



GAVI Health System Strengthening Support Evaluation

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Liberia Case Study

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Submitted by

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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CBA	Community based agents
CHW	Community health worker
c-MYP	Costed-Multi Year Plan
DFID	Department for International Development
DPT-Hep b+Hib	Diphtheria-Pertussis Tetanus, hepatitis B and Haemophilus influenzae vaccine
EPI	Expanded Program on Immunisation
EU	European Union
GAVI	Global Alliance for Vaccines and Immunisation
GoL	Government of Liberia
ICC	Inter-agency Coordinating Committee
ISS	Immunisation Support Services
HSCC	Health Services Coordinating Committee
HSS	Health system Strengthening
HIV	Human Immune Deficiency Virus
MDGs	Millennium development Goals
MoHSW	Ministry of Health & Social Welfare
MoF	Ministry of Finance
MTEF	Medium Term Expenditure Framework
NHC	Neighbourhood Health Committees
NHSP	National Health Strategic Plan
UNICEF	United Nations Children's Emergency Fund
USAID	US Agency for International Development
WHO	World Health Organisation

Summary of key findings, conclusions and recommendations

Context

After decades of economic mismanagement and fourteen years of a brutal civil war, Liberia is in the process of rebuilding. The country has been at peace since 2003 and there is still a large UN peace keeping presence. Two rounds of free and fair elections in 2005 led to the inauguration of a new government in January 2006. The economy is now expanding, with growth accelerating to over 9% in 2007.

The response from the health system

The National Health Plan outlines a framework for moving from humanitarian assistance to a sector development approach and from vertical to integrated health systems development. This framework is organised around four main components¹:

- Basic Package of Health Services
- Human Resources for Health
- Infrastructure Development
- Support Systems to Strengthen Decentralization

HSS proposal design

The GAVI proposal was developed by a small team drawn from the MoHSW, WHO, UNICEF and USAID, led by the MoH's Deputy Minister for Planning and the Chief Medical Officer. There was no external TA used in the development of the plan and the \$50,000 available for that purpose was not used.

The main objectives of the GAVI HSS proposal were to underpin the implementation of the NHP through supporting:

- The strengthening of primary health care services through the **Basic Package of health Services (BPHS)**, with child survival as an entry point to operationalize the national health plan;
- **Linking health services with the community** by expanding the community-based workforce including the development of clear guidelines, training plans and the provision of training leading to increased access to health services;
- **Evidence based management support systems** for primary health care service provision; and

¹ Republic of Liberia, National Health and Social Welfare Plan, 2007 - 2011

- **Human resources development for health** through expansion of community-based health workers, development and use of a strategy to ensure efficient performance of existing community health workers at the county level in offering integrated BPHS.

A total of \$US 4,089,520 was requested over a four year period to support these activities. The availability of funding through the GAVI HSS window was vital, as significant funding gaps still remained.

A critically important use of the GAVI funding has been its use for the employment of key programme staff within the MoHSW. Seven staff members have been hired with the HSS funding including a technical adviser on the BPHS and the Directors of the Training Unit, Family Health Division and Information Technology Unit. Liberia is a HIPC country and consequently has had stringent limits imposed on the size of its public sector, which would have prevented the employment of additional staff.

HSS money is deposited into the GAVI account held by the MoHSW. This account is managed by the MoH Office of Financial Management (OFM) according to normal MoH procedures. The management and oversight of the OFM and Pool Fund in Liberia has been outsourced to Price Waterhouse Coopers (PwC).

Annual Progress Reporting (APR) on HSS

One of the great challenges faced by the MoHSW is having access to reliable and timely health information, including on the implementation of the GAVI HSS activities.

The reconstruction of the HMIS is at an early stage. There are some concerns still about the quality of data and the reliability of reports.

Financial Reporting

The 2008 APR provided a comprehensive description of the activities that had been undertaken during the year and included detailed reporting of expenditure against each activity. The MoH has instituted a system of quarterly review meetings to assess progress against the annual plan.

Result indicators

There was detailed reporting against the 10 result indicators included in the original HSS proposal. For FY 2008, all 10 indicators were reported on together with a description of the source of data used. For three of the indicators (DPT3, Measles and U5M), the report indicated that the targets established in the original HSS proposal had either been met or exceeded.

There is little doubt that the requirements for developing an annual performance report to GAVI puts considerable additional pressure on the MoHSW. There are very limited numbers of staff at the mid and senior levels of the health system who are able to put a report of this nature together.

Recommendation: to look at ways in which GAVI and the Global Fund could cooperate and work together in order to reduce the transaction costs and increase impact

HSS progress to date

Despite a slow start in 2007, the GAVI APR for 2008 indicated that much greater progress had been made in implementing activities. A total of \$US1,286,704 was spent during the year. Much of the money has been used for the development of new policies, systems and processes at the central level, although there was a significant amount of training of community health workers in the BPHS at the county level reported.

End of HSS Assessment

The improvements in immunisation coverage at the end of the HSS grant are likely to be modest given that there were high immunisation coverage rates in Liberia at the time of proposal design.

It will be important when designing the 2012 evaluation to look at the impact of GAVI HSS funding at the macro and micro levels. **There are a range of key questions that will need to be asked including:**

- What have HSS funds been used for and why were the decisions made to use them in this way?
- How effectively have they been employed? Have they complemented other sources of funding or have they been the sole source for certain activities?
- What has been the quality of the activities supported? Are the interventions supported leading edge and evidence based?

- How has the use of the GAVI funding had an impact at the service delivery level? What have been the specific impacts at that level?
- How have the planning and coordination processes worked? Have these been effective?
- Have the funds been used in the ways originally envisaged in the HSS proposal? If not, what has been the process to re-orientate funding and was this in-line with GAVI requirements?
- Has value for money been achieved? Are there alternative ways in which the resources could have been used which would have generated greater impact?

Technical support for proposal design and approval

The WHO and UNICEF played a key role in helping the MoHSW to develop the original GAVI HSS proposal and those inputs were greatly appreciated by the MoHSW. There was general consensus among the people that had worked on the GAVI HSS proposal that the Independent Review process had been a useful exercise.

Technical support for HSS implementation

There was little evidence of any systematic support being provided by either the WHO or UNICEF to support the implementation of the HSS proposal.

Alignment of HSS with GAVI Principles

The proposal addresses identified gaps within the priority areas of the national health plan and it can be described as being fully country driven. It was developed by a small team drawn from the MoHSW, WHO, UNICEF and USAID, led by the MoH's Deputy Minister for Planning and the Chief Medical Officer.

Alignment with broader development and health policies

The GAVI proposal is fully aligned with the priorities identified in the National Health Plan and with Liberia's PRS which formed the basis for the NHP.

Alignment with budget and reporting cycles

In terms of alignment with budget and financial management procedures, GAVI HSS resources, as with all of the GAVI funds are "on plan" and "on budget".

Is GAVI HSS Harmonised?

The GAVI HSS funds are managed and reported on separately and have their own bank account operated by the MoHSW's Office of Financial Management. GAVI funding is not

channelled through the MoHSW's Pool Fund. Whilst the GAVI HSS programme uses the MoHSW's M&E system, it is reported on separately.

The MoHSW produces an annual report of its progress and activities. **Potentially, the reporting on GAVI funded activities could be included as a separate section in the annual report or better still, incorporated into the existing report format.**

Is GAVI HSS funding predictable?

The GAVI HSS funds have been disbursed on time according to the agreed schedule. In comparison with other funding sources, there is less bureaucracy required for the disbursement of funds from the GAVI HSS grant. **The MoHSW in particular, appreciates the fact that the funds are provided as a single annual disbursement rather than a series of quarterly tranches.** This has reduced bureaucracy considerably.

Is GAVI HSS accountable, inclusive and collaborative?

MoHSW partners in general do not have a detailed understanding either of GAVI or of the HSS work. CSO representatives are very supportive of the Minister of Health and his team and the intensive efforts that are being made to improve sector coordination and working relationships with partners. The CSO representatives were also very appreciative of the strong anti-corruption position adopted by the Minister of Health and the fact that he matched his words with action when necessary.

There are a large number of sector coordination committees that collectively absorb a very significant amount of MoHSW senior management time and energy.

Recommendation: The MoH should give consideration to streamlining its coordination arrangements to maximise the efficient use of senior management and other staff time.

Does GAVI HSS have a catalytic effect?

There is some evidence that partners are now using the improved information being produced by the HMIS and the BPHS health facility accreditation process to make informed decisions and to target their resources more effectively. **There is no evidence** that the GAVI HSS funding has produced additional efforts to strengthen health systems or has attracted additional donor support.

Is GAVI HSS Results Oriented?

The Liberia HSS proposal contained a set of very specific indicators against which progress/results could be judged. In the 2008 APR, the MoHSW went to considerable efforts

to report against this indicator framework in order to demonstrate the results that are being achieved.

What is less evident is how results oriented the GAVI Secretariat can realistically be?

It is clear what should happen if the IRC is faced with a poorly written and incomplete APR. The country concerned would be asked to rewrite or improve the APR by the GAVI Secretariat, and provide any missing information. Until that is done, further disbursements of funding would be suspended. Conversely, if an adequate APR is received, this should be quickly approved by the IRC and the disbursement of the next tranche of funding made.

The real question is: faced with a well written and credible APR, how can the IRC/GAVI Secretariat confirm that the information contained within it is accurate and a realistic representation of the situation on the ground. Faced with a large number of APRs from over 70 countries, this will be a very challenging process both managerially and technically.

Recommendation: review the processes and procedures required to periodically test the adequacy of information provided to GAVI by recipient countries?

GAVI HSS sustainability issues

Liberia is at a very early stage in its post conflict reconstruction. It is in the process of trying to rebuild shattered health infrastructure and systems and to train new service providers. Realistically, the MoHSW has acknowledged that it is going to require significant donor support for many years to come.

Does HSS funding help improved equity?

The Liberia HSS proposal does not have a specific poverty or equity focus. The MoHSW's justification for this was that at the end of the civil war, the vast majority of Liberians were living in poverty.

1 Scope, Approach and Methodology

1.1 Background

This report contains the findings of the case study conducted in Liberia in May 2009 as part of the GAVI HSS Evaluation Study. This is one of 11 In-depth case studies that have been conducted in the following countries, all of them recipients of GAVI HSS grants: Burundi, Cambodia, Democratic Republic of Congo (DRC), Ethiopia, Kyrgyzstan, Liberia, Nepal, Pakistan, Rwanda, Vietnam and Zambia. An additional 10 countries were also studied that did not involve country visits but just review of available documentation combined with email/phone interviews by the study team. These countries were Bhutan, Honduras, Georgia, Ghana, Kenya, Nicaragua, Nigeria, Sierra Leone, Sri Lanka and Yemen.

Other issues relating to the overall study methodology (evaluation framework, key questions, study components, guidelines for data collection, sampling method, etcetera) are publicly available documents that can be requested for HLSP. To keep this report short these broader methodological issues will not be discussed here. A summarised description of the study approach can be found in Annex 3.

1.2 Brief conceptual framework of the Evaluation

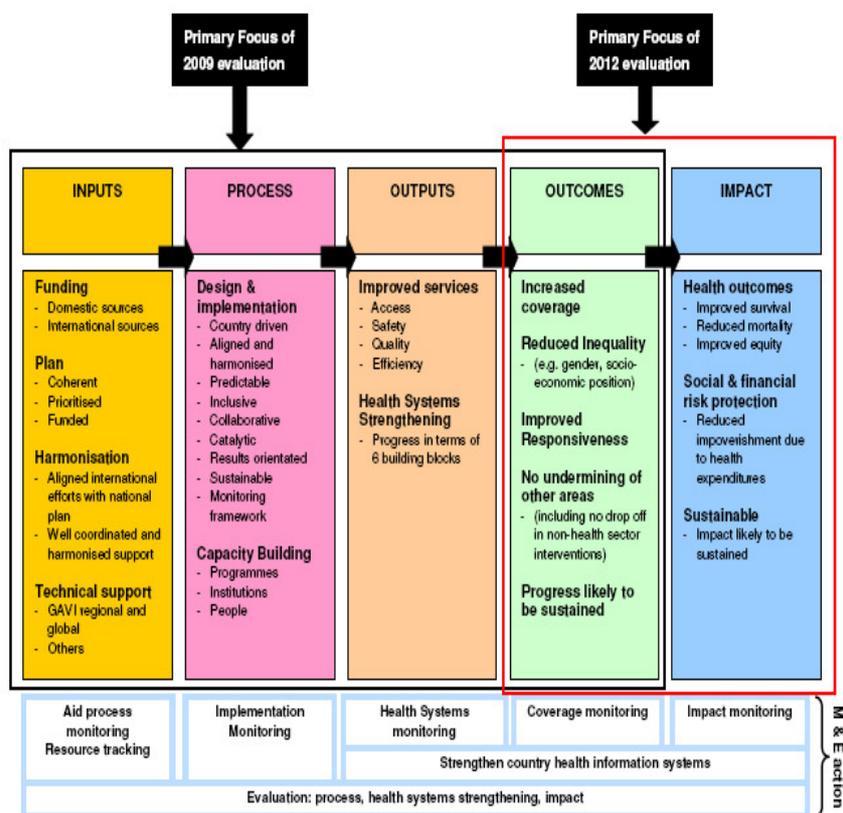
This evaluation is being conducted to inform three areas of decision making:

1. The Board decision in 2010 about whether or not to increase the funding available to the GAVI HSS window
2. How to improve current and future implementation. (This is valid even if the window is not expanded, because there are considerable sums of money which have been awarded but not yet disbursed.)
3. To enhance the quality of the 2012 evaluation.

It is important to note given the short time elapsed since the first HSS applications were approved in 2006 that this evaluation – the first one ever conducted on the GAVI HSS component - will focus primarily on issues linked to: proposal design; approval and review processes; early start up measures; nature of inputs, processes and outputs involved in grant implementation and annual performance review; and assessment of activity and outputs achieved to date. The study will also reflect on the nature and quality of global, regional and

national technical support systems delivered by a range of stakeholders in support of HSS grants. The conceptual framework for this evaluation is shown in Figure 1.

Figure 1: The conceptual framework - logical progression from inputs to impact



Our priority questions have been summarised in Box 1 below.

Box 1: Examples of Questions for the HSS Evaluation Study

- Is GAVI HSS on track to achieve what it set out to (in general and in individual countries)? If not, why not? How might GAVI HSS be improved?
- What would have happened if GAVI HSS had not been created? Is it additional money and does it add value to existing ways of doing business?
- Are the “right” bottlenecks being identified – i.e. are they priorities and relevant to the desired outcomes?
- Are design and implementation processes consistent with GAVI principles?
- What factors can be linked to countries being on- or off-track?
- Are HSS-related monitoring frameworks well designed? Do they measure the right things? Are they being appropriately implemented? Do they take into account country capacity to deliver?
- Are they consistent with existing country monitoring frameworks? Where they differ, what value is added and at what expense in terms of extra transactions costs?
- What do we know about outputs and outcomes? How realistic is it to try and attribute improved outputs and outcomes to GAVI support? What are some of the key contextual factors which influence results?
- How sustainable are the results likely to be?
- What have regional and global support mechanisms delivered?
- What effect have they had – how could they have been improved?
- What should the 2012 evaluation cover and what need to be done now to support it?

1.3 Approach to the Country Case studies

All 11 countries included for in-depth review underwent at least one country visit by the HLSP country lead consultant helped by one or more national consultants or national research institutions depending on the circumstances.² In the case of 6 countries (DRC, Ethiopia, Kyrgyzstan, Nepal, Vietnam and Zambia) the HSS evaluation team were able to count on the invaluable support and previous work of another study team conducting the so called GAVI HSS Tracking Study in those countries. The Tracking Study -led by the JSI/InDevelop-IPM covers very similar areas (albeit from a different angle) to those aimed at in our HSS Evaluation study, so it was highly synergistic for us to be able to use the Tracking Study guidelines and their extensive network of contacts and country knowledge for the purposes of our own evaluation study. To all members of the Tracking Study team including their country collaborators we wish to express our most sincere thanks and appreciation for their generous collaboration.

In Liberia as in other countries the country case studies were triggered by a letter from the Executive Secretary of the GAVI Alliance Secretariat addressed to the Minister of Health and copied to the main stakeholders involved in follow up or implementation of GAVI grants at national or regional level, including the so-called “Focal Points” based at either the World Health Organisation (WHO) or UNICEF.

It was later found that several people copied in such letters were no longer in post and that new stakeholders had been missed, which is *why this study has recommended the GAVI Alliance Secretariat to review and update the list of country contacts on an annual basis. This will not only help other eventual study teams but will improve effective communications between the GAVI Alliance and the countries, particularly as the GAVI Alliance is not formally present in countries.*

Once the letters had been sent, the Country Lead Consultants began the process of documentation (see list of documents reviewed in Annex 2). They approached potential country researchers to work with them and they began preparing the country visits with country and regional stakeholders. In the case of Liberia the country visit took place between the 11th and the 22nd of May. A list of people met for this evaluation is included in

² The main circumstances that determined the kind of support required by the HLSP Country Lead consultants included the size of the country, the size and complexity of the HSS grants, whether the grants were targeting any specific geographical areas, etc.

Annex 1. Most meetings took place in Monrovia and a field visit to health facilities was undertaken. Quarterly reports from a sample of districts were also reviewed.

After the visit to Liberia, a draft report was prepared that was shared with the Deputy Minister of Planning at the Ministry of Health as agreed during our visit. It was also suggested to the Deputy Minister that following their approval of a revised version of the report they might like to get it circulated, with restrictions, among the members of the Health Sector Coordinating Committee.

1.4 Acknowledgements

We would like to thank the Ministry of Health in Liberia and particularly the Deputy Minister for Planning and his staff for the excellent support received for this evaluation study. Thanks are also expressed to WHO for the excellent logistical support provided to the mission members, UNICEF, UNDP and USAID.

2 Snapshot of the Liberian health system

2.1 Progress towards MDGs

After decades of economic mismanagement and fourteen years of a brutal civil war, Liberia is in the process of rebuilding. The country has been at peace since 2003 and there is still a large UN peace keeping presence. Two rounds of free and fair elections in 2005 led to the inauguration of a new government in January 2006. The economy is now expanding, with growth accelerating to over 9% in 2007.

Achieving the MDGs will be a challenge for many developing countries, but it will be even more difficult for Liberia because of the legacy of the war. While most countries were making at least some progress toward the Goals between 1990 and 2003, Liberia was moving dramatically backwards and losing the human, economic and infrastructure capacity needed for their achievement. All of Liberia's indicators were worse in 2000 than they were in 1990. Thus, to achieve any of the Goals, Liberia must make larger gains in a shorter period of time than almost any other country has ever managed to achieve.

Table 1 - Progress as per successive DHS surveys

	1986	2007
Infant mortality	144/1000	71/1000
Under-five mortality	220/1000	110/1000
Maternal mortality	--	994/100,000
Deliveries with skilled attendant	58.1%	46.3%
Contraceptive Prevalence Rate	8.4%	13.3%
Total fertility rate	6.5	5.2

Source: DHS

The still high maternal and infant mortality rates in Liberia are major causes of concern and require the intervention of all stakeholders and partners in order to meet the MDGs. Non

communicable diseases, including mental health and consequences of gender-based violence, also need to be addressed³.

The major burden of disease is made up of preventable communicable diseases. Malaria, acute respiratory infections, diarrhoea, tuberculosis, sexually-transmitted diseases (STDs), worms, skin diseases, malnutrition, and anaemia are the most common causes of ill health. Malaria accounts for over 40% of outpatient department attendance and up to 18% per cent of inpatient deaths. Among children below 1 year of age, malaria was the most common cause of outpatient mortality followed by ARI, diarrhoea, anaemia and neonatal tetanus.

Diarrhoeal diseases in Liberia are the second leading cause of morbidity and mortality. HIV/AIDS is a problem of mounting severity. Existing data are inadequate to draw firm conclusions about internal variations in HIV prevalence. It appears that Monrovia and the south-eastern region have higher HIV prevalence rates than the rest of the country.

The major health indicators include the following^{4,5}:

- Average life expectancy at birth is 48 years: 48.7 for females and 44.7 for males
- Infant mortality rate of 71/1,000
- Under-five mortality rate of 110/1,000
- Maternal mortality ratio of 994/100,000 (among the highest in the world);
- HIV prevalence rate is estimated at 1.5 %.
- Exclusive breast-feeding of children less than six months of only 35%;
- Moderate and severe underweight rates of under-fives of 27% and 7% respectively;
- Total fertility rate of 5.2
- Contraceptive use among married women – 11%
- Access to safe water and sanitation estimated at 24% and 26% respectively;

2.2 The response from the health system

Liberia has made significant progress over the last few years with significant reductions in infant and child mortality rates, a reduction in the fertility rate, and greatly expanded access to HIV and AIDS treatment and care. The Government has developed a comprehensive National Health Policy and Strategic Plan, and initiated a National Two-Year Transition Plan in 2006; as a short-term emergency intervention to prevent the potential crisis that was developing as a result of the departure of humanitarian NGOs. The Government secured

³ WHO Country Coordination Strategy, Liberia, 2005 - 2010

⁴ 2007 Liberia Demographic and Health Survey

⁵ Liberia, National Health and Social Welfare Plan, 2007

increased donor funding for NGOs to implement the transition plan, and they continue to operate over 80% of health facilities nationwide.

The overall goal of the health sector is to expand access to basic health care of acceptable quality and establish the building blocks of an equitable, effective, efficient, responsive, and sustainable health care delivery system across Liberia. The National Health Plan outlines a framework for moving from humanitarian assistance to a sector development approach and from vertical to integrated health systems development. This framework is organised around four main components⁶:

- 1) Basic Package of Health Services
- 2) Human Resources for Health
- 3) Infrastructure Development
- 4) Support Systems to Strengthen Decentralization

Specifically, the Government is aiming to ensure that 70% of health facilities in each county provide a Basic Package of Health Services (BPHS) by December 2010. The Government is aiming to further reduce the child mortality rate by 10 to 15% and the maternal mortality rate by five to 10% over the same period.

The BPHS is the cornerstone of the national health plan. It includes the health services that the Ministry of Health and Social Welfare (MOHSW) will make available to every Liberian. The BPHS standardizes prevention and treatment services throughout the health system to ensure that all individuals, wealthy or poor, living in urban or in rural areas, are able to receive the same basic package of care.

The BPHS is a “minimum package” to be delivered as an integrated whole. Additional services not currently included in the BPHS will, once approved by the MoHSW, be added to, but not substituted for, those already included in the BPHS. User fees for the services included in the Basic Package will be suspended at all public facilities, at least for the current interim period. Public sector health funds are allocated, preferentially, to fund the implementation of the BPHS. To achieve these goals, the Government will aim to address six strategic priority areas:

⁶ Republic of Liberia, National Health and Social Welfare Plan, 2007 - 2011

Expanding access to the Basic Package of Health Services (BPHS):

The BPHS focuses on six national health priorities: maternal and newborn care, child health, reproductive and adolescent health, communicable disease control (including HIV and AIDS), mental health, and emergency care. The Government is suspending user fees until the country's socio-economic situation improves and financial management systems perform at a level that ensures a more poverty focused distribution of revenues.

Rehabilitate Health Infrastructure

Liberia requires between 500-550 health facilities to reach the target of a quality facility within 10km of every community. This represents a significant increase from the estimated 350+ facilities currently functional. By 2012, the Government intends to rebuild and renovate over 200 health facilities, and construct rehabilitation facilities for mental health services and young people. Communities will work with health providers to determine the location of the health facilities to be renovated and constructed and to develop local management structures to guarantee grassroots participation.

Further Develop Support Systems

The MoHSW is promoting a culture of transparency and accountability in its decision-making and operations. It is decentralizing a number of management responsibilities: local governments will be responsible for primary health services, while the central Government will focus on policies, aggregated planning, and standardization.

The MoHSW is in the process of introducing a computerized Health Management Information System (HMIS). It also plans to develop a supply chain and logistics management system able to help forecast demand, facilitate the procurement of medical supplies, and coordinate with county level systems. Databases and electronic systems for human resources, infrastructure, and finance are also in the process of being developed and introduced.

Strengthening Health Financing

With almost two thirds of the population estimated to be living in poverty, many individuals have limited financial capacity to pay for health care and the demand for alternative financing is high. In 2007, public health expenditure per capita was about US\$5, compared to the estimated US\$34 required to achieve the MDGs. The Government will not be able to independently fund the health sector without sustained donor support and private provider participation for at least the next 10 years.

The MoHSW is working with its partners to develop a national health financing strategy that incorporates a range of financing mechanisms. In the interim, the Government has established a pool fund mechanism within the ministry as a short-term intervention for partners to co-finance and better coordinate their support to the public health sector.

In spite of these impressive efforts and despite reasonably good geographical access, coverage of key health interventions remains low. Significant inequalities exist in service coverage between higher and lower socio-economic groups as evidenced by the recent 2007 DHS. Low staffing levels continue to hinder health system capacity, particularly in rural areas.

3 The GAVI HSS proposal – inputs, outputs and progress to date

This section will review the main issues surrounding the GAVI HSS design and application processes and will attempt to summarise progress to date. It concludes with a reference to the issues that ought to be covered in the assessment of the HSS grant at completion in 2010. Intentionally, this section will be mainly descriptive, while the assessment of the meaning of these findings in relation to GAVI principles and to the questions of the evaluation study will be done in section 4 in order to avoid repetition.

3.1 HSS proposal design

Liberia's first GAVI HSS proposal was developed in early 2007 in challenging circumstances. The recently appointed Minister of Health had managed to put together a senior management team by late 2006. There were very few positions at mid and lower levels in the MoHSW structure filled with public servants able to provide effective support to the new senior management team. After the civil war, the health system was in a run-down condition with a major lack of trained health workers and little reliable information was available for decision making.

The country was in a difficult post-conflict situation. Many of the NGOs who had been present during the immediate aftermath of the conflict, providing humanitarian and medical services across the country, looked as if they might withdraw their assistance. They were providing 80 per cent of all health services throughout Liberia. The MoHSW was in no position to fill the void in service provision that their departure would have created. At the Liberia Partners Forum held in Washington DC in February 2007, the Minister of Health declared that the MoHSW would not be able to take on the responsibility of running any additional health facilities until the beginning of the next National Health Plan in 2011. At the 2007 forum, Liberia's development partners were unable to provide any long-term commitments to rebuilding the health sector.

In this context, the availability of funding through the GAVI HSS window was vital. The National Health Plan had been developed and a number of donors including: USAID, World Bank, EU, DFID and Irish AID had agreed to support a number of different elements of the plan.

Table 2: Proposed Areas of HSS Support

Liberia HSS Proposal Activity / Area for Support		Year 1	Year 2	Year 3	Year 4	TOTAL COSTS
		2007	2008	2009	2010	
		Supporting Health Interventions				
1	Develop and disseminate an Integrated Basic Package of Health Services	35,000				35,000
2	Define the role of the community in the delivery of a range of health interventions	17,000				17,000
3	Develop & deliver BPHS training package for community health workers	75,000	75,000	50,000	50,000	250,000
4	Establish a training unit and define its roles and responsibilities	15,000				15,000
5	Develop or revise treatment protocols and guidelines	10,000			10,000	20,000
6	Develop training manuals for the integrated BPHS, including training materials for training health institutions.	25,000				25,000
7	Undertake outreach sessions using the BPHS	75,000	112,000	112,000	112,000	411,000
8	Coordination with sector partners	15,000	15,000	15,000	15,000	60,000

9	Purchase of 2 vehicles for training unit	50,000				50,000
Development of HR System						
10	Develop HR plan and initiate the establishment of an HR database	30,000	15,000	15,000	15,000	75,000
11	Local TA to assist with developing an HR plan and organization of HR unit	30,000	20,000	15,000	15,000	80,000
12	Identification and selection of 800 community health workers	200,000	250,000	250,000	250,000	950,000
13	Standardize curricula of CHW, develop skill-competency testing, train CHWs to deliver the specific BPHS interventions.	50,000	50,000	50,000	50,000	200,000
14	Purchase 1 vehicle for HR unit	25,000				25,000
Health Systems Management						
15	Establish community based surveillance and information systems.	30,000	30,000	30,000	30,000	120,000
16	Develop district and county micro-plans for the delivery of the BPHS	30,000	30,000	30,000	30,000	120,000
17	Conduct operational research for community based interventions.	30,000	30,000	30,000	30,000	120,000
18	Develop Health Management Information System	120,000	180,000	190,000	190,000	680,000

19	Data management tools and refresher training of key health workers on data collection, analysis, management of information and resources.	20,000	50,000	50,000	50,000	170,000
20	Establish a computerized drug & equipment management and logistics system	20,000	30,000	30,000	30,000	110,000
21	Establish an M & E system	20,000	40,000	40,000	30,000	130,000
22	Purchase 1 vehicle for M&E unit	25,000				25,000
	Management costs	50,000	70,000	90,000	90,000	300,000
	Technical support	25,380	25,380	25,380	25,380	101,520
	Total Costs	1,022.38 0	1,022.38 0	1,022.38 0	1,022.38 0	4,089.52 0

Source: MoH HSS Proposal

The main objectives of the GAVI HSS proposal were to underpin the implementation of the NHP through supporting:

- The strengthening of primary health care services through the **Basic Package of health Services (BPHS)**, with child survival as an entry point to operationalize the national health plan;
- **Linking health services with the community** by expanding the community-based workforce including the development of clear guidelines, training plans and the provision of training leading to increased access to health services;
- **Evidence based management support systems** for primary health care service provision; and
- **Human resources development for health** through expansion of community-based health workers, development and use of a strategy to ensure efficient performance of existing community health workers at the county level in offering integrated BPHS.

GAVI HSS funds have been used to support the implementation of the four main components of the national plan identified above. 18 action points and 22 activities have been identified to be delivered between over the lifetime of the proposal (2007 – 2010).

Use of GAVI HSS Funding

The GAVI HSS funding has been used to fund activities in six main areas: developing policies and plans; creating systems and procedures; training; local long and short term technical assistance; transport; and accreditation. Table 3 provides a breakdown of the activities by area and expenditure. Given the acute lack of resources in the sector, it has most certainly been additional funding to the sector.

Table 3 GAVI HSS Funds: Receipts and Disbursal

\$US	Year	
	2007	2008
Amount of Funds Approved	1,022,380	1,022,380
Date the Funds Arrived	27/07/2007	27/07/2008
Amount Spent	27,171	1,286,700
Balance	995,209	730,885
Amount Requested for following year	1,022,380	1,022,380

Technical Assistance/Staff Salary Support

A critically important use of the GAVI funding has been its use for the employment of key programme staff within the MoHSW. Seven staff members have been hired with the HSS funding including a technical adviser on the BPHS and the Directors of the Training Unit, Family Health Division and Information Technology Unit. The consultants had the opportunity to meet with many of these staff during their mission to Liberia and were impressed with their competence and evident commitment to the many tasks that need to be done. Whilst only 6% of the HSS funding has been spent on local TA, this money has been absolutely essential to rebuilding the human resource capacity within the MoHSW.

Liberia is a one of the group of highly indebted poor countries (HIPC). As part of its agreement with its creditors, a hiring freeze has been instituted across the public service, making it very difficult to bring new people into the MOHSW as traditional public servants. The GAVI HSS funding has been invaluable in providing the opportunity / flexibility, at least in the short term, to bring talented people into the MOHSW to work on the rebuilding the sector. Of course, there are significant questions relating to the sustainability of this approach in the

longer term. Clearly, the MoHSW needs to be thinking about the longer term and developing a strategy to enable it to retain good people in the absence of GAVI or similar time-limited funding.

Plans and Policies (focus on BPHS)

Significant amounts of the GAVI HSS funding have also been used for the development of policies and plans, particularly around the planning and delivery of the BPHS, human resources and the development of micro-plans at the county and district levels. The consultants had the opportunity to review a number of these plans and were impressed with their quality and also with the energy and effort with which the MoHSW was trying to implement them. GAVI HSS funding has been used to support the development and dissemination of the BPHS policy and plan and to create a BPHS communication strategy. Also, funds have been used to develop operational guidelines for Community Health Committees and to reactivate the CHCs in 35 districts. Training materials for Community Health Volunteers have been developed.

Human Resources

An HR unit was established within the MOHSW in December 2007. Much of 2008 was spent reviewing the MoHSW requirements, including staff assessments, and developing policies and plans for HR. This work has been supported with GAVI HSS funding as well as resources from elsewhere. A range of HR standard operating procedures were developed and staffing norms created. An HR census has been undertaken looking at both health workers employed by the government sector and by NGOs. GAVI HSS funding has been used to develop a computerised HR information system.

The HR Unit has been active in trying to create effective working relationships between the Govt. and NGOs. An agreement has been reached whereby the MOHSW and NGOs have agreed to offer health workers engaged in service delivery, similar terms and conditions of employment. This has been important in increasing the salaries of Govt. workers to realistic levels and has reduced the “poaching” of Govt. health staff by NGOs. A range of non financial rewards for health workers is being investigated.

A Training Unit was created to coordinate all training within the sector. Prior to the establishment of the unit, training had been undertaken by the vertical disease programmes within the MoHSW in an unsystematic and uncoordinated way. This had led to problems with the inefficient use of resources and staff time, together with quality issues connected with the standard of training.

GAVI HSS funding is currently supporting a highly able Training Unit Director and is providing the funding to develop training manuals for the BPHS as well as the funding to train 800 community health workers in the delivery of the BPHS at community level. The Training Unit is in the process of undertaking a training of trainers programme (35 district health officers trained thus far) that will enable the counties to assume a more significant role in this area. GAVI HSS has funded the purchase of 100 motor cycles to be used for the monitoring and supervision of community health workers.

In the words of the MoHSW HR Director – “GAVI HSS funding has had a ‘great’ impact on the development of the HR and Training functions within the Ministry.”

3.2 HSS application and approval processes

The GAVI proposal was developed by a small team drawn from the MoHSW, WHO, UNICEF and USAID, led by the MoH’s Deputy Minister for Planning and the Chief Medical Officer. There was no external TA used in the development of the plan and the \$50,000 available for that purpose was not used. The plan was drafted through an interactive and inclusive process involving a wide range of partners including limited involvement of CSO partners. The proposal addresses identified gaps within the priority areas of the national health plan. The proposal was reviewed and endorsed by the National Health Sector Coordination Committee and the ICC as required by the GAVI guidelines.

The following box summarises the key dates involved in the HSS proposal preparation and approval:

Box 3. Key dates in the Liberia HSS proposal

Feb 2006	Minister of Health Appointed
Sep 2006	MoH Senior Management Team in place
4 th Qtr 2006	National Health Plan drafted
Jan/Feb 2007	HSS Proposal drafted & discussed with Partners
27 Feb 2007	HSS proposal approved by the HSCC
2 March 2007	Proposal submitted to GAVI
20 April 2007	IRC approval with clarifications
12 May 2007	Approval decision by GAVI Board
27 June 2007	First disbursement received \$1,022,500
8 Feb 2008	Second year disbursement made \$1,022,500
15 May 2008	APR with HSS section submitted by Liberia

Whilst, a small project team drawn largely from the MoH, WHO, UNICEF and USAID had very quickly drafted the proposal for HSS funding, there had been discussions with other partners in the course of drafting. The HSS proposal was submitted to the HSCC for discussion and endorsement at the end of February 2007. All of the Health Sector's major cooperating partners are represented at the HSCC, including CSOs working in health.

The MoH and partner staff interviewed as part of this evaluation thought that that the proposal design process had been fair in terms of the additional workload demands placed on the MOH. WHO and UNICEF were actively involved in the development of the proposal.

3.3 HSS Start up measures

Implementation of the HSS activities was delayed at the outset due to a lack of senior and mid-level staff in the MoH to develop policies and plans, and to coordinate activities. The development of an operational plan for the HSS work after the arrival of the resources in Liberia clearly led to some delays in the implementation of the 1st year activities. In total, only \$US 27,000 were spent during 2007.

A critically important use of the GAVI funding has been its use for the employment of key programme staff within the MoHSW. Seven staff members have been hired with the HSS funding including a technical adviser to the BPHS and the Directors of the Training Unit,

Family Health Division and Information Technology Unit. The consultants had the opportunity to meet with many of these staff during their mission to Liberia and were impressed with their competence and evident commitment to the many tasks that need to be done. Whilst only six percent of the HSS funding has been spent on purchasing local TA, this money has been absolutely essential to rebuilding the human resource capacity within the MoHSW in the short to medium term.

Liberia is a one of the group of highly indebted poor countries (HIPC). As part of its agreement with its creditors, a hiring freeze has been instituted across the public service, making it very difficult to bring new people into the MOHSW as traditional public servants. The GAVI HSS funding has been invaluable in providing the opportunity/flexibility, at least in the short term, to bring talented people into the MOHSW to work on the rebuilding of the sector. Of course, there are significant questions relating to the sustainability of this approach in the longer term. Clearly, the MoHSW needs to be thinking about the longer term and developing a strategy to enable it to retain good people in the absence of GAVI or similar time-limited funding.

HSS money is deposited into the GAVI account held by the MoHSW. This account is managed by the MoH Office of Financial Management (OFM) according to normal MoH procedures, the same systems and procedures applied to other GAVI grants. Such systems and procedures already had clear accounting and financial management arrangements in place within the MOH.

The management and oversight of the OFM and Pool Fund in Liberia has been outsourced to Price Waterhouse Coopers (PwC). The evaluation team was presented with comprehensive (but un-audited) statements of account which indicated that the GAVI account was being operated and managed effectively. The Auditor-General's office is responsible for auditing all the MoH accounts. There is not a specific audit undertaken of the GAVI account which is included in the general audit of the MoHWS's accounts.

3.4 Annual Progress Reporting (APR) on HSS

In this section we discuss issues linked to the quality of APR reporting on HSS and to the relevance and alignment of APR HSS reporting in the context of Liberia's established health reporting and accountability mechanisms.

One of the great challenges faced by the MoHSW is having access to reliable and timely health information, including on the implementation of the GAVI HSS activities. It is in the process of rebuilding the HMIS and is strengthening the collection and analysis of data throughout the health system. There is no money in the government budget for M&E. The GAVI HSS funding has been used to try and give a broader focus to M&E efforts. It has been used for the development of a national M&E policy and plan together with providing training in M&E for programme staff.

The reconstruction of the HMIS is at an early stage. There are some concerns still about the quality of data and the reliability of reports. These problems should diminish as the HMIS becomes embedded, as staff become familiar and more experienced with operating it, and as data audits become routine.

The M&E Unit is also receiving significant amounts of support from the Global Fund for capacity building. The Global Fund has provided significant personnel support to the unit and it currently funds the Director and three junior staff members. The GF's main focus is on generating data to monitor the programmes that it is funding. This is creating some problems of accountability within the M&E unit, and work within the unit has had to be allocated according to the funding source which is less than optimal. Currently, UNDP is the principal recipient of GF resources and it has a separate M&E unit monitoring malaria and TB. The MoHSW will take over the monitoring of the GF funded HIV/AIDS programme in June 2009.

The MoHSW submitted the GAVI APR report for 2007 including information on the HSS window on the 10th of May 2008. During its quarterly meeting on 15 August 2007, the ICC, after having been briefed on the GAVI HSS Support, recommended that the technical team which had developed the GAVI HSS proposal should work on an operational plan. The technical team met twice and agreed on priority action points for implementation in August to December 2007. These were then approved by the HSCC.

Financial Reporting

The APR provided a comprehensive description of the activities that had been undertaken during the year and included detailed reporting of expenditure against each activity. The MoH has instituted a system of quarterly review meetings to assess progress against the annual plan. These were referred to in the APR.

Result indicators

There was detailed reporting against the 10 result indicators included in the original HSS proposal. For FY 2008, all 10 indicators were reported on together with a description of the

source of data used. For three of the indicators (DPT3, Measles and U5M), the report indicated that the targets established in the original HSS proposal had either been met or exceeded.

There is little doubt that the requirements for developing an annual performance report to GAVI puts considerable additional pressure on the MoHSW. There are very limited numbers of staff at the mid and senior levels of the health system who are able to put a report of this nature together. Without exception all are deeply involved in the process of re-building the shattered health system and the commitment of their time in planning, managing and reporting on activities within the sector is intense. Significant overstretch is clearly visible in almost every department. The Deputy Minister for Planning is responsible for drafting the annual report to GAVI. He is supported in this process by assistance from other partners including WHO and UNICEF.

Given the very challenging situation faced by the MoHSW in Liberia, it would seem sensible to look at ways in which the reporting requirements of individual funding sources such as GAVI can be minimised. The focus of the MoHSW team should be on rebuilding of the sector in order that the quality and accessibility of health services can be improved.

One suggestion made during the course of the evaluation was to look at ways in which GAVI and the Global Fund operate in order to reduce the transaction costs on the MoHSW, which are considerable. Both organisations are supporting HSS. There may be the potential to combine the support provided by each. This could involve the development of one proposal, one disbursement system and one system of monitoring and reporting to cover the support to HSS. Given the flexibility of GAVI funding versus the Global Fund, the point was made that this could be an attractive option but only if current GAVI processes were used rather than those of the GF.

3.5 HSS progress to date

Despite the slow start in 2007 the GAVI APR for 2008 indicated that much greater progress had been made in implementing activities. A total of \$US1,286,704 was spent during the year. Much of the money has been used for the development of new policies, systems and processes at the central level, although there was a significant amount of training of community health workers in the BPHS at the county level reported.

As the table overleaf indicates activities have begun implementation in a number of key areas. Good progress has been made in strengthening the health information system with 70% percent of counties now having an operational health information system and 50% of those reporting in a timely way.

Table 4 Progress Against Output and Impact Indicators

	Indicator	Target	Baseline	2008
HSS Inputs	% of health facilities providing the BPHS	70%	0%	?
	% of counties with a functional health information and resource management system	70%	0%	70%
	% of timely and complete reports received at national level	80%	0%	50%
HSS Activities	% of counties implementing a comprehensive BPHS	70%	0%	60%
	% of health facilities with two working CHWs per facility	70%	0%	20%
	% % of counties implementing a quality HMIS and resource management database	70%	0%	70%
Outputs (impacts on the quality of the system)	% of health facilities with improved quality of integrated PHC at the lower level	50%	20%	20%
Impact on Immunisation	Coverage of DPT3 (Pentavalent after 2008)	90%	87%	92%
	Coverage of routine measles vaccine	95%	95%	95%
Impact on child mortality	Under 5 mortality rates	225/100	235/1000	

3.6 End of HSS Assessment

The improvements in immunisation coverage at the end of the HSS grant are likely to be modest given that there were high immunisation coverage rates in Liberia at the time of the design stage. However, as the HSS funding is being invested in developing systems and processes in addition to supporting the roll-out of the BPHS, significant improvements in the effectiveness of the health system can be expected at a number of different levels.

The significant investment provided to develop the HR and training functions at the national and local levels together with the support of the BPHS and the training of CHWs can be expected to bring substantial improvements to the provision of primary health care across the country. Similarly the support provided to strengthening health information and the M&E systems both at the national and local levels should bring important benefits to the way the health system is managed.

It will be important when designing the 2012 evaluation to look at the impact of GAVI HSS funding at the macro and micro levels. Questions that will need to be asked include:

- What have HSS funds been used for and why were the decisions made to use them in this way?
- What has been the impact of the activities supported?
- How effectively have they been employed? Have they complemented other sources of funding or have they been the sole source for certain activities?
- What has been the quality of the activities supported? Are the interventions supported leading edge and evidence based?
- How has the use of the GAVI funding had an impact at the service delivery level? What have been the specific impacts at that level?
- How have the planning and coordination processes worked? Have these been effective?
- Have the funds been used in the ways originally envisaged in the HSS proposal? If not, what has been the process to re-orientate funding and was this in-line with GAVI requirements?
- Has value for money been achieved? Are there alternative ways in which the resources could have been used which would have generated greater impact?

The first GAVI HSS grant to Liberia was focused on a small range of specific technical areas but did not have a geographical focus. All 15 counties are being supported during the period of the existing proposal. The rationale provided by the MoHSW for this decision is compelling. At the end of the civil war most Liberians lived in poverty and most lived in distant rural areas. The needs of the health system in terms of reconstruction and rebuilding were fairly uniform across the country. In 2006, the MoHSW was a shell, without capable staff or effective systems. In this context, the decision was made to focus the GAVI HSS resources on efforts to rebuilding the MoHSW and its key systems. PHC across the country was to be supported by investing in the recruitment and training of CHWs and the provision of training to deliver the BPHS.

The situation in 2012 may be different and it would seem sensible to revisit this approach at that stage to see if it is still relevant. This could feed into the development of any future HSS proposal to give it a greater focus on the population groups who make less use of the health system for financial, social or other reasons.

3.7 Support systems for GAVI HSS

Technical support provided by various agencies can be classified in the following way: (a) at proposal design and approval stage; (b) at APR; (c) for HSS proposal implementation. These are briefly reviewed now in the case of Liberia. Please refer to the typology of HSS support systems in Annex 4.

3.7.1 Technical support for proposal design and approval

The WHO and UNICEF played a key role in helping the MoHSW to develop the original GAVI HSS proposal and those inputs were greatly appreciated by the MoHSW. Officials from both organisations were closely involved with the drafting of the proposal and in supporting the subsequent consultation and approval process.

There was general consensus among the people that had worked on the GAVI HSS proposal that the Independent Review process had been a useful exercise. The IRC did not require any major changes to the proposal, which was approved by the GAVI Board without needing to be re-written. However, members of the proposal writing team felt that the main value of the IR process had been as a reminder that they needed to produce a well written and coherent document that responded to the needs of the sector and that was consistent with the GAVI HSS application requirements.

3.7.2 Technical support to the APR

The APR was drafted by the Deputy Minister for Planning's office and then circulated to partners for comment.

3.7.3 Technical support for HSS implementation

There was little evidence of any systematic support being provided by either the WHO or UNICEF to support the implementation of the HSS proposal. Since the original inputs to the proposal design in 2007, and some limited support to reviewing the APRs, there has been little or no TA provided to directly support the implementation of the GAVI HSS programme by either WHO or UNICEF. However, both organisations have a good working relationship with the MoHSW and are closely involved with its on-going programme of work. Implementation of the GAVI HSS programme is at an early stage and it may be that WHO/UNICEF are called on to provide more TA as programme proceeds.

Many of the activities included in the GAVI HSS programme are in support of existing work that is being funded by a wide range of partners who may also be providing TA to the MoHSW. The GAVI HSS programme itself is funding the provision of TA to a number of key programmes.

Additionally, many of the MoH's programmes are led by highly competent and motivated individuals who may have little need of technical assistance in their areas.

4 Alignment of HSS with GAVI principles

This section will attempt to analyse the extent to which the Liberia HSS grant adapts to the following GAVI principles, some of which have been slightly modified to accommodate specific questions being asked in this evaluation such as the concepts of accountability and additionality of GAVI HSS funding:

- Country driven
- Aligned with national plans and M&E
- Harmonised
- Predictable funding (inc financial management and disbursement)
- Inclusive and collaborative processes (accountability has been added)
- Catalytic effect
- Results orientated – How are results measured?
- Sustainable – what is being funded? What will happen when there is no HSS money?
- Does HSS funding help improved equity?

4.1 Country Driven

A rapid health sector assessment was carried out in early 2006 and its recommendations were incorporated in the National Health Policy and formed the basis for the development of the National Health Plan. A very participative process was employed to develop these key sector documents involving a wide range of health stakeholders. The consultation involved representatives from the national, county and community levels as well as a wide range of development partners.

The GAVI HSS proposal plan was also drafted through an interactive and inclusive process involving a range of partners. The proposal addresses identified gaps within the priority areas of the national health plan. The proposal was reviewed and endorsed by the National Health Sector Coordination Committee and the ICC as required by the GAVI guidelines.

4.2 Is GAVI HSS aligned?

In this section we consider several dimensions of alignment as discussed in the evaluation study guidelines: Alignment with broader development policies such as the PRSP and the national health plans and priorities; alignment with planning and reporting systems; alignment with budget and financial management systems.

4.2.1 Alignment with broader development and health policies

The GAVI proposal is fully aligned with the priorities identified in the National Health Plan and with Liberia's PRS which formed the basis for the NHP.

4.2.2 Alignment with budget and reporting cycles

Liberia's financial year runs from July – June. The GAVI HSS financial year begins in January. However, the MOHSW are developing an FMIS within its Office of Financial Management (OFM) that is able to report according to the GAVI reporting requirements.

Clearly, it would be helpful if the GAVI planning and budget cycles were aligned with Liberia's. The MoF has proposed moving to the calendar year for financial and planning purposes, although this remains under discussion. Better alignment with the GAVI financial year is not the principal driver of this potential change.

In terms of alignment with budget and financial management procedures, GAVI HSS resources, as with all of the GAVI funds are "on plan" and "on budget".

4.3 Is GAVI HSS Harmonised?

GAVI HSS funding is being used to support the implementation of the NHP. In that sense it can be said to be fully aligned with national plans. However, the GAVI HSS funds are managed and reported on separately and have their own bank account which is operated by the MoHSW's Office of Financial Management. GAVI funding is not channelled through the MoHSW's Pool Fund. Whilst the GAVI HSS programme uses the MoHSW's M&E system, it is reported on separately. As has been mentioned previously, this is a time consuming process and the MoHSW that does not have a great deal of spare capacity.

The MoHSW does produce an annual report of its progress and activities. Potentially, the reporting on GAVI funded activities could be included as a separate section in the annual report or better still, incorporated into the existing report format.

4.4 Is GAVI HSS funding predictable?

The GAVI HSS funds have been disbursed on time according to the agreed schedule (see Table 5 below). The first disbursement of funds was made in July 2007. The second disbursement was made in July 2008 for the period up to December 2009. The Funds are readily available and accessible. In comparison with other funding sources, there is less bureaucracy required for the disbursement of funds from the GAVI HSS grant than there is

from other donors. The MoHSW in particular, appreciates the fact that the funds are provided as a single annual deposit rather than a series of quarterly tranches. This has reduced bureaucracy considerably.

Table 5 GAVI HSS Funds: Receipts and Disbursal

\$US	Year	
	2007	2008
Amount of Funds Approved	1,022,380	1,022,380
Date the Funds Arrived	27/07/2007	27/07/2008
Amount Spent	27,171	1,286,700
Balance	995,209	730,885
Amount Requested	1,022,380	1,022,380

4.5 Is GAVI HSS accountable, inclusive and collaborative?

The proposal development process was led by the MoHSW with the participation of development partners, notably UNICEF and WHO. CSOs did not participate to any great extent in the design process. However, they have been heavily involved in the development of the National Health Policy and Plan which formed the basis of the GAVI HSS proposal. CSOs are represented on the National Health Sector Coordination Committee (HSCC) and the ICC, which reviewed and endorsed the GAVI HSS proposal in accordance with the GAVI guidelines. The HSCC and ICC are also involved in the ongoing monitoring of HSS implementation.

The HSS proposal design team was of sufficient seniority, experience and perspective to ensure that the broader requirements of the health system were incorporated into the proposal. There was little specific emphasis given to EPI apart from it being a key part of the BPHS.

The consultants were invited to a coordination meeting of the International CSOs involved in health. It was apparent from the meeting that the participants did not have a detailed understanding either of GAVI or of the HSS work. All of the participants however were very supportive of the Minister of Health and his team and the intensive efforts that are being made to improve sector coordination and working relationships with partners. The CSO representatives were also very appreciative of the strong anti-corruption position adopted by the Minister of Health and the fact that he matched his words with action when necessary.

The MoHSW makes considerable efforts to involve its partners in the monitoring of sector plans. Quarterly review meetings are held with all the counties to assess the progress made against their annual plans. A wide range of stakeholders from the National, County and District levels participate in these meetings. CSO and donor partners are also invited to participate in these meetings. At the national level, regular meetings of the HSCC and ICC are held where there is very active participation of partners. Additionally, a number of technical working groups are being convened to look at specific sector issues.

Coordination Mechanisms

The Health Sector Coordinating Committee is the main coordination and decision making body in the health sector. It promotes intra-sectoral collaboration at national level. Membership of the HSSC includes: The Minister of health with his four deputies and advisors, the heads of all key organisations active in the health sector; a representative of the NGO's and Civil Society Organizations working in health; the private sector; and the multi & bi-lateral missions with health development objectives. The HSCC is chaired by the Minister of Health and Social Welfare.

There are also a number of other coordination committees operating at different levels of the health system. These include:

Programme Coordinating Team (PCT); this senior management team was established to coordinate financial resources, technical assistance and programmatic implementation of the National Health Plan. The Deputy Minister for Health Services (Chief Medical Officer) is the Chair of the PCT. The membership includes: The four Deputy Ministers; Assistant Ministers; major disease programme managers; and Long-Term Technical Advisers: the Pool Fund Manager; and the Senior International Financial Comptroller of OFM.

Technical Committee for child survival: coordinates and provides strategic directions of child survival interventions and advises the HSCC on policy issues.

The inter-agency coordinating mechanism (ICC) for immunization is the coordination and decision making body for agencies and partners that are supporting immunization services. The ICC is responsible for coordinating and guiding the use of the GAVI ICC support. The Minister of Health chairs the ICC with the EPI Manager as secretary. Other members include: WHO, UNICEF, UN HC/RC, WB, Rotary International, USAID, EU, MOF, MICAT, MIA and MPEA.

Technical Coordination Committee (TCC) is responsible for technical issues related to EPI. The TCC meets monthly. Members are: EPI Manager, MOHSW, WHO, UNICEF, UNMIL, Red Cross Society and NGOs Coordinator.

Liberia Coordinating Mechanism (LCM) provides oversight and coordination for Global Fund programmes. It consists of government agencies, U.N. agencies, donors and nongovernmental organizations, and is chaired by Minister of Health.

Quarterly Review Meetings are held every three months to review the progress in implementing the annual plans. Senior management and programme staff from the MoHSW are involved, as are county health teams, NGO and donor representatives.

County Health Team (CHT) is the management structure at County level and is responsible for co-ordination of all activities at the health facility level. The County Health Officer is the head of the CHT.

Pool Fund Steering Committee: This steering committee approves all proposals for use of health sector pool funds. The membership consists of three permanent members, namely: the Minister of Health and Social Welfare; the Minister of Finance; and the Minister of Planning and Economic Affairs. Other members include all donors who have entered into a Joint Financing Agreement with the Ministry of Health and Social Welfare; and a group of provisional representatives (UNICEF, WHO, UNFPA, World Bank, Liberian Business Association, and the European Commission).

Whilst the efforts of the MoH to develop excellent coordination are to be applauded, as the above list amply demonstrates, there are a large number of sector coordination committees that collectively absorb a very significant amount of senior management time and energy. The main focus of senior management should be on effectively managing the sector; making sure that policies and plans are implemented as effectively and efficiently as possible.

In the context of the GAVI HSS funding there is some discussion as to the best forum to monitor its implementation. The focus of the ICC is very much on immunisation rather than on health systems strengthening. However, the composition of many of these committees is very similar in terms of the individuals and organisations represented. There is ample scope for the MoH to give some thought to streamlining its coordination arrangements to maximise the efficient use of senior management time.

Irrespective of which forum is ultimately thought most appropriate for monitoring the HSS funding, it should possess the following characteristics:

- Access to the most up to date data and information on HSS and sector;
- The active participation of MoHSW senior officials and representatives from partner organisations with the knowledge and experience required to sensibly discuss/debate HSS issues;
- The ability to take decisions;
- A secretariat for the organisation and minuting of meetings.

4.6 Does GAVI HSS have a catalytic effect?

There is some evidence that partners are now using the improved information being produced by the HMIS and the BPHS health facility accreditation process to make informed decisions and to target their resources more effectively.

There is not any evidence that the GAVI HSS funding has produced additional efforts to strengthen health systems or has attracted additional donor support. It is too early to determine the impact that GAVI HSS funding is having on the health system. It is always going to be a challenge in a health system which is receiving HSS support from a range of sources to attribute particular results or impacts to one source or another.

4.7 Is GAVI HSS Results Oriented?

The Liberia HSS proposal contained a set of very specific indicators against which progress/results could be judged. In the 2008 APR the MoHSW went to considerable efforts to report against this indicator framework in order to demonstrate the results that are being achieved. The MoHSW is putting considerable effort into improving its information and M&E systems in order to be able to improve its future standard of reporting. These efforts are visibly delivering results in a very challenging environment.

What is less clear is how results oriented the GAVI Secretariat can realistically be? The IRC's response to the 2007 APR was pretty perfunctory – admittedly there was very little to comment on as only \$27k of the \$1.022 million disbursed had been spent in 2007. The 2008 disbursement of \$1.022 million was duly authorised and deposited in the MoHSW's GAVI account on receipt of the 2007 APR. Half of the total value of the HSS grant (\$4.089 million) was made without the MoHSW having to demonstrate any performance at all, beyond the

drafting of credible APRs for 2007 and 2008. This is no reflection on the MoHSW who the consultants believe to be doing an excellent job in very difficult circumstances, but merely a commentary on how the system is currently operating.

It is clear what should happen if the IRC is faced with a poorly written and incomplete APR. The country concerned would be asked to rewrite or improve the APR by the GAVI Secretariat, and provide any missing information. Until that is done, further disbursements of funding would be suspended. Conversely, if an adequate APR is received, this should be quickly approved by the IRC and the disbursement of the next tranche of funding made. The real question is: faced with a well written and credible APR, how can the IRC/GAVI Secretariat confirm that the information contained within it is accurate and a realistic representation of the situation on the ground. Faced with a large number of APRs from over 70 countries, this will be a very challenging process both managerially and technically. What are the processes and procedures that need to be put in place to periodically test the adequacy of information provided to GAVI by recipient countries?

4.8 GAVI HSS sustainability issues

Liberia is at a very early stage in its post conflict reconstruction. It is in the process of trying to rebuild shattered health infrastructure and systems and to train new service providers. Its economy, whilst showing strong signs of revival, is going to take time to recover. Realistically, the MoHSW has acknowledged that it is going to require significant donor support for many years to come. Recognising that long-term financial sustainability is an issue that needs to be addressed the MoHSW has recently convened a working group to look at options for financing the sector. That work is on-going.

GAVI HSS funding has been very important in enabling the MoHSW to employ talented individuals in key positions within the sector. Clearly, if GAVI HSS funding were withdrawn at short notice this would have a major negative effect on the efforts to rebuild the sector.

Much of the GAVI HSS funding is being spent on rebuilding key systems and on training in areas essential to the effective operation of any health system. The focus on supporting the implementation of the BPHS with its package of cost-effective, evidence based interventions will contribute to the long-term sustainability of the GAVI HSS investment. See Table 6 below.

These activities are likely to have a substantial impact on the performance of the health system. If GAVI funding were to be withdrawn this would have a serious impact on a number of these activities unless and until alternative sources of funding could be identified.

A significant amount of the GAVI HSS funds has been used to purchase vehicles, motorcycles and computers. All of these items have associated running costs, a limited lifespan and will need to be replaced at some time.

Table 6 Expenditure of GAVI HSS Funding by Area in 2008

HSS Proposal Activity number	Activity	% Activity completed	Expenditure (\$US)	% of Total
Policies and Plans				
1.1	Develop & document the Basic Package	100	13,100	
2.1	Define role of community in delivering basic health	70	17,000	
3.1	Define roles and responsibilities of community health	60	42,905	
3.3	Develop/revise treatment protocols		11,422	
3.8	Develop HR plan and database	25%	43,868	
3.13	Establish community based surveillance & information	50	2,150	
3.14	Develop county and district level micro-plans	100	30,263	
	Total – policies and plans		160,710	
Systems & Procedures				
3.16	Develop MIS & database for health, HR and financial	60	231,022	
3.17	Provide data management tools and training to key	80	1,500	
3.18	Develop a computerised stock management system	50	19,379	
3.19	Establish an national M&E system	60	19,959	
	Total – systems and procedures		271,860	
Training				
3.2	Establish a training unit & define its roles and	80	13,027	
3.4	Develop manuals for the integrated BPHS	50	11,536	
3.10	Identification & training of 800 community health	50	412,120	
3.11	Standardize curricula of CHW & develop skill	50	0	
	Total – training		436,683	34%
Technical Assistance				
3.9	Local TA to assist with developing HR plan & Unit	100	26,400	
	TA (programme staff salaries)	60	47,509	
	Total – TA		73,909	
Transport				
3.7	Buy 2 vehicles for training unit	100	50,000	
3.12	Buy 1 vehicle for HR unit	100	25,000	
3.20	Buy 1 vehicle for HMIS unit	100	25,000	
	Vehicle running costs	75	101,243	
	Total - transport		201,243	
Accreditation				
3.5	BPHS accreditation of health facilities	50	128,856	10%

3.6	Support annual meetings with line ministries and DPs	100	13,438	1%
Operations Research				
3.15	OR for community based services and BCC/IEC	25	0	0
Total Expenditure FY 2008			1,286,700	100

Source: 2007 GAVI HSS Application

4.9 Does HSS funding help improved equity?

The Liberia HSS proposal does not have a specific poverty or equity focus. The MoHSW's justification for this was that at the end of the civil war, the vast majority of Liberians were living in poverty. There were huge unmet health needs across the country. This was compounded by a lack of data on which to base rational decision making. Given these circumstances, it was decided to implement the GAVI HSS activities on a nationwide basis. The emphasis on building systems and delivering the BPHS through CHWs should ensure that the poorest and least served populations in Liberia benefit from the HSS funding.

Given the lack of trained staff and information in the MoHSW when the GAVI proposal was put together in 2007, the approach adopted seems sensible and pragmatic. As information systems are improved and the capacity of the County and District teams increases, it should prove possible to improve the targeting of sector resources.

Annex 1 List of people met

1.	Dr. W. T Gwenigale	Minister of Health and Social Welfare
2.	Dr. S.Tornorlah Varpil	Deputy Minister for Planning and Research
3.	Dr. Bernice Dahn	Deputy Minister for Health Services
4.	Mr. Chea Sanford Wesseh	Assistant Minister for Statistics
5.	Dr. Julie Brown	Director of Human Resources Management
6.	Dr. Sodey Lake	Director of Training Unit
7.	Mr. Thomas Nagbe	EPI Programme Manager
8.	MS Bentoe Tehoungwe	EPI
9.	Mr. Gabriel Thompson	Director, Health Management Information System
10.	Mr. George Jacobs	Ag Director, Monitoring and Evaluation Unit
11.	Alex Nartey	Director Office for Financial Management (OFM)

Bomi County Health Team

12.	Davidson O. Rogers	Hospital Administrator
13.	Dorothy J. Gray	Human Resources
14.	Harry S. Komeh	EPI
15.	Justin Z. Saye	County Health Inspector
16.	Seh D. Sirleaf	Accountant
17.	Willie Z. Taweh	Data base Manager
18.	Elizabeth Doe	Child Survival Focal Person
19.	Thomas L.Jallah	County Health Team Pharm.

Interviews/Meetings with Donor Community

Global Fund

1.	Mariam Traore	Global Fund Programme Manager
2.	Japhet Taratibu	M&E Specialist
3.	Priscilla Dormon	M&E Officer
4.	Roland Nyanamo	M&E Officer

UNICEF

5.	Terkula Alagh (Ben)	
6.	Cefanee Kanneh-Kessely	

WHO

7.	Dr. Nestor Ndayimirije	WR
8.	Eric Johnson	HSS
9.	Edvida Barclay	Administration

BASICS

10.	Franklin Baer	Consultant
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Pool Fund

11.	Jacob Hughes	Pool Fund Manager
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International NGO Forum

12.	Susan Grant	SCUK Chair of INGO Meeting
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USAID

13.	Chris McDermont	Health Officer
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European Union

14.	Joan Casanova	Official responsible for Health Sector
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Annex 2 List of Documents reviewed

Poverty Reduction Strategy, July 2008

Interim Poverty Reduction Strategy

National Health Policy, January 2007

National Health and Social Welfare Plan, 2007 – 2011

Liberia, Rapid Assessment of Health Situation, June 2006

GAVI HSS Application, March 2007

cMYP 2006 – 2010

GAVI APRs 2007 & 2008

GAVI M&E assessment Feb 2008

ICC minutes

HSCC minutes

IRC report, Liberia

World Bank, Health Systems Strengthening Project Memorandum

Annex 3 Summary GAVI HSS Evaluation Approach

The GAVI Alliance HSS Evaluation Study Approach

On February 2009 HLSP Ltd won the contract for the 2009 GAVI Health Systems Strengthening (HSS) support Evaluation. The expectation for this evaluation is to determine to what extent operations at country level and support from global and regional levels, as well as trends in health systems and immunization are heading in the right (positive) direction. Qualitative and quantitative information will be collected and analyzed both retrospectively as well as prospectively beginning from the time that the application process commenced in country throughout implementation and monitoring and evaluation of the project to date.

There are five main objectives and areas of evaluation:

1. What has been the experience at country level with GAVI HSS in terms of *each* of the following: design, implementation, monitoring, integration (harmonization and alignment), management, and outputs/outcomes?
2. What have been the main strengths of GAVI HSS at the country level, and what are specific areas that require further improvement?
3. How has GAVI HSS been supported at regional and global levels—what are the strengths of these processes and which areas require further improvement?
4. What has been the value-added of funding HSS through GAVI as compared to other ways of funding HSS?
5. What needs to be done, and by when, at country, regional, and global levels to prepare for a more in-depth evaluation of impact of GAVI HSS in 2012?

The GAVI HSS evaluation will develop **five In-depth country case studies**. These are structured in such a way that independent consultants teamed with local consultants spend time in countries documenting country experiences. We anticipate up to two visits to each in-depth country between the period of May and June 2009. The first visit will focus largely on interviewing key country stakeholders to map key areas of interest, information and gather initial data. This visit may also include engaging / commissioning a local research institution to conduct further research into particular districts/ activities. During the second visit we anticipate any outstanding stakeholder interviews being conducted, all data collated and subsequently presented to all key stakeholders. We will explore with national stakeholders the opportunity and convenience of conducting an end-of-mission 'validation workshop' in order to provide countries with feedback on the in-depth case studies, and seek validation of these.

In addition, the results from the in-depth case studies will be **complemented by the results of 6 on-going GAVI HSS Tracking Studies** being conducted by the JSI-InDevelop-IPM research group that will become fully fledged GAVI HSS Evaluation studies. Finally, the HSS Evaluation team will desk review all HSS application forms, HSS proposals and HSS Annual Progress Reports produced to date in order to **develop a database of HSS countries**. All these sources of information put together will aim to answer the five study questions mentioned above.

Annex 4 Typology of areas for HSS support

Key stages in the HSS 'funding cycle'.	Support available	Responsible for support
Information about HSS funding and processes	Policies; broad 'rules of the game'	GAVI Secretariat
	Guidelines for applications	GAVI Secretariat, HSS Task Team
	Communication with countries re funding rounds, proposal guidance, dates and deadlines	GAVI Secretariat
Proposal development	Financial support for TA (\$50k max) TA	TA provided by UNICEF, WHO, other national or international providers
Pre –application review	TA to check compliance, internal consistency etc.	WHO
Pre application peer review	Regional support, inter-country exchanges, tutorials, learning from experience, etc.	WHO HSS Focal Points
Submission of proposal and formal IRC review	<i>Internal process</i>	IRC-HSS
IRC recommendations	<i>Internal process</i>	IRC-HSS
Decision on proposals	<i>Internal process</i>	GAVI Board; IFFIm Board
Countries informed	Information to countries on decision, conditions, amendments, etc; and steps to obtain first tranche funding	GAVI Secretariat
Funding	Finances transferred to country	GAVI Washington office
Implementation	TA (if budgeted)	UNICEF, WHO, other national or international providers
M & E	TA (if budgeted)	Defined in proposal, e.g. National Committee.
APR pre review	Validation of APR	HSCC / ICC
APR consideration	Feedback to countries	IRC-Monitoring