

MCHIP Liberia: End-of-Project Report

September 2009–December 2013



Photo Credit: MCHIP Liberia Staff

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Submitted by:

Marion Subah, Comfort Gebeh, Nyapu Taylor, Varwo Gbassie, and Alishea Galvin

The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health's flagship maternal, neonatal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria, nutrition, and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening.

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Country Summary: Liberia



Selected Health and Demographic Data for Liberia	
GDP per capita (USD)*	414
Total population*	4,190,000
Maternal mortality ratio (deaths/100,000 live births)**	770
Skilled birth attendant coverage**	61.1
Antenatal care, 4+ visits***	66
Neonatal mortality rate (deaths/1,000 live births)**	26
Infant mortality rate (deaths/1,000 live births)**	54
Under-five mortality (deaths/1,000 live births)**	94
Oral rehydration therapy for treatment of diarrhea**	61.6
Diphtheria-pertussis-tetanus vaccine coverage (3 doses)**	71.4
Modern contraceptive prevalence rate (%) **	19.1
Total fertility rate**	4.7
Total health expenditure per capita (USD)^	112.4

Sources: *World Bank; **Liberia DHS, 2013; *** UNICEF; ^WHO.

Program Activities:

- Family Planning
 - Training of National Trainers
 - RAPID Model Advocacy
 - Site Strengthening at Redemption Hospital
 - Goodwill Ambassador
 - Market Peer Provider Project
 - Beauty Salon and Barber Shop Family Planning Program
 - Religious Leaders Project
- EPI/FP Integration
 - Immunization and Family Planning Demonstration Project
 - Stakeholders Meeting
- Prevention of Postpartum Hemorrhage
- AMTSL and Introduction of Facility-Based Distribution of Misoprostol
- Newborn Health
 - Kangaroo Mother Care
 - Chlorhexidine for Cord Care



Program Dates	September 2009–December 2013					
Total Mission Funding to Date by Area	Total: \$2,280,000; Family Planning : \$1,430,000 Maternal and Child Health: \$850,000					
Total Core Funding to Date by Area	Total: Maternal and Child Health (Newborn): \$119,802 Family Planning (FP/EPI Integration): \$154,899					
Geographic Coverage	No. (%) of counties	12	No. of districts	80	No. of facilities	80
MCHIP In-Country Contacts	Marion Subah: marion.subah@jhpiego.org; Comfort Gebeh: comfort.gebeh@jhpiego.org; Nyapu Taylor: nyapu.taylor@jhpiego.org; Varwo Sirtor-Gbassie: varwo.sirtor-gbassie@jhpiego.org					
HQ Managers and Technical Advisors	HQ: Alishea Galvin: alishea.galvin@jhpiego.org; Emmanuel Otolorin: emmanuel.otolorin@jhpiego.org; Gahan Furlane: gahan.furlane@jhpiego.org; Anne Pfitzer: anne.pfitzer@jhpiego.org; Gbenga Ishola, M&E Advisor: gbenga.ishola@jhpiego.org; Technical Support: Holly Blanchard: holly.blanchard@jhpiego.org; Chelsea Cooper: chelsea.cooper@jhpiego.org; Rebecca Fields: Rebecca_Fields@jsi.com; and Jeffrey Smith: jeffrey.smith@jhpiego.org.					

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Abbreviations

ACCESS	Access to Clinical and Community Maternal, Neonatal and Women’s Health Services
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
BCC	Behavior Change Communication
BCS	Balanced Counseling Strategy
BEST	Best Practices at Scale in the Home, Community and Facilities
CHT	County Health Team
CHTS	County Health Team Supervisor
CHV	Community Health Volunteer
CHW	Community Health Worker
CM	Community Midwife
COC	Combined Oral Contraceptive
CPR	Contraceptive Prevalence Rate
CSHGP	Child Survival and Health Grants Program
CWG	Chlorhexidine Working Group
DHS	Demographic and Health Survey
DMPA	Depo-Provera
DRHS	District Reproductive Health Supervisor
EC	Emergency Contraception
EPI	Expanded Program on Immunization
EPI/FP	Expanded Program on Immunization and Family Planning
FGD	Focus Group Discussion
FHD	Family Health Division
FP	Family Planning
FP/MCH/N	Family Planning/Maternal and Child Health/Nutrition
gCHV	General Community Health Volunteer
GOL	Government of Liberia
HMIS	Health Management Information System
HQ	Headquarters
HTSP	Healthy Timing and Spacing of Pregnancy
IEC	Information, Education and Communication
IP	Infection Prevention
IRC	International Rescue Committee
IUD	Intrauterine Device
JSI	John Snow, Inc.
KMC	Kangaroo Mother Care
LAM	Lactational Amenorrhea Method
LARC	Long-Acting Reversible Contraception

LD	Liberian Dollar
LPMM	Liberian Prevention of Maternal Mortality
MCH	Maternal and Child Health
MCHIP	Maternal and Child Health Integrated Program
MCP	Malaria Communities Program
MDG	Millennium Development Goal
M&E	Monitoring and Evaluation
MMR	Maternal Mortality Ratio
MNH	Maternal and Newborn Health
MNCH	Maternal, Newborn and Child Health
MOHSW	Ministry of Health and Social Welfare
MTI	Medical Team International
MSF	Médecins sans Frontières
PMP	Performance Monitoring Plan
PNC	Postnatal Care
POP	Progestogen-only Pill
PPAL	Planned Parenthood Association of Liberia
PPFP	Postpartum Family Planning
PPH	Postpartum Hemorrhage
QA	Quality Assurance
QI	Quality Improvement
RBHS	Rebuilding Basic Health Services Project
RH	Reproductive Health
RHTC	Reproductive Health Technical Committee
SBA	Skilled Birth Attendant
SBM-R	Standards-Based Management and Recognition
SITAN	Situational Analysis
TFR	Total Fertility Rate
TM	Traditional Midwife
TOT	Training of Trainers
TTM	Trained Traditional Midwife
USAID	U.S. Agency for International Development
USG	United States Government
UNCoLSC	UN Commission on Lifesaving Commodities
UNFPA	United Nations Population Fund
USAID	U.S. Agency for International Development
VSI	Venture Strategies Innovations
WHO	World Health Organization

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- Montserrado County Health Team
- Bong County Health Team
- Lofa County Health Team

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- The hospital administration and professional staff at Redemption Hospital, JFK Hospital and CB Dunbar Hospital

- Members of the Reproductive Health Technical Committee
- Venture Strategies Innovations (VSI) for its work in supplying and registering misoprostol in Liberia
- All health professional staff of MOHSW in MCHIP-supported districts.
- All trained traditional midwives/traditional midwives; health care workers; FP providers at markets, beauty salons and barber shops; and religious and local leaders in MCHIP-supported districts.
- Local community members throughout the country who demonstrated enthusiasm for education and actively participated in building and strengthening the health care system.

Executive Summary

In Liberia, although important achievements have been realized in maternal, newborn and child health (MNCH), there is still need for improvement. Postpartum hemorrhage (PPH) remains the leading cause of maternal mortality in Liberia and accounts for about 34% of maternal deaths.¹ The maternal mortality ratio decreased from 994/100,000 live births in 2007 to 770/100,000 in 2013, while neonatal mortality decreased from 32/1,000 live births in 2007 to 26/1,000 in 2013.² The contraceptive prevalence rate (CPR) increased from 10.3% in 2007 to 19% in 2013. Continued dedication and support to address MNCH programming is necessary to sustain and replicate successes. As is outlined in Liberia's National Health Policy 2007–2011 and the Essential Package of Health Services, the government of Liberia (GOL)/Ministry of Health and Social Welfare (MOHSW) is committed to comprehensively address MNCH programming to improve health outcomes for pregnant women and their families.

The original goal of USAID's Maternal and Child Health Integrated Program (MCHIP) in Liberia was to address the country's provision of FP services by updating the skills of all cadres of health workers for providing a wider range of family planning and reproductive health (FP/RH) methods, in particular hormonal and long-acting methods, as well as advocate and provide public education to support a positive and stronger FP/RH environment. The scope was later expanded to initiate a program to reduce postpartum hemorrhage for women who deliver at home and improve newborn health by assessing and developing a plan to address gaps in essential newborn care. Since then, MCHIP has been providing support to the MOHSW to help operationalize the national FP/RH Strategy and implement the Accelerated Action Plan to Reduce Maternal and Neonatal Mortality, thereby contributing to significant reductions in maternal, newborn and child mortality toward the Millennium Development Goals (MDGs) 4 and 5.

MCHIP was well-positioned to support the Liberian MOHSW to address MNCH interventions, drawing on technical and programmatic expertise from previous global programs. MCHIP Liberia's FP strategy took a four-pronged approach, including national- and county-level advocacy, increasing access to quality FP services, increasing coverage of FP services, and raising awareness/stimulating demand at the community level for FP services.

MCHIP ensured an approached of no missed opportunities and advocacy in supporting high-impact and evidence-based interventions, as well as building the country capacity in MNCH and FP by working with the MOHSW at the national level and with the Montserrado, Margibi, Grand Bassa, Lofa and Bong county health teams (CHTs) at the facility and community levels. Thanks



One of 25 national trainers learns IUD insertion during training.

¹ Khan KS et al. 2006. WHO analysis of causes of maternal death: a systematic review. *Lancet* 367(9516): 1066–1074.

² Liberia Institute of Statistics and Geo-Information Services (LISGIS) [Liberia], Ministry of Health and Social Welfare [Liberia], National AIDS Control Program [Liberia], and Macro International Inc. 2008. *Liberia Demographic and Health Survey 2007*. Monrovia, Liberia: Liberia Institute of Statistics and Geo-Information Services (LISGIS) and Macro International Inc.

to the strong partnership with the Liberian MOHSW and other implementing partners and support from USAID, many achievements were observed throughout the duration of the project.

MCHIP supported and worked with the Reproductive Health Technical Committee (RHTC) to revise the service delivery guidelines and standards for FP and developed an FP training course, including all natural, short and long-acting reversible methods, for providers that is endorsed by the MOHSW and is the basis for pre-service FP training. Using this course, MCHIP held the first MOHSW-sponsored FP technical updates for frontline health care providers since the war ended. Building on these technical updates, MCHIP strengthened Redemption Hospital to create an FP “Center of Excellence” as a teaching institution to further develop competent FP providers.



In further support of the Liberia National Family Planning Strategy and the Accelerated Action Plan for the Reduction in Maternal Mortality, MCHIP amended the RAPID model to help the MOHSW at the central and county levels to reprioritize and strengthen its leadership to advocate for additional resources and the integration of FP into the basic package of health services. Additionally, at the request of USAID, MCHIP reviewed USAID’s portfolio within the context of the Liberian environment to produce an internal strategy, *USAID’s Liberia Family Planning Roadmap to Support the MOHSW in Reducing Unintended Pregnancies*, based on the Best Practices at Scale in the Home, Community and Facilities (BEST) approach as strategic guidance for cooperating agencies to assist the MOHSW on implementation.

Over the course of the project, MCHIP has also played a key role in contributing to a number of much-needed strategies and training materials that will be used nationwide including:

- National Family Planning Strategy
- National Family Planning Standards
- National Community-Based Family Planning Training Materials
- Adolescent Reproductive Health Strategy
- USAID’s Liberia Family Planning Roadmap to Support the MOHSW in Reducing Unintended Pregnancies
- Accelerated Action Plan for the Reduction of Maternal and Neonatal Mortality in Liberia
- Community Health Policy and Strategy and Roadmap
- WHO home-based maternal and newborn care training materials for curriculum of community health volunteers, including trained traditional midwives (TTMs), adapted for the Liberian context
- EPI/FP Implementation Guide and Training and BCC materials
- National Kangaroo Mother Care (KMC) Guidelines
- Chlorhexidine for Cord Care



A patient is counseled on FP methods after being referred through immunization services, Lofa County.

- National Implementation for Chlorhexidine
- Postpartum Hemorrhage Clinical Guidelines
- Prevention of Postpartum Hemorrhage Counseling Cards and Flipbooks for TTMs

In an effort to improve demand for FP, MCHIP worked to bring health education information and services closer to the community in rural and urban areas, using already proven effective and innovative approaches. As part of this effort, MCHIP conducted behavior change communication (BCC) strategies at the community level to work with religious leaders, barber shop and beauty salon workers, and market vendors, aimed at addressing the many cultural practices and accessibility issues that result in early teen pregnancy and low use of modern methods of contraception. One market volunteer provider stated: *“We are grateful, because this program is really good for us. It helps us to space our children and it also makes it easier for us to get our refill without taking much of our time because we are busy people.”* In total, 100,367 people have been reached with these healthy timing and spacing messages from all community-level activities.

Through the MOHSW, MCHIP carried out a demonstration project of immunization and FP integration in selected facilities in Bong and Lofa counties. This approach involved vaccinators providing a few short, targeted FP and immunization messages and same-day FP referrals to mothers bringing their infants to the health facility for routine immunization. This effort resulted in an increase in new contraception users by 90% in Lofa County (517 to 983) and 73% in Bong County (1,182 to 2,039) for a total increase of 1,323 new contraception users. Service providers and clients reported that the integrated service delivery process had increased their knowledge and changed their views about FP. Moving forward with the expansion and scale-up of activities will include the reinforcement of reminder messages about the next vaccination to clients by vaccinators and community midwives (CMs) at every point of contact and to remind EPI-referred clients about the child’s return date for the next vaccine before they leave the FP room to help mitigate the potential dropout of EPI clients.

To contribute to the prevention of PPH, which is the leading cause of maternal death in Liberia, MCHIP conducted an initiative in Grand Bassa for the prevention of PPH for both facility and home deliveries. This introductory program was designed to increase use of uterotonics for all births. Misoprostol was distributed during antenatal care (ANC) visits or by trained MOHSW clinical staff to women in the community who were at risk of not making it to the facility to give birth. Using this approach, the project was able to reach only 22% of women who delivered at home because of long distances to communities, limited road infrastructure and transportation.

Misoprostol as a PPH prevention intervention was embraced by pregnant women. Based on the data from this initiative, the MOHSW approved moving forward with the distribution of misoprostol at the community level as well as expanding this lifesaving initiative to additional communities in Liberia.

To improve newborn survival and reduce under-five mortality, Liberia’s MOHSW has focused its efforts on addressing the leading causes of newborn deaths. In 2012, MCHIP supported the MOHSW to undertake a newborn situational analysis (SITAN) and conducted a review of Liberia’s readiness to introduce and scale up select newborn health interventions. Several RHTC working groups were formed to facilitate the rapid review, approval and implementation of KMC, chlorhexidine for umbilical cord care, and home-based MNH care. MCHIP facilitated the training of 23 national KMC trainers from five hospitals



TTMs hold misoprostol distribution job aids, Fenutoli Clinic, Bong County.

where KMC was to be introduced. KMC units were established in all five hospitals, where a total of 26 preterm/low birth weight babies were attended to in the units. To improve home visits by community health workers (CHWs) to pregnant women and newborns, the MOHSW was supported with the design and printing of counseling cards/booklets for the Home-Based Maternal New Born Health Care Training Manual. A total of 25 midwives were trained as trainers and 120 CHWs were trained in rural Montserrado County using the curriculum. Forty-three newborns were visited during the postnatal follow-up visit.

Based on the lessons learned from the MCHIP programs as well as the Liberian priorities, MNCH needs to continue to be a focus to ensure that the momentum and work that MCHIP has done to date to improve the technical competencies of frontline health care workers and community volunteers is maintained. MCHIP leaves a legacy of competent frontline health care workers and empowered community members, as well as training materials for how to implement facility- and community-level MNCH initiatives and scale up facility- and community-based distribution of misoprostol for PPH reduction and EPI/FP programs. In addition, MCHIP has provided all the training materials to MOHSW at the national and county levels as well as to other implementing partners so they can continue to implement the program long term.

MCHIP/LIBERIA Project: Goals and Objectives

- Objective 1:** Support the MOHSW in implementing the national RH/FP program and advocating for the FP agenda;
- Objective 2:** Increase access to high-quality FP services;
- Objective 3:** Increase knowledge of and demand for FP services at the community level;
- Objective 4:** Expand coverage of FP services and reach to the community through innovative approaches;
- Objective 5:** Reduce the incidence of PPH at home births through a prevention of PPH program that includes use of misoprostol at home births; and
- Objective 6:** Contribute to improvement of newborn health by working with the MOHSW and implementing partners to access and develop a plan to address gaps in essential newborn care, including management of newborn sepsis.

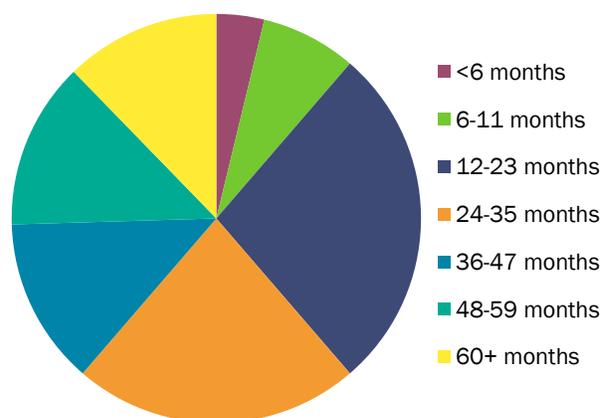
Introduction

In 2007, the maternal mortality ratio (MMR) of Liberia was 994/100,000, one of the highest in the world, with a total fertility rate (TFR) of 5.2. This high rate was partially due to the modern contraceptive prevalence rate (CPR) being only 10.3%,³ with an unmet need of 36% despite the fact that 87% of women have knowledge of a family planning (FP) method.⁴ The CPR has increased slightly in the three last Demographic and Health (DHS) Surveys done since 1986 (by 2.6% and 2.2%, respectively). Eighty-four percent of women have at least one antenatal visit, but only 37% give birth in a facility. Median duration of breastfeeding is 20 months but exclusive breastfeeding is practiced for only one month. Forty-one percent of women have birth-to-next-pregnancy intervals of less than 23 months (Figure 1).⁵ An MCHIP re-analysis of the 2007 Liberian DHS found the unmet need for postpartum family planning (PPFP) to be 82% among women within two years after childbirth. Forty-eight percent of young women who are 18 are either pregnant or have a child.⁶ The World Health Organization (WHO) Technical Consultation advocates that women should wait 24 months before conceiving another child; therefore, special attention needs to be given to increasing access to effective FP methods for postpartum women.

The first postpartum year is also when routine immunization typically takes place. While Liberia's national immunization schedule calls for children to be vaccinated at birth, 6, 10, and 14 weeks and nine months of age, the actual ages at which these vaccination contacts take place is believed to be somewhat later.⁷

Postpartum hemorrhage (PPH) remains the leading cause of maternal mortality, accounting for approximately 34% of maternal mortality in Liberia.⁸ Efforts to reduce mortality from PPH must be focused at both facility and community levels, especially in Liberia where 61% of births occur at home, without a skilled birth attendant (SBA).⁹ To reduce PPH-related maternal mortality and morbidity, all women must be

Figure 1. Birth-to Next-Pregnancy Non-First Births, Liberia, DHS 2007



Liberian National Family Planning and Reproductive Health Strategy:

- Provide integrated MNCH/FP/RH services whenever possible at facility and community levels to minimize missed opportunities and improve quality of care.
- Increase the number and capacity of health workers at the facility and community levels to deliver safe, effective, and acceptable FP services.
- Strengthen key systems and infrastructure, including management, monitoring and evaluation, and supervision to support FP services at community and facility levels.
- Conduct advocacy to increase visibility of FP as a key investment for improving the lives, health, and well-being of the Liberian people.
- Meet special needs of under-served and/or vulnerable populations, including adolescents, young adults, victims of sexual exploitation and rape survivors, and men.

³ Ibid.

⁴ Ibid.

⁵ MCHIP re-analysis of Liberia DHS 2007. Located at: <http://www.k4health.org/toolkits/ppfp/liberia-2007-dhs-reanalysis-ppfp>.

⁶ Liberia Institute of Statistics and Geo-Information Services (LISGIS) [Liberia], Ministry of Health and Social Welfare [Liberia], National AIDS Control Program [Liberia], and Macro International Inc. 2008. *Liberia Demographic and Health Survey 2007*. Monrovia, Liberia: Liberia Institute of Statistics and Geo-Information Services (LISGIS) and Macro International Inc.

⁷ Ibid.

⁸ Republic of Liberia MOHSW. 2012. *One Year Summary Report of Maternal and Newborn Mortality in Liberia*. Monrovia, Liberia.

⁹ Liberia Institute of Statistics and Geo-Information Services (LISGIS) [Liberia], Ministry of Health and Social Welfare [Liberia], National AIDS Control Program [Liberia], and Macro International Inc. 2008. *Liberia Demographic and Health Survey 2007*. Monrovia, Liberia: Liberia Institute of Statistics and Geo-Information Services (LISGIS) and Macro International Inc.

protected from PPH through use of an uterotonic drug at birth, regardless of where they deliver. In an effort to be able to offer this care to all women, women and communities are encouraged to deliver at health facilities with skilled providers, to be aware of potential pregnancy and delivery complications, and to know how and where to seek additional care.

Since 2009, the situation with neonatal health has slowly improved. However, for Liberia to meet Millennium Development Goal (MDG) 4, deaths in the neonatal period will need to decrease further and faster. Indeed, if the neonatal mortality rate does not drop significantly, Liberia would have to effect an additional 13.5% reduction in its under-five mortality rate by 2015. As in other low-resource settings globally, a majority of newborn deaths in Liberia result from three preventable or treatable causes: complications of prematurity; intrapartum events/birth complications (primarily birth asphyxia); and newborn infections.

USAID AND MCHIP'S APPROACH IN LIBERIA

In 2009, the U.S. Agency for International Development (USAID)/Liberia requested the assistance of the Maternal and Child Health Integrated Program (MCHIP) to address the dire situation in the country related to provision of FP services. Since then, MCHIP provided support to the Ministry of Health and Social Welfare (MOHSW) to help operationalize the national family planning and reproductive health (FP/RH) strategy. MCHIP's FP strategy took a four-pronged approach, including strengthening national- and county-level advocacy, increasing access to quality FP services, increasing coverage of FP services, and raising awareness/stimulating demand for FP services. MCHIP supported and worked with the Reproductive Health Technical Committee (RHTC) to revise the FP service delivery guidelines and standards and developed an FP training course for providers, which was endorsed by the MOHSW and became the basis for pre-service FP training. Utilizing this course, MCHIP trained 25 national trainers in its first year, and began step-down trainings for providers at the county level in six counties as well as providing supportive supervision to the trainers.

A facility that is a "Center of Excellence" in FP assists in the management of the sector to effectively and efficiently deliver comprehensive, quality FP counseling and services that are equitable, accessible, sustainable, and in line with the MOHSW's mission. The FP "Center of Excellence" operates in accordance with international standards and meets 80% or more of the national FP standards. It provides all FP methods inclusive of permanent methods for couples who have decided that their families are complete. The Center of Excellence serves as training institute for both pre-service and in-service education.

In the second year of implementation, MCHIP's activities focused on increasing access to high-quality FP services through providers with up-to-date FP information. Step-down trainings in Sinoe, Grand Kru, Grand Bassa, Margibi, Grand Gedeh, and Maryland reached 237 providers with a focus on all reversible methods, counseling, and infection prevention. Training activities also included detailed information on USAID's FP policies and compliance issues, including principles of volunteerism and informed choice. Simultaneously, MCHIP worked to strengthen two FP sites, Phebe Hospital and Redemption Hospital, to develop "Centers of Excellence" in FP. In 2012, the geographical coverage of MCHIP shifted to specifically focus on Montserrado, Margibi, and Grand Bassa counties. The previous work at Phebe Hospital in Bong County transitioned over to the Rebuilding Basic Health Services Project (RBHS) Project. By 2012, the Redemption Hospital FP out-patient department met the criteria for a "Center of Excellence" by scoring 87% on the FP standards in the external quality assurance (QA) assessment and the national accreditation.

Additionally, MCHIP collaborated with the MOHSW to demonstrate a model for integrating the service delivery of immunization and FP on a limited basis in selected facilities in Bong and Lofa counties. The approach involved vaccinators providing a few short, targeted FP and immunization messages and same-day FP referrals to mothers bringing their infants to the

health facility for routine immunization. A formative assessment was conducted to inform the strategy, message, and materials design.

In an effort to improve demand for FP, MCHIP worked to bring information and services closer to the community, using already proven effective and innovative approaches. To create awareness and spread health promotion messages, MCHIP worked with market peer providers, barber shop and beauty salon workers, and religious leaders to reach their clients and congregations to discuss misconceptions, lack of FP knowledge, especially in the postpartum period, and teenage pregnancy.

Through the support of the MOHSW and USAID, MCHIP introduced a service delivery initiative using misoprostol as an intervention to reduce the incidence of PPH. During the initial phase, in Campwood and District #3 in Grand Bassa, the program generated evidence to inform future policy on the expansion of uterotonic coverage for all women giving birth to prevent PPH by using a two-pronged facility-based and community-based approach. This program was designed to provide all women with uterotonic coverage during the third stage of labor. Based on the results of the learning phase, the MOHSW approved the scale-up of this intervention at the facility and community levels for the distribution.

In 2013, MCHIP, in collaboration with the MOHSW and other implementing partners, drafted the newborn situation analysis and continued to build on innovative health sector interventions to reduce the neonatal mortality rate by expanding chlorhexidine (CHX) for cord care through the development of the policy document *Chlorhexidine for Cord Care* and *National Implementation Guidelines for Chlorhexidine*. Furthermore, MCHIP established new Kangaroo Mother Care (KMC) in facilities to increase survival of low birth weight newborns.

Major Accomplishments

CONTENT AREA 1: IMPROVING FP ACCESS AND QUALITY

National Strategic Documents, Policies, and Training Materials

In 2009, the MOHSW had formulated a strategy on FP/RH but it had not yet been operationalized. Service delivery guidelines for FP did not exist, but a training course was in development for FP providers. The pre-service curricula had not been updated since the country's conflict began in the 1990s. There also lacked an updated in-service FP training curriculum as well as trainers competent in FP service delivery. USAID/Liberia set the objective for MCHIP to work with partners to increase access to FP services by building local capacity to train and supervise providers in provision of high-quality FP/RH services in response to these gaps.

This approach also involved working at the policy level to improve the service delivery environment, and encourage communities and health care providers to work together to bring FP to the forefront of health advocacy. To address the issue of FP in pre-service education, MCHIP linked with the RBHS Project, a USAID-funded initiative working to increase access to basic health services and to support the decentralized management of the health system. The project also supports the development and implementation of a revised FP curricula and trained teachers from the Tubman National Institute of Medical Arts and the Esther Bacon School of Nursing and Midwifery in contraceptive technology and clinical teaching skills. MCHIP worked with the MOHSW, RBHS, and other partners, such as Africare, the Liberian Prevention of Maternal Mortality (LPMM), Medical Team International (MTI), Curamericas (supported by the Child Survival and Health Grants Program [CSHGP]), UNFPA and Planned Parenthood Association of Liberia (PPAL), to ensure the FP course was adapted and incorporated into the curricula for multiple cadres (nurses, midwives, physician assistants, and medical doctors) at educational institutions.

The curricula was also adapted and utilized for in-service training so that all counties have providers who have been updated in FP. The revised curricula, policies, and training materials are intended to increase the technical knowledge of skilled providers, and improve the quality, availability, and demand for services. MCHIP collaborated with multiple partners in the RHTC and the MOHSW on the development (adolescent RH, FP standards and the FP in-service training materials) and revision (FP, community-based FP and community health volunteers [CHVs] training materials) of strategic MOHSW documents and national training materials promoting FP services for all individuals of reproductive age, especially focused on the gap in services during the postpartum period.

USAID requested that MCHIP review USAID's portfolio within the context of the Liberian environment and situation and produce an internal strategy using the Best Practices at Scale in the Home, Community and Facilities (BEST) approach for state-of-the-art programming in FP,

MCHIP technical inputs included on the following MOHSW documents:

- National Family Planning Strategy
- National Family Planning Standards
- National Community-Based Family Planning Training Materials
- Adolescent Reproductive Health Strategy
- USAID's Liberia Family Planning Roadmap to Support the MOHSW in Reducing Unintended Pregnancies
- Accelerated Action Plan for the Reduction of Maternal and Neonatal Mortality in Liberia
- Community Health Policy and Strategy and Roadmap
- WHO home-based maternal and newborn care training materials for community health volunteer's curriculum, including TTMs, adapted for the Liberian context
- EPI/FP Implementation Guide and Training and BCC materials
- National Kangaroo Mother Care (KMC) Guidelines
- Chlorhexidine for Cord Care
- National Implementation for Chlorhexidine
- Postpartum Hemorrhage Clinical Guidelines
- Prevention of Postpartum Hemorrhage Counseling Cards and Flipbooks for TTMs

maternal and child health, and nutrition (FP/MCH/N). MCHIP finalized the five-year *USAID's Liberia Family Planning Roadmap to Support the MOHSW in Reducing Unintended Pregnancies*, as strategic guidance for cooperating agencies to assist the MOHSW on implementing the MOHSW's *Accelerated Action Plan for the Reduction of Maternal and Neonatal Mortality in Liberia*. FP is identified as a key intervention for addressing adverse consequences of unplanned pregnancies. This strategy used the BEST approach guidelines and drew on evidence-based interventions. The BEST action plan confirms commitment to programming in FP/MCH/N. It strengthens USAID's technical leadership and scales up proven interventions in Liberia. The roadmap built on ongoing FP work and integrates programs where it makes sense to do so. The strategy considered the relevant learning and policy recommendations from the Liberian MOHSW Rwanda FP study tour, such as looking to achieve “smart” integration to reduce the lack of missed opportunities.

As part of maternal mortality reduction efforts, the government of Liberia (GOL) through the MOHSW started promoting community outreach of FP through the implementation of several community-based FP projects with support from partners. The growing momentum is a testimony of increasing effective community mobilization and increasing investment in repositioning FP in the country. To address critical barriers to FP uptake during the extended postpartum period, MCHIP collaborated with RBHS, the International Rescue Committee (IRC), Equip, and the MOHSW to develop FP and PFP counseling messages, materials and a training module for general community health volunteers (gCHVs). Messages and materials addressed Lactational Amenorrhea Method (LAM), healthy timing and spacing of pregnancies (HTSP), considerations related to return to fertility, and the benefits of FP for the mother, infant, husband, and family. All materials included referrals to health facilities for quality FP services.

MCHIP coordinated with the MOHSW, counties, and institutional partners to introduce this PFP component to the CHVs. Additionally, radio promotional messages that highlight the idea that “FP is good for baby ma” were created. The messages emphasized that mothers of babies can in fact use modern contraceptive methods even if they are breastfeeding. Mothers are encouraged to access the local health facility for FP services. All of these materials have been finalized and approved by the MOHSW to be used nationally by implementing partners. The future use of these materials and the radio messages by the County Health Teams (CHTs) and implementing partners will increase awareness for the community members to seek out FP services.

Advocacy

In addition to assisting with the revision and development of enabling and quality focused FP and RH policies and training materials, MCHIP also advocated to increase resources and funding for the delivery of FP services. The RAPID Model is a computer-based tool that was used to demonstrate the impact of a rapidly growing population on various development sectors. It combines socioeconomic indicators with demographic information and population projections, and estimates impacts up to 30 years in the future. In many countries, RAPID is also being used to increase FP support and resources at the decentralized level using district-specific analyses of population trends, health, the environment, and other factors. The evidence-based argument made through RAPID that strategic investment in FP would free up resources otherwise required for other key population-focused services in the future, such as health, education, jobs, and food security, is powerful and easy for decision and policymakers to grasp when presented clearly. MCHIP updated Liberia's existing RAPID advocacy presentation to demonstrate the impact of the current population growth in Liberia.

In direct support of the *Liberia National Family Planning Strategy* and the *Accelerated Action Plan for the Reduction in Maternal Mortality*, the RAPID Model helped the MOHSW at the central and county levels reprioritize and strengthen its leadership to advocate for additional

resources and the integration of FP into the basic package of health services. Staff members of the Family Health Division (FHD), MOHSW, who were also trained to be MCH champions, were oriented to the use of the tool and created an action plan for lobbying legislative support and funding for MOHSW implementation. The dissemination plan included identifying other private and public stakeholder audiences to be addressed, international donors, and internal leaders within the MOHSW.

Six MOHSW staff members presented to the Liberian House of Representatives on the quality of population over quantity, or sheer numbers. The message resonated with the House of Representative members present. Addressing health disparities, especially for women and children, is important for the government and legislators requested a closer working relationship with the Liberian House of Representatives and House of Senate Standing Committees on Health and other relevant committees in the future. Government officials received a summary outlining the resources needed and the associated costs. The legislators promised to study MOHSW's funding proposal to increase the MOHSW budget and propose specific allocations for maternal and newborn health (MNH) services, especially for FP. The latest GOL health budget included a \$40,000 increase in MNH services, which includes FP.

Training

When MCHIP implementation started in Liberia, there was no competency-based course on FP for service providers. This gap prompted USAID/Liberia to set the objective for MCHIP to work with partners to increase access to FP services by building local capacity to train and supervise providers in provision of high-quality FP and RH services. The majority of pre-service tutors acknowledged that they would benefit from an updated course on FP and added that while their students received didactic information on FP in their training programs, they did not have the opportunity to provide services to clients in their clinical training sites.

On the service delivery side, providers who had received recent training have only participated in a basic emergency obstetric and newborn care course but had not benefited from other in-service education, especially in FP. As a result, providers at most facilities could not offer evidence-based counseling for a wide array of methods, but offered only condoms, injectables, and progestin-only pill (POPs) or combined oral contraceptive pills (COCs) to their clients. Emergency contraception (EC) was used for rape victims only. Furthermore, providers had many misconceptions about the intrauterine device (IUD), and the contraceptive implant was not stocked by the MOHSW. The only exception was Redemption Hospital FP clinic that had been supported by Médecins sans Frontières (MSF) and had conducted training in insertion of Jadelle implants and interval IUD insertion. However, at the time, implants were not provided through the supply chain and MSF transitioned out of Liberia in June 2010. Even with trained providers, few IUDs were inserted because of providers' prevailing misconceptions about their use and hesitancy to counsel women about them. MCHIP worked to update skills and knowledge of service providers and develop clinical trainers to address the ever-growing need for clinical training. By the end of the project, 500 postpartum IUDs were inserted in the maternity ward at Redemption Hospital by MCHIP-trained clinicians.



Trained provider offers FP advice to a new mother.

With the limited array of long acting reversible contraceptive (LARC) FP methods being provided in Liberia, MCHIP worked with USAID and MOHSW to expand women's access to a wider range of modern methods through technical updates in implant and IUD insertion and removal to strengthen the national training capacity. MCHIP's support provided an important

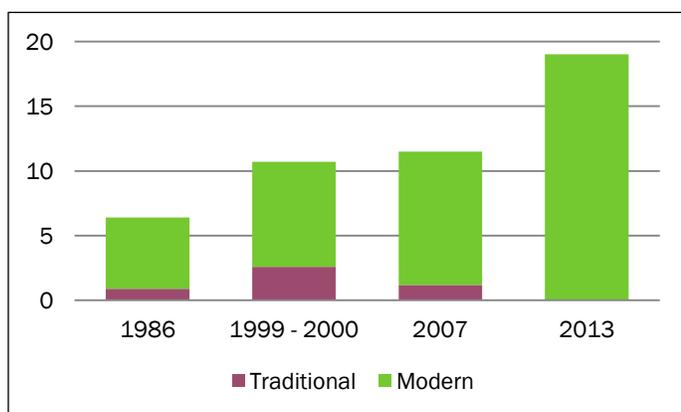
mechanism to encourage standard FP training and to ensure that the commodities were available before the training through work with UNFPA and other members of the RHTC. The initial round of training developed 25 new national FP trainers, who further co-facilitated additional courses with MCHIP technical advisors. With MCHIP assistance, these trainers planned and conducted technical update roll-down training in their targeted geographical areas. These trainings were the first MOHSW-sponsored FP technical updates since the war ended. In the MCHIP counties, the team trained providers at health facilities to reach additional women. (See Table 1 for number of people trained.)

Table 1. Number of People Trained by Course Titles and Category of Participants

COURSE NAME	CATEGORY OF PARTICIPANT	NUMBER OF PARTICIPANT
RAPID tool for advocacy and resources allocation	MOHSW officials	6
FP/RH regulation		682
FP step-down training	Nurses, midwives and training instructors	153
Misoprostol distribution	ANC providers (nurses, midwives)	9
Active Management of the Third Stage of Labor (AMTSL)	Nurses, midwives	17
DRHSs trained in misoprostol counseling and distribution	District Reproductive Health Supervisors (DRHSs)	2
Mapping of pregnant women	Trained traditional midwives (TTMs)	160
Maternal and newborn health	Nurses, midwives	25
Postnatal care (PNC) home visits	Nurses, midwives	41
PNC home visits	Community health workers (CHWs)	120
Refresher training on treatment of sick newborns with possible severe bacterial infection	Nurses, midwives	47
Expanded Program on Immunization (EPI)/FP integration	Nurses, midwives	45
Total Trained		1,307

MCHIP continued to follow up and reinforce the technical updates provided to health care providers on FP, short and LARC methods, FP statutory and policy requirements, and infection prevention during joint supportive supervision visits with the CHT. All participants of MCHIP FP workshops were taught WHO medical eligibility criteria and how to reduce client barriers to access, as well as how the provider can determine how to be reasonably sure that the client is not pregnant through taking her history. The competency-based FP training included: contraceptive technical update, counseling skills, infection prevention, and U.S. government (USG) legislative compliance principles of volunteerism and choice. During the training workshops, all participants developed competency on anatomical models first before proceeding with a clinical practicum in a FP or postpartum clinic and ward.

Figure 2. Trends in Current Use of Contraceptive Methods (percentage of currently married women using any method), Liberia DHS 1986–2013



Additionally, participants practiced FP counseling skills with patients waiting for antenatal services or postpartum patients bringing their children in for pediatric services.

As of the end of MCHIP's project, implants are now the third most used contraceptive method in Liberia.¹⁰ Before the initial MCHIP-led FP technical training, FP knowledge and practice were antiquated, presenting many barriers to clients who wanted to use a modern contraceptive method. The FP competency-based training provided practice sessions among peers and in the various MCH service delivery areas so that participants were able to practice and ask questions after delivering FP services to clients. MCHIP worked with partners to increase access to FP services by building local capacity to train and supervise FP providers nationwide, which contributed to the increase in the CPR to 19%¹¹ from 11.4% in the 2007 DHS. This is an unprecedented 8% increase in six years (see Figure 2).

Site Strengthening at Redemption Hospital

As part of its efforts to improve the quality of FP service delivery, MCHIP worked with Redemption Hospital in Monrovia and Phebe Hospital in Bong County to improve infrastructure and FP services, with a vision of creating “Centers of Excellence” in delivery of FP services. Redemption Hospital is the maternity facility with the highest number of deliveries in the country and reaches an underserved population with strengthened FP and PPFPP services. Since both hospitals are pre-service teaching sites where students acquire practical skills, they provide special opportunities for sustainable improvement of service provision. MCHIP worked with the MOHSW and partners to strengthen services and monitor these facilities.



Participant in FP training learning skills through use of an anatomical model.

Site-strengthening activities included infrastructure improvements to the FP service delivery rooms and waiting areas at both hospitals. The postpartum ward and training hall were also refurbished at Redemption Hospital. MCHIP completed the refurbishment of infrastructure by the end of September 2011 for both hospitals and MCHIP staff conducted a spot check on the work completed. In FY12, Phebe Hospital transitioned to the RBHS Program for continued supportive supervision and guidance for capacity building.

Site-strengthening activities continued at Redemption Hospital with monthly supportive supervision for providers seeing women for postabortion care and postpartum services at the FP clinic and in the maternity ward. Prior to MCHIP support, maternity health workers were unaccustomed to providing FP. They assumed that clients were not at risk, were not interested or thought somebody else would provide them with such information. It was found that the majority of postpartum and postabortion clients are interested in preventing another pregnancy for at least two years. Integrating FP services (counseling and commodities) into these services is important to further reduce unmet FP need. This included contraceptive technical updates on PPFPP, postabortion FP, supportive supervision and the QA process. Since 2012, more than 500 women accepted a method from the postpartum ward.

Redemption Hospital attained the status of “Center of Excellence” status, including being one of only three facilities in the country to achieve over 87% on the national FP standards.

Redemption has been able to ensure that the services follow the national standards, including

¹⁰ DHS Liberia 2013

¹¹ *Demographic and Health Survey Liberia 2013.*

infection prevention (IP). Records of services provided were reviewed quarterly and MCHIP worked with the health facility staff using the MCHIP-developed data quality and quality improvement (QI) monitoring tool. From 2011 to 2013, the Redemption FP clinic has seen an increase in new acceptors (15,732) and continued acceptors (17,345).

CONTENT AREA 2: INTEGRATED FP WITH IMMUNIZATION SERVICES

The 2007 DHS in Liberia indicated that there is a substantial unmet need for FP using modern contraceptive methods. According to a re-analysis of the 2007 DHS data conducted by MCHIP, less than 10% of women 6–12 months postpartum use any type of modern contraception. This same time period postpartum also overlaps with the schedule for routine infant immunization. Liberia’s national immunization schedule calls for children to be vaccinated at birth, 6, 10, and 14 weeks and 9 months of age; however, the actual ages at which these vaccination contacts take place are believed to be somewhat later. These vaccination-related contacts with the health system during the infant’s first year of life offer a promising opportunity to also address women’s FP needs during the same period.



Mother receives FP counseling during her child’s immunization visit.

The MOHSW has recognized the significant role that FP can play in reducing maternal and newborn morbidity and mortality in the country. With the government’s commitment to reduce the high levels of unmet need for FP, the concept of using vaccination contacts to increase access to FP—and possibly immunization—is supported by high-level MOHSW officials. MOHSW officials also pointed out the need to maximize the use of limited human and financial resources to achieve as broad a health benefit as possible. For this reason, MCHIP and the MOHSW designed an approach to integrate the delivery of FP and routine infant immunization services on a demonstration basis in a limited number of health facilities.

From March to November 2012, Liberia’s MOHSW, with technical assistance from MCHIP, and supported by USAID, piloted a model for integrating the service delivery of immunization and FP in 10 health facilities in Bong and Lofa counties. The approach involved vaccinators providing a few short, targeted FP and immunization messages and same-day FP referrals to mothers bringing their infants to the health facility for routine immunization.



A vaccinator practices counseling a patient on FP as part of the training.

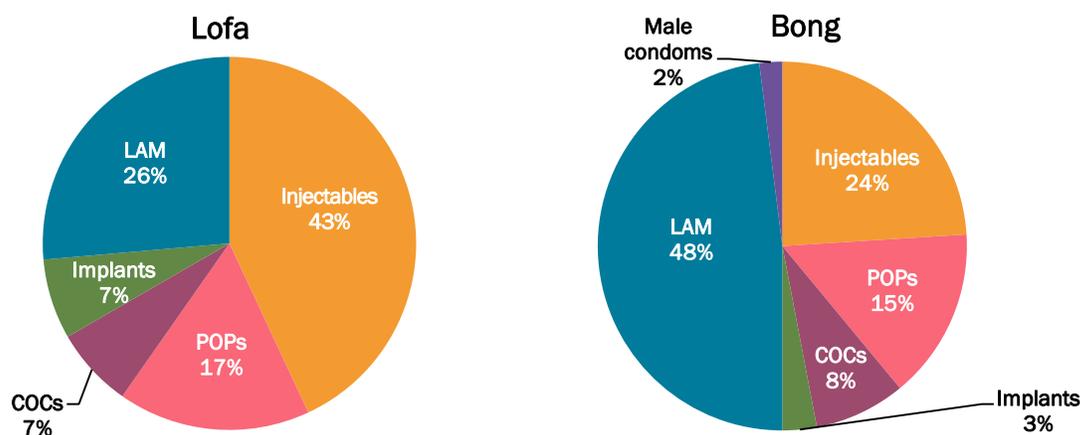
A final assessment was conducted in December 2012 to assess the outcomes of integrated service delivery. The assessment relied on the following sources of data: service statistics (both EPI and FP) collected during the MCHIP/MOHSW monthly supervision visits to each participating facility; observations during supportive supervision visits and training activities; MOHSW EPI data for demonstration facilities and all other facilities in Bong and Lofa counties

for 2011 and 2012; and interviews and focus group discussions (FGDs) with clients, service providers, program managers, and partner agency representatives.

For the immunization component, demonstration facilities in both counties experienced an increase in the number of doses of Penta 1 and Penta 3 administered. However, in both counties, the increase in Penta 1 doses administered outpaced that of Penta 3 doses, resulting in a net increase in the dropout rate. An examination of possible explanations showed that the demonstration facilities had a higher than average background rate of dropout prior to participating in the demonstration and that, in Bong, the findings were affected disproportionately by one large facility that experienced a drop in immunization due to human resource constraints in 2012.

These findings suggest that the changes in immunization were more likely due to broad external factors rather than the integrated EPI/FP service delivery itself. The findings were reviewed with stakeholders, and opportunities to further strengthen EPI outcomes through integrated service delivery were identified. For example, the EPI component of the EPI/FP training was updated to include more content around vaccinator communication and the importance of reminding clients about return dates for their next vaccine. FP providers will also be asked to remind EPI-referred clients about the return date for their next vaccine at the completion of the FP visit.

Figure 3. Contraceptive Method Mix among Same-Day Referral Acceptors in Participating Facilities, March–November 2012



Among EPI-referred women who accepted an FP method on the same day, the contraceptive method mix varied slightly between the two counties (see Figure 3). In Lofa, the largest portion of referral acceptors selected injectables (43%), followed by LAM (26%), POPs (17%), and implants (7%) and COCs (7%). In Bong, the largest portion of referral acceptors selected LAM (48%) followed by injectables (24%), POPs (15%), COCs (8%), and implants (3%). It should be noted that although IUDs are offered in most facilities in Liberia, none of the FP referral acceptors were provided an IUD on the same day. Barriers to IUD uptake in demonstration facilities and in the country as a whole may include lack of availability of IUD insertion kits, shortage of trained providers, provider bias, and cultural stigma and misconceptions surrounding this method.

Results showed that both counties experienced large increases in the numbers of new contraceptive users. By comparing the intervention period (March–November of 2012) with the same period of 2011, the number of new contraceptive users at participating facilities increased by 90% in Lofa County (517 to 983) and 73% in Bong County (1,182 to 2,039) for a total increase of 1,323 new contraceptive users above the same period of the previous year. It should be noted

that LAM was not monitored during the baseline, although providers were not routinely tracking LAM and LAM use was likely extremely low.

Table 2. Number and Percentage Change in Number of New Contraceptive Users in Demonstration Facilities Comparing March–November 2011 and March–November 2012

COUNTY	HEALTH FACILITY	NEW CONTRACEPTIVE USERS		% CHANGE
		March–Nov 2011	March–Nov 2012	
Bong	Fenutoli	79	386	+389%
	Garmu	227	456	+101%
	Phebe (hospital)	670	826	+23%
	Salala	127	233	+84%
	Zoweinta	79	138	+75%
Lofa	Borkeza	79	235	+197%
	Curran (hospital)	117	306	+162%
	Ganglota	73	135	+85%
	Gbonyea	143	164	+15%
	Kpaiyea	105	143	+36%

FP users who were referred from EPI and accepted the method on the same day accounted for a large proportion of the total number of new contraceptive users in participating facilities. During the demonstration period, 44% and 34% of all new contraceptive users in participating facilities in Bong and Lofa (respectively) were same-day EPI-referral acceptors.

Findings from the qualitative component of the final assessment also revealed that the integrated service delivery increased vaccinators’ sense of confidence and value within the health system and community. The approach was so appreciated that integrated service delivery continued at demonstration sites by its own accord even after the demonstration phase was completed. Service providers and clients also reported that the integrated service delivery process had increased their knowledge and changed their views about FP. Many mothers reported that before the vaccinator had spoken with them about FP, they were not aware that women with young infants (“baby ma”) could take FP. One client said, *“It is good to hear about FP, good for us so we can teach each other, so we can be in a better condition than we are today.”* Another woman was noted as saying, *“If I hadn’t gone [for FP services], I would have been pregnant now. In the past, I got pregnant before 1 year, but I didn’t know baby ma can take FP.”*



“The integrated immunization and family planning program has given me vast knowledge and skills about family planning,” says Midwife Garmai Zubawuo.

Following review and discussion of findings from the demonstration phase, the MOHSW granted formal approval to scale up the EPI/FP integrated service delivery approach to additional sites within the country. Implementing partners in Bong and Lofa counties will scale up the program, with technical support from MCHIP, given that the MOHSW granted formal approval for scale-up. Africare, IRC, Médecins du Monde, and Save the Children were involved at the county level with the approach, which will further enable scale-up efforts moving forward. The approach has been adopted by IRC and will be implemented in CSHGP activities. MCHIP developed an implementation guide that will be distributed in country to assist implementing partners in scaling up the approach.

At a global level, FP and immunization integration has drawn attention as a promising practice by nongovernmental organizations and donor agencies, although limited evidence exists to date, especially regarding immunization outcomes. Results from this demonstration activity have helped to inform the dialogue about optimal integration models and factors that inhibit and maximize success for both FP and immunization outcomes. A journal manuscript outlining the findings is in progress to share with a broader audience. Findings from Liberia have been shared through the FP and Immunization Integration Working Group, and tools, materials, and program learning from the Liberia experience were included in the FP and Immunization Integration Toolkit, a clearinghouse for resources on this topic.¹² It additionally informed the development of a USAID High Impact Practices brief on EPI/FP integration as a promising practice.

Five Key MNH Messages:

- **Pregnancy:** Women should attend ANC at least four times to be prepared for the delivery and to identify potential complications.
- **Labor and delivery:** All women should deliver with a SBA.
- **Postpartum mothers:** A new mother should go for a checkup one to two days after delivery.
- **Newborns:** All newborns must be kept warm, dry, and clean, and should only be breastfed. The newborn must be taken for a checkup one to two days after being born.
- **HTSP and FP:** Practice HTSP and use of FP by waiting at least two years to get pregnant again; wait six months after an abortion; and all girls should delay first pregnancy until after 18 years of age.

CONTENT AREA 3: INCREASE DEMAND AND ACCESS TO FP THROUGH COMMUNITY OUTREACH

To improve demand for FP, MCHIP worked to bring health education information and services closer to the community in rural and urban areas, using already proven effective and innovative approaches. As part of this effort, MCHIP conducted community-level and behavior change communication (BCC) to work with religious leaders, barber shop and beauty salon workers, and market vendors. MCHIP aimed to address the many cultural practices and accessibility issues that result in early teen pregnancy and low use of modern methods of contraception.

Goodwill Ambassadors

The MOHSW appointed Goodwill Ambassador, Miatta Fahnbulleh, as a national public figure to advocate for the reduction of maternal and newborn mortality. It is her role to engage in outreach and resource mobilization in communities for strengthening antenatal, labor and delivery, and comprehensive care for newborns and postpartum mothers. Emphasis is also placed on making all FP methods accessible to all women, especially in the rural areas. MCHIP provided technical guidance and logistical support to the Goodwill Ambassador for her work in MCHIP-supported counties.

The national Goodwill Ambassador's methodology is to work with CHTs using a bottom-to-top approach. The goal of the advocacy meetings was to provide an opportunity for participants to discuss and share activities by working with community-selected local goodwill ambassadors. The problem of the unacceptably high maternal and newborn mortality rates in the country was highlighted and the important role the community plays in mitigating the issue. Evidence-based

Community-Level Action Plans Developed with the Goodwill Ambassadors to Promote Maternal Health:

- Stress the importance of ANC and promote deliveries at a health facility.
- Create awareness about the dangers of teenage pregnancy.
- Create health clubs and conduct talks in schools.
- Map all pregnant women in the community.
- Follow up with pregnant women at home before and after the delivery.
- Encourage health workers to establish working relationships with TTMs.
- Ensure that TTMs refer and accompany pregnant women for services.

¹² <http://www.k4health.org/toolkits/family-planning-immunization-integration>.

interventions and best practices for reducing the high maternal and newborn mortality rates were shared and five key messages were distributed. Participants identified and shared actions that they can implement in their districts to reduce maternal and newborn death rates.

Religious Leaders

MCHIP helped to develop sermon guides (based on the ACCESS-FP project) with local religious leaders; the sermon guides provided religious texts that support HTSP messages for the well-being of the mother and child. Religious leaders in Montserrado and Grand Bassa used these guides within their congregations to share healthy timing and spacing messages during services and community outreach campaigns.

Liberian Muslims United for Progress, a Muslim organization in Monrovia, approached MCHIP to collaborate on using the previously adapted healthy timing and spacing messages from the Qur'an in eight neighborhoods (Clara Town, Via Town, Duala, St. Paul Bridge, Logan Town, West Point, Plumkor, and Benson Street Central Mosque) to conduct community health education awareness. A similar activity in Grand Bassa was conducted with the Christian organization Bassa Ministers Association. A total of 269 community mobilizers, including youth and men, were trained to create awareness around healthy timing and spacing of births and the risks associated with teenage pregnancy. Approximately 6,233 of people have heard a health message through these community mobilizers.

Barber Shops and Beauty Salons

In Liberia, beauty salons and barber shops often operate as communication hubs. Salon workers have wide-reaching contacts within the local community, see many of the same clients on a regular basis, and build trusting relationships with these clients. Clients also bring friends and family members to accompany them to the salon during appointments, adding to the social atmosphere of the salon. Therefore, beauty salons and barber shops can serve as a critical mechanism for communicating health messages, including messages about FP to members of the local community.

To raise awareness about FP and link clients to needed services, MCHIP conducted a campaign to engage salon workers to promote and refer women for family planning. MCHIP trained salon workers from four salons in Monrovia to discuss FP with their clients, distribute condoms, and provide FP referrals to the local health facility, Redemption Hospital. Since MCHIP is already working on FP service strengthening at Redemption Hospital, the beauty salons and barber shops for this campaign were all located in the near vicinity of this health facility. One beauty salon employee who was trained to distribute messages and condoms said that *“family planning will reduce the poverty rate. It will help families be happy together, because if you have too many children, there will be no time to care for them all.”* A total of 16,550 condoms were distributed to 1,100 clients since 2012. The findings from this approach indicated that it reaches primarily male participants, particularly adolescents, who may not seek FP services from a health clinic. Providing FP outside of the formal health sector allowed for a new avenue to access to commodities.



Gbeni Taylor, a beauty salon trained participant, cuts a client's hair and discusses FP methods with her, Bushrod Island, Monrovia.

Table 3. Number of Condoms Distributed and Clients Reached at Beauty Salons and Barber Shops, October 2012–November 2013

Total # of condoms distributed	16,550
Total # of clients accepting condoms	1,100*
<i>*Each client provided with condoms was given 15 units.</i>	

Marketplace Project

Building on the MOHSW request to increase access to and utilization of quality FP/RH services outside the health facility, MCHIP implemented the Market Contraceptive Project in nine markets in Montserrado, Grand Bassa, and Margibi. This approach aimed to increase access and utilization of FP services (counseling, contraceptive distribution, BCC activities and referrals) in urban and peri-urban market settings by vendors, shoppers, and young people using two approaches: CHVs and trained volunteer market vendors. Trained market vendors conducted BCC activities, provided counseling on all methods using the Balance Counseling Strategy (BCS) approach, and provided short-term methods, as well as referrals of clients requesting LARCs to the nearest health facility.



A volunteer with the Market Contraceptive Program at her market stand, with FP sign, Nancy B. Doe Market, Monrovia.

One trained volunteer market vendor said that she *“like[s] and enjoys[s] this program because it has increased [her] knowledge on family planning.”* This same volunteer recognized the impact that she is having because knowledge can save lives. *“This makes me feel very good because I am helping my country to reduce the teenage pregnancy, prevent women from dying because of childbirth since many women and girls are having children too soon and too close.”*

A total number of 12,119 cycles of pills were provided to over 6,050 clients and with over 200 referrals for LARCs. Each client received two cycles of pills per visit. A total of 11,500 male condoms were distributed to over 1,000 clients.

CONTENT AREA 4: PREVENTION OF PPH

PPH remains the leading cause of maternal mortality. Efforts to reduce mortality from PPH needed to be focused on both the facility and community levels. The MOHSW, with technical support from MCHIP, is implementing a program for the prevention of PPH. The program strengthens AMTSL and management of PPH at health facilities, as well as counseling, and advances distribution of misoprostol by health care providers and DRHSs to pregnant women for self-administration at home births. The intervention is implemented in two districts: Campwood District and District #3 in Grand Bassa County. The learning phase was implemented from December 2012 to June 2013.

The program was designed by the MOHSW with assistance from MCHIP. Venture Strategies Innovations (VSI) supplied the misoprostol. A dose of 600 µg of misoprostol (3 x 200-µg tablets taken orally) was agreed upon for this intervention.

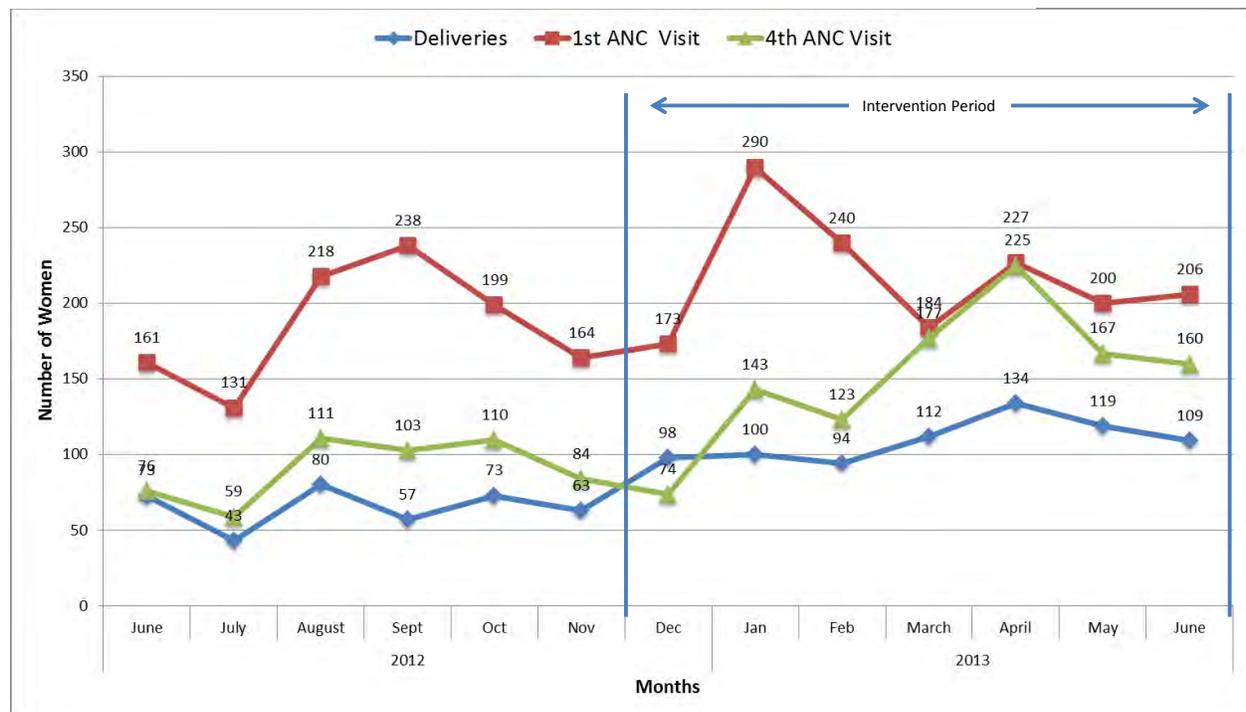
Table 4. Misoprostol Distribution Rate of Women Who Received PPH Prevention Package of Counseling and Advance Distribution of Misoprostol

INDICATOR	NUMBER	PERCENTAGE
Estimated number of pregnant women	1,826	-
Distribution rate: Pregnant women, of total estimated pregnancies, provided counseling and misoprostol	980	53.7%
At ANC by health care provider	766	78%
At home by DRHS	214	22%
Percentage of expected pregnant women not reached	846	46.3%

Eight health facilities were included in the implementation including one general hospital and seven clinics. At the facility level, 17 SBAs were trained on AMTSL, counseling, and advance distribution of misoprostol to women at/after 32 weeks of gestation for self-administration. DRHSs in the two districts also were trained on misoprostol counseling and distribution at household level, and County Reproductive Health Supervisors were trained for program supervision. To create demand for antenatal care (ANC) services and to better reach pregnant women, 160 TTMs were trained on mapping pregnant women in the communities, and referring them to health facilities for antenatal, delivery, and postpartum care, as well as on counseling on the dangers of PPH and the role of misoprostol in preventing PPH. Monthly meetings were arranged with the TTMs for the purpose of refreshing health information, data collection, and supportive supervision.

During this learning phase, 980 (53%) pregnant women were contacted and enrolled in the program. Of these, 766 (78%) were contacted and enrolled at the health facilities during ANC visits, and 214 (22%) were contacted at home by a DRHS. According to the Liberia DHS 2007, ANC 4 rate for Liberia was 66%, whereas ANC 4 rate in Grand Bassa was 59.6%. In this intervention, however, 42% (766/1,826) of women in the target area in Grand Bassa received counseling and misoprostol through ANC services, making the misoprostol distribution rate less than the local ANC 4 rate. Health care providers reached only 70% of women who came for ANC. Women were provided misoprostol during either the facility or the community interaction, but not both, to prevent double distribution.

Figure 4. Number of Deliveries in Participating Facilities, June 2012–June 2013



As a result of this PPH prevention intervention, 676 (98%) women delivering in health facilities received oxytocin, as collected through the project registers at the health facilities. Of the estimated deliveries expected at home (n=1,091) only 265 (23%) women took misoprostol for self-administration after home birth. Reaching pregnant women at home only through involvement of DRHSs was challenging and only minimally effective. Of the women who delivered at home, only a nominal number received the misoprostol from DRHSs (23%). Use of ANC services was only moderately better in distributing the misoprostol. Of the 1,851 anticipated births in the catchment area, only 41% were reached through ANC, compared with

rates of ANC (four visits) in Grand Bassa of 66%. When women came for ANC, only three out of five were provided misoprostol and relevant counseling. This may have been the result of having only one certified midwife (CM) in many of the demonstration site facilities. If the provider was busy with a delivery or not present at the facility some pregnant women would not have received ANC and misoprostol counseling services.

Figure 4 presents numbers of women who received one and four ANC visits, and number of deliveries in participating health facilities during the learning phase (collected from health facility registers). The trend line shows increased numbers of ANC 4 visits and deliveries in the participating health facilities from the start of the intervention. Before this intervention, policy allowed only SBAs to provide a uterotonic, which was recorded on the partograph or the woman's hospital record.

The results of the learning phase guided the MOHSW and its partners in determining next steps for expansion of the intervention into additional districts by demonstrating it is feasible in rural Liberia to implement a PPH prevention intervention, combining improved services at health facilities and a community focus to reach women who were unable to deliver at health facilities. It also demonstrated that it is safe to provide women with a dose of misoprostol in advance of their delivery for self-administration after the birth should they deliver at home. Advance distribution of misoprostol for self-administration at home birth does not reduce the numbers of women coming to deliver at facilities. In general, the number of facility births in the two districts started to increase before the intervention and continued to increase after the intervention began.

It was found that misoprostol is acceptable to pregnant women for PPH prevention. A high proportion of women who took the medication expressed satisfaction in terms of willingness to take it again if pregnant and intended to recommend it to another woman. Fewer women, however, said they would be willing to pay 5 Liberian Dollars (LD) (~\$0.06 USD) for the three tablets. Their willingness to pay may be influenced by the declaration of the MOHSW that medications are to be provided free of cost. One woman who received misoprostol said, *"The tablet is very good. I want to thank you for bring[ing] this medicine for helping people like me who cannot make it on time to the hospital."*

CONTENT AREA 5: NEWBORN HEALTH

To improve newborn survival and reduce under-five mortality, Liberia's MOHSW has focused its efforts on addressing the leading causes of newborn deaths. In 2012, MCHIP supported the MOHSW to undertake a newborn SITAN and conducted a review of Liberia's readiness to introduce and scale up select newborn health interventions. The latter was done using benchmarks developed and tested in 15 countries by Save the Children's Saving Newborn Lives program, as well as by using MCHIP's scale-up mapping tool. MCHIP then supported the Liberian MOHSW to convene a stakeholder meeting in September 2012 to review the draft SITAN, examine the benchmarks, and complete a scale-up map.

Key outcomes of the meeting included consensus to present findings from the benchmark review, mapping and SITAN at the MOHSW's annual program review meeting with CHTs in October 2012. MCHIP participated in this review meeting, which allowed for a well-informed review of Liberia's strengths and weaknesses, identification of possible solutions, and discussion of how to improve county-level planning for newborn health.

Following these initial activities, the MCHIP newborn health team secured the support of the MOHSW and other members of the RHTC meeting, which unanimously agreed to MCHIP's proposed newborn interventions. Several RHTC working groups were formed to facilitate the rapid review, approval, and implementation of KMC, CHX for umbilical cord care, and home-

based MNH care. Subsequently, in Year 5, MCHIP used Core funds to publish the final SITAN report and provide targeted technical assistance to address some of the gaps/opportunities described in that report, including introduction of KMC, introduction of CHX for umbilical cord care, and strengthening of home-based MNH care.

Kangaroo Mother Care

As mentioned above, in Year 5, MCHIP used Core funds to introduce KMC for management of preterm/low birth weight newborns. Drawing upon documents from Save the Children and MCHIP experiences implementing KMC in Tanzania and Malawi, respectively, and with financial support from MCHIP, the MOHSW published its own national KMC guidelines in March 2013, stating:

“The Kangaroo Mother Care guideline will be used by the policy makers, planners, implementers and partners to guide the establishment and implementation of Kangaroo Mother Care services at National, Regional, County and health facility levels to ensure survival and optimal development of preterm and low birth weight babies.”

- Dr. Bernice Dahn MD,MPH, Chief Medical Officer/Deputy Minister of Health

Foreword to the Republic of Liberia’s “Kangaroo Mother Care Guideline,” March 2013

Following the adoption of these national guidelines, MCHIP facilitated the training of 23 national KMC trainers. Participants included doctors and nurses from five hospitals where KMC was to be introduced, one tutor from each of three schools of nursing/midwifery and Reproductive Health Supervisors from the three counties in which the hospitals are located, as well as national Coordinators for Maternal, Newborn and Child Health from the MOHSW. The training was facilitated by an MCHIP-sponsored neonatologist consultant from Ghana who also supported assessment of the five hospitals. Those assessments identified basic equipment and supplies, which MCHIP procured and distributed to each KMC facility.

Step-down trainings on KMC were conducted for 205 health workers in the maternal, newborn and child health (MNCH) section of the five hospitals. All five hospitals now have functional KMC units. At the end of September 2013 (five months after the establishment of the units), 26 preterm/low birth weight babies were attended to in these units; five died and two absconded, while the remaining continued with the KMC while in the units and after discharge. One of the schools subsequently adopted KMC in its pre-service curriculum.

CHX for Umbilical Cord Care

Findings from the MCHIP-supported newborn health SITAN informed the MOHSW’s decision to adopt CHX for umbilical cord care:

“Chlorhexidine will be applied to the tip of the cord, the stump and around the base of the stump cord of all babies delivered in Liberia immediately after cutting the cord and with repeat application once daily until the cord separates.”

Ministry of Health and Social Welfare, Republic of Liberia

Policy on the use of Chlorhexidine for Cord Care

Adopted April 2013

In addition, the MOHSW incorporated 7.1% chlorhexidine digluconate for umbilical cord care into Liberia’s RH commodities list. This addition, and the Ministry’s strong endorsement of CHX for cord care, should ensure the eventual inclusion of 7.1% chlorhexidine digluconate into Liberia’s Essential Medicines List.

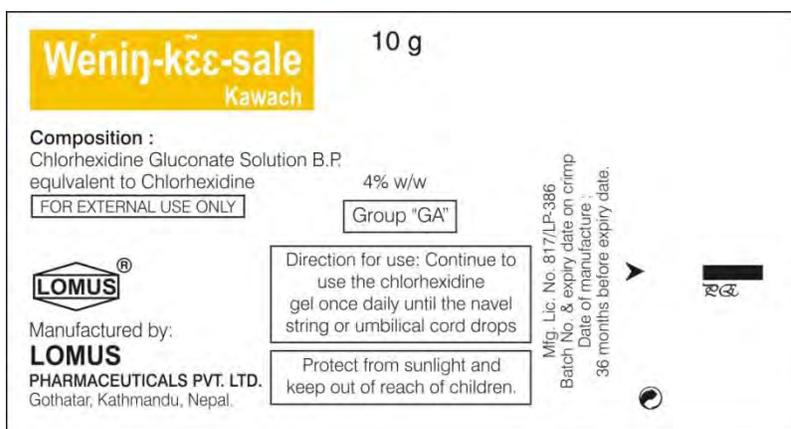
In preparation for the implementation of CHX for cord care in Liberia, MCHIP conducted a rapid assessment of consumer preferences, with technical support from the PATH-lead Chlorhexidine Working Group (CWG) of the UN Commission on Lifesaving Commodities (UNCoLSC). Results showed that over 70% of pregnant women interviewed preferred a gel formulation of the CHX as opposed to an aqueous solution.

In conjunction with the Health Promotion unit of the MOHSW, MCHIP supported the design, production, and distribution of information, education, and communication (IEC) materials on CHX to the initial target health facilities. Using funds from PATH/CHX CWG, Save the Children procured 15,000 tubes of 3g CHX, which MCHIP then distributed to five hospitals and nine clinics in Montserrado County, where approximately one-third of Liberia’s population resides.

The introduction of CHX in Montserrado was also intended as a catalyst for other implementing partners to roll it out in their respective counties. It also served as a learning county to address the challenges associated with procurement and distribution of the product to health facilities and to the mothers, and any associated users (both service providers and mothers). Save the Children Liberia was able to secure a small but catalytic amount of private funding to allow for the expansion of the CHX program to all facilities in the Montserrado County and to introduce it in Margibi County as well. UNFPA has pledged financial support to allow for further expansion of the intervention. Partners, including UNICEF and RBHS, have agreed to procure CHX for use at the facilities they support.



The CHX product name in Liberia, **Weniñ-kεε-sale**, translates to “naval string medicine,” was selected by the MOHSW. The CHX is packaged in a tube of 10 grams for multiple application; to be used daily until the cord falls off. The 7.1% chlorhexidine digluconate for umbilical cord care has been incorporated into Liberia’s RH commodities list.



All of the CHX used for umbilical cord care in Liberia must be imported because there are no pharmaceutical manufacturers in the country. In the short term, the CHX product is being imported from Lomus Pharmaceuticals Pvt. Ltd., in Nepal (7.1% CHX digluconate gel in a tube). It may be possible to import the CHX product from Nigeria once manufacturing is established there. Local manufacturing in Liberia is not currently feasible.

In conjunction with the MOHSW’s Health Promotion Unit, IEC materials on CHX were designed, produced, and distributed to the health facilities. Initially, 15,000 tubes of 3 g CHX were procured using funds from PATH/UNCoLSC and distributed to all five hospitals and nine

clinics; CHX is presently being given to mothers who deliver at the health facilities to care for their babies.

Home-Based MNH Care

To improve home visits by CHWs to pregnant women and newborns, MCHIP supported the MOHSW in designing and printing counseling cards/booklets for the *Home-Based Maternal Newborn Health Care Training Manual* adapted from the WHO training manual on community-based care of maternal and newborn health for CHWs. Twenty-five participants—including midwives and supervisors for the nine clinics in rural Montserrado County where the project is being implemented—were trained as trainers using the curriculum. Step-down training on home-based MNH was then conducted for 120 CHWs (TTMs/gCHVs) in the nine clinic catchment areas where the project was implemented.

CHWs are expected to visit all pregnant women in their catchment area at least three times during the antenatal period and conduct postnatal follow-up visits to mothers and newborns three times within a week of delivery for term babies and five times within two weeks for preterm babies, with the first visit on day one after birth. The training was conducted in the last quarter of the project and 43 newborns were visited according to the protocol by the CHWs. In addition, MCHIP conducted refresher training for 47 health workers on treatment of sick newborns with severe bacterial infection using the national guidelines on integrated management of newborn and childhood illnesses. The participants were midwives and nurses from nine clinics and two hospitals.

CONTENT AREA 6: MONITORING AND EVALUATION

In the last two years of MCHIP implementation in Liberia, a performance monitoring plan (PMP) was developed highlighting operational plan indicators and program indicators. Targets were set for specific indicators and a quarterly reporting format was developed. While the program relied extensively on MOSHW for routine data from health facilities, a link was established with the data unit of the counties for generating the monthly data. MCHIP collaborated with the MOHSW's Health Management Information System (HMIS) unit to develop appropriate recordkeeping formats for generating routine data for the FP, EPI/FP, newborn health, and PPH prevention interventions. The HMIS unit approved the development of recordkeeping formats to capture minimal data elements that cannot be tracked through the existing system. Supportive supervision checklists were developed to ensure the quality of services for FP, newborn health, and PPH prevention at the facility level. These forms were collected monthly. Also, a simple monthly data collation format was designed for routine data collection from the 10 health facilities that participated in the EPI/FP integration program.

At the community level, MCHIP developed appropriate recordkeeping formats, especially for the operators of barber shops and salons, religious leaders, and market leaders. Monthly data entry ensured effective quarterly reporting.

Two major evaluations were conducted during the implementation of MCHIP in Liberia: 1) EPI/FP integration demonstration study, and 2) PPH intervention learning phase study.

Cross-Cutting Themes

The MCHIP Liberia program addressed a number of cross-cutting themes during its implementation, such as:

Equity was addressed in a number of the project areas. The program focused on women gaining equitable access to FP services and methods that are acceptable to them. By advocating for the introduction of implants and Depo-Provera, it ensured that Liberian women, who have an extremely high unmet need for FP, would expand their choices, particularly for LARC methods. In addition, improving access to information and services for a broad range of methods encourages clients' rights and empowerment. The work with the RAPID model will allow for additional financial support for FP to make it more widespread throughout Liberia.

MCHIP's support for advocacy also ensures equitable access to health services beyond the health facility. Additionally, MCHIP's work with community initiatives ensures that FP health education and services will reach women and men in the communities in which they live and work. This approach increases the chances of the Liberian population learning about maternal health services, dispelling myths, increasing awareness, and promoting health behavior change.

Scale-up is another important component of MCHIP Liberia's activities. All technical components that MCHIP introduced were designed with scale-up in mind. The MOHSW has agreed to move forward in scaling up misoprostol distribution, EPI/FP integration, and support for KMC and CHX to reduce neonatal sepsis in additional counties beyond the geographical scope of MCHIP. The EPI/FP project is scaling up to more facilities in Bong and Lofa counties through local implementing organizations, IRC in collaboration with the CHTs. The PPH project is scaling up with a revised facility- and community-based distribution approach based on the results of the learning phase. MCHIP staff will continue to provide technical assistance to the MOHSW and implementing agencies during scale-up. An EPI/FP procedure manual is currently in development and will be shared upon completion. Two separate journal manuscripts outlining the findings from the EPI/FP integration and PPH learning phases are in progress to share with a broader audience.

Integration was the focus of inclusion of HTSP and PFP within FP training and service delivery and the EPI/FP integration demonstration. The unmet need for FP among postpartum women is extremely high. The EPI/FP project took the opportunity of women seeking vaccination for their infants to increase access to FP among women in the extended postpartum period. The integration effort was designed to increase FP access for women in this critical period as well as to reinforce the importance of immunization. A lack of integration of FP, MCH, and neonatal services can result in substantial missed opportunities to increase availability and use of key interventions.

As previously mentioned, **community involvement** was integral to MCHIP's work in Liberia. Engaging directly with key community leaders and members through adaptable approaches was integral for success and sustainability. These approaches reach different groups in communities with FP messages and services. For example, the initiatives outside of the health facilities, barber shops, and market places allowed MCHIP to reach adolescent youth in and out of school, particularly males, with FP messages and for distribution of condoms. This group can often be hard to reach as they have limited contact with the health system and these types of community approaches ensure that their FP needs are met.

From the beginning, **training** was an extremely important element of MCHIP Liberia's programming to ensure quality of health care services. All trainings focused on building capacity and updating knowledge of frontline health providers and CHVs, as well as the

MOHSW national- and county-level staff providing mentoring and oversight for the long term. In each workshop, participants achieved competency first on models, followed by a clinical practice session. These practice sessions generated the most excitement among providers and communities alike; many women volunteered to become FP clients, with implants found to be a method of choice for many.

During the technical updates, national trainers, and County Health Team Supervisors were oriented to the national supportive supervision checklist and FP compliance issues to guide them when providing supportive supervision at the county level. MCHIP Technical Advisors conducted supportive supervision visits with the MOHSW following trainings to reinforce knowledge taught during the trainings, especially focusing on infection prevention and the balanced counseling strategy to be in line with national FP standards. Supportive supervision was always part of the training process, given that it is an important part of system strengthening. Supervision continues mentoring and provides opportunities to address gaps in implementation so that there is clear understanding and acceptance of the updated competency-based training contents.

Quality improvement was the cornerstone of MCHIP Liberia's activities. All of the activities focused on QI based on evidence-based approaches for service provision; development, reinforcement, and use of job aids; regular supportive supervision; and data quality. All participants involved in MCHIP training and supportive supervision were introduced to the QI process and the use of the national FP standards. Additionally, all workshop participants and supervisees were coached on using balanced counseling skills and a humanistic training approach to minimize risk to clients through achieving competency in the particular health procedure performed.

Also, a new integrated data quality and QI monitoring tool was developed by MCHIP to be applied quarterly during the supportive supervision visits at health facilities. It includes a check-in on national QA efforts, review of FP service provision, and assessment of quality of key FP data. Going over the tool with the facility staff helps them identify gaps on the quality of services and address them accordingly.

Lessons Learned and Way Forward

Given that FP is a critical component in the reduction of maternal and neonatal mortality in the country, MCHIP recommends that FP services be integrated with other MNCH services, such as antenatal and postnatal care, to reduce the number of missed opportunities for increasing the uptake of contraceptive use. Also, it is important that there be an emphasis on HTSP through PFP and that FP services are adopted through effective and innovative community-based approaches to increase access among the general population, especially among those who may not seek out services at the health care facility. To ensure the standardization of community-based services, a toolkit, with IEC materials and job aids, should be developed for implementation of innovative community-based FP strategies with non-health workers. Additionally, non-monetary incentives that are in line with MOHSW policy should be considered.

MCHIP supported counties that experienced recurrent problems with contraceptive stock-outs. To address this ongoing issue, MCHIP staff worked at both the county and national levels with the MOHSW and other implementing partners to identify bottlenecks and work through the existing forecasting and logistical systems in transporting commodities. MCHIP worked directly with the county pharmacist to learn about the schedule and distribution process for the outlying facilities. At the central level, MCHIP assisted the CHTs to contact the central level staff to report issues as well as conduct advanced forecasting, especially for upcoming community outreach events. When absolutely necessary, MCHIP would assist in transporting commodities to the rural clinics where supportive supervision was conducted. During supportive supervision visits, the FP registers were reviewed for data quality and discrepancies that could potentially affect upcoming commodities forecasts.

In all community-based activities, it is important to ensure strong referral linkages with nearby facilities for complementary FP services. This approach will not only prevent stock-outs at the community level, but will also strengthen the relationship between the health facility and community level, and promote compliance with the statutory policy and requirements. With the increased demand for FP commodities, it is important to work with the DELIVER Project and the MOSHW's Supply Chain Management unit for forecasting and record-keeping in line with service delivery data. Additionally, it is suggested that partners advocate with the MOHSW to include FP commodities among the tracer drugs shipments to the counties to prevent transportation delays.

Throughout the project, providers were interested in acquiring new skills and technical knowledge; however, the routine application of good practices and overall quality of services depends on consistent follow-up and supportive supervision. Future programs should continue to build on developing the capacity of MOHSW and CHT staff to supervise and provide feedback and follow-up to frontline health workers to achieve the national QI standards emphasizing the aspect of recognition as an important motivator. The concept of low-dose, high-frequency was the methodology behind MCHIP's supportive supervision visits. This approach built on the competency-based training of facility staff and provided many opportunities for MCHIP staff to mentor and provide feedback to facility staff on clinical procedures, using the BCS and reviewing the data records with the facility staff to use it for decision-making and planning. The high frequency of supportive supervision also allowed MCHIP to work with new facility staff who were not provided an opportunity for competency training due to reassignment. It is recommended that all integrated MCNH activities should be included in the existing supportive supervision tools.

From the EPI/FP integration intervention, MCHIP identified a weakness in our training materials. Going forward, it is recommended that additional reinforcement of referral and reminder messages about the next vaccination should be provided to clients by vaccinators and CMs at every point of contact, starting from the first one for BCG and to remind EPI-referred clients about the child's return date for the next vaccine before they leave the FP room.

Additionally, it is important to strengthen the EPI component of EPI/FP training, including strategies for preventing and addressing EPI dropout. This could include having CMs restate to mothers when they should bring their child back for the next vaccination. Working on an integrated activity allows for opportunities to strengthen CM skills in PFP counseling, including LAM and transition, and such activities should be incorporated into planning.

Community-level workers were instrumental within the MCHIP project and it is advised to expand training to gCHVs to reach the maximum numbers of pregnant women and women of reproductive age at the community level. Although TTMs can be used to mobilize women to come for ANC and FP, relying mostly on the existing health system structures has not provided high coverage due to long distances from rural communities and limited access to transportation. Engaging directly with the TTMs by allowing them to distribute misoprostol or FP commodities, as is done in other countries, may be necessary to achieve the desired high coverage. Ultimately, more community engagement and additional innovative strategies may also be needed to reach the most remote and vulnerable women.

A key recommendation based on the PPH learning phase was that uterotonics for PPH prevention are provided for all vaginal births including cesarean sections. Given that these women also are at risk of PPH, the national protocols for administration of oxytocin (10 IU either IM or IV) to women during cesarean sections should be updated. In moving forward, the supply chain management and commodity availability—to avoid stock-outs—must be addressed during scale-up. Appropriate packaging of misoprostol (three tablets) is needed to ensure commodity integrity. In addition, use and disposition plans must be developed to prevent waste, given that increased coverage together with increased facility-based births may result in significant amounts of misoprostol that are returned unused. Additionally, MCHIP found the identification of women at the community level for follow-up difficult because they often registered a different name at the facility than what they are known by in the community. This was particularly a challenge in conducting the postpartum interviews at the community level, which resulted in delays in data collection and the inability to track some patients. In the absence of universal registration, additional information, such as a contact phone number, should be used during the registration and mapping process.

The data collation system with the data flow from the counties' monitoring and evaluation (M&E) units ensured that the same data are reported by both government and the program. This is a good system but could have worked better if data was received in a timely manner. Permission from HMIS unit of the MOHSW to use additional record keeping formats to capture data on specific PPH indicators not on the existing system provided the program the opportunity to track and report those essential indicators over time. This could have been averted if the existing HMIS has provision for the indicators. The incorporation of these indicators into the existing formats will help in establishing a good sense of ownership and continuous availability of data for government. The supplemental EPI/FP register, which was used for data collection during the demonstration phase, should no longer be used. Instead, referral acceptance/denial could be recorded directly in the EPI register on the same line as the child's name.

The project has contributed significantly to improving newborn health in Liberia, with the introduction of CHX for cord care and standardization of the care of premature/low birth weight newborns using the KMC method. The project was implemented in close collaboration with MOHSW at both national and county levels, which facilitated the active participation and ownership demonstrated by the MOHSW. There is need to strengthen monitoring and supervision of the project so as to improve the quality of the services. The various working groups formed should be sustained and made more functional so as to guide the effective scale-up of interventions. Finally, there is a need to scale up the interventions to increase access and coverage.

Annex 1: Indicator Matrix

OBJECTIVE AND INDICATOR	ACTUALS	ACTUALS FY13	COMMENTS
Program Objective 1: Support the MOHSW in implementing the national FP/RH program and advocating for the FP agenda			
Number of MOHSW officials trained to use the RAPID tool for advocacy and resource allocation	6	2	MOHSW staff were busy with other national health programs.
Program Objective 2: Increase access to high-quality FP services; tasks include orientation of staff and students to PFPF, support to central and county RHTCs to move FP forward, and bi-monthly meetings with maternity and pediatric wards			
Number of people trained in FP/RH and FP regulations with USG funds	682	69	Some of the participants did not turn up for the training.
Number of people who received FP methods	331,635	78,922	154,177 new acceptors and 177,458 continued acceptors
Number of supportive supervision visits conducted	15	10	All supportive supervision visits were conducted in collaboration with MOHSW.
Number of service delivery sites implementing QA/Standards-Based Management and Recognition (SBM-R®) in FP	80	80	All 80 facilities are still using SBM-R.
Number (%) of service delivery sites implementing QA in FP that achieved at least 80% of national FP standards	2.5%	N/A	Only Redemption Hospital and New Georgia Clinic are reporting 80%
Project Objective 3: Increase knowledge of and demand for FP services at community level			
Number of people reached with FP/RH messages through community outreach with support from USG	100,367	85,000	Includes those reached by religious leaders and during market and community outreach efforts
Number of FP sessions held by religious leaders among their congregations	180	180	
Number of beauty salons and barber shops providing FP referral to their clients	4	4	All four beauty salons are still operational.
Program Objective 4: Expand coverage of FP services and reach to the community through innovative approaches			
Number of counseling visits for FP/RH as a result of USG assistance	149,077	48,020	Note that most FP counseling in health facilities were not recorded in the FP registers. This is a major constraint on data relating to FP counseling.
Number of innovative approaches implemented	4	2	
Program Objective 5: Reduce the incidence of PPH at home births through a prevention of PPH program that includes use of misoprostol at home births			
Number of deliveries conducted by SBAs	670	670	No target was set for this indicator for the reporting period.
Number of providers trained in MNH	25	25	No training was conducted in the reporting period. New staff were not added in the health facilities as proposed.

OBJECTIVE AND INDICATOR	ACTUALS	ACTUALS FY13	COMMENTS
Number of pregnant women in districts of implementation who were counseled on use of misoprostol for PPH prevention	1,463	1,463	No target was set for the indicator during the reporting period.
Number of pregnant women in districts of implementation who received misoprostol for PPH prevention	980	980	No target was set for this indicator for the reporting period.
Proportion of vaginal deliveries by SBAs for which AMTSL was applied	620	620	This represents 97.6% of vaginal deliveries by SBAs for which AMTSL was applied.
Project Objective 6: Contribute to improvement of newborn health by working with MOHSW and implementing partners to assess and develop a plan to address gaps in essential newborn care, including in the management of newborn sepsis			
Number of health workers trained on PNC home visits	25	41	
Number of CHWs trained on PNC home visits	120	120	
Number of health workers who received refresher training on treatment of sick newborns with possible severe bacterial infection	47	47	
Number of hospitals providing KMC services	5	5	
Number of newborn infants visited at home within two days after delivery	43	100	
Percentage of sick newborns identified as having possible severe bacterial infection who were correctly treated	74%	74%	

Annex 2: Success Stories

SAVING MOTHERS' LIVES: PREVENTING POSTPARTUM HEMORRHAGE WITH MISOPROSTOL

By Varwo Gbassie and Alishea Galvin

Grand Bassa, Liberia—Marthalin Dolo, a 32-year-old mother of three children, had never visited a health facility for prenatal visits or to give birth. But when she became pregnant with her fourth child, she decided to break with the past and visit a health facility. She made this decision after talking with Jejay Wonyou, a trained traditional midwife who lives nearby.

In visits to Dolo's home, Wonyou explained to the expectant mother, her husband and her mother-in-law the benefits to mother and child of giving birth in a health facility with skilled care. Because the clinic was a three-hour walk away, she emphasized the importance of planning for a birth.

"She told me that at the clinic the [midwife] would check and see if me and the baby were doing okay," recalled Dolo.

Equally important, Wonyou shared information with the family about the warning signs of postpartum hemorrhage and a medication that prevents excessive bleeding after birth—the leading cause of maternal deaths in the developing world. Dolo's mother-in-law was familiar with the drug, misoprostol, which is known in the local Basso language as poweh and means "after pregnancy." Wonyou told Dolo she could obtain the medication from the clinic when she reached her eighth month. Dolo's mother-in-law—an influential voice in this traditional society—encouraged her to go to the clinic and prepare herself in case she was unable to give birth at the health facility. It was a strong endorsement of this lifesaving intervention, a key, community-based initiative to reduce maternal and newborn deaths supported by the government of Liberia in partnership with the U.S. Agency for International Development's Maternal and Child Health Integrated Program (MCHIP).

Wonyou is one of 160 trained traditional midwives participating in MCHIP's efforts to raise awareness about the importance of delivering at a health facility and preventing postpartum hemorrhage. This innovative program is part of a phased-in approach—implemented by MCHIP and Jhpiego in collaboration with the Ministry of Health and Social Welfare—to help save mothers' lives.

At eight months, Wonyou and Dolo visited the clinic together. The staff midwife counseled Dolo, who had experienced difficult births in the past, and provided her with misoprostol in case she couldn't get to the health facility to deliver. The midwife explained to Dolo how to store the medicine, when to take the pills, how many tablets to take and what to do with the empty pack. Wonyou also spoke to Dolo about the importance of family planning after the birth of a baby.

Liberia is one of several countries in which MCHIP has rolled out the prevention of postpartum hemorrhage program with distribution of misoprostol at facilities and community-based health education. Liberia was primed for this intervention because of its high maternal mortality ratio (994 deaths per 100,000 live births), high rate of home births and limited access to health care facilities. These factors have contributed to the introduction of this lifesaving intervention into



Jejay Wonyou (left), a trained traditional midwife, persuaded Marthalin Dolo (right) to visit a health facility to prepare for a safe and healthy birth.

communities in Liberia at this time. The six-month program is designed to help the Ministry of Health and Social Welfare carry out its maternal health objectives by building the capacity of health workers to expand this innovative, facility- and community-based initiative throughout the country.

When it came time for Dolo to give birth, even though the family had saved money for transportation to the health facility, none was available. Dolo gave birth with Wonyou at her mother-in-law's house. As soon as the baby was born, the midwife checked to make sure there were no other babies, and Dolo took the three tablets of misoprostol as she had been instructed by the clinic midwife. As soon as transport was available, Dolo, her husband and their new baby traveled to the clinic with the empty packages of the medicine for a postnatal visit.

For many women like Marthalin Dolo, the ability to take misoprostol on their own after giving birth at home without a skilled provider will reduce the risk of heavy bleeding and potentially save their lives. "The tablet is very good," she said, in describing her experience. "I want to thank you for bringing this medicine to people like me who cannot make it on time to the hospital."

BARBER SHOP AND BEAUTY SALON PROGRAM EXTENDS FAMILY PLANNING SERVICES TO LIBERIANS

By Gahan Furlane and Alishea Galvin

Monrovia, Liberia—When Gbeni Taylor was 16, she learned she was pregnant and worried how she would tell her family. It was a frightening and uncertain time for her and one that she would wish on no other young person. She feared her father would throw her out of the house, but her mother and other family members ensured that she remained at home and attended night school to complete her education. Gbeni's experience is all too common in Liberia where, according to the most recent Liberia Demographic and Health Survey 2007, literacy rates are low and about one-third of girls ages 15 to 19 have begun childbearing.

In hospitals in Monrovia, says Gbeni, “you see babies carrying babies. We need to talk to them. They don't know. They do it out of ignorance.”

Gbeni's life-changing experience, as well as seeing her friends become mothers when they were too young, led the 21-year-old hair stylist to participate in an innovative program in Liberia to educate young women about properly spacing their families. The barber shop and beauty salon family planning program, an initiative under the U.S. Agency for International Development's Maternal and Child Health Integrated Program (MCHIP), trains employees of beauty salons and barber shops to provide family planning messages, condoms and referrals to a nearby hospital for family planning services. A total of 16 workers have been trained in four salons and shops. Since 2012, they have reached 1,100 clients and distributed 16,550 condoms through this initiative.

Since 2009, MCHIP has been working with the Ministry of Health and Social Welfare in Liberia to increase family planning services. In addition to training providers and strengthening their skills, MCHIP has identified effective approaches to increase family planning services and awareness using community-based distribution of condoms, birth control pill refills through marketplace volunteers, religious leaders to promote family planning, immunization and family planning integration, and the beauty salon and barber shop initiative. Through these efforts, 331,000 women have accepted a family planning method and health care access and quality have improved for more than 3.2 million Liberians.

For hair stylist Gbeni, early intervention with youth is key. She believes that if people begin talking to youth about family planning, it will help them stay in school, get an education and delay having children. Through the beauty salon, Gbeni is able to reach both men and women, though women between the ages of 18 and 30 are her most frequent clients.

When approaching the sensitive topic of family planning with clients, Gbeni begins the conversation by talking about local politics or the latest gossip. As her clients relax and join in, Gbeni gradually brings up the less-than-popular topic of family planning. She asks her clients if they are practicing family planning. If a client is not using a method but interested, Gbeni will counsel the woman, give her condoms and offer a referral card to the nearest hospital family planning clinic to receive a long-acting, reversible method. This referral card ensures that a woman will be seen quickly at the hospital for family planning services.



Becoming a mother at age 16 taught Gbeni Taylor the importance of educating youth about family planning.

Gbeni believes the barber shop and beauty salon program can have a significant impact. Family planning, she says, “will reduce the poverty rate. It will help families to be happy together, because if you have too many children, there will be no time to care for them all.”

Comfort Gebeh also contributed to this article.

TAKING ACTION TO STRENGTHEN FAMILY PLANNING SERVICE DELIVERY IN LIBERIA

By Chelsea Cooper and Holly Blanchard

Bong County, Liberia—During a routine immunization visit for her infant at Phebe Hospital, a mother listened intently as the vaccinator shared information vital to the woman's health. Mothers who delay pregnancy for at least two years after giving birth are better able to care for themselves and their families, the mother was told.

Interested to know more, the woman was referred that day to family planning services where she met midwife Anna Flomo.

At 41, this mother had been pregnant 10 times, given birth to eight children and had seen seven survive. As Flomo counseled the woman on the family planning methods available at the hospital, the mother knew she didn't want to be pregnant again. The woman chose a tubal ligation, expressing relief that she wouldn't have to face another unwanted pregnancy.



Vaccinator sharing family planning information during a child's immunization visit, an example of integrating maternal health services. (Photo by C. Cooper)

More than half of the women who brought their children for vaccinations on this day sought family planning services, following a conversation with a vaccinator. For Flomo, this was her first opportunity to provide such family planning education and counseling in an integrated service setting since attending a capacity-building workshop on this innovative approach.

Phebe Hospital is among 10 health facilities in Liberia where the Ministry of Health and Social Welfare has integrated family planning with routine infant immunization services through the U.S. Agency for International Development's global Maternal and Child Health Integrated Program (MCHIP), led by Jhpiego. Supported by MCHIP, the ministry embarked on this demonstration project to address Liberian women's unmet need for family planning, build skills among health providers and strengthen the country's health system. MCHIP partners, Jhpiego and JSI, participated in this work.

The latest Liberia Demographic and Health Survey (DHS 2007) reported contraceptive prevalence among married women at 10.3 percent for modern methods, a total fertility rate of 5.2 and a maternal mortality ratio of 994 per 100,000 live births, one of the highest in the world. According to an MCHIP analysis of Liberian health data, 82 percent of Liberian women who are within two years of giving birth report an unmet need for family planning services.

An integrated approach to meeting this need is not only innovative, but has shown promise in other countries. Through routine child immunizations, caregivers have multiple contacts with mothers in the year after birth. These frequent contacts present a clear opportunity to reach women with family planning services while they are already at the health facility.

Vaccinators provide a few short, targeted family planning messages to mothers during routine immunization visits. For women who express interest in learning more about family planning options on the same day, vaccinators provide referrals to nearby services. Targeted job aids and

information, education and counseling materials have also been developed to support the process of integrating services.

MCHIP began working in Liberia in 2010 to strengthen family planning services. It is part of Jhpiego's ongoing efforts to help countries build the capacity of health workers to deliver skilled and comprehensive care, strengthen health systems and innovate to save lives.

One of the facilities where MCHIP is working is Redemption Hospital, the largest free maternity hospital in Liberia, located in an urban slum of Monrovia. When MCHIP first began working there in 2010, the midwives required clients to show proof of current menses to rule out pregnancy before starting them on a modern contraception. This mandate undermined women's ability to obtain contraception.

Vicky Youqui and Anita K. Kollie, midwives at the Redemption Hospital's family planning clinic, participated in capacity-building family planning workshops, sponsored by MCHIP/Jhpiego. During these sessions, they learned about effective counseling skills, provision of long-acting methods, infection prevention practices and postpartum family planning. They now know how to be reasonably sure that a woman isn't pregnant by asking her six simple questions. And they have seen success.

To highlight the hospital's achievements, Youqui proudly showed an MCHIP trainer the family planning register. Between October 2011 and January 2012, she and Kollie have seen an average of approximately 1,100 clients per month. Kollie shared the reaction of one of many clients to whom she provided a long-acting contraceptive implant.

"The woman really appreciated the care, saying that she had an [unsafe] abortion and promised herself that she would never do that again. Now she can breathe easy."



MCHIP family planning advisor Comfort Gebeh (center) discusses integration of family planning and child immunization services with Redemption Hospital midwives Vicky Youqui (left) and Anita K. Kollie (right). (Photo: H. Blanchard)

MARKET DAY IN LIBERIA: SALT, PALM OIL AND EXPANDED FAMILY PLANNING SERVICES

By Comfort Gebeh and Alishea Galvin

Buchanan, Liberia—When Marwo Weagai opens for business at the local market here, she sells bags of salt, bottles of palm oil and dried spices—and also offers free family planning (FP) advice and supplies to interested shoppers. Marwo is among 22 market vendors participating in an innovative program in three counties in Liberia to increase women’s access to FP counseling and services.



Marwo Weagai, a Grand Bassa Market vendor, participates in an MCHIP-funded initiative to increase access to family planning services.

Many of the market vendors know from personal experience the challenges faced by Liberian women who want a safe and reliable method to plan their families. For example, long lines at health facilities are a deterrent to accessing services for women who are busy caring for and trying to support their growing families. In Liberia, the average number of children per family is five. And, according to the latest Liberia Demographic and Health Survey (LDHS 2007), the unmet need for contraceptives is 36 percent. Moreover, the maternal mortality ratio is 994 per 100,000 live births—one of the highest in the world.

To address these issues, Jhpiego—through the support of the U.S. Agency for International Development’s Maternal and Child Health Integrated Program (MCHIP)—partnered with the Ministry of Health and Social Welfare and developed an innovative program to train women who work in the markets to be FP peer counselors and providers. Their market stalls are now posted with signs that say “Free Family Planning Services.”

In Grand Bassa, the volunteer counselors promote healthy behaviors and provide counseling, condoms and refills for contraceptive pills; they refer first-time users to a health facility.

“I like and enjoy this program, because it has increased my knowledge on family planning,” says Marwo, who also talks with family and neighbors outside the market about their FP options and encourages them to visit her stall in the market. “Every morning, when I come and put my market wares on the table, I go around talking to my peers about FP; those who are interested and are continuous users come for refills, and new clients, I encourage them to go to any government health facility of their choice for FP services.”

MCHIP has been working to increase FP services in Liberia since 2010. In addition to strengthening the skills of FP providers and integrating FP and immunization services at selected health facilities, MCHIP is identifying effective approaches to increase FP services and awareness through community-based distribution. To date, the market contraceptive program has served more than 1,500 clients in markets in the three targeted counties of Grand Bassa, Margibi and Montserrado.

Reaching out to adolescent girls has been a priority for the program. The statistics are telling: in Liberia, 48 percent of girls have begun bearing children by the time they are 18 (LDHS 2007); Grand Bassa County has a teenage pregnancy rate of more than 68 percent (UN 2008 Common Country Survey); and among all women of childbearing age, 25 percent of deaths are associated with maternal complications.

Consistent access to FP services can save lives.

Marwo recognizes the impact she is having

because knowledge can save lives too. “This

[program] makes me feel very good, because I am

helping my country to reduce teenage pregnancy

and to prevent women from dying because of

childbirth since many women and girls are having children too soon and too close,” she says.

“Because of the program, I have counseled all my younger sisters and they have accepted a FP method.”



Clients and members of the Marketing Association discuss the program with MCHIP staff.

Other market FP peer providers have also noted that the program is helping women to prevent unwanted pregnancy and unsafe abortions.

As part of this program, MCHIP has trained both market peer providers and Ministry of Health and Social Welfare health facility providers. In addition, MCHIP has supplied ongoing supportive supervision and data collection for routine monitoring.

During a visit at the Monrovia Junction market in Buchanan, an MCHIP staffer had the opportunity to speak with clients of the market contraceptive program; one woman reported that: “We are grateful, because this program is really good for us. It helps us to space our children and it also makes it easier for us to get our refill,” without spending a lot of time waiting in long lines at a busy clinic.

CHRISTIAN AND MUSLIM GROUPS IN LIBERIA UNITE TO PROMOTE FAMILY PLANNING

By Comfort Gebeh

In an effort to improve demand for family planning (FP) in Liberia, USAID’s flagship Maternal and Child Health Integrated Program (MCHIP) is bringing information and services closer to the community. And while the Program continues to employ traditional methods to improve FP services and demand—such as training providers and strengthening their skills—staff are also working with market peer providers, barber shop and beauty salon workers, and religious leaders to help spread key messages.



Kunu Fahnbulleh, a representative of PLUM (Liberia Muslims United for Progress), a Muslim organization in Monrovia

Since work began with the Ministry of Health and Social Welfare in 2009, 331,000 women have accepted a FP method and health care access and quality have improved for more than 3.2 million Liberians. Religious leaders have proved particularly effective in these efforts, reaching their congregations to dispel misconceptions, increase awareness of teenage pregnancy, and generally improve uptake of FP services.

MCHIP worked with these leaders to develop sermon guides, which provide religious texts to support messages about healthy timing and spacing of pregnancy for the benefit of both mothers and children. Staff also worked with religious leaders to address cultural practices and accessibility issues, focusing on prevention of teen pregnancy and the low use of modern contraception methods.

After the first workshop with religious leaders, representatives from PLUM—Liberia Muslims United for Progress, a Muslim organization in Monrovia—approached MCHIP about using the adapted messages in eight neighborhoods to conduct community health education awareness. PLUM’s Kunu Fahnbulleh says FP in Liberia was formally embraced across religious groups after the MCHIP workshop: “Muslims who hadn’t shown interest in FP on account of traditional beliefs participated in this workshop alongside the Christians,” he said. “[They] became more involved in active FP counseling and services by creating awareness of FP with the promotion of the use of modern contraceptives.”

Working with a MCHIP mentor, Fahnbulleh supervised 160 MCHIP-trained community mobilizers—youth, women and men—in creating awareness of the importance of healthy timing and spacing of births, and the risks associated with teenage pregnancy. Supervision, monitoring and mentoring activities were conducted by MCHIP and PLUM, including monthly meetings for sharing experiences and answering questions. Talking one-on-one, these volunteers ultimately reached 6,233 community members with key FP messages, referring many to the nearest facilities for FP counseling and services, as well, and earning the respect of local imams.

“We get thanks every day for helping to save the lives of our people, especially the youth,” said Fahnbulleh of the community outreach efforts.

LIBERIA - A KANGAROO MOTHER CARE SUCCESS STORY

Twenty-year-old Porpu lives with her aunt in a small community on the outskirts of the Liberian capital, Monrovia. In August 2013, Porpu gave birth to a son at Monrovia's Redemption Hospital. Delivered prematurely at the gestational age of 30 weeks, Porpu's son weighed only 1.2 kg (approx. 2.6 lbs). Porpu was reluctant to accept her son, feeling he would be too small to survive.



Porpu's son at the KMC unit at Redemption Hospital in Monrovia for his last follow-up visit

The staff at Redemption Hospital, where MCHIP has established a Kangaroo Mother Care (KMC) unit, began counseling both Porpu and her aunt on low birth weight babies and the benefits of KMC to reassure Porpu that despite her newborn son's age and small size, he could survive as other premature and low birth weight babies have before him. After some initial hesitation, Porpu accepted the staff's counseling and both she and her aunt received training on KMC. To ensure that her son reached a healthy weight, Porpu and her aunt remained at the hospital for one month. While Porpu breastfed her newborn son, Porpu's aunt provided continuous skin-to-skin contact with her great-nephew.

At the end of the month, the baby's weight had nearly doubled to 2.0 kg (or 4.4 lbs). Porpu's aunt agreed to continue to assist with KMC at home and was counseled on caring for her young nephew. "I want my little nephew to survive just as other babies have and I will do my best with this child in order for him to survive," she stated.

Both Porpu and her aunt continued practicing KMC at home and returned to the hospital for follow-up visits. At three months of age, Porpu's son is doing well with the help of his great-aunt and the continued support of the staff trained in KMC at Redemption Hospital.

Annex 3: List of Presentations at International Conferences and Publications

- Liberia Maternal Health Indicators (PPH and pre-eclampsia/eclampsia), Poster, MCHIP Africa Regional Meeting on Interventions for Impact in Essential Obstetric and Newborn Care, February 2011
- EPI & Family Planning Integration in Liberian Health Facilities, Presentation, Women Deliver Conference, May 2013
- Advance Distribution of Misoprostol for Prevention of Postpartum Hemorrhage (PPH) at Home Births in Two Districts of Liberia, Journal Manuscript, *BMC Pregnancy and Childbirth*
- Contraceptive Day in Liberia Successfully Increases Contraceptive Use Among Youth, Poster, International Conference on Family Planning, November 2013

Annex 4: List of Materials and Tools Developed or Adapted by the Program

DOCUMENT TITLE	TYPE OF RESOURCE	DESCRIPTION	YEAR DEVELOPED
FP Materials			
FP Roadmap	Roadmap	The Ministry of Health asked Jhpiego to develop a roadmap for the reduction of unplanned pregnancies in Liberia	2013
MCHIP Sermon Guides for Christian and Muslim Leaders	Job Aid	Provides examples on how to address messages about HTSP for Muslim and Christian leaders	2011
Beauty Salon Briefer	Briefer		
Postpartum FP HTSP messages	Radio Messages		2013
Moving Forward: The Impact of Population Growth in Liberia—A RAPID presentation	Presentation	Presentation on population growth and potential impacts in Liberia	2012
Standard Days Method: A Simple Fertility Awareness-Based Approach to FP	Presentation	Presentation from SDM 1-day training	2012
FP brochure	Leaflet	Leaflet with information for women and their husbands on FP	2011
Infection prevention job aids and handouts for health care providers			
Progress Report			
MCHIP Liberia “Centers of Excellence” Specification of Workmanship and Materials—Redemption Hospital Refurbishment: Report on Progress, March 2011	Progress Report	Progress report on hospital refurbishment at Redemption (March)	2011
MCHIP Liberia “Centers of Excellence” Specification of Workmanship and Materials—Redemption Hospital Refurbishment: Report on Progress, April 2011	Progress Report	Progress report on hospital refurbishment at Redemption (April)	2011
Workshop and Training Reports			
Grand Gedeh FP Step-Down Training	Training Report	Report on the 5-day FP step-down training in Grand Gedeh County for 12 providers	2010
Five-Day Clinical Training Skills Report	Training Report	Clinical training skills workshop report for 25 national trainers	2010
Religious Leaders Meeting To Promote Maternal Health and Child Survival: Report	Meeting Report	Report about religious leaders meeting	2010
FP Step-Down Training Report	Training Report	Step-down training report	2010
Two-Week FP Technical Update Training Report	Training Report	Technical update training report	2010
Bassa Marketer’s Peer Providers FP workshop report (July 19-20, 2012)	Workshop Report	Report on peer providers workshop	2012

DOCUMENT TITLE	TYPE OF RESOURCE	DESCRIPTION	YEAR DEVELOPED
EPI/FP Materials			
Liberia EPI/FP Final Assessment Report	Report	Report detailing findings from the endline assessment for the EPI/FP integration activity	2013
EPI Process/Implementation Guide	Implementation Guide	Implementation guide including supervision and training tools, overview of implementation process, for use by counties/agencies interested in scaling up the approach	2013
EPI/FP Stakeholder Meeting Report	Meeting Report	Overview, discussion of key findings and next steps from the EPI/FP meeting in March 2013	2013
EPI/FP Poster	Poster	Poster to complement messages shared by the vaccinator. Stationed at EPI and FP service delivery sites	2012
Mid-process assessment report	Report	Mid-term report detailing ongoing challenges, successes, and recommended adjustments to the approach	2012
FP Referral Card	Referral Card	Given by vaccinators to those women who accept FP referrals	2012
Formative Assessment Report	Report	Formative assessment to inform the development of EPI/FP integration strategy and messages/materials	2011
Integrating EPI and FP Service Delivery in Liberia: Advocacy Presentation	Presentation	Highlights rationale for integrating EPI and FP services in Liberia	2011
Advocacy/Pre-Implementation stakeholders meetings report	Report	Summary of initial meeting with key stakeholders to discuss EPI/FP integration in Liberia	2011
Job Aid for Vaccinator	Job Aid	Job aid for vaccinators with messages on FP for postpartum women	2011
FP leaflet for postpartum mothers	Leaflet	Leaflet that outlines benefits of FP to mother, child, and father. Given to the postpartum women who did not agree to go to the FP provider on the same day as her child's immunization	2011
PPH Materials			
Community Based (TTM) Service Providers Counseling Cards	Training Material	Counseling cards for PPH were developed in collaboration with the MOH to aid TTMs in counseling of pregnant mothers	2012
Prevention of PPH Reference Manual	Training Material	Reference material for PPH prevention training	2012
Prevention of PPH Facilitators Guide	Training Material	PPH facilitator guide for use during training of TTM	2012
Report on PPH Project County Level Advocacy Meeting: Buchanan	Report	Report from advocacy meeting in 2012 in Buchanan for PPH	2012
Report on prevention of PPH training for health workers in Bassa and Bong Counties	Training Report	Report on 3 days training for HWs	2012

DOCUMENT TITLE	TYPE OF RESOURCE	DESCRIPTION	YEAR DEVELOPED
Report on training for prevention of PPH at home birth for TTMs in Bassa & Bong Counties	Training Report	Report on 2-day training for TTMs	2012
Report on refresher training for prevention of PPH at home birth for TTMs in Bassa and Bong Counties	Training Report	Report on 1-day training for TTMs	2012
Report on refresher training for prevention of PPH at home birth for HWs in Bassa and Bong Counties	Training Report	Report on 1-day training for HWs	2012
Report TTM PPH monthly meeting	Meeting Report	PPH prevention report	2013
Monthly PPH supportive supervision report	Supervision Report	PPH prevention supportive supervision report	2013
Monthly supportive supervision report	Supervision Report	Supportive supervision PPH prevention report	2013
Report TTM PPH monthly meeting	Meeting Report	PPH prevention report	2013
Liberia PPH brief	Brief	Brief outlining the PPH project in Liberia	2013
Liberia PPH dissemination presentation	Presentation	Presentation given at the dissemination meeting for the PPH project	2013
Newborn Health			
Policy on the use of CHX for cord care	Policy Document	The adoption and procedure for the use of CHX for cord care	2013
National Implementation Guideline on KMC	Training/Implementation Document	Implementation guidelines on the institutionalization of KMC in the health facilities and communities in Liberia	2013
Project Reports			
Bi-Weekly Reports			
Liberia Activity update April 16-27, 2012	Bi-Weekly Report	Bi-Weekly Report for April 16-27, 2012	2012
Liberia Activity update April 27-May 11, 2012	Bi-Weekly Report	Bi-Weekly Report for April 27-May 11	2012
Liberia MCHIP Achievements to Date (May 22, 2012)	Achievements Report	Achievements as of May 22, 2012	2012
MCHIP-Liberia Activity Update May 16-31, 2012	Bi-Weekly Report	Bi-Weekly Report for May 16-31, 2012	2012
MCHIP Activity Update June 1-15, 2012	Bi-Weekly Report	Bi-Weekly Report for June 1-15, 2012	2012
MCHIP Activity Update June 16-30, 2012	Bi-Weekly Report	Bi-Weekly Report for June 16-30, 2012	2012
MCHIP July 1-15, 2012	Bi-Weekly Report	Bi-Weekly Report for July 1-15, 2012	2012
MCHIP Liberia Activity Update July 15-31, 2012	Bi-Weekly Report	Bi-Weekly Report for July 15-31, 2012	2012
MCHIP Liberia Activity Update August 1-15, 2012	Bi-Weekly Report	Bi-Weekly Report for August 1-15, 2012	2012
MCHIP Bi-Weekly Report August 15-31, 2012	Bi-Weekly Report	Bi-Weekly report for August 15-31, 2012	2012

DOCUMENT TITLE	TYPE OF RESOURCE	DESCRIPTION	YEAR DEVELOPED
Liberia Activity Update September 1-15, 2012	Bi-Weekly Report	Bi-Weekly Report for September 1-15, 2012	2012
Liberia Activity Update September 15-30, 2012	Bi-Weekly Report	Bi-Weekly Report for September 15-30, 2012	2012
MCHIP Liberia Activity Update October 1-15, 2012	Bi-Weekly Report	Bi-Weekly Report for October 1-15, 2012	2012
MCHIP Liberia Activity Update October 16-31, 2012	Bi-Weekly Report	Bi-Weekly Report for October 16-31, 2012	2012
MCHIP Liberia Activity Update November 1-12, 2012	Bi-Weekly Report	Bi-Weekly Report for November 1-12, 2012	2012
MCHIP Liberia Activity Update: November 12-26, 2012	Bi-Weekly Report	Bi-Weekly Report for November 1-12, 2012	2012
MCHIP-Liberia Activity Update December 1-15, 2012	Bi-Weekly Report	Bi-Weekly Report for December 1-14, 2012	2012
MCHIP Liberia Activity Update December 15-31, 2012	Bi-Weekly Report	Bi-Weekly report for December 15-31, 2012	2012
MCHIP Liberia Activity Update January 1-15, 2013	Bi-Weekly Report	Bi-Weekly Report for January 1-15, 2013	2013
MCHIP Liberia Activity Update January 16-31, 2013	Bi-Weekly Report	Bi-Weekly Report for January 16-31, 2013	2013
MCHIP Liberia Activity Update February 1-15, 2013	Bi-Weekly Report	Bi-Weekly Report for February 1-15, 2013	2013
MCHIP Liberia Activity Update February 16-28, 2013	Bi-Weekly Report	Bi-Weekly Report for February 16-28, 2013	2013
MCHIP Liberia Activity Update March 1-15, 2013	Bi-Weekly Report	Bi-Weekly Report for March 1-15, 2013	2013
MCHIP Liberia Activity Update March 16-30, 2013	Bi-Weekly Report	Bi-Weekly Report for March 16-30, 2013	2013
MCHIP Liberia Activity Update April 1-15, 2013	Bi-Weekly Report	Bi-Weekly Report for April 1-15, 2013	2013
MCHIP Liberia Activity Update April 16-30, 2013	Bi-Weekly Report	Bi-Weekly Report for April 16-30, 2013	2013
MCHIP Liberia Activity Update May 1-15, 2013	Bi-Weekly Report	Bi-Weekly Report for May 1-15, 2013	2013
MCHIP Liberia Activity Update May 16-31, 2013	Bi-Weekly Report	Bi-Weekly Report for May 16-31, 2013	2013
MCHIP Liberia Activity Update June 1-15, 2013	Bi-Weekly Report	Bi-Weekly Report for June 1-15, 2013	2013
MCHIP Liberia Activity Update June 16-30, 2013	Bi-Weekly Report	Bi-Weekly Report for June 16-30, 2013	2013
MCHIP Liberia Activity Update July 1-15, 2013	Bi-Weekly Report	Bi-Weekly Report for July 1-15, 2013	2013
MCHIP Liberia Activity Update July 16-31, 2013	Bi-Weekly Report	Bi-Weekly Report for July 16-31, 2013	2013
MCHIP Liberia Activity Update: August 1-15, 2013	Bi-Weekly Report	Bi-Weekly Report for August 1-15, 2013	2013
MCHIP Liberia Activity Update August 16-31, 2013	Bi-Weekly Report	Bi-Weekly Report for August 16-31, 2013	2013
MCHIP Liberia Activity Update September 1-15, 2013	Bi-Weekly Report	Bi-Weekly Report for September 1-15, 2013	2013

DOCUMENT TITLE	TYPE OF RESOURCE	DESCRIPTION	YEAR DEVELOPED
MCHIP Liberia Activity Update September 16-30, 2013	Bi-Weekly Report	Bi-Weekly Report for September 16-30, 2013	2013
MCHIP Liberia Activity Update October 1-15, 2013	Bi-Weekly Report	Bi-Weekly Report for October 1-15, 2013	2013
MCHIP Liberia Activity Update October 16-31, 2013	Bi-Weekly Report	Bi-Weekly Report for October 16-31, 2013	2013
MCHIP Liberia Activity Update November 1-15, 2013	Bi-Weekly Report	Bi-Weekly Report for November 1-15, 2013	2013
MCHIP Liberia Activity Update November 16-30, 2013	Bi-Weekly Report	Bi-Weekly Report for November 16-30, 2013	2013
MCHIP Liberia Activity Update December 1-31, 2013	Bi-Weekly Report	Bi-Weekly Report for December 1-15, 2013	2013
Quarterly Reports			
Quarter 1 Report (October-December, 2010)	Quarterly Report	FY 11 MCHIP Q1 Report	2011
Quarter 2 Report (Jan-March, 2011)	Quarterly Report	FY 11 MCHIP Q2 Report	2011
Quarter 3 Report (April-June, 2011)	Quarterly Report	FY 11 MCHIP Q3 Report	2011
Quarter 4 Report (July-September, 2011)	Quarterly Report	FY 11 MCHIP Q4 Report	2011
Quarter 1 Report (October-December, 2011)	Quarterly Report	FY 12 MCHIP Q1 Report	2012
Quarter 2 Report (January-March, 2012)	Quarterly Report	FY 12 MCHIP Q2 Report	2012
Quarter 3 Report (April-June, 2012)	Quarterly Report	FY 12 MCHIP Q3 Report	2012
Quarter 1 Report (October-December, 2012)	Quarterly Report	FY 13 MCHIP Q1 Report	2013
Quarter 2 Report (January-March, 2013)	Quarterly Report	FY 13 MCHIP Q2 Report	2013
Quarter 3 Report (April-June, 2013)	Quarterly Report	FY 13 MCHIP Q3 Report	2013
Country Summary Reports			
Country Summary: Liberia, Period: FY 2012, Quarters 1 and 2	Quarterly Report	Country summary page for Liberia summarizing activities in Quarters 1 and 2	2013
Country Summary: Liberia, Period FY 2012, October 2011-September, 2012	Quarterly Report	Country Summary Page for Liberia summarizing activities in FY12	2013
Annual Reports			
Liberia MCHIP FY 10 Annual Report	Annual Report	Annual report covering September 2009-September 30, 2010	2010
Liberia MCHIP Annual Report for FY11	Annual Report	Annual report covering October 2010-September 30, 2011	2011
Liberia MCHIP Annual Report for FY 12	Annual Report	Annual report covering October 2011-September, 2012	2012
Liberia MCHIP Annual Report for FY 13	Annual Report	Annual report covering October 2011-September, 2013	2013

DOCUMENT TITLE	TYPE OF RESOURCE	DESCRIPTION	YEAR DEVELOPED
Trip Reports			
Patricia Gomez: MCHIP Program Trip Report	Trip Report	Purpose of trip was to conduct assessment of FP activities at all levels of the health system in Liberia; work with USAID/Liberia and other partners to formulate MCHIP workplan	September/October 2009
Holly Blanchard and Martha Appiagyei: MCHIP Program Trip Report	Trip Report	Work with RBHS and MCHIP team in Liberia, orient Comfort Gebeh, the Liberian MCHIP RH-FP Advisor to the FP workplan and introduce the MCHIP team to RH/FP stakeholders	February 2010
Holly Blanchard and Martha Appiagyei: MCHIP Program Trip Report	Trip Report	Conduct a Training of Trainers (TOT) for national FP trainers and orient the RBHS and MCHIP to a TOT in FP	April 2010
Martha Appiagyei: MCHIP Program Trip Report	Trip Report	Conduct second FP training	June 2010
Martha Appiagyei: MCHIP Program Trip Report	Trip Report	To prepare proficient FP service providers to conduct competency-based FP training	August 2010
Holly Blanchard: MCHIP Program Trip Report	Trip Report	To facilitate the LARC workshop in Monrovia for the national trainers, and co-facilitate the LARC step-down training in Grand Bassa county. Assess the implementation of SBM-R at facility level	January 2011
Catherine McKaig and Rebecca Fields: MCHIP Program Trip Report	Trip Report	Design FP/Immunization Activity	February 2011
Debra Prosnitz: MCHIP Program Trip Report	Trip Report	Debra Prosnitz was in Nimba County, Liberia, to conduct a site visit and provide technical assistance to PMI's Malaria Communities Program (MCP) grantee EQUIP Liberia, and in Margibi and Montserrado Counties to conduct a site visit and provide technical assistance to PMI MCP grantee MENTOR Initiative. The trip included a debriefing meeting with PMI Liberia Advisors, RBHS and NMCP representatives.	March 2011
Mary Drake: MCHIP Program Trip Report	Trip Report	Provide support to integrate monitoring into routing site visits and conduct quality assessment	April 2011
Chelsea Cooper: MCHIP Program Trip Report	Trip Report	Provision of BCC technical support for MCHIP FP activities in Liberia	April/May 2011
Jeffrey Smith: MCHIP Program Trip Report	Trip Report	Support the design of a PPH reduction program including use of misoprostol	May 2011
Chelsea Cooper: MCHIP Program Trip Report	Trip Report	Provision of BCC technical support for MCHIP EPI-FP integration activities in Liberia	June 2011
Galina Stolarsky and Alishea Galvin: MCHIP Program Trip Report	Trip report	Provide management and administrative support to MCHIP program in Liberia	September 2011

DOCUMENT TITLE	TYPE OF RESOURCE	DESCRIPTION	YEAR DEVELOPED
Holly Blanchard: MCHIP Program Trip Report	Trip Report	Assess quality FP services to MCHIP-trained providers in Montserrado, including availability of implants at health center level, facilitate the infection prevention training for RH/FP services to Redemption, Montserrado, Margibi and Grand Bassa personnel, and work with staff to make Redemption Hospital a center of excellence in FP services	January/February 2012
Rachel Feilden: MCHIP Program Trip Report	Trip Report	Participate in the multi-agency national EPI review as an external (international) team member	January/February 2012
Chelsea Cooper: MCHIP Program Trip Report	Trip Report	Co-facilitate EPI/FP integration training activities in Bong and Lofa counties and provide BCC technical support for other MCHIP FP activities in Liberia	February/March 2012
Emmanuel Otolorin, Alishea Galvin: MCHIP Program Trip Report	Trip Report	Provide programmatic and administrative support to assist MCHIP staff on planning and implementation activities	March/April 2012
Indira Narayanan: MCHIP Program Trip Report	Trip Report	Gather information and prepare for the development of the situational analysis on newborn health	April 2012
Emmanuel Otolorin, Holly Blanchard: MCHIP Program Trip Report	Trip Report	Provide programmatic and administrative support to the Liberia MCHIP team on program implementation	June 2012
Chelsea Cooper: MCHIP Program Trip report	Trip Report	Provide technical support for MCHIP EPI/FP integration and FP activities in Liberia	August 2012
Alishea Galvin: MCHIP Program Trip Report	Trip Report	Provide programmatic and administrative support to the Liberia MCHIP team on program implementation and to orient the new Maternal Health Advisor on the PPH program.	August 2012
John Murray, Indira Narayanan, Deborah Sitrin, Joseph de Graft-Johnson: MCHIP Program Trip Report	Trip Report	Complete a review of newborn scale-up readiness benchmarks in Liberia; disseminate and discuss finding from a MCHIP-led Situation Analysis of Newborn Health in Liberia	September 2012
Gbenga Ishola: MCHIP Program Trip Report	Trip Report	Provide M&E technical back-up on the ongoing PPH study and to the overall MCHIP Liberia program	September 2012
Jeffrey Smith: MCHIP Program Trip Report	Trip Report	Provide technical support to the MCHIP program in Liberia	October 2012
Chelsea Cooper: MCHIP Program Trip Report	Trip Report	Provide technical support for MCHIP EPI/FP integration and FP social and behavior communication activities in Liberia	December 2012
Joseph de Graft-Johnson: MCHIP Program Trip Report	Trip Report	Provide technical assistance to initiate selected newborn health activities	January 2013

DOCUMENT TITLE	TYPE OF RESOURCE	DESCRIPTION	YEAR DEVELOPED
Gbenga Ishola: MCHIP Program Trip Report	Trip Report	Provide M&E technical back-up on the use of data collection tools for the ongoing PPH study and to the overall MCHIP country program in Liberia	January 2013
Comfort Gebeh: MCHIP Program Trip Report	Trip Report	Participated in the Africa Regional Meeting on Interventions for Obstetric and Newborn Care in Addis, Ethiopia	February 2011.
Comfort Gebeh: MCHIP Program Trip Report	Trip Report	Participated in the five-day M&E meeting workshop held in Nairobi	April 2011
Comfort Gebeh: MCHIP Program Trip Report	Trip Report	Participated in a study tour to Rwanda's Community-Based Family Planning Health Service Project	September 2012
M&E Documents			
MCHIP PMP	M&E plan	The PMP is a document describing MCHIP's intervention activities by identifying the associated measurable indicators to be used in measuring progress. The document described the type of monitoring to be conducted and how data will be collated and reported	2012/2013
Routine data template for FP services	Data entry and reporting	The template was developed using Microsoft Excel to ease collation on monthly basis and reporting on quarterly basis. The template shows the number of FP counseling visits by gender, number of new and continued users of FP methods and the quantities of FP methods dispensed. It also helps in determining couple years of protection attained by methods over the reporting period	2012
Quarterly M&E reporting format	Reporting format	The purpose of this format is to demonstrate performance of MCHIP operational plan as well as program indicators on a quarterly basis to send reports to USAID. It shows relationship between set targets by indicators and level of attainments' on a quarterly basis	2013
Routine data collection template for misoprostol distribution	Data entry and reporting	The template was developed using Microsoft Excel to ease collation on monthly basis and reporting on quarterly basis. It show the number of pregnant women counseled on misoprostol and how many were issued on monthly basis	2012
Misoprostol counseling register	Recordkeeping	This register was designed to capture number of pregnant women attending ANC who were counseled on use of misoprostol and issued the drugs. The register was developed because the existing ANC register has no provision for tracking misoprostol counseling	2012

DOCUMENT TITLE	TYPE OF RESOURCE	DESCRIPTION	YEAR DEVELOPED
PPH follow-up data entry template	Data entry and analysis template	The template was developed using the SPSS. It is being used for data entry and will be used for analyzing the data for reporting the outcomes of the intervention	2012
Data collectors presentation	Training material	The presentation was developed using PowerPoint. It explained the purpose of the PPH intervention and data collection and sampling procedures. The document also explained the concepts of data and data quality	2013