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Final Evaluation of Ebola Community Care Centers (EC3) Project in Liberia

DECEMBER 2015

This publication was produced for review by the United States Agency for International Development (USAID), Office of Foreign Disaster Assistance (OFDA). It was prepared by Project Concern International (PCI Liberia). The authors are Principal Investigator Justice Ajaari (MSc.Med.) and Contributing Investigators Emmanuel Mahama (MSc.) and Alexander Ansah Manu (MD, PhD)

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ACKNOWLEDGMENTS

The Consultant and the Evaluation team for the EC3 project would like to thank the PCI Liberia team, specifically: PCI Liberia Country Director Jolene Mullins; PCI International Office Monitoring and Evaluation Technical Advisor Jennifer Simpson; PCI Liberia Monitoring and Evaluation Manager Woldu Terefe; and EC3 Project Coordinator Rebecca Martinez for their invaluable technical and logistic support.

We thank Jim DiFrancesca and Magdalene Larrance of PCI international office for the insight, inputs and the tremendous feedback they provided in the design of the evaluation methodology and evaluation instruments.

We are also grateful to the County Medical Officers and the entire membership of the County Health Teams (CHT) of Bomi County, Bong County, Nimba County and Grand Cape Mount County for their support in conducting County level Indepth Interviews (IDIs), access to 87 Health Facilities in their respective Counties to Conduct Health Facility Assessment and their overall invaluable contribution to the success of this evaluation. The team is also very grateful to the District Health Teams (DHT) their entire membership for their participation in the study. We are thankful to the Managers and Staff of the 87 Health Facilities in Bong County, Nimba County, Bomi County and Grand Cape Mount County for the enormous support they provided to the evaluation team (in spite of the busy schedules) to conduct a successful health facility assessment.

We are thankful to the Town Chief and the Community members of the communities that were involved in pretesting for the enormous support they provided to the evaluation team to conduct a successful pretesting exercise in their communities.

We also appreciate the enormous contribution of the general Community Health Volunteers (gCHVs) in the four counties who participated in the evaluation and provided invaluable support to the evaluation team in reaching the deprived and remote communities and organizing focus group discussions (FGDs) and conducting household interviews, thereby contributing to the success of this evaluation effort.

This work would not have been possible without the committed and dedicated qualitative and quantitative fieldwork team, who traveled the length and breadth of Bong County, Bomi County, Nimba County and Grand Cape Mount County and worked day and night for data collection and transcriptions. To the gallant fieldworkers, we say bravo, well done!

We appreciate the hard work of Selwyn Mukkath and Christopher Curley of PCI Liberia towards contractual obligations and logistic support for the engagement of this amazing and exceptional fieldwork team.

Finally, we would like to say a big thank you to the entire PCI EC3 team in Liberia for its excellent logistics management in this successful fieldwork.

ACRONYMS

BPHS	Basic Package of Health Services
CCC	Community Care Centers
CDC	Centers for Disease Control
CDCS	Country Development Cooperation Strategy
CHMT	County Health Management Team
CSOs	Civil Society Organizations
DHS	Demographic and Health Survey
DRR	Disaster Risk Reduction
EC3	Ebola Community Care Centers Project
EFSP	Emergency Food Security Program
ETU	Ebola Treatment Unit
EVD	Ebola Virus Disease
FGD	Focus Group Discussions
GBV	Gender Based Violence
GCHV	General Community Health Volunteers
GDP	Gross Domestic Product
GOL	Government of Liberia
HFA	Health Facility Assessment
HH	Household
HHS	Household Survey
IPC	Infection Prevention and Control
IPTT	Indicator Performance Tracking Table
KII	Key Informant Interview
LAUNCH	Liberia Agriculture Upgrading, Nutrition and Child Health
LOP	Life of Project
M&E	Monitoring and Evaluation
MOHSW	Ministry of Health and Social Welfare
MSCM	Most Significant Change Methodology
NGO	Non-Governmental Organization
NHP	National Health Package
OFDA	Office of Foreign Disaster Assistance
OHCHR	Office of the UN High Commissioner For Human Rights
PCI	Project Concern International
PE	Performance Evaluation
PMP	Performance Monitoring Plan
PPE	Personal Protective Equipment
PPS	Probability Proportion to Size

PWD	Person with Disability
QA/QC	Quality Assurance/Quality Control
REACT	Rapid Ebola Awareness Communication and Training Program
RITE	Rapid Isolation and Treatment of Ebola
STEP	Support to Ebola Treatment Units Project
TNHP	Transitional National Health Plan
UN	United Nations
UNHAS	United Nations Humanitarian Air Service
UNMIL	United Nations Mission in Liberia
USAID	United States Agency for International Development
USG	United States Government
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization
WHO CCS	World Health Organization Country Cooperation Strategy

EXECUTIVE SUMMARY

Background; Project Concern International (PCI) has been working in Liberia since 2010 to increase access to food, reduce chronic malnutrition, and increase access to improved livelihood and educational opportunities. PCI has been responding to the Ebola Virus Disease (EVD) emergency through three different USAID/OFDA funded emergency response projects. Since the beginning of the Ebola outbreak, PCI has reached more than 190,000 people in Bong and Nimba counties with Ebola related interventions through the USAID/OFDA-funded *Rapid Ebola Awareness, Communication and Training Program (REACT)* and *Support to Ebola Treatment Unit (STEP)* projects; and as part of the USAID/FFP-funded *Liberian Agriculture Upgrading, Nutrition and Child Health (LAUNCH)* program. PCI also received funding from USAID/FFP for an Emergency Food Security Program (EFSP) in Bomi and Grand Cape Mount counties. Through these projects PCI responded to the Ebola crisis by equipping communities and health professionals with the knowledge, infrastructure, and supplies necessary to prevent the spread of Ebola and curb any possible increase in cases. Specifically, PCI is implementing and expanding community education campaigns, training health care providers, supporting infrastructure for the isolation of suspected cases, and providing supplies, such as PPEs, and sanitation necessities to minimize the spread of the virus. All of PCI's programming in Liberia integrates protection, gender and disability considerations. This includes the REACT, STEP, LAUNCH and EFSP activities that complement those implemented within the EC3 project, such as activities implemented through Care Groups; farmer groups; PTAs; training Lead Mothers; and reaching children, youth, men, women, persons with disabilities (PWD), and the elderly with Ebola prevention awareness, as well as capacity building activities and specific assistance to the most vulnerable EVD-affected households (ESFP Cash Transfer Program). PCI Liberia ensures that all staff members are trained on personal protection, and adopt the PCI Code of Conduct and comply with its practices, procedures, and guidelines. PCI responded to the Ebola emergency through different emergency response projects. The Emergency Community Care Centers (EC3) Project began October 29, 2014 and ran through December 31, 2015. PCI implemented EC3 Ebola response in Bong, Nimba, Bomi and Grand Cape Mount Counties with funding from the USAID's Office of Foreign Disaster Assistance (USAID/OFDA). PCI has been implementing the project in close collaboration with the Ministry of Health and Social Welfare (MOHSW), County health offices, District health offices, and general Community health volunteers (gCHVs). Initially planned as a six month project, during which time PCI EC3 was to construct and manage 10 Community Care Centers (CCCs), as the Ebola situation in Liberia evolved, so too did project strategy. After much negotiation with the MOHSW and OFDA, PCI EC3 ended up managing three CCCs that were constructed by UNICEF and Oxfam; Two in Nimba County (Saclepea and Karnplay) and one in Bong County (Handii).

Following an official modification to the project proposal, indicators/targets and donor agreement on July 31, 2015, PCI expanded EC3 activities into two additional counties (Bomi and Grand Cape Mount) and included a broader focus on community education and general support to existing health system structures (such as infrastructure upgrades at primary health facilities and clinical training for staff) and mechanisms (such as the Rapid Isolation and Treatment of Ebola (RITE) Teams, referral networks, etc). The two performance indicators being evaluated in this report were added to the project with this modification, i.e. the indicators only cover the period from July 2015 – December, 2015.

EC3 Project Goal: To respond to the evolving needs in communities affected by the ongoing Ebola outbreak in Liberia and to strengthen local capacity to prepare for, respond to, and recover from outbreaks in the future.

Health Sector Objective: To support the health sector to safely and adequately prepare for and treat Ebola patients.

Description of Key EC3 Activities:

Sub-sector 1: Health system and Clinical Support:

- Renovation or upgrade of the health facilities to ensure they meet all appropriate standards.
- Support the county health teams (CHTs) in case investigation, contact tracing, case management, referral and rapid response teams to identify, isolate, and treat cases at the appropriate facility.
- Train health facility staff to run the CCCs and ongoing supportive supervision of management and operations (including on-site mentoring).
- Mobilize community awareness of and support for the facilities.
- Provision of PPEs and other essential supplies.
- Support data collection, monitoring and reporting.
- Supervision, management and maintenance of the facilities, including compliance with basic protection and gender standards.
- Facilitation of data sharing between ETUs, CCCs, MOHSW and other partners.

Sub-Sector 2: Medical Commodities Including Pharmaceuticals

- Provide essential supplies for healthcare facilities and workers based on need.

Sub-Sector 3: Community Health Education / Behavior Change

- Conduct community trainings and outreach.
- Strengthen community resilience and preparedness.
- Support reintegration of Ebola survivors.
- Support cross-border initiatives.

Evaluation Objectives; The final evaluation was to assess the project's results and understand how the project management and implementation contributed to the national Ebola emergency response, assess achievement for key outcome indicators, identify successes and challenges and document the key lessons learned.

The final evaluation has the following specific objectives:

- To examine whether EC3 was efficient and effective in responding to EVD emergency response.
- To examine the behavior change of community members as a result of EC3 community level interventions.
- To measure the change of health facilities in the areas of infrastructure, supplies, clinical staff capacity and service quality.
- To assess whether the project results were achieved in line with the stated objective, sub-sector intervention and their performance targets.
- To measure two outcome level indicators of EC3 (IPTT indicators # 1.1 and 3.1).
- To assess successes, constraints, lessons learned and best practices as well as opportunities for future similar programs.

Methodology; The evaluation design employed a mixed methods approach of both qualitative and quantitative methodologies including household survey, health facility assessment using the Ministry of Health assessment tools, focus group discussions (FGD), Key informant interviews (KII) and Most Significant Change Methodology (MSCM) to assess the most significant social and behavioral changes observed at community level in addressing community attitudes towards Ebola Virus Disease (EVD) protection. Both Health Facility Assessments (HFA) and Household Surveys (HHS) were conducted in the project operation counties of Bomi, Bong, Nimba and Grand Cape Mount by a total of 30 experienced field staff trained on all aspects of the study protocols. All tools were pre-tested and revised appropriately prior to the main fieldwork. The QA/QC was implemented at multiple levels throughout

the period of the evaluation and all tools were completely reviewed for inconsistencies, blanks/missing data, appropriateness and thoroughly verified to ensure conformity with the actual state of events.

Sampling Design: As per the USAID/FFP standard guideline for evaluations¹ the survey was carried out covering the entire program intervention area/counties, therefore, the sample was drawn from all four counties to ensure sample representation. A multi-stage sampling strategy was used which included:

- Firstly, purposive and convenience sampling of counties and districts
- Secondly, systematic random sampling of primary sampling units (communities) from sampled districts.
- Thirdly, systematic random sampling of secondary sampling units (respondent's household compound/house) from the sample communities by spinning a pen. This is where a household compound (house) was selected without any knowledge of the composition of the household members through a spinning technique ensuring that, there were 2 household compounds/house between current household respondent compound/house and the next household respondent continuously.
- Fourthly, random sampling of study participants from the sampled households by tossing a coin. This where actual respondents were selected for interview through a lottery system from the selected household compound/house.

Household Survey: the HH survey was intended to primarily collect data on the performance of an outcome indicator “number and percentage of *community members utilizing Ebola health education message practices.*” The survey was designed to capture the change in community knowledge, attitude and practice as a result of the EC3 intervention. The sample households were selected using systematic random sampling technique from the total population in the geographic area. Since EC3 has no baseline study, the final evaluation followed a simple descriptive study in line with the stated objectives.

Household Survey Response Rate: a total of 420 potential respondents were contacted by the evaluation team (averaging 10 households per community for a total of 42 communities), out of this number 30 (7.1%) potential respondents refused to be part of the evaluation exercise for diverse reasons and 390 agreed to be part of the evaluation and were therefore consented and interviewed. However, during data cleaning, 12 records did not meet the required data quality standards and were therefore removed from analysis. The final cleaned dataset was based on final sample size of 378.

PCI EC3 Intervention Facilities: PCI Liberia, through its EC3 project, was operational in 87 health facilities to improve the quality of service delivery and capacity, and collected pre-intervention information using the health facility assessment checklist developed by the Liberian MOHSW. Thus, to measure the post-intervention performance for the outcome indicator “*Improved healthcare facility capacity to provide quality treatment*” the final evaluation re-assessed all 87 health facilities and reports on the percent change as a result of the EC3 project using the same facility assessment checklist used before intervention.

Response Rate: All the 87 PCI EC3 intervention Health Facilities were contacted and they all agreed to be part of the evaluation exercise. The facility leadership were therefore taken through the informed consent process and the assessment conducted. The data was taken through cleaning and ensured that the required data quality standards were met. The final cleaned dataset was based on final sample size of 87 health facilities which represents a response rate of 100%.

Qualitative Approach: The field team conducted a total of 28 qualitative interviews; 12 KIIs, 12 IDIs and 6 Focus Group Discussions (FGDs) with 84 participants in a total of 42 communities in 7 districts in the 4 intervention counties.

¹ Robert Magnani (1999): FANTA III Sampling Guide.

Each FGD included 10 community members, including a men’s group, women’s group and a mix of men, women, boys, girls, elders and religious group leaders as well. The qualitative approach of the study focused on the following:

- Knowledge of PCI EC3
- PCI EC3 interventions in the community
- Effectiveness of PCI EC3 intervention
- Behavior change as result of PCI EC3 intervention
- Observed changes in health facilities as a result of PCI EC3 intervention
- PCI EC3 achievements, successes and challenges
- Best Practices
- Opportunities for future projects
- Lessons learned
- Recommendations and suggestions

Key Findings;

- **Performance of Sub-Sector 1: Health System and Clinical Support;** the key indicator for assessing the performance of Sub-Sector 1: Health System and Clinical Support is; “Improved Healthcare Facility Capacity to Provide Quality Treatment” and the Life of Project (LOP) target for this indicator was 20% improvement. The results of the 87 PCI EC3 intervention health facilities that were involved in the health facility assessments shows that, overall, there was a significant difference of 25% increase in Improved Health care facility capacity to provide quality treatment from, 57% at pre-intervention to 82% at post-intervention. The LOP target was therefore exceeded by 5%.
- **Performance of Sub-Sector 3: Community Health Education Behavior Change;** the indicator used to assess the community health education behaviour change as; “the number and percentage of community members utilizing [Ebola] health education message practices”. The life of project (LOP) target for this indicator was 90% of the surveyed population which is calculated by summing up all respondents that indicated that they have received and are utilizing Ebola health education message practices, express as a percentage of the survey population. The numerator is all respondents that indicated that they have received and are utilizing Ebola health education message practices whilst the denominator is the entire study population.
The findings of the household surveys indicate that a majority, 366 (96.8%) of the respondents have ever received and were utilizing Ebola health education messages from PCI EC3 whilst 12 (3.2%) did not receive and were not utilizing the Ebola health education messages. Out of the 366 (96.8%) respondents who had received and were utilizing Ebola health education messages, 166 (45.4%) were males and 200 (54.6%) were females. The evaluations indicate that, this has resulted in significant behaviour change especially in; hand washing with soap under running water; environmental cleanliness and cooking food very well before consumption. The target and performance of the sub sector 3 indicator; “Number and percentage of community members utilizing Ebola health education message practices” has therefore been significantly exceeded by 6.8%.

Conclusions and Recommendations; Despite the many challenges posed by the outbreak, such as the difficult logistical hurdles posed by reaching remote areas; forging trust with new remote communities; creating rapid behavior change around entrenched cultural practices to prevent the spread of Ebola; sorting out the structural and operational challenges for managing infection prevention and

control effectively within community care clinics so as to protect the health of staff and patients; and the operational and human resource challenges posed by an ever-evolving consensus on the best strategy to fight Ebola—the EC3 project performed well and exceeded its performance targets for key activities that helped stop the spread of Ebola. This include;

- overall significant increase of 25% in improved health care facility capacity to provide quality treatment; from 57% at pre-intervention to 82% at post-intervention
- 366 (96.8%) household members received and utilizing Ebola health education messages

The success of the project could be attributed to the efficient and effective health facility and community engagements which inculcated the sense of ownership of the project among health workers and in the communities. The effectiveness of the training programs provided to the stakeholders was also a significant to the success of the project.

However, the most effective and efficient campaign strategy of the project was the use of the general community health volunteers (gCHVs) to engage community members on one-on-one. The community members were more use to the gCHVs, they therefore identified with them and the Ebola health messages that they were promoting with ease, thus, enhancing community's ownership of the project and acceptance of the Ebola health messages.

The evaluation findings strongly suggest the use of gCHVs as the most effective and efficient strategy for similar community level and facility level interventions and thus, recommend as such.

I.0. CHAPTER ONE: INTRODUCTION AND BACKGROUND

Political Context; Liberia continues to enjoy a stable and democratic government since the conflict ended in 2003. Since then, it has organized two presidential and legislative elections, including a Special Senatorial Election held in December 2014. President Ellen Johnson Sirleaf is now completing the second and final six-year term which ends in 2017. Presidential and Legislative elections are to take place in October 2017 and the newly elected government will be inaugurated in January 2018 (World Bank, 2015). While multinational peacekeeping force is still deployed in Liberia, the United Nations has lifted the suspension placed on the drawdown of peacekeepers from Liberia. The Security Council, in resolutions 2190 (2014) and 2215 (2015) set June 30, 2016 as the deadline for the Liberian Government to fully assume its complete security responsibilities from the UN Mission in Liberia (UNMIL) (World Bank, 2015). Until mid-2014, Liberia was on a stable path in implementing its ambitious medium-term development strategy, the Agenda for Transformation. However, the deadly Ebola Virus Disease, which was first reported in March 2014, lasted close to 16 months and resulted in a death toll of about 4,000 persons. The outbreak also began destroying the fabric of Liberia's economic and service delivery system (World Bank, 2015).

Economic Context; The Ebola crisis has eroded some of the important gains that Liberia has made in reducing poverty and vulnerability. The Liberian economy has been hit hard by the Ebola epidemic and the related health crisis. Real gross domestic product (GDP) growth which was estimated at 8.7% in 2013 and projected at 6% for 2014 before the crisis was estimated to be less than 1%. Rubber production and exports, which had already slowed reflecting lower international prices, were also affected by the quarantines and curfews implemented because of the Ebola crisis. Growth in manufacturing continued to be constrained by inadequate electricity and the generally weak business environment. The epidemic resulted in disruption of production processes across several sectors. Household incomes have suffered from the substantial loss of wage jobs and self-employment. In addition, the fear associated with the outbreak has considerably slowed down economic activities; large concession companies have suspended their investment plans and relocated a number of their expatriate staff to other countries (World Bank, 2015). Liberia's GDP growth forecast of 2-3% for 2015, is attributable mainly to

resumption of activities in the agriculture, construction and general services sectors. The traditional drivers of economic growth in the economy, namely iron ore and rubber are projected to decline in terms of contribution to GDP, because of falling commodity prices and low output. Agriculture sector registered negative contribution to GDP, despite modest increases in rice production during the year 2015. Services sector is the key driver of economic recovery in 2015, particularly construction (both road and residential), retail and distribution services (World Bank, 2015). The Ebola outbreak is however expected to have a substantial impact on Liberia's economy over the medium term. Expenditures directly related to the crisis and additional social protection expenditure policy will result in pushing up the fiscal deficit to 10% of GDP in FY15 and subsequently projected to ease down to 5.4 % in FY16. On the other hand, the slow-down in production as well as delays in investments in key concessions in mining and agriculture caused by the Ebola outbreak will lead to lower exports and increased trade deficit in the medium term. An effective implementation of Liberia's Post-Ebola Economic Recovery Plan is critical to mitigating the twin effects of the EVD and the declining global commodity prices, on the economy in the medium term (World Bank, 2015)

Health Context: According to the World Health Organization's Liberia Country Cooperation Strategy (CCS), Liberia's health indicators, though improving, remain unsatisfactory. The country's health sector is experiencing a transition from an emergency phase to a development phase. With support from a number of partners, the Ministry of Health and Social Welfare developed a comprehensive national health policy and a national strategic health plan (2007-2011), as well as a two-year emergency transition plan to prevent a potential crisis that was evolving as a result of the departure of a number of international nongovernmental organizations that provided the greatest share of health services during the conflict period. The National Strategic Health Plan sets out the priorities of the health sector for the five year period to include: the Basic Package of Health Services, Human Resources for Health, Infrastructure, and Support Systems. However, while the Basic Package of Health Services and Human Resources for Health are core for reviving the sector, cost implications and financing are major challenges for implementing the plan. While some level of progress has been attained in the health sector, the country's health challenges remain immense. (WHO, 2011). The USAID/Liberia Country Development Cooperation Strategy (CDCS) for Liberia indicates that, Liberia's health sector exhibits the devastation from years of conflict superimposed on a skewed and rudimentary health system that failed to meet most basic needs of the largest share of the population even before the war. According to the USAID/Liberia CDCS, the MOHSW led a participatory process of revising the National Health Policy (NHP) and the development of a five year Transitional National Health Plan (TNHP) which covered the period 2007 to 2011 was the cornerstone of the Basic Package of Health Services (BPHS) - a package of high impact interventions that GOL is committed to providing to the entire population. Even though the NHP was considered a success with improvements in under five morbidity and mortality, malaria still remains the leading cause of morbidity and mortality (USAID/Liberia CDCS, 2013-2017).

Ministry of Health Structure: A Minister who is the chair of the Health Sector Coordinating Committee (HSCC) heads the Ministry of Health. The HSCC serves as the highest decision-making body in the health sector. It is comprised of senior managers at the MOH, country representatives of United Nations agencies, the Ministry of Finance and Development Planning, civil society and NGO representatives. Three Deputy Ministers, from Administration, Health Services and Planning and Policy, support the Minister. The Ministry runs a three-tier health services delivery system at the county, district and community levels. Health service delivery in Liberia is organized into primary, secondary and tertiary levels. There are Primary Health Care Clinics Levels I and II. At the secondary level there are health centers and County Hospitals located in the capital city of each county with referral to the tertiary level. County health officers (CHOs) are responsible for the county-level health system, while district health officers manage the district level. The county, district and community levels are the implementation levels of national health plans, while the central level formulates policies and plans and mobilizes resources for the health system. To fulfill the Government's decentralization initiative, the Ministry in 2006 decentralized administrative and management functions to the county level. However,

this has not been particularly successful since county health boards and community health committees are not fully functional. The health management structure practices seem top-to-bottom driven, with the central level making most of the policy decisions. According to county health authorities, the central Ministry usually signs memoranda of understanding with NGOs to work in the counties without ministerial involvement. This practice is also replicated at the county level by county authorities. Community residents are not generally involved in making decisions about health delivery services. Overall, community participation in health-related activities is minimal in urban communities than rural communities. Most of the health policies and relevant strategic documents, including operational plans, are available in limited printed copies and are not widely disseminated. Lack of information dissemination between health leadership and community members remains a problem (Liberia Health Systems Assessment Report, 2015).

Figure 1: Map of Liberia with Evaluation Counties and Districts



Source: http://www.ephotoipix.com/liberia_political_map.html

Profile of Project Concern International (PCI); Project Concern International (PCI) has been working in Liberia since 2010 to increase access to food, reduce chronic malnutrition, and increase access to improved livelihood and educational opportunities. PCI has been responding to the Ebola Virus Disease emergency through different emergency response projects. Currently in 16 countries across Africa, Asia, and the Americas, PCI's portfolio includes significant Disaster Risk Reduction (DRR) and humanitarian response; health and infectious disease prevention and mitigation; food and nutrition security; WASH; capacity building; and urban and rural livelihoods programming, reaching over six million people each year. In the last seven years, PCI has implemented emergency response and/or DRR interventions through approximately 70 separate initiatives worldwide, including 12 OFDA-funded programs (5 of which were in sub-Saharan Africa). PCI has a long history managing large scale USG-funded public health and emergency projects, with particular success in scaling-up enhanced infectious disease services at local, regional, and national levels. As a recognized leader in the use of local programmatic platforms (such as uniformed services, schools, self-help groups, Care Groups, etc.) in order to reach the most vulnerable populations, PCI has used innovative advocacy, communication, social mobilization and behavior change strategies to prevent and mitigate the spread

of infectious diseases such as polio, leprosy, TB, malaria, H1N1, chagas, cholera, and HIV/AIDS. In addition to addressing access to supplies, services, and treatment, PCI is particularly known for its ability to mobilize communities and address the social drivers of epidemics such as stigma, fear, misconceptions, cultural beliefs and other major influencers that are contributing to the Ebola crisis. Since the beginning of the Ebola outbreak, PCI has reached more than 190,000 people in Bong and Nimba counties with Ebola related interventions through the USAID/OFDA-funded *Rapid Ebola Awareness, Communication and Training Program (REACT)* and *Support to Ebola Treatment Unit (STEP)* projects; and as part of the USAID/FFP-funded *Liberian Agriculture Upgrading, Nutrition and Child Health (LAUNCH)* program. PCI have also received funding from USAID/FFP for an Emergency Food Security Program (EFSP) in Bomi and Grand Cape Mount counties. Through these projects PCI responded to the Ebola crisis by equipping communities and health professionals with the knowledge, infrastructure, and supplies necessary to prevent the spread of Ebola and curb any possible increase in cases. Specifically, PCI is implementing and expanding community education campaigns, training health care providers, supporting infrastructure for the isolation of suspected cases, and providing supplies, such as PPEs, and sanitation necessities to minimize the spread of the virus. All of PCI's programming in Liberia integrates protection, gender and disability considerations. This includes the REACT, STEP, LAUNCH and EFSP activities that will complement those implemented within this project, such as activities implemented through Care Groups; farmer groups; PTAs; training Lead Mothers; and reaching children, youth, men, women, persons with disabilities (PWD), and the elderly with Ebola prevention awareness, as well as capacity building activities and specific assistance to the most vulnerable (ESFP Cash Transfer Program).

2.0. CHAPTER TWO: EBOLA TRANSMISSION and PREVENTION

The Ebola virus causes an acute, serious illness which is often fatal if untreated. Ebola virus disease (EVD) first appeared in 1976 in 2 simultaneous outbreaks, one in Nzara, Sudan, and the other in Yambuku, Democratic Republic of Congo. The latter occurred in a village near the Ebola River, from which the disease takes its name. The outbreak in West Africa, (first cases notified in March 2014), was the largest and most complex Ebola outbreak since the Ebola virus was first discovered in 1976. There were more cases and deaths in this outbreak than all others combined. It has also spread between countries starting in Guinea then spreading across land borders to Sierra Leone and Liberia, by air (one traveler) to Nigeria and USA (one traveler), and by land to Senegal (one traveler) and Mali (two travelers). The most severely affected countries, Guinea, Liberia and Sierra Leone, have very weak health systems, lack human and infrastructural resources, and have only recently emerged from long periods of conflict and instability. On August 8th, the WHO Director-General declared the West Africa outbreak a Public Health Emergency of International Concern under the 2005 International Health Regulations. The virus family Filoviridae includes three genera: Cuevavirus, Marburgvirus, and Ebolavirus. There are five species that have been identified: Zaire, Bundibugyo, Sudan, Reston and Tai Forest. The first three have been associated with large outbreaks in Africa. The virus causing the 2014 West African outbreak belongs to the Zaire species (WHO, 2015).

General Transmission of EVD; It is suspected that fruit bats of the Pteropodidae family are natural Ebola virus hosts. The theory is that Ebola virus is introduced into the human population through close contact with the blood, secretions, organs or other bodily fluids of infected animals such as chimpanzees, gorillas, fruit bats, monkeys, forest antelope and porcupines found ill or dead or in the rainforest. Ebola then spreads through human-to-human transmission via direct contact (through broken skin or mucous membranes) with the blood, secretions, organs or other bodily fluids of infected people, and with surfaces and materials (e.g. bedding, clothing) contaminated with these fluids.

Health-care workers have frequently been infected while treating patients with suspected or confirmed EVD. This has occurred through close contact with patients when infection control precautions are not strictly practiced. Burial ceremonies in which mourners have direct contact with the body of the deceased person can also play a role in the transmission of Ebola. People remain infectious as long as their blood contains the virus.

Sexual Transmission of EVD; More surveillance data and research are needed on the risks of sexual transmission, and particularly on the prevalence of viable and transmissible virus in semen over time. In the interim, and based on present evidence, WHO recommends that:

- All Ebola survivors and their sexual partners should receive counselling to ensure safe sexual practices until their semen has twice tested negative. Survivors should be provided with condoms.
- Male Ebola survivors should be offered semen testing at 3 months after onset of disease, and then, for those who test positive, every month thereafter until their semen tests negative for virus twice by RT-PCR, with an interval of one week between tests.
- Ebola survivors and their sexual partners should either:
 - abstain from all types of sex, or
 - observe safe sex through correct and consistent condom use until their semen has twice tested negative.
- Having tested negative, survivors can safely resume normal sexual practices without fear of Ebola virus transmission.
- If an Ebola survivor's semen has not been tested, he should continue to practice safe sex for at least 6 months after the onset of symptoms; this interval may be adjusted as additional information becomes available on the prevalence of Ebola virus in the semen of survivors over time.
- Until such time as their semen has twice tested negative for Ebola, survivors should practice good hand and personal hygiene by immediately and thoroughly washing with soap and water after any physical contact with semen, including after masturbation. During this period used condoms should be handled safely, and safely disposed of, so as to prevent contact with seminal fluids.
- All survivors, their partners and families should be shown respect, dignity and compassion (WHO, 2015).

Symptoms of EVD; The incubation period, that is, the time interval from infection with the virus to onset of symptoms is 2 to 21 days. Humans are not infectious until they develop symptoms. First symptoms are the sudden onset of fever fatigue, muscle pain, headache and sore throat. This is followed by vomiting, diarrhea, rash, symptoms of impaired kidney and liver function, and in some cases, both internal and external bleeding (e.g. oozing from the gums, blood in the stools). Laboratory findings include low white blood cell and platelet counts and elevated liver enzymes (WHO, 2015).

Prevention and Control of EVD; Good outbreak control relies on applying a package of interventions, namely case management, surveillance and contact tracing, a good laboratory service, safe burials and social mobilization. Community engagement is key to successfully controlling outbreaks. Raising awareness of risk factors for Ebola infection and protective measures that individuals can take is an effective way to reduce human transmission.

Risk reduction messaging should focus on several factors:

- **Reducing the risk of wildlife-to-human transmission** from contact with infected fruit bats or monkeys/apes and the consumption of their raw meat. Animals should be handled with gloves and other appropriate protective clothing. Animal products (blood and meat) should be thoroughly cooked before consumption.
- **Reducing the risk of human-to-human transmission** from direct or close contact with people with Ebola symptoms, particularly with their bodily fluids. Gloves and appropriate personal protective equipment should be worn when taking care of ill patients at home. Regular hand washing is required after visiting patients in hospital, as well as after taking care of patients at home.
- **Reducing the risk of possible sexual transmission**, because the risk of sexual transmission cannot be ruled out, men and women who have recovered from Ebola should abstain from all types of sex for at least three months after onset of symptoms. If sexual abstinence is not possible, male or female condom use is recommended. Contact with body fluids should be avoided and washing with

soap and water is recommended. WHO does not recommend isolation of male or female convalescent patients whose blood has been tested negative for Ebola virus.

- **Outbreak containment measures**, including prompt and safe burial of the dead, identifying people who may have been in contact with someone infected with Ebola and monitoring their health for 21 days, the importance of separating the healthy from the sick to prevent further spread, and the importance of good hygiene and maintaining a clean environment (WHO, 2015).

3.0. CHAPTER THREE: EC3 PROJECT BACKGROUND AND EVALUATION OBJECTIVES

PCI responded to the Ebola emergency through different emergency response projects. PCI implemented an Ebola Community Care Centers (EC3) Project in Bong, Nimba, Bomi and Grand Cape Mount Counties with funding from the USAID's Office of Foreign Disaster Assistance (USAID/OFDA). PCI has been implementing the project in close collaboration with the Ministry of Health and Social Welfare (MOHSW), County health offices, District health offices and general Community health volunteers (gCHVs).

The EC3 project began October 29, 2014 and ran through December 31, 2015. It was initially planned as a six month project during which time PCI was to construct and manage 10 Community Care Centers (CCCs). As the Ebola situation in Liberia evolved though, so too did the project strategy. In short, after much negotiation with the MOHSW and OFDA, PCI ended up managing three CCCs that were constructed by UNICEF and Oxfam. Two in Nimba (Saclepea and Karnplay) and one in Bong (Handii). While waiting to resolve the CCC issue, OFDA requested that PCI use EC3 funds flexibly to respond to the needs identified by (and with) the County Health Teams. However, the project proposal, indicators/targets and agreement with the donor were not officially modified until July 31, 2015. Following the modification, PCI expanded EC3 activities into two additional counties (Bomi and Grand Cape Mount) and included a broader focus on community education and general support to existing health system structures (such as infrastructure upgrades at primary health facilities and clinical training for staff) and mechanisms (such as the Rapid Isolation and Treatment of Ebola (RITE) Teams, referral networks, etc.). The two performance indicators being evaluated in this report were added to the project with this modification, i.e. the indicators only cover the period from July 2015 – December, 2015.

EC3 Project Goal and Health Sector Objective

EC3 Project Goal: To respond to the evolving needs in communities affected by the ongoing Ebola outbreak in Liberia and to strengthen local capacity to prepare for, respond to, and recover from outbreaks in the future.

Health Sector Objective: To support the health sector to safely and adequately prepare for and treat Ebola patients.

Description of Key EC3 Activities:

Sub-sector 1: Health system and Clinical Support:

- Renovation or upgrade of the health facilities to ensure they meet all appropriate standards.
- Support the county health teams (CHTs) in case investigation, contact tracing, case management, referral and rapid response teams to identify, isolate, and treat cases at the appropriate facility.
- Train health facility staff to run the CCCs and ongoing supportive supervision of management and operations (including on-site mentoring).
- Mobilize community awareness of and support for the facilities.
- Provision of PPEs and other essential supplies.
- Support data collection, monitoring and reporting.
- Supervision, management and maintenance of the facilities, including compliance with basic protection and gender standards.

- Facilitation of data sharing between ETUs, CCCs, MOHSW and other partners.

Support for CCCs: PCI’s EC3 Project supported the management of CCCs in Bong and Nimba in coordination with UNICEF and the county health teams (CHTs) until the decision was made to decommission them. The purpose of the CCCs was to provide safe spaces where suspected or confirmed cases of Ebola could be isolated, tested and referred as appropriate, while receiving care and reducing risk to family and community members. PCI EC3’s role was to ensure that the CCCs were constructed, supplied, staffed and monitored to ensure compliance with the National Strategy for Community Care Centers in Liberia and other standards. The functioning of the CCCs was integrated with PCI’s other Ebola-related initiatives, including contact tracing and surveillance, provision of PPEs and other essential materials, community mobilization, and capacity building. The CCCs were designed and operated in coordination and consultation with the CHTs and efforts by other agencies. Specific PCI EC3 support was determined in consultation with OFDA, local officials, and other partners.

Some of the proposed PCI EC3 support to the CCCs were:

- Renovating or upgrading the facilities to ensure they meet all appropriate standards. Where renovation or upgrading needs are identified, the appropriate PCI intervention will be determined in consultation with OFDA and other relevant stakeholders.
- Supporting the CHTs in case investigation, contact tracing, case management, referral and rapid response teams to identify, isolate, and treat cases at the appropriate facility.
- Training of health facility staff to run the CCCs and ongoing supportive supervision of management and operations (including on-site mentoring).
- Mobilizing community awareness of and support for the facilities.
- Provisioning PPEs and other essential supplies.
- Supporting the collection of data, monitoring and reporting.
- Providing conflict resolution and coordination of the CCCs’ activities with other institutions and activities involved with the response.
- Supervising, managing and maintaining the facilities, including compliance with basic protection and gender standards.
- Facilitating data sharing between ETUs, CCCs, MOHSW and other partners.
- Providing payment to CCC staff.

Support to Health Facilities Infrastructure: PCI EC3 provided support to health infrastructure to strengthen the ability of the local health system to prepare for and respond to cases of Ebola. PCI EC3 worked with the CHTs and other partners to assess the specific needs at CCCs, clinics, triage units and other critical facilities throughout each county. PCI EC3 supported the rehabilitation, repair or upgrade of existing structures to better meet national and international standards of preparedness and care for all patients, and especially those with suspected or confirmed EVD.

Training for Clinical Staff: PCI EC3 conducted trainings around IPC, case management, medical supplies management, data collection and reporting, and other best practices (for example, psychological first aid and protection) for those in close contact with possible, suspected or confirmed Ebola patients, such as health workers, outreach workers, CCC staff, general community health volunteers (gCHVs), health screeners at checkpoints, birth attendants, etc. Necessary trainings were identified through PCI EC3’s ongoing monitoring of preparedness, technical capacity, and care provided at CCCs and other health facilities throughout the counties and in collaboration with county officials and other partners.

Supporting County Health System Capacity: PCI EC3 was committed to supporting local efforts to prepare for, respond to, and recover from this and future outbreaks. Each county’s specific needs were different and varied over time as the outbreak evolved. PCI EC3 worked closely with county, national and international partners to identify and respond to the technical and material needs of the local government in this fluid environment with shifting priorities and resources. For example, PCI EC3

supported each county's implementation of the Government of Liberia's Rapid Isolation and Treatment of Ebola (RITE) strategy, which was created to address localized outbreaks, or "hotspots". PCI EC3's role in the rapid response was to support the CHT's efforts to ensure a rapid, comprehensive response to every reported/suspected Ebola case. To that end, PCI provided the technical, material, logistical, and other support as requested to facilitate the county's implementation of their strategy.

Sub-Sector 2: Medical Commodities Including Pharmaceuticals

Essential Supplies for Healthcare Facilities and Workers: PCI EC3 supported the distribution of medical and other essential supplies to under-resourced healthcare facilities and staff throughout the four intervention counties. PCI EC3 has medical personnel on staff who worked with the health facilities, the counties, and other partners to accurately determine the needs and conduct training to ensure that the receiving health facility staff was able to appropriately utilize and dispose of the distributed items. PCI EC3 facilitated linkages to the government supply chain as appropriate, to promote more sustainable solutions to resource challenges. PCI EC3 also coordinated with JSI and other logistics cluster partners to distribute supplies directly to the central MOHSW and CHTs and, as necessary, facilitated connections to the MOHSW supply chain. PCI EC3 did not procure additional medical equipment but instead utilized existing stocks of medical and essential supplies, available under other PCI projects or through partners. PCI EC3 had no plans to import additional PPEs, as reflected in the revised project technical narrative. PCI EC3 facilitated local partners to provide essential supplies to other workers who came in close contact with possible, suspected or confirmed Ebola patients, such as contact tracers, community outreach workers, health screeners at checkpoints, etc. The needs were identified and distributions conducted in concert with the CHTs and other partners, but included such items as thermometers, face masks, chlorine bottles, gloves, data collection and reporting materials, etc. The assessment of the performance of Sub-Sector 2: Medical Commodities Including Pharmaceuticals was not part of the scope of this evaluation and therefore this was not directly measured.

Sub-Sector 3: Community Health Education / Behavior Change

Community Trainings and Outreach: PCI EC3 conducted regular trainings for PCI staff, gCHVs, and community-based groups on various Ebola messages. The exact training topics were determined and, where appropriate, materials developed or revised in partnership with county and district officials and community representatives, and coordinated with other partners. Some topics included transmission and prevention information; rumour/fear control, for example addressing concerns about the safety of utilizing health care facilities for non-Ebola needs; ways to recognize the trauma inflicted by Ebola among members of the community and how to seek support; ways to support Ebola survivors and other Ebola-affected persons, especially orphaned children; ways to build community level preparedness and resilience for future outbreaks; etc. PCI EC3 also worked closely with survivor support services as coordinated by the MOHSW.

PCI EC3 also trained appropriate groups on community education strategies and skills so they were able to more widely disseminate and reinforce the messages received. Those who received this training were participants in PCI EC3's community outreach and awareness raising activities. Specific outreach activities varied in each community, but they included, for example, individual or household level conversations, community wide messaging, radio education programs, small groups, targeted at-risk groups such as taxi drivers or schools, and public gathering places such as markets.

Strengthen Community Resilience and Preparedness: PCI has had great success working through Care Groups and Disaster Management Committees in Bong and Nimba counties under the USAID/FFP funded LAUNCH project. From the very beginning of the Ebola outbreak in 2014, PCI was able to use these groups to disseminate Ebola prevention messages throughout their communities and support the community-level preparedness and response capacities. To build on the lessons learned from LAUNCH and to expand that community-based approach to other communities in this project, whenever possible, PCI EC3 worked through existing community groups. PCI EC3 also provided the material support necessary for the communities to implement the Ebola prevention, preparedness and response strategies they developed and for which they were trained. For example, trainings on IPC at schools or places of

faith (churches, mosques) included provision of hand washing buckets and/ or soap as needed. This material support was coordinated and provided in collaboration with local, national and international partners.

Support for reintegration of Ebola survivors: In order to facilitate the recovery from the trauma that Ebola created throughout the country, focus was maintained on how to help the most vulnerable, those who had lost members of their family and community, and who had experienced abuse or violence. In particular, those who had survived Ebola were supported to be reintegrated in society in a dignified fashion. PCI EC3 worked with identified communities who have been considerably affected by the outbreak to develop strategies to identify, support and reintegrate Ebola survivors and other affected persons. PCI EC3 facilitated a process that encouraged communities to develop their own strategies to prevent discrimination, stigma and abuse, supported family reunification and strengthened community-based networks. Examples included conducting symbolic ceremonies for an Ebola survivor and/or their household, or providing material support to the person or household. Particular attention was given to identifying and addressing the needs of vulnerable groups such as orphans, girls, gender based violence (GBV) survivors, persons with disabilities, elderly and others. PCI EC3 worked, particularly through existing support groups and initiatives, to identify and monitor children who were orphaned by Ebola and ensure they were appropriately placed and that they were receiving the care and support they needed to address any ongoing physical or mental needs they were having as a result of their illness or loss.

Support to Cross-Border Initiatives: PCI EC3 was highly motivated to support cross-border initiatives that helped to slow Ebola's spread by limiting its transmission across borders, and to ensure the best possible care for people in all three countries. In addition to the structural support proposed, PCI EC3 explored ways to support the community mobilization and education efforts in the border regions. Specific strategies and interventions were determined in collaboration with all stakeholders, some examples include improving communication networks near international borders and in remote areas to facilitate case identification, referral systems, contact tracing, and other services in coordination with partners.

Evaluation Objectives; The final evaluation was to assess the project's results and understand how the project management and implementation contributed to the national Ebola emergency response, assess achievement for key outcome indicators, identify successes and challenges and document the key lessons learned. The final evaluation has the following specific objectives:

- To examine whether EC3 was efficient and effective in responding to EVD emergency response.
- To examine the behavior change of community members as a result of EC3 community level interventions.
- To measure the change of health facilities in the areas of infrastructure, supplies, clinical staff capacity and service quality.
- To assess whether the project results were achieved in line with the stated objective, sub-sector intervention and their performance targets.
- To measure key outcome level indicators of EC3 (IPTT indicator # 1.1 and 3.1).
- To assess successes, constraints, lessons learned and best practices as well as opportunities for future similar programs.

4.0. CHAPTER FOUR: EVALUATION METHODOLOGY

The evaluation design employed a mixed methods approach of both qualitative and quantitative methodologies including household survey, health facility assessment using the Ministry of Health and Social Welfare (MOHSW) assessment tools, focus group discussions (FGD), key informant interviews (KII) and Most Significant Change Methodology (MSCM) to assess the most significant social and

behavioral changes observed at community level in addressing community attitude towards EVD protection.

Training of Evaluation Team; A centralized briefing was conducted. Field training was conducted by the Survey Team Leader with assistance from the Statistician and two experienced Trainers. To ensure that there was uniformity in the training, enumerators, quality control officers and supervisors were part of the training and they were taken through the basic techniques of facility selection methods, appointment booking, introductions and facility entry, respondent selection within the facility, questionnaire administration, and general interviewing skills. Other issues that were covered during the training include:

- Survey objectives
- Sampling methodology adopted
- Supervisor's/interviewer's roles
- Quality control officer's roles
- Explanation of key Terminologies
- Questionnaire practice and explanation
- Field plan and movements
- Transcriptions of Qualitative data

At the end of training, mock interview and role-play were organized to take interviewers through fieldwork simulations. These were done to assess the interviewer's understanding of the evaluation techniques and questionnaire administration using the various local languages. It was important because it ensured identification of possible problems that could arise from the field before hand and strategies were adopted which greatly mitigated against all potential fieldwork challenges.

Data Collection and Supervision; The survey team leadership was made up of Justice Ajaari (Msc. Med. Field Epidemiology)-the Evaluation Team Leader; Emmanuel Mahama (Msc. Medical Statistics); Shalom Abokyi (MPH Monitoring and Evaluation) and Dr. Alexander Ansah Manu (a Medical Officer with PhD in Epidemiology). Each member of the evaluation team has more than 10 years' experience in research, monitoring and evaluation. The team leader was responsible for facilitating the training and coordinating the overall field operation jointly with the PCI Monitoring and Evaluation (M&E) team in Liberia and the International Office and program officer.

Figure 2: Enumeration team members undergoing training and interview Simulations



Both the Health Facility Assessment (HFA) and Household Surveys (HHS) were conducted in the four project operation counties- Bomi, Bong, Nimba and Grand Cape Mount Counties. Eight Supervisors, two Quality Assurance (QA) and Quality Control (QC) Officers and 20 enumerators with extensive experience and capacity to collect and process high quality quantitative and qualitative data in Liberia were recruited and trained on the study protocols, research ethics, research methods, community entry, health facility entry, household selection, qualitative and quantitative interview techniques.

Eight teams were composed after the training to pretest both qualitative and quantitative tools and also get to know each other. All tools were revised appropriately after the pretesting for the main fieldwork. QA/QC was implemented throughout the period of the evaluation: pre-fieldwork, during fieldwork and post fieldwork. All tools were checked and double-checked before deployment. The first level of QA/QC was adhered to strictly by the enumerators and they ensured that the protocols of the evaluations were not violated. The second level of QA/QC was conducted at the supervisors level where all completed tools were completely reviewed for inconsistencies, blanks/missing data, appropriateness and thoroughly verified to ensure conformity with the actual state of events. The final level of QA/QC was conducted by the leadership. The following key quality control (QC) measures were employed:

- Clear recruitment guided by questionnaires
- Screening of respondents pre-groups
- Screening questions of respondents in group by moderator and replacement
- Replacement of wrongly recruited groups
- The research tool – i.e. discussion guide/s are brainstormed and designed well
- Well- experienced moderator with high qualifications in health used on FGDs and KIIs
- Verbal report back after the first FGD and KII to amend the discussion topics if necessary
- Intense involvement of the relevant champion from the core team
- Interactions with moderators
- Iterative approach to analysis if required
- Use of analytical frameworks
- Continuous iteration of the guide there-after depending on responses
- Respondents engaged through refreshments, short and sharp guides and motivating moderators

Organization of Evaluation; Organization, staffing and logistics are illustrated below. Figure 3 shows the organization structure and Figure 3 diagrams the evaluation study flow and steps.

Figure 3: Evaluation Team Structure

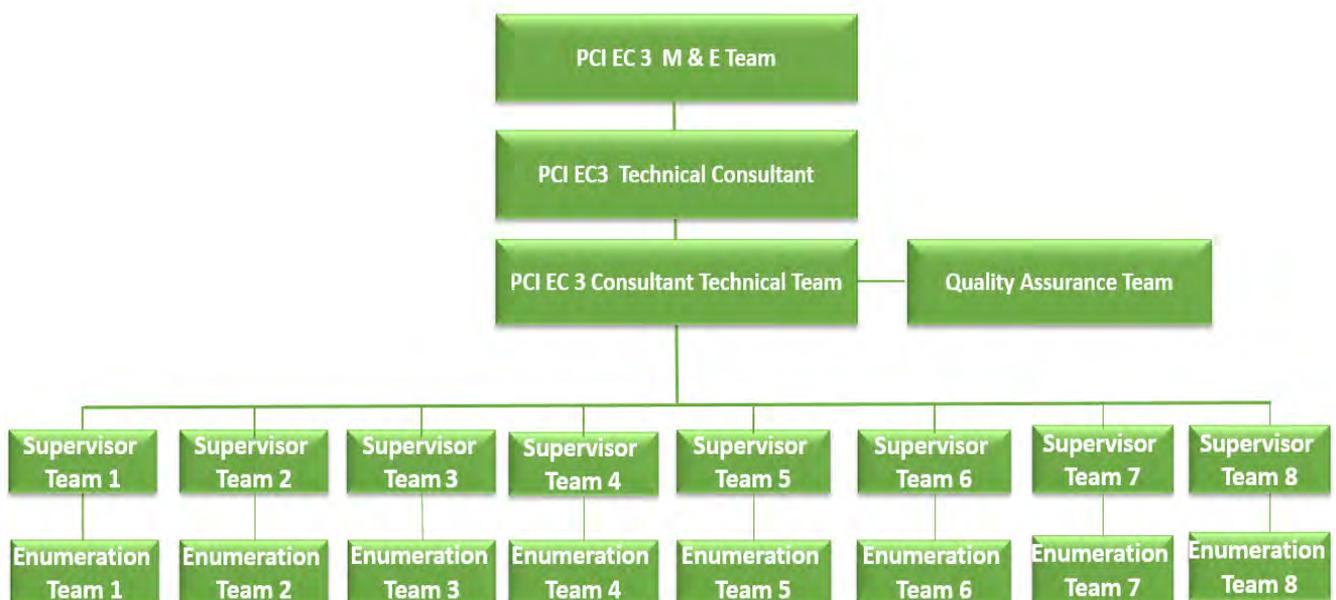
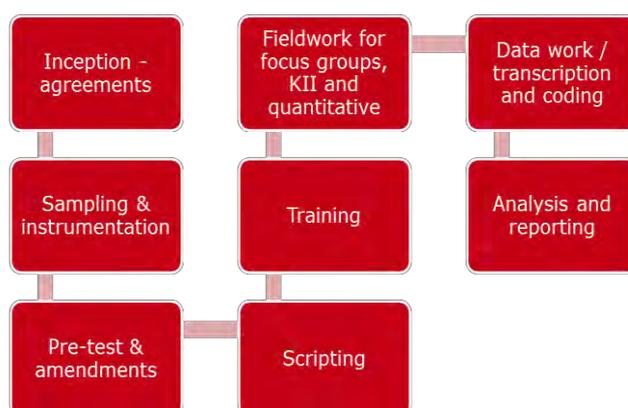


Figure 4: Organization of the Evaluation



Sampling Design; As per the USAID/FFP standard guideline for evaluations² the survey was carried out covering the entire program intervention area, therefore, the sample was drawn from all the four counties to ensure sample representation. A multi-stage sampling strategy was used which included:

- Firstly, purposive and convenience sampling of counties and districts
- Secondly, systematic random sampling of primary sampling units (communities) from sampled districts.
- Thirdly, systematic random sampling of secondary sampling units (respondent’s household compound/house) from the sample communities by spinning a pen. This is where a household compound (house) was selected without any knowledge of the composition of the household members through a spinning technique ensuring that, there were 2 household compounds/house between current household respondent compound/house and the next household respondent continuously.
- Fourthly, random sampling of study participants from the sampled households by tossing a coin. This where actual respondents were selected for interview through a lottery system from the selected household compound/house.

Household survey: the HH survey was intended to primarily collect data on the performance of an outcome indicator “number and percentage of *community members utilizing Ebola health education message practices.*” The survey was designed to capture the change in community knowledge, attitude and practice as the result of the EC3 intervention. The sample households were selected using systematic random sampling technique from the total population in the geographic area. Since EC3 has no baseline study, the final evaluation followed a simple descriptive study in line with the stated objectives. Sample size for the descriptive study where the population is believed to be infinite/large, for performance indicators presented as a percentage, is calculated as:

$$n = D ((Z\alpha^2 * p (1-p)) / [d^2 * (1-r)])$$

Where:

n = minimum sample size required

D = design effect; D = 2 in two-stage cluster sampling design.

p = Expected value of the key indicator at survey time (end line); for this case p=0.9 (90% target for an outcome indicator of interest taken from IPTT).

d = desired margin of error on the estimate of p (standard 5%, d = 0.05)

² Robert Magnani (1999): FANTA III Sampling Guide.

Z_{α} = Z-score for the desired degree of confidence ($\alpha = 0.95$, $Z_{\alpha} = 1.96$)

r = adjusted for non-response error (normally = 0.1, 10%)

Hence, $n = \{[2*(1.96)^2*0.9(1-0.9)] / [(0.05)^2 *(1-0.1)]\} = 307$ households.

Making a total sample of 337 households from the EC3 intervention communities. The proposed sample size was sufficient enough to provide reliable estimates with less than 5 percent margin of error for the outcome indicator.

Response rate: 420 potential respondents were contacted by the evaluation team (averaging 10 households per community for a total of 42 communities), out of this number 30 potential respondents refused to be part of the evaluation exercise for diverse reasons and 390 agreed to be part of the evaluation and were therefore consented and interviewed. However, during data cleaning, 12 records did not meet the required data quality standards and were therefore cleaned out. The final cleaned dataset was based on final sample size of 378, exceeding the sample size requirement of 337 by 12%.

Study Population; The study population included the general population in EC3 intervention areas (direct and indirect beneficiary households) in the target counties. The sample size and methodology is robust and produces representative sample size using statistically sound methods

Household and respondents' selection: Households in each community were selected randomly by spinning a pen and selecting the household that the tip of the pen points to. Once household entry protocols were observed and household entries were done, the selection of a household respondent was also done randomly by asking the household head's permission to be interviewed or to interview any volunteer household member, in instance where more than one household member volunteers for the interview a coin is tossed to determine the household respondent. Each study participant or respondent was taken through an in-depth informed consent process for concurrence prior to the interview. The process was very successful because of the enormous community level support from the gCHVs who facilitated the movement of the research team in the various communities.

Qualitative Approach: The field team conducted a total of 28 qualitative interviews; 6 Focus Group Discussions (FGDs) with 60 participants in 42 communities, 7 districts in the 4 intervention counties. The FGDs included 10 community members per session and this included men group, women group and a mix of men, women, boys, girls, elders and religious group leaders as well gCHVs. A total of 10 in-depth interviews (IDIs) were also conducted with the County Medical Officers or their representatives, district medical Officers or their representatives and key PCI EC3 staff. Key Informant Interviews (KIIs) were also conducted with 12 General Community Health Volunteers (gCHVs) in 42 communities in the 7 districts of the 4 intervention counties [Table 1].

The most significant change (MSC) methodology was employed as part of the qualitative data collection process. MSC was incorporated in the FGDs, the process involved the collection of significant change (SC) stories emanating from the field level through the study population, and the systematic selection of the most significant of these stories by designated stakeholders and evaluation team members. The study beneficiaries were asked as part of the FGDs to do a free listing of the significant changes that have occurred as results of the PCI EC3 intervention in the community. The study beneficiaries were further asked do a list of the most significant changes out of the free list done earlier after which the designated stakeholders and evaluation team members made the final determination of the most significant changes that have occurred in the community as a result PCI EC3 interventions.

The qualitative approach (FGDs, KIIs, MSC and IDIs) of the study focused on the following;

- Knowledge of PCI EC3
- PCI EC3 interventions in the community
- Effectiveness of PCI EC3 intervention
- Behavior change as result of PCI EC3 intervention
- Observed changes in health facilities as a result of PCI EC3 intervention

- PCI EC3 achievements, successes and challenges
- Best Practices
- Opportunities for future projects
- Lessons learned
- Recommendations and suggestions

Table 1: Summary of Qualitative Interviews

Type of Interview	Target Group	Total Number	Total Number of Participants
Focus Group Discussions (FGDs)	Beneficiary Community Members	6	60
Key Informant Interviews (KIIs)	General Community Health Volunteers	12	12
Indepth Interviews (IDIs)	County & Health Workers	10	10
Indepth Interviews (IDIs)	PCI EC3 Management	2	2
Total		28	84

****Note: MSC was used as part of the FGDs, KIIs and IDIs**

Figure 5: Enumeration team member moderating a Focus group discussion with group of men



Health Facility Assessment

Health Facility Assessment Tool: The MOHSW Infection Prevention and Control (IPC) taskforce developed a checklist to be used to determine if clinics, health centers and hospital can safely operate during the Ebola outbreak at the same time as providing the path for sustainable safe health care. The goals of the assessment tool was not to provide an overall assessment of health facilities, but rather to provide a checklist of minimum standards that ensures that a health facility can operate and provide care in an environment that is safe for both patients and staff. The standards were developed to address core components of IPC: administrative controls (i.e., IPC structure with defined focal point and budget, triage and patient placement, staff training and health), environmental controls (i.e., waste management, water and sanitation) and Personal Protective Equipment (PPE). The tool is an adaptation of the document “Components for Infection Prevention and Control Programs (WHO, 2008)”. Each of the areas is critical in ensuring that care is delivered in a safe and effective manner for both staff and patients.

As these are the “minimum standards” for which a facility must be able to say “yes” to each and every one in order to safely operate. Due to resource availability, some standards are only applicable in larger health facilities such as hospitals and health centers. This tool was adopted for the EC3 pre and post intervention health facility assessment.

EC3 Intervention Facilities: PCI Liberia, through its EC3 project, was operational in 87 health facilities. To identify existing gaps and plan to improve the quality of service delivery and capacity EC3 has conducted pre-intervention information using the health facility assessment checklist tool developed by the Liberian MOHSW. Thus, to measure the post-intervention performance for the outcome indicator “*improved healthcare facility capacity to provide quality treatment*” the final evaluation re-assessed all 87 health facilities and reports on the percent change as a result of the EC3 project using the same facility assessment checklist used before intervention.

Response Rate: All the 87 PCI EC3 intervention health facilities were contacted and they all agreed to be part of the evaluation exercise. The facility leadership were therefore taken through the informed consent process and the assessment conducted. The data was taken through cleaning and ensured that the required data quality standards were met. The final cleaned dataset was based on final sample size of 87 health facility which represents a response rate of 100%.

Figure 6: Enumeration team members conducting facility assessment at Grand Cape Mount



Analysis of Health Facility Data: Completed Questionnaires entered into Health Assessment tool designed on MS Excel platform was extracted using commands “=IF(AND(Almadiya!\$B\$204="X"),1,IF(AND(Almadiya!\$D\$204="X"),0,0))” into an SPSS binary format ; “1” representing a Yes for a Yes answered question and “0” for No representing a No answered questions in excel format for all 87 health facilities assessed. The data was then exported to an SPSS platform for further processing and analysis. Percentage scores was computed for the various sections /area of assessment as indicated in the table 1 below;

Table 2: Health Facility Assessment Analysis Plan

Area of Assessment	Numerator	Denominator
Administrative control	Sum of all “YES” variables in administrative control section	Sum of total variables (8 variables)
Supply and Equipment	Sum of all “YES” variables in supply and Equipment section	Sum of total variables (5 variables)
Personnel/Staffing & Training	Sum of all “YES” variables in Personnel/staffing and training section	Sum of total variables (4 variables)
Availability of Triage	Sum of all “YES” variables in triage	Sum of total variables (4 variables)
WASH/Waste Management	Sum of all “YES” variables in WASH section	Sum of total variables (8 variables)
Availability of Isolation Unit	Sum of all “YES” variables in Isolation unit	Sum of total variables (3 variables)
Miscellaneous	Sum of all “YES” variables in Miscellaneous section	Sum of total variables (4 variables)
Improved Health care facility capacity to provide quality treatment	Sum of all “YES” variables in all the sessions	Sum of total variables (36 variables)

The overall health facility performance was then computed by summing up all scores for variables in the various sections as the numerator and the denominator; the total number of all session variables. Averages was computed for each sessions as a result of the various interventions made in various beneficiary health facilities and this was used to plot a bar chart to show the overall results of the post-intervention.

Confidence intervals (CIs) were computed for each session as well as the overall performance at 95% significance level to demonstrate the statistical significance of the findings

5.0. CHAPTER FIVE: EVALUATION FINDINGS

Household Survey Findings

Socio-Demographic Characteristics of Household Survey Respondents

As presented in Figure 7, a total of 378 households were sampled and interviewed for this survey, 204 (54%) of those interviewed were females compared to 174 (46%) who were male respondents. Majority of respondents 149 (39.4%) were aged between 20 to 30 years whilst 24 (6.4%) were aged between 14 to 19 years.

Figure 7: Distribution of Household Respondents by Sex and Age

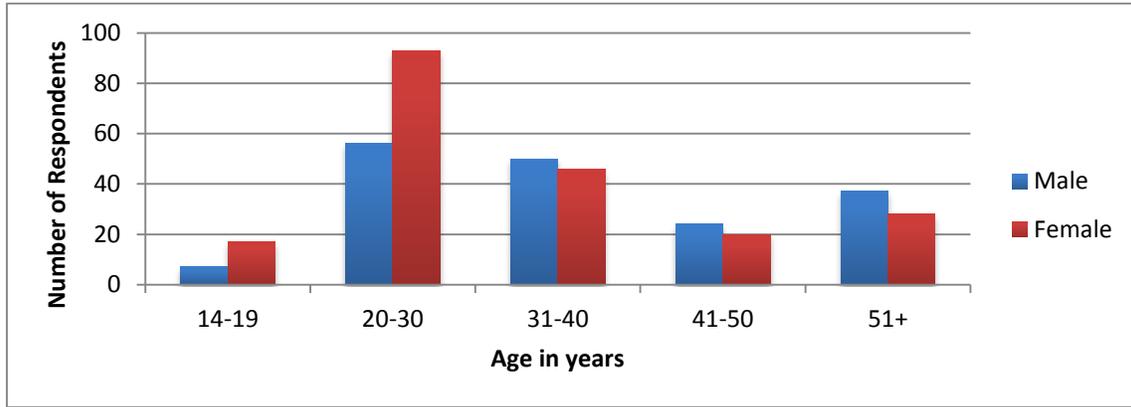
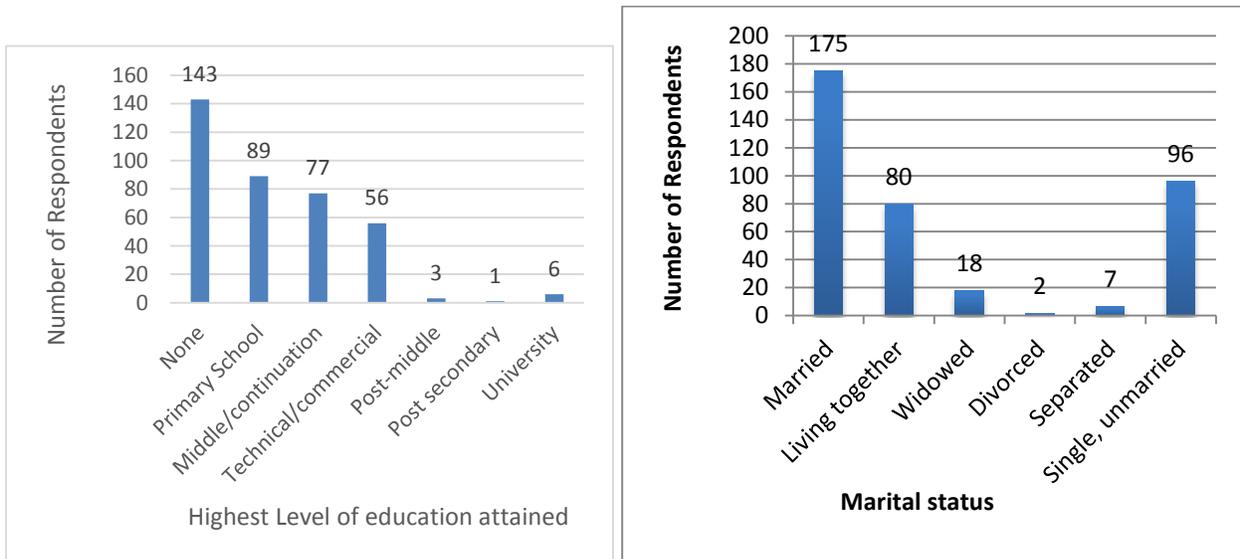


Figure 8, indicates that most of the respondent, 143 (38.1%) had no formal education whereas 89 (23.7%) had primary education followed by 77 (20.5%) with middle school education and 6 (1.6%) who attaining university education. Similarly, majority of respondents 175 (46.3%) were married, followed by 80 (21.2%) of them who were living together or cohabiting and 96 (25.4%) who were single or unmarried.

Figure 8: Distribution of Household Respondents by Marital and Educational Status



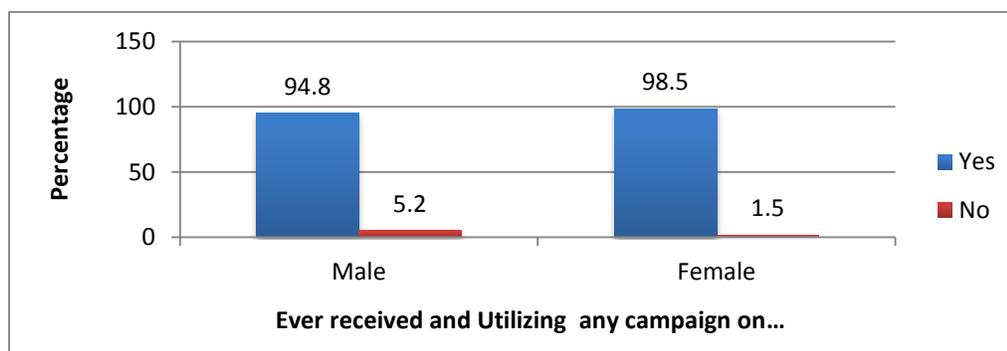
5.1. Performance of Sub-Sector 3: Community Health Education / Behavior Change

The key indicator for assessing the performance of Sub-Sector 3: Community Health Education / Behavior Change is; “number and percentage of community members utilizing [Ebola] health education message practices” and the life of project (LOP) target for this indicator was 90% of the surveyed population.

The findings of the household surveys with specific reference to the utilization of PCI EC3 Ebola health education messages indicates that; majority 366 (96.8%) of the study participants have received and are utilizing Ebola health education messages from the project. Out of those who received and are utilizing these messages, 166 (45.4%) of them were males compared with 200

(54.6%) females. This has contributed to significant behavior change among the beneficiaries in the communities [Figure 9].

Figure 9: Proportion of Community Members Utilizing Ebola Health Education Message Practices



The target and performance of the sub sector 3 indicator; “**Number and percentage of community members utilizing [Ebola] health education message practices**” has therefore surpassed the target by 6.8%.

Mode of Campaign Messages Received Through PCI EC3

More than half of respondents 51.4% (188/366) received the Ebola messages through radio whilst 178/366 (48.6%) did not receive them through radio. Among these, 42.5% (80/188) males and 57.5% (108/188) females received the message through radio [Figure 10]. A clear majority of respondents, 86.9% (318/366) received campaign messages on one-on-one basis through the gCHVs whilst 13.1% (48/366) did not get the message through gCHVs. Of the community members who received Ebola campaign messages one-on-one through gCHVs, 44% (140/318) were males and 56% (178/318) were females [Figure 11].

The most effective and efficient mode of campaign messages was the one-one-one through gCHVs. We strongly recommend the use for this strategy with an enhance scope for similar interventions in future.

Figure 10: Proportion of Community Members Campaign who received Ebola Messages through Radio

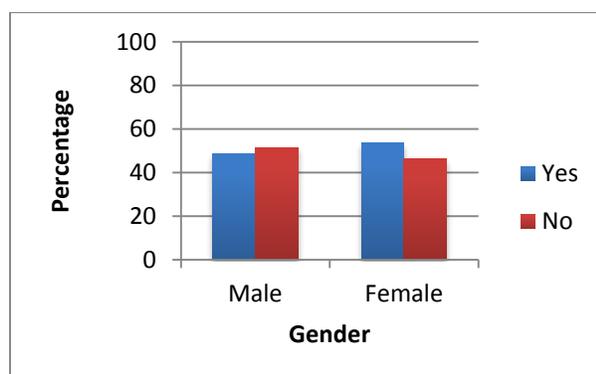
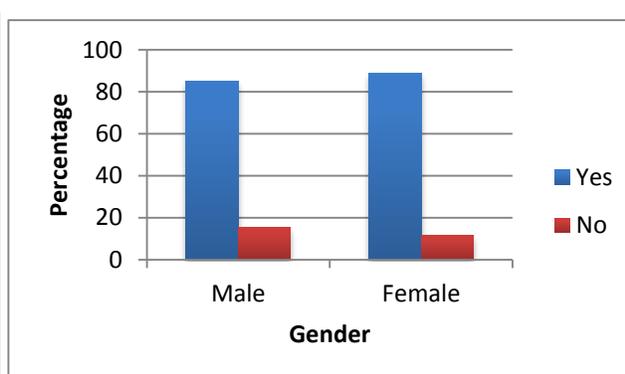


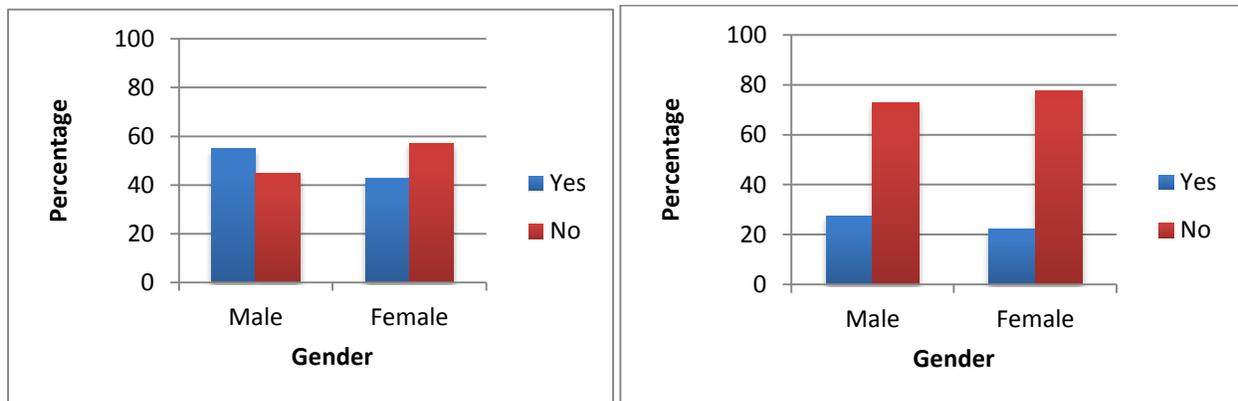
Figure 11: Proportion of Community Members who received Ebola Campaign Message from gCHV



Less than half (177/366, or 48.4%) of respondents who received campaign messages through posters. Out of these, 51.4% (91/177) of them were males and 48.6% (86/177) females [Figure 12].

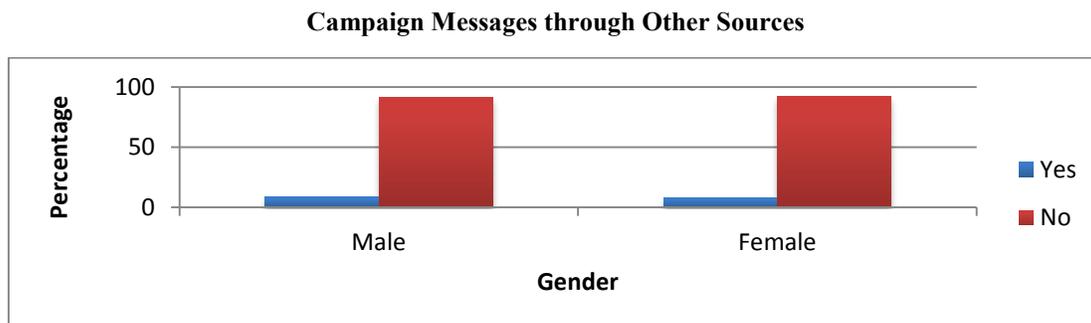
Amongst the 366 respondents who received and were utilizing the Ebola health messages; less than half of respondents 24.6% (90/366) received the messages through pamphlets whilst 75.4% (276/366) did not receive campaign messages through this medium. Out of the 90 (24.6%) respondents who received the Ebola health education messages through pamphlets, 50% (45/90) of them were males and the other 50% (45/90) were females [Figure 13]. The use of pamphlets as a strategy for the Ebola health education messages was not very effective and efficient compared with the use of the gCHVs for on-one-on engagement with beneficiaries.

Figure 12: Proportion of Community Members who received Ebola Campaign Messages through Posters **Figure 13: Proportion of Community Members who received Ebola Campaign Messages through Pamphlets**



Ebola campaign messages through other sources were also ascertained; only 30/366 (8.2%) of the community members received Ebola messages from non-PCI EC3 sources and outside the ones ascertained. Out of these, 46.7% (14/30) of them were males whilst 53.3% (16/30) were females [Figure 14]

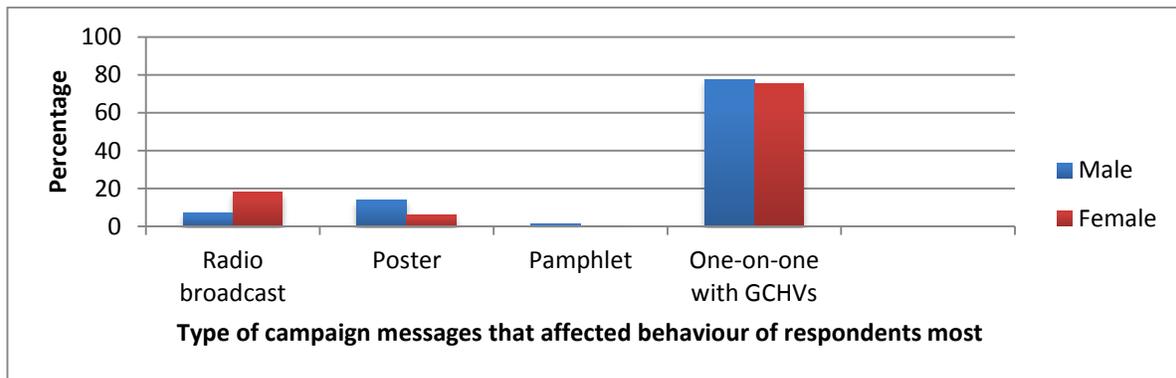
Figure 14: Proportion of Community Members who received Ebola Campaign Messages through Other Sources



Effectiveness of the Ebola Campaign Strategies

Amongst the several Ebola campaign message strategies, some were more effective in terms of behavior change for community members. When respondents were asked which of the campaign messages affected their behavior most, most of them 280/366 (76.5%) mentioned one-on-one messages they have received through gCHVs, followed by radio broadcast 48/366 (13.1%), poster 35/366 (9.6%) and pamphlet 3/366 (0.8%). Amongst those whose behavior has been affected most by EC3's messages; 35% (128/366) of them were males whilst 65% (238/366) females [Figure 15]. The one-on-one engagement of gCHVs with the project beneficiaries was the most efficient and effective strategy in terms of both coverage and utilization of the Ebola health message education as well as behavior change.

Figure 15: Effectiveness of the Ebola Behavior Change Strategies by Uptake



Type of Ebola Messages Received By Community Members

As per the type of messages delivered by EC3, the message with the highest recipients and beneficiaries was;

- Ebola behavior change messages such as s; avoid hand shaking, avoid unprotected sex, avoid crowded places, etc. [348 (95.6%)];
- Ebola prevention messages such as; environmental cleanliness, distancing from dead bodies, and safe burial, etc. [333 (88.1%)]
- Ebola Awareness messages such as; causes of Ebola disease, transmission of Ebola disease, etc. [312 (82.5%)]
- Ebola disease symptoms messages such as; diarrhea, rashes, headache, vomiting, fever, etc. [276 (73.2)]. [Table 3].

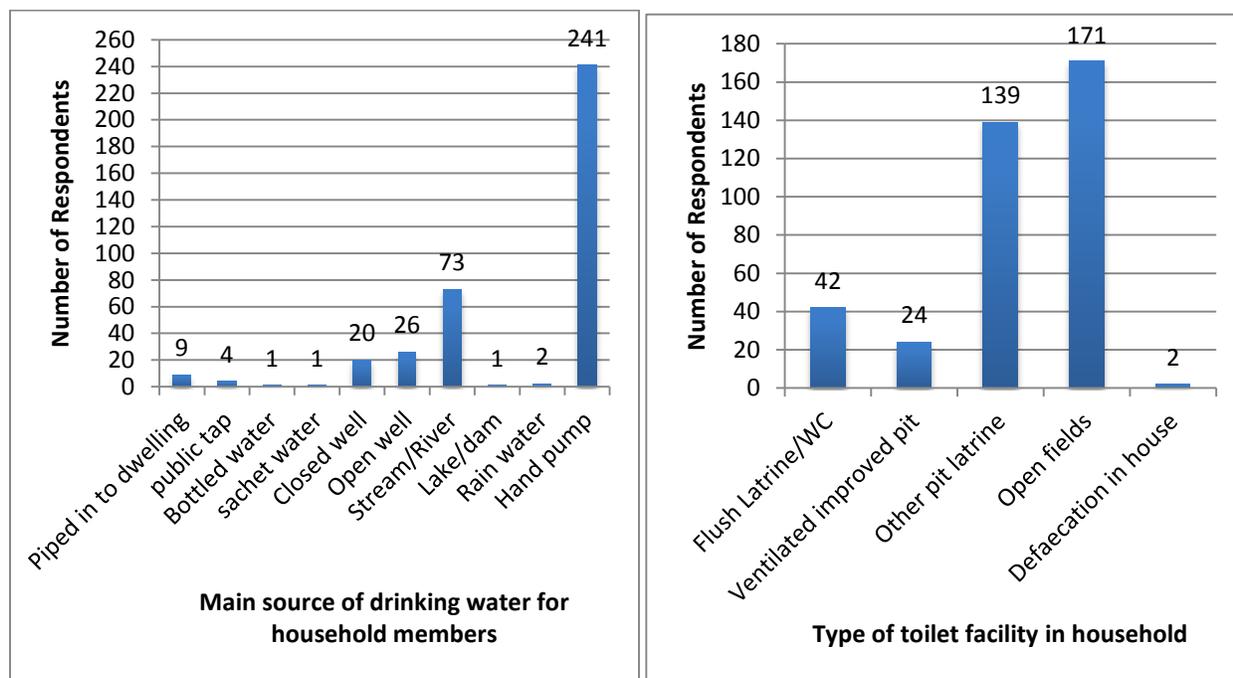
Table 3: Ebola Messages received By Community Members

Which of the following messages were received from PCI EC3? (N=378)		
Type of Message	Yes, n (%)	No, n (%)
Ebola Behavior change (e.g. avoid hand shaking, avoid unprotected sex, avoid crowded places. etc.)	348 (95.6)	16 (4.4)
Prevention (e.g. Cooking food well, environmental cleanliness, safe burial, distancing from dead bodies, mixing of chlorine and hand washing)	333 (88.1)	45 (11.9)
Ebola Awareness (e.g. causes of Ebola, Transmission of Ebola, etc.)	312 (82.5)	66 (17.5)
Ebola Clinic services	250 (66.1)	128 (33.9)
Ebola Symptoms (e.g. diarrhea, Rashes, Headache, Vomiting, fever, etc.)	276 (73.2)	101 (26.8)
Addressing EVD stigma	115 (30.7)	259 (69.3)
Reintegration of Ebola survivors	166 (44.2)	210 (55.8)
Early warning systems for Ebola	160 (42.3)	218 (57.7)

Drinking Water Source: Water and sanitation for household members were explored as part of the survey. The main source of drinking water 241 (63.8) for members of households was from hand pumps; 73 (19.3%) got their drinking water from streams or rivers, whilst 26 (6.9%) of them had open wells as their main source of drinking water and only 9 (2.4%) piped water in their dwelling place [Figure 16].

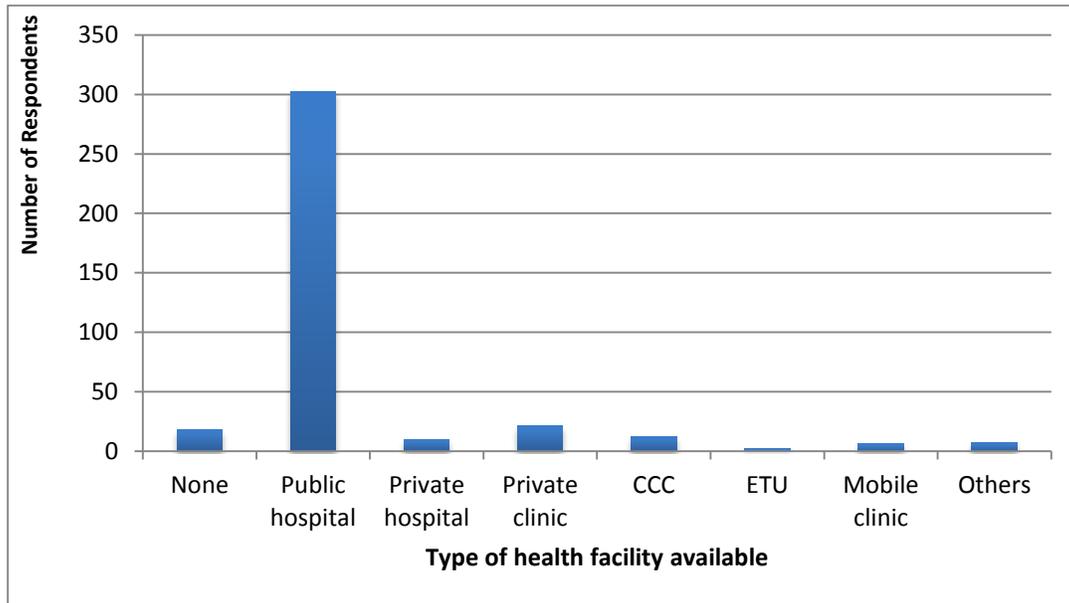
Toilet Facilities: Most households 171 (45.2%) did not have toilet facilities and defecated in open fields, followed by 139 (36.8%) who defecated in other pit latrines, whilst 42 (11.1%) had flush latrines or water closets (WC) and 24 (6.3%) defecate in ventilated improved pits (VIP) [Figure 16]. The availability of toilet facilities contribute to improving the sanitation of the community and overall environmental cleanliness which is very important for Ebola prevention.

Figure 16: Distribution of Community Source of Drinking Water and Toilet Facilities



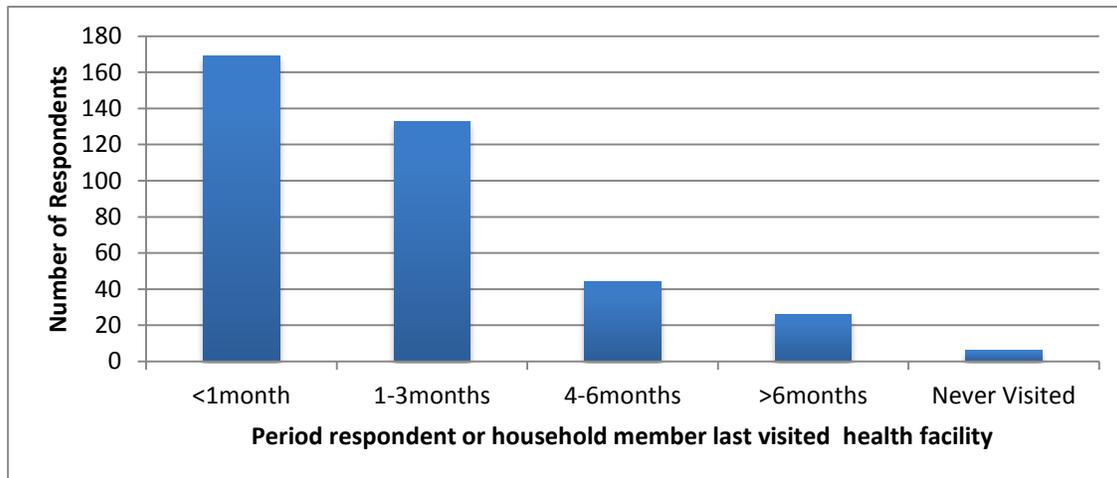
Access to Health; The survey assessed access to health facilities in the communities by asking study participants, the most common places that they go for health care: the findings indicated that, the most common health facilities available in the communities where household members seek medical care were public hospitals where 79.9% of the respondents going for health care); 5.6% of the study participants attend private clinic; 3.2% of the respondents and their household members seek medical care from CCC whilst 4.8% do not seek care from any health facility [Figure 17].

Figure 17: Distribution of Type of Health Facilities Accessed in the Community



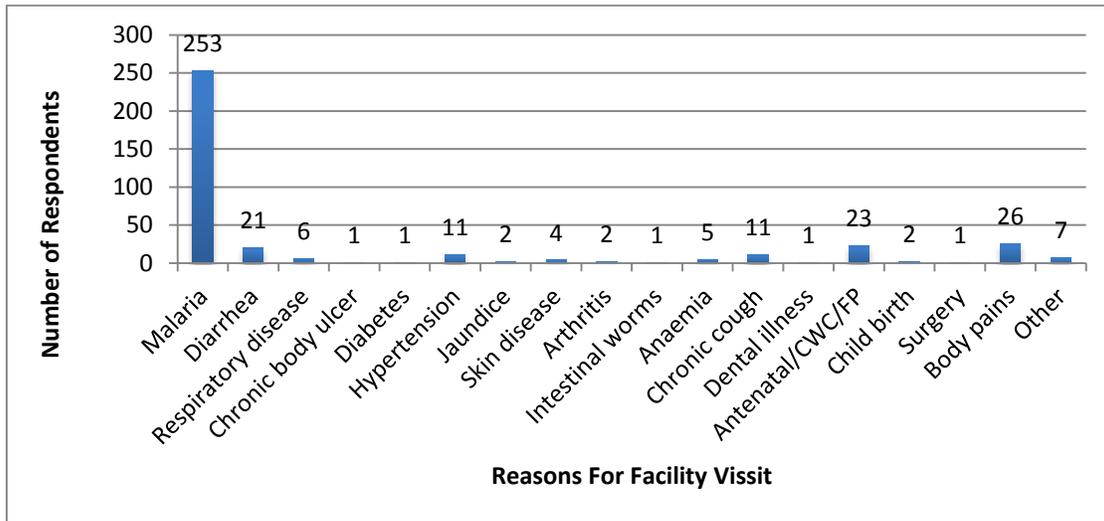
Out of the 366 study participants, a total of 169 (46%) respondents and household members reported that they last visited a health facility less than a month ago and 133 (36%) respondents reported they last visited a health facility between one to three months ago [Figure 18].

Figure 18: Distribution of Health Facilities Accessed Durations in the Community



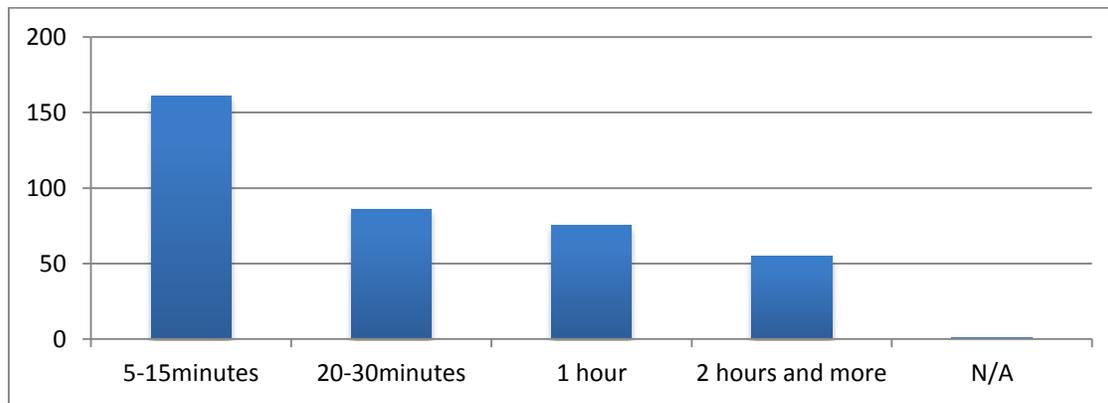
Several respondents and their household members visited various health facilities for different reasons. For those who visited health facilities, Malaria constituted majority 253 (66.9%) of the reasons why they sought health care, followed by 26 (6.9%) body pains, 21 (5.6%) sought medical care because of diarrhea and 11 (2.9%) sought care because of hypertension [Figure 19].

Figure 19: Distribution of Causes of Health Facility Visits in the Community



On the other hand distance to the nearest health facility in terms of walking distance in time was assessed. Less than half of respondents 161 (42.6%) lived 5 to 15 minutes walking distance from the nearest health facility, similarly 86 (22.8%) lived 20 to 30 minutes walking distance from the nearest health facility, followed by 75 (19.8%) who lived one hour from the health facility and 55 (14.6%) who lived 2 hours and more from the nearest clinic or hospital [Figure 20].

Figure 20: Distribution of Distance to Health Facilities in the Communities



Health Seeking Behavior; Health seeking behavior in the communities visited was generally high. Study participants were asked where they will go for health care if they thought they might have EVD or any other disease, majority of respondents 99.2% (375) indicated they will visit the clinic if they thought might be sick, to seek medical care.[Figure 21]. Similarly, most 98.1% (369) of the respondents prefers to visit clinic if they thought they might have Ebola or another disease; only 1.3% indicated that they prefer to visit other places for medical care instead of the clinic or hospital [Figure 22].

Figure 21: Preferred Places of Health Care with any Sickness

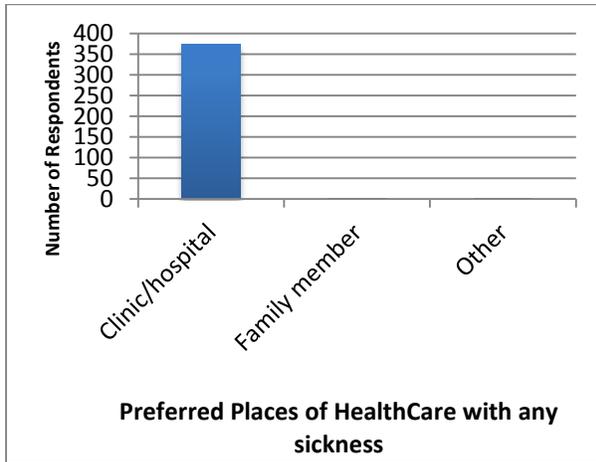
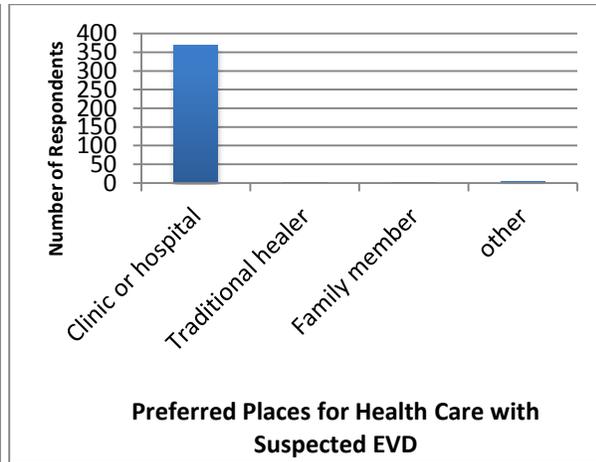
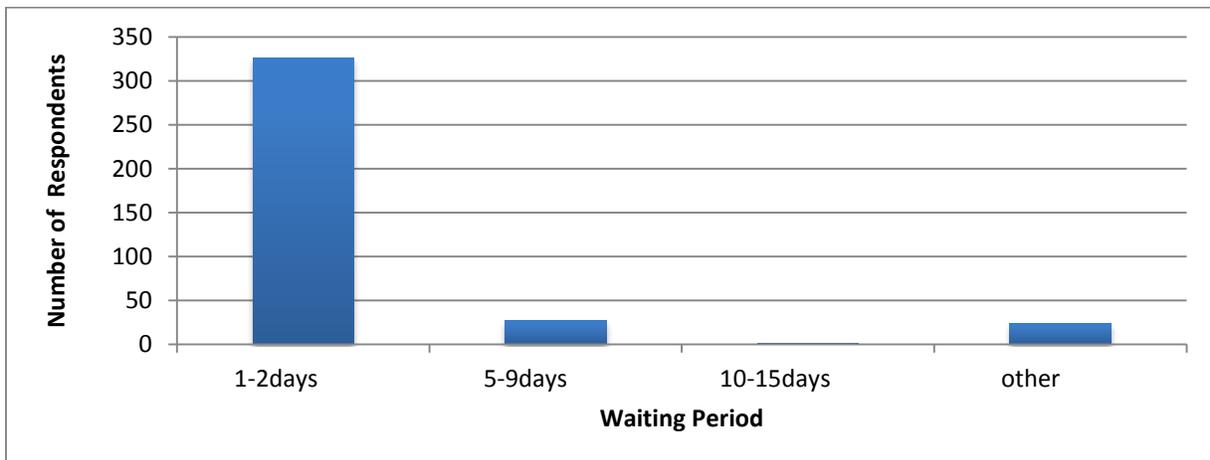


Figure 22: Preferred Places of Health Care with Suspected EVD



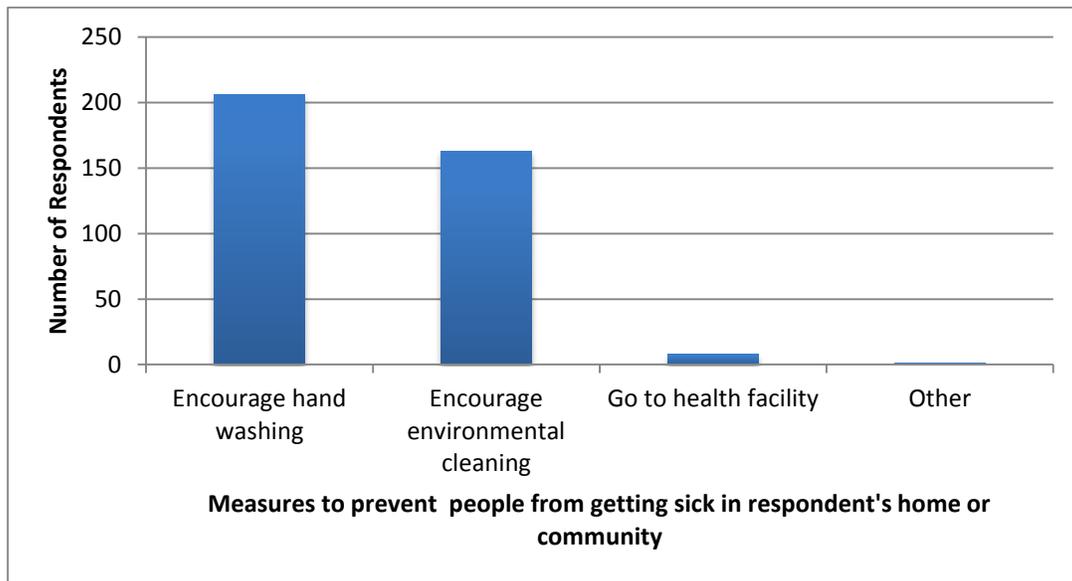
Health Seeking Behavior for Suspected Ebola Case; Health seeking behavior in terms of suspected Ebola symptoms among respondents was very high. Most of the respondents 326 (86.2%) said they would wait for 1-2 days before seeking treatment for any suspected symptoms of Ebola whilst 27 (7.1%) would wait for 5-9 days before seeking treatment and 24 (6.3%) would do other things before seeking for treatment [Figure 23].

Figure 23: Distribution of Waiting Time for Suspected Ebola Case



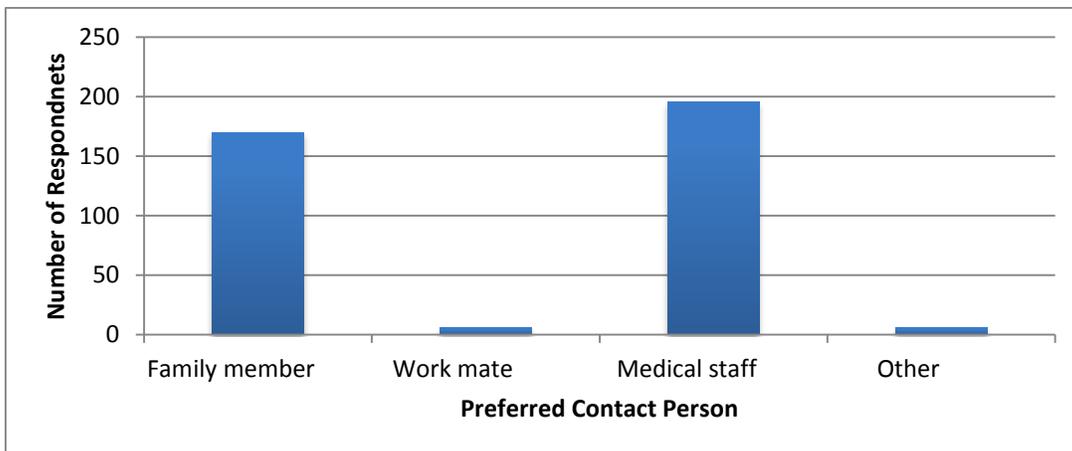
Knowledge of Ebola Prevention; Knowledge on health practices in homes and communities that will prevent people from getting sick, with respect to Ebola specifically was also assessed. More than half of the respondents 206 (54.5%) mentioned encouraging hand washing as a major sickness prevention measure, whilst 163 (43.1%) stated encouraging environmental cleaning as another prevention method and 8 (2.1) cited going to the health facility [Figure 23]

Figure 23: Distribution of Ebola Prevention Strategies in the Communities



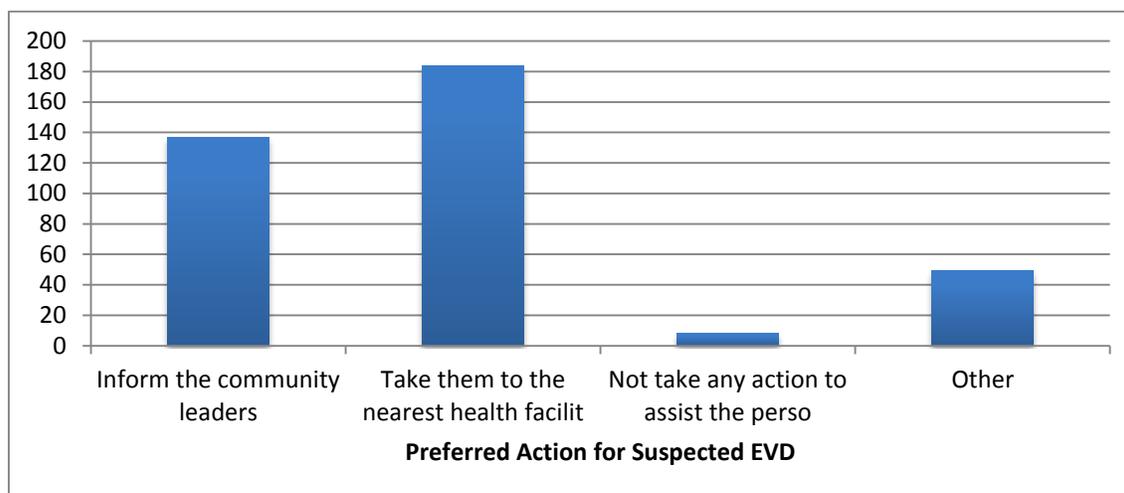
Preferred Contact Person for Suspected Ebola Case; More than half 196 (51.8%) of respondents would talk to a medical staff about their illness if they suspected they had Ebola, whilst 170 (45%) would talk to their family members and only 6 (1.6%) would talk to their work mates about their illness [Figure 24].

Figure 24: Distribution of Preferred Contact Person for Suspected Ebola Case



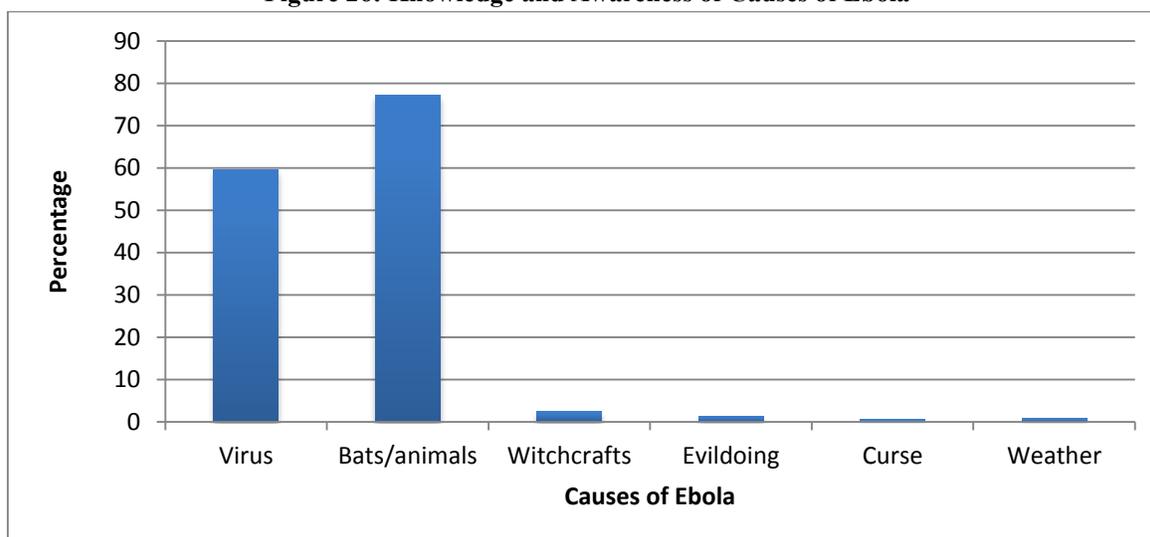
Support for Suspected Ebola Case; Just under half of respondents 184 (48.7%) would take patients showing signs or symptoms of Ebola or other diseases such as malaria, typhoid, etc. to the nearest health facility, whilst 137 (36.2%) would inform the community leaders or other leaders such as traditional, religious, etc. about the disease and 8 (2.1%) would not take any action to assist the person with the symptoms [Figure 25].

Figure 25: Distribution of Preferred Action for Suspected Ebola Case



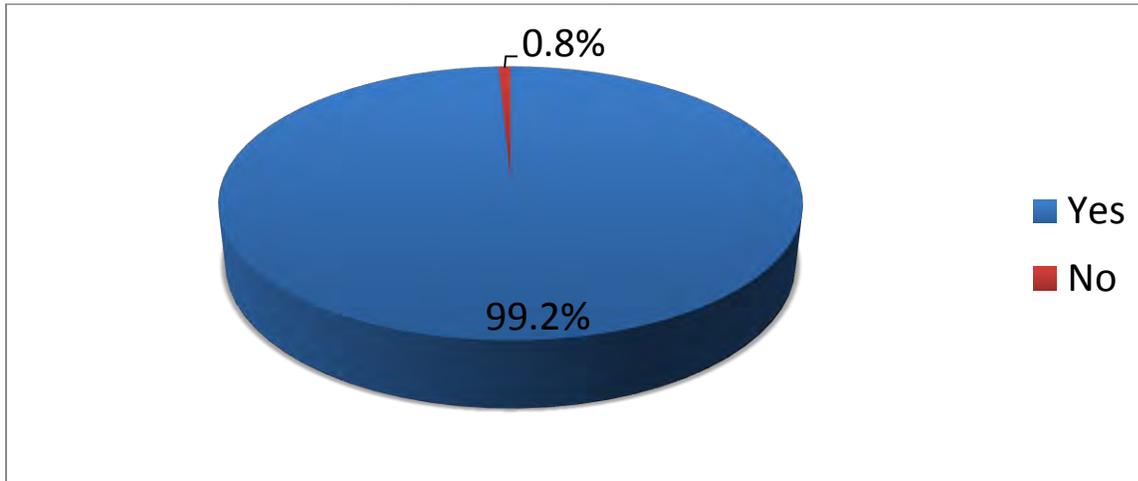
Knowledge and awareness of Ebola; The survey asked respondents questions to assess general awareness and knowledge of Ebola. Among the causes of Ebola, majority 291/378 (77.2%) mentioned bats/monkeys/chimpanzees and other animals as the major source of transmission of the disease. Similarly, 224/378 (60%) mentioned viruses as another source of transmission of Ebola [Figure 26].

Figure 26: Knowledge and Awareness of Causes of Ebola



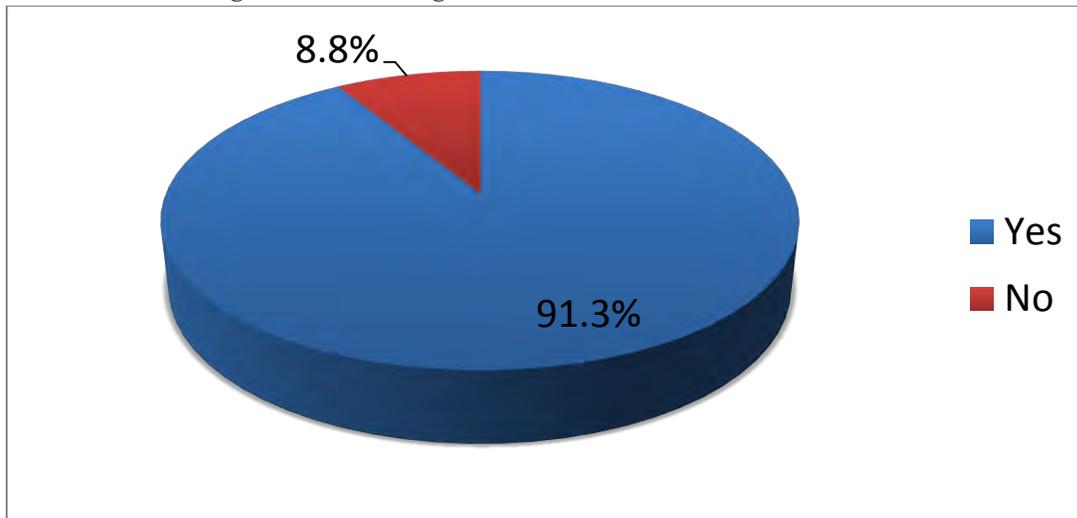
On the knowledge and awareness of the existence of the Ebola disease, almost all respondents, [374 (99.2%)], were aware of the existence of the Ebola disease compared to 4 (0.8%) who have not heard about the disease [Figure 27].

Figure 27: Knowledge of Existences of Ebola



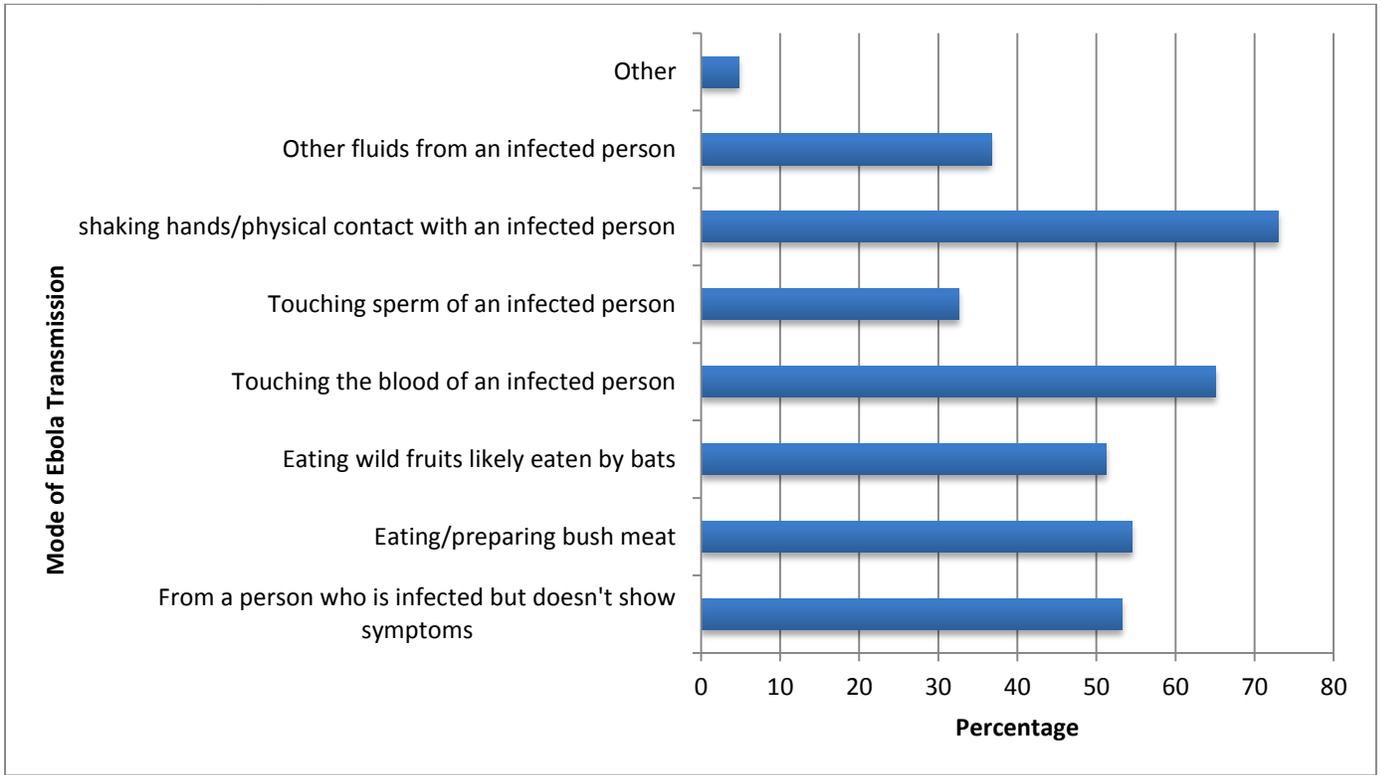
On the knowledge and awareness of EVD survival rate, most of the respondents [334 (91.3%)] believed someone could get Ebola and survive, whilst 34 (8.8%) thought otherwise [Figure 28].

Figure 28: Knowledge and Awareness of EVD Survival Rate



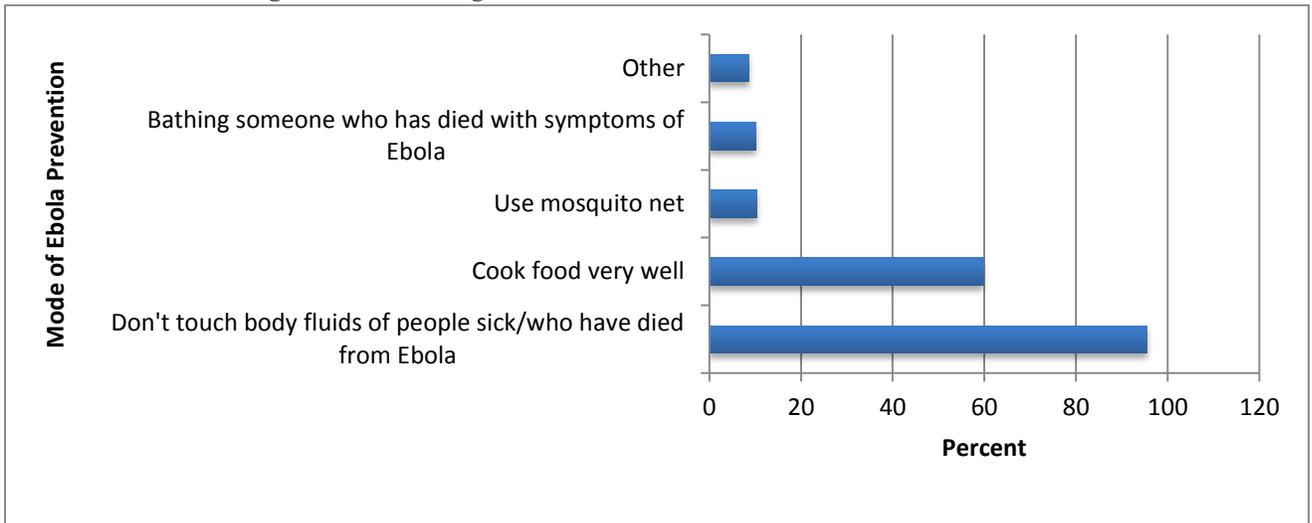
On the knowledge and awareness of mode of Ebola transmission, majority of respondents [276 (73%)] mentioned that shaking hands or other physical contact with an infected person could get a person infected with Ebola. Similarly, 246 (65%) mentioned touching the blood of an infected person as another means of getting infected with Ebola [Figure 29].

Figure 29: Knowledge and Awareness of Mode of Ebola Transmission



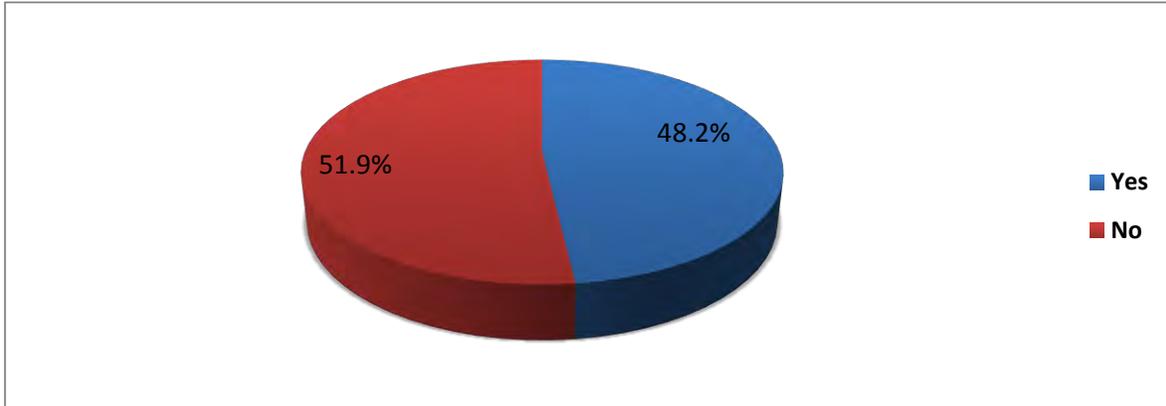
On the knowledge and awareness of mode of Ebola prevention; the respondents were asked whether they knew how a person could prevent getting Ebola. Most of them 360 (95%) mentioned avoiding touching the skin or body fluids of people sick with/who have died from Ebola. Similarly, 225 (60%) of respondents mentioned cooking food very well before eating [Figure 30].

Figure 30: Knowledge and Awareness of Mode of Ebola Prevention



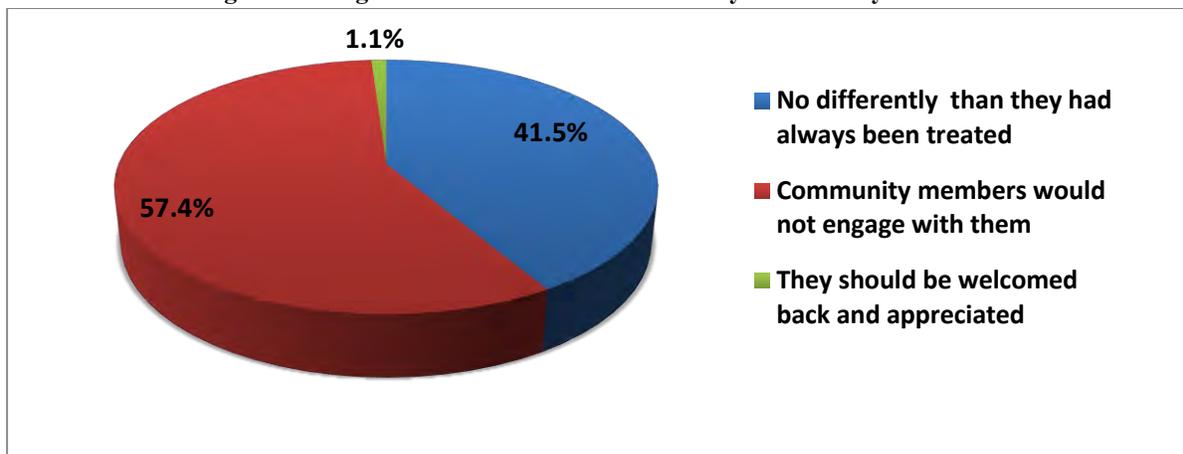
On the knowledge and awareness of people who can get Ebola, study participants were asked whether they share the view that, they themselves or any member of their family could get infected with EVD; less than half (48.2%) of the respondents were of the view that, they and any member of their family members could get infected with EVD; 51.9% of the study participants were of a contrary view [Figure 31].

Figure 31: Knowledge and Awareness of People who can get Ebola



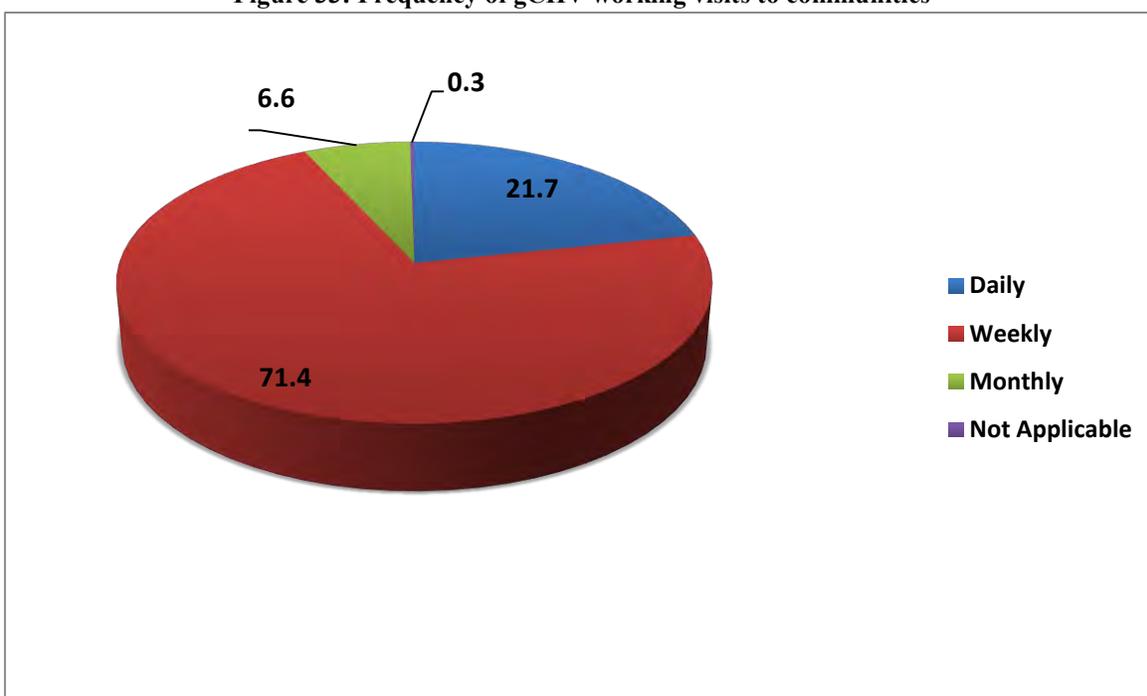
Stigmatization of Ebola Survivors; Stigmatization is one of the key barriers in the fight against Ebola. Stigmatization greatly affects the smooth reintegration of Ebola survivors to be with their families or join their community members and be accepted by the family or community and live a normal life. Therefore members of the community were asked about how community members who were Ebola survivors will be treated or accepted if they returned to the community on their own or they are brought back to the community by the government to reintegrate with them; more than half (57.4%) of the study participants were of the view that, they would be discriminated against and community members would not like to engage with them; however 41.5% of the respondents were optimistic that, community members would treat Ebola survivors not differently than they had always been treated [Figure: 32].

Figure 32: Stigmatization of Ebola Survivors by Community Members



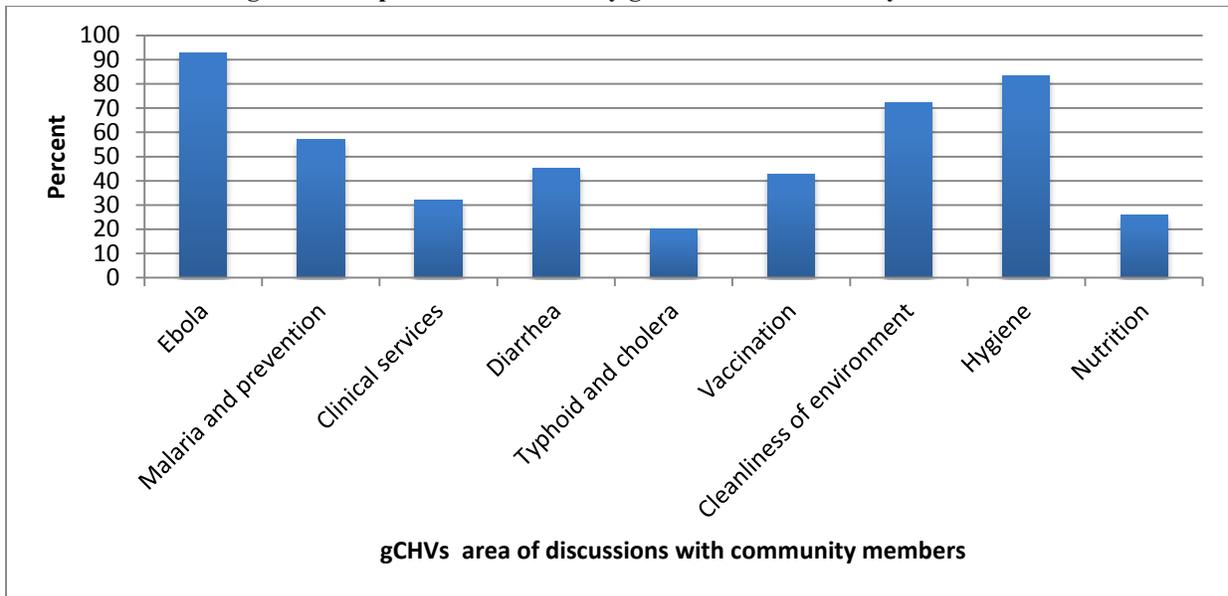
The Role of Community Health Volunteers; General Community Health Volunteers (gCHV) are very essential for the Liberia Health System. General Community Health Volunteers were an integral part of EC3 project activities, especially the community based interventions. This evaluation is examining the roles and responsibilities of the gCHVs in the context of the EC3 project. Community members were asked how often they see gCHVs working in their community; majority (71.4%) of the community members were of the view that, they see gCHVs working in their communities on weekly basis whilst 21.7% and 6.6% of the study participants see gCHVs working in their communities on daily and monthly basis respectively (Figure 33).

Figure 33: Frequency of gCHV working visits to communities



After knowing the frequency of gCHVs role in the communities, it was imperative we know what they do, so the activities of the gCHVs were also explored by asking the question- what does gCHVs in your communities usually do or discuss with community members. The finding indicate that, majority of the gCHVs were involved in community mobilization and sensitization with respect to Ebola awareness creation and prevention (92%); Hygiene (82%); Environmental Cleanliness (72%); Malaria prevention (58%) and Vaccination (42%). The gCHVs had also conducted community mobilization and sensitization with respect to nutrition, diarrhea, typhoid, cholera and clinical services availability [Figure 34].

Figure 34: Topics of Discussions by gCHV with Community Members



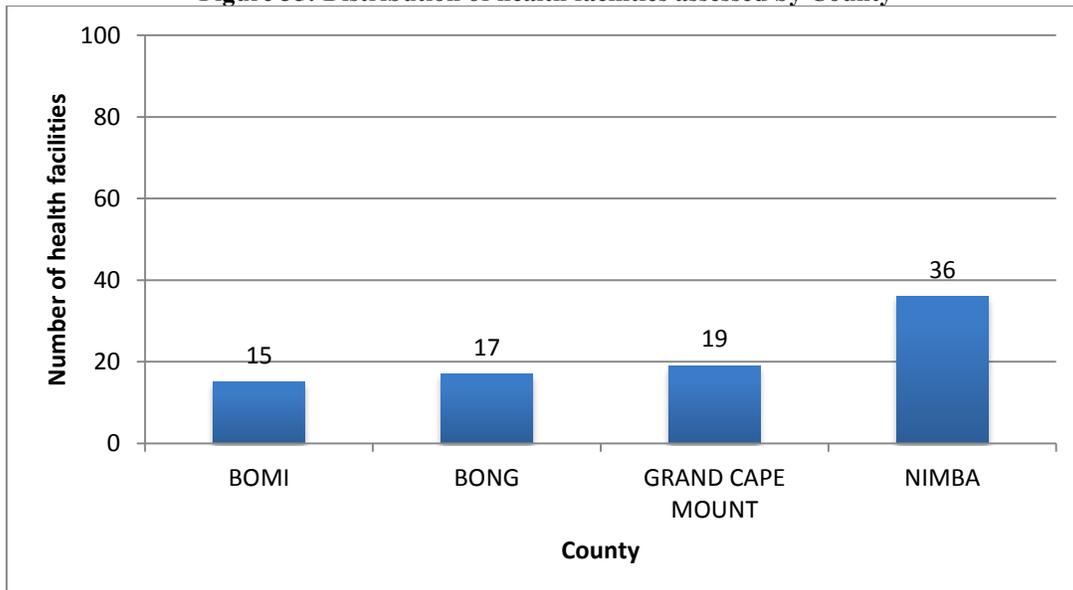
Health Facility Assessment Findings

Description of Health Facilities Assessed.

A descriptive analysis of the facilities involved in the assessment by location, district and level are presented in Figures 35 and 36

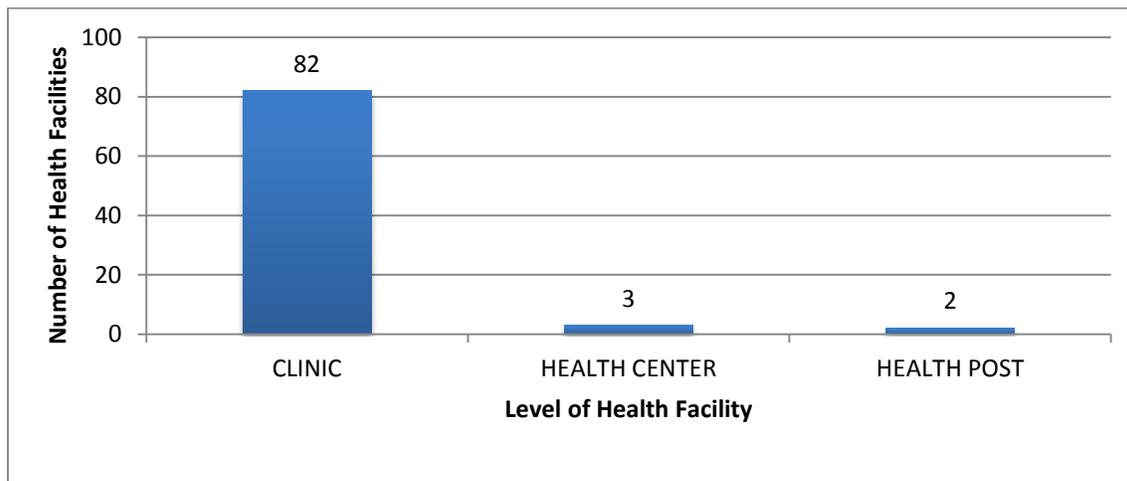
Location of health facilities by county: A majority 41% (36) of health facilities were in the Nimba County; 59% (51) of the facilities were evenly distributed amongst Bomi County- 17% (15); Bong County- 19% (17) and Grand Cape Mount- 22% (19) [Figure 35]

Figure 35: Distribution of health facilities assessed by County



Health Facility Level: The facilities that were involved in the assessments were either clinics, health centers and health posts. The majority, (94 percent (82) of the facilities were clinics.

Figure 36: Distribution of Health Facilities Assessed by Levels



The Liberia health system is divided into; primary care, secondary care and tertiary care. The primary care is made of the community health system which is the main primary care provider. It includes:

- a. **Community Level Services;** A standard set of outreach, health promotion and referral services will be provided for communities more than one hour walk (5km) from the nearest health facility by: Community Health Volunteers (CHVs). CHVs include: Household Health Promoters (HHPs), Trained Traditional Midwives (TTMs) and general Community Health Volunteers (gCHVs).
- b. **Primary Health Care (PHC) Clinic Level 1;**The PHC Level 1 Clinic covers isolated clustered communities with a population of up to 3,500. Each PHC Level 1 is, at minimum, expected to be open 8 hours each day between Monday and Friday.
- c. **PHC Clinic Level 2:** The PHC Level 2 Clinic covers a catchment population of 3,500 to 12,000 and provides outreach services (see d) to the portions of their catchment population outside of a 5km radius. Each PHC Level 2 is, at minimum, expected to be open 8 hours each day between Monday and Friday.
- d. **Integrated Outreach Programs;** Based at the PHC Level 2 Clinic, they provide basic primary care, at least weekly, to isolated catchment communities that are more than one hour walk (5km) from the clinic

Secondary Care is made up of the district health system which is the first provider of secondary care, focusing on maternal and child health. It receives referrals from the community system. The district health system has a catchment population of 25, 000 to 40, 000 has either the following;

- a. **Health Centers;** Health Centers receive referrals from PHC Level 1 and 2 Clinics in the district; have up to 40 beds and a laboratory. Each Health Center is expected to be open 24 hours every day
- b. **District Hospitals;** Where a dense catchment population, large network of clinics and far distance from a county hospital warrants it, Health Centers may upgrade to District Hospitals with higher clinical capacity, including emergency surgery and Comprehensive Emergency Obstetric and Neonatal Care (CEmONC). Each District Hospital is expected to be open 24 hours every day.

The Tertiary Care is the national system and it is the main provider of tertiary level care. It consists of two types of hospitals: Regional Hospitals and the National Hospital, John F. Kennedy Medical Center (JFKMC).

5.2. Improvement in Healthcare Facility Capacity to Provide Quality Treatment

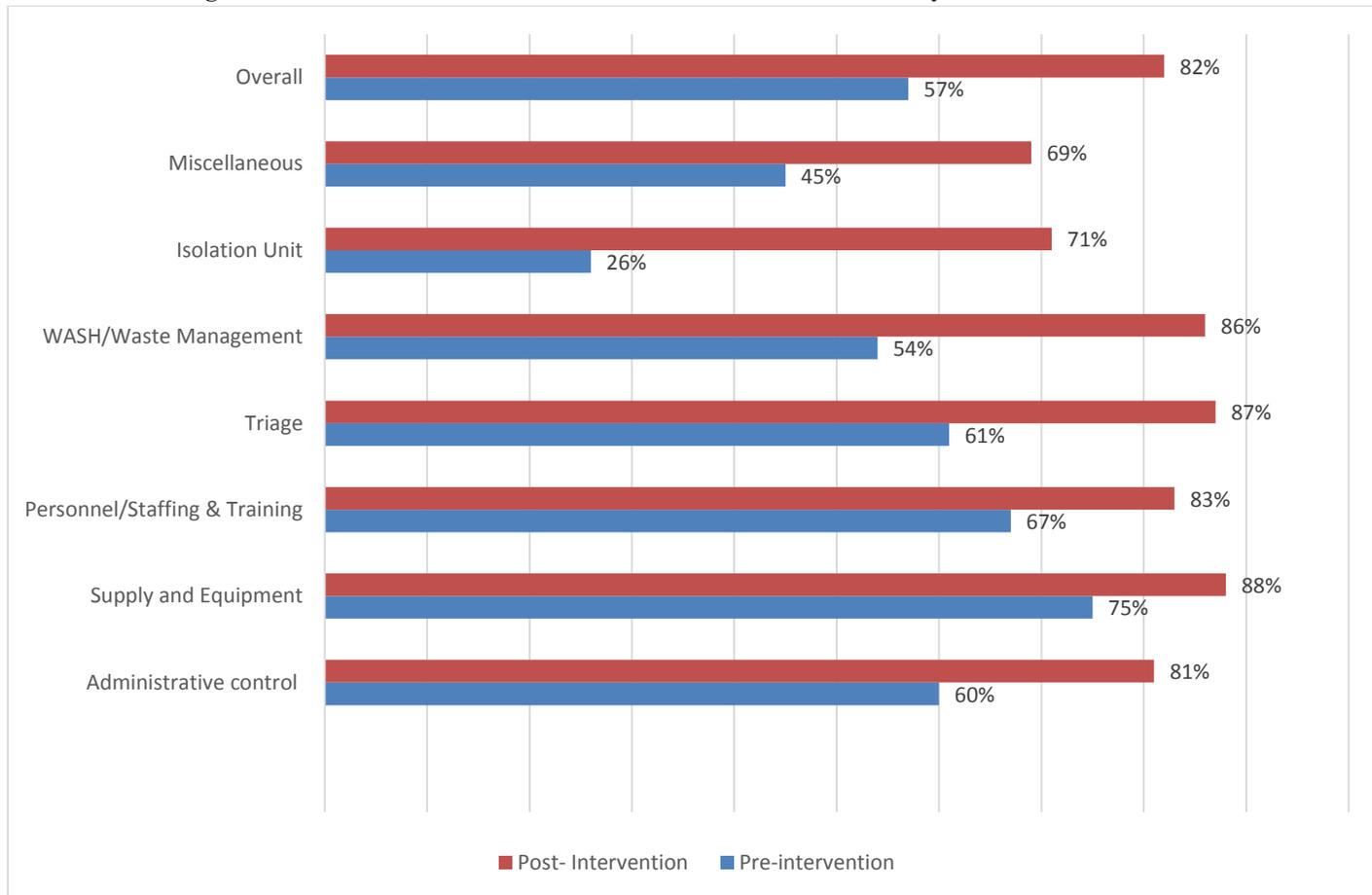
The key indicator for the assessing the performance of Sub-Sector 1: Health System and Clinical Support is; “improved healthcare facility capacity to provide quality treatment” and it’s LOP is 20% improvement over baseline.

The results of the 87 project intervention health facilities that were involved in the health facility assessments revealed that, overall, there is 25% improvement from an average score of 57% (95%CI: 46-67%) at pre-intervention to 82% (95%CI: 74-90%) at post-intervention. This difference is statistically significant at 95% confidence level. As presented in Table 1, the LOP target was also exceeded by 5%. Similarly, there is statistically significant difference in improvement within each of the areas of assessment.

Table 4: Performance of PCI EC3 Intervention Health Facilities by Sections

Description/Area of assessment	Pre-intervention	95% CI, Lower	95% CI, Upper	Post-Intervention	95% CI, Lower	95% CI, Upper
Administrative control	60%	47%	73%	81%	72%	90%
Supply and Equipment	75%	64%	85%	88%	81%	95%
Personnel/Staffing & Training	67%	55%	79%	83%	74%	92%
Availability of Triage	61%	48%	74%	87%	79%	95%
WASH/Waste Management	54%	40%	68%	86%	78%	94%
Availability of Isolation Unit	26%	8%	44%	71%	60%	82%
Miscellaneous	45%	29%	61%	69%	57%	81%
Improved Health care facility capacity to provide quality treatment	57%	43%	71%	82%	73%	91%

Figure 37: Performance of PCI EC3 Intervention Health Facilities by Sections



Administrative Controls: Administrative controls were made up of the assessment of standard operating procedures (SOPs) including:

- Infection Prevention and Control (IPC) Focal Person identified with TOR
- Budget allocated to IPC programs
- Availability of reliable communication device
- Availability of job aids such as posters.

In line with the overall improvement in the proportion of improved health care facility capacity to provide quality treatment, more than half [60% (95% CI 47%-73%)] of all health facilities assessed at pre-intervention had administrative controls but at post-intervention, 81% (95% CI 72%-90%)] of the facilities were having administrative controls such as infection prevention and control focal person with TOR, reliable communication device and job aids (posters). This represents an increase of 21% which was statistically significant at 95% level of confidence ($p=0.0106$) [Figure 37: Table 4]

Figure 38: Terms of Reference for IPC and Job aids

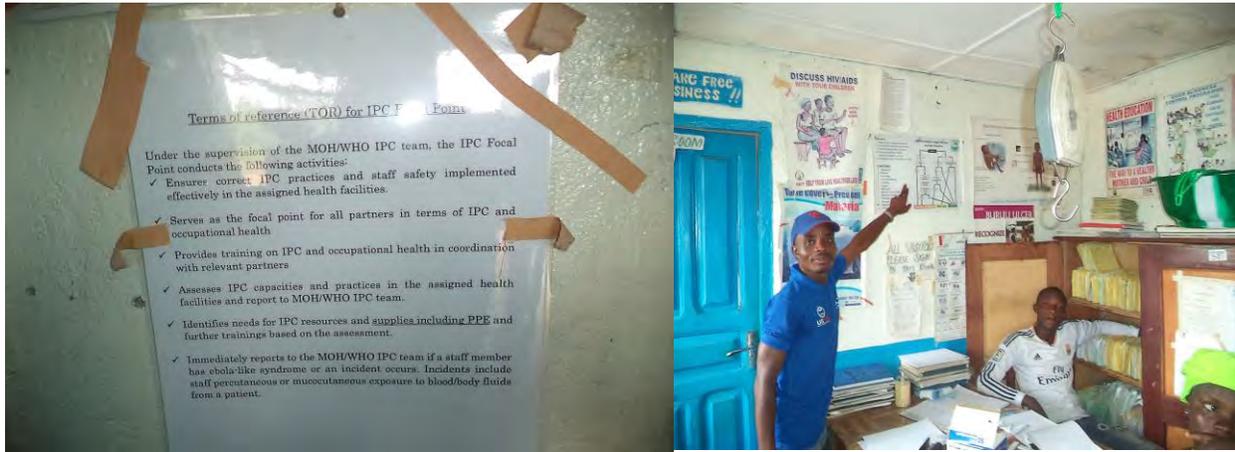
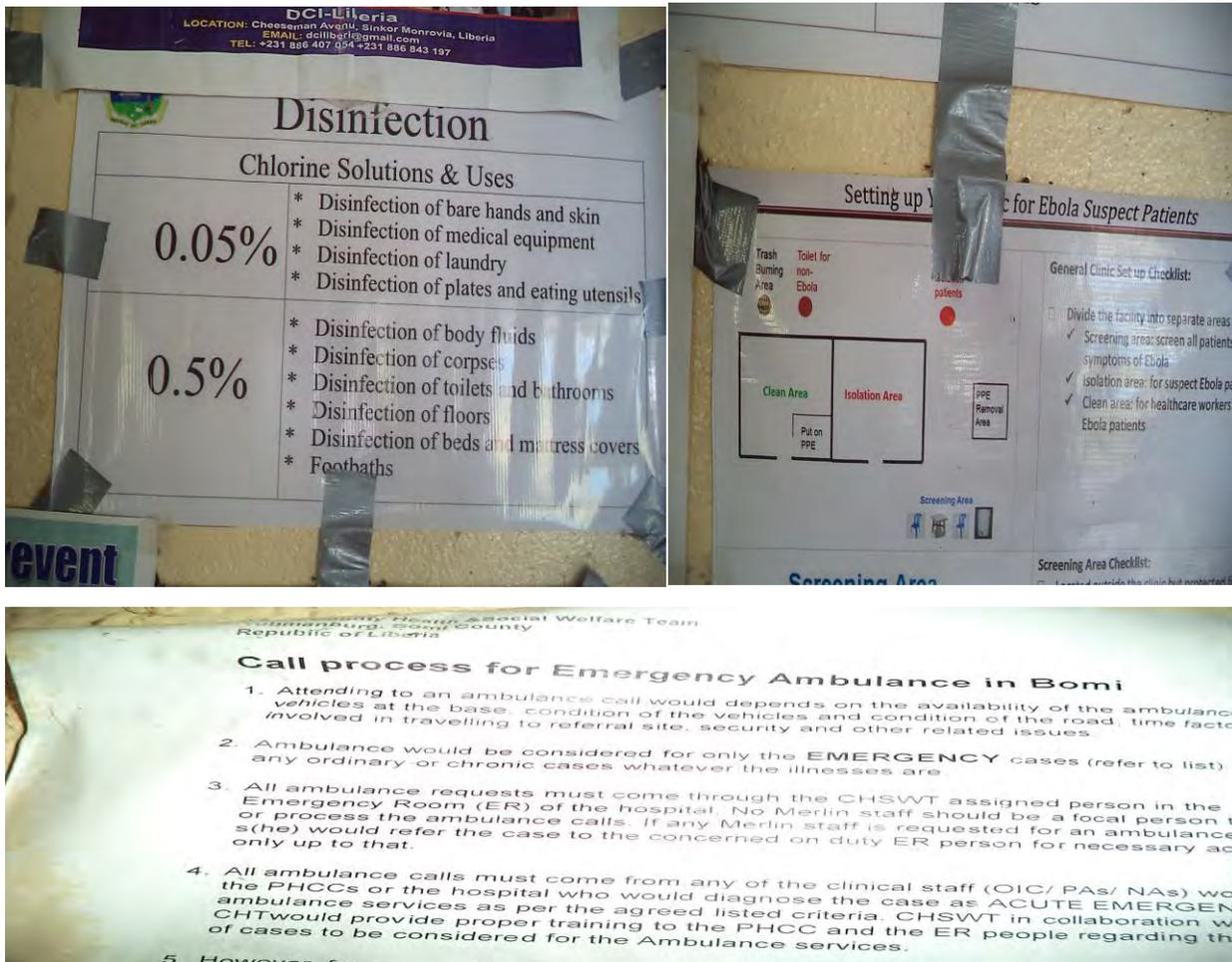


Figure 39: Job aids and Call Process for Emergency Ambulance



Supply and Equipment: Essential medical supplies including pharmaceuticals for healthcare facilities and workers based on need were assessed through interviews and observations. This assessment was done based on:

- One month of IPC supplies availability at the facility observed
- Basic PPE and functioning thermometers present and available for use at triage
- Puncture-resistant sharps containers are available in all patient care and other relevant areas
- Needles and syringes are not reused
- Availability of functional sterilization equipment for use

Three-fourths of [75% (95% CI 64%-85%)] healthcare facilities assessed had essential medical supplies and equipment at pre-intervention, whilst at post-intervention, there was an increase of 13% [88% (95% CI 81%-95%)] and this was statistically significant at 95% confidence level ($p = 0.0452$). [Figure 37; Table 4].

Figure 40: Facility Supplies and Equipment

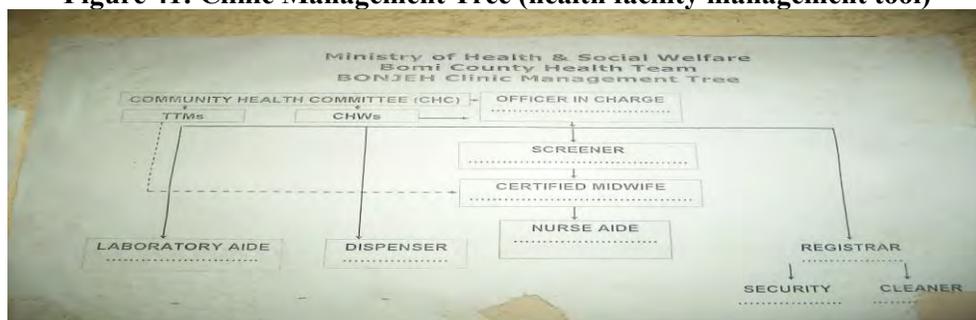


Personnel/Staffing and Training: Personnel training was assessed through interviews and observations. The assessment was based on:

- Whether healthcare facility staffing met or exceeded the criteria outlined in the MOHSW Essential Package of Health Services,
- Whether staff have been trained in the MOHSW Keep Safe Keep Serving Package,
- Whether at least one clinician was present in the clinic whenever it was opened
- Availability of a system for checking and reporting staff health issues, including daily temperature checks during EVD outbreak, was in place.

Accordingly, about two-thirds [67% (95% CI 55-79%)] of the health facilities assessed met this description at pre-intervention but there was 16% increase [83% (95% CI 74%-92%)] in the facilities assessed at post-intervention that met these criteria and this was statistically significant at 95% level of confidence ($p = 0.0348$) [Table 4: Figure 37].

Figure 41: Clinic Management Tree (health facility management tool)



Availability of Triage: The triage availability assessment was done through interviews and observations. This was done based on:

- Whether there was an established limited number of designated entry points to the facility for triage of patients, staff and visitors
- Whether all persons (patients, staff and visitors) entering the facility are triaged
- All triage areas should at minimum have hand washing stations, functioning thermometers, and PPE available
- Whether distance between patient beds was at least 1 meter in all patient rooms.

At pre-intervention, 61% (95% CI 48%-74%) of facilities met this criterion of assessment and demonstrated availability of triage and at post-intervention, there was an increase of 26% [87% (95% CI 79%-95%)] of facilities at post-intervention that were having triage. This finding was highly statistically significant at 95% confidence level ($p = 0.0007$) [Table 4: Figure 37].

Figure 42: Triage decision making chart and appropriately spaced patient beds



Availability of WASH/Waste Management Facilities: This assessment was conducted through interviews and observations and it was based on:

- Whether health facilities have systems in place for standard waste disposal
- Availability of waste management SOP based on national standards in the facility
- Existence of written plan for management of dead bodies
- Availability of functioning latrine or toilet facility for staff and for patients
- Existence of protocols for waste segregation, storage and disposal
- Availability of potable water source for the facility
- Whether all patient rooms were well ventilated
- Availability of space dedicated to and supplies for mixing/making the appropriate chlorine solution dilutions daily.

Slightly more than half [54%(95%CI40%-68%)] of health facilities had WASH/Waste management facilities in place at pre-intervention stage of the assessment, this increase to 86% (95% CI 78%-94%) after the intervention which represents a significant increase of 32% and this was highly statistically significant at 95% level of confidence ($p = 0.0001$) [Table 4: Figure 37].

Figure 43: Waste Disposal Methods Job aids



Figure 44: Hand Washing Job aid and Waste Disposal Facility



Figure 45: Portable Water and Clean Toilet Facilities



Availability of Isolation Unit: Health facilities were assessed on the availability of isolation units for managing suspected EVD cases. This was done through interviews and observations and it was based on:

- Whether a written plan exists for management of suspect/probable EVD cases, for facilities with isolation space
- Whether this includes supplies and an area for health care workers to put on and take off enhanced PPE
- Whether facility-appropriate isolation space exists and is prepared for isolation of probable or suspect cases awaiting transport, and – in hospitals and health centers – to provide care for suspect/probable patients who cannot be transferred.

The results indicate that, less than half [26%(95% CI 8%-44%)] of the facilities assessed at the pre-intervention stage had isolation units in place. However, after the intervention, there was a remarkable increase of 45% [71% (95% CI 60-82%)]. This finding was highly statistically significant at 95% confidence level ($p = 0.0002$) [Table 4: Figure 37].

Figure 46: Isolation unit



Miscellaneous Facilities: The next stage of the assessment focused on miscellaneous centered on:

- The presence of safe and reliable electric supply
- Whether the MOHSW list of priority diseases is available at the facility
- Reporting systems in place
- Whether laboratory personnel have been trained in safe collection, packaging, and transport of biological specimens
- Whether remediation has occurred in response to any Ebola-related IPC audit previously conducted in the facility.

The results indicate that, less than half [45% (95%CI29%-61%)] of the facilities at pre-intervention met this criterion, however after the intervention there was a significant increase of 24% [69% (95% CI 57%-81%)] and this was statistically significant at 95% confidence level ($p = 0.0179$), [Table 4: Figure 37].

There was statistically significant improvement within each of the areas of assessment. Additionally, there was an overall improvement of 25% in health care facilities capacity to provide

quality treatment at post-intervention. This improvement was highly statistically significant at 95% confidence level ($p = 0.0028$).

Figure 47: Priority disease case definition job aid and facility sign post



6.0. Quality of EC3 Program

The program quality assessment of the project was conducted with qualitative research tools such as; Observations, Focus Group Discussions (FGDs), In-depth Interviews (IDIs) and Key Informant Interviews (KIIs) with county level beneficiaries, district level beneficiaries, health facility level beneficiaries and community level beneficiaries. Participation and partnership with government offices and other stakeholders. The proxy program quality assessments dimensions were:

- Awareness and knowledge of the PCI EC3 project
- Intervention activities in the community
- Effectiveness of EC3 with respect to emergency response
- Behavior of community members after EC3 intervention
- Some specific observed changes
- Observed Changes in health facility resources as a result of PCI EC3 intervention
- Community events or campaigns to strengthen resilience
- Awareness and knowledge of EC3 project objectives
- Some observed achievements of EC3 project
- Some observed successes of EC3 project

- Some challenges of EC3 project
- Lessons learned
- Some behavior changes observed
- Most significant changes observed
- Benefits and sustainability
- Best practices
- Opportunities for similar projects in future
- Recommendation and suggestions

Awareness and Knowledge of the EC3 project; On knowledge on the PCI EC3 project, most respondents got to know the project after the Ebola outbreak once CCCs were constructed and community health workers were trained on awareness and methods of prevention such as hand washing and cleaning of surroundings. Some respondents also did not know the project until they were invited for training to learn about the mission of the project. The community chiefs mentioned that they received visitors with materials to resource the health facilities. Also, from the health directorate it was indicated that the project was an important intervention due to the nature of the outbreak. This is supported by the quotations below:

“PCI EC3 per-se in Bomi, this is an organization that came in at the time we were dying and in need of partners to help us in surveillance activities like contact tracing, case sets, community awareness, creating awareness in the community; helping our people in the community also to break this EVD awareness and even on maternal death they were doing that; that’s what I know at my own department” (Representative of the County health officer)

“.....So they start, I think the place we can wash our hands and other place where your skin hot too much you wait.....” (Community Chief).

“.....Yes. I worked with the EC3 project in Handii [Bong County] as a gCHV. We were doing awareness in the communities – like Ebola prevention, how to take care of the community, if somebody has Ebola how to contact the nearby hospital. We were focused on awareness and prevention. They brought supplies for us: they brought bags, they brought T-Shirts, they brought training materials. They brought some materials during our last training”. (Community key Informant)

“.....An agreement was met to build CCCs in this community which was built to meet the challenges in case of an outbreak.....” (District Reproductive Health Officer)

Intervention Activities in the Community; Both FGDs and in-depth interviews portrayed that many items were received by the various health facilities including medical and non-medical supplies to facilitate health workers’ response to normal cases and emergency cases; however, some respondents mentioned lack of funds for maintaining some facilities. Many people were trained to handle emergency cases. There were also infrastructure deployment and capacity building on community mobilization and sensitization and behavior change communication (BCC). The members of the communities are very excited about the project and resources that are being provided to their communities. These are supported with the quotations below:

“We received items – medical and non-medical supplies from PCI EC3 at Handii clinic... Yes they donated few items. According to them, they were doing it all over all the health facilities and hospitals. But I was not there, but according to them, they did it. I think the DHO should know about it because he was to sign”.....“Due to the absence of new cases, workers are now more focus on Community outreach/engagement, creating awareness and the radios and through gCHV” (Reproductive Health Supervisor)

“....PCI assistance in the provision of major drugs and distribution to health facilities....they have also provided training to staffs for better first aid and safe healthcare delivery.....Surprisingly they have started building isolation structures in various facilities as is very much needed but lacking. It was mandated that all health facilities have similar structure but evidently there is no funding.....PCI EC3 also assisted in the provision of IPC material to various health facilities, like boots, apron, etc.”(District Reproductive Health Officer)

“Well, as county surveillance officers, they have a group in Klay and Swen District that they trained, the gCHVs that they were supporting, in active case sets, carrying on sensitization on swab collection, that is dead body spit collection, they were doing that and also on blood collection the lab high temperature that WHO said we should do, they were doing that; they were supporting those groups that were on surveillance system” (Representative of County Health Officer)

Effectiveness of EC3 with Respect to Emergency Response; Most community key informants and health workers viewed the project in diverse ways. While most responses affirm that the project was very effective and placed much emphasis on community sensitization and prevention measures toward the outbreak of the disease - thereby improving the involvement and awareness situation and increase in surveillance. Some of the respondents interviewed were not pleased about the timelines of the project and referred to the untimely closure of the project as not very good. Additionally, a respondent mentioned that the program did not cover the entire district, which was a demerit. This is shown in the responses below:

“Yes, it was efficient and effective but the gCHVs selected did not cover the entire district”.
(District Medical Officer)

“For me as a gCHV and as a nurse of this community, the time specifically is not really enough. It’s not really enough, because the quitting of the project as we been hearing that they will be closing the project you know, not really fine for that because we just heard another outbreak again few days ago in Liberia and then immediately PCI EC3 is talking about closing the project. We find that that is not a good step”. **(Community Key Informant)**

“To some extent I can say yes. But I was not involved with them; I saw them. I saw a lot of nurses at that time. But the only thing, they never had patients. But we saw at least in our communities telling our people about the virus and how to take prevention and other things. Even though I was not at the clinic, but once I heard we had an emergency and one of the nurses from the CCC even helped at that time” (Reproductive Health Supervisor)

“The PCI EC-3 was always prepare and ready for any emergency. And because of this reason more focuses were placed on community involvement/awareness. And it’s evident by the way the towns are now clean (clean environment) and less sick people”. **(District Reproductive Officer)**

“Yes. It was very much effective. We saw PCI EC3 was one of the NGOs that came into Fuamah District and it was effective and the relationship between the gCHVs and the staff in Handii was very much cordial. The efficiency of the project was nice for me” (Community Key Informant)

“.....they actually did actually did well because at that time this two district was lacking but the coming in of PCI EC3 help me a lot so that I was receiving report; I was receiving cases; I was receiving samples from these two districts that they were in” (Rep of County Health Officer)

Behavior of Community Members after EC3 intervention; Concerning behavior change as a result of the PCI project, most people interviewed came out that the project has actually changed the life style of the community members positively due to the sensitization and the awareness created. Also according to their response the health seeking behavior of the people has changed from previously where they were hiding patients to current active hospital attendance due to the training that was given to them. The community members are therefore prepared to respond to any emergency situation after the intervention. The following quotes support the assertion:

“I’ve observed my community behavior change in the area of going to clinic. They are coming to clinic often. Because before then, few people never use to come to clinic. But during the PCI EC3 project, with the awareness being provided by the gCHVs under PCI, people in the community heard it and that change came to their minds that they need to go to hospital and they’ve began to come to hospital. Most often people attend clinic as a result of the awareness being provided to them by the gCHVs”. (Community Key Informant)

“There has been a big change. In our communities, we see a clean environment, less sick people, people no longer goes into bush/forest to use open pit latrines to defecate and visit the clinic often. Of all hand washing and clean environment are the main interests”. (District Reproductive Officer)

“Oh! Thank you, the people change totally. Mainly, with the hand washing and handshakes behaviors is going away gradually. They conducted training for us at the clinics how to work with the communities and how to respond if there is an Ebola case”. (Community Key Informant)

“Yes like the issue of hiding sick people in the community, they are getting to know that it is very important and necessary that when someone is sick to seek care as soon as possible in order to stand 100%. Or at least 90% chance of survival. Yes so there are lot of changes been carrying on that they were not doing before then, they are at least practicing lot of good health care practices if I made say” (County Medical Officer)

“I have been putting it into practice. Even in the way that you see the sick and mostly how you used to see the sick people in the town is not like that because every day I go to their houses talking to the babies mothers, how to take care of the babies, big belly should go to the clinic and now the drugs self I signed for I still keeping them because nobody getting sick. We are now prepared to fight any disease because no one medical doctor near us and you can see the distance like from here to the clinic so before when disease enter here we will feel it before medical people come here. Because we are not prepared to facing that. The first thing PCI EC3 taught me is preventive measures. And what we should do to avoid these sickness. Yea, and I can still tell them sometimes I call meetings. You can see any society some people there can listen, and those that can listen, and those that can’t listen. Some can say that true that by talking of washing hands” (Community Key Informant)

Some Specific Observed Changes; Respondents mentioned that the project has brought about visible changes as a result of the way the program supported in the construction of isolation areas and triages, trained staff and supplying of essential drugs regularly to support the health facilities to be able to carry out its duties during the outbreak and the people have also come to realize that the disease is real as well as accepting survivors into their fold. However, there was a response that supporting staff at health facilities were not enough to deal with emergency cases. Some of the observed changes that occurred as a result of the intervention are hand shaking and hand washing. These are supported with the following quotes:

“First in this community the people never accepted the fact about Ebola when the virus first entered. But now when they say someone sick this way for people to just go there, no. I see them really taking their own time to visit people. When we even go to visit, no touching”. **(Reproductive Health Supervisor)**

“There have been changes, the construction of isolation areas and triages, staffs are being train though there are still shortages of staffs to handle the case load. Essential drugs are provided through PCI EC3 assistance”. **(District Reproductive Health Officer)**

“Yes, I see PCI EC3 supplying drugs on monthly basis, I saw them build triages and isolated areas at the clinics” **(Female community member)**

“One very important behavior change was accepting Ebola survivors in this community. For me I saw it as very good. We accepted them, interacted with them and they feel free moving in the community”. **(Community Key Informant)**

“Yes, yes because number one, washing hand is existing before but now people get used it. Hand shaking not too much. Then Ebola gone but the handshaking not too much. You see when you entered self, if someone was shaking hands, I can’t tell; but I think you saw it” **(Community Health Volunteer)**

Observed Changes in Health Facility Resources as a Result of EC3 Intervention; From the respondents’ view, the project has been able to provide basic training to the health volunteers to respond to cases, provided structures for admitting cases and also provided professional staff to assist in referral of cases to the health facilities. They also provided material and non-material resources to support the program. The following quotes support the findings:

“...Yes, PCI EC3 has trained gCHVs with some basic training. And they goes into the community talking to people as how to respond in case they see sick people and how to treat people treated of Ebola....” **(District Reproductive Officer).**

“...Yes, for Handii; but for Bong Mines, it’s a company area but I can say its commercial also. For I’ve not seen anything pertaining to the infrastructure right now. But for Handii, USAID is building a triage, they are trying to build a pump too because pump business is hard there. Before the facility staff were seven but for now the staff is at USAID standards, because they said they need six professionals and eight support staffs. With the help of those professionals and the support staffs, the services are very ok for our community people, because they are not bringing complaints...”. **(Community Key Informant)**

“.....Yes, of course, changes are there; you see they got place to keep our big belly for time to deliver. I think if I am not mistaken 6 bedroom house with mattresses everything there. So, that alone washing hands, but before you enter there you must wash yours at 2 or 3 places. They get places there so you can't throw dirt around so forth. Another structure there, but the doctor and nurses that assigned from other places live there. At time the way of talking to us harsh. But Saturday, when you carry big belly there for emergency you can see nobody there. Only security, no doctor and she was crying and even gave birth the child died. When you tell the people your go to the clinic, they say nobody there.....” (Community Health Volunteer)

“...For now, we have not had any reported case of priority diseases. For infrastructure, no idea. PCI EC3 supplied drugs and medical supplies recently. No staff capacity building has been provided. Yes, they are doing quality services with the IPC protocols...” (Community Key Informant)

Community Events or Campaigns to Strengthen Resilience; On campaigns to strengthen resilience against any outbreak, most respondents affirmed that there have been resilience campaigns as a result of the PCI EC3 project to sensitize the community people by getting to the grass roots creating awareness on the radio as well as house to house campaigns against the disease; and developed documents on prevention details like washing of hands, avoiding human body contact and how to handle the sick people. These responses support their position on the matter:

“...Yes, there has been many, many campaigns from PCI EC3 and other partners like UNFPA on awareness of Ebola prevention and other priority diseases prevention..” (District Medical Officer)

“..Yes, (the PCI EC3 trained gCHVs) go into the community to advise our people on this Ebola issues and explain what Ebola is and how people can get it..” (Community Key Informant)

“...The PCI EC3 trained staff, too, used to go on the radio to carry out awareness. I used to see them moving from community to community going to other communities. When the nurses where, they used to move from community to community sometimes to do their own awareness too. If there is an event, I think they are prepared to handle it, because they are all professionals...” (Reproductive Health Supervisor).

“.....Of course the community now has a handout. PCI EC3 has been doing that and the gCHVs have been doing that. Specially, we have been giving them awareness, Ebola awareness from house to house. We visit from house to house giving them some basic ideas about preventive measures. Like a topic we had called preparing them for prevention. Because prevention has a whole lot to do: washing your hands, prepare yourself not to come in body contact with somebody, not frequently handling out sick people by yourself. And those are some of the trainings on awareness that we received from PCI EC3 and we having been given to the community so that they can be prepared...” (Community Key Informant)

Awareness and Knowledge of EC3 project Objectives; Responses from community members as well as community key informants on the knowledge of the program's objective was solely to deal with the disease outbreak by supporting them to care for patients as well as creating awareness, but some health service workers mentioned that the objective of the project was to strengthen and equip the health facilities to be able to respond to emergency cases and provide adequate prevention methods like awareness creation. These are supported by the quotes below:

“...Is an Ebola community care center where they provide basic services in strengthen the health system and to strengthen communities on and also educating communities on outbreaks like EVD and to provide some level of safety mechanisms for the community in case of outbreakbasically is a project structured to improve the community in term of any outbreak to be able to be on their alert, to address issues regarding community well-being....” (District Medical Officer)

“...I really can’t tell more especially because I was not a major staff of the PCI EC3 project to have known the main objective. PCI EC3 focus point was dealing with Ebola issues. They say all their business was relating to Ebola: to give awareness to community people in where they reside, teaching community dwellers about how to prevent themselves, how to care for themselves, how to be prepared should in case of any outbreak they will know little about themselves...” (Community Key Informant)

“....Yes. One of the objective for me that I can name was to help the community. The EC3 helped the community greatly and they talked more about Ebola awareness, prevention, stigmatization, behavior change, malaria, typhoid and so on.....” (Community Key Informant)

“.....The main objective is to strengthen health facility and renovation of facilities. (Triage and isolation area)....” (Male community member)

Some Observed Achievements of EC3 Project; On the issue of whether the project has achieved the results needed, most respondents indicated that though they have gotten much assistance from the project through provision of resources to respond to the outbreak there is the need for more to be done in totality. However, the program’s support on provision of triage for the emergency response has been very helpful to the communities. These positions are supported by the quotes below:

“Yes. Because we believe from our talking they understood the importance of the CCC that was erected by PCI EC3 in Handii” (Community Key Informant)

“If they build the triage like you see in Handii, and then preparing for the future just in case of any other outbreak. Okay which of course we see PCI EC3 planned in their project that it will be done at the Health Post and it has not been done. So I see that they have to do more.....they still need to do more. I do believe the objectives have been achieved partly” (Community Key Informant)

“They taught us that this is not the place where Ebola victims are kept. This is the place where when you skin hot you can go there” (Male community member)

“Yes, to some level, it had help our people; train some of our youth and they gave our clinics support, but more needed” (Representative of the County health Officer)

Some Observed Successes of EC3 Project; While some community members affirm that there was total success achieved for the project due to the resources and the support benefitted by the communities through compliance, other responses from especially health officers claim that there has been partial achievement because there is still much to be done in some areas to ensure maximum freedom from the disease outbreak. The following quotes support their position on the matter:

“Partially yes, not in full, they have been doing extremely well but I don’t know the actually target and extend to which they want to reach, but I think it is almost been achieved” (District Medical Officer)

“Yes, some of the success was that, it helped us as community members to go there and PCI EC3 really did well when it comes to gCHVs payment;.....PCI EC3 never one day delay gCHV payment. It always come on time. So I believe that’s one of the successes” (Community Key Informant)

“Mainly successful, ...I can see that the training provided for the gCHVs to go in their own communities and teach their own people; that has been one of the big successes that I see mainly.....they also looked at the various health post, they began to strengthen them, to give them some medical supplies” (Community Key Informant)

“Yes, we don’t hear any Ebola case again” (Male community member).

“Yes, people are safe now. They keep themselves clean and wash their hands. Ebola is gone” (Female community member)

“Behavior changes among people, provision of infrastructure development and timely supply of IPC materials” (District Reproductive Health Officer)

Some Challenges of EC3 Project; According to the respondents there were many challenges facing PCI EC3 in working with the communities, among them are lack of places of convenience (toilets), bad road network and longer distances between communities, lack of transport facilities to transport health workers and volunteers, lack of current information flow or updates between project staff and health workers, inadequate airtime for their phone to facilitate communication, inadequate skilled workers and accommodation facilities at the health facilities; problems of cultural and traditional beliefs and practices were also major challenges for the program. Some volunteers added that some people, even after receiving education, are still doubtful about the outbreak. These are supported by the evidence below:

“Under the EC 3 project, one of the major challenges that I saw as gCHV was that, there was lack of transportation. We just walked. Even if I make my report for this community I will have to walk from here to Handii. If I don’t walk to go to Handii, I either find a Motorbike or pay my own way to carry that information to Handii”..... “Now when we look at, most especially last month, where they talked about providing us scratch cards for us to call in case of any problem in the field that the gCHVs can call that has not been provided. They only provided it one or two times and then they cut it off. So it was that very difficult; it was a challenge for us when we get in the field how do we communicate with our heads” (Community Key Informant)

“Yes, one of the challenges is the distances. So far the project to actually reach to all the people in the district is a difficult task” (District Medical Officer)

“Bad road network, lack of well-trained health workers (clinic and CCC Staff) and Staff house to accommodate the workers” (District Reproductive Health Officer)

“One big challenge is no latrine, household goes to the bush, only two household have toilet” (Male community member)

“Yeah, there are some improvements, people begin to adhere to but there is a lot of challenges also the messages were going but because of traditions and cultural beliefs people were still not adhering to the messages because Bomi is actually a traditional county that people believe in this cultural relations and other things so that was one of the challenge that we met...not only PCI EC3, even other partners” (Representative of the County Health Officer)

“There are lot of challenges when it comes to reaching community, yes, we look at our road condition, very bad, making it difficult to even engage community and to actually implement the project it has been so difficult but when it comes to project like this where you have not been dealing with communities, just bringing new ideas, it take time for the community to get it so in dealing with the community it has been challenging” (County Medical Officer)

“Okay some of the challenges are we still have some people in our community that when we go to them, they can tell us that we are making our money. People still doubt that Ebola is real. They usually tell us that we always go around taking their names; we want to know how much the population is so we can kill more people”. (Community Health Volunteer)

Some Behavior Changes Observed; from the respondents there has been numerous changes as a result of the introduction of the intervention. Among the impacts reportedly derived from the program were the acceptability to visit the health facility by many people through the awareness created, generally accepted washing of hands which was previously not the practice, the reduction of cases due to the intervention as well as basic knowledge on stigmatization. The quotations below support their position on the matter:

“There were lots of confusions that existed before the Ebola came. Ebola came with some kind of thing that it brought hatred and then the changes I saw, after that changes came where people may not want to accept you but when EC 3 project came and then began to train gCHVs to go in the field, not only in Mawah alone, but the district as a whole. Not only the PCI EC 3 project, other NGOs too came and had some awareness in the community like doing some psychosocial training and teaching people how to forgive and to forget.....” (Community Key Informant)

“The EC3 project, it has built my capacity to some extend because it has actually been focusing on community care and have been addressing other issues regarding services, provision at the level of the facilities and I also have some knowledge regarding community sensitization social mobilization” (County Medical Officer)

“Through PCI EC3 mobilization network, the community started washing hand; cleaning their environment and keeping themselves from contact and other things” (Representative of the County Health Officer)

Most Significant Changes Observed; Regarding some of the most significant changes observed, the respondents mentioned awareness creation on day to day basis as a preventive measure, provision of resources to facilitate the works of the health workers and supporting them with well trained staff as some of the most significant changes observed and this has resulted in:

1. Improvement in the quality of health care delivery as well as the capacity of the health system
2. Improvement on awareness and knowledge of EVD at the community level.

3. Improvement in behavior change and utilization of Ebola preventive strategies
4. Improvement in the general health seeking behavior of community members.

They supported this with the following quotes:

“.....Yes, talking to the people making sure people goes to the facilities. Also my activities every day I pass around and sometime call them together and has been a most significant change....”
(Community Health Volunteer)

“.....PCI EC3 project was a project that kept the people on day to day information about the disease; right now, we are seeing the people keeping to their hand washing buckets in Bomi, most especially in the towns, as you may have seen it during your assessment work, right.....”
(Representative of the County health Officer)

“.....Well as I continue to say, my community is well prepare with medical staff that are prepared for any disease, yesterday, we did not know about what happen but for today, we will know about what happen, so in that we are in readiness anytime. God forbid anything happen we will know what kind of precaution to take and this is more than a most significant change”. **(Community Health Volunteer)**

Benefits and Sustainability; With both Focus Group Discussions (FGDs) and the In-depth Interviews (IDIs) conducted, respondents were of the view that the project brought immense benefit to the community through the awareness creation, preventive measures, responding to emergency cases and the numerous trainings given to the health staff as some of the merits and the project can be sustained because most of the health workers trained were still in the system performing their duties. In the communities, PCI EC3 contributed to reducing the fear of keeping away from the health facilities which significantly contributed to reduce the number of cases in the communities;

“.....Yes, it is sustainable and gCHVs are still on the field carrying the messages just in case someone get sick, or someone dies, they know what to do. Local leaders have been involved and trained and this we hope will continue for good...” **(District Medical Officer)**

“.....Oh yes let me look at the awareness issues, because of that awareness that they created here.... And I think they have more than 50 gCHVs not only from Mawah alone. So the 50 gCHVs came from different, different communities in Fuamah District. And they had the training and the training was provided to give the people awareness so that awareness went across and the people now became free to interact with one another, to prepare themselves. They know the importance of washing hands and this can be sustained.....” **(Community Key Informant)**

“.....we benefitted from the PCI EC3 project because at the time of the Ebola outbreak in the community we were not having anyone to come and talk to us concerning Ebola and other sickness but PCI EC 3 is here telling people this is a thing that affecting people and if you don't listen this is what is going to happening and people started going by what they were telling us and tis is sustainable”..... **(Community Health Volunteer).**

“Yes, as I said am at the county level; my county benefitted a lot because PCI EC3 brought in training, that is they built the community health volunteers' capacity in awareness; in active case surveillance; and also they were able to support my health workers in training; in surveillance and

I also benefitted because at the time I needed to engage in the air (conduct sensitization and education on radio).....” (Representative of the County Health Officer)

Best Practices and Lessons Learnt; Respondents saw some of the best practices as involving of the hand washing exercise in the communities, cleaning of surroundings, new method of burying the dead bodies, disseminating information to the community and as some of the practices preferred by the people.

*“The best practices of the project are the hand washing when you come from the latrine and cleaning your surrounding and don’t just bury in your community always be preventive”
(Community Key Informant)*

*“.....The best role of the gCHVs is to carry out the messages in the communities.....”
(Community Key Informant)*

“.....They use their own solution, and the time those items were not around, what they used to do was they use to get enough plastic that they were using before but when PCI EC3 came on ground now they told them no though what you have been using to protect yourself is good, but for now we will come to help with other items that is better.....” (Community Health Volunteer)

“.....Our role as gCHVs is to go out to do awareness, telling people about Ebola... how to prevent ourselves from Ebola and also telling people about signs and symptoms of Ebola and this is best practice.....” (Community Health Volunteer).

Lessons Learned; With reference to lessons learned from the program, most of the people interviewed responded of acquiring some knowledge by way of community entry and interaction as well as having opportunity to learn some medical terms which were not known to them previously. In other words, it was an exposure for them to know more about the disease and for some also improved their skills in working with the community members. The following quotes support the assertion:

“I learned how to interact really with most of the community dwellers, some from out from various villages. Where they may not be able to come and stay, but they come for medication then we are able to communicate with them.....” (Community Health Volunteer)

“I’ve learned lessons such as one, community entry. Some of us never knew how to enter community and we were taught. Some of us never knew the importance of Ebola and we got to know it. Some of us never knew the importance of stigmatization but we got to know it through PCI”. (Community Key Informant)

Opportunities for Similar Projects in Future; Most people interviewed were hopeful of similar future project due to the success of the initial one. They also suggested for the extension of the project to support the community. However respondents were not pleased about the sudden end of the program but few were also optimistic that in future the project would be extended to many communities. They supported it with the following quotes:

“Of course, yes because you know like this project has benefitted the county and community at large, so I see it a potent future for similar projects to come because now that the

project is almost ended and there any opportunity to sustain the facilities in term of health care services” (County Medical Officer)”

“Even on the form, they had place to write, we write that the program should be extended” (Community Health Volunteer)

7.0. IMPLEMENTATION PROCESS

PCI’s EC3 success depended largely on the oversight of effective implementation and progress tracking of interventions to improve its performance. Without accurate M&E data, the project would have been unable to make management decisions in relation to project strategies and activities. The project had an effective and efficient M&E capacity and system in place by emergency project standard that was able to provide quality data for performance measurement and management decision making which contributed to the overall success of the project. However, similar future projects would require improved M&E skills among gCHVs, District and County officials in order to enhance the efficiency and effectiveness of collecting, collating, processing, analyzing and reporting on credible performance data with greater integrity.

8.0. CONCLUSIONS AND RECOMMENDATIONS

Despite the many challenges posed by the outbreak, such as the difficult logistical hurdles posed by reaching remote areas; forging trust with new remote communities; creating rapid behavior change around entrenched cultural practices to prevent the spread of Ebola; sorting out the structural and operational challenges for managing infection prevention and control effectively within community care clinics so as to protect the health of staff and patients; and the operational and human resource challenges posed by an ever-evolving consensus on the best strategy to fight Ebola—the EC3 project performed well and exceeded its performance targets for key activities that helped stop the spread of Ebola.

The results of the 87 PCI EC3 intervention health facilities that were involved in the health facility assessments revealed that, overall, there was a significant difference of 25% increase in health care facility capacity to provide quality treatment from 57% at pre-intervention to 82% at post intervention. The LOP target was therefore exceeded by 5%

The findings of the household surveys revealed that a majority [366 (96.8%); 166 (45.4%) males and 200 (54.6%) females] of the respondents were utilizing the Ebola health education message practices and this has resulted in significant behavior change. Three of the key PCI EC 3 Ebola health education message practices that were being utilized and consequently resulted in behavior were: Hand washing with soap under running water; Environmental cleanliness, and cooking food very well before consumption. The target and performance of the sub sector 3 indicator, “Number and percentage of community members utilizing [Ebola] health education message practices” has therefore been significantly exceeded by 6.8%.

The success of the project could be attributed to the efficient and effective health facility and community engagements which inculcated the sense of ownership of the project among health

workers and in the communities. The effectiveness of the training programs provided to the stakeholders was also a significant to the success of the project.

However, the most effective and efficient campaign strategy of the project was the use of the general community health volunteers (gCHVs) to engage community members on one-on-one. The community members were more use to the gCHVs, they therefore identified with them and the Ebola health messages that they were promoting with ease, thus, enhancing community's ownership of the project and acceptance of the Ebola health messages.

The evaluation findings strongly suggest the use of gCHVs as the most effective and efficient strategy for similar community level and facility level interventions and thus, recommend as such

Additionally, the evaluation addressed the key evaluation areas with respect to relevance, effectiveness, efficiency, capacity building/sustainability, impact, coverage, participation, engagement and coordination, accountability and cross-cutting issues. The key evaluation areas below attest to the success of the PCI EC3 intervention:

Relevance of the intervention: the objectives of PCI EC3 were very consistent with the expectations and objectives of the targeted beneficiaries. This contributed to the buy-in and ownership of PCI EC3 activities in intervention communities as shown in the qualitative findings. The objectives were met largely because of the intervention communities' ownership of the activities.

Effectiveness and Efficiency of the intervention: the evaluation did not go into cost benefit analysis and value for money analysis. However, findings from both the qualitative and quantitative results indicate that, project resources were utilized judiciously in attaining the project goals and objectives. The utilizing of the local resources also positions the project in a way that ensures sustainability.

Capacity Building/Sustainability: PCI EC3 undertook key essential health facility level capacity building activities and vital community level capacity building activities in spite of the challenging local environment. The capacity building activities innovatively inculcate local content with local resources that ensures sustainability as demonstrated in the results from the qualitative and quantitative findings. This strategy contributed significantly to the overall positive performance of the PCI EC3 project.

Impact: The PCI EC3 project post intervention evaluation was not designed to be a conventional impact evaluation using intervention and comparison communities or intervention and comparison health facilities. The pre- and post- intervention results of the health facility assessment shows significant improvement in the overall performance of health facilities and quality of care. The qualitative and quantitative results also show significant behavior change among the beneficiary population in the communities.

Coverage: The findings indicated that, the interventions reached the intended beneficiaries in the communities and exceeded the target by 6.8%. The intended beneficiary health facilities were also successfully reached and significant improvement in the health facilities was recorded.

Participation, Engagement and Coordination: The PCI EC3 project did not work with parallel structures. All the intervention activities were carried out through the approved local structures such as the local government structure, MOHSW, county and district health teams, gCHVs and community members.

Accountability: The PCI EC3 project demonstrates the existence of meaningful feedback and compliance mechanisms that ensured openness and transparency throughout the project life cycle. There was not any dissatisfaction at the facility and community level among project beneficiaries with respect to project transparency and accountability.

Cross Cutting Issues: Evidence from both the qualitative and quantitative results indicates that, the PCI EC3 project team ensured that gender considerations, equity, diversity and sustainability were highly considered and this is indicated in the demographic profile of the study population and the incorporation of local content in the interventions.

There were very important recommendations and suggestions from the study participants. Most of the health workers interviewed suggested that the project should be continued to support the communities, extend the project to cover all communities and take care of the need for more training for health workers. However, few respondents were of the view that the indigenes were not involved deeply in the project. Some also requested for more support in terms of equipment and resources as well as adequate working staff to facilitate the work of the clinics:

“First recommendation is to extend the project in the district just as I said; we have so many areas that are hard to reach, my district is one of the remote districts. In fact the most remote district and I like for PCI EC3 to extend if they have funding” (Community Health Volunteer).

“Yes, we would like more training and maybe extend agriculture and other things. PCI should not only limit the training to gCHVs but rather work with the District Health Office.... So from the level of the District Health Office, we can be able to spread in the district and the work they are doing will be having more zeal than just dealing with gCHVs” (District Medical Officer)

“My recommendation is that PCI EC3 should build latrine, hand pump water to keep people safe..” (Male community member).

“My recommendation is the project should be extended and PCI EC3 should please renovate our hand pump in the York Island” (Community Health Volunteer)

“...My recommendation to the project / donors is, when a project like this comes out, they should be able to involve the community fully and even the CHT, especially those key players that are to be in the knowhow and be included in the process.....” (County Medical Officer)”

“.....My recommendation is that PCI head office should still continue to support PCI EC3 in Bomi County because their presence is great, we need them, especially at my department at the Surveillance Department they provided a lot of help for me, so the county need them; the county need them in not only surveillance, the county need them because they help us to even carry messages about this maternal deaths; about EVD even agriculture projects I saw they supported in Bomi so we need them; let them continue until we can be able to stand on our own, but now we need capacity building; we need partners in the county.....” (Representative of County Health Officer)

“.....I recommend that to see that all clinics in Liberia should be well resourced, well supported by the PCI EC 3 project. They should sustain us as they were doing. They should provide us compensation. We say providing for the nurses most especially at the health facility. The health posts are not on government stipend and they are just volunteers.....” (**Community Key Informant**)

However, the evaluation team is of the view that:

1. Community Mobilization and Sensitization on EVD should be continuous process and as part of the outreach program of MOHSW and its partners such as PCI, especial focus on the use of the gCHVs.
2. Generally, the health system is still weak and it is very important that MOHSW and its partners such PCI continue to provide logistics and infrastructural support as well as continuous capacity building to support health system strengthening.

9.0. LIMITATIONS AND CONSTRAINTS

The primary limitation of this research design is the relatively small sample size for county-level estimates but the survey estimates are still adequately representative due to the random selection process.

Response and Social Desirability Bias

Another limitation is response bias: the survey respondents may understate the coverage of PCI EC3 interventions in their communities in the hope of attracting additional external aid. This bias implies that our estimates on PCI EC3 interventions are likely to be lower bounds on the true coverage of the PCI EC3 interventions. But as long as this bias is equally likely to occur across the counties and districts, it does not affect our estimates of the *relative adequate coverage of PCI EC3 interventions*.

Implementation and Logistical Constraints

The research team collected data over three weeks in December, 2015. Implementation challenges such as poor road network and long distance travels and broken down vehicles could have resulted in interviewer fatigue and tiredness in the application of the interview procedures and processes. The research team was taken through a mitigation plan and scenarios to overcome this situation. The timing of the evaluation during the Christmas period affected the evaluation timelines and the deadline for the final report.

Confounding Factors and Attribution

The PCI EC3 beneficiary health facilities, counties, districts, communities and households could have also benefitted from other interventions that might have contributed to the observed achievements of PCI EC3. Therefore the success of the PCI EC3 intervention could have been affected by other similar interventions (confounding factors). *Extreme care should therefore be taken in interpreting the results of this evaluation.*

10.0. REFERENCES

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11.0.ANNEXES

Annex A: TOR of Evaluation

PCI Liberia, EC3 Project Final Evaluation Terms of Reference

1. Introduction

Project Concern International (PCI) has been working in Liberia for the past five years to increase access to food, reduce chronic malnutrition, and increase access to improve livelihood and educational opportunities. PCI has been responding to the Ebola Virus Disease emergency through different emergency response projects. Currently PCI is implementing an Emergency Community Care Centers (EC3) in Bong, Nimba, Bomi and Grand Cape Mount Counties with funding from the USAID Office of Foreign Disaster Assistance (USAID/OFDA). The project was started in October 2014 to be terminated in April 2015, which later was extended to December 2015.

PCI has been implementing the project in close collaboration with the Ministry of Health, County health offices, District and general Community health volunteers (gCHVs). PCI is commissioning a final evaluation to assess the project's results and understand how the project management and implementation has contributed to the national Ebola emergency response, assess achievement for key outcome indicators, identify successes and challenges and document the key lessons learned. Accordingly, PCI Liberia is seeking a qualified consultant with an extensive quantitative and qualitative experience, evaluating emergency public health response projects in Africa and developing countries with strong experience in managing USAID/OFDA projects.

Project Goal: To respond to the evolving needs in communities affected by the ongoing Ebola outbreak in Liberia and to strengthen local capacity to prepare for, respond to, and recover from outbreaks in the future.

Strategic Objective: To support the health sector to safely and adequately prepare for and treat Ebola patients.

2. Description of Key EC3 Activities:

Sub-sector 1: Health system and Clinical Support:

- Renovation or upgrade of the health facilities to ensure they meet all appropriate standards.
- Support the county health teams (CHTs) in case investigation, contact tracing, case management, referral and rapid response teams to identify, isolate, and treat cases at the appropriate facility.
- Train health facility staff to run the CCCs and ongoing supportive supervision of management and operations (including on-site mentoring).
- Mobilize community awareness of and support for the facilities.
- Provision of PPEs and other essential supplies.
- Support data collection, monitoring and reporting.
- Supervision, management and maintenance of the facilities, including compliance with basic protection and gender standards.
- Facilitation of data sharing between ETUs, CCCs, MOHSW and other partners.

Sub-Sector 2: Medical Commodities Including Pharmaceuticals

- Essential supplies for healthcare facilities and workers based on need.

Sub-Sector 3: Community Health Education / Behavior Change

- Conduct community trainings and outreach.
- Strengthen community resilience and preparedness.

- Support for reintegration of Ebola survivors.
- Support cross-border initiatives.

PCI will share key project documents such as project proposal, Performance Monitoring Plan (PMP), detail implementation plan and project performance reports and others as appropriate for the winning consultant to help understand the project concept in detail.

2. Main objectives of the final evaluation.

The final evaluation has the following specific objectives:

- To examine how EC3 has been efficient and effective in responding to EVD emergency response.
- To examine the behavior change of community members as a result of EC3 community level interventions.
- To measure the change of health facilities in the areas of infrastructure, supplies, clinical staff capacity and service quality.
- To assess whether the project results have been achieved in line with the stated objective, sub-sector intervention and their performance targets.
- To measure key outcome level indicators of EC3 (IPTT indicator # 1.1 and 3.1).
- To assess successes, constraints, lessons learned and best practices as well as opportunities for future similar programs.
- To provide recommendations for sustainability.

3. Evaluation Methodology

The evaluation design will use a mix of qualitative and quantitative methodologies including household survey, health facility assessment using the Ministry of Health assessment tools, focus group discussions (FGD), Key Informant interviews (KII) and Most Significant Change Methodology (MSC) to assess the most significant social and behavioral changes observed at community level in addressing community attitude towards Ebola Virus Diseases (EVD) protection.

3.1 Sampling Design

As per the USAID/FFP standard guideline for evaluations³ the survey will be carried out covering program intervention area, therefore, the sample is drawn from all the four counties to ensure sample representation. A two-stage cluster sampling strategy will include primary units (communities) selected using Probability Proportional to Size (PPS), and secondary units (households) selected using systematic random sampling technique from the sample community. The sample communities will be drawn using the probability to proportionate to size (PPS) methodology. To provide the chance of being selection for each community, the list of EC3 community and respective HH size will be used to pick the sample community using the PPS method.

Household Survey: the household survey is intended to primarily collect data on the performance of an outcome indicator (IPTT # 3.1) “*community members utilizing Ebola health education message practices.*” The survey will capture the change in community knowledge, attitude and practice as a result of the EC3 intervention. The sample household will be selected using systematic random sampling technique from the total population in the geographic area.

Since EC3 has no baseline study, the final evaluation will follow a simple descriptive study in line with the stated objectives. Thus, the consultant will follow PCI sampling methodology to sample an appropriate sample size of 337 households. Sample size for descriptive study where the population is said to be infinite/large, for performance indicators presented as percentage is:

$$n = D ((Z_{\alpha}^2 * p (1-p)) / [d^2 * (1-r)])$$

n = minimum sample size required

³ Robert Magnani (1999): FANTA III Sampling Guide.

D = design effect; D = 2 in two-stage cluster sampling design.

P = Expected value of the key indicator at survey time (end line); for this case p=0.9 (90% target for an outcome indicator of interest taken from IPTT).

d = desired margin of error on the estimate of p (standard 5%, d = 0.05)

Z_{α} = Z-score for the desired degree of confidence ($\alpha = 0.95$, $Z_{\alpha} = 1.96$)

r = adjusted for non-response error (normally = 0.1, 10%)

Hence, $n = \{[2*(1.96)^2*0.9(1-0.9)] / [(0.05)^2 *(1-0.1)] = 307$ households

Correction factor: in addition to the 307 households a 10% adjustment/correction factor will be used, making a total sample of 337 households from the EC₃ intervention communities. The proposed sample size will be sufficient enough to provide reliable estimates with less than 5 percent margin of error for the outcome indicator Health Facility Assessment.

Health Facility Assessment: PCI Liberia, through its EC3 project, has been operational in 87 health facilities to improve the quality of service delivery and capacity, and collected pre-intervention information using the health facility assessment checklist developed by the Liberian MoH. Thus, to measure the post-intervention performance for the outcome indicator (*improved Healthcare facility capacity to provide quality treatment*) the final evaluation will re-assess all 87 health facilities and report on the percent change as a result of EC3 project using the same facility assessment checklist used pre-intervention.

3.2. Qualitative methods

The study will include qualitative methodologies such as FGDs, KII and MSC methods with different community groups. MSC, FGD and KII methods will help to identify good practices and make appropriate recommendations for future programming.

Focus Groups will include 8-12 community members including men group, women group and a mix of men, women, boys, girls, elders and religious group leaders as well gCHVs. Whereas the key informant interview will be made with key government health professionals, clinical service provides and gCHVs.

4. Key Evaluation Areas

The evaluation is required to carry out an in-depth assessment of the project, in these basic evaluation areas appropriate to short term EVD emergency response projects:

- **Relevance:** investigate in detail the extent to which the objectives of the project are consistent with the target group's priorities.
- **Effectiveness:** assess whether the project has contributed to achieving its goal. Assess the extent to which the project has attained its objective in an efficient and sustainable way.
- **Efficiency:** evaluate how the project economic resources/inputs are converted into project outputs and beneficiary level outcomes.
- **Capacity building/sustainability:** examine the likelihood that the positive results of the project (such as capacity building/skill and knowledge, supplies, facilities and services) will persist for an extended period in the future and examine long term threat of the project in the local communities.
- **Impact:** Examine the significant changes in the lives of the beneficiary population and in the health institutions as perceived by them and other partners.
- **Coverage:** assess if interventions reached the intended groups. To what extent did the program respond to unplanned outcomes/community concerns?
- **Participation, engagement and coordination:** assess how the project has been working with the local government sectors and the wider community.

- **Accountability:** examine the existence of meaningful feedback and compliance mechanism that openness and transparency throughout the project cycle.
- **Cross-Cutting issues:** examine mechanisms how the project been incorporating lenses on gender, equity and diversity and sustainability.

5. Study population

The study population will include the general population in EC3 intervention areas (direct and indirect beneficiary households) in the target counties. Therefore, the consultant should use the proposed sample size and methodology, or propose a more robust and representative sample size using statistically sound methods, to conduct the household survey.

5.1 Data Collection and Supervision

This survey will be conducted in four project operation counties. PCI is recruiting a consultant with extensive experience and capacity to collect the data using mobile devices/tablets. The survey team leader has to be a health specialist and will be responsible for facilitating the training and coordinating the overall field operation jointly with PCI M&E team and Chief of Party. The consultant should also recruit BA/BSC holders and experienced field data collectors and supervisors who are able to use the mobile devices for data collection and synchronization, and understand and communicate in the local dialect during the data collection process.

5.2 Data storage and analysis

The consultant is expected to create and use SPSS and/or another robust statistical software The consultant should organize the quantitative dataset using SPSS/other statistical software and submit the SPSS/other raw data to PCI Liberia M&E unit with the first draft and final report. Moreover, the consultant is expected to submit the qualitative raw dataset using word file or excel spreadsheet.

6. Required Qualifications and Team Composition

The lead consultant must be a health specialist who holds a minimum of Master's degree in public health and or Epidemiology or equivalent. The lead consultant is expected to provide at least one health specialist, statistician/data manager and data quality supervisor with extensive experience in managing USAID/OFDA projects, carrying out standard quantitative and qualitative surveys and managing and evaluating emergency response project in developing countries . Qualifications must include:

- Extensive experience (minimum five years) in managing, designing, implementing and evaluating emergency response projects with particular experience in public health emergency response.
- Proven track records in leading evaluation teams and producing quality reports.
- Proven knowledge and experience in monitoring and evaluation of USAID/OFDA projects, extensive qualitative and quantitative research and quantitative data analysis experience using statistical software's (SPSS, Stata, and others).
- Work experience in public health emergency response in Africa and/or developing countries.
- Proven ability to work with community and Liberia government stakeholders.
- Proven consultancy and/or work experience with NGOs, preferably with USAID projects as well as experience with other international and bilateral organizations on health.
- Good knowledge of Ebola Virus Diseases and Ebola emergency response.
- Good knowledge of Project Cycle Management.
- Excellent writing and presentation skills
- Good Teamwork spirit and inter-cultural sensitivity

7. Roles and Responsibilities of the Consultant

The roles and responsibilities of the consultant are as follows:

- Provide a technical and financial proposal to PCI with due attention to the details of methodologies and strategies of the consultancy work.
- Develop an evaluation work plan that will operationalize and direct the evaluation
- Work closely with PCI Liberia and PCI International Office, and County health teams, in planning and implementation of the field work and plan process.

- Design qualitative and quantitative data collection instruments and tools.
- Recruit and train qualified and experienced data collectors/enumerators and supervisors.
- Review and analyze key project documents such as approved project proposals, Annual achievement reports, IPTT, PMP, DIP and field monitoring reports.
- Ensure that the evaluation focuses on the overarching objectives taking into account, outcome indicators, as well as the challenges, opportunities and the lessons learned as a result of the project.
- Review and design evaluation questions, checklists and field guides and other instruments to be used as tools in the collection and analysis of the field findings and secondary sources.
- Coordinate and supervise the fieldwork during data collection period.
- Provide overall guidance to the evaluation team members in the data collection processes as per the established methodology and work plan.
- Code, encode and analyze collected quantitative data using Statistical Package for Social Science (SPSS) or other statistical software
- Ensure that lessons learned are well identified and incorporated in the report.
- Facilitate consultative, debriefing and feedback meeting and discussions with PCI and county health team.
- Discuss and agree on work schedule, methodologies, timeframe and other arrangements for undertaking the evaluation exercise.
- Produce and submit interim reports (field report, first draft and second draft) on fieldwork findings per the agreed format and schedule.
- Submit final report after incorporating comments from PCI and partners.
- Present findings of the evaluation to PCI M&E team and other stakeholders as requested

8. Deliverables

The consultant will prepare: 1) Detailed and complete evaluation methodology 2) Evaluation work plan. 3) Evaluation questionnaires and tools, and 4) Presentation to PCI and USAID Liberia team, 5) Final evaluation report, and summary of the report in ppt in accordance with PCI and USAID/OFDA reporting standard and requirements and including success stories in the main report.

Reports will be expected at critical junctures that will provide a review of the accomplishments made thus far (those interim reports will be drafted as sections of the final report, and should be included in the latter to fully document the process). The consultant is expected to submit the interim and final reports to PCI Liberia office, specifically to the M&E manager. The expected interim reports includes but not limited to:

- **Interim report 1:** to be produced before initiation of enumerator and supervisors training. Contain should include the final selection of communities and the field manual and the questionnaire forms. The consultant must develop the evaluation questionnaires, field data collection tools and present to PCI Liberia for review and feedback before the commencement of the actual field work and trainings.
- **Interim report 2:** to be produced at the end of the training of enumerators and supervisors. Updates the first inception report with the results of instrument field tests and corresponding adjustments in the field manuals.
- **Interim report 3:** to be produced at the end of fieldwork to list all the challenges that emerged in the field, and how they were addressed. If necessary, all changes made during the field phase to the instruments will be explained in this report.
- **Interim report 4:** to be produced at the end of the data entry and cleaning procedures. It will include all the data, with double entry validation tables, frequency distributions for detection of outliers and any other relevant problems encountered during the data. At this stage the consultant is expected to produce and submit the dataset for PCI review and feedback.
- **Draft and Final reports:** the content has to be well framed and organized by title and subsections. The consultant will be responsible for producing a report that combines qualitative and quantitative data. The detail reporting template in annexed (Annex 1).

9. Ethical issues:

The consultant/s should adhere to the following ethical issues:

- All terms/conditions stipulated in the contract agreement.
- Conducting himself /herself in a respectful manner, while undertaking assignment, which includes not making any commitments to communities and any other persons, on behalf of PCI and Liberian government.
- Time-frame and conditions outlined in the ToR and consultancy agreement.

10. Tentative Schedule

The full process of the evaluation commence on October 15, 2015. The consultant is expected to complete the evaluation (including final report) by November 30, 2015, within 45 calendar days from the time the agreement is signed with PCI. The brief summary of the evaluation timetable is as follows:

Tentative Schedule		
No.	Task/deliverables	Timeline
1.	Winning consultant is recruited and contract agreement entered and signed off	Oct 15/15
2.	Indicators and instruments/questionnaire (quantitative), sampling, methodology, logistics are finalized. (First inception report presented)	Oct 19/15
3.	Field manuals, tools/questionnaires developed by consultant are finalized and presented to PCI technical team. Pilot testing begins.	Oct 19/15
4.	Consultant provides training for enumerators and supervisors and make field tests; pilot testing ends. Manuals, questionnaires/tools updated. (Second inception report presented).	Oct 21/15
5.	Actual field data collection commences.	Oct 22/15
6.	End of fieldwork and fieldwork report (third inception) is submitted by consultant.	Oct 29/15
7.	Consultant submits field report, challenges and solutions (fourth interim report).	Oct 31/15
8.	Consultant submits gender disaggregated cleaned raw data to PCI.	Nov 4/15
9.	Consultant submits first electronic draft report with detail of the performance of outcome indicators and SPSS/other dataset to PCI.	Nov 12/15
10.	PCI provides comments on the first draft report.	Nov 16/15
11.	Consultant submits second electronic draft report to PCI M&E-Liberia.	Nov 21/15
12.	Prepare power points and present the summary of the report to PCI and USAID.	Nov 23/15
13.	Comments on the second draft report received by the consultant from PCI.	Nov 24/15
14.	Final report is submitted by the consultant.	Nov 30/15

11. Budget and cost breakdown

PCI will conduct the final evaluation through hiring qualified consultant within the threshold of the approved budget for the final evaluation. Thus, PCI will not request additional budget for the final evaluation work.

Note: interested consultants can send expression of interest via email to Jonah Kotee atjkotee@pci-lib.org to collect the evaluation ToR. Applicants are invited to submit their proposal by no later than October 9, 2015.

Contact Information physical Address:

Jolene Mullins
Country Director
Liberia-Monrovia, Benson Street, Bright building
Address: +231-880711148, email: jmullins@pci-lib.org

Annex 1. Evaluation report guidance. The content of evaluation report should at least include the following sections:

- **Cover page:** Title page with date, logos of USAID and PCI and RFA #, evaluator's name and organization.
- **Executive summary:** a brief of maximum 2-3 pages description of the main findings, methodologies, recommendations and conclusions of the assessment.
- **Acknowledgements**
- **Background;** includes overview of the program strategy and history of operating context.
- **Evaluation purpose and objective of evaluation, evaluation methodology.**
- **Sub-sector 1: Health system and clinical support**
 - Brief description of interventions
 - Service delivery strategies and approaches: quality, successes & challenges
 - Implementation process and achievement of results against the target
 - Other achievements
 - Lessons learned and best practices
- **Sub-sector 2: Medical Commodities Including Pharmaceuticals**
 - Brief description of interventions
 - Service delivery strategies and approaches: quality, successes & challenges
 - Implementation process and achievement of results against the target
 - Other achievements
 - Lessons learned and best practices
- **Sub-sector 3:**
 - Brief description of interventions
 - Service delivery strategies and approaches: quality, successes & challenges
 - Implementation process and achievement of results against the target
 - Other achievements
 - Lessons learned and best practices
- **Program Quality:**
 - Participation and partnership with government offices and other stakeholders
 - Sustainability and exit strategies
 - Gender and cross-cutting theme
- **Implementation process:**
 - Monitoring and evaluation
 - Project resource/commodity management
 - Financial and human resource management
- **Conclusions and Recommendations:**
 - Specific and general recommendations in line with the three sub-sectors.
- **Appendices:**

- List of abbreviations and acronyms
- Evaluation ToR
- Evaluation plan and schedule
- Evaluation methods and tools (quantitative and qualitative survey questionnaires) List of sites visited
- List of key FGDs and communities visited
- Summary tables on finance, commodities and human resources
- List of indicators and other relevant report materials.

Annex B: Letter of Permission



December 9, 2015

TO WHOM IT MAY CONCERN

The bearer of this letter is a member of PCI's external evaluation team for our Ebola Community Care Center (EC-3) project.

The external evaluators will be conducting key informant interviews, focus groups discussions, household surveys and health facility assessments in a number of communities in Bomi County.

We appreciate your kind assistance and cooperation as the team evaluates our work in the fight against Ebola and in support of community health and health system strengthening in Liberia.

If I may be of any further assistance please do not hesitate to contact me at 088-0711148.

I thank you for your continued support.

Sincerely yours,


Jolene M. Mullins, MPH
 Country Director

PCI-Liberia Program, Bright Building, Benson Street, Mamba Point, Monrovia, Liberia, Cell: 0880711148, Web: www.pciglobal.org

Annex C: Health Facility Informed Consent Tool

USAID/ EC 3 Project

Evaluation of Ebola Community Care Centers in Liberia



USAID
FROM THE AMERICAN PEOPLE



Health Facility Assessment Information Sheet and Consent Form. Final Version-7th December, 2015

1.0. Introduction

Project Concern International (PCI) has been working in Liberia for the past five years to increase access to food, reduce chronic malnutrition, and increase access to improve livelihood and educational opportunities. PCI has been responding to the Ebola Virus Disease emergency through different emergency response projects. Currently PCI is implementing an Emergency Community Care Centers (EC3) in Bong, Nimba, Bomi and Grand Cape Mount Counties with funding from the USAID Office of Foreign Disaster Assistance (USAID/OFDA). The project was started in October 2014 to be terminated in April 2015, which later was extended to December 2015. PCI has been implementing the project in close collaboration with the Ministry of Health, County health offices, District and general Community health volunteers (gCHVs). PCI is commissioning a final evaluation to assess the project's results and understand how the project management and implementation has contributed to the national Ebola emergency response, assess achievement for key outcome indicators, identify successes and challenges and document the key lessons learned.

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2. Description of Key EC3 Activities:

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- Renovation or upgrade of the health facilities to ensure they meet all appropriate standards.
- Support the county health teams (CHTs) in case investigation, contact tracing, case management, referral and rapid response teams to identify, isolate, and treat cases at the appropriate facility.
- Train health facility staff to run the CCCs and ongoing supportive supervision of management and operations (including on-site mentoring).
- Mobilize community awareness of and support for the facilities.
- Provision of PPEs and other essential supplies.
- Support data collection, monitoring and reporting.
- Supervision, management and maintenance of the facilities, including compliance with basic protection and gender standards.
- Facilitation of data sharing between ETUs, CCCs, MOHSW and other partners.

Sub-Sector 2: Medical Commodities Including Pharmaceuticals

- Essential supplies for healthcare facilities and workers based on need.

Sub-Sector 3: Community Health Education / Behavior Change

- Community trainings and outreach.
- Strengthen community resilience and preparedness.
- Support for reintegration of Ebola survivors.
- Support cross-border initiatives.

3. Main objectives of the final evaluation.

The final evaluation has the following specific objectives:

- To examine how EC3 has been efficient and effective in responding to EVD emergency response.
- To examine the behavior change of community members as a result of EC3 community level interventions.
- To measure the change of health facilities in the areas of infrastructure, supplies, clinical staff capacity and service quality.
- To assess whether the project results have been achieved in line with the stated objective, sub-sector intervention and their performance targets.
- To measure key outcome level indicators of EC3 (IPTT indicator # 1.1 and 3.1).
- To assess successes, constraints, lessons learned and best practices as well as opportunities for future similar programs.

You and your health facility are being invited to participate in this evaluation that is to be conducted in 87 health facilities mainly in Bong, Bomi, Nimba and Grand Cape Mount Counties. The evaluation will involve observations and administration of a standardized data collection tool from the Ministry of Health and Social Welfare (MOHSW).

Recruitment and Participation: You have been contacted because your health facility is one of the selected health facilities for the USAID/EC 3 evaluations. You will be asked questions about quality of care and services, continuum of care, culture of quality assurance and quality improvement, community support, etc.

Assessment Follow-ups: You and your health facility will be visited at the health facility by the assessment team for interviews and observations once. In instances where, the assessment team is unable to complete its work at your facility, a follow up visit will be arranged with you and an appropriate date will be agreed with you for the completion of the assessment in its entirety in your facility.

What are the risks in participating in the assessment? There is minimal risk to you and your health facility if you and your health facility are part of the assessment. The assessment may take longer duration than envisaged. Competent and experienced assessment team members will ensure that any potential discomfort and uneasiness is well managed and minimized.

What are the benefits of participating in the assessment? The evaluation will be used to assess the performance of the USAID/EC 3 project. It will also inform the USAID Health Portfolio in Liberia and could lead to the intensification of efforts in areas where shortcomings have been identified for the overall good of the general population.

There may not be additional direct benefits to you and or your health facility. However, your and health facility's participation will help to improve health service delivery that may eventually be beneficial to the whole community that you serve and the entire country.

What if new information becomes available? During the course of the assessment, you will be informed of any findings that may affect your decision to allow yourself and/or your health facility to continue participating in this assessment in its entirety.

Will you and/or facility be compensated for participating in this assessment? If you happen to be off duty, you will be refunded for the cost of traveling to your health facility to purposely attend to the assessment team to ensure a successful assessment exercise.

How will my confidentiality and that of my facility be maintained? If you decide to participate in the assessment with your health facility, the assessment team will collect health services delivery information about your health workers and health facility as part of the assessment. People who work for or with the donor (USAID), and others like the independent ethics committee or the institutional review board (IEC/IRB) for the assessment, will have access to this information. They will check to see if the assessment is going on well and to ensure your rights are protected. All assessment team members that collect information from your facility will keep it confidential. All records and data about you and your facility will be kept in locked cabinets.

Voluntary withdrawal from the study: You and your facility may withdraw from the study at any point in time during the duration of the study. You will not be required to give any reason for this action. However, information collected from you will be used as part of the study's analysis.

What if I have questions about the assessment regarding me and my health facility rights as research participants? If you have any questions about this assessment, if there are things that you do not understand about the assessment or if any member of your facility is offended by the assessment team, contact: **Justice Ajaari, USAID/PCI EC3 Independent External Consultant on 0776879778** or contact him by email on; ajaarijustice@gmail.com

Statement of understanding: I consent for *me and* my facility to participate in this assessment. I confirm that I have read the statements in the informed consent form for this assessment. I have been given time and opportunity to read the information carefully (or, have had it read to me), to discuss it with others and to decide whether I will take part in this assessment. I have had the opportunity to ask questions about this assessment and my questions have been answered to my satisfaction.

I understand the conditions and procedures and know what the possible risks and benefits are for *me and my facility* participating in this assessment written above. *My participation as well as that of the facility are* voluntary and I may decide to **discontinue myself and my facility's** participation or to withdraw from the assessment at any time without penalty or loss of any benefits or treatment to which we are entitled. The assessment may be discontinued without my consent by the assessment team conducting the study or by the donor of the study.

I hereby give my voluntary informed consent for *me and my facility to participate*.

I understand that I/my facility do not give up any of our legal rights by signing this form. I will be given a copy of this informed consent form to keep for my own information throughout the assessment.

Name and Signature of Head of Facility/ Designated Health Worker

Date

Name and Signature/thumbprint of Witness

Date

Name and Signature of Interviewer

Date

Name and Signature of Team Coordinator (Reviewer)

Date

Name and Signature of Team Leader

Date

Annex D: Health Facility Informed Consent Tool

USAID/ EC 3 Project

Evaluation of Emergency Community Care Centers in Liberia



USAID
FROM THE AMERICAN PEOPLE



[Community Information Sheet and informed Consent Form. Final Version-9th December, 2015](#)

1.0. Introduction

Project Concern International (PCI) has been working in Liberia for the past five years to increase access to food, reduce chronic malnutrition, and increase access to improve livelihood and educational opportunities. PCI has been responding to the Ebola Virus Disease emergency through different emergency response projects. Currently PCI is implementing an Emergency Community Care Centers (EC3) in Bong, Nimba, Bomi and Grand Cape Mount Counties with funding from the USAID Office of Foreign Disaster Assistance (USAID/OFDA). The project was started in October 2014 to be terminated in April 2015, which later was extended to December 2015.

PCI has been implementing the project in close collaboration with the Ministry of Health, County health offices, District and general Community health volunteers (gCHVs). PCI is commissioning a final evaluation to assess the project's results and understand how the project management and implementation has contributed to the national Ebola emergency response, assess achievement for key outcome indicators, identify successes and challenges and document the key lessons learned.

Project Goal: To respond to the evolving needs in communities affected by the ongoing Ebola outbreak in Liberia and to strengthen local capacity to prepare for, respond to, and recover from outbreaks in the future.

Strategic Objective: To support the health sector to safely and adequately prepare for and treat Ebola patients.

2. Description of Key EC3 Activities:

Sub-sector 1: Health system and Clinical Support:

- Renovation or upgrade of the health facilities to ensure they meet all appropriate standards.
- Support the county health teams (CHTs) in case investigation, contact tracing, case management, referral and rapid response teams to identify, isolate, and treat cases at the appropriate facility.
- Train health facility staff to run the CCCs and ongoing supportive supervision of management and operations (including on-site mentoring).
- Mobilize community awareness of and support for the facilities.
- Provision of PPEs and other essential supplies.
- Support data collection, monitoring and reporting.

- Supervision, management and maintenance of the facilities, including compliance with basic protection and gender standards.
- Facilitation of data sharing between ETUs, CCCs, MOHSW and other partners.

Sub-Sector 2: Medical Commodities Including Pharmaceuticals

- Essential supplies for healthcare facilities and workers based on need.

Sub-Sector 3: Community Health Education / Behavior Change

- Community trainings and outreach.
- Strengthen community resilience and preparedness.
- Support for reintegration of Ebola survivors.
- Support cross-border initiatives.

4. Main objectives of the final evaluation.

The final evaluation has the following specific objectives:

- To examine how EC3 has been efficient and effective in responding to EVD emergency response.
- To examine the behavior change of community members as a result of EC3 community level interventions.
- To measure the change of health facilities in the areas of infrastructure, supplies, clinical staff capacity and service quality.
- To assess whether the project results have been achieved in line with the stated objective, sub-sector intervention and their performance targets.
- To measure key outcome level indicators of EC3 (IPTT indicator # 1.1 and 3.1).
- To assess successes, constraints, lessons learned and best practices as well as opportunities for future similar programs.

You and your community are being invited to participate in this evaluation that is to be conducted in 337 households from the EC 3 intervention communities mainly in Bong, Bomi, Nimba and Grand Cape Mount Counties. The evaluation will involve observations and administration of qualitative tools such as a structured household survey instruments and qualitative tools such as Focus Group Discussions (FGDs), In-depth Interviews (IDIs), Key Informant Interviews (KIIs) and the Most Significant Change Strategy.

Recruitment and Participation: You and your community are being contacted because your community is one of the selected communities for the USAID/EC 3 evaluations. You will be asked questions about the USAID/EC3 intervention activities in your community.

Evaluation Follow-ups: You will be visited in your community by the evaluation team for interviews, discussions and observations. In instances where the evaluation team is unable to complete its work in your community, a follow up visit will be arranged with you and an appropriate date will be agreed with you for the completion of the evaluation in its entirety in your community.

What are the risks in participating in the Evaluations? There is minimal risk to you for taking part in the evaluations. The evaluations may take longer duration than envisaged. Competent and experienced evaluation team members will ensure that any potential discomfort and uneasiness is well managed and minimized.

What are the benefits of participating in the assessment? The evaluation will be used to assess the performance of the USAID/EC 3 project. It will also inform the USAID Health Portfolio in Liberia.

There may not be additional direct benefits to you and or your community. However, your participation will help to improve health service delivery that may eventually be beneficial to the whole community that you serve and the entire country of Liberia.

What if new information becomes available? During the course of the interview/discussions, you will be informed of any findings that may affect your decision to allow yourself and/or your community to continue participating in this evaluation in its entirety.

Will you be compensated for participating in this evaluation? If you happen to incur transport cost, you will be refunded for the cost of traveling within your community for the purpose of this exercise to attend to the evaluation team to ensure a successful evaluation exercise.

How will my confidentiality and that of my Community be maintained? If you decide to participate in the evaluation, the evaluation team will collect information on the performance of the USAID/EC 3 intervention activities in your community as part of the evaluation. People who work for or with the donor (USAID), may have access to this information. All evaluation team members that collect information from you and your community will keep it confidential. All records and data about you and your community will be kept in locked cabinets.

Voluntary withdrawal from the study: Participation is completely voluntary. You and your community may withdraw from the evaluation at any point in time during the duration of the evaluation without any consequences. You will not be required to give any reason for this action. However, any information collected from you may be used as part of the evaluation's analysis.

What if I have questions about the evaluation regarding me and my community's rights as evaluation participants?

If you have any questions about this evaluation, if there are things that you do not understand about the evaluations or if any member of your community is offended by the evaluation team, contact: **Justice Ajaari, USAID/EC3 Independent External Monitoring and Evaluation Consultant on 0776879778** or contact him by email on; ajaarijustice@gmail.com

Statement of understanding: I consent for *myself and my* community to participate in this evaluations. I confirm that I have read the statements in the informed consent form for this evaluation. I have been given time and opportunity to read the information carefully (or, have had it read to me), to discuss it with others and to decide whether I will take part in this evaluation. I have had the opportunity to ask questions about this evaluation and my questions have been answered to my satisfaction.

I understand the conditions and procedures and know what the possible risks and/or benefits are for *me and my community's* participating in this evaluation written above.

My participation and the participation of community are voluntary and I may decide to **discontinue myself or my community's** participation or to withdraw from the evaluation at any time without penalty or loss of any benefits or treatment to which we are entitled. The evaluation may be discontinued without my consent by the evaluation team conducting the evaluation or by the donor of the EC 3 project.

I hereby give my voluntary informed consent for *me and my community to participate*.

I understand that I and my community do not give up any of our legal rights by signing this form. I will be given a copy of this informed consent form to keep for my own information throughout the evaluation period.

Name and Signature of Respondent

Date

Name and Signature/thumbprint of Witness

Date

Name and Signature of Interviewer

Date

Name and Signature of Team Reviewer

Date

Name and Signature of Team Leader

Date

Annex E: Household Survey Data Collection Tool

<p>USAID/ EC 3 Project Evaluation of Emergency Community Care Centers in Liberia</p> <div style="display: flex; justify-content: space-around; align-items: center;">  <div style="text-align: center;"> <p>USAID FROM THE AMERICAN PEOPLE</p> </div>  </div> <p style="color: blue; font-weight: bold; margin-top: 10px;">Household Survey Data Collection Tool- Final Version-9th December, 2015</p>	Form No.
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FORMNO

1.0. Basic Information:

1.1. Study ID:.....	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%; text-align: center;">E</td> <td style="width: 12.5%; text-align: center;">C</td> <td style="width: 12.5%; text-align: center;">3</td> <td style="width: 12.5%; text-align: center;">0</td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> </tr> </table>	E	C	3	0					STUDYID
E	C	3	0							
1.2. Respondent's name:.....		RESPNAME								
1.3. Community Name.....		CNAME								
1.4. District Name.....		DISTNAME								
1.5. County Name.....		COUNTNAME								
1.6. Date of visit: (dd/mm/yyyy).....	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%;"></td> <td style="width: 12.5%; text-align: center;">2</td> <td style="width: 12.5%; text-align: center;">0</td> <td style="width: 12.5%; text-align: center;">1</td> <td style="width: 12.5%; text-align: center;">5</td> </tr> </table>					2	0	1	5	DATEVISIT
				2	0	1	5			
1.7. Interviewer Name:		INTERNAME								
1.8. Has consent been given (check from complete consent form)?.....	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; text-align: center;">1. Yes</td> <td style="width: 50%; text-align: center;">2. No</td> </tr> </table>	1. Yes	2. No	CONSENT						
1. Yes	2. No									

NOTE: If Consent is not given, Please kindly cancel the rest of the form with a diagonal double line

1.9. Date of consent (dd/mm/yyyy).....	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 12.5%;"></td> </tr> </table>									DATECONS

2.0. Socio-Demographic Characteristics:

2.1. What is your age? (in years) [Confirm with 2.1, estimate age if yyyy = NK,].....	<table border="1" style="width: 100%; border-collapse: collapse;"> <tr> <td style="width: 50%; height: 25px;"></td> <td style="width: 50%; height: 25px;"></td> </tr> </table>			AGE

2.2 Sex of respondent?.....

1. Male	2. Female
---------	-----------

SEX

2.3. What is your highest educational level?

1. None	2. Primary school	3. Middle/continuation school, JHS	4. Technical/commercial/SHS secondary school	5. Post-middle college – teacher training, secretarial	MEDLEV
6. Post-secondary – nursing, teacher, polytechnic, etc.		7. University	8. informal education (Religious institutions like Church, Mosque, etc)		8. Not known

2.4. What is the number of years completed at the highest educational level reached?
[88 = NK, 99 = NA, 00 = no education].....

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NUMYRS

2.5. Are you currently single, married, or living with a man, or are you widowed, divorced or separated?

1. Married	2. Living together	3. Widowed	MARRIED
4. Divorced	5. Separated	6. Single, unmarried	

3.0. Section A: Water & Sanitation

3.1. What is the main source of drinking water for members of your household?

1. Piped into dwelling/yard/plot	2. Public tap	3. Bottled Water	4. Sachet/Pure Water	5. Closed well	6. Open well	WATER
7. Stream / river	8. Lake / dam /pond	9. Water trucks	20. Rain water	21. Handpump / closed bore hole	22. Other	

3.3. What kind of toilet facility does your household have?

1. Flush latrine / WC	2. Ventilated improved pit (VIP) /KVIP	3. Other pit latrine	4. Open fields	DEFAEC
5. Defaecates in house, faeces transferred elsewhere / bucket latrine		6. Other: Specify.....		

4.0. Section B: Access to Health

4.1. What type of health facilities are available here?

1. None	2. Public Hospital	3. Private Hospital	4. Private Clinic	HFACILITAVAILAB
5. CCC	6. ETU	7. Mobile Clinic	8. Field Hospital⁴	
9. Other-Specify.....				

4.2. When did you or any member of your HH last visit a health facility (*not traditionalist/ chemical store*) to seek health care?

1. < 1 month	2. 1 – 3 months	3. 4 -6 months	4. > 6 months	5. Never visited	VHOSP
--------------	-----------------	----------------	---------------	------------------	-------

4.3. Which reason best describes why you or your household member last sought health care in this facility?

1. Malaria	2. Diarrhea disease	3. Respiratory disease	4. Chronic body ulcer	RVHOSP
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⁴ Field hospital is an unofficial medical facility established to treat casualties on site, ideally to stabilize patients so they can be safely transported to more permanent medical facilities. They can be established in houses, basements, schools, mosques, or clinics, and are often unmarked for security reasons.

5. Diabetes	6. Hypertension	7. Jaundice (yellow eyes)	8. Violent Accidents
9. HIV/AIDS	10. Skin disease	11. Arthritis	12. Intestinal worms
13. Anaemia	14. Chronic Cough	15. Dental illness	16. Ebola
17. Antenatal, CWC,FP	18. Child birth	19. Surgery	20. Body pains
			21. Other:.....

4.3. How far do you live from the nearest health clinic or hospital (walking distance in time)?

1. 5-15 Minutes	2. 20-30 Minutes	3. 1 hour	4. 2 Hours and more	5. N/A, HF
-----------------	------------------	-----------	---------------------	------------

HFDISTAN

5.0. Section C: Health Seeking Behaviour

5.1. Where do you usually go if you are sick, or to treat a general health problem?

1. Clinic or hospital
2. Traditional healer
3. Family member
4. Other (specify) _____

5.2. If you answer ‘Traditional healer or family member, what would make you go there before you go to the health facility?

.....

.....

.....

.....

.....

.....

.....

5.3. If you thought you might have Ebola or another disease, where would you go?

1. Clinic or hospital
2. Traditional healer
3. Family member
4. Other specify _____

5.4. If you had symptoms of Ebola, how many days would you wait before seeking treatment?

1. 1-2 days
2. 5-9 days
3. 10-15 days
4. Other specify _____

5.5. What do you do to prevent people from getting sick in your home or community?

1. Encourage hand washing
2. Encourage environmental cleaning
3. Go to the health facility
4. Other specify _____

5.6. Who would you talk to about your illness if you had Ebola?

1. Family member
2. Work mates

- 3. Medical staff
- 4. Other specify _____

5.7. If someone in your community were showing signs or symptoms of Ebola or other diseases (Malaria, Typhoid, etc), what would you do?

- 1. Inform the community leaders or other leaders (Traditional, religious, etc)
- 2. Take them to the nearest health facility
- 3. Not take any action to assist the person
- 4. Other (specify) _____

6.0 Section D: Community Events or Campaigns

6.1. Have you ever received any Campaign on EBOLA from PCI EC 3?.....	1. Yes	2. No	9.NA	EBOLACAMP
6.2. Have you ever heard of any messages on EBOLA from PCI EC 3?.....	1. Yes	2. No	9.NA	EBOLAMESSAGE

6.3.1. Which of the following EBOLA messages have you received from PCI EC 3?

6.3.1. Ebola Awareness.....	1. Yes	2. No	EBOLAWARE
6.3.2. Safe Burial.....	1. Yes	2. No	SBURIAL
6.3.3. Distancing.....	1. Yes	2. No	DISTANCE
6.3.4. Symptoms.....	1. Yes	2. No	SYMPTOMS
6.3.5. Prevention.....	1. Yes	2. No	PREVENTION
6.3.6. Behaviour Change.....	1. Yes	2. No	BCHANGE
6.3.7. Clinic Services.....	1. Yes	2. No	CSERVICES
6.3.8. Malaria.....	1. Yes	2. No	MALARIA
6.3.9. Mixing of Chlorine and Handwashing.....	1. Yes	2. No	MCHLORINE
6.3.10. Diarrhea.....	1. Yes	2. No	DIARRHEA
6.3.11. Typhoid and Chlorea.....	1. Yes	2. No	TYPCHLOREA
6.3.12. Addressing Stigma.....	1. Yes	2. No	ADSTIGMA
6.3.13. Reintegration of EBOLA Victims.....	1. Yes	2. No	REINTVICTIMS
6.3.14. Early Warning Systems For Ebola.....	1. Yes	2. No	EWSEBOLA
6.3.15. Other 1.....	1. Yes	2. No	OTHER 1
6.3.16. Other 2.....	1. Yes	2. No	OTHER 2

6.4.1. Ranked the following EBOLA messages that you received from PCI EC 3 with the one that affected you the **MOST** and Caused a change in your behaviour as the topmost? (from 1-16)

1. Ebola Awareness.....	
2. Safe Burial.....	
3. Distancing.....	
4. Symptoms.....	
5. Prevention.....	
6. Behaviour Change.....	
7. Clinic Services.....	
8. Malaria.....	
9. Mixing of Chlorine and Handwashing.....	
10. Diarrhea.....	
11. Typhoid and Chlorea.....	
12. Addressing Stigma.....	
13. Reintegration of EBOLA Victims.....	
14. Early Warning signs For Ebola.....	
15. Other 1.....	
16. Other 2.....	

6.5.1. Where did you received PCI EC 3 EBOLA Campaigns? (Check all that is applicable)

6.5.1.1. Radio Broadcast.....	1. Yes	2. No	RADIOCAMP
6.5.1.2. Poster	1. Yes	2. No	POSTERCAMP
6.5.1.3. Pamphlet.....	1. Yes	2. No	PAMCAMP
6.5.1.4. One-on-one with GCHVs.....	1. Yes	2. No	GCHVCAMP
6.5.1.5. Other.....	1. Yes	2. No	OTHERCAMP

6.6.1. Did any of the PCI EC 3 campaigns influence you to change your behaviour?

1. Yes	2. No	9.NA	EBOLACAMP
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6.7.1. Which of the EBOLA campaign mediums affected your behaviour the MOST?

1. Radio Broadcast	MOSTCAMP
2. Poster	
3. Pamphlet	
4. One-on-one with GCHVs	
5. Other	
6. Not Applicable	

6.8.1. Could you kindly state three of the behaviour changes that have occurred in you as result of the PCI EC3 BOAL awareness Campaign?

- 1.....
- 2.....
- 3.....

6.8.1. Are the following available in your household or community as a result of EC 3? (**OBSERVE**)

6.3.1. Health Education Posters and Flyers.....	1. Yes	2. No	EBOLAWARE
6.3.2. Clean Latrine.....	1. Yes	2. No	SBURIAL
6.3.3. Mosquito Nets in Used.....	1. Yes	2. No	DISTANCE
6.3.4. Handwashing Facility.....	1. Yes	2. No	SYMPTOMS
6.3.5. Clean Environment.....	1. Yes	2. No	PREVENTION
6.3.6. Clean Water.....	1. Yes	2. No	BCHANGE
6.3.7. Clinic Services.....	1. Yes	2. No	CSERVICES

7.0. Section E: Knowledge and Awareness of EBOLA

7.1. What causes Ebola?

7.1.1. Virus.....	1. Mentioned	2. Not mentioned	VIRUS
7.1.2. Bats/Monkeys/Chimpanzees/Other Animals	1. Mentioned	2. Not mentioned	BATS_ANIMALS
7.1.3. Witchcraft.....	1. Mentioned	2. Not mentioned	WITCHCRAFTS
7.1.4. Evil Doing.....	1. Mentioned	2. Not mentioned	EVILDOING
7.1.5. Curse.....	1. Mentioned	2. Not mentioned	CURSE
7.1.6. Sunshine/Weather.....	1. Mentioned	2. Not mentioned	WEATHER
7.1.7. Other1: _____	1. Mentioned	2. Not mentioned	OTHER 1
7.1.8. Other2: _____	1. Mentioned	2. Not mentioned	OTHER 2

7.2. Can someone get Ebola and survive?

1. Yes
2. No

7.3. Have you ever heard of Ebola?

1. Yes
2. No

7.4. Can you name three signs and symptoms of Ebola?

1.
2.
3.

7.5. Do you know how a person can get Ebola?

(Select all that apply.)

1. From a person who is infected but doesn't have any signs or symptoms
2. Eating/preparing bush meat
3. Eating wild fruits likely eaten by bats
4. Touching the blood of an infected person
5. Touching Sperm of an infected person
6. Shaking hands or other physical contact with an infected person
7. Other fluids from an infect person
8. Other specify _____

7.6. Do you know how a person can prevent getting Ebola? (Select all that apply.)

1. Don't touch the skin or body fluids of people sick with/who have died from Ebola
2. Cook food very well
3. Use mosquito net
4. Bathing someone that has died with signs and symptoms of Ebola
5. Other (specify) _____

7.7. Do you think you or someone in your family could get Ebola?

1. Yes
2. No

8.0. Section F: Stigmatization

8.1. Do you know people who had Ebola?

1. Yes
2. No

8.2. If there is a person who survived Ebola, when he/she come back to your community, how would they be regarded/treated?

1. No differently than they had always been treated
2. Community members would not engage with them(wash with them, eat with them or visit them)
3. They would be welcomed back and appreciated
4. They would not be allowed into the community

8.3. Can people who survived Ebola make others sick?

1. Yes
2. No

9.0 Section G: gCHV Role in the Community

9.1. Have you been seeing the gCHVs working in your community?

1. Yes
2. No

9.2. How often do you see the gCHVs working in your community?

1. Daily
2. Weekly
2. Monthly
4. Not Applicable

9.3. What does the GCHV in your community normally discuss with the community members?

(Select all that apply.)

1. Ebola prevention and control
2. Malaria and prevention (using mosquito net)
3. Clinical services
4. Diarrhea
5. Typhoid & cholera
6. Vaccination (deworming, polio & measles)
7. Cleanliness of environment (toilets, surrounding, etc)
8. Hygiene (Hand washing, etc)
9. Nutrition (food and its nutrients)

END OF FORM. CHECK YOUR FORM AND THANK THE STUDY PARTICIPANT

Annex F: Focus Group Discussions (FGDs) with Intervention Community Members Guide

USAID/PCI EC 3 Project

Evaluation of Emergency Community Care Centers in Liberia



USAID
FROM THE AMERICAN PEOPLE



[Focus Group Discussions \(FGDs\) with Intervention Community Members. Final Version-9th December, 2015](#)

Focus Group Discussions (FGDs) with Intervention Community Members

Instruction: Kindly identify Intervention Community Members and conduct 2 FGDs per District. First FGD should be among a group of EC3 female beneficiaries and they should be between 8 to 10 members. The second FGD should be among a group of EC 3 male beneficiaries and they should be between 8 to 10 members. Kindly use the voice recorder to record every detail of the FGDs after the informed Consent Processes and ensure notes are also taken.

-
1. Could you kindly tell me what your professional/demographic background is?

2. What would you do if you encounter someone in your community who is sick? What do you see others do? **Probe**
3. Have you noticed any changes in your community since Ebola came to Liberia? **Probe**
4. Do you think community members are prepared to fight infectious diseases in (name of community)? Why or why not? **Probe**
5. Were the GCHV in your community helpful? If yes how, if no why? **Probe**
6. What do you think the biggest challenge will be for your community and individuals in your community to remain disease-free? Why? **Probe**
7. What are some of the most important things you have learned this year about keeping your community safe and healthy? **probe**
8. What do you know about the PCI Emergency Community Care Center (EC 3) Project?
9. What did the PCI EC 3 project do in your community? **Probe for the PCI EC 3 activities and package**
10. Has PCI EC3 been efficient and effective in responding to EVD emergency response? **Probe for timeliness and appropriateness of the interventions. Probe for reasons why PCI EC 3 was efficient and efficient if YES Probe for reasons why PCI EC 3 was not efficient and efficient if NO**
11. How has the behavior of the community members' change as a result of PCI/EC3 community level interventions? **Probe for specific BCC interventions/Messages and what worked and what did not worked. Probe for each of the following:**
 - **Community trainings and outreach.**
 - **Strengthen community resilience and preparedness.**
 - **Support for reintegration of Ebola survivors.**
 - **Support cross-border initiatives.**
12. Have you observed and Specific behavior changes? **Probe for the behavior changes observed?**
13. Has there been any changes in your health facilities in the areas of infrastructure, supplies, clinical staff capacity and service quality as a result of PCI implemented EC 3 interventions? **Probe for each, e.g. infrastructure, supplies, clinical staff capacity, quality of service, etc, Probe for the following:**
 - **How safe do health facility staff feel to respond to suspected Ebola cases?**
 - **How prepared do they feel now as compared with before the crisis?**
 - **What activities were most useful in increasing their preparedness?**
 - **Did they receive adequate tools/training to respond?**
 - **If not, how did they handle it?**
 - **Did they implement any of their own solutions?**
14. Has there been any community events or campaigns to strengthen resilience or preparedness from EC 3? **Probe for Specific events and campaigns**
15. What do you know about the objectives of the EC 3 project?
16. Do you think the EC3 project results have been achieved? If not why? If yes how? **Probe**
17. What are some of the successes of the PCI EC3 project in your community? **Probe**
18. What are some of the challenges the PCI EC3 project in your community?
19. What lessons you learned from the PCI EC3 project?

20. What changes in terms of behavior have occurred in your community as result of the PCI EC3 Project? **Probe for changes such as health behavior changes, disaster preparedness, EVD awareness, etc.**
21. What are the MOST Significant changes in terms of behavior that have occurred in your district as result of the PCI EC3 Project?
22. Did your community derived any benefit from the EC 3 project? **Probe**
23. How did your community benefitted from the EC3 project. **Probe**
24. Do you think these benefits are sustainable? Why? **Probe**
25. What will you say are some the best practices of the PCI EC3 project? **Probe**
26. What do you think is the best role for gCHVs during an EVD outbreak? What do you think? **Probe for the most appropriate and effective role of gCHVs and activities of gCHVs during and an EVD outbreak.**
27. What are your recommendations/Suggestions for a similar project? **Probe**

Annex G: Indepth Interview (IDIs) with District Medical Officer or Representatives Guide

USAID/PCI EC 3 Project

Evaluation of Emergency Community Care Centers in Liberia



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Indepth Interview Guide (IDI) with District Medical Officer or Representatives. Final Version-9th December, 2015

Indepth Interview (IDIs) with District Medical Officer or Representatives

Instruction: Kindly identify the District Medical Officer or his/her representative and conduct this indepth interview (IDI) on one-one and use the voice recorder to record every detail of the interview after the informed Consent Processes.

1. Could you kindly tell me what your professional background is?
2. What do you know about the PCI Emergency Community Care Center (EC 3) Project?
3. What did the PCI EC 3 project do in your district? **Probe for the PCI EC 3 activities and package**
4. Has PCI EC3 been efficient and effective in responding to EVD emergency response?
5. How has the behavior of the community members' change as a result of PCI/EC3 community level interventions? **Probe for specific BCC interventions. Probe for each of the following:**
 - Community trainings and outreach.
 - Strengthen community resilience and preparedness.
 - Support for reintegration of Ebola survivors.
 - Support cross-border initiatives.
6. Have you observed and Specific behavior changes? **Probe for the behavior changes observed?**

7. Has there been any changes in your health facilities in the areas of infrastructure, supplies, clinical staff capacity and service quality as a result of PCI implemented EC 3 interventions? **Probe for each, e.g. infrastructure, supplies, clinical staff capacity, quality of service, etc,**
8. Has there been any community events or campaigns to strengthen resilience or preparedness from EC 3? **Probe for Specific events and campaigns**
9. What do you know about the objectives of the EC 3 project?
10. Do you think the EC3 project results have been achieved? If not why? If yes how?
11. What are some of the successes of the EC3 project in your district?
12. What are some of the challenges the EC3 project in your district?
13. What lessons you learned from the EC3 project?
14. What changes in terms of behavior have occurred in your district as result of the EC3 Project? **Probe for changes such as health behavior changes, disaster preparedness, EVD awareness, etc.**
15. What are the MOST Significant changes in terms of behavior that have occurred in your district as result of the PCI EC3 Project?
16. Did your district derived any benefit from the EC 3 project? **Probe**
17. How did your district benefitted from the EC3 project. **Probe**
18. Do you think these benefits are sustainable? Why? **Probe**
19. What will you say are some the best practices of the PCI EC3 project? **Probe**
20. In your professional opinion, do you see opportunities for similar programs in future?
21. What are your recommendations/Suggestions for the PCI EC3 project? **Probe**

Annex H: Indepth Interview (IDIs) with County Medical Officers or Representatives Guide

USAID/PCI EC 3 Project

Evaluation of Emergency Community Care Centers in Liberia



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Indepth Interview Guide (IDI) with County Medical Officers or Representatives. Final Version-9th December, 2015

Indepth Interview (IDIs) with County Medical Officers or Representatives

Instruction: Kindly identify the County Medical Officer or his/her representative and conduct this indepth interview (IDI) on one-one and use the voice recorder to record every detail of the interview after the informed Consent Processes.

1. Could you kindly tell me what your professional background is?
2. What do you know about the PCI Emergency Community Care Center (EC 3) Project?
3. What did the PCI EC 3 project do in your county? **Probe for the PCI EC 3 activities and package**
4. Has PCI EC3 been efficient and effective in responding to EVD emergency response?

5. How has the behavior of the community members' change as a result of PCI/EC3 community level interventions? **Probe for specific BCC interventions. Probe for each of the following:**
 - a. Community trainings and outreach.
 - b. Strengthen community resilience and preparedness.
 - c. Support for reintegration of Ebola survivors.
 - d. Support cross-border initiatives.
6. Have you observed and Specific behavior changes? **Probe for the behavior changes observed?**
7. Has there been any changes in your health facilities in the areas of infrastructure, supplies, clinical staff capacity and service quality as a result of PCI implemented EC 3 interventions? **Probe for each, e.g. infrastructure, supplies, clinical staff capacity, quality of service, etc,**
8. Has there been any community events or campaigns to strengthen resilience or preparedness from EC 3? **Probe for Specific events and campaigns**
9. What do you know about the objectives of the EC 3 project?
10. Do you think the EC3 project results have been achieved? If not why? If yes how?
11. What are some of the successes of the EC3 project in your county?
12. What are some of the challenges the EC3 project in your county?
13. What lessons you learned from the EC3 project?
14. What changes in terms of behavior have occurred in your county as result of the EC3 Project? **Probe for changes such as health behavior changes, disaster preparedness, EVD awareness, etc.**
15. What are the MOST Significant changes in terms of behavior that have occurred in your county as result of the PCI EC3 Project?
16. Did your county derived any benefit from the EC 3 project? **Probe**
17. How did your county benefitted from the EC3 project. **Probe**
18. Do you think these benefits are sustainable? Why? **Probe**
19. What will you say are some the best practices of the PCI EC3 project
20. In your professional opinion, do you see opportunities for similar programs in future?
21. What are your recommendations/Suggestions for the PCI EC3 project?

Annex I: Key Informant Interview (KIIs) with General Community Health Volunteers (gCHVs) Guide

USAID/PCI EC 3 Project

Evaluation of Emergency Community Care Centers in Liberia



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Key Informant Interview with General Community Health Volunteers (gCHVs). Final Version-9th December, 2015

Key Informant Interview (KIIs) with General Community Health Volunteers (gCHVs)

Instruction: Kindly identify two General Community Health Volunteers (GCHV) in each district and conduct this Key Informant Interview (KII) on one-one and use the voice recorder to record every detail of the interview after the informed Consent Processes.

1. Could you kindly tell me what your professional background is?
2. What do you know about the PCI Emergency Community Care Center (EC 3) Project?
3. What did the PCI EC 3 project do in your district? **Probe for the PCI EC 3 activities and package**
4. Has PCI EC3 been efficient and effective in responding to EVD emergency response? **Probe for timeliness and appropriateness of the interventions.**
5. **Probe for reasons why PCI EC 3 was efficient and efficient if YES**
6. **Probe for reasons why PCI EC 3 was not efficient and efficient if NO**
7. How has the behavior of the community members' change as a result of PCI/EC3 community level interventions? **Probe for specific BCC interventions. Probe for each of the following:**
 - **Community trainings and outreach.**
 - **Strengthen community resilience and preparedness.**
 - **Support for reintegration of Ebola survivors.**
 - **Support cross-border initiatives.**
8. Have you observed and Specific behavior changes? **Probe for the behavior changes observed?**
9. Has there been any changes in your health facilities in the areas of infrastructure, supplies, clinical staff capacity and service quality as a result of PCI implemented EC 3 interventions? **Probe for each, e.g. infrastructure, supplies, clinical staff capacity, quality of service, etc, Probe for the following:**
 - **How safe do health facility staff feel to respond to suspected Ebola cases?**
 - **How prepared do they feel now as compared with before the crisis?**
 - **What activities were most useful in increasing their preparedness?**
 - **Did they receive adequate tools/training to respond?**
 - **If not, how did they handle it?**
 - **Did they implement any of their own solutions?**
10. Has there been any community events or campaigns to strengthen resilience or preparedness from EC 3? **Probe for Specific events and campaigns**
11. What do you know about the objectives of the EC 3 project?
12. Do you think the EC3 project results have been achieved? If not why? If yes how?
13. What are some of the successes of the EC3 project in your district?
14. What are some of the challenges the EC3 project in your district?
15. What lessons you learned from the EC3 project?
16. What changes in terms of behavior have occurred in your district as result of the EC3 Project? **Probe for changes such as health behavior changes, disaster preparedness, EVD awareness, etc.**
17. What are the MOST Significant changes in terms of behavior that have occurred in your district as result of the PCI EC3 Project?
18. Did your district derived any benefit from the EC 3 project? **Probe**

19. How did your district benefitted from the EC3 project. **Probe**
20. Do you think these benefits are sustainable? Why? **Probe**
21. What will you say are some the best practices of the PCI EC3 project? **Probe**
22. What do you think is the best role for gCHVs during an EVD outbreak? What do you think? **Probe for the most appropriate and effective role of gCHVs and activities of gCHVs during and an EVD outbreak.**
23. Did gCHVs received training from PCI EC 3 project? **Probe for all supports received.**
 - Was training/support sufficient? **Probe for all supports received**
 - What could be done better? **Probe for all supports received**
24. In your professional opinion, do you see opportunities for similar programs in future? **Probe**
25. What are your recommendations/Suggestions for the similar project? **Probe**

Annex J: Indepth Interview with PCI EC3 Key Staff Guide

USAID/PCI EC 3 Project

Evaluation of Emergency Community Care Centers in Liberia



Indepth Interview (IDI) with PCI EC 3 Key Staff. Final Version-9th December, 2015

Indepth Interview (IDIs) with PCI EC3 Key Staff

Instruction: Kindly identify one PCI EC3 key staff and conduct this Indepth Interview (IDI) on one-one and use the voice recorder to record every detail of the interview after the informed Consent Processes.

28. Could you kindly tell me what your professional/demographic background is?
29. What do you know about the PCI Emergency Community Care Center (EC 3) Project?
30. What did the PCI EC 3 project do? **Probe for the PCI EC 3 activities and package**
31. Has PCI EC3 been efficient and effective in responding to EVD emergency response?
Probe for timeliness and appropriateness of the interventions.
Probe for reasons why PCI EC 3 was efficient and efficient if YES
Probe for reasons why PCI EC 3 was not efficient and efficient if NO
32. Has there been any behavior changes as a result of PCI/EC3 interventions? **Probe for specific BCC interventions. Probe for each of the following:**
 - **Community trainings and outreach.**
 - **Strengthen community resilience and preparedness.**
 - **Support for reintegration of Ebola survivors.**
 - **Support cross-border initiatives.**

33. Have you observed and Specific behavior changes? **Probe for the behavior changes observed?**
34. Has there been any changes in the health facilities in the areas of infrastructure, supplies, clinical staff capacity and service quality as a result of PCI implemented EC 3 interventions? **Probe for each, e.g. infrastructure, supplies, clinical staff capacity, quality of service, etc,**
Probe for the following:
- **How safe do health facility staff feel to respond to suspected Ebola cases?**
 - **How prepared do they feel now as compared with before the crisis?**
 - **What activities were most useful in increasing their preparedness?**
 - **Did they receive adequate tools/training to respond?**
 - **If not, how did they handle it?**
 - **Did they implement any of their own solutions?**
35. Has there been any community events or campaigns to strengthen resilience or preparedness from EC 3? **Probe for Specific events and campaigns**
36. What do you know about the objectives of the EC 3 project?
37. Do you think the EC3 project results have been achieved? If not why? If yes how?
38. What are some of the successes of the EC3 project in your district?
39. What are some of the challenges the EC3 project in your district?
40. What lessons you learned from the EC3 project?
41. What changes in terms of behavior have occurred as result of the EC3 Project? **Probe for changes such as health behavior changes, disaster preparedness, EVD awareness, etc.**
42. What are the MOST Significant changes in terms of behavior that have occurred as result of the PCI EC3 Project?
43. What will you say are some the best practices of the PCI EC3 project? **Probe**
44. What do you think is the best role for gCHVs during an EVD outbreak? What do you think? **Probe for the most appropriate and effective role of gCHVs and activities of gCHVs during and an EVD outbreak.**
45. Did gCHVs received training from PCI EC 3 project? **Probe for all supports received.**
- Was training/support sufficient? **Probe for all supports received**
 - What could be done better? **Probe for all supports received**
46. In your professional opinion, do you see opportunities for similar programs in future? **Probe**
47. What are your recommendations/Suggestions for the similar project? **Probe**

Annex K: Deployment Plan

USAID-PCI EC3 PROJECT DEPLOYMENT PLAN			
	NAME	TITLE	ASSIGNED COUNTY
TEAM 1	JAMES LYNCH MONBO	SUPERVISOR	NIMBA COUNTY
	TRACY WENDOR KHEPE	ENUMERATOR	
	M. ALLISON PAYE	ENUMERATOR	
	CYNTHIA YAH GLAY	ENUMERATOR	
	PEAL P. H. NYENKAN	ENUMERATOR	
TEAM 2	JACOB J. FLOMO	SUPERVISOR	BONG COUNTY
	BLESS E. DAITEY	ENUMERATOR	
	GOLDY KONTOE	ENUMERATOR	
	WAYEJAIN L. K. GIBSON	ENUMERATOR	
TEAM 3	PRINCE O. GBONEH	SUPERVISOR	CAPE MOUNT
	ELIZA GEORGE	ENUMERATOR	
	EUSEBIUS T.Y. ALLISON	ENUMERATOR	
TEAM 4	CALVIN RAYMOND SUMMON	SUPERVISOR	BOMI COUNTY
	JANNIE FAHNBULLEH	ENUMERATOR	
	SONNIE F. BLAMA-TALI	ENUMERATOR	
TEAM 5	JOYCE TUAH	SUPERVISOR	BONG COUNTY
	SANDO O. JOHNSON	ENUMERATOR	
	ELIJAH F.T. GIAH	ENUMERATOR	
	THOMPSON B. WOODS	ENUMERATOR	
TEAM 6	LAWOLO E. GIBSON II	SUPERVISOR	NIMBA COUNTY
	TONIA E. DAVIS	ENUMERATOR	
	HANNAH OLIVANT	ENUMERATOR	
TEAM 7	T. TROKON HARRIS	SUPERVISOR	CAPE MOUNT
	ADEL M. METZGER	ENUMERATOR	
	JOE S. PEWU-LAKE JR.	ENUMERATOR	
TEAM 8	GRACE L. GEE	SUPERVISOR	BOMI COUNTY
	WINNIE M. SIAKOR	ENUMERATOR	
	ARTHUR S. DAFUWAH	ENUMERATOR	

Annex L: List of Sampled Communities

USAID-PCI EC3 PROJECT COMMUNITIES						
NO.	COMMUNITY	DISTRICT	COUNTY	NAME	CONTACT	
1	DEVINE VILLAGE	SENJEH	BOMI	MAIMA DAVID	770401060	CALVIN (TEAM 4)
2	SACKIE TOWN	SENJEH	BOMI	AMOS K. CARANDA	770048433	
3	VAI TOWN	SENJEH	BOMI	EVON LABLAH	770048433	
4	STEWARD TOWN	SENJEH	BOMI	ABRAHAM B. CASSELL	880453510	
5	HARMON HILL COM.	SENJEH	BOMI	AMELIA BIOMAH	775995342	
6	WILLIAM COMM.	SENJEH	BOMI	JOEL Z. KPASSAY	775088398	
7	FEFEH	SUEHN MECCA	BOMI	LAHAI M. COLE	888524499	GRACE (TEAM 8)
8	DABAN	SUEHN MECCA	BOMI	CLARANCE WILLIAM	776767496	
9	SUEHN TOWN	SUEHN MECCA	BOMI	LUCIA CRANSHAW	886260805	
10	GOLA GORDEE	SUEHN MECCA	BOMI	THOMAS BOIMAH	777378176	
11	JUNK TOWN	SUEHN MECCA	BOMI	MORRIS J. SMITH	886604807	
12	MECCA	SUEHN MECCA	BOMI	GEORGE P. CHEA	777626684	
13	ODESSA FARM	FUAMAH	BONG	LAWRENCE HOLDER	880754732	JACOB (TEAM 2)
14	OLD VARNEY TOWN	FUAMAH	BONG	PATRICK F. FALLAH	886879054	
15	FROG ISLAND	FUAMAH	BONG	JOSEPH K. HARMON	880688635	
16	MAWAH	FUAMAH	BONG	THOMAS V. ZEALEN	776256795	
17	AIRFIELD	FUAMAH	BONG	ALEXANDER DUMAH	886764270	
18	BODUALA	FUAMAH	BONG	WILLIAM KEAYN	770568186	JOYCE (TEAM 5)
19	WAYCORMAH	FUAMAH	BONG	THOMAS FLOMO	886693459	
20	NEW CEPHUS #1	FUAMAH	BONG	GEORGE T. TAMBA	88824009	
21	GWILLY TOWN	FUAMAH	BONG	ANTHONY G. KOLLIE	888153769	
22	SIAFFA TOWN	FUAMAH	BONG	DEARIE M. CRAWFORD	777786782	
23	SOSO TOWN	TEWOR	GCM	LAMIN MASSALAY	886402638	PRINCE (TEAM 3)
24	TIENII TOWN	TEWOR	GCM	ABEL REEVES	880460276	
25	MANO	TEWOR	GCM	LAWRENCE JALEIBAH	888552385	
26	GAMBIA	TEWOR	GCM	TENNEH KAMARA	N/A	
27	YORK ISLAND	TEWOR	GCM	MORRIS KIAWEN	888166162	
28	GBAJALA	PORKPA	GCM	PRINCESS LLOYD	886892875	TROKON (TEAM 7)
29	COLLIER VILLAGE	PORKPA	GCM	VARNIE COLLIER	886745155	
30	BOESAN	PORKPA	GCM	ALIEU FAHNBULLEH	776995879	
31	BAMBALLAH	PORKPA	GCM	BETTY PATRICK	886362455	
32	SIMSON TOWN	PORKPA	GCM	SARAH T. KPINGBAH	880391841	
33	GBAHN	SACLEPEA MAH	NIMBA	RUTH BUNNAH	N/A	LYNCH (TEAM 1)
34	FLUMPA	SACLEPEA MAH	NIMBA	ALLEN MEHN	N/A	
35	KPAYTUO	SACLEPEA MAH	NIMBA	EMMANUEL GRUGBAY	N/A	
36	LOYEE	SACLEPEA MAH	NIMBA	BOB SONKALAY	N/A	
37	KPEIN	SACLEPEA MAH	NIMBA	MARY KPOKOR	N/A	
38	KAIRPLAY	GBEHLAY GEH	NIMBA	KELVIN TARKPOR	N/A	GIBSON (TEAM 6)
39	GIAPLAY	GBEHLAY GEH	NIMBA	TELVIS YEAMIE	N/A	
40	LOELAY	GBEHLAY GEH	NIMBA	SOLOMON DAHN	N/A	
41	VAYENLAY	GBEHLAY GEH	NIMBA	YEESAH DEHMIE	N/A	
42	KARNPLAY ZONE 3	GBEHLAY GEH	NIMBA	ANGELINE YEAMIE	N/A	

Annex M: List of Sampled Health Facilities

	Count	District	Health Facility
1	Bong	Fuamah	Degai Clinic
2			Haindii Clinic
3			Mawatta Health Post
4			Mawah Health Post
5			Yarwayar Health Post
6		Sanoyea	Sanoyea Clinic
7			Gbonota Clinic
8			Kelebei Clinic
9		Salala	Tokpaipolu Clinic
10			Totota Clinic
11			Salala Clinic
12		Suakoko	Gbarnla Clinic
13			Fenutoli Clinic
14			Gbartala Clinic
15		Suakoko	Zeansue Clinic
16		Jorquelleh	Wainsue Clinic
17		Zota	Belefanai Clinic
18	Bomi	Dewion	Bonjeh Town Clinic
19			Darweh Town Clinic
20			Jenneh #3 Community Clinic
21			Vortor Community Clinic
22			Beh Town Clinic
23		Senjeh	Ahmadiyyi Clinic
24			Beafine Clinic
25			Sackie Town Community Clinic
26			Yomo Town Clinic
27			Beh-Sao Clinic
28		Suehn Mecca	Fefeh Town Community Clinic
29			Mecca Clinic
30			Suehn Town Clinic
31			Weawolo Clinic
32		Klay	Golodee Lansana Clinic
33	Cape Mount	Gola Konneh	Than Gola-Konneh Clinic
34			Lofa Bridge Clinic
35			Varguaye Clinic
36		Porkpa	Bamballa Community Clinic
37			Bendaja Community Clinic

38			Damballa Health Center
39			Kawelahun Clinic
40			Kongo Clinic
41		Tewor	Bangorma Community Clinic
42			Bo-Waterside Community Clinic
43			Diah Community Clinic
44			Fahnja Clinic
45			Gonelor Community Clinic
46			Gordama Community Clinic
47			Jene Wonde Clinic
48			Kulangor Clinic
49			Mambo Community Clinic
50			Than Mafa Community Clinic
51			Tienii Community Clinic
52	Nimba	Gbehlay-Geh	Beo-yoolar Clinic
53			Duoplay Clinic
54			Garplay Clinic
55			Gbe-vonwea Clinic
56			Give Them Hope Clinic
57			Goagortuo Clinic
58			Karnplay Health Center
59			Kpairplay Clinic
60			Loguatuo Clinic
61			Slangonplay Clinic
62			Varyenglay Clinic
63			Younlay Clinic
64			Zorgowee Clinic
65		Zoo-Geh	Bahn ULIC
66			Beadatuo Clinic
67			Lepula Clinic
68			Paree Clinic
69			Wehplay Community Clinic
70		Yarwin Mehnsonoh	Zekepa Clinic
71			Mehnla Clinic
72			Kwendin Clinic
73		Tappita	Mid Baptist Clinic
74			Graie Clinic
75			Zuolay Clinic
76		Saclepea Mah	Saclepea Comprehensive Health Center

77			Karnwee Clinic
78			Bunadin Clinic
79			Flumpa Community Clinic
80			Flumpa Inland Clinic
81			Kpein Clinic
82			Duo Clinic
83			Beindin Community Clinic
84			Gbehyi-Duayee Clinic
85			Kpaytuo Clinic
86			Cocopa Clinic
87			Zahn Blanla Clinic

Annex N: List of Evaluation Team Members

N O.	NAME	QUALIFIATION	PHONE NUMBER	EMAIL ADDRESS
1	JUSTICE AJAARI	MSc. Med. Epidemiology	0248566085	ajaarijustice@gmail.com
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4	SHALOM ABOKYI	MPH Monitoring and Evaluation	0200185830	aashalom@gmail.com
5	CHARLES KEYI	BA Development Studies	0243328390	kyeicharles77@yahoo.com
6	T. TROKON HARRIS	College Graduate	0886588004	harristrokon@gmail.com
7	HANNAH OLIVANT	University Graduate	0880952008	olivanth@yahoo.com
8	GOLDY KONTOE	University Student	0886251490	goldykontoe@gmail.com
9	ADEL M. METZGER	University Graduate	0886565795	adel4real@yahoo.com
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11	TRACY WENDOR KHEPE	College Graduate	0776835682	tracykpehe2014@yahoo.com
12	EUSEBIUS T.Y. ALLISON	College Graduate	0776465398	aeusebiusallison@gmail.com
13	M. ALLISON PAYE	University Graduate	0770352127	allisonpaye2@gmail.com
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18	SANDO O. JOHNSON	High Sch Graduate	0886596558	sjohnson34@gmail.com
19	THOMPSON B. WOODS	College Student	0886880304	woodthompson20@gmail.com
20	TONIA E. DAVIS	University Graduate	0886624146	davistoniam@yahoo.com
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29	JACOB J. FLOMO	University Student	0777342826	jjflomo1@gmail.com
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