Promoting Accountability of Public Resources

PERFORMANCE AUDIT REPORT

On the Effectiveness of Government of Liberia Response to COVID-19

December 2022

P. Garswa Jackson, Sr. ACCA, CFIP, CFC
Auditor General, R.L.

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ACRONYMS

ACRONYMS	MEANING
COVID-19	Corona Virus Disease
NPHIL	National Public Health Institute of Liberia
IMS	Incident Management System
IPC	Infection Prevention and Control
HCF	Health Care Facility
HCW	Health Care Worker
ICU	Intensive Care Unit
WHO	World Health Organization
CDC-USA	Center for Disease Control- United States of America
PCR	Polymerase Chain Reaction
RDT	Rapid Diagnostic Test
POC	Precautionary Observation Center
POE	Port of Entry
EPI	Expanded Program on Immunization
MOH	Ministry of Health
AZDIZZ	AstraZeneca
GSA	General Services Agency

Definition of Key Terminologies

	Definition of Key Terminologies
Triage	A place build to quickly examine sick or injured people
Contagious Disease	A disease that spread from one person or organism to another by direct or indirect contact
Threat	A person or thing likely to cause damage or danger.
Surge	A sudden large increase in something that has previously been steady, or has only increase or develop slowly.
Disease	Illness or sickness characterized by specific signs and symptoms.
Virus.	Is an infectious microbe consisting of a segment of nucleic acid.
Criteria	A principle or standard by which something may be judged or decided.
Symptom	A physical or mental feature which is regarded as indicating a condition of disease.
Escalation	A situation in which something becomes greater or more serious.
Asymptomatic	A patient tests as carrier for a disease or infection but experiences no symptoms.
Symptomatic	A sign of a disease or illness.
CHO	County Health Officer
AFDB	African Development Bank
USAID	United States Agency for International Development
GOL	Government of Liberia
UN-SDG	United nation Sustainable Development Goal
MOH	Ministry of Health
DHO	District Health Officer

TRANSMITTAL LETTER

The Honorable Speaker of the House of Representatives and Honorable President Pro-Tempore of the House of Senate.

We have undertaken a Performance Audit on the Effectiveness of Government Response to COVID-19 for the fiscal years 2020 to 2022. This audit was conducted in line with the Auditor General's statutory mandate as enshrined under Section 2.1.3 of the GAC Act of 2014.

The audit was conducted in line with the International Organization of Supreme Audit Institutions (INTOSAI), Performance Auditing Standards and Guidelines as enshrined in the Performance Audit Manual. The Act that created the Ministry of Health was also used as a baseline for the evaluation of the performance of the sector.

As indicated in the methodology segment of this report, all findings conveyed in the report were formally communicated to the Management of the Ministry of Health/Incident Management System for their responses. Where responses were provided, they were evaluated and incorporated in this report. We are therefore thankful to the auditee (MOH) for assisting us in completing the audit.

We will carry out Follow–Up at an appropriate time in the future regarding actions taken in relation to the recommendations in this report.

We ask that you pay particular attention to the following matters that if implemented, will significantly improve the health sector.

MOH/IMS should build permanent structures in line with international standards at all major entry points to be used as triage.

All triages should have medical staff assign and equip with essential medical supplies as required.

Ensure that all citizens in the age range must be fully vaccinated to minimize the spread of the virus.

Increase awareness of the important of taking vaccines by engaging citizens /residents in regular townhall discussion, radio talk shows, social media platforms etc.

MOH should enforce its mandate on proof of being fully vaccinated to access public and private buildings.

IMS/MOH should ensure that national standards are developed for the establishment of reference labs across the country and make sure they are decentralized in the four regions of the country.

Expand regional public health diagnostics and community-based surveillance to respond quickly to any outbreak.

Have an effective IPC measure in place in the fifteen (15) counties to respond to any outbreak of diseases.

Adopt a stringent approach at enforcing declared health protocols of mask wearing, social distancing, hand washing etc.

Provide health workers and facilities the needed tools and materials used for adherence to health protocols.

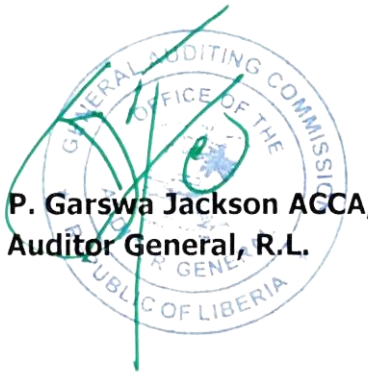
Strengthen information dissemination through clear messages in the various local languages towards COVID-19 prevention activities including, hand washing, social distancing, testing, vaccinating etc.

Ensure that requisite logistics; vehicles and motorbikes, are available for the monitoring teams to collect data of health workers assigned at health facilities, seaport and land borders.

Ensure that policy on recruitment of staff during an emergency period is given due care to avoid the recruitment of more staff than required.

Establish a database for all health staff and community volunteers for future work.

Given the significance of the matters raised in this report, we urge the Honorable Speaker and the Members of the House of Representatives and Honorable Pro-Tempore and Members of the Liberian Senate to consider the implementation of the recommendations conveyed herein with urgency.



P. Garswa Jackson ACCA, CFIP, CFC
Auditor General, R.L.

Monrovia, Liberia
December, 2022

Executive Summary

Background

Liberia confirmed its first case of COVID-19 on March 16, 2020. The affected person was a government official who travelled from Switzerland to the Roberts International Airport (RIA) in Harbel Margibi County. The Government of Liberia through MOH declared a national health emergency on March 22, 2021 upon receiving information that Patient Zero was undergoing treatment after being tested positive of the Coronavirus. His contacts were traced and specimens were taken to be tested for COVID-19.

The Government of Liberia constituted the Incident Management System (IMS) composed of professionals from the Ministry of Health and the National Public Health Institute of Liberia. The IMS is responsible for the implementation of the Public Health Strategies for effective actions through pillars set up in Montserrado and the various counties. The pillars include: Coordination of Public Health Emergency Operation; Case Management; Laboratory; Case Investigation; EPI Surveillance; Infection and Prevention Control; Contact Tracing; Risk Communication; Dead Body Management; Community Engagement; Psychosocial; WASH; Port of Entry; Logistic/Supply Chain, and Finance and Administration. These pillars were established to adequately respond to COVID-19 in Liberia.

The General Auditing Commission has commissioned a Performance Audit of the COVID-19 pandemic to establish the effectiveness of government response through the Incident Management System. The audit focuses on the resources mobilized and provided during the entire period of the pandemic. The audit further seeks to find out general and recurrent issues that may have undermined the fight against COVID – 19. In addition, the audit seeks to assess the application of lesson learnt from the EBOLA VIRUS DISEASE and how the system has improved. We selected and visited 5 counties as a sample size for the 15 counties within Liberia. The counties were selected base on the number of COVID – 19 confirmed cases and the amount of resources provided by Government and Donor Partners. The visit to those counties were essential to conduct in-person interviews of staff, counties IMS structures, review documents and also ensure that personnel working on the COVID – 19 Response were duly paid.

From the financial records reviewed, the Government of Liberia spent about thirty-eight million, one hundred eighty-one thousand, nine hundred eighty-five united states dollars (US$ 38,181,985.00) and thirty-nine million, four hundred eight thousand, eight hundred sixty-six Liberian dollars ninety-eight cent (L$ 39,408,866.98). In addition, Non-Governmental Organizations (NGOs) namely; AFDB, USAID, European Union, World Bank, International Monetary Fund, United Bank for Africa and other private entities donated the amount of seventy million, one hundred seventy- six thousand- five hundred united states dollars (US$ 70,176,500.00) in support of the response to COVID-19.

Despite the efforts applied by the Government of Liberia, donors' community, authorities at MOH and IMS, 7,397 persons got infected by the virus and 294 persons died in the process. All the fifteen political subdivisions (counties) got affected by the COVID-19 Virus.

Liberia signed off to the United Nations Sustainable Development Goals 2030. The UN_SDG three (3) aim is to ensure healthy lives and promote well-being for all at all ages. To achieve this goal, Liberia needs to provide basic health services for all. As a result, IMS is doing everything possible in making sure that pillar leads established for effective response remain in active to engage any surge in the country.

Objective and scope of the audit.
The overall objective of the audit is to assess whether the Government of Liberia through MOH and IMS was prepared to adequately respond to COVID-19 in the country.

Methods used in gathering audit evidence
We reviewed documents, analyzed data, carried out interviews and physical observations to gather sufficient, reliable and relevant audit evidence for reporting purposes.

Assessment Criteria
Assessment criteria for the audit were drawn from the following documents

1. National Public Health Law
2. Policy on Vaccine up- Take
3. National Policy and Strategic Plan on Health Protocol
4. Standard Establishing a Triage Station
5. Guidance for Establishing a National Health Laboratory System and
6. Contract on Compensation

Summary of the findings

Partial-Adherence to the Health Protocols by the General Public
There were measures put in place by the Government of Liberia through the Incident Management System for the general populace to observe during the 1st, 2nd and 3rd waves of the COVID -19 virus in Liberia, but CHOs in the counties visited informed the audit team that people were not in total observance of the measures as mandated. People gathered at entertainment centers, market places, and were having discussions in large forums and watching games at video clubs/ sport bars without observing the health protocols. Further, at land borders entry points, hand washing stations were built but not functional at the time of our visit in March 2022. IMS only operated two testing centers located in Montserrado and Margibi counties. In the midst of efforts from government and the donor's community, Liberia encountered 7,393 confirmed cases, out of this, 7092 recovered constituting 96%, and 294 died constituting 4% during the response period.

Slow Patch in the Administration of COVID-19 Vaccine in the Country
Available vaccine data provided by the Ministry of Health on July 1, 2022 shows that Liberia has surpassed its set national target to fully vaccinate 70% of the targeted group of age range 12 years and above which amount to 3,035,497 constituting 78% of the selected population. Notwithstanding, Liberia has fully vaccinated 2,352,992 persons, constituting 51% of the country's total population of 4.6 million. The country made a significant progress in this regard but they are yet to achieve the target set by WHO. Liberia is still lacking behind with 19% to reach 70% of the country's total population of 4,650,676 people though the targeted date of June 30, 2022 has expired. Additionally, 591,582 persons also received one dose of either AstraZeneca or the Pfizer vaccine while 1,706,102 of the population have not taken any of the doses.

Inadequate Monitoring of COVID-19 Activities.
Our analysis of data collected through interviews and questionnaires shows that monitoring was conducted at the quarantine centers and health centers as required, but not at the land border points and in affected communities. During the visits at land border points, we were informed by border

health workers on assignments that County Health Teams applied less efforts to monitor the activities at their respective places of assignments especially during the escalation period of the response. We did not also receive any evidence of monitoring done by CHT.

Congested Triage Built at Land Point Entries

Triage constructed at land borders during the response period to screen/host suspected COVID-19 patients were not well ventilated, and not up to required standards to host suspected COVID-19 patients. The True-Life Construction Company constructed a Building at Bo-waterside through a contract awarded by the IOM for incoming and outgoing passengers but was congested and the room used for short stay has no means for ventilation. There was no medication seen in the building as required and the health workers were seen in another triage performing the same task that should have been performance in the building that was constructed for that purpose.

Limited Referral Laboratories Nationwide.

There are limited laboratories constructed in the country to respond adequately to the surge like COVID-19 Virus and other infectious diseases in the country.[1] During the entire response period, IMS depended only on the National Reference Lab located in Charlesville, Margibi County to handle all the COVID-19 related cases around the country. The transportation of specimens from the fourteen counties to the only Reference Lab in Margibi County was an issue of constraints considering the long distances, bad road conditions and the safety of the specimen.

Claim by Health Worker for Stipend Payment.

From the review of the financial documents presented by the IMS pillar lead on Finance, we noticed that all contractors signed contracts for the duration of their respective services and payments were made through commercial banks. We noted that the IMS spent about US$ 2,055,281.55 as monthly stipends for the period March 16,2020 to June 30, 2022. Despite the amount spent on stipends by IMS, health workers in 2 of the 5 counties visited, namely: Grand Cape Mount and Grand Gedeh informed us that they were hired by their respective County Health Teams to work at selected land borders, seaports, communities and in hospitals during the response period, but did not receive the full compensation.

We requested contract documents signed between them and the CHTs for the services rendered, they failed to provide said document. The CHTs of counties could not also confirm full payment to those hired but financial records at head office showed that all service providers including contractors that were processed/hired for the purpose of the COVID-19 response were paid in full. The CHO from Bong County provided a list of 22 health workers that served the county during the response at different health facilities but did not receive hazard benefit in the amount of US$ 12,959.

Conclusions

The Government of Liberia through MOH and IMS have applied efforts in making sure that all the activities related to the response were decentralized to all the counties through the CHTs and payments were done through bank account or mobile money services. The health of the citizens comes first in the application of health protocols and all standing health rules developed to support the fight against COVID-19 were applied.

In the midst of efforts, the IMS felt short of some of the measures that were put in place as follow:

1 NPHIL Strategic plan final Nov 2018

Citizens and residents failed to observe the health protocols as instituted by the Government of Liberia through the Ministry of Health. People were gathering at entertainment centers, in market places, at discussion forums, and watching games at video clubs/ Sport bars without observing the health protocols.

GoL through the IMS failed to meetup with WHO June 30, 2022 target to vaccinate 70% of the county Population.

IMS through CHTs were unable to carry out efficient monitoring of COVID-19 activities based on the unavailability of logistic.

Constructed triage across the country during the escalation period of COVID-19 were not in accordance with guidelines and standards of WHO.

There are limited laboratories constructed in the country to adequately respond to the COVID-19 Virus and other infectious diseases.

Recommendations

Based on the audit findings and conclusions, we recommend the following:

1. GOL should adopt a more stringent approach at enforcing declared health protocols of mask wearing, social distancing, hand washing, etc.

2. IMS should provide health workers at health facilities with tools and materials use for the adherence to health protocols.

3. GOL should strengthen information dissemination through clear messages in the various local languages, simple English/ pidgin, fliers, radio jingles, strong awareness strategies for trending negative perception towards COVID-19 prevention and activities, encouraging hand washing, social distancing, testing, vaccination etc.

4. GOL through the Incident Management System should ensure that the population under the target of WHO must be fully vaccinated to minimize the spread of the virus.

5. The communication pillar of the Incident Management System; through the County Health Teams, should increase awareness of the importance of taking the vaccines and counter vaccine misinformation among residents/citizens; engaging citizens/residents in regular townhall discussions, radio talk shows, etc. in every district of the country to meet the target.

6. GOL should enforce its mandate for all government and private employees, and those accessing public places to show proof of being fully vaccinated. There should be periodic spot checks carry out at all facilities to boost vaccine uptake.

1. GOL through the Incident Management System should ensure the requisite logistics are available for the monitoring team to effectively carryout their functions.

1. MOH should follow the acceptable guidelines and standards, such as the WHO guideline, for establishing triage.

2. Emergency health care workers should be trained in the requirement of managing a triage.

3. Every triage should have a medical staff assigned and equipped with essential medical materials such as thermometers, hand cloves, hand sanitizers, Polymerase Chain Reaction and Rapid Diagnostic Test to be used in the response to COVID-19.

4. GOL through MOH should develop standards for the establishment of labs in the country to respond to any outbreak of diseases.

1. GOL through the Incident Management System should build a reference lab in the western and northern region of the country to serve in case of another surge.

2. GOL should ensure that existing labs conform to international standards.
3. The National Public Health Institute of Liberia should strengthen regional and local offices capabilities to control diseases at the early stage or point of source.

4. NPHIL should expand regional public health diagnostics and community-based surveillance to respond quickly in case of another surge of virus.

5. Testing of all travellers traveling to and from Liberia using the land border entries should be carry out to prevent the spread of the virus.

6. GOL through the National Public Health Institute of Liberia should have an effective Infection Prevention and Control measures in place in the fifteen (15) counties to respond to any outbreak of diseases.

1 CHAPTER 1: INTRODUCTION

1.1 BACKGROUND TO THE AUDIT

1.1.1.1 Coronavirus is a contagious disease that causes severe acute respiratory syndrome. The first known case of COVID- 19 was identified in Wuhan, China, in December 2019. The virus has since spread worldwide, leading to an ongoing pandemic. Symptoms of COVID-19 are mutable, but often include fever, cough, headache, fatigue, breathing difficulties, loss of smell and taste. Symptoms may begin in the period of one to fourteen days after exposure to the virus.

1.1.1.2 Africa experienced its first case of COVID-19 pandemic on January 14, 2020 in Egypt. The Egyptian Health Minister announced the first case in the country at Cairo International Airport involving a Chinese national on February 14 2020. On March 6, 2020, the Egyptian Health Ministry and WHO confirmed 12 new cases of Coronavirus infection. The infected persons were among the Egyptian staff on-board the Nile cruise ship MS River Anuket, who were travelling from Aswan to Luxor. The first confirmed case in Sub-Saharan Africa was announced in Nigeria at the end of February 2020. Three months later, the virus spread throughout the continent. By May 26, 2020, most African countries were experiencing community transmissions, and testing capacity was an issue.

1.1.1.3 Liberia confirmed its first case of COVID 19 on March 16, 2020. The affected Patient was a government official who traveled from Switzerland to the Roberts International Airport (RIA) in Harbel. MOH and NPHIL declared a national health emergency on March 22, 2021 upon receiving the information from health authorities that Patient Zero was kept in an isolated area and was undergoing treatment after being tested positive of the Coronavirus. His contacts were traced and specimens were taken to conduct COVID-19 tests.

1.1.1.4 The Government of Liberia constituted the Incident Management System comprising professionals from the Ministry of Health and the National Public Health Institute of Liberia. The IMS is responsible for the implementation of the public health strategies for effective actions through pillars set up by the team in the various counties. The pillars include Coordination of Public Health Emergency Operation, Case Management, Laboratory, Case Investigation, EPI Surveillance, Infection and Prevention Control, Contact Tracing, Risk Communication, Dead Body Management, Community Engagement, Psychosocial, WASH, Port of Entry, Logistic/Supply Chain and Finance Administration to respond adequately to COVID-19 in Liberia. Furthermore, during the response to COVID-19, 7,393 persons were affected from the Virus and 294 persons were pronounced dead by health authorities constituting 4% of the people that encountered the virus and all of the fifteen counties got affected by COVID-19 Virus.

1.1.1.5 The Ministry of Health and National Public Health Institute of Liberia are responsible for health undertakings, preventive services and including specific health interventions.

1.1.1.6 The Government of Liberia also constituted an Executive Committee on Coronavirus (ECOC) headed by the Director General of GSA to supervise a single set of the national strategic objectives for defeating the Coronavirus disease. She coordinated the National COVID-19 multi-sectoral response plan, in coordination with the United Nations (UN), donor partners, Ministry of Health and the National Public Health Institute of Liberia. The Government also

appointed the Chief of protocol of the Executive Mansion as the National Compliance Manager of ECOC with the responsibilities to monitor the overall allocation and disbursement of the response logistics and resources.

1.1.1.7 The Government of Liberia and donor community estimated commitment towards the COVID-19 response was in the tune of $108,421,767.54 USD and $39,408,866.98 LRD for the period March 16 – June 30, 2020. Additionally, US$ 25,000,000.00 was used to provide food assistance to residents from vulnerable communities affected by the pandemic according to the World Food Program Report.

1.1.1.8 The National Public Health Institute of Liberia is the coordinating arm for the Ministry of Health to detect and respond to outbreaks, strengthen existing infection prevention and control efforts, laboratories, surveillance, infectious control, public health capacity building, monitoring of diseases with epidemic and respond to public health threat in a timely manner.

1.1.1.9 Liberia is a member of the United Nations Sustainable Development Goals 2030. The UN_SDG 2030 aim is to ensure healthy lives and promote well-being for all at all ages. To achieve this goal, Liberia needs to provide basic health services for all.

1.1.2 Motivation

1.1.2.1 FrontPage Africa stated in its March 23, 2020 edition that Liberia declared a State of Health Emergency in the wake of the coronavirus pandemic on March 23, 2020. The Government of Liberia, in its latest move to contain the spread of the Coronavirus Disease 2019, declared a state of national health emergency and has even gone further to invoke the Public Health Law of Liberia, designating Montserrado and Margibi Counties as infected areas.

1.1.2.2 As a measure to curtail the spread of the Pandemic, New Dawn Newspaper reported on April 14, 2020 that police and other officers within the joint security forces had arrested several persons for allegedly violating a lockdown measure banning movement of people after 3pm in the fight against coronavirus. The arrests of the unspecified number of persons came as the joint state security faced criticism for beating and chasing people from marketplaces and forcing those at home to leave their porches and stay indoors in the first few days of enforcing the stay-at-home measures.

1.1.2.3 It was reported by Middle East North Africa Financial Network (MENAFN) on 4/5/2020 that local health officials of Liberia said that the country registered its first COVID-19 death in Liberia. The Health Minister of Liberia said that the deceased was a 72-year-old man who has been diagnosed with the virus and he died while being treated.

1.1.2.4 FrontPage Africa on March 27, 2020 also reported that Liberia is yet to discover the source of the third confirmed COVID-19 case but the National Public Health Institute of Liberia (NPHIL) had announced additional three suspected cases while dealing with 390 contacts of which 45 were high-risk cases.

1.1.3 Objective of the Audit

1.1.3.1 The overall objective of the audit is to assess whether the Government was prepared through the National Public Health Institute of Liberia to adequately respond to COVID-19 in the

country.

1.1.4 Scope of the Audit

1.1.4.1 The audit is focused on the Effectiveness of Government response to COVID-19 in five (5) of the fifteen (15) counties in Liberia. The audit covers the period from March 16, 2020 to June 30, 2022 at the National Public Health Institute of Liberia.

1.1.5 Methods of Data Collection and Analysis

1.1.5.1 We reviewed documents, conducted interviews with key personnel at the National Public Health Institute of Liberia, the Ministry of Health, land borders, seaports and visited health facilities to gather information on whether the Government of Liberia was effective in its response to COVID-19 pandemic in Liberia. See appendix 1 & 2 for documents reviewed and list of officials interviewed.

1.1.5.2 We also visited five (5) out of the 15 counties to gather information on the implementation carry out by CHT during the COVID-19 response as mentioned below.

Counties visited

No:	Counties
1.	Nimba
2.	Lofa
3.	Grand Gedeh
4	Grand Bassa
5	Grand Cape mount

Source: GAC Analysis

1.1.6 Assessment Criteria

1.1.6.1 To respond to the audit questions and assess the activities of National Public Health Institute of Liberia, the assessment criteria were drawn from the documents below;

7. National Public Health Law
8. Policy on Vaccine up- Take
9. National Policy and Strategic Plan on Health Protocol
10. Standard Establishing a Triage Station
11. Guidance for Establishing a National Health Laboratory System
12. Contract on Compensation

2 CHAPTER 2: SYSTEM DESCRIPTION

2.1 Introduction

2.2 Governing Legislations

2.2.1.1 The Incident Management System in Liberia is governed by governing policies, laws and legislations in the response to COVID-19. Below are legislations governing the sector:

2.3 Public Health Law

2.3.1.1 The document provides comprehensive legislation on matters relating to public health, including control of diseases, environmental sanitation, and regulation of drugs.

2.4 National Public Health Institute of Liberia Strategic Plan 2017-2022

2.4.1.1 This plan is intended to develop, enhance, and expand the surveillance platform, establish a comprehensive, integrated, and sustainable public health diagnostic system, establish a multi-sectoral epidemic preparedness and response capacities and capabilities.

2.5 Policy on Vaccine Uptake

2.5.1.1 The aim is to measure Government target in line with policy on vaccine.

2.6 National Policy and Strategic Plan on Health Promotion

2.6.1.1 The Strategic Plan on Health Promotion catalogues sustainable framework that will guide all stakeholders in the provision of accurate, relevant and appropriate health information that will help individuals, families and communities make informed decisions to improve their health and wellbeing.

2.7 Standard Establishing a Triage Station

2.7.1.1 The Standard provides guidance on how to rapidly establish a triage area at a healthcare facility (HCF). The intended users of this document are healthcare officials/personnel who are responsible for Case Management (CM) and infection prevention and control (IPC) at the facility. Ideally, regardless of the type of facility, each entry point into the HCF should have a triage station, where patients will be screened for COVID-19.

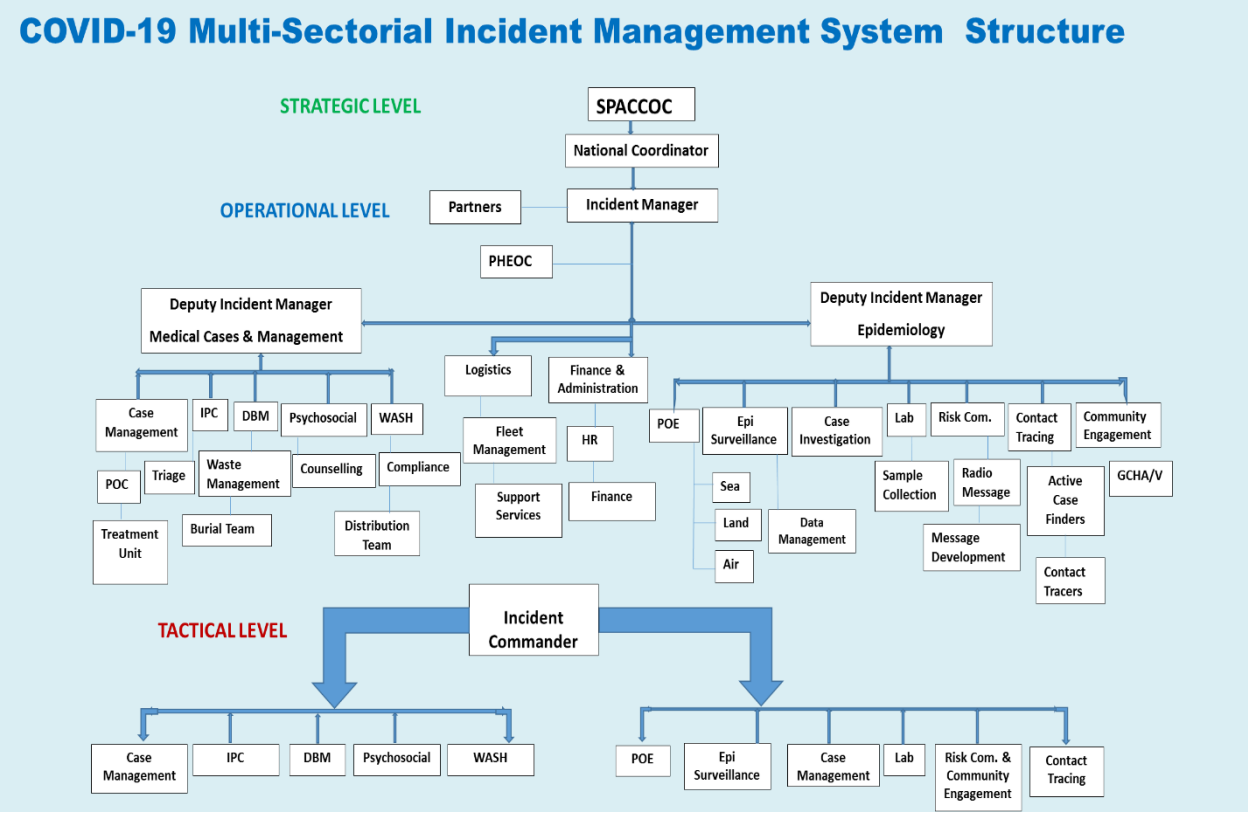
2.8 World Health Organization Guidance on Establishing a Laboratory

2.8.1.1 This Guideline is intended to support Member States of the WHO African Region in their efforts to develop and implement an effective national health laboratory system. This Guidance document is directed primarily at policy makers in the Ministry of Health, as policies, strategies, regulations and management practices necessary to strengthen the national health laboratory system and coordinate laboratory networks.

2.9 Policy on Compensation

2.9.1.1 This policy provides guidelines on compensation contracts and packages for those hired and involved with GOL response to the COVID-19 pandemic. See Appendix 3 for role and responsibilities of staff involved with the response to COVID-19 pandemic.

Below is the structure of the Incident Management System in the response to COVID-19



Source: NPHIL

2.10 Process Description

2.10.1.1 In its response to the Management of COVID- 19, the Government of Liberia through the Incident Management System issued the following processes to be observed by the public as indicated below:

2.11 Land Checkpoints Screening for COVID-19 at Crossing Points

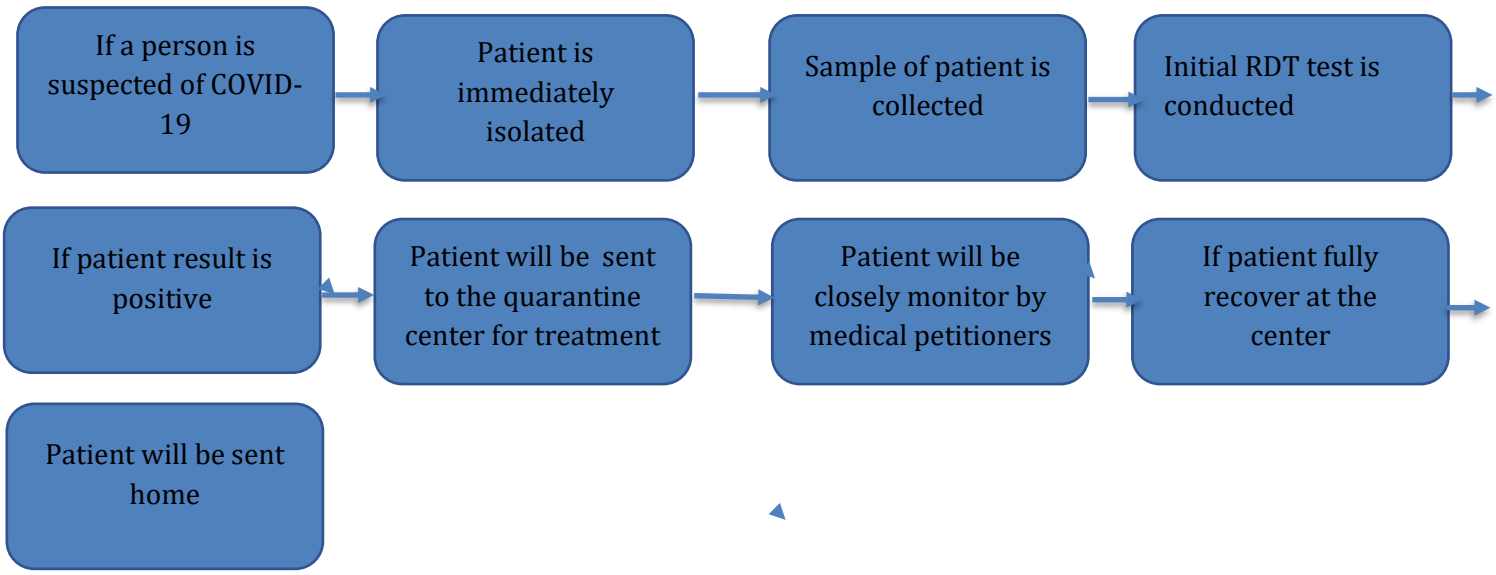
2.11.1.1 In observance of the health protocol, all persons, including passengers on board of a vehicle entering or leaving the country, must go through a screening process by forming a queue; observing 6 feet, and proceed to the hand washing station. After these processes, all travelers will proceed to the triage for the health worker to take their temperatures to determine whether it is below or above 37oc. Health workers will collect and verify the health documents and interview the travelers/passengers to determine the medical conditions of those on board. Health workers will ask all travelers/passengers questions specific to signs and symptoms of COVID-19. If the health worker checks a person's temperature and notices that it is above 37oc, such person will be quarantined for fourteen (14) days at a specified quarantine center to be carefully observed for any further signs and symptoms of COVID-19. If there are signs and symptoms of the virus, health authority will contact the officer in charge of the designated health facility to further confirm the test. After the check of travelers/passengers and the health worker is certain that there are no sick travelers/passengers and those on board meet all health requirements, the travelers/passengers will be allowed entry in the country or move to the next level of their

journey.

2.12 Airport Procedures Screening for COVID-19

2.12.1.1 Travelers disembarking from aircrafts will form a queue (at least two meter or six feet apart from each other) from the exit point of the plane to the hand washing station. This process is followed by preliminary screening via thermal scan. Any traveler whose temperature is or above 38oc will immediately be taken off the queue to rest for at least 15 minutes to recheck his/her temperature. If the temperature remains constant after the 15 minutes rest, said person will be isolated and sent to designated facility for secondary screening and ensure IPC measures are followed while transporting suspected cases. Furthermore, if the person's temperature declines after 15 minutes and is not from a country of high transmission of COVID-19, the health worker encourages self-quarantine and the individual will be monitored by a health worker. After these initial screening procedures, all travelers will take their documents to the health screener for additional checks to establish travel histories. All travelers going through the process will be given masks to proceed to immigration before going to the POC for secondary screening. All travelers with no history from high transmission countries will be allowed to proceed to immigration for normal checking as per the regulation of the POE. Any traveler that meets the case definition will be transported to the POCs and placed under a fourteen (14) day observation. Monitoring period for travelers that will require secondary screening will be escorted, along with his or her luggage, to the POC. Absolutely no family, relative, friend or any other person who is not a member of the screening team will be allowed to interact with travelers during the entire screening process and on the way to the POC. Moreover, no family or relative of a suspected traveler will be allowed to take any of the traveler's belongings while enroute to the POC.

PROCESS MAP



2.13 Funding

2.13.1.1 The response to COVID-19 is financed by the Government of Liberia and Donors. The Government of Liberia provided direct allocations and or funding from through the MFDP to the Accounts of the Incident Management System. The IMS, in parallel operations with others, established testing centers at the RIA and the Union Building on Sophia Road. Those testing centers became operational in November of 2020. The testing process requires all incoming and outgoing passengers to pay fees of US 50.00 – 75.00. Testing fees were directly paid to the United Bank for Africa, a commercial Bank authorized by the Government of Liberia to collect fees paid by passengers.

2.13.1.2 The Incident Management System collected the amount of 4,711,985.00 as testing fees for both incoming and outgoing passengers respectively. ***See tables 1 and 2*** *below for detail on funding from GoL and the donor community toward COVID-19 response.*

Table 1: Government of Liberia

Funding Sources	US$	L$
Initial Funding -GoL	700,000.00	39,408,866.98
Approved Budget COVID-19-GoL	32,770,000.00	
Fund generated by IMS through testing fees	4,711,985.00	
Total	**38,181,985.00**	**39,408,866.98**

Source: GOL report

Table 2: Donors

Funding Sources	US$
AFDB	4,000,000.00
USAID	20,000,000.00
European Union	6,000,000.00
WORLD BANK	15,000,000.00
IMF	25,000,000.00
UBA	150,000.00
Other (private donation, etc.)	26,500.00
Total	**70,176,500.00**

Source: GAC Financial Statement Audit 2020

2.13.1.3 The online payments for the COVID-19 test was faced with challenges at the beginning that resulted to the Government losing the amount of US$ 96,237. This was due to failure of incoming travelers to verify their online transactions from their respective banks after getting the services or tested at the RIA. Those responsible to verified payments at the level of IMS and the bank, were not also taking into consideration bank confirmation for all online transactions before satisfying payments rather, they acted on receipts and only to later realize that said payment was unsuccessful. Notwithstanding, the issue was later resolved and the IMS was able to generate US $ 29,401 for the same period after putting in place mechanism such as direct deposit at COVID-19 windows for all incoming and outgoing travelers including reimbursement for all double payments.

3 CHAPTER 3: FINDINGS

3.1 Introduction

3.1.1.1 This chapter presents audit findings on the effectiveness of Government response to COVID-19 through the Incident Management System. We acknowledged the leadership roles played by the Government of Liberia through the Ministry of Health and the National Public Health Institute of Liberia during the response. In the midst of efforts to respond to the COVID -19 Virus, the following findings were noted:

3.2 Partial-Adherence to the Health Protocols by the General Public

3.2.1.1 Chapter 14 of the Public Health Law of Liberia states that the management of the pandemic shall include mandatory wearing of masks at all times in public; ensuring social physical distancing of a minimum of three (3) feet from each other in public; washing of hands frequently with soap and clean water or sanitize with alcohol-based hand sanitizer; all persons tested positive for Covid-19 and their contacts will be managed according to Liberia's Case Management Guidelines. They must comply with guidance from health authorities and related health rules.

3.2.1.2 During interview with the IMS coordination pillar lead/PHEOC Manager at the head office, he revealed that citizens were in compliance with the health protocols at the beginning of the waves but when the pandemic de-escalated, they returned to their normal ways of life and were in total disobedience of the health protocol. The head nurse and the pillar lead on risk communication at a Hospital in Nimba also said that adherence to the health protocol in Nimba was very poor because of their belief that COVID-19 was not real or did not exist in Liberia.

3.2.1.3 During the review of reports from IMS and conversation with Counties Health Teams of counties visited during field verification, we noted that during the 1st, 2nd and 3rd waves of the COVID-19 virus in Liberia, citizens and residents were not observing the health protocols as instituted by the Government of Liberia through the Ministry of Health. People were gathering at entertainment centers, in market places, at discussion forums, and watching games at video clubs/sport bars without observing the health protocols. As a result of the non-adherence, many citizens and residents were infected with the virus.

See Table 3 for details on the number of persons that were affected by the COVID-19.

Counties	Number of confirmed cases	Recovered cases	Number of deaths
Bomi	64	62	2
Bong	149	129	20
Gbarpolu	62	60	2
Grand Bassa	108	102	6
Grand cape Mount	61	58	0
Grand Gedeh	63	63	0
Grand kru	26	26	0
Lofa	165	130	35
Margibi	297	290	7

Counties	Number of confirmed cases	Recovered cases	Number of deaths
Maryland	359	345	14
Montserrado	5706	5533	169
Nimba	235	202	33
Rivercess	16	13	3
River Gee	69	68	1
Sinoe	13	11	2
National	**7393 (100%)**	**7092 (96%)**	**294 (4%)**

Source: NPHIL Situational report for the month of March 2022

3.2.1.4 In the midst of the last wave of the virus, we visited Loguatuo land border and noticed that the only hands washing station was no longer in use and travellers were seen passing without being tested and washing their hands. Similar condition was also observed at Yekepa land border, where the hand washing station was no longer functional at the time of the team visit in March 2022. At Ganta land border, which is considered as one of the major crossing points in the country, we established that hand washing station for travellers between Guinea and Liberia was not functional.

Below are pictures indicating hand washing stations:

Non-functional handwashing station at Loguotuo land border ***Source: GAC Photo 1***

Non-functional hand washing station at Yekepa land border

Source: GAC Photo 2

Non-functional hand washing station at Ganta land border

Source: GAC Photo 3

3.2.1.5 Also, during interviews with citizens and residents in affected communities, we were informed that the noncompliance posture to the protocols on their part was due to the lack of basic households needs such as food, medication and disbelief about the existence of the COVID-19 Virus in the country. Residents in the affected communities were compelled to visit marketplaces on a daily basis in search of livelihood. As such, the wearing of nose masks/face masks and social physical distancing of three feet were not observed. Others interviewed complained about breathing difficulties while wearing nose masks/ face masks.

3.2.1.6 The non-adherence posture of citizens/residents in the country led to the increase in the number of confirmed COVID-19 cases across the country. This situation, if not carefully handled, may lead to an increase in the number of deaths. Further, failure of MOH/IMS to build hand washing stations in keeping with standards and maintain them will lead to travellers not observing the protocol that required hand washing at land border points, thus, increasing the risk of COVID-19 transmission among the population.

3.3 Limited testing centers at border entry around the country

3.3.1.1 In the midst of the over 17 official border entries and many unofficial entries with Ivory Coast, Sierra Leone and Guinea, the IMS only conducted testing in Montserrado and Margibi Counties. There was no testing done for both incoming and outgoing travelers from counties that have land border entries. Travellers were only asked to do temperature check and hand washing. During the interview with IMS Coordination Pillar Lead/ PHEOC Manager, he stated that there was a need to conduct testing at all land border entries but the IMS was challenged with the issues of staff. He further stated that in order to effectively manage testing at land border entries, they needed a routine staffing system in place which was not done during the response period.

IMS RESPONSE

3.3.1.2 The IMS noted your observation on the "partial adherence to health protocols with keen interest. Like many countries, Liberia was challenged with informing its citizens on the importance of following health protocols. The IMS and development partners supported the risk communication pillar through direct and indirect means in creating public awareness on the Dos and DONTs of health risk communication and behavioral practices during pandemics. Thankfully, there were more stringent measures put in place by the government, which reinforces the need for citizens to abide by and cooperate with the IMS, thereby reducing the spread of the virus.

Auditor General's position

3.3.1.3 We acknowledge Management assertion. However, we maintain our finding and recommendations. We will follow-up on the implementation of our recommendations during subsequent audit.

3.4 Slow Patch in the Administration of the COVID-19 Vaccine in the Country

3.4.1.1 The Government of Liberia launched a nationwide COVID-19 vaccination campaign on April 1, 2021 with the objective to achieve the following targets considering the total population of the country: 10% at the end of September 2021, 40% at the end of December 2021 and 70% at the middle of 2022. In addition, the World Health Organization also set a target of 70% of the total population of the country to be vaccinated by the end of June, 2022 and the national target was set at 70% of the population from 12 years and above at the end of the same period (June 30, 2022).

3.4.1.2 Statistics provided by the Ministry of Health through the Expanded Program on Immunization (EPI) Unit from the fifteen counties show that 2,352,992 persons have been fully vaccinated; constituting 51% of the total population of 4,650,676. With the above figure, the country is lagging behind with 19% to reach WHO set target to vaccinate 70% of the country's total population as of June 30, 2022. However, further analysis of the data provided also indicates that MOH has surpassed its set national target to fully vaccinate 70% of the targeted group of persons with age range of 12 years and above which amount to 3,035,497 at June 30, 2022.

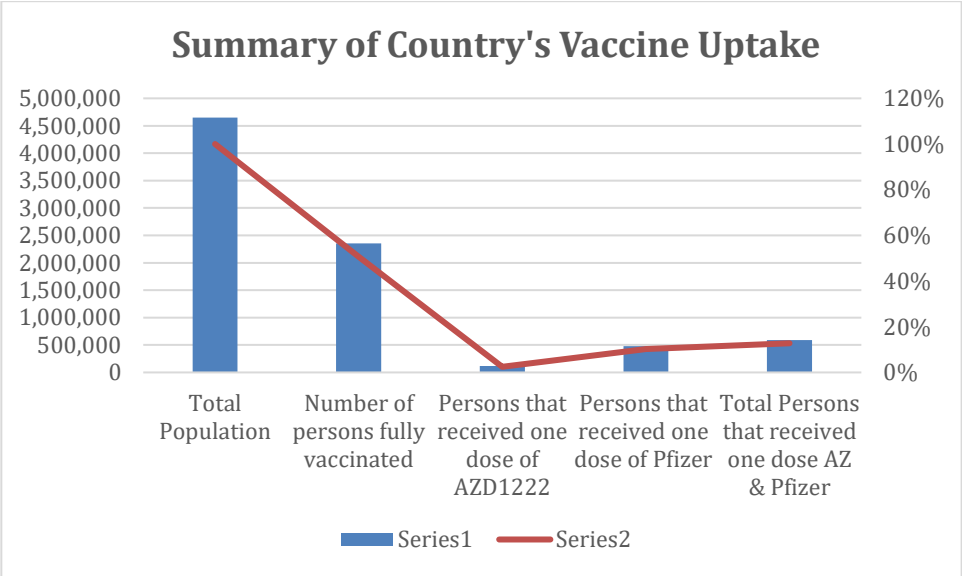
3.4.1.3 In the midst of the various vaccines administered, we noted that 591,582 persons received only one dose of AstraZeneca or the Pfizer, while 1,706,102 are yet to take any vaccine as of June 30, 2022. See table 4 below for reference.

Country's Vaccine Uptake as at June 30, 2022

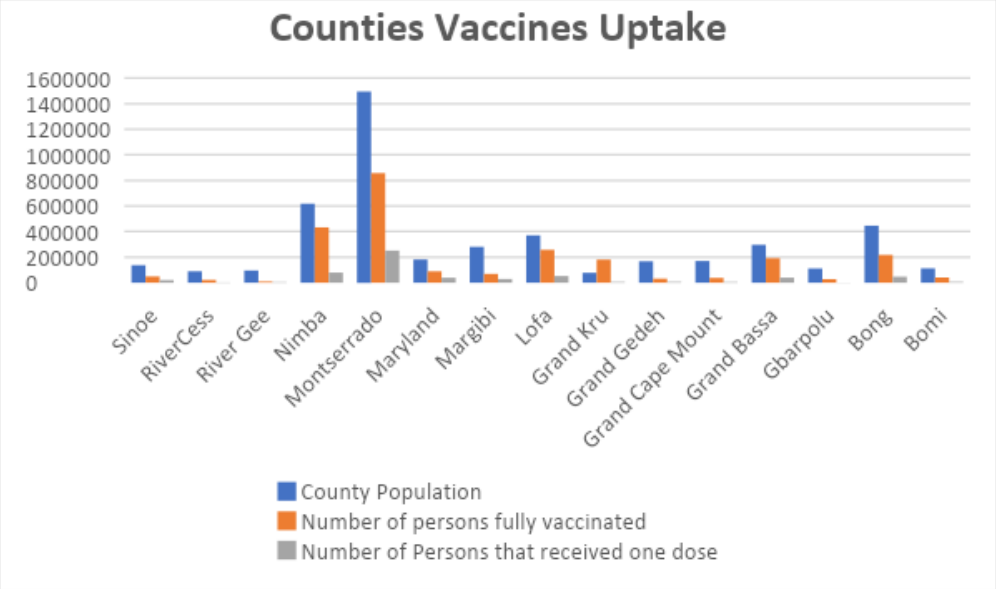
No	Counties	County Population	Number of persons fully vaccinated	Number of Persons that received one dose
1	Sinoe	136,970	49,096	20,228
2	River Cess	89,345	21,526	2,767
3	River Gee	95,657	9,216	4,388
4	Nimba	618,054	432,999	79,105
5	Montserrado	1,495,876	857,302	251,331
6	Maryland	181,845	89,125	38,944

No	Counties	County Population	Number of persons fully vaccinated	Number of Persons that received one dose
7	Margibi	280,815	69,256	29,243
8	Lofa	370,361	257,534	52,363
9	Grand Kru	77,470	181,126	6,110
10	Grand Gedeh	167,558	32,062	6,732
11	Grand Cape Mount	169,990	37,609	5,376
12	Grand Bassa	296,560	191,957	39,754
13	Gbarpolu	111,548	28,327	1,284
14	Bong	446,099	217,445	47,257
15	Bomi	112,526	41,352	6,700
Total		**4,650,676**	**2,352,992**	**591,582**

Source: GAC Analysis on EPI Data



Source: GAC Analysis on EPI Data



Source: GAC Analysis on EPI Data

3.4.1.4 During interview with citizens in counties visited, we established that the Ministry's failure to reach WHO target was due to some residents/citizens fear of negative reactions from the vaccine and disbelief by some in the existence of the COVID- 19 Virus in the country. Further, heads of public and private institutions/places are not implementing the Government health mandate for everyone accessing public/private buildings to show evidence of vaccination before granting them right to entry as was mandated by GOL through the Ministry of Health. The Head of the EPI at the Ministry of Health also informed us that strike action by health workers during the administration of the vaccine was one of the factors of not meeting WHO target. Moreover, the vaccination team was unable to reach most of the towns and villages in the southeastern region based on the bad road condition.

3.4.1.5 Failure to fully vaccinate citizens and residents may lead to a wider spread/transmission of the Virus, and create variants that could spread more rapidly and may lead to more severe health conditions and uptake in deaths related to the virus.

IMS Response

3.4.1.6 The Expanded Programme on Immunization acknowledges the slow uptake of COVID-19 vaccination exercise in Liberia at the start of the vaccination rollout process which hinder the country of attaining the June WHO target set. However, this was due to several factors ranging from some residents/citizens fear of negative reactions from the vaccine and disbelief by some in the existence of the COVID- 19 Virus in the country. Further, implementation of Government health mandate for everyone accessing public/private buildings to show evidence of vaccination before granting them right to entry was not adhere to by most institutions. This couple with the strike action by health workers during the administration of the vaccine was one of the factors of not meeting WHO target. Moreover, the vaccination team was unable to reach most of the towns and villages in the southeastern region based on the bad road condition.

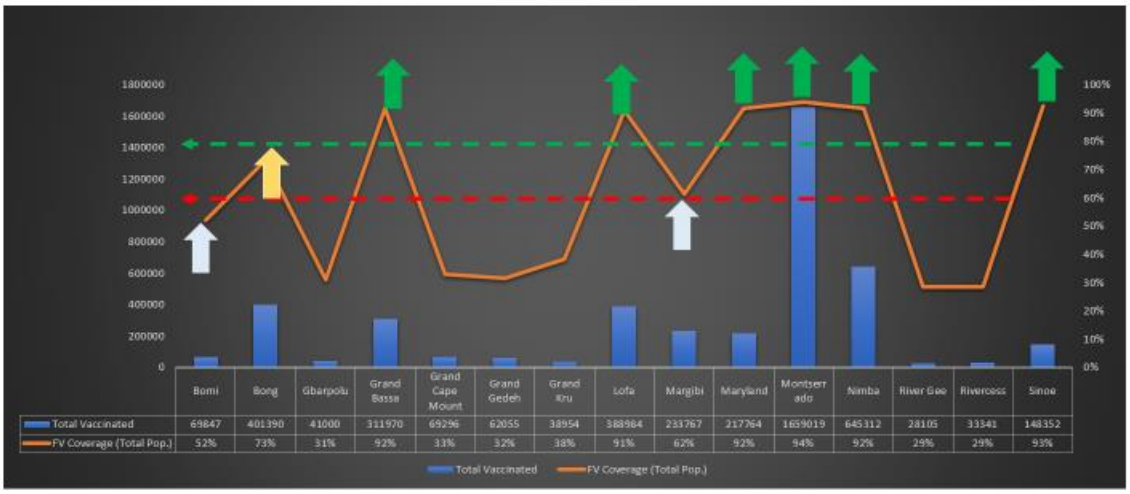
3.4.1.7 Amid this, the Incidence Management System (IMS) of the COVID-19 Response along with its partners made a renew commitment, re-assess its COVID-19 vaccine delivery strategies, as well as vaccination investment envelope immediately after its intra-action review. Consequently, this culminated into remarkable progress in the vaccination uptake with Liberia ranking 3rd in Africa and 1st in West Africa by the World Health Organization October 9, 2022, update on COVID-19 rollout in Africa. Kindly see tables and graphs below depicting the tremendous progress made that worth collective celebration.

Table XX: COVID-19 vaccination uptake by county, April 1, 2021 – November 24, 2022

County	Number of Persons Fully Vaccinated	Total Vaccinated
Bomi	**58598**	**69847**
Bong	**327640**	**401390**
Gbarpolu	**34794**	**41000**
Grand Bassa	**272215**	**311970**
Grand Cape Mount	**56076**	**69296**
Grand Gedeh	**52921**	**62055**
Grand Kru	**29669**	**38954**
Lofa	**336620**	**388984**
Margibi	**187361**	**252927**
Maryland	**166976**	**217764**
Montserrado	**1405710**	**1659019**
Nimba	**567805**	**645312**
River Gee	**27458**	**28105**
Rivercess	**25652**	**33341**
Sinoe	**126705**	**148352**
Liberia	**3676200**	**4368316**

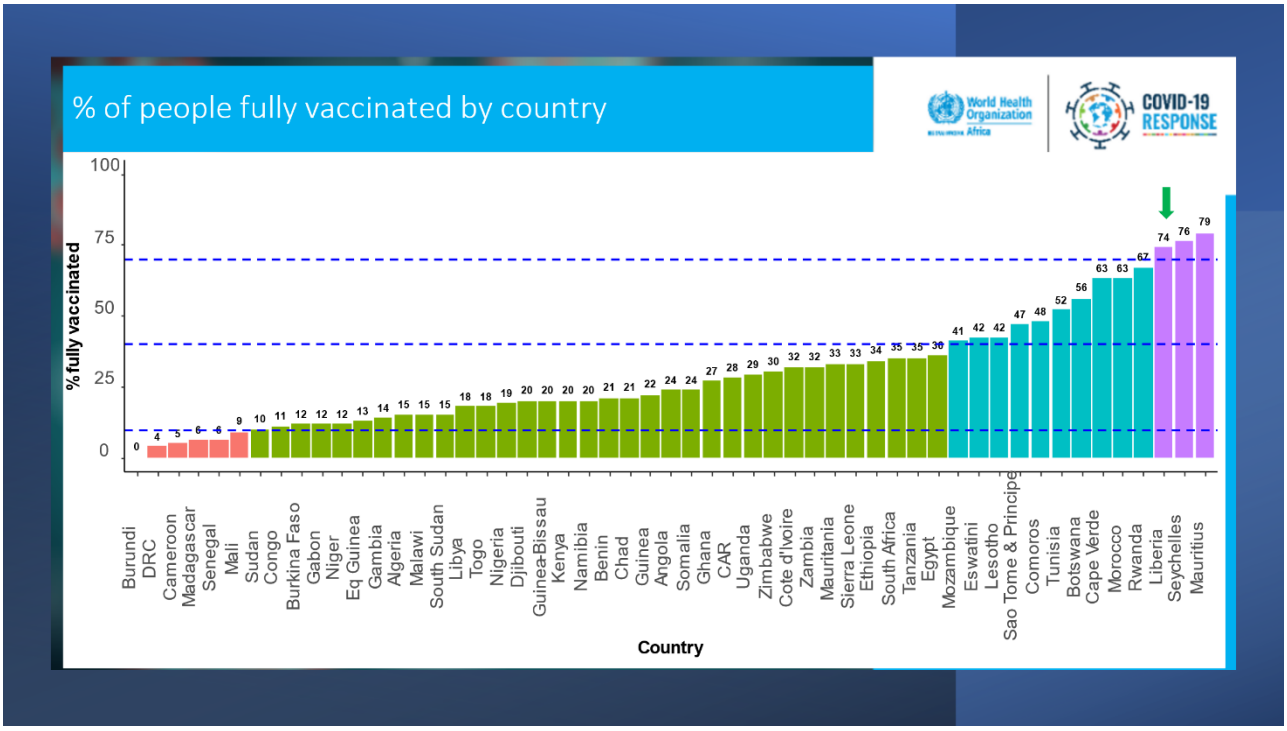
The above table indicates that a total of 4,368,316 people are vaccinated and 3,676,200 people of the total population are fully vaccinated. This data covers the period April 1, 2021 to November 24, 2022.

Figure XX: Comparative Analysis of Fully vaccinated vs Total vaccinated by county, April 1, 2021 to November 24, 2022



1. Total vaccinated: **4,368, 316** Fully vaccinated: **3,676, 200** (79%), 60+ years: **122, 688**, HWF: **17, 844**, Lagging: **6/15** counties have coverage < 50%, Gender: Male – **51%** & Female – **49%**
2. Pediatric Pfizer Dose Arrival: Nov. 28, 2022.
3. Start Date Remaining Counties: Dec 1-14, 2022

Figure XX: Percent of people fully vaccinated by country



The above graph of October 9, 2022, by the World Health Organization (WHO) shows three top performers in Africa with Liberia ranking 3rd right after Seychelles with 74% of its total population being fully vaccinated.

Auditor General's position

3.4.1.8 We acknowledge Management acceptance of our finding and recommendations. We will follow-up on the implementation of our recommendations during subsequent audit.

3.5 Inadequate Monitoring of COVID-19 Activities

3.5.1.1 The National Policy and Strategic Plan on Health Promotion, Section 7.3 page 31 indicates that the joint monitoring team should ensure development of standardized data collection tools to deliver a cost-effective, multidimensional monitoring and evaluation system that supports continuous improvement of health promotion in Liberia. Additionally, to improve efficiency of M&E and promote triangulation of data from different sources/systems to enable a comprehensive evidence-based approach to M&E, Health Promotion indicators will be collected through the HMIS to monitor progress against targets.

3.5.1.2 We visited selected counties to gather data on monitoring conducted at border point of entries, quarantine centers, referral hospitals and COVID-19 affected communities. The analysis of data collected shows that monitoring was conducted at the quarantine centers and health centers but not at the land border points and in communities affected. During our visits at land border points, we were informed by border health workers on assignments that CHT did less to monitor the activities at their respective places of assignments during the period of the response. Health border workers at Loguatuo, Yekepa, Sulumba, Bo-waterside and Ganta were left alone to use their own discretion during critical investigations to issues related to the response. We requested evidence of monitoring reports from CHOs and other pillar leads concerned but they failed to submit said documents.

3.5.1.3 Analyses of interviews conducted with pillar leads at the IMS, MOH and officials of CHT indicates that IMS inability to carry out effective monitoring of activities at the border points and movement from one facility to another, was due to logistical constraints; lack of vehicles, motorbikes, fuel and maintenance cost.

3.5.1.4 Failure on the part of the Ministry of Health/IMS to fully monitor activities of COVID-19 response across the country may lead to bridge in health protocols, lack of essential supplies at health facilities and other lapses without the knowledge of authorities.

IMS RESPONSE

3.5.1.5 The IMS adequately monitored COVID Activities through and by using its multifaceted coordination leadership platform, replicated throughout the 15 counties. In light of the limited resources from the inception of the COVID - 19 RESPONSE, the IMS worked with Port Health officers, case finders, surveillance officers, and case investigators to monitor individuals suspected of having COVID or those who came in contact with confirmed and suspected cases. While it is a fact that there were challenges in getting citizens to cooperate with the health care measure on COVID prevention, Liberia still thrives in her effort to cure the potential spread of the disease to a comparable level of other countries in Africa. The IMS intends to carry out more training and simulation exercises to prepare for future pandemics and avoid these observations' reoccurrence.

Auditor General's position

3.5.1.6 Management 's assertion that "The IMS adequately monitored COVID Activities through and by using its multifaceted coordination leadership platform, replicated throughout the 15 counties" was not supported by documentary evidence. Therefore, we maintain our findings and recommendations. We will follow-up on the implementation of our

recommendations during subsequent audit.

3.6 Congested Triages at Land Border Point of Entries.

3.6.1.1 World Health Organization standards on the establishment of a triage state that a triage should be opened and well-ventilated and located usually at entrances to Healthcare Facilities.

3.6.1.2 At the triage, a laboratory should be established to rapidly test those suspects with mild or moderate symptoms. If possible, for cases requiring emergency care, a test sample should be collected. Inside the isolation area, there should also be the emergency care area where patients with severe symptoms are rapidly placed for emergency care. Inside this emergency care area, supplies, medical equipment, and PPE should be available to care for a rapidly declining patient. Emergency medical services to stabilize the patient should be properly set-up in this space.

3.6.1.3 During the physical inspection at Yekepa, Ganta and Bo Waterside borders, we observed that triages constructed to screen suspected COVID-19 patients were not up to standard in keeping with WHO requirements. The triages were congested, ignoring WHO 1–2-meter rules between the travelers and the healthcare workers and we did not see medical equipment or PPE to care for rapidly declining patients.

3.6.1.4 Furthermore, at Sulumba border point in Foya District Lofa County, which served as a major entry point between Liberia and Guinea, there were no triage constructed to identify or host suspected patients of COVID-19; instead, travelers' temperatures were taken in an open area at the border. The daily passengers/traveler's average to this border point is about fifty (50) persons.

3.6.1.5 We also observed that the International Organization for Migration (IOM) awarded a contract to construct a building to be used as Triage at Bo Waterside to host and provide rapid emergency care to declining patients with severe symptoms and provide emergency medical services to stabilize them. During our inspection, there were no medical equipment, supplies, and PPEs available at the facility to provide emergency care for patients, nor did we see evidence of existence of same. It was further observed that the temporary holding room within the building to host patients while undergoing emergency care/treatment lacks means of ventilation.

3.6.1.6 The room did not have window and measured 10ft by 8ft, while the entire building measured 31ft-60" – by 27ft-0". The cost of the building is US$ 14,000.00 according to the contractor (True Life Construction Company, TLCC). The size of the withholding room and the lack of medical supplies are issues that require serious attention**. See photos below showing triage at land borders:**

Triage constructed at Bo waterside
Source: GAC Photo 4

short stay without window at Bo-Water
Source: GAC Photo 5

Triage built at yekepa land border
Source: GAC Photo 6

Triage built at Ganta land border
Source: GAC Photo 7

3.6.1.7 Failure of MOH/ IMS to construct standardized triages to test travelers during entry and departure at health facilities and land borders may lead to breach of the law on distancing and may result in an increase in the number of cases.

IMS RESPONSE

3.6.1.8 The IMS acknowledges your observation and has begun work on a nationwide assessment of all triages and potential quarantine centers to adequately prepare in case of outbreaks in the future. The IMS has seen these centers' use as critical to improving Infection Prevention Controls measures and mitigating the risk of the spread of diseases across all bordering counties.

Auditor General's position

3.6.1.9 We acknowledge Management acceptance of our findings and recommendations. We will follow-up on the implementation of our recommendations during subsequent audit.

3.7 Limited Referral Laboratories Nationwide

3.7.1.1 In keeping with best practice, labs are to be decentralized either by counties or regions to avoid the huge cost of transportation between counties, delay in delivering results due to

bad road conditions and the safety of the specimen. WHO also provides that said labs should contain Organization and Management, Personnel, Equipment Purchasing and Inventory, Process Control, Documents and Record, Occurrence Management Assessment, Process Improvement, Client management, Information Management, Facility and Safety.

3.7.1.2 From the review of documents, we established that there are limited laboratories constructed in the country to adequately respond to the COVID-19 Virus and other infectious diseases in the country.2 During the period of the COVID-19 outbreak, the National Reference Lab located in Charlesville, Margibi County was the only reference lab available to handle all COVID-19 or COVID-19 related cases.

3.7.1.3 Authorities of the National Reference laboratory informed us that staffing is a challenge at the Lab. They indicated that by standard, all the technical departments of the Lab should have at least four technical staff, but currently they are working with only two per department. They further said that staff may be overwhelmed with the workload which could hamper their level of efficiency and effectiveness. We observed that the transportation of specimens from the fourteen counties to the only Reference Lab in Margibi was a constraint during the escalation period of the response, considering the long distances and the safety of the specimen. Samples from hard-to-reach areas were difficult to be transported to the National Reference Lab by road. The distribution result after testing is also another major challenge. Health facilities closer to the lab will receive their result faster and those far from the lab often receive it late. Air transport was used in a few counties as means of transport. The road leading to the lab is a laterite and not easily accessible during the rainy season due to its bad condition. The situation is causing serious challenges for all those working at the lab, especially the female staff.

3.7.1.4 Failure of the Government of Liberia through the Ministry of Health to decentralize labs by counties or by regions may lead to high cost to transport specimens and increase in the waiting time to receive results after testing at the only reference lab in Margibi County.

IMS Response:

3.7.1.5 As part of the Lab pillar decentralization process for COVID-19, we did access two labs (Phebe and Jackson F. Doe hospitals) on the safety and capability to handle COVID-19 testing. After the assessed these two labs were included on the referral pathway for specimen testing for some Southeastern counties and Central Northern regions.

3.7.1.6 Most of the lab facilities in country were constructed for routine clinical Lab diagnosis but not for confirmation of public health diseases that many required specialized facility designed and equipment to minimized risk to staff, environment and specimen. The need to build and decentralized standardized laboratories regionally with all equipment, safety and security features in place including trained staff is essential for emerging and re-emerging diseases diagnosis and research. As of July 2021, the IMS decentralized testing to the 15 counties using Rapid Antigen test kits (Ag RDT) after going through serious

[2] NPHIL Strategic plan final Nov 2018

validations and prequalified by WHO (World Health Organization). We also included some private facilities as part of testing expansion using Ag RDTs.

3.7.1.7 On the staffing for COVID-19 testing at the NRL, the lab had four (4) teams comprising of six (6) staff per team and two (2) team per day. One team work day shift and the second team at Night. The staffing challenges at the NRL is the number of permanent for testing others infectious diseases. The NRL has Five (5) employed technical staff which cannot handle day to day testing. These technical employed staff per standard requirement are for one department. The NRL has Four functional technical unit that requires minimal of four (4) staff per unit. This point to the need to employed additional fulltime staff to fill the technical HR gaps at the Lab.

3.7.1.8 With sample transportation, there is a cold chain system in place for movement or relaying during transportation of sample from one location to the hub to the NRL that may not alter the integrity of the sample. Though the road is still a challenge during sample movement especially during raining season but we have safety and security measures in place and the riders are trained on safe specimen handling. The road leading to the lab is a laterite and not easily accessible during the rainy season due to its bad condition. The situation is causing serious challenges for all those working at the lab, especially the female staff.

3.7.1.9 On the released of Lab results, every test done reports are sent to the County Health officers / Team (CHT) for onward dissemination to health facilities. The challenges are report delayed or not send from the CHT to the district health team and from district team to peripheral facilities.

Auditor General's position

3.7.1.10 We acknowledge Management 's assertion. However, during our field visit to Phebe and Jackson F. Doe hospitals, there was no evidence of COVID-19 testing reference lab. Therefore, we maintain our findings and recommendations. We will follow-up on the implementation of our recommendations during subsequent audit.

3.8 Claim by Health Workers for Stipends Payment

3.8.1.1 Section 3 of the contract agreement between IMS and hired staff during the response states that it is mutually agreed and understood by the parties that in consideration for the services of the contractor under this Agreement, the Ministry shall pay, or cause to be paid, to the contractor the amount owed for the services rendered per month.

3.8.1.2 From the review of the financial documents presented by the IMS Pillar Lead on Finance, we observed that all contractors signed contracts for the duration of their respective services and payments were made through commercial banks. We further established that the IMS spent about US$ 2,055,281.55 as monthly stipends to all COVID-19 staff for the period March 16, 2020 to June 30, 2022. Despite the amount spent on stipends by IMS, health workers in 2 of the 5 counties visited, namely: Grand Gedeh and Grand Cape Mount informed us that they were hired by their respective County Health Teams to work at selected land borders, seaports, communities and in hospitals during the response period,

but did not receive the full compensation.

3.8.1.3 When we inquired about contract documents signed between health workers and the CHTs for the services rendered, they failed to provide said documents. The CHTs of counties could not also confirm full payment to those hired by them but records from IMS Pillar Lead on Finance at head office shows that all service providers including contractors that were processed for the purpose of the response were paid in full.

3.8.1.4 From the analysis of the interview notes of seventy-two (72) persons, we observed that thirty (30) staff constituting 41.6% of those interviewed did not receive full compensation. Notwithstanding, we could not authenticate the claims due to their failure to present written contracts or evidence of job performed for validation though they stated months worked for and amount owned them as mentioned below. **See table 5 for details information.**

No	Category of Staff Interviewed	Number of staff Interviewed	Number of staff Not fully compensated	Monthly salary per position US$	Number of months not paid
1	CHOs	7	4	1,350	2 Months each
2	Head Nurses	9	7	600	2 Months each
3	Contact Tracers	11	4	250	2 Months each
4	Case Investigators	24	7	600	2 Months each
5	Health Volunteers	11	3	150	2 months each
6	Land Boarder HW	3	3	150	2 Months each
7	Case Managers	7	2	1,350	2 Months each
Total		**72**	**30**		

Source: GAC Analysis

3.8.1.5 During the period of data collection, the CHO from Bong County presented a list of 22 health workers that served the county during the response period at different health facilities but did not receive hazard benefit for the services rendered in the amount of US$ 12,959. *See **appendix 4** for details. **See table 5 & 6 details***

Table 5: Below is the county that reported in line with the amount received.

No.	Name of County	Amount Received		Amount spent		Status
		USD$	L$	US$	L$	
1	Montserrado	122,282.00	13,160,477.32	122,282.00	13,160,477.32	Full report with supporting documents

Table 6: List of Counties that received funds but failed to present expenditure report.

No.	Name of County	Amount Received		Amount spent		Status	
		US$	L$	US$	L$		
1	Margibi	13,000.00					
2	Lofa	9,000.00					
3	Nimba	11,500.00					
4	Gbarpolu	8,000.00					
5	Grand Bassa	65,955.00					
6	Bong	11,500.00					
7	Maryland	11,500.00					

8	Grand Cape Mount	7,000.00					
9	Sinoe	8,000.00					
10	Grand Gedeh	2,500.00					
11	Grand Kru	2,500.00					
12	River Gee	2,500.00					
13	Bomi	33,985.00					
14	Rivercess	8,000.00					
Total		**194,940.00**					

Source: GAC Analysis

3.8.1.6 We requested financial reports from the fifteen County Health Teams to verify the amount received from IMS and transactions carried out in the counties but 14 out of the 15 counties failed to submit full report.

IMS Response:

3.8.1.7 *The Incident Management System has paid all health care workers hired through the appropriate channel as described during the conduct of the audit and as inscribed in its Emergency Standard Operating Procedures. There are absolutely no outstanding liabilities owned health care workers that participated in the response. The IMS would be glad to review the evidence of claims made by presentation of contracts of those making the claims. Additionally, the IMS has made available financial reports to the GAC on most of the counties contrary to what is within the report.**Please see below matrix of counties with whom follow-ups have been made to provide reports on funds receive.***

Counties that have presented financial reports

1. Grand Bassa ----------13,500

2. Grand Kru---------- 1,000

3. Nimba ----------3,500

4. Montserrado ---------- 8,910

5. Grand Bassa----------32,925

6. Maryland----------7,000

Total----------66,835

Counties that have not presented financial reports.

1. Montserrado ----------1,500

2.Margibi----------5,000

3. Bong ----------4,500

4. Bomi----------3,000

5. River Cess---------- -1,000

6. River Gee----------1,000

7. Nimba----------3,500

8. Maryland----------4,500

9.Gbarpolu----------1,000

10.Sinoe----------1,000

11.Lofa----------1,000

12.Cape Mount----------1,000

13. Grand Gedeh----------1,000

Total----------29,000.00

Auditor General's position

3.8.1.8 We acknowledge Management's assertion. However, we maintain our findings and recommendations. We will follow-up on the implementation of our recommendations during subsequent audit.

4 CHAPTER 4: CONCLUSIONS

4.1.1.1 This chapter presents the conclusion of the findings against the audit objectives as to whether the Incident Management System was effective in its response to COVID-19 during the escalation period. In the midst of the efforts apply by both the authorities of the Incident Management System and the Ministry of Health, we conclude the following:

4.1.1.2 Measures instituted by the Government of Liberia through the Incident Management System regarding the adherence to the health protocols during the response period were not effectively adhered to across the 15 counties.

4.1.1.3 IMS/MOH did not achieve its targets to vaccinate 70% of the total population of the country by June 30, 2022. Further, measures announced to boost vaccine uptake, such as proof of vaccination certificate to access public buildings were not enforced.

4.1.1.4 The Incident Management System through the County Health Team did not provide the requisite logistics; vehicles and motorbikes, for effective monitoring purposes.

4.1.1.5 Triage constructed by either the donors or Ministry of Health during the COVID-19 response were not in accordance with guidelines and standards of WHO.

4.1.1.6 GOL/MOH failed to decentralize reference Laboratories in the country to adequately handle all testing and results related issues.

4.1.1.7 The Incident Management System did not institute mechanism or policy that would have prevented County Health Teams from hiring without approval from the National office.

5 CHAPTER 5: RECOMMENDATIONS

5.1.1.1 This chapter presents recommendations to the Government of Liberia through the Incident Management System. If implemented, these recommendations will help the effective response to COVID-19 in case of another surge in the country.

5.2 Partial adherence to the Health Protocols by the General Public

5.2.1.1 The National Public Health Institute of Liberia through the Government of Liberia should enforce the following COVID-19 guidelines in case of anther surge of the virus:

- Government should adopt a more stringent approach at enforcing declared health protocols of mask wearing, social distancing, hand washing, etc.

- IMS should provide health workers and facilities the tools and materials used for adherence to health protocols.

- IMS should strengthen information dissemination through clear messages in the various local languages, simple English/ pidgin, fliers, radio jingles, larger involvement of local county authorities, strong awareness strategies for trending negative perception towards COVID-19 prevention medication and activities, including hand washing, social distancing, testing, vaccinating etc.

5.3 Limited vaccine uptake

5.3.1.1 The Government of Liberia through the Incident Management System should ensure that all citizens in the age range must be vaccinated to minimize the spread of the virus.

5.3.1.2 The Communication Pillar of the Incident Management System; through the County Health Teams, should increase awareness of the importance of taking the vaccines and counter vaccine misinformation among residents/citizens; engaging citizens/residents in regular townhall discussions, radio talk shows, social media platforms etc. in every district of the country in order to meet the target.

5.3.1.3 MOH should enforce its mandate on proof of being fully vaccinated to access public and private buildings.

5.3.1.4 MOH should constantly review reports from counties on the level of vaccination administered in order to establish the level of progress made by counties in line with the target set by WHO.

5.4 Inadequate Monitoring of COVID-19 Activities

5.4.1.1 The Government of Liberia through the Incident Management System should ensure the requisite logistics; vehicles and motorbikes, are available for the monitoring teams to monitor and collect data of health workers assigned at health facilities, seaports and land borders on the level of work done. The vehicles and motorbikes should also be used to transport specimens from remote areas to the regional and national reference labs in a timely manner.

5.5 Congested triage at land border points

5.5.1.1 Considering the different waves experienced from the outbreak of COVID-19 to present, we recommend that in keeping with WHO Standards, MOH/IMS should build permanent structures in line with international standards at all major border entry points to be used as triage.

5.5.1.2 Every functional triage should have medical staff assigned and equipped with essential medical supplies as required.

5.6 Limited Reference Laboratories Nationwide

5.6.1.1 The Government of Liberia through the Incident Management System and the Ministry of Health should decentralize reference labs according to the four regions of the country. GoL should also ensure that national standards are developed for the establishment of labs across the country.

5.6.1.2 The National Public Health Institute of Liberia should strengthen national and local capabilities to stop disease at the early stage or point of source.

5.6.1.3 NPHIL should expand regional public health diagnostics and community-based surveillance to respond quickly to any outbreak.

5.6.1.4 The Government of Liberia through the National Public Health Institute of Liberia should have an effective IPC measure in place in the fifteen (15) counties to respond to any outbreak of diseases.

5.7 Claim by health workers for stipends payment

5.7.1.1 IMS at head office should put in place a mechanism or policy that will prevent counties from hiring without central office approval.

5.7.1.2 CHOs of the various counties should make sure that the policy on recruitment of staff during an emergency period is given due care to avoid the recruitment of more staff than required.

5.7.1.3 MOH/CHT should establish a database for all health staff and community volunteers for future work.

6 APPENDIXES

Appendix 1: List of documents reviewed

Document Reviewed	Reason for documents reviewed
Liberia COVID-19 Standard Operating Procedures for Points of Entry: (Air, Sea and Ground Crossings)	To establish whether people traveling in and out of Liberia adhere to the procedures in the response to COVID-19.
Liberia COVID- 19 Pandemic Situational Reports	To established the number of cases confirmed, recovered cases, active cases, deaths and medical professionals affected by COVID-19
The COVID-19 Resource Management Emergency Standard Operating Procedures (ESOP)	To understand how effective was Government in the response to COVID-19
Donors and GoL contribution towards the response to COVID-19	To establish how much was spent during the GOL response of COVID-19.
Financial Statements for July 1, 2020-June 30,2021 (unaudited)	To understand the Financial Operation of the Interim Management System (IMS)
Organizational structure of NPHIL	To understand the departments, division, bureau and units that are directly connected to the response to COVID-19
Internal Control Disbursement Policy for COVID-19	To understand the processes involved in the disbursement of cash
Policy used for the distribution of essential medical supplies	To establish how the distribution of medical supplies was carried out

Source: GAC Analysis

Appendix 2 list of officials interviewed

Interviewees	Reason for the Interview
Incident Manager	To have an overall understanding in the response to COVID-19 pandemic
Deputy Incident Manager for Curative Services/ Case management	To gather information on the fight against COVID-19 Pandemic
Deputy Incident manager for laboratory services	To get clear information on the spread of COVID-19 Pandemic
Deputy for Administration and Finance/ IMS	To have clear understanding about expenditures made during the fight against COVID-19 pandemic
Director for Public Health Diagnosis / laboratory (NPHIL)	To gather information on how patients were diagnosed and tested in the response to COVID-19
County Health Officers	To establish the number of cases and the level of intervention made in the response COVID -19
Medical Doctors	To understand their roles in the response to COVID-19
Director for Communication	To understand how information was disseminated in the response to COVID-19
Director for Procurement	To have an idea how goods were procured in the response to COVID-19
Case Manager	To establish the number of confirmed cases of COVID-19
Contact Tracers	To have clear understanding of the role of contact tracers in the response of COVID-19
Case Investigators	To understand the method used to carry-out investigation in the response to COVID-19
Officers in Charge (Health facilities)	To establish the number of cases and the level of intervention made in the response to COVID-19

Interviewees	Reason for the Interview
Head of Nurses	To gather information on the number of cases and the level of intervention made in the hospitals and health centers
Head of Lab	To understand the process involved in taking specimen to lab and being tested
Community Health Volunteers	To understand their role in the response to COVID-19
Border Health Workers	To know their involvement in the response to COVID-19
Immigration Officers	To know their role played in the response to COVID-19

Source: GAC Analysis

Appendix 3: Role and responsibilities of key players in the response to COVID-19 pandemic

Incident Manager

1. Provide direction and make critical decision of the response
2. Determine operational period and objective of the response and the Incident Manager makes the final decision on the any issues of the response
3. Ensure Incident Action Plan is developed that will provide guidance on response strategies and resource mobilization
4. The IM supervises directly the 2 Deputies, Finance/Administration, Logistics and Coordination pillars
5. The IMS approves all requests as seen necessary including all recruited staff listing
6. Ensure all pillars of the response are active and access resource to implement their plan
7. Provide daily or periodical update to the strategic level/SPACCO on the status of the response
8. Chair all IMS Technical Leadership and general Coordination meetings
9. Mobilize resources and coordinate partners activities to support the response
10. Ensure donated resources for the response at properly accounted for and encourage all responders to be transparent and sincere in implementing their duties
11. Determine the movement of resources and ensure resources are provided to the responders

Deputy Incident Manager for curative services / case management

12. Provide daily and regular update to Incident Manager and highlight critical issues of the response for redress
13. Chair IMS meetings in the absence of Incident Manager or when designated by the IM
14. ensure all pillars under your supervision develop their Incident Action Plan with specific operational period, strategies and objective
15. follow-up pillars to ensure specific issues of pillars are addressed promptly
16. ensure pillars conduct pillar specific technical meetings with absolute involvement of the partners
17. Encourage pillar leads to attend IMS Technical leadership meetings
18. Ensure treatment and isolation units are established appropriately across the country where necessary
19. Develop strategies that will strengthen and effectuate the Home Base Care across the country
20. Make appropriate recommendation to the Incident Manager on strategies that will enhance response
21. Ensure all pillars SOPs are developed and distributed to the appropriate end users or Subject

Matter Experts

22. Develop reporting template for pillars' daily and weekly report
23. Ensure the appropriate resources are provided to the pillar to enhance the implementation of their various plans
24. Attend daily IMS Technical leadership and Coordination meetings
25. Ensure medical supplies are provided in all treatment units and conduct supervision at the various treatment and isolation units
26. Support training and provide technical guidance for all the pillars under your supervision
27. Ensure appropriate staff are recruited in all the pillar and list of staff to be recruited should be reviewed by the Incident Manager, however should it require immediately, recruit and inform the Incident Manager on your decision
28. Ensure resources contributed by partners are well coordinated and encourage pillar leads to submit technical report to partners

Deputy incident manager for laboratory services

29. Provide daily and regular update to Incident Manager and highlight critical issues of the response for redress
30. Chair IMS meetings in the absence of Incident Manager or when designated by the IM
31. ensure all pillars under your supervision develop their Incident Action Plan with specific operational period, strategies and objective
32. follow-up pillars to ensure specific issues of pillars are addressed promptly
33. ensure pillars conduct pillar specific technical meetings with absolute involvement of the partners
34. Encourage pillar leads to attend IMS Technical leadership meetings
35. Ensure the Lab produce/release credible, reliable and timely results
36. Develop strategies that will strengthen and effectuate Laboratory activities across the country
37. Make appropriate recommendation to the Incident Manager on strategies that will enhance response
38. Ensure appropriate and quality data is disseminated daily to inform policy decision making
39. Encourage requisite pillars to investigate all cases and trace all contacts promptly
40. Ensure all pillars SOPs are developed and distributed to the appropriate end users or Subject Matter Experts
41. Ensure Port of Entries are organized by screening and testing all travelers passing through the various ports
42. Develop reporting template for pillars' daily and weekly reporting
43. Ensure the appropriate resources are provided to the pillar lead to enhance implementation of their various plans
44. Support pillar lead of Risk Communication to ensure appropriate risk communication messages are develop and disseminated
45. Ensure Town Chief, Religious Institutions and other social group leaderships are engaged for their full involvement
46. Attend daily IMS Technical leadership and Coordination meetings
47. Conduct intensive monitoring and supervision across all pillars to ensure their active response to the population needs

48. Support training and provide technical guidance for all the pillars under your supervision
49. Ensure appropriate staff are recruited in all the pillar and list of staff to be recruited should be reviewed by the Incident Manager, however should it require immediately, recruit and inform the Incident Manager on your decision
50. Ensure resources contributed by partners are well coordinated and encourage pillar leads to submit technical report to partners

Deputy for Administration and Finance/ IMS

51. The pillar is responsible for managing the financial and Human resources of the response.
52. Provide guidance on the resource request and disbursement processes of the IMS
53. Ensure the IMS adhere to financial Laws of the Republic of Liberia
54. Ensure all responders contract and compensation is paid on time as agreed by the IMS
55. Work with other pillars leads to recruit surge as identified by the various pillar leads
56. The financial pillar endeavors to mobilize resources through developed strategies and plan for the COVID-19 response, and institute transparent mechanism that will ensure proper accountability and compliance to acceptable national and international standards such as the Public Financial Management (PFM) Law, the Public Procurement, Concession and Commission (PPCC) regulation among others.

Director for Public Health Diagnosis and Laboratory /NPHIL

Collect sample across the country of suspected cases and test
Release Laboratory results timely to the appropriate authorities at both county and national levels

57. Ensure reagents and other supplies of the Laboratory are available at all times
58. Conduct inventory of all Laboratory consumables and supplies and provide update to IMS to determine available supplies and encourage to procure supplies where necessary
59. Ensure the establishment of sub-laboratory at the county level
60. Provide training for all laboratory technician across the country
61. Recruit surge staff as may see necessary and submit list to coordination and Incident Manager for verification and endorsement
62. Support the conduct of enhance surveillance activities in the communities
63. Establish voluntary sample collection site following the endorsement of the IMS

County Health Officer

64. Serve as a liaison between the central Ministry and health facilities in the county and provide leadership and supervision at this level.
65. Coordinate partners for health in the county and to ensure that projects are implemented and carried out as they should. Lastly, represent the MCHT at meetings and other official functions.

Director of Communication

66. Develop risk communication messages on the information of the disease
67. Dissemination of risk communication messages to the various institutions, communities, etc to keep the public health inform
68. Attend all pillars meeting and encourage partners to attend meetings

69. Conduct community awareness meeting with community leaders

Director of Procurement

70. Provides administrative support services to the entity in accordance with the Public Procurement and Concessions Act.
71. It centrally handles all procurement functions in close consultation with the Procurement Committee.

Case Management

72. Ensure all confirmed COVID-19 cases are admitted at the treatment units and properly managed
73. Provide training for all health workers to manage to detect suspected and manage COVID-19 confirmed cases
74. Conduct pillar specific meetings with the involvement of partners
75. Make request of all needed supplies for the treatment unit
76. Identify need for surge staff and submit list to incident manager for approval
77. Support the development of Case Definition
78. Ensure all COVID-19 treatment units are functional and up to standard across the country.

District Health Officer

Ensuring access to public health information about the nature of the communicable disease as well as access to information on available treatment to the following individuals:

79. those that are at risk of a communicable disease of public health importance
80. those who are suspected or confirmed of a communicable disease of public health importance.

Case Investigation and Contact Tracing

81. The Case Investigation pillar is responsible to conduct the investigation of all suspected and confirmed cases.
82. The pillar establishes epi-link of confirmed cases
83. The team also develop line list of contact of confirmed cases
84. The contact tracing team follow-up and monitor all contact at their various location
85. The team develop the Case Definition of the response
86. Determine the need to recruit surge staff
87. Make request of all supplies and other logistical support
88. Conduct activates case search in the communities
89. Support the conduct of enhance surveillance

Communities Health Volunteers/Assistant

90. Develops relationships with the community and its key informants such as, local leaders, traditional healers, drug store owners, religious houses, etc. within the border communities. If he/she finds out about someone with signs and symptoms of COVID-19 or notices the presence of stranger in their communities

91. The CHA/CHV will send an alert to any member of the boarding party of that border

community for immediate action

92. The CHA/CHV at PoE community should virtually identify travellers with overt signs and symptoms of COVID-19 and immediately notify the relevant surveillance actors for action

Appendix 4 for details on staff, amount owned and area of assignment.

No.	Name	Contact Numbers	Facility	Amt to be Received	Comment
1	Stanley N. Kollie	880395277	Totota Clinic	546.50	Enlarged mobile money Wallet
2	David B. Sakui	880415353	Jorwah Clinic	668.00	Enlarged mobile money Wallet
3	James D. Nyankelan	880648032	Foequelleh Clinic	668.00	Enlarged mobile money Wallet
4	Ezekiah Yarkpawolo	880749345	Wainsue Clinic	606.50	Enlarged mobile money Wallet
5	Justus Bondo	881062736	Tokpaipolu Clinic	606.50	Enlarged mobile money Wallet
6	Exodus Klemee	881126209	Samay Clinic	606.50	Enlarged mobile money Wallet
7	John K. Binda	880381658	Gbansuslomah Clinic	546.50	Enlarged mobile money Wallet
8	Augustine Kerkulah	880381656	Shankpallai Clinic	274.50	Enlarged mobile money Wallet
9	Daniel Tonkollie	881435271	Tamayta Clinic	606.50	Enlarged mobile money Wallet
10	Angeline Zeantoe	881866071	Africa Fundamental Baptist Mission Clinic	606.50	Enlarged mobile money Wallet
11	Arnorld S. Pewu	880984222	Belefanai Health Center	606.50	Enlarged mobile money Wallet
12	Omiford W. Vanwolo	886100393	Garmue Clinic	848.00	Enlarged mobile money Wallet
13	Samuel Gweh	880529096	Yila Clinic	546.50	Change number and Enlarge Wallet mobile money Wallet
14	J. Benjamin Urey	886202384	Bah-ta Clinic	606.50	Enlarged mobile money Wallet
15	James Momo	880984956	Phebe Hospital	546.50	Change number and Enlarge mobile money Wallet
16	Moses Onepound	886385232	Gbecohn Clinic	546.50	Enlarged mobile money Wallet
17	John S. Kpor	886616793	Sanoyea Clinic	546.50	Enlarged mobile money Wallet
18	Andrew C. Sumo	886663120	Gbartala Clinic	546.50	Enlarged mobile money Wallet
19	Numen Dogbay	886719096	Bellemu Clinic	546.50	Enlarged mobile money Wallet
20	David Gbakolay	886768223	Gbalatuah Clinic	546.50	Enlarged mobile money Wallet
21	Jerry King	880381494	Gbarnla Clinic	790.00	Change number and Enlarge mobile money Wallet
22	Moses Gbai	888123869	Janyea Clinic	546.50	Enlarged mobile money Wallet