Final Evaluation:

Accelerated Child Survival Initiative Project in Gbarpolu County, Liberia

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This report has been produced at the request of UNICEF Liberia. The comments contained herein reflect the views of the African Development Associates (ADEAS)

SUBMITTED TO:
Madam Zainab Al-Azzawi
Monitoring and Evaluation Specialist
United Nations Children’s Fund (UNICEF), Liberia

SUBMITTED BY:
AFRICAN DEVELOPMENT ASSOCIATES
BENSON STREET, MONROVIA, LIBERIA

PHONE NO 231-886-513397/ 231-77-515705/231-886-845-405

EMAIL: adeas_liberia@yahoo.com

Website: http://www.adeasliberia.org
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FOREWORD:
In December 2011, the Ministry of Health and Social Welfare published the Revised National Community Health Services Strategy and Plan 2011 – 2015. The document is aimed at reducing the number of maternal deaths by 10% and reducing the number of under-five deaths by 15%. However, challenges ranging from poor road condition; lack of skilled health workers, poor referral system and limited resources for Liberia’s health sector are major causes for maternal and child mortality as well as malaria, diarrheal and ARI. These conditions are similar for other parts of Liberia, in particular the South Eastern counties.

Recognizing these challenges, ChildFund with funding from UNICEF Liberia implemented the Accelerated Child Survival Initiative (ACSI) project in Gbarpolu County in 2010. The project was aimed at increasing access to health services, most especially for pregnant women and children under five on an equitable basis. The core intervention was focused on reducing maternal and child mortality rates; improving access to health care services for Children under 5; enhancing the capacity for the prevention of common childhood illnesses and new born death; upgrading skills for the effective management of childhood illnesses; and enhancing the capacity of Gbarpolu County Health for efficient management of the ACSI project.

Nine months after project implementation, the final evaluation for the ACSI Project was authorized by UNICEF Liberia to; inter alia, access the relevance, effectiveness, efficiency, and impact of the project.

ADEAS hopes that the findings and recommendation of the evaluation will achieve the intended results, and areas yet to be improved will be given serious thoughts when the project is replicated in other counties.

Respectfully submitted:

James Kormon
Chairman, Board of Directors, ADEAS

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**Acronyms**

<table>
<thead>
<tr>
<th>Acronym</th>
<th>Description</th>
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<tr>
<td>ACSI</td>
<td>Accelerated Child Survival Initiative</td>
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<td>ADEAS</td>
<td>African Development Associates</td>
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<tr>
<td>Abbr</td>
<td>Meaning</td>
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<td>-------------------------------------------------------</td>
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<td>AHA</td>
<td>African Humanitarian Action</td>
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<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
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<td>ANC</td>
<td>Antenatal Care</td>
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<td>HHS</td>
<td>Households</td>
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<td>ARI</td>
<td>Acute Respiratory Infection</td>
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<td>CCC</td>
<td>Core Commitment to Children</td>
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<td>CDA</td>
<td>County Development Agenda</td>
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<td>CFSNS</td>
<td>Comprehensive Food Security and Nutritional Survey</td>
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<td>CHC</td>
<td>Community Health Committee</td>
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<td>CHSS</td>
<td>Community Health Services supervisor</td>
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<td>CHT</td>
<td>County Health Team</td>
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<td>CRC</td>
<td>Convention on the Rights of the Child</td>
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<td>DAC</td>
<td>Development Assistance Committee</td>
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<td>FGDs</td>
<td>Focus Group Discussions</td>
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<td>GCHVs</td>
<td>General Community Health Volunteers</td>
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<td>GDP</td>
<td>Gross Domestic Product</td>
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<td>HHPs</td>
<td>Household Promoters</td>
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<td>HIV</td>
<td>Human Immune Virus</td>
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<td>ICCM</td>
<td>Integrated Community Case Management</td>
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<td>IPs</td>
<td>Implementing Partners</td>
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<td>ITNs</td>
<td>Insecticide Treated Mosquito Nets</td>
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<td>KAP</td>
<td>Knowledge Attitude and Practices</td>
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<td>KII</td>
<td>Key Informant Interview</td>
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<tr>
<td>LISGIS</td>
<td>Liberia Institute of Statistics and Geo-information Services</td>
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<tr>
<td>LURD</td>
<td>Liberia United for Reconciliation and Democracy</td>
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<tr>
<td>M &amp;E</td>
<td>Monitoring and Evaluation</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>MOH&amp;SW</td>
<td>Ministry of Health and Social Welfare</td>
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<td>NDS</td>
<td>National Drug Service</td>
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<tr>
<td>NGOs</td>
<td>Non-Governmental Organizations</td>
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<tr>
<td>OECD</td>
<td>Organization for Economic Cooperation and Development</td>
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<tr>
<td>OIC</td>
<td>Officer-in-Charge</td>
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<tr>
<td>CGNSP</td>
<td>Child Growth and National Program</td>
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<td>ORS</td>
<td>Oral Rehydration Salts</td>
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<td>SI</td>
<td>Specialized Interviews</td>
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<td>SPSS</td>
<td>Software Products and Service Solutions</td>
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<td>SRS</td>
<td>Systematic Random Sampling</td>
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<td>SSI</td>
<td>Semi-Structured Interviews</td>
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<td>TMs</td>
<td>Traditional Midwives</td>
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<td>TTMs</td>
<td>Trained Traditional Midwives</td>
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<tr>
<td>UN</td>
<td>United Nations</td>
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<tr>
<td>UNDP</td>
<td>United Nations Development Program</td>
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<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WHO</td>
<td>World Health Organization</td>
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<td>YAPA</td>
<td>Youth in Action for the Prevention of HIV and AIDS</td>
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EXECUTIVE SUMMARY

Background: Gbarpolu County is one of the least developed counties in Liberia. The road conditions are extremely poor. Most people, for example, residents of SLC and Camp Antel in Kongba District and Kpayeakwelleh in Guo-wolala District have to walk for more than three hours before reaching a health facility; others for over 24 hours. Consequently, Gbarpolu County’s health facilities and service delivery system are poor. With funding from UNICEF Liberia, a child centered UN agency, ChildFund, in conjunction with support of the Gbarpolu CHT and central MoHSW, implemented the ACSI project from April 2010 to December 2011 in the six districts of Gbarpolu County. The project targeted 14,825 under-5 children and cost US$418,072.32. The project was aimed at reducing child mortality by supporting child survival, maternal health and nutrition through selection and training of community based health volunteers in community-level case management of uncomplicated ARI, diarrhea and malaria.

Nine months after project implementation, a final evaluation was commissioned by UNICEF Liberia. This evaluation is in accordance with the OECD 2006 DAC criteria which aimed at analyzing the effectiveness of the project; identifying impact made from project intervention; assessing the relevance of project; analyzing the level of coherence, efficiency and sustainability of the ACSI project as well as offering recommendations.

Methodology: The research tools used to evaluate the project included a literature review, pilot testing, the administering of questionnaires; several structured and semi structured interviews; Focus Group Discussions (FGDs); Key Informant Interviews (KII); informal conversations, and direct observations. An SPSS database was designed; data cleaned and analyzed.

The final evaluation covered eighteen communities in the six political districts of Gbarpolu County. The 18 communities constitute 19% of the total number of communities targeted (95). Communities were selected through Systematic Random Sampling (SRS), while households were selected through simple random sampling. A sample size of four hundred ninety-five (495) respondents was distributed among the eighteen communities. Households were selected randomly for interview. The number of communities selected in each district along with the actual sample size was disaggregated by sex. Since the project major targets were pregnant women and children, 93% of respondents were females.

Major constraints encountered during the final evaluation included poor road condition. Disaggregated health data (communities and districts) was not possible as the CHT could not provide records on this data. However, aggregated health data on Gbarpolu County from the HMIS Unit at the Ministry of Health and Social Welfare were
reviewed. Finally, most interviews had to be conducted during the morning or late evening hours due to the harvest season.

**Major Findings:** After two weeks of field research, these are the findings:

**Coherence of the Project:** The Accelerated Child Survival Initiative project was in line with both national and international documents. Nationally, the project was in line with the Ministry of Health and Social Welfare (MOH&SW) National Strategy for Child Survival; Revised National Community Health Services Policy; Revised National Community Health Services Strategy and Plan 2011 – 2015; and the Poverty Reduction Strategy with emphasis on Pillar Four (the provision of infrastructure and basic social services). Internationally, the project was also coherent with UNICEF policy of preventing common yet treatable diseases amongst children under the age of five and the World Health Organization goal of providing basic health care services to children under five and pregnant women. Most importantly, the project was in line with the United Nations Millennium Development Goals 4 (Child Health) and 5 (Maternal Health) and various elements of MDGs 1 (End Poverty and Hunger); 6 (Combat HIV and Aids); and 7 (Environmental Sustainability).

**Coverage:** Although the project initially targeted 85 communities in the six districts of Gbarpolu County, it was implemented in 95 communities of all six districts in the county. Besides the 95 targeted communities, the impact of the project also spill over to surrounding communities. Surrounding community residents visited the same clinic where TTM was trained to advise pregnant women to desist from community delivery. Residents of surrounding communities also benefited from the vaccination outreach program.

**Relevance of the Project:** Both Focus Group Discussion (FGD) and household (HH) interviews suggested the existence of serious health needs in the targeted communities before the ACSI project. The lack of health services in targeted communities was mainly attributed to bad road conditions which prevented health personnel and organizations from bringing in much needed medical needs. Moreover, the communities lack of information on health education and behaviors; untrained traditional midwives and lack of essential drugs were issues prior to the programme. Consequently 96% of respondents mentioned serious health problems in their communities before the implementation of the ASCI project.

**Effectiveness of the Project:** The effectiveness of the project was measured by the extent to which each objective was met and whether activities under the project were implemented in a timely manner as per the logical framework. Semi Structured Interviews (SSIs) with Child Fund personnel indicate that most of the activities of the project were not implemented as per scheduled. Some reasons given were that funds
were not disbursed on time; divergence of interest of stakeholders; and difficulty in hosting meetings due to the lack of telephone network coverage in most of the communities. Despite the delays in project implementation, all four objectives of the project were implemented to some extent.

Under Objective One, health care services were provided to children under five through the establishment of various structures. The Community Health Committees (CHCs), whose role was mostly administrative, yet created awareness and sensitization in the various communities, were the first to be formed. However, many of the beneficiaries did not know about the existence of the CHC in their communities. Only 48% of HHs interviewed knew of the existence of the CHC. Over 50% of the respondents did not know about the existence of the CHC or its functions. Most HHs interviewed, indicated that it is the Town Chief that usually called for clean-up campaigns.

The gCHVs (general Community Health Volunteers) on the other hand were selected in line with the Ministry of Health and Social Welfare guidelines. The gCHVs, in line with the MoHSW policy, treated under-five year old children for malaria, diarrhea, and ARi cases. 76% of HHs knew of the existence of gCHVs and 85% of them rated their performance as “good”. FGDs participants also rated the performance of gCHVs very highly in the delivery of health services to children under-five. All communities visited commended the gCHVs for the swift manner in which they responded to the calls of parents.

The Household Promoters (HHPs) were older women who were selected and trained to monitor households; sensitize their environments on hygiene promotion; and ensure that pregnant women were taking their medication on time. Although the performance of the HHPs was rated high, there was a bit of misunderstanding between the roles of the HHPs and the TTMs. Community dwellers did not know who were actually TTMs or HHPs since both were Traditional Midwives before the training. In a nutshell, pre project roles were confused with roles prescribed by the project. Notwithstanding, 70% of respondents knew of the existence of the HHPs.

The Trained Traditional Midwives (TTMs) catered to pregnant women in the targeted communities. These women were trained to discourage community deliveries and encourage pregnant women to go to health centers in order to have their babies. 92% of HHs interviewed knew of the role of TTMs in the targeted communities. FGDs revealed that TTMs performed their roles satisfactorily. The TTMs efforts to discourage community deliveries were buttressed by the Local Government authority. A fine of L$1500.00 was imposed on TTMs who carried out community delivery outside of a health facility and a token of US$17.00 was given to the TTM who referred the highest number of referral cases for delivery in a district.
In short, objective #1 of the project was achieved to a very large extent. Pregnant women and under-five children in 95 communities of the six districts of Gbarpolu County had access to health services from their communities. Minor cases of common sickness did not have to be taken to health center as the gCHVs could handle them while serious cases were given first aid treatment and referred to health centers.

Objective #2 (Enhance Capacity for the Prevention of Common Childhood Illnesses and New Born Death by 2011 in 95 communities of the six districts of Gbarpolu) of the project was also achieved to some extent, although most of the activities were not on time. Most of the community health structures were trained. A total of 425 CHC members from the 95 communities were trained. The training focused on the strengthening of the administrative arm of the project at community level, especially in setting up criteria for the selection of gCHVs, TTM, and the Household Promoters. Also a total of 110 gCHVs were selected based on MOH standards and trained in the case management of diarrhea, malaria and ARI. The gCHVs work within their communities. Post validation comments from Child Fund revealed that Child Fund trained 110 gCHVs, although AHA had a grant from the Pool Fund that required the training of 70 gCHVs. But with similar objectives in the same locations, despite different projects, Child Fund and AHA resolved in their coordination agreement that the former (Child Fund) will train all the gCHVs and the latter (AHA) will provide motivational incentives, in particular gifts-in-kind.

The HHPs or Grandmas were also trained by Child Fund to work with HHs. The TTM were also selected from the six districts and trained for eight days. Trainings for the TTM were centered on antenatal, post natal, and care for new born babies. The TTM were also trained to encourage deliveries at health centers and discourage community deliveries. A total of fourteen (14) Community Health Development Committees (CHDCs) were set up after the training of the Community Health Committee members to coordinate the activities of the various clinics in Gbarpolu County between the community dwellers and Clinical Staff. Members of the CHDC are Chairpersons from the various CHCs in a given catchment.

With the selection and training of all community health structures, the project achieved objective #2 to a large extent. However, a combination of other sources reveals that the training of gCHVs in Child Growth and Nutrition was not conducted because the amount given by UNICEF was insufficient to include the gCHVs.

Under objectives #3 (upgrade skills for the effective management of childhood illnesses including referrals by 2011 for clinical staff in 10 Health Facilities) of the ACSI Project, Clinical Staff at health centers in the six districts were trained. SI and FGD reveal that vaccinators were trained to monitor the performance of gCHVs while OICs were trained to effectively manage cases of diarrhea, malaria and ARI, referred by the gCHVs.
Objective # 4 (Enhancement of Gbarpolu County Health Team capacity for efficient management of programmes). Of the project was also achieved although it did not make any significant impact. SI with a MoHSW official revealed that the County Health Service Administrator, the County Health Department Director, the Child Survival Focal Person and the Nursing Service Director were trained at the beginning of the project. However, all of the trained staffs were replaced before the end of the project. Consequently, the project ended with new staff who did not benefit from the ACSI training.

On the whole, the project succeeded in providing health care services to under-five children in the targeted communities through the dedicated services of the gCHVs, the HHPs and the TTMIs. Additionally, there were remarkable achievements made in the training of community health structures. All of the communities set up by the project were trained. Additionally, clinical staffs were also trained to monitor the work of gCHVs and manage referral cases. However, Clinical Staff present at health facilities could not present any ledger for their activities involving under five children, pregnant women, gCHVs and referral cases. When asked to provide documents regarding their activities, most responded that the OICs were not around, while others recommended the Bopolu Health Center where all documents have been sent. But at the Bopolu Health Center, no document was available.

Impact of the Project: There were significant impacts made by the project, although the impact of the project varies by accessible districts and those districts that are inaccessible by motor vehicles. Belle, Guo-wolala and Kongba District residents reported lesser impact compared to the other three districts of Bopolu, Bokomu, and Gbarma that had high sampling sizes. Respondents in these districts were less knowledgeable about the activities of the project and there were less momentum among community dwellers. However, 86% of all respondents interviewed said that there has been improvement made in the health condition of their families. This could be attributed to the following reasons:

- Health education from the gCHVs contributed to a response of 89% HHs stating that they and their children slept under ITNs distributed by the Ministry of Health Malaria Control Program which was verified by ADEAS’ researchers
- 85% of HHs stated the incidence of malaria has reduced.
- 77% of respondents also said that incidence of ARI has reduced; while 85% said that the incidence of diarrhea has reduced in HHs.
- 72% of households have their under-5 children fully immunized.
- 44% of pregnant women received Ante Natal Care (ANC) from TTMs
- Community deliveries have reduced from 63% to 37%
- Deliveries in health centers have increased from 37% to 63%
88% of HHs expressed satisfaction with the services provided under the project.

**Sustainability of the Project:** Although the capacity of the County Health Team was not built to sustain the project, the African Humanitarian Action (AHA) is still utilizing the structures set up by the ACSI Project to cater to under five children and pregnant women. However,

- The capacity of the CHT was not sufficiently built to sustain the project
- No regular supply of drugs from MoHSW
- Inactiveness of CHC
- Communities have not taken ownership of project

Distances pregnant women cover to reach health centers could undermine deliveries at health centers

**Project Challenges:** Major challenges faced by the project include poor road network, difficulty in communication due to lack of telephone networks in most of the targeted communities and lack of cooperation from the CHT. The latter was attributed to the lack of monitoring and evaluation funding in the budget of the CHT. Other challenges include distances pregnant women and children who are referred have to cover to access health facilities.

### I. BACKGROUND

Liberia is one of the poorest countries in the world. According to the UNDP Human Development Index\(^1\), Liberia ranks 182 out of 187 countries. 63.8% of Liberia’s 3.5 million people are living in poverty, despite the abundance of natural resources. 1.3 million Liberians, mostly women and children live in extreme poverty. Illiteracy rate stands at 56%\(^2\). In most districts, cultural practices have led to high infant mortality rate; malnutrition amongst children; poor sanitation and poor access to safe drinking water. The most common yet treatable diseases affecting children under five include malaria, diarrhea, and acute respiratory infection. One of the most affected counties is Gbarpolu County, the most recently created and newest of Liberia’s fifteen political sub-divisions.

Gbarpolu County\(^3\) is found in the Western part of Liberia; is rich in natural resources such as gold and diamond, but its inhabitants are desperately poor. A recent statistics from the Liberia Institute of Statistics and Geo-Information Services (LISGIS), estimates

\(^1\)http://hdr.undp.org/en/statistics; Liberia is above Chad (183), Mozambique (184), Burundi (185), Niger (186) and the Democratic Republic of Congo (187).

\(^2\) Republic of Liberia, Poverty Reduction Strategy p. 25

\(^3\)The County is bordered on the East and North by Bong and Lofa counties; the West by the Republic of Sierra Leone and the South by Bomi County. Gbarpolu County was formed from the combination of two Statutory Districts, Bopolu and Gbarma, former lower Lofa as it was known.
the population of Gbarpolu as 83388 with children under 5 constituting 18% and reproductive women constituting 23%. The County has six administrative districts - Gbarma, Kongba, Bopolu, Belle, Bokomu and Gou-wolala. Although the county is host to the sixteen ethnic groups in Liberia, popular tribes include Kpelle, Gola, Belle, Gbandi, Lorma and Kissi.

During the Liberian Civil War, Gbarpolu County served as a major route for the Liberia United for Reconciliation and Democracy (LURD), one of several ferocious warring factions. Consequently, the county experienced extensive damages to its infrastructure and basic social services as well as mass displacement of its inhabitants and the loss of lives. After years of civil conflict and the ushering in of a democratically elected government in 2005, the road network is still in a deplorable condition; there are serious health problems, most especially, the lack of health centers, coupled with the shortage of trained medical practitioners, midwives, and medical equipment and drugs. Most children from 0-5 are yet to be registered, despite the official birth registration campaign. Gbarpolu County has one of the highest infant mortality rates in Liberia.

Although the Liberian Government enacted the Public Health Laws of Liberia in 1997; followed by the National Health Policy and the National Health Plan (2007 -2011), the National Strategy for Child Survival and the Revised National Community Health Services Strategy, the 2011/2012 National Budget for community health services for Gbarpolu County is a meager US$40,000.00, which constitutes 0.01% of the total national budget. Consequently, most children under 5 in the six districts of Gbarpolu County do not have access to early childhood health facilities. A significant number of children under 5 are suffering from acute respiratory infection and malnutrition, malaria, ARI, diarrhea and other communicable diseases, despite the abundance of natural resources.

In an effort to help the Government of Liberia to support child survival and development, thereby helping to meet the needs of children under 5; and women of childbearing age, Child fund, a child centered NGO, implemented the Accelerated Child Survival Initiative (ACSI) project. With funding from UNICEF Liberia, a child centered UN agency, Child fund implemented the project from April 2010 to December 2011. The project aimed at the following objectives:

1. access to improved health care services by 2011 for Children <5 in 95 communities

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5 The birth registration campaign was initiated by the government of Liberia in 2011. However, the exercise has not reached all of the 15 counties. A total of six (6) of the fifteen (15) counties have been reached.
2. **enhanced capacity for the prevention of common childhood illnesses and new born death by 2011 in 95 communities of the six districts of Gbarpolu**
3. **upgrade skills for the effective management of childhood illnesses including referrals by 2011 for clinical staff in 10 Health Facilities**
4. **Enhancement of Gbarpolu County Health Team capacity for efficient management of programmes.**

The overall aim of the project was to reduce child mortality by Supporting child survival, maternal health and nutrition. It was done through selection and training of community based health volunteers in community-level case management of uncomplicated ARI, diarrhea and malaria.

In accordance with the Paris Declaration on aid effectiveness and good humanitarian practices, UNICEF Liberia authorized a final evaluation of the project. This report constitutes the final evaluation. It begins with the methodology, scope and sample size of the final evaluation, data collection processes, major constraints, literature review and major findings. The report ends with a conclusion, recommendation and ten (10) appendixes.

**II. METHODOLOGY**

**a. SPECIFIC OBJECTIVES OF THE EVALUATION**

The final evaluation assesses the effectiveness, impact, relevance, coverage, coherence, efficiency and level of sustainability of the ACSI project which fall within the context of the OECD 2006 DAC criteria. Lessons learnt and best practices are also highlighted. The objectives (verbatim) of the evaluation are to:

I. **Analyze the effectiveness of the project (Assess to what extent the program had realized its planned results as identified in the proposal)**

II. **Identify impact made from project intervention**

III. **Assess the relevance/pertinence of project intervention to the humanitarian context of the target population**

IV. **Identify best practices and lessons learned and recommendation that can be used by UNICEF, Government of Liberia and partners for future program design**

**b. SCOPE AND SAMPLE SIZE OF THE STUDY**

The final evaluation covered eighteen communities in the six political districts of Gbarpolu County. The 18 communities constitute 19% of the total number of communities targeted (95). These communities were selected through Systematic Random Sampling (SRS). However, eight of the eighteen Communities were inaccessible. Consequently, these communities had to be replaced with proxy communities.
A sample size of Four hundred ninety-five (495) respondents was distributed among the eighteen communities. Households were selected randomly for interview. The matrix below shows the number of communities selected in each district along with the actual sample size disaggregated by sex. 93% of respondents were females.

**Figure 1: Actual Sample Size**

<table>
<thead>
<tr>
<th>District</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>% of Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belleh</td>
<td>12</td>
<td>14</td>
<td>26</td>
<td>5.2525253</td>
</tr>
<tr>
<td>Bokomu</td>
<td>3</td>
<td>71</td>
<td>74</td>
<td>14.949495</td>
</tr>
<tr>
<td>Bopolu</td>
<td>9</td>
<td>140</td>
<td>149</td>
<td>30.10101</td>
</tr>
<tr>
<td>Gbarma</td>
<td>2</td>
<td>160</td>
<td>162</td>
<td>32.727273</td>
</tr>
<tr>
<td>Guo-wolalah</td>
<td>7</td>
<td>12</td>
<td>22</td>
<td>4.4444444</td>
</tr>
<tr>
<td>Kongba</td>
<td>0</td>
<td>62</td>
<td>62</td>
<td>12.525253</td>
</tr>
<tr>
<td>Total</td>
<td>33</td>
<td>462</td>
<td>495</td>
<td>100</td>
</tr>
</tbody>
</table>

Appendix I shows the list of communities along with the Sample sizes:

### c. DATA COLLECTION PROCESS

The final evaluation was undertaken by an eight member team composed of the lead consultant, research officers and data entry clerks. The team used a multi-phase participatory approach to gather the relevant information. Both qualitative and quantitative methods were applied; primary and secondary sources consulted. A questionnaire (Appendix I) was designed; reviewed, edited and approved. Background documents received from UNICEF Liberia were reviewed and data collection tools developed. Emphasis was placed on structured and semi-structured interviews (SSI), Specialized Interviews (SI) Focus Group Discussions (FGDs) as well as direct observations. A total of seventeen specialized interviews and six focus group discussions were disaggregated by sex.

Prior to the collection of data, two major in-house trainings were undertaken for researchers and data entry clerks; followed by a one-day training with UNICEF ACSI Consultant on the 12th of November 2012 at ADEAS’ Benson Street Field Office. Although other survey tools were briefly discussed, the training focused on techniques in asking questions; and other research methodologies. The training also reviewed the project documents with emphasis on the logical framework – objectives, results, indicators and assumptions. The trainings achieved various outcomes.

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6Conceptualized the advantages and disadvantages of the closed-ended questionnaire vis-a'-vis the open-ended questionnaire; maximized the advantages of both types of questionnaires; ensured the shortest, yet clearest form of questioning; avoided ambiguous words; did away with bias and double-barreled questions; avoided background premises that will generate arguments; and did away with conditional responses or forcing a response. During the training, researchers also engaged in mock interviews.
and order of each question was critically discussed. For the FGDs, SI/KII and SSI, researchers were encouraged to ask follow-up questions.

The research team departed for Gbarpolu on Wednesday, the 14th of November and undertook the pilot test on Thursday in Gokala Community, Bopolu District, Gbarpolu County. The necessary amendment was made on the questionnaire. Data collection began on 16th of November 2012 and lasted up to the 27th of November 2012. The team also held Focus group discussions; undertook Direct Observations and held Informal conversations and Specialized interviews.

An SPSS (Software Products and Service Solutions, previously referred to as Statistical Package for Social Scientists) database was designed and finalized; data inputted and analyzed. The questionnaire was coded and data inputted according to code; and quality check was conducted for data verification. During the process of editing, the entire data was highlighted and frequencies processed (Appendixes 6-9).

In a nutshell, the major research methods used were literature review, training of researchers; gathering of primary and secondary data, analysis of data and the presentation of findings. Thus, the research ensures a high degree of triangulation by corroborating findings from various sources.

**Ethical Consideration:** The Principles of Good Humanitarian Practices; the Rights to Intellectual Property and the Principles of Professional Conduct were strictly adhered to. Child fund ethical practices and UNICEF’s principles on Core Commitments for Children in Humanitarian Action were fully applied.

**d. Major Constraints**

**Poor road condition:** The road condition in Gbarpolu County served as a major impediment during the field work. Roads connecting major communities and headquarters of the six districts were in poor Conditions, thus making it difficult for the team to visit all of the communities that were selected through SRS. The heavy down pour of rain during this season led to the destruction of makeshift bridges. Due to these constraints, eight communities were replaced with proxy communities.

**Inaccessible Communities:** A significant number of communities in Gbarpolu County are not accessible by motor bikes and vehicles. A member of the research team had to

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7 Household question # 19 (DID THE PROJECT ATTEND TO THOSE HEALTH NEEDS was amended to DID THE PROJECT ATTEND TO SOME OF THOSE HEALTH NEEDS). The reason is the previous question is implying all of the health needs, and if respondents respond NO for communities that don't have health centers, the survey result for those communities will not reflect the reality since the building of health facility was not a project objective.

8 The former, inter alia, frowns on child abuse; the latter covers amongst other issues confidentiality, objectivity, integrity, honest presentation of research findings as well as recommendations and acknowledgment, whilst the Rights to Intellectual Property frown on plagiarism.
travel by foot for almost a day and even had to sail on a ferry (Tuma River)\(^9\) in order to get to Belle Yalla, while two members of the research team had to travel by motor bikes to SLC and Camp Antel in Kongbo District and Dorkosu in Bokomu District in order to obtain information on the ACSI.

**Timing**: Due to the harvest season, respondents in some of the communities had to be waited upon for hours. Consequently, the originally agreed sample size of 535 dropped to 495; a 7% reduction. Notwithstanding, the final evaluation sample size is far above the baseline sample size (425), a 16% increment.

**Paucity of Health Data**: Despite several and timely contacts/engagements, efforts to obtain health data from the CHT proved futile. The new CHT was still trying to put in place a concise record keeping system.

\(\text{e. LITERATURE REVIEW}\)

In addition to the project documents, both national and international documents were consulted. Project documents included the project proposal, logical framework and midterm evaluation and final report. Prominent amongst the national documents reviewed were the Poverty Reduction Strategy, Gbarpolu County Development Agenda (CDA), Comprehensive Food Security and Nutritional survey (CFSNS), Ministry of Health and Social Welfare Annual Reports and policy documents. The literature reviewed also covered various internet sources, books, periodicals and relevant publications on the ACSI. These documents provided background information on the project. Findings from these documents were corroborated.

**Project Documents**: The project proposal, midterm review and end of project report were critically analyzed. Although the approved child fund project proposal had four defined objectives, there were too many indicators to monitor for objectives I and II, eight and seven indicators, respectively. The project had a total of 21 indicators which made it difficult for the baseline survey, midterm evaluation and final report to capture all indicators. Notwithstanding, the various documents presented some salient information.

**National Documents**: The Poverty Reduction Strategy (PRS) was extensively reviewed. Prior to the Agenda for Transformation (AFT) and Liberia Rising Vision 2030 documents, the PRS was the blueprint for Liberia’s social economic development. Its implementation began April 1, 2008 and ended on June 30, 2011. Derived through a

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\(^9\) To get to Dorkorta, one has to cross the Tuma River by ferry and then walk for more than an hour to get to Kpanta. To get to Bellehkpalamu, one has to cross much talked about “Goma Hill”, one of the most dangerous route. The Hill is almost impossible to either ascend or descend
consultative process, the PRS identified four (4) key areas of intervention. According to the Poverty Reduction Strategy, life expectancy at birth was 45 years; there were only 51 physicians and 297 midwives. 96% of the pre-war 325 health facilities were partially or wholly destroyed. Maternal mortality increased from 578 in 2000 to 994 per 100,000 live births in 2007. Although infant mortality rate has been falling, it remains one of the worse in the world. It stood at 72 per 1,000 live births. Under-five mortality rate was 111 per 1,000 live births. A critical analysis of the PRS reveals under achievements, most especially with the delivery of basic social services – access to schools, roads, water and sanitation, electricity, and basic health services.

Another important document reviewed was the Comprehensive Food Security and Nutritional survey (CFSNS) conducted by the Ministry of Health and Social Welfare in 2006. The report reveals that 39% of children under five were stunted or too short for their ages, while 6.9% were wasted or too thin for their heights. On the other hand, 27% of children under five were underweight. In view of the findings, it was recommended among other things, that the Government of Liberia should increase access to health services and food availability. Notwithstanding, the health sector is still constrained by untrained health practitioners, shortage of skilled personnel and poor infrastructure as well as inefficient referral systems. Poverty coupled with poor nutritional system of pregnant women, high fertility rate, and the numbers of teenage pregnancies are just few of the major problems that continue to exist.

Annual reports from the Ministry of Health and Social Welfare covering the period 2007 to 2011 were reviewed. The 2010 Annual Report shows 9781 reported under-five cases of malaria and 1,137 cases of malaria amongst pregnant women. A review of the basic health indicators of Liberia establish that maternal mortality is caused partly due to the poor nutritional status of pregnant women. Maternal mortality remains high and appears to have increased in recent years from 574 deaths in 2000 to 994 deaths in 2007.

Poor health contributes significantly to increase of poverty in Liberia. Most of Liberia’s health systems are still in a state of disrepair, leaving many of its population vulnerable to diseases such as malaria, diarrhea, dysentery and typhoid.

The Republic of Liberia National Budget for the Fiscal Year July 1, 2011 – June 30, 2012 and Liberia’s Progress towards the Millennium Development Goals were extensively reviewed. Budgetary allotment on Gbarpolu community Health Services in the 2011/2012 National Budget was US$40,000. Thus, Gbarpolu County, like other counties relies greatly on humanitarian partners, for examples, UNICEF Liberia, Plan Liberia, ZOA Liberia, OXFAM Liberia, ACDI/VOCA, and CRS Liberia for providing basic social services.

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10 The four Pillar of the PRS are Consolidating Peace and Security, Revitalizing the Economy, Strengthening Governance and the Rule of Law and Revitalizing Infrastructure and delivering Basic Social Services
11 PRS, p.30
13 PRS, p.30
14 The budget for the fiscal year 2011-2012 was US$516,430,000.00 (L$37,182,960,000.00)
Global Documents: The United Nations Convention on the Rights of the Child (UNCRC) was also reviewed. It defines a child as anyone below the age of eighteen, except otherwise provided by national laws\(^\text{15}\). The Convention espouses several rights, for examples, non-discrimination, the right to life, survival and development as well as the right to identity, and freedom of expression. Notwithstanding, one of the recurrent problems facing most under five children in Liberia is access to health services.

Although UNICEF has reported a global improvement in child survival (\(\text{www.unicef.org/health/index_malaria.html}\)), statistics emanating from Liberia remains bleak. UNICEF reports that approximately 9.7 million children die every year. The Accelerated Child Survival Initiative\(^\text{16}\) is therefore one of UNICEF efforts towards the attainment of Millennium Development Goals (MDG) 4 and 5 and elements of MDGs 1, 6, and 7. The ACSI is aimed at reaching every child in every town / village. Notwithstanding, most under-five deaths in Liberia are attributed to preventable diseases such as diarrhea, malaria and ARI. Malnutrition and the lack of ante natal care contribute significantly to under-five deaths.

According to WHO, life expectancy at birth is 54/57 for male/female. Probability of under-five death is 78 per 1000 live birth. Total expenditure on health per capita in 2010 was US$49, while total expenditure on health as a percentage of GDP is US$11.8. Consequently, Liberia’s infant and under five mortality fall under the five highest in the world. More than 15% of children die before reaching their first birthday (\(\text{www.who/country/lbr/en/} ; \text{http://www.who.int/countries/lbr/en/}\)).

Appendix X gives a detailed listing of the most prominent sources that were reviewed.

III. MAJOR FINDINGS:
   a. Coherence:

The project was consistent with several national and international policy documents. Nationally, the project was consistent with the Ministry of Health and Social Welfare (MOH&SW) National Strategy for Child Survival; Revised National Community Health Services Policy; Revised National Community Health Services Strategy and Plan 2011 – 2015; the Poverty Reduction Strategy with emphasis on Pillar Four (the provision of infrastructure and basic social services). These documents address, inter alia, policies of treating under-five children with diarrhea at home; policies on the provision of

\(^{15}\) In Liberia, the 1985 Constitution is mute on the age of a child, but voting age is eighteen and the age of consent is eighteen. Moreover, Liberia ratified the CRC in 1993 and presented its First Country Report in November 2000. Several other policy and administrative documents confirm the CRC age limit and equally re-emphasize the rights enshrined under the CRC; Government of Liberia, First Country Report on the Convention on the Rights of the Child (CRC), 2000, Monrovia: Sabanoh Printing Press Ltd. 2000, P.22.

\(^{16}\) The ACSI is aimed at, inter alia, care for new born babies; provision of food including micronutrient supplement; prevention of mother-to-child transmission (PMTCT) of HIV; Provision of maternal and childhood immunization; malaria prevention through insecticide-treated nets (ITNs); promotion of the Integrated Management of Childhood Illness (IMCI) strategy
appropriate treatment for children affected by malaria, ARI, malnutrition and policies on antenatal care.

The project was also coherent with UNICEF policy of preventing common yet treatable diseases amongst children under the age of five, and the provision of neonatal care (http://www.unicef.org/health/index_childsurvival.html). Moreover, the project was in line with the World Health Organization goal of providing basic health care services to children under five and pregnant women. Most importantly, the project was coherent with the United Nations Millennium Development Goals 4 (Child Health) and 5 (Maternal Health) and various elements of MDGs 1 (End Poverty and Hunger), 6 (Combat HIV and Aids) and 7 (Environmental Sustainability).

The convergence of interest on the project was visible during the launching program in Gbarpolu County. Major stakeholders ranging from Child fund, UNICEF, AHA, officials of Government as well as the Ministry of Health and Social Welfare personnel, the CHT, Local Government officials and direct beneficiaries were all in attendance and hopeful of the effectiveness, efficiency and impact of the project. Despite the enthusiasm for the project, the sharing of information during the implementation of the project was lukewarm, for example, between child fund and the County Health Team.

b. Coverage

Irrespective of the rough terrain, the project covered the six districts of Gbarpolu County. The actual areas of intervention were 95 communities as compared to 88 communities that were targeted in the project document. Although some communities that are reflected in the 2008 LISGIS National Housing and Census Results were not reached, the project covered 95 targeted communities and nearby towns and villages.

Cost effective services provided to beneficiaries included care from gCHVs, HHPs, TTM, CHC for pregnant women and under five children. Notwithstanding, the need to still engage the targeted communities is still visible, not to even mention the untargeted communities.

c. Relevance of the ACSI Project:

Both Focus Group Discussions (FGDs) as well as specialized interviews point to the fact that there were numerous health needs in Gbapolu County before the start of the project. FGD with women of Timber village Indicated that the health needs in their communities were compounded by the poor road condition which posed serious threats to institutions that wanted to bring much needed relief to the county. The (Women)

17 The LISGIS 2008 National Housing and Census Results shows some towns / villages with population as low as two persons, for example, Amadu Village and Safula Village in Bopolu and Siryon Village in Gbarma). Out of a total number of 416 towns / villages, over 185 towns / villages have population less than 51 persons, while 245 towns / villages have less than 100 persons and 297 towns and villages have population less than 200 persons.
further indicated that the lack of health education and untrained Traditional Midwives endangered normal delivery of pregnant women while untrained health practitioners and lack of essential drugs contributed to the high rate of under-five death in the county. An overwhelming 96% of beneficiaries of the ACSI project acknowledged the existence of serious health needs in the targeted communities prior to the ACSI project.

Figure 2: Level of Community Health Needs before ACSI Project

They identified ARI, diarrhea and malaria amongst some of the diseases that contributed to the increase in death rate of under-fives.

The graph below disaggregates by districts the number of respondents that acknowledged health needs before the ACSI project.

Figure 3: Health Needs of Respondents Disaggregated by District

From figure 3, communities found in the districts of Bokomu (100%), Bopolu (93%), and Kongba (97%), had high health needs prior to the ACSI project.
d. EFFECTIVENESS OF THE PROJECT:

In order to analyze the effectiveness of the project, the Evaluation Team conducted an in-depth review of the project’s objectives and the extent to which each of these objectives was met.

i. Objective #1: Provide improved health care services for children under five years in 85 communities by 2011

Unlike the project document which earmarked 85 communities for implementation, specialized interviews\(^{18}\) revealed that the project was implemented in 95 communities in Gbarpolu County. In accordance with objective #1 of the project, Child fund Liberia undertook a baseline study that took into consideration community child health, infant and young child feeding practices, skills and KAP.

In order to achieve objective #1 (health care services for children under five), FGDs revealed that several structures were put in place and there were several trainings\(^{19}\) undertaken to build the capacity of individuals who were directly responsible for the project implementation. According to specialized interviews with an authority of Child Fund, the Community Health Committee (CHC) was the first group to be established. The roles of the CHCs were to mobilize and raise awareness on sanitation and health among community dwellers through regular meetings. The CHC recommended individuals to Child Fund to serve as general Health Volunteers (gCHVs).

1. Performance of the CHC:

The establishment of the CHC had the inputs of the Child Survival Technical Coordinator, OICs, AHA, YAPA and the CHT. FGDs revealed that despite a well-defined roles and responsibilities\(^{20}\), the CHC failed to provide appropriate incentives and motivation for gCHVs. Additionally, there was low awareness on the existence of CHC in most of the communities visited. Of the 495 households interviewed, only 48% knew of the existence of the CHCs. 30% did not know about the existence of CHCs while

\(^{18}\)National Health Advisor/Cluster Coordinator, Child fund.

\(^{19}\)Some of the training included Community Based management of Diarrhea in Childhood and ARI.

\(^{20}\)The CHC was organized to have administrative oversight responsibility over the Community Health Policy and appropriate forms of incentives and motivation for CHVs among other functions. Community Health Committees were trained to act as an administrative support mechanism for gCHVs, TTMss and HHPs. The trained CHCs were to develop individual community strategy for the sustainability of services, particularly focusing on ways communities could give supportive compensation to the gCHVs, TTMss and the Household Promoters. According to xxxx a three-days training for five members of each CHC was conducted in all of the six political districts of Gbarpolu County. The training focused on the strengthening of the administrative arm of the project at community level, their activeness in exercising their roles as CHC especially in setting up criteria for the selection of gCHVs, TTMss, and the Household Promoters. A total of 425 CHC members from 95 communities were trained and installed by Child Fund.
22% said that there were no CHCs in their communities. Figures four and five below show the details.

**Figure 4: Knowledge of the existence of CHCs**

<table>
<thead>
<tr>
<th>Does your community have a CHC?</th>
<th>Yes 48%</th>
<th>No 22%</th>
<th>Don't know 30%</th>
</tr>
</thead>
</table>

**Figure 5: Knowledge of the Existence of CHCs disaggregated by District**

<table>
<thead>
<tr>
<th>District</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belleh</td>
<td>1</td>
<td>4</td>
<td>21</td>
</tr>
<tr>
<td>Bokomu</td>
<td>40</td>
<td>10</td>
<td>24</td>
</tr>
<tr>
<td>Bopolu</td>
<td>90</td>
<td>21</td>
<td>38</td>
</tr>
<tr>
<td>Gbarma</td>
<td>66</td>
<td>50</td>
<td>44</td>
</tr>
<tr>
<td>Guo-wolalah</td>
<td>1</td>
<td>12</td>
<td>9</td>
</tr>
<tr>
<td>Kongba</td>
<td>29</td>
<td>6</td>
<td>27</td>
</tr>
</tbody>
</table>

Findings from the evaluation revealed that the performance of the CHC was not impressive as expected. FGD in all of the communities visited revealed that meetings were called by the Town Chiefs who instructed them to clean their communities. Due to the inactiveness of the (CHCs), most targeted communities did not know their functions and responsibilities.

In a nutshell, the CHCs did not mobilize support from the community for gCHVs; did not monitor gCHVs on the administering of drugs and did not mobilize the communities for clean-up campaigns.

### 2. Performance of the gCHVs

The evaluation reveals that the gCHVs were very effective in the discharge of their duties. There was immense awareness on the existence of the gCHVs in all of the communities visited (See graphs below).
Additionally, overwhelming appreciation was given to the general Community Health Volunteers (gCHVs) performance in the selected communities on the execution of their roles and responsibilities21. 85% of beneficiaries rated the performance of the gCHVs as “good” (See graphs below).
One respondent from Guyanta community was quoted as saying, “They are not charging to treat our children and any time you call them, they are always available especially when they are in the community”. Participants in another FGD also indicated that the gCHVs refer cases that are beyond their control to health facilities. The gCHVs informed the Evaluation Team in several Semi-structured (SI) and Key Informant interviews that they were supplied essential drugs to cater to under-fives in their communities.
Table 1: Drugs supplied to gCHVs during the project cycle

<table>
<thead>
<tr>
<th>#</th>
<th>DRUGS</th>
<th>PURPOSE</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Ferrossulphate:</td>
<td>• For blood</td>
</tr>
<tr>
<td>2</td>
<td>ORS</td>
<td>• For the treatment of diarrhea</td>
</tr>
<tr>
<td>3</td>
<td>Paracetamol</td>
<td>• To manage malaria until the child is taken to the health center</td>
</tr>
<tr>
<td>4</td>
<td>Septrine</td>
<td>• Used for the treatment of Cough/ARI</td>
</tr>
<tr>
<td>5</td>
<td>Vermox</td>
<td>• For worm prevention, which was given to under-five children every month</td>
</tr>
<tr>
<td>6</td>
<td>Vitamin supplements</td>
<td>• Taken by children under five every three months</td>
</tr>
</tbody>
</table>

With the constant supply of drugs to gCHVs under the project, they were always in readiness to answer to calls from community members. Consequently, 83% of respondents said that gCHVs were always available when called upon. Figure 10 below shows the details.

Figure 10: gCHVs availability to cater to health needs of Respondents

![Pie chart showing 83% Yes, 6% No, 11% Don't know]

Figure 11: gCHVs availability to cater to health needs of Respondents disaggregated by District

<table>
<thead>
<tr>
<th>District</th>
<th>Yes</th>
<th>NO</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belleh</td>
<td>4</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>Bokomu</td>
<td>59</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Bopolu</td>
<td>132</td>
<td>8</td>
<td>0</td>
</tr>
<tr>
<td>Gbarma</td>
<td>78</td>
<td>4</td>
<td>4</td>
</tr>
<tr>
<td>Guo-wolalah</td>
<td>1</td>
<td>0</td>
<td>17</td>
</tr>
<tr>
<td>Kongba</td>
<td>57</td>
<td>4</td>
<td>0</td>
</tr>
</tbody>
</table>

Findings from the evaluation also revealed that in addition to supplying first aid drugs and referring patients, the gCHVs also disseminated health messages in their
respective communities. Thus 83% of households were aware that gCHVs conducted health education in their communities.

**Figure 12: Awareness of gCHVs spreading health education in communities**

![Pie chart showing awareness of gCHVs conducting health education]

**Figure 13: Awareness of gCHVs spreading health education in communities disaggregated by District**

![Bar chart showing awareness of gCHVs in different districts]

FGDs with women in several of the communities also revealed that no under-five death occurred in their communities as a result of treatment administered by the gCHVs. Community dwellers further emphasized the gCHVs commitment to their duties.

### 3. Performance of HHPs

The study also revealed that although 70% of beneficiaries acknowledged the existence of the HHPs, they did not fully understand the roles of the HHPs and could not differentiate them from those of the TTMs because they were all traditional midwives before the ACSI Training. The graph below shows beneficiaries who acknowledged the presence of HHPs in their communities.
Many of the beneficiaries interviewed acknowledged the presence of older women in the targeted communities who encouraged young baby mothers to breastfeed their children and help them to reduce harmful practices such as the giving of water to children below six months. The study also revealed that 72% respondents indicated that HHPs visited HHs in the discharge of their duties (see graphs below).
Figure 16: Level of visitation of HHPs at HHs

![Pie chart showing the level of visitation of HHPs at HHs.]

Did the HHPs monitor your household regularly?

- Yes: 72%
- No: 9%
- Don't know: 19%

Additionally, 78% of respondents also rated the performance as good. The graph below gives the details.

Figure 17: Level of visitation of HHPs at HHs disaggregated by district

<table>
<thead>
<tr>
<th>District</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belleh</td>
<td>1</td>
<td>1</td>
<td>23</td>
</tr>
<tr>
<td>Bokomu</td>
<td>41</td>
<td>15</td>
<td>4</td>
</tr>
<tr>
<td>Bopolu</td>
<td>94</td>
<td>10</td>
<td>15</td>
</tr>
<tr>
<td>Gbarma</td>
<td>116</td>
<td>6</td>
<td>17</td>
</tr>
<tr>
<td>Guo-wolalah</td>
<td>1</td>
<td>2</td>
<td>15</td>
</tr>
<tr>
<td>Kongba</td>
<td>42</td>
<td>5</td>
<td>2</td>
</tr>
</tbody>
</table>

Additionally, 78% of respondents also rated the performance as good. The graph below gives the details.
Figure 18: Level of performance of HHPs

If yes, what was the level of the HHP performance?

- Good: 78%
- Poor: 5%
- Fair: 3%
- Don’t know: 14%

Figure 19: Level of performance of HHPs disaggregated by district

<table>
<thead>
<tr>
<th>District</th>
<th>Good</th>
<th>Fair</th>
<th>Poor</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belleh</td>
<td>1</td>
<td>5</td>
<td>13</td>
<td>9</td>
</tr>
<tr>
<td>Bokomu</td>
<td>38</td>
<td>0</td>
<td>0</td>
<td>7</td>
</tr>
<tr>
<td>Bopolu</td>
<td>96</td>
<td>5</td>
<td>9</td>
<td>16</td>
</tr>
<tr>
<td>Gbarma</td>
<td>112</td>
<td>2</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Guo-wololah</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>16</td>
</tr>
<tr>
<td>Kongba</td>
<td>41</td>
<td>1</td>
<td>0</td>
<td>1</td>
</tr>
</tbody>
</table>

4. PERFORMANCE OF TTMS

Several FGDs in communities visited revealed that the TTMs are taking good care of pregnant women by checking and advising them on health practices. Information from HH data revealed that 92% of respondents agreed that there are people in the community who regularly check on pregnant women.
Women in all of the communities visited indicated that TTM also adhere to the regulation of non-community delivery and constantly refer pregnant women to various health centers when they were in labor. A penalty of L$1,500 is imposed by the local authority on any violator for community delivery outside of a health facility. Interview with beneficiaries in several communities confirmed that the imposition of penalty for community delivery has enhanced the cooperation of the TTM. Consequently, more women are now having babies at health centers. It was also revealed that the project gave a little token to TTM who made the highest number of referral on a monthly basis.

Thus, the gCHVs, TTM, and HHP were very active in reaching health care to children under-five in all communities visited.
ii. **Objective #2: To build the capacity of the Community Health structure for the prevention of common childhood illnesses and new born death in all 85 communities in all six districts by 2011**

FGDs in all communities indicate that under objective #2, several community structures were selected and trained to effectively implement the activities of the project. For example, the selections of gCHVs were in conformity with policies of Ministry of Health & Social Welfare (MOHSW). According to FGD participants, selection and verification of the gCHVs began after the training of each CHC Team. Each selected gCHV represented a community of 1,000 populations. A total of 110 gCHVs were selected and verified in a process conducted in community meetings and were monitored by OICs, Child Fund, YAPA and AHA. From SIs, the criteria for recruiting gCHVs were good moral behavior, a minimum of six grade academic qualification; and approval by the community.

**Training of GCHVs:** SSI with Child Fund and AHA revealed that, 110 gCHVs were orientated in Community Health Policy and trained in case management of Diarrhea, ARI and disease prevention in keeping with the MoHSW guidelines. Specialized interview revealed that the training of gCHVs was executed by both AHA and Child Fund. 70 gCHVs were trained by AHA while 40 were trained by Child Fund. These trainings were jointly facilitated by the OICs in each of the districts.

gCHVs were trained in three stages beginning April 7, 2010. The first stage lasted for four days, second stage for four days and the third stage for one week. Even though, the project document recommended that the gCHVs should receive the fourth and fifth module trainings in Community Child Growth and Nutritional Program (CGNSP) to be conducted by the Certified Midwives, this aspect of the training was not implemented. However, trainings for gCHVs were aimed at identifying symptoms of malaria, ARI and diarrhea. Minor cases were handled, but major cases were referred to health centers.

In a FGD with gCHVs in Guyanta, Bopolu District, they were mainly trained to treat diarrhea and ARI. gCHVs were also trained to treat malaria, but were later told that malaria tablets are sensitive and that malaria cases should be referred.

**Training of HHPs:** According to the Executive Director of YAPA and the Cluster Coordinator of ChildFund, the HHPs were recruited from the Communities and were named “grandmas”. All of the HHPs selected, were trained by ChildFund for three days. This group composed of older women in the community and worked voluntarily with households. Information also revealed that each HHP was assigned to a given number of households and received supervision from the gCHVs.
**Training of TMs:** In accordance with the project document, trainings were provided for the Traditional Midwives. FGDs with TTMgs revealed that all of the women selected by their communities were trained for eight days. Specialized interview with ChildFund indicate that training for TMs were based on community health policy and strategy orientation, especially new roles in de-emphasizing community deliveries and emphasizing ANC, Post Natal Care, Health Education, care for new born babies were highlighted.

TTMs engaged young and pregnant women in the targeted communities. Education on basic hygiene practices; referrals of pregnant women to health centers for delivery were among some of the functions carried out by the TTMs. TTMs also encouraged baby mothers to breastfeed their babies for the period of six months.

Reports from SIs and FGDs revealed that only TMs underwent training in child growth, although an amount of US$1,200.00 was disbursed and intended to train both gCHVs, and HHPs.

**iii. Objective #3: To upgrade the skills of clinical staff for the effective management of childhood illnesses referrals in all 10 Health Facilities by 2011**

Although there were series of challenges in accessing health centers in the county, the project was successful in training the clinical staff in all six districts in Gbarpulo County. Vaccinators were trained to monitor the treatment administered by the gCHVs especially when administering vaccinations.

Since the gCHVs were to only identify cases of ARI, malaria, and diarrhea and to refer them to health centers, the OICs at the health centers were trained to manage referral cases that emanated from the communities. However, some mothers in FGDs informed the Evaluation Team that in some cases, referrals from the community to the health centers were further referred to the hospital in Bopolu, the capital of the county.

**iv. Objective #4: To build the capacity of the Gbarpolu County Health Team to efficiently manage programmes.**

Although the Gbarpolu County Health Team was not involved in the formulation of the project document, the project hired the services of Mother Pattern College of Health Sciences to train few members of the CHT. Those trained included the County Health Service Administrator, the County Health Department Director, the Child Survival Focal Person and the Nursing Service Director. Notwithstanding, the CHT experienced serious staff attrition for those occupying these positions. Consequently, the high

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22 Upon the commencement of the project, Mr. Charles Kpessay served as County Health Service Administrator; but was replaced by Mr. Isaac Dweh; Mr. Abraham Massally served as County Health Department Director, but was
turnover of staff directly affected the project. There was no institutional memory to properly follow-up on the activities of the project. Findings from key informant interviews also revealed that the project did not build the logistical capacity of the CHT. No allocation was made in the project budget for the CHT. Interviews with stakeholders at the Ministry of Health and the CHT revealed that the CHT never had the logistical capacity to monitor the project. Specialized interview with some Child Fund authorities attested to the fact that the project should have built the capacity of the new members of the County Health Team in order to effectively take over the project, despite the high turnover of staff at the CHT. There was also no proper exit strategy. Instead, an amount of US$11,000.00 was given by UNICEF to the CHT to maintain the project.

e. IMPACT OF THE PROJECT:

As a result of the achievement of objective #1 and 2, impacts of the project are being experienced in all parts of the county, although the impact varies from district to district. Impact is higher in the accessible communities than communities that are inaccessible by vehicle and motorbikes. For example, it was observed that Belle, Guo-wolala and Kongba districts experienced little impact, while there was much impact in the districts of Bokomu, Bopolu and Gbarma which had high sampling sizes. Observation by researchers revealed that respondents in these districts were less knowledgeable about project activities than districts that are accessible by vehicle. Notwithstanding, there were some major impacts made on the overall. On the overall, 78% of respondents indicated that the project improved the health of their families. Figures 22 and 23 show the details of the findings.

*Figure 22: Extent to which project met health needs HHs*

<table>
<thead>
<tr>
<th>In your opinion, did the project meet your family's health needs?</th>
<th>YES 78%</th>
</tr>
</thead>
<tbody>
<tr>
<td>Not at all</td>
<td>9%</td>
</tr>
<tr>
<td>Not too much</td>
<td>9%</td>
</tr>
<tr>
<td>Very much</td>
<td>4%</td>
</tr>
</tbody>
</table>
FGDs revealed that HHs in targeted communities are beginning to understand that childhood sicknesses that were attributed to spiritual reasons or curses, are treatable and avoidable. Households now understand that illnesses like malaria, ARI and diarrhea can be diagnosed and treated. FGDs further revealed that deaths resulting from pregnancy or delivery are often due to the lack of trained midwives or adequate equipment to handle complicated cases and that these kinds of deaths can be avoided.

As a result of the project intervention, HHs confirmed improvements in health conditions. Out of 484 households, 86% confirmed improvements in their household health conditions since the inception of the project in the county.
Due to the knowledge provided through health education by YAPA, Child Fund and AHA, beneficiaries are now taking health matters seriously and acting on their own to combat targeted diseases. From figure 25, Bopolu (97%), Gbarma (94%) and Kongba (97%) record significant improvement. But Belleh (16%) and Guo-wolalah (10%) recorded less.

**Malaria - Number of households that use mosquito nets:**
The use of ITN which was distributed by the Malaria Control Program through the County Health Team, contributed significantly in reducing the incidences of malaria. FGDs with some HHs revealed that before the project, they did not know the importance of sleeping under mosquito nets. However, with the health education received from the gCHVs they are now using the nets which were only kept in the past. Consequently, a total of 89% of the households interviewed in the districts are having their under-5 sleep under the ITNs. This information was authenticated by inspection of bed nets in various households. The graphs below show the detail of respondents who slept under mosquito nets nights before the evaluation.

"When the small doctor says that I get malaria, he can give me some paper and medicine, then send me to the hospital",
Female Respondent from Okai Village

**Figure 25: Extent to which health condition of HHs improved since the coming of the project disaggregated by district**

<table>
<thead>
<tr>
<th>District</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belleh</td>
<td>4</td>
<td>0</td>
<td>21</td>
</tr>
<tr>
<td>Bokomu</td>
<td>62</td>
<td>4</td>
<td>6</td>
</tr>
<tr>
<td>Bopolu</td>
<td>141</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Gbarma</td>
<td>151</td>
<td>7</td>
<td>2</td>
</tr>
<tr>
<td>Guo-wolalah</td>
<td>2</td>
<td>1</td>
<td>17</td>
</tr>
<tr>
<td>Kongba</td>
<td>58</td>
<td>3</td>
<td>0</td>
</tr>
</tbody>
</table>

**Figure 26: Number of Children who slept under mosquito net night before the survey**
In Bopolu (92%), Gbarma (92%) and Kongba (97%), most children slept under mosquito nets.

**Knowledge on the treatment of Malaria:** Knowledge on the treatment of malaria is diverse. A vast majority of respondents follow the child survival positive behavior compliance pattern. The HHPs or gCHVs imparted primary knowledge for uncomplicated cases. Most importantly, positive behavior compliance for many of the households means an early alarm. According to them, any suspicion of fever is quickly referred to a gCHV in the community. “When the small doctor\(^{23}\) say that I get malaria, he can give me some paper and medicine, then send me to the hospital”, remarked an 18 year old mother of Okai Village. In a KII with the District Health Coordinator of Gbarma, the incidence of complicated malaria has reduced at the various clinics in Gbarpolu County as a result of early referral.

**Level of reduction on incidence of malaria:** There is a reduction in the number of incidences of malaria within the County according to respondents. A number of

\(^{23}\)gCHVs were referred to as small doctors by community members.
households spoken to confirmed the reduction of incidences of malaria as a result of the Accelerated Child Survival Initiative. From a total of 487 households interviewed in the districts, 85% affirmed reduction in the various households (See graphs below).

**Figure 28: Level of reduction of incidence of Malaria in HHs**

<table>
<thead>
<tr>
<th></th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
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</tr>
<tr>
<td>Bokomu</td>
<td>144</td>
<td>4</td>
<td>5</td>
</tr>
<tr>
<td>Bopolu</td>
<td>65</td>
<td>9</td>
<td>1</td>
</tr>
<tr>
<td>Gbarma</td>
<td>2</td>
<td>16</td>
<td>17</td>
</tr>
<tr>
<td>Guo-wolalah</td>
<td>60</td>
<td>2</td>
<td>0</td>
</tr>
<tr>
<td>Kongba</td>
<td>4</td>
<td>5</td>
<td>19</td>
</tr>
</tbody>
</table>

**Figure 29: Level of reduction of incidence of Malaria in HHs disaggregated by district**

Reasons for this reduction, according to female respondents, in FGDs are the access to health services, health education and awareness on sanitation.

**Level of reduction of incidence of ARI:** There is a considerable level of reduction in instances of ARI in households spoken to within the six districts of Gbarpolu County. From 485 households spoken to, 77% expressed confirmation on the reduction of ARI in their households. Many respondents attributed this achievement to knowledge gained from health education and awareness provided under the project. Clothing children properly is a popular preventive measure amongst households. This behavior was confirmed through observation. Even though ARI is an airborne disease, gCHVs are combating ARI through the administering of first aid drugs. Figures 30 and 31 show the level of reduction of ARI both in the County and on the district level.
Figure 30: Level of reduction in the incidence of pneumonia in HHs

Have incidence of pneumonia reduced in your household?

- Yes 77%
- No 16%
- Don’t know 7%

Respondent from Dorkosu

“I can give glucose to my children to stop running stomach, but I can go to the small doctor because they say we must go there.”

Figure 31: Level of reduction in the incidence of pneumonia in HHs disaggregated by district

<table>
<thead>
<tr>
<th>District</th>
<th>Yes</th>
<th>No</th>
<th>Don’t know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belleh</td>
<td>4</td>
<td>0</td>
<td>20</td>
</tr>
<tr>
<td>Bokomu</td>
<td>57</td>
<td>5</td>
<td>11</td>
</tr>
<tr>
<td>Bopolu</td>
<td>124</td>
<td>11</td>
<td>11</td>
</tr>
<tr>
<td>Gbarma</td>
<td>133</td>
<td>13</td>
<td>15</td>
</tr>
<tr>
<td>Guo-wolalah</td>
<td>2</td>
<td>0</td>
<td>18</td>
</tr>
<tr>
<td>Kongba</td>
<td>55</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

Diarrhea - Household knowledge on the treatment of diarrhea: Diarrhea is popularly known as “running stomach” amongst rural dwellers in Gbarpolu. On the treatment of diarrhea, respondents are more knowledgeable in describing the treatment than those of malaria and ARI. From teen-agers to grown-ups, the use of ORS, commonly known as “glucose” amongst them is becoming increasingly accustomed to them. For many, it does not require further prescription on administering the ORS. A respondent in Dorkosu stated emphatically, “I can give glucose to my children to stop running stomach, but I can go to the small doctor because they say we must go there”.

Level of reduction in the incidence of diarrhea: A substantial level of reduction in instances of diarrhea was made in households within the six districts as well. Of the 482 households who responded to the question of diarrhea reduction, 85% said the incidence of diarrhea have reduced in their homes (Figures 32 and 33).
It was observed that most of the beneficiaries are having access to safe drinking water. Furthermore, the importance of safe drinking water is now being taken seriously in the various communities due to the health education provided by YAPA, Child Fund and AHA. Sensitization has also created a decrease in the cases of diarrhea at community level. Community hand pumps used for drinking were seen in fence and clean. From the above figure, Bopolu (93%), Gbarma (92%) and Kongba (98%) recorded the highest reduction.

Although the final evaluation revealed an 85% reduction in incidences of both malaria and diarrhea, and 77% in the reduction of incidences of ARI in targeted communities, the Ministry of Health and Social Welfare data\textsuperscript{24} shows a 5% increment in the cases of malaria, a 21% reduction in cases of diarrhea, and 77% increment in the cases of ARI in Gbarpolu County covering the period 2011 to July 2012.

\textsuperscript{24} Ministry of Health and Social Welfare 2010 and 2011 Annual Reports and data from Health Management and Information System (HMIS)
### Table 2: Ministry of Health and Social Welfare health data

<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Cases of Malaria</td>
<td>9,781</td>
<td>14,325</td>
<td>1,648</td>
<td>1,801</td>
<td>1,780</td>
<td>2,507</td>
<td>2,699</td>
<td>2,701</td>
<td>15,074</td>
<td></td>
<td>5.228621</td>
<td>-749</td>
</tr>
<tr>
<td>2 Cases of Diarrhea</td>
<td>831</td>
<td>663</td>
<td>81</td>
<td>59</td>
<td>97</td>
<td>86</td>
<td>61</td>
<td>54</td>
<td>524</td>
<td></td>
<td>-20.9653</td>
<td>-139</td>
</tr>
<tr>
<td>3 Cases of ARI</td>
<td>5,431</td>
<td>3,170</td>
<td>885</td>
<td>908</td>
<td>644</td>
<td>717</td>
<td>815</td>
<td>773</td>
<td>855</td>
<td>5,597</td>
<td>76.56151</td>
<td>2,427</td>
</tr>
<tr>
<td>4 Child Mortality</td>
<td>25</td>
<td>8</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td>7</td>
<td></td>
<td>-12.5</td>
<td>-1</td>
</tr>
<tr>
<td>5 Maternal Mortality</td>
<td>0</td>
<td>3</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>-66.6667</td>
<td>-2</td>
</tr>
</tbody>
</table>

#### Level of Immunization:
The Project also made impact on immunization of children in the County as required in its objectives specifically Objective 1 Indicator 2. The monthly vaccination campaign instituted by Child Fund according to its Team Leader created access to immunization in all 95 communities the project targeted. The Team Leader further said that the outreach program was being carried out by Vaccinators and gCHVs. Of the 461 households that had under-5 children in the six districts, final evaluation statistics indicate that 72% of households have their under-5 children fully immunized, while 18% said that their children are in the process of being fully immunized. HHs said that their decision to immunize their children was in response to HHPs household sensitization on Child Survival Positive Behavior Compliance and Child Growth awareness provided by TTMs in the communities. The Evaluation Team requested for and inspected the Road to Health Cards from respondents in order to verify their answers.

#### Women knowledge and access to prenatal care:
The final evaluation shows that there have been significant impacts made on women knowledge and access to prenatal care. Women in several FGDs told evaluators that no one was allowed to give birth in...
the town. They asserted further that violators are faced with a fine of not less than L$1,500. The issue of penalty for community delivery is a local government mandate and is implemented by Local Government Officials in an effort to buttress the efforts of the ACSI objectives. Women spoke of the importance of constant visitation to the health facility for pre-natal care. However, due to terrible distances from communities to health facilities, the TTM's and HHP's of the ACSI Project play an important role in bringing relief to these women by providing some form of pre-natal care. Consequently 92% of respondents confirmed that there are women in the communities who check pregnant women (See figures 34 and 35 below).

Figure 34: Women access to prenatal care

Are there people who check pregnant women in your community?

<table>
<thead>
<tr>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>92%</td>
<td>5%</td>
<td>3%</td>
</tr>
</tbody>
</table>

Figure 35: Women access to prenatal care disaggregated by district

<table>
<thead>
<tr>
<th>District</th>
<th>Yes</th>
<th>No</th>
<th>Don't know</th>
</tr>
</thead>
<tbody>
<tr>
<td>Belleh</td>
<td>20</td>
<td>2</td>
<td>4</td>
</tr>
<tr>
<td>Bokomu</td>
<td>71</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>Bopolu</td>
<td>136</td>
<td>8</td>
<td>3</td>
</tr>
<tr>
<td>Gbarma</td>
<td>145</td>
<td>7</td>
<td>1</td>
</tr>
<tr>
<td>Guo-wolalah</td>
<td>10</td>
<td>5</td>
<td>7</td>
</tr>
<tr>
<td>Kongba</td>
<td>59</td>
<td>2</td>
<td>0</td>
</tr>
</tbody>
</table>

Figure 36 shows individuals who check pregnant women in the community.
Beneficiaries’ knowledge and access to prenatal care according to statistics has resulted into reduced maternal mortality in the targeted communities. Motivational package of US$17.00 for the TTM with the highest referral of pregnant women in labor to the health facility coupled with TTMs acceptance that community delivery is not good have further contributed to the massive reduction in maternal mortality. Consequently, KII with the Team Leader of Child Fund revealed that there were only three maternal deaths reported during the implementation of the ACSI project.

Although the distances to access health facilities are far, 59% of respondents interviewed still visit health centers for antenatal care.
f. Sustainability of the Project:

The Child Survival Program may not be sustained due to the below factors:

- The lack of capacity building of the County Health Team as a result of attrition personnel. The Team that was trained by the project has been changed and the present team does not have appreciable knowledge of the project activities.

- Authorities at the Ministry of Health and Social Welfare are not prepared to put in requisition for drugs at the National Drugs Service (NDS) to supply drugs to the gCHVs to continue the project. Since the project ended, gCHVs are finding it difficult to get first aid drugs.

- CHCs which should serve as the administrative organ of this project to take initiative at community level are inactive in most of the communities. The CHC failed to galvanize support for the gCHVs to serve as incentives for services rendered. Thus most of the gCHVs have left to seek livelihood for their families.

- Another factor that posed serious threat to the sustainability of the project was the unwillingness of communities to take ownership of the project. Although some community members spoke of making farms and using the proceeds to purchase drugs, nothing was done up to the time of the evaluation.

- Child Fund assigned six Staff for six months after the project implementation to each of the districts to work along with CHT to continuously monitor the project and AHA intends to tap on the expertise of former ACSI personnel.

g. Challenges of the Project

Although the project impacted the lives of beneficiaries, it had several challenges.

- The poor road conditions in most part of the project coverage area prevented normal movements of people/groups who were involved with project implementation.

- Gap in communication as a result of the lack of network for communication devices amongst project implementers especially the 14 CHSS of YAPA who were to monitor the 110 gCHVs.

- Due to the long distances covered by patients to access health centers, pregnant women refuse to go to the hospital after being transferred.

- Lack of motivation from the community dwellers to compensate the gCHVs.

- Shortages of drugs and delay in supply experienced under the CHT implementation in 2012. gCHVs are only operating on referral basis even for minor cases.
• There is no allocation for transportation reimbursement for CHT. This has impeded monthly meetings on health matters.
• Distances covered by pregnant women in pain to health centers, sometimes cause women to give birth on the road.
• Death of under-five children while trying to reach referral centers.
• Cost of accessing health centers compared to cost of medication received at health centers undermine the referral system
• Vaccinators did not have appropriate access to the motorbikes; instead they were most of the times used by OICs.
• There was no budget line in the Project for MOHSW both central and county level for motivation, M&E and supervision.
• All health centers are understaffed— one Physician Assistant (PA) and one Certified Midwife (CM). In their absence, patients are left at the mercy of either a Vaccinator or some uncertain situation
• Usage of motor bike ambulances was not defined by UNICEF, whether from health facilities to referral or from community to health facilities. Motor bike ambulances were not appropriate for the terrain and therefore, were unable to reach many communities under the project.

IV. Conclusion

Although the ACSI project encountered challenges, the success outweighs the challenges. In the midst of immense health needs in Gbarpolu County, the project was very relevant in easing the health needs of the targeted communities. The project was also coherent because it conformed to both national and international documents and was implemented in line with the CCC of UNICEF. Additionally, the project was implemented in all of the 95 targeted communities.

Based on the findings of the evaluation, ADEAS wishes to draw the following conclusions:

• **Access to Health Care:** the project was successful in providing health care to under-fives in all communities visited. The dedicated services and commitment of the community health structures like the gCHVs, TTM and HHPs greatly contributed to achieving this objective, unlike the CHC who were inactive in most of the communities.

• **Training and Setting up of community structures:** With the exception of the training of gCHVs in the area of Child Nutrition and Growth, all trainings under the project were conducted. The successful training of the community health structures led to the exceptional performance of gCHVs, HHPs and TTM during the implementation of the project.
• **Capacity building of Clinical Staff:** The training of clinical staff under the project was a good initiative. However, the distances some beneficiaries have to travel to access health centers could easily undermine this effort. In some cases where the cost of transportation is higher than the cost of drugs administered at these health facilities, respondents are likely to purchase drugs from community based drug vendors instead of going to the health centers.

• **Up-grading the capacity of County Health Team:** The capacity of the CHT was not sufficiently built during the project. This has undermined the sustainability of the project to a large extent.

• **Impact of the Project:** On the overall, the project greatly impacted the lives of the beneficiaries. Children and pregnant women in all communities visited had access to health care. Health education was an important component of the project that recorded major impact. Community members had an appreciation for the ITNs and made use of them. Many HHs also knew how to treat diarrhea by orange juice and salt in the absence of ORS.

There were also some negative impacts of the project. Referral cases of malaria, diarrhea, and ARI to health centers are often further referred to hospitals due to lack of facilities or essential drugs to handle cases. Additionally, the distances to access health centers in most cases are very far and costly. On the other hand, pregnant women who were encouraged to use health facilities to give birth had to walk for hours to access these facilities. In some cases, babies were born enroute to health centers. The distances to health centers even resulted to the loss of lives of some babies whose mothers could not make it to health centers on time.

However, the impact of the project was felt more in districts accessible by vehicles than those that were not accessible.

• **Sustainability of the Project:** The project has little or no prospect of being sustained. With no institutional memory from the CHT and the inactiveness of the CHC, coupled with the lack of supply of essential drugs to the gCHVs, the project is not likely to be sustained.

**Critical Issues:**

• While delivery at health centers is a step in the right direction to decrease infant and maternal mortality rates, the distances pregnant women have to travel to access health centers could also posed serious threats to the lives of mothers and babies.

• Referral of complicated cases of malaria, ARI, and diarrhea is also a positive initiative, but distances and cost to access health centers may result to death of under-fives.
V. Recommendations

Based upon the findings, analysis and conclusion drawn from the end of term evaluation of the ACSI Project, the following recommendations are offered to the major stakeholders.

Government of Liberia

1. The government should improve road networks throughout the country. Poor road network lead to delay in project implementation, especially during the rainy season and undermine efficiency.
2. Government should increase the number of health facilities in the county so as to enable patients with referral cases to have easy access to health centers.
3. Salaries and incentives of the CHT should be increased to attract more health workers to take assignment in the rural areas.
4. Due to the lack of adequate health facilities in the county, coupled with the long distances covered by people seeking medical attention, the government should introduce another strategy to allow gCHVs administer additional health services to children under five.
5. Roles of gCHVs, TTMs, HHPs are very important in alleviating the numerous health needs in the county. Government of Liberia should therefore continue the program by increasing the budgetary allotment for community health services.
6. There should be proper coordination between the CHT, communities and IPs, and each stakeholders should be encouraged to maintain accurate records.

MOH/County Health Team

1. Ministry of Health and Social Welfare should be actively involved in the implementation of all health projects.
2. CHT should be more involved with health interventions of both local and international partners.
3. The criteria set up in selecting members of the CHCs should be re-visited to conform to self-reliance and self-sustenance so as to eradicate the dependency syndrome which leads to de-motivation of community structure administrators.
4. Town Chiefs of various communities, who already command the respect of the people, should form part of the CHC.
5. There should be timely supply of drugs to gCHVs through the various clinics to avoid complicated cases at community level.
6. GCHVs and TTMs motivation should not only be left to the community, but the government should take initiative in enhancing the motivation package put
together for the gCHVs and TTMss by Partners. Government should include this initiative in the budget especially for gCHVs and TTMss. This will enhance access to health care delivery at community level; create easy information dissemination on health issues to community level.

7. Maternal waiting centers should be constructed near every health center in the county to accommodate pregnant women who are in delivery pain, but come from far places to allow them to remain near the health center until delivery. This will encourage pregnant women who are in labor pain not to be kept in the community for fear that they may return without giving birth because of the lack of accommodation. It will prevent complication in delivery cases especially for late arrivals.

8. More logistical support should be given to gCHVs and TTMss in addition to periodic training in order to tackle common yet treatable diseases, for example malaria.

9. In order to address the issue of capacity building at county level and to efficiently manage health programmes, in particular the ACSI, the government should institute a periodic nationwide training for health administrators since attrition of health personnel is still a major problem.

10. Since gCHVs easily reach pregnant women and under-fives, more logistical support, incentives, and training should be given to them in order to tackle malaria, ARI and diarrhea.

11. There should be timely supply of drugs to enable gCHVs function properly

**ChildFund**

1. Training of CHT should be implemented three times during the project cycle (at the beginning, at the midpoint and at the end). This will enable the CHT to be prepared for sustainability of the project and at the same time fill in the gap of any staff change.

2. If the project is to be replicated to other counties, the County Health Team should actively get involved with the project from its inception. The CHT is the arm of the MOHSW at county level on which the continuation of the project is relied upon and as such the CHT must understand the design of the project.

3. GCHVs and TTMss motivation should not only be left to the community, but the government and implementing partners should also take initiatives in enhancing the motivational packages for gCHVs, TTMss and HHPs.

4. Method of supervision should be changed from vaccinator to nurse aid. Vaccinators are not necessarily health personnel to supervise the community structures. Vaccinators were not trained to supervise the gCHVs.
5. There should be a specific budget line for MOHSW Team at central and county level for motivation, M&E and supervision.
6. Future projects should take into consideration preventive health care for malaria by administering anti-malarial drugs since access to health centers are far and costly.

UNICEF

1. UNICEF should disburse funds for projects on time to enhance efficiency and effectiveness
2. The reason for the poor performance of CHCs was attributed to lack of incentives. Motivational packages could boost the morale of the CHC and make them active
3. UNICEF should access the terrain before procuring equipment for use. The motorbike ambulances did not effectively serve the intended purpose since it was not appropriate for the road.
4. The uses of the motorbike ambulances were not clearly defined. Whether to take patients from the community to the health centers or whether from the referral center to the hospital. This led to misunderstanding among stakeholders. In future the use of similar equipment for project implementation should be clearly defined.

VI. Appendixes