



**INTERNATIONAL RESCUE COMMITTEE
LIBERIA PROGRAM**

QUARTERLY REPORT

MONROVIA EBOLA TREATMENT UNIT (ETU)

(CONTRACT NO: AID-OFDA- A-15-00002)

OCTOBER, NOVEMBER, AND DECEMBER 2014

PRESENTED TO:

**THE USAID OFFICE OF FOREIGN
DISASTER ASSISTANCE**

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I. Executive Summary

PROGRAM TITLE: Monrovia Ebola Treatment Unit (ETU)

PROJECT NO: AID-OFDA- A-15-00002

AGENCY: International Rescue Committee (IRC)

COUNTRY: Liberia

REPORTING PERIOD: Quarter 1, FY2015: October, November, December 2015

GOAL: To support the safe re-opening of Ebola-affected health facilities, with the ultimate goals of reducing patient mortality and transmission of the Ebola Virus Disease (EVD) in the community.

OBJECTIVES:

1. To provide clinical care to Ebola Virus Disease (EVD) patients in Monrovia, with the ultimate goals of reducing patient mortality and transmission in the community.
2. Ensure safe sanitation and hygiene at the Ebola Treatment Unit (ETU).
3. Provide psychosocial support services to patients, families, and IRC staff.

BENEFICIARIES:

Total Number of Individuals Affected in the Target Area:	1,144,000
Total Number of People Targeted (Individuals):	N/A
Total Number of IDPs Targeted (Individuals) as subset of above:	N/A

LOCATION: Montserrado County, Liberia

DURATION: Six (6) months

I. Introduction:

The IRC began working in Liberia in 1996 when civil wars in both Liberia and Sierra Leone caused extensive internal displacement and triggered a flood of refugees to Guinea. The IRC Liberia's initial programming focused on emergency response and humanitarian aid; however, as the country has slowly transitioned to a development phase so too did the IRC's work. The IRC's primary goal in Liberia has been to foster durable solutions for recovery and development. To this end, the IRC works to support access to health services, protection programming for children, youth, women and girls, and the creation of economic opportunities.

As the Ebola Virus Disease (EVD) epidemic raged throughout the country in 2014, the IRC adapted or suspended many program activities across its entire portfolio, while expanding its work within the health sector in order to respond appropriately. The IRC engaged with the humanitarian, development, public health community and the Government of Liberia (GOL) as a leading partner in the nation's efforts to control the epidemic and recover from its effects.

In response to the EVD outbreak in Liberia, the World Health Organization (WHO) committed to constructing five Ebola Treatment Units (ETUs) in Montserrado County, which encompasses Monrovia. ETUs are emergency health facilities that provide diagnostic and treatment services to suspected and confirmed EVD cases. In the absence of sophisticated infection control clinics, which do not exist in Liberia, ETUs provide one of the only chances for surviving the virus.

The original design of the Monrovia Ebola Treatment Unit project was to run a 100-bed ETU built by WHO at Samuel Kay Doe Stadium (SKD 1), the objective was to provide clinical care to EVD patients in Monrovia, and the ultimate goals were to reduce patient mortality and transmission in the community. The IRC expected to treat approximately 2,300 patients in the confirmed, suspected and probable wards over the course of six months (October 2014 through March 2015).

However, shortly after the IRC launched this program, public health experts began to warn that while the Ebola epidemic in Liberia is far from over, the context of the EVD epidemic has since changed. As a result, health experts argued, the response by international organizations must be adapted for this new context.

Currently, hot spots of the EVD are still emerging in rural areas of Liberia, but the densely populated urban neighborhoods of greater Monrovia have proved the most challenging areas for EVD prevention and response interventions. As long as these areas remain hot spots for new EVD infections, Greater Monrovia will continue to be at risk for a surge in cases. With public pressure on the government to re-open closed public facilities for non-Ebola patients increasing, and more private facilities re-opening each week, the prevention of EVD transmission in health facilities has become the crucial next step in fighting the epidemic and eventually eradicating Ebola in Liberia.

Given the declining number of patients at ETUs in Monrovia, the number of empty beds at ETUs that are already operational, and the delays in the completion of the WHO facilities at SKD, the IRC decided to delay the opening of the ETU at SKD 1. Instead, the IRC is maintaining the status of the 50 bed capacity facility at ready to open should other ETUs in Monrovia close for repairs, or if there is a spike in EVD cases. This decision was made following close consultation with both the Ministry of Health (MOH) and USAID/OFDA.

As the EVD rate subsides, health experts have also turned their focus to the overall health system in Liberia. The lack of investment in health facilities in Monrovia prior to the epidemic created the perfect conditions for an urban explosion in EVD cases. Hospitals and clinics became major sites of transmission, and before most of them closed indefinitely, almost 100 health workers died after contracting the virus. Since affected facilities closed over summer 2014, medical care for non-EVD cases has been almost entirely absent within the greater Monrovia area.

Increasingly, operational ETUs in Monrovia began reporting in late 2014 that non-Ebola patients were seeking care at ETUs, as there were (and still are) few other facilities providing health services. Likewise, for patients testing negative at ETUs, partners had limited options for referrals for on-going treatment. In this unsustainable situation, with the lack of access to health services creating a secondary public health crisis, it is clear that facilities will re-open. What is far less certain is whether health facilities will re-open safely, with measures in place to prevent a resurgence of EVD cases in Monrovia.

In order to address this rapidly emerging facet of the Ebola crisis, the IRC redirected selected project resources (trained staff and supplies) from the ETU to support the safe re-opening of health facilities that were forced to close during the peak of the

outbreak. In particular, and at the request of the GOL, the IRC has been focusing on Redemption Hospital in New Kru Town, a government-run health facility just north of downtown Monrovia that was devastated by the first phases of Ebola. In this way, the IRC has been supporting the next phase of the response to Ebola through the implementation of proper infection prevention and control (IPC) at targeted health facilities, while remaining at-the-ready to respond to any peak in the EVD outbreak with a fully-functional 50 bed ETU.

II. Summary of Activities

The IRC program activity focuses on three main thematic areas:

- Health
- Water, Sanitation, and Hygiene (WASH, or Environmental Health)
- Protection (specifically psychosocial support)

Key program accomplishments during Q1 included:

Building the team:

Scaling up from 26 team members in October to a peak of 282 in November, the IRC eventually stabilized at 255 team members by the end of December. At the end of Q1, the IRC employed 233 national staff (59 women and 174 men) and 22 international staff (10 women and 12 men), and there were only six unfilled positions (2.4% of the anticipated total).

Development of Health and WASH standard operating procedures (SOPs), followed by training on their use:

The Health and WASH teams spent much of Q1 focusing on developing, disseminating, and training staff in detailed standard operating procedures (SOPs) on a number of critical subjects, including:

- ETU admission procedures (pre-screening, triage, and admissions);
- General care procedures (systematic treatment, symptomatic treatment, screening, palliative care, etc);
- Special care procedures (pediatrics, care for pregnant women, and nutrition);
- Laboratory procedures;
- Discharge procedures;
- Personal protective equipment (PPE) donning and doffing;
- Laundry; and
- Accident management at EVD sites.

Procurement of essential medicines for the ETU:

In addition to the standard slate of medicine, we also fully stocked medicines related to maternity, as well as Survival Kits.

Launch of community mobilization activity:

Based on the recommendations of the IRC's anthropologist, who spent six weeks in-county, the team planned and carried out community meetings in the local communities that are close to the SKD ETU. Focus groups in those areas identified the main issues and fears related to the ETU. The meetings helped to develop and maintain positive relationships with these communities. The team accompanying the Community Outreach Worker for each meeting included a clinician, a psychosocial worker, and a member of the WASH team. The meetings consisted of a short presentation from each technical person addressing the specific fears and concerns and then a question and answer session followed. In total, 230 community members participated in these meetings.

Tours of ETU for community members:

ETUs are sources of gossip and rumor, so inviting the local community into an empty ETU can allow them to address some of their fears. Guided tours of the empty IRC ETU were offered to the seven local communities, including traditional and religious leaders, and also to families and friends of ETU staff. A total of 51 community members, including many community leaders from surrounding communities, visited the ETU to gain a better understanding of what happens inside an ETU and be able to communicate that information to their communities.

Training for District Task Force members:

The IRC invited 50 members of the District Six Ebola task force and 12 senior community leaders to the ETU for a special one-day training session. Objectives were to 1) continue relationship building between the ETUs and community, 2) to address specific concerns that have come up regarding ETUs; 3) to encourage wide messaging of these issues in District Six through the Ebola Task Force; and 4) to improve the coordination between ETUs, especially in consistent messaging by inviting a representative from each ETU in Monrovia. The day included a tour of the ETU from the perspective of a patient, briefings from clinical staff, IPC team members, and members of psychosocial technical team. The purpose of the tour and briefings was to address the most common fears/concerns reported from District Six residents. In the afternoon, one representative from each of the other ETUs in District Six was invited to speak to visitors.

III. Indicator Tracking

Table: Objective Achievements for Project by Indicator

Indicator	Unit	Target	Actual Q1	Cumulative	Remark
Health					
Number of health care facilities supported and/or rehabilitated by type (e.g., primary, secondary, tertiary).	Facility	TBD	25	25	24 primary health facilities were selected to receive IPC training Keep Safe, Keep Serving (KSKS), IPC supplies, waste management, monitoring, and supervision. 1 secondary health facility (Redemption Hospital) has been the IRC's focus and has basic work underway, and will receive major rehab work soon (emergency services and pediatrics wards, sewage, waste management).
Number of health care providers trained by type (e.g., doctor, nurse, community health worker, midwife, and traditional birth attendant), disaggregated by sex.	Person	TBD	74 (34M/40F)	74 (34M/40F)	Int'l Doctors 9 (M4, F5) Int'l Nurses 11 (M6, F5) Medical Doctors 2 (M2) Physician Assistants 12 (M11, F1) Registered Nurses 16 (M0, F16) Nursing Assistants 24 (M11, F13).
Number of referrals accepted from Ebola Treatment Facilities (ETUs).	Referrals	0	0	0	During Q1 the ETU was not operational, therefore no cases were received.
Number of supplies distributed by type (e.g., medical kits, equipment, consumables).	Item	TBD	0	0	This activity will begin in Q2.
Number of people trained, disaggregated by sex, in the use and proper disposal of medical equipment and consumables.	People	TBD	78 (35M/43F)	78 (35M/43F)	PPE training 73 staff (M34, F39) 1 Pharmacist (M0, F1) 4 Drug Dispensers (M1, F3)
Number of stock outs of infection prevention control supplies at supported facilities.	Occurrence	TBD	0	0	This activity will start in Q2. The IRC will offer IPC materials support to the 24 primary health facilities.
Incidence and prevalence of high-morbidity rates by type (e.g. diarrhea, acute	Percentage	TBD	0	0	This activity will begin in Q2.

Table: Objective Achievements for Project by Indicator

Indicator	Unit	Target	Actual Q1	Cumulative	Remark
respiratory infection (ARI), measles, and other), disaggregated by sex and age.					
Number and percentage of cases diagnosed and treated per standardized case management protocols such as IMCNI, disaggregated by sex and age.	Number and Percentage	TBD	0/0	0/0	This activity will begin in Q2.
Number and percentage of suspected, probable, and confirmed EVD cases in the ETU triaged, diagnosed, and treated per standardized case management protocols, disaggregated by sex and age (in accordance with the scale-up plan).	Number and Percentage	0	0	0	During Q1 the ETU was not operational, therefore no cases were received.
Number of cases discharged, disaggregated by negative non-case and negative recovered, and sex and age.	Number	0	0	0	During Q1 the ETU was not operational, therefore no cases were received.
Case fatality rates for EVD cases in the ETU, disaggregated by sex and age.	Percentage	0	0	0	During Q1 the ETU was not operational, therefore no cases were received.
Number of quality control checks performed by day to ensure strict infection prevention and control practice.	Number	0	0	0	This activity will begin in Q2
Water, Sanitation, and Hygiene (WASH)					
Number of people benefiting from solid waste management, drainage, and/or vector control activities.	Person	TBD	0	0	This activity will begin in Q2
Protection (Psychosocial)					
Number of people trained in psychosocial support, by sex.	Person	TBD	693 (344M/349F)	693 (344M/349F)	349 women / 344 men

IV. Constraints and Challenges:

Perhaps the biggest direct constraint for the IRC in Q1 was the slowness of WHO to complete construction on the SKD ETU that was to be the focal point of the IRC's original program. The continual delays made it impossible for the IRC to begin work as scheduled, and in fact WHO delayed for so long that the crisis phase of EVD in Liberia had ended before the facility was ready to open. Recognizing the shifting context of the EVD crisis, the IRC reoriented its intervention to address the more immediate gaps in the healthcare system. In the long run, we believe that this works out in favor of the GOL and the people of

Liberia, since little is being done elsewhere to re-open regular healthcare facilities, but in the short term, the IRC was prevented from starting its work, and lost considerable time and momentum due to construction delays by WHO.

Another major constraint for the IRC in Q1 was the unpredictable nature of the Ebola outbreak. Whereas initial estimates had the virus spreading to millions of victims, following a spike in deaths in November, December saw a sudden and major decline in the number of victims. For practical purposes, the opening of another ETU would have been an inefficient use of resources. What this has meant for the IRC is that a program that had been destined as primarily an ETU is now pivoting, at the request of the GOL and USAID/OFDA, to a program that will support the safe re-opening of regular healthcare facilities in Monrovia. This has led to significant reconfigurations of the staff, including a number of terminations, and has required the IRC to re-draft its plans for the future to fulfill expectations by both GOL and USAID/OFDA.

Finally, as the project has pivoted to support the safe restoration of health services, there has been significant top-down pressure by the GOL to immediately re-start all services in the country, including the health care system, schools, and other high-risk workplaces where Ebola could quickly be transmitted. However, the vast majority of staff members in those locations still have not received adequate training in Ebola screening and prevention protocols, nor do they have equipment (including basic material such as thermometers and hand-washing stations) required to safely manage their facilities against the danger of Ebola. The IRC's partners in hospitals and health clinics are therefore under intense pressure to re-open their facilities before safety can be assured, which means that the IRC is continually being asked by our local partners (and by proxy the GOL) to sacrifice safety for speed.

V. Activities for the Following Quarter:

In Q2, the IRC will give particular emphasis to helping Redemption Hospital to re-open as safely as possible.

Infrastructure rehabilitation at Redemption Hospital:

The major initiative for the IRC in Q2 will be to rehabilitate key sections of Redemption Hospital, specifically the pediatric ward, emergency ward, sewage system, and waste management facilities. We anticipate completing this activity in Q2, and perhaps adding additional rehabilitation work on facilities such as the morgue.

Coordination among partners, government, and staff at Redemption:

Also at Redemption, the IRC will help coordinate the many international partners operating in and around the hospital. This is essential to the safe and efficient re-opening of the facilities, as the administration needs assistance, and there has been a lack of clarity in terms of who is supposed to be doing what.

Finalizing SOPs and training staff at Redemption:

The Health team will finalize and update its SOPs to account for the new context, and will train medical staff in their use.

Startup of clinical treatment for pediatrics and obstetrics at Redemption:

When the Redemption pediatrics and emergency wards are rehabilitated, the IRC intends to deploy medical staff to begin providing clinical treatment in the hospital.

Infection prevention and control in Montserrado County:

Through the WASH team, the IRC will also focus on IPC management, including supply and training, across health facilities in Montserrado County, with a particular emphasis on Redemption Hospital.

Psychosocial care and focused community mobilization:

In terms of protection and psychosocial support, the IRC will be closely involved in community mobilization efforts and training around both Redemption Hospital and the SKD ETU. We will conduct training for local Task Force officials and community leaders in psychological first aid and peer support; will facilitate creation of peer-led support groups; and will lead dialogues to mitigate against stigma and discrimination related to EVD. Inside Redemption Hospital, the team will focus on the quality, accessibility, and responsiveness of mental health services, including staff well-being as well as community engagement and public perception of the hospital.