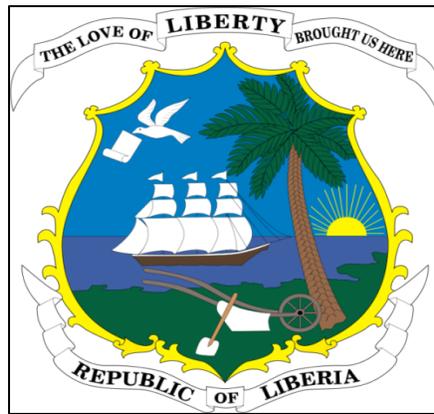


LIBERIA

CONTRACTING IN GUIDELINES

BACKGROUND AND CONTEXT



Republic of Liberia
Ministry of Health and Social Welfare

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ACKNOWLEDGEMENTS

“Contracting In – Background and Context to Performance Contracts between the MOHSW and CHSWT” provides the basis under which the Ministry of Health and Social Welfare (MOHSW) enters into performance contracts with the County Health and Social Welfare Teams (CHSWTs). Due to its length, it has been separated from the ***“Guidelines for Contracting- In: Summary of Systems, Procedures, and Core Competencies for the CHSWT”*** which is designed to help counties prepare for effectively implementing performance based contracts with the central Ministry. It provides thorough referencing of key events and documents that have culminated in this approach to decentralization of health services. A participatory method was used to develop these guidelines. The approaches used to develop this document and the guidelines included: 1) Review of key documentation including policies, plans, guidelines, protocols, and reports generated by the Ministry of Health and Social Welfare (MOHSW) as well as international documents. 2) Findings from the February 2012 assessment of the Bomi CHWT’s decentralization Performance-Based Contracting Pilot. 3) Information gathered during the National Health Sector Review meeting of 2012. 4) Consultative meetings held in Liberia in October 2012 with the MOHSW senior management, CHSWT teams, county Superintendents, Non-Governmental Organizations (NGOs), and international partners.

On behalf of the senior management of the MOHSW, I would like to extend our heartfelt thanks and appreciation to all institutions and individuals that made the development of these guidelines possible. This document and the ***“Guidelines”*** are outstanding examples of the interdepartmental collaboration which is essential to the successful decentralization of health service delivery.

In particular I would like to express my gratitude to the United States Agency for International Development (USAID) for providing the funding and technical assistance through RBHS for the development of this summary and the guidelines for the counties.

We look forward to continued collaboration with all of our partners and pledge our support to the counties to lead and manage the effective delivery of quality health services to all Liberians.



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ACRONYMS

BPHS	Basic Package of Health Services
CHSWT	County Health and Social Welfare Team
EPHS	Essential Package of Health Services
GC	Governance Commission
GoL	Government of Liberia
IP	Implementing Partner
M&E	Monitoring and Evaluation
MIA	Ministry of Internal Affairs
MOHSW	Ministry of Health and Social Welfare
MOPEA	Ministry of Planning and Economic Affairs
NGO	Non-Governmental Organization
NHSWPP	National Health and Social Welfare Policy and Plan
NFP	Not For Profit providers
PBC	Performance-based Contracting
PBF	Performance-based Financing
RBF	Results-based Financing
RBHS	Rebuilding Basic Health System project
USAID	United States Agency for International Development

PURPOSE

The purpose of the ***Contracting In - Background and Context to Performance Contracts between the MOHSW and CHSWT*** is to provide the MOHSW and the CHSWTs with a document that highlights efforts by the MOHSW to reform and strengthen the health sector through application of performance contracts and decentralization of the health and social welfare section. The document serves as the backdrop to performance contracting in between the MOHSW and the CHSWT under a de-concentrated health system. In parallel to this document, the ***Contracting In Guidelines – Summary of Systems, Procedures, and Core Competencies for the CHSWT*** as well as the ***Contracting In Guidelines – Additional Reference Documentation for the CHSWT*** have been developed to guide the CHSWT as to how the MOHSW expects the counties to be operating under performance contracts. These guidelines are intended to serve as a functional tool to provide orientation on procedures and processes leading to an effective decentralization of the health care delivery system employing the health system¹ approach of Performance-Based Financing with a specific focus on “Contracting In”.

In line with the overall guidance tools on decentralization and management of the health system and the PBF operational manual, the CHSWT is to have basic systems, processes, and procedures in place in the areas of Leadership and Governance, Financial Management and Procurement, Human Resource Management, Service Delivery, Monitoring and Evaluation (M&E) and Use of Health Management Information System (HMIS), and Supply Chain Management of Essential Medicines and Supplies. What follows in the Contracting In Guidelines is therefore an overview of the main functions, or competencies, which must be operational for effective contracting “in” of key public health functions through a PBF Scheme (a performance contract)². Once these functions are fully operational, the CHSWT will deliver effective health services, increase the quality of care, and harmonize data through transparent public health management practices.

PERFORMANCE-BASED FINANCING

Performance-Based Financing (PBF) is one of the cardinal financing schemes utilized under a Results-Based Financing Approach to health systems strengthening. The overall concept of PBF or Results-Based Financing (RBF) is payment (monetary and/or non-monetary) issued based upon achievement of a predetermined performance target or result. Performance payments may target supply-side (e.g., clinic, health center, health worker) and/or demand-side (e.g., patients, pregnant women, children under one year of age) recipients. Throughout both the industrial and developing world, a number of PBF schemes or mechanisms can be found. Examples of PBF include, but are not limited to, Performance-Based Contracting (PBC), Pay for Performance (P4P), Results-based Financing (RBF), Performance-based Incentives, Output-based Aid (OBA), Fee-for-service (FFS), Vouchers, Conditional Cash Payments, and Conditional Cash Transfer (CCT) Programs.

¹ Health System includes the institutions, human resources, financing, commodities, information, management and governance strategies, systems, and processes.

² Note: These guidelines do not cover the essential capacities that the MOHSW will need in order to be an informed and responsive purchaser / contractor of health services from the CHSWTs.

PBF is an output-based strategic purchasing concept that improves health worker productivity and morale and catalyzes actions of many individuals and service providers to find solutions from the bottom up. It also improves governance and accountability in the health and social welfare sector and promotes positive changes in how information is generated and used for decision-making. PBF in Liberia currently employs a supply side scheme utilizing performance contracts (targeting health care providers). Some pilot demand side schemes (targeting beneficiaries of services) are being tested in the Social Welfare sector.

The MOHSW PBF Operations Manual states that, “Performance-Based Financing is an implementing strategy of the National Health Policy and Plan (NHPP). The overarching goal of the NHSWPP is to improve the health and social welfare status of the population of Liberia on an equitable basis.¹”

SUPPLY-SIDE PBF

Inherent in any PBF scheme is the creation of incentives (or motivation) based upon results. In PBF there are two types of motivation – intrinsic and extrinsic. Intrinsic motivation is based upon the premise that health workers seek to “do good” as part of their moral duty as professionals, on the other hand, extrinsic motivation stems from monetary or otherwise tangible incentives provided to the health worker as a reward for good performance.

For the most part, PBF focuses on the latter, extrinsic motivation, focusing on the service provider’s behavior to achieve results. In Liberia, the MOHSW is employing incentives in the form of bonuses that may be provided to individuals, facilities or sub-national levels (CHSWTs). Currently there are plans to complement the supply-side focus of PBF with a scale-up of demand side incentives through employing Community-Based PBF schemes.

THE PBF UNIT

The PBF Unit, within the MOHSW, is charged with oversight of the PBF strategy in Liberia, in coordination and partnership with the Office of Financial Management (OFM), the Monitoring and Evaluation (M&E) Department, the External Aid Coordination Unit, County Health Services among others in the Ministry. Its main mission is to provide technical oversight for the development of PBF schemes at the national level, build the capacity of county-level institutions and structures, guide the decentralized implementation of PBF principles, concepts and tools, and propose strategies and activities for PBF implementation. The Unit falls under the supervision of the MOHSW Deputy Minister/Chief Medical Officer for Health Services.

PERFORMANCE BASED-CONTRACTING

A performance contract between different actors is a mechanism to “operationalize” PBF. Performance-based Contracting (PBC) is a supply-side output-based PBF tool, intended to improve health facility and worker performance. It differs from “input financing” in that payment of contract Implementing Partners (IP) (e.g., contractors or NGOs) is based upon progress against results delivered.

Performance contracts entered into under the Contracting Out mechanisms differ from those entered into under the Contracting-In". "Contracting Out" is when the MOHSW enters into a legal contractual arrangement with an independent private entity such as a Non-Governmental Organization. The contracted entity is given complete authority over all resources (human, material and financial) to provide health services; this process involves the Ministries of Justice, Finance, and Health and Social Welfare. On the other hand, a "Contracting In" scheme is one whereby the government, for example, the MOHSW, enters into contractual agreement with sub-entities of government. An example of contracting-in is when a central Ministry of Health contracts directly with a lower level entity of the health systems such as a county, province, district, municipality, or other for the provision of services based on the concepts and principles of PBF.

Whether contracting out or contracting in, all PBF contracts contain clear objectives, performance indicators and targets, mechanisms to collect and validate data, time frames, and a budget. Regardless of the mechanism or contractual arrangement, in Liberia all service delivery contracts must contain the same performance indicators to measure progress. In Liberia, there are currently 20 performance indicators (service delivery and administrative) being measured to gauge performance under contracts. Rewards are paid for good performance and sanctions are applied for non-performance³.

HISTORY AND LEGAL FRAMEWORK PERFORMANCE CONTRACTS IN THE HEALTH AND SOCIAL WELFARE SECTOR IN LIBERIA

Under Liberian law, the MOHSW "...may engage in partnerships with public, non-profit or government entities through grants or contracts"⁴. In addition, all contract recipients must maintain valid accreditation with the Ministry of Planning and Economic Affairs (MOPEA)⁵. Entities (providers) are to be certified by the External Aid Coordination Unit at the MOHSW for Accreditation purposes. In addition, the CHSWT must see proof of that certification.

CONTRACTING OUT

Since 2008, the Liberian Ministry of Health and Social Welfare (MOHSW) has had in place a national policy on Performance-based Contracting (PBC), under which Non-Governmental Organizations (NGOs) are hired under contract to provide and manage Primary Health Care (PHC) services in Liberia⁶. The rationale for contracting out in post-conflict Liberia was to take advantage of the already existing service delivery capacity of NGOs while public sector systems and capacity were gradually developed and strengthened.

³ In Liberia the bonus strategy that will be used specifies that 80% will be allocated to Health Facilities (HF) and 20% to the CHSWT. The HF bonus will be split whereby individual HF staff will receive 50% of their allotted bonus and HF management and those involved in community mobilization will receive the other 50%.

⁴ Chapter 30 Amendment to Executive Law of 1972. The Executive Law also provides for priority to be given to applications from community-based organizations that are representative of the population to be served. Where community organizations lack experience, partnership with international organizations may be encouraged.

⁵ National Policy on Non-Governmental Organizations for the Republic of Liberia.

⁶ Performance-Based Contracting Policy 2008-2011. MOHSW

The first performance contract mechanism put into place in Liberia was in 2009 through contracts with International Non Governmental Organizations (INGOs) and local NGOs, known in Liberia as Implementing Partners (IPs), to provide the Basic Package of Health Services (BPHS). The BPHS has now been expanded and is known as the Essential Package of Health Services (EPHS) in a number of specific target areas in the country, and contracts have been modified to encompass the EPHS. The focus of the BPHS and the EPHS, under PBC, is on the provision of Primary Health Care (PHC) services.

REBUILDING BASIC HEALTH SERVICES PROJECT AND THE FIXED AMOUNT REIMBURSEMENT AGREEMENT

The first mechanism to operationalize PBC in Liberia was in 2009 through a United States Agency for International Development (USAID)-funded project, Rebuilding Basic Health Services (RBHS). The RBHS project is run by a US-based NGO that subcontracts under performance agreements to INGOs and local NGOs. Originally, five NGOs were contracted to provide support to 112 Health Facilities (HF) in seven counties. RBHS partners report directly to Project staff. In 2012, RBHS gradually began to transition performance contracts to the MOHSW. RBHS is working with the MOHSW to build capacity at the central MOHSW and CHSWT levels for this transfer of skills and responsibility.

The Fixed Amount Reimbursement Agreement (FARA), a USAID assistance mechanism is in place in Liberia whereby the MOHSW is reimbursed a fixed amount for the successful completion of specified activities or outputs. In the agreement, USAID reimburses the ministry for either the cost of implementing performance contracts with IPs (contracting out), or with CHSWTs (contracting in), for health service delivery and monitoring and evaluation of services. The FARA mechanism, intending to build GoL capacity, replaced the RBHS-managed performance contracts with IPs.

THE POOL FUND

The second contract mechanism put into place, also in 2009, was through the Pool Fund with support from the Department for International Development (DFID), Irish Aid, the United Nations Children's Education Fund (UNICEF), and the Swiss Development Corporation. Under the Pool Fund, two types of PBCs were instituted: management contracting-out to five NGOs supporting 87 health facilities in seven counties, and contracting-in with the Bomi CHSWT. The Bomi CHSWT, as part of a decentralization pilot, was contracted through a performance contract to provide services in 20 Health Facilities (HF). The Bomi CHSWT, in turn, sub-contracted management of some of those facilities to an INGO.

Although, under the pool fund mechanism these contracts were designed to be performance-based, the MOHSW did not put into place a methodology or tool to actually assess performance, and no bonuses were paid under the Pool Fund. Pool Fund IPs report directly to the MOHSW Pool Fund staff. The Pool Fund mechanism has been revamped and modified to encompass changes in performance financing schemes to be monitored by the PBF Unit in the MOHSW.

THE EUROPEAN COMMISSION

The European Commission (EC) also supported health service delivery in three counties; however, EC support was through a basic input-financing model rather than through a PBC.

Instead of channeling its funds through the MOHSW, EC funds were channeled through the Ministry of Planning.

Approximately 75% of all government health facilities were covered by one of these arrangements. Public facilities that were not contracted under any of these mechanisms were run, and are still being run directly by the CHSWTs using budget subsidies from the Government of Liberia (GoL) under a more traditional input model that does not include performance measures or incentives.

CONTRACTING IN

The 2011-2021 National Health and Social Welfare Policy and Plan (NHSWPP) states, “On an increasing basis, PBCs will be used between the central MOHSW and the County Health and Social Welfare (CHSWTs).” This is known as contracting in; when one level of government or a public institution (i.e., the central-level MOHSW) contracts with a lower level of government (i.e., a county, district, province, or facility) to deliver services. This mechanism serves as a way to introduce private sector concepts and business strategies into public sector management in a non-threatening way, as decision-making and resources are retained within the public sector.⁷ PBC in the form of contracting in also helps to shape the decentralization policy of the MOHSW through defining through contracts, the functions of the central MOHSW, as well as the CHSWTs.

The Ministry wishes to clarify that because the County Health and Social Welfare Team is not an independent legal entity separate from the Ministry of Health and Social Welfare, the CHSWT may not legally bring suit against the MOHSW. Therefore the term “contract” may have multiple meanings depending upon requirements of particular funding sources.

Nevertheless, the CHSWT is obligated to under a “performance contract” to preform in accordance with contract terms, and financial incentives in the form of bonuses will be provided depending upon performance.

NATIONAL HEALTH AND SOCIAL WELFARE POLICY AND PLAN 2011-2021

“The diverse group of partners, including international donors, Non-Governmental and Faith-based Organizations (NGO and FBO) and Private for Profit providers (PFP) working in the health sector and social welfare sector are motivated by a range of different mandates, interests, resources, and ways of working. The Government, in order to enable their participation and ensure their actions are coherent with the principles of this NH[SW]PP, will continue to guide partnerships for health and social welfare in order to create long-term, sustainable working relationships. Continuous and frank consultations, information sharing, clear rules, transparent transactions, and explicit incentives will characterize partnerships.”¹

⁷ Abramson, W. B., Evaluation of Bomi County Contracting-In Form of Performance-Base Contract March 2012

GOVERNANCE AND ADMINISTRATIVE DECENTRALIZATION IN LIBERIA

In January 2011, the GoL approved the Liberian National Policy on Decentralization and Local Governance⁸. The Inter-Ministerial Committee for Decentralization, Decentralization Task Force and the Governance Commission, in collaboration with the Ministry of Internal Affairs (MIA), have assumed their leadership roles on matters of implementing decentralization on a national scale.

The Superintendent's office receives funding on an annual basis from the MIA for development projects⁹. In some counties, local government is also considering requiring household contributions to the social development fund (so as to increase revenue and ownership).¹⁰

In addition, the Superintendent's office also provides technical guidance and support to relevant line Ministries' efforts towards decentralization. The Decentralization Policy includes a long-term goal of devolving authority over several fiscal and administrative responsibilities directly to County Administrations. Currently the CHSWT budget remains independent from County Administration, although it is important for the Superintendent's office to be aware of both activities and budgets for each of the line ministries operating in the county. The Superintendent's office is responsible to the President of the Republic for reporting on progress of line ministries at the county level.¹¹

OPERATIONALIZING DECENTRALIZATION POLICY IN THE HEALTH AND SOCIAL WELFARE SECTOR

The Superintendent in each county chairs monthly sector-wide development meetings of the County Steering Committee. (S)he also chairs quarterly county health board meetings, in which the local government officials are updated as to the status of health situations and activities by the County Health Officer (CHO)¹² and/or the County Health Services Administrator (CHSA). Under the County

⁸ Part VI Section 6.0 falls under a Constitutional Amendment for "The implementation of this National Policy on Decentralization and Local Governance and framework for the devolution of political, fiscal and administrative powers to county governments under Chapter V Articles 29 and 34, and Chapter VI, Article 54 and all relevant provisions of the Constitution of the Republic of Liberia shall be amended through national referendum for the purpose of implementation this decentralization policy."

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

¹⁰ The district government extends into the community with chiefdoms, clans and other local organizations. 3.6.3 "Each district shall elect a volunteer advisory board which shall meet at least four times a year, advise the district commissioner regarding chiefdom and clan conditions and needs, and provide input for the district planning process. "

¹¹ 3.4.3 "The Superintendent shall keep collaborating line ministries and agencies and all such national authority institutions informed on matters regarding status of their national programs and projects; similarly, the line ministries and agencies shall keep the superintendent informed of matters regarding operations of their national programs in the county; the Superintendent shall have authority to supervise their condition and effective administration.

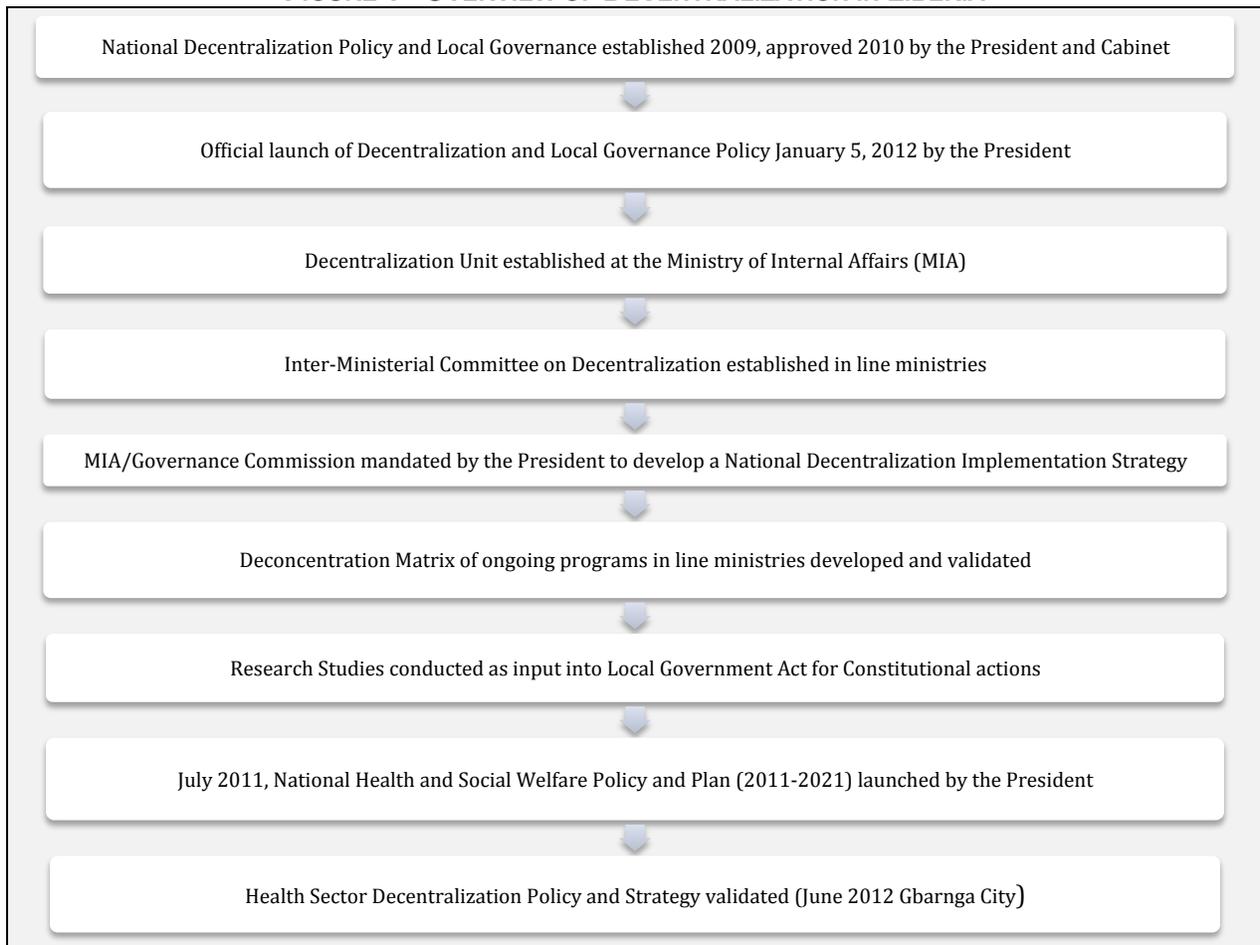
¹² 3.6.1 "The district administrative office shall include a project identification, planning and development officer, a health officer, education officer, an agriculture services officer..... the county personnel shall be employed and supervised by the appropriate county bureaus, which shall be responsible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

NATIONAL DECENTRALIZATION POLICY AND PLAN

“The Government of Liberia remains committed to decentralization and many of the characteristics of the future decentralized public structure are now clear. Health and social welfare departments will be formed in each county administration. Therefore, the de-concentration of MOHSW management responsibilities and the building of performing systems at the county level will adapt to the county administrative structure in an incremental and pragmatic way. The MOHSW will progressively relinquish responsibilities to County Administrations as they are equipped to assume them.

Superintendent sits the District Commissioners¹³ who oversee the planning and development of programs. At the community level the Community Health Development Committees (CHDCs), comprised of local leadership by Paramount Chiefs, Clan Chiefs and Sub Chiefs, interact with the general Community Health Volunteers (gCHVs), the Trained Traditional Midwives (TTMs) and the Officers in Charge (OICs) at each Health Facility (HF).

FIGURE 1 - OVERVIEW OF DECENTRALIZATION IN LIBERIA



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

LEGAL FRAMEWORK FOR DE-CONCENTRATION IN THE HEALTH AND SOCIAL WELFARE SECTOR IN LIBERIA

Guided by the Liberian National Policy on Decentralization and Local Governance, the 2011-2021 National Health and Social Welfare Policy and Strategic Plan (NHSWPP), the Public Sector Reform Statement (2010), the Amended Chapter 30 of the Executive Law of 1972, and with external technical and financial assistance, the GoL is currently undertaking a number of relevant activities representing the roadmap towards decentralization. In particular, the GoL has begun a process of decentralization of the health and social welfare sector beginning with a de-concentration and delegation of authority and responsibilities to CHSWTs.

The Liberian NHSWPP addresses three general objectives; the second object refers to the transfer of management and decision-making to lower administration levels. The NHSWPP states that by increasing access and utilization of the EPHS, CHSWT has been empowered to serve as "... its [MOHSW] operational arm and to manage all Ministry-owned facilities, Ministry-employed human resources, and Ministry-provided material resources in their county."¹⁴

LIBERIAN NATIONAL HEALTH AND SOCIAL WELFARE POLICY AND PLAN FOR 2011- 2021

"County health authorities will manage health facilities (HF). They will be responsible for financial management and personnel management and will be fully accountable to local constituencies as well as to overseeing public bodies. The [central] Ministry will focus on health legislation and law enforcement; policy formulation, revision and enforcement; resource mobilization and allocation; national and long-term planning; broad health sector programming, monitoring and evaluation; and technical oversight of service delivery, regulation, major research and development initiatives."

Similarly, "... the central level will focus on establishing policies and standards, resource mobilization and allocation, aggregate planning, monitoring and evaluation and research....[the] County level shall be responsible for service delivery; and partner oversight, while the Central level will focus on establishing policies and standards, resource mobilization and allocation, aggregate planning, monitoring and evaluation, and research and development."¹

"Make health and social welfare services more responsive to people's needs, demands and expectations by transferring management and decision-making to lower administration levels, ensuring a fair degree of equity."

¹⁴ National Health & Social Welfare Policy & Plan 2010-2021, MOHSW, 2011

In June 2012, the MOHSW finalized its National Decentralization Policy and Plan through a consultative workshop. This document, like the NHSWPP, articulates a transfer of certain functions and responsibilities from the central to the county level. In the Liberian Health and Social Welfare Sector, decentralization policy is, to a large extent, manifested through performance contracts between the central MOHSW and the CHSWTs.

SEPARATION OF FUNCTIONS UNDER DE-CENTRALIZATION

In order to avoid any misunderstanding or conflicts of interest, and in an effort to create a transparent health system that ultimately works to improve health outcomes, it is vitally important that there be clarity on separation of functions within the system, including, Financing, Purchasing (or procurement), Oversight and Regulation, Policy and Planning, and Provision of Services. The following are frequently used terms to describe a separation of functions between levels of the healthcare system:

- ✓ *Financier* pays for services (e.g. GoL through Ministry of Finance, donor, or private sector);
- ✓ *Purchaser* buys services (e.g. central MOHSW PBF Unit the case of PBC “in” or CHSWT in the case of PBC “out”) and is responsible for negotiating targets, monitoring results progress and verifying results. The purchaser essentially buys results from providers.
- ✓ *Provider (in Liberia IP)* delivers services (e.g. Health Facilities and Community) and is primarily responsible for implementing health care services. It is important that providers are given sufficient authority to be able to effectively plan, operate, and allocate resources under any guidelines or budgetary parameters as specified under contract.
- ✓ *Verifier or Monitor* provides oversight of services (e.g. CHSW Board or sub-committee of the Board at the county or district level).

NATIONAL DECENTRALIZATION POLICY AND PLAN

“...Decentralization of authority from the central level of government (MOHSW) to the county level of the health system (CHSWT) requires a reallocation of authority and responsibility for health sector performance.”

“...County level shall be responsible for service delivery; and partner oversight, while the Central level will focus on establishing policies and standards, resource mobilization and allocation, aggregate planning, monitoring and evaluation, and research and development.”

“...The MoHSW will intervene in strengthening the operational capacities of County health bodies such as the CHSW Board, the CHSWTs, the Community Health Development Committee (CHDC) and general Community Health Volunteers (CHV).”

NATIONAL DECENTRALIZATION POLICY AND PLAN

“... the challenge for the MoHSW is to progressively allocate and transfer resources to the county level according to the responsibilities it has been assigned and the activities it has planned. This will require developing an administrative framework that will align the health and social sector support systems with a national vision for local governance.”

In particular, “...the MOHSW has committed itself to decentralization in broad terms, wherein the County level shall be responsible for service delivery and partner oversight.” Furthermore, reference to formalization of partnerships between the CHSWTs and IP is articulated in Section 4.1.2. It states, “Because relationships gain in transparency, efficiency and effectiveness when they are formalized into

mutual binding commitments, contracts [with Not for Profit (NFP) providers] will be used for the provision of public health and social welfare services.” These providers include In INGOs, local NGOs, and Faith-Based Organizations (FBOs).

“The intent is to gradually reduce the role of NFPs and increase the role of CHSWTs in managing government facilities. CHSWTs may, in turn, contract directly with government health facilities for service delivery as well as with privately owned facilities (primarily non-governmental and faith-based). In all instances where contracts are used, emphasis will be placed on establishing distinct catchment populations in a given health system to ensure appropriate allocation of resources and measurable performance.”¹⁵

In Liberia under a contracting in model whereby the central ministry contracts with the CHSWT, the county provides oversight, monitoring, and management of service provision. Thus the CHSWT serves in a number of roles – Regulatory body, Monitoring Body and Management / Provider of Services¹⁶.

¹⁵ National Health & Social Welfare Policy & Plan 2010-2021, MOHSW, 2011

¹⁶ The role of the CHSWT to perform these distinct though inter-related functions could present a conflict of interest; PBC “in” needs to be designed in such a manner to avoid possible gaming of the system.

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Mr. Joel Bimba	Department Coordinator
Clr. Tolbert G. Nyenswah	Assistant Minister, Preventive Services
Dr. Saye D. Baawo	Assistant Minister, Curative Services
Mrs. Louise Mapleh	Manager, PBF Unit
Mr. Alex Nartey	Ernst & Young (E&Y) Financial Management Advisor
Dr. Francis.B. Zotor	Manager, Health Sector Pool Fund
Mr. Toagoe T. Karzon	Comptroller, OFM
Mr. Ka-Rufus Morris	Procurement Director
Mr. Momolu V.O. Sirleaf	Director, External Aid Coordination Unit
Mr. James Beyan,	Personnel Director
Mr. Justine A. Korvayan	Director, Planning & Decentralization
Mr. Luke Bawo	Director, HMIS
Mr. George P. Jacobs	Director, M & E
Dr. Angela Benson	Manager, FARA
Mrs. Margaret Korkpor	Director, Community Health Services
Mr. Tambo Boima	Director, Community Health
Mr. Matthew T.K. Flomo	Deputy Minister, Administration
Mr. John Linga	Assistant Minister, Administration
Mr. John Wilson, Esq.	General Counsel
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Dr. Paul Wesseh	Nimba
Dr. Joseph Siaka	River Gee
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Hon Samuel F. Brown	Bomi
Hon. Edwarda S. Cooper	Grand Bassa
Hon. W. Geeron Smith	River Cess
Hon. Nazerene Brewer Tubman	Maryland

OTHER	
Dr. Rose Macauley	RBHS, Chief of Party
Dr. Theo Lippeveld	RBHS, Deputy Chief of Party
Dr. Vamsi Vasireddy	RBHS, Capacity-Building Director
Mr. Bal Ram Bhui	RBHS, Monitoring and Evaluation Director
Ms. Zaira Alonso	RBHS, Finance and Administration Director
Dr. Floride Niyuhire	RBHS, PBF Advisor
Mr. David K. Franklin Sr.	RBHS, Mental Health Advisor
Mr. Mohammed A. Massaley	RBHS, Capacity-Building Officer Bong Co.
Mr. Kapil Dev Singh	CHAI, Supply Chain Analyst
Ms. Laura M. O'Hara	UNICEF, Chief Child Survival and Development
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Ms. Rianna L. Mohammed	World Bank, Health Specialist
Dr. Robert Seoters	World Bank, Consultant
Mr. Shunsuke Mabuchi	World Bank, Consultant
Mr. Ernest Gaie	Africare, County Director
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Bong	Dr. Garfee Williams
Gbarpolu	Dr. Anthony Tucker
Grand Cape Mount	Dr. Julious Garbo
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Grand Gedeh	Dr. Fred Amegashie
Grand Kru	Dr. Abraham Keita
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Maryland	Dr. Odell Kumbek
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Rivercess	Dr. Wilmot L. Smith
River Gee	Dr. Joseph Sieka
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