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Ebola Community Action Platform II
Funded by USAID/ Office of Foreign Disaster Assistance
Fiscal Year (FY) 2015 Quarter 4 Report
July 11 – September 30, 2015

(Photo redacted)

Project Summary:

Award Number:
AID-OFDA-A-15-00033
Start Date: July 11, 2015
End Date: July 10, 2016
Report Date: October 30, 2015
Total Award: \$12,000,000

I. Program Overview

The Ebola Virus Disease (EVD) hit West Africa in March 2014, turning into an epidemic that reached 28,457 total cases confirmed with 11,312 lives lost in the West Africa region by October 4, 2015. Early October marked the first week with no new cases of the disease in the region since the beginning of the epidemic. Although cases continue to surface in Guinea and Sierra Leone and Liberia experienced a small outbreak of the disease in June and July of 2015, the affected countries are beginning to turn their attention to the work of strengthening systems to prevent future outbreaks.

The Ebola Community Action Platform (ECAP) 2 program is a follow-on to the successful Office of Foreign Disaster Assistance (OFDA)-funded ECAP program, which enhanced awareness and uptake of behaviors that reduced EVD transmission across Liberia. ECAP 1 used a sub-granting methodology to establish partnerships with local and international NGOs, who then spread health messages to local communities. Drawing on lessons learned from ECAP 1 and responding to the evolving context in Liberia, ECAP 2 strives to support civil society organizations and community structures to build preparedness at the grassroots level against a possible future outbreak of EVD and other diseases with similar symptoms.

II. Quarter Executive Summary

ECAP 2 has met all of its work plan objectives for the first quarter of program implementation. For the reporting period of July through September 2015, which represents the startup period of the program, ECAP 2 has: conducted a Request for Application (RFA) process to support partner selection; met with pre-approved partners to discuss field research; conducted trainings for partners; met with various stakeholders; and designed monitoring and evaluation (M&E) tools.

Award-Level Beneficiaries¹

Cumulative Period Targeted		Reporting Period Reached		Cumulative Period Reached	
Total	IDP	Total	IDP	Total	IDP
1,500,000	N/A	N/A	N/A	N/A	N/A

Sector-Level Beneficiaries

SECTOR: HEALTH					
Cumulative Period Targeted		Reporting Period Reached		Cumulative Period Reached	
Total	IDP	Total	IDP	Total	IDP
1,500,000	N/A	N/A	N/A	N/A	N/A

¹ Because work this quarter concentrated primarily on program startup activities, indicator and beneficiary information is not yet available.

SECTOR: HUMANITARIAN COORDINATION AND INFORMATION MANAGEMENT					
Cumulative Period Targeted		Reporting Period Reached		Cumulative Period Reached	
Total	IDP	Total	IDP	Total	IDP
1,500,000	N/A	N/A	N/A	N/A	N/A

Indicators

SECTOR: HEALTH			
INDICATORS	TARGET	PROGRESS (FY2015 Q4)	TOTAL PROGRESS
SUBSECTOR: Health Systems and Clinical Support			
# and percent of Community Health Committees (CHCs) operating at a functional level	TBD	N/A	N/A
# and percentage of CHCs engaged in the government health system	TBD	N/A	N/A
SUBSECTOR: Community Health Education and Behavior Change			
# and percentage of communities that have developed Community Health Risk Reduction Plans (CHRRPs)	1,500	N/A	N/A
# and percentage of community members utilizing target health education and message practices	TBD	N/A	N/A
SECTOR: HUMANITARIAN COORDINATION AND INFORMATION MANAGEMENT			
INDICATORS	TARGET	PROGRESS (FY2015 Q4)	TOTAL PROGRESS
SUBSECTOR: Coordination			
# of humanitarian programs actively coordinating	20-30	N/A	N/A
# of humanitarian organizations actively participating in the Inter-Agency coordination mechanisms (e.g., Humanitarian Country Team, clusters, etc.)	20-30	N/A	N/A
SUBSECTOR: Information Management			
# and percentage of humanitarian organizations directly contributing to information products (e.g., situation reports, 3W/4W, digital tools)	20-30	N/A	N/A
# and percentage of humanitarian organizations utilizing information management services	20-30	N/A	N/A
# of products made available by information management services that are accessed by clients	3 reports and 2 conference presentations	N/A	N/A

III. Security Context and Situation Overview

After a short outbreak of Ebola in June and July, the country was declared Ebola-free once more on September 3, 2015. In the region, Guinea and Sierra Leone have experienced a decrease in EVD cases. According to the World Health Organization (WHO) *Ebola Situation Report*, there were four confirmed cases of EVD reported on September 27, all in Guinea. Case incidence has remained below 10 cases per week since the end of July this year. Over the same period, transmission of the virus has been geographically confined to several small areas in western Guinea and Sierra Leone.

During the quarter under review, no major security concerns reported in the country that would affect the operation of the ECAP 2 program.

IV. Program Activities

During the quarter under review, ECAP 2 activities focused primarily on program startup, and all work plan objectives were met. The program addresses four main areas to achieve its goals and objectives. Following is a summary of program activities by area of focus.

1. Civil Society Engagement

In this program area, Mercy Corps is working once more through civil society to ensure a broad reach throughout the country and build the capacity of local organizations to prevent and respond to potential future health emergencies. Additionally, Mercy Corps and its partner network will coordinate and collaborate closely with other organizations and agencies to harmonize interventions and take advantage of program synergies.

To support this program area, partnerships with twenty-five ECAP 2 sub-awardees were solidified over the course of the quarter, through both a non-competitive process and a competitive process.

The six partners approved through a non-competitive process all successfully implemented aspects of the original ECAP 1 program, and thus were pre-selected in order to enable field work to commence in a timely fashion. For the two technical partners, Population Services International (PSI) and International Research and Exchanges Board (IREX), this accelerated startup gave them time to get set up for their work. PSI and IREX will be responsible for the rollout of activities at the national level. IREX will focus on supporting media professionals and radio stations to disseminate health messaging in all 15 counties of Liberia, while PSI will provide technical support to the Ministry of Health, serve as a resource to community health organizations and workers, and roll out training on behavior change communication.

For Mercy Corps and the four preselected implementing partners - Community Health Education and Social Services (CHESS-Liberia), the Lutheran Church in Liberia (LCL), Women's Campaign International (WCI) and the Young Men's Christian Association (YMCA Liberia) - the early start provided an opportunity to commence research and learning activities right away. This will benefit the partners subsequently selected through the competitive process. These implementing partners focused their field work/research on the functionality of community health services, preparedness and accessibility of health catchment areas, the reception of the program by community health officials, activities of other implementing organizations, if any. In a round table discussion, the findings were discussed, early possible challenges identified and recommendations made to the implementing partner

network to help with their field work. As we anticipated, there are some insufficiencies at clinics in terms of drugs, staffing and hours of operation. In many areas, clinics are overwhelmed by the number of people they are to serve. Only one partner had to re-select their catchment area because of work of another agency, but for the remainder there was no overlap. The health catchment area findings are presented in the “strengthening of community level health structures” section of this report.

Partners selected through the competitive process responded to a Request for Applications (RFA) issued by Mercy Corps. Mercy Corps received and reviewed 140 applications from the RFA. An Independent Application Selection Committee was established, comprised of two senior officials from the Ministry of Health (MoH), Johns Hopkins University and the International Medical Corps (IMC). The committee used an application scoring methodology based on Mercy Corps’ best practices worldwide, and determined that 32 applications were eligible for consideration. Of these, 19 were selected, and a pre-award financial responsibility assessment was conducted for each of them. These partners will be responsible for strengthening community health structures and linking them to the MoH community health services structures and increasing public awareness on EVD and other preventable illnesses with high morbidity and mortality rates.

During the quarter under review, Mercy Corps also began to establish and strengthen existing linkages with a range of actors whose insight during the program startup phase is essential for successful implementation, and whose involvement will support enhanced program impact and sustainability. On the national level, Mercy Corps met with various Ministry of Health (MoH) officials to introduce ECAP 2 and deepen collaboration with them, especially the Community Health Services and Health Promotion divisions. A meeting was also conducted with the Chief of Chiefs to gain his support and endorsement of ECAP 2 with all the town chiefs throughout the country.

Partners also had discussions with county, district and local-level health officials to gain support for the program and better understand the functionality of community health services on the ground. In general, because partners have good community relationships, there were no problems networking with health officials. Following these discussions, Mercy Corps distributed tents donated by USAID through PAE to the county health teams, to help improve their facilities where they best see fit.

Throughout its implementation, ECAP 2 will strive to build the capacity of its implementing partners, a process which has already begun. To make sure that partners understand their responsibilities in grants management, Mercy Corps conducted a two-day finance and compliance training for all partner finance managers and officers. It also delivered a week-long, off-site program workshop for all partners. The workshop opened with presentations from the Director of the MoH Community Health Services Department and the Deputy Director of the MoH Health Promotion area, who spoke about the principles behind the MoH community health strategy, and presented basic facts on public health issues in Liberia. Other sessions covered the ECAP 2 program strategy, lessons learned from ECAP 1, community entry strategies, incorporating gender concerns into programming, and behavior change communication, among other topics. The workshop provided representatives from partner organizations the opportunity to ask questions and network with one another.

2. Creation of Health Information Systems

This part of the program is designed to provide timely, quality information to facilitate data-based decision making for MoH, partners and communities. This program component requires a great deal of set-up and training, but progress has been made. In particular, over the course of the quarter, the anticipated online health learning system was established using CommCare. It has been set up as both a data collection application and also an online learning platform, with learning modules and quizzes included. This online health learning system enables partner managers and Mercy Corps to track data and learning

3. Strengthening of Community Level Health Structures

Liberia's decentralized community health system starts at the village level through voluntary, participatory groups, called Community Health Committees (CHCs), which monitor community health and promote sound health practices. These groups are the links into the MoH community health structure most often exemplified by a clinic that serves a set number of communities, called a catchment area. ECAP 2 will work with all of the communities in a catchment area to facilitate either the creation or strengthening of the CHCs so that trust is rebuilt in the country's health system and that they serve and act as early warning sentinels of major disease outbreaks, particularly EVD.

Initial field research by our pre-approved partners on potential catchment areas in their respective counties centered on the existence or not and functionality of CHCs and other community health groups/activities, and found that very few CHCs are functioning. Another community structure that is meant to be the collective representing all communities in a catchment area is the Community Health Development Committee (CHDC); these are also not functional. Furthermore, in some areas the CHDCs exist but not CHCs, which has created confusion among both health professionals at the local level and communities about what the community health structures are. The county, district and local health officials are uniformly positive about ECAP 2 and see the opportunity for help getting the community health structures organized and functioning.

4. Increase Public Awareness

When work commences with the CHCs, members will be trained on delivering community-level behavior change campaigns. This program component is designed to support the uptake of healthy behaviors and continued vigilance against EVD and to build trust in the health system. To support this objective, during the quarter under review Mercy Corps' technical partners began designing training modules and materials.

PSI, along with Mercy Corps' health advisor, worked with the Health Promotion division of the MoH on the message campaign that will be broadcast using various communication channels that is in effect throughout the period of ECAP 2's implementation. With support from Mercy Corps, PSI has also put together a training manual for the partners' Community Support Officers (CSOs) to train CHC members (training of trainers for sustainability) using the Listen, Learn, Act adult learning methodology that was effective in ECAP 1. In addition, a simple chart of diseases with Ebola-like symptoms was developed for CHC training. This simple chart will also help community members identify prevalent diseases in their communities and prepare CHCs to develop a Community Health Risk Reduction Plan (CHRRP)

Community radio trainers have been hired by IREX and introduced to all partners to ensure that partners teach their CSOs about how to access community radio to support their work. CSOs will then disseminate this information to their CHCs. These trainers will also work with community radio stations to help them develop programming and original content to support the goals and objectives of ECAP 2. Community radio is a primary source of information for most people in the country, and it is planned that 750,000 people will be reached by these community radio stations to build public awareness and knowledge.

V. Monitoring and Evaluation

The program's M&E tools have been designed and include the 'Community Registration' participatory process, the monthly 'CHC Functionality Reports' and the health focused baseline survey. The qualitative research strategy has also been developed along with various research guides and reporting tools. The first research activity will take place in November 2015. Finally, the M&E Capacity Building modules for partners have been finalized. These modules focus on four topics: preparing qualitative research tools, data analysis on Excel, data management and using data to inform program direction.

VI. Challenges

The main challenges encountered by ECAP 2 this quarter include:

- 1) ECAP 2 continues to work through a network of local and international organizations for implementation. While this achieves the objective of building Liberia's civil society capacity in emergency response, it is a challenge to build capacity in the network because the organizations are at different levels of development. A "buddy system" may be introduced to pair partners to enhance peer learning, but more time is needed to determine how it will work. The partners indicated at the workshop that they support this idea. Training also has to be targeted to the mid-level with ECAP 2 support staff providing more support to lower-capacity partners. Partners also have different strengths and weaknesses, but Mercy Corps' ECAP 2 staff will calibrate their efforts to provide the appropriate support each partner requires.
- 2) The initial investigation of the community health context by ECAP 2 partners revealed that many of the community structures the program will work with are either dormant or nonexistent. Many of the clinics are also poorly equipped and lack sufficient staff, so linkages into the MoH's community health services may be difficult to sustain. We had anticipated that this would be the case and have decided with the partners to build on any local groups addressing health in their communities as part of community entry and acceptance. The minister in charge of planning at the MoH advised us to work with these groups because she thinks that they are in most communities.
- 3) Communication infrastructure remains weak, but through the lessons learned from ECAP 1, we have attempted to improve the way data is collected (tablets v. smart phones), as well as access to and understanding of analyzed data and batching results when there is connectivity.
- 4) During the rainy season the roads in remote areas become impassable. The program start-up in November with major activities through May will be in the dry season, which will improve accessibility.

VII. Conclusions

The program is off to a good start with no real surprises. We have a strong, committed network of partners supported by a capable ECAP 2 team. We have learned from ECAP 1 and adapted and will continue to learn and adapt for ECAP 2.

VIII. Next Quarter Activities

The next quarter will be devoted to the full implementation of the plan. We will be involved with more training and start monitoring partner activities and capacity. The baseline data will be collected and submitted to USAID, the first research studies will be conducted and the learning system will be implemented and debugged. The selection of health catchment areas will be finalized and work with the CHCs will be in fully implemented: assessing, training, meeting, building linkages and knowledge. Behavior change, radio and mass media campaigns will start and the first Lessons Learned conference will be held.