# Mid-Term Evaluation of the Liberia Urban Programme

Full Report

Oxfam GB Programme Evaluation

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## Executive summary

Liberia has experienced serious political-economic disruptions and intermittent civil war from 1989 to August 2003. The 14-year civil war in Liberia ended in 2003 with the signing of a Comprehensive Peace Agreement. 15,000 UN peacekeepers were deployed to oversee the implementation of the peace agreement, whilst the National Transitional Government of Liberia (NTGL) was appointed to lead the country in the transitional phase towards elections – held in October 2005.

In addition to the above, successive conflicts have destroyed much of the infrastructure of the country, especially in and around the capital. As a result, water, sanitation and health infrastructure is very poor. With approximately 1 million people currently residing in and around Monrovia,[1] with the majority densely packed in urban slums, the risk of an outbreak of water and sanitation related diseases remain high[2]. Oxfam GB is currently implementing an integrated public health programme in Monrovia funded by ECHO and targeting cholera 'hot spot' communities in:

1. Urban slums – West Point & Clara Town
2. Two IDP camps – Soul Clinic & Mount Barclay
3. Host communities nearing the IDP camps

An internal midterm review was carried out by two advisers from HD using a participatory approach, which involved the national team. The findings were discussed with the team and a results consensus exercise carried out.

In the ECHO proposal the specific objective for public health was:
*Targeted communities in two districts and two IDP camps in urban Monrovia have access and availability of water and sanitation facilities and are able to take action to protect themselves against protection and public health risks.*

The indicator is no major outbreaks of disease in target areas during the project period. One could argue that this objective has been partially achieved. The IDP camps have access to both water and sanitation. The problem lies more within the slum areas and the newly identified areas around Paynesville. There was a major outbreak of disease (cholera) to which Oxfam responded – a frequent occurrence related to weather patterns. The actual outcome of the water, sanitation and hygiene promotion will only be visible next year when the cholera season comes around again. However the UNICEF head of health praised Oxfam for "correctly addressing" the problem through hygiene promotion. The WHO communicable diseases officer also felt that the ORT corners had been instrumental in preventing dehydration – often the cause of death in cholera cases.

## Public health promotion

One area that was looked at was the whole concept of community participation. Initially most of the team thought the Oxfam approach was very participative after some discussion, it was agreed that sometimes it was consultation with some

1 Monrovia was initially designed to accommodate up to 300,000 people. Note that younger populations (particularly ex-combatants) are expressing their desire to continue to reside in urban Monrovia.

2 Certain areas in urban Monrovia already have a history of recurrent outbreaks of acute watery diarrhoea. A serious cholera outbreak occurred in 1996, 2003 and to a lesser extent in June 2005.

manipulation due to time constraints and the watsan focus in the programme. There is nothing wrong with this as true participation is hard to achieve in a short humanitarian programme but the important thing is that the team recognises this and factors it in to their work.

The PHAST approach has recently been introduced to the team who have not received any formal training. The review team looked at the appropriateness of this approach especially in an urban setting where people are not able to make choices about facility design or siting. Working with a community that is not cohesive is a challenge for any programme wanting to use a participatory approach. Modifications do need to be made.

The team has trained a great many community motivators – 343 in WestPoint and Clara Town plus the ones currently being trained in semi-rural communities. This is apparently according to Sphere standards although the water and sanitation will not follow the same standards.

Dropout among volunteers is generally considered to be high. Studies from volunteer programmes in other countries have shown that supervision and training have a positive impact on retention rates but that few volunteers continue after this support is withdrawn. The team looked at the whole question of community motivators and possible alternative solutions in order to minimise dropouts.

**Water and sanitation**

Poor or limited access to sanitation facilities for disposal of excreta poses the second highest risk to public health especially in peri-urban areas of the programme. The public toilets in one of the slum areas are operated by the national Housing Association. Five Liberian dollars were charged per visit and the money collected was used to pay staff working and for desludging. One of the visited toilet/latrine block was connected to a sizeable septic tank but this and the inspection manholes were full and blocked. One of the causes was usage of too little water as the overhead tanks for flushing are no longer working but also inability to collect enough money to desludge the entire septic tank. These public latrines are also dependent on the one desludging truck in Monrovia.

Much as Liberia Water and Sewerage cooperation is chlorinating water distributed to Clara Town (one of the Oxfam programme slum areas), leakages observed and changes in pressure pose a greater risk from recontamination. The water mining sites are being upgraded but there is still potential for post-collection contamination. The whole urban water system needs a major overhaul, which is way beyond anything Oxfam, can do.

Garbage is a major concern in the urban slum areas especially as there is no safe final dumping place. At the moment all the waste is being moved from site to the river or to the sea, a move that does not solve the problem. Although the team was concerned, they were also able to appreciate the complexities of solving this problem.

*Recommendations*

PUBLIC HEALTH PROMOTION

- Explore ways of providing handwashing facilities (with improved water quality and provision of soap) at slum latrines with support from janitors. This point is already in the project work plan and the team is committed to rehabilitating or building handwashing facilities.
- Radio messages should be explored, as there are so many radios in the slum area – songs and jingles could be used sung in Liberian English using for example children. The team has experience in this area from the cholera response and are already working on adapting these to the current situation.
- Remove the message that Lipton's tea can be used for rehydration in cases of diarrhoea – tea is a diuretic
- It would be a good idea if the team asked where people had heard about both chlorination and SSS – it could be noted on the monitoring form and would give an idea about the effectiveness of the community motivators
- Focus groups should not be confused with village meetings – one or other should be used at one time. People should not be turned away from a focus group unless there is a large crowd. It would have been better to use pictures of the different latrine designs and to get a technician to talk through the advantages and disadvantages of each design
- The PHAST methodology for the current programme in semi-rural areas should be modified (as agreed with the team). This can be done by shortening the time between community meetings without diluting the participation aspect. An example of this would be in Garzah where a village meeting on latrine design with the technicians could be held followed by a pocket voting system. This discussion should be a meeting rather than a focus group as all the community members should participate. Separate meetings with children could be facilitated if the community is agreeable to having a separate child-friendly latrine. The old, chronically ill and disabled should also be considered
- The PHAST method for the urban slums is more problematic – there is no cohesive community and people do not have the time for lengthy meetings. Although some of the participatory methods can be used, I would be careful about calling it PHAST. It is also difficult when people are not able to make many choices regarding types of latrines or where water points can be sited. The team needs to be more realistic when talking about participation of the community. The reference group is a good start but should be representative of all community groups – roles and responsibilities should be discussed
- Reduce the number of community motivators and link them to the reference groups or water management committees – make sure roles and responsibilities, work plans and TOR are understood by all parties
- Consider using other methods such as Child-to-Child with schools, playgroups and children's groups
- Delete the question on boiling water on the monitoring form
- The team should be encouraged to do more observation and sharing of qualitative data, not just as upward monitoring
- Although ECHO does not fund preparedness, there are opportunities to train the reference groups in responding to cholera outbreaks as discussed with the chairperson for the reference group in WestPoint. Oxfam has cholera guidelines that could be used for this training

- There has been so much investment in staff training: what is required now is mentoring and on-the-job training. The team also needs to try out more PRA methods so that they become part of an every day toolkit
- Capacity building (on the job mentoring) of the coordinators and team leaders by an outside adviser who **must** be conversant with Oxfam public health, HIV mainstreaming and PHAST. This person should build on existing skills within the team and assist with areas identified by the team[3]
- HIV/AIDS should be mainstreamed rather than having awareness programmes and TBA training that require more than just a few sessions and are actually labour intensive

WATSAN

- Consider use of alternative toilet designs like compost latrines where possible and where space can be found to minimise need for desludging and investigate possibilities of using human excreta from septic and latrines for generating income
- Review or look at alternative technologies for sanitation such as composting latrines as well as standards
- Concentrate on water and sanitation with less emphasis on drainage
- Increase the number of technicians for the remaining project period in order that water and sanitation interventions can be implemented concurrently
- Consider leaving garbage disposal until the new project is implemented when the whole garbage disposal system should be explored – community to end site
- Discuss garbage disposal with other stakeholders for example UNDP
- Discuss desludging with government and other stakeholders in order to see the system as a whole process and not just a problem for the two slum areas If the use of public latrines is to be maintained and sustained, the desludging system needs to be considered in totality. This may not only require looking at improving the water system (by for example installing hand pumps to raise water to overhead tanks) to flush the toilets but also linking it to the desludging truck and where the sludge is finally deposited.
- Explore possibilities for fee-paying composting family latrines in the slum areas run by women's groups
- The team needs to be realistic as to what is both feasible and appropriate for latrine designs in semi-rural communities
- Lobby government to take responsibility for facilities in slum areas – latrine maintenance and water systems but based on a through analysis and advocacy plan
- Explore alternatives for safe household water for example water filters

- GENERAL
- Involve logistics and finance in public health programming – as suggested by the staff

[3] The Darfur capacity-building initiative could be a model

    - Link the urban programme to the wider Liberia programme so that training and planning workshops can be factored in to the programme and not seen as a hindrance to implementation
    - Country Programme Advisers should try to coordinate visits and advise to teams in order not to overburden staff and managers
    - Some of the public health indicators need to be adjusted to reflect the reality of the programme
    - It is strongly recommended that Oxfam continue both the rural returnee and the urban slum programmes in order to discourage rural-urban shift and to support returnees in livelihoods
- Although it is appreciated that Oxfam has already started discussions in Garzah and other similar communities, the intervention should be as low key as possible in order to concentrate on finishing the work in the two slum areas
- In the new programme, factor in the possibility for a cholera outbreak (include under Assumptions on the LogFrame). As a lead watsan agency and given the low capacity of the government at present, Oxfam would have a moral obligation to respond
- As the team suggested, if livelihoods are linked to public health then there is a greater chance that community motivators as part of women's groups or other CBOs will continue working. We need to be careful that these people are not seen as paid health promoters but as volunteers who happen to also be part of an income-generating activity
- Livelihoods interventions in future programmes in slum areas should have a public health aspect to address the environmental health issues. This not just be limited to hygiene promotion as messages without the resources will not lead to behaviour change[4]
- The new programme should be limited to high-density cholera-prone areas where we are most likely to have better measurable outcomes
- Explore possibilities for separating excreta and general refuse for uses such as recycling or biogas – the livelihoods adviser should explore ways to use the end product from composting latrines to generate income

[4] This assumption is based on several behaviour change models and extensive literature

## 1.0 Introduction

Liberia has experienced serious political-economic disruptions and intermittent civil war from 1989 to August 2003. The 14-year civil war in Liberia ended in 2003 with the signing of a Comprehensive Peace Agreement. 15,000 UN peacekeepers were deployed to oversee the implementation of the peace agreement, whilst the National Transitional Government of Liberia (NTGL) was appointed to lead the country in the transitional phase towards elections – held in October 2005**.** Although much progress has been made in stabilising Liberia, RR process has been shaky, economic growth is slow and security situation remains volatile.

In addition to the above, successive conflicts have destroyed much of the infrastructure of the country, especially in and around the capital. As a result, water, sanitation and health infrastructure is very poor. Moreover, communities have seen scarce resources depleted as a result of hosting IDPs. With approximately 1 million people currently residing in and around Monrovia,[5] with the majority densely packed in urban slums, the risk of an outbreak of water and sanitation related diseases remain high[6]. Coupled with weak social and community cohesion and leaders at all levels (community and national) working with impunity, the challenges facing Oxfam GB are high.

Oxfam GB is currently implementing an integrated public health programme in Monrovia funded by ECHO and targeting cholera 'hot spot' communities in:

4. Urban slums – West Point & Clara Town
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6. Host communities nearing the IDP camps

### 1.1 Terms of reference

The field visit is two-fold: (1) to review the objectives of the intervention and the results achieved against the objectives (2) facilitate discussions and lead on training with the team on community indicators. Both objectives should recommend short-term (for the duration of the programme) and medium-term (for next ECHO proposal) actions - with a particular focus on improving community participation and management.

Objectives of field visit:

1. To assess the design of the intervention, it's rationale and objectives and the extent of achieving the aims and objectives.
2. To examine existing methods and tools for monitoring improved hygiene behaviour and practices
3. Facilitate training on community indicators and strategies to improve participation and accountability (building on work previously carried out)
4. Together with the team develop community focused tools for public health activities
5. Analyse organisational constraints and challenges to institutionalising participatory monitoring systems in complex emergencies and recommend

5 Monrovia was initially designed to accommodate up to 30,000 people. Note that younger populations (particularly ex-combatants) are expressing their desire to continue to reside in urban Monrovia.

6 Certain areas in urban Monrovia already have a history of recurrent outbreaks of acute watery diarrhoea. A serious cholera outbreak occurred in 1996, 2003 and to a lesser extent in June 2005.

recommendations to support institutionalising participatory monitoring systems

## 2.0 Methodology

It was decided that the whole process would be participatory in order for the urban team to critically look at their own work and to input into recommendations. The advisers acted as facilitators. The involvement of the community was limited to several focus groups and discussions with key people in the community; however, this contact was enough to get some idea of how the beneficiaries view Oxfam and what they would like for the future.

Other sources of information were:
Project documents – baseline survey report, Capacity building HSP reports, project proposal, sitreps, evaluation report from 2004
Field visits to Clara Town, WestPoint, and Garzah community
Discussions with
Public Health and Watsan Coordinators
UNICEF head of health programme
Oxfam gender adviser and programme officer
WHO representative

## 3.0 Results from the participatory workshop

The reviewers spent four half days with the team looking at their own programme and discussing various aspects through a facilitated process of self-analysis.

### 3.1 Proud, Sorry and Fears

Everyone was given three cards and was asked to write three things they were proud of, three things that they were sorry about and three fears about the future.

| Proud of | Sorry for | Things I fear |
|---|---|---|
| Involvement of the community in designing the programme facilities | At the end of the project Oxfam will pull out of the community<br>- There may be new outbreaks of cholera | Problems that may cause the project to stall |
| Suitability of the design to the community | Not meeting the beneficiaries on time due to a traffic jam in Paynesville | Not working as a team and taking initiative |
| We were able to assist in some form of conflict reduction among community leaders | Not being able to address all concerns of the beneficiaries X 2<br>There is a serious shortage of water in the community | Not lowering our standards in order to finish the project on time |
| Quick response to severe diarrhoea outbreak in Clara Town<br>(Also in West Point)<br>(Establishment of ORT centres)<br>(Reduction of public health risks in urban communities) | Not enough time in the field<br>May not finish on time<br>Short programme duration | Community managed water systems not working |
| Our entry into the community during these difficult times in our country<br>(Our mobilisation and involvement of the community) | Motivators are not working too well these days. I'm pressing and continue motivation but am not too satisfied with their work.<br>That the project was not started | I am afraid the project is coming to an end and we may not be able to meet our timeline X 5<br>Completing the programme on time considering the previous |

| | | |
|---|---|---|
| (Discussions, mapping identifying problems and finding solutions using PRA) | with some little micro credit project to help motivate our community motivation<br>Incentives to community mobilisers | number of breaks and holidays X 2<br>The time set by the donors for the end of the project (also donors agreeing on a time)<br>If same donors will continue to sponsor the programme (if not completed on time) |
| The motivators were able to spread the message on chlorination – most people in two of our zones know about chlorination | More integration and coordination needed within the teams<br>Better analysis linked to using the information | Sometimes support from community members and leaders |
| The level of training to carry out the work<br>(Training received)<br>(The role of our work)<br>(Planning of our work) | Delays in commencing technical works due to HP activities which could have been completed earlier | When Oxfam leaves how will the community respond to PH issues in general? |
| The information for awareness given to beneficiaries<br>The project gives the community opportunity to fully participate | Unable to achieve gender equity in paid labour | Manager leaving before the end of three years X 2 |
| The way Oxfam works<br>(Proud of being part of the project)<br>Oxfam's ways of working – encouraging gender equality<br>Targeting of vulnerable groups | Community not cohesive<br>There are always problems of violence in West point<br>More time with the community to plan together<br>Full participation in the project from start to finish | Fear that cholera will break out if water tanks are not working<br>That by the end of the programme the people's way of life may not change |
| Support from team members<br>(Team effort to support and understand each other)<br>Coordination and collective teamwork by the PHPs | Not meeting Sphere standards | That violence in the community will affect the work<br>The community not being fully involved |
| Flexible programme and donor support | Slow way in which logistic support programme implementation | That people will understand my way of working |
| Established good relationship within all programme areas | My approach sometime<br>Continuing with one thing over and over with the community who don't seem to understand me | Need more time and support from donors |
| Programme manager support to the programme, planning and activities | Assessments slow and lengthy | That the livelihood programme will take a long time to be brought on board in the public health programme since we are using this programme as an entry point |

*Points for further discussion*

- Community motivators in Paynesville motivators were trained in December, which meant that there were only two months left to supervise them in the field. Some of the team felt that the motivators would continue working even after Oxfam left other felt that a new programme was planned for Paynesville including the motivators– therefore this was actually only a preparation phase.

- General concerns about motivators and the sustainability of behaviour change
- Urban slum communities are not cohesive and are only interested in making money in order to survive. The team did feel though that the reference groups were the first step towards getting communities to have a common voice.
- Team are worried about completing the work on time

### 3.2 Community visits

#### *3.2.1 Clara Town – women's group*

The discussion was held with about six women outside someone's house. The facilitation was quite directive at times giving the women little time to reflect. The discussion was on sanitation problems in the community. The women explained how they had to pay for latrine visits[7], how they sometimes had to resort to using plastic bags, which were then thrown in the river (this is especially a problem at night due to safety issues[8]). The facilitator talked about using potties and then suggested that the women hold a meeting to discuss these issues. There was some reluctance and one wonders if the meeting was agreed to satisfy the facilitator rather than because it was felt to be helpful.

#### *3.2.2 Clara Town – men's group*

The group was well facilitated although the original time had been set to 15 minutes, which is unrealistic if everyone is to be given a chance to speak. The commissioner, the chairman for UDA, the chairman for the motivators and the chairman for the water management team were all present. The discussion was again on latrines. There were several participants who felt that Oxfam had been slow in starting the work on the water point rehabilitation. Edwin pointed out that the MOU had taken three months to sign.

When the commissioner was asked if he was satisfied that the response was appropriate, his unhelpful reply was: "anything is better than nothing." The other members of the group did express satisfaction with Oxfam especially the response during the cholera outbreak.

A transect walk was carried out. At the existing water mining points the outlet was full of dirty water and the water pipes for filling the jerricans were lying on an open concrete apron. Adjacent to two water points was one point that was being upgraded with an elevated tank to replace the two old points. The review team was informed that upgrading of 12 points out of 30 points was underway and two points are complete. During a transect walk, leaks were observed on the main water distribution line close to a sewage collection system, which according to community members interviewed often overflows

According to the UDA chairman, overflows of the sewage system happened frequently as all the public toilets are interconnected although disconnected from the main sewer line. Due to increased population the sewage collection points dislodging was required every two weeks at about $Liberian 1,500 per trip. Five Liberian dollars

[7] $5 for two visits
[8] Distance to public latrines and poor lighting

are collected for two visits to the toilet and according to the chairman of UDA whereas the money collected is not enough to sustain the running of the toilets, the main challenge was perceived to be availability of a desludging truck as Monrovia has only one truck, for which there is high demand.

Environmental cleanness is one of the activities promoted in the slum area but there were concerns among the community and from the technical team leader about the whole process from collection to disposal. Cleaning of drains also paused a big challenge as some houses were built over drains and drains also act as toilets and garbage disposal points.

### *3.2.3 West Point – women's group*

The group met in the local school and went over two school periods, which resulted in noise from the bell as well as the children changing classrooms. It was often difficult to hear. The group was well facilitated with the women being able to discuss – at times the facilitator did not pick up on a subject, which could have been interesting to explore.

There was a discussion around latrines and water as well as protection issues. One woman felt that the protection work by Oxfam had helped: she left a leaflet out for her boyfriend and after he read it he had become less violent. There were still many issues around gender-based violence.

When asked if the community motivators would continue working, one said she would probably do it for a couple of months after Oxfam left and then stop. Another felt she would continue but both felt that some sort of income was necessary. This was not in the form of payment but in a loan or an income-generating activity.

After the discussion, the team did two monitoring visits using the forms. They have a system of going to the centre of their zone and spinning a pencil. In both houses, the women did not understand the abbreviation SSS but when it was explained, they were able to describe how to make it. When I asked one woman where she had heard about it, she said she had overheard someone talking about it, tried it out and was now telling others.

There was also a woman sitting on the floor behind us – she was very thin and weak. The team needs to be more observant when doing monitoring visits as they can learn a great deal about vulnerable households with potential PLWHAs. There seems to be a tendency just to fill in the form and not observe.

One of the motivators interviewed was adamant that she would continue working even if Oxfam withdrew. However, she was unemployed and it is debateable whether she would be able to continue working the daily two hours as a volunteer unless she has some sort of income. When challenged she agreed that a source of income was a necessity.
*It would be a good idea if the team asked where people had heard about both chlorination and SSS – it could be noted on the form and would give an idea about the effectiveness of the community motivators.*

### *3.2.4 Discussion with key people in WestPoint*

The commissioner was (as one could expect) full of praise for Oxfam especially during the cholera outbreak. However, one interesting aspect of the discussion was that of garbage collection. The commissioner has two people employed to collect garbage and wanted support to do more. The problem is though that she felt the end point was the disposal of garbage either into the sea or into the river; she was really surprised when we pointed out that this only exacerbated the problem and could lead to the spread of cholera. There does seem to be a lack of understanding that the garbage problem cannot be solved within one community but needs to be considered as a national whole.

The chairperson of the reference group was also pleased with Oxfam's response during the cholera outbreak. She also felt that the group had seen how to respond to a cholera outbreak and that the group would be able to organise ORT sites themselves without outside help; this, of course, remains to be tested.

### *3.2.5 Sanitation in the community*

One of the chairperson's concerns was the lack of toilets in the town. Asked whether the community could consider alternatives to latrines that blocked frequently and require desludging, she responded that the community would need technical guidance to look at different options.

*It will possibly help for the technicians to discuss the different possible options with the communities to determine the most appropriate and sustainable solution to excreta disposal.*

The Supervisor of one of the public toilets that are operated by the national Housing Association took the review team around one of the public latrines. Five Liberian dollars were charged per visit and the money collected was used to pay staff working at the public latrine and 4-5 trips for desludging. The public latrine was connected to a sizeable septic tank but this and the inspection manholes were full and blocked. The supervisor explained that one of the causes was usage of too little water to flush the toilets as the overhead tanks for flushing are no longer working but also inability to collect enough money to desludge the entire septic tank, which would otherwise take eight months to fill if fully emptied. The supervisor had no idea about where the excreta from septic tank was dumped and whether it would be of any commercial value. Again these public latrines are also dependent on the one desludging truck in Monrovia.

A quick walk through the accommodation revealed that the houses were crowded but some of them still had some space in their backyard.

*If the use of public latrines is to be maintained and sustained, the desludging system needs to be considered in totality. This may not only require looking at improving the water system (by for example installing hand pumps to raise water to overhead tanks) to flush the toilets but also linking it to the desludging truck and where the sludge is finally deposited.*

*Consider use of alternative toilet designs like compost latrines where possible and where space can be found to minimise need for desludging and investigate possibilities of using human excreta from septic and latrines for generating income.*

### *3.2.6 Visit to Garzah near Soul Clinic*

This community is a semi-rural community near the Soul Clinic camp. The population is settled and were not displaced. It does not appear that there will be any significant number of returnees to the area.

The meeting was held in the school shelter with the schoolteacher, the village leader, the women's group leader and members of the community. The meeting was supposed to be a follow-up to the previous one where people had discussed the types of latrines they required. The meeting was very directive with the Oxfam facilitator setting the agenda. Although the design of latrines was being discussed, no technician was present. The community was asked to decide on when they would begin but before they did so, the facilitator split them into two groups (men and women) to discuss what had been achieved. In the women's group, only some of the group were asked to be in the group. By this time the technician had arrived and joined the men's group. Then the group reconvened and were asked to come up with a common solution – despite the fact that they had been talking in separate groups!

My observation was that the facilitator was nervous and possibly thrown by the evaluator visit. However, if this is the PHAST approach, the community must be given time to discuss issues among themselves without a facilitator. I appreciate that there is a pressure on the staff to complete activities before the end of the project but rushing the community will have a deleterious effect on the sustainability of the facilities.

It was encouraging to observe that the men's group was well facilitated with a discussion on practical issues and with an effort on the part of the facilitator to include all the men. The technician clearly understands participatory methods, which is also encouraging.

The motivators had been trained a couple of weeks before the visit. They were proud to point out that cleaning was going on around the houses and that drying racks had been built. However, one of the motivators did say "we are expecting visitors anytime" which begs the question – whose agenda?

*Focus groups should not be confused with village meetings – one or other should be used at one time. People should not be turned away from a focus group unless there is a large crowd. It would have been better to use pictures of the different latrine designs and to get a technician to talk through the advantages and disadvantages of each design.*

### *3.2.7 Visit to Soul Clinic camp*

Quick discussions were held with the camp manager who said that IDPs were registering to return to the original villages but many preferred to stay within the surrounding communities. Facilities planned for rehabilitation will still be useful not

only to host communities around the camp but also the IDPs settling among the villages. One damaged hand pump was visited and the technical team leader said that repairs for hand pumps and latrine construction to replace full ones was going on.

*It will be good to review the maintenance system as management of the watsan facilities in the camps changes from IDPs only to host community and IDPs. A more community based maintenance system may be relevant here.*

### 3.3 Communication within the teams

Teams were asked to rate communication on a scale of 1-5 (1 being bad and 5 being good) both in their geographical teams and in the whole programme team. The ratings were as follows:
Own team 1 – 1, 2 – 1, 3 – 3, 4 – 7, 5 – 3
Whole team 1 – 1, 2 – 5, 3- 7, 4- 3, 5- 0
According to the team the communication has improved over the last few months although there is still a way to go before the whole team is able to share information and work on common issues.

After one of the field visits, a fish bowl exercise was carried out where two of the promoters fed back to the whole group the results of their focus group and what information they had received. They were asked to describe what they would do with the information and how they would use it to make changes in their approach.

*A similar fish bowl exercise should be carried out once in a while so that the whole team is able to benefit. It is also a good method of actually using information from focus groups as part of the monitoring system.*

### 3.4 SWOT analysis

| STRENGTHS | WEAKNESSES |
|---|---|
| 1. Quick response to the cholera outbreak, which resulted in 90% decrease in cholera cases. This was attributed to:<br>• Good forward planning<br>• Trained staffs<br>• Available resources like materials, funds and logistics<br>• Community willingness and participation.<br>2. Training of staffs in various areas was acquired like in monitoring, surveys, water testing, protection, communication<br>3. Having the capacity to deal with added and unplanned activity like completion of 27 latrines from the previous ECHO project, which had not been completed.<br>4. Improvement on planning, implementation and reporting. Especially involving different stakeholders in the programme cycle.<br>5. Improved good team spirit and good working relationship<br>6. Monitoring of indicators<br>7. Integrated approach and ideas through | The following weaknesses were identified but suggestions to reverse such weaknesses were also given and follow every weakness.<br>I. Weak sharing of information among Public Health Team members.<br>Suggestions to reverse this include:<br>• Presentations of programme progress and sharing of work plans by each team in PHT in regular meetings.<br>• Displaying of weekly plans on notice board or walls for all members to view<br>• Exchange visits amongst different geographical programme areas and different programmes within the Liberia programme.<br>II. Lack of contingency plans, inadequate support, untimely and poor planning and teamwork amongst different departments like logistics, finance, gender<br>• Integrate Public health Plans with the Overall Liberia programme |

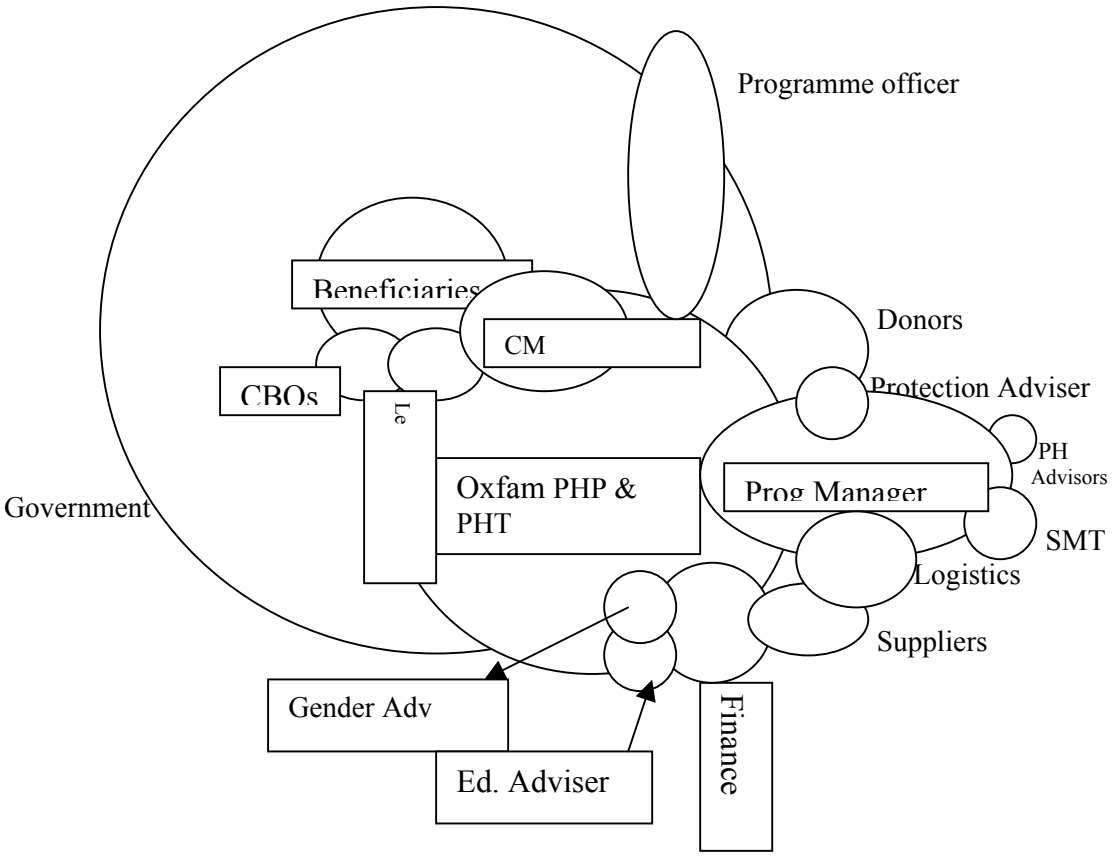
| | |
|---|---|
| meetings between the Programme Manager and teams.<br>8. Training of beneficiaries, community motivators, water and sanitation committees (WASCOM) and CWTs<br>9. Strengthening communication structures<br>10. Moving delivery of programme to 40% despite difficulties encountered. | • Improve co-ordination, share plans, involve and plan across the different support departments<br>• Improve information sharing<br>III. Poor time management by the team and managers especially when meeting with communities leading to delays in programme delivery.<br>• Share plans on timely basis<br>• Stick to and respect agreed plans<br>• Involve logistics in planning<br>Community Motivators (CM) not functioning as expected<br>Suggestions:<br>• CMs could be given incentives in kind<br>• Explore possibilities linkage of CMs to a livelihood programme<br>• Provide recognition incentives like certificates<br>IV. Untimely, delayed delivery of materials and over-reliance on one suppler by the logistics team<br>• Integrated and forward planning with logistics<br>V. Delay in programme implementation.<br>• Early recruitment of staff and review of staff requirements to complete existing programme<br>• Improved planning<br>VI. Uncoordinated sharing of resources like vehicles, resulting in loss of programme delivery time.<br>• Sharing agreed plans<br>VII. Delayed payment of semi and unskilled labourers that have resulted into threats to staff and at times stoppage of work and therefore loss in programme delivery time.<br>• Team members could be responsible for payments of labourers<br>• TTL should facilitate and assist in payment of labourers<br>Not enough skills in using facilities like computers leading to longer time for report writing |

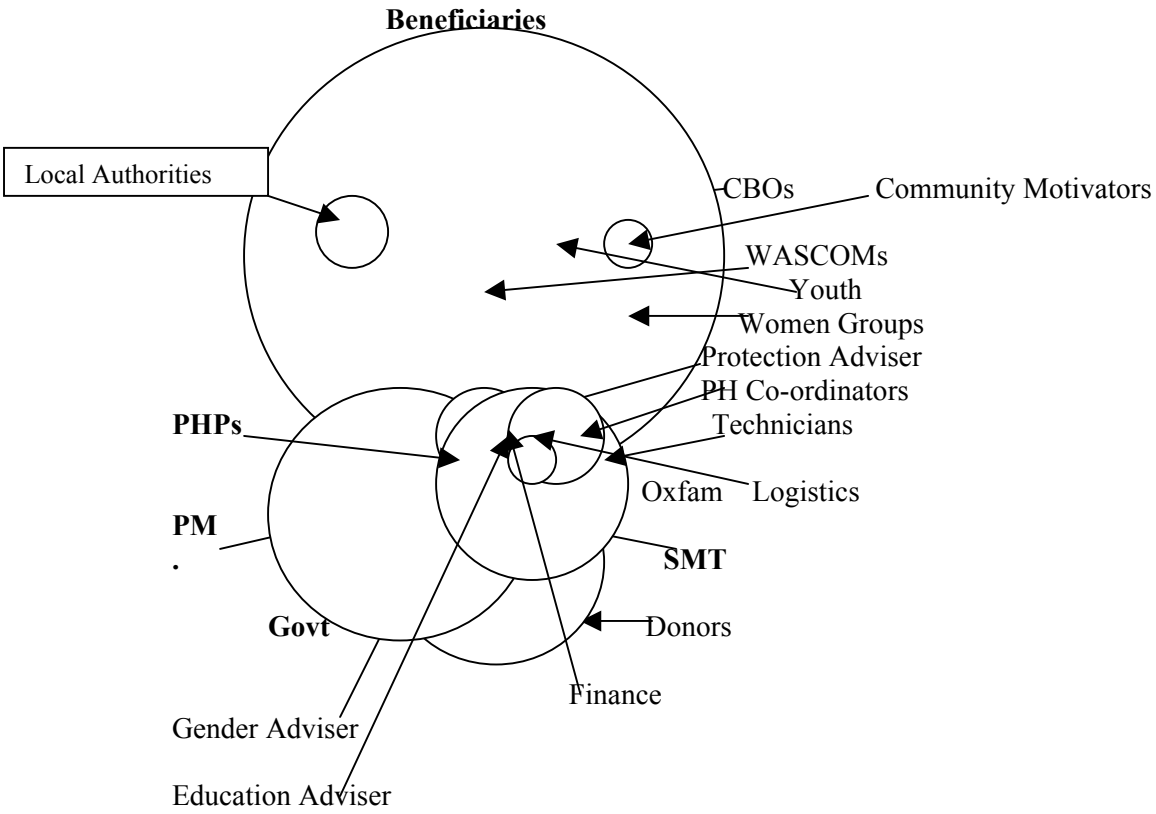
| OPPORTUNITIES | THREATS |
|---|---|
| o Existence of CBOs in communities will contribute to sustainability<br>o Improved services and support to staff like life insurance and medical cover and therefore less worries<br>o Training of Community Motivators (CMS) and Water and Sanitation committees (WASCOMS) in the communities will serve as a backing force for the work of PHPs and PHTs.<br>o Good rapport with donors will provide good ground for future support/funding.<br>o Good interpersonal relationship amongst | 1. Election Violence -there was fear of possible violence before and after elections and run-off elections and insecurity was and is still a threat to programme delivery through demonstration within the city and camps<br>2. Long duration of rain that led to flooding and limiting number of hours and actual physical construction during the rain season.<br>3. Unexpected and abrupt changes in programme plans as a result of other indirect activities<br>4. Unavailability or unwillingness of community members to attend meetings and |

| | |
|---|---|
| staffs especially PHPs, PHTs, TTL, and manager will help in achieving programme objectives<br>o Good co-operation with local structures in communities will help in the successful completion of projects.<br>o Easy entry into communities paves the way for the rest of programme implementation.<br>o Opportunity to work in same communities has helped to build trust, respect and co-operation with communities.<br>Training and skills gained by staff have been helpful in entry in communities and could be used to work in any other new community | finding it difficult to have community structures working in urban programme areas.<br>5. Delay in procurement and supply of materials in the field<br>6. Procedure for paying casual labourers, which leads to delayed payments that may create insecurity with the casual workers and loss of trust which may also lead to unavailability of labour<br>7. Unavailability of PHAST tool kits at the beginning of the programme<br>8. Delay in community members providing their contributions to the programme and therefore leading to delay in the overall programme delivery<br>Limited time remaining in comparison to the large volume of work. (This can be mitigated by improved support from logistics and finance and increased support from Team Leaders and Management) |

### 3.5 Venn Diagrams

**The Peri-Urban Public Health team Perspective of the relationship of the different stakeholders in the programme**






**Perspective of the relationship of the different stakeholders by the Technician in Oxfam's peri-urban programme**

**Key issues from the Venn diagram**

- There is an improvement in integration from last years' evaluation of the programme
- PH Co-ordinators are seen as isolated from programme activities and therefore not providing the required support.
- SMT is seen as removed from programme implementation and beneficiaries, which raised issues of support

.

## 4.0 Discussion

### 4.1 The programme –input to output/outcome

#### *4.1.1 Outcomes*

Impact is usually used in a LogFrame at Principal or overall Objective level which is a longer-term goal to which Oxfam as only one small component contributes[9]. It is therefore not possible through a midterm review to say whether this objective has been achieved.

At the specific objective level, one is able to measures outcomes – what can be directly attributed to the programme. In the ECHO proposal this objective for public health was:

[9] In the case of the ECHO proposal "to alleviate the impact of war on the civilian population in Liberia through provision of humanitarian assistance."

*Targeted communities in two districts and two IDP camps in urban Monrovia have access and availability of water and sanitation facilities and are able to take action to protect themselves against protection and public health risks.*

The indicator is no major outbreaks of disease in target areas during the project period.
One could argue that this objective has been partially achieved. The IDP camps have access to both water and sanitation. The problem lies more within the slum areas and the newly identified areas around Paynesville. There was a major outbreak of disease (cholera) to which Oxfam responded – a frequent occurrence related to weather patterns. The actual outcome of the water, sanitation and hygiene promotion will only be visible next year when the cholera season comes around again. Will there be any reduction in the number of cases or in the spread? It is too early to tell.

### *4.1.2 Results (Outputs)*

There are three results that pertain to public health.
Result I: Men, women, boys and girls have access to safe drinking water of sufficient quantity and quality
Indicators under this result are:

- 100 safe drinking water facilities are constructed or rehabilitated using appropriate technologies
- 95% of water facilities constructed are still in working order by end of project
- 25% increase of targeted beneficiaries using protected water sources for drinking water
- Female and child beneficiaries can access clean drinking water in safety
- 0 faecal coliforms per 100ml achieved at all water points
- 30% increase of knowledge and means to practise household chlorination by community members

Indicator no3 is not easy to measure even if the baseline survey indicates that 47% get their water from a perceived source, as it is not known where all the safe water points are. Keep no 5 instead.

Upgrading of 12 out of 30 water drawing points had just began in Clara town and 3 out of the 4 tanks were being constructed in West point. The review could not therefore talk of impact but discussions with Liberia Water and Sewerage Corporation (LWSC) revealed that the company maintained residual chlorine in the distribution network and most important, the chlorination was being done in jerricans by the water sellers. Water from the water points was perceived by the communities to be safe but the review could not estimate the proportion of the community that used safe water points.

*This is an area that requires to be monitored to establish the impact of the programme, as more water points become operational.*

Existing water points are flooded whenever it rains and inspection of two water points that the current water filling points (pits) can easily lead to contamination as they were observed to be filled with dirty standing water. Further, leaks were also observed on water distribution lines. By proxy, upgrading of these water points and provision

of water tanks above the ground will not only reduce contamination but also increase availability of safe water even when water pressure in pipes reduces.

Considering the situation in programme area, this is an appropriate approach to meeting result one though it will not be until the next rainy season that impact may be measured.

The main concern drawn from discussions from the women group was a possible conflict between the management of water points in west point and the water sellers as the four planned water tanks and water points were considered to be few.

*Renewed efforts to mobilise communities, water management and LWSC to complete upgrading of water points will be needed in the immediate future and priority should be given to monitoring their effective use after the completion of the upgrading.*

Result 2: men, women, boys and girls have appropriate and safe access to sanitary facilities
Indicators under this result are;

- 95% of facilities constructed are still in working order by the end of the project
- 30% increase in men, women and children safely disposing faeces
- All communal latrines have hand-washing facilities that are in use by end of project
- 25% increase in hand washing at key times
- Female and child beneficiaries can access latrines in safety
- 65% of targeted community areas identify and use a central dumpsite for garbage disposal

Indicator one is not practical, as the sanitation facilities will be completed towards the end of the programme.
Under indicator 2, desludging latrines in the peri-urban areas may not lead to an increase in their usage and likewise as many latrines in IDP camps have filled up and capped, new latrines being constructed are mostly a replacement and may not necessary lead to an increase in men, women and children using them. May be improve access to safe sanitation facilities to xxx population or Make xxx latrines accessible for use to xxx communities for so many months (this indicator may accept the fact that if the current system is not sustainable unless the entire desludging process and new options are addressed in totality) Vivien-your monitoring expertise will be needed here.

Indicator 4 may not be feasible if handwashing facilities are not provided, as you can't wash hands without being facilitated to do so. If the programme is not providing handwashing facilities then consider reviewing indicators 3 and 4.

One fundamental issue about safe access to latrines at night is their location and lighting. Whereas location is well addressed in the camp and rural host communities, it may not easily be addressed in the peri-urban areas unless alternatives like potties for children and new facilities are constructed. I suggest that you add 'during the day' at the end of indicator five.

Indicator six is achievable and measurable but for the activity to add value to the overall objective, the dumpsite needs to be linked to the entire disposal system. I suggest the following indicators:

No garbage left or seen or remains in the immediate environment of the programme area for longer than xxx days (weeks).

Xxx cubic metres of garbage (or truck loads) cleared and transported from the programme area. (This indicator will help in accounting for the work done though it will not be good for impact)

Result 3: Men, women, boys and girls take part in decision-making and action against their public health and protection risks
The indicators under this result

- At least 1 equitable community volunteer group established and functional in 70% of the communities
- Community-based trainings for community volunteers and pump technicians on health promotion and maintenance of facilities held at least once a month
- At least 50% of men and women in focus group discussions express satisfaction[10] at the level of consultation in (a) siting of facilities (b) design and technology choice (c) management of cost sharing and cost recovery for operation and maintenance (d) monitoring
- Routine and preventative maintenance undertaken on 95% of the water and sanitation facilities
- 30% increase of knowledge and means to prepare ORS (oral rehydration solution) and SSS (Salt, Sugar Solution) by community members
- Appropriate information media and communication messages developed

There are six indicators, two of which are actually activities (four and six). In indicator three the number is expressed as a %, which is not a method compatible with qualitative data.

*The indicator should rather read as "at least two thirds" or "over half" – using a proportion rather than a percentage. It should also state how many focus groups.*

Indicator five is measurable, as the team has established a baseline for at least some of the areas. However, this indicator may have to be adjusted as it is set to measure two different treatments: ORS and SSS. The baseline in July showed that 85.5% knew what ORS is, 76.3% knew how to prepare it. It would be difficult to increase these levels by 30%. On the other hand, knowledge of SSS was very low (under 7%). Usage of ORS/SSS was found to be low – 36.2%[11].

The team has wisely decided to concentrate solely on SSS as households indicated that ORS was unaffordable. *Therefore the indicator should be adjusted to reflect this change: the number of people who know how to prepare SSS.* It would have

[10] Satisfaction will need to be defined in terms of safety, privacy, dignity, accessibility, suitability, adequacy and other community-defined indicators, and seek the viewpoint of all vulnerable groups
[11] Kerry Zaleski. Report on LQAS for baseline survey: training, data collection and analysis ECHO III programme 2005

been better to measure how many people had used it but unfortunately the baseline questionnaire does not differentiate between ORS and SSS. This should be adjusted for future baseline surveys. Unfortunately due to the tardiness of the hardware component, it has not been possible to check on indicator three.

### 4.2 The cholera response

An outbreak of cholera happened when the programme had just started and all effort was diverted to a cholera outbreak[12] at a request from ECHO and MSF. Staff felt that the response went well and the outbreak was arrested earlier than previous years (confirmed by WHO). This was also collaborated in community meetings, focus group discussions held with sections of beneficiaries in Clara town and West point during the review. The UNICEF head of health felt that Oxfam had "correctly addressed" the problem by concentrating on hygiene promotion at household level and not by trying to chlorinate the water system. The WHO communicable diseases officer felt that household chlorination and the ORT corners had been effective and appropriate. He also expressed concern for the next year if NGOs did not respond, as the Ministry does not have the capacity.

It is difficult to attribute the perceived decease in cases to Oxfam's response only. However, five out of six and seven out of 11 women interviewed in a FGD in Clara Town and WestPoint areas respectively knew main the transmission routes for cholera, household chlorination dosage and what to do in case of diarrhoea.

The safe water campaign as part of the cholera response helped to raise awareness within the beneficiary communities at a time when it mattered most and whereas the response was perceived by staff to have delayed the core programme, awareness seems to have been raised about SSS and rendering water safe to drink. It would have been unethical for Oxfam not to respond as a lead water and sanitation agency working in the area.

### 4.3 Participatory methodology

A discussion was held on what participation is: some of the terms used were involvement, working together, interaction, sharing information and ideas and community action. No one mentioned sustainability and empowerment. We then talked about whether we were doing participation, manipulation, consultation or coercion. Initially most people thought the Oxfam approach was all about participation but after some discussion, it was agreed that sometimes it was also only consultation with some manipulation due to time constraints in the programme. There is nothing wrong with this as true participation is hard to achieve in a short humanitarian programme but the important thing is that the team recognises this and factors it in to their work.

The PHAST approach has recently been introduced to the team who have not received any formal training. They have been given the manual by the programme manager and have been learning by doing. The public health coordinator is also not familiar with the approach. Some, but not all of the team members have participated in training on PRA tools carried out by the Gender HSP.

[12] Declared an outbreak by Ministry of Health and WHO.

*The PHAST methodology for the current programme in semi-rural areas should be modified (as agreed with the team). This can be done by shortening the time between community meetings without diluting the participation aspect. An example of this would be in Garzah where a village meeting on latrine design with the technicians could be held followed by a pocket voting system. This discussion should be a meeting rather than a focus group as all the community members should participate. Separate meetings with children could be facilitated if the community is agreeable to having a separate child-friendly latrine. The old, chronically ill and disabled should also be considered.*

*The PHAST method for the urban slums is more problematic – there is no cohesive community and people do not have the time for lengthy meetings. Although some of the participatory methods can be used, I would be careful about calling it PHAST. It is also difficult when people are not able to make many choices regarding types of latrines or where water points can be sited. The team needs to be more realistic when talking about participation of the community. The reference group is a good start but should be representative of all community groups – roles and responsibilities should be discussed.*

### 4.4 The Community Motivators

The team has trained a great many community motivators – 343 in WestPoint and Clara Town plus the ones currently being trained in semi-rural communities. This is apparently according to Sphere standards although the water and sanitation will not follow the same standards.

Dropout among volunteers is generally considered to be high. Studies from volunteer programmes in other countries have shown that supervision and training have a positive impact on retention rates but that few volunteers continue after this support is withdrawn. The team was very divided in their opinion about motivation and dropouts. One person felt that out of 80 motivators, 20 were still working. Others felt it to be higher. All agreed that it is difficult to meet all the motivators and to really supervise them in their work. The monitoring forms will show if the messages about household chlorination and SSS have been effective but they do not show how this has happened. According to the Social Diffusion Theory, knowledge sharing can also be through friends and relatives as well as the motivators.

The use of so many motivators is the camp approach and may not be suitable for an urban slum programme; it is certainly not sustainable in its current form. Although the decision to only deliver two messages (SSS and household chlorination) was a good one, there is still no evidence that all 343 motivators are still working.

In the semi-rural communities, community motivators will work for approximately two months before being left on their own. It takes a very motivated community to support these people. I am not sure that it is worth putting a great deal of effort into training and follow-up. I would suggest using committees or influential people like the schoolmaster in Garzah to do Child-to-Child activities instead.

*Recommendation: reduce the number of community motivators and link them with reference groups or water management committees – make sure roles and responsibilities, work plans and TOR are understood by all.*
*Consider using other methods such as Child-to-Child with schools, playgroups and children's groups.*
*On the household monitoring forms, identify sources of information.*

### 4.5 Monitoring methodology

#### *4.5.1 Quantitative data*

The current monitoring system of household visits seems to be working well. Originally it was planned that the public health coordinator would collate the results and feedback to the team areas for concern, using a "traffic light system." This does not seem to have worked and the team are now analysing their own data. They lack a database and are doing everything by hand. Having someone who is not involved with the day-to-day fieldwork doing the analysis of monitoring data has proved to be problematic in other Oxfam programmes around the world. It is vital that the people who collect the information also input it, analyse it and see for themselves, which areas need to be addressed. The team appears to be perfectly capable of doing this. I would strongly recommend that this system continues. A simple database could be set up using Excel (something the IT team could facilitate).

*On the actual format, one question should be deleted. People are not boiling their water and results from other countries have often been poor in this area. Especially in urban areas, where charcoal is expensive, there will be a tendency to partially heat the water. The risk of drinking warm water considered to be safe is too great. The concentration should be on household chlorination. There is no point in monitoring something that is not being practiced or not being taught.*

#### *4.5.2 Qualitative data*

The team felt that they did collect qualitative information both in the form of focus groups, observation walks and interviews. However, it is what they do with this information and how they both record and use it that is important. Opportunities for combining qualitative and quantitative data should not be missed as in the case of the WestPoint monitoring visit where the forms were used but little discussion was had with the family.

*The team should be encouraged to do more observation and sharing of qualitative data, not just as an upward reporting.*

#### *4.5.3 Participatory monitoring and community indicators*

The team was briefly introduced to community indicators as a follow-up to the training they received from the capacity building HSP. Examples were given from other programmes and the method for how to decide on community indicators was also described.

At the moment the Oxfam PHPs do the monitoring at household level and there the motivators are not really involved. Participatory monitoring and the use of community indicators is easier to set up in a cohesive community such as the semi-rural areas. Especially if Oxfam will only work in the community for a couple of months until the

latrines and the water points are completed, there needs to be some system that the community can manage by themselves and that they feel is appropriate. Community indicators can be discussed but the bottom line here is that the community will take responsibility and it is their decision whether they monitor latrine usage and motivator activity or not.

In the urban areas, the motivators could be involved with monitoring but it would be important to check on dropout rates first. The reference groups are the nearest Oxfam will get to having a cohesive community voice: these people should be involved in monitoring of water points and latrines as well as being more responsible for the motivator activities. If the programme continues to work with public health in these slum areas, an agreed method of monitoring should be agreed upon between the reference group and Oxfam so that information can be fed back to Oxfam in progress against the indicators. The household monitoring by the PHPs can continue but should be complimented by reference group information.

Not all the team have focus group facilitation skills nor are they all able to differentiate between a meeting and a focus group. Some of the team are very directive and have poor listening skills. This is an art that needs to develop over time. *There has been so much investment in training: what is required now is mentoring and on-the-job training. The team also needs to try out more PRA methods so that they become part of an every day toolkit.*

### 4.6 Technical support

At the moment there is a public health coordinator who has been in post since May. The previous public health adviser was supposed to capacity build this person but according to the coordinator little mentoring was done as the adviser's time was taken up with training both in and out of country.

The TOR for this post are very extensive and require a range of skills and proven experience. The TOR match those of international HSPs who have many years of Oxfam experience and who have responded to fast-onset emergencies. This makes it a difficult post to fill given that the urban programme is moving away from the typical Oxfam camp programming to public health in the more difficult urban slum setting that requires careful planning and an innovative approach. The possibility that there could be outbreaks of violence in the neighbouring countries resulting in an influx of refugees means that this person would also have to be able to respond with a rapid assessment and scale-up.

There is obviously a lack of trust and lack of willingness to engage by both the coordinators and the urban team. The coordinator is extremely critical of the programme and the team are very defensive. The situation seems to have reached an impasse. At this stage it is unhelpful to tease out whose fault it is. The role of the review team is to look at what technical assistance is needed by the urban team and from where this assistance can be sought.

From a public health promotion point of view, the urban team needs assistance in adapting the PHAST methodology, mainstreaming HIV/AIDS according to Oxfam guidelines, ensuring integration (also according to an accepted Oxfam approach), adapting to an urban slum setting with all its limitations for community involvement

and the issue of sustainability. It is the review team's opinion that this support can only be partially supplied by the coordinator and that outside assistance should be sought.

The TOR for the water and sanitation Co-ordinator post is very ambitious and the function of the water and sanitation co-ordinator to support the Urban programme appears to work more on an ad hoc and personal basis than the advisory support that is expected. The co-ordinator was critical of the urban programme, which he was expected to advise. It was not clear whether this was caused by the structure and the way the co-ordinator is expected to input in the programme. In discussion with the urban public health and the Bong team, support is required in drawing standards and designs and linking them to government standards and other actors. In case of any emergency, the co-ordinator would be in a position to carry out assessments and kick-start a response. However, an induction in emergency response and Oxfam's approach to emergencies will be required to enable the co-ordinator to perform this role.

*Capacity building (on the job mentoring) of the coordinators and team leaders by an outside adviser who* ***must*** *be conversant with Oxfam public health, HIV mainstreaming and PHAST. This person should build on existing skills within the team and assist with areas identified by the team*[13]

### 4.7 The way forward

The team was asked to look at how they would plan a new programme in two settings: urban slums and semi-rural communities. The results from the discussion are as follows:

| *Urban slum* | *Semi-rural community* |
|---|---|
| 1. Embed livelihoods component in the public health programme. Some issues to consider here are;<br>• The need to include community motivators without seeming to be paying people to carry out health messages<br>• Community motivator drop-out rate is high due to lack of motivation and incentives<br>• There would be a need to do some vulnerability mapping and set criteria in order to ensure that the right people were targeted<br>• Composting latrines could be way to combine public health and income generation<br>2. Use a modified PHAST approach, taking into account<br>• People are busy trying to make a living<br>• It is difficult to target the poorest of the poor<br>3. Need to include influential people but could also randomly select households | 1. Use a modified PHAST approach taking into account the time constraints and making sure all the team is able to use a variety of tools (Child-to-Child is also an option)<br>2. Develop suitable materials that are culturally appropriate<br>3. Empowering the community through capacity building and assistance to lobby with facilities such as schools<br>4. Livelihoods although it is recognised that it is difficult to choose beneficiaries<br>5. Work with existing structures or help set up new ones<br>6. Work closely with the community to set up indicators – use participatory monitoring<br>7. Set up cost recovery system<br>8. Develop exit strategy<br>9. Develop MOU with communities<br>10. Training of community groups in for example book-keeping<br>11. Build Oxfam staff capacity by using skills within the team as well as on-the-job training<br>12. Mainstream HIV/AIDS by trying to reduce stigma and giving information |

[13] The Darfur capacity-building initiative could be a model

| | |
|---|---|
| through blocks to participate in discussions<br>4. Need to work with and empower community-based organisations<br>5. Need a longer-term programme with a flexible budget in order to respond better to people's needs<br>6. Need to include protection, conflict-resolution, gender and HIV mainstreaming. One example is by lobbying for adapted latrines<br>7. Helping the slum dwellers to engage proper authorities in terms of advocacy | 13. Mainstream gender, conflict reduction and protection<br>14. Develop a contingency plan in case of unforeseen events<br>15. Develop a training manual specific to Liberia<br>16. Carry out needs assessment and baseline for new programme |

### *4.7.1 Staff recommendations for improvements*

1. *Involve logistics and finance while planning public health programme delivery and conduct regular joint programme meetings.*

2. *To overcome untimely deliveries, besides planning together with logistics and finance, all materials for the planned activities should be drawn out of the proposal at the initial programme delivery planning meeting and supplies' requests for bulk purchases immediately written. The technician/hygiene promoters should write clear descriptions for the materials requested and where quality is unknown, samples should be presented to the specialists (technicians and hygiene promoters) to assist in making decisions on quality.*

3. *To improve community participation in programme delivery, to review there will be need to co-ordinate with other actors in any given location to harmonise participatory approaches. Oxfam should also explore alternative ways of motivating volunteers.*

4. *To ensure integrated public health programme delivery, the technicians and health promoters the teams need to share information through conducting and agreeing on joint plans, regular meetings and joint monitoring and reviews. Public Health team plans need to be linked into the overall Liberia programme to minimise disruptions in programme delivery*

### *4.7.2 The review team's suggestions*

#### 4.7.2.1 Public health promotion

1. *As long as there are no handwashing facilities at the public latrines in WestPoint and Clara Town, there is little point in discussing handwashing with communities. Despite the fact that people are saying they wash their hands, it is not physically possible at the latrines. The plan is to concentrate on handwashing and latrine use in January and February but this is only possible if the hardware is in place.*
2. *It would be feasible in some places to set up handwashing facilities (with improved water quality and provision of soap) in the slum areas latrines but one would need buy in from the janitors in order to keep them filled up and functioning.*

3. *Radio messages should be explored as there are so many radios in the slum area – songs and jingles could be used using children and speaking Liberian English. The use of drama groups has been tried by the team and is a good way of attracting attention as long as it is not viewed solely as entertainment.*
4. *Although ECHO does not fund preparedness, there are opportunities to train the reference groups in responding to cholera outbreaks as discussed with the chairperson for the reference group in WestPoint. Oxfam has cholera guidelines that could be used for this training.*
5. *It is important to factor in events such as the cholera outbreak – Oxfam will be called upon to assist again and this should not impact on programme activities. It should be under Assumptions in the new LogFrame.*
6. *As the team suggested, if livelihoods are linked to public health then there is a greater chance that community motivators as part of women's groups or other CBOs will continue working. We need to be careful that these people are not seen as paid health promoters but as volunteers who happen to also be part of an income-generating activity.*
7. *Livelihoods interventions in future programmes in slum areas should have a public health aspect to address the environmental health issues. This not just be limited to hygiene promotion as messages without the resources will not lead to behaviour change*[14]
8. *The new programme should be limited to high-density cholera-prone areas where we are most likely to have better measurable outcomes.*

**4.7.2.2 Safe water provision**

Much as Liberia Water and Sewerage cooperation is chlorinating water distributed to Clara town, leakages observed and changes in pressure pose a greater risk fro recontamination.

- *Making water safe in the peri-urban areas needs to be focused and emphasised on jerrican and household chlorination besides upgrading of the system. This may also apply to IDP camps and other cholera hotspots that use other water sources to make beneficiaries get used to chlorinated water. If this practice takes root then any future cholera outbreak may be easier to control.*

Water tanks/water points being upgraded and installed in Clara town and West point are fewer compared to the population and some people within those communities may be getting water from unsafe sources. The response may also create bad feelings between the water sellers and the management of the new water points.

- *It is recommended that the programme explore further ways of improving the quality of water at household level besides household chlorination like household filters.*

- *Inclusion of the some representatives of the water sellers association on the water management committee for the new water points and also explore possibilities of water sellers who serve areas far from the new water points to get safe water from the tanks.*

[14] This assumption is based on several behaviour change models and extensive literature

Creation of water management committees and reference groups to manage water facilities in the camps and host rural communities and in the per-urban areas is a good idea. These management structures need to be linked to government departments to sustain their operations and maintenance.

- *Explore possibilities of government bodies or parastatals like Ministry of Rural development and LWSC taking responsibility of ensuring that water facilities that being installed, upgraded and rehabilitated are*

To sustain operations of the water points communities and their management structures need to be linked to some income generating activities to be responsible for their systems.

**4.7.2.3 Safe access to sanitary facilities**

Poor or limited access to sanitation facilities for disposal of excreta poses the second highest risk to public health especially in peri-urban areas of the programme. Programme delivery in this sector has been focused on de-commissioning and replacing latrines where necessary in Soul Clinic camp. This is rightly so as access to safe disposal of excreta in peri-urban areas is complicated and needs to be given considerable thought and consultations need to be made with beneficiary community and other stakeholders. This is also valid for garbage collection and disposal, which is not a localised problem to only Oxfam's slum programme areas but to the entire Monrovia city and its periphery.

Desludging latrines in peri-urban areas will temporary improve access to safe disposal of excreta however, the use of public latrines cannot be sustained with the fee collected and the number of public latrines is too few to match the population to be served. Further, the system of desludging relies on efficiency of the only desludging truck. It is likely that desludging will be operating close to overflowing state most of the time if the entire desludging system is not analysed, supported and monitored. If access to safe sanitation is to be improved, the dislodging process needs to be looked at in totality coupled with investing other alternatives.

Garbage is not a threat in camps and rural programme areas but poses health risk in slum programme areas The slum areas are also unfortunately the most poorly drained areas. Drains are used as dumping sites for garbage and human excreta. Environmental clean ups have been organised but the whole system of garbage collection and disposal is not complete and fully understood or supported by city policy or system. Even though the garbage and poor drainage pose a health risk, clean up of garbage and drain will only shift problem from one location to another if they are not linked to overall systems or plans of garbage collection and disposal and drainage of the areas. Activities done in these areas with considering the entire systems will have limited impact and sustainability.

*Recommendations:*

- *Investigate alternative technical solutions like compost latrines where possible to complement public latrines in slums but also in high population density areas and areas with high water table.*
- *Explore use of desludged excreta for economical and /or livelihood like conversion to biogas or compost.*

- *Concentrate on activities on water and sanitation that will have more impact and drop drainage and garbage in this phase but consider garbage collection and drainage systems in future programmes.*
- *Discuss with the government and other stake holders putting in a garbage collection and disposal system*

### 4.8 Delay in implementation

In a community meeting with CBOs, youths, water user association and local authorities in Clara point and a focus group discussion with a women group at West point, programme delivery was perceived to be slow. Public health Staffs also listed down time limitations as one of the weaknesses and threats to programme and the timeline drawn by staffs also indicated delays experienced in programme delivery due to response to cholera outbreak, elections, heavy rains and unplanned training/meetings.

Construction of watsan facilities was considered by the PH staff to be more delayed than the hygiene promotion that benefited from mobilisation. Though some of the promotion activities like handwashing can also not be done without the facilities put in place

**Reviewers' comments/suggestions**

Whereas heavy rain and unplanned training and meetings were partly responsible for the delay in the main programme implementation, the main delay of about two months was caused by the programme not having enough capacity to respond cholera and implementing the core programme at the same time and delays caused by threats of violence due to elections.

Even though response to cholera was viewed as a diversion to the main programme, the response formed a strong basis for the main programme. Prevention of epidemics and forms part of the main objective of the programme and since cholera is endemic in the programme area; response to cholera should not have been considered as a delay if it had been factored in the main response in case of an outbreak. It was however difficult to predict how much more time would be lost in programme delivery due to elections and run-off elections.

- *Future programmes in cholera hot spot areas should factor in materials, equipment and staff to respond to cholera.*

- *Consider recruiting more technicians to work on sanitation along side water in the peri-urban areas.*

### 4.9 HIV Mainstreaming

Little has been done in this area. The adviser carried out some training for the staff on HIV/AIDS but little on mainstreaming – although this was one of the objectives of the training. The PH coordinator talked about identifying VCT sites in order to inform people as well as doing training with TBAs. The Watsan coordinator talked about siting latrines and water points near to households where there are people living with HIV/AIDS but this is simply not feasible in the urban slum setting. There does appear to be limited expertise in mainstreaming in the programme at this time. Certainly it will be a challenge to mainstream in the slum setting but as there are probably quite

high prevalence rates or opportunities for spread, innovative ways to mainstream should be found. These could be lobbying the latrine owners to adjust a latrine for people who are weakened by the virus or suggesting potties for use by these people and encouraging free emptying into public latrines.

*HIV/AIDS should be mainstreamed rather than having awareness programmes and TBA training that require more than just a few sessions and are actually labour intensive*

### 4.10 Gender mainstreaming

It is encouraging to see how conscious the team is of the importance of gender. Meetings are held with both men and women separately and women are encouraged to speak. This appears not just to be the hygiene promotion team but also the technicians. The fact that the technicians are facilitating focus groups in a very participative way is nice to see. It is a pity that there are no female technicians – something that the technical team leader brought up under the Proud and Sorry exercise. The gender adviser stated that she has been supportive to the team in providing information and materials when requested as well as providing trainings Although she has been on some field trips with the team, it would be good to have input every so often followed by a fishbowl exercise to discuss issues – looking at good practice as well as constraints. however. Within the team there is a great deal of gender experience that is being utilised to influence the programming.

### 4.11 Coordination within the Oxfam office

There have been several advisers coming to the country for varying periods to train and work with the urban programme team. In the office there are public health coordinators, a gender adviser, a protection adviser as well as the monitoring and evaluation officer (programme officer). All are eager to be involved in the planning and implementation of the programme and to advise the team. It is understandable that programme managers may feel threatened. All these internal people visit the field and although they apparently share their reports afterwards, they do not appear to combine visits. The M&E officer does not go with the public health coordinators for example. The only good working relationship appears to be with the protection adviser.

Our concern is that there is added pressure on the teams to accommodate all these people as well as outside advisory visits. Especially on community participation, there are three people who have told us that their role is to look at this aspect – one can only hope that they are coming at it from the same angle as well as being aware of the differences in approach needed in the three programme sites: urban, semi-rural and camps.

It is important for all these advisers to remember that some staff have many years experience with Oxfam working on some of these issues and in some cases, team members may actually have more experience than advisers. There needs to be more of a mutual trust and less of an assumption that everyone needs to be “sensitised.”

*Advisers should try to coordinate visits and advise to teams in order not to overburden staff and managers*

## Appendix 1: Timeline for the Urban Public Health Programme

| Dates | Events |
|---|---|
| May'05 | • Programme starts/safe water campaign<br>• Mapping Exercises<br>• Rapid needs assessment<br>• Training in accountability – 3 days (half days discussions) led by Zia Choudhury<br>• Feedback to communities and decision made to work with which communities<br>• Held more discussions with Clara town, West point & amongst team regarding which approach to use such as reference group or leadership |
| June'05 | • Cholera outbreak in Clara town and West Point<br>• PHTL took leave<br>• Identification of volunteers<br>• Setting out ORT corners<br>• Training of volunteers<br>• Training in LQAS and monitoring (2 weeks)<br>• Started the completion of the 27 latrines in the community |
| July'05 | • Heavy rain leading to flooding of areas of work<br>• 10-days visit by Suzanne Ferron – training on indicators<br>• ORT corners continued<br>• Independence day |
| August | • Closure of ORT first two weeks<br>• Concluding MOU for water points upgrading in Clara town<br>• Identification and recruitment of Community Motivators and water management team<br>• Identification of sites for tanks<br>• Identification of stakeholders<br>• Training on water testing<br>• Monitoring<br>• Discussion on MOU with dealers<br>• Two technicians recruited. |
| September | • Training of Community Motivators<br>• Two new PHPs are recruited<br>• Awareness on H/H chlorination<br>• Jeri can cleaning and chlorination campaign<br>• Acquisition of land space for water tanks construction in at West point.<br>• Monitoring<br>• MOU finalised – for desludging in Clara Town agreed<br>• Completed the 27 latrines in communities<br>• Training in camp guides in Soul clinic<br>• Distribution of NFI<br>• Election campaign started<br>• |
| October | • Discussions and meetings<br>• Started construction of water tanks<br>• Concluding contracts for sewage works at Clara town<br>• Two staff took leave<br>• Election<br>• Demolition of watsan facilities in camp where IDPs were being resettled-Mt Barclay<br>• Meeting with the community using PHAST approach in Paynesville community<br>• Strategic workshop |
| November | • Election |

| | |
|---|---|
| | • Security Issues/ CDC demonstration<br>• Training in water testing<br>• Training of Community Motivators<br>• Monitoring of PH Activities<br>• Construction of Oxfam T-11 started in West Point<br>• Trained 75 CWT in Soul Clinic IDP camp<br>• Mobilise community casual labour<br>• Siting facilities for construction |
| December | • Training of Community Motivators in Paynesville<br>• (Only 1 member of the team participated in this)<br>• Finalise discussion for Water Management Team (MOU)<br>•<br>• Carry out Monthly monitoring forms in camps |

**Appendix 11: Timetable for the review**

| Date | Activity |
|---|---|
| December 4th | Leave for Liberia, arrive in evening |
| December 5th | Meeting with programme manager, briefing and planning of review<br>Meet the urban team |
| December 6th | Weekly security meeting<br>Field visit to Clara Town<br>Workshop start |
| December 7th | Field visit to WestPoint<br>Workshop continues |
| December 8th | Field visit to Soul Clinic communities and camp<br>Workshop continues |
| December 9th | Workshop continues<br>Discussion with PH coordinators<br>Drinks with urban team |
| December 10th | Field visit to Bong County |
| December 11th | Report writing |
| December 12th | Confined to guesthouse due to security incident |
| December 13th | Meeting with Toneih Wiles – gender adviser, Emmanual Paivey – programme officer<br>Meeting with UNICEF<br>Feedback to staff and results consensus<br>Drinks with ACF and ICRC |
| December 14th | Meeting with WHO<br>Debrief with SMT<br>Technical meeting with TTL<br>Leave Liberia |

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For further information on the issues raised in this document email phd@oxfam.org.uk

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