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EVALUATION

USAID/LIBERIA REBUILDING BASIC HEALTH SERVICES FINAL PROJECT EVALUATION

March 2015

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DISCLAIMER

The author's views expressed in this publication do not necessarily reflect the views of the United States Agency for International Development or the United States Government.

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ACRONYMS

BCC	Behavior change communication
CHB	County Health Board
CHC	Community Health Committee
CHDC	Community Health Development Committee
CHO	County Health Officer
C-HMIS	Community health management information system
CHSWT	County Health and Social Welfare Team
DHO	District Health Officer
DHT	District Health Team
EPHS	Essential Package of Health Services
ETU	Ebola Treatment Unit
FARA	Fixed amount reimbursement agreement
FP	Family planning
gCHVs	General community health volunteers
HMIS	Health management information system
HSS	Health systems strengthening
ICD	Institute for Collaborative Development
i-CCM	Integrated community case management
IP	Implementing partner
IPC	Infection prevention and control
IRC	International Rescue Committee
JHU-CCP	Johns Hopkins University Center for Communication Program
JSI	John Snow, Inc.
LMIS	Logistics management information system
MCH	Maternal and child health
MOHSW	Ministry of Health and Social Welfare
MSH	Management Sciences for Health
NHSWPP	National Health and Social Welfare Policy and Plan 2011-2021
NGO	Non-governmental organization
OIC	Officer-in-Charge
PBC	Performance-based contract
PBF	Performance-based financing
PPE	Personal protective equipment
PRISM	Performance of Routine Health Information System Management in Liberia
RBHS	Rebuilding Basic Health Services
RH	Reproductive health
SOW	Scope of work
TTM	Trained traditional midwife
WHO	World Health Organization

EXECUTIVE SUMMARY

EVALUATION PURPOSE AND QUESTIONS

The purpose of this endline evaluation was to review the process and achievements of the second phase of the six-year Rebuilding Basic Health Services (RBHS) project in Liberia, providing the U.S. Agency for International Development (USAID) mission with external insight and recommendations to inform health systems strengthening (HSS) and capacity-building work with the Ministry of Health and Social Welfare (MOHSW) through follow-on projects. Evaluation findings will inform the implementation of follow-on projects, particularly in the context of the current health system's response to emergencies.

The evaluation team used five study questions proposed by USAID. These, in broad terms, were to review: (1) the effectiveness of the project design, capacity-building approaches and results; (2) the progress of decentralization of health services, noting challenges and lessons learned; (3) capacity-building needs of the MOHSW and county health services identified during the Ebola outbreak and how the project helped to capacitate the government and community partners to respond to that crisis; (4) effectiveness of the support to the MOHSW in area of health financing; and (5) strengths and weaknesses of the community health program.

PROJECT BACKGROUND

The RBHS project was a six-year and four-month cooperative agreement (2008-2015) led by John Snow Research and Training Institute, Inc. (JSI), in collaboration with Jhpiego, the Johns Hopkins University Center for Communication Programs (JHU-CCP) and Management Sciences for Health (MSH). The project started in 2008 with a focus on improving health service delivery in the counties of Bong, Nimba, Lofa, River Gee and Grand Cape Mount. In 2011, RBHS shifted from its original focus to capacity-building of the MOHSW and County Health Teams in Bong, Lofa and Nimba counties. Adhering to the National Health Policy and guided by the WHO Health Systems Strengthening Conceptual Framework, the project worked to develop or strengthen six “building blocks:” health services, workforce, finance, access to drugs and supplies, information management and governance and leadership. A major objective of this second phase was to transfer management of performance-based contracts from the project to the MOHSW. The strengthening of community health structures and systems, [community health workers and Community Health Development Committees (CHDCs)] was also a major aim.

EVALUATION DESIGN, METHODS AND LIMITATIONS

A team of five external evaluators contracted by USAID through GH Pro used a case study approach to conduct a final evaluation of RBHS, with primary data collection occurring from February 9 to March 6, 2015. A variety of qualitative study methods were used, including interviews with the MOHSW, County Health and Social Welfare Teams (CHSWT), performance-based contracting agencies and other stakeholders. Additionally, the team observed community initiatives and conducted focus group discussions and interviews with community health workers and local representatives serving on CHDCs. During its travels, the team also met with organizations responding to the Ebola outbreak. Methods of analysis included triangulating information provided by different sources and noting common themes.

Because the country was in the midst of intense activity to eradicate Ebola Virus Disease, key MOHSW and CHSWT informants had limited time to spend with the team. Additionally, during the field visits, a national Deconcentration Platform was launched in Bong County by the President of Liberia, H.E. Madam Ellen Johnson Sirleaf; this included a three-day workshop attended by senior county officials including health officers and health department directors. This presented challenges in scheduling interviews and limited access to stakeholders such as county superintendents.

KEY FINDINGS

Evaluation Question I: How effective was the RBHS project in supporting the National Health Policy and Plan’s strategic goals, objectives and activities, reviewing the strengths and weaknesses of the project design based on the WHO HSS conceptual framework, the implementation approach and activities, and accomplishments and results since the project modification in 2011 (up to the Ebola response), including progress made in achieving the goals of the revised scope that incorporates capacity building¹ and two intermediate results: “increased utilization of quality services” and “more responsive services²”?

Taking a holistic approach, the project design addressed the six health system building blocks. This resulted in an ambitious and complex multi-focal project requiring diverse expertise and capacity-building approaches.

Capacity-building approaches used by the consortium included joint capacity assessments followed by participatory planning, provision of short- and long-term technical assistance, embedded advisors, exposure trips primarily to countries in the region, formal training program development, training of trainers and cascade training modalities, supportive supervision and regular data review meetings. The project also supported facility renovation; minimal equipment aid was provided. Additionally, the project assisted the MOHSW to develop and operationalize linked electronic databases, including the human resources and logistics management software.

Overall, the evaluation team heard from central and county governmental partners that RBHS’s capacity-building work was highly valued, and they could point to improvements in how systems were working or to new capacities that had been built. The use of focused and explicit embedded technical assistance was noted as particularly effective in developing new systems, e.g., the performance-based financing (PBF) unit at the MOHSW, which assumed contracting functions previously managed by RBHS, the Health Monitoring, Evaluation and Research division and the national health information system using the new DHIS 2.4 software, which is now functional in the counties.

In terms of areas that could be strengthened, several informants from the CHSWTs and MOHSW (central level) mentioned that the project could have been stronger if it had taken a “comprehensive”³ approach. Suggestions ranged from broad recommendations for developing systems to ensure adequate workforce and salaries, sufficient drug and other supplies, and adequate financing for operations, to more specific recommendations such as provision of more material aid, (e.g., “transport for supervisory visits”) to ensure that government staff were sufficiently equipped to carry out their functions.

The RBHS project had two intermediate results: “Increased utilization of quality services,” and “More responsive services through effective health system decentralization.” The evaluation team heard from the MOHSW and CHSWTs that they perceive services to be more responsive; they attribute this to improved systems, facilities, services and practices developed with assistance from RBHS. These include clinical training; joint supervisory visits; quality-improvement processes; performance-based incentives for county teams, health care staff and community-led improvements; facility renovations; community monitoring and involvement in quality improvement; and community-based delivery of maternal and child health (MCH) and family planning/reproductive health (FP/RH) high-impact interventions, e.g., Contraceptive Days with mobile clinics delivering counseling and short- and long-acting methods.

¹ As defined in the MOHSW Capacity Building Strategic Plan (produced in summer, 2012 with RBHS) “... capacity development is understood as a process through which individuals, organizations and society obtains, strengthens and maintains the capabilities to set and achieve their own development agenda.” (Decentralization policy, 2012)

² “More responsive services” means increased equitable access to safe, effective services to those who need them when and where they are needed (USAID results framework, which is aligned with the MOHSW 10-year plan).

³ This word was used by two key informants from central MOHSW and several CHSWT members.

Under the first intermediate result, MOHSW and CHSWTs reported an increase in utilization of services and an improvement in the preparedness of the health workforce and facilities to provide quality care. As an indicator, facility-based deliveries rose in the facilities supported in the three counties from under 20 percent in July 2009 to 68 percent in June 2012. This pattern appears to have remained stable with 66 percent utilization reported in the July 2013-June 2014 report of HMIS data.⁴

It is clear that RBHS has made significant contributions to both intermediate results. The RBHS project was highly productive, producing a large quantity of deliverables and outputs. To strengthen the body of evidence, more data—or perhaps better documentation, recording and analysis—is needed to show the outcomes as a result of the project outputs. As an example, project reports do not show how the joint supervisory visits contributed to actions and improvements.

Several project results related to organizational or system development were not fully recognized; both RBHS staff and governmental partners explained that this was due in part to the short timeframe of the second phase of the project (after the primary mandate shifted from service delivery support to capacity-building), and more so to the negative impact of the Ebola crisis, which halted or disrupted many planned activities. As examples, the communication strategy was drafted as planned, but has not yet been approved or disseminated by the MOHSW; similarly, the electronic human resources system (iHRIS) and the community health information system (C-HMIS) were developed, with instructional modalities established and trainers trained, but they have yet to be operationalized in the counties.

Evaluation Question 2: What lessons have been learned by RBHS and others who are supporting health service decentralization or “deconcentration” processes (central and county) and building capacities of counties to assume greater responsibility for the planning, management and delivery of health and social welfare services, to inform follow-on interventions?

“More responsive services through effective health system decentralization” is an explicit goal of USAID/Liberia’s Country Development Cooperation Strategy 2013-2017 and aligned with the objectives of the 10-year National Health and Social Welfare Policy and Plan 2011-2021. Thus, building capacity for more decentralized management of the health system represented a key crosscutting theme for the RBHS. While the written project goals, objectives and targets were not specific to decentralization, the project did work to build capacities in counties to assume new functions related to deconcentration⁵ in support of the Government of Liberia’s long-term goal of decentralization. RBHS activities to support county readiness included providing support to develop HMIS systems at the county level, and technical support and mentoring to CHSWTs in the three target counties to build their capacities for planning, workforce development, data management, supervision of health services and quality improvement.

Progress was particularly notable in the area of health data management, as facility service data is now entered in all fifteen counties using the new DHIS 2.4 software. CHSWTs in the three target counties also assumed new roles with their increased involvement in joint supervision of county health facilities and quality improvement processes, functions normally fulfilled by the central MOHSW. In 2014, RBHS supported the Bong County CHSWT to assume responsibility for implementing a performance-based contract⁶ to manage a percentage of health facilities in the county.

⁴ RBHS annual reports, 2012 and 2014.

⁵ Deconcentration may be defined as the national government reassigning responsibilities to the field offices of national ministries without placing these offices under the control of subnational governments, reassigning authority among different central government levels. It can shift operational responsibilities from central government officials in the capital city to those working in regions, provinces or districts, or it can create strong field administration or local administrative capacity under the supervision of central government ministries.

https://www.google.com/webhp?sourceid=chrome-instant&ion=1&espv=2&es_th=1&ie=UTF-8#q=USAID+deconcentration

⁶ County implementation of PBC contracts is referred to as “contracting-in,” an important shift from the traditional performance-based contracting with NGOs.

The major challenges to implementation of Government of Liberia deconcentration/decentralization objectives reported to the evaluation team included: (1) lack of clarity about functions to be deconcentrated/decentralized, e.g., workforce in-service and continued education training,⁷ and the level of authority to be devolved from central to CHSWTs for planning of new externally funded projects and services, budgetary decision-making and control of funding at the local level, (2) underdeveloped management capacities and (3) insufficient resources (e.g., professional staff), sub-optimal infrastructure and lack of adequate transport at the county level. The establishment of measurable benchmarks would have helped RBHS show evidence of progress made during the project.

Evaluation Question 3: What have been the implications of the current Ebola crisis for capacity-building of the MOHSW, and how effective were RBHS interventions in helping the MOHSW to respond to the crisis?

As has been publicized by the international press, the health care system was not prepared to diagnose and care for patients with Ebola Virus Disease, a new disease for the Liberian health system. Perhaps even more critically, the county did not have an infectious disease surveillance and response system to respond to acute outbreaks. The Ebola outbreak identified gaps including the lack of emergency preparedness plans and contingency stocks for epidemics, lack of county emergency command centers and permanent isolation facilities, systems for communicating real-time data, epidemiological skills (particularly at the county level) and infection prevention and control (IPC) practices within the health system, including the correct use of personal protective equipment, setting up triage/temporary isolation spaces at clinics and provision of early treatment. The lack of a sufficient ambulance/transport system was critical, and, according to CHSWTs, this serious gap was identified even before the Ebola outbreak.

RBHS and partners were well placed given their presence in counties with outbreaks and the collaborative relationship with the MOHSW, and thus they were able to make significant contributions to the response. The RBHS project Chief of Party, upon request of the Deputy Minister for Health Services, led the National Infection Prevention and Control task force, and with WHO and support from CDC and other USAID implementing partners developed and supported IPC training for the health care workforce that continued after project close-out. RBHS also was instrumental in supporting the MOHSW to distribute PPE in the early phase of the outbreak. Structures and systems that had been developed by the project contributed to the emergency response; these included use of general community health volunteers (gCHVs)—leveraging their established community presence and communicable disease reporting skills to assume new roles in contact tracing and active case finding—and the use of HMIS staff capacities to introduce electronic Ebola Virus Disease surveillance software.

Evaluation Question 4: To what extent have RBHS project interventions at individual, organization and system levels related to the health financing building block been effective in responding to the needs and priorities of the MOHSW in the area of health financing, and how can the RBHS experience inform future interventions supported by USAID? Key intervention areas to review include: PBF management, management of performance-based contracts (PBCs) with NGOs, design of national health insurance and health financing reform proposals (e.g., Health Equity Fund), and public financial management.

In the first phase of RBHS, a key component of the RBHS program focused on provision of direct support for delivery of primary and secondary health services, implemented through performance-based sub-contracts with NGOs. The PBF scheme is highly valued by MOHSW and county informants, who noted increased staff focus on reaching targets and improved staff motivation with the provision of facility performance bonuses. The community bonuses have resulted in greater community engagement,

⁷ Technical staff in the counties discussed lack of clarity about who (CHSWTs or central MOHSW) is to provide and control resources for staff technical training.

with more ownership of local health facilities and increased community contribution to improvements, e.g. for construction of maternity waiting rooms and fencing at clinics.

During the project's second phase, USAID transitioned the funding for service delivery into a direct government-to-government agreement with the MOHSW, and RBHS supported the transition the management of the PBCs to the MOHSW with the technical assistance of an embedded RBHS advisor to establish a central MOHSW PBF unit. This unit is now functioning without external technical assistance. An acute issue noted by the evaluation team from CHSWT members, health care staff and PBC staff, and verified by the MOHSW PBF unit, is that bonuses have not been paid since 2013 due to factors ranging from cash flow problems at the Ministry of Finance to delayed processing of data verification by the MOHSW. This may be due in part to the fact that the MOHSW could not counter-validate performance data due to limitations on field travel during the Ebola outbreak. The sub-par quality of PBF reports, particularly related to service data, was also reported as a chronic issue.

A variety of approaches were used by RBHS to support the MOHSW in exploring new health financing schemes, in line with health financing priorities outlined in the National Health and Social Welfare Financing Policy and Plan 2011-2021. Interventions such as exposure trips to Ghana, consultative meetings and expert technical assistance were instrumental in developing the Health Equity Fund concept, a proposal for a comprehensive health financing reform to improve sustainability of health financing while improving efficiency and equity. While endorsed by the President of Liberia, the fund is still being debated within in the government, and draft legislation has yet to be formally introduced to the legislature.

Evaluation Question 4: What are the strengths and weaknesses of RBHS interventions to develop community health systems and services, including major challenges, results and recommendations for incoming projects?

Significant work to strengthen community health services was supported by RBHS in partnership with the MOHSW Community Health Division and Health Promotion Department. In the project's second phase, major outputs included facilitating a participatory process to develop the national operational guide—the “Community Health Roadmap,” designing a C-HMIS, and operationalizing high-impact practices such as task-shifting of implementation of integrated case management of childhood illnesses to gCHVs and conducting Contraceptive Days with mobile clinics to provide long-acting contraceptive methods. CHDCs were also developed with support of RBHS and are now “serving as liaison between the clinic and the communities” and taking actions to improve facilities. The lack of resources to operationalize and sustain the community health delivery structures was reported as a major challenge.

RECOMMENDATIONS

The following recommendations build on the RBHS experience, lessons learned and results and are presented using the framework of the five specific evaluation questions.

Capacity-building approaches: As noted by several informants from the central and county levels, and recommended by the evaluation team, all capacity-building activities require: (a) clear, specific and time-bound objectives, and if technical assistance, terms of reference; (b) technical advisors, trainers or coaches with expertise, relevant experience and skills in knowledge transfer and teaming; (c) clear benchmarks; and (d) careful monitoring of performance by the project/donor. Planning new capacity-building interventions will require strong commitment, input and buy-in of MOHSW and county leaders and certain conditions to be in place, such as personnel with the capacity to absorb new knowledge and skills, and taking a more comprehensive approach to capacity-building and organizational development, i.e., ensuring that systems are in place for personnel to be managed, supervised and sufficiently equipped.

Relevant to building capacities of the Liberian health care services, it is recommended that increased focus be given to developing capacities to (1) manage central, county and district health care systems and services; (2) develop quality assurance processes at the facility level; (3) provide packages to attract and retain skilled workforce in rural areas; (4) create improved governance systems, such as the development of active county-level health boards; (5) develop orientation, skills training and continuing education modalities with focus on efficiency (low cost and minimizing time away from work) as well as quality (expertise of instructors, appropriate teaching aids—perhaps virtual learning methods, competency testing and certification); and (6) create a data-driven culture to ensure adequate resources, service coverage, health equity and accountability of resources.

The RBHS experience shows that multiple approaches are needed to effectively address these objectives. It is recommended to consider the use of embedded management specialists with the CHSWTs to address the first three objectives. Additionally, development of a professional association for county health officials may drive professionalization of CHSWTs. In addressing the third and fourth recommendations, it is recommended that short-term technical advisors be availed to the MOHSW and CHSWTs to develop policies and packages using best practices and testing of innovative approaches. Exposure trips to countries that have effectively addressed these issues may be conducted as complementary learning opportunities and to accelerate the process of system development and strengthening.

Deconcentration/Decentralization: Supporting accelerated deconcentration of management of essential health care services and public health functions from the MOHSW to county and district health teams will require a systems approach, strengthening MOHSW functions and skills of personnel to carry out their oversight role and monitoring responsibilities while supporting county government as it assumes increasing responsibilities. Assisting with clarifying functions for each level of government and the necessary systems, terms of reference and skill sets required will be critical first steps in developing a detailed implementation plan and clear benchmarks for monitoring the process and progress. It is recommended that USAID support the development of governance and management systems and skills, with special focus on planning, finance/accounting and monitoring skills from central to local government. The development of strong governance mechanisms, including county health boards, is critical, as is further refinement of structures for community monitoring and oversight at the local level (i.e. Community Health Committees and CHDCs).

Ebola Response: The Ebola crisis has brought to the forefront the need for much stronger disease (and injury) prevention and control. It is recommended that USAID work in partnership with other key international agencies to provide technical assistance and capacity-building to develop a Public Health Service, within which community health, social mobilization, environmental health and health promotion functions are contained in addition to disease surveillance and outbreak/epidemic management to carry out the essential governmental public health services.⁸

Health Finance: Given the international aid architecture and the country's political dynamics, strong collaborative and coordinated efforts are required to advance the health financing objectives outlined in Government of Liberia policies and plans. A multi-faceted strategy is needed and may necessitate development of several portfolios, given the need to work at different levels and branches of government and the need for myriad approaches (e.g. revenue collection, federal and county appropriations, external aid mobilization, workforce recruitment and retention, and private/public partnerships) and specific expertise and experience of technical advisors and implementing agencies. Specific to the government's objective to develop health insurance mechanisms, it is recommended that future USAID initiatives build on the RBHS work with the MOHSW to develop the health equity fund

⁸ <http://www.health.gov/phfunctions/public.htm>

concept, facilitating wider participation of relevant ministries and key stakeholders and providing technical expertise in health insurance and policy development.

Additionally, it is recommended that the external aid provided for service delivery continue to be performance-based and expanded to include community based work—potentially including both curative and preventative health services by professional or trained lay workers.

Community Health: It is recommended that USAID support initiatives that build on RBHS work to develop the continuum of care at the facility and community levels with development of supportive supervision. USAID should also support quality assurance and improvement; community health data management (C-HMIS); health, hygiene and nutrition education; and referral and follow-up systems. Additionally, more support is needed to institutionalize and finance community health services.

This is an opportune time to build on the demand for “more community engagement;” this was heard frequently in discussions with government, as they had observed the important role that communities have played in preventing spread of disease. It is recommended that work continue to develop the Community Health Committees (village level) and CHDCs (health facility catchment area) using Performance-Defined Quality or other similar methodology to foster greater community involvement in responsive quality services. It is also recommended to build local capacity to foster community action to prevent disease and injuries by addressing environmental factors, risky personal behaviors, and social and cultural practices.

I. INTRODUCTION

EVALUATION PURPOSE

As commissioned by USAID, the purpose of this endline process evaluation was “to review the process and document the achievements of the six-year Rebuilding Basic Health Services (RBHS) project, and provide the mission with insight and recommendations to inform health systems strengthening (HSS) and capacity-building work with the MOHSW through follow-on projects. Additionally, the mission hopes to extract lessons learned by observing how the project prepared the government and community partners to respond to the Ebola crisis. The evaluation findings will advise USAID/Liberia on any needed redirection of strategies, approaches or priorities in light of lessons learned from RBHS (and the Ebola response), which might inform the implementation of the follow-on project particularly in the context of the current health system’s response to emergencies.”

EVALUATION QUESTIONS

USAID and the Global Health Performance Cycle Improvement Project (GH Pro), the mechanism contracted to carry out the evaluation, formulated the following five main evaluation study questions (further elaborated in Annex I. Evaluation Statement of Work).

1. How effective was the RBHS project in supporting the National Health Policy and Plan’s strategic goals, objectives and activities, reviewing the strengths and weaknesses of the project design based on the WHO HSS conceptual framework, the implementation approach and activities, and accomplishments and results since the project modification in 2011 (up to the Ebola response), including progress made in achieving the goals of the revised scope, which incorporates capacity building⁹ and two intermediate results: “increased utilization of quality services” and “more responsive services¹⁰”.
2. What lessons that could inform follow-on interventions have been learned by RBHS and others that are supporting health service decentralization or “deconcentration” processes (central and county) and building capacities of counties to assume greater responsibility for the planning, management and delivery of health and social welfare services?
3. What have been the implications of the current Ebola crisis for capacity-building of the MOHSW, and how effective were RBHS interventions in helping the MOHSW respond to the crisis?
4. To what extent have RBHS interventions at the individual, organization and system levels related to the health financing building block been effective in responding to the needs and priorities of the MOHSW in the area of health financing, and how can the RBHS experience inform future interventions supported by USAID? Intervention areas to review include: management of performance-based financing (PBF); management of performance-based contracts (PBCs) with non-governmental organizations (NGOs); design of national health insurance and health financing reform proposals, i.e., the Health Equity Fund; and public financial management.

⁹ As defined in the MOHSW Capacity Building Strategic Plan (produced in summer, 2012 with RBHS) “... capacity development is understood as a process through which individuals, organizations and society obtains, strengthens and maintains the capabilities to set and achieve their own development agenda.” (Decentralization policy, 2012)

¹⁰ More responsive services means increased equitable access to safe, effective services to those who need them when and where they are needed. (USAID)

5. What are the strengths and weaknesses of RBHS interventions to develop community health systems and services, including major challenges, results and recommendations for incoming projects?

II. PROJECT BACKGROUND

The Rebuilding Basic Health Services (RBHS) project was a six-year and four-month cooperative agreement (2008-2015) with JSI Research and Training Institute, Inc. in partnership with Jhpiego, the Johns Hopkins University Center for Communication Programs (JHU-CCP), Management Sciences for Health (MSH) and, later in the project, Institute for Collaborative Development (ICD). Following a modification in 2011, the project was revised, shifting from its original focus on service delivery to capacity-building and health system strengthening. This was in part due to a U.S. Government shift in strategy that called for direct government-to-government support, leading to the funding mechanism called the fixed amount reimbursement agreement (FARA). RBHS was tasked with supporting MOHSW towards carrying out FARA deliverables through a process of participatory and comprehensive capacity building. USAID also expanded the project to include responsibility for the management of the final phases of the Participant Training and Human Capacity Development Project (FORECAST), support for a research project being conducted with the MOHSW and assistance to the Liberian Board of Nursing and Midwifery and the Liberian Medical and Dental Council to develop accreditation procedures for their training institutes.

Adhering to the 2011-2021 National Health and Social Welfare Policy and Plan (NHSWPP),¹¹ the revised project design was developed around the six building blocks of health systems strengthening developed by WHO:¹² (1) delivering essential health services, (2) the health workforce, (3) health information systems, (4) access to essential medicines, (5) health systems financing and (6) governance and leadership. For this second phase of the project, there were two main intermediate results: (1) increased access to basic health services through improved provision of quality health services and adoption of positive health behaviors; and (2) increased quality of health services through improving infrastructure, health workforce and systems performance by enhancing capacity to plan, manage and monitor a decentralized health system.

Capacity building is defined as a process of **workforce development** (capacity of individual health workers to meet objectives), **organizational strengthening** (activities to improve the organizational setup and communications of implementing organizations), and **systems strengthening** (strengthening various elements such as policies, strategies or operational plans of the overall health system and sub-systems) that enables the health sector to meet objectives and perform better, resulting in improved health outcomes. (MOHSW and RBHS. Capacity Building Strategic Plan. 2012.)

By building capacities within each of these blocks at the central and county levels, the RBHS project planned to contribute to the national strategy for decentralization whereby the County Health and Social Welfare Teams (CHSWTs) would gradually assume responsibility for managing all aspects of county health service delivery. It was recognized that in order to successfully carry this out, the project would also need to strengthen the capacity of the central MOHSW.

According to project documents, a participatory planning process was facilitated by RBHS in 2012, starting with a baseline capacity assessment at the central MOHSW and in three counties (Bong, Lofa and Nimba). These results were used by the MOHSW and CHSWTs to develop the MOHSW Capacity-Building Strategic Plan. As described in that plan, “The goal of the capacity building process is to build comprehensive capacity at all levels—individual, organizational, and health system. Each level is closely related to the others; building capacity at the individual level occurs simultaneously with building capacity at the organizational and health system levels. For example: training of workforce (individual level) in

¹¹ Varpilah ST, Safer M, Frenkel E, Baba D, Massaquoi M, Barrow G. (2011). Rebuilding Human Resources for Health: A Case Study From Liberia. *Human Resources for Health*. May 9(11).

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>

using the Logistics Management Information Systems (LMIS) will be followed by a roll out of LMIS at CHSWTs (organizational level) and linking LMIS data with HMIS and financial databases (health system level). This results in a stronger Supply Chain Management System where quality data is collected in a timely and accurate manner, enabling MOHSW to use the data to make evidence-based decisions for ensuring access to essential medicines (Building Block 4).”

The MOHSW and the three target counties then developed their plans for each of the building blocks. The following excerpts illustrate the plan formats and content:

Table I. Capacity-Building Plan Excerpts

MOHSW Capacity-Building Plan			
Building Block I: Delivering Essential Health Services			
Objective	Interventions		
	Individual	Organizational	Health System
Establish a mechanism for supportive supervision at all levels to ensure adherence to Health Service Delivery Standards by July 2013.	<ul style="list-style-type: none"> Train CHSWT staff on conducting, documenting, and providing feedback on supportive supervision. Train central MOHSW supervisors on documenting supervisory visits and providing feedback to CHSWT staff. 	Establish coordinated supervisory schedule with the input of the CHSWTs.	Create a user-friendly method for documenting and providing feedback on supervisory visits, following up on supervision feedback and measuring progress on feedback provided.
Bong County Capacity-Building Plan			
Building Block I: Delivering Essential Health Services			
Objective	Interventions		
	Individual	Organizational	Health System
Implement a system of written feedback for supervision conducted at health facilities.	<ul style="list-style-type: none"> Orient the supervisors toward Essential Package of Health Services (EPHS) policies, plans and targets. Conduct a thorough orientation on EPHS. Train the supervisory staff to provide written feedback to the people they are supervising. Train CHSWT staff on coaching health facilities during supervision. 		

The following are examples of deliverables gleaned from these plans for each building block:

- 1. Health services:** Supportive supervision system at all levels
- 2. Workforce:** Human resources information system developed to keep track of staffing data at CHSWT and at the health facility level
- 3. Health information system:** National system using DHIS 2.4 software rolled out
- 4. Access to essential medicines:** LMIS operationalized
- 5. Health systems financing:** Training of CHSWT staff on financial management policy and distributing financial management manual to CHSWT
- 6. Governance and leadership:** Communication strategy and policy developed and disseminated

To support the central and county plans, RBHS utilized several capacity-building approaches including:

- Technical assistance from international and national partner staff and consultants to develop policies, guidelines, training programs and software
- Training of central and county-level trainers and use of cascaded training modes
- Exposure trips to countries in Africa, e.g., Ghana for health financing
- Embedded staff to provide technical assistance and to mentor in the use of organizational systems developed (e.g., HMIS or LMIS)
- Exchange trips within the country
- Facility renovations and provision of material aid

A Capacity Building Core Group, led by the MOHSW's monitoring and evaluation unit, was established to monitor the capacity-building processes and progress, using the baseline assessment as a reference point. Additionally, RBHS and counties agreed to form core groups at the county level to assist with monitoring activities. According to RBHS project staff, the latter were not well developed given the disruption caused by the Ebola outbreak, but the quarterly review meetings were used to monitor progress of activities with the Capacity Building Core Group and each of the three CHSWTs participating. No benchmarks were set to track changes in level of capacities or decentralization of functions.

The project work plan was dynamic; in addition to the capacity-building interventions, additional tasks were assigned by USAID after the initial planning of the second phase. In mid-2013, RBHS was tasked with supporting the Government of Liberia to develop a new health financing system. RBHS then developed a formal partnership with ICD to assist the government priority of improving sustainability of health care funding and its objectives¹³ related to universal health coverage. Additionally, findings from a 2013 risk mitigation assessment conducted by USAID were incorporated into capacity-building activities. As an example, based on the assessment finding of an "absence of established means of communication between county and central office procurement staff" that was identified as affecting interpretation of regulations, RBHS was tasked with assisting the MOHSW to design a communication strategy.

While not an exhaustive list, there were several significant events that challenged project implementation. These were the 2011 presidential election, two health worker strikes and the 2013 onset of the Ebola outbreak, which spread fear among health care workers and communities and interrupted delivery and use of essential health services.

In 2014, JSI consultants and staff conducted an internal assessment¹⁴ of the MOHSW and FARA counties. The purpose of the assessment was to: (1) document achievements and capacity changes by each building block; (2) identify gaps; and (3) recommend approaches to inform implementation of future projects. It used a mix of methods, including the administration of the RBHS Capacity Assessment Tool, originally used in 2012 to assess baseline capacity. The overall findings were generally positive but noted: "Capacity has improved across the board, but uneven across the three counties and six building blocks; reflected in quantitative self-assessment scores... 'developing and new' activities require continued support."

The timeframe of the project was extended from the planned end-date in October 2014 until February 2015 to continue support for management and health service quality improvement and to assist the

¹³ NHSWPP. National Health and Social Welfare Policy and Plan 2011-2021.

¹⁴ RBHS. Endline Capacity Assessment of MOHSW and FARA Counties Report, May 12 – June 27, 2014.

MOHSW with the Ebola response, particularly prior to the ramp-up of the international response effort. Since the beginning of the outbreak, RBHS has been part of the collaborative effort of the MOHSW and its local and international partners. RBHS was asked by the MOHSW to take the lead in developing and conducting outbreak-related infection prevention and control trainings at routine health facilities with WHO and to lead the National Infection Prevention and Control Task Force. JSI also partnered with the Clinton Health Access Initiative in supporting the MOHSW with initial management of essential supplies received and distributed for the Ebola response prior to the activation of the UN Logistics Cluster system. This activity responded to the urgent need for health worker personal protection equipment and enabled the Liberian government to meet the needs of facilities as efficiently as possible. The RBHS project also assisted the contact-tracing team to develop a standard contact list for patients and medical staff to complete.

III. EVALUATION METHODS AND LIMITATIONS

This external process evaluation was commissioned by USAID to gather practical information about RBHS achievements, approaches and lessons learned since 2011 to inform follow-on projects. A mixed case study approach was used, triangulating findings from a desk review of program documents, interviews and focus group discussions with stakeholders and capacity-building activity recipients, and observation of project-supported systems and community works. A desk review of RBHS project documents was conducted, with most attention given to the second phase of the project. Interview guides were developed around the five evaluation questions. A team of five evaluators hired by GH Pro traveled to Bong, Lofa and Nimba counties, and, using semi-structured interview guides (Annex II), listened to members of each county health team, observing systems introduced by the project.

Using purposive and convenience sampling strategies, the evaluation team visited two¹⁵ public health facilities and catchment areas in each county. In these communities, the team conducted interviews and or focused group discussions with clinic staff, Community Health Development Committees (CHDCs)¹⁶ and community volunteers—general community health volunteers (gCHVs), community volunteers working on the Ebola response (CHVs) and trained traditional midwives (TTMs)—as they were available (the CHSWTs helped with contacting district health officers or, in their absence, clinic staff). These methods were primarily designed to learn about the roles and activities of community structures supported by RBHS. Additionally, teams observed facility improvements undertaken by RBHS, (i.e., new clinic rooms) as well as those by the PBC implementing partners and the CHDCs, (e.g., maternity waiting homes, fencing, meeting rooms and sheltered waiting spaces). In Bong County, an additional visit was made to a demonstration site where the project had worked to develop community-led health promotion and the use of Partnership-Defined Quality.

Table 2. Informants Interviewed by County

Level	Bong	Lofa	Nimba ¹⁷
Health Facilities	3 clinics	2 clinics	2 clinics
CHSWT and District Health Team (DHT) members	14 CHSWT members 2 District Health Officers (DHO)	12 CHSWT members	9 CHSWT members 1 DHO
Community volunteers and/or supervisors	9 gCHVS 1 CHV and 2 supervisors 14 TTMs 1 midwife supervisor	Eight gCHVs 1 CHV	2 supervisors from 2 facilities 2 CHW
CHDCs, CDC	2 CHDCs 1 CHC Quality Improvement Team (demonstration site)	2 CHDCs	2 CHDCs
PBF Steering Committee		1 (2 community-based organizations represented)	
PBC (NGO) staff	1	2	1

¹⁵ A third health clinic was included in Bong County, which demonstrates well the RBHS work to mobilize community involvement in improving quality of care and facilities.

¹⁶ CHDCs operate at the catchment area of a health facility; these structures include representatives from community health committees (CHCs), which are from communities and work at the community level.

¹⁷ Scheduling interviews was most challenging in this county. Fewer personnel were available, or available for only short visits, for several reasons: a new outbreak investigation was underway with WHO and CDC, and an infection protection workshop and the presidential deconcentration workshop were being conducted. Community representatives from the CHDCs were not available due to “farming” or “traveling,” so the team was only able to meet with Officers in Charge (OICs) who also serve as CHDC members.

As time allowed during field visits, the team held short discussions with external stakeholders (WHO, UNICEF, CDC and African Union) regarding the Ebola response. In Monrovia, the team conducted face-to-face or phone interviews with seven present or former senior staff of RBHS, three senior management staff of PBC implementing partners (Africare and International Rescue Committee) and 13 officials from MOHSW. (See Annex III for list of contacts.)

The scheduling of this evaluation was not optimal, given that the country is just starting to recover from a deadly Ebola outbreak that caused a national crisis. Serious time constraints continue for key informants at the central, county and community levels as they continue to be busy with Ebola-related activities; for example, two counties were holding large workshops on infection prevention and control. Also, since the project was in the final stages of closure, many of the key RBHS staff were not in country; however, they were responsive to telephone interviews.

Additionally, in the midst of the field visits, the very important Deconcentration Platform was launched in Bong County by the President of Liberia, H.E. Madam Ellen Johnson Sirleaf. This was followed by three days of national planning attended by senior county officials, including health officers and health department directors. This event limited access and time available for interviewing these key informants. In addition to individual consultations, the evaluation team had hoped to hold group consultative meetings with central stakeholders around the major study foci: decentralization, Ebola response and capacity-needs identified, and community health programming. These meetings were not possible, because the participants were busy developing plans and budgets for the new MOHSW National Investment Plan for Building a Resilient Health System.

During the field visits, the team noted with appreciation the natural beauty of rural Liberia and the open and frank nature of people they talked to. The team also noted challenges to accessibility, such as the poor road conditions in some areas (e.g., the road from Bong to Lofa County) and how access could be limited during the rainy season, the lack of cell phone coverage, the poor availability of electricity and the continued presence of many international organizations and intense activity relating to the Ebola response.

Preliminary evaluation findings were presented in separate briefings to the USAID team and to MOHSW staff from relevant departments and units on March 4-5. The comments and feedback from these briefings and from RBHS staff assisted with interpretation of findings.

IV. FINDINGS

In this section, key findings are presented for each of the evaluation questions.

EVALUATION QUESTION 1: EFFECTIVENESS OF CAPACITY-BUILDING INTERVENTIONS

RBHS Project Design using the WHO HSS Conceptual Framework

Adhering to the National Health Policy, the project used the WHO HSS Conceptual Framework to design activities to build capacity relating to its six building blocks (health services, health workforce, health information system, access to medical products, vaccines and technologies, access to drugs and supplies, health financing, and governance and leadership). By addressing the building blocks, the project design took a holistic approach to HSS. This shift in the second phase resulted in a multi-focal project, requiring diverse internal capacities and varied approaches to address each of the blocks, including governance and leadership, the “complex but critical building block of any health system.” JSI Research and Training Institute, Inc. led the consortium of well-recognized technical organizations composed of JHU-CCP, Jhpiego, MSH and, later in the project, ICD.

From its review of project activity documents and discussions with MOHSW and CHSWTs, the team noted that improvement of service delivery—including development of supervision and quality improvement systems, infrastructure improvements, workforce development and assistance with supplies—remained a primary focus, which meant that less work was done to build the critical foundation building blocks of health system management and support services: (human resources, supply chain, health finance, resource mobilization and governance mechanisms such as county health boards). CHSWTs reported the critical need to address essential elements such as management systems, sufficient qualified human resources and sufficient tools, supplies, transport and infrastructure). This was recognized as requiring in-depth attention to revising central processes, national policies and financing, and to phasing, as appropriate, the development of skills and systems at the county level.

RBHS Capacity-Building Approaches

The project’s capacity-building approaches included software adaptation for electronic databases, provision of short- and long-term technical assistance, embedded advisors, exposure trips (primarily to countries in the region), formal training program development, training of trainers and cascade training modalities, regular data review meetings and joint processes for capacity gap assessments, supportive supervision followed by participatory planning, and provision of infrastructure improvements and equipment.

The following describes the perceived value and effectiveness as well as criticism of several key capacity-building approaches as heard from recipients or stakeholders during the evaluation.

Software and Electronic System Development

RBHS was instrumental in strengthening the HMIS system with the development of the DHIS 2.4 software and through building the capacity of MOHSW, CHSWTs and facility staff to manage the HMIS data. This was highly appreciated at central and county levels. Technical assistance and support for adapting the software for the iHRIS system was also valued by central MOHSW, and introductory training on the system was provided to county human resources staff. The downside to the use of web-based systems is the need for financial resources to ensure stable internet connection and electricity.

Embedding of Project Staff and Advisors

Both central and county recipients voiced appreciation of embedded RBHS staff; these were particularly effective in the case of developing the new PBF unit within the MOHSW and in developing HMIS capacity in the counties. During interviews, there were mixed opinions about the use of the “capacity-building officers” embedded with the CHSWT. Central and county critics mentioned lack of sufficient expertise and the non-specificity of the terms of reference, while proponents among CHSWT noted with appreciation the assistance of these personnel with planning health services and organizing joint supervisory visits and quality improvements. At the central level, the evaluation team heard differing opinions about RBHS advisors housed at the MOHSW, with critics noting that the advisors were “stretched too thin as they tried to advise several departments/units” and to meet project deliverables. As articulated by a senior official at the MOHSW, “embedding advisors works if there is someone to transfer knowledge to,” noting the risk that advisors will be used to carry out staff workload.

Experiential Learning

The Bong County health team, along with Africare, now has a PBC to manage public health care financed by USAID under the FARA. This approach is known as “contracting-in.” The CHSWT is learning how to plan, budget and oversee the services and performance of several facilities, with the initial assistance provided by the RBHS capacity-building officer and ongoing assistance by Africare, an experienced PBC that is managing the other county facilities. Both Africare and the CHSWT noted with appreciation the value of the collaborative and experiential learning processes that continue during joint supervisory visits and planning actions for service improvements.

Formal Training and Education

In conversations with the CHSWTs and health care staff, the evaluation team noted the high demand for formal training “by experts” and opportunities to access pre-service and post-graduate training programs. Stakeholders at the county level applauded the quality of formal training provided by RBHS. The criticism mentioned by both CHSWTs and PBC implementing partners was the lack of coverage of important formal trainings; all mentioned more training on supportive supervision as an unmet need. The need for continual HMIS training—both refresher for old staff and initial training for new staff—was also mentioned by the CHSWTs and implementing partners.

RBHS developed trainers at the county level; during the evaluation, RH and MCH supervisors stated that they have acquired skills to provide on-the-job training for new or untrained staff, e.g., on how to insert implants, but that “formal training is also needed.” When questioned, CHSWT technical staff denied having teaching aids and materials for conducting cascaded training. In a visit to the Community Health Division at the MOHSW, the team heard personnel concerns relating to lack of adequate IT hardware and the need for improved systems for storage of training modules (hard and soft copies).

Finding the best way to deliver formal training was a challenge for the project. As noted by RBHS staff, during the project they were asked repeatedly by the MOHSW to minimize the time that staff were away from their workplace. Therefore, more attention was given to on-the-job training and mentoring.

Tracking staff training and competencies continues to be difficult. The adapted iHRIS software will provide an important database to track that staff have completed core training programs and to verify reported needs for training.¹⁸ The iHRIS is not yet functional at the county level, having just been established at the central level in 2014.

¹⁸ The importance of this tracking system was illustrated during the visits to one county, where a technical supervisor stated that only a few members of the CHSWT have been trained in supportive supervision. This was refuted by a senior member of the CHSWT who said that all of the supervisory staff had received training. It is recognized that this debate may relate to the issue of formal versus informal training.

Exposure/Cross Fertilization Trips

Several exposure/learning trips were supported. Examples include a trip to Ghana to learn about its national health insurance schemes, and, in the first phase of the project, to Sierra Leone to learn about its experience with i-CCM. These were highly regarded learning experiences for the participants, who were largely from central MOHSW. A participant of the Ghana trip reported how it benefited the task force: “After hearing their experiences we came back and had to re-think our concept.” The few criticisms heard about this approach had to do with selection of participants (e.g., “The Ministry of Finance sent junior rather than senior officials”) and by county-level technical staff (e.g., “We do not get to go along on exchange visits”). While CHSWTs mentioned traveling within the three counties for workshops, County Health Officers (CHOs) expressed the need for more learning from their peers in the region.

The project also promoted the addition of a capacity-building officer to the county health office, as well as the development of the regional support teams to assist with developing capacities. These were conceptualized later in the project and with the Ebola crisis were not fully implemented. The need for an orientation program was noted. In the three counties the CHOs are relatively new¹⁹ to the position; none reported having had a formal orientation (“just my job description and what I learn from the County Health Department Director”) or special training for the position. All mentioned need for more training in management and public health.

While the project also supported facility renovations, two of the three CHSWTs would have liked to have had more assistance to ensure that public health facility infrastructure meets minimal standards (concerns mentioned were the needs for improved roofing, water and sanitation). During these discussions, complaints were also raised about the low level of allotment funding for counties. Several interviewees from MOHSW and the CHSWTs mentioned that they had hoped the project would help to equip them; the need for vehicles (both ambulances and vehicles for transporting supervisory teams and delivering supplies) was most frequently mentioned.

A challenge to effective capacity building, stated repeatedly in project reports and echoed by several central and county informants, is the lack of relevant experience and minimum skills possessed by personnel who have been recipients of RBHS efforts and are in vital positions. A related concern voiced is the need for more inclusive training to ensure that senior managers are oriented to training provided to staff reporting to them.²⁰ This relates to another frequently mentioned gap that affects uptake of electronic systems: the lack of basic computer literacy among staff. RBHS personnel also noted being challenged at times by a lack of willingness to learn or unavailability on the part of key Government of Liberia personnel, resulting in poor transfer of skills and functioning systems.

A common theme in discussions about capacity-building approaches with CHSWTs and several MOHSW officials was the need to strengthen technical assistance with (1) clear, specific and time-bound terms of reference, (2) selection of personnel with expertise, relevant experience and capability for knowledge transfer and teaming,²¹ (3) clear measureable benchmarks for the capacity-building activity and (4) careful monitoring of performance by the project and donor. In one county, the senior members

¹⁹ The most senior CHO has been in place for three years, the second started just before the Ebola outbreak and the third has been in place for three months. All are physicians and former Hospital Chief Medical Officers who were selected and appointed by the MOHSW.

²⁰ Examples include: a CHO who was formerly a Chief Medical Officer mentioned that he was not oriented to the Improvement Collaborative process; only the hospital supervisors (reporting to him) received the training. “I had to read the materials on my own,” he reported. County health administrators also mentioned concerns that they are not included in training for support staff who report to them.

²¹ Discussions with MOHSW and CHSWTs showed that expectations placed on embedded county capacity-building officers were difficult to meet, given the myriad systems to strengthen (finance and accounting, human resources, infrastructure improvement, supply chain, service delivery, quality improvement and development of community health services).

of the CHSWT expressed a desire for more involvement in selecting the capacity-building approach and developing terms of reference for advisors or embedded staff.

Additionally, the evaluation team heard from several informants from the CHSWTs and the central MOHSW that the project could have been stronger if it had taken a “comprehensive” approach. When asked what this would entail, suggestions ranged from the broad (the need to develop national and county systems for ensuring adequate workforce and salaries, stable and efficient supply systems, and adequate financing mechanisms for operations) to the specific (the need for more direct material aid, such as “transport for supervisory visits,” to ensure that they are sufficiently equipped to carry out their functions).

Results per Building Block

The following section describes several of the outputs produced as found in project documents and mentioned during field visits.

Health Services

During the second phase of the project, RBHS assisted the MOHSW, working closely with the Community Health and Health Promotion units and the County Health Services Department, to finalize the Community Health Road Map, an operational guide for counties and districts.

Joint supportive supervision was scaled up, with the county and PBC implementing partners making monthly and quarterly visits with MOHSW technical staff. A 29-page checklist, “National Integrated Monitoring of the EPHS,” provided by the MOHSW, was observed being used. This tool, according to clinical supervisors and advisors, is redundant, cumbersome and hard to administer, as there is no guidance for posing questions or for observing conditions and practices. It also limits the time needed for providing mentoring, coaching and on-the-job training. Informants from the MOHSW County Health Services Department were aware of the need to refine the joint integrated supervisory tool to be more user-friendly, qualitative in nature and focusing on quality assurance. Both CHSWTs and MOHSW staff interviewed noted with appreciation the benefits of joint visits, i.e., the sharing of information, the greater efficiency both for the supervisors and supervisees, and the use of findings for planning actions at the time of visit.

RBHS worked with central and county clinical supervisors and MCH/RH officers to operationalize²² high-impact MCH/RH interventions, such as community-based family planning, i.e., Contraceptive Days coupled with mobile clinics to provide long-acting contraceptives; this has resulted in rising demand for implants. According to CHSWT and midwives visited, the use of trained traditional midwives (TTMs) to accompany women for facility-based deliveries has contributed to an increase in skilled birth attendance. Community-based distribution of misoprostol (for emergency home births) by TTMs has just started in Bong County, and the expanded continuum of care (including development of gCHV roles and responsibilities, such as task shifting or sharing in areas such as i-CCM) is in varying phases of implementation. According to CHSWTs, gCHVs and their supervisors, the barrier to scaling up iCCM is primarily due to a breakdown in the supply chain. This is an example of how the building blocks interconnect and illustrates the importance of a holistic approach.

The use of the “improvement collaborative” process was initiated in four hospitals in 2013, with RBHS providing technical assistance to the MOHSW to develop inpatient clinical standards and quality

²² It was noted with appreciation that the project assumed management of several initiatives when USAID-funded projects closed. One included operationalizing the Global Health Bureau’s flagship Maternal and Child Health Integrated Program (MCHIP) work to have trained traditional midwives (TTMs) distribute misoprostol to women who delivered at home (those not choosing to have recommended facility-assisted births) or where there was not time to travel to medical facilities.

assurance processes. The timeline of the project did not allow for these processes to be expanded to primary health care settings.

Workforce

In addition to staff development as described above, according to MOHSW, RBHS supported staff to customize the iHRIS, an open-source, electronic human resources information system for health, and trained central staff on how to gather and input data. Introductory training was provided to county human resources staff prior to the Ebola outbreak; CHSWTs reported that the human resources directors had received training, but that the system has had major challenges, including connectivity issues, computer competency of staff and collection of personnel data. Creative ways have been developed to compensate for the lack of unique identifiers, e.g., national registration numbers, but these may not be optimal for tracking staff as they move from county to county. Currently, the iHRIS is only being operated by the central MOHSW.

In all three counties, the evaluation team heard that the use of non-government clinicians and support staff at facilities continues, as do the complaints from these staff that their “incentives” have not been paid for months; this practice needs more in-depth study. When questioned about the possibility of enacting a staff performance appraisal system (included in the RBHS plan but not operationalized), CHWTs replied that this is not applicable, because the governmental human resources system has mechanisms in place for rewarding or sanctioning poor performers.

Health Management Information System (HMIS)

RBHS worked with the MOHSW to develop training packages for preparing staff to use the web-based DHIS-2.4. HMIS officers were embedded in each CHSWT to train, coach and mentor personnel to implement data management processes and to use the systems. All three counties expressed their strong appreciation of the assistance provided by RBHS to develop the HMIS system and facility personnel skills to gather information, record and report standardized data. In Nimba County, the HMIS service is decentralized at the district level, where data are collected and entered at all the districts. Bong County is also in the process of training eight of the eight districts’ monitoring and evaluation focal persons to deconcentrate data entry to the district level. In all three counties, facilities providing the EPHS are using the national data management system. A constraint to the use of the DHIS is that continuous internet connection is required, and funds are often scarce. In one county, data managers told evaluators that they are paying for internet out of their own pockets. In another county, connectivity was said to be possible only due to the contribution of funding by an Ebola-response NGO.

In looking at results, it was of interest to review the report of the follow-up assessment conducted by RBHS staff in 2014 using PRISM methodology.²³ As may be noted in the following table, there were significant improvements as compared to the PRISM assessment in 2012.

Table 3. HMIS Performance Indicators

HMIS performance	Facilities (2012)	Facilities (2014)	Districts (2012)	Districts (2014)
Data accuracy	55%	84%	78%	88%
Completeness	52%	79%		
Timeliness	74%	88%		
Use of data	38%	58%		75%

²³ Performance of Routine Health Information System Management in Liberia

During interviews, CHSWTs, the MOHSW and PBC implementing partners raised concerns about the timeliness and completeness of reports from facilities and, to some degree, the quality of service data. When questioned about the factors that cause or contribute to poor reporting, CHSWTs noted that, “Some do not understand or care,” and, “Reports are not checked carefully before being sent or brought by the implementing partners.” The HMIS staff noted that facilities may depend on overworked midwives to compile the data, because there are no registrars or data clerks.

The 2014 PRISM report also noted that analysis of HMIS data remains underdeveloped at the county level. Team members visiting the HMIS offices noted graphs of maternal death, and HIV data. The evaluation team looked for but did not observe the posting of dashboard graphics at the county health office, though a county administrator mentioned that this had been displayed in 2014. At the clinics visited, only the traditional hand-drawn graphics showing immunization coverage were seen. As to increasing use of data, in one county the data manager reported that the new CHO is asking for monthly analysis of the indicators in addition to the quarterly report.

Data verification for the HMIS staff was also reported to be challenging, as health facilities may have poor telephone networks and the transport for CHSWTs to travel to facilities is often limited.

Building on prior work by the Community Health Division at the MOHSW, RBHS provided technical assistance to develop standard operating procedures for the new C-HMIS, which links to the HMIS and training modules. Trainers were trained, but the roll-out of the system was halted by the Ebola outbreak.

Access to Supplies

Working in collaboration with the USAID DELIVER Project, the CHSWTs reported training provided by RBHS on the new LMIS system during the first phase of the project. This included instruction on the use of bin cards, ledgers and requisition forms. In the second phase, mentoring and coaching was provided to county personnel by embedded capacity-building officers to encourage the use of the LMIS, and with PBC implementing partners to assist with the supply chain, as county logistics and transport systems remain poorly capacitated. Training was provided by RBHS on quantification, forecasting and planning. RBHS capacity-building officers and technical advisors provide mentoring to CHSWTs to promote use of the LMIS. The end-line assessment conducted by RBHS and discussions/observations with relevant CHSWT staff and facilities noted that the manual LMIS is being used. The electronic LMIS is not being used; barriers are said to be primarily related to insufficient numbers and computer skills of personnel.

Accountability measures (e.g., the special internal controls outlined in the MOHSW’s “Interim Approach” supply chain plan) were introduced; this has engaged the CHDC in monitoring supplies to clinics.

While tracking and manual reporting have improved, according to assessment reports and discussions with the CHSWTs, drug distribution and transport systems remain ad hoc, as described in the 2012 SLICE assessment, and stability of supplies continues to be problematic.²⁴ Stock-outs of essential medicines continue, according to CHSWTs and health care workers who were interviewed. This ongoing issue may be underreported; the RBHS July 2013-June 2014 report using HMIS data shows that 83 percent of facilities report not having stock-outs of tracer drugs. Even in counties where fewer complaints were articulated about shortages of supplies, the actual status of county systems for

²⁴ The team observed the complexity of the issue firsthand in Nimba County, where the OIC reported a lack of childhood vaccines for three months, as well as no supply of amoxicillin and paracetamol. She stated that she had been reporting this to the district health officer to no avail. According to the USAID monitor visiting, there had been a shortage of vaccines during the Ebola outbreak. He suggested that the OIC call the County Health Department to check on supplies. When she did this, she learned that the supplies were now available and dispatched the vaccinator by motorcycle to pick up the supplies, as the district health officer did not have transport capacity.

accessing essential supplies may be skewed, because the PBC implementing partners are assisting with transport and may be covering short-gaps in supplies.²⁵ In interviews, all of the CHSWTs reported that they are in need of additional vehicles for transport of supplies and funds for fuel.

As has been described in prior assessments and both internal and external reports,²⁶ there are also infrastructure needs to ensure proper storage. In Bong County, evaluation team members visited the drug depot, which is housed within the hospital and was observed to have cramped and very high-temperature conditions.

Health Finance

The areas of study relating to health financing include: (1) performance-based financing and contracting, (2) health financing reform and (3) public health management.

According to MOHSW and PBC implementing partners, the transfer of the PBF program and contracting of service delivery partners from RBHS to the MOHSW was successfully completed early in the second phase, and contracts were continued with two large international NGOs (Africare and International Rescue Committee). In 2014, the Bong County Health Department was signed on as an implementing PBC partner, managing several county facilities in addition to those managed by Africare. RBHS continued to support an embedded advisor from MSH within the PBF unit under the MOHSW's FARA department. Continuing the performance appraisal system, an additional assessment of client satisfaction was developed. These assessments were carried out in 2013 by community-based organizations contracted by PBF steering committees in each county. PBF staff report that these assessments have identified performance issues not previously captured (e.g., staff not keeping to clinic schedules).

The MOHSW reported high satisfaction with the technical assistance provided by RBHS to explore new health financing schemes. The Health Equity Fund, a new concept for health financing, was developed. While endorsed by the President of Liberia, the Ministry of Finance has questioned the capacity of the government for managing the scheme. Work to continue the dialogue has halted since the project's end and the Ebola outbreak.

A joint risk-mitigation assessment was conducted by MOHSW and RBHS, resulting in recommended action steps to improve financial and procurement practices as well as communications within and between MOHSW and the counties. According to project staff and CHSWTs, RBHS capacity-building officers followed up with training of county accountants to help them understand the newly revised MOHSW Financial Management Policies and Procedural Manual. Counties continue to use spreadsheets rather than a standardized computerized system. According to CHSWT and MOHSW informants, there have been no improvements in liquidation and allotment dispersals. In all three counties, the evaluation team heard of the need for more in-depth problem analysis of the allotment fund system, training and mentoring.

During field visits, the evaluation team observed the excitement and heard about the struggles as CHSWTs worked (with the help of implementing partners and the FARA unit) to develop proposed activities and budgets for the MOHSW's National Investment Plan for Building a Resilient Health System post-Ebola. This is intended to complement the 10-year NSWPP and outline additional needs and priorities for the health system between 2015-2012. A budget worksheet developed by FARA with support of RBHS was reported as helpful in thinking through necessary inputs and costing.

²⁵ At a clinic visited, the staff reported that they have no problem with stock-outs: "(Partner that will remain anonymous) takes care of us." Another partner noted that it does not have additional funding to cover drug shortages, but it has bought malaria drugs, as "it is one of the performance indicators."

²⁶ "Endline Capacity Assessment," (RBHS 2014); "SLICE - Supply and Logistics Internal Control Evaluation" (Deloitte Consulting 2012).

Governance and Leadership

With the assistance of RBHS technical staff, a communication strategy was developed by the MOHSW. Dissemination of the strategy was planned for 2013 but was halted due to the Ebola outbreak.

Senior CHSWT members were involved in joint and self-assessment of county capacities and gaps; these resulted in joint planning of capacity-building activities. CHSWTs noted that they are more active in coordinating the health sector, holding regular meetings with partners and projects to share information and to avoid duplication of efforts.

While strengthening the county health boards was planned by RBHS for 2013-14, this important governance work was not conducted because of the Ebola outbreak. Given that the County Health Boards are not active, the evaluation team was unable to meet with members.

CHDCs were developed with the support of RBHS and PBC implementing partners and, according to CHSWTs, are taking “ownership” of local facilities as well as acting as a watchdog over the functioning of clinics and staff. One CHO related how active CHDCs have become, “Just today they contacted me advising us to remove staff that are rude; another contacted me this past year asking us to keep staff at the clinic instead of transferring them to another position.”

RBHS Contributions to Intermediate Results

The RBHS project had two intermediate results: “Increased utilization of quality services,” and “More responsive services¹ through effective health system decentralization.”

Under the first intermediate result, the MOHSW and CHSWTs report an increase in utilization of services and better prepared workforce and facilities to provide quality care. As an indicator, RBHS documents using HMIS data reported that facility-based deliveries rose in supported facilities in the three counties from under 20 percent in July 2009 to 68 percent in June 2012. This utilization pattern appears to have remained stable, with 66 percent utilization reported in the July 2013-June 2014 report of HMIS data. While few quality-of-care indicators are reported regularly per the HMIS, project documents show that significant progress was made that reflects improved quality of care: From July 2011 to December 2013, the proportion of pregnant women who were tested for HIV at their first antenatal visit and counselled after receiving their results increased from 26 percent to 81 percent.

The evaluation team heard from the MOHSW and CHSWTs that they perceive that services are more responsive; they attribute this result to improved systems and practices developed with assistance from RBHS. These include clinical training; joint supervisory visits; quality improvement processes; performance-based incentives for county teams, health care staff and community-led improvements; facility renovations; community monitoring and involvement in quality improvement; and community-based delivery of MCH and FP/RH high-impact interventions (e.g., Contraceptive Days with mobile clinics delivering counseling and short- and long-acting methods).

The RBHS project produced a large quantity of deliverables and outputs; a review of the deliverables list found nearly 180 in number. In discussions with MOHSW, CHSWT and RBHS staff, it was reported that several of the deliverables were not yet approved (e.g., the communication strategy) or not fully operationalized (e.g. iHRIS and C-HMIS systems), due to the negative impact of the Ebola crisis that halted or disrupted many planned activities. As noted by a RBHS staff member, “We lost almost a year in implementing our planned activities (because of the Ebola crisis).”

It is clear that RBHS has made significant contributions to both intermediate results. To strengthen the body of evidence, more data, or perhaps better documentation and analysis, is needed to show the outcomes of the project interventions. As an example, project reports do not show how the joint supervisory visits contributed to actions and improvements. Discussions with the supervisors from one

CHSWT revealed that there was weak documentation of improvements made as a result of supervisory and monitoring visits.

The challenges to measuring the intermediate results are appreciated. For example, tracking utilization of quality services requires that the services provided are of verified quality, that utilization data are reliable and that there is careful analysis to show trends of utilization by facility. The second intermediate result is also complex, requiring triangulation of qualitative as well as quantitative data to provide evidence of responsive services and further to show how changes in responsiveness are related to changes in measurable decentralization.

Major inroads were made by the RBHS and MOHSW in developing the HMIS system, though the functioning of the data management system is recognized as still sub-optimal; key informants noted that issues continue around the timeliness, accuracy and completeness of HMIS reporting. The PRISM assessment found that data analysis remains underdeveloped at the county level but that data usage is growing at the district level.

RBHS and MOHSW staff interviewed also recognized the need for further development of the quality of care monitoring and evaluation framework and indicators linking these with the HMIS. As an example, the indicator, “percentage of women receiving AMTSL who delivered in a health facility by skilled birth attendants,” is not routinely measured nor reported as part of the HMIS. RBHS, working with the FARA/PBC unit, introduced monitoring of client satisfaction as part of the performance-based appraisal of facilities. While still nascent, such an activity, if conducted systematically and reported, will be useful in tracking both responsiveness and quality of care.

EVALUATION QUESTION 2: DECENTRALIZATION

A major aim of the RBHS project was to support the decentralized management of the health system in Liberia, as outlined in the 2011-2021 National Health Policy and Plan and as part of the EPHS. As national and project documents were reviewed, the evaluation team did not find decentralization plans or clear documentation about how decentralization was being defined by the stakeholders or the specific functions to be devolved. In its initial discussion with USAID, the team was advised that Liberia is moving toward “deconcentration”²⁷ as a short-term strategy, because the decentralization process has legal implications that the Government of Liberia has not yet formally addressed. Instead, the current government priority is focused on deconcentrating management capacity and service delivery down to the county level, while formal accountability for resources and sector performance lies ultimately with line ministries. During the time of this evaluation, President Ellen Johnson Sirleaf presented the new National Deconcentration Platform, whereby sector-specific services will be immediately moved from Monrovia to the counties to bring real and tangible improvements in the lives of the Liberian people. She mentioned ensuring that Liberians have easy access to postal delivery, quality health service delivery, electricity and education. She indicated that decentralization is a long process and that the government hopes to achieve the Decentralization Reform Agenda in two phases. “Our first phase is to continue to move the delivery of public services out of Monrovia to county center and to do so in an efficient and coordinated manner to ensure that at the county level we build synergies among the service delivery ministries and agencies of government so that our people can be served more effectively,” she indicated. She announced that county superintendents are conferred with the authority to coordinate and manage the delivery of services in their counties. In the second phase,

²⁷ Deconcentration may be defined as the national government’s reassignment of responsibilities to the field offices of national ministries without placing these offices under the control of subnational governments. In other words, deconcentration reassigns authority among different levels of the central government. It can shift operational responsibilities from central government officials in the capital city to those working in regions, provinces or districts, or it can create strong field administration or local administrative capacity under the supervision of central government ministries. Democratic Decentralization Programming Handbook, USAID, June 2009.

greater political authority will be given to local governance institutions, which will involve the election of superintendents, local councils and some sub-county officials and vesting them with authority.

Progress

Important progress was made in devolving responsibility for managing the PBCs from RBHS, an international NGO, to the MOHSW. The initiation of contracting-in²⁸ on a pilot basis under the USAID FARA in Bong County was a major step toward deconcentration, with the shift from reliance on international implementing partners to greater responsibility placed on CHSWTs in order to execute direct U.S. Government financing through the FARA.

The evaluation team did not find national or county deconcentration/decentralization plans with clear definitions of functions to be deconcentrated, nor specific objectives, targets, benchmarks or implementation plans. Rather, the RBHS capacity-building strategy was intended to assist the MOHSW to help counties become more ready to assume new functions. The following illustrates some of the ways that RBHS project helped counties prepare to assume greater responsibilities for management and provision of essential basic services:

- a. Capacity assessments were conducted around the six building blocks and gaps identified jointly by RBHS, MOHSW and CHSWTs. Risk-mitigation assessments conducted by USAID and the MOHSW also increased awareness of areas in need of strengthening at the central and county levels. These findings were used to plan capacity-building activities and other actions, e.g., development of a communication strategy (the dissemination of which was halted by the Ebola outbreak) and revision of the MOHSW Financial Management Policies and Procedural Manual (training for finance officers was provided, but substantial work is needed before applying at the county level).
- b. A finding from the risk-mitigation assessment performed by MOHSW and USAID was used to successfully advocate for recently hired additional finance staff at two of the counties visited.
- c. The RBHS-supported assessment processes are also credited in part with the county health department breaking away from the Phoebe Hospital and becoming an independent county service. The Chief Medical Officer had also been the County Health Officer.
- d. Within counties, innovative work was aimed at rethinking the health system management structure at the county level, e.g., districts assuming HMIS data input functions in Nimba County and CHDCs taking on more responsibility for improvements and maintenance of the local health facilities. Though not a direct result of the RBHS project, work is being done to develop district health teams; the one visited in Bong County previously consisted of one District Health Officer but now includes a MCH/RH supervisor, HMIS officer and a social worker.
- e. Both Bong and Nimba Counties had district teams instead of a lone District Health Officer.
- f. CHSWTs reported that RBHS embedded capacity-building officers helped with planning of services and coordination, e.g., the Health Sector Meeting where all organizations working in the county came together to identify gaps and to avoid duplication of efforts, the quarterly data review meetings and joint supervision systems (CHSWTs with international implementing partners, and CHSWTs with the MOHSW).

During the address to launch the new deconcentration platform, the President noted that considerable progress has been made in restoring health delivery and establishing health facilities as well as

²⁸ “Contracting-in” means that CHSWTs enter into performance-based funding agreements with the MOHSW to manage a set number of health facilities, as opposed to “contracting-out” to NGOs under PBCs, as has been the practice since onset of the PBF.

strengthening county-based health care, but she noted that that the Ebola pandemic and the responses to it indicated that government has not done enough.

Challenges to Deconcentration of Functions to the County Level

The lack of a MOHSW plan for decentralization or even deconcentration was a critical gap that limited the development of a results framework and plan. Discussions with the MOHSW revealed differing perspectives, primarily relating to the management of human resources, oversight of county health services (e.g., the County Health Officer as an extension of the MOHSW or of the county government) and staff development and training responsibilities. It was noted in conversations with central and county stakeholders that there is an inherent conflict of interest for the central MOHSW in deconcentrating supervision and training functions to the counties, because central technical officers/master trainers want to travel to the field to supplement their low salaries with the daily subsistence allowance, and because the MOHSW holds the funds for training. It was noted with interest that the recently designed Investment Plan for Building a Resilient Health System in Liberia makes little mention of investing in deconcentration of functions.

During interviews, senior CHSWT members in two counties emphasized the need to devolve more authority to them and for donors and the MOHSW to consult with the CHSWT to prioritize needs and plan interventions. CHOs noted that the need for this was intensified during the Ebola response, as humanitarian organizations and donors frequently worked directly with the MOHSW (“They go around us”) rather than planning response activities with the CHSWTs.

Key informants, including the three CHOs, noted the underdeveloped management systems and finance, budgeting and accounting skills of the CHSWTs. As noted earlier, the CHSWTs have limited budgeting skills and experience; this was highlighted during field visits, as county teams were enthusiastic but struggled to develop plans and budgets to contribute to the new MOHSW Investment Plan for Building Resilient Health Services. This workforce issue was noted as the root cause of poor liquidation, leading to significant underspending of MOHSW allotment funds at the county level. Interlinking with human resource systems, these rural counties described chronic problems with both recruitment and retention. “We train them and they leave to work with NGOs or other better paying jobs,” was a frequent CHSWT complaint.

Toward the end of the RBHS project, an idea was conceptualized by the MOHSW to form “regional support teams” made up of technical county service-unit and finance staff to help guide CHSWTs through the decentralization process. Raising the idea of the support teams with CHSWTs, their verbal responses were vague, indicating that they had heard of the idea but the teams had not yet been initiated. MOHSW informants noted that counties were well-informed and had input to the terms of reference for the regional support teams. When questioned about the team make-up, the MOHSW acknowledged both the lack of management specialists for the team and the need. A candid informant from a MOHSW officer posed the question, “Will they (the regional support team) know more than the CHSWT how to run county health services?”

In discussions about decentralization, CHOs noted the importance of the county health boards to good governance, supporting the County Health Department with strategic direction and oversight, providing checks and balances, and assisting with mobilizing resources and political support. In all three counties, these governance mechanisms are either inactive (two counties) or minimally functioning, for example, holding no meetings since the Ebola outbreak. In the three counties, the CHSWTs reported that there are conflicting views on who should chair the board: the county or the development superintendent. The team was informed of a national policy delegating this role to the development superintendent. In conversation with one county superintendent, the official questioned, “Why would this be made a policy without county superintendent input?” A senior MOHSW official noted too that the county health boards in the past have been “crafted from here (central) and that this must change so (there is) greater

ownership of the counties.” Using the Social Impact review of decentralization in Liberia²⁹ as a reference point, overall decentralization has not progressed far since 2012 (except for Bong County now managing a PBC) and in some respects may have regressed, as seen in the functionality of county health boards.

Lastly, CHSWTs list the poor county office infrastructure (Nimba County pointed out its lack of a meeting space) and lack of logistical resources such as vehicles for managing the supply chain and conducting supervision as critical needs to successful deconcentration of functions.

After the debriefing to USAID and the MOHSW, the evaluation team had an opportunity to visit with the two-person decentralization unit within the Planning and Development Office. They reported that a key role of the unit is to assist with reviving the county health boards and creating district health boards. They are challenged with lack of funding, human resources and technical support to carry out their functions.

The project’s participatory approach that brings together the MOHSW and CHSWTs to plan the capacity-building strategy and plan is to be applauded, and the challenges of organizational development and systems strengthening in a tight timeframe are appreciated. Several key informants from RBHS, the MOHSW and CHSWTs noted that building capacities for deconcentration or decentralization takes time, and the project’s second phase (three years) was “much too short to see much progress.”

EVALUATION QUESTION 3: EBOLA OUTBREAK

RBHS Contributions to the Ebola Virus Disease Response

Prior interventions and experience, a strong presence and well-developed relationships helped RBHS to assist the Government of Liberia during the early outbreak phase. As a key indication, the RBHS chief of party was called upon by the MOHSW to lead the National Infection Prevention and Control (IPC) Task Force, working closely with WHO, CDC and other USAID implementing partners.

The IPC Task Force was instrumental in:

- Establishing a logistical system for the massive inflow of supplies such as personal protective equipment, body bags, IV fluids, etc., including intake and distribution around the country. Assisting with this was a key activity of RBHS working with the Clinton Health Access Initiative early in the outbreak, and it was expanded further with the influx of expertise and support of other humanitarian agencies.
- Providing technical assistance to develop standard operating procedures containing detailed guidance on essential IPC measures for various levels of care (households, community, health centers, community care centers and hospitals).
- Strengthening the contact tracing system.
- Developing a training program for religious leaders—both Christian and Muslim—and traditional healers with accurate information about Ebola, how they can protect themselves and the steps to take when someone presents symptoms.

RBHS supported and led several critical activities in coordination with the Task Force, with outputs that included:

- Development of a comprehensive IPC training package, “Keep Safe, Keep Serving,” for non-ETU (Ebola Treatment Unit) health workers and facility support staff (such as cleaners and kitchen staff) that includes training materials, job aids and monitoring tools. These trainings, adapted from the WHO Ebola Virus Disease Outbreak Response Training Package, were designed to

²⁹ Social Impact and USAID. An Assessment of Decentralization and Local Governance in Liberia, pp 56-57. September 2012.

educate health care workers and facility staff to recognize suspected cases of Ebola and to protect themselves and others from transmission.

- Provision of IPC trainings for non-ETU health workers and facility support staff, and maintenance of the IPC training database. According to project documents, nearly 7,000 health workers, facility support staff, community members and NGO representatives received IPC training between July and December 2014.
- Restoration of the joint supportive supervision visits to facilities to ensure adherence to IPC protocols and adequate availability of IPC supplies.
- In talking with governmental health officials at central and county levels, they recalled the high level of fear, the lack of preparation for the Ebola outbreak and the appreciation for the assistance provided by RBHS. Several senior MOHSW officers mentioned the important role that RBHS played in providing leadership and support to MOHSW units during the early phases. As stated by one informant, “She (the RBHS COP) would go from office to office talking with us, encouraging us.”

Additionally, prior RBHS interventions contributed to the response. The following are selected illustrations:

- RBHS had worked with CHSWTs to lead coordination efforts in order to identify gaps and avoid duplication of efforts; these capacities were important with the influx of many agencies and organizations responding to the Ebola outbreak.
- The MOHSW’s PBC implementing partners (IRC and Africare), which were contracted and advised by RBHS during the early phase of the project, had collaborative relationships with county health teams and facilities, so they were able to assist with the response by providing logistical support and supplies and developing systems for case finding, contact tracing and environmental health services.
- The gCHVs (developed by RBHS) with community presence and basic reporting skills have been widely utilized by county health departments and the international community to assume the new roles of contact tracing and active case finding.
- The HMIS staff capacities built by RBHS are being expanded to use the electronic software for Ebola reporting introduced by CDC.
- Basic infection prevention had been taught to nurses and midwives and incorporated into RBHS-supported training and quality improvement processes.
- RBHS’s prior emphasis on health promotion and introducing behavior change concepts helped to prepare the county environmental health technicians and gCHVs to work within communities and with local leaders, sharing messages and prevention measures, and to handle sensitive issues such as burial practices.

The legacy of the project’s success in building MOHSW planning and budgeting capacity was also observed during the evaluation as CHSWTs worked to develop proposed plans and budgets for the Investment Plan for Building a Resilient Health System in Liberia³⁰ with coaching and mentoring by contracted PBC implementing partners and with strong guidance provided by the FARA unit for preparation of budgets; this opportunity was described as “exciting” by Lofa and Nimba County teams.

³⁰ This plan was being drafted at the time of the evaluation; a copy of the plan was presented by a MOHSW official to the evaluation team on the last day of field work in Liberia.

Impact on RBHS Activities and Results

The Ebola outbreaks had serious impact, halting many of the planned activities for the final year of the RBHS project. Several important initiatives were not recognized, among them the roll-out and dissemination of the communication strategy, the Community Health Roadmap, and the C-HMIS.

Concerns were voiced that the progress made during the RBHS project (e.g., in demand for facility-based deliveries) would regress. Additionally, concerns were noted about the potential rise in unwanted pregnancies as FP services were interrupted and also about the negative effect on volunteerism caused by the UN and NGO practice of paying gCHVs to do Ebola-related activities.

More positively, the massive national and international response to the Ebola crisis in Liberia has reinforced and will potentially accelerate several MOHSW and USAID shared objectives and results, such as (1) deconcentration of functions so that counties have greater capacity to plan for emergencies as part of their County Operational Plans, to manage local outbreaks and to train and supervise staff; (2) the importance of community structures in disease prevention as a part of the continuum of care (early identification to treatment to follow-up); (3) further refinement to ensure strong data management systems with increased use of data for planning and mobilizing resources; and (4) the importance of supervision and monitoring to ensure that facilities and workers are well equipped and delivering quality care.

Capacity Building Needs Identified During Ebola Outbreak

Health Care System

As has been recognized by many and publicized in the press, the health care system was not prepared to diagnose and care for patients with Ebola Virus Disease, a new disease for the Liberian health system. County health officials reported the need for clinical skills and facilities to identify suspected cases, refer, diagnose and treat new communicable diseases. Specific concerns included:

- Lack of permanent isolation facilities or space at clinics and health centers for triage, the setting up of triage and temporary isolation spaces at clinics, and the provision of early treatment
- Unequipped and ill-prepared laboratory staff and resources at reference labs for handling highly infectious material
- Inadequate systems for communicating real-time data, communication in areas without cell phone coverage
- Underdeveloped referral and transport systems, few ambulances
- Lack of system for maintaining the EPHS during a major disaster or epidemic, adapting service delivery modes at each level (including community). A gap was noted as well in the humanitarian response to assist with maintaining essential public health services (immunizations, FP or wider-scale provision of safe delivery kits), given that in some locations patients were not using facilities for several months and community volunteers were not supplied.³¹
- Poor adherence to or practice of IPC standards, in spite of infection prevention training embedded in clinical skills training. There is widespread concern among international

³¹ gCHVs, told the team about how their services were interrupted. One group stated that they had been told “do not touch,” so they could not continue i-CCM; another stated that they were not able to be resupplied, so clients did not receive their oral or injectable contraceptives. One group of TTMs reported that they could manage home births by buying new razor blades in the market and using plastic bags as protective gear (hands and shoe covers); this instruction was provided by the clinic midwife.

organizations about the lack of good understanding among health workers about cross-contamination and the correct use of personal protective equipment.

Many of the needs above will require planning and developing sustainable systems (i.e., mandatory orientation to infection prevention and control as well as proper use of personal protective equipment for all health workers), referral and communication systems, rosters for mobilizing staff and contingency stocks of personal protection equipment, as well as routine rigorous quality assurance processes to ensure good infection control procedures and practices in facilities.

Public Health Service

In discussions with central and local personnel and other stakeholders working to respond to the outbreak, there is acute awareness of the need for a strong and responsive public health system. Gaps noted were:

- Lack of county epidemic preparedness and management plans, county emergency command centers and response systems
- Underdeveloped surveillance systems
- Lack of contingency stocks for epidemics
- Insufficient in-county personnel within the region with epidemiological, disease investigation and control skills and systems
- Undeveloped public awareness protocols and channels (collaboration between governmental/local leaders and health officials and lack of clarity about who should make public announcements were reported as challenging during the initial outbreak phase)
- Efficient systems for communicating real-time data about suspected and confirmed cases³²
- Mechanisms for more rapid deployment and utilization of local community structures
- Lack of good understanding about preventing the spread of disease and correct use of personal protective equipment among community workers and volunteers
- Need for more skills training for county officials to plan terms of reference and conduct coordination, partner and technical meetings. As pointed out by external agencies in one county, the Ebola response meetings have lost their distinct terms of reference and thus are redundant.

As will be further discussed in the recommendation section, the gap in national capacities for effective communicable disease prevention, early identification and control must be addressed.

EVALUATION QUESTION 4: HEALTH FINANCE

Key Findings Related to Performance-based Financing (PBF)

In the first phase of the RBHS project, PBF was introduced as a promising approach³³ to accelerate quality implementation of the EPHS. In the second phase, the MOHSW established a PBF unit with technical assistance from RBHS and financing from USAID (through FARA) and from other donors and partners. The design of the Liberian PBF system provides for financial rewards for facility improvement,

³² During the initial phases of the epidemic, CHSWT staff report that they were receiving reports of suspected cases using their private cell phones.

³³ In similar post-conflict settings such as Rwanda and Burundi, use of PBF demonstrated increased availability and quality of health services, improved use of the limited resources, improved management of health facilities and enhanced motivation of health workers (RBHS case study report, 2014).

with oversight of CHDCs and incentives for staff and the CHSWT if designated health indicators are met. The PBF as well as the management structure (the PBF and FARA units) are financially supported by USAID through the FARA with MOHSW to implement Liberia's 2011-2021 National Health and Social Welfare Policy and Plan.

While the outcomes and impact of the PBF have not been evaluated, the team heard from members of the MOHSW health service departments, CHSWT supervisors and health practitioners that the PBF has helped staff to become more focused on their work and on reaching service targets, and that the bonuses resulted in improved staff motivation, "especially because salaries are low." According to CHSWTs, PBC implementing partners and the CHDCs visited, the community bonuses have resulted in greater community engagement, ownership of local health facilities and contributions to improvements. Construction of maternity waiting rooms and fencing were among the CHDC-led activities observed by the evaluation team. The community members of CHDCs that were interviewed were proud to show off the improvements that they had led. The MOHSW expressed hope to scale up this financing scheme to other counties where health financing is provided by a pool of bilateral donors.

Criticism of the PBF by the MOHSW heard during the evaluation was primarily about the sustainability of the fund, which relies on external funding, and the need to widen the focus from a few performance indicators to broader attention to how well quality-of-care standards are met.

Both central and county officials, advocating for expanded community health services, expressed the need to add community health services to the PBC portfolio, providing incentives to trained community health workers based on performance.

Performance-based Contracting (PBC)

Between 2009 and 2012, RBHS piloted and managed PBCs with NGOs for service delivery at the primary and secondary levels. A major shift occurred in 2012, with USAID and the MOHSW agreeing that PBCs would be managed by a special unit within the FARA unit. During the second phase, according to the MOHSW and RBHS, the management of the PBCs was successfully transferred to the PBF unit at the MOHSW with the technical assistance of an embedded RBHS advisor.

According to PBC implementers, the transition of PBC implementation and management from RBHS to government went reasonably well. Except for the initial period, PBC partners noted there have not been delays in operational funds from the MOHSW to the partners. An acute issue now exists: health workers, CHSWT team members and implementing partner staff report that the performance bonuses³⁴ have not been paid since the last quarter of 2013. The FARA and PBF unit acknowledge that performance bonuses are pending and report that a major reason is that data reported by PBC partners remains under review by the MOHSW. The delay in providing definitive answers is frustrating for implementers and their county and facility partners, though there is recognition that the Ebola outbreak has affected travel by the monitoring and evaluation teams to conduct data validation.

According to the implementing partners, the PBC reporting requirements have changed, e.g. more condensed reports as compared to reporting under RBHS. The evaluation team heard that there is considerable back and forth between USAID and the FARA unit after deliverable reports are submitted by the MOHSW. However, when FARA unit, PBF unit and USAID staff were questioned, no perceived need was heard to revise the reporting format.

A criticism heard several times in discussions with CHSWTs and PBC implementers is that monthly and quarterly feedback mechanisms are not working as well as under RBHS, before PBC shifted to MOHSW. Central key informants report that it is difficult to replicate RBHS processes, i.e., to involve central

³⁴ Performance bonuses are paid through PBCs and distributed using a formula to the implementing partners, qualifying facilities and staff and to pay for improvements to the facility as prioritized by the CHDCs.

technical supervisors to join with the MOHSW PBF unit and Monitoring, Evaluation and Learning team at the central level in reviewing the quarterly narrative and quantitative data reports. “They (technical staff) would rather be in the field as they need the DSA (daily subsistence allowance).”

County-level PBF steering committees developed by the MOHSW and PBC implementing partners have started contracting with community-based organizations in counties to conduct client satisfaction surveys. As noted by CHSWT staff, “they (community-based organizations) are not biased.” FARA staff reported that these surveys have identified concerns not found during by other supervisory or monitoring activities, such as staff not keeping to posted hours or behaving rudely. Clinical supervisors in counties noted that these findings have not been disseminated to them.

As mentioned by the CHSWTs, the implementing partners (international NGOs) are able to cover shortfalls or gaps in the PBF with other corporate or project funds, though how much of this they are doing was not clear. One partner admitted that it buys malaria drugs if needed, “as it is one of the performance indicators.” During a visit to an implementing partner management clinic, the staff stated that they never have stock-outs as “[the partner] takes care of this.” CHSWTs also describe the assistance provided to them to serve non-PBC facilities: “They (partners) help us with transport of drugs and supplies and when conducting joint monitoring.” It is recognized by the CHSWTs that these are short-gap measures and are not sustainable.

With contracting-in being implemented with USAID support through FARA in a limited number of facilities in Bong County, the Bong County CHSWT reports a sense of ownership and more active involvement in the field with the facilities managed. The major challenge reported was not having capacity to cover costs of managing facilities when the first dispersal of PBF funds was late; “The implementing partners have corporate funds to cover any financial gaps.” According to the CHSWT, relationships with the PBF unit are “open;” “They are accessible to help us with cost-shifting as it is allowed within budget categories.” Cross-fertilization was reported, e.g., with the experienced implementing partners and CHSWTs conducting joint supervision visits to each other’s facilities and solving problems together.

While there are many indications of the benefits of contracting-in, it is noted that Bong County may have unique features, e.g., it is supported by many NGOs in addition to Africare and has easy access to Monrovia. It is suggested that a retrospective implementation study is needed to assess if Bong County’s experience can be replicated in Lofa and Nimba Counties.

Health Financing Policy

In 2013, RBHS was tasked by USAID to support the MOHSW as it explored new health financing schemes in line with NHSWPP policy objectives. This initiative was to assist the government to develop sustainable health financing mechanisms while also improving equity (financial protection) and efficiency (active purchasing of health services instead of input-based financing). Senior MOHSW officials expressed appreciation for the technical assistance and support of RBHS. In July 2013, according to program documents, RBHS began the first round of formative research, which included stakeholder interviews and a high-level meeting with President Ellen Johnson Sirleaf and a literature review of health financing reform and insurance design options. The aim was to understand the policy and epidemiological context for health and insurance in Liberia, the recent history of the health system, and the viability of specific insurance design elements. Further technical assistance approaches included facilitating a consultative meeting bringing in external experts, supporting a task force at the MOHSW, sending representatives to Ghana to learn from their experience, and then providing long-term technical assistance to the task force.

These efforts were instrumental in developing the Liberia Health Equity Fund concept. Though draft legislation has been prepared, according to RBHS advisors and MOHSW, the fundamental aspects of the

design have not yet been fully elaborated. While endorsed by the President of Liberia, the concept is still in debate with the Ministry of Finance, which is questioning the governmental capacity for managing such a scheme.

Several key stakeholders mentioned that a lesson learned is “to get critical buy-in up front,” particularly from the Ministry of Finance. Given the political nature of health care financing and insurance schemes, they suggest that more advocacy for higher-level involvement of key ministries is needed to revive the health financing dialogue. The RBHS advisors, recognizing this need, facilitated the attendance of two Liberian deputy ministers from the Health Services and Administration departments at a WHO-sponsored course on health insurance for universal health care in low-income countries. “Increasing knowledge of and interest in health insurance at the higher levels within the MOHSW will help sustain the Liberia Health Equity Fund initiative, as well as improve coordination and communication across departments.”³⁵

Key informants from the MOHSW also noted that behavior change strategies will be needed to shift Liberian populations away from universal free health care and that mobilizing residents is important to advocacy efforts and “must go to the grassroots to help push for better health financing and services.” Several key informants mentioned the urgent need to restart fee-for-service as soon as possible to address acute gaps such as stock-outs.

Several senior MOHSW officials mentioned their continued interest³⁶ in the Rwanda model for health insurance, while recognizing the potential challenges to replication in a different political context.

Public Financial Management

The poor functionality of the financial management system(s) was and continues to be viewed by central and county government as a critical issue. Embedded RBHS capacity-building officers worked with CHSWTs to help them understand the recently updated Financial Management Policies and Procedures Manual and to help with budgeting (according to CHSWTs). A CHSWT Financial Management Manual was developed but not disseminated because of the Ebola outbreak. Gaps and needs noted are:

- According to CHSA and CHOs, one of the most frequently reported reasons for poor financial accounting is the insufficiency and poor preparedness of accountant staff.
- The accounting practices remain underdeveloped according to these informants, and a manual rather than computerized system continues.
- Funding levels are low; allotment funds are not based on county population or documented needs. Appropriations are much less than requested. (How or whether CHSWTs are re-budgeting needs more in-depth study.)
- At the central level, concerns about poor liquidation at the county level were perceived to be caused by lack of general accounting capacities and failure to adhere to “budget allocations” and basic procurement practices by the CHSWTs.
- According to CHSWTs, the problems start with late dispersal of first quarterly tranche of the allotment fund from MOHSW. CHSWTs report challenges with counter-planning and budgeting, saying that the allocations are made for them and that the late dispersal of funds limits the possibility of good planning and a high burn rate and eventually leads to under-utilization of the county appropriations. In all three counties, senior CHSWT members

³⁵ RBHS. “Toward Universal Health Coverage,” case study. 2014.

³⁶ According to project documents, the interest in exploring Rwanda’s health insurance model was raised by the MOHSW during the project’s consultative process. At that time, RBHS technical consultants advised that replicability of this model might not be feasible given the differences between the countries’ political and economic situations.

complain that lengthy reconciliation and validation processes require the county accountant to be frequently in Monrovia.

- Counties also report that adherence to the central government’s policies and procedures for procurement and documentation is difficult, given transactions that may cover two tax years, unregistered vendor situations and the dysfunctional cash flow systems.
- Except for the addition of another accountant in two counties visited, the system was not reported to have been improved. In all counties, the CHSWT reported that the “accountants are usually in Monrovia” working on reporting and dispersal issues.
- CHSWTs complain that most of the vertical projects do not contribute to operating costs.
- The evaluation team heard that a study of the funding streams into the MOHSW was underway.

In discussions with RBHS staff, the evaluation team was informed that the project did not have a strong mandate to address the financial management and accounting deficits, but rather to assist the MOHSW (which was being advised by another technical contractor) with the dissemination of guidance to the counties. RBHS and governmental stakeholders interviewed as well as discussion with GEMS project³⁷ staff note that much more focus and support is needed to comprehensively address financial management and accounting capacities and performance issues within the system (central and county).

EVALUATION QUESTION 5: COMMUNITY HEALTH SERVICES

RBHS provided technical assistance to the Community Health Service Department (CHSD) to develop several important documents on community health policies, guidelines, strategies and tools aimed at increasing demand for and use of health services and improving case management referrals. These include the national community health services policy, the national community health services strategic plan, operational guidelines for CHCs and CHDCs, the community health services supervisor checklist, and gCHV training modules for diarrhea, malaria and acute respiratory infections.

Partnering with the Health Promotion Division at the MOHSW, RBHS provided technical assistance to develop behavior change communication strategies, messages and channels. Together with the CHSD, demonstration sites were developed, with the project working closely with the CHCs and CHDCs. In a community where this was piloted, the evaluation team heard from community representatives how their use of Partnership-Defined Quality had led to improved staff-patient relationships and more user-friendly procedures and spaces; e.g., a CHDC had created a nicer waiting area. The Quality Improvement Team hopes to become more involved with the new emphasis on community hygiene and promotion of disease prevention measures.

As noted during the earlier discussions related to the Ebola crisis and response, there is high awareness of how important community engagement is to improving health outcomes. The President noted this in her speech to launch the Deconcentration Platform: “This launch sends a strong signal and message to the Liberian people of our determination to ensure that they are active partners in the delivery of services and in the governance of their communities and counties.” She noted that, “In the delivery of health care, considerable progress has been made in restoring and establishing health facilities and strengthening county-based health care capacity although the Ebola pandemic and our responses indicated that we have not done enough. A critical element that we did not factor into these responses

³⁷ USAID-GEMS is a five-year technical assistance project to support the Government of Liberia’s initiatives to improve service delivery to the Liberian people. One of their objectives is “Management systems and key organizational functions of participating Government of Liberia institutions—such as human resources and financial management, procurement and communications—conform with international good practice standards.”

was community capacity and preparedness.” The following sections note several strengths as well as gaps or weaknesses in the community health services supported by the government.

Community Health Services: Strengths

Significant work to strengthen community health services was supported by RBHS, including:

- a. A highly participatory approach was facilitated by RBHS to standardize community structures, described in a document titled Community Health Roadmap. This was an important undertaking, because so many differing community structures had been and were continuing to be implemented by NGOs after the conflict.
- b. Several community-based high-impact practices were either introduced by RBHS or operationalized by the project, continuing efforts of other U.S. Government-funded programs. These included:
 - Task-shifting/sharing to use gCHVs to provide i-CCM in communities is in various stages of being operationalized in the three counties.
 - Conducting Contraceptive Days coupled with mobile clinics to provide long-acting contraceptive methods has led to increased demand and use of implants.
 - Systematically involving TTMs to promote and accompany women to facilities for pregnancy, delivery and postpartum/newborn care is credited with increasing skilled birth attendance.
 - Supporting the community distribution of misoprostol by TTMs to prevent post-partum bleeding (a major cause of maternal mortality) in women who are not able to go to facilities for delivery has just been initiated.
 - Constructing maternity waiting homes by implementing partners and/or CHDCs with the PBF community bonuses has become popular and is being scaled up.
- c. CHDCs were developed to “serve as liaison between the clinic and the communities” and are taking actions to improve facilities by using the PBF community bonuses and donated time and supplies from residents. Facility improvements observed were: maternity waiting homes, fencing around clinics, meeting rooms and shaded waiting areas. As a component of the work to build capacities of the drug/supply chain, the “Interim Approach” was established, whereby CHDCs monitor inputs coming to the clinic, thus promoting better accountability and transparency between the facility staff and client population. The use of the Partnership-Defined Quality methodology has been shown to improve the user-friendliness of services and staff/client relationships.
- d. gCHVs are now being chosen by their communities; they are articulate about what they have done in the past and are doing now, and they want to learn and assume new responsibilities such as i-CCM. In Lofa County, gCHVs have added contraceptive injectables to their community-based FP services.
- e. Standard operating procedures and training modules were developed to establish the C-HMIS, which can link with the national health information system. Due to the Ebola outbreak, this system has yet to be established in the three counties.
- f. Innovative ideas are being generated, (e.g., both MOHSW and gCHV informants mentioned the idea of creating a career ladder to incentivize volunteers or are already using this to support community volunteers.)

Potential promising practices: The team noted innovative activity in Bong County, where a community is annually providing land for CHVs and TTMs to farm. At this location, TTMs have formed a cooperative

to dye cloth and make baby clothes for sale. A long-term MOHSW community health staff person described a pre-conflict mechanism for supporting community health workers that included a revolving fund coupled with fee for services and preventative health measures supplied by the workers.

Community Health Weaknesses/Gaps

- a. The Community Health Roadmap has yet to be fully disseminated to counties because of the Ebola crisis. As mentioned, the MOHSW has identified the need to revise the roadmap to include disaster preparedness and emergency response and to potentially add first aid responsibilities to gCHVs' scope of work.
- b. Inadequate workforce and budget affect counties', districts' and facilities' ability to meet the recommended community health supervisor positions as defined in the Roadmap. Vaccinators are used because they can "make reports and have transport to the communities," but they have not been trained in supervision.
- c. Currently, gCHV roles and responsibilities vary between and within counties, as task-shifting, (e.g., i-CCM) has either not yet started (most frequent reason was "lack of supplies") or is being phased in. Only in Lofa County did the team meet gCHVs who are engaged in providing contraceptive injectables. Members of the CHSWTs in the other counties expressed their discomfort with this practice.
- d. The establishment of supervisory and community-based data management systems and appropriate gCHV incentive packages has yet to be established and is considered by CHSWTs and MOHSW as critical to the delivery of responsive community-based services and provision of preventative health measures.
- e. At the central level, a more comprehensive approach is desired to capacitate the relevant departments and units to be able to provide guidance in the field, perform monitoring functions, provide technical updates, train trainers (community health and health and WASH promotion) and improve knowledge management and archiving.

V. CONCLUSIONS

In reviewing the RBHS approaches to capacity-building and in particular to decentralization, health finance, Ebola response and community health, there is much for USAID and follow-on projects to learn from and much on which to build. The use of joint assessments and supervisory systems introduced by RBHS provided opportunities for central and county-level stakeholders to acquire common language, shared awareness of gaps and resource needs, and the level of application of standards. The provision of technical advisors was shown to have been effective when the terms of reference and objectives were explicit.³⁸ The PBF scheme developed by RBHS was consistently credited with improving focus toward better health outcomes and motivation of clinicians in addition to funding the provision of curative services, assisting with availability of essential medicines, improving supervision at the facility level and strengthening service delivery data reporting. Additionally, the PBC with counties, which started last year in Bong County, induces accountability and transparency and allows counties to learn to manage resources as they take more responsibility for health activities. This illustrates a positive step toward decentralization.

While appreciating the holistic intent of the ambitious RBHS project, this review suggests that more attention is needed to the building blocks of governance and leadership, health finance and human resources, as these are foundational and critical to building a strong health care system.³⁹ Additionally, the supply chain needs to be systemized at each level. The threats to sustaining the systems (e.g., HMIS) as they were developed are the lack of management capacities and sufficient resources, including funding, equipment and tools, and appropriate staffing and expertise. This applies across all six building blocks and at all levels: MOHSW, County Health Departments and District Health Teams. As well, it is clear that the complexity of the support services, such as finance, human resources and supply chain, are interlinked and require involvement of several ministries. The constant turnover of staff is a significant risk to developing responsive quality services, thus recruitment and retention must be addressed; this will reduce the need for and high costs of orientation and skills training.

Future programs can build on the work performed by the RBHS project to build individual and organizational capacities for more institutional work with the MOHSW (and relevant ministries) and county government managers to develop finance, human resources and supply and governance systems that support the public health departments and health care facilities and services.

Related to the call for more focus on building management capacities, there is a need for more concerted use of data to advocate for improving availability of inputs, access to services and equity to preventative health measures as well as systems for ensuring quality of care.

Although the Ebola outbreak led to an interruption in RBHS efforts and MOHSW health reforms, it increased government and donor awareness of the need for a prepared, active and skilled public health service in addition to strengthening the provision of health care, i.e. curative services to diagnose and treat old, new and emerging infectious diseases.

The Ebola outbreak and response also dramatically illustrated the importance of community participation and involvement in improving health status. During the review, a constant mantra, “more community engagement,” was heard; this arose from observing the important role that communities have played in preventing the spread of Ebola Virus Disease. New community engagement processes

³⁸ Clear, specific and time-bound terms of reference, technical advisors, trainers and mentors with both expertise and relevant experience and capability for knowledge transfer and teaming, clear benchmarks for the capacity-building activity and careful monitoring of performance, as well as appropriate recipients of the capacity-building activities.

³⁹ These conclusions are congruent with those of the mid-term review and external evaluation of the RBHS done in 2012 (reviewed after the field work of this evaluation was completed).

have been introduced, which build on the behavior change communication (BCC) work done by RBHS; it is an opportune moment to use heightened community awareness about spread of disease to address risky practices besides care of the dead and burial practices, for example, “quacks” providing injections or improper sanitation practices. Now is also an opportune time to develop the governmental public health service, to revitalize community health systems and to encourage strong community action to ensure prevention of communicable diseases and promotion of individual, family and community resiliency and well-being.

As the national focus is shifting toward deconcentration as a stepping stone to the more complicated strategy of decentralization, it is expected that there will be a clearer vision and sharper definition of the functions, roles and responsibilities of MOHSW, County Health Departments and newly forming District Health Teams. Guided by this framework, it is expected that follow-on projects with governmental partners will be able to plan more focused, sequenced and interlinked activities using a comprehensive coordinated approach to enact change at the central government and to increase readiness of counties, districts and communities in assuming new responsibilities. Further, the follow-on projects will be able to measure the deconcentration process, progress and effectiveness at all government levels.

VI. RECOMMENDATIONS

In this section, specific recommendations are presented for follow-on projects and broader recommendations for new USAID programming.

SPECIFIC RECOMMENDATIONS RELATING TO CAPACITY-BUILDING APPROACHES AND AREAS OF FOCUS

The following recommendations build on RBHS results. As noted by several informants from the central and county levels, and recommended by the evaluation team, all capacity-building activities require: (a) clear, specific and time-bound terms of reference or learning objectives; (b) technical advisors, trainers or coaches with expertise and relevant experience and capability for knowledge transfer and teaming; (c) clear benchmarks and (d) careful monitoring of performance by the project and donor. Planning new capacity-building interventions will require strong commitment, input and buy-in of MOHSW and county leaders and certain conditions to be in place, such as personnel with the capacity to absorb new knowledge and skills to carry out functions and taking a more comprehensive approach to capacity-building and organizational development (i.e., ensuring that systems are in place for personnel to be managed, supervised and sufficiently equipped).

1. Improve quality of services.

- Refine the integrated supportive supervisory tool to allow for more in-depth assessment, coaching, mentoring by technical advisors and time for planning necessary actions.
- Develop facility-level quality assurance systems and personnel skills.
- Develop tools and skills for managers and supervisors to document and validate processes and results (e.g., how joint supervisory visits contribute to improvement plans, which resulted in responsive (equitable, safe and effective) services). A suggestion is to explore use of COPE or a similar internal audit to promote client and staff satisfaction with the work environment and procedures and to scale up the use of Partnership-Defined Quality by CHDCs, facilitating cross-fertilization visits to those actively involved in quality improvements.
- Further develop community monitoring mechanisms with the use of the community score card or similar methodology to assess the availability, access, equity and quality of clinic- and community-based services and preventive health measures, and to listen to non-users to understand the barriers to using services and measures.

2. Develop the continuum of care and preventive health services.

The project's work with the MOHSW toward more community-based service delivery by gCHVs and TTMs has been critical to addressing the poor access and equity to basic health services in Liberia. For example, in Bong County 52 percent of the population lives more than 5 km from health care services. These outreach services extend the continuum of care and thus must be considered part of the health care service delivery system. At the community level, these trained lay workers also have responsibilities to promote individual, household and community health and prevention measures. This integration requires that central and county curative and preventive health departments and personnel collaborate to create responsive, sustainable service delivery models.

The following activities will require collaborative efforts of the follow-on HSS and community health projects:

- Develop systems for supportive supervision of community-based service delivery and for better reporting. This includes, for example, scheduling monitoring, reporting and restocking activities

so that gCHVs only need to travel one day a month. If cell phone coverage is improved in areas far from clinics, explore use of SMS for reporting real-time data for the HMIS (particularly important with communicable disease reporting).

- Scale up i-CCM and FP provision by lay community health workers where needed to ensure access to services and equity to health measures (i.e., in remote or hard-to-reach communities), or to deconcentrate tasks where there are overloaded MCH/RH staff. For these nursing aides, it is recommended that a performance-based incentive program be devised.
- Find creative solutions to rewarding/compensating the gCHVs such as community donations, land for and assistance with farming, and government assistance with entrance to formal education. Based on discussions at the MOHSW, there may also be merit to adopting the Health Extension Worker model used in Ethiopia, limiting it (because of cost and need) to only remote, hard-to-reach areas of rural Liberia. This scheme could be part of a career ladder, where locally trained HEWs who perform well for a designated tenure are then assisted to go on to physician assistant training, returning to work in their county.
- Continue work to develop change agents and role models with CHCs, gCHVs and TTMs. Explore the possibilities of involving them in social marketing of preventive health measures, e.g., insecticide-treated bednets, condoms, ORS, fuel efficient stoves, making and marketing of reusable sanitary napkins or diapers.⁴⁰
- Pilot the new C-HMIS system all the way through the cascading process before planning wide-scale roll-out. Ensure that the users understand the need for the data from the national perspective, as well as how these relate to their level of services (more interactive work to understand how data are analyzed and can be used is suggested).
- Replicate proven e-learning and virtual learning methodologies and materials to keep rural primary care clinicians and community workers stimulated and updated.⁴¹

3. Attract, equip and retain a rural workforce.

- Assist the health workforce to develop constructive advocacy platforms for equitable workforce benefits and salary scale adjustments.⁴²
- Develop central capacities for developing low-cost training and orientation programs, and for county trainers to use teaching aids and materials for cascaded clinical training and training in supportive supervision skills. Ensure that these meet the demand for “formal” training by experts by ensuring qualifications of instructors, competency-based instruction and certifications. Explore the use of e-health and virtual learning methodologies for orientation and continuing education for greater efficiency (low cost and minimizing time away from work).
- Ensure a comprehensive approach to ensure adequate equipping as well as training.
- Promote community support for attracting and retaining health professionals.

⁴⁰ Note practices such as *Shashya Shebikas*, whereby CHVs are given small loans to establish revolving funds, which they use to make money by selling health products at a small markup. These products include oral contraceptives, birthing kits, sanitary napkins, iodized salt, condoms, essential medications and vegetable seeds.

http://www.mchip.net/sites/default/files/MCSP_CHW_Case%20Study%20Summaries.pdf

⁴¹ <https://www.k4health.org/resources/bangladesh-knowledge-management-initiative-ehealth-pilot-results-summary>;

<https://www.k4health.org/resources/health-population-nutrition-etookit-field-workers>;

<https://www.k4health.org/resources/virtual-learning-and-knowledge>

⁴² Support MoHSW High Investment Areas as related to building a demand driven and productive health workforce. (Investment Plan for Building a Resilient health System in Liberia, MoHSW, 2014.

- Explore the development of a volunteer nurse aide program, where local youth receive minimal training to assist clinic staff with registering and recording clients, taking vital signs and measurements and helping with health education presentations at the clinic and in the communities. (Objectives are to provide support to overworked staff and to encourage youth to consider health professions).

4. Create a data-driven culture.

- Support the recommendation actions described in the 2014 PRISM report (Annex IV). Build the capacity of the CHSWTs to use data to mobilize resources and to plan and improve services.
- Support the deconcentration of certain data management functions (data input, simple analyses and use) to the district level, and encourage analysis and use of district- and county-level data, ensuring the funding for internet connectivity, as the DHIS 2.04 is web-based.
- Support development of expert PBF support team to work with each county to acquire good reporting skills, using quarterly meetings for monitoring and capacity-building in planning actions to improve performance, responsiveness of services and utilization.
- Institutionalize C-HMIS and supervisory systems working with resources at hand, which may necessitate training vaccinators to be supervisors and to oversee data collection.
- Institutionalize additional methodologies for measuring health status and community behavioral practices (e.g., institutionalizing of the Lot Quality Assurance Sampling⁴³ annually by CHSWTs and using findings to guide districts and communities in planning of behavior change campaigns and health promotion services).

5. Develop county budgeting, finance and accounting skills and systems.

More information is needed to understand the poor functioning of the county finance and procurement systems. It is recommended that a shadowing exercise be supported, whereby expert accountants explore with CHSWTs, accountants and relevant MOHSW departments the root causes and barriers/bottlenecks within the public health finance management system. Tools such as WHO's OASIS may benefit this evaluative process.⁴⁴

6. Strengthen the PBF Unit of the MOHSW.

Innovative ideas are needed to promote engagement of central and county management, technical, finance, and monitoring, evaluation and learning personnel in reviewing quarterly reports and planning actions based on the data. A suggestion is to modify the conceptualized Regional Support Teams⁴⁵ to include central and county members with proven expertise and to assign each team to meet on location at each of the FARA counties. As a short-term measure, it is suggested that an experienced public health manager be embedded with each team until high-performing County Health Department Directors are identified to be peer advisors. The use of regional teams would provide for shared learning, cross-fertilization and improved communication, and they should promote more active resource mobilization and response to issues such as positions unfilled by the central MOHSW.

To improve the performance appraisal and validation processes, it is recommended that the follow-on project explore with MOHSW its idea to use an external agency to limit bias and to achieve greater efficiency. Short-term, it is critical to assist the PBF unit as needed to complete the investigation of data

⁴³ LQAS was conducted in 2011 and well received by the MOHSW, but has yet to be institutionalized.

⁴⁴ http://www.who.int/health_financing/tools/oasis_manual_version_october.pdf?ua=1

⁴⁵ The Regional Support Teams were conceptualized by MoHSW and supported by RBHS. Questions remain as to how qualified the proposed central level team members are to advise county management, finance, monitoring, evaluation and learning and technical staff.

irregularities and declare results, as the lack of information and non-payment of bonuses threatens perceptions of the transparency, accountability and integrity of the fund and its donor.

7. Assist county and district health departments to develop supply chains.

Within each county, there is a need to develop systems with appropriate technology for record-keeping, reporting, communication and transporting of supplies, as fits the geographical context and low-resource setting. It is suggested that short-term advisors with relevant and proven experience be embedded to help CHSWTs think innovatively about how to set up functional warehousing and transport systems and to develop sustainable management of the electronic LMIS.

8. Develop strong governance systems and leadership skills (central, county, district and community).

The development of strong and active county health boards is critical as well as working closely with the county and development superintendents, given their important role with the evolving deconcentration of functions and the need for accountability and transparency measures to be in place.

A high priority should be given to develop professional, managerial and leadership capacities of County Health Officers, County Health Department Directors and District Health Officers. At the county level, to forward the development of County Health Officers and County Health Department Directors, it is suggested that USAID explore with these partners the idea of developing an association of county health officials modeled after the National Association of County and City Health Officials.⁴⁶ This institution has been instrumental in professionalizing governmental public health officers and improving public health practices in the U.S.

The new projects are urged to develop community leadership and community engagement by tracking CHC and CHDC actions and local contributions, e.g., the Community Giving Barometer, to encourage community pride and competition between communities and to document the level of community engagement.

BROAD PROGRAMMING RECOMMENDATIONS

The following are broad areas for new focus and/or continued USAID consideration and support:

I. USAID with other relevant U.S. Government agencies and others⁴⁷ should develop a Government of Liberia Public Health Service, as part of a wider governmental emergency preparedness and disaster management system, but also to contain community health, social mobilization for behavior change and risk-reduction, environmental health, injury prevention, health promotion functions, disease surveillance and epidemic management.

The following core functions have been drawn from the “Ten Essential Public Health Services”⁴⁸ with relevance to public health activities at varying governmental agency, facility and community levels. It is recommended that specific responsibilities and activities within the functions be assigned to the National Public Health Institute and regional public health services, as well as public health staff on CHSWTs, DHTs, clinic outreach staff and community health committees.

⁴⁶ For more information on the National Association of County and City Health Officials in USA visit <http://www.naccho.org/>

⁴⁷ CDC and Department of Defense-NAMRU as well as other partners such as WHO, World Bank, African Union, Carter Center and UNICEF.

⁴⁸ <http://www.health.gov/phfunctions/public.htm>. Note: modifications made to the ten essential public services are the deletion of functions related to personal health care and development of personal health care workers. These are proposed to remain the domain of curative (personal) health care services.



- Monitor health status to identify and solve community health problems.⁴⁹
- Diagnose and investigate health problems and health hazards in the community.
- Inform, educate and empower people about health issues.
- Mobilize community partnerships and action to identify and solve health problems.
- Develop policies and plans that support individual and community health efforts.
- Enforce laws and regulations that protect health and ensure safety.
- Link people to needed personal health services.
- Assure competency of the public health care workforce.
- Evaluate effectiveness, accessibility and quality of population-based health services.
- Research for new insights and innovative solutions to (preventing and mitigating) health problems.

The development of a delineated national public health service, rather than a non-discrete part of the national health care system, would necessitate revision to the National Health Policy as well as the Community Health Roadmap and the National Health and Social Welfare Decentralization Strategy.

With a central-oversight Public Health Institute established,⁵⁰ the team recommends that regional public health services are developed and strategically placed geographically to support three to four counties working directly with county and district health teams. It is also suggested that public health posts be established at border crossings with skilled outreach workers performing active surveillance and behavior change interventions to reduce risks for transmission of disease and conflict.

⁴⁹ The use of Lot Quality Assurance Sampling methodology was successfully used by the USAID-funded MEASURE project in 2011 and 2012. These surveys are useful for small geographical areas (such as districts) and provide data on health behaviors and health outcomes at the household level, triangulating these with service-related and other data.

⁵⁰ Note that the development of a National Public Health Institute is a high priority but there is no indication of how public health services would be deconcentrated or decentralized in the Investment Plan for Building a Resilient Health System in Liberia, MOHSW 2015 (hard copy only).

2. USAID, working in collaboration with other donors, should support accelerated deconcentration of health care and public health functions and authority from MOHSW to county and district health departments.

This will entail several steps:

- a) Rigorous dialogue and guidance to clarify the specific functions and sub-functions, roles and responsibilities that are to be deconcentrated or devolved to the counties and districts and that are in part or fully the domain of the central MOHSW
- b) Design of a health care systems framework, with key stakeholders from central and county government, which has clear vision and aims for the new central, county and district functions and institutions, and which details critical skill sets and other structural and infrastructural inputs
- c) Collaboration with governance commission and high-level task forces working on issues relating to finance, public sector human resources, national drug formulary and supply, and health care accreditation and workforce certification to plan interventions for strengthening the management of support services (encompassing short- and long-term strategies)
- d) Development of an interlinked and sequential implementation plan with SMART objectives, tailored to each county's specific needs, and with measurable benchmarks and output and outcome indicators. The MOHSW's 2012 Health and Social Welfare Decentralization Strategy provides relevant guidance, such as the following:
 - Reduction of administrative costs by condensing and merging departments, divisions and units
 - Progressive shift from political appointments to transparent competency- and experience-based recruitment
 - Progressive shift from central-level appointment of officials to county and community recruitment
- e) Development of designated entities to monitor process and progress: It is suggested that a central entity be selected, trained and equipped (e.g., the decentralization unit under Planning and Development) to monitor progress of deconcentration at the central and county levels. It is also suggested to develop the monitoring functions of the county health boards chaired by the Office of County Superintendents.
- f) Continued support for strengthening of core central functions, e.g., resource mobilization and policy development by MOHSW, with mechanisms in place for county and district representation during national policy and guideline development processes. Within central government, provide technical assistance to develop efficient technical monitoring systems to ensure that systems for each of the building blocks are in place, functional and well managed, and that supervisory and quality assurance and improvement systems are effective at the county level.
- g) Rapid development of management structures⁵¹ and skills for each level and department/unit relating to the six building blocks to implement the implementation plan. Suggested steps are to:
 - Jointly with central, county and district government, assess management systems and competencies of current managers, and plan the most appropriate approach of increasing competencies, e.g., short courses followed by mentoring and coaching, technical assistance

⁵¹ Recommendations heard during the review are to explore piloting the placement of personnel with strong management experience and skills to manage relevant entities, units or departments, rather than developing clinicians (central and county levels).

from non-governmental, private or government sectors, twinning (placing an experienced manager to work alongside less experienced managers) and following recommendations for provision of technical assistance as noted during review by key stakeholders.⁵²

- Take a comprehensive capacity-building approach to: (1) develop competencies and leadership capabilities to use data to plan, allocate resources and monitor and improve quality and equity of services, and, at the facility level, to manage quality assurance processes, (2) establish an individual performance-based appraisal system, (3) support ongoing mentoring, advising and monitoring systems (between central and counties and between counties and districts) and (4) provide sufficient tools to carry out management roles and responsibilities at each level of government and all public health care facilities. It is recommended that the MOHSW initiate a performance appraisal process for central health staff who serve as managers, monitors and advisors, modeling this to other levels of the health care system.
 - Develop a data-driven culture by ensuring that county, district, facility and community data management systems collect and provide useful data that meet both national data needs and those of managers for annual planning. Establish an accountability mechanism, such as dashboard indicators, for senior management (county and central) to track functionality of support services monthly, using these data to identify bottlenecks and root causes, to keep county health boards aware of key issues, to plan remedial actions and to demand central assistance or response.
- h) As cell phone and internet coverage improves, explore more efficient methods for transmitting data and improving supervision and providing technical advising to clinical staff and workers in remote areas.

Illustrative Content for Monthly County Management Dashboard

- Service: Number of facilities without basic utilities (water, electricity), community/citizen complaints, major staff concerns
- Availability of drugs: list of stock-outs of drugs and supplies, functioning of transport fleet, completion of forecasting/requests
- Human resources: Number of positions unfilled (by profession), number of professional staff remaining without government worker status, number of staff not receiving monthly salaries/incentives, staff complaints, absenteeism, number of staff needing core training
- HMIS: Facilities/districts not reporting on time, connectivity
- Finance: Status of allotment funds received, liquidation, past due payables, burn rate
- Governance: Status of board, CHSWT and central actions taken to address last month's findings, status of improvements by CHDC

3. USAID with Government of Liberia Stakeholders and Other Donors Should Develop a Multi-faceted Strategy to Support Health Financing.

⁵² Clear, specific and time-bound terms of reference, expertise and relevant experience, capability for knowledge transfer and teaming, clear benchmarks for the capacity-building activity and careful monitoring of performance by the project/donor, and recipient has sufficient potential for development and growth.

Given the international aid architecture and the political dynamics in county, strong collaborative and coordinated efforts are required. The strategy may necessitate development of several portfolios, given the need to work at different levels and branches of government and the need for myriad approaches and specific expertise and experience of technical advisors and implementing agencies.

- a) **Health insurance:** Significant and long-term support will be needed to develop health care insurance and risk-pooling schemes; this will require an implementing partner with strong economics expertise, insurance industry experience, political savvy and experience in developing social welfare and safety net systems in counties with a high poverty level. It is recommended that USAID design a unique health governance project to build on RBHS-supported work, with higher-level partnerships formed, perhaps a Presidential task force, and the embedding of experienced technical advisors with the finance and health ministries.

There is also a need for short-term financing schemes. In addition to continuing support for the PBF, it is recommended that USAID advocate for an out-of-pocket fee structure (subsidized as needed) to be restarted, and for safety-net procedures such as a sliding fee scale to be put in place to ensure equity access to health care services for the very poor. The benefits of revenue collection by clinics and health centers would (1) help address serious shortfalls of basic drugs and lack of funds for fuel for transport, (2) help populations transition from dependency on free care to self-reliance and (3) provide experiential learning opportunities for a HSS project to build financial and accounting capacities at all levels of the health care system.

- b) **Revenue collection and appropriations:** Assistance to the MOHSW to address financing problems fits well within a HSS project portfolio, as this is a central function. The use of good data (health outcomes and status, access to service delivery points, population and poverty) is needed to advocate to the parliament and Ministry of Finance and Planning for higher appropriations and within MOHSW for equitable and evidence-based distribution of county appropriations.

It is suggested that introduction of a “sin tax” on beer purchases be explored to pay specifically for public health services such as oversight, surveillance and disease control measures, building on the momentum for better public health services started during the Ebola outbreak.

- c) **Budgeting and allocation of county appropriations:** This is integral to the HSS follow-on project’s deconcentration work with county managers and finance departments to be given and to assume authority and to have more developed capacities for decision-making and developing and monitoring budgets.
- d) **External aid resource mobilization:** Work with the donor working group to mobilize external funds that meet prioritized needs of counties for ensuring quality care and prevention of disease and injuries. Advocacy is needed for vertical program funding to contribute to operational costs. At the county level, it is recommended that the HSS projects develop resource-mobilization skills of county health boards and CHSWTs, including data-driven advocacy to access the county and social development funds.

As part of follow-on HSS and community health projects, it is suggested to explore the creation of block grants⁵³ and innovative funds to foster county, district and local ownership and creativity to address prioritized needs and to build local capacities to manage funds in an accountable fashion.

⁵³ For more discussion on pros and cons, visit <https://fas.org/sgp/crs/misc/R40486.pdf>

- e) **Fundraising and resource mobilization at the community level:** Building on RBHS results, it is recommended that the HSS and community health projects continue to promote and facilitate community use of performance-based bonuses and community donations for facility improvements and staffing facilities to attract and retain health professionals. These efforts need to be well-documented, disseminated (e.g. by a community donation barometer) and celebrated.
- f) **Retention of skilled workforce:** This is critical not only to ensuring quality provision of health care and public health services but also to promoting greater savings, given the high costs of continual training and orientation for new staff. In addition to improving salaries, it is recommended to explore benefit packages and incentives (housing, transportation or schooling opportunities for children of staff). One idea is to explore supporting community-owned or quasi-private birthing centers in very rural communities to attract local clinical midwives.⁵⁴ It is recommended that project continue to promote the establishment of a performance appraisal process for employees, along with a system for recognizing excellent work and service.
- g) **Lay worker/volunteer incentive programs:** Basic service delivery is deconcentrating to the community, with gCHVs assuming more responsibility for curative as well as preventative health care. How to incentivize these workers is being hotly debated. USAID follow-on projects (HSS and community health) may be asked to facilitate the exploration of viable models. This will necessitate facilitating strong collaboration between MOHSW curative and preventive health departments and with other relevant ministries and NGOs working on workforce issues, such as the Clinton Health Access Initiative, to create affordable, sustainable and high-quality service delivery models. Addressing the lack of access for men, women and children to basic health services is critical. Task-shifting the provision of curative services to lay workers is limited and should be seen as only a stop-gap measure until resources are mobilized to establish services by professional clinicians. Long-term outreach services by skilled lay workers is important for an effective continuum of care.

Last but not least, it is recommended that USAID-supported agencies and governmental and civil society partners continue to **create a learning environment**, whereby old practices and traditions which had potential protective and sustainable qualities are reexamined; new and promising practices are validated and scaled up; best practices are considered and tested for replication; central, county, district and community mechanisms for ensuring accountability and transparency are rigorously monitored by stakeholder groups; and innovative ideas from communities, districts, counties and central government are identified and exchanged between U.S. Government-funded programs, across communities, within districts and counties, nationally and globally.

⁵⁴ UNICEF. Innovative Approaches to Maternal and Newborn Health Compendium of Case Studies. 2013. Accessed at http://www.unicef.org/health/files/Innovative_Approaches_MNH_CaseStudies-2013.pdf

ANNEX I: EVALUATION STATEMENT OF WORK

Global Health Program Cycle Improvement Project -- GH Pro
Contract No. AID-OAA-C-14-00067
EVALUATION OR ANALYTIC ACTIVITY STATEMENT OF WORK (SOW)
Date of Submission: 1/27/2015

TITLE: Rebuilding Basic Health Services (RBHS) Final Project Evaluation

Technical Directive Number (assigned by GH Pro): 042

Requester / Client:

USAID Country or Regional Mission (select by using Region pull-down menu) –

Africa: Liberia

Asia: Choose an item.

Europe & Eurasia: Choose an item.

Latin America & the Caribbean: Choose an item.

Middle East: Choose an item.

Funding Account Source(s): (Click on box(es) to indicate source of payment for this assignment)

3.1.1 HIV

3.1.2 TB

3.1.3 Malaria

3.1.4 PIOET

3.1.5 Other public health threats

3.1.6 MCH

3.1.7 FP/RH

3.1.8 WSSH

3.1.9 Nutrition

3.2.0 Other (specify): Mission

Cost Estimate: \$ (Note: GH Pro will provide a final budget based on this SOW)

Performance Period: (Use pull down to indicate expected start and end dates – choose any day in the month and year on pull down calendar)

Expected Start (on or about): 27-Jan-2015

Anticipated End (on or about): 31-May-2015

Location(s) of Performance Period: (Indicate locations where work will be performed to implement this evaluation or analytic activity)

Liberia: Monrovia, and Bong, Lofa and Nimba Counties

Type of Analytic Activity (Check the box to indicate the type of analytic activity)

EVALUATION:

Performance Evaluation (Check timing of data collection)

Midterm

Endline

Other (specify): _____

Performance evaluations focus on descriptive and normative questions: what a particular project or program has achieved (either at an intermediate point in execution or at the conclusion of an implementation period); how it is being implemented; how it is perceived and valued; whether expected results are occurring; and other questions that are pertinent to program design, management and operational decision making. Performance evaluations often incorporate before-after comparisons, but generally lack a rigorously defined counterfactual.

Impact Evaluation (Check timing(s) of data collection)

Baseline

Midterm

Endline

Other (specify): _____

Impact evaluations measure the change in a development outcome that is attributable to a defined intervention; impact evaluations are based on models of cause and effect and require a credible and rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. Impact evaluations in which comparisons are made between beneficiaries that are randomly assigned to either a treatment or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured.

OTHER ANALYTIC ACTIVITIES

Assessment

Assessments are designed to examine country and/or sector context to inform project design, or as an informal review of projects.

Costing and/or Economic Analysis

Costing and Economic Analysis can identify, measure, value and cost an intervention or program. It can be an assessment or evaluation, with or without a comparative intervention/program.

Other Analytic Activity (Specify)

PEPFAR EVALUATIONS (PEPFAR Evaluation Standards of Practice 2014)

Note: If PEPFAR funded, check the box for type of evaluation

Process Evaluation (Check timing of data collection)

Midterm

Endline

Other (specify): _____

Process Evaluation focuses on program or intervention implementation, including, but not limited to access to services, whether services reach the intended population, how services are delivered, client satisfaction and perceptions about needs and services, management practices. In addition, a process evaluation might provide an understanding of cultural, socio-political, legal, and economic context that affect implementation of the program or intervention. For example: Are activities delivered as intended, and are the right participants being reached? (PEPFAR Evaluation Standards of Practice 2014)

Outcome Evaluation

Midterm

Endline

Other (specify): _____

Outcome Evaluation determines if and by how much, intervention activities or services achieved their intended outcomes. It focuses on outputs and outcomes (including unintended effects) to judge program effectiveness, but may also assess program process to understand how outcomes are produced. It is possible to use statistical techniques in some instances when control or comparison groups are not available (e.g., for the evaluation of a national program). Example of question asked: To what extent are desired changes occurring due to the program, and who is benefiting? (PEPFAR Evaluation Standards of Practice 2014)

Impact Evaluation (Check timing(s) of data collection)

Baseline

Midterm

Endline

Other (specify):

Impact evaluations measure the change in an outcome that is attributable to a defined intervention by comparing actual impact to what would have happened in the absence of the intervention (the counterfactual scenario). IEs are based on models of cause and effect and require a rigorously defined counterfactual to control for factors other than the intervention that might account for the observed change. There are a range of accepted approaches to applying a counterfactual analysis, though IEs in which comparisons are made between beneficiaries that are randomly assigned to either an intervention or a control group provide the strongest evidence of a relationship between the intervention under study and the outcome measured to demonstrate impact.

Economic Evaluation (PEPFAR)

Economic Evaluations identifies, measures, values and compares the costs and outcomes of alternative interventions. Economic evaluation is a systematic and transparent framework for assessing efficiency focusing on the economic costs and outcomes of alternative programs or interventions. This framework is based on a comparative analysis of both the costs (resources consumed) and outcomes (health, clinical, economic) of programs or interventions. Main types of economic evaluation are cost-minimization analysis (CMA), cost-effectiveness analysis (CEA), cost-benefit analysis (CBA) and cost-utility analysis (CUA). Example of question asked: What is the cost-effectiveness of this intervention in improving patient outcomes as compared to other treatment models?

BACKGROUND

Background of project/program/intervention:

Activity: USAID/Liberia- RBHS Project Final Evaluation
Cooperative Agreement # (669-A-00-09-00001-00)
Prime Implementing Partner: JSI Research & Training Institute, Inc

Length of Project: November 5, 2008-February 28, 2015
Total Estimated Cost: \$69,520,960.00

BACKGROUND

The Rebuilding Basic Health Services (RBHS) project is a six-year cooperative agreement (2008-2015) with JSI Research and Training, in collaboration with Jhpiego, the Johns Hopkins University Center for Communication Programs (JHU-CCP) and Management Sciences for Health (MSH). Following a modification of the project in 2011, the project has two main intermediate results: (1) increased access to basic health services through improved provision of quality health services and adoption of positive health behaviors; and (2) increased quality of health services through improving infrastructure, health workforce and systems performance by enhancing capacity to plan, manage and monitor a decentralized health system.

The significant input for the capacity-building conceptual framework comes from the six building blocks of health systems strengthening developed by WHO⁵⁵: (1) Delivering essential health services; (2) the health workforce; (3) health information systems; (4) access to essential medicines; (5) health systems financing, and; (6) governance and leadership.

Describe the theory of change of the project/program/intervention.

RBHS started with service delivery interventions for three years and transitioned to capacity building interventions for about three years.

Strategic or Results Framework for the project/program/intervention (*paste framework below*)

What is the geographic coverage and/or the target groups for the project or program that is the subject of analysis?

Bong, Lofa, Nimba Counties

SCOPE OF WORK

Purpose: Why is this evaluation or analysis being conducted (purpose of analytic activity)? Provide the specific reason for this activity, linking it to future decisions to be made by USAID leadership, partner governments, and/or other key stakeholders.

The purpose of this evaluation is to review the performance and document the achievements of the six-year Rebuilding Basic Health Services (RBHS) project, and provide the mission with insight and recommendations to inform HSS and capacity-building work with the MOHSW through follow-on projects. The final project evaluation shall identify factors enabling or impeding effective implementation of different components of the project. The evaluation will also advise USAID/Liberia on any needed redirection of strategies, approaches, or priorities in light of lessons learned from RBHS, which might inform the implementation of the follow-on project particularly in the context of the current health systems response to emergencies. More specifically, the evaluation team is expected to assess the progress made in achieving the goals of the revised scope, which incorporates capacity building and two intermediate results (“increased utilization of quality services” and “more responsive

⁵⁵ 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>

services through effective health system decentralization”).

The review should also include a cursory look at the progress made in relation to operationalizing the six key principles in the program description.

Additionally, the assessment team shall identify lessons learned and provide suggestions for the future direction of Liberia’s health initiatives in order to assure a comprehensive and consistent implementation of the EPHS and determine new areas for technical support. The team will allocate approximately 85 percent of its effort to assessing RBHS project accomplishments and JSI’s management approach, and the other 15 percent will be allocated to making recommendations for the future direction of health initiatives in Liberia.

The team members will—through interviews, data collection and review of the resources provide answers to the evaluation questions outlined in the methods. The evaluators should consider a range of possible methods and approaches for collecting and analyzing the information required to assess the evaluation objectives. The methodology will include, but not be limited to: team planning meeting (TPM), document review, key informant interviews (including USAID/Liberia staff, Government of Liberia and other donors/international agencies), site visits to several of the Fixed Amount Reimbursable Agreement (FARA) supported counties (Bong, Lofa and Nimba), Nursing and Midwifery Board, Liberia Dental and Medical Board, training schools (Esther Bacon School of Nursing and Midwifery, Tubman National Institute of Medical Arts) and direct observation.

Audience: Who is the intended audience for this analysis? Who will use the results? If listing multiple audiences, indicate which are most important.

MOHSW, USAID and health sector donors

Applications and use: How will the findings be used? What future decisions will be made based on these findings?

Findings from this evaluation will inform the USAID follow-on projects

Evaluation questions: Evaluation questions should be: (a) aligned with the evaluation purpose and the expected use of findings; (b) clearly defined to produce needed evidence and results; and (c) answerable given the time and budget constraints. Include any disaggregation (e.g., sex, geographic locale, age, etc.), they must be incorporated into the evaluation questions. USAID policy suggests 3 to 5 evaluation questions.

	Evaluation Question Evaluation findings for each question below should include specific examples and evidence.
	The significant input for the capacity-building conceptual framework comes from the six building blocks of health systems strengthening developed by WHO. How effective was this conceptual framework as the basis for RBHS’ approach to support the MOHSW in achieving the goals of the National Health Policy and Plan, and what were the strengths and weaknesses?
	What lessons have been learned (strengths, weaknesses) through RBHS’ approach to support and strengthen decentralization and decentralized management of services that can inform follow-on interventions? This should include: <ul style="list-style-type: none"> • how effectively RBHS worked with the County Health and Social Welfare Teams (CHSWTs) to build their capacity • the challenges and strengths in working at the county level • to what extent capacity-building interventions are or are not making progress towards sustainability, and factors are likely to enable or inhibit sustainable change

	<ul style="list-style-type: none"> effectiveness of the RBHS capacity-building interventions to strengthen planning and management at the county level as the country moves to a more decentralized health system, including the contracting-in and contracting-out implementation models supported by RBHS what additional support is needed to strengthen the capacity at the county level
	<p>What have been the implications of the current Ebola crisis for capacity-building of the MOHSW, and how effective were RBHS interventions in helping the MOHSW to respond to the crisis? This should include:</p> <ul style="list-style-type: none"> Whether and how capacity-building approaches were adapted, or should be adapted, in light of the Ebola crisis and the response to it Lessons learned through project interventions since the start of the Ebola crisis that should inform interventions under the next project Extent to which RBHS interventions and approaches provided a platform to address key needs/issues for Ebola response, such as: focus on behaviors and practices that have been essential in responding to Ebola outbreak; focus on data quality and availability of up-to-date, real-time data; collaboration and communication between MOHSW and CHSWTs and their partners; infection prevention training of health workers; establishing and maintaining ministry leadership of key response operations, teams, committees; intra-ministerial collaboration; use of community structures, formal and informal leadership channels and groups and internal and external communication strategies.
	<p>To what extent have the RBHS project interventions related to the health financing building block been effective in responding to the needs and priorities of the MOHSW in the area of health financing, and how can the RBHS experience inform future interventions supported by USAID? Key intervention areas include:</p> <ul style="list-style-type: none"> Management of performance-based financing (PBF) Management of performance-based contracts (PBCs) with NGOs Design of national health insurance and health financing reform proposals Public financial management
	<p>What are the strengths and weaknesses of RBHS interventions on community health systems and services, including major challenges, results and recommendations for incoming projects? This should include:</p> <ul style="list-style-type: none"> Extent to which community structures are seen and valued as an integral part of the health systems (e.g. by CHSWTs and health workers, and by communities themselves) Lessons learned through RBHS' contribution to the recently completed Community Health Services Roadmap Interventions related to health communications and delivery of messages to achieve behavior change at the community level

Other Questions [OPTIONAL]

(Note: Use this space only if necessary. Too many questions leads to an ineffective evaluation.)

Methods: Check and describe the recommended methods for this analytic activity. Selection of methods should be aligned with the evaluation questions and fit within the time and resources allotted for this analytic activity. Also, include the sample or sampling frame in the description of each method selected.

■ **Document Review** (*list of documents recommended for review*)

To understand context and project objectives, interventions and results, documents related to the project and the Liberian health context will be reviewed. These data will also be used as part of the thematic review to address the evaluation questions. Documents to be reviewed include:

- USAID key documents
- MOH FARA agreement
- USAID Liberia Country Development Cooperation Strategy (CDCS) 2013-2017

- USAID RBHS mid-term evaluation report, 2012
- RBHS key documents
- Cooperative agreement RBHS (2008) and amendments
- RBHS revised program description of 2012
- RBHS M&E plan and indicators
- Internal project assessment: May 16–June 1, 2011
- RBHS capacity-building strategy (June 2012)
- Endline Capacity Assessment of MOHSW and FARA Counties: May 12–June 27, 2014
- PRISM baseline and endline assessments
- Liberia Health Equity Fund (LHEF) Purchasing Agent and Roadmap, August 2014
- The Liberian Health Equity Fund (LHEF): A Narrative History, October 2014
- Contracting-in Series
- C-HMIS tools
- RBHS annual reports
- RBHS semi-annual performance reports
- RBHS third through sixth year work plans
- RBHS end-of-project technical reports/technical briefs
- Ebola SOPs and training curriculum
- Government of Liberia key documents
- National Health and Social Welfare Policy and Plan 2011-2021
- MOHSW Country Situational Analysis Report
- MOHSW Decentralization Policy
- Community Health Roadmap and Operational Map
- MOHSW National Monitoring and Evaluation Policy and Strategic Plan 2012-2021
- National Human Resources Policy and Plan for Health and Social Welfare 2011-2021
- National Health and Social Welfare Financing Policy and Plan 2011-2021
- Supply Chain Master Plan
- Improving Commodity Security through Improved Accountability and Controls—An Interim Approach
- EPHS Secondary and Tertiary Care—The District, County and National Health Systems
- EPHS Primary Care—The Community Health System
- MOHSW 2013 Facility Accreditation Report and Sexual and Reproductive Health Policy
- National Family Planning Strategy
- National Guidelines for Community-Based Distribution of Family Planning Services
- Liberia DHS 2013, MIS 2011
- Comprehensive Food Security and Nutrition Survey 2010
- MEASURE’s Health Outcome Monitoring Capacity Building Surveys in 2011, 2012 and 2013

Secondary analysis of existing data (*list the data source and recommended analyses*)

Data Source (<i>existing dataset</i>)	Description of data	Recommended analysis

Key Informant Interviews (*list categories of key informants, and purpose of inquiry*)

Information will be collected through personal and/or telephone interviews with key contacts and stakeholders. Finalization of this list will be in consultation with USAID/Liberia and will include, but not be limited to:

- RBHS program managers and sector specialists in the field, including representatives of all RBHS IPs (JSI, Jhpiego, Africare, IRC)

- USAID/Washington and USAID/Liberia technical team members
- Government of Liberia/MOHSW counterparts
- Donors (World Bank, UNDP, UNICEF, DFID, GFATM, WHO, EU)
- Project directors for other USAID projects or other partners providing related technical assistance to the MOHSW, such as DELIVER, PSI, CHAI
- Pool Fund donors
- County Health and Social Welfare Teams, local government leaders and Africare and, in Lofa County, County Health Team and IRC
- RBHS beneficiaries, from communities to health workers to MOHSW staff (e.g. the HMIS unit, PBF unit, etc.).

Note: If the evaluation team is unable to convene in Liberia by or around January 26, 2015, it may be necessary to begin the KIIs remotely. In this case, the international evaluation staff will conduct the interviews by phone and/or Skype, supported by local evaluation staff conducting interviews with stakeholders for whom the team feels a virtual interview is not recommended.

Focus Group Discussions (*list categories of groups, and purpose of inquiry*)

Group Interviews (*list categories of groups, and purpose of inquiry*)

Client/Participant Satisfaction or Exit Interviews (*list who is to be interviewed, and purpose of inquiry*)

Facility or Service Assessment/Survey (*list type of facility or service of interest, and purpose of inquiry*)

Verbal Autopsy (*list the type of mortality being investigated (i.e., maternal deaths), any cause of death and the target population*)

Survey (*describe content of the survey and target responders, and purpose of inquiry*)

Observations (*list types of sites or activities to be observed, and purpose of inquiry*)

Bong, Lofa and Nimba County Health and Social Welfare Teams will be observed to see how they manage and support the HSS based on the six building blocks of HSS.

At least six communities should be included in site visit plan, looking at RBHS community health demonstration sites in Bong, Lofa, Nimba and other sites.

Note: If the evaluation team is unable to convene in Liberia in a timely manner to conduct these observations, the team leader and evaluation specialist will virtually train the local evaluators on the observation methodology and data collection instruments. If this is necessary, the team leader, with support of the evaluation specialist, will supervise the evaluators remotely. This may require daily check-ins and debriefings via phone or Skype.

Data Abstraction (*list and describe files or documents that contain information of interest, and purpose of inquiry*)

Case Study (describe the case, and issue of interest to be explored)

Rapid Appraisal Methods (ethnographic / participatory) (list and describe methods, target participants, and purpose of inquiry)

Other (list and describe other methods recommended for this evaluation, and purpose of inquiry)

If impact evaluation –

Is technical assistance needed to develop full protocol and/or IRB submission?

Yes No

List or describe case and counterfactual”

Case	Counterfactual

ANALYTIC PLAN

Describe how the quantitative and qualitative data will be analyzed. Include method or type of analyses, statistical tests, and what data it to be triangulated (if appropriate). For example, a thematic analysis of qualitative interview data, or a descriptive analysis of quantitative survey data.

Qualitative thematic analyses will be conducted with data drawn from the document reviews, key informant interviews and observations. Cross-verification of all qualitative findings will be conducted. Whenever possible, quantitative data findings from RBHS routine performance monitoring, DHS, Comprehensive Food Security and Nutrition Survey, USAID/Liberia CDCS and other data reports on Liberia will be used to triangulate with qualitative findings.

ACTIVITIES

List the expected activities, such as team planning meeting (TPM), briefings, verification workshop with implementing partners and stakeholders, etc. Activities and Deliverables may overlap. Give as much detail as possible.

Note: The following activities assume the evaluation team is able to convene in Liberia on or around the end of January 2015. If this is not possible, the following activities will be adapted to be managed remotely by the team leader with support of the evaluation specialist, until (if possible) the full evaluation team can convene in Liberia. If this becomes necessary, the team leader and the evaluation specialist will work remotely from their home base, with virtual management and supervision of the local evaluators. This may require daily check-ins and debriefings via phone or Skype. GH Pro will also arrange for web conferencing, as needed.

Team Planning Meeting (TPM)

The evaluation team will start its work with a two-day planning meeting prior to the onset of key stakeholder meetings and field work. The purpose of the TPM will be to clarify team roles and responsibilities; to develop the work plan and methodology; and to create a timeline and action plan for completing the deliverables. In the meeting, the team will specifically:

- Share background, experience and expectations of each of the team members for the assignment;
- Formulate a common understanding of the assignment, clarifying team members' roles and responsibilities;

- Agree on the objectives and desired outcomes of the assignment;
- Establish a team atmosphere, share individual working styles, and agree on procedures for resolving differences of opinion;
- Revisit and finalize the evaluation timeline and strategy for achieving deliverables;
- Develop and finalize data collection methods, survey questionnaire and guidelines;
- Develop preliminary outline of the team’s report and assign drafting responsibilities for the final report.

During the TPM, an in-briefing with USAID/Liberia will be held to discuss expectations of the assessment.

Data collection:

The information collected will be mainly qualitative guided by a key set of questions. Information will be collected through personal and/or telephone interviews with key contacts, through document review and through field visits. The full list of stakeholders and contacts will be provided. Additional individuals may be identified by the evaluation team at any point during the final evaluation. Key informant interviews will include but not be limited to:

- RBHS program managers and sector specialists in the field
- USAID/Washington and USAID/Liberia technical team members
- Government of Liberia/MOHSW counterparts
- Donors (World Bank, UNDP, UNICEF, DFID, GFATM, WHO, EU)
- Project directors for other USAID projects and other NGOs/organizations providing technical assistance to the MOHSW such as DELIVER, PSI etc.
- Pooled Fund
- County-level local leaders, administrators, stakeholders
- RBHS beneficiaries, from communities to health workers to MOHSW staff (e.g. the HMIS unit, PBF unit, CHSWT, infrastructure and pre-services education institutions etc.)

Field visits:

The team will coordinate with USAID/Liberia to prepare for and conduct site visits while in-country, and to interview key informants at these sites. Site visits will be conducted in the three FARA counties, Bong, Lofa and Nimba. Interviews will be conducted with CHSWT members and contracted out partners. At least six communities should be included in site visit plan, looking at RBHS community health demonstration sites in Bong, Lofa, Nimba and other sites.

Briefing/final debriefing meetings with USAID/Liberia Staff:

The evaluation team will meet with the USAID/Liberia Health Team to review the scope of the final evaluation, the proposed schedule, and the overall assignment. The initial briefing will also include reaching agreement on a set of key questions and will take place over one day (or could be incorporated into the TPM).

At least two days prior to ending the in-country evaluation, the team will hold a debriefing with USAID to present the major findings and recommendations of the evaluation that will focus on the accomplishments, weaknesses and lessons learned in the program, including recommendations for improvements and increased effectiveness and efficiency of the capacity-building program.

DELIVERABLES AND PRODUCTS

Deliverable / Product	Timelines & Deadlines <i>Note: This timeline represents the best possible scenario, and</i>
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	<i>will be adjusted as needed, particularly if the evaluation team is not able to convene in Liberia by the end of January 2015.</i>
<input checked="" type="checkbox"/> Launch briefing	January 30, 2015
<input checked="" type="checkbox"/> Pre-trip draft work plan with timeline	January 30, 2015
<input checked="" type="checkbox"/> Work plan with timeline	End of in-country TPM
<input checked="" type="checkbox"/> Analytic protocol with evaluation methodology and data collection tools	KII Question Guide: January 30, 2015 Final: End of in-country TPM
<input checked="" type="checkbox"/> In-briefing with mission	Within a day of arrival in Monrovia, on or about February 4, 2015
<input type="checkbox"/> In-briefing with target project/program	
<input checked="" type="checkbox"/> Routine briefings	At least weekly
<input type="checkbox"/> Findings review workshop with stakeholders with Power Point presentation	
<input checked="" type="checkbox"/> Out-briefing with mission with Power Point presentation and draft annotated outline of evaluation report highlighting key issues/findings	On or about first week of March 2015 (before departing Liberia)
<input checked="" type="checkbox"/> Draft report	March 13, 2015
<input checked="" type="checkbox"/> Final report	April 6, 2015
<input checked="" type="checkbox"/> Raw data	close of evaluation
<input checked="" type="checkbox"/> Final report formatted, 508 compliant, and posted to the DEC	May 6, 2015
<input type="checkbox"/> Dissemination activity	
<input type="checkbox"/> Other (specify):	

Note: February 11, 2015 is a Liberian public holiday-Armed Forces Day; and January 19 and February 16, 2015 U.S. holidays (USAID will be closed)

Estimated USAID review time

Average number of business days USAID will need to review deliverables requiring USAID review and/or approval? 10 business days

TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT (LOE)

Evaluation team: When planning this analytic activity, consider:

- Key staff should have methodological and/or technical expertise, regional or country experience, language skills, team lead experience and management skills, etc.
- Team leaders for evaluations must be an external expert with appropriate skills and experience.
- Additional team members can include research assistants, enumerators, translators, logisticians, etc.
- Teams should include a collective mix of appropriate methodological and subject matter expertise.
- Evaluations require an evaluation specialist, who should have evaluation methodological expertise needed for this activity. Similarly, other analytic activities should have a specialist with relevant methodological expertise.

Note that all team members will be required to provide a signed statement attesting that they have no conflict of interest, or describing the conflict of interest if applicable.

List the key staff needed for this analytic activity and their roles. You may wish to list desired qualifications for individual team members, or for the team as a whole.

Key Staff 1 Title: Team Leader

Roles & Responsibilities: The team leader will:

- Finalize and negotiate with USAID/Liberia the evaluation work plan;
- Establish evaluation team roles, responsibilities and tasks;
- Develop data collection instruments/questionnaire
- Facilitate all necessary meetings in the U.S. and in Liberia;
- Ensure that the logistics arrangements in the field are complete;
- Coordinate schedules to ensure timely production of deliverables;
- Coordinate the process of assembling individual input/findings for the evaluation report and finalizing the evaluation report

Qualifications: Expertise in health systems development, health management information systems, public health management and/or institution building. The team leader will be an international consultant with extensive USAID program implementation and evaluation experience and must possess proven skills in evaluation and analysis of post-conflict/transitioning development programs. S/he must have a proven track record supervising teams in the field and producing high quality and concise reports, as well as extensive experience working in Africa and similar fragile/post-conflict settings.

Key Staff 2 Title: Evaluation Specialist

Roles & Responsibilities: Serve as a member of the evaluation team, providing quality assurance in the field on issues related to evaluation implementation, including methods, development of data collection instruments, protocols for data collection, data management and data analysis.

Qualifications:

- At least 5 years of experience in USAID M&E procedures, project and organizational management
- Strong knowledge, skills, and experience in qualitative and quantitative evaluation tools
- Experience in design and implementation of evaluations

Number of consultants with this expertise needed: 1

Key Staff 3 Title: Evaluators (Local Consultants)

Roles & Responsibilities: Assist in key informant interviews, data collection, qualitative instrument preparation and analysis of collected data

Qualifications: Broad knowledge of Liberian health issues will assist in key informant interviews, data collection, qualitative instrument preparation, and analysis of collected data. Combined qualifications should include: expertise in health systems strengthening (delivering essential health services, health workforce, health information system, access to essential commodities, health system financing, and governance and leadership), decentralization, community health and maternal and child health. Number of consultants with this expertise needed: 2-3

Key Staff 4 Title: Logistics/Program Assistant (Local consultant)

Roles & Responsibilities: Assist the team with setting appointments, travel, lodging and other programmatic and logistic support as needed

Qualifications: Well organized; familiar with how to arrange and book travel and lodging in Liberia; good interpersonal skills

Number of consultants with this expertise needed: 1

Other Staff Titles with Roles & Responsibilities (include number of individuals needed):

--

Will USAID participate as an active team member or designate other key stakeholders to as an active team member? This will require full time commitment during the evaluation or analytic activity.

Yes – If yes, specify who: _____
 No

Staffing Level of Effort (LOE) Matrix Instructions:

This LOE Matrix will help you estimate the LOE needed to implement this analytic activity. If you are unsure, GH Pro can assist you to complete this table.

For each column, replace the label "Position Title" with the actual position title of staff needed for this analytic activity.

Immediately below each staff title enter the anticipated number of people for each titled position.

Enter Row labels for each activity, task and deliverable needed to implement this analytic activity.

Then enter the LOE (estimated number of days) for each activity/task/deliverable corresponding to each titled position.

At the bottom of the table total the LOE days for each consultant title in the 'Sub-Total' cell, then multiply the subtotals in each column by the number of individuals that will hold this title.

Level of Effort in days for each Evaluation/Analytic Team member

Activity / Deliverable		Evaluation/Analytic Team			
		Team Leader	Evaluation Specialist	Evaluators	Logistics
Number of persons →		1	1	2-3	1
1	Launch briefing	1			
2	Desk review	4	4	4	
3	Preparation for team convening in-country: Draft work plan, virtual KIs, etc.	6	5		2
4	Travel to country	2			
5	Team planning meeting, ending with work plan	3	3	3	3
6	In-briefing with mission	1	1	1	1
7	Training data collectors	1	1	1	1
8	Preparation/logistics for site visits	1	1	1	2
9	Data collection/site visits	12	12	12	12
10	Data analysis	4	4	4	1
11	Debriefing with mission with presentation	2	2	2	1
12	Depart country	2			
13	Draft report	8	5	4	
14	GH Pro report quality control, review and formatting				
15	Submission of draft report to mission				
16	USAID report review				
17	Revise report per USAID comments	4	2		
18	Submission of final report				
19	508 compliance review				
20	Upload evaluation report to the DEC				

Activity / Deliverable		Evaluation/Analytic Team			
		Team Leader	Evaluation Specialist	Evaluators	Logistics
Number of persons →		1	1	2-3	1
	Sub-Total LOE	51	40	32	23
	Total LOE	51	40	64-96	23

If overseas, is a 6-day workweek permitted Yes No

Travel anticipated: List international and local travel anticipated by what team members.

Team leader to travel to Monrovia, Liberia. For data collection the team will travel to Bong, Lofa, Nimba,

LOGISTICS

Note: Most Evaluation/Analytic Teams arrange their own work space, often in their hotels. However, if Facility Access is preferred GH Pro can request it. GH Pro does not provide Security Clearances. Our consultants can obtain Facility Access only.

Check all that the consultant will need to perform this assignment, including USAID Facility Access, GH Pro workspace and travel (other than to and from post).

USAID Facility Access

Specify who will require Facility Access: _____

Electronic County Clearance (ECC) (International travelers only)

GH Pro workspace

Specify who will require workspace at GH Pro: _____

Travel -other than posting (specify): _____

Other (specify): _____

GH PRO ROLES AND RESPONSIBILITIES

GH Pro will coordinate and manage the evaluation team and provide quality assurance oversight, including:

- Review SOW and recommend revisions as needed
- Provide technical assistance on methodology, as needed
- Develop budget for analytic activity
- Recruit and hire the evaluation team, with USAID POC approval
- Arrange international travel and lodging for international consultants
- Request for country clearance and/or facility access (if needed)
- Review methods, workplan, analytic instruments, reports and other deliverables as part of the quality assurance oversight
- Report production—If the report is public, then coordination of draft and finalization steps, editing/formatting, 508ing required in addition to and submission to the DEC and posting on GH Pro website. If the report is internal, then copy editing/formatting for Internal Distribution.

USAID ROLES AND RESPONSIBILITIES

Below is the standard list of USAID's roles and responsibilities. Add other roles and responsibilities as appropriate.

USAID Roles and Responsibilities

USAID will provide overall technical leadership and direction for the analytic team throughout the assignment and will provide assistance with the following tasks:

Before Field Work

SOW.

Develop SOW

Peer Review SOW

Respond to queries about the SOW and/or the assignment at large.

Consultant Conflict of Interest (COI). To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CV's for proposed consultants and provide additional information regarding potential COI with the project contractors evaluated/assessed and information regarding their affiliates.

Documents. Identify and prioritize background materials for the consultants and provide them to GH Pro, preferably in electronic form, at least one week prior to the inception of the assignment.

Local Consultants. Assist with identification of potential local consultants, including contact information.

Site Visit Preparations. Provide a list of site visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs.

Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation).

During Field Work

Mission Point of Contact. Throughout the in-country work, ensure constant availability of the Point of Contact person and provide technical leadership and direction for the team's work.

Meeting Space. Provide guidance if requested on the team's selection of a meeting space for interviews and/or focus group discussions (i.e. USAID space if available, or other known office/hotel meeting space).

Meeting Arrangements. Assist the team in arranging and coordinating meetings with stakeholders.

Facilitate Contact with Implementing Partners. Introduce the analytic team to implementing partners and other stakeholders, and where applicable and appropriate prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Field Work

Timely Reviews. Provide timely review of draft/final reports and approval of deliverables.

ANALYTIC REPORT

Provide any desired guidance or specifications for Final Report. (See *How-To Note: Preparing Evaluation Reports*)

The submission of the final report will be five days after receipt of the comments from USAID/Liberia. It will be the property of USAID. Dissemination of relevant findings will occur through official channels at local (Mission, U.S. Government and stakeholders) as well as Washington levels. The report shall not exceed 30 pages, excluding the annexes

The revised final unedited report will be provided to the mission five days after the comments are received.

Once the mission signs off on the final unedited report, the consulting firm/GH Pro will have the documents edited and formatted and will provide the final report to USAID/Liberia for distribution (five hard copies and CD ROM). It will take approximately 30 days for contractor to edit/format and print the final document. This will be a public document and will be posted on the USAID/DEC and the GH Pro websites.

Suggested Format for report

- Executive Summary
- Table of Contents
- List of Acronyms
- Introduction
- Background
- Methodology

- Findings & Issues
- Conclusions
- Recommendations
- Lessons learned
- References
- Annexes (institutions visited, persons interviewed, etc.)

GH Pro will provide the edited/formatted/508-compliant final document approximately 30 business days after USAID provides final approval of the report. The consulting firm will provide four hard copies along with an electronic final copy. The final report will be released as a public document on the USAID Development Experience Clearinghouse (DEC) (<http://dec.usaid.gov>) and the firm project web site.

USAID CONTACT PERSON

	Primary Contact	Alternate Contact	Alternate Contact	Mission M&E Coordinator
Name:	Sophie Parwon	Alex Siafa	Ben Zinner	Courtney Babcock
Title:	Deputy Health Team Leader/ AOR/RBHS			
USAID Office / Mission	USAID/Liberia	USAID/Liberia	USAID/Liberia	USAID/Liberia
Email:	sparwon@usaid.gov	asiafa@usaid.gov	bzinner@usaid.gov	cbabcock@usaid.gov
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Cell Phone (optional)				

EVALUATION DESIGN MATRIX (Version 2.11 submitted to USAID after initial formal briefing)

The purpose of this evaluation is to review the performance and document the achievements of the six-year Rebuilding Basic Health Services (RBHS) project, and provide the mission with insight and recommendations to inform HSS and capacity-building work with the MOHSW through follow-on projects. Additionally, the mission hopes to extract lessons learned by observing how the project prepared the government and community partners to respond to the Ebola crisis. The evaluation findings will advise USAID/Liberia on any needed redirection of strategies, approaches, or priorities in

light of lessons learned from RBHS (and the Ebola response), which might inform the implementation of the follow-on project particularly in the context of the current health systems response to emergencies.

Data Source/ Collection Methods	Sampling/ Selection Criteria	Data Analysis
<p>Question One: How effective was the RBHS project in supporting the National Health Policy and Plan strategic goals, objectives and activities , reviewing the: (a) strengths and weaknesses of the project design based on the WHO HSS conceptual framework, (b) the implementation approach and activities, (c) accomplishments and results since the project modification in 2011 (up to the Ebola response) including progress made in achieving the goals of the revised scope, which incorporates capacity building and two intermediate results: <i>Increased utilization of quality services</i> and <i>More responsive services</i>⁵⁶.</p>		
<p>Desk review RBHS project documents and background documents.</p> <p>Debrief by USAID followed by brief semi-structured discussion</p> <p>Semi-structured interviews or facilitated group discussions with RBHS project staff from JSI and partners</p> <p>Semi-structured interviews with MOHSW – Senior partners/liaisons</p>	<p>Purposive sampling-recognized key stakeholders and informants</p>	<p>Comparison of reported completion of project interventions, accomplishments and results with plans, targets and expectations</p> <p>Project design (complexity of addressing all six building blocks simultaneously, usefulness of the WHO conceptual framework and guidance)</p> <p>Project efficiency and effectiveness of capacity-building approaches and implementation of interventions by JSI and partners (descriptive noting lessons learned, perceived quality)</p> <p>Project relevance (Liberian context, collaboration or synergy with other HSS/C.B. initiatives (USAID and others)</p> <p>Alignment with U.S. Government HSS/C-B strategies and other conceptual frameworks</p> <p>Responsiveness to government goals and objectives</p> <p>Documented approaches for institutionalizing, sustaining C-B/HSS and perceived or documented results</p>
<p>Question Two: What lessons have been learned by RBHS and others who are supporting health service decentralization or “deconcentration” processes (central and county) and building capacities of counties to assume great responsibility for the planning, management and delivery of health and social welfare services so to inform follow-on interventions? This should include:</p> <ul style="list-style-type: none"> • Noting the changes in the three country counties, • Noting how effectively RBHS worked with the County Health and Social welfare teams (CHSWTs) to build their capacity to assume new responsibilities. Identifying lessons learned and promising practices in building or strengthening planning and management capacity of the County Health and Social welfare teams (CHSWTs) in three counties 		

⁵⁶ More responsive services means increased equitable access (safe, effective services to those who need them when and where they are needed)

Data Source/ Collection Methods	Sampling/ Selection Criteria	Data Analysis
<ul style="list-style-type: none"> • Noting effectiveness of the RBHS capacity building interventions to strengthen planning and management at the county level as the country moves to a more decentralized health system, including the contracting-in and contracting-out implementation models supported by RBHS • Identifying to what extent capacity building interventions are/were or are not making progress towards sustainability, and factors are likely to enable or inhibit sustainable change • Identifying the challenges and strengths in working at the county level. • Assessing needs for additional support to strengthen the capacity at the county level to assume and maintain new roles and responsibilities 		
<p>Desk review RBHS work plan, reports and technical documents, and review of national and MOHSW decentralization policies and central operational plan and county operational plans, functional analysis report, OCA/capacity assessments, end-line capacity assessment, minutes/documents from relevant coordinating committee and task forces.</p> <p>Observation of central and county decentralization operational plans and progress.</p> <p>Semi-structured interviews with RBHS (JSI and partners)</p> <p>Semi-structured interviews with relevant Ministries-MOHSW and Ministry of Internal Affairs and Good Governance Commission</p> <p>Semi-structured interviews with USAID advisors and other U.S. Government-funded projects, GEMS project, World Learning (social welfare), and DELIVER</p> <p>Semi-structured interviews with central and county-level officials from MOHSW Ministry of Planning and other relevant departments, CHSW Teams, Boards and County Superintendents, selected District Health Teams (may conduct group interviews at central and county/district levels)</p>	<p>Purposive-key informants involved in the decentralization process</p> <p>Purposive sampling of county officials and convenience sampling of district officials and teams</p> <p>Snowball-key informants for other organizations or initiatives working on decentralization</p>	<p>Use of exploratory and thematic analysis approaches to:</p> <p>Identify how National Policy for Decentralization and county organizational assessments guided RBHS interventions) to prepare counties for assuming new responsibilities-(related to the six building blocks to become decentralized.</p> <p>Compare decentralization/deconcentration status with plans or aims for the counties</p> <p>Identify common themes and factors affecting decentralization progress both positively and negatively in each county.</p> <p>Capture perceptions of key stakeholders about how project capacity-building approaches, process, and interventions supported the decentralization process, what has been done by others, what has worked and what has not worked well, what are the major factors or root causes for weaknesses or barriers, what are the gaps or needs for system strengthening and capacity building and what are the proposals/plans to address these.</p> <p>Compile lessons learned during the project that relate to building capacities for decentralization/deconcentration of health services.</p>
<p>(if possible, semi-structured interviews with community-based organizations assessing performance)</p> <p>Semi-structured interviews with implementing partners, i.e. Africare, IRC, etc.</p>	<p>Purposive-key informants involved in the decentralization process</p>	

Data Source/ Collection Methods	Sampling/ Selection Criteria	Data Analysis
Semi-structured interviews with other key actors or stakeholders working with MOHSW decentralization: World Bank, CHAI, WHO, CDC? etc.		
<p>Question Three (Ebola Crisis): What have been the implications of the current Ebola crisis for capacity-building of the MOHSW, and how effective were RBHS interventions in helping the MOHSW to respond to the crisis? This should include:</p> <ul style="list-style-type: none"> • Describing RBHS Ebola response interventions. • Noting how RBHS capacity-building approaches were adapted in light of the Ebola crisis and the response to it • Identifying the extent to which RBHS interventions and approaches provided a platform to address key needs/issues for Ebola response, such as: focus on behaviors and practices that have been essential in responding to Ebola outbreak; focus on data quality and availability of up-to-date / real-time data and use of data; collaboration and communication between MOHSW/CHSWTs and their partners and intra-ministerial; infection prevention training of health workers, establishing and maintaining Ministry leadership of key response operations/teams, committees; use of community structures, formal and informal leadership channels and groups and internal and external communication strategies. • Documenting lessons learned and capacity needs identified during the Ebola crisis and response that should inform future interventions under new projects. 		
<p>Desk review of RBHS documents relating to Ebola response, processes for development of IPC, minutes of coordination meetings, etc.</p> <p>Semi-structured interviews with USAID, RBHS and partners working on Ebola Response</p> <p>Semi-structure interviews or facilitated group discussions with central government officials leading/directing relevant Ebola response activities</p> <p>Semi-structured interviews with county and district health officers/managers/officers in charge involved in Ebola response-also as is relevant, CHV and other community mechanisms involvement</p> <p>Facilitated group discussions with community health workers (or their supervisors) involved with Ebola response.</p> <p>Semi-structured interviews with others working on Ebola response (donors, coordinating bodies, technical assistance, training, information/education/ communication, BCC and social</p>	<p>Purposive and Snowball sampling</p>	<p>Use of exploratory and thematic analysis approaches to:</p> <p>Note how RBHS plans and approaches were adapted in because of and in response to the Ebola crisis.</p> <p>Assess effectiveness, relevance of RBHS response and how prior CB/HSS interventions prepared MOHSW and communities to respond to the Ebola crisis (post-mortem review of how the project helped the MOHSW to be prepared/equipped for addressing/responding to the Ebola crisis).</p> <p>Compile lessons learned or new information gained by RBHS and others about MOHSW (central, county and community) capacities and needs for strengthening systems.</p>

Data Source/ Collection Methods	Sampling/ Selection Criteria	Data Analysis
<p>mobilization, and medical responders (WHO, CDC, World Bank, UNMEER, UNICEF, CHAI, DELIVER, MSF, IMC, OFDA, etc.</p> <p>Observation of coordination processes led by RBHS (or partners at MOHSW) if feasible/relevant</p>		
<p>Question Four (Health Finance): To what extent has the RBHS project interventions at individual, organization and system related to the Health Financing building block been effective in responding to the needs and priorities of the MOHSW in the area of health financing, and how can the RBHS experience inform future interventions supported by USAID? Key intervention areas include:</p> <ul style="list-style-type: none"> • Management of performance-based financing (PBF) • Management of performance-based contracts (PBCs) with NGOs • Design of national health insurance / health financing reform proposals, i.e. Health Equity Fund • Public financial management: Budgeting, allocations, accounting, management of expenditures and obligations; flow of funds and reporting 		
<p>Document review (RBHS reports, technical documents, national guidelines/manuals developed related to health financing), performance appraisal reports</p> <p>Semi-structured Interviews with USAID, JSI and MSH advisors and from GEMS project</p> <p>Semi structured Interviews with central officials from MOHSW, MOF as relevant</p> <p>Interviews with county officials (County superintendent, Health Officer, CHSWT, County Planning and Finance, selected DHSWT</p> <p>Interviews with PFC organizations, i.e. Africare, IRC, Medical Team International, Mercy</p> <p>Interviews with others working on Health Finance, e.g. WHO Universal Health Coverage Partnership; Liberia Health Sector Pool Fund.</p>		<p>Efficiency and effectiveness of the RBHS capacity-building approaches and interventions relating to PBF, PBC, health insurance dialogue and planning, and management and administration of public funds at the central and county levels.</p> <p>Perceptions of key stakeholders about how project capacity-building approaches, process, and interventions supported the health finance development, what has been done by others, what has worked and what has not worked well, what are the major factors or root causes for weaknesses or barriers, what are the gaps or needs for system strengthening and capacity building and what are the proposals/plans to address these.</p> <p>Identification of common or critical factors relating to capacities affecting management, performance, description of efficiency of PBC.</p>
<p>Question Five (Community Health): What are the strengths and weaknesses of RBHS interventions to develop community health systems and services, including major challenges, results and recommendations for incoming projects? This should include:</p> <ul style="list-style-type: none"> • Noting the status of community health program within the three counties with special focus on interventions related to health communications and delivery of messages to achieve behavior change at the community level • Assessing the extent to which community structures are seen and valued as an integral part of the health systems (e.g. by CHSWTs and health workers, and by communities themselves) • Lessons learned through RBHS' contribution to design and operationalizing of the recently completed 		

Data Source/ Collection Methods	Sampling/ Selection Criteria	Data Analysis
Community Health Services Roadmap		
<p>Desk review of RBHS documents, national policies and guidelines relating to community health and county operational plans, reports and data, studies (LOQ, PRISM and other surveys, assessments or evaluations of community health services or uptake of preventative health measures.</p> <p>Semi-structured interviews with RBHS, USAID, PBC organizations, e.g. IRC, and perhaps others such as Global Fund, CDC, UNICEF?</p> <p>Structured interviews with Deputy of Health and heads of Community Health and Health Promotion and head of Monitoring and Evaluation and Research (surveys, studies, HMIS)</p>	<p>Purposive, Convenience, and Snowball</p>	<p>Use of exploratory and thematic analysis approaches to: Describe RBHS community health model and capacity-building approaches and processes to develop community health services including BCC. Special focus to how community participation and action is being promoted and documented.</p> <p>Identification of factors affecting planning, funding provision and quality of community health services, e.g. lack of or little use of community health data.</p> <p>Process to promote and initiate high impact interventions, e.g. IMCI-case management by gCHVs. Lessons learned, promising or best practices.</p>
<p>Structured individual interviews with county health, officers in charge and HMIS managers.</p> <p>Facilitated (semi-structured) group interviews with CHSWT, at least two DHSWT, selected officers in charge and gCHV supervisors. Potential structured surveys of other DHSWTs</p>	<p>Purposive, Convenience</p>	<p>Perceptions of key stakeholders about how project has supported developing community health services and piloting new high impact interventions, BCC, continuum of care, referral and follow-up systems, what has been done by others, what has worked and what has not worked well, what are the major factors or root causes for weaknesses or barriers, what are the gaps or needs for system strengthening and capacity building and what are the proposals/plans to address these.</p> <p>Lessons learned, promising or best practices. Analyze county and district as well as community (targeted populations) involvement in design and monitoring of community health systems.</p>

ANNEX II: EVALUATION METHODS, LIMITATIONS AND DATA COLLECTION INSTRUMENTS

EVALUATION METHODS

A mixed case study approach was used triangulating findings from a desk review of program documents, interviews or focus group discussions with key stakeholders and capacity-building activity recipients and observation of project-supported systems and community works. A desk review of key RBHS project documents was conducted putting more emphasis on the last second of the project. Interview guides were developed around the five evaluation questions. A team of five evaluators hired by GH Pro traveled to Bong, Lofa and Nimba Counties and using semi-structured interview guides (note section C.), listened to members of each county health team, observing systems introduced by the project, and interviewing staff from the PBC implementing partners in each county. A USAID monitor assisted the team with making contacts.

Both purposive and convenience sampling strategies were used. Criteria used for the purposive sampling was (1) to visit at least one community with facility managed by the CHSWT and one managed by the PBC implementing partner, (2) to visit sites where that would illustrate achievements, challenges or lessons learned. Ideas for sites which would meet these criteria were generated through discussions with the CHSWT and PBC implementing partner. Given time limitations and road systems, sites were narrowed down for convenience, with sites selected that were reasonably accessible. For the sake of efficiency, the team divided into two groups to make the community visits.

Name of Community Visited	Name of District	Name of County
Lawlazu Clinic	Voinjama	Lofa
Barkedu Clinic	Quardu Gboni	Lofa
Bindin Clinic	Saclepea	Nimba
Kpein Clinic	Saclepea	Nimba
Fenutoli Clinic	Suakoko	Bong
Totota Clinic	Salala	Bong
Salala Clinic	Salala	Bong

In these communities, interviews were conducted with district health officers and teams as were available, clinic staff, and focus group discussions or interviews were conducted with CHDCs and community volunteers (general community health volunteers and trained traditional midwives). These contacts were organized with the assistance of the CHSWTs assisted with making contact with district health officers or in their absence with clinic staff). These methods were primarily designed to learn about the roles and activities of community structures supported by RBHS. At each of the sites, the teams observed facility improvements undertaken by the CHDCs. In Bong County, an additional visit was made to a “demonstration site” where the project had worked to develop community-led health promotion and the use of Partnership-Defined Quality.

As time allowed during field visits, short discussions (often ad hoc) were held with external stakeholders, i.e. WHO, UNICEF, CDC and African Union regarding the Ebola response. In Monrovia face-to-face or phone interviews were carried out with the staff from RBHS, PBC implementing partner senior management (Africare and International Rescue Committee), and MOHSW—focusing on departments and units with whom the RBHS project primarily partners (Note list of contacts in Annex III).

Analysis of findings was performed triangulating findings from different sources, observing for common themes, lessons learned as articulated by key stakeholders, and potential promising practices or ideas.

LIMITATIONS

The scheduling of this evaluation was not optimal, given that the country is just starting to recover from a deadly Ebola outbreak which caused a national crisis. This was particularly the case in Monrovia where several key informants were not able to be reached or to keep scheduled appointments. Frequently, the team was faced with only having ten minutes instead of the 30-45 minutes scheduled with MOHSW personnel. The evaluation team had hoped to hold consultative meetings with key central stakeholders around the major study foci-Decentralization, Ebola response and capacity-needs identified and Community Health programming. These meetings were not possible, as the organizers and targeted informants were busy, actively developing the Restoration of Health Services project plan and budget. The evaluation team highly appreciated the time that was allotted by MOHSW staff and the informative visits with Deputy Minister of Health Services, Deputy Minister of Planning and Development and the Deputy Minister of Administrative Services.

In the counties, CHSWTs also were busy with Ebola related activities, (e.g. two counties were holding large Infection Prevention and Control workshops) and/or in planning sessions to develop proposals and plans for the Restoration of Health Services project. Frequently, finance officers were not available as “in Monrovia”, this appeared to be a chronic problem. Additionally in the midst of the field visits, the very important Deconcentration Platform was launched by the President of Liberia, H.E. Madam Ellen Johnson Sirleaf in Bong County, followed by three days of national planning attended by senior county officials including county health officers and county health department directors. This event limited access to and/or time available for interviewing these key informants. As an example, interviews were conducted late one evening with the Nimba County Health Officer and County Health Department Directors as their busy schedules did not allow for meeting during normal business hours. Only one County Superintendent (Bong County) was accessible for a short meeting.

There were also challenges in meeting with district health officers (only three district health officers were met), with the others being out of the county for meetings, continuing their education or the positions were temporarily unfilled. Because of the short notice provided to facilities of our visits, the busy schedules of personnel and volunteers and communication challenges, there was significant variation in numbers of community volunteers visited.

Also, since the project was in the final stages of closure, many of the key RBHS staff were not in country-though they were responsive to telephone interviews. In county, the interviews were held with the RBHS Chief of Party, Finance Director and with the JHU-CCP advisors.

Although mentioned in the initial scope of work, the evaluation team did not meet with other Liberian partners such as the Nursing and Midwifery Board, Liberia Dental and Medical Board, training schools (Esther Bacon School of Nursing and Midwifery, Tubman National Institute of Medical Arts), as they were not relevant to the evaluation questions.

Preliminary evaluation findings were presented to the USAID team on March 4, 2015 and then on March 5th to MOHSW staff (and representatives from RBHS project) from relevant departments and units. Again the busy schedules of MOHSW personnel did not allow for optimal time for in-depth discussion of key findings and/or recommendations. The time provided did allow for feedback which assisted with interpretation of findings.

DATA COLLECTION TOOLS

The evaluation team developed and used two tools, an interview guide for key informants in counties visited and focus group discussion guides for gathering information from community volunteers. When

interviewing MOHSW personnel, open-ended questions were used ranging from broad questions about (1) RBHS contribution to capacity-building of MOHSW, (2) assistance with Ebola response, (3) perceived effectiveness of their capacity-building approaches, and (4) unmet needs relating to deconcentration and epidemic response. More narrowly, the evaluation team followed up observations from field visits with targeted questions to specific departments and units (Planning and Development, Decentralization Unit, FARA, Performance-Based Finance Unit, County Health Services, Community Health, Health Promotion, Monitoring, Evaluation and Research, HMIS, Human Resources and Administrative Services).

Interview Guide for Lofa, Bong and Nimba Counties in the Republic of Liberia February 14-27, 2015

Audience: This tool is prepared to interview key informants from the CHSWT including County Health Officers, County health Department Directors, County Health Administrators, Finance Officers, Logistics Officers, Pharmacy Officers, Human Resource Officers, Disease Surveillance Officers, Community Health Officers, Environmental Health Technicians, Health Promotion focal persons, Monitoring and Evaluation Officers, HMIS Data Managers, Clinical Supervisors, MCH and FP/RH Officers, District Health Officers (and district team members), Officers-in-Charge, Clinic Midwives, gCHV Supervisors, and other key stakeholders (Performance-Based Contract Implementing Partners and international agencies responding to the Ebola outbreak)

Guidance for Conducting Interviews:

- I. Introduce yourself and where you come from, state the Evaluation Objective, establish verbal consent**

Thank you for agreeing to participate in the interview. My name is <insert name>. I am conducting this interview on behalf of <United States Agency for International Development (USAID)> to evaluate the effectiveness of the Rebuilding Basic Health Services (RBHS) project in Liberia in order to capture lessons that can be used in future interventions.
- II. Ensure confidentiality (anonymity) of the interview and state the duration of the interview**

This interview is expected to take (estimate time according to audience). I will be taking notes during the interview. All responses **will be kept anonymous**. This means that your interview **responses will only be shared with research team members** and we will ensure that any information we include in our report **does not identify you as the respondent**. Remember, you don't have to talk about anything you don't want to and you may end the interview at any time. Are there any questions about what I have just explained? Do you have any questions before we start?
- III. Document informant information**
 - Date and time
 - County and location (district, name of community or facility)
 - Name of informants, title and contact info
 - Name of interviewers
- IV. Ending the interview**
 - Thank the informant(s)
 - Allow time for questions or comments
 - Note contact names and info of other key informants as identified during the interview

Master Interview Guide

I. Questions Related to RBHS Capacity Building Approach at the County Level

Q1.1 How did RBHS contribute to building county health capacities?

(Superintendent, CHO, CHSWT and potentially CHB)

Prompt if needed to learn more about approaches and areas of focus.

- Service delivery (joint supervision and quality improvement, community health)
- Workforce (training, IHRIS)
- Health Information Management (HMIS, data quality and reporting, use of data)
- Access to Drugs, Logistics (LMIS)
- Financial Management (accounting, budget monitoring, liquidation)
- Leadership and Governance (county health boards, management training, planning, coordination)

Q1.2. How beneficial or effective were the capacity-building approaches used by RBHS?

(CHO, CHSWT, PBC-IPs, potentially CHB)

Q1.3 From your perspective, has there been improvement since 2008 in the health service delivery in (Bonga, Lofa, Nimba) counties due to the RBHS project?

(Superintendent, CHO, CHSWT and potentially CHB)

II. Questions Related to Decentralization

Q2.1 What is happening with decentralization in this county?

(CHO, CHDD, CHB, County Superintendent, PBC IPs)

Q2.2. Have any plans been developed for decentralizing responsibilities for public health services to the county?

(County Superintendent, CHO, CHSWT, PBC IPs)

If Yes, prompt and ask to see the plan. What has been the progress? Note benchmarks.

Q2.2 How has RBHS supported decentralization at the county level?

(County Superintendent, CHO, CHSWT, PBC IPs)

Q2.3 How has the MOHSW or other ministries helped to build county capacities and skills for assuming new functions?

(County Superintendent, CHO, CHSWT, PBC IPs)

Q2.4 What decentralization activities have been most and least effective in this county?

(CHO, CHSWT, potentially CHB)

Probe for interventions and approaches.

Q2.5 What new responsibilities has the county assumed for planning, directing, providing and monitoring health services?

(County Superintendent, CHO, CHSWT, potentially CHB)

Probe for how county staffing and structure has changed.

Q2.6 What are the challenges for the county to assume or carry out new roles and responsibilities?

(County Superintendent, CHO, CHSWT, potentially CHB)

Q2.7 What are the unmet needs at the county level to assume more responsibility for planning, managing and delivering public and health care services?

(CHO, CHSWT, CHSWB)?

Q2.8 What has been learned, any success stories, promising practices?
(CHO, CHSWT and potentially CHB)

III. Questions Related to Ebola Crisis: Approaches/Lessons Learned
(CHO, CHSWT, CHB, Disease Control Officer, DHO, OIC, CHDC)

Q3.1 How was the health system affected by the Ebola crisis?

Prompt, how were the following entities affected?

- Primary health care facilities
- Community-based health services
- Hospital services
- CHSWT
- Implementing agencies, e.g. Africare and IRC

Q3.2 How did the following perform during the Ebola epidemic?

- Describe the governance and leadership (coordination, communication, logistics) activities between and from MOHSW, CHSWT, CHO, DHST.
- Describe the capacity of HMIS (central, county) to generate timely, quality surveillance and clinical data.
- Describe how the public health services provided service delivery such as:
 - a. Surveillance, case-finding
 - b. Contact training
 - c. Follow-up
 - d. Community education
 - e. Referral
 - f. Primary Care
 - g. Hospital
 - h. Ebola treatment
- Access to infrastructure, supplies
- Workforce (staffing, skills to respond to Ebola)

Q3.3 How did RBHS's prior interventions help the county to respond to the Ebola crisis?

(Extent to which RBHS capacity-building interventions and approaches⁵⁷ provided a platform to address key needs/issues for Ebola response such as)

- focus on behaviors and practices that have been essential in responding to Ebola outbreak
- focus on data quality and availability of up-to-date / real-time data and use of data
- collaboration and communication between MOHSW/CHSWTs and their partners
- infection prevention training of health workers
- establishing and maintaining Ministry leadership of key response operations/teams, committees; intra-ministerial collaboration
- use of community structures

⁵⁷ Note specific approaches, (e.g. formal training, in-service, exposure trips, or exchange visits, embedded technical assistance, provision of equipment, etc.)

- formal and informal leadership channels and groups
- internal and external communication strategies

Q3.4 What was learned by the county about their needs for responding to epidemics such as Ebola: Strengths/weaknesses/future recommendations?

VI. Questions Related to Health Finance

Q4.1 What has RBHS done or to build capacities and systems for improved health finance management in this County (Lofa, Nimba, and Bong)?

(CHO/CHSWT)

Probe:

- Dissemination and follow-up of MOHSW Financial Management Policies and Procedural Manual?
- Dissemination and follow up of the communication strategy? Were the counties involved in developing the communication strategies and channels?

Q4.2 What has changed as a result of the RBHS assistance?

(CHO/CHDD, Community Administrator, Finance Officer)

Probe:

- Annual planning and budgeting processes, probe for use of data
- Budget execution and management
- Reallocation of funds
- Accounting skills and practices, probe for e-processing, use of new manual
- Financial reporting
- Liquidation
- Cash flow/receipt of allotments
- Any change in communications between central government and counties, if not, what is the problem?

Q4.3 What have been the challenges to improve finance management?

(CHO, Community Administrator)

Prompt if they are aware of the manual land communication strategy to address finance barriers.

Q 4.4 Tell us how PBF is working in this county?

(CHO, CHSWT, DHT, OIC, PBC IP)

In Bong County: how the hybrid model is working, how the contracting-in is working

Q4.6 In terms of “contracting-out” mechanism, how does the current PBF system compare with phase one of the RBHS project when RBHS was managing performance-based contracting (PBC)?

(CHO, CHSWT, PBC IP)

Probe for changes and positive and negative effects.

Q4.7 Ask about the demand for the “contracting-in” mechanism?

(CHO, CHSWT, CHB)

Q4.9 How have PBF bonuses been used for facility improvements or to improve access?

(CHO, CHSWT, DHO, CHD, CHDC)

Q4.10 How have performance appraisal findings been used to improve quality of care/services, e.g. scheduling?

(CHO, CHSWT, DHO, CHDC, DHT, OIC)

V. Questions Related to Community Health

Q5.1 What are the community health structures and services provided?

(CHSWT, DHO, OIC, Community Health Supervisors/Officers)

Probe for use of community health volunteers, provision of i-CCM and RH/FP services by gCHVs, the oversight and the supervisory system.

Q5.2 How familiar is the county with the new Community Health Roadmap?

(CHSWT, DHO, OIC, Community Health Supervisors/Officers)

Q5.3 What community health capacity-building interventions and approaches provided/supported by RBHS were of most value?

(Community Health Focal Person, OIC, DHO, OIC, CHDC)

Q5.4. (If relevant to the specific county) What are your perceptions of demonstration sites and the results of these demonstration sites?

(Community Health Focal Person, OIC, DHO, OIC, CHDC)

- What were lessons learned?
- Plans to scale up this model?

Q5.9 What have been the major behavior change communication activities?

(Community Health Focal Person, CHDC, CHC, person trained on BCC in county)

Probe for use of Partnership-Defined Quality, campaigns, other channels and approaches

Q5.5 What have been the challenges in planning, financing and implementing the community health services?

(CHO, DHO, Community Health focal person)

Q5.6 How are the Community Health Development Committees functioning?

(Community Health focal person, DHO)

Probe for achievements, perceived role and value.

Q5.7 Are quality assurance and improvement processes being used at the community health level, if so by whom? What have been the benefits or results? If so, how will this be scaled up and sustained?

(Community Health focal person, DHO)

Probe if Partnership-Defined Quality has been initiated.

Q5.8 What guidance is provided by the MOHSW to develop referral systems in the county and how is it functioning?

(DHO, OIC, CHV supervisor, Disease Control Officer)

Probe for how it worked during the Ebola crisis.

Q5.10 What has been documented that shows the effectiveness of the BCC? What evidence is there of positive behavior change?

(Community Health Focal Person, DHO, OIC, CHDC, CHC, person trained on BCC in county)

Probe for use of LQAS.

Q5.11 From your perspective, how have community-based health services improved since 2011 (shift of RBHS interventions)?

(Community Health Focal Person, DHO, OIC, CHDC, CHC, person trained on BCC in county)

Q5.12. What are the county strategies for sustaining capacities, for continuation of community health services, focusing on those provided by general CHVs and BCC?

(Community Health Focal Person, DHO, OIC, CHDC, CHC, person trained on BCC in county)

Probe for ideas and promising or best practices.

Focus Group Discussions (FGD) Guide for Community Health Development Committee (CHDC)

The following questions are designed to learn about the CHDCs and to gain an insight into their role and duties especially in community health: how their duties changed since the Ebola outbreak, how they helped in the Ebola response, how have they have been involved in improving facilities and/or utilization of services, their awareness and perception of outreach programs and other health promotion activities; and to identify their challenges as well as suggestions to help them perform their duties better.

- Q1. What is your role as CHDC in the community?
- Q2. How many members are there?
- Q3. How is the committee membership composed? Who are the members of the CHDC?
- Q4. How as the CHDC developed? When was it developed? Who supports the CHDC?
- Q5. How do you work with other with other community health workers (TTMs, gCHVs)? Probe also their working relationship with the health facility.
- Q6. What kind of community outreach and health promotion programs are you involved in?
- Q7. How have you been involved in improving facilities and utilization of services? Probe for their role and approaches in promoting healthy behaviors and practices.
- Q8. How have your duties and activities changed since the Ebola outbreak? Probe to find out what their role was during the Ebola outbreak and their role in the Ebola response. Probe for if they have received Ebola awareness and prevention training and who supports them in the Ebola response.
- Q9. What are your ideas about how to support and sustain your community health services? Probe for services (i-CCM, vaccination etc.) provided by community volunteers?
- Q10. What does the CHDC need to perform its role better?
- Q11. Is there any other thing you want to add?

Focus Group Discussion (FGD) Guide for General Community Health Volunteers (gCHV)

The following questions are designed to learn more about the General Community Health Volunteers (gCHV) and to gain an insight into their role in community health: what their usual responsibilities are and if they have received training, how their duties changed since the Ebola outbreak, how they helped in the Ebola response, who supports their activities, how they are supervised, how they work with TTMs and CHDCs in health promotion and awareness activities, how have they have been involved in improving utilization of services (e.g. referrals), and to identify their challenges as well as suggestions to help them perform their duties better.

- Q1. What is your role in the community? Probe if they are providing i-CCM, DOT, vaccination, HIV prevention, care and support of orphans and vulnerable children—emphasis on pre-Ebola activities.
- Q2. Where do you provide these services? Probe for their approach for community health promotion (marketplace, door-to-door household visit, vaccination days, contraception days, etc...)
- Q3. What kind of training have you received before the Ebola outbreak and from whom? Probe for training provided since Ebola outbreak.

Q4. How are you supervised? Probe for how often, by whom they are equipped with supplies, drugs.

Q5. How do you report when you find communicable diseases, e.g. measles, malaria, in your community? Probe about Ebola.

Q6. How do you refer sick patients from the community to the health facility? Probe for the referral system, e.g. how they help sick children go to health care facilities and how the clinics or hospitals ask them to follow up or provide home services to patients after they leave the facilities.

Q7. How do you document and report your activities? Probe for to whom they report, how often.

Q8. Who supports your activities? Probe for community support.

Q9. How has your role changed since the Ebola outbreak?

Q10. What do you need to perform your role better?

Q11. Is there any other thing you want to add?

ANNEX III: SOURCES OF INFORMATION

This annex contains (A) lists of contacts, (B) documents reviewed and (C) the field visit schedule.

A. LIST OF CONTACTS

#	NAME	TITLE	ORGANIZATION
Lofa County			
1	A. Mark Sesay	County Diagnostic Officer	Lofa CHSWT
2	Abraham B. Flomo	Clinical Supervisor	Lofa CHSWT
3	Marduo Garmi and vaccinator supervising gCHVs	Acting OIC	Lawlazu Clinic
4	Abu M. Ballo	CHDC Co-chairman	Barkedu Clinic
5	Alexander Gargy	Finance Officer	CHSWT
6	Ambulley Koryon	PBF Steering Committee	HICOD, Lofa
7	Anra Corpuz	WHO Lofa County Coordinator	WHO, Lofa
8	Bob Malley Omayya	Health Coordinator	IRC, Lofa
9	Edmund Eisah	CHDD	Lofa CHSWT
10	Elizabeth Tamba	Reproductive Health Supervisor	Lofa CHSWT
11	Emmanuel Boylah	Health Manager	IRC, Lofa
12	Goveg B. Thompson	County Data Manager	Lofa
13	Hardii A. Zobombo	PBF Steering Committee	Lofa
14	Hena Kawala	PBF Steering Committee	ARD, Lofa
15	Jimel A. Kamara	PBF Steering Committee	Lofa
16	Josephus Borlongie	CHO	CHSWT
17	Kendric Stauffer	CDC Case Investigator	Lofa-Nimba-Bong
18	Laulazu CHDC	4 CHDC members	Lofa
19	Prince K. Sesay	CHSA	Lofa CHSWT
20	Prince M. Kromah	PBF Steering Committee	HICOD, Lofa
21	Momlu Z. She	HR Manager	Lofa CHSWT
22	Mustapha Daboh	PBF Steering Committee	ARD, Lofa
23	CHDC Salia M. Seayan	CHDC Chairman	Barkedu Clinic
24	Sylvester Dunbar	OIC	Barkedu Clinic
25	Talawallay Alou	Volunteer for surveillance office-Guide	Lofa
26	Tamba S. Alpha	Surveillance Officer, Ebola Virus Disease Field Coordinator	Lofa CHSWT
27	Wilhelmina Dixon with three gCHVs and pharmacy clerk	General Community Health Volunteers and Certified Midwife	Barkedu Clinic, Quardu Gboni District, Lofa
28	William Sherman	Senior Environmental Health Officer/Health Promotion Focal Person	Lofa CHSWT
29	Wolobah Y. Moore	County Pharmacist	Lofa CHSWT

#	NAME	TITLE	ORGANIZATION
Nimba			
30	Abednego S. Wright, vaccinator supervising gCHVs and 1 gCHV	OIC, member of CHDD	Beinden Clinic, Nimba
31	Benedict Kolee	CMO Jackson Doe Memorial Hospital	Nimba
32	C. Paul Nyanze	CHDD	Nimba CHSWT
33	Collins Bowah	CHO	Nimba CHD
34	Dorr Cooper	Development Superintendent	Nimba
35	Emmanuel G Mensaon	County Data Manager	Nimba
36	Issac B. Cole	County Surveillance Officer	Nimba CHSWT
37	John Newmah	M&E Officer	Africare, Nimba
38	Karntay Deemie	County Clinical Supervisor	Nimba CHSWT
39	Massa M. Dukuly, along with vaccinator who supervises gCHVs and one CHV	OIC Kpein Clinic, member of CHDC	Kpein Clinic Saclepea District,
40	Rancy Larkpor	DHO	Sanniquellie District
41	Rancy Leesala	CHSA	Nimba CHSWT
42	Priscilla Mabiah	County RH Supervisor	Nimba CHSWT
43	Rufus G.Sayu	County Clinical Supervisor	Nimba CHSWT
Bong			
44	Alfonso Kofa	CHDD	Bong CHSWT
45	Bornor Korlewala	RH Supervisor	Bong CHSWT
46	Dorothy Dennis with 14 TTMs	Clinical Midwife	Totota Clinic, Salala District
47	Fatorma Jusu	CHSA	Bong CHSWT
48	Fatu G. Garteh	Community Health Supervisor at Bong County	Bong CHSWT
49	Gabrielle DeFang	Lab. Specialist, NAMRU	Bong Co. Referral Lab
50	George Toc, Jr.	Senior Primary Health Coordinator	Africare-Bong
51	George Watson	Accountant	Bong CHSWT
52	Gerries L. Walker	HR Officer	Bong CHSWT
53	Gormah G. Cole	RH Supervisor	Bong CHSWT
54	Ibrahm Tejan Bah	Community health	Bong CHSWT
55	John Gleekiah	Clinical Supervisor	Bong CHSWT
56	Joseph Gartee	District Health Officer	Bong-Suakoko
57	Kathleen w. Gaye	RH supervisor	DHT-Salala
58	Korwan Z. Flomo	Accountant	Bong CHSWT
59	Lawrence S. Don	Social worker	DHT-Salala
60	Meita Yankee	OIC with 8 other members of Quality Improvement Team	Salala Clinic, Salala District
61	Melepalay K. Suma	Community Health Supervisor at Bong County	Bong
62	Melvin F. Fania	Data Manager	Bong CHSWT
63	Miata Sonkarlug	UNICEF Health Officer	UNICEF-Lofa, Bong
64	Roseline M. Dologban and 7 gCHVs	OIC	Fenutoli Clinic, Suakok District Bong

#	NAME	TITLE	ORGANIZATION
65	Salayah Dukuly	DHO	Bong-Salala District
66	Samson Arzoaquoi	CHO	Bong CHSWT
67	Samuel T. Gayflor	County Pharmacist	Bong CHSWT
68	Sayaah Freeman and Joseph Bondo, vaccinators and 3 CHVs	Vaccinators/gCHV supervisors 2 gCHVs 1 Ebola-focused CHV	Totota Clinic
69	William S. Flomo Nora S. Matadi, Joan Davis, Rebecca T. Kennedy, Lawrence Don	CHDC members	Totota Clinic catchment area
Monrovia-Implementing and Other Partners			
70	Abigail McDaniel	Deputy Director	IRC
71	Garfee Williams	CHO	Africare
72	Margaret Korkpor	Technical Expert (former MOHSW County Health Service Director)	Africare
73	Lauren Zinner	Deputy Country Director	CHAI
74	Cyprian Kamaray, Deputy Chief of Party; Murvee Gardiner, Financial Management Advisor and Tsri Apronti, Procurement Advisor	GEMS staff	GEMS
75	Yusuf Babaye	COP	JSI-DELIVER
MOHSW			
76	Bernice Dahn	CMO	MOHSW
77	Dominique Togba	Head of RBF unit	MOHSW
78	James Beyan	Director of Personnel (brief discussion)	MOHSW
79	John Sumo	Director of Health Promotion (brief discussion)	
80	Louise Mapleh	FARA Coordinator	MOHSW
81	Luke Bawo	Director of M&E	MoSHW
82	Matthew Flomo	Deputy Minister for Administration	MOHSW
83	Mike Mulbah	M&E Officer, PBF Projects	MOHSW
84	Steve Gabayn	Director of HMIS (IHRIS)	MoSHW
85	Tamba M. Boima	Director of Community Health	MoSHW
86	Tijli Tarty Tyee Jr.	Decentralization Officer	MOHSW
87	Vera Mussah	Director of County Health Services	MOH
88	Yah Zolia	Deputy Minister for Planning	MOHSW
USAID			
89	Alexander Siafa	M&E and Budgeting	USAID/Liberia Health
90	Ben Zinner	HSS Sub-Team Leader	USAID/Liberia Health
91	Christie Reed	Malaria Resident Advisor	CDC/PMI
92	Courtney Babcock	M&E/ Program	USAID/Liberia Program and Project Development Team
93	Jannie Horace	Community Health Specialist	
94	Karolyn Kuo	Democracy and Governance Officer	USAID/Liberia DG Team
95	Ochi Ibe	Community/HHG Advisor	USAID/Liberia Health

#	NAME	TITLE	ORGANIZATION
96	Pamela Bernard-Sawyer	FP/RH Specialist	USAID/Liberia Health
97	Siana Tackett	Health Officer	USAID/Liberia Health
98	Sophie Parwon	Deputy Health Team Leader	USAID/Liberia Health
99	Stephen Dziti	MNCH Advisor	USAID/Liberia Health
100	Tara Milani	Health Team Leader	USAID/Liberia Health
RBHS			
101	Erik Josephson	Health Financing Advisor	ICD
102	Judith Oki	Former Director Capacity Building	JSI
103	Marietta Yekee and Teah Doegmah,	BCC Advisors	JHU-CCP
104	Rose Macauley	RBHS COP	JSI
105	Theo Lippeveld	Former DCOP	JSI
106	Zaira Alonso	Finance Director	JSI

B. LIST OF DOCUMENTS REVIEWED

USAID Documents

1. USAID/Liberia Country Development Cooperation Strategy (CDCS) 2013-2017
2. USAID/MOH FARA agreement
3. USAID/Liberia Country Development Cooperation Strategy (CDCS) 2013-2017
4. USAID RBHS Mid-term Evaluation Report, 2012

RBHS Documents

5. RBHS Revised Program Description of 2012
6. RBHS Special Annex 2012
7. RBHS M&E plan and indicators
8. Internal Project Assessment: May 16 – June 1, 2011
9. RBHS Capacity Building Strategy (June 2012)
10. End-line Capacity Assessment of MOHSW and FARA Counties: May 12 – June 27, 2014
11. PRISM baseline and end-line assessments
12. Liberia Health Equity Fund (LHEF) Purchasing Agent and Roadmap, August 2014
13. The Liberian Health Equity Fund (LHEF): A Narrative History, October 2014
14. Contracting-in and Contracting-out Guidelines
15. C-HMIS tools
16. RBHS annual reports
17. RBHS Semi-annual Performance Reports
18. RBHS third through sixth year work plans
19. RBHS Case Studies and Technical Briefs
20. JSI website; <http://www.jsi.com/JSIInternet/IntlHealth/where/display.cfm?tid=1030&id=399>
21. “Evaluation of Bomi County Performance-Based Contracting-In Pilot,” USAID/MOHSW/JSI, 2012.

Government of Liberia Documents

22. National Health and Social Welfare Policy and Plan 2011-2021
23. MOHSW Country Situational Analysis Report
24. MOHSW Decentralization Policy
25. Community Health Roadmap and Operational Map
26. MOHSW National Monitoring and Evaluation Policy and Strategic Plan 2012-2021
27. National Human Resources Policy and Plan for Health and Social Welfare 2011-2021
28. National Health and Social Welfare Financing Policy and Plan 2011-2021
29. Improving Commodity Security through Improved Accountability and Controls – An Interim Approach
30. EPHS Primary Care – The Community Health System
31. MOHSW 2013 Facility Accreditation Report
32. MOHSW Sexual and Reproductive Health Policy
33. National Family Planning Strategy
34. National Guidelines for Initiating and Managing Community-Based Distribution of Family Planning Services
35. Investment Plan for Building a Resilient Health System in Liberia

Other Reference Materials

36. Supply and Logistic Internal Control Evaluation (SLICE) USAID 2012
37. Liberia DHS 2013, MIS 2011
38. MEASURE’s Health Outcome Monitoring Capacity Building Survey in 2011, 2012, and 2013

39. "Rebuilding Human Resources for Health: A Case Study from Liberia. Human Resources for Health," Varpilah, et al 2011.
40. "Monitoring the building blocks of health systems: a handbook of indicators and their measurement strategies," WHO. Available at:
<http://www.who.int/healthinfo/systems/monitoring/en/index.html>
41. "An Assessment of Decentralization and Local Governance in Liberia..." pg 56-57, Social Impact, USAID, September 2012.
42. USAID's Leadership in Public Financial Management PFMRAF Stage 2 Report MOHSW
43. "Updated Risk Management Plan, USAID June 2014
44. "Who Benefits from Government Subsidies to Public Health Facilities in Liberia," Health Systems 20/20, USAID, 2010

C. FIELD VISIT SCHEDULE

Date	Activity	County Name
Feb. 8	Team meeting: methods and compilation of C-B interventions and approaches	
Feb. 9	Meet with Sophie at Mamba Hotel at 9:00 AM Meet with MOHSW Develop tools	
Feb. 10	Meeting with USAID technical advisors and program staff 9-11 Finalize tools, send to GPro for review	
Feb. 11	Holiday	
Feb. 12	Conduct interviews in Monrovia	
Feb. 13	Conduct interviews In Monrovia	
Feb. 14	Travel to field	Lofa
Feb. 15	Field visit in Lofa/Meeting with CHT	Lofa
Feb. 16	Field visits/Meeting with IRC	Lofa
Feb. 17	Field visits/Community clinic visits	Lofa
Feb. 18	Travel to Bong/Meeting with CHT	Bong
Feb. 19	Travel to Nimba/Field visit in Nimba/Meeting with Africare	Nimba
Feb. 20	Travel to Bong/Field visit in Bong/Community clinic visits	Bong
Feb. 21	Field visits-community level	Nimba
Feb. 22	Sunday rest	Nimba
Feb. 23	Field visits in Bong	Bong
Feb. 24	Field visits in Bong/Community clinic visits/Travel to Monrovia	Monrovia
Feb. 25	Monrovia interview with MOHSW	Monrovia
Feb. 26	Monrovia interview with MOHSW/other stakeholders	Bong
Feb. 27	Monrovia interview with MOHSW	Monrovia
Feb. 28	Monrovia Team preliminary finding discussion	Monrovia
Mar. 1	Sunday rest	Monrovia
Mar. 2	Monrovia interview with MOHSW	Monrovia
Mar. 3	Monrovia interview with MOHSW/CHAI	Monrovia
Mar. 4	Presentation of preliminary findings and discussion with USAID	Monrovia
Mar. 5	Dissemination of key findings and interpretation with MOHSW	Monrovia

ANNEX IV: RECOMMENDATIONS FOR IMPROVING HMIS-2014 PRISM REPORT

1. Ensure that aggregated data are assessed for accuracy and completeness prior to transfer and timely transmission.
2. Establish standardized feedback mechanism between levels. Provide feedback systematically to all reporting units on the quality of their reporting (i.e., accuracy, completeness and timeliness) and use of data for decision-making based on their submitted report.
3. Develop standard data management and information use training material.
4. Widely disseminate (to the health facilities) the national HMIS Reference Manual developed in 2010 for data management.
5. Strengthen CHTs' capacities to do data validation and analysis and use information for planning, health services management and supporting system strengthening.
6. Conduct targeted training for health facility staff on data analysis, problem solving and continued use of information.
7. Regular publication of a newsletter to show success stories of where information was used to improve health facility performance.
8. Institutionalize regular monthly review meetings to monitor health facilities' and CHT's performance against objectives using HMIS data. Make the performance review meetings more regular at CHTs level.
9. Better integration of various data sources via the establishment of an integrated data warehouse.
10. Develop mechanism to integrate data needed by different programs to accommodate new interventions—ensure HMIS data are used to generate reports for vertical programs (iCCM, nutrition, disease specific reporting, etc.). Revise the HMIS indicator set by integrating some program related indicators to avoid parallel reporting.

ANNEX V: DISCLOSURE OF ANY CONFLICTS OF INTEREST

USAID NON-DISCLOSURE AND CONFLICTS AGREEMENT

USAID Non-Disclosure and Conflicts Agreement- Global Health Program Cycle Improvement Project

As used in this Agreement, Sensitive Data is marked or unmarked, oral, written or in any other form, "sensitive but unclassified information," procurement sensitive and source selection information, and information such as medical, personnel, financial, investigatory, visa, law enforcement, or other information which, if released, could result in harm or unfair treatment to an individual or group, or could have a negative impact upon foreign policy or relations, or USAID's mission.

Intending to be legally bound, I hereby accept the obligations contained in this Agreement in consideration of my being granted access to Sensitive Data, and specifically I understand and acknowledge that:

1. I have been given access to USAID Sensitive Data to facilitate the performance of duties assigned to me for compensation, monetary or otherwise. By being granted access to such Sensitive Data, special confidence and trust has been placed in me by the United States Government, and as such it is my responsibility to safeguard Sensitive Data disclosed to me, and to refrain from disclosing Sensitive Data to persons not requiring access for performance of official USAID duties.
2. Before disclosing Sensitive Data, I must determine the recipient's "need to know" or "need to access" Sensitive Data for USAID purposes.
3. I agree to abide in all respects by 41, U.S.C. 2101 - 2107, The Procurement Integrity Act, and specifically agree not to disclose source selection information or contractor bid proposal information to any person or entity not authorized by agency regulations to receive such information.
4. I have reviewed my employment (past, present and under consideration) and financial interests, as well as those of my household family members, and certify that, to the best of my knowledge and belief, I have no actual or potential conflict of interest that could diminish my capacity to perform my assigned duties in an impartial and objective manner.
5. Any breach of this Agreement may result in the termination of my access to Sensitive Data, which, if such termination effectively negates my ability to perform my assigned duties, may lead to the termination of my employment or other relationships with the Departments or Agencies that granted my access.
6. I will not use Sensitive Data, while working at USAID or thereafter, for personal gain or detrimentally to USAID, or disclose or make available all or any part of the Sensitive Data to any person, firm, corporation, association, or any other entity for any reason or purpose whatsoever, directly or indirectly, except as may be required for the benefit USAID.
7. Misuse of government Sensitive Data could constitute a violation, or violations, of United States criminal law, and Federally-affiliated workers (including some contract employees) who violate privacy safeguards may be subject to disciplinary actions, a fine of up to \$5,000, or both. In particular, U.S. criminal law (18 USC § 1905) protects confidential information from unauthorized disclosure by government employees. There is also an exemption from the Freedom of Information Act (FOIA) protecting such information from disclosure to the public. Finally, the ethical standards that bind each government employee also prohibit unauthorized disclosure (5 CFR 2635.703).
8. All Sensitive Data to which I have access or may obtain access by signing this Agreement is now and will remain the property of, or under the control of, the United States Government. I agree that I must return all Sensitive Data which has or may come into my possession (a) upon demand by an authorized representative of the United States Government; (b) upon the conclusion of my employment or other relationship with the Department or Agency that last granted me access to

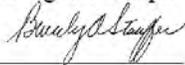
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.



Digitally signed by Beverly Stauffer
DN: cn=Beverly Stauffer, o.ou,
email=bstauff@hotmail.com, c=US
Date: 2015.01.15 12:56:48 -05'00'

01/15/15

Signature

Date

Beverly A. Stauffer

Consultant Team Leader

Name

Title

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.

9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.

ACCEPTANCE

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Signature

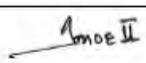
Date *January 26, 2015*

Edward J. Boehl

Name

Title *Evaluator*

GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
PROJECT

<p>Sensitive Data; or (c) upon the conclusion of my employment or other relationship that requires access to Sensitive Data.</p> <p>9. Notwithstanding the foregoing, I shall not be restricted from disclosing or using Sensitive Data that: (i) is or becomes generally available to the public other than as a result of an unauthorized disclosure by me; (ii) becomes available to me in a manner that is not in contravention of applicable law; or (iii) is required to be disclosed by law, court order, or other legal process.</p>	
<p>ACCEPTANCE The undersigned accepts the terms and conditions of this Agreement.</p>	
<hr/>	
Signature	Date: 21 Jan. 2015
	
<hr/>	
Name	Title: Consultant
<i>Ikem Eronini</i>	

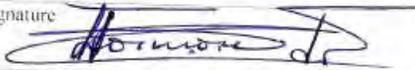
GLOBAL HEALTH PROGRAM CYCLE IMPROVEMENT
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ACCEPTANCE

The undersigned accepts the terms and conditions of this Agreement.

Signature



Date

Jan. 27, 2015

Name

James D. Hornum, Jr

Title

Independent Consultant

Global Health Performance Cycle Improvement Project

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