Assessment & Evaluation for Health Education, Sensitization, Mobilization and Advocacy (HSAM) Activities in the Liberian Onchocerciasis Programme

February 8th-19th 2010
MISSION REPORT

ASSESSMENT AND EVALUATION (SCOPING MISSION) OF HEALTH EDUCATION, SENSITIZATION, ADVOCACY AND MOBILIZATION (HSAM) ACTIVITIES IN THE ONCHOCERCIASIS PROGRAMME IN LIBERIA

08 – 19 FEBRUARY 2010
# LIST OF ABBREVIATIONS:

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>APOC</td>
<td>African Programme for Onchocerciasis Control</td>
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<tr>
<td>BCC</td>
<td>Behavioural Change Communication</td>
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<tr>
<td>CDD</td>
<td>Community Directed Distributor</td>
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<tr>
<td>CDI</td>
<td>Community Directed Intervention</td>
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<td>CDTI</td>
<td>Community Directed Treatment with Ivermectin</td>
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<tr>
<td>CHC</td>
<td>Community Health Committee</td>
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<tr>
<td>CHO</td>
<td>County Health Officer</td>
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<td>CHT</td>
<td>County health Team</td>
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<tr>
<td>CHW</td>
<td>Community Health Worker</td>
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<td>CMO</td>
<td>Chief Medical Officer</td>
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<td>DEO</td>
<td>District Education Officer</td>
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<tr>
<td>DHO</td>
<td>District Health Officer</td>
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<tr>
<td>FLHF</td>
<td>Front Line Health Facility</td>
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<tr>
<td>GCHV</td>
<td>General Community Health volunteer</td>
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<tr>
<td>IEC</td>
<td>Information, Education, and Communication</td>
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<td>IEP</td>
<td>Inclusive Education Program</td>
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<tr>
<td>KAP</td>
<td>Knowledge, Attitudes, and Practices</td>
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<tr>
<td>LF</td>
<td>Lymphatic Filariasis</td>
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<td>MOH</td>
<td>Ministry of Health</td>
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<td>NECP</td>
<td>National Eye Care Programme</td>
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<tr>
<td>NGDO</td>
<td>Nongovernmental Development Organization</td>
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<td>NOCP</td>
<td>National Onchocerciasis Control Programme</td>
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<td>NOTF</td>
<td>National Onchocerciasis Task Force</td>
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<td>NTDs</td>
<td>Neglected Tropical Diseases</td>
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<tr>
<td>OIC</td>
<td>Officer in Charge (at front line health facility)</td>
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<tr>
<td>Oncho</td>
<td>Onchocerciasis</td>
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<td>PEC</td>
<td>Primary Eye Care</td>
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<td>PHC</td>
<td>Primary Health Care</td>
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<td>PHU</td>
<td>Primary Health Care Unit</td>
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<td>SSI</td>
<td>Sightsavers International</td>
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<tr>
<td>SOP</td>
<td>Standard Operating Procedure</td>
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<tr>
<td>TTM</td>
<td>Trained traditional Midwife</td>
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<tr>
<td>UNICEF</td>
<td>United Nations Children’s Fund</td>
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<td>WAHO</td>
<td>West Africa Health Organization</td>
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<td>WHO</td>
<td>World Health Organization</td>
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INTRODUCTION

Background and purpose of mission

HSAM is one of the four main pillars of Community directed Treatment of Ivermectin (CDTI), the strategy used by APOC in the control of Onchocerciasis. As the name implies this is a strategy that is implemented at community level by the community. HSAM activities therefore need to be appropriate and target specific to ensure that all stakeholders including political and administrative authorities at all levels (national, regional, district and community), partners, and end beneficiaries understand the message and are fully committed to the achievement of the goals and objectives of the programme.

One of APOC’s objectives is to ensure that projects are fully sustainable by the time APOC ceases operations in 2015. Countries that have undergone crisis have experienced large treatment gaps as a result of conflict in those countries. Despite some improvements in treatment coverage in Liberia over the past two years treatment has remained as low as 32% in some parts of the country. HSAM including behavior change is a critical component for the successful implementation of CDTI, increased treatment coverage as well as ownership and sustainability of the programme.

To be effective, an HSAM strategy should be evidence-based and the objectives identified should be targeted at specific audiences with the activities and messages vehicled via appropriate, credible and familiar channels that will bring about the expected outcomes, and lead to the achievement of programme goals. It was within this framework that APOC decided to collaborate with the NOTF of Liberia to undertake a scoping mission from 8 to 19 February 2010 to carry out an assessment and evaluation of HSAM activities implemented at the national and Project levels in the Liberia Onchocerciasis Control Programme.

The purpose of the mission was to review and analyze the different techniques, approaches and methods used in HSAM, and how appropriate they were for the target audience and to what extent the activities, messages, channels and materials being used were effective in reaching the people and achieving programme goals and objectives; solicit the needs, views, and perspectives of those identified as stakeholders in the program, including community members, and identify potential resources for assisting with health communication.
Methodology

The methodology used was to gather information through focus group discussions, individual interviews, small group discussion and literature review (existing results of other evaluations/assessments carried out previously).

The assessment team identified in advance several groups of main stakeholders to interview. This included agenda setters (policy makers and researchers), organizations providing health services and products, media representatives, technical assistance organizations and donors. Specifically, senior program managers within the Liberia Onchocerciasis Control Program and Ministry of Health, Health Promotion Department, Community Health Services Department, directors and support staff of organizations providing related support to the program, representatives of religious organizations and community leaders in Oncho endemic areas, the media in Liberia at national and community levels and a cross section of community members including men, women youth, and students were targeted.

The Ministry of education was also targeted as a key stakeholder for any possible future integration with other programmes e.g. Neglected Tropical Diseases. The objective is to obtain an overall analysis of where there are capacity and knowledge gaps in health promotion and advocacy activities of the Liberian Onchocerciasis Control Programme.

The tools developed were three separate questionnaires for community members, community directed distributors (CDDs) and county and district level stakeholders.

Composition of team

WHO/APOC staff
Zainab Akiwumi, WHO/APOC Communication and advocacy Officer, Burkina Faso

Ukam E. Oyene, WHO/APOC technical Advisor, Liberia

Ministry of health and Social Welfare
Helena Kamara , Program Manager, NECP

Anthony Bettee, Coordinator Onchocerciasis

Jammie J.M. Kekulah, Health promotion Officer

Daniel Wessih, Community Health Services
NGDO Partner
Adoley Sonii, Country Director, Sightsavers International, Liberia

Consultant
Geordie Woods, behaviour change and communication advisor WHO/ SSI consultant

One or two members from the county health teams usually accompanied the team to the different communities to introduce the assessment team and also to act as interpreters when necessary.

Three drivers conveyed the team to the field.

EXECUTIVE SUMMARY

Purpose of mission
To enable APOC provide evidence-based assistance to countries to develop and implement effective and strategic health education, sensitization, advocacy and mobilization (HSAM) for their Onchocerciasis programmes a scoping mission was conducted in Liberia from 8 to 19 February 2010 to carry out an assessment and evaluation of HSAM activities carried out in the Liberia Onchocerciasis Control Program.

The purpose of the mission was to review and analyze the different techniques, approaches and methods used in HSAM, and assess how appropriate they were for the target audience, and to what extent the activities, messages, channels and materials being used were effective in “reaching” the people and achieving programme goals and objectives; solicit the needs, views, and perspectives of those identified as stakeholders in the program, including community members, and identify potential resources for assisting with health communication.

Methodology
Three tools (questionnaires) were developed for community members, community directed distributors (CDDs) and county and district level stakeholders.

The assessment team identified in advance several groups of main stakeholders to interview. This included potential audience members, agenda setters (policy makers and researchers), organizations providing health services and products,
media representatives, technical assistance organizations and donors. The minister of health, senior program managers within the Liberia oncho and other health programmes, representatives of religious organizations and community leaders in Oncho endemic areas, the media at national and community levels and a cross section of community members including men, women youth, and students were targeted.

Interviews at central level

The first day Monday 8th February in-depth interviews were held with the Assistant Minister of Health, NECP programme managers, the health promotion, malaria, NTDs and community health services divisions at MOH and with SSI, the NGDO partner for the Liberia Onchocerciasis Control programme.

Field visits 9th to 17th February

The assessment team departed from Monrovia early on Tuesday for the field trip and visited communities in all three CDTI Projects as follows:

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<tr>
<th>Projects</th>
<th>County</th>
<th>Health District</th>
<th>Communities</th>
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<tbody>
<tr>
<td>Southeast</td>
<td>Grand Gedeh</td>
<td>Tchien &amp; Bhai &amp;</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Sinoe</td>
<td>Greenville &amp; Tarjuwon</td>
<td></td>
</tr>
<tr>
<td>Southwest</td>
<td>Bomi</td>
<td>Clay &amp; Tubmanburg &amp;</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td>Margibi</td>
<td>Gibi</td>
<td></td>
</tr>
<tr>
<td>Northwest</td>
<td>Bong</td>
<td>Zota &amp; Suakoko &amp;</td>
<td>4</td>
</tr>
<tr>
<td></td>
<td>Nimba</td>
<td>Tappita &amp; Sanniquelli</td>
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At the county level, the team held interviews with county superintendents, assistant or deputy superintendents, members of the county health team whose composition varied from county to county but included chief medical officers, county health officers, Community health department director, county oncho focal persons, clinical supervisors, eye care supervisor (in Sinoe County), county pharmacist, county education officer and local media representatives. The initial plan also included health promotion focus persons but none of the counties visited except one had a full time health promotion staff, and he was absent at the time.

At the district level, targeted stakeholders included district commissioners, school principals and district education officers (DEO), as well as district health officers (DHO) and clinic officers in charge (OIC). At the community level the team held community meetings with town chiefs, elders, youth, men and women. Where possible, separate in-depth interviews were held with CDDs, school teachers and students. It should be noted that the stakeholders present through out the course of this field visited varied from county to county based on the availability of the targeted stakeholders.
Due to logistical constraints (adequate accommodation for the night for all members of the mission) the team decided to return to Liberia on Tuesday, 16th after completing the interviews in Margibi County, and do a day trip from Monrovia to the last county, Bomi on Wednesday 17th.

Thursday 18th was spent discussing the results of the field trip and preparing the presentation for the debriefing of the minister of health which was scheduled for Friday 19th.

Friday 19th

On Friday CAO and TA/ Liberia had a debriefing session with the WHO Representative who was away from the office on 8th February when the team arrived for the assessment mission.

At 10 AM the team had the debriefing session at the MOH. Participants at this debriefing included the two assistant ministers of health, the dean of the school of pharmacy, chair of the NOTF/CMO , the NECP, representatives from health promotion, NTDs and other divisions in the MOH, Sight Savers international and other health partners and members of the media.

The meeting was chaired by the Assistant Minister for Curatives Services, Dr Pewu, who is also co-chairman of the NOTF Liberia. After the presentation of the results and findings of the mission, participants were invited to ask questions and/or make comments. The general consensus was that the scoping mission was timely and that Liberia needed assistance in the area of HSAM in order to improve adherence to treatment so that the projects will increase therapeutic coverage; that after so many years of conflict in the country many resources, both human and technical were lacking and they were grateful for any assistance that APOC could provide to help them improve the implementation of the three projects so that communities would benefit.

Dr Pewu concluded by requesting that APOC should continue to support the onchocerciasis programme in Liberia as the country was not in a position to take over financially at the present time.

FINDINGS

1. SOME THINGS THAT WORKED WELL

- High demand for Mectizan and testimonies of its efficacy in some counties – due in part to its de-worming effect
• Dedication of some community directed distributors, some have been volunteering since 1999

• The wide use of local radio to disseminate health messages

• Involvement and commitment of community leaders in some areas

2. BARRIERS IDENTIFIED INCLUDED:

• During the crisis in Liberia NGOs and external aid by-passed the local government structures and paid volunteers directly for community based interventions. Communities now seem to expect compensation for every health and development programme being implemented in the community

• Communities do not appear to have accepted the onchocerciasis programme as their own. In many communities they see it as something brought in by outsiders.

• Lack of county political involvement in the onchocerciasis programme in some counties

• Frequent changes of the management at National Secretariat of the Onchocerciasis Control Program

• Onchocerciasis is not one of the diseases prioritized in the Basic Packages of Health services

• Lack of a full-time health Promotion focal person at county level (only one county visited had a full time health promotion officer)

3. SUMMARY OF GAPS IDENTIFIED

• Across Liberia there is a clear need for more Onchocerciasis disease specific information at the county and community level

• Lack of communication that emphasizes community ownership

• Non-availability of health education materials at all levels

• Inadequate capacity of health workers to deliver health education

• Inadequate training for health workers and CDDs

• Non-involvement of other stakeholders outside of the health sector, health education sector

• Many community based interventions in Liberia with principles that conflict with the CDTI philosophy.

• National Community Health Department has not fully recognized Onchocerciasis under the national policy for community health.

• From desk research, overall lack of evidence based research for communication strategies in Liberia
4. GENERAL RECOMMENDATIONS

- An effective communication plan for health promotion (health education, sensitization, advocacy, and mobilization), backed by a strategic plan with planned activities and delegated roles and responsibilities for these activities must be developed.
- Partnership with other development sectors will be critical for CDTI activities to fully take off. Examples include: the media particularly community Radio stations, Ministry of Education, Teachers, community associations.
- Targeted activities and messages for advocacy at all levels, particularly at county and community, local government and other opinion leaders to engage them fully in the programme.
- In line with local realities promote the use of appropriate channels such as community meetings, town criers, community radio, and school health should be strengthened. A multi-channel approach is more effective.
- Social mobilization should be prioritized at community level.
- All counties should appoint a focal person fulltime and solely responsible for health promotion.
- Onchocerciasis, eye care and other NTDs must be prioritized in the national health plan.
- CDTI training should include a component on HSAM especially social mobilization – it is easier to start the right way than to correct shortcomings afterwards.

CONCLUSION

From our visits and interviews it was clear that some county health staff are committed to the onchocerciasis Control programme and that the programme is appreciated and is working well in some communities. The impact of HSAM, especially social mobilization, on treatment coverage, acceptance and compliance was visible and positive in some communities. This shows that when done effectively and strategically HSAM is a vital component for the successful implementation of CDTI, and its importance should not be ignored or minimized.

Target-specific HSAM with objectives, activities, channels and messages selected based on evidence should therefore be promoted and strengthened at all levels. The central onchocerciasis secretariat in collaboration with the CHTs should include an HSAM package in the CDTI training for health workers, CDDs and other resource persons in the community.

Due to logistical reasons and time constraints, the team could not visit all counties nor interview all communities but we believe we were able to collect enough data to make a reliable assessment of the situation of HSAM activities in
the CDTI Projects in Liberia and can help the programme develop a HSAM strategy that will be evidence-based.

We strongly recommend as immediate action to be taken the conduct of a 10-day training workshop for the design of a workable HSAM strategy and plan for the Liberia onchocerciasis Control Programme. The dates proposed for this workshop are 12 to 22 April 2010, subject to confirmation by the NECP. As this workshop is intended to be participatory participants should not exceed 25 to ensure that every participant will get the best from the workshop through their active participation. The workshop will be conducted by Zainab Akiwumi, CAO and Geordie Woods, Communication and BCC advisor with the Technical Advisor in Liberia as facilitator. Participants for the workshop will be drawn from: county onchocerciasis supervisors, health promotion, community radio/media, NGDO, education sector, CDDs, front line health facility, resource persons from the county and the community.

Interviews at the Ministry of Health and Social Welfare—8th February 2010

Mrs Jessie Duncan - Assistant Minister responsible for preventive services — courtesy visit

Interview with Dr Pewu – Deputy Minister responsible for curative services:

As regards CDTI:

1. Though APOC is coming to an end the government is not in a position to take over. Government priorities at this time do not include Onchocerciasis though it is accepted that it is a public health problem
2. Government has been focusing on building roads since last year and there has been less money for health on the rationale that road networks need to be improved to make them accessible for health delivery
3. Welcomes the APOC mission because a few weeks before had gone to do a follow up with the oncho coordinator and found that community members did not remember how many tablets they had received nor when they received them
4. APOC should consider Liberia as a special case because of the 14 years of war it has endured. The country needs help in financing and also capacity building. CDDs are a dynamic group and require constant retraining.
Health promotion division

Director, Mrs Chris Dagadou and other staff.

This division has been working with other health programmes in the ministry of health but not with the onchocerciasis programme.

Their work involves:
- research to get evidence-based data,
- workshop for messages development
- pre-testing of messages and materials
- work is target audience specific
- social mobilization and advocacy
- BCC training

Lessons learnt:

Good results with working with religious leaders
Works in collaboration with other partners, not just health: social organizations, public works, Red Cross, line ministries such as agriculture, education.

Have been developing a national communication strategy which is still in the draft stage

Community Health Services Division – CHS – Mrs Mary Momolou Director

This is a new division and has been concentrating on establishing a system of various services to address gaps in communities. The objective of this programme is to provide basic health services since health facilities are limited.

They welcomed the opportunity going into the field at this time as there is a need to know the community so that programmes can be sustainable
The CHS strategy is 1 community health volunteer (CHV) to 1000 persons whereas the CDTI philosophy is 1 CDD to 100 persons.

Print media house

Emmanuel Johnson – private print journalist

Works with different units and programmes at the ministry of health but does mainly ad hoc reporting on events and activities carried out. There is no ongoing or continuous health programme with the media, and to his knowledge there is
no specific health media in Liberia. The feels the media in Liberia can contribute meaningfully to the onchocerciasis programme.

**Malaria division**

Dr Joel Jones – programme manager

The division has benefited form HSAM and has a focal person for IEC/BCC and two other staff who specialize in community-based communication.

They involve the traditional chiefs in their activities and community volunteers from within the community. They do health education and awareness and also use radio and community health volunteers.

From his experience posters do not work and he believes a more direct approach is required for better impact such as training in malaria prevention for parents and care givers to educate them on the issue.

A communication strategy for malaria was developed, finalized and produced and this is being used to develop activities and messages.

**NTD division**

Mr Kassor Kollie - Director

This is a new division and their focus will be on having an integrated approach

Currently onchocerciasis is the only NTD that has full implementation in the county.

Other activities going on include: Passive surveillance of Guinea worm, LF mapping. At present leprosy is combined with TB and is a separate programme but it is planned to integrate it with the other NTDs.

This division, like so many others in the ministry, are faced with certain constraints:

- Human resources (brain drain due to the war)
- Logistics such as vehicles for supervision that are needed by the counties now that the MOH is trying to decentralize and each county is responsible for its own implementation
- Need for mapping - in order to have baseline data.
- Technical and financial support needed from partners
SSI

Mrs. Adoley Sonii – Director

Financial officer – Alex Bedel

Sightsavers has eye care programmes in the South East in five counties - Grand Gedeh, Sinoe, River Gee, Maryland, Grand Kru, and is the NGDO working with the MOH on eye care and oncho programmes.

The NGDO has been supporting monitoring and supervision and training and building capacity of MOH staff involved in the implementation of CDTI. Last year they also funded the production of registers for CDDs because there was a shortage.

To date SSI has received no request from MOH for support for communication, advocacy and social mobilization activities but agree that the people in the community must be empowered, that health education must be continuous and that therefore special attention should be given to support and training in this area.

National Eye Care Programme - Oncho secretariat – central level

Helena Kamara – Programme manager

Anthony Bettee Deputy programme manager and oncho coordinator

Activities at central level include advocacy to decision makers to get their support and this they do through meetings.

The NECP works closely with the NOTF and has their full support.

HSAM activities carried out at central level

This has been limited to reprinting of posters, leaflets and flipcharts that had been produced some years before. These were sent to health facilities with the objective that CDDs would use them to do health education. Unfortunately due to budgetary constraints the quantity reprinted was not enough to go round all the communities.
total of six counties, 11 health districts and 20 communities. This included two counties from each of the three projects in Liberia. In each county the team met with stakeholders at the county, district and community levels. (See appendix E for full trip itinerary)

At the county level, the team held interviews with county superintendents, assistant or deputy superintendents, members of the county health team whose composition varied from county to county but included chief medical officers, county health officers, county health department director, county oncho focal persons/supervisors, clinical supervisors, eye care supervisor (in Sinoe County), county pharmacist and county education officer and local media representatives. The initial plan also included health promotion focus persons but none of the counties visited except one had a full time health promotion staff, and he was absent at the time.

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It should be noted that the stakeholders present throughout the course of this field visited varied from county to county based on the availability of the targeted stakeholders. The following gives a brief summary of each of the counties, districts and communities visited.

SINOE COUNTY

Sinoe County Health Team

Activities being implemented: The county health team identified several communication activities that had taken place with regards to the Onchocerciasis control programme. The county health team has worked with the local community radio station to host a weekly talk show on health. Onchocerciasis has been featured several times in the past. The number of CDDs in Sinoe County has drastically decreased and the health team indicated that community ownership was one of the key messages that needed to be promoted. The CHO indicated that more support was needed from local government officials such as the superintendent and other top level officials, and that lack of this support is one of the perceived barriers to the success of CDTI in Sinoe.
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Some jingles had already been recorded in English and local languages and the new team simply sent these to the radio to be broadcast. There has been no time to evaluate the effectiveness or impact of these printed materials or radio announcements.

Way forward

1. Advocacy must be continuous and intensified at all levels
2. Communication materials should be evaluated and local people in the communities should be involved to ensure appropriateness of audio visual materials
3. Collaboration with the NGDO partner should be increased and fine-tuned in the planning and implementation of activities
4. NGDO partners should attach importance to all activities concerning the programme and not be selective in their support
5. Work with the media on advocacy with local authorities to create more awareness at community level
6. Train more health workers at health facilities and also others like school teachers.
7. Ensure that training for CDDs is adequate and more thorough
8. NECP staff also require training as they are new to the programme – they need to know more about APOC and the CDTI philosophy and HSAM and development of messages and materials

Oncho focal persons in counties are responsible for other activities and so do not focus on oncho. There is a need to increase motivation for oncho focal persons.

The oncho coordinator at central level is not on government payroll and some incentive from APOC would help.

Field visits from Tuesday 9th February 2010

The assessment team visited communities in all three oncho projects (Northwest project, Southwest Project, Southeast Project): two counties per project giving a
Sinoe Community Radio

Interview with one of three permanent staff members at the Sinoe community radio station (the others are all temporary staff and mainly students). The station is entirely community owned but operation is primarily subsidized. Cellcom telecommunications provides them with electricity. The station is an affiliate station to Star Radio in Monrovia and reaches approximately 85% of the county. The station hosts a 45 minute call in talk show three times a week. Mr. Bella, the director had several suggestions of how the radio station could collaborate with the Onchocerciasis control programme. This included passing on the various messages and announcements provided from the national and county levels as well as following up directly in the communities with one-on-one interviews with CDDs and community members who have participated in the Mectizan distribution exercises. These interviews and testimonials could then be played on air. While some activities such as this are already happening, one of the main barriers to follow up on programming remains transportation and budgeting for such activities. Mr. Bella also suggested posting any printed materials such as posters at the radio station.

Greenville District

Po River Community (see cover picture)

The Po River Community is just on the outskirts of the main town of and is one of many communities that comprise the greater Greenville city. Po river community is reported to have approximately 2000 residents. In this meeting with the community the chairman, assistant chairman, secretary, and one of the six CDDS for the community were present. Other participants included a mix of approximately 20 men and women and smaller children. Every one in this community reported to having heard of onchocerciasis, referred to as river blindness in this community. Several women reported having severe side effects after having taken the drug the previous year and the group maintained that no one in the community was affected by river blindness. Despite the influence of
Suggestions from the county team:

The CHT outlined several suggestions for improvement of HSAM for the CDTI programme. These included:

- more community participation and more involvement in and endorsement of the programme by county officials
- Involving community health committee (CHCs) in training for health education.
- There was also a request for more printed materials such as posters and leaflets from the health promotion division.

The county team also talked of clinic based distribution of Mectizan. This is a clear indication of the need to re-enforce the CDTI concept at the county level.

Challenges

- Though the community is sensitized that oncho is a community programme the CDDs still expect compensation. Since some other programmes pay money, they expect oncho to pay too. Some leave the programme and this has a negative effect on treatment coverage
- During the rainy seasons, the roads are very bad so communities are hard to reach and the dry season is farming season and the people are busy so it is also hard to reach them during distribution times.
- As regards health education, lack of good roads poses a problem. Those who live close by will receive health education and those in hard to reach areas are left out.

The mission team also visited the office of the superintendent who has recently taken up this position. He emphasized the problem of bad roads and that without roads it was impossible to reach the people with Ivermectin and other medicines. He agreed to record a radio message for the team to mobilize community support and promised to give full support to the programme. It will be critical for the county health team to now follow up with him to ensure that this takes place.
Juason District

Gbason Community

The community members of Gbason provided a clear example of how well CDTI can work when the community takes ownership of the distribution of Mectizan. Overall, the group interviewed was aware of river blindness. Members of this community were informed about the distribution through the town crier. The main obstacle for CDTI for the Gbason community is the burden placed on the CDD. The CDD in Gbason is responsible for 9 surrounding communities. The community supports him by tending to his farm during the distribution period. There was a clear respect for the CDD in this community and he is part of every meeting for the distribution of mectizan and is the focal person for other diseases. Many of the community members cited that he was the person they went to for health questions and information. Even though they heard messages on the radio they say their most credible source is the CDD. If there are any refusals the CDD will take the person to the town chief and then to a higher authority because "they do not want any disease in their community" (another sign that the message has gone down well and the people understand the various ramifications of the disease and its treatment – everyone must take the drug to avoid retransmission). The community chairman expressed that receiving written information from the county health team would greatly improve acceptance and validate communication for oncho activities.

Billibokree Town

This was the last community visited in Sinoe County. The experiences and knowledge of the members of this community greatly differed from the previous community. Although there seemed to be some awareness of the disease, the politics surrounding the drug distribution and the role of the CDD in the community made it difficult to determine actual knowledge. The NGO Merlin is very active in this community. CDDs have previously been paid for activities done with Merlin. This has created tension surrounding the distribution of Mectizan. The experience in Billibokree community highlights the importance of what message is shared with the larger community of how to support the CDDs. The commissioner prefers to get his messages via the radio but the CDD said he preferred someone to come to them in the communities so they can ask questions because there is no feedback from the radio.

GRAND GEDEH COUNTY

County Health Team- Zwedru

The assessment team met with Jeremiah Davis, the Grand Gedeh County Onchocerciasis supervisor along with the CHO and other country health staff at
the CDD present the woman that had such side effects said that she would not take the drug again because of what she had experienced. Some people in the group spoke about the poster that they had seen but this was limited to very few people in the community. The Po River community members are active churchgoers and along with sports activities this was cited as the main source of entertainment.

Congo Town

Congo town is also a smaller community in the greater Greenville district. This was a smaller group of people because many had left for their farms. It was clear that the communication about CDDs and their role in drug distribution must go through community leaders to engage support of the full community. Also participants at this community meeting cited the need for visual aids to show all aspects of river blindness. Group members explicitly cited town criers and the radio for preference of how to be informed of various activities concerning health.

Banah Community

The team met with a group of teachers and students in the Banah community. There was some awareness of river blindness (or filaria as they call the disease) amongst the students. However, there was quite a lot of misinformation with regards to what oncho is and where it comes from. All of the students stated that they had taken the treatment in the past years. Most of the students stated that they go to the nearby medical clinic for information about river blindness.
the Zwedru hospital. With regards to the oncho program, the local radio station has been the main strategy for informing the community about the river blindness programme. The radio announcements sent from the national level were played over the local station shortly before distribution times. The county health team has also spoken on the call in show on several occasions. This activity was planned 1-2 months ahead of distribution. However health talks have been mainly for HIV/AIDS and other diseases. Oncho has not been featured yet. Although there is a county budget for meetings and communication these activities are often held up because counties have to wait for the oncho budget to be approved from the national level.

- OICs have made most of the selections of CDDs in Grand Gedeh County
- Advocacy is done through meetings called by county authorities and partners. There seemed to be no clear agenda or set of points to follow with regards to the oncho programme agenda
- Health promotion officer role has been assigned to the county social worker. This is an additional role for this person.
- ICRC and Merlin are active partners who help to spread messages since they go to various areas.

What could be done to improve communication activities for oncho and other programmes?

- Suggested bulletin boards at the hospital and in selected areas in the city.
- Health promotion focal persons have not maintained the position for long periods in the past. Suggestion of training in health promotion for other personnel.
- Health Promotion role should be a full time position
- Strengthen advocacy to get the communities to own the programme, make it their own and come up with ways to sustain it.
- More logistical support such as fuel, bikes. Sometimes during distribution there is no money to carry out activities.

A visit to the county superintendent made it clear that a lot of targeted advocacy at the level of county authorities was needed. The superintendent said he did not know whether the oncho programme was in the county and that he had never received any briefing on activities such as sensitization or awareness about oncho being carried out in the communities. We apologized for this gap and requested his support and engagement with the oncho programme in his county.
Smile FM – Community Radio

Smile FM covers 75% of Grand Gedeh County. The team spoke with Alex Khan, the station manager, and Jerry Kai, the programme director. Smile FM has collaborated on several health campaigns. Most notably they have done a lot of work with the yellow fever campaign. For this they produced several jingles and a radio drama. Most of the staff has received training from Liberia Media Center as well as some from Talking Drum Studios. Their major challenge is funding outreach activities and costs associated with transportation. Little has been done with the oncho programme. They suggested the following for better collaboration on oncho with the county health team:

- The oncho team should contact them ahead of time so they can be involved earlier to sensitize the community
- Production of messages can be improved at their level
- They are a community-based radio so awareness etc. and anything concerning the community is their mandate

Tchien District

Gorbowogba Town

This was the first community visited in Grand Gedeh County. The team met with the town chief along with a small group of community members that had been mobilized. Awareness of Onchocerciasis in this town was extremely low. The health workers knew but the people did not. There was quite a lot of misinformation about what river blindness is and where it comes from. It seems the message being passed on is not clear or detailed enough. As in most of the other smaller communities the team visited, the town crier was listed as the most effective channel to pass on important information. There is no radio coverage in this town. Again the community requested for more printed materials about river blindness. These should be posted at the clinic, the shop and the school. They stressed that posters alone would not do it but should be used as backup or as a tool to do health education and sensitization of the people about the dangers of the disease and the importance and effectiveness of continuous treatment and why everyone should take the medicine.
Kumah Town

The community members in Kumah town recognized river blindness as the "one with the medicine with the stick". There was a poster hanging in front of the health clinic for the river blindness programme. They know the name of the drug and said the CHT comes to the town chief with a poster and tell him that they are coming to share the tablet and to tell his people not to go anywhere. The two main information sources about the river blindness program cited by the group were radio messages along with the posters provided by the county health team. Members of the community cook for the CDD during distribution periods. The CDD mentioned that he needed more posters because sometimes the people want to keep the posters.

Bhai District

Toe Town
A small group was interviewed in this community on the border of Ivory Coast. Everyone in the group was aware of river blindness although the disease directly affects no one in the community. The town crier has played a major role in communicating messages about the CDTI exercises. There are 6 CDDs in this town. The CDD interviewed reported that some people had refused to take the drugs because of the side effects they had experienced in previous years. Brochures were available in the past years for meetings with the community. This brochure talks about the community providing transportation and gifts for the
CDD. This message seems to be ineffective. Also, because of the size of this town video clubs are a very popular form of entertainment. They suggested producing a video film for older people on the disease and the treatment. Questions are still being asked even after 4 years of taking the drugs so they feel if a special video is produced it will help to educate the people. During European season football video, club owners may agree to show a short health education film during half time. The community also enjoy drama and one was produced on oncho on the radio.

Sampson

This community has been participating in Mectizan distribution since 2006. Amongst the community members interviewed everyone was aware of river blindness. There seemed to be a disconnect between river blindness and filaria in this community. The two terms were seen as separate diseases. Some interesting views on filaria came up in the discussions in Sampson. Many felt that taking a cold bath or not covering oneself well could cause filaria and the severe itching associated with it. Also it was mentioned that some women in the community believed that the Mectizan tablets could cause a woman to abort. When refusals happen they are not followed up. There was a great amount of discontent in this community about the services available at the hospital and clinics in town because of the long waiting times. Because of this most people in the group stated that the drugstore was the first place they would go to receive information about health issues or treatment. This community felt that the creation of a community committee would help to communicate the oncho programme distribution and activities.
NIMBA COUNTY

County Health Team- Saniquellie

Members present: County Surveillance Officer, Director Community Health Department, Other county Health Staff

Nimba is a very large county with over 525 key communities. The Nimba county health team has focused on communication to local authorities such as the superintendent, chiefs, and local media with regards to the Onchocerciasis Control programme. The county team admitted that early on in the programme the message had been difficult to get across. They felt that the community health department has strengthened the concept of CDTI. Last year a cassette was recorded with the superintendent to give support to CDTI. The Nimba county health team has also collaborated with local marketing association and other NGOs for advocacy and communication. The team stated however that recording a cassette was not sufficient and that direct interpersonal communication needed to be strengthened wherever possible. There is currently no health promotion focal person for Nimba County. Like the other counties visited this person is currently in Monrovia receiving training. Filaria rather than river blindness or Onchocerciasis is how the disease has been introduced into Nimba County. Prior to APOC there was some awareness of filaria, however this was not fully assessed.

Barriers for implementation of communications for oncho programme:

- Transportation
- Nimba is a border county and there are large influxes of persons moving in and out
- During the conflict period NGOs bypassed local government structures and paid community volunteers directly. This has altered people's idea of doing voluntary work without any remuneration and has made it difficult for the CDTI concept to be implemented where the community is expected to support the CDDs.
- Mistrust of free drugs
- Insufficient numbers of printed materials such as the flipcharts provided by the NOCP

What worked well?

- Acceptance of Mectizan on a community level
- Involvement of local government
- Training package for NOCP
What were difficulties?
- Insufficient drugs
- Reports from CDDs in the districts

What could help to pass on the message?

1. When APOC started the programme there were flip charts that were given to the CDDs to do health education. Nimba has a large population with 525 key communities. Not enough flipcharts to go round – more would improve things
2. Communication and media support require quarterly funding – funding for media support
3. Marketing association of Nimba county is a partner – a group of women selling important goods, plantains, cassava. When they speak people listen and they can give information to the people. They get involved in polio campaigns and get some financial motivation

The role of the health worker in the community is one issue that arose during this meeting. The OICs in communities are considered to be the direct supervisors of the CDDs. One suggestion was that the county provides detailed checklists for their roles and responsibilities. There seemed to be a great understanding of the CDTI concept at the county level in Nimba. The gap seems to be between the county, district and community levels.

Radio Nimba

Radio Nimba has coverage in the entire county of Nimba and is also picked up in Guinea and Ivory Coast. They air a health call in and talk show every Friday. They do not have the ability to go into the field to do follow up with programming but host a feedback show at the end of every month. The staff interviewed at radio Nimba highlighted the importance of producing local language spots in the counties. They noted that in the past some radio spots sent from the national level were not always appropriate or correct in the local dialects.
New Tappita

Tappita is divided into 8 zones that make up the larger city. The team met with the New Tappita community on the evening of the 12th of February. Not the entire group present was from the New Tappita community. Many people in the group talked of filaria, and according to the community chairman the disease affects mostly farmers and some say the disease is caused by witchcraft. The message received in this community over the radio and from their community chairman was to inform them to go and receive treatment at the local clinic. The concept of CDTI was not known in this community and there were no CDDs present. Also community members had not seen any printed materials regarding onchocerciasis. They said no one tells them anything and that they only hear on radio. The majority of the people will refuse treatment and give all kinds of excuses. Since it is voluntary work no one accepts to do it. They feel that Tappita town is a big city and is the headquarters of the county and that things are hard in the city.

Vahn Town

There was a large group of community members from Vahn town present when the assessment team arrived. The disease is known as filaria in this community and everyone present had some awareness of this disease. Many people had a lot to say about the effects of filaria and where the disease comes from. The discussion in this community raised the issue of the possible need for a more in-depth and unbiased survey on the perception of filaria and river blindness. People know the disease by different names in different parts of the country. The role of CDD in this community is assigned to the CHV. The town crier announces and tells the people to go to the chief elder's place. They are also informed by the radio about the time of distribution.

Community members in Vahn Town
Zoulay

The team met with the zone chief, the youth leader, the trained traditional midwife (TTM), as well as other general community members. Most people associated filaria with itchy skin and bone troubles in this community. One elderly lady reported having heard a lot about filaria but did not know anything about the disease. The youth leader also reported itchy eyes and skin but was not sure if there was a connection to filaria. There has clearly been very little education or clear information about the disease in this community. When asked who the disease affected most the group responded “children”. Despite the lack of knowledge about the disease everyone in the community reported having taken the drug. There are 2 CDDs in this community. The CHV plays a vital role in this community, as he is the person that people in the group said they would go to for information about oncho or other diseases. Messages about the drug distribution had come mostly from information from other communities sharing the drugs and some from the radio. The Zoulay community has a cultural and dancing group that has worked in the past with other health interventions. The people considered this to be the most popular way to educate the community.

Sanniquellie District

Darvoyee

The town of Darvoyee welcomed the team warmly with the traditional protocol of kola nuts. Most people in this community have heard of filaria. Many people complained of the severe itching that one gets. Very little technical knowledge of oncho was present in Darvoyee. Some mentioned wet areas such as the swamps where one can get the disease while some indicated that filaria could be caught from eating sweet things. Information in this town is scanty and erroneous. They talk of treating themselves with traditional medicine, drinking or bathing with water from boiled leaves or eating bitter cola. There were also conflicting reports of the tablets taken. Like other communities the importance of the chief and town crier was paramount.
BONG COUNTY

Bong County Health Team – meeting in Zuacoco town

The Bong county health team kindly came in to the office on a Sunday afternoon to meet with the assessment team. The members from this team included the county surveillance officer, the community health director, the oncho clinical supervisor, as well as the data manager for the county. Communication activities in the county for the oncho programme have consisted of meetings with health partners, radio talks, monthly meetings with the health steering committee and development partners. The town people communicate through town criers during the time of distribution. Community health volunteers also pass on messages. CDDs are trained to carry information to the community. All health activities are coordinated from this office. There are many river blindness posters available at the county level. One comment made by the team suggested that bi-lateral and NGO donor logos on posters do not encourage community ownership of programmes. When the people see the logos, they immediately think that money is being paid to distributors. The CHT would like to be involved in the design and development of audio-visual communication materials rather than them coming directly from the oncho secretariat in Monrovia. The county health team partners with the radio station but admits that the radio is only effective in urban communities. Motivation like scholarships to go to nursing school or even support to finish high school will go a long way to encourage volunteerism.

Challenges:
- Collecting reports from CDDs
- Training of CDDs
- Demand for incentives by CDDs
- Lack of coordination between the central and county levels – even with regard to distribution
- Funding and logistical support for communication activities – advocacy sensitization
- Health education in the county has been ad hoc and limited in scope. This should be a continuous process throughout the year for the oncho programme and a full time health promotion person is required.

Zota district

Belefanar town

This town is divided into 3 quarters and we met with the city mayor, the quarter chiefs, representative of the youth chief and the chief elder.
They have all heard of river blindness but believe that it comes from cold water. Only one person heard on the radio that the disease is caused by flies that are found where fast running water is and swamps. They also heard information from the clinic. They know about the tablets but have only taken it once – last year in November. Feels the CDD is their son and was selected by them so should do volunteer work for them. Complained that the OIC gets no support for his oncho work – no fuel to go and collect reports.
Main source of information is the clinic health workers in the community.

Pelelei Town – Zota district

Community members included the Deputy town Chief and the youth Chairman

The people in the community know about the itching. They talk of “getting devil in the eyes” and cannot see clearly, and of skin blisters. Say that older people get it more. They know about the medicine for the disease but the CDD said that only a few people come for the tablets. When he informs the town chief he takes action. He can also report this to the clinic. This town has no town crier.

Important information should be told to the town chief. People do not seem to know the importance of the medicine because despite announcements they do not turn up for the medicine. The OIC will need to reinforce the messages. There are announcements on the radio.

There was clearly some friction in the town. The people said that the CDD does not disseminate information and keeps things secret and that they are not aware when the tablets arrive. Since 2007 the town chief has not been involved in the distribution process. More follow up is needed from the CHT to monitor such things. It came out later that the CDD had been selected by the commissioner and the CHT and this was not approved by the community. They do not like the way he was selected – but will accept him if he is introduced to the community by the clinic.

Suacoco district

Zeansue town

The meeting took place at the clinic and present were the OIC, certified midwife, pharmacist, nurses and some patients (well baby clinic was in session). Also present were some CDDs that included a pastor. The people knew about river blindness and had heard about it in the local clinic and also at Phebe (the capital of the county) hospital. They also know about the medicine and the distribution. They have heard information on the radio too, and the CDDs inform them in the community. They are informed one month before distribution but have not seen any pictures. In some communities they can be informed by the town chief to
take the medicine or else they will be fined, so everyone takes it. The OIC goes for the workshop then comes back and holds a workshop to teach the community health workers how to carry the message to the people. She holds health talks for the patients for them to take back to their villages. The clinic serves several villages.

People are concerned about river blindness and would like to be able to get the drugs at clinic. Awareness is also done in church. The medicine is distributed to the school and information is given to the students. Selection of distributors is done through vote by the community. Community members were not told to support CDDs so did not give anything. They believed they are getting USD but now that they know better they will give some support.

Challenges:

- Reports are not coming through
- Some distributors have not been trained
- Lack of equipment such as boots, raincoat, flashlight, folders, transportation bicycle
SUACOCO DISTRICT

Gbartala City

The community has zonal heads (community leaders) who assist the city mayor and they have regular meetings. Information about the distribution is given by the OIC and on the radio. The OIC goes for training before distribution. Here the CDDs are chosen by the OIC and the mayor. The CDDs are 6 in all and have been working for three years. The mayor understands the essence of the treatment and can also sensitize the people. Poster is posted at the clinic. Important information should be told to the city mayor who will inform the different leaders to take the message to the community or put on radio. The city mayor complained that the CHT do not give enough notice to the community regarding treatment and wants to be informed several weeks beforehand and not a day or a week before.

There have been some refusals because of side effects after treatment but the de-worming effect of the medicine has increased demand for the tablets. Sometimes force is used to get people to take the tablets.

The town law is not to ask for money and the CDDs are expected to give them the medicine free. The CDDs are used for vaccination campaigns to enable them get some incentive. The issue of CDD incentive is difficult to manage because some NGOs say that the communities must not pay any money for anything. This hinders the communities from supporting the CDDs. Community participation (support) has been spoilt by the message from the NGOs that no payment must be given to volunteers. Community participation must be emphasized during training.

The community would like to see an increase in visuals aids and feel that sensitization and awareness must be done throughout the year including using the community radio as a channel to pass on messages and other health programmes. The community prefers video films and drama about river blindness to posters because not everyone understands them.

Meeting with Gbartala elementary and Junior High school

A small group discussion was held with some of the teachers comprising the principal, the vice chancellor for Student affairs, the registrar and some teachers. The programme has never been in the school though the principal heard it over the radio. The school has never been involved in the oncho programme and no information is given about oncho. They have not seen any posters on oncho (there were posters on HIV/AIDS on the walls in the library where the meeting was held).
One teacher said that people are seen only when distributing the tablets and that no prior information is given. Many people are not informed about distribution. One person said he took mectizan in 1997 and another in 2007. Another teacher said that in his village every person is asked to pay $5 to those distributing the tablets so people are reluctant. They talked of partiality in the selection of CDDs and lack of consensus among community members about the choice. The people may reject the medicine because they do not approve of the CDD. The School believes they can help to disseminate messages through the CHT meeting with the teachers and with the students. They can pass on information to each other and to their parents.

Small group discussion with eight students aged 16 to 20 – girls and boys

Those who have heard of river blindness say you get the disease when you work and sweat, when you do not bathe or you wear dirty clothes or drink dirty water. One talked of the cow fly around the river and that they are advised by the clinic to take herbs. Two of the girls mentioned people coming to their houses with a measuring stick and tablets and that each person was asked to pay 10 Liberian dollars. One boy said that in 2006 he had heard on national radio, but that he did not feel concerned by the message. Students have received health education talks done by the clinic staff – HIV/AIDS and yellow fever but not on oncho.

Margibi County Tuesday 16th

Kakata town

Meeting with County Health Team
County Coordinator, Save the children UK, Oncho supervisor, Community Health Supervisor, Hospital Administrator, County Pharmacist Margibi, Medical Director

Activities are done mainly around distribution time in three districts. Unlike other programmes oncho is strictly community-based. Advocacy starts at the highest levels because when the message comes from this level people will listen. The CHT meets with the superintendent to record an announcement that is taken to the radio. The town criers also announce messages to the people. These are tough times in terms of cooperation with the people because they think distributors are being paid as is the case for other programmes. The last time there was a shortage of drugs and now people are demanding the tablets. The OIC who lives in community has been putting emphasis on eye care so there is awareness and people appreciate the treatment.

There is no input from the county for the development of messages and the CHT feels this is necessary to ensure appropriateness of the materials sent to the communities. They try to use a multi-channel approach because the population is
quite diverse - some people will prefer to listen to the town crier and others to the radio.

Ways to improve the programme:

- Timely supply of drugs in order not to discourage users - involvement of the pharmacist and SOP to manage the drugs procurement will help.
- volunteer payment
- recognition of the work of the volunteer – celebration of their effort with certificates, T-shirts, Bicycles
- More advocacy, sensitization and awareness throughout the year instead of only once a year would be more effective and give more momentum. Other programmes are more active in the field
- Need for a full time health promotion officer

Challenges include:
- Transportation to carry out activities around the communities is a problem.
- Consistent communication from central to county needed. The existence of GCHVs and CDDs is causing a lot of confusion in the communities especially as regards the number of people each type of volunteer is supposed to cater for: GCHV 1 to 1000 and CDD 1 to 100 people. Having one person responsible for 1000 people in the rural area is a problem and is not practical as the distances are great especially when there is no means of transportation, or no fuel is available
- Demand for incentives by CDDs

Meeting with Special Assistant of Superintendent in Kakata

Also present were:
Red Cross representative, county education officer, procurement officer,
The superintendent's office is always aware of things happening in the health sector through intervention with CHT. They are informed of all health projects being conducted and will give their support.

The assistant superintendent used to be the commissioner of Chazon district in Lower Margibi and was very involved with the river blindness programme when it
started, and assisted the CHT to recruit people from the towns to distribute the drugs. Lately he has not heard much about it. The process must be revived and he stated that his office is open to cooperate especially as regards mobilizing the people, chiefs, elders to assist CHT to reach the community.

The development superintendent is the one who is involved with the CHT. He reiterated that his doors are open and that the willingness is there to play the role assigned and  to assist whenever necessary. He agrees that communities must own the programme so they will benefit from it, but that they are not playing their role to sustain the programme. He mentioned the approach used in lower Margibi which involved holding discussions with people in their community (elders, religious people; traditional people), bringing the group together and having the health team come in to tell them why this programme was important and why the community should own it. People were very receptive and to this day are still requesting the tablets. When community members have taken part in the discussion or training they will take the tablets – so the CHT should continue with this approach.

On how to support CDDs, he admitted that in Liberia people are not keen to do voluntary work. It is a challenge and however much you try to convince them to serve they refuse and say that “empty bags cannot stand”. He suggested giving them some small incentives like food to help pacify them. There are some people who will volunteer but others will demand something. A way needs to be found to see how to solve this problem that still remains a serious challenge.

The Red Cross works in the community and trains some volunteers who do awareness. They work with the CHT and are part of the team. They work with visual aids, posters that they get from the MOH. Volunteers and CBOs are trained before they go into the community. The Red Cross does first-aid training and holds talks on health for some school clubs in junior and senior high. They are not focusing on oncho but do more HIV/AIDS, Health and hygiene, disaster management and family tracing.

The Education sector has not been involved in river blindness and would like to have school health included in the curriculum and be more involved in health programmes. There is no oncho information in schools and no health clubs. They want people from the hospital to come to the schools to talk to the students.

Use of faith-based organizations is a good approach and recently a health programme was launched in the church and the mosque by the Minister himself and almost the entire community was mobilized that day.
Gibi district

Peter’s town

The meeting was held at the Peter’s town clinic and present were the OIC, the oncho coordinator for Gibi district, town chief, a pastor who is a CDD and three other CDDs.

The community members have heard about river blindness (filaria) and about treatment. They heard it on radio and the CDDs go to the community to tell them. Everyone takes the tablets. Some people reported experiencing some physical manifestation of oncho and that after treatment the itching stopped, so that has helped to make people appreciate the tablets. Information for the community is usually passed through the town chief. They have health talks given at the clinic regularly and they discuss health matters including oncho at their town meetings. They have children’s clubs to carry messages about different things around the community, and use a town crier and the radio. They are satisfied with the work of the CDDs and give them some small token such as rice and cassava.

Interview with the CDDs (who are called CHVs)

The CDDs are selected by the community and have been working now for 2 years, 5 years and 6 years respectively. They were selected to go for training and are the link between the community and the clinic. They do health education and talk to the people about hygiene and clean surroundings. They Inform the community about the distribution a week ahead of time, and before that the message is passed on through the town crier, the church the mosque and over the loudspeaker. As regards the people taking the tablets, the CDDs said that they sometimes argue and are reluctant but the town chief intervenes. There is no problem now and they take the medicine. For reactions, they are sent to the clinics.

The community looks up to the distributors – they love them for the work they are doing and they have respect for them. They said that in some communities the people are hard headed and know the medicine is free so will not give the distributor anything.

Worhn town

This town is supported by Save the Children UK.

The Commissioner was present and the people have heard of oncho through posters, announcements in the community by the town crier, radio and the clinic. Important information should go to the commissioner who will pass it on to the paramount chief and then on to the clan chief, general town chiefs, town chiefs,
youth leader, women leader for dissemination to the rest of the community. They hold quarterly meetings that comprise community members, men, women, youths and also CDDs, quite a large group. Topics discussed at these meetings include development of roads, schools, clinics, health matters. CDDs are selected by the community.

Challenges

Volunteers are not being paid and they sometimes have to travel far distances - 8 – 10 hours on foot. At meetings they are encouraged by the community but they want to recommend compensation because CDD work is hard and involves report writing, so the CDDs request money. They ask why polio programmes give money and oncho nothing when oncho work is so much harder. Because of EPI money they do not believe that oncho gives nothing so are demanding money.

Group discussion with CDDs

They have been working as CDDs since 2000 and 2003 and are happy with the work they are doing. They are professional people in their own right and professions include: district education officer, town chief, farmer, teacher, business man selling medicines, nurse aide and school principal.

They said that it was a new start and that more sensitization was needed. They feel that this kind of meeting from our team was important and that they would discuss this at their Friday meeting emphasizing that the work is purely voluntary. They recommend that the CHT should help with sensitization. Representatives of the CHT must meet with community elders to help to sensitize the people.

For relaxation they watch films at the video shops or sit under the tree drinking palm wine. There was a very convivial atmosphere at the meeting with this group that comprised leaders, CDDs and community members mixed ages, sexes etc. There was a lot of laughter and joy.

BOMI COUNTY

Tubmanborg district

Tubmanborg city

Meeting with the superintendent – Mr Mohammed Massalley

He is also the chairman of the county health board, is on review board and is involved in health matters. The county administration has a strong partnership with the CHT. The superintendent has also been involved with the oncho programme. He stated that everyone is covered, that the programme is effective and should continue to improve. The health board meets as a group. There is an
information officer who collects and analyses data and decisions are made on the basis of these data. The radio is used often to pass on messages in local languages.

Challenges:

The Bomi oncho programme is now in its 4th year but because of the war it will take time to build things up again and every sector in the country is suffering from lack of capacity and will require assistance for logistics and capacity building for the programme. Awareness workshops are needed for the towns and villages. There are plans to promote the establishment of health clubs in schools to highlight oncho and other health matters in collaboration with the CHT. The local leadership including town chiefs etc has a place on local health board, so they can take control of the matter for the oncho programme.

Meeting with CHT

Present were: community health director, oncho supervisor (COS), acting county health services director, administrator, clinical supervisor (very active and involved with his Muslim community for health matters and other issues).

Activities at county level include radio talk shows with phone-in every Tuesday and oncho is one of programmes discussed. The OICs are sent for training that emphasizes sensitization and social mobilization. Community meetings are held to pass on information to the people. CDDs are recruited to participate in most campaigns as a means of encouraging and compensating them.

There is 100% radio coverage and the level of reach 50-60%. Community mobilization is done through town hall meetings and health education is conducted for those that do not listen to the radio. Posters and flip charts were used in 2009 by the CDDs to explain about the disease and the tablets. Health talks are given every morning. They do not have any jingles and general information comes from central level. No schools are targeted at present, including teachers. The Bomi county health team also provides services for some areas of Montserrado County which is next to Bomi.

Advocacy is done at the level of political authorities. In the beginning community leaders were not supporting the programme but after contacting the commissioner who contacted the paramount chief there is better cooperation from the people. There is a need for continuous health education to convince the leadership about the importance of the programme. Religious involvement is positive – sensitization is carried out in churches and mosques. One of the CDDs is an assistant imam and is a useful help for all health programmes. Generally other health programmes are working well with health education. The county has a full time staff for health promotion and is the only county visited by the team.
that has one. However oncho has been cut down from the county budget. There is difficulty in adjusting county budget so they cut down some programmes.

There is strong support and cooperation for the oncho programme from the chief medical officer Dr. Rhoda Peters who insists on seeing reports, analyses them and signs them

Suggestions to make oncho CDTI activities more successful
Encourage the people to take ownership of the programme. There is a need for more awareness and sensitization to reach the people

Using CDDs to take part in the polio, yellow fever campaigns as a means of encouraging them to continue distributing Mectizan

Encourage CDDs to serve as role model for health in the community and do outreach work

Encourage communities to take ownership of the programme- more sensitization needed – talking to them so they understand – if they understand the message they will be more committed

Tubmanborg district

Weakama town

We met with the town chief and the CDD who is an elder of the town. People know about the medicine but go to their farms or rubber tapping very early so they can miss their medicine. Information about the disease and treatment is given by the CDD and the County Oncho Supervisor. Information is also disseminated on the radio and at meetings. There is also house to house dissemination but no posters are used for explanation at community level. Important messages are to be given to the town chief who will call a meeting. If somebody is sick they will tell the town chief first and then take the person to the clinic. They have meetings twice a month in the school building.

The CDDs are selected and appreciated by the community – they are thanked warmly and given food–the people are happy with the distributors. The people are happy with the deworming effect of the drug. There were some refusals at the start because of reactions and they were scared, but after many explanations they are now complying better.

The community loves drama and this could be a useful and effective channel.
Clay district

Gayah Hill
Some people have heard of filarial from the hospital. Seems they have been taking the medicine without knowing the causes of the disease. There was not much knowledge in this town and it was difficult to get information from them.

Meeting with the Chair of the NOTF - Dr. Bernice Dahn - 19th February (she was away from Monrovia on 8th February)

She stated that she was aware the project was not doing well and added that they were trying to improve. The high turnover of central oncho staff has not helped the situation.

Dissemination of information was a big challenge, not just for oncho but for all health programmes. There is a need to look at different strategies to see how to do effective and strategic communication. Felt that health promotion work has focused too much on production of posters and that this was not necessarily the most effective way.

Dr Dahn welcomed the idea that APOC was planning to conduct training workshops for the development of communication strategies and communication materials and emphasized that APOC support was clearly needed in this area. She also requested that NTD should be integrated in this exercise.

Debriefing with WHO Representative - Friday 19th, 8:30 am (he was away from the office on 8th February)

The representative said that the weakest link in many health programmes is community involvement and recommends the development of guidelines and tools for each resource person at community level - what activities and orientations should be emphasized, and what staff should do what at community level to promote health programmes.

Feels that a kit or a package that can be used by resource persons would be practical and help facilitate implementation of different activities.

Suggested that it may be helpful if tools in a bag could be given to CDDs and other communication resource persons - such as laminated messages and other audiovisual materials (posters, leaflets can be torn or get blown away by the wind).
The WR believes that an integrated approach for various health programmes would be more effective and have better impact. Since health is a total and there is a need to look at the broad picture because health is indivisible. APOC cannot ignore the other health problems especially since it is at the community level.

There needs to be a kind of agreement as to how to use resources for a joint health benefit effective, and not just focus on one disease.

There is a need to discuss with the communities, for them to say what they want. They need to understand the seriousness of the disease and the effectiveness of the treatment. They should be given the opportunity to ask questions and receive answers.

He added that they were expecting a lot of support from APOC in terms of how to develop Community interventions as there is a lot of communication gaps:

1. More training should be done at community level
2. In post conflict countries there is need to think of how to sustain these activities and programmes in the future
3. Cost sharing from APOC in the WR office – computer, Fuel, electricity, generator

DEBRIEFING at MOH - Friday 19th, 10: a.m

Opened by Deputy Minister for Curatives Services, Dr Pewu who is also co-chairman of the NOTF Liberia

Dr Pewu thanked the mission team for their presentation and the recommendations made and invited comments from participants:

Dr Pewu stated that after 10 years several areas are still struggling with a lack of interest whereas after such a long time the programme should be doing well.

Stakeholders like MOH, government of Liberia and APOC need to look for new ways to arouse opinion leaders to solicit compliance, acceptance, adherence and support

Oncho is a bandwagon by which other commodities and drugs could be distributed. This is therefore an opportunity to turn things around.

The CDDs have the closest contact with the community and they know every member through the census carried out. The training given to CDDs should
be strengthened and expanded to include modules on health education and social mobilization for community members.

Dr Diallo, Dean of the school of pharmacy, MOH said it was worrisome that there was no full time health promotion staff at county level as this is key to disseminating the right messages from national to county to community, and emphasized the need to reinforce the county health teams by training mid-level professional at community level to carry out full time health promotion.

Dr Pewu

A big problem in Liberia is that people are overworked because they are doing too many things and are therefore not effective.

Mr Kassor Kollie – NTD Director

The gaps for oncho will be the same for the NTDs so wants the strategic communication plan to be developed in collaboration with APOC to include NTDs

NECP

There is a need to train more health workers and involve other people in the community because it was noticed during the mission that in some communities, many people did not know much about oncho or the treatment. These could include, teachers, senior students, chiefs and other respected community members.

Health education, sensitization and social mobilization should be strengthened at community level and not just limited to distribution time.

The introduction of the general community health volunteer (GCHV) system was causing some problems with the CDTI system and the MOH must look into GGHV, CDD roles in the community.

Next steps

Posters, pamphlets are not really the most effective as a lot of the population is illiterate.

Local radios should be allowed to participate in the development of radio programmes - materials should not just come from Monrovia.

Community involvement is necessary to be more effective.
BCC works better with interpersonal communication, that is, dealing with people one on one through the elders, through market women, for example. There is a need to know what materials are relevant to the people.

Some media representatives were also present and expressed the desire to be involved in the work of health programmes to conduct health education, and they also requested training in this area.

Dr Pewu informed them that the ministry was working on organizing a media health unit in the ministry.

To close the meeting, Dr Pewu again requested that APOC should extend its support to Liberia even though the Southwest project started many years ago.

WHAT WORKED WELL

- High demand for Mectizan and testimonies of its efficacy in some counties – due in part to its de-worming effect
- Dedication of some community directed distributors. Some have been volunteering since 1999
- The wide use of local radio to disseminate health messages
- Involvement and commitment of community leaders in some areas

SUMMARY OF BARRIERS IDENTIFIED

- During the crisis in Liberia NGOs and external aid by-passed the local government structures and paid volunteers directly for community based interventions. Communities now seem to have become dependent on the money given to them during the crisis and just after the war and expect compensation for every programme that comes to their town
- Heavy reliance of counties on the support from the national level for HSAM activities.
- Communities do not appear to have accepted the oncho programme as their own. In many communities they see it as something brought in by outsiders.
- Lack of county political involvement in the oncho programme in some counties
- Frequent changes of the management at National Secretariat of the Onchocerciasis Program
Onchocerciasis is not one of the diseases prioritized in the Basic Packages of Health services
- Lack of a full-time health Promotion focal person (only one county visited had a full time health promotion officer

**SUMMARY OF GAPS IDENTIFIED**

- Across Liberia there is a clear need for more disease specific information at the county and community level
- Onchocerciasis is known by several different names across the country. Some counties have focused on Filaria while other have focused on River Blindness
- Lack of communication focused on community ownership
- Non-availability of health education materials at all levels
- Inadequate capacity of health workers to deliver health education
- Inadequate training for health workers and CDDs
- Non-involvement of other stakeholders outside of the health sector
- Disconnect between NGO interventions and the role of the government (MOH)
- Many community based interventions in Liberia with principles that conflict with the CDTI philosophy.
- National Community Health Department has not fully recognized Oncho under the national policy for community health.
- From desk research, overall lack of evidence based research for communication strategies in Liberia

**RECOMMENDATIONS**

- An effective communication plan for health promotion (health education, sensitization, advocacy, and mobilization), backed by a strategic plan with planned activities and delegated roles and responsibilities for these activities must be developed
- Partnership with other development sectors will be critical for CDTI exercises to fully take off. Examples include: the media particularly community Radio stations, Ministry of Education, Teachers, community associations
- Targeted activities and messages for advocacy at all levels, particularly at county and community local government and other opinion leaders to engage them fully in the programme
- In line with local realities promote the use of appropriate channels such as community meetings, town criers, community radio, school health should be strengthened. A multi-channel approach is more effective
Social mobilization should be prioritized at community level
All counties should appoint a focal person fulltime and solely responsible for health promotion
Onchocerciasis, eye care and other NTDs must be prioritized in the national health plan
To organize a workshop to develop a strategic communication plan for the oncho program to be followed by a media/Health education materials development workshop.

CONCLUSION

From our visits and interviews it was clear that some county health staff are committed to the oncho programme and that the programme is appreciated and is working well in some communities. The impact of HSAM, especially social mobilization, on treatment coverage, acceptance and compliance was visible and positive in some communities. This shows that when done effectively and strategically HSAM is a vital component for the successful implementation of CDTI and its importance should not be minimized.

Target-specific HSAM with objectives, activities, channels and messages selected based on evidence should therefore be promoted and strengthened at all levels. The central oncho secretariat in collaboration with the CHTs should include an HSAM package in the CDTI training for health workers, CDDs and other resource persons in the community.

Due to logistical reasons and time constraints, the team could not visit all counties nor interview all communities but we believe we were able to collect enough data to make a reliable assessment of the situation of HSAM activities in oncho projects in Liberia and can help the oncho programme develop an HSAM strategy that will be evidence-based.
Appendix A

FINDINGS AND RECOMMENDATIONS

CDD Selection

In communities where distributors were not selected by the community but were imposed on them by political authorities, there was resistance, leading to refusal to take the Mectizan, and the distributor does nothing about it. In other communities where the selection was made by the community the CDDS would call on the town chief to take action if anyone refused treatment.

Recommendation: The CHT must explain why it is important for the community to choose and approve of the CDDs for otherwise messages will not be heeded and the whole process will be ineffective.

Community Ownership, CDD Retention and Incentives

That the community is the owner of the programme and should support the CDDs did not appear to have been absorbed by many of the communities visited although a few appreciate the work done by the CDDs and do their own part by brushing their farms in a village in Sinoe for example.

The issue of compensation or incentive for the CDDs came up in nearly every community we visited. Sometimes even the county health teams expressed the wish for more funding from APOC for the CDDs or for oncho activities because they sometimes have to trek for long hours to far distances to distribute drugs or collect reports.

Recommendation: the message needs to be strengthened to emphasize the meaning of community ownership and community participation and their support to the CDDs.

With regards to CDDs trekking for long hours and far distances to distribute drugs, there is a need to increase the number of distributors and ensure they are responsible only for their own villages, work only within a reasonable distance and can easily monitor the people after treatment.
Involvement of County, Community and Opinion Leaders

In almost all the communities visited the people said that if there was an important information/message they needed to know about then it should be told to the town chief who will ensure that they receive it either by sending a message house-to-house or by calling a town meeting to inform the people.

In communities where community and opinion leaders were fully engaged and involved the distribution was better organized and the compliance rate was high. County, community, religious and opinion leaders are seen as credible sources by the people and messages given by them will be heeded.

Recommendation: Advocacy at the level of these leaders must be intensified and strengthened to engage county, community and opinion leaders. The message is not just to inform them but to convince them to buy into the process and actively support the programme in all aspects.

Community Knowledge and Message Content

The level of the knowledge of the disease, its cause, symptoms, prognosis, treatment, retransmission etc. differed from community to community and from county to county. It was clear that the Information, the message was not always effectively communicated and appeared to stop at some level and did not filter down to the community. In some communities even the CDDs seemed ignorant about the cause of the disease- one talked of the disease being caused by a fly from the river and if you drink the dirty water from the river.

Recommendation: The objective of sensitization, awareness and health education must be more than just to pass on information to the people. The message being passed on should be more than “river blindness is in your community and you must now swallow some tablets once a year”. The people need to know more. They need be given a clear and detailed explanation of the disease, the causes and the manifestations, and they need to be told about the treatment and about possible side effects, and that there is treatment available for those and why they should continue taking the treatment.

The training given to health workers and CDDs before they start implementing the programme must also aim to build their capacity such that they develop the skills to carry out health education at community level.
Choice of Channels and Sources

In some communities, different members prefer different ways of receiving their information and messages. Some prefer the radio, some the town crier and others prefer to be informed by the town chief or the clinic nurse at a community meeting.

We found that community radio is widely used to pass on information. This is a good channel but it has its drawbacks. It does not always cover all the communities and it is hard to measure actual reach, that is, who heard and who did not. Also, the radio does not always engage the listener. Some students interviewed said they had not heeded the message nor taken any action because they did not think the message on the radio about oncho and meitzan tablets concerned them.

Recommendation: A multi-channel approach would ensure that everyone is reached one way or the other.

Community radios should be used as more than just passing on information. They could be given appropriate and adequate training so that they can do health education in partnership with the CHT.

In message delivery the source must be credible as this ensures that the message is accepted by the target audience. Credible sources must be identified in the communities and counties and trained to do health education.

For relaxation communities play football, kickball, ludo, chequers, and in bigger towns they watch video films. These could all be used as effective channels to do health education about oncho – to mobilize and engage the people. The people must be brought to understand the cause, symptoms and seriousness of the disease and must also understand how important it is for every eligible member to take the drugs every year avoid retransmission.

Many towns have drama troupes and would be an effective channel with which communities are familiar. One community said that drama will talk to them better and clearer and should be used to pass on key messages. Schools, teachers and senior students are a good channel and a credible source in the community and they can reach and influence other students, teachers and parents.

As far as possible or feasible, communities should be allowed to choose their preferred method and channel of sensitization and awareness as this
would be more appropriate to their setting and more credible and acceptable.  

**Health Education, Advocacy, Sensitization, (Social) Mobilization**

Some communities visited had never seen manifestations of the disease and did not know anyone with the disease. They have heard of the symptoms like becoming blind or itching of the skin but had never seen any manifestations or even pictures. In the absence of manifestations that in themselves would normally send a clear message sensitization and health education should be more detailed and continuous.

All the components of HSAM have their place and their impact on target audiences but we found that that in places where social mobilization /community mobilization, (that is involvement and engagement of community leaders, youth leaders, women's leaders, professional associations, like the marketers association, clinic staff, CDDs, schools, teachers, religious leaders and community members) had occurred, there was solidarity among the people, commitment around drug distribution, compliance with treatment and satisfaction with the work of the CDDs who are also happy to be serving their people.

**Recommendation:** People must be taught to develop health-seeking behaviours and this can only be done through target-specific health education/ health promotion. They must understand that their health is at risk and that they have the means and power to protect their health.

For communities social mobilization should be prioritized and strengthened so people come to accept that this is a health issue affecting the entire community and that it must and can be handled and managed together for the good and well being of everyone.

**Training for health workers and all those who interact with the communities for oncho activities should include social mobilization**

**Audio Visual Materials – Development, Choice**

To date all audio visual materials are done at central level and sent to the counties. This past year the oncho secretariat reprinted some old posters, leaflets, and flipcharts and recorded some spots developed previously without any evaluation or research done to ascertain whether they have contributed to achieving programme objectives. These materials cost a lot of money especially if they are to be produced in very large quantities, money that could be spent more efficiently doing other HSAM activities.
Recommendation: The oncho secretariat should realize that posters are not necessarily the best and only channel for health education. If the decision is taken to produce them they should be explicit and must be in response to a specific objective. Attention must be given to the fact that a good percentage of the population is illiterate or semi-literate and that it is not always easy to understand the meaning of pictures or the message without words, and if people cannot read.... Some of the participants at the debriefing at the MOH mentioned that they have never been able to understand posters when there are no words. And these are highly educated professionals working in health!

Posters and other materials, audio or visual must also be pre-tested and with members of the target audience before finalization and printing. As much as possible counties and communities should be allowed to participate in the development of audio visual materials to ensure appropriateness of these materials for their settings.
Appendix B

Focus Group Discussion Guide for Community Members

1. Have you heard of Onchocerciasis/ River Blindness? (local term)

2. Are there people in the community with Onchocerciasis? Who is most affected by Onchocerciasis? Who gets it most often? Why?

3. What does it mean to get Onchocerciasis in your community? What do people say or believe about someone with Onchocerciasis? Are they scared of them? Do they reject them?

4. Do you know the treatment for Onchocerciasis? Have you taken the treatment before?

5. How are community members informed of the treatment exercises for Onchocerciasis?

6. If you had any questions about oncho or other health issues whom would you ask?

7. Have you seen or heard any messages for Onchocerciasis in your community?

8. If yes, what do you think about them?

9. What do they say? What do they mean to you?

10. Why would some members in the community refuse to take the oncho drugs? ......Do you all take the medicine? If no why not? Why would some members refuse to take the medicine?

11. Why is it important for everyone who is eligible to take the oncho medicine?

12. What types of gatherings take place in this community?

13. Where do people go for entertainment or fun?

14. If we had very important information and we needed your community to be aware of, whom should we contact in your community? How would you prefer to be informed?

15. Where would you prefer the information to be given?
Appendix C

In-depth Interview Guide for Community Drug Distributors (CDDs)

1. What are the major health problems of people in this community?

2. How long have you been a community volunteer? (CDD)

3. How did you become a CDD?

4. As a CDD what are the activities that you do?

5. Did you receive training to become a CDD? When? How many times?

6. How did you distribute the tablets/oncho medicine?

7. How was the community informed about the distribution of the medicine?
   (Probe if from media, community members, church, imams, town crier, etc.)

8. Does everyone take the medicine? If not, why not?

9. What would help encourage community members take the drugs?

10. What are some of the side effects members of the community experience after taking the drugs?

11. What do the community members think of your work as a CDD?
Appendix D

In Depth Interview Guide for County and District Level stakeholders:

1. What communication activities have taken place with regards to the Onchocerciasis programme or any other programmes?

2. How are the activities coordinated? Who ensures that messages and materials reach the community?

3. Were the activities implemented as planned?

4. Were the activities the same for the entire county/district?

5. Did the staff think they were able to implement the activities as planned?

6. Did you receive feedback from the community members? If yes, what did they have to say?

6. What activities worked well? Why did it work?

7. What activities did not work well? And why did not?

8. In your opinion what could be done to make oncho/CDTI activities more successful?

Health promotion focal persons....

***What capacity do you have to implement health promotion activities in your county/district? Can you give me examples?
Appendix E

COMMUNITIES IN WHICH ASSESSMENT CARRIED OUT

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NAMES OF ASSESSMENT TEAM AND PERSONS MET

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<tr>
<td>1</td>
<td>Jammie G.W. Terkulah</td>
<td>NHPD/MOH 06564652</td>
</tr>
<tr>
<td>2</td>
<td>Zainab Akiwumi</td>
<td>WHO/APOC 06539548</td>
</tr>
<tr>
<td>3</td>
<td>Anthony K. Betsee</td>
<td>NECP/MOH 06552114</td>
</tr>
<tr>
<td>4</td>
<td>Helena K. Kamara</td>
<td>NECP/MOH 065536105</td>
</tr>
<tr>
<td>5</td>
<td>Daniel S. Wessih Jr.</td>
<td>CHSD/MOH 06536105</td>
</tr>
<tr>
<td>6</td>
<td>Adoley Sonii</td>
<td>SSI 06512089</td>
</tr>
<tr>
<td>7</td>
<td>Ukam Oyene</td>
<td>WHO/APOC 06475320</td>
</tr>
<tr>
<td>9</td>
<td>Geordie Woods</td>
<td>SSI/APOC behaviour change and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>communication advisor (consultant)</td>
</tr>
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<td>10</td>
<td>James Massaley</td>
<td>Driver/WHO</td>
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<tr>
<td>11</td>
<td>Henry Slight</td>
<td>Driver/MOH</td>
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Persons met
Central level – Monrovia

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<tr>
<td>1</td>
<td>Mrs Jessie Duncan</td>
<td>Assistant Minister, Preventive services</td>
<td>MOH 06517797</td>
</tr>
<tr>
<td>2</td>
<td>Dr Moses Pewu</td>
<td>Assistant Minister, curative services</td>
<td>MOH</td>
</tr>
<tr>
<td>4</td>
<td>Mrs Mary Momolou</td>
<td>Director, Community health services</td>
<td>MOH</td>
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<tr>
<td>5.</td>
<td>Mr. Kassor Kollie</td>
<td>Director, EPR/NTDs focal point</td>
<td>MOH</td>
<td>06532903</td>
</tr>
<tr>
<td>6.</td>
<td>Dr Joel Jones</td>
<td>Program Manager Malaria program</td>
<td>MOH</td>
<td>077516577</td>
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<tr>
<td>7.</td>
<td>Mrs Chris Dagadou</td>
<td>Director, National health promotion Division</td>
<td>MOH</td>
<td>06405120</td>
</tr>
<tr>
<td>8.</td>
<td>Jammie G.W. Terkulaah</td>
<td>NHPD</td>
<td>MOH</td>
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<tr>
<td>9.</td>
<td>Helena K. Kamara</td>
<td>Program Manager</td>
<td>NOCP/NECP</td>
<td>06552114</td>
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<tr>
<td>10.</td>
<td>Anthony Bettee</td>
<td>Deputy Program Manager/oncho Coordinator</td>
<td>NOCP/NECP</td>
<td>06539548</td>
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<td>11.</td>
<td>Alex Bedel</td>
<td>finance officer, SSI</td>
<td>SSI, Liberia</td>
<td>06827700</td>
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<td>12.</td>
<td>Mrs Adoley Sonii</td>
<td>Country Director, Sight Savers International</td>
<td>SSI, Liberia</td>
<td>06512089</td>
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<tr>
<td>13.</td>
<td>DR Bernice Dahn</td>
<td>CMO/NOTF chair, Liberia</td>
<td>MOH</td>
<td>06557636</td>
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<td>14.</td>
<td>Dr Nestor Ndayimirije</td>
<td>WHO Representative</td>
<td>WHO</td>
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County level

1. Sinoe County

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<td>Matthew K. Boloe</td>
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<td>Lager N. Yober</td>
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<td>David Kofa</td>
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<td>James bolu</td>
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<td>18</td>
<td>Hon John Tugba</td>
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<td>19</td>
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2. **Grand Gedeh**

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<td>5</td>
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<td>Zwedru</td>
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<td>Cephus Krah</td>
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<td>Zwedru</td>
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<td>Alex Kahn</td>
<td>Manager</td>
<td>Smile FM Radio Station</td>
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<td>14</td>
<td>Jerry M. Kei</td>
<td>Program Director</td>
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3. **Nimba County**

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### 4. Bong County

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<td>10</td>
<td>Clarence Wilson</td>
<td>Special Assist. To the Sup.</td>
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### Jeremiah Ouave Procurement Officer
- Name: Jeremiah Ouave
- Position: Procurement Officer
- City/Town: Kakata

### Koko Peton Trainer /LNRC
- Name: Koko Peton
- Position: Trainer /LNRC
- City/Town: Kakata

### David Greavee County Edu. Officer
- Name: David Greavee
- Position: County Edu. Officer
- City/Town: Kakata

### E. Harweton Shilling Officer in Charge
- Name: E. Harweton
- Position: Officer in Charge
- City/Town: Peter Town Clinic

### Emmanuel Baryoegar
- Name: Emmanuel
- Position: Baryoegar
- City/Town: Peter Town

### Alexander B. Weeter CDD
- Name: Alexander B.
- Position: Weeter CDD
- City/Town: Peter Town

### James Massaquoi CDD
- Name: James
- Position: Massaquoi CDD
- City/Town: Peter Town

### Solomon j. John Pastor/Church of God
- Name: Solomon j.
- Position: John Pastor/Church of God
- City/Town: Peter Town

### 6. Bomi County

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