UN EBOLA RESPONSE MPTF
FINAL PROGRAMME[1] NARRATIVE REPORT
DATE: 18.3.2016

Project Number(s) and Title(s)	Recipient Organization(s)
Project Number: 00093218 **Title:** Accelerating Progress Towards Interruption of Ebola Response – Project #10	**RUNO(s):** WHO, UNDP, UNFPA **Project Focal Point:** Dr. Alex Gasasira (WHO) Sekou Toure, Mamba Point, Monrovia Telephone: +231 77528 1157; gasasiraa@who.int Dr. Remi Sogunro (UNFPA) Sekou Toure, Mamba Point, Monrovia +231 77000 40001; sogunro@unfpa.org Cleophas Torori (UNDP) Sekou Toure, Mamba Point, Monrovia +231 77000 4000; cleophas.torori@undp.org
Strategic Objective & Mission Critical Action(s)	**Implementing Partner(s)**
SO1: STOP the Outbreak **MCA01:** Identify and trace people with Ebola	Ministry of Health (MoH), 6 County Health Teams, Incident Management System (IMS), Montserrado IMS, Africare, MERCI and Action Aid, Community Youth Groups (CSOs)
Location:	**Sub-National Coverage Area:**
Liberia	Initial Phase - All 15 Counties ; Extension Phase – 7 Counties - Bomi, Bong, Gbarpolu, Grand Cape Mount, Lofa, Montserrado, and Nimba Counties
Programme/Project Cost (US$)	**Programme Duration**
Total approved budget as per project proposal document: MPTF[2]: WHO-$3,655,050 UNFPA-$4,549,552 UNDP-$3,398,610 **TOTAL: $11,603,212**	Overall Duration: *13 months* Project Start Date[3]: 19.12.2014 Originally Projected End Date[4] *30.5.2014* Actual End date[5]*31.12.15* Agency(ies) have operationally closed the programme in its(their) system Yes ☐ No ■ Expected Financial Closure date[6]: 30.6.2016

[1] Refers to programmes, joint programmes and projects.
[2] The amount transferred to the Participating UN Organizations – see MPTF Office GATEWAY
[3] The date of the first transfer of funds from the MPTF Office as Administrative Agent. The transfer date is available on the online MPTF Office GATEWAY.
[4] As per approval of the original project document by the Advisory Committee.
[5] If there has been an extension, then the revised, approved end date should be reflected here. If there has been no extension approved, then the current end date is the same as the originally projected end date. The end date is the same as the operational closure date, which is the date when all activities for which a Participating Organization is responsible under an approved project have been completed. As per the MOU, agencies are to notify the MPTF Office when a programme completes its operational activities. Please see MPTF Office Closure Guidelines.
[6] Financial Closure requires the return of unspent funds and the submission of the Certified Final Financial Statement and Report.

Programme Assessment/Review/Mid-Term Eval.
Evaluation Completed ☐ Yes ■ No Date: *dd.mm.yyyy* Evaluation Report - Attached ☐ Yes ■ No Date: *dd.mm.yyyy*

Report Submitted By
○ Name: Kathryn Weber ○ Title: Donor Reporting Officer ○ Date of Submission: 18.3.2016 ○ Participating Organization (Lead): WHO ○ Email address: weberk@who.int *Signature:*

PROJECT/PROPOSALRESULT MATRIX (Phase 1- December 2014 – May 2015)

Project Proposal Title:						
Strategic Objective to which the project contributed	**To accelerate progress towards interruption of transmission of Ebola virus in Liberia through enhancing capacity for early detection of EVD cases for isolation and treatment in the 15 counties in Liberia.**					
MCA [1] [7]	**Identifying and tracing of people with Ebola**					
Output Indicators	**Geographical Area**	**Target**[8]	**Budget**		**Means of verification**	**Responsable Organization(s).**
Proportion of counties with at least 90% of districts submitting weekly active surveillance reports	*All 15 counties in Liberia*	100%	USD 3,250,000		County Surveillance Reports	UNDP, UNFPA, WHO
At least 95% of all project staff are recruited, trained and deployed	*All 15 counties in Liberia*	100%	USD 2,850,500		MoH Reports CHT Reports	UNDP, UNFPA, WHO
MCA [1]						
Effect Indicators	**Geographical Area (where the project directly operated)**	**Baseline**[9] In the exact area of operation	**Target**	**Final Achievements**	**Means of verification**	**Responsable Organization(s)**
Proportion of counties with 100% districts implementing active surveillance and effective contact tracing	*All 15 counties in Liberia*	20%	100%	100%	Independent monitoring MoH Reports CHT Reports	UNDP, UNFPA, WHO

[7] Project can choose to contribute to all MCA or only the one relevant to its purpose.
[8] Assuming a ZERO Baseline
[9] If data is not available, please explain how it will be collected.

PROJECT/PROPOSALRESULT MATRIX (Phase 2 – July - December 2015)

	Proposal Title: Accelerating progress towards interruption of Ebola virus transmission in Liberia				
Strategic Objective to which the Proposal is contributing[10]	**Identifying and tracing of people with Ebola**				
Effect Indicators	**Geographical Area (where proposal will directly operate)**	**Target**	**Cumulative Results**	**Means of verification**	**Responsible Org.**
Number of New EVD cases resulting from unknown transmission chain	*Montserado, Bomi, Bong, Gbarpolu, Grand Cape Mount, Lofa and Nimba*	0	2	MOH situation reports	UNFPA, UNDP, and WHO
National strategy and operational plan developed by GOL to integrate EVD surveillance as part of comprehensive IDSP	*National*	1	1	MoH	WHO
Output Indicators	**Geographical Area**	**Target[11]**		**Means of verification**	**Responsible Org.**
% of contacts that have been followed up daily	*Montserado, Bomi, Bong, Gbarpolu, Grand Cape Mount, Lofa and Nimba*	100%	100%	MOH reports Monitoring visits	UNFPA, WHO, UNDP
Number of active case finders/contact tracers incentivized on time	*Montserado, Bomi, Bong, Gbarpolu, Grand Cape Mount, Lofa and Nimba*	656 (UNFPA) 2,146 (WHO)	2,802	Payments submitted to MoH	UNFPA, UNDP, WHO
% of community deaths that have been swabbed	*Montserado, Bomi, Bong, Gbarpolu, Grand Cape Mount, Lofa and Nimba*	100%	100%	Lab, and MOH reports	WHO, UNDP
Proportion of communities per county with enhanced active surveillance mechanisms	*Extension phase - 7 counties (WHO-Montserrado, UNFPA-Bomi, Bong, Gbarpolu, Grand Cape Mount, Lofa and Nimba)*	100%	100%	MOH and monitoring visit reports	UNFPA, WHO

[10] Proposal can only contribute to one Strategic Objective
[11] Assuming a ZERO Baseline

FINAL PROGRAMME REPORT FORMAT

EXECUTIVE SUMMARY

The Ebola Virus Disease (EVD) outbreak in West Africa has had a devastating impact on Liberia, accounting for a total of 10,673 confirmed cases of EVD and 4,809 deaths nationally. Ebola entered Liberia in March 2014. By October 2014, about 50% of the cases and deaths in the region were ascribed to Liberia, and the highly urbanized and populated Monrovia had become the epicenter. Within a short time period, the geographic coverage of the epidemic expanded to all the 15 counties in the country. It became apparent that the nature of the Ebola outbreak required an increased multi-disciplinary approach to provide an integrated response.

The UN Ebola Response Project was initiated in December 2014 with funding from the UN Global Ebola Response Multi Partner Trust Fund (MPTF) through a collaborative effort between WHO, UNFPA and UNDP. The project aimed to enhance the capacity of all 15 counties in Liberia to detect every single chain of EVD transmission in a timely manner through high quality active surveillance and contact tracing activities.

The project has supported the recruitment, training and deployment of over 10,090 Contract Tracers/Active Case Finders (ACFs) who have been instrumental in bringing Ebola cases down to the zero in Liberia. They led the search for the sick and the dead, ensured they were taken out of the communities or quarantined in order to break the chain of infection. Project activities have provided critical support, leading to the break in transmission of EVD in Liberia and WHO subsequently declaring the country Ebola-free on 9th May 2015 and 3rd September 2015.

Background and Situational Evolution

The Ebola Virus Disease (EVD) outbreak in West Africa has had a devastating impact on Liberia, accounting for a total of 10,673 confirmed cases of EVD and 4,809 deaths nationally. Ebola entered Liberia in March 2014. By October 2015, about 50% of the cases and deaths in the region were ascribed to Liberia, and the highly urbanized and populated Monrovia had become the epicenter. Within a short time period, the geographic coverage of the epidemic expanded to all the 15 counties in the country. It became apparent that the nature of the Ebola outbreak required an increased multi-disciplinary approach to provide an integrated response.

The UN Ebola Response Project was initiated in December 2014 with funding from the UN Global Ebola Response Multi Partner Trust Fund (MPTF) through a collaborative effort between WHO, UNFPA and UNDP with WHO as the lead partner. The project aimed to enhance the capacity of all 15 counties in Liberia to detect every single chain of EVD transmission in a timely manner through high quality active surveillance and contact tracing activities. The timely detection of each chain of transmission aimed to allow for timely initiation of activities to interrupt the chains of transmission.

By November 2014, Liberia had registered more than 20,000 contacts from over 6,000 reported EVD cases. Liberia had a total of 3,865 contact tracers/active surveillance personnel, yet the estimated national need was approximately 14,000. Quality and capacity of contact tracing/ active surveillance was sub-optimal, not only due to inadequate numbers of contact tracers, but also the lack of incentives causing a lack of motivation and insufficient support. Due to the gaps in contact tracing, several undetected chains of EVD transmission in many counties remained. In response, the key priority of the initial phase of the project was to close the gaps in contact tracing and active surveillance to enable timely detection of every

single chain of EVD transmission in the country. By ensuring timely detection of all remaining chains of transmission, the Liberian national authorities, with support of international technical partners, could focus on achieving interruption of EVD with a minimum number of secondary infections.

During the initial project period from December 2014-May 2015, the implementing partners supported contract tracing and active surveillance activities in areas they were already supporting. UNDP supported Montserrado County, UNFPA supported 6 counties (Bomi, Bong, Gbarpolu, Grand Cape Mount, Lofa and Nimba) and WHO supported the remaining 8 counties (Grand Bassa, Grand Gedeh, Grand Kru, Margibi, Maryland, Rivercess, River Gee and Sinoe). The project supported a total of 10,090 Contact Tracers/Active Case Finders nationwide until July 2015.

New contact tracers receive kits for surveillance

MPTF funding for the Liberia Ebola response was originally supposed to end on 30th May 2015. However due to the presence of EVD in the sub-region, and a new EVD outbreak in Margibi County in June 2015, MPTF granted a No Cost Extension to use remaining funds. The project was extended until December 2015 with the primary goal of early case detection and rapid identification of the sick and dead, and their visitors. As the EVD transmission receded, a roadmap was drawn to phase out the workforce. During the extension phase, the number of these trained workforce was reduced to 4171 in August 2015 and finally reduced by 50% to 2146 in December 2015.

In order to sustain the project interventions, WHO along with other Development Partners are supporting the GoL in streamlining the health care workforce under Liberia's "*Investment Plan for Building a Resilient Health System*". The revised policy will help to develop an incentivized community health workforce to improve community-based health care service deliveries. Liberia's National Health Services policy and the strategy identify the gCHVs as the key candidates for recruitment as Community Health Agents. The gCHVs will be on regular incentive and help to bridge gaps in delivery of essential package of health services to remote communities- those 5kms away from health care facilities. Additionally, the gCHVs will be engaged in community mobilization and health promotion from communities within 5km of radius from health care facilities. Experiences from the EVD response with the gCHVs and Active Case Finders; and with the gCHVs in immunization programs, demonstrate that they play a central role in accessing communities and improving delivery of health messages and essential services both in rural and urban areas.

The 2146 trained workforce supported under the project will be subsumed under the broader Integrated Disease Surveillance Response (IDSR) system and work as gCHV to track and respond to 15 priority diseases at the community level. Under IDSR roll-out, the MoH and partners facilitated community-level trainings for gCHVs on IDSR, including **Community Event Based Surveillance (CEBS)-,** covering all priority diseases and events. WHO is engaging with the MoH to promote curriculum development and training for Community Health Services and county and district level coordination of community health service activities

Key Achievements

In the 15 counties in Liberia, UNDP, UNFPA and WHO have been working to implement high quality active surveillance, case searching and contact tracing.

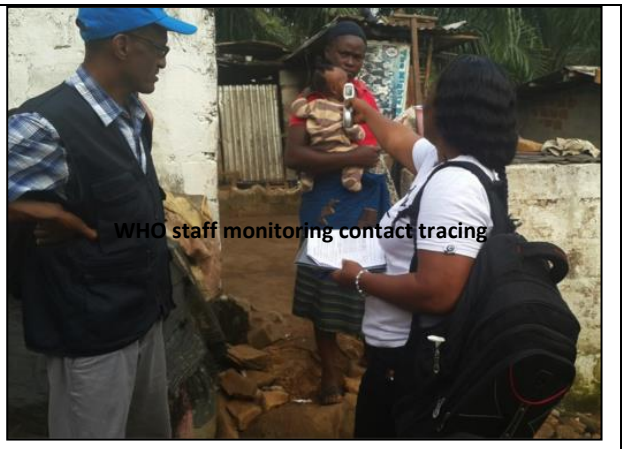
OUTPUT INDICATORS

Indicator[12]	Geographic Area	Projected Target (as per results matrix)	Cumulative Project Results (quantitative)	Delivery Rate (cumulative % of projected total)
Description of the quantifiable indicator as set out in the approved project proposal				
Proportion of Counties that have trained ACFs in all districts	All 15 counties	15	15	100%
Proportion of ACFs that have been trained using the recommended national Standard Operating System	All 15 counties	10,090	10,090	100%
Proportion of County surveillance offices that have data processing equipment	All 15 counties	15	15	100%
Proportion of County surveillance offices that have functioning internet connection	All 15 counties	15	15	100%
Proportion of district offices that submit surveillance reports on time including zero (0) reports.	91 Health Districts	91	91	100 %
Proportion of districts offices that have at least one supportive supervision visit from national or County level per week	91 Health Districts	91	91	60 – 70 %
Proportion of Counties that have weekly meetings to review active case finding during the preceding week and have written meeting reports with clearly identified action points	All 15 counties	15	15	100 %
Proportion of confirmed EVD cases that were on the contact list prior to becoming symptomatic	All 15 counties	100 %	All except 2	
EFFECT INDICATORS (if available for the reporting period)				
Identifying and tracing of people with Ebola: Proportion of Counties with 100% districts implementing active surveillance and effective contact tracing	All 15 counties	15	15	100%

- The break in transmission of the disease in Liberia and declaration of the country by WHO as Ebola-free on 9th May 2015 and 3rd September 2015 as well as the successful control of the November/December 2015 outbreak.
- Recruitment, training and deployment of over 10,090 Contract Tracers and 5,459 Active Case Finders (ACFs) who have been instrumental in bringing Ebola cases down to the zero in Liberia. They led the search for the sick and the dead, ensured they were taken out of the communities or quarantined in order to break the chain of infection.
- ACFs identified and addressed several factors that were contributing to the spread of the disease including:
    - Lack of feedback to families on the status, laboratory results, conditions and locations of ETU where family members were taken. This led to denial and refusal to bring out sick

[12] The Indicators should be disaggregated by gender, age and region as and where applicable

relatives.
    - Delayed response by the ambulances to reported cases that may have contributed to increase in cases and deaths.
    - Slow response in providing food to quarantined families.
    - Little or no education to communities on the possibility of Ebola transmission by EVD survival may have contributed to some of the cluster of cases.


WHO staff monitoring contact tracing

- Reduction in the number of cases from over 150 cases per day to '0' cases in Monrovia, and the entire country.
- Availability of a critical mass of experienced youth community volunteers (i.e. over 5,000 Active Case Finders) successfully recruited and trained under the project and remain a backup human resource for the country. Some are supporting other health programs.
- In spite of being declared Ebola-Free, the Liberian Government through the Incident Management System (IMS) continued to maintain high surveillance, while working towards strengthening the health delivery system in the country, to respond effectively to future epidemics. The ACFs continued their surveillance in the communities.
- Heightened public awareness and cooperation in the fight against the disease through the ACFs and other field personnel outreach work to over 1.5 million people in the country.
- The project helped to institute a culture of continuous surveillance in the communities even during long periods without any confirmed cases and after Liberia was declared EVD-free.
- Prevention of the potential spread of the disease widely in Montserrado and to other counties.
- The critical intervention of the Active Case Finders during the Caldwell, Popo Beach, and New Kru Town outbreaks, for instance, helped to zero down on the new cases, identify contacts, and stopped a new spread of the disease, in the course of the response.
- With the involvement of the communities in the search for the sick, dead, contact tracing and quarantines, the community-based approach also reduced the level of stigmatization and enhanced openness in reporting Ebola cases, and supporting those in need.
- Community engagement interventions for sustained surveillance that were started as part of the project's exit strategy had concluded with community inception meetings, community structure mapping and initiated community mobilization and support activities with structures to enhance community led disease surveillance in the counties

MPTF funding has also supported the MoH in building national and district level capacity for IDSR. Results included:

- The IDSR guidelines were redeveloped in a more practical and usable fashion and nearly 1,500 health care workers were trained in the signs and symptoms of the diseases and conditions and how to report and respond to them. This work was undertaken in partnership with the MOH Disease Prevention and Control (DPC) Department as well as US Center for Disease Control (CDC).
- Successful working groups were implemented and co-led by WHO with MOH for IDSR implementation at the community level.

- An electronic platform for reporting of priority diseases was designed, developed and rolled out in 4 pilot counties. This was led by WHO in collaboration with MOH. This will have a direct impact in the future in the speed of response to epidemic prone diseases, therefore, minimizing the spread and the number of individuals impacted.

Monitoring Visit to Malma Health facility in Bomi County by UNFPA Contact Tracing Field Associate

- Development of a toolkit to enable MOH and WHO field teams to work with counties to develop county specific epidemic preparedness and response plans. This work was undertaken jointly with MOH with in-county partner engagement.
- Development of an IDSR surveillance reporting tool to aid in analysis and reporting of priority epidemic prone diseases.

Delays or Deviations

With the increase and decrease in EVD cases and eventual declaration of Liberia as Ebola-free, the number of trained workforce was reduced to 4171 in August 2015 and finally reduced by 50% to 2146 in December 2015. Following the declaration of Liberia as "Ebola-free" by the WHO, the project field strategy was expanded to include reporting all dead bodies in the community to the County Health Team, and ensuring they are all swabbed. This saved the country from a potential 'explosion' of the disease, through the early detection of the Neidowein case through dead body swabbing, under the vigilance of the ACFs.

Best Practice and Summary Evaluation

In addition to initial community entry and engagement with relevant opinion leaders, the project's community-based approach employed a regular meeting as a strategy in engaging and sensitizing community members on the need to allow bodies of their dead relatives to be swabbed. Community leaders made a regular visit in their communities and encouraged members to report new visitors and strangers, for recording and monitoring. The approach also facilitated the identification of sick people in the community, and linking them to the nearest health facility. Cases identified were reported to the Zonal Surveillance Officers for coordination and support to the County Health Team, as part of the enhanced surveillance system, for early detection and management of any outbreak. This approach contributed immensely to the break in the transmission of the disease and the current Ebola-free status of the country.

This strong collaboration and support for county health teams has continued into 2016, even after official project closure, to promote sustainability of the health workforce. The implementing partners have continued engagement with MoH promoting curriculum development and training for Community Health Services and county level coordination of community health service activities. As part of the Community Health Services Working Group, training modules have been developed to roll-out training on essential skills for health teams. Drafts for guidelines to support county-level coordination of community health service activities, as well as operational guidelines for roll-out of community health services to improve coordination among different stakeholders, are currently under development. Activities such as these help to promote stakeholder coordination to ensure improvements in the health workforce continue to be registered, even as key projects are concluded and official donor support ends in the post-Ebola recovery period.

Lessons Learned

- **Need to strengthen Government Accountability, Transparency and Trust:** The initial reaction of disbelief and denial led to resistance to awareness-raising efforts. This was partly due to the absence of public confidence and trust for the government, on the suspicion that EVD was being used by the government to raise funds from the international community for political gains.

- **Need for Prompt Response to Epidemics:** Weak health systems and capacities, delay by the International community to Liberia's calls for assistance and initial lack of resources are some of key factors which contributed to the spread of the disease and its resultant casualties. The lack of resources to sensitize and mobilize communities, build enough ETUs and procure adequate number of ambulances, among others, hampered the separation of the sick and the dead from the communities and thus further spreading the disease. The impact from the improved government leadership and coordination, coupled with coherent international support and community involvement reflect that swift and focused response could have curtailed the spread of the disease and saved lives.

- **Need for Preparedness for Emergency Response:** Logistical and operational challenges encountered in the course of EVD crisis, such as inadequate number of vehicles, ambulances, protective gear for Health workers and response teams, laboratories and ETUs to host the sick, as well as poor community physical planning layout and inaccessibility, highlights the need to have in place a health system equipped to deal with such and future outbreaks. An effective and well-resourced national disaster emergency response plan and system will also contribute to preventing any outbreak to the scale witnessed.

- **Need for Community Engagement in Decision Making and Development Interventions:** The crisis demonstrated the crucial role that communities and civil societies can play in responding to an outbreak by engaging the communities and CSOs in taking decisions that affect them in all development interventions. This helps in building trust, commitment, and capacity for effective implementation and sustainability of projects.

Stories on the Ground

Development of Contact Tracer Database- A contact tracer database was developed by each of the implementing partners to simplify the identification process during payment of their incentives. "***The identification tags provided to the contact tracers have helped them knock on doors of various households in communities without being kicked out"…..*** *Randolph Howard, Contact tracer in Grand Cape Mount*

Success of Community-Based Initiative to break EVD Transmission – Account by Dr. Mosoka Fallah- It is around 6:30 am, the team of community volunteers from Caldwell North Road, headed by Boye Cooper meets and prepare to begin their daily active surveillance. They will cover every house in their block looking for the sick, the dead and potential contacts that have secretly moved into the communities. The team discovers a body of a man who had come to reside with his sister in Caldwell to seek treatment from a herbalist, as two prominent hospitals have rejected him. The team initiates the response for the burial team and the body is picked up and quarantines the contacts, i.e. the couple. However, the couple disobeyed and flees to Chicken-soup Factory Community; several miles from Caldwell. Cooper and his team launch a frantic search and are able to reach them by phone. They counseled and encouraged them to return to their house in Caldwell. They returned and are peacefully quarantined for 21 days. The team provides daily visitation at a safe distance, and provide them with water and food that they have collected from community members. A few days later, the sister of the deceased falls sick and is taken to the Ebola Treatment Unit (ETU). Within the next few days the brother falls sick. However, the ETUs are all filled, but the team remains relentless and provide him with pain killers, oral rehydration salt (ORS) and psychosocial support. The patient is frustrated that he is not been taken to the ETU, but they encouraged him. Miraculously he is recovering at home. The team is still keeping watch over him.

Imagine with me for a second, how a new chain of Ebola infections would have started in Chicken-soup Factory Community if the team had not tracked and returned them to be quarantined. This story, illustrates what is currently occurring in communities in which we have initiated the CBI strategy.

There are over 50 community-based quarantines instituted by these volunteers. They are providing daily messages to the homes and doing active surveillance. They have adopted the CBI strategy and running with it. Just two weeks ago, we were invited by the Soul Clinic Community volunteers to participate in a re-integration ceremony of those they had quarantined. The community welcomes them back with love and they asked us to provide basic education on cases, contacts and the importance of quarantine in reducing the spread of the Ebola. This approach alone reduces the stigma and enhances openness in reporting Ebola cases. Community volunteers are arranging meetings with the Imam of the Muslims of Caldwell to develop strategy that would reduce traditional and religious burials practices that tend to spread the disease. Yes, the road is long as the fight against EVD is a marathon, but with the support of community volunteers and funding from organizations like UNDP, we will win one battle at a time

Declaration of the End of the Ebola Outbreak in Liberia- 9 May, 2015- After successful completion of the end of the 42-surveillance period, Liberia held a declaration ceremony. The WHO Representative for Liberia presented the Ebola Free declaration statement to the Head of the Incident Management Team who in turn handed it over to the Minister of Health and the President of Liberia. On 11 May 2015, the Government of the Republic of Liberia hosted another ceremony marking the end of Ebola outbreak in Liberia at a colorful event held at the Centennial Memorial Pavilion, Monrovia.

Quarantine Period Ends in Liberia- After the reemergence of Ebola in Liberia in November 2015, the family of the EVD positive cases, 165 people were identified as contacts and the communities were placed under quarantine for 21 days.

At the end of the 21-day period, on 11 December a ceremony was held in a local church to celebrate. The ceremony included songs of praise and the opportunity to celebrate a new milestone and the return to normal life for those who had been placed in quarantine over the 21-day period. The Deputy Minister of Health spoke at the event, cautioning against complacency.

Contact Tracer Helps Pregnant Woman Access Care- Yabayah is a small hard to reach community in Fuamah district, Bong county and in late 2015, one of the sixty UNFPA supported contact tracers operating through the REDEP (Reach Every District and Every Pregnancy) system in Fuamah identified a pregnant woman in one of his gazetted households. As required and through training of the contact tracers, he offered her counselling on need to attend ANC as well as encouraged her to deliver at a health facility when the time comes. The contact tracer had noticed hesitation from the pregnant woman but he persisted and continued visiting this household from time to time.

Incidentally, the contact tracer decided to influence her decision to attend ANC through other pregnant women in her community that were more receptive to maternal health services. During one of their community meetings, she went into labor and with her consent, community members rushed her to a nearby Handii clinic in Fuamah. Unfortunately, she could not deliver naturally but the community including the supportive pregnant women managed to take her to Phebe Hospital where she later underwent a C-section surgery and gave birth to a set of healthy twins. To date, this mother of twins is grateful to our contact tracer for not having given up on her for she realized she could have lost her life if she indeed went on to deliver at a TBA's home.

Report reviewed by *(MPTF M&E Officer to review and sign the final programme report)*

The Report states that by the end of the Joint Project in December 2015, the Effect Indicator – 'Proportion of counties with 100% districts implementing active surveillance and effective contact tracing' – reported 100% progress against the target 20%. In consultation with UN partners and observations from the monitoring visits, it's verified that the Surveillance and Contract Tracing Teams have been active during the project period and post end of the project as Liberia experienced there relapses in EVD – in November 2015 and in March 2016. These sporadic and recurrent emergence of EVD cases reinforced the Ministry of Health and County Heath Teams to continue to remain vigilant with technical support from the development partners. Additionally, technically contact tracing is possible only when there are active cases and hence it was active until May 2016 when Liberia was declared Ebola free. There are Emergency Response Teams identified in each county which h could be mobilized in case of future outbreaks.

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