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QUARTERLY REPORT

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Abbreviations and Acronyms

CBO	Community-Based Organizations
COP	Chief of Party
C-HMIS	Community Health Management Information Systems
C-HRIS	Community Human Resource Information System
C-LMIS	Community Logistics Management Information Systems
CHDD	Community Health Department Director
CHSS	Community Health Services Supervisors
CHRM	Community Health Road Map
CHS	Community Health Services
CHSD	Community Health Services Division
CHT	County Health Teams
CHV	Community Health Volunteer
CLTS	Community-Led Total Sanitation
CM	Community Mobilization
CSH	Collaborative Support for Health Systems Strengthening
CSO	Civil Society Organization
DEHT	District Environmental Health Technicians
DHSWT	District Health and Social Welfare Teams
DSW	Department of Social Welfare
EPSS	Essential Package of Social Services
ETL	Education through Listening
EVD	Ebola Virus Disease
FARA	Fixed Amount Reimbursement Agreement
GOL	Government of Liberia
GC	Global Communities
HCO	Health Communication Officer
IRC	International Rescue Committee
HPD	Health Promotion Division
M&E	Monitoring and Evaluation
MGCSP	Ministry of Gender Children & Social Protection
MIA	Ministry of Internal Affairs
MOH	Ministry of Health
MPW	Ministry of Public Works
NGOs	Non - Governmental Organizations
NHCS	National Health Communication Strategy (NHCS)
NL	Natural Leaders
NLN	Natural Leaders Network
OVC	Orphans and Vulnerable Children
PACS	Partnerships for Advancing Community Services
PBF	Performance based financing
PPAL	Planned Parenthood Association of Liberia
PCI	Project Concerns International
PSI	Population Services International
QA	Quality Assurance
TOT	Training of Trainers
TNIMA	Tubman Institute of Medical Arts
WQ	Water Quality

I. Introduction

Despite significant improvements in the health of Liberians since the end of the country's civil war in 2003, large disparities in access to care still exist. The Government of Liberia (GOL) has prioritized community level health, social welfare and WASH services as an effective means of further improving the health status of Liberians, and this focus has been articulated in various policies, strategies, and plans. However, the Ministry of Health (MOH), Department of Social Protection at the Ministry of Gender, Children & Social Protection (MGCSP) and Ministry of Public Works (MPW), as well as other key ministry departments lack the resources, capacity, planning, supervision, and coordination at both central and county levels to operationalize these guidance documents. These institutional limitations were further exacerbated by the Ebola Virus Disease (EVD) outbreak in 2014, which highlighted suboptimal organization and management of health services. The health crisis caused by EVD underlined a need for not only substantial investment in institutional capacity building to develop and implement strategies aimed at strengthening health systems and the delivery of health services, but also in effectively engaging the communities in the management of their health and sanitation needs.

The PACS strategy is to develop tailored capacity building packages for Ministry counterparts and local civil society organizations (CSOs) to help them manage and deliver quality community-based services, while emphasizing alignment with national guidance documents and close coordination with Government of Liberia (GOL) ministries, other USAID partners, as well as implementers funded through other donors. A comprehensive and fully participatory approach to institutional strengthening and capacity building will go beyond knowledge transfer and address context-specific factors, including those issues critical for a post EVD environment. Within Government of Liberia (GOL) ministries, this is supported through a coordinated technical assistance (TA) model that blends embedded TA with targeted short-term TA (STTA) to ensure high quality inputs are integrated into day-to-day work. Within civil society, a dedicated Partnership Team serves as a consistently available point of contact for local CSOs, walking them through a series of self-driven steps for performance improvement and eventual graduation to direct grant management.

The PACS project brings together a qualified set of international and national NGOs to advance community-based services for health in Liberia, with a particular focus on Bong, Lofa, and Nimba counties. The International Rescue Committee (IRC), Global Communities (GC), and Population Services International (PSI) offer extensive global expertise as well as over 36 years of programming in Liberia. Local NGOs, the Planned Parenthood Association of Liberia (PPAL) and Young Men's Christian Association of Liberia (YMCA) are proven field level implementers of health and social welfare activities and are leading the way for Liberian civil society. This team consolidates its skills and resources to increase access to quality community-based health services, support the implementation of effective health communications strategies, and improve access to safe WASH services.

Project Goal, Objectives and Expected Results

The PACS goal is to build the capacity of Ministry counterparts and local civil society organizations (CSOs) to manage and deliver quality community-based services, while emphasizing alignment with national guidance documents and close coordination with Government of Liberia (GOL) Ministries, other USAID partners, as well as implementers funded through other donors.

PACS project has the following objectives:

- Broadened capacity of Ministry of Health (MOH), Community Health Teams (CHTs), NGOs, and community organizations to implement and manage community services.
- Increased availability of community-based health and social welfare service
- Improved health-seeking behavior and practice
- Improved access to safe WASH services

This report covers the activities and results of the PACS Project for the period July 1, 2015-September 30, 2015 (Quarter 2 of Year 1). It is structured according to the areas of intervention that are outlined in the Program's description and work plan. The report consists of three parts. The first part includes the introduction and synthesis of principal results attained over the quarter. The second part presents in detail the project's strategies and approaches, activities implemented, and results obtained. The third part presents key challenges and the activities planned for the upcoming quarter.

II. SUMMARY OF PRINCIPAL ACTIVITIES AND RESULTS

Project Management

- Preparation and submission of the PACS modification technical proposal and budget;
- Preparation of PACS year 2 annual implementation plan;
- Mobilization of the logistics material for the PACS modification;
- Preparation of the modifications to the sub-grant agreements between IRC and consortium partners' members (GC, PSI, PPAL, and YMCA).

Result 1: Broadened capacity of the MOH, CHTs, NGOs/CBOs/CSOs to implement and manage community services

- PACS facilitated MOH units (Community Health Services Division – CHSD, Health Promotion Division – HPD, and Division of Environmental & Occupational Health – DEOH);
- Completed Self-Assessment for 3 MOH units (Community Health Services Division – CHSD, National Health Promotion Division – HPD, Division of Environmental & Occupational Health – DEOH);
- Successfully negotiated and finalized the content of the technical agreements with the MOH units;
- Maintained coordination and collaboration with other key USAID implementing partners.

Result 2: Increase availability of community-based health and social welfare services

- Completed the mapping of the CSOs/CBOs in the counties of Bong, Nimba and Lofa;
- Mapping reports are available with the CBOs/CSOs proposed to support the provision of the community health, social and welfare services;
- Contributed to the definition of the content of the standardized Integrated Service Delivery Package to be provided at the community level and the review/design of the national Health Services Policy and the national health promotion policies;
- Assisted the MOH in conducting the training in iCCM, and IPC for 149 community health cadres (gCHVs) in the counties of Bong, Lofa, and Nimba.
- Provided iCCM kits and materials to all of the 149 trainees to be able to provide community health services.

Result 3: Improve health-seeking behaviors and practices

- Completed the design for the Knowledge Attitude and Practices (KAP) study and received IRB approval in September 2015;
- Conducted pilot training of 150 gCHVs in Education Through Listening (ETL) across 3 counties and 6 districts;
- Conduct TA visits to support and monitor the application of ETL by gCHVs in the community;
- Facilitated the validation and administration of BCC Self-Assessment tools by the MOH;

Result 4: WASH Infrastructure Management Improved

- Trained 627 natural leaders in charge of implementing WASH/CLTS activities;
- Triggered 181 CLTS communities and more than 50% of those communities became ODF;
- Triggered communities constructed 4,494 household latrines;
- communities constructed 4,751 hand washing facilities, 10,546 dish racks, 11,595 clotheslines and 846 using local materials such as bamboo, compost pits with fences;
- Completed data collection, analysis and internal dissemination of the private sector Water, Sanitation and Hygiene (WASH) mapping study.
- Conducted WaterGuard sales and promotion (billboards, jingles, market place events) across the three counties (6).

III. Project technical management

1. Preparation and submission of the PACS modification technical and cost proposal

On July 23 2015, the lead implementing partner, IRC, received a request for application to amend the PACS's Cooperative Agreement in order to rapidly restore community-based services and expand the Project's geographic coverage to three additional counties (Margibi, Grand Bassa, and Rural Montserrado). In alignment with the call for application requirements, PACS developed a technical proposal articulated around two important points: (1) maintaining and reinforcing activities carried out in Bong, Lofa and Nimba and (2) the restoration and expansion of sustainable community-based services in Margibi, rural Montserrado and Grand Bassa.

Maintaining and reinforcing activities: As Liberia transitions to post-Ebola recovery, PACS proposed to maintain, reinforce and restore community health services in Bong, Lofa and Nimba, while supporting the rapid restoration of these services to the three additional counties of Margibi, Grand Bassa and rural Montserrado.

Restoration and expansion of sustainable community-based services: While maintaining its activities proposed under the original award in Bong, Lofa and Nimba, PACS will reinforce service delivery in the counties by ensuring rapid restoration of the community based services. These interventions include:

- Recruiting/Re-mobilizing and deploying general Community Health Volunteers (gCHVs), trained traditional midwives (TTMs) as well as community health services supervisors (CHSS), together making up the Community Health Cadres (CHCs);
- Providing technical assistance (TA) at the county level to strengthen supply chain and information systems for community-level service delivery;
- Complete training of gCHVs and TTMs in iCCM;
- Integrate universal precautions/infection prevention control (IPC) into community health services delivery;
- Cover operational expenses for the Community Health Cadres working with PACS's support.
- Build community trust in health services, thereby increasing the utilization of essential health services with special consideration given to border communities and other vulnerable (hard to reach) communities and;
- Strengthen community-level social mobilization and WASH committees and systems to promote hygiene and sanitation and reduce risks; and promote community emergency preparedness.

All of these interventions proposed above are targeted at the community, district, county, and central levels.

IRC submitted the first draft of the technical and costs proposals to USAID on August the 5th 2015. PACS received USAID's feedback 4 weeks later and submitted the final technical and cost proposal, integrating all the comments, questions and clarifications, to USAID for approval on September 23, 2015. USAID approved and submitted the amendment to the PACS original cooperative agreement on September the 30th, 2015.

2. Preparation of PACS year 2 annual implementation plan

The annual implementation plan for year (AIPY2) was due to USAID on August 31, 2015. In order to ensure that the AIPY2 fully integrates the MOH annual proposed activities but also its alignment with key partners, PACS negotiated and obtained a deadline extension from USAID to submit it on September the 21st, 2015. PACS then prepared a workshop where all key stakeholders were convened to go through the draft AIPY2, review and validate the proposed activities. Therefore, on the 14 of September 2015 a one day AIPY2 review meeting was held in Gbarnga city, Bong County. 32 participants attended the meeting including government stakeholders from the various units of the Ministry of Health (MOH), both from central units, counties and districts, Ministry of Public Works (MPW) and members of the PACS consortium. The proposed activities were presented and reviewed in groups and then in plenary session.



Participants during work group session

The PACS's COP (and his team) co-facilitated the workshop with the directors of Community Health Services Divisions (CHSD) and Health Promotion Division (HPD). Both Directors appreciated that PACS organized this workshop to ensure that implemented activities respond to the needs of the Liberian people. The participants reviewed and provided feedback to the proposed draft. PACS integrated this feedback and submitted the final AIPY2 to USAID on September 21, 2015.

3. Preparation of the modifications to sub-grant agreements between IRC and Consortium partners' members: GC, PSI, PPAL, and YMCA.

In anticipation of the PACS modification, IRC prepared modifications of the sub-grant agreements between and its various partners (GC, PSI, PPAL and YMCA) during the quarter. The modifications include the PACS newly proposed activities with an emphasis on those that will be implemented in the new counties of Margibi, Grand Bassa, and rural Montserrado.

4. Mobilization of the logistic material for the PACS modification

PACS guiding principle for the implementation of the modification activities is to minimize the operational costs and allocate the large portion of the funding to services delivery. Therefore, PACS did not plan to procure any additional vehicles, motorcycles, or laptops for the implementation of the technical activities in the 3 additional counties.

IRC, as implementing partner, assigned to PACS (from its own assets list) 5 additional vehicles and 10 laptops (received from PAE) to facilitate the implementation of the field activities. It is expected that other consortium members will transfer additional assets to PACS during the upcoming quarter.

IV. PRINCIPAL ACTIVITIES AND RESULTS

Result 1: Broadened capacity of the MOH, CHTs, NGOs/CSOs to implement and manage community services

1.1. Management and technical capacity of the MOH and CHT strengthened

1.1.1. Obtain and Maintain stakeholder agreement at national and county levels

One of PACS key responsibilities is to enhance coordination among community based-services actors at all levels of the health system. At the national level, PACS facilitated the MOH units (Community Health Services Division–CHSD, Health Promotion Division–HPD, and Division of Environmental & Occupational Health–DEOH) in establishing and organizing five coordination meetings during the reporting period. This was highly welcomed by the units as they were initially not engaging at all and in some instances, at loggerheads with each other. Through the establishment of the coordination meetings, the benefits of collaborating and coordinating their activities especially as it relates to the community services has become more apparent. Although these units have not yet coordinated their priority lists to convene these meetings on a scheduled basis, with the persistent support of the PACS’s embedded TAs, they are being held monthly. PACS has recorded substantial representation from the units at these meetings and the Technical Advisors ensure that the minutes are documented and filed. The meetings provided the platform for the units to share annual work plans to identify synergistic areas for close collaboration during implementation; created the opportunity to meet and validate the draft Technical Agreements to be signed by the CMO on behalf of the MOH as well as created the opportunity for the teams to have a common understanding of PACS and how the various partners involved in the consortium will be working with them.

PACS maintained coordination and collaboration with other key USAID implementing partners to leverage resources and complement efforts. In this regard, PACS held several coordination meetings with Collaborative Support for Health (CSH) during the quarter to enhance close collaboration and information sharing and to learn from the findings of the governance assessment conducted by CSH in Bong, Lofa and Nimba with a focus on county health Boards and County Health Teams. In the same vein, PACS has been closely coordinating with JSI/DELIVER to ensure the acquisition and distribution of drugs and supplies to the trained community health cadres. These supplies move through the Supply Chain Management Units of the MOH to the county’s pharmacists over to the health facility and then to the community health cadres.

1.1.2. Establish partnership agreements with MOH units and CHTs

During the quarter, PACS drafted the technical agreements and adapted them to reflect the intended collaboration with all the central units of the MOH and the CHTs. The objective of the agreements is “through a strong coordination mechanism, provide support and assistance to the Government of Liberia in the decentralization process and for ensuring that county and community level systems are equipped to deliver high quality community-based services in line with key MOH strategies in Bong, Lofa, Nimba, Margibi, Grand Bassa, and rural Montserrado Counties”. The technical agreements specify the respective commitments of PACS and of the respective units of the MOH and the CHTs. PACS’s commitments include technical assistance and logistics support at the national, county, and community level of the health system. MOH’s commitments include the development of national policies, guidelines and other regulatory documents related to improving community services provision and making sure that they are implemented from the county to the community level.

PACS shared the draft technical agreement documents with the respective units of the central MOH, the MPW and the CHTs for review in August 2015 and requested that they provide feedback on the content after which it would be finalized for signing. PACS received preliminary feedback, amended the documents and sent them back for final review. One delay in the signing of these agreements is the need to confirm them with the Chief Medical Officer, as the signee, and the request by the divisions for logistical support from the project to facilitate implementation of their work plans. PACS has provided clarification and clear and applicable commitments made by all parties. The Technical Agreements are scheduled to be signed by early November 2015.

Facilitate self-assessment with MOH units and CHTs

During the quarter, PACS adopted the MOH/RBHS Capacity Self-Assessment Tools and modified them for use in assessing the various units of the MOH. In addition to the MOH/RBHS Tools, PACS adopted and contextualized the PSI Behavior Change Communication Tools (used by PSI to assess its own BCC and outreach programs in a USAID-funded project in Nigeria, where they contributed to important improvements to health promotion activities). Therefore, PACS pulled together a set of assessment tools designed to examine capacities and systems around Organizational Systems, Implementation, and Quality Assurance indicators. The finalization of the tools included the gathering of the materials and information from the current context of post-Ebola transition in Liberia. PACS facilitated then a one-day workshop, with these 3 central units of the MOH (CHSD, HPD and DEOH) to validate the tools.



View of the CHSD participants to the Self-assessment.

This process was then followed by the actual implementation of the self-assessment exercise spearheaded by the MOH units. The workshop was conducted in Gbarnga, Bong County, from the 28th September to 1st October, 2015 and covered the CHSD, DEOH & HPD units of the MOH. The capacity self-assessment tools assessed both institutional capacity and staff capacity. The exercise was organized in the form of a training to enable the MOH units' staff and the PACS County Coordinators to develop skills required for the roll out of the tools at the county level. In total, 19 staff from MOH participated in the Self-assessment process (5 from the CHSD, 6 from DEOH, and 8 from HPD). PACS is analyzing data collected from the self-Assessment exercise and will disseminate the results during the upcoming quarter.

1.1.4 Support the MOH counterparts to execute national and county performance improvement plans:

Due to the late implementation of the Capacity Self-Assessment exercise at the central level resulting from competing priorities of the various units, the development of the performance improvement plans was moved to the upcoming quarter.

1.1.5 Support the reorganization of CHTs functions and staff positions:

Activity planned in Y2 of PACS.

1.1.6 Improve county-level coordination through county-level forums and meetings.

At the county level, the PACS Field Teams fostered coordination between CHT units as well as among implementing partners in the counties.

As PACS is more focused on Community-based Services, WASH and Behavior Change Communication, it is obliged to establish strong ties with representatives of these units at the county level. This results in PACS working very closely with the Community Health Department at the county level, the Health Promotion focal Point, the CLTS Focal Point and the County WASH Team under the Ministry of Public Works.

To ensure coordination at the county level, the PACS field teams in Bong, Lofa and Nimba have integrated firmly not only with the CHTs but also with the local administrative authorities in the counties. PACS continues to provide support to the CHTs in organizing the monthly county health coordination meetings where all implementing health partners the counties present on their activities (achievements, possible areas for better coordination and challenges). The PACS field teams remained instrumental in documenting action points from the meetings and assisting CHTs to follow-up with responsible partners on the implementation of these action points and in preparation for reporting back in the next meeting. The PACS field teams have taken the lead in ensuring that PACS activities are coordinated well between the consortium partners' teams in the field through the weekly coordination meetings and joint planning and supervision.



Participants to the Monthly coordination meeting in Bong County

1.1.7 Improve coordination and overall support for CHS at central-level:

As already mentioned above under 1.1.1, PACS has and continued to provide support to the three MOH units (CHSD, DEOH & HPD). Through the embedded TAs at central level, PACS continued to mount efforts in stimulating regular and ongoing collaborative efforts with the aim of enhancing integrated programming dynamics at the community level.

Activity 1.1.8: Performance monitoring and cyclical self-assessments at CHSD and County levels

PACS's Embedded Technical assistants have been supporting their respective counterparts (CHSD, HPD, DEOH, Counties) for monitoring performance on an ongoing basis as well as through scheduled monthly and quarterly meetings. During the quarter PACS supported several meetings at the central level but also at the counties. These meetings provided an opportunity to present and discuss progress relative to targets, identify gaps, and adjust capacity building and technical assistance priorities, including provision of STTA.

Activity 1.1.9: Document and build an evidence base for technical assistance and capacity building that can be replicated in other counties.

Activity planned in Y3 of PACS.

1.2. Local CSO capacity to implement, manage and oversee community services strengthened.

1.2.1. Conduct county-level mapping of local CSOs/CBOs engaged in health, social welfare and WASH activities:

Health, social welfare, and WASH services provided by the government, the civil society organizations (CSOs), some community-based organizations (CBOs) and faith-based organizations (FBOs) have yielded appreciable outcomes in enhancing community-based health service delivery and ensuring active community participation and positive behaviour change practices. Despite concerted efforts to improve the health status of the Liberian population, improving the health indicators remains a challenge. As one of the USAID key project focused on advancing the community-based health, social welfare, and WASH services, PACS is focused on the reduction in morbidity and mortality rates particularly among women and children under five. There are still huge gaps in this area and there is a need to combine a broad range of strategies including working with the CSOs, CBOs and FBOs already established in the focus counties to serve as the driving force of community-based health services. The mapping of those organization is one of the key steps needed to be able to direct them towards community service provision.

The CSOs/CBOs mapping exercise is part of PACS deliverables, expected at the end of year one of the project. The aim is to obtain sufficient information on the existing CSOs/CBOs to identify the most suitable organizations that can work with PACS on the provision of community health, social welfare and WASH services in Lofa, Nimba, and Bong counties. The mapping of the CSOs/CBOs occurred in the three counties in July and August 2015. YMCA (in collaboration with the Nimba County Health Team) led this exercise in Nimba County; PPAL led the exercise in Bong County while the Lofa County Health Team implemented it in Lofa County. In total 106 local organizations were mapped out in the three counties.

Design of the mapping tool and preparation of the mapping.

In preparation for the mapping exercise, PACS collaborated with the CHSD and the CHTs to develop the mapping tool. In July 2015, the CHSD organized a workshop focused on the validation of the mapping tool associated with the training of the staff in charge of conducting the CSOs/CBOs mapping. The mapping tool consisted of an excel database that the teams used to collect the various information related to four main domains: (1) organizational structure; (2) Technical work of the organization; (3) Internal management systems; and (4) Reputation and linkages of the organization with the community. These domains are detailed in the “Methodology” section below.

Methodology used for the mapping

The mapping teams from the different counties organized themselves in sub-teams in order to be able to cover all the health districts in each county within the allotted time. All the teams used the same CSOs/CBOs mapping questionnaire which, as referenced above, contains four domains as explained below (the tools are attached in an annex):

- *Organization structure:* This section relates to key information such as: the start date, registration/accreditation status, existence of a board, organogram/structure of organization, years of active service and availability of constitution and policy documents.
- *Work of organization:* This section relates to aspects including: previous work/track record, current work, sector focus, cooperation/coordination with the local government and other local organizations, networks and references.

- *Internal Management Systems:* This section compiles information on systems in place regarding leadership, decision making process, transparency and accountability pertaining to human resources management and financial management. It also includes systems for documentation and reporting, strengths and weaknesses of the organization as well as attitude towards gender mainstreaming.
- *Reputation and linkages with the community:* This section compiles the views of local population (potential beneficiaries) about the awareness of the organization, what the focus of the organization is and how it involves local people in the implementation of activities.

PACS chose these four domains as they can support the decision making process for the: (1) provision of a clear picture on how the organizations are structured and their organizational capacity, (2) provision of information on an organization's capacity for financial and programmatic monitoring, and (3) provision of information that would facilitate the selection of potentially viable organizations that PACS could work with in the delivery of community health services.

In addition to formal interviews using the questionnaire, data collectors conducted informal interviews to gather qualitative information from the community to complement the data collected from the local organizations.

Outcome of the mapping exercise

The mapping allowed PACS to have a clear idea on the number of local organizations active in the three counties. In total, 106 CSOs/CBOs were mapped out with Bong County having 46 CSOs/CBOs while Nimba and Lofa had 35 and 25 CSOs/CBOs respectively. The results of the mapping clearly highlighted issues surrounding equity as it relates to coverage where some health districts have no CSO/CBO working and others have only one CSO/CBO delivering services. The Suakoko health district in Bong county and Vahun Health district in Lofa County are examples of two health districts with there is no active CSO/CBO involved in the community-based provision of health services. The data analysis also pointed out the fact that the CSOs/CBOs mapped are at different maturation stages. Some are registered and accredited while others are yet to obtain registration and accreditation status. PACS categorized the different organizations and selected 2 organizations per county to support the provision of community health services through the community health cadres in the three counties.



Community leaders interviewed on the work of NGO/CBO in the Town of (Sehyikimpa)

In order to be consistent in the selection of the CBOs/CSOs to start with PACS and the counties applied additional selection criteria to the high ranking organizations. These additional criteria include:

- CSOs/CBOs currently operating in county and providing community level services within the county;
- CSOs/CBOs with a functional office;
- CSOs/CBOs currently implementing one or two other programs and/or has ended one or two projects within the past 3 or 4 months (justified by end of project report or last quarter report);
- CSOs/CBOs that have established working relationship with the County Health Team;
- CSOs/CBOs have proper financial systems in place;
- CSOs/CBOs demonstrated evidence of good record keeping and reporting.

The analysis of the collected data is ongoing and will be refined and presented to USAID for feedback. The feedback will be then incorporated into a final report that will be presented to MOH (central and counties) for final decision for the selection of NGOs to be supported by PACS over years.

1.2.2 Establish partnership agreements with local CSOs:

Under the PACS consortium, PPAL and YMCA are the local organizations with whom the IRC signed sub-grant agreements. As members of the consortium, their area of focus is to bring their experience in the capacity building process of other local organizations. Through YMCA and PPAL, PACS will lead a partner-driven approach to capacity building that will enable local CSOs/CBOs operating in the PACS counties to take on an increased role and graduate to direct grant management.

1.2.3 Facilitate self-assessment and develop performance improvement plans for local CSOs:

Planned for year 2

1.2.4 Develop/adapt resource materials to help execute performance improvement plans.

This activity will draw from the activity 1.2.3 above. Meanwhile, PACS has started to conduct a literature review in order to put together a capacity building approach for the selected CSOs/CBOs. PACS will build on existing resources in this domain including IRC and USAID materials. These materials include organizational self-assessment tools and capacity building tools.

1.2.5 Provide intensive capacity building support to local CSOs to execute their performance improvement plans:

Activity planned in Y2 of PACS.

Result 2: Increase availability of community-based health and social welfare services

2.1 Sub-awards to local CSOs designed and managed

2.1.1 Support the MOH to organize a national workshop to define role of local CSOs in the delivery of community services

This activity was delayed to Y2 of PACS.

2.1.2 Design sub-award mechanisms in collaboration with USAID

Activity planned in Y2 of PACS.

2.1.3 Develop program descriptions that outline the types of activities to be funded under each sub-award mechanism:

Activity planned in Y2 of PACS.

2.1.4 Conduct specific technical trainings and coaching for local CSO staff:

Activity planned in Y2 of PACS.

2.2 Comprehensive TA for community health and social welfare services provided to MOH and CHTs

2.2.1 Support the MOH to review, develop and roll out an updated, standardized and “consolidated” national package of community health and social welfare services to be delivered by community health cadres including CHWs and CHVs

In May 2015, the CHSD, supported by PACS and Last Mile Health organized a retreat to: (1) orient the participants on the Community Health Workforce component of the Investment Plan, (2) discuss and validate the updated Community Health Road Map, (3) identify steps to revise the Community Health Policy and Plan, and (4) develop a six month Action Plan to be implemented in preparation for the launch of the national Community Health Workforce Program in January 2016. The “training and supervision sub-group” established after the retreat was given by the MOH the responsibility of clearly defining the areas of focus to be considered in the integrated service delivery package. PACS is intensively supporting this sub-group among other groups. With PACS technical support, the sub-group agreed that in order to provide a standardized national package of health services to be delivered at the community level, the CHWs need to be trained and supported. These CHWs will then have the capacity to provide a comprehensive package of preventive, promotional and curative services at the household level. The following services were agreed upon after consultation with the MOH divisions and health partners to be considered as the standardized Integrated Service Delivery Package content and these include but are not limited to:

- i. General services (referral of cases to health facilities and follow-up; household visits on a regular basis, ensuring each household in the catchment area is visited at least once a month and Community engagement for all areas listed in service package).
- ii. Disease surveillance and control: Build relationships, communicate and coordinate with other community key informants, resource persons and existing formal and informal networks for information dissemination and reporting; Map communities and register populations, including birth registration; Record deaths, with special emphasis on maternal and neonatal deaths; Identify priority diseases and event triggers as they occur in the community, including early case detection through active case finding.
- iii. Reproductive Health: Family planning promotion, counselling, and distribution and dispensing of family planning commodities; referral for family planning services where needed.

- iv. Antenatal Care (ANC): ANC education and promotion and referral to health facilities for ANC visits; Identification of high risk pregnancies and referral to health facilities; Referral to facilities for deworming; Distribution of misoprostol; Distribution of pre-natal vitamins; Distribution of Insecticide-Treated Nets (ITNs); Birth planning and preparedness, including education on items needed for delivery and birth spacing; Awareness on PMTCT and referral to facilities for identified HIV positive mothers (collaborate with HIV/PMTCT officers where available); Treatment of malaria.
- v. Postnatal Care: Monitoring of routine preventive misoprostol immediately post-partum; Family planning; Vitamin A administration; Immediate and subsequent post-partum home visits.
- vi. Neonatal Care: Promotion of essential care of the newborn and essential nutrition actions (exclusive breastfeeding); Cord care, including chlorhexidine application; Support for Kangaroo Mother Care (KMC) application; Education on neonatal danger signs; Identification of danger signs and referral to higher level of care.
- vii. Child Health: Vaccination drop out tracing; Under-5 vitamin A administration and de-worming.
- viii. Nutrition: Mid-upper arm circumference (MUAC) screening; Community-based bi-directional referrals, particularly for newborns, for severe malnutrition and follow up on treatment at health facility; Nutrition education at a household level, including: optimal nutrition for women, exclusive breastfeeding up to 6 months for infants, optimal complementary feeding starting at 6 months with continued breastfeeding to 2 years of age and beyond, nutritional care for the sick and malnourished.
- ix. First aid and Basic Life Saving Skills (BLSS)
- x. Integrated Community Case Management (iCCM) for malaria, ARI and diarrhea with bi-directional referral system: Diarrhea including provision of ORS and zinc; Pneumonia including provision of cotrimoxazole and pediatric paracetamol; Malaria: referral of suspected cases if RDTs are not available; confirmed case management with ACT for children under-5 and pre-referral rectal artemether for severe cases; provision of pediatric paracetamol; Community-based bi-directional referrals, particularly for newborns, for severe dehydration, malaria, acute respiratory infections (ARIs), and other emergency cases.
- xi. Communicable Diseases: HIV/AIDS (Transmission, Prevention, Testing & Treatment; ARVs and Clinic Visits for HIV+ Patients; Referring Patients for HIV Testing & HIV Test Counseling; Overview of ARVs and Side Effects of ARVs); Tuberculosis (Background, Symptoms, Prevention; TB Treatment; Recognizing Side Effects of TB Treatment; Counseling TB Patients); Leprosy (Background, Causes, Symptoms, Prevention; Leprosy Treatment, Referrals, and Counseling, Reducing Stigma); Stigma, Discrimination, Confidentiality (Experiencing Stigma & Discrimination, Causes and Effects of Stigma & Discrimination and Prevention of Stigma & Discrimination).
- xii. Mental Health: Identify & refer patients in the community with signs and symptoms of mental health disorders, particularly post-partum depression; Provides home visits; Provide mental health education for patients, families and communities to reduce stigma within community; Monitor compliance with medication regimens; Monitor side effects; Monitor for early signs of relapse and make quick referrals when necessary.
- xiii. Health and hygiene promotion, and environmental sanitation: Communication among CHT to include Health Promotion Focal Person/Coordinators (as applicable in each county) to ensure health promotion activities are clearly defined and materials/resources are distributed as necessary and Basic Information, Education and Communication (IEC) and Behavior Change and Communication (BCC) for community health promotion and disease prevention.

The sub-group is currently working on the development of an integrated and standardized curricula to be approved by the MOH for use in training the Community Health Workers. The trainings will be done in phases beginning with TOT of national trainers followed by county trainers and county focal points, then health facility supervisors and lastly the CHWs. Each session will have a maximum of 30 participants to enhance a participatory and interactive process thereby ensuring the transfer of knowledge and skills. The CHWs should only be trained when there is assurance that all essential supplies are available for distribution after the training to facilitate the application of skills acquired and smooth implementation of service delivery. Refresher training will be provided semiannually for the CHWs coupled with the proposed monthly supportive supervision and on-the-job training. During the upcoming quarters, PACS will continue supporting the CHSD in developing, testing and finalizing these materials as well as of the trainings of trainers and CHWs.

2.2.2 Improve the alignment of HMIS and LMIS tools and systems

The PACS project organized and participated in coordination meetings with the MOH and its partners to ensure alignment of the ongoing community-based services with existing HMIS and LMIS system at national level. PACS called these meetings because the partners were not using the standardized national HMIS/LMIS tools for data collection and reporting. As such, information generated by partners using specified tools developed to suit their projects could not be entered into the national database thereby leading to the loss of vital data. Therefore, there is a need to harmonize and synchronize all existing data tools with the standardized national tool. At the meetings, partners agreed to coordinate and support the MOH in the development of a comprehensive and common tools that will be used for data collection at all levels. At the community level the system will now be called Community-Based Information System, replacing the original Community Health Management Information System. During the quarter, PACS in collaboration with the MOH, developed draft data collection tools that will be used at the community level for the Community-based Information system (CBIS) and integrated with the national Health Information Systems (HIS). PACS has also been involved in the fine-tuning and scaling up of the community based HMIS at the national level with the MOH/CHSD to ensure that community data management system is integrated into the national health information system. Amidst the MOH efforts to develop a vibrant national Health Information Systems (HIS), PACS has coordinated with the sister project, CSH, to support the MOH. PACS's plan for Community-based Information system (CBIS) was outlined in the National HIS Strategy Plan and subsequently added to the MOH matrix.

2.2.3 Develop a harmonized performance-based incentive structure for CHVs

PACS as a standing member on the recruitment and remuneration sub-group, established by the MOH, has been an active contributor to all the discussions surrounding harmonizing an incentive structure for the community health cadres. As indicated in the Investment Plan, the proposed amount by the MOH is \$70USD for payment of Community Health Workers (CHWs). Being cognizant of the fact that gCHVs facilitate the delivery of community-based health care services at the moment as we await the health workforce launch, the committee took time to discuss the gCHVs' compensation. The discussions were looking at either the payment of cash incentives or in kind incentive, termed a motivational package. For the gCHVs whom, under the revised CHSD policy, will concentrate their health promotion activities within a 5 km radius of the health facility, the committee agreed that organizations working with them now could choose either the motivational package or cash payment depending on budgetary strength. The discussions surrounding the development of the PBF scheme for these community health cadres are yet to start but will look at the provision of performance-based incentives to the best performing community health cadres.

2.2.4: Link CHVs to professional development and training opportunities: Activity planned in Y3 of PACS.

2.2.5 Update and develop new supervision packages for community-based health services:

The training and supervision sub-group, also established by the MOH, is tasked with developing the supervisory tools to be used in monitoring the activities of the community health cadres. These tools will be developed alongside the training modules, a process that is supported by PACS as mentioned under activity 2.2.1 above.

2.2.6 Support for specific elements of the decentralization process:

Activity planned in Y3 of PACS.

2.2.7 Provision of TA for the revision of orphanage (residential care centers) accreditation guidelines and systems for monitoring institutions and institutional care.

PACS faced serious challenge in trying to schedule the follow-up meeting with the Ministry of Gender, Children and Social Protection to discuss the technical application of the project as it relates to social welfare. The restructuring process that the ministry is currently undergoing poses a challenge as it relates to designating a point person to work along with PACS. The project will continue concerted efforts to engage the MGCSW and expect that during the upcoming quarter this will yield some fruits. PACS will then lead into initiating activities related to the addressing issues surrounding social welfare in the communities.

2.2.8 Develop national foster parent guidelines and roll out in the targeted counties.

This activity was delayed to Y2 of PACS

2.2.9. Reinforce iCCM (including malaria) activities

In order to gradually restore community health services in Bong, Nimba, and Lofa counties, PACS in coordination with the CHTs, CHSD, and the NHPD prepared and trained 149 gCHVs on integrated community case management (iCCM) including malaria, acute respiratory infections, diarrhea; infection prevention control (IPC) and education through listening (ETL). The preparation process included an orientation session for the national level trainers followed by the training of the county level trainers. The latter conducted the iCCM, IPC, and ETL trainings in the different counties. For the three health problems, the following topics were discussed: (1) generalities on the health problem, (2) symptomatology, and (3) conduct to be adopted in the presence of the problem. For their deployment, PACS provided to the gCHVs with functional kits as defined by the MOH. The kits comprised of:

1. Stationery/supplies: Ledgers for note keeping, touch light (solar); rulers, pens, pencil, eraser, sharpener, marker (permanent), A-4 sheet, Backpack (USAID logo printed on bag); rain gear (suit + boots + umbrella);
2. Medical and Non-medical Supplies: Respiratory ARI Timer, Arm Circumference (MUAC), Infra-red Thermometer, disposable hand gloves, Cotton wool 500mg, Hand Sanitizer, BCC material, wooden box, safety boxes.
3. gCHVs Forms: Registers (Forms); Community Based Report forms; Identification cards; Examination gloves; AIR training facilitator guide (10 pages); Diarrhea training facilitator guide (7 pages); Malaria training facilitator guide (28 pages); Community Based Management of ARI Module; Community Based Management of Diarrhea Module; Community Based Management of Malaria Module.
4. Other training Materials: small rubber cup; pitcher; table spoon; cup (1Lt); sanitizer L/S; Chloral L/S; Dettol L/S.

Finally, during the quarter, PACS coordinated with SCMU/MOH through the USAID-DELIVER Project to define standards operation procedures (SOP) for the drugs and IPC supplies. These SOP included various quantification, requisition and distribution processes. As previously described, PACS prepared and made a presentation to the SCMU and then drafted a letter for the SCMU to sign and send to the County Pharmacist. The letter, signed on October 8, 2015 authorizes the County Pharmacist to supply the gCHVs deployed in the county with the required medical commodities for their daily iCCM activities. These commodities include: Oral rehydration salts and zinc for diarrhea; cotrimoxazole for ARI; artemisinin-combined treatments for malaria; and paracetamol for pain and fever.

2.3 Quality Assurance strategies for community-based services designed and implemented

The activities under this section are rescheduled to be implemented in Year two of PACS, as the Performance-based Technical Working Group (which is charged with responsibility to select indicators for tier 1 CSOs and FARA partner) was not established by the MOH. However, during the quarter, PACS supported the MOH to establish a National Health Information System revision subgroup to review data collection tools and assess feasibility of adaptation to the community level. PACS was selected by the MOH to serve on the sub-group, and has helped in developing five (5) indicators and data collection tools that will be used at community level for community health and health promotion divisions. Similarly, PACS supported the MOH in developing realistic targets for performance indicators that will be measured on a quarterly, semi-annual and annual basis.

RESULT 3: Improved health seeking behavior and practices

The objective of this result area is to support the MOH, in particular the Health Promotion Division (HPD), to develop and implement quality behavior change communication activities. This approach will lead to sustained improvements in health promotion programming for Liberia. Many of the strategies developed by the HPD are implemented by the Community Health Services Division (CHSD) through the County Health Teams (CHTs) and their cadre of general Community Health Volunteers (gCHVs). Likewise, PACS works with the Natural Leaders network through the Ministry of Public Works (MPW) to improve health promotion activities. Therefore, PACS activities must target and engage with these departments to achieve its desired results. This approach ensures the project's contributions achieve a sustainable impact that will continue to change behaviors beyond the life of the project.

A key deliverable for PACS was to embed a Behavior Change Communication (BCC) Manager within the Health Promotion Division (HPD) to lead capacity building and systems strengthening for the department. PACS advertised the position online and in the Daily Observer, a major Liberian newspaper, but after several rounds of interviews a suitable candidate was not found. Fortunately, PACS identified a highly qualified and experienced candidate who had previously worked with the MOH during the peak of the Ebola crisis, who agreed to return to Liberia and provide TA to the HPD. The candidate, from the region, had over 11 years' experience in health promotion and development work across West Africa, most recently with the West Africa Health Organization (WAHO) as a Health Promotion Specialist in Liberia.

The BCC Manager joined PACS in mid-August and hit the ground running. After "re-introduction" with the Director of HPD and the rest of team, the BCC Manager began splitting time between the Ministry of Health to support the HPD's work on the BCC Self-Assessment Tools development and in the field to support roll out of the Education Through Listening training in Lofa, Bong and Nimba.

3.1.1: Development of operational plan for the NHCS

The purpose of this activity is to support the HPD to draft and disseminate a National Health Communication Strategy (NHCS). PACS would facilitate the operationalization of the NHCS in Year 2 by supporting the development of an implementation plan, rolled out to the county level. When this activity was initiated with the HPD Director, PACS learned that the unit was working on a National Health Promotion Policy (NHPP) which needed to be completed before work on the NHCS could begin. The HPD appointed a "core team" to work on both the policy and strategy documents, consisting of the HPD (primary lead on both the policy and strategy documents), WHO (technical lead on the policy), UNICEF, HC3, and PACS (technical lead on the strategy). The HPD appointed this "core team" to fast track development of the NHPP and the NHCS, and would check in with the Health Promotion Technical Working Group (also known as the Social Mobilization TWG) for wider inputs and feedback. Progress on the NHCS was delayed by WHO's appointment of a consultant to lead the development of the policy, as requested by the HPD Director. The consultant is scheduled to arrive in Monrovia in late October, following which work is expected to be prioritized by the HPD. This delay represents a significant challenge to PACS's ability to work on the NHCS, however we do expect to complete work on both the NHPP and the NHCS in the first quarter of Year 2.

3.1.2: Support the county-level implementation

This activity was delayed to Y2 of PACS

3.2: High quality health communications designed and implemented at national and county levels

The purpose of activity 3.2 is to build the capacity and strengthen systems within the HPD to develop and produce an integrated mix of health promotion tools and materials. PACS will achieve this by mentoring the HPD through the process of collecting audience insights for behavior change, translating those insights into strategies and objectives, which are used to guide the design and production of messages and materials.

Activity 3.2.1: Conduct desk review and ethnographic research.

The main activity planned for this quarter was to conduct a Knowledge Attitude and Practice (KAP) study. This study is designed to identify and measure significant determinants of behavior to guide the development of high impact BCC activities. The results from the study will inform a series of qualitative studies designed to provide further insights into behavior, planned to be carried out in Year 2. During the quarter, PACS drafted the study design and questionnaires. Several stakeholders were consulted during the development of the tools, including the HPD Director, the MOH's Research, Monitoring and Evaluation (RME) working group, HC3, the CDC, the National Malaria Control Program, USAID and PMI. In most cases, the Research Manager met with these organizations in small groups of 1-2 people, except for the RME working group which consisted of nine people from six different organizations (Mercy Corps, JHU/CCP, PSI, CDC, USAID and MOH). The tools include the KAP study design and a quantitative questionnaire. The study design explains the objectives of the study and the methodology that will be used, including the sampling plan, respondent selection criteria. The questionnaire includes questions to measure behaviors and determinants of key behavior change objectives. PACS will use the results to set baseline indicators in the PMEP and will inform its behavior change strategies. A particular challenge was the need to include pregnant women in the study design. Because pregnant women do not naturally constitute a large percentage of the population, a separate study had to be designed that specifically sampled pregnant women in order to get enough respondents. The full study was presented to the University of Liberia's (UL) Institutional Review Board (IRB) on September 24 and was approved with minor comments. The UL-IRB consists of four members, including a female lawyer, and a UL Professor, and the Director and Program Coordinator from the Atlantic Center for Research & Evaluation. Data collection is scheduled to begin in October 2015.

Activity 3.2.2: Roll out an overarching umbrella campaign.

This activity was delayed to Y2 of PACS

3.3: Local CSOs mobilized to engage communities and create enabling environment

The purpose of activity 3.3 is to improve the quality of implementation of BCC activities by CSOs. PACS will also look at implementation under the County and District Health Teams and adapt the Education Through Listening (ETL) approach to fit the Liberia context, combining motivational interviewing, adult learning, and stages of change theories to promote behavior change.

3.3.1 Adapt ETL to Liberian Health Context.

PACS will adapt the Education through Listening (ETL) approach to fit the Liberia context, combining motivational interviewing, adult learning, and stages of change theories to promote behavior change. Activity completed during the Quarter 1 of PACS.

3.3.2 Establish monitoring system linked to Community scorecard

Activity planned for Y2 of PACS.

3.3.3 Roll out ETL and provide QA

PACS piloted the ETL methodology in a gCHV training conducted in September, in two districts each across Lofa, Bong and Nimba. In all, 149 gCHVs were trained in the ETL skills and principles. A highlight was the attendance by the Directors of the HPD and CHSD at the training in Sanoyea district. Both Directors had positive feedback on the training, and requested it to be scaled up nationally. They both agreed the ETL curriculum should be included in the national training package for gCHVs. After the training, PACS began visiting the field to follow up with gCHVs who received the ETL training to see how well they were able to apply the skills they learned. Feedback from many gCHVs was very encouraging, such as the realization that behavior change is a process, and that behavior change requires the right message to be delivered. A general CHV in Bong County, Mr Osumane Keita, says:



gCHVs in ETL training in Sonoyeah, Bong County

“I now know that for people’s behavior to change, it isn’t a hurry-hurry business, I also know that not all messages can lead to behavior change, so I am careful of the kind of messages I share with my people in helping to change their behavior at different levels.”

PACS will use observations from the training and follow up visits in the field to further refine the ETL training curriculum. Feedback from HPD and CHSD will also be incorporated into the approach. Early next quarter, PACS will submit the final curriculum to HDP and CHSD so that it may be included in the integrated training package for gCHVs.

3.3.4 Expand and advance CLTS triggering by building capacity of CHTs and CSOs.

The purpose of this activity is to ensure that Community Led Total Sanitation (CLTS) teams, including CHTs and other partners will engage new Natural Leaders (NL) at the initial triggering phase, continually providing trainings, supervision, and guidance over the course of the effort to ensure that most of the targeted communities become Open Defecation Free (ODF).

Triggering of CLTS communities

As an integral phase of the CLTS process, triggering creates an enabling environment for community members to begin sustainable improved sanitation and hygiene practices such as constructing household latrines and hand washing facilities. Having an entry strategy coupled with effective pre-triggering in operational communities is vital during this initial stage of PACS. During the triggering phase, target communities are encouraged to discuss their current hygiene and sanitation environment and develop workable solutions themselves. Natural Leaders (NLs) facilitated the entire process in collaboration with Environmental Health Technicians (EHTs), the National Technical Coordination Unit (NTCU) and PACS.



PACS STTA delivering a Certificate to Community leaders during ODF celebration in Kandakai Community

During the quarter, in total, PACS triggered 181 additional communities in Bong, Lofa and Nimba counties: 83 in Bong, 75 in Lofa and 23 in Nimba. Also, during the quarter, with PACS support, these 181 triggered communities constructed 4,494 individual household latrines (1,428 in Bong, 1,415 in Lofa and 1,651 in Nimba) which are used by approximately 112,350 individuals (assuming about 25 persons per latrine). Additionally, using local materials such as bamboo, during the quarter communities constructed 4,751 hand washing facilities, 10,546 dish racks, 11,595 clotheslines and 846 compost pits with fences. Triggered and ODF communities are also conducting mass community clean up campaigns on a monthly basis with support from NLs.

Conduct training for Natural Leaders

Natural Leaders are critical to implementing the WASH component, especially CLTS. NLs emerge during the initial stage of CLTS and present themselves as volunteers to lead the process. They work willingly with their communities and neighboring communities to ensure that they attain and maintain ODF status. NLs are self-motivated, passionate individuals who strongly believe that proper sanitation and hygiene is the path to sustainable development. The minimum of NLs per triggered community is two and can increase depending on the size of the community. During the quarter, PACS trained and certified 627 Natural Leaders (360 in Bong, 136 in Lofa and 131 in Nimba) in the CLTS methodology and approach. NL trainings focused on effective triggering, supportive monitoring and supervision and community mobilization. As a result of the above achievement, 16 Natural Leader Networks (NLNs) – one per district – have been established by PACS in the three counties (six in Bong, six in Lofa and four in Nimba).

Result 4. WASH Infrastructure Management Improved

The objective of this result area is to support the Ministry of Public Works (MPW) and the MOH Division of Environmental and Occupational Health (DEOH) to provide access to WASH infrastructure, while improving the adoption of health WASH behaviors and practices, including Community Led Total Sanitation (CLTS) at the community level.

4.1. Access to WASH infrastructure and products expanded

4.1.1: Develop capacity of water and sanitation personnel to effectively manage water and sanitation infrastructure.

County support creates a reasonable platform for authorities and communities to freely discuss WASH and CLTS issues and come up with a common plan for the way forward. Therefore, it is imperative for County CLTS meetings to be held and supported throughout the life of the program. PACS started and will continue supporting these meetings. Monthly County CLTS meetings refresh government officials on CLTS best practices and build new capacity to maintain and sustain CLTS gains during and after PACS implementation. PACS replicated the county-level meetings at the district level on a monthly basis to ensure that the entire project operational area is covered. To minimize the occurrence of meetings, PACS is now ensuring that most of the meetings are incorporated into the traditional monthly WASH coordination meetings. Therefore during the quarter, PACS supported 9 county-level coordination meeting and 16 districts level WASH coordination meetings.

4.1.2: Support GOL in deploying adequate and equipped water and sanitation staff

During the quarter, in consultation with national and sub-national actors PACS identified the areas of data collection, development of a reliable database and the flow of information between the sub-national and national levels as capacity gaps. The need for improvement in these areas is critical and more pronounced in the area of water point data collection at the sub-national level and data management to ensure that it reaches the national level. Unfortunately the training could not take place during the quarter, as planned due to the absence of WASH personnel in Bong, Lofa and Nimba counties as a result of recent downscaling at the MPW. MPW staff that has worked in the civil service for more than 25 years were retired as per GoL employment policy and this affected most of the staff that were targeted for such training. However, PACS met with MPW leadership to discuss this issue and both parties agreed to have a bigger meeting with other WASH stakeholders as UNICEF and the WASH Consortium in order to find a better way forward. MPW has consented to chair such meeting with active participation from other key WASH partners including MOH. PACS has made significant preparations for this training that will now be conducted in Y2.

4.1.3: Improve the GOL ability to test drinking water sources at critical times and take corrective action

Activity planned in Y2 of PACS.

4.1.4: Facilitate community level linkages between health and WASH community structures

Activity completed in Quarter 1, Y1 of PACS.

4.1.5: Strengthen county- and district level focal points for WASH infrastructure and maintenance with an emphasis on coordination of resources and partners

Provide support to County CLTS meetings

County support creates a reasonable platform for authorities and communities to freely discuss WASH and CLTS issues and come up with a common plan for the way forward.

During the quarter, PACS maintained its technical and logistical support to these meetings. In total, during the quarter, PACS supported nine County CLTS meetings.

Provide support to District CLTS meetings

During the quarter, PACS replicated the monthly WASH coordination meetings at the district level. In total 24 meetings were conducted targeting 8 districts.

4.1.6: Support knowledge management, data collection and reporting from community to county to central levels

Capacity building is a key objective of the PACS project. In consultation with national and sub-national actors PACS has identified the areas of data collection, development of a reliable database and the flow of information between the sub-national and national levels as capacity gaps. The need for improvement in these areas is critical and more pronounced in the area of water point data collection at the sub-national level and data management to ensure that it reaches the national level. The national level can use data to inform national planners on areas of intervention for hand pump construction and repair in critical locations of need and accessibility. Unfortunately this training could not take place during the quarter as planned due to the absence of WASH personnel within the counties as a result of recent downscaling at the MPW. MPW staff that have worked in the civil service for more than 25 years were retired as per GoL employment policy and this affected most of the staff that were targeted for such training. However, PACS met with MPW leadership to discuss this issue and both parties agreed to have a coordination meeting with other WASH stakeholders such as UNICEF and the WASH Consortium in order to find a better way forward. MPW will call and chair the meeting with active participation from all key WASH partners including MOH. In parallel, PACS, has made significant preparations for the training, should it be confirmed in Year 2.

4.1.7: Creates linkages with TNIMA to support career ladder of gCHVs and NLS

The Tubman National Institute of Medical Arts (TNIMA) is the primary training institution for government Environmental Health Technicians. PACS plans to support TNIMA in preparing EHTs to effectively manage WASH infrastructure by conducting guest lectures on CLTS and providing 12 Environmental Health students during Y1 with internships that expose them to community-based work. Illustrative internship activities include conducting monitoring visits with EHTs, assisting communities in planning ODF celebrations and water quality testing and analysis. As there are about 12 graduates per year and no graduates placed on payroll for the past three years, it was estimated that about 36 graduates will be available for internships at the outset of PACS. During the reporting period one meeting was held with the new graduates (11 in total) with the objective of engaging them as interns. This activity will be reviewed and intensified during the upcoming quarter.

4.1.8: Liaise with MIA to promote WASH as an effective starting point for development

Activity completed in Quarter 1, Y1 of PACS.

4.1.9: Establish a pump fund to prepare MPW for future management of WASH infrastructure improvement programs

Initiate construction of wells through pump fund

Access to safe drinking water in ODF communities significantly improves the health status of project participants and reduces the disease burden when compared to before becoming ODF. Providing safe drinking water to target communities that have maintained their ODF status can serve as a motivating factor for a clearly defined path to development. Other neighboring communities can be also motivated to drive their communities to ODF so that they can receive further assistance.

In order to encourage ODF communities to maintain their status and motivate new communities to accept the program, PACS supports selected ODF communities through the provision of protected hand dug wells in order to increase their water coverage. Selection of target communities for the construction of hand dug wells is based on the following criteria put together by the WASH committee including County WASH Team, NLs, EHTs and PACS. The general procedure agreed is “first come, first serve,” for ODF communities that:

- maintain and sustain ODF status and have functional WASH Committee; these include but are not limited to maintaining latrines in good condition with hand washing facilities, maintaining a very clean environment with appropriate garbage control and other sanitation and hygiene facilities;
- have safe water source as a serious issue in terms of population and distance from existing safe water point; safe water sources are protected water points fitted with hand pumps within reasonable distance from the consumer;
- have constructed additional latrines after attaining ODF status.

PACS, in collaboration with the County WASH Team, NLs and the EHTs has identified 90 communities (30 per county) for the construction of 90 hand dug wells fitted with Afridev hand pumps. Women and children played a key role in the selection process as they are more involved in household water collection activities, although the technical aspects were dealt with by EHTs and trained and certified WASH Entrepreneurs. Trained and certified WASH Entrepreneurs will carry out well construction through the Pump fund in Bong, Lofa and Nimba counties. This will further ensure ownership and long term sustainability of WASH facilities, especially water points in terms of operation and maintenance. The WASH Entrepreneurs are selected NLs that are trained and certified in hand dug well construction, small business skills and soap making. They ensure that WASH facilities within their communities are maintained and operational at all times with support from community members. Procurement of well construction materials especially imported materials was initiated at the central level during the reporting period. Construction materials procured will be pre-positioned at all field locations in readiness for actual well construction work that will start toward the end of rainy season in October to November 2015. The team headed by the WASH Technician have identified and selected 30 Potential WASH Entrepreneurs (10 per County), who will work closely with community authorities to construct three hand dug wells each.

4.2. Access to WASH infrastructure and products expanded

The objective of Result 4 is to identify and develop plans to address gaps in the private sector WASH market, including the products and service providers required use hand pumps, latrines and household drinking water disinfectants like WaterGuard.

4.2.1: Conduct formative research to identify affordable, inclusive and desirable WASH products and services

A key activity in Year 1 was to conduct a private sector WASH market study. PSI's Regional Researcher, led the development of the study design and questionnaire tools. Although PSI routinely uses its MAP (Measuring Access and Performance) methodology to analyze private sector markets, this tool is usually applied to fast moving consumer goods (such as condoms, or water disinfectant) and it was an interesting opportunity to expand and adapt the approach to services such as hand pump maintenance service providers. PSI developed the study design in consultation with IRC and Global Communities, who will ultimately be the primary user of the results.

The preliminary results were disseminated internally to senior PACS staff, with a follow up dissemination to Global Communities M&E staff for further refinement. The study is now complete, and PACS will use the results to develop an Integrated WASH Market Facilitation (IWMF) Plan in Year 2. The IWMF Plan was planned for Year 1, but was pushed to Year 2 due to delays in implementing the WASH MAP study.

Key findings from the study include:

- The **geographic coverage of WASH infrastructure** (hand pump spare parts or latrine spare parts) is generally very low in urban and rural areas of Lofa, Bong and Nimba counties, meaning that only a small proportion of enumeration areas (villages, urban neighborhoods) have shops that sell these products;
- Less than 30% of all enumeration areas have at least 1 outlet that sells **household water treatment products**, with the majority of those products being multi-purpose (for example: Chloro/Chlorox which can be used for water treatment, hand washing or cleaning).
- **NGO subsidies** likely cause confusion in the WASH market. Although some business owners and service providers enjoy the benefits of NGO-funded projects, consumers may not see the same benefit if the projects are not being implemented in their communities (and may reinforce the “waiting for the NGO to come” mentality).
- The vast majority of business owners report buying their products in Monrovia, resulting in **high transportation costs** and lost time. However, the local service providers rely solely on these business owners to purchase their spare parts and building material, resulting in a logical supply chain linkage.
- Business associations seem to play a critical role in providing support and access to financing options for select business owners - those who do not belong to these groups find it harder to access loans, often due to high interest rates/collateral. No such organizations exist for service providers.

4.2.2: Develop and implement integrated WASH market facilitation plan:

Activity planned for Y2 of PACS.

4.2.3: Support establishment and expansion of WASH SMEs

Activity planned for Y2 of PACS.

4.2.4: Utilize market-based approaches in promoting hygiene behaviors and products

In July, PACS erected six billboards promoting WaterGuard, with two billboards erected in each county. One of the billboards in Lofa was vandalized, and PACS is now in the process of renting a new space in Lofa for placement of another billboard.

In August, PACS purchased a total of 1,060 radio spots to promote WaterGuard across the three priority counties (318 in Bong, 477 in Nimba, and 265 in Lofa). The radio spots use a dramatic narrative to inform people of the benefits of treating their drinking water (such as diarrhea prevention) and the correct way to use WaterGuard.

One challenge with implementing radio in Liberia is monitoring whether the stations implement the media plan and air the spots as agreed. Unlike other counties, there are no media monitoring agencies which can track and report compliance to media plans.

PACS is now exploring options to monitor its radio programming using cellphones, which has promise to provide low cost, immediate feedback on exposure and impact of its radio spots.



Demonstration on how to use WaterGuard at a market place event in Bong County

4.2.5: Support WASH workforce development:

The establishment and training of NLs and other interested community members that have basic skills in mechanics such as bicycle maintenance as WASH Entrepreneurs is vital for ownership and long term sustainability of all WASH facilities and requires meaningful support from WASH line ministries like MPW, MOH, MIA and MOE. Its purpose is to empower and encourage local artisans to learn how to conduct hand pump repairs and begin selling WASH products and services at the community level. The process should identify and select interested NLs who have basic mechanical skills and train them in hand pump repairs, small business management skills and soap making to promote hand washing at all times within target communities. PACS will contract trainees to do some repairs as an initial financial base, and then to encourage them to look for personal contracts and establish their own businesses. The plan is to target all health districts in Bong, Lofa and Nimba counties. This training will be done in two phases. The initial training will target 100 new WASH Entrepreneurs identified and selected by program staff including County WASH Committees, EHTs, NLs and Global Communities. The second training phase known as refresher training will target both new and old WASH Entrepreneurs (including those trained during IWASH, about 64). This second training is vital as it will provide lessons learned to help ensure that challenges faced would be overcome, thus creating an enabling environment for the WASH Entrepreneurs to perform more effectively.



A cross-section of WASH Entrepreneurs during training session conducting practical demonstration of hand pump installation

During the reporting period, PACS trained and certified 101 WASH Entrepreneurs (35 in Bong, 36 in Nimba and 30 in Lofa). PACS trained one additional person in Nimba as the request of district authorities based on the willingness and technical capacity of the individual. The training lasted for 12 days and focused on the following activities:

- Hand dug well construction and operation and maintenance of hand pumps with specific focus on AFRIDEV
- Basic business training skills
- Soap Making

The purpose of the above training is to ensure that target communities have continuous access to improved and sustained WASH products and services that they can pay for at all times. The six key objectives of the training are as follows:

1. Trainees acquire basic knowledge on how to repair AFRIDEV hand pumps.
2. Trainees acquire basic skills in hand pump operation and maintenance including routine management
3. Trainees acquire basic skills on how to start and manage a small business in WASH services and products
4. Trainees are encouraged to start their own WASH product and services business
5. Trainees certified and equipped with basic tool kits for hand pump repairs, installation of hand pumps and
6. Trainees acquire basic knowledge in soap production and marketing.

At the end of the training all 100 trained and certified WASH Entrepreneurs received start-up kits to establish their own business. Start-up kits include spanners, saws, hammers etc. Furthermore, all 100 WASH Entrepreneur trained were linked to target community members during ODF verification ceremonies. Therefore, community members were made aware of what they do regarding WASH services and product promotion within their communities.

III. CHALLENGES

- The Consortium partner, PSI, suffered a major robbery in which up to 24 laptops and other valuable items were stolen. PACS lost 12 laptops, which were replaced by PSI Washington with no additional cost to PACS.
- Lack or weak of finance management infrastructure at the county level (banking, electronic transfer, etc.). This proved particularly difficult during the gCHV training, when staff had to cover trainings in two different districts, and were responsible for making payments to vendors and training participants
- Field implementation has coincided with the rainy season impacting the roads and causing a delay in construction of household CLTS latrines and hand dug wells;
- Late start in CLTS implementation due to preoccupation of DEOH and all other actors with Ebola programming;
- All WASH related monthly meetings, including monthly CLTS meetings, were incorporated in one traditional WASH coordination meeting due to the EVD response;
- The AKVO training was delayed due to lack of MPW WASH Coordinators at the county level especially in Lofa and Nimba; they were retired based on GoL employment policy.

IV. PLANNED ACTIVITIES FOR NEXT QUARTER

Result 1:

- Support the MOH central units/CHTs in collaboration with CSH to improve existing partners mapping template and procedures;
- Support coordination meetings between community-based service delivery units at central MOH (CHSD, DEOH, HPD & NMCP) and regularly review performance;
- Support county level quarterly coordination meetings including documentation;
- Share validated draft of partnership technical agreements with USAID and other partners;
- Organize 4 workshops to present assessment findings and facilitate the development of performance improvement plans for central units;
- Support the MOH units/CHTs to mobilize resources for the implementation of the improvement plan (Advocacy to support the improvement plans);
- Lead the policy sub- group and coordinate the review and development of the CHSD revised Policy with partners;
- Review and update community health cadres training modules.

Result 2:

- Support training of trainers of CHWs in the counties on the integrated package for community-based health services, including iCCM;
- Support cascaded trainings of gCHVs/TIMs/CHWs in the counties on the integrated package for community-based health services including iCCM;
- Support the provision and distribution of startup kits for CHWs;
- Support CHSS supervision visits to the gCHVs;
- Co-facilitate meetings with CSH and Deliver Project in the process for the creation of a technical work group on C-HMIS/C-LMIS;
- Compile documents, templates, and reports currently being used under the established C-HMIS/L-HMIS system for review and updating;
- Have the partnership agreements with the selected CSOs/CBOs signed;
- Adapt and apply self-assessment tools to selected CSOs/CBOs.

Result 3:

- National Health Promotion Policy and National Health Communication Strategy;
- Complete the data collection and analysis for the KAP study;
- Support HPD to include Education Through Listening (ETL) in the national training package for gCHV;
- Workshop to develop Integrated WASH Market Facilitation Plan.

Result 4:

- Triggering of CLTS communities;
- NTCU visits for ODF Verification of CLTS communities;
- Conduct training for Natural Leaders;

- Provide support to County and districts CLTS meetings;
- Initiate construction of wells through pump fund;
- Conduct AKVO-FLOW training for County WASH Teams.