#53

# MPTF OFFICE GENERIC FINAL PROGRAMME[1] NARRATIVE REPORT
## REPORTING PERIOD: 29 April 2016 – 27 July 2017

| Programme Title & Project Number | Country, Locality(s), Priority Area(s) / Strategic Results[2] |
|---|---|
| • Programme Title: Strengthening Reproductive Maternal, New born and Adolescent Health Service Delivery, Death Surveillance and Response in South Eastern Liberia<br>• Programme Number: 00100247<br>• MPTF Office Project Reference Number:[3] *#53* | *Country/Region: Liberia, Maryland County*<br><br>*Priority area/ strategic results*<br>*S03 Ensure Essential Services*<br>*MCA6 Access to Basic Services* |
| **Participating Organization(s)** | **Implementing Partners** |
| • Organizations that have received direct funding from the MPTF Office under this programme<br>**Focal Point:**<br>• Dr. Remi Sogunro, UNFPA Representative Cell: +231 770004001 Email: sogunro@unfpa.org<br>• Dr. Alex Ntale Gasasira, WHO Representative Cell: +231 775 281 157 Email: gasasiraa@who.int<br>• Suleiman Braimoh, Ph.D., UNICEF Liberia Representative Cell: +231 0770267100 Email: sbraimoh@unicef.org | • Ministry of Health (MoH), Republic of Liberia |
| **Programme/Project Cost (US$)** | **Programme Duration** |
| Total approved budget as per project document: US1,000,000.00<br>MPTF/JP Contribution[4]:<br>• *by Agency (if applicable)*<br>Agency Contribution<br>• *by Agency (if applicable)* | Overall Duration 15 months<br>Start Date[5] 28.04.2016<br><br>Original End Date[6] 28.04.2017 |

[1] The term "programme" is used for programmes, joint programmes and projects.
[2] Strategic Results, as formulated in the Strategic UN Planning Framework (e.g. UNDAF) or project document;
[3] The MPTF Office Project Reference Number is the same number as the one on the Notification message. It is also referred to as "Project ID" on the project's factsheet page on the MPTF Office GATEWAY.
[4] The MPTF/JP Contribution is the amount transferred to the Participating UN Organizations – see MPTF Office GATEWAY
[5] The start date is the date of the first transfer of the funds from the MPTF Office as Administrative Agent. Transfer date is available on the MPTF Office GATEWAY
[6] As per approval of the original project document by the relevant decision-making body/Steering Committee.

| | |
|---|---|
| Government Contribution *(if applicable)* | |
| Other Contributions (donors) *(if applicable)* | |
| **TOTAL:** | US$1,000,000.00 |

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|---|---|---|
| Actual End date[7] | 27.07.2017 | |
| Have agency (ies) operationally closed the Programme in its (their) system? | Yes ☐ | No ☒ |

Expected Financial Closure date[8]:
UNFPA-30th June 2018
WHO-31st December 2020
UNICEF-27th July 2018

**Programme Assessment/Review/Mid-Term Eval.**

Evaluation Completed
☐ Yes ☐ No Date: 15.09.2017

Evaluation Report - Attached
☐ **Yes** ☐ No Date: *27.11.2017*

**Report Submitted By**

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**Report Cleared By**

This report covering activities implemented by the three (3) Agencies for the Joint Programme #53 has been prepared by UNFPA as lead Agency and clear by;

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- Date of Submission: 6th, February 2018
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[7] If there has been an extension, then the revised, approved end date should be reflected here. If there has been no extension approved, then the current end date is the same as the original end date. The end date is the same as the operational closure date which is when all activities for which a Participating Organization is responsible under an approved MPTF / JP have been completed. As per the MOU, agencies are to notify the MPTF Office when a programme completes its operational activities. Please see MPTF Office Closure Guidelines.

[8] Financial Closure requires the return of unspent balances and submission of the Certified Final Financial Statement and Report.

**List of Acronyms**

| | |
|---|---|
| ANC | Antenatal Care |
| ASRH | Adolescent Sexual Reproductive Health |
| BEmONC | Basic Emergency Obstetrics and Neonatal Care |
| CEmONC | Comprehensive Emergency Obstetrics Neonatal Care |
| CBIS | Community-based information system |
| CHA | Community Health Assistant |
| CHDC | Community Health Development Committee |
| CHSS | Community Health Service Supervisor |
| CHT | County Health Team |
| CHWs | Community Health Workers |
| DHT | District Health Team |
| DPC | Disease Prevention and Control |
| EmONC | Emergency Obstetrics and Neonatal Care |
| FP | Family planning |
| EVD | Ebola Virus Disease |
| HFDC | Health Facility Development Committee |
| H4+ | Partnership of UN agencies concerned with maternal and child health |
| IDSR | Integrated Disease Surveillance and Response |
| IPC | Infection Prevention and Control |
| LMA | Liberia Midwifery Association |
| MCH | Maternal and Child Health |
| MNDSR | Maternal Neonatal Death Surveillance Response |
| MPNDSR | Maternal Perinatal Neonatal Deaths Surveillance and Response |
| MNH | Maternal Neonatal Health |
| MoH | Ministry of Health |
| RMNCAH | Reproductive Maternal Neonatal Child and Adolescent Health |
| RDT | Rapid Diagnostic Test |
| SRMNCAH | Sexual Reproductive Maternal Neonatal Child and Adolescent Health |
| TTM | Trained Traditional Midwife |
| UNFPA | United Nations Population Fund |
| UNICEF | United Nations Children's Fund |
| WHO | World Health Organization |

## EXECUTIVE SUMMARY

The programme was commenced in April 2016. By July 2017, all three targeted health facilities namely; Karloken, Fish Town, and Glofarken Clinics – were providing basic emergency obstetric and neonatal care (EmONC), Reproductive Maternal Neonatal Child & Adolescent Health (RMNCAH) referral and services. Antenatal Care 4+ increased from 46 to 81 per cent, delivery in health facilities increased from 38 to 73 per cent, and postnatal care increased from 12 to 56 per cent. The overall level of facilities with no stock out improved from 66% to 93.3%. There has been marked improvement in the quality of data collection, analysis and reporting from these health facilities as well as the holding of regular monitoring and supportive supervision and monthly health facility development committee (HFDC) meetings. An ambulance and three motorbikes were acquired and turned over to the Ministry of Health (MoH) as logistical support to facilitate the referral of pregnant women and girls to and from the project facilities to the county's referral hospital. At least five professional staff were recruited to provide maternal, newborn and adolescent health services in the second quarter of 2017. During the period under review, reports gathered from community health workers covering the three facilities revealed no stock out in two of the three facilities. Maternal and neonatal deaths surveillance and response (MNDSR) improved couple with the implementation of the revised national MNDSR guidelines.

## I. Purpose

Liberia has a high disease burden and vulnerability to outbreaks, such as the Ebola virus disease (EVD). The health system's vulnerability is predominantly attributed to inadequate health workforce, 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. All of these factors contributed to the 2014-2015 Ebola outbreak. They continue to impede the on-going recovery of the health system in the immediate post-Ebola and medium-term periods. The government has been involved in the 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, newborn and child health remains a priority for attention. 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 just ended 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 agency's comparative advantages and excellent collaboration with the Ministry of Health.

**Goal:** The project aims to contribute to the reduction of maternal and newborn mortality in Maryland; one of the south-eastern counties by the end of 2016.

**Specific Objectives:**

a. Increase access to quality, equitable maternal and newborn health services that significantly contribute to maternal newborn 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.

**i) Narrative reporting on results:**

From April 2016 to July 2017, the project responded to strengthening reproductive maternal, newborn and adolescent health service delivery, death surveillance and response in Maryland County, Southeastern Liberia by increasing access to quality, equitable maternal and newborn health services; increasing access to the provision of reliable data on maternal deaths that informs health actions; and strengthening information dissemination that increases knowledge and potential utilization of sexual and reproductive health services among adolescents in districts and communities. The project was jointly implemented by the Ministry of Health through the Maryland County Health Team under the supervision of UNFPA, UNICEF and WHO.

**Outcomes:**

The MPTF/JP support to Liberia contributed to ensure that mothers and their children, including adolescents, received the care they required, while preventing the spread of EVD and other transmitted diseases. The support ensured the restoration of essential reproductive, maternal and neonatal health services required to maintaining infection prevention and control and maintaining zero cases of EVD in Maryland from April 2016 onwards. Pregnant women (including pregnant adolescents) and their babies directly benefited from this support. The indirect beneficiaries are the health workers who received training in order to provide quality maternal and new born care. While it may prove difficult to measure the contribution of this programme to the reduction of maternal and new born mortality in Maryland in relatively short period of time period, by July 2017, one critical achievement remains the establishment of the systems to timely record and report on maternal, neonatal, adolescent and stillbirth in the three health facilities and surrounding communities. This change is institutional since the improvement of the recording and reporting system is embedded in the health management information systems which previously focused only on maternal mortality; starting from community level to the health facility, district, county, and national level. The communities especially in the catchment areas of the three targeted health facilities also showed better engagement in utilizing maternal and new born including adolescent health issues.

**Output 1: Access to and utilization of Emergency Obstetric and Neonatal Care services and routine Reproductive Maternal, Neonatal, Child, and Adolescent Health services for women and girls 15-49 years of age is increased.**

The three targets under output 1 were achieved. Coverage of antenatal care (ANC4+) increased from 46 to 81 per cent. There was also an increase in access to and utilization of basic emergency obstetric and new born care (BEmONC) as defined by fulfilling the seven signal functions as per essential package of health services (EPHS). During baseline assessment, only two health facilities (Fishtown and Karloken) fulfilled the requirement. By July 2017, the three targeted health facilities provided BEmONC. The facilities also provided adolescent sexual reproductive health (ASRH) services. The number of adolescents and youth accessing family planning increased from 489 to 1,347 and clients benefitted from HIV prevention services including safe motherhood services.

The above output was achieved through the following major activities:

- Recruitment and deployment of five midwives at Karloken (one), Glofarken (two) and Fishtown clinics (two). Liberia has a very low ratio of health workers according to WHO's definition and Maryland is not an exception. At the onset of the project, only one of the three facilities had a professional midwife assigned. Thus, this support was aimed at ensuring that there are at least two midwives assigned at each of the three health facilities. The recruited staff were provided with motivational incentives. They also received regular mentorship on the use of the partograph and other obstetric tools by senior midwives, district and county Reproductive Health Supervisors. These efforts certainly contributed to the increased access to and utilization of services at the three clinics (See Fig 1&2).
- Refurbishment of the three health facilities; creating an enabling environment for health workers to provide Basic EmONC services. The facilities were giving a facelift to include the construction of toilet facilities and the tiling of the floor in the MCH in the line with the national infection prevention and control measures.
- Provision of an ambulance to facilitate the referral of pregnant women and girls in response to maternal and new born emergencies. Provision of three motorbikes to facilitate, monitoring, supportive supervision and coordination.

**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.**

The availability of essential medicines for EmONC and family planning commodities stocks improved considerably. Two out of three health facilities had no issue of stock (100%) during the duration of the project's implementation over the five quarters. One facility reported stock out in the 3rd quarter of the project's implementation due to worsening road conditions during the rainy season giving an 80% stock out level. Therefore, a 93.9% achievement of no stock out was realized. The project also provided equipment, medical and laboratory supplies for the provision of quality maternal and newborn services.
The use of Chlorhexidine digluconate 7.1% for umbilical cord care served as best practice for newborn survival at these facilities.

**Output 3: Community health structures are strengthened to provide community-based RMNCAH services in all targeted health facilities catchment communities**

All health facility development committees (HFDCs) or formerly community health development committees (CHDCs) conducted regular monthly meeting. The "dormant" HFDCs were re-activated. During those meetings, discussions were focused on the referral of pregnant women to health facilities for delivery by trained traditional midwives. Action points and recommendations from these meetings were reported to the health facilities and discussed during monthly meeting and quarterly review in the district. An example of some issues which were brought to the attention of the health facilities was home delivery and plan to fine any trained traditional midwives (TTMs) who assisted home deliveries instead of referring the mothers to the health facilities. The number of referral by community health workers (gCHVs, TTMs, and CHAs increased from 139 to 683 (target was 504).

Postnatal visits within two days of deliveries was not part of the HMIS and the system only collected postnatal visit to postpartum mothers within six weeks. With the improvement of the systems, now the data is available and postnatal care increased from 12 to 56 per cent. The important contribution from this programme is improvement of data recording and reporting on disaggregated age for pregnant women and girls; this process led to the disaggregation of age groups for all services on the national reporting forms.

**Output 4: Maternal death surveillance and response systems strengthened at all levels in accordance with national protocols**

Despite the delay in the implementation of this particular activity by the country, the target for Maryland under this programme was achieved, and actually beyond the expected target.
During the implementation, maternal deaths as stated in Output 4 implies both maternal and neonatal deaths including stillbirths (perinatal deaths), and not only for three targeted health facilities but the whole county. In fact, Maryland is the first county that piloted the implementation of the maternal perinatal neonatal deaths surveillance and response (MPNDSR) using the revised guidelines. The fund from MPTF supported the training for better use of MNDSR revised guidelines and strengthening of the surveillance and response systems. Forty-one health workers from 24 health facilities including district surveillance officers and data managers in the county were trained.
During the baseline assessment, 100 per cent of maternal deaths were notified but there was no investigation (verbal autopsy) from the community level. Neonatal deaths report was neglected. During the implementation of the programme, the notification, investigation and review were improved. The county agreed that for this phase, verbal autopsy will be carried on for maternal deaths and only consider the neonatal deaths investigation at the community level.
In 2016, during implementation of the programme, one (1) maternal death occurred in Karloken clinic and it was reviewed (100 per cent). In 2017, by week 40, all health facilities deaths for both maternal and neonatal deaths were reviewed (6 maternal deaths and 49 neonatal deaths). For the community level, verbal autopsy for maternal deaths had been conducted using the new field form. Discussions were carried out with the MoH to ensure continuity through additional technical support.

**Output 5: Effective coordination and monitoring of RMNCAH services improved at all levels in targeted county.**

1) All three health facilities have standards of care for RMNCAH care available and in use. Some of the protocols on assessment and treatment care have been put on the wall in the clinics for guidance.
2) HMIS has been improved, however, the contribution from the programme that have data disaggregation by age groups is currently being review by the system. Another improvement is with the implementation of community-based information systems (CBIS) which now is also available online for few counties in Liberia including Maryland. Data from CHAs were reported to CHSS and uploaded to the systems. This was only implemented in August 2017; therefore, it is still work in progress.
3) The health coordination meeting to discuss important health issues including maternal, new born and child health conducted every month and led by the CHT with support from partners.

**ii) Indicator Based Performance Assessment:**

| Outputs | Baseline: | Planned Target: | Achieved Indicator Targets | Reasons for Variance with Planned Target (if any) | Source of Verification |
|---|---|---|---|---|---|
| **Output 1: Access to and utilization of EmONC services and routine RMNCAH services for females of reproductive ages 15-49 years is increased** | | | | | |
| Indicator 1.1: Proportion of Health facilities achieving targeted number of ANC 4 visits | 66% | 100% | 100% | N/A | program report |
| Indicator 1.2: Proportion of BEmONC facilities actually providing services according to guidelines | 66% | 100% | 100% | N/A | program report |
| Indicator 1.3: Number of health facilities that provide ASRH services | 0% | 100% | 100% | N/A | program report |
| **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** | | | | | |
| Indicator 2.1: Proportion of health facilities reporting no stock out of tracer commodities for RMNCAH | 66% | 100% | 93.3% | Break in national supply chain and flooding that worsened the road condition rendering one of the health facilities (Glofarken) inaccessible during the 2nd quarter of 2017. | Program report, national HMIS |
| Indicator 2.2: Proportion of community health workers reporting no stock- out of iCCM commodities including contraceptives | 60% | 100% | 92.30% | Break in national supply chain and flooding that rendered one of the health facilities (Glofarken) inaccessible during the 2nd quarter of 2017 | Program report, MOH |
| **Output 3: Community health structures are strengthened to provide community based RMNCAH services in all targeted counties** | | | | | |
| Indicator 3.1: Targeted communities organize monthly CHDC meetings with action plans | 33% | 66% | 100% | N/A | Program report, national HMIS |

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|---|---|---|---|---|---|
| Indicator 3.2: Number of Newborn and mothers who received two home visits from the CHVs within 2 days after delivery. | 139 | 232 | 779 (424 in 2016 + 355 in 2017) | N/A The indicator should be the number of newborn and mothers who received two home visits from the CHVs within 2 days after delivery (within 48 hours) and not 3 days | Program report, MOH |
| Indicator 3.3: Proportion of skilled delivery in facilities referred by CHVs/TTMs | 139 | 504 | 783 | N/A | Program reports, health facility reports |
| **Output 4: Maternal death surveillance and response systems strengthened at all levels in accordance with national protocols** | | | | | |
| Indicator 4.1: Proportion of maternal and new born deaths notified by health facilities are investigated | 100% | 100% | 100% | N/A | Program report, MoH? |
| Indicator 4.2: Proportion of maternal and new born deaths in targeted communities are investigated through verbal autopsy | 50% | 100% | 100% | N/A | Program report, MoH? |
| **Output 5: Coordination and Monitoring of RMNCAH services improved at all levels in targeted counties** | | | | | |
| Indicator 5.1: Number of health facilities that have standards of care for RMNCAH care available | 3 | 3 | 3 | N/A | Program report, Health facility reports, MOH |
| Indicator 5.2: Number of health facilities with enhanced and integrated HMIS at county, district and health facility levels | 3 | 3 | 3 | N/A | Program report, Health facility reports, MOH |
| Indicator 5.3: Number of targeted health facilities with functional and results based coordination mechanisms at county and district levels. | 3 | 3 | 3 | N/A | Program report, MOH |

**iii) Evaluation, Best Practices and Lessons Learned**

In August 2017, the MOH and Maryland County Health Management team in collaboration with the project agencies conducted an internal evaluation to ascertain whether the project had impacted RMNCAH in the project sites according to the project result frame work. The County Health Management Team conducted an intra-county review of project supported health facilities considering their status before and during the project implementation period. Data from the National HMIS, Health facility reports, the county reviews and program reports were collected and desk review conducted. Analysis showed that the project contributed immensely to improving RMNCAH in the project sites evident by incremental trends realized in some key indicator coverage.

I. Service Delivery

The project increased access to quality right based RMNCAH care. Key inputs by the project, including increasing the number of skilled birth attendants, delivery of essential drugs and medical supplies, coaching and mentoring of service providers on critical lifesaving skills. These valuable contributions led to regaining trust of the community which transcended into increase utilization of services at the health facilities. All the three project supported health facilities achieved above 75% of the annual ANC 4 and skilled institution delivers: Fish Town Clinic ANC4- 94.7% (216/228), Skilled delivery-102.0% (208/204); Glofarken Clinic: ANC4-84.5% (372/440), Skilled delivery-79.8% (316/39) and Karloken Clinic ANC4-134.0% (353/264), Skilled delivery-110% (264/240). Karloken achieving above its target can be attributed to its close proximity towns Ivory Coast that are accessing heath care at the facility also while the fluid movement between Fish Town and Harper could have influence achieving more than its target. Fig. 1 & 2 show trend in ANC4 and deliveries attended by skilled providers, before and during project period, key proxy indicators for access and availability.

Fig. 1: ANC4 Coverage

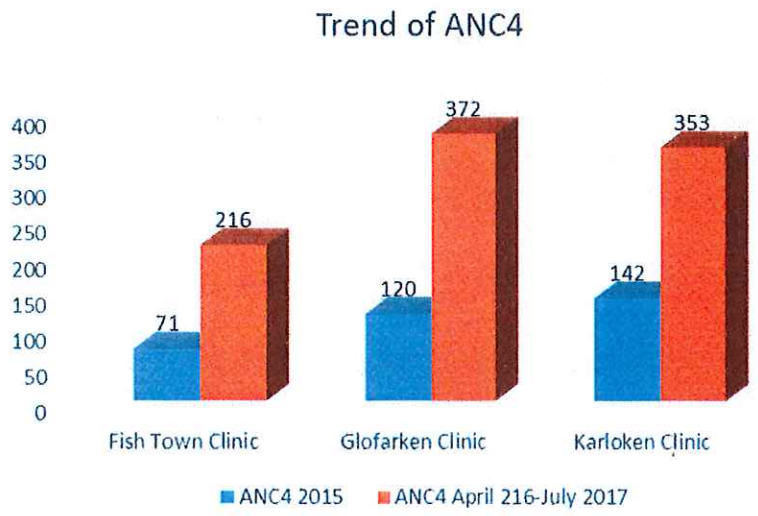
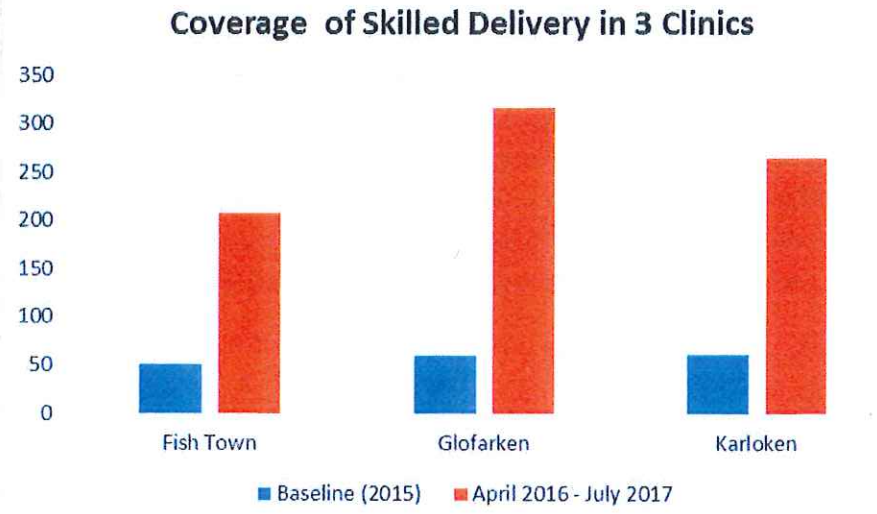


Fig. 2: Skilled Delivery coverage




II. Increase information on Maternal health including MNDSR

The project has impacted generation, dissemination and use of Maternal Health data that has benefitted the entire country. Data tool developed and has impacted the nation HMIS tool update. RMNCAH data is now being disaggregated by age which will inform decision making at all levels. Data Managers at all levels benefitted from capacity building that has now improved reporting, data collection and use, moving accuracy, completeness and timeliness if report from 56 per cent in 2015 to 89.8 per cent in 2017 (HMIS).

III. Community Engagement

It was proven that the project was able to strengthen the linkage between the health facilities and communities. Community leaders are increasingly taking ownership as they are now discussing more frequently in community forums issues affecting services provision and utilization at the health facilities and communities. The barriers hindering women and girls from accessing and utilizing services are being minimized evident by the increase in key RMNCAH indicators in the project supported health facilities. TTMs and other community cadres are adhering to national regulations as they are referring pregnant women for ANC and facility delivery as well as PNC and conducting distribution of commodity at the community level.

Project short fall

Though the project made a lot of gains, stock out at one of the facilities, Glofarken still persisted to the end of the project period. Periodic break in national supply chain, deplorable road condition leading to this facility and depleted project funding that could not allow employing of other strategies to mitigate the constraints alluded to this.

The deployment of additional professional staffs contributed immensely to service availability and quality. However, as the project comes to an end, the MOH and County Management Team are concern about losing

the gains as these additional staffs have not being absorbed in the Government payroll. This concern is shared by all partners of the project as well as other health partners in the country.

Recommendations
It has been recommended by the MOH and County Management Team that a project transition plan be developed and implemented to sustain the gains at health facility, community, county and district levels while the GOL/MOH mobilize resource to continue implementation of the high impact, evidence based intervention implemented through the project support.

**Delay in programme implementation:**

- ✓ Delayed in the implementation of Community Health Assistant Programme due to the delay in the finalization of the training modules for CHAs and CHSS. The CHA programme was launched in July 2016 in Liberia. In Maryland, the training for CHAs (4 modules) was completed in June 2017 and actual implementation started in July 2017.
- ✓ Due to other competing national priorities, the joint supportive supervision and data verification was delayed leading to a delay in finalizing the quarterly report. This delay led to social mobilization and health promotion activities in the three health facilities' catchment populations, which are still on going.
- ✓ Delayed in the validation of the MNDSR training module led to a delay in the MNDSR training at national and county levels. As a consequence, the activities related to MNDSR following the training were also delayed. The national training of trainers was conducted in July 2017 with the cascade training in August 2017.
- ✓ Delayed in the implementation of the activities to assess the impact of dissemination of key MNCH messages in three health facilities catchment population by community health workers and the activities will be completed in November 2017

The delayed in the programme implementation affected the overall achievement of results. The impact could not be seen because some of the indicators need longer time observation, for example, the impact of improved health services delivery to the reduction of maternal and neonatal deaths. The other challenge is also the competing priorities and due to the limited human resources and capacity at MoH and the county, the challenges remain.

**Best Practices**: Early engagement and leadership of MoH and Maryland CHT since the very beginning of the programme enhanced the implementation of programme activities. Central MoH and Maryland CHT were fully involved in the revision of the reporting tool which was developed based on the programme's results framework. The new tool made the approach more specific according to different age groups and could be more focused for particular groups, such as adolescents and youths, since the data are disaggregated by age groups. In addition, partnership and close collaboration with other implementing partners in Maryland also contributed to achievements. Maryland CHT conducted MNDSR field tests with support from Partners in Health, and their paediatrician is part of the MNDSR committee. Moreover, improvement in data management starting from the data collection in the community to the health facilities, district, county and central levels will improve the programme's monitoring and evaluation. The addition of community-based information

systems into the online HMIS facilitated analysis and provided feedback to improve the programme implementation.

**Lesson Learned:**

1. Sustained community engagement is critical to avert preventable maternal and neonatal deaths. The majority of these deaths occur during childbirth and the majority of deaths are due to late referrals from communities to the health facilities. Many pregnant women still give birth assisted by traditional midwives or traditional healers outside health facilities. The continuous effort to ensure the sustainability through direct approach to the communities/religious leaders, community meetings, women's groups meetings, all involving as much male participation as possible has been found fruitful in tackling these bottlenecks.
2. Skilled and motivated health workers are important in order to ensure the quality of health care services because increased coverage alone is not enough. The three targeted health facilities under this programme have a minimum of two health workers to provide RMNCAH services. However, they need regular training and skill practices with regular monitoring, supervision, and mentoring to ensure their work is up to standard. In addition, they need to receive their salaries on time and be incentivized for working extra hours (at night or during the weekend). This is a very important issue since the programme only provided support for a limited time and government must be ready to take over to ensure the sustainability of quality health services. MoH and Maryland CHT have been involved from the very beginning of the programme and the issue of including the health workers under this funding's support in the government's payroll has already been discussed with the government, although it is likely to take some time to implement it.
3. Management and utilization of the data is very important, and the challenges in this area lie in every step (data collection, recording, reporting, analysis, recommendation for action) and at every level (from the communities, health facilities, district, county, and central levels). Training was conducted to improve data management and utilization for feedback and actions taken during the quarterly meetings. The training, monitoring and technical assistance given to support the improvement of data management and utilization were not only supported by this fund but also from different donors in collaboration with different partners and this approach has proven effective in strengthening the CHT's capacity.
4. Recommendation to include all health facilities in one county as target for programme implementation instead of only few health facilities. The reason is because even if the key MNCH indicators in targeted places have improved, the achievement will be diluted when it comes to the achievement of the county, as it is usually done for the evaluation of programme implementation. If the resource is limited, it is better to have one county only rather than stretch it to too many different places, or have fewer but effective interventions.

**iv) A Specific Story**

**Problem / Challenge faced:** Describe the specific problem or challenge faced by the subject of your story (this could be a problem experienced by an individual, community or government).

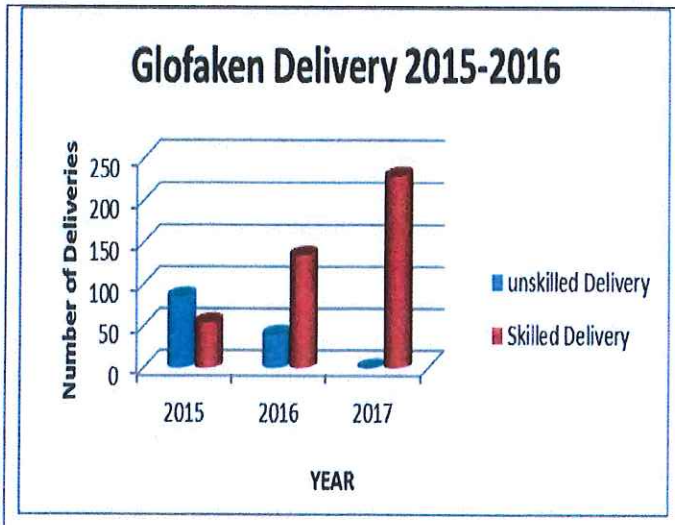
Glofaken town is located in the health district of Barrobo Whojah, approximately 2 hours' drive from Harper. The only clinic in Glofaken is a public facility that provides primary care services to the population of the district. The clinic has a catchment Population of 9,074 with women of childbearing age (WCBA) population of 2,087. The expected monthly delivery target for Glofaken clinic is 34. Prior to the MPTF #53 project, Glofaken clinic faced serious challenges of skilled birth attendant. The OIC of the facility, a skilled health worker, was the only trained health personnel assigned at this clinic and often had to be away from the clinic to attend workshops or seminars. Also, being a male, pregnant woman in the community were reluctant to deliver at Glofaken Clinic, giving the cultural and traditional sensitivity of delivery being carried out by male. Whenever the OIC was away, deliveries at the clinic were conducted by trained traditional midwives (TTMs). Though these deliveries were facility-based, they were conducted by unskilled persons by WHO definition. This became alarming. For example, in 2015 the number of deliveries performed by the TTMs exceeded those of the skilled birth attendant - OIC. In as much as this trend needed to be addressed, it was very difficult to attract qualified health workers to these hard-to-reach communities.

**Programme Interventions:** How was the problem or challenged addressed through the Programme interventions?

In August 2016, with the hiring and deployment of two (2) registered midwives under the MPTF project, things took a turn for the better. The number of skilled deliveries increased dramatically (see graph below) almost doubling the total deliveries carried out in 2015. Since this intervention, there has been no delivery conducted by unskilled birth attendant in Glofaken most part of 2016 and 2017. This success is largely attributed to the support of MPTF in supporting the government of Liberia restore basic maternal and new born health services.

**Lessons Learned:** What did you (and/or other partners) learn from this situation that has helped inform and/or improve Programme (or other) interventions?

Accountability, and transparency led to total involvement and full participation of all parties involve including the community, central ministry and county health management team. It has the potential to ensure sustainability. Strengthening community linkage with the health facilities improved utilization of services. Motivation including coaching and mentoring on critical lifesaving skills improved the quality of care and increase client trust in the facilities. Implementation of project through partnership (UN agencies and Government) has a prospect for sustaining program gains.




*Baby mothers at Glofaken Clinic*