



Ebola Community Action Platform II
Funded by USAID/ Office of Foreign Disaster Assistance
Fiscal Year (FY) 2016 Quarter 3 Report
April 1 – June 30, 2016



ECAP 2 partners have strengthened over 1,560 CHCs through the course of the program. Photo credit: Cassie Cladis for Mercy Corps

I. Program Overview

The Ebola Virus Disease (EVD) hit West Africa in March 2014, turning into an epidemic that directly affected nearly 29,000 people, with over 11,000 deaths in the West Africa region as of mid-year 2016. Although the epidemic has been declared officially over by the World Health Organization, Ebola remains a threat to the region, evidenced by recurrent emergences of the virus in the three most-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 to 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 high-risk diseases with similar symptoms.

Quarter Executive Summary

During the fourth and final quarter of program implementation, ECAP 2 met or exceeded most of its work plan objectives and targets. For the reporting period of April through June 2016, ECAP 2's implementing partners worked in 1,599 communities with a cumulative population of 1,021,475 direct and indirect beneficiaries, to strengthen Community Health Committees (CHC) and support outreach that increases resilience against EVD and other high-risk diseases. The primary focus during the final quarter was on:

- The Community Health Risk Reduction Plan (CHRRP) was rolled out to every CHC for completion by their communities, which outlined ways of addressing primary disease-related health risks as identified by the communities.
- A Community Health Toolkit was developed and printed for every CHC and the MoH Community Services and Health Promotion Divisions.
- Implementing partners focused on preparing CHCs for ongoing sustainability as the field work on the program ended in early May.
- Population Services International (PSI) delivered its last field training, focusing on skill building for partner field teams so that they then more effectively cascaded the adult learning methodology, Listen, Learn, Act, to CHC members.
- CHCs were supported to ensure that mutually respectful and accountable relationships with clinics and health professionals were developed and lasting.
- Mercy Corps' Subawards & Compliance technical staff worked one-on-one with partners to close out their grants and deliver final technical assistance and capacity building in financial management and grants compliance.
- The Monitoring Evaluation Research and Learning (MERL) team conducted community field visits with the aim to assess the level of sustainability of CHCs. Furthermore, the team produced the health survey report which compares the baseline and endline data on health

behavioral change throughout the program. The M&E officers of partner organizations completed the final technical M&E workshop.

- The Partner Support team worked with partners to ensure CHRRPs were being properly implemented, the Community Health Toolkit was properly distributed and positioned as a key reference tool for CHCs and that partners were proceeding with program close out appropriately.
- The program's Communication Specialist continued to mentor partners on media outreach and worked with them to develop materials that market them as a capable network and resource for further emergency/development work in Liberia.
- ECAP 2's Health Advisor attended all MoH Health Promotion and Incidence Management System (IMS) meetings. She also served as a conduit of information to the Community Health Services Division about problems at clinics, both at the facility and staff levels so that community-level feedback could be received and addressed.
- An independent evaluation expert was contracted to assess two ECAP 2 program topics that were considered to have significant learning opportunities: 1) the extent to which sustainable CHCs have been developed and strengthened in ECAP communities; 2) the impact of the support and coordinating approach used by Mercy Corps in program design and implementation.

Through ECAP 2, attention continues to be focused on strengthening health systems to minimize the impact of future EVD outbreaks. A significant result of ECAP 2 has been the acknowledgement by the MoH, official and traditional leaders throughout the country at various levels and the international community that Liberia has a strong and competent civil society sector, committed to helping the country address emergencies and develop itself. Working alongside the country's public and private sectors, it is clear that Liberia's own dynamic civil society network represents a largely untapped resource to help the country recover, thrive and improve its human development standing in the world.

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)	N/A	1,021,475 population; 986,120 ¹	N/A	1,021,475; 986,120	N/A

¹ 1,021,475 direct and indirect beneficiaries calculated on the basis of population of target communities. There were 334,590 (53% female, 47% male) attendees at specific events at the end of this quarter. The radio listenership survey indicated a total of 986,120. It would be misleading to add the numbers together to arrive at total beneficiaries because of the possibility of double counting. As such, beneficiary counts were considered separately such that CHC work would reach at least 750,000 persons in 1,500 communities and radio would reach at least 750,000 throughout the country.

by mass media)					
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Sector-Level Beneficiaries

SECTOR: HEALTH					
Cumulative Period Targeted		Reporting Period Reached		Cumulative Period Reached	
Total	IDP	Total	IDP	Total	IDP
1,500,000 (750,000 CHC; 750,000 mass media)	N/A	1,021,475; 986,120 ²	N/A	1,021,475; 986,120	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	1,021,474; 986,120 ³	N/A	1,021,475; 986,120	N/A

² Ibid.

³ Ibid.

Indicators

SECTOR: HEALTH			
INDICATORS	TARGET	PROGRESS (FY2016 Q3)	TOTAL PROGRESS
SUBSECTOR: Health Systems and Clinical Support			
# and percent of Community Health Committees (CHCs) operating at a functional level	1,500	1,566 (104%)	1,566 (104%)
# and percentage of CHCs engaged in the government health system	1,500	1,375 (92%)	1,375 (92%)
SUBSECTOR: Community Health Education and Behavior Change			
# and percentage of communities that have developed Community Health Risk Reduction Plans (CHRRPs)	1,500	1,524	1,524
# and percentage of community members utilizing target health education and message practices	60%	38% of individuals surveyed (baseline)	64% of individuals surveyed, or 653,744 (endline)
SECTOR: HUMANITARIAN COORDINATION AND INFORMATION MANAGEMENT			
INDICATORS	TARGET	PROGRESS (FY2016 Q3)	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	3	5

II. Security Context and Situation Overview

The small flare-ups of EVD that have occurred in previous quarters 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. 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 following the epidemic.

ECAP 2's implementing partners have reported ritual killings in some areas of the country. Working with traditional leaders has minimized the security risk for staff. Travel problems persist, but partners have adapted to situations rapidly and have remitted program data despite poor connectivity and travel conditions. Presently, there are no major security concerns that would affect the final close-out 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 a particular emphasis on CHC sustainability. With the wind-down of field activities in early May, the ECAP 2 team has worked with partners on program close-out. Overall, the program met most of its targets except for meeting with government health structures due to distance from clinics, poor transportation networks and poor coordination and notice of meetings. Following is a summary of program activities by area of focus.

1. Civil Society Engagement

“[This is] a good model for the community. [The community people] like it because we link them to the hospital, we educate them and they are taking it serious.”

William Cummings, Sokopa Community CHC, Nimba County

In this program area, Mercy Corps is working with civil society organizations to ensure broad reach of EVD-related prevention activities 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) to mentor partner leadership and management in effective communication with high level MoH and government officials; undertake effective advocacy on issues important to beneficiaries; engage media constructively, and effect overall good governance; and 2) to 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 to successfully end ECAP 2 in their catchment communities in all 15 counties in Liberia. They concentrated their efforts to ensure that CHCs are sustainable and effectively linked to their community health structures. They also reviewed the six ECAP-supported MoH health topics with CHC members to solidify their understanding of key messages (e.g., hand washing, keeping sick people separate, addressing stigma, not touching dead bodies, seeking health care at the clinics) and capacity to communicate these messages to their community so that healthy behaviors are widely adopted. Some partners facilitated peer learning visits for CHC members to encourage the spread of community-led innovations (e.g. reed hand washing stations, income-generating

projects such as gardens with quick turnover produce like peppers and cassava, rotational savings and loans schemes to support CHC sustainability and community-driven emergency funds).

Partners also emphasized the importance and primacy of the CHC role with the community health system by making sure they consolidated good relations with clinic health professionals and district health structures. In many communities, partners reported that the CHCs were digging wells and latrines and putting fencing around some of the clinics and community water sources to help keep them clean. CHCs demonstrated they understood and then promoted community hygiene, some of them imposing fines on community members for open defecation and failure to keep their residences clean. Many CHCs also helped their communities and the health system promote vaccination and malaria prevention campaigns.

ECAP 2 has made great strides in the elevation and visibility of its partner network. Liberia's civil society is a bright spot for the country given that the public sector is hobbled by inadequate revenues for budgets and corruption and its private sector is largely captured by foreign interests that export profits and commodities, leaving a low tax base and limited low-wage employment opportunities. Liberia's civil society, as represented by ECAP 2 partners, demonstrates knowledge, competence and a commitment to humanitarian interventions to improve the lives of their country-men and women and fills a gap that the other sectors cannot. Many partners have been asked and are serving as standing members of county health structures and are increasingly requested to participate in public health campaigns and MoH policy discussions. In addition, many partners have been approached by the international community to help them implement programs and provide advice about community engagement in their respective counties.

In technical areas of capacity building, the Mercy Corps team worked with partners to improve their financial management and to help them close out their grants in compliance with their sub-grant agreements. The team particularly worked with their finance officers and management to advise them about improving procurement practices and how to more effectively implement internal control over their financial management. All partners' subgrants were successfully closed with only minor adjustments to some partner reported expenditures against their grant budgets.

During the quarter under review, the MERL team worked with partner M&E officers on the endline health survey. MERL also conducted one final workshop to consolidate their program M&E learnings and to review in detail the health survey. They were advised on collecting final program data, and taught how to compare baseline and endline data. The M&E officers also had the opportunity in this training to learn how to properly interpret data and then use the data to help their organizations implement adaptive management. The Communications Specialist further worked with partners to develop marketing products for their organizations which highlight work undertaken through ECAP as well as their organizational strategy and mandate, and worked to support visibility for the ECAP civil society network.

ECAP 2's third and final Lessons Learned Workshop was held at the end of May. The focus of this conference was to consolidate linkages with the MoH, share experiences and learnings, and build motivation and encouragement for the network beyond ECAP 2. The conference was attended by a number of high-profile and inspirational internal and external speakers including the Acting US Ambassador; OFDA representatives; the Deputy Minister of Health and the Mercy Corps Country Director. In addition, a total of six people from each organization were invited so that a broad cross-section of partner program staff including field officers could participate.

This conference differed from previous learning events in that it was deliberately turned over to the partners so that they could map out a consensus for the future of the network post-ECAP 2. In preparation for this, partners were asked to lead learning sessions, and they prepared fact sheets about their organizations and shared them in a world café event. Partners were able to come to a consensus about their network, and laid the ground work for network governance and principles. A date was set for June for the network to meet (meeting minutes attached, Annex 3) and initial marketing plans were discussed and embarked upon. For example, one partner reached out to the U.S. Embassy and USAID for a small grant involving work with Ebola survivors on stigma reduction and the network organizers contacted USAID about a small grant for network start-up.

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.

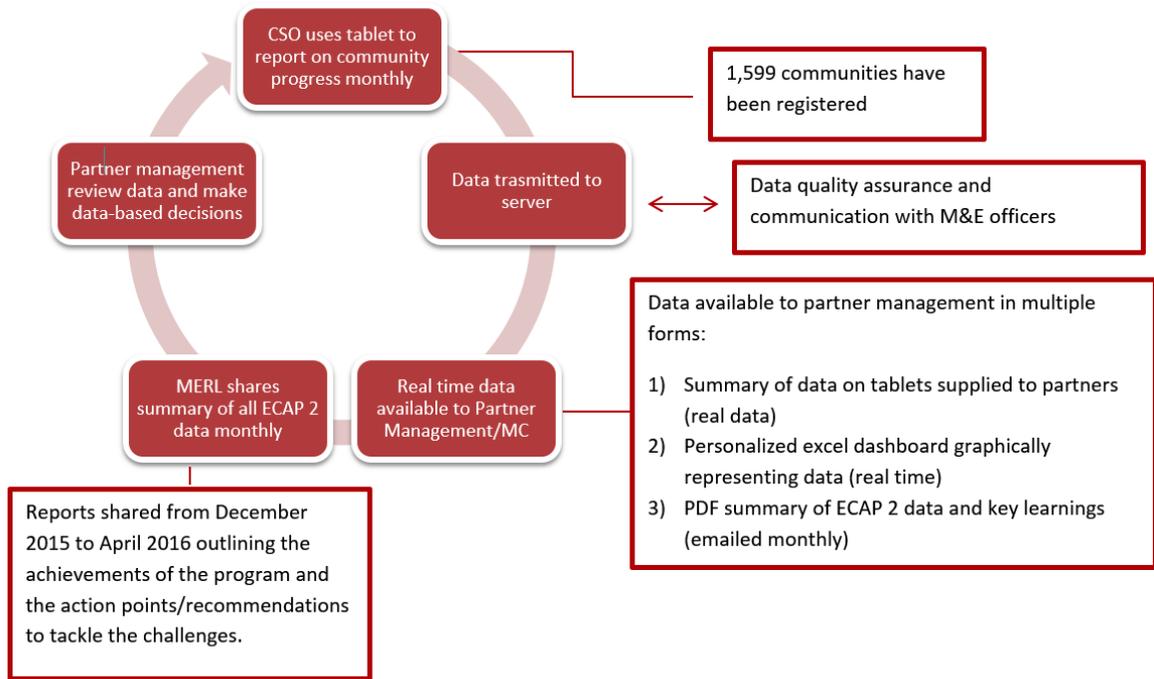
IREX led the mass media component of the ECAP 2 program by supporting the development of innovative and targeted health-related content including talk shows, jingles, spot messages and dramas, through training and mentorship of 29 media partners (27 community radio stations and two Monrovia-based outlets) in all 15 Liberian counties. The content is designed to support efforts to increase communities' resilience against disease by promoting healthy behavior change on key topics (including trust and use of clinics, community mobilization on health issues, hand-washing, EVD vigilance etc.).

2. Creation of Health Learning Systems

During this quarter, the system focused on tracking the rollout of the Community Health Risk Reduction Plan (CHRRP) in ECAP 2 communities. Partner Community Support Officers (CSO) reported whether the CHRRP was finalized and implemented and they also flagged some of the challenges encountered in the CHRRP process. 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 to program implementation (e.g. bad roads, aid dependency, distance to clinics, clinic responsiveness to community health needs)
- Rollout and implementation of CHRRPs

Mercy Corps' MERL team has been actively ensuring 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 MERL team conducted data quality checks and reported inaccuracies and concerns to the partners' M&E officers, which fed the overall learning process and program response.



An SMS-based platform (short code 3227) enabled community members and partner staff across all the counties to provide feedback directly (and free of charge) to Mercy Corps on health or accountability issues, which further supports rapid identification and response on the ground once issues have been identified by communities or partner staff. The SMS platform was available where there was connectivity, therefore usage was somewhat limited. However, the introduction of a reporting platform to communities and to the partner network gave them knowledge that direct accountability mechanisms are available and can be used in support of adaptive management.

3. Strengthening of Community Level Health Structures

“CHCs have worked well in uniting our communities and resuscitating their minds. People learned to appreciate the health facility they have, and are now willing to render their own voluntary health services to [improve] the facilities.”

Bishop Abraham T. Gheway, Assistant Superintendent, Grand Gedeh County

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 for major disease outbreaks, particularly EVD.

During the quarter under review, partner field teams and management were active in their respective catchment communities, working with CHCs on a weekly basis to reinforce their roles and responsibilities as the primary link to the public health system. Particular emphasis was placed on the importance of the CHC leadership to represent community health needs and advocate 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.

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. All communities participated in the CHRRP process and for almost all of them, it was the first time they had ever led a community wide initiative of this sort. One benefit of the CHRRP was to facilitate community understanding of health issues, causes of major health problems and the actions they could take individually and collectively to stay healthier.

This planning exercise also served to reinforce the role and importance of CHC members in their communities and the health information they can in turn provide to the health system, particularly clinic staff. Some communities were highly mobilized during the CHRRP and initiated the digging of wells and latrines, placed hand washing stations throughout the community, repaired broken bridges and paths to clinics, fenced water source areas, built fences for clinics and helped start the construction of maternal waiting halls. In addition, some communities provided 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. Malaria, running stomach and STIs were common illnesses highlighted in the CHRRP process; therefore, community and personal hygiene measures were emphasized in action plans. Many communities were creative and improvised ways to access cleaner water and dispose of waste. Most communities conducted general clean-up campaigns and many instituted fines for residents not adhering to the community's new hygiene protocols.

PSI conducted its final *Listen, Learn, Act!* training in this quarter, focusing on CSOs cascading the methodology effectively to CHC members. This 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. Many CHCs after this training reported that they now had a powerful tool to communicate with their community members. Some said they would use this tool for

other community issues and felt that they now had the means to tackle more community concerns that would improve the lives of their neighbors.

CSOs and CHCs also reported that CHC members felt respected in their communities and now had the knowledge to carry on their very important public service. This is a key behavioral outcome that will help sustain CHCs and promote effective disease surveillance and first line defense against possible EVD outbreaks so that they are controlled and transmission reduced. An important design feature of ECAP 2 was that no incentive payments were to be made to CHC members for their work. It was a program tenet that aid payments for matters that people can accomplish themselves only undermines personal agency. Partners have emphasized that the knowledge CHC members are gaining from ECAP 2 is far more valuable than a small, temporary stipend. The benefit of knowledge is life long and enables “you to move forward in your life under your own direction.” This feature also adheres to the Community Health Services Policy which has the underlying philosophy that “people should not be paid to take care of their own health,” according to the Director of Community Health Services. In some communities where ECAP 2 works that were less exposed to receiving material aid, community members easily adapted to these messages. In other communities, it took a more concerted effort for them to see that knowledge about their health and being respected in the community was more valuable than being paid a short-lived stipend for their work would have been.

By the end of this quarter, many CHCs conducted varied outreach events like market place dramas, school places of worship presentations and door-to-door discussions. In total, CHC outreach activities directly reached 334,590 people, a 17% increase over last quarter. ECAP 2 also continued to make sure that the CHC linkages with government clinics and health personnel were strong. Each partner has tried to facilitate the attendance of CHC representatives to monthly Community Health Development Committee (CHDC) meetings with the health officials at their clinics. In addition, the partners attended monthly County Health Team (CHT) meetings to support the linkage between communities and their clinics and help the health structures function according to Liberia’s Community Health Services policy.

During this quarter, partners made it clear to the public health staff at different levels that ECAP 2 was ending and that it was important for them to continue to meet with the CHCs, visit communities when possible and help the CHC members more deeply understand health issues. Mercy Corps, in collaboration with the MoH, developed a community health reference resource for each CHC. For mutual benefit, the OIC was also encouraged to use this tool to help promote good health.

“We go around and tell the people, when they are sick, they can go to the hospital, they can see they got medicines there. When you get belly, you go to the hospital. When you get baby, that person will go to the hospital and get the baby vaccine, everything. People from here now they go to the clinic more. There are big changes, the sickness all gone down, no mosquitos around, all those flies that were all around they gone. Every second week Saturday, it our meeting in the clinic, I can ask any question, anything that going wrong we can ask a question and they can answer it. The meetings work very good.” Gaye Nyah, Town Chief, Boe Community, Grand Gedeh County

During the report period, fieldwork ended at the end of April, with some final activities conducted in the first two weeks of May by some partners. ECAP 2 partners worked with 1,599 communities served by 166 health facilities for program implementation. By the end of April 2016, there were 11,110 CHC members. Of this, 43% were females. By the end of April, 1,566 CHCs met the definition for being

functional (holding regular meetings and reaching quorum). Additionally, 1,375 CHCs engaged with the health system through attending CHDC meetings, the purpose of which is to discuss community health issues and challenges they have with the health system. Unfortunately because of bad transport systems and distances to clinics, not all CHCs were able to attend CHDC meetings. However, by the end of the program over 90% of communities had attended at least one CHDC meeting at their clinic. This marks significant progress from before the ECAP 2 program when community engagement was severely limited.

While some reports indicate continuing problems with the public health system (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 to better serve their catchment communities. Partners report that the local, district and county health officials acknowledge that budgetary constraints hamper their efforts to fully implement the community health services policy and some also admit that some health staff engage in extra-income earning opportunities to help them at least keep the clinics open and operating at a very basic level. These factors all contribute to the importance of people understanding and adopting healthy behaviors so that the health system can better cope with essential health services for the population.

Partners and the MoH lauded ECAP 2 because they viewed it 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

“Bringing local leaders to discuss health issues like Ebola helped people to take the disease more seriously. Many parents were [also] rejecting vaccinations but since ECAP 2, people have begun to accept vaccinations for their children. “

Presley Nya Boozahn, Director of Programs, Radio Kerghemahn

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. Because the IREX contract expired at the end of March 2016, during this quarter there was only radio programming with five stations near the border of Bong and Nimba counties with Guinea. This emergency response, which was an action taken by ECAP 2 upon a request for assistance from the MoH, was due to the EVD outbreak in Guinea near the Liberian border. 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 reported a significant increase in demand for health services at the clinics and Mercy Corps' Health Advisor worked closely with the MoH to identify bottlenecks, capacity limits, staff shortages and professional knowledge/behavior problems, and inadequate drug supplies to name some of the more pressing concerns. Partners report, verified by some clinics, that 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.

To support health education and awareness, 1,800 water-resistant Community Health Toolkits were also disseminated to all CHCs, the MoH and international partners and soft copies were made available to County Health Teams and District Health Teams. Developed together with the MoH, these visual toolkits provide simple messaging and illustrations to help community members recognize signs and symptoms of common or high-risk diseases such as EVD, Lassa Fever and Measles, and promote relevant health-seeking practices. Key behaviors promoted by the toolkit include hand washing with soap and clean water (especially at critical times), use of latrines, going to the clinic for treatment and diagnosis, and timely reporting of suspected cases of EVD.

Trainings were also given to CSOs to cascade to CHCs, with the intention of facilitating understanding of the toolkit and how it could be used as an effective outreach tool at the community level.

Certification ceremonies were also widely held for CHCs as well as ECAP 2 ‘Healthy Life Ambassadors’ following a national award scheme whereby CSOs and community members submitted nominations for exceptional community-based health champions. This was intended to recognize and champion volunteerism and inspire and motivate other CHCs, during and beyond the program.



ECAP 2 celebrated CHCs as well as the special contributions of ‘Health Champions’ who went the extra mile to improve people’s health in their communities

IV. Monitoring and Evaluation

In the month of May, the M&E officers of ECAP 2 partners successfully completed the community health survey data collection. The health survey report compares the baseline and endline data on health behavioral change throughout the program. The key conclusions are:

- Knowledge uptake was increased in two of the seven focus areas: hand washing and keeping sick people separate.
- For three of the topics, namely, stigma, childhood vaccinations and dead body testing, positive attitudinal change occurred throughout the course of the program.
- Evidence of concrete behavior change was however limited across targeted areas. This may be linked to supply-side gaps relating to some of the program areas (e.g. resourcing constraints on dead body testing teams), and the limited program duration which perhaps resulted in an over-dependence on messaging above substantive understanding of the topics at hand. Lasting behavior change may require a longer period of exposure and reinforcement.

During this quarter, the MERL team conducted community field visits, covering all twenty-three partners. The scope of the assessment was twofold. On the one hand, the visits aimed at validating the quality and reliability of monthly data submitted by CSOs. On the other, the team conducted a qualitative assessment

of the level of sustainability of CHCs. The study finds that the level of sustainability varies from partner to partner, although the overall level is satisfactory. The sustainability report highlights four major factors that affect the level of sustainability of CHCs in ECAP 2:

- Involvement of community leaders in CHCs
- Level of motivation of CHC members
- Presence of sustainability projects (e.g. farming schemes)
- Management of expectations in communities so that people are reasonable about what the CHCs can and cannot accomplish.

Moreover, the MERL team conducted a three-day workshop with M&E officers. The workshop had three major components: lessons learned from the program, M&E capacity building on data management and analysis and training on the health survey.

A qualitative study on the impact on women of female participation in CHCs was completed in the month of April. Generally, most women reported personal benefits as a result of their work. The assessment highlights that the involvement of women in CHCs positively increased personal confidence and community support. However, for those women who do not have spousal support for their activities outside the home, a small number of participants highlighted experiencing conflict and risks concerning personal security. This research was captured and shared with partners working in the community health arena to inform future programs with female health volunteers.

Finally, the team provided technical support to the external program performance evaluator. The evaluation aims at assessing the level of sustainability of CHCs after ECAP 2 and the general level of coordination and support provided by Mercy Corps to its partners. The evaluation report will be included in the final ECAP 2 program report.

V. Challenges

The main challenges encountered by ECAP 2 this quarter include:

- 1) The close-out of the subgrants required intensive work by the ECAP 2 Subawards and Compliance Team, augmented by Mercy Corps technical experts at the country office and headquarters. Even though many partners do not have sophisticated financial management systems or personnel, there were only minor financial adjustments that were made to partner subgrant reports and all partners' subgrant contracts were closed by the end of the grant period.
- 2) Some partners reported challenges meeting the government engagement target with CHDCs. This was a particular problem in remote areas where communities and OICs had difficulties attending meetings because of distance from clinic, transportation costs and some poor coordination in calling meetings. Some CHCs set up some revenue-making activities and used a part of the money earned to attend meetings to address this issue.
- 3) The challenge of low-capacity and -resourced government health facilities 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 and our partners will continue to advocate for more support for the community health system 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 was essentially delivered as planned, targets mostly met and impact achieved. 1,566 Community Health Committees are actively working to improve public health in their community, with many going 'above and beyond' expectations in undertaking health-related development projects; community awareness on disease risk reduction has been significantly strengthened, and community engagement with clinics has generally increased, especially in areas where clinic and district health teams have actively supported and enabled these efforts. Most importantly, ECAP 2 communities also report increased confidence in their ability to manage outbreaks of diseases, which, alongside strengthened linkages with the public health system, should help Liberia control future outbreaks and prevent epidemics. The civil society implementation approach, while challenging to manage, has delivered 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.

VII. Next Quarter Activities

The next quarter, which is only ten days in July, will be devoted to close out, finalizing the external evaluation and contracting for external audits for partners meeting the audit threshold.

List of Annexes:

- I. Outreach products**

- II. Final Lessons Learned Notes and Agenda**

- III. Minutes from Network's first meeting post ECAP 2**

I. Annex 1: Outreach Products



LOCAL NGOS CELEBRATE COMMUNITY HEALTH ACHIEVEMENTS AT NATIONAL CONFERENCE

PAYNESVILLE, May 26, 2016 --- Today Mercy Corps Liberia hosted a national workshop that brought together Liberian NGOs, officials from the Ministry of Health, USAID and media partners who have contributed to a 1-year community health program known as ECAP 2, which has now directly benefitted 1.3 million Liberians with critical health information through community campaigns.

ECAP 2 partners have worked with communities to reduce risks of Ebola and other infectious diseases, and have strengthened, trained and mentored over 1,500 Community Health Committees (CHCs). They have also engaged clinics to build trust and usage of health facilities so that Liberians seek the best possible care and treatment when they are sick.

Speaking at the conference, **Penelope Anderson, Country Director of Mercy Corps** said that the ECAP program showed the great things that could be achieved when communities are genuinely empowered to take charge of their health through strong local partnerships.

“We are immensely proud of what the ECAP network has achieved over the last 18 months, from tackling Ebola to building community resilience to future outbreaks,” she said. “Together we have helped ensure that ECAP communities know what to do and where to go if an outbreak should occur, and we have contributed to healthier communities and healthier lives.”

With support from Mercy Corps, PSI, IREX, USAID and the Ministry of Health, Phase 2 of the Ebola Community Action Platform (ECAP 2) trained and engaged 23 Liberian NGOs to engage communities on major preventive health issues, and promote vigilance to Ebola, as well as 27 community radio stations.

As a result of this program, more than 970,000 people heard ECAP 2 health messages on community radio; community-level campaigns provided health information to at least 335,000 more people spread across all 15 counties, and over 1,500 local health groups known as CHCs have mobilized communities to take action to improve hygiene, sanitation and reduce their risks of disease.

The conference took place at the Golden Gate Hotel in Paynesville and aims to share experiences from all those who have been involved in ECAP 2, which closes in July 2016.

ECAP was initially established at the peak of the Ebola outbreak and was Liberia’s largest network of organizations doing social mobilization on the Ebola response.

Overcoming the Burden of Distance to Improve People's Health

Blog by Chris Oscar, Research Officer

Gbarpolu County is one of the most newly established counties in Liberia. It is an incredibly diverse county with many cultures and tribes, and has high levels of poverty, a challenging road network – much of it next to impassable in the rainy season, as well as lack of network connectivity. It is extremely remote. From Bopolu, the county capital, to Kongbor district for instance, is about a 7 to 8 hour drive, and there is only one health facility providing services to all of the communities. The health challenges are extreme, but one partner, Equip Liberia, has achieved great success in engaging communities to take charge of their health through the ECAP 2 program, which has been funded by USAID and led by Mercy Corps.

In Gbarma and Kongba Districts, EQUIP Liberia has successfully established 80 functional community health committees (CHCs) in 80 communities. These CHCs are actively involved in community mobilization activities such as: sharing Ministry of Health-approved health information, doing awareness on community health issues, linking communities with health facilities, encouraging communities to trust and use clinics, carrying out cleanup campaigns, helping communities to identify potential health risks, and supporting them to address these challenges.

The Officer-In Charge (OIC) of the Kongbor Clinic, the district's one health facility states, ***“The attendance here at this facility has increased more than 300 percent. Before EQUIP started implementing the ECAP 2 program, attendance was between 5 and 10 people coming per day but now it has increased to about 45 to 50 patients. Patients come from far distances, even walking about 6 to 8 hours to get to this facility for health care”.***

There are many factors that have influenced Equip's success in the field but our Research Team have identified the below as key:

Recruitment of field staff - EQUIP technique of selecting/recruiting their community support officers (CSOs) was one of the key factors attributed to the success of ECAP 2. EQUIP was strategic in selecting and assigning CSOs to communities based on experience working in the most challenging places, residency in the county and ability to speak the local languages of their assigned areas. Furthermore, the CSOs who were assigned to the most challenging areas, such as Kongba District where there is no network coverage and poor roads, were chosen also based on their passion and ability to handle extreme situations.

Upwards and downwards information flows - EQUIP's community engagement process has been vital to the success of ECAP 2 in Gbarpolu County. The organization adopted a bottom-up approach: EQUIP started engaging the county authorities from the onset of the program and then went down to the community level to share information on the goals and objectives of the program, ensuring full participation throughout the project cycle. EQUIP organized kick-off conferences in all the districts where they are implementing ECAP 2 involving District Commissioners, Clan Chiefs, Paramount Chiefs, Town Chiefs and Elders.

Regular monitoring and evaluation - The Management of EQUIP put in place a rigorous monitoring and supervision system to enhance implementation and impact. M&E and project officers persistently went to the field to identify progress and gaps or challenges and provide support in the response.

Peer support and comradeship - Finally, peer support among field staff contributed to the success of EQUIP's implementation. CSOs established a strong interpersonal relationship with each other in the field; they have been engaged with visiting one another's assigned communities, sharing challenges and providing support to their colleagues.

The ECAP 2 program has made a significant impact on the lives of the people in Gbarpolu County, specifically in in Gbarma and Kongbor Districts; our assessment interestingly identified that the inhabitants of these areas' behaviors have changed positively. Community dwellers consider their health as a primary objective; they are developing their own health initiatives, trusting and using clinics, and articulating the benefits of such despite their remoteness and distances involved, and keeping their environments cleaner and healthier than before. Moreover, many of the communities' CHCs are encouraging every household to take the initiative to construct a pit latrine attached to their house. Community members consider ECAP 2 to be a lifesaving mission, in a county where many had previously experienced very little contact with their health services.



II. Annex 2: Final Lessons Learned Notes and Agenda

ECAP 2 Final Lessons Learned Workshop – Notes

Golden Gate Hotel - Monrovia

Day one - 26/05/2016

Opening of Workshop - Penelope Anderson – Mercy Corps Country Director

Penelope Anderson officially opened the third and last Lessons Learned Workshop of the Ebola Community Action Platform (ECAP 2). She outlined the great work done by the 23 partners and highlighted positive changes that took place since the beginning of ECAP in August 2014. The Country Director brought attention to a few key aspects:

- ECAP has engaged communities in a period of high distrust due to the Ebola virus. ECAP reached out to 2.5 million of people in over 3,000 communities throughout Liberia;
- ECAP 2 had an even more ambitious program of building resilience in communities. ECAP 2 achieved results beyond expectations by reactivating over 1,500 communities and spreading the health messages to more than 900,000 people via radio;
- ECAP 2 successfully worked with Community Health Committees (CHCs) without providing financial incentives. ECAP 2 provided great lessons learned. For instance, Mercy Corps learned that

community engagement can lead to meaningful change and the program brought about a great national network of local NGOs.

Regina Parham – OFDA Regional Advisor

Regina Parham acknowledged the great work done by ECAP 2 partners. She remarked that the Lessons Learned Workshop shall not be seen as the end of the program but as the beginning of a great network. The support of grassroots is necessary to build effective policy, and local partners shall not stop doing their great work, especially in light of the many challenges that Liberia has been facing.

Tolbert Nyenswah – Deputy Ministry of Health

Tolbert Nyenswah addressed some key messages:

- When the ECAP program started in August 2014, Ebola outbreak was already out of control, and there was widespread fear, frustration and desperation in Liberia. ECAP's design benefitted from the lessons learned from the polio campaign where the Ministry of Health went from house to house and trained community volunteers. The approach deployed for Ebola was similar, where community members worked together to stop Ebola. Hence, it was fundamental that the ECAP program had to be led by local Liberian NGOs.
- The stop of Ebola was possible because of partners' work and community leadership. However, Liberia is still facing challenges, especially in vaccination campaigns and maternal health. Mothers do not take their children to clinics for vaccination. ECAP 2 has done a lot in this direction since the program spread messages to ensure that mothers go to facilities and get their children vaccinated. Liberia has a lot of things to improve and challenges, but there are a lot of cost-effective technologies to improve people's lives.

The Deputy Minister of Health also acknowledged the great results of the local NGOs. He stated that he traveled around Liberia in the past three weeks and saw ECAP 2 communities in full operation.

Q&A, Comments, and Recommendations

- **Jzhon, Executive Director of CHESS**, recommended that the Ministry of Health push the County Health Team to make CHC members part of health promotion in Liberia. For instance, they could be involved in polio vaccination campaign;
- **James Sloan, Program Manager of LCL**, raised concern on leaving more than 1,500 communities since people would be discouraged to continue their work. He recommended support from the Ministry of Health, especially in policy making;
- **Paul Quilmie, M&E Officer of EQUIP**, pointed out that ECAP 2 messages were around health promotion and use of clinics. In some cases, however, clinics are too distant, and the MoH should take action to make clinics more accessible;
- **Janice, Executive Director of LCL**, pointed out that ECAP 2 in eight months was able to bring about behavioral change, such as the use of mosquito nets. However, there is still a lot of work that we need to do regarding health and the upcoming elections;
- **Urlick, CSO of WCI**, stated that the ECAP 2 network should be used for other development programs;

- **William, CSO of ACHWS**, shared his positive experience on how people trust clinics after the program;
- **Luis, CSO of SAIL**, shared her negative experience with dead body testing, since in one case the dead body testing team never showed up;
- **The Manager of Radio Totota** lamented that community radio is not well supported and that many health workers are not willing to talk to the radio station. He recommended that the MoH communicates to clinics so that they can work together for the interest of community members.

Group work & presentations

This session was about group discussion on four topics:

- 1) Innovations and strategies used during ECAP 2 that had great impact on beneficiaries;
- 2) Future opportunities of CHCs;
- 3) How communities achieved better health outcomes;
- 4) How community radio can leverage the impact of partners' work.

Topic 1) Innovations and strategies used during ECAP 2 that had great impact on beneficiaries.

1.1) What innovations or strategies did you use during ECAP 2 that had great impact on our beneficiaries?

1.2) How did that positive impact work? How did you use these strategies during the implementation?

Presentation from NAYMOTE, RESPECT, SAIL and WANEP - **“Innovations/Strategies in ECAP 2 implementation”**.

ECAP 2 had some innovative strategies:

- ECAP clustered and assigned CSOs to work together as teams in health districts;
- Signboards at the entrance of each community. This increased visibility;
- Supporting, attending and flagging out health issues from communities at the County Health Team monthly coordination meetings;
- Partners organized community sporting activities to share health messages;
- Organized CHCs/community leaders for lessons learned, experience sharing and close-up project workshop;
- Commemorating important health days such as the World Malaria Day and Hand Washing Day;
- Regular home visits and follow-up monitoring to observe behavior change;
- Organized games for children. Children were able to pass the messages to siblings and parents;
- CSOs were engaged in clean-up campaigns with CHCs and visiting places of worship, market places and farms to deliver health messages;
- Support for immunization campaigns (e.g. Polio);
- Dramatization of MoH approved health messages by CHC members in marketplaces. Drama was a good way to deliver messages, especially to illiterate people;
- Carried out activities on holidays, weekends and market days;
- Encouragement of OICs to visit catchment communities to show support for and cooperate with CHCs and encourage community members to visit the clinics when sick. CHC members acted as a link between communities and clinics. The encouragement reinforced the trust and use of clinics;

- Building strong collaboration with local leadership, County Health Team, gCHWs and CHWs;
- Organized rotational CHDC meetings in communities for equal participation and project impact;
- Worked with community leaders and CHC members to establish cashbox savings to sustain CHC activities;
- Included community leaders into CHC activities;
- Worked with people of diverse background and age to understand health problems that affect sub-groups of the population;
- CSOs and project team integrated into assigned communities, established personal relationships with CHCs, OICs, and community members;
- Spending extra time with CHCs and residents to provide more mentoring and coaching support;
- Made use of local language in creating awareness on approved MoH messages by CHCs;
- Joint CHC initiatives, such as roadside brushing, raising local resources, etc.

Q&A, Comments, and Recommendations

Q- Lawrence, CSO of YMCA, asked how to ensure that messages reach all members of communities, including marginalized groups.

A - Participation has many levels. The first level is to consult at the community level. In the end, there is self-management where community members take the lead of their health. One example is NAYMOTE where the organization makes sure that there is at least 50% of women participation in CHC meetings.

Q – Roland, the representative of EQUIP, asked how to set up and manage a cash box system to ensure accountability.

A - The CHCs in one catchment community came together and put the savings from the farming season. Other CHC members engaged in Cassava Farms.

Q – Collen, CSO of EQUIP, asked how to ensure women participation

A – In WANEP, CSOs postponed meetings if there were not enough women. They also tried to involve women more if they were too quiet.

Additional strategies from other groups:

- During the World Malaria Day/Hand Washing Day, CSOs invited communities outside ECAP 2;
- Radio Totota was able to mobilize motorcyclists and share information very quickly;
- CSOs shared information and challenges with management;
- Use of the LLA methodology to spread the messages;
- CSOs hosted meetings at night because of the farming season;
- CSOs facilitated the process of inclusion of marginalized people;
- CSOs worked with women, mobilized them and outlined the importance of using the clinics.

Topic 2) Future opportunities for CHCs.

2.1) What are the future opportunities for CHCs?

Presentation from AFROMED, PHIL, YUDA and YMCA. “What are the future opportunities for CHCs.”

There are many opportunities for CHCs:

- Constant training to meet emerging health challenges;
 - Capacity building of CHC members in hygiene promotion and other areas;
 - Adult literacy training program for CHCs;
 - Health promotion training;
 - Various training acquired including the LLA and CHRRP to address community health and development needs;
- Revised community health policy. This policy has a component related to community engagement;
- Frequent health campaigns such as polio immunization, Africa vaccine weeks and other health campaigns;
- Knowledge of the CHRRP is key for advocacy and community service by CHCs to local health authorities;
 - The CHRRP may link communities to other NGOs to resolve community-related problems;
- The community toolkit is an opportunity to keep training the CHCs and do health promotion;
- Unity between CHCs and gCHVs and between CHCs and community members;
- Community mobilization and human resources available;
- Exchange visits, sharing ideas and learning from other successes and challenges;
- Ability to plan and manage community-based projects. The CHRRP taught that community members should take the lead of their health;
 - Recognition by community members. CHC members are respectful and trustworthy people;
 - Credibility of CHC members due to past achievements;
- Influence over decisions that affect their community health.

Problems: Limited or inadequate availability of materials and educational support to CHCs and lack of follow-up and supportive supervision by the MoH. Moreover, distance to clinic makes treatment and attendance at CHDC meetings particularly challenging.

Recommendation: Regularly monitoring of CHCs by the MoH and integrating CHCs in MoH structures along with some incentive.

Q&A, Comments, and Recommendations

Q – CSO of LCP, asked how CHCs can solve the problem of lack of health material/tools.

A - CHCs can engage community members by using the resources available in communities. For instance, people built latrines by using their resources. It is enough that communities have information, knowledge and skills.

Q – Roland, the representative of EQUIP, suggested that the MoH should give some incentive to CHCs so that they can do some projects.

A – The ECAP 2 network should move ahead with one voice. It is not sustainable to give money to CHCs. It is important to support the community ownership of health to sustain the intervention of ECAP 2.

Other comments related to future activities from the floor:

- CHCs can now be trusted by the MoH to do outreach activities;
- CHCs can do a daily monitoring and make sure that there is a continuous linkage between community members and clinics;
- CHCs can receive support from community members themselves;
- CHCs have the opportunity to discuss with clinics on health issues;
- The structure of CHCs is already in place so that NGOs can use the existing structure to enter the community;
- The CHRRP is an effective way to market the CHCs in their counties. The CHRRP is already in place, and other NGOs can use it;
- The CHCs to be used for many development projects and interventions, such as education, peacebuilding, etc. The CHCs can be net producers for new interventions in communities;
- CHCs provide information to health facilities;
- CHCs are integrated into the health management in the community and at the county health level;
- We had closure meetings from CHCs, and most of the CHCs said that they will be starting a cassava farm. CHCs can sustain themselves;
- CHCs can be trained to do the dead body testing in communities;
- The CHCs can be used as a medium of NGOs and government to deliver any message. They are credible in the community;
- Now CHC members receive help from community members, and they get information from the clinic and establish a relationship with the OIC;
- CHCs were trained on LLA to discuss health issues;
- CHCs got very good skills from the CSOs to carry on health messages;
- Behavior change is a long process;
- When we have FGDs, we should engage women to better understand the issues. We cannot postpone meetings just because there are not enough women;
- CHCs are the agents in the community and they carry on health messages and refer to the clinic;
- CHCs have enough skills from CSOs, and they should work along side health actors in communities;
- CHCs can be fully deployed by communities through other NGOs;
- The youth was part of CHCs and after training, they felt much more empowered.

Topic 3) How did communities achieve better health outcomes?

There are two key aspects:

- Accountable community engagement
 - a. Effective community entry
 - b. Clear project objectives
 - c. Facilitation of CHCs in aligning their achievement to project's goals
 - d. Monitoring system through active participation of beneficiaries
 - e. Organization of periodic reflection meetings in the field
 - f. Project review meetings with stakeholders
 - g. Effective feedback system

- CHC-led community engagement and participation
 - a. CHCs have engaged community members over time
 - b. Attendance at CHDC meetings allowed addressing community health issues to the OIC
 - c. CHCs have been empowered, and they can advocate for communities' problems
 - d. CHCs part of monitoring system
 - e. Mercy Corps and ECAP 2 partners provided capacity building to CHCs
 - f. CHCs commenced sustainability projects

Topic 4) How can community radio leverage the impact of your work?

Community radio stations have played an important role in reconstructing Liberia after the civil war. They have increased in coverage by strengthening advocacy, peace building, and health promotion.

Community radio had a relevant impact on the project:

- Increased coverage of beneficiaries
- Enhanced project stakeholders awareness and participation
- Increased project visibility
- Provided a real-time feedback mechanism.

Community radio stations had some challenges:

- Rare visits to communities
- Poor infrastructure
- Difficulty in planning interviews with beneficiaries because of lack of staff.

Recommendations:

- Coordination with NGOs to increase available resources
- Donors should assure minimum budget for community radio in programs
- Local stories should be prioritized.

Day 2 - 27/05/2016

What did we achieve in ECAP 2?

The ECAP 2 team was comprised 23 local and international NGOs who directly implemented the program, two technical partners, 30 radio stations and seven radio mobilizers.

ECAP 2 has engaged 1,599 communities in all 15 counties of Liberia, achieving 1,566 functional CHCs in April. These CHCs conducted awareness campaigns, directly reaching out to 334,590 people in communities. Moreover, community radio stations reached out to 968,120 people, and the potential pool of community members who potentially directly benefitted by the program is 899,357 people.

Over 1,500 CHCs have completed the CHRRPs, and some of them have started the activities outlined in these plans. Our partners have also distributed 1,800 Community Health Toolkits to CHCs and the

Ministry of Health to promote sustainability in CHCs after the program along with projects that have already been undertaken by CHCs. Furthermore, Ebola awareness and vigilance, as well as hygiene best practices have increased at the community level.

During ECAP 2 team field visits, it was reported that the number of people going to clinics has increased. Partners reported that the practice of dead body swabbing before burial had been accepted and practiced by communities despite the initial challenges.

CHDCs register a good level of activity, and the relationship between communities and clinics has dramatically improved. Furthermore, mothers are taking their children to the clinics for vaccinations. These results were achieved through continuous CHC advocacy work.

What are the strengths and weaknesses of your civil society network? What is the future of it?

The network has different expertise but same interests.

What do we want? How to define a network?

Partners were then divided into four groups:

- NAYMOTE, RESPECT, SAIL, and WANEP
- AFROMED, PHIL, YUDA, and YMCA
- WONGOSOL, A2N, EQUIP, and WCI
- LCL, SHALOM, NEP, and CHESS

Three areas of concentration in group discussion:

- 1) Purpose. Why do we want to network?
- 2) Standards. What standards do we want to have?
- 3) Reputation. What quality of reputation do we want to have?

Each group discussed two points.

1) Purpose

- To build synergies and build each other's capacity
- Sharing information and lessons learned
- To attract donor's support
- Coordination and effectiveness
- To leverage our strengths for service delivery

2) Standards

- Accountability and transparency
- Depoliticized network
- Transparency
- Credible record in communities

- Each member of the network should be highly skilled

3) Reputation

- The work should be in compliance with donor requirements
- Trust
- Transparency
- Credibility and unity
- Effectiveness and responsiveness in service delivery
- Highly independent and professional

Terms of Reference of the Network

- To coordinate and strengthen service delivery
- Network meetings
- Cooperate with national government
- Achieve the same goal
- Advocate for health services delivery

Action Points

- Research resources that address community needs
- Design a program that develops the network constitution
- Access to lesson learning among partners
- Combination of notes and skills
- Develop and maintain relationship among CSOs
- Boost community development

The executive directors shall meet and define a concrete plan to establish the network. The first meeting will be on Friday 17th of June 2016 at 12:00 pm at EQUIP Liberia main office in Monrovia.

Who is going to take responsibility to make sure that it happens?

- Executive directors and program managers shall take the lead and constitute the board;
- A consultant shall be hired;
- Support from Mercy Corps to provide technical support on drafting document;
- Mercy Corps should also provide technical, financial, logistical, monitoring and management support;
- A committee should be set up to draft the document.

World café

Partners had five-minute presentations on their organization.

4:00 pm Closing Remarks

Sheila Paskman – Deputy Chief of Mission USAID

Sheila Paskman closed the third Lessons Learned Workshop by acknowledging the great work done by the ECAP 2 network. She praised the resilience of Liberian communities in taking the effort to fight Ebola. She stated that two important things came out of the Ebola period:

- 1) Health issues are not local but involve everyone. Zika virus is showing this to the world. The international community is fighting Zika, and it is taking it seriously because of the lessons learned from Ebola;
- 2) Local NGOs should let politicians know that they understand the communities they work in and that they are capable of running successful programs. Local NGOs are building communities and giving themselves the strength to live better. Nobody can come and take this away from them. “Every step you take is part of the thousands of steps to achieve what you have.”

Sheila Paskman closed her speech by saying that she is hopeful for the future of Liberia because of local NGOs, although they need to show to everyone what they do and what they can do.

Q&A, Comments, and Recommendations

James, LCL, stated that people need education, especially for the upcoming elections.

Emmanuel, EQUIP pointed out that it is important to reach out to people at the grassroots’ level, that’s why ECAP worked. It is fundamental to share information at the very low level. There is a strong need to improve health education at the local level.

Joyce –Executive Director of PHIL– stated that this network should look forward to full engagement in women’s participation. This network can use the existing platform to enhance voter registration and promote women’s participation.

Sheila Paskman said that USAID has already started to work with the Liberian election commission. They are pushing to have registration as high as possible and work with the UN to see what kind of support can be done.

3rd Lessons Learned Conference
May 26 and 27, 2016
Venue: Golden Gate Hotel, ELWA Road, Paynesville

DAY 1: Thursday, May 26: Moderators, Varney Gaie & Catherine Brown

8.00 – 9:00am	Breakfast & Registration	Partner Support, MERL & Compliance
9:00 – 9:15am	Opening of Workshop Mercy Corps OFDA/USAID	Penelope Anderson, Country Director Regina Parham, Regional Advisor
9:15 – 9:30am	Keynote Address	Hon. Tolbert Nyenswah, Deputy Minister of Health
9:30 -10:00	Q&A	
	Tea/Coffee Break	All
10:00-1:00pm	Group work & presentations Innovations/Strategies in ECAP 2 implementation by partners What are the future opportunities for CHCs	NAYMOTE, RESPECT, SAIL, WANEP AFROMED, PHIL, YUDA, YMCA
1:00-2:00pm	Lunch	All
2:00-4:00pm	Group work & presentations: How did communities achieve better health outcomes? How can community radio leverage the impact of your work	WONGOSOL, A2N, EQUIP, WCI, NEP LCL, SHALOM, NEP, CHESS
4-4:00pm	Summary	Partner Support team
6:00 – 9:00pm	Dinner Party	LCP band

DAY 2: Friday, May 27: Moderators, Varney Gaie & Catherine Brown

8.00 – 8.30am	Breakfast & Registration	Partner Support team, MERL, Compliance
8.30 – 8.45am	Recap of Day 1	Isaac Capehart
8:45 – 9:30am	ECAP 2 contribution to community health	Director Tamba Boima
9:30 -12:00pm	World café CSO breakout session	Partners Partner Support
12:00-12:30pm	What did we achieve in ECAP 2	Joseph Smith
1:00 -2:00pm	Lunch	All
2:00 – 3:30pm	What are the strengths and weaknesses of your civil society network? What is the future of it?	Partner management
3:30 –4:00pm	Certificate presentations	Partner Support team
4:00 - 4:15pm	Closing Remarks	Sheila Paskman Deputy Chief of Mission USAID
4:15-4:30pm	Evaluation of Workshop	ECAP 2 Partners

III. Annex 3

Minutes from Network's first meeting post ECAP 2

ECAP-II Network Meeting

June 17, 2016

Attendance: The meeting was attended by Executive Directors from: SAIL, LCL, LDS, LNRCS, CHESS-Liberia, Equip, ACHWS, SHALOM, NMCL, WCI, RESPECT

Meetings started at 3:30pm. Earlier by 12 noon few organizations came for the meeting based on the initial time set from the 27th because they did not get the new change in time for the meeting.

Welcome by Patience Flomo.

Participants received a copy of the notes compiled at the meeting held on the 27th of May during the LLW workshop. After each person had few minutes to read over the minutes the meeting was called to order by Patience Flomo who chaired the meeting.

Executive Directors made the below changes having read the notes:

Purpose of the Network

The Network shall exist as a non-religious, non-political CSO and function within the confines of regulations of the Liberian government. The network shall exist to share vital information in the interest of a common goal and leverage individual strengths for effective service delivery utilizing our unique skills and experiences of each organization in the network. We shall build synergy that support each member work.

Standard of the Network

The Network shall maintain high standard for all members. Members shall have the history of credible records within the communities of operations. High reputation shall be the hallmark of the Network, every member shall have a history of compliant with donors' regulations and possessed evidence of donor compliance. Accountability, reliability, transparency, high level of professionalism integrity and guided principles.

Terms of Reference of the Network

A Technical Committee will be selected to derive the details of meeting dates and time. The committee shall work to produce a constitution, SOP, MOU/legal paper work.

The TOR of the Network shall be:

Seek funding as a network whenever there is an opportunity like a specific call for a Network. The Network exist to bring together members for collaboration. Coordinate, strengthen, integrate and provide effective service delivery. Research and mobilize resources and design programs that address community's needs. The Network shall provide opportunity for peer networking, support, lesson learning events, personal and professional development amongst network members. Develop and maintain relationship with other medial entities and CSOs.

Actions taken at the meetings

1. Formulation of the Technical Committee:

9 members Technical committees selected at the meeting were:

1. CHESS
2. SAIL
3. AfroMed
4. Shalom
5. LCL
6. NMCL
7. Equip
8. Respect
9. Phil

AfroMed and Equip will coordination information sharing for the Network for now.