GLOBAL EBOLA RESPONSE

EBOLA RESPONSE MULTI-PARTNER TRUST FUNDPROPOSAL

Proposal Title: Community Perception of Ebola Study/Survivors' Care Project	**Recipient UN Organization(s):** World Health Organization (WHO)
Proposal Contact: Name and Title: Dr. Alex Gasasira Address: Sekou Toure Ave, Monrovia, Liberia WHO Representative Telephone: +231775281157 E-Mail: gasasiraa@who.int	**Implementing Partner(s) – name & type (Government, CSO, etc):** Center for Liberia's Future (CFLF)
Proposal Location (country): Please select one from the following ☐ Guinea ☒ Liberia ☐ Sierra Leone ☐ Common Services	**Proposal Location (provinces):** The study will be undertaken in all 15 counties in Liberia (Bomi, Bong, Gbarpolu, Grand Bassa, Grand Cape Mount, Grand Gedeh, Grand Kru, Lofa, Margibi, Maryland, Montserrado, Nimba, River Gee, Rivercess and Sinoe) including towns, villages, and cities- rural and urban. Support services offered will prioritize 6 high burden counties ((Montserrado, Grand Bassa, Grand Cape Mount, Nimba, Margibi and Bong)
Project Description: *One sentence describing the project's scope and focus.* The project will consist of three parts: 1) a perception study to understand how Liberian's perceive Ebola and the type of support survivors need to enhance their reintegration into society, 2) public outreach to share the findings, and 3) service delivery for survivors and affected populations based on needs identified through the survey.	**Requested amount: USD249,952** **Other sources of funding of this proposal:** Bill and Melinda Gates Foundation (USD 1,495,650)
	No. of Beneficiaries 1000 direct beneficiaries will participate in the community perception survey. 500people will receive services based on their articulated needs.
	Start Date: November 2016 **End Date: August 2017** **Total duration (in months): 10 months**

STRATEGIC OBJECTIVES AND MISSION CRITICAL ACTIONS to which the proposal contributes. The SO and MCAs to which each project contributes should be identified. For proposals responding to multiple Mission Critical Actions (MCAs) within one or more Strategic Objectives (SOs), [usually one only] please select the primary MCA to which the proposal contributes.

☐ SO 1 Stop Outbreak MCA1: **Identifying and tracing of people with Ebola**
☐ SO 1 Stop Outbreak MCA2: **Safe and dignified burials**
☐ SO 2 Treat Infected People MCA3: **Care for persons with Ebola and infection control**
☐ SO 2 Treat Infected People MCA4: **Medical care for responders**

☐ SO 3 Ensure Essential Services MCA5: **Pprovision of food security and nutrition**
☒ SO 3Ensure Essential Services MCA6: **Access to basic services**
☐ SO 3Ensure Essential Services MCA7: **Cash incentives for workers**
☐ SO 3Ensure Essential Services MCA8:**Recovery and economy**
☐ SO 4 Preserve Stability MCA9:**Reliable supplies of materials and equipment**
☐ SO4Preserve Stability MCA10: **Transport and Fuel**
☐ SO 4Preserve Stability MCA11:**Social mobilization and community engagement**
☐ SO4Preserve Stability MCA12: **Messaging**
☐ SO5PreventFurther Spread MCA13:**Multi-faceted preparedness**

Recipient UN Organization(s)[1] *WHO*	*Chair of the Advisory Committee, Ebola MPTF:*
Dr. Alex Gasasira **WHO** **Signature** **Date & Seal**	**Dr. David Nabarro** **Signature** **Date:**
Representative of the Government of Liberia **Dr. Francis Kateh, MD** **Chief Medical Officer/Deputy Minister of Health** **Signature** **Date**	

NARRATIVE (Max 2 Pages)

a) **Rationale for this project:** *This section summarizes briefly why this project is the best way to achieve/contribute to the relevant Strategic Objective (SO) and the associated mission critical actions (MCA).*

Relevance to SO and MCAs

This project will address the strategic objective of ensuring essential services for Ebola affected populations: survivors, orphans, and caregivers in Liberia. Rather than taking a prescriptive approach to messaging and community engagement, as many previous Ebola response projects have done, this project will seek to determine community perceptions and attitudes that lead to discrimination and stigmatization in Ebola survivors, orphans and caregivers leading to the adaptation of preventative health communication and messaging in line with the study's findings, to help create systems that can facilitate affected population's reintegration. The project will also incorporate a care component, to address and provide support for the health and livelihoods needs of survivors, orphans and caregivers.

Rationale

[1]If there is more than one RUNO in this project, additional signature boxes should be included so that there is one for every RUNO.

During the Ebola epidemic, Liberia became the most heavily affected country in West Africa, with widespread loss of lives and devastation to society. The impact of Ebola has been pervasive and far-reaching, affecting individuals and communities psychologically, economically, and socially. The aftermath of the Ebola outbreak presents challenging times for Liberian families and communities, most especially, the nation's Ebola-affected populations, which face unparalleled needs as long-term unemployment, hunger, health complications, and homelessness.

The initial focus of social mobilization interventions and messaging was targeted to vulnerable groups, educating communities on behavior change interventions to stop the spread of the disease. This messaging and corresponding interventions were generally comprised of western activities designed by international professionals, rather than approaches designed directly by Liberians which draw on indigenous knowledge, local customs and cultural norms.

Ebola survivors, orphans and caregivers are stigmatized and discriminated against throughout Liberia. Through media and family influences, the status of being an Ebola survivor, orphan and caregiver is not judged favorably by mainstream Liberian society. Yet, there is a remarkable lack of understanding of community perceptions about Ebola: the illness, its causes, treatment, severity and after care needs of these affected populations. Further, few studies have focused on the beliefs, practices and experiences of local, average citizens, who have been most vividly affected by the epidemic.

In the post-outbreak climate, support for survivors remains limited. Most interventions seek to fill the gap in clinical support services, but few are targeted to addressing the stigmatization and discrimination survivors, orphans and caregivers face and the cultural and societal barriers to reintegration. Programming that has addressed these issues, has been designed from an outside perspective to mitigate the stigmatization and discrimination. Instead, this project seeks to first genuinely understand the roots causes, community perceptions and prejudices that lead to this behavior, and then design solutions which adequately and properly address these behaviors.

Preliminary research findings from the Center for Liberia's Future (CFLF) on community perceptions of Ebola survivors and affected populations depict a broad spectrum of needs. Ebola survivors, orphans, and caregivers highlight an array of health, economic, psychosocial, educational and general livelihood needs. Survivors report health problems related to their eyes, muscles, and head (neurological). Manifesting the trauma that many suffered, adults report mood swings, regular nightmares, problems maintaining social relationships, while orphans are reported to be involved in physical fights with peers, high drop-out rates from school, coupled with sexual promiscuity, even low levels of involvement in criminal behaviors. Caregivers highlight that economic hardships are their number one challenge. In the education realm, orphans face the need for tuition, uniforms, transportation fare, textbooks, and stationeries.

Interventions

The project is comprised of three main interventions:

1. Conduct a national perception survey December 2016-August 2017
2. Disseminate findings through public outreach and education August 2017-December 2017
3. Targeted service delivery for survivors, orphans and caregivers December 2016-October 2017

1. National Perception Survey

The project is aimed at conducting a national perception study to discover how Liberians perceive Ebola, asking, what factors might influence their perceptions, and what types of care and supports survivors need to enhance their reintegration in society. It draws on indigenous knowledge, and enables the collection of data on how local populations respond to disease, which will lead to the design and adoption of culturally appropriate

preventative health messaging and behavior change communication that are more likely to be adopted and sustained than outside interventions. In the event of a future outbreak, the locally designed solutions are likely to be more quickly adopted and sustained, accelerating behavior change so that communities can properly manage and achieve early detection and response.

Methodology:

The proposed work is aimed at covering all 15 counties (political sub-divisions) of the country, including villages, towns, and cities- rural and urban. Currently, studies have been done in parts of 8 counties involving 608 participants. The targeted population is 1000 adults and children residing in villages, towns, and cities across Liberia. A multistage sampling technique is being used. In the first stage, one urban county will be selected along with two large size rural counties and one medium size rural county. We are using a semi-structured questionnaire to evaluate the perceptions and beliefs of adults and children participating in the study. The questionnaire is in three parts: the first gathers demographic data, the second elicits awareness of Ebola, and the third explores attitudes, beliefs and perceptions toward Ebola survivors, orphans and caregivers. Attitudes such as fear, avoidance, anger, suspicion, mistrust, and hostility are considered negative, whereas sympathetic and mainstream survivors, orphans and caregivers are considered positive attitudes.

The data is being collected and analyzed throughout the process of the research and preliminary findings are emerging. The project is ongoing and as noted above, partial funds in the amount of (USD 1,495,650) have been provided by the Bill and Melinda Gates Foundation for the phase that has been completed thus far. Hence, for survivors, many were acutely stigmatized at the peak of the outbreak, but discrimination may be reducing. For orphans, they lack sustainable support to attend to their basic needs and are facing behavioral difficulties at home and school. Caregivers, relatives or friends who have tried to maintain the traditional safety net through kinship care are overwhelmed by array of socioeconomic challenges, coupled with stigmatization and discrimination. A final project report will be composed by the project team and validated with selected participants.

2. Public Outreach and Education

Once the final project report has been completed and validated, the staff will focus on the next stage of the project, sharing the findings with key stakeholders, and the general community. This component aims to educate practitioners, policy makers and the general population on the perceptions, behaviors and experiences of communities and individuals affected by Ebola and how these have led to stigmatization and discrimination of survivors.

The project team will share the final report in academic journals and the popular press. Meanwhile, we have completed two popular press articles to socialize the public with our findings. The first was on orphans and the second on caregivers. The third will be on survivors. In addition, shorter articles and first-person stories will be developed and disseminated to the popular press to reach the general population less likely to read the full project report. These will be captured in locally appropriate language and style and shared with media outlets widely-accessible to local communities.

The team will also participate in public outreach activities including radio and television interviews whenever possible to increase visibility and opportunities to share these findings.

3. Service Delivery for Survivors and Affected Individuals:

The research study consists of four main focus groups including; survivors, caregivers, orphans and other community leaders (i.e. religious leaders, teachers, chief medical officers, police officers and motorcycle riders).

While documenting their perceptions, experiences and health seeking behaviors, preliminary findings have uncovered a strained communal care system in which few resources are available for these populations. Urgent need exists to build an imaginative model of social service delivery to attend to the emerging needs of this special population. Based on this, CFLF will hire an exclusive group of care managers to administer the services.

To address this gap, this project component will provide care and support interventions to these groups, which have generally been hard to reach, under-researched, and under supported.

The affected individuals and support provided can be divided into two groups:

1. Orphans (as a result of Ebola) and Caregivers: most significant needs are for livelihoods
2. Survivors: have varied needs, including health needs and livelihoods needs

Service Delivery Model

The initial phase of this work begins with the research, where we encounter people in need of our services. However, the service delivery occurs in four phases:

1. Engagement of an assessment (December 2016-March 2017)
2. Intervention plan development (March 2017-May 2017)
3. Plan implementation(June 2017-October 2017)
4. Transition from service (January 2018 onwards)

Phase One: Engagement of an Assessment – CFLF staff works with the targeted beneficiary closely to build trust and ownership of the process. Essentially, it involves using our clinical assessment tools to acquire targeted information from the beneficiary about their needs.

Phase Two: Intervention Plan Development – CFLF staff moves from engagement and assessment of strengths/needs to evolving a wraparound set of core services based on the perceptions of the affected populations in total: individual, home, and community. This is a resilience-based framework where needs are prioritized and juxtaposed with the professional support team strengths and expertise, that of the beneficiary included. Here, a context-specific reintegration plan is developed to suit the beneficiary.

Phase Three: Plan Implementation – Data gathered in the previous two phases and then translated into a plan, often multi-dimensional in nature, covering economic, psychosocial, health, education, livelihood, security and other needs is implemented. Regular meetings are organized for continuous data collection and review to determine what's working or not thus sustaining the ongoing reintegration of the beneficiary and communal system at-large.

Phase Four: Transition from Service – Noteworthy, the onset of CFLF's intervention, the research process is the formal transition point of all its activities. Reintegration milestones are reviewed and accomplishments celebrated and a transition plan developed. The beneficiary may choose to share his or experience with others still receiving wraparound services.

Specific Objectives for Service Delivery Component:

1.To provide psychosocial support to orphans, survivals, and caregivers in six counties (Montserrado, Grand Bassa, Grand Cape Mount, Nimba, Margibi,and Bong) in 10 months to enhance community reintegration

2. To provide basic educational and domestic support for 500 orphans and caregivers in 6 hardest hit EVD counties covered the study in 10months

3. To facilitate livelihood sustainability for survivors, orphans and caregivers in all 6 counties of

1.0 Orphans behavior normalized with peers and community members
- 1.1 Mental health counselling for orphans
- 1.2 Sporting/recreational activities with peers

2.0 Survivors feel fully reintegrated with in communities
- 2.1 community leadership training for survivors
- 2.2 Survivors engage in recreation activities

3.0 Caregivers are emotionally/mentally stabled to relate with orphans in homes
- 3.1 stress management training for caregivers
- 3.2 recruit and train community based psychosocial volunteers

4.0 Orphans are kept in school
- 4.1 pay orphans school fees
- 4.2 provision of school supplies
- 4.3 provision of medical services
- 4.4 provide feedings

5.0 Survivors or caregivers livelihood activities are facilitated
- 5.1 small scale business
- 5.2 capacity building (Tailoring, Agriculture, General Construction, etc.)

6.0 Survivors accessed post Ebola medical care
- 6.1 provide information on post Ebola Care for survivors
- 6.2 Make sure survivors do routine check up

Results/Output:

Output 1:

Indigenous knowledge on public health preparedness and Ebola recovery documented through the national perception study in the targeted population (Public health professionals at MOH and INGOs, Policy Makers (Legislative, Executive, and Judiciary), and the Media).

Indicators:
1.1 Sample of People – including EVD survivors, orphans, medical professional, policy makers, CSOs & general public – participated in the study on 'Community Perception of Ebola Study/Survivors' Care'
1.2 Survey conducted in all 15 Counties and at the National level
1.3 Draft survey findings developed and disseminated at County and at Nation level
1.4 Number of multi media coverage received for sharing the findings (Print, Radio, Social Media, TV Broadcast)

Output 2:

Strengthened capacities of CFLF staff to undertake a high quality survey.

Indicator
2.1 Number of staff and locals trained to conduct the survey, analyze data and document findings

Output 3:

Awareness and sensitization among the public and key stakeholders enhanced at all levels

Indicators:
3.1 Number of caregivers in health care facilities sensitised
3.2 Number of survivors engaging in awareness campaigns

Overall Project Outcomes:

This project aims to support beneficiaries to build strong organic peer networks, continue to share experiences with others, feel less alone, develop new friendships, help others, gain support and hope from others facing similar experiences, learn new coping skills, become more self-confident, and thus, feel less anxious and afraid.

On a societal level, the project seeks to foster greater community awareness and lead to a better understanding of Ebola among the public, breaking down fears and mistrust about the disease and those who are survivors. Greater public awareness will address and aim to lessen stigmatization toward survivors. Therefore, the overall outcome is as follows:

Access to health care and social welfare services improved by the EVD survivors and orphans

Indicators:

1.1 Increase in the access of health services by survivors and EVD affected population
1.2 Increase in the number of orphans accessing education services
1.3 Increase in the number of survivors and affected populations with improved livelihood opportunities

This holistic approach, we envision and hope will result in safe, authentic, and positive relationships which can be corrective and restorative to survivors of Ebola – meaning the whole society (primary and secondary survivors), while focusing on strength and resiliency. It is important that we note that a respectful, collaborative approach rather than a provider-client approach which is rooted in the strongest belief that the survivor is the expert on her or his life and feelings lies at the roots of both interventions.

The findings will hopefully be of utility to health policy makers in the design of localized, and culturally appropriate interventions and responses in the future.

b) Coherence with existing projects: *This section lists any of the projects which are supporting the same SO or MCA in the same country or area of operation*

Currently there are no projects supporting the MPTF Strategic Objective of Ensuring Essential Services for Ebola survivors, orphans and caregivers in Liberia. This project will address gaps in existing programming, by providing a theoretical foundation to create systems that can facilitate survivors, orphans, and caregivers' reintegration.

c) Capacity of RUNO(s) and implementing partners: *This section should provide a brief description of the RUNO capacity in the Country, including the overall current emergency budget and the staff deployed. It should include its expertise in the targeted area of support. This section should also outline any additional implementing partners, including their role and experience and how the RUNO will provide quality assurance.*

This project will be implemented through direct collaboration between:

1. The Center for Liberia's Future (CFLF)
2. The World Health Organization (WHO)

Additionally, The Ministry of Health and The Ministry of Finance will be consulted and engaged throughout the implementation of this project. The partnership and collaboration between all organizations will be mutually reinforcing, with leadership and capacity offered from each entity.

The Center for Liberia's Future (CFLF), will serve as the lead implementing organization on this project. CFLF was established, led by Dr. Emmanuel Dolo, borne out of the recognized need for locally-led and culturally-sensitive research to inform policy makers and implementers, CFLF maintains extensive, multi-level relationships across various sectors of Liberia, the sub-region of West Africa, and the world. CFLF seeks to bring about transformative change through mainstreaming indigenous knowledge into positive action. During the EVD outbreak, current CFLF staff worked for institutions like the Ministry of Health, and International Organization for Migration (IOM).

Dr. Emmanuel Dolo is the Principal Investigator/ Project Director of this research study and service delivery interventions. Dr. Dolo is one of the few citizens of the sub-region that has worked not only at ground zero of the Ebola outbreak, but also at a policy level working alongside the three presidents of the most-affected nations to develop a post-Ebola recovery plan. He worked with many key stakeholders, his office situated in that of UN Mission for the Ebola Emergency Response (UNMEER) and served as the Head of the Secretariat of the Presidential Advisory Council of Ebola (PACE), a policy think tank that developed both the national and regional strategies that brought Ebola to zero. Dr. Dolo was also responsible for convening and leading three key stakeholder conferences involving government entities from the sub-region alongside multinational and donor partners that developed strategies to combat the EVD. In addition, Dr. Dolo served on the Liberian Incident Management System as the direct representative of Liberia's President, while working alongside David Nabbarro and Anthony Banburry and other senior level UN and UNMEER representatives.

WHO will serve as the RUNO for the project. WHO has been actively engaged in Ebola response and recovery activities in Liberia, directly supporting the Ministry of Health and Government of Liberia to implement a continuum of activities ranging from contact tracing to social mobilization and survivor mental health care.

WHO currently has staff operational in all 15 counties, supporting county health teams and engaging communities and local leadership for community messaging and behavior change interventions. As the chief technical organization to the Ministry of Health, WHO has strong working relationship and extensive reach to work collaboratively with the MoH, development partners, county health teams, community leaders and the general public.

Since August 2014, WHO has been working directly in Liberia to combat Ebola, and has implemented several Ebola response and recovery programs, which includes interventions such as EVD surveillance, case management, infection prevention and control, water, sanitation and hygiene, integrated disease surveillance, logistics, survivor care, mental health care, as well as other Non-Ebola projects covering a continuum of health interventions and activities.

d) **Proposal management:** *This section identifies the oversight structure or mechanism responsible for the effective implementation of the project and for the achievement of expected results. If need be, an organogram can be included to help understand the structures.*

Project implementation will be undertaken by the Center for Liberia's Future (CFLF), and directly managed and administered by a Principal Investigator/ Project Director, Dr. Emmanuel Dolo. The research team is comprised of 7 members: 1 PHD, 3MPHs, 1MPH graduate student, and two BSCs. They are responsible for collecting the data, and producing the final report and press pieces for dissemination.

As Liberia does not have a strong research tradition, and lacks training resources, extensive support is provided to the team by the project director and other experienced professionals from abroad. The team holds daily professional development sessions to build their skills. Two additional senior researches with extensive qualitative experience are recruited as consultants who help to tabulate the quantitative data from the study.

WHO will serve as the RUNO for the project. CFLF will serve as the primary implementer, and WHO will provide support services, including support for award management, monitoring and reporting.

Regarding disposal of the equipment procured for this project at its end, CFLF is seeking additional grant to expand its research in the Mano River Basin nations. Should this grant process, which is in advanced negotiations be approved, the plan would be to keep using the equipment for continuation of the work in the four Mano River Basin nations. However, should CFLF not get this grant, the equipment acquired will be transferred to the Government of Liberia, which is currently providing technical oversight for the project.

In terms of WHO monitoring strategy, CFLF has already provided its fieldwork plan to WHO and the MPTF M&E staff assigned here in Liberia to enable monitoring of the data collection process. CFLF has a clear data management and analysis process, which would also be made accessible to WHO for monitoring. In addition, CFLF will provide a budget and procurement plan to WHO, and thus involve WHO in all procurement processes relative to the MPTF funding to enable transparency and accountability.

e) **Risk management:** *This section sets out the main risks that may jeopardize project implementation, their likelihood, severity, and risk management, including responsibility for risk management/ mitigation.*

The project team will, in collaboration with appropriate stakeholders, and project sponsors, will work to ensure that risks are actively identified throughout the life cycle of the project. Risks will be identified as early as possible in the project so as to minimize their impact.

Table 5 – Risk management matrix

Risks to the achievement of SO in targeted area	Likelihood of occurrence (high, medium, low)	Severity of risk impact (high, medium, low)	Mitigating Strategy (and Person/Unit responsible)
Capacity: Will we be able to acquire adequate number of trained personnel to staff the project and retain them for the 1 year duration?	Low	Medium	The project will hire a research team of seven students/ recent graduates, and support them with regular trainings and capacity building provided by the research director.
Cost: Will the funding be sufficient to cover the scope of the project, given that it targets the entire country?	Medium	High	A cost monitoring system will be established and employed. All project staff will communicate effectively and timely with one another, and the project accountant.
Coverage: Will we be able to fully cover the entire country during the life course of the project?	Medium	Low	Due to issues with reaching rural areas during the rainy season due to the rough terrain, we will plan accordingly to reach the less difficult areas during the rainy season, and during the dry season approach the more difficult areas. By planning implementation for mixed locations this will allow us to better mitigate this risk.
Contextual: Will we be able to address stakeholders expecting quick results without appreciating that behavioral change is a long-	High	High	We will use a mix of qualitative measures: focus groups, observations of conditions and human interactions, and use street intercepts to collect narrative information on

term process and we may face many barriers to change?			program participants' perceptions (survivors, community members, policy makers, and donors) of change, to capture myriad of data and viewpoints.

f) Monitoring &Evaluation: *This section sets the M&E arrangements and responsibilities for the proposal, including who will be responsible for the collection and analysis of data required in the result framework.*

This project will involve work at the national and sub-national levels. Therefore, key elements of program performance through record keeping, regular reporting, and periodic surveys will be utilized. At the national and sub-national levels of implementation, we will monitor inputs (human resources, financing supplies, processes procurements and training) and outputs (services delivered) as essential means of assessing the project performance. This will enable us to align the implementation of planned activities with the project design. We will use both routine and self-acquired survey data collection processes gathered through qualitative approaches. We will collect information on few indicators important for action instead of overburdening our staff. Attention will be paid to a clear definition of the use of the information, specifying the primary users; indicators for monitoring will be selected; an M&E officer will be contracted for the project to cut down cost.

The project director will oversee the development of a comprehensive M&E plan, in consultation with the project team, and key stakeholder. Theplan will contain an introduction articulating the framework for monitoring and evaluating the project, the scope of the M & E operations, specifying goals and objectives, the methodological approach – addressing the design, relevant indicators and data sources, implementation plan, which will describe the activities, roles, and responsible entities, time table for those identified activities, such as data collection, data analysis, report writing, dissemination, etc. Finally, it will contain the dissemination plan, budget, and plan for reviewing the M & E plan.

PROPOSAL RESULT MATRIX

	Proposal Title: Community Perception of Ebola Study/Survivors' Care Project				
Strategic Objective to which the Proposal is contributing[2]		To ensure essential services for Ebola affected populations: survivors, orphans, and caregivers in Liberia through assessing community perceptions and attitudes that perpetuates discrimination and stigmatization of Ebola survivors, orphans and caregivers.The outcome of the survey findings will enable to adapt preventative health messages for public awareness, promoting health seeking behaviors and to create an enabling environment to reintegrate the EVD affected populations.			
Effect Indicators	**Geographical Area (where proposal will directly operate)**	**Baseline[3]** In the exact area of operation	**Target**	**Means of verification**	**Responsable Org.**
Only insert relevant Result indicators for your proposal (source Fund Result Matrix, MPTF Office can provide)					
Access to health care and social welfare services improved by the EVD survivors and orphans	6 Counties (Montserrado, Grand Bassa, Grand Cape Mount, Nimba, Margibi, and Bong)				CFLF
Indicators:					
Increase in the access of health services by survivors and EVD affected population		X - TBC (post survey findings)	% increase (TBC post survey based on baseline data)	Survey Reports Consultation Reports Community Group Meeting Reports	
Increase in the number of orphans accessing education services		300 - TBC (post survey findings)	% increase (TBC post survey based on baseline data)	Survey Reports Consultation Reports Community Group Meeting Reports	
Increase in the number of survivors and affected populations with improved livelihood opportunities		X - TBC (post survey findings)	% increase (TBC post survey based on		

Proposal can only contribute to one Strategic Objective

[3] If data are not available please explain how they will be collected.

				baseline data)		
MCA [6][4]		**Messaging**				
Output Indicators	**Geographical Area**	**Baseline**	**Target[5]**	**Budget**	**Means of verification**	**Responsable Org.**
Output 1: **Indigenous knowledge on public health preparedness and Ebola recovery documented through the national perception study in the targeted population** (Public health professionals at MOH and INGOs, Policy Makers (Legislative, Executive, and Judiciary), and the Media). Indicators :	Nationwide	0	Single Comprehensive Report produced		Focused Group Discussions/Interviews	CFLF/WHO
1.1 Sample of People – including EVD survivors, orphans, medical professional, policy makers, CSOs & general public – participated in the study on 'Community Perception of Ebola Study/Survivors' Care'	National level and at all 15 counties	0	Sample of 1000 individuals		Survey Forms and Reports Minutes of the Meetings Data analyses Reports	CFLF
1.2 Survey conducted in all 15 Counties and at the National level	Nationwide	0	15 Counties & National level		Survey Data forms Reports on Methodology and Field visits	
1.3 Draft survey findings developed and disseminated at County and at Nation level	Nationwide	0	7 Consultations		Consultation Reports	CFLF

Project can choose to contribute to all MCA or only the one relevant to its purpose.
Assuming a ZERO Baseline

1.4 Number of multi media coverage received for sharing the findings(Print, Radio, Social Media TV Broadcast)	Nationwide	0	20 (X per month)		Newspaper Articles Radio/TV Broadcasts Reports Social Media posts	CFLF
<u>Output 2:</u> **Strengthened capacities of CFLF staff to undertake a high quality survey.** <u>Indicator</u>						
2.1 Number of staff and locals trained to conduct the survey , analyse data and document findings			10		Training Reports	CFLF
<u>Output 3:</u> **Awareness and sensitization among the public and key stakeholders enhanced at all levels** <u>Indicators:</u>						CFLF
3.1 Number of caregivers in health care facilities sensitised	6 Counties	0	300 Caregivers			CFLF
3.2 Number of survivors engaging in awareness campaigns	6 Counties	0	TBC (post survey)			CFLF
Coordination Fees[6]				**XX%**		
Personnel						
Contractual Services						
Frongien and local travel						
Indirect Cost max 7 %						
Total Project Cost in USD				**249,952**		

Should not exceed 20% including the indirect cost

Project budget by UN categories

PROJECT BUDGET	
UN Budget CATEGORIES	**Ebola MPTF budget**
1.Staff and other personnel (include full details)	73,000
2.Contractual services (include full details)	12,000
3.Travel (include full details)	16,000
4.Equipment, Vehicles, and Furniture (including Depreciation) (include full details)	77,000
5.General Operating and other Direct Costs (include full details)	51,900
6.Supplies, Commodities, Materials (include full details)	3,700
7.Transfers and Grants to Counterparts (include full details)	0
Sub-Total Project Costs	**233,600**
8. Indirect Support Costs*	16,352
TOTAL	**249,952**

* *The rate shall not exceed 7% of the total of categories 1-7, as specified in the Ebola Response MOU and should follow the rules and guidelines of each recipient organization. Note that Agency-incurred direct project implementation costs should be charged to the relevant budget line, according to the Agency's regulations, rules and procedures.*

The Center For Liberia's Future Budget Period: 2016-2017 (November 2016-August 2017 All costs in US$	# of Units for Unit Cost	Qty	Frequency	Unit of Measure Description		Percentage % of the Budget
Personnel						
Project Coordinator	$1,400.00	1	10	Months	$14,000.00	
Project Director	$700.00	1	10	Months	$7,000.00	
Project Assistant	$300.00	1	10	Months	$3,000.00	
Monitoring and Evaluation Officer	$300.00	1	10	Months	$3,000.00	
Social Workers	$350.00	7	10	Months	$24,500.00	
NASCORP-Employer's Contribution	$850.00	1	10	Monthly	$8,500.00	
Fringe Benefit	$1,300.00	1	10	Monthly	$13,000.00	
Sub Total Personnel:					**$73,000.00**	**29.21%**
Contractual Services :						
Community Program Execution/per dim	$1,000.00	1	5	Months	$5,000.00	
Community leaders Meetings	$200.00	1	5	Months	$1,000.00	
Contractual Services	$2,000.00	1	3	Months	$6,000.00	
Sub Total Contractual Services					**$12,000.00**	**4.80%**
Foreign & Local Travels						
Local travel all staff	$1,000.00	1	10	Trips	$10,000.00	
Foreign Travel	$3,000.00	1	2	Trip	$6,000.00	
Sub Total Travel					**$16,000.00**	**6.40%**
Project Procurement and Transport Cost						
Vehicles	**$60,000.00**	**1**	**1**	**Vehicle**	**$60,000.00**	
60 KVA Generators	**$17,000.00**	**1**	**1**	**Gen.**	**$17,000.00**	
Sub Total Procurement and Transportation Cost					**$77,000.00**	**30.81%**
Supplies						
Laptop, computer and accessories	$800.00	2	1	Unit	$1,600.00	
Project Mobile Phones	$300.00	2	1	Unit	$600.00	
Office Supplies & Others	$150.00	1	10	/Month	$1,500.00	
Sub Total Supplies					**$3,700.00**	**1.48%**
General Operating & Other Direct Costs						

Programming Expenses						
Communication and Internet	$400.00	1	10	Months	$4,000.00	
Meeting Costs (M&E Advisory Committee,(WHO/MOH)	$500.00	4	1	Lumpsum	$2,000.00	
Data Collection/Storage	$200.00	1	3	Quarter	$600.00	
Printing	$200.00	1	5	Months	$1,000.00	
Fuel, and Maintenance for Vehicle and generator	$3,130.00	1	10	Months	$31,300.00	
Facility Rental	$400.00	1	10	Months	$4,000.00	
Building Maintenance and others	$300.00	1	10	Months	$3,000.00	
Administration- Securities drivers, and Others support staff	$200.00	3	10	Months	$6,000.00	
Sub Total direct Costs					**$51,900.00**	**21%**
Total Direct Costs					**$233,600.00**	**93%**
WHO Oversight (indirect cost) 7%					**$16,352.00**	**7%**
Grand Total					**$249,952.00**	**100.00%**