Grand Cape Mount Child Survival Project
Improved Child Health in a Transitional State through IMNCI

Grand Cape Mount County, Liberia

October 2006 – September 2010

Annual Report – Year 3
October 1, 2008 to September 31, 2009

Child Survival and Health Grants Program (CSHGP)
Cooperative Agreement No. GHS-A-00-06-00019

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Annexes

Acronyms

CHAL	Christian Health Association of Liberia
CHC	Community health committee
CHDC	Community health development committee
CHDD	Community Health Department Director
CHO	County Health Officer
CHPs	Community health promoters
CHT	County Health Team
CSP	Child survival project
CSSA	Child Survival Sustainability Assessment
DHO	District Health Officer
FAM	Finance and Administration Manager
GCM	Grand cape mount
HHPs	Household health promoters
HMIS	Health Management Information System
IMCI	Integrated management of childhood illness
IMNCI	Integrated management of neonatal and childhood illness
IPTp	Intermittent Presumptive Treatment (of malaria) during pregnancy
JSI	John Snow International
LQAS	Lot quality assurance sampling
MoHSW	Ministry of Health and Social Welfare
RBHS	Rebuilding basic health services
USAID	United States Agency for International Development

Executive Summary: Medical Teams International has been operating the Grand Cape Mount Child Survival Project since October 2006. The project Goal is *"to reduce morbidity and mortality of children under five and improve the health of women of reproductive age within Grand Cape Mount County in Liberia."* The strategic objective is "improved health outcomes through appropriate household practices & use of quality health services within a supportive sustainable environment by 2011." The four intermediate objectives are as follows:

- Intermediate Result 1: Communities assume responsibility for their own health with strengthened community structures, linkages with health facility staff, and enhanced human resource capacity.
- Intermediate Result 2: Improved health behaviors and actions at the household level.
- Intermediate Result 3: Improved quality of care in health facilities through the implementation of Integrated Management of Neonatal and Childhood Illness (IMNCI) and capacity building in complementary areas.
- Intermediate Result 4: Strengthened institutional capacity of MTI and partners to implement effective Child Survival activities.

The project directly benefits 21,429 children under 5 and 29,941 women of reproductive age. Capacity-building components of the project indirectly benefit all 127,076 residents of the county.

In a post conflict situation, the project uses a two-pronged approach to improve the health status of women of reproductive age and children under 5 years of age: (a) The project contributes to the revitalization and roll-out of IMNCI training for health facility staff in Grand Cape Mount County and provides follow-up supervision and mentoring, and (b) MTI supports the local partner, Christian Health Association of Liberia (CHAL), to provide intensive community mobilization and health education for behavior change using the Care Group model of Household Health Promoters (HHPs). Community mobilization is based on the C-IMNCI framework, with no community-based treatment activities. HHPs are linked to local health facilities through a community referral system, when health services are needed for women of reproductive age and children under 5 years of age, to Community Health Committees (CHCs) at the community level and to Community Health and Development Committees (CHDCs) at the district/health facility level.

Achievements of the project during year 3 include the strong performance and stability of Care Groups, improvements in health and nutrition indicators, and capacity building of CHCs, CHDCs, and health facility staff. Factors that impeded progress were turnover of Child Survival Project, County Health Team (CHT) and health facility staff and inadequate involvement and ownership of the CHT in Child Survival activities.

In July of 2009, MTI was awarded a contract through the Rebuilding Basic Health Services (RBHS) grant funded by USAID and implemented through JSI. The project's aim is to support Liberia's goal, outlined in its National Health Policy and Plan, of increasing access to basic health services and strengthening the decentralized management of the health system. MTI will support the implementation of the national Basic Package of Health Services at 24 health facilities, including 20 health clinics and one health center in Grand Cape Mount County, two clinics in Bomi County and one health center in Montserrado County. The RBHS project offers opportunities to strengthen many activities implemented through the Grand Cape Mount Child Survival Project and continue support after September 2010.

A. Accomplishments of the Project

The project is continuing to make important contributions to the health of women and children in Grand Cape Mount County. Achievements during year 3 include the strong performance and stability of Care Groups, improvements in health and nutrition indicators, and capacity building of CHCs, CHDCs and health facility staff.

1. *Maturation of Care Groups*: During the transition from relief to development, the Care Group approach has proven an effective strategy for training, supervising, motivating, and retaining volunteers. MTI has worked to establish a sustainable volunteer network of HHPs that provides the support the volunteers need to do their job without making their responsibilities too burdensome. Support provided for the HHPs includes monthly training on health issues, monthly support visits from the Project Community Health Promoters (CHPs) and occasional in kind incentives such as hand soap and umbrellas. Another important source of support is the encouragement and assistance the HHPs receive from other HHPs. A group of volunteers working toward shared goals work together with greater commitment and mutual support than volunteers who work as individuals in their communities. As Care Group members review the program data together and see the impact of their work on the community, each sees that she has played an important role in the process. As a result of the intensive support provided, the retention rate for the HHPs is high with 507 of the 520 HHPs who began working in 2007 still presently providing services in their communities.

   During year 3 the HHPs made 49,830 home visits and facilitated 685 group education sessions to provide health information. They also made 2,046 referrals to health facilities for children with fever, cough, difficult breathing, diarrhea, seizure or signs of malnutrition. During year 3 their role expanded to making follow up visits for children taken to health facilities to reinforce with caretakers the need to follow the treatment prescribed at the health facility and return to the facility if needed.

   Interviews conducted with HHPs by Project staff and MTI's Child Survival Advisor during September 2009 indicated that the volunteers are especially interested in maternal care and infant and young child nutrition. During the interviews, the HHPs recalled accurate and consistent messages regarding responsive feeding practices and preparation of complementary foods with local ingredients such as rice or cassava flour, pounded fish, ground nuts or beni seeds and palm oil.

2. *Improvement in health and nutrition status and health practices*: The hard work of the Care Groups has succeeded in sustainably changing the behaviors of mothers and other community members leading to a decrease in malnutrition and improved care giving practices. Results for year 3 Project indicators are reported in Annex 1. Community health education efforts during the third year focused on infant and young child feeding, nutrition during pregnancy, antenatal care, correct usage of drugs prescribed at the health facility, and mitigating the harmful effects of black baggers.

   The year 3 Lot Quality Assurance Sampling (LQAS) survey showed that the percentage of children who are underweight decreased from 27.1% at baseline to 15.5%. Immediate breastfeeding improved from 33.7% in 2006 to 82% in 2009. The number of infants 6-9 month receiving breastmilk and complementary foods increased from 37.5% in 2006 to 72.16%.

Prevention and care seeking practices related to diarrhea also improved. The number of caregivers with a hand washing stand and reporting practicing appropriate hand washing improved from 19% at baseline and to 83% at the end of year 3. The number of children with diarrhea who were offered ORS or recommended home fluid increased from 74.2% at baseline to 97% at year 3. The number of children with diarrhea who were offered the same amount or more food improved from 18% at baseline to 54%.

3. *Building the Capacity of Community Health Committees and Community Health and Development Committees*: Support for CHCs during year 3 focused on strengthening their capacity to identify problems, plan and implement solutions and support household health promoters. Priorities for CHCs are establishing emergency transport systems and emergency health funds. To assess how effectively the committees were functioning and identify needs for capacity building, the Project facilitated a self-assessment with the CHCs in June 2009. The assessment was intended to measure progress the committees made in developing and implementing workplans, establishing emergency transport systems and emergency health funds, supporting HHPs and using Care Group data for planning.

   The self–assessment revealed that 123 of the 132 CHCs committees have established workplans with 45% reporting they are on track with implementing their workplans and 55% reporting they have made at least some progress. Seventy three committees (56%) discuss and use Care Group data for planning. None of the committees reported using Care Group data at midterm.

   One hundred (76%) of the committees have established emergency transport systems which are working well. To ensure emergency transport the committees have procured or designated a stretcher or hammock and keep it located in a designated household.

   Ninety three of the committees have established an emergency health fund with 59 (45%) reporting the fund is functioning effectively. The funds are established by collecting a contribution from each family in the community and managed by a designated member of the CHC. While substantial work still needs to be done to reach the Project target of 60% of CHCs having functioning emergency health funds, this is an impressive improvement over 13% at midterm.

   Substantial work also needs to be done to build the CHCs' capacity to support HHPs. Only 50 (38%) of the committees report providing material support or recognition to HHPs, with 13% actively doing so. To support the HHPs, some CHCs have mobilized community members to assist HHPs with planting their rice plots and gardens and, in some instances; community members have provided HHPs with rations of rice for their families. CHCs also publically acknowledge the work of the HHPs, help HHPs solve problems they encounter, and reinforce health messages promoted by the Project.

   In January 2009, MTI assisted the CHT to establish and train new CHDCs at five health facilities. Presently, 23 of the 30 health facilities in the county have CHDCs. The CHT plans to establish committees at the seven remaining health facilities during year 4 after hiring district health officers (DHO) for each facility coverage area. The DHO is a new CHT staff position to support decentralization of health services at the health facility and CHDC level.

   The CHDCs are functioning moderately more effectively than reported at midterm. Thirty three percent of the CHDCs report using health management information system (HMIS) data for

planning, while none had reported doing so at midterm. The CHDC self-assessment revealed that 62% of CHDCs have established workplans, with 14.3% reporting they are on track with implementation of the activities.

4. *Strengthening Services at Health Facilities*: During year 3, the Project facilitated a third round of health worker training in IMNCI during which 8 health facility staff and 5 Child Survival Project staff were trained. During monitoring and support visits 32 health facility support staff were provided with an orientation to the components of IMNCI relevant to their roles.

   The MTI IMNCI Coordinator and IMNCI Mentor use a Quality Improvement Verification Checklist for monitoring and feedback during IMNCI follow-up visits. Reports from quarterly monitoring visits indicate that 60% of facilities are offering growth monitoring, an improvement over 44% at midterm. The numbers of clinical encounters in which all assessment tasks are made by the health worker for sick children improved from 28% at midterm to 53% and the number of health facilities using HMIS for decision making improved from 44% at midterm to 63%. Eighty percent of health facilities received an external supervision visit during the past three months.

5. *Capacity Building for Child Survival Project Staff*: During year 3 the Community Outreach Coordinator visited World Relief Mozambique to bring back lessons learned from their experience with Care Groups. Project staff were provided with training in supportive supervision, conflict prevention and a refresher training in social and behavior change.

   The CHAL Community Outreach Coordinator benefited from a **cross visit to World Relief – Mozambique** to learn from their approach to implementing Care Groups. She shared with the Project team World Relief's strategy for sustainability and strategies for community support for Care Groups. The lesson which primarily impressed the team is that the most important motivation for volunteers is personal development through an opportunity for training and learning new skills.

   A consultant trained by Engenderhealth provided a six day training of trainers in **Facilitative Supervision for Quality Improvement** for Child Survival Project coordinators and supervisors, MTI Liberia's Primary Health Care Program and Finance and Administration Managers and a representative from the CHT. The training covered modules on leadership, communication, team building, coaching and mentoring and provided opportunities to practice these skills during practice supervisory visits to two health facilities. Following the training of trainers, the team adapted and cascaded the facilitative supervision training for 19 CHPs and the new IMNCI Mentor.

   Since July 2009, both clinical IMNCI and C-IMNCI staff have adopted facilitative supervision skills during supervision and support visits to health facilities, HHPs and CHCs. They found the skills of participatory problem identification, joint action planning and providing constructive feedback have made their jobs easier and more pleasant for both the supervisor and supervisee. Health facility staff have reported they appreciate the more structured and constructive approach to providing support.

   During September 2009, the Director of the Resource Center for Community Empowerment provided a three-day training in **conflict prevention and mitigation** for Project CHPs, supervisors and coordinators. The training focused on types, sources and effects of conflict and

violence and techniques for preventing and mitigating conflict. During the first quarter of year 4, the CHPs and supervisors will cascade this training for HHPs, CHCs, and CHDCs to enable them to resolve conflicts that arise within households, between households and community volunteers, and conflicts in the community at large.

MTI's HQ Child Survival Advisor provided refresher training in concepts of **social and behavior change** for Child Survival Project coordinators and supervisors, and two representatives from the CHT. During the training the team reviewed and revised the Project's social and behavior change strategy and community education plan.

B. Activity Status

The project is essentially on track with the workplan at the end of Year 3. A Workplan Activity Status Table is included as Annex 2.

All activities relating to Intermediate Result 1: *Communities assume responsibility for their own health with strengthened community structures, linkages with Health Facility staff, and enhanced human resource capacity* have been completed or are on target except for CHCs developing economic plans for health emergencies.

All activities related to Intermediate Result 2: *Improved health behaviors and actions at the household level* are on target.

For Intermediate Result 3: *Improved quality of care in health facilities through the implementation of IMNCI and capacity building in complementary areas*, joint supervision visits are not on target but individual supervision and monitoring is regularly provided by Project staff. Three health facilities need to improve their ORT corners. Only 23 of 30 health facilities have functioning CHDCs. MTI has offered assistance to the CHT to establish CHDCs at the remaining 7 facilities. The CHT plans to do so during year 4 after hiring DHOs for each health facility coverage area.

One activity for Intermediate Result 4: *Strengthened institutional capacity of MTI and partners to implement effective Child Survival activities* is pending. The capacity building Plan for year 3 included training for MTI & CHAL and CHT staff in Facilitative Supervision for Quality Improvement, conflict prevention and, for MTI and CHAL staff, supply chain management training. Facilitative supervision training was provided in July 2009 and training on conflict prevention in September 2009. Supply Chain Management training is planned for November 2009.

The workplan for year 4 is attached as Annex 3. Year 4 activities will focus on developing the capacity of CHCs and CHDCs, handing over support for HHPs to the CHCs, coordinating with and handing over support for health facilities to the RBHS project, and the Project final evaluation.

C. Factors Which Have Impeded Progress toward Achievement

Constraints which impeded progress during year 3 were turnover of Child Survival Project, CHT and health facility staff and inadequate involvement and ownership of the CHT in Child Survival activities.

1. *Turnover of Child Survival Project staff:* Discussed in section J.

2. *County health team and health facility staff turnover:* The CHT experienced turnover during year 3 as the County Health Officer (CHO) and Community Health and Department Director (CHDD)

both transitioned out of the Grand Cape Mount CHT. An interim CHO was appointed by the Ministry of Health and Social Welfare (MoHSW) and in July 2009 a permanent CHO assumed duties in the county.

There has been high staff turnover at the health facility level as well. Out of 56 health workers trained in IMNCI by the Project over the past 3 years, only 33 of them are presently providing services. Training for 20 additional staff is planned for January 2010.

3. *Inadequate involvement and ownership of the CHT in Child Survival Project activities:* Collaboration with the CHT has been problematic. Quarterly coordination meetings continue to be held but, in general, the CHT has not followed through on actions agreed upon during the meetings. Participation in joint supervision of health facilities has also been low. MTI's recent award by JSI of the Rebuilding Basic Health Services Project (RBHS) in Grand Cape Mount provides budget for capacity building and logical support and is expected to strengthen CHT ownership for management of health facilities. Between July and September 2009, the CHT Clinical Supervisor and MTI IMNCI staff made three joint supervision trips.

D. Progress Made toward Addressing Midterm Evaluation Recommendations

Progress made toward addressing midterm evaluation recommendations is reported in Annex 4.

E. Technical Assistance Required

Technical support will be provided during year 4 to support MTI Liberia's financial systems, plan and implement phase-down of Project activities, and conduct the final evaluation.

1. *Monitoring and Evaluation*: MTI's Monitoring and Evaluation Specialist will travel to Liberia during October 2009 to assess implementation of the HMIS at the facility and county levels, identify training needs for health facility and CHT staff, and provide training needed. He will also provide training in EPI Info for the Child Survival Project Manager and Monitoring and Evaluation Coordinator.

2. *Technical support for finance systems*: MTI HQ's Director of Finance will travel to Liberia during the first quarter of year 4 to audit MTI Liberia's financial records and provide training for the new Finance and Administration Manager (FAM).

3. *Technical support for phase-down*: Support from the MTI HQ Africa Regional Program Manager and Child Survival Advisor will be provided to support phase-down of activities, coordination of Child Survival activities with the RBHS project and provide feedback for the exit strategy.

4. *Final Evaluation*: For the final program evaluation, an external consultant will be contracted to objectively assess the program's outcomes, impact and lessons learned. MTI HQ M and E Specialist will travel to Liberia to assist the team to carry out the KPC survey and Health Facility Assessment and analyze the data collected. The MTI Child Survival Advisor will participate as an evaluation team member.

F. Substantial Changes in the Program Description from the DIP

There will be a need for a budget realignment due to both over and under-expenditures of some line items due to actual costs incurred and program adjustments. MTI will submit a formal request for a budget re-alignment before December 30, 2009.

G. Progress Made toward Sustainability Plan

The project used the CSTS+ Child Survival Sustainability Assessment (CSSA) tool during the DIP process, holding a one-day Sustainability Workshop to complete Steps 1 through 3 of the CSSA process (1. Define the system, its actors and its vision; 2. Define goals and shared vision, challenges and strategies to overcome; and 3. Identify elements of each dimension, responsibilities and indicators). As planned, Step 4 (to measure and map indicators) was completed in September 2008 at midterm and during 2009 at end of year 3 as presented below.

The vision developed by the project and partners is: *Viable, knowledgeable communities in control of their own health outcomes through positive behaviors which overcome barriers, and strong interconnected community structures in collaboration, and through linkages with high quality health (and other sector) structures within a decentralized, empowered and interconnected system.*

Dimension I: Health outcomes and services

Goal: To provide health & social services that will support the implementation of interventions to improve health indicators within communities in Grand Cape Mount County.			
Indicator	**Targets at final**	**Progress as of September 2008**	**Progress as of September 2009**
Ia. Improvement in indicators for health behaviors at community level and at health facility level	See M and E table, Annex 1	See M and E table, Annex 1	See M and E table, Annex 1
Ib. % of communities using a HMIS for decision making	40% of communities using a HMIS for decision making	0 CHCs using HMIS for decision making	56% CHCs discuss Care Group data and use for it planning

Dimension II: Organizational capacity and viability

Goal: To promote high quality care services in Grand Cape Mount County through collaboration /cooperation between the CHT and local NGOs with the involvement of local structures & sectors.			
Indicator	**Targets at final**	**Progress as of September 2008**	**Progress as of September 2009**
IIa. % of organizations using the HMIS to make decisions	75% Health facilities and CHDCs using HMIS for decision making	44% health facilities using HMIS for decision making 0% CHDCs using HMIS for decision making	63.3% health facilities using HMIS for decision making 33% CHDCs using HMIS for decision making
IIb. % of community structures and health facilities coordinating and implementing activities	50% of health facilities meet accreditation standards for the BPHS by December 2008 and 70%	The pre-accreditation assessment of 15 Grand Cape Mount health facilities in June 2008	An accreditation assessment of all 32 Grand Cape Mount health facilities in

based on an approved Standard Health Plan	by the December 2009.	resulted in an average score of 75%.	January 2009 resulted in an average score of 65%. The accreditation assessment of 12 priority health facilities in September 2009 resulted in an average score of 80%

Dimension III: Community competence and political environment.

Goal: Provide an improved, empowered community with the support of local, administrative & national leadership to develop appropriate policies that will sustain political, social & economic community-based programs for the people of GCM County.			
Indicator	**Targets at final**	**Progress as of September 2008**	**Progress as of September 2009**
IIIa. # of CHP and HHPs providing homes visits and referrals	At least 266 HHPs (51%, ~2 per each of 132 communities) providing home visits and referrals.	20 CHPs, 520 HHPs providing home visits and referrals	20 CHPs and 507 HHPs providing home visits and referrals
IIIb. # of communities with CHCs and health facilities with CHDC who have met in last 3 months.	132 communities have CHCs who have met within the past 3 months At least 24 (80% of 30) health facilities have CHDCs who have met in the last 3 months	126/132 (95.5%) of communities have CHCs who have met within the past 3 months 16 of 30 (53%) health facilities have CHDCs who have met in the last 3 months	98/132 (74%) of communities have CHCs who have met within the past 3 months 15 of 30 (50%) health facilities have CHDCs who have met in the last 3 months

To establish an exit strategy, the Project will hold CHDC/community level conferences in December 2009 to involve health facility staff, HHPs, CHPs, and representatives from CHCs in assessing the sustainably of project activities and steps that need to be taken during year 4 to ensure continuation of activities after September 2010. Project partners will meet in January 2010 to discuss outcomes from CHDC/Community conferences and formalize the exit strategy.

H. Information Requested from Review of Midterm Evaluation

1. Interaction with MOHSW on the roll-out of IMNCI in adjacent counties: Presented as a results highlight in Annex 5.

2. Impact of phasing out MTI-supported drug supplies and health worker incentives: MTI supported 5 clinics from July 2007 to March 2009, providing incentives for health facility staff, logistic support, essential drugs and supplies. The 5 health facilities were handed over to the CHT in March 2009 according to a mutually agreed upon plan. MTI continued to assess the situation for critical gaps between March and June 2009 and found that health facility staff were not paid regularly and there were frequent stock outs of essential drugs. There were also frequent shortages of vaccines and limited logistical support for outreach services. In July MTI

resumed supporting these facilities through the RBHS project and has been working with the CHT to address these issues.

3. Updated population figures: Below are the updated population figures based on the 2008 national census.

	2006	2008
Infants < 12 months:	5,085	3,920
Children 12-23 months:	4,576	3,026
Children 0-23 months:	9,661	6,946
Children 24-59 months:	11,950	14,483
Women 15-49 years:	21,611	29,941
Children 0-59 Months Women 15-49 years:	52,883	58,316
Population of Target Area:	127,124	127,076

I. Expectations for Progress toward Phase Out (Included under Section F Plan for Sustainability)

J. Project Management System

The project continues to be effectively managed by MTI Liberia with support from technical and regional management teams at MTI headquarters. Backstopping in areas of behavior change, monitoring and evaluation and general capacity building is provided by HQ through monthly telephone coordination meetings and weekly email exchanges. The Africa Program Manager and MTI Vice President for Finance provide oversight for managerial and financial operations of the project at HQ. Monthly project reports are submitted on time by field staff and receive feedback from relevant parties at HQ. Challenges to project management are discussed below.

1. *Financial Management System*: Financial oversight of the CSP project remains strong. The MTI Vice President for Finance conducted an internal audit in March 2008 and another audit will take place in December 2009. At MTI HQ, financial records were audited in July 2009, including a single audit as required by Jones & Roth, CPAs, and received an unqualified opinion.

   MTI Liberia hired an experienced FAM in November 2008. The new FAM has assumed full duties from the Country Director who filled the vacancy when the former MTI Liberia FAM resigned in March 2008 to attend graduate school. Accounting and administrative procedures continue to be strengthened under the leadership of the new FAM with all MTI Liberia and CHAL staff fully trained and adhering to appropriate accounting policies and procedures. Weaknesses previously identified have been improved in areas of petty cash management, cash and travel advance reconciliations, personnel documentation, use of time sheets and monthly review of reports at the program manager level.

2. Human Resources: Currently all MTI Liberia Child Survival Project positions are filled. However, during the past year the Project faced significant human resource challenges with the

turnover of key project personnel. In August 2008, the Child Survival Project Manager resigned his post to assume the position of Director for Family Health Division at the national Ministry of Health. The Project IMNCI Coordinator functioned in a dual role in the interim, serving as the acting project manager, with support from the Country Director, from August 2008 until April 2009 when a new project manager was hired. The Project IMNCI Coordinator and Monitoring and Evaluation Coordinator both resigned in April 2009. The IMNCI Coordinator accepted a job with USAID funded and JSI managed Rebuilding Basic Health Services Project as County Coordinator for Grand Cape Mount County and the Monitoring and Evaluation Coordinator accepted a position within the monitoring and evaluation unit of the Global Fund Program at the Ministry of Health.

In spite of these setbacks, the Project has filled these three positions with equally qualified people. The new Project Manager comes to MTI after 3 years as Health Coordinator for Goal Ethiopia's programs in the Sidama, district. As health coordinator he was responsible for managing Goal's Child Survival Project. He brings strong management and monitoring and evaluation skills.

The Child Survival Project implementing partner, CHAL, faced a similar challenge of key personnel turnover. The Community Outreach Coordinator (COC) resigned in May 2009 for family reasons. It was decided to shift oversight of the position to MTI to provide better management and supervision support for the CHP team. A strong candidate has been identified and MTI hopes to make a job offer by mid-November.

3. Communications: A challenge to effective communication continues to be the lack of internet access in Grand Cape Mount. Limited access to e-mail for Project staff while in Sinje delays communication with headquarters. Cell phone coverage remains fairly reliable and is used to bridge communications between MTI HQ, MTI field, CHAL, and CHT staff in the field. MTI is looking into a grant opportunity with a Seattle-based private foundation to provide infrastructure that will support better communication. If MTI is able to secure the grant, it will provide V-SAT equipment for both Monrovia and Sinje offices and cover one year of service fees. This will greatly enhance communications for the Project and MTI as an organization.

4. Local partner relationship: Project partners meet quarterly to discuss project implementation, achievements and problems. Challenges in the Project's relationship with the CHT are discussed in section C. Over the last three years, MTI and CHAL Project staff have formed a strong team. Sharing a field office has contributed to effective communication, planning and collaboration. CHAL and MTI Project staff meet monthly to review workplans and discuss challenges.

   At the management level, however, recent downsizing of CHAL personnel has created a gap in management support. The MTI Country Director and especially the Child Survival Project Manager have worked to fill these gaps by providing technical backstopping and supervision support for CHAL staff.

5. PVO Collaboration in-country: MTI regularly participates in county level health coordination meetings facilitated by the CHT. During year 3 MTI also provided health information and support with transportation during several health campaigns including measles and polio immunization outreach, de-worming, and vitamin A distribution.

At the national level, MTI sits on several task forces including the MoHSW IMNCI strategy group, the Malaria Steering Committee, and Reproductive Health Committee. MTI was one of three agencies that represented Liberia at this year's annual Global Fund mock Technical Review Panel in Kenya.

6. Vehicles: Four vehicles and six motorcycles facilitated travel to and from Project communities. Due to increased maintenance costs, MTI retired two vehicles funded under another grant, thus reducing the MTI fleet to two vehicles (one Child Survival Project vehicle funded by MTI and one MTI vehicle designated for the Project). Project staff have managed this gap by tightly coordinating project activities in conjunction with good fleet management.

K. Local Partner Organization Collaboration and Capacity Building

Partners meetings took place in November 2008 and January, April and August of 2009. During the meetings, midterm evaluation findings and recommendations and CHC and CHDCs self-assessment findings were discussed. An action plan was developed to address gaps in meeting the evaluation recommendations and capacity building needs identified in the CHC and CHDC self assessments.

The capacity building Plan for year 3 included training for MTI & CHAL and CHT staff in facilitative supervision, conflict prevention and, for MTI and CHAL staff, supply chain management training. Facilitative supervision training was provided in July 2009 and training on conflict prevention in September 2009. Supply Chain Management training is planned for November 2009. An update to the project technical assistance plan is included as Annex 6.

L. Mission Collaboration

Collaboration between the USAID Liberia mission and MTI remains strong. USAID Liberia's priorities in health programming focus on supporting public and nongovernmental organizations to deliver a basic package of essential health services to underserved areas of the country with a specific focus on family planning, reproductive health, malaria, HIV/AIDS, poor sanitation and hygiene, and lack of safe birthing services. MTI supports these efforts through both the Grand Cape Mount Child Survival Project and the recently awarded Rebuilding Basic Health Services program administered by John Snow International.

Liberia is a focus country for the President's Malaria Initiative. This Child Survival project complements the large-scale efforts of the President's Malaria Initiative in Liberia through promotion of behavior change and appropriate care practices at the community level and strengthening health facility staff use of IMNCI protocols for malaria diagnosis and treatment.

Annex 1: Monitoring and Evaluation Table
Medical Teams International in Liberia
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	Intermediate Result 1: Communities assume responsibility for their own health with strengthened community structures, linkages with Health Facility staff, and enhanced human resource capacity					
Indicator	**Method**	**BL**	**MTE Result**	**Year 3 Result**	**Status at Year 3**	**Final Target**
% of HHPs referring patients to clinic.	Care Group monthly reports	0%	100%	**100%**	**Target exceeded.** 507 HHPs referred 2,046 sick children to a health facilitiy during year 3.	75%
% of HHPs who received a supervisory visit during the last three months	CHP monthly reports	0%	100%	**100%**	**Target exceeded.** All HHPs receive regular supervision visits by project staff, with use of a QIVC form for feedback.	75%
% of communities using information from community HIS for decision making	Community Profile and CHC self-assessment	0%	0%	**56.2%**	**Exceeded.** The July CHC self-assessment found that 56.2% of CHCs discuss Care Group data and use it for planning	40%
% of CHCs (changed from CHDCs as formation done by CHT without MTI participation) with one or more women participating on the committee.	CHT information	0%	75%	**75%**	**Target exceeded.** Supervision areas 1 and 2 report an average of 1 female among the 5 members on each CHC, area 3 reports an average of 2 females, while area 4 reports no female CHC members.	65%
% of health facilities with active CHDCs who have met in the last three months.	Community Profile	0%	53%	50%	**Not yet met**. According to the CHDC self-assessment, 50% of health facilities have CHDCs which have met within the past three months.	80%
% of communities with an economic plan for emergency health needs.	Community Profile and CHC self-assessment	0%	13%	**45%**	**Target not yet met.** The CHC self-assessment during year 3 showed that 70% of the CHCs have an emergency health fund system in place with 45% reporting the system is working effectively.	60%
% of communities with an emergency transport plan.	Community Profile and CHC self-assessment	0%	16%	**76%**	**Target exceeded.** The CHC self assessment during year 3 showed that 76% of CHCs have effective emergency transport system in place.	65%

	Intermediate Result 2: Improved health behaviors and actions at the household level.						
Indicator	**Method**	**Baseline**	**Year 3 target**	**MTE Result**	**Year 3 result**	**Status at Year 3**	**Final Target**
% of newborns who were put to the breast within one hour of delivery and did not receive pre-lacteal feeds	KPC Survey: BL,FE LQAS: MTE	33.7% (28.3-39.3)	42%	51.0% (41.0-61.0)	**81.82%**	**Exceeded**	60%
% of infants 6-9 months receiving breast milk and complementary foods	KPC Survey: BL,FE LQAS: MTE	37.5% (22.7-54.2)	51%	40.6% (30.8-50.5)	**72.16%**	**Exceeded**	65%
% of children 0-23 months who are underweight (<-2 SD weight-for-age WHO/NCHS reference standards).	KPC Survey: BL,FE LQAS: MTE	27.1% (22.1-32.6)	22%	20.8% (12.7-28.9)	**15.63%**	**Exceeded**	17%
% of children 6-23 months who received a dose of Vitamin A in the last six months (Mother's recall).	KPC Survey: BL,FE LQAS: MTE	76% (67.8-83.3)	81%	85.4%	**91.67%**	**Exceeded**	85%
% of children 12-23 months who received DPT3 before they reached 12 months by the time of the interview as recalled by the mother or card verified.	KPC Survey: BL,FE LQAS: MTE	31% (22.2-40.1)	41%	60.4%	**73.47%**	**Exceeded**	65%
% of children aged 12-23 months who are fully vaccinated by 12 months of age.	KPC Survey: BL,FE LQAS: MTE	18.9% (12.1-27.5)	30%	39.5% (29.8-49.4)	**44.90%**	**Exceeded**	55%
% of mothers with children age 0-23 months who were protected against Tetanus (at least 2 TT) before the birth of the youngest child.	KPC Survey: BL,FE LQAS: MTE	61.3% (55.6-66.9)	71%	66.7% (57.2-76.1)	**70.71%**	**Met**	80%
% children 0-23 months with diarrhea in last 2 weeks who received ORS and/or recommended home fluids.	KPC Survey: BL,FE LQAS: MTE	74.2% (63.8-82.9)	80%	79.2% (71.2-88.7)	**96.88%**	**Exceeded**	85%
% of children 0-23 months with diarrhea in the last two weeks who were offered more fluids during the illness	KPC Survey: BL,FE LQAS: MTE	52% (40.8-62.4)	61%	64.5%	**69.79%**	**Exceeded**	70%
% of children 0-23 months with diarrhea in the last two weeks who were offered the same amount or more food during the illness	KPC Survey: BL,FE LQAS: MTE	18%	n/a	n/a	**54.17%**	**n/a**	n/a
% of households of children 0-23 months that treat water effectively.	KPC Survey: BL,FE LQAS: MTE	22% (17.1-26.8)	31%	7.3%	**25.25%**	**Not yet met**	40%
% mothers of children 0-23 months who live in house-holds with soap or ash at the place for hand washing and washed their hands with soap or ash at least two of the appropriate times during a 24 hour recall period.	KPC Survey: BL,FE LQAS: MTE	19.0% (14.7-23.9)	30%	43.7% (33.8-53.7)	**82.83%**	**Exceeded**	70%
% of children age 0-23 months with chest-related cough and fast/difficult breathing in the last two weeks who were taken to an appropriate health provider.	KPC Survey: BL,FE LQAS: MTE	43.2% (35.3-51.4)	54%	83.3% (75.9-90.8)	**81.25%**	**Exceeded**	85%

% of children 0-23 months who slept under an insecticide-treated bed net the previous night.	KPC Survey: BL,FE LQAS: MTE	17.7% (13.5-22.5)	27%	67.7% (58.4-77.1)	**66.67%**	**Exceeded**	70%
% of children 0-23 months with a febrile episode that ended during the last 2 weeks who were treated with an effective anti-malarial within 24 hrs after fever began.	KPC Survey: BL,FE LQAS: MTE	12.5% (5.9-17.7)	32%	49.0% (39.0-59.0)	**53.13%**	**Exceeded**	50% New target: 65%

Intermediate Result 3: Improved quality of care in health facilities through the implementation of IMCI and capacity building in complementary areas.						
Indicator	**Method**	**BL**	**MTE Result**	**Year 3 Result**	**Status at Year 3**	**Final Target**
% of health facilities that offer growth monitoring (at least 30 days per month	R-HSPA BL & FE	0%	44%	**60%**	**Improved.** 18 out of 30 health facilities offer growth monitoring	85%
% of health facilities clinical encounters in which all assessment tasks are made by the HW for sick child (check ability to drink or breastfeed, vomits everything, convulsions, presence of cough or fast/difficult breathing, diarrhea, fever, assess nutritional status, feeding practices, check vaccination status)	R-HSPA BL & FE	9%	28%	**53.3%**	**Improved.**	85%
% of health facilities clinical encounters in which treatment is appropriate to diagnosis for malaria, pneumonia and diarrhea. (Record review)	R-HSPA BL & FE	46%	89%	**76.6%**	**Target not met.** 23 out of 30 health facilities that were assessed made appropriate treatment to diagnosis.	85%
% of health facilities clinical encounters in which the caretaker whose child was prescribed antibiotic, anti-malarial or ORS can correctly describe how to administer all prescribed drugs	R-HSPA BL & FE	49%	34%	Information will be collected through the HFA during the final evaluation in September 2010	**No improvement.** This is the weakest area of IMCI at MTE. Project will add activities to promote knowledge of rational drug use with training for health facility staff and HHPs for follow-up in the community.	75%
% of health facilities that received external supervision at least once in the last THREE months (two or more of: deliver supplies, check records/reports, observe work, provide feedback)	R-HSPA BL & FE	5%	56%	**80%**	**Exceeded.** 24 clinics out of 30 were supervised by CSP team and/or RBHS team. Three of the supervision visits were joint monitoring with the CHT Clinical Supervisor.	75%

% of health facilities utilizing information from the HMIS for decision making	R-HSPA BL & FE	NA	44%	**63.3%**	**Improved.** 19 out of 30 health facilities use HMIS for decision making.	75%

Intermediate Result 4: Strengthened institutional capacity of MTI and partners to implement effective CS activities.						
Indicator	**Method**	**BL**	**MTE Result**	**Year 3 Result**	**Status at Year 3**	**Final Target**
% of organizations with a functional financial management system	IA BL & FE	33%	n/a	n/a	Indicator dropped as not relevant. Partners have functional systems.	n/a
% organizations (CDHCs) using information from HMIS for decision making	IA BL & FE	0%	0%	33.3%	There are 23 functional CHDCs and a third of them discuses health facility and Care Group data and use it for planning	100%
% of organizations and health facilities meeting approved Standard Health Plan.	CHT report	0%	The pre-accreditation assessment of 15 Grand Cape Mount health facilities in June 2008 resulted in an average score of 75%.	An accreditation assessment of all 32 Grand Cape Mount health facilities in January 2009 resulted in an average score of 65%. The accreditation assessment of 12 priority health facilities in September 2009 resulted in an average score of 80%	Improved. Support to attain accreditation will continue to be provided through the RBHS project.	50%
% of indicators for capacity building are achieved	IA BL & FE	0%	Action taken to improve 36% of indicators for all 3 partner: MTI Liberia, CHAL, and GCM CHT.	The Organizational Capacity Survey will be updated for each partner during the project final evaluation.	All key systems are in place with finalization of an emergency preparedness plan as a priority for MTI. Strengthening of logistics in Y4 is a priority for MTI Liberia and CHAL.	80%
Use of CSSA is institutionalized (annual reviews are being conducted)	Annual Report	No	Review at midterm conducted.	CSSA updated at end of year 3.	Midterm review by MTI and partners refined the CSSA plan prepared during DIP and established baseline values. The CSSA was updated at end of year 3.	Yes

Lessons learned and best practices are disseminated utilizing at least three different media (program manual, presentations, conferences, web site, articles, etc.)	Final Evaluation	No	In process.	In process	Internal presentations of midterm evaluation results and discussions of lessons learned were held at MTI headquarters and field offices. Lessons learned from the Liberia Child Survival Project are disseminated and used in MTI community health programs in Africa and Asia. Project staff shared experience and lessons learned during workshops to develop the national Child Survival Strategy and training manual for Community Health Volunteers. The Project Manager co-facilitated training on IMNCI supervision for nurses and physicians assistants from Bomi, Gbarpolu, Montserrado, Margibi and Rivercess counties.	Yes
% of annual national budget dedicated to health.	Final Evaluation	n/a	n/a	n/a	This indicator has been dropped as the project has limited ability to influence and measure influence of this indicator.	n/a

Annex 2: Work Plan Activity Status Table Years 1 - 3
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IR 1: Communities assume responsibility for their own health with strengthened community structures, linkages with Health Facility staff, and enhanced human resource capacity		
Related Key Activities	**Status of Activities (Completed, On target, Not yet on target)**	**Comments**
C-IMCI curriculum developed and appropriately implemented	On target	Curriculum development completed during 1st year of the project. It has been appropriately implemented since then.
Supervisors and CHPs trained in behavior change, community mobilization and C-IMCI	Completed	Project Coordinators, Supervisors and CHPs provided with training in C-IMCI and behavior change during year 1 with refresher training during year 3. Training on community mobilization was provided during year 2.
Community based referral system established and functioning	On target	507 HHPs have actively been providing referrals to health facilities. During year 3 2,046 sick children were referred to nearest health facilities due to fever, cough and difficult breathing, diarrheal episodes, seizure and signs of malnutrition.
Supportive supervision system established and functioning	On target	Project Manager, Coordinators and Supervisors provided with training in Engenderhealth Facilitative Supervision methodology during year 3. Project Manager, Coordinators and Supervisors use QIVCs during training and supervision visits to provide feedback to supervisors, CHPs, HHPs, and health facility staff
Community HMIS functioning	On target	HMIS functioning and data provided to Child Survival Project, CHT and communities.
CHCs develop economic plans for emergency health care	Not yet on target	70% of the CHCs have emergency health fund system in place with 45% reporting they are working effectively.
CHCs develop emergency transport plan	On target	76 % of the CHCs have effective emergency transport system in place.

IR 2: Improved health behaviors and actions at the household level		
Activities	**Status of Activities (Completed, On target, Not yet on target)**	**Comments**
CHPs and HHPs use traditional communication channels and radio to disseminate health messages	On target	Traditional ways of learning (song, story telling, drama, case studies) integrated into C-IMCI curriculum and CHPs and HHPs are using traditional communication channels in education sessions.

IR 2: Improved health behaviors and actions at the household level		
Activities	**Status of Activities (Completed, On target, Not yet on target)**	**Comments**
		Midterm evaluation consultant advised against developing radio spots as these can be costly or ineffective in remote rural areas.
Behavior change messages disseminated in communities and health facilities	On target	HHPs made 49,830 home visits during year 3 to provide health education and referrals for families with children U5. They also conducted 685 group sessions for women in the community to involve older women who are influential for behavior change.
	On target	Health messages are disseminated during Friday prayers by Muslim religious leaders and during Christian church services on Sundays.
	On target	Counseling and health education provided at health facilities
	On target	Political and traditional leaders involved through CHDC activities.
Network of Care Groups functioning	On target	A network of 132 Care Groups with 507 Household Health Promoters (HHPs) covers 132 communities.
System for monitoring behavior change functioning	On target	KPC survey at baseline and LQAS during years 2 and 3 conducted
	On target	Community Profile established at baseline and updated at midterm
	On target	Supervision checklist used to monitor behaviors at HHP, CHP and health facility levels.
	On target	R-HFSA used to evaluate behaviors at health facilities at baseline and MTE.
Strategy developed for mitigating harmful effects of black baggers.	On target	During September 2009, the Project provided training for CHCs on mitigating harmful effects of black baggers. During the first quarter of year 4, the CHCs will cascade this training to their communities.

IR 3: Improved quality of care in health facilities through the implementation of IMCI and capacity building in complementary areas.		
Activities	**Status of Activities (Completed, On target, Not yet on target)**	**Comments**
Tools for monitoring implementation of clinical IMCI developed and utilized	On target	The Project uses a checklist adapted from the WHO Supervisory Checklist for Monitoring /Supervision of IMCI Activities.

IR 3: Improved quality of care in health facilities through the implementation of IMCI and capacity building in complementary areas.		
Activities	**Status of Activities (Completed, On target, Not yet on target)**	**Comments**
CSP and health facility staff trained in IMCI	On target	56 Physician assistants, registered and licensed practical nurses and certified midwives and 5 CSP staff members trained in IMCI and 132 health facility support staff provided with orientation to the components of IMCI relevant to their roles.
IMCI services provided at 25 clinics and 1 health center.	On target	IMCI services provided at 25 health facilities and one health center.
Health facility staff are provided with monitoring and mentoring	On target	Monitoring and mentoring visits provided at 26 facilities every 2 -3 months.
GIK supplied to health facility as needed	On target	From July 2007 to March 2009, MTI regularly supplied the 5 MTI-supported clinics with essential IMCI drugs (except for TB or malaria, which are supplied by the MOHSW) and medical supplies. From September 2008 to June 2009 GIK MTI provided one shipment of GIK medical supplies included gloves, syringes, needles, maternity pads, and sutures. Drugs or supplies not available in Liberia were purchased through the National Drug Service. Since July 2009, MTI has been providing essential drugs to 21 health facilities in GCM through the RBHS project.
ORT corners established and functioning in each facility trained in IMCI	Not yet on target	23 of 26 health facilities that implement IMNCI have ORT corners established and functioning.
Field Supervisors provided with training in principles of supportive supervision	Completed	All the Child Survival project staff were provided with training in Facilitative Supervision for Quality Improvement during the third quarter of year 3.
Joint monitoring visits conducted at health facilities and communities involving partners(CHT Supervisors, IMCI Mentor & Coordinator, M&E Coordinators and CHAL Supervisors)	Not yet on target	The CHT clinical supervisor was invited on several occasions to participate in joint supervision visits but has participated only three times. This issue has been raised with the new CHO.
32 CHDCs revitalized and supporting clinic management	Not yet on target	23 CHDCs have been established. The County Health Team plans to establish CHDCs at the remaining 7 facilities with MTI's assistance during year 4.

IR 3: Improved quality of care in health facilities through the implementation of IMCI and capacity building in complementary areas.		
Activities	**Status of Activities (Completed, On target, Not yet on target)**	**Comments**
Zinc supplementation strategy developed and implemented	n/a	Although the government policy for the Basic Package of Health Services recommends the use of zinc during episodes of diarrhea and national IMCI training protocols include orientation to use of zinc, zinc is not readily available in Grand Cape Mount County. MTI will contribute to capacity building of health staff in this improved protocol when zinc becomes available.

IR 4: Strengthened institutional capacity of MTI and their partners to implement effective and efficient child survival activities		
Activities	**Status of Activities (Completed, On target, Not yet on target)**	**Comments**
Action plan with indicators for capacity building developed based on baseline Institutional Capacity Assessments	Completed	Technical Assistance Plan for Institutional Capacity Building was developed during the DIP development process and updated at midterm.
Capacity building plans are carried out, monitored and reported.	On track with the exception of supply chain management training	The Capacity building Plan for year 3 included training for MTI & CHAL and CHT staff in Facilitative Supervision for Quality Improvement, Conflict prevention and Supply chain management training. Facilitative supervision training was provided in July 2009 and training on conflict prevention in September 2009. Supply chain management training is planned for November 2009.
System for information sharing among MTI and stakeholders developed (quarterly meetings, annual evaluation/planning meeting)	On target	Child Survival Project partner coordination meetings were held in November 2008 and January, April and August 2009. Meetings were held with community groups to share Care Group data and with partners to discuss on the follow up needed for the midterm evaluation recommendations.
Input contributed to process of development of Standard Health Plan for the county	On target	MTI participated in the development of the Grand Cape Mount county health plan in 2007. During 2008 and 2009 the Grand Cape Mount County Health Team did not invite MTI or other NGOs working in the county to their health planning meeting. The CHT, however, provided a draft health plan and MTI provided input.

IR 4: Strengthened institutional capacity of MTI and their partners to implement effective and efficient child survival activities		
Activities	**Status of Activities (Completed, On target, Not yet on target)**	**Comments**
CSSA focus utilized with partners as part of the DIP development process	On target	The CSSA was utilized during DIP process to develop sustainability plan and indicators. The CSSA was revised at midterm and at the end of year 3.

Annex 3: Workplan – Year 4
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	Year 4											
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**
Community IMNCI// Care Groups												
Refresher training on antenatal care, self care during pregnancy and danger signs during pregnancy including the promotion of tetanus toxoid and understanding of IPTp and its benefits												
Refresher training on Immunization: Stressing on the benefits of Vaccines for Children <1												
Additional training in differentiating between common cold and serious ARI, care-seeking for pneumonia, and home management for common cold												
Refresher on Malaria: Stressing on Danger Signs, Preventions and Hygiene promotion messages.												
Refresher training on active feeding practices and introducing complementary foods at 6 months												
Training on new complementary food options using locally available foods												
Feeding during illness												
Refresher on Control of Diarrhea: Stressing on Danger Signs, Preventions												
Train HHPs on how to resolve conflict at household level and/or community level for benefits of peace within the community, bringing development and healing												
Refresher training on counseling on drug use (frequency, quantity and benefits).												
Strengthen linkages between HHPs and CHCs and system for HHPs reporting to CHCs on their activities												
Community festival and hand over of HHPs to CHCs												
Community Mobilization												
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**

Support CHCs to identify black baggers and prevent circulation of unauthorized drugs												
Training in conflict resolution for CHCs and CHDCs												
Work with communities to complete the setting-up of Emergency Transport System and Economic Health Care Plan												
Support CHCs to establish links with the CHDCs.												
Support CHCs and CHDCs to develop work plans for after September 2010												
Assist CHT to establish CHDCs in facilities where a committee does not exist (Timeframe depends on the CHT recruiting District Health Officers)												
Facility IMNCI / Strengthening Health Services												
Monitoring and mentoring of HF staff using facilitative supervision approach												
Follow up on mentoring for support staff on orientation provided on IMNCI protocol relevant to their roles												
Conduct training in Clinical IMNCI for 20 health facility staff												
Joint monitoring of health facilities with CHT												
Provide additional training and support for health facility staff on operating ORT corners												
Provide medical equipments to 9 health facilities that do not receive support from RBHS project based on needs assessment												
Refresher training for health workers on one-to-one counseling on the use of drugs by mothers and fathers												
Provide support to health facility staff in using pictorial drug dosage labels (Timeframe depends when pictorial drug bags are available through the RBHS project)												
Capacity Building												
	Oct	**Nov**	**Dec**	**Jan**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**Jul**	**Aug**	**Sept**
Systemize facilitative supervision support to HHPs, CHCs, CHDCs, and health facilities												
Training in supply management and logistics for MTI and CHAL												
Sustainability												
Meet with HHPs and CHCs to develop work plan for after September 2010												

Meet with CHT and CHDCs to develop work plan for after 2010												
CHDC/Community Conferences to discuss achievements of Project and plans for sustainability												
Coordination meeting with Project partners to discuss outcomes from CHDC/ Community conferences and formalize exit strategy												
Coordinate with RBHS project for follow up for implementation of IMNCI and support for health facilities												
Monitoring and Evaluation												
Update CHC and CHDC self assessments												
Bi-annual review of IMCI monitoring data to identify gaps												
Year 4 KPC Survey												
Year 4 Health Facility Assessment												
Final evaluation led by external consultant												

Scaling up IMNCI

Liberia first began implementing Integrated Management of Childhood Illnesses (IMCI) in 2002. The program and services were interrupted in 2003 due to the civil war. Efforts to reinitiate the program began in September 2005 with the designation of a MoHSW Family Health focal person and creation of a national IMCI task force. During 2006 the IMCI training materials were adapted and Grand Cape Mount County was selected as the pilot county for clinical IMCI.

In August 2007, with support from Liberia's MoHSW, Dr. Saye Baawo, the former Grand Cape Mount Child Survival Project Manager, participated in a WHO-supported training in Ghana to be certified as an IMCI Course Director. He and IMCI consultants from Ghana then trained IMCI Master Trainers in Liberia. In September 2007, the Grand Cape Mount Child Survival Project provided the first IMCI case management training for 21 health workers from 20 health facilities and 3 Child Survival Project staff. Since then, the Project has trained a total of 56 physician assistants, registered and licensed practical nurses and certified midwives and 5 Child Survival Project staff members in IMCI. During monitoring and support visits project staff have provided 132 health facility support staff with orientation to the components of IMCI relevant to their roles.

Since first piloting IMCI, the MoHSW has included IMCI in the National Basic Package of Health Services. The Rebuilding Basic Health Services project includes IMCI as a key component. During 2009, to address the high rates of neonatal mortality, IMCI training and services were expanded to include newborn care and the program is now known as Integrated Management of Neonatal and Childhood Illnesses (IMNCI). At present, Liberia has two IMNCI training centers, the first at JFK Hospital in Monrovia and second at Phebe hospital in Bomi County. IMNCI services are now being implemented in 6 counties including Grand Cape Mount, Bomi, Gbarpolu, Montserrado, Margibi and Rivercess. During 2010, the MoHSW and UNICEF plan to train an additional 15 national trainers, 2 course directors and 2 national supervisors who will then train health workers from the nine remaining counties.

A future challenge for the National IMNCI program will be establishing a strong monitoring and supervision component. At present, Grand Cape Mount is the only county with a decentralized supervision and support system. Supervision in other counties is provided by MoHSW supervisors from Monrovia. After training, the Grand Cape Mount Child Survival IMNCI Coordinator and Mentor conduct follow-up supportive supervision visits to health facility staff to mentor them in the application of their new skills, visiting each facility at least once a quarter. A Quality Improvement Verification Checklist form similar to the World Health Organization *Supervisory Checklist for Monitoring/Supervision of IMCI Activities* is used during IMCI mentoring visits. Findings are reviewed with the health facility staff themselves and CHT leadership.

Date: September 30, 2009

Capacity Building needs for all three agencies

Category	Priority Activities	Indicators	Who is Responsible	When will it be Completed	Comment
Leadership & Agency Plan	Conduct monthly CSP program coordination meetings with partners and MTI	# times CSP committee met	CHO, CS Project Manager, Community Outreach Coordinator, MTI Country Director,	September 2010	Meetings were established in Y1; at end of Y2 meetings were sporadic; Regular quarterly meetings resumed during yr 3.
Financial Management	Continue annual financial management reviews and provide training in areas of identified weakness	# of reviews # of training	MTI Finance & Administrative Manager CHAL Accountant CHT Administrator	July 2007	Complete
Administration & Human Resources	Develop training/professional development plans for staff related to CSP	# staff trained in CS related activities	MTI Country Director CHAL Executive Director CHO	December 2009	Performance appraisals were conducted but did not include establishing professional development plans for each staff person
	Review and/or develop procedures and policies on Logistics and medicines and supply management systems and train staff in the correct use of these systems	# relevant staff familiar with policies and procedures related to logistics and medicines and supply management systems	MTI F& A Manager MTI, CHAL & CHT Logistician, HQ Commodity support officer	November 2009	Systems established; plan to provide additional training in supply mgmt in November 2009.
Project Design & Management	Conduct training in Program Cycle Management	# of CSP program and partner staff trained in PCM	HQ Technical Services HQ Africa Region	July 2007	Complete

Category	Priority Activities	Indicators	Who is Responsible	When will it be Completed	Comment
	Develop Conflict Resolution guidelines and train staff in conflict resolution methods and local capacities for peace.	# CSP program and partner staff who received training in conflict resolution strategies	CHAL Peace Building Team	September 2009	Complete
	Conduct training in BEHAVE Framework, IEC/BCC strategies and methods	# of CSP program and partner staff trained in BEHAVE, IEC/BCC	CS Advisor, BCC Specialist, CSP Training Coordinator	October 2007 and September 2009	Complete
	Conduct training in IMCI	# CSP program and partner staff trained in IMCI	CSP Manager Training and IMCI Coordinators	July 2008	Complete Training provided during Yr 1&2, and Yr 3
	Conduct training in adult learning teaching strategies and methods, and in development of curricula and teaching materials	# CSP program and partner staff demonstrate competency in informal teaching methods	HQ Capacity Building/Training Advisor	May 2007	Complete
	Conduct training in Qualitative Care Methods	# CSP program and partner staff who received training in COPE	CS Advisor CSP Training Coordinator	December 2009	Removed
	Conduct Training on Community Transformation and mobilization	# CSP program and partner staff who received training in Community Transformation and mobilization	Community Transformation Consultant	November 2006	Complete
	Conduct Training on KPC, HFA and Qualitative Research Methods	# CSP program and partner staff who received training KPC, HFA and Qualitative Research Methods	M&E Specialist CS Consultant Community Consultant	November 2006	Complete
	Conduct training on community participatory processes in planning and development	# CSP program and partner staff trained in participatory processes and community development	Development Education Network-Liberia (DEN-L, local NGO)	November 2007 and May 2008	Complete
	Training in use of monitoring and evaluation plans to report on progress against objectives and indicators	# CSP program and partner staff competent in M&E and reporting procedures	MTI M&E Specialist CSP M&E Coordinator	July 2007	Complete
	Conduct Training in Health Management Information Management System	# CSP program and partner staff who received training in Health Information Management Systems	CS Specialist CS Project Manager MOH Disease Surveillance Division	March 2008	Complete
	Develop a feasible health management information system	Existence of an implemented HMIS that is used for decision making	CHO CHAL Community Outreach Coordinator,	May 2007	56% of CHCs discuss and use Care Group data for planning.

Category	Priority Activities	Indicators	Who is Responsible	When will it be Completed	Comment
			CS Country Director		33% of CHDCs report using HMIS data for planning,
	Develop CSP exit strategy	Existence of a sustainable CSP exit strategy	CS Project Manager CHAL Executive Director GCM CHO	January 2010	Planned for year 4
Infrastructure & Relationships	Train staff use of electronic state of the art resources and project information/documents for technical health intervention support	# staff who demonstrate competent use of electronic and technical resources	MTI Country Director CSP Training Coordinator	April 2010	Planned for year 4