

## **Liberia RBHS Annual Report PY1**

---

Liberia RBHS

November 5, 2008 – September 30, 2009

This report was made possible through support provided by the US Agency for International Development, under the terms of Cooperative Agreement Number 669-A-00-09-00001-00. The opinions expressed herein are those of the author(s) and do not necessarily reflect the views of the US Agency for International Development.

---

Rebuilding Basic Health Services (RBHS) Project  
Management Sciences for Health  
784 Memorial Drive  
Cambridge, MA 02139  
Telephone: (617) 250-9500  
[www.msh.org](http://www.msh.org)

# LIBERIA REBUILDING BASIC HEALTH SERVICES (RBHS)



**USAID**  
FROM THE AMERICAN PEOPLE



**ANNUAL REPORT**  
**5 NOVEMBER 2008 –**  
**30 SEPTEMBER 2009**



*The Rebuilding Basic Health Services (RBHS) Project is funded by the United States Agency for International Development through Cooperative Agreement No: 669-A-00-09-00001-00 and is implemented by JSI Research and Training Institute, Inc. in collaboration with Jhpiego, the Johns Hopkins University Center for Communication Programs (JHUCCP), and Management Sciences for Health (MSH).*

*This document is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of JSI Research and Training Institute, Inc. and do not necessarily reflect the views of USAID or the United States Government.*

## TABLE OF CONTENTS

EXECUTIVE SUMMARY .....	4
BACKGROUND AND INTRODUCTION .....	8
IR 1: INCREASED USE OF BASIC HEALTH SERVICES.....	9
1. Transition Grants (SO 1.1, 1.2, 1.3).....	10
2. Performance-based Financing and Contracts (SO 1.1, 1.2, 1.3, 1.4).....	16
3. Behavior Change Communication (BCC) (SO 1.2, 1.3, 2.5; IR 3) .....	27
IR 2: IMPROVED HEALTH WORKFORCE, SYSTEMS PERFORMANCE, AND INFRASTRUCTURE .....	30
1. Pre-service Education (SOs 2.1, 2.2, 2.3).....	31
2. In-service Education and Capacity Building (SOs 2.2, 2.5).....	36
3. Infrastructure Development (SOs 2.1; 2.5).....	38
IR 3: YOUTH INFORMED AND NETWORKED ON REPRODUCTIVE HEALTH .....	40
ELEMENTS and CROSS-CUTTING ISSUES .....	40
PROJECT MANAGEMENT, FINANCE and ADMINISTRATION .....	45
Budget vs. Expenditures .....	47
Visitors and Consultants .....	47
Program Subcontracts .....	48
UPCOMING WORKPLAN ACTIVITIES (October 2009 – March 2010).....	49
ANNEX 1: RBHS INTERMEDIATE RESULTS AND SUB-OBJECTIVES.....	52
ANNEX 2: KEY USAID INDICATORS (November 2008 – August 2009).....	53
ANNEX 3: RBHS CONTRIBUTION TO LIBERIAN NATIONAL POLICIES, STRATEGIES, PLANS, AND TECHNICAL DOCUMENTS.....	54
ANNEX 4: RBHS PARTICIPATION IN NATIONAL COMMITTEES, WORKING GROUPS and TASK FORCES .....	55
ANNEX 5: RBHS STAFFING STRUCTURE, YEAR 2.....	56
ANNEX 6: BUDGET vs. EXPENDITURES.....	57

## EXECUTIVE SUMMARY

The Rebuilding Basic Health Services (RBHS) project began in November 2008 as the United States government's major initiative in support of the Liberian Ministry of Health and Social Welfare (MOHSW). Funded by USAID, RBHS is a partnership among JSI Research and Training, Jhpiego, the Johns Hopkins University Center for Communication Programs (JHUCCP), and Management Sciences for Health (MSH). Implementation of RBHS, which is to be over a 5-year period, is guided by a three-pronged strategic approach:

- strengthening and extending **service delivery** through performance-based contracts to NGO partners (IRs 1 and 3);
- strengthening Liberia's **health system** in the areas of human resource management, infrastructure, policy development, and monitoring and evaluation (IR 2); and
- preventing disease and promoting more healthful behaviors through **behavior change communication** and community mobilization (IRs 1,2 and 3).

### Service delivery and Performance-based Contracts

The core of the RBHS service delivery component is implementation of Liberia's Basic Package of Health Services (BPHS) in seven counties through NGO partners. Implementation was initially under eight-month transition grants and, since July 2009, has been through performance-based contracts. Between November 2008 and June 2009, four partners – Africare, EQUIP, International Medical Corps (IMC), and MERCI – supported 75 facilities and surrounding communities.

In early July performance-based contracts/grants were signed with five NGOs – Africare, EQUIP, International Rescue Committee (IRC), MERCI, and Medical Teams International (MTI) – for support of 108 facilities and their catchment communities. Under these contracts, partners are providing services to one million people, almost a third of Liberia's population. The PBCs were developed through an open and transparent process. RBHS developed a clear methodology and selection criteria against which all proposals were evaluated. The Proposal Evaluation Committee (PEC) was comprised of representatives from the Ministry of Health and Social Welfare (MOHSW), County Health Teams (CHTs), County Coordinating Committees (CCCs), and RBHS. The composition of the PEC was designed to minimize as far as possible the chances of bias or preferential review.

Table ES-1 summarizes the NGO responsibilities under both transition grants and PBCs.

Table ES-1: RBHS NGO implementing partners

	Transition grants		Performance-based contracts/grants	
	Number of facilities	Counties	Number of	Counties
Africare	37	Bong, Montserrado,	16	Bong
EQUIP	9	Nimba	22	Nimba
IMC	21	Bomi, Grand Cape Mount, Lofa	None	None
IRC	None	None	30	Lofa, Nimba
MERCI	8	River Gee	16	River Gee
MTI	None	None	24	Grand Cape Mount, Bomi, Montserrado
<b>RBHS total</b>	<b>75</b>	<b>7</b>	<b>108</b>	<b>7</b>

Utilization and coverage rates have demonstrated a mixed picture for RBHS implementing partners during the first year of implementation. Results for several indicators compare favorably with national averages and international standards (e.g. vaccination coverage, utilization rates, accreditation scores), while others demonstrate needs for significant improvement (e.g. facility-based births, IPT2 coverage for pregnant women, uptake of family planning).

During both the transition and PBC periods, RBHS partners combined to treat 380,996 patients, corresponding to a utilization rate of 0.56 consultations per person per year - within the range typical of developing countries of 0.5 to 1.0. Of those patients, 59,462 were children under five years treated for malaria, representing 47% of all presentations among children under five, and 16% of total consultations.

Table ES-2 shows a number of key service delivery indicators RBHS tracked during both transition and performance-based contract periods. Given the high rate of maternal mortality in Liberia, the low proportion of deliveries occurring in facilities highlights the need for RBHS and its partners to redouble efforts to improve women’s access to this important service. Similarly, while pregnant women are being well covered by tetanus toxoid immunization, their uptake is much lower for prevention of malaria, as reflected by low IPT2 coverage.

Couple-years of protection is a family planning indicator that combines various forms of contraception into a single number. For instance, the 3,802 number in the table includes over 173,000 condoms distributed. Overall, uptake of family planning remains consistently low across RBHS-supported facilities.

**Table ES-2: Key RBHS service delivery indicators (Nov 2008-Aug 2009)**

	Number	Coverage
Deliveries in facility	3,043	14%
Deliveries in facility with skilled birth	2,136	10%
Pregnant women receiving IPT2	6,658	30%
Pregnant women receiving TT2	16,845	97%
Couple-years of protection (contraceptives)	3,802	NA
Children under 5 receiving pentavalent-3	16,517	74%
People tested for HIV	3,494	NA
STI cases treated	9,393	NA

### **Behavior change communication (BCC)**

In addition to providing health services, RBHS is working to promote more healthful behaviors and to mobilize communities around public health issues. For the reporting period most Behavior Change Communication (BCC) activities focused on assessments, preparatory work for demand generation, and capacity building of counterparts within the MOHSW. RBHS has developed a clear strategy to guide its BCC activities that combines an integrated approach at the household and community levels complemented by periodic phased national vertical campaigns. Key to this strategy will be the new Family Health Card, which has been developed in collaboration with various departments within the MOHSW and other stakeholders.

RBHS has recently collaborated with the MOHSW's National Malaria Control Program (NMCP) and Health Promotion Division (HPD) on the design of a national campaign to promote the use of insecticide treated nets (ITNs), to be launched in November. The campaign involves widespread dissemination of pre-tested messages at every level, from community to mass media outlets, as well as community mobilization through a range of channels. RBHS has also been working with its partners on the development of youth-focused family planning and sexual health materials and messages, in preparation for another campaign to be launched in January. Central to all of RBHS's work in BCC is capacity building of its counterparts within the MOHSW, especially the HPD, including collaboration on the MOHSW's Communication Strategy and the establishment of a National Health Promotion Technical Committee.

### **Pre-service education**

Through its Pre-service Education Strengthening (PSE) Initiative, RBHS is aiming to improve the undergraduate training of mid-level health care providers, the teaching skills of instructors and clinical preceptors, the educational environment at selected learning institutions, and the overall management of these institutions. The Initiative is supporting two of Liberia's most important schools for nursing and para-medical staff – the Tubman National Institute for Medical Arts (TNIMA) in Monrovia and the Esther Bacon School of Nursing and Midwifery (EBSNM) in Zorzor. It is expected that several of the processes and materials being developed will ultimately be adopted nationally.

Among the key accomplishments of the PSE Initiative has been the development of education standards for the training institutions and clinical standards for health facilities. An assessment using the educational standards has provided both TNIMA and EBSNM with a baseline measure of their performance and has allowed them to develop plans to improve that performance over time. Similar assessments at the clinical training sites are planned using the clinical standards.

In addition, RBHS is currently working with key stakeholders to revise job descriptions and core competencies for four cadres of mid-level providers (registered nurses, certified midwives, physician assistants, environmental health technicians), and to update their respective training curricula. Central to this process has been the integration of materials from the national programs (e.g. NMCP, National AIDS Control Program) into the curricula. Other important activities have included conducting an effective teaching skills (ETS) course, an assessment to determine appropriate technologies to support learning at the schools, training for instructors on malaria case management, the purchase of equipment and supplies, and the establishment of Educational Development Centers at the schools.

### **In-service education and capacity building**

RBHS continued its contributions to the roll-out of the MOHSW's In-service Education Strategy, in an effort to up-grade the skills of existing mid-level health care providers. Specific activities have included contributions to the in-service curriculum, participation in the training of Master Trainers, preparation of a training site in Nimba County, and the completion of an in-service training inventory at RBHS-supported facilities. Challenges to the broader implementation of in-service training have related to capacity limitations within the MOHSW's Training Unit and sub-optimal progress on the development of the integrated curriculum.

Consistent with its commitment to capacity building, RBHS staff have provided technical input into important MOHSW policies and plans (e.g. reproductive health policy, mental health policy) and participated as active members of at least 10 Ministry-led committees and working groups (e.g. health

promotion; monitoring, evaluation and research). Moreover, RBHS has provided technical assistance to MOHSW counterparts on a range of issues (e.g. mental health, health promotion), supported important consultancies (e.g. national malaria strategy, essential nutrition actions), supported numerous workshops (e.g. Malaria Operational Plan, Clinical Standards), and procured 15 vehicles for the MOHSW.

## **Infrastructure**

The RBHS infrastructure program has ambitious objectives, including the rehabilitation of two nursing schools, the rehabilitation of the proposed headquarters of the NMCP, the upgrading of five Emergency Obstetric and Neonatal Care (EmONC) Centers, and the rehabilitation of many of the 108 health facilities supported through the PBCs. Priority has been given thus far to the infrastructure work at TNIMA and EBSNM, as well as the EmONC centers. Negotiations continued over the scale of the NMCP headquarters.

The major activities have included architectural and engineering designs for TNIMA and EBSNM, designs for the proposed NMCP Headquarters, assessments and planning for the upgrading of five EmONC Centers, and assessments of 39 priority clinics and health centers. Construction work is expected to commence early in the dry season of year 2.

## **Project Elements**

In addition to fulfilling its sub-objectives, RBHS has specific responsibilities related to five central project elements: Maternal, Neonatal and Child Health; Family Planning and Reproductive Health; Malaria; HIV; and Water and Sanitation. A broad range of specific activities related to the elements are detailed in the report. In summary, these include: assessments, trainings, service delivery, policy and guideline development, technical assistance, consultancies, advocacy, BCC, and the provision of vehicles and equipment.

## **Finance and Administration**

RBHS completed many project start-up, system development, and office setup activities during the reporting period. Chief among these were: refurbishment of and move into new office space; recruitment of key personnel (e.g. Monitoring and Evaluation Director); finalization of operations systems and operations manual; and several major procurements (e.g. drugs for 75 health facilities; purchase of 20 vehicles).

## **Challenges and Constraints**

During this first year, most challenges have related to the ambitious nature and high expectations of the project, the need to balance the demands of competing priorities, limited capacity among some counterparts and partners, and budgetary gaps. These issues led RBHS to revise its workplan for Year 1 and set less ambitious targets for Year 2.

## **MISSION STATEMENT – RBHS LIBERIA**

*RBHS supports the Ministry of Health and Social Welfare to establish and maintain a comprehensive range of high quality health services for Liberia through the pillars of the national health plan (human resources, infrastructure, the Basic Package of Health Services, support systems) and mobilizing communities for health. RBHS is committed to the principles of partnership, participation, capacity building, and evidence-based decision making. Youth sensitivity and gender equity are emphasized in all RBHS activities.*

## **BACKGROUND AND INTRODUCTION**

Five years after the end of two prolonged and devastating conflicts, Liberia is beginning to demonstrate gradual and encouraging progress in a range of political, economic, and social outcomes. The health sector was as severely impacted as any other by the wars, with limited resources, loss of staff, destruction and deterioration of infrastructure, and major disruption of health systems and programs. For years, the national health system has depended to a large degree on international donors, non-governmental organizations (NGOs), and faith-based organizations (FBOs). Until recently up to 70% of health facilities have depended on external assistance to ensure on-going functioning.

The successful transition to power of a popularly elected president in 2005 has led to greater political stability and improved security throughout the country. Within this still relatively new government, the Ministry of Health and Social Welfare (MOHSW) has emerged as one of the strongest and most effective. Over the past 3 – 4 years the MOHSW has demonstrated strong leadership and vision; developed a sound National Health Policy and Plan; and coordinated effectively and transparently with international partners. While the health sector will require substantial external assistance for years to come, it is clear that it is the MOHSW that is taking the lead on setting national policies, strategies, and plans. The cornerstone of the Liberian National Health Plan is the MOHSW's Basic Package of Health Services (BPHS), which outlines the essential services to be provided at each level of the health system.

Early indications suggest that there have already been improvements in some important health outcomes. Infant and child mortality have reduced considerably since earlier in the decade and now compare favorably with regional rates (see Table 1). On a more macro level, Liberia has edged up slightly on the Human Development Index, improving by 7 places (169 out of 182 countries). One important exception to this trend has been the maternal mortality ratio, which has reportedly almost doubled in recent years.

**Table 1: Key Health Indicators for Liberia**

	Liberia	Regional Average	Global Average
Infant Mortality Rate (DHS 2007)	72	97	47
Under-5 Mortality Rate (DHS 2007)	111	169	68
Maternal Mortality Ratio (DHS, 2007)	994	1100	400

In light of these and other political and economic developments, there is renewed optimism for the reconstruction of the health system in Liberia. Already, many international public health experts are suggesting that Liberia could become a model for post-conflict health system reconstruction and are eager to learn lessons from the country's experience.

The Rebuilding Basic Health Services (RBHS) project is the United States government's major initiative in support of the Liberian Ministry of Health and Social Welfare (MOHSW). Funded by USAID, RBHS is a partnership among JSI Research and Training, Jhpiego, the Johns Hopkins University Center for Communication Programs (JHUCCP), and Management Sciences for Health (MSH). Implementation of RBHS, which is to be over a 5-year period, is guided by a three-pronged strategic approach:

- strengthening and extending **service delivery** through performance-based grants to NGO partners (IRs 1 and 3 – see Annex 1);
- strengthening Liberia's **health system** in the areas of human resource management, infrastructure, policy development, and monitoring and evaluation (IR 2); and
- preventing disease and promoting more healthful behaviors through **behavior change communication** and community mobilization (IRs 1,2 and 3).

Since commencing in November 2008, RBHS has made good progress programmatically and administratively. This first annual report will focus on the major achievements of the past year, including on-going support to health service delivery in up to 108 health facilities; the finalization and commencement of innovative performance-based contracts; substantial contributions to pre-service and in-service training; participation in key policy development initiatives; and important assessments and preparatory work to guide behavior change communication and infrastructure activities. Most challenges have related to the ambitious nature and high expectations of the project, the need to balance the demands of competing priorities, limited capacity among some counterparts and partners, and budgetary gaps. These issues led RBHS to revise its workplan for Year 1 and set less ambitious targets for Year 2. Further analysis and negotiations over the budget are on-going at the time of writing.

In the coming years, the major task for the MOHSW, RBHS and other partners will be to capitalize on the effective policy and planning work undertaken centrally, and to ensure that systems and services are strengthened at county and community level. RBHS is fully committed to assisting the MOHSW in its goal of developing an effective, efficient, and equitable decentralized health system.

## IR 1: INCREASED USE OF BASIC HEALTH SERVICES

RBHS aims to increase the use and quality of BPHS services in seven counties: Bomi, Bong, Grand Cape Mount, Lofa, Montserrado, Nimba and River Gee (Table 2). The main service delivery strategy is via performance-based contracts (PBC) to five non-governmental organization (NGO) implementing partners, co-managed by RBHS and the MOHSW. These contracts commenced on July 1, 2009. Through the PBCs, services are currently being scaled up to 108 health facilities and their surrounding communities. In addition, technical and material support is being provided to county health teams (CHTs), to increase their capacity to manage the decentralized county health systems.

The PBCs were designed and timed to dovetail effectively with previous USAID grants in the target counties. To avoid any disruption of services, or transition gap, between the expiration of the earlier humanitarian grants and the longer-term developmental PBCs, RBHS provided transition grants to four NGO partners that were implemented between November 2008 and June 2009. This report will summarize information and data from both the transition grants and the first two months of the PBCs.

In addition to ensuring access to the preventive and curative services specified by the BPHS, RBHS is utilizing behavior change communication (BCC) tools and approaches to promote more healthful behaviors and to increase demand for services.

**Table 2:** Health facilities by county

COUNTY	NO. FACILITIES
Bomi	2
Bong	16
Grand Cape Mount	21
Lofa	18
Montserrado	1
Nimba	34
River Gee	16
<b>TOTAL</b>	<b>108</b>

### 1. Transition Grants (SO 1.1, 1.2, 1.3)

As noted above, transition grants were given to four NGO partners (Africare, EQUIP, International Medical Corps (IMC) and MERCI) to maintain the delivery of services at 75 facilities and their surrounding communities, until PBCs were formally issued (Table 3). The main activities under these grants included regular monitoring and supervision of health facilities, the distribution of drugs and medical supplies, and the payment of incentives to clinic staff. Moreover, the implementing partners gave special emphasis to the four main elements of the BPHS: maternal and neonatal care; child health; communicable disease control, including malaria and HIV; and adolescent and reproductive health.

**Table 3:** Transition partner details

	No. Clinics & HCs	Target Population	Counties
Africare	37	385,790	Bong, Montserrado, Nimba
EQUIP	9	164,530	Nimba
IMC	21	229,245	Bomi, Grand Cape Mount, Lofa
MERCI	8	48,069	River Gee
<b>Total</b>	<b>75</b>	<b>827,634</b>	<b>7</b>

For the transition period, it was agreed that the four implementing partners would maintain their previous reporting systems and formats. As a result, the health data collected is not standardized and it is therefore not possible to provide consistent summary results. Nonetheless, their monitoring and evaluation activities have yielded some useful findings that were helpful in identifying needs and priorities for the subsequent PBCs.

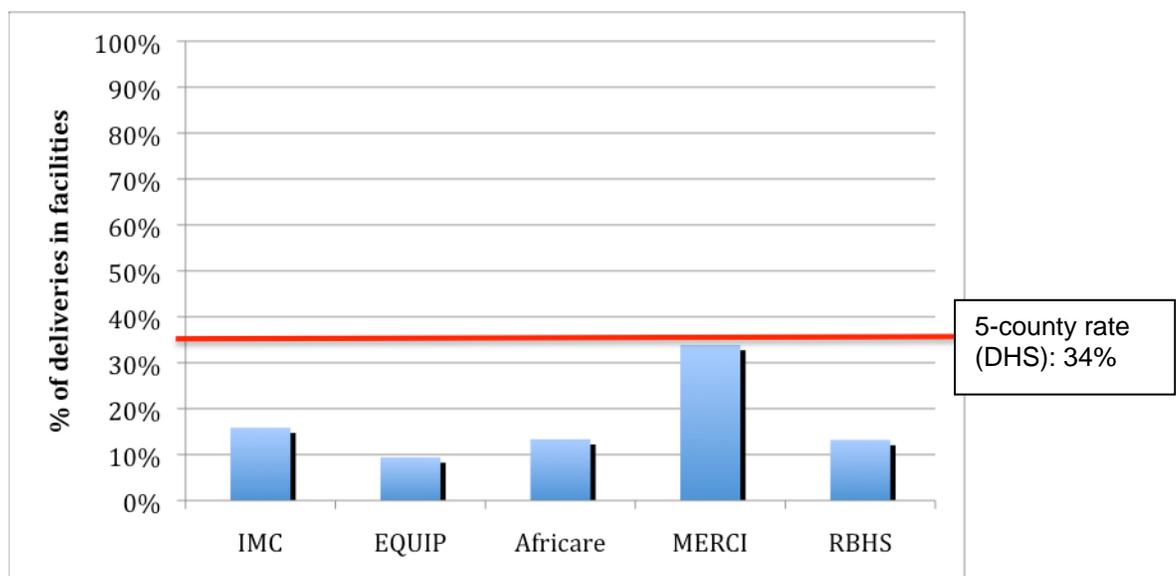
The data below cover activities during the period of the transition grants, from November 2008 through June 2009 (approximately 8 months).

### Maternal and Neonatal Care

All partners reported the provision of antenatal services and activities to promote skilled attendance at birth. Africare's maternal and neonatal care services include comprehensive antenatal care; safe delivery (with mechanisms for handling obstetric emergencies); follow-up with mother and baby to ensure that women return to their pre-gravid state of wellness; basic life saving skills (BLSS); and home-based life saving skills (HBLSS) at the community level to address emergencies in hard-to-reach areas.

RBHS-supported facilities conducted 11,307 ante-natal exams of pregnant women. A total of 2,206 women delivered in RBHS-supported facilities. Percentages varied from 9-34% (see Figure 1), with an RBHS average of 13%, well below the average of 34% for the five main RBHS counties (Grand Cape Mount, Bong, Lofa, Nimba, River Gee), as determined by the 2007 Liberia Demographic and Health Survey. It seems likely that the DHS substantially over-estimated the proportion, since the RBHS-supported facilities should be at worst representative of all facilities in those five counties. In any case, in light of the high maternal mortality rates in Liberia (994 deaths/100,000 live births), these data indicate an urgent need to scale up access to skilled obstetric care.

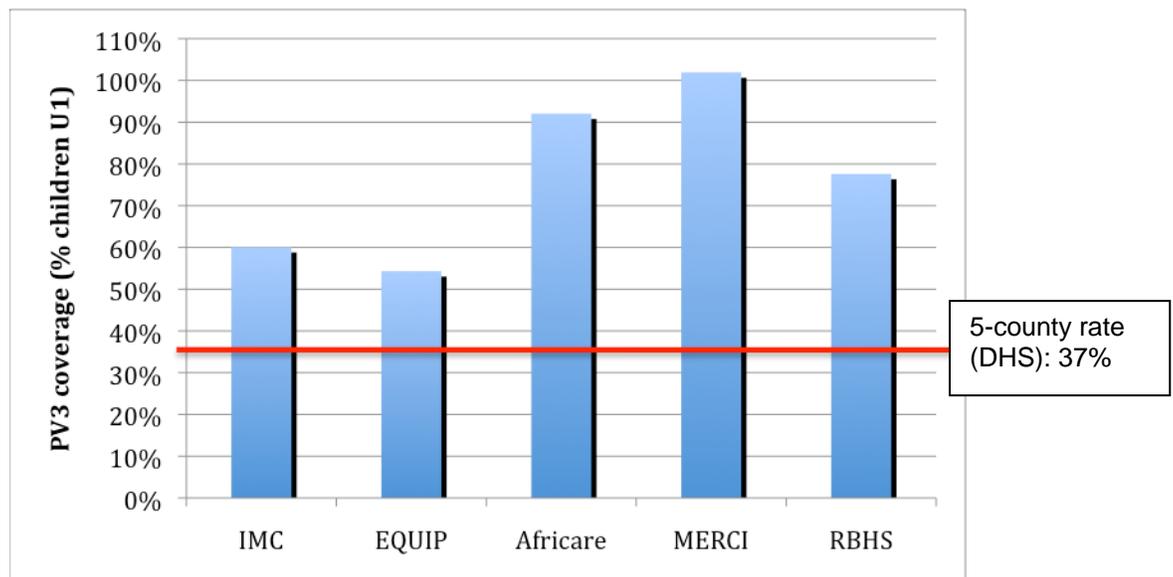
Figure 1: Deliveries in RBHS-supported facilities (Nov 2008-June 2009)



## Child Health

During the reporting period, the four partners combined to vaccinate 13,154 children under one year with the third dose of the pentavalent vaccine, used as a proxy for full immunization. This represents an approximate coverage of 78% of children under one for RBHS-supported facilities as a whole, far above the DHS five-county average; see Figure 2. (Coverage estimates are based on estimates of facility catchment populations, and so may reflect inaccuracies in the population estimates, as is likely with the MERCI coverage figure of over 100%.) Three of the partners reported giving vitamin A to 13,367 children under five years, which corresponds to an average RBHS coverage of 16%, but those figures do not include national vitamin A campaigns.

Figure 2: **RBHS-supported PV3 vaccination (Nov 2008-June 2009)**



Africare's growth monitoring program conducted weight-for-height measurements on over 35,000 children, of which 12.2% were moderately malnourished and 1.6% were severely malnourished. These data cannot be generalized to the entire population, as they apply only to children who presented to the facility, which may not be representative of the population as a whole. All partners promoted exclusive breastfeeding for children up to six months and continuation of breastfeeding for children up to 24 months.

## Reproductive and Adolescent Health, and Family Planning

Each RBHS partner offered a range of modern contraceptive methods, including oral contraceptive pills, Depo-provera, condoms, and intra-uterine device insertion, as shown in Table 4 below. Calculating from the tabulated data shows that the RBHS partners provided more than 3,000 couple-years of protection to members of the communities they served. It is clear that far more emphasis needs to be put on long-lasting methods such as IUDs, which are currently under-utilized.

Table 4: **Contraceptive provision through RBHS (Nov 2008-June 2009)**

	Pills (cycles)	Depo-provera	IUDs inserted	Condoms	Couple-years of
Africare	6,151	1,882	2	70,378	1,474
EQUIP	803	454	24	11,108	344
IMC	4,602	1,259	0	38,090	939
MERCI	331	547	0	12,952	267
<b>RBHS total</b>	<b>11,887</b>	<b>4,142</b>	<b>26</b>	<b>132,528</b>	<b>3,023</b>

In addition to preventive care, RBHS partners provided curative reproductive health care. For instance, EQUIP and IMC combined to treat 9,343 cases of sexually transmitted infections, accounting for over 7% of their total curative consultations.

#### Malaria control

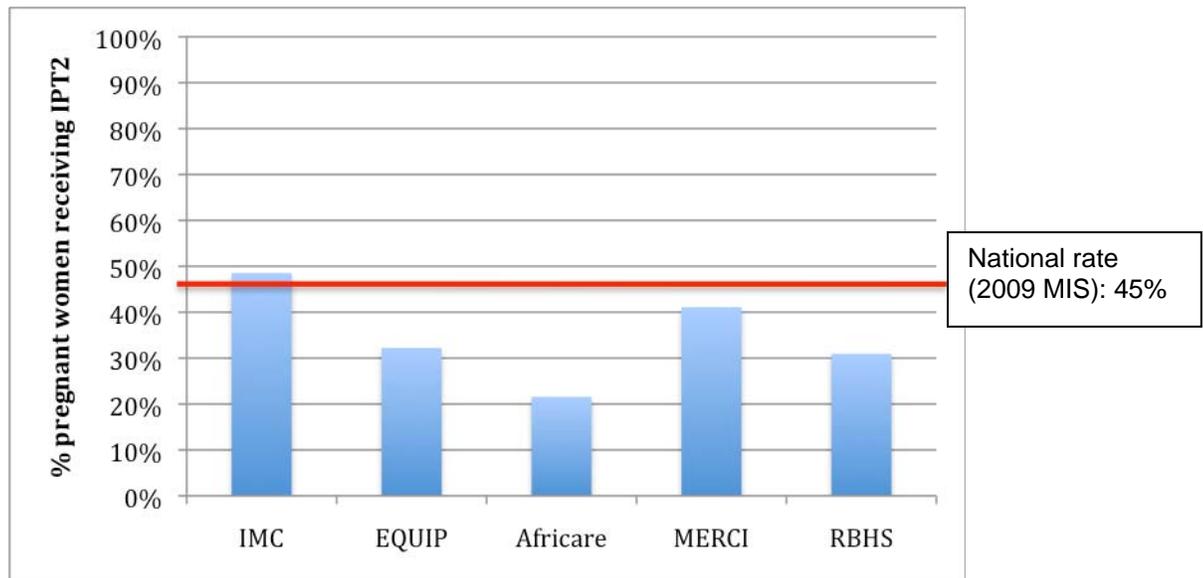
Malaria/fever was the major cause of morbidity in health facilities supported by all partners: Africare (34%), EQUIP (29%), IMC (27%), and MERCI (number not reported). The three partners reporting overall cases treated 84,533 cases of presumed malaria. The four partners combined to treat 44,050 cases in children under five years, representing 47% of all malaria cases (where the numerator includes only those cases reported by the three NGOs reporting total cases). Assuming a case-fatality rate for untreated malaria of 2%<sup>1</sup> in children, this would equate to 881 deaths averted over the nine-month reporting period.

Malaria control is the main priority of the Africare program. In addition to promoting effective case management, Africare provides intermittent presumptive treatment (IPT) of malaria in pregnancy, provides health education on malaria at facility and community level, and provided logistical support to the Bong CHT during an insecticide treated net (ITN) distribution campaign in Suokoko District. Similarly, EQUIP used radio spots and its Community Health Ambassadors to spread messages about malaria prevention and treatment. It also assisted DELIVER and the CHT to distribute 160,000 PMI-provided ITNs to communities in Nimba County. IMC reached an estimated 9,221 people with health education sessions about malaria.

All four partners used combination therapy for preventing malaria during pregnancy, providing intermittent preventive therapy (IPT) to women in facilities. The NGOs provided the second IPT dose to 5,050 pregnant women (see Figure 3 below).

<sup>1</sup> Rafael M, et al. Reducing the burden of childhood malaria in Africa: the role of improved diagnostics. *Nature*. <http://www.nature.com/nature/journal/v444/n11s/full/nature05445.html> (Accessed July 4, 2009). The authors quote a CFR of 1.5 – 4.0%

Figure 3: RBHS-supported IPT2 coverage (Nov 2008-June 2009)



## HIV

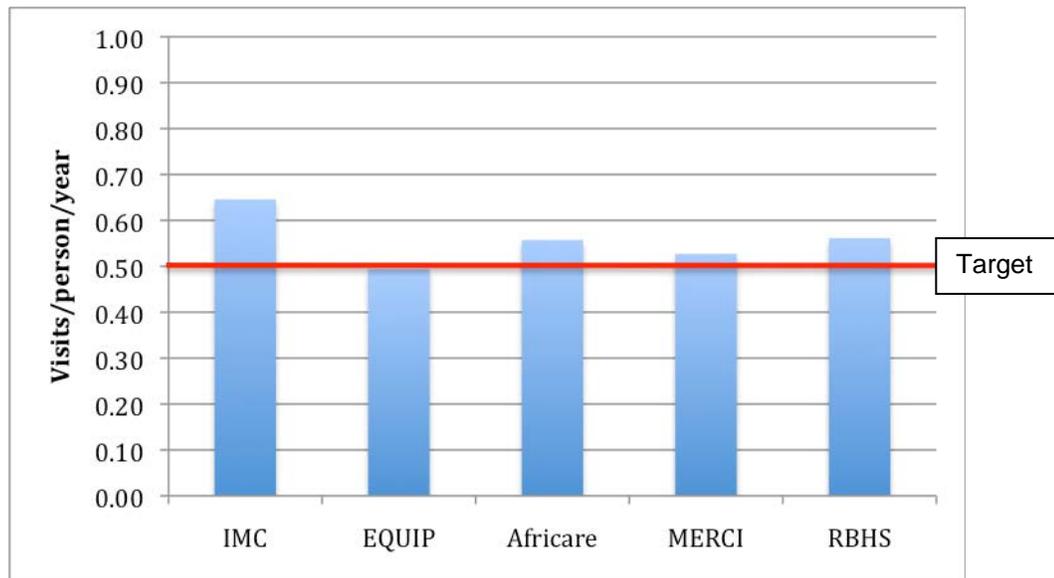
All partners conducted health education activities at community and facility level to raise awareness about HIV. IMC and Africare combined to reach almost 10,000 people (9,524 for IMC alone) with health education sessions on HIV and STIs. Associated with these prevention efforts, as noted in the Family Planning section above, RBHS partners distributed over 130,000 condoms.

Africare actively participated in the World AIDS Day activities in Gbarnga, Bong, in December. Moreover, Africare was the only partner that offered voluntary counseling and testing (VCT) for HIV, which were available at 21 of their 37 health facilities. Of 2,790 tests conducted during the reporting period, 90 (3.2%) were positive for HIV. Africare referred HIV positive individuals for CD4 counts and for anti-retroviral treatment, as indicated.

## Curative Services

Collectively, partners treated over 288,000 patients through their curative outpatient clinics during the reporting period: Africare 144,906; EQUIP 54,177; IMC 72,644; and MERCI 16,611. The major causes of morbidity were consistently malaria/fever, acute respiratory infections, diarrhea, and STIs. Utilization rates for curative care were remarkably consistent among the NGO partners, ranging from 0.49 to 0.65 annual new visits per capita, compared to the generally accepted target of 0.5 – 1.0 (Figure 4).

Figure 4: RBHS utilization rates (Nov 2008-June 2009)

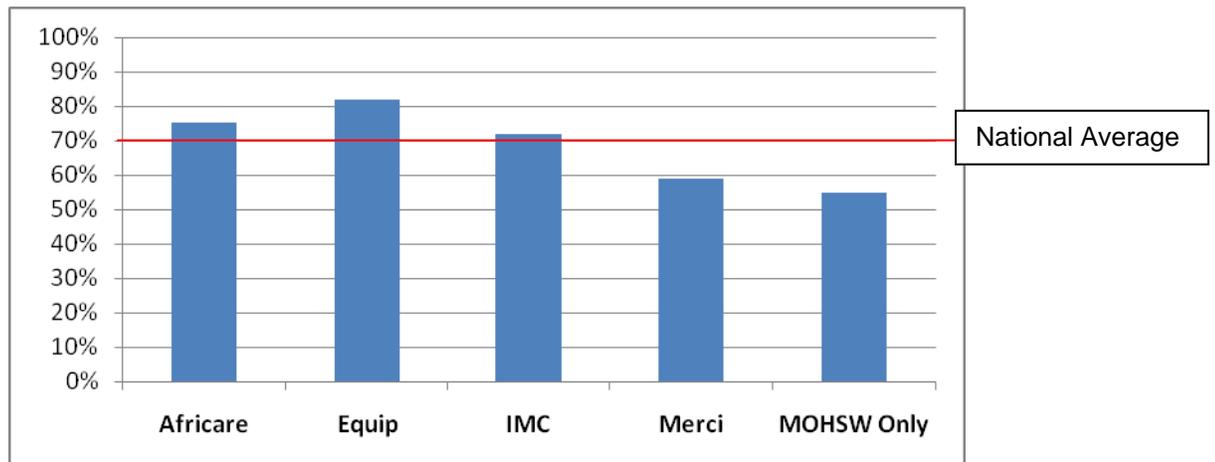


### Accreditation

The MOHSW conducted an assessment of all public and private health facilities in Liberia in January 2009. Each facility was assigned a score based on how well it met standards outlined in the BPHS. The score, in turn, determined the accreditation status of each facility: a score of 100% is required for full accreditation; a score of 85 – 99% results in provisional accreditation; 75 – 84% is an honorable mention; lower scores indicate non-accreditation. Of the 349 government facilities assessed, none received full accreditation and only 16 (4.6%) received provisional accreditation. The MOHSW has outlined ambitious targets for the accreditation process, aiming for 40% of facilities with provisional registration by the end of the year.

RBHS transitional partners did generally well in the accreditation process, with EQUIP (82%) obtaining the highest average score of all 16 NGO partners and Africare (75%) having the third highest score (Figure 5). The MERCI score of 59% remained higher than that of MOHSW-only supported clinics (55%). Note that these scores are for all facilities supported by those NGOs at the time, not just RBHS facilities.

Figure 5: Average accreditation scores (%)



## ***2. Performance-based Financing and Contracts (SO 1.1, 1.2, 1.3, 1.4)***

### **Planning for and awarding of Performance-based Contracts**

RBHS successfully completed the award of Performance-based Contracts through a robust, open and transparent competitive process. The performance-based contracts process commenced in February, 2009, with the awards being ultimately issued by June 30, 2009. RBHS worked closely with the MOHSW and USAID during this process, thereby building the Ministry's capacity.

RBHS maintained a close dialogue with partners and interested parties throughout the planning/design phase, including stakeholder meetings in December and February. Throughout this period RBHS educated NGO/FBO partners about performance-based contracting and sought their inputs into the process. Moreover, RBHS collaborated closely with MOHSW and USAID, establishing the objectives and services to be provided through the contracts. This process included determination of measurable performance indicators (7), quarterly administrative indicators (5), and other monitoring indicators (51). The monitoring and evaluation plan specified not only the various indicators, but also the methods of data collection. Once all components were finalized, the request for proposals (RFP) was issued.

The RFP for performance-based contracts was thoroughly disseminated and advertised through local media, the JSI website and direct emails to potentially interested parties. The RFP made a strong recommendation that international NGOs partner with local NGOs for the purposes of capacity building. In total, 15 proposals were submitted in response to the RFP (see Table 5):

Table 5: **Proposals received by County**

County	No. Proposals Received
Grant Cape Mount, Bomi, and Montserrado	3
Bong	3
Lofa	4
Nimba	3
River Gee	2
<b>Total</b>	<b>15</b>

RBHS developed a clear methodology and selection criteria against which all proposals were evaluated. The Proposal Evaluation Committee (PEC) was comprised of representatives from the MOHSW, County Health Teams (CHTs), County Coordinating Committees (CCCs), and RBHS. CHTs and CCCs were integrally involved in the review and approval of proposals for their respective counties. The composition of the PEC was designed to minimize as far as possible the chances of bias or preferential review. Several RBHS staff recused themselves from the selection process because of their prior employment by or association with one or more of the applicant NGOs. RBHS developed detailed guidance, including a non-disclosure agreement, for the selection committee members. The PEC was sequestered at a venue in Bong County during the review process, to minimize the potential for distractions.

Following the selection process, RBHS conducted a pre-award assessment of each potential awardee to determine their capacity to manage the contracts. As a result, it was decided that one local NGO (MERCİ) would require technical assistance to build appropriate systems and procedures prior issuing a PBC contract. A sub-grant would be given to support the delivery health services in River Gee in the interim. Four local and international NGOs were awarded PBC contracts/grants (see Table 6):

Table 6: **RBHS performance-based partners**

	Number of facilities	Catchment population	Counties
Africare	16	205,845	Bong
EQUIP	22	278,772	Nimba
IRC-Lofa	18	165,258	Lofa
IRC-Nimba	12	133,509	Nimba
MERCİ	16	66,089	River Gee
MTI	24	141,166	Grand Cape Mount, Bomi, Montserrado
<b>RBHS total</b>	<b>108</b>	<b>990,639</b>	<b>7</b>

**Capacity building of the MOHSW and local NGOs**

Throughout the procurement process RBHS worked closely with MOHSW to build its capacity to manage its performance-based contracts under the Pool Fund. Over the early stages, this

included regular collaboration, coordination, information sharing, and tools sharing. RBHS sponsored six MOHSW staff to attend the International Short Course on Performance-Based Financing (PBF) in Rwanda from January 26 – February 6. This intensive two-week program was attended by 17 health professionals from Ethiopia, Liberia, and Rwanda. Course work included an overview of results-based financing models and programs; designing a PBF system; developing a monitoring and evaluation system; implementing PBF processes; and field visits to health centers, hospitals, and district steering committee meetings. Less technical assistance to the MOHSW has been forthcoming in recent months, because of a lack of technical capacity and support within the RBHS project. But this problem will soon be rectified (see Challenges and Constraints below)

The importance of having a cadre of MOHSW staff capable of managing PBF/PBC is critical to the success of this approach in Liberia. The good progress of this capacity development was demonstrated at the successful World Bank-sponsored awareness workshops on PBF run by MOHSW staff in Bomi and Bong in the middle of the year. In addition, MOHSW staff were key presenters and facilitators for the RBHS Post-award Workshop in July (see below).

### **Post Award Workshop**

RBHS hosted a 3-day Post Award Workshop for its new PBC partners and representatives of MOHSW, CHTs, and USAID in mid-July. The objectives of the workshop were to introduce the new partners to the RBHS project, to provide technical training on PBF, and to provide an overview of the monitoring and evaluation requirements of the project. The workshop evaluations were overwhelmingly positive, with all sessions receiving a median score of 4 or 5 out of 5 on an ordinal scale.

### **Costing of Clinic, Health Center, and Hospital Services**

RBHS is assisting the MOHSW to estimate the costs of providing health care at a level that is consistent with the achievement of national health targets. During the first year of the project, two costing exercises were conducted: one at clinic and health center (HC) level and the second at hospital level.

The main objective of the clinic/HC exercise was to develop cost models for the provision of the BPHS services at these facilities. The models should then, in turn, enable the MOHSW to estimate the cost of the package at different levels of utilization and thereby guide financing, planning, and budgeting decisions. The report from the costing exercise was well received by the MOHSW and a validation workshop is being proposed for December. It is expected that the report and data from the recently completed hospital costing will also be available at that time and will also be validated at the workshop.

### **Results of the Performance-Based Contracts**

The NGOs are contractually obliged to report to RBHS quarterly, including data reported using standardized spreadsheets provided by RBHS. The first quarter will cover data from July through September, but to meet the deadline for the annual report, the NGOs made an interim report in September, covering data only from July and August. The data below have been taken directly as reported by the NGOs, without validating them using facility-specific records; such validation will be conducted quarterly going forward. At the end of this section, PBC data will be

combined with data from the transition grants to present a cumulative summary of RBHS facility-based activities from November 2008 through August 2009.

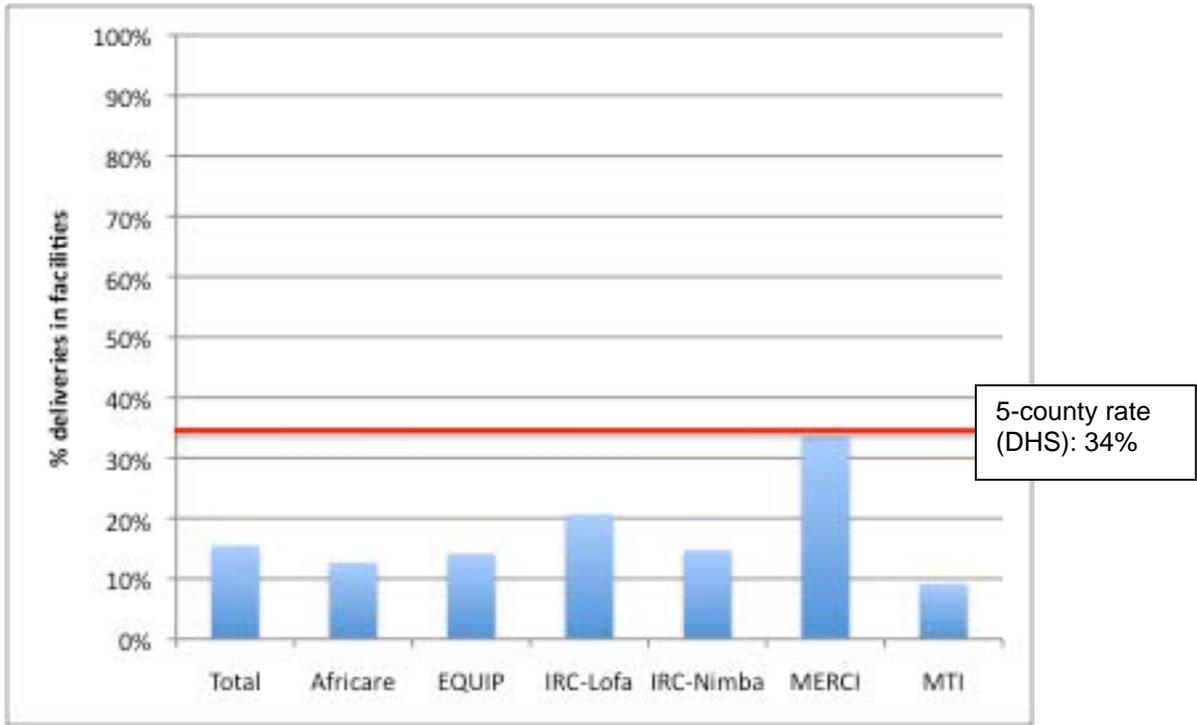
Even the July-August data are not entirely complete, since some NGOs have not yet taken over some facilities that will eventually receive their support and for several other facilities data have not been collected so far. The net result is that rather than 108 facilities, these data cover only 93. For service delivery statistics (where only volume is being measured), six clinics temporarily supported by MTI in Bomi county are included, bringing the total to 99, but those facilities are not counted in any coverage (%) estimates.

### Maternal and Neonatal Care

All partners were active in providing antenatal services and promoting skilled attendance at birth in facilities. As a measure of antenatal coverage, RBHS tracks the number of women who received a second dose of tetanus toxoid vaccine: 4,228 in two months, corresponding to coverage of 77% of the women estimated to be pregnant in the RBHS catchment area. Coverage for individual partner NGOs ranged from MTI's 31% to Africare's 102%. In at least one county – River Gee's 99% – high coverage may be explained by a UNICEF program that pays incentives for facility staff to provide comprehensive outreach services two or three days per month in hard-to-reach locations. Those services include curative consultation and antenatal checks, as well as vaccinations.

RBHS continues to encourage women to give birth in facilities, with skilled birth attendants. To date, only data on births in facilities have been collected, which indicate 837 facility births, an RBHS average of only 15%, further suggesting that the DHS baseline of 34% is not accurate (see Figure 6). Again, regardless of the real baseline, 15% is much too low and must be improved. Note that the MERCI figure is again 34%, exactly as in the transition grant period and once more by far the highest of the partners. One possible explanation is that MERCI has a program of providing kits to every woman who delivers in a facility – kits that include necessities such as soap, toothpaste, diapers, and other clothes – which may provide incentive for women to deliver in facilities. Such incentives could be applied to other counties to see if the same (relatively) high facility rate can be achieved.

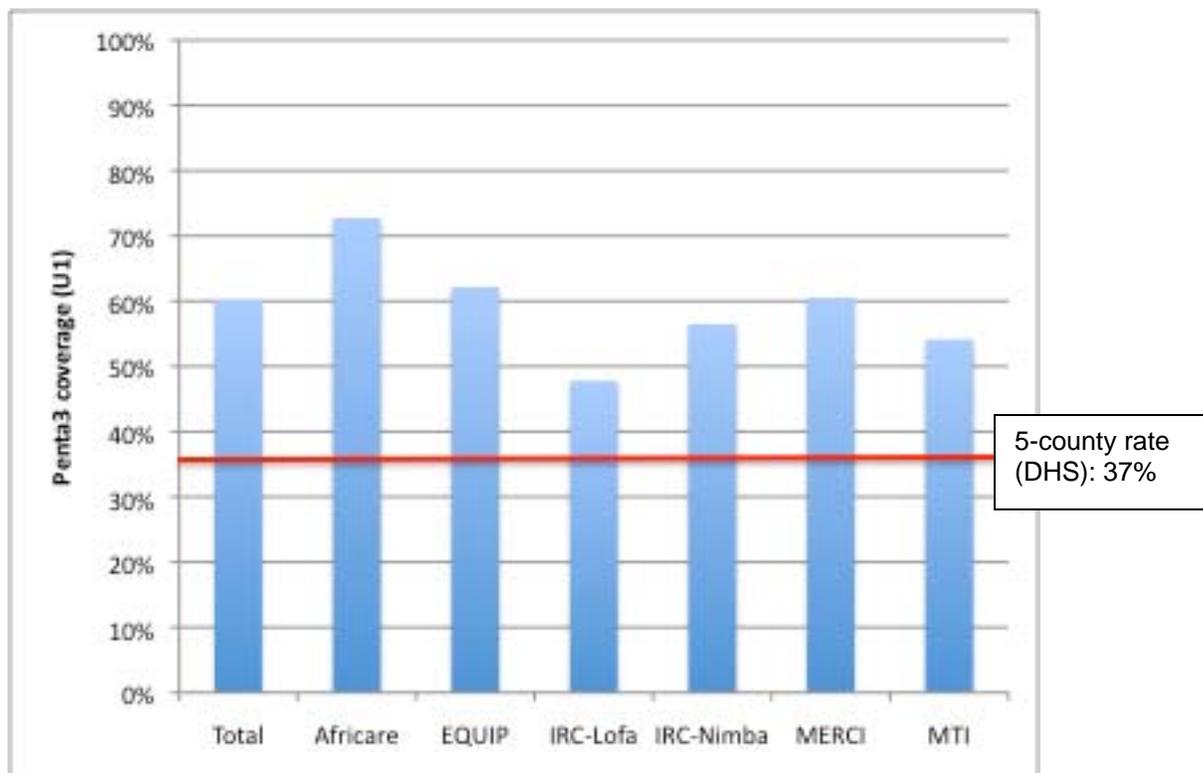
Figure 6: Deliveries in RBHS-supported facilities (July-August 2009)



### Child Health

During July and August, the RBHS-supported facilities combined to immunize 3,363 children under one year with the third dose of the pentavalent vaccine. That number represents an approximate coverage of 60% of children under one, far above the DHS five-county average; see Figure 7. Facilities reported giving vitamin A to 3,648 children under five years, which corresponds to an average RBHS coverage of 12%, but, as for the transition grant data, those figures do not include national vitamin A campaigns.

Figure 7: RBHS-supported PV3 vaccination (July-August 2009)



In addition to prevention, RBHS is also focusing on curing childhood illnesses. In the two-month period, the supported facilities treated 1,670 children under five with diarrhea and 4,045 with pneumonia. To measure quality of treatment, the RBHS indicators are the percentage children under five having diarrhea and treated with ORS and the percentage of children under five having pneumonia and treated with antibiotics. However, the former percentage works out to 117% and the latter to 99%, meaning that virtually all children with pneumonia are treated with antibiotics and more children are treated with ORS than have diarrhea. While it is conceivable that virtually all pneumonia cases are treated with antibiotics, that seems unlikely, especially in these early stages of the project and since several NGOs reported percentages greater than 100%, obviously impossible and suggesting data recording issues still to be resolved. (On the other hand, the counter explanation is that clinicians tend to over-treat with antibiotics, prescribing far too many, so it is not surprising that all pneumonia patients receive antibiotics). The explanation for the 117% diarrhea figure is that facilities are prescribing ORS for conditions other than diarrhea (e.g., malaria), but are recording those prescriptions as if given for diarrhea, improperly inflating the diarrhea indicator. For the time being, until these issues are straightened out, the two indicators are of little value for measuring quality.

#### Reproductive and Adolescent Health, and Family Planning

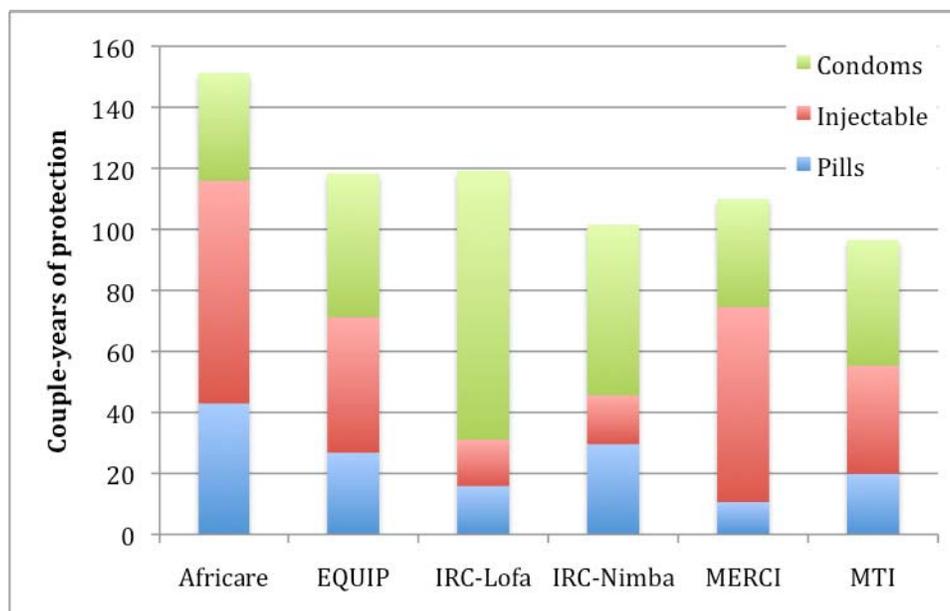
Each RBHS partner offered a range of modern contraceptive methods, including oral contraceptive pills, Depo-provera, condoms, and intra-uterine device insertion, as shown in Table 7 below. Calculating from the tabulated data shows that the RBHS partners provided more than 3,000 couple-years of protection to members of the communities they served. It is

clear that far more emphasis needs to be put on long-lasting methods such as IUDs, which are currently under-utilized. See Figure 8 for a graphical breakdown by contraceptive type.

Table 7: **Contraceptive provision through RBHS (July-August 2009)**

	Pills (cycles)	Depo-provera	IUDs inserted	Condoms	Couple-years of
Africare	644	292	0	4,246	151
EQUIP	402	178	0	5,649	118
IRC-Lofa	238	61	0	10,575	119
IRC-Nimba	444	64	0	6,713	102
MERCI	159	256	0	4,249	110
MTI	572	238	0	9,675	178
<b>RBHS total</b>	<b>2,459</b>	<b>1,089</b>	<b>0</b>	<b>41,107</b>	<b>779</b>

Figure 8: **Mix of contraceptives supported by RBHS (July-August 2009)**



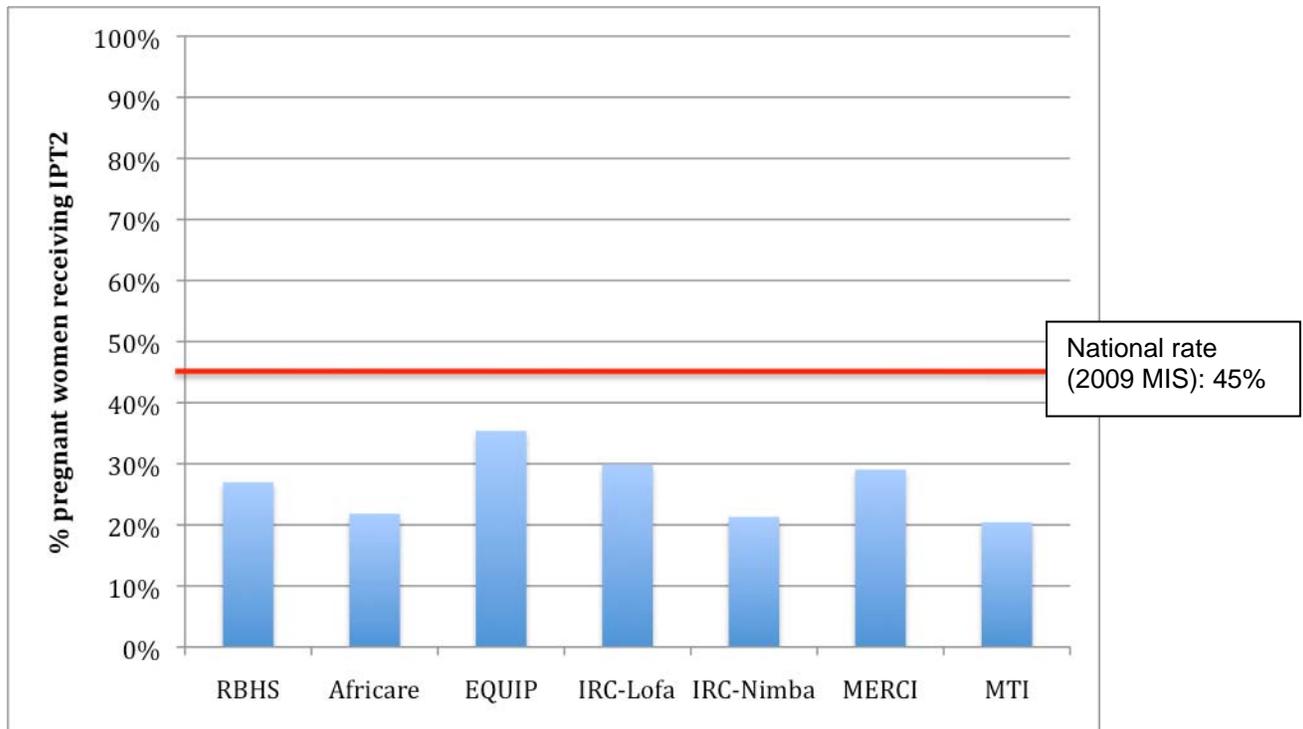
Although facilities are not yet generally collecting data on number of visits that include family planning counseling, Africare, EQUIP, and MERCI succeeded in gathering some data, and collectively reported 1,612 such visits over the two months.

#### Malaria control

With the data collected to date under the PBCs, the primary indicator relating to malaria relates to prevention: pregnant women receiving IPT. The NGO partners provided the second IPT dose to 1,492 pregnant women (see Figure 9 below). Clearly there is a lot of room for improvement

just to reach the MIS rate of 45% (though, again, the MIS figure seems unrealistically high, given the consistency from the NGO facility data).

Figure 9: **RBHS-supported IPT2 coverage (July-August 2009)**



A total of 15,592 children under the age of five were treated for fever with anti-malarials. Those cases represent 47% of all curative consultations for this age group and correspond to 311 deaths averted (using the same rationale as in Section 1 under Transition Grants). Not all NGOs reported whether treatment was with ACT or not; for the three that did report, 6,751 cases were treated with ACT, 81% of all (presumed) malaria cases.

Under the transition grants and PBCs combined, RBHS partners treated a total of 59,642 children under five for malaria, averting an estimated 1,213 deaths.

### HIV

Four of the NGO partners reported VCT activities as shown in Table 8 below. It is expected that, consistent with the National AIDS Control Program's scale-up plan, over time VCT will be extended to more facilities, but at this stage relatively few people are being tested. Note that data were collected only on testing and counseling, not on the results of the tests.

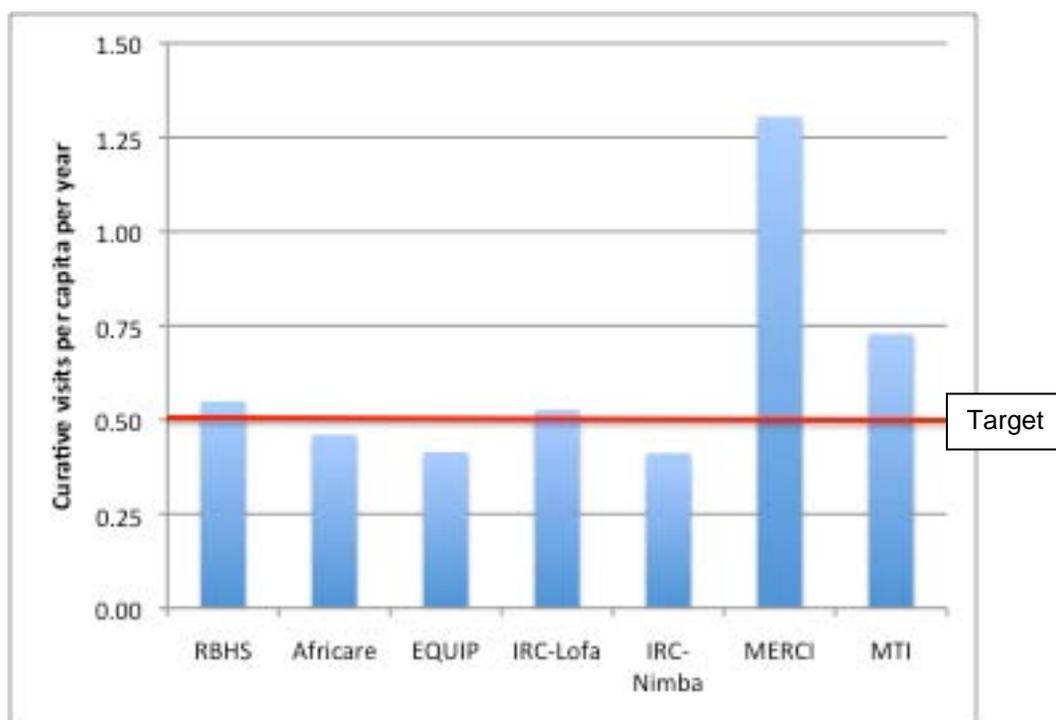
Table 8: **RBHS HIV counseling and testing (July-August 2009)**

	People receiving VCT and test results (non-	Pregnant women receiving VCT and test
Africare	146	378
EQUIP	29	22
IRC-Lofa	0	0
IRC-Nimba	42	55
MERCI	29	3
MTI	0	0
<b>RBHS total</b>	<b>246</b>	<b>458</b>

### Curative Services

Collectively, partners treated over 93,000 patients through their curative outpatient clinics during the reporting period: 32,964 children under five years and 60,169 patients five years or older. As noted, 47% of curative consultations for children under five were for presumed malaria; another 12% were for pneumonia and 5% for diarrhea. Utilization rates for curative care were more erratic than for the transition grants, ranging from 0.41 to 1.31 annual new visits per capita, again compared to the generally accepted target of 0.5 – 1.0 (Figure 10).

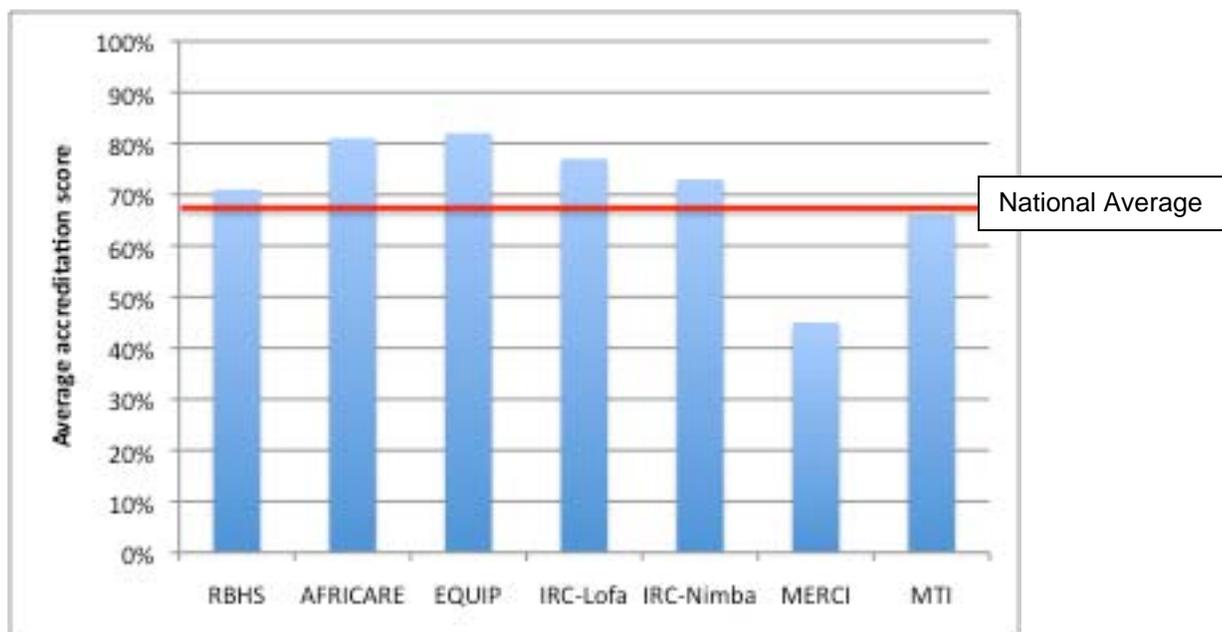
Figure 10: RBHS utilization rates (July-August 2009)



### Accreditation

Results of the January 2009 accreditation survey were presented earlier, but for the transition grant partners and not specifically for RBHS-supported facilities. Figure 11 shows accreditation scores for all RBHS-supported government facilities. It should be emphasized that these are scores measured before the performance-based contracts were established and in most cases before a particular NGO began supporting the facilities it is now responsible for. The average scores should therefore be considered as baselines, not as indicative of NGO (or RBHS) performance to date.

Figure 11: Average accreditation scores for RBHS-supported facilities (January 2009)



Summary of key USAID indicators

Because a full quarter under the performance-based contracts has not yet been completed, some data needed for calculation of key indicators have not yet been collected. However, Annex 2 combines figures from the transition grants and performance-based contracts. Table 9 below summarizes a select range of these summary indicators.

Table 9: Key RBHS service delivery indicators (Nov 2008-Aug 2009)

	Number	Coverage
Deliveries in facility	3,043	14%
Deliveries in facility with skilled birth	2,136	10%
Pregnant women receiving IPT2	6,658	30%
Pregnant women receiving TT2	16,845	97%
Couple-years of protection (contraceptives)	3,802	NA
Children under 5 receiving pentavalent-3	16,517	74%
People tested for HIV	3,494	NA
STI cases treated	9,393	NA

### Challenges and Constraints: Transition Grants and Performance-Based Contracts

- Drug supply. All RBHS partners reported shortages of essential drugs during the transition grants, including stock outs. A drug order that was submitted under the transition grants did not use a standardized quantification process; was delayed due to complicated regulatory requirements; and was estimated for only 75 health facilities. Hence, partners under the PBCs are already reporting shortages, which have been worsened by poor prescribing practices, including polypharmacy (i.e. prescription of multiple drugs per consultation).
  - *RBHS response.* Standard operating procedures (SOPs) were distributed to all partners and a careful quantification exercise undertaken in August-September. Attempts to centralize and streamline the process for the next drug order have been made. RBHS has secured an agreement from the MOHSW that drugs will be made available to supported facilities by the National Drug Service until the next order is delivered.
- Quality of care. Early field visits have indicated that the quality of care in some RBHS facilities remains poor, including inconsistent adherence to standardized protocols, multiple diagnoses, and polypharmacy. Moreover, staffing of health facilities is not consistent, especially when senior clinical staff are away to attend trainings or meetings. Too often, junior or unqualified staff are left with the responsibility of providing clinical care.
  - *RBHS response.* RBHS plans to work with the MOHSW, CHTs and implementing partners to establish a process for continuous quality improvement at RBHS facilities. RBHS will explore the application of the clinical standards developed through the Pre-service Education Initiative beyond just the clinical training sites (see below); the introduction and scaling up of standardized treatment protocols; and the development of a process to measure and improve quality. Furthermore, RBHS will work with partners to improve the staffing levels in clinics and to limit the impact of absences due to training and other demands.
- Insufficient technical support to the PBF process. Technical support for the PBF process was not as responsive, timely, or of the level that was required. RBHS has not provided the on-going technical assistance to the MOHSW that was initially committed.
  - *RBHS response.* RBHS has terminated the Performance Based Financing Team Leader position and will now provide the necessary inputs through short term technical assistance.

### **3. Behavior Change Communication (BCC) (SO 1.2, 1.3, 2.5; IR 3)**

During the reporting period of April - September 2009, the BCC team continued the assessments and preparatory work related to behavior change and demand generation, as well as capacity building of counterparts within the MOHSW. The main activities included:

i. Assessments and orientation at county level

The RBHS project continued visits to its five main operational counties to orient CHTs to RBHS and to collect information on activities at RBHS facilities and surrounding communities. Assessments of BCC activities were conducted in Lofa (April), Grand Cape Mount (June), Bong and Nimba (September). Previous assessments had been conducted in River Gee and Grand Cape Mount (preliminary). The assessments included meetings and interviews with key stakeholders (CHTs, RBHS implementing partners, health workers, community members,

community health volunteers, etc), direct observation in the facilities and communities, and review of materials, records, and reports. The findings were similar to those reported following earlier assessments (see *RBHS Semi-annual Report, November 5 – March 31, 2009*): most service providers did not have a plan or rationale for selecting health education topics; facility data was not generally used to guide topic selection; and the only topic for which there was adequate information, education, and communication (I,E,C) materials was malaria. Nonetheless, these materials were not linked to a planned and coordinated communication campaign. Similarly, there appears to be a consistent disconnect between the activities of community health volunteers (CHVs) and health facilities.

ii. Liberia RBHS Social and Behavior Change Strategy

A draft of the Social and Behavior Change strategy for RBHS was developed in May 2009. The Strategy is designed to support the MOHSW National Health Communication Strategy. It builds on past BCC programs in Liberia to further the health promotion aspects of the Basic Package of Health Services (BPHS). It is a first step in a process of strategic planning with partners. The strategy has at its core an integrated approach at the household and community levels, complemented by a series of periodic national vertical campaigns.

iii. Preparatory work for national Insecticide Treated Net (ITN) Campaign

- a. *Workshop for the development of materials and messages.* In collaboration with several divisions at the MOHSW, RBHS conducted a workshop from July 20 – 24, 2009, to develop draft materials and messages in preparation for a major BCC campaign to reduce malaria and morbidity through the promotion of ITN use. The campaign is being planned and timed to reinforce ITN use following a recent distribution of nets in Lofa, Nimba, Bomi, Grand Cape Mount, and Grand Bassa counties. The materials and messages are designed to encourage households to use their ITNs regularly and properly. The key message and theme developed at the workshop were: **Take cover to prevent Malaria, Sleep under the net Everywhere, Every night.** Drafts were developed for the following materials: three posters, one sticker, one CHV Reminder Card, and one leaflet for households. In addition, three draft audio messages were developed.
- b. *Pre-testing ITN Materials.* Initial pre-tests of both materials and messages were carried out within four communities of Margibi and Montserrado Counties during the workshop. Following refinements based on this initial work, a second series of pre-tests was conducted in three communities in Lofa County (Zorzor City, Fissibu, Sucromu) and three communities in Grand Cape Mount County (Robertsport, Sanje, Sajanama). All print materials were pre-tested in both counties. English and Kpelle versions of the audio message were pre-tested in Lofa, while English and Via messages were pre-tested in Grand Cape Mount.
- c. *Planning for ITN campaign launch.* In collaboration with the Liberian National Malaria Control Program, the MOHSW's Health Promotion Unit, and the US President's Malaria Initiative (PMI) RBHS has played a central role in the planning of the up-coming ITN campaign. The key elements include a national mass media effort, closely linked to widespread community mobilization activities. Campaign materials (posters, leaflets, reminder cards) and radio messages are currently being finalized, prior to the launch. CHTs, RBHS implementing partners, health workers, partners of the National Malaria Control

Program (NMCP), local traditional leaders and community health volunteers will lead and roll out the process at the community and household levels. Radio messages will reinforce community level activities. The campaign is slated for early November and will continue over a period of one year or more.

iv. Focus Group Discussion with Nursing Students (TNIMA & Esther Bacon)

RBHS led a formative study to determine conditions that would encourage graduates of Health Training Institutions to take up assignment and serve within under-served and remote communities. Four Focus Group Discussions were conducted with final year Nursing Students of the Tubman National Institute of Medical Arts (TNIMA), Monrovia and the Esther Bacon School of Midwifery, Zorzor, Lofa County. Respondents of the focus group were mixed (male and female) with approximately 12 members per session. The activity was carried out in collaboration with RBHS Pre-service Initiative. Once the data are analyzed, the report will be shared with the MOHSW, training institutions, and other stakeholders.

v. Development of Integrated Family Health Card

RBHS initiated a process with three divisions of the MOHSW, (Health Promotion, Expanded Program on Immunization, Family Health) to integrate two existing health cards (Mother's Yellow Card and the Child's Road to Health Card) into a more comprehensive and effective tool. The Family Health Card aims to capture relevant health information for both mother and child, to provide important health messages for families, and to enhance the service provider-client relationship. Existing family cards from Ghana and Ethiopia, together with mother and child information from Liberia, have been reviewed during the development process. This integrated tool, based on the BPHS, is expected to be used at the household level to prompt and assist families to act when the need arises. It will also help service providers at the facility and will assist supervisors to monitor the interactions between mother and facility and community service providers.

vi. Development of youth-focused family planning and sexual health materials and messages

Youth are considered one of the key audiences under the RBHS health promotion activities. On August 14, a day-long brainstorming session was held at RBHS to begin the process of designing materials and messages aimed at encouraging youths to delay first pregnancy, to access the various forms of family planning / birth spacing, and to develop positive attitudes towards sex and sexuality. Participating in the sessions were representatives from the MOHSW's Family Health Division, the Ministry of Education's School Health Division, UNFPA and civil society organizations. Outcomes from the day's exercise included one fact sheet on family planning and delaying pregnancy; one radio drama on the same subject; four posters and two radio spots. When developed, pre-tested and produced, these materials and messages will form a central component of one of RBHS's most important BCC campaigns, aimed at preventing teenage pregnancy and promoting adolescent health. It is expected that the campaign will launch in January.

vii. Collaboration with and capacity building of the National Health Promotion Division, MOHSW

RBHS engaged the National Health Promotion Division at MOHSW in a series of regular discussions to facilitate the undertaking of the following:

- Finalization and launch of MOHSW Communication Strategy
- Establishment of a National Health Promotion Technical Committee
- Planning for Global Hand Washing Day

Moreover, the Health Promotion Division has benefitted from the collaboration with RBHS and other partners, including NMCP, on the development of the ITN campaign, Family Health Card, and adolescent sexual and reproductive health campaign. Finally, one of the RBHS-support vehicles presented to the Ministry of Health and Social Welfare was assigned to the National Health Promotion Division (see below).

Challenges and Constraints: BCC

- Poor coordination of public health (PH) messaging. As reflected in the previous semi-annual report, this aspect remains a challenge. Given the widespread health needs in Liberia, there is a great need for health messaging on a broad range of topics. To date, much PH messaging has been ad hoc and poorly coordinated at community, facility, regional and national levels. To be effective, health messages must be coordinated around specific campaigns, prioritized, and sequenced.
  - *RBHS response.* RBHS has initiated and will continue to collaborate with the MOHSW and other partners to roll out a national BCC strategy to ensure that there is greater coherence, coordination, and consistency around PH messaging, as well as other aspects of BCC.
- Limited capacity of MOHSW's Health Promotion Division. As noted, the HPD has limited capacity to support other MOHSW departments and to lead effective BCC campaigns and initiatives.
  - *RBHS response.* RBHS is developing a plan to build the capacity of HPD staff. This will include one BCC skills building workshop every quarter over a period of a year; ongoing technical assistance and mentoring; opportunities to network with BCC experts; and sharing of resources.

## **IR 2: IMPROVED HEALTH WORKFORCE, SYSTEMS PERFORMANCE, AND INFRASTRUCTURE**

During its first full year of operation, RBHS has not only supported service delivery in up to 108 facilities and their surrounding communities it has worked closely with MOHSW and other partners on several aspects of health systems strengthening. Key among these have been human resource development (pre-service and in-service training) and the planning of a number of major infrastructure projects. Moreover, RBHS has provided technical input into important MOHSW policies and plans (e.g. reproductive health policy, mental health policy, in-service training strategy – see Annex 3) and participated as an active member of 10 Ministry-led committees and working groups (see Annex 4 for full list of committees and working groups in which RBHS staff have participated).

## **1. Pre-service Education (SOs 2.1, 2.2, 2.3)**

Through its Pre-service Education Strengthening (PSE) Initiative, RBHS is aiming to improve the under-graduate training of mid-level health care providers, the teaching skills of instructors and clinical preceptors, the educational environment at learning institutions, and the overall management of these institutions. The PSE Initiative is supporting two of Liberia's most important schools for nursing and para-medical staff – the Tubman National Institute for Medical Arts (TNIMA) in Monrovia and the Esther Bacon School of Nursing and Midwifery (EBSNM) in Zorzor. Nonetheless through its inclusive approach, stakeholders from other institutions involved in the training and development of four targeted cadres of health care providers (physician assistants, registered nurses, certified midwives, and environmental health technicians) have been engaged in the project. Given this inclusive process, it is expected that the processes and materials being developed will ultimately be adopted nationally.

Standards Based Education Management and Recognition (SBEM-R) has been introduced by RBHS as a method to improve the performance of both TNIMA and EBSNM. SBEM-R is a quality improvement process developed by RBHS partner Jhpiego that has proven effective in improving the learning experience at training institutions in several countries. Through SBEM-R, educators and health professionals actively participate in the development of educational and clinical standards, conduct baseline assessments against these standards, develop a process to incorporate the standards into their daily practice, and conduct on-going monitoring and evaluation of performance. The SBEM-R process is being shared with the Liberian Board of Nursing and Midwifery, Physicians Assistants Board, other professional associations and the MOHSW, so that it may become more broadly adopted.

The PSE approach focuses not only on strengthening the training institutions, but also on the clinical teaching sites, to ensure that lessons learned in the classroom are re-enforced at the bedside. Furthermore, the MOHSW policy of decentralization has helped guide the implementation of the PSE Initiative and its principles have been incorporated into all aspects of the project, so that technical and managerial skills will be strengthened at county and facility level.

Major start up activities implemented during November 2008 – March 2009 were detailed in the Semi-Annual Report submitted in April. During the current reporting period, RBHS has built upon these earlier activities and worked to institutionalize the previously developed educational standards, develop new clinical standards, establish core competencies for the four cadres of staff, revise job descriptions, and update curricula. The main activities and accomplishments have included:

- i. SBM-R Module One – Clinical Standards Workshop

While the educational standards will improve the level of instruction at the training institutions, clinical standards are also required to ensure that clinicians and students are providing the appropriate level of care at health facilities. The goal of this workshop was to develop draft clinical standards, based on the BPHS, which, when finalized and implemented, would contribute to improved performance and standardization of the quality of care at facility level. The workshop was hosted from April 21 – 24, 2009 and attended by 36 representatives/clinicians from the training institutions, MOHSW, CHT and NGOs.

Participants were oriented to the SBM-R model and process. They were then divided into six groups, based on the main elements of the BPHS – Maternal and Newborn Health; Child Health; Reproductive and Adolescent Health; Communicable Diseases; Mental Health; and Emergency Care. Within the six areas, the MOHSW has also identified 17 components or sub-areas, e.g. malaria. Groups then worked to develop draft standards for each of the components using existing global and national resources and references.

After four days, draft standards were adapted/developed for 17 sub-areas in the BPHS and two additional areas of infection prevention and health facility management. Several of the standards were pre-tested at JFK Hospital and an associated clinic, where participants were able to observe performance gaps between the level of care provided and the standards that they themselves had adapted/developed. The value of the standards as a practical tool for performance improvement was thereby once again highlighted. Based on the evaluation, participants were enthusiastic about both the standards and the SBM-R process and committed themselves to finalizing the clinical standards and using them in their facilities.

Following subsequent review and revision by the Education and Training National Working Group (NWG), the clinical standards have been finalized, and the baseline assessments of the first six clinical sites for TNIMA and EBSNM is scheduled for October.

ii. Baseline assessment using pre-service educational standards

Pre-service baseline assessments of TNIMA and EBSNM were conducted from May 11 to 15, 2009, using the recently developed national pre-service performance standards. Assessments were conducted in four specific areas: (1) School Management; (2) School infrastructure; (3) Classroom, practical instructions and assessment and (4) Clinical practice and assessment.

TNIMA received an overall score of 37% and met 22 of the 60 performance standards (see Table 9). EBSNM received an overall score of 40% and met 24 of the 60 performance standards. Of the four areas assessed the highest score was in School Management: TNIMA received a score of 53% and EBSNM a score of 47%. Both institutions had their lowest scores in Clinical Instructions, Practice and Assessment: TNIMA = 22% and EBSNM = 33%.

A series of recommendations were developed following the assessments relating to issues such as infrastructure, equipment and supplies, training for instructors and administrators, and institutional relationships with clinical preceptors. The RBHS has subsequently worked with both institutions to identify gaps and appropriate interventions to improve their performances, and to develop action plans to meet the agreed-upon standards.

Table 9. **Percentage of Performance Standards Achieved, Comparisons by Area Percentage**

<b>Standards Area</b>	<b>EBSNM</b>	<b>TNIMA</b>
Area 1: Classroom/practical instruction and assessment of learning	36%	36%
Area 2: Clinical instruction, practice, and assessment	33%	22%
Area 3: Institution infrastructure and educational resources	42%	27%
Area 4: Institution Management	53%	53%
<b>Total</b>	<b>42%</b>	<b>36%</b>

iii. Job Descriptions, core competencies and curricula changes

RBHS has led a series of activities to update the job descriptions and adapt and develop core competencies for each cadre of health worker.

a. *Physician Assistants (PAs)*

RBHS participated in the process, led by an external consultant hired by BASICS, of reviewing and updating the PA curriculum. Stakeholders agreed to continue with a 3 year course, including a 6 month rural assignment. Moreover, recommendations were accepted for two additional courses to be added to the PA curriculum: *Basic Simplified Diagnosis and Treatment* and *Rural Community Health Development*. A final course listing and sequence was developed, as well as compilation of course outlines and key documents to guide the final content of the syllabus for individual courses. Finally, progress was made on the revision of the *Handbook for Health Personnel in Rural Liberia*. Finalization of the syllabus for each course and of the handbook is expected during a subsequent consultancy under RBHS in October 2009.

b. *Environmental Health Technicians*

RBHS hosted a one day workshop attended by seven participants from the MOHSW, the Liberia Association of Public Health Inspectors/EHTs, and the director and instructors of the School of Environment Health Technicians, TNIMA. The EHT's job description was updated and the draft national EHT core competencies were adapted and developed. The core competencies and the EHT curriculum will be further developed through short term technical assistance in November 2009.

c. *Registered Nurses (RNs) and Certified Midwives (CMs)*

RBHS hosted a two day workshop in September, in collaboration with the MOHSW's Nursing Division and the LBNM, to develop core competencies for RNs and CMs and to draft a regulatory framework to strengthen nursing and

midwifery in Liberia. Twenty-six nurses and midwives, including administrators, managers and directors from across the country participated. The workshop achieved its objectives, with the production of a draft regulatory framework, updated job descriptions, and core competencies for both RNs and CMs.

d. *Integration of Communicable Disease Management (Malaria, HIV & AIDS, Tuberculosis & Leprosy) into pre-service curricula*

RBHS hosted a four-day workshop during September to ensure the input of relevant vertical programs and Ministry divisions into the pre-service curricula. The workshop was attended by representatives of the National Malaria Control Program, National AIDS Control Program, National Tuberculosis and Leprosy Control Program, and directors and faculty of TNIMA and EBSNM. Representatives of the vertical programs presented updated evidence based strategies, interventions, and concepts, as well as sharing their own teaching and technical materials. In a collaborative fashion, participants developed objectives, syllabus content, teaching methods and time allocation for incorporation into the pre-service curricula.

iv. Learning Technology Readiness Assessment (LTRA)

Separate Learning Technology Readiness Assessments were conducted at both TNIMA and EBSNM during July – August. The main objective of each assessment was to identify opportunities for the application of appropriate technologies to improve teaching and learning environments. A series of recommendations arising from the assessments focused on: provision of IT equipment; training of IT staff; computer training for faculty and administrative staff; establishment of computer labs; and promotion of distance learning;

v. Establishment of Education and Training NWG & Educational Development Centers

a. *National Working Group.* RBHS facilitated the convening and the development of the TORs for the Education and Training NWG. The NWG's primary purpose is to engage relevant stakeholders to advise and make recommendations on policies, approaches, and materials relevant to pre-service education. Membership of the NWG includes the Ministries of Health and Education, all of the professional boards and associations, and all of the pre-service medical, nursing and paramedical institutions.

b. *Educational Development Centers.* RBHS has assisted in the establishment of EDCs both at TNIMA and EBSNM. The main purpose of the EDCs is to ensure that faculty, both clinical and classroom, are regularly updated on evolving best practices, and scientific and educational developments. Furthermore, they are responsible for ensuring that teaching resources are updated, effective and functional. The members of the EDCs in both institution serves as focal persons, mentors and trainers in a continuous process of PSE strengthening.

vi. The First Education and Training NWG & Learning Technology Awareness Workshop

Twenty members of the NWG from the MOHSW, professional boards and organizations, RBHS and representatives of health-related training institutions attended the first Education and Training NWG & Learning Technology Awareness Workshop at the RBHS office in August. Findings and recommendations arising from the assessment were reviewed and discussed. The attendees also finalized the TORs for the NWG, the Educational Development Centers (see below) and National Coordinating Committee for Pre-service Training. They expressed eagerness to speed up the implementation of the recommendations arising from the LTRA, which will require on-going technical support from the consultant and capacity building of faculty.

vii. Pre-service Educational Standards Workshop and adoption of PSE Standards

At the request of the chairperson of the LBNM, the LBNM and the MOHSW hosted a national workshop of Nursing and Midwifery Directors, the Nursing Education Accreditation Committee, and representatives of the West African College of Nurses (WACN). The workshop was facilitated by the RBHS Education and Training Advisor. Participants were provided an orientation to SBEM-R, the educational standards, and findings of the baseline assessment. Following the workshop, the PSE standards were adopted as the National PSE Standards for Liberia. The general consensus was that the standards are critical for strengthening PSE and will be very useful in assisting management staff and teaching faculty to improve their performance.

viii. Effective Teaching Skills (ETS) Course

RBHS conducted two rounds of a 5-day ETS course for instructors from seven of the eight nursing schools in Liberia. A total of 39 participants benefitted from the training (24 in the first round and 15 in the second). The goal of the workshop was to improve the teaching skills of instructors. Sessions addressed issues such as the development of learning objectives, lesson planning, preparing the teaching environment, effective use of audiovisual materials, and facilitation of group learning activities. All participants were required to give an interactive presentation on the final day to demonstrate their competence. Each presenter received positive and constructive feedback (written and oral) from fellow participants and facilitators. Participants also developed an action plan to guide the application of their newly acquired knowledge and skills.

ix. Malaria Case Management Workshop

RBHS sponsored a 5-day Malaria Case Management Workshop facilitated by the NMCP at the EBSNM and Curran Lutheran Hospital (CLH) in September. Sixty-two senior midwifery students, faculty, CMs, RNs, LPNs and PAs, participated. The evaluation demonstrated a substantial overall increase in learning. The results of the pre-test revealed that of 59 attendees, 42 scored below 70% (mean = 45%; range = 6 - 80%). For the post test, only 17 persons scored less than 70% (mean = 75%; range 44 - 97%) and the lowest score was 44%. The same person had the lowest score in both pre-test and post-test even though that person had the most knowledge gained.

x. Procurement of equipment and supplies for TNIMA and EBSNM

RBHS has purchased a range of educational and medical equipment for the skills and computer labs, libraries, offices and classrooms at the two main training institutions. Included among this

equipment are: cloth pelvic models; advanced childbirth simulator models; CPR infant models; partographs and family planning posters; videos; teaching stethoscopes; educational charts; adult sphygmomanometers and stethoscopes; adult and infant weighing scales; and dopplers and gel. The items have already arrived in-country and will be handed over to the training institutions in November.

xi. Capping and Badging, EBSNM

Thirty-two females and one male junior midwifery students were capped and badged for the first time in over 20 years at the EBSNM, symbolizing their increasing responsibilities as midwifery students.

The President of Liberia, Mrs. Ellen Johnson Sirleaf, attended the ceremony and remarked on the historical significance of the program.

Challenges and Constraints: PSE

- Activities not completed. Some planned activities were not completed on schedule due to lack of personnel, competing and unexpected demands, and the ambitious nature of the workplan.
  - *RBHS response.* A more realistic workplan and timeline has been developed for year 2.
- Clinical standards baseline assessment. The finalization of the clinical standards and the planned baseline assessment have been delayed due to a combination of technical and programmatic issues. The participatory nature of the development process has resulted in standards that are more detailed than originally anticipated.
  - *RBHS response.* The timeline for finalization and baseline assessment has been adjusted, to accommodate broad stakeholder input.
- Strengthening the clinical training sites in Montserrado County. The clinical training sites that are used by TNIMA are not RBHS-supported facilities. These sites currently lack resources and some aspects of technical support required to ensure the quality of care and of training.
  - *RBHS response.* RBHS is exploring the options for assistance to these facilities, including material and technical support. STTA to assist with monitoring and evaluation, including on-going review of clinical standards, is planned for the first quarter of year 2.

## **2. In-service Education and Capacity Building (SOs 2.2, 2.5)**

RBHS continued its contributions to the roll-out of the MOHSW's In-service Education Strategy, in an effort to up-grade the skills of existing mid-level health care providers. The strategy includes the development of training modules for each of the six elements of the BPHS; training of Master Trainers and Trainers; the establishment of three regional training sites; and the subsequent training of up to 1,400 health professionals.

Progress on the in-service curriculum and implementation of the strategy have been slower than planned, due to gaps in the leadership and capacity of the MOHSW's Training Unit, as well as limitations with the technical assistance provided by external advisors for the curriculum

development. Specific activities undertaken by RBHS to support the in-service training activities have included:

i. Development of the in-service curriculum

Pre-existing modules for Maternal and Newborn Care and for Child Health (Basic Life Saving Skills from the American College of Nurse Midwives and IMCI from WHO respectively) have already been adopted by the MOHSW and used in the training of over 400 staff. But there has been a need to develop an integrated training curriculum to address the other four elements of the BPHS: reproductive health and family planning; communicable diseases; mental health; and emergency care. Development of these modules has been led by two Peace Corps volunteers, with assistance from MOHSW staff and partners. RBHS has assisted this process by advising on the syllabus for each module; contributing to negotiations on the relative time allocation for each module; and reviewing draft materials. A draft curriculum for integrated training has been developed, but is likely to evolve over time.

ii. Training of Master Trainers

Master Trainers have been identified by MOHSW to lead the training of trainers (TOT), in anticipation of the wider roll-out of the in-service strategy, including the integrated course. Three RBHS County Coordinators participated in the training of Master Trainers and will be available to assist with the planned TOTs.

iii. Preparation of training site in Nimba County

Three proposed regional training sites have been identified to support the TOTs and in-service trainings: one each in Nimba, Bong and Bomi. RBHS contributed to the planning and preparation of the Nimba site at the Ganta TB and Leprosy Hospital. Little progress been made on the development of the other two training sites, due to lack of resources.

iv. Completion of an in-service training inventory for RBHS health facilities

The RBHS County Coordinators have completed an inventory of the in-service training experience and status of all relevant staff at each RBHS-supported health facility. This inventory will permit more rational planning of subsequent in-service training for personnel at these facilities.

v. Drafting of a Capacity Building Strategy

RBHS has recently drafted a Capacity Building Strategy that aims to improve the management skills of MOHSW staff, especially those related to the nine Decentralized Management Support Systems identified in the National Health Plan. As such it complements the National In-Service Education Strategy and the activities of the RBHS Pre-Service Strengthening Initiative, which focus primarily on developing clinical and technical skills of health workers. Moreover, it will assist RBHS to assume the health systems strengthening activities of the BASICS project, which formally ceased its work on September 30.

Challenges and Constraints: In-service Training

- Limited capacity at the Training Unit of the MOHSW. The Director of the Training Unit resigned at the beginning of June and the three assistants have been unable to assume

the leadership responsibilities effectively, due to a combination of reasons. Fortunately, an interim Director has recently been appointed.

- *RBHS response.* RBHS will continue to provide technical assistance and moral support to the MOHSW and the Training Unit. We are assisting in the orientation of the interim Director and will make available our County Coordinators for the TOTs.
- Sub-optimal progress on the development of the integrated curriculum. Assistance from the Peace Corps Volunteers has not been as fruitful as expected – while they are expert educators, they have no clinical background. The volunteers end their assignment in October and MOHSW has been asked to ensure that their replacements have relevant clinical skills.
  - *RBHS response.* RBHS will continue to monitor and support the curriculum development process, providing technical inputs as needed.

### **3. Infrastructure Development (SOs 2.1; 2.5)**

The RBHS infrastructure program has ambitious objectives, including the rehabilitation of two nursing schools, the rehabilitation of the proposed headquarters of the National Malaria Control Program, the upgrading of five Emergency Obstetric and Neonatal Care (EmONC) centers, and the rehabilitation of many of the 108 health facilities supported through the PBCs. Preparatory work for these activities continued during the reporting period. Priority was given to the infrastructure work at TNIMA and EBSNM, as well as the EmONC centers. Negotiations continued over the scale of the NMCP headquarters.

All planning was coordinated with the Infrastructure Unit of the MOHSW, in spite of its own leadership and capacity problems. Moreover, all planning incorporated relevant elements of the RBHS environmental mitigation and monitoring plan (EMMP). The major activities included:

i. Architectural and engineering designs for TNIMA

A respected Liberian architectural and engineering (A/E) firm was contracted to undertake the major design work for TNIMA, including project cost estimates, bills of quantities, specifications, and project bidding documents. Utilization of environmentally friendly materials and equipment is a requirement of the contract, as is the use of alternative energy sources. The preliminary designs have recently been approved by RBHS, the Infrastructure Unit of MOHSW, and the management team at TNIMA and JFK Hospital.

RBHS is currently in the process of pre-qualifying construction firms prior to requesting bids for the rehabilitation work. In the interim the A/E firm is finalizing production of contract bidding documents, specifications, layout plans and drawings.

ii. Architectural and engineering designs for EBSNM

Similar progress has been made on the architectural and engineering design work for EBSNM. The same A/E firm was hired for the project and identical requirements have been specified in the contract. The preliminary designs have been approved by RBHS, the Infrastructure Unit of MOHSW, and senior staff at EBSNM. Once the pre-qualification process has been completed, RBHS will be requesting bids from construction firms for the rehabilitation work. The A/E firm is currently finalizing the contract bidding documents, specifications, layout plans and drawings.

iii. Architectural and engineering designs for the proposed National Malaria Control Program (NMCP) Headquarters

Following prolonged negotiations over the design and use of the proposed NMCP headquarters, MOHSW agreed to proceed with the original plans of a two-story facility that would not include a blood transfusion service. An A/E firm was subsequently contracted after a routine bidding process, and has recently completed the preliminary design work. These designs have been submitted for approval to both RBHS and the Infrastructure Unit. The A/E firm was given the go ahead to develop the structural design works activities.

iv. Assessments and planning for the upgrading of five EmONC Centers

RBHS is coordinating with the MOHSW and the US Navy to upgrade five facilities to have the capacity to provide comprehensive emergency obstetric care services. RBHS has prioritized the following three facilities: Fish Town Health Center (River Gee County), Bensonville Health Center (Montserrado), Curran Lutheran Hospital (Lofa). The US Navy will take the lead on developing the operating rooms, pre- and post-operative facilities at Sinje Health Center (Grand Cape Mount) and Du Port Rd (Montserrado) – although it is likely that RBHS will need to undertake some additional rehabilitation work at these facilities.

Following assessments by consultant engineers, bills of quantities have been submitted to MOHSW for comments and approval. Once the approval has been received, a request for proposals will be issued for local construction companies to bid for the rehabilitation works. Finally, draft equipment lists have been developed and are currently being compared with similar lists provided by the MOHSW. As soon as the list is finalized, including detailed specifications, it will be submitted to USAID for approval.

v. Assessment and planning for the rehabilitation of up to 108 clinics and health centers

Through its performance based contracts, RBHS is supporting 108 clinics, health centers, and hospitals in the seven target counties. Infrastructure rehabilitation needs assessments for facilities prioritized by CHTs were conducted in all seven RBHS catchment areas (River Gee - 7; Lofa - 8; Bong- 7; Nimba – 5; Grand Cape Mount – 8; Bomi – 2; and Monserrado - 2), a total of 39 assessments. Assessments of office space and water supplies for CHT premises in Lofa and Grand Cape Mount were also conducted including renovation requirements for the Bong Training Center at Phebe Hospital premises.

Copies of the assessed facilities were given to the respective RBHS NGO counterparts operating in the selected Counties to verify and assess which of the facilities they have capacity to carry out the planned rehabilitation on their own. A plan to complete the formal assessments of the remaining facilities is currently being developed with the MOHSW Infrastructure Unit. Once completed, information from the assessments will be shared with the awardees of the performance based contracts and a plan developed for the rehabilitation process.

Challenges and Constraints: Infrastructure

- Budget shortfalls. Rehabilitation cost estimates of the larger health facilities including complimentary and ancillary works such as water and sanitation, electricity, furniture, and equipment substantially exceed the originally planned infrastructure budget.
  - *RBHS response.* RBHS will rehabilitate those facilities for which we have a standing commitment (TNIMA, EBSNM, NMCP, EmONC centers). Within those facilities, we will focus on the essential components, e.g. classrooms,

dormitories, utilities. Clinics and health centers requiring rehabilitation will be prioritized in negotiation with CHTs and implementing partners. Based on available resources, a workplan will be developed with responsibilities for rehabilitation shared between RBHS and its partners.

- Lack of standardization and quality of previous construction work. Prior construction and rehabilitation activities were carried out haphazardly without any specific guidelines or standards from the MOHSW regarding roofing/ceiling, doors, windows, utilities, wall colors, medical waste disposal, etc.
  - *RBHS response.* RBHS will work closely with MOHSW and other stakeholders to adopt agreed upon standards.

### **IR 3: YOUTH INFORMED AND NETWORKED ON REPRODUCTIVE HEALTH**

See section of Family Planning and Reproductive Health below.

### **ELEMENTS and CROSS-CUTTING ISSUES**

In addition to those directly associated with the sub-objectives, the RBHS team has undertaken a range of activities related to elements and cross-cutting issues that are central to the project: maternal, neonatal and child health (MNCH); family planning and reproductive health, including adolescent health (FP/RH); malaria; HIV/AIDS; water, sanitation, and hygiene promotion (WASH); and mental health. While the following program elements have been referred to directly or indirectly throughout the report, this section presents a summary of some of the main activities by element since the commencement of the RBHS project in November 2008.

#### **1. Maternal, Neonatal and Child Health (MNCH)**

- *Provision of MNCH services by transition partners and PBCs (see IR 1).* These services include ante-natal care, delivery care, post-natal care, basic emergency obstetric care, basic life saving skills, and referral of complicated cases. Child health services include immunization, promotion of exclusive breast feeding, growth monitoring, and IMCI.
- *Contributions to the accelerated roll-out of BLSS and IMCI in-service training.* RBHS has been one of the main advocates for the roll-out of these trainings.
- *Development of MNCH protocols and procedures.* RBHS participated in a MOHSW sub-committee that developed these materials, intended for distribution to service delivery points. The second draft has been completed and will be edited and distributed by WHO.
- *Planning for comprehensive EmONC services.* All five proposed comprehensive EmONC facilities were visited and assessed. Although comprehensive EmONC (CEmONC) services require hospital capacity (specifically, surgical and blood transfusion), four of the five will be established at facilities that are currently health centers. Establishment of these EmONC facilities will clearly require major upgrading of

the physical structures, the services and systems, and the capacity of staff. In addition to those activities already described under the Infrastructure section, RBHS has developed a Scope of Work, Operational Plan, and equipment lists for the EmONC services. A drug list has also been finalized and a request for quotations issued. Moreover, RBHS is currently in discussion with the MOHSW and current PBC contractors to finalize our implementing partners for the CEmONC centers.

- *Consultation on incorporation of the Essential Nutrition Actions (ENA) into BPHS.* In collaboration with MOHSW and Unicef, RBHS is working to ensure that the ENAs become fully integrated into the BPHS. RBHS and Unicef co-hosted a 5-day workshop on the ENAs in September, which was attended by over 50 representatives from the MOHSW, NGOs, UN agencies, USAID, and other donors. A field assessment was completed with the assistance of STTA and planning for the promotion and scaling up of the ENAs commenced. The ENA plan for year 2 addresses issues such as advocacy, partnership, training (both in-service and pre-service), BCC, development of protocols and guidelines, and monitoring and evaluation.

## **2. Family Planning and Reproductive Health, including Adolescent Health**

- *Provision of FP/RH services by transition partners and PBCs (see IR 1).* To date, FP/RH services have received little priority from the MOHSW and operational agencies. Although much needs to be done to expand these services, during year 1 RBHS partners did exceed the USAID target for the number of counseling visits for FP/RH (actual = 12,795; target = 8,000) and almost reached the target for couple-years of protection (actual = 3,802; target = 4,500). Further expansion of these services will be addressed in year 2.
- *Recruitment of a FP/RH Advisor.* To ensure more detailed attention to the issues of FP/RH, RBHS recruited a full-time Advisor in September. She will have a range of strategic, technical and representational responsibilities related to FP/RH.
- *Contribution to the drafting of the National Reproductive Health Policy.* RBHS staff have been members of the Reproductive Health Technical Committee and made substantial contributions to the development of the *Sexual and Reproductive Health Policy for Liberia*. Importantly, adolescent RH is a theme that cuts across all sections of the policy paper. In addition, there is an entire section on adolescent RH that highlights issues such as appropriate messaging for youth, promotion of youth friendly services, and school-based health services.
- *Technical contribution to the drafting of in-service training module on RH and family planning.* This module is also expected to address the specific needs of adolescents.
- *Negotiation with Population Services International (PSI) over youth reproductive health program.* Over several months, RBHS has engaged in on-going negotiations with PSI on a program of condom social marketing and behavior change communication directed at youth aged 15 – 24 years. PSI proposes using subsidized pricing and culturally appropriate messages to increase the availability of and access to a branded condom that they have recently launched. Pre-tested messaging will promote condom use through radio, youth outreach, medical facilities (especially those providing youth friendly services), and advertising. The condom distribution campaign will be complemented by other efforts to promote more responsible and healthful sexual behavior. Included among these are a weekly radio show, peer education, and a school health program. RBHS has recently received a final proposal from PSI and expects to fund the program in October / November.

- *Advocacy with MOHSW on family planning.* RBHS participated in a series of three meetings with MOHSW (Assistant Minister for Preventive Services) and other stakeholders to advocate for the inclusion of FP in the start-up training of Community Health Volunteers (gCHVs). Following these meetings the ministry agreed to allow those CHVs already engaged in delivery of FP services to continue and to also include FP in the first rounds of training for gCHVs.
- *Planning for expansion of FP/RH at markets and college campuses.* RBHS has engaged in negotiations with the Liberia Market Women's Association and Ministry of Gender to introduce FP services at eight markets in Monrovia and Nimba County. A scope of work has been developed and a budget drafted. If successful, it is expected that these services will be expanded to additional markets in the other counties where RBHS is operational. Similar services are likely to be introduced at up to five college campuses.
- *Development of RBHS strategy and guidance document on FP/RH.* RBHS has recently drafted its own *Family Planning and Reproductive Health Strategy* and guidance document on *The Peri-natal Approach to Child Bearing*. Once finalized, these documents will be disseminated and institutionalized in RBHS project areas.

### **3. Malaria**

- *Provision of clinical and preventive services by transition partners.* As noted previously, RBHS partners treated almost 60,000 children under the age of 5 years with suspected or confirmed malaria during the reporting period. They also provided a second dose of IPT to 6,542 pregnant women, contributed to ITN distributions, and conducted numerous educational sessions (IMC sessions reached over 3,400 persons).
- *BCC activities in support of malaria control*
  - Assessment of existing BCC messages and materials related to malaria. This assessment was conducted as a component of a broader assessment of all available BCC materials. It included a review of the NMCP Communications Strategy.
  - Planning for major ITN campaign. As noted above, this has involved consultative work on the development of messages and materials; pre-testing of messages and materials in 10 sites in four counties; development of radio messages, jingles, and print materials (e.g. reminder cards for CHVs, posters); and a coordinated plan of advocacy through opinion leaders, government, and community institutions. The campaign is due to be launched in November.
  - Malaria messaging in Family Health Card. Messages related to ITN use, intermittent presumptive treatment of malaria in pregnancy (IPT), and early case management of malaria are included in draft versions of the Family Health Card.
- *Improving pre-service and in-service training* (see Pre-service section above under IR2 for further details)
  - Clinical standards for malaria. As noted, under the RBHS's PSE Initiative, clinical standards have been developed for each of six main areas of the BPHS. Under Communicable Diseases, standards have been developed for the prevention and management of malaria.
  - Integration of malaria into pre-service curricula. At a workshop in September, RBHS worked with NMCP and other vertical programs to ensure that their content and materials were integrated into the pre-service curriculum for mid-level health care providers.

- Workshop on case management of malaria. RBHS sponsored a 5-day workshop facilitated by the NMCP to update instructors and students on best practices in malaria case management.
- Integration of malaria into in-service curriculum. The Communicable Diseases section within the in-service curriculum includes a module on malaria that is based on materials provided by NMCP.
- *Improving NMCP capacity for program management and supervision.*
  - Identification and recruitment of malaria consultant to assist with Round 9 submission to GFATM. RBHS identified, sponsored and hosted a highly experienced consultant to lead the development of a Liberian proposal for Round 9 of the GFATM. After the first week it became evident that Liberia was not well placed to make a submission and that any such proposal would be unsuccessful. RBHS worked with the consultant to revise the scope of work to instead focus on an update of the National Malaria Strategic Plan. The scope of work had to be adjusted one more time, as many knowledge gaps and policy decisions needed to be addressed prior to updating the strategy. Nonetheless, the consultant's final presentation and recommendations were well received by the MOHSW, USAID, and RBHS.
  - Workshop on Malaria Operational Plan. RBHS sponsored and participated in the MOP Workshop conducted by PMI at Wulkie Farms on May 15. The workshop reviewed progress against the current MOP and presented proposed activities for the 2010 MOP.
  - Procurement of vehicles. RBHS procured two 4-wheel drive vehicles for the NMCP program, including one for the headquarters office in Monrovia and one to assist with surveillance activities at county level.
  - Assessment of decentralized health service management. Using a standardized tool, consultants recruited by RBHS conducted an assessment of decentralized health service management in five counties, including a specific concentration on NMCP. The findings indicated that the County Health Teams were generally satisfied with the implementation of malaria activities. The main issues requiring attention include: the centralized planning and scheduling of non-facility based malaria activities (e.g. ITN distribution); the lack of feedback from supervisory visits by NMCP staff; the lack of CHT-input into quantification of malaria commodities, including drugs; and fund allocation for malaria activities.
- *Planning for implementation of community case management (CCM) of malaria.* Together with the MOHSW's Community Health Division and the NMCP, RBHS is in the process of planning for the roll-out of CCM of malaria. Services are likely to commence in four or more districts in one or more RBHS counties.
- *Renovation of building to accommodate NMCP headquarters.* See Infrastructure section under IR2 for details.
- *Other*
  - Explored options for disposal of old ITNs. See Water, Sanitation and Environmental Health section below.
  - Participated in consultative meeting with Minister Gwenigale prior to executive meeting of Roll Back Malaria.

#### **4. HIV**

- *Services provided through transition grants and PBCs.* These include the distribution of over 173,000 condoms; the conduct of numerous educational sessions (IMC sessions reached over 3,200 people); testing of 3,494 people for HIV; and the referral of HIV positive clients for CD4 counts and consideration for anti-retroviral treatment. Services will be expanded during year 2, in line with the National AIDS Control Program's scale-up plan.
- *Assessment of existing BCC messages and materials related to HIV.* This assessment was conducted as a component of a broader assessment of all available BCC materials.
- *Improving pre-service and in-service training* (see Pre-service section above under IR2 for further details)
  - Integration of HIV into pre-service curricula. At the workshop in September, RBHS worked with NACP to ensure that their content and materials were integrated into the pre-service curriculum for mid-level health care providers.
  - Integration of HIV into in-service curriculum. The Communicable Diseases section within the in-service curriculum includes a 5-day module on HIV that is based on materials provided by NACP.
- *Mapping exercise of HIV activities in RBHS areas of operation.* In collaboration with an external consultant and the NACP, the availability of HIV services in RBHS-supported facilities has been mapped. This information is critical to the scaling up of services in year 2.
- *Negotiation with Population Services International (PSI) over youth reproductive health and condom social marketing program.* See FP/RH section above for further details.

#### **5. Water, Sanitation and Environmental Health**

- *Finalization of the RBHS Environmental Mitigation and Monitoring Plan (EMMP).* The plan outlines the various activities undertaken by RBHS that could have a detrimental environmental impact, the appropriate mitigation measures to be taken, and an appropriate monitoring plan. A more detailed report concerning progress on the EMMP has been submitted separately.
- *Guidance to implementing partners on medical waste management.* Procedures for the handling, labeling, treatment and storage of medical waste have been distributed via two virtual workshops. At a minimum, procedures discussed followed Chapter 8 of USAID's Environmental Guidelines for Small Scale Activities (EGSSA).
- *Contribution to assessment on current status of medical waste management in Liberia.* The RBHS Environmental Health Advisor contributed substantial assistance in the development of a successful proposal to the MOHSW by partner ETLog to conduct an assessment of medical waste management in Liberia. She has subsequently participated on field visits to 10 sites in Montserrado and Nimba Counties and helped to facilitate a two-day workshop for the MoHSW on medical waste assessment. The main outputs of the project will be an assessment of current medical waste management practices in Liberia and a draft plan for improved medical waste management moving forward.
- *Clarification of environmental mitigation and monitoring measures for construction work.* Relevant elements of the RBHS EMMP have been shared with the architectural and

engineering firms contracted for infrastructure work. These will also be shared with construction firms.

- *Exploration of options for disposal of used ITNs.* RBHS is coordinating with DELIVER and other partners to explore options for the collection and subsequent disposal of used ITNs. One identified option is to engage a private US-based company to collect the old nets and recycle them for use in outdoor decking. Approximately 50 bags, weighing as estimated 75 pounds each were observed in Nimba County, having been collected by RBHS partner EQUIP.
- *Guidance on water supply and sanitation.* Instructions on site selection, water supply, rainwater catchment, latrine selection and construction were addressed through the two virtual workshops. Furthermore, the main problem facing water supply systems at RBHS-supported facilities appears to be long-term maintenance, including provision of spare parts. RBHS is exploring the option of adding simple parts such as rubber gaskets for hand pump maintenance to the existing supply chain managed by NDS.

## **6. Mental Health**

- *Contribution to National Mental Health Policy.* There is currently very limited capacity to address the mental health needs of the Liberian population. Most activities to date undertaken by the MOHSW have been focused on policy and strategy development. As head of the Mental Health Secretariat within the MOHSW, the RBHS Mental Health Advisor played an important role in helping to coordinate the finalization of the policy. He is also participating in the consultative meetings on the policy at county level.
- *Contribution to pre-service and in-service curricula.* The RBHS Mental Health Advisor has assisted in the review of the in-service mental health curriculum and has advised the PSE Initiative on the pre-service mental health curriculum.
- *Contribution to National Mental Health Strategy.* RBHS is an active contributor to the drafting of the National Mental Health Strategy and Plan. The Mental Health Advisor is playing a central role in this process, helping to convene meetings, taking minutes, and disseminating all relevant documents and information to committee members.

## **PROJECT MANAGEMENT, FINANCE and ADMINISTRATION**

Project management and administration focused on a range of strategic, procurement, recruitment, and systems development issues. The major activities included:

### **i. Team Building Retreat**

In April, RBHS hosted a staff retreat to review the project mission and strategy, to discuss roles and responsibilities, to present activity updates, and to develop a sense of teamwork. Colleagues from the BASICS Project also participated and presented updates on their own progress. Feedback from participants was very positive, with a general consensus that the project had commenced well and that a common vision and direction was already developing.

### **ii. Strategic Planning Meeting**

The First Annual RBHS Strategic Planning Meeting was held from August 19 – 21. All RBHS technical and F&A staff participated, as well as representatives from USAID and BASICS. The

main objectives were to review progress of the project to date; to clarify the RBHS vision and mission; to review the staffing structure and focal points; to begin the development of a strategic framework for each of the elements; and to initiate the process of developing the year 2 workplan. An important theme to develop was the ambitious scope of the RBHS project and commitments, and the need to do realistic planning in the second year.

The RBHS team agreed on three main pillars for the project: health service delivery; health systems strengthening; and behavior change communication / community mobilization. The main outputs included a project mission statement, project vision statement, and new objectives to address each of the project elements (MNCH, FP/RH, malaria, HIV/AIDS and WASH). Working groups were established for each of the objectives to develop the related activities for the year 2 workplan. A number of team building activities were also undertaken. The meeting provided an effective forum to share experiences and expectations, and to identify the opportunities and constraints facing the project.

### iii. Finance and Admin (F&A) activities

Several project start-up, system and office set up activities continued during the reporting period. Routine F&A were also on-going. Specific tasks accomplished included:

- *Vehicle purchase.* RBHS successfully completed the procurement of 20 vehicles for the MOHSW, Counties and RBHS. The 15 vehicles for the MOHSW and Counties included five ambulances and were handed over to MOHSW by the USAID Mission Director. Furthermore, an order for 9 vehicles and 73 motorcycles for RBHS implementing partners was finalized, with the vehicles due to arrive on October 23.
- *Pharmaceutical procurement.* Drugs and reagents were purchased for a 6 month period for the 75 facilities managed under the transition grants. A major quantification exercise was completed using adapted standard operating procedures for the next 9 month purchase for 108 clinics and five EmONC centers.
- *Staffing and recruitment.* RBHS completed the recruitment of all project personnel including technical and F&A staff, and provided necessary training to carry out their responsibilities. See Annex 5 for updated staffing structure.
- *General procurement.* RBHS completed all major procurement for start-up activities.
- *Refurbishment of and move to new office space.* An expanded office space was renovated and equipped to accommodate the expanded RBHS team. The new office was occupied in May.

### Challenges and constraints: Finance and Administration

- Recruitment challenges. It had been difficult to identify and recruit suitable applicants for two main positions: Monitoring and Evaluation Director and Performance-based Financing Team Leader.
  - *RBHS response.* The M&E Director position was converted to an international hire and a highly experienced expat recruited. It was agreed with RBHS partner MSH that the PBF Team Leader position would be discontinued and that support to the project would be provided through short-term technical assistance (STTA).
- Budgetary Challenges. It has been difficult to follow the original Cooperative Agreement (CA) budget for expenditure as the original budget was either under estimated and/or

certain items were not included, e.g. costs associated with EMMP, phase-over of BASICS activities.

- *RBHS response.* RBHS has conducted a preliminary budget review and taken some cost cutting measures to address this issue. For example, RBHS has reduced the in-county per-diem and is investigating savings in partners' budgets. It is unlikely that these measures alone will be sufficient to resolve the shortfalls. RBHS is therefore engaged in on-going negotiations with USAID on other options for addressing this issue.
- Limited office space and warehouse. RBHS needed to recruit additional staff in order to meet programmatic commitments, but the office space was developed and rented according to the original CA staffing plan. In addition, four former BASICS staff joined the RBHS team as of October 1, 2009. RBHS has also developed a need for a warehouse.
  - *RBHS response.* RBHS has negotiated with MOHSW to keep the former BASICS office to accommodate RBHS staff. RBHS is currently looking into various options for a warehouse near to the RBHS office.

## ***Budget vs. Expenditures***

Please see Annex 6

## ***Visitors and Consultants***

The Project hosted 35 visits from RBHS partners during the year 1:

Table 10: **International visitors during year 1**

NAME	PERIOD	TITLE
1. Kara Cherniga	11/08/08 - 11/21/08	JSI Project Coordinator
2. Kristen Risley	11/08/08 - 11/21/09	JSI Project Coordinator
3. Kara Cherniga	12/05/08 - 12/17/08	JSI Project Coordinator
4. Shiril Sarcar	12/07/08 - 12/12/08	JSI Deputy Chief of Party
5. Helene Lefevre-Cholay	12/07/08 - 12/17/08	JSI Chief of Party
6. Frank Baer	12/07/08 - 12/17/08	JSI HMIS Consultant
7. Carrie Hessler-Radelet	12/10/08 - 12/17/08	JSI Senior Advisor
8. Carrie Hessler-Radelet	01/31/09 - 02/13/09	JSI Senior Advisor
9. Laura Sanders	02/03/09 - 02/13/09	JSI Finance Coordinator
10. Richard Brennan	02/03/09 - 02/13/10	JSI Public Health Consultant
11. Tamara Smith	02/08/09 - 03/05/09	JSI Management Consultant
12. Petra Vergeer	02/11/09 - 03/04/09	JSI Performance Based Contracting Consultant
13. Deirdre Rogers	02/14/09 - 02/28/09	JSI M&E Advisor
14. Toryalai Hart	02/25/09 - 03/18/09	JSI Environmental Health Consultant
15. Kara Cherniga	3/22/09-4/17/09	JSI Project Coordinator
16. Timothy Williams	5/18/09-6/5/09	JSI M&E Advisor

17. Deirdre Rogers	7/19/09-7/31/09	JSI M&E Advisor
18. Kumkum Amin	8/1/2009-8/9/2009	JSI Senior Advisor
19. Aleph Henestrosa	5/10/09-	JSI Consultant
15. Udaya Thomas	Dec, 2008	Jhpiego Project Officer
16. John Agbodjavou	Jan, 2009	Jhpiego, Regional Technical Advisor
17. Emmanuel Otolovin	02/16/09 - 02/18/09	Jhpiego, Technical Advisor
18. Martha Appiaguyei	03/28/09 - 04/03/09	Jhpiego, Pre-service Consultant
19. Paul E. Mertens	9/28/09-11/5/09	Jhpiego, Consultant
20. James Bontempo	7/27/09-8/3/09	Jhpiego, Learning Technology Advisor
21. Joyce Ablordeppey	10/2/09-10/16/09	Jhpiego/Ghana, Reproductive Health Officer
22. Martha Appiaguyei	8/22/09-9/4/09	Jhpiego, Pre-service Consultant
23. Tegbar Zigwei	8/22/09-9/4/09	Jhpiego, Pre-service Consultant
24. Joyce Ablordeppey	3/28/09-4/12/09	Jhpiego/Ghana, Reproductive Health Officer
25. Katie Frank	03/01/09 - 03/14/09	JHU-CCP Technical Advisor
26. Katie Frank	7/13/09-7/31/09	JHU-CCP Technical Advisor
27. Ian Tweedie	5/2/09-5/10/09	JHU-CCP Technical Advisor
28. Uder Antoine	Dec, 2008	MSH PBC Advisor
29. David Collins	2/15/2009 - 03/06/09	MSH Cost Analysis Consultant
30. Zina Jarrah	02/15/09 - 03/06/09	MSH Cost Analysis Consultant
31. MOHSW Trip to Rwanda (6 persons)	February, 2009	MOHSW Staff
32. Constant Kabwasa	February, 2009	RBHS Staff
33. Zina Jarrah	5/18/09-5/30/09	MSH Cost Analysis Consultant
34. Steve Redding	6/14/09-6/28/09	MSH Staff
35. Zina Jarrah	8/4/09-8/28/09	MSH Cost Analysis Consultant

## Program Subcontracts

Table 11 below provides a cumulative summary of all active program subcontracts.

Table 11: **Status of Program subcontracts**

Organization	Project Component	Type of contract	Current Status/Period	Amount
Africare	Performance-based Contract	Contract	Ongoing/2 years	\$1,806,247
EQUIP	Performance-based Contract	Contract	Ongoing/2 years	\$2,269,057
IRC-Lofa	Performance-based Contract	Contract	Ongoing/2 years	\$2,037,315
IRC-Nimba	Performance-based Contract	Contract	Ongoing/2 years	\$1,253,904
MTI	Performance-based Contract	Contract	Ongoing/2 years	\$2,304,156
MERCI	Grants	Grant	Ongoing/1 year	\$897,471

## UPCOMING WORKPLAN ACTIVITIES (October 2009 – March 2010)

During the coming six months, the project will place increased emphasis on scaling up technical activities, as well as on developing tools and systems to measure and document the progress and effectiveness of the project activities. Some highlights of the workplan for the next six months are as follows:

### **For the BPHS, FP/RH, and PBF teams:**

- Map availability of high impact, evidence-based interventions at RBHS-supported facilities;
- Identify service gaps and develop scale-up plans for implementation of high impact interventions;
- Promote the institutionalization of MOHSW-endorsed protocols, guidelines, and procedures at RBHS facilities;
- Introduce community case management (CCM) of childhood infections and community distribution of family planning commodities in selected RBHS communities;
- Commence the processes for establishing comprehensive emergency obstetric care services at five RBHS-supported facilities;
- Develop a comprehensive FP/RH strategy, with emphasis on special needs of youth;
- Roll out training for service providers in FP/RH;
- Commence provision of FP services at market places and universities;
- Collaborate with MOHSW and Unicef on the institutionalization of the essential nutrition actions;
- Conduct an assessment of mental health services in RBHS-supported facilities;
- Assist in capacity building of the MOHSW in performance based financing;
- Manage PBF/C implementation, including monitoring of subcontracts performance against milestones defined in the subcontracts.

### **For the BCC/IEC team:**

- Support NMCP in launch of national ITN campaign;
- Conduct health seeking behavior study in up to 5 counties;
- Prioritize subsequent national campaigns and community mobilization/BCC activities, based on results of formative research (e.g. MNCH; malaria; FP/RH; WASH, etc), in collaboration with Health Promotion Unit and MOHSW;
- Assist HPU in the pre-testing and finalization of integrated Family Health Card;
- Assist CHT to conduct community mobilization for setting up Community Health Committees;
- Commence training of gCHVs in BCC concepts, including CHEST kits, Journey of Hope Kits;
- Assist HPU in roll out of National Communication Strategy;

- Collaborate with PSI on social marketing campaigns, especially around condoms and point-of-use water treatment solutions.

**For the Pre-service Education team:**

- Ensure relevant elements of malaria in pregnancy, case management with ACTs, and IPT are introduced into the curricula for PAs, RNs, CMs, and EHTs;
- Finalize clinical standards and conduct Baseline Assessments for teaching (in TNIMA and EBSNM) and clinical sites (e.g. JFK Medical Center);
- Develop M&E plan for pre-service education, with process, outcome and impact indicators;
- Conduct on-going monitoring and evaluation of clinical standards at training sites;
- Review / revise curriculum for PAs, RNs, and CMs;
- Contribute to finalization of mental health component of pre-service curricula;
- Develop / adapt / identify and acquire teaching and learning resources, including assessment process and tools;
- Distribute equipment and supplies to schools.

**For the Capacity Building and In-service Education team:**

- Contribute to the roll-out of the In-service Strategy;
- Contribute to finalization of mental health component of in-service curriculum;
- Provide feedback to MOHSW to finalize the HMIS SOPs and forms;
- Collaborate with LISGIS and MOHSW to continue work on defining catchment population for health facilities;
- Assist MOHSW in the development and roll-out of performance-based contracts;
- Host a validation workshop for the costing exercise;
- Contribute to the development of the National Mental Health Strategy;
- Provide on-going technical assistance to the MOHSW on mental health issues;
- Assist MOHSW to update health facility database;
- Collaborate on Decentralized Management Support Systems (DMSS) development;
- Participate in Decentralization Working Group (DWG) and assist MOHSW in prioritizing next DMSS modules.

**For the Infrastructure and Environmental Health team:**

- Oversee renovations of TNIMA nursing school;
  - Submit final bid documents and design plans from A&E firms for approval;
  - Complete bidding process and award contract to construction company;
  - Provide training to contractors on EMMP;
  - Supervise rehabilitation process;
- Oversee renovations of EBSNM;
  - Activities as per TNIMA;
- Oversee commencement of construction of NMCP headquarters;
  - Activities as per TNIMA;
- Collaborate with PBC subcontractors on bidding processes for the architectural design and construction work for EmONC centers;

- Oversee the selection processes for architectural and construction firms for EmONC centers;
- Contribute to supervision of construction once it commences;
- Manage RBHS water and sanitation activities and sub-contracts.

**For the Monitoring and Evaluation team:**

- Work with RBHS technical teams (training, BCC/IEC, infrastructure, capacity building, etc) to further develop their M&E systems;
- Develop further RBHS project database(s);
- Collaborate with LISGIS and MOHSW to continue work on defining catchment population for health facilities;
- Implement data validation system at central, county and facility level;
- Review data from RBHS partners on a quarterly basis and provide actionable feedback;
- Produce quarterly and semi-annual reports;
- Supervise County Coordinators.

---

**Richard J. Brennan, MBBS, MPH**  
**RBHS Chief of Party**  
October 15, 2009

## **ANNEX 1: RBHS INTERMEDIATE RESULTS AND SUB-OBJECTIVES**

### **Intermediate Result 1: Increased Use of Basic Health Care Services**

#### **Sub Objectives:**

- 1.1. Deliver BPHS services in seven catchment areas, supported by innovative financing;
- 1.2. Expand service delivery to communities by strengthening community health worker capacity;
- 1.3. Strengthen the capacity of County Health Teams to manage a decentralized health system;
- 1.4. Support MOHSW to strengthen donor coordination.

### **Intermediate Result 2: Improved Infrastructure Health Workforce and Systems Performance**

#### **Sub-objectives:**

- 2.1. Enhance TNIMA & Zorzor learning environments & resources;
- 2.2. Improve staff capacity in teaching methods & mgmt;
- 2.3. Update and strengthen PA, RN, EH and CM curricula, teaching methods and learning results to improve BPHS;
- 2.4. Support TNIMA and Zorzor students willing to live and work in rural health facilities;
- 2.5. Strengthen MOHSW systems and human capacity at central and county levels

### **Intermediate Result 3: Youth Informed and Networked on Reproductive Health**

## ANNEX 2: KEY USAID INDICATORS (November 2008 – August 2009)

Indicator	USAID reference number	Indicator value
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence and/or being faithful	3.1.1.1	2,456
Number of individuals reached through community outreach that promotes HIV/AIDS prevention through abstinence	3.1.1.2	2,522
Number of targeted condom service outlets	3.1.1.4	63
Number of individuals who received counseling and testing for HIV and received their test results ( <i>includes general VCT and PMTCT</i> )	3.1.1.12	3,494
Number of people trained with USG funds in malaria treatment or prevention	3.1.3.3	73
Number of antenatal care (ANC) visits by skilled providers from USG-assisted facilities ( <i>assumes all ANC visits in facilities are with skilled providers</i> )	3.1.6.1	11,307
Number of deliveries with a skilled birth attendant (SBA) in USG-assisted programs ( <i>in facilities with SBA</i> )	3.1.6.3	1,491
Number of women receiving active management of the third stage of labor (AMTSL) through USG-supported programs ( <i>assumes all SBA deliveries in facilities include AMTSL</i> )	3.1.6.5	1,491
Number of newborns receiving essential newborn care through USG-supported programs ( <i>assumes all SBA deliveries in facilities include essential newborn care</i> )	3.1.6.6	1,491
Number of cases of child pneumonia treated with antibiotics by trained facility or community health workers in USG-supported programs ( <i>assumes all cases of pneumonia treated with antibiotics; PBC data showed 4,045 cases treated, 3,991 with antibiotics-99%</i> )	3.1.6.8	31,887
Number of children less than 12 months of age who received DPT3 from USG-supported programs ( <i>uses pentavalent-3 as proxy for DPT3</i> )	3.1.6.9	16,517
Number of children under 5 years of age who received vitamin A from USG-supported programs ( <i>does not include national campaign data</i> )	3.1.6.10	17,015
Number of cases of child diarrhea treated in USG-assisted programs	3.1.6.11	1,997
Couple years of protection (CYP) in USG-supported programs	3.1.7.1	3,802
Number of people trained in FP/RH with USG funds	3.1.7.2	108
Number of counseling visits for FP/RH as a result of USG assistance	3.1.7.3	12,795
Number of people that have seen or heard a specific USG-supported FP/RH message	3.1.7.4	5,166
Number of policies or guidelines developed or charged with USG assistance to improve access to and use of FP/RH services	3.1.7.5	3
Number of USG-assisted service delivery points providing FP/RH counseling or services	3.1.7.6	94

### ANNEX 3: RBHS CONTRIBUTION TO LIBERIAN NATIONAL POLICIES, STRATEGIES, PLANS, AND TECHNICAL DOCUMENTS

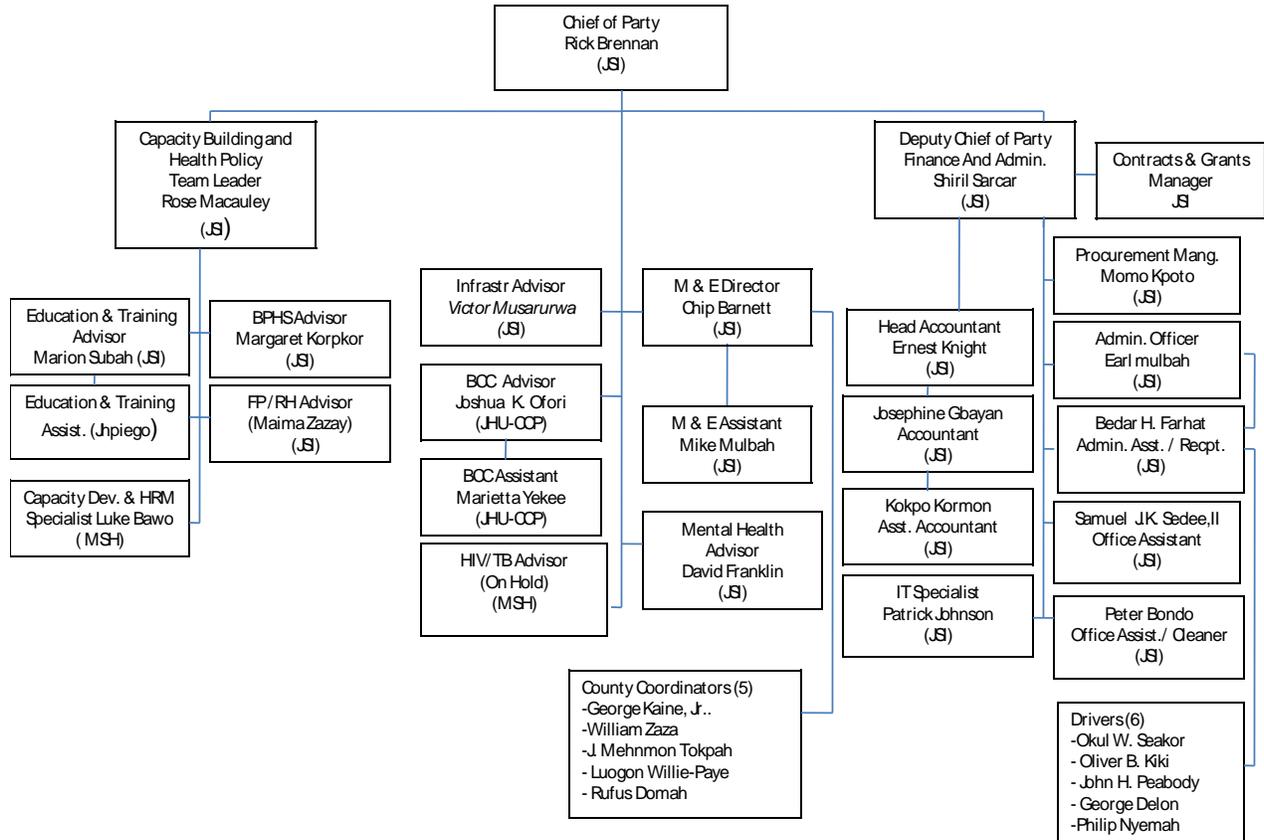
Policy / Document	RBHS Contributor
Maternal and Newborn Care Procedures and Protocols	Claudette Bailey, Marion Subah
National In-service Education Strategy	Claudette Bailey, Marion Subah
National Health Communication Strategy	Joshua Ofori
National Mental Health Policy	David Franklin
National Mental Health Strategy (draft)	David Franklin
Pre-service Education Standards (development led by RBHS; adopted by MOHSW)	Marion Subah
Sexual and Reproductive Health Policy for the Republic of Liberia	Claudette Bailey, Marion Subah

## ANNEX 4: RBHS PARTICIPATION IN NATIONAL COMMITTEES, WORKING GROUPS and TASK FORCES

Committee / Working Group*	RBHS Representative
Education and Training National Working Group	Claudette Bailey, Marion Subah
Health Financing Task Force	Richard Brennan, Constant Kabwassa
Health Promotion Working Group	Joshua Ofori
Health Sector Coordinating Committee	Richard Brennan
Human Resource Technical Committee	Claudette Bailey, Marion Subah
Mental Health Policy Working Group	David Franklin
Mental Health Strategic Planning Working Group	David Franklin
Monitoring, Evaluation, and Research Technical Working Group	Chip Barnett
National Task Force on Health Infrastructure	Victor Musarurwa
Reproductive Health Technical Committee	Claudette Bailey, Marion Subah

\* RBHS staff have also participated less actively in a number of other committees and task forces, including the Logistics Sub-committee of the National Task Force on Swine Flu and the National Task Force for Yellow Fever.

## ANNEX 5: RBHS STAFFING STRUCTURE, YEAR 2



## ANNEX 6: BUDGET vs. EXPENDITURES

JSI Research and Training Institute, Inc.  
Rebuilding Basic Health Services in Liberia (RBHS)  
Year 1 Budget vs. Estimated Expenditure through September 30,  
2009

LINE ITEM	YEAR 1 BUDGET*	EST. EXPENDITURE THROUGH SEPTEMBER 30, 2009 (PLEASE SEE NOTE BELOW)
SALARIES	\$683,614	\$561,110
INDIRECT COSTS (OVERHEAD)	\$327,831	\$353,953
CONSULTANTS	\$6,950	\$73,797
TRAVEL, TRANSPORTATION AND PER DIEM	\$59,812	\$184,485
ALLOWANCES	\$334,731	\$237,440
EQUIPMENT, MATERIALS AND SUPPLIES	\$302,817	

		\$392,457
OTHER DIRECT COSTS	\$69,354	\$305,590
PROGRAM COSTS	\$3,658,000	\$696,491
GRANTS	\$5,001,583	\$2,223,428
SUBAWARDS	\$2,470,315	\$525,204
TOTAL DIRECT COSTS	= \$12,915,007	= \$5,553,955
COST SHARE	\$1,040,000	-
GRAND TOTAL	= \$13,955,007	= \$5,553,955

Note: Please note that the above figures may not reflect and/or match the official JSI reports to USAID as the field office expenses have not been recorded through the JSI HQ accounting systems.

\* As per the Cooperative Agreement budget and JSI's final application.