

LIBERIA
REBUILDING BASIC HEALTH SERVICES (RBHS)

**EVALUATION OF BOMI COUNTY PERFORMANCE-
BASED CONTRACTING-IN PILOT**

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List of Acronyms

ANC	Ante-natal care
BCHSWT	Bomi County Health and Social Welfare Team
BPHS	Basic Package of Health Services
CHC	Community Health Committee
CHDC	Community Health Development Committee
CHDD	County Health Division Director
CHO	County Health Officer
CHSA	County Health Services Administrator
CHSWT	County Health and Social Welfare Team
CHV	Community Health Volunteer
CM	Certified mid-wife
CMO	Chief Medical Officer
DHIS	District Health Information System
DSO	District Surveillance Officer
DST	Decentralized Support Team
EHT	Environmental Health Technician
EPHS	Essential Package of Health Services
EPI	Expanded Program on Immunization
FHSD	Family Health Services Division
gCHV	general Community Health Volunteer
GoL	Government of Liberia
GCM	Grand Cape Mount
HMIS	Health Management Information Systems
IEC	Information Education & Communication
INGO	International Non-Governmental Organization
IPT2	Intermittent presumptive treatment of malaria 2 nd dose
JSI	JSI Research & Training Institute, Inc.
LMIS	Logistics Management Information System
MIA	Ministry of Internal Affairs
M&E	Monitoring and Evaluation
MOHSW	Ministry of Health & Social Welfare
MoF	Ministry of Finance
NACP	National AIDS Control Program
NDS	National Drug Store
NGO	Non-Governmental Organizations
NLTCP	National Leprosy and Tuberculosis Control Program
NMCP	National Malaria Control Program
OFM	Office of Financial Management
OIC	Officer-in-Charge
ORS	Oral rehydration salts
PBC	Performance-based contract
PBF	Performance-based financing
RBHS	Rebuilding Basic Health Services
TTM	Trained Traditional Midwife
UNICEF	United Nations Child Fund
USAID	United States Agency for International Development

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I. Executive Summary

This assessment reviews the two-year Performance-Based Contracting (PBC) “In” pilot between the Bomi County Health and Social Welfare Team (BCHSWT) and the central level Ministry of Health and Social Welfare (MOHSW) to identify areas needing strengthening, and to present lessons learned and suggestions for scaling up the PBC “In” model elsewhere in Liberia.

The Bomi Assessment methods included extensive document review, key informant interviews, focus groups, and observation visits to health facilities. Interviews were conducted with 14 MOHSW staff, 21 BCHSWT staff, 1 county government leader (Superintendent) and 12 Officers in Charge (OIC) of health clinics. A total of 12 health clinics were visited (eight publically run, two AHA managed and county-financed, and two private). Three focus groups were held (two at the community level and one with the four District Health Officers). The design of the assessment tools included a common set of themes to be explored across levels of the health system including Governance and Decentralization; Leadership and Transparency; Financial Management and Administration; Public Health Management, Performance and Oversight; and Monitoring and Evaluation.

The integration of PBC between levels of the health system (e.g. central and county) and the decentralization of the health system are two separate but symbiotic reforms going on in Liberia. Although there is not yet consensus at the central level as to what decentralization of the health sector should entail, a draft of a National Health and Social Welfare Decentralization Policy is under validation and review. In Bomi County the “deconcentration” of certain functions has already been put into place and the county has taken on responsibility for four core responsibilities: the county team has autonomous decision-making over finance and administration, human resource management, organization of service delivery and management of health services all in accordance with national standards, protocols and policies.

The county health team has shown great leadership and management in running the county’s health services with strong ties to local government structures and good efforts to keep the central MOHSW involved in their work when needed.

There are three types of contracts used in Bomi County’s health sector: PBC “in” between the central MOHSW and the county BCHSWT; PBC “out” between the BCHSWT and a Non-Governmental Organization (NGO) African Humanitarian Action (AHA); and service contracts between the county and locally hired staff and a vehicle maintenance company. Although there are mechanisms for accountability written into the PBC “in” contracts, they are not consistently employed. There has been poor verification of contract performance by the Purchaser (MOHSW) to date.

Despite the need for increased capacity in the field of financial management, the county’s financial and administration team functions well overall. The County has autonomy to quickly use its funds to carry out activities without delay, and over the two-year period, there were a number of measurable results, including infrastructure improvements, equipment, staffing, and training. The county team has learned to budget well and anticipate its real needs costs down to the health facility and Community Health Volunteer (CHV) levels. One of the main problems encountered is inconsistent financial reporting requirements and confusion over formats for the liquidation of accounts on a quarterly basis. These reports are sent to the MOHSW’s Pool Fund which is a part of the Office of Financial Management (OFM) where the team of accountants review the reports and send their queries back down to the county. Once the Pool Fund finds the information satisfactory, then the reports are sent for an internal audit to the

Ministry of Finance (MoF) for review. This process has become somewhat burdensome and has resulted in delays in funding. This problem is not unique to Bomi County Pool Fund recipients.

Management and supervision in the county is strong and there is a universal recognition of the importance of supervision and collection of data amongst the county team and the health facility staff. BCHSWT has instituted regularly scheduled meetings across levels of the system as a management tool for increased communication, coordination and problem-solving. Supervision is one of the county's strongest areas at all levels of the system. Efforts are being made to record each supervisory visit and corresponding observations in the facility visitor ledger, however supervision forms are not complete at the county headquarters. The District Health Officers (DHOs) offer strong links between the BCHSWT and the health facilities. They play an important role in communication, supervision and oversight of the county's health facilities. Human resource management is well-managed and decisions are made on recruitment, allocation and reallocation of personnel, hiring and firing. Although much progress has been made with 50% of health facilities with active Community Health Development Committees (CHDCs) and CHVs meeting on a monthly basis, community-based health promotion and disease prevention as well as surveillance need to be strengthened.

The county has made efforts to strengthen monitoring and evaluation and collection of data. Across the board, the county team members and health facility staff recognize the importance and accept the task of collecting routine Health Management Information Systems (HMIS) data. Although there are no written reports on data verification and M&E, there is a large effort on the part of the county to collect HMIS data to report to the central level. However the analytical capacity and use of real time data is still weak at the county level. Such is also the case at the central MOHSW, where there is a gap in sharing and use of data for decision-making and planning on a regular basis.

The "Bomi experience" offers invaluable insight into what it takes to effectively apply a PBC tool between levels of the health system. It also offers best practices in using the PBC model for deconcentrated health services and illuminates the need for clear policy reforms on a national level to create an environment conducive for model scale up.

As the Liberian health system is simultaneously developing its own model of PBC "in" with the County Health and Social Welfare Teams (CHSWTs) and "out" with Non-Governmental Organizations (NGOs) providers, it is also working to define the MOHSW vision of decentralization of the sector. Contracting "in", as it is being employed in Liberia, is really a tool to obtain results and for developing Liberia's National Health and Social Welfare Decentralization Policy while carefully defining the essential public health functions, roles and responsibilities of each level of the health system. This policy should distinguish between the various essential public health functions in the county and ideally indicate where each function should be situated within the health system. Specifically, the four functions which need to be separated in order to avoid potential for conflict of interest include: policy and regulation, financing/purchasing, service delivery, and monitoring and verification.

In order for the counties to be ready to serve as providers under contracting "in" mechanisms, they must have the capacity to manage and lead the county. Minimally, the CHSWT should have the following competencies in order to ensure strong management: Management and Leadership, financial management and accounting, public health planning, and an understanding of Performance-Based Financing (PBF)/PBC. It should be a requirement that all CHOs or at least the Deputy have formal public health training prior to signing of contracts. The importance of county leadership should not be underestimated for the success of contracting "in". The County Health Officer (CHO) needs to not only be well versed in public health management but also a strong leader with a vision for the county.

II. Introduction and Background

In 2007 the Liberian Ministry of Health and Social Welfare (MOHSW) developed its first National Health Policy and Plan 2007 – 2011, centered on a Basic Package of Health Services (BPHS). Under this policy, a decision was made to gradually decentralize the management and implementation of health services to the County Health and Social Welfare Teams (CHSWTs). The CHSWTs were expected to form a strategy and respond to the local health issues faced by their communities. In 2008 the MOHSW came out with its first Performance-Based Contracting (PBC) Policy, which was designed to seamlessly shift the management of international donor-supported emergency relief efforts from solely International Non-Governmental Organization (INGO)-led to Government of Liberia (GOL)-led. Under this Policy, INGOs and National NGOs would manage development-focused contracts. Two models of PBC to NGOs were created: one supported by the USAID-funded Rebuilding Basic Health Services (RBHS) Project, and the other supported by the MOHSW Pool Fund-financed Program. Under the MOHSW Office of Financial Management (OFM), Pool Fund support has served as a complementary funding mechanism to the Liberian national health budget. The Pool Fund is comprised primarily of funds from international donors and contributors to the efforts of the MOHSW; it funds the Bomi County contract.

As key NGO partners began phasing out their activities in Bomi County by the third quarter of 2009, an opportunity presented itself for the MOHSW to experiment with decentralization of management and delivery of countywide health services with increased resources. Bomi was originally chosen for this pilot initiative based upon its outstanding 2009 Facility Accreditation scores. Bomi's scores have successively increased each year so that by 2011, the county's overall average facility score reached 96%. The structure of the 2009 pilot initiative was a model, whereby the central-level MOHSW contracted with the Bomi County Health and Social Welfare Team (BCHSWT) under a US\$2.1 million, 20-month contract to provide all health and social welfare services as stipulated under the BPHS. This type of contracting is known as Performance-Based Contracting (PBC) "in". Bomi County has a total of 20 health facilities (19 health clinics and 1 hospital) which have been managed under this contract. Six of the health facilities are sub-contracted out by the county to an INGO, the African Humanitarian Action (AHA). RBHS supported two of Bomi's health clinics through September 2011. The county also has oversight responsibility for the five private healthcare facilities in the county.

Since this time, the MOHSW revised its package of health services to create the new Essential Package of Health Services (EPHS). A recently-approved second National Policy and Plan, covering the years 2011-2021 now maps the national health strategy for the next ten years.

A. Performance-Based Contracting (PBC)

Experience from around the world has indicated that PBC – a financing mechanism and tool that creates accountability for results by tying performance to payments – typically yields better results than those that tie payment to simple completion of activities. A performance-based contract gives providers/contractors a financial reward for meeting or exceeding agreed-upon targets and penalizes them for a sub-par performance. A performance-based financing model provides incentives for providers/contractors to deliver high-quality services in a way that uses resources most efficiently and effectively. The contract includes performance measures upon which payment is based. A financial incentive or a financial bonus helps to encourage motivation, innovation and efficient use of resources.

Poor performance of the public health system in many low-income countries is typically due to weak institutional systems and management, and therefore would most likely benefit from a performance-based

contracting model. A PBC requires providers/contractors to meet or exceed agreed-upon goals and targets in order to receive full payment, and penalizes them for sub-par performance. Performance targets are tailored to the contract and can address any number of variables, including service utilization, quality of services, achievement of specific results, etc.

“PBC In”, is when one level of government or a public institution (for example the central-level MOHSW) contracts with a lower level of government (i.e. a county, district, a province, or facility) to deliver services. This mechanism serves as a way to introduce private sector concepts and business strategies into public sector management in a non-threatening way, as decision-making and resources are retained within the public sector. In Liberia, the Bomi County “contracting in” model is unique in the country as well as in the region.

B. Decentralized Health Systems

It is important to situate Bomi County’s PBC “In” experience within the context of a larger, country-wide effort by the MOHSW to decentralize Liberia’s health system. In an effort to increase access to and utilization of the EPHS, the MOHSW has empowered County Health and Social Welfare Teams (CHSWTs) to be its operational arm and to “manage all Ministry-owned facilities, Ministry-employed human resources and Ministry-provided material resources in their county.”¹

In Bomi County’s case, the contracting “in” experience has effectively been also a pilot initiative in “deconcentration” of Liberia’s health system. As Liberia further develops its National Health and Social Welfare Decentralization Policy and defines which essential public health functions will be the responsibility of the central ministry and which will fall under the CHSWTs, the PBC model for strengthening health service delivery and management is evolving. This parallel development provides an opportunity for leaders in the health sector to consider how the Liberian health system will function and be managed using PBC while at the same time defining the essential public health functions, roles and responsibilities at each level of the healthcare system.

C. Purpose of Study

The purpose of this assessment is to examine the Bomi County Health and Social Welfare Team’s (BCHSWT’s) experience managing a PBC “in” pilot initiative over a two-year period to not only identify areas in which Bomi County can further strengthen its system, but to provide lessons learned from the pilot and make targeted recommendations to the Central MOHSW on designing a “PBC In” model that can be applied elsewhere in Liberia.² The assessment further identifies specific functions within the “PBC In” mechanism that must be refined and strengthened in order to successfully create a contracting “in” model for Liberia.

¹ “National Health & Social Welfare Policy & Plan 2010-2021,” MOHSW, 2011. Pg. 10.

² This assessment focused on the core functions of a deconcentrated health system rather than on an analysis of quality and utilization of service delivery.

III. Methodology

A. Methods

The Bomi assessment methods included document review, theme identification, key informant and stakeholder identification, tool development, data collection and analysis, and central ministry and county decision-maker validation of findings. The document review informed the development of a preliminary list of key informants and the design of a set of six assessment tools. The design of the assessment tools includes a common set of themes to be explored across levels of the health system (Figure 1). The team analyzed both quantitative and qualitative data; however, given some of the data limitations including difficulty obtaining various data sets and data quality and unreliability issues in-depth analysis of these data was not included in this assessment.

Document Review

A review of a variety of documents on Liberia preceded and informed the design of the assessment. These documents included MOHSW national policies and plans, annual and quarterly reports from central and county levels, Health Management Information Systems (HMIS) reports, facility-based ledgers, and all county-specific contracts served as references prior to and during the assessment. A list of documents included in the review appears in Annex C.

Key Informant Interviews

Interviews included key informants from across all levels of the health system, covering policy regulation, financing, purchasing, program management, service delivery, community volunteers, and support systems (human resources, financial and accounting, supply chain, and laboratory).

The assessment used semi-structured interviews and included personnel from the central, county, and facility levels, as well as community volunteer focus groups. County local government was also interviewed. Analysis included both triangulation and cross-verification of data collected. Table 1 lists key informant interviewees. A complete list of individuals interviewed appears in Annex D.

Table 1: Interviews and Observation Visits

National Level – MOHSW and AHA

Deputy Minister Health Services/Chief Medical Officer; Deputy Minister Planning; Assistant Minister Bureau Vital Statistics; Acting Director Monitoring and Evaluation Unit; Director External Aid Coordination Unit; Performance-Based Financing Coordinator; Acting Director Human Resources; Director of Personnel; County Health Services Coordinator; Director Family Health Division; Decentralization Focal Person; Pool Fund Manager; and a former Pool Fund Manager; African Humanitarian Action (AHA) County Director

Figure 1: Themes Explored in Assessment

- Decentralization and Governance
- Leadership and Transparency
- Management, Planning, and Supervision
- Financial Management and Administration
- Human Resources and Personnel
- Community Participation and Surveillance
- Other Support Systems: Supply Chain Mgmt., Laboratory Services, Technical Support (Annex B)

County Level – BCHSWT		
County Health Officer; Medical Director, County Health Services Administrator; Hospital Administrator; Financial Manager; Accountant; Human Resources Officer; Training Coordinator; Pharmacist; Monitoring & Evaluation Officer; Data Manager; Reproductive Health Supervisor; Child Survival Focal Point; County Surveillance Officer; Environmental Health Officer; Logistics Officer; Procurement Officer; 4 District Health Officers; and the Bomi County Superintendent		
Facility Level – Clinics	External Support	Staff
Suehn	Former SC-UK	OIC, CM
Fefeh Town	Former SC-UK	OIC, Vaccinator
Bonjeh	None	OIC (CM), RN, RN
Sasstown	Former MTI	OIC
Gayah Hill	None	OIC, Vaccinator
Sime Darby	Private concession	OIC (PA), RN
Gonzipo	AHA	OIC(CM), CM/RN, Vaccinator
Ahmadiyya	Private	OIC (Dr)
Beh Town	AHA	OIC/RN/ Vaccinator
Dagweh Town	None	OIC
Vortor	None	OIC/RN
Yomo Town	None	OIC, CM, Vaccinator
Community Level – Groups	Members Present	
TTM meeting (Yomo Town)	17 attendees (5 TTMs, 2 gCHVs)	
CHDC meeting (Dagweh Town)	4 CHCD, 13 TTMs	

Focus Groups

Three focus groups were held, two with community volunteers (TTM/gCHVs and CHDC/gCHVs) and one with the four District Health Officers.

Field Work Observation

An observation guide was developed for health facility walk through visits. The interview team, either prior to the formal interview or immediately afterwards used this guide to walk through the clinic and observe staff at work, look at posters and charts on the walls, review ledgers and data collection instruments, visit the pharmacy and dispensary and speak informally with other health facility staff.

Secondary Data Collection

Data were analyzed from the Liberian MOHSW HMIS from Bomi County (2009-2011).

The assessment team found that by interviewing across levels (i.e., central MOHSW, county-level BCHSWT, facility-level, and community level) that they were able to have a balanced and in-depth view of the Bomi pilot experience. This further enabled the team to verify sometimes conflicting information that emerged.

Two-person teams conducted the key informant interview, with one person conducting the interview and the other person taking notes and making observations. At the end of each day the team met to share and review highlights of the day. Upon completion of the field work, the team met in groups of two to work on individual topic area analysis. The small teams shared the initial findings with the rest of the group,

where the interpretation of information was finalized. The group created a list of queries and ambiguous information to verify and confirm.

B. Limitations

It is important to note that the assessment focused on the core functions of a decentralized health system and county and central MOHSW performance against those functions necessary to employ PBC “in”, rather than an analysis of the quality and utilization of service delivery. This study was confined to an assessment of Bomi County’s PBC “In” experience. It did not include a comparative analysis to other Liberian county experiences with PBC “Out” to NGOs. Such a comparison study between other counties in Liberia, both RBHS- and Pool Fund-financed, where NGOs are contracted “out” for management and oversight of health service delivery would have been an interesting analysis to county policy-makers. Nor did the assessment consider the financial cost of contracting “in” versus that of contracting “out”; which would also have been interesting to both MOHSW as well as other potential investors in this model.

IV. Political Decentralization, Governance, and Health Deconcentration

A. Central MOHSW

The Government of Liberia has stated its intention to proceed towards decentralization both in its first policy and plan 2007-2011 as well as the MOHSW’s new ten-year policy and plan 2011-2021. The de-concentration of management responsibilities requires the building of performing systems at the county level, as well as effective support systems at the central level. The 2007-2011 MOHSW National Health Policy states, “The Ministry will pursue de-concentration in an incremental and pragmatic way, by assigning to county authorities responsibilities they are equipped to assume and progressively expand these responsibilities”³

The new National Policy and Plan covering 2011 – 2021 states that “the CHSWT is the operational arm of the MOHSW. The CHSWTs manage all Ministry-owned facilities, Ministry-employed human resources, and Ministry-provided material resource. The [plan] is to progressively allocate and transfer resources to the county level ... once the National Decentralization Policy takes effect.”

The entity responsible for unfolding the Government of Liberia’s (GoL) National Health and Social Welfare Decentralization Policy and Strategy is the Office of Planning, Research and Development. This Office recently hired a Decentralization Director; however his position and Terms of Reference have yet to be formally approved. An external advisor worked with the MOHSW; and a draft Decentralization policy is in the process of being validated within the ministry. The draft Decentralization Policy in circulation states that "...the MOHSW has identified de-concentration of certain health-related responsibilities to CHSWTs as the most appropriate initial institutional model towards deeper devolution of authorities to County Administrations..."⁴

³ National Health Policy and Plan, 2008-2011, MOHSW, Pg. 10. The policy further indicated that “NGO/FBO partners will be involved in the reform, through conventions or contracts. Resources will be redistributed in favor of local communities, with the objective of improving the capacity of health services to respond to local health care needs. The county level shall be responsible for health service delivery, while the central level will focus on policies, resource mobilization and allocation, aggregate planning, standards setting and regulation. The exact boundaries of the decentralized structure will be clarified over time, through interaction of central and peripheral levels.”

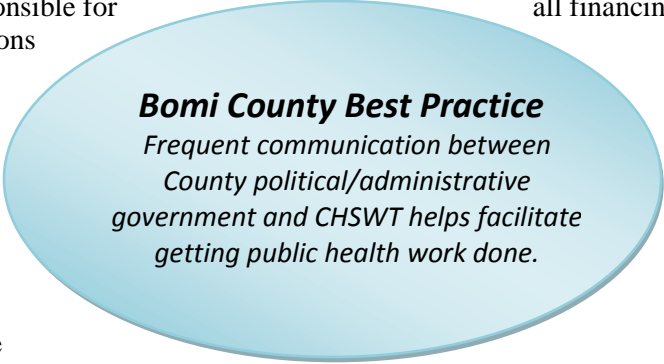
⁴ National Health and Social Welfare Decentralization Policy/Strategy 2011 draft, MOHSW, Pg. 7.

Based upon interviews and discussions with central and county level staff, there are differences in understanding of what functions, roles, and responsibilities should and should not be decentralized or “deconcentrated” to the county level; and no one interviewed brought up the notion of “devolution”. Although there were large differences of opinion as to what should and what should not be decentralized in Liberia, few leaders and managers in the MOHSW had a strong vision for reorganization of the health sector when interviewed. One manager did articulate a clear vision that requires a conscious effort to begin to think about how to separate functions in the health sector and includes the roles of Regulator (MOHSW), Fund Holder (Pool Fund), Purchaser (MOHSW), Service Provider (public sector, NGOs, private), and Oversight (PBF Unit).

B. County Level

At this time, the Liberian health system is one of “deconcentration” rather than “decentralization” whereby the MOHSW at the central level is gradually transferring responsibility to the County Health Teams. To date the CHSWTs have been responsible for oversight of NGO partners for service delivery, while the MOHSW central level has been responsible for all financing and resource allocation, human resource functions (including hiring, firing, standards, and allocations⁵), setting policy, planning, monitoring and evaluation, and determining priorities and setting targets.

The situation in Bomi County however is quite different from the other 14 counties in Liberia. In Bomi County the decentralization process has already been put into place and the county has taken on responsibility for four core responsibilities:



Bomi County Best Practice
Frequent communication between County political/administrative government and CHSWT helps facilitate getting public health work done.

1. *Finance and Administration* is carried out entirely by the county, with the exception of a US\$2,000 procurement threshold and budget line item flexibility stipulations which require MOHSW approval.
2. *Human Resource Management* including allocation and reallocation, capacity-building and training, recruitment, hiring, performance reviews for improvement, and firing.
3. *County-specific Policy and Planning* led by BCHSWT and with guidance and input from the central level.
4. *Oversight of Service Delivery and community health.*

C. County Governance and Health Systems Interface

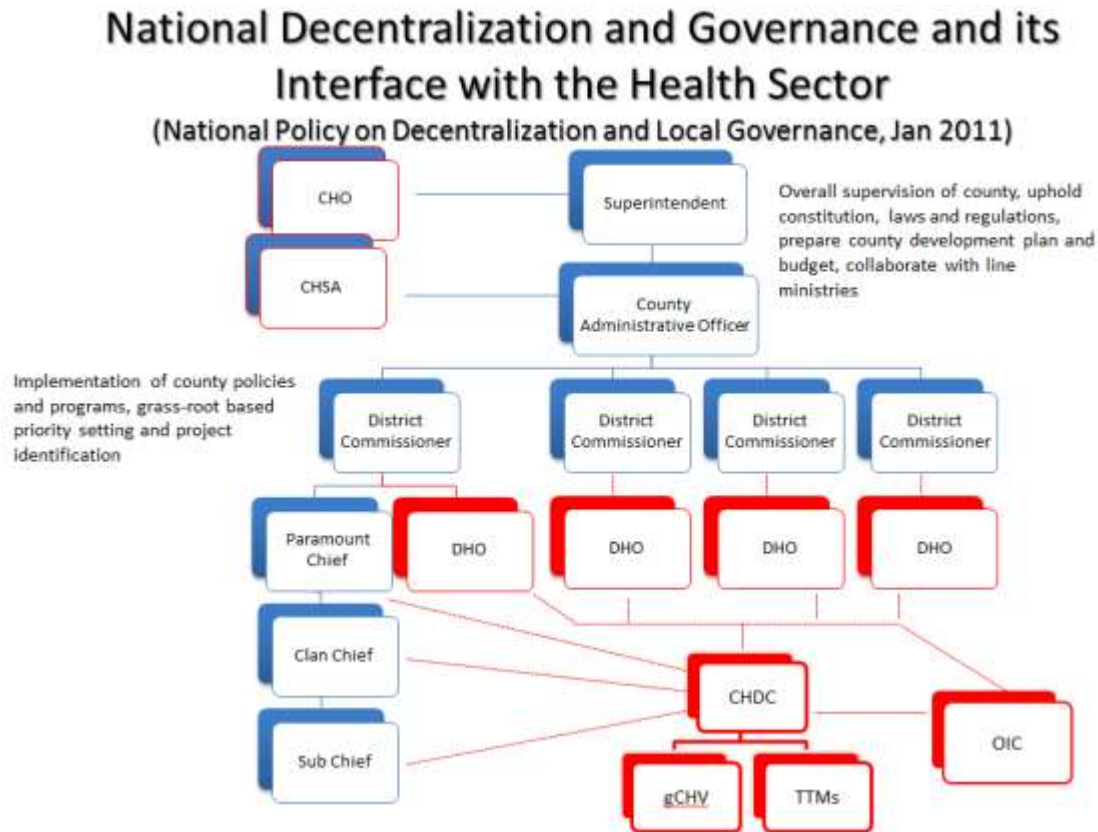
In January 2011, the GoL approved the Liberian National Policy on Decentralization and Local Governance⁶. Operationalization of the decentralization policy is in its nascent stages with the creation of

⁵ Staffing patterns are established at the central level in accordance with the EPHS as determined by the Essential Package of Health Services Primary Care: The Community Health System 2011 and the Essential Package of Health Services Secondary and Tertiary Care: The District, County and National Health Systems 2011 and the National Human Resources Policy and Plan for Health and Social Welfare 2011.

⁶ Part VI Section 6.0 falls under a Constitutional Amendment for “The implementation of this National Policy on Decentralization and Local Governance and framework for the devolution of political, fiscal and administrative powers to county governments under Chapter V Articles 29 and 34, and Chapter VI, Article 54 and all relevant provisions of the

local county level government structure. The Bomi County Superintendent's office, falling under the Ministry of Internal Affairs (MIA), represents the local government in Bomi and is the ultimate authority in the county. Under the County Superintendent sits the District Commissioners⁷. The Superintendent's office receives US\$200,000 annually from MIA for development projects⁸. However, given funding constraints in 2011, the Superintendent's office did not receive last year's tranche of funding. County local government is considering requiring household contributions to the social development fund (so as to increase revenue and ownership).⁹

Figure 2: National Decentralization and Governance and its Interface with the Health Sector



Constitution of the Republic of Liberia shall be amended through national referendum for the purpose of implementation this decentralization policy.”

⁷ 3.6 “Each county district shall operate a District Administrative Office, in a district headquarter; each district shall be managed by a principal administrative office known as the District Commissioner.

⁸ 3.6.2 “The District Commissioner shall be responsible for the implementation of county policies and programs in the districts as well as for leading a process of grass-root based priority setting and project identification which shall be submitted for the consideration in the district plan. The plan shall be submitted with cost estimated annually to the superintendent in time for the superintendent to consider developing the annual county plan and budget.”

⁹ The district government extends into the community with chiefdoms, clans and other local organizations. 3.6.3 “Each district shall elect a volunteer advisory board which shall meet at least four times a year, advise the district commissioner regarding chiefdom and clan conditions and needs, and provide input for the district planning process. “

The Superintendent chairs monthly sector-wide development meetings of the County Steering Committee. He also chairs quarterly county health board meetings, in which he is updated of the status of health situations and activities by the County Health Officer (CHO)¹⁰ and/or the County Health Services Administrator (CHSA). There is a close working relationship in Bomi between the Superintendent and the BCHSWT, and the Superintendent carries out his own monitoring of the health sector and visits health facilities on a regular basis. Positioned under the Superintendent are four District Commissioners, who oversee the planning and development of programs. On an informal basis, the four District Health Officers (DHOs) communicate with the four corresponding District Commissioners. At the community level the Community Health Development Committees (CHDCs), the general Community Health Volunteers (gCHVs), the Trained Traditional Midwives (TTMs) and the Officers in Charge (OICs) all interact with the Paramount Chiefs, Clan Chiefs and Sub Chiefs.

D. Leadership and Transparency

The BCHSWT has an extremely proactive leadership headed by the CHO who seeks out information on MOHSW policies and procedures and communicates them to the BCHSWT on a regular basis. Likewise, as mentioned earlier in this paper, the county team has autonomous decision-making over finance and administration, human resource management, organization of service delivery and management of health services all in accordance with national standards, protocols and policies.

E. Successes, Challenges, and Recommendations

Successes

There is an overall sense of teamwork and cohesiveness in the county. This is largely due to the way the county is being managed and led by the CHO and her staff. A series of management meetings to improve communication and transparency in decision-making have been taking place regularly. Regularly scheduled meetings include the following:

- Weekly Management Team meetings whereby every Monday morning the Management Team meets, take minutes of the meetings, identify issues to be addressed and action steps to take. The following week, these minutes are quickly reviewed for follow up and new issues are identified. From a review of previous minutes, a lot of problem-solving and planning takes place during these meetings. To date they have been highly transparent to date with discussions ranging from personnel problems, absenteeism, performance, or centrally mandated salary increases to how to best address a declining fleet of vehicles and shortages in fuel.

¹⁰ 3.6.1 "The district administrative office shall include a project identification, planning and development officer, a health officer, education officer, an agriculture services officer..... the county personnel shall be employed and supervised by the appropriate county bureaus, which shall be responsible for their pay and allowances."

- Monthly OIC Meetings between the BCHSWT and the OICs took place during 2010 and 2011. These meetings were chaired by the CHSA or the CHO.
- Quarterly Partners Meetings between the BCHSWT and the private clinic OICs have routinely been held in order to communicate information regarding policy changes, data collection parameters or other information and to hear from the OICs regarding clinic services.

The assessment team found that the staff interviewed at all levels in the county system are highly motivated to perform well and dedicated to their jobs. The county management team has initiated a system to provide public recognition for performance at all levels, including health clinics, the hospital, and county health team. The BCHSWT has created an innovative approach to increasing a sense of teamwork, performance, and staff motivation. Some of the efforts that have been put into place include:

Bomi County Best Practice
Staff and health facility recognition and rewards help to motivate health worker performance.

- Periodic appreciation events to recognize both health facilities as well as individuals within the facilities for outstanding performance. These events include refreshments and the presentation of a congratulatory letter from the CHO.
- Individuals from the county team also receive public recognition via similar staff appreciation events.
- At the hospital, funds generated from hospital care for patients referred by Sime Darby, the private concession clinic, are set aside to reward well-performing individuals on a monthly basis. Each individual receives a formal letter acknowledging his performance, along with US\$50 check. The number of individuals rewarded on a monthly basis depends entirely upon the amount of cash generated from Sime Darby referrals. (These rewards are done, however, on an ad hoc basis and not necessarily systematically each month).
- The county also instituted a US\$5 weekend package in 2011 whereby the clinic or health center will receive US\$5 weekly in order to keep one health staff available and on call should someone need urgent health care attention over the weekend. Funds are used to provide food for the staff over the weekend. Each facility can opt to participate in this package; to date all facilities are participating.

Bomi County Best Practice
*Regular, participatory, action-oriented meetings effectively transmit information at all levels:
 Weekly - county management team;
 Monthly – OICs;
 Quarterly – partners*

Although the Bomi CHO delegates responsibility well to her staff, she also takes care to regularly monitor service delivery at the facilities conducting random visits as much as her schedule allows.

Challenges (BCHSWT)

At the county level, challenges stem from inconsistent communication flow.

- Communication from Line Managers to middle management has on occasion resulted in a less participatory county team. Mid-level managers (mostly in the support systems such as finance and administration, human resources, logistics and procurement) feel less involved in decision-

making and to a certain extent feel less ownership and empowerment than the line supervisors. One example of this is that financial discussions and decisions do not always include human resource and personnel staff;

- In spite of the county's monthly OIC meetings, poor communication flow from the OICs to the rest of facility staff has been identified as a problem. Information shared at those meetings did not always trickle down effectively to the rest of the staff at the facility level. As a result, quarterly meetings of OICs and CMs (to be held on a Saturday so as not to disrupt work flow) will replace the monthly meetings; and,
- A majority of staff do not understand PBF/PBC concepts.

Bomi County Best Practice

Participatory team approach to decision-making fosters a feeling of ownership and empowerment throughout all levels of the county health system.

Challenges (MOHSW)

Any challenges or areas of weakness at the central MOHSW level will naturally affect productivity and outcomes at the county level.

- One of the challenges to effective contracting “in” has been the lack of communication between the central MOHSW offices and programs (and to the county level) as to what decentralization should look like, as well as what PBF/PBC concepts mean in reality.
- Additionally there is a lack of clarity at the central level as to the roles and functions of the central ministry offices in regards to PBF/PBC.

Recommendations for Bomi County

- Increased participation by all system stakeholders in planning, decision-making, and activity prioritization will ultimately strengthen not only a feeling of ownership by the staff but also increase transparency in decision-making across all levels of the county sub-system. The BCHSWT should actively include the following groups in these processes: CHDCs and CHVs, facility staff, DHOs, all BCHSWT staff, select MOHSW program staff, and local county government representatives (i.e. District Commissioners).
- Further increase communication and the flow of information from the top to down (i.e. County Management Team to mid-level team and county to DHO and all facility-based staff).
- Clearly define roles and responsibilities of key staff and share them widely (i.e. develop and communicate Terms of Reference for all staff working in Bomi).
- Ensure all facility and personnel recognition process is transparent and conclusions widely communicated so to avoid misunderstandings upon award. Criteria for good performance for both health facilities and for individual staff should be clearly and publically communicated.

MOHSW Recommendations

- ✓ The MOHSW should clearly articulate the separation of functions between the central and county levels in the health and social welfare sector through discussions on development of the Decentralization Policy prior to proceeding with further “PBC In” in other counties in Liberia beyond the Bomi pilot.
- ✓ An internal communications plan within the central MOHSW and the counties should be developed to share this new policy.
- ✓ The decentralization policy should be consistent with the National Decentralization and Governance Policy of January 2011 in order to align the two policies at the county level.
- ✓ Ensure the CHO is not only a strong manager but a strong leader.

V. Contracts in Bomi County

There are three types of contracts used in Bomi County's health sector: PBC "in" between the central ministry and the county; PBC "out" between the county and a NGO; and service contracts between the county and locally hired staff and vehicle maintenance.

A. Contract Negotiations between the MOHSW and BCHSWT

Contract negotiation between the central ministry and the county was a highly participatory process involving a number of offices from the central ministry as well as members of the county management team. There has been increased back-and-forth negotiation between the two parties, particularly in the target-setting exercise. Initially the BCHSWT gets its baseline data from the central Ministry's HMIS. The county then convenes the Officers In Charge (OIC) from the county's health facilities and asks them to determine their own monthly targets based on their historical data. The county then aggregates those data and presents these figures to the MOHSW, and a back-and-forth negotiation process begins between the county and the central ministry to confirm the targets.

B. Performance Mechanisms under contracts between the MOHSW and the BCHSWT

Contract #1 and Contract #2

The first two contracts between the MOHSW and the BCHSWT covering the period between November 2009 and December 31, 2011, included indicators chosen from the national core indicator set. These 17 National Indicators (5 administrative, 12 programmatic) are theoretically being used to monitor progress across all 15 counties in Liberia. Performance Component section of the first contract included a clause stating that, "up to 5% of actual expenditure against the obligated Agreement amount is eligible as an annual performance bonus... based on progress made towards the agreed targets." Whereas the second contract links the bonus to "... progress made towards the agreed service delivery targets". Likewise, the first contract links sanctions of 5% of actual expenditure against the obligated amount for failure to meet targets and the second contract links sanctions to failure to meet administrative targets.¹¹ The contract goes on to say that the proportion of the 5% to be paid is dependent upon the number of administrative targets met -- if all five administrative indicator targets are met there will be a 5% increase over budget as a bonus; if only one is met than 1% bonus will be granted.¹²

"Contracting In": MOHSW contracts the BCHSWT

There have been two signed contracts as of February 2012 between the MOHSW and the BCHSWT:

CONTRACT #1: November 1, 2009 – June 30, 2011 (US\$963,218)

CONTRACT #2: July 1 – December 31, 2011 (US\$800,000)

PROPOSAL: 3-month bridge contract to cover January 1 – March 31, 2012¹ (US\$511,476)

PROPOSAL: 27-month contract to

¹¹ Section 5.4 Performance Component under first contract; Articles 6.2 Detailed Budget and 6.4 Performance Component under second contract

¹² Article 6.3 Detailed Budget in second contract

Service delivery performance is addressed differently in the contracts from administrative performance. Specifically, "... up to 5% of actual expenditure will be awarded quarterly based on progress made towards the agreed upon service delivery targets.' Unlike administrative performance, there is no penalty for under performance in service delivery. The contract goes on to say that use of the bonus is at the discretion of the provider (BCHSWT)¹³.

Under contract the MOHSW determines the amount of incentive to be paid based upon performance results and funds are to be transferred directly into the county account.¹⁴ Although it is stipulated under the second contract that the MOHSW will, on a quarterly basis, review and validate county performance, this has not been done.

Contract #3

The proposed new 30-month contract has actually been broken down into two contracts – one covering the first three months from January 1 – March 31, 2012 and a second covering the remaining 27 months from April 1, 2012 – June 30, 2014. This new 30-month proposal includes 17 performance indicators (5 administrative and 12 programmatic/service delivery-focused), outlines the data sources for each, and provides the numerator, denominator, and baseline data as well. There are clauses under the proposed contract to include provider reporting requirements as well as a percentage award or sanction based upon verification of contract compliance and performance by the purchaser (MOHSW). In addition, the new proposal includes a LQAS and end of contract evaluation clause that the original contracts had not stipulated. And lastly, the proposed contracts include a clause for a yearly bonus/sanction of 10% (or 1% per target) over the cost of the contract. Monitoring and evaluation requirements include RHMS and MOHSW monitoring visits as well as LQAS, accreditation, and a MOHSW end-of-project evaluation. This new proposal also stipulates a full two-month advance to serve as a finance buffer in the event of delays in disbursement of funds by the Pool Fund. In addition, under the new proposed contracts, the Pool Fund would finance and purchase all Bomi County drugs and supplies on behalf of the entire county based upon county estimates of need.

C. Contracting out to AHA

The BCHSWT contracts out to AHA to run six of the county's clinics, however, unlike the negotiation process that occurred between the MOHSW and the BCHSWT, the sub-contracting process did not involve negotiation between the county and AHA, rather the contract was presented to AHA utilizing the

"Contracting Out": BCHSWT contracts the AHA

There have been two contracts between the county and the AHA:

CONTRACT #1: November 1, 2009 – June 30, 2010 (US\$186,093)

CONTRACT #2: July 1 – December 31, 2011 (US\$162,649). (Note: The latter contract stamped by AHA is for a different amount over the same time period of July 1-Dec 31, 2011 - US\$153, 104 so there is some discrepancy found in record-keeping.) Under contract terms, the AHA has been responsible for the procurement of drugs through NDS and paid under contract with the county.

"Contracting Out": Service Contracts

There are two types of service contracting underway in Bomi.

Employee service contracts: professional and non-skilled -- hired by the county locally to work in the health system

Vehicle maintenance contract: one-year between the county and Uptown Garage and Auto Parts signed on August 17, 2011.

¹³ Article 6.4, second contract July 1 – December 31, 2011

¹⁴ Articles 6.2, second contract

same contract template and standard language which the Pool Fund uses when it contracts out to Non Governmental Organizations (NGOs) in other counties. The performance measures under the sub-contract with AHA mirrored those of the central-to-county level contract. Presently a proposal is under development by AHA for the next iteration of a contract between the NGO and the county.

D. Service Contracts

There are two types of service contracts in Bomi – contracts with individuals for health care service delivery and contracts with companies for auxiliary services such as automobile repairs. For purposes of this evaluation contracts for auxiliary services are not be addressed. Service contracts between the county and the employee or “contractor” include a three-month probation period for a performance review and all employees are “at will” employees, whereby either party may terminate the contract with two weeks advanced notice. These service contracts between the BCSHWT and the “contractor” do not stipulate for any performance evaluations or other mechanisms for performance feedback between the county and the contractor.

E. Accountability Mechanisms and the Performance-Based Financing (PBF) Unit

Although there are mechanisms for financial and programmatic accountability written into the PBC “in” contracts, they are not consistently employed. Operationalization of accountability mechanisms and verification of information and data is still under development. There has been little to no verification of contract performance against programmatic or administrative targets by the Purchaser (MOHSW) to date. Similarly, while there are a few mechanisms for accountability written into the contracts between the BCHSW and AHA, there has been little enforcement to date.

In order to properly ensure contract verification and measures of accountability, the MOHSW has developed a new oversight unit called the Performance Based Financing (PBF) Unit. The PBF Unit falls under the Department of Health Services, which is led by the Deputy Minister Chief Medical Officer of the Republic of Liberia. This unit was created in July 2011 and consists of a team of five: a Manager, Data Officer, Data Analyst, Administration and Finance Officer, and Training Officer.

F. Reporting

Quarterly financial reports are sent to the Office of Financial Management (OFM) Pool Fund; further explanation on these reports is covered in the section on Financial Management and Administration. Quarterly programmatic reports are sent to the External Aid Coordination Unit in the central MOHSW. These reports detail activities over the preceding quarter including description of funds used, narrative on challenges and gaps, actual vs. planned output, problems encountered, performance matrix, financial report, pro forma invoices and disbursement schedule. Most of these sections are well developed. However the section on Planned Output versus Actual Achievements has quite a few errors in figures and explanations, and programmatic reporting was incomplete. That said, although the county prepares and submits quarterly reports on a timely basis, it does not appear that these reports are reviewed nor is feedback provided by the central MOHSW to the county.

G. Recommendations

As Bomi County continues contracting “in” with the Central MOHSW and contracting “out” with service providers, it should:

- Ensure negotiated targets with the MOHSW are realistic and based upon actual baseline data from the service delivery area and correspond to each of the health facilities in the county.¹⁵ The county needs to hold the health facilities (i.e. providers) accountable for meeting their targets.
- Work with the PBF Unit and any others in the MOHSW responsible for contract oversight to ensure that the design of the contract includes clear performance measures, timeframes, and mechanisms for performance verification, as well as bonus payments or sanctions.
- Develop contracts with the five private clinics in the county (i.e. Ahmadiyya, Gbah Jakeh, St. Luke's, Sime Darby, and the new clinic which holds an operations permit (i.e. AB Anderson Memorial Clinic). These contracts should specify what the public sector, BCHSWT, provides (i.e. medicines, cold chain and solar panel, trainings, etc.) and what the private clinics provide (i.e. timely reports and data, surveillance, use of CHVs and TTMs, outreach, assistance with transportation, etc.). Seek technical assistance in drafting and negotiating these contracts.¹⁶
- Amend all current and future service contracts with companies to include a clause for guaranteeing services (i.e. vehicle repair clause for 90 day service guarantee and clear local contractor/employee performance review guidelines to avoid potential misunderstanding).

MOHSW Recommendations

- ✓ Verify that the data being used for both baseline and targets under contract are both accurate and realistic and based upon the service delivery area corresponding to each of the health facilities in the county.¹
- ✓ Ensure that the design of the contract includes clear performance measures, timeframes, and mechanisms for performance verification by the central ministry.
- ✓ Institute quarterly monitoring of contract performance and provide corresponding bonus payments if applicable.
- ✓ Assist the county in development of contracts with the private faith-based or commercial clinics. These contracts should specify what the public sector, CHSWT, provides (i.e. medicines, cold chain and solar panel, trainings, etc.) and what the private clinics provide (i.e. timely reports and data, surveillance, use of CHVs and TTMs, outreach, assistance with transportation, etc.). Seek technical assistance in drafting and negotiating these contracts.¹

VI. Financial Management and Administration

The BCHSWT receives three types of funding within a given year: Pool Fund quarterly disbursements, Government of Liberia (GoL) yearly county allocations (given to and accounted for by all counties), and donations from partners through the central MOHSW. Donations from partners are based upon need and solicited through auxiliary funding requests from the county through the MOHSW Chief Medical Officer (CMO). An accounting for and liquidation of these donations are prepared and sent to the Office of Financial Management (OFM) in the MOHSW. This section focuses primarily on Finance and Accounting systems as they pertain to the Pool Fund monies.

¹⁵ Catchment data based on the census may not always be accurate and the county should work with each facility to determine the breadth of its work and how much can be accomplished over the quarter.

¹⁶ Under Liberian law all private clinics must provide all services in the EPHS. If there is a shortage of drugs or vaccines then these clinics cannot provide the required services. The county has the oversight responsibility to make sure the clinics perform as well.

A. The Pool Fund

In 2008 a health sector Pool Fund within the OFM was set up with initial outside support from an international accounting firm. The creation of the Pool Fund served as a transitional mechanism for international donors to fund health sector activities while ensuring strong financial management, accounting mechanisms and transparency are in place over the use of such funds. This transitional mechanism was intended as an interim phase to full GoL budgetary support. The Pool Fund serves to fund MOHSW initiatives, including PBC “out” of NGOs through eight contracts with five NGOs and PBC “in” with Bomi County.

B. County Level Financial Management and Accounting

BCHSWT has an entire unit within its organizational structure dedicated to Financial Management and Administration; there are five full-time financial and administrative staff in this unit as well as another full-time resource in the Hospital. In Bomi County, a County Health Services Administrator (CHSA) oversees the Finance Manager, County Accountant, Logistician, Procurement Officer as well as Human Resource Manager, and Training Coordinator. The Hospital Medical Director oversees the Hospital Administrator who also serves as the Accountant for the Hospital. By creating a separate F&A unit, the county is able to create and put into place proper accounting and administrative systems to run county operations.

In order for the Bomi F&A Unit to be able to manage and report on pool fund resources, the team did receive some training and capacity-building support. Three days of on-the-job training was provided to the county Finance Officer by the AHA finance officer. In addition, the county Financial Manager attended three (1 week long) intensive trainings held by the MOHSW OFM on the new single reporting system to be employed throughout all 15 counties.

The Finance and Accounting unit is responsible for producing two separate reports one on the GoL budget and another for the Pool Fund. Likewise, the Hospital Administrator is required to produce these same two reports. The GoL reports are submitted in Liberian dollars and the Pool Fund reports in US dollars. The GoL reports are not very detailed and only require expenditure breakdowns.

In the case of Bomi County, the Pool Fund provides the great majority of its funding. Under the contract between the county and central ministry, the financial reporting period is quarterly and corresponds to the GoL fiscal year of July – June. The contract stipulates that reports must be submitted within 30 calendar days of the end of reporting cycle and a delay will result in penalty¹⁷. The Pool Fund financial reports are very detailed and must include:

- Bankbook and ledger reconciliation for each expenditure
- Budget Monitoring Report
- Distribution schedule: show what was received broken down
- Performance invoice: requests for the quarter, contains formula to give how much is needed
- Access tracking form: for everything > US\$1,000
- Photocopies of all purchases

¹⁷ Article 6.2, second contract July 1 – December 31, 2011

The Pool Fund Secretariat provides quarterly disbursement to BCHSWT. The funding flow between the Pool Fund and the BCHSWT involves a solicitation process with three forms:

1. The County sends an Expenditure Report¹⁸ to the Pool Fund for review. This report serves as a Budget Monitoring Report. Upon approving the Report, the Pool Fund sends it to Internal Auditors at the Ministry of Finance (MOF), who are seconded by MOHSW.
2. A Disbursement Schedule is filled out which tracks periodic expenditures.
3. Based upon the disbursement plan, a Fund Request is made by the county.

Once the County receives a payment, the Finance Officer (who is supervised by the CHSA) in Bomi signs an official receipt and files a photocopy of the check.

While this management system exists, the deadlines and timing for submission of forms and subsequent approvals of disbursements are not always clear. For instance, although the county knows when they must submit their quarterly expenditure report, more often than not there are a series of queries and answers which results in delays in disbursements. Likewise, the county procurement requests over the \$2,000 sometimes take up to three weeks for approval.

Funds come directly from the MOHSW Ecobank account in Monrovia and are wired to the BCHSWT bank, LBDI. It takes five days for the bank to bank wire transfer to clear.

The county has a system under which it manages four separate accounts – two in Liberian dollars (one for the county and one for the hospital), and two in US dollars (one for the county and one for the hospital). Funds are tracked and reports made weekly on each of these accounts.

Although there is a great deal of flexibility and autonomy on the part of the BCHSWT in budget planning and financial management, a few areas still fall under the purview of the MOHSW OFM, including:

- There is a threshold of US\$2,000 maximum for all procurement¹⁹; anything above that needs central level approval. This requirement also allows for bulk procurement with economy of scale.
- The County must seek approval from the Pool Fund to reallocate funding between budget line items once a budget has been submitted and approved.

Procurement

In Bomi a system is in place whereby each county department and program places its own procurement requests through the CHSA. In order for the request to be processed, the Finance Officer must verify availability of funds. Next the procurement officer conducts an analysis of potential vendors and funds are then apportioned in accordance with the budget line items (there are 24 budget line items).

C. Internal and External Audits and OFM Oversight

Internal Audit

As mentioned above, the Pool Fund manager sends the quarterly liquidation reports, once approved, to the MOF internal auditors who represent the Pool Fund from the MOHSW, for their review. In addition,

¹⁸ The BCHSWT Accounting unit is responsible for producing two separate reports one on the GoL budget and another for Pool Fund. The latter is very detailed while the GoL report only needs to include the expenditure breakdown. Pool Fund reports are done quarterly and must include: Bankbook and ledger reconciliation for each expenditure; Budget Monitoring Report (BMR); Distribution schedule to show what was received broken down; Performance invoice: requests for the quarter, contains formula to give how much is needed; Access tracking form: for everything > US\$1,000; and photocopies of all purchases.

¹⁹ Infrastructure, equipment, essential medicines and fuel (including for hospital electricity supply) purchases are generally greater than \$2,000 and are done centrally.

these same OFM/internal auditors review financial records every six months. A team from the OFM goes to Bomi County and verifies how recording and filing is being done as well as whether daily recording is taking place correctly in both the cash book and in the excel spreadsheet. The OFM also monitors warehouse stock and coding of equipment. The OFM team has conducted this audit four times over the life of the contract.

External Audit

Under the second contract the provider (BCHSWT) is required to “... engage a reputable firm of public accountants to carry out an annual audit of the Provider’s books, statements, procedures, records, internal controls, and receipts related to this contract.” The cost of the audit is reimbursable under the contract by the purchaser (MOHSW)²⁰. This external audit is also included in the terms of the proposal for the new 30-month contract as something for which the county will contract out with an independent entity. If this clause is to remain in the contract, then the terms of the contract with an independent evaluation will need to be negotiated prior to signing the contract.

D. AHA Subcontractor Payment Process

After the BCHSWT receives their funds from the Pool Fund, AHA submits a quarterly disbursement request for their anticipated expenses.

This submission goes directly to the CHSA and the CHO, who then approve the funds to be released by the accounting officer. AHA signs a receipt of the quarterly disbursement amount. Unlike the county, AHA is not restricted by the US\$2,000 procurement threshold. The report AHA submits to the county finance office contains all of the same information as that which the county submits to the Pool Fund. The AHA report is sent to the Pool Fund and the county keeps a copy of it on file.



E. Success, Challenges, and Recommendations

Successes

BCHSWT has a semi-decentralized Finance & Accounting System. The County has the autonomy to quickly use its funds to carry out planned activities. There is little delay of work and one can note many measurable results including infrastructure improvements, equipment, staffing, training, etc. The county budgeting and financial planning exercise successfully anticipates costs (i.e. operating costs, training, scratch cards, fuel, and staff recognition).

Challenges

Despite successful financial planning and accounting, there are a few areas that could be strengthened, including:

- Reporting requirements are sometimes unclear and changes in the Pool Fund template have resulted in frequent delays in flow of funds to the county. All Pool Fund recipients under contract – NGOs and Bomi County – have reported confusion, which has resulted in their reporting not being up to Pool Fund standards.
- There is insufficient financial and accounting training as well as financial supervision by MOHSW (Pool Fund/OFM).

²⁰ Article 6.6, second contract July 1 – December 31, 2011

- Required central level approvals for re-budgeting and procurement over the set threshold of US\$2,000 place additional strain on county financial planning and can inhibit the timeliness of delivery of goods.
- Attention to detail in budgeting could be strengthened. For example, the new 30-month proposal budget includes funding for performance rewards. This is not customarily included in a budget submission as such.

Recommendations

In order to further strengthen the BCHSWTs already successful financial and administrative management, the following recommendations could be useful:

- BCHSWT should develop a one-year detailed monthly budget as part of the proposal process so that the county can better assess the flow of funds against actual expenditures and accruals against estimates of future costs. This would both enable the county to carry out more detailed planning of expenditures against activities and it will also permit the Pool Fund manager to anticipate future disbursement requests. As part of this budgeting exercise, it would also be useful for the county to submit - before the 3rd quarter of each year is completed – a Year 2 detailed month-to-month budget. This new yearly budget would include actual expenditures and accruals to date, plus projections for the next contract term;
- The BCHSWT should receive training in financial planning and budgeting;
- The Purchaser (Pool Fund) should systematically conduct quarterly on-site supervision and financial monitoring (verification) of the county in situ;
- Contracts (for both the county and partners) should include a financial performance indicator indicative of proper financial reporting; and,
- Rewards are provided by the purchaser based upon verification of performance. Remove budget line item in 30-month submission for performance rewards as this should be funds from the MOHSW [budget] not the county. Or if this line item refers to rewards by the county to staff and facilities and they wish to budget for them then this should be called “other administrative” costs.

MOHSW Recommendations

There are a few recommendations to the Pool Fund managers that will strengthen the county’s ability to plan, manage and report on its financial and administrative operations. Among these suggestions are:

- ✓ Re-examine the US\$2,000 threshold to see if it should be across the board or with some exceptions.
- ✓ Develop Pool Fund standard user-friendly reporting template for all financial reporting and accounting and ensure county financial and accounting staff are trained in its use and application.
- ✓ Streamline cumbersome liquidation processes (Pool Fund and MOF) to ensure approval of expenditure report and disbursement within two weeks of submission while continuing to provide a buffer of two months while this process takes place in order not to cause any delays in field activities.
- ✓ Strengthen collaboration and communication between the Pool Fund, PBF Unit and External Aid, to ensure performance- based bonuses are paid in a timely manner to influence results.

VII. Public Health Management, Performance, and Supervision

A. County Organizational Structure, Planning, and Supervision

The organizational structure of the BCHSWT is similar to that of other counties. Some positions have been added (e.g. Finance Officer, Procurement Officer) and some have been changed since the organizational chart was last updated and these positions will be mentioned throughout this report. See Figure 3 below for the official organizational chart of the county.

There is a Senior Management Team made up of Line Managers and Supervisors and led by CHO. The original position of the county Clinical Supervisor was upgraded to become a Clinical Health Services Director (CHSD) in order to both ease the management burden on the Community Health Department Director (CHDD) and make a clear distinction between work in community development and outreach versus the clinical supervisory functions.

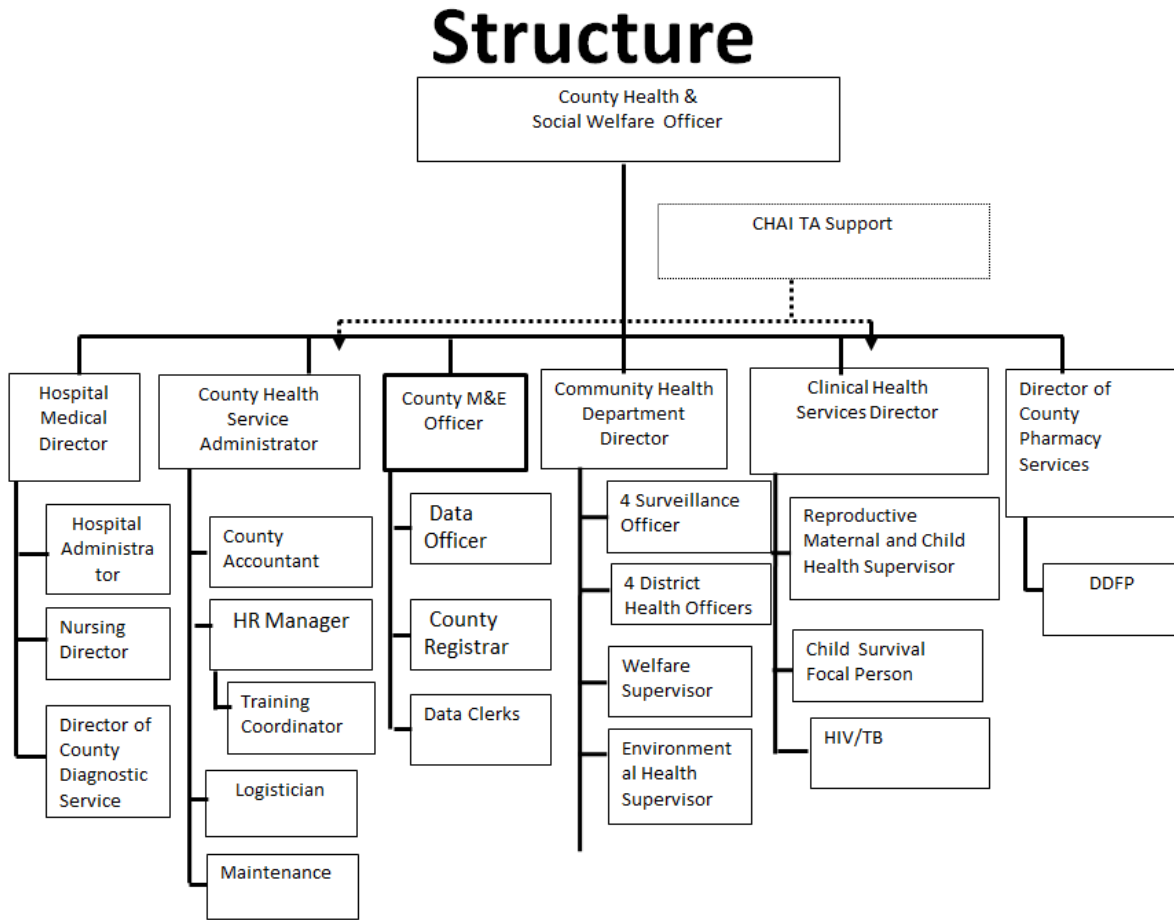
There are four District Health Officers (DHOs) who also fulfil the role of District Surveillance Officers who report to the CHDD. There are four District Environmental Health Technicians (EHTs) who report to the CHDD as well. The DHO plays a supervisory role to health facilities and serves as liaison between the health facilities and the BCHSWT. The DHO positions were filled a little over a year ago and although all four of the DHOs are clear as to their roles and responsibilities, they do not yet have written Terms of Reference under which to operate.

Under the DHOs is the Health Facility Level. Each facility is run by an Officer in Charge (OIC) who is a RN, BSN, or CM/RN. Each health facility, depending upon its size and catchment population has both professional and support staff supervised by the OIC. Under each health facility are the Community Health Volunteers (CHVs). There are two types of volunteers working in Bomi County, general CHVs (gCHVs) and Trained Traditional Midwives (TTMs). Below the CHVs, each facility is associated with a Community Health and Development Committee (CHDC).

In addition, the county allocated a position for a technical advisor from CHAI to sit in the county offices and provides advice and guidance (see organizational chart below). During the contract period, CHAI provided technical support through a Decentralization Support Team (DST) consisting initially of three advisors: a Decentralization Project Coordinator, a Bomi Field Coordinator providing support to the CHO, and a Clinical Mentor providing support to the county clinical staff.

The Decentralization Project Coordinator's principle contribution to the pilot was to advise the CHO and facilitate consolidation of the Bomi team. In particular the Project Coordinate helped to strengthen and foster a stronger team environment and culture and put systems were put into place which would ensure continuity of management systems. Another contribution of the advisor was to organize and facilitate a two-day team building workshop. The Coordinator position was filled for five months in mid- 2010.

Figure 3: County-level organizational structure for health service delivery system



Successes

Supervision and oversight of health service delivery are a large part of the BCHSWT’s every day work. Across all levels of the system staff understand the importance of supervision and expect it to take place. Regular supervision and oversight have become part of the institutional “culture” of the health service delivery system in Bomi County. The county has had a number of important specific successes in Planning and Oversight over the contract period, including:

- Line supervisors and managers from the BCHSWT and the DHOs make regular supervisory visits to all health facilities in the county. The BCHSWT makes monthly supervisory visits to the 19 public, six partner (AHA), and four (now five as a new clinic was just approved last quarter) private clinics. Weekly supervisory visits are made by the DHOs which allows the Clinical Health Services Director (CHSD) and the Community Health Development Director (CHDD) to obtain more frequent real time information from the field. The CHSD and the CHDD ultimately have oversight responsibility over health facilities through the DHO.

Bomi County Best Practice
County-wide focus on using supervision as a tool for oversight and improvement in service delivery

- Joint Supervision, as defined by supervision visits by both the BCHSWT and AHA supervisor occur on a quarterly basis to each facility. These visits are routinely discussed at the regular Monday morning meetings.
- The BCHSWT has created its own supervision tool to aid in their work.
- Efforts are made to both identify issues during supervision visits and to log them in written format in facility-based ledgers.
- The county Pharmacist created his own supervision check list and uses that to make periodic supervision visits to the facilities to query on stock outs and take stock of inventory²¹.
- Following the MOHSW guidance on health planning, the county developed its two-year operational plan (January 2012 – December 2013). This plan includes multi-stakeholder input, including business, civil society, local governance and health sector. The MOHSW reviewed drafts of the plan twice, and approved the final plan last year.

Challenges BCHSWT

Although supervision is one of the most impressive results from the Bomi Pilot, there are still a number of challenges found at the county level, among them:

- There is little feedback and problem-solving beyond recording visitors in ledger resulting from supervision.
- There are inconsistent and incomplete written records of visits and decisions made in the facilities and county offices by the BCHSWT and the DHOs (all levels).
- Although supervision takes place and monitoring data are routinely collected for reporting to the MOHS, staff do not yet incorporate or utilize these data as the basis public health planning whether at the county, facility or community level.

Challenges MOHSW

- There is inconsistent and very little MOHSW supervision over the county.

Recommendations for Bomi County

There are a number of things that the county could do to improve upon its already well performing management system. Among them:

- Seek out technical support for capacity-building in use of data for public health planning (begin at county level and then move downwards throughout the system for planning).
- Institutionalize as a best practice regular monthly recognition of high performing health facilities.
- Build upon the already successful staff and facility recognition initiatives in place and ensure that the criteria for good performance and receiving recognition is clearly understood by the staff, so as to remain as transparent as possible. Some thought needs to go into development of such criteria in order to make it broad enough that it does not limit or exclude a clinic or staff but specific enough that all involved know what is expected of them. The county could benefit from some technical support in devising and planning how to communicate these criteria.

²¹ At the time of the assessment there were no apparent stock outs in the clinics visited.

Recommendations for Bomi County

Planning needs to be strengthened at all levels in the county. Some short-term activities which could contribute to strengthening planning include:

- Systematically increase the involvement of the DHOs in planning activities to improve planning at facility level. The BCHSWT model of Weekly management meetings could be replicated at the facility level.
- Build capacity of the DHOs in health planning through a short one-day workshop as well as on-the-job competency-based training with technical advisor.
- Initiate quarterly OIC/CM meetings and structure agenda as to contribute not only for reporting by the county but to enhance facility planning and the outreach work of vaccinators and CHVs.
- Budgeting exercises for each clinic could include DHOs & OICs in order to further empower them regarding their own work.
- Although an impressive amount of emphasis has been placed upon supervision in the county; however there are a number of areas where the DHOs could be utilized even more strategically. These tasks include:
 - Strengthen feedback from BCHST and DHOs to facilities
 - Provide refresher training to DHOs in community health and clinical supervision
 - Standardize documentation requirements of DHOs for Community health supervision visits.

B. Human Resource Management and Personnel

MOHSW National Human Resource Policy and Strategy 2011 – 2021

The overall aim of the MOHSW National Human Resource Policy and Strategy 2011-2021 is to increase the number of high-performing facilities and institutions that promote continuous learning and assure quality. Following on this, the second objective of the human resource strategic plan is to improve performance of the workforce. The Human Resource Policy is very specific in articulating how workforce performance will be strengthened. See Annex A for a listing of the activities that will be carried out to achieve improved performance of the workforce. The BCHSWT has already begun to implement some of the activities laid out in the National Plan.

Civil Service Administration National Requirements

Under the Governance Commission Civil Service Agency (CSA) framework, "...a revamped public administration must be structured to ensure that it is not an elitist centralized, driven instrument from Monrovia...[it must be decentralized] so that it reflects the social composition of the whole nation and engenders the participation of the population. In essence, it must account for national, regional and local (community) participation. Eventually, when fiscal resources permit and as capacity develops, service delivery delegated to non-state actors can be recalled and undertaken directly by government."²²

Under the CSA regulation, all administrative personnel, with the exception of clinical personnel, must take a test in order to become a civil servant. Civil servants are paid with GoL funds through the Ministry of Finance (MoF). Those workers who are not civil servants are employed as contractors. This cadre is not paid directly with GoL national budget funds; rather, they are paid either by cooperating partners or through the Pool Fund. The MOHSW budget (or in this case BCHSWT budget) also funds contractor "incentives," which are monetary complements to a base salary.

²² P. 4, MFR Restructuring Ministries and Agencies – A Streamlined Framework by the Governance Commission Civil Service Agency and Liberia Institute for Public Administration. May 2010.

BCHSWT follows national performance review dismissal procedures, which include four steps: first a verbal warning is issued, then a written warning is issued, followed by a suspension from duty, and finally dismissal is requested by the BCHSWT and sent to MOHSW Office of Personnel with supporting paperwork for confirmation. This paperwork is then sent to the CSA, and the MoF removes the employee from payroll.

Likewise, the BCHSWT follows the national recruitment process. First, the BCHSWT develops the terms of reference; then the position is advertised. Qualified candidates are shortlisted and an interview panel is set up with a representative from MOHSW. It is important to point out that the BCHSWT pays transportation and per diem to the MOHSW representative to travel to Bomi and participate in the interview.

During the first year of the contract, Bomi experienced high attrition of personnel. This improved as the county held a team building workshop facilitated by the CHAI Project Manager and made efforts to strengthen communication at the county level.

Successes

In terms of autonomous decision-making over human resource management and personnel decisions, the BCHSWT has a great deal of autonomy over recruitment, hiring, training, and firing. During the Monday morning weekly meetings, the line managers discuss personnel issues, including resource allocation, identification of human resource needs, capacity restraints, and gaps and problems with staff performance. Some notable actions taken over the contract period include:

- The CHO successfully fired two civil service professionals for absenteeism;
- Human resource planning to avoid gaps in staffing. For example, in the case of vaccinators (high school graduates), a pool of applicants are trained on a regular basis and given certificates if they complete the program successfully. Personnel are recruited from this pool when vaccinators are needed at the facility level. This process has helped to keep the position filled because in the past high turnover has been a problem. Now there is always a pool of qualified applicants; and,
- AHA pays their staff directly under the sub-contract with BCHSWT.

Challenges

Despite considerable success and highly autonomous decision-making by the county over its human resource management and personnel, a few challenges remain. A few examples are:

- Human Resource management and decision-making has not been entirely decentralized; the county is not permitted to set staff salaries nor determine salary increases. Salaries are set at the central level;
- There is an underutilization of the Training Coordinator. For the most part line managers identify, design, organize and coordinate the county-level trainings themselves; and,
- Although clearly line managers feel a sense of empowerment and ownership over the county operations, middle level managers (i.e. those who work in support functions such as finance and administration, human resources and training, procurement and logistics) are sometimes left out of decision-making and this has resulted in a weaker sense of ownership and connection in county operations.

Recommendations for Bomi County

- Update the organizational chart every six months to reflect new positions or changes in current positions.
- Ensure there are Terms of Reference for all staff for clarity in responsibilities and reporting lines.

- Use training and human resource staff more to lighten load on line managers and further delegate real authority/responsibility. All county-level training and recruitment should ideally be coordinated by the HR Office by empowering and supporting the Training Coordinator with the authority to design, coordinate and implement training activities in collaboration with the Line Manager or supervisor in charge.
- Increase inclusion of support function staff in decision-making and problem-solving.

C. Community Participation, Surveillance, and Environmental Health

Community Health Services National Policy

The overall aim of the revised National Community Health Services Policy is to provide a standard set of outreach practices, health promotion techniques, and a referral process for communities more than one hour walk (5km and above) from nearest health facility. The Vaccinators, who are part of the health facility staff, are responsible for vaccine outreach and tracking of defaulters. The CHVs include general gCHVs, TTMs, and Community Health Support Groups²³. CHDCs serve as the governing body of all County Health Committees (CHCs) in a catchment community.

In Bomi County there is one CHDC per facility consisting of leaders from each village who are responsible for linkages within the community. The TTMs encourage women to come to health facilities to give birth and for post-natal health education. The gCHVs are responsible for surveillance, tracking of pregnant women, Oral Rehydration Salts (ORS) and zinc distribution, health education, and participation in campaigns sponsored by the health facility. Although the new policy sets the established ratio for the gCHVs to 250-500 population, in Bomi County there are on average 1,000 population per gCHVs.

In Bomi the DHOs play an important role in this area. In addition to their district health duties, they also serve as the District Surveillance Officer (DSO) responsible for active case search on priority diseases, investigation of cases/specimen collection, training/sensitization of health workers and data analysis.

Successes

- Approximately 50% of the county clinics have regular monthly meetings with the gCHVs/TTMs/CDHCs;
- The National Immunization Days (NIDS) have been well-coordinated with local government and have the active participation of District Commissioners, gCHVs, TTMs, and CHDCs;
- The gCHVs have received training in environmental health activities (i.e. water chlorination);
- The health facility staff provide health education for 20 minutes each morning on a rotating basis to patients in the waiting areas. Each facility has a television which helps to attract patients to the facility waiting area.
- There is a very strong push for facility-based deliveries at all levels of the system. A number of mechanisms are in place to encourage facility-based delivery including:
 - Incentives under development for TTMs to bring woman to clinics including notion of a performance bonus;
 - Village chiefs fine TTM with public community service if assisted home birth; and,
 - Encourage husbands to save a little bit at a time early on in pregnancy to pay TTM;

²³ Community Health Support Groups include the following groups: Household Health Promoters (HHPs), Community Directed Distributors (CDD), School health, Mass Drug Distributors (MDD)e. Community Directed Care Providers, and Community Based Distributors.

- County team discussing ways to motivate gCHV, TTM, and CHDC (Transportation reimbursement and Refreshments during meetings; and,
- Environmental Health initiatives – 4 district environmental technicians active in facilities and community use of incinerator, sharps boxes, and placenta pit.

Successes in Surveillance

- The DHOs conduct regular active surveillance and case search at facilities;
- The County Surveillance Officer strengthened the recording system at facility level with the introduction of ledgers; and,
- The R/H Officer, DHOs and OICs provide regular education sessions to TTMs and gCHVs.

Challenges in Community Involvement

- There is weak and inconsistent planning for immunization outreach sites and schedules. The linkage between the gCHVs and the clinic staff in terms of communication and planning is done on a need-be basis in most of the health facilities visits. Along similar lines, there is no accountability of facility outreach services and there is scant data on number of pregnant women and immunization defaulters collected. There is very little data collected on gCHV health promotion work in the community;
- There is a lack of compensation of any kind for any community volunteers although national policy accounts for it. The policy states that gCHVs as volunteers shall not receive a monthly salary, though they should be reimbursed for transportation, provided meals and lodging during activities and trainings, and provided with essential supplies needed to get their work done.²⁴
- Bomi County only has 1 gCHV per 1,000 people, which makes it difficult to effectively reach all communities.

Challenges in Surveillance

- There is an underutilization of CHVs (gCHV, TTM, CHDC) for surveillance work.
- There is weak communication and case notification by gCHVs in priority disease.

Recommendations for Bomi County

Community participation and outreach are two areas which the county has a lot of room with which to develop new strategies and approaches. Among them:

- Institute systematic supervision by the DHOs and OICs over the work of the CHVs to facilitate immediate action and inform planning for the catchment area.
- Strengthen Behavior Change Communication (BCC) work in the community targeted at religious leaders and schools in order to facilitate the gCHV and CHDC's community mobilization and participation in health promotion.
- Increase the number of gCHVs per capita (in accordance with the new policy) and make sure to include in the newly-proposed budget funding for transportation, refreshments and any essentials needed for their work.
- In order to strengthen the county's surveillance activities, the CHVs need to be trained in priority disease case definitions. It would also be helpful for the county to create a standard

²⁴ Insert reference

reporting channel from the CHVs to the OIC and the DHOs on opportune and timely identification of priority diseases.

- To strengthen health facility outreach, consider the following:
 - Strengthen planning of and develop schedules for outreach sites and communication with CHV and villages/communities;
 - Develop schedule and hold facility staff accountable for activities;
 - Institute integrated outreach services for MCH & EPI; and,
 - Use the concept of the “weekend bonus” to encourage and compensate health workers for outreach work. AHA developed this model in Gbarpolu and it has been effective.

MOHSW Recommendations

- ✓ In order to ensure quality of care in service delivery, it is important that the central MOHSW conduct quarterly supervision to the county level. This supervision could be designed so that it involves review of written records and documentation together with the BCHSWT line supervisors and includes random visits to a few health facilities each quarter.
- ✓ Use caution in transfer of staff from contractor to civil servants to avoid absenteeism, complacency and under performance.
- ✓ Include a performance indicator in the contract to reflect community participation. It would be important to consult with advisors in this area as to what indicator may be the most indicative of the use of community volunteers and the development committees to increase knowledge and attitudes about public health disease prevention and health promotion. Number of meetings held or number of CHVs participating don't necessarily reflect this.
- ✓ There must be clear Terms of Reference for a Decentralization Support Team (DST) and both the CHSWT and the central MOHSW should understand the role of the advisors. To avoid conflict of interests, the DST should not be paid for by the county rather these advisors should be paid by either the central MOHSW, Pool Fund, or a third party.
- ✓ The DST should be put in place for each county to assist in setting up systems prior to contract initiation. Three advisors would be ideal: Field Coordinator, to support in overall management systems (based in the county); Clinical Advisor (based in the county); and F&A Advisor from the OFM or at least someone familiar with OFM requirements (short-term technical assistance).

VIII. Monitoring and Evaluation

A. Reporting and Use of Data

The overall aim of Liberia's National Monitoring and Evaluation Plan and Strategy is to provide information to track health sector's efficiency and improve quality and coverage of health services. This policy is based upon data gathered from monthly MOHSW HMIS reports from facilities, quarterly monitoring by county and central levels, and annual reviews (evaluations) of yearly plans to assess

performance towards targets. In order to accomplish this goal, the BCHSWT has established a M&E Unit headed by a M&E Officer and staffed with a Data Officer, County Registrar, and Data Clerks.

Health Management Information Systems (HMIS)²⁵

The CHSWTs are expected to collect and analyze data from the Health Facilities in accordance with the HMIS guidelines²⁶. They are also expected to use data for decision-making, in particular for planning and monitoring and evaluation in accordance with National guidelines.

Successes

- In Bomi staff at all levels of the health system recognize the importance of data collection and it has become a large part of their everyday work. This is a huge success and an excellent step towards improved use of data;
- Quarterly programmatic targets were set under the last contract between BCHSWT and MOHSW (July – December 2011). The process for setting these targets was highly participatory involving the OICs, DHOs, and BCHSWT;
- On a regular basis, the DHOs collect the facility integrated reporting forms and deliver them to the M&E Officer at the end of the month. In addition, all four DHOs have laptops which they use to enter data collected into an excel spreadsheet;
- The county M&E Officer visits the health facilities on a regular basis to carry out data verification; and,
- County team takes responsibility for data collection and staff training in use of data. For example, in 2011 the county held trainings for vaccinators on analysis of EPI data and the use of wall monitoring charts. Now all health facility vaccinators analyze and post their progress on the wall for the public to view. The majority of the facilities visited had EPI, ANC and Malaria charts posted on facility walls for public viewing.

Challenges Bomi

- Although the county does a nice job at enforcing the importance of data collection, data are not customarily used for decision-making or action planning by BCHSWT, DHOs, or OICs. While in the case of EPI data the county made an effort to provide training on M&E, the vaccinators frequently got confused as to how to apply the formulas as well as in data interpretation;
- No written reports on data verification and M&E supervision exist, nor is there a checklist for M&E supervision to guide the county M&E Officer's work;
- Little to no feedback provided from the county level back down to the facilities; and,
- Data reporting channels at the county level are unclear and irregular; data reports are given to whomever visits the health facility (i.e. sometimes OIC to DHO or OIC to County).
- No data collection and reporting system for gCHVs and TTMs

Challenges MOHSW

The MOHSW is making an effort to revamp the country's M&E system and strengthen the county capacity to collect, compile and transmit data. One of the most noticeable challenges at the central MOHSW is that M&E data collected are not being utilized by the various programs and planners for decision-making. Once the MOHSW begins to strengthen their own cross communication and use of HMIS data, then the county development of M&E use of data for decision-making will follow suit.

²⁵ National Health Management Information System: Guidelines for County Health Teams

²⁶ National Health Management Information Systems Procedures Manual for Data Collection, Analysis and Use.

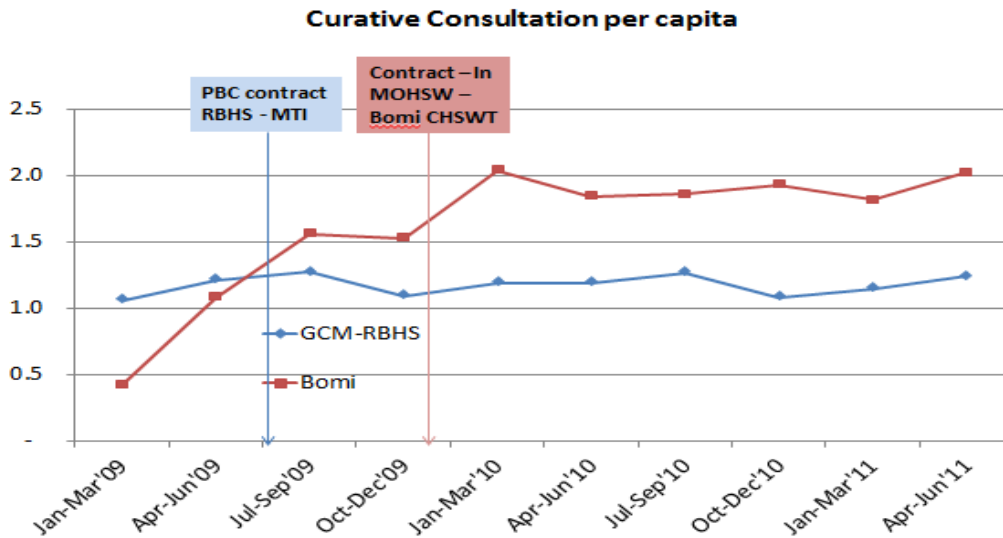
B. Performance Monitoring

Unfortunately the manner in which performance targets were presented under the contracts signed in Bomi county made it difficult to accurately assess whether the county met the service delivery targets laid out in the actual contracts. It is therefore difficult to present evidence on how the county fared in reaching performance targets based on funds allocated. Given that the MOHSW does not measure contract performance routinely and the fact that the indicators to measure contract performance differ from contract to contract, the assessment team was unable to analyze Bomi’s service delivery performance per contract terms.

Therefore, in order to get a sense of how Bomi county has performed while under contract, the assessment team drew upon service delivery data from the MOHSW HMIS other than the contract performance indicators. Service delivery data trends over nearly a three year period - from nine months prior to the PBC in Bomi (February 2009) through December 2011 were obtained, analyzed and are presented below by quarter.

In order to compare Bomi’s performance to a contracting out county, an analysis was carried out between the two PBC models in Liberia. Data from Bomi (PBC “in” through use of Pool Funds) and Grand Cape Mount (PBC “out” to NGOs under the USAID-funded Rebuilding Basic Health Services Project) were compared. To ensure that the data from Grand Cape Mount was comparable, data for this analysis were only derived from the health facilities which fall under NGO management and those facilities that are staffed and run by the CHSWT without NGO assistance were excluded. See figures 4-11 below.

Figure 4: Curative Consultation per Capita – Bomi and Grand Cape Mount



Source: HMIS MOHSW Liberia

From the Figure 4 it appears that the Bomi per capita utilization rate for consultation was trending upwards before the contracting period, and continued to increase steadily over the contract period examined. On the other hand the Grand Cape Mount curative consultation utilization rate remained constant throughout.

Figure 5: Pentavalent 3 Dose – Bomi and Grand Cape Mount counties

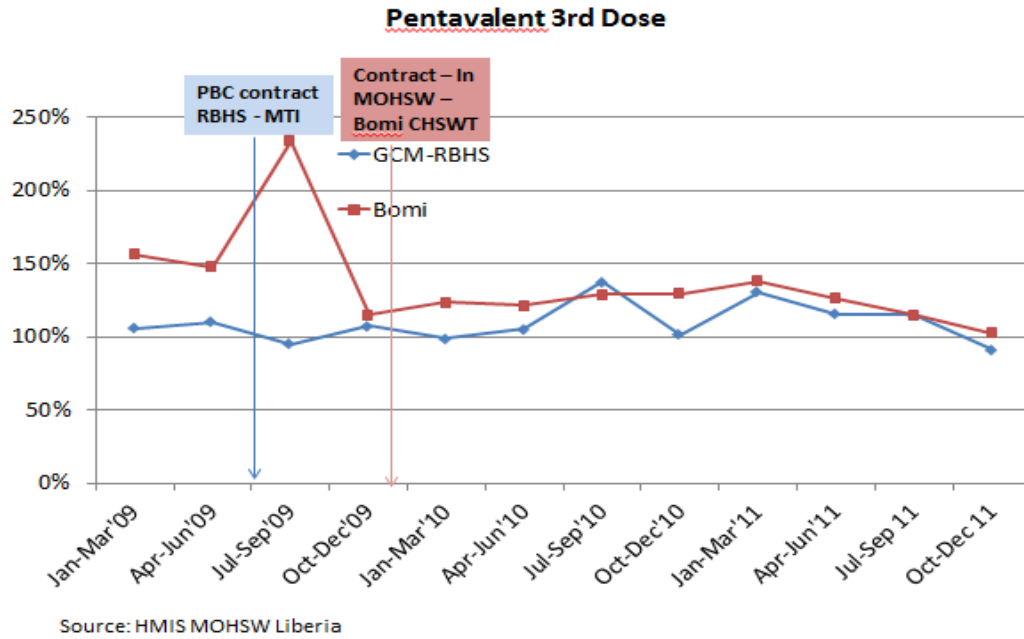


Figure 6: Pregnant Women Receiving 4 or more ANC – Bomi and Grand Cape Mount counties

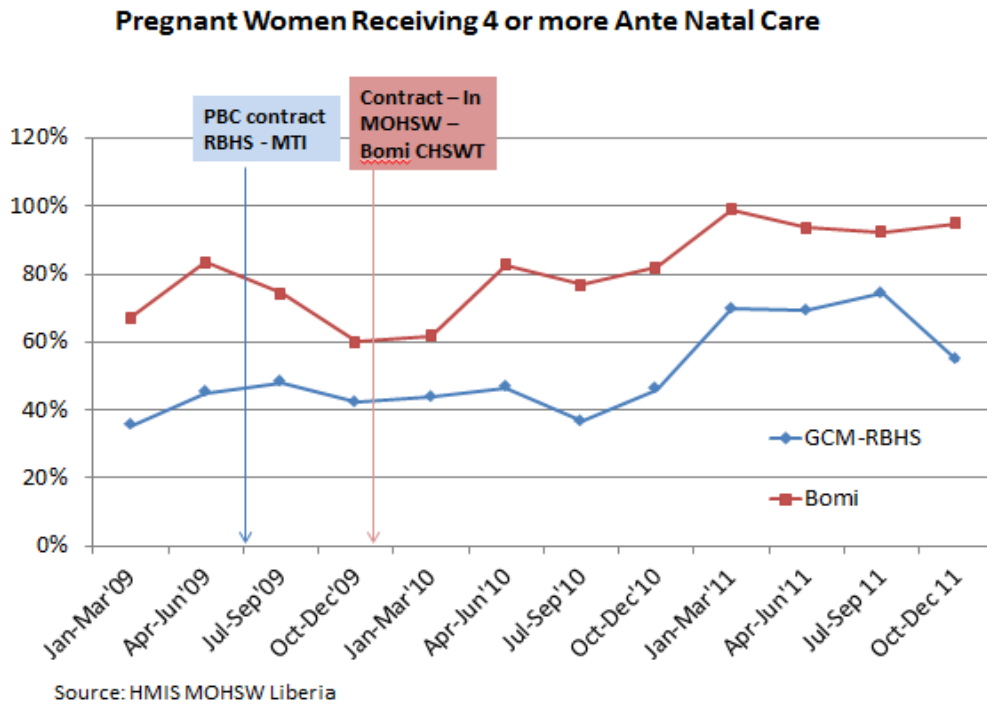
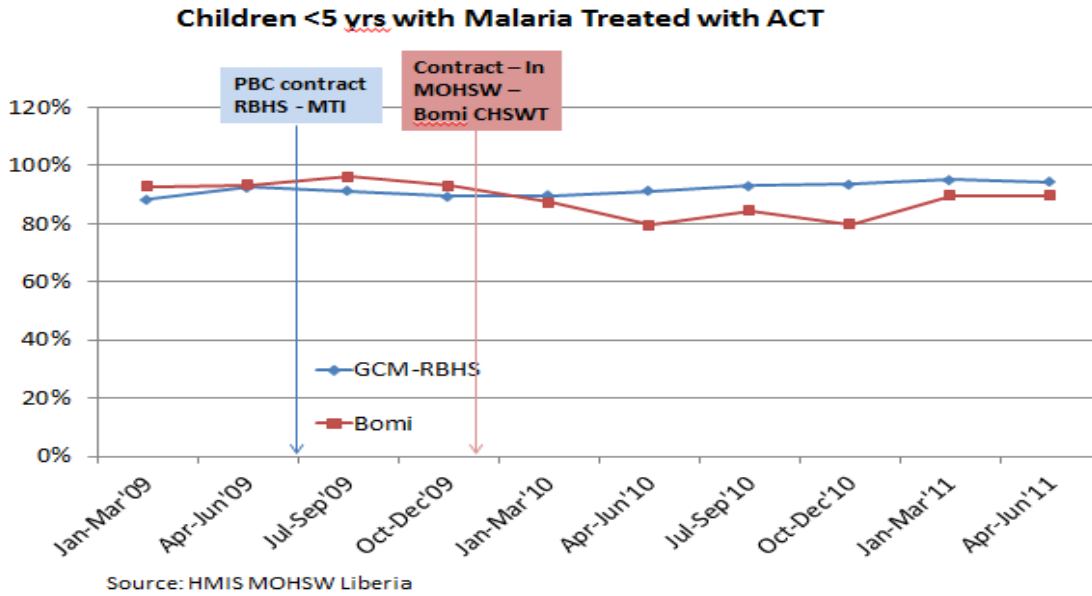


Figure 7: Children under 5 with Malaria Treated with ACT – Bomi and Grand Cape Mount counties



In both counties the EPI coverage (Penta3) and malaria treatment in children under 5 (children treated with ACT for malaria) indicators remained unchanged.

Figure 8: Facility Delivery by Skilled Birth Attendant – Bomi and Grand Cape Mount counties

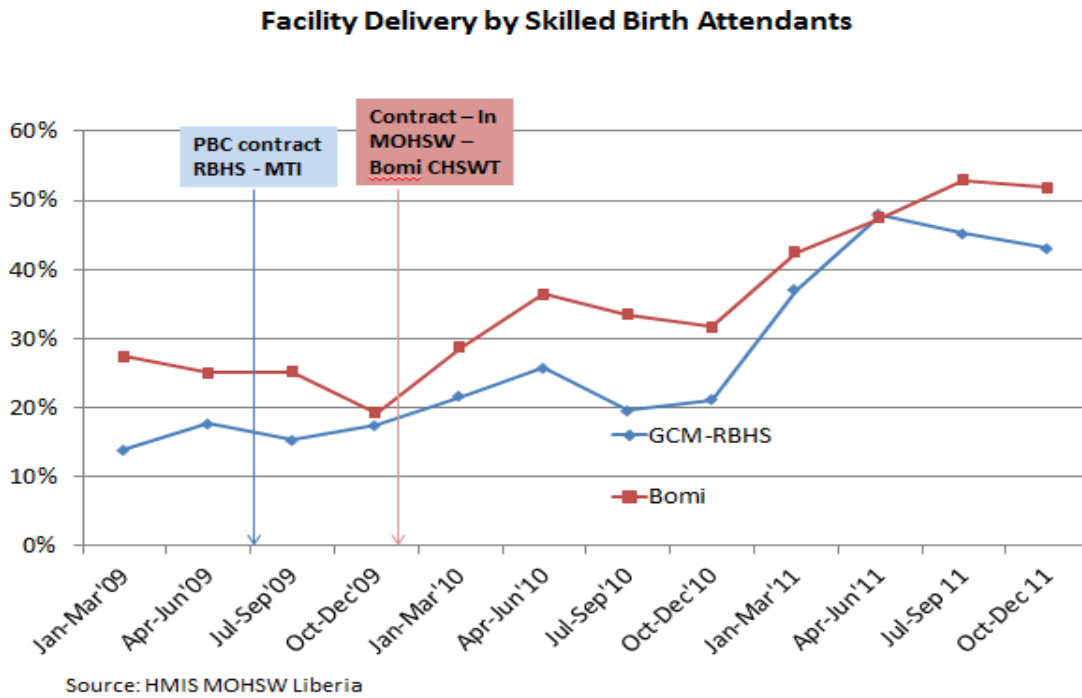
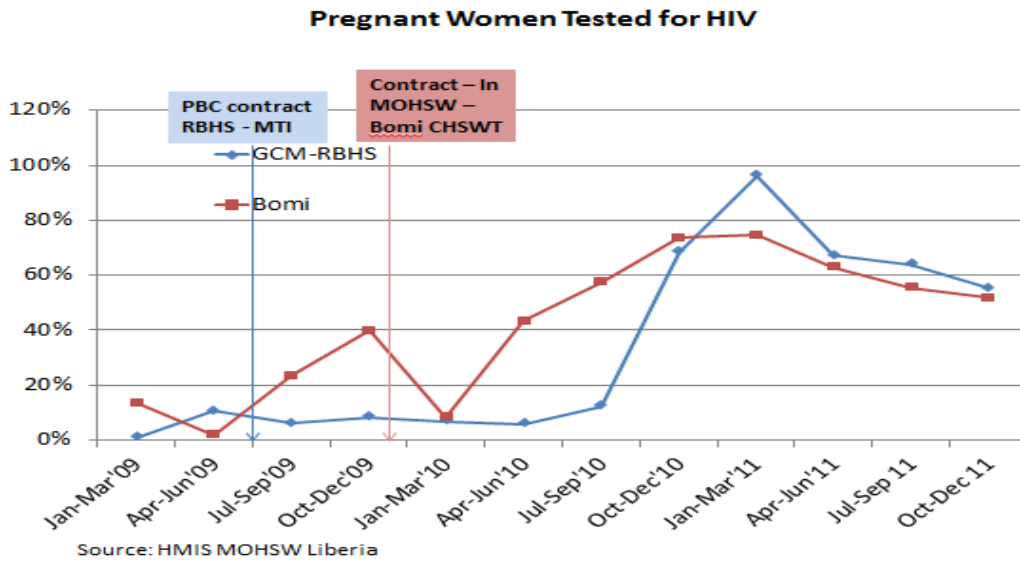
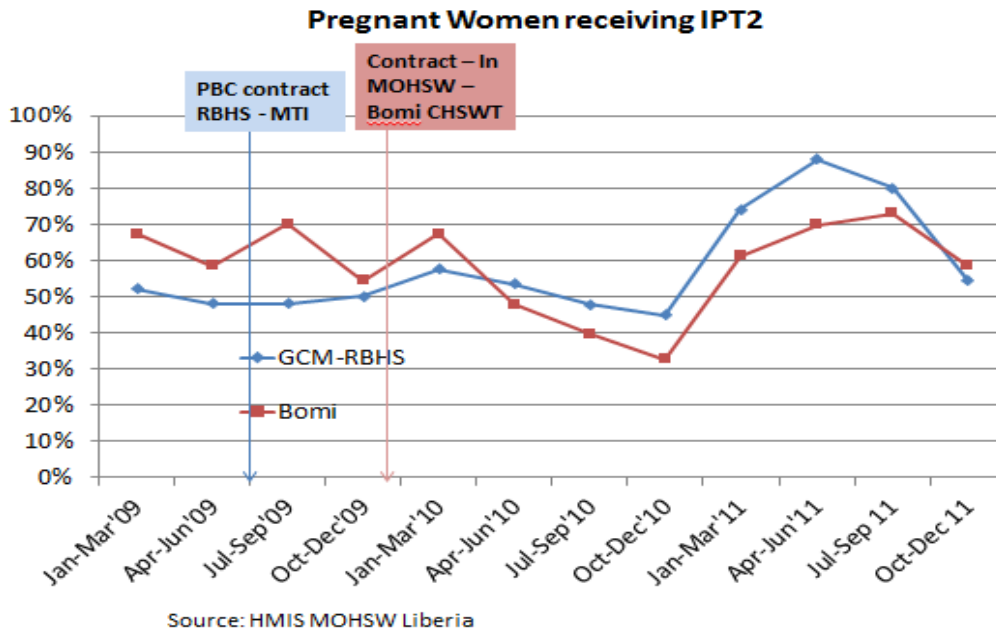


Figure 9: Pregnant Women Tested for HIV – Bomi and Grand Cape Mount counties



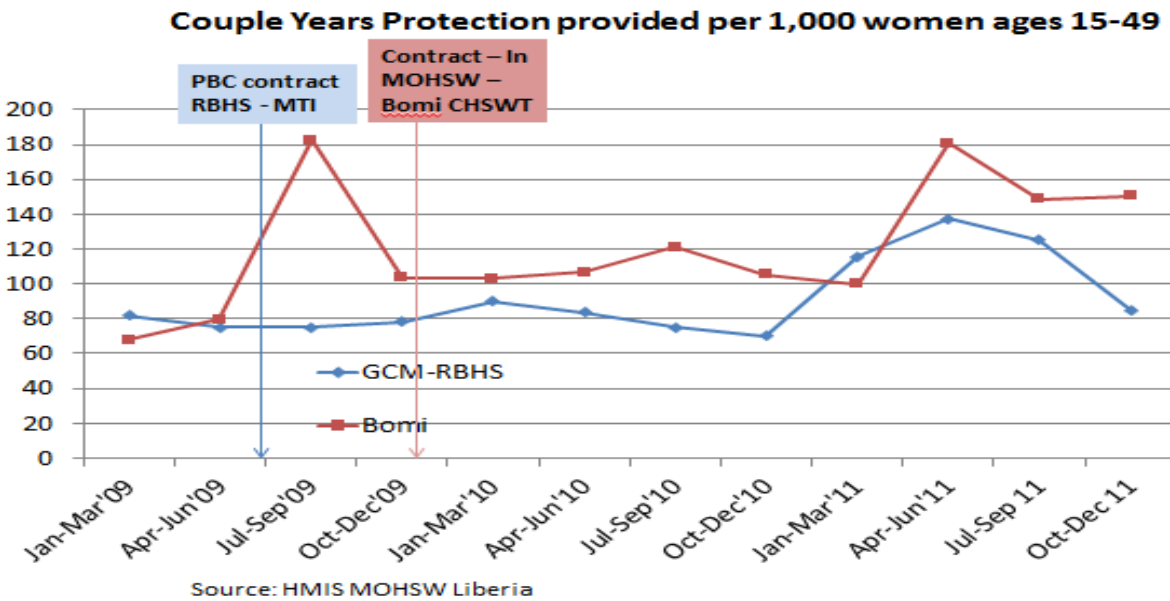
Both Bomi and Grand Cape Mount (RBHS facilities) showed improvements in the maternal health indicators (facility based deliveries by skilled birth attendants and pregnant women tested for HIV). Bomi increased their facility-based deliveries significantly from approximately 28% to 52% and Grand Cape Mount went from approximately 13% to 42%. The same upward trend is seen for testing of pregnant women for HIV with Bomi county increasing slightly and Grand Cape Mount increasing significantly from approximately 7% to nearly 58%.

Figure 10: Pregnant Women Receiving IPT2 – Bomi and Grand Cape Mount counties



In both Bomi and in Grand Cape Mount pregnant women receiving IPT2 decreased.

Figure 11: Couple Years Protection Provided per 1,000 Women ages 15-49 – Bomi and Grand Cape Mount counties



Contraceptive coverage as measured by Couple Years Protection increased in Bomi county over the contract period from about 100 CYP per 1,000 women to 158 CYP per 1,000 women. However, in Grand Cape Mount CYP did not increase rather it remained constant at around 80 CYP per 1,000 women.

Overall there does not seem to be any significant difference in performance between Bomi and Grand Cape Mount with the exception of Curative Utilization visits and Couple Years Protection; both of which Bomi performed better than Grand Cape Mount.

C. Recommendations

Bomi County

- Recommendations for Bomi County are the same recommendations for the MOHSW.

MOHSW Recommendations - Monitoring and Evaluation

- ✓ Strengthen central level sharing of HMIS data to strengthen the use of these data for decision-making and planning.
- ✓ Provide the M&E Officer with a standardized M&E supervision tool or check list for his every day work. Training on DHIS 2.0 (the system into which all HMIS data is fed) is needed.
- ✓ Provide competency-based on-the-job supervision (County Supervisors, DHOs, M&E Officer) in data analysis of key variables and data for decision-making.
- ✓ Take advantage of the registrars in each of the facilities to train them on data entry and possibly analysis.
- ✓ Implement community-based HMIS.
- ✓ Train CHT and facility staff on use of information for data management and on problem solving.

IX. Final Recommendations for Central MOHSW

A. General Recommendations for Central MOHSW

Liberia is well-positioned to create a PBC model based upon contracts between the MOHSW central level and the CHSWTs at local level given the stage of development of the health sector in which the country is operating. As a post-conflict or fragile state starting from very little, the GoL has had and continues to have the unique opportunity to design, create and build up an efficient and effective health system. Liberia decision-makers fortunately do not have to contend with inflexible and pre-existing public sector institutions which are the norm in more stable nations.

Before the MOHSW moves forward with further contracting “in” elsewhere in Liberia, it is important that a National Health and Social Welfare Decentralization Policy be officially developed, finalized, approved and put into place. It will be under the auspices of this decentralization policy which the MOHSW will be able to replicate and spread performance contracts between levels of the healthcare system. This policy should distinguish between the various essential public health functions in the county and ideally indicate where each function should be situated within the health system. Specifically, the four functions which need to be separated in order to avoid potential for conflict of interest include:

- Policy and Regulation
- Financing/Purchasing
- Service Delivery
- Monitoring and Verification

Given the confusion and vast differences of opinion at the central level of the MOHSW, it would be important to hold a workshop with key senior staff from the MOHSW with the following objectives: a) provide overall orientation to the differences between de-concentration, devolution, and privatization in health systems and to strengthen staff understanding as to what the essential public health functions and responsibilities are; and, b) have a discussion around what decentralization in Liberia should look like. It is through this type of workshop that top level ministry staff will be able to reach understanding and consensus on decentralization and a cohesive, collaborative and well thought out policy may be developed.

Additionally, if the Liberian MOHSW plans to scale up the Bomi “PBC In” pilot to other counties, it would be important to build the capacity of the central MOHSW to perform three key functions/responsibilities:

1. *Design and Manage Performance Contracts*: This function includes actual writing and development of the contract, negotiation of contract terms with the provider (i.e. CHSWT), and regular monitoring of compliance with the terms of the contract. Currently it is the External Aid Coordination Unit within the Bureau of Policy and Planning under the Department of Planning together with the Performance-Based Financing Unit within the Bureau of Preventive Services under the Department of Health Services that are slated to perform this function.
2. *Finance and Purchase Health Services*: The financing function revolves around prompt processing and payment to the provider (CHSWT) based upon submission of previously-agreed upon financial and accounting records of money spent under the contract. At present the Pool Fund which is a semi-autonomous entity within the MOHSW’s OFM performs the function of financier services. The MOHSW Office of External Aid on paper has served as the de facto purchaser of services though the Bureau of Policy and Planning and the Bureau of Preventive Services are in the process of restructuring how future contract negotiations and purchasing will take place.

3. *Monitor and Verify Performance Contracts:* This responsibility entails creation of a system to actually track contract data, indicators and validate results obtained under the contract. This function entails oversight of both financial and administrative data and administrative performance indicators as well as monitoring and evaluation of service delivery and outcome data. It is unclear where the responsibility for this function resides.

B. Specific Recommendations for Central MOHSW

Contract Negotiation, Design, Performance Measures, Accountability and Monitoring

Before signing any new contracts with the counties, the central Ministry should carry out a careful review and revision of all contract language. The contracts examined under this assessment indicate that much of the contract language is boilerplate and taken directly from contracts between the MOHSW and NGOs and is not entirely applicable to contracts between MOHSW and CHSWT. In addition, there are also a number of articles which need to include more specific language relevant to contracting “in” to reflect some of the nuances of human resource management and civil service reforms, financial management and reporting requirements, among others. Some additional suggestions include:

- Standard indicators to measure performance should be included in all service delivery contracts with the majority of them being easily obtained from the MOHSW HMIS. Those indicators that are not readily obtained from the HMIS should be measures that are easily verified by the MOHSW monitoring and verification team under the PBF Unit of the MOHSW or a third party.
- Ensure that the Performance Component contains not indicators and targets that are both realistic and reasonable and can be routinely captured by the MOHSW HMIS.
- Verification by the purchaser (MOHSW) of the provider (CHSWT) should be done on a quarterly basis in order to ensure contracts are truly performance-based and monitored, and do not become simply “granting” or “input-financing” mechanisms. Specifically the central MOHSW should verify whether the information contained in the quarterly reports is accurate and monitor progress against the agreed upon performance indicators. This will allow the county to receive much needed and immediate feedback on how their work is progressing;
- Performance rewards (or sanctions) should be paid (or deducted) on a quarterly basis based upon verification. Regardless of whether an outside independent contractor is hired to evaluate the contract performance or whether it is done internally by the PBF Unit in the MOHSW, the provider should be paid a bonus (or receive a sanction) based upon the outcome (e.g. both parties should abide by what is written under the contract);
- Future contracts should include a detailed format for financial reporting with explanation as well as a detailed format for programmatic/technical reporting;
- Add a financial management and a community participation indicator to contracts in order to create an incentive for the provider to strengthen its financial reporting as well as its coordination and partnership with the community for health promotion and disease prevention. Discuss with development partners and advisors which indicators would be most appropriate for each;
- Careful consideration should be given under future contracts as to whether or not the contract should stipulate how the bonuses should be used. To date, Bomi’s system for health facility and staff recognition provides motivation for improved performance. However, performance rewards are not universally or regularly applied within the county. The MOHSW may consider therefore, including language in the contract that suggests that future counties under contracting in include a reward system similar to the one Bomi has created, but in a more systematic manner. The county would have the flexibility to decide how to use the MOHSW bonus payment; and
- In the future, performance incentives would need to be guaranteed by the MOHSW and equitably distributed within the county. Although contracts between the BCHSWT and the MOHSW offer a budget increase of 5-10%, which may motivate teams for improved performance, the findings

from this assessment have shown that performance bonuses under the contract have not been the reason for Bomi's success. Performance results can be attributed more to team leadership, management and staff motivation initiatives.

Leadership and Transparency

- Streamline and strengthen internal MOHSW flow of information regarding PBC so that at the central level, all of the programs, offices, and units have an understanding of this financing mechanism. This will increase not only communication and collaboration between offices but transparency in operations can be maximized.
- It is essential that the CHO be a strong leader with open communication and transparency in decision-making. Ensuring strong leadership at the county's highest level to manage the health of the public is as important as being a strong manager.
- Strengthen alliances with the local Political/Administrative Governance structure (i.e. the County Superintendent and District Commissioners) for effective collaboration.

Management and Planning

- Require that all CHOs or at least the Deputy have formal public health training prior to signing of contracts. It would be ideal for the county leader to have masters level training in public health which is even more appropriate for management of the county than medical training.
- Assess the knowledge and skillset of the CHSWT²⁷ to determine which key capacities need to be built prior to signing new contracts. Utilize competency-based or in-service training throughout the first year of the contract. At a minimum, the CHSWT should have the following competencies in order to ensure strong management:
 - Management and Leadership (core CHSWT)
 - Financial Management, Accounting and Administration
 - Planning -- public health AND budgeting
 - PBF/PBC orientation.
- Conduct periodic team building workshops each year to ensure a well-functioning organization and to create and maintain a planning and decision-making culture.
- Share best practices from Bomi with other counties.

Financial Management and Administration

Re-examine the structure of the F&A team. The Bomi structure has worked well with a CHSA overseeing a Financial Manager and an Accountant. An additional full-time staff person to serve as an accountant assistant or cashier that would enable the team to keep well track of all funds that flow in and out of the systems and organize and properly document the vouchers. The Procurement Officer and Logistician and Human resource Manager are also part of the, and should fall under the F&A team. Each F&A team member should have specific Terms of Reference to describe and disaggregate individual duties.

Financial Management - Ensure that appropriate systems are in place prior to signing the contract by providing technical advisor to set up those F&A systems and work with the county team to train in their use. These systems will help to ensure transparency in financial management.

- Require under contract terms that the county create monthly financial reports reconciling the books and that when the quarterly financial reports are submitted these monthly reports are also included as back up to the three-month reports.

²⁷ The RBHS Capacity-Building Assessment tool once piloted, adjusted and finalized would be ideal for this purpose.

- Develop and train county Finance staff in three electronic finance and accounting systems:
 - A budget tracking tool to measure and track Pool Fund disbursements and county expenditures against planned budgets, and
 - A computerized accounting system to replace the current manual accounting system or at a minimum complement the manual system.
 - A simple tracking system for travel advances and expense reports.
- Provide adequate training for Finance staff that are in place (some might be hired after the contract is signed). Training should include:
 - Use of and entry of data into financial and accounting system tools;
 - Interpretation of financial reports (monthly, quarterly and yearly);
 - Management of accounting system (once it is created);
 - Contract management in terms of F&A in particular for oversight of sub-contracted NGOs in the county;

Procurement - For all administrative matters pertaining to procurement of both goods and auxiliary services the county needs to follow the Public Procurement Concession Commission (PPCC) policies and procedures. Each county should not only have a copy of this manual but the MOHSW should create a summarized, user-friendly version or guide that the county F&A staff can use and refer to easily to manage daily procurement transactions. In addition, the MOHSW should work with the PPCC to make an exception to the three quotation rule given limited supply of vendors at the county level. All procurement at the county level should be entered and tracked in a procurement filing system managed by the county Procurement Officer.

- Provide adequate training for Procurement staff that are in place (some might be hired after the contract is signed). Training should include:
 - Interpretation of financial reports for contract management (monthly, quarterly and yearly);
 - Contract management in terms of the terms and conditions for oversight of sub-contracted NGOs in the county;
 - All other forms and templates required for proper Procurement they are developed by the MOHSW (e.g. contracts, purchase orders, purchase requests, requests for quotation, request for proposals, goods and receipt notes, etc.)

Human Resource Management and Personnel

The MOHSW has excellent policies and procedures for human resource management in their National Human Resources Policy and Plan for Health and Social Welfare, 2011-2021. Many of these policies and activities are still under development but they are clear and well-thought out and should be applied across the board at the county and facility levels. The corresponding activities are geared towards improvement in the performance of the workforce and contain a number of clear and concise measures to create motivation and incentives for good performance of the workforce while avoiding potential complacency in staff. The MOHSW and the counties should refresh themselves with this guidance beginning under Section A. 1.2.1 to “Reinforce standardized recruitment procedures that are timely, needs-based, gender-sensitive, non-discriminatory, transparent and in line with Civil Service Agency’s Merit Base Appointment (MBA) process. [2011–2013]”²⁸.

²⁸ National Human Resources Policy and Plan for Health and Social Welfare, 2011–2021

- Conduct annual performance reviews. One of the most important activities highlighted in this manual is the annual staff performance reviews. These should be routinely held each year for each staff member – whether they are part of the GoL civil service or contract employee. A summary of these policies can be found in Annex A of this report.
- Create a user-friendly summary Human Resource Manual. In order to make application of the HR policies simple and straightforward for county staff, the MOHSW should create a user-friendly summary of the MOHSW HR manual that incorporates the principle policies and activities that the county needs to utilize to ensure staff performance. This manual should also include any other key activities and steps that the CSA or other central ministry documents might contain that would be useful for Human Resource Management at the county level. This summary document would then be distributed to all county staff and an orientation to its use and application given to senior managers and OICs at the county level.
- Put systems in place at the county level and train county managers and OICs in application of HR policies, procedures and activities. Both MOHSW and county managers should be trained in the application of the Human Resource Policy and Plan 2011-2021 and systems should be put into place to apply these policies and encourage good staff performance. In addition, careful collaboration between the Liberian Civil Service Agency (CSA), the MoF and the MOHSW on human resource management needs to take place in order to avoid complacency of the Liberian civil servant workforce as has been the case in many countries throughout the developing world. Ensure that there are clear mechanisms put in place for removal of underperforming staff.

Technical Assistance and Support

As mentioned throughout this report, one of the first steps that the central MOHSW must do before initiating further contracting in with other counties is to develop clear Terms of Reference for a Decentralization Support Team (DST) of advisors. To avoid conflict of interests, the DST should not be paid for by the county rather these advisors should be paid by either the central MOHSW, Pool Fund, or a third party.

Final Words of Advice

BCHSWT's current strong leadership, management, fairly autonomous decision-making staff have over the use of resources have led to strong performance in the county which can be attributed more to local pride, empowerment and ownership by staff in the county than to performance-based contracting itself. This is apparent based on the results of this assessment and the non-application of any performance-based rewards or sanctions. It is highly unlikely that the level of enthusiasm, empowerment and local ownership seen in Liberia exists in non-fragile, stable nations without the employment of performance incentives tied to clear targets. The Bomi pilot itself is quite unique to Liberia as a post-conflict state which fosters pride and optimism for a new future for the county of Liberia. Given this, it would be prudent for the MOHSW to institutionalize systems, procedures, and mechanisms which foster strong performance of the healthcare delivery system through linking rewards (and sanctions) to performance.

In order to properly scale up performance-based contracting “in” to other counties in Liberia a number of sequential steps must be taken and appropriately planned. One of the first steps to scale up would be to develop an Implementation Plan which lays out the steps and activities to be taken, the order in which they should happen, and a timeframe for each. By creating and following a well-designed implementation plan, the MOHSW will be able to scale up through a phased in approach setting the stage for each step along the way – from development and communication of a decentralization policy -- redesign of performance contracts and policies -- to capacity-assessment and capacity-building (both at

central MOHSW and CHSWT levels) -- to gradual transfer of select functions and responsibilities to the county – to de-concentration of functions and eventually autonomous county management.

Finally, it is best to start small and build gradually when scaling up contracting “in” to other counties. It may be prudent to begin in a single district in one county with a PBC contract, and with only one partner at first. Scale up could happen gradually to include other districts and partners. It is important to keep in mind that the Bomi experience is based upon a simple model with only one service delivery partner (AHA) overseeing six health facilities, in a very small county with relatively easy geographic access and relatively few facilities (only 23 clinics and one hospital). These are all factors that have set Bomi up for the success it has had; not all counties in Liberia have these same ideal conditions.

Best Practices

Regular meetings with County political-administrative leadership. The BCHSWT participates in monthly and quarterly meetings with the County Superintendent and District Commissioners. Additional ad hoc meetings and collaboration with local leaders from the Political/Administrative System (Superintendent, District Commissioners, and Chiefs, etc.) takes place on a need be basis.

Regularly-scheduled and focused BCHSWT meetings with clear agendas and outcomes help create the effective transmission of information among all levels within the county system. These meetings create an organizational culture that is based upon a participatory team approach which in turn fosters ownership and empowerment from all levels in the system – line managers, county team members, health facility staff and community health workers. This organizational culture must have strong leadership for real progress to be made.

- ✓ Weekly Monday management meeting model has proved to be extremely useful and includes a highly participatory and transparent action-oriented focus. During the Monday morning weekly meetings, the line managers discuss personnel issues, including resource allocation, identification of human resource needs, capacity restraints, and gaps and problems with staff performance.;
- ✓ Monthly OIC meetings (and in the future with clinical staff as well); and,
- ✓ Quarterly partners meetings that include private clinics.

Staffing and resource allocation discussed weekly. During the Monday management meetings, potential gaps in staffing due to illness, births, deaths or performance issues are discussed and staff facility coverage is adjusted as needed to cover for potential shortfalls.

Creation of a weekend emergency care system at the health clinic level. A US\$5 weekend package for each health care clinic was created in 2011 whereby the clinic receives US\$20 monthly in order to keep one health staff member available and on call should someone need urgent health care attention over the weekend. Funds are used to provide food for the staff over the weekend. Each facility can opt to participate in this initiative; to date all facilities have been participating.

Creation of rewards systems to provide recognition and/or material benefit to health facilities and individual staff for good performance.

- ✓ A financial reward system based upon performance. Performance award decisions are based two ways: during management team meetings whereby supervisors are asked to identify hardworking and committed staff or the Hospital Medical Director and the Hospital Administrator may choose awardees based upon direct observation of their work. During the monthly staff meeting these individuals are recognized publically and given a letter along with a monetary bonus of US\$50. Since early 2011 approximately 30 people have received this reward. Funds for these awards come from hospital cost recovery through billing the Simeraby Health Center concession for client referrals.
- ✓ Periodic facility appreciation events are held to give public recognition to the clinic as well as individuals for outstanding performance. BCHSW team members are also publically recognized for their performance and dedication. These events include refreshments and the presentation of a congratulatory letter from the CHO.

Broad participation by line supervisors and managers in activity planning and budgeting. Across the board managers and supervisors participate in determining budget needs including funds for training, fuel, scratch cards, etc.

A county-wide culture of regular supervision. County management and DHOs perform regular supervision over facility operations so that these visits have come to be an expected part of weekly activities in Bomi. Managers have effectively managed to instill in staff at all levels of the health care system an understanding of the importance of periodic supervision and feedback for improvement in performance of service delivery.

Annex A

National Human Resources Policy and Plan for Health and Social Welfare, 2011–2021

Activities for Improved Performance of the Workforce

- A. 1.2.1 Reinforce standardized recruitment procedures that are timely, needs-based, gender-sensitive, non-discriminatory, transparent and in line with Civil Service Agency's Merit Base Appointment (MBA) process. [2011–2013]
- A. 1.2.2 Implement appointment of workers in line with MBA guidelines and Standardized Operational Procedures to ensure that newly appointed workers are provided with an appointment letter, clear job description, and induction program and have access to a copy of the Employee Handbook and the Professional and Ethical Codes of Conduct. [2011–2013]
- A. 1.2.3 Increase the number of professional health and social welfare workers on the Civil Service Agency payroll, while improving the gender balance and disability representation. Decrease the number of unskilled workers on the CSA payroll by contracting out non-professional services (cleaning, laundry, security, etc.). [2012 and onwards]
- A. 1.2.4 Reinforce a system in which an employee serving in an acting position receives fair remuneration upon assuming an acting responsibility and will not serve in an acting capacity for longer than 2 years. [Ongoing]
- A. 1.2.5 Conduct performance evaluations to improve individual worker performance and development using standardized performance management tools. [Ongoing]
- A. 1.2.6 Establish and implement a public reward system, linked to performance appraisals, so that all facilities and institutions recognize outstanding performance of workers and students. The reward system should serve to highlight model professional and ethical patient care and inspire improvement in pre-service and in-service practice. [Ongoing]
- A. 1.2.7 Develop and implement promotion procedures for each cadre according to performance and qualifications, in line with MBA guidelines. [2012–2014]
- A. 1.2.8 Develop and implement a comprehensive, performance-based remuneration scheme for each cadre. [2011 and ongoing]
- A. 1.2.9 Develop and implement career progression schemes for each cadre and support career counseling, mentoring and coaching for students. [2014–2016]
- A. 1.2.10 Provide and promote equal—yet gender- and disability-sensitive—career advancement opportunities to develop the skills mix of the existing workforce, especially for qualified lower cadres, to advance their careers. [Ongoing]
- A. 1.2.11 Develop and implement a training program in leadership and management for managers of facilities, institutions, divisions, units; programs to build capacity for initiating and leading effective change; and performance management systems and processes for making evidence-based decisions. [Ongoing; to review in 2015]

A. 1.2.12 Offer fellowship programs for critical teaching staff (i.e. laboratory, pharmacy, psychiatry, radiology and anesthesia). [2011–2014]

A. 1.2.13 Conduct annual staff satisfaction surveys. [Ongoing]

A. 1.2.14 Renovate, upgrade and build new accommodations for teaching and clinical staff, especially in rural areas, that are accessible to persons with disabilities. [Ongoing through 2014]

Annex B

Supply Chain Management, Laboratory Services, and Technical Support

Supply Chain Management for Essential Drugs, Supplies and Vaccines

The County uses a Stock Balance Reporting and Requisition Form (SBRR) to request medicines and medical supplies. Each Health Facility sends their SBRR to the County Pharmacist on a monthly basis along with their HMIS reports. The Pharmacist reviews the requests and approves them based upon reported HMIS data, consumption, utilization and case load, and supervision visits. The Pharmacist places orders with the National Drug Store (NDS) or private vendors (BK or Lucky Pharmacy).

Once the drugs have been ordered, the county sends a vehicle to the vendor's warehouse or NDS in Monrovia to pick up drugs. They are then delivered to the County Depot/warehouse. The Pharmacist schedules distribution from the county drug depot to health facilities depending upon when vehicles may be going to the health facilities. If there is an urgent request, then emergency ordering and delivery can be arranged. NDS, through the Global Fund, supplies HIV, TB and Malaria Drugs. NDS also supplies essential medicines however if they are not readily available then the county will procure from private vendors (BK or Lucky Pharmacy). UNICEF and GAVI directly supply vaccines.

The County supply chain management works under the Health Facility Standard Operating Procedures for drugs, supplies and lab materials. The first step in the process is to fill out a ledger indicating the date, amount, and types of drugs delivered to facility. Drugs and supplies are then placed in the store room. There is an internal requisition process for the transfer of drugs from the store room to the dispensary. On a daily basis, a tally sheet is filled out to record the number and types of drugs dispensed. Finally, there is a Daily Consumption Book where an inventory of the dispensary is recorded using the First In/First Out (FIFO) inventory control.

Immunization stock of vaccines is kept separately through a separate daily tally and stock book ledger which was developed by the county.

Future Planned Supply Chain in Bomi

The next contract between the MOHSW and BCHSWT does not include a budget for drugs and supplies. From January 2012, the Pool Fund will finance and procure all drugs for the county. Bomi County will estimate needs over a six-month period and drugs will be delivered on a quarterly basis. This is the first time that the county has not had control over their supply chain since the PBC in pilot began.

Successes

- No stock-outs were reported in any of the facilities visited by the team;
- There appears to be good stock management and accountability at the facility level;
- Coordination in transport of drugs and supplies as well as cold packs for cold boxes is strong;
- Facility pharmacy and dispensaries are well-organized and have sufficient space for drugs and supplies. All facilities are equipped with an incinerator and sharps pit for proper waste management; and,
- The county developed and uses its own supervision checklist/tool.

Challenges

- There is no automated Logistics Management Information System (LMIS);
- Ordering of drugs and supplies is not standardized across facilities. Although all facilities use the SBRR form, some submit it monthly, others quarterly, and others based on consumption and stock on hand;
- There’s confusion on reporting channels for drugs and supplies. Frequently the M&E Officer or the DHO will pick up the SBRR form from the facilities and deliver to the pharmacist; other times it will be delivered to one of the line managers. This can lead to misplaced orders; and,
- Shortages at NDS have affected county supply in the past.

Recommendation for Bomi County

- Develop clear protocol for facility-based drug/medical supply order form submission to avoid confusion or misplacement of SBRR form;
- Standardize transportation days from county depot to health facilities for delivery of commodities;
- Include vaccines in monitoring/utilization procedures (in accordance with national policy);
- Standardize and incorporate ordering and distribution of supplies for CHVs; and,
- Train pharmacist (and potentially dispensaries at facility level) in drug and supply projections.

Laboratory Services

Pre Contract	Post Contract
1 lab in County	10 labs in county (7 functioning)
No in-service training of technicians	14 th 9-month in-service training for lab technicians
No supervision	Weekly supervision
No technical support	Technical assistance from Nat’l AIDS Control Program (NACP), Nat’l Dx. Unit (NDU), N. Malaria Control Program (NMCP), N. Leprosy and Tuberculosis Control Program (NLTCP)
Limited supplies	Equipment provided, fridges
Weak sporadic reporting	Monthly reports to County Medical Director though still not utilizing the M&E DHIS system

Successes

There are nine functioning clinics with TB smear diagnosis and other laboratory services currently operating in the county. A training of laboratory aides has been established. The county has been designated as a Regional Laboratory. A blood bank and CD4 county machine have been established.

Challenges

Although a lot has been accomplished over the contract period, there are a number of obstacles that still remain. They include: cramped workspace, limited staff, inadequate transportation for monitoring and supervision over lab services, and stock out of reagents.

Recommendations for Bomi County

- If a regional laboratory is in the plans for Bomi, either the present space needs to be expanded or a new laboratory with sufficient space should be constructed; and,

- Upgrade lab aides to full lab technicians over the medium to long-term.

Technical Assistance and Support

The BCHSWT has had intermittent Short Term Technical Assistance (STTA) and on-the-job mentoring en situ during the life of the “PBC In” pilot. However, much of the progress made in the county really is due to the enthusiasm and persistence of the BCHSWT over the last two years. The most useful technical support the county has received is through the CHAI Field Coordinator, who provided overall managerial support and assistance in the organization of the county weekly meetings and with decision-making processes. Several CHAI personnel had desks in the BCHSWT offices, including the CHAI Field Coordinator (July 2010 – December 2011) and the CHAI Clinical Mentor (July 2010 – July 2011), who worked with the Bomi team with clinical supervision and on-the-job training (particularly in maternal and reproductive health). These two advisors helped the county reorganize the structure of its management team and helped build management and oversight capacity.

In addition to the long-term technical assistance that Bomi received, the county also received the following intermittent technical support:

- Financial management and accounting training by the MOHSW OFM for one week prior to the first disbursement. The Acting CHO, the CHSA and the accountant were all trained.
- A financial training by the AHA Financial Director took place over a three-day period early on under the initial contract. This training was done on-the-job in the Bomi county offices and was reportedly quite helpful to the team.
- A Decentralization Project Coordinator was sent to work with the county for five months under the initial contract. At this time there were a lot of organizational and personnel problems in the county. The Project Coordinator worked with the BCHSWT to organize and hold a Team Building Workshop which helped enormously. [NOTE: the prior contracts as well as the new contract proposal both include a Project Coordinator as a key staff position as well as a budget line item under staffing. There is no Project Coordinator in place, nor are there plans to hire one.
- There has been some targeted capacity building of county staff in HMIS by the MOHSW. In particular, two trainings were held on how to use ledgers, reporting forms and databases.
- A consultant was used to help the county write the project proposals in 2009.
- At least 3 CHSWT members (CHO, CHSA, Data manager) have received MOHSW scholarships to study abroad, develop their skills and returned to the county to work.

Annex C

List of Documents Reviewed

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Annex D

Interviews and Focus Groups Participant List

MOHSW and AHA	
Dr. Bernice Dahn	Deputy Minister Department Health Services, Chief Medical Officer
Ms. Yah Zolia	Deputy Minister Planning
Dr. Raymond F. Kromah	Medical Coordinator - AHA
Dr. Sei D. Baawo	Director Family Health Division
Mr. Mawolo Kollie	Acting Director Human Resources
Mr. George P. Jacobs	Acting Director Monitoring and Evaluation
Mr. James Beyan	Director of Personnel
Mr. Justin A. Korvayan	Decentralization Coordinator
Mr. Kerkulah Tokpa	
Mr. Luke Bawo	Monitoring and Evaluation Research Coordinator
Mr. Morrison A. Tamba	Assistant Health Coordinator - AHA
Mr. C. Sanform Wesseh	Assistant Deputy Minister, Bureau of Vital Statistics
Mr. Momolu Sirleaf	Director External Aid Coordination Unit
Mrs. Jesseline Asamoah	Pool Fund Manager
Mrs. Louise Thomas-Mapleh	Performance-Based Finance Unit Coordinator
Dr. Margaret Korkpor	County Coordinator
Mr. Jacob Hughes	Former Pool Fund Manger
BCHSWT	
Dr. Linda Birch	County Health Officer
Mr. John Kollie	Community Health Department Director
Hon. Samuel Brown	Superintendent of Bomi County
Logistician and Procurement Officers	
Mr. Davidson Rogers	Hospital Administrator
Mr. Dennis Saylay	Monitoring and Evaluation Officer
Mr. Dorothy J. Gray	Human Resource Officer
Mr. Jimmie Slobor	Environmental Health Coordinator
Mr. Justin Saye	Environmental Health Supervisor
Mr. Mohamed B. Kiaw	Accountant
Mr. Mohammed Dukuly	Community Health Service Director
Mr. Boakai Karnley	District Health Officer, District Surveillance Officer
Mr. Foday Cole	District Health Officer, District Surveillance Officer
Mr. Yei Magbinne Dono	District Health Officer, District Surveillance Officer
Mr. Kerkulah Tokpa	District Health Officer, District Surveillance Officer
Mr. Moses Fomba	County Surveillance Officer
Mr. Mustapha Senesi	County Diagnostic Supervisor
Mr. N. Wee Rogers	Hospital Accountant
Mr. Samuel W. Quiah	Lab Supervisor, LGH
Mr. Sando Sirleaf	County Health Services Administrator
Mr. Seh D. Sirleaf	County Finance Manager
Mr. Thomas Jallah	County Pharmacist
Mr. William Taweh	Data Manager
Ms. Fatuh	Reproductive Health Manager
Ms. Elizabeth Doe	Child Survival Focal Person
Ms. Shirley T. Johnson	Training Coordinator

Health Facilities	
Ahmadiyyah	OIC
Dr. Mahmood Ahmad Nasi	
Beh Town	
Mr. Bendu Harris	OIC (RN)
Bonjeh	
Ms. Aminata K. Paykue	RN
Dagweh Town	
Ms. Carnetta BD Feury	OIC
Fefeh Town	
Ms. Elizabeth B. Joe	OIC (RN/CM)
Gayan Hill	
Mr. Sando Sirleaf Jr.	OIC
Gonzipo	
	OIC
Sasstown	
Ms. Shirley Kialen	OIC
Sime Darby	
	OIC, RN
Suehn	
Ms. Natalie Kpogba	OIC (CM, BSc/RN)
Tambah Borbor	
	OIC
Vortor	
	OIC
Yomo Town	
Mr. Koto D. Morris	OIC (BSc/RN)
Community Focus Groups	
Dagweh Town Clinic	13 TTMs, 4 CHCDs, 2 gCHVs, OIC, 3 Clinic staff, 9 chiefs (one from 9 villages incl, 1 clan chief, 1 gCHV)
Yomotown Clinic	17 TTM, 2 gCHV