

LIBERIA

REBUILDING BASIC HEALTH SERVICES (RBHS)



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RBHS Mission Statement

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

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Acronyms and abbreviations

ACT	Artemisinin-based combination therapy
AIDS	Acquired immune deficiency syndrome
ANC	Ante-natal care
ART	Anti-retroviral therapy
ASRH	Adolescent Sexual and reproductive Health
BCC	Behavior change communication
BLSS	Basic life-saving skills
BPHS	Basic Package of Health Services
CBT	Capacity Building Team
CHSD	Community Health Services Division
CHDC	Community Health Development Committee
CHEST	Community Health Education Skill Tools
CHO	County Health Officer
CHT	County Health Team
CHV	Community health volunteer
CHAI	Clinton Health Access Initiative
CM	Certified midwife
DHIS	District Health Information System
DOTS	Directly observed therapy – short course
DSS	Decision Support Systems
DWG	Decentralization Working Group
EBSNM	Esther Bacon School of Nursing and Midwifery
EHT	Environmental health technician
EML	Essential medicines list
EMMP	Environmental Mitigation and Monitoring Plan
EmONC	Emergency obstetric and neonatal care
ENA	Essential Nutrition Actions
EPI	Expanded Program on Immunization
EPHS	Essential Package of Health Services
ETS	Effective Teaching Skills
FBO	Faith-based organization
FGD	Focus group discussion
FHD	Family Health Division
FP	Family planning
GBV	Gender-based violence
gCHV	(General) community health volunteer
GWA	Good Will Ambassador
HBMNC	Home-based Maternal and Neonatal Care
HIS	Health information system
HIV	Human immunodeficiency virus
HMIS	Health management information system

HPD	Health Promotion Division
IEC	Information, Education and Communication
IMAD	Improved Malaria Diagnostic
IMAT	Inventory Management Assessment Tool
IMNCI	Integrated management of neonatal and childhood illness
IPC	Interpersonal communication
IPD	In-patient department
IPT2	Intermittent preventive treatment of malaria (in pregnancy), 2 nd dose
IPTp	Intermittent preventive treatment of malaria (in pregnancy)
IR	Intermediate result
IRC	International Rescue Committee
IRS	Indoor residual spraying (of anti-malarial insecticide)
ITN	Insecticide-treated net
IUD	Intrauterine device
JHU/CCP	Johns Hopkins University Center for Communication Programs
JSI	John Snow Research & Training, Inc.
LAPHT	Liberia Association of Public Health Technicians
LBNM	Liberia Board of Nursing and Midwifery
LISGIS	Liberia Institute of Statistics & Geo-Information Services
MCHIP	Maternal and Child Health Integrated Program
MDR	Multi-drug resistant
M&E	Monitoring and evaluation
MH	Mental health
MNCH	Maternal, neonatal, and child health
MNDSR	Maternal and Newborn Deaths Surveillance Report
MOHSW	Ministry of Health and Social Welfare
MOU	Memorandum of understanding
MOP	Malaria Operational Plan
MPCHS	Mother Pattern College of Health Sciences
MSH	Management Sciences for Health
MTI	Medical Teams International
MTP/SER	Midwifery Training Program/South Eastern Region
NACP	National AIDS Control Program
NDS	National Drug Service
NGO	Non-governmental organization
NHPP	National Health Policy and Plan 2007-2011
NHSWPP	National Health and Social Welfare Policy and Plan 2011-2021
NLTCP	National Leprosy and Tuberculosis Control Program
NMCP	National Malaria Control Program
NTCL	National Traditional Council of Liberia
OIC	Officer in charge
OPD	Outpatient department
ORS	Oral rehydration salts/solution
PA	Physician's assistant

PBC	Performance-based contract
PBF	Performance-based financing
PCT	Program Coordination Team
PLAL	Positive Living Association of Liberia
PLWHA	Persons living with HIV/AIDS
PMI	President's Malaria Initiative
PMTCT	Prevention of mother-to-child transmission
PPAL	Planned Parenthood Association of Liberia
PSA	Public Service Announcement
PSI	Population Services International
QA	Quality assurance
RBHS	Rebuilding Basic Health Services
REP	Reaching Every Pregnant woman
RFP	Request for proposal
RH	Reproductive health
RN	Registered nurse
RUD	Rational use of drugs
SBA	Skilled Birth Attendant
SBMR	Standards-based management and recognition
SOPs	Standard operating procedures
SP	Sulfadoxine-pyrimethamine (Fansidar)
STTA	Short-term Technical Assistance
TB	Tuberculosis
TFR	Total fertility rate
TNIMA	Tubman National Institute for Medical Arts
TOT	Training of trainers
TTM	Trained traditional midwife
TU	Training Unit
USAID	United States Agency for International Development
WAD	World AIDS Day
WASH	Water, sanitation, and hygiene promotion

Executive Summary

Due to the outbreak of Ebola in Liberia, all RBHS activities since June have focused exclusively on epidemic mitigation. During the outbreak, project staff have been actively involved by participating in social mobilization, community health, and reproductive health committees and working groups to support the emergency response. At a higher level, RBHS staff have played an active role on the National Infection Prevention and Control Task Force alongside MOHSW staff and national, and international partners and IPC experts in developing a comprehensive training package, which includes including standard operating procedures (SOPs) for various levels of care, job aids, and monitoring tools for health workers. Further details about these activities are contained within the report.

During the first six months of the RBHS extension year (November 2013-April 2014), prior to the outbreak of Ebola, RBHS interventions significantly increased the provision of high-quality health services (IR1) and strengthened the health system (IR2).

Improved provision of quality health services highlights include:

- RBHS provided technical assistance to extend the MOHSW's **postpartum hemorrhage (PPH) prevention** pilot beyond Grand Bassa County to Bong County. The intervention emphasizes community-based distribution of misoprostol tablets. RBHS collaborated with the family health division (FHD) of the MOHSW to develop national guidelines on PPH prevention, a supervisory checklist, and a trained traditional midwife (TTM) reporting ledger. More than 800 trained traditional midwives received training to counsel and distribute misoprostol in Bong County communities.
- RBHS participated in the revision of the prevention of **malaria in pregnancy (MIP)** guidelines to align with the new WHO protocol. The revised MIP guidelines were validated by Liberia's National Malaria Control Program (NMCP) in November 2014. In terms of service provision, in Nimba and Bong Counties, 61% and 71%, respectively, of pregnant women received two doses of IPT to prevent malaria in pregnancy, compared to an average of 53% during the previous year.
- The **Contraceptive Day concept and posters** were presented at international family planning conferences in Addis Ababa and Washington, DC. The Contraceptive Day concept enables stakeholders to plan and implement contraceptive days in their own communities. Contraceptive Days held in project districts have helped dramatically increase couple-years of protection since project inception.

RBHS continued to work closely with the MOHSW and the three project counties of Bong, Lofa, and Nimba in implementing a series of capacity-building interventions for the six WHO building blocks of the health system. Highlights include:

- **Performance-based financing (PBF)** was further institutionalized and decentralized to the county level. After RBHS PBF training, counties established county PBF steering committees. In June 2014, a MOHSW PBF team went to Rwanda to see first-hand how a fully functioning PBF system works.
- RBHS conducted an **internal capacity building assessment** in May and June 2014. The purpose of the assessment was to document achievements and capacity changes, identify

gaps, and recommend approaches to inform future capacity building activities. The assessment details key recommendations for strengthening capacity building initiatives in each of the six WHO health system building blocks.

- The **PRISM assessment** conducted in June 2014 showed that data quality and use has improved at the county and facility levels since it was last conducted in 2012.
- The **integrated Human Resources Information System (iHRIS)**, a database application to manage human resource information, was launched in early 2014. The interoperability between DHIS2 and iHRIS was examined during an Interoperability Academy, held in May 2014 with support from RBHS. Evidence-based decision-making came alive, as more than 80 data users, data managers, and system developers from nine African countries and all of Liberia's 15 counties gathered in this historical Academy to examine interoperability possibilities and challenges. The real success of the Academy will be in the use of data and information from both systems (DHIS2 and iHRIS) to strengthen health services and the workforce that delivers them. The iHRIS is a critical component of the Liberian government's Ebola response.
- The **Liberian Health Equity Fund (LHEF)** generated much positive momentum, and was endorsed by President Ellen Johnson-Sirleaf and Minister of Health Dr. Gwenigale. Efforts to institute it are expected to resume after Ebola is contained.

Background and Introduction

The Rebuilding Basic Health Services (RBHS) Project is the United States Government's key project in support of the Liberian Ministry of Health and Social Welfare's (MOHSW) National Health Plan and Policy. RBHS is a 6-year project which began in November 2008. JSI Research and Training Institute, Inc. is implementing the project in partnership with three US-based organizations¹. As part of the project implementation, RBHS employed a three-pronged strategic approach including: (1) strengthening and extending service delivery, (2) strengthening the health system in the areas of human resources, infrastructure, policy development, and monitoring & evaluation and (3) preventing disease and promoting more healthful behaviors through behavior change communication and community mobilization.

In response to USAID's new Global Health Initiative, USAID FORWARD, the RBHS's project was reconfigured by USAID in the summer of 2011. The main change was to move from service delivery to MOHSW capacity building and health system strengthening. In 2012, USAID requested RBHS to prepare a proposal for a one year cost extension which was granted in May 20, 2013.

During this first reporting period of Year 6, consistent with the changes to USAID's in-country strategy, RBHS continued to work closely with the MOHSW and the three FARA counties of Bong, Lofa, and Nimba in implementing a series of capacity building interventions. Major challenges during the first six months of implementation of this extension year have been the health workers strikes in November 2013 and in February 2014, as well as the Ebola outbreak in April 2014. These events have seriously delayed implementation of many interventions during the reporting period. In June 2014 USAID and JSI discussed a possible four month extension to RBHS to continue our support to the MOHSW. The four month extension was granted in October 2014.

This Annual report reviews the results, successes, challenges, and lessons learned in the sixth year of RBHS implementation, from November 1, 2013 to October 31, 2014. A summary is presented for the Ebola response activities and the interventions under IR 1 and IR 2, while annexes provide additional details on specific topic areas as well as a detailed status of the work plan activities implementation (see Annex 7). The report includes a project management and a summary report on expenditures to date.

¹ The four core partners of RBHS are JSI Research and Training, Jhpiego, the Johns Hopkins University Center for Communication Programs (JHU/CCP), and Management Sciences for Health (MSH).

Ebola Epidemic Response Activity Summary

The Ebola virus disease (EVD) outbreak, which began in Liberia in March 2014, is unprecedented in terms of the number of cases, deaths, and rapid geographic spread; the epidemic's magnitude has overwhelmed the entire national health system. Over 350 health workers have been infected with EVD in Liberia, of which half have succumbed to the disease. The Rebuilding Basic Health Services (RBHS) project, as the lead USAID partner to the Liberian Ministry of Health and Social Welfare (MOHSW) on the implementation of health care delivery, has been working with the Ministry and its local and international partners to prevent, control, and manage the spread of the Ebola virus. The RBHS Ebola activities have mostly focused on infection prevention and control among health workers through the improvement of their knowledge and skills, and the availability and appropriate use of supplies, and personal protective equipment.

During the initial months of the epidemic, prior to the large-scale deployment of international response workers, effectively controlling transmission of the disease was a major challenge for the Government of Liberia and partners for a number of reasons including, (1) community denial about the existence of Ebola; (2) inadequate supplies and logistics; and (3) refusal by family members of confirmed or suspected cases to allow health officials to safely bury bodies.

At this initial stage in the outbreak, the MOHSW placed a moratorium on all non-Ebola related health activities. Consequently, several routine project activities were delayed for extended periods of time or were cancelled completely. RBHS during this period began to play an instrumental role in preliminary Ebola response activities. Project staff worked with the MOHSW supply chain team and a partner organization to provide technical support by setting up a system to account for all supplies and commodities being received by the warehouse in support of the response. The preliminary system included:

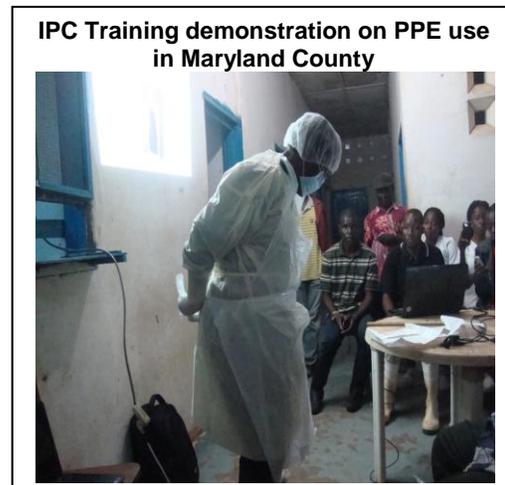
- Reorganizing existing, on-site MOHSW warehouses
- Taking full inventory of all items
- Setting up bin cards for each item
- Creating unique identification numbers for each item
- Setting up a monitoring system for requisitions submitted and items received and issued

Additionally, during this period RBHS staff provided technical assistance to the National Social Mobilization and Contact Tracing committees by supporting strategic planning guidance. Project staff worked with the MOHSW and partners to identify gaps in various response areas, and developed methods to optimize available resources to maximize emergency response efforts.

The RBHS Chief of Party took the lead in coordinating and conducting trainings for health workers to support the emergency response in non-Ebola facilities (i.e., health clinics, health centers, and hospitals) and standardize IPC practices across all health facilities. An initial training package was developed by adapting existing, pre-validated Ebola response training tools for the Liberian context. A series of TOTs was held for trainers before they were deployed to support health facilities in the eight initial response counties (Bomi, Bong, Gbarpolu, Grand Cape Mount,

Margibi, Montserrado, and Nimba). The Ebola training provided an opportunity to educate health workers on Ebola case management IPC measures, while also enhancing their confidence in their ability to safely provide patient care.

Health worker training efforts have evolved over the course of the epidemic. The National IPC Task Force emerged from the Case Management Committee following the second spike in cases in late August/early September 2014; RBHS staff have played an active role on the Task Force. Comprised of MOHSW staff and national, and international partners and IPC experts, the Infection Prevention and Control Task Force provides technical guidance on IPC-related issues, and coordinates and conducts health worker trainings. The group has developed a MOHSW-approved comprehensive IPC package, which includes including standard operating procedures (SOPs) for various levels of care, job aids, and monitoring tools for health workers. The SOPs contain detailed, stepwise guidance on essential infection control and prevention measures for patient care and treatment including triaging. The training curriculum includes instructive demonstrations and hands-on practical sessions on the safe application and removal of PPE for health worker cadres at all levels of care. Titled “Keep Safe, Keep Serving,” the IPC package reflects the underlying objective of ensuring that health workers have the confidence and skills needed to safely provide patient care.



RBHS ‘ continued support to the MOHSW’s integrated Human Resources Information System has enabled the MOHSW to begin using mHERO (mobile Health Worker Electronic Resource and Outreach) platform, co-developed by Intrahealth (a USAID HRH partner) and UNICEF. RBHS supported a national data entry effort to provide a robust data set for routine and emergency use within MOHSW.

RBHS county staff have played leading roles in the response at the county level. Based on skills and opportunities, staff members have led county monitoring and reporting efforts; co-chaired social mobilization teams; provided psychosocial support to families of infected individuals and survivors; and tracking and documenting partner activity.

Towards the end of the reporting period, the Project has reactivated existing interventions and initiated Ebola-related activities to support the emergency response as well as the restoration of routine health services. RBHS continued to work closely with the Family Health Division (FHD) of the MOHSW and County Health and Social Welfare Teams (CHSWTs) to improve access to quality maternal, newborn and child health (MNCH) services. Subsequently, the project’s Maternal, Newborn and Child Health (MNCH) Advisors conducted a series of refresher trainings at the district and community levels for Bong County supervisors, District Health Officer (DHOs) and trained traditional midwives (TTMs) on safe delivery, including the use of misoprostol for

postpartum hemorrhage prevention and the use of chlorhexidine for cord care to prevent neonatal sepsis. This was a critical intervention area, as facility-based deliveries have decreased considerably during the epidemic.

RBHS project staff have actively participated in social mobilization, community health, and reproductive health committees and working groups to support the emergency response.

Specific activities have included:

- Participation in mass media workshops to promote accurate, evidence-based reporting;
- The development and ongoing revision of Ebola-related messaging;
- Reactivation and scale-up of the Improvement Collaborative model to improve quality through shared learning and; and
- Participation in the development of a national reproductive health package to address the reproductive health needs within the context of an infectious disease epidemic

To date, 7556 health workers have been trained countrywide, thus contributing to improved knowledge of and adherence to the recommended IPC principles. The RBHS Project has been instrumental in the Ministry efforts to respond to the Ebola outbreak and to restore health services while protecting health workers and integrating IPC measures into the routine health system.

Intermediate Result 1: Increased access to basic health services through improved provision of quality health services and adoption of positive health behaviors

In the following sections we summarize activities undertaken between November 2013 and October 2014 in four program areas:

Intervention 1.1: Increase access to comprehensive maternal, newborn, and child health (MNCH) services

Intervention 1.2: Increase uptake of critical malaria interventions

Intervention 1.3: Increase access to comprehensive family planning (FP) and reproductive health (RH) services

Intervention 1.4. Mental Health Services

For more details we refer the reader to the Year 6 Work Plan Status Report in Annex 7.

Intervention 1.1: Increase access to comprehensive MNCH services

RBHS worked closely with the Family Health Division (FHD) of the Ministry of Health and Social Welfare (MOHSW) to improve access to quality maternal, newborn and child health (MNCH) services. Various approaches have been used: (1) providing technical support to the central MOHSW; (2) training managers and facility staff; (3) improving supervisory systems; and (4) conducting advocacy meetings with community stakeholders.

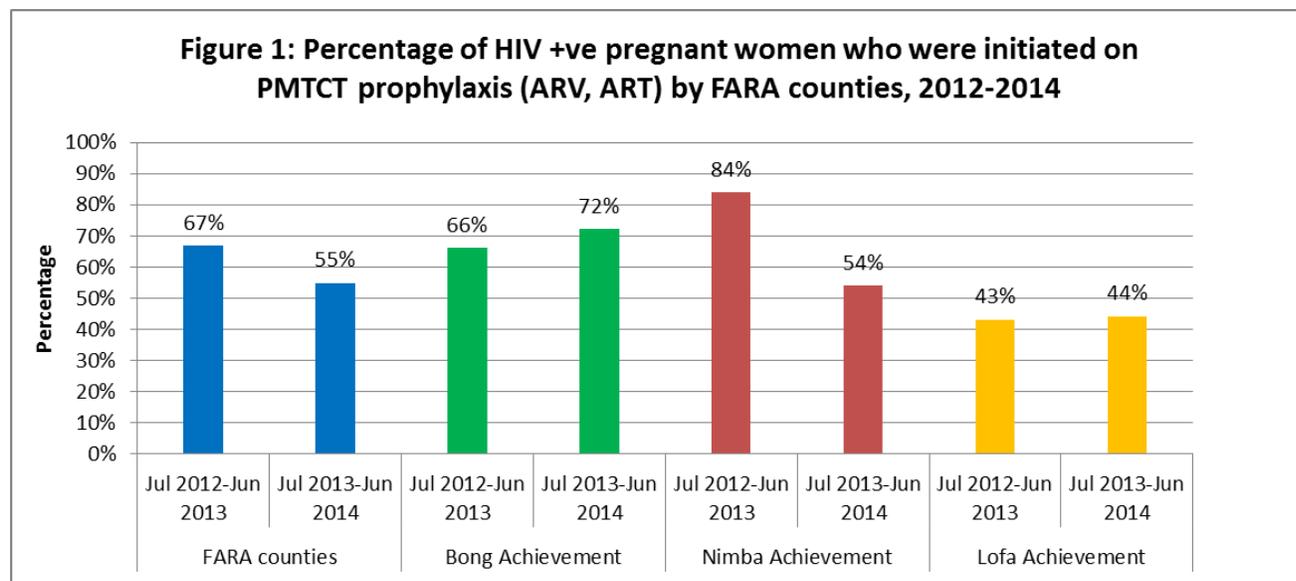
Activities undertaken and results

RBHS continued its support to the Ministry of Health and Social Welfare to improve maternal and newborn death reporting and audits. For this purpose a new guideline, the Maternal and Newborn Deaths Surveillance Report (MNDSR), was developed to improve the audit reports, outline causes of death and enable prompt action to prevent reoccurrences. Previously audits were not done properly or not done at all due to fear of being punished if findings indicated mismanagement. The MNCH Advisors are currently training approximately 150 health workers on the MNDSR in Lofa County.

Postpartum Hemorrhage (PPH) is one of the major causes of maternal death in Liberia. In 2013, a pilot on postpartum hemorrhage (PPH) management through community-based distribution of misoprostol was successfully implemented in a Grand Bassa district by the MOHSW with technical support from the MCHIP project. RBHS provided technical support to scale up this intervention first in Bong County. It was decided to include the TTMs in the intervention. The FHD in collaboration with RBHS developed national guidelines on PPH prevention, as well as a supervisory checklist and a Trained Traditional Midwife (TTM) reporting ledger. The guidelines and supervisory checklist have been used to train managers, supervisors, service providers and

TTMs on PPH prevention. Implementation in Bong County started with the County Health and Social Welfare Team (CHSWT) conducting a mapping study of TTMs for the entire county. FHD and RBHS supported the Bong CHSWT to conduct Training of Trainers (TOT) in PPH for 30 CHSWT supervisors, including District Health Officers (DHOs), DRHS, community focal persons as well as other county partner supervisors. These trainers now serve as trainers for PPH prevention both at facility and community levels in Bong County. Following the TOT, 78 staff from the 39 Bong county health facilities were also trained as part of the training roll out. RBHS supported the CHSWT to conduct a first counseling and distribution training for the 30 TTMs in Suakoko District.

The supportive supervision of PMTCT services has been a key intervention to reduce neonatal mortality in the FARA counties. RBHS county monitoring and evaluation officers have accompanied CHT supervisors to PMTCT treatment sites. Mentoring and coaching was done on the spot with Certified Midwives (CMs). Figure 1 shows the % of HIV+ pregnant women who were initiated on PMTCT prophylaxis in each of the counties. In Bong and Nimba, in July 2013-June 2014 between 54 and 72% of HIV+ pregnant women received prophylactic drugs, while in Lofa it was around 45%



As part of the MOHSW’s efforts to reduce maternal newborn mortality, RBHS has worked with the Good Will Ambassador (GWA) for Maternal and Newborn Mortality Reduction. Together they conducted community advocacy stakeholder meetings across the FARA counties. During these meetings, community stakeholders made commitments to several community initiatives. Community stakeholders included county superintendents, district commissioners and paramount chiefs; these stakeholders advocate for and monitor the implementation of community interventions, such as better referral practices of obstetrical and neonatal complications, the building of maternal waiting homes, and the appointment of community GWAs. These GWAs were selected by communities in consultation with the National Good Will Ambassador, Mrs. Miatta

Fahnbulleh, to complement her efforts. Additionally, local radio stations have aired MNCH messages in local dialects.

In collaboration with the NHPD and CHSWT, RBHS participated in the development of messages and materials on the prevention of PPH with the use of misoprostol, kangaroo mother care (KMC), and use of chlorhexidine for cord care. Following the development and production of 5 audio messages on MNCH, an “end-user pretesting” was conducted in Bong County. Audio messages pretested included: 1) misoprostol awareness, 2) relevance of ANC Visits, 3) benefits of facility delivery, 4) danger signs in pregnancy and 5) husband/male involvement. The two-day exercise was conducted by the NHPD. According to the summary report, all five messages were clearly understood by all of the respondents, evidenced by their interpretation of each message.

Another intervention that benefitted from RBHS support was the finalization of the IMNCI 6 day training course based on WHO materials. This adapted course is now available and will be used across the country to improve service delivery for newborn and child health.

RBHS also has given technical support to the FHD/MOHSW in drafting various training documents and participation in committees and workshops:

- Completion of the integration of chlorhexidine and KMC into the Home-Based Maternal and Newborn care (HBMNC) training modules.
- Integration of TTM counseling and distribution training manuals into one flip book.
- Participate in the monthly Reproductive Health Technical Committee (RHTC) meetings organized by FHD/MOHSW.

As a result of the interventions described, the HMIS shows progress in various maternal health indicators from July 2013 through June 2014. Seventy percent of women received ANC4+ in the FARA counties. Additionally, 62% of pregnant women received 2 doses of IPT to prevent malaria in pregnancy, compared to 51% during the same period from June 2012 through July 2013. The penta 3 coverage in the FARA counties remains at a stable 93%. For a more complete picture per county, see figures 2, 3, 4, and 5.

Figure 2: Percentage of Pregnant women who received ANC4+ by FARA counties, 2012-2014

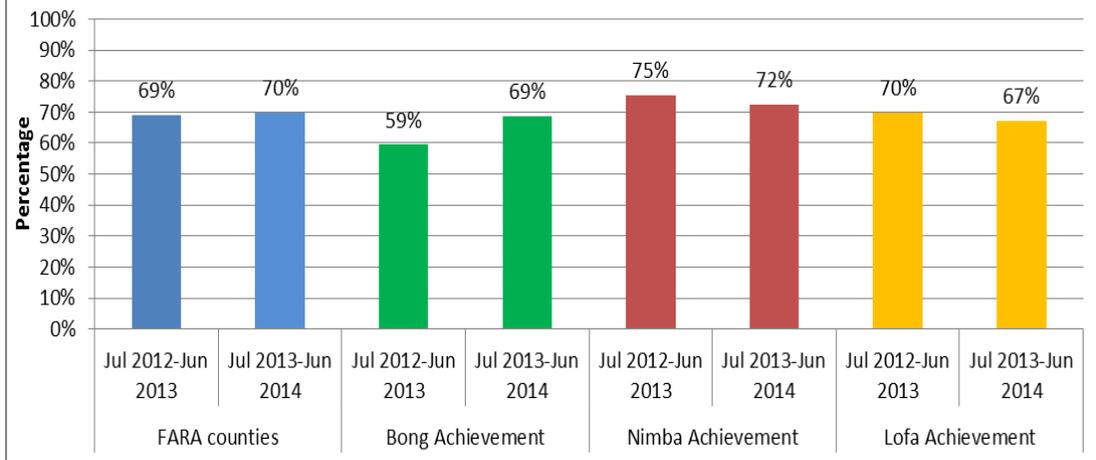
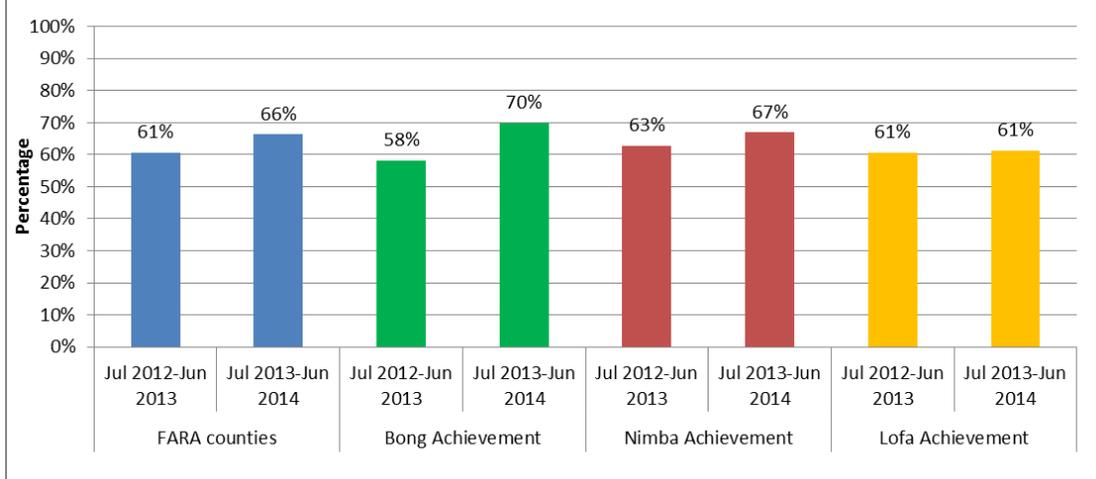
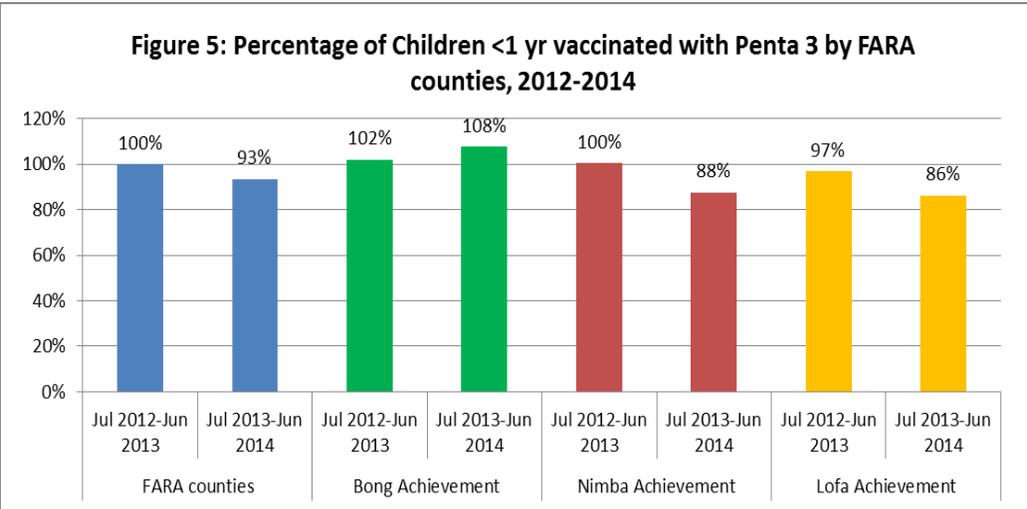
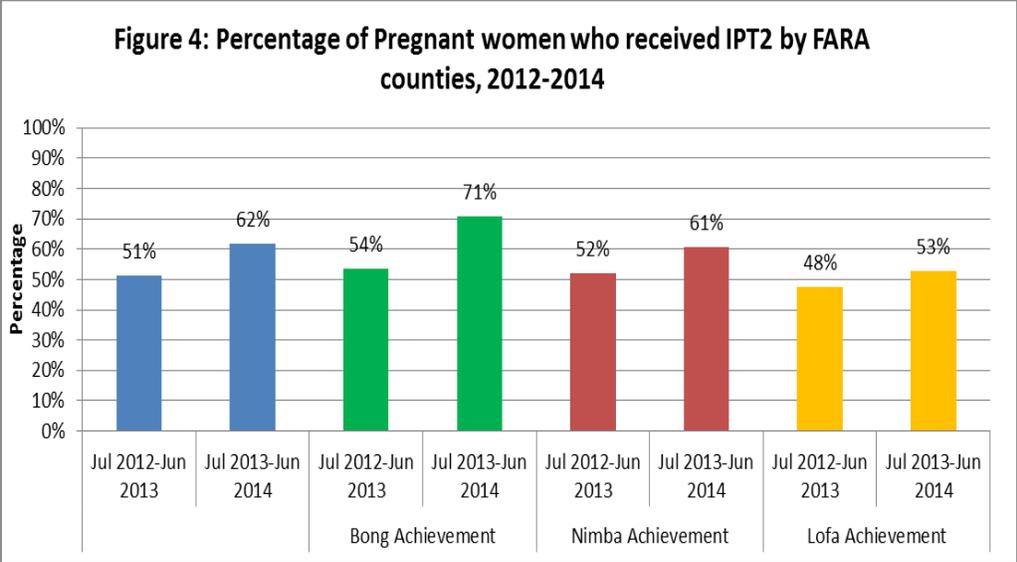


Figure 3: Percentage of deliveries in facilities assisted by skilled birth attendant by FARA counties, 2012-2014





Successes, challenges and lessons learnt

During the period under review, RBHS was particularly successful in the implementation of the prevention of PPH intervention. A substantial number of service providers were trained on PPH both for the facility and community levels, including District Health Officers, District Reproductive supervisors, community health focus persons, as well as selected TTMs who will serve as care providers at the community level.

Prior to the Ebola epidemic, facility deliveries increased considerably due to the building of maternal waiting homes, as well as the airing of health messages in various dialects within the three FARA counties.

Additional successes include:

- Collaboration with the Bong CHSWT to ensure the provision of misoprostol in the districts for distribution through the supply chain. Additionally, RBHS worked with the CHSWT to monitor and coach the misoprostol distribution process
- IMNCI refresher training for master trainers
- Continued work with CHSWTs in conducting HBMNC training, especially in the use of chlorhexidine and KMC
- MNCH messages were completed and aired within the three FARA counties and Montserrado

Intervention 1.2: Increase uptake of three critical malaria interventions: treatment with ACT, preventive treatment of pregnant women, and sleeping under ITNs

Malaria is a major public health problem worldwide, especially in low income countries. While the disease affects the lives of nearly everyone, children under 5 years and pregnant women are most at risk. Malaria continues to be the major cause of morbidity and mortality in Liberia, accounting for 33% of all in-patient deaths nationally (LDHS, 2007) and diagnosed in 60% of children under 5 in RBHS supported facilities over the past reporting period.

Activities undertaken and results

RBHS participated in the revision of the MIP guidelines to adopt the new WHO protocol for the prevention of malaria in pregnancy. The revised MIP guidelines were validated by NMCP and partners, with support from RBHS in November 2014.

RBHS collaborated with the National Malaria Control Program and the National Health Promotion Division to review, revise and develop materials and messages on the prevention and control of malaria during a four-day workshop. The exercise utilized findings from the formative research conducted by Plan Liberia in 2013 and from the recently updated Malaria in Pregnancy (MIP) Strategy of the NMCP. Outcomes of the workshop working sessions were two posters promoting routine facility-based ANC visits and IPTp uptake. Reminder cards for service providers at the health facility and for gCHVs/TTMs at the community level were also developed. These reminder cards contain key information for the service provider or gCHV/TTM to share with pregnant women as well as the specific services provided at the health facility for all client visits. Two audio message drafts have now been combined to produce one radio spot. The combined message focuses on the importance of the pregnant woman visiting the health facility several times for SP before delivery, receiving and using an LLIN every night, and getting treatment for malaria if tested positive. All of these messages and materials went through the first pre-test and comments from the field are being incorporated. The combined spot IPTp

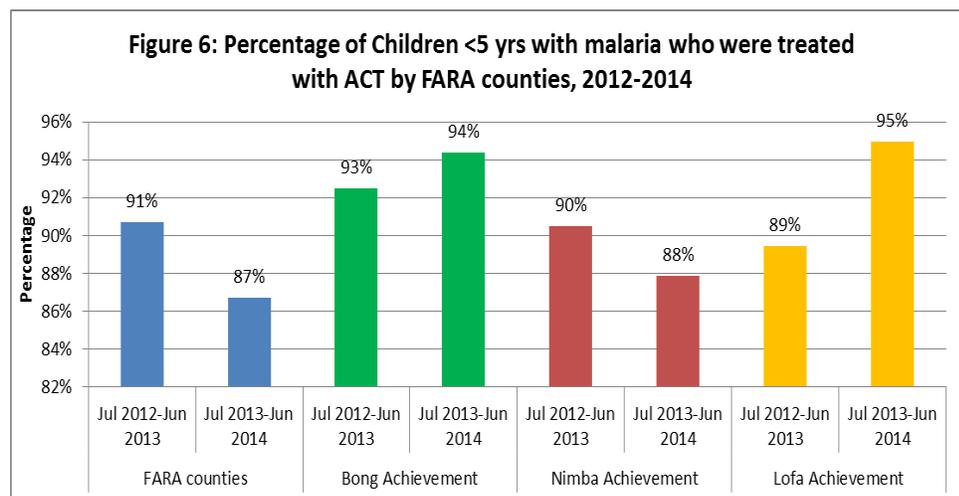
message has been produced and pretested. Messages and materials, including the posters and reminder cards, have been validated, produced and printed.

In order to increase demand for malaria prevention services, RBHS sponsored the airing of a 26-part serial drama, *Baby by Choice, Not by Chance*, which included malaria prevention and treatment messages. This serial drama was produced to address adolescent sexual and reproductive health (ASRH) issues, including malaria prevention and treatment. The drama was broadcast on seven community radio stations and one Monrovia-based radio station from September 2013 to February 2014.

RBHS participated in the planning process for the PMI FY 2015 Malaria Operational Plan (MOP) which was led by the National Malaria Control Program at which time RBHS made three presentations.

Malaria information cards in the CHEST kit have been revised to reflect policy changes for the treatment of malaria and the prevention of malaria in pregnancy and children under 5.

RBHS M&E officers in collaboration with the CHSWT M&E officers conducted regular monitoring of children under 5 treated within 24 hours of onset of fever at community and facility levels, and also continued to monitor IPT2 coverage. During the period under review nearly 90% of children under 5 who tested positive for malaria were treated with Artemisinin-based Combination Treatment (ACT) (see figure 6). IPT2 coverage has remained stable and is now between 60 – 70% in Bong and Nimba (see figure 4).



Successes, Challenges and Constraints and Lessons Learnt

Materials and messages on malaria prevention have been produced and distributed.

The revision of the MIP guidelines has been successfully completed, but the finalization of the MIP messages and materials progressed slowly due to delayed feedback and comments.

Intervention 1.3: Increase access to comprehensive family planning and reproductive health (RH) services

Increasing Access to Service Delivery

Activities undertaken and results

During this reporting period, RBHS collaborated with the Family Health Division in the MOHSW to implement various capacity building activities and foster institutionalization of high impact interventions. This included finalizing support materials such as validating and printing packages for community based FP and the adolescent friendly reproductive health services, as well as developing a toolkit that provides guidance for planning and implementing contraceptive days at national, county, district or community levels. The draft toolkit has been validated, and is being printed.

To support the creation of enabling environments for FP delivery, RBHS has taken steps to strengthen the FP Center of Excellence (COE) at C.B. Dunbar Hospital in Bong, and establish COEs at Telewoyan Hospital in Lofa and Saclepea Comprehensive Health Center in Nimba. These centers provide a space where training in FP can continue for both in-service professionals and pre-service students. RBHS completed training for 63 county and district level health managers in supportive supervision, monitoring for informed choice and volunteerism in FP provision, and community based programming approaches as per requirements of the MOHSW. The RBHS FP/RH Advisor also trained 46 staff from Telewoyan Hospital and Saclepea Comprehensive Health Center prior to launching the FP Center of Excellence. RBHS also provided training models to C.B. Dunbar and Telewoyan FP Centers of Excellence.

Community-based FP services

Activities undertaken and results

In addition to facility based FP service provision, RBHS has continued to assist CHSWTs in the delivery of community-based FP services. Nimba, the most populated of the FARA counties, completed implementation of contraceptive days in this project. Additionally, in collaboration with CHSWTs, RBHS identified district and markets for establishing the Market Contraceptive Initiative. Market Contraceptive Projects (MCPs) are being set up in 6 districts in Nimba, 4 in Bong and 1 in Bong. The MCPs will serve as additional service delivery points for increasing access to FP beyond the health facility. A total of 117 individuals in Bong, Nimba and Lofa have

been trained on FP provision in the markets. The training package consisted of: national guidelines for initiating and implementing community-based FP services; a training manual for community-based FP providers; and a flip book for community-based distributors (CBDs).

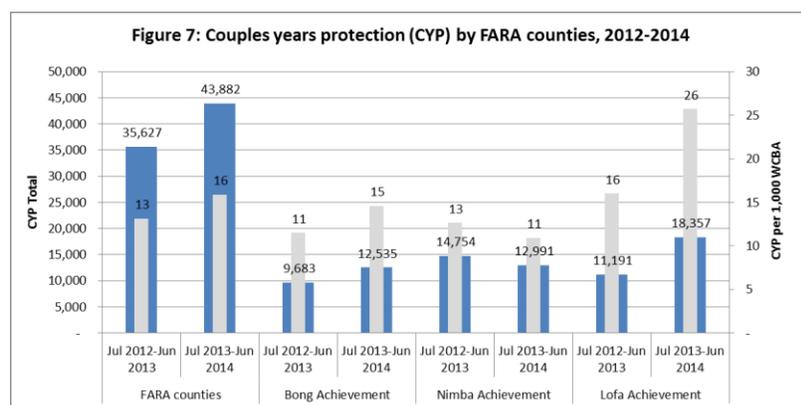
FP promotion through mass-media

Activities undertaken and results

RBHS completed the rebroadcast of the 26-part 30-minute radio drama serial “**Baby by Choice**”, which focused on Adolescent Reproductive and Sexual Health (ARSH) and emphasized how “teenagers can fulfill their future dreams” by avoiding early pregnancy and practicing safer sex. The serial was aired on one Monrovia-based and seven community-based stations in Bong, Lofa and Nimba Counties and ran over a period of 26 weeks (July 2013 through February 2014). Twenty-four listening groups (mainly adolescents) were established within selected communities to meet weekly and engage in discussions concerning health issues covered in each of the 26 episodes of Baby by Choice, in order to encourage the adoption of positive behavior change. Each listening group was led by a facilitator to discuss the content of each 30-minute radio episode using a ten-question instrument. At the end of the exercise, a total of 190 completed forms were returned from the 24 established listening groups in Bong (60), Nimba (43) and Lofa (87). A summary of the information gathered from the forms completed by the listening groups revealed that indeed the groups did listen.

Trainings and development of various documents have contributed to improved FP service provision during the reporting period as evidenced by increased number of first-time FP users in Telewoyan Memorial Hospital, Lofa. The training helped RBHS laid the foundation for the second COE. Training for county and district level managers has prepared them to conduct supportive supervision. Consequently, CYP in the FARA counties has nearly doubled (see figure 7).

The Contraceptive Day concept has been disseminated internationally and was presented in two poster presentations. It was first presented in Addis Ababa at the 3rd Family Planning International Conference in November 2013 and at the Consortium of Universities for Global Health Conference in Washington, DC in May 2014. It is envisioned that the Contraceptive Day Toolkit will enable stakeholders to plan and implement contraceptive days in their communities.



Successes, challenges and lessons learned

A major success was the completion of contraceptive days in three districts in Nimba. This round of contraceptive day delivered services to 946 clients who accepted 408 implants, 262 depo provera, 272 oral contraceptive pills, 4 CycleBeads and 1 IUD. These activities supported the institutionalization of the Contraceptive Day initiative.

The Center of Excellence initiative has led to contraceptive service delivery in the in-patient department (IPD) of Telewoyan Memorial Hospital in Voinjama, Lofa. For the first time, the IPD provided FP services to a substantial number of clients who would otherwise not have received services. Centers of Excellence have been established in Bong, Lofa and Nimba.

Several activities, e.g., completion of contraceptive days in Lofa, dissemination of the community based FP package, and Market Contraceptive Project kickoff activities in Lofa and Nimba were delayed because of the Health Workers Strike and the Ebola Epidemic.

Intervention 1.4 Mental Health Services

Major mental health activities for RBHS for the period under review centered on capacity building for healthcare providers, monitoring and supervision of mental health service delivery, and the facilitation of mental health awareness sessions for the general public.

Capacity Building

Activities and results undertaken and results

RBHS in collaboration with the Mental Health Unit, MOHSW and two county health teams (Nimba and Lofa) provided two capacity building sessions, providing technical mental health updates for 64 service providers (RNs, PAs, and CMs) of the present health workforce. In one of the training sessions, predominately comprised of midwives serving in facilities in Nimba County, emphasis was placed on post-partum mental conditions that are mostly missed in clinical settings. The screening instrument used to suspect post-natal depression, the Edinburg Post-natal Depression Scale (EPDS), was lengthily practiced and discussed. The 36 participants were encouraged by the senior County Clinical Supervisor to practice and use the instrument when dealing with post-natal clients in their facilities. The use of the scale would constitute a major observation point during future clinical supervisions. In another training session with the Lofa County Health and Social Welfare Team, the skills of twenty eight (28) health workers were enhanced to recognize common mental disorders, manage and/or refer to mental health clinicians in selected facilities, i.e. Telewoyan, Foya Borma, and Kolahun Hospitals. Additionally, RBHS actively participated in the training of the sixth cohort (9/13 – 3/14) of 23 mental health clinicians by the Carter Center Post Basic Mental Health Program. This activity completed the training of six cohorts of 123 mental health clinicians who are providing mental health services throughout the country.

Monitoring and Supervision

Activities and results undertaken and results

Monitoring and supervision of mental health service delivery followed the provision of mental health technical updates for Officers in Charge (OICs) of health facilities in June of 2013. The MHA has accompanied the County Mental Health Technician on a visit to fourteen selected facilities in Nimba in October, 2013. A newly developed supervision tool was used based on the MH clinical standards. The OICs of the facilities visited indicated that they can now recognize cases with mental health significance and refer them to facilities with mental health clinicians (usually at the county level). Six of the fourteen OICs indicated that they will take advantage of the mental health clinician training being offered by the Carter Center Mental Health Program. They also now realize the importance of counseling, especially for clients with relational issues in their communities. This interest in mental health was described as an outgrowth of the technical mental health updates conducted by RBHS and Africare.

Awareness/Advocacy

Activities and results undertaken and results

RBHS played an active role in organizing activities promoting World Mental Health Day in October, 2013 and World Epilepsy Day in March, 2014. The project also participated in a program organized by the United Nation Office on Drugs and Crime (UNODC) to join other stakeholders in designing projects to counter the proliferation of drugs and other sub-standard/harmful substances in the community.

Other activities

RBHS is continuously represented on the mental health technical coordinating committee (TCC) and its various subcommittees: *Children and Adolescents, Advocacy, and Research and Training*. The project led and participated, in collaboration with the Carter Center Mental Health Program, in the development of clinical standards for mental health service delivery. RBHS also worked with the MOHSW on the development of a set of mental health indicators for reporting through the HMIS.

Successes, challenges, and lessons learnt

Mental health is being widely discussed by health service providers. In Bong and Lofa, CMs and mental health screeners have been provided with technical updates on mental health issues; TTMs and gCHVs in Nimba have been targeted. However, while the skills of mental health workers are being enhanced, there are still considerable gaps in the overall institutionalization of mental health services. There is a clear need for additional support from partners, particularly ongoing capacity building for health workers in the three counties with an emphasis on identifying postpartum depression. Several activities were delayed or cancelled due to the Ebola epidemic.

Intermediate Result 2: Increase the quality of health services through improving infrastructure, health workforce and systems performance by enhancing capacity to plan, manage and monitor a decentralized health system

In the following paragraphs, activities undertaken between November 2013 and October 2014 in capacity building at central and county level, as well as in strengthening the regulatory mechanisms for health training institutions, are summarized. We look critically at the results in terms of successes, challenges and lessons learned.

For more details, please refer to the Year 6 Work Plan Status Report in Annex 7.

Intervention 2.1: Strengthen MOHSW systems and human capacity at the central and county levels

The effort of capacity building has many challenges. The capacity assessment undertaken in April-May 2012 not only has identified an urgent need for individual and system capacity building in both the central MOHSW and the counties, but it also revealed the fragmented nature of the central Ministry of Health with many overlapping functions between division/units and the resulting major communication gaps between them and with the CHSWTs. In the following paragraphs, we summarize achievements during the reporting period following the WHO health system Building Block Framework.

BB1 DELIVERING ESSENTIAL SERVICES

Strengthen MOHSW capacity to implement PBF strategies for delivery of EPHS

Activities undertaken and results

RBHS significantly contributed to knowledge and skills transfer through work sessions, on the job mentoring and coaching, and sponsorship to international PBF courses. As a result, the PBF Unit developed PBF institutional and implementation arrangements for the MOHSW and the counties. Henceforth, the MOHSW owns the scheme and the PBF unit effectively leads the activities at central level and provides oversight for the decentralized PBF implementation.

In this reporting period, the focus of RBHS support remained on improving the quality of work at central level, strengthen the oversight provided to implementing partners at county level, and strengthen decentralized PBF implementation at county level. This included: (1) ad hoc support to county implementing partners; (2) mentoring and coaching on effective use of PBF management tools, tracking performance achievements and gaps and providing timely feedback to relevant stakeholders, (3) monthly partners' meetings; (4) quarterly review meetings; (5) quarterly data counter-verification; and (6) monitoring PBF implementation and sharing findings with implementing partners (IPs), program directors and senior MOHSW staff. The quality of activity reports from the field improved greatly. The PBF unit is fully engaged with IPs and

counterparts at central level to ensure that key steps of decentralized implementation are effectively and efficiently implemented by the counties.

RBHS supported a standardized and individual county training in five out of six targeted counties for full roll out of decentralized PBF implementation (Bomi, Bong, Nimba, Lofa, and River Gee). The choice of counties was informed by existing capacity in managing the flow of input financing and availability of funds for PBF bonus. The county training focused on the following: supporting the creation of PBF county steering committee; training the PBF steering committee to fulfill its oversight mission on county PBF implementation; training CHT(s) and empowering them to actively take part in PBF implementation; training DHOs and supervisors as trainers for effective PBF implementation at the facility level.

The step-down county trainings are yielding results: for example, Bong, Nimba, Lofa and Bomi have functional PBF steering committees and have already recruited licensed local CBOs to conduct the customer satisfaction survey. Also, in Bong, Nimba and Lofa, the health facilities signed performance agreements and conceived business plans toward achieving performance targets. In Bomi, Bong, Nimba and Lofa the implementing partners and the CHTs, in particularly the DHOs and supervisors, all participate in the verification exercise before the invoices are submitted to the county steering committee.

RBHS supported the revision of PBF indicators. In particular, indicators performing well in the past quarters are just being monitored but not incentivized (i.e., children under five receiving ACT for malaria, and children under one receiving pentavalent-3 vaccination); whereas indicators that needed attention were added to the list of PBF indicators (i.e., TB treatment success rate and children under one receiving measles vaccination). Also, in light of persistent low scores on quality assessments, the PBF unit in collaboration with County Health Services Unit added quality indicators to be monitored on quarterly basis with the aim of keeping quality of care issues at the forefront scene of IPs and health facility. A quality assessment tool was developed, but could not be tested for timely implementation (because of the health workers' strike first and then the Ebola crisis).

Through technical discussions with concerned partners, RBHS supported harmonization of the MOHSW primary level PBF scheme and the secondary level PBF scheme. As a result, we made gains in harmonizing the institutional and implementation arrangements. The MOHSW PBF unit played a key technical and coordinating role by providing support through technical discussion, reviewing and providing input on technical documents, as requested. Secondary level PBF officers were involved in activities at primary level. This is expected to facilitate further harmonization down the road.

The PBF coordination and technical team from the Ministry conducted a study tour in Rwanda from June 23-27 in order to see a fully operational PBF scheme, and the extent to which PBF mechanisms can strengthen the health systems and promote quality health services. The aim was to use this south-south exchange platform to learn from the experiences, challenges and best practices of the Rwandan PBF scheme; which is mature and has demonstrated an impact on

health outcomes. From the study tour, the Liberian delegation identified preliminary best practices that can be introduced in the Liberian PBF scheme and further strengthen it:



- The PBF unit staffing and skills need to be visited to ensure the unit has the right mix of skills to fulfill its mission.
- The unit needs to conceive a plan to further coordinate and share information among key PBF partners (i.e., within the MOHSW, MoF, Development Partners); and advocate for sustainability of the PBF scheme.
- Counties have no staff dedicated to PBF implementation. Staffing the county with a PBF supervisor/manager can speed up the decentralized implementation and ownership by county health teams, as learnt

with the Rwandan experience.

- There is a need to further harmonize PBF approaches implemented at primary and secondary levels in Liberia; and ensure PBF promote complementarity between the two levels.

Successes, challenges and lessons learnt

The capacity of the PBF Unit to assert its role in providing oversight for decentralized PBF implementation has grown substantially over the past years. The PBF unit is leading the training, coaching, mentoring and roll out of the decentralized PBF implementation at the county level. To highlight some of the achievements, over the past ten quarters, the skilled birth attendance rate increased from 29% to more than 50%, the uptake of IPT2 increased from 33% to more than 50%, and the couple years of contraception increased from 2,500 to more than 13,600 in health facilities implementing PBF scheme. This is in spite of ongoing challenges (financial, managerial, and stock out of essential drugs) particularly in 6 of the 12 counties implementing PBF scheme.

The PBF county steering committees are required to keep abreast the CHSWB. In Lofa, this relation has re-energized the CHSWB; the latter was not functional prior to operationalizing the PBF steering committee. Also, early reports on customer satisfaction are encouraging and promise to boost delivery of health services that are more responsive to customers' inputs. In Lofa, the customer satisfaction survey revealed actionable information that the CHT is looking into and promised to address; the findings pertained to few health facilities that close way ahead of normal closing hours, and at least one facility charging a fee-for-service for services provided after government work hours or over the weekend.

Bomi has an assigned contact person for PBF implementation who liaises with PBF unit; this allows the CHT to ensure accountability, and ensure that actionable items are not falling through the cracks due to lack of delineated responsibility.

In FARA supported counties, feedback from HFs suggested that the PBF bonus has had an impact on health facilities and health workers: (1) HFs are more knowledgeable of their performance targets and strive to achieve their targets in order to yield the maximum bonus; (2) individual health workers testified on how the bonus directly benefited them; (3) and numerous HFs testified on how the bonus assisted in improving the HFs, for example, the construction of a maternal waiting home, or to finance outreach activities. However, bonuses allocated to CHSWTs may not have similar effects as that of HFs. The IP indicators are shared between the NGO implementing partners and the CHSWT; there are no specific indicators pertinent to functions of each actor; and the size of the allocated bonus for the IP and CHSWT is diluted by the multiple entitled individuals.

In spite of reported progress, there are still challenges. For instance, the quality of reports improved, but more work is needed in ensuring that actionable items are systematically acted upon by relevant actors (PBF unit, IPs at county level and program counterparts). The PBF manager has been acting for almost one year and the workforce in the PBF unit assigned to PBF at primary level has been shrinking. This affects the quality and speed of work due to increased individual work load. Additionally, a successful PBF implementation requires significant M&E functions. Better organization, timely availability of information and subsequent feedback to stakeholders can be improved upon with a skilled M&E officer embedded in the PBF unit and involved in day-to-day activities of the PBF unit, which the current arrangement does not provide.

System constraints, particularly pertinent to disbursement of funds and frequent stock outs of essential commodities, affected the timeliness of planned activities and limited the extent to which implementing partners could be held accountable for not achieving targets. This is reflected in persistent poor performing administrative indicators, whereas service delivery indicators have posted an upward trend. These challenges are more acute in 6 counties funded by the pool fund, and they influence negatively the overall performance of the PBF scheme.

Quality of Care and Supportive supervision

Activities undertaken and results

RBHS in collaboration with the County Health Services of the MOHSW conducted quarterly learning sessions rotationally at the pilot sites. At learning sessions, the teams and county coaches share progress, best practices and challenges, analyzed the challenges and Identified solutions to data quality and use for decision making. They also prepare quarterly work plans.

The first learning session was conducted in Sanniquellie, Nimba County and a total of 38 individuals participated. Participants included Medical Directors and IC team members of G.W.

RBHS QI Advisor consults with IC team members at C.B. Dunbar Hospital in Bong County



Harley, C.B. Dunbar, Kolahun, and Liberia Government Hospital (LGH) Hospitals, the CHO of Bong, a technical staff person of the PBF Unit implementing the World Bank Secondary Quality Assurance Program, and staff of the County Health Services Unit. MSH consultants provided technical assistance to the teams focusing on clinical capacity in the IC package including the priority standards under four clusters of inpatient clinical standards, and adding three new sub-clusters. RBHS and the MOHSW facilitated the second learning session which was held in C.B. Dunbar and a total of 20 staff participated. Dashboards were established at the pilot hospitals to display the teams' progress and other innovative achievements. On a monthly basis, county coaches conducted supportive supervision and mentoring of the teams. The central team comprising of IC facilitators and supervisors of RBHS, MOHSW and LPMM visited the teams on a quarterly basis to provide technical assistance and verify data. Analysis of the data from the IC teams indicate that correct use of partograph rise from 50% to 95%, AMTSL from 80% to 96%, Family Planning counseling from 10% to 96%.

The MOHSW and RBHS developed questionnaires to evaluate the county integrated supportive supervision tools. Also, RBHS in collaboration with the CHSWTs did a record review of the Joint Supportive Supervisions in Nimba and Bong counties respectively. The review looked at available hard copies of integrated supervision checklists in county health offices for the period of July to September 2013. Overall, 48 copies (77% of facilities) and 20 copies (48% of facilities) of supervision check list were available for review in Nimba and Bong County respectively. It is evident that both CHSWTs were short of ensuring that each facility receives at least one supervisory visit in a quarter. It was also found that in 25% of the records, key sections were (such as summary scores, actions to be taken, and comments and notes) were incomplete. These sections of the checklist are considered key relating to feedback and use of information. The findings of the study clearly show that supervisory information is not optimally managed, analyzed and used by the county health teams. Based on this study, the RBHS field team has worked with the county health teams to improve the documentation and use of information. Efforts have been made to file the checklist in proper ways and place.

Successes, challenges and lessons learnt

The Improvement Collaborative Approach provided opportunity to the three hospitals (C.B. Dunbar, LGH and G.W Harley hospitals) to improve the quality of services and rolled out 88 out of 351 IP clinical standards (30% of total). The team's compliance with three clusters of standards (Obstetrics, Neonatal/Pediatrics, Infection prevention) have substantially improved. The teams shared innovative approaches to the implementation of the standards. Documentation of services had improved.

The teams shared positive changes which were adopted by other teams. The team in Nimba used the standards and developed job aids for easy access to clinicians. C.B. Dunbar established week-end family planning and EPI Services, and LGH hospital established collaboration with a waste management cooperation called Zoomlion to collect non-medical waste from the hospital compound.

The Improvement Collaborative intervention on the overall has proven successful. However, there have been challenges in the pilot phase. Four sites were selected and IC teams trained and established but the pilot ended with three teams. The Kolahun IC Pilot could not continue due to unresolved internal conflicts at the hospital, and was dropped after series of attempts to motivate the team failed.

Other challenges were limited resources to implement standards as well as inadequate infrastructure e.g., inadequate space for labor and delivery at two of the hospitals. Also, several staff at the hospitals complained that the approach is an added responsibility, especially the burden caused by the intense documentation and reporting of care given.

Community Health and BCC/IEC

Activities undertaken and results

During this reporting period, RBHS supported the Bong CHSWT to scale up the Health Promotion Demonstration sites activities into the remaining five districts of the county. Advocacy and consultative meetings were held between March 27th and April 1st in Pantakpai, Jorquelleh, Zota, Sanoyea, and Fuama Districts.

RBHS supported the central MOHSW as well as the CHSWT of Lofa to scale up the establishment and strengthening of community health structures, in continuation of the health promotion demonstration sites in Bong County. Stakeholder meetings were organized in three districts with support of RBHS. These advocacy meetings were intended to increase the quality of and demand for community-based services related to the EPHS priority health areas. The meetings brought together key community stakeholders including commissioners, paramount, clan, and general town chiefs, women leaders, and youth leaders. Similar meetings were held in three districts of Nimba County.

District level advocacy meetings were followed by community meetings gathering OICs, gCHVs, TTMs, and CHDC members. Also attending were district health officers, MOHSW and CHSWT representatives, as well as Africare and RBHS representatives. These meetings aimed to strengthen links between the community and health facility and establish and maintain a functional CHDC and Community Health Committees (CHCs) in each facility catchment community. Discussions focused on a common understanding of the roles and responsibilities of CHDC or CHC members towards the community and towards the health facility; what difference their membership makes; how they can benefit as CHDC members; and how the community and health facility are benefiting from their membership. They also reviewed how to better support the work of the community health volunteers (CHVs), including trained traditional midwives (TTMs) and general community health volunteers (gCHVs) in their facility catchment areas and how to establish or re-establish functional CHCs in the communities.

RBHS in collaboration with the MOHSW and the Bong CHSWT initiated the process of introducing the Partnership Defined Quality (PDQ) approach through selected CHDCs in Bong County. RBHS consultant Rabi Ekele led the exercise, which began with the training of a team of 19 core

facilitators. Under the supervision of the consultant, the core facilitators implemented the Partnership Defined Quality (PDQ) approach and established three Quality Improvement Teams (QITs) at three facility catchment areas in Salala District namely Tokpaipolu, Totota and Salala Clinics. During the three days, the teams worked with community members and service providers to explore what is meant by “quality health services”. Both groups met separately to explore their own definitions of quality health services and their thoughts on how to improve the quality of health services at the health facility. The separate meetings were followed by a “bridging the gap” meeting where the two groups were brought to work in partnership to bridge the gaps in their ideas of quality. Issues identified and were discussed by both parties and consensus was reached for finding solutions to some of the issues. The Quality Improvement Teams developed action plans to address issue identified by both parties in order to improve quality services provided to their people. The same process was carried out in Totota and Salala. Each of the three established Quality Improvement Teams (QITs) developed action plans comprising the identified problems, solutions, actions, persons responsible and timelines.

A joint MOHSW/RBHS Team visited Bong County from March 25-28 to monitor the activities of Quality Improvement Teams (QITs) established at the three health facilities and catchment communities within Salala District namely; Tokpaipolu, Totota, and Salala. During visits with the QITs, it was observed that, although faced with some challenges, progress has been made since the QIT formation in early February 2014. It was established that all of the QITs have met at least once. It was also demonstrated that interpersonal relationships between the facility staff and the community are improving and there is now regular information flow from the facilities to the communities. Representative(s) from the QIT regularly visit the facility and co-sign drug supply waybills.

RBHS remained engaged with the NHPD and provided regular technical support in message development and production. The BCC also participated regularly in NHPD Technical Committee Meetings.

Successes, challenges and lessons learnt

The Partnership Defined Quality (PDQ) approach has been enthusiastically received in Salala District. During the Tokpaipolu PDQ event, there were scenes of jubilation, following the resolution of long standing issues between the community and service providers that affected service delivery. Community stakeholders and health service providers of the three health facilities have affirmed their commitment to work in partnership in providing “quality health services”.

The coordination of public health messaging continues to improve steadily, although challenges remain. However, the completed National Health Promotion Policy calls for the establishment of groups such as the Health Promotion Working Group and other Technical Working Groups. These groups can help ensure full participation and adherence to proper and effective messaging. To be effective, health messages must be coordinated around specific campaigns, prioritized, and sequenced.

As reflected in the previous semi-annual report, capacity of MOHSW's National Health Promotion Division is limited to support other MOHSW departments and to lead effective BCC campaigns and initiatives. RBHS continues to engage colleagues at the NHPD through the conduct of joint activities, field trips, trainings, and materials development.

BB2 HUMAN RESOURCE MANAGEMENT

Performance management

Activities undertaken and results

Performance Management remains a critical and difficult arena in which to maintain traction on forward movement. The finalization of the Civil Service Agency's Performance Management Handbook created a platform for developing and disseminating a MOHSW specific handbook. The initial draft of the handbook awaited finalization of the CSA guidelines and was then put on hold as attention was turned to the Health Worker strikes.

A new opportunity arose when the Compliance Officer included performance management in a Risk Mitigation ToT for central staff and leadership teams of six counties, approximately 40 participants. The six county ToT was an opportunity to raise awareness about the role of performance management in quality service delivery; to engage potential trainers in activities that required them to use the Performance Management Handbook, the Civil Service Standing Orders and the Code of Conduct for the Civil Service. The session was designed by the Deputy Director of the Personnel Unit and RBHS Capacity Building Director. They included Assistant General Counsel and CSA as resource persons to the session. The session itself though brief included a series of frequent asked questions whose answers were in the Standing Orders and/or Code of Conduct; and practical exercises using the revised job descriptions for county positions, supervision results and operational plans to set performance targets for staff. The session then moved quickly through each step in the Performance Management process; the knowledge and skills needed by managers to execute the steps; governing documents and principles; and finally the standard forms provided in the Performance Management Handbook.

Successes, challenges and lessons learnt

Creating the space to engage leadership in the Performance Management process has been challenging though there was wide participation and interest at the Risk Mitigation TOT. Restoring services in the aftermath of Ebola creates another opportunity to introduce the system as HWs come back to work in a changed mindset. There are ongoing challenges in human resources overall that consume the attention of the HR/Personnel teams. In addition to the challenges posed by Ebola, there is the overarching and longstanding issue of salaries of health workers and placing them on the GOL payroll. These issues as health workers experience them are also affected by the concurrent Public Sector Reform process and the recent Global Fund requirement that its supported staff be transitioned to GOL payroll within a certain time frame.

Integrated Human Resources Information System (iHRIS)

Activities undertaken and results

The DHIS2-iHRIS Interoperability Academy hosted by the MOHSW and supported by USAID through RBHS, Intrahealth, and the University of Oslo, generated renewed interest in iHRIS and its potential within the overall Health Management Information System of the MOHSW and as a critical contribution to achieving a major objective of the MOHSW Human Resources Policy and Plan.

The Ebola outbreak created additional interest and RBHS, HMIS, Health Services and Personnel were approached to consider the feasibility of a mobile messaging system that would use telephone contacts from iHRIS to broadcast various types of messages to health workers. This became an opportunity to accelerate and expand RBHS' support to data entry for iHRIS beyond the three FARA counties and Montserrado and to potentially speed up communication with health workers in the crisis. RBHS supported clerks for an intensive data entry period that resulted in more than 7000 records from all counties. The clerks were tested, trained, selected and supervised by Personnel and HMIS. This massive effort has also provided the Personnel office with a list of unverified personnel; personnel with missing information; and the opportunity to validate and cross check payroll records.

In addition to the potential as a platform for mobile messaging with health workers, the Ebola outbreak has created an opportunity to begin documenting health workers in-service training. Entering Ebola related training programs into individual health worker records will activate the use of the system to track in-service training. An adjustment to the education and in-service fields of the system has been made to accommodate this and training data can begin to be entered.

Successes, challenges and lessons learnt

The major consideration as RBHS winds down is the finalization of the governance of the iHRIS, including where it resides and which offices play which roles in terms of maintaining the data; maintaining the hardware and software; access and use rights, including mobile message. At present the critical HR functions are located in two departments, requiring a high degree of collaboration and support from higher levels. The policy and planning functions, which can be supported by iHRIS, are housed in the Planning and Policy Department, in a Human Resources Unit; the administration of personnel, including recruitment, selection, processing CSA requirements, payroll and benefits and performance management are house in the Personnel Unit in the Administration Department. The Training Unit is also in Policy and Planning. To date, although they have participated in two training events, the different unit directors have not had time to engage in actually developing the system or managing the data in the system. Another challenge is that beyond the HMIS and personnel units and the county HROs and CHSAs, there are few users of the system who have been trained or refreshed now that the system has a robust data set. As the MOHSW begins to build up again, the iHRIS can play an important role in planning and policy. When updated with non-ETU training data, the system can begin to look at HW training and its effect on health outcomes. The Ebola crisis provides an opportunity to share and use data on HW training and results. It is a beginning and can illustrate the potential of having a centralized training data base. This will in future require the cooperation of all of the

vertical programs, partners who provide training and county teams whose HROs can also directly input data into the system.

In-Service Training Strategy

Activities undertaken and results

RBHS facilitated a two day session to revise the in-service training strategy. The purpose of the meeting was to develop agreed upon content and a timetable for a completed strategy. RBHS had a limited role in this process, largely to support the Director of the Training Unit in gathering ideas from existing national trainers, representatives from key departments and the professional bodies. The participants agreed on the broad parameters for in-service training, specifically that it would focus on midlevel health workers, i.e., Nurses, PAs, Midwives, Lab Techs and Social Workers. In-service training refers to events that upgrade or update skills; can be a workshop or sending out materials for self-study and follow up on site. It does not include courses for certificates or credit, to distinguish it from CME; and it does not include advanced degrees. Participants also developed this Vision and Objectives for the In-Service Strategy.

While the group defined its mandate as clinical staff only, a representative of the Deputy Minister for Administration who joined the second day voiced the opinion that non clinical people need training as well in current systems. He proposed that trainings could be conducted twice a year, once in Monrovia and once in the field in key areas such as procurement policies and practices; Public Financial Management practices; and procedures; transition from private to public sector practices. He suggested targeting accountants and procurement specialists. The group developed an outline for the strategy and agreed that they would proceed to make assignments under the leadership of the Director of the Training Unit.

BB3 HEALTH INFORMATION SYSTEMS

The 10 Year National Health Policy and Plan has given high priority to the development of a decentralized Health Management Information System (HMIS) as an integral part of national health system. While RBHS has continued its support to HMIS, M&E, and Research (HMER) Division in strengthening both the production of quality data and the use of HMIS information for decision making, several activities planned for this last year of activities have not been implemented because of the Ebola epidemic.

HMIS/ME Strengthening

Activities undertaken and results

HMIS Review

In March 2014, the MOHSW with technical support from RBHS has initiated the review of the HMIS system which was designed in 2009. During the past five years new information needs have emerged, and various elements of the data collection and processing systems are not well adapted to the recent restructuring of the health services. The review process was planned to be comprehensive and included a review of the indicators, the HMIS recording and reporting instruments, design and printing of revised recording and reporting instruments, training on revised HMIS, revision of DHIS2 database, and migration of historical data to revised database in

DHIS2. Unfortunately, some of the later activities could not be finalized due to the Ebola epidemic.

The first step in the review process was to review the national list of indicators. A participatory approach was used inviting all the data users at central and county levels. A team of HMER and RBHS staff held separate meetings with each program or support system division. The review looked at the indicator definition, its potential use for decision making, the numerator and denominator statements, data source, frequency of data collection. If the division/unit judged that the indicator was still valid, it was kept. For some indicators particular elements were modified. Some indicators were deemed no longer important for the division/unit and therefore were suggested for deletion. Division/units also proposed some new indicators. For each new indicator, the joint team examined its potential use as well as the data source and feasibility of data collection. Some indicators could be better measured through survey at household or facility level instead of HMIS. On April 24, 2014 a national stakeholder meeting was convened where the revised list of indicators was presented to all users to provide feedback and more suggestions if any. The final list of indicators was prepared, although a few issues remain to be solved such as the final set of mental health indicators.

The second step in the process was to review the current HMIS reporting and recording forms in the light of revised list of indicators. From the revised national comprehensive list of indicators, indicators generated by HMIS as data source were examined further to see if they are appropriately reported and recorded in current HMIS tools. A group of MOHSW HMIS and M&E and RBHS staff has reviewed the reporting and recording forms with participation of concerned divisions/units. As a result a revised monthly report form was produced, and the DHIS2 data entry module modified to enter the new reporting form. The new form has been printed and pilot tested in a few facilities and is now ready for deployment nationwide.

Develop data warehouse

In early 2014, iHRIS, a database application to manage human resource information, was introduced in Liberia. The database was populated with current human resource data for most counties.

As a part of establishing a data warehouse, the interoperability between DHIS2 and iHRIS was examined during the DHIS2 & iHRIS Interoperability Academy, held in the Corina Hotel in Monrovia, Liberia on 13-16 May, 2014. Evidence based decision making came alive, as more than 80 participants from 9 African countries, including from all of Liberia's 15 counties, gathered in this historical Academy, hosted by the Ministry of Health and Social Welfare (MOHSW) of the Republic of Liberia. Participants included data users, data managers and system developers from Sierra Leone, Ghana, Burkina Faso, DR Congo, Mali, Senegal, Tanzania and Botswana. The Academy was supported by the Rebuilding Basic Health Services Project (RBHS) with funding by USAID. Lead trainers and facilitators were provided by Liberia's MOHSW; the West African Health Organization (WAHO); RBHS; IntraHealth; John Snow Inc. (JSI); and the University of Oslo.

The DHIS2 & iHRIS Interoperability Academy was a unique opportunity to bring together data managers, human resource managers and IT managers from fifteen counties in Liberia as well as MOHSW representatives, the West African Health Organization (WAHO) representatives and DHIS2 and iHRIS users from other African countries to improve technical and data use capacity of the two health information systems. There were several challenges noted including a need to build the capacity of analytical skills of data users. It was also noted that the quality of the data, particularly the iHRIS data, should be improved in order to support data demand and data use. Finally, participation from family planning county experts could have further enhanced the data use sessions and action plans.

The real success of the Academy will be in the use of data and information from both systems to strengthen health services and the workforce that delivers them. There may be opportunities for additional DHIS2 and iHRIS interoperability Academies in the future, also with data use sessions on various service delivery areas. It is anticipated that the MOHSW will create a Facebook group for Academy participants to sustain the energy for the health information systems and data use to improve family planning and other health service delivery areas.

Training on C-HMIS

HMIS currently does not collect data from community health volunteers. In 2013, the MOHSW moved forward designing a community health information system (C-HMIS) that would be integrated with current facility based HMIS. Various recording and reporting tools used by RBHS and other implementing partners were put together in a CHV ledger. The CHV ledgers were printed and distributed to counties. RBHS was asked by MOHSW to help with implementation and roll out of C-HMIS. As a first step, RBHS worked with the HMIS Unit and the Community Health Services Division (CHSD) to develop standard operation procedures (SOP) for existing C-HMIS recording and reporting tools. The printed CHV ledger was addressing mainly the gCHV information needs. Hence recording tools for TTM were developed in collaboration with the FHD. Also, a monthly Community Health report form was designed for use by both gCHVs and TTMs. SOPs for all community health recording and reporting tools have been included in a CH Operations Manual.

During this reporting period, the roll out of C-HMIS had been planned. RBHS facilitated a C-HMIS working group in the MOHSW to develop a training plan and training curriculum for the roll-out. The training plan employs a cascaded training approach. The first training of trainers will be provided to a group of central ministry staff and relevant staff from CHTs of all 15 counties. They will in turn provide training to relevant staff from each facility, which will then provide the training to CHVs at their facilities. The training curriculum and materials have been finalized in the first months of 2014.

In the week of June 9-14, the MOHSW and RBHS jointly organized the National Training of Trainers workshop in Ganta City, Nimba County. The training brought together about 60 participants including; Central MOHSW, CHSWT representatives from the 15 Counties, and partners (IRC, MTI, Africare, Equip, and Liberia National Red Cross). Facilitators were drawn from

the Community Health Services Division and M&E Unit at MOHW and RBHS. Objectives of the training were to prepare a pool of potential trainers on C-HMIS who can then train the second level of trainers. The training focused on both technical content of C-HMIS as well as on training methodology and skills. The participants learned various learning and teaching techniques so that they can effectively plan and deliver teaching of the technical content of the training. The training provided ample opportunity and time for the participants to practice recording, compiling and reporting. Also, plans for county level training were prepared. Unfortunately, the Ebola epidemic brought the roll-out of the C-HMIS to a standstill. At the time of the preparation of this report it is not clear when the roll-out process can be resumed. It is likely that a refresher training for the national master trainers will need to be organized when the roll-out resumes.

Refresher training on DHIS2

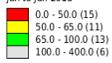
RBHS conducted a training workshop in each of three counties in January 2014. It was a two days workshop to improve the capacity of CHT staff in data analysis using DHIS2 and to conduct a data review meeting. RBHS supported the MOHSW to design the workshop modules and worked with a team of facilitators from HMER/MOHSW and the RBHS. HMIS Director, Mr. Stephen M. Gbanyan, Jr. and a data manager, Mr. Alexander Blide co-facilitated the workshop.

Participants on the first day were the county M&E team members. They were trained on producing charts and tables on key health indicators in format to better visualize service coverage, its trends and variations among the facilities. The data review meeting held on the second day was to be a model for the county team so that they can continue these meetings themselves every month. In the three counties, various program supervisors joined the data review meeting. The full CHT participated and was divided into 5 programmatic groups: Maternal Health, Family Planning, PMTCT, EPI, and Malaria. They were given a package of information products and templates to use for identification of problems and proposed solutions. After the group work, the team presented their work. Given the time limitation of workshop, the group was suggested to identify up to 5 low performing facilities and work on them for identification of and solutions to the root causes. The team then reported out in plenary. It was encouraging to see an active participation of CHT members in the data review meeting. For the first time, they got detailed feedback from DHIS2 and were very appreciative of it. It helped them to better understand coverage issues and identify problem facilities and engaged them in efforts to try to identify the causes of the problem and to propose feasible solutions. See figure 8 for a DHIS2 dashboard image.

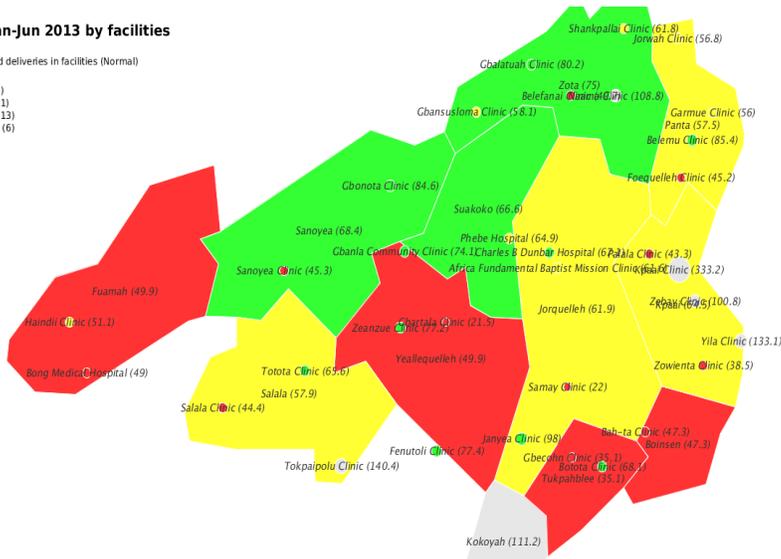
Figure 8. DHIS2 dashboard 1

Bong SBA Jan-Jun 2013 by facilities

Percentage of skilled deliveries in facilities (Normal)
Jan to Jun 2013



10 km



Support to HMIS and M&E technical working group meetings



MOHSW has started meetings of the M&E technical working group. Two meetings were held during the reporting period. RBHS updated the TWG on the HMIS review process and other M&E and HMIS activities. Also discussed was the independent data quality audit (IDQA) of

immunization program data as a GAVI requirement. A committee was set up to provide technical oversight to design, planning and implementation of IDQA. RBHS serves as member of the committee and is actively supporting the IDQA process.



Data quality assurance

RBHS and the implementing partners in the county have instituted data validation procedures to improve data quality at facility level. Both the county M&E team and the district health team are fully involved in data verification activities. Entering data in a week time is difficult for one data manager. Recently M&E and birth data registration clerks have joined in the entry of HMIS data. In Nimba, district level data clerks are helping the data manager to enter HMIS data. This has relaxed the burden on the data manager and improved the efficiency and developed shared responsibility.

RBHS continued to contribute to the PBF data counter verification in the FARA counties. RBHS county MEOs joined the central and county health teams to conduct on site counter verification of PBF data in selected health facilities. The MOHSW PBF unit drafts a counter verification quarterly report that is reviewed by RBHS before it is submitted to USAID. RBHS county MEOs have worked with CHT and county M&E officers in particular to address the issues raised by the reports.

PRISM assessment

In June 2014, another PRISM assessment was carried out by applying quantitative as well as qualitative methods. Data collection in the field was conducted in Bong, Nimba, Lofa and Grand Bassa counties. All of the four county health offices and a random sample of 76 health facilities (19 health facilities per county) were surveyed, and about 283 health managers and staff from these institutions were interviewed using the Performance of Routine Information System Management (PRISM) framework and tools.

Compared to 2012 assessment, the performance of HMIS in Liberia was better for the quality of data and use of information at health facilities and county levels. Various degree of improvements were also observed in HMIS processes, staff competence to carryout HMIS tasks, promotion of culture of information and HMIS management functions.

PERFORMANCE OF THE RHIS	Facilities		Counties	
	2012	2014	2012	2014
Quality of data				
Overall accuracy	55%	84%	78%	88%
Data completeness in facilities monthly reports	52%	79%		
Completeness of monthly reports at county level			91%	98%
Timeliness of reports of health facilities at county level			74%	88%

Use of information	38%	58%	-	75%
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Successes, challenges and lessons learnt

The results of the PRISM framework indicate that in the past two years, the county team as well as the health facility teams have considerably increased their capacity in data management and analysis and in use of information for decision making. But there are multiple remaining challenges. The CHT M&E team is still very dependent upon technical assistance by RBHS and lacks initiative. Also, the lack of resources make them dependent upon the implementing partners. This is particularly true for the access to reliable internet. This can seriously impact on the use of information and M&E activities in general.

The Ebola epidemic has seriously delayed the revision of the HMIS as well as the scaling up of the C-HMIS. Waiting for the epidemic to be under control, both activities will need to be rescheduled in the planned HSS follow-on project. Also, there is still no well-established community health supervisory system, which will hamper the institutionalization of the C-HMIS.

BB4 SUPPLY CHAIN MANAGEMENT and INFRASTRUCTURE

Supply Chain Management

Activities undertaken and results

Supply chain management issues continue to hamper the delivery of quality health services, resulting in stock-outs of vertical program commodities including anti-malaria drugs, STI, ITNs, HIV test kits and Family Planning commodities. A particular issue is the community supply chain. Without commodities, the scaling up of integrated community case management (iCCM) is impossible. Yet, the county capacity for supply chain management is very limited.

RBHS had planned for the extension year to start a process of capacity building of the CHT in management of supply and distribution of commodities as well as to pilot test a community supply chain system. Unfortunately, in the late summer of 2013 partners halted the distribution of donated health products for the MoHSW to put in place appropriate control measures that ensure health commodity security and accountability. In response, the MOHSW developed a comprehensive safeguard mechanism endorsed by MOHSW & NDS Board and implementation plan named "Interim Approach" for commodities. The Interim Approach is centrally managed and includes a top-up distribution approach within a 6 month period at all levels (central, county depot, and health facilities). Decentralization of supply chain management was therefore put on a hold.

During the reporting period, it was decided to extend the Interim Approach (IA) for another six months. In the FARA counties, the essential drugs were purchased by RBHS, and or managed by IPs Africare (Bong and Nimba) and IRC (Lofa), while the vertical program drugs are channeled through the central mechanism. The RBHS county staff has assisted the Supply Chain Management Unit (SCMU), DELIVER, and the IPs to organize the quarterly distribution of drugs in the FARA counties. They also have assisted facility staff in filling in the SBRR, the main LMIS report.

Supply Chain Management Stakeholders workshop

The SCMU of the MOHSW in collaboration with RBHS and USAID|DELIVER organized another stakeholders meeting on July 23-24 in Gbarnga to prepare for gradual decentralization of commodity management to the county level, and to ensure an uninterrupted delivery of essential drugs in Bong, Lofa and Nimba counties. More than 40 participants from Central Ministry of health (SCMU), from Lofa, Bong, Nimba counties, and partners attended these two day meeting. The counties were represented by the CHO, Pharmacist, DDFP, DA and DHO. Partners represented were: IRC, Africare, MTI, FARA/USAID, CHAI, NDS, RBHS, DELIVER.

The workshop main accomplishments are summarized below:

- The current experience with health commodities supply chain management (SCM) in the FARA supported counties was reviewed in the context of the interim approach (IA). Participants identified the strengths and weaknesses of the SCM system and made recommendations on improvement of the logistics.
- Opportunities were identified for a better integration and coordination between current FARA commodities distribution approach in the counties and the IA.

- Coordinated and integrated mechanisms for distribution of health commodities and logistics management information system (LMIS) in FARA supported counties after the project close were defined: SCMU, NDS and partners at central level defined their roles and responsibilities to support counties after RBHS close out.
- County supply chain action plan was developed based on the strengths and areas of improvements identified developed.
- Central (MOH and partners) follow up activities to support counties action plan implementation were defined

Infrastructure

Activities undertaken and results

Capacity Building of the Infrastructure Unit

RBHS assisted in adopting the MOHSW Infrastructure Policy which is the foundation of the Infrastructure Unit (IU) is built. The actual policy document was laid out, and 200 copies are being printed in Liberia. Following and based on this policy a number of activities were planned and carried out by RBHS and the Infrastructure Unit.

RBHS and the Infrastructure Unit staff conducted a functional analysis of the unit during February, March and April. The findings indicated sufficient staffing but a lack of support/recourses, skills, and organization needed to carry out the unit's responsibilities. The recommendations were based on the real world reality of the limited resources available. They included, reorganizing the unit and physically relocating some of the engineering staff regionally to enable them to carry out their responsibilities under the Ministry's decentralized policy; establishing an assistant IU director to improve the units efficiency and delegation of authority; in-service staff training; annual central and county level plans and budgets that: (1) enable the unit to carry out its duties; (2) implement the building standards; and (3) maintain and repair facilities. Based on the needs of the IU, RBHS has continued and will continue to support some of the Infrastructure Unit logistical needs when possible.

RBHS provide architectural and engineering software and training to use the architectural software in 2013 during project year 5. In April RBHS contracted with a US structural engineer with years of experience applying the software and recent experience in Liberia. The program began with a pretest and assessment of 6 RBHS and IU engineers' skill levels. With this information the planned course was modified to the trainees' skill levels and a 5 day training course using the RISA structural engineering software was conducted in April. The course was judged successful by all the trainees, the trainer and RBHS.

The Health Facility Infrastructure Standards were finalized and printed by the RBHS sub contractor, MASS Design, who developed the standards. Upon receipt of the final hard copies the IU and RBHS plan to hold a final meeting of the stakeholders to review the manual, its intended use and distribute CD copies to all those attending and those involved in maintaining, renovating/rehabilitating, repairing, expanding, and/or constructing new health facilities. This is in lieu of the pilot testing which was preliminarily included in the work plan.

As the initial step to develop the MOHSW capacity to maintain its health infrastructure RBHS has supported the IU, HMIS and ME departments to develop a maintenance inventory tool to build a detailed data base of health facilities. The computer based tool was developed and pilot tested in Lofa County in October using hand held PDAs and hard paper backups. The tool was then revised based on the Lofa experience and conducted again in Bong County in March. RBHS working with the IU and Nimba CHSWT scheduled the third and final testing and application of the tool in Nimba County in June. Unfortunately this was postponed due to the Ebola Epidemic in June and may be cancelled. The data from Bong and Lofa was analyzed, a reporting and management tool developed and its use was presented to the IU in October 2014.

RBHS's final support to the IU was to develop Project Management Guidelines (Manual) for new construction, renovations, rehabilitation and maintenance. This was completed in October and a one day training held with all IU staff to introduce them to all aspects for construction project management from initial designs and assessment through to owner occupancy. Both hard and soft copies of the Manual including an annex of 20 construction management forms, was distributed to all IU staff members in October 2014.

Finalization of Physical Renovations

Substantial progress was made on the final renovations included in the work plan. All but one have been turned over and are in use. The final renovation project at Barkedu in Lofa was completed in September 2014. Redesign and negotiations to resolve the EBSNM electrical project issues have been ongoing since October and were finalized and a contract signed in May. Materials were imported in July and August. Two new diesel powered generators were installed in October under a 1 year warranty. However the repair of the transmission system was delayed when the foreign contractor and Liberia subcontractor invoked the force majeure contract clause due to the Ebola Epidemic and contract was suspended until conditions permit.



Barkedu Health Facility

RBHS completed procurement and contracted for the installation of hand pumps and submersible pumps at the Fishtown Health Center and River Gbye Clinic water wells in River Gee. This work started in March and completed in August. The HMIS Solar and Battery Power system for the MOHSW server was successfully installed and completed in December 2013.

Rehabilitation of the wells and the installation of pumps at Barkedu clinic in Lofa and Zekepa Health Center in Nimba were completed in September and October respectively.

Finally, the renovation of three Family Planning Centers of Excellence was added to the scope of

work at CB Dunbar in Bong, Telowayan in Lofa, and Sacelepea in Nimba between February and May. Assessments and bid documents were prepared, the projects were contracted to one subcontractor, and the work began in May and was completed and inspected in September.

Work assisting the MOHSW, USAID and GF on the design, procurement and contracting of the Central Pharmaceutical (NDS) Warehouse continued throughout the period. Following the RBHS Initial Environmental Examination (IEE) and Environmental Report prepared and submitted to USAID in early 2012, a USAID environmental scoping report was completed by Cadmus, a centrally funded USAID environmental contractor, indicating construction could go forward on the chosen site with precautionary conditions, given inconclusive results of one soil test. The soil tests were redone showing no contamination and final environmental scoping report was completed in August 2014. The Liberia EPA received copies of the final scoping report in August, visited the site with RBHS, and renewed the EPA permit for three years in October 2014. The Warehouse Design Build Plans and Specifications were completed and given final approval by USAID in March. RBHS assisted the MOHSW in international advertising for and selection of prequalified bidders for the design build project. Seventeen applications were received and reviewed by a review panel consisting of representatives of the Infrastructure Unit, Procurement Unit, Assistant Minister of Administration, and Finance Department of the MOHSW, the National Drug Service (NDS), RBHS, WHO and USAID. Seven applicants were prequalified and notified by MOHSW in April 2014. RBHS worked with the Procurement Department of MOHSW to finalize the bid documents and they were approved by USAID and the GF in August.

MOHSW and USAID also agreed on the need to hire a Project Manager to oversee the construction of the project. RBHS and the Procurement Department prepared an RFP for the Project Manager which was approved by USAID and GF and the RFP was released in August. Expressions of interest were received in September from nine applicants and five were prequalified to submit proposals in October. Bids for the Project Manager and the DB Contractor are due in November 2014.

Finally, RBHS worked with USAID and GF to develop an MOU and FARA financing documents for the warehouse. MOHSW, USAID and GF signed the final MOU in August 2014.

Two surgical lights were installed in the new River Gee Hospital in December but problems persist with the electricity in the hospital. One of the units' transformers burned out and was sent to the US for repair and added spare parts. RBHS procured five voltage regulators/UPS units for all 5 surgical lights installed in the EmONC facilities around Liberia, which are plagued by similar electrical power supply problems. These and other spare parts were turned over to the MOHSW Medical Equipment Unit in October. The Medical Equipment Unit agreed to visit all five centers and install the voltage regulators/UPS with RBHS support before the end of December 2014.

RBHS completed its assistance to the Infrastructure Unit and Merlin (now part of Save the Children/UK) in installing solar powered lights and HF radios for rural health facilities throughout Liberia. In collaboration with RBHS Merlin's subcontractor completed the final installation of 6

solar power systems at RBHS supported and renovated clinics or health centers in Nimba County between November and March 2014.

RBHS also worked on the following activities during the period:

- Assisted the IU in turning over the Duport Road Clinic in Monrovia which had been renovated under a contract issued by the US Department of Defense (DOD).
- Renovation of the NMCP offices and conference room for USAID and CDC advisors was completed in March.

Successes, challenges and lessons learnt

The overarching success of the RBHS infrastructure program has been the ability to implement all the planned major activities, albeit with delays and in some cases cancelling of sub activities. It is important to keep goals, objectives and activities realistic. Eventually most objectives are achievable with extended schedules and higher levels of support than originally planned. One completed individual success was the RISA structural engineering software and training. This was realized through a combination of local counterpart interest and commitment to the activity and lessons learned from previous attempts to use local training resources to conduct the AutoCAD training. An international structural engineer experienced in structural engineering and the software, with more direction from RBHS, produced a training program which successfully met the trainees at their level of knowledge and they were able to learn how to use the software.

Challenges continue to be the lack of capacity and skills of contractors, designers, engineers, and local partners to act and/or follow through on commitments. Depending on the activity, this is due to a combination of a lack of skills, understanding, motivation or commitment.

On an individual activity basis the biggest challenge has been completing the EBSNM electrical system. The procurement and contracting with an international electrical firm to assess the design and installation took 5 months, and the procurement and the contract negotiations for the rehabilitation of the system with another international electrical firm took 6 more months. After a another 3 months of negotiation the contractor and RBHS signed a contract in May based on a revised scope of work more appropriate to the needs of the hospital, the equipment installed and the ability of the owner to operate and maintain the system.

BB5 HEALTH FINANCING

RBHS has been requested by the MOHSW to explore feasible mechanisms to provide health insurance to the Liberian population. While the long term vision for Liberia's health system is sustainable universal coverage, this is not an easy overnight solution, but one that will likely take a decade or more of persistently hard work to achieve. RBHS aims to provide technical assistance to the MOHSW to help establish them on the path to implementing an achievable, tailored health insurance framework for the country.

Health Insurance

Activities undertaken and results

Building on the previous scope of work and the *Roadmap to Universal Health Coverage* that were completed in August 2013, RBHS has focused on furthering the development of the Liberia Health Equity Fund (LHEF)—a national health protection mechanism that aims to increase the efficiency, equity, quality and sustainability of health expenditures and services. Specifically, RBHS is supporting the Ministry of Health and Social Welfare (MOHSW) in conducting the necessary technical analysis, advocacy, and stakeholder engagement for the proposed LHEF. RBHS has supported the MOHSW to draft the legislation required to bring the LHEF into being. The legislation codifies the entity which will manage the fund, enroll members and define the benefit package. The legislation also details who are the eligible beneficiaries of the LHEF, how much and in what way they will contribute. Lastly the legislation defines the revenue streams which will resource the fund. A first draft of the legislation was developed in December and later updated to a second draft in February.

In order to understand what level of resources which will be required, a service-level costing conducted by RBHS in 2008/09 of the MOHSW's Basic Package of Health Services (BPHS) has been used as a baseline. A national envelope has been established with assumptions for utilization and based on the numbers of facilities in Liberia today. RBHS also initiated a dialogue between the MOHSW and the Ministry of Finance (MOF) to discuss potential revenue streams for the LHEF and to assess how much each of these revenue streams would generate. The costs and revenues have been joined into a single model which will project the financial sustainability of the LHEF over a ten year time period.

The introduction of the LHEF represents a fundamental reform of the way in which the health sector is financed and operates; thus success depends on the engagement and participation of all stakeholders. In recognition of this need, RBHS has made advances in education, advocacy, and marketing (EAM) activities for the LHEF. In February, a Liberian delegation, including representatives from the MOHSW and the Ministry of Finance (MOF), visited neighboring Ghana and their National Health Insurance Agency. The delegation gathered useful lessons from Ghana's experience in health insurance. Most importantly the tour invigorated the MOHSW representatives in the delegation, most of whom had limited prior experience with health financing concepts and reforms.

In March 2013, a meeting was held between the MOHSW and the MOF in which the former presented the proposed LHEF for the first time. While the MOF did not immediately endorse the LHEF, the meeting represented an important first step in engaging the MoF in essential discussions on the commitment of the MOHSW to render the health sector more efficient. Additionally, RBHS has facilitated productive conversations between the MOHSW and professional groups, including the Liberian Medical and Dental Association, the Nurses' Association, and the Midwifery Association. Further education and advocacy activities will be undertaken with civil society groups, other labor-oriented associations and most crucially at this early stage, the Legislature.

The LHEF has generated much positive momentum and attention at the highest levels of the government. Both President Ellen Johnson-Sirleaf as well as Health Minister Gwenigale publically announced and endorsed the forthcoming LHEF on multiple occasions including on the occasion of a meeting of West African health ministers in Monrovia under the auspices of the West African Health Organization. During this meeting President Sirleaf was explicit in her endorsement of the LHEF during remarks which drew heavily from a brief prepared for her by RBHS for the occasion.

Successes, challenges and lessons learnt

Despite public support for the LHEF from the President and the Health Minister, the political process has been hampered by the lack of an inter-ministerial decision-making body (e.g. an Advisory Council) that can finalize design details for the proposed LHEF. The absence of such a group has also slowed engagement with other ministries (e.g. Labor, Transport, and Finance) whose support will be critical for success. Implementing the LHEF will require counteracting the negative public perception regarding insurance in general. One of the earliest lessons learnt was that a reform of this kind would need to be distanced from “insurance” and rebranded for wider acceptance, hence the name *Health Equity Fund*.

RBHS has been working actively for some months to reorient the primary thrust of the conversation on health financing away from a desire merely to increase the amount of funding into the health sector. Conversations with the Ministry of Finance have made it clear that there is little intention to agree to requests for additional funding above current levels, particularly in light of continued substantial external funding. An additional reason that the MoF is reticent to provide further resources to the MOHSW is a perceived lack of transparency and low level of managerial sophistication in the health sector, leading to inefficiency. There is therefore a compelling reason for the MOHSW to improve transparency and efficiency in the health sector. RBHS has been working with the MOHSW health financing team to look at a more rational resource allocation across Liberia’s fifteen counties, a process which will serve both to improve Health’s standing with Finance, but also as an initial step towards a capitated payment type under the LHEF.

The Ministry of Finance has shown little interest thus far in earmarking tax revenues for health, especially given the context of a resource-limited government. This however will in the end be a political decision. RBHS is simultaneously exploring innovative ways to harness the financing potential of the informal sector.

Financial Management in FARA counties

The RBHS support to the counties in building capacity in financial management has been modest as this was really an add-on piece of work that RBHS would support as needed. RBHS field staff have continued their ad hoc support to Bong, Lofa and Nimba in financial management.

The MOHSW budgeting tool has been rolled out to the counties but not much follow-up has been done due to the Ebola outbreak.

RBHS along with MOHSW development a first draft of the CHSWT Financial Management Manual. This manual for the counties came up in discussions with the MOHSW to ensure that counties have all the tools and resources to do appropriate financial management. Currently the manuals available address both central and county issues together. The hope is that having a CHSWT manual will make the document shorter and more streamlined for the counties. The GEMS updated Financial Management Policies and Procedures Manual will be used as well as the other MOHSW documents in the development of this county manual.

BB6 LEADERSHIP AND GOVERNANCE

The non-existence of defined internal communications procedures was identified during the capacity assessment in 2012 as a major contributing factor to the limited information sharing and dissemination at all levels of the MOHSW - central, CHSWT and facility. In 2013, RBHS started an intervention to support the MOHSW in improving internal communications. This initiative has been facilitated by JSI Communication Advisor Andrea Dickson. Findings from a detailed assessment conducted by the consultant identified four critical internal communications problems including: (1) Non-existence of telecommunication channels; (2) Lack of communication standard operating procedures; (3) Lack of a communication unit; and (4) Limited culture of information sharing. An internal communications strategy has been drafted to address each of these problems.

Activities undertaken and results

During this reporting period, implementation of the internal communication strategy has been stalled in part due to competing demands in the project. Since the initial activity last year September, the MOHSW has made some progress in costing the VHF repairs; stabilizing internet service within the main building; and recognizing that internal and external communications are separate functions. The Change Management initiative, linked to the strategy, was launched and then overtaken by the health workers' strike and not picked up again due to competing demands within RBHS and more recently the Ebola outbreak.

Program management

Activities undertaken and results

In 2013, RBHS has initiated capacity building in program management of various units and counties. The National Malaria Control Program (NMCP) was chosen as a first program because it is the most important in terms of resources injected. The organizational assessment has been completed and is currently being revised to reflect issues identified in the National Malaria Review and meeting the requirements of the Global Fund Conditions Precedent. RBHS has completed an "institutional TOR" for the NMCP which is consistent with the overall direction of the MOHSW toward a leaner overall structure, with more focus on policy, strategy and resource mobilization than actual implementation. A related organogram and job descriptions in a format supported by CSA have been developed. The organ gram is transitional, with a few more positions located at the program than are envisioned in the future. TORs were also drafted for the Community Health Division and the Infrastructure Unit of the MOHSW. Those drafts may also provide useful models for other work units with the MOHSW.

Successes, challenges and lessons learnt

The NMCP Institutional TOR and the format for the Job Descriptions are being shared within other Global Fund supported programs. The pieces of the final organizational assessment and plan, including the revised structure and staffing pattern have been completed and are under review in the MOHSW and on track to meet the GF deadline of 30 June. There is still a need to develop internal communications and support for the new structure and positions, though it is difficult to do so in the absence of final decisions. Engaging staff in the development of the program TORs and individual JDs has been challenging as the fear of losing jobs affected the content and quality of participation.

Revitalize CHSW Boards

Activities undertaken and results

The County Health and Social Welfare Boards (CHSWBs) have been operationalized in the three counties and institutionalized support for their continued functioning will continue through various mechanisms. The PBF scheme has set up a Steering Committee as a sub-committee of the CHSWB to oversee the results of implementation of the scheme. The MOHSW process for identifying county readiness for “contracting in” included a review of the frequency and substance of CHSWB meetings, as evidenced in meeting minutes. The newly formed Regional Support Teams will provide ongoing support as needed to strengthen the CHSWBs.

Leadership Training

Activities undertaken and results

Three activity areas fall into this intervention. The first was the *development of a leadership approach* within the MOHSW. This was launched in February 2014 with a consultancy that used an innovative, action training approach to leadership development. Assistant Ministers and Directors were invited to a discussion that was intended to highlight critical changes and decisions over the next several months, and to engage in a discussion of the practices that would result in effective, long-lasting change and change management. The initial meeting produced some key change targets but the discussions were truncated due to the health workers’ strike action and the need for the senior team to attend the Minister’s press conference and subsequent planning activities. Other planned project activities have kept this activity on a back burner. Over the next weeks, a final decision will be made about how far this can proceed before the end of the project.

Two other interventions in this area met with more success, as they were both launched and institutionalized earlier in the reporting period. The Contracting In Readiness Assessment and the launch of the Regional Support Teams have both gained traction as leadership activities in the MOHSW.

The *Contracting In Readiness Assessment* represents a process, a set of tools and the use of those tools by a cross section of MOHSW central office staff working in partnership with the counties. The tools were requested as a follow on to a set of operational guidelines developed for counties to use as they prepared for decentralization through a “contracting in” mechanism.

The initial guidelines were developed by a consultant with lots of input from various offices and were vetted and shared with counties during the mid-year health review in 2013. Although they were initially deemed helpful, very little actual use was made of the guidelines as the counties lacked the leadership, time and focus to do so. Taking lessons learned from that experience and determined to make the readiness assessment more realistic and practical, a different approach was taken to the development of the readiness assessment.

First of all, an institutional home was identified for the work, namely County Health Services. Secondly, two MOHSW staff members with strong backgrounds in county support and health systems were tasked to work with the consultant on a continuous basis and to identify and engage key players in all MOHSW departments as a Technical Working Group (TWG). As the tools were finalized, the TWG realized that they needed more participation in their respective departments and each team member oriented a second person in their unit. This has resulted in a strong core group of people who can conduct the readiness assessments and use the results to make recommendations for contracting in and/or for specific capacity development activities.

This process produced results on several levels. There are now finalized tools and procedures as well as county experience in self-assessment and capacity development planning. Collaboration between central and counties has improved. The overall process including the tools have been used to assess contracting in readiness in the FARA counties and six Pool Fund supported counties. The process has been led by the County Health Services and has been refined as lessons have been learned from its implementation. This intervention has been an important contribution to prepare counties for decentralization and target the support of central MOHSW offices to ensure county preparedness.

The Regional Support Team concept, initially vetted in February 2013 as a mechanism for supporting county capacity building, has been launched. Teams have been established for each of the five regions, with a senior manager as Team Leader/Chair and a Desk Officer from County Health Services assigned as secretary. An orientation of the teams' TORs was held in January for RST members. The meeting resulted in buy-in for the concept on the part of the MOHSW staff and a suggestion that an all-county meeting be held to orient CHSWTs on RSTs, Quarterly Review Meetings, and Community Health. Two of the Regional Teams have met and to review reports and data that could inform the kind of central support needed by various counties. The county orientation to the Regional Support teams was finally held on 2-3 June 2014 in Buchanan. While the CMO had appointed the teams in October 2013, giving them the mandate to be a "gateway to ensure timely assistance to counties through the provision of technical managerial, programmatic, financial and administrative support" and the team members had been oriented, the counties had not yet been engaged. This orientation and planning meeting was designed to ensure that counties and team members could operationalize the concept. Resources prevented an all-county meeting but it was possible to convene six counties, representing Regions 1 and 3. Region 1 includes Montserrado, Margibi and Grand Bassa; Region 3 is Bong, Lofa and Nimba. This represented the largest counties in the country. County Health Services and Community Health took the lead on the meeting, supported by relevant MOHSW and RBHS staff.

Over the course of the two days Regional Support Team members, senior ministry staff and counties engaged in intense discussions of the RST concept and the Community Health Roadmap. By the end of the workshop, the two Regional teams and their counties had agreed on the timing for a first “review meeting” in which each county would convene a discussion of key health indicators for the quarter, engaging their RST and CHSWB members in a dialogue about what the data was suggesting; what was driving high/low performance; and to problem solve and plan for the next quarter. The Community Health Roadmap was largely well received with a lively policy debate on the issue of stipends for gCHVs and other community cadres.

Successes, challenges and lessons learnt

The Contracting-In Readiness and the launching of the Regional Support Teams are among the successes of this reporting period. Both these efforts brought together multiple departments to support county capacity development based on specific county level findings and on a collaborative rather than top/down approach.

Challenges are mainly linked to the overload of interventions to be implemented in a limited remaining project period. The Leadership Development Assessment and Internal Communication Strategy did not get sufficient attention by RBHS and the MOHSW. The Leadership Development effort was truncated and not picked back up due to scheduling challenges. The Internal Communication strategy saw some movement in terms of communications infrastructure and then a setback as the appointed communications officer was redeployed to her original full time position and has not had time to move things forward.

Intervention 2.2: Assistance to Regulatory Boards for Accreditation of Training Institutions

In continuation of its support to strengthening of pre-service education to ensure qualified health workers in the provision of quality care, the Education and Training Strengthening Initiative focused on enhancing the functioning of two regulatory bodies: (1) the Liberian Medical and Dental Council (LMDC); and (2) the Liberian Board of Nursing and Midwifery (LBNM).

Activities undertaken and results

RBHS conducted a quarterly meeting of the Education & Training National Working Group. The 46 participants were from training institutions, the MOHSW, regulatory bodies, associations, RBHS and other stakeholders. The goal of the meeting was to finalize the Ownership, Support and Sustainability of the Education Training National Working Group and Education Development Committee (EDC) / Quality Assurance Committee (QAC)

One of the key functions of the LBNM is to institutionalize quality improvement at institutions training mid - level health workers, especially nurses and midwives. RBHS assisted the LBNM to monitor and evaluate adherence to effective teaching skills.

RBHS in collaboration with LMDC conducted a workshop to train 20 participants from Hospitals, Clinics, Professionals Associations and LMDC in Bong County. The goal of the training was to build the capacity of assessors to be able to utilize the newly developed LMDC monitoring tools effectively. The tools consist of 32 standards, with 5 different areas which include: administration, patient's care, service delivery, equipment & supplies and waste management. RBHS in collaboration with LMDC conducted an initial six day assessment using the newly develop monitoring tools. The assessors were divided into three teams to assess 36 major health facilities (hospitals, health centers and clinics) in RBHS three supported counties (Nimba, Lofa & Bong).

In continuation of RBHS assistance to the regulatory bodies to improve their performance, RBHS conducted a two day workshop in February to establish standards for accreditation of training institutions and professional staff. The workshop was facilitated by two STTAs from Jhpiego Dr. Emmanuel Otolorin and Julia Bluestone. The goal of the workshop was to enable regulatory bodies to make appropriate decisions on accreditation and licensing/re-licensing processes including continuous professional development (CPD). 32 participants from LMDC, LBNM, LAMLT, LAPHT, PA Association, Pharmacy Board, Training Institutions, Hospitals and MOHSW participated in the workshop. An additional two-day workshop was held to validate the accreditation, licensure and CPD processes that were developed by the regulatory bodies during the February workshop with the assistance of two STTAs from Jhpiego. 35 participants from LMDC, LBNM, LAMLT, LAPHT, PA Association, Pharmacy Board, Training Institutions, and MOHSW participated in the workshop.

RBHS also continued its technical support to strengthen the performance of the health training institutions. A workshop was held on Buruli ulcer (BU) effective teaching skills to enhance the abilities of instructors to utilize appropriate teaching methods in teaching about BU. Twenty five participants from 12 of the 16 mid- level training institutions (TNIMA, Phebe Training Program, United Methodist University, Smythe Institute, Cuttington University, EBSNM, Mabel McComb, Lofa County Community College, Grand Bassa Community College, Bomi County Community College, Dujar School of Nursing and The Adventist University of West Africa) attended. LBNM, LMDC and the Training Unit of MOHSW also actively participated in the training.

RBHS provided technical support at the workshop to *Review and Update the Pre-service Education Standards*. The exercise brought together 24 participants from 8 counties in Liberia and comprised 10 deans/directors, training directors and instructors from 16 nursing and midwifery schools. Also participating were the chairperson, registrar and staff of the Liberian Board of Nursing and Midwifery (LBNM) and the Chief Nursing Officer at the MOHSW. The purpose of the gathering was to initiate activities aimed at strengthening the accreditation process for pre-service institutions.

RBHS also provided training materials, state of the art models and text books to improve the learning environment, to 18 training institutions.

Through the implementation of the above activities, results are being seen, including the following:

- The Education and Training National Working Group identified gaps, concerning the implementation of the RN & RM curricula especially in updating content, for example, to include the new Malaria in Pregnancy policy
- Through the assistance of RBHS, quarterly external assessments were completed utilizing the National Pre- Service Education Standards at 14 training institutions implementing the updated curricula
- National Pre-service Education Quality Improvement Standards were updated making them more appropriate to these cadres.
- Participants during the validation workshop were able to finalize the accreditation, licensure re- licensure, as well as, the continuous professional development (CPD) processes.
- Faculty from training institutions who attended the Buruli ulcer workshop are now teaching updated Buruli ulcer content in their various institutions. Knowledge and skills acquired during the training have been shared with other instructors.
- The models, equipment, supplies, text books, and other training materials provided by RBHS are being used at all institutions

Successes, challenges and lessons learnt

The first part of the 6th year has been very successful for the Education and Training Strengthening Initiative at RBHS. All training institutions are now using the revised curricula and the pre-service education performance standards to improve the training of mid – level health care providers. TNIMA and EBSNM now have well equipped and designed simulation laboratories for students to master skills before going to care for patients.

The LBNM has institutionalized the process of continuous quality improvement at pre-service institutions and clinical sites and has reported the results to institutions and government including the Commission on Higher Education.

Faculty are now teaching using effective teaching skills as can be seen in their assessment results and the availability of lesson plans. The processes for accreditation of existing and new schools, licensure and re-licensure, as well as, continual professional development (CPD) are now being utilized by the regulatory bodies. Challenges include the competing many and needed priorities by the regulatory bodies as they enforced the provision of quality care by qualified health workers and the limitation of RBHS to meet all their needs completely as they would like.

Valuable lessons were learned from the Education and Training Strengthening Initiative:

- Involvement of stakeholders in all aspects of implementation promotes transfer of leadership;
- Importance of recognizing the value of regulatory bodies (LBNM and LMDC) in promoting quality improvement at training institution and health facilities.

Project Monitoring & Evaluation, Documentation and Close Out

Project M&E/PMP Addendum for extension year FY 2014 (Project Year 6)

RBHS developed and submitted to USAID a PMP addendum to its overall project M&E plan to cover the extension year. The scope of work of the M&E plan remains the same in the extension year as in the past 2 years and hence the original RBHS Project M&E plan is still valid and will serve as a reference for all RBHS M&E related interventions. This includes the Project Strategy and Principles, Project's Geographic Areas (Bong, Lofa, and Nimba counties), Transition Strategies, M&E strategy and frameworks, and monitoring and evaluation plans envisioned. The only exception is the household survey, which was planned for April-May 2014. Taking into account that the LDHS 2013 survey results will be known in July 2014, and given the high cost of conducting such a survey, it was decided to cancel the RBHS household survey.

The PMP addendum has used same structure and list of indicators. Three columns have been added to the right. One column displays the status of indicator in last year of the project which was FY 2013 and the second column displays the targets for the extension year FY 2014. The last column indicates the data sources for various indicators which include Health Management Information System (HMIS) of MOHSW, the MOHSW supportive supervision reports, the iHRIS, the planned end of project (EOP) evaluation surveys, the MOHSW Health Facility Accreditation Survey of MOHSW, and various project reports.

Project Monitoring

Close monitoring of the implementation of year 6 work plan is critical for RBHS as it is the last year of the project. In this light, RBHS organized a detailed monitoring meeting with the program and capacity building advisors of the central RBHS team at the end of the first quarter. RBHS counterparts in MOHSW were consulted as to the MOHSW priorities. As a result, RBHS has made adjustments to the Year 6 work plan, mainly canceling some activities that realistically could not be implemented before July 31 2014. RBHS has also organized bimonthly meetings with county-based staff to discuss progress made in the implementation of the county plans. Finally, on February 27 a meeting was organized with USAID to review the progress made during the first quarter on the Year 6 work plan.

RBHS performance monitoring

Annex 1A and Annex 1B provide the results of RBHS performance in the past semi-annual period of November 2013 to April 2014. The data comes from various sources such as HMIS, Supportive Supervision reports from health facilities, and the project training reports. The HMIS data indicators are presented on an annualized basis, meaning that the numerator and the denominators are for six months of the year. It should be noted that the data covers the six month period of July to December 2013, in continuation of the Annual Report 2013 which covered the period of July 2012 to June 2013.

The Annex 1A shows the End of Project targets, the FY 2014 targets (Project year 6) and achievements in the past six months. Some achievement data are given in percentages and others in absolute figures, depending on how the data has been measured. Among the

indicators falling short of the target, mostly the achievement is above 90%. Note that the July-December period of the year is a relatively low activity period because it is the rainy season and the holiday season which is reflected in HMIS data for past years. A number of indicators are based on a household survey. We hope to get the results for most of these from the LDHS 2013. Since the RBHS planned EOP household survey has been canceled, some of these will not be measured for year six.

Annex 1B shows the key service delivery indicators comparing the results for July-December 2012 with the results for July-December 2013. The performance of the FARA counties in July-December 2013 show remarkable improvements. 9 out of 11 service delivery indicators presented improved. For example, skilled facility delivery increased to 62% from 56%; IPT2 coverage to 57% from 46%; and CYP increased from 12,101 to 22,940. The improvements are consistent in all three counties. One exception is the % of children under five treated with ACT. As explained earlier in this report, the decrease can be explained mostly by ACT stock-outs in the reporting period.

Evaluation

The RBHS in-country M&E as well as the HQ-based team worked on planning for the end of project evaluation activities. The project EOP plan includes analysis of HMIS data, the endline Capacity Assessments, the endline PRISM assessment, and End of Project Household Surveys. The Capacity and PRISM Assessments will be conducted in May-June 2014. This is an internal independent assessment as it will be conducted by JSI HQ staff who were not involved in the implementation of the project in the country. As discussed earlier, it was decided in consultation with the MOHSW and USAID to cancel the end of project household evaluation survey and analyze the results of the LDHS 2013.

Endline Capacity Assessment of MOHSW and FARA Counties

During the reporting period, a team of JSI consultants implemented the RBHS endline capacity assessment of MOHSW and FARA counties between May 12 and June 27, 2014. The team was led by Deirdre Rogers (JSI/Boston), with team members Kumkum Amin (JSI/Boston), Kate Beal (JSI/Boston) and Heather Drummond (Consultant).

The purpose of the assessment was to document achievements and capacity changes in each of the WHO health system strengthening Building Blocks, on which the Liberian NWSWPP is built, and to review the progress of implementation of the RBHS project capacity building activities since the project scope change in 2012 (at which time a baseline capacity assessment was undertaken). The assessment comprises a significant component of the overall end of project evaluation activities. It complements other project evaluation activities including: Health Management Information System data analysis, PRISM assessment, and other analyses (e.g., Malaria Indicator Survey (MIS) comparative analysis (2009 vs. 2011), project reports and records, behavior change communication 'dipstick surveys', MEASURE Lot Quality Assurance Sampling surveys, and recent tracking of Ebola-related activities).

The capacity assessment documents factors that have enabled or impeded effective implementation of different capacity building components of the project, identify remaining gaps and suggest strategies or priorities for the anticipated health system strengthening as of June 2014. The assessment team used qualitative and quantitative methods to assess changes in health system capacity at all levels since 2012, and thus the contribution of the RBHS project towards achieving *USAID’s Strategic Objective: Increased Use of Essential Health Services*, and the associated Intermediate Results: *IR1: Increased access to essential health services through improved provision of quality health services and adoption of positive health behaviors*; and *IR2: Increased quality of health services through improving infrastructure, health workforce and systems performance by enhancing capacity to plan, manage and monitor a decentralized system*.

The qualitative assessment included individual and group interviews in which tailored questions were used to determine the extent to which RBHS project activities (in Figure 1 below) have contributed to changes in capacity for the central MOHSW and County Health and Social Welfare Teams (CHSWTs), professional training institutions and medical professional and regulatory boards, and, consequently, whether the above results were achieved.

Figure 1

IR 1 RBHS Project Interventions	IR2 RBHS Project Interventions
<ol style="list-style-type: none"> 1. Increase access to comprehensive MNCH services 2. Increase uptake of four critical malaria interventions 3. Increase access to quality HIV/AIDS and tuberculosis (TB) services with emphasis on prevention 4. Increase access to comprehensive family planning (FP) and reproductive health (RH) services with special focus on youth 5. Finalize infrastructure work including environmental and drug supply interventions 	<ol style="list-style-type: none"> 1. Build capacity of the central MOHSW through the six building blocks (BBs) of a health system <i>BB 1: Delivering essential health services</i> <i>BB2: Health Workforce</i> <i>BB3: Health Information System</i> <i>BB4: Access to essential commodities</i> <i>BB5: Health System Financing</i> <i>BB6: Governance and Leadership</i> 2. Build capacity at county level in Bong, Lofa and Nimba through the six building blocks of a health system 3. Strengthen professional health institutions, including TNIMA, Esther Bacon School of Nursing and Midwifery (EBSNM), Liberian Board of Nursing and Midwifery (LBNM), and Liberia Medical and Dental Council (LMDC)

Furthermore, implementation of the quantitative capacity assessment tool allowed the team to identify capacity changes in each of the CHSWTs and at the central MOHSW level in each of the health system building blocks noted below. The final assessment report was submitted in August 2014.

Documentation

RBHS staff have been documenting project activities and progress over time. End of project documents address the following technical areas: family planning, capacity building, PBF, quality assurance and improvement, community health, health information systems, infrastructure, universal health coverage, and pre-service education. Combined, these documents total over twenty pieces, including monographs, case studies, success stories, and technical briefs. These documents have been finalized by project management, printed, and uploaded to the DEC.

Close Out

RBHS has been monitoring the close out plan with support from the JSI head office. The Project is currently on track with its closeout activities and will focus on this in the next quarter as the project comes to an end. The closeout plan includes work related to termination of employees, repatriation of expats, final payments to vendors, shipment of files, etc.

Project Management, Finance, and Administration

Project management and administration focused on the support to all technical staff for the implementation of the year 6 work plan. The major activities included:

Human Resources

RBHS project has had a few changes in staffing in this reporting period since the project is ending February 2015.

The following is a list of positions whose contracts have ended as part of our closeout plan or staff that didn't want to renew through the extension period:

- Capacity Building Officer – Bong
- M&E Officer - Nimba
- FP/RH Advisor
- Mental Health Advisor
- IT Specialist
- Driver (1)
- Account Assistant
- Office Assistant

Procurement

Pharmaceutical procurement

During this reporting period RBHS received and safely distributed 12 pharmaceutical containers and four air shipments for the Procurement Order #6 of essential medicines for health facilities in Bong, Lofa and Nimba counties as well as 2 facilities in Montserrado County.

Other major procurements

Below is a sample list of the major procurements completed during this reporting period:

- Sponsored the recording and production of MNCH Messages
- Procured two 5KVA Robin generators for use by the Barkedu and River Gee clinics
- Printed and distributed 150 copies of national guidelines for initiating and managing community-based FP services
- Printed and distributed 200 copies of an FP manual for use by community health volunteers
- Printed and distributed 250 copies of a community-based FP Counseling flipbook.
- Printed and distributed 120 copies of Balance Counseling Strategy (BCS) cards, 120 copies of Medical Eligibility Criteria, 120 copies of LAM, 120 copies of BCS Algorithm A4 and 200 copies of BCS Brochures (set) in support of CHSWTs to strengthen and increase access to family planning services.
- Procured 16 alubond plaques and installed at renovated clinics in the counties.

- Printed and distributed 200 copies of the MOHSW Infrastructure Policy
- Supported the MOHSW to organize the ECOWAS Ministers of Health 15th Ordinary meeting in April 2014 by renting nineteen (19) vehicles.
- Printed and distributed 800 pieces of flip TTMs booklets to FARA counties
- Printed and distributed 250 copies of Misoprostol instruction sheets
- Procured, printed and distributed 800 bags to be used by the trained TTMs for PPH prevention
- Printed and distributed 117 sets of Market Contraceptive Day materials (penis model, wooden box and Sign post) for Family planning
- Procured and delivered to MOHSW assorted PPE and medical supplies for health facilities in response to the EBOLA epidemic as part of the IPC training worth about \$1
- Procured and turned over to the MOHSW one HP Server
- Printed and turned over to the MOHSW EBOLA 22,000 Sign sheets and 22, 000 brochures.
- Printed and turned over 6,000 EBOLA Case Investigation Forms for the use of MOHSW.

Training

The RBHS Admin/Finance team has managed the logistics and finances for all the RBHS trainings mentioned in the technical sections. A list of training activities organized can be found in Annex 4A.

Budget vs. Expenditures

Annex 6 gives a summary of estimated expenditures until October 31, 2014. It should be noted that accruals have not been included.

Visitors and Consultants

The Project hosted visits from JSI, RBHS partners and consultants as well sponsored MOHSW staff to participate in training, meeting and conferences during the reporting period, as shown in Table 1.

Conclusion

This project year (November 2013- October 2014) has been one of the most challenging for both MOHSW and RBHS. First it was the health workers strike in November 2013, then a second one in February 2014. Then came the first wave of Liberia's Ebola outbreak in March 2014, initially limited to Lofa county. This was followed however by a major outbreak in April 2014 which eventually affected all counties. These events had a great impact on our overall project year six implementation. While we were able to accomplish a number of activities in this, our last full year, many were delayed if not canceled due to the Ebola outbreak.

During the first six month of the project's year 6, RBHS worked closely with the central MOHSW and the three FARA counties Bong, Lofa and Nimba on the implementation of capacity building interventions. The second half of year six was focused on assisting the MOHSW on the Ebola epidemic response in an effort to stop transmission and restore health services.

Prior to the Ebola outbreak and in spite of the health worker actions, RBHS was able to accomplish a great number of things as mentioned throughout this report under both IR1 and IR2. Highlights of IR1 include:

- Scaling up of the prevention of post-partum hemorrhage in Bong County through the distribution of Misoprostol tablets at household level is well underway.
- Increasing deliveries by skilled birth attendants from 56% in 2012 to 62%.
- Finalized the revision of Malaria in Pregnancy (MIP) guidelines and begun dissemination.
- Increased IPT2 from 46% in 2012 to 57%.
- The primary care facilities in the FARA counties now offer mental health services.
- Increased CYPs largely due to community based distribution including Contraceptive Days, for which a planning toolkit has been produced.

Highlights of IR 2, capacity development in the six building blocks of the health system, substantial progress has been made in several areas addressing individual, organizational, and system capacity include:

- PBF has been further institutionalized and decentralized to the county level. The counties (FARA and others) have taken ownership through the establishment of county steering committees.
- The Improvement Collaborative Approach in three pilot hospitals was well received by service delivery staff, Medical Directors and CHOs. Following an extended delay related to the Ebola epidemic, the approach has been reactivated and is ready to be rolled out to 11 hospitals across the country.
- At community level, various structures have been strengthened, resulting in a better collaboration between health facilities, communities, and CHWs. The Partnership Defined Quality (PDQ) was successfully piloted in Salala district and will be scaled up in Bong County.

- The integrated Human Resources Information System (iHRIS) has been launched and additional funding available from GAVI and through Ebola response initiatives has resulted in training and data collection and entry in all 15 counties.
- County Health Teams have substantially increased their capacity in data management and use of information for evidence based decision making.
- Substantial progress has been made in building the capacity of the MOHSW Infrastructure Unit.
- The Liberian Health Equity Fund (LHEF) has generated positive momentum, and was endorsed by both President Ellen Johnson-Sirleaf as well as by the Minister of Health Dr. Gwengale.
- The Contracting-in Readiness Assessment as well as the launching of the Regional Support Teams (“a new way of doing business between the central MOHSW and the counties”) have strengthened leadership both at MOHSW as well as at county levels.
- Capacity building of LMDC and LBNM is on track. All training institutions are now using the revised curricula and the pre-service education performance standards to improve the training of mid-level health care providers.
- Two major end-of-project evaluations were completed: The Capacity Building Evaluation and the PRISM Evaluation. Both of these indicate progress in their respective areas and provide guidance for the future.

RBHS played a key and unique role in its support to the MOHSW in the early stages of the Ebola epidemic. With USAID flexibility, RBHS was able to obtain approval to quickly redirect resources to Ebola related activities including the following:

- Along with CHAI support the set up and management of the first Ebola PPE and supplies warehouse
- Work along with WHO to develop initial training curriculum for IPC training for health workers and non health workers.
- Lead and coordinate the initial IPC trainings for health workers in non-ETU facilities
- Lead and coordinated the development of an IPC task force.
- Support community social mobilization at the national and county levels
- Provide coordination and leadership, M&E support and psychosocial engagement at the county level.
- Strategic support to contact tracing.

RBHS has continued to support the MOHSW in the Ebola epidemic with a major focus on the implementation of the comprehensive IPC package developed by the Task Force and the expansion of the Improvement Collaborative approach as a way to promote quality assurance in IPC at the hospital level.

The Ebola outbreak, especially the high number of health worker infections resulted in a drastic reduction in the availability of services. Health workers and clients stayed away from facilities due to fear of infection. Restoring basic services is a critical element of the Ebola response and a major

current focus of the MOHSW. IPC and the Improvement Collaborative approach are critical elements of this program. Improved IPC is the key to restoring confidence of both health workers and community members in the public health system.

At the same time, RBHS has begun to identify areas in which the Ebola response has strengthened capacity of the MOHSW at central and county levels. This information will inform the transition plan that is under development to ensure the smooth exit of RBHS from the MOHSW Ebola and restoration activities.