



**USAID**  
FROM THE AMERICAN PEOPLE



**Samaritan's Purse®**



**Ebola Community Protection Program**  
Agreement No. AID-OFDA-G-15-00005—Final Report

**Field:**

**Kendell Kauffeldt**  
Country Director,  
KKauffeldt@samaritan.org  
Liberia  
(+231) 886 929 102

**Head-Quarters:**

**Aaron Ashoff**  
West Africa Regional Director,  
AAshoff@Samaritan.org  
Boone, North Carolina, USA  
+1 (828) 719-8261

## Table of Contents

List of Figures .....	2
List of Tables .....	2
Executive Summary.....	4
Introduction .....	4
Project Results .....	6
Number of Beneficiaries (Targeted vs Actual) .....	6
Overall Project Implementation and Performance.....	6
Health Sector Activities.....	7
Water, Sanitation and Hygiene Sector Activities .....	14
Logistical Support and Relief Commodities Sector Activities .....	15
Success Story.....	16
Challenges, Lessons Learned and Recommendations .....	17

## List of Figures

Figure 1: Targeted Areas of Implementation.....	5
Figure 2: Community members who are able to correctly identify methods of contracting EVD.....	10
Figure 3: Community members who are able to correctly identify symptoms of EVD.....	10
Figure 4: Schools where children were carrying out hand washing.....	12

## List of Tables

Table 1: Project Beneficiaries.....	6
Table 2: Sector 1 – Health.....	7
Table 3: Sector 2 – Water, Sanitation and Hygiene.....	14
Table 4: Sector 3 – Logistical Support and Relief Commodities.....	15

## Acronyms

ARC	American Refugee Committee
CCC	Community Care Center
CDC	Centers for Disease Control and Prevention
CHO	County Health Officer
CHW	Community Health Worker
ETU	Ebola Treatment Unit
EVD	Ebola Virus Disease
gCHV	Government Community Health Volunteer
GOL	Government of Liberia
HH	Household(s)
IHBI	Interim home-based interventions
IMC	International Medical Corps
IMS	Incident Management System
IPC	Infection Prevention and Control
MOH	Ministry of Health
NFI	Non-food Items
PPE	Personal Protective Equipment
RITE	Rapid Isolation and Treatment of Ebola
SP	Samaritan's Purse International Relief
UNICEF	United Nations Children's Emergency Fund
USAID	United States Agency for International Development
WHO	World Health Organization

## Executive Summary

The Samaritan's Pledge (SP) Ebola Community Protection Program was implemented in Lofa, Gbarpolu, River Gee, Grand Kru, Margibi and Montserrado counties in Liberia from September 16, 2014 to June 30, 2015. The initial project comprised of a health and logistics component, with a Water, Sanitation and Hygiene (WASH) component also added during the no cost extension.

Through both the health and logistical support and relief commodities sectors, 50,582 Infection Protection and Control (IPC) kits were distributed to households (HHs) in five counties. A total of 309,974 direct beneficiaries were reached with Ebola Virus Disease (EVD) awareness messaging during the project. Through the health sector activities, SP operated and de-commissioned three Community Care Centers (CCC) in three counties and trained Rapid Isolation and Treatment of Ebola (RITE) teams in five counties. A total of 171 health care workers were trained by SP to staff the CCCs and respond to EVD outbreaks. Through the WASH sector, which was added during the no cost extension, 5,614 community members and students were able to benefit from rehabilitated WASH facilities at schools in four communities. A total of 631,924 kg of commodities was transported through the logistical support and relief commodities sector during the project.

## Introduction

Due to the consistently changing nature of the EVD outbreak in Liberia and the ever evolving strategy of the Government of Liberia (GOL) and partners to respond, multiple strategies were implemented throughout the project to contribute to the overall goal of reducing the transmission of EVD. Implementation of activities was coordinated at multiple levels; the county level, community level and household and individual level. Community Care Centers were established and operated by SP to be an initial point of isolation for suspected EVD cases in counties that did not yet have an Ebola Treatment Unit (ETU) operational or the distance to the ETU was far. Rapid Isolation and Treatment of Ebola teams were also established at the county level with members of the County Health Team (CHT) trained in implementing a RITE response. At the community level, the strategy also shifted along with the changing nature of the outbreak. Initially, the focus was on creating EVD awareness and dispelling traditional myths about the disease. Coupled with this awareness, IPC kits were distributed to HHs to aid in preventing EVD transmission. As the number of cases decreased, the focus of community level awareness shifted to EVD preparedness planning to avoid future outbreaks and encouraging the resumption of regular health services. Psychosocial support to EVD affected persons at the community, household and individual level has also been a key component of programming throughout the project.

Figure 1: Targeted areas of implementation



Code:	Location:	Activities implemented:
<i>Yellow highlighted counties</i>	Lofa, Gbarpolu, River Gee, Grand Kru	4 main target counties where all IPC kit distributions, community-based EVD awareness, psychosocial activities and RITE training were implemented.
<i>Green highlighted counties</i>	Montserrado, Margibi	Initially targeted with IPC kit distributions, community-based EVD awareness and psychosocial activities, but ended implementation in these counties in December 2014 to concentrate efforts on more remote areas, with less partners implementing activities.
<i>Purple highlighted counties</i>	Maryland	Completed RITE training.
<i>Blue stars</i>	Zorzor, Lofa County; Morlakwelleh, Gbarpolu County; Fishtown, River Gee County	Indicates where SP operated and decommissioned CCCs. SP constructed CCCs were in Zorzor (Lofa) and Fishtown (River Gee). UNICEF constructed the CCC in Morlakwelleh (Gbarpolu).
<i>Red dot</i>	Gelensiyasu, Gbarpolu County	Indicates where SP completed a RITE response

## Project Results

### Number of Beneficiaries (Targeted vs Actual)

The program targeted 50,000 HHs to receive IPC kits, whereas slightly more than this was achieved, with an additional 582 HHs receiving kits. The total achieved number of beneficiaries for both the health and logistics sectors (which is the same group of beneficiaries) is less than that which was estimated as the target. This is due to beneficiary numbers having been estimated based on population information for each of the target counties that was obtained from the most recent census in 2008. In addition to the inaccuracy in population estimates, not every village in each target county was reached with IPC kits and awareness to avoid overlap with other partners who came in later to complete similar awareness activities. The beneficiary data is summarized in Table 1 below.

Table 1: Project Beneficiaries

Groups / Sectors	Target	Achieved
	Beneficiaries	Beneficiaries
Household recipients of IPC kits	50,000	50,582
Health - Total	484,953	309,974
Water, Sanitation and Hygiene - Total	N/A	5,614
Logistics Support and Relief Commodities – Total	484,953	309,974

### Overall Project Implementation and Performance

The overall project objective was to reduce transmission of EVD in Liberia. This objective was achieved through activity implementation in three sectors: 1) health; 2) WASH; 3) logistical support and relief commodities.

Due to the emergency nature of the project and standardized indicators to be reported on that were based only on activities achieved, a formal baseline survey or final evaluation were not conducted. However, activities and targets achieved were tracked throughout project implementation and are summarized in the tables below. Additionally, follow-up was regularly conducted after EVD awareness and IPC kit distribution was completed in targeted communities to assess beneficiary usage of IPC kits and practice and understanding of the EVD preventative health messages they had been taught. Although conducting a formal survey to assess impact wasn't included in program activities or added given the limited timeframe and geographical dispersion of activities, informal surveys were completed as part of standard follow-up procedures. These surveys were completed in target communities and schools to assess effectiveness of the implementation of EVD prevention plans and protocols. Results of this follow-up are included in the report.

## Health Sector Activities

Due to the nature of programming, health sector activities formed the bulk of project activities.

### Summary of Health Sector Accomplishments:

- Operated three CCCs in three counties (Lofa, Gbarpolu and River Gee); constructed two of these (Lofa, River Gee).
- Trained RITE teams in five counties (Lofa, Gbarpolu, River Gee, Maryland, Grand Kru) and CCC staff, comprising of a total of 171 health care workers.
- Initiated one RITE response to a remote EVD outbreak (Gounwailala District, Gbarpolu County).
- Reached 50,582 HHs with IPC kits and EVD awareness messaging.
- Trained 868 community leaders in implementing EVD preparedness plans in their communities.

The table below summarizes health indicators achieved.

Table 2: Sector 1 - Health

Indicator	Details	Baseline	Achieved	Target
<b>Sub-Sector: Health Systems and Clinical Support</b>				
<b>Number of healthcare facilities supported and/or rehabilitated by type*</b>	Community Care Centers	0	3	5
	Physician Assistants	0	30	N/A
<b>Number of healthcare providers trained by type</b>	Nurses, Nursing Assistants and Hygienists	0	129	N/A
	Community Health Workers	0	12	N/A
	Total	0	171	N/A
<b>Number and percentage of health facilities submitting weekly surveillance reports</b>	Community Care Centers	0 (0%)	3 (100%)	5 (100%)
<b>Number of consultations, by sex and age</b>	Male (15-49 yrs)	0	3	N/A
	Female (15-49 yrs)	0	1	N/A
	Female (50-60 yrs)	0	1	N/A
	Total	0	5	N/A
<b>Sub-Sector: Communicable Diseases</b>				
<b>Number and percentage of cases diagnosed and treated per standardized case-management protocols, by sex and age**</b>	Male (15-49 yrs)	0	2	N/A
	Female (50-60 yrs)	0	1	N/A
	Total Number	0	3	N/A
	Total Percentage	0%	2.63%	N/A
<b>Case fatality rates for diarrhea, ARI, measles, and other, by sex and age</b>	Other - Male (15-49 yrs)	0%	100%	N/A
	Other – Female (50-60 yrs)	0%	0%	N/A
	Other - Total	0%	66.67%	N/A
<b>Sub-Sector: Community Health Education/Behavior Change</b>				
<b>Number of community health workers (CHWs)</b>	Male	0	4	N/A
	Female	0	8	N/A

Indicator	Details	Baseline	Achieved	Target
trained and supported, by sex	Total	0	12	N/A
Number and percentage of community members utilizing target health education-message practices	Number***	0	36,346	N/A
	Percentage	0	83.95%	N/A
<b>Sub-Sector: Medical Commodities Including Pharmaceuticals</b>				
Number of supplies distributed by type	IPC kits	50,000	50,582	N/A
Number of people trained, by sex, in the use and proper disposal of medical equipment, and consumables	Male	0	232	N/A
	Female	0	104	N/A
	Total	0	336	N/A
Number and percentage of health facilities, supported by USAID/OFDA, out of stock of selected essential medicines and tracer products for more than one week	Number of CCCs	0	0	0
	Percentage of CCCs	0	0%	0%

*\*SP originally constructed and operated two CCCs, with an additional three CCCs planned to be operated as well. The additional three were constructed by UNICEF, however due to the delay in completion of construction and reduction in EVD cases, two of these CCCs were never opened.*

*\*\*None of the three cases listed as being treated in SP operated CCCs tested positive for EVD, yet were treated in the suspect ward due to symptoms displayed. Also, the total percentage is not disaggregated due to reports from the Ministry of Health (MoH) not including disaggregated data. The percentage is derived from the total # of cases treated by SP (3)/the total # of EVD cases in areas where SP worked (114).*

*\*\*\*Although this standardized indicator requires both the number and percentage to be reported, the number is not representative as only a sample of beneficiaries were measured to assess whether they were utilizing health messages. Thus it is only the sample number that was reported and the total number remains unknown. As a result, for this indicator, reporting in percentage form is more accurate than number form.*

### **Community Care Centers (CCCs)**

Samaritan’s Purse initially planned to construct and operate up to 15 CCCs in Liberia; two of which were constructed in Zorzor, Lofa County and Fishtown, River Gee County. Since these initial CCCs were constructed, the CCC strategy endorsed by the Government of Liberia (GOL) changed; prioritizing 15 new CCC sites selected across the country to be constructed by UNICEF and operated by USAID implementing partners. Samaritan’s Purse was asked to operate three of these additional CCC sites; two in Gbarpolu County and one in River Gee County. During the second quarter of the project, UNICEF completed construction on the CCC in Morlakwelleh, Gbarpolu County, which SP operated for the remainder of the quarter, after which it was decommissioned and handed over to the CHT. Construction of the remaining two CCCs was completed at the end of the second quarter and due to the reduction of

EVD cases and the lack of need to open the facilities, discussions were held with the respective CHTs and OFDA Disaster Assistance Response Team (DART) members and these sites were turned directly over to the CHTs as a result.

Due to the reduction of EVD cases and the ETU in Zorzor becoming operational, the Zorzor CCC was closed at the beginning of February, fully de-commissioned and handed over to the CHT for future use as a treatment facility, should the need arise. The Fishtown CCC continued to operate throughout the entire second quarter and was closed, de-commissioned and turned over to the CHT at the end of March. As the ETU in Fishtown never opened, the American Refugee Committee (ARC) began supporting the CHT in running this CCC as an isolation facility until a more permanent structure could be constructed within the existing health infrastructure.

*"My brother, Ebola is real because it killed so many people in Liberia. So, for you to come and teach us about Ebola and how to properly wash our hands is a good thing. Look at this community, we don't have buckets for hand washing or even chlorine to use, but we must tell God thank you that you have come to distribute them so that we can practice what we are hearing everyday".*

**~ Fancain Jallah, Nyorkoitahun Town Chief, Kolahun District, Lofa County**

### ***Infection Prevention and Control (IPC): Education and Protection for Non-Infected Households***

The IPC activities have been on-going since the project started. A total of 50,582 HHs in six counties received IPC kits, training in usage of the kit contents and EVD awareness education. During follow-up visits to assess usage of the IPC kits, it was found that 84% of HHs were utilizing the kits they received. The EVD awareness and education training that accompanies kit distribution has been essential in helping to dispute some of the traditional myths surrounding the cause and treatment of Ebola amongst community members. During the no cost extension, informal follow-up surveys were conducted with community members in communities that had received EVD awareness to assess the level of knowledge. Figure 2 below shows

the percentage of community members interviewed during follow-up who could correctly identify methods of EVD transmission. Of the 441 community members interviewed, touching the body of someone who has died from Ebola was identified by 86% as a means of contracting Ebola. This illustrates a vast improvement of knowledge and acceptance since the onset of the outbreak, when traditional burial practices were still being maintained. Figure 3 below shows the percentage of community members interviewed that could correctly identify symptoms of EVD. Of the 441 community members interviewed 81% could identify at least four of the most common symptoms indicative of Ebola. Only 1% of respondents did not know any symptoms of EVD; also indicative that awareness activities had been impactful.

Figure 2: Community members who are able to correctly identify methods of contracting EVD

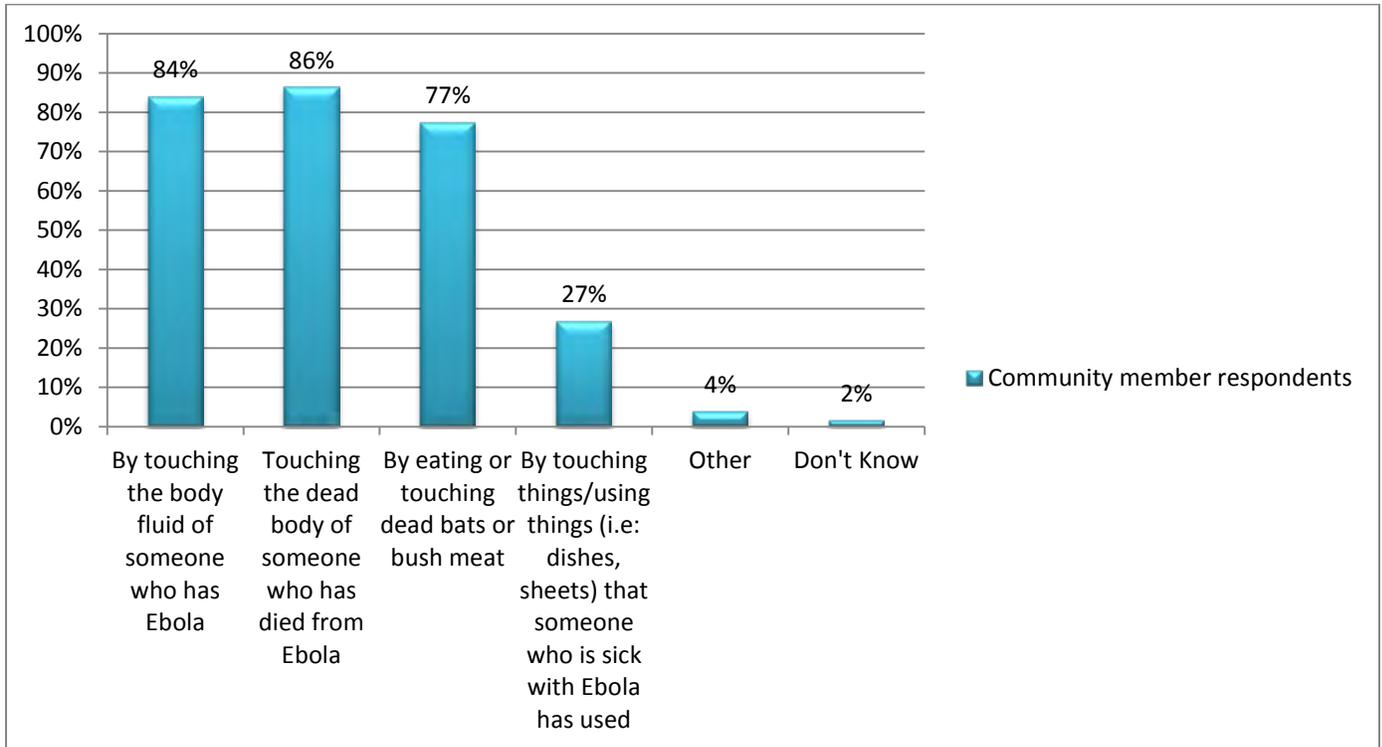
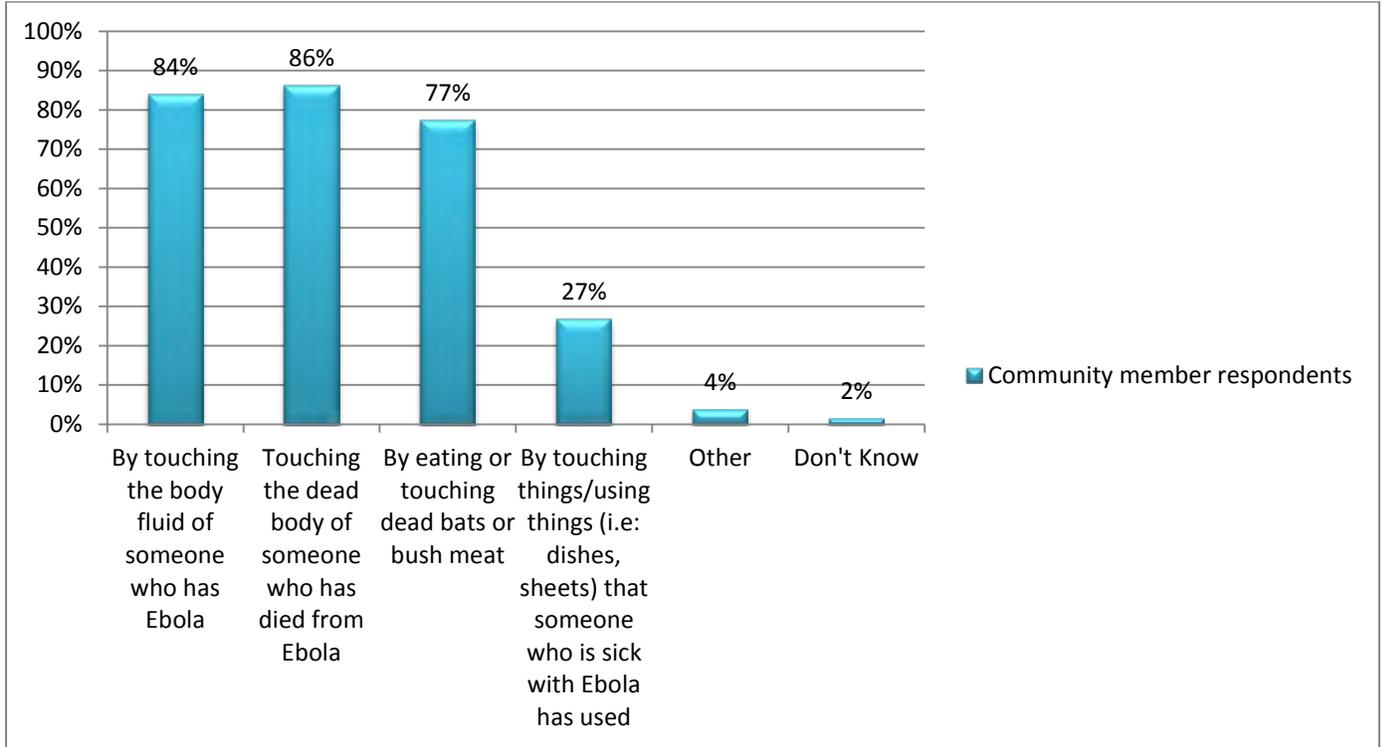
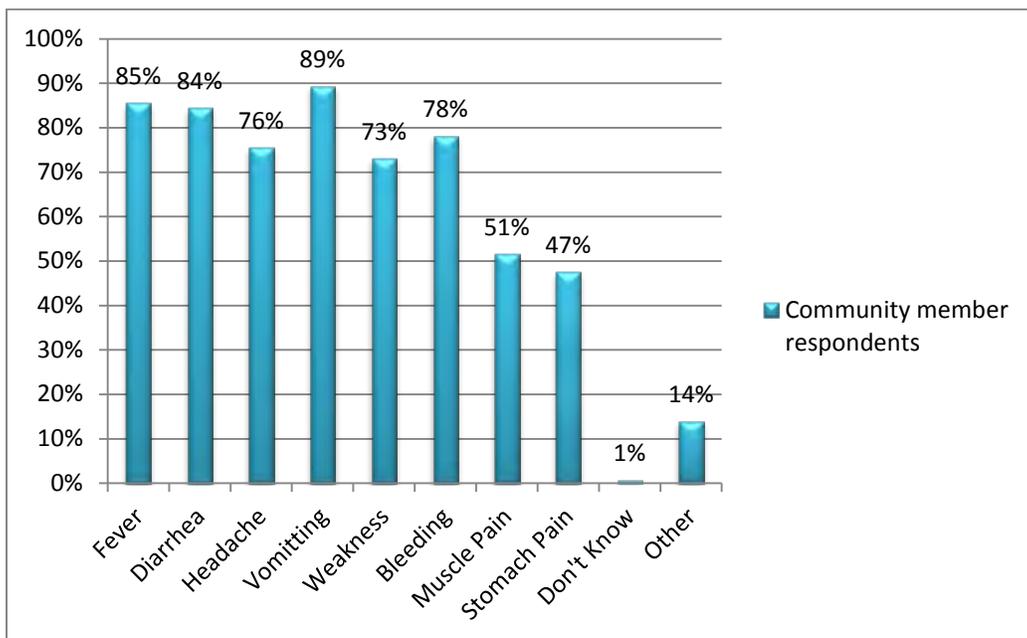
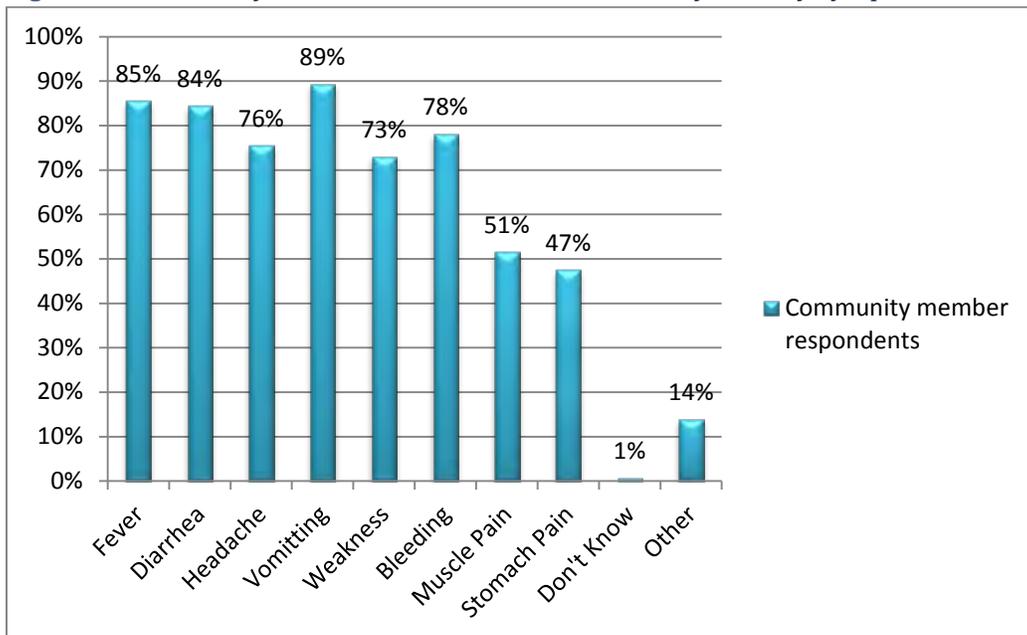


Figure 3: Community members who are able to correctly identify symptoms of EVD



**Rapid Isolation and Treatment of Ebola (RITE) Response**

Samaritan’s Purse has been the lead partner for supporting the CHTs/CHTs in RITE response activities in Lofa, River Gee and Gbarpolu counties. In coordination with the CHT and Centers for Disease Control and Prevention (CDC) during the first quarter of activities, SP responded to a remote hotspot in

Gbarpolu County that was inaccessible by vehicle. Due to the rapid and emergency nature of the RITE strategy, initially RITE team members consisted of both CHT staff and SP staff. However, in line with the government's strategy to promote capacity building and ownership to manage future EVD outbreak responses at the county level, SP trained selected CHT staff in Lofa, Gbarpolu, River Gee, Grand Kru and Maryland Counties in initiating and operating a RITE response. Additionally, at the request of the EVD Incident Management System (IMS), MoH and the World Health Organization (WHO), SP collaborated with International Medical Corps (IMC) to draft a RITE manual with recommendations for future strategy and training plans moving forward.

### ***Interim Home-Based Interventions (IHBI): Education, Prevention, and Supportive Care for Infected Households***

Initially, when the EVD outbreak was widespread and space in ETUs unavailable, up to 3,000 EVD patients were targeted to benefit from home-based interventions; training and equipping caregivers with kits to provide temporary home-based care. However, with the decrease in EVD cases and the government's adoption of the strategy to construct CCCs, no IHBI kits were distributed or caregivers trained. Some of the IHBI kit supplies that were purchased initially were re-purposed for use in RITE responses and staff trained in IHBI were used to support IPC awareness activities instead.

### ***Psychosocial Support Activities***

A total of 285 counselling sessions were facilitated by trained SP staff, who met with individuals, households and communities that were affected by EVD. At least 510 individuals who had been directly affected by EVD benefited from these counselling sessions and 60 EVD survivors were linked to survivor networks. Most of the counselling sessions were conducted in Lofa County, as it was the hardest hit by EVD amongst the counties where SP implemented activities. During the no cost extension, psychosocial activities were expanded beyond individual and household counselling sessions to include interactive and group psychosocial activities held at schools in highly affected communities.

Activities included inter-class and inter-school sporting events and dramas as well as counselling. A total of 20 schools benefitted from these activities, with a total of 411 students (234 males and 177 females) participating.

### ***Community EVD Preparedness Leadership Training and Follow-up***

During the no cost extension, additional activities were added that involved more closely targeting community leaders due to their overarching influence in their respective

*"I want to thank God and the American people who give the money for the program to go on and Samaritan's Purse staff for their courage and the comfort they provided me and my family. If SP couldn't have come at this time I could do something bad to myself because I had completely given up. But now I feel better because my friends are now visiting me and I feel encouraged."*

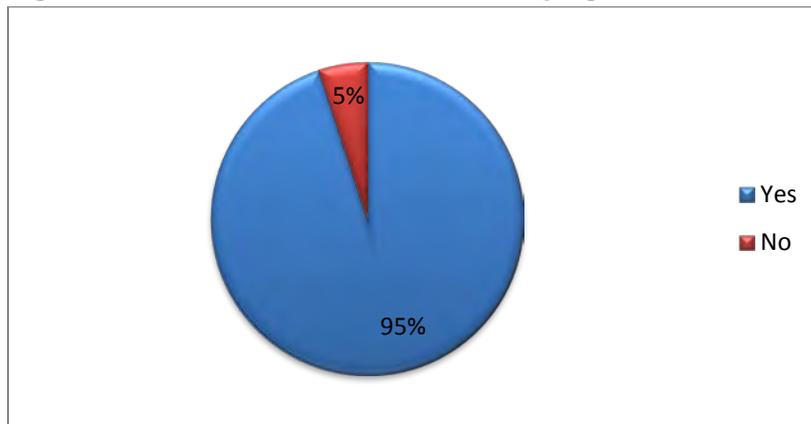
**~ Nowai Kollie, EVD survivor, Salayea, Lofa County**

communities. A total of 868 community leaders from SP's four target counties were trained in implementing EVD preparedness plans in their communities. After training leaders, staff followed up with these communities to ensure EVD plans had actually been put into place and leaders were implementing what they had learned in the training. Of the 437 community members interviewed from a total of 228 communities, 93% said their chiefs/community leadership had implemented EVD preparedness plans in their communities. When asked what plans entailed, answers focused on isolating anyone showing symptoms of EVD and informing the town chief, the government community health volunteer (gCHV) and relevant health authorities; ensuring the town chief is aware of all strangers entering the town; no secret burials practiced and deaths reported to health authorities, continual hand washing and prohibiting eating bat or monkey meat. Also, all but one respondent (99.7% of respondents) stated that they would go to a health facility if they got sick with any type of illness, with the one respondent who said they would not go stating the far distance to the health facility as the reason. This also demonstrates an improved level of trust by community members in health facilities as this was also viewed as an issue earlier on in the outbreak.

### ***School Follow-up***

Also during the no cost extension, follow-up was conducted at 166 schools in Lofa, Gbarpolu, River Gee and Grand Kru counties to assess usage of the IPC kits that had been distributed nation-wide and to ensure proper hygiene protocols were being followed. Of the number of schools visited, only two had not received the IPC kits and all schools who had received them had been trained in their usage; although the length of training varied amongst schools. Of the schools that received kits, 95% were using the kits as seen in Figure 4 below.

Figure 4: Schools where children were carrying out hand washing



In 95% of the hand washing stations there was water, whereas 5% were empty. Soap or chlorine was present at 91% of the hand washing stations, with 9% missing or out of these items. Thermometers were being used to check children's temperatures in 91% of schools visited, although it was reported that in some schools children who came late were not having their temperatures checked. Schools that were not using thermometers reported that they never received them with the kit, they had broken or in some cases they felt they were no longer needed as Liberia had recently been declared Ebola free.

However, even though most schools had received and were using hand washing kits, a common observation of the schools, was that many lacked safe water sources or sanitation facilities.

### **National Measles Immunization Campaign Awareness**

A nation-wide measles immunization campaign was launched in early May as an effort to vaccinate children who had missed out on vaccinations during the time when the EVD outbreak was widespread. Due to all of the fear and misinformation surrounding the campaign,<sup>1</sup> OFDA implementing partners were asked to also help disseminate correct information and provide awareness about the campaign to ensure effectiveness. Samaritan’s Purse conducted awareness in over 200 communities in Lofa, Gbarpolu, River Gee and Grand Kru counties. To assess the effectiveness of the awareness messaging conducted, during community follow-up visits, SP staff interviewed community members who had children under five years of age to see if they had taken their children to be vaccinated. Of the 406 community members interviewed, 98% reported that their child had been vaccinated. Only 1% of all respondents interviewed said they did not take their child to be vaccinated for fear that they would get Ebola.

### **Water, Sanitation and Hygiene Sector Activities**

Due to the consistently changing nature of the EVD outbreak and the need to shift project activities to stay relevant and effective, a WASH component was added to the program during the no cost extension. With school being declared open again and EVD cases still present in neighboring Guinea and Sierra Leone, completing WASH rehabilitation activities at schools within proximity of the border regions, became a priority. Using funds that had been originally slated to operate up to 15 CCCs, four schools situated close to the Guinea or Sierra Leone border benefited from rehabilitation of their WASH facilities.

#### **Summary of WASH Sector Accomplishments Achieved:**

- Four hand pump wells were rehabilitated at four target schools along the Guinea/Sierra Leone border.
- Three institutional latrines, including 17 (8 male, 8 female and 1 for teachers) cubicles, were rehabilitated at three target schools along the Guinea/Sierra Leone border.
- Eight pump technicians were trained in total; two at each of the target schools to maintain hand pumps.

The table below summarizes WASH indicators achieved.

Table 3: Sector 2 – Water, Sanitation and Hygiene

Indicator	Baseline	Achieved	Target
<b>Sub-Sector: Hygiene Promotion</b>			
<b>Number of people receiving direct hygiene promotion (excluding mass media campaigns and without</b>	0	1,025*	N/A

<sup>1</sup> Common rumors circulating among community members were that the measles vaccine would give their children Ebola and as such many people were initially afraid to take their children to be immunized.

<b>double-counting)</b>			
<b>Sub-Sector: Sanitation Infrastructure</b>			
<b>Number of people directly benefitting from the sanitation infrastructure program</b>	0	1,025	N/A
<b>Sub-Sector: Water Supply Infrastructure</b>			
<b>Number of people directly benefitting from the water supply infrastructure program</b>	0	5,614**	N/A

*\*Direct hygiene promotion activities focused on the student population at each of the 4 targeted schools where WASH activities took place. The communities where these schools were situated benefited from EVD awareness and IPC education and were included in the numbers reported under health sector activities and thus were not reported on for this indicator to avoid double-counting.*

*\*\*Those benefitting from water supply include both the school and community population as both the school and community will have access to the rehabilitated well.*

### Logistical Support and Relief Commodities Sector Activities

Logistical support has been critical to the success of the EVD response and implementation of project activities. Both the procurement of supplies and the movement of both commodities and personnel have enabled the construction of two CCCs, operation and de-commissioning of three CCCs, distribution of IPC kits and both initiating a RITE response and training RITE teams in five counties. Through the entirety of time that the CCCs were operating, there was never a shortage in stocks of medicine or Personal Protective Equipment (PPE). The project originally planned for the operation of up to 15 CCCs and thus supplies to enable the operation of these facilities were purchased at the onset. However due to the unpredictability of the EVD outbreak and the reduction of cases, significant excess supplies were un-used and remain in storage. During the project, SP received approval for some of these excess supplies to be used at the Foya Transit Center, which will remain in operation until the end of the year once safe isolation capabilities are established at the Foya Borma Hospital. A disposition plan for these supplies has been submitted to the AOR for review. Upon approval, these supplies will be distributed as is outlined in the plan.

#### Summary of Logistical Support and Relief Commodities Sector Accomplishments Achieved:

- IPC kits were transported to 50,582 HHs; many of which were situated in inaccessible and hard-to-reach areas.
- A total of 464 flights operated in order to move personnel and commodities to accomplish project objectives.
- A total of 631,924 kgs of commodities were transported by air, land and sea to ensure the distribution of IPC kits, the operation and decommissioning of the CCCs, and implementation of RITE activities.

The table below summarizes logistical support and relief commodities sector indicators achieved.

Table 4: Sector 3 – Logistical Support and Relief Commodities

Indicator	Details	Baseline	Achieved	Target
<b>Sub-Sector: Non-Food Items (NFIs)</b>				
<b>Total number and per item USD cost of NFIs distributed, by type</b>	Number - Water containers	0	101,164	N/A
	Unit cost – Water containers	N/A	\$1.93	N/A
	Number - Other	0	521,753	N/A

	Unit cost - Other	N/A	\$2.99	N/A
<b>Total number of people receiving NFIs, by sex and type</b>	Male – Water containers	0	27,382	N/A
	Male – Other	0	27,382	N/A
	Female – Water containers	0	23,200	N/A
	Female – Other	0	23,200	N/A
	Total – Water containers	0	303,492	300,000
	Total - Other	0	303,492	300,000
<b>Sub-Sector: Transport (Air/Land/Sea)</b>				
<b>Total USD cost of transport, by type</b>	Commodities	N/A	\$880,941.01	N/A
	Personnel	N/A	\$118,455.42	N/A
	Total	N/A	\$999,396.43	N/A
<b>Total number of flights/trips provided, by type</b>	Commodities	0	146	N/A
	Personnel	0	318	N/A
	Total	0	464	N/A
<b>Number of people transported, by transport type</b>	Land	0	4	N/A
	Air	0	1,393	N/A
	Total	0	1,397	N/A
<b>Total kilograms of commodities transported, by transport type</b>	Land	0	351,641	N/A
	Sea	0	25,500	N/A
	Air	0	254,782	N/A
	Total	0	631,924	N/A

## Success Story

After surviving Ebola, stigma and other obstacles continue to plague survivors. For KK, after surviving the virus, he then had to deal with rejection as he returned home to his community. KK came out of the treatment center thankful to be alive. He left with a bed sore still healing, but thankful that he was going to be able to continue to provide and care for his four children and return home. However, he was faced with rejection and shame upon entering his village, Nyorkoitahun in Lofa County; one of the hardest hit areas of Ebola in Liberia. Not only did his community reject him, but so did his family. He was denied access to using any toilet in the village and was referred to as ‘Ebola man.’ He felt discouraged and began to lose hope. Then SP staff came into his community providing psychosocial visits.

KK said, ‘When SP came into this community, they identified with me and tried to know my problems. I explained to the staff exactly what happened. I feel encouraged because the counsellor made me understand that when you survive from Ebola you can still be useful in the society. Another thing I have realized is that your presence in this community has made the community people to change their attitude toward me; they are now even trying to share food with me. The town chief told them not to call me ‘Ebola man’ again. Now I feel good about life and want to praise God for this.’

## Challenges, Lessons Learned and Recommendations

Since this project responded to an EVD outbreak that was unprecedented in both geographical scale and numbers of people infected, many of the challenges that resulted were simply due to the fact that the international and national response to the crisis was the first of its kind. The constantly changing strategy of both the Government of Liberia and international community presented challenges to implementation and also resulted in the amount of excess supply that remained un-used. However, the consistently changing strategy was also partly a result of the changing nature of the outbreak and the many 'unknowns' that were being considered. There were also implementation challenges due to a lack of coordination - at all levels - among actors responding to the EVD crisis; especially at the onset. The influx of organizations that began working in Liberia to respond to Ebola; all coming in with varying levels of knowledge of the context and a lack of coordination resulted in challenges avoiding duplication of some activities. Also, price increases of local commodities and salary scales also presented challenges at times. Although this is difficult to avoid in an emergency situation, better coordination from the onset could have solved some of these challenges. Improved initial coordination at the government level; between the national government and the county authorities, would have also been beneficial for a more effective response to EVD.

The RITE strategy, which also evolved throughout the project, could also have benefited from improved coordination and communication between partners and also within the levels of government. In training RITE team members that had been selected by the respective County Health Officer's (CHOs), it was found that some of the team members selected were unqualified or poorly informed about the role they were expected to fill in a RITE response. Also, with limited resources available, compensation and motivation for these participants will threaten the sustainability of implementing this strategy at the county level.

Throughout implementation of all project activities, working through and building the capacity of traditional leadership structures cannot be over emphasized. Although, all project activities were implemented in close coordination with government authorities at all levels, the traditional leadership structures must also be highly valued and incorporated into all activities to ensure effectiveness. Although government leaders definitely have a high level of authority, this is not always recognized or respected at the community level, where traditional or religious leadership structures can often times hold more influence. Prioritizing working with these leaders, especially when it relates to behavior change or altering traditional customs and practices is critical to an effective response.

The importance of both consistent messaging and follow-up was also a lesson for SP that was reinforced through project implementation. Especially important due to the health and EVD focus, ensuring messaging is accurate and in-line with the government and other partners is critical. Continuous follow-up, especially in behavior change messaging, is critical and must be an essential component to all future programs implemented.

