Annex 1 – Terms of Reference

Terms of Reference for the Interagency Health Evaluation in Liberia

I. Humanitarian Crisis and Health Sector Background

*= Adjusted from source: WHO report by Dr James Teprey, April 2005

Country Profile[*]

Liberia lies at Western coast of Africa flanked to the West by Sierra Leone, to the East by Côte d'Ivoire, to the North by Guinea. Liberia is divided in to 5 regions, 15 counties and 88 health districts. There are more than 200 chiefdoms, 200 clans and 3,694 towns and human settlements.

The last population census was conducted in 1984. Projections made from the 1984 census estimates the population at 3.3 million with a population growth rate of 2.5% in 2005. With illiteracy rate as high as 75%, poor water, sanitation and hygiene issues have been compromised.

The Vital statistics of Liberia show that the country is among the least in the world. Life expectancy has reduced from 55 years two decades ago to 47.7 in 2002. The total fertility rate is 6.4 and child bearing is early; three out of every four women aged 20-24 years of age have had a child. About 51.8% of the population is less than 18 years of age and 68% reside in the rural areas (UNICEF, 1999). At present, infant and under-five mortalities stand at 134 per 1000 live births and 194 per 1000 live births respectively. Liberia is therefore far above the Sub-Saharan Africa average of 175 per 1000 live births, and ranks 43 out of 46 countries in the WHO AFRO region. Maternal mortality has increased from 578 per 100,000 prior to the war to 780 per 100,000 by 2002. Malnutrition is widespread with 39% of children under five years of age stunted, 26% underweight and there is widespread micronutrient deficiencies among children and women.

*The Humanitarian Crisis**

Liberia fought two major protracted civil wars between 1990 and 1997 and from 1999 to 2003. This resulted into a very complex emergency situation and a catastrophic humanitarian crisis. There are over 365,000 Liberian refugees residing in the neighbouring countries and another 365,800 Internally displaced persons (IDPs) had been displaced in over 17 official IDP camps and irregular camps located across the country. Most of them are concentrated around Monrovia, Salala and Totota in Bong county and Saclepea in Nimba county. Few Ivorian refugees are also located in camps. Repatriation of the refugees and IDPs have began and over 81,000 of them have been relocated to their places of origin by middle of March 2005. During the period about 17,000 Sierra Leone refugees were also repatriated home.

*The Health Sector**

Total health budget as a proportion of GDP fell significant below the WHO stipulated minimum of 5%. The current expenditure level is less then $1 US per capita. Thus, the low level of government resources allotted and expended on the sector grossly affected the level and quality of health services.

The health sector suffered almost total destruction; almost all physical infrastructures have been damaged, health personnel have been dislocated, massive looting of equipment, drugs and

medical supply inventories. All national programs have also collapsed. The accessibility to health services rate is about 10% and health services are mostly located in the urban areas reducing further the accessibility of the rural population. This in turn accounts for the major causes of the country's high infant and child mortality rates. Full antigen coverage for children age one and less was 28% in 2002. Projected, these figures are expected to be lower now. International NGOs and the private sector continue to provide the lion share of health care services.

Malaria, cholera and other diarrhoeal diseases, acute respiratory infections, neonatal tetanus, measles, and malnutrition are the major causes of morbidity. The prevalence of communicable diseases such as HIV/AIDS, TB and River Blindness continues to escalate at an alarming rate. In 2002, the prevalence of HIV/AIDS is estimated to affect 8.2% of the population between the ages of 15-49 years in 2002 but due to the current situation it is estimated to be about 20%. The poor knowledge, illiteracy, poverty, and multi-sexual behavioural practices, pose great challenges for the health of young adolescents especially females who have been the main victims of rape and sexual abuse throughout the crisis.

*Human Resources**

Prior to the civil war in 1988, approximately 5,056 people worked in the health sector. The public sector employed 3,526, and the private the rest 1,855. These included 2,782 (55%) trained traditional midwives, 237 physicians (4.7%), 656 nurses and nurse midwives (13%) and 1,381 other supporting personnel (27.3%). Presently less than 30 national physicians remain in the country and whilst other cadres of health workers have also reduced by 60%. Most of the active health personnel in the facilities have been recruited and deployed by NGOs, and UN agencies. The few human resources available at their places of work are demoralized and traumatized.

*Health Organization And Management**

The Ministry of Health and Social Welfare has been managing a three-tier health system: namely strategic (central team MoH), technical (Counties' health teams) and operational (districts' health teams). In theory, there is a Health Sector Coordinating Committee (HSCC) meeting weekly, chaired by the Minister of Health and has the secretariat in MoH. Participants include MoH, representatives of the NGOs and the health and nutrition sector of the UN Agencies. This is an information-sharing forum where all sector activities; updates and policy issues are planned to be discussed. At present there is some confusion on its existence. During the escalation of hostilities, WHO performed the coordination role until the peace agreement was signed.

Recent findings

From May 15-22 2005 a preparation visit by a WHO/UNHCR consultant resulted in the set-up of a Steering Committee on the IHE. During this visit the majority of the stakeholders in health were consulted; this lead to the following description of the current context:

Liberia in transition phase of relief to development. Many relief oriented agencies have pulled out or plan to withdrawn in the coming year. It is felt that there are insufficient number of more development oriented donors to ensure an adequate transition and funding gaps are envisaged.
The RFTF was designed on information based collected more than one year ago. Today health actors wonder whether the objectives are still up to date. Some have criticized the document to be too much agency-mandate oriented with many vertical programmes, lacking cohesion and an integrated approach that is needed today in Liberia.

After the peace agreement many health actors have suffered from diminishing quality and frequency of the health sector coordination. Today stakeholders state that this has lead to many

frustrations and ineffectiveness of the humanitarian response in the health sector. It has caused more insular ways of working, possible duplication of activities and competition within the health sector. Amongst others, the competition in employing the same available health staff being in an environment with only small numbers of qualified staff has lead to various frustrations.

During the war many health actors provided health care for free. More than 20 months after the war ended this is still the case. The sustainability of this approach in a country in transition is now questioned and the audience in health seems to be polarized on yes or no to continue to provide formally free health care.

In Liberia sexual and gender based violence is deeply embedded in the society leading to enormous public health problems that have directly and indirectly implications on reproductive health, mental health, malnutrition amongst children and the spread of AIDS/HIV.

The health actors lack urgently and consistently baseline data on health indicators, baseline information on number of real functional health care facilities, health care personnel and their location. In addition, there is a great need for census data; catchment area for health care facility data, etc. Some actors are trying to fill these gaps (Unicef, HIC).
If the data is at all available, little is consistent, poorly shared, hardly centralized and poorly analysed on macro-level. The lack of baseline information causes a weak context to perform an IHE on impact, effectiveness and coverage of many health programmes in the past.

II. Evaluation Purpose

The main purpose of the inter-agency evaluation of the health sector[20] in Liberia, through a collaborative process involving all relevant stakeholders in health and nutrition[21], is to assist Ministry of Health and Social Welfare (MoH), and other stakeholders in health and nutrition to ensure improvement of the performance in the health sector.
The results from the IHE will feed into health sector-wide strategy development and planning and/or revision and adjustment. In particular, it will enable to optimize the planning for the (new) MoH after the elections foreseen in October 2005. In addition, the results will provide up-to-date reliable evidence on which to base resource allocation and for resource mobilisation in general.
The IHE results will also create opportunities whereby all stakeholders in health can learn from identified strengths and weaknesses from their performance as a whole.

III. Stakeholder Involvement

Representatives of stakeholders groups will be involved in the IHE through a participatory process. Involvement has begun with the establishment of an IHE Steering Committee, representing MoH, UN and donor agencies and NGOs. Prior to the IHE identification of representatives of affected populations is needed in order to include them as soon as possible in the whole evaluation process. (Some suggestions: community, refugee and IDP representatives).

The coordination for the Steering Committee (SC) will be facilitated and chaired by WHO (jointly with UNHCR). Save the Children UK is the secretary of the SC. Throughout the IHE process, but especially after the results of the actual IHE become available, the SC might find it important to redefine the roles and identify new chairing or supporting agencies.

[20] *Health Sector* refers to all health and nutrition programmes, services and initiatives
[21] MOH, UN agencies, Donor agencies, NGOS, representatives of affected populations

The SC as is stands now is merely a platform for all stakeholders in health who have been involved in establishing the IHE. They include Unicef, ACF, MSF/H-B, Liberian NRCS, UNMIL, IMC, EQUIP, Mother Patern College of Health Sciences, MDM, BPRM, ECHO, Save the Children UK, UNHCR, WHO, Ministry of Health, MERLIN, WFP, Africare, USAID, Merci, UNFPA, UNDP, ICR, AHA (and possibly ICRC).

During the first meeting of the SC on 19 May 2005 a Core IHE Working Group was formed that will be responsible on behalf of and in consultation with all interested health agencies to oversee the finalisation of the ToR and the development of the subsequent workplan for the evaluation, and to provide supervision and delegating responsibilities to different IHE Steering Committee members throughout the process; They are responsible for developing a plan for the dissemination of IHE findings and its follow up.

IV. Evaluation Scope and Key Questions

The LIBERIA IHE encompasses various domains ranging from general health governance, health financing and service delivery to the community, refugees/IDPS, to sexual and gender based violence. The IHE will not limit itself to specific geographic areas, except for those issues concerning specific vulnerable populations such as IDPs, returnees, refugees**,** etc. For obvious reasons accessibility constraints and 'no-go' areas defined by UNSECOORD should be taken into account when IHE team plan the field mission[22]. The IHE will focus on the time period starting from the Peace Agreement in August 2003 until now. The IHE will include a mixture of evaluation and assessment components. Key areas and related questions can be found in Annex 2.

V. Follow up on recommendations and lessons-learned

To be developed by the IHE Core Working Group of Steering Committee in consultation with all SC members.

VI. Work Plan and Schedule

A preliminary workplan is developed but needs more refining, finalising key evaluation tasks, planning of IHE, planning interviews and field visits for information gathering; and needs finalising a detailed time line for the evaluation process, etc.

The IHE process will take place over an eight month period (from May – December 2005). The IHE Core Working Group will follow the Liberia IHE. It will provide guidance and technical support to assist the IHE process and finalise this time planning.

VII. Methodology

The actual evaluation in the field will be done by the IHE team. During the first SC meeting 19 May 2005 it was decided that the team of evaluators themselves propose the methodology. It is likely that it will be a mixture of desk research (review of existing documentation[23] including reports, studies, surveys and assessments) and interviews (key informants, community, focus group), field visits/direct observation and case studies.

[22] As it stands now (21 May 2005) the whole country is accessible security wise.
[23] on www.humanitarianinfo.org/liberia many valuable documents are accessible

VIII. Reporting

The report will be prepared and submitted by the evaluation team. An initial review will be done by the IHE Core Working Group to see if the evaluators adhered to the ToRs. The draft report will be circulated to all stakeholders (in particular the Steering Committee) with the request to provide feedback on accuracy and adequacy of conclusions and recommendations.
The report should be no more than 30 pages and have an executive summary of no more than 3 pages. The report should include a short background to the humanitarian crisis in and health sector in Liberia, methodology, findings, conclusions, concrete recommendations, lessons learned, and annexes. The report will be made available through websites of participating agencies.

IX. Evaluation support to assist in the facilitation of the IHE

While the Core Working Group in collaboration with the Steering Committee will be responsible for the process, it is foreseen that support will be provided by the IHE-Humanitarian Crises Initiative Core Working Group that was launched in March 2004 in Geneva. This group is composed of representatives from ACF-France/AAH-UK, CDC, Epicentre, London School of Hygiene and Tropical Medicine, Merlin, MSF/H, SCF-UK, UNFPA, UNHCR, UNICEF, WFP, BPRM and WHO and holds monthly teleconferences. The chair and facilitation is provided by WHO and UNHCR in Geneva. How the Core Working Group in Liberia and the IHE-HIC Core Working Group will collaborate should be discussed by both and could be an agenda point for the first upcoming teleconference by IHE-HCI Core Working Group.

The composition of the IHE team: expertise of the evaluators should include health finance, reproductive health, health policy and health systems. In addition, experience with post-conflict context and refugees is required. The impartiality and independency of the team should be guaranteed throughout the IHE process.