



Annual Report
October 1, 2003 – September 30, 2004

Liberia Improved Community Health Project
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Acronyms

ABC	Abstinence, Be faithful, use Condoms
ACT	Artemisinin Combination Therapy
BCC	Behavior Change Communication
CCP	Johns Hopkins University Center For Communication Programs
CYP	Couple-Year of Protection
DIP	Detailed Implementation Plan
DPT	Diphtheria-Pertussis-Tetanus
EPI	Expanded Programme of Immunization
FPAL	Family Planning Association of Liberia
HIS	Health Information Systems
HIV/AIDS	Human Immune Virus/Acquired Immune Deficiency Syndrome
ICHP	Improved Community Health Project
IDP	Internally Displaced Persons
IPT	Intermittent Presumptive Treatment
IR	Intermediate Result
ITN	Insecticide Treated Nets
KPC	Knowledge, Practice and Coverage
LPMM	Liberia Prevention of Maternal Mortality
MERCI	Medical Emergency Relief Cooperative International
MSG	Mother Support Group
MSM	Morehouse School of Medicine
NACP	National AIDS/STI Control Program
NDS	National Drugs Service
NGO	Non-Governmental Organization
ORT	Oral Rehydration Therapy
PMP	Performance Monitoring Plan
REFLECT	Regenerated Freirean Literacy through Empowering Community Techniques
SIP	Support-Integrate-Promote
SPO	Special Objective
STI	Sexually Transmitted Infection
TB	Tuberculosis
TT	Tetanus Toxoid
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
VCT	Voluntary Counseling and Testing
WARP	West African Regional Partners
WHO	World Health Organization
WRA	Women of Reproductive Age
YMCA	Young Men's Christian Association

I. EXECUTIVE SUMMARY

The Liberia Improved Community Health Project (ICH) is a five year health development initiative – January 2003 to January 2008 – funded by the United States Agency for International Development Liberia Mission (USAID/Liberia) under a grant of \$7,371,002 million, with a non-USG match requirement of \$2.5 million, through a consortium comprising Africare as prime contractor, John Hopkins Bloomberg School of Public Health Center for Communications Programs (CCP) and Morehouse School of Medicine to address USAID/Liberia’s Strategic Objective 3 (SO3): **“increased use of essential primary health care services through civil society”**. (See **Strategic Objective and Results Framework** on pp. 8 – 9).

The project specifically targets women of reproductive age (WRA) and children and emphasizes six technical components – Malaria, Immunization, Reproductive Health, HIV/AIDS, Nutrition (Micronutrients and Complete Breastfeeding) and Control of Diarrheal Diseases in Children – and four cross cutting components: Behavior Change Communication (BCC), Health Information Systems, Community Health and Quality Assurance. The project is implemented through local partners utilizing three strategies: improvement and expansion of clinic services, community empowerment and local NGO capacity building. This report mainly covers the period September 2003 – September 2004 although there are references to project related activities that predates the period under review.

Since its inception in January 2003, project implementation has been fraught with delays. Shortly after the signing of the contract, field staffs were displaced to Monrovia as hostilities increased in the countryside. By the time the expatriate Chief of Party and Behavior Change Communication Specialist arrived at the end of March, the outbreak of warfare in Monrovia was imminent. They were evacuated at the end of May 2003. Before their return in September it was evident that the country was facing a complex emergency and humanitarian crisis that all partners in health care needed to address. This demanded that Africare engage itself in urgent humanitarian services before contemplating any initiation of the original design of the ICHP.

In this context, the ICH Consortium forged a partnership with a US based humanitarian and emergency response organization, AmeriCares, which since September 2003 has provided three airlifts, one airfreight and four sea freight containers of essential drugs, medical supplies and temporary structures. Their cash and in-kind contributions have so far totaled more than \$5 million. This has vastly expanded the ICH’s scope logistically and geographically and has in itself been a “project”. AmeriCares, then, pledged its continued support to our initiatives in Liberia as long as the need existed. The Consortium is now operating a warehouse (funded by AmeriCares) to receive, store and distribute AmeriCares donated commodities throughout Liberia. A number of international NGOs, the Ministry of Health and the National Drug Service have participated in the distribution.

With relative improvement in security, ICHP staffs have been visiting accessible clinics to assess and reactivate them, using AmeriCares donated commodities. The project has conducted urban

and rural baseline studies. The results have been analyzed and will be used to set annual implementation targets as well as monitor and track project objectives and indicators. The Consortium lost some of its earmarked clinics to other NGOs who provided support and staff incentives to these clinics when they were considered unsafe. As Africare is now providing incentives, the targeted number of clinics should be achieved though not in the previously selected localities.

Despite delays and obstacles the status of the Consortium's activities to date is as follows:

- Participated in the development of Global Fund proposal, "Malaria Strategy for Liberia", and submitted the ICHP's Global Fund budget.
- Reestablished Africare country office in Monrovia and field office in Ganta.
- Submission and approval of project Performance Management Plan (PMP) and Detailed Implementation Plan (DIP).
- Supplementary feeding centers funded by Food for Peace proposal through Catholic Relief Services and World Vision established.
- Renovated an unused structure in Salala for use by Phebe Hospital "in exile" which transformed a rudimentary health clinic into a full fledged health delivery center, complete with operating room and training facility for health providers.
- Constructed and equipped temporary AmeriCares structures in Monrovia, Salala, Totota, Gbarnga, Ganta and Tappita.
- Implemented 3 UNICEF funded nutrition and WATSAN projects in Montserrado and Nimba Counties, complementing and enhancing the ICHP.
- Conducted baseline surveys in Montserrado, Bong, and Nimba Counties.
- Provided emergency anti-TB drug for Liberia through AmeriCares.
- Conducted distribution of AmeriCares pharmaceutical and other medical supplies and donations to more than 20 health facilities, local NGOs and INGOs.
- Conducted two-week REFLECT Training of Trainers workshop for 14 implementing partners and other USAID funded projects; and training of facilitators workshop for 8 communities in Nimba and 7 in Bong.
- Conducted orientation workshop for prospective local implementing partners
- Conducted a multi partner countrywide curriculum design activity for *Integrated Reproductive Health*.
- Reactivated 24 clinics – 16 in Nimba, 8 in Bong.
- Executed 2 ICH funded sub-project proposals: 1 for FPAL, 1 for LPMM,
- Designed, produced and aired radio messages on nutrition promotion and prevention of diarrheal diseases in collaboration with Mercy Corps and its community radio network.
- Developed and initiated implementation of entertainment-education BCC radio magazine serial on malaria, safe motherhood, and immunization. Full broadcast begins in July.
- Developed and initiated implementation of national malaria BCC strategy.
- Established warehouse for storage and free distribution of essential drugs, medical supplies, hospital beds and other key materials.

A summary of key project achievements is attached as **Appendix E**.

II. BACKGROUND

Contract

Africare signed a cooperative agreement with the United States Agency for International Development (USAID) on 21st January 2003 for the implementation of The **Liberia Improved Community Health Project**, administered by a consortium composed of Africare, the prime contractor, and two other partners, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (CCP) and Morehouse School of Medicine (MSM). JHU CCP provides Behavior Change Communication (BCC) support to the project through a full time Technical Advisor for two years while MSM provides technical support to all aspects of the project through short term consultants.

The project is a reproductive and community health care initiative targeting women of reproductive age and children, and is intended to serve over 500,000 beneficiaries.

Taking into account the large proportion of the population that reproductive health addresses, and the relative benefits to all segments of the population, the consortium has prioritized its package of technical interventions as follows:

1. Malaria Control and Prevention: The program's first priority is to focus on malaria prevention and control targeting women of reproductive age (WRA) and children. The project will use several approaches to address the problem:

- ❖ *Distribution of insecticide treated nets (ITN)* at affordable prices. Several options will be explored, including subsidizing the cost of bed nets and distributing bed nets free to pregnant women and children.
- ❖ *Intermittent Presumptive Treatment (IPT)* for pregnant women using Fansidar which is reputed for its therapeutic and cost effectiveness.
- ❖ In compliance with new treatment protocols established by the World Health Organization and adopted by the Liberian Ministry of Health, the project will have service providers trained to be eligible to administer the new combined therapy (artussenin and amodiaquin). The drugs will be provided free to pregnant mothers and children.
- ❖ A BCC specialist from CCP to develop and implement strategies to promote care seeking behavior (especially for children and pregnant women), the use of ITN and IPT.
- ❖ The consortium will support an efficient health information system (HIS) to track related and relevant data i.e., bed net use, re-dip rate, IPT coverage, drug management and cost recovery.

2. Increase Full Immunization Coverage: The project plans to increase full immunization coverage from 24% to 60% within in three years after take-off. The project will train vaccinators, provide resources for maintaining the cold chain, conduct social mobilization campaigns for the expanded program of immunization (EPI) in catchment areas and utilize BCC to motivate pregnant women to attend prenatal clinics and receive immunizations at the

appropriate period of gestation to protect the unborn child and to attend postnatal clinics with their children to maintain vaccination schedules.

3. Reproductive Health, Safe Motherhood and Family Planning: The project appreciates the fact that reproductive health addresses the concerns of a large percentage of the population in their formative and peak productive years, thus determining the overall health and productive capacity of the population. This component therefore addresses the following reproductive health issues: i) general health and sexual behavior of women of reproductive age; ii) healthy outcomes of pregnancies if and when they occur; iii) adolescent health, sexual maturity and fertility; iv) interventions for healthy pregnancy for mother and baby; v) a safe delivery (with mechanisms for handling obstetrical emergencies); vi) follow up of mother and baby to ensure that the woman returns to her pregravid state of wellness; vii) protecting the child from preventable early childhood illnesses; viii) monitoring and nurturing in the early developmental stages to ensure optimum health; and ix) the attainment of normal developmental milestones.

4. HIV/AIDS Prevention and Control is the program's fourth priority. The project will utilize BCC to promote awareness, seek preventive services with emphasis on STI treatment VCT and dual protection with condoms. Appropriate service providers will be trained in testing and pre- and post-test counseling.

5. Nutrition Micronutrients and Breastfeeding: As its fifth priority, the project promotes exclusive breastfeeding for the first six months of a child's life, and continued breastfeeding for up to two years afterwards. Appropriate weaning foods and methods will be promoted with special emphasis at the community level. Micronutrients such as Vitamin A and Iron will be provided free of charge.

6. Control of Diarrheal Disease: The project will continue to emphasize prevention, home management and care seeking behavior. It will address the availability of drugs, the irrational use of antibiotics, water sanitation, refuse disposal and food handling.

There are four cross-cutting components: *quality control/assurance*, *community development/mobilization*, and *behavior change communication*.

- 1. Quality Assurance:** The ICH Project will use a system of standardization that will encourage a simultaneous improvement in clinic service and quality to the public.
- 2. Community Development:** Using the REFLECT method, the project will mobilize residents of target communities to identify, discuss, and take actions towards addressing community health problems and other economic, social and political issues that impact on their daily lives.
- 3. Behavior Change Communication:** A systematic programming and dissemination of messages about health knowledge, positive attitudes, and preventive behaviors will be promoted at clinic level, in the media and through community mobilization campaigns.
- 4. Monitoring and Evaluation:** the project will use health information systems to respond to critical health issues and to measure progress in attaining project goals.

Implementation Strategy

The Project will utilize three strategic approaches for the each of the components:

- ❖ ***Clinic-based approach:*** The ICH project will strengthen the capacity of clinics to provide more holistic and comprehensive care to their clientele and catchment areas through training and equipment, including the logistic means to travel and reach out to communities.
- ❖ ***Community-based approach:*** The Project will improve services at community level by training and equipping community service providers, and mobilizing and training community groups and persons to identify, treat and refer people, especially children, for services.
- ❖ ***Civil Society capacity building:*** The ICH Project will strengthen the capacity of civil society to participate in health care delivery by providing mechanisms for sound organizational structure, training staff in administration and other areas of business management. Staff will be trained and encouraged to become proactive in making policy and developing health care standards and protocols.

III. LIBERIA'S HEALTH INFRASTRUCTURE AND PROFILE

The intensified conflict of 2003 produced changes in the health care delivery system that were not anticipated in the design of the ICH Project. The changes that have most strongly affected the implementation of ICH are:

- Access roads and bridges to clinics have been destroyed.
- The security situation precluded access to the majority of project sites until February 2004.
- Some earmarked clinics have been destroyed or are in varying stages of disrepair.
- The fee for drug system has been indefinitely suspended.
- There is an acute shortage of drugs in Liberia
- The suspension of fee for drugs and the virtual breakdown of the fee-for-service scheme, coupled with government's inability to pay health workers' salaries, made the payment of stipends to service providers critical and inevitable.

IV. STRATEGIC OBJECTIVE

The project's overall objective is to achieve increased use of essential primary health care services through civil society. Three intermediate results (I.R.) will be tracked and monitored during the implementation process:

1. I.R. 1.1: Strengthened capacity of civil society to achieve sustainable primary health care service delivery, including access, quality and demand of services.
2. I.R. 1.2: Improved policy framework for primary health care delivery in Liberia.
3. I.R. 1.3: Increased availability of resources, including non-USAID resources, for health sector development in Liberia.

**Results Framework
Liberia Improved Community Health Project**

Improved Health Status

Strategic Objective 3: Increased use of essential primary health care services through civil society.
Indicators: a) CYP; b) DPT coverage; c) TT₂- coverage; d) use of insecticide treated nets; e) ORT utilization rate

IR 3.2: Improved policy framework for primary health care delivery service in Liberia.

Indicator: a) number of changes in policy framework due to project led interventions.

IR 3.1: Strengthened capacity of civil society to achieve sustainable primary health care service delivery, including access, quality and demand for services.

Indicators: a) Percentage of sub-recipient organizations demonstrating improved technical and managerial skills as measured by the organizational capacity index (OCI); b) number of REFLECT Circle members participating in civic organizations in targeted communities

IR 3.3: Increased availability of resources, including non-USAID resources for health sector development in Liberia.

Indicators: a) Amount of ICH Project's "match" funding obligation secured on an annual basis; b) amount of funds attracted vis-à-vis sources identified in the ICH proposal for PHC service interventions.

Sub-IR 3.1.1: Increased access to PHC services.

Indicators: a) DPT; b) Prevention of malaria amongst pregnant women; c) Increase in the volume of selected food crops by targeted farmers.

Sub-IR 3.1.2: Improved quality of PHC services.

Indicators: a) Measles coverage; b) exclusive breastfeeding

Sub-IR 3.1.3: Increased demand for PHC services.

Indicators: a) under-five consultations; b) knowledge of STI/HIV/AIDS

Baseline

In December 2003 the ICH Project conducted the first phase of the baseline collection exercise in urban and suburban communities of Greater Monrovia. This was followed by a rural survey in Bong and Nimba Counties in May 2004. This Knowledge Practice and Coverage (KPC) survey was followed one week later by the Expanded Program on Immunization (EPI) Coverage Survey in the same communities. On the average, the survey findings show that 27.6% of children under one year old had had their third dose of diphtheria-pertussis-tetanus vaccine (DPT₃) and DPT₁ coverage was 43.6%. 19.3% of women of reproductive age (WRA) had taken a second dose of tetanus toxoid vaccine (TT₂). 42.9 percent of those surveyed used insecticide treated nets (ITN) to prevent malaria and 22.9 percent used oral rehydration therapy (ORT) to prevent dehydration due to diarrhea¹.

See baseline report in Appendix A.

IR 3.1: Strengthened Capacity of Civil Society

Organizational Capacity Index

An organizational capacity index tool (OCI) was developed and used to measure the capacity of five local NGO in five key areas: **Financial Resource Management, Human Resource Management, Strategic Leadership/Management, Information Systems, and External Relationships**. All were very high in external relationships (average 89.4%) but low in human resource management (average 51.4%). The scores in this area ranged from as low as 22% to a mediocre 70%. Local partners are being individually assisted while work continues on a formal capacity building activity to from an integral part of next year's implementation plan.

Orientation of Partners

The workshop for the orientation of implementing partners to the Improved Community Health Program and its Performance Monitoring Plan was originally planned for June 2003. Due to the existing state of insecurity at the time and the difficulty in attracting partners because of the earlier policy of not paying incentives, the workshop was postponed. It was finally held from 26th to 28th February 2004 at Africare-Liberia's Monrovia office. Eight prospective ICHP partners sent their representatives. The workshop was facilitated by the project staff and the USAID Health Program Officer².

REFLECT Orientation Workshop

REFLECT is an acronym for Regenerated Freirean Learning through Empowering Community Techniques. Its methodology involves encouraging communities to identify their own needs and motivating them to take the necessary decisions and actions that address those needs. In April 2003, the Community Health Specialist and the Quality Control Specialist attended a three week REFLECT Orientation Training in Uganda. This visit was also followed by one week duty field trip to acquaint the staff of Africare-Liberia with the Africare-Uganda's Child Survival project in Ntugamo District and the implementation of the Gold Circle strategies.

¹ Appendix A-4

² Appendix A-3

The REFLECT Training of Trainers workshop for project staff and NGO partners originally scheduled to take place in 2003 was delayed because of security instability in the program operational areas and the constraints in recruiting a technical consultant. Arrangements for recruitment of the consultant were finalized in early May 2004 and the workshop was held from the 18th to 30th of May 2004. The consultant was assisted by staff of Africare-Liberia to finalize plans for the training. This training team collaborated with the National Adult Education Association of Liberia (NAEAL), a local NGO with expertise in REFLECT, to conduct the TOT

At least twenty-five persons including NGO partners of the ICH Project and staff of the Bong and Nimba County Health Teams were trained in REFLECT methodologies in program design and implementation. Subsequently, eight communities in Nimba and seven in Bong have been sensitized on the REFLECT modality of community mobilization. Training-of-facilitators workshops were held for members of the county health teams, community health workers, and equal numbers of male and female community facilitators in Nimba and Bong between July and September 2004³.

Semi-permanent Structures

Some Africare clinics were destroyed, damaged and/or rendered inaccessible as results of the last round of fighting in the country. Under the partnership with AmeriCares, 6 semi-permanent tent structures were erected in areas with the greatest need. These include Salala, Totota and Gbarnga in Bong County, Ganta and Tappita in Nimba County, and People's United Community Clinic in Sinkor, Monrovia. The structures in Monrovia and Totota are used to provide additional space for clinics; those in Gbarnga and Tappita are temporary replacements for damaged health facilities; the Salala tent will facilitate the process of upgrading the local clinic to a health center; and the one in Ganta will be used by the Methodist hospital there as an additional in-patient ward.

Africare/FPAL Partnership

Africare, through AmeriCares, is providing equipment in the form of delivery beds and instruments. FPAL has made some structural adjustments to its headquarters building to accommodate these services.

WARP Partners

Eight Liberian NGOs have benefited from capacity building in HIV/AIDS awareness and advocacy as a result of collaboration with the ICH Project in the implementation of the West African Regional Program (WARP) HIV/AIDS project funded by Population Services International (PSI). These organizations are Family Planning Association of Liberia, National AIDS/STI Control Program, Mother Patern College of Health Sciences, Liberia Society of Women Against AIDS, Media Against AIDS, AIDS Corps, Medical Emergency Relief Cooperative International and United Christian Churches Against AIDS (the last organization has been dropped from the program for failure to submit required deliverables)⁴. In addition to funding for project implementation and training workshops, the project has facilitated the purchase of IEC equipment (cameras, video/TV sets and electric generators), publication of

³ Appendix D

⁴ Appendix B-3

HIV/AIDS literature including a newsletter, training/teacher guides and a booklet titled “*Let’s Talk About AIDS*”.

IR 3.2: Improved Policy Framework for PHC Service Delivery

The ICH Project has been the technical lead in the following three policy framework changes:

1. **National Mid-Level Health Worker Refresher Curriculum:** The ICHP provided a curriculum design specialist for three months (February to April) to guide and coordinate the process of developing a reproductive health curriculum for Liberia. The curriculum is designed to provide in-service training for Registered Nurses, Certified Midwives, Licensed Practical Nurses and Physicians Assistants, who are experienced service providers. At the end of this process (30th April 2004) the draft curriculum, teaching materials, and supervisory check lists were submitted. The ICH staff will be responsible for the refining and final production of these documents.
2. **National Malaria Behavior Change Communication Strategy:** Developed jointly with the Ministry of Health and Social Welfare, this document “outlines an approach to improve home-based management of malaria in children and early referral of severe cases by providing information to parents and primary caretakers, improving coverage for IPT for pregnant women, ITNs for children/pregnant women, training service providers, and advocating for support from policy makers. The strategy was developed at a workshop in March 2004 and the final document was published one month later.
3. **Improved Reproductive Health Service:** The ICHP has been assisting the Family Planning Association of Liberia (FPAL) to increase its reproductive health care capacity. The FP clinic in Monrovia now provides prenatal, intra-partum, postnatal and adolescent health care services alongside its regular range of services.

Additionally, the ICH project has been a key player in the following national policy framework changes:

1. New Malaria Treatment Protocol
2. National Malaria Policy
3. National Malaria Strategy
4. Insecticide Treated Bed Net Policy
5. HIV National Strategic Plan of Action
6. Prevention of Parent-to-Child Transmission National Guidelines
7. Supplementary Feeding Center Guidelines

HIV/AIDS

Ongoing ICHP HIV/AIDS activities aimed at changes in policy framework include BCC training for sectoral agencies (including NACP, local NGOs, UN agencies and INGOs), and efforts at securing funds for a national communication strategy on HIV/AIDS.

Others Policy Issues

Following the revitalization of the targeted rural clinics, the Improved Community Health Project intends to work with other stakeholders to address the following critical policy issues: revolving drug fund/fee for service; standardization of the treatment protocol for endemic diseases; and the use of insecticide treated nets. As soon as the integrated curriculum for reproductive services is completed and approved, the ICH and other stakeholders will pursue the development of policies to guide the practice of the skills addressed in the training curriculum.

IR 3.3: Increased Availability of Non-USAID Resources

While waiting for improvement in the security environment to facilitate full scale commencement of main project activities, the ICH has made some inevitable humanitarian responses by way of short term programs that link emergency activities with developmental activities in order to realize the greatest sustainable gains that contribute to longer range plans. These have involved collaboration with local and international partners:

Africare – AmeriCares collaboration

Africare is collaborating with AmeriCares, a US based non-profit disaster relief organization which provides immediate response to emergency medical needs as well as support for long-term humanitarian assistance programs. Since September 2003, AmeriCares and Africare-Liberia have collaborated to provide emergency and long term medical assistance to hospitals, clinics, health centers, IDP camps and orphanages in Liberia using Africare's network of partnership with local and international NGOs and the Ministry of Health.

There is a persistent shortage of essential drugs in the Liberia. This has been offset to a limited extent by AmeriCares' donation of free drugs. Africare has worked in collaboration with the Liberian National Drug Service (NDS), local and international NGOs, church groups and government facilities to handle the distribution of the supplies.

Under the agreement with AmeriCares, Africare is committed to distribute the donated items free of cost in accessible communities with the greatest need. This has geographically and logistically expanded the scope of Africare activities. Since the start of the Africare – AmeriCares partnership in September 2003, AmeriCares has made three emergency airlifts, sent in one airfreight containing emergency drugs and medical supplies, including anti-tuberculosis drugs. Liberia had completely run out of anti-TB drugs when an urgent appeal was made to AmeriCares to which this immediate response was made. In addition, four sea shipments of drugs, medical equipment and supplies, and components of six semi-permanent structures have been sent to Liberia in support of the partnership.

Thus far, AmeriCares' donations are valued at more than \$5,000,000. These consist of 6 temporary structures, essential drugs, and medical supplies (including hospital beds and instruments, and infant feeds). Clearance, storage and distribution of the supplies were handled by Africare-Liberia in collaboration with the National Drug Service (NDS) from September to February when the sub-contract with NDS was terminated. The drugs and supplies are now stored in an AmeriCares funded warehouse that has been rented since December 2003. In February a Pharmacist and a Warehouse Manager were employed, their office set up, and management of the AmeriCares donations taken over by Africare.

The drugs and medical supplies were intended for use by the ICH Project to support national efforts in the immediate post conflict period in Liberia. They were distributed to the needy population through 18 local and international NGOs.

AmeriCares staffs, including their President, have made several visits to Liberia to monitor distribution of their donations and assess current needs. AmeriCares is committed to continued assistance as long as the need exists.

Africare –UNICEF Collaboration

The ICH Project is collaborating with UNICEF to implement the following four projects, thereby providing matching funds to the project grant award. Project components being addressed through partnership with UNICEF are nutrition and WATSAN.

1. ***Promotion of Optimal Young Child and Infant Feeding Practices in Liberia:*** A three month mass media and social mobilization effort in Montserrado County, reaching mothers of young children through radio and community based demonstration sessions, promoting exclusive breastfeeding for first six months and preparation of nutritious and locally available weaning foods. A total of \$62,065 was spent on the project: \$35,865 cash, \$18,545 in-kind, plus \$7655 for the production and airing of yellow fever radio programs.
2. ***Supplementary Feeding Program:*** This is a 6 month nutrition emergency response project to cater to an estimated 12,000 children under five years in 15 catchment communities in Saclepea, Nimba County valued at \$134,524.56 (\$22,648.29 cash, \$111,876.27 supplies).
3. ***Behavior Change Communication for Safe Water, Sanitation and Hygiene Promotion:*** Collection and analysis of formative research will support the development of IEC materials and support the contents of radio and community-based drama performances, to promote use of safe water, proper hand washing, and latrine use. The cost of this project was \$20,050.
4. ***Community Empowerment for WATSAN Promotion:*** Work with 15 communities in Monrovia and its environs to promote participatory planning, decision making, and practices that will improve water availability, safety, and environmental sanitation as well as hygiene promotion. The objectives of the project are:
 - To improve skills of community members for carrying out activities and practices to ensure availability and safety of drinking water and improve environmental sanitation.
 - To build the skills of community members in social mobilization for dissemination of health messages and sensitization for clean up campaigns to ensure hygiene promotion and improve environmental sanitation.
 - To rehabilitate twenty-three wells within fifteen communities in Monrovia and its environs.

The proposal for this project estimated at \$89,459.70 (UNICEF \$76,368.45, Africare \$12,971.25 and communities \$120) has been submitted and funding for implementation is pending.

WARP Project

The ICH Project was asked to manage activities of the West African Regional Program on HIV/AIDS (WARP) Ambassadors' Fund for a budget of \$58,183 to be subcontracted to local implementers. The activities of the local NGOs vary widely. For example, FFAL supports 20 local leaders in HIV/AIDS prevention and control; LIB-SWAA published and distributed 3 HIV/AIDS booklets for outreach to 1000 youths; MPCHS provides awareness among 50,000 persons in 8 Catholic Church parishes in Monrovia; MA-AIDS publishes 1000 copies of HIV/AIDS newspaper.

A brief chronology of the WARP HIV/AIDS initiatives is as follows:

- April 2003: Agreement signed .
- May 2003: 3 day workshop for 20 participants from 8 implementing partner organizations.
- June 2003: Pre-testing of WARP materials (literature) among Liberians in Sierra Leone – when instability in Liberia displaced local project staff and expatriates were evacuated to Sierra Leone.
- July 2003-January 2004: Activities stopped by donor. During this time the ICH Project remained in contact with the local implementing organizations.
- January 2004: No-cost extension signed .
- February 2004: Subcontracts with 8 implementing partners submitted to Africare-Washington.
- April 2004: Finalization and approval of subcontracts.
- June 2004: Completed first milestone
- August 2004: Second No-cost extension of the project to December 2004 as new end date

Sub-IR 3.1.1: Increased Access to PHC Services

Reactivation of Clinics

The Ganta Field Office was completely looted of all fixtures including windows, doors, bathroom sets and ceiling. The roof was riddled by bullets and rockets had landed on two sections. Intensive renovation and re-equipping efforts have been made to restore the office facility. The office is now at a level to serve project-relevant functions and provide requisite support to field based activities.

ICH has begun the reactivation of clinics in Nimba and Bong Counties. The Project is committed to the recruiting and paying incentives to qualified service providers in addition to the provision of essential drugs, supplies and equipment in all of the clinics. The process has been slowed by difficulties in recruiting qualified staff and the adverse conditions of access roads and clinic structures. To date, 24 clinics have been reactivated:

Nimba County (16): Sanniquellie St. Mary's Catholic, Zorgowee, Weiplay, Toweh Town, Gbloulay, Younlay, Vayenglay, Buutuo, Bonlay, Goagortuo, Gbeivonwea, Tappita Mid-Baptist, Yekepa YMCA, Tappita Consolata Catholic, Ganta K.L. Foundation and Karnwee.

Bong County (8): Salala, Tokpapolu, Fenutoli, Gbonota, Janyea, Zebay, Gbahlala and Yila Baptist Mission.

Negotiations are in process between the ICH Project and the administrations of Phebe Hospital in Bong County and Ganta Methodist Hospital in Nimba County to incorporate their primary health care services into the ICHP network of health facilities. Apart from these private facilities, the county health teams in Bong and Nimba have been engaged to sign Memoranda of Understanding for other clinics in these counties⁵.

Seven new clinics will be added in Montserrado when the sub-project agreements are concluded with the Family Planning Association (FPAL) and the Medical Emergency Relief Cooperative International (MERCII).

Other Sub-IR 3.1.1 Results

❖ Increase Full Immunization Coverage for Children Under 5

Sporadic EPI services are being provided in ICHP clinics. Mother Support Groups in project communities have been sensitized to mobilize mothers to get involved in the immunization of their children. The ICHP is also participating in the preparatory stages of the synchronized NIDs for polio immunization.

❖ Increase Access to Reproductive Health Services

The ICHP has conducted evaluation exercises on the status of reproductive health care services in the project communities prior to and during its phase-in activities. The assessment includes: KPC survey in randomly selected communities in project areas; assessment of reproductive health facilities; services and training needs in health facilities in Monrovia, Bong and Nimba participating in the project. These exercises identified and defined deficiencies in reproductive health knowledge, practices and quality of care in project operational areas. Among the significant outcomes of these efforts were:

- i. 20 primary health care service providers recruited from project clinics and enrolled of in a PHC course at Mother Patern College of Health Sciences. After 2 weeks in session the course was cancelled during the attacks on Monrovia in 2003.
- ii. A scope of work for a reproductive health curriculum design consultant to coordinate and supervise the development of a reproductive health curriculum for in-service health care service providers. The consultancy has been completed and the report submitted to the Chief of Party.

⁵ Appendix A-2

- iii. Medical equipment donated by AmeriCares to help improve quality of care and to provide pre natal intrapartum, postpartum and emergency obstetrical care were distributed to 5 MOH facilities (Salala, Totota, Slipway, PUCC, John F. Kennedy Hospital), 1 FPAL antenatal clinic and 6 MERCI clinics (Hydro, Lakpazee, Greystone, Jamaica Road, Paynesville, and EJ Goodridge. Salala and Totota are in Bong County while the rest are in Montserrado.
- iv. Subcontract agreement with Liberia Prevention of Maternal Mortality to administer emergency obstetrical care and establish a referral system in project communities in Monrovia.

❖ **Reorganization of Staff**

Mabel Kear, the incumbent Community Development Specialist resigned on May 21. USAID was informed about this development as well as a staff restructuring plan that would ease the work load of the field staff and make them more focused and efficient. Catherine Gbozee who had acted as de facto clinic supervisor in addition to her role as Quality Control Specialist was appointed as Community Development Specialist and two Clinic Supervisors were hired – one for Nimba and the other for Bong and Montserrado. Luke Bawo, the Health Information Specialist now serves as Field Coordinator. In this capacity, he shares some of Mabel Kear's functions with Catherine who in turn continues to lend assistance in quality control.

Sub-IR 3.1.2: Improved Quality of PHC Services

Malaria Control and Prevention

Results from the KPC surveys of 2003 and 2004 show that 34.7% of the target population has been immunized against measles while 49.9% of mothers practiced exclusive breastfeeding for the first six months.

A KPC study was conducted in randomly selected communities to determine malaria knowledge, treatment-seeking behavior and attitudes about prevention. Because of the change in treatment regimen by the Ministry of Health and WHO, amodiaquin and artesunate (the new first line drugs), fansidar, quinine, and chloroquine were included in a consignment of essential drugs procured through AmeriCares and other non-USAID sources. However, the amodiaquin and artesunate have not been dispensed to ICH supported clinics due to delays in training health workers in the administration of these new drugs. The other drugs were distributed to 11 health facilities and medical agencies, including some INGOs. Also through AmeriCares, the ICHP has procured and distributed 120 insecticide-treated nets (ITNs) to 8 health institutions (2 hospitals, 6 clinics) for use by pregnant women and children under the age of five.

HIV/AIDS Prevention and Control

The ICHP has been active in the formulation, development, and implementation of communication programs that provide target population with the necessary information about the causes, nature, and prevention and control of HIV/AIDS. The project has carried out an urban HIV/AIDS survey in Monrovia, the results of which has been analyzed in a disaggregated HIV/AIDS data detailing the comparative levels of

awareness between males and females of reproductive age. All respondents had heard about HIV/AIDS, 19.05% have been tested, 81.4% wanted to be tested but 61.4% did not know where to go for an HIV test.

A proposal for an HIV/AIDS Volunteer Service Corps has been developed and submitted to Africare headquarters in Washington. Request for proposals has been sent to five Liberian NGOs for the establishment of a VCT service.

Nutrition, Micronutrients and Breastfeeding

The ICH has formed and trained Mother Support Groups (MSG) in breastfeeding education using the SIP (support-integrate-promote) method. At clinic level, health workers have been trained to teach the LAM contraception techniques to mothers visiting the ICH health facilities. FPAL has been assisted in setting up a post-natal and well-baby clinic services at its head office in Monrovia.

The project has also collaborated with the Diompilor project of Mercy Corps to develop and air twenty-nine fifteen-minute radio dramas on breastfeeding and infant nutrition. The dramas are broadcast on 11 radio stations in the project communities reaching 37% of surveyed mothers of children under 5.

A section of each ICH clinic has been designated as "ORT corner" where the oral rehydration supplies can be obtained along with instructions for preparation. The MSGs are being used as mediums for training care-givers on the preparation of oral rehydration solution using locally available ingredients.

Baseline surveys have been completed in both rural and urban communities of project areas to gather information on current patient care attitudes and practices at the community and health facility levels in target locales where security allows. In the most significant project indicators except continuous breastfeeding, the rural area lags behind the urban area as the following brief summary shows: DPT₃ coverage – 41.9% urban, 13.2% rural; TT₂₊ coverage – 31.5% urban, 7.1% rural; mothers still breastfeeding beyond 6 months – 82.3% urban, 92.9% rural; malaria prevention during pregnancy – 86.3% urban, 74.5% rural; use of contraceptive – 10.3% urban, 2.7% rural.

Sub-IR 3.1.3: Increased Demand for PHC Services

Health Radio Programs

The KPC baseline surveys revealed that 96.0% of respondents have heard about HIV/AIDS. 75.6% of them cited radio as their source of information.

The ICH project has been integrally involved in health radio programming in collaboration with USAID-funded Mercy Corps Diompilor Project, with some UNICEF funding support. As the chair of the Liberia Health Technical Working Group, the ICH Project has facilitated the content frameworks for radio programming in cholera/diarrheal disease prevention, breastfeeding, infant weaning food and nutrition. Twenty-nine health

dramas, fifteen minutes in length, have been produced, in addition to 15 radio spots, totaling over 15 hours of air time.

The project was also able to contribute to a yellow fever vaccination campaign with funding from UNICEF. A radio spot in local languages and promotional materials advertised a yellow fever vaccination campaign.

A major entertainment-education radio program is in final stage of development. The ICH Project in collaboration with Mercy Corps Diompilor produced a design document for a 26-episode serial magazine radio show titled *Health is Our Wealth*, addressing malaria, safe motherhood, immunization and diarrheal disease prevention. Pre-testing of the radio programs was done in July 2004⁶. The final revision and recording are in progress. (Appendix B-1, 2, 3)

Community Theater

A weaning food demonstration project, implemented by a local partner, Breastfeeding Advocacy Group (BAG), has seen the implementation of 250 demonstration sessions, the distribution of over 7000 flyers, and use of 5 counseling cards by the 25 session facilitators. The demonstrations reached an audience of 12,913 mothers of children under 5 years.

An initial assessment of the results reveals that mothers of children under 2 who attended the demonstration sessions have better knowledge about breastfeeding, weaning foods and hand washing practices than mothers who did not attend the sessions. 37.31% of mothers surveyed said they heard the radio programs.

V. CONSTRAINTS

Insecurity in Liberia

The signing of the ICHP contract was shortly followed by deterioration of security in targeted project areas. Field staff personnel were displaced in Monrovia as hostilities increased in the countryside. The Chief of Party and Behavior Change Communication Specialist arrived in Liberia at a time when the capital Monrovia was increasingly feeling the impacts of the siege by advancing anti-governmental rebels. They were evacuated at the end of May and returned September when the country was in the midst of a complex emergency and humanitarian crisis that all partners in health care needed to address. This meant that Africare and the Improved Community Health Project consortium had to get involved in humanitarian relief operations before the commencement of actual activities contemplated by the original design of the ICHP.

Until January 2004 project areas beyond Salala in Bong County were inaccessible. Notwithstanding, other humanitarian relief NGOs ignored this precaution and began supporting clinics in these areas. In the process they lured personnel from ICH-designated clinics not only with the immediate provision of urgently needed emergency services, but also with the payment of incentives.

⁶ Appendix B-1

Loss of Targeted Health Facilities

In February and March the ICH Project lost ten clinics in Bong in due to lack of commitment to paying incentives. Africare requested and obtained USAID support to pay incentives to service providers in project supported clinics. Now that the problem of incentives has been solved, the next obstacle to implementation which seems even more critical is the lack of adequate supplies and variety of essential drugs. The availability of drugs from the National Drugs Service (NDS) is sparse and sporadic. NDS has lost its funding from UNICEF and what it currently gets from the European Union is minimal. The once successful community fee for service was suspended in 2003 as a consequence of the humanitarian and socio-economic problems created by the war in Liberia. Any drugs procured through NDS must now be bought at close to market prices instead of the previous subsidized rates. Africare has proposed a scheme for procurement of drugs.

Africare's inability to pay incentives because of restrictions imposed by the project cooperative agreement was the greatest impediment to project implementation. It was difficult to persuade staff to return to clinics without making a commitment to pay incentives. Prospective implementing partners were unwilling to make contractual agreements without including the payment of incentives. Some implementation initiatives were delayed until this issue was resolved.

Many health workers who fled from the rural areas during the crisis and others just completing professional studies in Monrovia are reluctant to take up posts in rural clinics. Some of the reasons for this attitude are poor working conditions, dilapidated structures, lack of essential drugs, medical supplies and equipment, and poor access to facilities due to bad road conditions.

Our best efforts to re-establish Africare-Liberia's offices in a timely manner were as successful as could be expected under the existing atmosphere. Vehicles, furniture and equipment were in high demand and slow in materializing. Restoration of land telephone lines, fax, e-mail and SSB radio communication has been slow and intermittent.

Loss of clinics also means loss of infrastructure (investments) made in the Community Health Initiative Project as the earmarked clinics were those previously supported by that project. The ICH Project was designed with the anticipation to build on those investments. In addition the lost clinics were those most easily accessible. In trying to replace these clinics ICH is now faced with supporting clinics that lack the infrastructure provided to those clinics that Africare had been supporting under the Community Health Initiative Project. This includes cold chain mechanisms (refrigerators, cold boxes etc) and community outreach activities established in the catchment areas. As already mentioned, access roads and bridges to some of these structures are extremely difficult, hazardous and sometimes impassable. Many have been neglected for long periods, needing extensive renovation.

VI. RECOMMENDATIONS

More than a decade of armed conflict and the recent struggle for Monrovia has left Liberia bereft of a health infrastructure to accommodate developmental activities. Even the most basic structures and amenities are lacking. Health workers over the years have worked in dilapidated

surroundings with worn out, dysfunctional and archaic equipment and without access to current information. Formal in-service education has been discontinued since 1989. In addition the attrition rate among health workers has forced those who remain to practice in expanded roles without the requisite in-service training, skills update, policies and protocols to practice safely and efficiently.

ICH as a developmental project, must take some steps to create the potential for successful implementation by addressing the urgent health priorities exacerbated by prolonged warfare. Here are some suggestions:

1. **Drugs:** A long term reliable mechanism for maintaining drug supplies to Africare supported clinics must be established. With the indefinite suspension by the Ministry of Health of fee for drugs, a community revolving drug fund is no longer possible. A source of funding to purchase drugs for free distribution must be identified immediately while working towards formulating a policy to support sustainable health service delivery.
2. **Infrastructures:** Continue to seek opportunities to restore clinics, hospitals and access roads damaged and destroyed by the war.
3. **Personnel:** Upgrade the skills of health workers who have not had in-service training in many years.
 - Continue the curriculum design process started this year
 - Work with MOH and stakeholders to adopt the curriculum and use it as a basis for a formal in-service program
 - Apply the curriculum in training courses for project service providers.
 - Collaborate with the MOH and other stakeholders to discuss a strategy for providing Life Saving Skills training for midwives and other health workers. When training is arranged, give priority to midwifery teachers and midwives working in isolated areas. Train midwives not only as service providers, but as trainers of other levels of service providers.
 - Strengthen basic training by ensuring that in-service curriculum is included in basic curricula.
4. **BCC:** Institutionalize BCC capability in Liberia by extending the BCC position on the project team for at least a year to enable:
 - Oversight and appropriate implementation of BCC strategies that have been developed.
 - Employment and training of a local BCC specialist by the BCC Technical Advisor.
5. **HIV/AIDS:** Continue to be proactive in the control and prevention of HIV/AIDS through:
 - Development of a HIV/AIDS curriculum for service providers
 - BCC activities including the ABC approach to prevention
 - Providing condoms for the prevention of HIV/AIDS and family planning
 - Advocating and promoting voluntary counseling and testing where possible
 - Use of antiretroviral drugs particularly for pregnant women.

6. **Ministry of Health:** Work with County Health Teams to improve quality of care through appropriate monitoring and supervision.
7. **Project Revision:** Revise the project to enable inputs to have a national impact and therefore lay foundations for institutional development and to address changes that occurred in the health care delivery system after the project had been designed. These changes include destruction of hospitals and clinics, suspension of fee for drugs, payment of incentives to health workers. Failure to readapt project design to existing realities will negatively impact on or impede project implementation.

Appendix A: Phase-in Activities

- A-1 Rapid Assessment Report
- A-2 Status of ICH Project Clinics
- A-3 Partners Orientation Workshop Schedule
- A-4 Summary of Baseline Survey

Appendix B: BCC Activities

- B-1 Health Working Group for Radio Program
- B-2 Design Document for Radio Serial Magazine
- B-3 WARP HIV/AIDS Orientation & Management Workshop
- B-4 Liberia National Malaria BCC Strategy

Appendix C: Curriculum Design Process

- C-1 Scope of Work for Curriculum Design Consultant
- C-2 Report on Curriculum Design Activity
- C-3 Learning Needs Assessment

Appendix D: REFLECT Activities

- D-1 Training of Trainers Workshop
- D-2 Training of Facilitators Workshop

Appendix E: Key Accomplishment of ICH Project

Appendix A

PHASE-IN ACTIVITIES

A-1

**RAPID
ASSESSMENT
REPORT**



Africare

**Rapid Assessment Report
(Bong & Nimba Counties)**

January 6-9, 2004

Report of Assessment Trip to Bong and Nimba Counties

Duration of Assessment

January 6-9, 2004

Team Composition:

Luke L. Bawo, Jr. Health Information Specialist
Catherine Gbozee Quality Control Specialist
George Slewion Driver

Purpose of Trip:

- To visit accessible clinics in Bong and Nimba Counties and reassure clinic staff of Africare's willingness to continue support to the facilities.
- Have brief discussions with the Community Health Departments/County Health Teams and other implementing partners and express Africare's commitment to continual collaboration in providing improved and sustainable health care and discuss the way forward.
- To assess the general health condition of the population
- Assess/observe the general security situation, condition of road travel and relationship between armed militia and civil populace.
- Assess condition of field office and the likelihood of reestablishment as soon as possible.
- Talk to people, gather on site information and inquire about the situation/condition of those clinics that are still not accessible.

Road/Travel Condition

Monrovia to Ganta

There is free movement of people and vehicles from Monrovia to Ganta. This is largely due to the deployment of UNMIL troops as far as Gbarnga and the regular UNMIL patrols conducted along the highways in Nimba where there are still no UNMIL troops stationed. *With the exception of Careysburg, Mount Barclay and Salala, which are* manned by GoL police and immigration personnel, all checkpoints up to Gbarnga are controlled by UNMIL troops. There are four militia checkpoints (2 LURD and 2 GoL) from the bridge forming the boundary between Bong and Nimba Counties to Ganta. No arms were visible at these points and our vehicle was waved through without question. Passenger vehicles however plying the route have to pay some fee.

Ganta to Beo-yoolar via Sanniquelle

There are two GoL militia checkpoints in Sanniquelle and one in Karnplay on the route to the border town of Beo-yoolar. Men guarding these checkpoints were unarmed and again their sole purpose was to collect fees from passenger vehicles. We drove through without incident. Neglect and lack of maintenance has worsened the already deplorable conditions of the road. Any vehicle other than 4 X 4's will have a hard time negotiating the road.

Ganta to Tapitta via Saclepea

The three checkpoints controlled by former GoL militia up to Kpaytuo were manned by unarmed men. There were six MODEL controlled checkpoints from Kpaytuo to Yreah Town close to Tapitta. There were armed MODEL fighters at these checkpoints. Armed fighters could also be seen walking along the road. We were granted passage without questioning. The team however encountered a little hitch on the way back from Tapitta in the town of Graie where they have a high concentration of MODEL fighters. The fighters refused to open the checkpoint and instead asked the driver and a team member to go and speak to a local commander seated under a tree beside the road. According to said commander, the driver on his way to Tapitta sped through the checkpoint without approval. He said that they have been instructed to grant passage to everyone but people going through the checkpoints must stop and be allowed to go through first and not "bulldoze" the checkpoints. We assured him that it was not our intention to go through road blocks without permission. The road is not in as bad a state as that of the Ganta-Beo-yoolar road but overgrowth of vegetation has narrowed the road. Towns and villages from Kpaytuo to Tapitta are virtually deserted with many unroofed and badly damaged structures. A few civilians were seen walking along the road with their personal effects.

Health Assessment and Clinics Status

Since February of 2003 when fighting in the region compelled Africare to cease the provision of health activities, there has not been any sustained and comprehensive health service of large coverage in the two counties. Presently MSF-Holland is providing some support to the Sanniquelle Hospital and a few clinics in Nimba County. EQUIP is also lending assistance to some clinics while MSF-Switzerland is running a Therapeutic Feeding Center (TFC), Inpatient and Outpatient care in Saclepea and conducting mobile health care in some towns.

The general health condition of the people especially along the border with the Ivory Coast and in the MODEL controlled areas is poor. The District Health Officer of the Gbelay-Geh District spoke of an increase in the number of malnutrition cases. Presenting clinic records, the clinic in Garplay diagnosed over fifteen cases of malnutrition in the month of November 2003. In December 2003, a suspected case of acute flaccid paralysis (AFP) was identified in Larpea #1. According to the DHO, specimens were collected and sent down to Monrovia. Sporadic cases of measles were also reported in Nimba County. In Bong County, Medecin du Monde (MDM) is reported to have investigated and confirmed a measles outbreak in the Palala area.

Many hand pumps have either broken down or were looted. These have contributed to the increase in the number of diarrhea cases in the counties. There are no EPI activities in Nimba County due to the lack of vaccines, kerosene and EPI materials in the county. With the exception of drugs supplied by MSF-Holland to the Beo-yoolar Clinic and a few other clinics that recently received drugs through EQUIP, all other clinics in Nimba County are out of drugs. Drugs requisitioned by Africare and given to the Nimba County Health Office for distribution in the county are still in Sanniquelle because of lack of logistics.

From direct observation and interviews with key informants, most of the clinics under the project are still intact but in need of repairs. The exceptions are Consolata Catholic

Clinic, Yourpea Clinic and the Ganta PHC which were all burned down. The status of the clinic in Bonlay is still unclear.

Current Situation in Major Towns

Ganta

Ganta in Nimba County is where the project has its field office. The town was captured by LURD in March, 2003 and after three months of heavy fighting, it was recaptured by GoL Militia. The resultant fighting and targeted burning of houses left the city center and other parts of Ganta burned down. Situated close to the Guinea border and on the route leading to the South-East of the country and the road leading to the Ivory Coast, Ganta has always been the commercial hub of Nimba County. We observed that Ganta is rapidly being repopulated with the fast growth of business activities. Shops and stores are reopening and two community FM stations are back on the air. The border with Guinea is reopened and busy with human and vehicle traffic.

The only health facility in Ganta is operated by EQUIP but it is overwhelmed with the high influx of patients. A local group, KL Foundation, has a building and health staff on the ground but does not have drugs and medical supplies.

The field office is intact but will need major renovation work to put it back in shape. The roof needs changing and other fixtures including bathtubs, commodes and face basins have to be replaced as they were looted.

Sanniquelle

Sanniquelle the administrative seat of Nimba County was unaffected by fighting and instead served as one of the places where people ran for refuge. MSF-Holland is entering agreement with the CHT to provide support to the county hospital.

A meeting was held with the Agriculture Relief Service (ARS), the local NGO meant to implement agriculture programs under the ICH project. They expressed their commitment to continue the partnership and look forward to the return of the project.

Saclepea

Saclepea has a higher than usual population given that civilians sought refuge there during the course of fighting. Saclepea plays host to IDPs in a local school and the camp constructed by UNHCR in early 2003 to host Ivorian refugees. LRRRC put the figure at 5,000 but MSF-CH estimates a lower figure, probably around 2,000. Estimates of the number of refugees from the Ivory Coast residing in the communities and the camp is 300. MSF-CH runs Inpatient, Outpatient care and a therapeutic feeding center (TFC) in Saclepea.

Tapitta

Until a few days ago, Tapitta had been under the occupation of MODEL, having captured it from the former GoL militia. Ethiopian UNMIL troops are now deployed and are consolidating their hold on the town. The town is still deserted with many burned and unroofed structures. A small portion of the Government Hospital was gutted by fire and the remaining section unroofed. UNMIL is encouraging civilians to come to town but

people are still a little apprehensive. UNMIL claims that civilians are coming to beg for food and seek medical care at the UNMIL health post and then returning to the bushes. This could be attributed to the fact that the MODEL soldiers are still parading the town with arms. We estimated at least 50 returnees sheltered in a building in Tapitta. UNMIL speaks of worsening health situation and are encouraging organizations to come in and render assistance. They are projecting that by the end of the month, the disarmament exercise will begin in Tapitta.

Gbarnga

UNMIL troops from Bangladesh are deployed in Gbarnga, the administrative seat of Bong County. Normal life is rapidly returning to the town with civilians moving back and commercial activities on the rise. Shop and stores are reopening and the transport union is operating. The C.B. Dunbar Clinic is burned down but MDM has renovated two structures nearby for clinic use.

Key Findings

- As stated previously, there are no EPI activities in Nimba County. Clinics in the Gbelay-Geh District still have the kerosene refrigerators for vaccine storage and preservation but they have all run out of kerosene to keep them on. These clinics have not received any replenishment of EPI spare parts and supplies since February, 2003 and as a result are out of lamp shades, wicks and burner parts. Refrigerators in areas that were affected by fighting were all looted. The vaccine depot in Sanniquelle is intact with functioning refrigerators but like those in the Gbelay-Geh Clinics they are out of kerosene. MSF-Holland is providing some assistance to the hospital but has not made any commitment as to the support of the vaccine depot which is the primary site for vaccine storage and eventual distribution to facilities in the county. EQUIP made one vaccine delivery in December but a regular transport system of vaccine transport from Monrovia to the county depot is none existent.
- With the exception of the facilities mentioned earlier, there are no drugs and medical supplies in the clinics. Drugs procured by the ICH project and given to the CHT for distribution to the facilities are still at their headquarters due their lack of logistics.
- The general health condition of the population is poor and continues to worsen especially in the border region and in MODEL controlled territories in Nimba County. The few health care providers in the area are overwhelmed with the high patient load. Interviews with clinic staff and record review show a rise in communicable diseases with measles outbreaks reported in both Nimba and Bong Counties. Malnutrition is also on the rise especially on the border with the Ivory Coast and in the Tapitta region. Farming activities were interrupted due to the fighting and in some areas the fighters harvested the farms after the civilians fled. The theft of hand pumps coupled with the absence a regular well chlorination program have lead to an increase in the episodes of diarrhea diseases in the area.

- Security and normality are returning rapidly to the two counties. This is evident by the reawakening of commercial activities and the rapid return of people to towns that are under the control of the warring factions. Only fighters in the MODEL control areas were seen carrying arms. One nonetheless will have to exercise caution in the area. The situation described from the MODEL checkpoint in Graie is a reminder that until there is disarmament of the fighters, security is still not 100% OK.
- Neglect and lack of maintenance is having a toll on roads particularly those of rural Nimba County. Road damage from erosion and vegetation overgrowth are the main causes. Feeder roads connecting the main road with off road clinics are nearly closed and in need of rehabilitation. Make shift log bridges on the roads pose another hassle. Many of them are worn out and rotted. They will have to be replaced.
- Some farmers' groups organized by ARS in the Gbelay-Geh and Sanniquele-Mah Districts are still intact. They claim to still have some of the tools distributed to them and are willing to recommence activities.

Key informants

Senior staff of ARS

Mehmon Tokpah

Martha Zegban

Logistics Officer

Mr. Karmo

Allen Zomonway

George Dehmie

J. Wrotto

Ordinary citizens

Local authorities

Farmers' Groups

Ethiopian UNMIL troops in Tapitta

Clinic Staff from:

-Zorgowee

-Karnplay

-Gbeivonwea

-Beo-yoolar

-Garplay

-Vayenglay

-Weiplay

-Flumpa

-Saclepea

-Palala

DHO/Gbelay-Geh District

Member/NCHO

MSF-CH

Supervisor/Bong County CHT

Coordinator/Ganta PHC

Director/K.L. Foundation

Head/Returnee Committee in Tapitta

Itinerary for Assessment Trip

Date	Time	Activity
Jan. 6	8:00 – 11:00am	Depart Monrovia and travel to Palala in Bong County
	11:00 – 12:00pm	Meet with staff of Palala Clinic
	12:00 – 1:00pm	Depart Palala and travel to Ganta in Nimba County
	1:00 – 2:30pm	Assess field office and Ganta Community
	2:30 – 3:30pm	Depart Ganta and travel to Sanniquelle
	3:30pm	Meet with Nimba County Health Team, members of the Community Health Department and the Agriculture Relief Service (ARS)
Over night in Sanniquelle		
Jan. 7	8:00 – 2:00pm	Travel and meet with staff in the clinics of Yekepa, Zorgowee, Goagortuo, Younlay, Gbeivonwea and Beo-yoolar
	2:00 – 3:00pm	Return to Sanniquelle
	3:00pm	Travel to Tapitta and assess conditions including the status of Consolata and Mid-Baptist Clinics
Over night in Sanniquelle		
Jan. 8	8:00 – 4:00pm	Travel and meet with staff in the clinics of Vayenglay, Weiplay, Saclepea and Flumpa
Over night in Saclepea		
Jan. 9	8:00 – 11:00am	Travel to Tokpapolu in Bong County
	11:00 – 12:00pm	Meet with staff of Tokpapolu
	12:00 – 1:00pm	Travel to Salala
	1:00 – 2:30pm	Meet with Bong County Health Team & members of the Community Health Department
	2:30pm	Depart Salala and travel to Monrovia



The Burned Catholic Clinic in Tapitta



A Malnourished Child



A Damaged Bridge on the Road to the Weiplay Clinic



Citizens Reconstructing Broken Homes in Ganta

A-2

**STATUS OF
ICH PROJECT CLINICS**



Africare

**Report on the Reactivation of Improved
Community Health (ICH) Project Clinics in
Nimba County**

January 28 – February 2, 2004

Date of Trip:

January 28 – February 2, 2004

Purpose of Trip:

- To quickly restart the Improved Community Health (ICH) Project activities in the field by reactivating accessible clinics and have them providing quality primary health care services.
- To locate Sam Biago, the Officer-in-Charge (OIC) of the Mid-Baptist Clinic in Tapitta, who resides in the area, to manage an emergency health post in Tapitta, to help cope with the dire health situation in the town. Investigate and find out if similar arrangements can be made in Toweh Town and Yourpea.
- To provide drugs to the KL Foundation Rapid Emergency Relief Clinic in Ganta in order to alleviate the high patient load at the only currently operating health facility in Ganta which is operated by EQUIP-Liberia
- To carry out further assessment with regards to security and the general health situation in the county

Team Composition:

Luke L. Bawo, Jr.	Health Information Specialist
Catherinc Gbozcc	Quality Control Specialist
Morris Konneh	Driver
George Sleweon	Driver

The mission succeeded in reactivating a total of eleven (11) of the project clinics in Nimba County. The exercise entailed the distribution of essential drugs and medical supplies to the facilities, putting in place professional clinic staff in clinics where they were not active, and the setting up of proper surveillance and reporting systems. The Mid-Baptist Clinic compound is being occupied by UNMIL troops and so a building was identified in the town that is hosting the emergency health clinic in Tapitta. A local Health and Sanitation NGO, K.L. Foundation, received assistance in drugs and medical supplies in order for them to provide curative health services in Ganta.

The Consolata Catholic Mission Clinic, Ganta PHC Unit and Yourpea Clinic were all burned down while the clinic in Gbloulay was completely looted. A recent eyewitness account revealed that the clinic in Bonlay is intact but the professional health staff have left the town.

General Observations/Findings**Security**

UNMIL has deployed and is gradually fanning out in Nimba County. Before the team's departure for Monrovia, the troops had arrived in Ganta. Apart from those checkpoints that existed prior to the recent hostility, all militia road blocks that were established on the roads have been dismantled. Unlike the Rapid Assessment Trip that was made two

weeks earlier, no one was seen in the county going around with arms. This also applies to the MODEL controlled areas. The unsubstantiated reason given by the local residents was that men seen with arms in the streets stood the risk of having them confiscated by their commanders which would cause them to lose their DDDR benefits.

Road Condition

The conditions of the roads remain poor with the over growth vegetation narrowing the feeder roads. The rapidly eroding dirt roads are an indication of what one can expect when the rains begin in a few months time. Commercial vehicles (most are looted Aid agency vehicles being driven by former fighters) plying the feeder roads are defective with very little maintenance. Bad road conditions and these vehicles can result into hair raising experiences. The mission witnessed one such vehicle overturned, spilling passengers and market goods into a valley after the brakes failed when the driver tried to avoid hitting the mission vehicle after we met in a deep bend. Fortunately there was no major casualty. Again on the main highway, thanks to the skills of our driver, we avoided a major collision but got a dent in the back bucket when another unlicensed driver drove recklessly across the road.

General Health Situation

All the clinics reported an increase in the number of consultations now as compared to one year ago. Malaria, diarrhea, ARI and skin infections are the most common causes for clinic visitation. Malnutrition is also on the increase. The acting County Health Officer (CHO) attributes this to inadequate diet and diseased conditions especially malaria and worms. MSF-Holland is running a therapeutic feeding center (TFC) in Sanniquelle in addition to the one operated by MSF-CH in Saclepea. The acting CHO says that they receive on an average 5 malnourish cases per day in Sanniquelle.

EPI services in the county are still virtually nonexistent. The county EPI supervisor reported having a few vaccines at the depot belonging to EQUIP but the depot was out of kerosene. The shortage of kerosene is being experienced at all the clinics, subsequently there is no routine EPI activity, static or outreach, in the county. Sporadic cases of measles are still being diagnosed in the Gbelay-Geh and Tapitta Districts. A case of whooping cough was reported from the Younlay Clinic.

Reproductive health services are minimal; the Toweh Town clinic reported a rise in the number of maternal deaths in the communities. In Kanwee, the team was compelled to modify their itinerary in order to transfer a pregnant woman with suspected cephalopelvic disproportion (CPD) to Ganta for commercial transport to the Phebe Hospital unit in Salala.

Tapitta

Security wise, the situation in Tapitta has improved dramatically as compared to the team's last visit two weeks ago. MODEL fighters are still roaming the streets but are no longer carrying arms. Unlike the last visit when there were only a few civilians in streets, the Ethiopian UNMIL troops in the town claim that the returnee registration at the time was 19,000 individuals. People are beginning to leave the bushes, come into town and

- MoH clinic situated in the Gbelay-Geh District
- Claim to have been instructed by the County Health Office, as with the other MoH clinic, to collect fee for service (FFS)
- Spoke of increased patient load (average 20/day)
- Has a refrigerator, cold box and vaccine carriers but no vaccines, kerosene and refrigerator spare parts to do immunization

Goagortuo Clinic

- MoH clinic situated in the Gbelay-Geh District
- Spoke of increased patient load (average 28/day)
- Has a refrigerator but no vaccines, kerosene and refrigerator spare parts to do immunization
- Recently referred 5 malnourished cases to the TFC in Sanniquelle

Younlay Clinic

- MoH clinic situated in the Gbelay-Geh District
- Has a refrigerator but no vaccines, kerosene and refrigerator spare parts to do immunization
- Hand pump is functioning but well usually dries up at the peak of the dry season
- A case of whooping cough reported.

Vayenglay Clinic

- MoH clinic situated in the Gbelay-Geh District
- Has a refrigerator and vaccine carrier but no vaccines, kerosene and refrigerator spare parts to do immunization
- Hand pump is functioning but needs to be chlorinated
- Two cases of measles reported from the catchment communities

Wehplay Clinic

- MoH clinic situated in the Zoe-Geh District
- Has a refrigerator but no vaccines, kerosene and refrigerator spare parts to do immunization
- Hand pump is functioning but needs to be chlorinated
- Lack materials for the oral rehydration therapy (ORT) corner

Gbeivenwea Clinic

- MoH clinic situated in the Gbelay-Geh District
- Has a refrigerator but no vaccines, kerosene and refrigerator spare parts to do immunization

Bautuo Clinic in Nyor-Bautuo

- Clinic is temporarily relocated in Nyor-Bautuo from Bautuo
- MoH clinic situated in the Zoe-Geh District
- Refrigerator is functioning and was carried to Nyor-Bautuo but the remaining clinic materials in Bautuo were looted
- Cases of malnutrition can be seen in the communities

Mid-Baptist Clinic

- Situated in Tapitta, Tapitta District and owned by the Mid-Baptist Church Mission
- Mission compound is being used by the UNMIL troops so emergency health post is located in a residential building in the center of town.
- Former clinic on the mission compound is intact but completely looted

Toweh Town Clinic

- MoH clinic situated in the Tapitta District
- Building is intact but refrigerator and other materials were looted
- Officer-in-Charge was transported back to Toweh Town from Saclepea
- Maternal deaths were reported from the communities

Trip Itinerary

Date	Activity
Jan. 28	Depart Monrovia and travel to Sanniquelle
Over night in Sanniquelle	
Jan. 29	Reactivate clinic, distribute drugs and set up surveillance system in Zorgowee, Goagortuo, St. Mary's Catholic and Younlay Clinics
Over night in Sanniquelle	
Jan. 30	Reactivate clinic, distribute drugs and set up surveillance system in Gbeivonwea, YMCA-Yekepa, Vayenglay and Weiplay Clinics
Over night in Sanniquelle	
Jan. 31	Reactivate clinic, distribute drugs and set up surveillance system in Consolata Catholic and Mid-Baptist Clinics in Tapitta
Over night in Saclepea	
Feb. 1	Reactivate clinic, distribute drugs and set up surveillance system in Toweh Town; Assess the preparedness of KL Foundation to receive drugs and provide care in the Ganta area.
Over night in Saclepea	
Feb. 2	Depart Nimba and Travel to Monrovia

M

New Clinics Assessment Report

Africare-Liberia

**In Collaboration with the
Bong County Health Team**

February 23-26, 2004

**New clinics Assessment Report
Bong County
February 29, 2004**

Introduction

On February 23, 2004, a team from Africare joined the Community Health Department (CHD) team in Salala to finalize schedule for the assessment of 8 clinics in Bong County. This assessment aimed at replacing clinics Africare lost to other agency as the result of the out break of fighting which covered the entire nation.

During the meeting status of EPI services in Salala and Tokpaipolu and the other clinics were also discussed. Fridges in the two clinics are presently non functional even though some repair work were done by Africare in collaboration with the Ministry of Health.

Prior to the war, Africare partnered with the Community Health Department (CHD) of Phebe Hospital to implement the Community Health Initiative (CHI) program within the catchment communities of 14 clinics. In an effort to continue the community health care program, a five years USAID funded project proposal was written and approved called " The Improved Community Health (ICH) Project" thus replacing the Community Health Initiative (CHI). Unfortunately, the out break of fighting resulted into the abrupt halt of the ICH activities in the targeted clinics and communities.

Immediately after the cessation of the hostility, five clinics in Bong County were taken over by other International NGOs. Therefore the CHD department identified clinics which Africare was asked to assess for possible inclusion into the ICH Program.

Using the assessment tools develop^{ed} by Africare (see attachment 1), the team in collaboration with the CHD represented by the EPI Supervisor was able to carry out the assessment successfully. Information written in this report was gathered through meetings with the community leaders. Infact all of the clinics assessed are presently non functional due to the fighting which damaged the infrastructures.

While en route to Gbarlatuah, the team made a brief stop at the Balafenia Clinic. This clinic was previously sponsored by Africare but it has been renovated and is presently operated by an International NGO called Medicens Du Monde (MDM).

Mr. Johnson Gokeneh, a citizen from Shainkpailai informed the team that the Shiankpailai clinic is burnt down while the Gbanshusolama Clinics is broken down. He also confirmed that the bridge to Siankpailai is broken.

Clinics assessed

Zeansu Community Clinic

- This clinic is located on the main Monrovia- Gbarnga high way about 43 Km from the Salala Phebe Hospital.
- Operated by CHD before the war.
- It contains 5 rooms.
- The building is de- roofed with doors, windows and ceiling damaged.
- It is surrounded by 15 large catchment communities and many other smaller villages
- The estimated distance to the farthest catchment community is about 3-4hrs. away whereas the nearest catchment community is about an hour away.
- There are 3 hand pumps in the town, two functional and one non functional but has not been treated since the out break of fighting.
- The clinic has a latrine containing two rooms' compartments but doors are damage.
- Community Leaders interviewed are: Alfonso G. King – Youth leader, J. Cyrus Kiazolu- Acting Clan Chief, and Lepolu Torlor -Youth Member

Gbartala Community Clinics

- This clinic is located on the main Monrovia- Gbarnga high way about 54 Km from the Salala Phebe Hospital.
- It was built to be used as a rice mill but later used by the Liberian Red Cross as a clinic.
- Regarding staffing, the CHD representative on the trip informed us that a certified midwife who lives in the community is willing to be assigned in this clinic.
- It contains 5 rooms that is partition with mats.
- The roof, doors, windows and ceiling are intact but need to be replaced.
- It is surrounded by 13 large catchment communities and many other smaller villages.
- The estimated distance to the farthest catchment community is about 3 1/2- 4hrs.
- The nearest catchment community is about one hour away.
- There are 2 nonfunctional hand pumps in the community.
- The clinic lacks latrine
- Community Leaders interviewed Mr. David Moye, Commissioner

Gbanda Community

- Is located 25 Km away from the main high way.
- There has been no clinic in this community prior to the crisis but the distance, the location and stories told by the community members about patients dying from common diseases and maternal complications prompted the Community Health Department of the Phebe Hospital to select the community to be assessed for the establishment for a clinic.
- The 6 rooms building identified by the community is owned by a community member who has agreed to allow the use of her building for two years.
- Half of the building roof is damage by the storm. The doors, windows and ceiling are also damaged and the entire building needs to be renovated.
- It is surrounded by 20 large catchment communities and many other smaller villages
- The estimated distance to the farthest catchment community is about 5 hrs.
- The community has one functional hand pump built by Phebe Hospital.
- Community Leader interviewed was Mr. Patrick Mulbah, the town chief

Yeandawoun Community

- This is located 21 Km away from the main high way.
- According to the community leaders interviewed, a clinic existed in this community in 1972 but was closed down when the OIC assigned departed the community in the late 70's. Since his departure, there has been no staff to work in the community. Presently the original clinic building does not exist but a community building containing 3 rooms was identified. Also like that of Gbanda, the distance, the location and stories told by the community members about patients dying from common diseases and maternal complications prompted the Community Health Department of the Phebe Hospital to select this community to be assessed.
- It is surrounded by 25 large catchment communities and many other smaller villages
- The estimated distance to the farthest catchment community is about 5 hrs.
- Lacks safe drinking water.
- Community Leaders interviewed were: the Clan Chief Mr. Moses Lasanah and the Acting Commissioner Mr. David G. Moye.

Gbarlatuah Community Clinic

- This clinic is situated 40Km away from Gbarnga and on the border between Bong and Lofa Counties.
- It was used as clinic before the war.
- The building contains 7 rooms and is de-roofed with doors, windows and ceiling damaged.
- Built in 1992 by World Vision International (WVI).
- It is surrounded by 19 large catchment communities and many other smaller villages.
- The estimated distance to the farthest catchment community is about 4hrs. on foot whereas the nearest catchment community is about 30mins.
- There are 7 hand pumps in the community, 3 functional and four non functional.
- Community Leader interviewed was the Acting Commissioner, Mr. Nukeimu Doran.

Jorpenmuc Community Clinic

- The clinic is located in Gbarnga about one Km away from Gbarnga main street, Bong County.
- It is one of the two clinics built by the United States Department of Defense Force before the last chain wars in Bong County.
- Contains 11 rooms but de-roofed with doors, windows and ceiling damage even though the window bars are intact.
- No one was found to be interviewed.

Yila Mid -Baptist Mission Clinic

- Is located off the main high way 29 Km away from the Palala Clinic.
- The clinic was constructed and operated by Baptist Missionaries prior to the war. According to the Pastor in Charge, the missionaries are expected to come for assessment in March 2004.
- The clinic contains 7 rooms.
- It is surrounded by 18 large catchment communities and many other smaller villages

- The estimated distance to the farthest catchment community is about 3hrs.
- The team interviewed Rev. Emmanuel Kollie, the pastor in Charge.
- The nearest clinic is 4hrs. away

Yowee Community

- Is located off the main highway 31Km away from the Palala Clinic.
- The community identified a building to be used as a clinic and it contains 4 rooms.
- Community is surrounded by 7 large catchment communities and many other smaller villages
- The estimated distance to the farthest catchment community is about 6hrs.
- The team interviewed Mr. Isaac Mawehn-General Town chief, Mr. Johnson Sherporlor Chief Elder, and Lorpu Maamah, Chairlady for entertainment.

Youth Mission Clinic

- This clinic was not assessed by the team but was later recommended by the CHD to be accepted for revitalization by Africare.

Visit to the Tokpaipolu Clinic

During the team's visit to Tokpaipolu one of Africare reactivated clinics, it was observed that one of the bridges to the community is almost broken, and without repair it will be difficult to carry out ICH activities in the clinic and its catchment communities. Drugs and medical supplies were provided to the clinic to be dispensed free of charge. The team also observed that Fee for service and Fee for treatment were being collected at the clinic from the first drugs donated, the CHD was informed about this situation. Africare/ AmeriCare free drug system was stressed to be implemented.

General observations/Information

- The team observed that all the structures assessed need major renovation works.
- Roads leading to most of the areas assessed are very bad with bridges almost broken.
- Security in the area is relatively fair despite the presence of UNMIL on the main road in Bong County. As the team move away from where UNMIL is deployed, it was observed that civilians are harassed by armed men.
- The estimated population is not stated in this document because civilians are gradually returning to the communities and there was no record to indicate the number of persons that have returned.
- Regarding the general health condition of the population, there were reports of many cases of diarrhea and malnutrition in the communities assessed but no case was seen during the visit. According to the community members interviewed, patients are mainly treated by quacks who charge exorbitantly. In Gbanda, one of such quacks was observed selling drugs and treating patients in the center of the town.

Recommendations

- Africare seeks approval from USAID to work in these clinics in place of the ones lost to other agencies.
- That the above mentioned clinics be accepted for renovation and revitalization by Africare.
- That Africare apply to UNMIL Quick Impact Program for assistance to renovate the clinics assessed.
- That Africare collaborate with the Mid Baptist Mission head office in Monrovia for the revitalization and operation of the Yila Mid Baptist Mission Clinic for sustainability.
- That the fridges in Salala and Tokpaipolu be replaced.
- That UNMIL patrol accessible communities frequently to provide security.

The composition of the team included:

1. Mr. Stephen S. B. Cooper-EPI Supervisor/ CHD
2. Mrs. Catherine Gbozee- QCS/Africare
3. Mr. George Sleweon- Driver/Africare

**Assessment of new clinics and Communities in Bong County for ICH project
Checklist**

Name of Clinic: _____, Location: _____

Strategy for the clinic and community assessment in Bong County

- ❖ Meet with Staff of the Community Health department of the County Health Team.
 1. Discuss the final schedule for the trip and areas to be assessed.
 2. Hold meetings with community leaders to gather information regard the proposed clinic using the below listed questionnaires.
- ❖ Assess the available clinic structure.
 1. What is the status of the clinic building?
 2. How many rooms does the clinic contain: _____
 3. Is the building owned by community?

The general health condition of the population

- ❖ Are there cases of malnutrition?
- ❖ Are there out breaks?

WATSAN

- ❖ Number Functional and nonfunctional Hand pumps in the communities.
- ❖ Does the clinic has a hand pump and latrine
- ❖ Describe the status of those facilities

Questions on the distance, community and population

- ❖ How many communities do this clinic served?
- ❖ What is the distance to the farthest community?
- ❖ What is distance to the nearest community?
- ❖ What is the estimated population?
- ❖ What is the distance to the nearest by clinic?
- ❖ What is the distance the nearest referral point?

The general condition of the road

- ❖ Describe the conditions of the bridges?
- ❖ Describe the conditions of the roads leading to the clinic community?

Security Situation in the area

- ❖ Are there UNMIL Troops in the area?
- ❖ Is the area safe for operating a clinic?
- ❖ What are some of the stories on security from the local people?

Attachment 1

**Update on Status of ICH Clinics in Nimba County
March 29, 2004**

I. Reactivated Clinics

1. Sanniquellie St. Mary's
2. Yekepa YMCA
3. Zorgowee
4. Gorguatuo
5. Younlay
6. Vanyenglay
7. Weiplay
8. Gbeivonwea
9. Toweh Town
10. Tapitta Mid Baptist
11. Buutuo

II. Clinics pending Reactivation

1. Gbloulay
2. Bonlay
3. Consolata Catholic (Tapitta)

III. Clinics Taken Over by Other NGOs

1. Beoyolar.....MSF-H
2. Garplay ULIC¹.....EQUIP
3. Flumpa ULIC.....EQUIP
4. Saclepea ULIC.....EQUIP

IV. Clinics Destroyed

1. Yourpea
2. Ganta Hospital PHC

¹ United Liberia Inland Church

**Update on Status of ICH Clinics in Nimba County
March 29, 2004**

Africare Assigned Clinics	Reactivated	Pending Reactivation	Taken Over by other NGOs	Destroyed	Partly Damaged	Newly Assessed	Comments
1. Sanniquellie St. Mary's	X						
2. Yekepa YMCA	X						
3. Zorgowee	X						
4. Gorguatuo	X						
5. Younlay	X						
6. Vanyenglay	X						
7. Weiplay	X						
8. Gbeivonwea	X						
9. Toweh Town	X						
10. Tapitta Mid Baptist	X						
11. Buutuo	X						
12. Bonlay		X					
13. Gbloulay		X					
14. Consolata Catholic (Tapitta)		X		X			
15. Beoyolar			MSF-H				
¹⁶ . Garplay ULIC ¹			EQUIP				
17. Flumpa ULIC			EQUIP				
18. Saclepea ULIC			EQUIP				
19. Yourpea				X			
20. Ganta Hospital PHC				X			

**Update on Status of ICH Clinics in Bong County
March 29, 2004**

I. Reactivated Clinics

1. Salala
2. Tokpaipolu

II. Clinics Pending Reactivation

1. Fenutoli
2. Bahta

III. Clinics Taken Over by Other NGOs

1. Palala..... MDM²
2. Zoweinta..... MDM
3. Belefanai..... MDM
4. Samay..... MDM
5. Gbecohn..... MDM

IV. Clinics Destroyed

1. Gbanshuloma
2. Shankpailai

V. Newly Assessed Clinics

1. Zeanzu
2. Gbartala
3. Yeanawon
4. Gbanda
5. Gbalatuah
6. Jokpenmue
7. Yila Mid Baptist
8. Yowee
9. Youth Mission

² Mediciens du Monde

Update on Status of ICH Clinics in Bong County
March 29, 2004

Africare Assigned Clinics	Reactivated	Pending Reactivation	Taken Over by other NGOs	Destroyed	Partly Damaged	Newly Assessed	Comments
Salala	X						
Tokpaipolu	X						
Fenutoli		X					
Bahta		X					
Palala			MDM ²				
Zoweinta			MDM				
Belefanai			MDM				
Samay			MDM				
Gbecohn			MDM				
Gbanshuloma				X			
Shankpailai				X			
Zeanzu						X	
Gbartala						X	
Yeanawon						X	
Gbanda						X	
Gbalatuah						X	
Jokpenmue						X	
Yila Mid Baptist						X	
Yowee						X	
Youth Mission						X	

Health Facilities Reactivated and Functional

List Updated 8/18/04 based on last field visit concluded on August 13, 2004

Nimba County: 16 out of 20 projected

1. Sanniquellie St. Mary's Catholic
2. Zorgowee
3. Weiplay
4. Toweh Town
5. Gbloulay
6. Younlay
7. Vayenglay
8. Buutuo
9. Bonlay
10. Goagortuo
11. Gbeivonwea
12. Tappita Mid-Baptist
13. Yekepa YMCA
14. Tappita Consolata Catholic
15. K.L. Foundation
16. Karnwee

Bong County: 8 out of 14 projected

1. Salala
2. Tokpapolu
3. Fenutoli
4. Gbonota
5. Janyea
6. Zebay
7. Gbanla
8. Yila Baptist Mission

Memoranda of understanding will shortly be concluded for the following major health centers and their satellites:

1. Ganta Hospital PHC
2. Phebe Hospital OPD
3. MERCI (6 clinics)
4. Family Planning Association of Liberia (1 ante-natal clinic)

**PARTNERS
ORIENTATION WORKSHOP
SCHEDULES**

AFRICARE – LIBERIA
Three Days Planning and Working Session with Project Partners
April 7 – 9, 2003
Workshop Schedule

DAY ONE MONDAY APRIL 7, 2003

Date	Time	Activity/Topic	Responsible Person
April 7	9:00- 9:30	Registration	Mary
	9:15-9:30	<ul style="list-style-type: none"> • Prayer • Official introduction of COP • Self Introduction • Ice breaker (warm-up exercise) 	Africare
	9:30-9:45	<ul style="list-style-type: none"> • Overview of workshop 	Africare
	9:45-10:15	Coffee break	Adm.
	10:15 – 11	<ul style="list-style-type: none"> • General review and discussion of proposal 	Africare Team
	11:00- 12:00	<ul style="list-style-type: none"> • Review of 2002 SWOT Analysis (Institutional group work) 	Luke
	12:00 -12:45	<ul style="list-style-type: none"> • SWOT analysis group work presentation 	BAG, FPAL, COHDA
	12:45 – 1:45	LUNCH	Adm.
	1:45 – 4:00	<ul style="list-style-type: none"> • Summary of SWOT / key issues 	Luke & all
	4:15 – 4:30	<ul style="list-style-type: none"> • Review of 2002 DIP 	FPAL
	4:30 – 5:00	<ul style="list-style-type: none"> • Wrap up of the day's activities • Evaluation 	Mary
		<ul style="list-style-type: none"> • Closing 	

DAY TWO: TUESDAY APRIL 8, 2003

Date	Time	Activity/Topic	Responsible Person
April 8	9:00- 9:20	Registration	Mary
	9:20- 9:45	<ul style="list-style-type: none"> • Prayer • Recap of day one activities 	FPAL
	9:45-10:15	Coffee break	Adm.
	10:15 – 1:30	<ul style="list-style-type: none"> • Institutional presentation of 2003 DIP 	Implementing partners (BAG, FPAL, COHDA)
	1:30 - 2:30	LUNCH	Adm.
	2:30 – 4:30	<ul style="list-style-type: none"> • Discussion of DIP 	FPAL
	4:30 – 5:00	<ul style="list-style-type: none"> • Wrap up of the day's activities • Evaluation 	BAG & COHDA
		<ul style="list-style-type: none"> • Closing 	

DAY THREE , WEDNESDAY APRIL 9, 2003

Date	Time	Activity/Topic	Responsible Person
April 9	9:00- 9:15	Registration	Mary
	9:15-9:30	<ul style="list-style-type: none"> • Prayer • Recap of day two activities 	BAG
	9:30-10:30	<ul style="list-style-type: none"> • Finalization of Consolidated DIP 	Group
	10:30 - 11:00	Coffee break	Adm.
	11:00 – 1pm	<ul style="list-style-type: none"> • General review and discussion of proposal 	Africare Team
	1pm – 2:00	LUNCH	Adm.
	2:00 – 2:45	<ul style="list-style-type: none"> • Review of Consolidated SWOT draft 	Luke & all
	2:45 –4pm	<ul style="list-style-type: none"> • Review and discussion of draft MOU 	FPAL
	4:pm – 4:30	Question and answer (Open discussion)	A.I
	4:30-5mp	<ul style="list-style-type: none"> • Wrap up of the day's activities • Final Evaluation 	BAG & COHDA
5:15pm	<ul style="list-style-type: none"> • Closing 		

Africare/JHUCCP & Morehouse School of Medicine

Improved Community Health (ICH) Project

Orientation Meeting- Review of Project Funding Guidelines

February 26-28, 2004

Africare Conference Room, Mamba Point, Monrovia, Liberia

February 26, 2004

8:30 - 9:00	Registration	
9:00 - 9:15	Welcome Remarks	Esther King_Lincoln, Project Coordinator
9:15-9:45	ICH Project and Time Plan Overview	Claudette C. Bailey, Chief of Party- ICH
9:45-10:15	Overview of Workshop schedule	Nancy Moses, Supervisor, Supplementary Feeding Program
10:15-10:30	Ice breaker	Mabel Kear, Community Health Specialist
10:30-10:45	Administrative Issues	Chris W. Coker
	Formation of working groups	
10:45 - 11:00	Coffee break	Administration
11:00 - 12:30	Review of ICH Project Proposal	Group work
12:30 - 1:30	LUNCH	
1:30 - 3:30	Review of Project components	
	<ul style="list-style-type: none">• Malaria & HIV/AIDS: Todd Ritter• Childhood immunization -Catherine Gbozee & Mary Momolu• Nutrition, Micronutrients & Breastfeeding: Mabel M. Kear & Nancy Moses• Reproductive health: Claudette C. Bailey, Chief of Party• Control of Diarrheal Diseases: Esther King_Lincoln	
	Crosscutting issues:	
	<ul style="list-style-type: none">• Quality Assurance: Catherine Gbozee• Monitoring & Evaluation: Esther King_Lincoln• Behavioral Change Communication: Todd Ritter	
3:30 -3:45	Coffee break	
3:45-4:45	Questions/Answers/clarification	Facilitators

4:45-5:00 Wrap up of day 1 activities Catherine
5:00-5:15 Feedback of Day 1 Activities/Evaluation of day 1

February 27, 2004

8:15 - 8:30 Registration Receptionist
8:30 - 8:45 Ice Breaker Exercise Mabel M. Kear
8:45 - 9:00 Review of day one's activities Nancy Moses-Supervisor,
Supplementary Feeding Project
9:00- 9:45 Working groups' feedback on project proposal
9:45-10:15 Coffee Break
10:15 -10:45 questions and answers Facilitators
10:45-11:15 Overview of Project Funding Guidelines Mary Momolu
11:15 - 12:30 Review of ICH funding proposal guidelines Group activity
Group Activity
12:30- 1:15 LUNCH
1:15 - 2:15 Continuation of Review of ICH Funding proposal guidelines (more
time if necessary)
2:15 - 3:00 presentation of feedback from group
3:00 - 3:45 Questions/answers and clarifications Africare
3:45-4:15 Africare Headquarters' approval process Jackie Fisher_
Johnson
4:15 - 4:30 Questions/answer/clarifications Facilitators
4:30-5:00 Wrap up and Evaluation of day two Africare

February 28, 2004

9:00 - 9:15	Registration	
9:15 - 9:30	Ice Breaker Exercise	Participants
9:30 - 9:45	Review of day two activities	Mary Momolu
9:45 - 10:45	questions and answers	Facilitators
10:45 - 11:00	Coffee Break	
11:00 - 12:45	Introduction to Performance Monitoring Plan (PMP) Dr. Lincoln & Luke Bawo	
12:45-1:45	Lunch	
1:45- 2:30	ICH Technical Components & Indicators	
2:30-3:30	Review of ICH Results Frameworks	Dr. Adams K. Lincoln & Luke Bawo
3:30-4:15	Questions & answers period	Facilitators
4:15-4:35	Group Activity	
4:35-4:50	Group presentation	
4:50 - 5:00	Final Evaluation & closing	Africare

Liberia Improved Community Health Project
Orientation Meeting for Review of Funding Guidelines for
Prospective Local Implementing Partners
February 26 – 28, 2004

Name of Organization	Type of Activity	Project Community
Medical Emergency Relief Cooperative International (MERC I)	Health care delivery	Montserrado County
Human Development Foundation (HDF)	Agriculture, WATSAN	Montserrado & Margibi Counties
National Adult Education Association of Liberia (NAEAL)	Adult literacy, training and capacity building	Montserrado, Margibi, & Grand Bassa Counties
United Methodist Church/Ganta Hospital	Health care delivery	Montserrado, Bong, & Nimba Counties
Liberia Prevention of Maternal Mortality (LPMM)	Establishing and strengthening reproductive health services	Montserrado County
Agricultural Relief Services (ARS)	Agriculture, rural development	Nimba County
Phebe Hospital	Supervise health facilities	Bong County
Breastfeeding Advocacy Group (BAG)	Promotion of infant breastfeeding	Nationwide
Family Planning Association of Liberia (FPAL)	Sexual and reproductive health services	Montserrado, Grand Bassa, & Margibi Counties
Catholic Health Secretariat (CHS)	Health care delivery	Montserrado, Bomi, Grand Bassa, And Cape Mount Counties
Mother Patern College of Health Sciences (MPCHS)	Health education, counseling	Montserrado, Grand Bassa, & Margibi Counties
KL Foundation	Health, women empowerment, education, agriculture	Nimba County

SUMMARY OF BASELINE SURVEYS

**Improved Community Health (ICH) project
Knowledge, Practice and Coverage (KPC) and EPI Coverage Surveys
In Urban Communities in Montserrat and Rural Communities in Bong and
Nimba Counties**

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INTRODUCTION

A. Project Description

The Improved Community Health (ICH) Project is a reproductive and community health care initiative that will assist Liberia civil society organizations to support improved primary health care delivery.

The 5-year, \$7.5 million (plus \$2.5 million matching grants) USAID-funded project was awarded in January 2003 to a consortium composed of Africare (as the prime), John Hopkins University Center for Communications Programs (JHU/CCP) and the Morehouse School of Medicine. The project will work local implementing partners in Montserrado, Bong and Nimba Counties of Liberia, with over 41 clinics and 450 communities to increase the capacity of civil society to address urgent public health priorities, primarily benefiting women of reproductive age (WRA) and children under the age of five.

The Strategic Objective (SO) of the project is increased use of essential primary health care services through the participation of civil society. The Intermediate Results (IR) are:

- Strengthened capacity of civil society to achieve sustainable primary health care service delivery, including access, quality and demand of services.
- Improved policy framework for primary health care service delivery in Liberia.
- Increased availability of resources, including non-USAID resources, for health sector development in Liberia.

The ICH Project has identified six(6) priority health technical areas and strategic approaches that it will address:

- Malaria
- Childhood Immunization Services
- Reproductive Health
- HIV/AIDS
- Nutrition, Micronutrients, and Breastfeeding
- Control of Diarrheal Diseases

The cross-cutting components are Quality Assurance, Monitoring & Evaluation and Behavior Change Communication (BCC).

B. Survey Objectives

The sampling methodology often used in developing countries for knowledge, practices and coverage (KPC) surveys is the 30-cluster rapid survey. The study population consists of mothers of children under the age of 24 months living in the project catchment areas. The target population for the Baseline II survey which followed similar methodology was male and females between the ages 15-49 years. An EPI coverage survey to determine vaccination coverage of children and women of reproductive age was also conducted during the time.

The data collected through these baseline studies will help Africare and the consortium to identify areas of greatest need related to the project objectives, and will help modify

project priorities, interventions and goals. The baseline will also assist the project in setting targets related to the project indicators as reflected in the Performance Monitoring Plan (PMP).

SURVEY METHODOLOGY

A. The questionnaire

The Knowledge, Practice and Coverage (KPC) questionnaire consisted of 84 questions and was designed to collect information from mothers of children under the age of 24 months of age. Many of the questions are taken from the standardized generic questionnaire format originally developed by the PVO Child Survival Support Project (CSSP) and modified and expanded by the Child Survival Technical Support (CSTS). Using the ICH list of indicators as a guide, the project team added a number of questions that will address those indicators.

A separate study, the Baseline II Survey, targeting males and females between the ages of 15-49 years was conducted simultaneously with the EPI Coverage Survey. Questions deemed relevant by project staff in providing useful information to address other pertinent issues including Emergency Obstetric Care (EmOC), HIV/AIDS, Contraception and Listenership were included in this section which comprised 49 questions. Questions were structured to better reflect the local phrasing and vocabulary.

B. Determination of Sample size

Sample sizes were calculated with the following formula:

$$n = Z^2(pq)/d^2$$

Where n = sample size; Z = statistical certainty chosen (95%) = 1.96; p = estimated prevalence/coverage rate/level to be investigated (0.5); q = 1-p; d = precision, or margin of error, desired = 0.1.

Given the above values, the following sample size (n) needed is:

$$\begin{aligned} n &= (1.96)^2 \times 0.5^2 / 0.1^2 \\ n &= (3.84)(0.25) / (0.01) \\ n &= 96 \end{aligned}$$

It would be time consuming to randomly select an identified individual from the survey population and then perform this selection 96 times to identify a sample of n = 96. A random selection of this nature would also require a sampling frame including every mother of a child under two years in the project area but a census list of this type does not exist in the project area. This survey follows the 30-cluster sample survey and in order to compensate for the bias which enters the survey from interviewing persons in clusters, rather than as randomly selected individuals, experience has shown that the sample size used should be approximately double the number of that required for a simple random sample. Thus a minimum sample of 210 (7 per cluster) should be used.

In the case of cluster sampling for a KPC survey, a sample size of 300 (10 per cluster) is generally used so as to ensure that sub-samples are large enough to obtain useful management type information. Therefore, the final number of interviews conducted was: 300 – Urban (Montserrado) and 300 – Rural (Bong and Nimba Counties).

C. Selection of the Sample

Clusters or towns for the survey were selected from the list of catchment towns accessing the health facilities supported by or proposed to be supported by the ICH Project. Clusters are selected following the process described in the EPI Coverage Survey Training Manual (WHO, Geneva, 1991 Revised edition) as summarized below:

Procedure for the Identification of Clusters/Towns/Villages

1. Make a list of all Towns/Villages in the Project's Area of Operation.
2. List along side the individual population of each town/village.
3. Calculate and write in the cumulative populations as each town/village is added. The final cumulative population is the same as the total population to be surveyed.
4. Determine the Sampling Interval, using the formula:

Sampling Interval = Total population to be surveyed/30
Round off to the nearest whole number

5. Select a random number which is less than or equal to the sampling interval. The random number must have the same number of digits as the sampling interval.
6. The 1st town/village is the one whose cumulative population equals or exceeds the random number.
7. The 2nd town/village is that whose cumulative population equals or exceeds the figure arrived at by the formula:
Random Number + Sampling Interval =
8. In identifying towns/Villages 3-30, use the following formula:

Number which identified **Sampling**
Location of the previous + **Interval** =
Town/Village

When the survey teams reached their designated cluster site each day, they selected their starting households and subsequent households as follow

1. They would start at a central point (approximate geographic center) in the cluster.

2. They spun a pencil/pen to point out or select a random direction.
3. They then walk to the periphery of the cluster in the direction pointed out by the pencil, counting the number of households along the way.
4. They will obtain a random number between 1 and the number of households in that line.
5. The first household to sample the household on that line which corresponds to that random number.
6. The next household is the nearest household to the right whose front door is closest to the front door of the one they just visited.
7. They will continue consistently in this way until the required number of households is sampled.

D. Training of Supervisors and Interviewers

Core team members and supervisors were selected for the ICH Project staff and partner INGOs and Local NGOs. A one day training of supervisors which focused on their supervisory roles was held initially. Subsequent training of supervisors and interviewers took place over a three days period. During the training the supervisors and interviewers reviewed the questionnaires and practice using them, learned how to select households other basic survey methodology. Most of the supervisors already had previous survey and supervisory experience. Many interviewers also had previous survey experience and were selected on the basis of ability and character.

E. Conducting Interviews

The surveys were done over a five days period. The core team member and supervisor were responsible for the selection of starting household. The core team member was responsible for the survey team management and the initial review of the completed questionnaire. Each questionnaire was to be checked for completeness before the team leaves the field. The survey coordinator did a counter check of questionnaires at the end of the work day.

F. Method for Data Analysis

The data for the KPC survey was entered into and analyzed using EPI-INFO 2002. The Baseline II survey and analyzed manually as was also the case of the EPI Coverage survey which was done using the standard EPI Coverage Survey Tabulation form.

ICH PROJECT INDICATORS AND BASELINE DATA

Strategic Objective (SO): Increased use of essential primary health care services through civil society.

Indicators:

a) Couple-year of Protection (CYP)

Urban	Rural	Average
0	0	0

b) DPT₃ Coverage

Urban	Rural	Average
41.9	13.2	27.6

c) TT₂+ Coverage

Urban	Rural	Average
31.5	7.1	19.3

d) Use of Insecticide Treated Nets

Urban	Rural	Average
52.9	32.8	42.9

e) ORT Utilization Rate

Urban	Rural	Average
28.3	17.4	22.9

I.R. 1.1: Strengthened capacity of civil society to achieve sustainable primary health care service delivery, including access, quality and demand of services.

Indicators:

a) Percentage of sub-recipient organizations demonstrating improved technical and managerial skills as measured by the organizational capacity index (OCI)

Organization	Percentage

b) Number of REFLECT Circle members participating in civic organizations in targeted communities

Urban	Rural	Average
0	0	0

Sub-IR 1.1.1: Improved access to PHC services.

Indicators:

a) DPT₁

Urban	Rural	Average
53.5	33.6	43.6

b) Prevention of malaria amongst pregnant women (Use of IPT)

Urban	Rural	Average
1.3	1.3	1.3

c) Increase in total volume of selected food crops produced by targeted farmers.

Crop	Percentage increase
XX	0

Sub-IR 1.1.2: Increased quality of PHC services.

Indicators:

a) Measles coverage

Urban	Rural	Average
47.0	22.3	34.7

b) Exclusive breastfeeding.

Urban	Rural	Average
38.2	61.5	49.9

c) Percentage of farmers replicating "best" agricultural practices on their individual farm(s), one year or more after the introduction of the "best" practices.

Town/Village	Percentage of Farmers
XX	0

Sub-IR 1.1.3: Increased demand for PHC services.

Indicators:

a) Under-five consultations

Urban	Rural	Average
0	0	0

b) Knowledge of STI/HIV/AIDS. (Percentage of men / women surveyed who can identify two or more correct methods of reducing risk of STI/HIV infection)

Urban	Rural	Average
73.7	46.7	60.2

I.R. 1.2: Improved policy framework for primary health care service delivery in Liberia.

Indicator:

a) Number of changes in policy framework due to project-led technical interventions.

Number of Policies under review	Number of Changes Effectuated
XX	XX

I.R. 1.3: Increased availability of resources, including non-USAID resources, for health sector development in Liberia.

Indicators:

**a) Amount of ICH Project's "match" funding obligation secured on an annual basis
XXX**

**b) Amount of funds attracted vis-à-vis sources identified in the ICH proposal for PHC service interventions
XXX**

Appendix B

BCC ACTIVITIES

B-1

**HEALTH WORKING GROUP
FOR
RADIO PROGRAMS**

**HEALTH WORKING GROUP FOR RADIO PROGRAM DEVELOPMENT
MESSAGE DESIGN MEETING REPORT**

I. Workshop Agenda

Saturday 27 September, 10:00AM, @ Mercy Corps

->Accomplish by the end of the day:

- Radio communication strategy that includes:
 - Communication objectives
 - Identification of key unifying benefit
 - Consensus on set of key messages
- Set of ideas for methods of integrating messages into radio programming and integrating radio programming into community based education sessions
- Umbrella theme for health radio programming

->Health focus - in the spirit of prevention of cholera and other diarrheal diseases

- Clean water
- Sanitation - excrement/trash
- Proper treatment and care seeking
- Hygiene - water and food handling

->Overview of problem/situation assessment

- Brief presentation and discussion about clinic aspects
- Recent information (numbers/anecdotal) about problem
- *CAUSES - how disease is spread
- *IDEAL actions
- *BARRIERS to correct behavior

->Audience

- Who's behavior must change?
- Segment audience - identify those most relevant / likely to respond to messages
- Characteristics/profile of those audience segments [those who listen to radio and in target community groups]

->Communication objectives

- What exactly do we want the target audience to DO in response to radio programs?
- For each audience segment define exactly what is the desired change in knowledge, attitudes/beliefs, behaviors/practices, and supportive environment -
WRITE 2 FOR EACH CATEGORY
- SMART objectives

- Ex. Increase correct knowledge about major symptom of cholera
- Ex. Increase number of mothers who wash hands before cooking

->Key benefit

- Unifying appeal - how can positive practices meet an unmet need for intended audience
- **Decide on one or two

->Behavior change theory

- List assumptions of KAP among audience underlying our strategy - based on formative research / personal experiences
- Which is the step to behavior change that is we want to emphasize?

Knowledge
Approval
Intention
Practice
Advocacy

->Key Messages

- List of 3-5 key messages for target audience addressing knowledge, attitude/beliefs, behaviors, supportive environment
- Include local idioms
- Emotional power

->Brainstorming Ideas for Radio

- How to present these messages in radio program format / spots

->Umbrella Theme for Health Radio Programming

- List of ideas for unifying theme - positive, relevant, motivating

II. Meeting Outcome Report

Outcome from 27 September, 2003 Health Working Group for Radio Meeting

Ideal Actions

- Accurate knowledge between cholera and diarrhea
- Knowledge of causes of cholera and diarrhea - link between disease and hygiene
- Hand washing at key times
- Use of treated water
- Water from safe source
- Proper water handling and storing
- Proper disposal of garbage and pupu
- Proper disposal of children's pupu
- Appropriate (early) care-seeking
- Proper food handling, storage, cooking (heat thoroughly), washing vegetables
- Latrine use and maintenance
- Handwashing facilities near latrines / proper locations
- Positioning latrines via wells
- Proper well placement and maintenance
- Keep breastfeeding during childhood sickness

Key Benefits

- Save money
- Save time
- Save resources
- Healthy happy family
- Less sickness and death

Unifying Theme

Health Habits, Better Life, New Liberia

Audience

- Primary audience: Caregivers of children under 5
- Secondary audiences: Community development committees; students (5-18)

Barriers

- a) Knowledge
 - Lack of or inaccurate knowledge
 -

b) Attitudes/Beliefs

- Belief that water that does not flow harbours germs - so not used for drinking
- Don not like chlorine taste - traditional belief that water for drinking should be tasteless and without odor
- Belief that children's feces is less or not harmful

c) Behavior/Practice

- Difficult to do ideal behaviors - hard work
- People don't like to be told what to do
-

d) Environment

- Lack of resources: access to clean water, water/food storage containers, latrines
- Distance to latrines (for ex.)
- Human resources/infrastructure missing (environmental inspectors not active)
- Inappropriate garbage disposal
- Commercial food vendors
- Market management
- Control, supervision, support to water vendors

Objectives

a) Knowledge

- Increase target audience's awareness about the existence and difference between cholera and diarrhea diseases.
- Upgrade target audience knowledge about causes and transmission of cholera and diarrhea diseases.
- Increase target audience knowledge about linkages between cholera/diarrhea diseases and hygiene practices
- Increase number of people who can differentiate between clean and safe drinking water.
- Increase number of people who can properly explain the preparation of oral rehydration fluid (SSS or home made ORS)
- Increase number of people who can explain proper water handling food handling procedures
- Increase number of people who can explain the importance of early care seeking for cholera / diarrhea diseases

b) Attitudes/Beliefs

- Increased self-care attitudes to prevent and treat diarrhea and other water/food-borne diseases.
- Increased perception of safe drinking water
- Increased perception that chlorinated water is safe to drink
- Increased positive acceptance of smell and taste of chlorinated water
- Increased perception that all feces, including children's, are harmful and need to be properly handled
- Increased perception of the factors contaminating water (river/creek, well, handling/storage containers, etc.)

c) Practice/behavior

- Increased number of people who wash hands at proper times
- Increased number of people who use safe drinking water
- Increase number of people who dispose of own and children's pupu properly in latrines.
- Increase number of people who give ORS/SSS to children with diarrhea
- Increase number of people who seek early treatment at proper health facility and proper time

d) Environment

- Increase number of vendors with improved food handling practices
- Increase number of people encouraging use of chambers for under fives or proper disposal of plastic bags.

Messages

- Stop flying "dudu birds" around - use the toilet house
- You can get sickness from pupu - don't throw it around
- Get rid of pupu properly before it end up in food and drinking water
- Rice water pupu every now and then means cholera and it can kill - don't waste time. Rush to the nearest hospital or clinic.
- 3 or more times watery pupu is diarrhea - drink ORS and go quickly to the nearest clinic or hospital
- If you see blood in your pupu - waste no time - go quickly to the hospital
- Use hand pump water and clean blow, cup and spoon (dishes) to fix ORS
- Cholera and diarrhea are not from witch - go straight to the clinic
- Hand pump water is safe - don't drink from open well
- Do you know that dirty area also causes running stomach - keep your area clean

III. Radio Program Content Outlines

RADIO PROGRAM FRAMEWORK CHOLERA AND RUNNY STOMACH

Five (5) 30-minute program episodes - each with different focus:

- 1) Cholera and diarrhea - definition and care-seeking
- 2) Prevention - clean water, water and food storage, handling, cooking
- 3) Prevention - latrine use, proper pupu disposal, handwashing
- 4) Treatment - ORS proper use, general care-seeking motivation
- 5) Environmental change - community improvement, changing social norms

The components of each 30 minute episode will be as follows:

- 1) Spots - up to 5 minutes per episode
- 2) Mini-drama - developed with the expectation that it will continue throughout this health topic and into future health topics.
- 3) Community champion - a process will be tested whereby interviewers will go into the community and select a champion (positive deviance model) that exemplifies the positive behaviors relevant for that episode. The champion will be interviewed regarding strategies and knowledge and recognized as an outstanding community member.

Primary audience: caregivers of children under five

Secondary audience: community development committees

Unifying theme: Healthy habits, better life, new Liberia

Key Benefits: If you take measures to prevent runny stomach and cholera, you will not only reduce sickness in your family, but help make your community a better place.

Situation Assessment: Immediate post-conflict Monrovia is suffering from cholera outbreaks and other diarrheal diseases. It is widely believed that the underlying causes for this disease transmission is the high water table with makes chlorination lose effectiveness in decontaminating water. Additionally, sanitation infrastructure is poor and social norms allow for defecation outdoors and in plastic bags that get thrown around. Knowledge about proper preventive behaviors is also small, contributing to the lack of hand washing, proper food and water storage/cooking, garbage disposal, etc.

CHOLERA & RUNNY STOMACH EPISODE #1 Definition and care-seeking

MAJOR PROBLEM: Lack of accurate understanding of difference between cholera and runny stomach (diarrhea) that causes delayed treatment seeking and lack of appreciation for severity of cholera.

- Purpose:** To educate target audience about the symptoms and severity of cholera and runny stomach (diarrhea) and to motivate timely and proper care-seeking behavior for cholera and runny stomach (diarrhea)
- Objectives:** *At the end of this program (segment/hour), audience members will*
- Know:**
- Difference between cholera and runny stomach (diarrhea)
 - Key symptom of cholera
 - Definition of runny stomach (diarrhea)
 - Proper care seeking behavior for cholera and runny stomach (diarrhea)
 - Cholera is a problem in Liberia
- Do:**
- Discuss cholera problem with family and friends
 - Discuss the key definition of cholera with family and friends
 - Motivate family and friends to seek proper care at a clinic or health facility after recognizing key symptom of cholera or runny stomach (diarrhea)
 - Utilize a strategy for saving or having money in case of need for care seeking
 - Seek treatment at clinic or health facility first - before visiting traditional healers
- Attitude:**
- Appreciation for the seriousness of cholera and runny stomach(diarrhea)
 - Desire for family and friends to be treated properly
- Content:**
- The key symptom of cholera is rice-water pupu every now and then
 - Cholera can kill very quickly and needs immediate medical attention - it is the most deadly diarrheal disease
 - If have rice-water pupu every now and then, could be cholera - goto nearest clinic/hospital right away
 - Runny stomach (diarrhea) is three or more watery stools a day
 - If audience or children under 5 are having runny stomach (diarrhea), drink ORS, then seek treatment at clinic or hospital
 - There is a major cholera problem in Liberia during this emergency time
 - Cholera and diarrhea can be prevented - wash hands before handling food and after using toilet, use water only from hand-pump or chlorinated at home
- Key Messages:**
- Rice water pupu every now and then means cholera and it can kill - don't waste time. Please rush to the nearest hospital or clinic.
 - 3 or more times watery pupu is runny stomach (diarrhea) - drink ORS and go quickly to the nearest clinic or hospital
 - If you see blood in your pupu - waste no time - go quickly to the hospital
 - Cholera and runny stomach (diarrhea) are not from witch, they are real sickness - go straight to the clinic

Cholera/Runny Stomach Episode # 2

Prevention of Cholera/Runny Stomach - Latrine Use, Pupu Disposal, Hand Washing

- MAJOR PROBLEM:** Target audience often does not use the latrine, does not dispose of children's waste properly, and they do not wash hands at proper times
- Purpose:** To educate the target audience about proper disposal of own and children's pupu as well as proper hand washing practices
- OBJECTIVES:** *At the end of this episode, audience members will:*
- Know:**
- >Linkage between cholera/runny stomach and hygiene practices
 - >Safe pupu disposal practices
 - >Reasons for proper disposal of pupu and proper use of latrine
 - >Proper hand washing times and places
 - >Reasons for proper hand washing practices
- Do:**
- >Discuss danger of pupu all around and improper disposal of pupu
 - >Explain benefits of proper hand washing practices
 - >Practice proper use of latrine and proper pupu disposal
 - >Wash hands at appropriate times
- Have an Attitude of:**
- >Motivated to carry out proper hygienic practices
 - >Confidence that proper hygienic practices will prevent runny stomach and cholera
- Content:**
- >The germs that cause cholera and runny stomach can be caught by unhygienic practices - especially not washing hands regularly
 - >To prevent runny stomach and cholera, hands should be washed with soap and water after using the toilet, and before and after handling food - especially before cooking
 - >The germs that cause cholera and runny stomach can be spread by pupu that is not disposed of properly - with pupu thrown all around, the germs that cause runny stomach/cholera are easily spread into our water and food
 - >Use the latrine when you pupu; if you do not have access, bury pupu in the ground.
 - >The best way to dispose of children's pupu is in a latrine - if you can't throw it in a latrine - bury it in the ground.
 - >When everyone disposes of pupu properly, there will be less runny stomach and cholera in our communities
 - >When you wash your hands at the proper times, you will prevent cholera and runny stomach for yourself and your family
 - >It is best put hand washing supplies near latrines
- Key Messages:**
- >Get rid of pupu properly before it ends up in your food or drinking water
 - >Do you know that dirty area also causes sickness - keep your area clean

- >Wash your hands before eating, after using the toilet and after cleaning children's pupu
- >You can get sick from pupu - don't throw it around
- >Stop flying 'dudu birds' around - use the toilet house

Cholera/Runny Stomach Episode # 3

ORS Treatment and Proper Treatment Seeking Behavior

- MAJOR PROBLEM:** Target audience unclear about when is the correct time to fix ORS, how to fix ORS, fixing ORS with unsafe water, and when is the appropriate time to seek further care
- Purpose:** To educate target audience about the appropriate time and method of ORS administration
- OBJECTIVES:** *At the end of this episode, audience members will:*
- Know:**
- > How to mix regular ORS and home-based ORS
 - >When caregivers should prepare and administer ORS
 - >When it is important to seek medical attention for cholera and runny stomach
- Do:**
- >Use properly mixed packet or home-based ORS at appropriate times
 - >Explain to others the appropriate times to use ORS
 - >Seek professional medical care early for cholera and runny stomach
 - >Discuss with others the appropriate times to seek medical care
- Have an Attitude of:**
- >Desire to keep those with runny stomach and cholera strong by using ORS to re-hydrate
 - >Motivation to seek proper medical care early when a child or family member might have cholera or diarrhea
- Content:**
- >Cholera and runny stomach causes loss of water and a person becomes dehydrated
 - >The best way to help someone with runny stomach (watery pupu 3 or more times in a day) or cholera is to mix ORS using safe water, then take them to the nearest health center or hospital
 - >Steps to mix ORS (from packet)
 - In a clean large cup or bowl, empty entire content of an ORS packet
 - Pour a clean soft drink bottle full of safe drinking water three times into the bowl
 - Stir to dissolve.
 - >Steps to mix home made ORS
 - In a clean large cup or bowl, pour a clean soft drink bottle full of safe drinking water three times
 - Cut and squeeze one orange or ½ grape fruit or ½ lime in said water
 - Add 2 lumps or 2 teaspoons full of sugar

- Add three fingers pinch of salt or ¼ teaspoon of baking soda
 - Stir to dissolve
- >For babies, give ½ cup with a spoon
->For children, give ½ cup after each pupu
->For adults, give 2 cups after each pupu
->Directions for home-made ORS is on back of children's vaccine card
->Keeping ORS packet at home will go far in helping someone with cholera/diarrhea
->Clean/safe water is vital when mixing ORS
->While treating with ORS - go immediately to clinic/hospital
->If suspect one has cholera - it is imperative they goto the nearest clinic as soon as possible
->Have ORS at home at all times to be used in case of emergency - could save someone's life

Key Messages:

- >Runny stomach can kill - don't waste time - rush to the nearest hospital/clinic first
->3 or more times watery pupu - drink ORS and go quickly to the nearest clinic or hospital
->Use hand-pump water and clean bowl, cup and spoon (dish:s) to fix ORS

IV. Analysis/Conclusion

Only 3 outlines for programs ended up being developed, and only three 15-minute dramas ended up being produced. The reasons that led to the less than anticipated production are: Search for Common Ground took a long time to get the dramas written so that they could be reviewed. Once they were reviewed, it was clear that they did not understand the program framework. Rather than requesting they re-write according to the framework, we ensured that the dramas contained factual information and encouraged SCG to have them produced quickly.

The production of these dramas was happening at a time when Search was ending its partnership with Diompilor, thereby causing the ICH/Diompilor dramas to be lowered in priority. Once the plans were afoot for Diompilor to open its own studio and hire production staff, they best choice was to wait until they could be engaged fully. Therefore, the original plan for the diarrheal disease radio work did not meet its original expectations.

B-2

**DESIGN DOCUMENT FOR
RADIO SERIAL MAGAZINE SHOW**

(See separate design document)

B-3

**WARP HIV/AIDS
ORIENTATION & MANAGEMENT
WORKSHOP**

WARP HIV/AIDS AMBASSADOR'S FUND WORKSHOP
REPORT

ORIENTATION, PROJECT MANAGEMENT AND
REPORT WRITING WORKSHOP
HELD: 21-23 MAY, 2003

AFRICARE - LIBERIA

Submitted to:
Sophie Cowppli-Boni
Population Services International

I. Introduction

Africare Liberia hosted a workshop for 21 participants from 8 local NGO's, beginning Wednesday 21 May, 2003 through Friday, 23 May, 2003. The Workshop served as the launch of the WARP project activities in Liberia, while also serving to increase participating organization's project development and management skills, monitoring and evaluation skills, and also report writing skills.

Participant feed-back and pre/post test results indicate that the participants were enthusiastic about the topics and learned information that they found useful to their organization and for the implementation of project activities.

II. Preparation

Africare Liberia held several staff meetings to specifically discuss the WARP HIV/AIDS Ambassador's Fund activities and to plan the 3-day workshop. The results of the planning meetings include:

- Scheduling of the workshop
- Development of workshop schedule and curriculum
- Invitation to local partners at least 14 days in advance of the scheduled workshop (example invitation letter is attached as Appendix 1)
- Logistics, including meals and snacks, arranged for workshop

III. Implementation

A. Schedule

Attached is the final schedule that was followed during the workshop (Appendix 2). The highlights of the workshop include the welcoming remarks by USAID Director of Health Programs, Dr. A. Lincoln and US Embassy Public Affairs Officer, Ms. C. Porche. Their remarks were published in a local newspaper, 'The News,' a copy of which is attached (Appendix 3). The major topics that were covered during the workshop include Performance Monitoring Plan, Managing for Results, Financial Management and Reporting, Behavior Change Communication, Monitoring and Evaluation and Report Writing.

B. Participants

There were 21 participants registered on the first and second day, and 20 participants registered on the third day. The participant registration lists are attached in appendix 4 and their signatures for travel allowance are also attached in appendix 5.

C. Evaluation

~~The pre and post tests were administered before and after the workshop (Appendix 6).~~
Results suggest that participants were largely unaware of performance monitoring plans and their strategic objectives for the WARP project, but were able to define these more concretely after the workshop. Additionally, participants were better able to define aspects of financial management and state why financial monitoring is important following the workshop.

IV. Workshop Outputs

As part of the participatory exercises to learn about managing for results and performance monitoring plans, the participants developed a results framework for the implementation of the WARP activities. Together they developed a strategic objective, 3 intermediate results, and indicators to gauge project effect. The results framework is displayed in Appendix 7.

Additionally, the participating organizations, at the request of Africare, formed the WARP Liberia Steering Committee. The list of committee members is attached as Appendix 8.

V. Africare Follow-up

Africare Liberia will be following up with the local implementing partners after the workshop in the following ways:

- Participants will receive a copy of the workshop report
- List of standardized pre and post test questions will be distributed to each implementing partner for use during their project activities
- List of standardized HIV/AIDS education points supporting the teaching of meaningful knowledge and dispelling myths will be distributed
- Notice will be sent about date for the first steering committee meeting and reminder about first set of deliverables due
- Composition and signing of MOU between Africare and each implementing partner
- Disbursement of funds once received by Africare

VI. Conclusion

The workshop went extremely well. The participants were pleased with the contents and the workshop coordinators went to great lengths to make the workshop participatory and respond to participant's feedback. Participants were enthusiastic about the project and even requested additional time to go more in depth on some of the topics. Everyone is looking forward to initiating the project activities.



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His Excellency
Nelson R. Mandela

Chairman:
George A. Dalley Esq.

President:
Julius E. Coles

7 May, 2003

James King
Media Against AIDS in Liberia
CO The Inquirer
Gurley Street
Monrovia, Liberia

Dear Mr. King:

You will be happy to know that the final contract for the West Africa Regional Partners (WARP) HIV/AIDS Ambassador's Fund has been signed as of 1 May, 2003. Africare is now beginning the process for initiating the activities with our partners that will result in a well-coordinated effort to prevent HIV in Liberia.

Africare would like to invite 2-3 representatives from your organization to a 3 day workshop to be held from Wednesday, 21 May, 2003 through Friday, 23 May, 2003. The workshop's main goal will be to strengthen report writing and project management skills, but will also layout the 6 month plan for conducting the WARP activities. The schedule for the workshop will be delivered under separate cover.

We request that you provide Africare with the following information prior to the end of next week (Friday, 16 May, 2003) delivered to the attention of Todd Ritter, BCC Specialist, so that we can properly prepare for the workshop:

- 1) The number and names of persons from your organization attending the workshop
- 2) A current/updated project proposal and 6 month detailed implementation plan (the project cycle will be May through October)

We will see you in 2 weeks and look forward to our partnership with you for the duration of this project.

Sincerely,

Todd Ritter
BCC Specialist, JHUCCP

APPENDIX 2 - WORKSHOP SCHEDULE

WARP HIV/AIDS Ambassador's Fund
Orientation Workshop - Project Implementation and Management
21-23 May, 2003
Africare, Mamba Point, Monrovia, Liberia

Wednesday, 21 May

8:30 - 9:00	Registration	
9:00 - 9:30	Pre-test	
9:30 - 9:45	Welcome Remarks	US Embassy Representative Dr. Adarr.s Lincoln, USAID
9:45 -10:00	WARP Project and Time Plan Overview	Todd Ritter
10:00-10:15	Overview of Workshop schedule	Esther King-Lincoln
10:15-10:45	Ice breaker	Mabel Kear &
	Administrative Issues	Catherine Gbozee
	Formation of Committees	
10:45 - 11:00	Coffee break	
11:00 - 11:45	Africare's Improved Community Health Project	Claudette Bailey
11:45 - 12:30	Behavior Change Communication and WARP	Todd Ritter & Esther King-Lincoln
12:30 - 1:30	LUNCH	
1:30 - 2:45	Managing for Results	Jim Dean & Alan Alemian
2:45 - 3:00	Break	
3:00 - 4:15	Project Management	Jim Dean & Alan Alemian
4:15 - 4:30	Wrap-up	Todd Ritter
4:30 - 5:00	Feedback of Day 1 Activities	Mabel Kear

Thursday, 22 May

9:00 - 9:15 Registration

APPENDIX 2 - WORKSHOP SCHEDULE

9:15 - 9:30	Ice Breaker Exercise	Participants
9:30 - 9:45	Committee Reports	Committees
9:45 - 10:45	Financial Management and Reporting	Mabel Kear, Alan Alemian & Othello Tamba
10:45 - 11:00	Coffee Break	
11:00 - 12:30	Financial Management and Reporting Group Activity	Mabel Kear, Alan Alemian & Othello Tamba
12:30-1:30	LUNCH	
1:30 - 3:00	Financial Management and Reporting Continued (more time if necessary)	
3:00 - 3:15	Wrap-up	Todd Ritter
3:15 - 3:30	Feedback from Day 2	Mabel Kear

Friday, 23 May

9:00 - 9:15	Registration	
9:15 - 9:30	Ice Breaking Exercise	Participants
9:30 - 9:45	Committee Reports	Committees
9:45 - 10:45	Performance Monitoring / PMP	Luke Bawo Jr. & Jim Dean
10:45 - 11:00	Coffee Break	
11:00 - 12:00	Monitoring and Evaluation	Luke Bawo Jr.
12:00 - 1:00	LUNCH	
1:00 - 2:00	Report Writing	Luke Bawo Jr.
2:00 - 3:00	Review / Tie up loose ends / Q&A extra time for presentations if needed	Africare
3:00 - 3:30	Final Evaluation and Post Test	Todd Ritter & Mabel Kear
3:30 - 4:00	Closing	

B-4

**LIBERIA NATIONAL
MALARIA BCC STRATEGY**

**Liberia National Malaria
Behavioral Change Communication Strategy**

FINAL DRAFT

APRIL 2004

**Liberia Ministry of Health and Social Welfare
Written in Collaboration with
Liberia Improved Community Health Project**

List of Acronyms

ACT
BCC
CHW
IEC
IPT
ITN
KAP
MOH/MCD
OPD
RBM
SP
WHO

Table of Contents

Liberia National Malaria Behavioral Change Communication Strategy

I. Background

In 1998, the World Health Organization (WHO) launched a Roll Back Malaria (RBM) initiative to reduce malaria mortality by 50% through 2008. As a signatory to the Abuja Declaration on Roll Back Malaria, Liberia is committed to its successful implementation at the highest political levels.

The Liberia National Strategy 2004-2006ⁱ has outlined the following objectives in the national strategic response to malaria control:

General objective: The overall objective of malaria control in Liberia is to reduce morbidity and mortality due to malaria by 50% by 2010.

Specific objectives:

Case Management:

- To increase access to prompt and effective treatment at health facility and community levels.

Prevention:

- To increase the use of Intermittent Preventive Treatment (IPT) and Insecticide Treated Nets (ITNs) among pregnant women.
- To increase the use of combination of personal and community protective measures among those at risk of malaria.

Cross cutting issues:

- Increase awareness and knowledge on malaria control and prevention practices.
- Ensure effective stewardship of malaria control activities by the Malaria Control Division (MCD).
- To generate evidence for policy planning and program management.

In order for partners in malaria control and prevention to successfully carry out the components of the Abuja Declaration, as devised in the national strategy, the Ministry of Health and Social Welfare (MOH/MCD) proposed in a 2003 draft of the national strategy for the development of a national Information, Education and Communication (IEC)/Behavior Change Communications (BCC) strategy.

Communications provides a powerful tool for the Liberian RBM initiative to have the desired impact. To date, there has not been a national concerted effort at a malaria BCC campaign; various national, local and international organizations have been carrying out independent malaria interventions in their respective program areas.

This document aims to map out a communication campaign strategy that all organizations involved in malaria behavioral change programs can buy into in a complementary and coordinated manner, leading to a more meaningful impact on the mortality and morbidity

of pregnant women and children under five years, and ensure a more efficient use of limited resources. The strategy was developed in a collaborative workshop in March 2004, with partners representing the Ministry of Health and Social Welfare, national NGOs, international NGOs, and UN agencies. Following the workshop, the strategy was drafted and reviewed by workshop participants and their organizations.

II. Problem Statement

Malaria is a major public health problem in Liberia. It is the leading cause of OPD attendance (40-45%) and is also the number one cause of inpatient deathsⁱⁱ. Hospital records suggest that at least 17.8% of inpatient deaths are attributable to malaria. Although the socio-economic impact of malaria has not been assessed, the cost of treatment to families and the cost of lost days of work should be considerably high.

Resistance to chloroquine which was the 1st line drug for malaria treatment has been rising and was first noted in Liberia in 1988. Published papers on the increase of chloroquine resistance in the sub-region are few. Published and unpublished works by Liberians and partners suggest that chloroquine resistance was between 5% to 17% in 1993 in different parts of the country, and by 1995, had reached 38% resistanceⁱⁱⁱ. Resistance to sulphadoxine-pyrimethamine (SP), which was the 2nd line drug, has also been documented.

The proper use of ITNs has been shown to reduce the incidence of malaria in populations which regularly use them. In the Republic of Liberia, ITNs use is not widespread. The Government of Liberia strongly advocates for the use of long lasting Insecticide Treated Nets, especially for pregnant women and children under five years.

Results from previous prevalence studies show hyper-holoendemicity. Prevalence rates may have since increased with the displacement, drug resistance problem and poor access to health services.

Malaria has the potential to cause death within 48 hours of the onset of symptoms, especially for children under five years old. A recent WHO study found that "... *effective home-based care intervention can reduce childhood mortality by 20-40%.*" Therefore, malaria control relies heavily on early effective treatment.

Various studies have demonstrated that the majority of childhood fevers are cared for at home, without consulting a health professional. Unfortunately caretaker's lack of adequate knowledge of antimalarial drugs and home management, often leads to inappropriate treatment of fevers. Severe complications and deaths due to malaria often result from the inability of caretakers to recognize the symptoms, manage appropriately, and refer promptly.

The high mortality is linked to the absence of appropriate drugs and adequately trained personnel at all levels of the health care delivery system. This situation is exacerbated by

the fact that the recent recommended first and second line anti-malarials have been shown to be compromised. Chloroquine has been the 1st line and SP the 2nd line drug for the treatment of uncomplicated malaria. However, resistance to both drugs has risen making them less efficacious. In light of this, and after consultation with WHO and other partners, the Government of Liberia decided to change the malaria drug policy to Artemisinin-Based Combination Therapy (ACT).

The civil war has displaced considerable number of people, destroyed health infrastructures and affected every facet of the health care delivery system in the country. In view of the above, the Government of the Republic of Liberia shall ensure prompt and effective treatment of malaria at health facility, community and household levels.

To progress to better home management of malaria the MOH/MCD shall prioritize the strengthening of the community health workers system making antimalarials available as close as possible to the homes. This has become all the more important in view of the fact that at least 90% of the population does not have access to adequate health care services^{iv}.

As an important component of malaria control strategy is the provision of ITNs and IPT for pregnant women.

It has been shown that the use of IPT by pregnant women can improve the outcome of pregnancies both for the mother and the fetus. Thus, the Ministry has approved the use of SP for IPT and encourages the use of ITNs for all pregnant women.

This paper outlines an approach to improve home management of malaria in children and early referral of severe cases by providing information to mothers as the primary caretakers, improving coverage for IPT for pregnant women, ITNs for children/pregnant women, training service providers, and advocating for support from policy-makers.

III. Knowledge, Attitudes and Practices (KAP) Situation Analysis

Malaria knowledge

Accurate knowledge on how malaria is transmitted is mixed. MERLIN reported 89% correct knowledge in Nimba county^v, while World Vision reported only 17% correct knowledge in Bomi and Cape Mount Counties^{vi}. A MOH&WHO KAP survey in Monrovia in October 2001 found knowledge of malaria to be high - 79% correctly reported mosquitoes as transmitters of malaria^{vii}. A study in Monrovia by Africare's Improved Community Health Project, found that 57% of respondents correctly identified mosquitoes.

In the first three studies, 74%, 90% and 90% of respondents respectively, were knowledgeable that mosquitoes breed in water.

Table 1. Percent correct knowledge per study.

Study	Location	Malaria	Mosquito Breeding
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		Transmission	
Merlin	Nimba	89%	74%
World Vision	Bomi & Cape Mount	17%	90%
MOH/WHO	Monrovia	79%	90%
Africare 2003	Monrovia	57%	

Treatment Seeking Behavior

In the World Vision study, 58% of respondents claimed that they visited health facilities when getting sick with malaria, 3% going to a drug store, with a further 20% claiming that they treated malaria at home. Only 5% claimed to use only traditional methods of treatment. 28% of respondents claimed to be treated for malaria at least three times a year with 92% stating that they pay an average of LD20 (LD50=US\$1) for treatment.

In the Merlin study, when getting sick, actions mentioned included: visiting a health centre (67%), visiting a drug store and home treatment (17%) and only 10% stating that they rely only on traditional medicines. 85% of those interviewed claimed to visit a health centre two to four times a month, and 50% claiming that such visits cost between US\$0.5 to US\$1 per visit.

The MOH/WHO study found that 69% of respondents claimed to seek immediate treatment of malaria and 75% claim seeking this treatment at a health facility. Only 3% claimed that they sought no treatment or sought treatment from traditional sources.

In the 2000 Bong and Nimba Africare study of mothers of children under 2, about one-third of children (33%) who had fever within the past 2 weeks were taken to a health facility for advice/treatment within 48 hours of fever onset. 17% in Borg and 28% in Nimba were treated at home with an anti-malarial drug by the second day of the fever.
INSERT AFRICARE 2003 RESULTS

Table 2. Percent of study respondents reporting treatment behaviors taken following suspected malaria.

Study	Location	Visit Health Facility	Pharmacy/Drug Store	Home
Merlin	Nimba	67%	17%	
World Vision	Bomi/Cape Mount	58%	3%	20%
Africare 2000	Bong/Nimba	33%		17-28%
MOH/WHO	Monrovia	75%	7%	8%
Africare 2003	Monrovia	65%	2%	

Prevention (Mosquito Net) Use & Knowledge

Data available concerning knowledge about correct methods to prevent malaria have also been mixed. Both the WHO and MERLIN study reported that 58% of respondents were

able to identify at least one method to prevent malaria. The World Vision study reported only 41% were able to identify a method to prevent malaria.

Knowledge that use of mosquito nets can prevent malaria was lower; the WHO study found only 31% knew that nets can prevent malaria and only 9% use nets. 35% of MERLIN'S study population correctly identified mosquito nets as a method to prevent malaria, while only 4% of World Vision's study population cited mosquito nets as a method to prevent malaria (however, 96% identified mosquito nets as a way to prevent mosquito bites). An Africare KPC with mothers of children under 2 found that only 1.7% from Bong and 2% from Nimba responded that mosquito nets or treated nets were a way to prevent malaria. 2.3% of the mothers from Bong and 5.3% from Nimba responded that they currently owned mosquito nets, and 21 out of 23 mothers stated that a child under 2 slept under the net the previous night.

The MOH/WHO study assessed knowledge and practice of prevention activities and they are listed in Table 1 below.

Table 3. Percent that could identify feasible malaria prevention methods.

Study	Location	% Correct
Merlin	Nimba	58%
World Vision	Bomi & Cape Mount	41%
MOH/WHO	Monrovia	58% (one only) <58% (more than one)
Africare 2003	Monrovia	20% (nets) 27% (EC) 27% (don't know)

TABLE 4. MOH&WHO KPC percent of knowledge and use of methods to prevent malaria.

Activity	Know(%)	Use(%)
Nets	31	9
Coils	29	24
Spray	43	43
Environmental Control	44	37
Fish	1	0
Herbs	4	1
No Activity	5	11

The same MOH&WHO KPC study assessed people's use history and preferences for mosquito nets - the results of which are presented in Table 2. According to the study, 38% of the sample have owned nets in the past and the main reasons people cited for not owning nets were the lack of availability and the cost.

TABLE 5. Mosquito net use and preferences.

Factor	Characteristic	Number	%
Mosquito Net	Known	92	92
	Not known	8	8
Used Mosquito net in past	Yes	49	49
	No	51	51
Owned net in past	Yes	38	38
	No	62	62
Why not own a net	Not available	35	35
	Too hot	1	1
	Too expensive	27	27
Own net now	Yes	9	9
	No	91	91
Why Like Net	Prevent mosquito	80	80
	Prevent Malaria	16	16
	Other	3	3
Why Not Like net	Too hot	1	1
	Too expensive	1	1

Clearly, more people will need to have knowledge about the relationship between mosquito net use and malaria prevention to meet the goals of over 50% utilization of nets by pregnant women.

IPT Use & Knowledge

The Africare 2000 KPC asked questions about IPT use during pregnancy. In Bong, 85% of mothers responded that they took malaria prophylaxis during pregnancy [of these 255 mothers, 76.9% said they took chloroquine, 4 said fansidar, 1 said quinine, and 51 said drug they could not identify]. The percentages were nearly the same for the mothers in Nimba county; 85% said they took prophylaxis, 73.7% of these said they took either chloroquine, fansidar or quinine (specific percentages are not available).

These results are encouraging given that chloroquine was formerly the recommended drug for IPT, and that there was a period that the Ministry suspended the policy of recommending IPT.

? INCLUDE ANC VISITATION INFO

Communication related - radio listening information, literacy, trusted information sources

There are low levels of literacy in Liberia. According to the 1999/2000 DHS^{xiii}, only 37% of Liberians are functionally literate (have completed at least a primary school education). There are twice as many literate males as females; 50% of males are literates versus 24% of females. Literacy levels are more than twice as high in urban areas (61%) as compared to rural areas (25%).

A Mercy Corps listenership study conducted in March 2003 in Margibi, Grand Bassa and rural Montserrado counties¹⁴ found that the language people prefer to hear on the radio is Liberian English (41.28%) followed by English (33.03%) followed by local languages (25.23%).

100

III. Strategic Approach

The national malaria communication strategy will use a multi-channel approach, with a combination of various communication channels mutually reinforcing each other. A multi-channel approach works best to build synergy among the various interventions to strengthen the overall campaign impact. The approach encompasses:

- Focus on four priority areas: infant and child care, prevention among pregnant women, improved service delivery provision and advocacy
- A slogan and symbol to unify all Malaria IEC/BCC interventions
- Community and county level communication activities to change social norms influencing care for the child's health within the home and community and the use of ITNs for pregnant women and children under five and IPT for pregnant women
- A national level media campaign to address and empower mothers regarding home-based management of malaria, treatment adherence, use of ITNs and importance of IPT for pregnant women;
- Enhancement of Community Health Workers(CHW) ability to educate and provide a full course of recommended anti-malarial treatment to caretakers and IPT for pregnant women through interpersonal communication and counseling skills training and provision of provider and client support materials;
- Advocacy and media initiatives that contribute to a more conducive environment for home-based management of malaria, IPT and ITN usage.

IV. Goals

1. Overall Goal: *To Reduce mortality and morbidity due to malaria in children under five years and pregnant women.*
2. Home-Based Care for Malaria Goal: *To increase the rural and peri-urban mother's ability to provide home-based care for children with malaria*
3. ITN Goal: *To increase the number of rural and peri-urban pregnant women and children under five years who sleep under ITNs.*
4. IPT Goal: *To increase the number of pregnant rural and peri-urban women who receive recommended IPT before full term.*
5. Improved Service Delivery for malaria management Goal: *To ensure service providers provide accurate and appropriate information and give prompt and effective treatment to pregnant women and children under five years with malaria, consistent with the messages of the RBM campaign.*
6. Improved Policy Environment Goal: *To ensure policy-makers provide political and financial support for IPT, ITNs, home-based care and service delivery of malaria.*

V. Infant and Child Communication Strategy

A. Situation Analysis

High mortality and complications for children under five years due to malaria are often related to late diagnosis and/or inappropriate treatment. Caretakers must be informed and confident on how to manage and prevent malaria in the home, by recognizing signs, promptly referring, giving the recommended first-aid and using ITNs. The most relevant audience for improving home-based treatment of malaria is through the primary caretaker, the mother. Home-based treatment with paracetamol or antimalarial drugs is often the first action taken by mothers. However, as currently administered, the dosage of the treatment is often inadequate and there is increasing drug resistance to locally available drugs, such as chloroquine. Liberia has recently reviewed its antimalarial medicine policy and recommends ACT as the new first line medicine. Until ACT is widely available and all community health workers are trained to dispense and administer it (not planned to happen until late 2004) caregivers are being encouraged to rely on prompt referral to health facilities, with paracetamol and/or sponging to make the child more comfortable on the way to the health facility. Mothers therefore need information about management and prevention to enable better responses to malaria attacks in their homes.

B. Audience

Mothers, as the primary caretaker, were chosen as the priority audience. These are women, 15 – 49 years old in the rural and peri-urban areas of Liberia. They are typically low literate, of low socio-economic status, and rely on local languages. The secondary audience who will also be exposed to the campaign will be fathers, boyfriends, mother-in-laws, relatives, those who have influence on the household decisions regarding care for malaria.

C. Behavioral Objectives

1. To increase the proportion of mothers who reduce their child's temperature in the home with paracetamol and by sponging in addition to referring to a health provider within 24 hours on onset of fever from $x\%$ in 2004 to $y\%$ by 2006.
2. To increase the proportion of mothers who recognize symptoms of severe malaria and promptly refer children to health facilities from $x\%$ in 2004 to $y\%$ by 2006.
3. To increase the proportion of mothers who administer the full course of new anti-malarial therapies from $x\%$ in 2004 to $y\%$ by 2006.
4. By the end of 2006, 50% of pregnant women and children <5 will consistently and correctly sleep under treated Mosquito net.

D. Home-based Management Recommendations

- Take the child to a health facility within 24 hours
- Give paracetamol and
- Sponge the child to reduce the fever to make the child more comfortable while on the way to a health facility
- Complete recommended dosage of anti-malarials, even if the child appears better

- **Take your child to the health facility immediately** if the fever does not go down in 2 days after starting treatment with anti-malaria medicines.
- **Go to the health facility immediately** if you or your child has any of the following danger signs:
 - is unusually sleepy or difficult to wake up
 - fits (convulsions)
 - stiff neck
 - has difficulty breathing
 - vomiting everything
 - Fever that does not get better 2 days after starting medication.

E. Desired Action Response

1. Primary Audience: "I will recognize the symptoms of malaria, sponge, administer paracetamol and refer to a health provider within 24hrs, recognize the danger signs of a severe case of malaria and seek care at a health facility as soon as practicable."
2. "I will ensure that my child sleeps under a treated mosquito net every night to prevent malaria."
3. Secondary Audience: "I will encourage and support my wife/relative to recognize the symptoms of malaria, refer to a health provider, apply first aid and, recognize the danger signs of a severe case of malaria and seek care at a health facility if needed."
4. "I will encourage my wife or relative to ensure that she and her child sleeps under a treated mosquito net every night to prevent malaria."

F. Key Barriers

There are numerous barriers affecting the success of home-based management and prevention of malaria in children under five years. Lack of knowledge is among the key barriers to effective home-management. Accurate knowledge includes, but not limited to: recognition of symptoms and danger signs of malaria; the current recommended anti-malaria medicine and its availability only through trained health workers; awareness that malaria is serious and should be treated promptly as well as prevented through the use of ITNs; and the fact that temporary relief of symptoms does not equal a cure. Caretakers need knowledge and skills so they are better able to respond appropriately to malaria.

Existing attitudes toward malaria also have a damaging effect on appropriate treatment. For example, malaria is a recurrent disease in Liberia, therefore malaria is not consistently perceived as a serious or life threatening. Harmful practices such as incomplete doses of anti-malaria treatment also create barriers to appropriate treatment of malaria in the home. Many Liberians use incomplete doses either because the child's health appears to improve and therefore see no need to continue with medication, or to save some pills for later use the next time malaria occurs.

Some believe ITNs to be hot to sleep under, so choose not to do so. Faced with difficulties meeting day-to-day needs, others receive ITNs at subsidized rates and re-sell them for profit, so that the intended audiences are not necessarily the beneficiaries. In

other homes the children are not allowed to sleep under the nets and rather the father does.

Various social norms within the households and communities pose a threat to accurate treatment and prevention of malaria in the home. In several communities, convulsions are seen as witchcraft (Dragon), so traditional rather than clinical cures are sought. Many people prefer and ask for the chloroquine injection thinking it will rid the body of malaria more quickly than the tablet. In many homes, the sequence for care-seeking can cause delays in getting the child to a health facility promptly. Mothers often need approval from the fathers or mother-in-laws, before going to the clinic. It is a general perception in certain parts of Liberia that mosquito nets are used for dead bodies and as such are not meant for the living.

There are also numerous economic barriers to improved home treatment and prevention. Although chloroquine is cheap, the recurrence of malaria and the cost of frequent purchases of antimalarial drugs quickly add up. There is also an economic burden of repeated episodes of malaria, costing families' money, time, and lost work. As chloroquine is inappropriately administered and deemed ineffective, more and more Liberians search for alternative malaria medications increasing the cost of treatment. Additionally, the cost of ITNs is currently \$6.00, which is not affordable to the ordinary Liberian. Even though nets are subsidized in some areas, uptake remains low.

Physical barriers pose another threat to effective home-based care and prevention. While there is fairly wide access to loose tablets and syrup chloroquine in Liberia, availability of the new combination therapy has started but not yet reached all parts of the country. Access to health facilities is also a problem for referral, especially for those who live in rural areas. Current national procurement and distribution mechanisms of ITNs are inadequate, so most caregivers do not have easy access; however, there is an expected increase in ITNs entering the country through the Global Funds.

G. Tone

The communication strategy to educate mothers on home-based care for malaria will balance an empowerment message with a nurturing tone. The campaign will emphasize enhancing the mother's confidence and competency in caring for their child's health and promote that the child's health is central to the family's overall well-being.

H. Tactics/Communication Channels

The lead component of the mother's communication campaign is community-based interventions, both event-based and on-going activities. The community is an important audience in order to change social norms to encourage home-based care and malaria prevention for the target audience, caretakers of children under five years. There will be various community events presented through music, drama, cultural troupes and games to create awareness about the importance of home based care. The community-based interventions will tap into the existing resources within the community, such as using local drama troupes and partners. Entertaining formats will make the messages more appealing to our audience. These activities will be developed in an interactive and

entertaining manner to elicit audience participation. County health officers and other partner organizations involved in malaria or child health at the County level will be encouraged to be a part of these activities and be available after the shows to respond to questions from the audience.

There will also be on-going community activities to maintain the campaign's presence in the community over the long term. As an integral part of reactivating the CHW system and their training for ACT, a curriculum will be developed for CHWs and local NGOs to use during community group activities. Community health workers will be given activity sheets and malaria information cards to use during client or group education sessions. Community education will also occur through local NGOs, mother's clubs, religious organizations, traditional leaders, and other gatherings at the community level. Activities at the county/community level will complement the national mass media campaign.

Radio spots, print materials, and various hand-outs to promote the home-based campaign in the communities will be distributed by all partners. This channel will focus on addressing normative issues like completing the full dose and seeking clinical treatment promptly following symptom recognition. Due to the high illiteracy rate in Liberia, these messages will need to focus on using radio in vernacular languages to have the greatest reach where radio is available.

Another important component employed in this campaign to inform caretakers will be the use of the print media disseminated nationally. A logo or slogan will be developed to unify the various components of the malaria campaign. The logo will introduce a recognized symbol and slogan that will be included in all of the radio and print materials, placed in all service delivery points and communities as well as affixed to all approved ITNs for Liberia. Leaflets with information on basic home-based care and stickers with malaria information and reminders will be produced to provide accurate information to mothers on the home-based care of malaria. There will be drawings and pictures to aid those mothers with low literacy. Posters promoting use of ITNs and showing symptoms of simple and severe malaria will be produced and distributed in communities and health facilities, and other places women may go or gather.

Mass media provides another communication channel to reach the large audience of Liberian caretakers. Radio is a widely available and popular channel which people respect and participate. Radio activities will include a national weekly radio magazine show with various sessions including a drama, questions and answers, and discussion on various child health issues, including home-based care and prevention of malaria. There will also be several radio spots in local languages to empower women to manage and prevent malaria in the home and to stress the benefits of referral and completing the full course of treatment. Mass media plays a critical role in raising the mother's knowledge of home-care of malaria. All campaign materials and the creative concepts will be pre-tested with relevant members of the target audience, prior to development.

VI. Service Provider Communication Strategy

A. Situation Analysis

Malaria is a common ailment, recurring often in Liberia. Especially in rural areas, caretakers usually cannot afford the time and money to visit a clinic each time a family member has malaria. People often bypass a visit to the health facility and purchase antimalarial medicine directly from shops or vendors, don't treat at all, or use traditional herbs. Drug sellers currently fill a gap in service and provide readily available, low-cost, antimalarial medicines although they may not be in line with accepted national policies. Drug sellers, however, rarely provide accurate information on home-based care and prevention of malaria.

Service provision for malaria occurs on several levels: facility based provision with trained providers, community based health workers, and sellers of drugs such as pharmacists, petty vendors and black baggers. With security improving throughout the country, more and more health clinics are being rehabilitated and opening for service. The MOH/MCD and JHU Mentor are training service providers in new malaria case management protocols, including ACT. In order that the health facility teams are thoroughly trained prior to using ACT, training courses prior to supply are mandatory according to national policy. Due to the inefficacy of chloroquine for malaria treatment, only service providers trained in the new treatment protocols should be promoted as service providers to visit.

Trained service providers are key constituents to act as health educators by providing messages consistent with the malaria BCC campaign and [dispensing ACT(???)]. [(???)Improved service delivery of ACT can lead to major impacts on the mortality rates of children under 5 due to malaria in Liberia.] This communication strategy aims to strengthen the capacity of service providers across Liberia through (malaria education training???) and support materials.

B. Target Audience

Facility-based trained health service providers who provide health services to children under five years and pregnant women. There are an estimated 2,100 (?is this correct?) community health workers providing important malaria prevention and care services in Liberia. Community health workers are often the first source mothers go to when their child has a fever, and therefore present a valuable opportunity to communicate care, treatment and prevention information to caretakers. Although they have completed secondary school, they do not have any specialized training in new anti malaria treatment.

Therefore, the priority audiences to improve access to the full course of anti-malarial should be Community health workers in rural and urban areas of Liberia. MOH however recommends a phased approach with the initial target being facility based trained providers. The reason being, ACT is new medicine that is being introduced and needs close monitoring initially, **to ensure safety and compliance.**

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Pharmacists are also important points of sale for antimalarials; however, they are clustered more in urban areas, thus limiting their reach. Public and private providers are all part of the campaign and they will be trained as well.

The secondary audience: Pregnant women and caregivers of children under 5.

It should be noted that traditional healers were considered as another source of information for caretakers; however training interventions with traditional healers would be complicated and too controversial.

C. Behavioral Objectives

1. 60% of service providers in communities and service delivery centers will counsel and give accurate information on Home-based management and prevention of malaria in children under 5 years and pregnant women by 2006.
2. Increase the proportion of service providers who educate caregivers on the importance of completing the full course of anti-malaria treatment, and the benefits of taking preventive measures for children under 5 and pregnant women.
3. [Remove? Can BCC address this? More of a clinical/logistic matter] To increase the proportion of service providers who dispense the full course of recommended anti-malarial to the caretaker from $x\%$ in 2004 to $y\%$ by 2006.

D. Desired Action Response

1. Primary Audience: "I will provide understandable and accurate information regarding home-based care of malaria and prevention in children >5 and pregnant women to my clients."
2. Secondary Audience: "I will demand accurate information and effective treatment regarding home-based care and prevention of malaria from my service provider."

E. Key Barriers

The service providers lack accurate information and training on the importance of providing the new combination therapy for malaria and best practices in the field of malaria management. Service providers are not motivated to provide health education due to the lack of time and heavy workload. They may not have time to adequately counsel clients on the need for prevention of malaria in pregnant women and the need for IPT and ITNs. That also applies to home management and ITNs usage for children <5.

Service providers also lack interpersonal communication skills and tools for counseling and health education, such as cue cards and flip charts. They also lack transportation such as vehicles, motor bikes and bicycles to carry out outreach activities in hard to reach communities.

The community health worker networks are not fully functional and do not have access to current treatment and prevention information on malaria. Incentives for CHW and other service provider are inadequate but they are still committed to service delivery.

The health service delivery system is generally poor; in terms of equipments, efficacious drugs, infrastructure and transportation.

F. Tone

The communication campaign will establish service providers as a friendly and knowledgeable source of reliable and accurate information regarding the treatment and prevention of malaria. The campaign will emphasize that strengthening the health education role will enhance the service providers standing in the community and in the long run reduce their workload because less and less people will be suffering from malaria.

G. Tactics/Communication Channels

Once again a multi-channel approach will be used to provide specific antimalarial information to service providers, increase awareness regarding the new combination therapy, recommended methods prevention of malaria in pregnant women and children under 5 through the use of IPT and ITNs, and the importance of service providers providing understandable and friendly information and services to their clients.

To enhance the quality of antimalarial services, service providers will be trained in interpersonal communication. There will be trainings for service providers during their regular meetings at the county level. The training will emphasize accurate antimalarial information and the need to counsel clients on the accurate and full use of the new antimalarial medicine. The service providers who attend the training will receive a button with the campaign logo to identify and promote their services within their communities.

These efforts will be further supported through the development and provision of print and educational materials for service providers. These print materials will aid the service provider in providing accurate information to clients. Each service provider will receive posters to hang in facilities and shops and leaflets to provide to caretakers with guidelines for full and complete treatment and prevention. They will also receive job aids with dosage reminders to motivate the service providers to comply with providing information to their clients.

Mass media will also be used to increase awareness regarding the service providers' role in providing information and antimalarial medications to the community. A service provider character will be incorporated into the radio magazine drama, modeling appropriate counseling and dispensing behavior. This will create awareness among mothers that service providers are knowledgeable about antimalarials and are a reliable source for the purchase of medicines and health information.

V. Pregnant Women's Communication Strategy: (IPT/ITNs)

A. CURRENT SITUATION:

As of October 2003, the Ministry of Health changed the national policy on Intermittent Preventive Treatment for pregnant women to Fansidar. Pregnant women are advised to take one dose during their second trimester and one dose during their third trimester. This policy replaced one that had chloroquine as the recommended drug for weekly prophylaxes for pregnant women.

Formative research determined that there is the practice of women taking malaria related drugs during pregnancy. Some surveys showed as high as 85% (in both rural and urban areas) the number of women who reported taking something during pregnancy to prevent malaria. Fansidar was rarely the drug that was taken, which is logical given the recent change in policy. This behavior is promising as sometimes common fears of hurting the fetus is a barrier to pregnant women taking IPT.

According to the 1999/2000 DHS, pre-natal visitation is high. Mothers received ante-natal care for 90% of births. The median time at first ante-natal visit is 3.9 months after pregnancy. However, about 35% have their first visit in the fourth and fifth months. Over 11% have their first visit from the sixth month, too late for the full benefits. The visitation often occurs with mid-level health workers or trained/untrained traditional midwives. While some are very diligent about repeated visitations, most visit few times, and begin late in pregnancy.

It was also determined during formative research that the use of ITNs for prevention of malaria among pregnant women was very low though generally acceptable.

B. TARGET AUDIENCE:

Primary: Pregnant women in peri-urban and rural Liberia between the ages of 15-45 years old in the rural and urban areas of Liberia. They are typically low literate, of low socio-economic status, and rely on local languages.

Secondary: The secondary audience who will also be exposed to the campaign will be fathers, boyfriends, mother-in-laws, relatives, who have influence on the household decisions regarding care and prevention of malaria

C. BEHAVIORAL OBJECTIVE:

1. By end of 2006, there will be a 20% increase in the percentage of pregnant women in peri-urban and rural areas who know the importance of taking IPT and using ITNs.

2. By end of 2006, there will be a 12% increase in the percentage of pregnant women in peri-urban and rural areas who complete 2 doses of IPT according to national protocol.
3. By the end of 2006, 30% of pregnant women and children under 5 consistently and correctly sleep under mosquito nets.

D. DESIRED ACTION RESPONSE:

1. **Target Audience:** "I will visit a trained health professional early in pregnancy and complete the 2 doses of IPT in my second and third trimester in order to protect myself and my unborn child."
2. "I understand the dangers of malaria during pregnancy to myself and my unborn child and will take action to prevent malaria by correctly and consistently sleeping in ITNs."
Secondary Audience: "I will encourage my wife/daughter/etc. to attend pre-natal care early in pregnancy and to take IPT in the second and third trimester and to sleep in ITNs in order to prevent malaria and ensure a healthy mother and baby."

E. KEY BARRIERS:

The barriers to pregnant women taking IPT are similar to the barriers to treatment seeking practices among caregivers. Pregnant women often do not know that it is important for them to take the IPT during pregnancy, so they may not seek it out. Additionally, the service providers they visit may not also know the importance of and therefore not recommend IPT. If a service provider does know the importance, they might not have access to the drugs and therefore cannot act upon the knowledge they do have.

Rural pregnant women are often without access to resources they may need to complete their IPT. They often lack access to money which may be necessary to travel to a service provider or to purchase the drugs. If they have money, they may not deem that expense a priority in light of the large demands on their day to day life. Trained and easily accessible health workers who can recommend and provide IPT are not available in many rural locations.

Traditional herbs are still used in many rural areas, and pregnant women and their communities believe that these herbs are preventing sickness in them and their baby, which reduces their motivation to get IPT.

Pre-natal care for pregnant women is not always practiced – so women are left to themselves to decide how to care for themselves during pregnancy. If more women were to visit trained health workers or mid-wives, they would be more exposed to the IPT concept and more likely to agree to use it.

Barriers to use of ITNs for pregnant women:

These are basically the same barriers encountered by care-givers for children <5. The same tactics will evidently be use to reach both targets as they overlap.

1. Lack of knowledge of causes of malaria; lack of knowledge that mosquito nets prevent malaria. While there is generally high knowledge that mosquitoes are the cause of malaria, there is also high incorrect knowledge of the causes of malaria.

Additionally, formative research showed that people do not associate mosquito nets with malaria prevention, but do associate them with stopping mosquitos.

2. Unavailability of the ITNs-The quantity of nets currently coming in the country is on a very low scale, these nets are only brought in country by a few business partners, and donor agencies. Effective demand is such that ITNs are most marketable in Monrovia.
3. Unaffordable cost of ITNs-There is no set policy on ITNs as regards cost and distribution channel, therefore nets owners determine their own prices which is not affordable to the target audience, if at all available.
4. Break down in the CHW network for easy distribution – ITN distribution through community health workers will necessitate the re-establishment of the national CHW system. Once present, and when they are reactivated, they are a convenient resource through which mosquito net promotion and distribution can take place.
5. Limited trained clinic staff and logistics for distribution and retreating nets – the rural service provision system was rendered to a halt during the fighting in mid-2003. Fortunately, services and people are gradually returning to these areas. Once the clinics are operating in an organized system, they will also be good mechanisms through which nets can reach rural areas.
6. Common complaints by Liberians about ITNs are that they are hot to sleep under and also, nets are used in some regions to cover dead bodies. This presents more of a challenge in motivating people to use the nets properly.
7. Not having enough nets for the whole family. It would be a difficult choice for a pregnant mother to make to decide if she or her other children should sleep under the net. This could have an effect on whether our target audience (pregnant women) is the users of nets that are in the home. Consideration needs to be given to the number of nets needed per household in order to address this barrier.
8. Other immediate needs so target audience will sell a free or low cost net for money rather than use it – times are difficult for rural dwellers, so the benefit of having and using a net may not be perceived as important if other more urgent needs are not met. People choose rather than using the nets to sell them and use the money for other purposes.

F. TONE:

The tone for the campaign targeting pregnant women will be one of empowerment and ability. Pregnant women can take the necessary few simple steps to provide the best care possible for themselves and their babies, and the campaign will emphasize this aspect. It will also focus on informing the secondary audiences how they can support pregnant women and why it is important to do so.

G. TACTICS:

Effective promotion of IPT among pregnant women needs to be in conjunction with the availability of IPT among the various levels of service providers. The campaign should roll out in conjunction or slightly after training takes place in a given area. Training for service providers – at facilities, CHWs, TBA's, TTMs – should include modules on ensuring providers provide reliable and understandable information to the pregnant women on why they should take the IPT, and encourage them to return for the second dose. These one-on-one interactions are important opportunities for motivating and educating pregnant women that should be maximized as much as possible.

In order for pregnant women to have the one-on-one opportunities with trained health professionals that will educate them about IPT and provide the service, the campaign should collaborate with safe motherhood campaigns in promoting pre-natal care visitations. Any messages that are targeting the primary audience should incorporate this important point.

Reaching the target audience needs to take place through a combination of communication channels. Women's CBOs are key opportunities for peer education to take place. These organizations can take many forms – Mother Support Groups, farming co-operatives, susu clubs, among others. Where groups do not exist, the strategy of initiating them should be considered. A module should be created for community health workers and TTMs/TBAs to assist them in carrying out education sessions among these groups.

In addition to peer education, mass media will be used to reach the target audience. Radio programs will be developed that include pregnant women as characters who will be confronted with the decision to take IPT. Also, radio spots will be produced and aired which encourage pre-natal visitation and preventing malaria for themselves and their unborn child. Low literate print media will also be developed that will reinforce the main messages. The formats will include posters for service delivery points and locations where rural women are known to gather such as local markets, churches, and others.

Reaching the secondary audience is equally important in order for pregnant women to gain the support and approval of family, friends and leaders. It is important to therefore create general awareness about IPT among these various populations as well.

VII. Advocacy for Key Constituencies Communication Strategy

A. Situation Analysis

Advocacy is a necessary component to the whole malaria communication strategy as public policy influences individual behavior change. This advocacy component aims to

build a supportive environment and to improve access to antimalarial medicines, ITNs and quality service provision. Not only is the idea of "home-based Management" an innovative idea requiring broad political support, but there are also several policy issues needing clarification.

Government and community leaders have given little priority to home-based Management of malaria in the past. Advocacy activities will be undertaken in an effort to begin changing this political and social context. Although the RBM strategy has approval at the highest level, there is still the need to gain the support of health providers, policy-makers, and community leaders for the various approaches to be successful within the community. The advocacy component will also spark discussion on policy and program options for the various approaches to malaria management and prevention of malaria through the news media.

Access to the new anti malaria therapy is another problem needing resolution from policy-makers. Presently, government policies regarding ACT are not clear, regulation of authorized persons to sell and used this medicine needs to be clarified. Without these issues being resolved, Liberians access to the complete and accurate course of approval antimalarial will be restricted.

At the moment the Government of Liberia depends solely on donor agencies for the supply of ACT, and does not have complete control of the quantity of ACT and ITNs that comes in at any given time into the Country. These greatly affect the supply and availability at various delivery points. Hopefully, with the coming in of the global funds this situation will greatly improve.

B. Audiences

There will be two sets of priority audiences, one for each aspect of the advocacy campaign. Key people in MOH/MCD, professional associations (Chemists, Pharmacists, Midwives, Traditional Healers, Private Practitioners, etc.), local NGOs/CBOs, and the news media will be targeted to gain political support for Malaria BCC Campaign. The donor community is also an important audience in order to gain financial and logistical support for the Malaria Campaign.

C. Behavioral Objectives

1. To provide political and financial support for the malaria communication campaign.
2. To provide policy support for the various components of the Malaria communication campaign in relation to medicines, ITNs and logistical support for service provision

D. Tone

With the numerous health issues and the complex emergency situation Liberia found itself in, there are competing demands for political and financial support. However, malaria is the top killer of children under 5 years of age, and deserves greater attention in Liberia. By building on existing community health practices and resources rather than creating new ones, this Malaria Communication Strategy is bound to have significant

impact on reducing malaria mortality. Policy-makers should be made aware to do more, with limited resources by working within and supporting this communication campaign.

Antimalarial drug policies will be more successful if they take into account the caregiver's difficulties in accessing and administering the medicines and formulate a policy to enhance access and compliance with the full course. Policy-makers need to be made aware that there is a close link between easy access to safe and efficacious antimalarial medicines and successful home-based management of malaria.

I. Tactics/Communication Channels

The advocacy activities will mainly use the interpersonal approach. This will consist of many informal and formal meetings with policy-makers and partners to come to consensus on the home-based care strategy and policy decisions. There will also be briefing packets produced for government officials and the news media. The news media will enhance the public dialogue regarding home-based care of malaria and provide further coverage on the need for easy access to efficacious antimalarials.

VIII. Research

The Malaria BCC campaign will make use of existing research wherever possible for the formative research. Identified sources of existing data include: ----- . A number of focus group discussions on fever-reduction practices and the use of ITMs and IPT already exist as background information. Further information needs to be collected to give a clearer baseline.

Once the baseline data is available, specific targets will be integrated into the project objectives. Process indicators will be used to monitor the implementation of planned activities. The source of information for these will be obtained primarily through existing surveys, which may include: adding some campaign exposure and malaria questions to the next DHS; and an Omnibus survey.

The impact of capacity building activities related to training will be measured primarily through the pre and post-tests and responses to follow-up questionnaires that assess application of training content to their job. Additionally, the capacity building of CWH program will be monitored and evaluated using: exit interview from mystery clients following an antimalarial purchase or consultation; and measuring the recall messages of CHW immediately following the training and 6 months from the training.

IX. Coordination

To facilitate implementation of the project activities, a Malaria Communication Working Group will be formed. This group will include representatives from the Ministry of Health (MOH) -----Africare. This group will be responsible for implementation and monitoring of the campaign and advocacy activities. The group will meet on an as needed basis to plan, review materials, provide input to the

design of community activities, provide guidance with regards to advocacy activities and in general facilitate decisions regarding the implementation of activities.

X. Workplan

A. Communication Strategy Development

- | | | |
|----|---|-------|
| 1. | Development of communication strategy for malaria | March |
| 2. | Identification of existing IEC materials on malaria | April |
| 3. | Formation of Malaria Communication Working Group | March |
| 4. | Consensus Building Workshop | April |

B. Development of Communication Interventions

- | | | |
|-----|---|-------|
| 5. | Advocacy package prepared | May |
| 6. | Prepare questionnaire for baseline resesarch | March |
| 7. | Conduct formative research (FGDs) | Done |
| 8. | Design workshop for radio magazine show | March |
| 9. | Develop campaign logo, print, and radio materials | April |
| 10. | Develop RBM curriculum for community groups | May |
| 11. | Development of radio magazine show | April |

C. Production of Communication Interventions

- | | | |
|-----|---|------|
| 12. | Pretest campaign logo, print, radio, and training materials | June |
| 13. | | |
| 14. | Production of radio spots | June |
| 15. | Production of print materials | June |
| 16. | Training of service providers | July |
| 17. | Distribution of print materials and logo signs | Aug. |

D. Launch of Communication Campaign

- | | | |
|-----|---|------|
| 18. | Campaign Launch Event | Aug. |
| 19. | Airing of radio spots at national level | Aug. |
| 20. | Airing of radio serial drama | July |
| 21. | | |
| 22. | County/communities activities | Aug |
| 23. | Local drama troupes in communities | Aug |

ⁱ Republic of Liberia. National Malaria Strategic Plan, 2004-2006. January 2004.

ⁱⁱ Ministry of Health Malaria Control Division. Routine surveillance, 1993-1998.

ⁱⁱⁱ Freeman, T.L., & Bolay, F.T. (1995). In vivo response of Plasmodium falciparum to standard chloroquine regimen in Buchanan, Grand Bassa County, Liberia (Unpublished).

^{iv} Liberia National Health Policy, 2000.

^v MERLIN.

^{vi} World Vision.

^{vii} Ministry of Health & Social Welfare and WHO.

^{viii} Liberia Demographic and Health Survey. 1999/2000.

^{ix} Mercy Corps, AED, Search for Common Ground – Diompilor Project.

Appendix C

**CURRICULUM
DESIGN
PROCESS**

C-1

**SCOPE OF WORK
FOR
CURRICULUM DESIGN CONSULTANT**

**Scope of Work
Curriculum Design Consultant
Liberia Improved Community Health Project**

1. BACKGROUND

The Liberia Improved Community Health (ICH) project is a reproductive and community health care initiative aimed at assisting Liberian civil organizations to support improved primary health care delivery. The five-year \$7.5 million (plus \$2.5 million matching grants) USAID funded project was awarded in January 2003 to a consortium composed of Africare (as the prime), John Hopkins University Center for Communication Programs (JHU/CCP) and the Morehouse School of Medicine). The project will work with local implementing partners in Montserrado, Bong, and Nimba counties, with over 40n clinics and 300 communities to increase the capacity of civil society to address public health priorities, primarily targeting women of reproductive age (WRA) and children under five.

Liberia has been ravaged by armed conflict since 1989, resulting in a steady decline and depletion of social services. There has been a particular dearth in areas of reproductive and community health, as evidenced by the following statistics:

- **Maternal mortality:** For every 100,000 live births, 540 women of reproductive age die (DHS, 1999).
- **Infant mortality:** For every 100,000 live births, 117 infants die (DHS), 1999.
- **Child mortality:** For every 100,000 live births, 198 children under the age of five die (DHS, 1999).
- The **adolescent pregnancy rate** is high.
- **Access to modern health care** has declined from approximately 30 percent in 1989 to approximately 10 percent in 2002, especially in rural areas
- Only 10 percent of the population **lives less than five kilometers from a health facility** (NHP, 2000) and many catchment communities are situated seven or eight hours on foot from the nearest clinic.

The ICH project is a response to these conditions and accordingly the consortium has prioritized its health package of interventions as follows:

- **Components:**
 - **Malaria Control :** This component is actively involved in the Roll Back Malaria campaign, targeting pregnant women and children and promoting and instituting the use of insecticide treated bed nets, Intermittent Preventive Treatment of pregnant women and combined therapy for first line treatment of malaria.
 - **Immunization :** Here the focus will be on pregnant women and children and efforts will be made to increase full immunization coverage from 30% to 60% in three years in project areas.

- **Reproductive Health: level of effort)** This component will promote a diversified method for family planning using the cafeteria approach, a reproductive wellness approach to Women' Health, a Preratal approach to childbearing, incorporating Safe Motherhood and Child Survival, Adolescent Sexuality and Fertility and Sexual and Gender Motivated Violence and Abuse.
 - **HIV/AIDS:** This component promotes STI/HIV/AIDS awareness and education, HIV/AIDS voluntary counseling and testing and the use of Antiretrovirals for HIV positive people.
 - **Nutrition, Micronutrients and Breastfeeding:** This component promotes exclusive breastfeeding for the first six months, continued breastfeeding for two years and the use of micronutrients: iron and Vitamin A.
 - **CDD—control of diarrheal diseases:** This component utilizes WATSAN approaches, education of mothers and responsible adult caregivers in treatment of diarrhea, use of ORS.
- **Strategies:**
 - **Clinic- Based Strategy:** The program will strengthen the capacity of clinics to provide more holistic and comprehensive care to their clientele and catchment through training and equipment, including the logistic means to travel to outreach communities.
 - **Community based Strategy:** The program will improve services at community level by training and equipping community based service providers and mobilizing and training other community groups to identify, treat and refer people, especially children for services.
 - **Civil Society Capacity Building:** The program will strengthen the capacity of civil society to participate in health care delivery, by providing a mechanism for ensuring sound organizational structure, training staff in administration and other areas of business management. Staff will also be trained and encouraged to take a proactive roll in policy making and development of standards and policy for health.
 - **Performance –Based Subcontracting:** Partnerships will be established with local NGOs through performance-based subcontracting. Activities to be financed will be small projects up to a maximum of \$20,000 over a period not exceeding six months. The prospective implementing partner will present a concept paper and preliminary budget to Africare. If these are acceptable, Africare will work with the partner to prepare a detailed

implementation plan and budget. Funding will be done in two stages: a preliminary advance and final disbursement dependent on objectives having been met satisfactorily.

II. PRESENT SITUATION IN HEALTH CARE

- Since March project staff in Nimba County have relocated to Monrovia as belligerent forces invaded their areas. Two months of armed struggle for Monrovia has only worsened the situation. Project areas in Bong and Nimba counties are still inaccessible. Meanwhile the humanitarian crisis in Monrovia has worsened following the recent killing, looting, vandalism and severe destruction of infrastructure and property. A further influx of an estimated over 200,000 displaced people sought shelter and safety in Monrovia fomenting the already desperate situation.
- Increased overcrowding, has led to increased drastically incidents of respiratory infections.
- Lack of or poor shelter has lead to increased incidents of malaria.
- Poor sanitation and refuse disposal leading to increased incidents of diarrheal diseases including dysentery
- Unsafe water supply led to a severe cholera epidemic
- Scarcity of food led to severe malnutrition in children under five in Monrovia

The interior of the country is still virtually inaccessible to health services and sporadic skirmishes are still being reported. Peacekeepers are deployed at check points from Monrovia to Totota and this area has been declared safe to travel through. Further deployment of peacekeepers will allow access to areas for situational assessment and eventual service provision. Information gleaned from the counties tells of continued looting of infrastructure including hospitals and clinics where roofs are being removed and sold across the border.

THE NEED FOR CURRRICULUM DEVELOPMENT

Registered Nurses, Certified Midwives, Licensed Practical Nurses and Physicians Assistants provide a wide range of primary and reproductive health care services at clinics independently. As the number of practicing physicians have dwindled over the years from over 800 to less than 50 the burden on these frontline service providers to offer comprehensive services increase. They are obliged to meet the demands of their ever expanding roles without the benefit of regular refresher , in-service or post graduate courses. Shortage of staff, lack of necessary equipment and supplies and other resources also contribute to the deterioration of skills and practice as observed on monitoring and supervisory checks.

One of the goals of this project is to improve service delivery particularly at the clinic and community level. An initial input towards the attainment of this goal must be training. Therefore training needs assessment and curriculum development are urgent first steps in this process.

Clinic staff serve as trainers and supervisors for community service providers in their catchment areas, an expanded role which must be addressed in curriculum development. A curriculum designer is required to work with a core of trainers to upgrade their skills and to guide them in participating in curriculum design tasks of curriculum development, training manual development and supervisory check list development.

WHO WILL PARTICIPATE IN CURRICULUM DEVELOPMENT ACTIVITY.

The curriculum design consultant will be responsible for leading the process, completing and submitting the deliverables at the end of the consultancy. Assistance will be provided by a core of reproductive health specialist/trainers from Africare (3), Ministry of Health (3) and Family Planning Association of Liberia(3). They are all experienced Registered Nurse Midwives with Family Planning training. The consortium's BCC specialist from John Hopkins University/Center for Communications Programs will be available for consultation and input.

THE DELIVERABLES

- ❖ Five-day Reproductive Health Curriculum Development Workshop for core of trainers.
- ❖ Workshop Report.
- ❖ Reproductive Health curriculum for service providers.
- ❖ Reproductive Health Training Manual (or modules) for training service providers.
- ❖ Supervisory Check Lists for all components of the curriculum.

Documents prepared during the course of the consultancy (e.g., newly created/adapted workshop materials, workshop report, reproductive health curriculum, training manual/modules and supervisory checklists) will be of professional standard and free of grammatical and spelling errors. They will be submitted in electronic (MS Word and/or Power Point) as well as hard copy to Africare. The ownership and use of these materials is governed by the Africare grant agreement with USAID.

WHO WILL THE CURRICULUM BE DESIGNED FOR

The curriculum will be designed to provide In-service training for Registered Nurses, Certified Midwives, Licensed Practical Nurses and Physicians Assistants, who are experienced service providers.

THE SCOPE OF THE CURRICULUM

The curriculum will address Reproductive Health as the well being and health of women or reproductive age (WRA-puberty to menopause), their partners and their offspring. The project components will specify some areas to be addressed, while the information gleaned from the learning needs assessment and Demographic Health Surveys(DHS) will determine the focus. Based on already available information, holistic reproductive health services (and therefore the curriculum) should include:

- ❖ Family Planning training aimed at promoting a diversified method mix.

- ❖ A perinatal approach to childbearing, which incorporates Safe Motherhood and Child Survival techniques.
- ❖ Adolescent fertility, sexuality and sexual behavior.
- ❖ Reproductive wellness approach to Women's Health.
- ❖ Prevention and control of HIV/AIDS and other STIs
- ❖ Malaria prevention and control in pregnant women and children.
- ❖ Sexual and gender based violence and exploitation.

DURATION AND PLACE OF CONSULTANCY.

This assignment should be completed in about 12 but not exceeding 16 weeks in Monrovia.

QUALIFICATION AND EXPERIENCE

- ❖ Health care professional eg, Physician, Midwife, Nurse, Health Educator, Physician's Assistant.
- ❖ Masters Degree with specialty in education or curriculum design.
- ❖ Experience in curriculum design.
- ❖ At least two years experience in developing countries.

C-2

**REPORT ON
CURRICULUM DESIGN ACTIVITY**

**Report of the Refresher/Update Curriculum Design Consultancy
Liberia Improved Community Health Project
February – April 2004**

Background

The Liberia Improved Community Health (ICH) Project is a reproductive and primary health care initiative. It has been implemented by a consortium composed of Africare, the Johns Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU/CCP) and Morehouse School of Medicine, and is funded by USAID and Africare. It works with local implementing partners to support more than 40 health facilities and their catchment communities in Montserrado Bong, and Nimba Counties.

The ICH project aims to assist Liberian civil organizations to strengthen their ability to provide primary health care services following many years of civil conflict. Several strategies are being employed to accomplish this. Among them, the clinic-based strategy aims to strengthen the capacity of clinics to provide more holistic and comprehensive care to their clientele and catchment through training and provision of equipment, including the logistic means to travel to outreach communities. Inservice education, designed to refresh and update knowledge and skills of clinic-based personnel, is an integral part of the strategy.¹ A second strategy, based in communities, will require the active participation of clinic-based personnel. Inservice education designed for that purpose will help to prepare them for work with communities.

While the project works primarily with local implementing partners in three counties, the need for inservice education exists throughout the nation. Africare has worked in consultation with the Ministry of Health and Social Welfare (MH&SW) other Non-Governmental Organizations (NGOs), and United Nations (UN) agencies in identifying priority topics and in developing inservice education materials that can be used with Register Nurses, Certified Midwives, Licensed Practical Nurses and Physician Assistants who provide the majority of primary and reproductive health care services in the nation's health facilities.

Consultancy Scope of Work

From the Scope of Work document²:

One of the goals of this project is to improve service delivery particularly at the clinic and community levels. An initial input towards attainment of this goal must be training.

¹ The need for inservice education was previously identified by a USAID assessment team in 1998. See *Rebuilding Liberia's Health Sector: Analysis, Strategies and Recommendations*, Barbara Hughes, C. Kirk Lazell, Alan Malina, Mary Mertens, Dr. Paul E. Mertens, Dr. David Ofori-Adjei, June 1998

² The full Scope of Work (SOW) for a Curriculum Design Consultant will be found in Appendix 6.

Therefore training needs assessment and curriculum development are urgent first steps in this process.

A curriculum designer is required to work with a core of trainers to upgrade their skills and to guide them in participating in curriculum design tasks of curriculum development, training manual development and supervisory checklist development.

The curriculum design consultant will be responsible for leading the process, completing and submitting the deliverables at the end of the consultancy. Assistance will be provided by a core of reproductive health specialist/trainers from Africare (3) Ministry of Health (3) and Family Planning Association of Liberia (3). They are all experienced Registered Nurse Midwives with Family Planning training. The consortium's BCC specialist from JHU/CCP will be available for consultation and input.

The curriculum will be designed to provide inservice training for Registered Nurses, Certified Midwives, Licensed Practical Nurses and Physicians Assistants, who are experienced service providers.

The curriculum will address Reproductive Health as the well being and health of women or reproductive age (WRA-puberty to menopause), their partners and their offspring. The project components will specify some areas to be addressed, while the information gleaned from the learning needs assessment and Demographic Health Survey (DHS) will determine the focus. Based on already available information, holistic reproductive health services (and therefore the curriculum) should include:

- ❖ Family Planning training aimed at promoting a diversified method mix.
- ❖ A perinatal approach to childbearing, which incorporates Safe Motherhood and Child Survival techniques.
- ❖ Adolescent fertility, sexuality and sexual behavior.
- ❖ Reproductive wellness approach to Women's Health.
- ❖ Prevention and control of HIV/AIDS and other STIs
- ❖ Malaria prevention and control in pregnant women and children.
- ❖ Sexual and gender based violence and exploitation.

The Approach to Curriculum Design

At the beginning of the consultancy it was agreed that the curriculum design activities should be inclusive, participatory, and consultative, so as to create a broad sense of ownership of the curriculum and materials. It should apply adult learning principles and make use of the experience and concerns of senior health workers in positions of authority who have identified weaknesses and gaps in service delivery and are likely to be primary users of the curriculum materials. The focus in the design is the learner and how to facilitate effective learning, in contrast to a more customary focus on the trainer and training.

The consultant's roles were 1) to facilitate the process, 2) to provide information on and encourage application of adult learning principles, 3) to identify and make available resources on each of the topics to be addressed, and 4) be responsible for documentation.

The adult learning approach was modeled during the Consultative Meetings on the Refresher/Update Curriculum Design held in March and was maintained throughout the consultancy. While the consultant often suggested ways to proceed, decisions were taken primarily by the curriculum writing teams.

The participatory approach required flexibility on the part of all participants, particularly the Africare staff. Some adjustments in the content of the curriculum were necessitated by insights gained in discussions with agency leaders and participants in the process.

Steps in the Curriculum Development Process

Curriculum development is a dynamic, ongoing process. The refresher/update curriculum is being developed in a series of meetings and activities that are taking place over time. The process got underway in early February and will continue into the future. It is described here as a series of steps.

- 1. Consult with prospective participants regarding the need, content and process of curriculum design.** Meetings were held with NGOs, UN agencies, the Board for Nursing and Midwifery, the Medical Board, and relevant divisions of the MH&SW to introduce the consultant and provide information on the refresher/update curriculum activities.³ At each meeting, the agency was encouraged to discuss training needs and identify personnel to participate in the process. Contact information (usually a cell phone number) was obtained for each prospective participant. Relevant documents still available after offices were looted, including training materials, checklists, policies, standards and protocols, were borrowed and photocopied. The copies were added to a small resource center, also being developed at Africare.

Some adjustments in the SOW were agreed as a result of information and suggestions collected during the meetings. Firstly, the number of writers was expanded from the nine persons initially identified to include senior health workers in additional agencies and departments. Secondly, when it was learned that a major effort to retrain health workers in treatment and prevention of malaria is being undertaken by MH&SW and the Johns Hopkins Mentor Initiative, a project for malaria control and prevention in complex emergencies, malaria was removed from the list of curriculum topics.

- 2. Consult with prospective curriculum writers.** A three-day consultative meeting was held March 1 – 3, with participants identified during the initial meetings, to consider the approach, specific topics, methods, materials and other details to be used in the curriculum design. Information to be collected in a Learning Needs Assessment was

³ The list of offices visited will be found in Appendix 1.

outlined by the participants, working in technical groups that would become curriculum writing groups.

- 3. Complete preparations to carry out a Learning Needs Assessment (LNA).** The assessment of learning needs was intended to both serve as a learning experience for the curriculum writers and help them to identify specific skills and knowledge that should be included in the curriculum. The LNA might also serve as a baseline of health worker performance and the equipment/supplies available for their use. Writers who designed the LNA decided to 1) observe health workers performance, 2) interview health workers in their facilities, 3) conduct exit interviews with clients, and 4) check for specific records, equipment and supplies. Four assessment instruments were developed.

The assessment took place over a period of ten working days. Despite the participants' wish to do the assessment throughout the country, security constraints limited the activity to Montserrado, Margibi, Bong and Nimba Counties. Some participants had other commitments during this period, so other senior health workers took part in the data collection activity.

- 4. Complete the LNA.** The data were entered and analyzed to identify specific learning needs by an epidemiologist from the MH&SW who undertook the task during his annual leave. Unfortunately, the data entry and analysis took longer than expected, due to computer difficulties and the large volume of information the participants identified as important.

When the assessment instruments are reviewed in light of the data analysis experience, it will be possible to reduce and adjust them for use in additional counties, when County Health Teams once again become active and are able to provide inservice education to health workers.

- 5. Begin writing the first draft of the curriculum.** Despite the delay in LNA data analysis, the writing teams began meeting and proceeded to develop curriculum modules, based on their experience and knowledge of the general situation. When the LNA analysis is available, the teams will adjust objectives and content of the modules. Where policies and protocols were available, they were consulted, as was the Safe Motherhood Needs Assessment. Writers were encouraged to consider using a wide variety of methods for learning, rather than thinking simply in terms of holding workshops.⁵
- 6. Conduct a first trial of the learning activities and materials.** This will be the next step in this curriculum development process. When a draft of learning activities has been completed on any topic, the writers will use them with health workers in groups or individually, depending on whether the activities are designed for group or individual learning. This step is particularly important, because it allows the writers to identify the activities and materials that are effective and those that need adjustment, to ensure they

⁴ A report of the Consultative Meetings will be found in Appendix 5.

⁵ The process used by the writing teams to develop modules is described on page 8.

actually help learners master a skill or understand information that underlies their work. The most useful format for the learners' materials can also be identified during the trial.

Though learning checklists were initially included in the materials to be developed by the writers, these are the standard way to test the learner's mastery/competence. Discussion with some writers led to recognition that checklists should be created *by* rather than *for* the learners. Checklists have long been used as tools for trainers and supervisors, providing them with specific items to observe in order to decide whether the learner has achieved competence in a given skill. When health workers construct learning checklists, they are more likely to feel ownership and are therefore more likely to use them to check their own progress toward mastery/competence in specific skills. The task is also likely to help learners remember the steps in performing a skill. Writers may wish to construct draft checklists to have on hand as they facilitate the construction process, but the potential benefits of learner-constructed checklists make it important to test them.

Similarly, supervisory checklists, which are necessarily far less detailed, should be constructed by supervisors in consultation with the health worker/learners they supervise, to insure they will be appropriate and useful. CHT members who use the curriculum to refresh/update the health workers they supervise, can work with them to review the learning checklists and select key steps to be included in observations during a supervisory visit.⁶

7. **Adjust the learning activities and materials.** Based on what is learned in the trial, the activities and materials should be adjusted and strengthened. It will then be possible to decide on a more permanent form of learners' and facilitators' materials. Since most health workers' homes and facilities were looted in the waves of conflict, and reference materials are currently scarce in Liberia, the learner materials may be most useful when produced in booklet form, by specific topic, to serve as references for the learners after they participate in refresher/update activities.
8. **Monitor the effectiveness of materials and learning activities.** The curriculum materials must be revisited periodically, to keep them up to date. Experience with the materials and learning activities should be monitored, and where changes are indicated, they should be incorporated in the revision process. The present materials are only a first draft of a "first edition".
9. **Work with learners and their supervisors to identify further learning needs.** The curriculum development process should expand beyond the initial topics and this first round of activities. The writers who have learned to develop materials in a step-by-step process can use it to address additional learning needs. Their knowledge and experience in inservice curriculum design should be utilized beyond the current activities. When health workers have positive experiences with the curriculum, they are likely to respond when invited to identify additional information and skills they need to improve the quality of care they provide.

⁶ See Appendix 5, beginning at page 37 for a discussion of supervision and learning.

Scope of the Curriculum

Technical topics included in the curriculum at this time come under the broad umbrella of Reproductive Wellness and include:

- Safe Motherhood
 - Antenatal Care
 - Labor and Delivery
 - Management of Emergencies during Labor and Delivery
 - Newborn Care
 - Postpartum Care
 - Use of the Partograph to Manage Labor
- Family Planning
- Adolescent Reproductive Health
- STI/HIV/AIDS
- Gender-Based Violence
- Nutrition, Breastfeeding, and Micronutrients
- Child Health and Diarrhea Control

When the draft curricula have been tried and adjusted, a learning module (learner's materials) and a facilitator's guide on each of these topics will be ready for printing.

Cross-cutting topics that should be addressed in all technical learning modules were identified. These topic areas will also require their own curriculum and materials. In the technical modules, learners should be encouraged to explore how the information gained in these topics informs and supports their work in the technical areas. The cross-cutting topics include:

- Communication, particularly Basic Counseling Skills
- Working with Communities
- Rational Use of Drugs

Some topics that were initially considered have not been included in this initial curriculum exercise:

Immunization was initially identified as another topic for which a refresher/update curriculum is required. While the staff of the Expanded Program on Immunization (EPI) expressed a desire to participate and develop the curriculum in their area of expertise, their busy field work schedules precluded their participation in any of the activities, so it was not possible to develop an immunization curriculum during the period of the consultancy. One can easily be developed in the future, however, when schedules permit.

Prevention and treatment of malaria was removed from the refresher/update curriculum list, as indicated above, since the MH&SW and the Mentor Initiative are in the process of re-training the nation's health care providers on malaria issues. The training introduces a new national malaria policy, new drug therapies, a new rapid

diagnostic testing procedure for *P. falciparum* malaria, and provides information on the use of insecticide-treated bed nets (ITNs). Under the new policy, only when they have completed the training will health workers have access to the new drugs for malaria treatment. In view of the changes, malaria is not suitable topic for refreshing or simple updating at present, with the possible exception of introducing intermittent presumptive treatment for pregnant women in their second and early third trimesters of pregnancy. In future, when health workers have been trained and are using the new policy and therapies, a refresher may become appropriate.

Some topics and issues will need to be addressed in the near future:

Obstetric emergencies are partially addressed in the Safe Motherhood section of the refresher/update curriculum. Emergency measures that midwives have been trained to provide are in the curriculum. However, an inservice refresher cannot provide the midwives with the knowledge and skills they require to perform more advanced procedures that have been documented to save lives of women in labor and delivery. The midwives did not learn advanced skills in their training and most have had no opportunity to learn them since. Maternal mortality statistics and the Safe Motherhood Needs Assessment provide ample evidence that training in advanced maternal life-saving skills is urgently needed.

Quality of care issues are linked to health worker competence and will be addressed further once health workers have used or experienced the learning activities. When they are able to demonstrate their competence in skills, measured with the aid of skill checklists they helped to construct, health workers will better understand quality of care and how they can provide it.

Laboratory skills training, while not a refresher topic, was identified in the initial meetings as a need in facilities without any laboratory capability. The suggestion was to help facility staff master basic laboratory skills related to diagnosis and care in the technical topic areas. Discussions with laboratory instructors from Phebe Hospital (where such training was done in the past) and Mother Patern College of Health Sciences (which has recently proposed such training) led to agreement that health workers can gain the necessary skills in a three-month training course. It may be possible to provide training partially in hospital or training school labs, then partially in the facilities. Quality control remains a major concern, so further planning will be required before such training can be made available. It was suggested that a laboratory supervisor be included on the County Health Teams, to provide supervision and quality control for laboratory activities.

County and District Health Teams require support. As they regain their ability to function effectively, these teams will be crucial partners in providing refresher/update learning opportunities to health workers as they supervise. To function effectively as facilitators, they will need to discuss/learn/agree on standards and gain skills to facilitate learning in several ways. They can provide "home study" materials and then follow up by discussing the topic with learners in their facilities or in one-day group meetings.

They can include learning activities in supervisory visits, do on-the-job skill training during clinic sessions, or arrange for health workers who are competent in specific skills to help their fellow health workers learn.⁷

Writing the Curriculum

The curriculum writing activities are carried out in a multi-step process. Writing teams meet at times and places determined by the members. Teams were initially organized by area of expertise, beginning with participants in the initial consultative meetings. Some teams later identified additional writers and brought them into the process, while some early participants dropped out due to their other responsibilities.

In their first meeting, the writers typically identify the goal and objectives of the refresher/update module. In a second meeting, the goal and objectives are reviewed and adjusted. Early in the process the writers consider "Why is it important to learn about this topic? How will it improve health care?" Answers to these questions lead to listing of the reasons, which helps them outline and develop an introduction for the module that motivates the learners.

Ideally, the LNA results inform the objective writing activity. Due to the delays encountered, the writers will instead need to revisit the objectives when the results are available, to ensure that areas of weakness found in the assessment are addressed in each curriculum topic.

The content is identified first in a rough outline. In a subsequent meeting or as "homework," writers develop the content to create as complete an outline as possible, keeping in mind the purpose is to refresh health worker knowledge and skills and to provide new information where appropriate. Up to this point, learner and facilitator materials are the same. The content is likely to be in bulleted form, which is easy for health workers and facilitators alike to read while covering all important points. References used in developing the content are cited in the outline.

When the content has been reviewed and agreed by the writing group, they identify activities that can be used to help the learner review, remember or learn new information or skills. They are encouraged to remember two pieces of advice they gave themselves during the consultative meeting as guidance for designing learning activities: 1) *begin with the learner's experience and knowledge* and 2) *include the reason "why" for any action to be taken. "Why do we do this?"*⁸ By inserting the learning activities, a draft version of a "facilitating guide" is created for the module.

The writing teams consider how to help the learners evaluate their own learning (self-evaluation) and identify materials that can initially be handed out to learners but will eventually be included in a learners' module. The team may choose to draft skill checklists so they have a list of items

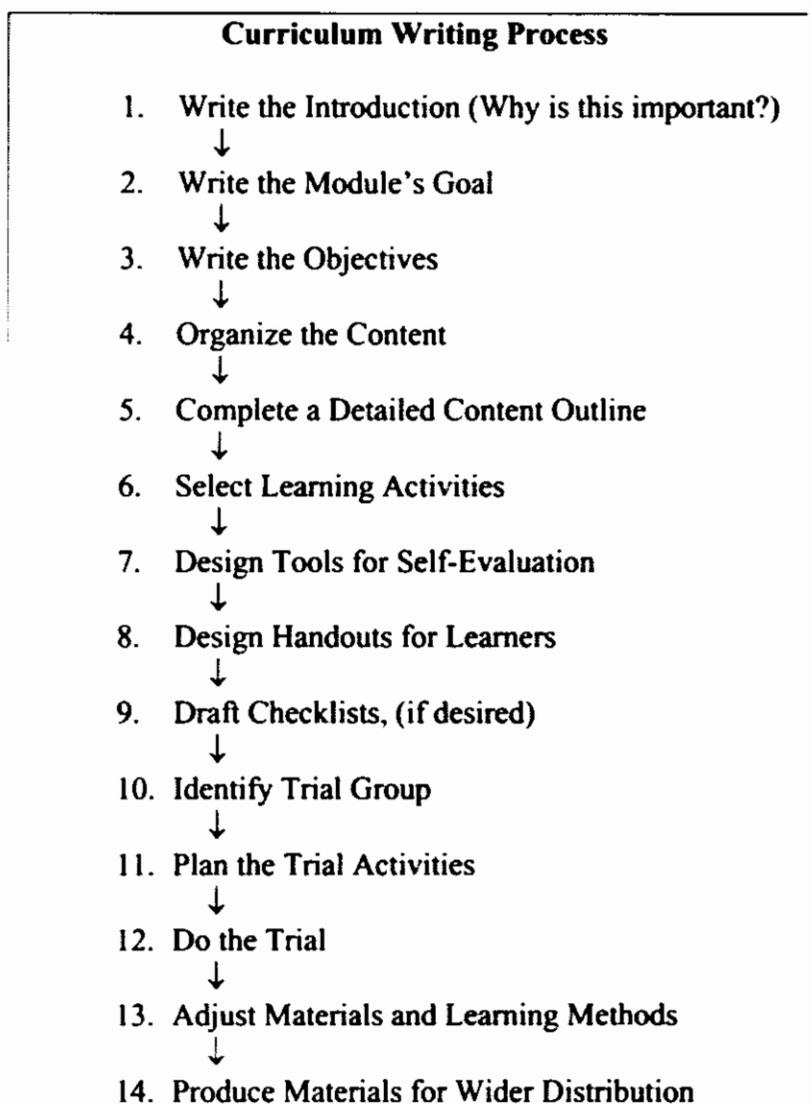
⁷ All the methods mentioned are described in more detail in Appendix 5, the report of the consultative meetings. Excerpts from the literature on the close relationship between supervision and training will also be found in Appendix 5, page 37.

⁸ The entire list of advice writers gave themselves will be found in Appendix 5, page 31.

they see as necessary, in preparation for working with learners as they construct their own checklists.

Once the materials are prepared, the writers will identify a group of health workers, then plan for and conduct a trial of the learning module. This may take place in a meeting, or it may be a test of the effectiveness of home study materials, an on-the-job training activity, a supervisory activity, and etcetera. During the trial, the writers must be attentive to the entire process, in order to identify where the module is successful, where learners have trouble, and where changes are required to strengthen the learning activities and materials. Active input from the learners must be encouraged. It is in the first trial that writers are likely to learn most about how to help health workers learn. The learners serve as teachers in this step.

After the trial, the writers should have a good understanding of what is required to strengthen the learner's and facilitator's materials, making them effective. Once the changes are made, the materials can be produced in a form suitable for wider distribution—a "First Edition".



Several of the senior health workers taking part in writing have indicated they like this approach to designing curriculum. They have enjoyed thinking through the content and strategies in a group process, which created much discussion and critical thinking. They noted that the content outlines were more complete because several people contributed to them.

One constraint encountered during the first three months of the process was writers' time availability. Many of the people who were important to the writing activity were in high demand by other organizations and agencies, including their own, and even by Africare for other activities, so that finding times to meet was sometimes difficult, and some writers had to miss meetings. A second constraint was the paucity of resource materials. Despite the best efforts of all concerned, printed resources for use in developing the curriculum content were limited, due to successive waves of looting during periods of conflict. A third constraint, minor security disturbances, forced cancellation or limited the time available for a few writers' meetings.

Learning from the Needs Assessment

As described above, the LNA was both an information gathering tool and a learning opportunity for those who participated. The analysis allowed identification of trends in health practice in the priority topic areas and spotlighted skills and practice that require refreshing or updating. It also provided information on the general availability of equipment and supplies at health facilities.

The LNA was a learning experience for the curriculum writers who participated in designing the instruments and gathering data. When the data processing and analysis are complete, the writers will be able to learn which of their questions or observation provided useful information and which did not, so that future needs assessments will be more streamlined. Before leaving Liberia, the consultant arranged with the Africare staff and MH&SW epidemiologist to meet with each writing team as soon as data processing and analysis are complete, to review the LNA findings relevant to their work and to consider why some items were not useful and can therefore be removed. County Health Teams are likely to find the instruments helpful in assessing learning needs. Hopefully this exercise will be the beginning of systematic assessments of health workers' learning needs, so that curricula are consistently designed to remedy specific deficiencies in the provision of health care as well as providing new information.

The Learning Needs Assessment report will be available at the Africare office in Monrovia as soon as the analysis is complete.

Next Steps in the Process

ICH Project staff have taken responsibility for moving the curriculum writing process forward with the writing teams. They have a tool for tracking progress of all writing teams.⁹ Their role should be facilitative. Where materials are hand written, the designated focal person on staff should to arrange for computer entry, printing and duplication for use by the team. Where

⁹ The tracking tool and details regarding the steps in the writing process will be found in Appendix 3.

arrangements of some sort are required, s/he should assist. Most of all, the ICH staff should communicate with the writing teams and, when possible, attend their meetings to accompany the process. The staff need not be experts in the topic area (except where they are members of the writing teams), but rather facilitators toward progress.

Conclusion and Recommendations

The Liberia ICH Project has initiated a dynamic curriculum development process, using a participatory approach that applies adult learning principles. The initial steps have been taken. Much remains to be done to produce an effective "First Edition" of learners' materials and facilitators' guides in ten priority topic areas. Once the materials have been produced, more work will be required to train facilitators and to find support for learning activities in the counties. To move the process forward:

1. Track the work of each writing group through reports from the designated focal person and frequently update the tracking tool. Each focal person should be fully aware of the progress of the writing team and should report actions taken to expedite the team's work. Remember that planned trial learning activities (workshops, home study, on-the-job learning, etc.) must be arranged and supported financially.
2. Work with the MH&SW epidemiologist and the writing teams to streamline their respective sections in the learning needs assessment instruments, to create a useful tool for County Health Teams (CHTs) in counties not included in the initial assessment.
3. Convene a meeting of senior health workers who are, or have served as members of County Health Teams or otherwise have knowledge and experience with them. Discuss what will be required to support effective functioning of the CHTs, regardless of whether Africare is currently able to provide such support. The CHTs are a crucial link in the health delivery system and much depends upon their effective functioning, including inservice education.
4. Increase the collection of resource materials, particularly resources designed for use in developing countries, to ensure that the health workers, writers and staff have access to good resources.
5. Meet with the Family Health Division of the MH&SW, the staff of the Liberia Prevention of Maternal Mortality (LPMM), UNFPA, UNICEF and other relevant parties to discuss a strategy for providing Life Saving Skills training for midwives. When a training course is available, consider giving priority to midwifery trainers and to midwives working in isolated facilities.

C-3

LEARNING NEEDS ASSESSMENT
(See separate report document.)

Appendix D

REFLECT Activities

D-1

**FINAL REPORT SUMMARY
OF THE
REFLECT TRAINING OF FACILITATORS WORKSHOP
(See separate report document)**

D-2

**FINAL REPORT SUMMARY
OF THE
REFLECT TRAINING OF FACILITATORS WORKSHOP
(See separate report document)**

Appendix E

**KEY ACCOMPLISHMENTS OF
ICH PROJECT**

KEY ACCOMPLISHMENTS OF ICH PROJECT

OBJECTIVE 1: Increase the availability and use of malaria information, prevention and treatment services for populations living in target areas.

- ❖ KPC studies conducted in randomly selected communities to determine malaria knowledge, treatment-seeking behavior and attitudes about prevention.
- ❖ Anti malaria drugs procured through AmeriCares and other Non USAID sources (chloroquine, fansidar, quinine, Amodiaquin and Artesunate).
- ❖ ITNs procured through AmeriCares.
- ❖ Developed national malaria BCC Strategy.
- ❖ Conducted malaria materials and methods design workshop – implementation to coincide with Malaria Control Division's implementation of Global Fund.

Objective 2: Increase full immunization coverage for children under five years in project communities.

- ❖ Sporadic EPI services provided in ICH clinics
- ❖ Meetings held with mother support groups in project communities to mobilize mothers to immunize their children.

Objective 3: Increase access to use of reproductive health services by women of reproductive age (puberty to menopause) and their partners.

- ❖ Conducted KPC survey in randomly selected communities in project areas.
- ❖ Conducted assessment of reproductive health facilities, training needs and services in health facilities in Monrovia, Bong and Nimba, participating in the project.
- ❖ Identified and defined deficiencies in reproductive health knowledge, practices and quality of care in project operational areas.
- ❖ Developed scope of work for consultant for curriculum design
- ❖ Identified and recruited consultant for conducting training needs assessment and development of reproductive health curriculum.
- ❖ Identified and mobilized core of trainers for reproductive health training.
- ❖ Reviewed, designed and developed reproductive health curriculum.
- ❖ Developed training materials for reproductive health.
- ❖ Recruited and enrolled 20 primary health care service providers from project clinics in PHC course at Mother Patern College of Health Sciences. After 2 weeks in session the course was cancelled during the attacks on Monrovia in 2003.
- ❖ Conducted rapid service facility survey to assess physical plant facility and define equipment needs for delivering reproductive health services in selected facilities in Monrovia.
- ❖ Equipment to provide pre natal intrapartum, postpartum and emergency obstetrical care distributed to FPAL and MERCI clinics.
- ❖ Sub contracted with Liberia Prevention of Maternal Mortality project to administer emergency obstetrical care and establish a referral system
- ❖ Standardize initial counseling for all methods of contraceptives available to clients to enable informed choice.
- ❖ Developed IEC and advocacy proposal for funding through UNFPA
- ❖ Develop proposal for reducing low birth weight (MCH) project with WFP to be funded by Canadian Impact Grant in November 2004.

Objective 4: Provide target population with the information, motivation and means to curtail the spread of HIV/AIDS

- ❖ Conducted baseline survey in Monrovia.
- ❖ Conducted 8 day BCC training for HIV for NACP, Liberian NGO, UN agency and international NGO staff.
- ❖ Developed scope of work for condom social marketing, received proposals from local NGOs and selected implementing partner
- ❖ Developed Voluntary Service Corps proposal for funding through Africare headquarters.
- ❖ Managed the implementation of West Africa Regional Partners HIV/AIDS Ambassador's Fund through performance-based sub-contracts with 8 local partners
- ❖ In process of procuring funding through UN Theme Group on HIV/AIDS for development of national communication strategy for HIV/AIDS
- ❖ Voluntary Counseling and Testing request for proposal developed and submitted to five local partners – proposals pending

❖ **HIV Baseline Findings**

- 99.7% urban and 96.0% rural respondents have heard about HIV/AIDS.
- Main sources of information are radio (87.9% urban, 63.7% rural) and friends/relatives (25.8% urban, 33.0% rural).
- 5.9% urban and 24.8% rural respondents think there is nothing that can be done to prevent HIV/AIDS or don't know if anything can be done.
- Top 2 prevention methods mentioned in urban study was: stay faithful to one partner or limit partner to one (76.8%) and condom use (70.1%); rural response was: stay faithful to one partner or limit partner to one (70.0%) and reduce number of sexual partners (47.7%).
- Prevention of parent to child transmission knowledge was high, 85.2% urban and 73.2% rural.
- Report of condom use to prevent HIV/AIDS or STI was 53.7% urban and 38.0% rural.
- 42.6% urban and 60.2% rural reported knowing someone who has HIV/AIDS
- 18.1% urban respondents and 11.1% rural respondents reported having been tested
- 76.3% of urban and 89.3% rural respondents reported wanting to be tested
- 49.7% of urban and 67.9% rural respondents did not know a location where they could obtain VCT.

❖ **WARP Management and Activities**

- Managed the implementation of West Africa Regional Partners HIV/AIDS Ambassador's Fund through performance-based sub-contracts with 8 local partners.
- Conducted organizational management workshop with 8 local partners on project and financial management.
- Received acceptable deliverables from 7 of the 8 partners; one performance-based subcontract was terminated

- o To date, the following activities have been conducted through the WARP project:
 - i. IEC equipment purchased by National AIDS Control Program and Mother Patern College of Health Sciences
 - ii. 1 Newsletter produced by Media Against AIDS
 - iii. Developed and implemented a training guide reaching 20 local leaders in Monrovia by Family Planning Association of Liberia
 - iv. Advocacy brochure developed by FPAL
 - v. Local leader advocacy workshop held with
 - vi. 18 girls from 10 primary schools were trained by AIDSCORPS prior to a sensitization meeting with the school authorities at the 10 schools
 - vii. Baseline survey conducted in 4 IDP camps near Monrovia
 - viii. "Lets Talk About AIDS" booklet and teachers guide developed by Liberian Society for Women Against AIDS
 - ix. Workshop conducted with 25 church leaders by United Campaign for Christians Against AIDS

OBJECTIVE 5: Improve the general nutritional status of children under five in project communities.

- ❖ Formed and trained Mother Support Groups (MSG) to adopt the SIP (support, integrate and promote) method of providing breastfeeding education.
- ❖ Conducted capacity building training for health workers on breastfeeding and LAM (lactational amenorrhea method of contraception).
- ❖ Established postnatal and well baby services at the Family Planning Association of Liberia clinic
- ❖ Created and disseminated messages about breastfeeding and infant feeding and their impact on the health of children
- ❖ Built capacity of MSGs in project communities expanding roles to include and provide nutrition information and growth monitoring.
- ❖ Trained MSGs on preparing weaning foods using locally available materials.
- ❖ Included iron supplement tablets in project's essential drug supply.
- ❖ Provided antihelmintic drugs to project clinics.
- ❖ Implemented breastfeeding and weaning food project with UNICEF funding that reached 12,091 mothers and caregivers in Monrovia through education sessions and weaning food demonstrations; implemented through performance-based sub-contract with local NGO partner BAG.
- ❖ In collaboration with Diompilor, developed twenty-nine (29) fifteen minute dramas, on breastfeeding and infant nutrition that aired on 11 radio stations in project counties

Objective 6: Improve care-seeking behavior and improve effective implementation of measures to treat and prevent diarrhea among under fives in project areas.

- ❖ Establish ORT corners at project clinics.
- ❖ Work with MSGs to train care givers to prepare and administer home made oral rehydration solution using locally available ingredients (coconut water, rice water, sugar and salt solution, or salt, orange and water) and to seek higher level care when needed.
- ❖ Implemented community-based performance workshops through a performance-based sub-contract with local NGO partner Flomo Theater

Productions, in 15 Monrovia communities, reaching an estimated 5000 persons with hygiene promotion messages.

Objective 7: Improve the quality of service delivery.

- ❖ Collected and assessed baseline information current patient care attitudes and practices at the community and health facility levels in target locales where security allowed.

Objective 8: Increase Liberian NGO/CBO capacity to participate in a defined range of quality primary health care and related services at the community and clinic levels

- ❖ Established NGO CBO subcontractor eligibility criteria
- ❖ Produced handbook for NGO CBO defining the performance based project proposal and contract instruments.
- ❖ Identified NGOs CBOs that meet the eligibility criteria.
- ❖ Conducted workshop to orient local NGO partners to the ICH project and the performance monitoring plan.
- ❖ Produced organizational survey tool.
- ❖ Assessed Organizational Capacity of all local partner NGOs.
- ❖ Prepared Scope of Work for consultant to coordinate REFLECT TOT workshop.
- ❖ Consultant for REFLECT TOT workshop recruited from ActionAid, Ghana and workshop conducted in Monrovia for trainers for ICH communities in Bong Nimba and Montserrado. Representatives from other USAID funded projects participated.
- ❖ REFLECT community sensitization conducted in Bong and Nimba counties and facilitators identified.
- ❖ REFLECT training of facilitators(TOF) conducted in Nimba County for 8 communities
- ❖ REFLECT TOF for 7communities in Bong in session.

Objective 9: Monitor /Report program progress and utilize findings to improve implementation.

- ❖ Developed baseline assessment tools and methods for collecting primary and secondary data.
- ❖ Conducted baseline surveys in Nimba, Bong and Montserrado.
- ❖ Completed baseline survey analysis
- ❖ Completed Performance monitoring Plan : baseline and targets

Objective 10: Improved policy framework for health care delivery in Liberia.

- ❖ During the first year of active project implementation which only started after project areas outside of Monrovia were declared safe, the project intends to address critical policy issues such as; Revolving Drug Fund/Fee for Service, Standardization of the Treatment Protocol for Endemic Diseases, Residual Spraying and the Use of Insecticide Treated Nets, the availability of ARVs for people living with HIV/AIDS, Training and Terms of Reference(TOR) for Community Health Workers(CHWs), the Availability of critical services to children under five and pregnant women, will be meticulously scrutinized, with the aim of identifying gaps and deficiencies to the delivery of an improved quality of PHC services

- ❖ As soon as the integrated curriculum for Reproductive Health Care is completed and approved, ICH will pursue the development of policies and protocol to guide the practice of the skills addressed in the training.

Objective 11: Increased availability of resources, including non-USAID resources for health sector development in Liberia.

- ❖ Collaboration with AmeriCares has yielded over \$5,000,000 in cash and kind donations. These include :
 - Essential drugs
 - Hospital and Clinic equipment
 - Semi-permanent structures to restore hospital and clinic facilities.
 - Warehouse and staff to receive and store AmeriCares donated goods.
- ❖ Collaboration with UNICEF has led to the implementation of two projects totaling over \$38,520.00:
 - A nutrition BCC project
 - A WATSAN BCC project.