



EVALUATION

Endline Performance Evaluation of the USAID Global Health Ebola Team (GHET) Ebola Virus Disease (EVD) Survivor Program - November 2018

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ABSTRACT

Within the GHET Pillar II portfolio, this performance evaluation is an outcome-level study to determine the endline effectiveness of the program's survivor-specific services. The evaluation questions are focused on whether program health services addressed the needs of Ebola survivors and were integrated into the public health system in order to mitigate the effects of further Ebola infection among the population.

In Guinea, Liberia, and Sierra Leone, this mixed-methods evaluation drew on quantitative health facility assessments, quantitative provider surveys, qualitative key informant interviews at endline, and use of baseline and endline quantitative surveys conducted among EVD survivors by implementing partners.

Overall, the GHET program on survivor services was effective, particularly in reducing the stigma EVD survivors experienced from health providers in Guinea and Liberia. In Sierra Leone, provider stigma was already the lowest among countries at baseline and remained so at endline; thus, the same reduction was not evident. While the GHET EVD survivor program also improved the availability of clinical services for EVD survivors, accessibility of care across the continuum of care (primary to tertiary facilities) was more difficult to improve at the primary level given systemic public health weaknesses in Guinea, Liberia, and Sierra Leone.

When considering program implementation and preparation for future public health crises, the establishment of and capacity-building support to EVD survivor networks and government bodies contributed positively to the program's efforts. However, the integration of survivor-specific services and processes into the general public health systems of Guinea, Liberia, and Sierra Leone remains a work in progress.

Cover Photo: On the wall of the Bong County Ebola Treatment Unit in Liberia, Ebola virus disease survivors left their handprints (2015). Photo credit: USAID_Images on Flickr.com (Adam Parr, USAID).

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About the BalanceD-MERL consortium

The Balanced Design, Monitoring, Evaluation, Research, and Learning (BalanceD-MERL) consortium, under the U.S. Global Development Lab's Monitoring, Evaluation, Research, and Learning Innovations (MERLIN) program at the United States Agency for International Development (USAID), is identifying solutions to commonly faced challenges in design (D) and implementation of monitoring, evaluation, research, and learning (MERL). D-MERL refers to the integration of program design, strategy, and implementation with MERL activities. The consortium provided support and technical assistance to USAID programs to enhance and conduct D-MERL activities. The consortium consists of five organizations: World Vision (prime awardee), Innovations for Poverty Action, Institute for Development Impact, Search for Common Ground, and William Davidson Institute at the University of Michigan.

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List of Acronyms

ANSS	Agence Nationale de Sécurité Sanitaire (Guinea)
APC	Advancing Partners & Communities
BalancedD-MERL	Balanced Design, Monitoring, Evaluation, Research, and Learning
CI	Confidence Interval
CPES	Comprehensive Program for Ebola Survivors (Sierra Leone)
DQV	Data Quality Verification
ETP&SS	Ebola Transmission Prevention and Survivor Services
EVD	Ebola Virus Disease
GHET	Global Health Ebola Team
HMIS	Health Management Information System
IP	Implementing Partner
IPA	Innovations for Poverty Action
IPC	Infection Prevention and Control
IR	Intended Results
IRB	Institutional Review Board
JSI R&T	JSI Research & Training Institute, Inc.
I4DI	Institute for Development Impact
MERL	Monitoring, Evaluation, Research, and Learning
MOH	Ministry of Health
RENASEG	Réseau National des Associations de Survivants d’Ebola de Guinée
SLAES	Sierra Leone Association of Ebola Survivors
UN	United Nations
USAID	U.S. Agency for International Development
WHO	World Health Organization
WV	World Vision

Executive Summary

This performance evaluation assessed the USAID Global Health Ebola Team's (GHET) survivor-specific programs in Liberia, Guinea, and Sierra Leone. The evaluation explored the achievement of several Intermediate and sub-Intermediate Results (IR) in the GHET Portfolio Results Framework, namely IR 3: Access to appropriate healthcare services is improved for Ebola survivors; sub-IR 3.1: Clinical services for Ebola survivors are strengthened and more accessible throughout the continuum of care; sub-IR 3.2: Stigma experienced by Ebola survivors when seeking care is reduced; and sub-IR 2.2: Governance and management are improved to advance national policies and systems. The evaluation drew upon primary data collected by the evaluation team at endline, including qualitative key informant interviews, quantitative health facility assessments, and quantitative health provider surveys. Secondary data sources included a variety of program and national reports, as well as implementing partner monitoring data. The evaluation also utilized data from baseline and endline quantitative surveys of Ebola virus disease survivors in each of the three countries, administered by JSI Research & Training Institute, Inc (JSI R&T), the lead program implementing partner.

Overall, the GHET program on survivor services was effective, particularly in reducing the stigma EVD survivors experienced from health providers when seeking care in Guinea and Liberia. In Sierra Leone, provider stigma was already the lowest among countries at baseline and remained the lowest at endline; thus, the same relative reduction was not evident. Furthermore, given the low baseline level and subsequent small change in observed stigma, the difference in provider stigma in Sierra Leone could not be determined with statistical significance. While the GHET program also improved the availability of clinical services for EVD survivors, accessibility of care across the continuum of care (primary through tertiary facilities) was more difficult to improve given systemic public health weaknesses in Guinea, Liberia, and Sierra Leone. While the program successfully established and implemented EVD-survivor specific health protocols and processes at all levels, the lower reported rates of adequate services for survivors available at the primary level and survivor reluctance to follow the referral system process were systemic deterrents to delivering accessible care, i.e. in closer proximity to where survivors resided. The individual findings considered for study conclusions by domain follow and represent sub-components that (1) explain why the overall GHET program activity was effective, (2) detail the systemic challenges the program faced and what approaches helped overcome some of those challenges, and (3) share how some of these challenges could be addressed by future implementers in similar settings.

Improved Healthcare Services for EVD survivors

According to EVD survivors surveyed, healthcare services for EVD sequelae improved. 74.7% of survivors in Guinea, Liberia, and Sierra Leone reported their access to healthcare was adequate and 79% of surveyed survivors reported satisfaction with the care they received. Furthermore, 81.7% of survivors indicated that survivor services were "much better" or "a little better" since the beginning of program implementation.

Strengthened but Limited Accessibility of EVD Survivor Services

While survivor care health services overall have been strengthened, accessibility of care across the continuum of healthcare is skewed heavily towards tertiary facilities. While this is an expected weakness of the public health system in Guinea, Liberia, and Sierra Leone, this distribution of survivor care services still represents a gap in survivor care accessibility. As such, the program successfully brought survivor service care capacity to tertiary facilities. Half of the tertiary facilities sampled had specialist healthcare providers for EVD sequelae on-site and 57% of these tertiary facility providers reported being able to “often” or “always” provide adequate care for survivors. These findings confirm the importance of a properly functioning referral system for survivors, and the push to get survivors with EVD follow-up needs to tertiary facilities. However, only 46% of providers felt EVD survivors were satisfied with the referral process. Qualitative findings also surfaced challenges in getting survivors to utilize and follow the referral system.

Strides in Health Provider Stigma Reduction for EVD Survivors

The stigma that EVD survivors experienced when seeking care was greatly reduced in Guinea and Liberia. Between baseline and endline, there was a 12.3% reduction (20.7% to 8.4%) of stigma in Guinea and 14.48% reduction (23.3% to 8.8%) in Liberia but a 2.2% increase (3.6% to 5.8%) in Sierra Leone (absolute reductions and increase). Results in Guinea and Liberia are statistically significant ($p < 0.001$) but insignificant in Sierra Leone. The lack of statistical significance on provider stigma data in Sierra Leone was expected given the small change that was required for detection. In terms of representing this change as a percentage of baseline stigma, Guinea and Liberia respectively showed 59.50% and 62.1% relative reductions in provider stigma. While data showed an increase, the level of reported provider stigma remained the lowest in Sierra Leone across all three countries at both baseline and endline. Additionally, survivor perceptions of stigma reduction were positive across all three countries, with 84% of survivors who received treatment reporting an improvement. Furthermore, nearly three-quarters (73%) of providers reported stigma training changed their behavior towards survivors “very much.” This was further triangulated by analysis of interview data. All respondent stakeholders (implementing partners, government representatives, survivor network representatives, and USAID field staff) cited provider stigma trainings as highly effective and contributing to this reduction in provider stigma.

Governance and Management Effects on EVD Policies & Systems

The program’s key impacts on improved national policies and systems were primarily through contributions to each country’s national guidelines on EVD survivor care, specific clinical guidelines on EVD care, and capacity building and support to survivor networks and government bodies responsible for implementation and management of survivor services. Additionally, in Guinea the program supported effective operation of surveillance sentinel sites. Overall, support to and often creation of survivor networks and government bodies responsible for implementing survivor services and care was successful. These institutions had continued positive impact on the program through direct engagement with or feedback to the program. Simply put, the networks and bodies performed necessary functions that positively benefited implementation of survivor work. Survivor networks organized and represented survivor interests, often directing survivors to services and providing feedback to implementing partners on how to best operationalize services and programming like

approaches to stigma reduction in communities and how to best engage survivors on referral processes. The government bodies engaged directly and eventually took more ownership of EVD programming and processes implemented throughout the course of the program.

At project endline, nearly three-quarters (73.8%) of survivor respondents in Guinea and Liberia reported they agreed with a statement that their Survivor Network could look out for their interests and represented them well. Similarly, 70% of respondents in Sierra Leone reported being “very confident” in their Survivor Network. However, when JSI R&T’s baseline and endline data are compared, two trends emerged. Confidence in the Survivor Network increased in Guinea (+13.2%) and decreased in Liberia (-15%). In Guinea and Liberia at endline, 69% of survivors agreed with a statement of confidence on the National EVD Government bodies. Similar to the trends for Survivor Network confidence, this represented an increase (+8.1%) in Guinea and a decrease (-19.1%) in Liberia.

Collaborative Program Implementation & Systemic Barriers to Implementation

Overall, program implementation was characterized as collaborative, and qualitative analysis showed that the program implementing partners regularly sought and received feedback from program stakeholders. Two-thirds of qualitative interviews described their interaction with the program implementing partners as “high” on both level and quality of engagement. This collaboration was cited to inform and update program stakeholders on progress and also contributed to minimizing duplication of efforts. Within this positive backdrop, interviews yielded suggestions for improving collaboration and communication- in particular to increase engagement more locally at the district level (Guinea) and engagement with the survivor network (Liberia & Sierra Leone).

Qualitative Insights from Implementation for Future Programming

Emerging from implementation experience, there are a number of important insights that may apply to future programming in similar post-epidemic settings. These insights were derived from qualitative analysis of key informant interviews and tie to program implementation barriers encountered. Interviews were conducted with implementing partners, government representatives, survivor network representatives, and USAID field staff with knowledge of implementation, engagement with the program, and sectoral context.

Insight: More Local Level Community Engagement

While the APC ETP&SS program did have local components, respondents frequently noted the benefits of engaging the broader community affected by EVD, not just survivors or healthcare providers in order to ease community concerns at all phases of planning and implementation. Additionally, with the understanding that this particular program operated within allotted funding and limited timeframe, interview respondents (particularly in Guinea, which had extensive local engagement through sentinel surveillance sites) voiced the potential benefits of engaging more at the local district level, which they believed would also help ensure better monitoring and preparation for future public health outbreaks.

Insight: Overcoming Systemic Barriers to Treatment & Referral Actualization

Building on the theme of systemic public health system challenges and unanticipated costs of referrals for survivors, interview respondents felt that being more aware of the limits of the healthcare system

(in particular lack of medication and limited ability to deliver goods and services to health facilities) and fully understanding and responding to the hidden costs of referral for survivors would be beneficial for future programming. In Sierra Leone, the issues around referrals were partly addressed through the use of “referral coordinators,” who helped bridge gaps in understanding that both healthcare providers and survivors had on the referral system and bureaucratic processes. Embodying the softer human side of public health administration, roles like referral coordinator should be considered and factored into similar future interventions.

Insight: Health Systems Overall vs Survivor Specific Activities

Given the systemic nature of weak public health systems, interviewees also noted the tension between focusing on survivor specific interventions as opposed to broader public health systems strengthening work. While this program was mandated to focus specifically on improving survivor services within a limited timeframe, many respondents raised the tradeoff between improving survivor specific services versus improving the health system overall given the existing public health system challenges in Guinea, Liberia, and Sierra Leone. Respondents raised the point that the program could have benefited from taking a broader approach to improving healthcare versus focusing exclusively on setting up survivor-specific services and processes.

Insight: Engaging Early & Often with Government Entities

Interviews for this study yielded both concerns about the pace of government responsiveness and effective approaches to building trust and encouraging government ownership of programming. In post-epidemic settings, the importance of maintaining communication and relations with government agencies in host countries is well-known. Respondents across stakeholder types often mentioned the collaborative nature of program implementation and high levels of engagement with stakeholders. Implementing partners in all three countries worked closely and sought positive relationships with government partners and some illustrative best practices emerged in each country that speak to approaches fostering buy-in and ownership of program efforts over time, including co-design of program components, a focus on a systemic view towards public health outbreaks, high levels of engagement, and encouragement of host government ownership of programming.

Conclusion

Overall, the GHET program for survivor services was effective, particularly in reducing the stigma EVD survivors experienced from health providers when seeking care in Guinea and Liberia. While the GHET program also improved the availability of clinical services for EVD survivors in Guinea, Liberia, and Sierra Leone, accessibility of care across the continuum of care (primary to tertiary facilities) was more difficult to improve at the primary level given systemic public health weaknesses in Guinea, Liberia, and Sierra Leone. While the program successfully established and implemented EVD-survivor specific health protocols and referral processes, lower levels of adequate services for survivors available at the primary level and survivor reluctance to follow the referral system process were systemic deterrents in delivering accessible care particularly in closer proximity to survivors at the primary facility level. Finally, when considering accessibility of care and preparation for future public health crises, the establishment of and capacity-building support to EVD survivor networks and government bodies contributed positively to the program’s efforts through strategic direct engagement with and

feedback to the program. However, the integration of survivor-specific services and processes into the general public health systems of Guinea, Liberia, and Sierra Leone remains a work in progress.

Introduction & Program Background

Program Background

Between 2014 and 2016 the nations of Guinea, Liberia, and Sierra Leone experienced an unprecedented Ebola epidemic, which resulted in more than 28,600 cases of Ebola virus disease (EVD) and more than 10,000 survivors (Center for Disease Control and Prevention, 2017). In partnership with host governments, the global response included UN agencies, bilateral and multilateral donors, and non-governmental organizations. Among these institutions, the United States Agency of International Development (USAID) launched a four-pillar strategic response: control the epidemic (Pillar 1); recover from second-order impacts of Ebola (Pillar 2); build coherent leadership and operations (Pillar 3, crosscutting); and strengthen global health security in Sub Saharan Africa (Pillar 4) (Office of Inspector General US Agency for International Development, 2018).

Since January 2015, the USAID Global Health Ebola Team, situated in the Global Health Bureau, has overseen a \$150.5 million portfolio of health-related projects falling under Pillar II of the U.S. Government's response. Activities supported critical non-Ebola health services, health systems, and transmission prevention of Ebola virus from the West African survivor community. Funding for survivor work commenced in June 2016. The GHET program's development objective is that affected countries will be better equipped to sustain a "resilient zero" of Ebola cases (World Health Organization, 2015; USAID, 2017), meaning:

1. Effective infection prevention and control (IPC) within a wider context of patient safety
2. Strengthened integrated disease surveillance and response capacities (IDSR) as part of enhancing the resilience of local health systems
3. Reactivation of a basic package of essential health services in affected countries
4. Rebuilding of health workforce capacities as a foundation for sustainable health workforce strengthening
5. Services addressing the specific needs of Ebola survivors are in place and integrated into the public health system to help mitigate further Ebola infection among the population

The 23 projects of the GHET portfolio, carried out by 12 implementing partners at national and regional levels across the three countries, aimed to mitigate the second-order impacts of the Ebola crisis, prevent further development losses, and strengthen key institutions and infrastructure. Their objectives were:

1. Delivery and utilization of essential primary healthcare services are restored;

2. Health system functions are strengthened to respond appropriately and adequately to future public health crises
3. Prevention and treatment services that address the needs specific to Ebola survivors are available and utilized.

In 2016, GHET commissioned a performance and process evaluation of its survivor-specific programs in Guinea, Liberia, and Sierra Leone. Implemented by JSI R&T in conjunction with local partners in each country, the Ebola Transmission Prevention and Survivor Services (ETP&SS) project (AID-OAA-A-12-00047) was embedded in the larger Advancing Partners and Communities (APC) program. The APC program is a five-year USAID-funded project that supports the expansion and strengthening of community health services, especially in relation to family planning. The three ETP&SS country programs had a budget of \$21,925,000, including a \$650,000 Regional program (the latter was not part of this evaluation). In each country, various activities focused on the geographic areas with the highest numbers of EVD survivors, with select activities conducted at a national level.

In Liberia, the ETP&SS focused in four priority counties with the preponderance of registered EVD survivors: (1) Bong, (2) Lofa, (3) Margibi, and (4) Montserrado. In these locations, key program activities included, but were not limited to, health provider training on survivor clinical care guidelines, as well as clinical rotations and other training, coordination with the EVD survivor network, and renovation and equipping of health facilities. Partnering subgrants included those with the Liberia College of Physicians and Surgeons for clinical specialist consultants to provide EVD survivor care and train other pre- and in-service medical staff; Phebe School of Nursing and Rural Training Institute for implementation of mental health clinical training in Bong County; and Eternal Love Winning Africa Hospital and Saint Joseph's Catholic Hospital, both faith-based organizations that provided free clinical care services for registered EVD survivors.

The program in Sierra Leone focused on six USAID priority districts with the most EVD survivors: (1) Bombali, (2) Kailahun, (3) Kenema, (4) Port Loko, (5) Western Area Rural, and (6) Western Area Urban. Key program activities included, but were not limited to, health provider training and mentorship on specialty care for EVD survivors, including strengthening of the referral network, and capacity building to the EVD survivor network. Partnering subgrants included those with Kings Partnership Sierra Leone for specialty care capacity building; Partners in Health for survivor network capacity building; GOAL and Save the Children for various field implementation and/or technical assistance activities; and War Trauma Foundation for psychological first aid training.

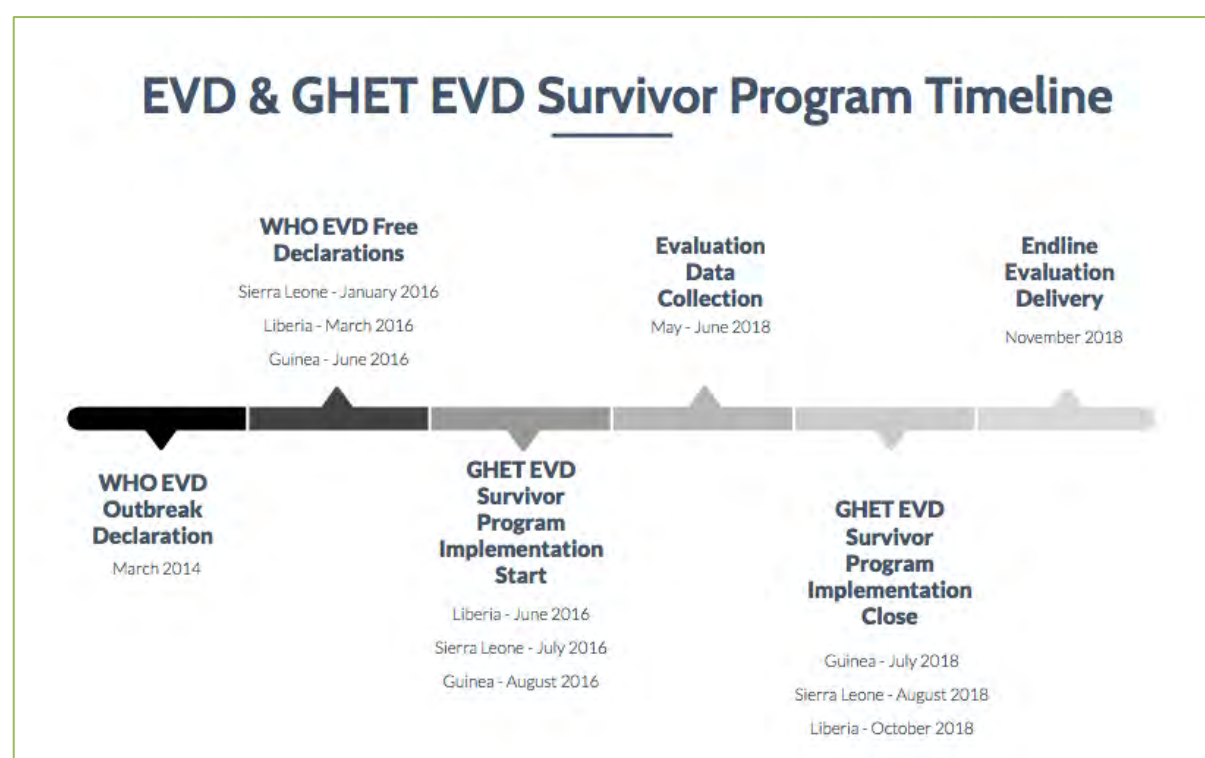
In Guinea, the ETP&SS focused on three priority regions with the most EVD survivors: (1) Conakry, (2) Kindia, and (3) Nzérékoré. Program activities included, but were not limited to, support to survivor networks and stigma reduction sensitization campaigns; support for community-based survivor monitoring; clinical training on EVD sequelae management; and renovation and equipping health facilities. A partnering subgrant with International Medical Corps covered capacity building for survivor organizations, health provider training on EVD sequelae management, and strengthening the referral system.

With regard to the latter, in all three countries, examples of basic primary care for EVD-specific sequelae include conditions such as arthritis or headache. Complicated sequelae were to be referred

to designated secondary and tertiary health facilities, where specialists were more likely to be located in accordance with national health policy and planning strategies to manage scarce human resources for health (Ministere de la Sante, 2015; Ministry of Health and Sanitation, 2015; Republic of Liberia Ministry of Health and Social Welfare, 2011).

Evaluation & Program Timeline

Some implementing partners had multiple projects within and across countries, and survivor-related activities overall were staggered across the period of mid-2016 through 2018 following official EVD-Free declarations by the WHO.



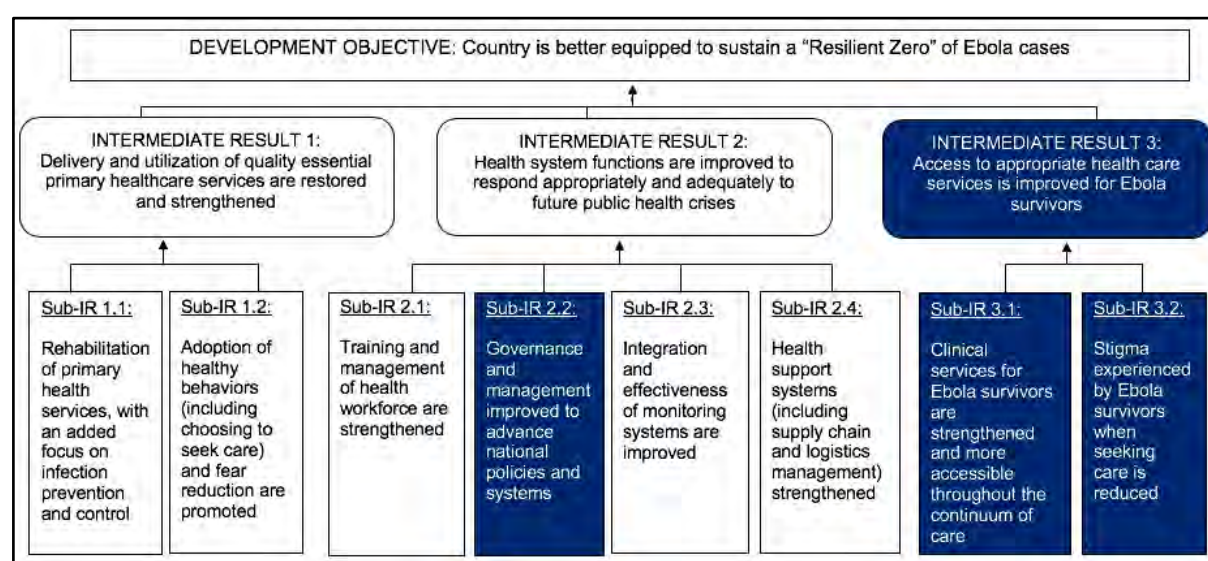
Evaluation Purpose & Objectives

The overall purpose of this evaluation was to determine to what extent the third intermediate and sub-intermediate results, as well as subIR 2.2, of the GHET portfolio were achieved during the life of the survivor program activities to date. In lay terms, the evaluation sought to answer two questions: (1) was the survivor program an effective activity and (2) why or why not?

Results Framework & Lines of Inquiry

The lines of inquiry for this evaluation were based on whether services addressing the specific needs of Ebola survivors were in place and integrated into the public health system to help mitigate further Ebola infection among the population. The lines of inquiry were also linked to the GHET results framework, specifically IR3 and its two sub-IRs, as well as sub-IR 2.2 (Figure 1).

Figure 1: GHET Results Framework



Given the complexity of GHET survivor programming, no single indicator captured all the desired outcomes. Thus, the evaluation lines of inquiry unpacked the IRs and subIRs into activities, outputs, and outcomes (Box 1). For example, what survivor specific health services were available and where, the degree to which they were utilized, whether they were adequate and sufficient, and whether they were improved. With regard to stigma, the evaluation followed a similar pattern of examining what activities had been carried out and whether survivors subsequently experienced less stigma from providers. With regard to governance and management, the evaluation assessed role and additions to national policies, the role of the survivor networks and survivor-related government bodies and survivor confidence in these groups, and the tangible improvements to governance and management.

Box 1: Evaluation Lines of Inquiry (Linked to GHET Results Framework)

<u>Availability and Use of Quality Services</u>	
1.	To what extent are quality health services focused on Ebola survivors available at different types of health facilities? Specific health services established for survivors? Regular health services? Referral to specific survivor services at higher level facilities? <i>(Outcome)</i>
2.	Capacity/Equipment Question: To what extent are survivor health services (other than primary healthcare services) and resources adequate and sufficient to meet the health needs of Ebola survivors? <i>(Output)</i>
3.	Survivors question: To what extent are Ebola survivors educated on services and accessing them? To what extent are Ebola survivors utilizing services available to them? <i>(Outcome)</i>
<u>Stigma</u>	

1. To what extent do survivors experience stigma from health providers, and do survivors report that this stigma has decreased since the beginning of the program? *(Outcome)*
2. Management of health workers: To what extent are health professionals trained to minimize the effects of stigma during patient-provider interaction? *(Output)*

Policy/Systems

1. To what extent have policies, structures or networks (eg survivor networks) improved the services available for Ebola survivors? *(Outcome)*
2. What policies, structures or networks have been strengthened to ensure adequate services are available for Ebola survivors? *(Output)*

Intended Use & Users of Report

This report is intended to provide a view into the effectiveness of program implementation as related to intended outcomes and goals outlined above, of particular interest to program stakeholders including but not limited to funding program managers, implementing partners, and government representatives. Additionally, the report seeks to share qualitative-insights derived from implementation experience relevant to future public health interventions in post-epidemic settings in West Africa and beyond.

Methodology & Analytic Approach

The study employed mixed methods, using both quantitative and qualitative methods. The study design primarily assessed cross-sectional endline data from quantitative health facility assessments, quantitative health provider surveys, and qualitative key informant interviews, carried out in the three countries in May and June 2018 (See Annex B for instruments). These data were supplemented with quantitative survey data collected from EVD survivors (see Annex B for relevant survey items), administered by JSI R&T at program baseline and endline, as well as a mix of other secondary data sources.

For data collection from facilities and providers, the health facility was the primary sampling unit. Facilities were sampled from USAID priority areas in each country- typically those with the highest proportions of EVD survivors. In total, more than 80 facilities were assessed, including a mix of facility types across the continuum of care (primary, secondary, tertiary) that had received APC ETP&SS interventions (Table 1).

In Liberia and Guinea, a near census of facilities was completed in the USAID priority areas (29 of 30 facilities in Liberia, 14 of 14 facilities in Guinea). In Sierra Leone, 39 of 66 facilities receiving ETP&SS interventions were assessed in areas with high EVD survivor presence. One respondent per facility

answered the facility assessment, most typically the person or administrator-in-charge. To be included in the facility assessment analysis, the facility respondent had to have three years or more of facility work experience so that pre-Ebola comparisons could be made. The facility assessment inquired about the provision of essential health services, presence of trained personnel, and availability of commodities, as related to EVD survivor needs.

Table 1: Endline Facility Assessments and Provider Survey Respondents, Number by Country and Type

Country (Region)	Facility Type	Health facility assessments	Providers
Guinea (Conakry, N'Zerekore, Kindia)	Primary (Health Posts)	1	1
	Secondary (Health Centers, CMC)	10	21
	Tertiary (Hospitals)	4	5
Liberia (Montserrado, Lofa, Bong, Margibi)	Primary (Clinic)	9	9
	Secondary (Health center)	12	23
	Tertiary (Hospital)	8	14
Sierra Leone (Western Area)	Primary (MCHP, CHP, CHC)	31 ¹	32

¹ While 32 primary facility assessments were attempted, one facility did not have any staff available with sufficient work history at that facility, so only 31 primary facility assessments were analyzed.

Urban, Bombali, Port Loko, Western Area Rural, Tonkolili)	Secondary (District Hospital)	3	6
	Tertiary National Hospital)	5	7

In the second stage at each facility, health providers were sampled for participation in a quantitative survey measuring their participation in various training initiatives and their opinions and practices with regard to treatment of Ebola survivors. At smaller facilities, one provider of any type was recruited to participate, and two or three health providers were recruited at larger facilities, such as hospitals or larger secondary facilities. In total, there were 27 providers surveyed in Guinea, 46 in Liberia, and 45 in Sierra Leone. Among providers, nurses were the most common type of respondent overall, but there was some variation between countries.

Twenty individuals per country were selected for in-person or phone-based qualitative key informant interviews. Using an open-ended, semi-structured questionnaire, the interviews explored the efficiency, effectiveness, and sustainability of GHET-funded survivor specific programming; management of program activities; systemic challenges and opportunities; and other process evaluation topics. Informants were selected based on their knowledge of and responsibility for program implementation and familiarity with past and current levels of clinical care for EVD survivors. The final set of interview participants represented varying levels of management seniority, across a variety of institutional affiliations (Table 2).

Table 2: Endline Qualitative Key Informants, Number by Type and by Country

Country	Implementing Partners & Subgrantees	Government Representatives	Survivor Network Representatives	USAID Field	Total Interviews
Guinea	6	4	2	3	15
Liberia	10	3	1	1	15
Sierra Leone	9	3	3	3	18

The primary data collected by the Balanced-MERL team were supplemented with other secondary sources. Most notably, survivor insights were captured from two cross sectional quantitative surveys carried out by JSI R&T at baseline (early 2017) and endline (mid 2018) in Guinea, Liberia, and Sierra Leone. Their sampling frame was derived from various survivor lists in each country, such as Ministry of Health or survivor network records. Then random samples were drawn that considered the population of survivors in the target geographic areas and survivor gender. There were some variations in the sampling approach that JSI R&T used in each country; the detailed methodologies can be found in JSI R&T's baseline and endline reports for each country. In all three countries, the Balanced-MERL analysis is limited to the unweighted sample in the USAID high priority geographic areas and/or the areas with high presence of EVD survivors, in accordance with the evaluation Scope of Work (Table 3 and Annex F).

Table 3: Survivor Survey Sample in USAID High Priority Areas, by Country

Country	Number of Participants in JSI R&T's Baseline Survivor Survey	Number of Participants in JSI R&T's Endline Survivor Survey
Guinea	442	531
Liberia	433	213
Sierra Leone	491	480

The survivor surveys differed somewhat between the three countries. At endline only, the Balanced-MERL team embedded a module of questions into each country's survivor survey to answer questions specific to the GHET survivor program performance evaluation. For the purpose of this evaluation, the survivor surveys were used to answer questions regarding perceptions of survivor healthcare services, provider stigma, and survivor networks.

As available, other secondary data sources (Annex A) were used to understand program plans, activities completed, reach, and challenges. These included IP reports, program monitoring and evaluation data derived from IPs, and other program-level documents. A supplementary data quality verification assessed the integrity, reliability, and timeliness of the IP data, to inform decisions about its usefulness (Annex D).

All evaluation materials were reviewed and approved by the internal Institutional Review Board (IRB) at Innovations for Poverty Action. Additionally, individual ethical approvals were obtained locally in each country through the following organizations: Ministry of Health and Sanitation, Ethics and Scientific Review Committee (Sierra Leone); University of Liberia Pacific Institute for Research and Evaluation (Liberia); and the National Committee for Ethics in Health Research (Guinea).

LIMITATIONS

The principal limitation of this performance evaluation was the lack of comparative data, particularly trustworthy baseline data for certain outcomes of interest. Key informants, facility personnel, and, in some instances, EVD survivors used recall to help reconstruct the situation at baseline. As such, there is a threat of recall bias, in which respondents do not remember prior events accurately or completely. Triangulation across a variety of sources allowed for conclusions to be drawn about the contribution of the GHET survivor program to outcomes.

The JSI R&T survivor survey, while a good opportunity to leverage resources and reduce burden on survivors, presented some analytical challenges. While the instruments in Liberia and Guinea were very similar to one another at both baseline and endline, there were notable differences in the structure of the instruments used in Sierra Leone. For example, the items used to measure provider stigma were different between Sierra Leone and the other two countries. Where the BalancedD-MERL items were added to the instrument used in Sierra Leone at endline, there was a substantial shift in the instrument to explore care seeking and the care experience by each specific sequela, in parallel to the general care seeking and experience questions that were maintained between baseline and endline instruments. This made it difficult to compare to the endline measurements in Guinea and Liberia, as well as the baseline situation in Sierra Leone. On several items in the Guinean and Liberian instruments, there were inconsistent time reference points, hampering the ability to analyze responses for certain subsets of respondents with validity.

That said, the survivor surveys gave voice to the experience and perceptions of the program's primary intended beneficiaries and offered a number of high quality items to evaluate the program. Moreover, a survey monitoring exercise conducted by the BalancedD-MERL team revealed a high degree of reliability in the data that JSI R&T collected from survivors (Annex D). It should be noted, however, that how the survivor survey data were analyzed for this report may differ from JSI R&T's analysis and reporting to GHET (e.g., this performance evaluation report limited the analysis in Sierra Leone to only those in five contiguous districts with high prevalence of survivors; how the stigma items were analyzed; etc.).

In Liberia, the saturation of viewpoints sought from Survivor Network representatives and USAID field staff was not reached, giving only single interviews for each category after repeated attempts to secure more interviews.

While not evaluation limitations, per se, there were a variety of challenging situational factors that the APC survivor program faced during its implementation. The general difficulties of working in a post-emergency environment are acknowledged in this report, particularly as they relate to the systemic public health challenges. However, there were some challenges that were not picked up by instruments for analysis in the study like elections in Liberia and Sierra Leone and a lawsuit brought by the Sierra Leone Association of Ebola Survivors against the government of Sierra Leone.

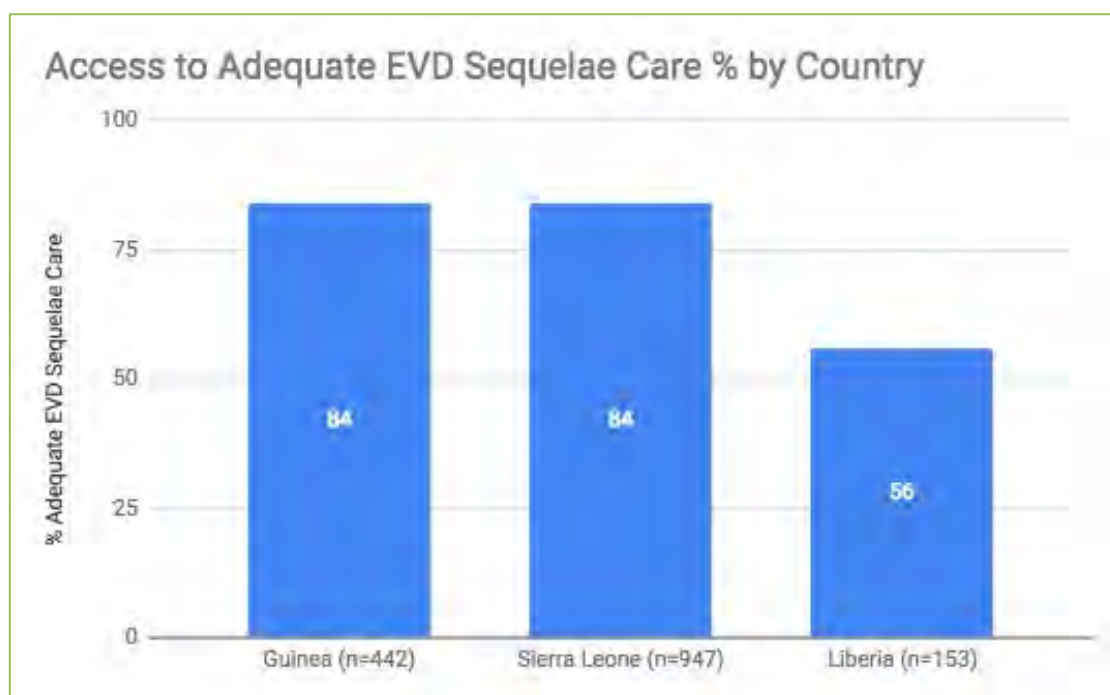
EVALUATION FINDINGS BY DOMAIN

Healthcare for Survivors

Appropriate healthcare services for EVD survivors have improved.

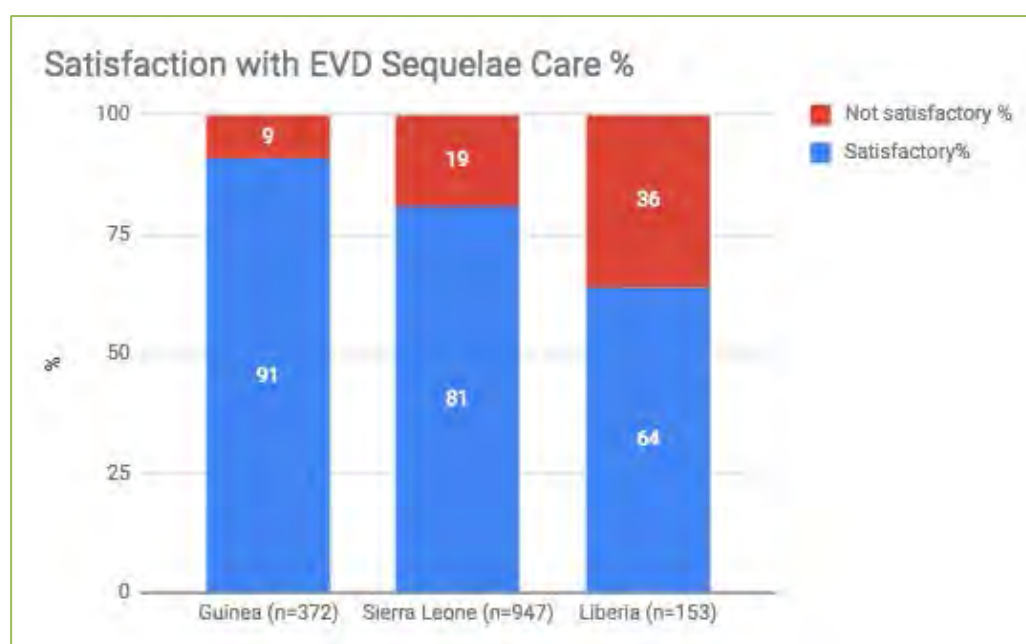
This was determined by analyzing EVD survivor responses to the following question which was included in JSI R&T's endline surveys of survivors: "Do you feel that your access to healthcare for this problem was adequate?" On average across countries at endline, for EVD sequelae for which treatment was sought, three-quarters of EVD survivor responses (74.7%) indicated access to healthcare services were adequate. While 84% of EVD survivor respondents in Guinea and in Sierra Leone reported access to healthcare services for EVD sequelae were adequate, just 56% of respondents in Liberia reported the same (Figure 2). Perceptions about access to adequate care services did not differ statistically by respondent gender in any of the three countries.

Figure 2: Adequate EVD Sequelae Care % by Country (Data Source: JSI R&T Endline BalanceD-MERL module)



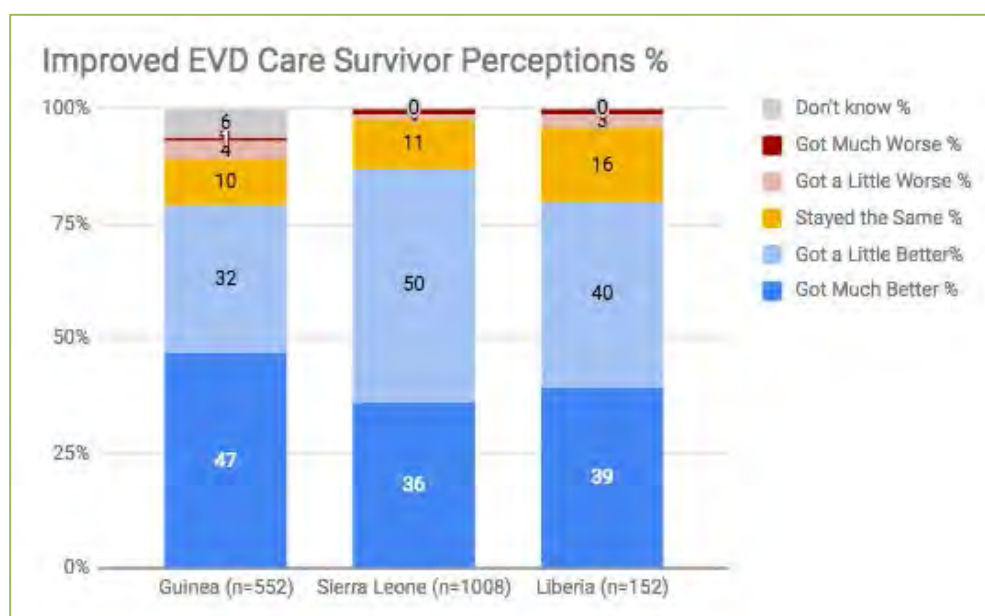
To measure satisfaction with care received, survivors were asked the following question in JSI R&T's endline surveys of survivors: "Was the quality of healthcare that you received satisfactory?" On average across countries at endline, for EVD sequelae for which treatment was sought, over three-quarters of EVD survivor responses (78.7%) indicated satisfaction with services received (Guinea 91%, Sierra Leone 81%, Liberia 64%) (Figure 3). In Liberia, satisfaction differed by gender, 72.1% of females reported they were satisfied with the quality of healthcare received versus 53.7% of males ($p=.019$). In Sierra Leone, where satisfaction was measured separately for each sequelae type, there were gender differences only for satisfaction on eye care, with 82.2% of males satisfied with treatment versus 62.0% of females ($p=.007$). In Guinea, there were no statistical differences in satisfaction by gender.

Figure 3: Satisfaction with EVD Sequelae Care% (Data Source: JSI R&T's Endline BalanceD-MERL module)



Furthermore, survivor perceptions of EVD care improvements were measured through the following question inserted into the JSI R&T endline surveys of survivors: “In the past two years (since the end of the Ebola time), do you feel that care for this problem has- possible responses: gotten much better, gotten a little better, stayed the same, gotten a little worse, gotten much worse.” At endline, a little over four-fifths (81.7%) of surveyed EVD survivors in Guinea, Liberia, and Sierra Leone stated that survivor services had gotten either “much better” or a “little better” since the beginning of program implementation (Guinea 79%, Liberia 79%, Sierra Leone 87%) (Figure 4). In each country, a very small percent of respondents indicated that survivor care had gotten worse. There were no significant differences in perceptions of care improvement by gender.

Figure 4: Survivor Perception of Improved EVD Care% (JSI R&T Endline BalanceD-MERL module)



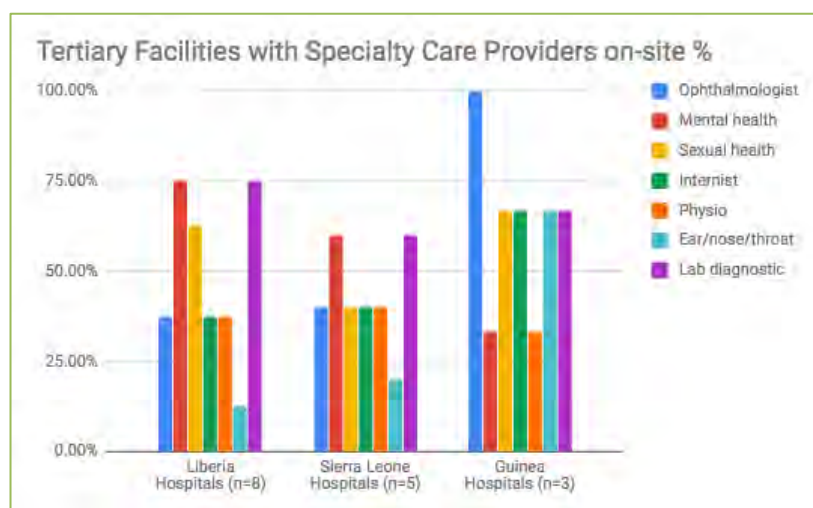
Accessibility of EVD Survivor Services

Many health providers surveyed at facilities for this study reported being trained on EVD sequelae², but training numbers alone did not tell a complete story about the extent to which EVD survivor services were accessible. While specialist care providers for EVD sequelae were not intended to be present at primary health facilities, a closer look at the presence of specialist care providers for EVD sequelae at all facilities was useful in helping to explain findings on adequate care for survivors at varying levels of facilities. In addition to a general checkup, recommended specialty care for EVD-related sequelae included musculoskeletal evaluation, ocular evaluation, auditory evaluation, abdominal evaluation, neurological evaluation, mental health evaluation, and sexual health evaluation (World Health Organization, 2016).

When only considering tertiary facilities, the presence of specialist care providers for EVD sequelae was 50.99% of facilities sampled (Figure 5). While specialist care providers were not expected to be at primary facilities, the lack of presence at primary facilities was a challenge for initiating the referral process for survivors which is designed to be initiated at the primary level.

“For many in the general population, [the notion is] that a tertiary [facility] is the only place that has good [specialized] care. So [survivors] bypassed the primary and secondary [facilities] and went straight to the tertiary care [facility] to receive primary healthcare.” Implementing Partner – Liberia

Figure 5: Tertiary Facilities with Specialty Care Providers % (Data Source: BalanceD-MERL Health Facility Assessment)



² As research design and sampling was not a census of health providers or facilities, reporting data on percentages of providers who received training on EVD-sequelae were determined not to be useful given performance evaluation objectives. In Liberia, 79% of sampled facilities reported providers trained on EVD-sequelae care. In Guinea, 93% of sampled facilities reported providers trained on EVD-sequelae care. In Sierra Leone, 87% of sampled facilities reported providers trained on EVD-sequelae care.

More telling on accessibility of care across the continuum of care were the perceptions of providers on their respective facility's ability to provide adequate care for EVD survivors. This was determined through a question in the Balanced-MERL provider survey: In your opinion, how often is this facility able to provide Ebola survivors with health services sufficient in quantity to achieve their therapeutic needs? – possible responses: Always, Often, Sometimes, Rarely, Never. On average, only 38.5% of staff at all sampled health facilities (primary, secondary, and tertiary) self-reported that their facilities “always” or “often” provided adequate care for EVD survivors. This trend differed by country, with a higher proportion of providers in Guinea and Sierra Leone reporting “always” or “often” compared to Liberia (Guinea 44.5%, Liberia 26.5%, Sierra Leone 44.4%) (Figure 6). When only considering provider responses from tertiary facilities, the perceptions of care adequacy were better, with 57% of providers at tertiary facilities self-reporting that their facilities are “always” or “often” able to provide adequate care for EVD survivors (Guinea 60%, Liberia 50%, Sierra Leone 50%) (Figure 7).

Figure 6: Providers at all facility levels (primary, secondary, and tertiary) reporting adequate services for EVD survivors (Data Source: Balanced-MERL Provider Survey)

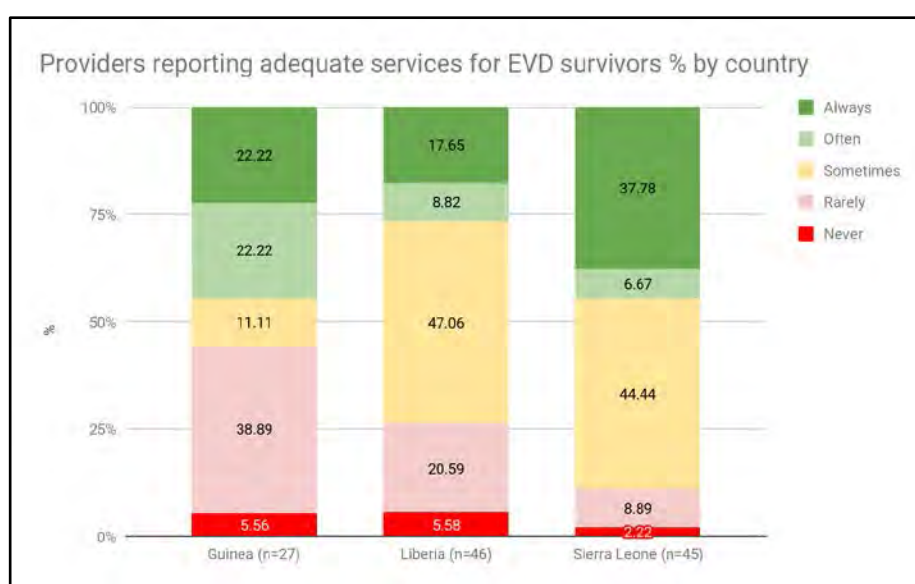
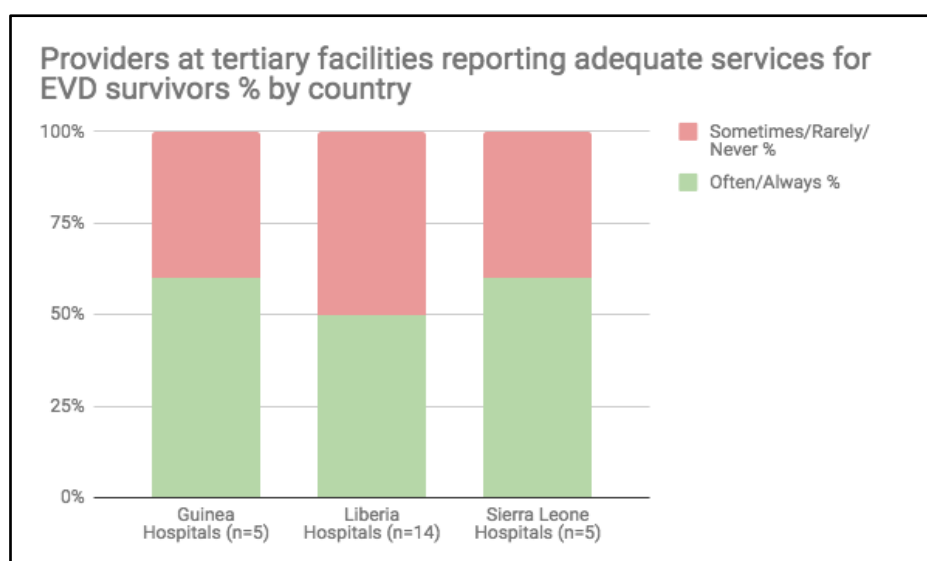


Figure 7: Providers at tertiary facilities reporting adequate services for EVD survivors (Data Source: Balanced-MERL Provider Survey)



Care accessibility among EVD survivors is also somewhat illuminated by an analysis of the number of visits and actualized referrals to tertiary and secondary facilities provided by the main implementing partner, JSI R&T to GHET through quarterly reports. These figures indeed showed that the referral system was utilized in each country (Figure 8 & 9). However, this study cannot definitively comment on the rise and fall in visits and actualized referrals, but given the program established the referral system and process for survivors, the program can certainly be linked to the usage patterns that have been reported. Additionally, these figures may be underreported as a quality verification of these data revealed inconsistent tracking of survivor visits at facilities. In some instances, survivor visits were purposefully not tracked in order to encourage EVD survivors to visit facilities when needed (though implementing partners note that this situation was adjusted when survivor care guidelines were updated).

“There was initially a patient identification card for Ebola survivors and a little booklet for each survivor... to show to get the free medical care and medicine. Based on input from RENASEG [Guinea Survivor Network], which felt that this would further stigmatize patients and made them more identifiable and different from other patients, we did not [require use] of those cards” Implementing Partner - Guinea

According to qualitative key informant respondents, survivors themselves hesitated to self-identify as survivors. As such, referral data (not officially in HMIS but reported to GHET by implementing partners) likely do not capture the full usage of clinical services by EVD survivors, but instead only paint a picture of referral system use in broad strokes. Implementing partners in Sierra Leone were able to provide the GHET team with data on actualized referrals, and while the numbers are lower compared to visits reported in Guinea and Liberia, actualized referrals represent a higher-level outcome to measure the referral system. The referral coordinators deployed in Sierra Leone certainly allowed for capture of higher quality data- in this case on actualized referrals.

Figure 8: Visits by EVD survivors to secondary and tertiary facilities in Guinea & Liberia (Data Source: APC Quarterly Reports)

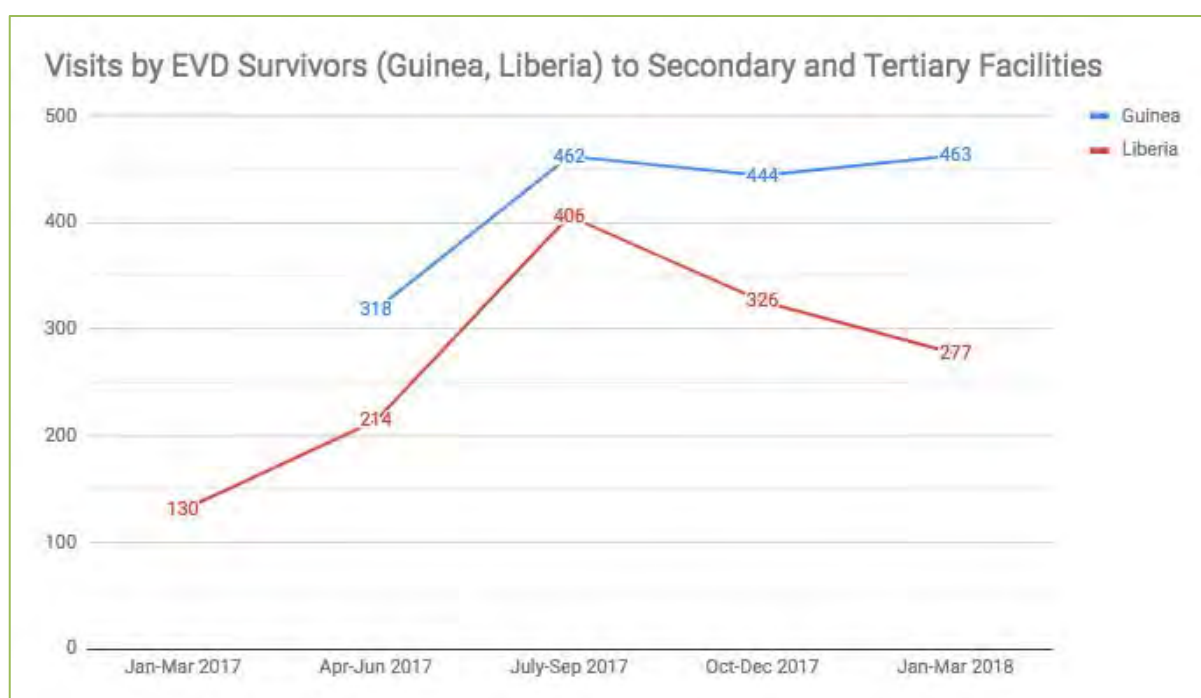
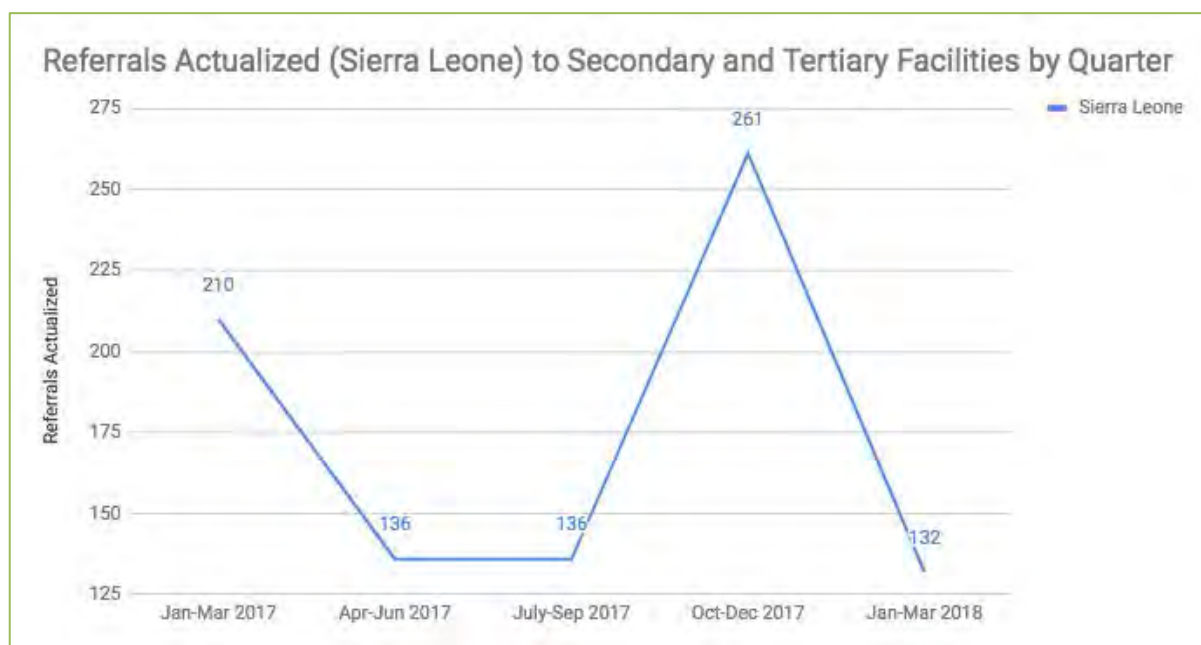


Figure 9: Actualized referrals by EVD survivors to secondary and tertiary facilities in Sierra Leone (Data Source: APC Quarterly Reports)



Qualitative analysis also highlighted that implementation partners only fully recognized the “hidden costs” associated with the referral system of care (e.g., the extent of associated costs for survivors in having to travel for care) as a major barrier to provision of care after implementation was well underway. Across countries from the view of caregivers, only 46% of providers felt that their EVD survivor patients were satisfied with the referral process. Qualitative key informants revealed that when survivors did seek care they often skipped the referral process altogether and proceeded directly to tertiary facilities--becoming a barrier to effective care implementation given that it strained the health system’s ability to both track and provide care efficiently.

“A lot of the survivors are not taking advantage of the [referral] system. They bypass the system and go the next level. There are a few of them [survivors] that will follow the system, but a lot of them do not.” Implementing Partner - Liberia

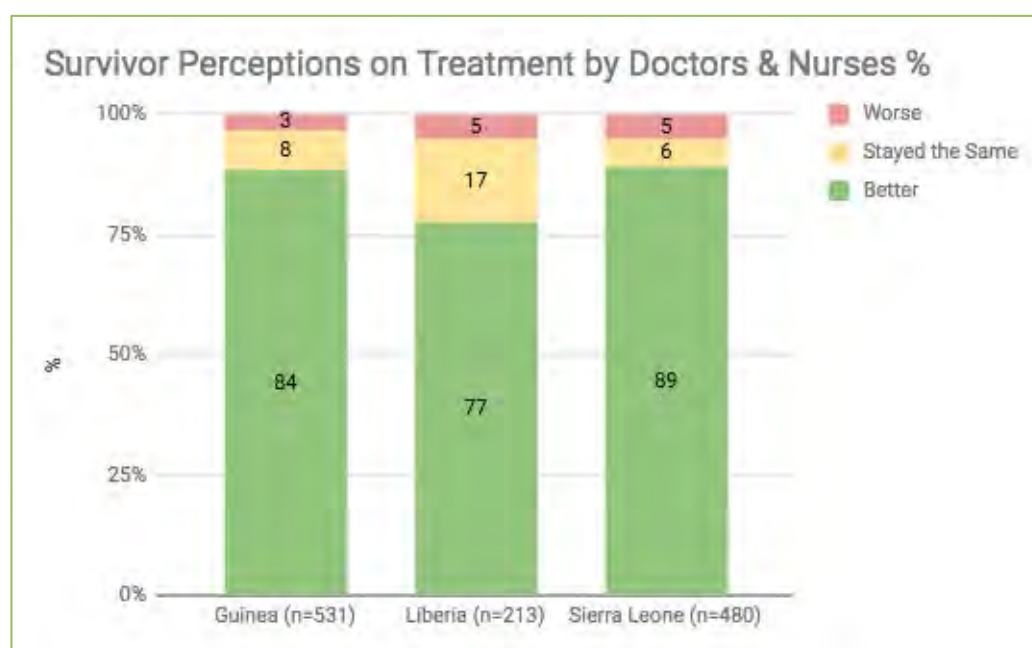
EVD Health Provider Stigma

Several different measures explored EVD survivor perception of stigma from health providers. In combination, the measures showed that while some provider stigma remained, there has been a significant reduction over time in Guinea and Liberia. In Sierra Leone, stigma remained the lowest among countries but a statistically significant change could not be detected.

Included in the JSI R&T endline survivor survey through a BalanceD-MERL module, the following question sought perceptions of survivors on their treatment by health providers: Do you think that treatment of Ebola survivors by doctors and nurses has gotten better, gotten worse, or stayed the same since just after the Ebola time? – responses: Better, Worse, Stayed the Same. Most surveyed EVD survivors in each country indicated that treatment of EVD survivors by physicians and nurses had

improved since the program began (Figure 10). However, small proportions indicated that survivors were treated worse by providers over time. There were no significant differences by gender.

Figure 10: Survivor Perceptions on Treatment by Doctors & Nurses (JSI R&T Endline BalanceD-MERL module)



Across countries, EVD survivors were queried about specific examples of provider stigma at baseline and endline by JSI R&T.³ Each country collected data on provider stigma differently.

In Guinea, the JSI R&T survivor survey baseline and endline asked survivors to indicate whether they experienced the following 5 examples of provider stigma:

Medical personnel refused to treat you or do tests for you because of your Ebola status.

The wait time to be seen by a medical staff was longer for you than for other patients.

Medical staff took excessive precautions when examining you.

³ In Guinea and Liberia, perceived provider stigma was measured using five items among all survey respondents, without screening for whether they had recently received care at a health facility. In Sierra Leone, perceived provider stigma was measured using three items and limited to those who had received care at a health facility in approximately the year prior to the survey. The composite stigma data presented herein is an average of respondent answers across items, by country. This differs from the stigma index approach used by JSI R&T. In Liberia and Guinea, JSI R&T calculated perceived stigma as the percent of respondents who indicated two or more of the five stigma items. In Guinea, this equated to 29.9% at baseline and 6.8% at endline. In Liberia, this equated to 30.3% at baseline and 8.9% at endline. In Sierra Leone, JSI R&T calculated perceived stigma as the percent of respondents who had received care at a health facility in the year prior to the survey and who indicated any of three stigma items. JSI R&T's data in Sierra Leone were from a national sample and weighted. In Sierra Leone, this equated to 23.5% at baseline and 11.9% at endline.

Medical staff gossiped about your Ebola status.

You received less attention / care than the other patients.

In Liberia, the JSI R&T survivor survey baseline and endline asked survivors to indicate whether they experienced the following 5 examples of provider stigma:

The doctor/nurse refused to treat you or refused to do relevant tests.

You had to wait longer for the doctor/nurse to treat you than other patients.

The doctor/nurse appeared nervous or uncomfortable treating you.

The doctor/nurse gossiped about your survivor status.

You received less care/attention than other patients.

In Sierra Leone, the JSI R&T survivor survey baseline and endline asked survivors to indicate whether they experienced the following 3 examples of provider stigma:

You were denied health services because of your Ebola survivor status.

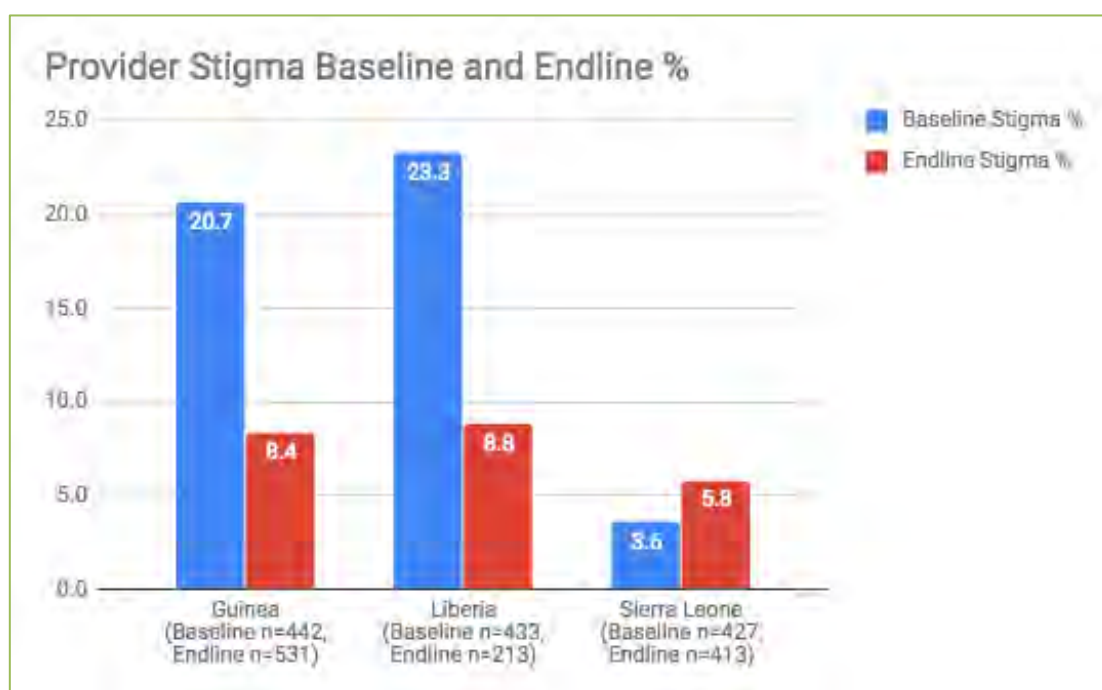
Healthcare workers talked badly about you because of your Ebola survivor.

A health worker disclosed your Ebola survivor status without your permission.

When survivors indicated they had experienced one of the examples above, the response was counted as an experience of provider stigma. Given the variance in measurement by country, the BalanceD-MERL team created a stigma percentage score for each country by taking the average of each provider stigma measure for use as a composite country average of provider stigma for each country.

The perception of provider stigma towards EVD survivors declined substantially between baseline and endline in Guinea and Liberia; in absolute percentage terms, there was a 12.3% reduction of stigma in Guinea and 14.5% reduction in Liberia (Figure 11). The results in Guinea and Liberia were statistically significant ($p < 0.001$). In Sierra Leone, the level of provider stigma as reported by survivors increased over time (2.2% in absolute terms). However, Sierra Leone had the lowest levels of provider stigma at baseline and endline across all three countries. Furthermore, results in Sierra Leone are not statistically significant- in part due to the smaller change that needed to be detected and resulting larger required sample size. In terms of representing these changes as a percentage of baseline stigma, Guinea and Liberia showed a 59.5% and 62.1% relative reduction in provider stigma, respectively.

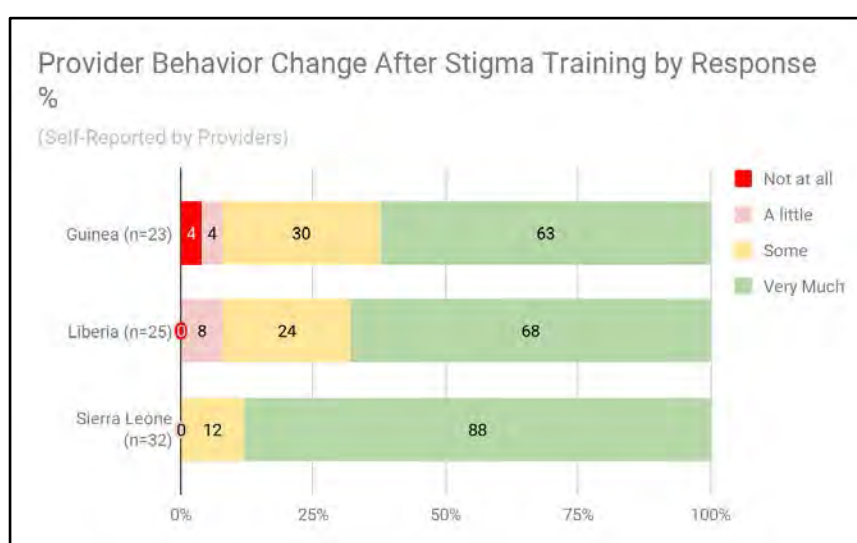
Figure 11: Provider Stigma, Baseline and Endline % (Data Source: JSI R&T Survivor Baseline & Endline)



Perceived provider stigma rarely varied by respondent gender. In Liberia, there were no statistical differences by gender at baseline or endline, although the endline data trended toward more men reporting these problems than women. In Sierra Leone, there was no statistical difference by gender at baseline; at endline more males reported that “healthcare workers talked badly about you because of your Ebola survivor status” (8.1% of males versus 2.5% of females, $p=.03$). There were no other statistical differences in individual stigma items in Sierra Leone. In Guinea, there were no statistical differences by gender at baseline or endline.

Survivor perceptions on the reduction of provider stigma were further validated by the perspectives of health providers who received stigma training. Providers at sampled health facilities were asked the following question: To what extent did your behavior when caring for Ebola survivors change as a result of this training? – responses: Not at all, A little, Some, Very Much. Nearly three-quarters of providers (73%) across countries reported that stigma training changed their behavior towards survivors “very much” (Guinea 63%, Liberia 68%, Sierra Leone 88%) (Figure 12). In fact, all provider respondents in Liberia and Sierra Leone reported that stigma training changed their behavior, and 96% of providers in Guinea reported the same.

Figure 12: Provider Behavior Change After Stigma Training (Data Source: BalanceD-MERL Provider Survey)



Qualitative analysis provided additional supporting evidence of reduced provider stigma. All stakeholder types interviewed (IPs, Government, USAID, and Survivor Networks) felt the program made strong contributions to reduction of provider stigma, most effectively through provider training and education. However, key informants also noted that a residual amount of general stigma around mental health issues remained, regardless of EVD status.

“Survivors indicated that since after the training [health workers] received [survivors] have been treated with respect and that confidentiality has been improved...and [providers] are no longer afraid to treat them[survivors]” Implementing Partner - Liberia

“Not only [has] training helped reduce stigma, but continuous engagement with [providers] about all the programs. So slowly [providers] came to accept that [survivors] are not infectious, and [survivors] came to access healthcare.” Government Representative - Sierra Leone

“Training brought a great change by explaining to providers that survivors, once they recover from the disease, the disease can't be transmitted- that you can treat them as you treat other people. This built confidence in [providers], helped them treat survivors in their facilities, and increased survivors' confidence in seeking care.” Survivor Network Representative – Liberia

Governance & Management Effects on EVD Policies & Systems

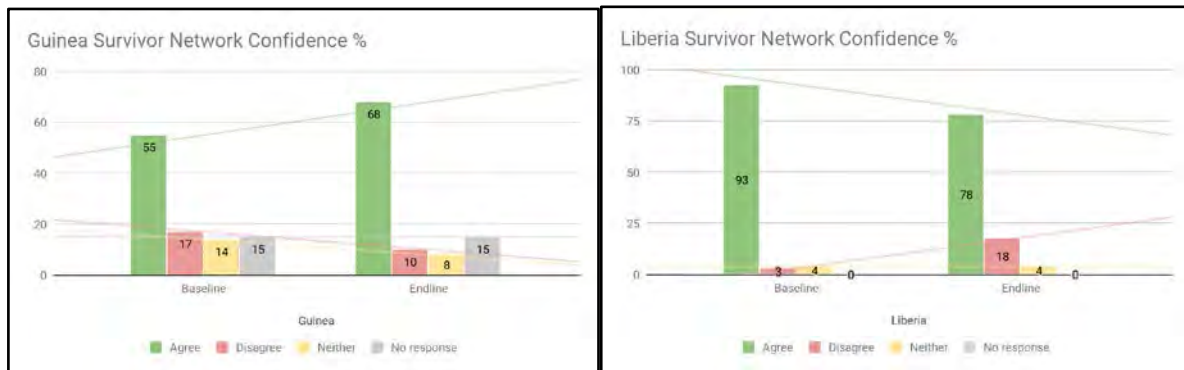
The program strengthened national policies and systems primarily through contributions to each country's national guidelines on EVD survivor care, specific clinical guidelines on EVD care, and capacity building and support to survivor networks and government bodies responsible for implementation and management of survivor services. Additionally, in Guinea the program supported effective and efficient operation of surveillance sentinel sites.

Overall, the support to, and often creation of, survivor networks and government bodies responsible for implementing survivor services and care was successful. Moreover, these activities had downstream ripple effects, via the contributions that the networks and government bodies subsequently made to survivor program design and implementation. These institutions had continued positive impact on the program through direct engagement with or feedback to the program. Simply put, the networks and bodies performed necessary functions that positively benefited implementation of survivor work. Survivor networks organized and represented survivor interests, often directing survivors to services and providing feedback to implementing partners on how to best operationalize services and programming, like approaches to stigma reduction in communities and how to best engage survivors on referral processes. The government bodies engaged directly and eventually took more ownership of EVD programming and processes implemented through the program.

The JSI R&T survivor baseline and endline surveys in Guinea and Liberia shed light on how survivors perceived various EVD bodies. At endline, nearly three-quarters (73.8%) of survivor respondents in Guinea and Liberia reported they agreed that the Survivor Network looked out for their interests and represented them well. There were no significant differences in perception by gender in either country. Similarly, 69% of respondents in Sierra Leone reported being "very confident" in their Survivor Network at endline. However, in Sierra Leone, confidence in the Survivor Network differed by gender. Among males, 76.0% were very confident in the Survivor Network, compared to just 62.2% of females ($p < .001$). Moreover, 17.2% of females said they did not have any confidence in the Survivor Network in Sierra Leone, compared to 6.6% of males.

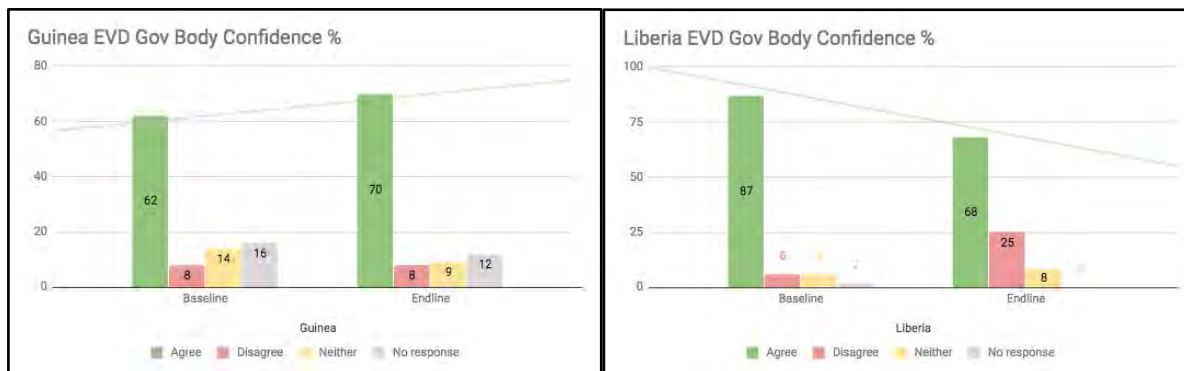
While there were no baseline data from Sierra Leone for comparison, when comparing baseline and endline survivor data for Guinea and Liberia, two trends emerged. Confidence in the Survivor Network increased in Guinea (+13.2% in absolute numbers) and decreased in Liberia (-15% in absolute numbers) (Figures 13 and 14). Quantitative data collected from survivors did not allow for additional analysis on what led to the increase and decrease in survivor confidence in these respective institutions.

Figures 13 & 14: Confidence in Survivor Networks Guinea & Liberia (Data Source: JSI R&T Survivor Survey Baseline/Endline)



At endline, 69% of surveyed survivors in Guinea and Liberia agreed that they had confidence in the National EVD Government Bodies. In Guinea, more men had confidence in their governmental EVD body than women, 75.5% versus 61.4% ($p=.023$). There was no significant difference by gender in Liberia. Similar to the trends for Survivor Network confidence, over time there was an increase in confidence in the National EVD Government Body in Guinea (+8.1% in absolute numbers) and a decrease in Liberia (-19.1% in absolute numbers) (Figures 14 and 15).

Figures 14 & 15: Confidence in National EVD Bodies Guinea & Liberia (Data Source: JSI R&T Survivor Survey Baseline/Endline)



As noted earlier, survivor networks and national EVD government bodies were centrally located strategic stakeholder bodies that also contributed to survivor program implementation decisions. Qualitative data analysis showed that survivor networks in particular had an impact on program implementation, in shaping survivor community engagement and in referral system implementation. Survivor networks not only were the conduit for feedback from survivors on services but also held the power to both encourage and deter survivors from visiting health facilities (Liberia) and were identified as a key to better working relationships with the government (Sierra Leone). These qualitative insights will be further elaborated later in this report.

Program Implementation & Barriers

Collaborative Nature of Implementation

Overall, program implementation was characterized as collaborative. Qualitative data showed that the program implementing partners sought and received feedback from program stakeholders. Two-thirds of qualitative interviews described their interaction with the program implementing partners as “high” on both level and quality of engagement. This collaboration was cited to not only have kept all program stakeholders informed but to also have contributed to minimizing duplication of efforts.

“JSI [Research & Training, Institute Inc.] wouldn't do anything without engaging us, they had us very fully engaged; in fact, [we] had very major input... into the processes all along the way. I don't even remember the number of times we have met. We met so many times, every step of the way...so we were involved from the very beginning up to the very end.” Government Representative - Liberia

“It was a beautiful program from the beginning till the end- the way it was structured, the way it was designed... addressing the issue from two sides, creating two networks and making sure that they connected together; working with both of them to try and make them better and bigger all the time, and then connecting them. That was really, really good.” Implementing Partner - Sierra Leone

Against this positive backdrop, key informant interviews nevertheless yielded suggestions for improving the reach and impact of programming. In particular, interviewees suggested deepening engagement at the district level (Guinea) and improving engagement with the survivor network (Liberia & Sierra Leone). While both the overall collaborative nature of implementation and the short time-period for implementation were acknowledged, the following suggestions are offered for future public health interventions working through similar constraints.

District Level Engagement

While the program worked with limited budget and mandate, interview respondents noted that overall, greater district level engagement could have increased receptiveness of survivors and the broader community beyond survivors- effectively a call for more “bottom-up” decision making.

“How to communicate and ensure that messages reach the targets [at the local level] should have been researched and analyzed before. The [EVD] Secretariat was not passing messages down to the district level. Messages about when specialists would be available should also have been put out before specialists started making visits.” Implementing Partners - Liberia

The best approach is to involve survivors, religious leaders, communities, all of them in decision-making. So that decision comes from the bottom-- bottom-up and not top-down.” Implementing Partner – Guinea

Deeper insight on this point was drawn from qualitative interviews with key informants:

Insight: More Local Level Community Engagement

There are two dimensions to this expanded insight, and the study team has earlier referenced the program's implementation contribution to local surveillance sites in Guinea. First, interview respondents frequently noted the benefits of engaging the broader community affected by EVD, not necessarily just survivors or health providers in order to ease community concerns at all phases of planning and implementation.

"Not only [knowledge] for survivors but for the general population... when people get knowledge, this influences their behavior to make change... [knowledge was] one of the most important things that stopped Ebola in its tracks here." Government Representative-Sierra Leone

"I would suggest from the onset of any Ebola crisis, the survivors, the community, the healthcare workers, should all form a target of behavior change communication intervention. Why do I say that? Survivors live in the community, and continuous engagement with the community will empower the community to take the actions that they can. People in the community have different practices, so engagement would help [implementers] see what they need to seek to help that community." Survivor Network Representative - Liberia

Second, with the understanding that this particular program operated within allotted funding and limited timeframe, interview respondents (particularly in Guinea) voiced the potential benefits of engaging even more at the local district level, which they believed would also help ensure better monitoring and preparation for future public health outbreaks.

"You need the engagement of the districts to prevent another outbreak, and the districts were actually not so much supported by the project." Implementing Partner - Guinea

SA-Ceint [surveillance sites] started a bit late; we should have organized that from the moment the outbreak ended. If we don't do the same in the DRC we risk having unpleasant surprises in the future, as we don't know the final outcomes of Ebola. These kinds of [local surveillance] structures should be in place until we have the knowledge and means to avoid resurgence." Government Representative - Guinea

"Yes, the central level is there, but it [only] takes into account what the community level may want." Implementing Partner – Guinea

Survivor Network Engagement

Overall, the survivor networks were determined to be helpful in organizing survivors and representing their views. While there were varying levels of tension between the Survivor Network and implementing partners (especially in Liberia), interview respondents reiterated the need for greater engagement and the benefits to even more coordination and collaboration with survivor networks, despite differences and varying levels of capacity.

"You had a high participation rate in your last testing campaign. What do you think that was due to? I think it's due to the local associations, the peer interaction between the Ebola

survivors, and by the survivor network.” Implementing Partner - Guinea

“Any institution that wants to work with survivors has to work with the survivor network. You work together, you will be able to achieve your objectives. If you don't work with the survivor network, you won't achieve [your objectives].” Survivor Network Representative - Liberia

“I think having that common link [with the survivor network], where there is somebody who understands Ebola, who has fought so hard to end this outbreak, and who is going to help survivors.... is an important message.” USAID Field Staff – Guinea

Persistent Barriers to Implementation

Systemic Barriers

Primarily from the implementing partner perspective, there were a number of oft-cited barriers to program implementation, many at a systemic level which persisted throughout implementation. While the program was not mandated to address systemic-level issues affecting provision of healthcare in all three countries, implementation was of course impacted by these underlying conditions. The largest barriers identified across countries were related to a lack of both general health infrastructure and logistics in-country required to get equipment and medication⁴ where it was needed. These conditions limited provision of and access to care and also were cited as reducing survivor motivation to seek care directly at primary health facilities or to follow the referral system (referring survivors to tertiary facilities) for survivor care.

⁴ Interviews for this study were conducted after media reports of medicine stock-outs in early May (example [Liberian Observer, May 10, 2018.](#))

Further qualitative insights drawn from interviews with key informants further illustrates the challenges faced in implementation and a promising practice that emerged on the use of “referral coordinators” in Sierra Leone. Insight: Systemic Barriers to Treatment & Referral Actualization

As referenced, interview respondents felt that being more aware of the limits of the healthcare system (in particular lack of medication and services and ability to deliver these goods and services to health facilities) and fully understanding the costs of referral for survivors would be beneficial for future programming. The lack of medication raised by the first and second quotes in this box were not in ETP&SS control.

“The system has problems. Sometimes there are drugs you need to buy because they are not there from the government. It's free healthcare from the government but the government is not providing them. I want to operate [on a survivor]. But after the operation, this patient needs... some drugs to survive. I have to ensure that these drugs are there before I operate. So, these patients are given a [task]... they have to bring those postoperative drugs.” Implementing Partner - Sierra Leone

Consultants started paying for medications themselves. But we told them to stop because it was not solving the problem. Medications did not arrive until the very end of the project. In some locations the hospital did not even have aspirin.” Implementing Partner – Liberia

“Referral everywhere costs a lot of money... for the patient because [when] you go to the primary level they give you a referral slip and usually it is a long distance [to the next facility]. You have to pay for more... laboratory tests. [The cost] is part of the referral... it costs more money and more resources.” Implementing Partner - Guinea

“One of the main barriers to getting mental healthcare especially for those that are located far away is the cost. To travel from Lofa to Montserrado is at least 10 hours, the travel costs [include] accommodation... so most people are very unlikely to seek this care or use the referral system” Implementing Partner - Liberia

In Sierra Leone, the issues around referrals were partly addressed through the use of “referral coordinators,” bridging gaps for both providers and survivors on the referral system and process. As part of the Survivor program, referral coordinators were assigned to each District Health Management Team to support clinical services and referrals for EVD survivors, often assisting both survivors and providers with the nuances and necessary coordination of the referral process. Embodying the softer human side of public health administration, roles like referral coordinator should be considered and factored into similar future interventions.

“There was a significant increase in the use of this system by survivors. And this was strongly helped by the referral coordinators and the teams moving between the communities, the district hospitals, and the tertiary care centers” Government Representative - Sierra Leone

“It is the referral coordinator that has improved care... one in terms of documentation- the referral form. Completing that [form], [the referral coordinator] also provides a lot of support... but these are people that have [also] been trained on hospital preparedness. If the patient is coming to Freetown for an emergency or for the laboratory, the referral coordinator can just call [ahead].” Government Representative - Sierra Leone

“Now there is a much more formalized referral pathway with a network of referral coordinators who collect data on service availability. Therefore, [referral coordinators] are able to provide that service availability data to get patients to the right place at the right time. Timing is quite important.” Implementing Partner - Sierra Leone

*If you have a referral coordinator in your facility, you're more likely to receive [patients]”
Implementing Partner - Sierra Leone*

While again acknowledging the limited and focused scope of the program on survivor services, related to the systemic issues that program stakeholders noted, qualitative interviews yielded insights and considerations for future implementation.

Insight: Health System Overall vs Survivor Specific Focus

While the program was mandated to focus specifically on improving survivor services within a limited timeframe, many respondents raised the tradeoff between improving survivor specific services versus improving the health system overall given the existing public health system challenges in Guinea, Liberia, and Sierra Leone.

Specifically, from the perspective of IPs, Government, and USAID Field respondents, given that EVD survivor care is embedded in and affected by the quality of the overall public health system, respondents felt that the program would have benefited from a broader approach to care for survivors versus focusing exclusively on setting up survivor-specific services and processes.

“From the side of government, with the Survivors Care Support Policy, other line ministries besides the MOH should have offered [more], including the Ministry of Gender or Ministry of Justice to better enforce the other pillars of the policy. Unfortunately, the MOH has [only] done [its part] on three pillars- clinical care, stigma reduction & discrimination, and mental health” Survivor Network Representative - Liberia

“The project did not do anything with regards to the other parts of the [EVD survivor] policy that were for legal, education, or economic support. But the MOH is [also] not doing anything either for [survivors] in this regard- even though the policy says they should.” Implementing Partner - Liberia

Again, while the program’s mandate was limited to survivor services and programming, integration of Ebola specific healthcare, processes, and data into the broader public health system has not been completed and are likely to pose ongoing challenges in the future.

“Are they tracking Ebola inside HMIS or the new management information system? They're only tracked within the [Ebola] Secretariat or the Survivor Network Secretariat. Nobody [else] has tracked them in this country. Nowhere. Nowhere else. Only here.” Liberia - Government Representative

“There have been many kinds of [data] identification but up to now, there is no official data. There is one form at the Ministry of Social Welfare. If you go to SLAES they have their list. If you go to the Ministry of Health they have theirs. So, we still have this issue.” Sierra Leone- Implementing Partner

Program Specific Barriers

In Guinea and Sierra Leone, the slow pace and responsiveness of government bureaucracy were cited as having contributed to delays in programming. In Liberia, poor relations between the Implementing Partner and the Survivor Network were cited at times as even discouraging survivors from accessing care at health facilities.

“There were some delays, sometimes because of the Ministry of Health or the Ministry of Social Welfare. Working with the Ministry of Social Welfare, was at times a little bit difficult...”

Implementing Partner - Sierra Leone

“The ANSS [representative] was... a problem for program delays... not allowing the program to move forward and without responding [to the IP] for over 4 months... from the period of October 2016 until March 2017, he did not accept activities to be implemented.” Implementing Partner - Guinea

“In late 2017, no survivors presented themselves at the healthcare facilities. According to a [survivor], the Survivor Network leader was dissatisfied about some issue with JSI Research & Training Institute, Inc. and had instructed survivors not to attend [medical] consultations.” Implementing Partner - Liberia

“We found out that the Survivor Network coordinator asked survivors not to go in [to medical facilities] because of the transportation reimbursement issue and this was why they were not coming in” Implementing Partner – Liberia

Despite these difficulties, qualitative interviews with key informants shed additional insight and emerging best practices for future implementation with respect to host government engagement in similar settings.

Insight: Engaging Early & Often with Government Partners

Especially in post-epidemic settings, the importance of maintaining regular communication and good relations with government agencies in host countries is well-known. Interview respondents across stakeholder types often mentioned the collaborative nature of program implementation and high levels of engagement with stakeholders. Given implementing partners in all three countries worked closely and sought positive relationships with government partners, there were some illustrative best practices that emerged in each country that speak to approaches that work to foster buy-in and ownership of program efforts over time.

“We did our [design] analysis together with ANSS; they showed us the activities [for] SA-Ceint [surveillance]... We had our activities list and analyzed them in relation with the needs identified and priorities set by ANSS. In agreement with ANSS, we identified the [joint] needs and those were the needs that JSI Research & Training Institute, Inc. [was asked to] address.” Implementing Partner - Guinea

“I think the big impact, the big success here is that we are working and educating the government to think more about a health system approach perspective rather than [just] response.” Implementing Partner - Sierra Leone

“The biggest difference between CPES Phase 1 and Phase 2... Phase 2 is Ministry led. This was a conscious decision to [have the] Ministry lead- made by the Ministry, implementing partners, and USAID.” Government Representative - Sierra Leone

“We had participation from the Minister of Health. We supported the MOH Communication Unit as well as the Liberia College of Physicians and Surgeons. We sat together to develop the messages.” Implementing Partner - Liberia

Conclusion

Overall, the GHET program for survivor services was effective, particularly in reducing the stigma EVD survivors experienced from health providers when seeking care in Guinea and Liberia. Comparing levels of stigma at baseline and endline, survivors reported a 59.5% reduction in provider stigma in Guinea and a 62.1% reduction in Liberia. In Sierra Leone, provider stigma was already the lowest among countries at baseline (3.6% of survivors reporting stigma when seeking care) and remained the lowest at endline (5.8%); thus, the same relative reduction was not evident. Qualitative findings confirmed that from the perspective of implementing partners, government representatives, survivor network representatives, and USAID field staff that provider trainings and education campaigns on stigma were effective.

While the GHET program also improved the availability of clinical services for EVD survivors, accessibility of care across the continuum of care (primary to tertiary facilities) was more difficult to improve given systemic public health weaknesses in Guinea, Liberia, and Sierra Leone. Survivors did report high levels of access to adequate care (74.7%), satisfaction with care received (79%), and an improvement in survivor services since the beginning of program implementation (81.5%). However, only 38.5% of healthcare providers at primary, secondary, and tertiary facilities sampled indicated their facilities were able to “often” or “always” provide adequate care for survivors. When only considering responses from tertiary facilities, the figure increased to 57%. While the program successfully established and implemented EVD-survivor specific health protocols and referral processes, lower levels of adequate services for survivors available at the primary level and survivor reluctance to follow the referral system process were systemic deterrents in delivering accessible care particularly in closer proximity to survivors at the primary facility level.

Finally, when considering accessibility of care and preparation for future public health crises, the establishment of and capacity-building support to EVD survivor networks and government bodies contributed positively to the program’s efforts. However, the integration of survivor-specific services and processes into the general public health systems of Guinea, Liberia, and Sierra Leone remains a work in progress.

Annexes

Annex A: References

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Annex B. Instruments

BalanceD-MERL Facility Assessment

Starting on next page

Field	Question	Answer																														
Survey Information																																
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facility_name_search	Select the correct facility from the list below:	<table border="1"> <tr> <td>-77</td><td>Cannot find the name</td></tr> <tr> <td>facility_name</td><td>facility_name</td></tr> </table>	-77	Cannot find the name	facility_name	facility_name																										
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Survey Information > consentgrp																																
introduction	Hello, my name is . (Enumerator name) I am a researcher for Innovations for Poverty Action, a research and policy non-profit organisation that discovers and promotes effective solutions to global poverty problems. I am visiting you today because we are a conducting a study about the health system in Liberia.																															
purpose	The purpose of this survey is to better understand the current state of the health system, including information about local health facilities, health providers, and community members who may use those health services.																															
procedures	If you choose to participate, you will be asked to complete a survey. The survey will cover: Information about the facility, including staffing, infrastructure, and services offered Information about external support the facility has received since the Ebola Virus Disease outbreak The survey will take approximately 1 hour of your time.																															
risks_benefits	Risks and Benefits: We hope that this research will help us better understand the current state of the health system for Ebola Virus Disease survivors to improve future public health interventions. We do not anticipate any risks to you from study participation. You are free to skip any question that makes you feel uncomfortable.																															
confidentiality	No names will be stored with survey responses and no names will be published from the study. The research staff will not share your personal information with anyone outside the study, and they will do their best to protect your information.																															
voluntary_participation	Participation in this study is voluntary. That means you do not have to participate if you do not want to. Ending participation at any time for any reason will not have any negative consequences for you. You may withdraw at any time, which you can do by simply telling me that you no longer want to be part of the study. Refusal to answer any individual questions will not have any negative consequences for you.																															
contact	For questions regarding the research or about your rights as a research participant please contact:																															
questions	Do you have any further questions?																															
consent (required)	If I have answered all your questions, do you agree to participate in this study?	<table border="1"> <tr><td>1</td><td>Yes</td></tr> <tr><td>0</td><td>No</td></tr> </table>	1	Yes	0	No																										
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signature (required)	Please sign here to indicate that you agree. Question relevant when: \${consent} = 1																															
All_questions																																
Group relevant when: \${consent} = 1																																
All_questions > Respondent profile																																
enu_note_1	I'd like to ask you a few questions about you and the facility you work in																															
facility_in-charge (required)	Are you the facility in-charge?	<table border="1"> <tr><td>1</td><td>Yes</td></tr> <tr><td>0</td><td>No</td></tr> </table>	1	Yes	0	No																										
1	Yes																															
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Field	Question	Answer	
position (required)	What is your position Question relevant when: \${facility_in-charge} = 0		
facility_operational (required)	How long has this facility been operational?	1	3-4 years
		2	5-7 years
		3	8-10 years
		4	above 10 years
		-999	Don't know
		-888	Refuse to say
facility_work_exp (required)	How long have you been working at this facility?	1	Less than 3 years
		2	3 years or more
		-999	Don't know
		-888	Refuse to say
All_questions > Questions for qualified respondents			
Group relevant when: \${facility_work_exp} = 2			
All_questions > Questions for qualified respondents > Facility Profile			
cathment_pop (required)	What is the size of the catchment area population of this facility?		
All_questions > Questions for qualified respondents > Facility staff			
providers_physicians_full (required)	How many physicians are full time at this facility?		
providers_physicians_part (required)	How many physicians are on part time at this facility?		
providers_physicians_ass_full (required)	How many physicians assistants are on full time at this facility?		
providers_physicians_ass_part (required)	How many physicians assistants are on part time at this facility?		
providers_nurse_full (required)	How many nurses are on full time at this facility?		
providers_nurse_part (required)	How many nurses are on part time at this facility?		
providers_nurse_aide_full (required)	How many nurse aides are on full time at this facility?		
providers_nurse_aide_part (required)	How many nurse aides are on part time at this facility?		
providers_midwives_full (required)	How many midwives are on full time at this facility?		
providers_midwives_part (required)	How many midwives are on part time at this facility?		
facility_inpatients (required)	Does this facility take inpatients?	1	Yes
		0	No
		-999	Don't know
		-888	Refuse to say
facility_bed (required)	Does this facility have beds?	1	Yes
		0	No
		-999	Don't know
		-888	Refuse to say
facility_bed_number (required)	How many beds does the facility have? Question relevant when: \${facility_bed} = 1		
All_questions > Questions for qualified respondents > EVD_Clinical_Services			
All_questions > Questions for qualified respondents > EVD_Clinical_Services > EVD			
Enu_note_2	I now want to ask you about some of the services offered to EVD survivors at this facility.		
ebola_survivors_record (required)	Do you keep a record of how many Ebola survivors are treated at this facility?	1	Yes
		0	No
Enu_note_3	I would like to ask you some questions about how many ebola survivors are treated here. If they do not have records or cannot get the records , ask them to answer from memory.		
answer_type (required)	Is the person giving answers from a written record? Question relevant when: \${ebola_survivors_record} = 1	1	directly in a written record
		2	written record and memory
		3	Telling you from memory
registered_survivors_received (required)	How many registered EVD survivors have received care at this facility since the end of the ebola time? (From June 2016 to date) If the respondent does not know please enter -999		
All_questions > Questions for qualified respondents > EVD_Clinical_Services > screen_refer			
serv_offer	For each of the following EVD survivor services, please could you tell me if they were delivered before the Ebola time, during the Ebola time, and now?		
screen_refer_eye (required)	Basic eye screening and referral Please select all that apply	1	Offered before ebola
		2	Offered during ebola
		3	Offered now
		4	Never offered
		-999	Don't know
		-888	Refuse to say

Field	Question	Answer	
screen_refer_auditory (required)	Basic auditory screening and referral Please select all that apply	1	Offered before ebola
		2	Offered during ebola
		3	Offered now
		4	Never offered
		-999	Don't know
		-888	Refuse to say
screen_refer_abdominal (required)	Abdominal clinical screening and referral Please select all that apply	1	Offered before ebola
		2	Offered during ebola
		3	Offered now
		4	Never offered
		-999	Don't know
		-888	Refuse to say
screen_refer_neuromusc (required)	Neuromuscular screening and referral Please select all that apply	1	Offered before ebola
		2	Offered during ebola
		3	Offered now
		4	Never offered
		-999	Don't know
		-888	Refuse to say
screen_refer_mental (required)	Mental health screening and support (counselling, trauma healing, stress management, psychotherapy) Please select all that apply	1	Offered before ebola
		2	Offered during ebola
		3	Offered now
		4	Never offered
		-999	Don't know
		-888	Refuse to say
screen_refer_sex (required)	Sexual health and Family planning services Please select all that apply	1	Offered before ebola
		2	Offered during ebola
		3	Offered now
		4	Never offered
		-999	Don't know
		-888	Refuse to say
lowest_number (required)	C.03. In the last seven days how many EVD survivors used this facility Ask the respondent to estimate, If the respondent does not know please enter -999		
evd_survivors_specific (required)	C.04. Of the [lowest_number] of EVD survivors who used this facility, how many needed survivor specific services? If the answer to any of these is yes, it is a survivor specific service: 1) Is the health problem a direct result of survivor status? 2) Is the service only available to survivors? 3) Does the health worker need specific training on EVD survivors to deliver this service? Question relevant when: \${lowest_number} >=1		
All_questions > Questions for qualified respondents > EVD_Clinical_Services > specialists			
intro_spec	How many specialists who can treat the ailments/illnesses common to EVD survivors do you have at this facility?		
specialist_opthamologist (required)	Ophthalmologist		
specialist_mental_health (required)	Mental health specialist		
specialist_sex_health (required)	Sexual health specialist		
specialist_internsit (required)	Internist (for EVD specific abdominal complications)		
specialist_physio (required)	Physical rehabilitation therapists (Physiotherapist)		
specialist_otorhinolaryngologist (required)	Doctor specialised in ear, nose and throat diseases (Otorhinolaryngologist)		
specialist_lab_diagnostic (required)	Lab diagnostic service specialist		
All_questions > Questions for qualified respondents > EVD_Clinical_Services > trained_providers			
providers_trained	C.10. How many regular health providers at this facility have been trained to provide EVD specific services?		
train_eye_screen (required)	Basic eye screening and referral		
train_auditory_screen (required)	Basic auditory screening and referral		
train_abdominal_screen (required)	Abdominal clinical screening and referral		
train_neuromusc_screen (required)	Neuromuscular screening and referral		
train_rheumatology (required)	Rheumatology screening and referral		
train_mental_screen (required)	Mental health screening and support (counselling, trauma healing, stress management, psychotherapy)		
train_sex_screen (required)	Sexual health and Family planning services		

Field	Question	Answer	
adequate_services (required)	C.11. On a scale of 1 to 5, How would you rate your facility's capacity when it comes to providing EVD survivors with adequate access to health services (other than primary healthcare services) and resources to meet their health needs? You may read the options to the respondent	5	5...Excellent
		4	4...Good
		3	3...Fair
		2	2...Poor
		1	1.. Very poor
		-999	Don't know
		-888	Refuse to say
		sufficient_services (required)	C.12. On a scale of 1 to 5, How would you rate your facility's ability to provide EVD survivors with sufficient quality health services (other than primary healthcare services) and resources to meet their health needs? You may read the options to the respondent
4	4...Good		
3	3...Fair		
2	2...Poor		
1	1.. Very poor		
-999	Don't know		
-888	Refuse to say		
All_questions > Questions for qualified respondents > Section D: REFERRAL SYSTEM QUESTIONS			
refer_other_facility (required)	D.01. Are there facilities you can refer Ebola survivors to for survivor-specific services that are not provided here?	1	Yes
		0	No
refer_track (required)	D.02. Does the facility record referrals made? Question relevant when: \${refer_other_facility} = 1	1	Yes
		0	No
refer_counter	D.02b Does the facility record counter-referrals? Counter referrals are referrals made to the facility.	1	Yes
		0	No
refer_other_facility_num (required)	D.03. In the last three months, how many Ebola survivors have you referred to other facilities for survivor-specific services? Question relevant when: \${refer_track} = 1		
refer_this_facility (required)	D.04. Do other facilities refer Ebola survivors to this facility for survivor specific services?	1	Yes
		0	No
refer_this_facility_num (required)	D.05. In the last three months, how many Ebola survivors have been referred to this facility for survivor-specific services? Question relevant when: \${refer_this_facility} = 1		
medication	Section F : Medicine		
All_questions > Questions for qualified respondents > observations			
meds	I now want to ask you some questions about medication and equipment available at the facility. When possible, please show me the actual medication or equipment. Please ask to observe the following medicines. If the nurse cannot show you them, please ask if they are just unavailable today, or never available.		
paracetamol (required)	Paracetamol Used for mild to moderate pain relief	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
		ibuprofen (required)	Ibuprofen Used for treating pain, fever, and inflammation.
3	Observed but expired		
4	Reported to have today, but not observed		
5	Not present today, but normally in stock		
6	Not usually stocked		
-999	Don't know		
-888	Refuse to say		
prednisone (required)	Prednisone (oral and IV) Medication that treats inflammation		
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say

Field	Question	Answer	
methotrexate (required)	Methotrexate Used to treat cancer and autoimmune diseases	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
ranitidine (required)	Ranitidine Medication that decreases stomach acid production	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
omeprazole (required)	Omeprazole Medication that decreases stomach acid production	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
amoxicillin (required)	Amoxicillin Antibiotic useful for the treatment of a number of bacterial infections	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
ivermectin (required)	Ivermectin Medication that is effective against many types of parasites	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
fluoxetine (required)	Fluoxetine Used to treat depression	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say

Field	Question	Answer	
diazepam (required)	Diazepam Used for the short-term relief of symptoms related to anxiety disorders; and ...	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
haloperidol (required)	Haloperidol Antipsychotic medication	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
amitriptyline (required)	Amitriptyline Medication used to treat mental/mood problems such as depression	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
prednisolone (required)	Prednisolone acetate drops 1% Steroid medicine used to treat eye swelling	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
atropine_drops (required)	Atropine drops 1% Used before eye examinations and to treat certain eye conditions	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
cyclopentolate (required)	Cyclopentolate 1% Used before eye examination	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say

Field	Question	Answer	
timolol (required)	Timolol drops 0.5% Used to treat increased pressure inside the eye	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
tetracycline (required)	Tetracycline ointment Antibiotic that works by stopping the growth of bacteria	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
tears (required)	Artificial tears Lubricant eye drops used to treat the dryness and irritation associated with deficient tear productin	1	Observed and in date
		3	Observed but expired
		4	Reported to have today, but not observed
		5	Not present today, but normally in stock
		6	Not usually stocked
		-999	Don't know
		-888	Refuse to say
All_questions > Questions for qualified respondents > medicine_use			
generated_note_name_130	I would like to ask who these medicines are used for		
paracetamol_evd (required)	Paracetamol Used for mild to moderate pain relief	1	Available only to EVD survivors
		2	Available only to people who have never had ebola
		3	Available to both
		4	Not available
ibuprofen_evd (required)	Ibuprofen Used for treating pain, fever, and inflammation.	1	Available only to EVD survivors
		2	Available only to people who have never had ebola
		3	Available to both
		4	Not available
prednisone_evd (required)	Prednisone (oral and IV) Medication that treats inflammation	1	Available only to EVD survivors
		2	Available only to people who have never had ebola
		3	Available to both
		4	Not available
methotrexate_evd (required)	Methotrexate Used to treat cancer and autoimmune diseases	1	Available only to EVD survivors
		2	Available only to people who have never had ebola
		3	Available to both
		4	Not available
ranitidine_evd (required)	Ranitidine Medication that decreases stomach acid production	1	Available only to EVD survivors
		2	Available only to people who have never had ebola
		3	Available to both
		4	Not available

Field	Question	Answer
omeprazole_evd (required)	Omeprazole Medication that decreases stomach acid production	1 Available only to EVD survivors
		2 Available only to people who have never had ebola
		3 Available to both
		4 Not available
amoxicillin_evd (required)	Amoxicillin Antibiotic useful for the treatment of a number of bacterial infections	1 Available only to EVD survivors
		2 Available only to people who have never had ebola
		3 Available to both
		4 Not available
ivermectin_evd (required)	Ivermectin Medication that is effective against many types of parasites	1 Available only to EVD survivors
		2 Available only to people who have never had ebola
		3 Available to both
		4 Not available
fluoxetine_evd (required)	Fluoxetine Used to treat depression	1 Available only to EVD survivors
		2 Available only to people who have never had ebola
		3 Available to both
		4 Not available
diazepam_evd (required)	Diazepam Used for the short-term relief of symptoms related to anxiety disorders; and ...	1 Available only to EVD survivors
		2 Available only to people who have never had ebola
		3 Available to both
		4 Not available
haloperidol_evd (required)	Haloperidol Antipsychotic medication	1 Available only to EVD survivors
		2 Available only to people who have never had ebola
		3 Available to both
		4 Not available
amitriptyline_evd (required)	Amitriptyline Medication used to treat mental/mood problems such as depression	1 Available only to EVD survivors
		2 Available only to people who have never had ebola
		3 Available to both
		4 Not available
prednisolone_evd (required)	Prednisolone acetate drops 1% Steroid medicine used to treat eye swelling	1 Available only to EVD survivors
		2 Available only to people who have never had ebola
		3 Available to both
		4 Not available
atropine_drops_evd (required)	Atropine drops 1% Used before eye examinations and to treat certain eye conditions	1 Available only to EVD survivors
		2 Available only to people who have never had ebola
		3 Available to both
		4 Not available
cyclopentolate_evd (required)	Cyclopentolate 1% Used before eye examination	1 Available only to EVD survivors
		2 Available only to people who have never had ebola
		3 Available to both
		4 Not available

Field	Question	Answer		
timolol_evd (required)	Timolol drops 0.5% Used to treat increased pressure inside the eye	1	Available only to EVD survivors	
		2	Available only to people who have never had ebola	
		3	Available to both	
		4	Not available	
tetracycline_evd (required)	Tetracycline ointment Antibiotic that works by stopping the growth of bacteria	1	Available only to EVD survivors	
		2	Available only to people who have never had ebola	
		3	Available to both	
		4	Not available	
tears_evd (required)	Artificial tears Lubricant eye drops used to treat the dryness and irritation associated with deficient tear productin	1	Available only to EVD survivors	
		2	Available only to people who have never had ebola	
		3	Available to both	
		4	Not available	
All_questions > Questions for qualified respondents > Section H: Basic Equipment and Commodities				
bhc	Section H: Basic Equipment and Commodities			
intro_bhc	I now want to ask you some questions about equipment available at the facility. When possible, please show me the actual equipment.			
All_questions > Questions for qualified respondents > Section H: Basic Equipment and Commodities > equipment				
All_questions > Questions for qualified respondents > Section H: Basic Equipment and Commodities > equipment > Lampes à fente				
lamp	Are slit lamps A slit lamp is a lamp that emits a narrow but intense beam of light, used for examining the interior of the eye.			
slit_lamps_normal_stock (required)	Normally in stock	1	Yes	
		0	No	
slit_lamps_available (required)	Reported to be in stock	1	Yes	
		0	No	
slit_lamps_observed (required)	Observed	1	Yes	
		0	No	
slit_lamps_evd (required)	Available to EVD survivors	1	Yes	
		0	No	
slit_lamps_non_evd (required)	Available to people who have never had ebola	1	Yes	
		0	No	
All_questions > Questions for qualified respondents > Section H: Basic Equipment and Commodities > equipment > Tonometers				
tonometer	Are Tonometers: A tonometer is an instrument for measuring the pressure in a part of the body, such as the eyeball (to test for glaucoma) or a blood vessel.			
tonometers_normal_stock (required)	Normally in stock	1	Yes	
		0	No	
tonometers_available (required)	Reported to be in stock	1	Yes	
		0	No	
tonometers_observed (required)	Observed	1	Yes	
		0	No	
tonometers_evd (required)	Available to EVD survivors	1	Yes	
		0	No	
tonometers_non_evd (required)	Available to people who have never had ebola	1	Yes	
		0	No	
All_questions > Questions for qualified respondents > Section H: Basic Equipment and Commodities > equipment > ophthalmoscopes				
ophthalmoscope	Are ophthalmoscopes : An Ophthalmoscope is an instrument for inspecting the retina and other parts of the eye.			
ophthalmoscopes_normal_stock (required)	Normally in stock	1	Yes	
		0	No	
ophthalmoscopes_available (required)	Reported to be in stock	1	Yes	
		0	No	
ophthalmoscopes_observed (required)	Observed	1	Yes	
		0	No	
ophthalmoscopes_evd (required)	Available to EVD survivors	1	Yes	
		0	No	

Field	Question	Answer	
ophthalmoscopes_non_evd (required)	Available to people who have never had ebola	1	Yes
		0	No
All_questions > Questions for qualified respondents > Section H: Basic Equipment and Commodities > equipment > audiometers			
audiometer	Are audiometers : An audiometer is a device used for measuring hearing.		
audiometers_normal_stock (required)	Normally in stock	1	Yes
		0	No
audiometers_available (required)	Reported to be in stock	1	Yes
		0	No
audiometers_observed (required)	Observed	1	Yes
		0	No
audiometers_evd (required)	Available to EVD survivors	1	Yes
		0	No
audiometers_non_evd (required)	Available to people who have never had ebola	1	Yes
		0	No
All_questions > Questions for qualified respondents > Section H: Basic Equipment and Commodities > equipment > tuning_forks			
tuning_fork	Are Tuning Forks: A tuning fork is a device used for measuring hearing		
tuning_forks_normal_stock (required)	Normally in stock	1	Yes
		0	No
tuning_forks_available (required)	Reported to be in stock	1	Yes
		0	No
tuning_forks_observed (required)	Observed	1	Yes
		0	No
tuning_forks_evd (required)	Available to EVD survivors	1	Yes
		0	No
tuning_forks_non_evd (required)	Available to people who have never had ebola	1	Yes
		0	No
end	We have now come to the end of the interview, thank you for taking part in this interview. Please inform the respondent about the small gift you have for them.		
comment (required)	Comment		

BalanceD-MERL Provider Survey

Field	Question	Answer																														
A. Survey Information																																
enumerator_name	Enumerator name	<table border="1"> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> <tr><td></td><td></td><td></td></tr> </table>																														
county_select (required)	County	<table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>																														
district (required)	District name	<table border="1"> <tr><td></td><td>district</td><td>district</td></tr> </table>		district	district																											
	district	district																														
type (required)	Facility type	<table border="1"> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> <tr><td></td><td></td></tr> </table>																														
facility_name_search (required)	Select the correct facility from the list below:	<table border="1"> <tr> <td></td> <td>-77</td> <td>Cannot find the name</td> </tr> <tr> <td></td> <td>facility_name</td> <td>facility_name</td> </tr> </table>		-77	Cannot find the name		facility_name	facility_name																								
	-77	Cannot find the name																														
	facility_name	facility_name																														
A. Survey Information > consent																																
introduction	Hello, my name is . (Enumerator name). I am a researcher for Innovations for Poverty Action, a research and policy non-profit organisation that discovers and promotes effective solutions to global poverty problems. I am visiting you today because we are conducting a study about the health system in Liberia.																															
purpose	The purpose of this survey is to better understand the current state of the health system, including information about local health facilities, health providers, and community members who may use those health services.																															
procedures	If you choose to participate, you will be asked to complete a survey. The survey will cover Demographic information (e.g. level of education) Information about your work at the health facility (e.g. what kind of services you provide, what kind of training you have received) Your thoughts on your work (e.g. your beliefs about caring for patients with Ebola Virus Disease and EVD survivors) The survey will take approximately 1 hour of your time.																															
risks_benefits	Risks and Benefits: We hope that this research will help us better understand the current state of the health system for Ebola Virus Disease survivors in order to improve future public health interventions. We do not anticipate any risks to you from study participation. You are free to skip any question that makes you feel uncomfortable.																															
confidentiality	Confidentiality: No names will be stored with survey responses and no names will be published from the study. The research staff will not share your personal information with anyone outside the study, and they will do their best to protect your information.																															
voluntary_participation	Voluntary Participation: Participation in this study is voluntary. That means you do not have to participate if you do not want to. Ending participation at any time for any reason will not have any negative consequences for you. You may withdraw at any time, which you can do by simply telling me that you no longer want to be part of the study. Refusal to answer any individual questions will not have any negative consequences for you.																															
contact	For questions regarding the research or about your rights as research participant please contact:																															
questions	Questions: Do you have any further questions?																															
consent_select (required)	Do you agree to participate in this interview?	<table border="1"> <tr><td>1</td><td>Yes</td></tr> <tr><td>0</td><td>No</td></tr> </table>	1	Yes	0	No																										
1	Yes																															
0	No																															
signature (required)	Please sign here to indicate that you agree. signature Question relevant when: \${consent_select} =1																															

Field	Question	Answer																
A. Survey Information > Consent Yes																		
Group relevant when: \${consent_select} = 1																		
A. Survey Information > Consent Yes > B. Demographics																		
position (required)	B.01. What is your position at the health facility?	<table border="1"> <tr><td>1</td><td>Medical Doctor</td></tr> <tr><td>2</td><td>Physician Assistant</td></tr> <tr><td>3</td><td>Nurse</td></tr> <tr><td>4</td><td>Nurse Aide</td></tr> <tr><td>5</td><td>Medical Officer</td></tr> <tr><td>6</td><td>Midwife</td></tr> <tr><td>7</td><td>Community health worker/officer</td></tr> <tr><td>-777</td><td>Other (specify)</td></tr> </table>	1	Medical Doctor	2	Physician Assistant	3	Nurse	4	Nurse Aide	5	Medical Officer	6	Midwife	7	Community health worker/officer	-777	Other (specify)
1	Medical Doctor																	
2	Physician Assistant																	
3	Nurse																	
4	Nurse Aide																	
5	Medical Officer																	
6	Midwife																	
7	Community health worker/officer																	
-777	Other (specify)																	
position_specify (required)	Specify other: Question relevant when: \${position} = -777																	
specialization (required)	B.02. What is your specialization? Question relevant when: \${position} = 1 or \${position} = 3	<table border="1"> <tr><td>1</td><td>No Specialization/general practice</td></tr> <tr><td>-777</td><td>Other (specify)</td></tr> </table>	1	No Specialization/general practice	-777	Other (specify)												
1	No Specialization/general practice																	
-777	Other (specify)																	
specialization_specify (required)	Specify Other: Question relevant when: \${specialization} = -777																	
hf_duration (required)	B.03. How long have you worked at this health facility?	<table border="1"> <tr><td>1</td><td>Less than 1 year</td></tr> <tr><td>2</td><td>1-2 years</td></tr> <tr><td>3</td><td>3-4 years</td></tr> <tr><td>4</td><td>5-10 years</td></tr> <tr><td>5</td><td>More than 10 years</td></tr> </table>	1	Less than 1 year	2	1-2 years	3	3-4 years	4	5-10 years	5	More than 10 years						
1	Less than 1 year																	
2	1-2 years																	
3	3-4 years																	
4	5-10 years																	
5	More than 10 years																	
work_other (required)	B.04. Did you work at another facility before this one?	<table border="1"> <tr><td>1</td><td>Yes</td></tr> <tr><td>0</td><td>No</td></tr> </table>	1	Yes	0	No												
1	Yes																	
0	No																	
incharge (required)	B.05. Are you the facility in-charge?	<table border="1"> <tr><td>1</td><td>Yes</td></tr> <tr><td>0</td><td>No</td></tr> </table>	1	Yes	0	No												
1	Yes																	
0	No																	
trained_EVD (required)	B.06. Have you been trained and/or recruited to provide EVD-specific services? If the answer to any of these is yes, it is a survivor specific service: 1) Is the health problem a direct result of survivor status? 2) Is the service only available to survivors? 3) Does the health worker need specific training on EVD survivors to deliver this service?	<table border="1"> <tr><td>1</td><td>Yes</td></tr> <tr><td>0</td><td>No</td></tr> </table>	1	Yes	0	No												
1	Yes																	
0	No																	
A. Survey Information > Consent Yes > C. EVD Services																		
enu_note_2	I now want to ask you some questions about the services available for Ebola survivors at the health facility																	
EVD_training (required)	C.01. What training have you received to provide specific EVD services? Select all that apply Question relevant when: \${trained_EVD} = 1	<table border="1"> <tr><td>1</td><td>EVD service specialist type</td></tr> <tr><td>2</td><td>Basic eye screening and referral</td></tr> <tr><td>3</td><td>Basic auditory screening and referral</td></tr> <tr><td>4</td><td>Abdominal clinical screening and referral</td></tr> <tr><td>5</td><td>Neuromuscular screening and referral</td></tr> <tr><td>6</td><td>Mental health screening and support (counseling, trauma healing, stress management, psychotherapy)</td></tr> <tr><td>7</td><td>Sexual health and Family planning services</td></tr> <tr><td>-777</td><td>Other (specify)</td></tr> </table>	1	EVD service specialist type	2	Basic eye screening and referral	3	Basic auditory screening and referral	4	Abdominal clinical screening and referral	5	Neuromuscular screening and referral	6	Mental health screening and support (counseling, trauma healing, stress management, psychotherapy)	7	Sexual health and Family planning services	-777	Other (specify)
1	EVD service specialist type																	
2	Basic eye screening and referral																	
3	Basic auditory screening and referral																	
4	Abdominal clinical screening and referral																	
5	Neuromuscular screening and referral																	
6	Mental health screening and support (counseling, trauma healing, stress management, psychotherapy)																	
7	Sexual health and Family planning services																	
-777	Other (specify)																	
training_specify (required)	Specify other: Question relevant when: \${EVD_training} = -777																	
survivors_serv (required)	C.02. In the In the last three months, how many Ebola survivors have you yourself provided services to? If no exact number, please provide your best estimate																	
facility_serv (required)	C.03. In your opinion, how often is this facility able to provide Ebola survivors with health services sufficient in quantity to achieve their therapeutic needs?	<table border="1"> <tr><td>1</td><td>Never</td></tr> <tr><td>2</td><td>Rarely</td></tr> <tr><td>3</td><td>Sometimes</td></tr> <tr><td>4</td><td>Often</td></tr> <tr><td>5</td><td>Always</td></tr> </table>	1	Never	2	Rarely	3	Sometimes	4	Often	5	Always						
1	Never																	
2	Rarely																	
3	Sometimes																	
4	Often																	
5	Always																	
A. Survey Information > Consent Yes > D. Referral System																		

Field	Question	Answer
facility_no_refer (required)	D.01. How often is this facility able to provide survivor services without needing to refer patients to other places? Please read the options to the respondents	1 Never 2 Rarely 3 Sometimes 4 Often 5 Always
facility_refer (required)	D.02. Are there facilities you can refer ebola survivors to for survivor specific services that are not provided here?	1 Yes 0 No
A. Survey Information > Consent Yes > D. Referral System > Survivors Referred		
survivor_refer_fac	D.03. In the last three months, how many ebola survivors have you referred to an EVD service specialist AT THIS FACILITY? For each service how many people has the provider referred to a specialist within the facility? (AT THE SAME FACILITY)	
refer1 (required)	Basic eye screening and referral	
refer2 (required)	Basic auditory screening and referral	
refer3 (required)	Abdominal clinical screening and referral	
refer4 (required)	Mental health screening and support (counselling, trauma healing, stress management, psychotherapy	
refer5 (required)	Neuromuscular screening and referral	
refer6 (required)	Sexual health and family planning services	
A. Survey Information > Consent Yes > D. Referral System > Survivors Referred Other Group relevant when: \${facility_refer} =1		
survivor_refer_oth	In the last three months, how many ebola survivors have you referred to an EVD service specialist AT ANOTHER FACILITY? For each service how many people has the provider referred to another facility?	
refer_other1 (required)	Basic eye screening and referral	
refer_other2 (required)	Basic auditory screening and referral	
refer_other3 (required)	Abdominal clinical screening and referral	
refer_other4 (required)	Mental health screening and support (counselling, trauma healing, stress management, psychotherapy	
refer_other5 (required)	Neuromuscular screening and referral	
refer_other6 (required)	Sexual health and family planning services	
other_facility_refer (required)	D. 04. Do other facilities refer Ebola survivors to this facility for survivor specific services?	1 Yes 0 No
survivor_referred (required)	D.05. In the last three months, how many ebola survivors have been referred to this facility for survivor specific services? Question relevant when: \${other_facility_refer} =1	
A. Survey Information > Consent Yes > D. Referral System > Shared documentation		
information_shared	D.06. When a patient is referred to another facility, what documentation if any, is shared between providers/facilities about that patient's treatment history (e.g. diagnosis, lab results etc).	1 Information/ records shared between providers 2 Information/ records shared between facilities 3 Not shared
share1 (required)	Referral sheet	1 Information/ records shared between providers 2 Information/ records shared between facilities 3 Not shared
A. Survey Information > Consent Yes > D. Referral System > Provider referral satisfaction		
provider_satisfied	D.07. How satisfied are you with the following aspects of the referral system?	1 Very Satisfied 2 Satisfied 3 Neutral 4 Dissatisfied 5 Vey Dissatisfied
availability (required)	Availability of providers to whom you can refer your patients	1 Very Satisfied 2 Satisfied 3 Neutral 4 Dissatisfied 5 Vey Dissatisfied
proximity (required)	Proximity and ease of access of your patients to the referral providers	1 Very Satisfied 2 Satisfied 3 Neutral 4 Dissatisfied 5 Vey Dissatisfied

Field	Question	Answer	
quality (required)	Quality of providers to whom I can refer my patients	1	Very Satisfied
		2	Satisfied
		3	Neutral
		4	Dissatisfied
		5	Vey Dissatisfied
documentation (required)	Documentation sharing between health providers in the referral system	1	Very Satisfied
		2	Satisfied
		3	Neutral
		4	Dissatisfied
		5	Vey Dissatisfied
collaboration (required)	Collaboration between health provideres in the referral system	1	Very Satisfied
		2	Satisfied
		3	Neutral
		4	Dissatisfied
		5	Vey Dissatisfied
survivor_satisfied (required)	D.08. How satisfied are your EVD survivor patients with the referral system?	1	Very Satisfied
		2	Satisfied
		3	Neutral
		4	Dissatisfied
		5	Vey Dissatisfied
A. Survey Information > Consent Yes > E. EVD Stigma			
enu_note_3	I now want to ask you some questions about the risk of ebola transmission associated with certain activities		
A. Survey Information > Consent Yes > E. EVD Stigma > E.1. Beliefs Transmission			
enu_note_4	E.1.1. We want to understand how risky you think it is to do the following activities on a scale of 0 (no risk) to 10 (high risk). So if you thought an activity posed no risk of transmission, you would rate it a zero. If you thought it posed a moderate risk of transmission you might rate it a 5 or 6. If you thought it posed an extremely high risk of transmission you might rate it a 9 or 10 MAKE SURE THE RESPONDENT UNDERSTANDS THE RISK SCALE		
risk_handshake (required)	Shake hands with someone who had Ebola, but has now recovered and been declared well	0	0 (no risk of transmission)
		1	1
		2	2
		3	3
		4	4
		5	5
		6	6
		7	7
		8	8
		9	9
		10	10 (high risk of transmission)
risk_inject (required)	Give an injection to someone who had Ebola, but has now recovered and been declared well	0	0 (no risk of transmission)
		1	1
		2	2
		3	3
		4	4
		5	5
		6	6
		7	7
		8	8
		9	9
		10	10 (high risk of transmission)
risk_services_evd_ppe (required)	Providing services to someone who CURRENTLY has Ebola, using PPE	0	0 (no risk of transmission)
		1	1
		2	2
		3	3
		4	4
		5	5
		6	6
		7	7
		8	8
		9	9
		10	10 (high risk of transmission)

Field	Question	Answer	
risk_services_evd_noppe (required)	Providing services to someone who CURRENTLY has Ebola, WITHOUT PPE	0	0 (no risk of transmission)
		1	1
		2	2
		3	3
		4	4
		5	5
		6	6
		7	7
		8	8
		9	9
		10	10 (high risk of transmission)
risk_services_baby (required)	Give routine checkup to a healthy baby who has never had ebola	0	0 (no risk of transmission)
		1	1
		2	2
		3	3
		4	4
		5	5
		6	6
		7	7
		8	8
		9	9
		10	10 (high risk of transmission)
precaution (required)	E1.2. Do you need to take any EXTRA precautions when working with Ebola survivors who have recovered and been declared well? (compared to someone who never had Ebola)	1	Yes
		0	No
precaution_specify	E.1.3. What extra precaution do you need to take? Question relevant when: \${precaution} =1		
A. Survey Information > Consent Yes > E. EVD Stigma > E.2. Stigma- Training			
enu_note_5	We now want to ask you some questions about perceptions and care and treatment of Ebola survivors		
train_stigma (required)	E.2.1. Have you been trained on Ebola Survivor Stigma reduction? Training can be either formal classroom-based OR on the job mentoring/supervision.	1	Yes
		0	No
number_train (required)	E.2.2. How many such trainings have you received? Question relevant when: \${train_stigma} =1		
trainers (required)	E.2.3a. Who delivered the trainings? Select all that apply Question relevant when: \${train_stigma} =1	1	County health team (CHT)
		2	District health team (DHT)
		3	Health facility staff
		4	Civil Service Organization (CSO) / Non Governmental Organization (NGO)
		5	Medical / Nursing schools
		-777	Other (specify):
trainer_specify (required)	Specify other: Question relevant when: \${trainers} =-777		
organisations_train	E.2.3b. Please name the organisation(s) who delivered the Ebola Survivor Stigma reduction training Question relevant when: \${trainers} =-777 or \${trainers} =4 or \${trainers} =5		
knowledge_change (required)	E.2.4a. To what extent did your knowledge about caring for Ebola survivors change as a result of this training? Knowledge is what we KNOW Question relevant when: \${train_stigma} =1	1	Not at all
		2	A little
		3	Some
		4	Very much
knowledge_specify (required)	E.2.4b. Could you describe an example of this change in knowledge? Question relevant when: \${knowledge_change} =2 or \${knowledge_change} =3 or \${knowledge_change} =4		
attitude_change (required)	E.2.5a. To what extent did your attitudes about caring for Ebola survivors change as a result of this training? Attitude is how we FEEL Question relevant when: \${train_stigma} =1	1	Not at all
		2	A little
		3	Some
		4	Very much
attitude_specify (required)	E.2.5b. Could you describe an example of this change in attitudes? Question relevant when: \${attitude_change} =2 or \${attitude_change} =3 or \${attitude_change} =4		
behavior_change (required)	E.2.6a. To what extent did your behavior when caring for ebola survivors change as a result of this training? Behaviour is how we ACT Question relevant when: \${train_stigma} =1	1	Not at all
		2	A little
		3	Some
		4	Very much

Field	Question	Answer	
behavior_specify (required)	E.2.6b. Could you describe an example of this change in behavior? Question relevant when: \${behavior_change} =2 or \${behavior_change} =3 or \${behavior_change} =4		
A. Survey Information > Consent Yes > E. EVD Stigma > E.3. Stigma - Perceptions			
enu_note_6	I now want to ask you some questions about how ebola survivors should be treated		
stigma1 (required)	E.3.1. Ebola survivors should have separate screening and treatment areas to prevent transmission to others Please read out the options to the respndent	1	Strongly agree
		2	Agree
		3	Neither agree nor disagree
		4	Disagree
		5	Strongly disagree
stigma2 (required)	E.3.2. Ebola survivors have more access to care and treatment compared to patients with other illnesses, this is unfair Please read out the options to the respndent	1	Strongly agree
		2	Agree
		3	Neither agree nor disagree
		4	Disagree
		5	Strongly disagree
stigma3 (required)	E3.3. Community stigma negatively affects the lives of Ebola survivors Please read out the options to the respndent	1	Strongly agree
		2	Agree
		3	Neither agree nor disagree
		4	Disagree
		5	Strongly disagree
stigma4 (required)	E.3.4. You feel comfortable providing health services to Ebola survivors Please read out the options to the respndent	1	Strongly agree
		2	Agree
		3	Neither agree nor disagree
		4	Disagree
		5	Strongly disagree
stigma5 (required)	E3.5. Ebola survivors have a responsibility to disclose their status to healthcare providers Please read out the options to the respndent	1	Strongly agree
		2	Agree
		3	Neither agree nor disagree
		4	Disagree
		5	Strongly disagree
stigma6 (required)	E.3.6. Stigma in the community or at the health facility currently prevents Ebola survivors from seeking care Please read out the options to the respndent	1	Strongly agree
		2	Agree
		3	Neither agree nor disagree
		4	Disagree
		5	Strongly disagree
A. Survey Information > Consent Yes > E. EVD Stigma > E.4. EVD Stigma - Enacted			
stigma8 (required)	E.4.1. During the Ebola epidemic, did you ever see someone with Ebola denied services at a health facility?	1	Yes
		0	No
stigma8a (required)	E.4.2. Why were they turned away? Question relevant when: \${stigma8} =1		
stigma9 (required)	E.4.3. In the last year, have you seen an Ebola survivor denied care at any health facility?	1	Yes
		0	No
		-999	Don't know
		-888	Refuse to say
stigma9a (required)	E.4.4. Why were they turned away? Question relevant when: \${stigma9} =1		
stigma10 (required)	E.4.5. Does Ebola-related stigma occur at this health facility currently?	1	Yes
		0	No
		-999	Don't know
		-888	Refuse to say
A. Survey Information > Consent Yes > E. EVD Stigma > E.4. EVD Stigma - Enacted > E4.6a. Enacted Stigma, HF Group relevant when: \${stigma10} =1			
generated_note_name_125	I. What are some examples of Ebola-related stigma that still occur in this facility?		
stigma11	1.		
stigma12	2.		
stigma13	3.		
stigma14	4.		
stigma15 (required)	II. If you ever saw any of the above happening, would it be possible to report such an incident? Question relevant when: \${stigma10} =1	1	Yes
		0	No

Field	Question	Answer	
stigma16 (required)	III. If you ever saw any of the above happening who could you report it to? Select all that apply Question relevant when: \${stigma10} =1	0	No one
		1	My supervisor
		2	Facility Administration
		3	Other health facility staff member
		4	District health team staff member
		-777	Other (specify)
		-999	Don't know
stigma17 (required)	Specify other: Question relevant when: \${stigma16} =-777		
stigma18 (required)	IV. If a survivor believes that they are a victim of stigma and unfair treatment due to their Ebola survivor status, would it be possible for them to report such an incident?	1	Yes
		0	No
stigma19 (required)	V. Who could they report it to? Select all that apply Question relevant when: \${stigma18} =1	0	No one
		1	Their healthcare provider
		2	Other health facility staff member
		3	Facility administration
		4	District health staff team member
		-777	Other (specify)
		-999	Don't know
stigmaother (required)	Specify other: Question relevant when: \${stigma19} =-777		
stigma20 (required)	VI. Does Ebola-related stigma occur in the community?	1	Yes
		0	No
A. Survey Information > Consent Yes > E. EVD Stigma > E.4. EVD Stigma - Enacted > E.4.6. Enacted Stigma, Community Group relevant when: \${stigma20} =1			
generated_note_name_139	I. What are some examples of Ebola-related stigma in the community?		
stigma21	1.		
stigma22	2.		
stigma23	3.		
stigma24	4.		
generated_note_name_147	We have now come to the end of the interview, thank you for taking part in this interview. Please remember to present the small gift to the respondent.		
comment (required)	Comment		
generated_note_name_150	Thank you for taking the time to speak with me today. Question relevant when: \${consent} !=1		

BalanceD-MERL Key Informant Interview Framework

Framework of questions for KIIs with different respondent types

EVALUATION CRITERIA: EFFECTIVENESS, EFFICIENCY, RELEVANCE and ADAPTIVE MANAGEMENT

Domain	Purpose	Respondents	Questions
Topic 1: CLINICAL HEALTHCARE SERVICES FOR SURVIVORS	Effectiveness: To understand the various perspectives of project stakeholders about whether EVD survivors had improved access to appropriate healthcare services. To provide additional context to quantitative data from survivor and provider surveys to ascertain to what extent improvements to services are attributable or not attributable to GHET funding	Implementing Partners, Governments (Relevant Ministries and Agencies), Survivor Networks	1. In the context of EVD survivors, how would you define “appropriate” healthcare services? - <i>If I was to ask other stakeholders, do you think that everyone would have a shared understanding of appropriate healthcare services for EVD survivors?</i> 2. In your opinion, do EVD survivors have access to appropriate healthcare services in [country] context today? <i>Follow up question:</i> - <i>Was it always like this? How has this access changed over time?</i> - <i>Has this change led to improvement of access to appropriate healthcare services for ebola survivors?</i> 3. Do you believe the program has contributed to the improvement of healthcare services for EVD survivors? If so, how and how much? <i>Follow up question:</i> - <i>Who else or what other program(s) contributed to making improvements to services?</i> - <i>If so, how does the contribution of this program compare to the contributions of these other programs? Please provide details and/or evidence to support your response.</i>
	Adaptive management and efficiency: To understand how activities related to	Implementing Partners, Governments	1. What improvements to EVD survivor healthcare services did the program make throughout the duration of implementation?

	strengthening clinical services and accessibility were implemented and adapted by implementing partners over time.	(Relevant Ministries and Agencies), Survivor Networks	2. How did the IPs decide which services would be implemented and where? <i>Follow up questions:</i> - Did this change at any point in the program's implementation? - If so, how was that change managed? (Prompts: Who was involved? What was the process? What was the outcome?) 3. How has the intensity in the need for Ebola related clinical healthcare services changed throughout the implementation period? (please be specific) <i>Follow up question:</i> - Did that affect how you supported the provision of EVD survivor services through your targeted health facilities? Please explain your response and be as specific as possible.
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Topic 2: STIGMA REDUCTION	Effectiveness: To understand how different stakeholders perceive the effectiveness of the program as it relates to the reduction of stigma survivors face from health providers and members of their community (Liberia & Guinea only on community component)	Implementing Partners, Governments (relevant Ministries and Agencies), Survivor Networks	1. In your opinion, has there been a reduction in the enacted stigma of health providers against EVD survivors? <i>[Int. note: Enacted stigma is defined as discrimination or unfair treatment by providers against EVD survivors]</i> Please provide examples or data to explain your response. (Prompts: How was it at the beginning of the outbreak vs. now?) <i>Follow up question:</i> - If so, what do you think led to this reduction? What contributed to it? 2. Do you believe this program has contributed to the reduction of survivor stigma from providers in your [country] context? <i>Follow up question:</i> - If so, how? - Who else or what other program(s) has contributed to
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			<i>reducing stigma?</i> - <i>If so, how does the contribution of this program compare to the contributions of these other programs? Please provide details and/or evidence to support your response.</i> 3. In your opinion, how effective were the various campaigns implemented in your [country] context in reducing stigma experienced by survivors? (Prompts: SBCC? Other campaigns?) <i>Follow up questions:</i> - <i>If these campaigns weren't implemented, how would things be different? (prompt: What difference did these campaigns make?)</i> - <i>How would you compare the effectiveness of the various campaigns in your country? (prompt: Were some more effective than others and if so, how?) Please explain.</i> 4. How effective were stigma trainings provided to health professionals and community health volunteers/workers (int. note: Liberia & Guinea only) in minimizing the effects of stigma in the community? <i>Follow up questions:</i> - <i>What components of the stigma training were most and least effective?</i> - <i>Were there any instances where stigma trainings weren't effective? Please explain.</i> 5. Are stigma reduction trainings equally effective for both health providers and community members (Liberia & Guinea only)? Why or why not?
	Efficiency and Adaptive Management: To understand what stigma reduction approaches were implemented by IPs and the	Implementing Partners	1. Were the stigma reduction approaches you implemented uniform? <i>Prompts: a) within country, b) across different regions/prefectures and c) with approaches implemented in other countries (Guinea,</i>

	extent to which stakeholders have collaborated throughout the duration of implementation on any changes to approaches		<i>Sierra Leone, Liberia)?</i> 2. How were stigma reduction campaigns developed? <i>Prompts: Were they adapted from existing models or custom built?</i> <i>Follow up questions:</i> - <i>Has there been collaboration on designing and coordinating SBCC and other campaigns with other EVD response implementers in your country of operation or other countries affected by EVD?</i> - <i>If so, what was the process?</i> - <i>How was the process documented?</i> 3. How were stigma trainings designed? <i>Follow up questions:</i> - <i>Has there been collaboration on designing and coordinating trainings with other GHET stakeholders in your country of operation or other countries affected by EVD?</i> - <i>If so, what was the process?</i> - <i>How was the process documented?</i> - <i>Who determined what went into stigma trainings?</i> - <i>Were there adaptations? If so, how were they managed?</i>
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Topic 3: ACCESSIBILITY OF CLINICAL SERVICES	Effectiveness: To understand various perspectives of program stakeholders about its effectiveness in delivering outputs related to strengthening accessibility of clinical services through referral systems	Implementing Partners, Governments (Relevant ministries and agencies), Survivor Networks	1. In your opinion, what does a successful referral system look like? 2. Do you think the referral system for EVD survivors was successful? <i>Follow up questions:</i> - <i>Yes, why? No, why?</i> - <i>What are the main barriers to access?</i> - <i>How did the program address these barriers?</i>
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Efficiency: To understand how the program contributed to survivor education on access to services, including the referral system for survivors. To provide additional context to quantitative data from Facility Assessments, Survivor and Provider Surveys to ascertain to what extent success is attributable or not attributable to GHET funding	Implementing Partners, Government (Relevant Ministries and Agencies) Providers, Survivor Networks	1. How does the referral system for survivors work? <i>Follow up questions:</i> - Are staff at health facilities (e.g. physicians and nurses) clear on the criteria for referrals? - In your opinion, how closely are those guidelines followed? - In your opinion, does the referral system work equally well for all survivors or are there some individuals (or groups) that systematically fall out of the scope of referral? If so, please explain in as much detail as possible. 2. What is your perception of what survivors think about the referral system? Please provide details on what your opinion is based on? 3. In your opinion, how educated are survivors in general about services available to them and how to access them? 4. Do you believe the program has contributed to education of survivors about available services? If so, how and how much? <i>Follow up question:</i> - What training/education programs were offered and to whom? - Who else or what other program(s) contributed to survivor education in this regard? - How does the contribution of this program compare to the contributions of these other programs? Please provide details and/or evidence to support your response. 5. If you were to do this over, what would you do differently?
Adaptive management and relevance: To understand how relevant the service package for survivors was from the	Implementing partners, Government (Relevant	1. How relevant do you think the service package available to survivors was and is to survivor needs? (prompt responses by periods): • during the active ebola outbreak

	perspective of implementation partners and survivor networks and to identify lessons learned that can inform future programming. To provide additional context for quantitative data collected through Facility Assessments, Survivor and Provider Surveys to ascertain to what extent success is or is not attributable to GHET funding	Ministries and Agencies), Survivor Networks	• <i>post ebola outbreak [use the date of the WHO ebola-free declaration for each country as a point of reference- current period]</i> 2. What lessons did you learn [can be drawn] from the implementation of this component of the program? <i>Follow up questions:</i> - <i>How were these lessons integrated into implementation? What changes (if any) were made?</i> - <i>What was the process through which these changes were made?</i> - <i>If you were to do it over again, what would you do differently?</i> - <i>Would you remove or add anything?</i>
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Topic 4: GOVERNANCE AND MANAGEMENT IMPROVEMENT (national policies and systems)	Effectiveness: To harvest outcomes and understand the effects that the program had on national policies and systems and improving governance and management as a result of capacity building activities of the program. To understand how National Governments and Survivors Networks are perceived, including confidence in their work from various respondents	Implementing Partners, Governments (relevant ministries and agencies), Survivor Networks	1. What changes to national policies and systems relating to ebola or IPC took place during the course of the program? <i>Follow up questions:</i> - <i>How did these changes affect services available to survivors? (prompts: if respondents need prompts, use words such as improvements, enabling, facilitated)</i> - <i>Are these changes specifically tailored to survivors? If not, were survivor considerations integrated into broader changes focused on ebola and/or ipc?</i> - <i>Have these changes led to improvements? If so, what contributed to these improvements?</i> 2. Do you believe the program has contributed to improvements to national policies and systems (governance and management) that occurred as a result of capacity building activities of the program? (prompts: which enabled/facilitated improvements in survivor services?) Please explain in as much detail as possible.
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			<i>Follow up question:</i> - <i>Who else or what other program(s) contributed?</i> - <i>How does the contribution of this program compare to the contributions of these other programs? Please provide details and/or evidence to support your response.</i> 3. In your opinion, how well known are National Government bodies working towards EVD support for survivors and Survivor Networks among different stakeholder groups? (Please list) <i>Follow up questions:</i> - <i>Does awareness of a survivor network connect with access and use of services? How?</i> - <i>Are they trusted to represent interests of survivors adequately? Alternative: What is the level of confidence stakeholders have in the work of the National Government and Survivor networks?</i> - <i>What do you think attracts survivors to or deters them from joining the networks?</i>
	<i>Efficiency:</i> To understand challenges faced by the program and identify and document lessons learned from the perspective of Implementing Partners and government stakeholders	Implementing Partners, Government (relevant ministries and agencies)	1. What lessons were learned with respect to how programs like this one contribute to policy change and challenges associated with policy change? Please be specific.

	Relevance: To understand the relevance of capacity building components of the program aimed at strengthening the management and administration of survivor services	Implementing partners, governments (relevant ministries and agencies)	1. Do you think that the trainings offered by the program were an efficient way to address capacity gaps in the administration of survivor services? Please explain your answer. <i>Follow-up questions</i> - <i>What are the capacities [skills and knowledge] that were built?</i> - <i>How did your experience with these trainings affect your perspective on what skills are the most critical for management and administration of survivor services? Please explain and provide examples.</i>
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Topic 5: LESSONS LEARNED RELATED TO PROGRAM EFFECTIVENESS	Effectiveness: To understand how governance and management have improved to advance national policies and systems and based on the experiences of this program, what do managers and policy decision-makers consider the best approaches for behavior change	Implementing Partners, Governments (relevant ministries and agencies), USAID	1. Based on the experiences of this program, what do you consider as the best approaches for behavior change? <i>[Behavior change related to survivors accessing health facilities, reducing provider stigma of ebola survivors, and increasing government capacity to administer survivor programs]</i> Please explain. <i>Follow up question:</i> - <i>What worked and what did not?</i> - <i>Why or why not?</i> - <i>What factors influenced effectiveness?</i>
Topic 6: STAKEHOLDER ENGAGEMENT AND FEEDBACK LOOPS	Adaptive management and relevance: To understand the level of stakeholder engagement and feedback loops used by the program to inform decisions and adapt to changing circumstances from the perspective of IPs and various stakeholder groups.	Implementing Partners, Governments (relevant ministries and agencies), Survivor Networks, International Orgs, USAID	1. To what extent have key program stakeholders been engaged to inform programmatic decisions (who was engaged, how, and what was their role)? <i>Follow up questions:</i> - <i>What sources of feedback were sought? (Prompts: for example, were/and if so how/ stakeholders involved to determine satisfaction by survivors and determining distribution of services across levels of access?)</i> - <i>How was this done? How often?</i> - <i>What communication channels were used?</i> - <i>How were subsequent decisions communicated back to stakeholders?</i> 2. In your opinion, how satisfied are stakeholder groups with level and quality of their engagement on programmatic decisions? <i>Follow up questions:</i> - <i>Is satisfaction level uniform across all stakeholder groups or are some stakeholders more satisfied than others? Please explain your perspective and provide details.</i>

Topic 7: BARRIERS TO SERVICE DELIVERY	Efficiency: To understand barriers to service delivery and how program partners addressed them, as well as to identify lessons learned that can inform future programming	Implementing Partners, Government (relevant Ministries and Agencies), Survivor Networks	1. What have been the barriers to appropriate service delivery for EVD survivors? <i>Follow up questions:</i> - <i>How did the program address these barriers?</i> - <i>What was the process that was followed?</i> - <i>How was that process documented?</i> <i>What are some lessons learned from implementation about effective ways of addressing barriers to service delivery in contexts such as this one?</i>
Topic 8: GENERAL PROGRAM PERFORMANCE (PRODUCTIVITY)	Efficiency: To understand to what extent the program has: 1. Produced outputs on time; 2. Met targets for outputs; and the process through which these were determined and what accounts for any variance	Implementing Partners, USAID	1. To what extent have program implementation plans been implemented as planned? 2. To what extent have you met your program targets? <i>Follow up question:</i> - <i>What accounts for the variance?</i> 3. Tell me about factors that influenced your team/program's performance as it relates to meeting targets on time? <i>Follow up questions:</i> - <i>Why was this so? What contributed to this?</i> - <i>How were the program targets set?</i> - <i>What factors were taken into consideration when setting output targets?</i> - <i>What lessons did you learn from the process of setting the targets and managing towards achievement on this program?</i>

JSI Research & Training Institute, Inc. Endline Survivor Survey Questions

Question	Response Code	Response Option
Healthcare		
Do you feel that your access to healthcare for this problem was adequate? ⁵	1	Yes
	0	No
Was the quality of healthcare that you received satisfactory? ⁶	1	Yes
	0	No
In the past two years (since the end of the Ebola time), do you feel that care for this problem has: ⁷	1	Got much better
	2	Got a little better
	3	Stayed the same
	4	Got a little worse
	5	Got much worse
	98	Don't know
Stigma (Liberia)		
The doctor/nurse refused to treat you or refused to do relevant tests	1	Yes
	0	No
You had to wait longer for the doctor/nurse to treat you than other patients	1	Yes

⁵ In Sierra Leone, asked per health problem identified. In Guinea and Liberia, asked about health problems in general.

⁶ In Sierra Leone, asked per health problem identified. In Guinea and Liberia, asked about health problems in general.

⁷ In Sierra Leone, asked per health problem identified. In Guinea and Liberia, asked about health problems in general.

	0	No
	1	Yes
The doctor/nurse appeared nervous or uncomfortable treating you	0	No
The doctor/nurse gossiped about your survivor status	1	Yes
	0	No
You received less care/attention than other patients	1	Yes
	0	No
Stigma (Guinea)		
	1	Yes
Medical personnel refused to treat you or do tests for you because of your Ebola status.	0	No
	1	Yes
The wait time to be seen by a medical staff was longer for you than for other patients.	0	No
	1	Yes
Medical staff took excessive precautions when examining you.	0	No
	1	Yes
Medical staff gossiped about your Ebola status.	0	No
	1	Yes
You received less attention / care than the other patients.	0	No
Stigma (Sierra Leone)		

You were denied health services because of my Ebola survivor status	1	Yes
	0	No
	99	Don't know
Healthcare workers talked badly about you because of your Ebola survivor status	1	Yes
	0	No
	99	Don't know
A health worker disclosed your Ebola survivor status without your permission	1	Yes
	0	No
	99	Don't know
Stigma (All)		
Do you think that treatment of Ebola survivors by doctors and nurses has gotten better, gotten worse, or stayed the same since just after the Ebola time?	1	Better
	2	Worse
	3	Stayed the same
EVD Bodies (Liberia and Guinea)		
I feel very confident about the survivor Network's ability to get better support for people like me.	1	Agree
	2	Neither agree nor disagree
	3	Disagree
	99	No response
	1	Agree

I feel very confident about the [National EVD Government Body's] ⁸ ability to get better support for people like me.	2	Neither agree nor disagree
	3	Disagree
	99	No response
EVD Body (Sierra Leone)		
How confident are you in the survivor network's ability to support/address your needs and represent you?	1	Very confident
	2	Somewhat confident
	3	Not at all confident
	777	Skip

⁸ Name varied by country.

Annex C. Data Quality Verification summary

The Global Health Ebola Team (GHET) supplied a list of indicators related to their Pillar II portfolio for which they desired data quality verification (DQV), including data originating from health facilities and/or health management information systems (HMIS), training data, and data derived from other sources, such as project surveys. The purpose of the verification activity was to guide GHET on public use of these indicator data. The BalanceD-MERL team completed a verification of 55 indicators in total, among which were 14 training and ‘other’ indicators⁹ relevant to the GHET survivor program activities: seven in Guinea, four in Liberia, and three in Sierra Leone.

For each indicator, the verification included an extraction of data from implementing partner reports, a sampling of up to two data reporting periods, a request for lowest level “raw” data from the implementing partner, and then comparison of data reported by the implementing partner against the lowest level “raw” data available that was re-calculated by the BalanceD-MERL consortium. Issues with the data and analysis were recorded, including those related to integrity, reliability, and timeliness – the three USAID quality standards that this Data Quality Verification activity was best positioned to assess. Each training or other indicator verified was given a color code based on this exercise to guide GHET on public use of these indicator data.

- Green = Safe for public use. No or very low error rate overall (less than 5%) and sufficient ability to verify data.
- Yellow = Cautioned for public use. Low to moderate margins of error overall (5% or greater, but less than 8%) and/or minor challenges with verifying data. Consider potential limitations before posting.
- Orange = Cautioned for public use. Moderate margins of error (between 8% and 12%), notable data reliability or integrity issues, and/or significant challenges with verifying data.
- Red = Do not use publicly. Large margins of error (12% or greater) and/or inability to verify data.

As seen in Table E.1, of the 14 indicators specific to the GHET survivor program activities, six were given a green designation, three were given a yellow designation, and five were given an orange designation. Most indicators designated green were recommended for public use without caveats and may even be safe for scientific use. Indicators designated orange were not recommended for scientific purposes, and their public use would require major caveats. The data associated with these indicators were found to have substantial integrity and reliability issues and, as such, have very limited value to support a narrative around GHET’s contribution.

⁹ The BalanceD-MERL team did not verify any HMIS-derived indicators that were specific to the GHET survivor program activities.

Table E.1: Summary of DQV Findings

Country	Frequency/Type	Indicator	Code
Guinea	Quarterly/ Training	# of healthcare workers trained or mentored to provide appropriate and safe clinical services needed by Ebola Survivors	Green
Guinea	Quarterly/ Training	# of health workers trained or mentored in stigma reduction	Green
Guinea	Quarterly/ Training	# of community members trained or mentored in stigma reduction	Green
Guinea	Quarterly/ Other	# of visits for secondary and tertiary clinical care services at supported secondary and tertiary healthcare facilities	Yellow
Guinea	Quarterly/ Other	# of visits by Ebola survivors for secondary and tertiary clinical care services at supported secondary and tertiary healthcare facilities	Yellow
Guinea	Quarterly/ Other	# of referrals issued at primary care sites for secondary and tertiary care services at secondary and tertiary healthcare facilities	Yellow
Guinea	Twice during project/ Other	Proportion of Ebola survivors reporting the perception of health provider stigma	Green
Liberia	Monthly/ Training	# of healthcare workers trained or mentored to provide appropriate and safe clinical services needed by Ebola survivors	Orange
Liberia	Quarterly/ Other	# of visits for secondary and tertiary clinical care services at supported secondary and tertiary healthcare facilities	Orange
Liberia	Quarterly/ Other	# of visits by Ebola survivors for secondary and tertiary clinical care services at supported secondary and tertiary healthcare facilities	Orange
Liberia	Life of project indicator/ Other	Proportion of Ebola survivors reporting the perception of health provider stigma	Green
Sierra Leone	Quarterly/ Other	# of referral visits actualized by Ebola survivors for specialized clinical care services at secondary and tertiary healthcare facilities	Orange

Sierra Leone	Twice during project/Other	Proportion of Ebola survivors reporting stigma during their last visit to a healthcare facility	Green
Sierra Leone	Quarterly/ Other	# of visits by Ebola survivors for primary clinical care services at supported primary healthcare facilities	Orange

Annex D. BalanceD-MERL Monitoring of EVD Survivor Surveys

1. PURPOSE & OBJECTIVES

As part of its own program monitoring and evaluation activities, JSI R&T conducted program baseline and endline quantitative interviews with Ebola virus disease (EVD) survivors in Sierra Leone, Liberia, and Guinea. The BalanceD-MERL team leveraged the JSI R&T data from both points in time, including adding a module to the JSI R&T endline survey, for its performance evaluation of the GHET survivor programming. To this end, the BalanceD-MERL team sought to understand (1) whether the EVD survivor data as recorded by JSI R&T was a correct representation of the data and (2) what implication this had on the usefulness of the data for the performance evaluation.

The BalanceD-MERL team employed a methodology in which BalanceD-MERL enumerators accompanied JSI R&T enumerators and independently recorded a sample of EVD survivor responses separately. This established a framework in which a subsample of respondents had two measurements for every question in the survey, collected at the same time. The dual measurements theoretically were expected to be equal. This reliability assessment broadly involves analyzing the inconsistency or measurement error, if any, between the data recorded by the BalanceD-MERL enumerators versus the JSI R&T enumerators for every subject at endline.

2. BACKGROUND

Survey measurement errors occur under the assumption that the variable being measured has a true value that is constant (Kane, 2008). Such errors derive from two types of sources. Sampling errors occur when a subset of the population is measured rather than a complete census. Sampling errors may be minimized through the development of a comprehensive sampling frame, random sampling, and the drawing of larger sample sizes. Non-sampling errors are any other type of measurement error that is unrelated to sampling, such as those occurring from the process of data collection (Banda, 2003).

There are many potential causes of non-sampling errors. For example, a poorly designed instrument, including confusing questions or vague terms, may result in a respondent providing an inaccurate answer (Marsden and Wright, 2010). Such instrument errors can be minimized through rigorous survey design. Interviewers may cause measurement error by leading or suggesting answers to a respondent, fabricating data, or making transcription errors (Marsden and Wright, 2010). Robust enumerator training may staunch such interviewer errors. However, irrespective of interviewer performance, respondents can create measurement error by incorrectly reporting their response to the interviewer (Marsden and Wright, 2010). Techniques to promote accurate reporting from respondents include rapport building and assurances of respondent confidentiality.

The present analysis concerns itself with variations in measurement that occur due to non-sampling errors, particularly those caused by the interviewer. This annex includes an overview of the methodology and the analytical framework, followed by detailed procedures and findings for each of the three countries where data were collected. Finally, a conclusion section summarizes findings and their implications for use of the JSI R&T data.

3. METHODOLOGY OVERVIEW

Considered highly accurate for estimating measurement error, a gold-standard re-interview occurs when a second interview is conducted in similar conditions using questions whose answers should not change over time. These data allow the estimation of simple response variance and the reliability ratio between the two interviews, creating an estimate of measurement error (Biemer and Lyberg, 2003).

For the present study, the gold standard re-interview was deemed too taxing on the Ebola virus disease survivors. Hence the BalanceD-MERL team adapted the gold standard re-interview process. In this study, the BalanceD-MERL enumerators accompanied a random sample of JSI R&T survivor surveys, observing interviews, and recording survivor responses separately. In Sierra Leone and Liberia, Innovations for Poverty Action (IPA) monitored the JSI R&T surveys while in Guinea, the Institute for Development Impact (I4DI) monitored the JSI R&T surveys.

This adapted re-interview methodology involves the following assumptions:

a) Errors come from the following sources:

1. The two measurements are made using the same instrument and at the same time. This would imply that any non-sampling errors that arise due to the instrument and/or respondent cognitive processes to arrive at the answer would be common to both measurements.
2. Hence, any differences between recorded data can be ascribed to the enumerator transcription process (that is, differences in the way the answers are comprehended and reported by the two enumerators).

b) The response(s) as recorded by the BalanceD-MERL enumerator is a stand-in for the “truth”

1. Accompaniment of JSI R&T enumerators without “blinding” could have caused the respondents and JSI R&T enumerators to become conscious of being observed or evaluated. Therefore, the performance and responses observed may not be representative of a typical ‘unaccompanied’ interview.
2. In general, interviewers may perform better than usual in an observed interview, thus, underestimating the true error rate.
3. A well trained BalanceD-MERL enumerator is still capable of making data entry mistakes. Therefore, it is acknowledged that the exact source of discrepancies in the two measurements remain unknown.

c) The adapted re-interview methodology offers information on how often transcription mistakes are likely to occur on average. The procedure allows the measurement of how often both the enumerators *agree to the response*, rather than measuring how often the item is entered *correctly*.

4. ANALYSIS FRAMEWORK

Based on the characteristics of this re-interview framework and its methodological limitations, the BalanceD-MERL team concluded that the best estimators to answer questions about usefulness of the data would be:

- a. **Simple agreement/error rates** with confidence intervals for categorical questions
- b. **Reliability ratios** for continuous and ordinal questions, as calculated using intra-class correlation coefficients

Categorical Questions

Simple agreement rate is related to the gross differences for measurements of binary data in a survey—the difference in response between the two data points for each question averaged over the element in the population. For example, a simple agreement rate of 0.75 would mean that in 75% of the observations there was agreement in the measurement by the two enumerators. Simple error rate is the inverse of the simple agreement rate: $1 - 0.75 = 0.25$ is the simple error rate.

The simple agreement rate in the sample of dual observations is not the same as the distribution of the true error rate in the population. To obtain the true agreement rate, a survey of the entire population (a census) would be necessary. Hence, the simple agreement rate estimates are reported along with their confidence intervals reported at the 95% confidence level. Confidence intervals (CIs) are the range of possible values within which an estimated value of a population parameter could fall. For example, consider a simple agreement rate of 0.96 with a confidence interval of (0.87 - 0.99). This means that for the monitored set of surveys, 96% of the time the two measurements agree (an error rate of 4%). Confidence intervals are always reported with the confidence level - the desired "degree of confidence." In error measurement literature, a 95% confidence level is used most often. Using the above example, if repeated measurements were made of the same variable, 95% of the time, the true agreement rate of the population will lie between 0.87 and 0.99.

The confidence intervals also will account for the fact that some questions were observed more than others. Questions with narrower CIs will be better estimates of the true values than ones with wider CIs. Consider the agreement rates and CIs for two hypothetical variables: 1 (0.48 - 1) for question A and 0.96 (0.87 - 0.99) for Question B. Even though question A has a higher agreement rate, it has a much wider confidence interval. This suggests that 0.96 is a better estimate of the agreement rate for Question B than 1 is for Question A.

Ordinal and Continuous Questions

Simple agreement/error rates treat all errors the same way. This is acceptable for categorical questions where one category error is similar to another. But this is not the case for ordinal and continuous questions where an error due to a difference of 1 is very different from an error by a difference of 2 or 4 or 20.

To account for this, the reliability ratio is used. The reliability ratio gives a quantitative measure of how much of the variance in the observations is true variance instead of variance from measurement error. For example, a reliability ratio of 0.8 implies the data are capturing 80% of the true variance (with 20% coming from error); the JSI R&T enumerators could be reported to be 80% reliable. As with agreement rates, reliability ratios are also reported with their respective confidence intervals.

Acceptable levels of agreement and reliability ratios

Since there is no definitive measure for an acceptable level of agreement, this report will utilize a measure of 75-90% as a benchmark for a reliable question for simple agreement rates, as suggested by Bajpai and Chaturvedi (2015) and their comparison of different measures. For the reliability ratio classification, this report will utilize a similar benchmark as based on existing literature (Bajpai & Chaturvedi, 2015). Below is the benchmarking used in evaluating results:

Simple Agreement Rates

Level	Classification	Color Code
Less than 0.75	Poor	Gray
0.75-0.9	Moderate	Yellow
Greater than 0.9	Excellent	Green

Reliability Ratio

Level	Classification	Color code
Less than 0.5	Poor	Gray
0.5 – 0.75	Moderate reliability	Beige
0.75 – 0.9	Good reliability	Yellow

Greater than 0.9	Excellent reliability	Green
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Simple agreement rates and reliability ratios are evaluated in conjunction with their respective confidence intervals. Consider a reliability ratio of 0.80 with a CI of (0.75 – 0.85). The width of the CI is calculated as the difference between the upper limit and lower limit (0.85-0.75 = 10). In this example, the estimate could be classified as ‘good’, per the table above, because the entire range of estimates fall within the Good reliability range of 0.75 to 0.9. However, a reliability ratio of 0.90 with a CI of (0.50- 0.95) would be difficult to classify because the range spans across multiple classification categories. In this example, it is impossible to state whether the value would fall in the poor, moderate, or good category.

Therefore, confidence interval widths are also considered in the assessment of the simple agreement rates and reliability ratios. Estimates that exceed the maximum confidence interval width were not evaluated for this report. Such estimates were not color coded at all.

Confidence interval widths

Width	Classification
21- 30	Moderate, with 30 being the maximum width
11- 20	Good
0- 10	Excellent

Survey questions analyzed

Across the three countries, there were differences in the overall surveys designed by JSI R&T, with the biggest differences occurring within the survey fielded in Sierra Leone compared to those fielded in Liberia and Guinea. The BalanceD-MERL team inserted questions into each of the three instruments to address the research objectives of its performance evaluation, and these additional questions also varied somewhat between countries, due to the existing structural differences in the JSI R&T instruments.

The survey items analyzed for this reliability assessment are the core measures used to inform the performance evaluation of the GHET survivor program. Given the differences in survey instruments, as well as varying field procedures, the results for each country are presented separately in this report. However, the analysis framework was the same in each country regardless of survey design.

5. COUNTRY SPECIFIC ANALYSIS

Sierra Leone

1) Field Process

In Sierra Leone, there were four BalanceD-MERL monitors (from IPA) for this activity, all of whom with considerable experience both conducting and monitoring surveys. As well as standard IPA training, the four monitors received the full three-day enumerator training run by JSI R&T and Focus-1000, the organization that JSI R&T contracted to carry out its endline surveys. On the final day of training, several EVD survivors were invited to the training location to enable enumerators to fill out test entries. Given the training coordination between the JSI R&T enumerators and IPA monitors, subsequent discrepancies in the data are unlikely to be due to training methods.

JSI R&T informed IPA of the field plan of Focus1000. IPA then designed a monitoring plan that would allow observation of 75 surveys in USAID's five priority districts. The field plan was organized such that IPA could observe all 12 enumerators working in these districts. IPA aimed to monitor surveys proportionately by district. However, in some cases this was not possible. For example, Focus-1000 changed the field plans to reach its target number of respondents, and this did not give IPA sufficient time to deploy monitors to new locations. In Bombali district, Focus1000's data collection had nearly concluded before IPA was made aware that data collection had started earlier than planned. Focus-1000's enumerators delayed the final two interviews in Bombali, allowing IPA monitors to observe those interviews.

Initially, IPA had planned to monitor a sample of 10% of JSI R&T's surveys in Sierra Leone. JSI R&T planned to conduct 742 surveys in Sierra Leone, including 476 in USAID's five priority districts. Ultimately, JSI R&T conducted 751 surveys nationwide and 480 in USAID's priority districts. Of these, IPA monitored 70 JSI R&T surveys (14.5%) in the five priority districts, which equated to monitoring 9.3% of JSI R&T's nationwide total (Table F.1).

Table F.1: Surveys monitored by district- Sierra Leone

District	# of JSI R&T surveys conducted	# of surveys monitored	% of JSI R&T surveys that were monitored
Bombali	40	2	5%
Port Loko	200	27	14%

Tonkolili	39	8	21%
Western Area Rural	101	24	24%
Western Area Urban	100	9	9%
Total	480	70	15%

Both IPA monitors and Focus-1000 collected data electronically on tablets using SurveyCTO. Before the launch, JSI R&T sent IPA their final coded tool to ensure there were no differences in coding that would cause discrepancies. To protect the anonymity of respondents, names or other identifying information were not collected by monitors. The surveys were linked using a unique ID assigned by JSI R&T. In JSI R&T's full dataset of the 480 respondents, 95% of cases were unique by this ID but JSI R&T's data contained eleven pairs of duplicates (22 surveys), 3 pairs (six surveys) of which were among the 70 surveys monitored by IPA. At the time of this analysis, Balanced-MERL was unable to resolve the issue with the IDs, which was likely due to enumerator error, and therefore the 3 surveys in question were excluded from the Balanced-MERL data file. Thus, in Sierra Leone there were 67 surveys available for reliability comparison.

2) Reliability Findings

The Balanced-MERL team compared answers recorded by monitors and enumerators on key variables. Survey respondents were first asked which health problems they had experienced in the past year, and for each health problem there were four follow-up questions. For three of these items (S.1, S.3, and S.4), Table 2 shows the percentage of complete responses for which both the Focus-1000 and IPA enumerator recorded the same response (i.e., the simple agreement rates). The confidence intervals appear in parentheses. For example, on item S.2 among four surveys in which respondents reported abdominal problems, there was a 75% agreement. This means that the JSI R&T and IPA enumerators entered the same value on three of the four relevant surveys. For some health problems appearing in Table 2, there are very low agreement values because the sample is small. For example, some cells show an agreement coefficient of 0% in cases where n=1.

In Tale F.2, there are six cells for which the number of observations and the confidence interval width allow for the assessment of data quality. In each of these six cells, the data have been classified as excellent, per the benchmarks described above.

Table F.2: Sierra Leone Agreement Rates (Categorical Questions): Health Problems and Other

Health Problems <i>Respondents were asked these questions about each health problem they reported</i>	S.1 Did you seek care for your [health problem]? (yes/no)	S.3 Do you feel that your access to care for your [health problem] was adequate? (yes/no)	S.4 Was the quality of healthcare that you received for your [health problem] satisfactory? (yes/no)	Number of observations
Abdominal Problems	0.75 (0.19 - 0.99)	1.00 (0.40 - 1)	1.00 (0.40 - 1)	4
Emotional problems	1.00 (0.03 - 1)	1.00 (0.03 - 1)	1.00 (0.03 - 1)	1
Eye problems	0.75 (0.51 - 0.91)			20
Fever	0.80 (0.44 - 0.97)	1.00 (0.69 - 1)	0.90 (0.55 - 0.99)	10
Headache	0.96 (0.79 - 0.99)	0.92 (0.73 - 0.99)	1.00 (0.86 - 1)	24
Hearing related problems	-	-	-	0
Joint problems	0.74 (0.57 - 0.88)	0.91 (0.75 - 0.98)	0.97 (0.84 - 1)	35

Numbness, dizziness, or pins and needles	0.0 (0 - 0.98)	1.00 (0.03 -1)	1.00 (0.03 - 1)	1
Other problems	0.60 (0.26 -0.89)	0.90 (0.55 - 0.99)	0.90 (0.55 - 1)	10
Pain	0.91 (0.71 - 0.98)	0.85 (0.62 - 0.97)	0.90 (0.68 - 0.99)	22
Problems during pregnancy	-	-	-	0
Reproductive health problems	1.00 (0.03 - 1)	1.00 (0.03 -1)	1.00 (0.03 - 1)	1
Sexual health problems	1.00 (0.03 - 1)	0.0 (0 - 0.975)	1.00 (0.03 - 1)	1

Table F.3 below presents simple agreement rates for questions relating to stigma. Like the results in Table F.2, the average agreement rates for individual questions with a reasonably large number of observations ($n \geq 10$) and acceptable confidence interval widths ranges from 90% to 97%.

Table F.3: Sierra Leone Simple Agreement Rates (Categorical Questions): Stigma

Question: In the last year, have you faced these issues (Yes/No)		Number of observations
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People talked badly about you because of your Ebola survivor status	0.90 (0.8 - 0.96)	67
Has there been any improvement since then?	0.80 (0.59 - 0.93)	25
Someone else disclosed your Ebola survivor status without your permission	0.94 (0.8 - 0.98)	67
Has there been any improvement since then?	0.83 (0.59 - 0.96)	18
You were verbally insulted, harassed and/or threatened because of your Ebola survivor status	0.96 (0.87 - 0.99)	67
Has there been any improvement since then?	1.00 (0.66 - 1)	9
You were physically assaulted because of your Ebola survivor status	0.96 (0.87 - 0.99)	67
Has there been any improvement since then?	0.40 (0.05 - 0.85)	5
You felt that people did not wanted to sit next to you, for example on public transport, at church or mosque, or in a health facility because of your Ebola survivor status	0.90 (0.79-0.96)	67

Has there been any improvement since then?	1.00 (0.48 - 1)	5
You were denied health services because of my Ebola survivor status	96 (0.87 - 0.99)	67
Has there been any improvement since then?	1.00 (0.48 - 1)	5
Healthcare workers talked badly about you because of your Ebola survivor status	0.96 (0.87 - 0.99)	67
Has there been any improvement since then?	0.67 (0.09 - 0.99)	3
A health worker disclosed your Ebola survivor status without your permission	0.93 (0.83 - 0.98)	67
Has there been any improvement since then?	0.75 (0.19 - 0.99)	4
Have you ever been treated badly by health staff because of your status as an Ebola Survivor (for example, whether you have been refused service, or made to wait for longer than other patients)?	0.97 (0.90 - 1)	67

Table F.4 presents the reliability ratios for answers recorded to question S.7—an item that was measured on a 5-point ordinal scale (1. *Got much better*, 2. *Got a little better*, 3. *Stayed the same*, 4. *Got a little worse*, 5. *Got much worse*). Among the four items with sufficient observations and suitable

confidence interval widths, two have an 'excellent' reliability ratio and the other two have a 'good' reliability ratio. This could be because some judgment is necessary to code these answers. If a respondent gives an answer that could reasonably be interpreted as either "Got much better", or "Got a little better", then the monitor and enumerator might code different answers. In such situations, the enumerator ideally should have probed further to obtain a conclusive answer, but this may not have always happened. Almost all the observed differences between the monitor and enumerator coding on this item are of one degree, as in the example above. Further, the discrepancies are not systematic. They did not skew in one direction.

Table F.4: Sierra Leone Reliability Ratios (Ordinal Questions): Health Problems and Other

Health Problems <i>Respondents were asked these questions about each health problem they reported</i>	S.7 <i>In the past two years (since the end of the Ebola time), do you feel that care for [health problem] has got</i>	Number of observations
Abdominal Problems	1.0	4
Emotional problems	-	1
Eye problems	0.89 (0.72 - 0.96)	20
Fever	0.95 (0.79 - 0.99)	10
Headache	0.80 (0.55 - 0.92)	24
Hearing related problems	-	0
Joint problems	0.89 (0.78 - 0.94)	35
Numbness, dizziness, or pins and needles	-	1
Other problems	0.98	10

	(0.93 – 1)	
Pain	0.79 (0.5 - 0.91)	22
Problems during pregnancy	-	0
Reproductive health problems	-	1
Sexual health problems	-	1

Note: For questions with 0 or 1 observation the reliability ratio cannot be calculated

3) Other quality findings

In Sierra Leone, the IPA monitors noted issues with the administration of the survivor surveys including the following issues, which could affect the accuracy and precision of the data:

- **Leading questions:** During questions about whether services for various health problems had improved, some JSI R&T enumerators read out only the positive options: *“Got much better, Got a little better”*, but not the neutral or negative options *“Stayed the same, got a little worse, or got much worse”*. This might guide respondents towards selecting a positive response. This problem was reported in less than 10% of surveys monitored.
- **Translation:** The tool was coded into the mobile devices in English, with each JSI R&T enumerator responsible for translating the survey into Krio (Sierra Leone’s lingua franca most commonly spoken in the capital) or another local language spoken by the respondent, at the time of the interview. IPA monitors, who are all fluent in the local language of the areas they were monitoring, reported that in some cases the translations varied between different surveyors.
- **Probing:** IPA monitors reported that some enumerators did not take sufficient time to explain some questions, or probe when respondents gave answers that might only have been partially complete.

Finally, as with all surveys, social desirability bias can influence results. While it is difficult to determine whether social desirability bias affected the data provided by EVD survivors in Sierra Leone, very few survivors indicated that they had experienced emotional, sexual, or reproductive problems. Indeed,

in JSI R&T's full survey of 459 respondents (in 5 districts), only 3.5%, 2.6%, and 2.1% respectively reported experiencing these problems.

Liberia

1) Field Process

There were five BalanceD-MERL monitors (from IPA) in Liberia, all with extensive experience both conducting and monitoring surveys. As well as standard IPA training, the monitors received the full four-day enumerator training run by JSI R&T. On the fifth day of training the IPA team participated in a field test and debrief session with the JSI R&T team. Given the training coordination between the JSI R&T enumerators and IPA monitors, subsequent discrepancies in the data are unlikely to be due to training methods.

The number of interviews to be conducted in each Liberian county was pre-determined based on targets that JSI Research & Training Institute, Inc. had established in their field plan. IPA aimed to monitor 30% of the surveys conducted in each of the four counties of interest. IPA monitors randomly selected interviews to be observed by writing the names of all the respondents due to be interviewed on a given day on small pieces of paper which were folded and placed in an envelope. A team member then blindly picked names from the envelope. If a respondent did not consent to have their interview monitored another name would have been randomly selected; however no refusals were recorded, and no replacements were needed.

Due to the difficulty associated with conducting unannounced visits, the IPA teams accompanied the JSI R&T teams for the entire duration of field work, which lasted 20 days in part due to a survey boycott mounted by the survivor network in Lofa and parts of Montserrado. The IPA team was able to monitor surveys conducted by all 11 of JSI R&T's enumerators. JSI R&T Liberia had a sample size of 213 and IPA observed 69 surveys (Table F.5). This equated to 32% of the national sample. While surveys were monitored in each of the four counties of interest, the preponderance of monitored surveys were in Montserrado, in proportion to the JSI R&T survey sample.

Table F.5: Surveys monitored by county - Liberia

County	# of JSI R&T surveys conducted	# of surveys monitored	% of JSI R&T surveys that were monitored
Bong	14	3	22%
Lofa	26	8	31%
Margibi	36	11	31%
Montserrado	137	47	34%
Total	213	69	32%

Both IPA monitors and JSI R&T enumerators collected data electronically on tablets. The IPA monitors used SurveyCTO and the JSI R&T enumerators used ONA. The difference in platforms used for data collection had no impact on findings as JSI Research & Training Institute, Inc. sent IPA their final coded tool prior to launch ensuring that both teams had the same tool. To protect the anonymity of respondents, no names or other identifying information were collected by monitors. The surveys were linked using a unique ID assigned JSI R&T. In JSI R&T's full dataset of the 213 respondents, all cases were unique by this ID.

2) Reliability Findings

The BalancedD-MERL team compared answers recorded by monitors and enumerators on key variables. Tables F.6 and F.7 present the simple agreement rate and confidence intervals for a variety of categorical questions asked of survivors in Liberia. Table F.8 presents reliability ratios and confidence intervals for select ordinal questions. Overall, the simple agreement rates and reliability ratios were deemed excellent. In almost all instances the answers recorded by the IPA monitors matched those recorded by the JSI R&T enumerators.

Table F.6: Liberia Simple Agreement Rates (Categorical Questions): Health Problems and Other

Question (Yes/No)		Number of Observations
When you had this problem, did you go to a clinic or health facility to get treatment?	0.98 (0.90 – 1)	52
Was the quality of healthcare that you received satisfactory?	1.00 (0.93 – 1)	52
Do you feel that your access to healthcare for this problem was adequate?	0.92 (0.81 – 0.98)	52
Have you heard of any group which represents survivor interests?	0.97 (0.90 – 1)	69
Have you heard of a group called the Ebola Survivors Network?	1.00 (0.95 – 1)	69
Are you a member of the survivor network?	0.95 (0.87 – 1)	63
Have you heard of a group within the Ministry of Health called the National Ebola Survivors Secretariat?	0.99 (0.92 – 1)	69
Have you ever received information about services that are available for Ebola survivors?	0.97	69

	(0.90 – 1)	
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Table F.7: Liberia Simple Agreement Rates (Categorical Questions): Stigma

Question: In the past 12 months, has any of the following things happen to you at a health facility because you were an Ebola survivor? (Yes/No)		Number of Observations
The doctor/nurse refused to treat you or refused to do relevant tests	0.97 (0.90 – 1)	69
You had to wait longer for the doctor/nurse to treat you than other patients	1.00 (0.95 – 1)	69
The doctor /nurse appeared nervous or uncomfortable treating you	0.97 (0.90 – 1)	69
The doctor/nurse gossiped about your survivor status	1.00 (0.95 – 1)	69
You received less care/attention than other patients	0.99 (0.92 - 1)	69
Have you ever avoided or delayed seeking healthcare treatment because you were afraid of the doctor/nurse's attitudes towards you as an Ebola Survivor?	0.99 (0.92 - 1)	69

Table F.8: Liberia Reliability Ratios (Ordinal Questions): Health Problems and Other

Question (Agree, neither agree nor disagree, disagree)		Number of observations
I feel very confident about the survivor network's ability to get better support for people like me	1.00 (0.94 – 1)	63
I am happy with the work that the survivor network is doing	0.97 (0.89 - 1)	63
I feel very confident about the secretariat's ability to get better support for people like me	0.97 (0.83 – 1)	32
I am happy with the work that the secretariat is doing	0.94 (0.80 – 1)	32
Question (gotten better, gotten worse, or stayed the same)		
Do you think that treatment of Ebola survivors by doctors and nurses has gotten better, gotten worse, or stayed the same since just after the Ebola time?	0.98 (0.92 – 1)	69
Question (got much better, got a little better, stayed the same got a little worse, got much worse)		
In the past two years (since the end of the Ebola time), do you feel that care for this problem has	0.96 (0.93-0.98)	52

3) Other quality findings

In Liberia, monitors noted issues with the administration of survivor surveys during the field testing. For example, it was noted that some enumerators were paraphrasing questions and not reading the options correctly to respondents. Monitors also observed that in some survey sections that required explanation the JSI R&T enumerators were not explaining as prompted. These issues were addressed during the re-training session conducted by JSI R&T and were not reported again during final data collection.

The tool was coded and administered in English, with each enumerator responsible for explaining the questions in Liberian English if the respondent did not understand the question. This situation was anticipated during the training and standard explanations in colloquial were given for all enumerators to adhere to. Monitors reported that JSI R&T enumerators adhered to these explanations uniformly.

Guinea

1) Methodology

There were two BalanceD-MERL monitors (from I4DI) in Guinea, with experience conducting and monitoring surveys. The monitors received enumerator training run by I4DI. Given that instruments, training materials, and the field plan were provided to I4DI only after the JSI R&T enumerator training had been completed, BalanceD-MERL monitors were unable to participate in JSI R&T provided training for enumerators. Given the training coordination issue, subsequent discrepancies in the data are possibly due to inconsistent training methods.

The number of interviews to be conducted in Guinea was pre-determined based on targets that JSI R&T had established in their field plan. I4DI aimed to monitor 10% of administered survivor surveys, which took longer given JSI R&T's difficulties in coordinating survivors. I4DI extended collection monitoring times in Conakry to accommodate for this delay on the ground. I4DI monitors paired up JSI R&T enumerators to observe interviews. If a respondent consented to have their interview monitored, the I4DI monitor would join the interview and record responses separately, noting the shared identification code. In total, 11% of the JSI R&T surveys were monitored, all from the Conakry region (Table F.9).

Table F.9: Surveys monitored by region - Guinea

Region	Surveys conducted	Surveys Monitored	% of JSI R&T surveys monitored
N’Nzérékoré	181	0	0
Conakry	107	58	54
Kindia	160	0	0
Faranah	24	0	0
Boké	17	0	0
Kankan	42	0	0
Total	531	58	11

2) Reliability Findings

The BalanceD-MERL team compared answers recorded by monitors and enumerators on key variables. Tables F.10 and F.11 present the simple agreement rate and confidence intervals for a variety of categorical questions asked of survivors in Guinea. Table F.12 presents reliability ratios and confidence intervals for select ordinal questions. Overall, most of the simple agreement rates were deemed excellent. Due to wide confidence intervals, only one reliability ratio was assessed against the benchmarks. It, too, showed excellent reliability.

Table F.10: Guinea Simple Agreement Rates (Categorical Questions): Health Problems and Other

Question (Yes/No)	% Correct	Number of Observations
When you had a health problem: Did you visit a health facility or clinic for treatment?	0.92 (0.73 – 0.99)	24
Was the quality of healthcare you received satisfactory?	1.00 (0.92 – 1)	46
Have you received information on the services available to Ebola survivors?	0.96 (0.88 - 1)	56
Do you feel that your access to healthcare for this problem was adequate?	0.94 (0.83 – 0.99)	50
In the last two years (since the end of the Ebola time), do you feel that the problem for which you received health service has been resolved?	0.67 (0.22 – 0.96)	6
Do you know one or more local groups or associations that represent the interests of Ebola survivors?	0.96 (0.88 – 0.99)	56

Have you heard about a group called the National Network of Ebola survivors in Guinea? (RENASEG)?	0.92 (0.81 – 0.98)	52
Are you a member of an Ebola survivors association?	1.00 (0.93 – 1)	52
Have you heard of an institution called the National Agency for Health Security (ANSS)? Formerly known as National coordination of Ebola Control.	0.87 (0.68 – 0.97)	24

Table F.11: Guinea Simple Agreement Rates: Stigma

Question: In the past 12 months, have any of the following things or actions occurred in the health facility or did you visit for care as a survivor or healed of Ebola? (Yes/No)	% Correct	Number of observations
Medical personnel refused to treat you or do tests for you because of your Ebola status	1.00 (0.59 – 1)	7
The wait time to be seen by a medical staff was longer for you than for other patients	0.98 (0.89 – 1)	50
Medical staff took excessive precautions when examining you	0.98 (0.56 – 0.82)	50
Medical staff gossiped about your Ebola status status	0.71 (0.56 – 0.83)	51

You received less attention / care than the other patients	0.86 (0.73 – 0.94)	50
Have you ever avoided or delayed seeking healthcare treatment because you were afraid of the medical staff attitudes towards you as an Ebola Survivor	0.88 (0.76 – 0.96)	51

Table F.12: Guinea Reliability Ratios (Ordinal Questions): Health Problems and Other

Question (Agree, Neither Agree nor Disagree, Disagree)	Reliability Ratio	Number Surveys
I am very confident in the ability of the Ebola survivors network to get the best support for people like me	0.59 (0.39 – 0.78)	27
I am happy with the work that the Ebola survivors network does	0.52 (0.32 – 0.71)	27
I have confidence in ANSS's ability to provide the best support for people like me	0.67 (0.35 – 0.90)	12
Do you think that the treatment of Ebola survivors by doctors and nurses has improved, worsened or remained the same since the outbreak of Ebola?	0.96 (0.88 – 0.99)	56

3) Other quality findings

Unlike Sierra Leone and Liberia, JSI R&T Guinea's baseline and endline collection were conducted manually, using paper copies of the survey instrument. This created multiple opportunities for potential data entry issues both in initial recording of data on paper forms to eventual submission and conversion of data into digital format.

I4DI monitors noted that there were some language difficulties encountered by enumerators in administering the survey. There were local dialects that the survey instrument itself was not translated into, but enumerators made efforts to translate the questions to the best of their ability.

For monitoring data entry, the tool was coded in French, with each monitor responsible for submitting their entries to a database for analysis. This code was then crosswalked against JSI R&T Guinea's framework and assessed. A digital collection would have simplified both the accuracy of collection and subsequent analysis.

6. CONCLUSION

In summary, the three countries varied in terms of the number of survey questions available for analysis and the number with sufficient observations to be scored in this reliability assessment (Table F.13). Liberia had the highest number of survey questions scored, followed by Guinea and then Sierra Leone. This variation primarily results from the instrument design in Sierra Leone; a subset of questions were asked for each specific health problem that a respondent experienced. Because every respondent would not have experienced all the listed health problems, the number of observations related to specific health problems were low.

Table F.13: Number of questions analyzed and number of questions scored, by country

	Health Problems and Other (Categorical)	Stigma (Categorical)	Health Problems and Other (Ordinal)	Total
Sierra Leone				
Total No of Questions	39	17	13	69
Total Scored	6	9	4	19
Liberia				
Total No of Questions	8	6	6	20
Total Scored	8	6	6	20
Guinea				
Total No of Questions	9	6	4	19
Total Scored	8	5	1	13

Within the questions that have an adequate number of observations, there were high estimates for agreement rates and reliability ratios in all three countries (Table F.14). The data from Liberia had the best reliability, followed by Guinea and then Sierra Leone. These differences also could be due to the survey structure.

Table F.14. Reliability scores, by analysis type, by country

	Health Problems and Other (Agreement rates)	Stigma (Agreement Rates)	Health Problems and Other (Reliability Ratio)
Sierra Leone			
Excellent	6 (100%)	9 (100%)	2 (50%)
Good	NA	NA	2 (50%)
Moderate	0	0	2 (50%)
Poor	0	0	0
Liberia			
Excellent	8 (100%)	6 (100%)	6 (100 %)
Good	NA	NA	0
Moderate	0	0	0
Poor	0	0	0
Guinea			

Excellent	7 (88%)	2 (40%)	1 (100 %)
Good	NA	NA	0
Moderate	1(12%)	2 (40%)	0
Poor	0	1(20%)	0

Due to the nature of the estimates (agreement rates and reliability ratios) and the varying number of observations reported, it is impossible to summarize them meaningfully into a single estimate for every country. Within the sample of questions that have sufficient observations, the agreement estimates are generally excellent, although a couple were good and one rated as poor (Guinea). These high reliabilities generally suggest that JSI R&T enumerators did not make transcription errors when entering answers reported by respondents, with the exception of the one item with poor agreement rates. Assuming that performance on the questions with sufficient observations is reflective of those questions without sufficient observations, as well as those not analyzed herein, there would likely be high agreement estimates across the entire survey dataset in each country.

In cases where the BalanceD-MERL monitor and JSI R&T enumerator recorded different responses, it is impossible to determine which of them (if any) was correct. Indeed, there is some subjective judgment required when entering verbal responses into electronic tools.

The findings presented herein only explore issues of enumerator reliability; they are not indicators of accuracy. There are several potential biases that could reduce accuracy. These include social desirability bias, where respondents give answers they believe are wanted or necessary, such as minimizing answers that might make the respondent look bad or embellishing answers that might result in the respondent obtaining additional assistance. The survey boycotts in Liberia may have affected the validity of those data uniquely. Regardless, any issues with data validity are not captured by this analysis.

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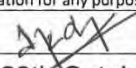
Annex E: Disclosures of Conflict of Interest

Among the research team, there were no conflicts of interest. The following are signed statements verifying that there were no conflicts of interest.

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Arja Dayal
Title	Country Director, IPA Sierra Leone and Liberia
Organization	Innovations for Poverty Action
Evaluation Position?	☐ Team Leader ☒ Team member
Evaluation Award Number (contract or other instrument)	AID-OAA-A-15-00061
USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	Global Health Ebola Team Pillar II Ebola Virus Disease Survivor Program
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: <i>Real or potential conflicts of interest may include, but are not limited to:</i> 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	

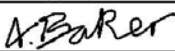
I certify (1) that I have completed this disclosure form fully and to the best of my ability and (2) that I will update this disclosure form promptly if relevant circumstances change. If I gain access to proprietary information of other companies, then I agree to protect their information from unauthorized use or disclosure for as long as it remains proprietary and refrain from using the information for any purpose other than that for which it was furnished.

Signature	
Date	28th October, 2018

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Arthur Baker
Title	Research Coordinator
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Evaluation Position?	☐ Team Leader ☒ Team member
Evaluation Award Number (contract or other instrument)	AID-OAA-A-15-00061
USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	Global Health Ebola Team Pillar II Ebola Virus Disease Survivor Program Advancing Partners and Communities; Ebola Transmission Prevention and Survivor Services Project; JSI Research & Training Institute Inc; AID-OAA-A-12-00047
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
If yes answered above, I disclose the following facts: <i>Real or potential conflicts of interest may include, but are not limited to:</i> 1. Close family member who is an employee of the USAID operating unit managing the project(s) being evaluated or the implementing organization(s) whose project(s) are being evaluated. 2. Financial interest that is direct, or is significant though indirect, in the implementing organization(s) whose projects are being evaluated or in the outcome of the evaluation. 3. Current or previous direct or significant though indirect experience with the project(s) being evaluated, including involvement in the project design or previous iterations of the project. 4. Current or previous work experience or seeking employment with the USAID operating unit managing the evaluation or the implementing organization(s) whose project(s) are being evaluated. 5. Current or previous work experience with an organization that may be seen as an industry competitor with the implementing organization(s) whose project(s) are being evaluated. 6. Preconceived ideas toward individuals, groups, organizations, or objectives of the particular projects and organizations being evaluated that could bias the evaluation.	

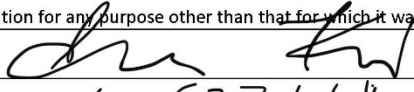
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Signature	
Date	28-Oct-2018

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Azra K. Nurkic
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USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	Global Health Ebola Team Pillar II Ebola Virus Disease Survivor Program
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
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Signature	
Date	10/23/18

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Bridget C. Lavin
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Evaluation Position?	☒ Team Leader ☐ Team member
Evaluation Award Number (contract or other instrument)	AID-OAA-A-15-00061
USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	Global Health Ebola Team Pillar II Ebola Virus Disease Survivor Program Advancing Partners and Communities Program; Ebola Transmission Prevention and Survivor Services Project; JSI Research & Training Institute Inc.; AID-OAA-A-12-00047
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
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Signature	<i>Bridget C. Lavin</i>
Date	10/28/18

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Jose Santos
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USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	Global Health Ebola Team Pillar II Ebola Virus Disease Survivor Program
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
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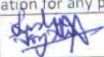
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Signature	
Date	October 23, 2018.

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Leslie Joy Alex
Title	Research Associate
Organization	Innovations for Poverty Action
Evaluation Position?	☐ Team Leader ☒ Team member
Evaluation Award Number (contract or other instrument)	AID-OAA-A-15-00061
USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	Global Health Ebola Team Pillar II Ebola Virus Disease Survivor Program
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
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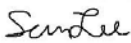
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Signature	
Date	30/10/2018

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Samuel S. Lee
Title	Lead Researcher
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Evaluation Award Number (contract or other instrument)	AID-OAA-A-15-00061
USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	Advancing Partners and Communities Program; Ebola Transmission Prevention and Survivor Services Project; JSI Research & Training Institute Inc.; AID-OAA-A-12-00047
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
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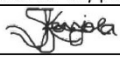
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Signature	
Date	10/23/2018

Disclosure of Conflict of Interest for USAID Evaluation Team Members

Name	Sibongani Kayola
Title	Research Associate
Organization	Innovations for Poverty Action
Evaluation Position?	☐ Team Leader ☒ Team member
Evaluation Award Number (contract or other instrument)	AID-OAA-A-15-00061
USAID Project(s) Evaluated (Include project name(s), implementer name(s) and award number(s), if applicable)	Global Health Ebola Team Pillar II Ebola Virus Disease Survivor Program
I have real or potential conflicts of interest to disclose.	☐ Yes ☒ No
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Signature	
Date	10/31/2018

Annex F: Original Statement of Work

Introduction

The BalanceD-MERL consortium is conducting the end-line evaluation for the portfolio of GHET Survivor programs in Sierra Leone, Liberia, and Guinea. The field data collection components of this evaluation will take place between February and April 2018, with the final evaluation report due at the end of September 2018.

This evaluation scope of work and design has been collaboratively prepared by Innovations for Poverty Action (IPA) and the Institute for Development Impact (IDI), with support from World Vision US. USAID GHET has been engaged in prioritization of the lines of inquiry and will approve the final design of the evaluation by November 30, 2017.

Program description

The USAID Global Health Ebola Team (GHET) oversees a portfolio of health-related projects that fall under Pillar II of the U.S. Government's (USG's) response to the 2014 to 2016 Ebola virus outbreak in Sierra Leone, Guinea, and Liberia. The GHET has oversight of a \$150.5 million portfolio of activities that support critical non-Ebola health services, health systems, and transmission prevention of Ebola virus from the West African survivor community. The GHET program's development objective is that affected countries will be better equipped to sustain a "resilient zero" of Ebola cases¹⁰, meaning:

1. Effective infection prevention and control (IPC) within a wider context of patient safety.
2. Strengthened integrated disease surveillance and response capacities (IDSR) as part of enhancing the resilience of local health systems.
3. Reactivation of a basic package of essential health services in affected countries
4. Rebuilding of health workforce capacities as a foundation for sustainable health workforce strengthening
5. Services addressing the specific needs of Ebola survivors are in place and integrated into the public health system to help mitigate further Ebola infection among the population

¹⁰ World Health Organization, Ebola Response Phase 3: Framework for achieving and sustaining a resilient zero, September 2015, http://apps.who.int/iris/bitstream/10665/184693/1/ebola_resilientzero_eng.pdf?ua=1, and USAID Global Health Ebola Team Results Framework, June 7, 2017.

Implemented by 12 partners at national and regional levels across the three countries, the projects in the GHET portfolio aim to contribute to the mitigation of second-order impacts of the Ebola crisis, prevent further development losses and strengthen key institutions and infrastructure, with the following stated objectives:

1. Delivery and utilization of essential primary healthcare services are restored;
2. Health system functions are strengthened to respond appropriately and adequately to future public health crises
3. Prevention and treatment services that address the needs specific to Ebola survivors are available and utilized.

Some implementing partners have multiple projects within and across countries, and activities overall have been staggered across the period of 2016-2018. Other evaluation exercises are examining the first two sets of activities focused on the restoration of delivery and utilization of primary healthcare services and health systems strengthening. This is a cross-sectional study of the current status of GHET portfolio Ebola survivor-focused activities only.

As much as possible, baseline data will be researched from literature to provide context. Any GHET-funded activities that will be continuing beyond the timeframe of this evaluation may consider this a midline survey and are welcome to use the data and findings for appropriate course correction.

Evaluation purpose

The overall purpose of this evaluation is to determine to what extent the third intermediate and sub-intermediate results of the GHET portfolio have been achieved during the life of the program to date.

Evaluation risks (limitations) & monitoring / contingency plans

Risk	Mitigation Strategy
Overlapping Ebola response evaluation efforts	BalanceD-MERL is planning to coordinate with JSI R&T to share information, instrument development and even sampling strategies to eliminate burden on evaluation participants and ensure consistency where appropriate. This is particularly critical as it relates to conducting survivor surveys.
Survivor survey dependencies	Data collection from survivors is dependent on JSI R&T's plans for respective endline survivor surveys and ability to coordinate. BalanceD-MERL will rely on USAID assistance in ensuring that our input in JSI R&T survey development is incorporated and this data is obtained.
Alignment of IPs' result frameworks and reporting, to GHET's theory of change and overall results framework	GHET has aligned IR and sub-IR indicators in the GHET results framework with the indicators which partners have been tracking and reporting over the course of their activities. This design is around lines of inquiry to evaluate the specific Survivor IR (3) and sub-IRs (3.1, 3.2, 2.2) in the overall results framework.
Access to data and documents for literature and secondary review, as well as other non-financial resources.	We will work together to review resources required at each stage of engagement to ensure resources are available from GHET and the implementing partners. Early and persistent engagement with GHET and IPs is critical to ensuring that all documentation is acquired and/or made available for review, prior to the analysis and reporting on primary data collected through this exercise.
Availability of GHET primary points of contact for final decision-making on evaluation design	Biweekly meetings with GHET are scheduled. This ensures that a critical threshold of meetings enables adequate contact with primary stakeholders.
Seasonal liabilities - rainy season	Data collection activities are planned before the onset of the rainy season in West Africa in 2018.

National Elections in Liberia (2017) and Sierra Leone (2018)	Data collection activities will be planned around the election cycles in Liberia (October 2017) and Sierra Leone (March 2018) to reduce potential security concerns.
IPs' staff availability	Early sampling and adequate notice will be supplied to IP key informants so they can be either available in the field or remotely for interview. If they are no longer with the activity being evaluated then we plan to arrange telephone or Skype interviews.
No baseline survey data for comparison	Where possible, findings will be compared with pre-outbreak and pre-GHET activity data. However, data availability and reliability is variable and this will limit comparison. Therefore, this evaluation should be considered a cross-sectional study and conclusions will be made against standards set out in country and UN policy.
Risks to evaluation independence	As noted above, this evaluation relies on coordination with JSI R&T on design and input into an existing endline survivor survivor. As such, particular care will be given to maintain evaluation independence through (1) conducting independent training of our enumerators; (2) availability of all training materials for our enumerators to GHET (3) conducting of unannounced visits to observe JSI R&T interviews (4) use standardized instruments to evaluate data collection.

Study design

Main Evaluation Questions

The lines of inquiry for this evaluation are based on whether services addressing the specific needs of Ebola survivors are in place and integrated into the public health system to help mitigate further Ebola infection among the population. The study will entail findings on Ebola survivor response strategy and activities, identification of program strengths and weaknesses.

These evaluation questions link specifically to the GHET results framework: IR 3: Access to appropriate healthcare services is improved for Ebola survivors; sub-IR 3.1: Clinical services for Ebola survivors are strengthened and more accessible throughout the continuum of care; sub-IR 3.2: Stigma experienced by Ebola survivors when seeking care is reduced; sub-IR 2.2: Governance and management improved to advance national policies and systems.

Availability and Use of Quality Services

1. To what extent are quality health services focused on Ebola survivors available at different types of health facilities? Specific health services established for survivors? Regular health services? Referral to specific survivor services at higher level facilities? (Outcome)
2. Capacity/Equipment Question: To what extent are survivor health services (other than primary healthcare services) and resources adequate and sufficient to meet the health needs of Ebola survivors? (Output)
3. Survivors question: To what extent are Ebola survivors educated on services and accessing them? To what extent are Ebola survivors utilizing services available to them? (Outcome)

Stigma

4. To what extent do survivors experience stigma from health providers, and do survivors report that this stigma has decreased since the beginning of the program? (Outcome)
5. Management of health workers: To what extent are health professionals trained to minimize the effects of stigma during patient-provider interaction? (Output)

Policy/Systems

6. To what extent have policies, structures or networks (eg survivor networks) improved the services available for Ebola survivors? (Outcome)
7. What policies, structures or networks have been strengthened to ensure adequate services are available for Ebola survivors? (Output)

Detailed lines of inquiry questions for these main evaluation questions can be found in Appendix A.

Methods

The following considerations apply to this study:

- It is balanced, according to D-MERL principles- relevant, right-sized, responsible, and trustworthy.
- The study is a single study across the three Ebola affected countries, even though activities and their timing have some variation.
- Data collection will be conducted simultaneously in each country. IPA will be responsible for data collection in Liberia and Sierra Leone. I4DI will be responsible for data collection in Guinea.
- Agreement needs to be reached on the quantitative and qualitative division of labor around instrument development, data collection, and data analysis.
- Health facilities are the main entry point for data collection; however, the focus will be on those facilities where USAID-funded activities are being conducted, in high Ebola survivor prevalence areas.
- When possible, an assessment of all major health facilities that received JSI R&T interventions will be conducted (Liberia & Guinea). In Sierra Leone, a sample of facilities stratified by type and intensity of intervention will be taken.
- The evaluation design does not include a separate survivor survey but seeks only to coordinate with existing JSI R&T plans to survey survivors potentially through the inclusion of a separate module. If this proves not possible, no separate survivor data collection will take place through this evaluation.

The study design comprises cross-sectional data collection activities to evaluate the research questions, allowing conclusions on overall program efficiency, effectiveness and achievement. Data collection activities, described below, center around health facilities, except for the key informant interviews and implementing partner monitoring data.

Health Facility Ebola Survivor Services Assessment

Survey and observation will focus on health facilities, with specific focus on Ebola survivor services:

- Infrastructure rehabilitation/renovation
- Availability and organization of survivor-specific services, equipment, medication, and commodities.
- Expected numbers: Sierra Leone (37), Liberia (30), Guinea (17)

Health Provider Survey

Quantitative surveys will measure:

- Health provider knowledge, skills and attitudes, particularly those towards survivors and reduction of stigma
- Availability of EVD survivor medical equipment, medicine, and commodities
- Development and availability of survivor-specific protocols, including referral procedures

- Facility-based and centralized levels of human resources for health (HRH) service provision.
- Familiarity with specific partner training programs, focusing on the skill level of providers regarding Ebola survivors, determining if they attended any GHET funded provider trainings.
- Access to care and utilization
- Expected numbers: Sierra Leone (44), Liberia (51), Guinea (33)

Key Informant Interviews

Key regional and central level informants (and district level informants as appropriate) based on country-specific programming will be interviewed to discuss:

- Capacity building with central level officials and district health management teams
- Programmatic decision-making, including any stakeholder engagement
- Logistics and supply chain management
- Development of new survivor-specific protocols
- Governance support
- Survivor network integration
- Survivor network management
- Expected numbers: Sierra Leone (20), Liberia (20), Guinea (20)

Key informant interviews will include but not be limited to the Evaluation Stakeholders List & KII Pool (Appendix C).

Survivor Survey

As previously mentioned in this document, this evaluation design does not include a separate survivor survey component, but intends only to coordinate with JSI R&T on an upcoming endline survivor survey. Specifically, this will entail working with JSI R&T HQ and respective JSI R&T field offices in Sierra Leone, Liberia, and Guinea to coordinate through input into design and questions of JSI R&T's endline survey instruments- proposing inclusion of an additional module (exploring lines of inquiry on survivor perceptions of availability of survivor-specific services, perceptions of survivor-specific policies and networks, etc), light complementary training of JSI R&T enumerators on the additional module as appropriate, and data quality/process checks on 5-10% of survivors surveyed. Data quality/process checks will consist of being present for surveys being conducted by JSI R&T enumerators and cross-checking processes and data entry. Pending further engagement with JSI R&T, additional details will be provided. JSI R&T is not a primary source of data, but the evaluation team seeks to leverage JSI R&T's endline survey with survivors to limit external surveying and taxing of survivors. Additionally, survivors are better interviewed by people who have already established trust and a history of engagement.

Per guidance from GHET, the operating assumption is that JSI R&T /APC will survey 700-800 survivors in each of the three countries. This would represent roughly half of the total number of registered survivors in Sierra Leone and Guinea.

Implementing Partner Monitoring Data

As part of this evaluation, a review of implementing partner monitoring data against implementing partner workplans will be conducted.

Facility Sampling Strategy, logistics and data collection plan

Health facilities will be used as the entry point for:

- Health facility assessments
- Health [paid] provider surveys

Health Facilities and Health Providers

A sample of up to 100 primary, secondary, or tertiary health facilities providing survivor health services in geographic regions that have a high prevalence of Ebola survivors that have received JSI R&T survivor-specific interventions, will be selected across the three countries. The sample frame is compiled from information supplied by implementing partners and from DHIS2¹¹. When necessary, facilities will be stratified by geography and type (e.g. country/district or prefecture; secondary/tertiary health facility). Only health facilities and associated providers in USAID-funded regions that received GHET funded interventions will be included in the sample. It is also expected there will be efficiencies to be captured between this sample and a broader data verification exercise proposed to GHET under separate forthcoming cover.

An enumerator will be deployed to selected health facilities, where he/she will conduct a 2-3-hour health facility assessment to observe and note the presence of survivor-specific programs and interventions. After completing the health facility assessment, the enumerator will interview the selected provider at that facility.

When a health facility is chosen for assessment, the senior health provider associated with that facility will be invited for interview. If they are not available, then the next most senior health provider will be invited. They must be a physician, nurse in charge or practitioner providing essential survivor services and paid to work at the selected health facility. For larger health facilities, 2-3 staff ranging from senior to lower level health providers (e.g. nurses) will be interviewed.

Health Provider interviews will be planned for the same day of the health facility assessment. Instructions will be provided to the health facility so that chosen staff can be available at the health facility on the day of assessment. This will minimize logistical constraints and costs.

Data will be collected using SurveyCTO on electronic devices. This facilitates real-time validity and completeness checks of data, as well as monitoring and analysis of descriptive statistics during the

¹¹ <https://data.humdata.org/dataset/health-facilities-in-guinea-liberia-mali-and-sierra-leone>

period of data collection. Responses in local languages and / or French (Guinea) will be translated into English for analysis.

Facility-based Sampling Strategy

Sierra Leone

In Sierra Leone, the Advancing Partners & Communities (APC) Ebola Transmission Prevention & Survivor Services program (ETP&SS) supports the implementation of the President's Recovery Priorities for Health, Key Result Area #3: the Comprehensive Program for Ebola Survivors. The Comprehensive Program for Ebola Survivors (CPES) is jointly led by the Ministry of Health and Sanitation and the Ministry of Social Welfare, Gender and Children's Affairs.

Through its support, the ETP&SS program seeks to prevent further Ebola virus disease transmission and reduce the risk of resurgence from viral persistence in survivors. The program strives to improve access to quality health services for survivors by (1) strengthening the capacities of the health system to provide specialized services needed by survivors, particularly through training and mentorship on mental health and neurology; and defining clear referral pathways. To reduce stigma and other barriers that keep survivors from accessing healthcare and social services, the program is (2) building the capacity of the Sierra Leone Association for Ebola Survivors and the CPES Program Implementation Unit to lead program implementation and monitoring. Through this program, Advancing Partners & Communities also (3) provides technical assistance to the Ministry of Health and Sanitation and the Ministry of Social Welfare, Gender, and Children's Affairs on clinical and non-clinical related matters.

We propose to focus data collection in the five districts that have the highest number of ebola survivors, Bombali, Port Loko, Tonkolili, Western Rural, and Western Urban. JSI R&T's CPES program conducted work in 66 of facilities in this district. We propose to assess 37 facilities, around 56% of facilities that received CPES interventions in these districts, and around 25% of all CPES facilities in Sierra Leone. These facilities will be randomly selected, stratified by district, facility type, and intensity of treatment. Facilities that received more survivor specific programming will be sampled more heavily.

<i>Health Facilities by district</i>	Bombali	Port Loko	Tonkolili	Western Area Rural	Western Area Urban	Total by Type	Proposed sample
MCHP (primary)	8	8	3	0	0	19	10
CHP (primary)	2	3	0	1	0	6	3
CHC (primary)	6	4	4	9	11	34	17

District Hospital (secondary)	0	1	1	0	0	2	2
Hospital (tertiary)	0	0	0	0	5	5	5
Total	16	16	8	10	16	66	
Proposed sample	8	17	4	5	11		37

Source: JSI R&T Sierra Leone

Liberia

In Liberia, APC's ETP&SS operates in four priority counties – Bong, Lofa, Margibi, and Montserrado. These counties account for over 90 percent of the population of registered Ebola survivors. Program activities in these focus counties include: (1) monthly coordination with the county-level chapters of the National Ebola Survivors Network of Liberia; (2) training on Ebola virus disease Survivor Clinical Care Guidelines led by ETP&SS; (3) clinical rotations and training provided by the Liberia College of Physicians and Surgeons' Clinical Specialist Consultant Program; (4) renovations for selected hospitals and clinical services; (5) distribution of equipment prioritized during the November 2016 facility infrastructure assessment; and, (6) a one-time distribution of essential medicines for use by survivors in target health facilities.¹²

JSI R&T's APC ETP&SS facility-based work involved 30 health facilities in the four priority counties (Bong, Lofa, Margibi, and Montserrado). The majority of this work was concentrated in eight secondary and tertiary facilities (six hospitals and two health centers), where JSI R&T provided training of health practitioners, provision of equipment, and infrastructure support. Work at the remaining 22 facilities (two hospitals, nine health centers, and nine clinics) was primarily limited to provider training. We propose to assess all 30 facilities that received survivor-specific JSI R&T interventions.

The table below breaks down health facilities by district and facility type:

<i>Health Facilities by District¹³</i>	Bong	Lofa	Margibi	Montserrado	Total by type	<i>Proposed sample</i>
Primary Facilities	4	2	1	2	9	9
Secondary Facilities	0	2	2	7	11	11
Tertiary Facilities	1	3	1	5	10	10
Total by district	5	7	4	14	30	30

¹² The program carries out supplementary activities in the seven non-focus EVD-affected counties, specifically EVD survivor mapping and clinical guidelines training; these counties include Bomi, Gbarpolu, Grand Bassa, Grand Cape Mount, Nimba, Rivercess, and Sinoe. The training activities are carried out in collaboration with the Ministry of Health and the World Health Organization (WHO).

¹³ A note on health facility classifications in Liberia: Primary facility = PHC Clinic Level 1&2; Secondary facility = Health Centers, District Hospitals, County Hospitals; Tertiary facility = Regional Hospitals, National Hospital

Proposed sample					30	
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Data Source: JSI R&T Liberia)

Guinea

In Guinea, APC's ETP&SS program focuses core activities on three priority regions—Conakry, Kindia, and Nzérékoré—with national coverage for selected activities. These three regions account for more than 80% of registered Ebola survivors.

The project assistance consists of: (1) support for supervision and coordination; (2) support for longitudinal care in selected high-volume health facilities in the three regions, including renovation and provision of small medical equipment and supplies; (3) support to community-based surveillance of Ebola survivors; (4) support to the national Ebola Survivors Association and stigma-reduction activities, including sensitization campaigns; and, (5) support for biological monitoring of viral persistence in semen.

Specifically, JSI R&T's APC ETP&SS facility-based work involved 14 health facilities in three priority prefectures and regions. The majority of this work is concentrated in eight high-volume facilities (two facilities in the region of Kindia, four in Conakry, including one tertiary care facility, and two facilities in the region of Nzérékoré), where JSI R&T is providing infrastructure support and provision of equipment. Work at the remaining six facilities is primarily limited to equipment support and training. We propose to assess all 14 facilities that received survivor specific JSI R&T interventions.

Beyond major health facility-based interventions, JSI R&T's work in Guinea also includes support for the design and implementation of a more sustainable "sentinel site" surveillance system to streamline community-based surveillance. The sentinel sites are currently undergoing a planned reduction from 700 sites at the height of the Ebola outbreak to a more sustainable 50 sites across the country. Given the transition underway, we propose assessing the sentinel site coordination units in each of the priority region and prefectures.

The table below gives a proposed sample size for each prefecture/region and facility type.

Health Facilities by Region¹⁴	N'Zérékoré Region	Conakry Region	Kindia Region	Total by type	Proposed sample
Sentinel Site Coordination Units	1	1	1	3	3
Primary Facilities	1	0	0	1	1
Secondary Facilities	3	3	4	10	10
Tertiary Facilities	2	1	0	3	3
Total by Prefecture/Region	6	4	4	17	17
Proposed sample				17	

(Data Source: JSI R&T HQ/Guinea)

Key Informants

In each country, up to 20 key informant interviews will be conducted with interviewees nominated from the Stakeholder & KII Pool List in Appendix C. Interviews will be conducted using an open-ended question guide, by a lead field researcher familiar with the GHET survivor activities that have been undertaken in that country.

Unless deemed culturally unacceptable, the interview will be audio recorded to facilitate note taking, coding and subsequent analysis. Sufficient time is built into the data collection plan so that the notes can be consolidated following each interview. French or local language discussions (Guinea) will be translated into English for analysis.

¹⁴ A note on health facility classifications in Guinea: Primary facility = Health Posts (PS); Secondary facility = Health Centers (CS), CMC (Urban); Tertiary facility = Hospitals, Regional Hospitals; National Hospitals.

Analysis Plan

Analysis of outcomes:

Because this final evaluation is primarily a post-test, only measurement of sites with varying degrees of program exposure, there likely are systematic differences between the groups in observable and unobservable confounding factors. A rigorous impact evaluation with statistical power is not possible in this scenario. Thus, the analysis of outcomes generally will follow a contribution analysis approach, whereby the occurrence of various quantitative results (e.g., ‘outcomes’ measured via health facility assessments, and provider surveys) will be documented and will be considered in tandem with programmatic and qualitative information about the delivery of the GHET portfolio and the process by which change may have occurred. While the resulting report will not offer definitive proof of ‘impact’, it will provide evidence from which we can draw a plausible conclusion that the GHET investment has made an important contribution to the documented results.

For analysis of the quantitative data, the research team will use SPSS or Stata statistical software to calculate descriptive statistic and conduct bivariate analyses of subgroup differences. For analyses of qualitative data, the research team will use Nvivo transcript-coding software to organize and synthesize the key themes that emerge. While this will include outcomes and results, as mentioned above, analyses of qualitative data also will focus on insights that might explain the quantitative findings. An a priori coding framework will be constructed using the research lines of inquiry and the results of the quantitative analyses, and the framework will be expanded as new themes emerge in the qualitative data using a constant comparative method to inductively develop a theory around the variables, their linkages to one another, and their contribution to the results.

Analysis of process:

The analysis of process will provide descriptive information on how the GHET Pillar II Ebola survivor-specific portfolio was implemented, the operational context, and barriers and facilitators to implementation uptake. It will rely heavily on program and policy documents, secondary data, and key informant interviews at central levels. The BalanceD-MERL team will gather as much documentation as possible on program implementation from policy documents, project work plans, quarterly reports, and secondary data records, and will complement these data with semi-structured key informant interviews in each of the three countries. As with the qualitative data collected for the outcome evaluation, the research team will use Nvivo software to analyze the key informant interviews data and will triangulate across respondents and source material to answer the relevant evaluation questions.

Products

The end-line evaluation report will be prepared following the period of data collection and analysis and will discuss in detail the study design, methodologies used, findings, conclusions and recommendations. The report will be co-written by members of the evaluation team and be submitted in draft to USAID GHET. Time will be allocated for two rounds of review and edits with USAID GHET,

at which point the report will be finalised and submitted to USAID GHET, marking the completion of this exercise.

A plan for sharing the evaluation findings with implementing partners and Government bodies will be finalised in conjunction with USAID GHET.

Administrative considerations

The following list is provided as important administrative considerations which are on the critical path of the study and may affect the currently proposed timeline:

1. Instrument development (including incorporation of cultural norms)
2. Translation and testing of instruments
3. IRB requirements and clearances
4. Collaboration with JSI R&T on survivor survey
5. The data-collection logistics plan (including travel and accommodation for enumerators)
6. Data access, privacy, and documentation (public use data-files, de-identifying (outlier removal)), and codebooks
7. Reporting/dissemination plan - expectations for USAID review/feedback/report finalization, in-person GHET presentation, webinar for field participation

Team members

Arthur Baker (Senior Research Associate - IPA Sierra Leone)

Arja Dayal (Research Manager - IPA Liberia)

Osman Siddiqi (Country Director - IPA Sierra Leone)

Samuel Lee (Lead Researcher - I4DI)

Al Housainne Bah (Lead Field Researcher - I4DI Guinea)

Azra Nurkic (Qualitative research expert - I4DI)

Linda Gassama (Field Manager - IPA Sierra Leone)

Team advisors

World Vision United States - Bridget Lavin

I4DI - Manny Sanchez

USAID GHET - Jeffrey Muschell

USAID GHET - Andy Rebold

Jessie Pinchoff – Population Council (previously IPA)

Budgets

The detailed budgets and budget narratives for this evaluation are presented under a separate cover. Please contact USAID GHET for detail.

GANTT chart

The following high-level Gantt chart details major activities. Timing is contingent upon approval of this plan, subsequent development and testing of instruments, country IRB processes, collaboration with JSI R&T on survivor surveys, and elections in Sierra Leone.

Key activities	2017		2018								
	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep
Study design / protocol											
Instrument development											
Develop tools											
Policy Review											
JSI R&T Survivor Survey Collaboration											
IRB submission and clearance											
Finalize research protocol											

Pilot/test instruments in-country											
Logistics planning											
Recruit enumerators											
Training of enumerators											
Data collection				SL	G/L	G/L					
Data cleaning											
Analysis											
Report writing											
Report dissemination / review & finalization											
Project Close											

Appendix A - Evaluation Question Lines of Inquiry

Availability and Use of Quality Services

1. To what extent are quality health services focused on Ebola survivors available at different types of health facilities? Specific health services established for survivors? Regular health services? Referral to specific survivor services at higher level facilities? (Outcome)

- Where are the survivors?
- Where are the services (EVD specific and general) available?
- What are the standard packages of survivor services at different levels?
- How does the referral system for survivors work?

2. Capacity/Equipment Question: To what extent are survivor health services (other than primary healthcare services) and resources adequate and sufficient to meet the health needs of Ebola survivors? (Output)

- What is the availability of survivor specific equipment, medicine, and commodities?
- What structures or networks have been put in place to ensure adequate services are available for Ebola survivors?
- To what extent is the program producing outputs on time and meeting targets for outputs?
- To what extent have IP project plans related to clinical services for survivors been implemented as planned?
- What have been the barriers to appropriate service delivery? How were they overcome?
- What adaptations, if any, have been made? What accounts for the variation?
- How did the IPs identify which services would be necessary and where to locate them?
- To what extent have the key stakeholders been engaged to inform programmatic decisions (who was engaged, how, and what was their role)?
- What proportion of survivors report that adequate services are available to them?

3. Survivors question: To what extent are Ebola survivors educated on services and accessing them? To what extent are Ebola survivors utilizing services available to them? (Outcome)

- What proportion of survivors report receiving education on services?
- What proportion of survivors accessed services when needed?
- What are the utilization patterns for survivor services?
- What proportion of survivors report improvement to access to appropriate health services as a result of the program?

Stigma

4. To what extent do survivors experience stigma from health providers, and do survivors report that this stigma has decreased since the beginning of the program? (Outcome)

- What are the main reasons leading to stigma from health providers?
- To what extent have SBCC and other campaigns reduced stigma reported by survivors from health providers and members of their community?

5. Management of health workers and communities: To what extent are health professionals and community health volunteers (volunteers in Liberia only) trained to minimize the effects of stigma in the community? (Output)

- What are the stigma reduction approaches implemented by IPs?
- How did the IPs identify these approaches and where to locate them?

Policy/Systems

6. To what extent have policies, structures or networks (eg survivor networks) improved the services available for Ebola survivors? (Outcome)

- To what degree have national policies been implemented to enable/facilitate improvements in services available to survivors?
- What is the degree of awareness of and confidence levels in the work of the National Government Survivors Body and Ebola Survivors Networks?
- Based on the experiences of this program, what do managers and policy decision-makers at different levels (national, regional, local, USAID-based) consider as the best approaches for behavior change - what worked and what did not?

7. What policies, structures or networks have been strengthened to ensure adequate services are available for Ebola survivors. (Output)

- What are the relevant policies, structures, and official survivor networks by country?
- How are the networks affiliated, supported by their respective MOH or equivalent?
- What is the level of organizational development of these Survivor Networks?

Appendix B - Summary of data collection instruments and purpose

Data Collection Instrument	Duration per collection activity	Who will be interviewed?	Purpose
Health Facility Assessment	2 - 3 hours	Nurse in charge at selected HF; observation of facility.	To visually inspect the HF for infrastructure improvements, provision of essential health services, availability of commodities, and presence of trained personnel
Provider Survey	1-1.5 hours	Sample of paid, trained providers based at selected HF (including community volunteers in Liberia)	To assess provider knowledge re: Ebola stigma and assess participation in GHET-funded provider training programming.
Key Informant Interviews	1 hour	Individuals selected with certain knowledge or experience in the health system	To assess the efficiency, efficacy and sustainability of GHET-funded survivor specific programming, management of activities, systemic challenges/opportunities, other process evaluation areas.
JSI R&T Survivor Survey Collaboration (TBD)		Survivors identified and surveyed by JSI R&T, likely through individual country survivor networks	To assess survivor perceptions of survivor services and the reach and effectiveness of survivor specific programming and activities

Appendix C - Stakeholder Groups & KII Pool

The following list are the groups (and individuals) who have a *major* interest in the evaluation, or will be substantially affected by it:

1. USAID Global Health Bureau
2. USAID Africa Bureau
3. USAID Liberia Mission
4. USAID Guinea & Sierra Leone Mission
5. FHI360 - Mobile Solutions Technical Assistance and Research (mSTAR)
6. International Organization for Migration (IOM) - International Organization for Migration (IOM)
7. John Snow, Inc. (JSI) - Advancing Partners and Communities Project (APC)
8. John Snow, Inc. (JSI) - Deliver Project (Deliver II) Task Order 7
9. John Snow, Inc. (JSI) - Supply Chain Management System (SCMS)
10. IBTCI
11. Johns Hopkins University-Center for Communications Programs (JHU-CCP) - Health Communication Capacity Collaborative (HC3)
12. Management Sciences for Health (MSH) - Systems for Improved Access to Pharmaceuticals and Services (SIAPS)
13. National Academy of Sciences (NAS) - Partnerships for Enhanced Engagement in Research (PEER) (Liberia)
14. University of North Carolina (UNC) - Monitoring and Evaluation to Assess and Use Results (MEASURE) Evaluation Phase IV
15. Government of Liberia
 - a. Ministry of Health
 - i. M&E Team
 - ii. County Health Teams
 - iii. District Health Teams
16. Government of Guinea
 - a. Ministry of Health and Public Hygiene
 - i. National Agency for Health Security (NAHS)
 - ii. District Health Teams
17. Government of Sierra Leone
 - a. Ministry of Health and Sanitation
 - i. CPES Program Implementation Unit (PIU)
 - ii. District Health Teams
 - b. Ministry of Social Welfare, Gender and Children's Affairs (MSWGCA)
 - i. District Teams
18. Survivors Associations
 - a. Sierra Leone Association of Ebola Survivors (SLAES)
 - b. National Ebola Survivors Network of Liberia (NESNL)
 - i. County Chapters
 - c. Ebola Survivors Association (RENASEG) (Guinea)
19. APC Sub-grantees in Guinea

- a. International Medical Corps (IMC)
 - i. Sentinel Site Coordination Units
- 20. APC Sub-grantees in Liberia
 - a. ELWA Hospital
 - b. Saint Joseph's Catholic Hospital
 - c. The Liberia College of Physicians and Surgeons
 - d. Phebe School of Nursing Rural Training Institute
- 21. APC Sub-grantees in Sierra Leone
 - a. Kings Partnership Sierra Leone
 - b. Partners in Health
 - c. Save the Children
 - d. GOAL
- 22. Post Ebogui¹⁵ (Guinea)
- 23. National Laboratory of Hemorrhagic Fever (Guinea)
- 24. Liberia College of Physicians and Surgeons' Clinical Specialist Consultant Program

¹⁵ Post Ebogui, a research project supported by the French government, has been conducting a longitudinal study in Guinea since the end of the Ebola outbreak to monitor and provide free clinical care to 801 survivors in Guinea (approximately two-thirds of survivors). Post Ebogui works in special care units (within the health facilities) in the regions of Nzérékoré and Kindia, and run their own private health care facility in the Conakry Region. The services provided by Post Ebogui are not following the official Guinean health system. Post Ebogui is scheduled to end in December 2018. Post Ebogui research areas overlap with the three priority regions and the survivors group supported by the ETP&SS program; therefore, it is expected that this will have an impact on the number of visits by Ebola survivors recorded by the program-supported health facilities.

Annex G: Research Team Biographies & Roles

Dr. Bridget C. Lavin has a PhD in health systems management and more than 15 years of experience evaluating public health and development programs. In addition to her role as Project Director of the BalancedD-MERL consortium, Dr. Lavin served as co-lead investigator for the endline performance evaluation of the GHET EVD survivor program. In this capacity, she contributed to the evaluation and instrument design, analyzed quantitative data, and authored portions of the final report.

Samuel S. Lee has a Master's in Public Policy and over 15 years of experience in international development, social impact investing, innovation, and program evaluation. Sam is the co-lead investigator for the endline performance evaluation of the GHET EVD survivor program. In this capacity, he contributed to evaluation and instrument design, managed field data collection and engagement, training of enumerators, completed data analysis integrating quantitative and qualitative data, and authored the final report.

Dr. Azra Kacapor Nurkic is a social development expert with over 20 years of experience and expertise in strategic program design, program effectiveness and staff capacity development in a range of operational and regional contexts. Dr. Nurkic advised on and contributed to study design and led all qualitative work including instrument design and analysis.

Jose "Pepe" Santos has a Master's in Global Affairs & Management with relevant experience in multinational business operations, strategic development, and research. As part of the consortium, Pepe conducted qualitative analysis on key informant interview data.

Arthur Baker has a Bachelors in Econ Politics and a Graduate Certificate in Economics. Arthur managed BalancedD-MERL activities in Sierra Leone including quantitative surveys and survivor survey monitoring. He was involved in the development of quantitative survey instruments, training of field staff, securing local ethics review board approval, coordinating between various organizations, quantitative data analysis and co-authoring the reliability assessment (Annex D).

Sibongani Kayola has an M.S postgraduate degree in Evidence-based social intervention and policy evaluation. Sibongani managed BalancedD-MERL activities in Liberia including quantitative surveys and survivor survey monitoring. She was involved in the development on the quantitative survey instruments, training of field staff, securing local ethics review board approval, coordinating between various organizations, quantitative data analysis and co-authoring the reliability assessment (Annex D).

Leslie Alex has a Bachelors in Industrial Engineering and micromasters credential in Data, Economics and Public policy. Leslie worked on designing, coding, and testing quantitative instruments, monitoring data collection and quality in Sierra Leone, development of evaluation framework for reliability assessment monitoring piece and co-authoring the reliability assessment (Annex D).

Arja Dayal has a Masters in Public Administration in Development Practice and has multi-sectoral knowledge, working on projects encompassing education, health, nutrition and WASH, both at grassroots as well as policy level. Arja managed all IPA activities in the BalancedD-MERL project across

Sierra Leone and Liberia. She oversaw project development efforts, stakeholder management and project finance management. Arja also co-authored the reliability assessment (Annex D) in the report.

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