Fund Procedures Manual, MOHSW, 2009.



The Pool Fund Manager has two main areas of activity: (1) management of the pool fund mechanism, which includes support to the steering committee as well as support to the MOHSW in development and implementation of proposals; and (2) management and control of fiduciary risk, which includes supporting the MOHSW's OFM in financial management and reporting, as well as monitoring expenditure. Initially, this technical assistance was provided by DFID, but since 2010 the technical assistance is funded by the pool fund itself. The MOHSW's Office of Financial Management makes all pool fund payments to suppliers and service providers.

2.3 Use of country systems

All pool fund expenditures are subject to the regulations established by the 2005 Public Procurement and Concessions Commission Act and the Ministry of Health and Social Welfare's Payment Policy Guidelines. In line with the 2005 Paris Declaration on Aid Effectiveness, the pool fund is positioned within government and relies entirely on national systems for use of the fund, including procedures for procurement, financial management, audit, monitoring and evaluation.³⁰ This was a condition required by the Minister of Finance prior to establishment of the fund. Although the government has not yet initiated multi-year sector budgeting, pool funds are separately identified in both MOHSW's annual report made to the Legislature as well as in the MOHSW's annual financial statements. The pool fund is audited by the General Auditing Commission and included in the Auditor General's Report for the Ministry of Health and Social Welfare, thus reinforcing the government's internal controls and accountability structures. In addition, the JFA includes provision for an annual, independent audit commissioned by the steering committee.

³⁰ <http://www.oecd.org/dac/effectiveness>

When the independent auditor’s report highlighted insufficient monitoring and evaluation of pool fund activities in 2009, pool fund resources were allocated to strengthening the MOHSW’s Monitoring and Evaluation Unit, including exceptional salaries, training, office operations, and logistics costs.³¹ This support increased the capacity of the MOHSW to monitor the use of pool funds, as well as to monitor NHP activities funded by other sources (government and donor). Similarly, other technical units within the MOHSW have also been allocated pool fund resources for the purpose of increasing their capacity to function effectively, including the Office of Financial Management, the Infrastructure Unit, the External Aid Coordination Unit and the Health Services Department. These systemic investments (under the NHP support systems component) not only strengthen systems but also enable their increased use by donors and increased capacity for budget-execution of government funds.

2.4 Conditionality and selection of priorities

All allocations from the pool fund are based on proposals initiated by the MOHSW for discussion and agreement by the steering committee, in accordance with the JFA.³² Funding priorities follow the core components of the National Health Plan that also serve to meet health deliverables from Liberia’s PRS, including: (1) the Basic Package of Health Services (BPHS)³³, (2) human resources, (3) infrastructure, and (4) support systems. The MOHSW’s internal management team, the Program Coordination Team, determines which unfunded NHP priorities will be proposed for pool funds. Figure 6 depicts the process for determining priorities.

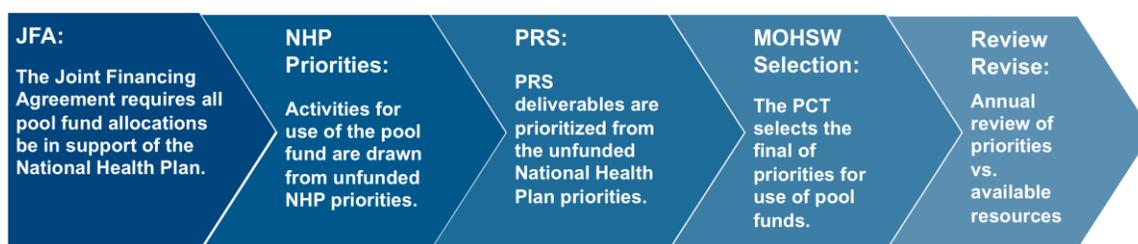


Figure 6: Process for Determining Use of the Health Sector Pool Fund

Although all allocations are based on proposals from the MOHSW, the ministry has successfully used partnership to leverage the capacity of NGOs in managing service delivery. In line with the NHP, the MOHSW developed a contracting policy in 2008 that allows for contract-

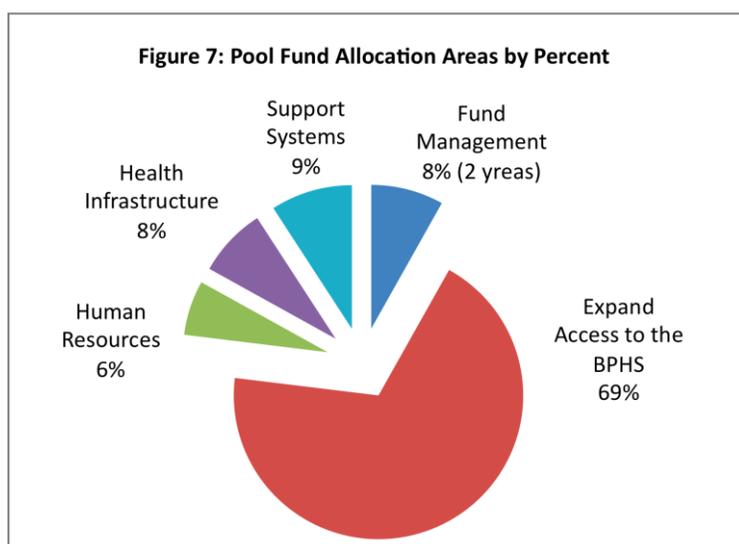
³¹ *Audit of the Health Sector Pool Fund for the Period March 15, 2008 to June 30, 2009*, Ernst & Young, 2009, p. 51.

³² Health Sector Pool Fund Procedures Manual, MOHSW, 2009.

³³ The BPHS includes services provided at the primary and secondary (hospital) facility levels.

ing NGOs and county health teams to deliver the BPHS.³⁴ Award of contracts to NGOs is untied and follows a public procurement process to ensure fairness and value for money.

Figure 7 presents pool fund priority areas as a percentage of total pool fund allocations for the main components of the NHP. The proportion of pool funds allocated for technical assistance to the MOHSW's Office of Financial Management is shown as the Pool Fund Management costs for a two-year period. The high proportion of funds for service delivery versus support systems reflects the diminishing donor support for service delivery indicated in section 1.2 and indicates an implicit tension between increasing sustainability by investing in system strengthening and fulfilling immediate service delivery needs.



2.5 Fiduciary risk management

Positioning a multi-donor fund close to government in the context of a weak public financial management framework exposes the fund to a high degree of fiduciary risk. Broadly speaking, fiduciary risk is the risk (1) that resources will not be properly accounted for, (2) that resources will not be used for the intended purposes, and (3) that the expenditure does not represent value for money.³⁵ The need for robust fiduciary risk management was identified in the pool fund proposal and incorporated into the design of the pool fund mechanism. This was a key factor in the viability of locating the pool fund within government in a high-risk context. The following are the main ways in which the pool fund addresses each area of fiduciary risk:

³⁴ National Policy on Contracting Health Services, MOHSW, 2008.

³⁵ *Managing Fiduciary Risk When Providing Direct Budget Support*, DFID, 2002.

1. *Proper accounting:* As a component of the technical assistance provided to the Office of Financial Management, the Pool Fund Manager is responsible for ensuring that pool funds are properly accounted for, including effective budgeting, expenditure management and reporting. The PFSC monitors fund manager-performance and receives an annual external auditor's report on pool fund accounting and management.
2. *Intended purpose:* The JFA between contributing donors and the MOHSW includes carrying out an annual external audit of the pool fund, of fund management and of the use of pool fund resources to ensure they are used for their intended purpose. The Government of Liberia's General Auditing Commission plays a part in determining the terms of reference for the annual independent audit, thereby increasing country ownership of the independent audit findings (see also section 2.3).
3. *Value for money:* Achieving value for money occurs at all levels, from ensuring that quality health services and health commodities are provided at health facilities to ensuring that the necessary services are being efficiently provided with attention to equity. It is the role of the steering committee to ensure that the pool fund attains value for money by overseeing the effective mitigation of risks 1 and 2, as well as by making sure that the pool funds serve to support the effective implementation of the NHP.

All pool fund allocation proposals are required to be accompanied by a fiduciary risk management note to ensure that the risks associated with the proposed allocation have been identified and a strategy is in place to mitigate the risks. The Good Practice Principles for budget support were applied to the pool fund to establish benchmarks for a Fiduciary Risk Assessment Review.³⁶ The steering committee monitors an Annual Statement of Progress on the fiduciary risk review report, and the fund manager produces the Fiduciary Risk Assessment Review and the Annual Statement of Progress.

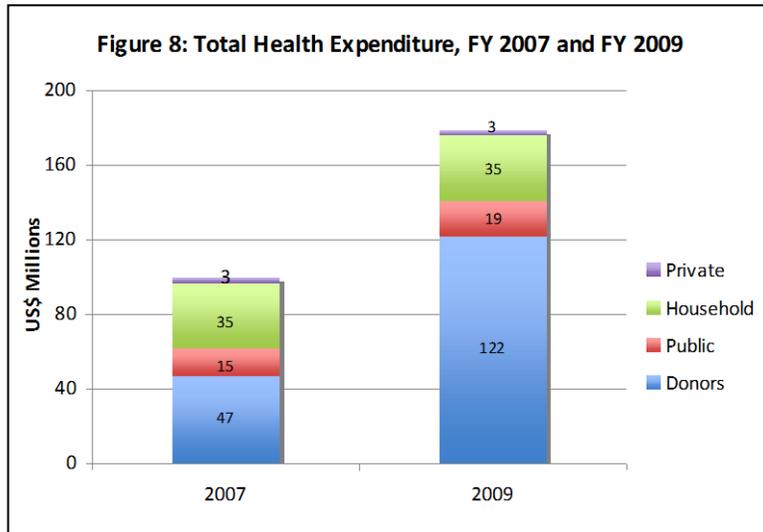
3. Quantitative assessment

3.1 Proportion of total health expenditure (THE)

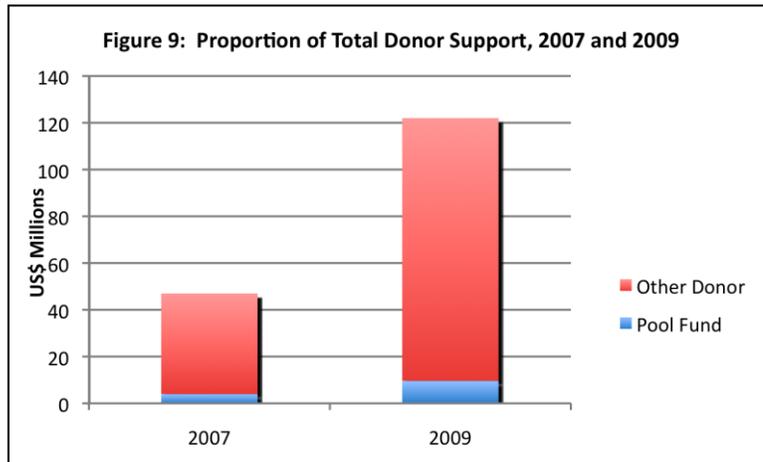
According to National Health Accounts (NHA) data, Total Health Expenditure (THE) in FY 2007 was US\$ 100.5 million.³⁷ Preliminary 2009 NHA data indicates that THE increased to US\$ 179 million, an increase of 78% in just 2 years. This corresponds with the launch of the 2007 NHP and appeal for support described in section 1.3 and the international popularity of the Sirleaf government. As Figure 8 (next page) indicates, donor funds were the largest source of funds for health, constituting almost 50% of THE in 2007 and over 65% in 2009.

³⁶ *Fiduciary Risk Review of the Health Sector Pool Fund*, PricewaterhouseCoopers Africa Ltd., 2008.

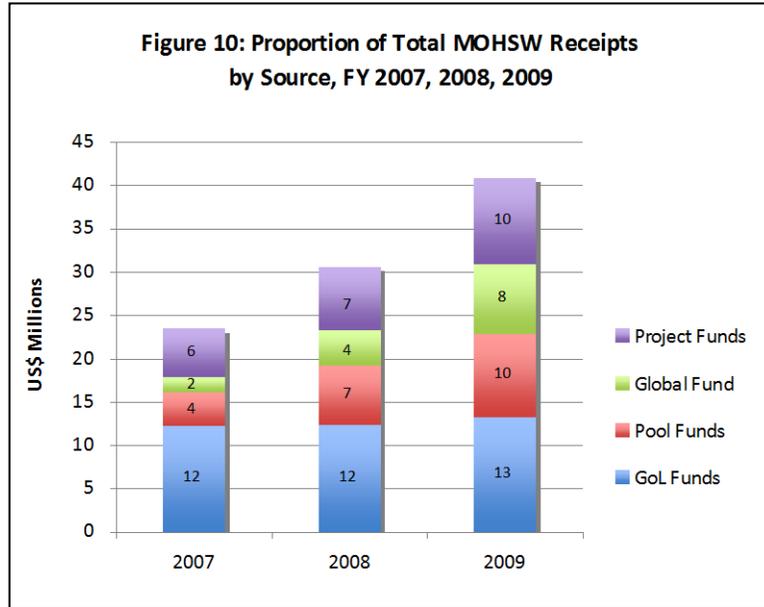
³⁷ National Health Accounts, MOHSW, 2009 (for FY 2007–2008)



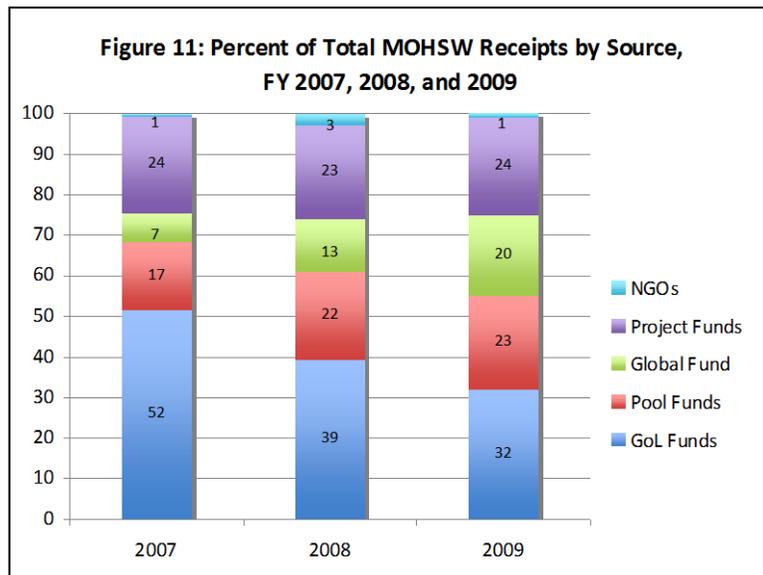
At the close of FY 2010, total of all commitments made to the Health Sector Pool Fund exceeded US\$ 40 million and the total amount of contributions received was US\$ 24 million. Funds are drawn down from donor contributions on an annual basis, according to bilateral agreements, to cover planned expenditures consistent with the NHP. On average, the pool fund has been used to channel about 10% of total donor support for health. Figure 9 presents the proportion of donor funds channeled through the pool in fiscal years 2007 and 2009. During the same period, 66% of all donor funds were channeled directly to NGOs. The balance of donor funds was either spent on technical assistance or channeled through the MOHSW as earmarked project funds.



Corresponding with the pool fund investments made to strengthen support systems described in sections 2.3 and 2.4, figure 10 shows the volume of funds managed by the MOHSW increased by almost 80% between FY 2007 and FY 2009.³⁸



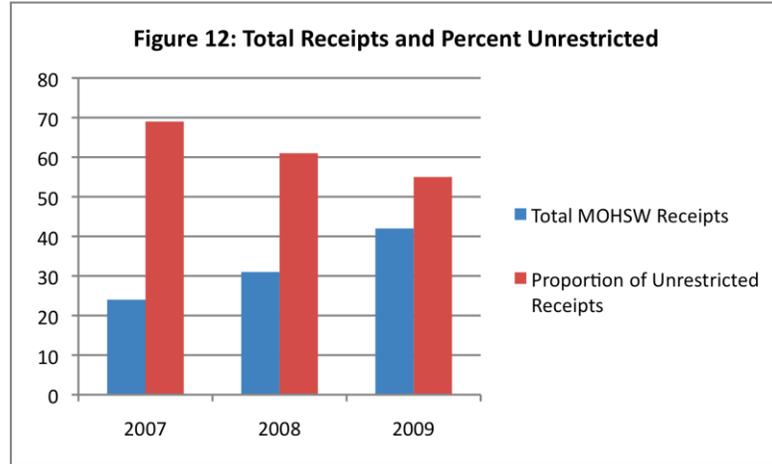
While Figure 10 shows the increasing volume of funds managed by the MOHSW between FY 2007 and FY 2009, Figure 11 presents each source of funds as a percentage of the total funds managed. Of particular importance is the increasing proportion of earmarked funds



³⁸ Liberia Institutional Health Spending FY 2009, Key Findings and Implications. Ministry of Health and Social Welfare / Health Systems 20/20, 2011. Financial Statements for the year ended June 30, 2007, 2008 and 2009, MOHSW.

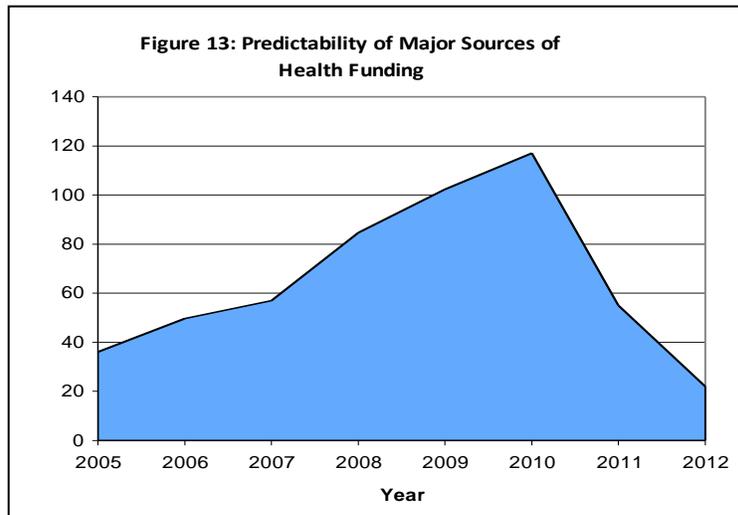
(NGO, Global Funds and other Project Funds) managed by the MOHSW and the decreasing combined proportion of unrestricted (pool and government) funds.

Figure 12 shows these contrasting trends of increasing funds managed by the MOHSW and diminishing fund flexibility, or diminishing decision-making space. Thus, the MOHSW increasingly took on the role of implementer of project-based funding, such as the World Bank funded Health System Reconstruction Project, moving away from its mandate to develop policy and standards and mobilize resources for county-provided services.



3.2 Predictability of donor funding

Figure 13 reinforces problem of shortsighted decision-making by showing 2010 health-funding commitments (donor and government) and the dramatic reduction in known commitments for subsequent years.³⁹ Given the long period of time inherent to public procure-



³⁹ Source: Ministry of Health and Social Welfare, External Aid Coordination Unit, 2011.

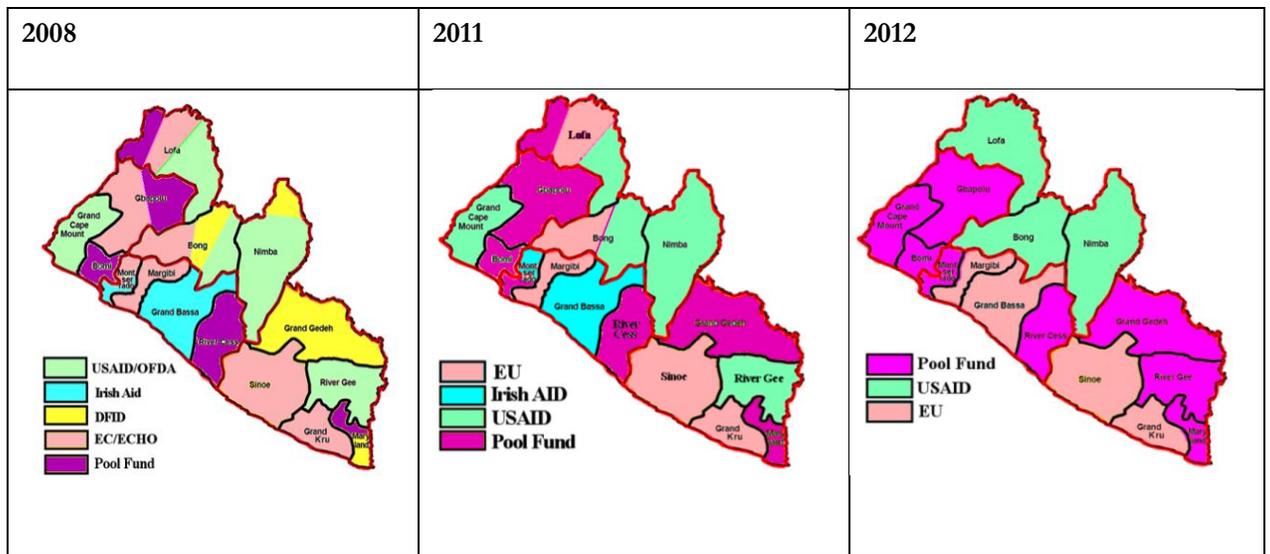
ment, contract awards for health service delivery in this context must be kept short and regularly repeated, constituting a significant transaction cost for government. Until donors and government increase the duration of their commitments through multi-year budgeting, low predictability funding will continue to undermine the health planning.

4. Qualitative assessment

4.1 Harmonization / coordination of aid

As a mechanism that reduced the fragmentation of funding for the National Health Plan, by consolidating the financial support from four donors and linking directly to the National Health Plan (see section 2.1), the pool fund has contributed to improved harmonization and alignment of donor support to health. Figure 14 shows the progressive improvement in coordination of donor support for delivery of the BPHS between 2009 and 2012. As the number of donors funding through the pool fund has increased, the number of different donors funding delivery of the BPHS through parallel mechanisms has decreased. Coordination improvements materialized both in terms of defragmentation of donor funding through the pool fund itself as well as by a reduced number of NGOs funded per county, resulting in less effort required by the County Health Teams (CHT) to manage and coordinate partners.

Figure 14: Geographic Coordination by County of Major Donor Funding 2008 to 2012



However, the reduced fragmentation of aid has not been without a transaction cost for the MOHSW. The Pool Fund Steering Committee makeup is almost identical to that of the Health Sector Coordinating Committee, the GFATM’s County Coordinating Mechanism and GAVI’s Inter-Agency Coordinating Committee for Vaccination. The different donor oversight committee meetings are held separately and according to different procedures. Thus, scarce MOHSW capacity, time and resources are allocated to maintaining separate gov-

ernance mechanisms for each of many major sources of funding, including the pool fund, resulting in duplication of planning functions and impeding overall sector efficiency.

Moreover, improved geographic donor coordination has not necessarily resulted in more equitable distribution of aid. Donors do not fund service delivery according to a universally agreed formula; therefore, resources are inequitably distributed among counties. For example, the USAID health project, Rebuilding Basic Health Services, included a capacity-building component (including training and logistical support) for CHTs, but only in counties where USAID was funding service delivery. Conversely, the EU humanitarian funding (ECHO) was explicitly prohibited from being used for non-humanitarian purposes and no significant amount of resources was programmed for CHT capacity building. Other examples of variable inputs that have an impact on equitable distribution of resources include facility renovation, facility staffs training and the allowable NGO administrative overheads, which affect efficiency and management quality.

The MOHSW took a different approach in one county and used the pool fund to fully fund the Bomi CHT to deliver countywide health services, as opposed to channeling restricted donor project support to Bomi County through NGOs. Bomi CHT received a US\$ 2.1 million pool-funded contract from the MOHSW, which at the time was considered by some as a high-risk pilot attempt at intra-government contracting of basic services. Unexpectedly, the result was that Bomi County scored the highest of all 15 counties in the 2011 BPHS accreditation survey.⁴⁰ Bomi CHT achieved an average facility score of 96% for the 20 government health facilities (19 clinics and one hospital), 12% above the national average, thus demonstrating that flexible funding and increased decision-making ability can have a major impact on results.⁴¹

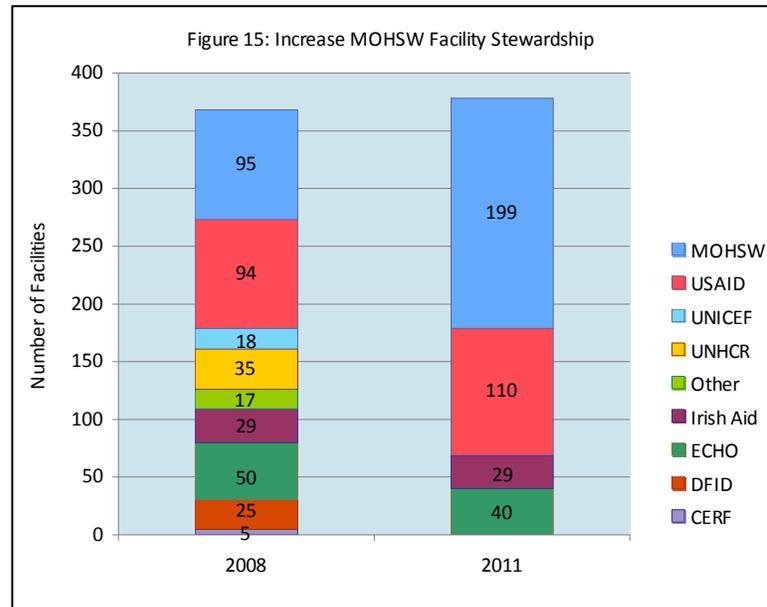
In addition to the 20 health facilities in Bomi County funded with pool funds, 100 additional health facilities are also funded with the pool fund in other counties through contracts between the MOHSW and NGOs, bringing the total to 120 out of 378 functioning government health facilities. Both the Bomi CHT and NGO-funded contracts are in principle performance-based, but in reality the MOHSW has not implemented the performance component of those contracts due to institutional capacity constraints. This is an area the MOHSW intends to strengthen in FY 2011–2012 and beyond. Nationwide, the 120 health facilities supported with pool funds had an average BPHS accreditation score of 88%, consistent with facilities supported by the EU and USAID.⁴²

As Figure 15 (next page) shows, the number of facilities whose primary source of support for service delivery was provided by the MOHSW (either directly or through contracted NGOs) increased from 95 in 2008 to 199 in 2011. As stated above, 120 of these 199 facilities

⁴⁰ BPHS Accreditation Final Results Report. Ministry of Health and Social Welfare, 2011.

⁴¹ The accreditation survey assesses facilities against criteria in 9 core areas, including: human resources, drugs and supplies, equipment, diagnostics, medical records and service delivery.

⁴² BPHS Accreditation Final Results Report, MOHSW, 2011.



are funded by the MOHSW using the pool fund, either by contracting NGOs (100) or by funding the Bomi CHT (20).

This has several important implications: the Government of Liberia is increasingly seen by its citizens as providing basic services (especially important after the long civil conflict); expenditures by the MOHSW for reliable service delivery is an attractive candidate for increased funding and potential sector budget support; increased stewardship of service delivery funds has been accompanied by increased opportunity for the MOHSW to expand CHT contracting, which reinforces decentralization (or de-concentration) in accordance with the NHP. Ultimately, the number of MOHSW-supported facilities is scheduled to increase from 95 in 2008 to 309 of 378 by the end FY 2011, by which time all USAID funds designated for performance-based financing of NGOs will be channeled directly through the MOHSW.

4.2 The USAID FARA Approach

In September 2011, USAID and the Government of Liberia (GOL) signed a Fixed Amount Reimbursement Agreement (FARA) for up to \$42 million in financial support for implementation of Liberia’s National Health Plan between September 2011 and June 2015. According to the agreement, “a FARA is a U.S. Government assistance mechanism whereby the host government implementing agency is reimbursed a fixed amount for the successful completion of specified activities or outputs with previously agreed upon specifications or standards.”⁴³ In the agreement, USAID will reimburse the MOHSW for the cost of implementing specific activities from the National Health Plan, namely performance-based contracting of

⁴³ “Fixed Amount Reimbursement Agreement. 669-FARA-A11-11-01: Support to the Ministry of Health and Social Welfare (MOHSW) for implementation of Liberia’s 2011-2021 National Health and Social Welfare Plan and Policy.”

NGOs for health service delivery as well as certain health system strengthening activities such as monitoring and evaluation.

Reimbursement to the MOHSW is based on pre-determined amounts, irrespective of actual cost, and is contingent upon USAID verification and approval of each agreed deliverable. USAID has the right to withhold reimbursement until it verifies that each deliverable has been produced as per the verification criteria, but commits to thereafter completing the reimbursement within 45 days. The MOHSW agrees to keep USAID apprised of implementation progress through quarterly reports as well as to manage and monitor FARA supported activities. USAID source-origin policies for procurement of goods and services are waived in the agreement and all goods from the “Free World” are considered eligible (restricted countries include Cuba, Iran, North Korea and Syria). A limited number of additional terms and conditions are included such as pre-approval for drug procurement and requests for proposals (RFPs) that will exceed \$1.5 million in value, based upon recommendations made during a 2010 USAID Office of Acquisition and Assistance Procurement System Assessment of the MOHSW. However, USAID accepts that reimbursable expenditure will be based on the MOHSW’s systems for planning, procurement and financial management.

The FARA replaces the previous arrangement whereby USAID funds for service delivery were provided through a cooperative agreement with the U.S.-based company, John Snow Incorporated. This change in approach reflects the USAID FORWARD Objective 1. Implementation and Procurement Reform, which commits USAID to “Strengthen[ing] partner country capacity to improve aid effectiveness and sustainability by increasing use of reliable partner country systems and institutions to provide support to partner countries.”⁴⁴

The MOHSW had originally proposed that USAID make the FARA reimbursement payments into the Health Sector Pool Fund mechanism, which would have increased the harmonization of aid and increased USAID’s multilateral collaboration (reflecting USAID FORWARD Objective 6). However, other donors to the pool fund felt that “. . .the concept was based on the premise that other donors underwrote USAID’s risk. Donors will find it difficult to advance money from the pool fund.”⁴⁵ Unfortunately, the Government of Liberia had not yet published its 2011 National Budget at the time the pool fund steering committee discussed linking the pool fund to the FARA agreement. In the 2011 National Budget (passed by the legislature in September 2011), the GOL set aside \$6 million to pre-finance the FARA-funded activities. This budget allocation eliminates the need for other donors to underwrite USAID’s risk.

The decision taken by the Pool Fund Steering Committee resulted in missing rare opportunity for both the Government of Liberia and USAID to participate in a pool fund; ironically, it resulted in a USAID using a more progressive approach. Instead of the pool fund, FARA reimbursements will be made directly into the Central Bank of the Republic of Liberia, effec-

⁴⁴ See <http://forward.usaid.gov/node/317>

⁴⁵ “Pool Fund Steering Committee Meeting Minutes, July 22, 2011.”

tively resulting in USAID providing earmarked sector budget support in advance of any other donor.

4.3 Accountability and transparency

The policy framework for accountability and transparency in which the pool fund is situated is based on the National Health and Social Welfare Policy. The national policy states that “Adequate political, financial and administrative mechanisms are needed from the Government and all stakeholders to ensure that decision-makers are accountable for the transparent use of health and social welfare resources . . . enabling the public to understand how decisions are taken, how resources are allocated and how results are achieved.”⁴⁶ The MOHSW’s principal strategy to ensure accountability and transparency has been through maximizing public participation in the health policy and plan development process. The National Health Plan is a ‘bottom-up’ plan that is based on compilation of 15 county plans developed in a participatory manner by community members and local authorities.⁴⁷

The MOHSW has sought maximum accountability for service delivery and use of resources, as evidenced by the substantial increase in stewardship for service delivery described in section 4.1. Section 2.5 addresses the fiduciary risk management and built-in pool-funded audit requirements necessary to determine whether funds were used for their intended purpose and according to the 2009 Public Financial Management Act. Steering committee representation is inclusive of national and international NGO observers, representation from the private sector (the Liberian Business Association) as well as non-contributing donors who are active in the health sector to ensure close coordination and minimize potential duplication. Finally, for transparency, all pool fund administrative and progress reports, independent audits and steering committee minutes are public information intended to be posted on the MOHSW’s website, according to the pool fund procedures manual.⁴⁸

4.4 Results achieved

To date, the progress in implementing the NHP has not been disaggregated by source of funds. Nevertheless, some positive results in addition to increased donor harmonization and alignment with MOHSW priorities are attributable to the pool fund, including:

- *Increased capacity of national systems:* The pool fund is the main non-GOL source of financial assistance supporting the MOHSW’s Office of Financial Management (OFM), financing the majority of hardware and software investments. The annual volume of funds managed by the MOHSW’s OFM has increased by 80% since the

⁴⁶ National Health and Social Welfare Policy and Plan, 2011–2021, MOHSW, 2011, p. 13.

⁴⁷ National Health and Social Welfare Policy and Plan, 2011–2021. MOHSW, 2011, p. 43.

⁴⁸ Health Sector Pool Fund Procedures Manual (Revised). MOHSW, 2009. [http://: www.moh.gov.lr](http://www.moh.gov.lr)

establishment of the pool fund in FY 2007 to over US\$ 40 million in FY 2009–2010, accompanied by corresponding increases in reporting and audit requirements.

- *Improved coordination of donor funding:* The number of counties with one main source of donor funding for service delivery has increased from 8 in 2008 to 11 currently, while by the end of FY 2011 the number will increase to 14 out of 15 counties.
- *Increased stewardship of service delivery:* The number of health facilities where the principal source of funding for service delivery is provided by the MOHSW has increased from 95 in 2008 to 199 currently (see Figure 15). This will increase to 309 out of 378 facilities by the end FY 2011.

More general results to which the pool fund contributed include expansion of the public network of facilities by 24% (from 306 in 2006 to 378 in 2011) and to increasing the percent of facilities providing the BPHS from 36% to 82% in just two years. Expansion of the facility network and increased accessibility to the BPHS could have contributed to reducing malaria prevalence in children from 66% to 32% in four years and to a 50% decline in under-5 mortality from wartime estimates.

One area where the pool fund did not achieve the desired results was in attracting some of the major-donor funding for health. In addition to the missed opportunity for USAID to participate in a pool fund described in section 4.2, the European Union's 10th European Development Fund (EDF) also did not use the pool fund. The 10th EDF set aside 30 million Euros for the health sector from 2009 to 2013. However, the EU chose a project-based approach instead of contributing to the pool fund because of a Brussels policy shift away from using multi-donor mechanisms. The Global Fund for HIV, TB and Malaria (GFATM) funding was also provided to the MOHSW outside of the pool fund because of the GFATM requirement to link its funds directly to Global Fund-financed expenditure and outputs, whereas pool fund expenditure is not attributed to individual donor contributions and expenditures and outputs are reported jointly. Finally, the World Bank Health System Reconstruction Project (HSRP) funding did not use the pool fund because the HSRP project approach was conceptualized and approved by the World Bank board prior to the establishment of the pool fund.

5. Comparison of aid mechanisms

5.1 Intra-sector

Of the aid mechanisms described in section 1.3 (budget support, multi-donor, project, humanitarian and technical assistance), neither sector nor general budget support is being provided for health in Liberia. Humanitarian funding has been phased out as of the start of FY 2011 (with the exception of recent humanitarian funding for refugees from the Ivory Coast along to border) and technical assistance values are not available. However, the table below

presents the main donor aid mechanisms being used in the health sector, whether it uses country systems (financial management, procurement, M&E), the participating donors, the estimated annual expenditure and the proportion of THE.

Table 1: Main Aid Mechanisms in the Health Sector, 2011

Aid Mechanism	Pool Fund	Project Funding	Disease-Specific Project Funding
Main Features	Uses country systems	Uses donor systems	Uses parallel systems
Participating Donors	DFID, Irish Aid, UNICEF, UNHCR ⁴⁹	USAID, EU	GAVI, GFATM, PMI
Annual Expenditure	US\$ 10 million	US\$ 18 million	US\$ 35 million
Proportion of THE	6%	11%	20%

As Table 1 indicates, disease-specific project funding is the most widely used aid mechanism, representing 20% of THE. This type of project funding is entirely earmarked for specific activities, commodities and targets that generally require separate systems (financial, reporting and M&E) to verify outputs. Pool funding is the least commonly used of these three mechanisms, representing just 1/16 of THE. It is noteworthy that the least commonly used mechanism is credited with enabling significant increases in institutional capacity, government stewardship and donor coordination.

5.2 Principles of Aid Effectiveness

Although the 2009 survey data is not complete, according to Organization for Economic Cooperation and Development (OECD - DAC) data, Liberia receives more untied health funding than many other countries. However, while the number of donors supporting health has increased, the average amount of donor support decreased, indicating a donor environment of continued proliferation and fragmentation. The OECD – DAC Paris Declaration for improving aid effectiveness includes these core principles:⁵⁰

⁴⁹ The Government of France has signed an agreement to begin contributing to the pool fund in late 2011.

⁵⁰ The Paris Declaration on Aid Effectiveness (2005).
<http://www.oecd.org/dataoecd/30/63/43911948.pdf>

- i. *Ownership*: Countries should establish and implement their own national strategies
- ii. *Alignment*: Donors should align behind country priorities and strategies.
- iii. *Harmonization*: Donors should better coordinate among themselves.
- iv. *Results*: Donors and recipients should shift focus to achieving measurable results.
- v. *Mutual accountability*: Donors and recipient both accountable for the results attained.

Table 2 describes the characteristics of each aid mechanism used in the health sector, as well as other multi-donor mechanisms used in the education and public works sectors, according to the core Paris principles.⁵¹

While the characteristics of each mechanism are not identical, given the low baselines, most aid mechanisms have achieved some degree of success according to their respective intended purpose. The BPHS project mechanisms, such as USAID's RBHS project, have likely contributed to achieving nationwide coverage targets for provision of the BPHS. Disease-specific funding, such as that for malaria, likely contributed to the achievement of output-based targets such as bednet coverage and potentially to a reduction in malaria prevalence. The pool fund mechanisms for health and education strengthen country ownership by requiring contributions to be spent on the national plans, harmonization by improving donor coordination and alignment by using country systems. The World Bank-managed Infrastructure Trust Fund, established in 2008, achieves some aspects of its intended purposes, namely increasing harmonization and it has raised US\$ 170 million in commitments. However, as the infrastructure fund is administered outside of government system, it does not serve to increase recipient accountability or strengthen national systems.

⁵¹ The World Bank administers the Liberia Reconstruction Trust Fund and UNICEF administers the Education Pool Fund.

Table 2: Applying the Paris Declaration Principles to Aid Mechanisms in Liberia

Aid Mechanism	Country Ownership	Alignment	Harmonization	Results*	Mutual Accountability
Health Sector Pool Fund	√ - Spending follows the National Health Plan	√ - Strengthens country systems	√ - Improves donor coordination	√ - Expanded coverage	√ - Enhances mutual accountability
BPHS Project Funding	Tied to donor priorities	Avoids country systems	Fragments donor support	√ - Expanded coverage	Accountability to donor
Disease Project Funding	Tied to donor priorities	Duplicates country systems	Fragments donor support	√ - Increased Output-based results	Accountability to donor
Education Pool Fund	√ - Spending follows the National Education Plan	√ - Strengthens country systems	√ - Improves donor coordination	√ - Increased Output-based results	√ - Enhances mutual accountability
Infrastructure Trust Fund	√ - Spending follows the Poverty Reduction Strategy	Avoids country systems	√ - Improves donor coordination	Too early to measure	√ - Enhances mutual accountability

*Due to the absence of rigorous evaluation methods, it is impossible to attribute results to any of these specific aid mechanisms. However, a check in this box reflects whether the funding went to specific coverage or outputs and whether there was an increase or improvement in these measures since 2005.

6. Conclusions

6.1 Enabling conditions

After a long civil conflict that destroyed the health system in Liberia, health outcomes are at last improving. A reform-minded government, strong leadership and a great deal of investment created enabling conditions for improvements to occur; additional factors included:

- Building and maintaining public confidence in the government's commitment to transparency and accountability;
- Timely development of a realistic, medium-term National Health Plan that had sector-wide participation in its development and implementation;
- Establishment of a clearly defined package of high-impact health interventions accompanied by standardized resource requirements to deliver the services;
- Leveraging the comparative advantage of each partner, using flexible funding to build institutional capacity, project funding to support the rollout of nationwide programs, and the administrative capacity of NGOs to support delivery of standardized services.

Actions by the MOHSW that increased public confidence in the government's commitment to transparency and accountability and enabled establishment of the pool fund included:

- Establishing participatory oversight mechanisms for coordinating the use of health sector resources such as the Health Sector and Pool Fund Steering Committees;
- Acknowledging weaknesses, requesting and investing scarce resources to build institutional capacity, particularly in the area of financial management;
- Accepting a high degree of scrutiny (technical, financial and political) and adopting recommendations;
- Actively seeking to resume the service delivery functions that government historically provided in Liberia.

In addition to the funding provided, corresponding actions by donors that resulted in the establishment of the pool fund included:

- Accepting increased risk in order to attain increased results, especially through the use of country systems;

- Educating and managing their own constituents (HQ and NGO partners) about the potential benefits that accompany increased risk;
- Providing responsive support, direct financial and long-term technical assistance, to enable MOHSW institutional strengthening.

6.2 Opportunities and challenges

The comparatively small proportion of health expenditure made through the pool fund and the corresponding increases in donor coordination, MOHSW stewardship and government decision-making space indicate the unrealized potential that remains in the large amount of project aid that donors continue to provide directly to NGOs. Beyond Liberia, there are other countries currently lacking government capacity and receiving highly fragmented aid outside of nascent country systems. In Haiti, for example, while the World Bank / IDA–managed multi-donor trust fund is important for mobilizing resources, an initially small pool fund that relies on government systems with an effective fiduciary risk management strategy could incrementally strengthen the Haitian government’s institutional capacity to fulfill its core functions. Investing in state capacity early in the state-building process is essential to establishing sustainable systems that will endure long after windfalls of donor assistance dry up.

The challenges to increasing the proportion of health funds channeled through pool funds that use national systems include overly risk-averse development assistance strategies that rely on project approaches, as well as other forms of multi-donor mechanisms that do not use national systems and compete for the same funds, such as World Bank-managed multi-donor trust funds. Legal impediments faced by some donors that prohibit participating in multi-donor pooling mechanisms are also an obstacle. Finally, there is an inadequate amount of investment in increasing the strategic orientation of recipient countries with regard to their aid architecture, the options they have and how they can maximize the potential of the resources available.

6.3 Policy recommendations

The experience of the health pool fund in Liberia has shown that multi-donor mechanisms in early recovery can indeed rely on national systems where government leadership and commitment to transparency and accountability exist. The enabling factors for the health system reconstruction and the actions taken by the MOHSW and donors described in section 6.1 represent important lessons from which recommendations can be drawn:

- i. Investment should be made to develop national plans and standardized packages of services that can be quickly rolled out to jump start the system, but which are technically sound enough to be expanded as the country develops;

- ii. National plans and standardized packages of services should be costed in a timely manner in order to allocate resources proportionate to need, including areas such as health system strengthening versus service delivery and primary versus secondary care;
- iii. In the context of early recovery, recipients and donors should be explicit about the necessary balance to be struck between investing in sustainable systems and ensuring the accessibility of services—they should be clear about what it is they are trying to achieve and then adhere to it;
- iv. Where leadership and the necessary commitment exist, donors should adhere to the Paris Principles and prioritize the use of multi-donor mechanisms that rely on country systems, investing in capacity and fiduciary risk management as necessary;
- v. As Liberia has shown, the importance of long-term, embedded technical assistance in core functional areas of government should not be overlooked as a valuable means of increasing institutional capacity, accountability and sustainability;
- vi. Flexible funding should be used where it can do the most good and project funding should be channeled where need exists without constraining the system;

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