



USAID
FROM THE AMERICAN PEOPLE



REBUILDING BASIC HEALTH SERVICES PROJECT DESCRIPTION

Updated August 2010

The Rebuilding Basic Health Services (RBHS) Project is funded by the United States Agency for International Development through Cooperative Agreement No: 669-A-00-09-00001-00 and is implemented by JSI Research and Training Institute, Inc. in collaboration with Jhpiego, the Johns Hopkins University Center for Communication Programs (JHUCCP), and Management Sciences for Health (MSH).

This document is made possible by the generous support of the American people through the United States Agency for International Development (USAID). The contents are the responsibility of JSI Research and Training Institute, Inc. and do not necessarily reflect the views of USAID or the United States Government.

TABLE OF CONTENTS

ACRONYMS	4
INTRODUCTION and BACKGROUND	6
PROGRESS AFTER YEAR ONE.....	7
STRATEGY and PRINCIPLES.....	9
RBHS MISSION STATEMENT	10
RBHS VISION	10
INTERMEDIATE RESULT 1	10
Sub-objective 1.1: Increase number of health facilities providing full range of the Basic Package of Health Services, supported by performance-based financing.....	10
Sub-objective 1.2: Expand service delivery to communities	16
Sub-objective 1.3: Increase access to comprehensive maternal, neonatal, and child health (MNCH) services.....	19
Sub-objective 1.4: Increase uptake of three critical malaria interventions: Treatment with ACT, preventive treatment of pregnant women, and sleeping under ITNs	23
Sub-objective 1.5: Increase access to quality HIV and TB services	25
Sub-objective 1.6: Increase access to comprehensive family planning and reproductive health services.....	28
INTERMEDIATE RESULT 2	34
Sub-objective 2.1: Enhance TNIMA and Zorzor learning environments and resources	35
Sub-objective 2.2: Improve capacity of training institution staff to utilize modern teaching methods and manage health training institutions.....	35
Sub-objective 2.3: Update and strengthen PA, RN, EHT, and CM curricula	36
Sub-objective 2.4: Strengthen MOHSW systems and human capacity at central level.....	37
Sub-objective 2.5: Strengthen MOHSW systems and human capacity at county level	39
Sub-objective 2.6: Strengthen and assist in the roll-out of the National In-service Strategy...	41
Sub-objective 2.7: Improve environmental health at facilities and hygiene practices in communities.....	42
INTERMEDIATE RESULT 3	46
CROSS CUTTING ISSUES	46
Gender	46
Governance	46
Mental Health.....	47
MONITORING and EVALUATION	48
TECHNICAL CAPABILITIES and MANAGEMENT APPROACH	50
ANNEX 1 – KEY INDICATORS: END OF PROJECT TARGETS.....	57
ANNEX 2 – RBHS STAFFING STRUCTURE, Years 2 and 3.....	59

ANNEX 3 – RBHS STAFFING STRUCTURE, Years 4 and 5 60
ANNEX 4 – RBHS LEVEL OF EFFORT IN MONTHS FOR ALL STAFF, Years 1-5..... 61

#

ACRONYMS

ANC	Ante-natal care
BLSS	Basic Life Support Skills
CHD	Community Health Division
CHDC	Community Health Development Committee
CHO	County Health Officer
CHT	County Health Team
gCHV	(general) Community Health Volunteer
CM	Certified mid-wife
DHIS	District Health Information System
DOTS	Directly observed therapy – short course
DSS	Decision Support Systems
DWG	Decentralized Working Group
EBSNM	Esther Bacon School of Nursing and Midwifery
EHT	Environmental health technician
EML	Essential medicines list
EMMP	Environmental Mitigation and Monitoring Plan
EmONC	Emergency obstetric and neonatal care
EPI	Expanded Program on Immunization
FBO	Faith-based organization
FHD	Family Health Division
GBV	Gender-based violence
HMIS	Health management information systems
HPU	Health Promotion Unit
ICHP	Improved Community Health Project
IMAT	Inventory Management Assessment Tool
IMCI	Integrated Management of Childhood Illness
IPT	Intermittent preventive treatment of malaria (in pregnancy)
IPT2	Intermittent preventive treatment of malaria (in pregnancy) , second dose
IRC	International Rescue Committee
ITN	Insecticide-treated net
JSI	John Snow Inc
LISGIS	Liberia Institute of Statistics & Geo-Information Services
MDR	Multiple drug resistant
M&E	Monitoring and evaluation
MH	Mental health
MOHSW	Ministry of Health and Social Welfare
MTI	Medical Teams International
NACP	National AIDS Control Program
NLTCP	National Leprosy and Tuberculosis Control Program
NMCP	National Malaria Control Program
NTC	National Traditional Council
ORS	Oral rehydration salts
PA	Physician's assistant
PBC	Performance-based contract
PBF	Performance-based financing

PMI	President's Malaria Initiative
PMTCT	Prevention of mother-to-child transmission
POU	Point of use
PPP	Public-private partnership
PSE	Pre-service Education Initiative
QA	Quality assurance
RBHS	Rebuilding Basic Health Services
RN	Registered nurse
RUD	Rational use of drugs
SOPs	Standard operating procedures
STTA	Short-term Technical Assistance
TB	Tuberculosis
TFR	Total fertility rate
TNIMA	Tubman National Institute for Medical Arts
TOT	Training of trainers
TTM	Trained Traditional Midwife
TU	Training Unit
WASH	Water, sanitation, and hygiene promotion

INTRODUCTION and BACKGROUND

Five years after emerging from two prolonged and devastating civil wars, Liberia is beginning to make slow but measurable progress on a range of economic and social outcomes. The impact of the conflicts on the health sector were as severe as on any other and included loss of staff, destruction of infrastructure, disruption of health programs, lack of resources and resultant increased dependence on international donors. Until recently up to 70% of health facilities have depended on external assistance to ensure on-going functioning.

The Ministry of Health and Social Welfare (MOHSW) has emerged as one of the strongest and most effective government entities. Over the past 3 – 4 years the MOHSW has demonstrated strong leadership and vision, developed a sound National Health Policy and Plan, and collaborated effectively with its partners. While the health sector will require substantial external assistance for years to come, it is clear that the MOHSW is taking the lead on setting national policies, strategies, and plans. The cornerstone of the Liberian National Health Plan is the MOHSW's Basic Package of Health Services (BPHS), which outlines the essential services to be provided at each level of the health system.

Early indications suggest that there have already been improvements in some important health outcomes. Infant and child mortality have reduced considerably since earlier in the decade and now compare favorably with regional rates (see Table 1). On a more macro level, Liberia has edged up slightly on the Human Development Index, improving by 7 places (169 out of 182 countries). One important exception to this trend has been the maternal mortality ratio, which remains elevated at a troubling level and is still one of the highest in the world.

Table 1: Key Health Indicators for Liberia

	Liberia	Regional Average	Global Average
Infant Mortality Rate (DHS 2007)	72	97	47
Under-5 Mortality Rate (DHS 2007)	111	169	68
Maternal Mortality Ratio (DHS, 2007)	994	1100	400

In light of these and other political and economic developments, there is renewed optimism for the reconstruction of the Liberian health sector. Many public health experts are suggesting that Liberia could be a model for post-conflict health system reconstruction and are eager to learn lessons from the country's experience.

The Rebuilding Basic Health Services (RBHS) project is the United States government's major initiative in support of the MOHSW. Funded by USAID, RBHS is a partnership among JSI Research and Training, Jhpiego, the Johns Hopkins University Center for Communication Programs (JHU CCP), and Management Sciences for Health (MSH). Implementation of RBHS is over a 5-year period and is guided by a three-pronged strategic approach:

- strengthening and extending **service delivery** through performance-based grants to non-governmental organization (NGO) partners (IRs 1 and 3);
- strengthening Liberia's **health system** in the areas of human resource management, infrastructure, policy development, and monitoring and evaluation (IR 2); and
- preventing disease and promoting more healthful behaviors through **behavior change communication** and community mobilization (IRs 1,2 and 3).

In addition, the RBHS project has specific responsibilities in the areas of maternal and child health, family planning/reproductive health, malaria, HIV, and water and sanitation.

Twelve months after the start of the project, the RBHS team has reviewed the progress and challenges to date and has refined our vision and plans for the next four years. The purpose of this document is to outline RBHS's main objectives, approaches, and activities for the remainder of the project. It clearly outlines our commitment to the following results:

- Increased utilization and coverage of priority health services, especially maternal, neonatal, child, and family planning/reproductive health;
- Expanded availability of and access to services, including at community level (e.g. case management of childhood infections, family planning);
- Improved quality of health services, including improved health worker performance;
- Increased adoption of healthful behaviors by community members;
- Strengthened training institutions for mid-level health care providers;
- Strengthened health systems, especially in the areas of health management information systems, monitoring and evaluation, and drug management;
- Increased technical and management capacity of the MOHSW at central and county levels;
- Improved health infrastructure.

PROGRESS AFTER YEAR ONE

Much of the first year's activities consisted of assessments, preparatory work, and administrative set-up to lay the foundation for subsequent project implementation. While solid progress was made against most of the sub-objectives, several activities were slow to commence (e.g. infrastructure) and the coverage of some health services is lagging (e.g. reproductive health). On balance, however, the RBHS project has documented several notable achievements and is well placed to build on the momentum established during the first twelve months.

Service Delivery

RBHS played an important role in avoiding a "transition gap" in health funding to 75 health facilities through short-term grants to four NGO partners. This was followed by the successful negotiation of performance based contracts (PBCs) for over 100 health facilities in seven counties through a process that was generally viewed as open and transparent by the MOHSW and other stakeholders.

Utilization and coverage rates have demonstrated a mixed picture for RBHS implementing partners during the first year of implementation. Results for several indicators compare favorably with national averages and international standards (e.g. vaccination coverage, utilization rates, accreditation scores),

while others demonstrate need for significant improvement (e.g. facility-based births, IPT2 coverage for pregnant women, uptake of family planning). This data has been shared with the implementing partners and has proven useful in identifying strategies and interventions to improve the coverage and quality of services.

Systems Strengthening

RBHS's Pre-service Education Strengthening Initiative (PSE) has made substantial progress during year 1. PSE is upgrading training at two of Liberia's most important schools for nursing and para-medical staff – the Tubman National Institute for Medical Arts (TNIMA) in Monrovia and the Esther Bacon School of Nursing and Midwifery (EBSNM) in Zorzor. Among the key accomplishments are the development of education standards for the training institutions and clinical standards for health facilities. In addition, RBHS is currently working with key stakeholders to revise job descriptions and core competencies for four cadres of mid-level providers (registered nurses, certified midwives, physician assistants, environmental health technicians), and to update their respective training curricula.

RBHS also made important contributions to the roll-out of the MOHSW's In-service Education Strategy, in an effort to up-grade the skills of existing mid-level health care providers. Specific activities have included technical inputs to the in-service curriculum, participation in the training of Master Trainers, preparation of a training site in Nimba County, and the completion of an in-service training inventory at RBHS-supported facilities. Challenges to the broader implementation of in-service training have related to capacity limitations within the MOHSW's Training Unit and slower-than-expected progress on the development of the integrated curriculum.

Consistent with its commitment to capacity building, RBHS staff have provided input into important MOHSW policies and plans (e.g. Family Planning and Reproductive Health Strategy; Mental Health Policy) and technical documents (e.g. maternal, newborn and child health protocols; HMIS tools), and participated as active members of at least 10 Ministry-led committees and working groups (e.g. Health Promotion Working Group; Monitoring, Evaluation and Research Technical Working Group). Moreover, RBHS has provided technical assistance to MOHSW counterparts on a range of issues (e.g. mental health, health promotion), supported important consultancies (e.g. National Malaria Strategic Plan, Essential Nutrition Actions), supported numerous workshops (e.g. Malaria Operational Plan, Clinical Standards), and procured 15 vehicles for the MOHSW and 28 motorcycles for the county health teams (CHTs).

The RBHS infrastructure program has ambitious objectives, including the rehabilitation of two nursing schools, the upgrading of five comprehensive Emergency Obstetric and Neonatal Care Centers, the erection of a pre-engineered warehouse for the National Drug Service, and the rehabilitation of many of the over 100 health facilities supported through the PBCs. The major activities to date have included architectural and engineering designs for TNIMA and EBSNM, assessments and planning for the upgrading of five EmONC Centers, and assessments of 39 priority clinics and health centers. Construction work is expected to commence early in the dry season of year 2. Delays have related to staff turnover, prolonged procurement processes, and the need to investigate thoroughly the management options for multiple, simultaneous construction projects.

Behavior change communication

In addition to providing health services and strengthening health systems, RBHS is working to promote more healthful behaviors and to mobilize communities around public health issues. During year 1 most Behavior Change Communication (BCC) activities focused on assessments,

preparatory work for demand generation, and capacity building of counterparts within the MOHSW, especially the Health Promotion Unit (HPU). RBHS has developed a clear strategy to guide its BCC activities that combines an integrated approach at the household and community levels complemented by periodic phased national vertical campaigns using mass media. The first national campaign promotes use of insecticide-treated nets (ITNs) and was designed in collaboration with the MOHSW's NMCP and HPU. It was launched in early November 2009.

Challenges and Constraints

During the first year, many of the challenges related to the scale, ambitious nature and high expectations of the project. Balancing the demands of competing priorities has necessitated greater attention to prioritization and sequencing of activities, including the postponement of several initiatives until a later date. The lack of capacity of some counterparts in the MOHSW has slowed implementation of several activities and budgetary gaps have limited the scope of other activities. These issues led RBHS to substantially revise its work plan for Year 1 and to set more realistic targets for Year 2. Staff turnover in key positions (Deputy Chief of Party, Infrastructure Advisor) has also delayed implementation of several important activities.

STRATEGY and PRINCIPLES

RBHS embraces two main strategies and six key principles. Our strategy is based on:

- Alignment of all activities with MOHSW priorities. The MOHSW has set a clear vision and developed a sound National Health Plan (NHP). The NHP is, in turn, closely linked to Liberia's Poverty Reduction Strategy and the Millennium Development Goals. RBHS is committed to supporting implementation of the MOHSW's plan and will consistently adhere to and promote MOHSW policies, guidelines, and standard operating procedures.
- Emphasis on high-impact evidence-based interventions. Public health principles dictate that limited resources must be used to maximize the health benefits for the largest number of people. Guided by the local epidemiology, RBHS will focus on scaling up access to those cost effective interventions that have the highest impact on health outcomes – especially for women and children.

Project implementation is guided by the following principles:

- Participation. RBHS is committed to the active involvement of key stakeholders at each phase of project implementation. We aim to increase the ownership that the MOHSW, County Health Teams (CHTs), and communities have of their health system.
- Partnership. The partnerships that RBHS has forged with the MOHSW, CHTs, and implementing NGOs are based on open communication, transparency, mutual respect, and accountability
- Capacity Building. RBHS aims to develop both the technical and managerial capacities of our partners. We direct these efforts at the level of both the individual and the institution.
- Gender sensitivity. In recognition of the different needs of women, men and adolescents, RBHS is committed to gender-equitable development. We will continuously examine all aspects of our program to ensure that it has a positive influence on women's and girls' status – and that all beneficiaries benefit according to their needs.
- Youth focus. Liberia's youth face many health challenges, including a very high teen

pregnancy rate. Yet they often feel disconnected from or unwelcomed by the health system. RBHS is determined to address the special needs of youth, especially as they relate to sexual and reproductive health.

- Data driven. All important strategic and programmatic decisions will be guided by the collection, analysis and interpretation of high quality public health data.

RBHS MISSION STATEMENT

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

RBHS VISION

Effective and sustainable health services that contribute to improved quality of life for all Liberians.

INTERMEDIATE RESULT 1: *Increased access to basic health services through improved provision of quality health services and adoption of positive health behaviors.*

Through its performance-based contracts with implementing partners, RBHS will increase the range and quality of services available at both facility and community levels. Moreover, we will promote more healthful behaviors and mobilize communities around priority public health issues through an integrated behavior change communication (BCC) strategy that includes facility- and community-level activities, complemented by a series of phased national campaigns.

Sub-objective 1.1: Increase number of health facilities providing full range of the Basic Package of Health Services, supported by performance-based financing.

Key indicators	2010 target	2011 target	2013 target
Mean score from accreditation survey	78	88	92
Utilization rate	0.70	0.77	0.85

During the first year of PBC implementation, RBHS supported service delivery at 105 health facilities and their surrounding communities. Two large health centers were added to the RBHS responsibilities in October 2009: Sinje Health Center in Grand Cape Mount County (for which RBHS had previously only been responsible for emergency obstetric and neonatal care) and Saclapea Health Center in Nimba County (the largest health center in Liberia). In year 2 of the PBCs, the number of facilities to be supported by RBHS and our partners will increase to 112, as several facilities in Lofa County are transferred from other donors.

Scaling up access to high impact, cost effective interventions

RBHS is committed to increasing access to the full Basic Package of Health Services over the life of the project. The BPHS includes a comprehensive range of services that vary in their public health impact, cost-effectiveness, and ease of implementation. Given the broad scope of the package, it will not be possible to initiate all interventions simultaneously - or to ensure that they are all of high quality. Therefore, RBHS aims to prioritize and sequence the introduction and scaling up of essential health services, following a consideration of the local epidemiology, evidence base for effectiveness, availability of resources, cost effectiveness, and capacity of partners to implement.

As noted, Liberia currently has high infant and child mortality rates, high maternal mortality, and a high total fertility rate (TFR). The major causes of child mortality include neonatal deaths, pneumonia, malaria, and diarrhea. While the rate of global acute malnutrition/underweight (7%) is not excessive, 39% of children are stunted and 19% are underweight. RBHS will prioritize those interventions that address the major causes of morbidity and mortality, as well as aim to reduce the high rates of fertility.

Key interventions will include: intermittent preventive treatment of malaria in pregnancy (IPT); child spacing through effective family planning; early detection and referral of pregnancy complications (pathways for survival); active management of the third stage of labor; preventive post partum care; early detection and management/referral of newborn complications; kangaroo mother care; promotion of ITNs; promotion of essential nutrition actions; Vitamin A distribution; Expanded Program on Immunization (EPI); oral rehydration salts (ORS) for management of diarrhea; antibiotics for the treatment of pneumonia; early treatment with appropriate artemisinin-based combination therapy for the treatment of malaria; and community case management of malaria.

Strengthening service delivery through quality assurance and rational drug use

RBHS will promote the quality of care by institutionalizing standardized MOHSW clinical protocols, guidelines, and procedures at all RBHS-supported health facilities. Standardized protocols have already been developed by a number of vertical programs (e.g. National Malaria Control Program, National AIDS Control Program) and the Integrated Management of Childhood Illness (IMCI) guidelines have been adopted by the MOHSW. But not all clinical staff have been trained and the relevant protocols are not consistently followed or available at health facilities. During visits to health centers and clinics in Lofa, Grand Cape Mount, and Bong Counties over July – October 2009, not one facility had available all of the protocols and guidelines currently endorsed by the MOHSW. Moreover, the Ministry's own National Treatment Guidelines, Essential Medicine List (EML), and National Formulary have not yet been finalized or disseminated. Therefore, the quality of care and adherence to accepted guidelines vary substantially among both facilities and providers.

RBHS partner, MSH, through its SPS program, has been requested by the MOHSW to lead the finalization of the National Treatment Guidelines. RBHS will contribute to this process as needed. In addition we will ensure that the guidelines are incorporated into both in-service and pre-service training curricula, and that copies of standardized protocols and job aids are readily available and appropriately displayed at health facilities.

RBHS will further promote the quality of care through a process of continuous quality assurance. RBHS recognizes that “quality” has many dimensions, including technical competence, accessibility, effectiveness, interpersonal relations, efficiency, and physical environment, and amenities. Health professionals tend to consider quality in terms of clinical standards of care, while clients are often more focused on interpersonal communications. Quality assurance cannot be divorced from the people who either provide or receive services – RBHS will therefore consider both provider and client perspectives when defining, improving, measuring, and recognizing quality.

The RBHS approach to quality assurance (QA) includes four main components:

- Defining Quality – developing standards of quality, communicating those standards, and setting expectations of performance;
- Measuring Quality – systematic identification of the current level of quality through assessment, monitoring, and evaluation;
- Improving Quality – applying appropriate methods to close the gap between current and expected levels of quality; and
- Recognizing quality - external recognition incentives will be provided once performance reaches predetermined levels of care or systems functioning.

Through its Pre-service Education Initiative, RBHS has already established standards for infection prevention and 17 clinical areas within the BPHS. Baseline assessments have been conducted at six clinical training sites associated with TNIMA in Monrovia and EBSNM in Zorzor. Gaps between the current levels of care and the agreed upon standards have been identified and facility-specific plans have been developed to close those gaps by improving the quality of care.

RBHS plans to apply the same standards to all supported health facilities in each of the seven counties. A baseline assessment against the standards will be conducted in every facility and a similar process for promoting and assuring quality developed thereafter. Through training and collaborative team work RBHS will help MOHSW staff and health workers to expand their understanding of quality to include those dimensions considered important by the client. Likewise, RBHS will inform and educate clients and communities on the importance of the technical dimension of quality to strengthen their role as informed consumers. Client and community perceptions of and desires for quality will be actively sought and incorporated into quality improvement efforts.

RBHS will use quality recognition approaches based on independent measurements of performance according to explicit standards, coupled with external recognition incentives once performance reaches predetermined levels. Examples of recognition incentives include individual or facility certification, focused accreditation or facility accreditation, and/or licensing.

Linked to this process of establishing and promoting standards, RBHS will assist the MOHSW to institutionalize the rational use of drugs (RUD). Field visits have revealed that polypharmacy and poor adherence to protocols are common. RBHS will coordinate with SPS to provide technical assistance and opportunities for training for the staff of both the MOHSW and our NGO partners. .

Finally, RBHS will coordinate its QA and recognition activities with the facility accreditation process already implemented by the MOHSW. The RBHS QA approach will focus especially on standards of clinical and preventive care, as well as the performance of key systems, such as drug management and health management information systems (HMIS). It will therefore complement the accreditation process, which focuses more on the availability of services and systems, rather than

their quality. RBHS is exploring the possibility of including measures of quality in the next accreditation assessment with the MOHSW and the Clinton Foundation.

Renovating health facilities

Many of the over 100 health facilities currently supported by RBHS have previously been renovated by other partners. But the MOHSW's Infrastructure Unit and the CHTs have provided RBHS with a list of 36 priority health facilities in six of the seven counties that still require substantial renovations, including the planned comprehensive emergency obstetric and neonatal care (EmONC) facilities in Fish Town, Bensonville, Zorzor and Sinje (renovations at the latter two will be medium scale for RBHS). During Year 2¹, up to 15 of these facilities will be prioritized for rehabilitation, including repairs of roofs, windows, doors, floors, ceilings, and walls. Other facilities will be renovated in year 3. Up to five of the 36 may be appropriate for a pre-fabricated structure, rather than structural renovation – but this determination will need to be made following further assessments.

Given the complexity of bidding and managing the renovations of 36 facilities in six counties, RBHS is proposing to contract with a reputable firm to undertake both the project management and renovation components of the work, using a "Design Build" approach. Design-Build contracts are commonly used in other countries when large numbers of building or renovation units are proposed, e.g. housing developments. The Design-Build contractor would be responsible for the following key activities:

- a) Provide all management, materials, equipment and labor necessary to design and renovate the clinics from their current state through completion.
- b) Prepare a guaranteed maximum price for the two phases: first nine facilities and the remaining 27 facilities.
- c) Where appropriate, contract directly with local labor and subcontractors to do all or portions of the construction work.
- d) Monitor construction progress, payments, and certification of the work from start through completion. Provide this information on a clinic-by-clinic basis as well as the project as a whole.
- e) Complete the 36 clinics within an agreed project budget, including all management, design, overhead, profit, mobilization and other general project costs.

In addition to the priority facilities, up to another 30 RBHS-supported health facilities will eventually require major renovations and/or extensions. In the interim, RBHS partners are conducting minor repairs. Depending on the available budget following the completion of the priority work, RBHS will consider undertaking the renovations of these additional facilities.

During year 2, priority will be given to facilities in River Gee and those facilities in other counties requiring major roofing work. Water supplies, energy/electrical supplies, latrines, and medical waste management (including placenta pits) will also be reviewed and upgraded as needed. We will work with CHF, the recipient of a recent WASH contract from USAID, to ensure that the water and sanitation needs of RBHS-supported facilities are prioritized in their project. RBHS has shared a list of RBHS facilities with CHF that contains comprehensive information on issues such as water supply, sanitation, energy supply, and medical waste management.

¹ "Year 2" refers to the second year of RBHS implementation (RBHS commenced in November, 2008). But the performance based contracts commenced in July, 2009. Therefore, the years for RBHS implementation (October – September) and PBC implementation (July – June) are out of synch. Most of year 1 for PBC implementation actually occurred during year 2 of the RBHS project.

Finally, to address energy needs, RBHS is proposing to provide solar power to all RBHS-supported facilities, including the comprehensive EmONC centers. In addition to installation, RBHS will require that the contractors provide training to the facility staff and communities on use and maintenance of the solar units.

Providing essential medicines and improving drug management

RBHS will provide essential medicines to all health facilities, with the exception of those drugs already available through the national programs or other mechanisms, e.g. anti-malarials, anti-retrovirals, anti-tuberculosis drugs, family planning commodities. The project will provide all essential medicines until the end of year 3. Thereafter, the quantities of drugs will taper over years 4 and 5, with the expectation that local financing mechanisms (e.g. government, insurance, private) will expand to eventually replace donor funds. Standard operating procedures (SOPs) for the quantification of drugs have already been adapted by RBHS and successfully used by our implementing partners. These have also been shared with the MOHSW. In year 2, RBHS will undertake the procurement of a major supply of drugs for the MOHSW, through supplemental funds provided by USAID.

RBHS will also improve overall drug management of our partners through the institutionalization of supply chain SOPs and introduction of the Inventory Management Assessment Tool (IMAT). The MOHSW, with the assistance of DELIVER, has recently developed SOPs for supply chain management and RBHS has already organized training for staff and implementing partners. Further trainings and dissemination of the SOPs will be undertaken during year 2. Moreover, each drug store and pharmacy will be expected to conduct an inventory assessment at least once per year, using the standardized IMAT tool. The IMAT process reviews the accuracy of record keeping and stock levels through an analysis of up to 25 drugs over a 100 day period.

The refinement of quantification and supply chain procedures, together with the improvement of inventory management, and the institutionalization of rational drug use, will all contribute to a more efficient and cost-effective drug management system.

Finally, to assist the MOHSW with the improvement of its own supply chain management, RBHS will support the procurement of a suitable, pre-engineered warehouse and its construction/erection in Monrovia.

Managing Performance Based Contracts

Regular communications and close monitoring of implementing partners will ensure that their activities are in compliance with USAID rules and regulations on all relevant project-related issues, including procurement, recruitment, and reporting. Quarterly reports will be reviewed closely and actionable feedback provided where required. Disbursement of a proportion (up to 5%) of quarterly funds will be determined by evaluating the progress of the implementing partners towards meeting agreed-upon targets for five administrative indicators. The RBHS County Coordinators will conduct validation exercises quarterly to review the accuracy and reliability of the reported data.

Seven service-delivery performance indicators were established prior to the issuing of the PBCs and baselines and targets negotiated with the successful applicants. At the end of the first year of PBC implementation, progress towards meeting these targets will be reviewed and a performance bonus (or proportion thereof, determined by how many targets are met) will be issued to the partner. The utility and the relevance of the performance indicators themselves will also be reviewed at the end of each year and new indicators considered. Baselines and targets will be negotiated with each of the partners on an annual basis.

If a partner is unable to meet a significant proportion of the agreed upon targets, renewal of the PBC for the subsequent year will be reviewed and the option of replacing that partner considered. For the first year of PBC implementation, the RBHS partner, MERCI, has been working on a grant and not a PBC. An action plan has been developed with MERCI to develop their managerial and financial capacity. An analysis of MERCI's progress will be conducted during the second half of the year and the possibility of converting their agreement from a grant to a PBC considered.

During the first year of the PBCs the performance bonus will be given after 12 months. Already, it is clear that the performance bonus is not acting as the incentive to front-line health workers that it is supposed to represent. Therefore, RBHS is working with its partners and the MOHSW to determine a more appropriate frequency for disbursement of the bonus, e.g. quarterly or half-yearly. There are varying opinions on this frequency and partners are drafting their proposed plans at the time of writing. Incentive systems (how the form of bonus and process for disbursement) will be determined by each individual implementing partner, in consultation with CHTs and RBHS.

Monthly meetings with the country leadership of the implementing partners have been institutionalized and proven to be an effective forum for reviewing program data, sharing program approaches and lessons learned (e.g. to improve facility-based deliveries), and for clarifying operational and program issues. These will continue for the life of the project. Bi-monthly technical meetings to review current program implementation of specific interventions and strategies as well as best practices will commence in April, 2010. Regular meetings have also begun at the county level between RBHS (represented by our County Coordinators) and the respective County Health Teams and implementing partners. These meetings are now scheduled on a monthly basis and provide an important opportunity to promote information sharing and collaboration. Furthermore, a joint supervisory schedule has been developed among the county-level partners, to regularly review the delivery, quality, and appropriateness of services at facility and community levels.

Innovative Financing Approaches

RBHS remains a member of the MOHSW's Health Financing Taskforce and has led the costing exercises at clinic and hospital levels that will help to inform the health financing policy – a zero draft of which is due in June 2010. Costing of community-level activities is planned for year 2. Other partners are playing a more leading role in the development of the national policy, specifically Health Systems 2020, but RBHS will continue to contribute to these processes and discussions. Moreover, where appropriate and feasible, RBHS and its partners will explore innovative financing mechanisms, in coordination with the MOHSW. These approaches will clearly be informed by the Ministry's own policy decisions. Possible approaches include community-based health insurance, mutual health organizations, cooperatives, in-kind contributions, public-private partnerships, community-based small grants, and even conditional cash transfers.

Public-private Partnerships

JSI has already helped the MOHSW identify private sector partners by coordinating and facilitating introductions with companies, philanthropists, and foundations, like the International Bank of Liberia, Total, Hess Corporation, the Daphne Foundation and Acumen Fund. Moreover, RBHS has already engaged Cellcom to provide free SMS messaging to promote the use of insecticide-treated nets (ITNs), while our implementing partner, EQUIP, has secured 23 free cell phones and monthly subscriptions for network coverage to the CHT and all of EQUIP's 23 facilities. RBHS has recently facilitated the introduction of international managed care providers to support services for concessionaires. RBHS will build on these efforts to explore other options, including free radio broadcasting, printing (e.g. the new Child Health Card), co-sponsoring of events, development of community-based clinics or services at worksites (e.g. mines), etc.

Sub-objective 1.2: Expand service delivery to communities

Key indicator	2010 target	2011 target	2013 target
% of children under 1 year who received DPT3/pentavalent-3 vaccination	66%	75%	85%
Number of children under 5 years who received vitamin A	24,000	25,200	30,000

RBHS recognizes that communities form a central component of the health sector and that engaging them as full partners can improve both access to and quality of health care. But to date, there has been limited coordination or consistency among the community-level activities, as they have been designed and implemented by a variety of vertical programs and NGOs/Faith-based Organizations (FBOs). In collaboration with the MOHSW, RBHS plans to improve and expand the quality of services by informing and mobilizing communities, engaging them in relevant aspects of health system management, and introducing delivery of high impact, evidence-based interventions at community level. Activities will be consistent with and supportive of the Ministry's Community Health Strategy.

Informing and mobilizing communities

Early assessments by RBHS have demonstrated that there is no consistent strategy regarding public health messaging at either facility or community level. While most health facilities conduct regular health education sessions, the majority of service providers cannot explain their rationale for selecting a topic. And few, if any, utilize data from their own health facility to guide topic selection. In general there is a lack of good quality information, education and communication materials in the facilities, with the exception of malaria. Even then, malaria materials are not linked to a strategically planned and coordinated communication campaign. Similarly, where general community health volunteers (gCHVs) are present, their activities are usually not linked to those at the facility level.

In response RBHS is adopting an integrated strategy to ensure that households have information concerning priority health problems, steps they can take to promote their own health, and the range of services available at both community and facility level. Central to this effort will be a new Pregnant Woman's Health Card, and Child Health Card which include the key elements of both the Road to Health Card and the MOHSW's Mothers' Card. But the new cards will allow not only documentation of important family health data, they will also provide

families with health information in a manner that is culturally relevant and easy to comprehend (i.e. graphics and script). This health information can also be used by health workers for counseling and negotiation with families. Developed in collaboration with the MOHSW's HPU and Family Health Division (FHD), this integrated tool will help to establish and strengthen linkages between health facilities and communities. Messages promoted through these cards and CHVs will be consistent with and complement those provided at the facility level.

RBHS will also adapt two fundamental BCC tool kits and plan for mass production and dissemination of both. The Community Health Education Skills Tool (CHEST) kit is a set of materials addressing the most important public health issues relevant to Liberia, and is to be used by health workers at both facility and community levels. Relevant components include discussion cards and information cards on a range of health issues. The discussion cards will be used with communities to identify problems and develop solutions on issues such as reducing malaria transmission and improving community sanitation, etc. The information cards will be used primarily at household level to inform and mobilize families. The Journey of Hope kit is a tool for promoting participatory HIV prevention activities, with an emphasis on youth (see SO 1.5). It will be adapted to the Liberian context with the assistance of the NACP.

This integrated approach is to be supported by a series of phased, vertical mass media and community mobilization interventions, which aim to have a greater impact at the population level. A health-seeking behavior study to help inform the various strategies, approaches and target messages will be conducted together with the HPU early in Year 2.

The first major campaign was timed to follow on from the recent mass distribution of ITNs in three counties. Designed in collaboration with the NMCP, the campaign has used a broad range of channels to communicate consistent messages about regular net use, e.g. traditional leaders, folk media, radio, bulk SMS-texting, community-level activities. Radio messages have been produced in Liberian English and local languages and timed to ensure high numbers of listeners. Monitoring and evaluation of the campaign is being conducted through regular "dipstick" surveys (see SO 1.4).

Topics for other future campaigns include teen pregnancy (to be launched in year 2), early case management of malaria (years 2 and 3), IPT (timing to be determined), and HIV prevention. Each campaign will extend over 8 – 12 months and be staggered to avoid "information overload" and thereby dilution of messages. Messages, strategies and timing of each campaign will be determined in consultation with the MOHSW and other stakeholders.

RBHS partners and CHTs will play a crucial role in the implementation of all BCC activities. RBHS will engage them actively through various levels of training including:

- Training of Trainers for CHTs and partners including BCC concepts, Interpersonal Communication and Counseling (IPCC) skills, and Effective Use of IEC/BCC Materials and Tool Kits.
- Downstream training by trainers, especially for general CHVs (gCHVs) and social groupings such as market women, pehn-pehn boys, sports associations, FBOs, and community-based organizations, among others. The effect of trainings will be to further strengthen linkages between the facility and community.

Participants selected from their communities will also acquire skills to serve as peer educators and provide counseling services to help to address health needs.

Delivering services at community level

Several high impact, cost-effective interventions relevant to the Liberian context can be successfully delivered at the community level, including case management of childhood infections such as diarrhea, malaria, and pneumonia; distribution of family planning (FP) commodities; and directly observed therapy (DOTS) of tuberculosis. Both WHO and Unicef have endorsed community case management (CCM) by well-trained and supervised community health volunteers to reduce infant and child mortality. In response, the Liberian MOHSW has integrated CCM into the BPHS. In addition, consistent with Ministry policy, RBHS is adopting community distribution of FP to reduce fertility rates and to promote both maternal and child health (see SO 1.6) and community-based DOTs to tackle TB (see SO 1.5).

The MOHSW's Community Health Department (CHD) has developed technical guidelines and training modules for the initiation of CCM, with an initial focus on diarrhea. But successful implementation of CCM also requires careful planning and strong management. RBHS therefore sponsored a visit by eight representatives of the MOHSW, NGO partners, and RBHS to observe a successful CCM project in Sierra Leone in January 2010 that has documented a 40% reduction in child mortality. The trip was highly productive, with the delegation learning important lessons and making recommendations to the MOHSW. Key among these were: integrate the management of three diseases (malaria, diarrhea, pneumonia); conduct a baseline survey to allow monitoring of progress over time; start CCM on a modest scale, refine the model and then expand; revise Ministry policy to allow illiterates to be recruited as gCHVs; limit the number of tasks performed by gCHVs; review the supervisory mechanism and consider recruitment of peer supervisors; and provide training for all levels of supervisors.

While the importance of implementing CCM in Liberia is well appreciated by most stakeholders, skepticism and resistance persists among many clinicians, including senior staff. It is therefore essential that CCM activities be well designed and managed from the outset to increase the likelihood of success. Experience from other countries has demonstrated that among the most important issues to be addressed are engaging the communities, selecting gCHVs, supervision and motivation of gCHVs, M&E, and supply chain management. Similarly, experience has shown that a phased introduction, with perhaps different partners managing these issues in different ways, can allow the identification and refinement of successful approaches, which may then be taken to scale. Early success will increase the likelihood of long term commitment from communities and thus greater likelihood of sustainability. Thus, RBHS and three of its NGO partners (Africare, EQUIP, IRC) will work with and through CHTs in Bong, Lofa, and Nimba counties to phase in CCM in selected districts over a 6-8 month period, prior to scaling up to remaining districts and expanding services to other RBHS-supported counties. Working in close partnership with the CHTs will ensure that the roll out of CCM is taken forward by all implementing partners and is not limited to those working with RBHS.

Each of the three NGO partners already has some experience with CCM: IRC has a successful six-country CCM program, although this does not yet include Liberia; Africare has previously provided treatment of diarrhea at the community level and has operated an effective community-based FP program in Liberia; and EQUIP has also successfully provided CCM of diarrhea and malaria in the past in Nimba County. Furthermore, JSI has a proven track record in CCM in countries such as Nepal, and is providing important technical assistance to the MOHSW and our NGO partners. RBHS will build on this experience and expertise to inform the introduction and scale-up of CCM over three main phases.

Phase I: Selected District Level (May-December 2010)

In this phase, the three NGO partners will harmonize their approach to CCM with relevant elements of the MOHSW's Community Health Policy and Strategy, especially standardization of treatment guidelines, indicators, and M&E processes. RBHS will provide overall leadership in the development of protocols for conducting baseline assessment of communities, provision of supervisory training, ongoing M&E, and technical support through supervisory checklists, job aids, and BCC materials. Partners will be encouraged to be innovative in their approach to selecting and motivating gCHVs, and flexible in addressing supply chain issues. The results from this phase will be monitored, success stories documented, and plans for county level roll-out developed with full support from the CHTs.

Phase II: County Level Roll-out (January-October 2011)

In this phase, the NGOs and CHTs will jointly take forward the lessons from Phase I for wider implementation across the counties. The CHTs will be responsible for disseminating Phase I results, engaging all implementing partners in rolling out CCM, and managing the supply chain. RBHS will continue to guide the program's monitoring and evaluation, as well as documentation and dissemination of its successes. If they have not already done so, RBHS partners MTI (Grand Cape Mount, Bomi and Montserrado Counties) and MERCI (River Gee County) will phase in CCM, in collaboration with their respective CHTs.

Phase III: National Level (November 2011 onwards)

Recognizing that NGOs cannot by themselves ensure national scale-up of any public health program but that the MOHSW at the central and county levels must provide ongoing leadership, RBHS will turn over the reins for full implementation of CCM to all of the implementing partners under the leadership of the respective CHTs. The CHTs will lead the national level implementation across the rest of the counties under the leadership of the MOHSW. Although the CCM baton will be passed from RBHS to the MOHSW, RBHS will continue to monitor the impact of the program and its effects on neonatal, infant and under-5 mortality.

Engaging communities in managing health services

While each health facility is supposed to have a Community Health Development Committee (CHDC) to provide community linkages, support and oversight, many of these structures either do not exist or are poorly functioning. During the first quarter of PBC implementation, only 39% of RBHS-supported clinics reported having active CHDCs. Through its implementing partners, RBHS intends to establish and/or reinvigorate these structures, to ensure that communities have a role in the management of facility- and community-level health activities. Partners will assist the CHDCs to plan, monitor and evaluate services. Specific activities will include mobilization of communities around major health issues (e.g. vaccination campaigns), the establishment of referral systems, participation in M&E and quality assurance activities, physical maintenance of the health facility, general support of facility-based providers and gCHVs, and representation to the CHT. Implementing partners will conduct meetings with the CHDCs (up to two per quarter), to share data, provide programmatic feedback, listen to concerns, problem solve, and develop collaborative action plans.

Sub-objective 1.3: Increase access to comprehensive maternal, neonatal, and child health (MNCH) services

Key indicators	2010 target	2011 target	2013 target
----------------	-------------	-------------	-------------

% of deliveries in facility with a skilled birth attendant	25%	28%	35%
% of pregnant women receiving second or greater dose of tetanus toxoid	85%	89%	95%

As discussed, RBHS will continue to work with the MOHSW, implementing partners and other key stakeholders to scale up access to high impact, evidence-based interventions that result in sustainable improvements in MNCH status (see SOs 1.1 and 1.2). A range of activities will support this process, including standardization of protocols and guidelines, technical updates/ in-service training, distribution of job aids, supportive supervision, mentoring, monthly M&E and feedback, and engagement of communities.

RBHS is currently working with the Family Health Division to develop protocols and standards for MNCH. Once finalized, relevant elements will be incorporated into the proposed National Treatment Guidelines and in-service training curriculum. MNCH already forms a central component of the in-service program, with modules on IMCI, basic life saving skills (BLSS), family planning, and control of communicable diseases. RBHS will continue to support the roll-out of in-service training (see SO 2.6), including curriculum updates, and ensure that it is linked to monthly supportive supervision, effective M&E, and feedback. Moreover, we will collaborate with the MOHSW, professional associations, and other stakeholders to update pre-service curricula, as well as to provide technical updates for instructors on MNCH topics (see SO 2.3).

In collaboration with CHTs and CHDCs, RBHS will attempt to address the contextual factors that contribute to poor maternal, newborn and child health. Through its integrated BCC strategy, RBHS will promote positive behavior change, care seeking behaviors and increased demand for MNCH services. Specific interventions to increase service uptake will include the establishment of maternity waiting homes for women living far from health facilities; the distribution of “mama kits” to women delivering in facilities; and the integration of FP, HIV and nutrition services into ante-natal and post-natal care (ANC, PNC). RBHS recognizes that there are critical times when mothers and children interact with the health system (e.g. during deliveries, immunizations) and that opportunities must be taken to introduce them to a broader range of services.

Providing emergency obstetric and neonatal care

Given the high rates of maternal and neonatal mortality, a major priority for RBHS will be the establishment of emergency obstetric and neonatal care (EmONC) services. RBHS will support five comprehensive and nine basic EmONC centers (see Table 2). Key activities will include the physical renovation of health facilities (including the upgrading of four health centers to include an operating room); finalization of equipment specifications in collaboration with the Family Health Division; procurement and distribution of standardized equipment, drugs and supplies; recruitment of staff; and training of providers, including upgrading of surgical skills for selected physicians. Partners for the comprehensive EmONC Centers and the associated facilities are: International Rescue Committee (Curran Hospital, Lofa County; James N. Davies Junior Memorial Hospital, Montserrado); Medical Teams International (Sinje Health Center, Grand Cape Mount; Bensonville Health Center, Montserrado); and MERC I (Fishtown Health Center, River Gee).

In addition to establishing the 12 EmONC centers, RBHS will continue to improve the capacity of clinics to conduct safe deliveries, primarily through ensuring that trained midwives are at each facility. We will also intensify efforts to encourage women to deliver in facilities, though sensitization in communities and incentives to trained traditional midwives (TTMs) and women themselves (e.g., free ITN). That is one example of how facility-level EmONC services will be closely linked to those

in the community to minimize the “three delays”: delays in deciding to seek care; delays in reaching care; delays in receiving care. Stakeholders will be engaged at each level to develop “birth preparedness” plans. This will include preparations for a normal birth, while ensuring that measures are in place to rapidly identify, refer, and manage any maternal or neonatal complications. TTMs and gCHVs will play an important role in the birth preparedness processes, to identify pregnancy-related complications at community level and to refer rapidly. Communities will be mobilized to ensure that transportation is readily available for women experiencing an obstetric emergency. Close monitoring and evaluation of EmONC services will be undertaken, utilizing the well established UN process indicators.

Table 2: EmONC Centers to be supported by RBHS and partners

Facility Type	County	District	Health Facility Name	NGO
COMPREHENSIVE EMONC CENTERS				
Hosp	Lofa	Zorzor	Curran Lutheran Hospital	IRC
Hospital	Montserrado	Paynesville	Davies Hospital	IRC
HC	Montserrado	Careysburg	Bensonville HC	MTI
HC	Grand Cape Mount	Sinje	Sinje HC	MTI
HC	River Gee	Potupo	Fish Town	MERCI
BASIC EMONC CENTERS				
HC	Grand Cape Mount	Porkpa	Damballa	MTI
Hosp	Bong	Fuamah	Bong Mines Hospital	Africare
Clinic	Bong	Salala	Salala Clinic	Africare
Clinic	Bong	Sanoyea	Gbonota	Africare
HC	Lofa	Zorzor	Konia HC	IRC
Hospital	Nimba	Saclepea	Saclepea Health Center	EQUIP
HC	Nimba	Yarwein-M	Zekepa Health Center	EQUIP
HC	River Gee	Gbeapo	Gbeapo	MERCI
HC	River Gee	Sarbo	Sarbo Health Center	MERCI

Misoprostol has generated great interest as an affordable method for preventing and treating postpartum hemorrhage (PPH) in Liberia. But it is currently recommended by the World Health Organization (WHO) only for settings in which it is not possible to use oxytocin or other uterotonic medications – and then, only for prevention of PPH, not for treatment². RBHS will explore the appropriateness of introducing misoprostol in the Liberian setting with the MOHSW, although it is not yet on either the WHO or Liberian *Essential Medicine Lists for that purpose*. Studies are ongoing to determine its effectiveness, feasibility, and safety at community level and RBHS will follow the results eagerly. We are also exploring collaboration on a similar study with the University of Michigan in Liberia. If, following this research, WHO and the MOHSW determines that

² WHO. WHO Statement regarding the use of misoprostol for postpartum haemorrhage prevention and treatment. 2009.

misoprostol can and should be used more widely, we will work with the MOHSW to introduce and scale up access.

Improving nutrition: institutionalizing the Essential Nutrition Actions

RBHS is collaborating with the MOHSW and Unicef to institutionalize the essential nutrition actions (ENA) within the BPHS. The ENA framework is a recognized strategy to expand the coverage of six affordable and proven nutrition interventions that emphasize the prevention of malnutrition. The interventions can be applied at health facilities and in communities, and are promoted through a range of communications channel, including mass media. They include: exclusive breastfeeding for 6 months; adequate complementary feeding from 6-24 months with continued breastfeeding for at least two years; appropriate nutritional care of the sick and severely malnourished child; adequate intake of iodine by all household members; adequate intake of vitamin A for women and children; and adequate intake of iron for women and children.

The approach aims to reach at least 80% coverage of the ENAs through contact with mothers and children at those periods when they are most vulnerable and when malnutrition can be effectively addressed³. In so doing, RBHS expects to contribute to reductions in rates of acute and chronic malnutrition, which are measured through the Demographic and Health Survey. In September 2009, RBHS and UNICEF developed an action plan to integrate the ENA framework into existing health services, including at community level. Over subsequent months we have collaborated on the development of advocacy materials, training curricula (for managers, providers, and community groups), and MNCH job aids. Three training of trainer courses have been conducted, prior to cascade training at county level (see below). In addition, a BCC strategy has been developed, tested and finalized in collaboration with the MOHSW. This has included the insertion of ENA messages into the new mother and child health cards.

Moving forward, RBHS will continue to collaborate with Unicef and MOHSW at the national level to update and harmonize the nutrition components of all relevant trainings, including pre-service curricula, in-service curricula (e.g. IMCI and integrated modules), and community health worker modules (e.g. gCHV, TTM). Moreover, we will seek advocacy opportunities to raise awareness at national and county levels (“Why nutrition matters”), and to promote greater collaboration among stakeholders.

At county and community levels, RBHS will work with Unicef to roll out the cascade training of facility-based providers, gCHVs and TTMs. The planning and conduct of all trainings will be done in collaboration with the CHTs. These will be complemented by a series of job aids and checklists for key MNCH interactions (e.g. ante-natal care, post-partum/family planning, EPI, sick child visit), which will also address the relevant ENAs. A system of quarterly review meetings will be established at the CHT level to enhance technical and managerial skills among health providers.

We will distribute up to 40,000 mother’s cards and 40,000 child cards, to act as a source of information for families and as a reference for counseling/negotiation by health workers. Quarterly review meetings with gCHVs and TTMs will be established at the community level to enhance counseling and negotiation skills. We will co-sponsor the broadcast of radio spots

³ These periods are during: pregnancy, delivery and postpartum, the first six months of life, six to 24 months, childhood illness, and adolescence/youth.

developed by Unicef to promote the importance of infant and young child feeding and to reinforce messages provided at the health facilities.

Sub-objective 1.4: Increase uptake of three critical malaria interventions: Treatment with ACT, preventive treatment of pregnant women, and sleeping under ITNs

Key indicator	2010 target	2011 target	2013 target
% of pregnant women provided with 2nd dose of IPT for malaria	33%	50%	85%

Malaria remains the major cause of morbidity and mortality in Liberia. It accounts for 34.5% of all outpatient visits and 33% of all in-patient deaths⁴ – and 47% of diagnoses among children under the age of 5 in RBHS facilities during the first quarter of PBC implementation were malaria. The RBHS approach to improving malaria prevention and control is closely linked to the Operational Plan (MOP) of President’s Malaria Initiative (PMI) and has been designed following close consultation with the NMCP. It includes components that address BCC, clinical services at facility and community levels, training, and capacity building and management support of the NMCP.

BCC

RBHS is implementing a range of strategic BCC activities that aim to promote positive attitudes and behaviors to the four critical malaria interventions. These activities will be implemented through the integrated community/facility level approach outlined in SO 1.2, complemented by a series of phased national campaigns. Standard BCC best practices are being observed in the development and roll-out of the messages and materials, including broad stakeholder consultation, pre-testing, utilization of local languages, and monitoring and evaluation (utilizing “dipstick” surveys). Malaria messaging is designed to be consistent and re-enforcing at every level (e.g. community, facility, county, national) and through every channel (e.g. gCHVs, Mother’s and Child’s Health Cards, providers, opinion and traditional leaders, mass media, posters, bulk SMS texting).

The first national campaign is focusing on ITNs and was launched in November 2009. It has included several of the channels outlined above, including broadcasting of over 5,000 messages in 10 languages on 11 radio stations. The National Traditional Council (NTC) of Liberia and the Liberian Crusaders for Peace have been engaged to undertake a series of advocacy meetings with the traditional chiefs in each county. Funding is being directed to the Crusaders for Peace who will, in turn, work with the NTC to mobilize chiefs and other community leaders around the issue of ITN use. Subsequent campaigns addressing early case management of malaria and

⁴ Health Facility Survey, NMCP, 2009

IPT will be phased in over time. Each of the campaigns is scheduled to run for 8 – 12 months initially, with subsequent cycles of shorter duration.

Pre-service and In-service Training

RBHS has recently hosted workshops to ensure that the malaria modules of the pre-service and in-service curricula are consistent with NMCP standards and guidelines. Key stakeholders, including NMCP, MENTOR and representatives of the training institutions, have contributed to updating the modules on malaria in pregnancy (MIP), malaria case management, and IPT. RBHS will ensure that any future changes in national standards or guidelines are reflected in the curricula. For example, the NMCP is planning changes to the formulation of artemisinin-based combination therapy (ACT) used in the national treatment protocol. When this change takes place, RBHS will move quickly to disseminate the new protocol and to collaborate with its partners to update both in-service and pre-service curricula.

Improving Access to and Quality of Malaria Case Management

RBHS will ensure the quality of malaria case management at the facility level through institutionalization of the national protocol, monthly supportive supervision, and a process of continuous quality assurance (see SO 1.1). We will also pursue the implementation of CCM of malaria, once the national protocol is finalized. As outlined under SO 1.2, RBHS considers CCM of malaria and other childhood infections as a critical intervention to reduce infant and child mortality in Liberia. The success of the CCM approach will be dependent to a large degree on the selection processes for the CHVs, and the systems established for supervision and M&E. RBHS plans to introduce CCM in 2 to 4 districts initially, refine the management model, and scale up services to other districts thereafter (see SO 1.2).

Improving NMCP Management Capacity

RBHS has recently recruited an international consultant to assist the NMCP to update the National Malaria Control Strategy, to contribute to the costing of the strategy, and to prepare a submission for Round 10 of the Global Fund for AIDS, TB and Malaria (GFATM). RBHS is currently working with NMCP to identify an advisor to assist with the costing of the strategy. As the need arises, RBHS is prepared to provide further assistance to the NMCP to make subsequent adjustments to the strategy in the future. In addition, we will explore options to support the attendance of NMCP staff at short courses and conferences, to develop both their technical and managerial skills. Specifically, NMCP staff will be supported to attend a workshop on monitoring and evaluation in Ghana in June 2010.

NMCP's capacity to manage malaria services at the county level will be expanded through the development and roll-out of the National Health Plan's nine support services. RBHS is playing a key role in this process, especially through the roll out and institutionalization of guidelines/SOPs for County-level planning and budgeting, health management information systems (HMIS), supervision, vehicle maintenance, and supply chain management (see SO 2.5). Moreover, we will assist in the development and roll-out of the remaining support systems, in collaboration with the MOHSW and other partners (these include human resources, stakeholder coordination, procurement, and health financing).

Finally, RBHS received funding from USAID to support the renovation of a building as the new headquarters of the NMCP. But a quotation from an architectural and engineering (A&E) firm indicates that this activity is substantially under-budgeted. It is expected that RBHS will receive

supplemental funds to instead support the erection of a pre-engineered warehouse for the National Drug Service (NDS) which will, in turn, assist the NMCP to address some of their drug management and supply chain needs.

Sub-objective 1.5: Increase access to quality HIV and TB services

Key indicators	2010 target	2011 target	2013 target
Number of people who received HIV counseling and testing and received their test results	2,500	7,000	10,000
% of RBHS facilities providing the minimum package PMTCT services according to national and international standards	50%	60%	80%

Access to and uptake of HIV services remains limited throughout Liberia, including counties where RBHS is operational. While the national HIV prevalence rate of 1.5% is relatively low compared to many other African countries, sentinel surveillance of pregnant women in urban antenatal clinics has demonstrated a rate of 5.7% among this group. There is some evidence that countries emerging from conflict are at risk of escalation of the HIV epidemic; so it will be important to expand services rapidly and effectively in Liberia. Early in year 2, the NACP had drafted a phased scale-up plan to introduce a comprehensive range of HIV services into prioritized health facilities and communities across the country. RBHS had originally aligned its own HIV plan with that of the NACP, but the NACP plan has recently been shelved. RBHS is therefore in the process of drafting its own scale-up plan at the time of writing. Similarly, the NLTCP is developing its own scale-up plan, including access to community-based DOTs, and RBHS will align our activities where possible.

BCC and Social Marketing

Like the NACP, the RBHS strategy places special emphasis on prevention, but links it closely to care and treatment. We aim to increase positive attitudes and behaviors concerning HIV through BCC and social marketing. Firstly, we will review existing messages and materials in collaboration with the NACP and evaluate their effectiveness. Thereafter, we will undertake formative research to refine existing messages and materials, and/or develop new ones. These will be pre-tested with a range of target audiences, especially youth, prior to broader dissemination. Messages will be designed to appeal to both those in the general population exhibiting risk behaviors (e.g. multiple partners), as well as specific known vulnerable populations (e.g. in- and out-of school youth, STI clients, TB clients, commercial sex workers, and mobile populations such as truckers). In addition to promoting abstinence, being faithful, and appropriate use of condoms (ABC), RBHS will work with NACP to develop messaging that addresses stigma reduction and prevention for positives, and encourages uptake of services.

A multi-level communication strategy will be employed, including interpersonal communication (e.g. through gCHVs, TTMs, peer educators, and facility-based providers), printed materials, and electronic media. We will trial prevention information outlets (PIOs) to communicate ABC messages among youth. Furthermore, RBHS will conduct master training for implementing partners on the Journey of Hope Kit - a package of resources designed to facilitate discussion on five main topics: HIV prevention, promoting VCT, promoting early care seeking, reducing stigma and discrimination, and support for persons living with HIV/AIDS (PLWHAs).

Through a sub-grant to partner Population Services International (PSI), RBHS is currently undertaking a condom social marketing and BCC campaign. Data from the Liberian DHS demonstrates that individuals aged 15 and 24 years are those most likely to engage in higher risk sex and least likely to use condoms. Liberia also has the second highest teenage pregnancy rate in the world, providing evidence of a large sexually active teenage population. These youth require targeted services including prevention of unintended pregnancy and HIV, and voluntary counseling and testing (see SO 1.6). The social marketing and associated BCC activities aim to reduce the transmission of HIV and unintended pregnancies by encouraging responsible sexual behavior and increasing condom use among sexually active youth.

Pre-service and In-service Training

As with malaria, RBHS has collaborated with stakeholders to ensure that the HIV and TB modules of the pre-service and in-service curricula are consistent with NACP and NLTCP standards and guidelines. While it was not possible to incorporate NACP training modules in their totality into the in-service training (e.g. training on HIV counseling and testing alone extends for 8 days), the HIV module nonetheless constitutes the largest single component of the Communicable Diseases section of the in-service training program.

Supporting Service Delivery

Consistent with the NACP scale-up plan, national standards for HIV services will be introduced into RBHS-supported health facilities. Standards have been established for key interventions, including HIV counseling and testing (HCT), prevention of mother to child transmission of HIV (PMTCT), and treatment with anti-retroviral drugs (ARTs). During year 2 of RBHS, the original NACP plan called for introduction of HCT services at 18 facilities, PMTCT at 40 facilities, and ART at two – although the recent cessation of the plan is requiring a recalculation by RBHS. PMTCT will also be introduced at all comprehensive EmONC centers supported by RBHS. RBHS will coordinate with NACP to ensure that staff receive the relevant training, supervision, and support, and that services are of good quality. In addition, we will ensure that the NACP M&E procedures and tools are consistently applied. Referral systems will be established for those seeking HCT and PMTCT services when these are not readily available, as well as for those testing positive for HIV. Health worker safety will be secured by enforcing the recently-developed standards for infection control and by instituting standardized waste management procedures.

RBHS will also support and develop services for PLWHAs, through collaboration with the Positive Living Association of Liberia (PLAL). PLAL has recently received funding from Bristol-Myers Squibb to train peer counselors, to develop a home-based care protocol, to undertake a strategic planning exercise, and to establish mechanisms for M&E. RBHS will provide technical assistance to PLAL on these issues and on the integration of services, such as FP and nutritional care. Provided that funding is available, we will also explore the potential of expanding its activities to other RBHS counties beyond Bong and Montserrado.

Finally, we will look for opportunities to implement multi-sectoral approaches to HIV prevention and control, working with Ministries of Education, Youth and Sports, Gender and others, making use of the JSI Fellows program to identify opportunities for collaboration. RBHS will explore collaboration with other USAID technical teams and development programs to facilitate linkages and offer opportunities in areas such as education. Potential partnerships with private sector organizations may provide additional channels for reaching at-risk populations, e.g. through work-place programs, special events, etc.

Increasing access to TB services

Key indicators	2010 target	2011 target	2013 target
Case detection rate of new smear-positive pulmonary TB cases	70%	72%	75%
Treatment success rate for of registered new smear-positive pulmonary TB cases	80%	85%	>85%

The number of reported cases of TB has doubled in Liberia over the past eight years due to a combination of co-infection with HIV and increased detection through improved surveillance. In 2006, the World Health Organization estimated that there were close to 12,000 individuals with TB in Liberia, although this is almost certainly an underestimate. As noted previously, the NLTCP is in the process of developing a scale-up plan to increase access to TB services. This needs to be done with close supervision and oversight, as NLTCP data indicates that cure rates have been below 75%, with the associated risk of contributing to drug resistance. Cases of multiple drug resistant (MDR) TB were detected for the first time in 2008, highlighting the need for a tightly run program.

The task of ensuring good quality TB services is difficult, given that most staff are poorly trained and motivated to treat TB, and that many patients live far from health facilities and/or come from across the border in Sierra Leone and Guinea. These types of patients are frequently lost to follow-up.

RBHS will work closely with the NLTCP to institute both facility-based and community-based TB services in a phased approach, aligned with the NLTCP timetable. We aim to detect over 70% of smear-positive pulmonary TB cases and to successfully treat over 85% of those cases, by 2011. This will be achieved through improved patient education, and training and close supervision of health workers. Special attention will be given to those patients co-infected with HIV and TB. RBHS will also assist in the dissemination of the NLTCP's Tuberculosis Manual, scheduled for release later in 2010. The new manual outlines clinical standards for care of TB patients and RBHS will ensure that the standards are consistently applied.

At community level, we will facilitate the NLTCP's phased introduction of community-based DOTs, including a patient "buddy" system. RBHS's partner in Bong County, Africare, is already collaborating with NLTCP on a community-based DOTS pilot program linked to five facilities. Since commencement, TB detection rates have increased from 2 per month to 8 per month, and gCHVs are supporting TB patients with drug delivery and emotional support.

With the assistance of our implementing partners, RBHS will monitor and support the supply chain to ensure a consistent stock of TB drugs. Together with NLTCP, we will strengthen laboratory services through training and institutionalization of quality assurance for sputum microscopy. We will implement close monitoring and evaluation of detection rates and treatment success rates. NLTCP has faced a challenge collecting data from the counties and we will assist with surveillance and data management.

Where appropriate, RBHS will also provide technical assistance to the NLTCP on issues such as policy development, treatment guidelines, and implementation of the recently developed national standards and infection control procedures. We will explore the possibility of conducting an evaluation of the national TB program, in consultation with technical experts from USAID. All activities will be conducted in close consultation with NLTCP leadership.

Sub-objective 1.6: Increase access to comprehensive family planning and reproductive health services

Key indicators	2010 target	2011 target	2013 target
Number of counseling visits for FP/RH	13,000	35,000	50,000
Couple-years of contraceptive protection provided by RBHS-supported facilities	4,500	9,000	13,000

RBHS emphasizes a comprehensive approach to reproductive health⁵ (RH), but gives special emphasis to family planning (FP) and youth services. While the BPHS includes FP/ RH, these services remain poorly developed and inadequately delivered at both facility and community levels. The need for such services is high in Liberia (total fertility rate of 5.9; teenage pregnancy rate of 48%; contraceptive prevalence rate of 11%; unmet need for contraception of 36%). Long-acting and permanent methods of contraception are under-utilized, meaning that most couples are not using the most effective methods to space or limit their births. In addition, the majority of couples who say that they have finished their family size are still use short-acting methods (pills and injectables).

RBHS Approach

It will take concerted efforts in Liberia to encourage men and women to adopt family planning, to empower those women interested in spacing births for longer than two years, and to limit the transition period from short-acting methods to longer-term methods. There are a number of constraints to the uptake of FP/RH services, including poor health workers skills, limited FP choices, knowledge gaps and attitudes among community members, and inconsistent demand. In addition, the MOHSW has historically given relatively low priority to FP/RH, although this is gradually improving. RBHS will address each of these issues through activities at community, facility, county and national levels.

RBHS is adopting a two-pronged approach to scaling up FP services:

- Advocacy and technical activities at central level, with a flow-on effect for all 15 counties;
- Comprehensive programming in the seven counties supported by RBHS, including community-level services.

Advocating with and providing technical assistance to MOHSW

At the central level, RBHS was a significant contributor to the MOHSW's Sexual and Reproductive Health Policy and advocated strongly for the inclusion of community-based distribution of FP commodities within that policy. More recently, we have been playing a leadership role in drafting the National Family Planning Strategy, which will guide service delivery at both facility and community levels. Furthermore, we remain an active member of the Ministry's Reproductive Health Technical Committee. RBHS will capitalize on its close relationship with the FHD and other MOHSW units to continue our advocacy for increasing the access to and quality of FP/RH services. Our full-time FP/RH Advisor represents RBHS to the MOHSW, provides technical assistance as necessary, advises on policy, and works to ensure that FP/RH remains among the Ministry's main priorities.

⁵ See SO 1.2 for details on maternal health/safe motherhood and SO 1.5 for details on HIV STIs.

The technical and advocacy work with the MOHSW will have an impact beyond the seven RBHS counties and extend to all 15 counties in Liberia. Ongoing and future activities include: further development and refinement of family planning strategies and approaches; development of training curricula, training manuals and job aids; design of services to meet the special needs of adolescents and youth; and efforts to improve contraceptive availability, security and supply.

Building health worker skills

Human resource constraints in Liberia are real, and will affect the project if not addressed. Few health workers are knowledgeable about FP/RH issues – baseline data from our implementing partners suggest that only 42% of RBHS-supported facilities had a staff member skilled in counseling on FP, although this has recently improved to 72% due to recruitment efforts by our implementing partners. In addition, motivation for promoting FP is often low, due in part to its low prioritization within the Liberian health system. RBHS plans to address these problems by strengthening curricula, providing access to formal and on-the-job training, sensitizing health workers to FP/RH issues, and providing supportive supervision.

RBHS is playing a key role in revising the pre-service curricula for registered nurses (RNs), physician assistants (PAs), and certified midwives (CMs). FP/RH is a key component of these curricula, which address the full range of FP choices and counseling skills. In addition to curriculum development, RBHS will strengthen the skills of instructors, who will be given priority for attendance at in-service and other planned trainings, and build the capacities of clinical training sites to provide FP/RH services.

RBHS has also been a strong advocate for inclusion of FP/RH in the integrated modules of the in-service training program (see SO 2.6). Upgrading the skills of current providers is a priority, but the two-day in-service module on FP/RH is more introductory in nature and unlikely to fully develop the competencies of participants. RBHS is therefore collaborating with MCHIP, which is implementing a comprehensive, evidence-based training that standardizes and upgrades clinical skills. We are working with MCHIP in the development, planning, and roll-out of this program, including the identification of pre-service tutors, clinical preceptors, and in-service trainers. Thirty trainers will be trained from the MOHSW and partners, after which RBHS will help to coordinate cascade training for all of our counties. RBHS will also provide material and technical support to strengthen the clinical training site at Redemption Hospital, which will be essential for the success of the training.

Through training and on-going supportive supervision, RBHS will sensitize health workers on the importance of FP/RH services, including the impact that birth spacing has on maternal and child health outcomes. Supervision will also be important to monitor the quality of services, as well as of to provide on-going mentoring and capacity building. Job aids will be distributed to each RBHS health facility and copies of standardized protocols provided, e.g. for the treatment of sexually transmitted infections (STIs).

Expanding the range of services

Working through our partners, RBHS will widen the FP choices available; integrate FP/RH into other services (e.g. ANC, HIV); build the capacity of service providers; inform and educate communities; extend the availability of services beyond the health facilities; address the special needs of youth; and advocate with the CHTs. The image of family planning will need to be improved at all levels – including between couples. Improvements in access to and quality of

services can increase uptake, improve continuation, instill confidence in the methods, and improve knowledge and acceptability of family planning in communities.

Already we have documented some progress. Data from the first quarter of the RBHS performance-based contracts demonstrated low coverage for all FP/RH indicators. Encouragingly, however, these same indicators revealed significant improvements by the third quarter, with the greatest gains in the number of counseling visits for FP/RH (from 3,159 to 8,073 visits per quarter) and couple-years of contraceptive protection (CYP) (from 1,135 to 1,633 years). Note that we measure contraceptive use in two ways: CYP is a measure of services delivered and is a proxy for the contraceptive prevalence ratio (CPR), an RBHS impact indicator that gives the proportion of women of reproductive age who use a modern method of contraception. Our 5th-year CYP target of 13,000 roughly corresponds to our end-of-project CPR target of 12%.

RBHS will offer a comprehensive range of FP services and is committed to providing informed choice to individual women and men, as well as couples. Clients will be informed of the full range of modern (e.g. pills, injections, condoms, IUDs, lactational amenorrhea, long-term methods) and natural/traditional methods, as well as how and where they may be accessed. Posters outlining the range of FP options will be placed in consultation rooms at all RBHS-supported facilities. We will ensure the consistent availability of FP commodities at the clinics and health centers, and work with partners such as DELIVER and the National Drug Service to address supply chain problems. Clients will be referred for services when they are not available locally.

Together with the MOHSW's Family Health Division (FHD), we will develop standards and policies to ensure that FP counseling and provision is integrated into other health services, including antenatal and postnatal care, post-abortion care, sexually transmitted infection (STI) consultations, HIV services (e.g. PMTCT), and child health and welfare services. RBHS is promoting the Peri-natal Approach to Childbearing, which offers a broad package of education and care from the first antenatal visit to the end of the post natal period, six weeks after delivery. Services made available through this package will include antenatal care, labor and delivery care, exclusive breastfeeding, FP, and post-partum monitoring and follow-up.

RBHS will ensure that the following services are consistently available at all RBHS-supported health facilities:

- Clinics: oral contraceptive pills, injectables, condoms, promotion of lactational amenorrhea, fertility awareness methods;
- Health centers: all of the above, intra-uterine devices;
- Hospitals: all of the above; permanent methods (sterilization)

RBHS will initiate and strengthen the referral system to ensure that clients can access their preferred method of choice.

Informing the community

FP/RH are among the key topics to be addressed through RBHS's integrated BCC strategy for facility and community levels. We will inform and mobilize communities on issues such as the health benefits of birth spacing, the importance of delaying sexual debut for youth, and the prevention and response to GBV. TTMs and gCHVs will be trained to educate households on

relevant topics, to distribute FP commodities (see below), and to refer for more comprehensive services. Religious leaders and tribal chiefs will be engaged to determine how culturally appropriate messages can be effectively delivered to their congregations and communities. Messages at community level will be consistent with those provided at the health facilities. Posters and other printed materials will be placed where people congregate, such as markets, hair braiding salons, schools, etc. The Mother's and Children's Health Cards each have a section dedicated to FP (two pages and one page respectively).

Messaging through mass media will complement the community- and facility-level activities. County or community level campaigns using dramas and peer educators may also be effective. These combined efforts will be key to increasing demand for and use of FP/RH services. During year 2 RBHS will collaborate with the MOHSW on a national campaign to address the important issue of teen pregnancy. Developed in collaboration with the HPU and FHD, the campaign will encourage youth to consider the risks and implications of early sexual activity, and to make smart, informed choices regarding their reproductive health. Messages and materials are being developed with the assistance of youth groups and pre-tested among target audiences such as school students, out-of-school youth, pehn-pehn boys, and wheelbarrow boys. The main theme will be "Baby by choice, not by chance". The campaign is being coordinated with PSI to ensure that messages are consistent and complementary.

Providing services at community level

As referenced in SO 1.2, RBHS intends to extend access to FP services through community-based distributors linked to local health facilities. Projects in Bong, Montserrado and Nimba counties, funded through USAID and UNFPA, had previously documented good results with community-based distribution (CBD). But the cessation of the two projects has since led to a weakening and, in most areas, discontinuation of services. Together with the MOHSW, RBHS is designing a comprehensive strategy to extend services to the community level in three main settings: household (house-to-house approach), workplace, and universities/colleges.

Similar to CCM, success of the CBD activities will depend on strong management. RBHS is working with the MOHSW to develop a phased roll out plan that will initially begin in four RBHS-supported counties (Bong, Grand Cape Mount, Montserrado, River Gee), but will expand to all seven counties during year 3. We are taking the lead in developing technical materials (CBD guidelines, trainers/supervisors manual, trainee manual, job aids) that can be disseminated and used nationally, beyond RBHS counties. In addition, we are assisting the MOHSW to select and train Master trainers in CBD, who will then train county-level trainers and supervisors. RBHS will work with the MOHSW and our partners to address contraceptive security including streamlining logistics to ensure consistent availability of family planning commodities at facility and community levels. Lessons learned from advocacy and community mobilization efforts to generate demand for CBD services will also be shared with stakeholders in non-RBHS counties.

The house-to-house approach will be introduced by RBHS partners in three counties (Bong, Grand Cape Mount, River Gee) in year 2, with expansion to other counties in year 3. Similar to our approach to CCM, there will be three phases:

- Phase 1: Selected District Level (May – December, 2010). Community mobilization efforts will be designed to inform stakeholders and generate demand. While FP choices and indicators will be standardized, partners can be flexible in the process of selecting, design of supervisory structures, motivation mechanisms, etc. Both gCHVs and TTMs

will be trained as distributors, using standardized curricula. The introduction and scale-up of activities will be timed to coincide with the building of health worker skills, so that appropriate supervision of distributors occurs and so that facilities are adequately staffed to receive referrals. MOHSW policy precludes the payment of a regular salary or incentive to volunteers, but does permit transportation and daily subsistence allowances in certain circumstances (e.g. supervisory meetings). To increase motivation and sustainability, RBHS will provide these allowances and explore other options to incentivize gCHVs and TTMs (e.g. T-shirts, caps, trainings, non-monetary rewards for good performance). RBHS will provide technical leadership, including guidance on baseline assessments, supervision, job aids, etc. Lessons learned, including success stories, will be documented and disseminated, and plans for county-level roll out developed.

- Phase 2: County Level (January – December 2011). RBHS partners and the CHTs will take the lessons from the first phase to guide the expansion of services to cover all districts in the original counties and to introduce and expand services in the other RBHS-supported counties. The CHTs will take the lead on engaging all non-RBHS implementing partners in rolling out CBD and managing the supply chain. RBHS will continue to guide the program's monitoring and evaluation, as well as documentation and dissemination of lessons learned.
- Phase 3: National Level (January 2012 onwards). RBHS partners will ensure that they attain full coverage of their counties, where feasible and appropriate. Together with its partners, RBHS will work with the central MOHSW and CHTs to further disseminate tools, strategies, and lessons learned so that CBD is eventually implemented on a national scale. While CHTs will be encouraged and empowered to take the lead in managing activities together with NGO partners, RBHS will continue to play important monitoring and technical roles.

Not only will RBHS extend access to FP through gCHVs, we will introduce services at market places and university campuses. RBHS's Market Women's Health Project, to be conducted in collaboration with the Family Planning Association of Liberia (FPAL) and co-funded by UNFPA, will provide counseling, contraceptive commodities, and referrals to women where they work and shop, ensuring that services are readily accessible. The likelihood of uptake will be increased, as peers with whom the women work and already have relationships will provide services. BCC materials (posters, leaflets) will be used to facilitate health talks and will be placed in conspicuous areas in the market place. Health education flipcharts from the MOHSW will be used to train service providers and will serve as a useful resource for counseling clients. Education on safe sex practices, including HIV and STI prevention, will be provided in all service areas. Clients will have direct access to sources of information and condoms. RBHS will ensure close monitoring and evaluation, including data validation. Referral points will be identified in collaboration with the County Health Teams and local health facilities, and arrangements made for follow up of referrals. Activities will initially be introduced at seven urban/suburban markets in Monrovia, specifically: Duala Market, New General Market Waterside, Jorkpen's Town (Nancy B. Doe) Market, Rally Time Market, Gobachop Market, Logan Town Market, Super Market Gardnerville. Expansion to markets in the other RBHS-supported counties (which generally operate one day per week), will be included in Phase 2 activities by our implementing NGO partners, with a minimum of two markets targeted per county. Saclapea Market in Nimba County is one of the largest in the rural areas and will be specifically targeted.

During the last quarter of year 2, RBHS will begin to introduce FP services on the campuses of five universities and colleges: African Methodist Zion University, African Methodist Episcopal University, Smythe Institute of Management, United Methodist University, and University of

Liberia. A similar range of services will be provided as per the market women's project: counseling, contraceptives, and referral. Students will be trained as peer counselors and as distributors. The implementing partner for this project will be determined following the release of a request for proposals. RBHS will oversee close monitoring and evaluation of activities.

Addressing the needs of youth

Liberia's teenage pregnancy rate is the second highest in the world at an alarming 48%. The health risks posed by pregnancy and delivery prior to full physical maturity are substantial, and include anemia, fistula, low birth weight, and death. In fact, 80% of fistula repairs conducted in Monrovia are reported to be among teenage girls. And because teenagers do not usually intend to become pregnant, there is reportedly an increasing number of illegal and unsafe abortions in Liberia. The high pregnancy rate also indicates that youth commonly engage in unprotected sex and are therefore exposed to STIs, including HIV.

In spite of these problems, many youth are reluctant to access FP/RH services, or are unaware of their availability. In addition, negative attitudes among parents, teachers, and providers often discourage teens from accessing services. RBHS intends to address the challenges by providing information and outreach, tailoring services to the specific needs of youth, supporting social marketing of condoms, and exploring school-based health services.

BCC activities will aim to inform youth of the health consequences of teenage pregnancy, increase knowledge about HIV and STIs, and promote responsible sexual behavior. RBHS will employ targeted interpersonal communication (including peer-to-peer), community outreach, and mass media to communicate messages that promote abstinence, delayed sexual debut, fidelity, and FP and condom use. Messages and materials specifically targeting youth will be developed in collaboration with the MOHSW, RBHS partners, and other stakeholders. The national campaign to reduce teenage pregnancy will be one of RBHS's major activities during year 2 (see above). Through our partner PSI, we will continue the social marketing of condoms, targeting sexually active youth aged 15 – 24 years (see SO 1.5). We will also collaborate with PSI to help youth accurately assess the risks associated with having multiple partners, cross-generational relationships and transactional sex.

RBHS will sensitize health workers to the specific FP/RH needs of youth, to reduce stigma and to promote the uptake of services. Together with the MOHSW and our implementing partners, we will review the criteria and guidelines for youth-friendly services developed by UNFPA and WHO, to determine what can be adapted and used in Liberia. We will explore the integration of youth-friendly services at existing service sites and consider the establishment of non-traditional sites. RBHS will ensure that the latest materials and field lessons are analyzed, especially from those African programs with demonstrably successful youth-friendly services. Consideration will be given to establishing youth-oriented ANC days at selected RBHS facilities.

Finally, RBHS will lead the development of age-specific educational materials on human sexual development and adolescent reproductive health. We will seek broad collaboration on this activity, especially with the FHD and the Ministries of Education, Youth and Sport, and Gender and Development. We will explore the introduction of a school-based health curriculum and, potentially, limited school-based health services.

Preventing and responding to Gender-based Violence

Gender-based violence (GBV) was widespread during the wars, although a 2007 study indicates that the incidence has reduced during the post-conflict period.⁶ Nonetheless, 61.5% of respondents to the study reported lifetime experience of intimate partner violence. President Ellen Johnson-Sirleaf has identified GBV as a major national priority – but unfortunately coordination among key stakeholders remains suboptimal. Preventing and responding requires a multi-sectoral response that includes medical, psychosocial, legal, and community services. RBHS and its partners will not be able to provide the full range of services, but we will ensure that the relevant care is available at our health facilities and that survivors are then referred appropriately.

Through our BCC activities, RBHS will reach out to young men to identify and promote positive role models in an effort to change attitudes and to prevent GBV. As a priority, RBHS aims to provide survivors of rape and other forms of GBV with access to good quality clinical care. We will collaborate with the MOHSW, the Ministry of Gender and Development, and partners to ensure that national protocols for the clinical care of rape survivors are introduced at RBHS-supported facilities. Most clinical staff have never been trained in the appropriate care of rape survivors and there are often cultural and other constraints that limit access to such care. We will explore the use of the IRC's interactive multi-media tool *Clinical Care of Sexual Assault Survivors* to sensitize health facility staff to the special needs of survivors and to train providers in appropriate clinical management. In collaboration with our partners and GBV stakeholders, we will work to develop a referral network to ensure that survivors have access to the full range of services.

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

The Liberian *National Health Plan* specifies four main components on which the health system is to be reconstructed: 1) The Basic Package of Health Services; 2) Human Resources for Health; 3) Infrastructure; and 4) Support Systems.⁷ During year 1, RBHS has collaborated with the MOHSW on developing each of these - primarily human resources, infrastructure, and health policy (as one of the nine support systems). In year 2 we will continue our work on human resources and infrastructure, while our role in support systems development will expand, as we assume those activities previously undertaken by the BASICS project. BASICS made substantial contributions to health systems strengthening in Liberia, especially in the areas of planning and budgeting, health management information systems (HMIS), logistics and communications (e.g. vehicle maintenance), and monitoring and evaluation (e.g. supervisory SOPs). RBHS will continue to develop and strengthen each of these support systems, as well as work with the MOHSW to prioritize the development of others. Through these activities we aim to strengthen the delivery of health services, build the capacity of the MOHSW at both central and county levels, and support the national process of health system decentralization.

⁶ Tomczyk B, Goldberg H, Blanton C, et al. Women's Reproductive Health in Liberia: The Lofa County Reproductive Health Survey, January–February 2007

⁷ The nine support systems include: Policy formulation & implementation; Planning & Budgeting; Human Resources Management; Health Management Information Systems; Drugs & Medical Supplies; Facility & Equipment Maintenance; Logistics & Communication; Supervision, Monitoring & Evaluation; and Stakeholder Coordination.

Sub-objective 2.1: Enhance TNIMA and Zorzor learning environments and resources

As discussed, the RBHS infrastructure program has ambitious objectives. During year 2 the major projects will include substantial renovations at two of Liberia's most important health worker training institutions: the Tubman National Institute for Medical Arts in Monrovia and the Esther Bacon School of Nursing and Midwifery in Zorzor, Lofa County. Not only will physical renovations take place, RBHS will assist in providing the necessary equipment to create a physical environment conducive to teaching and learning (see SO 2.2). These activities will complement those of the RBHS Pre-service Education Initiative, which is upgrading the skills of instructors and school managers, as well as updating training curricula (see SOs 2.2 and 2.3).

Architectural and design work for each of the institutions was completed during year 1. Pre-qualified local contractors will be selected for the construction work following a competitive bidding process early in year 2. Contractors will be trained on and expected to comply with environmental mitigation and monitoring requirements specified by USAID. Close supervision of construction at each site will be undertaken by both a contracted architectural firm and the RBHS Infrastructure Advisor.

Renovations at TNIMA will focus on the main lecture theater, classrooms, skills lab, offices, and the cafeteria. More extensive work will be undertaken at EBSNM, including classrooms, female dormitories, and water supply and electrical systems. Additional renovation work will be undertaken at EBSNM in year 3, to include offices, male dormitory, and staff housing. RBHS infrastructure work on clinics, health centers, and EmONC centers is described under SOs 1.1 and 1.3.

Sub-objective 2.2: Improve capacity of training institution staff to utilize modern teaching methods and manage health training institutions

Key indicator	2010 target	2011 target	2013 target
Number of pre-service educators trained with RBHS support	90	100	100
Number of graduates from TNIMA and EBSNM	145	145	145

Through its Pre-service Education Initiative (PSE), RBHS aims to improve the post-secondary/undergraduate curriculum of mid-level health care providers, the teaching skills of instructors and clinical preceptors, the educational environment in both the classroom and clinical sites, and the overall management of selected teaching institutions. All activities are undertaken in collaboration with the MOHSW, professional and regulatory bodies, and other key stakeholders. Efforts are directed primarily at improving the education for trainee RNs, PAs, CMs, and Environmental Health Technicians (EHTs) at TNIMA and for trainee CMs at EBSNM. Meanwhile several of the strategies, standards, and tools developed by PSE have already been adopted by Liberia's six other schools for mid-level health workers, as well as the associated professional boards and associations.

With the cooperation of the schools and other stakeholders, PSE has adopted Standards Based Management and Recognition (SBM-R) as a framework for upgrading pre-service training in Liberia. The SBM-R approach establishes standards of performance; assesses and monitors performance against those standards; develops improvement plans to close the gap between

observed performance and the standards; and then provides recognition and incentives for attaining agreed upon levels of care or systems functioning. PSE has already led the development of both educational and clinical standards for the training institutions. Baseline assessments against the educational standards were conducted in year 1. Assessments against the clinical standards will be conducted at six clinical training sites early in year 2 and plans then developed to improve performance.

Performance monitoring tools and job aids will be developed/adapted in collaboration with clinical staff from the training sites. Preceptors and clinicians will be trained on the monitoring tools, as well as on data collection and analysis of service statistics related to the standards. A process for continuous monitoring and evaluation of performance will then be established. On-going monitoring of performance against the educational standards (including for classroom instruction, clinical instruction, infrastructure, and school management) will also continue. Technical updates will be provided for teaching faculty and clinical preceptors on FP/RH, EmONC, safe motherhood/ANC (including malaria in pregnancy and PMTCT), and IMCI using the in-service curriculum (see SOs 1.6 and 2.6).

The learning environment at both TNIMA and EBSNM will be further enhanced through the provision of essential resources and teaching aids. RBHS will provide computers, audiovisual equipment, medical equipment (e.g. stethoscopes, delivery kits), training models (e.g. manikins, childbirth simulators), text books, and teaching materials. Staff will be trained in how to properly use, maintain and store the equipment. An information technology (IT) focal point will be trained at each institution to assist and train others in e-learning, as well as to do provide basic IT support. RBHS will also build the capacity of teaching staff in “blended learning” – the integration of a variety of training methods, e.g. web-based, interactive CD-ROMS, workshops, workbooks, etc, to meet a learning need.

Workshops will be conducted for faculty (classroom and clinical) on skills lab orientation, managing clinical practice, assessing student performance, and learning technology development. Training of trainers (TOT) will be undertaken on effective teaching skills and student performance assessment.

These combined activities will lead to improved classroom teaching and strong clinical training sites, both of which are critical for developing high performing mid-level providers. RBHS will also assist the MOHSW to develop a retention and deployment plan to ensure improved national coverage of skilled health workers. Investing in and empowering faculty, students and recent graduates will contribute to them becoming change agents around the country.

Sub-objective 2.3: Update and strengthen PA, RN, EHT, and CM curricula

RBHS will conduct a task analysis of recent graduates (past 2 years) in RBHS-supported counties to determine if activities undertaken by mid-level health workers are adequately addressed in the existing core competencies, job descriptions (JDs), and pre-service curricula. Analyzing the actual tasks of new graduates will allow a realistic and critical review of the skills required of each cadre of health worker. Information from the task analysis will be critical to guide the full development and finalization of the competencies, JDs, and curricula.

RBHS will ensure that the key elements of the BPHS (MNH, child health, FP/RH, communicable diseases, mental health, emergency care) are adequately addressed in the curricula. We will continue to work with the MOHSW, especially the main vertical programs (e.g. NMCP, NACP,

NLTCP), to ensure that their protocols, standards, and training materials are appropriately incorporated.

Technical assistance and capacity building will be provided to the Education and Training National Working Group (NWG), as well as the Educational Development Centers (EDCs) at both TNIMA and EBSNM. The NWG's primary purpose is to advise and make recommendations on policies, approaches, and materials relevant to in-service and pre-service education. Membership of the NWG includes the Ministries of Health and Education, all of the professional boards and associations, and all of the pre-service medical, nursing and paramedical institutions. The role of the EDCs is to ensure that faculty, both clinical and classroom, are regularly updated on evolving best practices, and scientific and educational developments. Furthermore, they are responsible for ensuring that teaching resources are updated, effective and functional. Technical assistance will also be provided to similar bodies at the other six paramedical schools, as well as to the professional boards and associations.

Following a recent request from the MOHSW, RBHS will also provide technical assistance for the updating of the laboratory technician curriculum. We will convene a working group of relevant stakeholders to review the content of the existing curriculum and engage technical experts to assist in its revision. This process will benefit from other PSE activities, such as the effective teaching skills and student performance assessment workshops, and the blended learning initiative.

Sub-objective 2.4: Strengthen MOHSW systems and human capacity at central level

A major priority for the MOHSW is further development of the support systems previously described, followed by training of central- and county-level staff in their management. Successful decentralization to county levels will depend on effective implementation of the support systems, most of which are not yet fully developed. RBHS aims to contribute to this process by building on the earlier successful work of BASICS. RBHS will also continue to support the MOHSW at central level through technical assistance, capacity building of selected Ministry departments/units, contributions to policy development, participation in national working groups, further costing work on health services, and funding of a limited number of activities. We will contribute to the planning of the National Health Review and Quarterly Reviews, explore opportunities for public-private partnerships (PPPs), and remain flexible to provide assistance when unexpected needs arise, e.g. infectious disease outbreaks. RBHS has been requested to contribute to the development of the 10-year National Health Development Policy and Plan, and will engage policy and health systems experts to contribute to that process. Moreover we will lead an analysis using the Lives Saved Tool (LiST) to inform policy and planning decisions.

Supporting development of the HMIS

As discussed, RBHS has assumed several of the activities previously implemented by BASICS. One of the most important is the on-going development and strengthening of the national HMIS. We will contribute to the finalization of the Data Management Standard Operating Procedures and forms, and provide feedback on the evolving indicator lists. When completed, RBHS plans to provide financial support for the printing of the health facility registers and forms, and assist in their distribution. On-going technical assistance and training will be provided for the further development of the DHIS platform (District Health Information System) used for the HMIS. This will include consultation on the possible incorporation of new functionalities from JSI's Decision Support Systems (DSS) software into the DHIS system.

In collaboration with the MOHSW and the Liberia Institute of Statistics and Geo-Information Services (LISGIS), RBHS is working to estimate catchment populations for each health facility. As part of this activity, we will assist the MOHSW to update their health facility database. The population figures will be useful as denominators for calculating rates and proportions from routine HMIS data. We have already provided technical assistance, logistic support, funding, and manpower to undertake the field work, and are contributing to the analysis and interpretation of the collected data.

Finally, RBHS has committed to assist the MOHSW to produce a Quarterly Health Services Bulletin. We will contribute to the review and discussion of data from the HMIS and other sources, and contribute to the bulletin's dissemination.

Contributing to system documentation

The MOHSW aims to develop documentation (policies, SOPs, training manuals) for all nine of the decentralized support systems, as well as a national pool of trainers. RBHS intends to support this process for a sub-set of the support systems. As noted, BASICS and RBHS have already contributed to system documentation for budgeting and planning, HMIS, M&E (supervision), logistics and communications (vehicle management), and stakeholder coordination. We plan to build on these earlier efforts by assisting in the completion of the system documentation and collaborating on roll-out at county level. Through active participation in the MOHSW's Decentralization Working Group (DWG), we will contribute to the prioritization and phased roll out of the decentralized management support systems (DMSS) at county level (see SO 2.5).

Institutionalizing performance-based financing (PBF)

RBHS has committed to provide on-going technical assistance to the MOHSW as it develops its own performance-based contracts and PBF processes. Through these efforts we hope to further align RBHS activities in PBF with those of the MOHSW. Continued sharing of tools and lessons learned from our own experiences with PBF will be key. Moreover, the MOHSW has requested specific assistance on issues such as selecting indicators, determining baselines and targets, monitoring and evaluating PBC implementation, data validation, incentive systems, and capacity building of CHTs.

RBHS will also continue its participation in the Health Financing Task Force, although most technical assistance to the MOHSW on this issue will be provided through other partners. Following validation of the costing work done for clinics and hospitals, RBHS will update these analyses following a review of norms, assumptions, utilization data, and costs. Additional costing work will be conducted for community-level services.

Building capacity of MOHSW technical units

In recognition of their limited technical and managerial capacity, RBHS intends to continue its support to entities such as the Health Promotion Unit (HPU), the Training Unit, the Community Health Division, and others. This will include on-the-job training and mentoring on strategic, technical, and managerial issues. We will also share relevant technical resources and explore

options for short-term trainings and conference attendance. Several senior RBHS technical staff will be accommodated in offices on the Ministry grounds and will have regularly scheduled meetings and interactions with their MOHSW colleagues.

An important discipline in which the MOHSW has a major lack of capacity is mental health (MH). There is no full-time MH expert currently employed within the MOHSW and the RBHS MH Advisor has therefore been required to fill important technical and strategic gaps - including representation of the MOHSW at national and international meetings. He contributed significantly to the finalization of *National Mental Health Policy* and will participate in the subsequent national consultative workshops to review the policy. He is currently playing a pivotal role in the development of the *National Mental Health Strategic Plan*, chairing three technical working groups. RBHS intends to provide on-the-job training, mentoring, and technical advice once the MOHSW recruits its own MH staff. Awareness raising workshops on MH for other MOHSW staff are also planned by RBHS.

Consistent with the widely held view that there is “no health without mental health”, RBHS will continue to support the MOHSW to roll out its Mental Health Strategy. The strategy has been developed with the understanding that patients with mental health problems are less compliant with their treatment; that parents with mental health problems provide less nurturing care to their children, including lower use of health services; and that health care providers with mental health problems are poorer communicators and provide poorer levels of care. MOHSW has proposed undertaking a baseline study of the status of mental health services at Liberian health facilities. RBHS has recommended adding a module on the mental health status of health care providers and then designing an intervention to address their specific needs. RBHS is in the process of negotiating our involvement in this study at the time of writing.

Other related activities

Many other RBHS activities are also likely to build MOHSW capacity – either directly or indirectly. Collaboration on activities such as updating the national treatment guidelines, developing systems for quality assurance, phasing in community case management, and launching national BCC campaigns will help to build technical, strategic, and managerial skills of Ministry counterparts. Similarly, RBHS’s ongoing participation on numerous national committees and task forces⁸ will have benefits. Finally, we plan to collaborate with other partners to explore opportunities for public-private partnerships (PPP). As noted, RBHS has already engaged cell phone companies to undertake bulk SMS texting for the MOHSW – and there are further opportunities for free radio messaging and trialing of free cell phones for clinics and health centers. Moreover, we are playing a facilitating role to introduce international managed care providers to Liberia, who have been targeted to provide health care services for concessionaires. We will build on these efforts and explore other options, including collaboration on a framework for monitoring concessionaires’ health obligations

Sub-objective 2.5: Strengthen MOHSW systems and human capacity at county level

Key indicators	2010 target	2011 target	2013 target
Number of joint (CHT and NGO) supervisory visits per	0.6	1.0	1.0

⁸ RBHS is an active member of the following MOHSW committees and working groups: Education and Training National Working Group; Health Financing Task Force; Health Promotion Working Group; Health Sector Coordinating Committee; Human Resource Technical Committee; Mental Health Policy Working Group; Mental Health Strategic Planning Working Group; Monitoring, Evaluation, and Research Technical Working Group; National Task Force on Health Infrastructure; Reproductive Health Technical Committee

facility per month			
% of timely, accurate and complete HIS reports submitted to the CHT during the quarter	85%	90%	>95%

RBHS is committed to expanding the capacity of the CHTs to manage the increasingly decentralized health system. In collaboration with our five implementing partners, we intend to assist CHTs to institutionalize the support systems, as these are sequentially developed. RBHS acknowledges that successful decentralization requires more than the roll-out of systems and the delegation of authority and responsibility – CHTs must have the resources to manage the health services and systems with which they have been entrusted. We will therefore advocate with the MOHSW, donors, and other stakeholders to ensure that the County Health Officers (CHOs) and their staff are given adequate financial, material, and human resources to do their work. Through our county coordinators we will maintain regular communications with the CHTs and our field-level partners, conduct joint supervisory visits, and ensure that the county-level plans of our partners are aligned with those of the CHTs.

Implementing the support systems at county level

Through our role on the DWG, RBHS will contribute to the prioritization and roll-out of support systems at county level. Once the training modules, policies and SOPs for the priority support systems have been developed, we will collaborate with the MOHSW and partners to develop a phased roll-out, starting with HMIS and Monitoring and Evaluation. RBHS implementing partners having the primary responsibility of organizing and funding the workshops. The instruction is to be competency based, with individual on-the-job training (OJT) to reinforce group training events. An inventory will be maintained, to ensure that all relevant staff from each CHT receives instruction on the appropriate support system.

One of the challenges of instituting such a training plan is that it requires that many senior staff be taken away from their work - sometimes for extended periods. The trainings therefore need to be prioritized, sequenced, and scheduled in a manner that results in the least disruption possible to the CHT’s work. The plans will be developed in a consultative manner with the central MOHSW, CHTs, county authorities, and implementing partners, to minimize these problems.

In association with the trainings, RBHS and our partners will collaborate with the CHTs on the practical implementation of the support systems. This will entail technical support and coordination around county-level health planning and budgeting, HMIS reporting, in-service training (see SO 2.6), drug management (e.g. IMAT), and referral system development. Regular joint supervisory visits to health facilities by the CHTs, implementing partners, and RBHS county coordinators, using standardized tools and methods of analysis, are planned. Monthly meetings among the three partners will provide a forum to review topics such as HMIS data, inventory management, staff performance, and issues identified during joint field visits. Such feedback and analysis will be highly useful for management purposes. Again, many of the routine activities and initiatives of RBHS and its partners should also build the capacity of the CHTs – either directly or indirectly. Included among these are introduction of clinical standards, quality assurance processes, and rational drug use. Opportunities for short-term trainings and conference attendance by CHT members will also be considered.

RBHS plans to conduct a series of trainings for BCC focal points from each CHT, in collaboration with the HPU. The CHTs are central to the success of the BCC strategy – both the integrated community-facility level component and the national multi-media campaigns. So, it is essential that they have a staff member skilled in basic health communications. Instruction will focus on developing and testing health messages and materials, strategizing on message roll-out, mobilizing communities, engaging opinion leaders, etc. The CHTs have already proven their value in assisting with the ITN campaign, as they provide a credible and authoritative introduction to communities.

Finally, RBHS has been asked by the MOHSW to conduct training for M&E Officers from each CHT. These staff are currently being selected and the RBHS training is expected to assist with a range of CHT functions – supervision, HMIS management, drug management, etc. All training and capacity building will be conducted in coordination and collaboration with the AED/FORCEAST Project, who are already building the capacity of a number of government ministries, including the MOHSW.

Sub-objective 2.6: Strengthen and assist in the roll-out of the National In-service Strategy

Key indicator	2010 target	2011 target	2013 target
% of staff funded by NGOs paid on time in the quarter	95%	>95%	>95%

The MOHSW has developed an ambitious National In-service Strategy that aims to train all mid-level providers in a standardized curriculum, build its own capacity to implement and oversee in-service activities, and develop the capacity of training institutions and licensing boards to conduct in-service trainings. Targets within the strategy are also ambitious, with the goal to train all 1,880 mid-level providers in Liberia on a standardized curriculum by the end of 2012. There are already many constraints to the successful implementation of the strategy, including lack of leadership and resources - and the MOHSW is already substantially behind on its timeline. While it is unlikely that the 2012 targets will be met, RBHS remains committed to supporting the MOHSW as it strives to improve the skills of its existing cadres of health workers, specifically RNs, CMs, and PAs.

Perhaps the main challenge to the strategy’s successful roll-out is the limited capacity of the MOHSW’s Training Unit (TU). As discussed, RBHS intends to assist with the recruitment and development of staff for the TU and to provide appropriate training, mentoring and technical assistance. Senior RBHS technical staff were closely involved in the development of the in-service strategy and have remained engaged throughout its implementation – they will therefore be well placed to orient and support new TU colleagues.

The MOHSW has led the development of an in-service course consisting of three main components, all of which are to be taught separately: maternal health (2 weeks: consists of Basic Life Support Skills - BLSS); child health (2 weeks: Integrated Management of Childhood Illness - IMCI); and the integrated component (3 weeks: communicable diseases, FP/RH, mental health, and emergency care). Training modules for the first two components have already been developed and modules for the integrated component recently drafted. RBHS is leading a final technical review of the integrated component and has organized a series of workshops with technical experts to analyze the course content and the instructional design. It will be essential to ensure that the content of the integrated curriculum is consistent with the

pre-service curricula being developed for RNs, CMs, and PAs. Any required changes to the modules will be made in consultation with the Peace Corps volunteers who led the integrated curriculum development.

In ensuring that the content of the integrated curriculum is consistent with the BPHS and pre-service curricula being developed for RNs, CMs, and PAs, the clinical standards and the BPHS required tasks are being used as resource materials in the technical review. The results from the Task Analysis will also inform the final in-service curricula. Any required changes to the modules will be made in consultation with the Peace Corps volunteers who led the integrated curriculum development.

Scaling up the implementation of the in-service program will require development of skilled trainers, establishment of training sites, planning and scheduling of courses, mobilization of resources, development of training inventories, and monitoring and evaluation. Moreover, linking the trainings to a process of supportive supervision will help to ensure that lessons learned in the classroom will be applied at the clinical sites. RBHS is preparing to assist the MOHSW with all of these activities.

Trainers have already been recruited and engaged for the teaching of the BLSS and IMCI courses – but another cadre is required for the integrated component. RBHS has contributed to the training of Master Trainers (three RBHS staff are Master Trainers) and will assist in the development of a TOT curriculum for the integrated component. Thereafter, we will contribute to the training of up to 45 trainers – three per county. Training sites have been established for BLSS and IMCI, but need to be developed for the integrated component. RBHS has assisted in the set-up of a training site at Ganta, but another four sites are required if targets are to be met. At this stage, it is unlikely that the financial and human resources exist to establish all five sites. But RBHS will work with the MOHSW to prepare sites at Phebe Hospital and, perhaps, Bomi. RBHS will provide technical inputs and limited funding for equipment and, possibly, renovations. Where possible, we will seek other sources of funds to develop the training sites.

The MOHSW's existing training plan is already well behind schedule (240 health workers were to be trained on the integrated curriculum by the end of 2009) and RBHS will collaborate with the TU to set more realistic targets. Similar to the training of CHT staff, it will be essential to prioritize and sequence the courses so that health workers are not away from their clinics and health centers for prolonged periods. Even if several courses are on-going at different sites simultaneously, the MOHSW has mandated that no more than 100 participants be drawn from service delivery at any given time. As discussed, priority for attendance at the in-service trainings will be given to faculty and clinical instructors from the paramedical training institutions (see SO 2.2). RBHS will also provide technical assistance to upgrade the training inventory. RBHS county coordinators have already assisted in the compilation of attendance data at county level and we will work to refine the system so that tracking of participation in trainings is accurate.

Sub-objective 2.7: Improve environmental health at facilities and hygiene practices in communities

Key indicator	2010 target	2011 target	2013 target
% of facilities with operating hand pump or an	70%	80%	>90%

equivalent safe water source			
------------------------------	--	--	--

The RBHS approach to environmental health will focus on three main issues:

- Improved water, sanitation, and hygiene practices (WASH) at facility and community levels,
- Improved medical waste management at facility level, and
- Mitigation of any adverse environmental impacts caused by RBHS activities, e.g. renovation of health facilities.

Our WASH activities aim primarily to prevent water-borne (e.g. cholera) and water-washed (e.g. scabies) diseases by providing adequate quantities of good quality water, access to adequate sanitation, and the promotion of good hygiene practices. These activities will be based on the Hygiene Improvement Framework (HIP), which incorporates three pillars: Access to Hardware/Products; Hygiene Promotion; and Enabling Environment (see Figure).

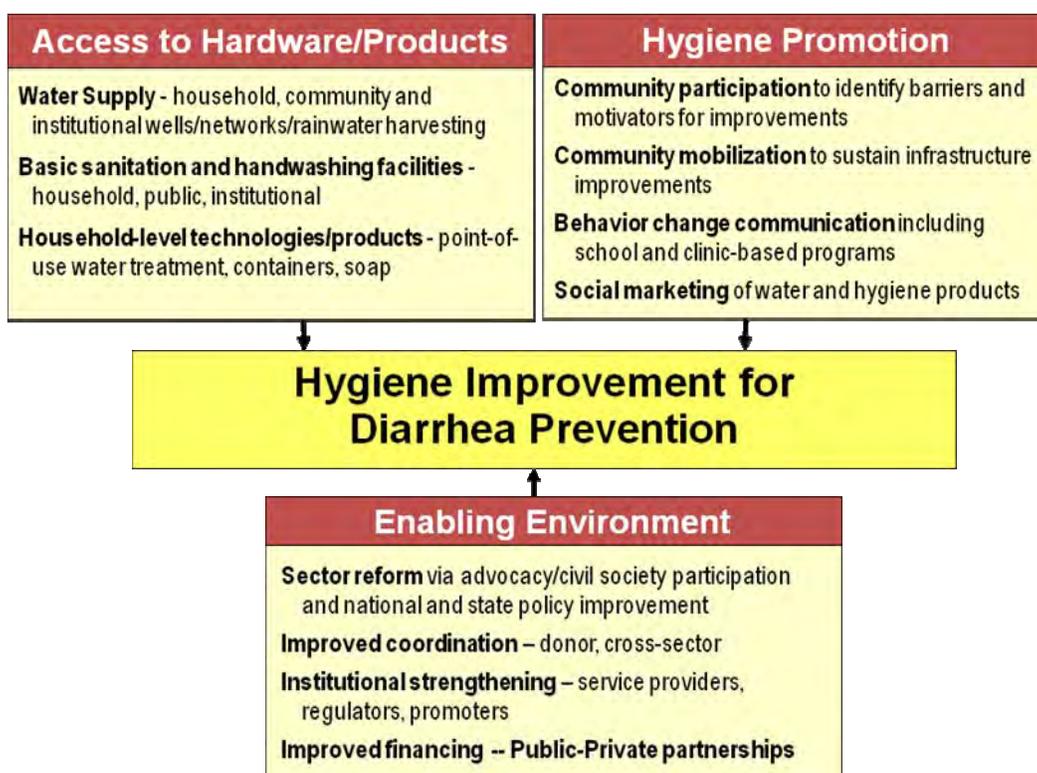


Figure: HYGIENE IMPROVEMENT FRAMEWORK

Improving access to hardware and products

The main priority is to ensure that RBHS-supported health facilities and institutions have improved water supplies and sanitation. RBHS does not have sufficient funds to install hardware at all facilities, so we will need to prioritize. Major water supply projects are required at EBSNM and three of the comprehensive EmONC facilities (Bensonville, Fishtown, Sinje). Less extensive plumbing work is needed at TNIMA and Curran Hospital (EmONC). These facilities will be prioritized during year 2. Up to 15 other clinics and health centers identified by our implementing partners will also have water supply systems

installed or upgraded during year 2– options include hand-dug wells, boreholes, and rain water catchment; and construction and/or rehabilitation of water towers and reservoirs. Other facilities will have their water supply upgraded at a later date.

These same facilities and institutions will also be prioritized for improved sanitation infrastructure. Communal pit latrines will be installed or rehabilitated at each site. Mechanisms to ensure the on-going maintenance and cleaning of latrines will also be established, including the provision of cleaning materials and supplies.

RBHS is committed to coordinating all activities with CHF, the successful applicant for USAID's recent RFA - *Water, Sanitation and Hygiene (WASH) Program in Liberia*. We will seek to ensure that the RBHS health facilities and their surrounding communities are prioritized by this project, including improved water supply and sanitation at institutions such as health facilities, schools and market places.

We will ensure that appropriate hand washing stations at all the health facilities supported by RBHS. Routine access to soap and appropriate hand washing practices by health workers will also be promoted (see below).

At household level we will promote adapted solutions for ensuring water quality. RBHS will actively encourage point-of-use (POU) water treatment. Given that CHF has recently given PSI a sub-grant to promote its chlorine solution ("WaterGuard") through social marketing in communities, RBHS will explore the option of extending distribution sites to health facilities, e.g. through ante-natal clinics. We will also ensure that safe drinking water is consistently available at health facilities, for both staff and patients, through use of the chlorine solution.

Promoting improved hygiene practices

Improved hygiene practices are a main priority of the RBHS BCC campaign, especially the integrated component for community/ facility level. Personal hygiene and related messages (e.g. on water source protection, water storage and sanitation/latrine use), are among the key issues addressed through the CHEST kits, to be used by gCHVs. Appropriate hygiene practices are also highlighted in the Children's and Mother's Health Cards.

Messages and materials will be developed in consultation with the HPU, the MOHSW's Environmental Health Unit, and other stakeholders. Issues such as hand washing, latrine use, appropriate household water storage, POU water treatment, and solid waste disposal are to be addressed. Messages will be gender sensitive, in recognition of the different hygiene needs of women and men. Training and technical assistance is to be provided to health workers, gCHVs, and CHDCs. The relevant hygiene promotion materials will be distributed and posted in the health facilities and community level (e.g. schools, market places). We will work at county level to ensure that hygiene messages are promoted effectively at schools, including through social clubs, child-to-child initiatives, and the use of CHEST kits. We will target between three and five primary schools per year in the catchment areas of each of the RBHS facilities. From year 3 RBHS will also collaborate with the MOHSW on its annual WASH campaigns that aim to promote improved hygiene practices, improved water storage, and POU water treatment, and are timed to coincide with the start of the wet season.

All hygiene promotion activities will also be coordinated with CHF. We will attempt to complement and coordinate any messaging, material development, trainings, community mobilization activities, and mass media campaigns. Meetings have already commenced

between our agencies. In addition, we will explore collaboration on innovative approaches such as Community-led Total Sanitation.

Strengthening the enabling environment

Oversight and technical work in the WASH sector is shared among four government ministries,⁹ making it somewhat difficult to coordinate technical assistance and policy work. Given our relatively limited resources in the WASH sector, RBHS therefore envisages a more limited role in promoting the enabling environment. Again, we intend to support the activities of CHF, who are expected to take the lead in this area. Suitable activities for RBHS include: limited technical support to the Environmental Health Unit of the MOHSW, promotion of gender equity in WASH initiatives, and advocacy on relevant policy changes.

Improving medical waste management

RBHS has standardized the approach to medical waste management across all health facilities. Guidance has already been given to implementing partners on the categorization and separation of medical waste (general, hazardous, highly hazardous, glass). Options for the disposal of waste (e.g. burning in open pits, burial in lined sanitary pits, incineration, transportation for disposal) have also been provided. A waste management plan for each facility is to be developed based on these guidelines.

Where appropriate, incinerators will be erected at RBHS facilities, e.g. comprehensive EmONC. Sanitary pits/placenta pits will also be established at selected facilities. On-going monitoring of medical waste management practices will be undertaken during supervisory visits.

RBHS is contributing to a process that aims to establish national standards and approaches for medical waste management in Liberia. Once these have been finalized and institutionalized by the MOHSW, RBHS may adapt its own guidance for our implementing partners to align with these standards.

Mitigating the environmental impact of RBHS activities

RBHS has established a sound EMMP, to limit any potential adverse environmental impact of its activities. Several of the steps outlined in the plan have already been referred to earlier, e.g. medical waste management, solid waste management. The EMMP also outlines mitigation measures for rehabilitation/construction and WASH activities. RBHS will train sub-contractors on the EMMP and will provide on-going monitoring to ensure that all activities are in compliance. In addition, NGO partners have received training on the EMMP. RBHS will continue to monitor partner compliance with the EMMP, including the requirement for Environmentally Preferred Purchasing (EPP) of medical supplies and vaccine holders. We will also coordinate with the JSI DELIVER project to ensure the appropriate handling and disposal of old and expired ITNs.

⁹ Ministry of Health and Social Welfare, the Ministry of Public Works, the Liberian Water and Sewer Corporation, and the Ministry of Lands, Mines and Energy.

INTERMEDIATE RESULT 3 : *Youth informed and networked on reproductive health*

Activities relevant to this IR are covered under SOs 1.1, 1.2, 1.3, 1.5, and, especially, 1.6.

CROSS CUTTING ISSUES

Gender

RBHS is very committed to gender-equitable development, and we will continuously examine all aspects of our program to ensure that it has a positive influence on women's and girls' status. A gender-integrated approach is a strategy for bringing women's and men's concerns and experiences to the design, implementation, monitoring and evaluation of policies and programs so that they can benefit equally from the program. It focuses on the different needs of women, men, adolescents and communities, and encourages their active and shared participation in health planning and decision-making. Advocacy will again feature prominently in our approach as we develop community mobilization and behavior change interventions that address GBV and feature women as role models and agents for change. Key elements of our approach include:

- Institutional commitment to gender-integration to ensure that RHBS maintains a high priority on programs that target women and others who are underserved and vulnerable;
- Promotion of active and shared decision-making in families, communities and facilities;
- Advocacy for an active role for women in all aspects of health decision-making, by providing training and mentoring to wives and mothers, female health providers, and women in NGOs and government;
- Active engagement of men and boys in RH and promotion of positive role models; and,
- Multi-sectoral linkages that promote synergies between sectors, combining health services with interventions that address women's economic empowerment, literacy, etc.

Governance

The Minister of Health and his Deputies have already set a high standard for good governance within the Ministry, but they require support to institutionalize the behavioral changes needed to sustain accountability and transparency in Ministry operations. The Ministry has already begun purposive socialization of staff, demanding honesty and good stewardship in all Ministry operations. But that must be reinforced through strong systems that monitor and enforce accountability and transparency, particularly in the areas of budgeting, policy, and human and material resource allocation.

Our primary strategy for strengthening good governance is to support the Ministry in these efforts by developing the strong systems needed to monitor and enforce accountability, including M&E and sharing our tools and experiences with data validation. We believe that RBHS support for performance-

based contracting will also further this cause by ensuring that Ministry contract recipients are held accountable for results. PBF approaches provide a basis for strengthening the legitimate role of the MOHSW in setting standards and allocating resources and for reinforcing the voice of communities in design and management of systems that serve them.

Sustained good governance at any level requires appropriate, reasonable, and effective policy environments; therefore, RBHS also sees integrated advocacy as fundamental to its good governance approach. Each of the technical strategies presented above includes an element of advocacy to develop, revise, disseminate, and enforce enabling policies at the national, regional, county, and local levels. For instance, RBHS will provide training and TA to NGOs and community networks to help their members act as forceful advocates for effective implementation of health services, transparent decision-making, programs that are responsive to community needs, honest stewardship of health resources, and adequate funding for health. Finally, and most importantly, the effective delivery of health care services increases confidence in the government and serves as a stabilizing force, particularly in urban slums and marginalized communities. RBHS activities to deliver services to these communities will support the GOL's goal of creating a stable, democratic nation.

Mental Health

Mental health (MH) cuts across the health sector in Liberia in a number of important ways. Before the civil crisis, mental health services were confined to one psychiatric hospital in Monrovia using limited psychiatric interventions and medications. With the mass violence, multiple losses and brutal deprivation brought on by the civil crisis, many people, especially children, were severely traumatized. Moreover, the civil conflict disrupted social structures that had historically provided support and protection, especially for women, youth and children, thereby increasing their vulnerability to psychosocial problems.

Recognizing the pervasiveness of these problems and their effect on the overall health and welfare of the population, the MOHSW has included MH in the National Health Policy/Plan as well as in the BPHS. However, specific policies, protocols, standards and strategies have not yet been adequately defined or articulated. The MOHSW has therefore prioritized the development of mental health and social welfare policies.

RBHS has seconded a Mental Health Specialist to the MOHSW to support the development and implementation of the MOHSW mental health policy and plan. This full time technical advisor has played a pivotal role in the development of the *National Mental Health Strategic Plan*, chairing three technical working groups. He will now also be central to the roll-out of that strategy, including operationalizing activities related to training, service delivery, and monitoring and evaluation. Moreover, through our Advisor, RBHS intends to provide on-the-job training, mentoring, and technical advice to the MOHSW mental health staff, once they are recruited. Awareness raising workshops on MH for other MOHSW staff are also planned by RBHS.

Consistent with the widely held view that there is “no health without mental health”, RBHS will continue to support the MOHSW to roll out its Mental Health Strategy. The strategy has been developed with the understanding that patients with mental health problems are less compliant with their treatment; that parents with mental health problems provide less nurturing care to their children, including lower use of health services; and that health care providers with mental health problems are poorer communicators and provide poorer levels of care. MOHSW has proposed undertaking a baseline study of the status of mental health services at Liberian health facilities. RBHS has recommended adding a section on the mental health status of health care

providers and then designing an intervention to address their specific needs. RBHS is in the process of negotiating our involvement in this study at the time of writing.

Once the assessment of service providers is completed, perhaps one of the most valuable contributions that RBHS could make in the area of mental health, is designing interventions to address their specific needs – including psychosocial approaches (e.g. leadership training, advocacy with the MOHSW to improve working conditions) and preferential referral for more specialized care, e.g. to the clinics proposed by the Peter C Alderman Foundation.

Although our interventions in this area will be relatively modest, RBHS will build on and incorporate the efforts and best practices of existing projects, such as Medecins du Monde (Bong) and coordinate with those proposed by the Carter Center and Peter C Alderman Foundation. As needed, RBHS will assist the MOHSW to define National Standards of Diagnosis and Treatment and update the Essential Drug List (EDL) to include appropriate psychotropic medicines.

RBHS is currently providing technical assistance in the establishment of the proposed Liberian Association of Mental Health Professionals (LAMP), which aims to improve the skills, status, and numbers of mental health providers. We will assist efforts by the Carter Center and LAMP to develop a cadre of nurses and PAs specifically skilled in mental health. RBHS will also work with the accreditation team to standardize the accreditation process for mental health practitioners, including MHRNs, social workers, and counselors. We are contributing to the standardization of the pre-service curricula and inservice training module on mental health.

Finally, there is also an urgent need to link health center mental health services with hospitals and other specialty centers (e.g. proposed Alderman Mental Health Clinic in Bong County) through effective referral, including communication and transportation. Although the development of (and training for) in-patient mental health services is beyond the scope of this project, RBHS will work actively with the MOHSW and other partners to advocate for and assist (as appropriate) in planning for specialist care.

MONITORING and EVALUATION

The RBHS project quantifies progress on activities by calculating 76 reportable indicators, along with a number of process indicators for internal use. These indicators are chosen to cover all aspects of the project, and specifically to address each of the project sub-objectives discussed in detail above.

Using the higher-level outcomes as a starting point, we have designed an RBHS M&E framework with activities, outputs and outcomes. This framework forms the foundation for our M&E plan and guides RBHS's strategic planning. The RBHS indicator matrix provides a list of the illustrative indicators that we will track and report on to determine progress toward the desired project outputs and outcomes. Key indicators with 5-year targets are shown in Annex 1. Indicators are designed to be as simple as possible, while maintaining their effectiveness. Wherever possible, indicators were chosen from existing MOHSW and USAID indicator lists. Where applicable, indicators will be disaggregated by sex and age as part of our focus on both gender and youth. A database has been established to store and manage the full range of indicators. The monitoring system will be responsive to additions and/or adjustments as agreed to by USAID and supported by the MOHSW.

RBHS uses a variety of methods to monitor and evaluate activities:

- tracking key data elements available from MOHSW facility HMIS monthly reports;
- extracting indicators from project administrative records (e.g. reports on trainings conducted) including performance-based contractor reports;
- using data obtained through annual health facility accreditation surveys conducted by the Clinton Foundation in support of the MOHSW;
- conducting and analyzing results of annual community surveys; and
- conducting and analyzing focused quantitative and qualitative evaluation studies.

RBHS uses data from the sources cited above to:

- assist in building an “information culture” contributing to use of data for informed decision-making among county and other stakeholders;
- provide timely quantitative and qualitative information to fine-tune RBHS implementation strategies and adjust program inputs as necessary;
- measure changes in selected indicators of effectiveness and impact achieved by the project activities;
- help establish a firm basis for policy discussions at county and national level; and
- provide evidence to Liberian stakeholders as well as the international development community of which strategies and activities are most likely to lead to achievement of desired results.

To strengthen facility reporting to the MOHSW, RBHS requires that our NGO implementing partners use the standard government HMIS tools. As noted, RBHS is working at the national level to further develop those tools and to ensure their effective rollout throughout the country, thus allowing for the collection of standardized data to adequately monitor RBHS activities and outcomes. Through its partners, RBHS is encouraging timely and accurate reporting from facilities to County Health Teams. And by reporting progress to stakeholders at all levels, RBHS is helping to establish a culture of information use that will strengthen service delivery in a sustainable manner beyond the end of the project. As noted, RBHS is also working closely with the MOHSW and the Liberia Institute of Statistics and Geo Information Services (LISGIS) to use the 2008 census results to develop accurate estimates of health facility catchment populations; those catchment figures will inform both RBHS coverage indicators and numerous MOHSW calculations.

As described earlier, the major component of RBHS is its support to over a hundred health facilities through performance-based contracts to five NGOs. Since those contracts are performance-based, the importance of validating reported data is even greater than with typical sub-contracts. For that reason, RBHS is applying rigorous data validation procedures that include cross-checking NGO-reported data with facility registers and with the central MOHSW indicator database. RBHS also holds quarterly M&E meetings with its Ministry and NGO partners to review data from the previous quarter and to discuss both programmatic performance and issues relating to data collection and quality. One of the primary objectives of the meetings is to allow for sharing of ideas and approaches among the implementing partners.

A strong M&E system contributes to developing MOHSW governance and it is our priority to ensure that the M&E plan and indicators are in line with those of the MOHSW. To that end, RBHS will also conduct training for the new M&E focal points within the CHTs, as noted above, and provide technical and material support to the M&E Unit within the MOHSW.

USAID plans to engage an independent partner to conduct annual Outcome Monitoring surveys using lot quality assurance sampling (LQAS) to track progress in RBHS-supported counties.

These surveys will use districts as Program Management Areas (PMAs) and the process will allow for aggregation of data and calculation of point estimates for coverage indicators at county level. These geographic areas do not completely correspond to RBHS-supported areas (e.g. RBHS supports approximately 60% of facilities in which we are present). Therefore, we will complement the data collected through the LQAS surveys with annual facility surveys to obtain RBHS-specific data on a range of facility-based indicators, including quality of care.

We will work with each sub-grantee NGO/FBO to ensure that it has a simple, but comprehensive monitoring plan (including indicators) that is directly linked to the national M&E framework. As part of performance-based contracting, each NGO/FBO will be responsible for reporting on its indicators on a quarterly basis, to ensure timely reporting and use of data and facilitate ongoing monitoring of support to service delivery. We will submit quarterly progress reports to USAID and the MOHSW. Data will be reviewed at the Partners Meeting (for senior management and technical staff) and the regular M&E meetings (for M&E staff) on a quarterly basis. We will assist implementing partners and stakeholders to use the data collected and analyzed to inform programming and management decision-making. In addition, a Final Program Report will be submitted to USAID and the MOHSW, providing evidence of our progress toward the program's overall objective and achievement of the IRs.

TECHNICAL CAPABILITIES and MANAGEMENT APPROACH #

Staffing - Key Personnel

During year 1 it became evident that a number of important staffing changes were required. The most important changes related to key personnel were the following:

- Recruitment of an expatriate Director of M&E (Mr. Chip Barnett), after it became evident that it would not be possible to identify a Liberian national with the requisite skills. After 9 months in the position, RBHS is proposing to elevate Mr. Barnett to Director of M&E and Strategy, to assist in the scaling up of key interventions, as well as overseeing M&E activities,
- Discontinuation of the Performance-based Financing Team Leader position, following sub-optimal performance and an inability to identify a suitably skilled replacement. Work to be undertaken by this position will now be undertaken through short-term technical assistance (STTA),

JSI has since assembled a strong team of professionals to serve as the key personnel and Senior Management Team of the RBHS Project. They include: Dr. Richard Brennan (Chief of Party - COP), Zaira Alonso (Deputy COP – Finance and Administration Manager), Dr. Rose Macauley (Technical Team Leader), Mr. Paul (Chip) Barnett (Director of Strategy and M&E), and Ms. Marion Subah (Medical Education and Training Advisor). All staff have demonstrated outstanding leadership and strong technical skills, and are well qualified to guide this program.

A brief description of each key personnel and his or her position is included in the text below. Curricula vitae for all proposed personnel and full job descriptions are available from RBHS. Additionally, JSI's extensive work in West Africa and experience in public sector programming has provided a large pool of STTA from which to draw upon. Our RBHS management team will be complemented by a varied and highly skilled roster of STTA to strengthen the technical quality of this program on issues such as M&E, community health, HMIS, and family planning. A full outline of the staffing plan is presented in Annexes 2 - 4.

Chief of Party (JSI)**Richard Brennan, MBBS, MPH**

- Provide overall leadership and coordination in planning, implementation and evaluation of all program activities;
- Serve as JSI's chief program and technical representative to USAID, the MOHSW, international and Liberian NGOs, donors, and other stakeholders;
- Directly supervise the senior management team;
- Provide general program and technical direction, and ensure compliance with USAID reporting requirements;
- Oversee the development of strategic planning, program monitoring, management and control systems to ensure informed decision-making and timely implementation of program activities;
- Monitor Annual Workplans and Monitoring and Evaluation Plan to ensure that the program is meeting its goals and objective;
- Analyze and trouble-shoot any challenges to program implementation and resolve any human resources issues that arise;
- Ensure full compliance with the USAID Cooperative Agreement (CA);
- Oversee the financial/administrative aspects of the project including monitoring the budget.

Dr. Brennan is a public health physician and practitioner of emergency medicine with over 15 years of international experience in humanitarian response and post-conflict health system support. He has a proven track record of building and managing high performing teams, including a 10 year tenure as Senior Health Director at the IRC headquarters in New York. He spent 2.5 years with the Centers for Disease Control, based out of Atlanta and Hawaii. He has worked in over 30 countries, The COP position is funded for three years as an expatriate position, after which it is expected that the role will be assumed by a Liberian national

Deputy Chief of Party – Finance and Administration Manager (JSI)**Zaira Alonso, BS**

- Oversee and coordinate JSI systems and finance and administrative personnel;
- Assist the Chief of Party in managing the Cooperative Agreement;
- Assist the Chief of Party in managing partner sub-agreement;
- Oversee the financial management of sub-grant awards;
- Coordinate with USAID counterparts as needed to ensure appropriate financial and administrative management in regard to USAID requirements;
- Supervise finance and administrative staff including maintaining their attendance records, HSV, and time sheets;
- Assist the COP to identify and recruit staff when the need arises;
- Provide oversight of procurement of equipment and commodities in compliance with JSI and donor regulations and procedures;
- Ensure transparency, accountability and effective use of JSI resources and assets;
- Ensure the effective implementation of JSI policies and procedures;
- Coordinate staff orientation to JSI's policies and procedures.

Zaira Alonso, is an experienced compliance and operational manager in international development. She specializes in assessing needs, developing, managing business operations, compliance policies, procedures, and cost containment strategies that increase program efficiency. She has previously worked for the BASICS Project, Management Sciences for Health, and the Futures Group, and has extensive experience abroad in Latin America, Africa and Asia.

Capacity Building and Technical Team Leader (JSI)**Rose Macauley, MPH, MD**

- Supervise the RBHS technical staff, ensuring that activities are consistent with the annual work plan and that targets are being met;
- Oversee capacity-building initiatives in close collaboration with the MOHSW;
- Act as the technical focal point for maternal, neonatal and child health (MNCH) issues and community health;
- Collaborate with other technical staff on the scale-up of high impact, cost effective interventions;
- Lead the development and implementation of the RBHS quality assurance process;
- Coordinate long- and short-term technical assistance support to health systems strengthening and policy development;
- Act as a technical resources for RBHS partners and the MOHSW on
- Coordinate RBHS capacity-building efforts with other USG, bilateral and multilateral partner, NGOs/FBOs and others;
- Assist the COP and DCOP in coordinating NGO/FBO sub-grant activities;
- Work closely with other agencies, donors and contractors to assure that capacity-building results are achieved;
- Represent the Project in matters pertaining to policy;
- Represent RBHS on the MOHSW's Program Coordinating Team, and other committees as requested;
- Responsible for ongoing process of developing, evaluating, refining and verifying capacity-building indicators in conjunction with the MOHSW and Performance and Results Managers and M&E team.

Dr. Macauley has over 20 years experience in international health and development. Her specialties include USAID project management and coordination; immunization; MNCH; IMCI; health systems management; health worker training (including curriculum development and materials development); quality assurance; supervision; health policy and planning, with special focus on national and district-levels; survey research for disease control; and monitoring and evaluation.

Education and Training Advisor (Jhpiego)**Marion Subah, MSN**

- Oversee technical assistance and project support for medical education and in-service training;
- Represent the project to medical training institutions and Liberian professional associations;
- Work with the Curriculum Strengthening Group (CSG) to assess training institution capacity and identify TA needs to strengthen teaching skills, curricula and pre-service education implementation for the PA, RN and CM programs;
- Ensure collaboration between pre- and in-service training instruction, curricula and clinical sites;
- Work with the Infrastructure Specialist to ensure quality in renovating and equipping medical and training institutions;
- Assist in curriculum development to include BPHS content areas;
- Work with training institutions staff to use innovative learning approaches such as ModCAL®;
- Roll-out Learning Resource Packages (LRPs) to provide on-going support for trainers and educators;
- Coordinate training for key faculty and clinical staff using Jhpiego's Faculty and Trainer Development (FTD) Pathway;
- Assist the MOHSW and training institutions to determine innovative ways to attract students from rural areas.

Ms. Marion Subah is a program management, training, and service delivery expert in maternal and child health and reproductive health with more than thirty years of experience. She has designed, planned, conducted and evaluated training courses in safe motherhood, child survival and reproductive health, community health and primary health care in basic, post-basic, and continuing/ in-service education programs. She has previously worked with Africare, Johns Hopkins Hospital, and Northwest Medical Teams. She is a Liberia national.

Infrastructure Advisor (JSI)

Position vacant

- Provide leadership on all aspects of RBHSs infrastructure activities, including development of the overall infrastructure strategy and implementation plan,
- Manage needs assessments process for infrastructure work and provide clear documentation of requirements for structural repairs,
- Lead the prioritization, planning and sequencing of infrastructure work
- Supervise and manage the RBHS infrastructure team
- Oversee all rehabilitation, renovation and equipping of training and health facilities;
- Lead pre-bid conferences, site visits and walk-through, and evaluation of bids
- Ensure all facilities are in line with MOHSW standards and priorities;
- Represent RBHS to external agencies on all issues related to infrastructure
- Liaise with USAID to ensure project activities are aligned with USAID's health strategy.

RBHS is currently recruiting for a new Infrastructure Advisor. It is proposed that this position be extended into year 3, because of challenges with implementation of the infrastructure activities.

Director of M&E and Strategy

Paul (Chip) Barnett, MS, MLS, MPH

- Monitor the quality and completeness of RBHS data for documenting project performance, and solve data problems if and when they arise;
- Compile and analyze data from each of the project technical areas (BCC/IEC, training, infrastructure, performance-based subcontracts, capacity building activities) and support the project technical team in presenting recommendations to the Chief of Party for improvements in implementation on a quarterly basis;
- Represent the Project in the area of monitoring, evaluation and research at meeting with stakeholders, including government partners, USAID, and other agencies;
- Serve as main contact and person responsible for coordinating data collection in facilities/among performance-based sub-contracts;
- Oversee the development and maintenance of RBHSs database(s), ensure timely data entry, and supervise the day-to-day work of the M&E Data Manager;
- Disseminate, and assist RBHS staff to disseminate data on project progress and results to JSI and to the international public health community (e.g., through reports, presentations at professional meetings, submission of journal articles, JSI working papers, etc);
- Develop Terms of Reference for technical consultants, support their recruitment and ensure proper monitoring of their work in the area of qualitative and quantitative data collection, database design, and other relevant activities;
- Plan and draft the baseline, midline and final evaluation reports for the Project.
- Oversee the strategies to ensure appropriate scale-up of high impact interventions, including those related to MNCH, HIV and TB

Chip Barnett is an accomplished public health professional with seven years experience in managing health programs in Nepal, Ethiopia and the Republic of Congo. A mathematician by training, Mr. Barnett established highly effective systems for monitoring and evaluating an ambitious health program in Nepal, including routine HMIS and intermittent surveys. He is proficient in many computer applications: word processing, spreadsheet, database, and statistical packages (Stata, SAS, EpiInfo, SPSS).

Staffing - Additional Local Positions

During the first year of implementation, it became clear that several additional local positions were required to ensure the effective implementation of the project, specifically: HIV/TB Advisor, FP/RH Advisor, M&E Assistant, Infrastructure Assistants (2), County Health Coordinator, Accountant, Assistant Accountant, Office Assistants (2), and a Driver. Justification for these new positions can be found in the accompanying budget narrative.

Management Plan

Structure/Roles and Responsibilities

JSI has developed an approach to USAID project implementation that includes careful and balanced attention to the management of the project, the well-being of staff, the cohesion of the in-country team and headquarters partners and the technical content of the program. Equally important as the technical approach are strong professional working relationships with key counterparts (MOHSW, USAID and other key stakeholders); effective management of project resources (local and external); rapid fielding of appropriate consultants; effective use of partner resources and tools; timely and efficient home office support and thorough documentation of project activities. These components form the framework for JSI's management plan.

As an international organization, JSI strongly believes in building project teams that include high quality professionals, both local and international, at all program levels. While project support is provided efficiently and effectively from JSI's home office, our overseas projects emphasize a decentralized management structure where decisions are made close to project implementation. JSI is fully committed to managing the RBHS Project in the field, under the complete leadership, authority, and responsibility of the COP who will be based in Monrovia. JSI vests full authority and responsibility for project design and implementation, including financial and administrative functions, to our COP and the field staff, with support from headquarters. The COP and field staff will have full authority to negotiate and implement all decisions and actions concerning project staff (hiring and firing), local contracts/sub-awards/grants, project strategic planning, annual workplan development, procurement, all project reporting (including financial reports), organizing any international or local short term technical assistance. Program communications will be channeled through the COP, who will speak for the Program team and the consortium in all technical and non-technical issues in Liberia. Communications with JSI's home office will be conducted primarily via e-mail, Skype, JSI's intranet, telephone and DHL.

Management Procedures: JSI's Basic Management Package (BMP) provides management guidance for adaptation to local circumstances in areas such as strategic planning, work planning and budgeting, financial management, client relations, and M&E. This tool improves management quality and control and reduces internal bureaucracy, while ensuring compliance with U.S. Government regulations and prudent management of funds.

Home Office Support: JSI's home office supports a Senior Advisor who will serve as the principal interface between the team and JSI's corporate structure. The Senior Advisor, Kumkum Amin will visit the Program at least once a year to assess progress and to conduct an independent "client audit" with the MOHSW and USAID. She will supervise the COP and provide corporate oversight for the Program on behalf of JSI. Day-to-day administrative and financial support to the field will be the responsibility of a home office Program Coordinator who will provide the key link to the Finance Department to ensure that funds flow smoothly. Our home office team provides additional support as needed in M&E, financial management; HR management, fielding short-term personnel; technical support; and maintaining regular communications with the field.

JSI is joined by partners Jhpiego, Johns Hopkins Center for Communication, and Management Sciences for Health, bringing together five organizations with extensive experience in all of the areas needed to effectively guide and manage RBHS. Each partner brings a set of skills and experience that strengthens our ability to effectively plan, implement, monitor and evaluate RBHS activities. Collectively, we have a significant history in Liberia. We have already established solid partnerships, both organizational and individual, with MOHSW counterparts, private sector leaders, and NGO/FBO/CBO counterparts. JSI is committed to ensuring that each partner is able to bring its best resources and maximize its added value to support the MOHSW and the Liberian people. JSI will actively support and nurture the contribution of our partners so that their technical work can flourish in the RBHS project environment. Each plays a very key role in the project and RBHS will not be successful without the full contribution of each partner. Our COP and Senior Advisor will ensure that each staff person and each partner is well-supported to do their work.

Level of Effort

All staff positions as identified on the Staffing Plan are full-time positions funded over the life of project except the Infrastructure Advisor. In addition, we expect to transition several key positions from expatriate to Liberian staff during the third year of the project, including the the BCC Advisor and the Chief of Party. During year three, we expect to promote Rose Macauley (or another Liberian of equal qualification) to the role of Chief of Party. We do this for several reasons: first, we take seriously our capacity-building role, and expect all of our staff to mentor Liberian counterparts to take on roles of increasing responsibility. Furthermore, expatriate advisors are very expensive, and we would prefer to put RBHS resources towards program activities. Given the human resource crisis at this time, expatriate technical advisors are necessary in Liberia, but by Year Three of the project, we hope that both economic development gains and stronger health systems will attract talented Liberian professionals to the positions that will be vacated by our expatriate staff.

Coordination with Key Stakeholders

RBHS will continue to work closely with the MOHSW, USAID/Liberia, NGO/FBO partners, donors and other key stakeholders in Liberia, as JSI has for the past few years. We are fully committed to supporting the Ministry in building its health system and implementing its National Health Plan, and through that, contributing directly to the achievement of USAID/Liberia's Intermediate Results 1 and 2 for health. We view our role as capacity-builders, not independent operators. As such, it is our preference, if space allows, to continue our close working relationship with the MOHSW by co-locating several of our staff in the Ministry of Health building. Because we are committed to strong partnerships with our partners, we will strive throughout RBHS implementation to include key stakeholders as appropriate in all aspects of project planning and implementation. We tried to model this process in the development of this proposal, meeting with over 25 partner organizations and implementing NGOs/FBOs in Liberia, in an effort to share our technical approach and include their input in our application.

Developing Local Capacity

Our Staffing Plan places highest priority on building the capacity of Liberian staff to fill key technical roles. Most of the long-term RBHS staff are Liberian nationals. Additionally, as mentioned above, by years four and five of the project, most of our expatriate staff will transfer their responsibilities to a Liberian national. This capacity-building approach is less expensive and more sustainable than expatriate-driven models: it builds local capacity, provides additional opportunities for advancement for motivated and talented Liberians, and ensures that program direction is ultimately led by national staff.

Innovative and Sound Methods for Financing Health Services

As described in more detail in our Technical Approach, our primary strategy for financing health services, especially in the early years of RBHS, is performance-based grants to NGOs/FBOs to support service delivery and health systems strengthening in RBHS areas. In Year One of the Project, we conducted a cost analysis of the BPHS at clinic and hospital levels to reduce facility operating costs and improve BPHS cost-effectiveness. At the same time, we will explore public-private partnership and innovative financing arrangements to increase the resources coming to the health sector, build community ownership and investment in health and increase sustainability at community and county levels.

Additionally, we will work with CHTs, CHDCs and others to mobilize county and local constituents for health who advocate to their elected officials and county managers for increased county and community-level funding for health service delivery. By the later years of project, MOHSW will increasingly contribute to the operating costs of service delivery from budgetary support. Finally, by improving health systems capacity, we will contribute to improving financial management and accountability within the MOHSW, thus making available resources more efficient and effective for health.

Implementation Plans

JSI and its partners have extensive experience in sub-granting and will follow grants management procedures that have been developed through more than 3 decades of experience with USAID in more than 100 countries around the world. All sub-grants will comply with USAID rules and regulations as defined in USAID's General Provisions.

Workplans and annual budgets will guide the development and implementation of RBHS activities over the life of project. Training plans will also be developed annually as part of the overall workplan development process. Evaluations of the prior year's trainings and the expected outputs for the coming year will shape each year's plan. Program evaluation and information management occurs throughout the project.

RBHS Sub-granting Procedures

- Determination by RBHS, MOHSW and USAID that a subgrant is needed with another organization
- Careful preparation of a scope of work and technical specifications
- Preparation of a request for proposal or bid, including criteria for their evaluation
- Advertisement and other distribution of Request for Applications
- Evaluation of proposals by a specially selected expert committee
- Selection of a sub-grantee and negotiation of a formal agreement
- Securing of required approvals, as needed.

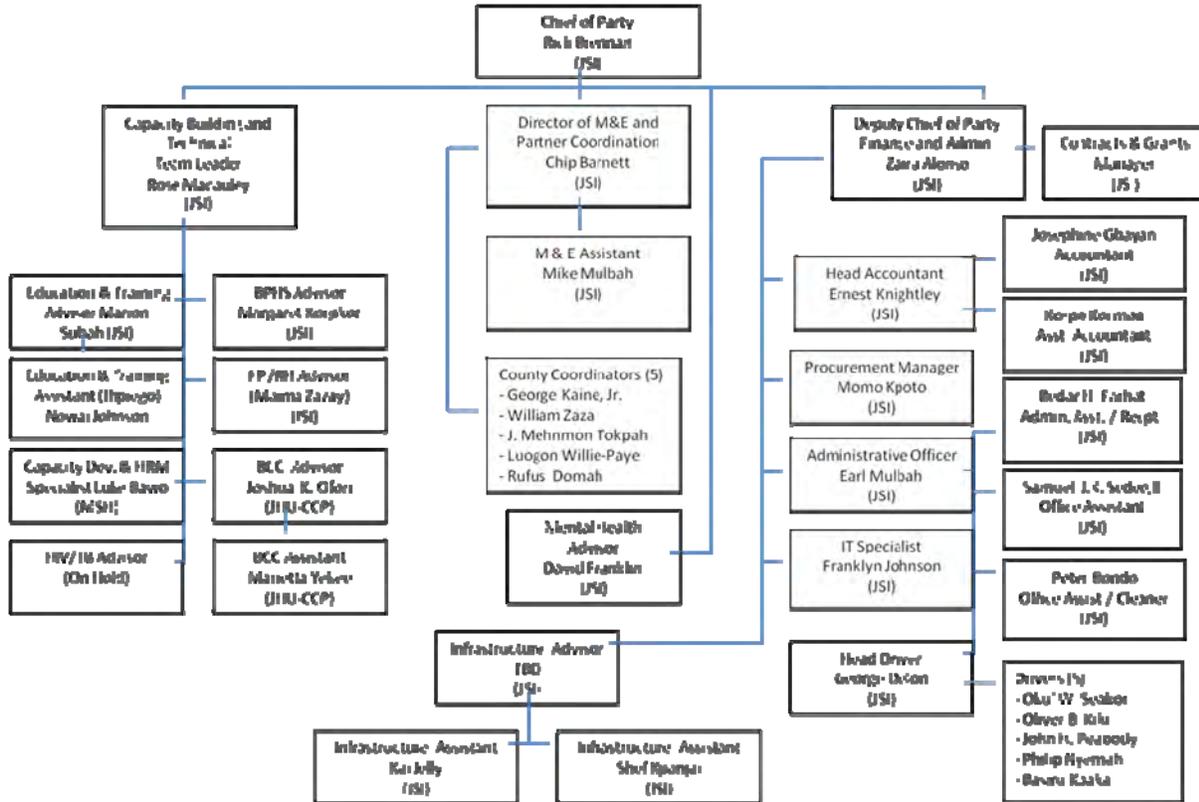
ANNEX 1 – KEY INDICATORS: END OF PROJECT TARGETS

Indicator	5th-year (2013) target
Impact	
% of women 15-49 currently using modern contraceptives by marital status, age, region of residence	Baseline: 7% (2007) - 5 counties Target: 12%
% of pregnant women who slept under a treated bednet previous night	B: 36% (2008) [rural] T: 85% (2013) [NMCP] - national
% of children under 5 who slept under a treated bednet previous night	B: 28% (2008) [rural] T: 85% (2013) [NMCP] - national
% of women and men age 15-24 reporting having sexual intercourse and using a condom during the last intercourse	B: 4% (F), 9% (M) (2007) - 5 counties T: 10% (F), 20% (M)
SO 1.1	
Mean score from accreditation survey	92
Utilization rate	0.85
SO 1.2	
% of children under 1 year who received DPT3/pentavalent-3 vaccination	85%
SO 1.3	
% of deliveries in facility with a skilled birth attendant	35%
% of pregnant women receiving second or greater dose of tetanus toxoid	95%
SO 1.4	
% of pregnant women provided with 2nd dose of IPT for malaria	85%
Number of children under 5 years who received vitamin A (facility level)	30,000
SO 1.5	
Number of people who received HIV counseling and testing and received their test results	10,000
% of RBHS facilities providing the minimum package PMTCT services according to national and international standards	80%
Case detection rate of new smear-positive pulmonary TB cases	75%
Treatment success rate for of registered new smear-positive pulmonary TB cases	>85%
SO 1.6	
Number of counseling visits for FP/RH	50,000
Couple-years of contraceptive protection provided by RBHS-supported facilities	13,000
SO 2.2	
Number of pre-service educators trained with RBHS support	435
SO 2.5	
Number of joint (CHT and NGO) supervisory visits per facility per month	1.0
% of timely, accurate and complete HIS reports submitted to the CHT during the quarter	95%

SO 2.6	
% of staff funded by NGOs paid on time in the quarter	>95%
SO 2.7	
% of facilities with operating hand pump or an equivalent safe water source	>90%

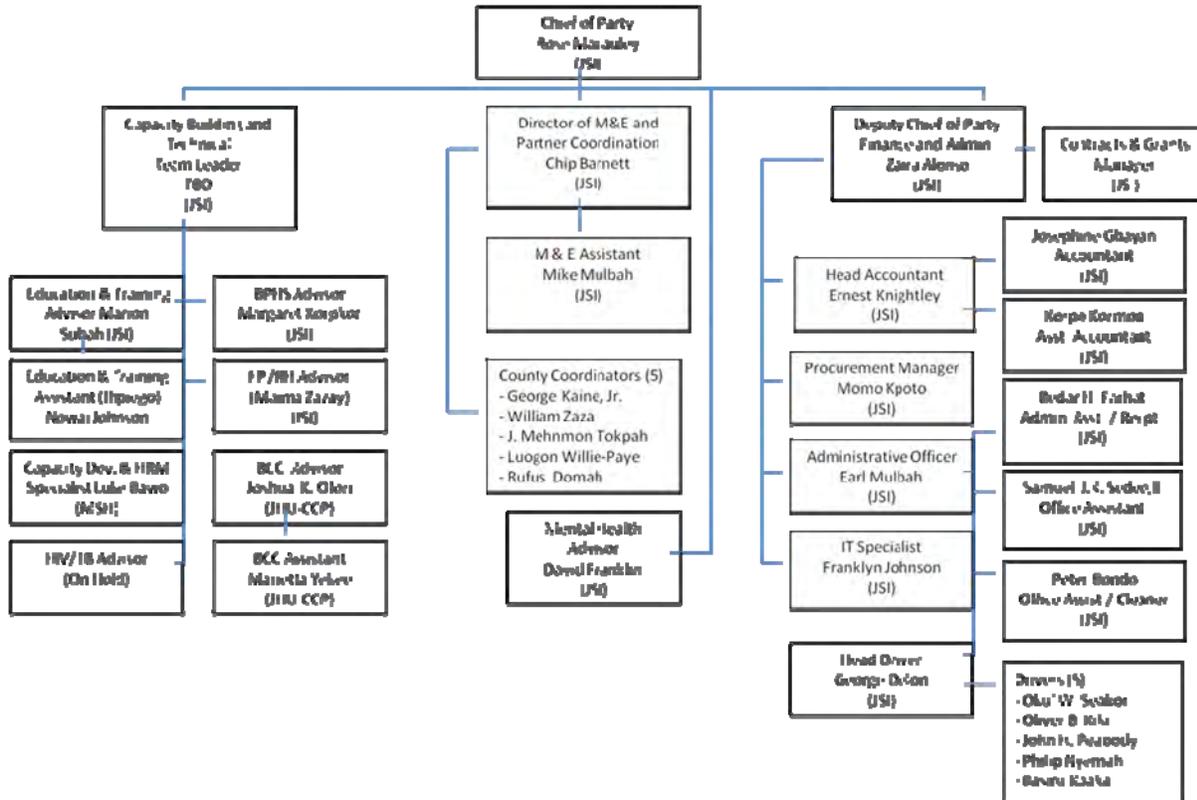
ANNEX 2 – RBHS STAFFING STRUCTURE, Years 2 and 3

Rebuilding Basic Health Services in Liberia Staffing Plan (Project Year 2)



ANNEX 3 – RBHS STAFFING STRUCTURE, Years 4 and 5

Rebuilding Basic Health Services in Liberia Staffing Plan (Project Year 4 & 5)



ANNEX 4 – RBHS LEVEL OF EFFORT IN MONTHS FOR ALL STAFF, Years 1-5

EXPAT/TCN STAFF	YR 1	YR 2	YR 3	YR 4	YR 5
Chief of Party, Rick Brennan	6.0	12.0	12.0	0.0	0.0
Deputy Chief of Party, Shiril Sarcar	10.0	2.0	0.0	0.0	0.0
Deputy Chief of Party, Zaira Alonso	0.0	9.5	12.0	12.0	12.0
Infrastructure Advisor, Victor Musarurwa	10.0	12.0	12.0	0.0	0.0
M&E Director, Chip Barnett	3.0	12.0	12.0	12.0	12.0
Capacity Building Team Leader, Rose MacCauley*	1.0	12.0	12.0	12.0	12.0

LOCAL STAFF	YR 1	YR 2	YR 3	YR 4	YR 5
Capacity Building Team Leader - TBD	0.0	0.0	0.0	12.0	9.0
BPMS Advisor - Margaret Korkpor	1.0	12.0	12.0	12.0	9.0
FP/RH Advisor - Maima	1.0	12.0	12.0	12.0	9.0
HIV/TB Advisor - TBD	0.0	6.0	12.0	12.0	9.0
Family Health Advisor - Saye	1.0	6.0	0.0	0.0	0.0
Procurement Manager - Momo	7.0	12.0	12.0	12.0	9.0
Mental Health Advisor - David	6.0	12.0	12.0	12.0	0.0
County Coordinator - George (Grand Cape Mount)	5.0	12.0	12.0	12.0	7.0
County Coordinator - Luogon (Nimba)	4.0	12.0	12.0	12.0	7.0
County Coordinator - Topka (River Gee)	4.0	12.0	12.0	12.0	8.0
County Coordinator - William (Lofa)	6.0	12.0	12.0	12.0	7.0
County Coordinator - Rufus (Bong)	1.0	12.0	12.0	12.0	7.0
Contracts/Grants Manager - TBD	0.0	6.0	12.0	12.0	12.0
Head Accountant - Ernest	1.0	12.0	12.0	12.0	12.0
Accountant - Josephine	1.0	12.0	12.0	12.0	12.0
Assistant Accountant - Korkpor	1.0	12.0	12.0	12.0	12.0
Administrative Officer - Earl	1.0	12.0	12.0	12.0	12.0
Administrative Assistant/Receptionist - Bedar	1.0	12.0	12.0	12.0	12.0
M&E Assistant - Mike	1.0	12.0	12.0	12.0	9.0
IT Specialist - TBD	0.0	12.0	12.0	12.0	12.0
Infrastructure Assistant - Kai	0.0	7.5	12.0	0.0	0.0
Infrastructure Assistant - Shef	0.0	7.5	12.0	0.0	0.0
Office Assistant (2)	2.0	24.0	24.0	12.0	12.0
Driver - Okul	2.0	12.0	12.0	12.0	9.0
Driver -Phillip	2.0	12.0	12.0	12.0	9.0
Driver - Oliver	2.0	12.0	12.0	12.0	9.0

LOCAL STAFF	YR 1	YR 2	YR 3	YR 4	YR 5
Driver - John	2.0	12.0	12.0	12.0	12.0
Driver - Basiru	1.0	12.0	12.0	12.0	12.0
Driver - George	2.0	12.0	12.0	12.0	12.0