



REPUBLIC OF LIBERIA



MINISTRY OF HEALTH & SOCIAL WELFARE

PERFORMANCE BASED FINANCING

OPERATIONAL MANUAL

March 2012

Contents

Acronyms	4
Acknowledgement.....	7
Preface.....	8
I. Background	10
I.1. Country profile.....	10
II. Aim, Concept and Definitions.....	11
II.1. Definitions	12
II.2. Objectives of Performance Based Financing in Liberia	12
III. The PBF Institutional & Implementation Arrangements	14
III.1. Regulator	14
III.2. PBF Fund Holder/Purchaser	15
III.3. PBF County Steering Committee	16
III.4. Implementers	16
III.5. Health Service Provider	17
III.6. Performance Verification at County Level	18
III.6.1. Verification of Service Delivery Indicators (Health Facilities)	18
III.6.2. Validation of Service Delivery Indicators (County level)	20
III.6.3. Validation at the Community Level (County Level).....	21
III.7. Counter-Verification by Central MOHSW.....	23
III.7.1. Counter-Verification of Administrative Indicators – Implementers’ Level.....	24
III.7.2. Counter-verification of data at health facilities.....	25
IV. Implementation of PBF – Mission, Responsibilities and Tasks of Key Stakeholders.....	27
IV.1. Peripheral Level.....	27
IV.2. Intermediate Level – County Level	28
IV.2.1. District Health Team	28
IV. 2.2. Implementers (CHT and/or NGO)	28
IV.2.3. PBF County Steering Committee	29
IV.3. Central Level MOHSW.....	30
IV.3.1. PBF Governance.....	30
IV.3.2. PBF Unit.....	30
IV.3.3. PBF Technical Committee.....	31
IV.3.4. External Aid Unit.....	32

IV.3.5. Pool Fund Secretariat.....	32
IV.3.6. M&E and HMIS	32
V. Tools for Performance Based Financing Implementation	33
V.1. Tools for Management of Performance Based Financing.....	33
V.1.1. Development of Simple Business Plans for Performance Improvement.....	33
V.1.2.The Performance Contracts/Agreements	34
V.1.3. Performance Reports	36
V.2. Tools for Accounting and Financial Management.....	37
V.3. Information System	37
V.4. Performance Indicators	37
V.5. Bonus Computation	41
VI. Financing of PBF Scheme	44
VI.1. Process for Bonus Payment.....	44
VI.1.1. Bonus Payment for Health Facilities/Clinics.....	44
VI.1.2. Bonus Payment for Implementers.....	45
VI.1.3. Bonus Payment Based on Score Given in Community Validation	45
VI.2. Time Frame for Payment of Bonuses.....	46
VI.3. Payment of Bonus to Health Facility/Clinic Staff.....	47
VII. Monitoring and Evaluation of PBF Implementation.....	48
VII.1. Levels and Actors of the Monitoring and Evaluation System.....	48
VII.1.1. First Level: Service Delivery - Recording and Verification of Data	48
VII.1.2. Second Level: County Level - Registration, Archiving and Communication	49
VII.1.3. Third Level: Counter-verification, Strengthening HMIS, Payment Approval.....	49
VII.2. Strengthening Capacity and Providing Support to PBF Actors	50
VIII. Conflict Resolution	50
IX. Annexes.....	50
Annex 1a – MOHSW PBF Indicators	50
Annex 1b – Implementers’ Indicators and Assigned Weights.....	54
Annex 1c –Indicators for Health Facilities/Clinics	55
Annex 2a – Invoice for Achieved and Validated Data for Health Facility	56
Annex 2b - Data Counter-verification sheet	57
Annex 2c – Invoice for Achieved and Validated Data for Implementer	67
Annex 3a – Sample Performance Agreement between MOHSW and Implementer	68

Annex 3b - Performance Agreement between Implementer and Health Facility.....	80
Annex 4 - Simple Business Plan for Health Facilities (HF) - MOHSW Liberia	84
Annex 5 – Reporting Tool for Health Facility (use of earned bonus)	98
Annex 6a – Summary Verification of Beneficiary’s Existence and Satisfaction.....	100
Annex 6b – Individual Questionnaire for Beneficiary’s Satisfaction.....	100

Acronyms

ACT	Artemisinin-based Combination Treatment
ANC	Ante-natal care
ARI	Acute respiratory infections
ARV	Anti-retroviral
BPHS	Basic Package of Health Services
CBO	Community Based Organization
CHD	County Health District
CHDC	Community Health Development Committee
CHO	County Health Officer
CHSWT	County Health and Social Welfare Teams
CHT	County Health Team
CHV	Community Health Volunteer
CHW	County Health Worker
CM	Certified Midwife
CSO	Civil Society Organization
CYP	Couple Years of Contraceptive Protection
DFID	Department for International Development (UK government department)
DHIS	District Health Information System
DHO	District Health Officer
DHS	Demographic and Health Survey
EPHS	Essential Package of Health Services
EPI	Extended Program for Immunization
FARA	Fixed Amount Reimbursement Agreement
FBO	Faith-Based Organization
FP	Family Planning

gCHV	General Community Health Volunteer
GOL	Government of Liberia
HCT	HIV Counseling and Testing
HF	Health Facility
HMIS	Health Management Information System
HSW	Health and Social Welfare
IP	Implementing Partner
IUCD	Intrauterine Contraceptive Device
LMHRA	Liberia Medicines and Health Products Regulatory Authority
LMIS	Liberia Malaria Indicator Survey
MCH	Maternal and Child Health
MDGs	Millennium Development Goals
M&E	Monitoring and Evaluation
MOHSW	Ministry of Health and Social Welfare
NDS	National Drug Service
NGO	Non-Governmental Organization
NHA	National Health Accounts
NHPP	National Health Policy and Plan
OFM	Office of Financial Management
OIC	Officer in Charge
OOP	Out-Of-Pocket
OPD	Out-Patient Department
PBC	Performance Based Contracting
PBF	Performance Based Financing
PHC	Primary Health Care
PIT	Provider-Initiated Testing
PMTCT	Prevention of Mother to Child Transmission

QA	Quality Assurance
RBHS	Rebuilding Basic Health System project
RDT	Rapid Diagnostic Test
SCMU	Supply Chain Management Unit
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
TB	Tuberculosis
TBA	Traditional Birth Attendant
TTM	Trained Traditional Midwives
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WB	World Bank

Acknowledgements

Performance Based Financing (PBF) is one of the strategies being used to implement the National Health Policy and Plan in Liberia. It aims to strengthen the linkages between financial resources and the health outputs/outcomes. This Operational Manual is critical as it will make the implementation of PBF much clearer and more user friendly.

The Ministry of Health and Social Welfare (MOHSW) expresses its gratitude to the donors of PBF (the governments of the United State, the United Kingdom, and Ireland), the partners who implement the performance contracts, and the technical support from the United States Agency for International Development (USAID)/Rebuilding Basic Health System (RBHS) project and the World Bank (WB).

The MOHSW would also like to acknowledge gratitude for the commitment of the Liberia health facilities workers and the County Health Teams' (CHTs) staff, who provided great collaboration in the PBF implementation.

Preface

Performance Based Financing is an implementing strategy of the National Health Policy and Plan (NHPP). The overarching goal of the NHPP is to improve the health and social welfare status of the population of Liberia on an equitable basis. The Ministry of Health and Social Welfare aims to strengthen accountability and efficiency of service delivery through the separation of functions by contracting implementers of health programs through performance based contracts (PBC), while the Central MOHSW focuses on the regulatory and resources mobilization roles in the delivery of the Essential Package of Health Services (EPHS). Additionally, the MOHSW aims to shift focus from input to results and to motivate health workers and other stakeholders in an effort to improve their performance.

The PBF policy states that the MOHSW will be responsible for leading PBF in the health sector and will establish adequate regulatory capacity in the fields of legislation, standards setting, operational guidance, and monitoring and evaluating performance. The PBF Operational Manual provides: a) the relevant institutional and implementation arrangements; b) the roles and responsibilities of different stakeholders; and c) the implementation instruments (for example, the Performance Improvement Business Plan Guide, the methodology for setting performance targets, the methodology for verifying and reporting performance, and the tools for monitoring and evaluation). It ensures the key functions of performance based financing are implemented by avoiding, to the extent possible, the conflicts of interests in its implementation and validation of performance. PBF functions include: the regulation, fund holding, purchasing of the EPHS, provision of services, performance reporting, and independent verification and monitoring and evaluation (M&E) of PBF implementation.

The PBF Operational Manual is built on global experiences and best practices of ongoing PBC in the health sector in Liberia, mainly from the RBHS project and its subcontracted implementing partners (Africare, MTI, Equip, IRC, and MERCI). Successful practices extend to areas such as: the utilization of the dashboard for the PBC monitoring and evaluation, the elaboration of the performance business plan by the facilities, the performance agreements at all levels, and the joint verification of the facility performance by the CHTs and the implementer organizations.

The process of designing the PBF Operational Manual included a joint WB/RBHS assessment conducted in May 2011, a stakeholders' workshop for validation of the PBC assessment, selection of the preferred options for the operational manual, and a training workshop in June 2011 with the County Monitoring Officers and technical staff of the PBC implementing partners (IPs). The consultation process also included two debriefings about the PBC proposed operational arrangements with the decision makers of the MOHSW (Minister, Deputy and Assistant Ministers, and the directors and coordinators of national departments and programs).

The PBF operation plan will require some imperative adjustments during the process of scaling-up of performance based financing at the national level. The adjustments will be based on evidence of the best practices and constraints of PBF implementation in Liberia. Operations research interventions, in partnership with research institutions and development partners, will constitute an important component of the monitoring and evaluation of the PBF scheme.

Finally, the PBF manual will provide guidance for proper implementation of performance agreements leading to the improvement of the Liberian health and social welfare status.

Minister of Health and Social Welfare

I. Background

I.1. Country profile

Liberia has 15 administrative counties. The “big six” (Montserrado, Nimba, Bong, Lofa, Grand Bassa, and Margibi) account for 75 percent of the total population. The population of Montserrado County has more than doubled (from 491,078 to 1,118,241) since 1984; one-third of all Liberians live in Monrovia. Nationally, 47 percent of the entire population lives in urban areas. Currently, County Health and Social Welfare Teams (CHSWTs) comprise the operational arm of the MOHSW. Under the direction of the Central MOHSW, CHSWTs manage all Ministry-owned facilities, Ministry-employed human resources, and Ministry-provided material resources in their counties. A County Health and Social Welfare Board, chaired by the County Superintendent, advises the CHSWTs, assists with resource mobilization and coordination, and monitors the implementation of the County Health and Social Welfare Plan. In some districts, generally with a secondary care facility, a District Health Officer (DHO) coordinates district planning and supervision. Not all counties have fully developed health districts. In these cases, the DHO is based at the county level and coordinates planning and supervision in assigned facilities.

The 2007 Demographic and Health Survey (DHS) reported the maternal mortality ratio at 994 deaths per 100,000 live births, the infant mortality rate at 71 deaths per 1,000, and the under-five mortality rate at 220 deaths per 1,000. The total fertility rate is 5.2 and the contraceptive prevalence rate is 11 percent. The DHS also reported just 46 percent skilled attendance at birth and only 37 percent of deliveries taking place in a health facility. The full vaccination coverage rate is 51 percent. Forty-two percent of children under-five have chronic malnutrition. Malaria, acute respiratory infections (ARI), diarrheal diseases, and malnutrition remain the main causes of under-five deaths. Malaria remains the leading cause of morbidity and mortality in Liberia, and accounted for 38 percent of out-patient consultations and 42 percent of in-patient deaths. The 2007 DHS reports a nationwide HIV prevalence of 1.5%; urban residents have a higher prevalence at 2.5% compared to rural residents at 0.8%. Epidemiological mapping shows a wide distribution of onchocerciasis, lymphatic filariasis, soil transmitted helminthes, schistosomiasis, and leprosy in all counties.

In 2010, there were 550 (378 public and 172 private) health facilities; 31 percent of private facilities met minimum facility accreditation criteria, while 80 percent of government facilities met the criteria for delivering a Basic Package of Health Services (BPHS). The package was a set of high-impact interventions that prioritized the services thought to be most critically needed to improve the health status of the Liberian population, including: 1) Maternal and Newborn Health; 2) Child Health; 3) Reproductive and Adolescent Health; 4) Communicable Disease Control; 5) Mental Health; and 6) Emergency Care. In July 2011, the BPHS was expanded to the EPHS (document available at

www.moh.gov.lr/doc/Final%20EPHS.pdf). This expanded package includes all elements of the basic package as well as non-communicable and neglected tropical diseases, and provisions for strengthening the referral system from the community to the tertiary level of health services.

Human resources for health are still a challenge in Liberia. In 2009, a national human resources census recorded 8,553 paid public-sector health and social welfare workers; 62 percent (5,346) were “clinical” and 38 percent (3,207) were non-clinical (including security guards, registrars and cleaners). However, only 48 percent (2,568) of the clinical workers were skilled providers (physicians, physician assistants, nurses, midwives, pharmacists, laboratory technicians, etc.). The remaining were lower skilled workers such as paraprofessionals (nurse aides, traditional midwives, assistants, etc.) and unskilled workers. Almost 70 percent of the total workforce was either non-clinical or unskilled. Deployment of health personnel to rural areas has been difficult because the salary is not fixed to the facility, but instead to the staff and inadequate incentives to retain skilled providers in remote areas.

The National Health Accounts (NHA) report for fiscal year 2007-2008 reported total health expenditure of US\$100,517,382 million for Liberia, representing a per capita expenditure of \$29. Donors and out-of-pocket (OOP) expenditures accounted for 47 and 35 percent respectively, while government spending was 15 percent; health expenditures comprised only 7.7 percent of total government expenditures.

The National Drug Service (NDS) serves the Department of Health Services and manages the central warehouse and the regional depots. NDS is responsible for the procurement, distribution, and management of medicines for the public sector and non-profit institutions. Drug requisition forms from counties are compiled and sent to the NDS for procurement. Funding for the procurement of drugs is fragmented: the Government of Liberia pays for drugs at facilities which it is exclusively supporting; bi-lateral donors pay for drugs at facilities supported through non-governmental organizations (NGOs); vertical program donors pay for drugs that are provided free to all public facilities.

The MOHSW has undertaken efforts to strengthen collection of health related information. Health service delivery information is already captured in the Health Management Information System (HMIS); supply chain information captured in the Logistical Management Information System (LMIS) will soon start reporting through HMIS. The ultimate goal is to channel all health information through HMIS, including that pertinent to governance, financing, and human resources for health.

II. Aim, Concept, and Definitions

The NHPP aims to improve the health and social welfare status of the population on an equitable basis. In an effort to achieve this goal, the MOHSW established a policy for contracting the implementers of health programs and is committed to leading performance

based contracting/financing in the health sector and establishing the adequate regulatory capacity in the fields of legislation, standards setting, operational guidance and monitoring and evaluation of the performance.

Contracted implementers (CHT and/or NGO) will be responsible for implementing the EPHS. The MOHSW intends to strengthen accountability and efficiency of invested resources through the separation of functions. In this paradigm, the MOHSW will focus on the regulatory and resources mobilization roles in the delivery of quality EPHS.

II.1. Definitions

Performance Based Financing refers to the transfer of incentive (mainly payment based on fee-for-service or other monetary payment) from a funder or other supporter to a recipient, *conditional* on the recipient taking measurable action or achieving a predetermined performance target. Recipients may be institutions and/or individuals (health facilities, clinics, and/or health care providers).

On the other hand, Performance Based Contracting uses a supply-side PBF approach involving the development of a contract or other formal agreement.

A Result Based Financing glossary developed by the WB notes that: “PBC refers to contracts between a financing agent and an NGO, with payment depending on achievement of a performance measure that include coverage targets and quality norms for a set of services. The contrast with PBF is that the latter concentrates on agreements with providers. Of course, the NGO operating under a contract may also be the provider or may in turn contract with providers, so the distinction between PBF and PBC is not strict; and PBC can be used more generally to refer to any contract where payment depends on a specific definition of performance”.

The Liberian national scheme will be referred to as Performance Based Financing. This will involve three (3) processes: 1) Contractual arrangements between the MOHSW and County Health and Social Welfare Teams (contracting-in) 2) Contractual arrangements between MOHSW and NGOs/Civil Society Organizations (management contracting), and 3) Performance agreement between the implementing partner and health facilities. For the time being, PBF will be implemented *only* in health centers and clinics. All health facilities contracted under PBF will be implementing the EPHS. The WB is considering a PBF pilot project, tentatively scheduled for 2013, that will focus at the hospital level and will pilot a fee-for-service program for PBF indicators.

II.2. Objectives of Performance Based Financing in Liberia

Existing policy within the Liberia MOHSW allows for the contracting of health services. The contracting policy states that the MOHSW will lead PBC in the health sector and will

establish adequate regulatory capacity in: a) standards setting, and b) operational guidance. Standardized contracts, reporting, and monitoring tools will be developed. A mixture of approaches will be tried. This includes: a) *contracting in*, when one level of government contracts with another, b) *contracting out*, when a partner is contracted with complete authority over all resources (human, material, and financial) to provide health services, and c) *management contracting*, when a partner is contracted to provide management services alone over government resources. Specific objectives of PBF are to:

- Extend coverage of essential health care services to underserved and targeted populations through contractual arrangements with implementing partners and service providers
- Improve the quality of health services, especially in the areas of maternal and child health, family planning, malaria, and HIV/AIDS
- Improve the capacity of the MOHSW for effective oversight of the health sector through M&E and data analysis for evidence-based decision making
- Enhance motivation and healthy competition in the delivery of health services and management of resources
- Improve the skills and efficiency in health care planning and mobilization of resources for achieving set targets

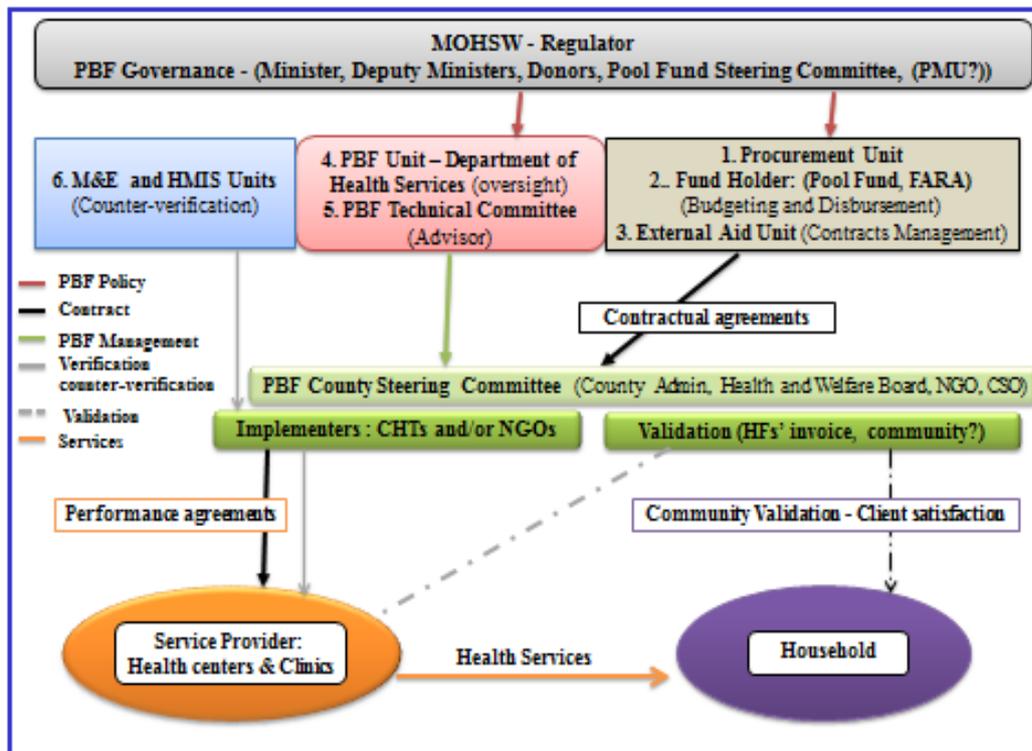
Within the health sector there are currently two main funding mechanisms governed by PBCs between fund holders and implementing/management agencies of health service delivery. The two contracts are called “Performance Based Contracts”, meaning that key achievements are defined, evaluated, and the appropriate decisions are made as agreed upon by the two parties. The two mechanisms currently implemented are:

1. The RBHS/USAID sponsored project. This PBC scheme started in mid-2009 by contracting five NGOs to provide support to 112 health facilities in six counties. The project is transitioning into a new phase to be completed in June 2012, where implementation responsibilities are being transferred from RBHS to the MOHSW. Going forward, RBHS activities will mainly be focused on capacity building and skills transfer after June 2012.
2. The MOHSW in 2009 through the Pool Fund, with support from the Department for International Development (DFID), Irish Aid, and UNICEF, instituted two types of Performance Based Contracts: contracting-in with Bomi County Health Team, and management contracting with five NGOs supporting 87 health facilities in seven counties. The Bomi County health team also sub-contracted one NGO.

III. The PBF Institutional & Implementation Arrangements

The PBF scheme in Liberia can be broken down into five key functions: (i) regulation, (ii) fund holding/purchasers, (iii) implementing, (iv) health service provision, and (v) verification and counter-verification. Figure 1 represents the proposed institutional and implementation arrangements including these five key functions. These are also described in subsequent text. Details of the roles and responsibilities of each stakeholder are explained in Section IV.

Figure 1 – PBF Institutional and Implementation Arrangements



III.1. Regulator

The regulator is responsible for the **development of policy and oversight of PBF implementation**, development of guiding documents and tools, and provision of technical oversight and supervision. The function of regulation is assumed by the central level of the MOHSW.

Oversight of the PBF scheme is conducted by the MOHSW through regular mechanisms. The Departments of Planning, Research and Development, Health Services, and Administration will coordinate to ensure the financing and technical regulations are harmonized. Specifically, the Department of Administration will regulate the financial aspects, while the departments of Health Services and Planning will assume responsibility for the programmatic aspects (i.e. designing performance contracts, performance counter-verification, and monitoring of service indicators)

Key entities within the MOHSW that are relevant to the PBF scheme are summarized below:

- The governance of the PBF scheme will be assumed by a committee comprised of the Minister, Deputy Ministers, donors, and the Pool Fund Secretariat. Specifically, the committee will be in charge of setting PBF policy, mobilizing resources in collaboration with the External Aid Unit, and assessing progress on overall implementation of PBF.
- The External Aid Unit will be in charge of partnership building, which includes resource mobilization for the PBF scheme. It will assume the responsibility for managing the contractual agreements.
- The PBF Unit is composed of a Manager, Data Officer, Data Analyst, Administration and Finance Officer, and Training Officer. This unit reports to the Chief Medical Officer and will be in charge of oversight of the PBF scheme, working in partnership with the M&E Unit, the Office of Financial Management (OFM), the Pool Fund Secretariat, and the External Aid Unit. Each partner, based on their areas of specialty, will facilitate the design of performance contracts, development of performance verification, validation and counter-verification tools, standard financial reporting tools, accounting mechanisms, bonus calculation tools, and monitoring for the efficient roll out of the PBF scheme.
- The M&E Unit will coordinate the counter-verification, monitoring, and impact evaluation of the PBF scheme in collaboration with relevant units and other stakeholders.
- The PBF technical team will be composed of the PBF Unit and technical advisors from key units of service delivery, planning, and vital statistics. The main responsibility is to advise the PBF Unit based on their area of expertise and ensure relevant priorities in their area of expertise are incorporated.

III.2. PBF Fund Holder/Purchaser

This entity is responsible for the mobilization and disbursement of funds for implementation according to the contractual agreement and reporting period. In the Liberian scheme, this function is fulfilled by the MOHSW Office of Financial Management situated in the Department of Administration; the Pool Fund Secretariat works closely with the OFM. Additionally, the Fixed Amount Reimbursement Agreement (FARA) finances the contractual agreement through regular MOHSW mechanisms (FARA does not contribute to the Pool Fund). The fund holder disburses money to the implementer, who in turn contracts the health service providers for delivery of services.

The current PBF fund holder is the MOHSW Finance Department (the Pool Fund and FARA). Formal agreements will strengthen the accountability of different stakeholders. Each level of the health system will be responsible for its own specific targets, even though they will have global performance enforced by sharing the total bonus.

III.3. PBF County Steering Committee

Currently, counties have in place a County Health and Welfare Board led by the County Superintendent and is comprised of members of the county administration, the CHT, the representative of civil society, and representatives of health partners where applicable. The board advises the County Health Officer (CHO) on health matters and assists in resource mobilization for the county.

The PBF County Steering Committee will be the decentralized unit that will oversee the implementation of the PBF scheme at the county level. The committee builds on the County Health and Welfare Board; it will include varied members that may include representatives from the county and district administrations, CHTs, DHOs, and from partners (NGOs, civil society organizations [CSOs], or technical partners). The broader composition of the PBF County Steering Committee will enhance transparency of the PBF scheme, mitigate potential conflict of interest, and ensure county health interests and goals are kept in check.

The PBF County Steering Committee is responsible for the validation of results. The group conducting the validation is composed of representatives from the county and district administrations, the CHO, a representative of other health programs (i.e., malaria, extended program for immunization [EPI], HIV and family planning), and representatives of technical or financial partners (NGOs, CSOs, or technical partners).

Thus, the group is responsible for validation of its validation of the documentation showing numbers reached in relation to the health facility indicators; also referred to as the invoices for health facility indicators (and for commissioning the community validation, when it becomes operational).

III.4. Implementers

The implementing partners (CHT or NGO) are responsible for the verification of health services produced by health facilities on behalf of the fund holder; and foremost, for ensuring availability of quality health services for the population in the catchment area.

The implementer is responsible for **building the capacity** of health facilities, supplying key inputs, providing trainings, supportive supervision, data management & reporting, outreach services, and community health services.

The decision as to whether a county or NGO will be contracted as implementer rests with the MOHSW. The capacity to manage involved tasks and ensure effective coverage of health services will be among the considered criteria.

There are two types of implementers:

1. NGO (“management contracting”): The NGO submits a budget which includes all necessary activities for one year, including the amount for overheads. The contracted NGOs receive 90% of agreed upon funds to initiate delivery of health services. NGOs ensure that the health facilities (HFs) in their catchment areas meet quarterly performance targets. NGOs and county health teams verify services provided, while the Central MOHSW is responsible for the counter-verification of implementers’ indicators. An additional 10% bonus is allocated based on performance of both the implementer and the health facilities in the catchment area.
2. CHT (“contracting in”): Similarly, the contracted county will receive 90% of the funds to initiate delivery of health services. The county ensures health facilities in their catchment areas meet quarterly performance targets. The CHT can sub-contract management of some health facilities to an NGO implementer. The CHT and relevant partners verify services provided while the Central MOHSW is responsible for the counter-verification of implementers’ indicators. An additional 10% bonus is allocated based on performance of both the implementer and the health facilities in the catchment area.

The PBF implementer will cover preferably all facilities of a county to ensure a better collaboration with the CHT and DHTs and, if necessary, will have sub-contractors. The administrative catchment area to be covered by a PBF implementer will be the District.

To strengthen the supervisory and supporting functions of the implementer, the selected PBF indicators will be based on a mix of supervisory/management performance and clinical results. Current performance indicators for implementers along with their assigned weight can be found in Annex 1b.

III.5. Health Service Provider

The health clinics and the health centers are the PBF health services providers. They are responsible for **delivering agreed upon health services** and achieving performance targets including the defined quality criteria. The PBF health services indicators are part of the EPHS. The MOHSW may decide at a later date to extend the PBF scheme to hospitals.

The health clinics and health centers can incorporate community health services in their package. The implementer has the flexibility to have a performance sub-agreement for a

specific hospital service (example: maternity ward for emergency obstetrical care). Under certain circumstances and conditions, private for-profit facilities could also be contracted.

To ensure the quality of health services delivered, the PBF selected indicators will be based on a mix of administrative and management areas, outputs and outcomes, and the clinical and quality criteria. Current performance indicators for health centers and clinics, along with assigned weights, can be found in Annex 1c.

The health service provider (health facilities) will produce the HMIS monthly report by filling out the integrated report form and will highlight the PBF indicators for all stakeholders. The report will remain at the facility for verification and collection. The DHO, under CHT supervision, is responsible for collecting the monthly report. This will remove the burden from the facility to transmit the report and standardize data collection.

III.6. Performance Verification at County Level

III.6.1. Verification of Service Delivery Indicators (Health Facilities)

The purpose of the verification, or cross-checking, is to strengthen the quality of the data collected at health facilities and captured in the District Health Information System (DHIS); the HMIS Unit manages the DHIS. Additionally, it will also serve for the quantitative verification of PBF selected indicators. This verification is conducted at the county level. Implementers (CHTs and NGOs) are responsible for the coordination and logistical support for facility visits and data verification; whereas the DHO ensures the monthly integrated report forms are collected and submitted to the county data manager by the 5th of each month.

For better coordination, efficient use of resources, and strengthening of HMIS data, the verification of PBF indicators will collaborate with the clinical supervision and M&E tasks conducted each month. For instance, the county health team, which is in charge of clinical supervision, has monthly and quarterly scheduled supervisory activities. The County Clinical Supervisor, County M&E Officer, County Data Officer, and M&E Officers from varied programs (EPI, malaria, HIV, family planning [FP], etc.) contribute to this activity. The PBF verifier(s) and the team conducting the clinical supervision and M&E will train together in order to conduct the verification of PBF indicators, per contractual agreement.

The officer in charge (OIC) ensures the integrated report form is filled out promptly each month. The District Health Officer collects the integrated report forms from the health facilities assigned to him/her and ensures the forms get to the county health office by the 5th of each month. The data is then entered into the DHIS at the county level; this takes two weeks and the data is then transmitted to the HMIS by the 15th of each month. The HMIS Unit conducts the quality checks and resolves pending queries within one week from receipt of data; the data can then be made available to other units. The entire process takes three weeks, after which the county team can then start planning for the verification.

With the above workforce, each county will be able to constitute approximately three teams for verifiers, with each team comprised of three members. Each team will be assigned estimated 7-10 health facilities. Thus, these tasks shall be completed in three weeks. The verification team cross-checks the data collected through the DHIS with the source data at the facility level (i.e. ledgers, registers), and conducts the verification of PBF indicators. Discrepancies identified during the verification exercise will be brought to the attention of the data manager for the county, who will amend the records in the DHIS. Thus, at the end of this process, records sent to the Central MOHSW will be verified and accurate. The verification of health facilities' PBF indicators is conducted on a quarterly basis by the implementers.

The verifier will have accessible a copy of the HMIS report for the corresponding period, to which is annexed a report of "declared data" (Annex 2a), corresponding to services provided by the health facility with regards to PBF performance indicators. S/he will cross-check against the original data in registers and other documents held by the health facility. This verification will yield two types of reports:

1. HMIS verified data: consists of accurate quantitative data of services provided at the health facility, regardless of whether information on required identifiers or care received by the service beneficiary is complete or incomplete.
2. PBF indicators verified data: consists of quantitative data for services provided with regards to PBF indicators and will only include verified data that meets the conditions as specified in the performance agreement (i.e. beneficiary's name, age, address, diagnosis, treatment, date).

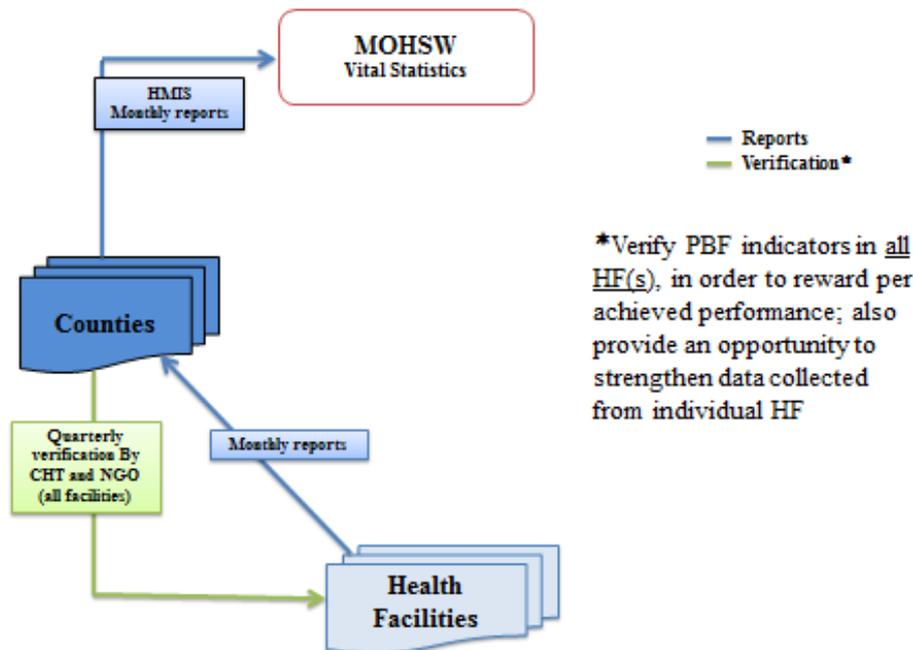
Certain types of discrepancies will be more severely sanctioned than others. For example, knowingly falsifying the data in order to increase the earned bonus will result in withholding of any bonus earned on the concerned indicator by the health facility for that quarter. If this is a repeat offender situation, the concerned health facility may be debarred from participating in the PBF scheme for a determined period of time.

The exclusion of repeat offenders from participating in the scheme will be proposed by the implementer, who will supply documentation of the offenses; the County PBF Steering Committee will review and approve the decision. The decision will be communicated to the PBF Unit which will learn from the experience and develop strategies, in consultation with counties, to mitigate similar situations in the future.

The verifier will have a blank quarterly invoice (Annex 2a) to be filled out on site for each health facility. The form has fields for declared data and for verified data. Upon completion, the invoice will be signed by the OIC and the team that conducted the verification. A copy of this invoice will remain at the health facility for their records. The transmission of the PBF verified report will be submitted by the PBF implementer to the PBF County Steering Committee for validation.

A summary of the verification process is illustrated in the graph below:

Verification of Service Delivery Indicators (Health Facility)



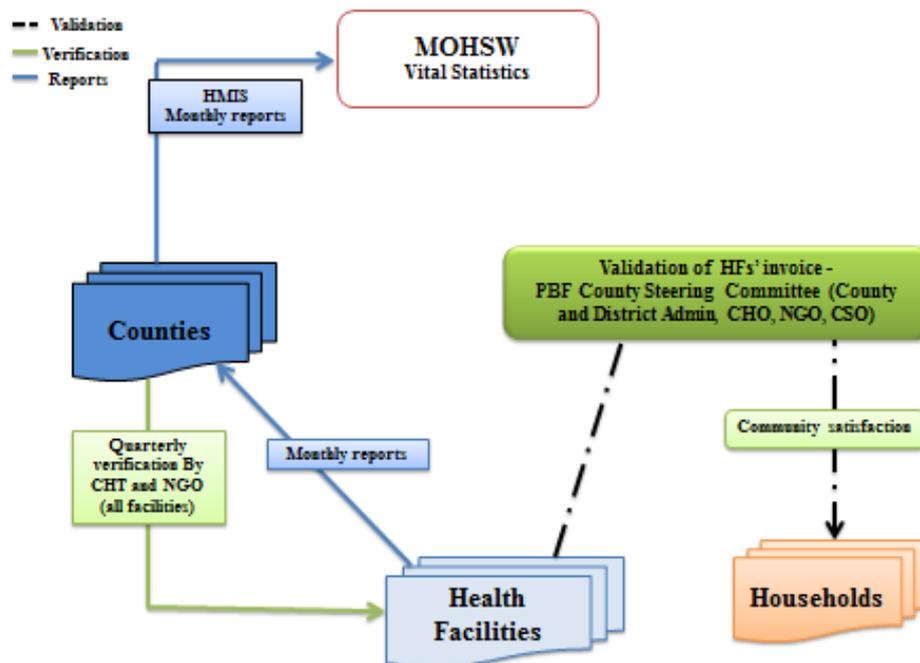
III.6.2. Validation of Service Delivery Indicators (County level)

The validation of health facilities’ results is the responsibility of the PBF County Steering Committee and will be conducted on a quarterly basis. It will take place once the verification of the health facilities’ results by implementers (CHT jointly with NGO) is completed, about 45 days after the end of the quarter.

The PBF County Steering Committee will review the procedures followed by implementers in their verification tasks, review achieved results by health facilities, and check for any potential discrepancies; hence, this task will be conducted at the county level. The PBF County Steering Committee will then validate the invoice by co-signing. Afterwards, the implementers will submit the invoices for HF validated results to the External Aid Unit, with copy to the PBF Unit. Other documents submitted along with the invoices for validated results from the HFs are: the quarterly report from implementers and an invoice of non-validated results pertinent to the implementers’ indicators.

A summary of the validation process, including validation at the community level, is illustrated in the graph below:

Validation of Service Delivery Indicators (County Level)



III.6.3. Validation at the Community Level (County Level)

The main purpose of the data validation at the community level is to: (i) confirm the existence of beneficiaries randomly selected in registers at health facilities, and (ii) assess how satisfied the beneficiaries are in regards to received services. The findings of the validation exercise at community level will be factored into calculating the final bonus earned by the health facility. An indicator, “perceived quality of services”, with a relative weight of 10.0, will be included on the list of indicators applicable for health facilities. Thus, this will bring a renewed attention by health care workers to ensure patients have an improved experience during their visit at the HF. Detailed questions for the validation at community level are included in the verification and validation tools.

Establishing a System to Conduct the Validation

The validation of data at the community level is to be conducted every quarter. **A third party, contracted by the County Steering Committee, conducts this activity.** Local associations, especially those whose mission is to fight poverty or advance public health objectives (i.e. reproductive health, community health), can be sub-contracted as the third party to conduct the validation of delivered services at the community level. Only registered local associations will be eligible. Preferably, the local association will be assigned to the catchment area of a health facility. Also, there shall be no ties between the health facility and the local association conducting the validation in order to avoid conflict of interest.

The responsibility for validation of data at the community level is incumbent to the PBF County Steering Committee. The PBF and M&E Units will assist the County Steering Committee in the initial stages and assist with capacity building efforts toward fulfillment of this function by the PBF County Steering Committee. It needs to be emphasized that this validation may not be conducted directly by the PBF County Steering Committee; community based organizations (CBOs) can, however, fulfill this mission under the guidance of the committee. Hence, this is a good opportunity to engage the communities in PBF implementation, and thereby favor sustainability of the scheme.

Determine Service Beneficiaries to be validated

Preferably, two community based organizations (CBO or local NGO) will be recruited per county. An average county has about 20 health facilities, thus each CBO will be assigned to approximately 10 health facilities. For each health facility, two villages will be randomly selected and five beneficiaries of services will be selected in each village. For each of the selected beneficiaries, the CBO will verify (i) their existence, as well as (ii) the subjective quality of service provided by the health facility by asking a set of questions designed solely to capture the perceived quality of care.

If any of the selected beneficiaries reside outside of the concerned county, it may not be financially sound to track them; thus, they will be replaced by another selection of beneficiaries. If the random selection yields an excessive number of beneficiaries who reside outside of the HF catchment area and/or county, this could be an issue linked to the situation on the ground (i.e., influx of refugees). The health center will not get penalized for such a situation. However, efforts should be invested in assuring it is not a fraudulent situation by the health facility. The person conducting the validation has the responsibility to notify the PBF County Steering Committee of these incidences; the Steering Committee will then decide whether an investigation is warranted.

Conduct the Validation at Community Level

The surveyor conducting the validation at community level (i.e. local association) will be given a form with only necessary details to track the beneficiaries in the community (i.e. first and last name, county, district, locality, and/or name of chief of family) and key elements to be verified by the patient. Care will be taken to protect the privacy of individuals' health information. Also, when the surveyors visit the household(s), the family will be informed of the purpose of the survey and will freely decide whether to respond before the survey can take place.

Some of the information to be collected will act to ensure the surveyor visited the household, as s/he will not be able to fill out the form without actually visiting the household and speaking with the service beneficiary or a member of the household. For example, the surveyor will need to request the age of the patient, note the date of the visit to the health facility, length of stay, gender, and, for pregnant women, the rank of pregnancy (i.e., 1st, 2nd, or 3rd pregnancy).

Score Resulting from the Validation

The score resulting from the validation at community level will be recorded under the indicator: “perceived quality of services”, which has a relative weight of 10.0. Details on the calculation of this score are included in the verification and validation tools; a sample summary sheet for scoring the community survey is attached in Annex 6a (extracted from verification and validation tools).

Health facilities are responsible for correctly recording patients visiting their institution. Each identified case of a “ghost” patient will be given a score of 0; thus, this will affect the overall score and potential bonus to be earned by the facility. If this is a repeated offense, the concerned health facility may be debarred from participating in the PBF scheme for a determined period of time.

Additionally, for traced patients, their perceived satisfaction of services provided by a health facility will be gauged and classified in three levels and given a score of either 0, 5, or 10 (i.e. waiting time at the health facility will have three responses: too long, medium, short; they will respectively get a client satisfaction score of 0, 5, or 10). A sample for questions assessing the client satisfaction is attached in Annex 6b (extracted from verification and validation tools).

III.7. Counter-Verification by Central MOHSW

The purpose of the counter-verification of the performance reports is to strengthen the quality of the data by detecting errors and preventing over reporting, especially given that there is a financial bonus linked to performance.

The counter-verification will be conducted on a quarterly basis. To increase the level of integrity, avoid any conflict of interest, and ensure reliability of the results, to the extent possible, the counter-verification will be conducted by a party with no ties to the financial incentive resulting from the PBF scheme, or by a third party organization. Alternatively, the make-up of the counter-verification team can be expanded to varied groups (i.e. other stakeholders) thereby lessening the potential for conflict of interest.

To allow for proper planning, this activity will be initiated five days after completion of the verification, or 45 days after the end of quarter. The counter-verification conducted by the Central MOHSW is a two-fold process:

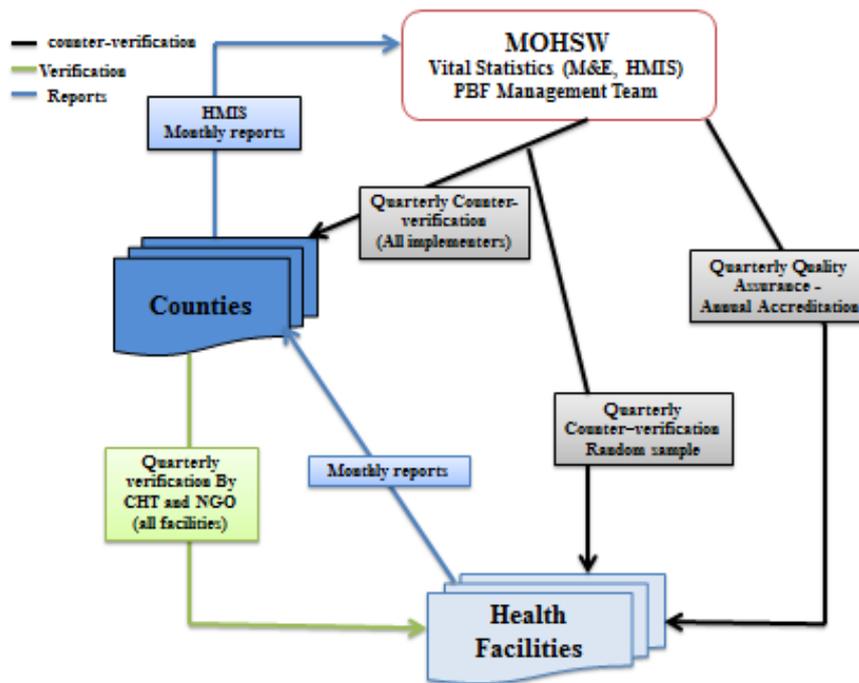
- Counter-verification of administrative indicators for all of the implementers
- Counter-verification of data at 20% of randomly selected health facilities

Additionally, the Central MOHSW County Coordination Unit conducts annual accreditations of health facilities and clinical standard assessments; implementers are also assessed on how health facilities in respective catchment area perform on the annual accreditation and the

clinical standard assessment. The County Coordination Unit and the PBF Unit will explore the incorporation of quarterly quality assurance (QA) into PBF indicators.

A summary of the counter-verification conducted by the Central MOHSW is in the graph below:

Counter-Verification of Administrative Indicators (Central MOHSW)



III.7.1. Counter-Verification of Administrative Indicators (Implementers' Level)

In the Liberian scheme, the counter-verification of administrative indicators (or implementers' indicators) will be the responsibility of the Central MOHSW. At central level, this function will be assumed by the M&E and HMIS Units (primary units responsible), in coordination with the PBF Unit. In the current PBF scheme, the Central MOHSW is not eligible for the PBF bonus; thus, the conflict of interest is minimized in this arrangement.

Through the PBF scheme, the MOHSW's aim is to coordinate and advance ongoing initiatives targeted at improving the quality of care. The PBF indicators at the implementers' level include a set of administrative indicators tailored to the responsibilities of the implementers. These indicators are designed to advance and strengthen the managerial and supervisory role of the implementers (counties and NGOs), and to facilitate the accreditation and attainment of quality assurance objectives by health facilities in their catchment area.

Additionally, implementers' performances will in part be evaluated on the performance of the health facilities in their catchment area. To accomplish this, the results of the counter-verification at randomly selected health facilities (2-4 health institutions per county) will be considered to account for not only how the health facilities are performing, but also on the

accuracy of the verification of health facilities' performances conducted by implementers. All implementers are subject to quarterly counter-verification of all relevant administrative indicators. The last indicator listed on the implementer's invoice reflects the random counter-verification performed at a few of the facilities; and will have a relative weight of 5.0.

Every quarter, each implementer will submit a report of "declared data" in the quarterly invoice (Annex 2c) to the MOHSW, as specified in the contractual agreement. The team conducting the counter-verification is to cross-check the "declared data" with records of accreditation and quality assurance, the report of supervisory visits, and financial statements. Two forms will be used to assist with the tasks of the counter-verifier:

- (a) Data counter-verification sheet: it will be used for each PBF indicator counter-verified at the implementer's site. This is to assist with the work, as different ledgers and record books might be used; it will also serve to document the thoroughness of the counter-verification. A sample of the form is attached in Annex 2b, along with specific instructions on how to work with the data element for counter-verification, the data source, the kinds of staff to be involved, and the cross-check data elements.
- (b) While at the implementer's site, the counter-verifier will fill out the column designated "Achieved and Validated Data" on the counter-verification invoice for the implementer (Annex 2c). Both the counter-verifier and a representative of the implementer will sign on the invoice. A copy of this bill will remain at the county office for their records. The other copy will be submitted to the PBF Unit.

Note: The last indicator listed on the implementer's invoice reflects the random counter-verification performed at a few of the facilities. Thus, the entire row will have data under "achieved and verified" only after completion of the random counter-verification. More details on this activity are to follow.

Suspected cases of falsifying results will be documented and severely sanctioned. For example, knowingly falsifying the data in order to increase the earned bonus will result in the withholding of any bonus earned by the implementer for that quarter. If this is a repeated offense, the concerned implementer may be debarred from participating in the PBF scheme for a determined period.

The exclusion of the repeat offender from participating in the PBF scheme will be proposed by the M&E and PBF Units conducting the counter-verification, who will supply supporting documentation; the PBF Steering Committee will review and approve the decision.

III.7.2. Counter-Verification of Data at Health Facilities

The validation or counter-verification at the facility level will be conducted on a random sample of health facilities (about 20% of HFs). A proportionate stratified random sampling, where the counties constitute the strata, will be used to ensure a fair representation of health

facilities by counties. The average county has about 20 health facilities; therefore, about two to four health facilities per county will be subjected to validation each quarter (this number could be slightly higher for counties with an increased number of health facilities). This counter-verification will be conducted on PBF indicators, as per contractual agreement.

To the extent possible, the counter-verification will be conducted by a party with no ties to the financial incentive resulting from the PBF scheme. Currently the central level of the MOHSW does not benefit from the bonus earned by the health facilities. The MOHSW will be responsible for conducting the counter-verification at the few selected facilities. The team from the Central MOHSW, while in-county to conduct the counter-verification of relevant implementers' indicators, will also organize and conduct a counter-verification of data in randomly selected health facilities per county (about 2-4, depending on total number of health facilities). Again here, two forms will be used to assist in the activities of the counter-verifier:

- (a) Data counter-verification sheet: it will be used for each PBF indicator counter-verified at the health facility level. This is to assist with the work, as different ledgers and record books might be used; it will also serve to document the thoroughness of the verification. A sample of the form is attached in Annex 2b, along with specific instructions on how to work with the data element for validation, the data source, the kinds of staff to be involved, and the cross-check data elements.
- (b) While at the health facility site, the counter-verifier will fill out the column designated "Achieved and Validated Data" on the counter-verification invoice for the concerned HF (Annex 2a). Both the counter-verifier and OIC or his/her representative will sign the invoice. A copy of this bill will remain at the health facility for their records. The other copy will be submitted to the PBF Unit.

The implementer is responsible for the primary verification of PBF health facility indicators. Thus, discrepancies noted at this stage of counter-verification will be reflected on the implementer's invoice. Specifically, the score for "random counter-verification at health facility" is added to the list of the implementer's indicators and represents the percentage of accurately reported indicators as a proportion of the verified data.

If there are discrepancies at this late stage, they will be brought to the Central HMIS Unit for amendment of records.

A timeline of the data collection, verification, validation, and counter-verification activities is summarized in Table 1 below:

Table 1

Calendar for Verification and Validation of PBF Results (Liberia)															
Activities	Duration (day)	Time Table in weeks (after the end of quarter)													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14
End of quarter															
Fill out integrated report forms and collect forms	5	x													
Record data in HMIS, conduct data quality checks and make data available	15		x	x	x										
Analysis of data by counties/NGO and planning for verification	5					x									
Verification of PBF indicators: Cross-check HMIS data against HF and clinics' registers and records	20					x	x	x	x						
Submit verified data for implementers and for HF to MOHSW	1								x						
Counter-verification of implementers indicators and few selected HF by central MOHSW	15									x	x	x			
Counter-verification of HF results by independent 3rd party/CBO	15									x	x	x			
Submit validated data to MOHSW	1													x	
Analysis of validated data and summary report by PBF team	3													x	
Final publication of validated data and re-adjusted payment of bonuses by MOHSW	1														x

i. Opportunity: Shorten process?

ii. County Committee validate invoice – and bonus is paid

Adjust bonus payment after counter-verification

IV. Implementation of PBF – Mission, Responsibilities and Tasks of Key Stakeholders

IV.1. Peripheral Level

Key players at the peripheral level are the health centers and clinics.

The mission of health facilities and clinics is to:

- Offer the EPHS in its catchment areas
- Improve quality of health services provided to the population
- Motivate the general community health volunteers (gCHV) to provide good services and results, and to support community health interventions

Specific tasks for health facilities include:

- Elaborate on a business development plan under the supervision of the implementers. A suggested template for a business plan is available in Annex 3c
- Submit business plans to the implementer
- Sign quarterly performance contracts with the implementers
- Offer quality health services to the population

- Promote community health and train community health volunteers
- Subcontract services of the EPHS to secondary providers
- The OIC ensures the integrated report form is filled out by the 5th of each month; submit the monthly report on PBF contracted health services
- Facilitate verification and counter-verification activities at the health facilities
- Distribute bonuses to health workers based on set criteria (i.e. performance, attendance to work). Additional guidance is provided in the section on bonus calculation for health facilities.
- Improve the health facility by using part of the performance bonus received

IV.2. Intermediate Level – County Level

IV.2.1. District Health Team

Normally the district health team will be the most peripheral arm of the MOHSW. However, in the Liberian context, health districts are in the early stages of implementation. Some counties have health districts with DHOs, others have DHOs but they have their offices at the county health office. In either case, DHOs' mission includes supporting activities of the CHT in assigned districts.

Additionally, The PBF County Steering Committee is extended to the district administration and the district health members.

All DHOs have a clinical background and their main responsibilities include:

- Supporting the CHT in its health promotion mission in its assigned area
- With regards to the PBF scheme, DHOs are responsible for collecting the integrated report form from health facilities and clinics, and ensuring the forms get to the County Health Data Manager within five days of the end of each month.

IV. 2.2. Implementers (CHT and/or NGO)

The main mission of counties and/or contracted NGOs is to ensure availability of quality health services for the population in its catchment area.

Tasks of the implementers (CHT and/or NGO) include:

- Sign performance agreements with the HFs and clinics in catchment area
- Ensure necessary inputs are provided to HFs and clinics
- Ensure implementation of the EPHS, as agreed upon in the contract
- Ensure compliance with the rules and guidelines established by the MOHSW

- Supervise and train, if necessary, contracted health facilities in applicable norms and standards of care; facilitate path to accreditation of health facilities and clinics in catchment area
- Conduct quantitative verification of services provided by health centers and clinics (quarterly)
- Submit verified quantitative data of services provided and accompanying reports to County Steering Committee for validation of invoice (quarterly)
- Submit quarterly invoice and reports for co-signature by the County Steering Committee
- Organize feedback sessions with service providers in catchment area
- Submit validated invoices for health facilities to HMIS Unit and PBF Unit

Additionally, CHTs are responsible for:

- Ensuring monthly and quality data from health facilities is recorded in HMIS
- Maintain an M&E dashboard for the county, especially the County Data Manager would ideally maintain the county dashboard.
- Compiling and communicating the drug needs to the NDS and ensure their on-time supply to HFs
- Organizing feedback sessions with partners in the county (NGO implementers and/or health facilities) with regards to qualitative and quantitative assessments
- Supplying drugs and other equipment from the MOHSW
- Public health services (public hygiene, National Campaign for Immunization, vitamin A distribution, ITNs distribution, etc.) and for other activities of health facility coordination

IV.2.3. PBF County Steering Committee

The PBF County Steering Committee is the decentralized unit that will oversee the implementation of the PBF scheme at the county level. This committee builds on the existing County Health and Welfare Board, and expands to members of the county and districts administration, CHTs, civil society, and representatives of partners (NGOs, CSOs, or technical partners). As highlighted in the previous section, the broader composition of the PBF County Steering Committee will enhance transparency of the PBF scheme, mitigate potential conflict of interest, and ensure county health goals are kept on track.

Responsibilities of the PBF County Steering Committee include:

- Co-signing contractual agreements between fund holders and implementers
- Analyzing processes for conducting verification activities
- Analyzing differences between the data declared by health facilities and the verified data, as well as notes for observed differences

- Validate invoices in relation to PBF verified data from HFs and validating the invoices by co-signing them
- Contracting third party organizations (i.e., CBOs) for the survey of customer satisfaction and validation at the community level
- Solving eventual conflicts pertinent to implementation of PBF in the county in collaboration with the PBF Management Team

IV.3. Central Level MOHSW

Key Players at the central level of the MOHSW are:

- PBF Governance
- PBF Unit
- PBF Technical Committee
- Monitoring & Evaluation and HMIS Units (data quality and analysis, and counter-verification)
- External Aid Unit (partnership building, resource mobilization)
- Pool Fund Secretariat (budgeting and disbursement)
- Procurement Unit

IV.3.1. PBF Governance

PBF Governance is assumed by a committee composed of the Minister of Health, Deputy Ministers (Health Service Delivery; Planning, Research and Development; Finance), the Pool Fund Secretariat, the PBF Unit, and donors (The Program Management Unit [PMU], once in place, may be part of the PBF Governance committee). The mission of the committee in the PBF scheme is to assume the governance and coordination of PBF implementation at the national level and the coordination of stakeholders.

The PBF Governance's responsibilities include:

- Develop guiding policies for PBF implementation
- Monitor the implementation of PBF at the national level
- Evaluate the performance of the PBF Unit
- Validate quarterly reports submitted by the PBF Unit
- Support the MOHSW in funds mobilization

IV.3.2. PBF Unit

The PBF Unit reports to the Department of Service Delivery and is the executive branch of the PBF Governance Committee. Its main mission is to provide technical oversight and to implement PBF at the national level, as well as propose strategies and activities for PBF implementation in line with the NHPP and PBF policy set by the PBF Governance Committee.

The PBF Unit is composed of a PBF Manager with a background in public health, a Deputy PBF Manager with a background in public health, management, economics or health planning, and a PBF M&E Officer with a background in monitoring and evaluation or public health. The PBF Unit's responsibilities include:

- Provide technical oversight of PBF implementation at national level
- Facilitate the development of PBF program plans and budgets (including procurement plans), ensure timely availability of these documents, and make recommendations for the PBF Governance Committee's consideration
- Ensure that PBF implementation is in line with national guidelines, the legal framework, and agreements between the MOHSW and funding partners
- Develop, in collaboration with other units of the MOHSW, activities for PBF implementation
- Develop operational manuals and required PBF implementation tools, and update as necessary
- Train implementers (CHTs and/or NGOs) on the operational manual and the different implementation tools
- Coordinate key players in the PBF scheme at central level: PBF Unit, PBF Technical Committee, Pool Fund Secretariat, M&E and HMIS Units, and donors
- Organize consultation meetings with the PBF technical team at least once a quarter or as needed
- Review quarterly performance reports from implementers (counties and NGOs), prepare summary observations and feedback to implementers, and hold implementers' feedback sessions
- Review requests for bonus payment by implementers, ensure they are consistent with performance agreements and the verification and counter-verification conducted by M&E and HMIS Units, concur on the request for payment, and forward request for payment to Pool Fund Secretariat
- Submit quarterly reports to the PBF Governance Committee for performance review.

IV.3.3. PBF Technical Committee

The PBF Technical Committee acts as an advisory committee to the PBF Unit. The aim of this unit is to ensure greater coordination among ongoing initiatives at the MOHSW and the PBF initiative. The PBF Technical Unit includes technical advisors of different programmatic areas (maternal and child health [MCH], tuberculosis [TB], Malaria, HIV/AIDS, and FP) and technical advisors from other ongoing initiatives (i.e. M&E, HMIS, and Management of Pharmaceutical Products).

The PBF Technical Committee's responsibilities include:

- Provide technical advice in their areas of expertise to the PBF Unit and PBF Governance Committee.
- Meet at least once a quarter (or as needed) to review performance of indicators with regards to their areas of expertise and make recommendations for adjustment of indicators based on identified needs
- Make other recommendations for consideration by the PBF Unit and PBF Governance Committee.

IV.3.4. External Aid Unit

The External Aid Unit reports to the Department of Administration. In the PBF scheme, the External Aid Unit prepares contractual agreements to be signed by interested parties and assists in resource mobilization. The contracts can be between: (i) MOHSW and counties (non-legal document), or (ii) MOHSW and local and/or international NGOs (legal documents).

The main responsibilities of the External Aid Unit include:

- Prepare request for proposals
- Prepare performance agreements and organize proposal reviews
- Negotiate and sign contractual agreements with implementers (CHTs and/or NGOs) on behalf of the MOHSW
- Monitor contractual agreements with assistance from the PBF Management Team

IV.3.5. Pool Fund Secretariat

In the PBF scheme, the Pool Fund Secretariat (budgeting and disbursement) work in collaboration with Department of Administration, while the Procurement Units report to the latter. The Pool Fund Secretariat is responsible for monitoring budgets and disbursements of each contract, and the OFM is responsible for payment.

Responsibilities of this unit include:

- Monitor budget, disbursements, and supporting documents
- Develop and disseminate standardized tools for financial reporting
- Make payments and archive supporting documents per standard operating procedures (SOPs) in place

IV.3.6. M&E and HMIS

The Monitoring and Evaluation and HMIS Units report to the Department of Planning, Research and Development, and are within the Division of Vital Statistics. The main mission

of this unit with regards to the PBF scheme is to conduct counter-verification in collaboration with the PBF Unit and the county M&E Officers. Ultimately, the M&E and HMIS Units aim to ensure the accuracy and quality of health data, including PBF indicators. The M&E and HMIS Units lead M&E activities pertinent to the PBF scheme, and will contribute to the evaluation of the PBF scheme.

Tasks include:

- Ensure timely availability of accurate, quality, and reliable HMIS data
- M&E for the implementation of the EPHS and PBF indicators, in collaboration with the PBF Unit
- Maintain M&E dashboard
- Supervise and train county M&E Officers
- Conduct county's quarterly counter-verification of administrative PBF indicators in collaboration with the PBF Unit
- In collaboration with the PBF Unit, conduct the counter-verification of PBF indicators at health facilities that are randomly selected
- Facilitate validation at community level, in collaboration with the PBF Unit, and prepare the terms of reference for an independent third party contracted to conduct this validation at the community level (as counties strengthen their capacity, this activity will be passed on to the PBF County Steering Committee).

V. Tools for Performance Based Financing Implementation

V.1. Tools for Management of Performance Based Financing

V.1.1. Development of Simple Business Plans for Performance Improvement

A PBF mechanism as a means for performance improvement is not business as usual. It requires the capacity to develop innovative ways for improvement. Based on the respective expected performance, the providers will develop local strategies for filling in the gaps in order to achieve results.

For example, the CHTs and the NGO will conduct the assessment of key administrative services such as supply chain management, data management, and consequently plan innovative strategies for reducing the bottlenecks. Whereas the health facilities will review the root causes for low utilization of the services, the problems linked to quality of services, and, consequently use the funds earned from the incentives/bonuses to improve performance in these areas.

Table 2 below illustrates an example of a simple business plan for a health facility. For each identified problem, the health facility will propose a strategy to resolve the issue and propose specific activities aimed at achieving that goal. An estimated budget for conducting these identified activities will also be developed. In order to strengthen management of health

facilities and clinics, the business plan will also include a simple table allowing them to keep track of revenues, expenses, and human resource needs. The business plan will then be submitted to the implementer for approval and performance based financing. It is noteworthy that most activities of the health center already have a budget allocated. Therefore, the exercise will allow the HF staff to identify shortcomings in funding for activities that would help them achieve the set targets. This is where they can determine how some of earned bonus will be spent.

The PBF implementer will review and approve the health facility’s business plan, after ensuring that the plan is evidence based and doesn’t contravene the best practices and public health rules. The performance business plan is implemented *only* after it has been approved.

Table 2: The Simple Performance Business Plan Format

Simple Performance Business Plan			
Period:	County:	District	Facility
Signature:			
Indicator 1: [# and] % of deliveries that are facility-based with a skilled birth attendant			
Target for the Quarter: 75 deliveries			
Identified Problems	Strategy	Interventions	Estimate Budget
Problem 1: Home delivery by traditional birth attendant (TBA) and the risks identified	Strategy 1: Incentive/bonus for TBA for supporting delivery in health facilities	Activity 1: Meeting with TBAs for agreement	
		Activity 2: Training on the referral mechanism	
		Activity 3:	
	Strategy 2:		
Problem 2:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	

V.1.2. The Performance Contracts/Agreements

There will be three levels of performance contracts/agreements for more accountability and each level will be allocated incentives based on specific performance indicators applicable to their specific levels. The implementers (CHTs and NGOs) will have their own indicators

(see Annex 1b) that differ from those of the service providers (health facilities; see Annex 1c). However, all of the contracted entities (CHTs/NGOs/health facilities) will operate as one team and the financial incentives/bonuses will be determined on the overall performance of the PBF implementer.

The bonus calculating tool will determine the bonus for an expected 100% performance. However, the actual bonus paid to the implementer will be based on the level of performance of the NGO's team, the CHT, and the facility team compared to the performance target. Each team will use the bonus for staff motivation or other interventions aimed at improving the performance of PBF indicators.

Guidance will be developed to allow the health facility to conduct a transparent process of bonus sharing among staff. For example, the share of bonus will be based on the salary index or grade, account for the level of responsibility, punctuality, and/or absenteeism. There is a need to also determine how the non-used bonus funds will be disposed. Though the estimated budget is based on a 100% performance target, it is unlikely that all of the implementers and health facilities will all achieve the 100% performance target benchmark (to be discussed later on).

Levels of Performance:

1. Level One: At this level, an Agreement for Performance and Management takes place between the fund holder (Pool Fund & FARA) and the PBF implementer (CHT or NGO). If the fund holder is contracting a county, the contractual agreement is a non-legal document, as one level of the MOHSW is entering into an agreement with another level of the MOHSW. However, the contractual agreement is a legal document when the fund holder contracts with an NGO. A sample of a contractual agreement is attached in Annex 3a.
2. Level Two: Having been awarded a performance contract by the central level, the implementer (CHT or NGO) may enter into a sub-performance agreement with another PBF implementer. For example, an NGO that has been awarded a contract by the central level *must* award to the CHT a subcontract for the provision of services and management. This is for the purpose of building capacity of the CHT, strengthening its HMIS, and management of medicines and other logistics. On the other hand, when a CHT is awarded a contract in level one, it may contract a local NGO for the same reasons, as well as for expanding county-wide coverage.
3. Level Three: At this level, the agreement for performance of services provision is entered into between the PBF implementer and the service providers or the facilities (health centers & clinics). Although the contribution and performance of key staff is critical for the attainment of set targets, the PBF implementer seeks to improve the performance of the entire team and not that of individuals. Therefore, there will not be

individual-based performance agreements. The health facilities will be responsible for the service delivery targets as a team.

V.1.3. Performance Reports

Monthly HMIS and verification report:

Each month, individual health facilities fill out an integrated report form which captures activities performed by the health facilities that month. Additionally, the health facilities submit a report of “declared data”, representing the services provided with regards to PBF performance indicators. This information is recorded monthly in the HMIS. The HMIS report is used for the verification of contracted indicators. Note: the PBF report is submitted on a quarterly basis.

Quarterly verification report:

The verification report is produced at the end of each quarter by the implementer (county or NGO). The respective county for the implementer(s) compiles and sends the quarterly report to the PBF Unit and to the Pool Fund Secretariat. The verification report retraces verification activities, identifies constrains and positive points, asks for follow-up on recommendations from previous reports, and provides current recommendations. In addition, the validated invoice (by the PBF County Steering Committee) for health facilities performance indicators (Annex 2a) and the invoice for implementers’ indicators (Annex 2b) will be sent with this report.

Quarterly counter-verification report:

The counter-verification will be conducted and reported at the end of each quarter jointly by the HMIS and M&E Units (prime responsible party) and the PBF Unit. The counter-verification report retraces counter-verification activities, identifies constrains and positive points, follows-up on recommendations from previous reports, and provides current recommendations. This report is shared with the Pool Fund Secretariat and FARA manager, and will also include the counter-verified invoices reflecting the amount to be paid out.

The counter-verification report is to incorporate findings from:

- the counter-verification of administrative indicators
- the counter-verification of data collected at randomly selected facilities
- Accreditation and quality assurance results

V.2. Tools for Accounting and Financial Management

The Pool Fund Secretariat, FARA, and the OFM collaborate and ensure harmonization of contractual agreements with implementers. It is noteworthy that this responsibility is beyond the sole responsibility of the PBF Unit; though the PBF Unit will provide feedback where appropriate in order to facilitate standardization of procedures.

Standardized tools for preparing accounting and budget reports, along with tools for requesting reimbursement, will be supplied to contracted implementers at the issuance of the contract. The contracting units will additionally ensure they have in place tools for good management of funds (well defined and documented administrative, accounting, and financial procedures; quarterly and annual budget plans; well defined and documented procurement procedures; well defined and documented systems to authorize payments, monitor the disbursement of funds, monitor account balances, and check and control mechanisms).

V.3. Information System

Each month, health facilities are required to fill out an integrated report form for activities conducted in the preceding month. This standardized form captures information designed to feed into the HMIS and covers all thematic areas. District Health Officers and/or NGOs (if an NGO is the implementer) are responsible for collecting the report forms in their catchment areas and submitting them to the CHT by the 5th of the following month. The county M&E team (M&E Officer-head, Data Manager, and County Register) is responsible for ensuring the forms are accounted for, for each health facility or clinic, and for recording the health information in the HMIS by the 15th of each month. The HMIS Unit takes an additional five days to conduct a data quality check and resolve queries before the data is made available to users.

V.4. Performance Indicators

Implementers (CHTs and NGOs) and contracted health facilities are responsible for the implementation of the EPHS. Specific indicators are selected from the EPHS and are included in the PBF indicators, thus the choice of selected indicators is guided by the NHPP and are in line with the national goal of achieving the health related Millennium Development Goals (MDGs). Indicators linked to high impact interventions, quality of care, and strengthening managerial skills of implementers will be prioritized in the choice of PBF indicators to be incentivized. A key characteristic of PBF indicators is that they have to be **SMART**, meaning: **S**pecific to the act being assessed, **M**easurable, **A**tttributable to the individual performing the activity, and **R**ealistic in the given **T**imeframe.

PBF indicators are assigned a relative weight ranging between 1.0 and 5.0, based on level of needed attention/urgency to improve the determined indicator and advance the country health objectives. As conditions in relation to a particular indicator improve or new priorities emerge, the weight assigned to a particular indicator may be re-assessed, as will the list of indicators to be incentivized in the PBF scheme. Therefore, the process is dynamic and regular adjustments are to be made as needed.

Quality indicators: The Quality Assurance Unit within the Department of Health Services has ongoing initiatives to promote the quality of health services. Accreditation of health institutions and clinical standards assessments are conducted on an annual basis. Indicators pertinent to these two activities are already included in the list of PBF indicators. However, there is a need to ensure quality is a focus year-round. Already the QA Unit conducts supervision activities on (i) a monthly basis, from counties to all health institutions, and (ii) on a quarterly basis, from the Central MOHSW to selected health institutions. The PBF Unit is consulting with the QA Unit in order to include PBF quality indicators that could be assessed on a quarterly basis and maintain the quality focus in an efficient way.

Ultimately, the aim is to provide quality health services to the population. Thus, an additional indicator, “perceived quality of services”, with a relative weight of 10.0, will be included on the list of indicators applicable for health facilities. This indicator will allow for validating the health institutions’ data and providing additional information on the “perceived quality of services” by the end users without violating the patient confidentiality. It will, therefore, provide useful feedback to the health institutions. Findings from the validation at community level will be factored into the final bonus earned by the health facility.

Finally, at the implementer level, a score for “counter-verification of health facilities” data will be added to the list of implementers’ indicators. This is intended to enhance the quality of verification activities conducted by the implementers at health facilities.

The table below illustrates the list of current MOHSW PBF indicators; it will be updated once the quarterly quality indicators are finalized.

MOHSW - PBF Service Delivery Indicators				
No.	Indicators	Numerator	Denominator	Source
1	[# and] % of deliveries that are facility-based by a skilled birth attendant	Total deliveries in facility by skilled personnel (physician, certified midwife, physician assistant, nurse)	Expected deliveries in catchment population	HMIS
2	[# and] % of pregnant women provided with 2nd dose of IPT for malaria	Total pregnant women provided with 2nd dose of IPT	Expected pregnancies in catchment population	HMIS
3	[# and] % of children under 1 year who received DPT3/pentavalent-3 vaccination	Total children under 1 year who received DPT3/pentavalent-3 vaccination	Population of children under one	HMIS

4	[# and] % of children under 5 receiving artemisinin-based combination treatment (ACT) for malaria, who tested positive for malaria (RDT, microscopy)	Total children under 5 receiving ACT	Total number of malaria cases in under 5 (clinical, RDT & microscopy)	HMIS
5	Couple-years of contraceptive protection (CYP) provided by supported facilities and community health volunteers (CHVs) (disaggregated by method)	CYP estimates the contraceptive protection provided by FP commodities distributed over a period (usually a year). It is calculated by multiplying the quantity of each method distributed to clients by a conversion factor. The individual CYPs are then summed up to obtain a total CYP figure. The CYP conversion factors are: 15 cycles of oral contraceptives per CYP; 120 condoms per CYP; 4 doses of injection per CYP; 3.5 CYP per IUD inserted; 3.5 CYP per implant; 10 CYP per permanent sterilization.	HMIS and distribution outlets	HMIS and distribution outlets
6	[# and] % of ante-natal care (ANC) clients who received HIV counseling and testing and received their test results: prevention of mother-to-child transmission (PMTCT)	Number of pregnant women attending ANC at a PMTCT site that are counseled, tested and received their results	Total number of pregnant women attending ANC at PMTCT site	HMIS
7	[# and] % of HIV positive pregnant women who are initiated on anti-retroviral (ARV) prophylaxis	Number of pregnant women who tested positive and initiated on ARV prophylaxis	Total number of pregnant women who tested positive for HIV	HMIS
8	[# and] % of gCHVs who received at least 1 supervision visit in last quarter	Number of gCHVs who received at least 1 supervision visit in last quarter	Total number of gCHVs	gCHV records Supervision reports
9	[# and] % of facilities whose Community Health Development Committees (CHDCs) held three meetings during the last quarter	Number of Community Health Development Committees that held at least three meetings in the last quarter	Number of facilities	IP Report (HMIS later)

10	[# and] % of timely, accurate and complete HMIS reports submitted to CHT during the quarter	Number of timely, accurate and complete HMIS reports submitted	Total HMIS reports submitted for the quarter	Central HMIS Reporting Checklist
11	[# and] % of timely, accurate and complete LMIS reports submitted to CHT during the quarter	Number of timely, accurate and complete LMIS reports submitted	Total LMIS reports submitted for the quarter	Central LMIS Reporting Checklist
12	Perceived quality of health services by clients	Combined score obtained on "validation of existence of client" and "perceived quality of service by client"	Maximum score corresponding to the total number of randomly selected clients	Computed by designated tool for validation at the community
MOHSW - PBF Administrative Indicators				
No.	Indicators	Numerator	Denominator	Source
13	[# and] % of facilities reaching two-star level in accreditation survey (once a year)	Number of facilities reaching two-star level in accreditation survey	Total number of facilities surveyed	Accreditation report
14	[# and] % of facilities achieving 70% average score on clinical standards assessment (once a year)	Number of facilities achieving 70% on clinical standards in accreditation survey	Total number of facilities assessed	QA Assessment Report
15	[# and] % of facilities with no stock-out of tracer drugs during the quarter (amoxicillin, cotrimoxazole, paracetamol, ORS, iron folate, ACT, FP [Depo, Implant]) [0 day of stock out]	Number of facilities with no stock-out of tracer drugs	Total facilities supervised	Supervision report
16	[# and] % of facilities that received at least 1 joint supportive supervision visit in last quarter	Number of facilities jointly supervised in the quarter	Total functional facilities	Supervision report
17	[# and] % of facilities that received at least 3 supportive clinical supervision visits in last quarter	Number of facilities supervised in the quarter	Total functional facilities	Supervision report

18	Timely and complete quarterly report to MOHSW (financial, narrative and performance reports)	CHT/NGO report reaching MOH on or before reporting deadline (30th of month following end of quarter)	Total number of CHT/NGO	PBC Team Reporting Checklist
19	Timely, accurate and complete LMIS reports submitted by CHT/county pharmacist to the SCMS during the quarter (once per month)	Number of timely, accurate and complete LMIS reports submitted	Total LMIS reports submitted for the quarter	Central LMIS Reporting Checklist
20	Score for counter-verified HF (random sample)	Number of indicators at randomly selected HFs counter-verified by Central MOHSW that were correctly verified and has all required data points (i.e., name, age, address, diagnosis, partograph filled out where applicable, ledger correctly filled out)	Number of PBF indicators verified by implementers at randomly selected HFs	Central LMIS Reporting Checklist

V.5. Bonus Computation

The performance incentives/bonuses disbursement, management, and reporting:

Ten percent of the budget allocated to the implementer will be withheld pending verification and validation of health facility indicators and counter-verification of the implementer's indicators. Tools were developed to assist in determining bonuses earned by implementers and by health facilities, and assist with bonus distribution among staff. Performance bonus payments will be disbursed quarterly. This will be done for each contracted facility in order to arrive at the total bonus budget. Thus, the final budget for bonuses will also depend on the available funds.

All implementers (counties and NGOs), health facilities, and clinics are responsible for the delivery of the EPHS (available at: www.moh.gov.lr/doc/Final%20EPHS.pdf). From the EPHS, a few key indicators are selected and contracted in the PBF scheme; additional quality and administrative indicators may be added to the PBF indicators. Targets for each selected indicator are set in conjunction with the PBF Unit and implementers at the county level, and in conjunction with implementing partners and health institutions at the health facility and clinic levels. Individual service delivery indicator(s) will be rewarded if they reach a threshold of 75% of the target; whereas the threshold for administrative indicators is set at 100% of the target.

It is estimated that the collection of data from health facilities and clinics, verification and validation of health facilities' and clinics' data, and submission of invoices to the Central

MOHSW will take up to 45 days. The earned bonus for health facilities will be honored in the 10 days following the submission of the validated invoice; this arrangement will allow paying the bonus earlier for the health workers in health facilities. The earned bonus by implementers will be honored only after completion of the counter-verification of the implementers' indicators. The counter-verification of implementers' indicators will be initiated within seven days after the implementers send the report to the PBF Unit. Findings from the data counter-verification processes for the ending quarter will be reflected in the bonus allocated to implementers.

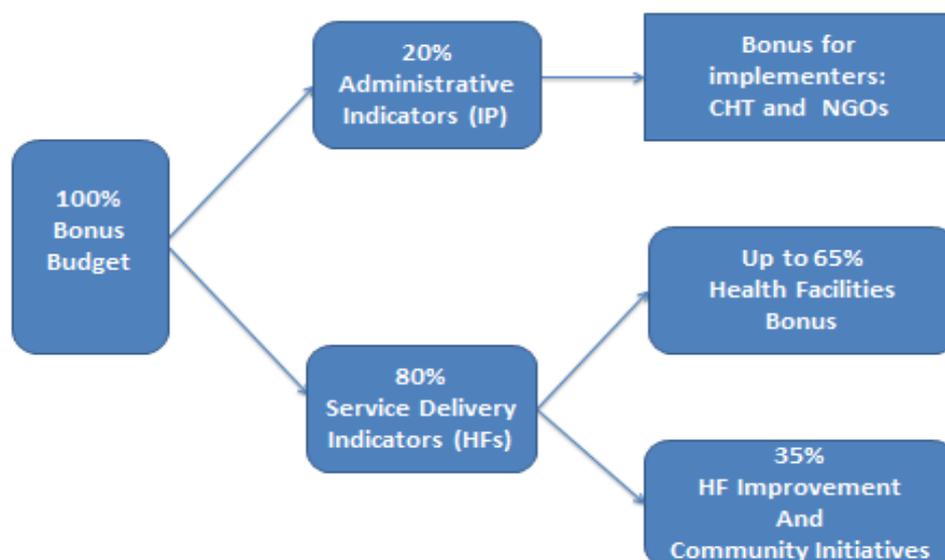
The bonuses to be earned at each level of health service delivery are linked to performance within their realm of control. For example, the implementers' performances are assessed on indicators pertinent to the supervisory role they assume toward health facilities. These indicators include administrative indicators, as well as overall performance of health facilities on qualitative and quantitative indicators (i.e. accreditation, quality assurance, and quantity of delivered services), while the health facilities' and clinics' indicators are tied to delivery of health services.

The amount of the performance bonuses will not be set using a simple consistent percentage across the entire county. Rather, the amount set aside for potential bonus to be earned by a particular county, or by an individual health facility/clinic within a given county, will account for the differences in size of counties and health facilities/clinics.

The total amount of performance bonuses will be calculated for each contracted entity and the bonuses will be used as planned in the performance business plan. The recommendation is to allow up to 65% of the earned bonus to be used for staff motivation, while accounting for certain criteria such as: base salary, responsibility, years of experience, absenteeism from work, etc. The remaining 35% of the earned bonus can then be used for innovative activities that are likely to improve the performance towards achieving a set goal. For example, the health facility may choose to use the 35% of earned bonus to stimulate gCHVs in order to improve certain health indicators, buy nicer curtains in the maternity wing/consultation room, or conduct outreach activities and training.

The graph below illustrates the bonus distribution between implementers and health facilities:

Bonus Allocation MOHSW PBF Scheme



As emphasized, PBF is not a business as usual model, and it works better when health facilities have room to implement solutions appropriate and tailored to local challenges. The health facility should have the flexibility to use their earned bonus as they deem fit in order to achieve the health facility/clinic targets, even though the performance bonuses are considered public resources. To assist in this task, a simple HF reporting tool will be conceived and kept simple as the PBF providers may not have high skills in the matter. The reporting tool provides simple formats to capture:

- The bonus allocation for individual staff /total bonus allocated to HF staffs
- The bonus allocated for community initiatives to assist the HF achieve set targets
- The amount allocated to cover recurring expenses to assist HF achieve set targets
- A summary report of bonus allocations

A full template of simple financial reporting tools for health is provided in Annex 5. The extract below shows an example of a summary financial bonus report by a HF/clinic.

Summary Report of the Bonus Allocation

Liberia Facility PBF - Summary Financial Bonus Report					
County:		District:		Facility:	Period:
Date	Bonus income amount	Bonus expenditure			
		Date	Item	Amount	

02/15/2012	\$1,000.0	02/18/2012	Staff bonus	\$650.0
		02/25/2012	Community activities	\$200.0
		03/14/2012	Recurring expenses	\$150.0
Total	\$1,000.0			\$1,000.0
				Signature:

Similarly, the implementer should have the flexibility to use their earned bonus as they deem fit in order to achieve the agreed upon targets, even though the performance bonuses are considered public resources. Thus, in order to achieve transparency, promote good management of the earned bonus, and favor sustainability of the PBF scheme, they will submit to the PBF Unit a report of bonus allocation.

VI. Financing of PBF Scheme

Implementers (CHT or NGO) and, subsequently, the health facilities will be allocated 90 percent of the obligated funds upfront, per contractual agreement, to allow for the delivery of the needed services to the population. The Pool Fund Secretariat and relevant disbursement units coordinate with one another to ensure timely disbursement of funds, responsible management of the funds allocated upfront, and the use of standard reporting tools currently used by the MOHSW. An example of a contractual agreement used by the Pool Fund is attached in Annex 3a. This template agreement may be revised as the MOHSW considers contracting in more counties.

Up to 10 percent of actual expenditures against the obligated contract amount is eligible as an annual performance bonus. This performance bonus will be awarded quarterly based on progress made towards the agreed upon targets.

The Pool Fund and Disbursement/Procurement Units are to coordinate with PBF, M&E and HMIS Units and ensure the implementer is producing a report satisfactory to all, without duplicating the effort.

VI.1. Process for Bonus Payment

VI.1.1. Bonus Payment for Health Facilities/Clinics

The implementers are responsible for ensuring the quality of the collected data and conducting the verification of services provided by the health care providers. The invoice for declared and verified data for PBF indicators will be completed on site upon completion of the verification. Both the OIC (and representative) and the verifier will sign the invoice. The

verified invoice will be submitted for validation to the PBF County Steering Committee. The verification and validation processes will be completed 45-50 days after the end of the quarter.

The validated invoice for health facilities/clinics, the invoice for achieved results for implementers and the quarterly report for the implementers are then sent to the PBF Unit with copy to the unit charged with disbursing the funds (Pool Fund Secretariat and Disbursement/Procurement Units). The PBF Unit, overseeing the implementation of PBF, will initiate payment of the bonuses for the health facilities/clinics.

The process of paying health facilities/clinics bonuses will be completed within 10 days of receiving the report and supporting documents. Ideally, the funds will be deposited directly into the bank account of the beneficiary health facilities/clinics. However, not all health facilities/clinics have bank accounts. Therefore, the funds will be sent to the implementer who, in turn, will ensure the bonus is forwarded to each health facility/clinic in a timely manner.

To recap, the payment of the bonuses to HFs will be initiated after submission of the validated invoices and will be proportionate to the achieved results with regards to the health facilities' PBF indicators. The payment of the bonus is to be completed within 10 days following receiving the invoice. Note: the payment of the bonus for implementers' indicators will be withheld, pending counter-verification by the Central MOHSW.

VI.1.2. Bonus Payment for Implementers

The M&E, HMIS, and PBF Units will initiate the counter-verification of implementers' indicators and the counter-verification of 20% health facilities/clinics randomly selected. The above units currently do not benefit from the incentive linked to PBF indicators; this minimizes potential conflict of interest. Validated invoices are signed jointly by the implementers and the counter-verifier on site, while the summary of counter-verified data from the few selected health facilities/clinics is signed by both the verifier and OIC (or representative).

Once the counter-verification process is completed, the PBF Unit (primary responsibility), in conjunction with the units that carried out the counter-verification, will send the validated invoice to the unit charged with disbursing the funds (Pool Fund Secretariat and Disbursement/Procurement Units); the bonus payment for implementers will then be carried out. This process will be completed 90 days after the end of the quarter.

VI.1.3. Bonus Payment Based on Score Given in Community Validation

Due to the limited capacity of the PBF County Steering Committee, the counter-validation of health facility data at the community level will be lead initially by the M&E (primary

responsibility), HMIS, and PBF Units by contracting with an independent third party (i.e. teaching institution, NGO or CSO). The results yielded from the validation at the community level reflect, in general, the level of community satisfaction with services provided by the health facilities/clinics and the accuracy of the data maintained by the health facilities/clinics. There will not be retroactive adjustments to bonuses allocated to the health facilities/clinics for the completed quarter; the score for this validation will be reflected in the bonus payment of the ensuing quarter.

Per PBF contractual agreement, only PBF indicators that meet agreed upon qualitative and quantitative targets are incentivized. The PBF Unit is responsible for compiling validated reports, producing an integrated report of the counter-verification, and ensuring that findings from the data counter-verification are reflected in the paid out bonuses.

VI.2. Time Frame for Payment of Bonuses

The table below summarizes the time line for bonus payments to health facilities and implementers in a sequential manner with activities listed in the order they must occur. The goal is to pay out the bonus as soon as possible so that performance and motivation of personnel is not diminished by unnecessary delays. For example, if the quarter ends on March 31st, the bonus payment to the health facility will be completed by May 25th and the payment of bonus to the implementer(s) will be completed by June 30th.

Calendar for Bonus Payment (Liberia)															
Activities	Duration (day)	Time Table in Weeks (End of Quarter)													
		1	2	3	4	5	6	7	8	9	10	11	12	13	14
End of quarter															
Data collection and record data in HMIS	20	x	x	x	x										
Verification and validation of HF PBF indicators	20					x	x	x	x						
Prepare and send report to central MOHSW	5									x					
Pay health facilities' invoices	10										x	x			
Validation/Counter-verification of implementers indicators and selected HF	15										x	x	x		
Counter-verification of HF results by independent 3rd party/CBO	15										x	x	x		
Submit validated data to MOHSW	1														x
Analysis of validated data and summary report by PBF team	3														x
Pay implementers' bonus	5														x

VI.3. Payment of Bonus to Health Facility/Clinic Staff

The health facility receives a payment corresponding to the achieved results, with regards to contracted PBF indicators. As described, up to 65 percent of the earned bonus is used for staff motivation while accounting for pre-set criteria, with regards to bonus sharing among health facility workers; the ceiling for an individual staff bonus will be the equivalent of one additional month of salary per quarter. The remaining 35 percent of the earned bonus is used for innovative activities aimed at improving the performance of the health facility/clinic. The health facility/clinic may elect to spend less on staff motivation and spend more on ensuring conditions that will enable them to meet their targets in the future and earn the full bonus in the future (at least in the first quarter[s]).

A template for bonus calculation is shown in the illustration below. The illustrated worksheet is extracted from the tool conceived to assist with management of the PBF scheme; only information highlighted in green needs to be inputted and the additional information is computed automatically. The template is set so that the health center will only need to input the score earned by individual health workers (in green on the template) and the bonus earned by the individual health worker will automatically be calculated.

Health Facility Staff PBC bonus calculation										
No	Name of staff	Staff category	Salary (month)	Salary grade points	Performance Appraisal points	Attendance points	Total points	Indices of the period	PBC bonus pay out	Signature of receipt
1	A	OIC	150	100	10	30	30,000	0.0037	\$111.7	
2	B	Nurse	120	80	10	30	24,000	0.0037	\$89.4	
3	C	Nurse	100	67	10	30	20,000	0.0037	\$74.5	
4	D	Nurse	100	67	10	30	20,000	0.0037	\$74.5	
5	E	Nurse	90	60	10	30	18,000	0.0037	\$67.0	
6	F	Support staff	70	47	10	30	14,000	0.0037	\$52.1	
7	G	Support staff	70	47	10	30	14,000	0.0037	\$52.1	
Total			700				140,000		\$621.4	
								Indices score for the period:	0.00	
PBC Bonus earned for the period:					521.37					

VII. Monitoring and Evaluation of PBF Implementation

The monitoring and evaluation of the PBF scheme aims at enabling the timely adjustment of the processes in order to successfully implement PBF. It will focus on implementation of the arrangements and utilization of the operational mechanisms and tools. The PBF implementers are required to document the processes of the implementation and publish the practices every three months. The PBF Unit will analyze the best practices and lessons learned, and will publish this report every six months.

Additionally, transparency in the use of allocated funds and a strong system to monitor and evaluate is essential in order to:

- Assess the management processes of performance indicators and monitor other indicators that may have unintended consequences
- Monitor output and impact indicators
- Monitor PBF implementation steps and timeline carefully
- Detect early, and resolve, any PBF implementation issues
- Showcase efficacy of the intervention: are the expected results being attained? What are the necessary adjustments that need to be made in order to achieve efficacy and efficiency?
- Objectively and transparently show to beneficiaries the invested efforts in preventive and curative care, and assess consumer satisfaction
- Monitor the resources (i.e. financial and human resources, time) and the expected results (products, services, etc.)

VII.1. Levels and Actors of the Monitoring and Evaluation System

The monitoring and evaluation system of PBF implementation is essentially conducted at three levels. Actors corresponding to each level assume a fundamental role in the successful implementation of the PBF scheme.

VII.1.1. First Level: Service Delivery - Recording and Verification of Data

This level represents where the health services are delivered. It plays a key role in service delivery, registering the beneficiaries, and collecting data that feeds into the county and national health information systems. Data from this level will be verified by the county and counter-verified by the central level MOHSW.

The health facility/clinic staff, led by the OIC, will review at least once a month the data and gauge how they are faring in comparison to the target they need to meet by the end of the quarter. They will also assess progress made on strategies/activities proposed in their

business plan. Health facilities/clinics will also review other non-PBF indicators to ensure they are not neglected. The information gathered may assist the health facility/clinic to request proper support from the CHT/DHO.

The health facility/clinic may implement practices to help them monitor progress on specific performance indicators - i.e. make simple chart(s) and post them in visible areas.

VII.1.2. Second Level: County Level - Registration, Archiving, and Communication

This level is represented by the county health system. Health information collected from health facilities/clinics will be assembled at the county level, entered into the HMIS, and used for management purposes. This level is also responsible for collecting data from health facilities/clinics and conducting the verification.

In the PBF scheme, the implementer (county health team and/or NGO) will approve the business plan presented by the health facility/clinic before it can be implemented. The implementer may use this leverage to ensure quality objectives are incorporated (i.e. compliance with the accreditation and quality assurance programs, quality and completeness of collected data). The implementer will monitor the health facility/clinic's performance and assess it against the approved business plan.

A performance dashboard will assist the implementer/CHT monitor and evaluate facilities in its catchment area. The implementer should review and discuss the quarterly verified data collected from health facilities/clinics, identify health facilities/clinics that might need additional support, and/or use the information to better tailor the regular supervisory visits. The gathered information may assist the implementer to request proper support from the CHT/Central MOHSW.

The implementers will participate in monthly coordination meetings organized by the PBF Unit, in coordination with the HMIS and M&E Units.

The CHT and implementers will ensure the quarterly report (narrative and financial) and corresponding invoices are submitted on time.

VII.1.3. Third Level: Counter-Verification, Strengthening HMIS, and Payment Approval

The third level is represented by different units of the Central MOHSW. The M&E and HMIS Units, along with the PBF Unit, play a key role at this level. They are responsible for the counter-verification of implementers' indicators. Any discrepancies found will be queried and adjustments made in the HMIS.

These units organize PBF technical committee meetings and ensure high participation of key stakeholders within the MOHSW on a quarterly basis. The PBF Unit is ultimately responsible for ensuring cohesion of the PBF scheme with other ongoing initiatives and/or

departments within the MOHSW. The PBF, M&E, and HMIS Units will ensure strategic information is used in order to improve PBF implementation.

At the end of the quarter, the PBF Unit is responsible for reviewing reports submitted by the implementers, providing individual feedback to implementers, and holding plenary sessions for all implementers. The PBF Unit will ensure lessons learned are shared with the implementers and concerned program areas.

This level is also responsible for assessing the impact of the PBF scheme, specifically by documenting the impact of PBF on the health outcomes and the efficiency and sustainability of the PBF scheme for policy makers. Preferably, the impact evaluation will be conducted by an independent institution, such as a research institution, to guaranty quality and integrity of the research outcome. The fund holders may enter into a contract with the research institutions through the appropriate tendering processes. Partnership between international and national research institutions will be encouraged for capacity building.

VII.2. Strengthening Capacity and Providing Support to PBF Actors

Continuing training sessions, with regards to PBF mechanisms, will be held for different actors within the health system. A special emphasis will be put on all levels of implementation in order to ensure ownership and sustainability of the PBF scheme. Equally, all aspects (technical, financial, management, etc.) of the PBF scheme will be assessed and strengthened.

The PBF Unit will also seek to improve the communication among the different levels of PBF actors. A mechanism of providing feedback on the performance of different actors will be implemented. The feedback provider will be careful in collecting inputs from all those involved, so that real concerns from implementers can be reflected and addressed in further adjustments of the PBF scheme.

In cases where a county does not have the capacity to implement PBF, an experienced NGO will be recruited to act as implementer. The NGO is to work closely with the county health team and contribute to building the capacity of the CHT. Preferably, a plan for building the capacity of the CHT should be elaborated and agreed upon upfront.

VIII. Conflict Resolution

Most conflicts result from the lack of information sharing, differences in values and experiences, and other external factors. Regardless of their origin, conflicts deserve to be analyzed in order to determine the involved parties (primary and secondary parties), the motives and stakes of the conflict, and to take appropriate measures and prevent the conflict from further escalating.

At the health facility level, conflict between the implementer and health facility will first attempt to be solved with an amicable resolution between them. If no amicable resolution can be reached between the implementer and the facility, the case will be brought to the PBF County Steering Committee, which shall have a final say. Conflicts at this level may arise from findings of the verification and subsequent sanctions.

The health facility may receive sanctions ranging from withholding of bonus for a particular indicator, to temporary suspension from participating in the PBF scheme, or to administrative sanctions for the health facility leadership for the following reasons:

- Falsifying data reported on the integrated report form in order to inflate revenue of the health facility
- Underperformance with regard to the agreed upon performance targets for the quarter
- Obstruction of the verification or counter-verification activities

At the individual worker level, in cases of serious wrongdoing, the health center management team may decide to suspend the eligibility for bonus for a maximum period of three months. However, this decision will need to be approved by the implementer. If parties are not satisfied, the PBF County Steering Committee will have a final say in the matter.

In addition to sanctions in the context of the PBF scheme, regular administrative sanctions, as provided by the law, may still apply.

At the implementer level, the PBF County Steering Committee will intervene in attempts to solve conflict amicably. If parties are not satisfied, the Committee will review the case. The contractual agreement at this level is a legal document, when an NGO is contracted. Thus, a case unresolved by the PBF County Steering Committee may be submitted to a legal court system for handling. The implementer may receive sanctions ranging from withholding of the bonus for particular indicator(s), to temporary suspension from participating in the PBF scheme, or to administrative sanctions as provided by the law. Sanctions for the implementers may result from:

- Falsifying data in order to inflate revenue
- Underperformance and/or recurring wrongdoing
- Obstruction of the verification or counter-verification activities
- Mismanagement of bonus funds allocated to facilities and/or staff at implementer level

IX. Annexes

Annex 1a – MOHSW PBF Indicators

MOHSW - PBF Service Delivery Indicators				
No.	Indicators	Numerator	Denominator	Source
1	[# and] % of deliveries that are facility-based by a skilled birth attendant	Total deliveries in facility by skilled personnel (physician, certified midwife [CM], physician assistant, nurse)	Expected deliveries in catchment population	HMIS
2	[# and] % of pregnant women provided with 2nd dose of IPT for malaria	Total pregnant women provided with 2nd dose of IPT	Expected pregnancies in catchment population	HMIS
3	[# and] % of children under 1 year who received DPT3/pentavalent-3 vaccination	Total children under 1 year who received DPT3/pentavalent-3 vaccination	Population of children under one	HMIS
4	[# and] % of children under 5 receiving artemisinin-based combination treatment (ACT) for malaria, who tested positive for malaria (RDT & microscopy)	Total children under 5 receiving ACT	Total number of malaria cases in under 5 children (clinical, RDT & microscopy)	HMIS

5	Couple-years of contraceptive protection provided by supported facilities and CHVs (disaggregated by method)	CYP estimates the contraceptive protection provided by FP commodities distributed over a period (usually a year). It is calculated by multiplying the quantity of each method distributed to clients by a conversion factor. The individual CYPs are then summed up to obtain a total CYP figure. The CYP conversion factors are: 15 cycles of oral contraceptives per CYP; 120 condoms per CYP; 4 doses of injection per CYP; 3.5 CYP per IUD inserted; 3.5 CYP per implant; 10 CYP per permanent sterilization.	HMIS and distribution outlets	HMIS and distribution outlets
6	[# and] % of ANC clients who received HIV counseling and testing and received their test results: PMTCT	Number of pregnant women attending ANC at PMTCT site counseled, tested and received their results	Total number of pregnant women attending ANC at PMTCT site	HMIS
7	[# and] % of HIV positive pregnant women who are initiated on ARV prophylaxis	Number of pregnant women tested positive and initiated on ARV prophylaxis	Total number of pregnant women tested positive for HIV test	HMIS
8	[# and] % of gCHVs who received at least 1 supervision visit in last quarter	Number of gCHVs who received at least 1 supervision visit in last quarter	Total number of gCHVs	gCHV records/Supervision reports
9	[# and] % of facilities whose CHDCs held three meetings during the last quarter	Number of Community Health Development Committee that held at least three meetings in the last quarter	Number of facilities	IP Reports / (HMIS later)

10	[# and] % of timely, accurate and complete HMIS reports submitted to CHT during the quarter	Number of timely, accurate and complete HMIS reports submitted	Total HMIS reports submitted for the quarter	Central HMIS Reporting Checklist
11	[# and] % of timely, accurate and complete LMIS reports submitted to CHT during the quarter	Number of timely, accurate, and complete LMIS reports submitted	Total LMIS reports submitted for the quarter	Central LMIS Reporting Checklist
12	Perceived quality of health services by clients	Combined score obtained on "validation of existence of client" and "perceived quality of service by client"	Maximum score corresponding to the total number of randomly selected clients	Computed by designated tool for validation at the community

MOHSW - PBF Administrative Indicators

No.	Indicators	Numerator	Denominator	Source
13	[# and] % of facilities reaching two-star level in accreditation survey (once a year)	Number of facilities reaching two-star level in accreditation survey	Total number of facilities surveyed	Accreditation report
14	[# and] % of facilities achieving 70% average score on clinical standards assessment (once a year)	Number of facilities achieving 70% on clinical standards in accreditation survey	Total number of facilities assessed	QA Assessment Report

15	[# and] % of facilities with no stock-out of tracer drugs during the quarter (amoxicillin, cotrimoxazole, paracetamol, ORS, iron folate, ACT, FP [Depo, Implant]) [0 day of stock out]	Number of facilities with no stock-out of tracer drugs	Total facilities supervised	Supervision report
16	[# and] % of facilities that received at least 1 joint supportive supervision visit in last quarter	Number of facilities jointly supervised in the quarter	Total functional facilities	Supervision report
17	[# and] % of facilities that received at least 3 supportive clinical supervision visits in last quarter	Number of facilities supervised in the quarter	Total functional facilities	Supervision report
18	Timely and complete quarterly report to the MOHSW (financial , narrative and performance reports)	CHT/NGO report reaching MOH on or before reporting deadline (30th of month following end of quarter)	Total number of CHT/NGO	PBC Team Reporting Checklist
19	Timely, accurate and complete LMIS reports submitted by CHT/county pharmacist to the CSMS during the quarter (once per month)	Number of timely, accurate and complete LMIS reports submitted	Total LMIS reports submitted for the quarter	Central LMIS Reporting Checklist

20	Score for counter-verified HF (random sample)	Number of indicators at randomly selected HFs counter-verified by Central MOHSW, that were correctly verified and has all required data points (i.e., name, age, address, diagnosis, partograph filled out where applicable, ledger correctly filled out)	Number of PBF indicators verified by implementers at randomly selected HFs	Central LMIS Reporting Checklist
----	---	--	--	----------------------------------

Annex 1b – Implementers’ Indicators and Assigned Weights

#	Indicators for Implementing Partners (CHT/NGO)	Weight
1	[# and] % of facilities reaching two-star level in accreditation survey (once per year)	4.0
2	[# and] % of facilities achieving 70% average score on clinical standards assessment (once per year)	4.0
3	[# and] % of facilities with no stock-out of tracer drugs during the quarter (amoxicillin, cotrimoxazole, paracetamol, ORS, iron folate, ACT) [0 days of stock out]	5.0
5	[# and] % of facilities that received at least one joint supportive supervision visit in the last quarter	5.0
6	[# and] % of facilities that received at least three supportive clinical supervision visits in last quarter	5.0
7	Timely and complete quarterly report submitted to MOHSW (Financial, Narrative, and Performance Reports)	5.0
8	Timely, accurate, and complete LMIS reports submitted by CHT/county pharmacist to the SCMS during the quarter (once per month)	4.0
9	Score for counter-verified HF (random sample)	5.0

Annex 1c –Indicators for Health Facilities/Clinics

#	Indicators for health facilities/Clinics	Weight	
1	[# and] % of deliveries that are facility-based with a skilled birth attendant	3.0	
2	[# and] % of pregnant women provided with 2 nd dose of IPT for malaria	3.0	
3	[# and] % of children under one year who received DPT3/pentavalent-3 vaccination	3.0	
4	[# and] % of children under five receiving artemisinin-based combination treatment (ACT) for malaria	2.0	
5	Couple-years of contraceptive protection provided by supported facilities and CHVs (disaggregated by method)	3.0	
6	[# and] % of ANC clients who received HIV counseling and testing and received their test results: PMTCT	2.0	
7	[# and] % of HIV positive pregnant women who are initiated on ARV prophylaxis	2.0	
8	[# and] % of gCHVs who received at least one supervision visit in last quarter	1.0	
9	Three CHDC meetings held during the quarter	3.0	
10	Timely, accurate, and complete HMIS reports submitted to CHT during the quarter (once per month)	3.0	
11	Timely, accurate, and complete LMIS reports submitted to CHT/county pharmacist during the quarter (once per month)	3.0	
12	Perceived quality of health services	10.0	Community validation

Annex 2a – Invoice for Achieved and Validated Data for Health Facility

SAMPLE Quarterly PBF Indicator Results and Payment Invoice											
Health facility:											XYZ HF
Year 2012 / Quarter:											
Date:											
No	Indicator	Weight	% Weight [A]	Target [B]	RESULTS				Cap	Allowed	% Overall
					Achieved [C]	% of Target Achieved [B ÷ C]	Achieved & Verified	% of Target Achieved & Verified			
1	[# and] % of deliveries that are facility-based with a skilled birth attendant	3									
2	[# and] % of pregnant women provided with 2nd dose of IPT for malaria	3									
3	[# and] % of children under 1 year who received DPT3/pentavalent-3 vaccination	3									
4	[# and] % of children under 5 receiving artemisinin-based combination treatment (ACT) for malaria	2									
5	Couple-years of contraceptive protection provided by supported facilities and CHVs (disaggregated by method)	3									
6	[# and] % of ANC clients who received HIV counseling and testing and received their test results: PMTCT	2									
7	[# and] % of HIV positive pregnant women who are initiated on ARV prophylaxis	2									
8	[# and] % of gCHVs who received at least 1 supervision visit in last quarter	1									
9	Three (3) CHDC meetings held during the quarter	3									
10	Timely, accurate and complete HIS reports submitted to the IP during the quarter (once per month)	1									
11	Timely, accurate and complete LMIS reports submitted to CHT/County pharmacist during the quarter (once per month)										
12	Perceived quality of Health Services	10									
		TOTAL	33	100%							
FP fees (\$)											
Estimated CYP in all HFs											
12% of estimated CYP in all HFs											
Bonus Payment		Potential Bonus / Quarter	Bonus earned / Quarter	Loss	Bonus for individual staff (65%)	Bonus - Performance improvement (35%)					
Results and Invoice Submitted by:						Results and Invoice Approved by:					
By: _____						By: _____					
Title: _____						Title: _____					
Signature: _____						Signature: _____					
Date: _____						Date: _____					

Annex 2b - Data Counter-Verification Sheet

Name of staffs involved in data counter-verification: _____ Date: _____ Time frame: _____ to _____

- 1.
- 2.
- 3.

Name of Facility: _____

Name of HF staff involved: _____

Part A: **Recount of data**

Indicator: Number of contraceptive commodities provided by facilities					
Data source : Ledger (FP ledger)	Data recount				Name of service providers involved
NB: check any related subsidiary ledger and stock book in the case of condom commodities					
Data elements::	Month 1	Month 2	Month 3	Total	
Male Condoms					
Female Condoms					
Pills					
Depo					
IUCDs					
Implants					
Name of data selected for cross check					

Source documents	Month1	Month2	Month3	Total	HF staff involved
Note specific problems on recording and reporting practices					
Discussion and action points					

Table 1: Data collection for counter-verification of reported performance data in facility levels

Number	Data element for counter-verification	Data source	Concerned facility staff to be involved	Process	Cross check data elements
	Total score in accreditation survey	Accreditation Survey Report		Get the total accreditation score from national accreditation survey reports	
	Total score in Quality Assessment	Quality Assessment Survey/supervision of quality of care	Concerned service provider based on technical quality being assessed	Calculate total quality of care score from Quality Assessment	
	No stock-out of tracer drugs during the quarter (amoxicillin, cotrimoxazole, paracetamol, ORS, iron folate)	Stock and Dispensary Ledgers	Facility Dispenser	Review stock entries and levels for each of the tracer drugs in both stock book and dispensary ledgers. Stock is defined as the zero balance in both stock and dispensary ledgers. Look for tricks: sometimes dispensers/screeners stop dispensing a particular drug when it reaches a low level to avoid recording stock-out of zero. S/he could also start providing an alternative drug in place of protocol drugs. This kind of practice is considered a stock-out.	Check consultation register if prescription follows protocols Patient chart

Table 1: Data collection for counter-verification of reported performance data in facility levels

Number	Data element for counter-verification	Data source	Concerned facility staff to be involved	Process	Cross check data elements
	Stock-out of ACT drugs	Stock and Dispensary Ledgers	Facility Dispenser	Review stock entries and levels for ACT drugs in both stock book and dispensary ledgers. Method explained in “No stock-out” indicator (above)	Check prescription of other malaria drugs and find out reasons. Count number of under-five malaria cases
	Stock out of RDT	Stock and Dispensary Ledgers	Facility Dispenser	Review stock entries and levels for RDT in both stock book and dispensary ledgers. Method explained in “No stock-out” indicator (above)	Number of RDT tests done
	Number/proportion of all out-patient department (OPD) patients for whom no more than three drugs are prescribed (based on random sample of 20 patients from OPD register)	OPD Register (both under and over five)	Facility Screener	Take a random sample of 20 patients using systematic random sampling method. For each selected patient registry, check the treatment column and see number of drugs prescribed. Count each record where not more than three drugs were prescribed. Report the following figures: - Number of total patients - Number of sample patients who got no more than three drugs	Exit interviews and checking of prescription for multiple prescription and/or under prescription - check patients cards
	IP submitting timely and complete quarterly report to MOHSW	IP Report	IP focal person	IP should submit all required reports.	

Table 1: Data collection for counter-verification of reported performance data in facility levels

Number	Data element for counter-verification	Data source	Concerned facility staff to be involved	Process	Cross check data elements
	Number of CHDC meetings in last quarter	Facility meeting ledger	OIC	Look for the meeting minutes in the meeting ledgers and count the ones with meeting minutes	Ask OIC about the meetings
	Number of gCHVs who received at least one supervision visit in last quarter	Completed supervision checklist from NGO	NGO M&E Officer	Have NGO submit copy of supervision checklists. Review the supervision checklist and count if it meets requirements	Ask about who from facility conducts supervision of gCHVs
	Number of children under one year who received DPT3/pentavalent-3 vaccination	EPI Ledger	Vaccinator	Check age of child and date when DPT3/Penta-3 is given in the EPI register. If the child is under one year of age when DPT3/Penta-3 is received, count it. If child is more than 12 months when he/she received DPT3/Penta-3, it should not be counted.	Check tally sheet: Number of children receiving DPT1/Penta 1. Number of vaccine vials used
	Number of deliveries that are facility-based and assisted by a skilled birth attendant	Delivery ledger	Certified Midwife (CM)	Check for the name of person who delivered in the delivery register. Count if it is delivered by CM, registered nurse, or trained person. Delivery done by trained traditional midwife (TTM) should not be counted	Partographs, AMTSL
	Number of pregnant women provided with 2 nd dose of IPT for malaria	ANC ledger	CM	Check in the ANC ledger the women receiving IPT 2 nd dose. Check the age of gestation.	Number of women who received IPT 1 st dose, number of SP drugs

Table 1: Data collection for counter-verification of reported performance data in facility levels

Number	Data element for counter-verification	Data source	Concerned facility staff to be involved	Process	Cross check data elements
					expensed by CM.
	Number of children under five with malaria treated with Artemisinin-based Combination Treatments (ACTs)	Under five OPD ledger	Screeener	Check in the under-five consultation register for all malaria diagnosis and corresponding treatment column to see if ACT was prescribed. Count all malaria cases treated with ACT drug	Drug consumption, drug stock-out situations. Check consultation registers for prescription of other malaria drugs, stock-out of ACT
	Number of people who received HIV counseling and testing (HCT) and received their test results (PMTCT)	HCT ledger	CM	Count all tests done for all including voluntary counseling and testing (VCT), provider-initiated testing (PIT), and PMTCT.	Number of test kits consumed, number of pregnant women tested for HIV, number of antenatal care visits (first contacts)
	Number of HIV positive women on ARV prophylaxis	PMTCT ledger	CM	Count new pregnant woman starting on ARV prophylaxis	Availability of drugs, number of pregnant women HIV tested
	Number of contraceptive commodities provided by facilities and CHVs	Family planning ledger	CM	Check from family planning ledgers the number of family planning commodities by methods	
	Male condoms	Family planning ledger and consultation ledger	CM, Screeener	Count condoms distributed in family planning registers and in consultation registers for sexually transmitted	Stock books, stock-out incidences

Table 1: Data collection for counter-verification of reported performance data in facility levels

Number	Data element for counter-verification	Data source	Concerned facility staff to be involved	Process	Cross check data elements
				infections (STIs)	
	Female condoms	Family planning ledger and consultation ledger	CM, Screener	Count condoms distributed in family planning registers and in consultation registers for STIs	Stock books, stock-out incidences
	Pills	Family planning ledger	CM	Count number of pill cycles (all types) distributed	Stock books, stock-out incidences
	Depo	Family planning ledger	CM	Count number of women receiving Depo	Stock books, stock-out incidences
	Intrauterine Contraceptive Devices (IUCDs)	Family planning ledger	CM	Count number of women receiving IUCD	Stock books, stock-out incidences
	Implants	Family planning ledger	CM	Count number of women receiving implants	Stock books, stock-out incidences
	Male sterilization	Family planning ledger	Doctor	Count number of men having sterilizations	Stock books, stock-out incidences
	Female sterilization	Family planning ledger	Doctor	Count number of women having sterilizations	Stock books, stock-out incidences
	Number of joint supportive supervision visits received in last quarter	Facility visitors logbook	OIC	Check the facility visitors' logbook and check the names of supervisors; purpose is to identify if there were joint supportive supervisions. Get copy of completed supervision forms	Ask OIC about the supervision

Table 1: Data collection for counter-verification of reported performance data in facility levels

Number	Data element for counter-verification	Data source	Concerned facility staff to be involved	Process	Cross check data elements
				from IP to verify	
	Timely, accurate, and complete HIS reports submitted to the CHT during the quarter	CHT HMIS	CHT Data Officer/M&E Officer	Visit CHT Data/M&E Officer and check the date each report was received, check for completeness of reports. Count all that meets the criteria	Ask or find out when facility sent report, see completeness
	Number of staff funded by IPs paid on time during the quarter	IP records of staff payment	IP focal person	Ask IP staff to provide a copy of pay given to each facility staff. See the date it is paid/received by the payee. Count if it is before 5 th of the month	Ask facility staff during validation when they received the payments

Annex 2c – Invoice for Achieved and Validated Data for Implementer

SAMPLE Quarterly PBF Indicator Results and Payment Invoice										
Health facility:				XYZ HF						
Year 2012 / Quarter:										
Date										
No	Indicator	Weight	% Weight [A]	Target [B]	RESULTS				Cap Allowed	% Overall
					Achieved [C]	Target Achieved [B x C]	Achieved & Declared	% of Target Achieved & Verified		
1	[# and] % of facilities reaching two-star level in accreditation survey (once a year)	4.0								
2	[# and] % of facilities achieving 70% average score on clinical standards assessment (once	4.0								
3	[# and] % of facilities with no stock-out of tracer drugs during the quarter (amoxicillin, cotrimoxazole, paracetamol, ORS, iron folate, ACT) [0 day of stockout]	5.0								
5	[# and] % of facilities that received at least 1 joint supportive supervision visit in the last	5.0								
6	[# and] % of facilities that received at least 3 supportive clinical supervision visits in last	5.0								
7	Timely and complete quarterly report to MOHSW (Financial, Narrative, and Performance	5.0								
8	Timely, accurate and complete LMIS reports submitted by CHT/County pharmacist to the CSMS during the quarter (once per month)	4.0								
9	Score for counter-verified HF (random sample)	5.0								
TOTAL		37	100%							
Bonus Payment		Potential Bonus / Quarter	Bonus earned / Quarter	Loss	Bonus for individual staff (65%)	Bonus - Performance improvement (35%)				
					-	-				
Results and Invoice Submitted by:					Results and Invoice Approved by:					
By:					By:					
Title:					Title:					
Signature:					Signature:					
Date:					Date:					

Annex 3a – Sample Performance Agreement between MOHSW and Implementer

The below sample was borrowed from the MOHSW with no alteration, as this is a legal document, except blocking out implementer and financial information.

OVERVIEW

Contract Issued By: Ministry of Health & Social Welfare, Republic of Liberia
Coordinating Contact: Email:
Telephone:

Implementer: **XXX County Decentralization Team**
Headquarter Address:
Coordinating Contact:
Email:
Telephone:

Period of Contract:

Type of Contract:

Total Maximum Cost:

Total Obligated Amount:

Budget Summary

Category	Approved Budget (... months)
Personnel Expenditure Salaries and Benefits	
Goods & Services Travel and Transportation	
Training/Workshops	
Other Direct Costs	
Capital Expenditure Equipment, Furniture and Supplies	
Equipment over \$10,000	
Overhead/Indirect Costs	
Total	

TABLE OF CONTENTS

OVERVIEW.....	Error! Bookmark not defined.
GENERAL.....	70
THE ARTICLES.....	70
ARTICLE 1: LEGAL BASIS	70
ARTICLE 2: PROVIDER WARRANTIES	71
ARTICLE 3: SERVICES TO BE PROVIDED UNDER THE CONTRACT	71
ARTICLE 4: MONITORING AND EVALUATION	71
ARTICLE 5: LOCATION AND DURATION.....	72
ARTICLE 6: PAYMENT	72
ARTICLE 7: REPORTING REQUIREMENTS	74
ARTICLE 8: PROJECT ADMINISTRATION	74
ARTICLE 9: OBLIGATIONS OF THE PARTIES.....	75
ARTICLE 10: CONFLICT AND DISPUTE RESOLUTION.....	76
ARTICLE 11: INDEMNIFICATION	76
ARTICLE 12: TERMINATION CAUSES OF THE CONTRACT	76
ARTICLE 13: ENTIRE AGREEMENT	78
ARTICLE 14: ACCEPTANCE	78
ARTICLE 15: AMENDMENT.....	78
ARTICLE 16: NOTICES	78
ARTICLE 17: SEVERANCES	79
ANNEX I: PROGRAM DESCRIPTION.....	Error! Bookmark not defined.
ANNEX III: LIST OF HEALTH FACILITIES TO BE SUPPORTED.....	Error! Bookmark not defined.
ANNEX IV: DETAILED BUDGET	Error! Bookmark not defined.
ANNEX V: REPORTING TEMPLATES.....	Error! Bookmark not defined.
ANNEX VI: VISIBILITY	Error! Bookmark not defined.

GENERAL

This agreement (hereinafter referred to as the “Contract”) dated this **July 1, 2011** is made by and between the Ministry of Health and Social Welfare of the Government of Liberia (hereinafter referred to as the “Ministry”) and the implementing **County Health Team (hereinafter referred to as the “Implementer”)**. The Ministry and the Implementer will be referred to jointly in this Contract as “the parties”.

WHEREAS, the Ministry desires to extend the coverage of and increase access to the Basic Package of Health Services (hereinafter referred to as the “BPHS”) to the people of Liberia; and

WHEREAS, the Ministry desires to utilize public-private partnerships to contract with non-governmental organizations (NGOs), faith-based organizations (FBOs) and community based organizations (CBOs) to support provision of the BPHS in certain areas of the country; and

WHEREAS, the Provider has an interest in pursuing the well-being of the people of Liberia by supporting their right to basic primary health care services;

WHEREAS, the Provider has proposed that it is willing and able, with such financial assistance, to support the health facilities in the designated areas to ensure that the BPHS is available to the people served by those facilities;

WHEREAS, the Provider is willing to enter into a partnership with the Ministry in pursuit of the foregoing objectives;

NOW THEREFORE, in consideration of their mutual interests, promises, warranties and covenants set forth herein, the parties hereto, intending to be legally bound, hereby agree as follows:

THE PARTIES CONVENE OF THE FOLLOWING:

ARTICLE 1: LEGAL BASIS

The Ministry is charged under Amended Chapter 30 of the Executive Law of 1972 with administering government activities pertaining to the protection and improvement of public health and social welfare, including provision of medical care and treatment through public hospitals, health centers and clinics.¹

In fulfilling this charge to provide care and treatment, the Ministry may engage in partnerships with public, non-profit or government entities through grants or contracts for the cost of providing services, provided the entity makes sufficient assurances that the nature and quality of the services and management provided will conform to the Ministry’s requirements.²

¹ Act to Amend Chapter 30 of the Executive Law of 1972, Duties of the Minister of Health and Social Welfare, Sub-section (b).

² Act to Amend Chapter 30 of the Executive Law, 30,18(3)(a)(ii); 30.18(6).

In making grants and contracts for the provision of services, the Ministry shall prioritize projects based on relative need, giving special attention to areas with few financial resources, rural communities, facilities providing comprehensive services, and facilities that will provide training of health professionals.³

In compliance with the laws of Liberia, the Implementer shall maintain valid registration with the Ministry of Planning and Economic Affairs and will remain in good standing with the Ministry of Finance with respect to payment of applicable taxes. **No tax exemptions are provided for under this Contract.**

ARTICLE 2: IMPLEMENTER WARRANTIES

Under its organizational charter, the Implementer warrants that it is authorized to perform the duties and responsibilities that it is undertaking under this Contract and that it has the staff, equipment, knowledge, and experience to undertake the activities required of it in this partnership. The Implementer further warrants that it is familiar with and has experience in operating in furtherance of the National Health Policy and the National Health Plan adopted by the Ministry and is experienced in the provision of the BPHS to people in the area to be served under this contract.

ARTICLE 3: SERVICES TO BE PROVIDED UNDER THE CONTRACT

The services to be provided by the Provider under this contract are set forth in “*A Basic Package of Health and Social Welfare Services For Liberia*” (BPHS) that can be found on the internet at www.liberiamohsw.org. An abridged summary of the BPHS is attached hereto in ANNEX I: Program Description, along with the Implementer’s Technical Proposal and subsequent clarifications required by the Ministry.

ARTICLE 4: MONITORING AND EVALUATION

Accomplishment of the services to be provided shall be assessed by the indicators and targets agreed upon by both parties, as set forth in ANNEX II. These targets may be revised as additional data become available.

The achievement of targets will be jointly assessed using the following methodologies:

Reports: Review of project reports submitted by the Implementer.

Routine Health Management Information Systems (HMIS): Examination of the HMIS data will be done jointly by the Ministry and the Implementer.

Data Verification and Validation to be conducted by an independent entity

Monitoring visits: Scheduled and unannounced visits will be conducted to guide, support, and supervise implementation. The Implementer will provide unimpeded access to any of the supported facilities and documents for such purposes.

³ Act to Amend Chapter 30 of the Executive Law, 30.18(9)(a)(i-iv).

Surveys: Lot Quality Assurance Sampling and Health Facility Accreditation.

The Ministry will be responsible for end of project evaluation.

ARTICLE 5: LOCATION AND DURATION

The services named in ARTICLE 3 will be delivered to the entire catchment population of the health facilities listed in ANNEX III: List of Health Facilities to be supported. The services will be provided for the period starting on July 1, 2011 and ending on December 31, 2011. The Provider will be entitled to reimbursement only for expenditures against the advance provided for items and services provided on or after the beginning date of the project through the ending date of the project. This clause does not prevent the Implementer from using project funds up to 30 days after the ending date to liquidate obligations it has for items and services provided during the project period.

ARTICLE 6: FINANCIAL MANAGEMENT AND PAYMENT FOR PERFORMANCE BASED CONTRACT (PBC)

6.1. The Ministry shall pay the Provider a total amount not to exceed US\$ for its work in carrying out the Contract.

The County Health Team (CHT) agrees to submit a six month PBC work plan and budget to the MOHSW prior to signing of this contract which will be included in this contract as Appendix **. This plan must specify the strategies, activities to be implemented for the purpose of fulfilling its obligations as referred to in the scope of work in article above. This plan will indicate the resources (human, material and financial) that are necessary for carrying out the PBC work plan and reaching the objectives and targets set forth. The CHT/NGO plan will also incorporate the consolidated PBC work plans from all of its health service providers, and regional and primary hospitals including the PBC administrative costs. The CHT/NGO work plan, approved by the MOHSW, is an integral part of this contract.

6.2 PBC

The MOHSW will review and validate the CHT's performance on the numbers of negotiated administrative and service delivery indicators.) quarterly, and determine the total amount of incentive to be paid based upon the PBC results attained. This will be communicated to CHTs and their performance incentive will be transferred directly into their accounts.

Health facilities that are supported by the CHTs will also receive performance incentives for their contributions to achieving the targets of the PBC contract.

Penalties will be levied for administrative indicators not met. On the other hand, in case of falsification of data, sanctions of varying degrees will be levied. Details of sanctions and penalties can be found in the draft PBC Manual.

Article 6.3 Detailed Budgets

The Ministry shall pay the amount set forth in Article 6.1 in accordance with the Detailed Budget set forth in ANNEX IV. Payments in accordance with ANNEX IV require the timely completion and submission to the Ministry by the Provider of all reports required by the Ministry, including those set forth in ANNEX V, as described in ARTICLE 7. Of the total budget, an amount of 5% will be withheld subject to validation of administrative results.

Article 6.3 Pro Forma Invoice

Following the signing of this Contract, the Provider shall submit to the Ministry a pro forma invoice for the first four months of expenditure in the format included in ANNEX IV. This pro forma invoice shall be consistent with the budget line amounts prescribed in the Detailed Budget. Upon approval of the pro forma invoice, the Ministry shall release the first disbursement to the provider.

After two months of implementation, the Provider shall “liquidate,” or submit a photocopy of all receipts, expenditure documentation including the financial report provided in Annex V, and a subsequent pro forma invoice requesting additional funds. The net effect of this will be to allow a two-month buffer of funds on hand to remain with the Implementer. The duration of subsequent pro forma invoices shall be quarterly unless otherwise indicated by the Ministry.

Article 6.4 Performance Component

Up to five percent (5%) of actual expenditure against the obligated Contract amount is eligible as an annual performance bonus. This performance bonus will be awarded quarterly based on progress made towards the agreed targets (see ANNEX II: Performance Indicators.). Conversely, up to five percent (5%) of actual expenditure against the obligated Contract amount will be withheld for under performance on the agreed targets. Therefore, the effect of the performance component will be to set the range of the contract value from 95 to 105% of the obligated amount, depending upon the level of performance. Use of the performance bonus shall be proposed by the Implementer and must be approved by the Ministry. Examples of use of the bonus are explained in the draft operational manual.

Article 6.5 Financial Management

The Provider shall keep accurate and systematic records and accounts for services rendered in the implementation of this agreement that will clearly identify all charges and expenses paid. The Provider will maintain a separate set of accounts for the funds received under this Contract and will deposit these funds in a separate, dual signatory bank account. Both signatories shall be officers of the Provider organization. All interest earned shall be accounted for and in the quarterly financial reports indicated in ARTICLE 7.

Article 6.6 Audit

The Provider shall 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 this audit shall be considered eligible expenditure and shall be reimbursable under this contract.

The Ministry reserves the right (without obligation) to audit or to nominate a reputable firm of public accountants to audit the Provider's records relating to amounts claimed under this Contract during the term of this agreement and any extension thereof and for a period of one (1) year thereafter.

ARTICLE 7: REPORTING REQUIREMENTS (current)

Article 7.1 The Implementer shall submit to the Ministry all certifications, reports, notices or other documents required under this Contract, including its ANNEXES, and such other certifications, reports, notices or other documents as the Ministry may from time to time request.

Article 7.2 Specifically, the Implementer will provide narrative reports related to activities undertaken in fulfillment of this Contract to the County Health Team and to the Central Ministry. Such reports will be furnished according to the formats set forth in ANNEX V: Reporting Templates.

Article 7.3 Four (4) hard copies of all quarterly reports shall be properly bound and submitted to the central Ministry along with an electronic copy. One additional hard copy shall be provided to the County Health Team.

Article 7.4 in hard and electronic version, the financial report shall also be submitted to the central Ministry along with a pro forma invoice for further funds.

Article 7.5 The reporting period shall be quarterly (every three months) and cover the quarterly periods of the Government's fiscal year (July through June). Financial and narrative reports shall be submitted within 30 calendar days of the end of the reporting period. Any delay will attract a penalty according to the agreed administrative indicators.

Article 7.6 The Ministry shall validate data and reports submitted (including supporting financial documentation). These clarifications must be resolved before bonus and withheld 5% administrative budget can be paid. Program support costs will not be withheld. d. The ministry shall endeavor to disburse additional funds within one month of receipt of the quarterly report and pro forma invoice; however, this will be dependent upon the timeliness of clarifications made by the Provider.

ARTICLE 8: PROJECT ADMINISTRATION

Article 8.1 Coordinating Contacts.

The parties to this Contract shall each nominate a single person (the "coordinating contact") as the principal contact between the Ministry on the one hand, and the Implementer on the other. Each party may replace or dismiss their respective coordinating contact. The existence of the coordinating contacts shall not prevent communications or interaction between the staffs of the two parties as to matters for which they are responsible.

Article 8.2 Independent Organization.

It is acknowledged that the Ministry is retaining the Implementer in the capacity of independent organization. Therefore, organizational staff of the Implementer shall not be considered employees, agents, or representatives of the Ministry for any purpose.

Article 8.3 Procurement and Accounting Procedures.

Procurement and accounting procedures under this Contract shall be those of the Implementer. These policies and procedures shall be maintained in hard copy form in the Monrovia and project site offices of the Provider.

All drugs and medical supplies necessary to implement the BPHS shall be obtained in accordance with the Ministry of Health's Essential Drug List.

Article 8.4 Fixed Assets.

The Provider shall maintain a fixed asset list of items with a purchase value of over \$1,000 that are purchased with funds provided under this contract. The fixed asset list shall be submitted as an annex with the quarterly report. All fixed assets acquired under this Contract shall be transferred to the Ministry upon completion of the project.

ARTICLE 9: OBLIGATIONS OF THE PARTIES

Article 9.1: Authority and Responsibilities of the Ministry

On its part, the Ministry has the following authority to:

Ensure that the conditions of the Contract are met by the Implementer;

Terminate the Contract if the Provider fails to meet the conditions of the Contract;

Take other actions short of termination as described in ARTICLE 12 to ensure that the services covered by this Contract are being properly implemented;

In addition to the terms of this Contract, the Ministry has the following responsibility to:

Pay the Implementer on time and to pay all health workers;

Assign health workers necessary to staff the health facilities according to BPHS staffing levels, as staffs and funds are available;

Quickly address, discuss and resolve any issues that the Implementer might have that the latter feels interfere with its performance under this Contract.

Article 9.2: Authority and Responsibilities of the Provider:

On its part, the Implementer has authority over the recruitment, hiring, remuneration, and customary managerial decision-making over its own organizational employees. Those staff shall have no claims against the Ministry, the Government of Liberia or county government.

The Implementer has the responsibility for and will:

Provide support for provision of health care delivery services as determined in the Basic Package of Health Services. These services will be provided through application of Ministry policies, clinical norms, standards and treatment protocols. In the absence of such norms and protocols, WHO standards will apply. In addition the Provider will:

Provide on a timely basis to the County Health Team and to the Ministry all reports stipulated under the Health Management Information System (HMIS);

Install and maintain any signage or visibility requirements, in a format prescribed by the Ministry, for the purpose of identifying the ‘owner’ of the facility and source of funding for its support (see Annex VI, Visibility Policy);

In the event that that Government is unable to pay health workers and upon written notification from Government, provide performance incentives for health workers in health facilities receiving assistance from the Provider under this Contract in a manner consistent with the BPHS incentive guidelines. Budget under-spends in this area shall not be reprogrammed without the written consent of the Ministry.

The Provider may request county health officials to transfer health workers that it feels are not working properly or who are actively interfering with the Provider’s work under the Contract;

Notify the Ministry within ten (10) working days of any change of legal status of the Provider that could affect its relationship to the Ministry or the services provided under this contract, especially as it relates to a change in legal representation (including bank signatories) or headquarters relocation. This information must be sent to the County Health Team and the Ministry with a certified copy of its new legal representation.

ARTICLE 10: CONFLICT AND DISPUTE RESOLUTION

The Parties shall use their best efforts to settle amicably all disputes arising out of or in connection with this Contract or its interpretation. The Provider may bring to the attention of the Ministry any serious complaint that it feels interferes with accomplishment of the objectives and services described in this Contract. Any dispute between the Parties as to matters arising pursuant to this Contract that cannot be settled amicably within thirty (30) days after receipt by one Party of the other Party’s request for such amicable settlement will be submitted to a mutually agreed arbitrator in Liberia. If the Parties are unable to resolve the dispute amicably or through arbitration, the laws of the Republic of Liberia will prevail in the resolution of the dispute.

ARTICLE 11: INDEMNIFICATION

The Provider agrees to indemnify, defend, and hold harmless the Ministry, and its respective officers and employees, from and against any and all loss, damage, injury, death, expense, proceeding, demand, cost, claim, or liability incurred (including, without limitation, claims by third parties or claims by Provider’s employees), arising out of the acts, errors, omissions, breach of contract, or negligence of the Provider or its agents, subcontractors and employees. The Provider explicitly and expressly waives any right to immunity under applicable insurance laws with respect to any action against the Ministry, and agrees to assume liability for actions brought by its employees against the Ministry as provided above. This provision shall expressly survive termination of this Contract.

ARTICLE 12: TERMINATION CAUSES OF THE CONTRACT

Article 12.1 Termination

This Contract may be terminated for any of the following causes: a) Expiration of the agreed term; b) Failure to comply with obligations of this Contract; and c) Unforeseen incidents and force majeure. Whenever possible a written notice should be sent to the other party, at least thirty (30) days in advance of such termination, so that the parties may not be harmed. The notice of termination of the Contract shall not affect the progress and conclusion of activities in progress. Expenditure shall be eligible until through the notification period, up to and including the date of termination.

Article 12.2 Sanctions

The Ministry may, at its sole discretion: (i) insist on a meeting with the senior management of the Implementer based internationally or in Liberia regarding any failures to meet the conditions of the Contract; (ii) write directly to the Board of Directors of the Implementer and expect a specific written reply to concerns that they have; (iii) ask for the replacement of field level managers of the Implementer for sub-par performance, although it is understood that this will not be requested in a frivolous manner; and, (iv) bar the Implementer from receiving further contracts from the ministry.

Article 12.3 Termination of the Contract by the Ministry:

The Ministry may terminate this Contract, by not less than thirty (30) days written notice of termination to the Implementer after the occurrence of any of the events specified below, but in keeping with the above regarding the settlement of disputes:

If the Implementer does not remedy a failure in the performance of its obligations under the Contract within thirty (30) days after being notified or within any further period as the Ministry may have subsequently approved in writing;

If the Implementer becomes insolvent or bankrupt;

If, as the result of Force Majeure, the Implementer is unable to perform a material portion of the BPHS for a period of not less than sixty (60) days; or

If the Implementer, in the judgment of the Ministry, has engaged in corrupt or fraudulent practices in competing for or in executing the Contract. "Corrupt practice" means the offering, giving, receiving, or soliciting of anything of value to influence the action of a public official in the selection process or in contract execution. "Fraudulent practice" means a misrepresentation of facts in order to influence a selection process or the execution of the Contract. In the event of such conduct, the thirty (30) day notice requirement may be waived in order to prevent theft, misuse, wastage, or other loss of funds or other property of the Government.

Article 12.4 Termination of the Contract by the Implementer:

The Provider may terminate this Contract, by not less than thirty (30) days written notice to the Ministry after the occurrence of any of the events specified below, but in keeping with ARTICLE 10 above regarding the settlement of disputes:

If the Ministry fails to pay any monies due to the Implementer pursuant to this Contract and not subject to dispute within thirty (30) days after receiving written notice from the Implementer that such payment is overdue; or

If, as the result of Force Majeure, the Implementer is unable to perform a material portion of the BPHS for a period of not less than sixty (60) days.

Article 12.5 Prejudice

The termination of this Contract howsoever arising shall be without prejudice to the rights and obligations of any party accrued prior to termination.

ARTICLE 13: ENTIRE AGREEMENT

Article 13.1: This Contract contains the entire and only agreement between the parties and supersedes all previous agreements between the parties respecting the subject matter of this Contract.

Article 13.2: Each party acknowledges and agrees that in entering into this Agreement it has not relied on, and shall have no remedy in respect of, any statement, representation, undertaking or warranty, whether oral or in writing, save as are expressly set out in this Contract.

Article 13.3: Each party acknowledges and agrees that the only remedy available to it for breach of this Contract shall be breach of contract under the terms of this Contract.

Article 13.4: Nothing in this clause shall limit or exclude liability for fraud.

ARTICLE 14: ACCEPTANCE

By their respective signatures below, the parties to this Contract indicate their understanding and acceptance of the terms herein. This Contract shall be governed and construed in accordance with the laws of the Republic of Liberia. Neither party may transfer or assign any of its rights or obligations under this Contract without the express written consent of the other party.

ARTICLE 15: AMENDMENT

Amendments and modifications of this Contract shall be made in writing and signed by the parties hereto or their respective authorized agents. The terms of this agreement shall extend to and be binding of the parties and their successors in office during the life of the Contract.

ARTICLE 16: NOTICES

Article 16.1: Any notice required to be given under this Contract shall be in writing and signed by the person giving it and may be delivered personally or sent by facsimile transmission or other electronic means or by first class post to the address set out above in respect of each of the Parties or to such other address as may otherwise be notified by either party to the other as being an alternative address.

Any notice so served shall be deemed to be received:

if delivered personally, at the time of delivery;
if sent by facsimile transmission or other electronic means, on the day of transmission provided it is sent during business hours on a business day and if not on the next business day; and

For purposes of this section, business hours means between 9:00 a.m. and 5:30 p.m. on days (other than Saturday or public holiday) on which the Ministry is open for general business.

ARTICLE 17: SEVERANCES

Article 17.1: If any provision of this Contract shall be found by any court or administrative body of competent jurisdiction to be invalid or unenforceable, such invalidity or unenforceability shall not affect the other provisions of this Contract which shall remain in full force and effect.

Article 17.2: If any provision of this agreement is so found to be invalid or unenforceable but would be valid or enforceable if some part of the provision were deleted, the provision in question shall apply with such modification(s) as may be necessary to make it valid and enforceable.

Article 17.3: The Parties agree, in the circumstances referred to in Article 17.1, to attempt to substitute for any invalid or unenforceable provision a valid and enforceable provision that achieves to the greatest extent possible the same effective as would have been achieved by the invalid or unenforceable provision.

Signed and dated by:

Name:
Title:

Signed and dated by:

Name:
Title: Deputy Minister/Health Services/CMO/RL

Attested to by:

Signed and dated:
Name:
Title:

Annex 3b - Performance Agreement between Implementer and Health Facility

PERFORMANCE BASED FINANCING AGREEMENT BETWEEN IMPLEMENTER AND HEALTH FACILITY

BETWEEN:

The implementer

Dr. /Mrs. /Mr.....

And

..... Health facility (HF), represented by

Mrs. / Mr.Officer in Charge of the Health Center

The following is agreed upon:

Preliminary:

In regards to successes attributed to performance based financing (PBF) towards achieving the health related Millennium Development Goals in developing countries, and Liberia's own experience in improving health indicators in similar projects, the MOHSW decided to implement PBF mechanisms in health facilities.

PBF mechanisms contribute to strengthening autonomous management of health facilities. Indeed, the bonus received for good performance by the health center increases the resources of the HF and is directly managed by the HF. Additionally, this strategy contributes to the MOHSW and its partners' initiatives to improve accessibility to quality health services and equitable utilization of available resources.

1. Objective of the Performance Agreement

The current performance agreement aims to effectively implement PBF in health center; and establish functional, managerial, and practical arrangements between the health center and the implementer. The pursued aim is to:

- Contribute to strengthening autonomous management of health facilities
- Render health services more accessible to the population in health center's catchment area
- Improve the quality of health services and involve beneficiaries in appreciation of quality of care
- Increase consciousness of responsibility at hand by promoting an effective participation of the personnel in defining and delivering results, and by ensuring their hard work is acknowledged (allocation of bonus based on performance).
- Increase health center resources for needed items in the health center.

2. Duration of the Performance Agreement

The duration of this performance agreement is months, corresponding to the quarter of the year of implementation. This performance agreement is valid from (date) for a period of months. It runs from to 20.....

This performance agreement may be revoked by the implementer after consultation with the PBF County Steering Committee unilaterally at any time in case of fraud or continued underperformance.

3. Performance Indicators for Health Facility and Weight Attributed

The table below shows the list of contracted PBF indicators and their assigned weight for the quarter. The assigned weight will impact the bonus paid for a particular indicator.

Note: The actual amount of potential bonus to be earned by the health facility is valid for the quarter they are signed in and are subject to possible readjustment by the PBF Unit. Previous bonus levels are not a guarantee for future bonuses.

#	Indicators for health facilities	Weight	
1	[# and] % of deliveries that are facility-based with a skilled birth attendant	3.0	
2	[# and] % of pregnant women provided with 2 nd dose of IPT for malaria	3.0	
3	[# and] % of children under one year who received DPT3/pentavalent-3 vaccination	3.0	
4	[# and] % of children under five receiving artemisinin-based combination treatment (ACT) for malaria	2.0	
5	Couple-years of contraceptive protection provided by supported facilities and CHVs (disaggregated by method)	3.0	
6	[# and] % of ANC clients who received HIV counseling and testing and received their test results: PMTCT	2.0	
7	[# and] % of HIV positive pregnant women who are initiated on ARV prophylaxis	2.0	
8	[# and] % of gCHVs who received at least one supervision visit in last quarter	1.0	
9	Three (3) CHDC meetings held during the quarter	3.0	
10	Timely, accurate, and complete HIS reports submitted to the IP during the quarter (once per month)	3.0	
11	Perceived quality of health services	10.0	Community validation
		35	

4. Obligations of the Parties

4.1. The health center commits to:

- Create favorable conditions for the implementation of the PBF mechanisms in management of HF activities
- Sensitize HF personnel and community partners in catchment area on importance of PBF and their respective role for successful implementation
- Involve team members at the HF in the elaboration of action plans, and defining the criteria for bonus distribution among health facility staff
- Develop and/or use tools for patient referral
- Prepare, in collaboration with the implementer, a quarterly business plan for the implementation of PBF indicators; guidelines were prepared to assist with creating this plan
- Submit the business plan to the PBF County Steering Committee for approval
- Submit monthly reports of curative and preventive services using the standardized forms developed for that use
- Facilitate supervisory mission by CHT and implementer
- Implement recommendations made by the supervisory team, in order to improve quality of services
- Facilitate verification of achieved results
- Conduct qualitative and quantitative supervision of CHVs in catchment area

4.2. The implementer commits to:

- Reinforce the capacity of the HF and communities for the comprehension and execution of the contractual approach
- In collaboration with the CHT, ensure timely procurement of drugs and supplies procured by the health facility
- Negotiate targets to be achieved by the individual health facility
- Assist HF in training on tools for the monitoring and evaluation of the contractual approach
- Validate and approve business plan submitted by HF
- Conduct monthly verification of quantitative results and send reports back to HF in timely fashion
- Facilitate counter-verification activities by the Central MOHSW
- Submit invoice to Central MOHSW for payment of bonuses corresponding to verified results

5. Business Plan

Within three months of signature of the present contract, the HF shall submit a business plan for the following months of activities (see format in the PBF manual). The business plan will outline the strategies considered in order to increase the quantity and the quality of its services. The business plan shall then be reviewed and approved by the implementer, representing the PBF County Steering Committee, and form an integral part of the present contract. The absence of a business plan or the non-compliance with its strategies may lead to the termination of the present contractual agreement after consultation with the PBF County Steering Committee.

6. Modalities for Payment of Bonuses

The quarterly validated final PBF invoice will be submitted to the MOHSW PBF Unit for payment on a quarterly basis. The bonus shall be paid to the health facility no later than 60 days after the quarter in which they were earned. Due to situational contexts, not all health facilities have an individual bank

account. Thus, the bonus earned by the health facility will be sent through implementer's or CHT's account.

The OIC shall ensure procedures are set and agreed upon by HF personnel, with regards to allocating the bonus.

7. Conflict Resolution

In cases of conflict, both parties will meet to find an amicable resolution; if necessary, they will seek assistance from a third person agreed upon by both parties. The PBF County Steering Committee and PBF Unit at the MOHSW are respectively the 1st and 2nd cadres for evaluation of progress and resolution of encountered issues in implementation of PBF activities and will serve as well as a cadre for conflict resolution.

8. Particular Conditions

The present convention is established to serve as an agreement for collaboration and partnership between the health center and implementer.

Done at On/...../201...

For The Implementer

Mrs. / Mr. _____

Signed _____

And

Officer in Charge - Head of the Health Facility

Mrs. / Mr. /Dr _____

Signed _____

Annex 4 - Simple Business Plan for Health Facilities (HF) - MOHSW Liberia

The purpose of the simple business plan is to assist HFs plan and implement activities in the context of PBF scheme; the OIC will lead the elaboration of the business plan, in collaboration with other staff members. For each PBF indicator, the HF staff will:

- Review the indicator and ensure they understand what is expected from them
- Review the target they need to meet for the quarter and how it compares to current HF facility production. Afterwards, the health center needs to decide if additional strategies are needed in order for them to meet the set target.
- Discuss identified problem(s) pertinent to each indicator
- For each identified problem, discuss strategies to solve it
- For each strategy, identify the activities that will be conducted
- Estimate the budget for the activity and fill in the information in the dedicated column

Note:

The field provided for each indicator does not need to be fully filled out; however, the health center is encouraged to conduct a thorough analysis in relation to achieving targets.

Most of the activities identified will likely be funded by the regular budget allocated to the health facility. This exercise will allow the HF to identify areas where the bonus earned could potentially be used to improve production of HF results.

Simple Performance Business Plan – Health Facilities			
Period:	County:	District	Facility
Signature:			
Indicator 1: [# and] % of deliveries that are facility-based with a skilled birth attendant			
Target for the Quarter:			
Identified Problems	Strategy	Interventions	Estimate Budget
Problem 1:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	
Problem 2:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	

Indicator 2: [# and] % of deliveries that are facility-based with a skilled birth attendant

Target for the Quarter:

Identified Problems	Strategy	Interventions	Estimate Budget
Problem 1:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	
Problem 2:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	

Indicator 3: [# and] % of children under 1 year who received DPT3/pentavalent-3 vaccination

Target for the Quarter:

Identified Problems	Strategy	Interventions	Estimate Budget
Problem 1:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	
Problem 2:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	

Indicator 4: [# and] % of children under 5 receiving artemisinin-based combination treatment (ACT) for malaria

Target for the Quarter:

Identified Problems	Strategy	Interventions	Estimate Budget
Problem 1:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	
Problem 2:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	

Indicator 5: Couple-years of contraceptive protection provided by supported facilities and CHVs (disaggregated by method)

Target for the Quarter:

Identified Problems	Strategy	Interventions	Estimate Budget
Problem 1:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	
Problem 2:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	

Indicator 6: [# and] % of ANC clients who received HIV counseling and testing and received their test results: PMTCT

Target for the Quarter:

Identified Problems	Strategy	Interventions	Estimate Budget
Problem 1:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	
Problem 2:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	

Indicator 7:[# and] % of HIV positive pregnant women who are initiated on ARV prophylaxis

Target for the Quarter:

Identified Problems	Strategy	Interventions	Estimate Budget
Problem 1:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	
Problem 2:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	

Indicator 8: [# and] % of gCHVs who received at least 1 supervision visit in last quarter

Target for the Quarter:

Identified Problems	Strategy	Interventions	Estimate Budget
Problem 1:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	
Problem 2:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	

Indicator 9: Three (3) CHDC meetings held during the quarter

Target for the Quarter:

Identified Problems	Strategy	Interventions	Estimate Budget
Problem 1:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	
Problem 2:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	

Indicator 10: Timely, accurate, and complete HIS reports submitted to the IP during the quarter (once per month)

Target for the Quarter:

Identified Problems	Strategy	Interventions	Estimate Budget
Problem 1:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	
Problem 2:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	

Indicator 11: Perceived quality of health services (community validation)

Target for the Quarter:

Identified Problems	Strategy	Interventions	Estimate Budget
Problem 1:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	
Problem 2:	Strategy 1:	Activity 1:	
		Activity 2:	
		Activity 3:	
	Strategy 2:	Activity 1:	
		Activity 2:	
		Activity 3:	
Total Budget			

Revenues	Past monthly revenues	Proposed monthly revenues new quarter
Salaries from government & other sources		
PBF subsidies from fund holder		
Contribution from other sources (specify)		
EPI		
Malaria / TB		
HIV		
FP		
Other		
Cash		
Statement of account		
TOTAL		

Expenses	Past monthly expenses	Proposed monthly expenses new quarter
Salaries/incentives		
Performance bonuses		
Subsidies for sub-contracts		
Cleaning and office costs		
Transport costs		
Social marketing		
Infrastructure rehabilitation		
Equipment and furniture		
Other		
Put into reserve		
TOTAL		

Staff categories	Current number of staff	Staff required next quarter
Staff 1		
Staff 2		
Staff 3		
Administrative staff		
Unskilled medical staff		
Cleaners, drivers, etc.		
Gardeners, security		
TOTAL		

For The Health Facility:

<p>By:.....</p> <p>Title:.....</p> <p>Signature:.....</p> <p>Date:.....</p>

For the Implementer, representing the PBF County Steering Committee

<p>By:.....</p> <p>Title:.....</p> <p>Signature:.....</p> <p>Date:.....</p>

Annex 5 – Reporting Tool for Health Facility (use of earned bonus)

1. Report of Bonus Allocation for Health Facility Staff

County:		District:		Facility:	
Liberia PBF staff bonus payment					
No	Names	Bonus amount	Date	Signature	
Total					

2. Report of Bonus Allocation for Community Initiatives (i.e. motivate trained birth attendants [TBA]/CHWs)

County:		District:		Facility:	
Liberia PBF - TBA/CHWs initiatives/bonus payment					
No	Activity	Bonus amount	Date	Signature	
Total					

3. Report of Bonus Allocation for Recurrent Expenses

County:		District:	Facility:
Liberia PBF - recurrent incentive/bonus report			
Date	Item	Unit cost	Total cost
Grand Total			
			Signature:

4. Summary Report of the Bonus Allocation

Liberia facility PBF - summary financial bonus report					
County:		District:	Facility:	Period:	
Date	Bonus income amount	Bonus expenditure			
		Date	Item	Amount	
Total					
					Signature:

Annex 6a – Summary Verification of Beneficiary’s Existence and Satisfaction

Counter- verification form								
10	Name of Health Center:							
11	Health center catchment area:							
12	Year 2012	/	Quarter:					
13	Date							
Summary verification of beneficiary’s existence and their satisfaction								
No	Name of Beneficiary	Gender	Age	Address	Result: Existence of beneficiary			Score de satisfaction
					YES	NO	Comment (Absent, moved, deceased, non-existent, other)	
18	1							
19	2							
20	3							
21	4							
22	5							
23	6							
24	7							
25	8							
26	9							
27	10							
Total Score								
Results of Clients satisfaction submitted by:								
Name :								
Title:								
Signature:								
Date:								

Annex 6b – Individual Questionnaire for Beneficiary’s Satisfaction

Questionnaire Beneficiaries' Satisfaction								
10	Name of Health Center:							
11	Health center catchment area:							
12	Year 2012	/	Quarter:					
13	Date:							
14	Name of Beneficiary:							
Category	Responses (Scores)				Score achieved	Comments		
	0	5	10					
18	1. What was your perceived reception by health care provider (attitude, hospitality)?		Bad	Medium	ok			
19	2. Was the health center / clinic clean (hallway, rooms, bathroom...)?		Dirty	Medium	ok			
20	3. How long did you wait at the health center / clinic?		Too long	Medium	short			
21	4. What is the overall perception of the service (consultation, hospitalization, laboratory...)?		Mediocre	Medium	ok			
22	5. Were the prescribed medications available at the health center / clinic?		None	Partial	Fully available			
23	6. Were you charged any fee at the health facility? If so, how much? For what service?		Expensive	Medium	Affordable			
24	7. Were you seen / examined by the health care provider in privacy (Confidentiality)?		None	Partial	Perfect			
25	8. Availability of health services every single day (did you see the health care provider on your first visit)?		None	Partial	Perfect			
Total score obtained								
Results of Clients satisfaction submitted by:								
Name :								
Title:								
Signature:								
Date:								