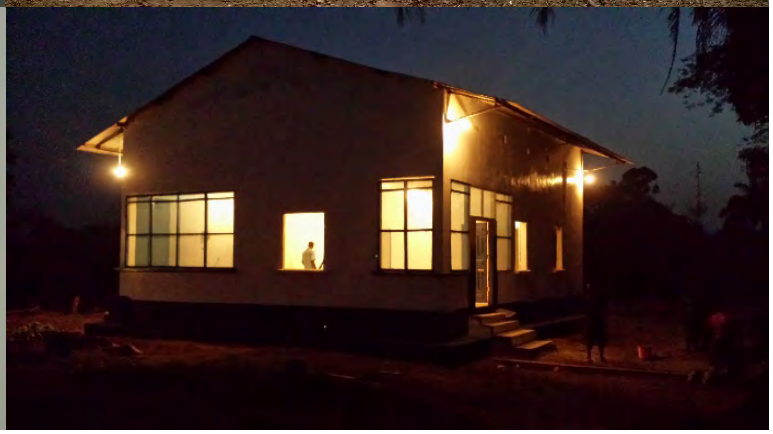
Liberia

Support to Ebola Treatment Unit Project (STEP):

One Step Closer to an Ebola-Free Liberia



Project End-line Evaluation Report

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SUBMITTED TO:

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List of Acronyms

CB-AECS:	Community Based Active EVD Case Surveillance
CDC:	Center for Disease Control
CHT:	County Health Team
CoP	Chef of Party
DHT	District Health Team
EVD:	Ebola Virus Disease
FGD	Focus Group Discussion
gCHVs	General Community Health Volunteers
GETU:	Ganta Ebola Treatment Unit
HC	Health Center
HF	Health Facility
IPC	Infection Prevention and Control
KII	Key Informant Interview
KSKS:	Keep Safe – Keep Serving
MOHSW	Ministry of Health and Social Welfare
OIC	Officer In Charge
PCI:	Project Concern International
PPE	Personal Protective Equipment
SQS:	Safe and Quality Service
STEP:	Support To Ebola Treatment Unit Project
TTMs	Trained Traditional Midwifes
UNICEF:	United Nations Children's Fund
UMU	United Methodist University
WHO:	World Health Organization

1.0 Executive summary

In response to the Ebola Virus Disease (EVD) emergency in Liberia, Project Concern International (PCI) implemented Support to Ebola Treatment Project (STEP) in Nimba County, funded by the USAID Office of Foreign Disaster Assistance (USAID/OFDA). Through STEP, PCI managed the Ganta Ebola Treatment Unit (GETU) in close partnership with the Liberian Ministry of Health and Social Welfare (MOHSW), endeavoring to slow the spread of EVD in Nimba County through the isolation of cases, the provision of a high standard medical care and the psychosocial support to EVD suspected and confirmed individuals and affected families at the GETU. In addition, STEP, leveraged skills and experience of its project staff and leadership to expand support to the County Health Team (CHT). Support included system strengthening and implementing IPC outreach programs to communities and health facilities throughout Nimba County. The project started in December 2014 and ended April 30, 2016. The project initially targeted to benefit 9,180 individuals in the area, but reached a total of 15,388 people (68% increase over target) by the end of the project period.

The end-line evaluation was conducted in Mid-March/April 2016, to assess project performance, the project's contribution to the control of the EVD outbreak, the contribution towards strengthening the health system of Nimba County, and to draw key lessons. The findings of this evaluation are reported herein.

The evaluation's population of study mainly comes from the county health systems: the CHT, District Health Team (DHT), health facilities, the staff who worked at the GETU[1], and community health facilitators or leaders. Primary data from key informant interviews (KII) and focus group discussions (FGD) using purposive sampling technique, and secondary data from the project quarter reports, IPTT, training database, and other sources were used as source data. All data collected were summarized and analyzed, and findings are presented in this report.

In summary, STEP project activities supported 78 health facilities (69 primary, five secondary and four tertiary level) in Nimba County, serving a catchment area of 200,000 people through different interventions and project activities as indirect beneficiaries. Activities included the provision of high standard clinical services the GETU, community outreach for social mobilization on EVD prevention; community based active case surveillance, trainings such as Keep Safe – Keep Serving (KSKS), Safe and Quality Service (SQS)[2], technical support to selected health facilities and health care workers (HCW) through mentorship and supportive supervision, IPC and basic medical supply provision, and other capacity building interventions.

Project achievements include:

[1] The Ganta ETU had been decommissioned since January 2016, and turned into a nursing training center by G. W. Harley Nursing School, UMU – the proprietor of the property.

[2] SQS (Safe and Quality Service) is a post-EVD outbreak health service delivery protocol, and is the replacement for Keep Safe Keep Serving (KSKS) protocol that had been used during the EVD outbreak for health service delivery.

- provided consultation services to 8,865 (4,030 male and 4,835 female) people at the facility (Gant ETU) and using outreach approaches;
- organized 24 community events for social mobilization and outreach level services;
- reached 46 of the health facilities through comprehensive IPC mentorship benefiting 867 (428 male and 439 female) health care workers - more than double of the targets;
- facilitated and supported the setup and erection of temporary triage and screening unities, waste management, and other IPC facilities during the mentorship visits in 20 of the 46 mentored health facilities;
- renovated and partially furnished two isolation and referral facilities;
- provided KSKS, Surveillance, Swab collection and transporting, SQS and other training to 3448 (75% over the target) health care workers and managers from the 78 health facilities;
- provided SQS training to 100% of the health care workers (2,764) in each of the 78 health facilities;
- provided IPC and other basic medical supplies to 58 of the 78 health facilities directly at least once, and in most cases more than twice, and STEP supported the CHT emergency medical depot to supply the remaining health facilities; and,
- reached 2,524 direct beneficiaries through different psychosocial support services.

The evaluation findings indicate that the quality of service provided by the project was consistently compliant and in adherence to MoH/WHO protocols for EVD. All protocols and procedures related to IPC were followed and were of the high standard of MOH/WHO, including hand hygiene, donning and doffing of Personal Protective Equipment (PPE), chlorine mixing for correct percentages, etc. Patient care followed MOH/WHO protocols and all required resources to run the GETU were available to provide a high standard of care. The facility was kept at a high level of cleanliness, all waste were disposed of appropriately and all medical supplies were properly maintained. There was proper segregation of red and green zones with proper precautions taken. The ETU had a constant and adequate supply of water and electricity ensuring proper cleaning and disinfections, ensuring WASH protocols were constantly observed. Patient care, including psychosocial services through mental health clinicians, was provided in a proper and timely manner. Most importantly, team work was encouraged and facilitated, and staff reported they felt supported and able to provide feedback to colleagues at all times.

The qualitative survey findings suggest that STEP significantly contributed toward improved service delivery to clients at the health facilities, and its interventions positively influenced the day to day behavior of health workers. All respondents answered with a resounding “yes”, when asked whether the project had any influence on their EVD related practices. Many pointed out, that training and mentorship led to better understanding of the importance of consistent IPC practices. Health workers observed PPEs donning and doffing procedures and wearing risk-appropriate PPEs to care for patients. Proper waste disposal practices were followed as much as possible. The mentorship activities, SQS training, and the need-based supply provision to selected health facilities was highly valued by all health care workers at all level. Respondents noted significantly improved triage and screening, case identification, waste management and hand hygiene skills.

Findings from the evaluation conclude that there are several key reasons for STEP's success: ambition from project staff, agility of the project in tracking the trend of the outbreak and making required adjustments to project priority activities based on evidence-based decision making process, and the interactive process and flexibility of the donor to accommodate anticipated needs during the no-cost extension (NCE). These factors significantly facilitated efficient use of available resources to enhance the prevention and control of EVD, to address priorities of the county health system, and, most importantly, to achieve the project objectives. Among others, the level of coordination and collaboration with the CHT, and partners like WHO, coupled with the level of STEP's dedication, commitment, and determination to work with the national IPC taskforce, the Nimba CHT and the DHT were instrumental in exploring and addressing priority needs on time.

The evaluation uncovered an inherently weak and dependent health system, ineffective community based health care, irregularities in the surveillance and preventive approaches, as well as the continued flare up of EVD and other disease outbreaks. These weaknesses challenge the advances made by the project. Interventions that can capitalize on the achievement of STEP need to exist, and the health system leadership must be supported to fully manage the system.

In conclusion, the STEP project implemented all its project activities in close collaboration with the CHT/MoH and surpassed its targets, thereby significantly contributing to the prevention of EVD, and added capacity to the county health system. The close coordination with the CHT, the determination of the project management, the hard work and motivation of the staff, and guidance and flexibility from the donor, were key to project success. However, contributions are not enough to meet the level of the need the health system has to prevent and manage a potential outbreak in the future, and further efforts to strengthen and move towards a self-reliant health system are strongly recommended.

2.0 Introduction

2.1 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 had also responded to the Ebola Virus Disease (EVD) emergency through different emergency response projects funded by USAID Office of Foreign Disaster Assistance (USAID/OFDA). As part of these response, PCI had been implementing an Ebola emergency response project, Support to Ebola Treatment Project (STEP) in Nimba County with funding from the USAID Office of Foreign Disaster Assistance (USAID/OFDA). The project started in December 2014 and initially planned to end in June 2015, but was later extended to April 2016.

The project initially targeted to benefit 9,180 individuals in the area, but reached a total of 15,388 people, by the end of the project period. STEP served a catchment area of 200,000 people through community outreach, technical supports of health facilities and HCW, SQS training, and supply provision, and other capacity building interventions. The same population is also served by the health facilities (hospitals, health centers and community clinics) whose staff are trained and supervised by STEP project staff. In addition, STEP managed the Ganta Ebola Treatment Unit (GETU) in close partnership with the Liberian Ministry of Health and Social Welfare (MOHSW), and the STEP/GETU outreach team provided continuous and appropriate Ebola-focused education, and CB-AECS at the community level as part of PCI's Ebola-focused social mobilization and early case detection and referral effort.

2.2 Program description:

The three important public health interventions aimed at any outbreak prevention and management as well as promoting health are categorized into primary, secondary and tertiary preventions. Each intervention has its focused purpose and time when it will be most important, and yet they all complement each other and have a strong synergetic effect if implemented in integration. The EVD epidemic may have been better controlled if there had been strong primary prevention interventions at household, community, and health facility levels with basic and proven preventive practices at an early stage. Had there been a strong community-based surveillance system with continuous situation analysis and response capacity, the outbreak may have been detected early enough and contained before it overwhelmed communities and an entire health system, and become a national and international public health emergency.

As there was no capacity to effectively implement primary and secondary preventive public health interventions, tertiary prevention using a facility with full isolation, safe and quality treatment capacity and service, was required not only to prevent death and disability of the infected individuals, but also to isolate the suspected and confirmed cases to reduce the risk of further spread. These facilities were the Ebola Treatment Units (ETUs), like that of GETU.

Therefore, together with support from USAID/OFDA, PCI implemented the STEP project. STEP was initially focused on managing and running the GETU, in close partnership with the Liberian Ministry of Health and Social Welfare (MOHSW). The goal was to slow the spread of Ebola in Nimba County through the isolation of cases, the provision of a high standard medical care, and the protection of individuals affected by Ebola at the ETU. As the result of the ambitious effort of and revelation by the project management and staff, the evidence-based decision making process, the strong partnership with the CHT/MoH and other partners in the county, and the interactive process and flexibility of the donor to understand the dynamics the outbreak, STEP was able to accommodate and address needs identified during the implementation process. Consequently, unlike similar projects in Liberia, STEP was positioned to also significantly contribute to primary and secondary preventions of EVD while still maintaining its original focus. In view of that, STEP subsequently expanded to strengthen the primary and secondary prevention of infection transmission through social mobilization in targeted communities, conducting active case surveillance at selected communities, and supporting and facilitating the integration of full EVD care to basic health service delivery system through building the capacity of the health facilities and health care workers in Nimba County.

PCI's STEP project managed both the clinical and non-clinical components of the GETU's operations and provided multiple services, including:

- provided high standard of medical care, and the psychosocial support of Ebola-suspected cases at the GETU, and screening and isolation services at the outreach level;
- conducted regular mentoring and needs-based training for health facility staff in patient care and comprehensive infection prevention and control (IPC); e.g. waste management, setting up triage and isolation, setting up PPEs procedures and practices for patient care, etc.;
- provided supportive mentoring and supervision of day to day operations of the project;
- supported in maintaining the highest standards of operation of the clinical services;
- supplied PPEs, and other IPC and medical supplies in collaboration with the MOHSW/CHT and WHO;
- supported data collection and reporting, administration of human resource functions and payment of salaries;
- restored the post-outbreak basic service delivery based on the MOHSW's newly launched SQS[3] approach;
- supported the Nimba CHT in epidemic preparedness and response activities; and,
- coordinated the activities of the GETU with other institutions and partner agencies involved in the response including the MOHSW at the county and national levels, the National Case Management Committee, a number of sub-committees, and WHO technical advisors at the national and county levels.

[3] SQS (Safe and Quality Service) is a post-EVD outbreak health service delivery protocol, and is the replacement for Keep Safe Keep Serving (KSKS) protocol that had been used during the EVD outbreak for health service delivery.

Further, as part of its effort to support the Nimba CHT, STEP provided mentorship and supportive supervision to health facilities, improved health facility capacity through provision of supplies and training of health care workers, continuously provided community outreach programming to promote IPC, and conducted active EVD case surveillance in different communities along the Guinea border with a mobile team. Throughout the project life, PCI/STEP coordinated its effort with a wide range of partners in the administration of the GETU, including UNICEF and WHO, the CHT and DHT, CDC and others. A summary of partners and activities is shown in the Table 1 below.

Table 1. Summary of STEP partners and coordinated activities

Partner(s)	Coordinated Activities
UNICEF and WHO	Provide the supplies and medicines needed to manage suspected and confirmed EVD cases
CHT	Coordinate referrals and surveillance in the catchment area
CDC and WHO	Strengthen capacity of surrounding health facilities in infection prevention, surveillance and early case detection and referral
Other international non-government partners, e.g. Global Communities and Riders for Health	Transport samples to laboratories, dead body management, and in support of international border surveillance.

3.0 Evaluation Scope and Objectives

STEP's performance is evaluated by gaging results against the project plan, appraising to what extent the project objectives are achieved by analyzing the overall effect/contribution of the project on health systems strengthening and identifying gaps in the system, and revealing key lessons for future programming.

More specifically, the objectives of the evaluation were to:

a) explore STEP's contribution in the EVD outbreak control and preventions using the set output/performance indicators;
b) assess the level of effort in building health workers' and health facilities' capacity throughout Nimba County;
c) determine the continued utilization/application of the skills obtained through training and mentorship; and,
d) identify key lesson learned and best practices for future programing.

Consequently, the evaluation aimed to answer the following key questions:

- whether the STEP had achieved its target/plan;

- whether the STEP had significant "effect/impact" in the prevention and control of EVD outbreak;
- to what extent STEP contributed to stabilize, restore and improve the capacity of the health facilities and health service providers so as to prevent and control EVD and similar possible outbreaks in the catchment areas;
- whether STEP's intervention/activities had been evolving to maximize the influence and ensure sustainability of the result;
- how STEP adapted programmatically in response to the trend of the Ebola outbreak and community and health system needs in the project area; and,
- what best practices and lessons were learned during the course of the project and share for future programing.

The primary purpose of the evaluation is to fulfil donor commitment and provide succinct information as to the outcome of the investment made to implement the project; however, the report further aims to provide donors, PCI, public health emergency professional, and other stakeholders with practical information for future decisions and actions regarding designing/planning, organizing, implementing, and monitoring similar initiatives, as well as conducting wise and continuous adjustments to maximize project resource utilization and enhance project results. Thus, users of this report include USAID/OFDA, PCI, CHT/MoH, and others.

4.0 Evaluation Methodology

4.1 Study population and data sources

Nimba County, STEP's operational area, was the focus for end-line evaluation; and the study population mainly includes county health system staff from the CHT, DHT, health facilities and the GETU[4], as well as community health facilitators or leaders. The evaluation used both primary and secondary data sources.

Primary Data: primary qualitative data was collected from focus group discussions (FGDs) and key informant interviews (KIIs). KIIs were conducted with CHT, DHT, WHO, and ETU staff, health care workers from the supported health facilities, and community leaders in the outreach activity areas. Further, one FGD was held with staff who had worked at the GETU; these were clinical workers, hygienists, social workers, administration staff and others, who were asked to explore their experience and reflect lessons while working for the project, how they perceived the contribution of the project in EVD prevention and control, and how working in the project

[4] The Ganta ETU had been decommissioned since January 2016, and turned into a nursing training center by G. W. Harley Nursing School, UMU – the proprietor of the property.

could have influenced their career. All assessment tools and questionnaires are provided in Annex 1.

Secondary data: secondary data was collected and organized using a thorough review of key project quarter reports, the project's Indicator Performance Tracking Table (IPTT). These sources were used to evaluate the project's plan versus achievement, and to recapture key lessons documented over the life of the project.

4.2 Sampling and data collection methods

Due to the limited number of the sample population, the evaluation used purposive sampling technique where the sample respondents were selected from the GETU, CHT and DHT, and health facility staff representing all the six districts of the county, as well as community leaders from the project target area. The GETU and CHT/DHT participants were selected to represent each of the service department, while the KII participants in the health facilities and communities were selected based on their availability, though the health facilities and communities were randomly selected. A total of 45 key informants were selected from the aforementioned lists (see Table 2).

Table 2: Distribution of Key Informant Interviews

Key Informant Category	# Interviewed
CHT, DHT and partners	5
ETU staff	13
Health Facility staff	16
Community members/leaders	11
Total	45

In addition, one FGD of seven participants, all from GETU staff representing the different areas of responsibilities/sections (1 physician assistant, 2 nurses, 2 hygienists, 1 WASH technician, and 1 ground maintenance supervisor) was used. The following table shows the distribution of key informant interview participants.

Five STEP staff were selected and trained based on their competence and previous experience. Field testing was done to provide practical training and testing on the data collection tools, and was done using some ETU staff and a health worker from a nearby hospital. These field tests were not included in the evaluation KIIs and are not included in this report. STEP CoP trained the data collectors and supervisors, ensured the questionnaires were tested, and revised tools based on the test feedback. While the KIIs were held at health facilities and in the communities, the CoP facilitated the FGD and KIIs with GETU staff. The STEP CoP led the design, collection, organization and analysis of the data, and preparation of the report. The PCI Liberia M&E manager reviewed the evaluation plan, reviewed the tools, and supported in cleaning the secondary data.

All information collected was transcribed and organized. The qualitative data from the KII was organized by respondent and question, cleaned and summarized. PCI M&E manager, and PCI technical support unit, reviewed to ensure the quality of the process and outputs, including reviewing the plan, tools, helping cleaning/summarizing the qualitative data and draft reports.

4.3 Limitations of the evaluation

This end-line evaluation is an internally conducted evaluation by project staff. They have better overall knowledge of the project and more familiar with the county health system and staff than an external evaluation team; however, because staff are very close to the subject matter, internal-evaluation biases may be introduced into the evaluation. Effort was made to minimize this bias through team training and allowing them to fully dedicate their time to the evaluation process. Each step of the evaluation was monitored/reviewed by additional staff across different technical units within PCI.

Another limitation is that the sample size was small and previous patients or others who received care during the project implementation could not be surveyed. However, the evaluation diversified the sample population as much as possible within the scope of the evaluation objectives and resources, to represent all levels of the health system, from county level to district, health facility and community level. Further, key partners were included as KII respondents.

5.0 Results and Interpretation:

5.1 STEP performance and contribution to EVD outbreak control and prevention

5.1.1 Review of project performance

Project Targets Reached: All findings from the primary and secondary data show that the project successfully achieved its task: all project activities were completed, and, as project IPTT and quarterly reports show, surpassing most project targets. The evidence from the secondary data show that STEP directly reached 15,388 beneficiaries, a 68% increase over target. More than 200,000 people in the project catchment area were reached indirectly through the different sectors and core activities/services. Table 3 shows planned versus actual beneficiaries, broken down by project sector.

Table 3: Beneficiaries targeted and reached[5]

Sector	Beneficiaries Targeted (Planned)	Beneficiaries Reached					
		Dec 2014 – Mar 2015	Apr – Jun 2015	Jul – Sep 2015	Oct – Dec 2015	Jan – Mar 2016	Cumulative (Dec 2014 – Mar 2016)
Health	9,180	687	4,715	3,597	4,366	722	14,087
Protection		355	512	434	1,075	148	2,524
Total	9,180	1,042	5,227	4,031	4,366[6]	722[7]	15,388[8]

The indirect beneficiaries include the population served by the health facilities (hospitals, health centers and community clinics) supported by STEP and/or served by the health care workers trained and/or mentored by STEP. Moreover, referred project records and KIIs suggested the GETU and the health facilities along the border with Guinea were also serving people from Guinea and adjacent counties, and therefore, the actual number of indirect beneficiaries could be higher than reported. There was no evidence to show documented internally displaced persons (IDPs) reached by this project.

[5] FY2016 Quarter two STEP project report, Project Concern International
[6] The protection sector beneficiaries were also health sector beneficiaries and, therefore, are not counted twice in this total.
[7] The protection sector beneficiaries were also health sector beneficiaries and, therefore, are not counted twice in this total.
[8] The protection sector beneficiaries were also health sector beneficiaries and, therefore, are not counted twice in this total.

Sector Health:

The objective of this sector was to provide the highest standard of medical care for Ebola patients in Nimba through the management of the GETU. Consequently, effort was made to explore three important factors: the level of service target achievement, implementation of the core components/activities, and the quality of service. The findings attest the implementation of the key planned activities as per the standard set by the MoH, and the targets had been reached (and in most cases exceeded) as outlined below.

Target: Despite the low EVD caseload in Liberia, STEP consistently reached large numbers of direct beneficiaries during the project period through both facility based and community outreach, CB-AECS and screening, and ongoing clinical training and mentorship of health facility staff from across Nimba County. This enabled the project to surpass its 9,180 target, reaching 14,087 within the Health Sector (53% increase over target).

Activity implemented: The appraised secondary data (reports and data sets) confirmed STEP implemented comprehensive case screening, referral, care and case management. All those services were delivered as per the Government of Liberia's strategy to respond to the EVD epidemic, which calls for the isolation of persons with suspected, probable, or confirmed EVD both at facility (GETU) level and outreach level. The project:

- supported 78 health facilities (69 primary, five secondary and four tertiary level) in Nimba County through training of their staff, mentorship, and basic IPC supply provision;
- trained 3,448 (1,597 male, and 1,851 female) health care workers working in the county, which is exceeded target by 75%. 80.2% (2,764) were trained in SQS, the remaining 19.8% (684) were trained in KSKS, Surveillance, and Swab collection and transporting, and other training;
- mentored 867 (428 male and 439 female) health care workers in 46 health facilities – more than double of the target;
- provided consultations and clinical services to 8,865 (4,030 male and 4,835 female) people at the facility (ETU) and using outreach approaches; and,
- organized 24 community events for social mobilization and outreach level services.
- reached 46 of the health facilities through comprehensive IPC mentorship benefiting 867 HCW, surpassed the target by over 100%;
- facilitated and supported the setup and erection of temporary triage and screening unities, waste management, and other IPC facilities during the mentorship visits in 20 of the 46 mentored health facilities;
- renovated and partially furnished two isolation and referral facilities
- provided IPC and other basic medical supplies to 58 of the 78 health facilities directly at least once, and in most cases more than twice, and STEP supported the CHT emergency medical depot to supply the remaining health facilities;

Quality*:* The GETU secondary data (quarter reports, staff work schedule and attendance, and event records) suggested that the ETU staff had maintained operational readiness at all times and

the facility had been open for service 24 hours per day, 7 days per week, and the staff were working in three shifts until the clinical services were closed on October 31st 2015. This was consistent with the MOH recommendations for staffing and working schedules of ETU across the county.

The reports and photos from the GETU indicated that each section and service point in the green and red zones were clearly demarcated and signposted. These included the green zone gate, staff waiting areas, donning and doffing rooms, triage and screening sites, all hand washing stations, WASH facilities in both red and green zones, the fencing and gate to the red zone, the suspected and confirmed, male and female, wet and dry symptoms, maternal and child wards were well separated, demarcated and visibly signposted. These was also physically verified during evaluation visits on April 4 and 5, 2016.

All patient records were properly documented, safely placed, and the GETU submitted its daily and weekly case investigation and surveillance reports to the CHT surveillance desk, as witnessed from the report copies and record books. The project continuously monitored the quality of the documentation, regularity of reporting on individual cases, and the weekly and monthly performance reporting as noted during the focus group discussion.

Facilities and operational support of the GETU: The GETU had two well maintained functional generators (165 and 150 KVA) working on alternate schedule. The facility had also two bore holes with functional submersible pumps, and six water tanks (each with 5,500 liters capacity) for water storage and well maintained and functional pipeline supplying all corners of the ETU. In addition, there were 18 hand washing stations (three at the different entry/exit points, five in the "green zone" and ten in the "red zone"). Based on available records at the GETU, the stations had been checked three times a day for presence of the appropriate hand washing supplies (water, chlorine solutions or soap) and the chlorine solutions were changed every 24 hours. All those facilities enabled the ETU to have sufficient water and steady power supply 24 hours a day throughout the week, which were a key to implement the IPC protocols consistently, and maintain WASH standard throughout the project life.

The records and checklists from the hygienist section, as well as KIIs and FGD discussions, revealed that the ETU staff consistently followed the IPC and PPE protocol for patient care followed by the ETU staff. All contaminated surfaces and instruments were disinfected with chlorine solution immediately after use. Staff assigned to the suspected or confirmed ward had been visiting patients at least twice during each working shift. Every time the staff left the wards, she/he decontaminated the PPEs immediately before leaving the "red zone". Each item was then properly disposed of, by the hygienist, at a designated location. All contaminated liquid wastes and containers were checked, disinfected and properly disposed of in a designated secure site three times in a day (every eight hours) seven days a week.

The FGD and KII respondents noted that all protocols and procedures related to IPC were followed and were of the high standard of MOH/WHO, including hand hygiene, donning and doffing of PPEs, chlorine mixing for correct percentages, etc. Patient care was also provided based on MOH/WHO protocols and all resources were available to provide a high standard of care. The facility was kept at a high level of cleanliness, all waste were disposed of appropriately and all medical supplies were properly maintained. There was proper segregation of red and

green zones with proper precautions taken. The ETU had a constant and adequate supply of water and electricity ensuring proper cleaning and disinfections, ensuring WASH protocols were constantly observed. Patient care, including psychosocial services through mental health clinicians, were provided in a proper and timely manner. Most importantly, team work was encouraged and facilitated with staff feeling supported and able to provide feedback to colleagues at all times.

One CHT respondent, during their KII, said, *"In my opinion, the project did extremely well in its compliance and adherence to MoH/WHO protocol for EVD in the county and can be describe as excellent. This is evident by the fact that there was no incident of cross infection reported at the ETU. The ETU also had adequate supply of medical, non-medical and the resources required for IPC and for the effective running of the ETU"*

The respondents believed that the GETU met and exceeded the minimum standards for the safe care in the context of Ebola, as outlined in the MOH protocol. During their interviews, they attributed such performance to be a result of:

- the initial training, and the continuous on-job training and mentorship given to all staff throughout the life of the project;
- clear tasks and responsibilities communicated to each staff as an individual and as a team member;
- availability of required supplies and materials all the time as need;
- continuous access to basic facilities and equipment (including continuous power and water, washing machines, reusable PPEs, etc.) for the provision of safe care; and,
- the level of monitoring and feedback process from project management.

Consultations and clinical services: Based on the project historical records (reports and data set) the project provided EVD focused clinical assessments and screening to a total of 8,865 (4,030 male and 4,835 female) people through the STEP/GETU mobile surveillance team's triage and screening as part of the CB-AECS. Of the total 8,865 consultations, only 48 (27 male and 21 female) were admitted and managed at the ETU, while the other 8,817 were screened at community level by an outreach team reaching out to different communities along the border with Guinea. Table 4 shows the sex and age distribution of all the medical consultation beneficiaries.

Table 4: Number of people received clinical consultations by age, sex and consultation site

Age group	Beneficiaries per consultation site						Total		
	ETU			Mobile CB-AECS site					
	M	F	Total	M	F	Total	M	F	G. Total
0-11 months	0	0	0	656	608	1,264	656	608	1,264
1 – 4 years	3	0	3	1,921	1,956	3,877	1,924	1,956	3,880
5 – 14 years	3	1	4	524	592	1,116	527	593	1,120
15 – 49 years	22	19	41	630	1,200	1,830	652	1,219	1,871
50 – 60 years	0	0	0	152	243	395	152	243	395
> 60 years	0	0	0	119	216	335	119	216	335

Total	28	20	48	4,002	4,815	8,817	4,030	4835	8,865

The KII respondents noted that the standard of care at the ETU was high and based on the MOH and WHO protocols for EVD care. The GETU team was trained in clinical case management and followed appropriate protocols to ensure IPC for the patients and the staff. The GETU team had a clear understanding of international protocols and procedures, they conducted live simulation drills to ensure staff was always prepared and made sure that all staff, including non-medical personnel were trained in IPC and SQS to ensure their safety and a high standard of care. One respondent from the Nimba CHT said, *"One of the thematic areas of STEP, clinical management of EVD cases, was a brain child of the CHT's own efforts to respond to the outbreak in Nimba. As such adhering to the protocol for EVD care provision, was present from the very beginning of the project. Over time and with experience, there were modifications made to address some pitfalls and improve on care provision. For example, two negative EVD PCR as criteria for discharge even in negative patients, and certification of only confirmed patients upon discharge; modification of the ETU structure to create dead spaces as a mean of enhancing IPC to protect staff and patient. The project implementation was flexible to incorporate MOH approved modifications of existing guidelines to improve overall clinical management of EVD cases"*

WASH and IPC protocol implementation at the ETU: The assessment findings revealed that the GETU had consistent and adequate water supply throughout, and adequate IPC supplies and materials in place for use all the time. Both the green and red zone had adequate and properly maintained functional WASH facilities (toilets, bathrooms, and handwashing stations, and functional water pipes). The WASH staff was trained on the operation and maintenance of the WASH facilities, operating the water source and pumping system, regulating the water storage and distribution, and, in collaboration with the hygienist, monitoring water flow to the different facilities within the ETU. During their KIIs, interviewees stated there was no single day that the ETU faced with shortage of water throughout the life of the project. The hygienist also was trained on: cleaning and disinfection of WASH facilities; preparation, monitoring and disposition of chlorine solutions; operating and managing the donning and doffing areas; and monitoring and refilling the hand washing stations. All types of waste were properly segregated by type and disposed; and all contaminated reusable objects, surfaces are disinfected and decontaminated.

Source of medical commodities and supplies: As per the project records and documents, the ETU received adequate supplies from UNICEF, WHO, PCI in-kind donations, and PCI-purchased from a project budget. According to project documentation, UNICEF provided all pharmaceuticals and medical supplies, and WHO donated some PPEs. The majority of the IPC supplies and commodities, including PPEs, came from an in-kind donations mobilized by PCI international office, private fund, purchased using project budget, and/or donations from other USAID/OFDA projects such as HHI (operating the Tappita ETU). All supplies and commodities were received prior to May 2015.

Management and utilization of medical commodities and supplies: PCI/STEP had a proper inventory and warehouse management system, utilization and inventory reports. All appropriate warehouse house management records (stock cards, airway bill, goods receiving and dispatching

note, etc.) and reports were available monthly, in both hard and soft copies. The review of these records and documents suggested that the ETU had been using STEP commodities for its GETU facility level services, outreach services, supporting the mentored health facilities under the direction of the CHT's supply chain management, conducting the SQS trainings, and supporting other PCI projects in IPC implementation in the workplace. There was no evidence to indicate the ETU went out of stock of any of the medical commodities and supplies throughout its operation. Furthermore, the FGD and the key informant interview (KII) respondents reported that the continuous availability of medical commodities and supplies were vital in keeping service quality to standard and consistently implement the MOH protocol for EVD treatment and care at the GETU.

Based on the inventory and supply management records, PCI/STEP utilized all its stock of pharmaceuticals, medical and IPC supplies, as described above, and the monthly inventory report for March 31st, 2016 showed zero balance. Annex 4 lists the health facilities benefitting from supply distributions.

Protection

The objective of this sector had been to provide protection to individuals affected by the Ebola outbreak at the GETU. The number of beneficiaries targeted for this sector (9,180) was based on the number of patients projected for the GETU when the project was initially designed in 2014. A total of 48 cases were admitted to the GETU; however, while the EVD caseload at the GETU remained low, STEP extended its services to community outreach and support activities for EVD survivors and other affected persons throughout the GETU catchment area, reaching, according to project documentation, 2,524 direct beneficiaries through different psychosocial support services.

The project used the MOHSW protocol for psychosocial support and child protection throughout the project life. As the project's reports document, the project facilitated and supported the integration of 11 EVD orphans to their relatives and guardians within one week time of identification. During outreach services, the GETU's psychosocial support team conducted community follow up visits to foster families taking care of EVD orphans.

The FGD respondents confirmed that the shelter for orphans and their families, created and supported by the STEP/GETU, provided food and psychosocial support until they were reintegrated into their communities with assistance by the psychosocial team and local leaders. The STEP/ETU psychosocial team was facilitating to minimize Ebola-related stigma of affected families through counselling and community dialogue, though community outreaches, dedicating staff time to provided radio talk show and educated community member through community healing dialogue and to share the work and purpose of the ETU. Such effort helped to the integration of EVD affected families and orphans into their community within one week of identification.

The project data base and reports indicated that, 4,478 people reached through social mobilization, of which 2,524 (1,112 males and 1,412 females) were targeted for special

psychosocial support and counseling focused on integrating EVD affected families and managing and supporting EVD affected children, including orphans, due to their special need..

5.1.2 Contribution to EVD prevention and post-outbreak basic health services restoration

Primarily, the project aimed to contribute to the national and global effort to prevent the spread of EVD outbreak in Nimba County, through the implementation of tertiary level clinical and psychosocial services at GETU. As the Ebola outbreak evolved, the STEP project also adjusted, addressing gaps in secondary and primary prevention of EVD. Evaluation shows that STEP visibly contributed to the overall prevention and control of EVD and to the post-outbreak restoration of basic health services, through:

- supporting the CHT in sharing the burden of service delivery in terms of staff capacity building and basic health commodities and supply provision;
- implementing and supporting/facilitating the implementation of the national IPC and case management protocols;
- improving IPC practices at health facility and community level, stimulating and supporting the planning and operationalization of epidemic preparedness and response plan; and,
- health facility capacity building.

Support to the county health system: The assessment confirmed that PCI, through STEP, took over the management of the GETU when the country needed it most. The project staffs' dedication, commitment, and willingness to work with the IPC team of Nimba CHT was instrumental in building their capacity, and was essential to building infrastructure - even temporary infrastructure - to support essential health services and rebuild the damaged health system. Throughout the KIIs, mentorship was consistently noted as being key to PCI/STEP's success in contributing to the rebuilding of health services in the county after severely hit with the EVD outbreak.

All respondents noted that they have seen a change not only in the health service capacity, but also in attitudes in themselves, their colleagues and their workforce as the result of the mentorship and trainings provided by PCI/STEP. The survey respondents noted that capacity and implementation had been enhanced, especially in IPC and SQS, through training and mentorship. They also noted that their own leadership and coordination capacity has improved as they saw increased communication, feedback and information sharing through STEP.

Compliance with national protocols: The KII respondents and FGD participants ascertained that the project did extremely well in its compliance and adherence to MoH/WHO protocol for EVD in the county with many describing it as excellent. Based on the KII respondents, FGD participants, and inventory report reviews the ETU had adequate supply of medical, non-medical and the recourses required for IPC and for the effective running of the ETU, and supporting the different health facilities in the County. The CHT worked closely with PCI/STEP and the Ganta ETU team to ensure that all clinicians are making maximum use of standard case definition and

make appropriate referral; and suspected cases were isolated, attended to, investigated and referred which all were done in line with MoH/WHO protocol for EVD case management.

Partnership and coordination: KII respondents from CHT and partners noted that project management remained engaged and transparent, with the door always open to the CHT throughout the implementation of the project. No challenges in regard to coordination and partnership were raised during the KIIs or FGD.

Many times planning was done along with the CHT. The CHT always played the lead in monitoring and supervision with support by STEP. Feedback from the CHT was acted upon. According to project staff, the relationship was very good and commendable. Even other partners, e.g. WHO and the central Ministry, noted the strong relationship between the CHT and PCI/STEP. One district level respondent commented, "*At the district level, PCI/STEP collaborated well with the DHT and shared their agenda with us, provided us transportation/ambulance support whenever needed for patient referral, and provided additional technical assistance to the DHT where there were limitation, especially during the mentoring sessions…*"

Strengthen IPC in the county: PCI/STEP contributed in shaping IPC practices in the county through the mentorship program, the SQS training, provision of essential medicines and medical supplies/equipment, and the setting up of temporary IPC infrastructure in different health facilities of the county. One participant said, *"In my opinion, PCI/STEP was the most outstanding partner of the CHT when it came to IPC practices in Nimba. During the peak of the EVD crisis and throughout the response, PCI/STEP took the lead on establishing and maintaining the culture of IPC practices not only in the healthcare facilities, but also in the communities."*

All KII respondents noted that PCI/STEP had made significant difference in the implementation IPC in Nimba County through either:

- the mentorship program,
- SQS training,
- need-based supply provision,
- setting up triage and isolation in many health facilities across the county, and/or
- the renovation of two infectious disease control centers.

Health facility/ Care worker capacity: Overall the KII respondents noted that mentorship program and the SQS training will make the most difference to the future of health care workers capacity building in Nimba County. The continuous training, supervision, and coaching both to the GETU staff and health care workers in health facilities across Nimba is a significant contribution to strengthen the health service delivery. One respondent said, *"About 95% of PCI/STEP staff were indigenous healthcare workers posted in Nimba. All of the trainings and experiences they gathered as responders during the outbreak will remain with the county as these service providers have now returned to routine healthcare delivery. The SQS training for both public and private healthcare workers, has strongly equipped these providers to provide*

safe and quality care. Each health facility (HF) also received the comprehensive SQS guideline as a reference for maintaining IPC standards in all HFs at all times."

In response to a question related to the contribution of the project's contribution to support the health facilities, a KII respondent from the WHO office in Nimba remarked, "*Capacity-building in the major areas of healthcare delivery, has been the major achievement of PCI/STEP during the project's lifetime. Human resource capacity building will remain a major asset for the CHT as it administers healthcare delivery in Nimba. Provision of implements such as caller user groups will enhance timely reporting and isolation of suspected cases surveillance diseases in line with national protocols. Standardized healthcare infrastructure to manage epidemic diseases will greatly help to contain future outbreaks, those are some the contributions of this project."*

A district health officer from Nimba also reflected on STEP's contribution to improve services at the health facilities: "*The training of health workers has improved their capacity to conduct contact tracing, investigate EVD related cases and formulate team to intervene in any emergency situation; PCI/STEP distributed assorted IPC supplied to all health facilities which have used appropriately to protect health workers, patients, and the communities from potential infections; and Temporary Triage and isolation units were built at some health facilities and helping to improve screening process."*

The setting up and renovation of the temporary isolation unit (triage) at some health facilities, even though they are temporary, did help to support the knowledge and skills acquired during the training, and significantly helped to prevent and control the spread of Ebola and other infectious diseases through strengthening the screening practice. The majority of respondents (32 of the 45) noted that the strengthening of the epidemic preparedness and response capacity at the county level, especially in border districts and health facilities, and support to the roll out at the district level was a key and long-lasting achievement.

The KII responses highlight the positive impact that PCI/STEP trainings have made on the capacity of Nimba County's health system. Respondents noted that the SQS training and mentorship has significantly improved triage and screening, case identification, waste management, and hand hygiene skills in the health facilities. The KII respondents from the health facility reported that PCI/STEP supplied medical and IPC supplies and equipment, had significant contribution in implementing the IPC protocols and improve service delivery and client satisfaction. It also improved the quality of services through the in-service staff capacity strengthening (professional and auxiliary), overall facility cleanliness, improvements in all service delivery (including laboratory, delivery room, etc.).

Respondents noted that the STEP had limitations in fully supporting the community based health care services. Health facility based KII respondents noted that STEP could have supported more gCHVs and strengthened linkages between the community and health facility. One respondent indicted that, "*while gCHVs have a significant role to play in community based promotive and preventive health services, the engagement and support activities from STEP were limited*". Over 40% of the respondents noted that additional training was necessary for all cadres of staff at the

health facilities, especially gCHVs and TTMs. Those interviewed also emphasized the need for the creation of community structures in support of IPC (i.e. committees) and the need to expand training to all community leaders, volunteers and key stakeholders, especially traditional healers. However, this was beyond the project scope.

5.2 Effort in building health workers' and health facilities' capacity in Nimba County;

Health Care Facilities Supported: As the evaluation shows, STEP supported all of the health facilities in the county through a combination of interventions that include mentorship, KSKS/SQS and other trainings, and supply provision. There were 78 functional health facilities in six health district in the county when STEP was operating (Annex 4 provides a cumulative list of health facilities supported by STEP during the project life). The secondary data show STEP reached 46 of the 78 health facilities through comprehensive IPC mentorship, thereby benefiting 867 HCW. STEP also facilitated the setup and erection of temporary triage and screening units, waste management, and other IPC facilities during mentorship visits to 20 of the 46 mentored health facilities. The KII and written reports show that. STEP also provided IPC and other basic medical supplies to 58 of the 78 health facilities directly at least once, and in most cases more than twice, and STEP supported the CHT emergency medical depot to supply the remaining health facilities.

Respondents noted SQS training, the need based supply provision, and the mentorship to the health facility that improved triage and screening, case identification, waste management and hand hygiene skills where among the valuable contributions of STEP project. The training served as a cornerstone to build staff capacity up to standard in terms of care provision. Further, the KII findings indicated that PCI/STEP project not only significantly contributed to improved service delivery to clients at the health facilities, but its interventions positively influenced the day to day behavior of the health workers. All respondents answered with a resounding "yes" to a question on whether the project had any influence on their EVD-related practice. Many pointed out, prior to the Ebola outbreak and in the early days of the crisis, health workers were not aware/observing proper IPC practices. Now, following training and mentorship, all respondents noted that they and their teams have a better understanding of the importance of consistent IPC practices. Health workers were observing PPEs donning and doffing procedures and constantly wearing risk appropriate PPEs to care for patients; and proper waste disposal practices were followed as much as possible.

Health care providers trained: The project records revealed that STEP trained 3,448 health care workers (1,597 male and 1,851 female), a 75% increase over the original planned target of 1,970. The SQS training covering 100% of the health care workers in all the health facilities (hospitals, health centers and clinics) in Nimba County, was the main reason for the over achievement. Apart from the SQS training, KSKS, EVD surveillance and response, psychosocial support, and swab sample collection were among the focus of the trainings supported by the project. Table 5 shows the training beneficiaries by profession and sex.

Table 5: Training Participants by sex and Profession

Professional Category	Number of participants		
	Male	Female	Total
Medical Doctor	15	6	21
Registered Nurses	252	368	620
Physician Assistant	35	8	43
Hygienist	217	170	387
Midwifes	4	53	57
Others	1073	1247	2320
Total	1597	1,851	3,448

In response to a question related to the contribution of the project's contribution to support the health facilities, a KII respondent from the WHO office in Nimba remarked, *"Capacity-building in the major areas of healthcare delivery, has been the major achievement of PCI/STEP during the project's lifetime. Human resource capacity building will remain a major asset for the CHT as it administers healthcare delivery in Nimba. Provision of implements such as caller user groups will enhance timely reporting and isolation of suspected cases surveillance diseases in line with national protocols. Standardized healthcare infrastructure to manage epidemic diseases will greatly help to contain future outbreaks, those are some the contributions of this project."*

A district health officer from Nimba also reflected on STEP's contribution to improve services at the health facilities: *"The training of health workers has improved their capacity to conduct contact tracing, investigate EVD related cases and formulate team to intervene in any emergency situation; PCI/STEP distributed assorted IPC supplied to all health facilities which have used appropriately to protect health workers, patients, and the communities from potential infections; and Temporary Triage and isolation units were built at some health facilities and helping to improve screening process."*

Considering the magnitude of training targets, effort was made to examine how successful the SQS training was. The SQS training has four levels: there are four master SQS trainers trained at national level, 43 county level facilitators trained as SQS facilitators by the master trainers, and 472 clinical level and 2,247 non-clinical level HCWs trained. Pre and post training test results from randomly selected health facilities were documented in the training databases, and these were compared. Further, reflections from key informant interviews regarding trainings were also collected.

The pre and post-test score comparison showed an average of 37 (64.5%) points gain in IPC, PSS, clinical practice knowledge among clinicians, and an average of 32 point (52.4%) increase in IPC practice knowledge among non-clinicians[9]. Although the passing point was 60%, as per the WHO/MOH set criterion, all four of the master SQS trainers 84% (36 of 43) of the county level SQS training facilitators, 99% (469 of 472) of the clinical HCW, and 96% (2152 of 2247) scored above 70% in the final test, highlighting the success of the SQS training. .. There were no drop outs in any category.

Based on the KII participants' reflections, the SQS training was among the most valued contribution of the project in strengthening the capacity of the health workers. Nearly all of the respondents from the health facilities reflected that the SQS training brought about several changes in the quality of health care services at health facilities and service provider confidence in case management and IPC. Improved knowledge and practice of IPC, through SQS trainings, was noted as a very important intervention at health care facilities. It was reported that these trainings, coupled with supplies of equipment and medicines, increased health care workers' capacity in risk assessment to identify emergency, priority and queue patients, improved sanitation and hygiene practices, and improved screening and case identification. Respondents noted that facilities were better organized and cleaner from improved waste management. In addition, respondents noted that creating temporary triage/screening areas in combination with the SQS trainings improved isolation of suspect cases. For example, one respondent noted that, SQS training complemented by the preceding mentorship "*practically demonstrates to us why every patient that comes to the clinic must enter through triage so that they are correctly screening for suspicious symptoms, and how and why a risk appropriate PPE should be utilized.*" Another respondent commented that the SQS training was helpful to the way it enabled them to better communicate with patients,noting that it "*helped improved our way of talking to a patient in a manner that makes them feel relaxed and comfortable*." Given the fear surrounding Ebola, this is an interesting remark regarding the benefit of the training. The trainings appear to be fundamentally important component of the success of the intervention. As one respondent noted, the trainings "*enlighten our minds on how to provide care to our patients*."

Mentorship: STEP, in collaboration with CHT and WHO, engaged in the mentorship of high priority health facilities in Nimba County. The purpose of the mentorship was to support the targeted health facilities overall system to implement the national IPC minimum standard in the context of EVD, and train and mentor the health care workers in those health facilities to comply and implement the IPC universal precautions and the Liberian IPC minimum standard in the context of EVD. Initially, the mentorship was started based on the then "Keep Safe Keep Serving," or KSKS, protocol, and later shifted to the Safe and Quality health Services (SQS) protocol[10] few months after Liberia was first declared Ebola free.

[9] The point gain/loss is calculated by subtracting the pre-test result from the post-test result.

[10] KSKS and SQS are both MOHSW standard protocols for IPC. KSKS protocol had been used to implement IPC intervention in the context of the EVD outbreak; now that the outbreak is under control, KSKS protocol was replaced with SQS during the reporting period.

The project records show that STEP covered 46 of the 64 mentored health facilities, above the target of 24 health facilities, which were initially targeted high priority health facilities. This coverage included mentoring on regular hand washing and hygiene practices, setting up and implementing triage and screening procedures, appropriate use and disposal of PPEs (including donning and doffing procedures), health facility waste management and environmental cleaning, and IPC supply chain management, were among the areas covered in each of the mentorship visits. As part of the mentorship, the mentors also supported the health staff in some of the facilities, to set up and rehabilitate temporary triage structures, established hand washing stations through providing staff time and supplies (e.g. buckets and forceps, chlorine solutions, etc.). The project staff mentored more than double the health care workers (324) originally targeted. The project records show that 867 (428 male and 439 female) health care providers in 46 health facilities were mentored over the life of the project (See Table 6).

Table 6: Health Facilities and Health Care Workers Mentored by STEP

Type Facility Mentored	Quantity	Health Care Workers mentored[11]						
		Clinician		Non-clinician		Total		Grand Total
		Male	Female	Male	Female	Male	Female	
Hospitals	5	49	78	55	48	104	126	**230**
Health Centers	2	13	15	37	38	50	53	**103**
Clinics	39	54	62	220	198	274	260	**534**
Total	**46**	**116**	**155**	**312**	**284**	**428**	**439**	**867**

The qualitative data gathered from KIIs noted mentorship as among the most important activities that facilitated IPC practices and improved capacity and confidence of the health care workers. The findings demonstrated that the mentorship component of STEP's outreach program helped build the technical knowledge and proficiency of health workers and strengthened IPC implementations in Nimba County.

An officer in charge in one health facility in Tappita district, said, *"PCI/STEP did especially very well in making hand washing practices are effective and consistent; screening of patients, visitors and staff before entering health facility; improved screening and isolation through building of temporary triage; and setup procedures to use PPEs, and improve the waste disposal and management in our facility – all as a the result of the conducted mentorship program at our clinic…."*

The respondents also noted that the mentorship activities improved health care workers' knowledge on prevention, assessment, case management, and met overall goal of behavior modification. It helped the service providers by making them aware of important routine practices such as on the need for hand hygiene, and their social behaviors including hand shaking, hugging etc.

[11] According to the CHT/MOH, Clinician HCW include: MDs, Physician Assistants, Nurses, and Clinical Midwifes; and Non-clinician HCW includes, hygienists, nurse aides, dispensers, vaccinators, cleaners, TTMs, and others.

According to the KII respondents, the mentorship also helped them learn how to engage with community-based health volunteers to support the health facilities in creating a safer environment. Mentorship helped increase active participation by gCHVs and community leaders to improve IPC infrastructure (fencing, waste disposal, and maintaining water points) of health facilities. Mentorship also brought improvement in community dead body management through health education and community awareness promotion. Mentorship contributed to the improvement of all aspects of IPC and health facility management. It also improved the quality of services through the building of staff capacity (professional and auxiliary), overall facility cleanliness, improvements in all service delivery (including laboratory, delivery room, etc.).

A medical director of one of the hospitals in Nimba County reflected, *"PCI/STEP conducted mentorship and 15-20 staff were mentored on IPC protocol; conducted SQS training that increased the knowledge capacity of all our staff in IPC practice, waste management and hand hygiene, case management; and taught us the KSKS approach to IPC practice, which is now replaced by SQS approach, and provided us IPC supplies – all these supports were very helpful to improve service quality"*

A staff member at the health facility in Zoe-geh district said, *"First, we never have knowledge on triage screening, hand hygiene, or IPC in general, but we acquired adequate knowledge on IPC protocol, waste management, and hand washing through the intervention of PCI/STEP. In addition, PCI/STEP brought positive changes to our patient care by sending mentor to refresh our knowledge and practice."*

5.3 Continued utilization/application of the skills obtained through training and mentorship

The key informant interview respondents pointed out that the mentorship activities positively impacted on their basic skills and knowledge, including the preparation of appropriate chlorine solutions, the disinfection of medical instruments and reusable PPEs, proper waste management, and how to clean environment in a manner to promote health. Key informants noted that hygiene practices are improved: hand washing stations are seen everywhere and patients and visitors are making use of such facilities to protect themselves. They also stated that patients and visitors are properly screened before entering health facilities. According to interviewees, trainings helped them as a key reminder to implement the IPC protocol and refresh on some basic skills on IPC and case management, which they had forgotten. The respondents also said that the mentorship has led to improved hand hygiene practices and the importance of consistent placement of hand washing stations at the health facility; proper patients and visitors screening before entering health facility; case separation and isolation, and organize the setup of the health facility to better implement the IPC protocol, including organizing the OPD area, the laboratory, in-patient service, donning and doffing areas, waste segregation and disposal, as well as fencing of the health facility.

Over 80% of the KII respondents and the FGD participants noted that, as the result of the STEP training and mentorship, they would now prepare chlorine solutions properly and know how to disinfect areas of possible contamination. They also noted that they would have more confidence

in caring for their patients appropriately, including triage and isolation. Waste management practices are essential to the prevention of infection and a majority of respondents noted that they have good knowledge of the importance of IPC and waste management.

One staff in one of the health facilities in Gbarlay-Geh district, said, *"Generally, the mentorship helped put things in order, for instance, the laboratory section was disorganized, waste was poorly managed and poorly disposed, and staff were not following IPC protocol, but the mentorship improved the system of waste segregation and management; it helped to clean and organize the laboratory working environmental, and the condition of the health facility. The mentorship also created room for gCHVs and community people involvement in health facility work thereby linked the gCHVs and community in improving health activities. Further, mentorship brought improvement in community dead body management by promoting health education and community awareness."*

Further, the health workers noted that the continued supply of the IPC and medical commodities helped them in demonstrating the appropriate IPC practices. One health facility staff from Saclepea district said, *"PCI/STEP supplied essential drugs, IPC supplies, patient bed, and other assorted medical supplies when we were really in need of them. Those support, not only will keep us safe and work in safe environment, but were very helpful to provide the routine health care services and to practically implement what we have gained during the trainings with confidence and without fear."*

Another KII respondent said, *"Due to the lack of IPC supplies at the health facility I am working, before, health workers in my facilities were not protected, but PCI/STEP provided those personal protective materials, chlorine, and other IPC materials; and trained us how and when to use them that improved our knowledge and skill in patient care and use of protective measures. As the result, I am set to serve in a very safe environment and highly motivated to do my job."*

5.4 Key lessons learned for future programming

- The aspiration and vision by the project management and staff, the flexibility of the project, the evidence-based decision making process, short decision-making path that PCI had, as well as the interactive process and flexibility of the donor to understand the dynamics the outbreak and accommodate needs identified during the NCE, had significantly helped the project to efficiently utilize available resources so as to speed up implementation of all project components, enhance its contribution to the prevention and control of EVD, addressed priority needs of the health system in the county, and, most importantly, to achieve the project objectives. Besides, as well noted by the key informants, due to the improved communication and feedback system, STEP facilitated joint planning exercises, and information sharing, thus improving leadership and coordination capacity of the key stakeholders at the county, especially the CHT.

- The level of coordination and collaboration with the CHT, and partners like WHO, significantly contributed to the success of the project. The effective engagement of PCI/STEP's staff to work with the national IPC taskforce, the CHT and the DHT of Nimba was instrumental in exploring and addressing priority needs on time, and had significantly contributed to improve the county's health system.
- Having a locally staffed ETU significantly improved STEP's ability to work closely with the communities and the CHT/MOHSW. Further, 80% of staff who transitioned from the GETU at the end of the project are now working in the different health facilities in the county, a continuing asset to the health system.
- The series of flare ups of EVD cases in Liberia after the country was declared free of EVD is an important indication and continued reminder to maintain high levels of vigilance to monitor the situation, examine trends, and intensify surveillance and social mobilization on IPC, and most importantly, for functional and robust community based health care.
- Mentorship was consistently noted as being key to PCI/STEP's success. Mentorship and the SQS training were most valued by all respondents, and all noted that those two components has well-appointed the HCWs in the county, with basic knowledge about patient care, hand washing practice, risk assessment, psychosocial services, set-up and use of triage and isolation facilities, and appropriate waste management, and use of risk appropriate PPEs. In addition, the respondents from the health facilities, noted the continuous provision of IPC and medical supplies had helped them to improve health services, and apply what they had learnt from the trainings and mentorship.
- The KII respondents strongly agreed that PCI/STEP interventions had significant influence in their day to day practice of IPC. They noted that *"Prior to the Ebola outbreak, and in the early days of the crisis, health worker were not aware of or observing proper IPC. Following training and mentorship, now all respondents noted that they and their teams have a better understand of the importance of consistent IPC. Health workers are adhering to PPEs donning and doffing procedures and constantly wearing risk-appropriate PPEs to care for patients; and proper waste disposal practices are being followed at much as it need to be"*
- Maintaining and strengthening relationships with all key stakeholders (schools and community based organizations; community, traditional, governmental and religious leaders; EVD survivors; and community health clinics) was an essential part of the effectiveness of STEP activities. These relationships can and must be maintained and replicated to build strong epidemic preparedness and response systems across the board through existing social and behavior change approaches, strengthening existing surveillance capacity, creating/improving community-facility linkages, and building community resilience.
- Despite mentorship and supervision activities, in 50% of the facilities technical assistance was challenged by a lack of or irregular supply of IPC supplies and consumables and poor infrastructure. Most respondents highlighted the severe infrastructure limitations of health facilities in the county as key challenges to consistently implementing the national IPC

minimum standards. Consequently, the respondents wished PCI/STEP would have built permanent incinerators, instead of simple renovations and putting zinc over damaged ones; requested construction of permanent triage and isolation areas, which was unallowable by the grant, would have been very important for health system rebuilding and strengthening.

- Based on survey findings and observation, while gCHVs have a significant role to play in community based promotive and preventive health services, the engagement and support activities from STEP were limited. All respondents noted that additional training was necessary for all cadres of staff at the health facilities, especially gCHVs and TTMs.
- The respondent also emphasized the need for the creation of community structures in support of IPC (i.e. committees) and the need to expand training to all community leaders, volunteers and key stakeholders, especially traditional healers.
- As the PCI/STEP closes, many respondents noted maintaining the level and scale of mentorship and on-site capacity building activities at all health facilities as an imminent gap. The survey participants noted that there was a will continue to be a need for continued mentorship and integrated supervision on SQS and a constant supply of IPC materials in all health facilities.
- Due to the emergency nature of the project, very short contracts (up to three months at a time) led to stress and uncertainty for most STEP staff. Additionally, lack of compensation for overtime work, sudden shifting to different responsibilities after the cessation of clinical services at the ETU, inconsistent and ineffective medical insurance, unsuccessful treatment outcomes for some patients, and finally, witnessing the decommissioning of the ETU when it could be used as a an infectious disease control center, were the most disappointing/low points as reflected by the project staff.

6.0 Conclusions and Ways forward

6.1 Conclusions

In conclusion, STEP project not only achieved and/or surpassed its targets, but also became a great opportunity to further continue health system strengthening in Nimba County. STEP implemented all its planned activities and performed well in achieving all its targets. All evidence suggests that STEP project, through the implementation of IPC promotion and demonstration at community and health facility levels, effectively supported surveillance activities, established effective triaging/screening and isolation protocols and facilities for suspected and confirmed cases, and improved the technical capacity of health workers through training and mentorship. These outcomes played a pivotal role in the EVD prevention and control efforts.

The provision of need-based IPC and other medical supplies support to selected health facilities, coupled with health care worker capacity strengthening, contributed to restoring basic health services post-outbreak, while strengthening the capacity of health facilities to prevent and contain a possible flare ups of EVD and/or other disease of outbreak potential.

Improved technical capacity of health workers, including staff working at the GETU, that resulted from the different trainings and mentoring sessions conducted by STEP, became a major asset to the county in terms of health system capacity. These capacities have been pivotal in current efforts to develop epidemic preparedness and response efforts in the county, and in restoring post outbreak basic health services, improving the quality of health services, and building communities' trust on the health system that had been lost during the outbreak. STEP project's capacity strengthening interventions significantly improved the day to day IPC practices of thousands of health workers in Nimba. This training and mentorship helped health workers to better understand the importance of consistent IPC and to put that knowledge directly to practice. During supervision and mentoring visits, health workers were consistently observed properly and constantly wearing risk appropriate PPEs, practicing PPE donning and doffing procedures, and regularly applying/following proper waste disposal practices/procedures.

An important element of success for STEP was the effective, consistent and ongoing coordination and collaboration with the CHT and DHT, partners like WHO, and the national IPC taskforce. Such coordination was instrumental to identify and address priority needs on time, improving the county's health system.

Additional elements that contributed to the project's success include the commitment and motivation from project management and staff, the agility of the project to identify and adapt to evolving circumstances, the evidence-based decision making process implemented for technical and operational decisions, as well as the flexibility of the donor to accommodate new requests that resulted from emerging needs identified during the NCE. All these significantly facilitated the efficient utilization of available resources, thus enhancing the project's contributions to the prevention and control of EVD, while responding to priority needs of the county's health system, and, most importantly, achieving project objectives.

Furthermore, STEP helped to improve leadership and coordination capacity of key stakeholders at the county, especially the CHT, through the effective and continuous communication which included a swift feedback system, facilitation of joint planning exercises, and regular information sharing activities.

6.2 Way forward

An inherently weak and dependent health system, ineffective community based health care, irregularities in the surveillance and preventive approaches, as well as the continued flare up of EVD and other disease outbreaks, will challenge progress made by the STEP project unless additional interventions are implemented to capitalize on its achievements. The following recommendations are made:

- Unless the health system has determined and functional leadership, that fully owns and leads at all levels of the system - and becomes fully accountable to its challenges, gains, and problems - maintaining or replicating positive lessons and good practices is always impossible.
- Epidemic preparedness and response should be further strengthened by having clear mandates and shared responsibilities and accountabilities among the key players. The series of flare up of EVD cases in Liberia and its neighboring two countries, after they had been declared Ebola free, serve as an important reminder of the need to ensure and maintain appropriate systems in place to monitor the situation, examine trends, and intensify surveillance and social mobilization on IPC, and most importantly, the strong need for functional and robust community based health care that includes surveillance.
- Training is an important component of capacity and health systems strengthening, as it provides participants with an opportunity to gain knowledge, skills and an incentives to implement a given task in a given setting. However, training by itself is not an end result, and it has to be complemented by supportive, effective, on site and regular mentorship. The lesson from this project is very clear in that mentorship was consistently noted as being key to PCI/STEP's success and the most highly valued element by health workers as a means of building their capacity and source of motivation. As the PCI/STEP closes, many stakeholders, from the county and district health team and health facilities, noted continued mentorship as an imminent gap to be addressed in the near future. Thus, though resource intensive, mentorship and a post-training supervision, should be prioritized as key interventions to uplift and improve the human resource capacity in Nimba, and in Liberia in general.
- As part of the community based health care system, maintaining and strengthening relationships with all community level stakeholders (schools and community based organizations; community traditional, governmental and religious leaders; EVD survivors; and community health clinics) will continue to be an essential part of an effective emergency

preparedness/response system. Using Social and Behavior Change approaches like the ones implemented by STEP, will help build upon surveillance capacity created by STEP and will contribute to building community resilience.

- As a key component of the health system, functional and robust supply chain management (SCM) is very crucial. Lack or weak SCM counteracts the positive effects of any technical assistance and other capacity strengthening achieved and will continue to undermine the system's ability to implement recently acquired technical capacity and motivation. Thus, efficient supply management system is another area that will continue to require the support and attention of health system leaders.

Finally, it is certain that 'health is made at home and fixed at the health facilities.' This is more accurate for resource-limited communities and nations like Liberia, where a strong community-based health care system, can be an efficient alternative to help prevent and address most of the health challenges in the country. At the heart of community-based health care is active and meaningful community engagement by its volunteers: gCHVs, TTMs, community health service supervisors, traditional healers, and community leaders. These community representatives would not only serve as change agents for better health and disease prevention at household and community levels, but would also act as bridges between the community and facility services, and would advocate for specific improvements needed. This component of the health system is crucial in helping minimize or prevent future potential outbreaks, while effectively promoting better health at household and community level.

Annexes

Annex 1: Survey tools and questionnaires

A1.1 STEP End-line Evaluation Key Informant Interview Guide

Definition and Purpose: Key informant interviews are qualitative in-depth, one-on-one interviews with people who have first-hand knowledge about their offices or health facilities or community, its staffing, and issues related to the different activities that PCI/STEP are implementing and trying to investigate.

This interviews aims to understand the understanding, perception, and values of the different interventions that PCI/STEP has been implementing in Nimba County, in general and in their particular district, health facility and/or community specifically. Therefore, the interview must be conducted based on the guiding points and instructions outlined below.

A. Instructions to the Interviewer:

1) Introduce yourself.
2) Establish the purpose for the interview.
3) Explain why his/her cooperation is important in collecting the information you need.
4) Explain what will happen with the collected information and how the community will benefit.
5) Ask the informant if they have any questions before you begin.
6) Ask the questions on the key informant interview guide, and where needed probe to learn additional information.
7) When give unclear answers, the interviewer should probe for fuller, clearer responses.
8) A few suggested techniques are: repeat the question, explain that you have limited understanding of the subject and ask for specific detail, or repeat the participant's reply.
9) Summarize main points from the interview.
10) Provide an opportunity for the key informant to give any additional information or co

B. Instructions to the Note taker:

1) Record major themes, ideas, comments and observations.
2) Use KII Note Taking Form.
3) Document verbal and non-verbal communication.
4) When in doubt, don't leave it out!
5) Do not throw away any papers with notes of the interview.
6) After completing the interview please review your notes for completeness before leaving the venue.
7) In evening, interviewer and note taker should review and consolidate notes to ensure complete documentation.
8) Capture any new insights that emerged as a result of this discussion with the interviewers.
9) *Save all notes* from FGDs

C. Interviewer/Note taker Information:

Name and signature of Interviewer: _____

Name and signature of Note taker: _____

District: _____ Health facility/community: _____

Date: _____Time: _____

D. Interviewee Information: As filled in the questionnaire (Optional)

Name: _____ Sex: _____, Position/profession: _____

E. Introduction (Interviewer):

Hi my name is _____ (interviewer), and this is my colleague, _____ (note taker), and we work with the _____. Thank you for sharing your time with us today. Before we begin, we need to inform you of several things.

The purpose of today's group discussion is to gather feedback about your experience with the work of PCI/STEP that manages the Ganta ETU. Sharing your experiences and opinions will help us document the lessons and improve our future similar interventions, so we would like you to be honest and open with your responses. We do greatly value your participation, but also need to let you know that your participation in this discussion is completely voluntary. You are not required to be here as to participate in this group discussion. By participating in this discussion you are consenting to allow us to use your anonymous responses to help inform program planning in the future.

I am going to ask you some questions about contribution of STEP/Ganta ETU, and my colleague (note taker) is going to take notes on our conversation. Your privacy is very important to us, and your name will not be linked to anything that you share with us today. We also request that you respect the privacy of others in the room and not share their comments outside of this group.

We anticipate this discussion to last for 1 hour. Please be patient and participate in the discussion through its entirety. Your views and opinions are valuable to us.

Remember that this is an open discussion and I would like you to share your views freely. If you are no comfortable in taking part in this you are free to say so. Please note that your refusal to take part in this will not be held against you in any of your interactions with PCI.

At this point, the interviewer asks whether the participants will take part in the interview. If yes, the interviewer continues. If not, the interviewer thanks the participant and excuses the participant from the interview.

Note to Interviewer: Instructions and probes for interviewers are bolded throughout the guide

Question 1:

Question 2: Etc…continue

Exit:

Thank you again for you time today. Your comments will help us to better understand how _____, and how we can improve future programs. Please remember that we will keep the information you provided anonymous, and we ask that you not share other participant's responses.

A1.2 STEP End-line evaluation Key Informant Interview Questionnaire

A. Introduction to the Questionnaire (this is to all questionnaires categories)

STEP Project has been managing the MOHSW-staffed Ebola Treatment Unit (ETU) in Ganta in order to slow the spread of Ebola in Nimba County through the isolation of cases, the provision of a high standard of medical care, the protection of individuals at the ETU affected by the Ebola outbreak, strengthen the primary prevention of infection transmission in Nimba County, and support and facilitate the integration of full EVD care to basic health service delivery system. Though the primary focus of the project was to manage the tertiary referral center for EVD suspected and confirmed cases at GETU, STEP also leverages the skills and resources of the GETU and its staff to support ongoing outreach programs to communities and health facilities in throughout Nimba County.

Thus, this exercises is aimed at looking at the performance of PCI/STEP over the last 15 months period, and document lesson and stakeholder reflection in the overall process and achievement of the project.

The major strategic approaches that have been used to achieve STEP's project objective have been:

- Providing high quality/standard medical care to admitted EVD suspected and confirmed cases at the Ganta ETU, based on the MoH protocol for EVD care;
- Providing psychosocial support and protection to individuals affected by the Ebola outbreak at the ETU ;
- Conduct focused primary and secondary EVD prevention interventions at community level, that includes social mobilization and active case surveillance;
- Strengthen the capacity of health facilities and health care workers to implement EVD focused and MoH minimum standard for infection prevention and control;

Based on this, it is important to get reflection from different stakeholders on the implementation process and results achieved. This helps PCI to learn and document the process of implementing the project, and take a lesson on what improvements must be considered while designing and/or implementing future public health or development projects.

Accordingly, PCI/STEP highly values your input and appreciates your contribution in outlining your thoughts on the issues below.

B. ETU Staff

Name: _____ (optional) Organization: _____

1. As PCI/STEP employee, what do you value most while working for STEP project?
2. Do you realize any change of attitude or understanding about EVD on yourself that as a result of direct involvement as a staff of the Ganta ETU? What are these changes you realized?
3. How do you describe your contribution in providing high quality/standard medical care to admitted EVD suspected and confirmed cases at the Ganta ETU, based on the MoH protocol for EVD care;
4. How do you justify if the medical services being provided to EVD suspected and confirmed cases at the Ganta ETU, were high/standard quality and were consistent to the MoH protocol for EVD care?

5. What was you direct contribution to maintain the quality of services to be high standard and quality services and as per the MoH protocol for EVD care;
6. You are among the health care workers running a high/standard quality medical care to EVD suspected and confirmed cases at the Ganta ETU. How would such experience influence/shape your future professional career?
7. What do you consider some of the most significant trends, events, and developments shaping the IPC practice in Nimba County you believe STEP has contributed to?
8. What do think is the key achievements of PCI/STEP during the course of the project implementation that you believe could make the most difference to the future of health care workers capacity building in Nimba County?
9. What do think is the key achievements of PCI/STEP during the course of the project implementation that you believe could make the most difference to strengthening the IPC implementation in Nimba County?
10. What do think is the key achievements of PCI/STEP during the course of the project implementation that you believe could make the most difference to strengthening the epidemic preparedness and response capacity of the county level health system in Nimba County?
11. What has been your major learning, insight, or discovery so far while working in the STEP project?
12. As an engaged professional, there are inevitably high points and low points, successes and frustrations. What stands out for you as a high point when you were part of an outstanding STEP/Ganta ETU team member?
    a. What has been a high point of your involvement with STEP? Why was it a high point?
    b. What do you especially value:
        i. About STEP as a project that adds value to EVD prevention and control project implementation?
        ii. About STEP, a key contributor to restore the basic health services through building the capacity of health facilities in Nimba County?
        iii. About STEP, as a key contributor/player to restore the basic health services through building the capacity of health care workers in Nimba County?
        iv. About STEP, as a key contributor/player to improve the infection prevention and control practices in Nimba County?
13. How do you think your experience and learning while working for STEP/PCI would shape your professional career, and enhance your contribution to the county health system or beyond?
14. What could PCI/STEP have done more to further boost its achievements and address areas which otherwise were not addressed during the course of the project? In terms of
    a. Health facility capacity?
    b. Health care workers capacity?
    c. IPC implementation?
    d. Community facility linkage to improve IPC?
    e. Others?
15. How do you think PCI/STEP could have achieved more or addressed these gaps?
16. What are the areas where you feel more projects like STEP engagement could have the most impact on improving IPC and Epidemic preparedness and response in Nimba County?

C. CHT, DHT, Partners

Name: _____ (optional) Organization: _____

1. As a key partner of PCI/STEP, what do you value most while partnering with STEP project to manage the ETU, jointly work on mentorship and all other efforts to improve the IPC practice in the county?
2. Do you realize any change of attitude or understanding on effective partnership on yourself and your office as a result of direct involvement with STEP project staff? What are these changes you realized?
3. In your observation, how do you describe the compliancy of the project to MoH/WHO protocol for EVD care, while providing high quality/standard medical care to admitted EVD suspected and confirmed cases at the Ganta ETU?
4. How open was the project management for partnership, receiving monitoring and supervision feedbacks from your office, in improving or maintaining the quality of services to the standard and quality services of the MoH protocol for EVD care?

5. What do you consider some of the most significant trends, events, and developments shaping the IPC practice in Nimba County you believe PCI/STEP has contributed to?
6. What do think is the key achievements of PCI/STEP during the course of the project implementation that you believe could make the most difference to strengthening the IPC implementation in Nimba County?
7. What do think is the key achievements of PCI/STEP during the course of the project implementation that you believe could make the most difference to the future of health care workers capacity building in Nimba County?
8. What do think is the key achievements of PCI/STEP during the course of the project implementation that you believe could make the most difference to strengthening the epidemic preparedness and response capacity of the county level health system in Nimba County?
9. What could PCI/STEP have done more to further boost its achievements and address areas which otherwise were not addressed during the course of the project? In terms of

    a. Health facility capacity?
    b. Health care workers capacity?
    c. IPC implementation?
    d. Community facility linkage to improve IPC?
    e. Others?

10. How do you think PCI/STEP could have achieved more or addressed these gaps?
11. What are the areas where you feel more projects like STEP engagement could have the most impact on improving IPC and Epidemic preparedness and response in Nimba County?
12. Any additional suggestions comments you would like to provide to PCI?STEP _____

Thank you for your time and contributions

D. Health Facility

Name: _____ (optional) Facility: _____

1. If you know PCI/STEP project that manages Ganta ETU, what interventions or in puts does the project have had in your facility or the health care workers in your health facility in the last one year?
2. From all the inputs/interventions PCI/STEP have had in your facility, which one(s) do you value most? And why?
3. Do you realize any change of understanding about EVD, EVD management and importance of IPC on yourself, as a result of the support from staff from PCI/STEP? What are these changes you realized?
4. How do you describe the contribution of the PCI/STEP support in improving the quality of service and implementation of IPC protocols in the health facility you are working?
5. If you were mentored by PCI/STEP staff, how does that mentorship helped you in improving your capacity to better carry out your responsibility as a health care provider?
6. What was the direct contribution of the mentorship activity to improve the quality of health care services in your health facility?
7. If you were trained on SQS by PCI/STEP staff, how does that training helped you in improving your capacity to better carry out your responsibility as a health care provider?
8. What was the direct contribution of the SQS training in improving the quality of health care services in your health facility?
9. What could PCI/STEP have done more to further increase its achievements and address areas which otherwise were not addressed during the course of the project? In terms of

    a) Health facility capacity?
    b) Health care workers capacity?
    c) IPC implementation?
    d) Community facility linkage to improve IPC?

e) Others?

10. How do you think PCI/STEP could have achieved more or addressed these gaps?
11. How do you think PCI/STEP could have achieved more or addressed these gaps?
12. Any additional suggestions comments you would like to provide to PCI?STEP _____

Thank you for your time and contributions

E. Community members or/and leaders

Name: _____ (optional) Community: _____

1. If you know Ganta ETU, and if any staff member from the ETU ever had visited your community, what had they done during that visit to your community?
2. What was the different services the health workers from ETU had been providing to your community?
3. How helpful was the Ebola screening services that the ETU staff had been providing to your community?
4. How helpful was the education on prevention of Ebola that the ETU staff had been providing to your community?
5. From all the inputs/interventions that the ETU staff had had in your community, which one(s) do you value most? And why?
6. What could ETU staff have done more to further increase their support/help to your community in the prevention of Ebola and other diseases and address areas which otherwise were not addressed during the course of the project?
7. How do you think the ETU staff could have helped the community in the prevention of Ebola and other diseases or addressed these gaps?
8. Any additional suggestions comments you would like to provide to PCI?STEP _____

Thank you for your time and contributions

A1.3 STEP End-line Evaluation FGD Guide

STEP End-line Evaluation Notes for Planning, Conducting, and analyzing FGD findings/outcomes

March 12, 2016

A. Planning:

a) *Staffing:* The focus group will have one facilitator/interviewer, who will guide the discussion, and one1 note-taker (and translator, if necessary). At the end of the session, the facilitator/interviewer and the note-taker should debrief in order to ensure that the main themes of the conversation were captured.
b) *Participants:* The focus group is conducted with 6-8 members of the ETU who make up the clinical group, and all have similar characteristics. These members are likely to be participative and reflective.
c) *Scheduling:* The focus group discussion will be done on the dates between March 25th and 30th, and is planned to last about two hours.
d) *Setting:* The focus groups is going to be organized in the staff training room of the then ETU, where participants are well familiar with and hoped to feel comfortable sharing their experiences. The seating will be arranged or configured in such a way that all members can see each other.

B. Essentials of the FGD process – the following basic actions guides will be ensured before, during and after the FGD:

a) A skilled facilitator/interviewer will remain neutral both in speaking tone and body.
b) Ask open-ended questions and being careful not to lead participants to particular answer.
c) *Welcome*: Welcome and thank the participants for sharing their time.
d) *Introductions*: The facilitator/interviewer should introduce him/herself and the note-taker. The facilitator/interviewer should allow the participants to introduce themselves.
e) *Set the stage:* Review the objective of the focus group. Explain how the information will be used and shared. Since the session is often a one-time occurrence, it's useful to have a few, short ground rules to encourage participation: 1) there are no right or wrong answers, 2) everyone's opinion is valued, and 3) we are interested in what was discussed in the session, not WHO said what.
f) *Note Taking:* Explain how the session will be recorded (e.g., notes).
g) *Focus group guide/Interviews and probes*: Ask questions on the focus group/interview guide, and where needed probe to learn additional information. When participants give unclear answers, the facilitator/interviewer should probe for fuller, clearer responses. A few suggested techniques are: repeat the question, explain that you have limited understanding of a subject and ask for specific details, or repeat the participant's reply.
h) *Participation*: Ensure even participation among the group, particularly in cases where one or two people are dominating the conversation.
i) *Conclusion*: Conclude the focus group/interview by thanking the participants for sharing their perspectives, and ask if they have any additional questions.

C. Guiding Principles during the FGD:

a) Only one person talks at a time
b) Assure confidentiality—"What is shared during FGD should not be shared outside FGD"
c) Important to hear everyone's ideas and opinions

d) Important to hear all sides—positive and negative—of issues
e) Important for men's and women's ideas to be represented equally

D. Facilitation – the following facilitation values will be warranted during the FGD:

a. Active listening
    i. Listen carefully and probe based on responses
    ii. Note nonverbal cues and behavior and respond accordingly
    iii. Look at participants when speaking
b. Maintain neutrality
c. Allow silence at times—can encourage elaboration
d. Encourage discussion, not consensus
e. Use probes (open-ended questions):
    i. "Please tell me more about…"
    ii. "Please explain what you mean by…"
f. Avoid interrupting respondents as much as possible
g. Use probes to clarify information
h. Avoid making assumptions—clarify with simple questions
i. Avoid leading respondents
j. Watch your time!

Note: When:

a. <u>Someone Dominates</u>
    i. Acknowledge contributions: "I really appreciate your comments"
    ii. Look directly at rest of group and note "I am interested in learning what other persons think of this issue"
    iii. Directly ask other group members "What do the other group members think about this issue/that comment?"
b. <u>When Women and Men Participate at Different Levels</u>
    i. Use same techniques as in previous slide
    ii. Directly ask women what they think
c. <u>No One Responds</u>
    i. Ask question in a different way
    ii. If topic seems sensitive, move to a less sensitive topic and attempt to bring up more sensitive topic later in discussion
    iii. If participants say they are uncomfortable with topic, thank them and do not bring it up again
    iv. If group appears to have exhausted an issue, ask if there are any additional comments and move on
d. <u>The Group/Interview is Off Topic</u>
    i. Steer group back to main topic, such as "Thank you for that interesting idea. It sounds like something that could be explored at a separate time. For the purposes of exploring the specific topics of this discussion, I would like to move on to the next question."
    ii. Provide a time check.
e. <u>Side Conversations</u>
    i. Stress in ground rules—only one person speaks at a time
    ii. Remind participants respectfully of ground rules
    iii. Ask if participants have something they would like to share with the group
    iv. Take a short break
f. <u>Participants Skip Ahead</u>
    i. As long as participants are discussing the topics, allow them to move ahead

ii. Probe and clarify in order to obtain adequate response to question
iii. Return to previous topics to ensure all FGD questions are answered

g. Participants Begin Leaving
   i. Provide a time check
   ii. Consider focusing on the most important issues before finishing

E. Note Taker: the Note take will be carefully selected to have the following skills.

a) Have good listening skills
b) Have good observation skills
c) Have good writing skills
d) Are able to take notes that are comprehensive but not word-for-word
e) Use the note taking form provided
f) Act as an observer, not as a participant
g) Can remain impartial (i.e., do not give her/his opinions about topics, because this can influence what people say)

F. Important guides to for Note Taking:

a) Record major themes, ideas, comments and observations regarding group dynamics
b) Use Note Taking Form
c) Document verbal and non-verbal communication
d) Document level of consensus among participants
e) When in doubt, don't leave it out!
f) Distinguish clearly between participant comments and your own observations
g) Do not throw away any papers with notes of the focus group discussion.
h) In evening, facilitator/interviewers and note takers should review and consolidate notes to ensure complete documentation
i) Capture any new insights that emerged as a result of this discussion with the facilitator/interviewer.
j) *Save all notes* from FGDs

G. A Quick Guide To Focus Group Analysis:

a) Read through all the answers to a question (from all the focus group transcripts/notes), looking for patterns and similarities.
b) Use the note Taking Form to keep key points together and organized. If a key point is repeated, place a tally mark next to that point. For example, if in answer to the question "What did you like about the savings group?" one participant said "I made new friends," and another said "It gave me a chance to socialize" then the key point would be "socializing," followed by 2 tally marks. Continue listing key points until every answer has been accounted for.
c) When summarizing the overall response to that question, consider:
d) Frequency - how many times the key point was made by different people
e) Specificity - how detailed particular responses were
f) Emotions - how much emotion, enthusiasm, or intensity was expressed in a particular answer?
g) Select a few quotes from the transcript to illustrate and provide insights for your summary.

A1.4 STEP FGD Questionnaire

FGD Questionnaires for ETU Staff

1. How would you justify the service provided by the ETU were high standard and as per the MoH/WHO protocol for EVD care?
2. How would you justify if Ganta ETU have been consistently meeting Liberia Minimum Standards for Safe Care Provision by Healthcare Facilities in the Context of Ebola?
3. What was your direct contribution to maintain the quality of services to be high standard and quality services and as per the MoH protocol for EVD care?
4. What were the supports Ganta ETU providing to Ebola affected families and orphans at the ETU and community level?
5. How had the ETU supported Ebola affected families and orphans to settle and integrate into their community?
6. As a staff of the ETU, what had been the low point of your involvement in the project – things you were not happy with/ disappointed or regretted of happening? Why?
7. If this were the time when the Ebola outbreak being, what would you differently that you have not done in the past?
8. Over all, what do think is the key achievements of PCI/STEP during the course of the project implementation that you believe could make the most difference to strengthening the IPC implementation in Nimba County?

Thank you for your time and contributions

Annex 2: List of Indicators and Results

Ind #	Indicator	Base-line	Disaggregation		LOP Total (to date)	LOP Target	Notes
Goal: Manage the MOHSW-staffed Ebola Treatment Unit (ETU) in Ganta in order to slow the spread of Ebola in Nimba County through the isolation of cases, the provision of a high standard of medical care, and the protection of individuals at the ETU affected by the Ebola outbreak.							
Sector: Health / Sub-Sector 1: Health Systems and Clinical Support							
1.1.1	Ganta ETU consistently meets Liberia Minimum Standards for Safe Care Provision by Healthcare Facilities in the Context of Ebola	NA	NA		100%	100%	Note that even though this is a new indicator added in the project modification approved in Nov 2015, we were collecting this data before and have, therefore, reported the information here.
1.1.2	Ganta ETU WASH facilities consistently meets the Minimum WASH Requirement – Ebola Treatment Unit	NA	NA		100%	100%	Note that even though this is a new indicator added in the project modification approved in Nov 2015, we were collecting this data before and have, therefore, reported the information here.
1.1.3	Number of healthcare facilities supported and/or rehabilitated to treat cases of Ebola by type (e.g. Primary, Secondary, Tertiary	0	Primary		69	1 ETU	Reported monthly per PMP; **required** indicator per USAID/OFDA guidelines
			Secondary		5		
			Tertiary		4		
1.1.4	Number of healthcare providers trained by	0	Doctors	Males	15	**1270**	Target revised in project modification approved Nov 2015. Reported monthly per
				Females	6		

Ind #	Indicator	Base-line	Disaggregation		LOP Total (to date)	LOP Target	Notes
	type (e.g. doctor, nurse, hygienists, physician assistants, midwives, etc.), by sex			Sub-Total	21		PMP; **required** indicator per USAID/OFDA guidelines; should include by type "doctor, nurse, community health worker, midwife, and traditional birth attendant."
			Nurse	Males	252		
				Females	368		
				Sub-Total	620		
			Hygienists	Males	217		
				Females	170		
				Sub-Total	387		
			Physician assistants	Males	35		
				Females	8		
				Sub-Total	43		
			Midwives	Males	4		
				Females	53		
				Sub-Total	57		
			Others	Males	1073		
				Females	1247		
				Sub-Total	2320		
			Total		**3448**		
1.1.5	Number and percentage of health facilities submitting weekly surveillance reports	0	NA		1	1	**Required** indicator per USAID/OFDA guidelines
		0%			100%	100%	

Ind #	Indicator	Base-line	Disaggregation		LOP Total (to date)	LOP Target	Notes
1.1.6	Number of consultations, by sex and age, per quarter	0	0 - 11 mo	Males	656	4,400	By quarter; **required** USAID/OFDA indicator
				Females	608		
				Sub-Total	1264		
			1 - 4 yrs	Males	1924		
				Females	1956		
				Sub-Total	3880		
			5 - 14 yrs	Males	527		
				Females	593		
				Subtotal	1120		
			15 - 49 yrs	Males	652		
				Females	1219		
				Sub-Total	1871		
			50 - 60 yrs	Males	152		
				Females	243		
				Sub-Total	395		
			60+ yrs	Males	119		
				Females	216		
				Sub-Total	335		
			All Ages Combined	Males	4030		
				Females	4835		
				Total	8865		

Ind #	Indicator	Base-line	Disaggregation		LOP Total (to date)	LOP Target	Notes
1.1.7	Number of community events to strengthen community resilience and /or preparedness	NA	Total		42	24	
1.1.8	Number of Healthcare Facilities at which staff are mentored by ETU staff on minimum standards for IPC, triage and use of PPE	NA	Total		46	24	Note that even though this is a new indicator added in the project modification approved in Nov 2015, we were collecting this data before and have, therefore, reported the information here.
1.1.9	Number of healthcare providers mentored by ETU staff on minimum standards for IPC, triage and use of PPE	NA	All Districts	Male	428	324	Note that even though this is a new indicator added in the project modification approved in Nov 2015, we were collecting this data before and have, therefore, reported the information here.
				Female	439		
				Total	**867**		
1.1.10	Percent of days that contaminated objects/surfaces are disinfected with chlorine solution	NA	NA		100%	100%	Indicator removed in the project modification approved in Nov 2015
1.1.11	Percent of days that all contaminated liquid wasted are disinfected and disposed of in designated, secured site	NA	NA		100%	100%	Indicator removed in the project modification approved in Nov 2015

Ind #	Indicator	Base-line	Disaggregation	LOP Total (to date)	LOP Target	Notes
1.1.12	Percent of observations of Handwashing Stations where water and soap were both present	NA	NA	100%	100%	Indicator removed in the project modification approved in Nov 2015
1.1.13	Percent of days in which 70 liters of water per staff per day were available at the ETU	NA	NA	100%	100%	Indicator removed in the project modification approved in Nov 2015
1.1.14	Percent of days in which 2 days of buffer water storage were maintained at the ETU	NA	NA	100%	100%	Indicator removed in the project modification approved in Nov 2015
1.1.15	Percent of drinking water samples from the ETU which had a minimum of 0.5 mg/L (ppm) free residual chlorine (FRC)	NA	NA	100%	100%	Indicator removed in the project modification approved in Nov 2015
Sector: Health / Subsector 2: Medical Commodities Including Pharmaceuticals						
1.2.1	Number and percentage of health facilities, supported by USAID/OFDA, out of	# NA	NA	0	0	Essential medicines include those for managing symptoms (fever, pain discomfort, confusion/aggression, hiccups, vomiting, seizures, ulcers, rash),

Ind #	Indicator	Base-line	Disaggregation		LOP Total (to date)	LOP Target	Notes
	stock of selected essential medicines and tracer products for more than 1 week	% NA			0%	0%	rehydration, testing and treating common conditions with symptoms similar to EVD; r**equired** indicator per USAID/OFDA guidelines
1.2.2	Number of people trained, by sex, in the use and proper disposal of medical equipment and consumables	0	Males		1597	1,970	Target revised in the modification in Nov 2015. **Required** indicator per USAID/OFDA guidelines
			Females		1851		
			Total		3448		
1.2.3	Number of supplies distributed by type	0	County and Local	Medical Kits	0	285,795	For consistency across the various supplies, each item is reported based on the smallest unit possible. Supplies for the effective control of Ebola virus, including sanitation materials and PPE; reported monthly; **required** indicator per USAID/OFDA guidelines
				Equipment	5295		
				Consumables/supplies	585815		
				Sub-Total	591110		
			International Procurement	Medical Kits	0		
				Equipment	7,664		
				Consumables/supplies	989,188		
				Sub-Total	996,852		
			Combined (County,	Medical Kits	-		

Ind #	Indicator	Base-line	Disaggregation		LOP Total (to date)	LOP Target	Notes
			Local, International)	Equipment	13,799		
				Consumables/supplies	1,575,003		
				Total	**1,588,802**		
Sector: Protection / Sub-Sector 1: Child Protection							
2.1.1	Average # of weeks required for resettlement of Ebola orphans back into a family or community setting	NA	NA		1	4	Reported as an average number of weeks. This indicator is included to fulfill USAID/OFDA requirement for second indicator that measures protection outcomes of the proposed activities
2.1.2	Number of people trained in child protection	0	Males		56	30	Target revised in the modification Nov 2015. **Required** indicator per USAID/OFDA guidelines, including disaggregation by sex
			Females		16		
			Total		**72**		
2.1.3	Number of Ebola orphans resettled into a family or community setting.	NA	NA		11	TBD	Note that even though this is a new indicator added in the project modification approved in Nov 2015, we were collecting this data before and have, therefore, reported the information here.

Ind #	Indicator	Base-line	Disaggregation	LOP Total (to date)	LOP Target	Notes
2.1.4	Number of Ebola affected individuals resettled into their community.	NA	NA	0	TBD	Note that even though this is a new indicator added in the project modification approved in Nov 2015, we were collecting this data before and have, therefore, reported the information here.
2.1.5	Ganta ETU has a Child Protection Policy in place	NA	The ETU is using the MoHSW protocol	1	1	Note that even though this is a new indicator added in the project modification approved in Nov 2015, we were collecting this data before and have, therefore, reported the information here.

* Age ranges are as follows: 0-11 months, 1-4 years, 5-14 years, 15-49 years, 50-60 years, and 60+ years, per USAID/OFDA guidelines
(Source: STEP Quarterly Indicator Performance Tracking Table for the period of Jan 1 – March 31, 2016. PCI, April 21, 2016)

Annex 3: Medical Commodities and supplies used/distributed by STEP

S/N	Item Description	Unit	Quantity used this quarter (Jan - Mar 2016)			Cumulative Jan 2015- Mar 2016		
			By the ETU	Distributed to HF	Total	By the ETU	Distributed to HF	Total
Medicines								
1	Alcohol Hand Gel	Btts	0	649	649	0	649	649
2	Alumimium hydroxide 500mg	Tablets	0	500	500	0	500	500
3	Amoxicillin (250mg)	Tabs		0	0	7200	0	7200
4	Amoxicillin 125mg oral susp	Bottles	0	9	9	0	9	9
5	Amoxicillin 250mg capsules BP	STRIPS	0	13	13	0	13	13
6	Amoxicillin 500mg	cap		0	0	5370	0	5370
7	Amoxicillin 500mg capsules BP	STRIPS	0	12	12	0	12	12
8	Antibactrium dressing jell	Bottles	0	9	9	0	9	9
9	Antibiotic Ointment	Tubes	0	0	0	3	0	3
10	Antibiotic Pain Relief Cream	Tubes	0	0	0	15	0	15
11	Anticide 500mg	Tabs	0	0	0	1000	0	1000
12	Artemether (15kg less than 20kg) (Coartem)	Strips	0	227	227	0	227	227
13	Artemether 20mg+Lumefantrine 120mg 5kg<15kg	STRIPS	0	30	30	0	30	30
14	Artemether 20mg+Lumefantrine 120mg 35kg above	STRIPS	0	110	110	0	110	110
15	Artesunate 60mg IV	vial		211	211	156	211	367
16	Ascorbic Acid 250mg	Tabs		900	900	2000	900	2900
17	Atropin salphate	AMPS	0	100	100	0	100	100
18	Avelox 400mg	Tablets	0	420	420	0	420	420
19	Azithromycin 250mg	Tablets	0	6	6	0	6	6
20	Bactigel	pcs.	1	6	7	1	6	7
21	Calcium Gluonat	AMPS	2	300	302	2	300	302
22	Cefixicime (400mg)	Tabs		0	0	120	0	120
23	Cefixime 200mg	Tablets	0	3,948	3948	0	3948	3948
24	Cefixime 200mg/tablet	Tablets	0	16,504	16504	0	16504	16504
25	Ceftriaxone	Vials		0	0	50	100	150
26	Ceftriaxone 1000mg	vial		0	0	94	0	94
27	Ceftriaxones sodium Eq 1 g base power vial	Vials	0	2,885	2885	0	2885	2885
28	Ceftriaxones sodium Eq 250mg base power vial	Vials	0	15,950	15950	0	15950	15950
29	Chloramphenicol 1g	vial			0	10	0	10
30	Cimetidine 200mg	amp			0	10	0	10
31	Cimetidine 400mg	Tabs			0	50	0	50
32	Ciprofloxacin (250mg)	Tabs			0	1600	0	1600
33	Ciprofloxacin (500mg)	Tabs		630	630	4000	630	4630
34	Ciprofloxacin 500mg tabs pacs 10	PKS	0	3800	3800	0	3800	3800
35	Coartem 15-25kg	Strip		30	30	443	30	473

S/N	Item Description	Unit	Quantity used this quarter (Jan - Mar 2016)			Cumulative Jan 2015- Mar 2016		
			By the ETU	Distributed to HF	Total	By the ETU	Distributed to HF	Total
36	Coartem 25-35kg	Strip		59	59	340	59	399
37	Coartem 35 above	Strip		175	175	349	175	524
38	Coartem 5-15kg	Strip		30	30	480	30	510
39	Co-trimaxazole syrup	btts		40	40	160	40	200
40	Co-trinoxazole 120mg	Tablets	0	3960	3960	0	3960	3960
41	Dexamethasone(4mg/ml)	Amp		2350	2350	190	2350	2540
42	Dextouse-5%	Btts		12	12	24	72	96
43	Dextros-50% (D-50%)	Btts			0	42	60	102
44	Dextroxe 5% (1000ml)	CRT	0	120	120	0	120	120
45	Diazapan 10mg	amp			0	23	0	23
46	Diazepam 5mg	Tablets	0	1830	1830	0	1830	1830
47	Dispensing bag	pcs		1800	1800	3200	1800	5000
48	DNS 1000ml	Btts		258	258	80	288	368
49	Doxycline 100mg	Tabs			0	1060	0	1060
50	Epinephrine 1mg/ml amp box 10	BOXES	0	3,500	3500	0	3500	3500
51	Epinephrine Galenica Senese	pks.	0	1,200	1200	0	1200	1200
52	Epinphrine Galenica IV	AMPS	0	500	500	0	500	500
53	Erythromycin (333mg	Tabs			0	459	0	459
54	Ferrous	Tabs		3000	3000	4000	3000	7000
55	Furesemide	pcs.	0	100	100	0	100	100
56	G-50%	Btts			0	1	0	1
57	Galenica H2O vial	pcs.	0	400	400	0	400	400
58	Gentamicin(40mg/ml)	Amp			0	400	0	400
59	Gentamycin 80mg	amp			0	30	0	30
60	Gestifloxacin (Eye Drop)	Btts			0	4	0	4
61	Girl Friend Hand & Body Lotion	bts.	0	9	9	0	9	9
62	Glenica senese water for injection	AMPS	0	400	400	0	400	400
63	Glucose 5% 500ml/box 20	bts.	0	1,708	1708	0	1708	1708
64	Glucose 50% IV GV	Vials	0	927	927	0	927	927
65	Glucose Inj. 50% W/v	bts.	0	854	854	0	854	854
66	Glucose Injection	pks.	0	5	5	0	5	5
67	Haloperidol 5mg for Injection 5mg in 1ml	AMPS	0	11,000	11000	0	11000	11000
68	Hydrocorlisone sodium succinate IV 100mg	Vials	0	2,900	2900	0	2900	2900
69	Hydrocortisone 100mg	Vials			0	43	0	43
70	Hyoscine 20mg	amp		300	300	20	300	320
71	Infusion set kit	pcs.	0	2280	2280	0	2280	2280
72	Lansoprazole (30mg)	Tabs			0	630	0	630
73	Levofloxacin (500mg)	Tabs			0	1000	0	1000
74	Levofloxacin (750mg)	Tabs			0	1900	0	1900
75	Magellan (1ml Insulin Safety Syringe)	pcs.	0	0	0	50	0	50

S/N	Item Description	Unit	Quantity used this quarter (Jan - Mar 2016)			Cumulative Jan 2015- Mar 2016		
			By the ETU	Distributed to HF	Total	By the ETU	Distributed to HF	Total
76	Mebendazole 500mg	Tabs	0		0	500	0	500
77	Metoclopramide	amp	0	4000	4000	100	4000	4100
78	Metro infusion 500mg	btts	0		0	4	0	4
79	Metroclopramide 10mg	Tabs	0	101,750	101750	1000	101750	102750
80	Metroclopromide 500mg	amp	0		0	2450	150	2600
81	Metronidazole 250mg	Tabs	0		0	73	0	73
82	Metronidazole 500mg	Tabs	0	200	200	8051	200	8251
83	Metronidazole 5mg	AMPS	0	100	100	0	100	100
84	Metronidazole IV	Bottles	0	416	416	0	416	416
85	Morphine sulfate 10mg	Tablets	0	12,000	12000	0	12000	12000
86	Morphine sulfate IV	AMPS	0	3,950	3950	0	3950	3950
87	Multi-Symptom cold	btts	0		0	3	0	3
88	Multi-vitamin 200mg	Tabs	0		0	5101	1000	6101
89	Neosporin+ pain relief	tubes	0	3	3	0	3	3
90	Normal Saline 1000ml	btts	0		0	66	30	96
91	Nystatin USP 100,000IU	Tablets	0	200	200	0	200	200
92	Omeprazole 20mg	PK	0	8	8	0	8	8
93	Omeprazole(40mg)	Amp	0		0	88	0	88
94	ORS	Sachet	0	20000	20000	4000	20000	24000
95	ORS Low osm 20.5g/L CAR/100	Sachet	0	55,500	55500	0	55500	55500
96	Oxytocin 10IU	AMPS	0	10	10	0	10	10
97	Paracetamol 100mg	Tabs	0	30200	30200	5200	30200	35400
98	Paracetamol 125mg oral solution	Bottles	0	475	475	0	475	475
99	Paracetamol 125mg/5ml, 60ml solution	Bottles	0	580	580	0	580	580
100	Paracetamol 325 mg	Tabs	0	980	980	58	980	1038
101	Paracetamol 500mg	Tabs	0		0	9450	0	9450
102	Paracetamol 500mg tabs pacs 100	PACK	0	12,163	12163	0	12163	12163
103	Paracetamol syrup	btts	0		0	70	0	70
104	Paracetamol syrup 100mg	btts	0		0	3	0	3
105	Povidone Iodine solution 10% bottle 200ml	PCS	0	400	400	0	400	400
106	Promethazine 25mg	Tabs	0	42000	42000	2100	42000	44100
107	Ringer Lactate 1000ml	btts	0	108	108	86	132	218
108	Robitussin 20mg	Tablets	0	800	800	0	800	800
109	Salbutamol 4mg	Tabs	0	90	90	100	90	190
110	Salbutmol sulfate 0.1mg/puff 200 puff, aerosal	pcs	0	200	200	0	200	200
111	Septrim 480 mg	Tabs	0		0	2000	0	2000
112	Silvrstat (Antibacterial wound dressing gel)		0	94	94	0	94	94
113	Sodium chloride 0.9%	Bottles	0	747	747	0	747	747

S/N	Item Description	Unit	Quantity used this quarter (Jan - Mar 2016)			Cumulative Jan 2015- Mar 2016		
			By the ETU	Distributed to HF	Total	By the ETU	Distributed to HF	Total
114	SODIUM LACTATE Comp inj 1000ml w/g. set box 10	PCS	0	2,068	2068	0	2068	2068
115	SODIUM LACTATE Comp inj 500ml w/g. set box 50	PCS	0	4,160	4160	0	4160	4160
116	Sterile water 1000ml	Btts	0	60	60	0	60	60
117	Tetracycline 1%	tubes	0	500	500	0	500	500
118	Vitamin A oral	cap	0	2,500	2500	0	2500	2500
119	Water for injection 10ml plastic ampule	PCS	0	24,000	24000	0	24000	24000
120	Zinc 20mg tablets, pac 100	PKS	0	3,400	3400	0	3400	3400
121	Zinc sulfate 20mg	Tablets	0	5,300	5300	0	5300	5300
Medical Supplies and consumables								
122	3M particulate Respiratory mask	Pcs	0	**7,680**	7680	0	7680	7680
123	Absorbent Cotton Guaze Swab (10 x 10cm)	ROLL	0	1,035	1035	0	1035	1035
124	ABSORBENT COTTON GUAZE SWAB	ROLL	0	4,800	4800	0	4800	4800
125	ABSORBENT COTTON GUAZE SWAB (7.5X7.5 CM)	ROLL	0	214	214	0	214	214
126	ABSORBENT COTTON WOOL (500G)	ROLL	0	183	183	0	183	183
127	ABSORBENT GAUZE PAD	Pcs	0	504	504	0	504	504
128	ABSORBENT PAD	PCS	0	1,500	1500	0	1500	1500
129	Adhesive tape	roll	0	114	114	11	114	125
130	Adult Diapers Large Size	Case	0	717	717	0	717	717
131	Adult Diapers Madium/regular size	CASE	0	144	144	0	144	144
132	Adult Diapers small size	CASE	0	144	144	0	144	144
133	AERO CHAMBER	PCS.	0	18	18	0	18	18
134	Alcohol and Betadine Pads & Swabs	PCS	0	4,950	4950	0	4950	4950
135	ALCOHOL PAD	PCS	0	500	500	0	500	500
136	Applicator Swabs (Q-Tips), Tongue Depressors, Cotton Balls	PCS	0	16,000	16000	0	16000	16000
137	Applicator Swabs (Q-Tips), Tongue Depressors, Cotton Balls	PCS	0	5,600	5600	0	5600	5600
138	Assorted Anesthetic materials	pcs	0		0	0	1500	1500
139	Assorted Foley catheter	pcs	0		0	0	503	503
140	Assorted Guazes and Bardanges	ROLL	0	244	244	0	244	244
141	Assorted IV cannulas	pcs	0	0	0	0	2013	2013
142	Assorted lubricating gel	pcs	0	0	0	0	5107	5107
143	Assorted medical gel	pcs	0	0	0	0	503	503
144	Assorted skin lotion	Btts	0	0	0	0	76	76
145	Assorted wound dressing materials	pcs	0	0	0	0	210	210

S/N	Item Description	Unit	Quantity used this quarter (Jan - Mar 2016)			Cumulative Jan 2015- Mar 2016		
			By the ETU	Distributed to HF	Total	By the ETU	Distributed to HF	Total
146	BABY JOHNSON POWDER	PCS	0	99	99	0	99	99
147	Bandage	roll	0		0	15	0	15
148	Bandages elastic	ROLL	0	91	91	0	91	91
149	Bandages gauzes	ROLL	0	282	282	0	282	282
150	Bandaids, Steristrips, Tape, Transparent Dressings	ROLL	0	8,500	8500	0	8500	8500
151	Bandaids, Steristrips, Tape, Transparent Dressings (tegaderm)	PCS	0	21,909	21909	0	21909	21909
152	BD SYRINGE (10ML)	PCS	0	600	600	0	600	600
153	BD VACUTAINER	PKS	0	3,000	3000	0	3000	3000
154	BD VACUTAINER REF: 364815	PCS	0	200	200	0	200	200
155	Blood Access tray	Set			0	0	6	6
156	Blood collection tubes	pcs			0	0	36	36
157	Blood Drawing Supplies (Vacutainer Holders & Needles, Butterflies, Lancets, Tourniquets)	pcs	0	9,464	9464	0	9464	9464
158	BLOOD LANCET	PCS	0	10	10	0	10	10
159	Blood transfusion tubing	pcs	0	0	0	0	73	73
160	Bottle plastic 250ml, wash bottle	PCS.	0	21	21	0	21	21
161	BREATHING CIRCUIT	PCS.	0	58	58	0	58	58
162	Broom and stick	PCS.	0	4	4	0	4	4
163	Buffalo Caps, Prn Adaptors And Other IV Infusion Supplies, Vial Spikes And Adaptors	PCS	0	6	6	0	6	6
164	Bulb Syringe (60ml)	PCS	0	74	74	0	74	74
165	Cannula 16g	pcs	0	781	781	0	781	781
166	Cannula 18g	pcs		2008	2008	15	2008	2023
167	Cannula 20g	Pcs		2126	2126	54	2126	2180
168	Cannula 22g	pcs		3459	3459	37	3459	3496
169	Cannula 24g	Pcs		530	530	35	530	565
170	Cannulas (23g)	Pcs	0	97	97	0	97	97
171	Canulas (14g)	Pcs	0	303	303	0	303	303
172	CHEMSPLASH (ENVRO GUARD)	PCS	0	780	780	0	780	780
173	Children's Diapers	Cases	0	210	210	0	210	210
174	Cidex Solution test strip	pcs			0	0	311	311
175	COMMODE TOILET TAP	PCS	0	2	2	0	2	2
176	Cotton	Roll			0	6	1	7
177	COTTON BALLS	PKS	0	95900	95900	0	95900	95900
178	Cotton roll	pcs	0	1	1	0	1	1
179	COTTON WOOL (500G)	ROLL	0	45	45	0	45	45
180	CREPE BANDAGE (10CM X 45M)	PKS	0	135	135	0	135	135
181	Disposable Bedding Kits	PCS	0	164	164	0	164	164

S/N	Item Description	Unit	Quantity used this quarter (Jan - Mar 2016)			Cumulative Jan 2015- Mar 2016		
			By the ETU	Distributed to HF	Total	By the ETU	Distributed to HF	Total
182	Disposable Syringes 2/3ml	pcs	0	300	300	0	300	300
183	Disposable syrings 5ml	pcs	0	1,183	1183	0	1183	1183
184	DRAINABLE POUCH	PCS.	0	2	2	0	2	2
185	Drapes Non-Sterile	PCS	0	760	760	0	760	760
186	ELASTIC BANDAGE (8CM X 5CM)	ROLL	0	1,120	1120	0	1120	1120
187	ELASTIC EARLOOP FACE MASK	PCS	0	65,400	65400	0	65400	65400
188	ELASTIC GUAZE BANDAGE (10CM X 4M)	ROLL	0	5,000	5000	0	5000	5000
189	ELASTIC GUAZE BANDAGE (6CM X 10CMX 4M)	ROLL	0	8,000	8000	0	8000	8000
190	ELASTIC GUAZE BANDAGE (6CM X 4M)	ROLL	0	20	20	0	20	20
191	EMPTY BOTTLES FOR DRUG (MEDICINE)	PCS	0	45	45	0	45	45
192	EPIDURAL LINES	PCS.	0	50	50	0	50	50
193	FEEDING TUBE (100CM)	PCS	0	95	95	0	95	95
194	FEEDING TUBE (40CM)	PCS	0	200	200	0	200	200
195	FEEDING TUBE ADJUSTABLE (ADULT 120CM) (PEDIATRIC 40CM)	PCS	0	200	200	0	200	200
196	First infant milk	btts			0	18	0	18
197	FOG FREE PROCEDURE MASK SO SOFT LINNING	PCS	0	400	400	0	400	400
198	Foley bags	Pcs			0	6	0	6
199	Foley Balloon catherter 18fr	pcs	0	219	219	0	219	219
200	Foley catheter	Set			0	17	61	78
201	FOLEY TRAY WITH BARD	pks.	0	35	35	0	35	35
202	Gauze And All Other Non-Sterile Dressings	PCS	0	875	875	0	875	875
203	GAUZE PAD (10 X 10) CM	PCS	0	250	250	0	250	250
204	GAUZE PAD (10 X 10) CM	PCS	0	200	200	0	200	200
205	Gauze pad 2x2, 4x4	box			0	0	1	1
206	GAUZE SWABS (10 X 10) CM. 8 FACH/PLY	PCS	0	1,000	1000	0	1000	1000
207	GAUZE SWABS (7.5 X 7.5) CM. 8 FACH/PLY	PCS	0	2,000	2000	0	2000	2000
208	Gloves	PCS	0	60	60	0	60	60
209	Gloves Exam, latex, power free, medium box 100	PCS	0	21	21	0	21	21
210	Gloves, Sterile	Pair	0	500	500	0	500	500
211	Glucose Meters	Pks			0	4	0	4
212	GRAVITY FEEDING BAG	PCS.	0	30	30	0	30	30
213	GURNEY first KITS	PCS	0	500	500	0	500	500
214	High Quality Bopp Tape	PCS	0	50	50	0	50	50

S/N	Item Description	Unit	Quantity used this quarter (Jan - Mar 2016)			Cumulative Jan 2015- Mar 2016		
			By the ETU	Distributed to HF	Total	By the ETU	Distributed to HF	Total
215	HOSPITAL BED (Gurney)	PCS	0	2	2	0	2	2
216	HOSPITAL MATRESS	PCS	0	12	12	0	12	12
217	I.V. CATHETER WITH WINGS AND INJECTION PORT (18G/45MM. (1 3/4")MM	PCS	0	700	700	0	700	700
218	INFUSION GIVING SET	PCS	0	3,628	3628	0	3628	3628
219	Infusion set	tubes	0		0	0	0	0
220	INLINE BURETTE SET 150ml	PCS.	0	18	18	0	18	18
221	INNER CANNULAS	PCS.	0	60	60	0	60	60
222	IRRIGATION SYRINGES TUBES AND TRAYS	PCS.	0	21	21	0	21	21
223	IV / NG tubing	Pcs			0	447	0	447
224	Iv Cannulas 20g	Pcs			0	0	50	50
225	Iv Cannulas 22g	Pcs			0	0	50	50
226	IV Cannulas 24g	Pcs			0	0	50	50
227	IV CATHETER 14g	PCS.	0	303	303	0	303	303
228	IV CATHETER 16g	PCS.	0	407	407	0	407	407
229	IV CATHETER 18g	PCS.	0	1,824	1824	0	1824	1824
230	IV CATHETER 20g	PCS.	0	2,070	2070	0	2070	2070
231	IV CATHETER 22g	Pcs.	0	3,309	3309	0	3309	3309
232	IV CATHETER 24g	PCS.	0	480	480	0	480	480
233	IV CATHETER/HUBER, BUTTERFLY FISTULA	PCS.	0	400	400	0	400	400
234	IV Primary Tubing	PCS	0	1,617	1617	0	1617	1617
235	IV START KIT	PCS.	0	100	100	0	100	100
236	IV SYSTEM DIMISION	pks.	0	600	600	0	600	600
237	IV tubing	Pcs			0	100	200	300
238	IV TUBING/NG TUBING	PKS	0	1725	1725	0	1725	1725
239	Lancet	Pcs			0	0	100	100
240	LATEX SURGICAL GLOVES	PCS	0	5,000	5000	0	5000	5000
241	LIMB HOLDER+	PCS.	0	6	6	0	6	6
242	LINERS, TRASH, CAN LAUNDRY	PCS	0	24	24	0	24	24
243	Lubricating Gel	PCS	0	60	60	0	60	60
244	Magellan 1m Syringes	pcs	0	50	50	0	50	50
245	Malaria Test	pcs			0	170	0	170
246	Medication Cup	Pcs			0	0	50	50
247	NASAL CANNULAS (Oxygen Mask)	PCS.	0	197	197	0	197	197
248	NASAL OXYGEN CANNULA	PCS.	0	238	238	0	238	238
249	Needles (21G)	Pcs			0	2024	2000	4024
250	NEEDLES 19g	PCS.	0	12,200	12200	0	12200	12200
251	NEEDLES 21g	PCS.	0	11,600	11600	0	11600	11600

S/N	Item Description	Unit	Quantity used this quarter (Jan - Mar 2016)			Cumulative Jan 2015- Mar 2016		
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252	NEEDLES 22g	PCS.	0	100	100	0	100	100
253	NEEDLES 23g	PCS.	0	400	400	0	400	400
254	NG Tube 6fr	pcs	0	39	39	0	39	39
255	NG Tube 8fr	pcs	0	51	51	0	51	51
256	Nitrile Powder Free Midical Examination gloves (Medium)	PCS	0	7,200	7200	0	7200	7200
257	Nitrile Powder Free Midical Examination gloves (Small)	PCS	0	2,000	2000	0	2000	2000
258	Nulife B alloon catherter 14fr	pcs	0	84	84	0	84	84
259	ORAL NASAL TRACHEAL TUBES	PCS.	0	48	48	0	48	48
260	Oxygen face mask	Pcs			0	5	0	5
261	Oxygen nasal prong	Pcs			0	9	0	9
262	PATIENT BED SHEETS (60 X 90) CM	PCS	0	188	188	0	188	188
263	PATIENTS BED SHEETS (40 X 60) CM	PCS	0	1,500	1500	0	1500	1500
264	Pediatric IV tubing	pcs			0	0	103	103
265	PILLOWS	PCS	0	67	67	0	67	67
266	Plastic disposable ampule opener	BOX	0	100	100	0	100	100
267	PLASTIC MEDICINE BAG (Dispensing Bag)	PCS	0	2,800	2800	0	2800	2800
268	Plston Syringes 60ml	pcs	0	50	50	0	50	50
269	Plumpy Nuts	Pcs			0	13	0	13
270	Power Milk (F-75)	Pcs			0	10	0	10
271	PRESSURE INFUSER	PCS.	0	64	64	0	64	64
272	Radial artery catheter tray	Pks			0	0	23	23
273	SILICONE COATED LATEX FOLEY CATHETER	pks.	0	96	96	0	96	96
274	Specimen Bag	pcs	0	74	74	0	74	74
275	specimen CUPS	PCS	0	700	700	0	700	700
276	SPECIMEN CUPS	PCS.	0	100	100	0	100	100
277	SPONGE FOAM MATTRESS	PCS	0	22	22	0	22	22
278	Sterile needles	pcs	0	8,300	8300	0	8300	8300
279	STOMACH TUBE (125CM)	PCS	0	75	75	0	75	75
280	STOMACH TUBE/ Dual Limen	PCS.	0	54	54	0	54	54
281	Straight catheter	pcs			0	0	125	125
282	STRETCHER SHEET (WHITE & BLUE)	PCS	0	1,600	1600	0	1600	1600
283	Surgical gloves	Pairs	0	3720	3720	2210	5070	7280
284	surgical mask	pcs	0	0	0	320	0	320
285	surgical mask 3-M	pcs	0	0	0	1080	0	1080
286	Surgical Skin Marker	PCS	0	32	32	0	32	32

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287	SUTURE POLYPROPYLENE	PKS.	0	396	396	0	396	396
288	SWABSTICK	PCS.	0	71	71	0	71	71
289	SYRING	PCS.	0	31	31	0	31	31
290	SYRINGE (2ML)	PCS	0	3,600	3600	0	3600	3600
291	Syringe (5ml)	Pcs		1606	1606	300	1706	2006
292	SYRINGE [50ML)	PCS	0		0	0	0	0
293	Syringe 10ml	pcs			0	342	25	367
294	Syringe 12ml	pcs		12,849	12849	30	12849	12879
295	Syringe 6ml	Pcs		2,100	2100	16	2100	2116
296	Syringe(2/3ml)	Pcs			0	100	100	200
297	Syringe(20ml)	Pcs		216	216	144	256	400
298	Syringe 3ml	pcs	0	1,500	1500	0	1500	1500
299	Syringes 30ml-BD	PCS	0	31	31	0	31	31
300	Syringes 3cc (With needles-20g)	PCS	0	47	47	0	47	47
301	Syringes 3cc (With needles-21g)	PCS	0	239	239	0	239	239
302	Syringes Hypodermic safety needls	pcs	0	150	150	0	150	150
303	Syringes, 1 cc/tb	PCS	0	6,923	6923	0	6923	6923
304	Syringes, 10cc & 12cc	PCS	0	7,563	7563	0	7563	7563
305	Syringes, 3cc (With needles- 23g)	PCS	0	11,281	11281	0	11281	11281
306	TRANS-PAC BIFUCATED MMONITORING	PCS.	0	5	5	0	5	5
307	Underpads, (Chux and Blue Pads)	PCS	0	4	4	0	4	4
308	Urinary Catheters (Straight)	PCS	0	563	563	0	563	563
309	Urinary Drainage Bags	PCS	0	14	14	0	14	14
310	URINARY/Uro-Trapper Drain Bag	PCS.	0	10	10	0	10	10
311	Vaseline	PCS	0	72	72	0	72	72
312	Veno Catheter (18g)	Pcs	0	0	0	30	0	30
313	Veno Catheter (20g)	Pcs	0	0	0	30	0	30
314	Veno Catheter (22g)	Pcs	0	0	0	30	0	30
315	Vinyl Pillow Case	PCS	0	18	18	0	18	18
316	VOLUMETRIC INCENTIVE SPIROMETER	PCS.	0	15	15	0	15	15
317	WHITE BED SHEET	PCS	0	35	35	0	35	35
318	WOODEN TONGUE DEPRESSOR	PCS	0	900	900	0	900	900
IPC Supplies and Commodities								
319	Abd Sterile Dressings 2x2, 4x4,	Pcs	0	5	5	0	5	5
320	Accent cleansing wash	btts			0	116	0	116
321	Alcohol	Btts		113	113	0	137	137
322	ANTIBACTERIAL LOTION SOAP WITH MOISTERIZERS	LITER	0	6	6	0	6	6
323	Applicator swab	pcs			0	0	800	800
324	Apron protection	PCS.	0	850	850	0	850	850

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325	Aprons (Green Aprons)	PCS.	0	90	90	0	90	90
326	Aprons (Surgical Aprons)	PCS	0	300	300	0	300	300
327	Bactigel Hand sanitizer	Bottles	0	3	3	0	3	3
328	BATH SOAP (BROWN) WARREN TRICOMI	CAKES	0	3,687	3687	0	3687	3687
329	Bathing soap	Cakes			0	999	0	999
330	Bathing towel	Pcs			0	5	0	5
331	Bed sheet	Pcs			0	15	56	71
332	Bio hazard bags (Plastic Roll Black)	Roll	0	99	99	0	99	99
333	BLACK BUCKET PLASTIC	PCS	0	143	143	0	143	143
334	blanket	Pcs			0	8	0	8
335	Blanket/Bed sheet	Pcs			0	19	50	69
336	Bleach	Gal			0	390	198	588
337	Bleach Classic	gal			0	467	0	467
338	Bleach Classic	btts			0	587	0	587
339	Bleach Classic (128 oz. Gallons)	Gasl	0	2914	2914	0	2914	2914
340	Body bag	pcs			0	0	90	90
341	Bopp Tape	roll			0	6	0	6
342	BOUFFANT CAP(Blue)	PCS	0	3500	3500	0	3500	3500
343	Broom with stick	Pcs			0	9	0	9
344	Brushes (Black)	PCS	0	48	48	0	48	48
345	BUCKET Without hole)-Small	PCS	0	69	69	0	69	69
346	Bucket + Lid, White plastic	PCS.	0	22	22	0	22	22
347	Bucket 20L with hole	PCS.	0	11	11	0	11	11
348	Bucket with top	PCS.	0	100	100	0	100	100
349	Buto-Asma	pks			0	4	0	4
350	Buto-asna	pks	0	45	45	0	45	45
351	Children clothes	Pcs			0	21	0	21
352	Children Diaper size 3	PCS	0	186	186	0	186	186
353	Children Diaper size 4	PCS	0	160	160	0	160	160
354	Chlorine	Btts			0	4	5	9
355	Chlorine (25kg)	Bucket		202	202	7	202	209
356	Chlorine (45kg)	Bucket			0	8	0	8
357	Clean & Fresh Liquid soap	btts			0	27	0	27
358	Clean and Fresh	Btle	0	35	35	0	35	35
359	Cleansing Wash	Btts			0	142	0	142
360	Clorox (Bleach)	Gals	0	63	63	0	63	63
361	Clothing Detergent (40lb pail)	GAL	0	3	3	0	3	3
362	Condom	Box	0	0	0	1544	0	1544
363	Containers, Basins, Emesis, Water Mugs, Pitchers, Glassware	pcs	0	1,601	1601	0	1601	1601

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364	Cup 250ML, green	PCS	0	89	89	0	89	89
365	DANLINE / TWINE ROPE	BOXES	0	6	6	0	6	6
366	DETERGENT POWDER SOAP(KLIM SOAP)	Sachet	0	378	378	0	378	378
367	DETOL (ANTISEPTIC DISINFECTANT)	Bottle	0	18	18	0	18	18
368	Dettol	btts			0	77	0	77
369	Diamond- PLASTIC WRAP	PCS	0	15	15	0	15	15
370	Disinfectant and Skin Cleansing Products	pcs	0	1,476	1476	0	1476	1476
371	Disposable Aprone	Pcs			0	100	0	100
372	Disposable cups	Pcs			0	926	100	1026
373	Disposable Examination gloves	pcs			0	15900	176000	191900
374	Disposable Face mask with anti-fog shield (2 boxes, 200 per box)	CRT	0	800	800	0	800	800
375	Disposable fork	Pcs			0	500	0	500
376	DISPOSABLE HOOD (E- HOOD)	PCS	0	4500	4500	0	4500	4500
377	Disposable plate	Pcs			0	1288	0	1288
378	Disposable Plates	Pcs			0	202	100	302
379	Disposable spoon	pcs			0	914	0	914
380	Disposable Spoons	Pcs			0	106	100	206
381	Drape Sterile	pcs			0	0	28	28
382	Drapes, Non-sterile	PCS	0	336	336	0	336	336
383	Drapes, sterile	PCS	0	712	712	0	712	712
384	Dressing Change Kits, Laceration Trays, wound Care	PCS	0	52	52	0	52	52
385	Duct Tape	roll			0	11	0	11
386	Emergency Cadaver Bag	PCS	0	15	15	0	15	15
387	Examination Gloves (XL)	Pair	0	1,700	1700	0	1700	1700
388	EXAMINATION GLOVES POWDER FREE LATEX (XL)	BOXES	0	150	150	0	150	150
389	Examination gloves	Pcs		560	560	5720	1560	7280
390	Examination Gloves (L)	PCS	0	5,750	5750	0	5750	5750
391	Examination Gloves (M)	PKS	0	5,500	5500	0	5500	5500
392	Examination Gloves (S)	PKS	0	5,100	5100	0	5100	5100
393	EXAMINATION GLOVES POWDER FREE, LATEX (L)	PCS	0	2,000	2000	0	2000	2000
394	EXAMINATION GLOVES POWDER FREE, LATEX (M)	PCS	0	25,000	25000	0	25000	25000
395	EXAMINATION GLOVES POWDER FREE, LATEX (S)	PCS	0	4,000	4000	0	4000	4000
396	Exergen	pcs	0	12	12	0	12	12
397	Eye wash refill bottles	BTS.	0	6	6	0	6	6

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398	Face Mask (Goggles, Protective , Surgical)	PCS	0	960	960	0	960	960
399	Face caps	Pcs			0	54	0	54
400	Face Mask - Surgical, Medline	PCS	0	4,920	4920	0	4920	4920
401	Face Mask (3M Respirator)	PCS	0	7,680	7680	0	7680	7680
402	Face Mask (3M- Tie- on)	PCS	0	16,200	16200	0	16200	16200
403	Face Mask (3M- Tie- on)-Loose	PCS	0	32,800	32800	0	32800	32800
404	Face Mask (Ear loop Shield)	PCS	0	400	400	0	400	400
405	Face Mask (Goggle, Protective, Surgical)	PCS	0	12,100	12100	0	12100	12100
406	Face Mask (Medical Protective)	PCS	0	50	50	0	50	50
407	Face Mask (Protective)	PCS	0	400	400	0	400	400
408	Face Mask (Smart Seal Surgical)	PCS	0	4,200	4200	0	4200	4200
409	Face Mask (Surgical) Kimberly Clark	PCS	0	900	900	0	900	900
410	Face Mask (N-95 Particulate- 3M)	PCS	0	20,000	20000	0	20000	20000
411	Face Mask (N-95 Respirator) 4 Pannel	PCS	0	3,500	3500	0	3500	3500
412	Face Mask (Respirator)	PCS	0	400	400	0	400	400
413	Face Mask (Tecnol Procedure)	PCS	0	500	500	0	500	500
414	Face mask ear loop with shield	pcs		0	0	1400	0	1400
415	Face Mask(Fluid Shield Fog- Free)	PCS	0	800	800	0	800	800
416	FACEMASK (HONEYWELL)	PCS	0	7,800	7800	0	7800	7800
417	Facial Tissue (Board Walk)	CRT	0	352	352	0	352	352
418	Fleece blanket- Dark green and Claret/garnet	PCS	0	996	996	0	996	996
419	Floor towel	Pcs		0	0	9	45	54
420	FLOOR TOWEL SCRUB	PCS	0	103	103	0	103	103
421	FOLIODRESS GOWN L/S	PCS	0	308	308	0	308	308
422	FOLIODRESS GOWN XL/S	PCS	0	224	224	0	224	224
423	Gloves Heavy duty	Pair	0	2,416	2416	0	2416	2416
424	Gloves Heavy duty, rubber/nitrile (Atlas, Large)	Pair	0	60	60	0	60	60
425	Gloves Heavy duty, rubber/nitrile , (L)-Clean Expert	Pair	0	1,872	1872	0	1872	1872
426	Gloves Heavy duty, rubber/nitrile pair L	PCS	0	120	120	0	120	120
427	Gloves Heavy duty, rubber/nitrile pair M	PCS	0	300	300	0	300	300
428	Gloves Heavy duty, rubber/nitrile pair S	PCS	0	80	80	0	80	80
429	Gloves, Non-sterile	Pair	0	1,000	1000	0	1000	1000
430	Goggle	pcs		151	151	447	755	1202
431	GOGGLE CLEANER	PCS	0	100	100	0	100	100
432	Goggles Safety (Uvex)	PCS	0	300	300	0	300	300

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433	Goggles Safety (Proviz Gard)	PKS	0	156	156	0	156	156
434	Goggles Safety (Pyramex)	PCS	0	2,453	2453	0	2453	2453
435	Goggles, Chemical Splash Vent Caps	CRT	0	325	325	0	325	325
436	Goggles, Masks, And Face Protection	PACK	0	2,880	2880	0	2880	2880
437	Goggles, Masks, And Face Protection	PACK	0	12,100	12100	0	12100	12100
438	Golggles Safety	PCS	0	40	40	0	40	40
439	Gown Foliodress	pcs			0	1040	0	1040
440	Gown Polywear - R	pcs			0	1400	1300	2700
441	Gowns, Patient, Inc Paper, Protector Cover-up	PCS	0	120	120	0	120	120
442	Gowns, Surgical, Non-sterile	PCS	0	386	386	0	386	386
443	Gowns, Surgical, Sterile	PCS	0	676	676	0	676	676
444	GREEN APRON (RUBBER)	PCS	0	205	205	0	205	205
445	Gueney Cover Dispos(Euipment Cover)	PCS	0	288	288	0	288	288
446	Gurney (Gurney Kits)	PCS	0	500	500	0	500	500
447	Gurney Cover	Pcs			0	6	0	6
448	Hair cover/hood	pcs		6000	6000	200	7900	8100
449	Hand Sanitizer	btts		24	24	4795	1752	6547
450	Hand sanitizer (500 ml bottles)	bts.	0	2,418	2418	0	2418	2418
451	Hard brush	Pcs			0	7	5	12
452	HEAD CAP / BOUFFANT (Green)	Pair	0		0	0	0	0
453	Heavy duty gloves	Pairs			0	334	244	578
454	Hood (TYVEK)	Pcs			0	1385	0	1385
455	Hydrated Lime	bag			0	8	0	8
456	INDUSTRIAL GLOVES	Pair	0	448	448	0	448	448
457	Insect killer	can			0	29	0	29
458	INSECT SPRAY GUN CAN(Killer)	CAN	0	45	45	0	45	45
459	Ioban 2 Antimicrobial Incise Drape, Sterile	PCS	0	3,920	3920	0	3920	3920
460	Isolation gown (yellow)/Basic PPE	Pcs			0	1560	2225	3785
461	Isolation Gown with Thumbloop 100ea size Large Polywear - Caloloympic (large: 42 cases of blue, 100/case; XL: 16 cases of blue, 100/case)	pcs	0	4,200	4200	0	4200	4200
462	Isolation Gown with Thumbloop 100ea size Regular, Polywear - Calolympic	PCS	0	2,392	2392	0	2392	2392
463	ISOLATION GOWN YELLOW (Disposable Surgical Gown)	PCS	0	100	100	0	100	100
464	Jerrycans Plastic, 1L	PCS	0	508	508	0	508	508
465	Kitchen Mate	Gal	0	5	5	0	5	5

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466	Klin powder soap	sachet			0	1344	72	1416
467	Lab Coat	Pcs			0	20	0	20
468	Lab Coats And Tunics, Scrub Suits, Surgical	PCS	0	436	436	0	436	436
469	Lab Supply Kit, Abg Syringes & Culture Supplies	KIT	0	2	2	0	2	2
470	Lab Supply Kit, General Lab Supplies	KIT	0	2	2	0	2	2
471	Lab Supply Kit, Vacutainer Tubes	KIT	0	2	2	0	2	2
472	Mask (3M)	Pcs			0	670	1440	2110
473	Mask earloop with shield	Pcs			0	100	0	100
474	Mask Respirator N-95	Pcs			0	1505	0	1505
475	Mattress	pcs			0	5	8	13
476	Measuring jugs	PCS	0	60	60	0	60	60
477	Med comfort pe apron (light)	PCS	0	700	700	0	700	700
478	Medical supplies (action medeor) pvc/nitril boots (white)	PCS	0	311	311	0	311	311
479	Medical supplies (ida) plastic corpse/ body bags (white)	pcs	0	1,190	1190	0	1190	1190
480	Medical supplies (ida) pvc boots (black)	pcs	0	110	110	0	110	110
481	Medical supplies (imres) black sagety boots (pvc)	pcs	0	107	107	0	107	107
482	Medical supplies (imres) body bag (black)	PCS	0	1,294	1294	0	1294	1294
483	Medical supplies (imres) body bag (white)-zipper	pcs	0	1,200	1200	0	1200	1200
484	Medical supplies (imres) nose mask	PCS	0	30	30	0	30	30
485	Medication cups	PCS	0	385	385	0	385	385
486	Mop bucket	Pcs			0	3	0	3
487	Mop head	Pcs			0	4	0	4
488	Mopper broom	pcs			0	10	0	10
489	Mosquito Netting	CASES	0	12	12	0	12	12
490	Mosquito Netting (White)	CASES	0	62	62	0	62	62
491	Mr. Clean Liquid soap	btts	1		1	222	0	222
492	N-95 Particulate Respirator and Surgical Mask (Yellow)	PCS	0	90000	90000	0	90000	90000
493	Napkin folder	folder			0	237	0	237
494	Napkin roll	Roll			0	3	0	3
495	Paper Towel	Pcs			0	189	250	439
496	Patient Supplies kit	PCS	0	3	3	0	3	3
497	Pillow case/cover	PCS	0	51	51	0	51	51
498	Plastic apron	Pcs			0	974	0	974

S/N	Item Description	Unit	Quantity used this quarter (Jan - Mar 2016)			Cumulative Jan 2015- Mar 2016		
			By the ETU	Distributed to HF	Total	By the ETU	Distributed to HF	Total
499	Plastic roll (white)	ROLL	0	3	3	0	3	3
500	Plastic sheets	Pcs			0	4	0	4
501	Plastic table cover	PCS.	0	56	56	0	56	56
502	Plastic tubs (large size)	PCS	0	9	9	0	9	9
503	Plastic tubs (medium size)	PCS	0	10	10	0	10	10
504	Ploywear-R	Pcs			0	1270	3775	5045
505	PPE Enhanced	pcs			0	1485	650	2135
506	PPE- Top Guard (Large)	PCS	0	1,900	1900	0	1900	1900
507	PPE -Top Guard (Medium)	PCS	0	375	375	0	375	375
508	PPE -Top Guard (XL)	PCS	0	1,600	1600	0	1600	1600
509	PPE- Tyvek Hood (Medium)	PCS	0	225	225	0	225	225
510	PPE- Tyvek Suit (Large)	PCS	0	400	400	0	400	400
511	PPE- Tyvek Suit (XL)	PCS	0	625	625	0	625	625
512	PPE -Tyvex Suit (Medium)	PCS	0	700	700	0	700	700
513	Prep Brush	pcs			0	0	714	714
514	PVC CLING FILM	PCS	0	8	8	0	8	8
515	Rainboot	Pairs			0	181	24	205
516	Ready-bath	pcs	0	63	63	0	63	63
517	RESPIRATOR PARTICULATE HEATHCARE FACEMASK	PCS	0	480	480	0	480	480
518	RESTRAIN PATIENT	BOX	0	37	37	0	37	37
519	Re-usable apron	pcs			0	26	192	218
520	Rubber cup	Pcs			0	56	0	56
521	Rubber Cup	Pcs	0	82	82	0	82	82
522	Rubber plate	pcs			0	183	0	183
523	Rubber spoon	Pcs			0	25	0	25
524	SAFETY GOGGLES	PCS	0	328	328	0	328	328
525	Safety Pin	PKs	0		0	0	0	0
526	Sanitary pad	Pcs			0	20	0	20
527	Scrub Brushes and Skin Prep Sets	PCS	0	556	556	0	556	556
528	Scrub care/povidine	pcs			0	0	711	711
529	SCRUBS Suit (S, M, L) set: top/bottom	pcs		361	361	60	361	421
530	Secure comfort tape	PCS	0	250	250	0	250	250
531	Sensi care power examination gloves (l)	PCS	0	4,000	4000	0	4000	4000
532	Sensi care power examination gloves (m)	PCS	0	20,000	20000	0	20000	20000
533	Sharp container	Pcs			0	19	33	52
534	Sharps collector glove box	each	0	6	6	0	6	6
535	Sharps container wall mount unit	each	0	35	35	0	35	35
536	Sharps Containers, Send Only w/ Lids	each	0	546	546	0	546	546

S/N	Item Description	Unit	Quantity used this quarter (Jan - Mar 2016)			Cumulative Jan 2015- Mar 2016		
			By the ETU	Distributed to HF	Total	By the ETU	Distributed to HF	Total
537	Shoe cover	pcs			0	1966	600	2566
538	Shoes cover machine	PCS	0	1	1	0	1	1
539	Shower slippers	PCS.	0	95	95	0	95	95
540	Skin barrier wipes	CRT	0	4	4	0	4	4
541	Skin specialties	PCS	0	58	58	0	58	58
542	Slippers	Pairs			0	2	0	2
543	Soap bar 200gm	Cakes	0	257	257	0	257	257
544	Soft broom	Pcs			0	30	0	30
545	Soft scrub (bleach cleanser)	PCS	0	30	30	0	30	30
546	Soft soap/ hand soap	btts	0	7	7	0	7	7
547	Specimen bag	pcs			0	200	0	200
548	Specimen container	pcs			0	0	10	10
549	Specimen tube	pcs			0	50	0	50
550	Split peas	bag			0	3	0	3
551	Sponges	pcs			0	0	27	27
552	Sprayer 1 Liter	CAN	0	15	15	0	15	15
553	Sprayer disinfectant 10 Liters	CAN	0	10	10	0	10	10
554	Sprayer disinfectant 10L	CAN	0	6	6	0	6	6
555	Spraying can	CAN	0	2	2	0	2	2
556	Spraying can (1liter)	Pcs		0	0	24	0	24
557	Spraying Can (Large)	Pcs		0	0	6	0	6
558	Sterilization, Tapes, Indicators, Wraps & Pouches	PCS	0	1,174	1174	0	1174	1174
559	Surgical apron (light yellow)	pcs	0	600	600	0	600	600
560	Surgical caps, hats and shoes cover	PCS	0	500	500	0	500	500
561	Tarpaulin	box			0	23	6	29
562	Tissue	Roll			0	980	36	1016
563	Tissue weib	PCS	0	16	16	0	16	16
564	Toothbrush	Pcs		16	16	73	16	89
565	Toothpaste	pack		15	15	70	15	85
566	Tournequet	PCS	0	200	200	0	200	200
567	Towel	Pcs			0	21	3	24
568	Trash bag	pcs			0	7827	2000	9827
569	Trash bag (black)	PCS	0	2,472	2472	0	2472	2472
570	Trash bag (white)	PCS	0	1,500	1500	0	1500	1500
571	Tyvek hood (dupont personal protection)	PCS	0	2,300	2300	0	2300	2300
572	Under clothes (woman)	pcs			0	6	0	6
573	Vinyl Bed Surface (Camp Bed)	PCS	0	19	19	0	19	19
574	Vinyl bed/ camp bed	Pcs			0	5	0	5
575	Vita cube	Pcs			0	900	0	900
576	Walker, Folding	each	0	4	4	0	4	4

S/N	Item Description	Unit	Quantity used this quarter (Jan - Mar 2016)			Cumulative Jan 2015- Mar 2016		
			By the ETU	Distributed to HF	Total	By the ETU	Distributed to HF	Total
577	WARNING TAPE	ROLL	0	2	2	0	2	2
578	Washing Soap	Cakes			0	1079	0	1079
579	WATER PLASTIC CONTAINER	PCS	0	21	21	0	21	21
580	WOVEN TARPAULIN	BOXES	0	80	80	0	80	80
Medical and IPC Equipment								
581	3-way stop cock	pcs	0	0	0	0	126	126
582	4-way stop cock	Pcs	0	0	0	0	50	50
583	Ambu bag	Pcs	0	26	26	9	26	35
584	Assorted IV tubing	pcs	0	0	0	0	101	101
585	Assorted Laboratory Materials	Ctn	0	0	0	0	2	2
586	Baby Scale	Pcs	0	0	0	0	1	1
587	BACK PACK SPRAYER CAN (12L)	can	0	25	25	4	25	29
588	Bandage	roll	0	0	0	15	0	15
589	Barrel (large)	Pcs	0	0	0	7	0	7
590	Barrel (XL)	pcs	0	0	0	15	0	15
591	Barrel Medium)	pcs	0	0	0	12	0	12
592	Bed Pan (Round Wash Basin)-Blue	PCS	0	60	60	0	60	60
593	Bed pan ((IMRES) adult size	pcs	0	250	250	0	250	250
594	BED PAN (PLASTIC) with lid and handles	PCS	0	100	100	0	100	100
595	Bedpans And Urinals	pcs	0	200	200	0	200	200
596	Blood Collection Tubes	tubes	0	137	137	0	137	137
597	Bowl, stainless steel, 180ml	PCS.	0	60	60	0	60	60
598	BP cuff	Pcs			0	10	26	36
599	BREAST PUMP	PCS	0	3	3	0	3	3
600	BREAST RELIEVER	PCS	0	2	2	0	2	2
601	Bucket (faucet)	Pcs			0	75	45	120
602	Bucket (small)	Pcs			0	160	27	187
603	Bucket (White with Lid)	Pcs			0	1	0	1
604	Container 5L (black)	pcs			0	3	0	3
605	Cooling vast	pcs	0	26	26	0	26	26
606	Cooling Vest	Pcs			0	65	0	65
607	Dust pan	Pcs			0	3	0	3
608	Electronic scale (bath room type)	PC	0	2	2	0	2	2
609	Empty spray can(1 litre)	PCS	0	20	20	0	20	20
610	Funnel	Psc	0	10	10	0	10	10
611	Glucose Meter	PCS	0	1	1	0	1	1
612	Hard brush	pcs			0	4	0	4
613	IR thermometer	Pcs		60	60	10	90	100
614	IV Extension & Secondary Tubing	sqm	0	1,728	1728	0	1728	1728
615	IV Pole	each	0	7	7	0	7	7

S/N	Item Description	Unit	Quantity used this quarter (Jan - Mar 2016)			Cumulative Jan 2015- Mar 2016		
			By the ETU	Distributed to HF	Total	By the ETU	Distributed to HF	Total
616	IV Primary Tubing, Including Blood Tubing	each	0	95	95	0	95	95
617	Jerry can (1L)	Pcs			0	160	0	160
618	Kidney bean Surgical bowl	Pcs		32	32	12	32	44
619	LARYNGNGOSCOPE	PC	0	1	1	0	1	1
620	Light, Exam	PCS	0	1	1	0	1	1
621	Light, Exam (Spoiled)	PCS	0	1	1	0	1	1
622	Nasal Gastric & Gastric Lavage Tubes & Kits	PCS	0	36	36	0	36	36
623	Nebulizer -Machine	Box	0	1	1	0	1	1
624	Nebulizer Supplies	PCS	0	146	146	0	146	146
625	Needles, Mixed Gauges	PCS	0	31	31	0	31	31
626	Oxygen Masks and Tubing	PCS	0	4	4	0	4	4
627	Pads, Wedges, Positioning Pillows	PCS	0	144	144	0	144	144
628	Patient ID Bracelet	PCS	0	4,000	4000	0	4000	4000
629	SPECIMEN CONTAINER	PCS	0	740	740	0	740	740
630	Sphygmomanometer	BOXES	0	139	139	0	139	139
631	SPRAYER CAN (1LITRE)	CAN	0	11	11	0	11	11
632	Stethoscope	Pcs		44	44	7	44	51
633	STRETCHER, foldable, alu	CRT	0	21	21	0	21	21
634	Suction Canisters & Lids	PCS	0	491	491	0	491	491
635	Suction Machine Low Portable	Box	0	1	1	0	1	1
636	Suprapubic catheter tray	Set			0	0	6	6
637	SURGICAL SCISSORS	PCS	0	15	15	0	15	15
638	Temporal Thermometers - Abatix (Patient Digital)	PCS	0	1,913	1913	0	1913	1913
639	THERMOMETER COVER	PCS	0	2,000	2000	0	2000	2000
640	Thermometer, Oral	each	0	6	6	0	6	6
641	Thermometer, Patient Digital	pcs			0	0	31	31
642	Thermometer/flash	Pcs			0	4	0	4
643	Urinary Catheters, Trays & Insertion Sets	PCS	0	5	5	0	5	5
644	Vena Thermometer	pcs		3	3	3	3	6
645	Ventilator Tubing and Supplies	each	0	174	174	0	174	174
646	Weighing (Baby)scale -CCC	PCS	0	3	3	0	3	3

(Source: STEP program performance report for the period of Jan 1 – Mar 31, 2016; PCI. April 21, 2016)

Annex 4: List of health facilities Supported by STEP by type of supported

S/N	Name of Health Facilities /Institutions	District	Level of HF[1]	Type of Support Provided				
				Medical commodities and supplies provision	Mentorship	Type of training		
						SQS Training[12]	EVD surveillance and response[13]	Safe swab sample collection and transporting[14]
1	Beoyoola Clinic	Gbarlay Geh	Primary	xxx		xxx	xxx	xxx
2	Gbaelay-geh DHT	Gbarlay Geh	DHT			xxx	xxx	
3	Duoplay Clinic	Gbarlay Geh	Primary	xxx	xxx	xxx	xxx	xxx
4	Garplay Mission Clinic	Gbarlay Geh	Primary		xxx	xxx	xxx	xxx
5	Gbeivonwea Clinic	Gbarlay Geh	Primary		xxx	xxx	xxx	xxx
6	Give them hope Clinic	Gbarlay Geh	Primary	xxx		xxx	xxx	xxx
7	Gorguatuo Clinic	Gbarlay Geh	Primary	xxx	xxx	xxx	xxx	xxx
8	Karnplay Health Center	Gbarlay Geh	Primary	xxx		xxx	xxx	xxx
9	Kpairplay Clinic	Gbarlay Geh	Primary	xxx	xxx	xxx	xxx	xxx
10	Loguatuo Clinic	Gbarlay Geh	Primary	xxx	xxx	xxx	xxx	xxx
11	Slanganplay Clinic	Gbarlay Geh	Primary	xxx		xxx	xxx	xxx
12	Vayenglay Clinic	Gbarlay Geh	Primary	xxx	xxx	xxx	xxx	xxx
13	Younlay Clinic	Gbarlay Geh	Primary	xxx	xxx	xxx	xxx	xxx

[12] At least three service providers from the listed health facilities and County/District offices have been trained on SQS, and the plan is to train 100% of the service providers in each HF.

[13] One staff representing the health facilities, DHT, and CHT have benefited from the training

[14] At least one lab aid or health service provider is trained per facility.

S/N	Name of Health Facilities /Institutions	District	Level of HF[1]	Type of Support Provided				
				Medical commodities and supplies provision	Mentorship	Type of training		
						SQS Training[12]	EVD surveillance and response[13]	Safe swab sample collection and transporting[14]
14	Zorgowee Clinic	Gbarlay Geh	Primary	xxx	xxx	xxx	xxx	xxx
15	Beindin Clinic	Saclepea Mah	Primary	xxx		xxx	xxx	xxx
16	Bunadin Clinic	Saclepea Mah	Primary	xxx	xxx	xxx	xxx	xxx
17	Cocopa Clinic	Saclepea Mah	Primary			xxx	xxx	xxx
18	Sclepea-mah DHT	Saclepea Mah	DHT			xxx	xxx	
19	Duayee Clinic	Saclepea Mah	Primary			xxx	xxx	xxx
20	Flumpa Comm. Clinic	Saclepea Mah	Primary		xxx	xxx	xxx	xxx
21	Flumpa ULIC	Saclepea Mah	Primary	xxx	xxx	xxx	xxx	xxx
22	Karnwee Clinic	Saclepea Mah	Primary	xxx	xxx	xxx	xxx	xxx
23	Kpaytuo Clinic	Saclepea Mah	Primary	xxx	xxx	xxx	xxx	xxx
24	Kpein Clinic	Saclepea Mah	Primary	xxx	xxx	xxx	xxx	xxx
25	Saclepea Clinic	Saclepea Mah	Primary			xxx		
26	Saclepea Com. HC	Saclepea Mah	Primary	xxx	xxx	xxx	xxx	xxx
27	Saclepea ULIC	Saclepea Mah	Primary			xxx	xxx	xxx
28	Tunukpuye Clinic	Saclepea Mah	Primary	xxx	xxx	xxx	xxx	xxx
29	Zahn Bahnla Clinic	Saclepea Mah	Primary	xxx	xxx	xxx	xxx	xxx
30	Duayee (Gbeyi Duayee) clinic	Saclepea Mah	Primary	xxx		xxx		
31	Docas Matto Memorial Clinic	Saclepea Mah	Primary		xxx	xxx	xxx	xxx
32	Duo Clinic	Saclepea Mah	Primary		xxx	xxx	xxx	xxx
33	Kpallah	Saclepea Mah	Primary	xxx		xxx		
34	Agape Clinic	Sanniquelle Mah	Primary			xxx	xxx	xxx
35	Arcelor Mittal Yekepa Hosp.	Sanniquelle Mah	secondary	xxx	xxx	xxx	xxx	xxx

S/N	Name of Health Facilities /Institutions	District	Level of HF[1]	Type of Support Provided				
				Medical commodities and supplies provision	Mentorship	Type of training		
						SQS Training[12]	EVD surveillance and response[13]	Safe swab sample collection and transporting[14]
36	Bomah Clinic	Sanniquelle Mah	Primary	xxx		xxx	xxx	xxx
37	CHT Emergency Pharmacy	Sanniquelle Mah	CHT	xxx		xxx		
38	Nimba CHT	Sanniquelle Mah	CHT			xxx	xxx	
39	Sanniquelle-mah DHT	Sanniquelle Mah	DHT			xxx	xxx	
40	Duotiayee Clinic	Sanniquelle Mah	Primary	xxx	xxx	xxx	xxx	xxx
41	Evening Star Clinic	Sanniquelle Mah	Primary			xxx	xxx	xxx
42	Free penticostal Clinic	Sanniquelle Mah	Primary	xxx		xxx	xxx	xxx
43	G.W.Harley Hospital	Sanniquelle Mah	tertiary	xxx	xxx	xxx	xxx	xxx
44	Gant ETU	Sanniquelle Mah	tertiary	xxx		xxx	xxx	xxx
45	Ganta Comm. Clinic	Sanniquelle Mah	Primary	xxx	xxx	xxx	xxx	xxx
46	Ganta Equip Clinic	Sanniquelle Mah	Primary	xxx	xxx	xxx	xxx	xxx
47	Ganta Methodoest Hospital	Sanniquelle Mah	Tertiary	xxx	xxx	xxx	xxx	xxx
48	Ganta Rehab. Hospital	Sanniquelle Mah	Secondary	xxx	xxx	xxx	xxx	xxx
49	J. Kohn Hosp.	Sanniquelle Mah	secondary	xxx		xxx		
50	KL Foundation Clinic	Sanniquelle Mah	Primary		xxx	xxx	xxx	xxx
51	Kozomoway Med. Clinic	Sanniquelle Mah	Primary	xxx		xxx	xxx	xxx
52	Lugbeyee Clinic	Sanniquelle Mah	Primary	xxx		xxx	xxx	xxx
53	Newman Clinic	Sanniquelle Mah	Primary		xxx	xxx	xxx	xxx
54	Power House Clinic	Sanniquelle Mah	Primary	xxx	xxx	xxx	xxx	xxx
55	St. Mary's Clinic	Sanniquelle Mah	Primary	xxx		xxx	xxx	xxx
56	YMCA Clinic	Sanniquelle Mah	Primary	xxx	xxx	xxx	xxx	xxx
57	Bonlay Clinic	Tappita	Primary	xxx	xxx	xxx	xxx	xxx

S/N	Name of Health Facilities /Institutions	District	Level of HF[1]	Type of Support Provided				
				Medical commodities and supplies provision	Mentorship	Type of training		
						SQS Training[12]	EVD surveillance and response[13]	Safe swab sample collection and transporting[14]
58	Consoleta Clinic	Tappita	Primary	xxx		xxx	xxx	xxx
59	Tappita DHT	Tappita	DHT			xxx	xxx	
60	Dilla (Gblor Dialla) Clinic	Tappita	Primary	xxx	xxx	xxx	xxx	xxx
61	Glahn Town Clinic	Tappita	Primary	xxx		xxx	xxx	xxx
62	Graie Clinic	Tappita	Primary	xxx		xxx	xxx	xxx
63	JFD Hospital	Tappita	Tertiary	xxx	xxx	xxx		xxx
64	Mid-Baptist Clinic	Tappita	Primary	xxx	xxx	xxx	xxx	xxx
65	New Yourpea Clinic	Tappita	Primary	xxx		xxx	xxx	xxx
66	Toweh Town Clinic	Tappita	Primary			xxx	xxx	xxx
67	Zuaplay Clinic	Tappita	Primary	xxx	xxx	xxx	xxx	xxx
68	Zuolay Clinic	Tappita	Primary	xxx	xxx	xxx	xxx	xxx
69	YM DHT	Yarwin Mehnsonnoh	DHT			xxx	xxx	
70	Kwendin Clinic	Yarwin Mehnsonnoh	Primary	xxx		xxx	xxx	xxx
71	Mehnla Clinic	Yarwin Mehnsonnoh	Primary	xxx	xxx	xxx	xxx	xxx
72	Zekepa Clinic	Yarwin Mehnsonnoh	Primary			xxx	xxx	xxx
73	Zekepa H. Center	Yarwin Mehnsonnoh	Primary	xxx		xxx	xxx	xxx
74	Boyee Clinic	Yarwin Mehnsonnoh	Primary	xxx		xxx		
75	Bahn AHA Camp Clinic	Zoe-Geh	Primary		xxx	xxx	xxx	xxx
76	Bahn Health Center	Zoe-Geh	Primary	xxx	xxx	xxx	xxx	xxx

S/N	Name of Health Facilities /Institutions	District	Level of HF[1]	Type of Support Provided				
				Medical commodities and supplies provision	Mentorship	Type of training		
						SQS Training[12]	EVD surveillance and response[13]	Safe swab sample collection and transporting[14]
77	Bahn ULIC	Zoe-Geh	Primary	xxx	xxx	xxx	xxx	xxx
78	Beadatuo Clinic	Zoe-Geh	Primary	xxx		xxx	xxx	xxx
79	Buutuo Clinic	Zoe-Geh	Primary		xxx	xxx	xxx	xxx
80	Buutuo United Lib Inland Clinic	Zoe-Geh	Primary		xxx	xxx	xxx	xxx
81	Zoe-geh DHT	Zoe-Geh	DHT			xxx	xxx	
82	Gblarlay Clinic	Zoe-Geh	Primary	xxx	xxx	xxx	xxx	xxx
83	Lapula Clinic	Zoe-Geh	Primary		xxx	xxx	xxx	xxx
84	Payee Clinic	Zoe-Geh	Primary		xxx	xxx	xxx	xxx
85	Wehplay Clinic	Zoe-Geh	Primary	xxx		xxx	xxx	xxx
86	Zoe-Geh M. Center	Zoe-Geh	Primary			xxx	xxx	xxx
87	Gbloulay Clinic	Zoe-Geh District	Primary	xxx		xxx	xxx	xxx

Source: summarized from STEP quarterly program performance reports for the period of Jul 1 – Sept 30, 2015; Jul 1 – Sept 30, 2015; and Jan 1 – Mar 31, 2016; PCI.