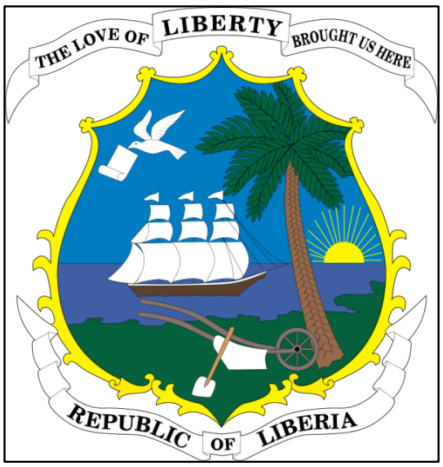
LIBERIA

MOHSW Contracting In Guidelines

Readiness Review and Assessment of County Health and Social Welfare Team (CHSWT) Performance



Republic of Liberia
Ministry of Health and Social Welfare

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ACRONYMS

ANC	Antenatal care
BPHS	Basic Package of Health Services
BMR	Budget Management Report
CBO	Community-Based Organization
CHDC	Community Health Development Committee
CHO	County Health Officer
CHSWT	County Health and Social Welfare Team
CHV	Community Health Volunteer
CSO	Civil Society Organization
DHIS	District Health Information System
DHO	District Health Officer
DHS	Demographic and Health Survey
EIO	Expression of Interest
EPHS	Essential Package of Health Services
EPI	Extended Program for Immunization
FBO	Faith-based Organization
gCHV	General Community Health Volunteer
GOL	Government of Liberia
EPHS	Essential Package of Health Services
EPSS	Essential Package of Social Services
HF	Health Facility
HMIS	Health Management Information System
IAS	International Accounting Standards
IP	Implementing Partner
ITP2	2nd dose of Intermittent Preventive Treatment
LMIS	Logistics Management Information System
MCH	Maternal and Child Health
M&E	Monitoring and Evaluation
MIA	Ministry of Internal Affairs
MOF	Ministry of Finance
MOHSW	Ministry of Health and Social Welfare
MOPEA	Ministry of Planning and Economic Affairs
NDS	National Drug Service
NGO	Non-Governmental Organization
NHSWPP	National Health and Social Welfare Policy and Plan
NFP	Not For Profit providers
OFM	Office of Financial Management
OIC	Officer in Charge
PBC	Performance-based Contracting
PBF	Performance-based Financing
Penta3	3rd dose of Pentavalent Vaccine
PC	Procurement Committee
PHC	Primary Health Care
PFP	Private For Profit providers
PPCC	Public Procurement and Concessions Commission

RBHS	Rebuilding Basic Health System project
RFP	Request for Proposal
SCMU	Supply Chain Management Unit
UNICEF	United Nations Children's Education Fund
USAID	United States Agency for International Development
WHO	World Health Organization

ACKNOWLEDGEMENTS

The ***MOHSW Contracting In Guidelines: Readiness Review and Assessment of County Health and Social Welfare Team (CHSWT) Performance*** will be used on a continuous basis to assess readiness and performance of CHSWTs to contract in. It will provide evidence-based data to determine when CHSWTs have a defined minimum capacity to implement performance contracts with the MOHSW; whether a CHSWT should receive future funding for contracts that are already in place; identify capacity-building needs of individual CHSWTs; and, provide publically accessible and transparent data on the use of Government of Liberia (GoL) funding for health services in the counties.

A participatory method was used to develop these guidelines. Specifically the approaches used included use of the following: 1) 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 National Health Sector Review meetings and semi annual meetings of 2012 and 2013; 4) Consultative meetings held in Liberia in October 2012, April 2013, and November 2013 with the MOHSW senior management and staff, CHSWT teams, county Superintendents, Non-Governmental Organizations (NGOs), and international partners. The development of this tool represents one of the finest examples of interdepartmental collaboration in MOHSW and its application will require comparable collaboration.

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 participated in and supported the development of these guidelines.
In particular I would like to express my gratitude to the United States Agency for International Development (USAID) for providing the resources for the development of these guidelines.

Two additional documents complement this tool:

- Guidelines for Contracting In: A Summary of Systems, Procedures and Core Competencies for the County Health and Social Welfare Team (CHSWT)
- Background and Context to Performance Contracts between the MOHSW and CHSWT".

We look forward to the collaborative use of this tool and the complementary resources to operationalize our commitment to decentralization of health services in order to more effectively delivery quality services to all Liberians.

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BACKGROUND AND CONTEXT

OVERVIEW OF 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. The most common form of PBF is, however, a supply side scheme between levels of the health system, health management and providers, and/or through providers and community volunteers. 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. These mechanisms are different tools for PBF.

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.

> 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 NHPP is to improve the health and social welfare status of the population of Liberia on an equitable basis.[1]"

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) is based upon progress against results delivered. Under PBC, a formal, legally binding contract or agreement is used as a mechanism or tool to tie payment to performance. The contract includes clear objectives, performance indicators and targets, mechanisms to collect and validate data, timeframes, and a budget. Performance indicators (service delivery and administrative) are measured to gauge performance under contracts. Rewards are paid for good performance and sanctions are applied for non-performance[1].

[1] 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%.

PERFORMANCE-BASED CONTRACTING IN THE HEALTH AND SOCIAL WELFARE SECTOR IN LIBERIA

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 Liberia. The rationale for PBC in post-conflict Liberia was to take advantage of the already existing service delivery capacity of NGOs while public sector systems and capacity are gradually developed and strengthened. "Contracting Out" is when the MOHSW enters into a legal contractual arrangement with an independent private entity such as a NGO. 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.

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.[2] 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.

Contracting In, through the use of Performance-Based Contracts (PBC), is a tool for the public sector to provide financial incentive to encourage pre-determined results or output.

The MOHSW in Liberia began contracting in of a CHSWT as a pilot in 2009 in Bomi County. Based upon a 2012 assessment of the BOMI pilot experience, the MOHSW began to transition from performance contracts with NGOs to direct performance contracts with individual CHSWTs to deliver the Essential Package of Health Services (EPHS)[3]. It is the intent of the MOHSW to gradually transition all public sector service delivery at the primary care level to fall under performance contracts between the central MOHSW and individual CHSWTs. As such, the Ministry of Health and Social Welfare (MOHSW) is in the process of transitioning its service delivery model from one under which Non Formal Providers (NFPs) or NGOs are contracted at the central level to provide the EPHS to a model whereby the CHSWT is responsible for all service delivery, either directly or through contracts with non-public entities.

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

[3] 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 perform in accordance with contract terms, and financial incentives in the form of bonuses will be provided depending upon performance.

GOVERNANCE AND ADMINISTRATIVE DECENTRALIZATION IN LIBERIA

In January 2011, the GoL approved the Liberian National Policy on Decentralization and Local Governance[4]. The Inter-Ministerial Committee for Decentralization, Decentralization Task Force and the Governance Commission, in collaboration with the Ministry of Internal Affairs (MIA), have assumed leadership on matters of implementing decentralization on a national scale.

The Superintendent's office receives funding on an annual basis from the MIA for development projects[5]. Additionally 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 mandated that the Superintendent's office be aware of both activities and budgets for each of the line ministries operating in the county, since the Superintendent's office is responsible to the President of the Republic for reporting on progress of line ministries at the county level.[6]

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 has undertaken 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 second objective of the Liberian NHSWPP 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's) operational arm and to manage all Ministry-owned facilities, Ministry-employed human resources, and Ministry-provided material resources in their county."[7]

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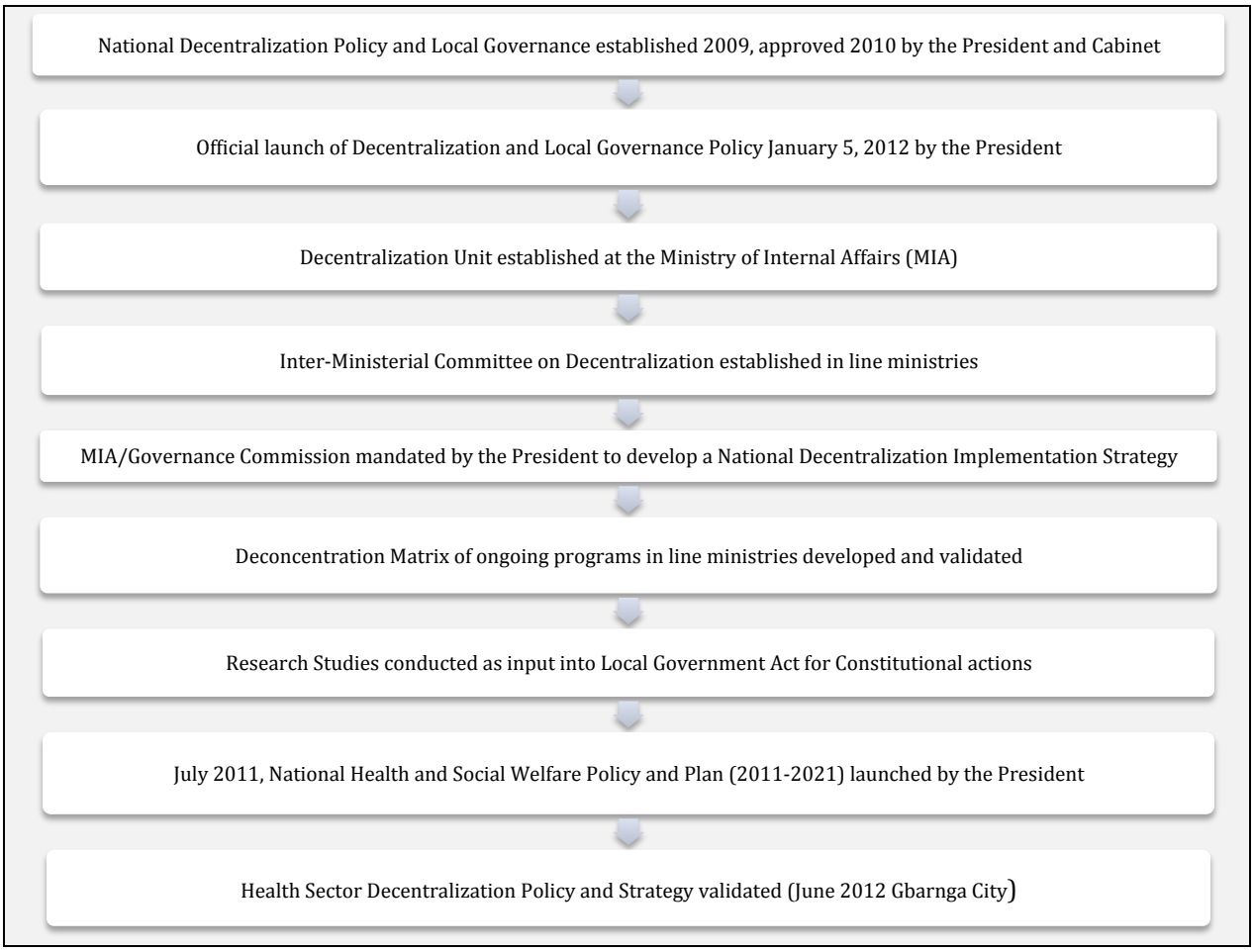
[4] Part VI Section 6.0 falls under a Constitutional Amendment for "The implementation of this National Policy on Decentralization and Local Governance and framework for the devolution of political, fiscal and administrative powers to county governments under Chapter V Articles 29 and 34, and Chapter 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 of this decentralization policy."

[5] 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."

[6] 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.

[7] National Health & Social Welfare Policy & Plan 2010-2021, MOHSW, 2011

FIGURE 1 - OVERVIEW OF DECENTRALIZATION IN LIBERIA



Operationalizing Decentralization Policy in the Health and Social Welfare Sector

The National Decentralization Policy and Plan, 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 operationalized through performance contracts between the central MOHSW and the CHSWTs.

"The intent is to gradually reduce the role of NFPs [Not for Profit providers] 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."[8]

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)."

Separation of Functions under De-Concentration

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 between the different levels of the Liberian health care system, including central, county, district, HF, and community. Transparency as to which level of the health care system is responsible for various functions of health system performance promotes accountability and ultimately efficiency in the use of resources.

The following are some frequently used terms to delineate functions:

- ✓ *Financier* pays for services (e.g. GoL through Ministry of Finance, donor, or private sector);
- ✓ *Purchaser* buys services (or results) from providers (e.g. MOHSW from CHSWT or CHSWT from an IP / NGO) and negotiates targets, monitor progress and verifies results.
- ✓ *Provider (in Liberia IP)* delivers services (e.g. CHSWT delivers management of services, Health Facilities and Community provide direct services) and is primarily responsible for implementing health care services. It is important that providers are given sufficient authority to be able to

[8] National Health & Social Welfare Policy & Plan 2010-2021, MOHSW, 2011

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. MOHSW at the central level and CHSW Board or sub-committee of the Board at the county or district level).

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 Implementing Partners 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 International Non-Governmental Organizations (INGOs), Non-Governmental Organizations (NGOs), and Faith-Based Organizations (FBOs).

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, whereas the MOHSW serves to make policy and plan, provide oversight and regulatory enforcement, purchase and procure goods and services, and monitor and evaluation CHSWT performance[9].

MOHSW FUNCTIONS

FINANCING BODY

- ✓ Ensure financing of health services
- ✓ Allocate resources
- ✓ Mobilize resources

PUCHASING / PROCUREMENT / CONTRACTING BODY

- ✓ Determine needs, develop ToR
- ✓ Design and negotiate contract terms
- ✓ Collect financial, administrative, and service delivery data
- ✓ Track performance data
- ✓ Monitor, Evaluate and Pay CHSWT based upon Performance

REGULATORY, NORMATIVE AND OVERSIGHT BODY

- ✓ Set clinical standards and norms
- ✓ Regulate health care providers
- ✓ Accreditation of health facilities

POLICY AND PLANNING BODY

- ✓ Set National Policies and Standards
- ✓ Carry out Research
- ✓ Set National Targets and Priorities

CAPACITY-BUILDING CHSWT

- ✓ Identify areas for improvement
- ✓ Facilitate capacity-building efforts

CHSWT FUNCTIONS

IMPLEMENTING BODY (CONTRACTOR)

- ✓ Manage finances, administer services
- ✓ Procure goods and services
- ✓ Manage Human Resources
- ✓ Provide health service delivery
- ✓ Monitor and Evaluate performance
- ✓ Manage Supply Chain for Essential Medicines and Supplies

OVERSIGHT AND PLANNING

- ✓ Health system Leadership, Governance
- ✓ Coordination
- ✓ Develop operational plans and budgets
- ✓ Set County Targets

PURCHASING / PROCUREMENT (PERFORMANCE-BASED CONTRACTING) BODY

- ✓ Prepare contract proposals
- ✓ Design and negotiate contract terms
- ✓ Lead and Manage a Competitive Bidding Cycle for Sub-Contracting out of partners
- ✓ Oversee and Monitor Sub-Contract performance data
- ✓ Pay sub-contract IPs

CAPACITY-BUILDING HF

- ✓ Identify areas for improvement

[9] 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.

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, and 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.

County Health Services

County Health Services (CHS) Unit is responsible for the monitoring and supervising of the implementation of the EPHS. One of the main components of the EPHS is Joint Integrated Supportive Supervision (JISS) on a quarterly basis and accreditation on all health facilities in the country (public and private); the CHS is responsible for this. Desk officers who are assigned to oversee regional clusters of counties are responsible for analyzing all health service delivery reports, identifying gaps and challenges, and providing feedback to the CHSWT supervisors. Based upon these analyses, the CHS department works with the rest of the ministry to develop and fine-tune capacity-building plans for the CHSWTs. The Contracting In process, including the selection of counties eligible for performance contracts, falls under the jurisdiction of this unit.

MOHSW CONTRACTING IN GUIDELINES: READINESS REVIEW AND ASSESSMENT OF CHSWT PERFORMANCE

The purpose of the Liberian MOHSW initiative of transitioning from management "contracting out" with NGOs by the Ministry and by partners to a model whereby the central MOHSW "contracts in" directly with individual CHSWTs, is to ultimately improve performance of the Liberian health system. In order to do this, the CHSWT in Liberia needs to have sufficient capacity as leaders, managers and public health practitioners to effectively provide the EPHS to the population.

CHSWT Contracting In Guidelines: Summary of Systems, Procedures, and Core Competencies

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.

As such, the ***Contracting In Guidelines: Summary of Systems, Procedures and Core Competencies for the County Health and Social Welfare Team (CHSWT) May 2013*** were created to provide an overview of the main functions, or competencies, which must be operational for effective contracting "in" of key public health functions through a performance contract[10]. These guidelines are intended to serve the CHSWTs as a functional tool that provides an orientation on procedures and processes leading to an effective decentralization of the health care delivery system employing the health system[11] approach. They provide minimum standards under which the CHSWT is expected to operate under performance contracts with the MOHSW.

In May 2013 the guidelines were disseminated, validated, and capacity was built in a national workshop held in Sanniquellie Nimba. The extent to which these functions are fully operational is directly tied to the capacity of the CHSWT to deliver effective health services, increase the quality of care, and harmonize data through transparent public health management practices.

[10] 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.

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

PURPOSE

In the past decisions on which counties to "contract in" were based upon emergency funding constraints of individual counties rather than on whether a county had the basic competencies necessary for proper and transparent management of public sector funds. The ***MOHSW Contracting In Guidelines: Readiness Review and Assessment of CHSWT Performance*** have been created so that Liberian public health authorities can make resource allocation decisions based upon objective measures of a CHSWT's real capacity and "readiness" to handle large sums of money in a fiscally responsible manner that produces desired results.

These guidelines serve as a tool to assist the Ministry to gradually move from the present health service delivery system to one whereby counties enter into performance contracts with the ministry based upon an objective analysis of their current real capacity to manage and implement performance contracts and oversee sub-contracts at the county level.

In addition, as the Government of Liberia (GoL) proceeds with de-concentration in the health and social welfare sector, the Ministry needs to monitor and assess CHSWT performance in a standardized manner across Liberia's 15 counties to determine whether to contract a CHSWT, if an already contracted CHSWT is performing at a sufficient level to receive future funding under a performance contract, identify capacity-building needs of individual CHSWTs, and provide publically accessible and transparent health system data on the use of GoL funding for counties.

The **purpose** of the MOHSW Contracting In Guidelines is to determine which CHSWT are performing at a level that would qualify them to be contracted "in" by the MOHSW. They serve as companion guidelines to the ***CHSWT Contracting In Guidelines: Summary of Processes, Procedures and Core Competencies*** that was validated in Saniqueillie Nimba in May 2013.

OBJECTIVES

- ✓ To provide evidence for MOHSW decision-making for future funding of CHSWTs through performance contracts as well as continued funding of already contracted counties;
- ✓ To promote public transparency in decision-making on county selection and funding for PBCs;
- ✓ To identify gaps in performance and create capacity-building plans for strengthening of individual CHSWTs that will steer them to deliver effective health services through transparent public health management practices;
- ✓ To measure progress and compare CHSWT capacity and performance over time through a step-by-step review process of key public health functions expected from the CHSWTs;
- ✓ To track the use of systems, processes, procedures, and results of sector de-concentration of authority under performance contracts; and,
- ✓ To provide evidence of the CHSWT's development and capacity for further decentralization of functions and authority to the local level in the health sector.

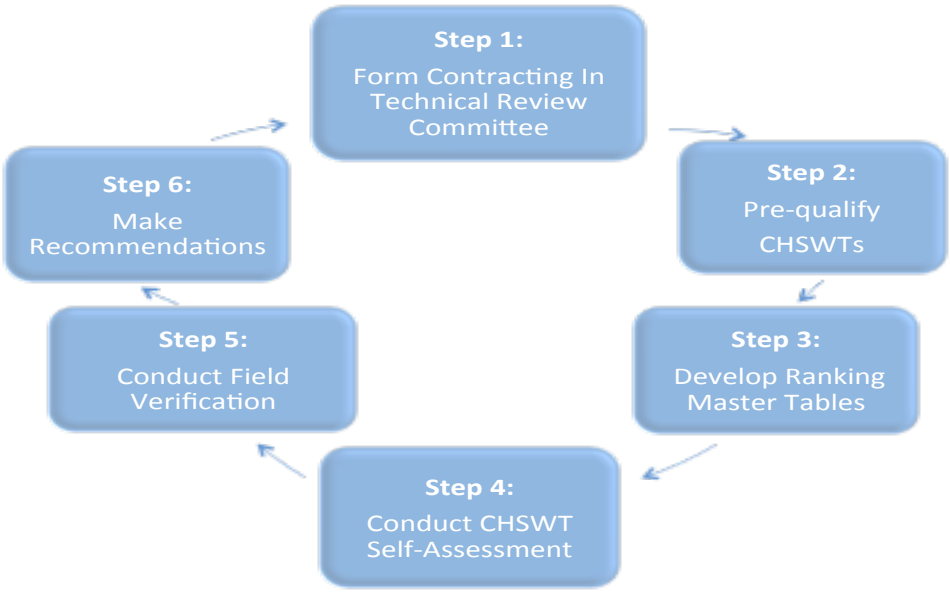
METHODOLOGY

The ***MOHSW Contracting In Guidelines: Readiness Review and Assessment of CHSWT Performance*** considers the six building blocks of a health system framework as defined by the World Health Organization (WHO)[12]. The review process encompasses these building blocks, and it focuses specifically on the key competencies necessary for good public administration through a PBC mechanism between the MOHSW and the CHSWT. Those core competencies include:

- ✓ County Leadership and Governance;
- ✓ Financial Management and Procurement;
- ✓ Human Resource Management;
- ✓ Health Service Delivery Management;
- ✓ Use of Health Management Information Systems and Monitoring and Evaluation; and,
- ✓ Supply Chain Management for Essential Medicines and Supplies.

Figure 2 depicts the six steps in the Contracting In Readiness Review and Assessment Process.

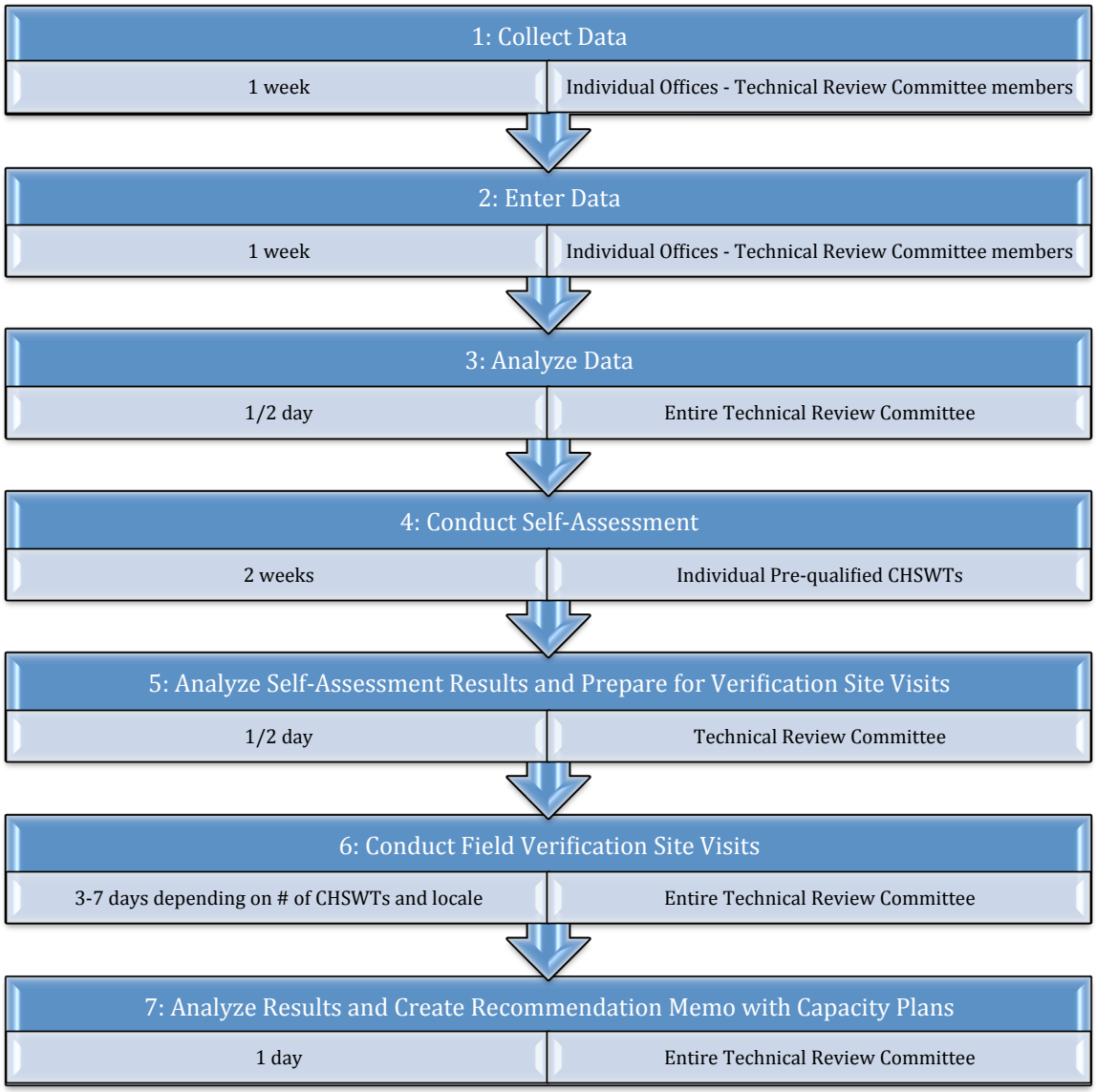
FIGURE 2 – MOHSW CONTRACTING IN READINESS REVIEW STEPS AND ASSESSMENT PROCESS



[12] World Health Organization, Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies. Available at: http://www.who.int/healthinfo/systems/monitoring/en/index.html

The process ideally takes place bi-annually with the same people participating during each cycle of review. Figure 3 indicates approximate timeframe and responsible parties for each of the six steps in the review process:

FIGURE 3 – MOHSW CONTRACTING IN READINESS REVIEW TIMEFRAME AND RESPONSIBILITES



The following is an overview of the steps involved in the review process.

STEP 1 FORM CONTRACTING IN TECHNICAL REVIEW COMMITTEE

A Contracting In Technical Review Committee ("the Review Committee"), comprised of the various MOHSW departments each with expertise in their particular competency area under review, is formed. Leadership for convening and facilitating the review and assessment process comes the County Health Services Office. It is comprised of the following representatives from across the ministry as well as one representative from a partner organization:

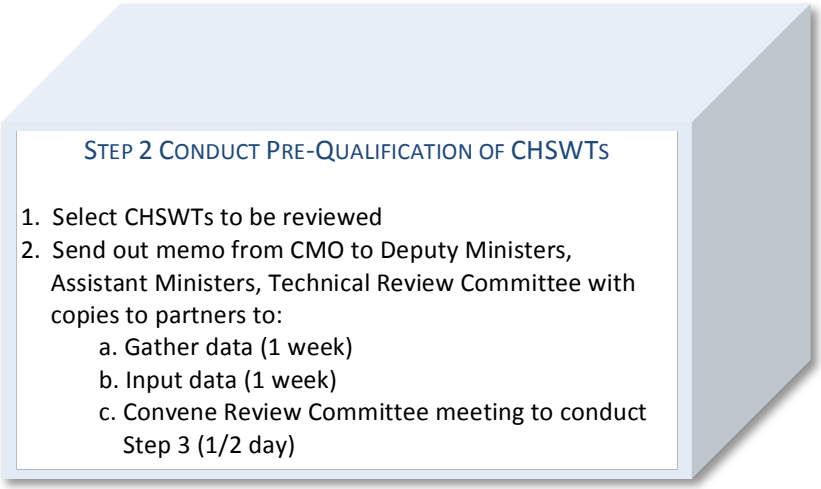
- ✓ Administration – Office of Financial Management (1 individual)
- ✓ Administration – Office of Personnel (2 individuals)
- ✓ Planning – Monitoring and Evaluation Unit (1 individual)
- ✓ Planning – Health Management Information Systems Unit (1 individual)
- ✓ Health Services – County Health Services (2 individuals)
- ✓ Health Services – Supply Chain Management Unit (1 individual)

This committee is responsible for participating in all steps laid out in these guidelines. Annex I contains Terms of Reference (ToR) for the MOHSW Contracting In Technical Review Committee.

STEP 2 CONDUCT PRE-QUALIFICATION OF CHSWTS

The first exercise of the Review Committee involves an analysis of a number of core competencies and functional areas with corresponding indicators to determine CHSWT capacity for contracting. During this step, an initial pre-qualification of the CHSTWs takes place through a review of routine data already collected by the MOHSW and, to a lesser extent, through requests for routinely collected information from the CHSWTs[13].

The individual members of the Committee are tasked with obtaining and analyzing those data corresponding to their area of expertise. For example, analysis of the financial indicator is the responsibility of the OFM, analysis of service delivery indicators is the responsibility of the Department of M&E, analysis of the leadership and governance data is the responsibility of the Office of County Health Services, and so on.



[13] The two important pieces of information that not periodically collected and that will need to be readily available at the central ministry include: CHSW Board Meeting minutes and CHSWT Staff Meeting minutes. Ideally these should be sent by the CHSWTs to the County Health Services central MOHSW on a regular basis.

Table 1 below contains the list of data to be collected for the review, the amount of data to be collected and inputted, and where it can be found within the Ministry.

TABLE 1. DATA NEEDED AND SOURCE FOR CONTRACTING IN REVIEW AND ASSESSMENT

DATA NEEDED	QUANTITY OF DATA	DATA SOURCE
Quarterly CHSW Board Meeting minutes	Previous 4 quarters	Health Services/County Health Services
CHSWT Weekly Staff meeting agendas/minutes	Previous quarter	CHSWT/County Health Services
HMIS Priority Coverage Rates	Previous 3 years	Planning/HMIS - DHIS
Operational Plan Targets for indicators	Previous 3 years	Planning/HMIS
Reporting Accuracy for Penta3	Previous 2 years	Health Services/PBF Unit
Quarterly Narrative Reports	Previous 4 quarters	Health Services/County Health Services
Accreditation Scores	Previous year	Health Services/County Health Services
Monthly Budget Monitoring Reports	Previous 6 months	Administration/OFM
OFM Financial Analysis Scores	Previous 4 quarters	Administration/OFM
Staffing-Administrative Positions with names of staff	Current actual	Administration/Personnel
Availability of Tracer Drugs	Previous 6 months	Health Services/SCMU

The indicators, chosen by the Ministry, are in accordance with ministry priorities and are deemed as the most representative of those priorities. They reflect the minimum requirements for measurement of a CHSWT readiness for Contracting In. Table 2 below indicates the Pre-qualification Criteria Indicators against which the CHSWTs are assessed.

TABLE 2. PRE-QUALIFICATION CRITERIA INDICATORS

CONTRACTING IN REVIEW - PRE-QUALIFICATION CRITERIA / INDICATORS BY CORE COMPETENCIES

Leadership and Governance

- ✓ Quarterly CHSW Board Meeting Minutes
- ✓ Record of Regular Weekly CHSWT Staff meeting Agendas and Minutes *(Note: The content of these meetings also serves as an indicator of all expected Competencies listed below)*

Human Resource Management

- ✓ Core Administrative CHSWT Positions Filled

Financial Management

- ✓ Timely and Complete Submission of the Budget Monitoring Reports (BMRs)
- ✓ Office of Financial Management (OFM) Regular Quarterly Performance Analysis Scores

Health Services Management and Delivery

- ✓ Timely and Complete Quarterly Reports
- ✓ Health Facility Primary Care Accreditation scores

Health Management Information Systems and Monitoring and Evaluation

- ✓ Priority Service Delivery Coverage Rates Compared to Targets (e.g. Penta3, Measles, IPT2, and ANC4)
- ✓ Accuracy in HMIS reporting (e.g. Penta3)

Supply Chain Management of Essential Medicines and Supplies

- ✓ Availability of Tracer Drugs

Specific indicator definition, source, methodology, examples, and instructions for analysis of each follow below.

LEADERSHIP AND GOVERNANCE

INDICATOR 1
Quarterly CHSW Board Meeting Minutes on File

The Superintendent's office is required by law to prepare annual county development plans and budgets for submission to the President of the Republic[14]. Under Liberia's Administrative and Governance policy[15] regular reporting by the CHSWT to the Superintendent's office is mandated. Reporting is done through quarterly CHSW Board Meetings chaired by the Superintendent or his/her designee, whose purpose is to advise on county-level policy and planning, assist with resource mobilization and coordination, and monitor CHSWT performance.[16] The County Health Officer (CHO) serves as the secretary to the board; the CHO or County Health Services Administrator (CHSA) participates in these meetings, and is responsible for taking meeting minutes; copies of the minutes are given to the Superintendent's office and County Health Services at the central MOHSW, and the original kept on file at the CHSWT office.

INSTRUCTION

INDICATOR 1: QUARTERLY CHSW BOARD MEETING MINUTES ON FILE

1. County Health Services obtains CHSW Board minutes
2. Read minutes and give one (1) point for each quarter that Board Meeting minutes were taken and submitted

BONUS POINTS

IMPROVEMENT IN REPORTING

3. Any improvement in reporting is given one (1) additional point; and a worsening in reporting loses one (1) point

Note: It is important to highlight that the success of CHSW Board meetings is not entirely dependent upon the CHSWT; rather, it also requires the will and effort of the Superintendent's office. If for some reason meetings are not taking place despite documented efforts by the CHSWT, consideration will be made for this deficiency during determination of CHSWT scoring.

QUALITY OF CONTENT

4. Up to three (3) extra points can be obtained if the quality of the content of the minutes is exemplary and shows that health and social welfare issues were discussed, actions identified, and steps assigned and/or taken to resolve those issues. In the next column, note any improvements in terms of more regular reporting and/or quality of reporting as well as any decrease in reporting over time.

[14] Part III, Sect. 3.4.1, 3.4.2 Liberian National Policy Decentralization and Local Governance. Governance Commission. Jan. 2010.

[15] Part III, Section 3.4.3 Liberian National Policy on Decentralization and Local Governance, Governance Commission. Jan. 2010.

[16] Chapter II, Section 2.10 NHPP. 2011-2021 MOHSW.

Note: For those counties that have not submitted records, ask the CHSWTs to submit copies of the minutes from the county quarterly board meetings. This is to be done through a written request from the Deputy Director of Health Services MOHSW to the County Health Officer (CHO)/County Health Services Administrator (CHSA) asking for copies of minutes of all board meetings over the past four quarters. This request states that in the event of missing board minute meetings the counties are to provide a completed and signed written statement by the CHO and CHSA with an explanation as to why the board minutes are not forthcoming in order to explain any gaps in reporting. There could be various explanations for lack of records of meeting, and these are to be explained in the response to the request (i.e., weak Administrative leadership, political upheaval, changing of office locale, etc.).

County Health Services is responsible for conducting this exercise in consultation with the Office of Personnel. An example is provided in Table 3 below.

EXAMPLE

TABLE 3. INDICATOR 1 – QUARTERLY CHSW BOARD MINUTES ON FILE

COUNTY	Q 1st	Q 2nd	Q 3rd	Q 4th	TREND	MEETING QUALITY CONTENT	TOTAL	COMMENTS / EXPLANATION
Meeting Minutes	0	1	1	1	+1	3	3 +1+3=7	FOCUS ON PROBLEM-SOLVING, & ACTION STEPS. CONSISTENT EFFORTS BY CHO / CHSA TO COORDINATE, DISRUPTION IN OCT DUE TO CHANGE IN CO. OFFICE LOCALE NO MINUTES TAKEN
TOTAL POSSIBLE SCORE	0	1	1	1	1	3	8	
TOTAL SCORE	0	1	1	1	1	3	7	
TOTAL SCORE (TOTAL / TOTAL POSSIBLE) X 100							88%	

INDICATOR 2

Record of Regular Weekly CHSWT Staff Meeting Agendas and Minutes

Good management practice includes regular communication, coordination, and collaboration amongst CHSW Team members. Although staff meeting agendas and minutes have not been previously required nor collected from the CHSWT, for the purpose of this review it is important that they are obtained.

Note: Although data to analyze this indicator may not be readily available and needs to be requested directly from the CHSWT, the content and substance of the weekly staff meetings is an important indicator as it reflects how the county is performing across all of the essential core competencies and functions.

INSTRUCTION

INDICATOR 2: RECORD OF WEEKLY STAFF MEETING AGENDAS AND MINUTES

1. Send memo from Deputy Minister for Health Services to the CHSWT to request weekly staff meeting agendas and minutes be sent to County Health Services.

Note: Although in the past there has not been any official guidance on frequency of CHSWT staff meetings, the CHSWT Contracting In Guidelines require that weekly action-oriented meetings be held in order to keep abreast of progress and perform ongoing decision-making. Guidance for content and methodology of staff meetings is found in the CHSWT Contracting In Guidelines

2. Read agendas and minutes and quantify content in the first column

BONUS POINTS

PERIODICITY AND INCLUSIVENESS OF COMMUNICATION

3. Award bonus points for periodicity and inclusiveness of communication (+ or -). If the county consistently holds weekly meetings involving key staff, including the CHO, CHSA, CHDD, Clinical Supervisor, Finance Manager or Accountant, Human Resources Manager, Pharmacist, M&E Officer, Pharmacist, M&E Officer, DHOs, and if the ministry is able to obtain the majority of agendas and minutes from each meeting, then the county is given an additional five (5) points.

QUALITY OF MEETINGS

4. Award bonus points for quality of meetings (+ or -). If the content of the staff meeting minutes shows that the CHSWT is sharing problem-solving as a team, determining action steps, and following through on actions, an additional five (5) points are given.

5. Add up points plus any bonus points awarded to calculate total points
6. Divide total points by total possible points, then multiple by 100 to get a percentage (%) score
7. Enter comments and observations in the last column

It is the responsibility of County Health Services to obtain the meeting minutes and agendas. If the county holds weekly meetings, the total possible score would be twelve (12) for the quarter (100%). Table 4 below provides and example of how this indicator is scored.

EXAMPLE

TABLE 4. INDICATOR 2 – COUNTY RECORD OF REGULAR SCHEDULED STAFF MEETINGS

COUNTY	WEEKLY	BONUS POINTS	TOTAL	COMMENTS / EXPLANATION
# Staff Meetings during Quarter w/minutes	**2**	0	**2**	Zero participation of HR Officer. Question actual existence of resource.
TOTAL SCORE	2	0	**2**	Urgent need for TA in good management and communication practice
TOTAL POSSIBLE SCORE			**12**	
TOTAL SCORE (TOTAL / TOTAL POSSIBLE) X 100			**17%**	COUNTY SAYS THEY HOLD REGULAR WEEKLY MEETINGS, BUT THEY ONLY SUBMITTED RECORDS FOR TWO.

HUMAN RESOURCE MANAGEMENT

INDICATOR 3

Core CHSWT Administrative Positions Filled

There are a number of key CHSWT administrative positions that are to be filled in order for a CHSWT to exercise proper financial management of GoL funds and procurement of goods and services. Those positions are non-negotiable and include: the County Health Services Administrator (CHSA), a Financial Manager, an Accountant or Junior Accountant (or bookkeeper/cashier), a Human Resource Officer, and a Procurement Officer or Logistician in procurement training.

INSTRUCTION

INDICATOR 3: CORE CHSWT ADMINISTRATIVE POSITIONS FILLED

1. The Office of Personnel requests a current organizational chart with names of staff in each position
2. Review the organizational chart. The county is to clearly demonstrate that key administrative positions are filled including: CHSA; Finance Manager or Lead Accountant; Accountant or Junior Accountant or Bookkeeper; Procurement Officer or Logistician in procurement training; Human Resource Officer

Note: If these positions are not filled, the county must demonstrate that they will be within a three-month time frame in order to receive points for this. If the county does not have one or more of these positions filled and it is apparent that no efforts are being made to fill these positions, no points are awarded. If a county has these positions filled, or shows that they are working towards filling these positions (either through proof of public job announcements, training of current staff to fill these positions, or other means), the county receives points (in particular, for the junior Accountant and the Procurement Officer since they have not been specified to the CHSWTs until now).

3. Enter data on administrative positions filled. For each position filled, the county receives one (1) point. If all of positions are filled, the county receives five (5) points (with each point representing 20% of the total.)
4. For unfilled positions, request documented evidence of efforts to fill these positions

BONUS POINTS
SEPARATION OF FUNCTIONS

5. If the county has both a CHO and a Hospital Medical Director as two separate individuals, then the county receives one (1) extra point.

6. Add up total points and multiple by 100% to calculate total percentage (%) score
7. Fill out Comments / Explanation column

Note: Flexibility is important in some of the less populated counties in order to ensure staff is not underutilized. In a smaller county for example, there would be a Finance Manager/Accountant, who reports to the CHSA, and a Procurement Officer, who also reports to the CHSA. The accountant would pay the bills. In this situation there are a total of four positions, so the county would receive 1.25 points for each as each one is worth 25%.

Data for this indicator is collected and analyzed by the Office of Personnel. An example can be found in Table 5 below where four positions are filled, and the fifth position is in the process of being filled; therefore, the county receives a 100% score.

EXAMPLE
TABLE 5. INDICATOR 3 – CORE CHSWT ADMINISTRATIVE POSITIONS FILLED

COUNTY	FILLED	IN PROCESS	NOT IN PROCESS	TOTAL	BONUS	COMMENTS / EXPLANATION
CHSA	1					
FINANCE MANAGER / LEAD ACCOUNTANT	1					
JUNIOR ACCOUNTANT / BOOKKEEPER / CASHIER	1					
PROCUREMENT OFFICER / LOGISTICIAN		1				IN PROCESS OF TRAINING LOGISTICS OFFICER IN PPCC AT THE LIPA IN MONROVIA
HUMAN RESOURCE OFFICER	1					PERSON IS NEW, NEEDS ORIENTATION. STAFF APPRAISALS NOT TAKING PLACE. NEED FOLLOW UP.
TOTAL POSSIBLE SCORE				**5**		
TOTAL SCORE	4	1		**5**		
TOTAL SCORE (TOTAL / TOTAL POSSIBLE) X 100				**100%**		

FINANCIAL MANAGEMENT

INDICATOR 4
Timely and Complete Submission of the Budget Monitoring Reports (BMRs)

The OFM tracks submission of the quarterly BMR by the CHSWTs reflecting expenditures as well as requests for funding for the following quarter.

INSTRUCTION

INDICATOR 4: TIMELY AND COMPLETE SUBMISSION OF THE BUDGET MONITORING REPORTS

1. Obtain and review the last eight (8) quarters of BMRs
2. Score each BMR report with either a Complete "C", and Incomplete "I/C" or a Not Submitted "N/S" score. Each "C" receives a two (2), each "I/C" receives a one (1), and each "N/S" receives a 0.

BONUS POINTS

IMPROVEMENT IN REPORTING

3. Award bonus points in the "trend" column. An additional two (2) points can be obtained if an improvement is seen in reporting. In the "trend" column, make note of an upward (improvement), downward (worsening), or stagnant trend. An upward trend is given two (2) additional points, a downward trend loses two (2) points (-2), and a stagnant trend does not gain nor lose a point. An additional two (2) points can also be obtained if the county implements previous financial management assessment recommendations.

4. Add up points from the eight (8) quarters to calculate total score
5. Divide total score by the total possible score, then multiple by 100 to get a percentage (%) score.
6. In the next column check off if recommendations were implemented for the most part.

Data analysis for this indicator is conducted by the OFM. Table 6 below provides an example of how this is to be done.

EXAMPLE

TABLE 6. INDICATOR 4 – TIMELY AND COMPLETE SUBMISSION OF BUDGET MONITORING REPORTS

COUNTY	1st 2011	2nd 2011	3rd 2011	4th 2011	1st 2012	2nd 2012	3rd 2012	4th 2012	TREND	RECOMMEND -ATION	
BMR	N/S	N/S	I/C	I/C	C	C	C	C	UP = 2	NO = 0	
TOTAL SCORE	0	0	1	1	2	2	2	2			**10 + 2 =12**
TOTAL POSSIBLE SCORE (2 X 8)	2	2	2	2	2	2	2	2			**16**
TOTAL SCORE (TOTAL / TOTAL POSSIBLE) X 100											**75%**

INDICATOR 5

Office of Financial Management (OFM) Regular Quarterly Performance Analysis Scores

The OFM conducts quarterly financial analysis by county and gives each county a score. This score is a composite indicator comprised of eight (8) financial variables.

INSTRUCTION

INDICATOR 5: OFM QUARTERLY PERFORMANCE ANALYSIS SCORES

1. Obtain and review CHSWT quarterly performance analysis scores
2. Give each ranking from the OFM report a numerical score

Note: The OFM analysis ranks the CHSWT, Health Center (HC), and Hospital financial reporting differently between reporting years. In 2010/11 rankings were: "Unsatisfactory", "Satisfactory", "Excellent", or "Not Available"; in 2011/12 rankings were: "Above Average" or "Below Average". Thus, for this analysis, give each ranking from the OFM report a numerical representation.

Excellent or Above Average = five (5);
Satisfactory or Average = three (3); and
Unsatisfactory or Below Average or Not Available = zero (0).

WEIGHTED SCORE

3. Weight the scores. Given the purpose of this exercise and the importance of a strong and capable CHSWT, and since at this time the CHSWT has direct authority and line of supervision over the use of its funding, the most relevant score overall comes from the CHSWT rather than the Hospitals or Professional Schools. Given this, the weight and subsequent number of points allocated for the CHSWT is five (5). The weight allocated for each Hospital and Professional School is one (1). Note: It is important to see in the CHSWT score an upward trend or same score from Year 1 (2010/2011) to Year 2 (2011/2012).

4. Add up the scores from both years and multiply by the weighting to obtain "total points"

BONUS POINTS

IMPROVEMENT OVER TIME

5. Award bonus points in the "trend" column. Extra points can be obtained if, over time, the CHSWT, HC, and/or Hospital show that they are earning better scores based upon OFMs' analysis. Improvement in scores over time indicates an upward or positive trend; likewise, a decline in financial scores over time indicates a downward trend. In the next column, make note of an upward, downward, or stagnant trend. An upward trend in the CHSWT team score is given five (5) additional points, a downward trend loses five points (-5), and a stagnant trend does not gain or lose points.

Note: Regardless of the county's score, if there is a clear downward trend in the CHSWT score, this county is not eligible for contracting in as they do not yet have the capacity to properly manage public funds; good financial management is a non-negotiable and critical capacity.

6. Add total points and trend score to get a total score.
7. Divide total score by total possible, then multiple by 100 to get a percentage (%) score.

The OFM gathers this data and conducts the analysis for this indicator. Table 7 below provides an example of the financial management score chart.

EXAMPLE
TABLE 7. INDICATOR 5 – OFM REGULAR QUARTERLY PERFORMANCE ANALYSIS SCORES

COUNTY	2010 / 2011	SCORE (A)	2011 / 2012	SCORE (B)	WEIGHT (C)	TOTAL POINTS (A+B) X C	TREND	TOTAL POSSIBLE SCORE	SCORE
CHSWT	S	**3**	Above	**5**	5	40	UP = +5	50	45
X Hospital	U/S	0	Below	0	1	0	0	10	0
X School	S	**3**	Average	**3**	1	6	0	10	6
TOTAL POSSIBLE SCORE								**70**	
TOTAL POINTS									**51**
TOTAL SCORE (TOTAL/TOTAL POSSIBLE) X 100									**73%**

HEALTH SERVICES MANAGEMENT AND DELIVERY

INDICATOR 6
Timely and Complete Quarterly Reports

A narrative Quarterly Report that follows MOHSW standard reporting categories on CHSWT activities is submitted on a quarterly basis to County Health Services by the end of the following month (e.g., if the quarter ends on March 31, narrative report is due by April 30).

QUARTERLY REPORTING REQUIREMENTS

1. Written overview of county progress over quarter (1/2 page)
2. List of objectives and planned activities for the quarter
3. Achievement against each planned activity
4. Challenges and Constraints against each planned activity
5. Lessons learned, recommendations from experience that quarter
6. Performance Framework Template for the reporting period

INSTRUCTION

INDICATOR 6: TIMELY AND COMPLETE QUARTERLY REPORTS

1. Review and analyze contents of CHSWT quarterly reports submitted by the CHSWT over the last four quarters
2. Record compliance with each reporting category in the County Quarterly Reporting Score Chart (as seen below), and reflect quarterly reporting over the past four quarters. A one (1) indicates a satisfactory category and a zero (0) indicates an unsatisfactory category.

BONUS POINTS
IMPROVEMENT IN REPORTING

3. Award bonus points. An extra one (1) point can be obtained if the CHSWT has shown improvement in reporting over time. Likewise, if a CHSWT is not consistently reporting, not incorporating all the categories that need to be included, etc., then one (1) point would be lost. No change in reporting neither gains nor loses points and a zero (0) is given.
4. In the next column, make note of any improvement or worsening in reporting.
5. Divide the total score by the total possible, then multiple by 100 to get a percentage (%) score.
6. Fill out Explanation / Comment in last column on spreadsheet

This indicator is analyzed and data are entered by County Health Services. Table 8 provides an example.

EXAMPLE

TABLE 8. INDICATOR 6 – TIMELY AND COUNTY QUARTERLY REPORTS

COUNTY	Q 1st	Q 2nd	Q 3rd	Q 4th	TREND	TOTAL	COMMENTS / EXPLANATION
Any Quarterly Report Submitted	1	1	1	1	1		
Progress Overview	1	0	1	1	1		
Objectives & Activities List	1	1	1	1	1		
Achievements against planned activities	0	1	1	1	1		
Challenges, Constraints against planned activities	0	1	1	1	1		Excellent identification of challenges relative to activities
Lessons Learned Recommendations	1	0	1	1	1		Content, depth of analysis show improvement; recommendations reasonable.
Performance Template Completed	0	1	0	1	1		Unsatisfactory completion; struggling with use of template. TA is needed.
TOTAL POSSIBLE SCORE	7	7	7	7	7	**35**	
TOTAL SCORE	4	5	6	7	7	**29**	
TOTAL SCORE (TOTAL / TOTAL POSSIBLE) X 100					**83%**		

INDICATOR 7
Health Facility Accreditation Scores

The HF Accreditation Scores measure the existence of services and management systems necessary to provide quality health care services.

INSTRUCTION

INDICATOR 7: HEALTH FACILITY ACCREDITATION SCORES

1. Using the MOHSW Accreditation Reports, record both health systems and services scores for each primary care facility (health centers and clinics)
2. Add up both scores to get a total score per HF
3. Divide the total score per HF by two (2) for an average score per HF
3. Add all HF total scores and divide by number of facilities to get an average score
4. Multiple the average score by 100 to get a percentage score

This indicator is analyzed by County Health Services. Table 9 provides an example where the county received a total score of 345 points divided by seven (7) HF; giving this county a 50% accreditation score.

EXAMPLE
TABLE 9. INDICATOR 7 – HEALTH FACILITY PRIMARY CARE ACCREDITATION SCORES

COUNTY / HEALTH FACILITY	TOTAL SCORE % HEALTH SYSTEMS (A)	TOTAL SCORE % HEALTH SERVICES (B)	TOTAL SYSTEMS/SERVICES (A+B) / 2
A Health Center	79	17	48
B Clinic	86	63	75
C Clinic	52	15	34
D Clinic	68	19	44
E Clinic	77	20	49
F Clinic	66	43	55
G Clinic	56	34	45
TOTAL POINTS			**348**
# OF HF			**7**
TOTAL SCORE (TOTAL POINTS / # HF) X 100			**50%**

HEALTH MANAGEMENT INFORMATION SYSTEMS AND MONITORING AND EVALUATION

INDICATOR 8

Priority Service Delivery Coverage Rates as Compared to Targets (e.g. ANC4, Penta3, IPT2, Measles)

CHSWT targets are based upon the previous year coverage. This indicator measures two things:

- ✓ Achievement in reaching yearly coverage targets by service delivery indicator; and,
- ✓ Skill in setting realistic yearly targets.

INSTRUCTION

INDICATOR 8: PRIORITY SERVICE DELIVERY COVERAGE RATES AS COMPARED TO TARGETS

1. Chart the past three (3) years of Fiscal Year (FY) coverage data for ANC4, Penta3, IPT2 and measles as reported by the county through the HMIS
2. Below each service delivery indicator, record the past three (3) years target coverage rate as identified by FY in the Yearly Operational Plan
3. Calculate achievement by looking at percentage (%) of actual coverage versus targeted coverage and award points for proximity of target.

Ranges for scoring are reflected below:
0 – 49% of target = 0 points
50 – 74% of target = .5 points
75 – 84% of target = 1.0 points
85- 100% of target = 1.5 points

BONUS POINTS

IMPROVEMENT OVER TIME

4. Award Bonus Points by giving one (1) extra point for improvement trend upwards in approximation of coverage rate to target set. A decrease in coverage will not be penalized.

NOTE: For this indicator, the total possible score is one point five (1.5) per year over three (3) years is equal to four point five (4.5) points plus one (1) additional point for a positive trend in coverage is equal to a total of five point five (5.5) for each indicator. Multiple five point five (5.5) points by 4 indicators for a total possible score of 22 points.

5. Divide the total score by the total possible, then multiple by 100 to get a percentage (%) score.
6. Fill out Explanation / Comment in last column on spreadsheet

The M&E Department will carry out this analysis. However the M&E Department together with HMIS and Health Services is to discuss the insertion of comments and how to adjust this score accordingly in order to consider any confounding factors such as counties bordering other countries with transient and/or migrant populations and for the capitol city. For example, if it is known that a particular county finds itself in a situation whereby Penta1 may be lower than Penta3, this county *will not* be penalized for special circumstances such as counties that border other countries or Montserrado County, as it is the capitol of the county and by nature residents of the other counties may find themselves frequently traveling to Monrovia to seek healthcare services. Table 10 below provides an example of this scoring.

EXAMPLE

TABLE 10. INDICATOR 8 – PRIORITY SERVICE DELIVERY COVERAGE RATES AS COMPARED WITH TARGETS

	INDICATOR	YEAR 1 (A)	YEAR 2 (B)	YEAR 3 (C)	ACHIEVE A+B+C = (D)	TREND (E)	TOTAL SCORE (D+E)	COMMENTS
1	ANC 4	54	65	75		UP =1		
2	TARGET	60	70	75				
	% ACHIEVEMENT [1/2]	90 = 1.5	93= 1.5	100 = 1.5				
	SUBTOTAL				4.5	1	**5.5**	
4	PENTA 3	62	70	75		UP=1		
5	TARGET	50	60	70				
	% ACHIEVEMENT [4/5]	124= 1.5	117= 1.5	107= 1.5				
	SUBTOTAL				4.5	1	**5.5**	
6	IPT 2	30	20	45				ERRATIC TREND – UP/DOWN/UP – NO EXTRA POINTS GIVEN
7	TARGET	35	50	50				
	% ACHIEVEMENT [6/7]	86= 1.5	40= 0	90= 1.5				NATMALPR & GF EMERGENCY BEDNET DISTRIBUTION STRATEGY
	SUBTOTAL				3		**3**	
8	MEASLES	10	26	35		UP=1		EPI WORKED W/COUNTY ON TARGET SETTING; MUST FOCUS ONLOST OPPORTUNITIES.
9	TARGET	30	35	45				
	% ACHIEVEMENT [8/9]	33= 0	74= .5	78= 1				
	SUBTOTAL				1.5	1	**2.5**	
	TOTAL POSSIBLE SCORE						**22**	
	TOTAL SCORE						**16.5**	
	% SCORE (TOTAL / TOTAL POSSIBLE) X 100						**75%**	OVERALL GOOD SCORE, HOWEVER MEASLES STILL LOW AND OF CONCERN

INDICATOR 9
Accuracy in HMIS Reporting (Penta3)

Accuracy in HMIS recording and reporting is captured by the PBF Unit and calculated on a quarterly basis as part of the unit's data verification exercise.

INSTRUCTION

INDICATOR 9: ACCURACY IN REPORTING

1. Obtain accuracy in reporting of Penta3 over the previous four (4) quarters
2. Record these percentage scores
3. Add up the four (4) quarter scores, divide by four (4) to obtain an average final percentage score.

BONUS POINTS

IMPROVEMENT OVER TIME

4. Ten (10) extra points can be obtained for an improvement trending upwards in reporting accuracy. A worsening in reporting accuracy will not be penalized.
5. Add up the Average Score plus the Bonus Points to get a percentage (%) score.
6. Fill out Explanation / Comment in last column on spreadsheet

The M&E Unit carries out this analysis with support from the HMIS Department. Table 11 below provides an example of how accuracy in reporting score is obtained.

EXAMPLE
TABLE 11. INDICATOR 9 – ACCURACY IN HMIS REPORTING (PENTA3)

COUNTY	Q 1st % (A)	Q 2nd % (B)	Q 3rd % (C)	Q 4th % (D)	AVERAGE (E) (A+B+C+D)/4	TREND (F)	COMMENTS / EXPLANATION
Accuracy in HMIS reporting Penta3	35	60	73	76		UP+10	MODEL COUNTY ON IMPROVEMENTS, CENTRAL SENT A M&E STAFF TO SPEND 5 FULL DAYS IN THE COUNTY WORKING WITH THE M&E OFFICER
TOTAL SCORE					**61**		
% SCORE (AVERAGE SCORE + BONUS POINTS)						**71%**	

Supply Chain Management of Essential Medicines and Supplies

Indicator 10
Availability of Tracer Drugs by Month

Using the Logistics Management Information System (LMIS) from the Supply Chain Management Unit (SCMU), this indicator tracks the availability of tracer drugs by month.

Instruction

Indicator 10: Availability of Tracer Drugs by Month

1. Record the total percentage (%) of available tracer drugs by month for the past six (6) months
2. Award points for availability of tracer drugs using the ranges.

Ranges for scoring are reflected below:
0 – 49% of target = 0 points
50 – 64% of target = .5 points
65 – 79% of target = 1.0 points
80- 100% of target = 1.5 point

Bonus Points
Improvement over Time
3. Award bonus point. One (1) extra point can be obtained for improvement trend upward in stock availability. A downward trend or decrease in availability will not be penalized.
4. Calculate the total by adding up the points from all six months plus the bonus point if applicable.
5. Divide total points by total possible points and multiply by 100 to get a percentage (%) score.

The SCMU conducts this analysis. Table 12 provides an example of this scoring.

Example
Table 12. Indicator 10 – Availability of Tracer Drugs

County	Month 1 (A)	Month 2 (B)	Month 3 (C)	Month 4 (D)	Month 5 (E)	Month 6 (F)	Trend (G)	Total (A+B+C+D +E+F+G)	Comments
%	68	56	63	72	75	80	Up=1		
Total Points	1	.5	.5	1	1	1.5	0	5.5	
Total Possible Score	1.5	1.5	1.5	1.5	1.5	1.5	1	10	
Total score (Total points / Total Possible) x 100								**55%**	Resident advisor in county from DELIVER or CHAI

STEP 3 DEVELOP RANKING MASTER TABLES

It is important to recognize the limitations of an analysis of any one of these indicators in isolation; therefore, ranking of county performance will depend upon performance across indicators and weighting for a number of factors. In addition, the MOHSW may also consider any information or extenuating circumstances in performance, including major disasters or epidemics, bottlenecks or delays in availability of drugs due to National Drug Supply (NDS) stock outs, change in leadership, and political or social upheaval, among others that may affect county performance on any one indicator and/or future ability to be contracted by the MOHSW.

This analysis serves as important information for identification of areas that the CHSWT needs to improve upon through targeted Technical Assistance (TA) in either leadership and governance, service delivery management, financial management, or/and service delivery or any other areas identified during the review. In addition it allows the MOHSW to have a comparative picture of how all CHSWTs are performing under a de-concentrated health and social welfare system. Also the Contracting In Review Committee will be able to clearly determine which counties are the top performers based upon objective criteria and are therefore eligible for continued and increased funding.

INSTRUCTION

STEP 3: DEVELOP MASTER RANKING TABLES

1. Once data have been collected and analyzed across all categories by each of the participants responsible for that category, call a meeting of the Contracting In Review Committee
2. Enter the final results as a team into a CHSWT Preliminary Ranking Master Table.
3. Construct a separate Master Table for each county for a total of 15 counties.
4. Display the Master Table results through a projector for committee members to collectively view results to have an initial comparison of performance across counties.

NOTE: The weighting of indicators for an analysis of CHSWT competency is included in the table. As mentioned previously, weighting is done since some criteria bear a greater weight than other criteria during this initial pre-qualification analysis.

Note: In the Health Service Management and Financial Management categories, a county must score at least a 70% to pre-qualify.

Table 13 provides an example of a master table. Looking across all indictors, the county in the example below received a total score of 75%. Although this is a low score, this county does pre-qualify to be considered for the next step. In addition, it is important to recognize that this county had high scores on the Leadership and Governance category as well as the Financial Management and Procurement category, which shows a serious commitment to transparency and accountability on the part of that county. Regardless of a county's total score, the MOHSW takes into consideration whether a county performs substantially worse in any of the categories than they do on their overall score when considering whether a county pre-qualifies for performance contracting.

EXAMPLE
TABLE 13. RANKING MASTER TABLE

	CORE COMPETENCY AND INDICATORS	SCORE %	WEIGHT	POSSIBLE SCORE	SCORE	SUBTOTAL
	Leadership and Governance			400		
1	Submission of quarterly CHSW Board meeting minutes & Collaboration with Office of County Superintendent	88	2		175	
2	Weekly CHSWT meeting agendas and minutes	17	2		33	
	SUBTOTAL					**208**
	Human Resource Management			200		
3	Core CHSWT Administrative Positions Filled	100	2		200	
	SUBTOTAL					**200**
	Financial Management and Procurement			450		
4	Quarterly BMR Submission	75	3		225	
5	Office of Financial Management (OFM) analyses	73	3		219	
	SUBTOTAL					**444**
	Health Services Management and Delivery			300		
6	Timely & Complete Quarterly Reports	83	2		166	
7	Health Facility Accreditation scores	50	1		50	
	SUBTOTAL					**215**
	HMIS and M&E			200		
8	Priority Service delivery Coverage Rates Compared to Targets (e.g. ANC4, Penta3, IPT2, measles)	75	1		75	
9	Accuracy in HMIS Reporting (Penta3)	71	1		71	
	SUBTOTAL					**146**
	Supply Chain Management of Essential Drugs and Supplies					
10	Availability of Tracer Drugs	55	1		55	
	SUBTOTAL					**55**
	POSSIBLE TOTAL SCORE					1700
	TOTAL					**1268**
	TOTAL SCORE (TOTAL SCORE / POSSIBLE SCORE) X 100					**75%**

NOTE: Only the top performers, those that receive a score of 70% or greater are pre-qualified for Contracting In and therefore eligible for performance contracts with the MOHSW. The pre-qualified counties go onto Step 4 of the review – CHSWT Self-Assessment.

STEP 4 CONDUCT CHSWT SELF-ASSESSMENT

Once the Committee has determined which counties have pre-qualified for performance contracts or for continued funding of existing contracts (e.g. the top performing counties with a score of 70% or greater), the next step in the re view is to ask these counties to conduct a self-assessment through a self-guided questionnaire.

CATEGORIES FOR SELF-ASSESSMENT

- ✓ Leadership and Governance;
- ✓ Human Resource Management;
- ✓ Financial Management and Procurement;
- ✓ Health Services Management and Delivery;
- ✓ Health Management Information Systems and Monitoring and Evaluation for Decision-Making;
- ✓ Supply Chain Management of Essential Medicines and Supplies

The self-assessment is based upon the same core competencies that the CHSWT is expected to perform and parallels the ***Contracting In Guidelines CHSWT Summary of Procedures, Processes and Core Competencies*** and the MOHSW Capacity Assessment Tool. Each functional area (or core competency) contains a checklist with a series of questions or a statement intended to encourage the CHSWT to focus on what they need to have in place to be ready to be contracted or/and continue to be under contract by the MOHSW. It is designed to help the CHSWT reflect on how they see the county's various systems performing within each functional area. While there is no quantitative scoring done by the CHSWT, the tool serves to help the CHSWT determine areas for improvement and to facilitate discussion between the MOHSW and the county on identifiable gaps in performance hence serving as a monitoring tool as well.

Note: The Self-Assessment Forms found in Annex III serve as a regular self-monitoring tool for all CHSWTs to apply on an annual basis as a tool to encourage self-reflection on county performance regardless as to whether they are under consideration for performance contracting.

INSTRUCTION

The Deputy Minister for Health Services sends a memo to the CHSWTs with a copy of the self-assessment forms and notifies them that they have two weeks to complete the assessment. Once the county has received the forms, the assessment itself is to be led by the CHO and conducted collectively with all members of the senior management team in the county that includes but is not limited to:

- ✓ CHO;
- ✓ Medical Director;
- ✓ CSHA;
- ✓ Hospital Director and Hospital Administrator if applicable;
- ✓ CHDD;
- ✓ County Clinical Supervisor;
- ✓ Finance Manager/Lead Accountant;
- ✓ Procurement Officer and/or Logistician
- ✓ County Pharmacist;
- ✓ Human Resource Manager;
- ✓ Monitoring and Evaluation and Research Manager; and,
- ✓ District Health Officers

Each CHSWT member is to respectively fill out the sections that correspond to their work. All forms are to be reviewed by the CHO and CHSA once they are completed and prior to submission to the Review Committee.

Annex II contains draft language for the memo to be sent to qualified CHSWTs requesting that they fill out the Self-Assessment Forms and outlining the Field Verification visit from central MOHSW.

Annex III contains the self-assessment forms for each core competency area and instructions for filling them out that are to be sent to the CHSWTs that pre-qualified during Step 3.

STEP 5 CONDUCT FIELD VERIFICATION

After the pre-qualified counties conduct their self-assessments and send the forms back to the County Health Services Department, the Review Committee meets to discuss the results and plan for field visits. During Step 5, the MOHSW verifies the CHSWT self-assessment results in order to follow up on any areas that are of concern, that may have arisen during the Pre-Qualification determination (Step 3), or that arise during review of the Self-Assessment forms.

The purpose of the field visits is to verify the information on the CHSWT Self-Assessment form, further investigate county capacity, and discuss the CHSWT self-assessment responses with the respondents. This visit is also devised such that the Review Committee has a chance to dialogue with the CHSWT management team regarding areas that they may discover need further strengthening and support from the ministry or partners prior to contracting in with the CHSWT.

Each member of the Review Committee will arrive in the county with a hard copy of the Self-Assessment forms. These forms will serve as the basis for discussions with the county to both verify what the county states their performance to be as well as dialogue around what the ministry team actually discovers. All areas and responsibilities that are on the Self-Assessment forms are to be covered during these discussions.

At the end of the day upon completion of the site visit, the MOHSW team meets with senior leadership and management of the CHSWT to have an interactive discussion on any discrepancies found between the CHSWT Self-Assessment Form and the MOHSW verification. Someone from the MOHSW takes notes in order to have a written record of the discussion and record agreements (or disagreements) resulting from the discussion and findings.

The instructions for team composition and tasks along with an illustrative agenda follow.

Note: Those counties that did not pre-qualify for contracting in as well as all other counties that filled out the Self-Assessment forms from Step 4 also require that Field Verficiation Step 5 takes place as part of the ministry's efforts to build capacity of all of the CHSWTs.

INSTRUCTION

STEP 5: CONDUCT FIELD VERIFICATION
TEAM COMPOSITION AND TASKS

TEAM1: Examines Leadership and Governance through meeting with Superintendent's office, individual discussions with CHSWT leadership and review of Human Resource Management. Comprised of one (1) staff from Administration (Personnel), one (1) staff from County Health Services, one (1) from Planning = *Team of three (3)*

- ✓ Visit to the Superintendent's office
- ✓ Meet with staff from the CHSWT to get their views on what they consider to be strengths and limitations in management and communication amongst CHSWT management
- ✓ Review of CHSWT headquarters files, shelves, notices, etc. to check for availability of guidelines, protocols and standards, and operating regulations.
- ✓ Review of all HR files.

TEAM 2: Covers review of health services files and records, HMIS and M&E files, and SCM of Essential Medicines and Supplies at CHSWT Headquarters. Comprised of two (2) staff from Health Services (Health Services, SCMU) and two (2) staff from Planning (M&E Unit, HMIS Unit) = *Team of Four (4)*

- ✓ Review of service delivery, clinical and supervision files in headquarters office including supportive supervision records and feedback provided by county to HF
- ✓ Review of all M&E and HMIS files
- ✓ Review of pharmacy management and implementation of SCM protocols and procedures
- ✓ Review of surveillance data and community health calendar of events and meetings

TEAM 3: Covers review of all finance, accounting, banking and procurement files and processes. Comprised of two (2) staff from Administration (OFM and Procurement). Note: If county is not really conducting procurement than substitute procurement staff for one (1) from Administration (Personnel) = *Team of two (2)*

- ✓ Meeting of the Administrative team: CHSA, Finance Manager / Head Accountant, Junior Accountant / Bookkeeper, Procurement Officer
- ✓ Review of files and records

STEP 5: CONDUCT FIELD VERIFICATION

FIELD VISIT AGENDA

08:00 – 9:00 ***Technical Review Committee arrives***

- ✓ Convene meeting between CHSWT senior management and supervisors and Review Committee to introduce the teams, discuss the purpose of the Contracting In Guidelines, and explain the verification visit process. (Review Committee/County Health Services)
- ✓ Assign individuals to each of the three working groups (Review Committee)
- ✓ Assign individuals from CHSWT to each of the three working groups (county)
- ✓ Identify work space and agree upon time and place to re-convene (county)

09:00 - 4:00 ***Self-assessment forms are validated***

- ✓ Three (3) working groups meet to review assessment forms, and to verify self-assessment form content through review of files, records, data, observation, and informal discussions (Review Committee and county)

4:00 – 5:00 ***Share Feedback and Discuss Verification Findings***

- ✓ Re-convene CHSWT senior management and Review Committee to discuss verification team findings, any discrepancies between the CHSWT self-assessment and the verification team findings and the way forward. (Review Committee and county)
- ✓ One representative from central from each working group reports on findings – five (5) minutes each. (Review Committee)
- ✓ Additional members from central may add to findings after each reporting (Review Committee)
- ✓ Members from the CHSWT may add their comments or observations (county)
- ✓ The Review Committee summarizes the self-assessment verification exercise findings and next steps in regard to capacity strengthening (Review Committee)

STEP 6 CONVENE REVIEW COMMITTEE - MAKE RECOMMENDATIONS

Once all site visits have been made, County Health Services convenes a meeting of the Contracting In Review Committee to discuss findings from all three stages of analysis – Desk-based (Steps 2 and 3), Self-Assessment (Step 4), and Field Verification (Step 5). This office ensures that there are separate files/folders for each county containing the following:

- ✓ Pre-qualification data and the Pre-qualification Master Table;
- ✓ The CHSWT Self-Assessment Form;
- ✓ The memo recording the discussion between the MOHSW and CHSWT on the Readiness Review Committee Site Visit Form versus Self-Assessment Form

Make a final decision as to which county is ready for performance contracting based upon the step analyses described in these guidelines.

Issue a written recommendation of the Review Committee to the Minister of Health and Social Welfare, the Chief Medical Officer / Deputy Minister for Health Services, the Deputy Minister for Planning, the Deputy Minister for Administration, and the Deputy Minister for Social Welfare as to which counties are ready to be contracted under a performance contract or/and which are deemed competent for continued performance contract funding. In that recommendation, also include any relatively minor areas that the Review Committee determines could be easily strengthened in the short-term prior to actual contracting. These areas are to be those that could be improved upon with minimal effort over the next quarter. Identify not only the specific area that could be strengthened (e.g. SCM inventory and stock sheets, documentation of procurement bids, HR recruitment processes, relationship with local governance structure, recording of minutes and action steps, ANC visits, etc.), but also how this could be done (e.g. refresher training in treatment guidelines, workshop on team-building and management, targeted assistance from OFM on accounting procedures, overview of PPCC practice, etc.), how it would be funded (e.g. MOHSW budget, a particular project or partner, an international organization, etc.), and a deadline for ensuring that capacity is built.

In addition, the Review Committee drafts a memo to each of the CHSWTs that went through the self-assessment and validation process (Steps 4 and 5) documenting the discussion between the Review Committee and the CHSWT during the visit. This memo documents convergence on areas to strengthen as well as any discrepancies found between the self-assessment form and the verification by the MOHSW. This is done for each county visited and serves as documentation of the process and interactions between the ministry and the county as well as gaps identified, steps to attempt to fill those gaps, and an estimated timeline for each activity and responsible party. An original memo is sent to the CHSWT, a copy is provided to the Office of the Chief Medical Officer, the Deputy Minister of Planning, the Deputy Minister of Administration and any donor agency that may potentially fund performance contracts between the MOHSW and a CHSWT through a contracting in mechanism.

STEP 6: CONVENE REVIEW COMMITTEE – MAKE RECOMMENDATIONS

1. Once all site visits have been completed, convene a meeting of the Contracting In Review Committee to discuss findings from all three stages of analysis – Desk-based (Steps 2 and 3), Self-Assessment (Step 4), and Field Verification (Step 5). The meeting is convened by County Health Services. This office ensures there are separate files for each county containing the following:

- ✓ Pre-qualification data and the Pre-qualification Master Table;
- ✓ The CHSWT Self-Assessment Form; and,
- ✓ The memo recording the discussion between the MOHSW and CHSWT on the Readiness Review Committee Site Visit Form versus Self-Assessment Form.

2. Review and discuss findings from the process to date and make a final decision as to which counties are ready to be contracted under a performance contract or/and which are deemed competent for continued performance contract funding.

3. Issue a written recommendation through a memo of the Review Committee to:

- ✓ The Minister of Health and Social Welfare;
- ✓ The Chief Medical Officer / Deputy Minister for Health Services;
- ✓ The Deputy Minister for Planning;
- ✓ The Deputy Minister for Administration; and,
- ✓ The Deputy Minister for Social Welfare

Table 22 below provides an example of an action-oriented capacity-building plan. In that recommendation include a plan identifying the following:

- ✓ Any relatively minor areas that could be improved upon with minimal effort over the next quarter prior to actual contracting;
- ✓ The specific areas that could be strengthened (e.g. SCM inventory and stock sheets, documentation of procurement bids, HR recruitment processes, relationship with local governance structure, recording of minutes and action steps, ANC visits, etc.);
- ✓ How this could be done (e.g. refresher training in treatment guidelines, workshop on team-building and management, targeted assistance from OFM on accounting procedures, overview of Public Procurement practice, etc.);
- ✓ How this may be funded (e.g. MOHSW budget, a project or partner, an international organization, etc.); and,
- ✓ A deadline for ensuring that capacity is built.

4. Draft a memo to each of the CHSWTs that went through the self-assessment and validation process (Steps 4 and 5) documenting the discussion between the Review Committee and the CHSWT during the visit. This memo documents convergence on areas to strengthen as well as any discrepancies found between the self-assessment form and the verification by the MOHSW. This is done for each county visited and serves as documentation of the process and interactions between the ministry and the county as well as gaps identified, steps to attempt to fill those gaps, and an estimated timeline for each activity and responsible party. An original memo is sent to the CHSWT, a copy is provided to the Minister of Heath and Social Welfare, the Office of the Chief Medical Officer / the Deputy Minister of Health Services, the Deputy Minister of Planning, the Deputy Minister of Administration and any donor agency that may potentially fund performance contracts between the MOHSW and a CHSWT through a contracting in mechanism.

STEP 6: CONVENE REVIEW COMMITTEE – MAKE RECOMMENDATIONS
NON-QUALIFIED CHSWTS

1. Record a list of those counties that are not yet eligible to be contracted.
2. Draft a memo to each CHSWT with a copy to MOHSW senior management team that includes a list of specific areas each county needs to strengthen in order to become eligible for contracting in during the next technical review and a capacity-building matrix using the action-oriented format shown in Table 22 for each county that will build the CHSWT capacity prior to the next review. This CHSWT capacity-building plan is an initial draft developed by the ministry for review and negotiation with the CHSWT. It identifies the following:

- ✓ Specific functional areas and within each area sub-categories for improvement/strengthening;
- ✓ Resources, technical support / technical assistance / advisors available for each functional area;
- ✓ Funding sources for capacity-building if easily identified;
- ✓ Timeline for provision of capacity-building;
- ✓ Responsible MOHSW office or/and partner for ensuring that capacity-building is provided; and,
- ✓ Monitoring and evaluation of capacity-building activities.

Table 14 below contains an illustrative example of a CHSWT Capacity-Building Plan Matrix.

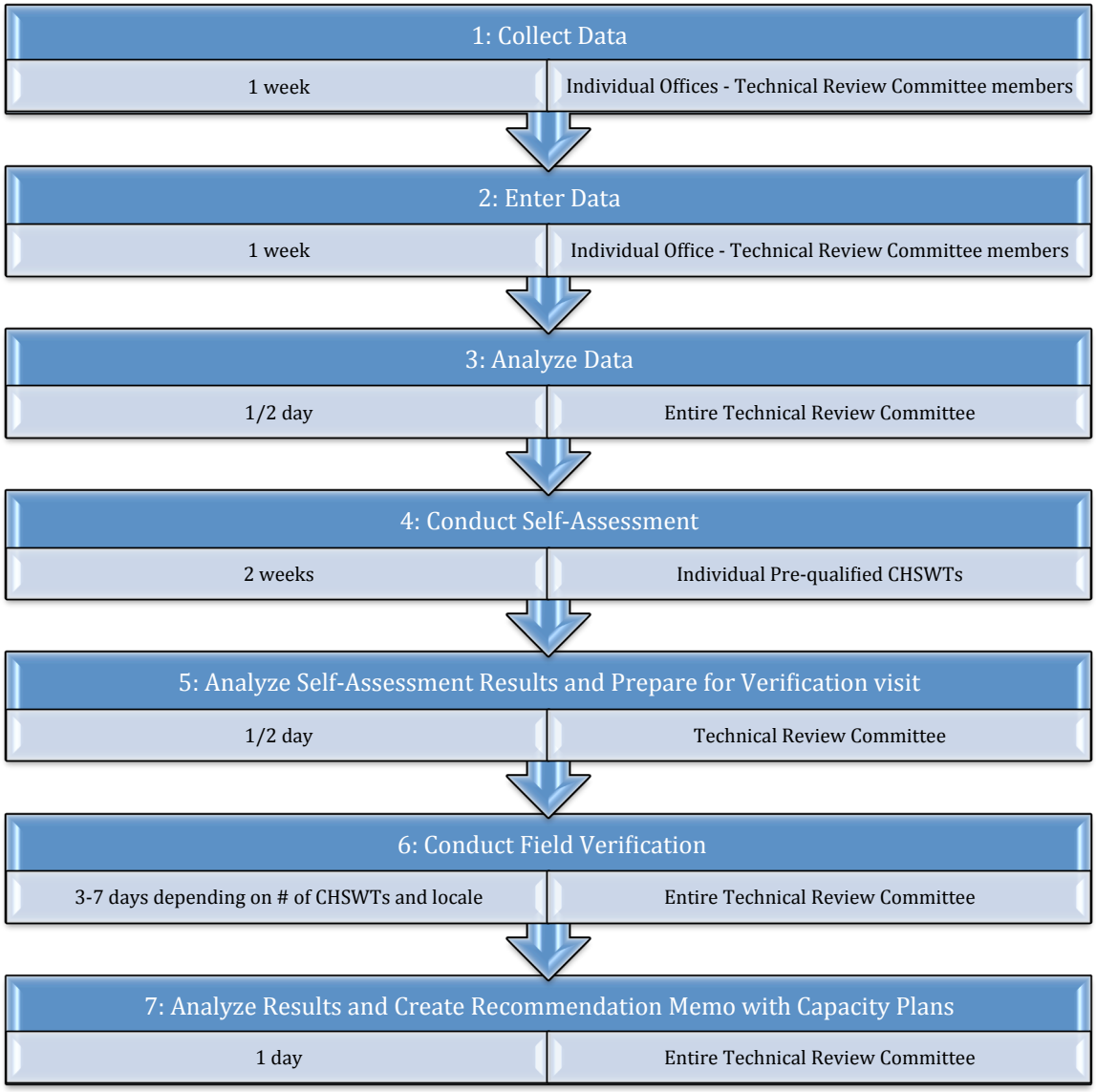
TABLE 14. ILLUSTRATIVE EXAMPLE OF A CAPACITY-BUILDING PLAN MATRIX

CORE COMPETENCY (INTERVENTION)	TARGET RECIPIENTS	RESPONSIBLE PARTY FROM CHSWT	MOHSW	TECHNICAL PARTNER	TIME FRAME	SOURCE OF FUNDING
LEADERSHIP AND GOVERNANCE Workshop on health planning; On-the-job mentoring	DHOs	HR, CHDD, CHSA	Office of Personnel	RBHS	3/2013	RBHS
FINANCIAL MANAGEMENT Budgeting, short workshop; with on-the-job follow up mentoring	DHO and HF	CHSA	OFM	CHAI	9/2013	OFM & CHAI
HEALTH SERVICES Supportive Supervision to HF ½ day workshop on provision of supervision feedback to HF	CHDD, CHSD, focal points -	CHDD	County Health Services -		10/2013	County Health Services
HEALTH SERVICES Reporting, planning, outreach. Quarterly OIC/CM meetings	HF – OIC and CM	RH Focal Point, CHSA	_____		4/2013	CHSWT
HEALTH SERVICES Supervision Community Refresher training in Community Health and Clinical Supervision	DHOs	HR Manager with back up CHDD	Community Health Division	TBD	9/2013	MOHSW
HEALTH SERVICES Supervision of Community Health, hold 2-hour workshop	DHOs	HR Manager & CHDD	Community Health Division	TBD		MOHSW
SUPPLY CHAIN MANAGEMENT Drug Inventory & Projections ½ day training	Pharmacy, Dispensaries	CHO	SCMU	USAID DELIVER	9/2013	USAID DELIVER

ANNEX I TERMS OF REFERENCE TECHNICAL REVIEW COMMITTEE

Each step in the MOHSW Contracting In Readiness Review and Assessment will require some action on the part of each of the Technical Review Committee members. The figure below depicts how long each step will require and who will be held responsible for completing each step.

With the exception of Step 4: Conduct Self-Assessment, the MOHSW Technical Review Committee is responsible for carrying out the entire Contracting In Review and Assessment process.



Individual Review Committee members are responsible for the following tasks:

Initial Individual Tasks - Individuals will be notified by memo and email as to which counties have been selected for review. Input Contracting In Indicator data into MOHSW excel spreadsheets.

a. Gathering data corresponding to each technical area.
b. Entering data corresponding to each technical area within one week of notification by memo.

The following are the data and source of those data that need to be collected and entered into the spreadsheet:

DATA NEEDED	QUANTITY OF DATA	DATA SOURCE
Quarterly CHSW Board Meeting minutes	Previous 4 quarters	Health Services/County Health Services
CHSWT Weekly Staff meeting agendas/minutes	Previous quarter	CHSWT / County Health Services
HMIS Priority Coverage Rates	Previous 3 years	Planning/HMIS - DHIS
Operational Plan Targets for indicators	Previous 3 years	Planning/HMIS
Reporting Accuracy for Penta3	Previous 2 years	Health Services/PBF Unit
Quarterly Narrative Reports	Previous 4 quarters	Health Services/County Health Services
Accreditation Scores	Previous year	Health Services/County Health Services
Monthly Budget Monitoring Reports	Previous 6 months	Administration/OFM
OFM Financial Analysis Scores	Previous 4 quarters	Administration/OFM
Staffing-Administrative Positions with names of staff	Current actual	Administration/Personnel
Availability of Tracer Drugs	Previous 6 months	Health Services/SCMU

c. Saving the spreadsheet version on a flash drive (one per committee member) with committee member's name and the date.
d. Following Step 2 of these Guidelines for a detailed description of Review Committee tasks and responsibilities.

Meeting one (1) of Review Committee - Review Committee convenes to identify CHSWTs that pre-qualify for contracting in. All individual members participate in all Technical Review Committee meetings.

a. Bringing data previously input onto spreadsheet on a flash drive.
b. Entering each member's data into spreadsheet and link to master table.
c. Reviewing data from the individual indicator entry and subsequent Review Committee analysis as they are linked to the master spreadsheet.
d. Developing a list of pre-qualified counties based upon county analysis.
e. Preparing a memo for signature of pre-qualified CHSWTs to be sent out the Self-Assessment form and instructions to those counties that pre-qualified.
f. Following Step 3 of these Guidelines for a detailed description of Review Committee tasks and responsibilities.

Meeting two (2) of Review Committee - Review the CHSWT Self-Assessment forms

a. Reviewing as a team each of the individual CHSWT Self-Assessment forms in order to understand the county's self-identified strengths and gaps.

b. Planning for verification visits based upon these forms, geographic location of the CHSWTs, Ministry and CHSWT activities, and Review Committee member schedules,
c. Following Step 3 and 4 of these Guidelines for a detailed description of Review Committee tasks and responsibilities.

Review Committee Field Verification - Verify results of CHSWT Self-Assessment

a. Conducting site visits to each of the pre-qualified CHSWTs. The purpose of the visit is to verify the information on the CHSWT Self-Assessment form, further investigate county capacity, and discuss the CHSWT self-assessment responses with the respondents as described in Step 5 of these guidelines.
b. Meeting with senior management of the CHSWT to discuss any discrepancies found between the CHSWT Self-Assessment Form and the MOHSW verification upon completion of the site visit.
c. Taking notes on discussions. One individual from the Review Committee will need to take notes in order to have a written record of the discussion and record agreements (or disagreements) resulting from the discussion and findings.
d. Following Step 5 of these Guidelines for a detailed description of Review Committee tasks and responsibilities.

Meeting three (3) of Review Committee – Make recommendations and develop capacity-building plan

a. Contributing to recommendation discussions and final memo. The end product is a memo containing notes on the discussion between the MOHSW and the CHSWT on any discrepancies found between the self-assessment form and the verification by the MOHSW. This memo should also contain capacity-building matrices for each CHSWT as illustrated in Table 14 of these guidelines.
b. Following Step 6 of these Guidelines for a detailed description of Review Committee tasks and responsibilities.

ANNEX II - DRAFT MEMO TO CHSWT

From: Dr. Bernice Dahn
Chief Medical Officer
Ministry of Health & Social Welfare

To: Dr. _____ [*CHO*]
County Health Officer
_____ [*county*] CHSWT

Subject: Contracting In Readiness Review Process – CHSWT Self-Assessment

Date: November 12, 2013

The Technical Review Committee of the Ministry of Health and Social Welfare has determined that _____ [*name of county*] county, per the *Contracting-In Guidelines: Readiness Review and Assessment of CHSWT Performance* has been qualified to take place in a CSHWT self-assessment of your county's performance.

The purpose of the guideline is to determine individual county readiness to be contracted "in". This guideline was developed to support the ministry's efforts to decide which CHSWT is performing at a level that would qualify them to be contracted "in" by the MOHSW. It serves as a companion guideline to the CHSWT Contracting-In Guidelines: Summary of Processes, Procedures and Core Competencies which all counties are required to be implementing at this time.

On _____[*date of field verification visit*] the Technical Review Committee will spend the day verifying the information that your team provides on the Self-Assessment forms. A team of eight (8) individuals from Central Ministry, comprising of Planning, Administration and Health Services will be visiting the county to conduct this verification. Prior to the field visit, I ask that you please fill out the attached ***Self-Assessment Forms***, which are designed to extract information concerning how well your county systems are functioning from your perspective.

Do not hesitate to contact _____ [*name*] or _____ [*alternate name*] for further information or clarity.

The forms must be completed in their entirety and then be sent to _____ [*name*] County Health Services by noon on _____ [*date*]. Please note that instructions for filling out the form follow at the end of this communication.

ANNEX III – CHSWT SELF-ASSESSMENT FORM AND PROCESS

INSTRUCTION

Brief overview of the MOHSW Contracting In Guidelines

The purpose of the MOHSW Contracting In Guidelines is to determine individual county readiness to be contracted "in". These guidelines were developed to support the ministry's efforts to decide which CHSWT is performing at a level that would qualify them to be contracted "in" by the MOHSW. It serves as a companion guideline to the "CHSWT Contracting-In Guidelines: Summary of Processes, Procedures and Core Competencies" which all counties are required to be implementing at this time.

Brief overview of the form

The Self-Assessment is based upon a self-guided questionnaire that is to be filled out by the CHSWT members. Each functional area contains a checklist with a series of questions or a statement intended to encourage your team to focus on what needs to be in place to be ready for contracting-in by the MOHSW. While there is no quantitative scoring done by the CHSWT, the tool serves to help the county determine areas for improvement as well as for ongoing self-monitoring of performance.

Step-by-step guide to fill-out the forms

1. The CHO should convene a meeting of the CHSWT senior management that includes but is not limited to: CHO, CSHA, Hospital Director, Hospital Administrator, CHDD, Finance Manager/Lead Accountant, County Pharmacist, Human Resource Manager, Monitoring and Evaluation and Research Manager, District Health Officers to review the forms together and assign team members to fill out them out in their entirety.
2. Each CHSWT member is to respectively fill out the sections that correspond to their work. For example, questions related to Financial Management are filled out by the Finance Manager or Lead Accountant, questions related to Human Resource Management are filled out by the HR Officer, and so on.
3. CHSWT reviews the forms to ensure that team members are in agreement with the content of the self-assessment. All forms are to be reviewed in final by the CHO and CHSA once they are completed and prior to submission to the Review Committee.
4. Send the completed forms back to the Technical Review Committee representative from County Health Services.

Explanation of the forms by column

1. First column defines what should be in place in the county;
2. Second column allows the respondents to rank CHSWT's status as: Excellent "E," Satisfactory "S," or Unsatisfactory "U/S";

3. Third column provides the CHSWT with an opportunity to indicate whether further capacity is needed and should have a check mark in the box corresponding to the particular gap area.
4. Fourth column allows for the CHSWT to provide further explanation as to the reasons for a particular ranking, or/and progress underway with specific description of what is currently being done to build capacity, or/and any attempts that have been made to build capacity and a description of those requests including to whom they were made and the date.

Practical example

For example, in the fourth column, if the criteria says: "Established and functioning County Health and Development Committee (CHDC) for each HF in the county as demonstrated by written documentation (e.g. minutes of monthly meetings)," then, proof of monthly meetings needs to be verified through review of recorded minutes of meetings. If only 4 out of 20 HF have kept regular records of meetings, this would be explained in the comment section, and an indication of a need to build further capacity in this area would be self-identified and recorded.

TENTATIVE SCHEDULE FOR FIELD VERIFICATION VISIT BY CENTRAL

Approximate Time	Tasks
08:00 – 9:00	***Technical Review Committee arrives –*** Convene meeting between CHSWT senior management and supervisors and Review Committee. The purpose of this meeting is to discuss the purpose of the Contracting In Guidelines, the self-assessment tool and the verification visit process.
09:00 - 4:00	***Self-assessment forms are validated –*** Validation of Self-Assessment information by three teams (see team composition below) each with at least one member from the CHSWT assigned to accompany the team.
4:00 – 5:00	***Re-convene CHSWT senior management and Review Committee -***The purpose of this meeting is to discuss verification team findings, any discrepancies between the CHSWT self-assessment and the verification team findings and the way forward.

TEAM COMPOSITION AND TEAM TASKS

Team 1: Comprised of MOHSW staff from Health Services, Planning (Decentralization) and Administration (Personnel) and CHSWT staff CHO, CHSA and HR Manager

Self-Assessment forms to be reviewed:

- ✓ Leadership and Governance,
- ✓ Laws, Policies, Plans, Procedures and Guidance
- ✓ Human Resource Management
  - A visit to the Superintendent's office
  - A review of CHSWT headquarters files, shelves, notices, etc.
  - A review of all HR files
  - Observation of notices posted on walls, documents in public areas, etc.
  - Individual meetings with staff from the CHSWT

Team 2: Comprised of MOHSW staff from Health Services, M&E, HMIS and CHSWT staff CHDD, Clinical Supervisor, M&E Officer, Data Clerk, DHOs, Pharmacist

Self-Assessment forms to be reviewed:

- ✓ Health Service Delivery
- ✓ Availability of Treatment Guidelines, Clinical Standards and Protocols at County Headquarters and HF
- ✓ Monitoring and Evaluation and Use of HMIS
- ✓ Supply Chain Management for Essential Medicines and Supplies
  - A review of all service delivery, clinical and supervision files
  - A review of all M&E and HMIS files (paper and electronic)

Team 3: Comprised of MOHSW staff from OFM and Procurement and CHSW Administrative staff: Finance Manager / Head Accountant, Junior Accountant / Bookkeeper, Procurement Officer/Logistician

Self-Assessment forms to be reviewed:

- ✓ Financial Management and Procurement
  - A review of all financial files, accounting ledgers, supporting documentation
  - A review of files and records
  - A review of all procurement files, supporting documentation, notices, etc.

Tables 15 – 22 below contain the self-assessment forms.

TABLE 15. CHSWT SELF ASSESSMENT – LEADERSHIP AND GOVERNANCE

	CRITERIA SYSTEM, PROCESS OR PROCEDURE CHSWT	STATUS E – S – U/S	CAPACITY NEEDED	COMMENT / EXPLANATION
1	Active participation and collaboration in the quarterly CHSW Board meetings and written record of minutes of these meetings			
2	Regular interactions and collaboration between the DHOs and the District Commissioners			
3	Quarterly submission of financial reports to the county's Superintendent's Office			
4	Established and functioning County Health and Development Committee (CHDC) for each HF in the county as demonstrated by written documentation (e.g. minutes of monthly meetings)			
5	Regular weekly CHSWT staff meetings (to discuss advances and achievements, challenges and issues, reallocation of human and material resources, supervisory visit reporting from past week and planning for following time period.) Agenda and minutes taken for each meeting			
6	Regular quarterly OIC and CHSWT meetings with recorded minutes, action steps, and follow up			
7	Regular weekly written and verbal reporting on all accounts held by the county Accountant and Hospital Administrator during weekly staff CHSWT meetings			
8	Commitment of CHSWT management to proper financial management with internal controls through budget transparency and decision-making			
9	Completed Operational Plan easily accessed by anyone on the CHSWT			
10	Availability of all official MOHSW policies, plans, procedures			

TABLE 16. CHSWT SELF ASSESSMENT – LEADERSHIP AND GOVERNANCE MOHSW AND GOL LAWS, POLICIES, PLANS, PROCEDURES AND GUIDANCE

DOCUMENT TITLE	AVAILABLE		COMMENTS
	Yes	No	
Civil Service, *Civil Service Agency Personnel Employment Record Form*			
Civil Service Agency, Civil Service Standing Order			
County Annual Operational Plan Guidelines for the Utilization of the Planning Tools, five Excel Workbook tools.			
Governance Commission Civil Service Agency & Liberia Institute for Public Administration, *MFR and Restructuring of Ministries and Agencies a Streamlined Framework* (May 30, 2010)			
Governance Commission, *Liberian National Policy on Decentralization and Local Governance* (January 2010)			
Government of Liberia, *Executive Order #38 - Establishing an Administrative Code of Conduct for members of the Executive Branch of Government* (January 6, 2012)			
Liberian Ministry of Health and Social Welfare, *Basic Package for Mental Health Care Service* (January 2010)			
Liberian Ministry of Health and Social Welfare, *Essential Package of Social Services 2011-2021*			
MOHSW, *County Annual Operational Plan Guidelines for Utilization of the Planning Tools* (2011)			
MOHSW, *National Health and Social Welfare Policy and Plan* (2011-2021)			
MOHSW, *Term of Reference MOHSW Personnel*			
Republic of Liberia, *Financial Management Policies and Procedures Manual* (January 2012)			
Republic of Liberia, *Public Procurement and Concessions Commission (PPCC) Act of 2005*			
Republic of Liberia, Liberia National Policy on Decentralization and Local Governance, Governance Commission (January 2011).			
Republic of Liberia Ministry of Health & Social Welfare, *National Community Health Services Strategy and Plans 2011-2015* (2011)			
Republic of Liberia Ministry of Health and Social Welfare, *National Decentralized Management Support Systems Implementations Strategy & Plan* (Draft) (November 2008)			
Republic of Liberia Ministry of Health & Social Welfare, *National Health and Social Welfare Decentralization Policy/Strategy* (2011).			
Republic of Liberia Ministry of Health and Social Welfare, *National Health and Social Welfare Policy and Plan 2011-2021* (2011)			
Republic of Liberia Ministry of Health & Social Welfare, *National Health Policy National Health Plan (2007-2011)* (2007)			
Republic of Liberia Ministry of Health & Social Welfare, *National Human Resources Policy and Plan for Health and Social Welfare 2011-2021* (2011)			
Republic of Liberia Ministry of Health and Social Welfare, *National Mental Health Policy* (Monrovia, Liberia, 2009).			
Republic of Liberia Ministry of Health and Social Welfare, *National Monitoring and Evaluation Policy and Strategy for the Health Sector*			

2009-2011 (January, 2009)			
Republic of Liberia Ministry of Health and Social Welfare, *Partnership and Coordination Manual* (September 2009)			
Republic of Liberia Ministry of Health & Social Welfare, *Revised National Community Health Services Policy* (2011)			
Republic of Liberia Ministry of Health and Social Welfare, *Stock Balance Reporting and Requisition Form* (2011)			
Republic of Liberia Ministry of Health & Social Welfare, *SUPERVISION: County-Level Policy and Procedure Manual, Decentralized Management Support Systems* (2009)			
Republic of Liberia Ministry of Health & Social Welfare, *Supply Chain Master Plan: A ten year plan for one, efficient, and effective public health supply chain in Liberia* (2010)			
Republic of Liberia Ministry of Health & Social Welfare, *Supply Chain Strategy 2015: A five year plan for an efficient and effective public health supply chain in Liberia* (July 9, 2010)			

TABLE 17. CHSWT SELF ASSESSMENT – HUMAN RESOURCE MANAGEMENT

	CRITERIA SYSTEM, PROCESS OR PROCEDURE CHSWT AND HOSPITAL	STATUS E – S – U/S	CAPACITY NEEDED	COMMENT / EXPLANATION
1	A copy of the MOHSW Human Resource Management Manual in the CHSWT office and readily available.			
2	At a minimum, key CHSWT positions are filled and there is clarity as to the roles and responsibilities and tasks of each team member. Team members: CHSWT Positions: CHO, CHSA, Accountant, Junior Accountant or Bookkeeper, HR Manager, M&E Manager, CHDD, Hospital Medical Director, Hospital Administrator, Hospital Nursing Director, Clinical Supervisor, Pharmacist, County Lab. Supervisor, MCH Focal Person, RH Focal Person, Surveillance Officer, Registrar, Social Welfare Supervisor, DHOs			
3	A copy of all personnel policies and procedures including those related to disciplinary action (e.g. demotion, dismissal, suspension, fines, reduction in salary, letter of formal reprimand, etc.) and personnel management procedures (e.g. hiring, retention, promotion, payment, etc.) is available in the CHSWT office.			
4	ToR for CHSWT staff are easily accessed by any county employee and the public (e.g. displayed on headquarters office wall).			
5	Employee Performance Monitoring process is in place in accordance with Chapter 4 Sections 1 and 2 of the Human Resource Policy. An Employee Performance Appraisal system is in place utilizing the MOHSW forms and procedures (e.g. self appraisal, identification of objectives, supervisor's evaluation, employee's response). A copy of all Performance Appraisals is available in the CHSWT office.			
6	A training needs matrix exists, the CHSA and HR Manager contribute to it quarterly.			
7	Develops ToRs for non civil service contracts, advertises positions, sets interview committees, carries out selection process, and records these steps in HR files.			
8	Contracts for non civil service staff are developed and appropriately filed.			
9	Supervisors identify skill and knowledge gaps of HF staff and communicate capacity-building needs during the CHSWT meetings. Follow up action taken by technical supervisor and HR to fill gaps.			

TABLE 18. CHSWT SELF ASSESSMENT – FINANCIAL MANAGEMENT AND PROCUREMENT

	SYSTEM, PROCESS OR PROCEDURE CHSWT	STATUS E – S – U/S	CAPACITY NEEDED	COMMENT / EXPLANATION
1	A copy of the MOHSW's Financial Management Policies and Procedures Manual (1/ 2012) in CHSWT office.			
2	Compliance with revenue collection and banking procedures including separate dual-signatory accounts and regular reconciliation of all bank accounts.			
3	Compliance with Financial Procedures Manual and regular update of Accounting Books (e.g. Cash Books / Ledgers).			
4	Adequate filing systems with all expenditures properly backed up by required supporting documentation.			
5	Regular submission of accurate, reliable timely financial reporting to the MoHSW.			
6	Budgets and plans covering GoL financial allocations prepared, approved, and submitted on a quarterly basis.			
7	On a quarterly basis comparisons made between budgeted and actual expenditures and adjustments made.			
8	Yearly, quarterly, and monthly budgets by activity developed and monitored.			
9	Adequate separation of accounting tasks whereby different individuals prepare checks, sign checks, conduct bank conciliation, and access cash receipts.			
10	Bank checks properly referenced on all purchase orders, vouchers, and contracts.			
11	Presence of an effective Finance Manager/Lead Accountant and Junior Accountant or Bookkeeper at post. Existence of either a Procurement Officer or proof that county is recruiting or training one.			
12	Overall adherence of procurement practices in line with MOHSW and PPCC guidelines. All procurement documentation adequate and maintained as dictated by PPCC.			
13	Adequate separation of procurement tasks with different individuals responsible for purchasing, obtaining receipts, approvals, and inventory stock controls.			
14	A procurement process with proper competitive bidding procedures in place, written justification for any non-competitive purchases, and records on file of all purchases over the last four quarters.			

	CRITERIA CHSWT USE OF ACCOUNTING FORMS AND DOCUMENTATION	DONE / CURRENT	DONE / NOT UP TO DATE	NOT DONE
1	Report Form A			
2	Report Form B			
3	Bank Reconciliation Account			
4	Ledgers			
5	Cash Book			
6	Petty Cash Book			
7	Documentation / Filing			
	SUMMARY			

TABLE 19. CHSWT SELF ASSESSMENT – HEALTH SERVICES MANAGEMENT AND DELIVERY

	CRITERIA SYSTEM, PROCESS OR PROCEDURE CHSWT	STATUS E – S – U/S	CAPACITY NEEDED	COMMENT / EXPLANATION
	HEALTH FACILITIES			
1	All Treatment Protocols and Guidelines are available at the CHSWT headquarters, and at each of the HF (see list below).			
2	A monthly schedule of integrated supervision visits is posted for public information in the CHSWT office.			
3	Written reports generated for all supervision visits and contain observations notes, issues encountered, actions to be taken. A copy of the report is provided to HF.			
4	The CHSWT discusses subsequent actions to be taken from each report during the weekly CHSWT team meetings, or through other venues, and appropriate follow up is taken.			
5	CHSWT supervisors act upon any gaps in skills identified during supportive supervision visits and meetings.			
	COMMUNITY HEALTH			
6	Supervisors identify skill and knowledge gaps of CHVs, and communicate capacity-building needs during the CHSWT meetings. Follow up action is taken by technical supervisor and OIC to fill those gaps.			
7	The DHOs together with the OICs ensure that regular CHDC meetings are held with written minutes taken and action steps identified.			

TABLE 20. CHSWT SELF ASSESSMENT – AVAILABILITY OF TREATMENT GUIDELINES, CLINICAL STANDARDS AND PROTOCOLS AT COUNTY HEADQUARTERS AND HF

CATEGORY	DESCRIPTION OF THE PROTOCOL AND GUIDELINE	YES	NO	DATE/EDITION
MNCH				
Reproductive Health, Adolescent Health and Family Planning	Labor and Delivery protocol and Guidelines			Aug 2009
	New Born Health Protocols and guidelines			
	Antenatal Care Protocols and Guidelines			
	Pre-Conception/pregnancy protocols			
	Post Partum Protocol and Guidelines			
	National Sexual and reproductive Health policies			Feb 2010
	BLSS Training Guidelines and HBLSS Guidelines			
	LSS (Life Saving Skills)			Nov 2008
	Resuscitation Guidelines			Oct 2010
	Oxytocin Guidelines			Oct 2010
	Episiotomy			Oct 2010
Child Health				
ENA	Job Aids for facility			
	Job Aid on ENA for CHVs and workers			
IMNCI				
	Integrated management of childhood illness (high HIV Setting)			
Malaria				
	National Technical Guideline Malaria Case Management			Aug 2005
	Technical Guidelines for Malaria in Pregnancy Malaria Control			2011
	Job AID on Malaria in Pregnancy			
	National Malaria Control Technical Guidelines			2011
HIV/AIDS				
	Liberia Integrated Guidelines			Nov 2010
	Liberia Integrated Guidelines 3rd Ed			April 2011
	Liberia Pediatric Guidelines			April 2011
	PMCT 2nd Edition Guidelines			April 2011
	STI Guidelines			2009
HIV/STIs				
	National Protocols for HIV/AIDS and ARV Care in Liberia			June 2005
Community Health				
	Diarrheal Training Guidelines			
	Malaria Training guidelines			
	ARI Training Guidelines			
	National Strategy and policy			
	Community health training facilitator guidelines			
Nutrition				
	IPF -- quick reference			2012
	OTP – SEP quick reference booklet			2012
	Magnesium Sulfate Protocol			
TB				
	User friendly TB Guidelines			Jan 2013

TABLE 21. CHSWT SELF ASSESSMENT – HEALTH MANAGEMENT INFORMATION SYSTEMS, MONITORING AND EVALUATION, AND USE OF DATA FOR DECISION-MAKING

	CRITERIA SYSTEM, PROCESS OR PROCEDURE CHSWT	STATUS E – S – U/S	CAPACITY NEEDED	COMMENT / EXPLANATION
	OICs fill out Monthly Integrated Report Forms on a timely basis			
	DHOs review Monthly Integrated Report Forms on a monthly basis with OICs, collect forms, and submit to M&E Manager			
	Monthly meeting held led by M&E Manager to discuss data, and enter data into DHIS			
	M&E Manager, CHDD, CHSD verify data at the HF			

TABLE 22. CHSWT SELF ASSESSMENT – SUPPLY CHAIN MANAGEMENT OF ESSENTIAL MEDICINES AND SUPPLIES

	CRITERIA SYSTEM, PROCESS OR PROCEDURE CHSWT	STATUS E – S – U/S	CAPACITY NEEDED	COMMENT / EXPLANATION
	HFs understand how to fill out the SBRR form and their reports are complete, accurate, and submitted to the SCMU on a timely basis using Logistics Management Information System (LMIS)			
	There is at least one-month supply of Buffer Stock in all HF			
	All medicines and medical supplies are kept in the County Depot under proper storage condition and space under lock and key. County Depot and warehouses meet regulation for refrigeration, air conditioning, generator, shelves, pallets, size, location, temperature, shelving, etc.			
	Drugs are distributed to HF on a monthly basis, and distribution levels mirror those of the HF SBRR reports.			
	When health products are received (at any level of the service delivery points) a proof of delivery (POD) document is received and signed by the distributor and the recipient.			
	On a monthly basis, the Pharmacist visits each HF with a supervisory checklist and oversees the quality and maintenance of the HF supply chain system.			
	CRITERIA SYSTEM, PROCESS OR PROCEDURE FOR THE HEALTH FACILITY (TO BE FILLED OUT BY THE CHSWT)	STATUS E – S – U/S	CAPACITY NEEDED	COMMENT / EXPLANATION
HF	HF submit monthly requisition of health care commodities from the CHSWT			
	HF ensure adherence to standard treatment guidelines (STGs) and prescription policies (at HF and Community levels)			
	Each HF has an inventory control system with individual stock-keeping records, transactional records, and consumption records system. At the clinic level, ledger cards, rather than bin cards, may be used for stock keeping records. The HF storekeeper manages the inventory control system on a daily basis.			
	All HF are equipped with incinerators and sharps pit for proper waste management. Expired health care products are returned to the County Depot or NDS.			
	HF fills out the SBRR Form on a monthly basis and submits them to the County Pharmacist on the 5th day of each month.			

ANNEX III - INDIVIDUALS CONSULTED

NAME	TITLE
Ministry of Health and Social Welfare	
Mr. Matthew T.K. Flomo	Deputy Minister, Administration
Dr. Bernice T. Dahn	Deputy Minister, Health Services/Chief Med. Officer
Mrs. Yah M. Zolia	Deputy Minister, Planning, Research & Development
Clr. Vivian J. Cherue	Deputy Minister, Social Welfare
Ms. Lydia-Mai Sherman	Senior Executive Coordinator
Mr.Joel Bimba	Department Coordinator
Clr. Tolbert G. Nyenswah	Assistant Minister, Preventive Services
Dr. Saye D. Baawo	Assistant Minister, Curative Services
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. 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
Mrs. Bentoe Zoogley Tehoungue	Assistant Director, Family Health Division
Mrs. Mary Momolu	Manager, EPI Program
County Health Officers	
Dr. Linda Birch	Bomi
Dr. Paul Wesseh	Nimba
Dr. Joseph Siaka	River Gee
Superintendents	
Hon. Grace Kpaan	Monserrado
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
Ms.. Judith Oki	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
Mr. Steven Korvah	UNICEF, PMTCT Specialist
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
Mr. Kevin Carew	World Learning, Country Director

ANNEX IV – COUNTY HEALTH OFFICERS CONSULTED

COUNTY	CHO
Bomi	Dr. Linda Birch
Bong	Dr. Garfee Williams
Gbarpolu	Dr. Anthony Tucker
Grand Cape Mount	Dr. Julious Garbo
Grand Bassa	Dr. Saybeh M. Vanyanbah
Grand Gedeh	Dr. Fred Amegashie
Grand Kru	Dr. Abraham Keita
Lofa	Dr Aaron Y. Kollie
Margibi	Dr. Hawa M. Kromah
Maryland	Dr. Odell Kumbeh
Montserrado	Dr. Ansumana Camara
Monserrado	Dr. Fred Amegashie (twice)
Nimba	Dr. Paul T. Whesseh
Rivercess	Dr. Wilmot L. Smith
River Gee	Dr. Joseph Sieka
Sinoe	Dr. Wilmot D. Frank