EBOLA RESPONSE MULTI-PARTNER TRUST FUND PROPOSAL

Proposal Title: Strengthening Reproductive Maternal, New born and Adolescent Health Service Delivery, Death Surveillance and Response in South Eastern Liberia	**Recipient UN Organization(s):** UNFPA, WHO and UNICEF
Proposal Contact: Dr. Remi Sogunro, UNFPA Representative Cell: +231 770004001 E-mail: sogunro@unfpa.org Dr. Alex Gasasira, WHO Representative Cell: +231 775 281 157 Email: gasasiraa@who.int Sheldon Yett, UNICEF Representative Cell: +231 770 267 100 Email: syett@unicef.org	**Implementing Partner(s) – Name & type (Government, CSO, etc.):** • Ministry of Health (MoH), Republic of Liberia
Proposal Location (country): ☐ Guinea ☒ Liberia ☐ Sierra Leone ☐ Common Services	**Proposal Location (provinces):** • Maryland County
Project Description: The project aims to support Government efforts to restore essential reproductive maternal and neonatal health (RMNH) services required to ensure infection prevention and control. In particular, the focus is on ensuring that non-infected but affected pregnant women have access to health services that promote hygienic/sanitary environments for them to deliver their babies safely. The project will also build on adolescent health care program in targeted county	**Requested amount:** USD 1,000,000 UNMEER budget: US$1,000,000 Other sources (indicate): Government Input: In-kind contribution **Start Date:** December 2015 **End Date:** December 2016 **Total duration (in months):** 12 months

STRATEGIC OBJECTIVES AND MISSION CRITICAL ACTIONS to which the proposal contributes.

- ☐ SO 1 Stop Outbreak MCA1: **Identifying and tracing of people with Ebola**
- ☐ SO 1 Stop Outbreak MCA2: **Safe and dignified burials**
- ☐ SO 2 Treat Infected People MCA3: **Care for persons with Ebola and infection control**
- ☐ SO 2 Treat Infected People MCA4: **Medical care for responders**
- ☐ SO 3 Ensure Essential Services MCA5: **Provision of food security and nutrition**
- ☒ SO 3 Ensure Essential Services MCA6: **Access to basic services**
- ☐ SO 3 Ensure Essential Services MCA7: **Cash incentives for workers**
- ☐ SO 3 Ensure Essential Services MCA8: **Recovery and economy**
- ☐ SO 4 Preserve Stability MCA9: **Reliable supplies of materials and equipment**
- ☐ SO 4 Preserve Stability MCA10: **Transport and Fuel**
- ☐ SO 4 Preserve Stability MCA11: **Social mobilization and community engagement**
- ☐ SO 4 Preserve Stability MCA12: **Messaging**
- ☐ SO 5 Prevent Further Spread MCA13: **Multi-faceted preparedness**

	ıt UN Organization(s)[1]
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[1] If there is more than one RUNO in this project, additional signature boxes should be included so that there is one for every RUNO.

NARRATIVE

a) Rationale for this project

Liberia made significant strides in healthcare recovery in the decade since the end of the war in 2013. The number of healthcare facilities increased by over 30% from 2007, institutional building and healthcare financing has been progressing very well with the percent of national budget allocated to the sector being 12%; only 3% below the target for the Abuja Declaration. Despite the health sector success, major gaps still remain. Liberia has a high disease burden and vulnerability to outbreaks, such as the Ebola virus disease (EVD). The health system vulnerability is predominantly attributed to health workforce shortage, management issues that cut across national, county and district levels, poor safety and quality of health services and a large unfunded gap in the health sector's annual budget to drive achievement of the strategic plan objectives. All of these contributed to the vulnerabilities exposed by the 2014-2015 Ebola outbreak and continue to impede the on-going recovery of the health system in the immediate post-Ebola and medium term periods.

The coverage of some of the effective interventions (ANC4+, SBA, PNC, Penta 3, fully vaccinated, etc.) were already low even before the Ebola outbreak; there is high unmet need for family planning particularly in late adolescence, a weak referral system (hospital care, rehabilitation center, etc.), and low population accessibility to some of the basic health services such as basic emergency obstetric and neonatal care (BEmONC) and comprehensive emergency obstetric and neonatal care (CEmONC), diagnostic, medicines, etc.

With nearly 150 days since the last EVD case, the government has been involved in rebuilding of the healthcare delivery system through an active resource mobilization and implementation of post EVD recovery plans aimed at creating a more resilient healthcare delivery system with a strong integrated disease surveillance strategy and plans. Maternal, new born and child health remains a priority for attention. A weak maternal and neonatal healthcare delivery system is mirrored in the health statistics specific to the situation of women in Liberia. Maternal mortality ratio of 1,072/100,000 live births in 2013 showed a worsening situation in comparison with 578 deaths per 100,000 live births in 2000 and 994/100,000 live births in 2007 (2013 LDHS). Against a sub-Saharan African average of 450, this maternal mortality level is very high. In addition, approximately 38% of women and girls 15-49 years old die from maternal or pregnancy related causes. The statistics point to the fact that coverage of quality (maternal) healthcare for women of reproductive age has not improved over the years.

Three-quarters of Liberia's population is classified as youth; that is, persons below 35 years of age; 63 per cent is less than 25 years old and 32.8 per cent is 10-24 years old. The youth, some of whom are ex-combatants, face formidable challenges, including limited access to employment and stable sources of income, and sexual and reproductive health information and services. Early marriage, sex work and teenage pregnancy are common among girls. Nearly 11 per cent of females initiate sex at ages 11-14. Teenage pregnancy contributes significantly to dropout rates among school going girls and 67 per cent of adolescent girls with no education are mothers, compared to 17 per cent of those with secondary and higher education. By age 15, about 11 per cent of girls are pregnant and this rapidly rises to 62 per cent by age 19. In addition, 26 per cent of adolescent pregnancies are unintended and 30 per cent end in unsafe abortion.

Also, 24.9 per cent of the population is women of childbearing age (15-49). Whilst the total fertility rate of the population has declined from 6.2 in 2000 to 5.2 in 2007, socio-cultural norms favoring high fertility are prevalent, making for a population increase over the next generation

even if the 2013 total fertility rate of 4.7 were to be brought down to a replacement level. There is a substantial difference in fertility levels between rural and urban women; at the current age specific fertility rates, rural women will give birth to over two more children than their urban counterparts during their reproductive years (6.1 and 3.8, respectively). In addition, the highest current fertility experience in the population occurs among women aged 20-24 and ASFRs for females at ages 15-19 is typically higher than those for women 35 years and above. Thus, adolescent sexuality and fertility have become problematic as children beget children. Teenage childbearing contributes to maternal deaths, unsafe abortion among adolescents and consequent low status of women.

Most of the young mothers are not sociologically and biologically prepared for the burden that childbearing and rearing impose upon them. Their partners may desert them upon knowing of the pregnancy and their physiological immaturity to bear children may result to complications of pregnancy and childbirth such as fistulas. Although there are no national data on the prevalence of fistula, 875 cases were repaired between 2007 and 2011, with patients having an average age range of 11-20 years. There is still a large backlog of obstetric fistula cases requiring treatment.

The modern contraceptive prevalence rate (CPR) has increased from 11 per cent in 2007 to 19.1 per cent in 2013. The CPR increases with age, reaching a peak at age 25-29 years (25 percent), and then declines to 6.2 percent among women 45-49 years. Notwithstanding that the youngest women exhibit the highest fertility potentials in the population, 87 and 77 per cent of the women in 15-19 and 20-14 age brackets, respectively, are currently not using any method of contraception. Unmet need for family planning has decreased slightly from 36 per cent in 2007 to 34 per cent in 2013. The low contraceptive uptake is due to inadequate family planning information and services, frequent stock-outs of contraceptive commodities, poor logistics management chain, and unhelpful cultural norms and beliefs. Consequently, there is a scare that if significant strides are not taken to improve on the contraceptive uptake, the current HIV/AIDS prevalence of 1.5 per cent may increase; given that the prevalence among pregnant women is higher at 4.0 per cent and adolescent girls are three times more at risk of contracting HIV than boys.

The low use of modern family planning methods exposes women to great risks of unwanted pregnancies, HIV infections and STIs. It is encouraging to note that 97.3 per cent of Liberian women and 96.2 per cent of men have heard of HIV. This female dominance is true for persons of all ages below 30, for never married persons (whether they have ever had sex or not) and for persons of no education, primary, secondary and higher levels of education. However, there are vast differences between awareness levels in urban (99.1 per cent) and rural (94.6 per cent) areas on the one hand, and between persons with no education (94.9 per cent) and those with secondary and higher education (99.9 per cent). In general, there is no significant difference between males and females with respect to knowing that (a) consistent use of condoms is a means of preventing the spread of HIV (75 per cent apiece), (b) limiting sexual intercourse to one faithful and uninfected partner can reduce the chances of contracting HIV (78-79 per cent) and (c) using condoms and limiting sexual intercourse to one uninfected partner is a safer behavior (68 per cent apiece).

Maternal deaths occur mainly among women under 35 years of age. The medical causes of maternal mortality are complications of pregnancy and delivery, particularly hypertensive disease of pregnancy (pre-eclampsia and eclampsia), obstructed labour, ante and postpartum haemorrhage, sepsis, unsafe abortion, toxaemia and anaemia; all due to inadequacy of comprehensive reproductive health services to deal with these clinical problems. The non-clinical causes of this spectacle include poverty, inadequacy of road and transport networks leading to low accessibility

of certain communities to health facilities, the occurrence of the "three (or four) delays model", patriarchal practices affecting the status of women and harmful traditional practices.

According to the 2013 LDHS, neonatal mortality rate is 26 and post-neonatal mortality rate is 28. The main causes of neonatal mortality are asphyxia, sepsis, complications from pre-term birth and pneumonia. About 45 and 75 per cent of neonatal deaths take place during the first day and week of life respectively. The sad aspect of the major causes of maternal and neonatal mortality is that they are almost entirely preventable or treatable with emergency obstetric care, skilled birth attendance and adequate postpartum care. Their occurrence is a needless loss of the human capital stock of the nation and should, therefore, be avoided.

The rate of adolescent (14-19 years) pregnancies in Liberia has also remained unacceptably high at 177/1,000 adolescents with a third of adolescents aged 19 either currently pregnant or already experiencing motherhood. More disturbingly, adolescents account for 17% of all maternal deaths and more than 19% of all pregnancies (2013 LDHS). In 2010, the Liberia Emergency Obstetric and New born Care (EmONC) needs assessment revealed an unacceptably inadequate number of health facilities with the capacity to perform lifesaving signal functions required to provide basic and lifesaving interventions to women and girls with birth and pregnancy complications. In addition, as a result of the weak supply chain system, more than 50% of maternities suffer frequent stock-outs of essential lifesaving drugs and medical supplies to respond to the critical health conditions of pregnant women. Furthermore, the need to ensure the availability of required skilled human resource, and effective mentoring and supervision is essential to performing interventions that contribute to maternal mortality reduction. Proven community based interventions that contribute to the prevention of maternal and new born health complications at the community level have not been implemented at scale in Liberia.

In Liberia, maternal deaths have been declared as notifiable events and incorporated into the integrated disease surveillance and reporting system. However, despite this, the current system has been unable to report the true magnitude of the situation let alone respond timely and effectively. There is gross underreporting and weak community linkages, partnership and insufficient monitoring of the current system. With a goal to eliminate preventable maternal mortality by obtaining and strategically using information to guide continuous public health actions and monitoring impact, an effective MDSR will guide the provision of reliable data that informs public health actions to reduce mortality, count every maternal death and permit an assessment of the true magnitude of maternal mortality and the impact of actions to reduce the number of preventable death among women and girls.

Maryland County

Maryland County is the most populated county in Southeastern Liberia with a total of 160,556 people. The Southeastern region relies on the county as a hub for administrative, commercial and other livelihood activities due to its cross boarder nature and fishing activities. The mining and rubber/palm plantation in the county attracts many people seeking employment in these various local and international companies. In addition, the county has the most reliable referral hospital where emergency cases are referred from Grand Kru and River Gee counties. Although the county is regarded as a reference for the other two counties, given its population the county health indicators are much worse than the other two counties in the same region. For example the unmet need for family planning is 22% and 31% in both River Gee and Grand Kru respectively while in Maryland County it is at 41%; and the contraceptive prevalence rate is also lower in Maryland County at 22% but it is 30% in River Gee County. Similarly, home based and unskilled delivery is high compared to the other two counties ranging from 45% to 47%. Maryland has one of the highest rates of babies born with low birth weights amongst seven counties. Like most other counties the adolescent pregnancy rate for Maryland County is also high at 31%. The county also

has a university that attracts young people as well as many staffers. Furthermore the county has only one health center in addition to one hospital. There is need to identify and support the upgrading of a second health center. Geographic inaccessibility to the county also makes it vulnerable in terms of the many logistical challenges the county faces in moving goods and commodities from the Monrovia area. These challenges also affect the supply chain making it difficult to move medical supplies and essential drugs to this region. As a result, frequent stock-out of health commodities remain a major challenge for the health sector. High staff turnover in this region has a negative impact on the availability of qualified human resources for health facilities to provide quality care. As part of national efforts to restore health services after the EVD crisis, the MoH has initiated plans to expand the hospital to ensure that obstetric emergency cases transferred from the region are receive quality care particularly in the area of maternal and child health. The only health center in the county has also been upgraded to provide Basic Emergency Obstetric and Newborn care (BEmONC) services to the population. There is need to upgrade additional health facilities to provide BEmONC services for the growing population. Community engagement to ensure that social behavior change through appropriate communication remains very crucial in a context where more than 44% of child births and care occur at home by unskilled personnel.

As the country moves forward in building a resilient health care system post EVD outbreak, the need to focus interventions in hard to reach counties and community remains crucial to national efforts in bridging the equity gaps between rural and urban settings in the country. With documented evidence in joint programming and partnership as evidenced by the current collaboration through the H4+ mechanism, UNFPA, WHO and UNICEF have the requisite leadership and experience in the implementation of a joint maternal health program based on each agencies comparative advantages and excellent collaboration with the Ministry of Health.

b) Coherence with Existing Projects

UNFPA, WHO and UNICEF are part of the global H4+ initiative on a number of health related projects and programs including maternal and new born health. Currently, a H4+ funding stream from the Swedish Development Agency (Sida) is used to support the improvement of maternal new born health services in the South Eastern part of Liberia. UNFPA's existing support to contact tracing and active case finding activities in 10 counties (including all counties in the southeast) will contribute to the implementation of the project activities. In addition, UNICEF is supporting the pilot of integrated community case management program (iCCM) in the southeast including Maryland county coupled with recent community health program involvement aimed at supporting five south eastern counties in the roll out of the Ministry of Health's new community health program. WHO's strong support to the roll out of the integrated disease surveillance, inclusively of community based surveillance at the county and district levels, will bring a further boost to improved data availability and use for informed decisions towards saving lives of women and babies. These are additional ongoing projects likely to contribute a synergistic effect in the implementation of this project.

c) Project Goal, Objectives and Outputs

Goal: The project aims to contribute to the reduction of maternal and new born mortality in Maryland, one of the south eastern Counties by the end of 2016.

Specific Objectives:

a. Increase access to quality, equitable maternal and new born health services that significantly contribute to maternal new born survival through health facility and

community interventions in the targeted county;

b. Increase access to the provision of reliable data on maternal deaths that informs health actions to reduce mortality through robust community engagement and community response systems, and

c. Strengthen information dissemination that increases knowledge and potential utilization of sexual and reproductive health services among adolescents in districts and communities in Maryland County.

Outputs

Output 1: Access to and utilization of EmONC services and routine RMNCAH services for women and girls 15-49 years of age is increased.

The County has only two health facilities with the capacity to provide Basic Emergency Obstetrics and new born care services. There is a limited number of health facilities that provide EmONC services and nearly 90% of health facilities in the county have only one midwife or skilled birth attendant to provide services. A minimum of three skilled birth attendants are required to provide EmONC service 24/7. Moreover, health care provides are not trained to engage and provide services to adolescents. In additional social cultural barriers to health seeking that favor child bearing and home births make it even more challenging for women and girls to access care in a timely manner. This output will aim to address some of these challenges.

Sub outputs

1. *Output 1.1:* Human resources capacity for maternal health strengthened through training and mentoring to provide quality care
2. *Output 1.2*: Capacity of skilled providers to provide adolescent friendly RMNCAH services improved
3. *Output 1.3*: Health facilities are upgraded to provide 24 hours BEmONC services
4. *Output 1.4:* Health facilities have access to standards of care for RMNCAH for improved quality of care
5. *Output 1.5:* Adolescent's access to pregnancy, STI and HIV prevention and management services including HIV testing and counselling (VCCT) and appropriate information for safe sex targeting adolescents and youth.

Output 2: Supply of essential commodities, including contraceptives, at health facility and community levels to ensure a zero stock out of supply of drugs and relevant supplies is improved.

Poor road conditions, distance from the central supply chain system and limited access to the terrain during the raining season are critical barriers in ensure regular supply of RH commodities for the county and the two other facilities in the region. The project will ensure increased supply of essential drugs and medical supplies including Reproductive health kits for post abortion care, rapid test kits for targeted health facilities. These and others will be procured and distributed using the national supply chain system on a quarterly basis. Upstream support through to facilitate commodity distribution and tracking will be provided to the Maryland County Health team and the national supply chain system.

Sub outputs

1. *Output 2.1:* Health facilities have access to essential maternal and new born health medicines and contraceptives in a timely manner
2. *Output 2.2:* County health teams have access to adequate logistical support that facilitate distribution of essential commodities
3. *Output 2.3*: Health facilities have knowledge and capacity to properly manage essential supplies and commodities.

Output 3: Community health structures are strengthened to provide community-based RMNCAH services in all targeted counties

Liberia has recently embarked on a new community health workforce program that is currently being rolled out in a gradual manner. The package of services to be provided by this new cadre of health workers include Home based management of maternal and newborn care services (excluding delivery care), community based distribution of family planning commodities as well as integrated management of childhood illnesses at community level. The project will support the roll-out of this new initiative to more than 10 targeted catchment communities as well as provide support to strengthen monitoring and supervision of CHWs activities to measure the following sub outputs.

Sub outputs

1. *Output 3.1:* Communities in the catchment area of the targeted health facilities organized monthly CHDC meetings with action plans
2. *Output 3.2:* CHVs trained in HBMNC to ensure regular home visits during antenatal and post-natal periods for the mother and new born according to protocol

Output 4: Maternal and Neonatal death surveillance and response (MNDSR) systems strengthened at all levels in accordance with national protocols.

Although an updated national MNDSR protocol exists, the current MNDSR system remains weak and underperforming. Death notifications are seldom with death reviews even less frequent in most counties and Maryland is no exception. Where death notifications are made only 25% are reviewed and rarely any recommendations or actions taken to avoid subsequent deaths. The following sub outputs will measure the effectiveness of MNSDR in the county and particularly in the catchment communities and supported health facility.

Sub outputs

1. *Output 4.1:* Maternal death identification and notification by health facilities are investigated according to protocol
2. *Output 4.2:* Maternal deaths identified/notified by targeted communities are investigated through verbal autopsy
3. *Output 4.3:* District and county health surveillance teams supported to enhance timely response with community involvement.

Output 5: Effective coordination and monitoring of RMNCAH services improved at all levels in targeted county. The MoH has succeeded in ensuring regular coordination of RMNCAH activities at central level. County level coordination of RMNCAH activities have not been as effective as required. There is need to support County health teams to conduct regular RMNCAH coordination as well as cascade these coordination activities to the level of districts as well as facilities and communities. The project will support the Maryland County health team to ensure that communities and districts participate in coordination activities for effective implementation and monitoring of RMNCAH services.

Sub outputs

1. *Output 5.1:* Enhanced and integrated HMIS at county, district and health facility and community levels.
2. *Output 5.2:* Functional and results-based coordination mechanisms at county and district levels improved.

d) Proposed Implementation Strategies and Activities:

Improve skilled birth deliveries at health facilities for all RMNCAH services particularly EmONC

Access to quality emergency obstetrics and new born care is very essential in saving the life of each woman and new born. In close collaboration with the Ministry of Health and County Health Teams, the project will ensure the identification and recruitment of skilled birth providers in targeted health facilities. As a result of the limited human resource in other health facilities in the county, Maryland County has only two health facilities providing Emergency obstetric and newborn care services including the hospital. Most health facilities have only one trained staff to provide maternal and child care services including antenatal care, labour, delivery and post-partum care services. There is need for a minimum of three skilled birth attendants on a 24 hour shift routine seven days a week to ensure full compliance of a facilities with Basic Emergency Obstetric and Newborn care (BEmONC) services. The project will support the upgrading of three health facilities to the level of BEmONC that ensure the provision of care according to standards. All trainings will use an on-site facility-based/on-the-job training approach that will be based on the specific facility data and context. In line with the road map for accelerating the reduction of maternal morbidity and mortality and the Essential Package of Health Services, UNFPA will continue to encourage a midwifery-led maternal healthcare approach in the delivery of services. Health facilities will be supported to provide 24 hours and 7 days a week maternal healthcare services as well as timely referral of emergency obstetric cases.

Skilled human resource in the absence of an *effective supply chain of medicines and medical supplies* that ensures that essential lifesaving medicines are continuously available at health facilities renders maternal death reduction difficult to achieve. Liberia has struggled to reduce the high levels of stock-out of drugs and medical supplies. The 2013 UNFPA supplies (GPRHCS) survey of commodity availability indicated that more than 50% of primary health facilities had stock-outs of reproductive health commodities including lifesaving maternal drugs.

UNFPA will work with the existing supply chain systems at all levels of stock movement and distribution in ensuring the required quantity and timely supply of medicines to health facilities. To ensure a 60% reduction in stock out of essential maternal health medicines and supplies, an innovative approach using mobile technology will be experimented in conjunction with the current system to improve the delivery of medicines to health facilities.

Emergency referral of pregnant women to the County referral hospital or Pleebo health center remains another critical area that will require adequate support. Pregnant women who are likely to die in childbirth are those that often need to be referred to other facilities for advanced care. The numbers of maternal deaths, therefore, will not decline in the absence of a functional emergency referral system. Building on the existing resources available at the county level, the project will work with various teams in optimizing the use of transportation and communication systems at various levels of care. An additional ambulance will be provided and also ensure expansion of the existing communication system to facilitate regular contact with referral facilities.

Adolescent's access to reproductive health services is often hampered by poor access to information among adolescents and limited skills of care providers to interact with adolescents in response to their needs. Social cultural or traditional beliefs often contribute to the many barriers faced by adolescents in receiving services and information. Perceptions that favour early child bearing and early marriage are common practices in Liberia as evidenced by the median age at first birth which is 18.9 years and 18.4 in Maryland County. Three out of every ten girls 15 to 19

years old are either already pregnant or experiencing motherhood. Through this project, UNFPA will ensure the integration of adolescent and youth-friendly service provision services and training content in planned EmONC facilities and trainings to ensure that health facilities provide friendly services to youths 14-19 years of age according to existing protocols.

Demand creation through information dissemination of culturally acceptable and sensitive messaging at community and health facility levels to improve knowledge about fertility, pregnancy prevention and safe motherhood will form part of the project implementation. Peer-to-peer education through community pregnancy prevention advocacy groups to advance Social Behaviour change using communication (SBCC) will serve as forums for adolescents to access information and services. Dialogue with various community groups including community leadership, women and male groups as well as youth and adolescent groups will form part of the SBCC approach. The use of media, IEC/BCC context approved strategies will be employed to increase the promotion of adolescent pregnancy prevention in catchment communities and districts.

Community engagement is crucial to maternal and new born healthcare and reduction of morbidity and mortality. Liberia has initiated the roll-out of the community health workforce nationwide. This initiative positions existing CHWs in a new role as formal cadres of the health care delivery system rather than volunteers at community level. UNICEF will ensure support to county health team to roll out the initiative in targeted catchment communities supported by the project. To ensure that CHWs are effective and active, UNICEF will strengthen the functions of community health committees (CHC) who have the oversite of CHWs activities and building the linkage with health facilities to ensure community engagement in planning, decision-making and review processes of various health interventions as well as MNDSR at community level. Specific activities include: (1) monthly meetings at health facilities to empower community leaders, men, and women to discuss and timely address barriers to access and utilize services; (2) community awareness meetings on MNDSR (notification, identification, investigation); and (3) support community activities organized by existing and new CHWs to enhance CHWs recognition and support them to perform their duties.

In addition, ***the project will aim to improve community-based MNH promotion and prevention for RMNCAH in targeted counties, districts and catchment communities*** through community-based health promotion and social mobilization interventions to increase awareness, knowledge and acceptability of RMNCAH interventions at the community level. The aim is to increase mothers' understanding of: (1) the importance of family planning and danger signs and referral mechanisms during pregnancy, childbirth and the postnatal period; (2) promotion of safe birth practices; (3) essential maternal and new born care and preventive measures for home delivery. These interventions are expected to be conducted by trained CHWs as part of their responsibilities according to the community health policy and standards. Maryland County Community services department will be supported to ensure effective monitoring and supervision of activities.

Ensuring that every death is counted among women and new born cannot be effectively achieved without the involvement of communities in MNDSR. UNICEF will ***establish and strengthen community maternal and new born surveillance and response (MNDSR).*** The community volunteers are involved in the implementation of the community event-based surveillance (CEBS). The MNDSR process will be triggered and led by community members hearing about a death in their area. Under this support, the following activities will be conducted by the communities: (1) establish systems to ensure community death identification, notification and reporting; (2) conduct community meetings for verbal autopsy on causes of deaths; (3) organize

feedback meetings and forums to hold health workers accountable for the actions identified to prevent future maternal and neonatal deaths and to check progress.

Strengthen implementation of Home Based Management of Maternal New born Care (HBMNC)

This intervention will be implemented through the CHWs providing integrated community case management (iCCM) at the community. These CHWs will be continuously equipped, monitored and supervised to strengthen the provision of integrated community-based care during antenatal (birth preparedness package and referrals), delivery (referral for SBAs and safe delivery), and postnatal periods. Special emphasis will be put on HBMNC and will include home visits to assess the mother and her new born(s), ensure appropriate thermal care, initiate/promote exclusive breastfeeding, provide family planning and nutrition counselling to the mother, check for danger signs and refer to health facility, if needed. UNICEF will collaborate with WHO to conduct joint monitoring and supervision to ensure quality implementation.

Strengthen support systems through real-time monitoring and regular reporting

UNICEF will support local managers to closely monitor progress and address health system bottlenecks to effective and safe delivery of community-based RMNCAH interventions. during monthly/quarterly review meetings. Additional activities will include: (1) provision of community–based reporting tools on a regular basis; (2) monitoring the stock-outs of essential RMNCAH commodities; (3) strengthening mentoring and coaching of community health volunteers (conducted by their supervisors); (4) organizing joint supportive supervision.

Coordination and partnership will remain crucial in the implementation of RMNCAH interventions. WHO will maintain the partnership with sister UN agencies and the government such as the H4+ Partnership as a feasible and results-driven platform for support to quality reproductive, maternal, new born and child healthcare in Liberia. The overall coordination and monitoring for impact activities will be spearheaded by WHO. In collaboration with UNFPA, UNICEF and County Health Team, WHO will ensure effective regular coordination meetings for RMNCAH in Maryland County. In a gradual manner, county level ownership of RMNCAH coordination will be enhanced.

Through this financial medium, technical and financial support will be provided to enhance the production and dissemination of **standards of services** nationally and, specifically, at the selected project health facilities in Maryland County. Job Aids and clinical practice protocol and guidelines for clinical care will be made available for improved quality of care.

WHO will also seek to further strengthen the **availability of RMNCAH data** through an enhanced and integrated HMIS at the level of the central MOH, county, districts and health facilities. The survival of mothers, newborns, children under-five, adolescents and reproductive health, in general, will be ensured through robustly working jointly with the existing partnership, joint actions and improving capacities at the service delivery levels including at the community level. Supportive supervision and monitoring will be among the lifesaving foundations.

Direct Beneficiaries:

Population	Project Target Population (Maryland)
County Population 2015	160,556
Women of Child Bearing Age	39,853
Women expected to give birth	8,028
Men and Boys	80,439

The project will serve a total of 160,556 persons in the targeted county. As shown in the table above, Women of reproductive age (39,853) will be the primary/ direct beneficiaries of the project. Approximately 5% of entire population is expected to be women likely to give birth (8,028). This sub-set of the primary beneficiaries is expected to be at high risk due to the risk associated with pregnancy in Liberia as evidenced by the high maternal mortality ratio. Men, boys and other family members are considered indirect beneficiaries. And as the role of men in women's health is very essential, the project will consider the engagement of men and boys in health promotion and education.

Project Sustainability

Liberia has continued to make steady gains towards the implementation of its investment plan for a resilient health system. Funds from this project are catalytic in nature and as such will use existing structures at the county level to implement activities in line with the existing MoH plan as it relates to ensuring reliance in the area of RMNCAH at various levels of health care delivery across targeted counties. Based on each agency's policies and procedures, some aspects of the project such as the international procurement will be handled by UN agencies while MoH will handle local procurement of supplies. Funds will be managed both by the MoH as well as specific UN agency. To ensure that the County Health Teams (CHT) and MoH fund management capacity is enhanced, on an agreed periodic basis agencies will release funds to the MoH for the implementation of activities. This approach whereby funds are disbursed on a periodic basis following clear reporting of expenditure will help to minimize risk and improve accountability. Indeed, this proposal has been reviewed and approved by the CHT and MoH that it is in compliance with, as well as an integral component of, the strategic thrust of the Investment Plan. Specifically, the new Director of Family Division, under whose direction this project would sit at the MoH along with the new Chief Medical Officer for the Republic have endorsed the proposal and have raised NO OBJECTION on behalf of the country. Therefore, all strategies and activities supported under this project are designed and embedded with the notion of suitability right from the beginning. The overall aim of the project will be to strengthen the capacity of counties to deliver RMNCAH services in a smarter and better manner.

The community engagement and participation component as described in the implementation arrangement is clearly in line with all strategic objectives of the community health road map; particularly, objectives; one, three and five of the document that aim to ensure the following:

(1) Build the capacity of communities to contribute to the reduction of maternal, newborn and child morbidity and mortality and to address issues of public health concerns at community level;
(2) Strengthen support systems for implementation of community health services, and
(3) Activate community-based surveillance system respectively.

With the intent of a nationwide roll out of the community health road map, the MoH has admonished all partners to support the implementation of the strategic document. Existing community health structures such as Community Health Committees and Community Health and Development Committees will be used where they already exist (or they may be created in accordance with the policy) to ensure strong community engagement and participation in the achievement of results. This project will ensure support as well as boost the implementation of the road map in selected counties, districts and communities in collaboration with the community health department at the central level as well as at the level of the counties along the lines of the three strategic objectives mentioned above.

In relation to health facility level implementation, all RMNCAH related activities including EmONC, routine maternal healthcare and Maternal Death Surveillance and Response are designed to suit ongoing or new strategies as described in the MoH plan to restore all health services including RMNCAH post-EVD. It is worth noting that the targeted counties are reportedly underserved with gross issues of limited coverage, inequity and quality in their delivery of RMNCAH services due to their geographic inaccessibility and limited partner support. In line with the roadmap for the acceleration of maternal mortality and morbidity reduction and various national protocols, the project will serve as a catalytic force to boost existing levels of implementation while improving the health of mothers and their newborn to ensure sustainability. The project will work with the County Health Management Team to enhance their capacity in the management of the RMNCAH activities in the county. All existing county level structures will be supported and utilized in implementation of the Project activities. Newly created coordination meetings and or mechanisms will be institutionalized in the CHTs management processes to ensure continuity and sustainability. For the purpose of sustainability across all levels, all newly created structures or activities will be fully institutionalized, integrated and managed by the CHT right at the onset of implementation to allow time for acceptability and monitoring for improvement and continuity.

e) Capacity of RUNO(s) and implementing partners

UNFPA is the leading United Nations agency in reproductive health with various programs to support initiatives in maternal health worldwide. UNFPA's recognized worldwide initiatives and contributions to country efforts are in the area of maternal health such as the Maternal Health Trust Fund and its flagship commodity security program, the Global Programme to Enhance Reproductive Health Commodity Security (GPRHCS) now referred to as UNFPA Supplies, and fistula prevention treatment and rehabilitation project. UNFPA's close collaboration and continued support to the Ministry of Health in the area of reproductive health particularly the Family Health Division and the Supply Chain Management Unit (SCMU) in support of health services for women and girls has contributed to improving access to family planning and the use of antenatal care services in Liberia as evidenced by the increase in contraceptive prevalence rate and antenatal care attendance recorded by the LDHS. UNFPA has demonstrated leadership in project implementation by mobilization of resources for the H4+ Sida maternal health project expansion, the Mano River maternal health project as well as in the area of adolescent sexual reproductive health, data for planning and decision-making through a nationwide strategy on contact tracing and active case surveillance at community level; which can be drawn upon to provide leadership in the implementation of this project.

UNICEF has great experience implementing and monitoring innovative community-based RMNCAH interventions. UNICEF continues to provide technical support and resources (human, financial) to the MoH to strengthen community engagement and social mobilization activities as part of EVD recovery efforts. In addition, UNICEF is currently providing technical and financial

support to the MoH to roll-out the new CHW programme in a phased manner, especially in 5 counties in the South East. The CHW package of care includes notification of births and deaths (CEBS system), health promotion and education, referrals, HBMNC including postnatal care and iCCM. This initiative will be integrated into the ongoing large-scale iCCM programme implemented in the South East with UNICEF support. The proposed Joint UNFPA/UNICEF/WHO Initiative will also build on lessons learned from the joint UN H4+ RMNCAH Initiative implemented in selected counties in the South East Region.

WHO's overall technical and coordination leadership in health brings an added value to the project implementation. With its leadership role in the handling of the EVD crisis and technical guidance in strengthening disease surveillance through the development of the integrated disease surveillance and response (IDSR) in collaboration with strategic partners during this EVD recovery period, the agency stands ready to ensure adherence to standards of care and overall monitoring for impact at both community and health facility levels in collaboration with UNFPA and UNICEF.

Proposal management:

In collaboration with MoH, the three agencies will coordinate the project with UNFPA as the Lead and Administrative Agent. In collaboration with UNICEF and WHO, UNFPA will collate and submit quarterly and annual reports of the project implementation as per donor requirement. Using the H+ framework, a Project Steering Committee (PSC) will be established with overall oversight and quality assurance roles. The PSC will meet on a monthly basis to monitor to ascertain progress and review risks, issues and strategies as well as to make recommendations for adaptations, if required. UNFPA, will also primarily support health facility interventions for RMNCAH including EmONC, MNDSR and referrals and ASRH services. At the community level, UNICEF will lead the community based interventions. WHO will lead the overall coordination, monitoring and surveillance of activities at county level.

a) Risk management:

Table 1 – Risk management matrix

Risks to the Achievement of Strategic Aims	Likelihood of Occurrence (high, medium, low)	Severity of Risk Impact (high, medium, low)	Risk Management and Mitigating Strategy	Responsible Partner/Unit
Political instability	Medium	High	Continuous engagement	Government leadership /All Partners
Community Resistance	Medium	High	Use culturally sensitive messages. Sensitize and engage communities in all activities	All Partners
Insufficient and untimely release of funds	Low	High	Early earmarking and disbursement of resources	MPTF and all Partners
Misappropriation of funds towards un intended purposes	Medium	High	Gradual disbursement of funds pending clear report on expenditure as per the work plan	All agencies and MoH

b) Monitoring & Evaluation:

The overall monitoring and reporting of the project implementation will be the responsibility to WHO in collaboration with UNICEF and UNFPA. Established district health teams will participate in both monitoring of activities at the level of the district, communities and facilities. The implementation of Joint monitoring activities will be led by WHO in collaboration with UNICEF, UNFPA and the County health teams. While each agency will be responsible for specific monitoring and supervision relative to defined intervention areas, WHO will support the overall field level coordination and monitoring of activities in collaboration with UNFPA, UNICEF and the MoH. At the level of the counties, monitoring and supervision will be implemented at community and health facility levels. UNFPA will ensure that all reporting requirements are fulfilled according to schedule and will compile quarterly reports from UNICEF and WHO for submission to the donor.

At the beginning of the project implementation, a joint baseline assessment will be implemented to complete the logical framework. Data from the baseline assessment will be used to inform programming. Through the implementation of joint biannual review meetings to determine progress and existing gaps, partners and the MoH will be informed to take action for improved delivery of services. WHO will lead and support the final evaluation of the project in collaboration with all partners. The final donor report will be compiled and submitted by UNFPA.

APPENDICES

APPENDIX I: PROPOSAL RESULTS MATRIX

Proposal Title: Strengthening Reproductive Maternal, New born and Adolescent Health Service Delivery, Death Surveillance and Response in South Eastern Liberia					
Strategic Objective 1 to which the Proposal is contributing[2]	Increase access to quality, equitable maternal and new born health services that significantly contributes to maternal new born survival through health facility and community interventions in Maryland County by the end of 2016;				
Effect Indicators	**Geographical Area (where proposal will directly operate)**	**Baseline[3]** In the exact area of operation	**Target**	**Means of verification**	**Responsible Organisation.**
Number of health facilities in the County that have improved emergency obstetric maternal and new born health care services based on indicated standards	Maryland County (Three health facilities to be determined)	**0**	**3**	• Health facility records • CHT Monthly reports, HMIS	**UNFPA**
Number of health facilities achieving 75% skilled institutional deliveries per catchment population	Maryland County (Three health facilities to be determined)	**0**	**3**	• Health facility records • CHT Monthly reports, HMIS	**UNFPA**
Strategic Objective 2 to which the Proposal is contributing[4]	Increase access to the provision of reliable data on maternal deaths that informs health actions to reduce mortality through robust community engagement community response systems, and				
Number of health facilities and community structures with improved MNDSR based on national guidelines	Maryland County (Three health facilities to be determined)	**0**	**TBA *(Six weeks after start date)***	• Health facility records • CHT Monthly reports, HMIS	**WHO** **UNICEF**
Strategic Objective 3 to which the Proposal is contributing[5]	Strengthen information dissemination that increases knowledge and potential utilization of sexual and reproductive health services among adolescents in districts and communities in Maryland County.				
Percentage increase in utilization of services by adolescents in targeted catchment communities in Maryland County	Maryland County (Three health facilities to be determined)	**TBD**	**50% increase**	• Health facility records • CHT Monthly reports, HMIS	**UNFPA**

[2] Proposal can only contribute to one Strategic Objective
[3] If data are not available please explain how they will be collected.
[4] Proposal can only contribute to one Strategic Objective
[5] Proposal can only contribute to one Strategic Objective

Outputs	Output Indicators	Baseline	Target	Data Source	Frequency	Responsible
Output 1: Access to and utilization of EmONC services and routine RMNCAH services for females of reproductive ages 15-49 years is increased	1. Proportion of Health facilities achieving targeted number of ANC 4 visits 2. Proportion of BEmONC facilities actually providing services according to guidelines 3. Number of health facilities that provide ASRH services	•47% of national ANC 4 coverage •No facility provides a full package of BEmONC •Health facilities do not provide ASRH services as prescribed by standards	•75% of ANC4 visits achieved in targeted facilities •100% of health facilities provide BEmONC services •3 health facilities provide ASRH friendly services	LDHS/ County health Health facility data	All data are collected on a monthly basis and reported on a quarterly basis	UNFPA, WHO and CHTs
Output 2: Supply of essential commodities including contraceptives at health facilities and community level to ensure a zero stock out of supply of drugs and relevant supplies is improved	1. Proportion of health facilities reporting stock out of tracer commodities for RMNCAH 2. Proportion of community health workers reporting stock- out of iCCM commodities including contraceptives	•23% of health facilities report no stock out of tracer commodities for Family Planning •70% of health facilities report no stock out of tracer commodities for EmONC •No data on community stock out levels of RMNCAH interventions	•70% of health facilities report no stock out of tracer FP commodity for more than one week •70% of health facilities report no stock-out of tracer commodity for EmONC •60% of Community health workers report no stock out of tracer RMNCAH commodities at	HMIS/LMIS data	All data will be collected on a monthly basis and reported on a quarterly a basis	UNICEF, WHO and CHTs
Output 3: Community health structures are strengthened to provide community based RMNCAH services in all targeted counties	1. Targeted communities organize monthly CHDC meetings with action plans 2. 3. Increased percentage of mothers who received two home visits from the CHVs within 3 days after delivery. 4. Increased number of new-borns who received two home visits from the CHVs within 3 days after delivery 5. Proportion of skilled delivery in facilities referred by CHVs/TTMs 6.	TBD *(following baseline assessment of Output 3, six weeks after start of project)*	•60% coverage achieved in CHDC meetings •15% increase in home visits by CHVs from baseline •15% increase in referrals by CHVs/TTM •Number of health education session on prevention of adolescent pregnancy *(Targets may be modified based on assessment results)*	HMIS and health facility data	All data will be collected on a monthly basis and reported on a quarterly a basis	UNICEF, WHO, UNFPA and CHTs

APPENDIX I: PROPOSAL RESULTS MATRIX (continued)

Outputs	Output Indicators	Baseline	Target	Data Source	Frequency	Responsible
Output 4: Maternal death surveillance and response systems strengthened at all levels in accordance with national protocols	• Proportion of maternal deaths notified by health facilities are investigated • Proportion of maternal and new born deaths in targeted communities are investigated through verbal autopsy •	TBD *(following baseline assessment of Output 4, six weeks after start of project)*	• 100% of maternal deaths identified/notified • 60% of new born deaths identified/notified *(Targets may be modified based on assessment results)*	HMIS and Community health work program data	All data will be collected on a monthly basis and reported on a quarterly a basis	UNICEF, UNFPA and CHT
Output 5: Effective Coordination and Monitoring of RHMCAH services improved at all levels in targeted counties	• Number of health facilities that have standards of care for RMNCAH care available • Enhanced and integrated HMIS at county, district and health facility levels • Functional and results based coordination mechanisms at county and district levels.	TBD *(following baseline assessment of Output 5, six weeks after start of project)*	• 3 health facilities have standards of care for RMNCAH care available and in use • District health teams have structured data collection and reporting tools • Number of county and district health teams conducting regular RH coordination meetings as planned *(Targets may be modified based on assessment results)*	HMIS and Community health work program data	All data will be collected on a monthly basis and reported on a quarterly a basis	UNICEF, WHO, UNFPA and CHTs

APPENDIX
PROJECT ACTIVITIES AND BUDGET SUMMARY

Strategies	Major Activity	Estimated Date of Completion				Key People Responsible	Budget	Comments
		Q1	Q2	Q3	Q4			
Output 1: Access to and utilization of EmONC services and routine RMNCAH services for women and girls of reproductive age 15 to 49 years of age is increased								
Strengthen the managerial capacity of County and district health structures to effectively monitor for results	Recruit and deploy project management staff for effective monitoring and timely implementation of activities					**UNFPA**	**$ 75,000**	
	Provide support to strengthen health facility MNDSR activities						**$ 30,000**	
	Provide logistical support to CHT and DHTs to effective management of service delivery						**$ 50,000**	
	Conduct an integrated least 2 review meetings on plan and progress to inform planning and implementation at all levels						**20,000**	
	Provide logistics to conduct monitoring of health facilities, regular mentoring and supervision of service delivery for RMNCAH						**$ 30,000**	
Strengthen health facility Human Resource Capacity for RMNCAH	Assess human resource gaps , recruit and deploy adequate numbers of midwives and other cadres of providers at health facility level						**$ 25,000**	
	Conduct training for midwives and other skilled birth attendants in EmONC and other RMNCAH including ASRH protocols and guidelines						**$ 25,000**	
Up-grade three health facilities for ensuring maternal and neonatal survival	Provide performance based package to BEmONC facilities that meet defined targets					**UNFPA**	**$ 237,977**	
	Procure and equip health facilities with equipment to carry out signal functions for critical service delivery areas							
	Conduct minor refurbishment of health facilities							

	following assessment							
Overall Subtotal							**$ 492,977**	
UNFPA Subtotal							**$ 429,977**	
Output 2: Supply of essential commodities including contraceptives at health facilities and community level to ensure a zero stock out of supply of drugs and relevant supplies is improved								
Strengthen the supply of drugs and medical supplies for RMNCAH to targeted health facilities	Support timely distribution of RH commodities to ensure 60% reduction of stock out of essential medicines including contraceptives through timely, tracking reporting and supply of essential drugs and supplies					**UNFPA**	**$ 78,500.00**	
	Support the quarterly review of RH commodities availability to inform planning						**$ 6,000.00**	
	Ensure availability of essential MNH commodities and equipment					**UNICEF**	**$ 36,916.00**	
Overall Subtotal							**$**	
UNICEF Subtotal							**$ 36,916.00**	
UNFPA Subtotal							**$ 84,500.00**	
Output 3: Community health structures are strengthened to provide community based RMNCAH services in all targeted counties								
Strengthen community structures and community engagement initiatives to provide community based RMNCAH services	Revamp community networks and linkages; CHDC monthly meetings at health facilities					**UNICEF**	**$ 30,000.00**	
	Community activities to enhance advocacy and strengthen social accountability through community networks, groups, and linkages							
	Community support to outreach activities organized by health facilities							
	Strengthen integrated iCCM/HBMNC supportive supervision mechanism; Mentoring and coaching of community health volunteers					**UNICEF**	**$ 20,000.00**	
	Conduct joint supportive supervision visits (MoH/WHO/UNICEF)						**$ 10,000.00**	
Overall Subtotal							**$ 60,000.00**	

UNICEF Subtotal							**$ 60,000.00**	
Output 4: Maternal death surveillance and response systems strengthened at all levels in accordance with national protocols								
Conduct community-based MNH promotion and prevention interventions	Social mobilization and health promotion activities; Community awareness meetings on MNDSR and other MNH issues					**UNICEF**	**$ 40,000.00**	
	Conduct health promotion for Adolescent pregnancy Prevention by supporting community-based radio programs targeted at disseminating SRH information to adolescents and youth, Develop and disseminate IEC/BCC materials including constructing billboards at targeted health facilities with messages on the availability of youth-friendly maternal health, including family planning services and					**UNFPA**	**$ 30,000**	
Establish and strengthen community MNDSR	Establish systems to ensure community death identification, notification and reporting (printing of investigation forms, reporting mechanism)					**UNICEF**	**$ 50,000.00**	
	Build institutional capacity to strengthen MNDSR in the community sector;							
	Conduct community meetings for verbal autopsy to assess causes of deaths; Community forums/public meetings and feedback meetings and forums							
Overall Subtotal							**$ 120,000.00**	
UNICEF Subtotal							**$ 90,000.00**	
UNFPA Subtotal							**$ 30,000.00**	
Output 5: Effective Coordination and Monitoring of RHMCH services improved at all levels in targeted counties								
Ensure data validation and use	Conduct supportive supervision					**WHO**	**$ 75,000.00**	
	Support coordination mechanisms at district level							
	Support Data reporting including via the Epi bulletins							
	Conduct end of project evaluation							
Strengthening support systems						**WHO**	**$ 65,187.00**	
	Capacity building for data officers at district and health							

through real-time monitoring and regular reporting and use of data for decision making (HMIS, LMIS)	facility levels							
	Support data review and validation at county and district levels							
Overall Subtotal							**$ 140,187.00**	
WHO Subtotal							$ 140,187.00	

Total by Agency								
WHO total							$ 140,187.00	
Indirect cost							$ 9,813.00	
Total for WHO							**$ 150,000.00**	
UNICEF total							$ 186,916.00	
Indirect cost							$ 13,084.00	
Total for UNICEF							**$ 200,000.00**	
UNFPA total							$ 607,477.00	
Indirect cost							$ 42,523.00	
Total for UNFPA							**$ 650,000.00**	
Grand Total							**$ 1,000,000.00**	

Project budget by UN categories

PROJECT BUDGET				
CATEGORIES	**UNFPA**	**UNICEF**	**WHO**	**TOTAL**
1. Staff and other personnel (include details)	100,000	Nil	Nil	100,000
2. Supplies, Commodities, Materials (include details)	210,977	30,000	Nil	240,977
3. Equipment, Vehicles, and Furniture, incl.Depreciation (include details)	112,500	Nil	Nil	112,500
4. Contractual services (include details)	15,000	107,000	Nil	122,000
5.Travel (include details)	20,000	10,000	20,000	50,000
6. Transfers and Grants to Counterparts (include details)	20,000	10,000	Nil	30,000
7. General Operating and other Direct Costs (include details)	129,000	29,916	120,187	279,103
Sub-Total Project Costs	**607,477**	**186,916**	**140,187**	**934,580**
8. Indirect Support Costs*	42,523	13,084	9,813	65,420
TOTAL	**650,000**	**200,000**	**150,000**	**1,000,000**

ANNEX 2

Proposal Appraisal
[THIS TEMPLATE NEEDS TO BE FURTHER STRENGTHENED]

To be completed by UNMEER
Provide concise summary evaluation of proposal against:

	General principles and selection criteria	
(a)	Must be explicitly based on the Ebola Response Plan and Budget	Yes ☐ No ☐
(b)	Must address high priority activities that have significant impact, and by nature must address timing imperatives and considerations.	Yes ☐ No ☐
(c)	UNMEER confirms that Recipient Organization is unable to meet high or urgent priority needs with existing level of funding (both core funding and bilateral funding.)	Yes ☐ No ☐
(d)	Must support national strategies	Yes ☐ No ☐
(e)	Must demonstrate Recipient Organizations comparative advantage for specific intervention	Yes ☐ No ☐
(f)	The organization must have the appropriate system to deliver the intervention	Yes ☐ No ☐
(g)	The Proposal must be effective, context-sensitive, cost-efficient and the outputs are tangible and sustainable	Yes ☐ No ☐
(h)	Must avoid duplication of and significant overlap with the activities of other actors	Yes ☐ No ☐
(i)	Must use strategic entry points that respond to immediate needs and yet facilitate longer-term improvements	Yes ☐ No ☐
(g)	Must build on existing capacities, strengths and experience	Yes ☐ No ☐
(k)	Does not overlap with ongoing programmes of UNMEER or other UN entities	Yes ☐ No ☐

Overall review of programme submission

Elaborate

Appendix II: List of Acronyms

ANC	Ante natal care
ASFR	Age specific fertility rate
BEmONC	Basic emergency obstetric & newborn care
CEBS	Community events-based surveillance
CEmONC	Comprehensive emergency obstetric & newborn care
CHDC	Community health development committee
CHT	County health team
CHVs	Community health volunteers
CPR	Contraceptive prevalence rate
DHT	District health team
EVD	Ebola virus disease
GPRHCS	Global programme to enhance reproductive health commodity security
HBMNC	Home-based maternal and newborn care
HIV	Human immunodeficiency virus
HMIS	Health management information system
H4+	UN agencies partnership for improving maternal & child health
iCCM	integrated community case management
LDHS	Liberia demographic & health survey
MDSR	Maternal death surveillance and response
MNDSR	Maternal and newborn death surveillance and response
MoH	Ministry of Health
PNC	Post natal care
RMNCAH	Reproductive maternal & newborn care and adolescent health
SBA	Skilled birth attendants
SCMU	Supply chain management unit
Sida	Swedish international development agency
STI	Sexually transmitted infections
TBD	To be determined
TTM	Trained traditional midwives
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
UNMEER	United Nations Mission for Ebola Emergency Response
WHO	World Health Organization