



**Ebola Community Action Platform 2 (ECAP 2)
Funded by USAID/Office of US Foreign Disaster Assistance
Final Report
July 2015 – July 2016**



Community mobilization in Margibi County. *Photo: Laura Keenan for Mercy Corps*

Context

The Ebola Virus Disease (EVD) hit West Africa in December 2013 and subsequently developed into an epidemic, resulting in over 28,000 total cases confirmed with more than 11,000 dead in the West African region by July 2016. The epidemic affected Liberia the hardest, with 10,678 cases and 4,810 deaths as of the first week of June 2016 according to the World Health Organization.

The epidemic was a full-scale emergency, with national, regional and global impacts. The response engaged leading specialist agencies such as the Center for Disease Control (CDC) and the World Health Organization (WHO), working in partnership with national governments, donors, United Nations (UN) agencies and international and local non-governmental organizations (NGOs). In Liberia, the response was led and coordinated through the Incidence Management System (IMS), co-chaired by the Ministry of Health (MoH) with lead partner agencies. The response incorporated both direct provision of health services and social mobilization to engage communities in preventing the transmission of EVD.

The epidemic highlighted the weakness of Liberia's public health system, and the international community stepped up to help the country take the first steps in its restoration. While Liberia's IMS system has proven to be effective in response to the occasional outbreaks of EVD, its community health services capacity has significant weaknesses, evidenced by one of the world's highest maternal mortality and neonatal death rates.

Liberia's community health services division of the MoH, with support from the international community, revamped its policy in preparation for a country-wide roll out of the strengthened community health care system, including better trained health workers and functioning clinics in January 2016. Much attention and support were focused on the various cadres of health workers because, according to a World Bank study, 10% of Liberia's doctors died (there were only 50 at the beginning of the epidemic) and 8% of nurses and other health care givers succumbed to EVD, losses that will negatively affect the country's health profile for at least the next decade. The entry point of Liberians into their health system, the Community Health Committee, was not addressed in the early recovery response and it was this gap that the MoH collaborated with Mercy Corps to address with USAID support through the Ebola Community Action Platform 2 (ECAP 2).

Executive Summary

The Ebola Community Action Platform 2 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. The first ECAP program used a sub-granting methodology to establish partnerships with local and international NGOs, which then mobilized communities to adopt EVD prevention behaviors. Drawing on lessons learned from ECAP and responding to the evolving context in Liberia, ECAP 2 strove to support civil society organizations and community structures to build preparedness at the grassroots level against future outbreaks of EVD and other diseases with similar symptoms.

The 12 month program, which ran from July 11, 2015 to July 10, 2016, achieved the following:

- Over 1 million residents reached in health catchment communities throughout Liberia, representing approximately 25% of the total population,
- 968,120 reached with health promotion and EVD prevention messages on community and national radio,
- 23 implementing partners engaged (22 Liberian civil society organizations, 1 INGO) with two technical partners,
- 1,599 communities reached, with 1,566 functional Community Health Committees (CHCs) established and strengthened,

- Communities were linked to their clinics and health workers, promoting usage of clinics, baby vaccinations and mutual accountability between communities and their public health care system,
- For the first time, communities identified their prevalent health risks and started on mitigation measures to address these (Community Health Risk Reduction Plans), in collaboration with their clinic health care workers,
- Empowered CHCs with basic health reference information (Community Health Toolkit) to sustain their health promotion and disease prevention activities,
- Another first was that the MoH received detailed community health reports from all over the country, giving the national health directors the information to better manage their physical structure and the human resources implementing the community health policy,
- The information management (health learning) system allowed our partners to report on knowledge, attitudes and practices (KAP), supporting adaptive management and information sharing,
- All partners had access to the Monitoring, Evaluation and Learning System (MELS) dashboard, which was open access,
- Rapid research studies were completed and behavior uptake measurements taken.

Mercy Corps (MC), with complementary training support from technical partners Population Services International (PSI) and media expertise provider International Research & Exchanges Board (IREX), strengthened implementing partners' capacity and helped them overcome challenges. The adaptive management processes employed by the program helped partners respond to changes in the environment. The program design worked: the partners collaborated with county and district health professionals in all 15 counties to choose health catchment areas and tailored community engagement to optimize acceptance and receptivity to program objectives and targets.

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	1,021,475 population; 986,120 ¹ mass media	N/A	1,021,475 population; 986,120 mass media	N/A

Sector-Level Beneficiaries

SECTOR: HEALTH					
Cumulative Period Targeted		Reporting Period Reached		Cumulative Period Reached	
Total	IDP	Total	IDP	Total	IDP
1,500,000 (750,000 CHC;	N/A	1,021,475 population;	N/A	1,021,475 population;	N/A

¹ 1,021,475 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 the program. The radio listenership survey indicated a total of 968,120. It is misleading to add the numbers together to arrive at total beneficiaries because of double counting, but when the targets were established, 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.

750,000 mass media)		986,120 mass media ²		986,120 mass media	
SECTOR: HUMANITARIAN COORDINATION AND INFORMATION MANAGEMENT					
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 population; 986,120 mass media ³	N/A	1,021,475 population; 986,120 mass media	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 (101.6%)
# 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	5	5

I. Security Context and Situation Overview

The lingering EVD 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 foreseeable future. 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.

Generally, security has been manageable during the program, with partners engaging traditional leaders to keep their staff safe. Country infrastructure challenges were creatively dealt with, but these challenges did result in some implementation hardships and less than optimal opportunities for information sharing and meetings with very isolated communities. These factors inhibited full participation, but should be considered in future funding so that isolated communities and regions are not further developmentally disadvantaged. Of note is that where there are pockets of international programs, there is evidence of aid-dependency which caused some of our partners extra community mobilization work in the beginning because the dependency jeopardized the ECAP 2 goal of CHC sustainability.

II. Program Activities

Following is a summary of program activities by area of focus. Generally, the engagement of Liberian civil society organizations to implement the program was one of ECAP 2's most notable successes, with far reaching positive consequences for Liberia's front line capacity to respond to emergencies and community development. The Health Learning System was also ambitious and innovative, demonstrating that even with enormous infrastructure and capacity difficulties, data can be captured, analyzed and used to optimize program implementation.

While it is anticipated that there will be some community structures that will struggle over time, community leaders did recognize that they are powerful and knowledgeable enough to keep their communities safer and healthier. CHC members appreciated the new knowledge and relationships they gained during ECAP 2. PSI's Listen Learn Act adult learning methodology was particularly appreciated because community leaders and CHC members viewed it as a tool that could be used for any community initiative or problem. Some community leaders even credited the program with helping them unify their communities and support their efforts to improve general community life beyond health. For many, the current cycle of dependency has been interrupted and their own agency discovered and celebrated.

"ECAP has brought more unity to Tubmanville than I have seen in all my time in the area".

Hon. Richard L. James, Tubmanville
Township Commissioner

Many clinicians are experiencing community support which is an important incentive for them, even in the face of hardships and low funding, to better serve their patients and advocate for improvements to their service delivery capacity. And for some, they now understand better the Community Health Services Policy and their role and responsibility to the communities they serve.

For the first time, there is concrete evidence that media plays an extremely important role in community programming and uptake of useful, correct, life-saving information. Community radio was strengthened and its visibility heightened by ECAP 2 so that these outlets can now undertake original programming, and are more aware of funding sources and the positive impact they can have to respond to emergencies and to support community development initiatives. Because of the role community radio played in both ECAP programs, community radio is now being considered as a component in more development programs and is

being recognized by the Ministry of Information as an important source of information for Liberians residing outside of Monrovia.

1. Civil Society Engagement

In this program area, Mercy Corps worked with civil society organizations to ensure broad reach throughout the country and build the capacity of local organizations to respond to future health emergencies. Additionally, Mercy Corps and its partner network coordinated and collaborated 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 was comprised of 23 NGOs (see Annex I for a list of partners), 22 of which were Liberian. The focus of this component of the program was 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.

Under the first component, Mercy Corps facilitated links between the Liberian CSOs involved in the program and the Liberian government throughout the program. The partners established strong working relationships with county, district and local health professionals. The ECAP 2 network worked with county and district level health professionals to identify and then work with remote, under-served communities so that they were connected to Liberia's community health system. The network also formed effective relationships with traditional leaders and government representatives by inviting them to opening and closing ceremonies and keeping them informed about the program to ensure broad support of the program.

The effectiveness of the partners approach and relationship management was confirmed by government officials in monitoring visits, indicating the acceptance by all leadership levels for our partners and program. By the end of the program, high MoH officials concretely recognized the importance of the ECAP 2 partners' contributions by promoting collaboration with them with other international agencies and by including a civil society component in the new community health policy. The Deputy Minister of Health and the head of the IMS directly expressed his appreciation of the ECAP 2 program and the partner network at the final Lessons Learned Workshop. He lauded Mercy Corps' program implementation approach of deploying Liberian civil society organizations to strengthen the community health system and communities so that the country would be better prepared for future health emergencies. Anecdotally, a partner reported that when President Sirleaf was traveling in the Todee District to recognize a school, she saw ECAP 2 visibility signs, highlighting our partner AfroMed as the implementer in this region. She stopped and told program staff who were in their remote office that she was glad to see this program and even more delighted that it signified Liberians implementing programs for Liberians.

The recognition by the MoH was earned by the partners' effective work at the national, district and local levels. The partners established good relationships with health officials by keeping them informed about the program in monthly meetings, helping clinics establish relationships with remote communities, underscoring the importance of using clinics to communities in support of the government's efforts to vaccinate children and decrease maternal and neonatal morbidity and mortality rates. In a way, their advocacy was best illustrated by action, cooperativeness and reporting rather than by rhetorical flourishes. Of significant note is the formation, post ECAP 2, of a civil society network of former- ECAP 2 partners. (The minutes from the first two meetings are attached in the annex). These civil society organizations, heartened by their participation in and results of ECAP 2 and the doors the program opened for them, understand that as a group they can have more influence over government policy and lead interventions that are community-based and

focused. They also understand that they can be a powerful voice, and maybe the only one, for communities outside of Monrovia to help them progress in their development and have the capacity to respond to emergencies. Although forming a more permanent civil society network was not an explicit objective of ECAP 2, it does represent a significant achievement for the country. With the private sector largely captured by foreign interests and the public sector under-funded and corruption plagued, Liberia's civil society is vibrant, motivated and capable.

Advocacy training is an area the partner network is interested in pursuing, acknowledging that now that the door has been opened for them, it is important that they understand and practice how to effectively advocate for the under-served.



ECAP 2 partners supported MOH vaccination campaigns nationwide alongside other government health priorities.

Through media training supported by Mercy Corps and IREX, the partners learned how to productively engage media in support of their work. They worked with community radio stations to promote CHC and ECAP 2 activities and participated in programs broadcasting ECAP 2 messages. NGO representatives were regular participants on ECAP 2-funded national and local talk shows, answered call-in questions and linked radio stations to local health experts and County Health Teams. Working collaboratively, several partners developed new programming together with radio stations that targeted particularly under-served members of their communities (e.g. women and youth) while across the country, NGOs facilitated the staging of popular and highly participatory community theatre sessions (known as 'Everybody Business' forums) to consolidate ECAP 2 health messaging in the communities where they were engaged.

While there was no specific governance training component of the program, good management practices and overall program oversight principles were emphasized to partners during monitoring visits by the partner support team and Lessons Learned Workshops. Many of these organizations are founder-led and have skeleton governance structures. The larger partners, e.g. YMCA and Liberian National Red Cross Society, have governance structures in line with their worldwide affiliates. Like advocacy, governance is an area that the partner network will take up as they progress in their organizational development.

The second part of this civil society program component was training focused on building partner capacity in financial management and grant compliance, monitoring and evaluation (M&E) and community engagement. In the ECAP 2 program, Mercy Corps had a separate unit of subaward and compliance professionals specifically tasked with training the partners in financial management and compliance. Partners' financial

reports were monitored to ensure partners were adhering to the cost principles of “allowable, allocable and reasonable” when managing and reporting expenses charged to their subgrants. The partners unanimously agreed in feedback to Mercy Corps that building this capacity in their organizations was one of the most highly valued knowledge transfers of the program. In fact, almost all partners showed significant improvement in this area of organizational development by the end of the program.

M&E trainings and an introduction to statistical analysis were also greatly appreciated by the ECAP 2 partners. Again, as part of program management, Mercy Corps had a separate unit of M&E, rapid research and statistics experts to support training of partners and the program’s own learning and research needs. As part of program design, every partner organization was required to employ at least one full-time M&E employee so that the substantial data collection and verification could take place. Three formal training sessions were developed and held by Mercy Corps’ M&E experts and partner M&E staff participated in baseline and endline data gathering and analysis. Partner M&E officers were also taught how to monitor and assess field data and had an introduction to simple statistics, adaptive management and rapid research. This program requirement resulted in more knowledgeable M&E program officers and emphasized to partner leaders that M&E is a vital component of any emergency/development program and a required organizational capacity, like finance and compliance, to implement any program, whether donor financed or not.

The third area of partner training focused on community engagement. While most partners exhibited sophisticated and nuanced approaches to communities, a critical success factor for ECAP 2 was the partners’ ability to build effective relationships and coordination with district and regional health structures to ensure understanding, support and cooperation so that linkages were formed throughout the levels of the health system and feedback loops established/reinforced to respond to people’s health issues and needs. Community engagement training/support was delivered by Mercy Corps’ partner support team, calibrated to the varying levels of expertise and needs per organization. There was also encouragement for peer to peer support and learning, demonstrated in Grand Bassa County when one of the three implementing partners there experienced some community resistance about their hiring practice for ECAP 2 field staff. While Mercy Corps helped the organization re-do their hiring process, the other two implementing partners and the MoH assisted with specific advice and support for local authorities to help the community accept the re-hiring process as it included some community leaders to redouble efforts at demonstrating hiring fairness and transparency.

ECAP 2’s three Lessons Learned workshops and its week-long program kickoff meeting were opportunities for the partner network to not only hear about and then adapt best practices learned from each other and from data the Mercy Corps health learning system captured, but also to coalesce and become recognized as an important Liberia civil society network. These meetings were particularly effective in media training, illustrating how “Everybody Business” radio and community re-enactment dramas could be put together and how to engage with print and radio journalists to get program messages widely disseminated and understood. Another issue the workshops were instrumental in addressing was the management of expectations, especially in aid-fatigued and dependent communities. Partners made presentations on this topic and as a group reinforced the importance of community self-reliance and agency. Because some field staff were invited to the conferences, it was also an opportunity for the partners and Mercy Corps to hear “voices from the field”, helping management stay grounded in the realities on the ground and hear problem solving ideas, like meeting with farming and mining CHCs in the evenings or after church, engaging clinic staff in community outreach events and helping CHCs engage in small revenue generating activities to support their work.

Technical Partner Roles

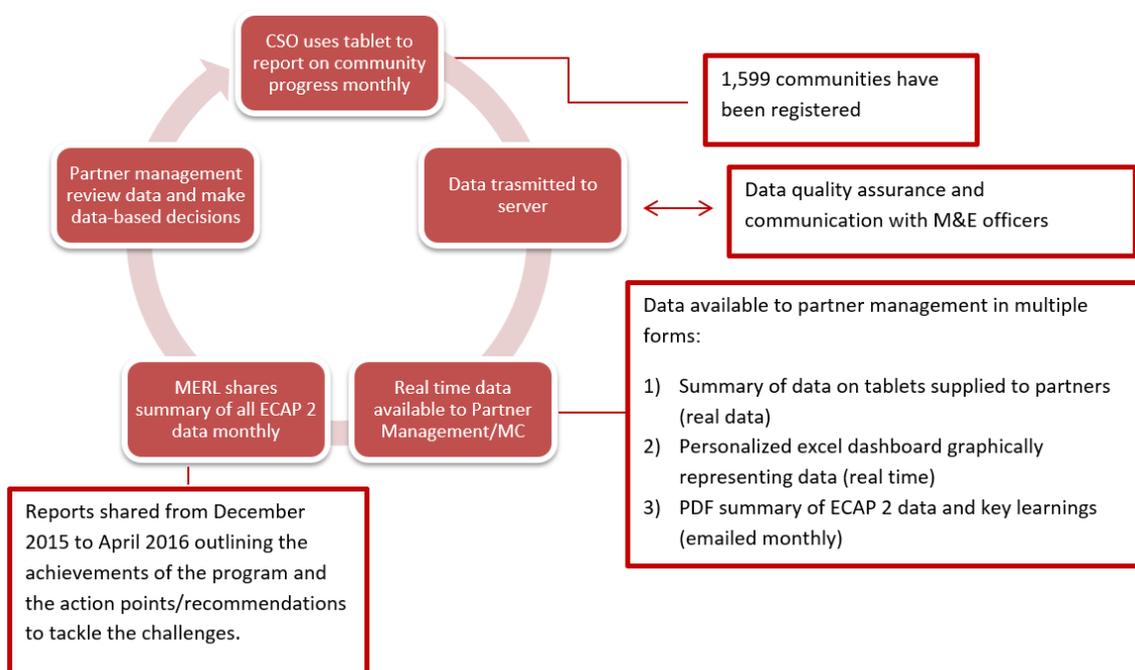
The program’s two technical partners, PSI and IREX, were responsible for providing technical training and support in behavior change communications and mass media engagement, respectively. PSI and Mercy Corps health staff attended MoH health promotion meetings and supported the Director of Health Promotion 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

contributed to the program by providing cascade-type training to the implementing partners' 389 Community Support Officers (CSO), who in turn trained CHC members on how to effectively communicate MoH-approved messages to their communities. Partners and communities felt that the Listen!Learn!Act! methodology taught by PSI was a communication tool with a useful life beyond that of ECAP 2 in that it could be applied for most community issues.

IREX led the mass media component of the ECAP 2 program by developing innovative and targeted content creation for 29 media partners (27 community radio stations and two Monrovia-based) to deliver Ebola prevention information in all 15 Liberian counties. The content was designed to support efforts to stop EVD transmission by promoting positive behavior change. As confirmed by Mercy Corps radio listenership survey, over 950,000 people heard ECAP 2's MoH approved messages. As over 70% of listeners indicated they believed what they heard on community radio, radio programs were an important source of information to reinforce the objectives and messages of ECAP 2

2. Creation of Health Learning Systems

The Monitoring and Evaluation system provided timely, quality information to track the program's outputs and to feed the learning process between Mercy Corps and partners. The ECAP 2 program had the CSOs acting not solely as activity facilitators but also as enumerators. CSOs submitted CHCs' monthly activity data, which was available to partners and Mercy Corps. The MERL team conducted data quality checks and reported inaccuracies or concerns to the M&E officer of each organization. This mechanism generated a first feedback loop between Mercy Corps and partners, which would feed the overall learning process. Cleaned data was then available to partner management through an Excel dashboard, reporting key findings related to each organization. In addition, the MERL team shared monthly reports outlining more in-depth findings and recommendations.



The health learning system was strengthened throughout the program with CSOs' refresher trainings, workshops aiming at building the capacity of partners' M&E officers on data management and analysis as well as inputs coming from qualitative studies and field visits.

While it would have been very beneficial for the MoH to take over this system, which is open platform, to incorporate it into the MoH's current M&E system, the MoH did not have the capacity to do so. As ECAP 2 was an early recovery program and the MoH itself was in the early stages of re-building after the Ebola epidemic with limited resources, it was not possible for the MoH to even consider taking on another M&E system. But as with other ECAP 2 initiatives, this work is available to the MoH for future expansion of its data capture and analysis.

3. *Strengthening of Community Level Health Structures*

"The CHCs are always carrying out awareness and this has increased the number of patients coming to the clinic. When they need help we also go to the community and clear their doubts. I am very happy to know that we have people there who have learned and who are helping the community."

Katrina Layweh, Clinic OIC, Rural Careysburg

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

After conferring with the MoH's County Health Teams, the partners identified catchment communities that would constitute their areas of program implementation. The partners then conducted community entry activities, collecting baseline data, identifying community leaders (both formal and informal) and community groups (particularly women and youth) and determining what if any health structures, CHCs, existed. The partners then worked with the community to (re)establish CHCs so that they fairly represented all population segments of the community and some established Memorandums of Understanding with the CHCs about the roles and responsibilities of each in support of community engagement with their health system (primarily clinics and health staff). Once this initial work was completed, CSOs worked with CHCs on a weekly basis (the community health policy indicates monthly meetings) with the goal of talking about the six approved MoH messages, how they would be disseminated to community members and reinforcing group cohesion for sustainability. The community health policy defines a functional CHC as one that achieves a quorum at meetings and 1,566 ECAP CHCs met this requirement.

The ECAP 2 target of 1,500 CHCs engaging with the government health structure fell short (1,375 CHCs attended monthly Community Health Development Committee (CHDC) meetings, representing 92% of target) because some communities were a 5-8 hour walk from their clinics, portions of transport routes and paths were in disrepair and/or impassable, some clinic officers failed to call meetings or did so at the last minute and some CHC representatives did not attend meetings when called. However, partners and clinics reported increased number of patients at clinics, particularly pregnant women and babies and communities and clinics now know each other so that overall there is expectation that the community health structure will be better able to cope with normal health needs and disease outbreaks. CHCs and clinics better understand the health issues and needs of community members 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 to ensure community engagement by the CHC leadership with community health issues was the introduction and preparation of the Community Health Risk Reduction Plan (CHRRP) which was led by the CHCs and owned by the community. The primary objective of the CHRRP was 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 program, nearly all communities had completed their CHRRPs and started implementing these plans by first cleaning up their communities. Many also prohibited open defecation and some

imposed fines on those violating this rule. Some instituted revenue-generating projects and used the proceeds to build/rehabilitate wells, pit latrines, hand washing stations, repair paths to the clinic, relocate garbage dumps and have transportation funds for CHDC meetings and medical emergencies in their communities. Several very ambitious CHCs even embarked on helping their clinics construct maternal waiting halls and one even started building a new clinic because its current clinic is very distant. A notable success of the CHRRP was that it was a community wide process whereby CHCs demonstrated their leadership and engaged their communities in broad discussions about health issues and what could be done to stay healthier and then taking action. Another positive outcome was that there was collaboration between the CHCs and their clinics on the CHRRPs so that the clinic became more aware of community health issues and CHCs became more informed about simple factors to reduce the risk of some common diseases such as malaria, runny stomach, typhoid and cholera.



This CHC is helping to construct a maternal waiting room in Gondoma Town for remote communities

To augment CHC knowledge about common health issues, ECAP 2's communication director, in collaboration with the MoH, designed and developed the Community Health Toolkit, which was laminated, bound and distributed to all CHCs, the MoH and partner agencies. Soft copies were also distributed to the MoH and all partners for further dissemination to county, district and local health professionals. In addition to providing a long-lasting, simple and illustrated health reference tool, this material along with a certificate issued by Mercy Corps to each CHC helped CHC members feel valued and important so that they would have additional non-monetary incentive to continue their important role as respected health ambassadors in their communities.

All of these initiatives were designed so that partners and CSOs would be encouraged to discover ways of empowering community groups to 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 understanding how to wean people

"I believe that the health of the community is its own reward."

Thelma J. Konneh, CHC Chair, Gold Camp Community, Cape Mount

away from handouts and dependence was 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 spread over the network, aided by Mercy Corps’ approach and the creativity of some partner leaders and staff, and it is hoped that this approach will be adopted in future programs.

By the end of the program, partners reported that communities wanted ECAP 2 to last longer because they not only realized its benefits but also enjoyed working with program field teams, getting to know their health professionals, coming to understand that they are an important part of the accountability of their health system and using the skills they learned to improve communal life. The program married the official and traditional leadership systems and proved to both that progress can be made when they all work together on a common cause.

4. Increase Public Awareness

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’ ... but [they] 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. Our children well in body; they going to school, they happy and healthy in body. And the way our children healthy and growing fine, we happy that one day they will help us in our old age...”

Yatta, Marchee Town, Montserrado County

This fourth program component was designed to support the uptake of healthy behaviors and continued vigilance against EVD, and to build trust in the health system. During the program, partners learned how to effectively engage with media and were encouraged to include CHC representatives, and community members, in community radio stations’ talk shows and radio dramas. In addition, CHCs delivered 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. Towards the end of the program, partners and many clinics reported a significant increase in demand for health services at the clinics. During the program, Mercy Corps’ Health Advisor worked closely with the MoH by attending meetings and writing reports to the Director of Community Health Services. These reports were one of the primary sources of information at the national level, providing information compiled from partner reports about bottlenecks, capacity limits, staff shortages and professional knowledge/behavior problems, and inadequate drug supplies to name some of the more pressing concerns at the clinics. While ECAP 2 messaging was successful in creating demand for using the clinics, capacity issues at the clinics remained a concern shared by partners, CHCs and the MoH.



Large crowds participate in an 'Everybody Business' forum in Bomi organized in partnership with community radio stations.

As described previously, IREX led the media component of the ECAP 2 program, and helped disseminate ECAP 2 health information, through partnerships with 29 radio stations (two Monrovia-based and 27 community radio outlets). 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 had 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 950,000 listeners heard ECAP 2 health messages.

In the third quarter of ECAP 2, there was an EVD outbreak in Guinea which affected Liberia. In response to a request by the MoH, Mercy Corps contracted five community radio stations to broadcast EVD transmission prevention messages and two implementing partners to provide on-the-ground emergency response. The outbreak was quickly contained. The MoH request and ECAP 2 response was a clear indication that not only were the ECAP 2 partners viewed as integral to an emergency response but that Liberia's capacity to deal with outbreaks was coordinated, rapid and effective.

III. Monitoring and Evaluation

The Monitoring, Evaluation, Research and Learning (MERL) team was focused on:

- Tracking the performance of the program
- Informing Mercy Corps and ECAP 2 partners about monthly field activities and results
- Evaluating the level of behavior change on six health topics
- Completing qualitative and quantitative research reports

In the month of May 2016, after field work was completed, partner M&E officers completed the community health survey data collection. The health survey report compared the baseline and endline data on health behavioral change throughout the program. The key conclusions were:

- Knowledge uptake and community attitudes were changed in two of the seven focus areas, those being hand washing and keeping sick people separate.
- For three of the topics, namely, stigma, childhood vaccinations and dead body testing, limited attitudinal change occurred throughout the course of the program.
- Because behavior change occurs slowly with many topics, it is not surprising that there was little movement in attitudes for three topics. This result could also be caused by weak message implementation and lack of intense program focus on the topics as messages were phased in during the program. It is important to note that the messages communicated in ECAP 2 came directly from the MoH and there was no flexibility in changing their content or date of rollout. However, the all-important hand washing and keeping sick people separate messages did show positive uptake.

The MERL team conducted qualitative and quantitative assessments throughout the program. The qualitative studies covered three areas:

- Barriers to children vaccination – Factors that limit mothers’ behavior in taking their children to the clinic for immunization. Support from fathers is an important element that affects mothers’ decision making.
- Functionality of CHCs – Factors that make a CHC functional. Functionality has to do primarily with participation with the community health system as measured by attendance at monthly CHDC meetings. (Report attached in Annex)
- Sustainability of CHCs – Factors that make a CHC sustainable after the ECAP 2 program. Four key factors were found to be contributors to CHC sustainability: 1) a high level of commitment from CHC members; 2) participation of community leaders in CHC activities; 3) sustainability projects (revenue generation) and 4) expectation management. Factors 3 and 4 received low scores due to limited implementation time and some difficulty by some partners to clearly communicate objectives. (Report attached in Annex)

The quantitative study focused on the radio listenership of ECAP 2 health messages throughout Liberia. The study showed that ECAP 2 exceeded the 750,000 listener target and reached almost one million people through radio and community radio stations. The study also revealed that community radio is a trusted source of information for over 70% of listeners.

Program Cost Effectiveness

Taking the number of beneficiaries in CHC communities, 1,021,475, and the amount of the grant that was spent, \$10.5 million, it cost \$10.28 per person to help re-establish the community health structure in over 1,550 communities and build preparedness at the grassroots level against future outbreaks of EVD and other diseases with similar symptoms. Grant proceeds were also used to strengthen 23 civil society organizations and engage two technical partners, PSI and IREX, as well as to produce a long-lasting, widely distributed, health reference toolkit.

Total head count working on the program was: 543 people employed by partners, PSI, IREX and Mercy Corps; 30 radio stations employed approximately 30 people, resulting in total program employees of 573. Subgrants to implementing partners amounted to \$7,642,274. PSI final expenditures were \$977,181 and for IREX this figure was \$390,043. The community radio component of the program, implemented by IREX, reached 986,120 listeners with messaging to promote healthy behaviors and safe practices, reinforcing work on the ground in supporting the community health structure for preparedness for Ebola outbreaks. This program component was a cost effective method to reinforce messaging, behaviors and use of the health system at \$0.40 per listener. The open access dashboard and the data collection tools were designed in-house and then built by a software engineer in India who charged approximately \$14,500 a significant savings when compared to rates charged by other providers. Considering program scale, ECAP was implemented very cost effectively and returned \$1.5 million in cost savings to USAID/OFDA.

Recommendations for Program Design Improvement

The sub-contracting component of the program which essentially devolved the implementation to 23 civil society organizations continued the approach of the first ECAP program. This method was chosen to support the scale of the program and ensure culturally appropriate approaches were used for community engagement.

As noted for the first ECAP program, the administration of the program could have been improved by having a sub-award structure specifically designed for partners that have implementing capacity but do not have the

same operating infrastructure that an international agency has. There needs to be an instrument that is more demanding than a Fixed Obligation Grant but more flexible than a sub-grant. The ECAP program has demonstrated that with the right oversight and program design, local civil society organizations can work together to deliver programs at scale cost-effectively. This approach also supports the empowerment of local organizations and has a positive impact on beneficiaries who are engaged appropriately and host government officials who see that their institutions are at the forefront of helping their societies.

Along with a more flexible and appropriate sub-award structure for local organizations, there should be a reconsideration of rules governing microgrants to community groups. The compliance requirements for microgrants is the same as for large grants and it is recommended that the documentation requirements be calibrated to match risk/reward levels. While partner disappointment about not having some small funding for their health improvement projects was managed, it would have been helpful for the most vulnerable communities to have some support in providing, for example, hand washing stations throughout communities and small emergency funds to support ill or pregnant women's transport to clinics.

Challenges

A challenge in the first ECAP program was working with a large number of implementing organizations in a very short period of time. For ECAP 2, we encountered similar challenges related to the short timeframe, but the number of partners was 23 (compared to 77 under the first program) and many of these organizations were familiar with Mercy Corps and the sub-award process, so this challenge was more manageable. While the partners were generally unfamiliar with the use of digital technology to capture data and the analysis and use of the data, this challenge was handled well by the ECAP 2 network.

By the time partners were chosen and vetted, sub-grants developed and signed, the M&E system designed, put on tablets and partner M&E staff trained, the actual time for field implementation was six months. While ECAP 2 was an early recovery program, it would have been beneficial to have had an additional two months for field work for the continued roll-out of communities' CHRRP and more familiarization with the Community Health Toolkit.

Communication and transport infrastructure gaps did present problems, but while they caused inconvenience, these problems were anticipated and therefore managed well. Partner staff needed training and mentoring on finance and compliance and their M&E capacity was not strong. These capacity building areas were known by Mercy Corps and while internal technical teams were strong, it was still a challenge to ensure that grant monies were accounted for and spent properly and that our partners understood what the data from their activities was telling them. Several partners had community entry problems, but the network, Mercy Corps and the MoH were on hand to help quickly resolve their problems.

Although not a specific objective, micro grants were part of the ECAP 2 proposal and budget (\$200,000). These grants were designed to be awarded to Community Health Committees (CHCs) to support the implementation of their Community Health Risk Reduction Plans (CHRRPs). When various options were considered as to how to implement these micro grants, Mercy Corps concluded that the compliance requirements of making grants to over 1,500 community groups rendered this part of the program infeasible due to the short implementation time period of the grant. While there was disappointment that micro grants would not be available, most communities doubled down their efforts to raise their own funds, use their own ingenuity for creative solutions to start to implement their CHRRPs. In fact, some partners felt that it was appropriate that this program component was not implemented because not doing it reinforced the program's efforts to encourage people to use their own resourcefulness to find solutions for improving their communities' identified health issues.

Although there were challenges of implementing ECAP 2, the program managed to reach over 1 million people all over the country and link them to their health system. Community relations with clinics were strengthened and clinic health professionals better understood the health needs of the people they served. At the end of the program, ECAP 2 left communities better prepared to respond to and contain any future EVD outbreaks.

Although it is challenging to work with organizations that present different levels of organizational development, ECAP 2 has demonstrated that these problems are surmountable. It is worth the effort and management complexity to engage civil society to achieve scale and impact. The goodwill engendered by this approach not only helps build broad-based support but also leaves a lasting legacy of the agency of national organizations and community groups.

ANNEXES

- I. ECAP 2 Partner Listing**
- II. Health Survey Comparing Baseline and Endline Data**
- III. CHC Functionality Report, April**
- IV. CHC Sustainability Report**
- V. Gender Study**
- VI. Partner Network Minutes, post ECAP 2**
- VII. PSI Final Report**
- VIII. IREX Final Report**
- IX. Evaluation Report**
- X. Photo Book**
- XI. Mercy Corps Liberia Golden Image Award**

ANNEX I: Community Partner Listing

1. Africa 2000 Network (A2N)
2. Afro-Medical Community Health and Welfare Services (ACHWS)
3. Community Health Education and Social Service (CHESS)
4. EQUIP Liberia
5. Liberia Crusaders for Peace (LCP)
6. Liberia National Red Cross Society (LNRCS)
7. Lutheran Church in Liberia (LCL)
8. Lutheran Development Service (LDS)
9. NAYMOTE Partners for Democratic Development (NAYMOTE)
10. National Empowerment Program (NEP)
11. National Mandingo Caucus of Liberia (NMCL)
12. Pentecostal Mission Unlimited (PMU)
13. People United for Sanitation & Health (PUSH)
14. Public Health Initiative Liberia (PHIL)
15. Resource Center for Community Empowerment & Integrated Development (RECEIVE)
16. Rural Education Sponsorship Program Enhancing Communities Together (RESPECT)
17. Serving Humanity with Affection and an Open Mind, Inc. (SHALOM)
18. Survivors Aid International Liberia (SAIL)
19. West Africa Network for Peacebuilding (WANEP)
20. Women's Campaign International (WCI)
21. Women NGOs Secretariat of Liberia (WONGOSOL)
22. Young Men's Christian Association of Liberia (YMCA)
23. Youth United for Development Association (YUDA)



BEHAVIOR CHANGE OUTCOMES FOR ECAP 2

Results from the Baseline and Endline Health Survey

JUNE 2016

A. Introduction

Program Background

Mercy Corps with help from the United States Agency for International Development/Office of Foreign Disaster Assistance (USAID/OFDA) is tackling the threat of Ebola re-occurrence at the community level through its implementation of the Ebola Community Action Platform 2 (ECAP 2) in all 15 counties of Liberia. The program focuses on building community preparedness for Ebola outbreaks, by strengthening Ministry of Health recognized community health structures, called Community Health Committees (CHCs), and re-establishing linkages between communities and government health services. In addition to this, the program, conducts behavior change campaigns at the community level in partnership with the Ministry of Health, focusing on priority health topics.

Study background

In line with Ministry of Health recommendations, the program identified six priority health topics to focus on at the community level through behavior change and messaging activities. Mercy Corps' technical partner, Population Services International (PSI) Liberia, developed behavior change and messaging guides and training materials on these six health topics. This information was cascaded through the ECAP 2 partner network of 23 NGOs and trainings on health topics for community health committee members were arranged in all 1,599 target communities. Community members were educated on these six priority health topics by the trained community health committees within each target community.

Community education occurred in a variety of forms depending on the size and nature of the community. Some used door to door house discussions, community meetings, and drama at market places, notices in churches and mosques and others during school assemblies. The aim was to engage as many people as possible on these health topics and to change behaviors in these communities towards healthier practices.

The six priority health topics were:

- Hand washing
- Keeping sick people separate
- Survivor stigma reduction
- Trust and use of clinics
- Childhood vaccinations
- Dead body testing



Methodology

In accordance with standard program management practices, Mercy Corps Monitoring, Evaluation, Research and Learning (MERL) Team conducted a large scale baseline and endline knowledge, attitude, practices (KAP) surveys in ECAP 2 target communities at the beginning and end of the program. These KAPs, titled the Health Survey, focused on the six priority health topics. In addition to this, they also examined perceptions of community control over health outcomes. A key aim of the development of the community health committees was that community members would feel they have a stronger ability to control the health conditions they face in their communities.

The baseline was carried out between November and December 2015, with a sample size of 2,168 respondents (51% male, 49% female) across all 15 counties. The endline was carried out in May 2016 with a sample size of 1,999 respondents (51% male, 49% female) again across all 15 counties of Liberia. A detailed methodology and study design is available in the annexes. The results from the baseline and the endline survey were compared to understand whether knowledge and attitudes have changed at the community level because of the messaging and behavior change tools employed.

This report outlines the results from the health surveys, including the level of knowledge and attitude uptake on the key health topics. The survey was broken down into seven key areas, the first six examining the priority health topics, and the seventh examining perceptions of community control over health outcomes. Within each topic area, there were a series of questions asked and a detailed breakdown of the results to those questions can be found in Section C of this report. A scorecard overview on each of the topics can be found in Section B.

B. Health Indicator Scorecard

The scorecard below outlines the level of success the ECAP 2 program achieved in improving community member's knowledge and attitudes, as demonstrated through the changes in results of the health surveys.

Topics where more there was a substantial improvement in a majority of indicators were graded as positive, with a green thumbs up. Topics where there was no change or very limited change in a majority of indicators were graded as mixed results, with a yellow circle. Topics where there was no change or negative change in a majority of indicators, were to be graded as negative, however, no topics met this grade.

TABLE 1: HEALTH INDICATOR SCORECARD

Hand washing	
Keeping sick people separate	
Survivor stigma reduction	
Trust and use of clinics	
Childhood vaccinations	
Dead body testing	
Community control over health matters	

C. Detailed Results

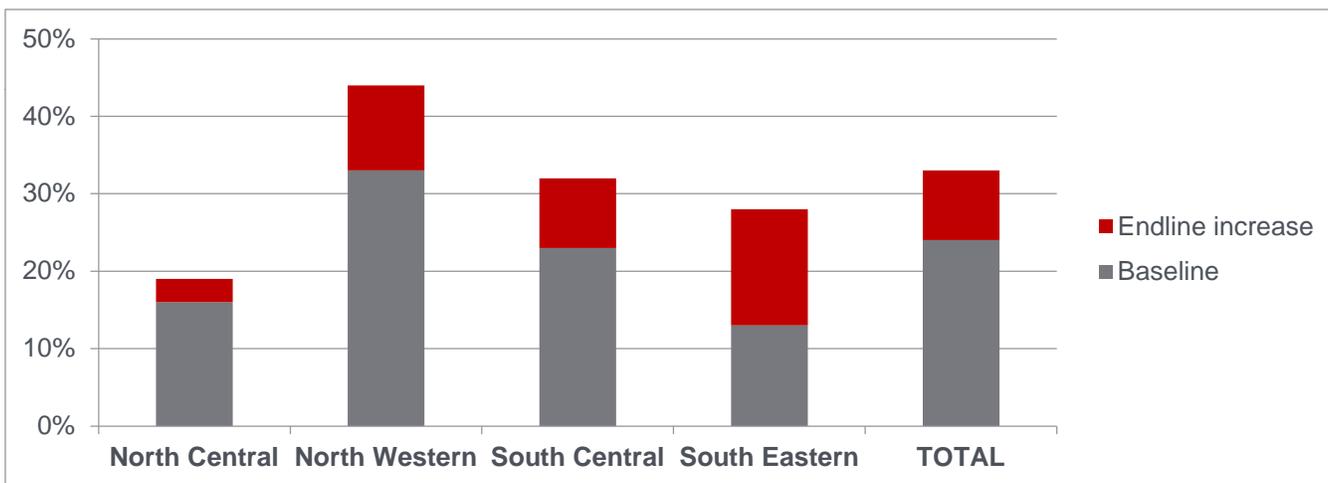
1. Hand washing

↑ Observed hand washing stations

The percentage of households visited that had an observed hand washing station, including water and soap/ash present, increased from 24% of households in the baseline to 33% of households in the endline. This represents a 38 percentage point change over the course of the program. This increase is likely due to the distribution of buckets by ECAP 2 partners and the recent Ebola outbreaks in Montserrado County and close to the Nimba County border.

The prevalence of handwashing stations varies considerably by geographic region, reflecting where bucket distribution occurred and where there were high risks of a potential Ebola outbreak. Table 2 demonstrates that at the beginning of ECAP 2 the South Eastern region had a low rate of hand washing stations, however, during the course of the ECAP 2 program the percentage of households with hand washing stations substantially increased to 28% because of a large increase in Sinoe County.

GRAPH 1: OBSERVED HANDWASHING STATIONS BY GEOGRAPHICAL REGION⁴



↑ Knowledge on key handwashing times

Knowledge on the key handwashing times increased substantially from baseline to endline. The indicator measured awareness on four out of five of the key handwashing times, and overall knowledge increased from 38% to 56% of respondents. There is a gender bias in the results with females more likely to be knowledgeable than men, however, this represents the linkages between key handwashing times and typical female duties such as preparing food and cleaning babies diapers.

⁴ Regions are defined as follows: North Central includes Bong, Lofa and Nimba Counties. North Western includes Bomi, Gbarpolu and Grand Cape Mounty Counties. South Central includes Grand Bassa, Margibi and Montserrado Counties. South Eastern includes Grand Gedeh, River Gee, Maryland, Grand Kru, Sinoe and Rivercess.

TABLE 3: KNOWLEDGE ON KEY HANDWASHING TIMES BY GENDER

Gender	Baseline Result	Endline Result	% Point Change
Female	46%	66%	43%
Male	30%	45%	50%
TOTAL	38%	56%	46%

↓ Attitudes to washing hands at checkpoints

Attitudes towards compliance with checkpoint hand washing decreased overall. This indicator was calculated based on results of two Likert scale questions:

- Washing your hands at checkpoints is not necessary
- Most of my friends wash their hands at checkpoints

The first question had a decrease in respondents valuing the necessity of handwashing by 6 percentage points. The second question had a mild increase in agreement by 4%.

This reduction in positive attitudes to checkpoint handwashing is likely due to the continual decline in the number of handwashing stations at checkpoints and a decrease in the perceived threat of Ebola. It also suggests that checkpoint handwashing was not substantially highlighted in the ECAP 2 health messaging process; however, this has not yet been verified by ECAP 2 partner management.

↑ Vomiting and diarrhea in previous 72 hours

There was an increase in the prevalence of vomiting and diarrhea in the previous 72 hours before the respondent's household was surveyed. This increased from 14% of households in the baseline to 16% of households in the endline. It is possible this is linked to the beginning of the rainy season and the increased health risks associated with the rainy season.

2. Keeping sick people separate

↑ Knowledge on need to separate family members sick with Ebola symptoms⁵

The results demonstrated a significant increase in respondent's knowledge that if a family member was sick with Ebola symptoms they should keep the sick family member in a separate part of the house. The baseline figure reported 42% stating they would separate the family member, compared to 72% of respondents in the endline. Despite this substantial increase, confusion over the messaging remains as 67% of the endline respondents also state that they would take the person to the clinic, in addition to separating them. This demonstrates that community members have learnt that the phrases associated with the messaging but still fail to understand practically what behavior is meant to be performed. There was no difference in results between male and female respondents.

↑ Perceived risk of catching Ebola

There was a very slight increase in respondent's perceived risk of catching Ebola in Liberia, from 71% to 77%. This low-level increase is surprising given the focus of the ECAP 2 messages on reinforcing that there is a continued risk of Ebola re-occurrence and suggests that this message has not been accepted by community members.

The result looks very different when broken down into further detail, as there are significant variations between the different geographical regions of Liberia. Perceived risk decreased in the North Central region during the course of the ECAP 2 program, whilst in the South East perceived risk increased. One possible explanation for this difference is that communities in the South East tended to be receptive to partners and new knowledge because of not having received much development assistance in the past, and thus not suffering from aid fatigue.

TABLE 4: PERCEIVED RISK OF CATCHING EBOLA BY REGION⁶

Region	Baseline Result	Endline Result	% Point Change
North Central	71%	63%	-12%
North Western	72%	76%	5%
South Central	76%	84%	11%
South Eastern	63%	86%	36%
TOTAL	71%	77%	8%

● Quick treatment = Ebola survival

⁵ Question states: 'If someone in your household was really sick with fever, running stomach, and vomiting, what would you do?' with multiple options available for selection including separating person, taking them to the clinic, informing the community leader etc.

⁶ Regions are defined as follows: North Central includes Bong, Lofa and Nimba Counties. North Western includes Bomi, Gbarpolu and Grand Cape Mounty Counties. South Central includes Grand Bassa, Margibi and Montserrado Counties. South Eastern includes Grand Gedeh, River Gee, Maryland, Grand Kru, Sinoe and Rivercess.

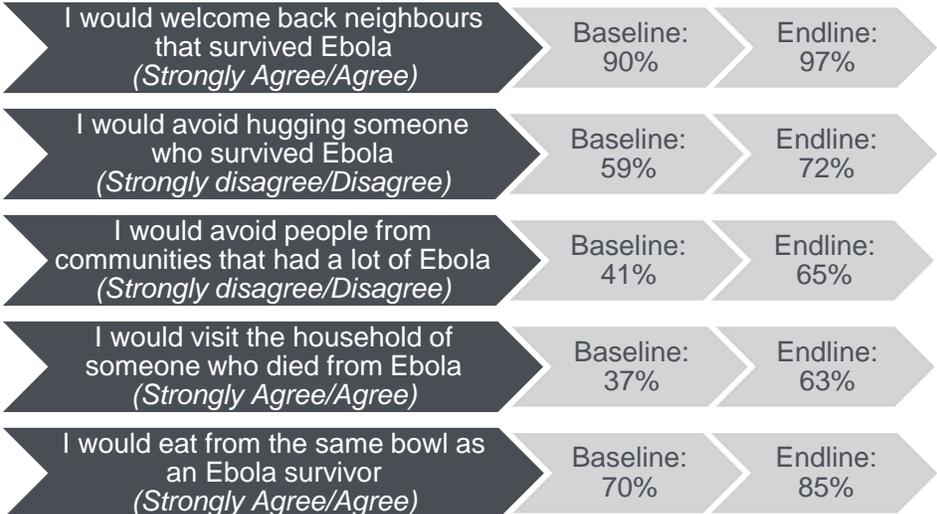
There was very little change in understanding that quick treatment at a clinic would increase an individual’s chances of surviving Ebola.⁷ [This is](#) likely because understanding on this issue was already very high at 95% of respondents at the baseline.

3. Survivor stigma reduction

↓ Stigma towards Ebola survivors and communities affected by Ebola

A number of questions were used to calculate the indicator on stigma towards Ebola survivors and communities affected by Ebola. Unsurprisingly, results varied significantly between the differing questions and between communities that had previously had Ebola cases compared to those that had not. The overall stigma indicator demonstrated a large reduction in stigma, jumping from 59% of respondents having low levels of stigma in the baseline to 76% of respondents have low levels of stigma in the endline.

The five questions⁸ used to determine the stigma indicator and the results from the questions are outlined below:



As the data above outlines, the two questions with the greatest change over the course of the program are the questions regarding ‘avoiding people from communities that had a lot of Ebola’ and ‘visiting the household of someone who died from Ebola’. The results for these two questions vary significantly when broken down by communities that had previously had Ebola cases, versus those that had not. Table 5 below shows that both Ebola affected communities and non-Ebola affected communities experienced an increase in stigma of people from Ebola-affected communities, though this increase was more marked in non-Ebola affected communities. Conversely, the likelihood of respondents visiting the household of an Ebola affected person increased in both types of communities, indicating a decrease in stigma against specific individuals and households.

⁷ Baseline result 95%, endline result 98%, equaling a percentage point change of only 3%.

⁸ Response options were: Strongly Agree, Agree, Disagree, Strongly Disagree

TABLE 5: STIGMA TOWARDS HOUSEHOLDS AND COMMUNITIES BY EBOLA AFFECTED AND NON-AFFECTED COMMUNITIES

	Baseline		Endline		% Point Change	
	Non-Ebola Affected Community	Ebola Affected Community	Non-Ebola Affected Community	Ebola Affected Community	Non-Ebola Affected Community	Ebola Affected Community
I would avoid people from communities that had a lot of Ebola (<i>Strongly disagree/ disagree</i>)	39%	53%	63%	70%	62%	33%
I would visit the household of someone who died from Ebola (<i>Strongly agree/ agree</i>)	36%	45%	60%	76%	65%	69%

● **Knowledge that Ebola survivors are not contagious through casual contact**

There was limited change in community members’ understanding that Ebola survivors are not contagious through casual contact, with the baseline figure of 92% of respondents understanding this compared to 94% of respondents in the endline. This limited change is most likely due to the fact that already a majority of the population had already accepted this fact.

4. Trust and use of clinics

Measuring individual perceptions and attitudes towards health facilities and clinics is very challenging given that respondents are reluctant to honestly admit their level of trust in facilities and often mistakenly report inaccurate clinic usage rates. Given this, the ECAP 2 team is concerned about the reliability of some of the indicators on this topic area and acknowledges that the questions highlighted below do not fully capture the outcome in these areas of intervention.

↑ Perception that clinics are functioning as they were before Ebola

There was a 14 percentage point increase in respondents' perceptions that clinics and health facilities are functioning as they were before Ebola.

↑ Understanding that health staff will wear protective gear such as gloves for everyone's safety

Respondents were asked questions two questions, the first measuring their understanding of "why" health staff wear protective gear and the second measuring "what" specific protective gear health professionals would be expected to wear. Understanding increased on both questions by approximately 10 percentage points from baseline to endline. Rates of understanding were already high for both questions in the baseline, around 75-80% understanding the correct answers to both questions. This suggests that knowledge on this area is well understood by community members in Liberia.

5. Childhood vaccinations

↑ Knowledge on number of times a baby should be taken for vaccinations

A major focus of the vaccination health topic in ECAP 2 was stressing to caregivers the number of times a baby should be taken to the health facility for vaccinations. This is in line with the Ministry of Health's campaign on "Take your child to the clinic for vaccines 5 times before they reach one year old". The purpose of this campaign is to ensure that all children in Liberia are fully immunized, as it is common for babies to partially complete their vaccination process.

There was a 39% improvement in caregivers' knowledge on how many times a baby should be vaccinated before they reach one year old

The results show a substantial increase, from 63% to 88%, in respondents' understanding from the beginning to the end of the program on the number of times a baby should be taken for vaccinations. This understanding did not vary by gender. The question referred specifically to children under the age of five.

This improvement in knowledge was most significant in the North Central and South Eastern geographical regions of Liberia. Knowledge levels improved from 22% in the North Central region baseline to 72% at the end of the program, and from 56% in the South East region baseline to 90% at the end of the program. The massive gains in these regions may be due to a lack of previous vaccination awareness campaigns in these areas.

● Understanding on importance of child vaccinations

Despite the increase in understanding of how many times a baby should be taken for a vaccination, there was zero increase in understanding on the importance of vaccinations for a child's health.

6. Dead body testing

↑ Knowledge on when dead body should be tested

The endline survey found a large increase in knowledge that all dead bodies should be reported and called for testing. The baseline data found that only 39% of respondents knew that dead bodies should always be tested compared to 66% of respondents in the endline.

↓ Understanding of dead body testing process

The increase in knowledge of when dead bodies should be tested was not matched by an increase in understanding of the dead body testing process. There was a slight reduction of 2 percentage points in understanding regarding the dead body testing process from baseline to endline. The questions on the dead body testing process focused on what happened if the test turned up negative and if the body could be buried in the traditional burial manner. This reduction shows that the message was not clearly understood by community members. Understanding of the message about the process may have been inhibited by the unreliability of the MoH's dead body management team, which did not always respond to requests for testing when they were made.

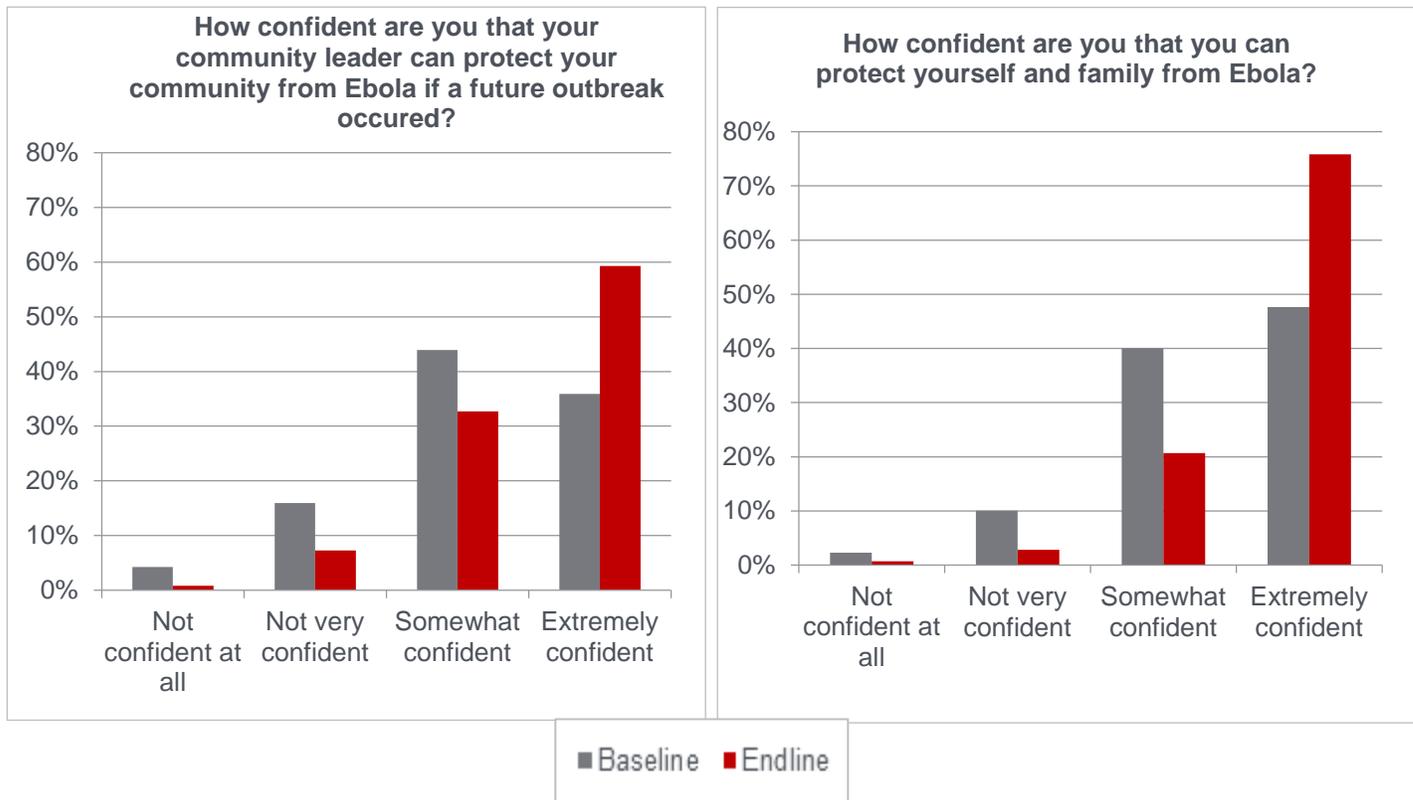
7. Community control over health matters

Community control over health matters was not the focus of any specific health message. It was, however, an overall aim of the ECAP 2 program and was emphasized to communities through the development of community health committees and as a continual background message throughout community visits.

↑ Confidence that community leaders and individuals can protect themselves from future Ebola outbreaks

The baseline results for confidence that community leaders and individuals can protect themselves were very high. 88% of respondents stated they were extremely confident or somewhat confident that they could protect themselves and their family from Ebola, and 80% of those same respondents stated they were extremely confident or somewhat confident that their community leader could protect their community in the event of a future Ebola outbreak. These high baseline figures may represent a cultural tendency to overrate confidence in being able to address community or individual issues, which has been noted in other Mercy Corps studies over the course of the past few years. Despite this, the endline figures suggest an improvement of 10 percentage points and 15 percentage points respectively, for both questions.

TABLE 6: COMMUNITY AND INDIVIDUAL CONFIDENCE IN ABILITY TO RESPOND TO AN EBOLA OUTBREAK



● Confidence that community structures can take action to protect their own health needs

A Likert scale of questions was utilized to measure overall confidence in community health structures in communities. These questions suffer from the same reliability issues as outlined above, with baseline figures all over the 90% range. It is not possible to generate major conclusions from these results given the high baseline figures and limited room for improvement. The diagram below outlines the baseline and endline figures for strongly agree and agree responses across all five Likert questions.



D. Conclusions

The ECAP 2 program endeavored to achieve positive behavior change outcomes around specific healthy behaviors in the communities where the program was implemented. The results of this study confirm that knowledge uptake and community attitudes were changed in two of the seven focus areas, those being hand washing and keeping sick people separate. Unfortunately, due to limitations in the data, major conclusions cannot be drawn on two of the topics, trust and use of clinics and community control over health matters.

It is pertinent to note that for three of the topics, stigma, childhood vaccinations and dead body testing, limited attitudinal change occurred throughout the course of the program. The study does not delve in to why the change was not more significant in these areas. However, it is likely that this occurred due to a mixture of the following reasons:

- Message was not able to be practically implemented by community members (*Dead body testing*)
- Poor messaging techniques and lack of behavioral change theory (*All three*)
- Lack of intense program focus on the topic (*Stigma*)
- Lack of time for message penetration (*All three*)

These results suggest that in future programming of a similar nature there needs to be a greater focus on using an evidenced behavioral change theory for each specific health message, and this theory and the tools developed must be tested and piloted before they are implemented. Furthermore, the results suggest

that future behavior change programming of this nature should allow for more time for message penetration at the community level.

Annex III: CHC Functionality Report

CHC FUNCTIONALITY REPORT

April 2016

Summary

The performance of the Ebola Community Action Platform 2 (ECAP 2) is satisfactory and sound in light of the achievements registered in April 2016: 98% of communities have regular meetings with quorum and the majority of Community Health Committee (CHC) members regularly take part in the monthly meetings at the clinic.

In the month of April, CHC meetings mostly focused on the CHRRP and the issue of sustainability after the ECAP 2 program. More than 200,000 people were reached with ECAP 2 health messaging, registering a new record high since the beginning of the program. Moreover, 24% of communities reported no challenges in the program implementation, signaling a potential sustainability in the short-to-medium period.

During the month of May, ECAP 2 partners should focus on fully supporting communities to gain self-dependence. First of all, partners should assure that CHC members understand the value and the scope of the CHRRP in their communities. Secondly, partners should provide as much support as possible to CHC members in order to make a smooth transition from ECAP 2. This should also be facilitated by a clear workplan with the action points to be taken. Finally, partners should ensure clear communication with CHC and community members in order to avoid misunderstanding and over-expectations.

Key Numbers from April



CHC Functionality Report – April 2016

The CHC functionality report of April 2016 marks the last month of implementation of the Ebola Community Action Platform 2 (ECAP 2). ECAP 2 partners submitted⁹ 1,571 reports, representing 98.2% of communities registered to the program¹⁰. This is a modest increase with respect to March, where the submission was 37 forms less. Damaged tablets and poor internet connection did not enable the reporting of all 1,600 communities.

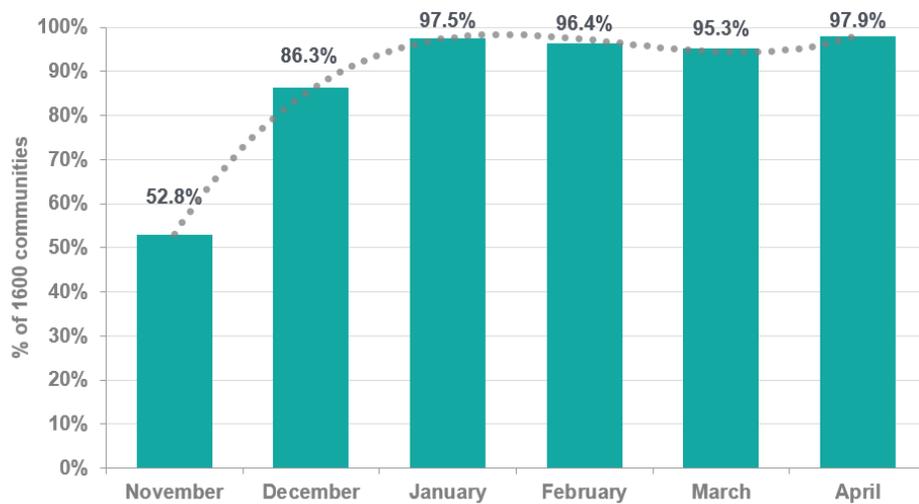
⁹ Forms submitted from April 11, 2016 to May 05, 2016.

¹⁰ 1600 communities in 15 counties.

General Information

The positive implementation of the program is confirmed by the high percentage of functional CHCs. 99.7% of communities submitting forms held at least one meeting in the month of April. Moreover, all communities reached the quorum to qualify them as functional. The month of April had the highest percentage of functional CHCs, 97.8% of all communities registered to the ECAP 2 program. The percentages of the previous months have been revised in light of a few changes in communities registration¹¹. The trend suggests that just after the first month of set up (November), partners were able to almost fully engage communities. From January to April, the number of functional CHCs has been above 95% and reached its peak (97.9%) during the last month of the program.

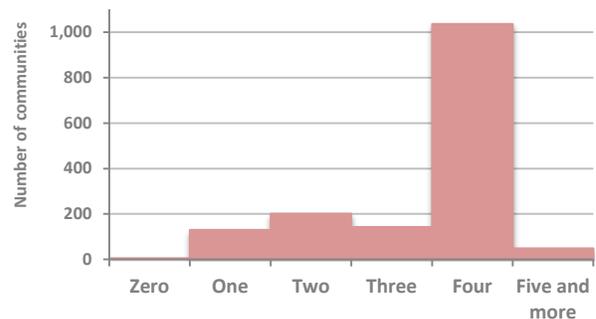
Figure 1 | Number of functional CHCs relative to the total number of communities registered, by month [USAID indicator]



The ECAP 2 network engaged 11,110 CHC members in the month of April. The average size of a CHC is seven members, comprising roughly four men and three women. The gender balance is in line with the previous months, being 57% men and 43% women. However, only 34% of CHCs have a balanced gender representation in their meetings.

Figure 2 shows the frequency of CHC meetings in ECAP 2 communities. Each community had on average 3.5 meetings in April: 66% of communities had four CHC meetings, while 22% had two to three meetings.

FIGURE 2 | FREQUENCY OF CHC MEETINGS IN ECAP 2 COMMUNITIES



¹¹ In the previous months the percentage of functional CHCs had as reference 1607 communities.



Each community had on average 3 to 4 CHC meetings in the month of February. Only 34% of CHC meetings either reached gender balance or had more women than men participating to them.

The level of engagement of community leadership is confirmed by their role as chairperson in CHC meetings. Roughly 32% of CHCs had the town chief, women leader, youth leader or youth leader as chairperson in their meetings. This is an important finding in light of the ECAP 2 close out. Highly involved leaders are more likely to support and sustain CHCs at the end of the program, given that they understand the mandate of the committees.

Topics Discussed

The community risk reduction plan (CHRRP) was discussed in 68.5% of CHC meetings. This is a reduction of 16 percentage points compared to March 2016, when the CHRRP was first rolled out. In contrast, the other major topics had an increase in the current month. In particular, the sustainability of CHCs after ECAP 2 was discussed in 66.7% of meetings (an increase of 13 percentage points from March). This information is very important in light of the end of the program since CHC members should have full awareness of their role and be responsible of their own community’s health from May onwards. Other major topics include ECAP 2 health messaging (67.7%), community cleaning campaign (61.6%) and health issues faced at the community level (24.3%).

Figure 3 | Top problems discussed at CHC meetings, % of forms submitted (percentage point difference compared to March 2016)



A further disaggregation of the topics does not show a major difference compared to the previous month. Community events were covered in 13.7% of meetings, while the functioning of clinics was discussed in just 11.7%. Among the health issues in communities, CHC meetings highlighted, once again, the lack of safe drinking water, diarrhea, typhoid and malaria.

97.6% of communities claimed to have taken action to tackle the issues addressed during the weekly meetings. The CSOs reported that CHCs will keep carrying out ECAP 2 health messages and community awareness. Cleanup campaigns are still the most widespread initiatives, while the implementation of the CHRRP is regarded as an opportunity to fix the problems in communities. As usual, some CHCs have taken the lead to do “out-of-the-box” actions:

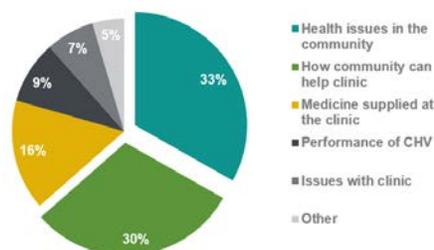
- In Sayalpolu community (Bong), CHC members are planning to dig a well as included in the CHRRP;
- In Maizen community (Bomi), “CHC committee members are doing door to door awareness, clean up campaign and now they are planting cassava farm, digging well and building toilet”;

- In Dowee Town (Montserrado), CHC members are going to fix the problem of unsafe drinking water by digging a well;
 - In GmagmaKpo (Sinoe), CHC members are going to build “a fresh toilet”;
 - In Duakollie Town (Montserrado), CHC members are planning to prepare hand washing and chlorinate water for drinking;
 - In Nyuah Town (Margibi), CHC members “...started bringing river sand for the building of their toilet/latrine in the town”.
- *1,375 CHCs attended CHDC meetings*
 - *731 communities had a visit from the OIC*
 - *438 CHCs went to the clinic to talk to the OIC*

Linkages among communities, clinics and health groups

In April, the number of CHCs attending the CHDC clinic increased by 8% on a monthly basis. 1,375 CHCs went to the monthly CHDC meeting. Figure 4 shows the topics discussed at the clinic during the meetings between the CHC’s and the clinic OIC. The graph shows a pattern that is similar to the previous months: health issues were discussed in 33% of the cases, followed by the linkage between community and clinic (30%), medicine supplied at the clinic (16%), issues at the clinic (7%) and performance of the community health volunteers (5%).

Figure 4 | Topics discussed at the clinic



Community Health Risk Reduction Plan (CHRRP)

The CHRRP has been introduced in 1,541 communities, representing 98.1% of CHCs submitting reports, while 96.4% of them finalized their plans. A smaller percentage of communities, 82.6%, has started to implement the actions as described in the plan. The CSOs reported that roughly two-thirds of communities have not faced any challenge in the CHRRP process. The remaining one-third states that the farming season and the lack of support in terms of tools from Mercy Corps make the process challenging. On a good note, some CSOs report that CHC members are becoming more familiar with the plan, despite having found it challenging at first glance.

PSI

In 1,523 communities (97% of submissions), an average of three outreach events were conducted in the month of April. Door to door campaigns, generic community events and cleanup initiatives were by far the most widespread outreach activities. Hand washing messages were shared within 90% of communities, followed by cleaning communities (61%). These are followed by activities aimed at increasing trust and use of clinics (40.3%), Ebola signs and symptoms (37.1%), Ebola response (36.1%) and vaccinations (35.9%).

Figure 5 depicts the total and gender-disaggregated number of people reached with ECAP 2 messaging in April 2016. 208,456 people heard about the ECAP 2 messages (48% men and 52% women). This value registered a 9% increase compared to March. The increasing inclusion of nearby communities led to a growing involvement of ECAP 2 “outsiders” who heard the messages, moving from 12,843 to 15,229 over-month.

Figure 5 | People reached with ECAP 2 health messaging, by month



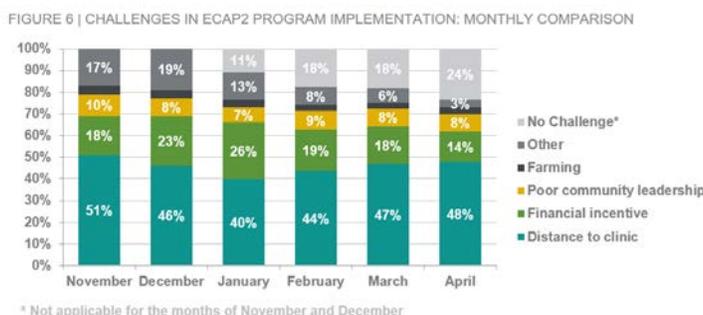
CSO Activity

CSOs visited each community between four to five times in a month, fulfilling the requirement of at least one weekly visit. 201 communities had between one to three visits in April. More than two-thirds of CSOs reported that the biggest challenge was to engage community members who were busy as Liberia is in the peak of farming season. Distance to communities is also another well-known challenge for CSOs.

Challenges in ECAP 2 Implementation

As ECAP 2 is about to close, 24% of communities do not report any challenge in the implementation of the program. Of the challenges experienced, one of the biggest was the excessive distance to clinics, which interfered with attendance at CHDC meetings. The decrease in financial incentives by 12 percentage points was also mentioned as a challenge.

Figure 6 | Challenges in ECAP2 Program Implementation: Monthly Comparison



Recommendations and Action Points

The closeout activities of the ECAP 2 implementation should focus on a full support to communities,

- ✓ **Action Point 1 – CHRRP & Toolkit**
 - Partners shall roll out the CHRRP to all communities making sure that leaders and community members are fully involved;
 - Partners shall ensure that CHC members understand the value and the scope of the CHRRP in their communities;
 - CSOs shall introduce the toolkit, emphasizing its usage and ultimate scope.

- ✓ **Action Point 2** – General support to communities
 - Partners shall provide as much support as possible to CHC members in order to have a smooth transition from ECAP 2;
 - Partners shall help CHC members to put in place a timeframe to make CHRRP implementation concrete.

- ✓ **Action Point 3** – Clear communication
 - Partners shall ensure that CSOs clearly communicate to CHC and community members in order to avoid misunderstanding;
 - Partners shall balance the expectations of CHC and community members and guide them on how to use the toolkit.

Key Data Summary

General Information

Number of forms submitted in March: 1,571 (98.2% of communities registered by partners)

Number of communities with at least a CHC meeting in March: 1,566 (97.8% of forms submitted)

Number of functional CHCs¹²: 1,566

Number of CHC meetings/community: 3.5 meetings per month

Average number of CHC members/meeting: 7 people (57% men and 43% women)

Topics Discussed

Most discussed topics in CHC meetings: CHRRP (68.5%), ECAP 2 health messages (67.7%), sustainability of CHC after ECAP 2 (66.7%), community cleaning (61.6%), role and responsibility of CHC (47.7%) health issues arising in the community (24.3%)

Linkages among communities, clinics and health groups

Topics discussed at the clinic: Health issues in the community (33%), how community can support clinic (30%), medical supplies at the clinic (16%), performance of CHV (9%), issues with the clinic (7%)

Number of CHCs who attended CHDC meetings: 1,375

ECAP 2 Outreach

Average of outreach events: 3 events per community

Main topics of outreach events: hand washing (90%), community cleaning (61%), trust and use of clinics (40.3%), Ebola signs and symptoms (37.1%), Ebola response (36.1%), vaccinations (35.9%)

Number of people reached by events: 208,456 (48% men and 52% women)

CSO Activity

Average number of visits by CSO: 4.3 times per month

¹² Functional CHC defined as a CHC that held at least one meeting in the past 4 weeks and reached the quorum

Biggest challenges: farming schedules (71.4%), distance to community (37.5%), busy community members (40.5%) and community members' disengagement (12.1%)

Community Challenge

Biggest challenges in program implementation: distance to clinic (48%), lack of financial incentive (15%), poor community leadership (8%) and no challenge (24%).

ANNEX IV. CHC Sustainability Report

SUSTAINABILITY OF COMMUNITY HEALTH COMMITTEES

A Qualitative Assessment on ECAP 2 Communities

JUNE 2016

Introduction

The Ebola Community Action Platform (ECAP 2) aims at building, strengthening and rejuvenating the linkage between communities and the Liberian health system, particularly at the clinic level. The quantitative and qualitative data collected by the MERL team of ECAP 2 showed that this objective was successfully achieved by building upon the existing community social structure. Community Health Committees (CHCs) were the groups targeted to reach out to community members on health best practices and to build a fruitful dialogue with the clinic Officer in Charge (OIC). In many cases, this linkage was built from scratch due to the recent Ebola outbreak which further alienated the population from their public health system. ECAP 2 has successfully achieved 1,566 functional CHCs and 1,375 CHC representatives attending the Community Health Development Committee (CHDC) meetings during the month of April. Furthermore, CHC members reached out to 334,590 people on messages regarding health topics, ranging from Ebola-prevention best practices to trust and use of clinics. These indicators, however, do not address the level of sustainability of CHCs.

The program close-out phase poses a number of questions: given the positive results of ECAP 2, what is the future of CHCs? To what extent are CHCs sustainable?

This report tries to bridge the M&E gap by assessing the level of CHC sustainability after the ECAP 2 program. The study is based on the following qualitative tools:

- Key informant interviews with community leaders;
- Focus group discussions and key informant interviews with CHC members;
- Key informant interviews with clinic OICs.

The field visits covered all fifteen counties of Liberia and twenty-three local and international NGOs who took part in the program. In total, the MERL team visited 165 communities, with a total of 163 interviews/focus group discussions with CHC members, 55 interviews with clinic OICs and 110 interviews with community leaders.

The study has two key questions:

- 1) What are the factors that bring about sustainability in CHCs?
- 2) To what extent are ECAP 2 CHCs sustainable?

Sustainability of CHCs – Key Factors

This report defines a CHC as sustainable if the committee shows evidence that it will continue to function after the end of the ECAP 2 program. The functionality of CHCs fulfills two requirements:

- The CHC has regular meetings (i.e. on a monthly basis) and conducts the core activities pertaining to community health awareness and mobilization;

- The CHC provides a solid linkage between the community and the clinic. In particular, this linkage is evidenced by regular CHDC meeting.

The qualitative study found four key factors (or themes) that stand out when assessing CHC sustainability:

- Participation of community leaders in CHC activities;
- Presence of sustainability projects;
- Commitment and motivation of CHC members;
- Management of expectations.

These factors, alone, are not able to predict the level of sustainability of CHCs. Some organizations adopted further coping strategies that could improve the maintenance of CHC activities in the long-run. It is challenging to list all the ingredients that make a CHC sustainable, especially when sustainability is compared against functionality. For instance, most of the organizations who implemented the program with good results in terms of CHC functionality have strong community support officers (CSOs). However, this could be a disadvantage for sustainability since community members would become too dependent on the organization, not being able to function after the program. Other factors affecting sustainability may be the relationship with the clinic OIC as well as the level of social cohesion in a community. The extent to which a CHC is sustainable depends upon factors that sometimes go beyond the CHCs and the organization which implemented the program. For instance, distance to clinics and bad road conditions are well-known constraints.

This study adopts the four aforementioned factors as key ones to assess sustainability, being aware that many other complex mechanisms contribute to it.

Participation of Community Leaders in CHC Activities

Community leaders are crucial in the social structure of rural communities, playing a pivotal role in engaging community members and assuring that CHC meetings are in place thereafter. The field visits clearly highlighted that in the cases where community leaders were members of the CHC, the leader of that community would have a much clearer strategic vision of the future of CHCs. Furthermore, the peculiarity of the ECAP 2 program, where there is no cash or material incentives, might cause a fast disengagement of community members if there is no strong leadership that is able to lead the committee.

Commitment and Motivation of CHC Members

The commitment and motivation of CHC members is the main pillar on which a sustainable CHC is built. It is intuitive that if members have a clear understanding of their role, mandate and function, it is likely that they will be able to volunteer as CHC members after the program. Motivated CHCs are important to take the lead on health issues of the community and to mobilize its members by generating a virtuous loop of information and good-practice sharing.

Sustainability Projects

Sustainability projects were carried out to ensure financial sustainability of CHCs in the long run, an important factor in sustainability. A successful example is farming projects. Many CHCs commenced cassava or corn farms in order to generate enough money to undertake small health-related projects, facilitate the transportation to the clinic and make the CHCs financially independent. Sustainability projects

also include cash-saving mechanisms and a variety of innovative ideas to generate enough money to keep CHC members together.

Management of Expectations

Finally, it was important during the program that community members had a clear understanding of the role of CHCs and expectations around compensation. In this, CSOs played a central role, explaining at the outset the role of CHCs, and communicating the Ministry of Health policy that people are not to be paid to look after their own health.

Methodology to Quantify Sustainability

Combining qualitative data from KIIs with community leaders, FGDs and KIIs with CHC members and KIIs with clinic OICs, the study summarizes the findings by assigning a score that ranges from 1 to 10, where 1 is the lowest value and 10 is the highest one. These scores were assigned to CSOs based on the findings from interactions with representatives of the communities and committees that a given CSO interacted with. Figure 1 shows the adopted scorecard. The values from 1 to 3 are assigned to a value *Low*; 4 to 7 are *Medium* and 8 to 10 are *High*. It is worthwhile to note that the size of the bands *Low* and *High* are smaller than the band *Medium*. This depicts a normal distribution.

FIGURE 1 | EXAMPLE OF SCORECARD



This scorecard is used to assess the total sustainability of CHCs through the four aforementioned factors that determine it. Each of the twenty-three partners was assessed through this scorecard in order to obtain the total level of sustainability by considering four factors:

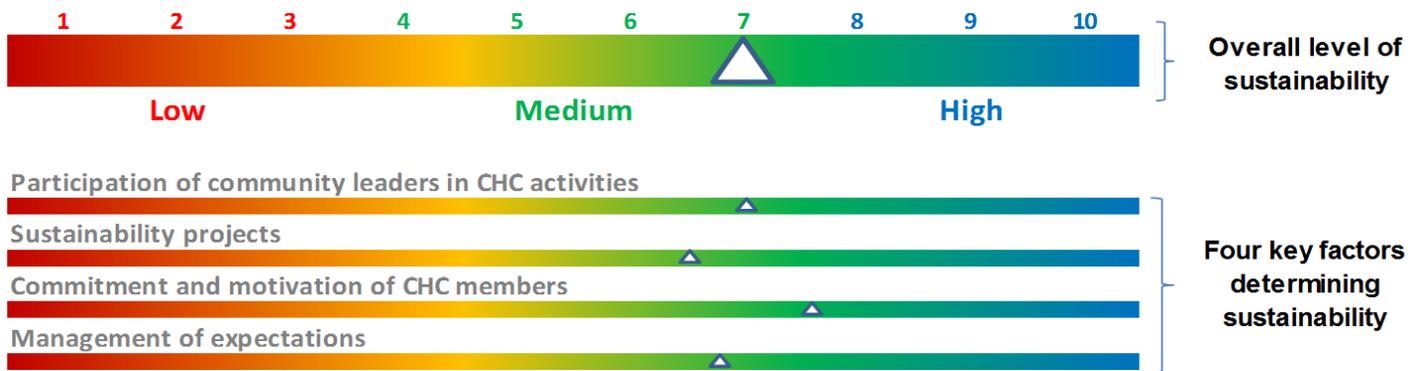
- Participation of community leaders in CHC activities;
- Presence of sustainability projects;
- Commitment and motivation of CHC members;
- Management of expectations.

The average of these twenty-three scorecards would then give the total level of sustainability of CHCs.

Results on Sustainability

Figure 2 shows the overall level of sustainability (top bar) determined by averaging the values of the “four key factors” suggested by field visits (low bars). The overall sustainability score is *Medium*. The four sub-scorecards show that each factor gave a different contribution to the overall sustainability. Indeed, the level of **commitment and motivation of CHC members** had a score of *High*, while **sustainability projects** had a value between 6 and 7 (*Medium*) (more on this in the following paragraphs).

FIGURE 2 | OVERALL SUSTAINABILITY OF CHCS - SCORECARD



The overall score is the average of 23 organizations, and was found to be *Medium*. Only two organizations performed *Low* in terms of perceived sustainability of CHCs supported, while 70% of organizations achieved the *Medium* band level. Five organizations ranked as *High*, suggesting that for five out of twenty-three organizations we are fairly confident that their CHCs will be functional in the medium-term. Conversely, the communities of the two organizations that performed *Low* are unlikely to have sustainable CHCs after the ECAP 2 program. The distribution suggests that organizations are evenly distributed and that they are particularly concentrated in the band that goes from 6 (*Medium*) to 8 (*High*).

The overall sustainability level is Medium. Only two organizations show low sustainability, while five have high-perceived sustainability.

FIGURE 3 | OVERALL SUSTAINABILITY OF CHC'S, NUMBER OF ORGANIZATIONS.

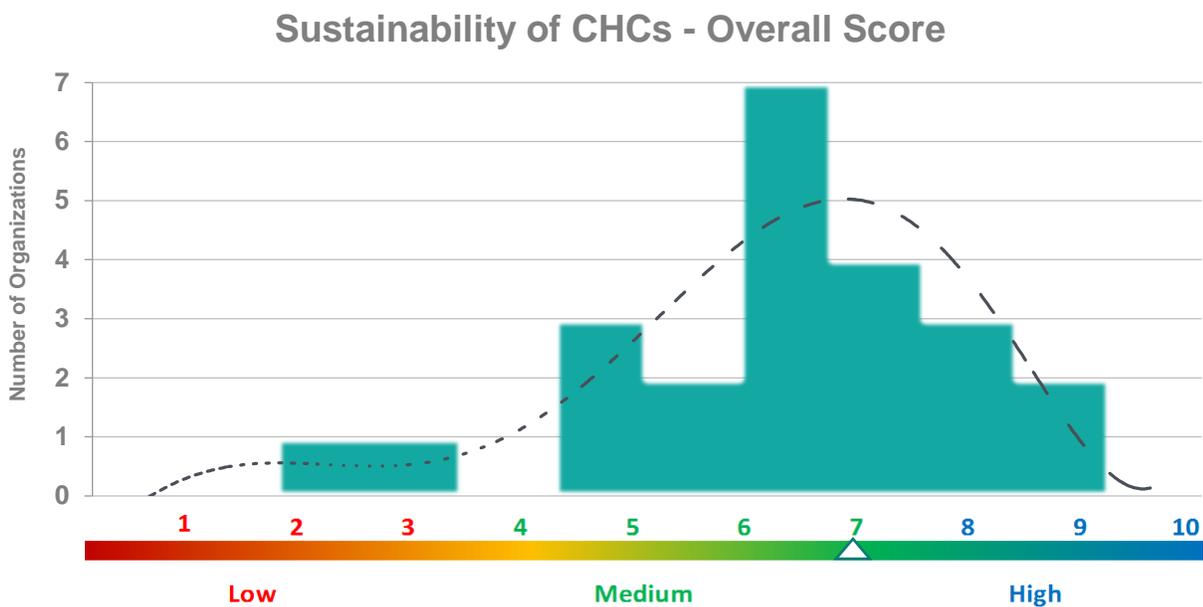
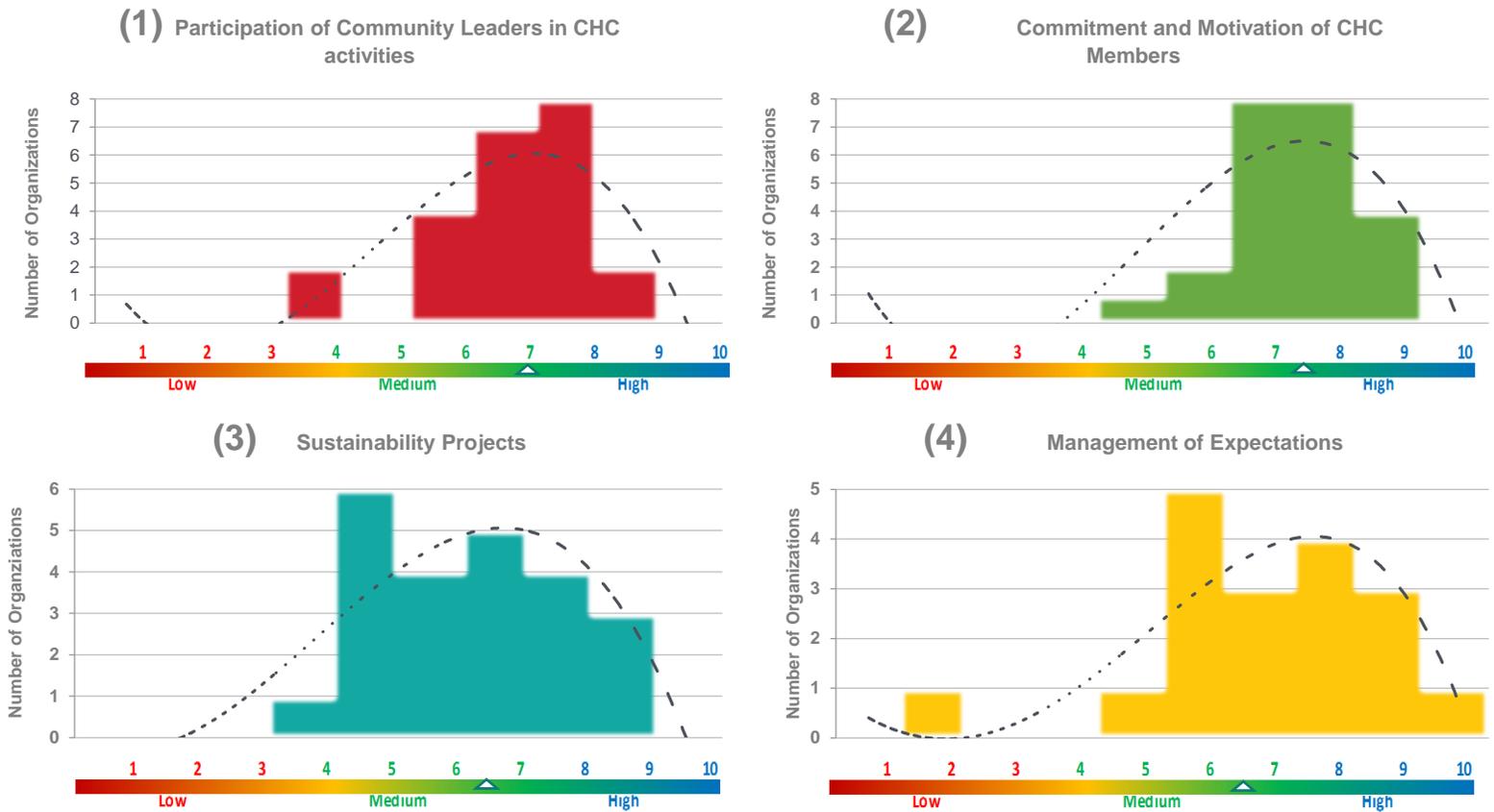


Figure 4 offers a closer insight into the four key factors that determine the overall score of sustainability:

- Participation of community leaders in CHC activities;
- Commitment and motivation of CHC members;
- Presence of sustainability projects;
- Management of expectations.

Recall that each factor contributes to the overall sustainability scorecard at the same degree.

FIGURE 4 | FACTORS THAT AFFECT SUSTAINABILITY, BY ORGANIZATION



Graph (1) shows the level of **participation of community leaders in CHC activities**. The average score is 7, i.e. **Medium**. A **High** score suggests that community leaders had a high level of involvement in the activities. The top performing partners had community leaders (mostly town chiefs) in their CHCs, demonstrating clear strategic vision on the future activities of CHCs. The graph shows that ten out of twenty-three partners reached the level **High**. This is an important result in terms of sustainability: highly involved leaders would be able to better monitor CHCs' activities and to motivate their members according to the needs of the committee. As already mentioned, community leaders are the most likely key people to assume the role of facilitators (previously covered by CSOs) after the ECAP 2 program, by scheduling meetings and directly working to link communities to clinics. This finding also suggests that organizations were able to successfully involve community leaders during the set-up phase of CHCs, indicating that the establishment process of CHCs was well performed.



The level of participation of community leaders is *High* in ten organizations, while the average level is *Medium*.

Graph (2) shows the level **commitment and motivation of CHC members**. The average score is between 7 and 8, i.e. ***High***. A ***High*** score suggests that CHC members had a very good understanding about the program, their role in the community and the importance of CHCs in the health of communities. In particular, organizations with a ***High*** score had CHC members who truly acted as intermediaries between communities and clinics, being OICs' and communities' focal points for health issues. The graph shows that twelve out of twenty-three partners highly performed in this regard, while the rest of partners lie in the ***Medium*** band. This result suggests that the program was well received by CHC members. Indeed, most of the CHC members showed deep appreciation for the program and they felt as a moral duty to continue their work in light of the training received by the CSOs. It is also worthwhile to note that this indicator is the highest among the four, suggesting that communities have the willingness to continue working as health volunteers despite the challenges and the many constraints.



CHC members showed a good level of commitment and motivation to their role. Twelve out of twenty-three partners had *High* performance.

The next indicator is the level of **sustainability projects** (graph 3). The average score is between 6 and 7, i.e. ***Medium***. A ***High*** level of sustainability project means that CHCs had concrete and solid projects that could help CHC members to be sustainable. This is mostly evidenced by projects that generate enough cash flow for CHCs to undertake health maintenance projects at the community level (e.g. fixing water hand-pumps) and to allow CHC members to take part to CHDC meetings. The field visits highlighted that the presence of sustainability projects can also bring about interest among community members around joining the CHC. The most popular projects were by far cassava and corn farms. Sustainability projects, however, received the lowest scores among the four indicators. It is undeniable that these projects were not easy to achieve, especially due to the short term nature of the program and insufficient time for many to gather the resources necessary to start projects. The graph shows that the majority of partners had a score between 5 and 7 (***Medium***), while seven partners were able to reach the status of highly sustainable



The presence of sustainability projects is assessed as *High* in seven of the twenty-three partners, while in the remaining organization the score is in the band of *Medium*.

Finally, graph (4) shows the level of **management of expectations** at the CHC and community levels. The average score is between 6 and 7, i.e. ***Medium***. A ***High*** level of management of expectations suggests that the organization was able to clearly communicate the objectives of ECAP 2 without over-promising. This is of pivotal importance since ECAP 2 is based on the work of volunteer CHC members who are not supposed to receive any kind of financial incentives nor tools. The graph shows that eight partners reached the level ***High***, since they were able to motivate the CHCs without boosting expectations. Conversely, one partner

had *Low* level of expectation management due to leak of information on micro-grants and the widespread anger among community and CHC members when these micro-grants did not take place. It is worthwhile to note that the information on micro-grants was spread by some organizations, although in most of the cases they were able to rebalance the expectations.



Eight out of twenty-three partners had a high management of expectations. Conversely, only one partner had low level.

Conclusion

Overall, the level of sustainability of the twenty-three partners is **Medium**. However, sustainability varies from partner to partner. Two of the partners had a *Low* sustainability level, while five had a *High* level. The remaining sixteen partners had a *Medium* level of sustainability.

The overall level of sustainability is determined through four key factors that have been identified in the field assessment as major contributors to sustainability. By looking at each of the factors, it is found that partners had a *High* level of commitment of CHC members to their role and responsibilities. Moreover, the participation of community leaders in CHCs' activities is regarded as more than satisfactory, being *High* in many cases. Sustainability projects and the management of expectations are the factors that received the lowest score; this is linked to the challenge to start projects that generate income and to the difficulty of partners to clearly communicate the objectives and tools used during the ECAP 2 program.

ANNEX V: Gender Study

ECAP 2: LEARNING REPORT

Rapid Gender Study

APRIL 2016

Study Background

Mercy Corps with help from the United States Agency for International Development/Office of Foreign Disaster Assistance (USAID/OFDA) is tackling the threat of Ebola re-occurrence at the community level through its implementation of the Ebola Community Action Platform 2 (ECAP 2) in all 15 counties of Liberia. The program focuses on building community preparedness for Ebola outbreaks, by strengthening Ministry of Health recognized community health structures, called Community Health Committees (CHCs), and re-establishing linkages between communities and government health services.

ECAP 2 recognizes that women face a great risk if Ebola were to re-emerge due to the caregiving role they play in Liberian society. It also recognizes the lack of female leadership in many community and district level structures, resulting in female voices being left out of planning and preparedness conversations. Given this, the program has encouraged equal female representation in field level staff numbers and equal female participation in Community Health Committees across the country.

The ECAP 2 Monitoring, Evaluation, Research and Learning team conducted a brief investigative study to understand the potential impact on women of participation in voluntary work within their communities.

Methodology

The research study took a qualitative approach focusing on answering the following question:

Do female Community Health Committee members face any positive or negative consequences in their personal or family life as a result of their voluntary position on the CHC?

The study was limited to females who were currently serving as CHC members within their communities. The study used Key Informant Interviews (KII) with individual female CHC members. Where multiple female members existed within a single CHC, the KII was conducted as a focus group discussion. Data collection was limited to Gbarpolu County, where EQUIP Liberia currently implements the ECAP 2 program. Gbarpolu County was selected due to the remote nature of its communities and the challenging conditions within the county (e.g. lack of communication and adequate transport networks, NGO support, health facilities etc.). Data was collected from six communities across Gbarma District and Kongbor District, and fourteen women were spoken to through the study.

The study is not intended to be a conclusive research piece on the personal impact CHC participation has on female CHC members, but rather aims to provide an insight into gender issues that may arise and provide a background piece to guide further research studies on gender.

Themes

The qualitative assessment revealed that women who work as volunteers in CHCs are affected in different ways. A majority of respondents reported personal and public gains from their involvement in CHCs, due to increased confidence and public support. However, approximately 20% (3 out of 14 respondents) reported spousal conflict and verbal abuse due to their role in the CHC.



“As for me, my man is happy for me to be part of CHC to work for my people. Sometimes he can help with money to pay my way to go for CHC training. He not get no problem with me.”

— Female CHC Member, Gbarma District, Gbarpolu County

Increased community and spousal support

A number of respondents mentioned that their participation in the CHC has brought a positive impact to their lives. This was largely due to the high level of respect they feel they are now receiving from their community members. Respondents reported becoming opinion leaders and decision makers for their communities because the community perceives them to be knowledgeable on the government health system and health related issues.

The study also revealed that some male spouses are encouraging their female partners to be proactive in the CHC activities by providing them emotional and financial support for meeting and training attendance. These male spouses are reportedly proud of their wives activities because they have been trusted and chosen to lead the health of people in their communities.

Gains in personal confidence

The research found that most women working as a CHC member were incentivized to participate by the training and new knowledge they acquired in their role. The respondents considered the trainings to be very important to secure good health outcomes for their family and relatives.

Women reported that because of the trainings and increased community respect, they now feel like proud and useful members of their communities. This has increased their personal confidence and encouraged them to take further action, creating new initiatives to ensure their communities are safe and healthy.

Spousal opposition and relationship conflict



“My husband is very jealous and he always attack me when I come back home from CHC meeting or outreach activity, he can be thinking that I cheating on him.”

— Female CHC Member, Gbarma District, Gbarpolu County

The study highlighted that some female CHC members (3 out of 14 females interviewed) encountered severe personal challenges as a result of their participation in the CHC. The personal challenges were the result of a lack of spousal support for their participation in the CHC. These male spouses perceived that their wives' commitment to the voluntary work had taken precedence over their household duties. Some male spouses were suspicious of their wives spending so much time out of the house in CHC meetings, particularly when the time was spent in CHC meetings and there were numerous men in the committee. This situation resulted in verbal abuse and threats of physical abuse towards their wives who were CHC members.

Conclusions

Female participation in community health volunteer work has both negative and positive effects on women's everyday lives. Generally, most women reported personal benefits as a result of their work. Many women who work as community health volunteer workers feel very proud of what they chose to do for their communities and reciprocally their community members give them high respect and honor for the service they render. However, for those women who do not have spouse support for their activities outside the home, there can be serious risks to these women which put their lives and personal security in danger.

This study highlights the critical need for a deeper examination of the impact the Liberian National Community Health Policy has on women engaged at the community level. Although these findings are limited to CHC members, it would be reasonable to suggest that similar findings may be found in a study on female Community Health Volunteers. Appropriate support and accountability mechanisms must be put in place to ensure women volunteering to support their community are protected from threats to their personal safety. Additionally, partners implementing Liberia's Community Health Policy must pre-identify gender violence risks that may occur and implement risk mitigation strategies.

ANNEX VI: Network Minutes

ECAP-II, First 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 supports 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 exists 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.

2nd Meeting of Network Members July 19, 2016

Attendance: Equip, AfroMed, Sail, NMCL,

Minutes of Meeting

This is the second meeting of the Network. The meeting was chaired by AfroMed. The meeting started at 4:30pm. Sorry for the late start due to some uncontrollable circumstances. To all who came and made attempt I say – THANK YOU. We will ensure to start on time on the next meeting.

Actions:

- Select an independent committee to review, evaluate and validate Network member organization for inclusion in the membership of the network
- Develop a MOU for every member to review and sign for inclusion in the Network membership

Members selected to evaluate members

- 1) CHESS
- 2) AfroMed – Lead
- 3) NMCL
- 4) PHIL

Members selected to draft the MOU

- 1) SAIL - Lead
- 2) SHALOM
- 3) LCL
- 4) EQUIP
- 5) RESPECT

Time Frame

Draft MOU deadline – July 20th 2016

Report on the evaluation progress – July 30th, 2016

Next Meeting

August 2, 2016, 3pm at EQUIP office. Main agenda it to discuss the draft MOU and Evaluation progress

ANNEX VII: PSI Final Report (see next page)

ANNEX VIII: IREX Final Report (see next page)

ANNEX IX: Final Evaluation Report (see next page)

Annex XI: Golden Image Award

For its work on ECAP 2, Mercy Corps was a recipient of the Golden Image Award, received 21st July, 2016, and signed by Ambassador Juli Endee.





