Joint Humanitarian Response for Ebola in Liberia

SHO Ebola Response Project (Bong and Margibi Counties)

Funded by the Samenwerkende Hulp Organisaties/
Dutch Collaborating Aid Organisations

EVALUATION REPORT

December 2015
# TABLE OF CONTENTS

<table>
<thead>
<tr>
<th>Section</th>
<th>Page number</th>
</tr>
</thead>
<tbody>
<tr>
<td>List of abbreviations</td>
<td></td>
</tr>
<tr>
<td>Executive summary</td>
<td></td>
</tr>
<tr>
<td>Introduction</td>
<td>1</td>
</tr>
<tr>
<td>The evaluation exercise</td>
<td>3</td>
</tr>
<tr>
<td>Process, implementation and outcomes</td>
<td>4</td>
</tr>
<tr>
<td>Achievements in relation to targets</td>
<td>7</td>
</tr>
<tr>
<td>The OECD/DAC evaluation criteria</td>
<td>11</td>
</tr>
<tr>
<td>Review in relation to humanitarian principles</td>
<td>13</td>
</tr>
<tr>
<td>Conclusions and recommendations</td>
<td>15</td>
</tr>
</tbody>
</table>

## Annexes

1. Logical framework
2. Terms of reference
3. Workplan
4. List of internal documents
5. Inception report
6. List of selected background documents
7. Itinerary consultant
8. List of persons met
9. Photographs
List of abbreviations

<table>
<thead>
<tr>
<th>Abbreviation</th>
<th>Full Form</th>
</tr>
</thead>
<tbody>
<tr>
<td>CHT</td>
<td>County Health Team</td>
</tr>
<tr>
<td>CWC</td>
<td>Community Water Committees</td>
</tr>
<tr>
<td>gCHV</td>
<td>general Community Health Volunteer</td>
</tr>
<tr>
<td>DFATD</td>
<td>Canada’s Department of Foreign Affairs, Trade and Development</td>
</tr>
<tr>
<td>DHMT</td>
<td>District Health Management Team</td>
</tr>
<tr>
<td>ETU</td>
<td>Ebola Treatment Unit</td>
</tr>
<tr>
<td>EUR</td>
<td>Euro (European currency)</td>
</tr>
<tr>
<td>EVD</td>
<td>Ebola virus disease</td>
</tr>
<tr>
<td>FA</td>
<td>Farmer’s Association</td>
</tr>
<tr>
<td>LDS</td>
<td>Latter Day Saints</td>
</tr>
<tr>
<td>M&amp;E</td>
<td>Monitoring and Evaluation</td>
</tr>
<tr>
<td>MOH(SW)</td>
<td>Ministry of Health (and Social Welfare)</td>
</tr>
<tr>
<td>NFI</td>
<td>Non-food Items</td>
</tr>
<tr>
<td>NGO</td>
<td>Non-Governmental Organization</td>
</tr>
<tr>
<td>OECD/DAC</td>
<td>Organisation for Economic Cooperation and Development/Development Assistance Committee</td>
</tr>
<tr>
<td>SHO</td>
<td>Samenwerkende Hulp Organisaties/Collaborating Aid Organizations</td>
</tr>
<tr>
<td>STEPP</td>
<td>Stop the outbreak/Treat the infected/Ensure essential services/Preserve stability/Prevent outbreaks in unaffected countries</td>
</tr>
<tr>
<td>UNICEF</td>
<td>United Nations Children Fund</td>
</tr>
<tr>
<td>UNMEER</td>
<td>United Nations Mission for Ebola Emergency Response</td>
</tr>
<tr>
<td>UNOCHA</td>
<td>United Nations Office for the Coordination of Humanitarian Affairs</td>
</tr>
<tr>
<td>WASH</td>
<td>Water, sanitation and hygiene</td>
</tr>
<tr>
<td>WFP</td>
<td>World Food Programme</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
</tr>
</tbody>
</table>
EXECUTIVE SUMMARY

The Collaborating Aid Organizations (SHO) Ebola Response
The Ebola Response project (budget EUR609,721) proposal was based on the response strategy ‘STEPP’ which was developed jointly with the Governments of the affected countries and launched on 16th September 2014 (Global Ebola Response; Making a Difference, May 2015).

The strategy supports the implementation of national response plans, as well as the broader societal, economic and political stability aspects of the current outbreak. The CARE/SHO project was planned in line with strategic objectives: 1) Stop the outbreak, 3) Ensure essential services and 4) Preserve stability. Expected outputs of the project were:

- Logistics support to District Health Teams (DHT) and Community Health Volunteers (gCHV) for contact tracing and data collection
- Food, nutritional and social safety net support to Ebola Virus Disease (EVD) survivors and affected families
- Increased public awareness on EVD prevention
- Strengthened health system in EVD affected communities
- Improved community participation and demand for health services

The evaluation approach
The purpose of the evaluation was threefold:

- Assess the performance of CARE’s intervention relative to OECD/DAC evaluation criteria.
- Develop lessons learned, recommendations that will assist CARE to improve its programmes and share its challenges and success with peer agencies
- Ensure accountability for the funds provided by SHO

The evaluation exercise consisted of a combination of a desk review of relevant documentation, key informant interviews and focus group discussions with beneficiaries, representatives from the relevant ministries and local authorities and CARE staff, while the main focus was placed on the beneficiaries.

The consultant reviewed internal CARE documentation on the project and background information on the Ebola response produced by the Government of Liberia, WHO, UNICEF, UNMEER and other organizations. Further, the consultant travelled to Liberia to conduct interviews, focus group discussions and meetings with beneficiaries and other key stakeholders of the SHO Ebola Response Project from 1st to 11th December 2015. People were met and discussions held with project staff, farmer groups, EVD survivors, community health volunteers, county officials, water committee members and sites visited, including water wells, group farms and clinics. Almost all the targets as detailed in the project proposal were found to have been met. Some points to note are the following:

Gender balance

Only 15% of the community health volunteers associated with the SHO project and only 32% of the participants of the training of the water committees are women. Especially the case of the gCHVs of whom only 15% are women is striking, because to effectively communicate at the grassroots level, it is extremely important that this communication can be conducted directly with the women as well as the men. Especially in the area of health and hygiene women play the more important role within the household and the community. It will be necessary when CARE engages gCHVs in their projects in future to actively promote the assignment of women in
consultation with the CHTs. In most cases information related to the SHO project is gender-specific but there are also some instances where information on gender is not available. CARE should ensure that in all instances gender-specific information is provided.

Accountability
The extent to which targets were met reflects positively on the accountability for the funds provided by SHO. Speaking strictly from a quantitative perspective there is only one target which was not met. An issue which is related to accountability and which can only be resolved by a financial audit is the fact that CARE was conducting similar activities in some of the same zones with funds from different sources: SHO, Latter Day Saints (LDS) and Canada’s Department of Foreign Affairs, Trade and Development (DFATD). It concerns especially water supplies and training of water committees conducted in Margibi County with SHO and LDS funds and in Bong County with SHO, LDS and DFATD funds. Further, assistance to survivors in Margibi County with funds from SHO and LDS. It is therefore recommended that a financial audit examine whether shared costs have been correctly charged to the various budgets.

Effectiveness, including timeliness and level of coordination
After the start-up activities had been completed in February, field operations started in March 2015, and through the task forces at the counties the assistance was directed at the communities and health facilities that needed it most, avoiding duplication where so many different organizations intervened. If several organizations worked in the same communities with the same groups of beneficiaries, they did provide different services. At the national level CARE was represented at the meetings of the Incident Management System and at the level of the counties, CARE participated in the coordination meetings, where all the organizations taking part in the Response were invited to exchange information and agree on who would do what and where. The conclusion is that in the case of the Ebola response, coordination was well organized and given a high priority, and that CARE participated in the system which had been put in place. In future CARE should do likewise and make an effort to include government officers at all levels in the consultations on the programmes they support in the communities even though these officers are busy and sometimes hard to locate. It is further noted that CARE collaborated closely with the counties especially by associating the gCHVs in their projects. The concept of the gCHV is extremely effective in linking the communities to the health system and promoting community ownership of activities and deserves to be exploited more and the function adapted to attract more women. It is therefore recommended that CARE should negotiate with the counties so as to agree on a uniform way of treating the gCHVs which are assigned to their projects in line with county and CARE policies and depending on the availability of resources. During the debriefing of the consultant it was clear that different counties look at this issue in different ways, so in these negotiations CARE may have some convincing to do.

Efficiency – What were the outputs in relation to the inputs?
The inputs were tailored to the targeted outputs and cost effectiveness was enhanced by the fact that CARE had several similar interventions ongoing at the same time so that certain operational costs could be shared and there also was an advantage of scale. When the budget was increased, some of the targets were raised accordingly. A workplan was elaborated and several monitoring visits were conducted by senior CARE staff and the m&e unit, progress reports were produced and recommendations were issued for improvements and adjustments. CARE recruited competent and experienced staff, who displayed the correct behaviour and attitude. Staff felt that they had been able to further develop their competencies on-the-job. Water wells were constructed and rehabilitated as planned and it was noted that it is important to properly manage and maintain these installations, because they are used intensively and open to abuse. In order to maintain these installations therefore enough individuals need to be trained so
that at any time some people are present in the town who can supervise the well. The maintenance and/or replacement of minor parts is not costly and could be borne by the community if a cost-recovery mechanism is introduced. CARE is advised to further look into this and the training (especially also of women) for future projects which aim at assisting community water supplies.

**Appropriateness**
The proposal for the SHO Ebola response took as it’s point of departure the ‘STEPP’ strategy, thereby linking up with initiatives that had been taken by the Government supported by WHO, UNICEF and other specialized agencies. In other words, the needs which the project proposed to address had been established independently by a consortium of specialized organizations and institutions and CARE had adopted the outcome of this assessment in it’s areas of competence. The project was able to provide an appropriate response to local needs and the priorities of the people, taking into account the specific needs of women and vulnerable groups. The project has also put the functioning of the health system - which was taken up by the Liberian Government in 2015 - on the agenda at community and district level. Thus, through training and workshops the project has promoted an interest in the health system at the district and community levels in line with the initiatives taken by the Government. In future CARE should try to capitalize on this by making the link between the health system and the communities, because it is as yet not clear how - if at all - the community health development committees function. However, the concept is useful and would provide the gCHVs with a structured entry point for health issues into the community. To understand how and to what extent this idea has been adopted and such committees are functional, CARE might want to do a follow up with the gCHVs.

CARE included the component of seeds and tools in order to contribute to the ‘Essential Services’ objective. The criteria, which had been introduced for the selection of the farmer groups rightfully ensured that the groups which were included, have a minimum organizational capacity. This is a guarantee that the assistance will most likely be put to good use. Also the fact that the groups were monitored after having received the funds and tools, contributed to success. It is recommended that CARE continue working with farmer groups in this way during the recovery programme.

**Stigmatization**
The issue of stigmatization continues to cause problems for the EVD survivors. On top of the fact that the physical presence of survivors is avoided, they are also the group which receives most assistance like the non-food items (NFI) and sometimes cash, while the other people in the community do not. This causes resentment, because poverty is common, the community as a whole was affected by the Ebola crisis and everybody feels in need of assistance. It is therefore recommended that CARE try to contribute to resolve the problems of stigmatization and poverty alleviation at once by promoting recovery programmes, which address the communities as a whole and not single out the EVD survivors.

**Effect of the intervention in terms of preservation of life and reduction of human suffering**
The suffering of the EVD survivors has been reduced by the provision of NFI kits and basic necessities for a dignified existence. An attempt has been made to reduce the extent to which they suffer from stigmatization and as a result the issue was included among the community sensitization activities by the gCHVs. It is likely to be reduced even more when a recovery programme gets underway which would not single out survivors.
1. Introduction

Background

Besides the medical consequences, the Ebola outbreak has had a wider impact on the security, economy and livelihoods in Liberia. Restrictions on movement out of, into and within the country have resulted in a shortage of availability of goods and services. As a result, food prices have increased and food insecurity affects poor households, in particular Ebola-affected households and families who have spent time in quarantine. To ensure basic non-Ebola services, provision of psychosocial support, gender sensitive protection and assistance to most vulnerable women, girls and young people is important. Social mobilizations and community engagement is important to preserve stability. UN OCHA states that training of community mobilizers in outreach techniques and messaging is one of the critical actions, as well as increasing public awareness.

SHO/Giro 555 comes into action in case of exceptional disasters all over the world. Then SHO connects 11 Dutch NGOs to collaborate with companies, broadcasters and radio stations, schools, faith institutions and sports clubs throughout the Netherlands. In a National Action they together raise money for the survivors of a disaster. Of the total amount raised for the Ebola response by the Dutch public (10.5 M euros), 609.721 euros was awarded to CARE Nederland.

The SHO Ebola Response Project

The project proposal was based on the response strategy ‘STEPP’ which was developed jointly with the Presidents and Governments of the affected countries and launched on 16th September 2014 (Global Ebola Response ; Making a Difference, May 2015). The strategy supports the implementation of national response plans for the Ebola outbreak, as well as the broader societal, economic and political stability aspects of the current outbreak and has five strategic objectives: 1) stop the outbreak, 2) treat the infected, 3) ensure essential services, 4) preserve stability and 5) prevent outbreaks in unaffected countries. The CARE/SHO project was planned in line with objectives 1, 3 and 4.

The first objective aims at stopping the Ebola outbreak by identifying and tracing people with Ebola, supporting safe burials, providing health care for patients, promoting clinical hygiene in treatment and health care facilities, and ensuring medical care for health workers. Besides the direct health crises, the Ebola outbreak is having a wider impact on the general health system, security situation, economy and livelihoods in the affected countries. Therefore, the strategy also includes the aim to ensure essential services and preserve stability by providing food and social safety net support, ensuring safe access to water and sanitation facilities, providing psycho-social support, increasing public awareness on Ebola prevention and social mobilization (objectives 3 and 4).

Expected outputs of the project were (for further details see Annex 1. Logical Framework1):

Logistics support to DHTs/gCHVs
to strengthen coordination amongst various actors for contact tracing and for data collection, collation, analysis and reporting and distribution of protective hygiene kits and disinfection materials to community health centers for disinfection against EVD and other diseases;

1 SO3/R2 : this should read ‘Construct 5 new wells and rehabilitate 20 existing wells ...’
**Food, nutritional and social safety net support**
to EVD survivors and EVD affected families, including:

- seeds and tools distribution to vulnerable farmers through farmers associations;
- access to clean water facilities including construction of new wells with hand pumps installed and rehabilitation of wells as well as training of Community WASH Committees (CWCs) on maintenance of wells;
- provision of protection to persons including children, vulnerable groups and communities affected by the Ebola outbreak through facilitation of community dialogues for stigma reduction and basic livelihood support to EVD survivors;

**Increased public awareness**
on EVD prevention through social mobilization and community engagement and Ebola preventive messages through local radio/television broadcasts;

**Strengthened health system**
in EVD affected communities through training of District Health Management Teams (DHMTs) on health service delivery, health facility management, and supportive supervision, effective surveillance and referral systems and advocacy to support regional and national health system processes;

**Improved community participation**
and demand for health services through the establishment and training of committees to act as interface between the community and three DHMTs;

**The terms of reference (see Annex 2)**

The purpose of the evaluation was threefold:

- Assess the performance of CARE’s intervention relative to OECD/DAC evaluation criteria.
- Develop lessons learned, recommendations that will assist CARE to improve its programmes and share its challenges and success with peer agencies
- Ensure accountability for the funds provided by SHO

The assessment of the degree to which CARE has met the expectations of SHO has been carried out in relation to the indicators mentioned in the project logical framework. Some indicators were rephrased for clarity by the consultant in consultation with the team members assigned by CARE. It is assumed that if the indicators have been achieved, the resources have been put to good use. Financial information and proper finance management will be assessed by a financial audit and does not fall within the mandate of this evaluation exercise.

---

2 The task and mandate of the District Health Management Teams is to:

- ensure timely and effective health service delivery,
- maintain concrete, observable, and achievable goals – to reduce the mortality and morbidity within their districts
- serve as the pivot between the community and the County Health Team and Partners,
- oversee health issues in the communities through weekly mentoring,
- provide supportive supervision to the primary health care staff,
- hold regular problem-solving meetings with the CHT and Partners
The evaluation has taken into account the OECD/DAC evaluation criteria, and the six essential humanitarian standards. During the period of project implementation, a wide range of actors was active in the response to Ebola in Liberia and Bong and Margibi counties. The evaluation has considered the extent to which the activities of the different interventions implemented by CARE were complementary to the work of other organizations, whether duplication was prevented and whether the project contributed to the larger response in the communities and the counties.

The evaluation exercise consisted of a combination of a desk review of relevant documentation, key informant interviews and focus group discussions with beneficiaries, representatives from the relevant ministries and local authorities and CARE staff, while the main focus was placed on the beneficiaries.

For the approach and methodology see also the ‘Draft workplan evaluation Ebola response project’ (Annex 3).

2. The evaluation exercise

Review of Documentation

The consultant reviewed internal CARE documentation on the project notably the project proposal, the budget, progress and final reports as well as training reports, minutes of meetings, distribution lists pertaining to NFI, hygiene and other items and agricultural inputs, lists of new and rehabilitated water wells, lists of farmer groups, contracts with FAs and gCHVs, powerpoint presentations, certificates, recordings of radio programmes, etc. (see Annex 4). This information was made available to the consultant by CARE in the course of his mission in Liberia, i.e. before, during and after the trips to Margibi and Bong counties (see Annex 5). All of this documentation together provides a rather complete picture of how the project was conducted and reasonable supporting evidence while the documents match the information gathered from beneficiaries and stakeholders.

The consultant also reviewed a host of background information on the Ebola response produced by the Government of Liberia, WHO, UNICEF, UNMEER and other organizations (see Annex 6). This documentation was especially useful at the stage of preparations for the meetings, interviews and focus group discussions and to understand the context in which field operations were conducted.

Interviews, focus groups and meetings

The consultant travelled to Liberia to conduct interviews, focus group discussions and meetings with beneficiaries and other key stakeholders of the SHO Ebola Response Project from 1st to 11th December 2015. See attached the detailed itinerary, which was agreed on with CARE senior management in Monrovia and adapted in the field by the team as deemed necessary as a function of available time and logistics (Annex 7). The consultant was accompanied in the field by CARE staff who had been especially assigned for this task by the project manager: Veleger Smith, SHO project administrator and Edwin Myers, CARE m&e officer.

---

3 The community health volunteers (gCHVs) have as their task to provide the linkage between the communities and the health system at district and county level. They are accredited by the County upon recommendation by the community
The project administrator coordinated the visits in close consultation with the consultant. People were met and discussions held with project staff, farmer groups, EVD survivors, community health volunteers, county officials, water committee members and sites visited included water wells, group farms, clinics as proposed by the consultant in his workplan (see Annex 8).

The only exception - i.e. sites not visited - are the 17 schools which had been supplied with hygiene kits, presumably because they are too distant and would take an exceptionally large part of the time available thereby causing the consultant to miss other meetings and sites. In any case, a certain bias towards easily accessible sites exists due to the limited time available as was already pointed out in the Workplan. The consultant was granted 14 days for this evaluation of which 11 were spent in Liberia.

3. Process, implementation and outcomes

The following assessment of how the project was conducted and it’s outcomes were achieved is based on a brain-storming session with the project staff conducted in Monrovia after the visits to Margibi and Bong counties. The assessment by the project staff on the process, implementation and outcomes coincides largely with the evidence obtained and the observations of the consultant.

Did we do a proper assessment beforehand so we would know what the real needs were?
Margibi was among the hardest hit counties and health facilities were not functional and in need of assistance. Bong found itself in a similar situation.

Did we set up and run the project within the timelines and other structures that we intended?
After the start-up activities including recruitment, procurement and orientation had been completed in February, the project workplan in relation to the three specific project objectives as executed as scheduled during the period March to November 2015. The only delays encountered were at water wells located in sites with difficult access during the rainy season. In one case a bridge had to be repaired in order to be able to deliver construction materials to the site.

Did we involve the people we intended to?
The aim was to create ownership. This was achieved by closely involving the WASH committees, the youth leaders and other community leaders and the farmer groups involved in the CARE DCR Pamoja programme. At the county level the County Health Teams were providing guidance and at County Task Force meetings - initiated to enhance planning, implementation and monitoring of

---

4 The County Health Teams have the overall responsibility for the health system in the county, which has been further defined in the Investment Plan for Building a Resilient Health System in Liberia as follows:

- Transitioning the established county task forces and community systems developed for the EVD into the health sector
- Establishing robust feedback systems and mechanisms from communities, through facility, district and county levels by having quarterly stakeholders fora at these levels involving communities, which discuss health issues and services
- Developing operational procedures for implementing health services at the county and district level in a de-concentrated form of governance.
- Building the leadership, governance and management capacity of county and district health teams to ensure they are able to coordinate, and manage provision of health services
- Establishing and ensuring functionality of sector coordination mechanisms at health facility and county levels
the epidemic response operations at the local level after a National Task Force been established - attended by all the organizations participating in the response it was agreed who would do what where.

Did we have or get adequate funding and other resources?
Yes, funding was adequate for a start and the subsequent increase allowed CARE to reach some more beneficiaries with NFI, safe water and agricultural inputs.

Were staff and others trained and prepared to do the work?
Staff were briefed, provided with laptops, modems etc. Training was conducted on reporting and personnel also learned while on-the-job.

Did we have the community support we expected?
Entry into the community was through the county, the district health teams and the town chiefs. Communities collaborated fully, were responsible for safeguarding project materials and provided lodging to personnel associated with the project.

Did we monitor and evaluate as we intended?
A workplan was elaborated in February and project progress reports were produced in May and August 2015. Social mobilization officers monitored the gCHVs, the farmer groups were monitored by the project officer and extension officer and sub-contractors were monitored by the WASH officers.

Was there good coordination and communication?
Staff meetings were held every Monday to communicate internally and external coordination meetings were attended at the County every last Thursday of the month when information was exchanged with the other organizations participating in the response. In Monrovia CARE participated in the Incident Management System.

Was the planning process participatory?
The project team worked closely together under the leadership of the project officer. Planning of activities at the field level involved all the stakeholders e.g. for the selection of the farmer groups and the health centers.

Did we find or hire the right people?
The CARE human resource procedures allowed for the right people to be recruited; the procedure includes a reference test. In one or two cases staff was recruited internally. Clear criteria were followed for the identification of sub-contractors for the construction of new and rehabilitation of existing water wells. For the selection of the farmer groups, criteria were set including that they be members of the ongoing CARE Pamoja development programme and there were consultations with the county agricultural officers to avoid duplication.

Implementation

Did we do what we intended?
Yes, all activities were conducted in association with the counties as intended.

Did we serve or affect the number of people we proposed to?
More people were reached than originally proposed. Thanks to an increased budget more survivors and farmers could be assisted, and more communities could be provided with safe
Did we use the methods we set out to use?

The information campaign methodology was coordinated by the Ministry of Health under supervision of WHO and UNICEF and included the use of buckets for prevention and the use of T-shirts printed with standard messages. Also the radio jingles and talk shows were prepared in collaboration with the MoH. The information campaign was spearheaded by the gCHVs, who had been assigned to the SHO project by the counties and provided with bicycles, mobile phones and campaign materials by CARE.

Did we reach the population(s) we aimed at?

The identification of EVD survivors and farmer groups was carried out in consultation with the County. The decision in which communities to construct new wells and/or rehabilitate existing ones, was made in consultation with the Ministry of Public Works.

What were the main obstacles and why?

Practical problems caused some delays e.g. due to inaccessibility of a construction site because of the state of the roads during the wet season and due to the difficulty of digging a well in a rocky site. Apart from the survivors others have a need for household items and clothes, such as the Ebola orphans and the people who were quarantined but not infected. These were excluded from assistance at the level of the Task Force.

Was the budget adequate?

Yes, adequate in relation to the targets. On water testing there were some savings as UNICEF supports the counties in this area so it becomes less costly to have these tests done for the other clients. On the other hand, not enough was provided for travel and per diem for monitoring visits.

Did we make intentional or unintentional changes, and why?

Some of the changes in the programme were: the increase in number of people served with NFI (from 400 to 1200) and the inclusion of orphans in the EVD survivor activities. Further, the increased number of farmer groups which received assistance (from 10 to 30) and an increase in the number of agricultural tools provided per group. Also an increased number of wells was rehabilitated (the number increased from 5 to 21).

Outcomes

What actually happened as a consequence of the project's existence?

Communities have access to potable drinking water, farmers have planted crops, survivors have kitchen utensils and clothes and six clinics have distributed hygiene materials and awareness on Ebola prevention has been created. However, the stigmatization of survivors persists.

Did our work have the effects we hoped for?

Yes, agricultural inputs and extension work have resulted in vegetable production and farmers have access to food and cash. Coordination of the health sector at national and county level has improved. Individuals have been trained and are training others.

Did it have other, unforeseen effects? Were they positive or negative (or neither)?

Some positive side effects of the project activities and the presence of project staff and gCHVs in the communities are: adoption of the habit of drying clothes on lines instead of on the ground and
the use of dish racks, repair of a bridge in Bong County, use of garbage pits leading to reduction of malaria cases.

*Do we know why we got the results we did?*

The results are especially due to good relationships with the communities and owing to a strong, well-trained, professionally skilled project team and good management.

*What can we change, and how, to make our work more effective?*

The plastic buckets, which had been handed out as an emergency measure at the peak of the crisis and are now worn out, should be replaced by hand-washing stations constructed from durable materials in appropriate locations.

*Did we take into account longer-term, interconnected and more structural problems?*

A case in point is the maintenance of the wells, pumps break down frequently due to intensive usage and lack of supervision. To improve supervision and management of the pumps eight trusted and influential people who are permanent in the community were trained to be members of the WASH committees. Another question is the leadership of the farmer groups, a transparent leadership style was promoted which allows for participation by the members. Leaders were discouraged from using authoritarian approaches. Another issue which was taken up with the communities is where to address their problems, it was explained to community representatives who at the district and county levels is responsible for health issues, who for agricultural issues etc.

*What has changed when comparing the situation before the intervention with the situation after the intervention?*

A number of specific changes are noted:
- the use of health facilities has increased;
- people are getting used to drinking water from wells instead of streams;
- hygiene at schools has improved;
- bodies are made available for checking before burial;
- gCHVs have improved their communication with community members;
- there is a constant flow of information between the gCHVs and the CHT as communication has been facilitated after CARE made bicycles and phones available for the gCHVs;
- good hygiene practices have been adopted including hand washing, garbage pits, dishracks, and clotheslines;
- the CHT is stronger and in a better position to control a disease outbreak;
- interventions are owned by the communities;

4. **Achievements in relation to targets**

For detailed information on activities, indicators and targets see Annex 1.

**Identify and trace people with Ebola**

20 gCHVs were contracted by CARE in Bong County (3 women and 17 men) and 20 were assigned by the CHT in Margibi County to the SHO project (3 women and 17 men). They were provided with logistics (bikes and phones) by CARE through the County offices and they

---

5 This should be understood against the background of what happened during the Ebola crisis, when fear and non-availability of health personnel had led to a dramatic decrease in attendance at health facilities
received training in relation to data collection and tracing. The training in Bong was conducted by CARE and in Margibi by some other NGOs, including Save the Children. The gCHVs are identified by the County upon recommendation of the community. Note that only 15% of gCHVs associated with the SHO project are women.

The gCHVs during the campaigns in their communities followed the strategy of house-to-house visits. According to written and verbal gCHV reports during a typical campaign they would reach more than 100 households each. This means that at least 40 times 100 = 4,000 households would have been contacted.

Hygiene kits were distributed once in June and July 2015 in six community health centers and one hospital. This was confirmed in the three sites visited by the consultant and by the county health officials in both counties. The distribution was conducted in conjunction with the CHT as the situation at these facilities was in flux - due to the Ebola crisis some health workers had died and others had abandoned their jobs - and several were closed for sometime and re-opened during the period of distribution. The items which were supplied were needed at the time and have now run out. The estimate of the number of people who have benefited from these items varies, but according to the project final report is at least 2,500. This seems likely as for example only Palala clinic has more than 14,000 people in catchment and attends to more than 100 patients a day.⁶

Provide food, nutritional and social safety net support to EVD survivors and affected families

Twenty FAs in Bong and ten FAs in Margibi counties were selected following nine criteria related to their functioning and the impact of Ebola on their communities and livelihoods. They each submitted a budget for seeds and other inputs totaling US$700 and were issued with a cheque to that amount by CARE. They bought the inputs and issued them to 30 or more of their members, majority of them women. They bought the seeds which they preferred, depending on their soils and the season. At least 900 farming households received inputs and more than 55% are represented by women.

Thirty FAs have received each 40 cutlasses, 30 hoes, 30 rakes, 30 axes and 40 files. These tools are kept by the FAs in toolsheds for use on the group farm. The members work together on the group farm during one day a week. Some of the tools are also used for the individual farms.

Provide access to clean water facilities in Ebola affected areas

Two new wells with handpumps were constructed in Bong County and three in Margibi, while 10 wells were rehabilitated in Bong and 11 in Margibi. After having talked to the committee members and users of a dozen wells, it is concluded that a well may serve on average 40 houses while the average number of individuals per house is approximately 15, thus a typical waterpoint would serve 600 people. The total served by 26 wells would then be 15,600, well beyond the target of 10,000. However, it was also found that there are cases of rehabilitated wells that have since ran dry or broken down again. Furthermore, the wells next to schools sometimes serve only

⁶ Information based on MoHSW and records kept at the health facility
the school, which may have a population of between 200 and 350 students. Some of the wells visited were funded by CARE/LDS.\textsuperscript{7}

Water quality tests for five newly constructed wells were conducted by the Division of Environmental and Occupational Health of the Bong CHT and the DEOH of the Margibi CHT. The outcome of these tests certifies that the water from these wells is fit for human consumption.

According to representatives of the water committees and as explained by the project WASH officers, the rehabilitated wells have been cleaned and treated with chlorine before use. This means that all 26 wells produce clean water.

Several training events for WASH committee members were held in Bong and Margibi counties. These were for the committees of a number of new wells constructed by CARE from different budgets (SHO, LDS, DFATD). In Bong County four one-day training events were conducted for a total of 40 participants belonging to 6 committees. In Margibi, five one-day events for members of five committees were conducted with a total of 43 participants. These numbers work out to 7.5 members trained per well. According to the final report of the SHO project 32\% of the participants were women. Unfortunately the available list of participants is not gender-specific. Presumably the cost of these training events was shared among the SHO, LDS and DFATD budgets.

**Increase protection to persons, including children, vulnerable groups and communities affected by the Ebola outbreak**

The gCHVs received training on Ebola prevention and social mobilization and the issue of the stigmatization of survivors was also discussed at these training events. The training was conducted for a number of gCHVs in each county by different organizations among which CARE. The 40 gCHVs associated with the SHO project each conducted the information campaign in their communities and normally would also try to discuss the issue of stigmatization. Not all of them were able to explain to the evaluation team how they treated this topic and what was the result. It is obvious that this is a sensitive matter and that stigmatization persists in most communities. However, we can safely say that among the 40 gCHVs, there were at least 20 who effectively introduced the topic during their information campaign.

The gCHVs during the campaigns in their communities followed the strategy of house-to-house visits to discuss with household heads. According to written and verbal gCHV reports during a typical campaign they would reach more than 100 households. This means that at least 20 times 100 = 2,000 household heads would have received the message. How effective the message was cannot be ascertained; stigmatization persists and the campaign has to include everyone to be effective.

EVD survivors in the communities which were agreed upon during the Task Force meetings at the County in Bong and Margibi, were identified by their ETU Certificate and 1,200 were

\textsuperscript{7} CARE had received funds from various donors to contribute to the Ebola Response in Montserrado, Bong and Margibi counties. Thus, similar activities were implemented with SHO, LDS and DFATD funds in different locations.
provided with NFI by CARE. Survivors seem to have received different items from different organizations, so for example in one and the same community CARE would distribute clothes and household items while Red Cross would distribute mattresses. According to the records in the project files 600 survivors (53% women) received support from CARE/SHO in Bong County and 600 in Margibi (56% women). Almost half the number of those who received assistance were children up to 14 years old. According to the final report the total number of beneficiaries was 1,187.

Increase public awareness on EVD prevention through social mobilization and community engagement

The social mobilization officer in Margibi conducted the information campaign through a series of meetings of a few hours each with groups of community folk, especially the members of the FAs. The number of farming households supported by the SHO in Margibi totalled 450, of whom more than 55% were represented by women. In Bong the social mobilization officer has conducted a week long campaign visiting 15 communities and thus had an exchange of information with 150 community representatives (85 men and 65 women) to clarify the messages. The target of 500 households was met and the gender balance is fair.

A list specifying hygiene and sanitary items as well as information materials supplied to 17 schools in Bong County has been availed. The consultant has not visited any of these schools, presumably they are too distant and time would not allow. The health centers referred to here are the six which received hygiene kits plus Dunbar Hospital. No CARE posters were displayed at the three health facilities the consultant has visited at the time of the visit. Presumably, 24 schools and health centers were reached instead of 30.

During the information campaigns in the communities - which they conducted during the period from April to October - the gCHVs would typically reach 300 households or 1,500 people. 40 gCHVs would thus reach 60,000 people. Obviously, there must have been lapses, although 300 households leaves a margin. In any case, the information passed on at health centers and schools (as well as churches, mosques and markets) would easily make up for the deficit.

A radio message or jingle of a duration of a few minutes in 5 different languages was produced and broadcast by two radio stations in Margibi and one radio station in Bong County. The total number of slots according to the project final report is 2,100. Further, several talkshows or interviews of between 15 and 45 minutes were produced whereby callers were invited to ask questions during the emission. It is certain that at least 189,470 listeners have been reached via the radio broadcasts. Radio Super Bongese alone covers Lofa, Bong, Nimba and Grand Bassa counties and according to their listener surveys has about 500,000 listeners during prime time.

No television broadcasts were conducted.

Strengthen current health system in EVD affected communities

Workshops were held at the Bong and Margibi County headquarters in April/May 2015 with a duration of two weeks, attended by 51 health officers (23 women and 28 men). Topics which were dealt with included: (-) health governance and policies, (-) pharmaceutical products and
equipment, (-) infrastructure for health, (-) health management system and financing, (-) human resources for health, (-) community dialogues for stigma reduction & support to ebola survivors, (-) linkages – community and district health management teams, (-) basic health management and leadership skills and community mobilization, (-) emergency preparedness and management, (-) community surveillance and referral system of EVD, (-) health system delivery.

According to the final SHO project report 40 health officials (16 women and 24 men) from Bong and Margibi participated in the topic ‘health system management’ during the April/May workshops.

Note that 43% of the participants of these health workshops and training events were women.

Improve community participation and demand for health services

The committees which act as interface between the community and the DHMTs are the community health development committees. A number of gCHVs confirmed that they play a role in their functioning. It has not been easy to get confirmation of this in discussions with community representatives. It is likely however, that such committees function in at least 20 out of the 40 communities covered by the gCHVs in Bong and Margibi counties.

The activities of these committees concern the whole community, so if 20 communities are affected, then at least 20 times 1,000 = 20,000 people would be involved. The demographics of this population would be a reflection of the regular sex ratio.

20 health workers (7 women and 13 men) benefited from the training on basic management skills, leadership and community mobilization conducted during the two-week workshops at Bong and Margibi counties and included in the relevant report.

5. The OECD/DAC evaluation criteria

Effectiveness, including timeliness and level of coordination

After the start-up activities including recruitment, procurement and orientation had been completed in February, field operations started in March 2015 when the inputs were needed and through the task forces at the counties the assistance was directed at the communities and health facilities that needed it, avoiding duplication where so many different organizations intervened. If several organizations worked in the same communities with the same groups of beneficiaries, they did provide different services.

Efficiency – What were the outputs in relation to the inputs?

The inputs were tailored to the targeted outputs and cost effectiveness was enhanced by the fact that CARE had several similar interventions ongoing at the same time so that certain operational costs could be shared and there also was an advantage of scale. When the budget was increased, some of the targets were raised accordingly.
Specifically on cost effectiveness a distinction has to be made between different types of interventions which have a greatly different cost per beneficiary. An estimate was made of the cost of six different types of services and goods delivered to beneficiaries. In estimating their cost - based on the revised budget - the implementation costs were equally distributed among each of the six activities:

- Contact tracing at EUR6 per person
- Distribution of NFI at EUR69 per household
- Distribution of seeds and tools at EUR110 per household
- Delivery of water at EUR7 per household or EUR1.4 per person
- Information campaign at EUR0.5 per person
- Training on health system management and service delivery at EUR106 per person trained per day

As a rule, the cost of EUR110 per household for delivery of agricultural inputs is within the norm for humanitarian assistance, the cost of NFI at EUR69 per household is lower than usual, but the aid package was reduced. Delivery of water at EUR1.4 per person is cost-effective especially taking into account that the service is sustainable and only requires minimal expense for maintenance. Training of one person at EUR106 per day compares to EUR82 per day in a similar context, but where a lower price of fuel applies. In any case, the high price of fuel would cause the cost of activities in Liberia to be higher than average.

Appropriateness

The project was able to provide an appropriate response to local needs and the priorities of the people, taking into account the specific needs of women who were the majority of the beneficiaries of the agricultural inputs and vulnerable groups among which the orphans who received NFI. An example of a good adaptation to the needs of the beneficiaries is the decision to provide cash to buy seeds instead of supplying the seeds in kind. This benefited especially women who were the majority of beneficiaries of the agricultural inputs and allowed them to purchase the right seeds for their farming conditions and at the right time taking into account the agricultural calendar.

Also the decision to include orphans among the category of those who received NFI, was appropriate taking into account their vulnerability.

Another example is the decision to increase the number of water wells to be rehabilitated as the budget was increased as many waterpumps are listed at the County as in need of repair.

Effect of the intervention in terms of preservation of life and reduction of human suffering

The suffering of the EVD survivors has been reduced by the provision of NFI kits and psycho-social support. An attempt has been made to reduce the extent to which they suffer from stigmatization and as a result the issue was included among the community sensitization activities by the gCHVs. It is likely to be reduced even more when a recovery programme gets underway which would not single out survivors.

Indirectly the project activities have contributed to the preservation of life through contact tracing and the information campaign on Ebola prevention. The 40 gCHVs supported by CARE and with
the help of CARE posters and radio jingles have been able to effectively inform the population in 40 communities on Ebola prevention. Moreover, hygiene and sanitation has improved in 26 communities thanks to safe water supply, which contributes to Ebola prevention as the availability of clean water allows the population to follow the practices which were proclaimed during the information campaign. Another effect is that farmers have been enabled to plant crops again and thus contribute to the improvement of the food security situation and reduced suffering due to malnutrition.

Sustainability/connectedness

Even though humanitarian interventions are not designed to be sustainable, some of the longer term needs and inter-connected problems have been considered (‘Building back better’). A case in point is the maintenance of the wells, pumps break down frequently due to intensive usage and lack of supervision. To improve management of the pumps eight trusted and influential individuals who are permanent in the community and members of the WASH committees were trained in each community. The training of the members of the water committees will contribute to the sustainability of the water supply.

The project has also put the functioning of the health system - which was taken up by the Liberian Government with the support of the UN organizations in 2015 - on the agenda at community and district level. Thus, through training and workshops the project has promoted an interest in the health system at the district and community levels and the initiative taken by the Government. Another issue which - as part of the ongoing development programmes in these communities which have been supported by CARE since before the Ebola crisis - was discussed is, which government institution to approach with certain problems and it was explained to community representatives who at the district and county levels is responsible for health issues, who for agricultural issues etc.

6. Review in relation to humanitarian principles

Intervention focused on the victims

The intervention has indeed focused on the victims, witness the individual support to EVD survivors who were supplied with basic necessities for a dignified existence. On the other hand, the singling out of survivors for individual assistance has also caused resentment and stigmatization, but this had been acknowledged at the time the project proposal was launched and an activity was planned to facilitate community dialogues for stigma reduction.

The intervention has also addressed the problems of the wider community, which was indirectly affected by the Ebola crisis, notably by facilitating communal hygiene and water supply and by providing individual assistance to members of farmer groups in the communities affected by Ebola.

Respect for coordination and collaboration

CARE has maintained a continuous coordination and collaboration with other actors including the Government staff at national and local levels in order to conduct effective and impartial interventions. As a matter of fact, the activities aimed at stopping the Ebola crisis and preventing
further outbreaks were coordinated by a National Task Force and task forces at the county level. These task forces had been put in place to ensure that the interventions by the various agencies would be complementary and to prevent duplication. At the national level CARE was represented at the meetings of the Incident Management System and on the operational side, CARE participated in the coordination meetings in Bong and Margibi counties, where all the organizations taking part in the Response were invited to exchange information and agree on who would do what and where.

**Independent needs assessment**

The proposal for the SHO Ebola response took as it’s point of departure the ‘STEPP’ strategy, which is aligned with the WHO Ebola Response Roadmap, the EVD Overview and Requirement, the UN plan, the National Strategy and operational plan, and the WASH Ebola AWAY Strategy of the National WASH Committee. Following the STEPP strategy - as a non-medical organization - CARE decided to intervene in the Stop Ebola phase in a supporting role (mainly logistics), in the Ensure Essential Services phase through the provision of drinking water, NFI and agricultural inputs and in the Prevent Ebola phase through an information campaign and training on health system management and health service delivery thereby linking up with initiatives that had been taken by the Government at national level. In other words, the needs which the project proposed to address had been established independently by a consortium of specialized organizations and institutions and CARE had adopted the outcome of this assessment in areas of competence.

**Appropriate design of the intervention**

The situation and the capacities of the affected population have been taken into account in order to meet their needs. Not only the physical needs of the EVD survivors were taken into account through the distribution of NFI, also their need for counseling was catered for so as to try and reduce the problem of stigmatization.

Other suitable elements which were introduced into the intervention included: (-) agricultural inputs for a population which depends mostly on farming while the epidemic had disrupted farming activities (-) new wells and rehabilitation of existing wells for a population which depends on handpumps for their water supply and thus their hygiene (-) an information campaign which was necessary due to the prevailing ignorance and even disbelief among the population concerning Ebola (-) activities to link the communities to the health system through the Community Health Volunteers.

---

8 From onset of the epidemic, a multi-disciplinary National Task Force (NTF) chaired by the Minister of Health and Social Welfare was re-activated in March 2014 to ensure effective coordination of the response efforts. The NTF meets on a daily basis to review the epidemic situation and provide guidance to the field teams. Similarly, the affected counties are being supported to establish a similar Task Force to enhance planning, implementation and monitoring of the epidemic response operations at the local level (Liberia operational plan for accelerated response to re-occurrence of Ebola epidemic, Government of Liberia Ministry of Health and Social Welfare, July – December 2014).
Performance, transparency and learning

A workplan was elaborated and several monitoring visits were conducted by senior CARE staff and the m&e unit, progress reports were produced and recommendations were issued for improvements and adjustments. Additional support and advice was provided by CARE’s sub-regional office.

Performance of humanitarian personnel

CARE recruited competent and experienced staff for this humanitarian intervention, who displayed the correct behaviour and attitude. Staff felt that they had been able to further develop their competencies on-the-job, no special training for staff was organized except for training on reporting.

7. Conclusions and recommendations

Coordination

It is clear from the background information on the Ebola response that coordination was a major concern and was assigned an important function. It is also explained how the National Task Force was established and the task forces at the county levels were promoted and it is made clear, that a lot of attention was placed on coordination and political clout applied to achieve it. During the meetings, discussions and visits conducted by the consultant it was confirmed time and again how CARE had made sure to participate in coordination at all levels and had respected decisions taken at coordination forums. Yet, during the debriefing session some county officials expressed dissatisfaction on this point, even though other county officials present did not agree with their colleagues and the CARE staff tried to explain that maybe one particular (agricultural or water) officer had not been consulted, but others had been ...

The conclusion is that in the case of the Ebola response, coordination was well organized and given a high priority, and that CARE has participated in the system which had been put in place by the Government. In future CARE should do likewise and make an effort to include government officers at all levels in the consultations on the programmes they support in the communities even though these officers are busy and sometimes hard to locate.

Gender balance

The target of 55% female participation and representation was only met in some instances: (-) EVD survivors, (-) farmer groups and (-) the community information campaign. The target was not met in the case of the gCHVs (15% women), the training of water committees (32% women) and the training of health officials (45% women).

Especially the case of the gCHVs of whom only 15% are women is striking, because to effectively communicate at the grassroots level, it is extremely important that this communication
can be conducted directly with the women as well as the men. Again, especially in the area of health and hygiene women play the more important role within the household and the community. It will be necessary when CARE engages gCHVs in their projects in future to actively promote the assignment of women in consultation with the CHTs. Also the case of the water committees is problematic. It is well known that women are responsible for water in the household on a daily basis and that they have a large interest in seeing to it that the water supply is well managed and maintained. This is why it makes sense to introduce the demand for 55% female participation in these committees. Although 32% is already meeting the target halfway, CARE will need to keep promoting the participation of women in these committees in all their water programmes.

In most cases information related to the SHO project is gender-specific but there are also some instances where information on gender is not available. CARE should ensure that in all instances gender-specific information is provided.

Collaboration with the counties

It is noted that CARE collaborates closely with the counties especially by associating the gCHVs in their projects. The concept of the gCHV is extremely effective in linking the communities to the health system and promote community ownership of activities and deserves to be exploited more and the function adapted to attract more women. Responsible county administrators are appreciative of the CARE mode of operation and would like to see this continue in future. It is also noted that different counties have different approaches when it comes to assigning gCHVs to NGO projects. In Margibi the gCHVs under the SHO project were assigned by the County and did not have a contract with CARE. In Bong gCHVs were also assigned by the County but each gCHV signed a service agreement for two months with a stipend of US$90 per month with CARE. Apart from the fact that it is more transparent when in different counties treatment of gCHVs by CARE is the same, the consultant noted that the gCHVs in Bong seemed more motivated than in Margibi. It is therefore recommended that CARE should negotiate with the counties so as to agree on a uniform way of treating the gCHVs which are assigned to their projects in line with county and CARE policies and depending on the availability of resources. During the debriefing of the consultant it was clear that different counties look at this issue in different ways, so in these negotiations CARE may have some convincing to do.

Stigmatization of EVD survivors

The issue of stigmatization continues to cause problems for the EVD survivors. Some cannot get their job back, others are barred from selling in the market as they used to do, they find it extremely difficult to afford to send their children to school and they suffer from the fact that people avoid them and feel marginalized. This is a huge problem and very difficult to resolve. It is obvious that more training would be required for the gCHVs to be able to discuss this issue effectively in their communities, which some have tried but it would be expecting too much for them to resolve this after one day training and a few weeks exposure in the communities. The more so because most of the gCHVs are men and may not have been able to reach women effectively with this message.
On top of the fact that the physical presence of survivors is not accepted, there is also the fact that they are the group which receives most assistance like the NFI and sometimes cash, while the other people in the community do not. This causes resentment, because poverty is common, the community as a whole was affected by the Ebola crisis and everybody feels in need of assistance. It is therefore recommended that CARE try to contribute to resolve the problems of stigmatization and poverty alleviation at once by promoting recovery programmes, which address the communities as a whole and not single out the EVD survivors.

N.B. The people who had been quarantined in their houses and had not been infected never qualified for the kind of assistance the survivors were given, but received some food through WFP for a few months.

Farmer groups

CARE has worked with farmer groups for a number of years in Liberia and also promoted the concept of the savings and loans association which - judging from the discussions with farmer group representatives - has caught on. Actually, a case was brought up of a group which had not been included among the 30, who benefited from the SHO funds, but had been able to purchase inputs anyway with the proceeds of their savings. The criteria, which had been introduced for the selection of the farmer groups rightfully ensured that the groups which were included, have a minimum organizational capacity. This is a guarantee that the assistance will most likely be put to good use. Also the fact that the groups were monitored after having received the funds and tools contributed to success. It is recommended that CARE continue working with farmer groups in this fashion during the recovery programme.

Community water supplies

Margibi and Bong counties in Liberia are endowed with a good drinking water resource, which is relatively easy to exploit. The population makes use of shallow wells of 10 to 20 meters deep, which can relatively easily be protected and equipped with handpumps at a reasonable cost. It is however important to properly manage and maintain these installations, because they are used intensively and open to abuse. The use also has to be monitored because they do not yield water indefinitely and most of the wells need a number of hours each day to replenish. This means that it is recommended to have a lock on the handle, which is removed for a few hours in the morning and late afternoon to allow people to come and fetch water. In order to maintain these installations therefore enough individuals need to be trained so that at any time some people are present in the town who can supervise the well. The maintenance and/or replacement of minor parts is not costly and could be borne by the community if a cost-recovery mechanism is introduced. CARE is advised to further look into this and the training (especially also of women) for future projects which aim at assisting community water supplies.

Accountability

The extent to which targets were met reflects positively on the accountability for the funds provided by SHO. Speaking strictly from a quantitative perspective there is only one target which was not met : 24 instead of 30 schools and health centers were reached in the Ebola prevention
campaign. Qualitatively there are a few other points to note: the gender balance in the case of the gCHVs and the water committees, the issue of stigmatization (but this is really far beyond the scope of the project) and the functioning of the community health development committees. On the matter of cost-effectiveness the donor can be assured that on the whole the project has delivered goods and services in a cost-effective manner except for the health system training which seems to have been comparatively costly, but the high price of fuel may have affected the operations taking into account that - apart from the fact that the cost of fuel causes prices of merchandise to be high in general - electricity, which in Liberia is mostly produced by every user individually by running a diesel generator, is needed for this type of training which makes use of air-conditioning and other equipment (beamers, computers etc.).

An issue which is related to accountability and which can only be resolved by a financial audit is the fact that CARE was conducting similar activities in some of the same zones with funds from different sources: SHO, LDS and DFATD. It concerns especially water supplies and training of water committees conducted in Margibi County with SHO and LDS funds and in Bong County with SHO, LDS and DFATD funds. Further, assistance to survivors in Margibi County with funds from SHO and LDS. It is therefore recommended that a financial audit examine whether shared costs (for the training for example) have been correctly charged to the various budgets.

The health system

The inclusion in the Ebola response project of activities to contribute to the health system in Margibi and Bong counties has been an ambitious move by CARE. It has however wittingly or unwittingly connected to an initiative by the Government of Liberia which with the support of WHO, UNICEF and other organizations launched an ‘Investment Plan for Building a Resilient Health System in Liberia in response to the Ebola Virus Disease Outbreak’ by early 2015. The existence of this national initiative had created a receptive climate for the DHMT training on health service delivery, health facility management, effective surveillance and referral systems and advocacy for the health sector, which was conducted in April/May 2015. The consultant has only met with a few of those who participated in this training but the training report is quite comprehensive and shows that this activity was quite well conducted and has effectively introduced these topics at the county and district levels. In future CARE should try to capitalize on this by making the link between the health system and the communities, because it is as yet not clear how - if at all - the community health development committees function. The response from community representatives to this question has been vague. However, the concept is useful and would provide the gCHVs with a structured entry point for health issues into the community. To understand how and to what extent this idea has been adopted and such committees are functional in at least some of the communities, CARE might want to do a follow up with the gCHVs.