Ministry of Health
Republic of Liberia

Monitoring and Evaluation Policy Strategy and Plan
(2017 – 2021)

Foreword

The Ministry of Health (MOH) has the responsibility of promoting and providing health care for all Liberians. To implement this mandate, the Ministry along with her partners developed the National Health Plan (2011-2021), the Essential Package of Health Services (EPHS), and the Investment Plan for Building a Resilient Health System. The overall objective of these plans is to provide access to quality and affordable health care to all Liberians on an equitable basis. Over the past two decades, the means of monitoring and assessing achievements in the health sector was limited to Demographic and Health Surveys (DHS), rapid assessments and specific studies.

Implementing the National Monitoring and Evaluation Policy and Strategic Plan will be a major step in the pursuit of the National Health Policy's vision statement: a healthy population with social protection for all. This vision is attainable only through commitments from stakeholders, and provision of resources and also by initiating and implementing a robust monitoring strategy, that clearly defines indicators that will be used periodically to evaluate the health care delivery system.

The M&E Policy provides the basis for measuring the progress of the National Health Plan, Investment Plan, the Essential Package of Health Services (EPHS) and the Health related Sustainable Development Goals. This policy establishes the framework through which the Ministry and partners collect, analyze, manage and disseminate data and information products. It also stipulates means by which the health sector will be monitored, reviewed and evaluated.

With the full implementation of this policy, gaps in the health care delivery system will be identified and necessary adjustments made to improve service delivery, data collection and management processes and procedures to facilitate the delivery of quality health services to all with equity assured.

We are grateful to all those who committed their efforts, time and resources to the revision and preparation of the national M&E Policy and Strategic Plan. We are confident that the implementation of this Policy will be challenging but achievable. We implore all actors to join us in this drive towards the transformation and development of the health sector. We are convinced that our collective efforts will contribute to improving the overall health system and eventually the health of the people of Liberia.

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List of Abbreviations and acronyms

CBO	Community-Based Organization
CHD	Community Health Department
CHT	County Health Team
CHO	County Health Officer
CHV	Community Health Volunteer
CSO	County Surveillance Officer
DHIS	District Health Information System
DHO	District Health Officer
DMHS	Deputy Minister for Health Services
DMP	Deputy Minister for Planning
DQA	Data Quality Audit
EPHS	Essential Package of Health Services
EPI	Expanded Program on Immunization
GOL	Government of Liberia
HMIS	Health Management Information System
HR	Human Resource
HRH	Human Resources for Health
HRIS	Human Resource Information System
HSE	Health Sector Evaluation
ICT	Information Communication Technology
IT	Information Technology
ITN	Insecticide Treated Nets
LDHS	Liberia Demography and Health Survey
LISGIS	Liberia Statistical and Geological Institute
LSS	Life Saving Skills
M&E	Monitoring and Evaluation
HMER	Health Management Information System Monitoring & Evaluation and Research
HMERTWG	Health Management Information System Monitoring & Evaluation and Research Technical Working Group
HMERCC	Health Management Information System Monitoring & Evaluation and Research Coordination Committee
MOH	Ministry of Health
NACP	National AIDS Control Program
NDS	National Drugs Service
NGO	Non-Governmental Organization
NHPP	National Health Policy and Plan
UNDP	United Nations Development Fund
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
USAID	United States Agency for International Development
WHO	World Health Organization

Republic of Liberia

Ministry of Health

MONITORING AND EVALUATION POLICY 2017-2021

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1.0 Introduction

This document contains the Monitoring and Evaluation (M&E) Policy and Strategic Plan of the health sector. It is revised based on the implementation framework of the 10-Year National Health Policy and Plan (NHPP)[1], and the Investment Plan for Building a Resilient Health System for Liberia[2]. It promulgates the purpose and scope of M&E processes and provides the policy context and principles that guide data collection, management, health system reviews, M&E coordination and reporting processes. The policy describes M&E coordination, leadership and governance, accountability and reporting on health system and programs performance. It defines the institutional framework for M&E in the health sector.

1.1 Policy context

The National Monitoring and Evaluation Policy outlines key attributes of a country-led platform for monitoring, evaluation and review of the health sector performance. The policy shall provide the legal, regulatory and enforcement framework for the health sector M&E.

As the Government moves towards long-term development planning, the Ministry has developed a 10-Year National Health Policy and Plan (NHPP 2011-2021)[1], and the Investment Plan For Building a Resilient Health System (NHIP 2015-202)[2]. These plans clearly articulate the MOH and development partner's commitment to fostering the culture of evidence-based decision-making to enhance the quality of health services and strengthen the health system. The NHPP, NHIP, the Government economic growth strategy; the Agenda for Transformation (AfT)[3], the International Health Regulation (IHR 2005)[4], the international Health Partnership Plus (iHP+)[5] and the Sustainable Development Goals (SDGs)[6] are the foundations on which the policy was developed.

1.2 Policy purpose

This policy is relevant to the health sector, including private institutions, development partners and other stakeholders. The policy is developed to provide the vision and framework for the M&E system that is capable of addressing challenges, such as data integration, information systems interoperability, data quality improvement, and the capacity to meet the sector's information needs. The purpose of the policy is to provide the guidance for monitoring and evaluation in the health sector. M&E as stated in the policy shall support continual program management function, fostering

systematic collection and analysis of data to track the performance of health service delivery towards the achievement of results.

1.3 Policy scope

This policy covers health service delivery, health system and other health related programs that shall be implemented in the health sector funded by the government of Liberia, or by multilateral and bilateral agencies, through NGOs and CBOs. It shall also cover programs and projects supported by any extra funding and resources from private sector to the health system. The MOH ascribes to the One M&E framework that calls for sector-wide approach to M&E.

1.4 Policy priorities

The following shall constitute the policy priorities:

1. A coordinated M&E System across the health sector.
2. An integrated MOH Information System.
3. Improved data quality and information use.
4. Decentralization of M&E functions
5. Capacity development for M&E

2.0 Situational Analysis

2.1 Demography

Liberia has a land area of 111,369 square kilometers administratively sub-divided into 15 counties and 92 health districts. Liberia's population is approximately 4.1 million with an annual growth rate of 2.1percent[7]. About 59 percent of the population lives in urban areas with more than 50 percent below age 35[7]. Rain forest and swampy areas are common geographic features of Liberia (LDHS, 2013)[8].

2.2 Socio-economic situation

Liberia ranked 177th out of the 188 countries included in the 2015 UNDP's Human Development Report. Life expectancy is 61 years, and an estimated 64 percent of the population lives in poverty[3]. Access to health care is 71percent while the proportion of the population with access to improved drinking water is 73percent and toilet 28 percent[8]. Adult literacy rate is 60 percent[8]. There are 16 major ethnic groups in Liberia and two major religious groups; Christianity constitutes 86% and Islam 12.2 percent[8]

2.3 Morbidity and Mortality

2.3.1 Maternal Health

The maternal mortality ratio is 1,072 deaths per 100,000 live births, one of the highest rates in the world. Total fertility rate declined from 5.2 in 2007 to 4.7 births in 2013. Contraceptive prevalence rate is 20 percent, and 61 percent of deliveries were assisted by skilled birth attendants in 2013 (LDHS, 2013)[8]. Only one-third of newborn mothers received postnatal care after delivery (MOH 2015)[9]. The Ministry of Health formulated the Liberia Road Map for Accelerating Reduction of Maternal and Newborn Mortality and Mobility in 2009[9].

2.3.2 Child Health

The infant mortality rate declined from 72 deaths per 1,000 live births in 2007 to 54 deaths per

1,000 live births in 2013 (LDHS, 2013)[8], thus resulting into Liberia achievement of the Millennium Development Goal 4. Under-5 mortality rate followed the same trend, decreasing from 111 deaths per 1,000 live births in 2007 to 94 deaths per 1,000 live births in 2013. Childhood immunization coverage remains low with only 55 percent of children under-one year of age received all basic vaccination in 2016 (MOH, 2016)[11]. The major causes of childhood illnesses are: malaria, acute respiratory infections, diarrheal diseases and malnutrition.

2.3.3 Communicable Diseases

Every year infectious diseases kill about 3.5 million people mostly young children and poor people in low and middle-income countries[12]. Communicable diseases are among the leading causes of mobility and mortality in Liberia with Malaria being number one. The prevalence of malaria parasitemia in children under five by RDT was 45percent in 2011, an 8 percent increase from 2009. Malaria prevalence among children under five using microscope was 28 percent in 2011[13]. .Additionally. HIV prevalence in the general population is 1.9 percent for HIV type one and 2.1 percent for type one and two combined[8]. In 2014 alone 952 pregnant women were tested HIV positive and placed on ARV for prevention of mother-to-Child transmission[11]. Tuberculosis prevalence in Liberia is 435 per 100,000. The estimated death due to all forms of tuberculosis in 2011 was 45 per 100,000 (WHO 2011).

2.3.4 Neglected Tropical Diseases

Neglected tropical diseases (NTDs) are a diverse group of communicable diseases that are found in tropical and subtropical conditions in 149 countries and affect more than one billion people, costing developing economies billions of dollars every year [14].

In Liberia over one million people were at risk of Onchocerciasis according to Rapid Epidemiological Mapping (REMO) conducted in 1999. Additionally, a high proportion of School age children are affected by soil-transmitted helminths (STHs) based on the result of mapping conducted in 2010., Buruli ulcer and Leprosy were mapped in 2012. Liberia was certificated for Guinea Worm free but active surveillance continues.

2.3.5 Non-Communicable Diseases

Non-Communicable Diseases (NCDs) make up 35 percent of disability-adjusted life years (DALY) experienced by Liberians. Less than 30 percent of DALYs due to NCDIs are attributable to CVD,

cancer, diabetes, & chronic respiratory diseases, with the majority attributable to other non-communicable diseases, injuries, violence, mental and neurological conditions, and musculoskeletal conditions. 53 percent of NCD DALYs and 76 percent of Injury DALYs occur before age 40 greatly impacting the potential productivity of the young work force[15].

2.3.6 Mental Health

Globally, the combine prevalence of mental health conditions is put at 10 percent. In Liberia, mental health is a major public health problem in post war Liberia. It is estimated that close to half a million people in Liberia suffer from mental health, epilepsy or addiction problems with about 130,000 from severe forms. Conflict, exposure to sexual violence, poverty, lack of meaningful occupation and employment all contribute significantly to the high rates of mental health disorder[16]..

2.3.7 Ebola Virus Disease

In 2013, West Africa was hit by Ebola virus disease, a severe often-fatal virus infection[17], with the outbreak starting in Guinea and rapidly spreading to Liberia, Sierra Leone and beyond[18]. Liberia diagnosed its first cases of Ebola in late March 2014 and by January 2016 had reported over 10,000 cases with about 4,800 associated deaths[18]. Amongst these, 372 health care workers had confirmed Ebola virus disease and 184 died[2]. On May 9, 2015, WHO declared the country free of Ebola. The Ebola crisis rolled back some of the major post conflict gains the country made.

2.4 Health Infrastructure

In 2015, there were 727 health facilities in Liberia of which 64% are public[11]. Two-third of health facilities have electricity and water supply. The majority (65%) of households walk to reach the nearest facility[8]. Although access to healthcare is improving, 29% of Liberians lack access to basic health services within 5KM or one hour of walk of a health facility.

2.5 Human Resources for Health

The Health Workforce Census conducted in 2016, documented 16,064 health workers of which 10,672 were employed within the public sector. One-third (5,294) of the clinical health workers include; 241 medical doctors, 829 certified midwives, 3,191 nurses and 453 Physician Assistants. Skilled health workers to general population ration is 11.4/10,000[20] The workforce is unevenly distributed and skewed towards urban areas. Inequitable distribution of health workforce, wage disparity coupled with limited institutional capacity to for absorption, retention and motivation of health workers are a few of the major constrains that need urgent attention.

2.6 Health Care Financing

The MOH developed its first health financing Policy in 2011. The policy seeks to endure the provision of affordable health services and prevent catastrophic spending by the households. Household out of pocket spending on health stands at 42.5 percent in Liberia[21]. The Government is making steady progress towards achieving the Abuja Declaration of 15 percent government spending on health. GOL expenditure on health has moved from 6.8 percent in 2005/2006 to 11.7 percent in 2015/2016. Despite this progress, the health sector is still heavily donor dependent in terms of financing. According to the NHA 2013, 67.9 percent of health expenditure came from donors support.

2.7 Medical products and Supply Chain Management

The quality of pharmaceutical products is a global concern not to mention developing countries like Liberia with poor infrastructure and weak governance for pharmaceutical regulation. The lack of reliable drug quality assurance systems often contributes to devastating diseases. Often, medicines do not meet official standards for strength, quality, purity, packaging, and/or labeling[22].

To mitigate some of the challenges, the government through the MOH has developed the 10-year Supply Chain Master Plan 2010-2020 that focuses on one efficient and effective public health supply chain in Liberia. The government wants to ensure the quality, safety, and efficacy of medicines and medical products. It has established Liberian Medicines Regulatory Commission and by extension the Liberia Medical Products and Health Regulatory Authority (LMHRA) through the Pharmacy Board of Liberia.

2.8 The M&E System

The Ministry of Health has a functional monitoring and Evaluation system at the national and county levels with varied capacities at each level. At the national level, M&E officers are assigned at the central M&E Unit and within the National disease specific programs (Malaria, HIV/AIDS and TB). M&E teams have been set up in all 15 counties with at least three (3) key staff in each unit including M&E officers, Data Officers and County registrar. In Collaboration with the Measure Evaluation, an assessment of the Ministry Health Information System was done in 2015 using the Health Metrix Network Framework. That assessment was complemented by an M&E System Strengthening Assessment in August of 2016 focusing on the counties. The assessment combined the Monitoring and Evaluation System Assessment Tool (MESS) Tool, and the Organization Behavior Assessment Tool (OBAT) a module of the PRISM framework[1]. These assessments were undertaken with involvement of broader HIS and M&E stakeholders and their respective findings informed the development of the Ministry's Health Information Strategy (2016 – 2021) and the M&E Policy and Strategy development.

The MESST, for example, uses a method of "stakeholders' informant workshop" in which key stakeholders including M&E professional, program and administrative staff including partners were brought together to complete the assessment. Following the assessment stakeholders build consensus on identified gaps as well as mitigation strategies and mesures. This assessment brought together County Health Managers, County M&E Staff, and NGO partners including WHO County Staff for each County Health Team to complete the MESST in three locations in 2016.

2.8.2 Assessment findings

M&E System strength (MESS Tool)

Despite the gaps and weaknesses in the MOH M&E System, the assessment pointed out considerable strengths in the M&E system at the lower levels. The M&E system has standardized data collection tools as well as reporting time lines and they were consistently followed at every level. There were written instructions to reporting entities on what to report, the sources of data,

[1] *PRISM is the Performance of Routine Health Information System management at https://www.measureevaluation.org/resources/publications/ms-12-51*

how to report, the time and to whom to submit the report. The M&E system has clear operational definition for all data elements and indicators that meet national and international definitions. Holistically there were significant positive changes in the county M&E system compare to previous MESS assessment. For example Data quality SOP was now available, Staff have received some level of training thought lot of those trained left largely due to low pay.

M&E system gaps or weaknesses (MESS Tool)

The MESS assessment found out that the M&E Unit's capacity to analyze and use data for decision-making at the lower levels remains a challenge. Limited, if any, logistics to support M&E activities in the counties and capacity for M&E plan development at county levels were very weak. For example, M&E plans are not being developed across counties and, except county operational plans, which gets developed with technical support of Central Ministry and Partners, most of the counties lacked adequate capacity to develop and independently complete their respective county operational plans. Consequently, most of the plans remain in draft from.

The MESS result further revealed that capacity for research is lacking in all counties and results of surveys conducted at the national level are not shared at the county level. Moreover, use of data for data for planning and making evidence based health system management decision at County and Districts Health Teams as well as the point of service delivery was minimum.

Feedback tendencies is largely unsystematic and in spite the system ability to identify issues affecting system effectiveness, propensity to mitigate gap in a timely manner is generally low due to limited funding and relevant resource commitment for M&E system strengthening interventions. The Assessment, although acknowledged that Districts and Counties review meetings served to create platforms for feedback, exchange and planning, it noted that the propensity to conduct regular quarterly review meetings across counties varied significantly with counties financial resource endowment or capacity to secure funding commitment for regular quarterly review meetings and that as a result, conduct of regular quarterly review meetings in some counties was not a common practice. It also noted risks of delayed feedback in circumstances where quarterly review meetings was the only means of sharing programmatic feedback.

The assessment also revealed the lack of strong evidence, at the county, district and health facility levels, of the existence of SOP and guidelines for data management, quality control and improvement and data sharing; even though there are some form of guidelines for reporting, SOP for data management uploaded to the Liberia instance of DHIS2 resource portal. This implies very low inclination for adherence to established guidelines and SOPS and further emphasizes the need to embark on efficient visibility and dissemination strategies.

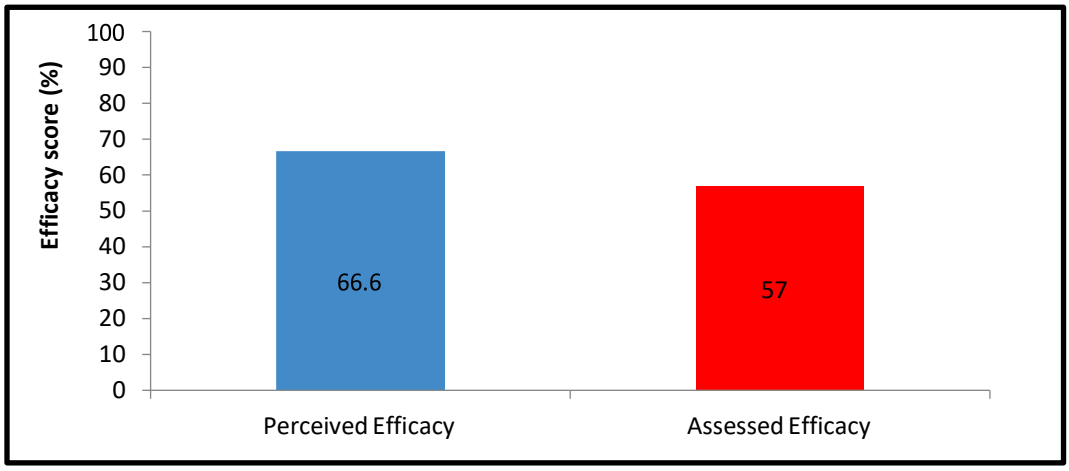
Data analysis, interpretation and packaging are key areas where the CHT M&E staff has limited skills. Those were found in the MESST and confirmed by the individual scores on the OBAT assessment[23].

Assessment results (OBAT)

As a component of the M&E system assessment, the Organizational Behavior Assessment Tool (OBAT) was adapted from the PRISM framework and used to assess efficacy of M&E staffs. Using the OBAT Tools, Participant (County M&E and Data Officers) were asked to score their self-confidence (perceived efficacy) in performing key M&E functions after which they were eventually evaluated using a practical exercise related to competencies assessed during the self-evaluation.

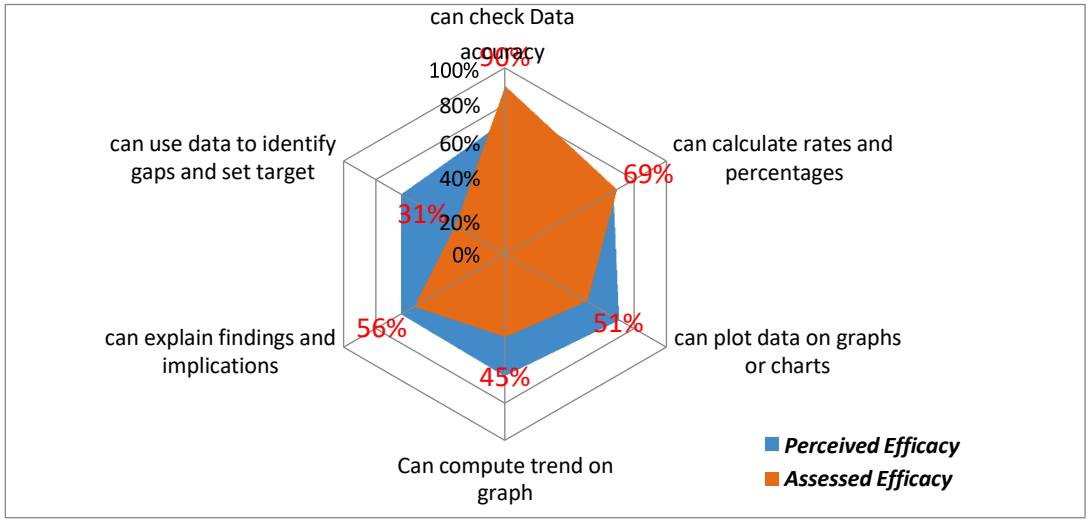
The finding shows that the mean and median scores on perceived capacity was 67 percent among County M&E and Data Officers. The overlap of the mean and medial is an indicator of normal distribution in the data. Interestingly, while the perceived efficacy stands at 67%, scores obtain from the assessment based on practical evaluation ranged from 34% to 97% with an average assessed efficacy score of 54%; thus revealing a difference of 9.4% between perceived and actual competencies. See figure 1 below showing the perceived and actual capacities few key skills.

Figure 1: Efficacy Scores of CHTs M&E and Data Officers based on OBAT assessment of technical capacities, (MESS & OBAT Assessment, 2016)



Further analysis revealed a serious lack of capacity to use data for problem identification and target setting (69%), inability to compute trend (55%), inability to interpret data (44%), inability to plot data on graphs or charts (49%); inability to calculate rates and percentages (21%) and inability to check data accuracy (10%). See figure 2 below. These findings shall inform planning and interventions for M&E and HIS system strengthening.

Figure 2: CHT M&E & Data Officers aggregate capacity on key M&E skills on OBAT Assessment 2016



Nationally, the MOH has made tremendous progress in developing a robust M&E system in the health sector with visible milestones reached; cardinal of which is the administrative decentralization of M&E functions across the fifteen counties. Notwithstanding, the M&E System is faced with several challenges including staff attrition and poor data quality. Financial and material resources for M&E remain limited and heavily donor dependent[23]. National Programs M&E activities remain vertical and not well coordinated with central Health Management Information System, M&E and Research (HMER) Division. This is making it difficult to harness donor funding to accrue the necessary long-term dividends for the M&E system and the MOH in general thereby raising concerns for sustainability.

Finally, Many of the MOH information sub-systems are not developed and those that have been developed are not linked or made interoperable[24]. An HIS & ICT Plan has been developed with a clear road map to strengthen HIS and ensure interoperability. A research policy is also been developed.

3.0 Policy Foundation

3.1 Mission, vision, goal and objectives

3.1.1 Mission

The mission of the M&E System is to ensure and capacitate an integrated health sector M&E system to timely generate a high quality evidence and information that influences policy formulation and evidence decision-making.

3.1.2 Vision

The vision is the use of generated evidence for improving health outcomes and ensuring a healthy population with social protection for all.

3.1.3 Goal

The goal of M&E system is to improve the health of the population of Liberia on an equitable basis through the gathering and utilization of evidence.

3.1.4 Objectives

The objectives of the Monitoring and Evaluation policy are:

a) To coordinate and harmonize M&E activities including data collection, analysis, sharing and use across the health sector;

b) To enhance M&E capacity to track performances, document lessons and disseminate results to inform decisions;

c) To improve information sharing and feedback mechanisms;

d) To improve data quality and promote the use of information for decision-making.

3.2 Guiding principles

The principles guiding this policy are: accuracy and credibility, accountability and transparency, efficiency, quality assurance and equity.

3.2.1 Accuracy and credibility

The M&E system shall ensure the accuracy and credibility of information products and data through capacity development, guidelines, SOPs, standard reporting and data capturing tools. It shall perform periodic evaluation of data and the M&E system with the necessary professional expertise to ensure credibility.

3.2.2 Accountability and transparency

Resources invested in health shall correlate with the corresponding results. The M&E system should be able to establish this correlation in a clear and transparent manner for all health programs. This includes the monitoring and evaluating of inputs, processes, and results. M&E will serve as an instrument for the promotion of good governance, accountability, and transparency.

Similarly, M&E should facilitate financial accountability of program management and health services improvement toward the achievement of NHPP&IP goals and objectives through judicial application of resources provided for health service delivery. Absorption of resources should be linked with desirable outputs that will be monitored routinely. Additionally, M&E should provide central management, County Health Teams and structures below with timely information as to whether expected outcomes in the health system are likely to be achieved in a cost effective manner so that appropriate adjustment can be made and crucial strategies employed to address any potential shortcomings are mitigated and good performance improve upon. The accountability framework will take into account the information needs of the public including civil society to enhance their participation into health management.

3.2.3 Efficiency

The provision of results on demand is critical for a functional M&E system. The system mentioned thereof is a reflection of the relevant competencies and skills contained therein. Hence, human

capacity will be assessed and appropriate measures taken to develop skills and knowledge of human resource for an efficient and effective M&E system.

3.2.4 Quality *assurance*

Quality information is essential to improving health outcomes. Therefore, vigorous effort shall be made to improve the quality of data that will be used for decision-making. This will be applicable to routine data, surveys and other M&E data. Quality data shall meet the following quality standards (dimensions): accuracy, reliability, completeness, validity, timeliness and integrity.

i. **Accuracy**: Data are correct. Deviations in data can be explained or are predictable.
ii. **Reliability**: Data collected over time are comparable. Trends are meaningful and allow for measurements of progress over time. Data collection methods and analyses are consistent over time.
iii. **Completeness:** All the requisite information are available
iv. **Validity**: Data measure what it is intended to measure
v. **Timeliness**: Data are collected in a timely manner to inform management decision - making and planning.
vi. **Integrity**: Data quality is routinely monitored. Data quality assessments are integrated into data collection processes and procedures to ensure data are not erroneously reported or intentionally altered.

3.2.5 Equity

The policy supports the establishment and maintenance of a simple and coherent system that measures results along gender, demography, geography and socio-economic status to ensure equal access based on needs.

3.3 Strategic Approaches

3.3.1 Integrated M&E system

The MOH shall maintain an integrated (One M&E) system for the health sector. This system shall provide standards for monitoring and evaluation of the health sector.

The HME&R Division shall put systems in place to ensure quality and periodically verify data against quality standards. The HIS Unit, CHTs and DHTs shall verify and validate routine data

quarterly and institute measures to improve data quality. The M&E Unit shall evaluate the routine data system through an annual Data Quality Audits (DQA).

3.3.2 Evidence-based decision-making

The M&E Unit shall provide data to inform decision-making at all levels of the health system. The data collected through monitoring and evaluation shall inform policy formulation, planning, programming and resource allocation in the sector.

3.3.3 Capacity Development

The capacity development for M&E is critical for health system strengthening and result-based management. The MOH and partners shall endeavor to enhance capacity at all levels in data management and analysis, evaluations, and report writing.

3.3.4 Decentralization

The delegation of responsibilities to lower levels of the health system is critical for performance management and implementation of the policy. Henceforth, M&E responsibilities shall be assigned appropriately at different levels as provided for in this policy based on capacity.

3.3.5 Partnership

The MOH shall forge broad-based partnership and collaboration for M&E at national, county and community levels with donors, NGOs, UN Agencies, other Governmental agencies, private institutions and communities to achieve the goal of this policy.

3.3.6 Coordination

Coordination is imperative for resource mobilization, information sharing and sustaining a functional M&E system. The MoH shall establish coordinating mechanisms at all levels to enhance healthcare delivery. At the central level, there shall be an M&E Coordination and Technical Committees chaired by the Assistant Minister for Vital and Health Statistics and HMER

Coordinator respectively. Similar committees shall be established at the county level for M&E coordination.

4.0 Policy Orientations

4.1 Organizational Policy

In fulfillment of the NHPP and NHIP vision and goal, the MOH hereby establishes a division of Health Information System, Monitoring and Evaluation, and Research (HMER) with the responsibility of coordinating HIS, M&E and Research activities in the health sector to ensure complementarity and synergy.

4.1.1. Health Information System, Monitoring and Evaluation and Research (HMER) Division

The HMER is responsible to lead and oversee the development and management of all information systems and sub-systems, coordinate all research, monitoring and evaluation studies and functions of the Ministry of Health to ensure quality, efficiency, and value for money and avoid duplication of efforts.

The HMER Division through the appropriate unit (M&E, Research, HIS and Vital registration) shall supervise and provide technical guidance to the National Programs, divisions and the County Health Teams on matters relating to M&E, Research and HIS, respectively. This division shall coordinate with donors and implementing partners to ensure quality assurance and avoid duplication. All resources for HMIS, M&E and Research shall be channeled and expanded through the HMER under supervision of the Assistant Minister for Vital registration and Deputy Minister for planning to ensure proper alignment to the MOH strategic priority for information generation, use, and knowledge management,

4.1.2 Monitoring and Evaluation Unit

Pursuant to its mission, the M&E Unit shall lead all programs, divisions and counties in monitoring and evaluation of the health sector. In particular, the M&E Unit shall coordinate all external evaluation and lead all internal evaluation for the health system, program and projects. Central M&E will ensure that all health partners, stakeholders, programs are consistently involved in developing an integrated M&E strategy. Specifically, the Central M&E Unit shall:

- Coordinate and lead all surveillance, monitoring, evaluation and review activities of the MOH.
- Develop National M&E policies, strategy plans, technical guidelines and SOPs
- Develop health sector indicators and systems for tracking progress
- Monitor health system and program performance including NGOs
- Generate information products and disseminates same to stakeholders
- Conduct monitoring studies, surveys and assessments to determine baseline, set targets and monitor progress
- Develop and implement M&E system strengthening measures including trainings, supervision and mentoring of M&E staff at the lower levels,
- Document lessons learned and best practices to inform management decisions, policy adjustment and planning.
- Evaluate health information system
- Lead and coordinate evaluation of all health system interventions

4.1.2 Health Information System Unit

The Health Information System Unit is the national repository of all health data.

The HIS Unit shall:

- Develop and maintain all health information sub-systems
- Lead the development of standard data collection and reporting tools
- Lead routine data collection processes
- Implement measures to improve health data quality
- Archive all health data

4.1.3 The Research Unit

The research Unit shall:

- Develop the National Health Research Agenda;
- Lead the coordination of health research activities within the health sector including health related training institutions, private health sector and health partner Institutions;
- Ensure adherence to standards and public health norms and ethics;

- Conduct special studies and operational research;
- Collaborate and coordinate with health related ethics committees in the country;
- Provide overall governance, management and coordination of research activities;
- Lead special health related studies,;
- Exercise oversight as well as technical support in research;
- Provide leadership in the development of research policy and strategic plan, technical guidelines and appropriate standards to improve the quality of research in the health sector, and;
- Archive research data and ensure its use by programs, partners and donors.

4.1.4 County level M&E Unit

At the county level, all HIS, M&E and Research activities including planning shall be led by the County Monitoring & Evaluation Director under the direct supervision of the County Health Officer. The M&E Officer is a line manager and a member of the CHT senior management Team.

The relationship between the CHT M&E and the Central M&E Unit is rather indirect. The central HMER provide capacity building and technical support but does not directly supervise the County M&E Teams.

The County M&E Unit shall consist of a Monitoring & Evaluation Director, Data Officer, County Registrar and Data Clerks. The unit shall:

- Lead and coordinate the production of data and generate information products
- Lead county health reviews meetings
- Promote data quality and information use.
- Lead County planning sessions
- Lead the production of performance reports for the county
- Track and compare performances of facilities and districts on key health system indicators and deliverables;
- The County M&E Director shall have a minimum qualification of bachelor degree.

4.1.4 Disease-specific Programs M&E Unit

Disease-specific programs (i.e. NACP, NLTCP & NMCP) are established to focus on specific disease conditions and are therefore permitted to maintain disease-specific M&E units. However, they shall operate under the umbrella of the Central HMER and shall be part of all coordination mechanisms. To ensure harmonization and consistency, all HIS, M&E and Research activities undertaken by these programs shall be coordinated through the appropriate Unit and be approved by the HMER Coordinator at the central MOH. The Deputy Minister for Planning Research and Development shall manage all M&E related funds to avoid duplication of efforts, and ensure investment in M&E are driven by quality, synergy, alignment MOH HIS Strategy[25] and this M&E Policy and Strategy and the MOH Research Policy[26].

All other program's HIS, M&E and Research needs will be met through the central HMER Division. No programs, Divisions or departments shall establish separate units or appoint individuals to M&E, Research and HIS roles.

4.2 Access to MOH Data

4.2.1 Access to HIS Data

Organizations or individuals shall be granted access to HIS data based on request to the Department of Planning. A Memorandum of Understanding (MOU) shall guide all access to MOH Databases.

4.2.2 Access request to Databases

The procedures for access to MOH Databases shall be as follow:

- Submit written request to the Department of Planning;
- Review of request and approval;
- Signing of MOU between parties;

4.3 Backup, Storage, archiving and disposal

4.3.1 Backup

The Ministry of Health shall develop a backup procedure and protocol for electronic data and manual records.

4.3.2 Storage of Records and data

Both paper-based and electronic records shall be stored in safe and secured condition. The MOH shall assess need and determine the choice of technologies for data storage.

Hard copy records should be stored in a secure location when not being used e.g. lockable filing cabinets, cupboards, rooms in a secured environment. The accommodation should comply with established requirements for assuring security and safety of health and medical records and shall have proper environmental controls and adequate protection against fire, flood and theft.

Electronic information should be stored on a designated server or location. Version control should be used in storing electronic information. Only one copy of the most recent updated version of the documentation should be stored.

4.3.3 Archiving and disposal of health records

All redundant health data including ledgers, reporting forms, patients' cards, completed surveys and assessment records shall be archived. The minimum period required for retention of health records shall vary with the nature and type of the records.

- Financial records shall be retained for a minimum period of five years,
- Health facility based records such as ledgers, registers, patient charts and reporting instruments shall be archived for as long as possible but not earlier than 10 years.
- Meeting minutes, performance report, and monthly summary reports for a minimum period of five years

4.3.4 Retention and Disposal Policy and procedures:

Retention and disposal policy and procedure as used in this context applies to records related to health and vital events and includes (Ledgers, Summary Morbidity and Mortality reports, minutes, completed surveys forms, periodic reports and all pertinent digital versions of health and vital records). The records may be held electronically and/or manually and may contain information from any of the categories below:

a. Clinical records
b. Administrative records including: HR, estates, financial and accounting (e.g. budget information, annual report information);
c. Information concerning complaint handling;
d. Manual (e.g. telephone messages, working papers);
e. Printouts of audit trails from computer/automated systems;
f. Microfiche;
g. Audio tapes,
h. cassettes;
i. Video tapes,
j. CD-Rom;
k. Computer media e.g. CDs, floppy discs;
l. Computer output e.g. paper, printout.

Regardless of type there is usually a requirement to keep a record for a minimum number of years. This period of time is calculated from the end of the calendar or accounting year following the last entry in the record (e.g. manual file, computer record). The minimum period required for retention of health and vital record varies with the nature, type and scope of the record under consideration. Routine data including ledgers and financial records shall be retained for a minimum period of 5 years, meeting minutes, performance report, and monthly summary reports for a minimum period of two years and health facility based records such as ledgers, registers and patient charts for a minimum period of ten years.

Each Health District shall establish a District Health Archive to store redundant patient charts and health records.

4.3.5 Disposal of Records

Disposal as used in this context does not necessarily imply destruction; it applies in addition, to the transfer of records from one media to another for archiving (paper records to CD Rom or external digital storage device), or the transfer of records from one organization to another (e.g. authorized archive office. The use of another organization for archive records shall be guided by an agreement/contract and such contract shall detail how the records will be archived and who will be allowed access to them. Assess to archived record must be authorized in official

communication by the Assistant Minister for Health and Vital Statistics and the archiving agency shall make indication of the following:

i. date access occurred,
ii. the details of the person gaining access
iii. the reason access was required.

When a record is removed from the archive a note must be made of:

i. the taker of the record,
ii. the taker's signature or a receipt from them,
iii. the expected date of return,
iv. the date the record is returned.

4.3.6 Destruction of Records

The destruction of records is an irreversible act. The determination of which record, when and how a health record is destroyed must be done with the consent and acquiescence of the Assistant Minister of Health and Vital Statistics and under the direct supervision of the Director of the Health Information System. HIS records may contain sensitive and/or confidential information and their destruction must be undertaken in secure locations and proof of secure destruction may be required.

Destruction of all records, regardless of the media, should be conducted in a secure manner to ensure there are safeguards against accidental loss or disclosure. The normal destruction methods shredding or incineration

4.4 M&E financing

The MOH shall mobilize resource to finance health sector M&E. In line with international best practices, 5-7% of MOH's budget shall be allocated to finance M&E. This include HIS and Research. Donors and other health sector's stakeholders shall be encouraged to fill resource gaps for M&E System strengthen and strategy implementation. This will happen when partners in the health sector adhere to the provisions of this policy to buy into the One M&E System.

4.5 M&E institutional capacity development

The MOH shall collaborate with training institutions in the establishment of pre-service training program for M&E capacity development. The MOH shall periodically assess M&E capacity and mobilize support for pre-service training in specialized areas of M&E such as Biostatistics,

Epidemiology, Health Informatics, and other specialized areas as stipulated in the HIS Strategy[25]. M&E capacity building shall be a continuous process for system strengthen in the MOH.

The MOH shall create the enabling environment for M&E at all levels and provide the needed inputs (infrastructure, equipment and logistics) to facilitate M&E functions. Obviously, capacity is not limited to the provision of training but include equipment, logistics as indicated above as well as the operational space. County Health Team should provide the functional space and resources needed to make M&E functional at the lower levels.

4.6 Coordination and partnership

The MOH shall promote coordination and partnership with various M&E actors across other ministries, agencies, training institutions through fellowships and other coordination mechanisms locally and globally.

To achieve the integrated M&E and harmonized information systems as described, requires coordination with all stakeholders. Coordination is the mechanism through which consensus are built around M&E systems, resources mobilization and system strengthening for M&E. M&E coordination shall take place at the policy and operational levels. The HMER Coordination Committee chairs by the Assistant Minister for Statistics is the policy level mechanism while the HMER Technical Working Group is the operational level mechanism for M&E, HMIS and Research Coordination.

5.0 Monitoring and Evaluation Framework

5.1 Monitoring framework

The National M&E Strategy shall articulate a monitoring framework and set of indicators to measure progress towards the achievement of the health sector goals and objectives. The M&E Unit shall monitor adherence to the National Health Policy against the overall performance of the health sector.

The implementation and enforcement of the Health Policy shall be continuously monitored. The M&E Unit shall produce annual reports that summarize inputs, outputs, and health status using core indicators.

5.2 Evaluation and reviews

MOH shall conduct periodic evaluations to assess level of progress towards the achievement of the NHPP and NHIP to understand change drives, bottlenecks and impediments and improve health programs and strategy. Health development initiatives and programs shall be evaluated at all levels..

All evaluations, be it external or internal shall be coordinated or led by the M&E Unit. This shall include evaluation commissioned by donors and NGO partners in the health sector. This will enable the MOH to keep track and use evaluation findings to improve strategies, test lessons learn from one part of the country and from one partner to the other.

The MOH shall conduct health system performance reviews at national, county and district levels to inform program improvement and health service delivery. Facilities should be encouraged and supported to do their one internal review to help identify their weaknesses and try to improve service quality and serve their patience better.

6.0 Enabling Environment and Implementation Arrangement

6.1 Legal Framework

The Public Health Law and the National Health Policy form the legal basis for the formulation and implementation of the M&E Policy.

6.2 Enforcement

The M&E Unit in collaboration with health regulatory bodies and the Ministry's Office of General Counsel (OGC) shall monitor and enforce provisions stipulated in this policy. Mechanisms shall be established to ensure compliance with existing and new M&E regulations, policies, SOPs, protocols and guidelines.

6.3 Implementation Arrangement

The Monitoring and Evaluation Unit shall implement the M&E Policy and Strategy under the supervision of the HMER Division and the Assistant Minister for Statistics. The Deputy Minister for Planning, Research and Development shall provide the overall leadership for the policy and strategy implementation. Implementation of all M&E activities including those of National Programs should be channeled through the HMER division dealing with the appropriate units to avoid duplication of efforts, waste of scarce resources and ensure value for money.

6.3.1 Assumptions

The implementation of this M&E Policy and Strategy is based on the following assumptions:

- There is political will to support M&E and enforce the policy;
- There is a stable political environment;
- There is logistical and financial support for M&E at all levels;
- There is adequate ICT infrastructure at the national, county and district levels;
- There is strong internal leadership at MOH and in the County Health Teams;

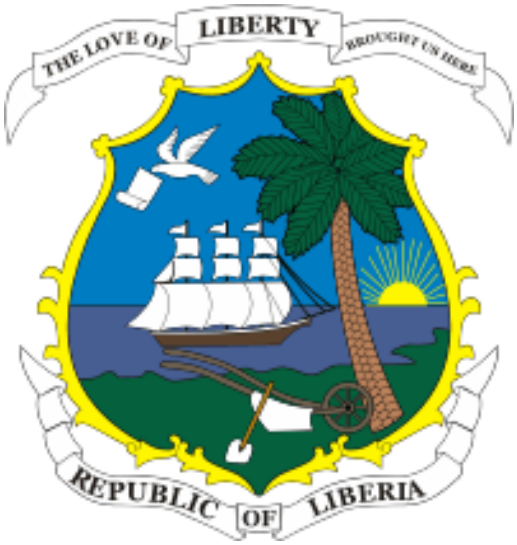
6.3.2 Risks

Risks to be considered while implementing this policy:

- Deviation from the national health priorities;
- Competing priorities, including donor preferences,
- Off budget spending;
- Weak coordination
- Lack of political will;
- Insufficient resources;
- Force majeure

Republic Of Liberia

Ministry of Health (MOH)



MONITORNG AND EVALUATION STRATEGY AND PLAN

2016- 2021

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Chapter 1: Background

1.1 Social and demographic outlook

Geography: Liberia is situated in West Africa, bounded by Côte d'Ivoire, Sierra Leone, Guinea and the Atlantic Ocean. It has a land area of 111,369 square kilometers with an estimated population of 4 million and an annual growth rate of 2.1%. More than 50% of the population is below the age of 35. Administratively, Liberia is sub-divided into 15 counties and 91 health districts. The most common geographic features of Liberia are rain forests and swampy areas.

Socio-economic situation: Liberia is ranked 177 out of the 188 countries included in the 2015 UNDP's Human Development Report. The country has 59% of its population in urban areas, with a life expectancy of 61 years and an estimated 54% living in poverty. About 71% of the population has access to health care, 73% has access to improved drinking water, and only 28% has access to toilets2. Liberia's adult literacy rate is 60% and the combined gross school enrollment is 57%. There are 17 major ethnic groups in Liberia and two major religious groups: Christianity constitutes 86% and Islam represents 12.2% of the population[3].

Morbidity and Mortality: In 2013, Ebola Virus Disease, a severe and often-fatal filo virus infection hit West Africa4. The outbreak started in Guinea, and rapidly spread to Liberia, Sierra Leone and beyond5. Liberia diagnosed its first case of Ebola in late March, 2014 and by January, 2016 had reported over 10,000 cases with about 4,800 associated deaths6. Amongst these cases, 372 health care workers had contracted the Ebola Virus Disease, of which 184 died7. Since the country as declared EVD free on June 9, 2016 there has been no reoccurrence.

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2 Liberia Demographic and Health Survey, 2013

3 Liberia National Population and Housing Census

4 Beeching NJ, Fenech M, Houlihan CF. Ebola virus disease. BMJ 2014; 349: 26-30.

5 Baize S, Pannetier D, Oestereich L, Emergence of Zaire Ebola Virus Disease in Guinea. New Eng J Med 2014; 15: 1418-1425.

6 World Health Organization. Ebola Situation Reports. Available: http://apps.who.int/ebola/current-situation/ebola-situation-report-6-january-2016 (accessed 19 Janaury 2016)

7 National Health Sector Investment Plan

Maternal Health: The 2013 Demographic and Health Survey (DHS) estimated maternal mortality ratio at 1,072 deaths per 100,000 live births; one of the highest rates in the world. Fertility rate declined from 5.2 in 2007 to 4.7 births . while contraceptive prevalence rate was measured at 20%, and 61% of deliveries were assisted by skilled birth attendants. Postnatal care continues to be low with only one-third of mothers and newborns seeking care after delivery. In response to the above rates, the Ministry of Health formulated the accelerated roadmap for the reduction of maternal mortality and for improving maternal health conditions in 2009.

Child Health: Infant mortality rate declined from 72 deaths per 1,000 live births in 2007 to 54 deaths per 1,000 live births (DHS) in 2013, thus contributing toward the achievement of Millennium Development Goal 4. Additionally, under-5 mortality rate also decreased from 111 deaths per 1,000 live births in 2007 to 94 deaths per 1,000 live births in 2013. Despite the gains in child health, only 55% of children under-one year of age received all basic vaccination in 2013. The major causes of childhood illnesses are malaria, acute respiratory infections (ARI), diarrheal diseases and malnutrition.

Health Infrastructure: In 2015, there were 727 health facilities in Liberia of which 64% are public8. Two-third of health facilities have electricity and water supply. The majority (65%) of households walk to reach the nearest facility9. Although access to healthcare is improving, 29% of Liberians lack access to basic health services within 5 kilometers or less than one hour walk-time to a health facility.

Human Resources for Health: The Health Workforce Census conducted in 2016, documented 16,064 health workers of which 10,672 were employed within the public sector. One-third (5,294) of the clinical health workers include 241 medical doctors, 829 certified midwives, 3,191 registered nurses and 453 Physician Assistants. The workforce is skewed towards urban areas Inequitable distribution of health workforce, wage disparity coupled with limited institutional capacity to for absorption, retention and motivation of health workers are a few of the major constrains that need urgent attention.

8 MOH Annual Report 2015

9 Demographic and Health Survey, 2013

1.2. Introduction of the M&E Strategy and plan

The Ministry has clearly articulated its commitment to fostering a data driven culture that promotes evidence-based decision making as indicated in the HNPP and Investment Plan. The National Monitoring and Evaluation Strategy and Plan was developed to fulfill this aspiration by generating the evidence for the effective and efficient management of the health system.

The National Monitoring and Evaluation Strategy and Plan outlines key interventions and activities to strengthen the country-led platform for monitoring, evaluation and review of the health sector performance. The strategy and plan provide the roadmap for accountability, learning and development in the health sector. It is based on the Government of Liberia Ten Years Health Plan and the Investment Plan for Building a Resilient Health System. It is aligned nationally with the Government's economic growth strategy - the Agenda for Transformation (AfT), and globally to the Sustainable Development Goals..

1.1.1 M&E System analysis

The Ministry of Health has a functional monitoring & Evaluation system that generates evidence to inform management decisions. There are M&E teams at the central MOH and in all fifteen counties. At the national level, there are the central M&E Unit and the National Programs (Malaria, HIV/AIDS and TB) have M&E and Research Units. Additionally, there are 15 M&E Officers and 15 Data Managers and 15 Registrars, one of each in every county) deployed at the county-level to perform M&E-related tasks. Other personnel at community, facility and district levels have been assigned specified M&E functions. For example Community Health Assistant, Clinic Officer-in-Charge and District Health Officers all have data collection and verification responsibilities as part of the main lines of duties. The capacities of these personnel varied and have implications for the effectiveness of the M&E system.

In August 2016, an assessment of the M&E system was conducted focusing on the county-level. The Monitoring and Evaluation System Strengthening Tool (MESST) and the Organizational and Behavior Assessment Tool (OBAT)[10] a module of the Performance of Routine Information System

10 OBAT is Organizational Behavior Assessment Tool is a module of the PRISM framework and tools

Management (PRISM)[11] were used. The assessment found couple of system weaknesses along three key dimensions: 1) M&E Planning, 2) Management Unit's (CHT M&E Unit) Capacity and 3) Data reporting System.

1) M&E Planning: all of the County Health team did not have an up-to-date M&E Plan. Only two have an M&E Plan but were not updated. All of the counties have draft Operational Health Plans that were at different levels of completion. Data use for decision-making was very limited due to low capacities of manager and supervisors to demand data and the supply side doe not have the capacity to generate information products and to stimulate managers to use them.

2) Management Unit Capacity: That M&E Units at the lower level generally have low capacity to perform key M&E functions. The management Units have limited skills to perform data analysis and interpretation to influence management decisions. Such capacity is also not at it fullest at central MOH. The CHTs got limited resources to regularly monitor implementation of health plan, inputs, and quality of services, and data quality in health facilities. Feedbacks mechanism on data quality and performance to the lower levels was weak.

3) Data reporting System: Facilities across all counties had rand out of one or more standardize ledgers and were using ordinary copybook to record data. Many of the health workers trained in the use of M&E tools have left and those fresh graduates that replaced them have not been trained. There was no evidence of SOPs and guidelines for handling, archiving and sharing data. Reporting procedures meant to ensure data quality is not consistently followed. Reporting system for drugs and medical commodities is under developed and weak. Not system to monitor training data to avoid training the same people over and again in one-program area. Community health data are not being captured in any system and therefore not processed and used[12].

Liberia's Health sector faces enormous challenges in Monitoring and Evaluation. The main challenges include, data quality improvement, insufficient capacity to collect, analyze, interpret and submit reports on time, and using data for decision making. Resources to fund key M&E activities including capacity building, provision of logistics and systematic programs and policies evaluation remain limited. M&E is grossly under funded in the health sector.

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11 PRISM is the Performance of Routine Information System Management framework developed by JSI and MEASURED Evaluation

12 Ministry of Health MESST Assessment Report, 2016

1.1.2 Current status of the health information system

Health Information System (HIS) provides valuable sources of data for monitoring, evaluation and review of the health system. Generally, an assessment of the Health Information System shows that the current HIS is inadequate. There is insufficient resource environment for HIS including policy and planning, financing as well as institutions and human resource. It also shows limited capacity to analyze data and use information for program improvement and resource allocation[1] as confirmed by the M&E Assessment.

The HIS Strategy and Plan 2016-2021 identified seven sub-systems[2] that need to be functional and interoperable for the HIS to reach its full capacity. Currently, the HIS is being developed on an incremental basis with only three of the seven sub-systems (facility base Information System, Human Resources Information and the Financial Management Information Systems) functional. Additionally, of the three functional sub-systems, only the facility Based Information System is fully functional. The three sub-systems currently operating are stand-alones and operating on three different platforms with no inter-connectivity and resource sharing.

The Community Based Health Information System, Logistics Management Information System, Laboratory Information System, Disease Surveillance Information and Asset Management Information Systems are yet to be developed.[1] The goal is to have a fully functional and integrated HIS that share resources across platforms by 2021.

1.1.3 Purpose of the M&E Strategy and plan

The need to consistently track progress, document change, lessons learned and good practices, is the driving force behind the development of M&E Strategy and Plan. It will provide a strategic direction for monitoring, Evaluation and review of the health sector over the next five years. It lays out plans and processes for tracking performance and evaluating results of the health sectors against set targets and benchmarks in Line with the National Health Policy and Plan, and the Investment Plan for Building a Resilient Health System. Finally, it will serve as a reference document for M&E Stakeholders coordination, Capacity development and M&E system assessment and review.

1.1.4 The M&E Strategy and Plan development process

The M&E Policy and Plan review was the second with the first one done in 2012. The revision was necessary in order to incorporate post Ebola developments including the National Investment Plan

for Building a Resilient Health System, a complementary strategy of the NHPP, and the Sustainable Development Goals among others.

The review process started with consensus building through the monthly HMERTWG meetings. The TWG endorsed the M&E Assessment and review. Desk review and subsequent conducts of an M&E System Assessment that focused on the counties was done. An HIS assessment conducted by the MEASURE Evaluation in late 2015 preceded the county level assessment. Additionally, a joint world Bank WHO Country M&E Assessment was done in early 2016 as part of the International Health Partnership Plus Process. The outcomes of these assessments informed this M&E review process. All key health stakeholders participated in these assessments.

The 2012 version of the Policy and Plan were review in-house by M&E staff with key areas that needed to be revised identified. Outputs from this in-house work was taken to a five day working session held at the Phebe Compound from October 3-7, 2016 to review and revise the document. This working session was held with M&E staff from central including one national program representative. Few partners including WHO, Partner in Health, Last Mile Health and Management Science for Health (MSH) participated. The draft was compiled and circulated to a wider stakeholder for comments. A validation meeting was held with senior staff and technicians of the MOH and partners, and the M&E Policy and Strategy was validate

Chapter 2: National health plans as basis for monitoring, evaluation and review

2.1 Goals of the national health plan

The goal of the National Health Plan is to improve the health status of the population of Liberia on an equitable basis.

2.2 Objectives of the national health plans

The objectives of the National Health Plan are to:

1. Increase access to and utilization of a comprehensive package of quality health services of proven effectiveness, delivered close to the community, endowed with the necessary resources and supported by effective systems;

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

3. Make health care and social protection available to all Liberians, regardless of their position in society, at a cost that is affordable to the Country.

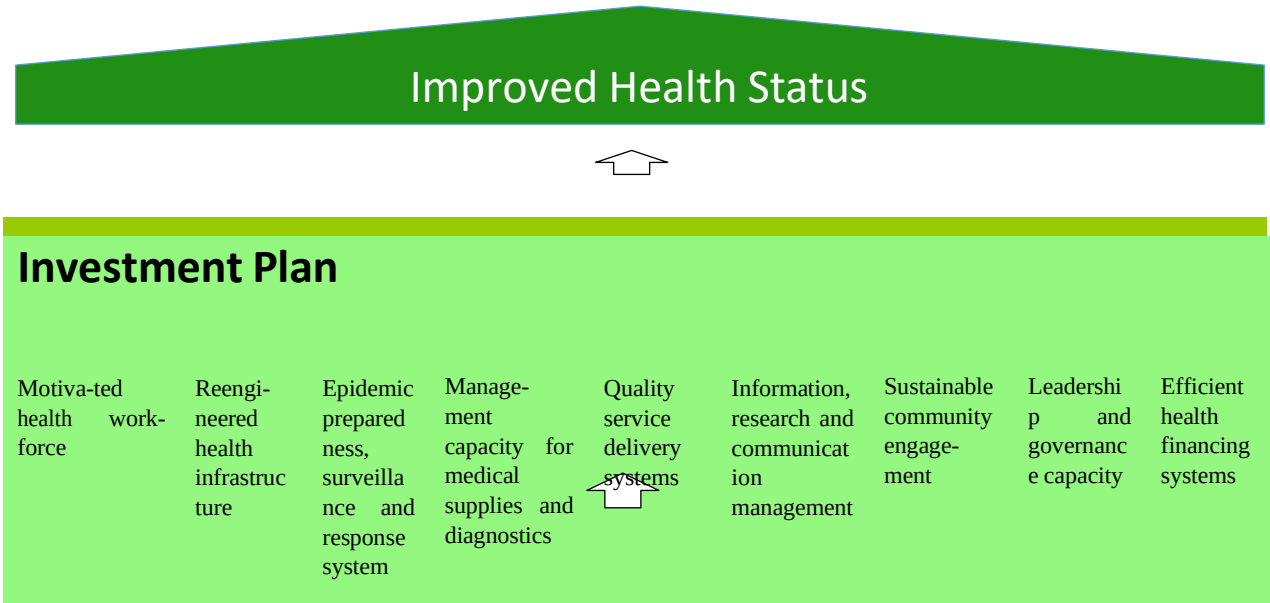
The objectives of the investment Plan are to ensure for Liberia:

1. Universal access to safe and quality services, through improved capacity of the health network for provision of safe, quality Essential Packages of Health Services.

2. A robust Health Emergency Risk Management System through building public health capacity for prevention, preparedness, alert and response for disease outbreaks and other health threats.

3. An enabling environment that restores trust in the health authorities' ability to provide services through community engagement in service delivery and utilization, improved leadership, governance and accountability at all levels.

2.3 Health system framework



Chapter 3: Monitoring and evaluation

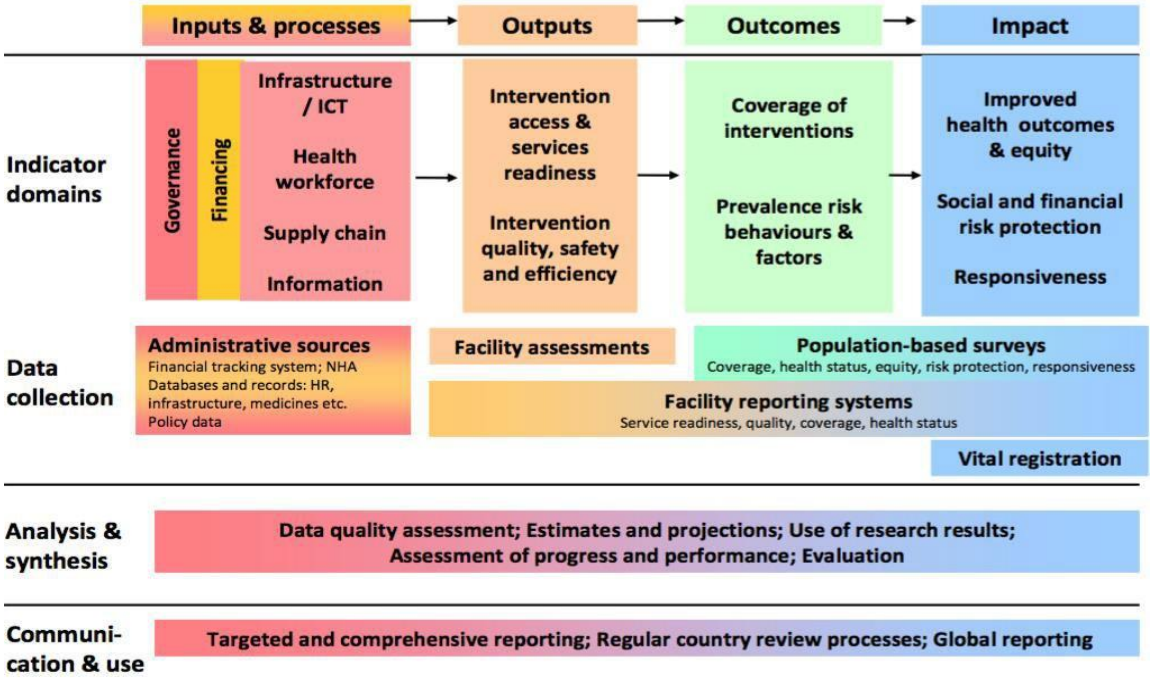
3.1 Monitoring and evaluation framework

The M&E plan for NHPP 2011- 2021 and IP 2015-2021 articulates a comprehensive Monitoring Framework for the health Sector that includes a wide range of key service and health system indicators with clear sources of data, frequency of data collection, and reporting. The monitoring activities for tracking progress are intended to produce information that will inform comprehensive monitoring and review of progress overtime.

Conforming to MOH's decentralization policy, the national M&E framework is consistent at all levels of implementation: Central (National), County, District, Facility and Community. The M&E Plan provides a detailed description of the roles, responsibilities and capacities necessary to carry out these roles of monitoring, evaluation and review.

Data analysis for monitoring and evaluation will be done in line with logical framework that illustrates how inputs and processes lead to desire impacts overtime. The logical framework is adapted from that of the M&E framework for health systems strengthening (HSS) developed through international partnerships. [Ref] The framework builds upon principles derived from the Paris Declaration on aid harmonization and effectiveness and the International Health Partnership (IHP+). It includes four key indicator domains: system inputs and processes, outputs, outcomes, and impact. The framework does not only facilitates the identification of core indicators along the results chain, but also links indicators to data collection methods; highlights the need for analysis and synthesis of data from multiple sources, including data quality assessment; and demonstrates how the data need to be communicated and used to inform decision-making at different levels. See M&E framework below.

Figure 2: Monitoring and evaluation logical framework



3.2 Indicators

Monitoring & Evaluation of the health system will be carried out using the National performance

Source:

framework comprised of core health system and service delivery indicators. The indicators will be used to track performance along the result chain (outputs, outcome and impact). Because the performance framework is to monitor the national health system performance, it includes only core indicators prioritized by the MOH and partners. The Central M&E Unit in consultation with stakeholders has selected 55 core indicators at input and process, output, outcome, and impact levels to monitor and evaluate the performance of the health system. The core indicators are defined with data sources, methods of data collection and frequency of reporting stated.

However, various disease specific Programs, projects, divisions and the County health Teams will need more process and outputs indications for effective monitoring. As such they will track additional indicators to meet their management information needs from the MOH comprehensive list of a little over a hundred and seventy-three indicators. Additionally, the M&E Unit will track additional indicators to meet international reporting requirements including WHO, WAHO and other regional and global initiatives, including the health SDGs. Please see Annex 1for performance framework.

3.3 Data sources

Identifying clear data sources for the indicators beforehand are pivotal for effective monitoring and evaluating the health system performance. It is therefore essential to specify data sources and how the data will be generated. Data for the MOH list of indicates are gathered from many diverse sources. The date sources are summarized in the table below.

Table 1: Data sources for MOH indicators

Data source	Definition	Frequency	Responsibility for collection
Facility based data	Facility data include monthly routine service delivery data generated from private and public health facilities	Monthly & Quarterly	HMER
Community based data	Community based data are generated by Community Volunteers working in various communities and reported to the nearby facilities	Monthly	HMER
Population based health surveys	This data source measures data from population health status indicators (population studies), health system research, clinical trials and community studies will also provide data for interoperation and possible use by the sector	DHS every 5 years	LISGIS & research institutions
Administrative data sources	This will provide information on health inventories, supervision, health Board and management meetings, logistics, governance and management, human resource, financial resource flows and expenditures at national and sub-national levels	Monthly & Quarterly	CHTs & MOH
Population and household census	This is the primary source of data on determining the size of population which is carry out after every 10 years	10 years	LISGIS
Civil registration and vital statistics systems	This provide source of quality data for birth, death and causes of death.	Periodically	CVRS

3.4 Data collection

Data collection system will include both quantitative and qualitative methods using standardized data collection tools and techniques. The data collection systems collect data monthly, quarterly and annually depending on the domain and type of indicator. Routine data for process and output indicators are collected and complied monthly while outcome and impact levels indicators are collected mostly through survey for instance in the Demography and Health Survey (DHS) and other monitoring surveys and studies. Data collection procedures are articulated in Liberian Health Information System & ICT Strategic Plan 2016-2021

3.5 Routine monitoring, monitoring Studies and data gaps

3.5.1 Implementation and performance monitoring

Monitoring is the collection of data on a routine basis to assess implementation and measure performance. Monitoring is very critical to the MOH in her quest for results based management. The M&E Units and those of the national programs will performed different but well-coordinated activities to achieve effective monitoring. There activities include gathering and analysis of primary and secondary data, as well as quantitative and qualitative data. These data will be collected and synthesized to provide complete information for management decisions. Most of the data will come from the routine HIS and periodic fieldworks.

Quarterly field works will be done with focus on qualitative assessment of implementation to compliment and explain some of the factor that influence the level of performance. These quarterly monitoring visits will reach all counties, selected facilities, communities and implementing partners. Compliance to policy, protocols and guidelines, and implementation of County Plans will be assessed.

3.5.2 Data gaps and monitoring studies

Monitoring studies will be conducted where information gaps exist or for indicator for which data cannot be gathered routinely. Other studies may be conducted to compliment and or explain findings from routine data analysis. Monitoring surveys may be carried out directly by Central M&E Unit, the national programs with Central M&E Support or contracted out. Some high level indicators will be monitored through national studies done by LISGIS. Some key monitoring studies that will be done over the life of this plan include: the LDHS to monitor outcome and impact levels indicators, Liberia Malaria Indicators Survey to track malaria program implementation and

outcome, Clients Satisfaction Surveys to monitor perceived quality of services, Service Availability and Readiness Assessment (SARA) among other. See table for detailed list of key monitoring studies and basic descriptions.

Table 2: List of monitoring studies

Monitoring studies	Methods	Scope/ Focus	Responsible Parties	Timetable
Demography and Health Survey (LDHS)	House Hold Survey with representative sample	Nationwide – outcome and Impact indicators	MOH & LISGIS	2018 (Every 5 year)
Malaria Indicators Survey (LMIS)	House-whole Survey	Malaria program monitoring	NMCP/M&E	2018 (Every 2years)
Service Availability and Readiness Assessment (SARA)	Census-Facility-based to monitor	Monitor inputs at all health facilities nation-wide	MOH M&E	Annually (Every Year)
Clients' satisfaction survey	Facility clients exit interview	Monitor perceived quality of health services	M&E	Semi-annually
Health Workforce census	Facility base Census at all health institutions	Health workers Nation-wide	M&E, HR and Research Units	2-3 years
TB Prevalence	Population based survey	Tuberculosis Program	NLTCP M&E	3-5 years
Antenatal Care Survey (ANC Survey	Facility based – Serio-prevalence survey	HIV study among pregnant women	NACP/M&E	Every 2 years

ART adherence & HIV	Facility based HIV retention	HIV care	Clients in	NACP/M&E MOH Research	&	2-3 years

Monitoring studies	Methods	Scope/ Focus	Responsible Parties	Timetable
lost to follow-up Study	study			
Integrated Bio-behavioral survey	Household survey	Sample of public	NACP/MOH & LISGIS?	???
Key HIV Population estimation study			NACP, MOH, NAC	???
Mode of HIV transmission study				
Nutritional and Health Survey	Nation-wide household survey	Child nutrition	MOH/M&E and LISGIS	2-3 years
Expanded Program on Immunization (EPI) Cluster Survey	EPI Coverage Survey	EPI coverage	MOH/M&E & Research Units	Every 2 years (Every other year)
Data Quality Audit	Facility base sample survey	Data quality Assessment	M&E Unit	Annually (Every year)
National Health Account study	Institution base health spending study	Health expenditure	Health Financing Unit	Annually (Every Year)

3.6 International reporting

Liberia as part of the international community has global reporting responsibility through various mechanisms. Reporting to international bodies including donor institutions, WHO and other UN

Agencies, WAHO, the African Union, among others will be harmonized and coordinated under the SDGs and the International Health Partnership Plus (IHP+) frameworks. In the interim data and written reports will be submitted to some partners until an integrated reporting framework

developed and agreed on. Some of the key reports include:

Table 3: Some key national and international reporting requirements

Report	To be submitted to	Focal Point in MOH
Health Sector AfT progress report	Ministry of Finance and Development Planning	Ministry of Health - M&E & Planning Units
World Health Statistical Report	World Health Organization	M&E/HIS
United Nations General Assembly Special Session (UNGASS) on HIV & AIDS	United Nations General Assembly	National AIDs and STI Control Program and the National AIDS Commission
Malaria data	Africa Leaders Malaria Alliance (ALMA)	National Malaria Control Program M&E Manager

3.7 Data analysis, synthesis and quality

3.7.1 Data analysis

Data analysis will be performed at every level of the health system to facilitate performance monitoring, evaluation and review. Various information products will be produced to make information accessible to all stakeholders who need to use them. Analysis will show results consistent with the health situation and progress towards core indicators and targets. The analysis will compare results achieved to targets, and trends over time for key indicators at each level. Internal and external benchmarking will be done. Internal benchmarking will compare performances across facilities, districts and counties and external benchmarking will compare health indicators nationally to other countries in the sub-region. Studies will be done to seek additional information to explain reasons for the level of performance and variation in performances.

Analysis for key indicators will account for equity. Where feasible, analysis will account for other social variables including gender, education status, wealth quintile and geography among others.

Table 4: Information productions from analysis

Information Products	Level of health the system products for						
	Frequency	Central	County	District	Facility	Commu-nity	Public
Synthesized performance report for fiscal year	Annually	X	X	-	-	-	X
Annual performance report for calendar year	Annually	X	X	-	-	-	X
Quarterly dashboards	Quarterly	X	X	-	-	-	-
Scorecards (Programs specific)	Quarterly	X	-	-	-	-	-
Quarterly central MOH Performance report	Quarterly	X	-	-	-	-	-
Online dashboard (DHIS-2)	Monthly	X	X	X	-	-	-
Data summery	Monthly	-	-	-	X	X	X

Capacity to do effective analysis is weak at all level of the health system. This is more so at the lower levels(HIS &MESS) and therefore systematic capacity development will be required on a continuous basis. As indicated in the HIS strategy, this capacity must include biostatistics and the use of M&E-related software such as statistical programs (Excel & STATA) and database software (Access & MySQL).Ref Effort should be made to strengthen the capacity of M&E staff from central to district levels to have a broad range of skills in data analysis. Capacity building for data analysis soft ware will focus on Microsoft Excel and STATA. This is because the MOH has a number of genuine licenses for STATA and is powerful enough to meet the MOH's analysis needs. Excel is readily assessable with no extra cost and is suitable for performing the kind of analysis that is done at every levels of the health sector using the MOH's routine data.

3.7.2 Synthesized progress reports

Performance towards the achievement of the health sector goal and objectives will be assessed annually by pulling data and information from all sources. These information will be validated and synthesized to paint a full picture of the health sector performance and identify gaps and weakness, strengthen and best practices. Routine data will be compliment by qualitative data and be analyzed through a stepwise approach to assess which policies and program were successful. This will be

derived from inputs such as financials, service access, utilization and quality of health services,

intervention coverage, health outcomes, and risk protection and responsiveness.

Context analysis will be conducted to assess contextual changes focusing on policy direction and non-health system changes. For example, policy compliance, primary health reforms, and socioeconomic developments that affect implementation as well as the outcomes and impact observed in the health system.

3.7.3 *Data quality assurance*

Data quality assurance starts far before data are collected. Therefore, measure to ensure data quality will include ongoing training, supervision and mentoring of those involve with data collection and compilation. Standardized data collection tools will be supplied. Additionally, Data will be reviewed for accuracy and integrity and periodic Data Verification and harmonization and Data Quality Audits (DQA) will be done at every level where data are collected and compiled. District Health Teams or District Health staff will conduct verification of data in all of their facilities. County should cover 50 to 100 percent of facilities with data verification every quarter. And Central HIS will cover 10 percent of facility with data verification every semester. Feedback will be submitted to the facilities regarding completeness, accuracy and validity of the data.

National-level staff, led by the HIS Unit will conduct regular data verification and harmonization exercises across the county at selected facilities. The objective of data verification is to ensure that the data reported are good. District teams will be supported and empowered to do regular and comprehensive data verification and harmonization in all facilities. The M&E Unit will lead annual DQA to assess the quality of data.

3.5 Health sector and programs evaluations

3.5.1 Health Sector's Evaluation

Evaluation is a rigorous and scientific process of gathering and analysis of data to judge program activities, characteristics, outcomes and or impacts; determine the merits of a specific program or intervention. It explains the determinants of results attained and where necessary estimate and attribute results to a specific program or intervention.

Evaluation will constitute an integral part of the health sector performance assessment. A mixed of

internal and external evaluation, as well as various type of evaluation ranging from implementation to impact evaluations will be done over the life span of the NHPP and the Investment plan with which this M&E framework is aligned. Some evaluations will focus on various programs and interventions of the health sector and specific evaluations will focus on the NHPP, the EPHS and the Investment Plan. The MOH will encourage internal and independent evaluation of programs or the NHPP&IP but all evaluations in the health sector will be coordinated through the M&E Unit to ensure quality, utilization of results and to guide against duplication. This will include evaluations commissioned by donors and NGOs and other health partners.

3.5.1 Program & Project Evaluation

Typically, health sector investments and interventions will be undertaken during the life of the NHPP&IP to complement the efforts of the MOH. Therefore, all projects will be subjected to rigorous evaluation. The type of evaluation to be planned for and conducted should reflect the nature and scope of the program or investment. For example, pilot projects that may be implemented amongst selected counties and facilities shall be selected for impact evaluation to determine whether or not such investment has made progress or is improving service delivery and should be scaled up.

As a minimum requirement, each project in this category will be required to conduct the following: (1) a baseline study during the preparatory design phase of the project (2) a mid-term review to assess progress against objectives and provide recommendations for corrective measures for improvement (3) a final evaluation will be done to determine their worth or value for money (VFM). All other projects or programs implemented in the health sector will be subjected to standard rigorous final evaluation as well.

The M&E Unit will be responsible for the design, management and follow-up of the programs and projects evaluations in collaboration with key stakeholders. All health projects or programs that are implemented during are required to budget for periodic project evaluations to determine how the implementation of the project furthers the objectives of the NHPP&IP. Evaluation reports shall be disseminated during the sector annual review meetings or the National Health conference.

3.5.2 Mid-Term Evaluation

A mid-term or implementing phase evaluation (MTE) of program or project is required under the NHPP&IP M&E platform. MTE will be done depending on the duration and status of the program

or project implementation phases. The NHPP&IP shall do a midterm evaluation when feasible.

The general objectives of the MTE will be to:

- Assess progress in meeting NHPP&IP toward 2021 targets and to make recommendations for their adjustment where necessary.
- Review the appropriateness of outputs in terms of inputs, processes and desired outcomes;
- Review the costing and financing mechanisms of the NHPP&IP

The MTE shall involve an extensive review of documents including routine reports and recent studies in the sector. Special in-depth studies may also be commissioned as part of the MTE and may conduct interviews with selected key stakeholders. The MTE will be undertaken in a participatory manner involving MOH and related line ministries, national level institutions, service delivery levels, civil society, private sector and academia. The analysis of such MTE should focus on progress of the entire sector against planned impact, but will also include an assessment of inputs, processes, outputs and outcomes. The main result will be a list of recommendations for the remaining NHPP&IP years. This will be an internal, joint exercise involving all stakeholders.

3.5.3 NHPP&IP End Term Evaluation

The Central M&E Unit and independent consultants shall undertake an end term evaluation of the NHPP&IP when the project plan ends in 2021 in order to enable the MOH to make use of the findings and recommendations to inform the formulation of the next or subsequent National Health strategy and plan. Like the mid-term review, the End

Term evaluation analysis will focus on the impact of the NHPP, but will assess the results pipeline to test the theory of change. That is how inputs and process led to desire outcomes and impact. And document what can be learned to improve the health system. The evaluation will answer questions of attribution (what works? And What works very well an made the difference?); and counterfactual (what would have happened had we not implemented the NHPP&IP?) The evaluation will take into account the context in which health services are produced and delivery and how this context impact health programs and intervention.

Additionally, considering the huge investment been made in the health sector, it is worth measuring to what extend resources invested have produced the optimal possible benefits to the population. The economic evaluation of the health sector will considered effectiveness, cost-effectiveness and cost-benefits of key interventions and strategies.

Table 5: Evaluation plan

Evaluation studies	Methods/ Design	Focus of the evaluation	Responsible Parties	Timetable
NHPP Midterm evaluation	Mixed methods time series study	Outcomes and implementation	HMER/ Central M&E	2017
PMTCT Impact Evaluation	Retrospective cohorts study	Measure Impact	HMER & NACP M&E	2018
ART Survival Study	Retrospective cohorts study	Measure retention & Survival	HMER & NACP M&E	2019
Performance base strategy	Quasi experimental study	Impact and cost effectiveness	HMER/Central M&E	
Community Based Program Evaluation				

Teams of independent in-country institutions, in close collaboration with international consultants with the highest acceptable credibility preferred by the MOH, will be expected to conduct the evaluation.

Evaluations in the health will consider the following dimensions based on type and focus of the evaluation. See table below

Table 5: Evaluation dimensions

a) Access	**b) Utilization**	**c) Coverage**
d) Quality	e) Efficacy	f) Efficiency

g) Effectiveness	h) Cost-effectiveness	i) Cost-benefit

3.6 Data dissemination and use

Information products including monitoring study results will be disseminated through many channels using diverse media to make information accessible and to facility use. Information will be placed in report, printed on postal, newsletter and brochures for wider dissemination. Information products will be burned to CDs and distributed to potential users. Finally, information products will be placed on the MOH's website to be assessable to all including researchers, academics, students, the media and the general public.

Chapter 4: Country mechanisms for review and actions

Lessons learned from sector wide and multi-sectorial approaches to health planning and review elsewhere, show that reviews are crucial for updating all stakeholders on health sector performance and challenges, and building consensus on remedial actions for improvement. [WHO] Periodic reviews is essential and must be inclusive, participatory and transparent.

4.1 Annual national health sector review

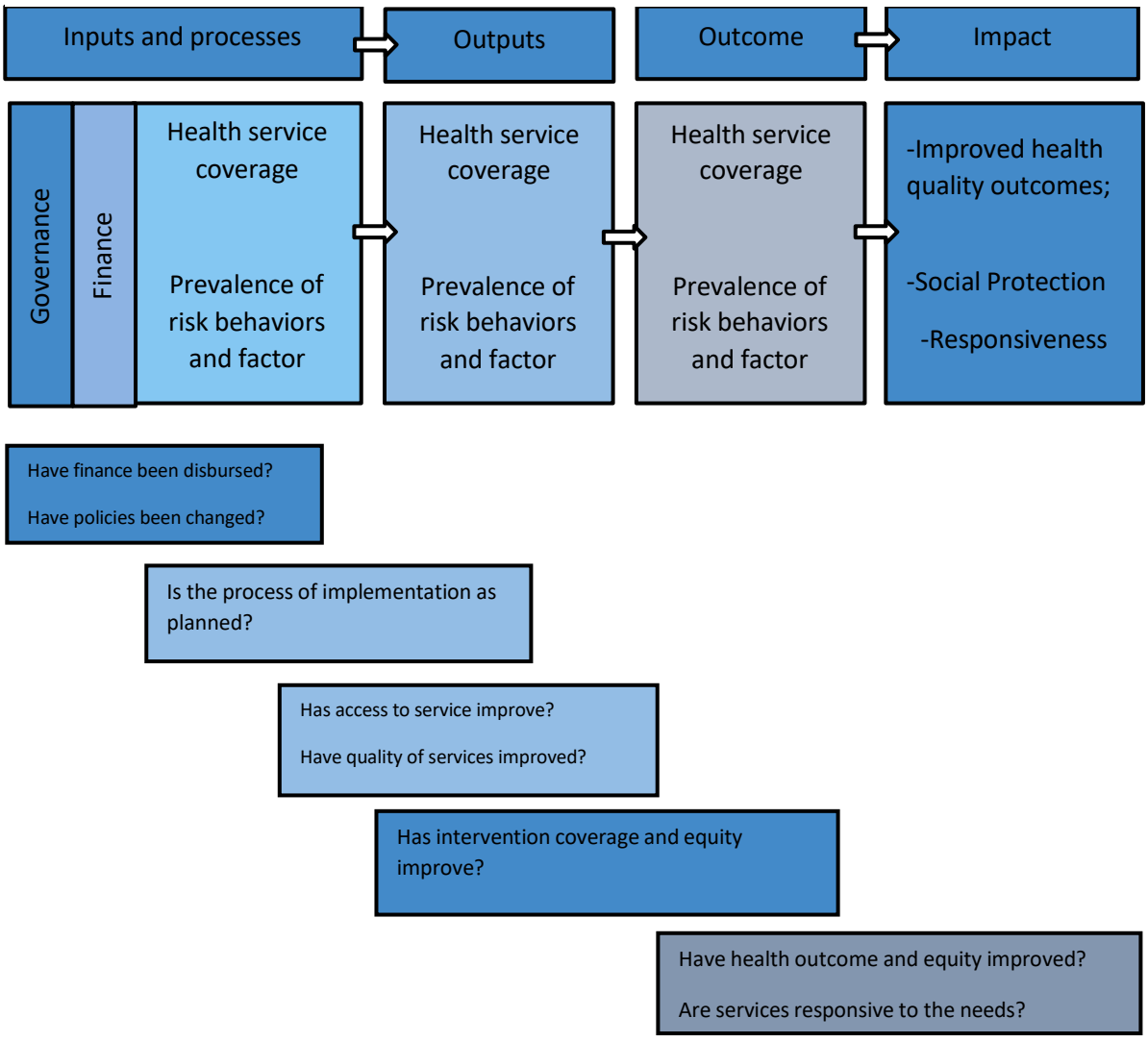
The MOH holds regular quarterly and annual review meetings since 2007 involving all partners. The M&E Unit succeeded in defragmenting quarterly review and coordinating these review meetings. But due to lack of budgetary supports and ineffective coordinating mechanism the quarterly program specific review meetings have been once again fragmented and program specific. The quarterly integrated programs review meetings coordinated by the M&E Unit has been discontinued. However, the annual health sector review is still been held annually but with more emphasis had been placed on the conference than the entire review process itself. But going forward the MOH and partners will conduct comprehensive analysis that takes into account the perspectives of all stakeholders including health managers, service providers, community leaders and service users. Routine data, research and evaluation reports will be synthesized to pint a holistic picture of the health sector performance, challenges, and weakness and strengthens, and to learn lessons for improvement

The annual national review will look at the results chain from output to impact to assess the sector's performance. A transparent data validation process involving key partners will be conducted on the routine data that will be used to measure performances on key indicators. This is to be sure that the results reflect true performances and are not the results of faulty or misleading data.

An annual health review conference will be organized to bring together all health stakeholders around the table to discuss sector performance and challenges, and forge common strategies and

remedial actions to address system weaknesses. The health system analysis will form the agenda for the conference. The NHC will be held in October of every year. All senior staff of the MOH including all County Health Officers will attend. Additionally, health partners, donors, UN Agencies, NGOs, line ministries, the Legislature Committees on Health and civil society organizations shall also be in attendance.

Figure 3: Health sector review framework



Contextual Changes

Non-health system determinant

4.2 Quarterly central performance review

The MOH through the M&E Unit will organize a quarterly review meetings at the end of every quarter to take stock of implementation levels, to assess progress on key deliverables, review service delivery. The MOH quarterly performance dashboard will be presented and form the key agenda items for discussion. It will look at quarterly work plans implementation and deliverables of programs, divisions, Units and partners. The meeting will come up with remedial actions plan to bridge gaps and overcome challenges. It will review action points and recommendations from the annual review and previous quarter reviews. The Central M&E Unit will organize this integrated review.

4.3 Performance Review at County and district Level

The counties are the main implementers of the NHP and Investment Plan; as such the overall performance of the health sector largely depends on them. Therefore the CHTs should keep close watch regularly on what the do and how they do them. The CHT review their performance using their annual operational plan on a quarterly basis to assess progress. Local authorities should be encouraged to participate in these reviews. The central MOH and partners should support the CHTs achieve this.

District level of review is encouraged and should involving the facilities and communities. Big counties with large number of facilities will obviously strengthen the district to do such review since will not be feasible to bring all DHOs and OICs in one place to hold a single county review. It may be difficult to hold an effective conversation if the participants are so many. In such case the CHT should support the districts to hold these reviews.

These review meeting should be a use to have frank conversation, through which challenges can be identified, good practices shared and lessons learned to improve the system performance. These lower level reviews should keep key service including maternal and child health and data quality as key discussion points. Concrete decisions should be taken to enhance health service delivery and system strengthening.

4.2 Program-specific reviews and linkages to national review

National program-specific reviews may be carried out but must be linked to the overall health sector review and contribute to it. Program-specific review should be conducted prior to the overall health

sector review, and help inform the content of the health sector review in relation to that specific program area. It is important that the specific program reviews involve academics and researchers not involved in the program itself to obtain an objective review of progress and assess contest specific recommendations in the literature for possible consideration in strengthen program implementation and outcomes.

Chapter 5: Coordination, and stakeholders roles and responsibility

5.1 Coordination mechanisms

The Health Sector Coordinating Committee (HSCC) is the highest governance and partnership coordination body of the health sector. The HSCC serves as a forum for dialogue on health sector policy involving the Liberian Government, development partners, professional associations, civil society and other stakeholders.

There are specialized coordination mechanisms in the health sector including the Health Information system, Monitoring and Evaluation and Research Coordination Committee (HMERCC) and Technical Working Group (HMERTWG) to coordinate HMIS, M&E and Research Activities at the policy and operational levels.

The HMERCC is the higher policy level body for HIS, M&E and Research in the health sector. It is comprised of Assistant ministers, head of programs, key directors and Donor institutions including key UN Agencies, multilateral and bilateral agencies and other government agencies including the National Statistics House; and is chaired by the Assistant Minister of Health for Statistics. See list of Membership in Annex 3 and ***Term of Reference in Annex 3.1***

The HMERTWG) is the coordination forum at the operational level focusing more on technical issues including support for the development of technical documents and standards. The HMERTWG is comprised of HMIS, M&E and Research professionals including those in the national programs. M&E heads of all NGOs implementing health programs in Liberia and technical personals of donor institutions are members. The HMER Division Coordinator chairs the TWG. See list of Membership in Annex 4 ***Term of Reference in Annex 4.1*** Additionally, Coordination takes place at the decentralized level through county Health Board and Health coordination meeting with Partners. However, coordination for M&E and Research has not taken off at the county except for the FARA supported counties. Lessons from those three counties will be passed unto the rest of the country to established coordination in forum in all of the counties for HIS, M&E and Research.

5.2 Stakeholders Roles and responsibilities in M&E

Roles of donor institutions

Donor institutions will provide resources to strengthen the MOH M&E System and ensure it implementing partners do not undermine the one M&E system or introduce vertical reporting or develop duplicate information system. They will participate in HMERCC in driving M&E and review policy wise.

Roles of development NGOs

NGO partners in health work in closed collaboration with the Ministry of Health and are expected

to comply with Government policies and guidelines. NGOs are required to comply straightly with the MOH's M&E Policy and uphold the one M&E principle subscribed to by the MOH. NGOs will use standardized data collection and reporting format and follow specified processes and procedures. The NGOs are to support MOH's M&E system and use it to meet their own information needs. They will fully participate in HMERTWG meetings and use available technical and financial resources at their disposal to strengthen the MOH's integrated M&E System. NGOs will support MOH's capacity building efforts for M&E at every levels of the health system.

Roles of the Liberia Institute of Statistics and Geo Information Services (LISGIS)

LISGIS is the government's institution responsible for coordination, harmonization and improvement of national statistics and to track national development agenda including the AfT and SDGs. LISGIS conducts national Studies including Census, Demographic and Health Survey among others. It provides population based and spatial data that are useful to the MOH, and monitors the MOH's impact indicators through the DHS. It is a member of the HMERCCC.

Roles of A.M. Doglotii College of Medicine

The University of Liberia's A. M. Dogloti College of Medicine, in addition to its primary mandate of capacity building and research in Health, it will collaborates with the MOH, and partners in supporting evaluation. For the past six years, the School has collaborated with the MOH to run the two-year epidemiology and biostatistics training programs. It is a member of the HMERCC.

Chapter 6: M&E Capacity and Capacity building

6.1 M&E System assessment

The effective M&E of the health system requires capacity at all levels, from central to the county and down to the facility and community. This capacity includes capable and motivated human resource and other inputs including M&E tools, resources and logistics.

The MOH conducts assessments to measure the level of capacity for M&E from time to time. An M&E System Assessment was done in August of 2016 focusing on the County level. This assessment followed and compliments the HIS assessment done in 2015 by MEASURE Evaluation for the MOH. Highlights of weaknesses and gaps identified by these assessments are in the situational analysis section of this document above and Health Information System Assessment (Health Information System ICT Infrastructure Assessment In Liberia, 2015).

6.2 Capacity building for M&E

The M&E System Assessment Report recommended key interventions to strengthen M&E. Those are in addition to those outlined in HIS Strategy and Operational Plan.[Ref] Recommended interventions have been prioritized in the M&E strategy to compliment, not to duplicate those in the HIS Strategy. See section 7 of the document for capacity building strategies for M&E.

Chapter 7: Monitoring & Evaluation and review strategies

Based on the capacity gaps identified, priority interventions have been identifies to strengthen capacities for M&E at all levels. Interventions presented in this section compliment those outlined in the MOH Health Information System Strategy and Operational Plan.[Ref] The interventions are presented alone the seven objectives below:

1. To strengthen human resource capacity for effective monitoring and review at every level of the health system systems.
2. To strengthen institutional capacity to effectively monitor the implementation and outcomes of the national Health Policy and Plans through routine assessment of service deliveries, access to and utilization of health services and quality of health services.
3. To promote access to information, feedbacks and improve data use for planning, resource allocation and ongoing management decision making at all levels of the health system
4. To periodically evaluate the health policy, plans, programs and interventions to explain outcomes achieved, impacts made, document good practices and institutionalize institutional learning and development
5. To improve stakeholders coordination in support of one M&E system

7.1 Strategic objective 1: Strengthen Human Resources for M&E

To strengthen human resource capacity for effective monitoring and review at every level of the health system.

- Train 15 Counties M&E teams (45 people) with curriculum based on core M&E functions including data validation, analysis and interpretation, information packaging and presentation);
- Train M&E focal points at district level in the data validation, basic analysis and presentation to facilitate data use for decision making);
- Train ten Central HMER staff in data analysis and interpretation and presentation;
- Train central M&E Staff in Policy analysis and writing policy brief to transform information products from data into policy to influence policy decisions;
- Set up a local M&E training program in partnership with local training institution to produce M&E professional on an ongoing basis (develop curriculum and mobilize resources);
- Organize M&E annual seminar for the exchange of knowledge, lessons learn and best M&E practices;

- Conduct cascaded mentoring for county and district M&E staff to reinforce skills acquired from training;

- Organize seminars for program managers and units head to enhance the culture of evidence-based decision-making.

7.2 Strategic objective 2: Strengthen institutional capacity for M&E

To strengthen institutional capacity to effectively monitor the implementation and outcomes of the national Health Policy and Plans through routine assessment of service deliveries, access to and utilization of health services and quality of health services.

- Conduct M&E System Strengthening Assessment at central and county levels to inform M&E Strategy and Plan review;

- Use annual data quality audit (DQA) to evaluate routine data quality at county, district and facility levels;

- Revise and disseminate M&E strategy and implementation Plan beyond 2021;

- Develop, print and disseminate indicators reference book

- Mobilized resources to secure logistics and support M&E Units at central and decentralized levels with needed equipment and logistics (computers, lap-tops, soft-ware and internet facilities);

- Procure vehicles to facilitate monitoring visits, M&E supervision and mentoring at the lower levels;

- Procure motorcycles for M&E teams at the local levels to facilitate monitoring and data quality checks;

- Provide maintenance, insurance, fuel and lubricants for central and decentralized M&E activities

7.3 Strategic objective 3: Improve access to information and promote data use

To improve access to information, feedbacks and promote data use for planning, resource allocation and ongoing management decision making at all levels of the health system

- Print and disseminate the national M&E documents including the M&E Policy Strategy and Plan to every level of the health system

- Conduct comprehensive analysis of data from diverse data sources to make valuable information available to health managers at every levels of the health system.

- Produce different kinds of information products packaged and presented in ways that meet the information needs of managers and service providers at different level of the health system.

- Produce policy briefs to influence policies and management decision making

- Build health managers' capacity at every level of the health system to demand and use information for ongoing decision-making and institutionalize the culture of evidence based management in the health sector

- Use the MOH website to make health information accessible to all stakeholders including health managers, training institutions (students and lecturers), researchers and the general public.

- Maintain two ways communication between the M&E Unit and all other stakeholders to receive feedbacks for learning, improvement and change.

7.4 Strategic objective 4: Coordinate and conduct systematic evaluations

To periodically evaluate the health policy, plans, programs and interventions to explain outcomes achieved, impacts made, document good practices and institutionalize result accountability, organizational learning and development

- Strengthen capacities for evaluations through peer mentorship by doing joint evaluation with experienced external evaluators through collaboration to conduct evaluation jointly

- Provide short-term training courses and fellowships for M&E staff to enhance their evaluation capabilities

- Coordinate all internal and external evaluations in the health sector, including NGOs evaluation projects to ensure standards and international best practices are followed and quality assured,

- Conduct program specific evaluation to inform programs review and improvement.

7.5 Strategic objective 5: Improve coordination

To improve stakeholders coordination to support and strengthen the MOH one M&E system

- Organize and hold quarter HMERCC meeting around M&E related policies, key decisions and to mobilize resources for M&E in the health sector at all levels.

- Organize and hold monthly HMERTWG meetings with all technical stakeholders to ensure harmonization avoid duplication and parallel systems.

- Support CHTs to establish and hold regular HMERTWG meetings at their levels involving all NGOs and key line ministries and agencies.

Chapter 8: Activities plan and budget

Work Plan and Budget

No	Objectives and Activities	Timetable & Budget					Total Budget for 5 years	Responsible Unit
		2016/2017	2017/2018	2018/2019	2019/2020	2020/2021		
1.0 **To strengthen human resource capacity for effective monitoring, evaluation and review at every level of the health system**								
1.1	Train 15 Counties M&E teams (45 people) with curriculum based on core M&E functions including data validation, analysis and interpretation, information packaging and presentation);	85,500	0.00	0.00	66,300	0.00	151,800.00	Central M&E and HIS
1.2	Develop training curriculum and materials based on needs identified through assessments	3000	0.00	0.00	0.00	0.00	3,000.00	Central M&E
1.3	Build ten Central HMER staff capacity in data analysis and interpretation, policy analysis and evaluation ;	125,000	24,880	24,880	24,880	24,880	224,520.00	Central M&E
1.4	Trained County M&E Team (TOT) to Train district Health team in data validation, analysis and interpretation and data use for decision-making	0.00	36,890	0.00	0.00	0.00	36,890.00	Central M&E and HIS
1.5	Support CHT M&E teams to train 91 districts teams in data validation, analysis and interpretation and data use for decision-making	0.00	75,000	0.00	0.00	80,000	155,000.00	Central M&E and HIS
1.6	Set up a local M&E training program in partnership with local training institution to produce M&E professional on an ongoing basis (develop curriculum and mobilize resources);	175,000	200,000	200,000	200,000	200,000	975,000.00	Central M&E

No	Objectives and Activities	Timetable & Budget					Total Budget for 5 years	Responsible Unit
		2016/2017	2017/2018	2018/2019	2019/2020	2020/2021		
1.7	Organize M&E annual seminar for the exchange of knowledge, lessons learn and best M&E practices	67,000	67,000	80,000	80,000	80,000	374,000.00	Central M&E
1.8	Organize seminars for program managers and units head to enhance the culture of evidence-based decision-making.	38,000	38,000	38,000	38,000	38,000	190,000.00	Central M&E
1.9	Conduct on-site mentoring in all counties to transfer skills and build M&E staff confidence in handling day to-day M&E functions	48,650	48,650	48,650	48,650	48,650	243,250.00	Central M&E
	Sub-total	**542,150**	**490,420**	**391,530**	**457,830**	**471,530**	**2,353,460.00**	

2. To strengthen institutional capacity to effectively monitor the implementation and outcomes of the national Health Policy and Plans through routine assessment of service deliveries, access to and utilization of health services and quality of health services.								
No	**Objectives and Activities**	**Timetable & Budget**					**Total Budget for 5 years**	**Responsible Unit**
		2016/2017	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**		
2.1	Conduct M&E System Assessment at central and county levels to inform M&E Strategy and Plan review;	0.00	0.00	0.00	58,900	0.00	58,900.00	Central M&E
2.2	Use (DQA) to evaluate routine data quality at county, district and facility levels;	86,000	86,000	86,000	86,000	86,000	430,000.00	Central M&E
2.3	Revise M&E policy, strategy and implementation Plan	0.00	0.00	0.00	91,000	0.00	91,000.00	Central M&E
2.4	Update, print and disseminate indicators reference book	0.00	0.00	0.00	46,000	0.00	46,000.00	Central M&E
2.5	Provide computers, lap-tops, soft-ware and internet facilities for county M&E teams	89,060	53,000	53,000	40,000	90,560	325,620.00	Central M&E

2. To strengthen institutional capacity to effectively monitor the implementation and outcomes of the national Health Policy and Plans through routine assessment of service deliveries, access to and utilization of health services and quality of health services.								
No	**Objectives and Activities**	**Timetable & Budget**					**Total Budget for 5 years**	**Responsible Unit**
		2016/2017	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**		
2.6	Procure vehicles, insurance and maintenance to for central M&E Unit	69,000	0.00	70,540	0.00	70,000	209,540.00	Central M&E
2.7	Procure Motorcycles, spare parts and insurance for County M&E team (2 bikes per county)	0.00	0.00	0.00	90,000	0.00	90,000.00	Central M&E
2.8	Refurbish and procure furniture and fixtures for M&E offices,	0.00	23,000	0.00	0.00	25,000	48,000.00	Central M&E
2.9	Procure office supplies, internet subscription, (computer, routers, stationery etc.) for central M&E Unit	0.00	10,000	7300	8000	12,865	38,165.00	Central M&E
2.10	Procure logistics (Fuel, Phone cards) for Central M&E Unit	0.00	21,300	23000	23,580	25,000	92,880.00	Central M&E
	Sub-total	**0.00**	**21,300**	**23000**	**23,580**	**25,000**	**1,430,105.00**	

3. To improve access to information, feedbacks and promote data use for planning, resource allocation and ongoing management decision making at all levels of the health system								
No	**Objectives and Activities**	**Timetable & Budget**					**Total Budget for 5 years**	**Responsible Unit**
		2016/2017	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**		
3.1	Produce quarterly and annual reports of health service system performance (Print information products)	13,200	13,200	13,200	13,200	13,200	66,000.00	Central M&E
3.2	Build strategic analysis capacities to produce information products that meet the needs of all stakeholders	23,660	20,890	18,700	16,400	16,400	96,050.00	Central M&E
3.4	Make the Strategic Information and Analytics Center functional to serve as the information hub (one stop shop) for the MOH	10,250	10,250	10,250	10,250	10,250	51,250.00	Central M&E
3.5	Build health managers' capacity at every level of the health system to demand for and use data for decision making	140,330	140,330	140,330	140,330	140,330	701,650.00	Central M&E
3.5	Leverage the score cards and dashboard capabilities in DHIS-2 and build managers capacity to access and use data for ongoing decision making	0.00	0.00	167,000	178,200	150,230	125,200.00	Central M&E & HMIS
	Sub-total	**140,330**	**140,330**	**140,330**	**140,330**	**140,330**	**701,650.00**	

4.0 To conduct routine Monitoring, periodic, evaluation and review of the health policy, plans, programs and interventions to explain outcomes achieved, impacts made and document good practices								
No	**Objectives and Activities**	**Timetable & Budget**					**Total Budget for 5 years**	**Responsible Unit**
		2016/2017	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**		
4.1	Conduct monitoring and verification of implementation with CHTs, and other implementing partners in counties on a quarterly basis	64,880	64,880	64,880	64,880	64,880	324,400.00	Central M&E
4.2	Hold quarterly integrated central level performance review meetings	160,000	160,000	160,000	160,000	160,000	800,000.00	Central M&E
4.3	MOH support to the Liberia Demographic and health survey	0.00	0.00	500,000	0.00	0.00	0.00	Central M&E & Research
4.4	Liberia Malaria Indicator Survey	567,890	0.00	0.00	586,900	0.00	115,4790.00	NMCP M&E
4.5	Review of TB/HIV collaborative program	0.00	77,300	0.00	0.00	110,890	188,190.00	NLTCP,NACP& HMER
4.6	HIV Clients survival monitoring study (ART)	0.00	**80600**	0.00	0.00	**89,460**	**170060.00**	NACP & HMER

4.0 To conduct routine Monitoring, periodic, evaluation and review of the health policy, plans, programs and interventions to explain outcomes achieved, impacts made and document good practices								
No	**Objectives and Activities**	**Timetable & Budget**					**Total Budget for 5 years**	**Responsible Unit**
		2016/2017	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**		
4.7	Antenatal Care (ANC) HIV prevalence Survey (PMTCT)	0.00	88,000	88,000	88,000	88,000	264,000.00	NACP AND M&E
4.8	Conduct Service Availability Readiness Assessment (SARRA)	368,000	368,000	368,000	368,000	368,000	1,840,000.00	Central M&E
4.9	Conduct National health account study (NHA)	136,332	136,332	136,332	136,332	136,332	681,657.50	Health financing
4.10	Conduct evaluation of the National Health Policy and plan (Mid-term and end-line evaluation)	150,900	0.00	0.00	0.00	180,000	330,900.00	Central M&E
4.11	Evaluation of the MOH Performance Based Strategy	0.00	168,560	0.00	0.00	170,340	0.00	Central M&E
4.12	Impact Evaluation of the PMTCT program	0.00	0.00	111,400	0.00	0.00	111,4000	Central & Program M&E
4.13	Evaluation of the Community Health Assistant Program evaluation	0.00	150900	0.00	0.00	170000	320,900.00	Central & Program M&E

4.0 To conduct routine Monitoring, periodic, evaluation and review of the health policy, plans, programs and interventions to explain outcomes achieved, impacts made and document good practices								
No	**Objectives and Activities**	**Timetable & Budget**					**Total Budget for 5 years**	**Responsible Unit**
		2016/2017	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**		
4.14	National AIDS expenditure monitoring	0.00	102,225	0.00	102,225	0.00	204,450.00	HF
4.15	Conduct ANC survey to monitor HIV infection among pregnant women		91,600	0.00	0.00	0.00	91,600	Central & Program M&E
4.16	HIV integrated Bio-behavioral monitoring study	0.00	0.00	252933	0.00	0.00	252933	Central & Program M&E
4.17	Designed electronic patience database starting with high volume HIV& TB facilities (hospital level)	0.00	0.00	0.00	$131,220	0.00	$131,220.00	Central & Program M&E
	Sub-total	655,231.50	592,331.50	1,092,331.50	592,331.50	772,331.50	3,704,557.50	

5.0 To strengthen stakeholders coordination in support of one M&E system								
No	**Objectives and Activities**	**Timetable & Budget**					**Total Budget for 5 years**	**Responsible Unit**
		2016/2017	**2017/2018**	**2018/2019**	**2019/2020**	**2020/2021**		
5.1	Hold quarterly HIS, M&E and Research Coordination Committee meeting around M&E related issues	2800	2800	2800	2800	2800	14,000.00	M&E,HIS & Research
5.2	Hold monthly HMERTWG meetings with all technical stakeholders	3500	3500	3500	3500	3500	17,500.00	M&E,HIS & Research
5.3	Support CHTs to establish and hold regular HMERTWG meetings at their levels involving all NGOs and key line ministries and agencies.	0.00	5000	5000	5000	5000	25,000.00	Central M&E
	Sub-total	**11300.00**	**11300.00**	**11300.00**	**11300.00**	**11300.00**	**56500.00**	
	Grand total	**19800.00**	**19800.00**	**19800.00**	**19800.00**	**19800.00**	**$99,000.00**	

Annex 1: MOH health sector Performance framework

Sn	Indicators	Baseline		Annual targets					Frequency	Data Sources
1	Total Couple Years Protection (All methods)	166714.9	HMIS 2015/16						Quarterly	HMIS
2	Contraceptive prevalence rate	19%	DHS 2013	-	24	-	-	27	5 years	
2	Percentage of pregnant mothers attending 4 ANC visits	54.4	Annual Report 2013	59	64	68	72	76	Quarterly/ 3−5 year	HMIS LDHS
3	Percentage of pregnant mothers receiving IPT-2	48	LDHS 2013	60	65	70	75	80	Quarterly/ yearly 2	LMIS/ HMIS
4	Percentage of HIV positive pregnant women who have received complete course of ARV prophylaxis or ART to reduce the risk of MTCT	47%	2014	55%	60	65	70	75%	Quarterly	HMIS& Spectrum
5	Percentage of deliveries attended by skilled personnel	61	LDHS 2013	63	65	68	70	72	Quarterly/ Biennially	LDHS
6	Percentage of infant born to HIV-infected mothers who are infected	8%	2015	5%	3%	2%	0%	0%	Quarterly/ Annually	HMIS
7	Percentage of infants fully immunized	65	Annual Report 2013	68	68	70	72	75	Quarterly/ Annually	LDHS
8	Percentage of children zero to five months of age exclusively breast fed									
9	Proportion of children one year old immunized against measles			70	78	83	87	90		

Sn	Indicators	Baseline	Annual targets		Frequency	Data Sources
10	National acute flaccid paralysis (none polio AFP) rate / 100,000	3.3	2011		Annual	
11	TB case detection rate (all forms)	56	AR/TB, 2013	75	Annually	HMIS
12	Percentage of Children under five years treated for severe malaria				Quarterly	HMIS
13	Percentage of sleeping places covered with LLINs					
14	Treatment Success rate among smear positive TB cases (Under Directly Observed Treatment Short Course)	85%	HMIS 2013		Quarterly	HMIS
15	% of health facilities (public and private) meeting minimum IPC standards					
16	Percent of Clients expressing Satisfaction with health services (KPI)					
16	Coverage of tracer interventions (e.g. child full immunization, antiretroviral therapy, tuberculosis treatment, hypertension treatment, skilled attendant at birth, etc.)	%				

Sn	Indicators	Baseline		Annual targets					Frequency	Data Sources
17	Percentage of population living within 5 km from the nearest health facility	71	(DHS, 2013)	73	74	76	78	80	Annually	DHS, Health Facility Survey
18	Proportion of counties with public health risks and resources mapped	%	TBD					90	Annually	IDSR Assessment and Planning (DSIS)
19	Percentage of new / re-emerging health events responded to within 48 hours as per IHR regulations	%	TBD					80	Annually	DSIS
20	Functional Health facilities per 10,000 persons	1.63 /10,000	(HSA, 2015)	1.7	1.8	1.9	2	2	Annual	SARA Survey
21	Percentage of health facilities with all utilities, ready to provide services (water, electricity)	55	(HSA, 2015)	60	65	70	75	80	Annual	Health Facility Survey (SARA)
22	Percentage of counties with funded outbreak preparedness and response plans	%	(IDSR, 2014)	100	100	100	100	90	Annual	IDSR Assessment and Planning (DSIS)

Sn	Indicators	Baseline		Annual targets					Frequency	Data Sources
23	Percentage of counties reporting information using event based surveillance	%	(IDSR, 2014)	100	100	100	100	100	Quarterly	DSIS (Weekly Bulletin)
24	Percentage of health facilities with no stock-outs of tracer drugs at any given time (amoxicillin, cotrimoxazole, paracetamol, ORS, iron folate, ACT, FP commodity)	62.3 %	Accreditation, 2011	66	70	75	80	85	Annually	(SARA)
25	OPD consultations per inhabitant per year	1.9	LDHS, 2013	1.9	1.9	2	2	2	Annually	HMIS
26	Percentage of facilities practicing IPC according to standards	%65	HSA, 2014	70	75	80	90	100	Annually	JISS
27	Skilled health workforce (physicians, nurses, midwives, physician assistants) per 1,000 persons	8.6/ 10,000	Personnel, 2015	9	9.5	10.	10.5	11	Annually	iHRIS
28	Number of counties that held monthly County health coordination meeting with partners	Meeting minutes						15	Monitoring visits	

Sn	Indicators	Baseline	Annual targets				Frequency	Data Sources
29	Proportion of health facilities with at least Two skilled health workers	Monitoring and Supervision report	85	90	95	100%	Monitoring and supervision to facilities	Planning
30	Proportion of health workers on government payroll	GOL Payroll					Payroll review	Personnel
32	Percentage of population living within 5 km from the nearest health facility	Annual assessment						
33	Health service utilization per capita							
34	Timeliness of routine facility based data	36%	(AR, 2013)			75	Monthly/ Quarterly	HMIS
35	Proportion of facilities with accurate HMIS reports	36 %	(AR, 2013)			75	Monthly/ Quarterly	HMIS
36	Percentage of communities beyond 5 kms to the nearest facility with two or more community health volunteers	28%	(CMR, 2013)			75	Annual?	Community Mapping
37	Proportion of health facility with functional community health committees	25%	(AR, 2013)			80	Annual?	Community Mapping
38	Proportion of counties with fully established and functional district health teams	%					Annually	

Sn	Indicators	Baseline	Annual targets		Frequency	Data Sources
39	Number of counties that held at least one board meeting per quarter	number of counties	0 (AR)		Annual	Annual Report
40	Per capita public health expenditure in USD	USD	65 (AR, 2013)	70	Annual	NHA
41	Public health expenditure as % of total public expenditure	%	12.3 (AR, 2013)	15	Annual	NHA

Annex 2: Participants at the 2016 M&E policy and strategy review working session

No	Names	Organization	Email
1	George P. Jacobs	Director M&E, MOH	*geopocobs@yahoo.com*
2.	C. Sanford Wesseh	Asst. Minister, MOH	*cswesseh@yahoo.com*
3.	Luke L. Bawo, Jr.	HMER Coordinator	*lukebawo@gmail.com*
4.	Benedict C. Harris	Asst. Minister, MOH	*cbenedictharris@gmail.com*
6.	Dr. Clement Peter	WHO	*clementp@who.int*
7.	Joe S. Kerkula	M&E Officer, MOH	*joeskerkula@yahoo.com*
8.	J. Mike Mulbah	M&E Officer	*j.mike.mulbah@gmail.com*
9.	Martin Dumoe	Director, Planning	*martindumoe@yahoo.com*
10.	Roland Nyanama	M&E Officer, MOH	*rnyanama@gmail.com*
11	Alexander Blidi	M&E Director CSH	*ablidi@cshliberia.org*
12	Jerome Korvah	M&E Officer, MOH	*Jk86korvah@gmail.com*
13	Janjay Jones	M&E Manager NACP	*Mjanjay@yahoo.com*
14	Eugene Wickett	M&E Director, Partner In Health (PIH)	*ewickett@pih.org*
15	Nick Gordon	M&E Officer Last Mile Health (LMH)	*ngordon@lastmilehealth.org*

Annex 3: HMER Coordination Committee members

No	Position	Institution
1	Chair	Assistant Minister for Vital Statistics, MOH
2	Co-chair	World Health Organization (WHO)
3	Secretary	HMIS, M&E and Research Coordinator
4	Member	Assistant Minister for preventive services (MOH)
5	Member	Assistant Minister for Planning and Policy (MOH)
6	Member	Assistant Ministration for Administration (MOH)
7	Member	Assistant Minister for Planning, MOH
8	Member	Assistant Minister for Curative Services, MOH
9	Member	Assistant Minster for Preventive Services, MOH
10	Member	Liberia Institute of Statistics & Geo Information Services (LISGIS)
11	Member	A.M. Dogliotti Collage of Medicine & School of Pharmacy, UL
12	Member	Cuttington University Graduate School of Public Health
13	Member	Liberia Medical and Dental Council (LMDC)
14	Member	National AIDS Commission (NAC)
15	Member	Japan International Cooperation Agency (JICA)
16	Member	World Bank Country Office (Health Section)
17	Member	USAID (Health team lead)
18	Member	United Nations Population Funds
19	Member	NGOs Representative
20	Member	Catholic Health Secretariat
21	Member	United Methodist Health Committee
22	Member	Liberia Public Health Institute
23	Member	Christian Health Association of Liberia
24	Member	United Nations Children Endowment Fund
25	Member	Pool Fund Manager/MOH
26	Member	J.F.K. Hospital (Administration)
27	Member	St. Joseph Catholic Hospital (Administration)
28	Member	HIM Director
29	Member	Research Director
30	Member	M&E Director

Annex 3.1 *Terms of Reference for the HMER Coordination Committee (HMERCC)*

Ministry of Health

Background and purpose

The MOH Monitoring and Evaluation Policy and Strategy mandates the establishment of a National Health Information, Monitoring, Evaluation and Research Technical Working Group. The role and functions of the National Health Information, Monitoring, Evaluation and Research Technical Working Group (HMER/TWG) is to provide policy direction and technical guidance for the development and implementation of Health Management Information System, Monitoring and Evaluation framework and Research Policy. Henceforth, this HMER/TWG is expected to discuss and amicably bring to closure of all issues arising from the implementation of strategic interventions and activities of the Units making up the HMER. In the situation, where the TWG is unable to resolve an issue or issues due to factors beyond her scope and workings, the unresolved issue or issues is or are automatically forwarded to the Health Information, Monitoring and Evaluation and Research Coordination Committee (HMERCC).

In line with the M&E Policy and strategy, the HMERCC provides the platform at which all unfinished businesses of the HIS, M&E and Research can be mitigated. However, issues that cannot be resolved at this level will be elevated further.

Composition and Mandate

The National HMERCC should be comprised of Assistant Ministers, program Managers, senior strategic officer or deputy director of the national statistics house, Director or deputy of Medical Training Institutions, key donor agencies and Senior NGO representatives. The HMERCC meets once in every quarter to discuss plans, key activities, implementation and challenges related to Health Management Information System (HMIS), Monitoring and Evaluation (M&E) and Research and strategically advise the HMER Division. The HMERCC will support and ensure better coordination in support of one M&E, one Research and one information System for the Health sector.

Objectives

1. Provide guidance and leadership for the development and implementation of Health Information System Strategy, Monitoring and Evaluation Plan and Research Policy
2. Coordinate and mobilize resources and interventions between stakeholders supporting HIS, M&E, and Research

Responsibilities

1) Assess, validate, and endorse technical recommendations from the HMER TWG
2) Assess, validate, and elevate policy recommendations to the HSCC

3) Monitor and evaluate implementation of HIS, M&E, and Research programs to ensure transparency, coordination, and accountability
4) Provide oversight for the development of SOP, trainers guide and other related tools to HIS, M&E and Research
5) Validate core list of national health indicators
6) Ensure health research follows national IRB policies and guidelines

7) Ensure alignment and effectiveness of resources and interventions to appropriate strategies and policies
8) Coordinate monitoring, evaluation and review mechanisms and processes in relation to the implementation of the National Health Policy and Plans
9) Advocate for evidenced-based decision-making and resource allocation

10) Provide technical input to inter-sectorial and international efforts in improving health information system and reporting health related information such as SDGs.

Reporting

The HMERCC reports to the Health Sector Coordination Committee (HSCC).

Membership

The HMERCC will be attended by principal opinion leaders in the following organizations:

- Ministry of Health
- Donors; including CDC, USAID, World Bank, Global Fund and others
- Relevant UN Agencies, including WHO, UNICEF
- Representatives from key NGOs

The HMERCC should be chaired by Assistant Minister for Statistics, and co-chaired by the coordinator for HMER.

Frequency of Meetings

The HMERCC will meet routinely, once every quarterly basis.

Amendments to the Terms of Reference (TOR)

This document is subject to amendment whenever the body decides to do so. The existing document will be circulated at a given time and the membership will be allotted time to make inputs for discussions and consensus building in a given sitting at given point in time.

Schedule for Amendments:

Series No.	Dates	Activities
1.	June 2014	First Amendment Session
2.	March 2016	Second Amendment Session
3.		Third Amendment Session

Annex 4: HMER Technical Working Group

No	Position	Institution
1	Chair	HMIS, M&E and Research Coordinator
2	Co-chair	M&E Director
3	Secretary	Research Director
4	Assistant Secretary	HIS Director
5	Member	County Health Services Director
6	Member	Pool Fund Manager
7	Member	Liberia Institute of Statistics & Geo Information Services (LISGIS)/Technician
8	Member	National AIDS Control Program
9	Member	Liberia Medical and Dental Council (LMDC)
10	Member	National AIDS Commission (NAC)
11	Member	Family Health Division Director
12	Member	Neglected Tropical Diseases Program Manager
13	Member	Non Communicable Diseases Program Manager
14	Member	Quality Management Unit Director
15	Member	USAID (Health Team)
16	Member	United Nations Population Funds
17	Member	Representative of Implementing NGOs
18	Member	Community Health Division Director
18	Member	Infrastructure Unit Director
19	Member	Expanded program on Immunization Program Manager
20	Member	Global Fund Program manager (MOH)
21	Member	National AISD and STI Control Program
22	Member	Liberia Public Health Institute
23	Member	National Leprosy and TB Control Program
24	Member	National Malaria Control Program (NMCP)
25	Member	FARA Manager (MOH)
26	Member	PBF Manager (MOH)
27	Member	Pool Fund Manager (MOH)
28	Member	John F. Kennedy Memorial Hospital
29	Member	St. Joseph Catholic Hospital
30	Member	Mental Health Director
31	Member	Nutrition Unit Director
32	Member	ICT Unit Director
33	Member	National Public Health Institute of Liberia
34	Member	Supply Chain Management Unit Director
35	Member	Health Financing Unit Director
36	Member	Decentralization Unit Director
37	Member	Human Resources Division Director

Annex 4.1: Terms of Reference for the HMER Technical Working Group (HMERTWG)

Ministry of Health

Terms of Reference for the HMER Technical Working Group (HMERTWG)

Background and purpose

The HIS and ICT Strategy 2016-2021 and National M&E Strategy mandate the establishment of a National Health Information System and ICT Technical Working Sub-group (HISTWG). These documents motivate the establishment and the roles and functions of the National Health Information System, M&E and Research Technical Working Group (HMER/TWG). The HMER/TWG is to provide technical recommendations, development and implementation of the national health information system, ICT infrastructure, health research, and monitoring and evaluation of health programs and population interventions.

Objectives

1. Coordinate HMER subgroups (ie. HIS subsystems, monitoring and evaluation, research, etc.) and liaise with internal and external stakeholders
2. Review and validate subgroup technical recommendations and provide forum for decision-making and seeking further clarification from technical advisors
3. Monitor implementation of strategic plans, activities and pilots,
4. Identify gaps and overlaps in the implementation of HIS, M&E, and research programs, and report to the HMERCC

Responsibilities

- Provide a forum for reporting ongoing activities and operational plans by subgroups
- Validate recommendations on software platforms, procurement, and proposed capacity building trainings in line with the overall strategy and HIS interoperability
- Develop SOPs, trainers guide and other tools related to HMIS, M&E and Research
- Develop and update national health indicators
- Advocate and promote information use for decision-making and resource allocation;
- Review and validate tools for monitoring and public health research

Reporting

All HIS, ICT, M&E, and health research related groups will report to the HMERTWG. The HMER/TWG reports to the HMERCC.

Membership

The HMER/TWG shall be attended by:

- Ministry of Health: i.e., HMER, ICT, Disease-specific Programs (NMCP, NLTCP, NACP and other Ministry of Health Division and Units that may attend to present and discuss technical issues as applicable.
- External technical partners, including:
    - NGOs; Carter Center, CDC, PIH, LMH, CHAI, MCSP, FHI 360,
    - USAID
    - UN technical partners including; WHO, UNICEF, UNFPA
    - all others implementing areas of the HIS, M&E, or Research Strategies

The HMER/TWG should be chaired by the HMER Coordinator.

Frequency of Meetings

The HMER/TWG will meet routinely on a monthly basis (particularly, on the first Thursday).

Amendments to the Terms of Reference (TOR):

This document is subject to amendment. Whenever the majority of the membership is not comfortable with any part of the document and decides to amend it, a sitting is called and a decision is reached to amend it. Below is a table of Amendments the document has undergone.

Series No.	Date of Amendments	Activities
4.	June 2014	First Amendment
5.	March 2016	Second Amendment
6.	August 9, 2018	Third Amendment

7.1 References

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