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Ebola Community Action Platform II
Funded by USAID/ Office of Foreign Disaster Assistance
Fiscal Year (FY) 2016 Quarter 2 Report
January 1 – March 31, 2016



CHC members do community campaigns in Margibi County. Photo credit: Laura Keenan for Mercy Corps

Project Summary:

Award Number:
AID-OFDA-A-15-00033
Start Date: July 11, 2015
End Date: July 10, 2016
Report Date: January-March
31, 2016
Total Award: \$12,000,000

I. Program Overview

The Ebola Virus Disease (EVD) hit West Africa in March 2014, turning into an epidemic that has reached 28,616 total confirmed cases with 11,310 lives lost in the West Africa region by April 10, 2016. Although the epidemic is officially over, Ebola remains a threat to the region, evidenced by recurrent emergences of the virus in the three affected countries.

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 2 again employs a sub-granting methodology to establish partnerships with local and international NGOs and media outlets, who then implement the program throughout the country. Drawing on lessons learned from the first ECAP program and responding to the evolving context in Liberia, ECAP 2 strives to support civil society organizations, local media and community structures to build preparedness at the grassroots level against a possible future outbreak of EVD and other diseases with similar symptoms.

Quarter Executive Summary

During the third quarter ECAP 2 is on track with its work plan objectives to meet or exceed program deliverables. For the reporting period of January through March 2016, ECAP 2's implementing partners worked in over 1,600 communities with a cumulative population of 899,357 beneficiaries, to strengthen Community Health Committees (CHC). The primary focus during this quarter was on:

- CHC members were trained and mentored on their roles and responsibilities.
- CHC outreach activities for community residents were facilitated.
- CHC understanding and uptake of effective communication methods were reinforced.
- CHCs were supported to establish mutually respectful and accountable relationships with clinics and health professionals.
- PSI delivered its last phase of training on disease preventive behaviors.
- Civil society was linked to media to maximize the reach of our health campaigns through mass media outreach.
- ECAP 2's Subaward & Compliance technical staff worked with partners to build their capacity in financial management and grant compliance and reviewed partners' financial operations.
- The Monitoring Evaluation Research Learning (MERL) team continued gathering data for use in the learning system, conducted in-depth research studies and monitored program implementation and reporting.
- The Partner Support team worked with partners to monitor program implementation and mentor partners' community engagement efforts, as needed.
- The program's Communication Specialist mentored partners on media outreach and developed program information, feedback and promotion materials targeted for diverse audiences and stakeholders.

- ECAP 2's Health Advisor attended all MoH Health Promotion and Incidence Management System (IMS) meetings, and developed the Community Health Risk Reduction Plan (CHRRP) and its roll-out to implementing partners. T
- The ECAP program continues to coordinate, collaborate and provide direct program feedback about health issues and concerns to the MoH directors, and acts as an information and communication conduit/facilitator for the Platform, the communities, the MoH and other public health actors.

Also of note, during the reporting period, an EVD outbreak occurred in Guinea near the border with Liberia, resulting in 5 deaths and 10 suspected cases. At the request of Liberia's Ministry of Health, ECAP 2 initiated a limited 30-day emergency response along Liberia's border with Guinea on March 24. Deploying five community radio stations and two ECAP 2 implementing partner organizations, this emergency response is designed to: 1) broadcast Ebola prevention and surveillance messaging and conduct radio talk shows in the border region; and 2) visit the most vulnerable border communities and mobilize them to heighten surveillance and preventive behaviors.

Through ECAP 2, attention continues to be focused on strengthening health systems to minimize the impact of future outbreaks. The new EVD cases make it clear that people still need to understand the necessity for practicing EVD prevention. Compared to the response to the EVD cases in Liberia last quarter, the Government of Liberia (GoL) has mobilized more quickly and effectively. In addition, for this outbreak response, the Ministry of Health (MoH) called upon ECAP 2 civil society partners to be key responders. This is a solid indication of the change in GoL attitudes about the important role Liberian civil society can play in engaging citizens, collaborating with government structures and building bridges and linkages between citizens and those institutions that serve them.

Award-Level Beneficiaries

Cumulative Period Targeted		Reporting Period Reached		Cumulative Period Reached	
Total	IDP	Total	IDP	Total	IDP
1,500,000 (750,000 by CHCs/750,000 by mass media)	N/A	1,867,477 ¹	N/A	1,867,477	N/A

Sector-Level Beneficiaries

SECTOR: HEALTH		
Cumulative Period Targeted	Reporting Period Reached	Cumulative Period Reached

¹ 899,357 indirect beneficiaries calculated on basis of population of target communities. There were 287,123 (53% female, 47% male) direct beneficiaries (number of attendees at specific events) at the end of this quarter.

Total	IDP	Total	IDP	Total	IDP
1,500,000 (750,000 CHC; 750,000 mass media)	N/A	899,357 ²	N/A	899,357	N/A
SECTOR: HUMANITARIAN COORDINATION AND INFORMATION MANAGEMENT					
Cumulative Period Targeted		Reporting Period Reached		Cumulative Period Reached	
Total	IDP	Total	IDP	Total	IDP
750,000	N/A	899,357 ³	N/A	899,357	N/A

² Ibid.

³ Ibid.

Indicators

SECTOR: HEALTH			
INDICATORS	TARGET	PROGRESS (FY2016 Q2)	TOTAL PROGRESS
SUBSECTOR: Health Systems and Clinical Support			
# and percent of Community Health Committees (CHCs) operating at a functional level	1,500	1,524 (102%)	1,524 (102%)
# and percentage of CHCs engaged in the government health system	1,500	1,270 (85%)	1,270 (85%)
SUBSECTOR: Community Health Education and Behavior Change			
# and percentage of communities that have developed Community Health Risk Reduction Plans (CHRRPs)	1,500	0	0 ⁴
# and percentage of community members utilizing target health education and message practices	65%	51% of individuals surveyed (baseline)	51% of individuals surveyed (baseline)
SECTOR: HUMANITARIAN COORDINATION AND INFORMATION MANAGEMENT			
INDICATORS	TARGET	PROGRESS (FY2015 Q4)	TOTAL PROGRESS
SUBSECTOR: Coordination			
# of humanitarian programs actively coordinating	20-30	25	25
# of humanitarian organizations actively participating in the Inter-Agency coordination mechanisms (e.g., Humanitarian Country Team, clusters, etc.)	20-30	25	25
SUBSECTOR: Information Management			
# and percentage of humanitarian organizations directly contributing to information products (e.g., situation reports, 3W/4W, digital tools)	20-30	23 (100%)	23 (100%)
# and percentage of humanitarian organizations utilizing information management services	20-30	23 (100%)	23 (100%)
# of products made available by information management services that are accessed by clients	3 reports and 2 conference presentations	2	2

II. Security Context and Situation Overview

In March, an Ebola outbreak occurred in Guinea near the Liberian border in Nimba County. Because of the outbreak, the MoH activated its response system and Mercy Corps was specifically asked to respond in the three counties bordering Guinea with community mobilization to reinforce EVD prevention and surveillance messaging. As a result, Mercy Corps coordinated a 30-day emergency response effort

⁴ Mercy Corps will report on this indicator next quarter.

through ECAP 2 and deployed the two NGO implementing partners and 5 radio stations in the Guinea border counties, Bong and Nimba, to reach the most at-risk communities with EVD awareness campaigns. Immediately following these efforts, there was an EVD outbreak in Montserrado County, Liberia. This outbreak occurred when a woman reportedly left Guinea for Liberia and subsequently died of EVD in Monrovia. Two of her children have EVD and are being treated at the ELWA Ebola Treatment Unit in suburban Monrovia. The emergency response this time, while more complicated when compared to the cases in late December 2015, appears better organized across the Ministry and partners.

These outbreaks underscore the importance of continued vigilance for suspected cases and long-term adoption of Ebola preventive behaviors. Health experts believe outbreaks may be correlated to persistence of the virus among Ebola Survivors, which would indicate sustained risks over the months ahead. According to the latest World Health Organization (WHO) situation report, the “virus present in the blood of one of the confirmed cases is closely related to the virus that circulated in southeastern Guinea in 2014.” The number of EVD survivors in West Africa is likely to be underreported and public health officials expect EVD outbreaks to occasionally appear over the next months or years as the epidemic winds down.

In addition to recurrent Ebola cases, ECAP 2’s implementing partners have continued to report ritual killings in some areas of the country and have taken precautions, including working with traditional leaders to enlist their help in protecting staff in remote areas, particularly females. The partners have, for the most part, conquered their travel problems left over from a severe rainy season and been resourceful in remitting program data, despite the ongoing struggle with poor internet connectivity. Presently, there are no major security concerns that would affect the operation of the ECAP 2 program.

III. Program Activities

During the quarter under review, ECAP 2 activities focused primarily on the implementation of field activities, with partner and staff fully trained and deployed to achieve program objectives. Overall, the program is on track to meet or exceed its targets. Following is a summary of program activities by area of focus.

1. Civil Society Engagement

“We will work with the communities and the CHCs to achieve the maximum. There is lot we can do as a group if we form a strong advocacy force; we can pressure the MOH and development partners to improve on drugs delivery and other services, and further support CHCs.”

Patience Flomo, Executive Director, AfroMed

In this program area, Mercy Corps is working with civil society organizations to ensure 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 are coordinating and collaborating with each other, the community health structure and professional staff, government and traditional society representatives, as well as with public health organizations and agencies to harmonize interventions and take advantage of program synergies.

The ECAP 2 implementing network is comprised of 23 NGOs, 22 of which are Liberian. The focus of this component of the program is two-fold: 1) mentor partner leadership and management in effective communication with high level MoH and government officials, appropriate advocacy on issues important to beneficiaries, productive mass media engagement and overall good governance; and 2) train partner staff in technical areas of finance and compliance, monitoring and evaluation and community engagement.

During this quarter, the focus for our network partners was effective community engagement and coordination with district and regional health structures to ensure understanding, support and cooperation so that linkages are built throughout the levels of the health system and feedback loops established/reinforced to respond to people's health issues and needs. For example, when clinic staff are not adhering to and/or are violating the community health policy (clinics rationing health care, clinics not open, health staff charging fees for free services and emphasizing general problems with the drug supply chain), partners have advocated at a higher level to resolve problems. The partners were also encouraged to find out about the activities/programs of other implementing agencies in their respective areas and where appropriate facilitate/advocate for services for their catchment communities. An example of this linkage is that the partner in River Gee County contacted Water Aid about broken water pumps; subsequently the pumps were fixed and the community members were taught how to maintain them.

ECAP 2 has had a positive impact on elevating the role of Liberia's civil society. A significant example of the role of civil society is that for the first time the MoH included several of them to participate in the drafting of the new Community Services Health policy. In this draft policy, there is a new section where civil society is called upon to participate in community engagement in health promotion campaigns, disease surveillance and monitoring the health system to ensure that it is appropriately serving the health needs of communities. In addition, many organizations in ECAP's network have been approached by other agencies to partner with them on various community-level projects. The director of community health services at the Ministry of Health has acknowledged the impact of ECAP's successes on the thinking of the Ministry of Health in including civil society in the new policy.

In technical areas of capacity building, the Mercy Corps team worked with partners to improve their financial management. The team advised partner finance staff on proper record keeping, how to conduct cash operations safely, the fundamentals of procurement and the proper role of a finance department. Intensive subaward and compliance monitoring was undertaken during the quarter to make sure the partners were in compliance with their subawards and allocating expenses appropriately to their grant.

During the quarter under review, the MERL team also worked with partner M&E officers to increase their capacity on data management and data analysis. In data management, the main topics of training were: data collection, data quality assurance and application of data management on Excel. For data analysis, the topics covered were: basic statistics, data interpretation and how to present data visually (graphs). The MERL team also introduced the concept of adaptive management to the M&E partner staff to help them understand what their data was telling them about the results from program implementation. The team was also on call to provide partners with technical assistance.

ECAP 2's second Lessons Learned Workshop was held at the beginning of March. The focus of this session was to emphasize field work and learnings from field staff to connect partners who were

creatively implementing the program and solving challenges in the field. One particular area of focus was how to overcome aid dependency and fatigue. Partners who were approaching this problem successfully counseled those who were struggling with the issue. The key to addressing aid dependency successfully is an approach that views people as agents of their own development. This approach is exemplified by first listening to what people have to say, encouraging them to find their own solutions (digging wells and pit latrines, cleaning around communities, planting cash crops to support CHC activities) Another key issue discussed was CHC sustainability when the program ends. Some compelling ideas for successful exit were: ensuring strong linkages to the clinic/health professionals; encouraging revenue generation ideas to support CHC activities; and reinforcing the understanding and practice of effective message delivery and the importance of continuous monitoring of the uptake of healthy behaviors.

Technical Partner Roles

The program's two technical partners, PSI and IREX, are responsible for providing technical training and support in behavior change communications and mass media engagement, respectively. PSI and Mercy Corps attend MoH health promotion meetings and support the Director of Health Promotion by serving as key members of the Ebola-specific Message and Materials Development (MMD) Committee and providing advisory services as requested. PSI, the technical advisor on health issues for ECAP 2, also contributes to the program by providing cascade-type training to the implementing partners' 389 Community Support Officers (CSO), who in turn train CHC members on how to effectively communicate MoH-approved messages to their communities.



CHCs working with WONGOSOL demonstrate the importance of dead body testing to protect against Ebola. Photo credit: Laura Keenan for Mercy Corps

IREX led the mass media component of the ECAP 2 program by developing innovative and targeted content creation for 30 media partners (27 community radio stations and three Monrovia-based) to deliver Ebola prevention information in all 15 Liberian counties. The content is designed to support efforts to

stop EVD transmission by promoting positive behavior change. As noted, the IREX subgrant ends on May 31, 2016, but all radio contracts and personnel contracts matured on March 31, 2016 in order to give IREX time for program close-out of its subgrant.

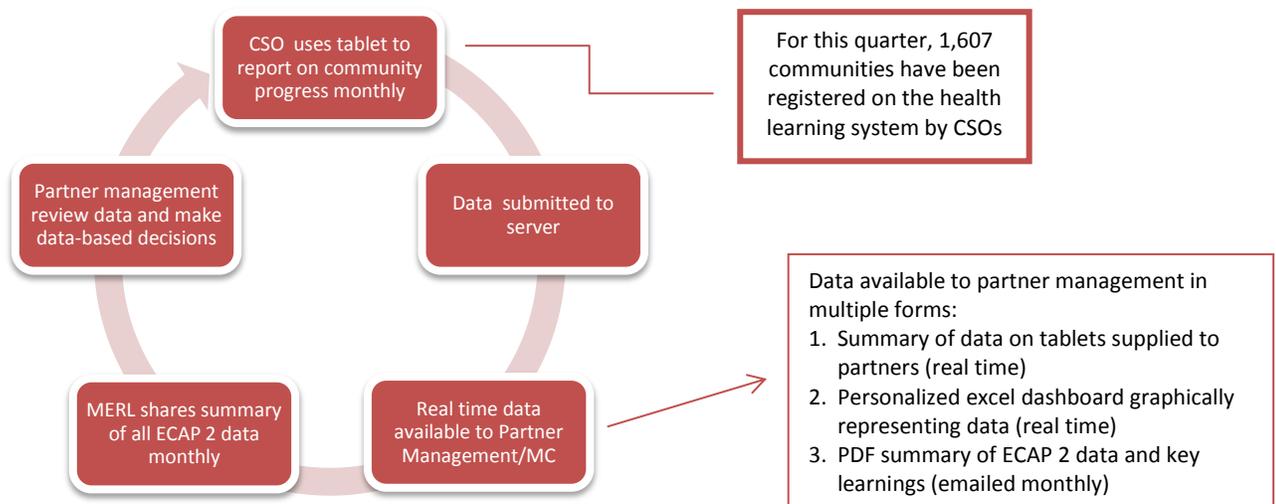
2. Creation of Health Learning Systems

During this quarter, the health learning system was fully operational and partner field staff and M&E officers were using it to document information on community health, health facilities, CHC functionality and the activities of CSOs. All data collected by CSOs and M&E staff is submitted on tablets allowing for real time response and accurate data collection.

During the quarter, the system captured topics discussed at CHC and clinic meetings (e.g., malaria, diarrhea, access to safe drinking water) and this information was used to report back to the MoH. The system also informed partner and Mercy Corps program management about the functionality of the CHCs and progress on accomplishment of program objectives and targets. Some data collected and monitored includes:

- Frequency of CHC meetings
- Number of people reached by ECAP 2 health messaging
- Topics covered at outreach events
- Participation in meetings with the clinics
- Challenges of program implementation (bad roads, aid dependency, distance to clinics, clinic responsiveness to community health needs)

Mercy Corps' Monitoring, Evaluation, Research and Learning (MERL) team has been active to ensure the health learning system has functioning feedback loops between Mercy Corps and all partners. The diagram below outlines how the learning system enables data flow within the ECAP 2 network.



The learning system has also been supporting partners to re-train and refresh CSO memories on their roles and responsibilities through the various digital learning modules available to CSOs on the tablets.

An SMS-based platform (short code 3227) has also been established to enable community members and partner staff across all the counties to feedback directly (and free of charge) to Mercy Corps on health or accountability issues, which supports rapid identification and response on the ground.

3. *Strengthening of Community Level Health Structures*

"Through the Community Health Committee we have been able to take charge of our health. Ourselves we used to be afraid of the clinic. Now the clinic people know me good. We go to the meetings at the clinic and raise our concerns, and the staff there take good care of you when you are sick."

- Abraham, CHC member from Gbanjala Community, Cape Mount County on how the CHC is helping link to clinics and health services after Ebola.

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 works with all of the communities in a selected catchment area and partners have focused on CHC functionality and linking them with the community health structure. The purpose of this program component is to establish mutually respectful and accountable relationships so that trust in the country's health system is restored and that communities serve and act as early warning sentinels of major disease outbreaks, particularly EVD.

During the quarter under review, partner field teams and management were active in their respective catchment communities, (re)establishing CHCs and working with them on a weekly basis to reinforce their roles and responsibilities as the primary link to the public health system. The CHCs are tasked with representing community health needs and advocating for the health services that their community members require. On the health system side of the relationship, the CHCs are the conduit by which the clinics understand the health issues and needs of communities so that they can better and more effectively serve them.



Community members map health priorities as part of the CHRRP process

A major program initiative is the Community Health Risk Reduction Plan (CHRRP) which is undertaken by the CHCs and "owned" by the community. The primary objective of the CHRRP is to help communities go beyond Ebola awareness and transmission prevention to take practical steps to protect themselves from diseases with high morbidity and mortality

rates. By the end of the quarter, over 1,000 CHRRPs had been completed.

A notable success of the program is that CHCs are discussing broad health issues, determining what they can do to stay healthier and then acting on risk reduction measures.

Partner field staff, Community Support Officers (CSOs), were trained by PSI to cascade their learnings about effective communication to CHC members. The Listen, Learn, Act! adult learning methodology is designed so that CHC members can adopt it to effectively communicate health promotion and disease prevention messages that result in the uptake of healthy behaviors. By the end of this quarter, many CHCs learned how to conduct drama shows at market events, and reach out to the media and radio stations so that the health messages were more widespread and exciting. In total, CHC outreach activities directly reached 287,123 people.

Partners and CSOs were encouraged to discover ways of empowering community groups so that they stand on their own and realize the value of leading their residents to have healthier and more productive lives. According to the Director of Community Health Services, people need to take their health “into their own hands,” but how to wean people away from handouts and dependence has been a challenge for partners in communities that suffer from aid/relief fatigue. Figuring out how to meet this challenge has resulted in one of the most valuable exchanges of the ECAP network: innovative ideas and approaches that motivate communities through a sense of self-value and pride. Incentive payments were deliberately excluded from the design of the ECAP 2 program in the belief that it lays the ground for unsustainability and undermines the agency of the beneficiary. The awakening to this idea has been spreading over the network, aided by Mercy Corps’ approach and the creativity of some partner leaders and staff.



CHCs in this catchment area in Cape Mount have self-mobilized to construct a maternal waiting room for pregnant women coming from distant areas. Photo credit: Laura Keenan for Mercy Corps

During the quarter, ECAP 2 facilitated linkages with government health programming. Each partner has encouraged the attendance of CHC representatives to monthly Community Health Development Committee (CHDC) meetings with the health officials at their clinics. In addition, the partners are required to attend monthly County Health Team (CHT) meetings in order to support the linkage between communities and their clinics and help the health structures function according to Liberia's Community Health Services policy. With push and pull at the different levels of the health system and the engagement of CHCs, ECAP has been instrumental in making the MoH's policy reality. Communities

are receiving the benefit of improved information from the health system as the health system in turn knows how to better serve the community.

Relationships of mutual trust and accountability have been put in place, which aids in the sustainability of the program's impact. In addition, the Mercy Corps Health Advisor reports findings from the field to the MoH at the national level, capturing both successes

Quick numbers for January - March

Number of CHCs that held a meeting: 1,524 (102%)

Number of CHCs engaged with CHDC: 1,270 (85%)

Average number of CHC meetings per community: 3

Average number of members in a CHC: 9 people

and lapses in clinic services and prevalent diseases.

During the report period, ECAP 2 partners worked with approximately 1,600 communities served by 166 health facilities for program implementation. By the end of March 2016, there were 11,554 CHC members. Of this, 44% were females. By the end of March, 1,524 CHCs met the definition for being functional (meetings with quorums). ECAP 2 program design requires CSOs to meet weekly with their assigned CHCs and thus far, despite often bad road conditions, the CSOs have managed to meet, on average, three times a month with their CHCs to support them and monitor their progress. Additionally, 1,270 CHCs are engaging with the health system through attending CHDC meetings. At these meetings, members discuss community health issues and challenges they have with the health system. This data is being collected and summarized for the Director of Community Health Services and the local/regional health teams to identify issues and facilitate solutions.

"For the first time in five years we are having the opportunity to interact with our [clinic] to discuss and find solutions to our health problems. Our people have been suffering and dying from bad sicknesses with nobody to really hear us and help, but at last we are happy that you people have been teaching us on how to help our community and making to meet with the OIC and explain some of the problems."

CHC Chairman, Jaytoken Community, River Gee County

This quarter saw many community clean-up campaigns and the repair of paths and simple bridges to facilitate travel to and from the clinics. In addition, due to re-established relationships with clinics, CHCs engaged in building fences around clinics, participating in constructing waiting areas for patients, clearing debris/grass away from the premises, providing housing for OICs in the community, and one particularly ambitious CHC is constructing a new clinic because current clinic distances are deemed to be too far away. While some reports indicate continuing problems (clinic hours, staff behavior and drug shortages), other information from the field reveals that clinics, CHTs, OICs and other health staff welcome community involvement and are trying to implement changes such as more clinicians, mobile

health services to better serve their catchment areas



CHC members fence their water pump in this border community in Cape Mount to improve hygiene and sanitation and protect against diseases. Photo credit: Laura Keenan for Mercy Corps

Partners continue to report that ECAP 2 is not only a welcome program from the community's perspective, but also is viewed as an important intervention by health professionals, community leaders and local government representatives. ECAP 2 has met or exceeded almost all of its targets and just as importantly, has had a positive impact on community health. All implementing partners have reported good working relationships with government, traditional leaders and community residents.

4. Increase Public Awareness

"I have been working with the clinic to promote use of clinics and to encourage baby mothers and fathers to take their children to the clinic for vaccines. We have been going out to the community and we see lots of people tuning into the radio. They appreciate the information they are getting to improve their health. They hear us talking to their own people, getting the voices of affected people, and this has an impact."

George, Station Manager for Radio Totota, Bong County

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. During the quarter, partners and communities engaged with community radio stations in talk shows and radio dramas. In addition, CHCs continued to deliver health messages door-to-door and developed public dramas held on market days at public markets to encourage people to use the clinics when sick, not to handle dead bodies and to vaccinate their children. Partners and clinics are reporting a significant increase in demand for health services at the

clinics and Mercy Corps' Health Advisor is working closely with the MoH to identify bottle necks, capacity limits, staff shortages and professional knowledge/behavior problems, and inadequate drug supplies to name some of the more pressing concerns. ECAP 2 messaging has been successful in creating demand for using the clinics, but capacity issues at the clinics remain a concern shared by partners, CHCs and the MoH.



Large crowds attend 'Everybody Business' forums organized in partnership with community radio stations. Photo credit: National Empowerment Program

IREX leads the media component of the ECAP 2 program, and has worked to enable increased partnerships, improved coordination among ECAP stakeholders, innovative and targeted content creation among media partners, and information dissemination to Liberian citizens in all 15 counties to increase awareness of Ebola and other diseases, and promote positive behavior change. The 27 community radio partners produced original targeted content, including jingles, talk shows, radio dramas, SMS Opinion Poll questions and Everybody's Business forums. This content was designed to ensure that Liberian citizens have access to accurate and up-to-date information to help them keep themselves and their families safe from Ebola and other diseases. Community radio trainers were provided with training so that they could access community radio to support their work. Community radio is a primary source of information for most people in the country, and over 900,000 listeners heard ECAP 2 health messages.

In response to the EVD cases in this quarter, Mercy Corps contracted five community radio stations to broadcast EVD transmission prevention messages. These messages include: hand washing at the appropriate times; reporting deaths and not touching dead bodies; and reassurance that taking preventive measures can stop the transmission of EVD. All five stations are conducting talk shows for the general public and some are targeting various audiences such as market women and school children. Security, school, political and border officials plus traditional chiefs have been talk show guests addressing people

along the border in their local languages and dialects. The two ECAP 2 implementing partners in Nimba and Bong counties, CHESS Liberia and the Lutheran Development Service, were contracted to provide on-the-ground emergency response. They coordinated with the MoH to select the most vulnerable border communities. Through these efforts, our partners have mobilized 77 border communities by meeting with health and border security officials for occasional joint outreach events, holding town hall meetings, facilitating community group discussions, supporting public awareness events such as drama performances with other actors, visiting individual homes, distributing anti-EVD flyers and posters, handing out hand washing materials when necessary and participating in media outreach. The term of the contracts are from March 24, 2016 to April 25, 2016.

IV. Monitoring and Evaluation

During this quarter, the MERL team identified areas of success and programmatic areas which need more attention for follow-up. The MERL team issued bi-monthly updates as functionality reports, adjusting questions and content to reflect the progression through the program and the challenges and accomplishments arising from ECAP 2 catchment communities. These updates have been reflected in an updated ECAP 2 dashboard for each individual partner, allowing partner management to use the most recently collected information.

The MERL team has supplemented digital data collection with in-depth field monitoring, augmenting and complementing the monitoring done by the program's Partner Support officers and Subaward & Compliance experts. This monitoring enabled the verification of data, resulting in more accurate measurement of program performance.

A qualitative research study on the factors affecting CHC success was done across two counties in Liberia. Key findings on what makes a difference:

- Effective facilitation by partner field staff on a weekly basis
- Communities that are nearer to clinics are more closely linked with the community health system
- Community members were directly involved in the selection of CHC members
- Inclusion of community leaders in CHC membership

The MERL team, in conjunction with partner M&E staff and IREX, completed a national quantitative study on community radio listenership. The study represents the first time the impact of community radio at the national level has been measured. This study confirmed that radio is the primary source of information for Liberians country-wide. This is true across all dimensions: gender, literacy, geography and urban/rural. An important finding is that 70% of people surveyed preferred and trusted community radio over national broadcasting stations because they were interested in local stories in their own vernacular. The study revealed that over 900,000 people have been reached with ECAP 2 messages, exceeding the 750,000 target.

V. 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 capability to respond to emergencies and be considered at the policy level, it is a challenge to build capacity in the network because the organizations are at different levels of development. We have connected some partners to directly speak to each other, but the "buddy system" was never rolled out because of the short period of time to implement this ambitious program. However, in counties where there are multiple implementing partners, they have held joint conferences to share learnings. The Lessons Learned Workshop (LLW) remains the most time-effective method for the entire network to share learnings. Increased monitoring by the Mercy Corps MERL team and the findings have improved the management of partners.
- 2) There is still a challenge with meeting the government engagement target because there are problems of organizing and attending CHDC meetings. Both the community and the OICs are having difficulties attending these meetings because of transportation costs. Partners are focused on overcoming this challenge so that at the very least relationships are established for the future and the CHCs and the health structure understand their respective roles and responsibilities. The partners are working with district and regional health structures to enlist their support in enforcing CHDC meetings and the CSOs are encouraging CHC attendance at these monthly meetings.
- 3) The challenge of low-capacity and -resourced community health structures has been highlighted in all quarterly reports. Many of the clinics are understaffed and poorly equipped, so linkages into the MoH's community health services may be difficult to sustain. We have seen some innovative ideas at the clinic level to address these problems, but there is no systemic mitigation plan at the MoH at this time. Mercy Corps will work closely with the MoH and other public health actors to present and share findings and innovations in the field to help Liberia's health system respond to community needs.
- 4) Communication infrastructure remains weak, but through the lessons learned from the first ECAP program like batching data and downloading it at internet connected sites, 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. At the final ECAP workshop, NGO leaders identified a need for more M&E capacity building. To meet this request and develop the program's ambitious health learning system component, Mercy Corps has required each partner to employ a dedicated M&E professional who is involved in helping field staff understand the importance and necessity for quality, on-time data submissions. M&E staff have also received intensive training in data analysis and integrity to better enable data to be used by implementing partner management to improve program implementation.

VI. Conclusions

ECAP 2 is an ambitious and complex early recovery program. Cumulative results indicate that the program is essentially being delivered as planned, targets are being met and impact is being achieved. The civil society implementation approach, while challenging to manage, has had positive yields above program targets. It has influenced the MoH and policy makers, it has influenced the way future approaches are being considered by the international community and most importantly it has instilled

pride and confidence in Liberian organizations and communities, with 1,600 Community Health Committees meeting regularly, and reaching nearly 1.9 million people, or 48% of the population.

VII. Next Quarter Activities

The next quarter will be devoted to final field implementation of the program. This includes completion of the CHRRP, monitoring CHC implementation of their risk reduction plans, ensuring relationships are established between CHCs and the clinics, distributing MoH-approved health reference materials for each CHC, conducting the final LLW, closing out subawards, finalizing and publishing research studies and contracting for an external program evaluation.

List of Annexes:

- I. Photos of Partner Activities**

- II. Stories from the Field**

- III. National Radio Reach Survey**

- IV. CHRRP Guideline**

- V. ECAP 2 Update in Numbers**

Annex 1
ECAP 2 Program Activities
Photos from Jan-March 2016



Vast community parades raise awareness in Margibi County. Photo credit: Laura Keenan for Mercy Corps



The Radio Bomi Team organize an 'Everybody Business' Forum in Bomi County focusing on 'Trust and Use of Clinics.' Photo credit: Laura Keenan for Mercy Corps



Community members participate in the dramas by giving health advice to the characters. Photo credit: Laura Keenan for Mercy Corps



Buckets and campaign materials are clearly evidenced in ECAP 2 communities in Bomi. Photo credit: Laura Keenan for Mercy Corps



Community Support Officers have trained close to 1,600 CHCs on health messages and CHC roles and responsibilities. Photo credit: Laura Keenan for Mercy Corps



ECAP 2 partners use a range of approaches to share health information including music, drama and cultural performances. Photo credit: Laura Keenan for Mercy Corps



Community dramas in local dialects draw in the crowds at busy market places, as in this border town in Grand Cape Mount. Photo credit: Laura Keenan for Mercy Corps



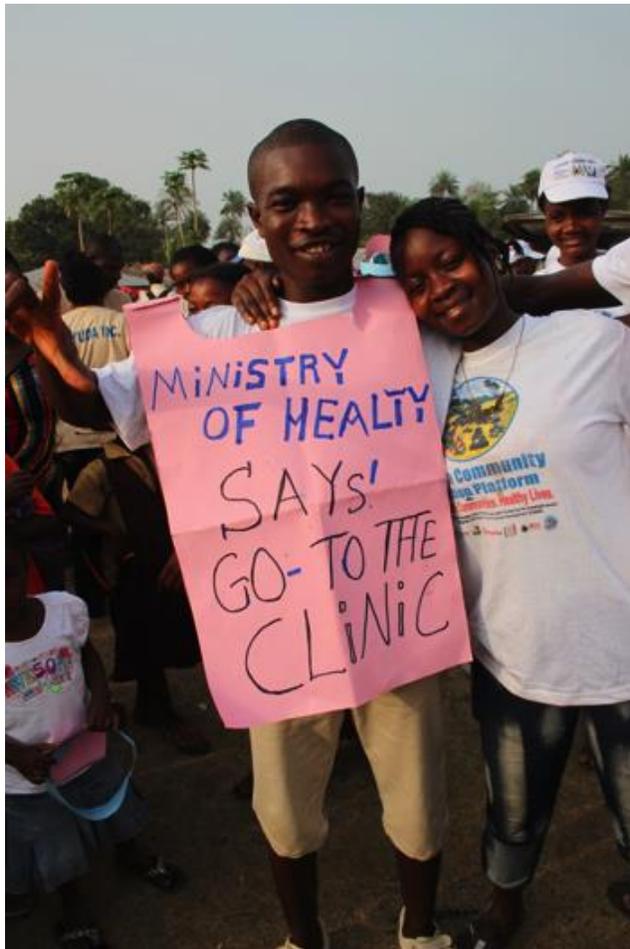
Drama sessions demonstrate the ongoing importance of Ebola vigilance measures in Grand Cape Mount County. Photo credit: Laura Keenan for Mercy Corps



Power to the people - ECAP community events have mobilized thousands of people around Liberia. Photo credit: Laura Keenan for Mercy Corps



ECAP 2 radio campaigns reached 970,000 people. Photo credit: IREX Liberia



ECAP 2 health campaigns helped build trust in clinics. Photo credit: Laura Keenan for Mercy Corps



SAIL CSOs mobilise CHC members in rural Margibi. Photo credit: Laura Keenan for Mercy Corps



Clinic visitations have significantly increased as a result of ECAP 2 campaigns. Photo credit: NMCL



Clean up campaigns are taking place across the country to improve community sanitation. Photo credit: NMCL



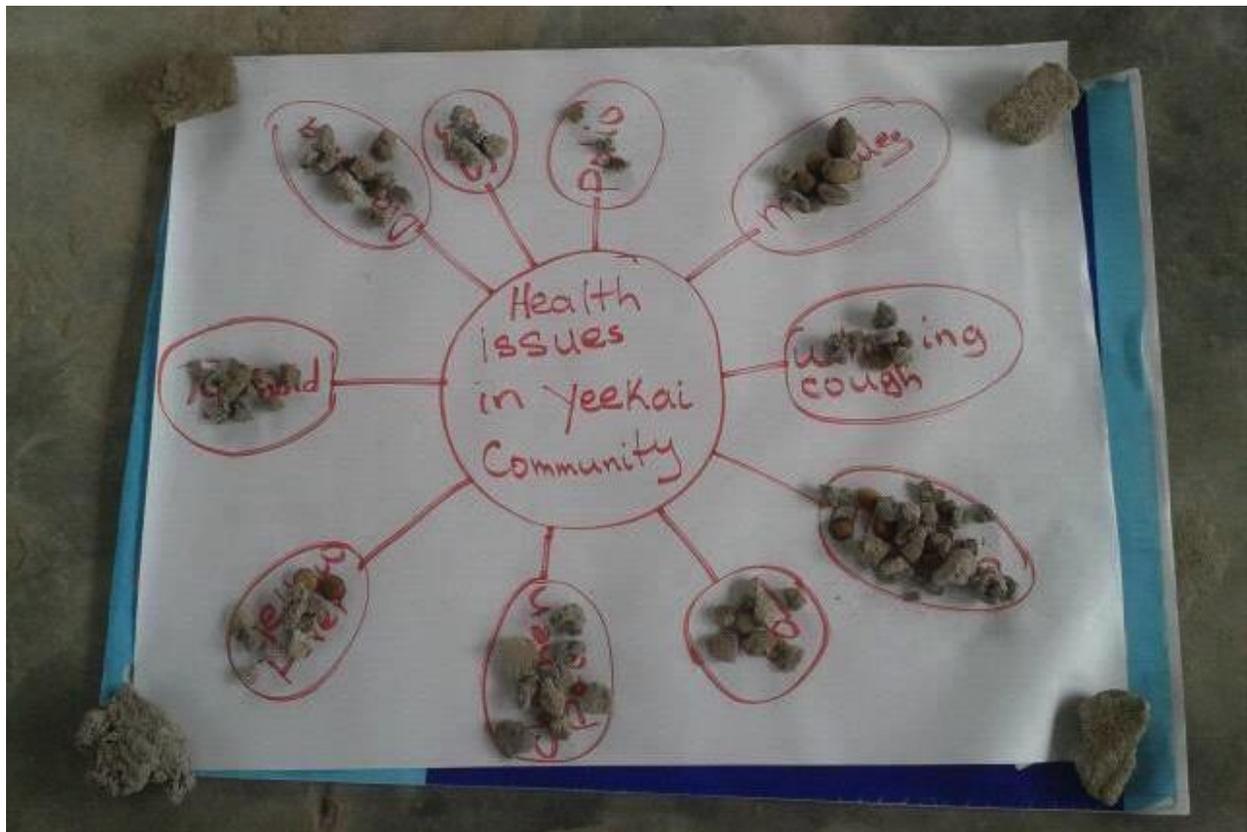
Communities take the initiative to build latrines in key areas to improve sanitation and disease prevention. Photo credit: NMCL



Community Health Development Committee meetings have helped link communities to clinics. Photo credit: NMCL



Mapping health priorities for the Community Health Risk Reduction Plan in New Cotton Tree. Photo credit: Daikor Darwolor



Prioritising health issues as part of the CHRRP process in Yeekai Community. Photo credit: Weseh Fullah



Communities have self-organised to built pit latrines in Montserrado County and reed hand-washing stations. Photo credit: Afromed

ANNEX II
Stories from the Field

Feature story: Harnessing the Power of Radio

Case study: Improving Sanitation in Old Banjor

Testimonial: Trust and Use the Clinics



FEATURE STORY

Harnessing the Power of Radio in Times of Crisis

Following Liberia's devastating civil war, two organisations, Mercy Corps and IREX, helped establish and strengthen many community radio stations across the country. After the crisis these were flagship projects, aiming to give communities greater voice in development and peacebuilding processes.

Many of these stations again partnered with the two organizations under the Ebola Community Action Platform (ECAP), funded by USAID, which has been Liberia's largest consortium of organizations working on the Ebola response.

Building trust through community radio partnerships

At the start of the Ebola outbreak in Liberia, there was significant suspicion and mistrust of Government health information. Myths and conspiracy theories abounded, with many denying the existence of Ebola.

Aid workers were blamed for bringing the virus to Liberia; treatment units were feared as sources of transmission and many hid their sick and their dead from the authorities, which contributed to the rapid spread of the disease. It was a terrifying time across the country.

To rapidly build trust, the ECAP program partnered with known local organizations, so that messages and information from the Ministry of Health could be better shared and received within communities. This included partnerships with 27 community radio stations, which produced and aired dramas, talk-shows and jingles relating to Ebola.

Localizing content increases legitimacy of health information

This localized approach proved critical to turn the tide of the virus, and bring communities onboard with Ebola preventive practices and treatment. It has also strengthened the capacity of local media to share critical public health information.

"In the past partners typically produced messages in the capital and we simply aired those messages. The unique thing about ECAP was that it allowed community radio partners to air and produce our own content, in our own languages, and communities themselves were involved in its production," says Zinnah Cassel, Station Manager of Radio Bomi.

"We have used opinion leaders, community leaders, youth, elders and women and religious leaders. We asked Survivors to share their stories and to tell the people about the importance of living by the

preventive measures. Through this approach, people became receptive to the information they received on the Ebola virus.”

Achieving scale in a rapidly evolving emergency

A recent nationwide survey conducted by Mercy Corps finds that community radio is not only the most prevalent but also the most trusted media in Liberia. Radio’s popularity is not surprising: illiteracy rates are high, especially in rural areas, and infrastructure challenging. However, people’s specific appreciation of community radio is revealing.

In the study, 7 in 10 people said they prefer community radio to national radio, attributing this to the availability of locally relevant news and information, as well as the use of local dialects. Roughly 80% of respondents say that community radio stations effectively cover local issues and allow people to engage in broader social discussions.

We know too that the community-centered approach has been effective. 970,000 people heard our health messages on the radio during three months of our latest campaign and over 90 percent of these respondents said that their understanding on targeted health issues increased as a result.

These are remarkable achievements that show the important role community radio stations can play in building awareness and cohesion, during a crisis, recovery and beyond. This is why Mercy Corps, together with IREX, has invested heavily in local radio through ECAP 2, the second phase of its program, which aims to rebuild trust in the health system following Ebola.

About ECAP

The ECAP program is led by Mercy Corps in collaboration with PSI, IREX and the Ministry of Health, and funded by the American people through USAID. Its second phase, ECAP 2, is an early recovery initiative that will run until July 2016.



CASE STUDY

Improving Sanitation in Old Banjor, Montserrado County through ECAP 2

An interview with James, by Lawrence Dolo, YMCA Liberia

“I am 80 years old and live here with my family of nice people. Ever since, we have all been using the bush for toilet and behind the house. We have been doing this for long now because we did not know the harm we were causing ourselves and the community. We thought it will cost us all we have to fix a toilet for our own use but thank God for the YMCA, because they train our daughters and sons to talk to us about our own health.

Every time, I see the CHC members going from house to house talking to people in white T-shirts. One day, they came across me in the morning time. I was concerned to hear what they have to tell me. They said plenty good things to me. They said we should not touch dead body or sick people, we should keep the sick people far from us and call 4455 when someone die and also tell the community leader.

They also talked about all the good things we can do so that we can't get sick. They explained that it was important we keep the place around us clean so that the flies, rats and roaches will not come around us. When I think about the place we normally attend nature, it was not far from where we stay. Rats, and roaches also come from the same bush where we attend nature and sit on our food and dishes making us sick.

When they left, I started to think about how I can help my people about this toilet business so that we cannot get sick again. I talked to a few people in my house and asked some boys to help me. They agreed to dig a toilet and clean the back of the house, and to also stop going in the bush.

I found a good place and we started digging the toilet. We have completed the digging and working on covering the hole. Not just did I keep this good message to myself, I have also succeeded in convincing my brother to do the same in his yard. I feel so happy working for my own health because once this toilet project is completed; we will have a safer community.

I want to say a big thank to YMCA for training our children and guiding us to do the right thing about our health. Since I decided to take this action, I notice that the price for prevention is less than the price for treatment. What I will pay for treatment will be far more that what I am using to build a toilet.”



TESTIMONIAL

Trust and Use the Clinics



"I say my people, my name Yatta. I market woman just like you and I from this Marchee town. Me and my husband Kollie got two children: Kpanah, and Tokpalo. Certain time came, our children started getting sick fast-fast. Because we think the hospital far away and the place can be pack with people, we used to buy medicine from the drug store.

But still they used to get sick. And then we started taking all kinds of ugly advice from our friends to carry our children to all kinds of people to fix country medicine for our children. But still no head or tail because they were getting sick, on and off. This thing really used to worry us.

But one fine day, one Community Health Committee or CHC woman came to our house and advised us to be taking our children to the clinic or hospital.

First we said 'no' because we felt that the doctor people can only give people small medicine. But the person told us that whether the place far or not, we must trust the hospital and clinic because da the best place to take our self and our children anytime somebody sick in the family. We try this one, and found out da true the person was talking. Since that time we been taking our children to the hospital and from the treatment they been getting from the doctor people, they hard to get sick this time. Our children are well in body; they going to school, they happy and healthy. And the way our children healthy and growing fine in body, we happy that one they will help us in our old age...

So my friend children ma them, your be like me and my husband. Any time any body sick in the family, don't go to the drug store or boil your own medicine. Don't even take it to be witch. The best place to go for treatment da to the hospital or clinic. To the hospital, the doctor them train to help you and your children get well so nothing bad can happen to them before their time.

Let's be going to clinic or hospital any time we or our children them sick so we can get well and continue to do our work. TRUST AND USE our HOSPITALS and CLINICS for good health and longer life."

A special health message from Africa2000 Network with support from Mercy Corps-Liberia with funding from USAID/OFDA for the ECAP 2 Project.

**ANNEX III
Radio Reach Survey
Summary Document**

70% of respondents prefer community radio to national radio

-  Community radio stations share local stories
-  Political discussion
-  Social issues
-  Advocacy tool in communities



80% of individuals believe that community radio provides accurate information

73% of respondents consider community radio as their main source of information

ECAP 2 health messages reached 970,000 people in Liberia



Vaccination



Dead body testing



Trust and use of clinics



Community engagement



92% of respondents believe their understanding on the 4 key messages has increased due to community radio

91% of individuals believe that community radio provides accurate information on 4 key topics



**ANNEX IV
CHRRP Guideline**

See following page.

ANNEX V
ECAP 2 Update in Numbers

Number of counties ECAP 2 is working in: 15

Number of communities ECAP 2 is working in: 1,607

Number of trained Community Support Officers: 395 (32% female)

**Number of communities with functioning CHCs in March: 1,524
(102%)**

Number of CHCs with links to the health system: 1,270 (85%)

Number of CHC members: 11,554 (44% female)

**Number of beneficiaries directly reached through ECAP 2 events in
March: 287,123**



Ebola Community Action Platform

Healthy Communities. Healthy Lives.

Procedure for Community Health Risk Reduction Plans (CHRRP)

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Community Health Risk Reduction Plans

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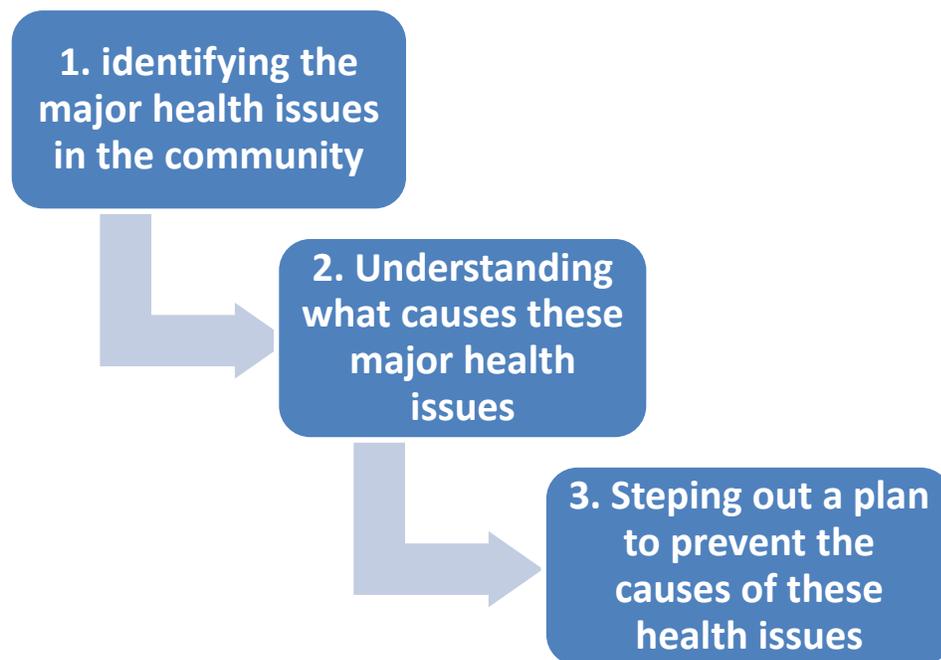
Community Health Risk Reduction Plans (CHRRPs)

As part of the ECAP 2 program, Community Health Committees are being asked to lead and complete Community Health Risk Reduction Plans (CHRRPs) within their community.

What is a CHRRP?

A CHRRP is a plan which is completed by COMMUNITY MEMBERS. The process of completing the CHRRP is led by the Community Health Committee.

Doing a community health risk reduction plan is a learning process that should carry all community members along the way. The process includes the following three major steps:



Why do we need to do a CHRRP?

By completing the CHRRP process community members and CHC's should be able to have a better understanding of the health issues in their community. Also, by being an active participant in this process they should feel motivated to take action and improve their community's health. The CHRRP process may also give the CHC some guidance on their activities for the next few months.

The CHRRP will only be successful if it is a community led process. If the CHRRP is completed only by the CSO then the CHRRP will not succeed in the community.

THE STEPS TO COMPLETING A SUCCESSFUL CHRRP

STEP 1: Collect information about the health situation in the community



The Program Manager and/or Field Coordinator should meet with the clinic OICs to inform them about the CHRRP and what it means for communities.

They should also discuss with the OIC on the major illnesses/sicknesses in the clinic catchment area. This information should be shared with CSOs (in a written form and also through a group meeting) so that CSOs are aware of what illnesses and sicknesses communities might mention during the CHRRP process.

STEP 2: Identify community health issues

Tools needed: Flip charts, poster sheets, marker pens!



First, CSO's should meet with the CHC to familiarize all CHC members with the CHRRP process. The CHC members are the ones who should lead this process so they need to understand it clearly and understand why they are doing it. If the CHC members cannot see value in the process, then they will not do a good job. The CSOs must first ***read through all these instructions*** before they meet with CHCs to explain the process.

Secondly, CHCs should organize a community meeting with all different members of the community. CSOs should ensure that women, elderly, disabled, youth and other groups are all represented at the meeting. The CHC should prepare the flip charts/poster sheets and pens and put them in the middle of the meeting.

CHC's should begin by explaining the CHRRP process.



SPIDER MAPPING

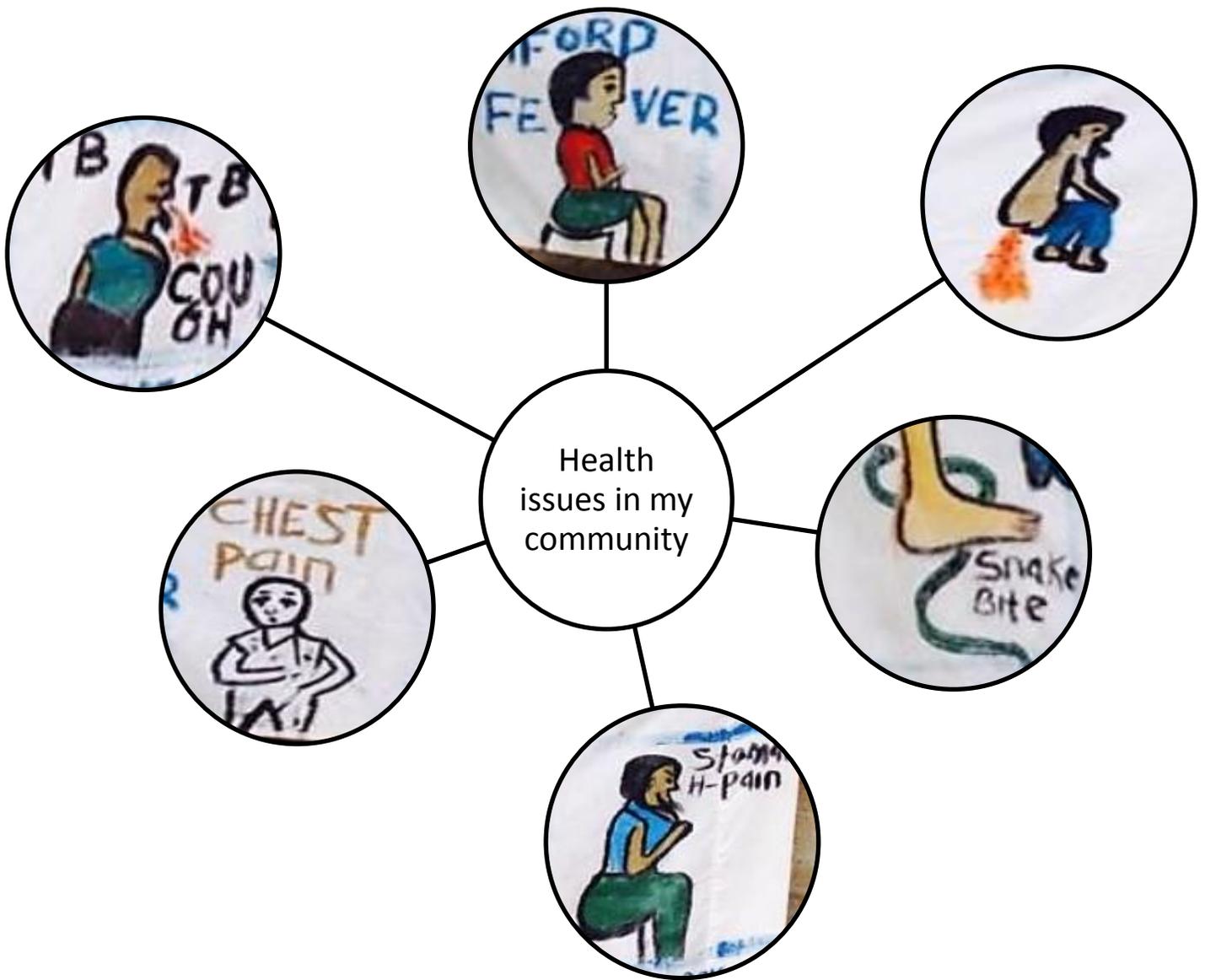
Explain they want to start by getting the community to identify the major health issues. A CHC member should draw a circle in the middle of the flip chart paper. Community members should talk about the different health issues arising in the community.

As each health issue is mentioned, the member of the community (maybe a youth) should draw a line from the circle, and draw a picture of the health issue mentioned. This is called “drawing a spider map”

The CHC members should keep probing the community members until they get them to identify a good amount of health issues.

CSOs can assist CHC members to probe for more information using the information collected from the OIC in STEP ONE.

At the end of this process, the CHC should end up with a diagram like the one below:



STEP 3: Cast the stone

Tools needed: *Small stones or sticks*



Now that the community has identified all the major health issues, the CHC should help the community to decide which of these issues are the most important to address.

Each community member should get five stones/sticks. Get community members to place the stones/sticks on the drawings of the issues they think are most important.

This should result in lots of stones on top of the issues which are most important to address, and less stones on issues which are less important.

******CHCs might want to stop the meeting here if community members are tired. They can continue the process at another community meeting******

STEP 4: What are the bad things that cause these health issues?

Tools needed: *The spider map drawn in Step 1. Additional flip charts/poster sheets, pens.*



The CHC should now have a clear list of the most important health issues in the community. The next steps should focus on these important health issues, not all the issues identified by the community.

As the CHC commences this community meeting, they should remind the community members on the issues prioritized at the last meeting. Bringing out the spider map previously drawn will help remind the community members.

Ask the community: “What do we think are the bad things that cause these health issues/sicknesses?”

As the community comes up with ideas about what causes the health issues, get a CHC member to write them down on a piece of flip chart/poster sheet. This process will require CHC members to ask lots of probing questions. CSOs should support CHC members to ask probing questions when needed.

Once you have a complete list of the factors which cause the health issues, please proceed to the next step.

STEP 5: What good things can we do to prevent these bad things from happening? How can we do these good things?



Now, you have a list of factor which cause health issues.

The CHC should ask the community: “What good good things can we do to prevent these bad things from happening?”

Get the community to think about what steps they can take to prevent these health issues from occurring. Once a list of steps is identified, the CHC should work with the community to make a plan on how to achieve each of these steps.

The plan should include information on:

- What activity needs to be done
- Who will do the activity
- When will the activity be done
- What resources will the community need to mobilize to complete the activity

CSO’s should provide guidance to ensure the activities are reasonable and achievable for the community! We don’t want them coming up with plans they cannot actually complete!!

At this stage, the CHC should thank the community for their input and explain they are going to write all these ideas up. They should explain they will present the full plan again at another community meeting once they have written it up.

****CHCs might want to close the community meeting and schedule a time for the next meeting where they will present the complete plan****

STEP 6: Completing the CHRRP



CHC members and the CSO should meet separately to complete the CHRRP form. A copy of this form is attached at the back of this document. This form should be copied so that there are at least three copies (one for CHC, one for CSO, one for OIC).

CSOs should encourage literate CHC members to fill in the form. If there is no literate CHC member, the CSO should assist by completing the form.

It is very important that this form is completed in the community with the CHC's engagement. It should not be completed by a CSO at their personal home or work place.

STEP 7: Sharing the CHRRP



Presenting to the community

Once the form is complete, get the CHC to think of a way to explain the plan to the community in a way they can understand. They may need to do a drawing of the plan so that all community members can understand.

CHC members should call another community meeting and share the plan with all community members. During this meeting, the CHC should ensure the community agrees with the plan and makes any changes the community thinks is necessary.

Presenting to the OIC/CHDC

A member of the CHC should present a copy of the plan to the OIC at the next CHDC meeting.

Sharing with program manager/supervisor

CSO's should share a copy of all plans with their supervisor or program manager. This will in turn be shared with Mercy Corps.

Is this the end of the CHRRP?NO!

After this process, CSO's should continue to work with CHC's to implement the steps contained within their CHRRP plan. This is the most important part!

Guidance on sign and symptoms of diseases similar to Ebola

Main Diseases	Signs of the Disease	Risk Factors (things that make the disease spread)	Prevention/Protection
Acute haemorrhagic fever syndrome (Ebola, Marburg, Yellow Fever, Lassa fever)	<ul style="list-style-type: none"> • Fever • Headache • Sore throat • Muscle pain • Sweating • Body weakness • Stomach pain • Vomiting • Diarrhea • Rash • Bleeding • Yellow skin or eyes (yellow fever only) 	<ul style="list-style-type: none"> • Touching of dead bodies who died from Ebola-like symptoms • Touching people who are sick with Ebola-like symptoms or their body fluids (blood, poo-poo, pee-pee, vomit, sweat, tears) • Eating food that rodents have contaminated (Lassa Fever) 	<ul style="list-style-type: none"> • Avoid contact with the dead body of people who died from Ebola and call 4455 • Always wash hands with soap and water • Avoid funeral or burial rituals that require handling the body of someone who has died from Ebola (washing the body, cutting the hair of dead body-remember to call 4455) • Protect your food from rodents ((Lassa Fever)
Malaria	<ul style="list-style-type: none"> • Fever • Chills • Sweating • Headache • Body weakness • Muscle and joint pain • Stomach pain 	<ul style="list-style-type: none"> • Mosquito bite • Stagnant water • Tall grass around the house 	<ul style="list-style-type: none"> • Avoid contact with the person and advise the person to go to clinic • Sleep under mosquito net • Drain stagnant water • Keep the area around your house clean without too much grass
Typhoid	<ul style="list-style-type: none"> • Fever • Headache • Body weakness 	<ul style="list-style-type: none"> • Open defecation • Lack of washing hands with soap after use of latrine/bush 	<ul style="list-style-type: none"> • Avoid contact with the person and advise the person to go to clinic • Always wash hands with soap and water after use of latrine/bush and before eating food • Use pit latrines for defecation • Boil food and drinking water before eating/drinking
Flu (Fresh cold)	<ul style="list-style-type: none"> • Fever • Headache • Body weakness 	<ul style="list-style-type: none"> • Sitting near the sick person in the first 24 hours of symptoms 	<ul style="list-style-type: none"> • Avoid contact with the person and advise the person to go to clinic
Cholera	<ul style="list-style-type: none"> • Watery diarrhea • Vomiting 	<ul style="list-style-type: none"> • Open defecation • Lack of washing hands with soap after use of latrine/bush 	<ul style="list-style-type: none"> • Avoid contact with the person and advise the person to go to clinic • Always wash hands with soap and water after use of latrine/bush and before eating food • Use pit latrines for defecation • Boil food and drinking water

NOTE: This list is not to be used for diagnosis. All persons who have one or more of these symptoms should go to the clinic

Community Health Risk Reduction Plan

Name of organization: _____

Contact: _____

County: _____

Community Name: _____

Organization Program Manager's Signature: _____

Date of Submission: _____

TEMPLATE FOR COMMUNITY HEALTH RISK REDUCTION PLAN

Name of the Community/CHC _____

Date: _____

Prioritized Diseases/ Health conditions	Risk Factors (things that make the disease spread)	What will Community do to Reduce the Risk	How will Community do it	Resources Needed		When will Each Activity Happen
				Available in the Community	What Community Needs to Contribute	

Full Name of CHC Members

Signature

Date
