Government of Liberia, Ministry of Health and Social Welfare

CAPACITY BUILDING PLAN TO IMPLEMENT THE GUIDELINES FOR KINSHIP CARE, FOSTER CARE AND SUPPORTED INDEPENDENT LIVING IN LIBERIA

2014-2018

With support from

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DSW CAPACITY BUILDING PLAN

to Implement Guidelines for Children Without Appropriate Care

18 September 2014

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Acronyms

AC	Alternative Care
CHDD	Community Health Division Director
CHSWT	Country Health and Social Welfare Team
CWAC	Children Without Adequate Care
De-Plan	Deinstitutionalization of Children Program
DSW	Department of Social Welfare
EPSS	Essential Package of Social Services
GoL	Government of Liberia
LGSM	Liberia Grants and Solicitation Management
MoE	Ministry of Education
MoFED	Ministry of Finance and Economic Development
MoGCSP	Ministry of Gender, Children and Social Protection
MoGD	Ministry of Gender and Development
MoHSW	Ministry of Health and Social Welfare
MTEF	Medium Term Expenditure Framework
NCDS	National Capacity Development Strategy
NHSWPP	National Health and Social Welfare Policy and Plan
SWA	Social Welfare Assistant
SWS	Social Welfare Supervisor
UNDP	United Nations Development Program
WGC	Working Group on Capacity
WL	World Learning

I. Introduction

This capacity building plan (CBP) was developed to support the implementation of the Liberian Guidelines for Kinship Care, Foster Care and Supported Independent Living ("The Guidelines"), undertaken under the assignment of the Technical Assistance Consultancy for the Development of Alternative Care System for Children without Appropriate Care in Liberia. It builds upon the on-going effort by the Ministry of Health and Social Welfare (MoHSW), Department of Social Welfare (DSW) to strengthen its capacity to improve performance and provide quality social welfare services to people in need of care and support, including vulnerable children particularly children without appropriate care (CWAC).

The development of CBP started with a rapid context assessment[1] that looked at the environmental conditions to build the capacities of the DSW to implement the Guidelines. After the Guidelines have been drafted, a zero draft of the capacity set for the plan was drafted. The zero draft was discussed within the Working Group on Capacity[2] (WGC) and amendments were proposed and included into an improved version. After a final feedback from the WGC, the plan was finalized and adopted.

II. Capacity building as a virtuous process

Capacity building is understood as a process by which an institution expands and improves its knowledge, competencies and working procedures to enhance its performances and achieve its organizational goals. The process is meant to be virtuous in the sense that it has to be progressing, incremental, and improvement oriented. The process of building the capacities of the DSW to implement The Guidelines for CWAC is a cyclical one, meaning that it is an on-going and constant process involving a number of steps, with feedback mechanisms.

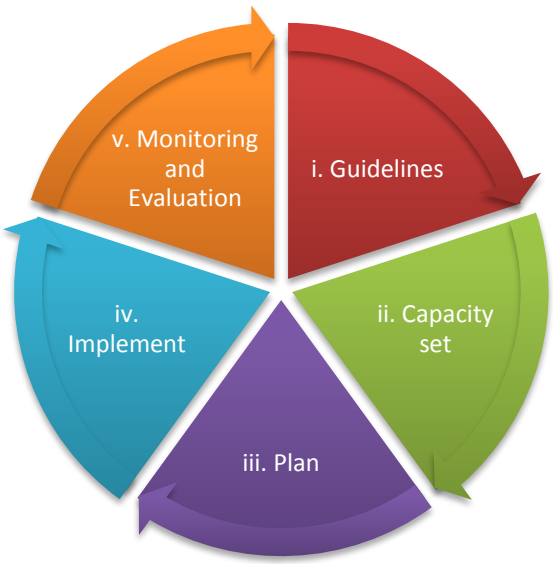

Figure 1: The capacity building virtuous process

The first step in the development of the DSW capacity plan was to identify the key strategies and activities spelled out in The Guidelines, and consequently, the second step, was defining the necessary and required capacities, aligned with the strategies and activities, that will constitute the full capacity set to be created. The third step was a planning process, where the interventions that will allow the DSW to build the capacity set have been defined, together with defining a number of key performance indicators that will allow the DSW to measure the progress in capacity development. The capacity plan will then have to be implemented,

[1] M. Cabran, Rapid context assessment to build the capacity of DSW to implement the guidelines for kinship care, foster care, and supported independent living, 2014

[2] The working group on capacity was created as a temporary group gathering capacity experts representatives from the CWAC Advisory Committee.

and regularly monitored and evaluated[3], in order to contribute to a review and improvement of The Guidelines, which will be possible thanks to a broader and more solid set of capacities available. If the capacity of DSW is strengthened, it is reasonable to expect that performance will improve with respect to the CWAC agenda, as well as the broader social welfare sector.

III. Which capacities to do what?

Capacities are defined as a set of skills, knowledge and competences, procedures and arrangements, required to perform specific functions at a satisfactory level (Cabran, 2014). They are put in place through a process which is called capacity building; the MoHSW and the Liberia Rebuilding Basic Health Services (RBHS) define it as the "process of workforce development, organizational (institutional) strengthening, and systems strengthening that enables the health sector to meet objectives and perform better, resulting in improved health outcomes for Liberia" (MoHSW, 2012). A similar definition is present also in the National Capacity Development Strategy 2012, "Capacity development is understood as a process through which individuals, organizations and society obtain, strengthen and maintain the capabilities to set and achieve their own development agenda" (Government of Liberia, 2011).

When it comes to building the capacities of an institution, it is essential to ask ourselves this question: "What is available and what is not, within the DSW, to make sure that the needs of children without appropriate care are met?" To answer this question, the United Nations Development Program (UNDP) framework[4] for capacity building has been helpful, reflected in the table 2 below specific to the Guidelines. The generic list of capacities has been contextualized to Liberia, made relevant to the DSW, and specific to alternative care for children without appropriate care.

	Which capacities?
Functional Capacities[5]	**Engage partners and build consensus** (e.g. identify, motivate and mobilize stakeholders; create partnerships and networks; promote the engagement of civil society, traditional representatives, faith-based groups and the private sector; manage open dialogue and mediate divergent interests; establish collaborative mechanisms); **Assess assets and needs** (access, gather, disaggregate, analyze and synthesize data and information; articulate capacity assets and needs; translate information into a vision and/or a mandate); **Formulate policies and programs** (explore different perspectives; set objectives; elaborate sectoral and cross-sectoral policies; manage mechanisms for prioritization); **Formulate, plan and manage projects and programs**, including budget preparation, costing of capacity development, setting indicators for monitoring progress. **Monitor and evaluate** (measure results and collect feedback to adjust policies; codify lessons and promote learning; ensure accountability to all relevant stakeholders; guarantee transparency at all steps of operations).
Technical capacities[6]	Promote **child participation** at all stages and at all level (develop child friendly material and procedures, include children's voice along all management's steps) **Best interest determinations** for children without adequate care (assess children's situations and make appropriate decisions considering aspirations, resources and environment characteristics) Provide, directly or indirectly, **adequate and quality services** for children (family mediation, tracing and reunification, psycho-social support, social protection, etc.) Improve knowledge and understanding of alternative care **definitions and concepts** (regarding legal aspects and social welfare processes and procedures) Promote **behavioral change**[7] to enhance family-based alternative care in communities

[3] See chapter VII for details of monitoring and evaluation.

[4] For more details, please see http://www.undp.org/content/undp/en/home/ourwork/capacitybuilding/overview.html

[5] Functional capacities are those necessary for the successful creation, management and review of policies, legislations, strategies and programs. UNDP, Capacity Assessment Methodology User's Guide, 2008

[6] Technical capacities are those associated with particular areas of professional expertise or knowledge, such as fiscal management, agriculture, education, etc. Technical capacities vary and are closely related to the sector or organizational context in focus. UNDP, Capacity Assessment Methodology User's Guide, 2008

Figure 2: List of capacities for The Guidelines

A capacity building plan requires, in principle, the definition of the objectives and results to be achieved. The Guidelines are not such a programmatic document; to bridge this aspect, the idea of the focus area has been introduce: a focus area is a dew point where sub-sets of capacities condensate in an organic way; they are:

i. Enhance coordination and expand partnership around CWAC
ii. Generate knowledge and manage information around CWAC
iii. Identify and support CWAC that might benefit from alternative care interventions

The CBP is intended to follow the Guideline, and as such discussion between the DSW and its partners revealed that the majority of the capacities are applicable across the care options – kinship care, foster care and supported independent living. All three are part of the same effort to expand the options of family based alternative care in Liberia. Many of their components included in the Guidelines, such as awareness raising and community mobilization, identification, reporting and general case management, are common to all three alternative care options and the areas where the capacity plan also has focus.

The three focus areas, coordination and partnerships, information and knowledge, and support and interventions, have been identified as the most efficient way to aggregate these crosscutting capacity aspects, without affecting the simplicity of the CBP structure.

Lastly, the Capacity Building Plan is aligned with the overall process of building the capacities of the DSW that started in 2013 with the Capacity Building Plan for the Ministry of Health and Social Welfare[8] that followed from the above-mentioned assessment.

IV. Levels of interventions and structure of the plan

The UNDP framework considers a set of technical and functional capacities, which are identified against the core issue, which is "to make the policy framework on alternative care operational"[9]. This plan spells out the capacity building interventions that are required at the individual, institutional and system levels. These three levels are aligned along a horizontal dimension (see Figure 3 below) which allows the capacity building practitioners to zoom-in and out from one level to the other. Each level should be considered with the other since each of them relies on the other for functioning. These levels, and their mutual relations, are shown in the following visual.

[7] Behavioral change can be defined as an intentional process by which individuals modify their conduct to comply with social or positive norms with a view of a possible benefit. Author's definition.

[8] Liberia Grants Solicitation and Management Program, Capacity Building Plan for the Liberian Ministry of Health and Social Welfare, Department of Social Welfare, 2013

[9] Liberian National Technical Assistance Consultancy for the Development of Alternative Care System for Children Without Appropriate Care (CWAC) in Liberia, Request for Applications, 2013

Figure 3: Horizontal levels of the CBP

Based on the discussions with the representatives from the CWAC Advisory Committee[10], the main focus of the plan should be at the system and institutional levels. The plan looks at the on-going interventions within the MoHSW regarding the adoption of performance management in the frame of the on-going reforms on the public finance management and civil service and the other development priorities as set in the Agenda for Transformation[11] and the National Capacity Building Strategy[12].

This CBP is also structured on a vertical dimension (see Figure 4 below); the plan follows the hierarchical structure of the DSW and its decentralized units, including the program responsible for CWAC, the Deinstitutionalization of Children Program (De-Plan) and the other Units[13]:

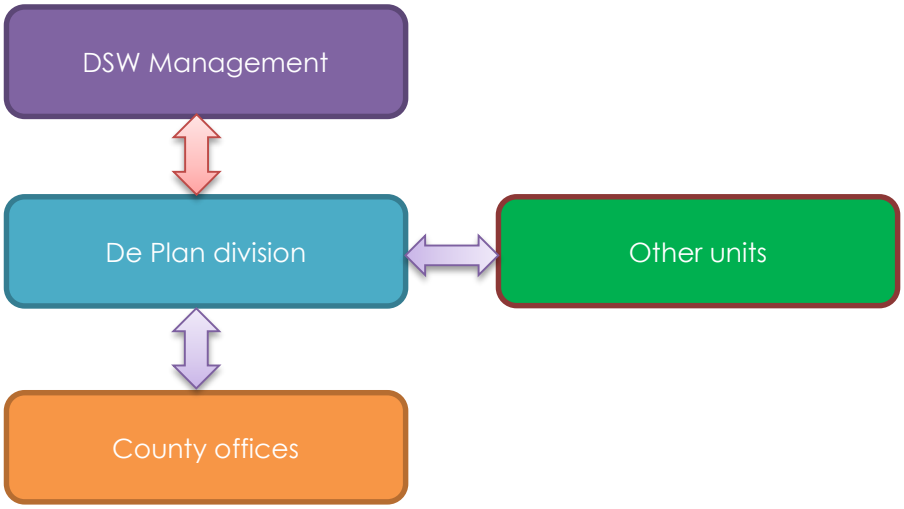

Figure 4: Vertical levels of the CBP

The vertical leveling of the CBP reflects the institutional architecture of the DSW and is functional to efficient management, coordination and reporting. In this sense, the DSW acts and behaves as a system, and as such, this means it is nested in other bigger systems (e.g. the overall MoHSW) and has smaller systems nested within it (e.g. county offices). This view makes it easier to replicate the process of capacity building planning at different levels and/or within the umbrella of different actors (e.g. considering the forthcoming creation

[10] Skype call on February 14th, 2014, and Webex call on February 27th, 2014.
[11] Government Of Liberia, Agenda For Transformation: Steps For Liberia Rising 2030, 2013
[12] Government of Liberia, National Capacity Building Strategy, 2011
[13] Community Welfare, Rehabilitation, Family Welfare, Institutional and Organizational Development.

of the Ministry of Gender, Children and Social Protection, which will absorb the functions of the Department of Social Welfare[14]).

The CBP does not address the capacity needs of all the actors that are or will be, involved in the alternative care of children without appropriate care. It focuses only on the capacity needs of the DSW. The main reason for this is that alternative care is still at a nascent stage, and there is still need to build buy-in from other actors; it was deemed important to start from the lead agency responsible for alternative care, although it is clear that this has implications for other stakeholders. This will require broad consultations, analysis and negotiations. This constraint has been addressed in the plan by putting full attention on the system level, which is where other stakeholders will be able to bridge their interventions in alternative care for children without appropriate care.

As Figure 5 presents, a comprehensive CBP for CWAC would require a look at the capacities of all involved actors at their institutional and individual levels, something not possible in the present initiative. The process adopted for DSW could be replicated in other areas by focusing the core of capacities at the system level. In this Figure 5 this level lies at the center and it is in common to all stakeholders. This will ensure that a systems approach be adopted and successfully implemented.

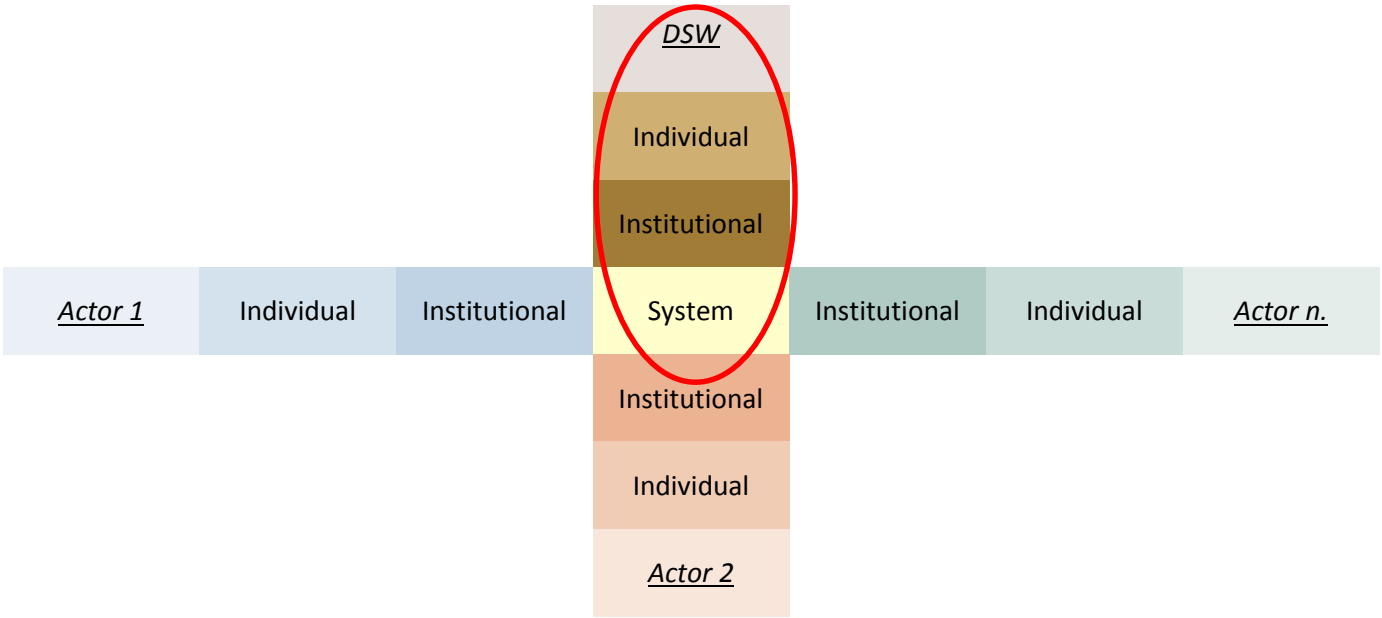

Figure 5: Capacity sets for each and all of the CWAC stakeholders

Such attention is revolving around the identification of key partners that play, or might play, a role in providing alternative care to children without appropriate care, such as line Ministries, (ministry of Education, Ministry of Justice, Ministry of Planning, Ministry of health), but also community leaders, traditional and religious authorities, health workers, teachers, policemen, and already existing structures such as the child welfare committees (CWCs) and the child placement committees (CPCs). Acknowledging that it might be premature, for the reasons articulated in the previous paragraph, to include their capacities in the plan without having gone through an assessment first, the present plan outlines what the DSWS can already do to strengthen other stakeholders' capacities. Once a broader range of stakeholders is involved, there will be the scope and opportunity to expand the capacities by including newcomers in a revised capacity building plan.

[14] See Governance Commission, An Act To Amend Chapter 38 Ministry Of Gender And Development, Of The Executive Law, To Establish The Ministry Of Gender, Children & Social Protection, 2013

V. Implementation of the plan

It is suggested that the CBP should be implemented in alignment and in the same timeframe as the "general" MoHSW capacity building plan (2014-2018). Given the absence of any indication about the amount of financial resources that will be put into the implementation of this plan, it is not possible to establish precise deadlines for each intervention; more, some are recurrent activities.

To address this, and to give indications of what should, or could, be implemented as soon as possible, a ranking exercise has been used to identify the top three priorities for each of the focus areas. The ranking exercise, conducted via an on-line survey, took into consideration two consequential criteria:

i. Which intervention is the most urgent because in its absence it will not be possible to work on other capacities? and
ii. What are the interventions that would require little (financial and human) resources to be implemented?

The results of the prioritization exercise, whose overall ranking are also reported in the plan table, follow:

Focus area	*Top three priorities*
Enhance coordination and expand partnership around CWAC	1. Coordinate the CWAC Advisory Committee to monitor activities for CWAC also outside its membership 2. Liaise with the Gender Coordinator in managing all practical aspects of coordination and partnerships at the county level 3. Coordinate the interventions for CWAC within the DSW through regular meeting with all the other directors
Generate knowledge and manage information	1. Collect information from the counties on coverage, outreach and impact of alternative care interventions and consolidate into a unique report 2. Report regularly to De-Plan on effectiveness and efficiency of serviced provision, by copying of what transmitted to CHDD 3. Persuade and influence cabinet and MPs to allocate more resources to MPs based on the base of evidence developed
Identify and support CWAC that might benefit from alternative care interventions	1. Develop a case management system, detailing steps for identification, standards for assessment and case plans, and informed by the principle of best interest determination, and the core principles for supporting CWAC 2. Identify and adapt services that are in the EPSS that are relevant for alternative care 3. Train SWS on the Guidelines, on case management and on monitoring of service providers

Figure 6: summary of top priorities interventions

For effective implementation of holistic alternative care services, it is critical that a wide range of stakeholders from various ministries, community-based mechanisms and civil society are brought into the capacity building discussions.

The Strengths, Weaknesses, Opportunities and Threats (SWOT) analysis (presented in Figure 7) that was undertaken during the rapid context assessment,[15] revealed that capacity building is a top priority in the national development agenda. The SWOT analysis contributed to the identification of positive and negative drivers of change (DoC) that can lead to the development of a theory of change for the process of capacity strengthening in the social welfare sector. The analysis also revealed the presence of a number of capacity

[15] M. Cabran, Rapid Assessment of the Capacity Context in Liberia, 2014

building opportunities already in place, which the DSW might benefit from when identifying potential partners to contribute to the capacity building interventions in the CBP.

	Helpful to achieve the objectives	**Harmful** to achieve the objectives
Internal origins (attributes of the organization)	**S**trengths • Capacity building legal environment is consistent and harmonized • DSW documents are fully aligned with the GoL priorities on decentralization and deconcentration • Staff in the DSW are committed and dedicated to their jobs • Good basic understanding of Social Welfare and Social Work • Solid understanding of the social reality, and specifically of the situation of CWAC	**W**eaknesses • Implementation of the decentralization • Deconcentration policies is challenged by a lack of funding, constraints in recruitment, weak strategic thinking, human resources management, and leadership • Lack of incentives and vertical mobility mechanisms • DSW struggle to translate the knowledge into practice for service provision • No consistent and continuous levels of investment in capacity building • DSW is a marginal part within the MoHSW in terms of the capacity strengthening initiatives • Poor human and financial resource investments and management for capacity building • Weak strategic vision on capacity building • No definition of which capacities are required to perform which Social Welfare functions • The capacity outcomes for the Social Welfare sector are not clearly defined. Few if no indicators detail the achievements of the capacity building interventions in the Social Welfare sector
External origins (attributes of the environment	**O**pportunities • Strong and harmonized normative framework for building and/or strengthening the capacities of civil servants • The GoL is putting considerable efforts in reforming the public sector by adjusting the institutional architecture, by improving Civil Service and by enhancing Public Financial Management and Performance Management Systems • GoL is investing considerably in strengthening the capacity set of its workforce • Several opportunities are already available to improve the provision of quality social welfare services while enhancing the ways it is managed to achieve its objectives	**T**hreats • The Social Welfare sector appears marginally in the normative framework • The Social Welfare sector seems overshadowed by the health sector and challenged by the nascent social protection sector • Broad Social Welfare governance issues • As a sector, Social Welfare is seen as fragmented, with social welfare interventions mainly split across MoHSW, MoGD, and NASSCORP Support from key development partners phasing out • Resource mobilization is nearly non-existent

Figure 7: SWOT analysis from rapid context assessment

VI. Capacity building plan

Focus Area	Level	Capacity building interventions	Responsible	Priority
1. Enhance coordination and expand partnership around CWAC	1.1. Syst.	1.1.1. Streamline preventive and protective services for CWAC in the programs of other social sectors' such as by MoGD, MoE, MoH, MoJ, MoIA	DSW Mgmt.	
		1.1.2. Expand the coverage and access to social services for CWAC to implement the CWAC guidelines providing services based on the EPSS through interagency agreements with CSOs, NGOs, FBOs, etc.		
		1.1.3. Formalize the CWAC Advisory Committee with clear membership, mandate and governance arrangements		
		1.1.4. Review the accreditation system of NGOs and CSOs with the MoP, to ensure the requirements meet the standards of quality for services for CWAC		
		1.1.5. Coordinate the CWAC Advisory Committee to monitor the implementation of the activities for CWAC	De-Plan	TOP
		1.1.6. Support the DSW management by providing the necessary technical information		
		1.1.7. Identify and mobilize stakeholders in the community Child Protection Network who might provide alternative care services	SWS	
		1.1.8. Coordinate the community Child Protection Network in planning and monitoring alternative care interventions at the county level		
		1.1.9. Liaise with the Gender Coordinator in managing all practical aspects of coordination and partnerships at the county level		TOP
	1.2. Inst.	1.2.1. Coordinate the interventions for CWAC within the DSW through regular meeting with all the directors	DSW Mgmt.	TOP
		1.2.2. Support the DSW management by providing the necessary technical information	De-Plan	

Focus Area	Level	Capacity building interventions	Responsible	Priority
		1.2.3. Work with the other directors within the DSW in ensuring the regular and quality provision of EPSS that fall under their responsibility and that could benefit the CWAC		
		1.2.4. Maintain a constant dialogue with SWS to make sure activities at the county level are progressing according to the plans		
		1.2.5. Conduct staff meetings with the social welfare assistants and the social workers, where present, to coordinate the implementation of interventions for CWAC	SWS	
	1.3. Ind.	1.3.1. Identify civil society, community, private sector, UN and government partners who have comparative advantages to move forward the guidelines for CWAC	DSW Mgmt.	
		1.3.2. Persuade and influence government and private sector partners in investing in CWAC		
		1.3.3. Effectively communicate content of the Guidelines and long term vision for alternative care to other decision makers in the Government		
		1.3.4. Lead and supervise the social welfare staff in moving forward alternative care options for CWAC	De-Plan	
		1.3.5. Analyze the coordination mechanisms to draw lessons learnt and improve the practice of the CWAC Advisory Committee		
		1.3.6. Collaborate with local civil society and community-based partners in planning interventions for CWAC and monitoring progress	SWS	
		1.3.7. Network with community leaders, traditional authorities, teachers, health workers, law enforcement officials to establish safety nets for CWAC		
2. Generate knowledge and manage information	2.1. Syst.	2.1.1. Utilize the quantitative and qualitative information generated by the De-Plan and with data gathered at the county level to inform policy development and orient budget allocations and expenditures	DSW Mgmt.	

Focus Area	Level	Capacity building interventions	Responsible	Priority
		2.1.2. Monitor, award and/or penalize NGOs and CSOs providing social services to CWAC, based on the standards developed with the MoP		
		2.1.3. Develop a system to track the expenditures for the provision of alternative care services to CWAC in partnership with the Ministry of Economic Affairs		
		2.1.4. Collect information from the counties on coverage, outreach and impact of alternative care interventions and consolidate into a unique report	De Plan	TOP
		2.1.5. Report regularly to De-Plan on effectiveness and efficiency of serviced provision, by copying of what transmitted to CHDD	SWS	TOP
		2.1.6. Collect data on coverage and outreach and results of alternative care interventions implemented in the county		
	2.2. Inst.	2.2.1. Report to the Minister and to Cabinet on the achievements, lessons learnt and challenges in implementing alternative care	DSW Mgmt.	
		2.2.2. Provide feedback to the SWS on the regular reports submitted to the CHDD, which the De-Plan is copied to	De-Plan	
		2.2.3. Aggregate the information from the counties and develop a national report on CWAC		
		2.2.4. Develop a format for SWS for standard report focusing on activities implemented and results achieved at the county level		
		2.2.5. Collect reports on contribution of social welfare contribution to the provision of services for CWAC at the county level	SWS	
	2.3. Ind.	2.3.1. Persuade and influence cabinet and MPs to allocate more resources to MPs based on the base of evidence developed	DSW Mgmt.	TOP
		2.3.2. Analyze the information collected by SWS on coverage of activities, results for children and utilization of resources	De-Plan	

Focus Area	Level	Capacity building interventions	Responsible	Priority
		2.3.3. Communicate the situation of CWAC through dissemination material to management and other directors		
		2.3.4. Collect data and transmit it to De-Plan with simple tables on Microsoft Word or Excel	SWS	
3. Identify and support CWAC that might benefit from alternative care interventions	3.1. Syst.	3.1.1. Strengthen the regulatory and normative framework by defining what is appropriate care, by developing standards of quality for service provision, aligned with the EPSS and based on life-cycle approach and on developmental milestones, with particular provisions for children with special needs	DSW Mgmt.	Low
		3.1.2. Develop a case management system, detailing steps for identification, standards for assessment and case plans, and informed by the principle of best interest determination, and the core principles for supporting CWAC		TOP
		3.1.3. Based on the information collected at the county level on the availability of eligible service providers, develop a referral mechanisms for effective service delivery		
		3.1.4. Develop guidelines for CWC and CPC on establishing and conducting family group conferencing, mediation and alternative dispute resolution		
		3.1.5. Standard Operational Procedures for CWC, chiefs, local leaders and authorities, teachers, and policemen to identify and report children who are in kinship care and at risk of harm or violence		
		3.1.6. Accountability mechanisms that include at least: complaint mechanisms for failure in providing services, client satisfaction surveys, transparency in mission and vision		
		3.1.7. Develop programmatic framework to introduce and pilot PBF for CWAC[16]		

[16] This capacity building intervention is borrowed from the DSW Capacity Building Plan, LGSM, 2013

Focus Area	Level	Capacity building interventions	Responsible	Priority
		3.1.8. Identify and adapt services that are in the EPSS that are relevant for alternative care	De-Plan	TOP
		3.1.9. Provide the SWS with advice in cases where decisions might result difficult to be made		
		3.1.10. Train SWS on the Guidelines, on case management and on monitoring of service providers		TOP
		3.1.11. Train local child welfare committees, social welfare assistants, social welfare workers, chiefs, community-based structures and civil society to better understand how that they can support and monitor children in all forms of alternative care, as well as increasing awareness on the Guidelines	SWS	
		3.1.12. Make home visits to households with new alternative care arrangements, and to families where there are child protection concerns, to monitor the wellbeing of children		
		3.1.13. Develop and disseminate community sensitization and awareness raising messages on alternative care and adapt them to the specific contexts		
		3.1.14. Manage the cases of CWAC, by conducting risks and needs assessment for children, make/support decisions on alternative placement based on the best interest of the child, developing case plans for each child, monitoring regular access to quality social welfare resources, health services, education, legal, financial, psycho-social and other supports as necessary		
		3.1.15. Support families with children in alternative care identified during community mobilization and without appropriate care and requiring some external support		
	3.2. Inst.	3.2.1. Review job descriptions of DSW staff and establish an appraisal mechanism to measure the performance in implementing the CWAC guidelines	DSW Mgmt.	

Focus Area	Level	Capacity building interventions	Responsible	Priority
		3.2.2. Supervise the director of the De-Plan in the implementation of alternative care		
		3.2.3. Supervise SWS at the decentralized level that are implementing or supervising community sensitization and community mobilization	De-Plan	
		3.2.4. Train SWS on alternative care procedures, resource management, and supervision of other staff deployed at the local level		
		3.2.5. Provide feedback to SWS on their regular reports on adherence to the national format and on quality of content, suggesting ways to improve it, including peers support		
		3.2.6. Develop and manage budget and procurement plans for service provision for children on alternative care	SWS	
		3.2.7. Implement PBF guidelines in managing interventions for alternative care services		
		3.2.8. Supervise the SWA, SWs (where presents) in the implementation and monitoring of community sensitization and awareness raising interventions		
		3.2.9. Report to De-Plan on effectiveness and efficiency of service provided at the county level		
	3.3. Ind.	3.3.1. Communicate the results achieved for CWAC to other policy makers to make a stronger case for CWAC	DSW Mgmt.	
		3.3.2. Formulate strategies to support the SWS in achieving their results in providing appropriate care for CWAC	De-Plan	
		3.3.3. Analyze the appropriateness of the EPSS for the needs of CWAC		
		3.3.4. Supervise and support the SWS in their tasks of implementing and monitoring services for CWAC		
		3.3.5. Plan and organize interventions for CWAC covering the continuum of	SWS	

Focus Area	Level	Capacity building interventions	Responsible	Priority
		activities from prevention to response		
		3.3.6. Ensure that results of ensuring appropriate care to CWAC are achieved		
		3.3.7. Communicate effectively, and in a manner fitting to their characteristics and level of comprehension, to children and their families		
		3.3.8. Undertake case management as outlined in Guidelines for each case of CWAC requiring formal interventions		

VII. Monitoring and evaluation (M&E)

It is essential to be able to demonstrate how, and how much, the actions of building capacities translate into improved, more efficient and effective performance. For this purpose a simple monitoring and evaluation framework has been developed. Based on the content of The Guidelines and the focus areas of the CBP, this M&E framework has identified context-specific indicators, benchmarks and standards for some of the capacities that are deemed as more effective in the demonstrating progresses in building the capacity of the DSW. They are defined as follows:

- *Indicators* – are distinct verifiable measures that track the performance of child protection governance systems. Indicators can refer to inputs, processes, outputs or outcomes;
- *Benchmarks* – are sets of related indicators that provide for meaningful, accurate and systematic comparisons regarding the performance of an institutional system or institutional sub-system at the same time. These can also be termed *Indices*;
- *Standards* – are sets of related benchmarks, indices or indicators that provide socially meaningful information regarding outputs or outcomes of distinct aspects of the governance system or sub-system.[17]

Different indicators can be identified for each capacity, and multiple benchmarks can be identified for each indicator. Considering the nascent state of alternative care for CWAC, and the capacities constraints of the DSW, the number of indicators has been limited to nine, each with one benchmark. This is to take into consideration that the higher the number of indicators and benchmarks, the more cumbersome data collection and analysis will be. Similarly, given the limited practice and the almost non-existent evidence of current levels of performance, the standards in this framework are based on common sense of what might reasonable, as discussed internally within the CWAC Advisory Committee and the members of the technical working group on the capacity building plan. Standards will need to be reviewed at the beginning of the implementation of the CBP and then regularly based on the new information produced along the implementation and monitoring of the CBP.

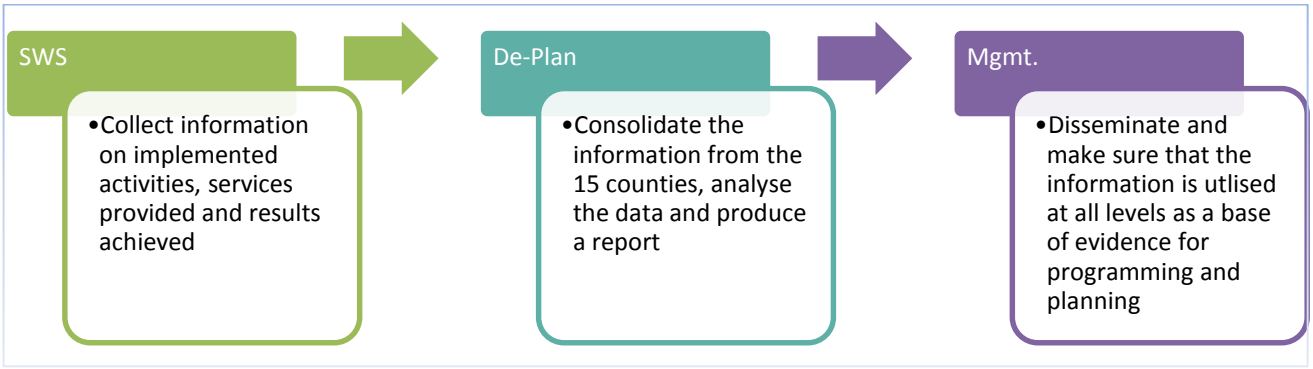

Figure 8: Main responsibilities and functioning of the M&E framework

This M&E plan will require monthly data collection; it will necessitate specific forms, as indicated in the capacity building plan; and people will need to be trained on their specific roles.

[17] Source: Monitoring and Measuring Child Protection Systems, UNICEF East Asia and the Pacific Regional Office, 2012 available at www.unicef.org/eapro/Measuring_and_monitoring.pdf

Focus area	Indicator	Benchmark	Standards
Enhance coordination and expand partnership around CWAC	Stakeholder's attendance on committees (CWC, CPC, CWAC Advisory Committee, etc.)	Percentage of the members of the committee attending the meeting	< 25% 26%<50% 51%<75% >76%
	Committees' secretariat activeness	Time required to circulate meetings' minutes to members of the committee	Within 2 working days Between 3 and 5 working days Between 6 and 10 working days 11 working days or more
	CWC coverage	Share of population covered by one CWC	More than 250,000 people Between 200,000 and 249,999 Between 150,00 and 199,999 Less than 149,999
Generate knowledge and manage information	DSW internal reporting	Number of monthly reports submitted in a year by SWS to De-Plan that met the requirements	3 or less Between 4 and 7 Between 8 and 11 12
	CWAC situation analysis	Number of counties providing quantitative and qualitative information on CWAC	3 or less Between 4 and 8 Between 9 and 13 14-15
	Implementing partners reporting	Share of registered and accredited implementing partners submitting adequate and timely activity and	< 25% 26%<50%

Focus area	Indicator	Benchmark	Standards
		result report	51%<75%
			>76%
Identify and support CWAC that might benefit from alternative care interventions	Community mobilization	Share of families assessed and eligible to foster one or more children per population	1:50,000 or less
			Between 1:50,001 and 1:100,000
			Between 1:100,001 and 1:150,000
			1:150,001 or more
	Foster care	Share of all children less than 15 years leaving residential care for a foster care placement, in a 12 month period	1:2
			1:3
			1:4
			1:5
	Kinship care	Ratio of children in kinship care identified in need of supported whose assessment confirmed such need	10% or less
			Between 11% and 30%
			Between 31% and 60 %
			61% or more
	Family support services	Time lapse between a case is reported to CWC and its first meeting to discuss the case	2 days or less
			Between 3 and 5 days
			Between 6 and 10 days
			11 days or more
	Independent Supported Living	Share of children reaching adulthood that successfully benefitted from ISL	10% or less
			Between 11% and 30%
			Between 31% and 60 %
			61% or more

Focus area	Indicator	Benchmark	Standards
	Budget allocation	Amount of Government budget allocated to services per children in foster care	5 USD or less 6-10 USD 11-15 USD 15 USD or more

VIII. Conclusions

Building the capacity of civil servants is clearly a top priority for the Government of Liberia, and at the core of the Agenda for Transformation. The DSW has acknowledged this and aligned his future programming in this direction. The implementation of the Guidelines will require adequate capacities, with feedback mechanisms to expand the knowledge of alternative care and improve the performance of kinship care, foster care and supported independent living.

The DSW remains committed in ensuring appropriate protection of the most marginalized and at risk children. This capacity building plan constitutes another step towards the strengthening of social welfare services for vulnerable populations in Liberia. Investing in the professional development of civil servants and other Government's partners, will guarantee that its staff will have the knowledge, competencies and working procedures necessary to provide an adequate level welfare, whatever the Ministry mandated with social welfare responsibility.