

LIBERIA REBUILDING BASIC HEALTH SERVICES (RBHS)

**Internal Project Assessment
May 16 – June 1, 2011**



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Acknowledgements

The consultants wish to acknowledge the support of all those who greatly contributed to making this assessment possible including the USAID Liberia Mission; staff of the MOHSW at the central and county levels; the staff of RBHS' PBC implementing NGO partners at the central and field offices; facility staff in the RBHS counties; other NGO stakeholders; and, members of the community who shared their insights and perspectives. This assessment would not have been possible without the tireless support and dedication of the RBHS staff.

This report is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of JSI and do not necessarily reflect the views of USAID or the United States government.

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Acronyms and Abbreviations

ACT	Artemisinin-based Combination Therapy
ANC	Ante-natal care
BCC	Behavior Change Communication
BPHS	Basic Package of Health Services
CCM	Community Case Management
CHC	Community Health Committee
CHDC	Community Health Development Committee
CHDD	County Health Division Director
CHEST	Community Health Education Skills Tool
CHSD	Community Health Services Division
CHO	County Health Officer
CHSS	Community Health Services Supervisor
CHT	County Health Team
CHV	Community Health Volunteer
CM	Certified mid-wife
CMO	Chief Medical Officer
DHIS	District Health Information System
DOTS	Directly observed therapy – short course
EHT	Environmental Health Technician
EmONC	Emergency obstetric and neonatal care
EPHS	Essential Package of Health Services
EPI	Expanded Program on Immunization
FHSD	Family Health Services Division
FP	Family Planning
gCHV	general Community Health Volunteer
GCM	Grand Cape Mount
HMIS	Health Management Information Systems
HP	Health Promotion
HPD	Health Promotion Division
i-CCM	integrated Community Case Management
IEC	Information Education & Communication
IMCI	Integrated Management of Childhood Illness
IPC	Inter-personal communications
IPT	Intermittent preventive treatment of malaria (in pregnancy)
IPT2	Intermittent preventive treatment of malaria 2 nd dose
IR	Intermediate Result
IRC	International Rescue Committee
ITN	Insecticide-treated net
JHU-CCP	Johns Hopkins University Center for Communication Programs
JSI	John Snow Research & Training, Inc.
MCHIP	Maternal Child Health Integrated Program
M&E	Monitoring and evaluation
MH	Mental health
MWFP	Market Women's Family Planning program

MOHSW	Ministry of Health & Social Welfare
MOU	Memorandum of Understanding
MTI	Medical Teams International
NACP	National AIDS Control Program
NGO	Non-Governmental Organizations
NLTCP	National Leprosy and Tuberculosis Control Program
NMCP	National Malaria Control Program
NTC	National Traditional Council
OIC	Officer-in-Charge
ORS	Oral rehydration salts
PBC	Performance-based contract
PBF	Performance-based financing
PMTCT	Prevention of mother-to-child transmission
PMU	Program Management Unit
PPAL	Planned Parenthood Association of Liberia
QA	Quality assurance
RBHS	Rebuilding Basic Health Services
RED	Reach Every District
STDs	Sexually transmitted diseases
STTA	Short-term Technical Assistance
TB	Tuberculosis
TOT	Training of trainers
TTM	Trained Traditional Midwife
UNFPA	United Nations Population Fund
UNICEF	United Nations Child Fund
USAID	United States Agency for International Development
WASH	Water, sanitation, and hygiene promotion
WHO	World Health Organization

I. Executive Summary

The Rebuilding Basic Health Services Project (RBHS) is the United States government's flagship health project in support of the Liberian Ministry of Health and Social Welfare's (MOHSW) National Health Policy and Plan. The Project is being implemented by John Snow Research & Training, Inc., (JSI) and its three sub-partners (Jhpiego, JHU-CCP, and Management Sciences for Health) from November 2008 to October 2013.

In spite of many post-conflict challenges, the Liberian MOHSW has demonstrated strong leadership and vision in recent years though acknowledging that it will remain dependent on the support of donors and partners throughout the long rebuilding process. The MOHSW has demonstrated some notable successes, yet numerous challenges still remain. As the flagship health project funded by USAID in Liberia, RBHS supports the ministry's efforts to rebuild the national health system and collaborates with it on activities that touch on almost all aspects of the health system.

The Project's implementation is guided by a three-pronged strategic approach:

1. Strengthening and extending **service delivery** through performance-based contracts to NGO partners at 112 health facilities in seven counties. [IR 1]
2. Strengthening Liberia's **health system** in the areas of human resource management, infrastructure, policy development, and monitoring and evaluation. [IR 2]
3. Preventing disease and promoting more healthful behaviors through **behavior change communication** and community mobilization. [IR1, 2, 3]

RBHS also provides technical guidance and leadership in maternal and child health, reproductive health/family planning, malaria, HIV, tuberculosis, water and sanitation.

As a management tool JSI has found the mid-term review beneficial to its projects (particularly those that are large and complex such as RBHS) for several reasons – the review enables the project team to take stock of its achievements, identify gaps, and consider recommendations for implementation going forward. The timing of RBHS' internal assessment is particularly crucial as the Project is in the process of undergoing a transition in its senior staff and a re-focusing of its technical scope.

This internal assessment was conducted from May 16th through June 1st and field work was carried out from May 19th through the 27th in Bong, Grand Cape Mount, and Nimba counties. These three counties represent 65% of all RBHS facilities and approximately 79% of its catchment population. Based on the Project's current scope and the emphasis on Performance Based Contracts (PBCs) and capacity building in the proposed Project redesign, the RBHS team identified four components for the internal assessment team to focus on: i) performance based contracting, ii) community health, iii) behavior change communications, and iv) capacity building. A fifth component, Pre-service, is being conducted separately in June.

The criteria for selecting the five components were three: i) each of these technical areas will be core to RBHS under the revised project description, ii) there is insufficient understanding of these areas to-date, and iii) the learning derived from the assessment would be of value to the RBHS team as well as for its partners, the (ministry and non-governmental organizations (NGOs). Each component team was led by a JSI consultant and comprised of RBHS staff as well as - when possible - staff of the MOHSW. The teams visited sixteen facilities and their catchment areas, and utilized a mix of methods to assess their components including review of Project and MOHSW documents; conduction of key informant interviews at the national and county levels; conduction of group discussions with various target populations; review of records; and, observations at health facilities and of health education sessions. The complete list of team members, facilities visited, and persons interviewed are attached in Appendices I-III, respectively.

This report provides a snapshot of the Project's performance in each of the four components. Highlights of the findings and recommendations are summarized below:

- 1) The performance based contracts managed by RBHS are central to the Project's first pillar, "strengthening and extending service delivery". This component is ultimately intended to assist the Liberian MOHSW in the implementation of the National Health Plan by: i) improving the provision, quality and efficiency of services contained in the Basic Package of Health Services (BPHS); and ii) building the capacity of the County Health Teams (CHTs). The five PBCs are implemented by four NGOs, i.e., Africare, Equip, International Rescue Committee (IRC), and Medical Teams International (MTI); one grant, issued to Merci, is managed exactly the same as the contracts but without the system of penalties and bonuses.

Data show that as a direct result of implementing the PBCs, access and quality of health services have improved markedly in the RBHS facilities – deliveries at facilities tripled, IPT2 doubled, and on-time payment of staff salaries stand at 100%; facility staff are motivated to work and are more accountable for demonstrating results; and facility linkages with the communities they serve have improved. However, the most unexpected finding mentioned consistently by all 5 NGOs is RBHS' contribution to building their capacity in data quality management through regular M&E feedback at monthly and quarterly meetings and to creating a learning environment that is data driven, fair and collegial.

Less progress has been made in building the PBC capacity at the central and county levels of the MOHSW. In part, this has been the result of a lack of leadership in managing the PBCs at the highest levels within the ministry, and insufficiently qualified staff at the county level. Moreover, RBHS' attention was focused on ensuring the contracts were being implemented satisfactorily and bonuses were paid against targeted results. In retrospect, it was unrealistic to expect NGOs to build CHT capacity in PBC given their own lack of capacity at the start.

Going forward, the ministry will assume responsibility for all PBCs, thus shifting RBHS' focus from the NGOs to supporting the MOHSW at the central and county

levels. Building upon the successes of RBHS's PBCs, the Project will recruit a PBF Advisor to work closely with the MOHSW's PBF Technical Team housed in the planned Program Management Unit (PMU).

Key recommendation: The assessment team recommends that the MOHSW consider co-locating its PBF Team Leader at RHBS for a short but intensive "apprenticeship" with clear deliverables. This will not only ensure that the ministry's leadership capacity in this area is built but that the full team responsible for moving the PBCs forward is developed, thus increasing the likelihood of sustainability long after the Project has ended. What this will require, however, is a strong up-front commitment by the MOHSW leadership to establish the PMU with the "right" staff, recruit a PBF Team Leader who is motivated to learn, able to supervise a team dedicated to implementing all aspects of the existing RBHS-run PBCs, ensure that the highest standards of professionalism are maintained in managing the PBCs including at the counties, and will remain on the job for at least 5 years.

- 2) RBHS' community health component falls under the "strengthening and extending service delivery" pillar of the project's activities and is implemented by its NGO partners under the PBC. Recognizing that communities form a central component of the health sector and that engaging them as full partners can improve both access to and quality of health care, each NGO developed its own approach based on prior experience and the needs of their communities. In addition to the community interventions undertaken as part of the PBCs, the NGOs also piloted an integrated community case management (i-CCM) program for diarrhea, malaria and pneumonia; a third program which sought to expand the availability of family planning methods and counseling in Monrovia was piloted and co-launched with United Nations Population Fund (UNFPA).

The NGOs have historically led all community-based interventions in Liberia. However, as the country implements its ten year health policy and plan for 2011-2016, the MOHSW is expected to play a more central role in guiding, coordinating and even implementing community activities. At this stage the MOHSW lacks an appropriate structure to coordinate and advocate for community health at all levels as well as strengthen facility-community linkages. This means that while there are community and Health Promotion (HP) focal points in vertical programs, they are not working together along with their NGO partners to create one harmonized community health approach.

The assessment team also found that while the i-CCM pilot is widely considered a success from the perspectives of the CHTs, health facility staff, community volunteers and community beneficiaries, part of the success is linked to the NGOs who provided extra support and created parallel systems to strengthen regular community supervision and circumvent the shortcomings of the existing supply chain systems. Thus, leaving unaddressed the need for a dedicated cadre of community volunteer supervisors and a reliable supply chain has important implications for scaling-up i-CCM. Also noteworthy is the selection criteria for general Community

Health Volunteers (gCHVs) which eliminates many dynamic community women who are important human resources in Liberia and are willing to volunteer to improve the health of their communities.

Key recommendations: In keeping with these key findings, the assessment team recommends that the ministry, supported by RBHS, plan a broad review of community pilot programs implemented in Liberia that includes representatives from all stakeholders including the MOHSW, United Nations Child Fund (UNICEF), World Health Organization (WHO), Global Fund, RBHS, NGOs, and CHTs. This is particularly important in light of the multiple pilot interventions that have taken place in Liberia supported by multiple donors. Incorporating best practices from this collective experience will not only be critical in drafting the national strategic plan but also in ensuring buy-in when the i-CCM program is scaled-up as well as in framing the structure of the program and the desired outcomes.

Moreover, it is highly recommended that phasing-in of the i-CCM program remains in step with the capacity to ensure program quality. This means that implementation plans must include dedicated supervision, reliable supply chain, clear selection criteria for community structures - the Community Health Committees (CHCs) and Community Health Development Committees (CHDCs) and Community Health Volunteers (CHVs), and strong community-facility linkages.

Finally, the MOHSW should create community health coordination structures at each level through which vertical programs and NGO partners can plan, coordinate, communicate and share on a regular basis. By leveraging community based funding available in the vertical programs to better support delivery of high impact community based interventions will not only spread incentives more evenly across the different cadres of volunteers, but more importantly, will ensure that improving the health of communities remains front and center. Specifically the vertical programs should be encouraged to develop common strategies for promoting healthy behaviors and mobilizing communities, as well as ensuring that the monetary resources (e.g., stipend for attending quarterly meetings) and non-monetary resources (e.g., bicycles) typically available through NACP, NMCP, NLTCP are pooled and distributed to CHVs. This leveraging of community level support will contribute to sustainable change in health behaviors among households and individuals while simultaneously ensuring closer ties between communities and facilities.

- 3) Behavior change communications, the Project's third pillar, contributes to all three intermediate results. Building on past Behavior Change Communication (BCC) programs in Liberia and supporting the MOHSW's National Health Communication Strategy, RBHS developed the Social and Behavior Change Strategy Framework. The framework employs a two-pronged approach:

- i) Integrated activities that address the wide spectrum of health topics in the BPHS;
- and ii) A series of campaigns that focus on 1-2 specific health issues that are

promoted at high intensity for limited duration. These two approaches are mutually re-enforcing and take place at community, county, and national levels. The BCC activities implemented by RBHS appear to be having the desired effect on creating awareness of messages for both bed net use and prevention of teen pregnancy (the slogan “baby by choice, not by chance”) as well as on the attitudes/behaviors of target audiences, particularly with regard to bed net use. However, despite having a strategy, the Project’s BCC activities have lacked sufficient focus and the campaigns have not been well coordinated with integrated interventions. Delays in production have further compounded the problem by pushing BCC efforts behind schedule by a year or even longer in some cases. Appointing a new health promotion director with experience at the MOHSW and who is keen to impact health outcomes through BCC is an important first step; yet the larger problem of frequently transferring good staff, not having a budget line item for health promotion, and an inadequate representation in the ministry’s policy and planning documents remain.

Key recommendation: The assessment team recommends that the highest leadership at the ministry must remain committed to not only supporting the recruitment and retention of committed staff at the Health Promotion Division (HPD) but also the BCC agenda itself. This means ensuring that the division’s capacity is staffed appropriately and for the long haul (as opposed to the current practice of frequent transfers) to enable them to assume full responsibility for developing the HP strategy and implementing plans; that a budget line item be created to take the work forward; and ensure that the role of health promotion is clearly and strongly articulated in the EPHS and MOHSW’s 10-year policy and planning document largely missing in the May 26, 2011 version. While the final version of the Plan document has been strengthened significantly, BCC is still not well incorporated into the various technical areas (e.g., communicable diseases).

Moreover, without a budget for HP and indicators that are linked to clear deliverables, it is no surprise that the weaknesses seen in this division stems from its lack of access to and control of financial resources; nor is it held directly responsible for outcomes. Donors, projects and NGOs have typically assumed responsibility for both to the detriment of the division.

RHBS can support this by mapping out, jointly with the HPD Director, a plan for how best to build the division capacity to better demonstrate value, effectively work with the HP focal persons of vertical programs to deliver on their indicators, and ensure that appropriate BCC indicators are crafted to measure short and long term impact of BCC interventions.

- 4) The capacity building component is central to the “health systems strengthening” pillar of RBHS’ deliverables. While pre-service (which is being assessed separately) constitutes a significant share of the deliverables, this report focuses on developing and strengthening support systems to build the capacity of the MOHSW at the central

and county levels and to facilitate for the national process of health systems decentralization.

RBHS' contributions at the central level of the ministry have been recognized at three essential levels: at the systems level through the development of policies and an HMIS, at the institutional level through the placement of staff in key positions and through training opportunities, and at the individual level through both in-country and international training opportunities. Moreover, RBHS' efforts in setting up and implementing PBCs have had a wide-reaching impact, though largely unintended, on building the capacity of the NGO partners. But having relied on the NGOs to take forward the capacity building of County Health Teams, the Project currently has no overall strategy for capacity building, and efforts have been reactive and piecemeal.

Key recommendations: The assessment team recommends developing a joint capacity building strategy under the guidance of an RBHS-appointed Capacity Building Advisor and a PBF Advisor who would work closely with the MOHSW at the central and county levels to implement the strategy. Equally, if not more important, the MOHSW needs to appoint motivated leaders in each of the critical technical areas to take the work forward and hold staff accountable for performance against clear deliverables.

In conclusion, although the team was in country for a short time, the range and scope of the secondary data review as well as primary data collection through group and individual interviews was extensive. This enabled the teams to cross-check information and to gain broad perspective on the project, its partners, and the impact that they have jointly had – in this short period - on the systems as well as health outcomes of Liberian families and communities.

The report is structured such that the discussion of each component stands alone; below is a brief outline of the key findings and recommendations:

II. Performance Based Contracting

i. Background

The Performance Based Contracts managed by RBHS are central to the Project’s first pillar, “strengthening and extending service delivery”. This component is ultimately intended to assist the Liberian MOHSW in the implementation of the National Health Plan by: i) improving the provision, quality and efficiency of services contained in the BPHS at facility and community levels; and ii) building the capacity of the CHTs. Funding is tied to the achievement of targets on 17 pre-determined and agreed upon performance indicators; penalties of up to 5% of the quarterly payment are levied for not meeting administrative targets, and a bonus of up to 6% of the total contract amount is given for meeting or achieving service-delivery targets. To function efficiently and effectively, the PBC system relies heavily on rigorous, independent quarterly data validation and communication between the fund-holder (the RBHS project) and the contracted parties (the NGOs).

The five RBHS-supported PBCs and one grant (managed exactly the same as the contracts but without the system of penalties and bonuses) began July 2009 in seven counties and has supported 112 facilities. Over the next 6-12 months the management of the USAID/RBHS PBCs will be transitioned over to the MOHSW to be funded either through the Pool Fund or through USAID, as outlined in the table below.

Transition plan for USAID-supported PBCs/grant

COUNTY	CURRENT PARTNER	START DATE: NEW PBC	DONOR: NEW PBC
Lofa	IRC	Jan 1, 2012	USAID/MOHSW
River Gee	MERCI*	Jan 1, 2012	Pool Fund/MOHSW
Bong	Africare	July 1, 2012	USAID/MOHSW
Nimba	EQUIP	July 1, 2012	USAID/MOHSW
Nimba	IRC	July 1, 2012	USAID/MOHSW
Grand Cape Mount	MTI	July 1, 2012	Pool Fund/MOHSW
Montserrado	MTI	July 1, 2012	USAID/MOHSW
Montserrado	IRC	July 1, 2012	USAID/MOHSW

*Grant

After July 1, 2012, RBHS’s PBC work will focus on central MOHSW capacity building (e.g., harmonizing PBC activities between the two donors, assisting the MOHSW with a national PBC scale up plan) and county-level MOHSW capacity building specifically for those CHTs in counties that continue to be supported by USAID, i.e., Lofa, Bong and Nimba.

ii. Objectives

While the process that led to the establishment of the contracts is well documented,¹ as are the quantitative results of the PBCs, less well documented is the *effectiveness* of the PBCs and how well RBHS has *managed* these contracts. The assessment specifically focused on RBHS' communication and relationship with the contracting NGOs, procedures for resolving indicator ambiguities and mitigating circumstances, procedures for data validation, effectiveness of certain indicators, and the extent to which RBHS has dealt with ongoing issues such as the distribution of performance bonuses.

iii. Approach

The PBC assessment team was led by Deirdre Rogers, JSI M&E Advisor and comprised of Bal Ram Bhui, the in-coming RBHS Monitoring & Evaluation (M&E) Director and Dominic Togba, the MOHSW's PBF focal point person. To meet the PBC assessment objectives, the following activities were undertaken:

- Off-site: Participated in the team planning meeting; reviewed RBHS documents on PBCs including the NGO monthly and quarterly data reports, meeting minutes from quarterly NGO M&E review meetings, NGO performance distribution documentation, original PBC request for proposals, list of RBHS indicators and specific PBC indicators; RBHS' 2009 and 2010 Annual and Semi-Annual Reports; RBHS' draft Revised Project Activities for 2011-2013; RBHS' Year 3 work plan; and, the complete list of RBHS' trainings.
- In Monrovia: Reviewed the recently completed consultant trip report and documents related to the proposed MOHSW PBC plans (e.g., the World Bank review of PBF in Liberia comparing the RBHS PBCs with the MOHSW Bomi PBC model); documents provided by the MOHSW on their plans for PBC including presentations on Family Planning (FP) regulations as it impacts PBCs, quality, regulations, PBC purchasing function, and setting national service delivery targets; the pool fund budget and payment plans related to PBCs planned under the pool fund (e.g., in Bomi county); documentation on the PBC workshop held by the MOHSW in early May 2011; and, the MOHSW draft PBC Operational Manual.
- Jointly with RBHS' M&E team: Developed and refined the interview protocols for meetings with the NGO central management staff, NGO field staff, MOHSW CHT staff, and MOHSW central staff. Questions included the appropriateness of indicators; the process for negotiating targets; timeliness of quarterly pay and incentives/bonuses; the working relationship between the NGO and the CHT counterpart; the relationship between the NGO and the health facilities; the impact of implementing PBCs on: NGO and CHT staff capacity; quality of services provided; health access and the use of services; innovations; staff

¹ Vergeer, Petra; Rogers, Deirdre; Brennan, Richard J; Sarcar, Shiril. (June 2010). "Identifying Indicators for Performance-Based Contracting (PBC) is Key: The Case of Liberia". World Bank.

motivation; the accreditation process and outcomes; community involvement; drug management systems; staff accountability; and, the data validation process and its contribution to an enhanced M&E system. See Annex IV.

- Jointly with the PBC assessment team: Interviewed 52 individuals either in groups or individually from the 4 contracted NGOs at the central and field levels, staff of the one NGO grantee at the central level, the MOHSW at the central level, members of the Nimba CHT, and two RBHS County Coordinators.
- Jointly with the Internal Assessment Team: Presented and participated in debriefings to the RBHS Chief of Party and M&E Director, USAID/Liberia health team, the MOHSW, and RBHS staff.

“RBHS is not simply a project, but a learning environment.”
- NGO Manager

iv. Key Findings: Successes & Challenges

Overall, NGO staff at the central and field levels found PBC a “successful and manageable model”, and were “satisfied with RBHS’s management” of the contracts and “provision of technical assistance and capacity building”. This was especially true in the area of M&E as it encouraged evidence-based decision making at all levels of the NGO. The assessment also found an impressive level of agreement on how successful the PBCs have been in motivating staff; building capacity of the NGOs at the central, field and facility levels in the areas of organizational management and the management of M&E systems; increasing staff’s sense of accountability; creating a “data culture” within the organizations; and, improving health outcomes. Also, there was near unanimous sentiment that “tough, consistent and impartial feedback” and analyses from RBHS was a significant factor that led to improved NGO capacity.

PBC data: Q1 to Q7

**Facility deliveries tripled from 19% - 58%.*

**IPT2 doubled from 46% - 103%.*

**100% of facility staff paid on time, up from 64%.*

Access, use and quality of services improved

Quantitative data from the first 7 quarters of implementing the PBCs has been extensively documented elsewhere and thus not included in this report. In general, however, after undergoing extensive validation for reliability and validity, data generated by the NGOs have demonstrated improvements in almost all areas measured. The extensive RBHS data validation system was routinely noted by NGO staff as being “painful and time consuming”, but at the same time was acknowledged as “a key, critical component” to the success of the PBCs. Furthermore, awareness of these improvements is universal at all levels of NGO staff who noted that not only has the quality of data improved but the quality of services is better in the PBC versus the non-PBC facilities.

Those NGOs that had both RBHS and Pool Fund PBCs (implemented through the MOHSW) noted that the “quality of data and services was better” in the RBHS-funded facilities; the Nimba CHT also noted that data quality was better in the RBHS facilities than non-RBHS facilities.

Overall, there was wide acknowledgement by NGOs and the CHT that as a result of the RBHS PBCs the “provision, quality and use of services have improved” over the life of the contracts as well as “expanded the capacity” of the NGOs to provide the full range of services in the BPHS.

*“[RBHS] completely changed how we manage and do M&E from the NGO to the facility level.”
- NGO Manager*

Though not always happy with the sheer number of indicators that NGOs are required to report on (70 in total of which 17 are tied to funding/incentives as part of the PBCs), NGO staff generally felt that the “indicators directly reflected” the needs of the communities and that the “quarterly penalty and bonus system was highly effective” at increasing staff motivation, improving quality, and resulting in better health outcomes.

Staff motivation improved

The NGO central and field staff mentioned that financial and non-financial incentives were both equally important motivators. The incentives most often cited were:

- Salaries paid on time made it worthwhile for health facility and NGO field staff to come in to work every day.
- Quarterly bonuses were seen as recognition of their work by health facility, NGO field staff and CHT staff.
- Monthly meetings held by RBHS with each NGO to review data and progress in meeting targets were valued by NGO staff at the central and field levels as it built capacity.
- Joint quarterly data review meetings held with all NGOs, MOHSW, and USAID motivated the NGO central team to showcase their achievements.
- Peer pressure to perform and not be seen as the reason why the team received a smaller bonus in a quarter was mentioned by NGO field and central staff as being a powerful motivator at the facility and field levels.

Reflecting on the effectiveness of the joint review meetings, an NGO manager said, “Having USAID in the room really puts the sting in it!”

Innovations promoted

By not being prescriptive but rather focusing on outcomes (i.e., “we don’t care how you do it, as long as you meet targets for specified indicators”), PBCs often foster innovations at the program level. The NGO staff interviewed generally felt that the RBHS contracts had in fact resulted in new and innovative approaches:

- Sharing best practices among staff to encourage improved performance of the team as a whole.
- Encouraging facility-based deliveries by distributing *Mama Kits* to new mothers.
- Providing educational kits to Trained Traditional Midwives (TTMs) to facilitate outreach to pregnant women, thus increasing facility-based deliveries.

- Encouraging TTMs to meet amongst themselves regularly to coordinate activities and review situation in their communities, and also to visit the facilities to which they are attached.
- Developing and disseminating an Indicator Guide so that each facility and its staff understand how their work impacts the outcomes sought under the PBC, and fosters great accountability.
- Increasing immunization coverage by conducting immunization days in the market place.
- Sharing cash bonuses with gCHVs to promote health prevention interventions and mobilize communities.
- Encouraging evidence-based decision making by discussing data at CHDC meetings which was not previously a routine practice.
- Providing a radio and mobile phone service at three facilities to improve community level access and use of emergency/ambulance services.
- Ensuring drugs and other supplies are delivered at night to minimize stock-outs at facilities.

In spite of these successes in the management and implementation of the PBCs through the NGOs, a few critical challenges have been identified that speak to issues of sustainability as well as the MOHSW's capacity to assume responsibility for PBCs over the next 6-12 months.

NGO ability to effectively allocate bonuses

Though the flexibility given to the NGOs in implementing the PBCs had real merit, particularly in the early phase of implementation, in retrospect NGOs could have benefited from more guidance by RBHS to ensure greater consistency across the organizations, e.g., on who to target for bonuses, how to apportion the bonus among different groups. Over the two years, RBHS has started increasing its guidance to NGOs in these areas.

CHT and NGO communications weak

NGOs were contracted to build the capacity of CHTs. By including a performance indicator (with a bonus for the CHT) that requires supportive supervision of facilities jointly by NGO/CHT, the NGOs and Nimba CHT agreed that joint supervision visits have increased. However, what remains unclear is the extent to which these visits have actually built CHT capacity in providing and/or sustaining supportive supervision beyond the life of RBHS.

Although joint planning was strongly encouraged by RBHS in Year 1 of the PBC implementation, and was a focus of the Post-Award Workshop, this is an area that remains a disappointment. NGOs did not develop their annual workplans and proposals for Years 2 & 3 jointly with the CHTs. In retrospect, RBHS could have provided specific guidance on joint planning and what it entails rather than merely encouraging it to happen.

In general the relationship between the NGOs and CHTs is not always clear in terms of expectations, roles and responsibilities, and lines of communication. This was most notable in the area of procurement of commodities through vertical programs. NGOs are reluctant to have performance indicators tied to funding for commodities that are outside their control as there is a perception that distribution of commodities by the CHTs is not always equitable and based on need. On the other hand, CHTs blame the NGOs for delaying submission of paperwork to ensure timely and appropriate delivery of commodities. RBHS's own assessment of the supply chain reveals problems at every link, including quantification at the facility level. NGO partners have also been slow to follow-up on identified problems and to recommend corrective actions.

Data validation procedures time consuming and inconsistent

To meet RBHS's requirement for rigorous quarterly data validation, each NGO manages its monthly data validation process. This was routinely noted as being time consuming, resource intensive and "painful". Every month, NGO M&E staff visit each facility, compile and collect the DHIS data reports and then forward the reports to the CHT (facility staff are not responsible for submitting their own data). While this ensures that data are received by the CHT in a timely manner, it places a large burden on staff to validate data prior to submission. Consequently, data are submitted to CHTs without thorough validation. NGO staff then returns to each facility to complete data validation of the 17 performance indicators prior to submitting the report to RBHS. This sometimes results in a discrepancy between the data submitted to the MOHSW's Health Management Information Systems (HMIS) through the CHT and the data subsequently validated and submitted to RBHS. Such discrepancies caught by RBHS as part of the quarterly data validation process cause the NGOs some distress, especially when it results in a penalty or being awarded less than the full bonus. NGOs reported that at times they had to put a hold on other planned activities in order to respond to RBHS and validating differences. This involves visiting and checking the entire service records data.

Despite the clear challenge that RBHS' PBC data validation process poses to NGOs, the general consensus was that though the process is incredibly time consuming, the very effectiveness of the PBCs hinges on valid and reliable data to support decision-making (including payments and bonuses). The NGOs underscored the importance of maintaining the data validation process and ensuring that when the contracts are managed by the MOHSW, the validation be external to the local CHT to ensure impartiality and reduce perceived conflict of interest.

MOHSW capacity to manage PBCs limited

A concern expressed repeatedly to the assessment team was "the uncertainty in the MOHSW's ability to technically and managerially take over the management of PBCs" as the work transitions from RBHS to MOHSW. The assessment found little evidence that the MOHSW's capacity to implement or manage PBCs had been built by RBHS (either by the NGOs or by the RBHS staff). This holds for both the central MOHSW and the CHTs. In large part this was due to RBHS' focus on the NGOs – who themselves had limited capacity in 2009 – to ensure that the required building blocks for a sound PBC system was put in place. This entailed strengthening the NGOs' M&E and data

management capabilities to provide the full basic package of health services. Consequently, while short term technical assistance (STTA) support was provided to the MOHSW at the national and county levels, relatively less emphasis was placed on building their capacity. In all fairness, until the time of this report there are insufficient numbers of qualified MOHSW staff at the national and CHT levels to implement and manage PBCs. Finally, the CHT staff has not been involved in NGO data quality assurance activities nor in RBHS quarterly data validation meetings, and thus their capacity to be involved or oversee similar validation efforts in the future has yet to be enhanced. These gaps and challenges are in the process of being addressed by the MOHSW and RBHS (e.g., through the development of a PBC Operational Manual; establishment of a PMU, a central level management structure within which a permanent PBF Technical Team will be housed; and, RBHS' focus on developing MOHSW capacity at the central and county levels under the Project's revised mandate).

v. Recommendations

The recommendations are intended to inform RBHS' strategy (for the remaining half of the Project) so that it can build upon its successes in managing the PBCs to date as these NGO contracts extend over the next 12 months; facilitate a smooth transition of the remaining PBCs to the MOHSW; and, build the MOHSW's capacity in PBC management at the central and county levels. The recommendations are grouped according to those aimed at the MOHSW and those aimed at RBHS.

For MOHSW

Finalize the PBC Operational Manual

- Ensure the PBC Operational Manual clearly delineates:
 - Staff roles & responsibilities at central level that includes the establishment of the PBF Technical Team
 - Staff roles and responsibilities at the county level that includes the appointment of a PBC focal person in each county
 - Appointment of a PBF Steering Committee with clear terms of reference and includes representatives from USAID, RBHS (until project ends), senior level CHT representatives, and MOHSW representatives from the Health Services, Health Financing, and Health Planning departments, as well as the External Aid Coordination Unit.
 - The proposed contracting mechanism.
 - Detailed description of the performance indicators, process for calculating the bonus, and payment terms.
 - Process for issuing the RFP, proposal review process, composition of the selection committee, and the review process.
 - Detail list of tools including for tracking indicators and progress toward targets; calculating bonus/payments; management dashboard tool; data validation processes; any other PBC templates and processes (e.g., balanced scorecard).

- Harmonize all aspects of the new USAID/MOHSW and Pool Fund/MOHSW PBCs.

- Widely distribute the PBC Operational Manual to MOHSW central and county staff, Liberian and international health NGOs operating in Liberia, donors and other identified stakeholders, and ensure appropriate orientation and training is undertaken.

Establish the PBF Technical Team

- Fast-track the establishment of a strong, effective and dedicated Performance-based financing (PBF) Technical Team that is well-resourced (in terms of staffing and budget) to manage the MOHSW's PBC activities including target setting, monitoring and validating data, providing regular feedback to NGOs. The PBF Technical Team should consist of, at a minimum: one senior-level overall manager/Technical Team Leader at the central level, one full-time M&E staff, one county level PBC focal person in each contracted county to oversee PBC data validation efforts who would report to the PBF Technical Team Leader.

Develop capacity building and mentoring plan for PBF focal point, M&E staff

- Ensure key central level MOHSW staff is initially working closely with the RBHS PBF Advisor and that the PBF focal point is *co-located in the RBHS project offices*. The mentoring plan should be structured for a 3-4 month period and linked to clear deliverables to ensure that the MOHSW technical focal point and her staff are tasked with implementing all aspects of the existing contracts and achieve mastery over key components. These components would include negotiating indicators and targets, validating data, conducting *ad hoc* analysis, leading monthly and quarterly joint meetings, calculating penalties and bonuses, making timely payments to contractors, and working with the External Aid Coordination Unit as they develop terms of reference for the contracts, etc.
- Help the PBF team to develop and institutionalize communication feedback loops with partners, for example, through monthly partner meetings, quarterly data reviews, quarterly partner feedback sessions, proposal feedback, and regular M&E feedback.
- The mentoring plan would also include overseeing the PBF focal persons at the counties with coaching from the RBHS PBF Advisor. It is only when the central and CHT staff are comfortable with the existing proven model will they be sufficiently capable of making changes to the model (as required) in the next round of contracts.

Develop capacity building and mentoring plan for county level PBF focal persons

The county-based dedicated PBF staff will work closely with the RBHS County Coordinators to conduct quarterly data validation and facility visits. It is suggested that the existing CHT M&E staff not be assigned this responsibility since the time commitment will be significant (at least 50% time each quarter) and it is preferable that CHT staff are not the ones validating their own data which could result in a real or

perceived conflict of interest. If, however, the MOHSW decides to use existing CHT staff to carry out data validation, it will be *essential* that a supplemental “objective” validation take place external to the county contracts on an annual or semi-annual basis.

Conduct population level verification

Implement counter-verification (verification at the household and community level) to ensure that the data recorded at health facilities is accurate and valid. With the assistance of the RBHS M&E team, a county level rapid household level health service coverage survey could be piloted as early as January 2012. This would allow several months of joint RBHS-MOHSW capacity building in designing and conducting such a survey. Based on the findings, counties could be ranked on a performance scale, providing a firm basis on which to provide additional incentives to the best performing counties.

For RBHS

Appoint a PBF Advisor to build MOHSW capacity in managing PBCs

- Hire a full-time PBF Advisor to work closely with the MOHSW staff who are seconded to RBHS, to oversee and directly provide technical assistance to the MOHSW at the central level, and to sit on the newly established MOHSW Steering Committee throughout the remaining life of the RBHS project.
- Jointly with MOHSW, develop a detailed capacity building and mentoring plan for the central and county level PBF team with clear activities, including timelines and responsibilities.

Hold PBC implementing partners accountable for CHT capacity building

- Ensure that each NGO is tasked with building the capacity/providing technical support to the CHT to help build/establish/maintain a solid working relationship. Each NGO should have a clear mandate to help build capacity beyond the joint supportive supervision indicators. Develop an MOU between the NGO and CHT to clarify expectations and lay out the terms of their communication. RBHS should provide clear guidelines on how to go about joint planning to encourage effective processes take place.

Improve data management capacity of health facilities

- Work with contracted NGOs to improve data management and capacity of health facility staff in quality assurance, and build capacity and expectation that health facilities report HMIS data directly to the CHT each month rather than relying on the NGOs as intermediaries.

Implement all tools on current RBHS PBCs prior to be transitioned to MOHSW

- A number of tools are being developed by RBHS for the MOHSW that are not currently being implemented by RBHS on the current PBCs. All tools should be developed and implemented over the next 13 months of contracts being managed

by RBHS so that RBHS can ensure capacity is built and that kinks are worked out prior to handing over the tools to the MOHSW. These tools include:

- Tool for tracking indicators and progress toward targets
- Calculation of bonus/payment
- Management dashboard tool
- Data validation processes
- Any other PBC templates and processes (balanced scorecard, etc.).

Increase measurement of quality of care

- Consider conducting patient exit interviews and/or a mystery patient approach to better assess changes in quality of care over time.

“It’s difficult to define a ‘volunteer’ program as each vertical program and/or donor has their own idea and supports their volunteers differently – the programs are not harmonized”.

Conduct comparative study of effectiveness of PBCs

- Funds permitting, conduct an evaluation of PBC and non-PBC health facilities to more rigorously examine the impact of PBCs on access and quality of services.

III. Community Health

i. Background

RBHS’ community health component falls under the “strengthening and extending service delivery” pillar of the project’s activities and is implemented by its NGO partners under the PBC. Recognizing that communities form a central component of the health sector and that engaging them as full partners can improve both access to and quality of health care, each NGO developed its own approach based on prior experience and the needs of their communities. However, there has been limited coordination or consistency among the NGOs and the different activities. This has been compounded by the fact that RBHS could not learn from the numerous community interventions designed and implemented in Liberia on a pilot basis by vertical programs as well as by NGOs and faith-based organizations (FBOs) as there have been few attempts to understand their impact and systematically apply the lessons learned from these experiments, e.g., the malaria CCM program undertaken by Mentor in Grand Cape Mount (GCM), the diarrhea CCM program supported by CCF in Lofa. Thus, much of RBHS’ work in communities has attempted to link in with its BCC interventions through collaboration with the MOHSW to improve and expand the quality of services by informing and mobilizing communities. The Project has also engaged communities in relevant aspects of health systems management and introduced the delivery of high impact, evidence-based interventions at the community level, consistent with the ministry’s Community Health Strategy.

Building on the 2006 pilot community case management of diarrhea introduced in Liberia, RBHS organized a week-long field trip to Sierra Leone in 2010 that included representatives of the Community Health Services Division (CHSD), NMCP and

implementing partners to consider the introduction of an integrated approach to community case management. This spurred important policy discussions and resulted in the introduction of integrated CCM (i-CCM) for malaria, diarrhea, and pneumonia through pilot projects across selected RBHS districts with the view to its eventual scale up. Also on a pilot basis, RBHS co-launched the Market Women’s Family Planning (MWFP) program with UNFPA to expand the availability of family planning methods and counseling in Monrovia. However, unlike previous pilots, RBHS has ensured that the NGOs document results to be shared broadly prior to scale up.

In summary, the community health component of the internal assessment addressed three community-based health initiatives undertaken by RBHS. Neither the community-based distribution of FP nor the directly observed therapy – short course (DOTS) for the TB initiative was included in this assessment; the latter is slated for review by the JSI TB consultant in June.

- Non-integrated CCM which included grants to its 5 NGO partners to create and/or strengthen community health committees (CHC) and community health development committees (CHDC); train 800 general community health volunteers (gCHV) in diarrhea management and nutrition; train approximately 600 traditional midwives (TTMs) in identification of high risk pregnancies; make referrals; provide counseling to pregnant/new mothers on birth preparedness and FP; and, reinforce health facility staff in supervising these volunteers.
- Integrated CCM pilot that was introduced in a subset of the RBHS districts, specifically 83 catchment communities of seven districts in three counties through one NGO working in each county.
- MWFP pilot program in eight Monrovia markets in collaboration with UNFPA.

ii. Objectives

Of the three community initiatives, there is considerable interest by the MOHSW, USAID, RBHS, and partner NGOs in the i-CCM pilot program. It is anticipated that funding will be made available through the NMCP malaria plan from USAID and GFATM for scale-up in non-RBHS supported counties once the lessons from the pilot are consolidated and shared. Due to this urgency in planning the scale-up, the community assessment team paid close attention to the pilot i-CCM with a view to capturing some of the lessons learned. The assessment also addressed the differences (if any) between the i-CCM and non-integrated CCM communities, the challenges to implementing i-CCM, whether and how the program should be scaled-up, and the lessons learned from implementing the MWFP pilot (which was still ongoing at the time of the assessment).

iii. Approach

The Community Health assessment team was led by Mary Carnell, JSI Senior Child Health Advisor and was composed of Catherine Gbozee, RBHS’ BPHS Advisor and several staff from the MOHSW and NGO partners: Asatu Dono, NMCP; Daniel Wessih,

CHSD; Joseph Tubman, Breastfeeding Advocacy Group; James Kollie, Africare; Melepalay Sumo, gCHV Supervisor Bong CHT; Gorma Cole, RH Supervisor Bong CHT; Joseph Kilikpo, Equip; and, Joseph Barkolleh, IRC. To meet the assessment objectives, the following activities were undertaken:

- Off-site: Participated in the team planning meeting; reviewed RBHS project report and documents and MOHSW National Strategy and Policy for Community Health Services 2008; identified moderator's guides for group interviews from USAID/MCHIP project for translation into English.
- In Monrovia: Reviewed additional RBHS and MOHSW documents; tailored 7 moderator's guides to Liberia context for group interviews; developed additional interview protocols for meetings with vertical programs; finalized list of interviews and travel schedule.
- Jointly with the Community Health assessment team: Refined and finalized protocols; interviewed over 200 individuals either in groups or individually from central level MOHSW, three vertical programs, two CHTs, Global Fund, MOH consultants, three contracted NGOs, PPAL headquarters and field, BRAC, four health facility teams, four CHDC/CHCs, gCHVs, TTMs, and beneficiaries.
- Jointly with the Internal Assessment Team: Presented and participated in debriefings to the RBHS Chief of Party, USAID/Liberia health team, the MOHSW, and RBHS staff.

iv. Key Findings: Successes & Challenges

Below is a general discussion of the environment in which community programs are being implemented in Liberia, followed by specific aspects of the three RBHS interventions.

General discussion of community approaches in Liberia

Policy framework for community health lacks consistency Liberia is actively working on many health policy fronts. Relevant to community health, the MOHSW, with input from partners, is updating the October 2008 *National Policy and Strategy on Community Health Services*. A consensus workshop to validate the final draft of the *National Health and Social Welfare Ten Year Policy and Plan* was held the last day of the assessment. The assessment team noted some gaps and inconsistencies regarding community health across the various documents.

While it is widely acknowledged that a large portion of the Liberian population has limited access to health facilities and that community-based approaches hold the potential to bring high impact interventions close to where people live and significantly impact health outcomes, the importance of their active engagement to attain critical health objectives - first for their families and then for the community at-large - does not clearly stand out in the current documents. The final versions of both documents are stronger on community health but still does not position community health central to the health outcomes sought by the MOHSW. Moreover, in the versions reviewed by the assessment team, volunteer cadres proliferate, the titles of these various cadres are not consistent across documents and their roles and responsibilities are sometimes inconsistent between documents including the EPHS. Most of these problems have been resolved in the subsequent drafts; however, it is important that this streamlining of cadres is clearly communicated at the county, facility and community levels so that everyone knows how the cadres that have been eliminated fit (or do not fit) under the new structure.

Finally, based on global experience, the success of integrated CCM depends largely on an uninterrupted supply chain and regular supervision by a dedicated supervisor who has transport. Yet, the policy and planning documents do not agree on who is best positioned among the available cadres to supervise community volunteers and is inconsistent with the recommendation in the EPHS. Scant mention is also made in all national documents on the importance and mechanism for strengthening the supply chain to ensure communities receive drugs/supplies.

Community strategies need to be holistic

At the end of the assessment, the team learned of an early draft of the *National Strategic Plan to scale up Community-Based Interventions for disease control in Liberia 2011 – 2015*. This early draft combines both preventive and curative community health services. It highlights the need to keep health prevention and promotion activities on equal

“Many believe that gCHVs are being paid by the ministry or partner organizations so that they don’t require payment from the community. It is difficult for community leaders to accept that gCHVs are not being paid when they are given uniforms and bags, go to trainings and meetings, and receive monies from the various vertical programs”.

standing with curative interventions. Curative services can easily dominate both from the community demand-side and from the health services supply-side. The community curative demand for services close to their homes is being partially met by integrated CCM in pilot areas and this community interest can be leveraged to enhance preventive activities. Each diarrhea, malaria and pneumonia case is an opportunity to counsel parents on the preventive actions they need to undertake. An illness episode is an excellent opportunity to negotiate for healthy actions in terms of hygiene, nutrition, use of ITNs, among others, when parents’ attention is acutely focused

on helping their sick child get better and stay healthy. This draft requires considerable effort to finalize so that it links preventive, curative and BCC components through communities and facilities, and envisions the management of the community health component at the national, county and facility levels. The lessons and recommendations

of the RBHS i-CCM and other pilot programs (e.g., the Child Fund pilot in Lofa) need to be reviewed by the MOHSW as well as by a broad cross-section of implementing partners to ensure that best practices are incorporated into this draft national strategic plan.

MOHSW structure lacks coordination and advocacy for community health

Since an organization's structure should typically follow its strategy, the lack of a clear policy and strategy document on community health has inevitably resulted in a compromised structure at the central and county levels. Moreover, the ministry has not yet identified a coordinating body that could oversee the planning, implementation, monitoring and evaluation of the various community-based efforts and serve as crucial advocates.

At the central level there is currently no mechanism in place to plan, coordinate and communicate regarding community interventions among the various vertical programs. Each vertical program has a community focal point at the national level and multi-lateral agencies, bilateral agencies and international NGO partners implementing community based health interventions do so directly with individual vertical programs. The CHSD, which is technically responsible for this component, has few staff and does not have the authority or mandate to coordinate community health interventions across the vertical programs.

At the county level the vertical program managers all have a keen interest in community mobilization and outreach as they are quite aware of the contribution of these efforts in attaining their coverage targets. For example, the EPI program relies heavily on reaching its target population through outreach efforts. However, the CHT has only one position for community health, the CHV Supervisor. Nevertheless, monthly meetings are held at the counties to coordinate the vertical programs including community health activities; plans are afoot to include District Health Officers and NGO partners. In one county the CHT and NGO partners established an additional coordination meeting to discuss community health interventions, challenges and the way forward. However, at the time of the assessment team's visit it was reported that these meetings were dormant due to other competing priorities.

Facility-Community linkages need strengthening

Without a clearly articulated relationship between the facilities and communities it is not surprising that coordination between the two is reliant on the interests and motivation of the Officer in Charge (OIC) and facility team, as well as the NGO staff where applicable. Currently, vaccinators attached to health facilities are the most familiar with communities as their responsibilities include regular immunization outreach sessions. However, vaccinators often lack the stature to dialogue with community leaders and negotiate with them on matters such as respecting the community's commitment to supporting the CHVs.

Vaccinators are also hampered in their ability to carry out their normal outreach duties due to demand for their services at the facility. When a second vaccinator is hired to even

out the work load between facilities and communities, the assessment team did not find an increase in the number of outreach sessions conducted (which remains at 3-4 per month). To reach its catchment population, one facility identified 17 outreach sites. At the rate of one session per week it takes this facility four months to complete a cycle. This schedule is not consistent with the EPI Reach Every District (RED) Approach. The lack of transportation remains a major constraint and the primary reason for insufficient community outreach. If there is a motorcycle at all, only one is assigned to a facility. Although intended for outreach work, the motorcycle is also used by the OIC to attend meetings and workshops at the county headquarters or to make his/her own supervisory visits to communities thus limiting the days available for scheduling community visits. It is also not unusual for motorcycles to be broken and rendered unusable (the motorcycle was broken in one of four sites visited by the assessment team).

Entry into communities requires careful consideration

According to the October 2008 *National Strategy and Policy for Community Health Services*, the CHC and CHDC structures are the entry point for mobilizing communities for health. Typically five individuals drawn from a community form the membership in a CHC. In turn, each CHC selects one member to represent them in the CHDC; each CHDC represents the entire catchment area of one health facility. The process of forming these structures was initiated by the CHTs with support from the OIC and NGO partners; orientation workshops for CHC/CHDC were organized in some communities.

The assessment team noted wide variation in the effectiveness of the entry process into the community. It generally appears that the traditional, political and administrative leadership in communities were not adequately sensitized on the important role community health plays in saving lives, saving money and developing their community. Moreover, these leaders were not sufficiently involved in selecting the CHC and CHDC members, and nor were they briefed on their proposed roles and responsibilities and the roles and responsibilities of the gCHVs and other health volunteer cadres. This, in large part, is because the CHSD never finalized and endorsed the Operational Guidelines for the CHDCs and CHCs, and the MOHSW has still not endorsed formal roles and responsibilities for these bodies.

The “hit or miss” aspect of working with existing community structures (resulting in lack of planning and ensuring that the “right” persons are selected to attend workshops) is captured in the story of one CHDC member (a teacher) who attended the initial orientation because no one else from his town was present; working backwards, he was then asked to suggest five ‘volunteers’ from his community to form the CHC. Other concerns were also raised about how well members of the CHDC and CHC understand their role, how engaged they are and what their contributions are to their communities.

Members of the CHC/CHDC also believe that they do not have sufficient status to hold their communities accountable for supporting community health volunteers as originally envisioned. In part this is because they are themselves not convinced that the gCHVs are “true” volunteers. Members noted that gCHVs wear MOHSW vests, carry MOHSW

backpacks, and are compensated during initiatives such as the national polio campaign (each gCHV receives USD 5 per day for five days) and for attending the quarterly DOTS meetings (each trained gCHV receives USD 15 as travel allowance). Given this appearance that gCHVs are supported by MOHSW and/or NGOs, CHC members have been reluctant to pressure the community to provide additional support to the gCHVs.

“People don’t trust anyone easily anymore. It is not uncommon for women to think that the only reason they are being told by the TTM to go to the facility for delivery is so that they can claim a lappa”.

Given that in this assessment only four CHCs/CHDCs were interviewed, a wider sampling of communities is required before generalizing conclusions.

Community support to volunteers raises some questions

For purposes of this assessment the discussion will focus only on gCHVs and Trained Traditional Midwives (TTMs) and not any of the other volunteer cadres referenced in the various policy and strategy documents. Across the four communities visited by the assessment team, gCHVs were either appointed or elected by their communities; literacy and grade six schooling are pre-requisites for being selected as a gCHV. The TTMs are generally not literate, inheriting their role from a mother or aunt first through apprenticeships as young girls, and then through more formal training of variable duration and content to become a TTM.

Although gCHVs, in particular, were initially proud to serve their community, many are quite discouraged by the lack of community support. This is particularly true for the gCHVs in communities that had promised at the outset, in some cases through a Memorandum of Understanding (MOU) signed by the CHT, CHC and the gCHV, that there would be an exchange for the time spent in serving their communities – either through help in the field, donations of rice or other in-kind assistance. This lack of support is worsening as CHCs/CHDCs themselves are unwilling to advocate on behalf of the gCHVs. This is because the official message is that all health services in the country are free, the gCHVs are part of the health system and receive visible support during health drives. A strong belief that the gCHVs are supported by the health sector and/or NGOs makes these poor communities reluctant to support them further.

As a group, TTMs are dynamic and motivated, and generally appear to be more accepting of the support received from the communities they serve this despite their changing role from doing deliveries in homes to accompanying women to the health facility for both antenatal care and delivery. Several TTMs mentioned that they like accompanying women to the health facility as it makes them feel “important” and more a “part of the health system”. Moreover, they often receive on the job training at the health facility, in some instances even assisting the Certified Midwife (CM). TTMs reported receiving a *lappa* for each woman they brought to the facility for delivery; others reported receiving one *lappa* for every four births depending on available supply. Some health workers believe that TTMs may continue to receive some other in-kind support directly from women they assist which has been the tradition. This information was not confirmed by

TTMs. However, this support is not consistently forthcoming within or across communities – some TTMs mentioned being dismissed without compensation by the woman and/or her family after being accompanied to the facility or being told that the only reason the TTM is kept is that the delivery takes place in the facility is because she'll receive a *lappa*.

Review of all pilot interventions prior to finalizing strategies and plans for scale up critical

The NGO partners' reports on the i-CCM pilot in RBHS supported communities provide a compelling case for scaling up the program. Pointing to HMIS data which show decrease in cases treated at the facilities and staff remarking that fewer cases of childhood diarrhea, malaria and pneumonia are presenting at the facility since i-CCM began, one CHO was emphatic that the program be extended to all corners of her county. It would be preferable, however, to first incorporate lessons learned from a wider evaluation effort engaging representatives from among all i-CCM stakeholders (MOHSW, UNICEF, WHO, Global Fund, RBHS, pilot i-CCM NGOs, CHT). A workshop of all who participated in such an evaluation would forge joint ownership of the plan and help the MOHSW to assure an appropriate pace and scope for finalizing the draft strategic plan and implementing scale-up. It would also ensure buy-in from the vertical programs and suggest innovative ways of leveraging their resources in support of Liberia's larger health agenda.

“If gCHVs are empowered and given the necessary support coverage will go up. Some diseases are decreasing and outbreaks are not happening. We see it in our database now following the CCM pilot. We want to roll out CCM all over the county. We have met with partners to discuss scale-up.”

Integrated CCM versus non-integrated CCM

In general, performance – at all levels – was significantly better in the integrated CCM communities as compared with the non-integrated CCM communities. In large part this was because the attention of the NGOs was focused on the performance of these communities relative to the others.

The gCHVs in i-CCM areas are more motivated than those in non-integrated CCM areas. When questioned, they appear more ready to continue their volunteer work despite not receiving in-kind support from the community compared to other gCHVs doing non-integrated CCM. gCHVs in the i-CCM pilot communities cite the main motivator for remaining a volunteer is the benefit their own children have derived from their training in identifying and treating important childhood illnesses. Their status in the community has also increased as parents seek them out for the care of their sick children. The gCHVs are motivated by the ‘learning’, and stated that they would like to have more training and be able to do more to benefit their families and their community. They did not feel they were overloaded with current responsibilities.

Although mothers mentioned the value and importance they placed on the community health talks conducted by gCHVs in the non-integrated CCM communities, they were particularly satisfied with being able to get care for their sick children near to their homes

in the i-CCM areas; the i-CCM program has saved them considerable time. When weighing the decision to walk one or more hours each way to a health facility, they cited that they now seek care earlier. They were satisfied with the care provided by the gCHVs and felt it was of good quality as their children's health improved.

Integrated CCM has also provided an excellent opportunity to reinforce earlier advocacy and sensitization efforts for all community volunteer health activities. In an effort to garner greater support for gCHVs during the i-CCM pilot, Africare conducted re-orientation workshops for CHC/CDHC in selected sites of Bong County. As part of this, expanded discussions were successfully held on the roles and responsibilities of CHC/CHDC, the community at-large, and the CHVs.

Pilot iCCM

i-CCM has been a powerful motivator for community health in that it has increased access to basic health education and strengthened the linkages between communities and health facilities - mothers recognize the added value of i-CCM to their lives; gCHVs are more empowered and better motivated to continue their volunteer efforts; and, CHTs and health facility staff want i-CCM expanded based on the impact it has had on their community's health.

The interviews, reports, and ledger reviews indicate that gCHVs can safely manage three of the most important childhood diseases if they are well supported with regular supervision and provided a regular supply of drugs, rapid diagnostic kits and other supplies. gCHVs demonstrated that they can also identify and appropriately refer more serious cases to the health facility, and are capable of following up treated children after three days to validate their progress.

Although the training modules used in CCM are national, each NGO conducted the training differently in terms of duration and training methods used. In some cases, the three modules were conducted in a two week long training period; in another, each module was held separately over three to five days, followed by one or more months of practice and supervision before going on to the next module. Generally, the shorter training periods were most appreciated by gCHVs who said that this allowed them to practice and get comfortable with new skills and materials before moving forward to tackle new ones. Shorter sessions also meant less time away from their other household and farming responsibilities. Regardless of approach, one thing was clear across all three NGOs: unless supplies were available post-training and guaranteed for a one year period, the best CCM training will prove worthless.

With respect to documentation of CCM activities, standard ledgers and reporting formats for CCM have not been developed yet; each NGO partner used its own method for documenting community data (EQUIP used its existing ledgers while IRC provided blank notebooks in which lines were drawn) and gCHVs carried these in their backpacks to record information in preparation for treating a sick child at any time. gCHVs say that it takes time to complete the register, but the data provided is useful for their supervisors (at both the facility and NGO levels) who consult the ledgers jointly with the gCHVs during

monthly supervision meetings. A monthly summary report is created together but no copy of the report is given to the gCHV.

The reports submitted by the three NGOs following the six month pilot demonstrated that gCHVs can safely manage three high mortality childhood diseases *if* they are regular supervised and provided an uninterrupted supply of the necessary drugs. The supervision and supply chain used for the pilot, however, were not the routine systems that would normally be relied upon for a scale-up. Instead, these two known barriers to the success of the pilot – dedicated supervision with transport and uninterrupted supply chain - were circumvented from the outset. However, mounting these alternative arrangements proved to be costly and cumbersome and is considered unsustainable even as interim measures:

- i) The supervision of gCHVs has largely been the responsibility of the Nurse's Aide/Vaccinator at the health facility; the CM is responsible for supervising TTMs. Given the inconsistent supervision of gCHVs by the Vaccinator (in large part due to lack of transportation to facilitate the process as well as a lack of supervisory skills) and of the TTMs by the CM (due to a shortage of CMs and lack of transportation), and often ineffective oversight by the OIC who may not view the whole catchment area as his/her responsibility, each NGO found its own solution – either by hiring a dedicated supervisor or assigning existing staff to provide joint supervision with the Vaccinator and gCHV Supervisor in the i-CCM communities. In most cases NGOs supplemented any supervision being done by the facility and CHT staff.
- ii) With respect to supply chain, here again the NGOs did an end run around the weaknesses and challenges in the national system. Each NGO gathered the necessary drugs and supplies and delivered these directly to the health facility for storage and distribution to gCHVs. Nevertheless, this proved challenging as there were three different supply chains for each of the three different programs: rapid diagnostic tests (RDT) and artemisinin-based combination therapy (ACT) were located at NMCP in Monrovia; RBHS supplied NGOs with Septrim; and zinc and ORS came through the regular CHT store to the health facility. The timeliness and completeness of reporting on drug stock levels and number of children treated varied by NGO and affected re-supply and stock-outs.

Market women FP program

This joint intervention between RBHS and UNFPA, and implemented through PPAL, was piloted in eight markets around Monrovia. UNFPA provides incentives for the nurse supervisors while RBHS provides the volunteer market vendor training and supplies (i.e., back packs, vests, registers). The MOHSW (through the FHD) provides family planning commodities.

Each market has a dedicated nurse paid for by PPAL who is located in a small office built adjacent to the market entrance. Each nurse serves two market sites and supervises the market vendors at those sites. The nurse and the vendors provide counseling but only the nurse has available the full range of methods; the vendors only dispense condoms and

pills. On days when the nurse is absent from one site, women can seek counseling, oral contraceptives and condoms from volunteer vendors in the market but if they want depo injections, they must come back another day or go elsewhere. The assessment team also interviewed the vendors who had been trained. Record keeping has evolved over the pilot period and continues to be challenging. The vendors expressed that they would like some financial compensation for the work they are doing. It was unclear if they would be motivated to continue after the pilot is completed. It was reported that the continued supply of commodities has been challenging because the quantity requested by the pilot program is usually reduced by the FHD resulting in frequent stock outs.

“Some gCHVs are real leaders in their communities, well respected, motivated, capable of mobilizing their communities. We should find a way to reward them - by selecting them to be dedicated gCHV supervisors at the health facility level and further up to the district and county levels as gCHV focal point. We need to build their capacities to supervise and provide some transportation such as a bicycle or motorcycle, whatever is appropriate for the level.”

The pilot was ongoing at the time of the assessment, however, discussions with the PPAL team suggests that the organization has limited experience managing such a program; the vendors were inadequately supervised; and the data gathered from this pilot program will likely be difficult to aggregate and compare across markets given the variation in the data collection formats used by each vendor in just the one market visited by the team.

v. Recommendations

It is internationally well accepted that health is fundamental to the development of each community and cannot be relegated as the sole responsibility of one sector. Consequently, inter-sectorial coordination and collaboration is crucial to bolster results and international NGOs are important resources in this process. Liberia’s national leadership must create the space for leveraging the experience of NGOs to support CHTs as they assume a leadership role in coordinating and monitoring all efforts in their communities. It is with this in mind that RBHS supports the MOHSW in its commitment to strengthening community health at the national, county and facility levels and to adopting a cross-sectorial approach. Thus, most of the recommendations outlined below are intended for the ministry as it assumes ever-greater responsibility for managing the provision of health care in Liberia.

For the MOHSW

Harmonize policy, strategy and planning documents

Review all relevant policy and planning documents concerning community health to assure they are clear and consistent:

- Clarify the roles and responsibilities of CHVs,

- Clearly identify the cadre responsible for supervising volunteers and their responsibilities,
- Address the financial and non-financial incentives for all volunteers (to be clearly communicated to counties, health facility staff and, most importantly, to communities and volunteers).

Clarify expectations from preventive/promotive health and curative community health
 Support for prevention, home management and referrals to facilities through mobilizing communities and fostering community-facility linkages needs more thorough articulation in the 10 year planning document. Plans for scaling up i-CCM should evaluate and document the community entry process, a crucial step to fully engage traditional, administrative and political leaders in the community's health agenda. Moreover, the MOHSW should consider conducting a review of the different pilot programs (by including representatives from all stakeholder groups especially the vertical programs and Global Fund) prior to finalizing a plan for scaling up i-CCM and incorporating these lessons learned into the draft national strategic plan. The outcome of the review should be clear guidelines for establishing the volunteer structure and supervisory framework, supply chain logistics, community level indicators, consistent entry strategies through a well-defined community structure, incentives for CHVs, and mechanisms for leveraging the community resources available to vertical programs.

Leverage vertical programs to support community interventions

The MOHSW must advocate at the highest levels to harmonize vertical programs and NGOs working on community health. This will entail creating community health coordination structures at each level where vertical programs and NGO partners can communicate and share on a regular basis and leveraging the community based funding available in various vertical programs to better support delivery of high impact community based interventions. For example, work with and through the Global Fund to ensure that the resources (both monetary and non-monetary) available to support CHVs are not siloed by the vertical programs but rather pooled and distributed across CHVs in targeted communities. Doing so would mean that the stipend for attending meetings given by one program and bicycles by another program are not allocated only to a few gCHVs in the community but rather used to support all eligible gCHVs serving the facility catchment area. As a result, interventions will be more cohesively integrated into the roles and responsibilities of the gCHVs (as opposed to singling out gCHVs by those responsible for TB, malaria, etc.) and CHVs will have the wherewithal to serve their communities and attend meetings regularly. This leveraging of resources will also ensure greater integration across programs at the highest levels, bring programmatic breadth to gCHV training and support, and result in comprehensive care for individuals, families and communities.

Create a CHT/ facility level budget line item for supervision

The provision of timely and consistent supervision by well trained staff is critical to the success of any program; this is particularly true of supervising and managing volunteers which, without a commensurate budget for salary and transportation, is challenging. The

assessment team recommends that the MOHSW institutionalize the Community Health Services Supervisor (CHSS) position by creating a budget line item, and establishing pre-service training curricula in supportive supervision, logistics, M&E, HMIS. As a longer term plan, the ministry could explore the opportunity to integrate into the pre-service curriculum a two-tier training of community health nurses who would take on the responsibility for implementing or supervising community health programs.

The MOHSW must decide on the cadre that will be responsible for this important job as a prerequisite to the establishment of this training curriculum - e.g., should it be the vaccinator as preferred by some, the environmental health technician (EHT) as recommended by others, or a completely new position drawn from among experienced community workers. Moreover, to ensure that the paid CHSS has a manageable span of control, the MOHSW should map out a structure for CHVs that ensures appropriate and cost effective oversight and offers a clear pathway for growing the skills of high energy volunteers (as a reward in lieu of salary). The ideal number of paid supervisors required for each county will depend on a number of factors including the number of CHVs within a county, their geographic spread, etc.

Few countries have invested adequately in ensuring proper supervision of their community volunteer cadres. Possible exceptions are Nepal and Ethiopia however their supervisory systems are still in process. If well thought through and implemented, Liberia may yet be able to demonstrate how a largely volunteer community program can be managed effectively in a resource constrained environment.

Ensure community structures exist to support interventions sustainably

For community level interventions to gain traction and have a chance at becoming sustainable, the entry point through formal structures and informal networks is of critical importance. This appears to be particularly true today as the role of traditional leaders has diminished among the younger generation living in a post-conflict Liberia; new leaders have emerged and must be tapped appropriately. Currently gCHVs and TTMs have few advocates within their communities and the CHC and CHDC structures (where they exist) have had limited impact in supporting these volunteers. This is in part due to the fact that the role of these structures is not well understood and their membership is often not drawn from the most influential pool of candidates. The MOHSW should review, finalize and endorse the Operational Guidelines which outlines the rationale for these bodies; their role as watchdogs of their health facilities, advocates for the needs of their communities, supporters of the volunteers (both gCHVs and TTMs) serving the mothers and children in their catchment communities. Without this, any community level intervention will be compromised and the MOHSW's limited resources expended on trainings, supervision, supplies, and impact monitoring will be suboptimal.

Review training schedules for CHVs to ensure learning and practice

Trainings conducted by the NGO partners during the i-CCM pilot varied – some trainings were several weeks long and others were of shorter duration allowing for pedagogy combined with field testing and practice. The latter approach has been well received by gCHVs and although resource-intensive, in that it requires close initial monitoring and

supervision, it is better suited to long term retention of training content and consequently, on the health impact of households and communities. This phased-in approach (combining classroom instruction with a supervised practicum) should be considered when planning for trainings and developing materials for the classroom, and protocols and checklists for field supervision.

Grow programs in step with structural and human resource capacity

Phase-in integrated community case management in step with the capacity to ensure program quality. Partner with NGOs who are willing and able to assist counties with iCCM scale-up. Ensure proper community mobilization and advocacy with influential and political community leaders. Scale up plan must be clearly defined to ensure consistency and incorporate illiterate mothers especially TTMs who are motivated. Ensure implementation plans include dedicated supervision, reliable supply chain, clear selection criteria for community structures (CHC/CHDC) and CHVs, and strong community-facility linkages.

Consider dynamic TTMs as a resource for integrated CCM

TTMs are an additional potential resource for integrated CCM if literacy requirements were relaxed, adapting non-literate training and record keeping materials that are used in some other countries. In many countries, women health volunteers have been better accepted to do child health and FP counseling and care as it is an extension of their usual family responsibilities for their children and families. Rather than recruiting new gCHVs to meet the revised ratio of 1:500 population that is under consideration, planners could consider utilizing the most motivated and appropriate TTMs to take on gCHV duties, particularly as TTM role in assisting deliveries is decreasing over time. This approach might first be piloted to assess the suitability of expanding such a strategy in Liberia.

For RBHS

Expand community level indicators

Knowing that what gets measured gets managed, the number of community indicators needs to be raised from the two (out of seventeen) currently included in the PBCs. Identifying new community level indicators in performance based contracts for CHTs and CHVs will help to identify current bottlenecks in drug logistics and supervision and to find innovative solutions at their levels. The RBHS team should engage the NGO partners and CHTs in identifying possible indicators that address both these areas that will impact the long term success of Liberia's community program.

Evaluate cost-benefit of MWFP pilot

Evaluate the market women FP pilot with thoughtful consideration to the added value of the vendors' contribution. One option to consider would be to continue only the FP clinic staffed by a nurse located adjacent to the market.

IV. Behavior Change Communications

i. Background

“Preventing disease and promoting more healthful behaviors through behavior change communication and community mobilization” is one of three pillars of the RBHS project. It supports and responds to all three intermediate results:

- **IR 1:** Increased use of basic health services in target areas;
- **IR 2:** Improved infrastructure, health workforce and systems performance (capacity building); and
- **IR 3:** Youth informed and networked on reproductive health.

Early assessments by RBHS demonstrated that there was no consistent strategy regarding public health messaging at either facility or community levels; most facilities conducted health education sessions without a rationale for topic selection; quality educational materials were lacking except for those in malaria; and, activities undertaken by gCHVs were typically not coordinated with those at the facility. As a result RBHS, jointly with the Health Promotion Division (HPD), conducted a health-seeking behavior study to help inform strategies, approaches and messages. Based on this, RBHS developed and is implementing the Liberia RBHS Social and Behavior Change Strategy Framework which is based on standard practices in BCC, supports the MOHSW National Health Communication Strategy, and builds on past BCC programs in Liberia. It employs a two-pronged approach: i) Integrated activities addressing the wide spectrum of health topics in the BPHS; and ii) A series of campaigns that focus on one or two specific health issues at a time and promoted at high intensity for limited duration. The two approaches are mutually re-enforcing, and take place at community, county, and national levels.

Integrated activities can be considered the foundation of social and behavior change efforts. These efforts seek to improve disease prevention and health care seeking behaviors, improve provider communication skills, increase community engagement and ownership, and improve health communication planning and implementation. Central to this effort are the new Pregnant Woman and Child Health Cards which allow not only documentation of important family health data but also provide families with health information in a manner that is culturally relevant and easy to comprehend. The information is also intended for counseling by health workers and discussion/negotiation with families. Developed in collaboration with the MOHSW’s HPD and FHD, the messages promoted through these cards and the CHVs will be consistent with and complement those provided at the facility level further establishing linkages between the demand and supply sides.

RBHS and the MOHSW have also adapted two BCC tool kits for mass production and dissemination to health facilities and gCHVs – the Community Health Education Skills Tool (CHEST) kit and the Journey of Hope kit.

The Project has promoted an ITN campaign employing a variety of communications channels (advocacy, radio spots, posters, stickers), and a radio campaign focusing on teen

pregnancy (Baby by Choice, not by Chance). Ongoing “Dipstick” surveys and exit interviews measure campaign impact.

RBHS’s BCC team works closely with Ministry counterparts and NGOs to craft national and local BCC activities and has engaged them actively through various levels of training, including:

- Training of Trainers for CHTs and NGO partners on BCC concepts, Interpersonal Communication and Counselling (IPCC) skills, and Effective Use of IEC/BCC Materials and Tool Kits.
- Downstream training for gCHVs and social groupings such as market women, sports associations, FBOs, and CBOs that are intended to both teach skills and strengthen linkages between the facility and community.

ii. Objectives

The internal assessment sought to answer the following questions:

- How well are plans and materials shared and disseminated?
- How effective have BCC activities been in affecting change in the behaviors of the target population?
- How can sustainability of BCC activities and programming at national and county levels be ensured?

To do so, the team focused on several areas: awareness, understanding, and buy-in to the project's BCC strategy; quality, quantity, and distribution of training and technical assistance (incl. effectiveness of cascade training); effectiveness and ease of use of BCC approaches chosen; sustainability; integration of activities across health topics, the Project's technical focus, and target audiences; obstacles to full implementation and effectiveness of BCC strategy and work plan; and opportunities for improvement and building on success.

iii. Approach

The BCC assessment team was led by Carol Hooks, Senior Communications Consultant and comprised of J.K. Ofori, RBHS BCC Advisor, Marietta Yekee and Teah Doegmah, RBHS BCC Officers. The HPD Assistant Coordinator for Research, Lahanna Jarwara joined the team for one day in Grand Cape Mount County. To meet the assessment objectives, the following activities were undertaken:

- Off-site: Participated in the team planning meeting; reviewed RBHS Project Description, 2009 and 2010 Annual Reports, Concept Paper, Year 3 work plan, 4th and 5th ITN Dipstick Survey reports, Social and Behavior Change Strategy Framework, BCC Year 3 Workplan, and the complete list of RBHS trainings; MOHSW National Health Communication Strategy, MOHSW National Health Promotion Policy; developed interview and discussion guides for meetings with key stakeholders at the MOHSW, Bong and Grand Cape Mount CHTs, and NGOs, as well as beneficiaries, influentials, and service providers. Questions covered respondent's role, expectations, and general feedback, training, BCC strategy and outputs, partnership, lessons learned, and sustainability.
- In Monrovia: Reviewed the RBHS Semi-annual Report for October 2010 –March 2011, National Health and Social Welfare Policy and Plan, RBHS IPCC Curriculum, CHEST Kit, Malaria ITN posters, Baby by Choice radio spots and scripts, ITN radio spots, gCHV Supervision Checklist, Bong and Grand Cape Mount County Health Plans 2007/2008, and the gCHV diarrhea training manual; finalized the interview and group discussion guides; interviewed the RBHS Chief of Party and five RBHS County Coordinators.

- Jointly with the BCC assessment team: Finalized the list of interviewees and travel schedule; interviewed 131 individuals either in groups or individually from central MOHSW (CHSD, FHD, HPD, NACP, NMCP), one contracted NGO at the central level (Crusaders for Peace/National Traditional Council), two contracted NGOs at county level (Africare and MTI BCC Focal Persons as well as MTI Coordinator and Community Health Promoters), the news director of one community radio station, facility- and community-based service providers, and members of the Bong and Grand Cape Mount CHT (CHDDs, Clinical Supervisor, HP Focal Persons).
- Jointly with the Internal Assessment Team: Presented and participated in debriefings with the RBHS Chief of Party, USAID/Liberia Health Team, the MOHSW, and RBHS staff.

iv. Key Findings: Successes and Challenges

In reflecting on the successes and challenges faced in implementing this component, the assessment team considered what successful BCC programming looks like. While a programmed approach is not necessarily the answer, there are some elements a strong BCC program should include that will more likely result in people adopting healthier behaviors:

- Policy makers and decision makers create an environment that supports behaviour change among providers, target populations, and those who influence the populations being targeted.
- Clients are at the center of all interventions which means messaging should start with where clients are on the change continuum, and service providers listen and help clients understand barriers to, and benefits of, adopting healthy practices.
- Messages are consistent, reinforced through multiple channels (health workers, media, opinion leaders), and updated in a timely manner based on feedback and as new information and protocols become available.
- Desired behaviors are encouraged and modelled by those in positions of power and influence.

Moreover, given the cross-cutting nature of BCC, interventions need to be conceived jointly to ensure buy-in from those through whom the program will be implemented, i.e., facility providers, community providers, community leaders, program managers, and others in positions of influence and authority. Leadership and management are, as always, key ingredients to propelling the work forward and in the direction intended.

RBHS's BCC strategy incorporates some of these elements, and while there have been challenges to implementation, the Project has made notable progress in some areas:

The RBHS social and behavior change strategy framework is basically sound

This framework – built on previous BCC interventions in Liberia and the health seeking behavior study conducted by RBHS - supports the BCC-related elements of the USAID-funded health program objective to increase access to basic health services in Liberia and is designed to support the MOHSW's National Health Communication Strategy. As such it focuses on increasing demand for and improving access to Liberia's Basic Package of Health Services, targeting key audiences and implementing activities described in the MOHSW strategy. The framework is intended to move individuals along the behavior change continuum from lack of awareness to maintenance of the new behavior. It also speaks to branding the MOHSW to create a unified identity for the wide array of BPHS health promotion interventions; building the capacity of the HPD and a variety of institutions and individuals who are, could be, or should be agents of change; and monitoring impact of activities and conducting formative research.

Dipstick surveys are an innovative and effective way to assess campaign impact

The Project introduced “dipstick surveys” that appear to be very effective in assessing how widely RBHS campaign messaging reaches its intended audience, how well the content is retained, and which channels are remembered as delivering the messages. The surveys also measure changes in reported behaviors over time. The first of these quarterly surveys was conducted in January 2010. The primary objective of the fifth “dipstick” survey, conducted in January 2011, was to measure how well the ITN campaign reached its target population, i.e., what proportion of women with children under five had been exposed to the Take Cover message and through which media. The survey followed a cluster design, interviewing 162 mothers of children under five in 27 randomly selected communities in RBHS catchment areas in Grand Cape Mount, Lofa, Bong, Nimba, and River Gee Counties. Interviewers showed respondents posters, leaflets, and stickers, and also played clips of the Take Cover jingle and one radio spot to test recognition of campaign components. The results showed that 84% of respondents had seen or heard some Take Cover message. Moreover, while most women and children who have nets are sleeping under them, only 53% of the households surveyed had a net present, limiting the effect of the campaign. (NMCP is conducting additional distribution campaigns to further increase coverage. On the other hand, of people who remember hearing a message on malaria, the most common message reported was to sleep under a net. Community-level progress continues to be less than expected, with few people hearing messages from chiefs or from gCHVs. One suggestion for improving on the already excellent dipstick surveys is to only test familiarity with radio jingles in the language in which it aired in that area, instead of whichever language respondents were most comfortable using, since it is not clear they would have heard it in that other “more comfortable” language.

Activities implemented are having the desired effect on awareness and attitude

The dipstick surveys and comments from those interviewed as part of this assessment show that messages from the ITN campaign have been seen, heard, shared, and remembered. Most respondents had seen and remembered the key messages of the ITN posters and had heard and remembered the ITN and Baby by Choice radio spots. Mothers know that they and their families should sleep under bed nets, and many of those who have bed nets do so. The Baby by Choice spots – aimed at adolescents – are especially

popular and easy to remember. While this is a positive outcome, for the campaign to have the desired impact it must be reinforced through interpersonal communications at the community and facility levels and cannot be measured in the short term.

BCC training conducted widely

RBHS instituted a four-part training to build BCC capacity nationwide that included the BCC/HP focal persons from the vertical programs, other MOHSW staff at the central and county levels and RBHS' technical team. Two-to-three month breaks between workshops allowed participants time to fully assimilate what they learned. The workshops focused on Leadership in Health Communication (March 2010), Material and Message Development (July 2010), Interpersonal Communication and Counseling Skills (October 2010), and the Use of Research in Communication Program Development and Evaluation (March 2011) and ended with the development of county health promotion work plans (the preparation of which was under-funded and lacked proper coordination). Efforts were made to ensure that the same people participated in all four workshops.

Praise for RBHS BCC support nearly universal, and training greatly appreciated

RBHS' capacity building efforts in BCC are highly valued, specifically the 4-part BCC training workshop; the idea to broadcast radio spots in local languages and the technical support given to develop them; training of gCHVs in the use of IEC materials; Journey of Hope and CHEST Kit training (demonstration kits have been provided to the county and district levels); and the step-by-step process introduced for developing and pretesting ITN campaign materials. HP and BCC focal persons gave examples of how they have put the BCC training to use (adopting a less didactic approach with communities and clients, training of gCHVs, using IEC materials more appropriately, developing radio messages for airing on community radio stations, helping communities and individuals change their behaviors and practices). Some previous participants appreciated the broader view that they now have of BCC – that it's not just materials development but also includes IPC and community mobilization. However, implementing this work fully into the routine activities of the CHT remains a challenge, further hampered by inadequate logistical support to carry out community-level activities, and lack of coordination and collaboration with fellow BCC/HP focal persons in their counties.

The Pregnant Woman and Child Health cards in high demand

These pamphlet-style health records contain health messages to guide discussion with pregnant women and caregivers and serve as a resource to women and other caregivers at home. Intended only for new mothers and babies, the popularity of these cards with mothers, who previously had the old health cards, has led to stock-outs. The MOHSW is printing additional cards and making the electronic file available to partners who would like to print them.

An IPC module has been incorporated into pre-service and in-service training curricula

The incorporation of the IPC module into the existing training curricula is a big step forward and should greatly improve communications between both new and current providers and their clients. Frequently cited reasons by clients for not visiting a facility is

the treatment they receive (rude and dismissive). However, resistance to implementing it by the MOHSW trainers needs to be better understood – whether it’s due to a lack of time or comfort level with the training materials, or a lack of appreciation for its value - before the right steps are taken to address it.

The challenges to implementation have been both external and internal to the RBHS BCC team:

The Health Promotion Division needs further strengthening

In need of strong leadership, a new Director was appointed for the HPD in late 2010 who has a vision for the division, has experience in BCC, and is strongly interested in making a difference; once on board, RBHS sponsored his participation in a BCC course in Nigeria. While these are critical first steps, the highest levels in the ministry must ensure that the eloquent words on the pages of the MOHSW Health Promotion Policy to describe the role and position of HP are actually realized on the ground. RBHS has worked to strengthen HPD in a variety of ways: training and mentoring staff; collaborating on materials development; inviting staff to co-facilitate workshops and assisting them in facilitating MOHSW workshops; helping to finalize the health communication strategy and health promotion policy; assisting what had previously been a Unit to gain the status of Division; and helping plan special events and campaigns (e.g., Global Handwashing Day, the ITN and malaria case management information campaign, a national RH advocacy meeting, National Health Fair, World Health Day, World No Tobacco Day, World AIDS Day, and World Malaria Day). The project has also provided the HPD with a vehicle to help facilitate supervision visits, and the RBHS BCC Advisor serves on the Health Promotion Working Group.

But in spite of these efforts, the division continues to be seen as just a materials development group; receives no funding from the MOHSW; is unable to adequately support, coordinate, and supervise county-level BCC activities nor retain trained staff (two highly regarded staff were transferred to other divisions); and has not been strategic in establishing itself as a valuable asset to other divisions in the ministry and as vital to achieving the nation’s health goals.

BCC and HP remain misunderstood and undervalued

The MOHSW Health Promotion Policy states that: “In its broad interpretation, health promotion concerns all those experiences of an individual, group or community that influence beliefs, attitudes and behavior with respect to health as well as the processes and efforts of producing change when it is necessary for optimum health (WHO, 2003).” This means that HP includes but is far from limited to, just BCC. Likewise, IEC is but one aspect of BCC—informing and educating, but not, by definition, taking additional steps usually required to help people adopt healthy behaviors. The assessment found that stakeholders interviewed did not really comprehend what health promotion and behavior change communications are intended to do, and at least one person saw the HPD as focused on raising the MOHSW’s visibility and developing educational materials. The language used to describe the work of the HPD also suggested that BCC was seen as being about telling and correcting, and not about listening and supporting. Regardless of

what they are called, HP and BCC play a crucial role in improving health. That said, what really matters should be what BCC and HP accomplish toward improving the health of Liberians.

But with health promotion under-represented in the May 26, 2011 version of the MOHSW 10-year plan and no budget line item, the HPD will find it even more difficult to carry out its functions over the next several years.

Gains in health promotion not yet sustainable

Of perhaps greater immediate concern than not having a voice within the ministry, is the lack of staff depth (in terms of appropriate experience and motivation) in the HPD. Consequently, supervision of BCC activities lacks consistency, training is often provided to the wrong people, coordination of BCC activities within counties and catchment areas as well as between HPD and the counties is insufficient, and a larger strategic vision towards which everyone – BCC staff, service providers, and managers – can work is missing. Trainings are not always additive as often different people are sent to trainings, and some participants may not be the most appropriate given their limited involvement in BCC (relative to others from the same locale/institution) at the implementation or supervisory levels. In referring to who attends workshops, someone commented that “Sometimes organizers are forced to go with the available and not the capable.”

Overall coordination at the intervention and Project levels lacking

BCC teams on projects are often mistaken in their notion that the technical teams will reach out to them; in fact the reverse is usually the norm. For any BCC program to succeed, its relevance has to be established by those who are its stewards through constant outreach and reminders and openness to supporting the larger agenda in the true spirit of being “client focused”. Thus, although BCC is well-integrated into RBHS, the technical teams and BCC do not always strategize together and plan ahead on the interventions required to support the broader mandate. This lack of coordination sometimes results in rushed decisions and execution or unfulfilled expectations. For example, the ITN and Baby by Choice campaigns have raised awareness of the messages through media and posters but service providers were not trained or supplied with materials to help them support and reinforce these messages, and contribute to changing behaviors. Of necessity, MOHSW staff and other partners involved in planning, approving, and implementing RBHS-supported BCC activities should be aware of the overall framework to better understand how activities fit and the outcomes sought (in support of the MOHSW’s communication strategy).

While not everyone wants greater involvement in the planning of BCC efforts, several commented on their preference for being informed sooner than has happened in the past, or for better and more timely communication of upcoming trainings to facilitate coordination and ensure that CHTs and OICs know who is being trained and in what.

Role of trainings for BCC needs to be re-evaluated

A variety of issues were raised with respect to BCC trainings. Facility level providers mentioned that they work well with clients and do not see the need for training in

interpersonal communications; of those who thought there might be value, this was not expressed with great conviction. However, feedback from communities tells a different story.

Cascade training has shown mixed results in that while follow-up training plans are made during workshops, lack of funding to support step-down training is a barrier to follow-through at least in a workshop format. Helping the BCC focal persons to plan for on-the-job training, including during monthly gCHV meetings, is being explored, as is providing a budget for such trainings.

With respect to training of gCHVs, while there is a recognition that this cadre of volunteers require strong interpersonal communication skills on how to approach, engage, and mobilize communities in order to effectively share health information, the CCM training manuals, for example, do not currently contain BCC or HP modules. The CHSD Director noted that, given the importance of BCC to improving community health, he wants to ensure all gCHVs receive BCC training and supervision to support their work.

The first “site mentoring” of facility on the effective use of IEC/BCC materials took place February 6-11, 2011, in eleven RBHS-supported health facilities in Grand Cape Mount County. The visits had four main purposes: (1) to assess BCC activities at each facility; (2) to assess available IEC/BCC materials using a checklist, (3) to mentor facility staff in the effective use of IEC materials and other IPC skills, and (4) to resume “field content gathering” for the Radio serial, *Baby by Choice*. Findings reveal that those mentored at the facilities visited by the assessment team did not initially remember the training, nor did the two who received IPC training during an FP workshop remember the content of the IPC module. While this could also be the result of unclear training objectives, based on the discussions it pointed to a lack of interest in the topic, a need to time supervisory visits appropriately and help staff identify areas where they need mentoring or training, and the need to immediately practice what they learned. Because supervision is inadequate more generally within the health system, on-the-job training is underutilized, and efforts to mentor facility staff at their worksites are limited or virtually absent.

Health workers still lack up-to-date IEC materials or not use them to best advantage

In addition to the common scene shown in the photograph above, clinics visited by the assessment team had materials on some topics but were in need of up-to-date flipcharts on FP (covering all methods), HIV prevention and treatment, and breastfeeding. While different clinics had different materials, most had malaria and HIV posters. Some clinic staff interviewed expressed a desire to learn to use IEC materials more effectively. Though clients seem to remember messages promoted recently (on ITNs and FP) myths, rumors and misinformation abound. For example, in discussing care and use of ITNs, community members mentioned that new ITNs need to be aired out for several days or weeks before use and that washing ITNs frequently improves the insecticide’s effectiveness. Both practices, if widely followed will reduce the effectiveness of ITNs.

RBHS, the HPD and the CHTs should identify the sources of this misinformation and correct it immediately.

Mothers and adolescents also indicated several false beliefs about FP methods and STIs, including HIV/AIDS. While there was awareness of FP, STIs, and HIV/AIDS, community members (including those who had used modern FP methods and condoms) mentioned that you could tell if someone has HIV by looking at them, and toilets and underclothes are sources of STIs; women and adolescents who had experienced side-effects using one FP method did not appear to have received counseling and support to try a different method.

Production delays pushed BCC implementation behind schedule

Unanticipated delays due to local printing and production capacity has severely impacted the introduction of the CHEST kits, Journey of Hope kits – intended to support household- and community-level exploration and management of a range of health problems - thus delaying the step-down training provided to gCHVs and other providers and realizing the full benefits of the initial TOT. The delays have also impacted other parts of the project and the ability of NGOs to meet targets related to numbers of people



reached with FP and HIV/AIDS messages. These delays will likely also prevent the Project from undertaking campaigns beyond the ITN, malaria case management, and adolescent and sexual reproductive health already conducted or planned.

Overall, work with traditional leaders has had little impact

In collaboration with the National Traditional Council and Crusaders for Peace, RBHS held county-level advocacy meetings to disseminate information on the use of ITNs at community and household levels. Despite extensive work to engage traditional leaders as malaria prevention advocates, the dipstick surveys show that they were among the least likely sources of ITN messaging (along with gCHVs). While this may be in part due to chiefs delegating responsibility, chiefs also made it clear that traditional leaders have lost a lot of influence. Moreover, in spite of their concern for the health and well-being of

their communities malaria did not seem to be a main priority whereas adolescent pregnancy seemed of greater concern.

v. Recommendations

The following recommendations are categorized by those intended for the MOHSW and those intended for RBHS with the view to supporting the MOHSW to deliver on its goals for improving the health of all Liberians.

For MOHSW

Strengthen role of health promotion in the new ten-year plan

Not dissimilar to the Community Health component of the assessment, the BCC team recommended that the role of health promotion in the MOHSW's ten-year policy and planning document be clarified and articulated clearly. The documents need to provide specific and concrete objectives and strategies for health promotion, the resources required to fulfill its support to Liberia's health agenda and the commensurate cost estimates for doing so. The monitoring framework attached to the plan needed HP indicators. Post-assessment, the final policy and plan have been developed, and HP is better incorporated, but these sections are still not ideal.

Strengthen the Health Promotion Division

With the appointment of an experienced and motivated Director, the HPD is poised to more substantively develop its capacity. However, support to the division must be ensured from the highest levels within the ministry. This means that the Director should have flexibility in identifying the staff required, have control over hiring and retention (not allow transfers if not in the division's interest), and in time be given a budget that reflects the value that the ministry places on this function.

Demonstrate the value of the HPD and potential impact of health promotion

Currently within the ministry, the HPD is largely seen as developers of IEC materials. This limits its ability to contribute to the larger health agenda of improving access to care, supporting individuals and households in taking responsibility for their health, and fostering community-facility linkages. The assessment team suggests that the HPD (with support from RBHS) select a motivated county as a "demonstration site" for developing an HP strategy and implementing it with the view to showing what is achievable within a 12-18 month timeframe when the HPD, CHT, communities and facilities all work towards a common purpose. Ideally, such an experiment would result in:

- Providers would listen to and advise clients more effectively.
- Posters in clinic waiting areas and in other high traffic areas would be spaced and rotated.
- Education sessions would be interactive and engage clients on their priority health topics.

- Health providers at facilities and communities would have updated and relevant materials.
- Attitudes and norms of individuals and households on key health issues would begin to shift.
- Service statistics would show improvement.
- Communities would be engaged in practices and behaviors that improve their health.
- HPD staff could provide strategic assistance to CHTs with less input from RBHS.

This practical, hands-on demonstration of HPD’s capacity and the value of BCC interventions will also enable the HPD to identify gaps in the skills and capacities it needs to build to ensure that it can take the work forward when the RBHS Project ends.

Provide HP training and support materials to gCHVs

To ensure that the health information acquired is shared, gCHVs should be trained on interpersonal communication skills and practice including how to approach, engage, and mobilize communities, and this component should be included in their training and training materials. The CHSD Director noted that, given the importance of BCC to improving community health, he would like to ensure that all gCHVs receive training on BCC and are appropriately supervised in support of their BCC work. Well implemented on-the-job training would reinforce learning by gCHVs and identify gaps for future workshops and in-service training modules delivered at monthly meetings. This will require that supervisors and MOHSW/CHT trainers have copies of all relevant BCC training materials suitably reformatted into brief OJT segments. Related, gCHVs need educational materials to explain and reinforce their messages to caregivers and communities; this is especially true when dealing with low-literate or non-literate clients.

For RBHS

Focus BCC efforts on achieving project objectives

Recognizing that it has limited time available to demonstrate results, the BCC team should more proactively work with the RBHS technical teams to identify priorities in terms of health areas, type of BCC support required, and impact sought over the next 18-24 months. To do so, the BCC work plan should be reviewed as well as the budget. The BCC team should work with RBHS leadership and technical staff to adjust priorities and re-set expectations based on past setbacks. Specifically this will mean setting firm deadlines with vendors, ensuring timely deliverables, implementing on the strategy and not allowing new priorities to derail agreed-upon plans, and ensuring educational and promotional materials are updated and available during and after trainings, and in support of campaigns.

Focus BCC efforts on promoting sustainability through strengthening the HPD

The BCC team must support the HPD in identifying gaps in its capacity so that the BCC work can sustain the momentum provided by RBHS and the work can continue to move forward when the Project ends. Working closely with the HPD and the “demonstration” county will provide feedback in real time on how successfully RBHS has been able to assist the division in making the transition to sustainability. However, this presumes that the BCC leadership and key staff are not transferred but rather allowed to develop their capacities for developing strategies and implementation plans in conjunction with other departments and programs within the ministry, working with the MOHSW’s M&E team to monitor and report on the impact of BCC interventions, and taking corrective actions as needed.

Move BCC efforts beyond awareness-raising

BCC is a continuum from raising awareness to creating sustained change in health practices. RBHS-supported BCC efforts have been effective in raising awareness and initiating change in attitudes towards use of ITNs and adolescent pregnancy. The harder part lies in moving further along the continuum all the way to sustained behavior change. This requires greater emphasis on the integrated activities in the Project’s behavior change strategy framework which would result in changed norms at the individual and community levels. For example, the RBHS-supported radio serial can potentially have powerful long term impact on the behaviors of individuals, households and the communities in which they live (as long as the attitudes and behaviors they model are supported at the service provision level). Sustained behavior change is by necessity long term and requires frequent reminders and reinforcement from multiple sources including from one’s peers and social networks.

Revisit and update BCC indicators

The BCC indicators are not well synchronized with RBHS’ broad scope. Specifically, five of the current eight BCC indicators are HIV-specific, and a sixth is the “number of targeted condom service outlets”; the last two indicators are “number of people reached with FP-RH messages” and “number of people trained in malaria treatment or prevention”. RBHS should base the revised indicators on the Project’s priorities going forward. MEASURE Evaluation lists tested BCC indicators at http://www.cpc.unc.edu/measure/prh/rh_indicators/crosscutting/bcc (accessed July 20, 2011).

VI. Capacity Building

i. Background

This component is central to the “health systems strengthening” pillar of RBHS’ deliverables. While pre-service (which is being assessed separately) constitutes a significant share of the component, this report focuses on the development and strengthening of support systems to build the capacity of the MOHSW at the central and county levels and for the national process of health systems decentralization. Specifically, the areas that were assessed include capacity building of central level MOHSW staff at the various departments/units and support for the development of technical strategies and plans; capacity building at the CHT level to improve staff ability to manage service

delivery; and, capacity building at the facility level to ensure staff has the required skills to provide quality services per the BPHS.

To date, the primary focus of RBHS' capacity building activities have been to the MOHSW at the central level through technical support to various ministry units (i.e., HPD, NMCP, Mental Health Unit, CHSD, Training Unit, FHD, PBF working group), and through participation on 22 ministry committees, working groups, and task forces in the development of 28 national policies, strategies and technical documents. This technical support has been on an as-needed basis – in some cases given by RBHS staff and in other cases given by short term consultants. With respect to capacity building at the county, district and facility levels, while the RBHS County Coordinators provide some support (among their other competing activities), at the county and district levels this effort has largely been undertaken by the project's NGO partners. However, the NGO partners do not employ staff extensively trained in, nor entirely devoted to, capacity building. Another obstacle to building the capacity of CHTs has been their lack of openness to this beyond receiving material support (e.g., vehicles).

With the proposed project redesign, RBHS will assume direct responsibility for capacity building at the county level and will expand support provided to the ministry centrally.

ii. Objectives

The primary objective in assessing this component was to understand whether the capacity building efforts provided by RBHS and its NGO partners have made a difference at any of the three levels – central, county, and facility – in how effectively the MOHSW guides service delivery in the country.

iii. Approach

The Capacity Building assessment team was led by Beth Gragg, World Education Senior Training Advisor and comprised of RBHS Capacity Building Specialist Yilaa Wloti Se', and Basiru Kpaka the RBHS driver. The following activities were undertaken:

- Off-site: Participated in the team planning meeting; reviewed RBHS documents on the project's capacity-building efforts; RBHS' 2009 and 2010 Annual and Semi-Annual Reports; and, RBHS' draft Revised Project Activities for 2011-2013.
- In Monrovia: Participated in a one-day orientation to the project in general and the areas being assessed in particular; met with RBHS County Coordinators for an overview of their work at the county level.
- Jointly with the RBHS Capacity Building team: Developed interview protocol and list of interviewees; interviewed the Chief Medical Officer (CMO), Director of the MOHSW HPD, RBHS Mental Health Advisor, three NGO implementing partners, a range of county- and facility-level MOHSW staff, and clients who had received services at two clinics; and, interviewed and debriefed with the RBHS

technical team and senior management. Questions included interviewees' understanding of capacity building; how capacity was built by RBHS and the Project's "success" in building capacity; and, the successes and challenges to building capacity more generally.

- Jointly with the Internal Assessment Team: Presented and participated in debriefing to the RBHS Chief of Party, USAID/Liberia health team, the MOHSW, and RBHS staff.

The assessment process allowed for input from many different perspectives, and travel to Bong and Nimba counties offered a glimpse into the challenges of moving around the country to see, first-hand, the state of repair and service delivery of primary- and secondary-level facilities.

Supervision visits are a critical component of the RBHS capacity building efforts. Unfortunately the team was unable to arrange participation in a supervision visit while in either county. Despite this challenge, substantive information was gathered which has enabled the team to draw conclusions that will help strengthen RBHS's capacity building efforts in the remainder of the project period.

iv. Key Findings: Successes & Challenges

While common themes emerged across all interviewees, capacity building meant different things to different people. Most commonly, it meant providing:

- Opportunities for helping people develop their potential/skills/knowledge.
- Resources such as equipment, drugs and transportation, or the availability of guidelines, policies and strategic plans, to carry out one's work.
- An enabling environment that includes incentives to carry out their jobs (e.g., fair salary, housing, technical support, supervision, recognition, mentoring).

Capacity building could also mean having one's own capacity improved as well as providing opportunities for others to improve theirs through trainings and/or supervision. Some interviewees distinguished between capacity building efforts aimed at strengthening the individual versus efforts aimed at building institutional capacity and/or systems level capacity. For sustainability, careful consideration needs to be given to the relationship between individual, institutional and systems level strengthening - without clear links between these three levels, capacity building of the individual will have limited impact on the institution and equally, this will have little influence on the system as a whole.

With this definition of capacity building in mind, interviewees spoke about RBHS's successes and challenges in building capacity. Overall, responses indicate that RBHS has been successful in building capacity on a number of different levels particularly with its NGO partners in the implementation of the PBCs and the MOHSW at the central level.

Capacity building at MOHSW central level successful

In terms of outputs, RBHS' contributions at the central level of the ministry have been recognized at all 3 levels - systems, institution, and individual - in that the Project has:

- Provided significant inputs into developing the HMIS, thus ensuring the ministry has a robust tool for measuring and monitoring its progress.
- Provided technical support as needed on PBF, quality assurance (QA), the ten year National Health & Social Welfare Policy and Plan, the FP & RH strategy development, and in-service training.
- Placed a full time Advisor at the Mental Health Unit whose efforts have substantially contributed to the development of the national mental health policy and strategic plan.
- Supported the Health Promotion Division in the development of its policy document, sponsored its senior staff to an international workshop, and provided on-going mentorship to its staff's on BCC message and materials development.
- Conducted numerous joint trainings with the ministry on a variety of technical areas including RH/FP, IMCI, BLSS, malaria, diarrhea and others, to staff of NGOs and their RBHS-supported facilities. In at least one case, having more than one person trained in a particular protocol has helped the facility build its institutional capacity to provide services. (See box at right).
- Provided vehicles for use at the central and county levels.

At one facility, both the Officer in Charge and the Certified Midwife were trained in IMCI and this cross-training was highly valued. In the words of the OIC, "Now when the midwife is gone I can assess, diagnose and treat more effectively than I could before. We don't have to stop that service because she is not here."

Capacity building opportunities have strengthened the skills and knowledge across sectors, enabling individuals to more effectively carry out their work and providing institutions with valuable human resources. The interdependency of sectors combined with choosing the *right* participants will ensure that, in the long term, building capacity across levels and sectors can contribute to the larger Liberian health system.

Capacity building of NGOs an unintended by-product

RBHS' efforts in setting up and implementing the PBCs have had a wide-reaching impact on building the capacity of the NGO partners. While this was never the primary focus of RBHS' capacity building efforts, the impact on the management and staff of all 5 NGOs has been significant - in the words of one NGO Director, PBCs have been "transformational" in building his organization's ability to manage finances, structuring and implementing strong monitoring systems, and measuring the quality of care being delivered at the facilities they support.

The three NGOs interviewed attribute these results to a strong emphasis on developing clear indicators, scrupulously validating data, and giving NGOs the flexibility to organize themselves internally to manage the contracts. This flexibility, combined with clearly articulated goals, objectives, indicators, and financial and non-financial incentives that are linked to individual and team performance have stimulated NGOs to strengthen their managerial systems.

Moreover, implementation of the PBCs appears to also have positively impacted staff performance at the facility level. Evidence of this was seen at two facilities in Bong and Nimba where the assessment team conducted patient exit interviews. Patients at both facilities expressed satisfaction with the level of care and attention they were receiving, and with the courteousness of the facility staff. Those patients who had visited the facility for more than two years mentioned seeing an improvement in the care they received over that time. In the post-conflict environment prevailing in Liberia, where communities appear less cohesive and supportive of government structures and institutions, these findings, though limited, are promising.

Provision of vehicles and equipment beneficial to program implementation

While this is not a surprise, the fact that RBHS provided vehicles, computers, internet access and other hardware and software has directly enabled the central MOHSW, CHTs and NGO staff to build their capacity and carry out their job functions. Computers and internet access increased the CHTs' ability to complete tasks that might otherwise not have been done, and the vehicles facilitated supervision visits that would presumably have taken place less often. For the NGOs, the vehicles have also greatly facilitated their work and the computers and other software have helped them track data and produce reports. The Director of one NGO said that RBHS helped his staff leapfrog from "using carbon paper to using computers."

As the RBHS team looks ahead to build upon this foundation and directly assume responsibilities for supporting the capacity building needs of the MOHSW at the CHT and central levels, much work still remains to be done. For example, RBHS's capacity building efforts have been somewhat less influential at the county level. While this, in part, lays in the fact that capacity building of CHTs was the responsibility of the NGOs, in retrospect this was likely an unrealistic expectation. The NGOs themselves required significant capacity building as they transitioned from relief to development organizations and implemented PBCs, a hitherto untried funding mechanism in Liberia.

Capacity building efforts reactive and piecemeal

Having relied on the NGOs to take forward the capacity building of CHTs, the Project currently has no strategy for capacity building. The lack of a capacity building needs assessment, strategy and related plan has resulted in an *ad hoc* approach to training and other related capacity building efforts. RBHS staff respond to needs as they arise rather than targeting knowledge and skills gaps based on priority human resource requirements (at the individual, institutional, and systems levels) and determining which cadres/how many personnel should be prepared and where they should be placed within the system.

A systems view of capacity building would maximize resources expended (time and money) and improve accountability by clarifying performance expectations and linking it to a performance appraisal process.

Benefits of capacity building limited by post-conflict challenges

The environment in which RBHS has been building capacity is characterized by several challenges not untypical in a post-conflict work environment:

- Participants in training programs enter with a low skill set and knowledge base and require more time to bring up to standard. This was stated several times by both NGO partners and RBHS staff meaning that it takes longer to “bring people up to speed.”
- Flexibility in designing capacity building opportunities is required as well as well-trained facilitators/supervisors who are able to adjust curriculum as required and are well enough equipped in their own knowledge and skills to meet participants at their level.
- Opportunities for applying newly acquired skills and knowledge are often lacking, e.g., due to inconsistent supply of essential drugs after a training. This inability to utilize learning can result in lost skills for the individual and institution, and wasted resources.

Impact of capacity building compromised by staff turnover and a “per diem culture”

Several factors contribute to staff turnover at facilities including poor salaries and living conditions, job postings to remote rural locations far from family, attraction of moving to a larger city or to an NGO. While not quantifiable, RBHS staff contends that “Every time we go for trainings, we are training someone new from the same clinic.”

Moreover, in this context of low salaries and inadequate life/work conditions, attending workshops are viewed as the major mode of delivering capacity building opportunities as they include *per diem*. Other, perhaps more valuable capacity building options, i.e., on-the-job training and/or mentoring, is sometimes not recognized as capacity building as they do not include the *per diem*.

Supervisory capacity and bench strength inadequate

Although the assessment team was unable to participate in a supervision visit, the level and quality of supervision is generally considered inadequate, ineffective and/or sporadic (although RBHS’ M&E team has devoted considerable time in ensuring that overall supervision is improved in terms of frequency, regularity and quality). It is not surprising, therefore, that trainings are not followed –up with supervisory visits. Without strong follow up and supervision, it is difficult to know if the right people are being trained, if the new skills are being applied effectively, and if the investment of resources is paying off. Non-technical supervision is equally critical but more often absent. There does not appear to be a transparent system of rewards, benefits, or repercussions (within the Ministry) due to non-performance; and, linkages between job description and performance appraisal are either unclear or not strongly enforced thus contributing to

little accountability or motivation. All these factors make supervision difficult to enforce. Improving bench strength at all levels of the MOHSW is critical – the same few people tend to go for trainings resulting in a “shallow” foundation of qualified staff, and a higher dependency on those few staff.

v. Recommendations

Going forward, since RBHS will be directly implementing capacity building at all levels of the MOHSW (at the county level in particular) it is highly recommended that the Project develop a joint capacity building strategy based on a robust needs assessment. This will be especially important as the PMU and PBF technical team assume responsibility for implementing the PBCs through the counties and improving the quality of service delivery at the facilities. An important step in this process is for RBHS to appoint a Capacity Building Advisor and a PBF Advisor to work closely with the MOHSW at the central and county levels to implement the strategy. However, it is equally, if not more important, that the MOHSW appoint motivated leaders in each of these technical areas to take the work forward and hold staff accountable for performance against clear deliverables. With the recent completion of the 10 year Health Policy and Plan and updating of the EPHS, capacity building efforts by the RBHS team should be strategic and focused on achieving sustainable long term impact:

- Continued strengthening of policy and planning documents for the different division/units at the central level.
- Development of management and supervisory skills at all levels of the ministry including the facility and community levels.
- Linking the provision of in-service trainings through pre-service institutions using non-traditional methods thus expanding the capacities of these institutions while simultaneously supporting ongoing skills development of facility staff and community workers in an efficient and cost-effective way.

Two areas that require RBHS’ support to the ministry but have not been addressed in this assessment are drug management and infrastructure. Both these areas also require capacity building and will be a part of RBHS’ broader mandate.

Annex I

Composition of Assessment Teams

Performance Based Contracts:

- Deirdre Rogers: Performance Based Contracting Consultant
- Bal Ram Bhui: RBHS Monitoring & Evaluation Director
- Dominic Togba: MOHSW PBC Focal Point

Community Health:

- Mary Carnell: Community Health Consultant
- Catherine Gbozee: RBHS BPHS Advisor
- Asatu Dono: NMCP Focal Point for Malaria CCM
- Daniel Wessih: MOHSW Deputy Director CHSD
- Joseph Tubman: Breastfeeding Advocacy Group
- James Kollie: Africare
- Melepalay Sumo: Bong County gCHV Supervisor
- Joseph Kilikpo: Equip
- Joseph Barkolleh: IRC
- Gorma Cole: Bong County RH Supervisor

BCC:

- Carol Hooks: Behavior Change Communications Consultant
- Lahana Jarwara: Assistant Coordinator for Research, HPD
- JK Ofori: RBHS BCC Advisor
- Marietta Yekee: RBHS BCC Assistant
- Teah Doegmah: RBHS BCC Assistant

Capacity Building:

- Beth Gragg: Capacity Building Consultant
- Yilaa Wloti Se': RBHS Capacity Building Specialist
- Basiru Kpaka: RBHS Driver

Annex II

Clinics/Communities visited

Montserrado County

- Monrovia

Grand Cape Mount County

- Senje
- Bo-Waterside clinic
- Tiene clinic

Bong County

- Fenutoli
- Zebay
- Phebe hospital
- Suakoko clinic
- Salala
- Yila clinic

Nimba County

- Sanniquellie
- Ganta
- Kpain
- Bunadin
- St. Mary's clinic
- Hope clinic

Annex III

List of Interviewees for PBC Assessment

RBHS

- Dr. Richard Brennan, *Chief of Party*
- Chip Barnett, *Director of M&E and Partner Coordination*
- Mike Mulbah, *M&E Officer*
- Rufus Domah, *County Coordinator, Bong*
- Luogon Willie-Paye, *County Coordinator, Nimba*

MOHSW

- Benedict Harris, *Policy and Planning*
- Dominic Togba, *PBC Focal Point Person*

MTI (Monrovia)

- Dr. Teferi Fissehatsyone, *Project Director*
- Anthony Kollie, *M&E Officer*

EQUIP (Monrovia)

- David Waines, *Country Director*
- Justin Pendarvis, *Deputy Country Director*

EQUIP (Ganta, Nimba)

- Kristen Cahill, *Medical Coordinator*
- Olive Teah, *HIV/TB Supervisor*
- Lawrina S. Dinkey, *RH Supervisor*
- John G. Nenwah, *Data Supervisor*
- Genevive T. Nuah, *RH Supervisor*
- Alimso G. Paygar, *Clinical Supervisor*
- Gayflor Barnar, *HIV/TB Supervisor*
- David Z. Membah, *EPI Supervisor*
- Abraham D. Tozay, *Clinical Supervisor*

Merci (Monrovia)

- Dr. Tete Brooks, *Executive Director*

Africare (Monrovia)

- Ernest Gaie, *Country Director*

Africare (Gbarnga, Bong)

- Dr. Benjamin Vonhm, *Health Coordinator*
- Eric G. Sackie, *M&E Officer*
- 9 field staff

Africare (Kpaai Clinic, Bong)

- G. Browne, *OIC* and other facility staff

IRC (Monrovia)

- Allan Freedman, *Country Director*

IRC (Sanequellie, Nimba)

- Nick Low, *Program Manager*
- Peny, *Clinical Supervisor*
- 9 field staff

Nimba County Health Team (Sanequellie)

- C. Paul Nyanzee, *County Health Division Director (CHDD)*
- Dr. Cuallau Jabbe-Howe, *CHO*
- Isaac B. Cole, *gCHV/County Health Surveillance Officer*
- Jonathan S. Tokpah, *County M&E Officer*
- Priscilla S. Mабiah, *County RH Supervisor*
- Sarah W Layweh, *County Registrar/Data Manager*

Due to logistical challenges and other meeting priorities of the Bong CHT the PBC assessment team could not meet with Dr. Garfee Williams, CHO; and Guzt Nyanplu, CHT M&E Officer.

List of Interviewees for Community Health Assessment

RBHS

- Dr. Richard Brennan, *Chief of Party*
- George Kaine, *County Coordinator, GCM*
- Luogon Willi-Paye, *County Coordinator, Nimba*
- J. Mehnmon Tokpah, *County Coordinator, River Gee*
- Rufus Domah, *County Coordinator, Bong*
- William Kowah Zazay, *County Coordinator, Lofa*

MOHSW

- Dr. Bernice Dahn, *Deputy Minister & CMO*
- Boima Tamba, *Director, CHSD*
- Daniel Wessih, *Deputy Director CHSD*
- Margaret Korpkor, *County Health Team Coordinator, CHSD*
- Xavier Modol, *Consultant, MOHSW Ten-year Health Plan*
- Frank Baer, *Consultant, MOHSW Ten-year Health Plan*

NMCP

- Tolbert Nyanswah, *Program Manager*
- Asatu Dono, *CCM Focal person*

GFATM

- David Logan, *Coordinator*

NLTCP

- Dr. Catherine Cooper, *Program Manager*
- Deddeh Kessele, *Deputy Program Manager*
- Su Su Thompson, *Field Coordinator*

PPAL

- Emree Mukum Bee, *Program Manager*
- Regina Hodges, *Medical Service Delivery Officer*
- Comfort Kolle, *Youth IEC & Public Relations Officer*
- Louise Gausi, *Supervisor Market-based FP Program*

BRAC

- Dr. Haroun Or Rashid, *Technical Health Manager*

Africare

- Dr. Benjamin Vonhm, *Health Coordinator*
- Anthony Yeakpalah, *Clinical Supervisor*
- James Kolliem, *Community Health Assistant*
- Patricia N. M. Amarah, *Maternal Nurse*
- Zowah Nyeneah, *RH Supervisor*

- John Gleekiah, *Child Survival*
- George Teo, Jr, *Communicable Disease Supervisor*
- Michael S. Bondo, *Community Health Assistant Nutrition Supervisor*
- Eric G. Sackie, *M&E Officer*
- Nelly K. Harris, *Community Health Supervisor*
- Aloysius Nyan, *Clerical Assistant*

Bong County Health Team

- Melepalay K. Sumo, *gCHV Supervisor*
- Tokpa S. Wakpolo, *TB/HIV Supervisor*
- Jerries L. Walker, *Human Resource Manager*
- Stephen S.B. Cooper, *CHT Supervisor*
- Taywah Bombo, *Liberia Prevention of Maternal Mortality Focal Person*
- Gormah M. Cole, *RH Supervisor*
- Arthur Loryoun, *Pharmacist*

Nimba County Health Team

- C. Paul Nyanzee, *CHDD*
- Dr. Cuallau Jabbe-Howe, *CHO*
- Rufus G. Saye, *County Supervisor*
- Isaac B. Cole, *gCHV/County Health Surveillance Officer*

IRC-Nimba

- Nicholas Low, *Project Manager*
- Larwuo Wuah, *Reproductive Health Office*
- Joseph M. Barkolleh, *IRC Community Health Supervisor*
- Perry P. Koffa, *Clinical Officer*
- Veleh L. Donzo, *Database Manager*

Equip- Nimba

- Kristen Cahill, *Medical Coordinator*
- Joseph K. Kilikpo, *County Coordinator*
- Roland T. Suomie, *National Coordinator*
- Sam Dahn, *Regional Supervisor*
- Edward B. Zaindo, *Assistant Supervisor*
- Esther M. Bartuah, *Regional Supervisor*
- Cooper S. W. Siaway, *Assistant Regional Supervisor/BCC Focal Person*
- P. Meney K. Hurlay, *PHC Regional Supervisor*
- Emmanuel S. Johnson, *Regional Supervisor*
- Alimso G. Paygar, *Clinical Supervisor*

- Blamah Molley, *Regional Supervisor*
- J. Emmanuel Tarr, *Assistant*
- Yeh G. Gweh, *Regional Supervisor*
- Joseph Z. Suomie, *Wash Field Coordinator*

Group discussions in Bong and Nimba counties

- 32 staff at 4 health facilities
- 20 mothers of children under-5 years
- 24 gCHVs
- 47 TTM/TMs
- 25 CHCs/CHDCs

List of Interviewees for BCC Assessment

RBHS

- Dr. Richard Brennan, *Chief of Party*
- George Kaine, *County Coordinator, GCM*
- J. Mehnmon Tokpah, *County Coordinator, River Gee*
- Luogon Willie-Paye, *County Coordinator, Nimba*
- Rufus Domah, *County Coordinator, Bong*
- William Kowah Zazay, *County Coordinator, Lofa*

MOHSW

- Tamba Boima, *Director, CHSD*
- Daniel Wessih, *Deputy Director, CHSD*
- Dr. Saye Baawo, *Director, FHD*
- Rev. John Sumo, *Director, HPD*

NACP

- Sonpon Sieh, *Director*

NMCP

- Daniel Soma, *BCC Coordinator*
- Joseph Tamba, *IEC/BCC Officer*
- Bismark Wleh, *IEC/BCC Officer*

National Traditional Council of Liberia, Montserrado County

- Asulana Garsbah, *Chief*

Crusaders for Peace, Monrovia

- Julie Endee, *Executive Director and Cultural Ambassador*

Radio Cape Mount, 102.4

- Osmasa Mark, *Director*

Bong CHT

- Alphonso Kofa, *CHDD*
- Joe E. Smith, *HP Focal Person*

Africare

- Markonee Zar, *Health Program Liaison & BCC Focal Person*

Phebe Hospital OPD

- Emmanuel Dweh, *OIC*
- Nurses, *ANC*
- Group discussion with 16-29 year old mothers of children under-5 years

Suakoko group discussions

- Caregivers & TTMs
- Traditional Chiefs
- Girls 15-24 years
- Boys 16-23 years

Salala Clinic

- Miatta Yekee, *OIC*
- Mary Tennie, *CM*
- Group discussion with gCHVs

Grand Cape Mount CHT

- Theresa Alpha, *CHDD*
- John Kallon, *Clinical Supervisor*
- Varney C. Massaquoi, *HP Focal Person*

MTI, Senje

- Jerry Zangor, *Head of Field Office, Bomi and Montserrado*
- Florence Rogers, *BCC Focal Person and SBC/Supervisor*
- Community Health Promoters
- Interview with 16 year old girl in 11th grade
- Group discussion with boys 17-25 years
- Group discussion with 16-26 year old mothers of children U5

Bo-Waterside Clinic

- Patricia Gboyo, *CM*
- Elizabeth, *Dispenser*
- Joseph Kpaka, *Vaccinator/Nurse Aide*
- Jennih M. Gray, *Registrar*

Tiene Clinic

- Mayango M. Akoi, *OIC*
- Maria S. Freeman, *CM*
- Mambudu Kroma, *Registrar*
- Varney Ferka, *Lab Technician*
- Group discussion with boys 15-18 years
- Group discussion with girls 14-21 years

List of Interviewees for Capacity Building Assessment

RBHS

- Dr. Richard Brennan, *Chief of Party*
- Chip Barnett, *Director of M&E and Partner Coordination*
- Mike Mulbah, *M&E Officer*
- JK Ofori, *BCC Advisor*
- Sarah Hodge, *EmONC Advisor*
- Maima Zazay, *FP/RH Advisor*
- David Franklin, *Mental Health Advisor*
- Laretta Nagbe, *HIV/TB Advisor*
- George Kaine, *County Coordinator GCM*
- Luogon Willie-Paye, *County Coordinator, Nimba*
- J. Mehnmon Tokpah, *County Coordinator, River Gee*
- Rufus Domah, *County Coordinator, Bong*
- William Kowah Zazay, *County Coordinator, Lofa*
- Gyanu Tamang, *Former Intern*

MOHSW

- Dr. Bernice Dahn, *Deputy Director & CMO*
- Rev. John B. Sumo, *Director, HPD*
- Dr. Meiko Dolo, *Director, Mental Health Unit*
- Ellen George-Williams, *Consultant, Mental Health Unit*

NACP

- Sonpon Sieh, *Program Manager*
- Dr. Julia Toomey Garbo, *Deputy Program Manager*

Nimba CHT

- Rancy W. Leesola, *County Health Service Administrator*
- Isaac B. Cole, *gCHV/County Health Surveillance Officer*
- Karntey Deemie, *Clinical Supervisor*
- Jonathan Tokpah, *County M&E Officer*
- Priscilla Mabiah, *County RH Supervisor*
- Sarah Lewah, *County Registrar*
- Lewis Momo, *County Pharmacist*
- Nelson Kartie, *Environmental Health Coordinator*
- Jerry Manneh, *County Accountant*
- Harris Nyankaryah, *County HRM Officer*
- Austin G. Mehn, *EHT*

IRC (Nimba)

- Nicholas Low, *Coordinator RBHS Program*
- Kofa Perry, *Clinical Supervisor*

St. Mary's Clinic (Nimba)

- Celestine Yenneh, *OIC*
- Mercy Gullisiah, *CM*
- Emmanuel Dahn, *Lab Technician*

EQUIP (Nimba)

- Kristen Cahill, *Medical Coordinator*
- Olive Teah, *HIV/TB Supervisor*
- Lawina S. Dinkeh, *RH Supervisor*
- John G. Nenwah, *Data Supervisor*
- Genevive T. Nuah, *RH Supervisor*
- Alimso G. Paygar, *Clinical Supervisor*
- Gayflor Bamar, *HIV/TB Supervisor*
- David Z. Membah, *EPI Supervisor*
- Abraham D. Tazay, *Clinical Supervisor*

Hope Clinic (Nimba)

- Susannah Dolo, *CM and Acting OIC*

Africare (Bong)

- Dr. Benjamin Vonhm, *Health Coordinator*
- Eric Sackie, *M&E Officer*

Africare

- Markonee Willie, *RH Supervisor*

Yila Clinic (Bong)

- Sarah Suah, *OIC*
- Eunice Neahn, *CM*
- Samuel M. Gweh, *Vaccinator*
- David Dolo, *Registrar*

Bong CHT

- 4 patients at Hope & Yila Clinics

Annex IV

Interview Protocols: PBC

1. In a few words, please describe how PBC works.
2. Has PBC had any impact on the access to and use of services provided? If so, how?
Which services
 - a. % U1 DPT3/pentavalent; % facility-based deliveries with skilled attendant; % pregnant women IPT2; # HCT and PMTCT ; % with staff member competent to provide counseling on informed choice; CYP
3. Has PBC had any impact on the quality of services provided? If so, how? Which services?
 - a. % achieving 80% clinical STDs assessment score
 - b. % NGOs submitting timely and complete quarterly report to RBHS
4. Data shows that more staff are paid on time now than at the beginning of the PBCs. Do you feel that this has increased staff motivation to provide quality services? If so, how?
 - a. % of staff funded by NGOs paid on time during quarter
5. Has it promoted accountability for results among staff? Do you feel workers feel a stronger link between what they do and results as a result of the PBCs?
6. Did PBC increase or encourage innovation in how you carry out activities?
7. Has the NGO capacity to manage procurement, distribution and management of essential medicines been impacted as a result of the PBC? If so, how? (forecasting, ordering, storage, managing stockouts)
 - a. Drug stockouts have clearly improved over the past couple of years
 - b. % with no stock out of tracer drugs (amoxicillin, cotrimox, paracetamol, ORS, iron folate, ACT)
 - c. % OPD patients for whom no more than 3 drugs prescribed
8. Many facilities dramatically improved in their accreditation status over the first couple of years of the PBC—how much of this, if any, do you feel can be attributed to the PBCs?
 - a. % reaching one star accreditation
9. As a result of PBCs, has community involvement improved? If so, how?
 - a. % whose CHDCs held at least 3 meetings in quarter
 - b. %gCHVs who received ≥ 1 supervision visit last quarter
10. Has PBC impacted how the NGOs/facilities interact with the County Health Teams? If so, how?

- a. % facilities receiving ≥ 2 joint supportive supervision visits last quarter
 - b. % facilities receiving ≥ 3 supportive clinical supervision visits last quarter
 - c. % of timely, accurate and complete HIS reports submitted to CHT during quarter
11. FOR CHT: How have the PBCs impacted your work? (training in new HMIS system, M&E, GIS, CORE+ tools, PBF, QA; improvements in NGOs submitting HIS and quarterly reports). Have they changed your motivation?
 12. Is the current system of disbursement of quarterly payments to NGOs appropriate and effective? Is there anything that can be done to improve it?
 13. RBHS: Did PBC improve the correlation between costs and results? Improve cost efficiency?
 14. How did RBHS manage the process of developing, selecting and finalizing the performance indicators and targets for years 1 and 2 of the PBCs? Were there any issues with the indicators and/or targets? If so, what were/are the major ones?
 15. What was the effect of not meeting a target (on paper vs. in reality)?
 - a. Who was it felt by: the NGO/provider/recipient?
 - b. Did providers/NGOs feel it was an implicit criticism of their individual performance?
 16. Did you feel sufficiently supported by RBHS in how to distribute the bonus? If not, what else could they have done?
 - a. Was the bonus sufficient in motivating behavior?
 17. Please describe RBHSs' data validation process.
 - a. What did you do to prepare for RBHSs' data validation process?
 18. As a result of PBC, are you addressing the greatest needs, as opposed to being forced to focus only on what is incentivized (i.e., do the incentivized indicators match the greatest needs in your region)?
 19. CHT: Do you feel that performance based contracting improved standardization of performance across facilities/counties/NGOs?
 20. How was and is the general communication between RBHS and NGOs/CHTs?
 21. What has worked well and what are the lessons learned or suggestions for the future in relation to how RBHS has managed Performance Based Contracts?
 22. Has performance based contracting improved the capacity of your organization? If so, how?

23. What are the main factors for success, ensuring PBC supports and encourages NGOs to meet targets? And do you think RBHS did enough to ensure that those factors were present?
24. What have been the main obstacles to success, and how did RBHS do in minimizing these obstacles?
25. Is PBC disadvantageous/biased against local NGOs or NGOs without strong international backing and support?

Interview Protocols: Community Health County Coordinators

1. Briefly describe the role and responsibilities of the CC? Does it vary by county (if so, why)? What is the relationship between the CC and the CHT, NGO?
2. How does the CC's work specifically support community activities? In what ways can the CC further strengthen their support to communities?
3. Given that the CCM program under RBHS is intended to train the gCHVs, educate communities, and assist CHTs in managing the implementation and support to CCM, how well has the pilot succeeded? How could the program have been strengthened? What could the CC do to enhance it?
4. What are the barriers to increasing the capacity of CHTs, CDHCs?
5. What if any is the interface between CCM and CBD activities in your county? How can TTMs support communities?
6. What impact has the various community interventions, BCC and facility level support had on your communities? Have individual and household practices changed? Have provider attitudes improved? In what ways? Can these efforts be sustained when RBHS ends? What do we need to put in place now to ensure that it happens?

Interview Protocols: Community Health NMCP

1. In how many communities has NMCP launched malaria CCM? Does the program look different in the RBHS communities from those implemented elsewhere? In what ways? How long has the program been in place? [Disaggregate RBHS communities from rest, who supports the non-RBHS CCM program.]
2. What have you learned from the implementation of the malaria CCM program thus far? What have been the challenges and barriers to implementation? How are these being addressed? [Probe on supply chain, stock outs, drug availability at facilities vs. community, supervision, “motivation”]
3. How does NMCP envision the roll out of the malaria component of the CCM? What roles – if any - are envisaged for the gCHVs, facilities, community structures, BCC? [Probe on task-shifting and its implications, mobilizing demand for ACT, bed nets.]
4. Is there value to integrating malaria CCM with other interventions (e.g., diarrhea, ARI, TB-DOTS, and CDD)? Certain interventions more so than others? Reasons.
5. What are the measures of success for the malaria CCM program? [Probe for facility and community levels, quantitative and qualitative measures.]
6. What are your insights on the 6-month data from the RBHS CCM program (i.e. why the numbers of reported malaria cases in communities have declined)?
7. How could the program’s sustainability be ensured? [Probe for role of CHTs, NGOs, and community structures.]

Interview Protocols: Community Health CHSD

1. How many different CCM interventions have been piloted in Liberia? In which counties, for what diseases, and who has supported these different programs? What are the similarities and differences between these programs? What lessons have been learned to-date?
2. The national CCM strategy has been evolving over the past several months (based on lessons learned?) – what is the current thinking on how CCM will be implemented in Liberia? [Probe on population size per gCHV and TTM, task shifting, formal linkages between TTMs and gCHVs, supervision at county and community levels, and supply chain at facility and community levels.]
3. What role is envisaged at the county level for implementation of CCM? How will it link to BCC and other community mobilization efforts including support to existing community structures? [Probe for overall supervision at CHT, role of CHCs and CDHCs and plans for strengthening their capacities.]
4. How will the CHSD ensure the integration of vertical programs through CCM? What are some barriers and challenges to doing so? How will these be addressed?
5. What role, if any, will NGOs play in supporting CCM in the counties in which they work? How will the CHSD support collaboration and coordination between NGOs, CHTs, community structures and vertical programs?
6. What are the anticipated measures of success for the CCM program?
7. What are your insights on the 6-month data from the RBHS CCM program (e.g., why the numbers of reported malaria cases in communities have declined)?
8. How could the program’s sustainability be ensured?

**Interview Protocols: Community Health
PPAL**

1. In how many communities has PPAL launched the CBD program for FP? Does the program look different in the RBHS communities from those implemented elsewhere? In what ways? How long has the program been in place? [Disaggregate RBHS communities from rest, who supports the non-RBHS CBD program.]
2. What have you learned from the implementation of the CBD program thus far? What have been the challenges and barriers to implementation? How are these being addressed? [Probe on supply chain, stock outs, method availability at facilities vs. community, supervision, “motivation”]
3. How does PPAL envision the roll out of the CBD program? What roles – if any - are envisaged for the TTMs, gCHVs, facilities, community structures, BCC? [Probe on task-shifting and its implications, mobilizing demand for methods.]
4. Is there value to integrating FP with other interventions (e.g., diarrhea, malaria, ARI, TB-DOTS, and CDD)? Certain interventions more so than others? Reasons.
5. What are the measures of success for the FP program? [Probe for facility and community levels, quantitative and qualitative measures.]
6. How could the program’s sustainability be ensured? [Probe for role of CHTs, NGOs, and community structures.]

Interview Protocol – Community Health Group Discussion Guide

Warm-up:

1. Introduce self – you are the moderator, and briefly explain what you are there to do. Introduce the note-taker and observers (if any). Participants should ignore their presence!
2. Tell participants why they have been invited, and let them know that you are interested in their opinions and experience and that there is no right or wrong answer – whatever they say is valid.
3. The meeting will take approximately 1 ½ hours.
4. Explain that you would appreciate if they spoke one at a time as that would help you to listen to them and for them to listen to each other.
5. The meeting is intended to be a discussion so not just talk to moderator but also to each other.
6. Participants don't have to agree with each other so it is okay – in fact it is good - if their experiences are varied.
7. The discussion will be kept confidential and only reported in aggregate – no attribution.
8. Ask if it is okay to tape the discussions (before turning on the tape recorder).
9. If it is okay, you can begin. Ask if they have questions for you.

Introduction:

1. You all may know each other but we don't know you, so please introduce yourselves and say one thing which others don't know about you (or some such ice breaker). Start with yourself again – your name and one thing about yourself.

Closing:

We have taken a lot of your time and greatly appreciate all that you have shared. Do you have any questions for me or my colleagues?

If not, ask the note-taker and observers if they have questions for the participants that have not been addressed. If nothing else, then thank everyone again, and end.

DISCUSSION GUIDE

Mothers

Key points of the introduction

Warm-up:

1. Introduce self – you are the moderator, and briefly explain what you are there to do. Introduce the note-taker and observers (if any). Participants should ignore their presence!
2. Tell participants why they have been invited, and let them know that you are interested in their opinions and experience and that there is no right or wrong answer – whatever they say is valid.
3. The meeting will take approximately 1 hour 30 minutes.
4. Explain that you would appreciate if they spoke one at a time as that would help you to listen to them and for them to listen to each other.
5. The meeting is intended to be a discussion so not just talk to moderator but also to each other.
6. Participants don't have to agree with each other so it is okay – in fact it is good - if their experiences are varied.
7. The discussion will be kept confidential and only reported in as a group with no individuals comments identified.
8. Ask if it's okay to tape the discussions (before turning on the tape recorder).
9. If okay, you can begin. Ask if they have questions for you.

Introduction:

1. You all may know each other but we don't know you, so please introduce yourselves and say one thing which others don't know about you (or some such ice breaker). Start with yourself again – your name and one thing about yourself.

Questions

Subjects to be covered	Introductory and probing questions
<u>Attitudes on care seeking</u>	<ol style="list-style-type: none">1. Tell us what happened when your child was sick recently. What did you do?2. Does everyone in your village do the same? What do others do in general to treat sick children?3. Are there any treatments you give at home first? What and for what conditions? – In persistent or severe cases, who do you turn to first?
<u>Services available in</u>	<ol style="list-style-type: none">4. How did you learn that the gCHVs could treat your sick child?

<u>the community</u>	<ul style="list-style-type: none"> -Where is the nearest gCHV to your home? How long did it take you to get there? -What kinds of problems can gCHV help with? <p>5. What are the hours when you can get help from gCHV?</p> <ul style="list-style-type: none"> -How did you manage to find the gCHV when your child was sick? How long did it take you to find her/him? <p>6. What other health services or health information is available in your community?</p>
<u>Assessment of the actions taken by the CHW</u>	<p>7. When your child has a fever, does the gCHV do a test?</p> <ul style="list-style-type: none"> - Do you find it useful? Why? - When the test is negative, and you are not given a drug against malaria, what do you tell the gCHV? How do they respond? <p>8. Do you think it is necessary to have a gCHV who can treat your sick child in your village? Why?</p> <ul style="list-style-type: none"> - What do you find different from before when your child got sick? <p>9. What do you think about the care your child received by the gCHV?</p> <ul style="list-style-type: none"> - For which illnesses are you most confident that the gCHV is competent to take care of your children? Explain - For which illnesses are you hesitant to have the gCHV treat your children?
<u>Knowledge of mothers already served by gCHV</u>	<p>10. What are the warning signs that might lead you to seek care immediately? With whom do you seek care?</p> <p>11. What can you do to prevent your child from getting diarrhea, malaria or pneumonia?</p> <p>12. When you receive treatment from the gCHV, how do you direct him to your home?</p>
<u>Suggestions</u>	<p>13. Are there specific things that you would suggest that the gCHV do differently? More of? Less of? Explain</p>

Conclusion

Are there issues that we have not covered in this discussion that you feel are important? Which ones? Please give us your opinion.

I heard that you said this morning / afternoon that- Have I summarized your thoughts correctly? Is there anything you would like to add or change to this?

Thank you very much for your time. The information you have provided will improve the program of community-based case management not only here in your community, but also throughout Liberia.

DISCUSSION GUIDE

CHC and CHDC Group discussion

Key points of the introduction

Warm-up:

1. Introduce self – you are the moderator, and briefly explain what you are there to do. Introduce the note-taker and observers (if any). Participants should ignore their presence!
2. Tell participants why they have been invited, and let them know that you are interested in their opinions and experience and that there is no right or wrong answer – whatever they say is valid.
3. The meeting will take approximately 1 hour 30 minutes.
4. Explain that you would appreciate if they spoke one at a time as that would help you to listen to them and for them to listen to each other.
5. The meeting is intended to be a discussion so not just talk to moderator but also to each other.
6. Participants don't have to agree with each other so it is okay – in fact it is good - if their experiences are varied.
7. The discussion will be kept confidential and only reported in as a group with no individuals comments identified.
8. Ask if it is okay to tape the discussions (before turning on the tape recorder).
9. If okay, you can begin. Ask if they have questions for you.

Introduction:

1. You all may know each other but we don't know you, so please introduce yourselves and say one thing which others don't know about you (or some such ice breaker). Start with yourself again – your name and one thing about yourself.

Questions

Subjects to be covered	Introductory and probing questions
<u>Development of the community based health program</u>	<ol style="list-style-type: none">1. How was the CHC/CHDC formed? How were you selected to be on the CHC/CHDC?2. Are there females on the committee? If yes, how many females are on the committee? If no, why do you think females are not participating?3. How were the gCHVs chosen? Do you think this is the right process? Do you have suggestions to improve the selection process?

<u>Operations of the committee</u>	<p>6. What are the day to day roles of the committee? What are the roles that you find the most important? Why?</p> <p>7. How does the committee operate?</p> <ul style="list-style-type: none"> - Who are the members? - How often are meetings held? When was the last meeting? - What are the topics discussed during these meetings? - Are there reports/minutes of meetings?
<u>Assessment of actions of community health volunteers</u>	<p>8. How do you assess the work carried out by the gCHVs and TTM?</p> <ul style="list-style-type: none"> - In which cases are you most satisfied with the CHVs? Explain - In which cases are you least satisfied with the CHVs -----? Explain.
<u>Motivation of community health volunteers</u>	<p>9. What has the CHC/CHDC done to help motivate the community health volunteers to continue to offer service in their communities?</p> <p>10. Do you think it is enough to sustain the program? Do you have suggestions on what else could be helpful?</p>
<u>Recommendations</u>	<p>11. Are there specific things that you would suggest that the CHVs do differently? More of? Less of? Explain</p>

Conclusion

Are there issues that we have not covered in this discussion that you feel are important? Which ones? Please give us your opinion.

We have taken a lot of your time and greatly appreciate all that you have shared. Do you have any questions for me or my colleagues?

If not, ask the note-taker and observers if they have questions for the participants that have not been addressed.

Thank you very much for your time. The information you have provided will improve the program of community-based health programs, not only in Liberia but also in other countries.

DISCUSSION GUIDE

General Community Health Volunteers- gCHVs

Warm-up:

1. Introduce self – you are the moderator, and briefly explain what you are there to do. Introduce the note-taker and observers (if any). Participants should ignore their presence!
2. Tell participants why they have been invited, and let them know that you are interested in their opinions and experience and that there is no right or wrong answer – whatever they say is valid.
3. The meeting will take approximately 1 hour 30 minutes.
4. Explain that you would appreciate if they spoke one at a time as that would help you to listen to them and for them to listen to each other.
5. The meeting is intended to be a discussion so it is not just talking to the moderator but also to each other.
6. Participants don't have to agree with each other so it is okay – in fact it is good - if their experiences are varied.
7. The discussion will be kept confidential and only reported in as a group with no individuals comments identified.
8. Ask if it is okay to tape the discussions (before turning on the tape recorder).
9. If okay, you can begin. Ask if they have questions for you.

Introduction:

1. You all may know each other but we don't know you, so please introduce yourselves and say one thing which others don't know about you (or some such ice breaker). Start with yourself again – your name and one thing about yourself.

Specific Questions

Subjects to be covered	Main questions and follow-up questions
<u>Selection</u>	1. How were you selected to be a gCHV? When was that done? How did it make you feel to be selected?

<u>Training</u>	<p>2. Can you describe the training you have received to do this job?</p> <ul style="list-style-type: none"> - How many sessions? - How many days each? - When did you last receive training? - What topics were included in the training? <p>3. What is your opinion on the quality of the training?</p> <ul style="list-style-type: none"> - What aspects would you suggest to change in the training to make it more useful and effective?
<u>Activities</u>	<p>4. Can you describe what activities do you do in the context of community based case management? Curative? Preventive?</p> <ul style="list-style-type: none"> - How many children do you see on average every month? Every day? Do you find that this is a lot? A little? - Why? - How do you organize both your family duties and work as a gCHV? <p>5. Are you using the rapid diagnostic test for determining whether a child has malaria?</p> <ul style="list-style-type: none"> - Do you find it useful? Explain why? - How do the mothers feel about the use of these tests? When the test is negative, what do the mothers say? How do you respond?
<u>Record keeping</u>	<p>6. How do you record the work you do? Do you make a report?</p> <ol style="list-style-type: none"> a. Is it difficult for you? How does it help you? b. Does anyone use the records you make? CHC? c. Has anyone given you any feedback on your work?
<u>Supervision</u>	<p>7. Can you describe the supervision you received after training?</p> <ul style="list-style-type: none"> - How many times? By whom? How long was each session? - When did you last receive supervision? - What was the last supervision on? Explain <p>8. How do you like this supervision?</p> <ul style="list-style-type: none"> - Did the supervision visit help you to do your work better? Explain - What do you enjoy most about supervision? Explain - What do you like the least about supervision? Explain <p>9. What aspects do you want to strengthen or change in the supervision to make it more useful and effective?</p> <ul style="list-style-type: none"> - Frequency? Explain - How to conduct supervisions? By whom? Explain

<u>Community Support</u>	<p>10. How does the community support your work?</p> <ul style="list-style-type: none"> - Are there people who assist you to do community engagement sessions? Who are these people? How do they work with you? - How do you and the TTM work together in the community? Do you meet on regular basis? Do you do any activities together? - If you have a problem with your work, is there anyone in the community you can go to? Who is it?
<u>Support Leaders</u>	<p>11. How do your leaders support your work?</p> <ul style="list-style-type: none"> - What is your opinion on the importance of support from your leaders? - What do you expect more from leaders? Explain.
<u>Motivation</u>	<p>12. You have been a volunteer for some time and still are today. What are the reasons that keep you volunteering? Explain</p> <p>13. Do you know anyone who has left the CHW program?</p> <ul style="list-style-type: none"> - If yes, why have some of your colleagues left the program? - Do you sometimes feel this way? Explain - Do some of you think of leaving the program at some point? Why is this? <p>14. Do you have any suggestions that would make you more motivated and interested in this job? Why? Explain</p>

Conclusion

Are there issues that we have not covered in this discussion that you feel are important? Which ones? Please give us your opinion.

I heard that you said this morning / afternoon that- Have I summarized your thoughts correctly? Is there anything you would like to add or change to this?

Thank you very much for your time. The information you provided will improve the program of community-based management, not only in your county but across Liberia.

DISCUSSION GUIDE

Health Facility Staff

Key points of the introduction

Thank you for granting us this interview. As you know, we are here to assess the progress with community based health activities in RBHS supported counties. Our group has specifically selected you to help us in this exercise because of your experience. Sharing your experience will help Liberia to expand and strengthen its community health activities in the future.

This discussion will take approximately 1 hour and 30 minutes, with your permission; we will proceed to record the interview.

Naturally, we want to know where things are going well and are not going well. We want to gather your thoughts, even if parts seem negative because it is the only way we can learn.

Questions

Subjects to be covered	Introductory and probing questions
<u>Role of health facility staff in community health programs</u>	<p>1. How many catchment committees do you serve? How far of a walk is it to the farthest communities in the catchment area of your facility? Can you describe the role of your health facility staff in community health programs? What do they do to support community health programs in the catchment area? Who is responsible for which programs?</p>
<u>Selection of gCHVs and TTMs</u>	<p>2. How many gCHVs do you have in the catchment area? How many female ones? How are the gCHVs and TTMs selected? Do you think there are other community health volunteers? What do they do?</p> <ul style="list-style-type: none"> – Do you think this is the right process? Why? – How were you involved in the selection process? <p>3. Have any of you participated in the training of gCHVs/TTMs? What was your role?</p> <p>4. Have any of you participated?</p>
<u>Management of gCHVs and TTMs</u>	<p>5. Describe your daily role with the gCHVs and TTMs</p> <ul style="list-style-type: none"> – What roles do you find most important? Why? – When do you meet with the gCHVs and TTMs? – What topics do you discuss with the gCHVs and TTMs when you meet with them? <p>6. Who is the supervisor of gCHVs? Who is the supervisor of TTMs?</p>

	<p>Can you describe how you do supervision? Tools you use? Reports? Feedback to workers? Feedback to OIC or CHDC?</p> <p>7. What is the role of the health facility to supply gCHVs with their drugs and supplies?</p> <p>8. Are there any scheduled meetings between gCHVs and TTMs? How do they coordinate community health activities in their community? How do they support each other?</p> <p>9. Give concrete examples of actions you have taken to support the CHW. What were they? When? What were the results?</p> <p>10. Do you find that your interactions with the CHW are sufficient? Why? Can you do more? Explain?</p> <p>11. What are the ways that the CHW is currently motivated to serve their community? Can you suggest additional ways to sustain their motivation?</p>
<p><u>Assessment of the actions taken by the gCHV</u></p>	<p>12. Does the gCHV in your area use the Rapid Diagnostic Test to determine whether a child has malaria? How many of the gCHVs were trained to perform RDT? ARI and diarrhea?</p> <ul style="list-style-type: none"> - Do you find that the RDT is useful for the gCHV? - How do mothers feel about the use of the test? When the test is negative, what do the mothers say? How do you respond? Do you believe that the gCHV responds the same way? Explain - How often do you submit reports? Do you have copies of your reports? <p>13. Do you find it useful to have gCHVs treating cases of diarrhea, malaria and pneumonia in the community, in addition to the children you treat here at the health facility? Explain</p> <ul style="list-style-type: none"> - What do you find is different before and after the opening of the CCM program? <p>14. How do you assess the quality of care given by gCHVs?</p> <ul style="list-style-type: none"> - For which illnesses are you the most satisfied with the work of the gCHV? - In which cases are you least satisfied with the work of the gCHV?
<p><u>Suggestions</u></p>	<p>15. Are there specific things that you would suggest to the CHW to do differently? More of? Less of? Explain</p>

Summary and Conclusion

Are there issues that we have not covered in this discussion that you feel are important? Which ones? Please give us your opinion.

I heard that you said this morning / afternoon that- Have I summarized your thoughts correctly? Is there anything you would like to add or change to this?

Thank you very much for your time. The information you provided will improve the program of community-based programs, not only in your area but also across Liberia.

BCC Assessment Description and Discussion Guides

Assessment Description

Project Goals:

- Provide quality health services
- Build MOHSW capacity to provide quality health services

Health Topics Covered:

- Malaria, HIV, TB, FP/RH, Safe Motherhood, Child Health, Childhood Immunization, Nutrition

Assessment Purpose:

- Inform strategy and activities in the second half of the project – what is working well, what needs to be improved
- Identify and document lessons learned for future application to JSI and USAID projects

BCC Assessment Components:

- Review of quantitative data already collected by RBHS (dipstick survey results).
- Qualitative expert review of the RBHS BCC strategy and the timeframe in which it has been implemented.
- Focus group discussions held in selected communities in at least two counties to investigate the extent to which community members are hearing and understanding BCC messages.
- Interviews with members of the MOHSW Health Promotion Unit, selected county BCC focal persons, and RBHS partner NGOs to assess how well they understand the strategy and how effectively they think it has been implemented.

Imperatives:

- Sample low-performing as well as high-performing counties, partners, trainee types
- FGDs with beneficiaries (reached and unreached)

BCC questions to answer:

- How well are plans and materials shared and disseminated?
- How effective have BCC activities been in affecting change in target population behaviors?
- How can we help ensure sustainability?

Key areas to cover:

- Quality, quantity, and distribution of training (including effectiveness of cascade training)
- Quality, quantity, and distribution of technical assistance
- Approaches chosen – relevance, ease of implementation, effectiveness
- Awareness, understanding, and buy-in to project goals and objectives, BCC strategy
- Sustainability
- Integration of activities across health topics, project arms, and audiences
- Obstacles to full implementation and effectiveness of BCC strategy and work plan
- Opportunities for improvement, replication, building on success

BCC Interview Guide – Partners, Implementers, Trainees

- [Intro: purpose, format, duration]

Respondent's role, expectations, and general feedback

- Your [respondent's] role
- What you expect from RBHS BCC
- What you are getting from working with RBHS BCC
- What kind of funding and TA do you get (in general and from RBHS)
 - How helpful are they?
 - What more do you need?
- What's working well?
 - How would you expand on it, replicate it, further improve it?
- What you would like to see working better?

Training

- Training received (ask about BCC training if not mentioned)
- How training is being used
- Any follow-up to training provided or needed
- Other training needed
- How easy or difficult has it been to translate training and TA into action?
 - Can you give an example or two?
- How easy or difficult has it been to pass them on to other staff/managers?
 - Can you give an example or two?

BCC Strategy and Outputs

- Are RBHS BCC efforts impacting basic public health services? If so, how [ask for examples]? If not, why do you think that is?
 - Strengths and weaknesses of ASRH efforts, malaria efforts, FP effort, HIV efforts
 - Attention to gender issues
- How can RBHS better support BCC efforts
- Familiarity with Malaria radio spots, posters, counselling cards
- Use of Malaria radio spots, posters, counseling cards
- Usefulness of Malaria radio spots, posters, counseling cards
- Areas for improvement with Malaria radio spots, posters, counseling cards
- Familiarity with, use of, and usefulness of Family Health Cards. Areas for improvement.
- Familiarity with, use of, and usefulness of Journey of Hope. Areas for improvement.
- Familiarity with, use of, and usefulness of CHEST kits. Areas for improvement.

- “Healthy Life for a Healthier Liberia” purpose, use, effectiveness
- For service providers, including gCHVs: Do you do patient education? Please describe what you do. [Probe as necessary.]
- For service providers, including gCHVs: Do you do community education? Please describe what you do. [Probe as necessary.]
- Aware of RBHS BCC strategy
- Seen/have copy of RBHS BCC strategy
- Thoughts on RBHS BCC strategy development, implementation, and assessment
- How realistic are the goals and objectives?
- Probe about:
 - Creativity and innovation
 - Most successful
 - Synergy between topic areas and or project elements
 - Harmonization of messages and activities
 - Pace of activities
- How well are formative or other research findings being applied to audience selection/segmentation, messaging, choice of strategies and activities?

Partnership

- BCC partnerships—how working, how many, what doing, successes, challenges
 - Effectiveness of collaboration
 - Harmonization of messages and activities
- What is [MOHSW, IP, other] doing differently because of BCC training/TA?
- To what extent do RBHS BCC efforts complement those of other development partners?
- Interaction between BCC and other areas (service provision, community health, pre-service)

Lessons Learned and Sustainability

- Lessons learned, lessons to take forward
- Please comment on the current capacity of the MOHSW (including NMCP, FPD, HPD, CHD, NACP, TB/Leprosy, etc.), CHT, and IP to plan, implement, and monitor BBC activities.
 - What would it take for them to become fully capable?
 - What stands in the way?
- For you, what would sustainability of RBHS’s BCC efforts look like?

General

- Questions from respondent
- Conclusion and thanks

BCC Group Discussion Guide – Beneficiaries

[Plan to get participants' reactions to sample materials and messages]

- Common health problems
- What they know about them and where they have learned it
- Any difference in where they sought treatment two years ago and where they have been seeking treatment lately
- What they know about child health and immunization, safe motherhood, family planning, community case management of childhood illness, malaria, HIV/AIDs, TB, and nutrition (as relevant to the specific audience/FGD group)
- Where they learned it
- What they would like to know
- How/where they get health information
- How they get other information (farming advice, where to buy specific things, etc.)
- Interaction with implementing staff and volunteers (gCHVs, CBDs, others?)
- [For adolescents especially] Who staff the FP clinic?
- Knowledge about how to prevent malaria, unwanted pregnancy, etc.
- Attitudes about health and FP issues
- Relevant health practices (prevention and treatment of malaria, diarrhea, respiratory infection, HIV/AIDS; family planning, reproductive health, malnutrition, etc.)
 - [As appropriate to the audience, ask if they practice the target behaviors and what they do if/when they wish to avoid pregnancy, a child has fever, a child has diarrhea, etc.]
- Familiarity with, understanding of, and “attractiveness” of RBHS messages and materials
 - [Show/play select materials after eliciting what they've heard/seen]
- Anything to add
- Any questions
- “Thank you for participating. The information you have shared will help us improve the project so that it has a greater impact on Liberians' health and welfare.”

Interview Guide – gCHVs

- How long have you been a gCHV?
- What do you like about being a gCHV?
- How many hours per week do you do gCHV work?
 - How much is education?
 - How much is identifying, treating, or referring for illnesses?
- How often do you go into the community?
- How many communities do you serve?
- How often does a supervisor visit you?
- Are there other volunteers in your community? What kind? (TTMs, HHPs, other)
- What training have you received?
- What skills did you learn?
- How did it help?
- What IEC materials do you have now?
- What are you teaching people about diarrhea? Malaria? TB? Pneumonia? HIV? HW? Vaccination?
- Do you teach them about anything else?
- Who selected you to be a gCHV?
- Do you have a training manual?
- What topics does it cover?
- Do you do anything differently since you became a gCHV?
- Do you see any changes in your community?
- How far do you walk to get to the furthest community you serve?
- Do you have a cell phone?
- For you, what are some challenges of being a gCHV?
- What do you dislike about being a gCHV?
- How often do you complete reports?

[Have a volunteer demonstrate using a picture card to conduct a community education session.]

Interview Protocols: Capacity Building

Non-RBHS Personnel

1. How long have you run this program?
2. What successes and challenges/constraints have you had in implementing the program?
3. How do any of these successes and challenges/constraints relate to the capacity of your people?
4. What does Capacity Building mean to you?
5. Is Capacity Building a part of your work plan?
6. What role have you played in capacity building within your project?
7. What methods have you used for capacity building?
8. Is supervision a part of your work plan? If so, how is supervision carry out?
9. What support has come from RBHS for Capacity Building?
10. How does this support come to you?
11. What has RBHS done to build or enhance the capacity of your staff and program?
12. With RBHS support, has there been any success in running your program? If yes, what are they?
13. With the support that RBHS provides, who are the direct beneficiaries in terms of capacity building?
14. Is RBHS providing enough support to your program for Capacity Development purposes? If no, where do you think RBHS could be more supportive?

Interview Protocol RBHS Staff

1. How long have you been in this employ?
 2. How do you like your current position?
 3. What do you really do in this position?
 4. What successes have you had in this position?
 5. What challenges have you faced?
 6. What does capacity building mean to you?
 7. What do you think capacity building means to your partners/Ministry?
 8. What methods have you used for capacity building?
 9. What successes have you had in building capacity with partners and/or with the Ministry?
 10. What challenges have you faced in building capacity with partners and/or with the Ministry?
 11. Do you think RBHS has done anything to strengthen or develop the capacity of the Ministry or partners? If no, why not?
 12. Has RBHS done anything to help you strengthen your skills or knowledge and/or your team's skills or knowledge? If so, what is that?
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