



OFFICE OF INSPECTOR GENERAL
U.S. Agency for International Development

The Impact of OFDA's Infection and Prevention Training To Prevent Ebola's Spread Was Unclear in Liberia and Sierra Leone

AUDIT REPORT 4-000-18-001-P
NOVEMBER 21, 2017

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MEMORANDUM

DATE: November 21, 2017

TO: USAID/OFDA Acting Director, Carol Chan

FROM: Regional Inspector General/Pretoria, John Vernon /s/

SUBJECT: The Impact of OFDA's Infection and Prevention Training To Prevent Ebola's Spread Was Unclear in Liberia and Sierra Leone (4-000-18-001-P)

This memorandum transmits the final report on our audit of training by the Office of U.S. Foreign Disaster Assistance (OFDA). Our audit objective was to determine whether OFDA achieved its goal to train and prepare healthcare providers to prevent the spread of Ebola through proper healthcare practices. We also assessed the impact of USAID-funded training for healthcare providers on patient screening, hygiene, and waste management.

We did not make recommendations and did not require formal management comments. Nonetheless, in finalizing the report, we considered the comments you provided on the draft and included them in their entirety in appendix B.

We thank you and your staff for the assistance extended to us during this audit.

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INTRODUCTION

The Ebola virus outbreak of 2014 infected about 24,799 people and killed 8,765 across Sierra Leone and Liberia, according to the World Health Organization (WHO). As the infection rate was increasing exponentially, in August 2014, the U.S. Centers for Disease Control and Prevention (CDC) estimated that “without additional interventions or changes in community behavior,” the infection rate in Liberia and Sierra Leone would be up to 1.4 million by 2015.

Because the healthcare communities in the affected countries were not consistently performing simple infection and prevention control (IPC) protocols such as patient triage and isolation, hand washing, and cleaning, USAID’s Office of U.S. Foreign Disaster Assistance (OFDA) sought to train healthcare providers to change their behaviors. OFDA led the efforts of the U.S. Government, the major donor, which spent over \$2.5 billion (as of June 2016) to help control the Ebola outbreak.

We conducted this audit to determine whether OFDA was achieving its goal to train and prepare healthcare providers to prevent the spread of Ebola in Liberia and Sierra Leone. We also assessed the impact of USAID-funded training for healthcare providers on patient screening, hygiene, and waste management.

To conduct this audit, we judgmentally selected six OFDA-funded grants totaling \$26 million that included infection and prevention control training for healthcare providers and the implementation of infection and prevention control protocols at health facilities in Liberia and Sierra Leone.¹ We did not include Guinea in this audit because OFDA’s involvement in IPC training in that country was limited. Details of our scope and methodology are provided in appendix A.

SUMMARY

OFDA cannot demonstrate that it achieved its goal to train and prepare healthcare providers to prevent the spread of Ebola because OFDA did not ensure that grantees reported accurate data. Data on the number of healthcare providers trained for three of the five grantees included in this audit were invalid and imprecise. Grantees included in their results training provided under previous programs not funded by OFDA, did not retain evidence to support training results reported, and did not reconcile the number of trainees they reported with the number of names on sign-in sheets. Further, the grantees did not establish a process to prevent double counting of healthcare providers who attended more than one training on the same topic. OFDA did not verify results, contributing to poor data quality.

¹ We used a judgmental sample because OFDA grants do not include costs by activity or objective, so OFDA could not provide us with a complete list of grants involving the activities selected for this audit. The six grants selected were implemented by five grantees.

Healthcare providers were on the front lines of the Ebola response. They needed to protect themselves not only to survive but also to keep from spreading the virus, and OFDA's grantees gave training to healthcare providers in Liberia and Sierra Leone to teach them how. Proper implementation of IPC protocols is critical to fighting and containing the Ebola virus or any infectious disease. However, our site visits showed that healthcare providers in Liberia were not consistently applying what they had learned. Specifically, at all 16 facilities we visited in Liberia, healthcare providers were ignoring IPC protocols such as screening patients and visitors for possible exposure to an infectious disease before allowing them to enter health facilities, washing hands, and taking appropriate measures to contain and dispose of medical waste. Although they confirmed that they had received training, the healthcare providers did not follow these key IPC protocols. Workers cited a number of reasons, including telling us the practices were new to them and would take some time to adopt.

We are not making recommendations in this report because we have separate work underway that is assessing lessons learned from the Ebola experience.

BACKGROUND

According to WHO, Ebola virus disease, formerly known as Ebola hemorrhagic fever, is a fatal illness that spreads through direct contact with the bodily fluids of infected people or animals, such as fruit bats or monkeys. Although no proven treatment for Ebola exists, early detection and treatment increase the chances of survival. Proper infection and prevention controls can mitigate the transmission of the disease between people.

According to WHO, the 2014 Ebola outbreak was the largest and most complex outbreak on record because it occurred in urban areas and struck multiple countries in West Africa simultaneously. In August 2014, WHO declared the outbreak a public health emergency of international concern given the rising infection rates; fragile health systems; deficits in human, financial, and material resources; inadequate infection control practices; and frequent cross-border movement.

Shortly after WHO's declaration in August 2014, U.S. Embassies in Guinea, Liberia, and Sierra Leone asked for emergency relief assistance. USAID's OFDA led the U.S. Government's international disaster response.² It had strategic objectives including these:

- Manage Ebola cases safely through rapid case identification, referrals, and transport and strict adherence to infection control guidelines.

² Other U.S. Government agencies involved were the CDC, the Department of Defense, and the Department of State.

- Restore essential health services through IPC trainings for healthcare providers, implement improved IPC protocols in health facilities, and provide personal protection equipment and supplies.

OFDA funded several grantees to assess and implement IPC practices at health facilities in Ebola-affected countries. Grantees undertook activities ranging from training healthcare providers and improving IPC protocols (patient screening and waste management) to building the capacity of government officials. The six grants we selected appear in table 1, with a brief description of their activities.

Table 1. OFDA-Funded Grants Audited

Country, Grantee	Grant Activities	Start Date	End Date	Amount
Liberia, John Snow, Inc. (JSI)	Provide IPC training, monitor IPC practices, distribute personal protective gear and supplies, and install or rehabilitate triage and waste management structures and mechanisms.	11/6/14	12/30/15	\$7,233,653
Sierra Leone, International Rescue Committee (IRC)	Provide IPC training in government hospitals and monitor IPC practices.	2/16/15	2/15/16	5,288,573
Sierra Leone, IRC	Provide IPC training in health facilities and monitor IPC practices.	11/15/14	10/31/15	4,400,000
Liberia, MENTOR Initiative	Provide IPC training, monitor IPC practices, and install or rehabilitate triage and waste management structures and mechanisms.	10/10/14	3/31/16	3,926,216
Liberia, International Medical Corps (IMC)	Provide IPC and other Ebola prevention training.	10/8/14	12/31/15	3,027,822
Liberia, Jhpiego	Provide IPC training, monitor IPC practices, and install or rehabilitate triage and waste management structures and mechanisms.	12/9/14	12/8/15	2,814,287
Total				26,690,551

Source: Grant agreements.

IPC training, developed through collaboration of officials from the host government, WHO, CDC, and various nongovernmental organizations, covered these specific measures:

- **Patient screening.** This involves assessing the patient's health prior to entry into the health facility by taking the patient's temperature, ensuring the patient washes his/her hands with soap and water or an alcohol-based hand sanitizer, and asking a

series of questions to assess the patient's health and possible exposure to an infectious disease.

- **Hand hygiene.** Participants learn about explaining and demonstrating proper hand-washing techniques, using gloves, explaining the importance of proper hand hygiene, and establishing hand-washing stations in the facilities.
- **Waste management.** Trainers teach participants about segregating waste into a three-trash-can system for sharps (needles and syringes), infectious, and general waste (as pictured below); transporting waste; and disposing of it safely.



Healthcare providers in Montserrado County, Liberia, participate in training on segregating waste. Photo: OIG (February 10, 2016)

USAID DID NOT ENSURE THAT GRANTEES REPORTED ACCURATE DATA ON WHETHER HEALTHCARE PROVIDER TRAINING WAS ACHIEVING ITS GOAL

USAID policy states that to be useful for monitoring, credible reporting, and decision making, data should be valid, sound, precise, reliable, and timely.³ However, OFDA did not ensure that data reported by grantees who were conducting healthcare provider

³ At the time of this audit, Automated Directives System (ADS) 203 was in effect (2012). However, in September 2016, it was incorporated in revised ADS chapters 200 and 201. These USAID guidelines are part of ADS 201.3.5.8.a, "Data Quality Standards."

training in Liberia and Sierra Leone met quality standards; not doing so limits OFDA’s ability to assess the impact of USAID funding in preventing the spread of Ebola through training in IPC protocols. We tested all seven indicators for the training of healthcare providers using data reported by grantees selected for this audit. We found data quality problems with four of the seven indicators tested—mostly with inflated numbers for the key indicator *Number of healthcare providers trained*. Details on the data quality problems with the primary indicator appear in table 2.

Table 2. Results Reported for Healthcare Providers Trained

Grantee	Results ^a	Auditor Verified	Overreported	Percent Overreported
IRC	6,696	0	6,696	100
IRC ^b	4,645	3,550	1,095	24
JSI	3,543	2,300	1,243	35
IMC	249	200	49	20
Total	15,133	6,050	9,083	60

^a Results as of September 30, 2015, for IRC and as of October 31, 2015, for JSI and IMC.

^b IRC separated the reporting on regular healthcare providers and community healthcare providers. According to IRC, community healthcare providers do work similar to that of healthcare providers but are not directly employed by the health facilities.

The three grantees providing training gave these reasons for overreporting:

- IRC delivered on-the-spot training but did not have sign-in sheets or evidence to support the results for *Number of healthcare providers trained*. IRC staff said they did not provide clear directions to employees on how to count the training. Instead, IRC decided to report the results of IPC training that its staff gave before getting the OFDA grant, albeit with funding from another donor—the United Kingdom’s Department for International Development. For its second indicator, *Number of community healthcare providers trained*, IRC acknowledged inadvertently overreporting the results and corrected the number.
- JSI officials said they inadvertently included in *Number of healthcare providers trained* those trained under a prior USAID program. According to the officials, at the beginning of the Ebola outbreak, they were working on a USAID-funded health program, and USAID asked them to provide IPC training under that program. However, JSI counted the results in the results it reported to OFDA.
- IMC did not provide an explanation for the overreporting despite our repeated requests.

Furthermore, data were imprecise. Many of the same beneficiaries attended sessions on the same topic given by different grantees. Because grantees had no methodology for ensuring that they counted each beneficiary only once, in some cases beneficiaries were double counted. Grantees said they counted the beneficiaries by the training type and assumed the reporting methodology was correct since OFDA personnel did not ask them to revise the information they reported.

While OFDA had some interaction with the five grantees, OFDA staff did not validate or verify reported results. According to OFDA officials, OFDA staff monitor the grantees to ensure they are working within the response objective or overall goal to combat Ebola. OFDA attributed this weakness to the limited number of staff available to monitor the high number of awards due to the scale and speed of the Ebola response.

OFDA's lack of proper oversight and limited staff contributed to poor data quality. The lack of accurate data hinders OFDA's ability to demonstrate that it accomplished its goal to train healthcare providers to prevent the spread of Ebola.

HEALTHCARE PROVIDERS IN LIBERIA WERE NOT CONSISTENTLY APPLYING PROTOCOLS THEY WERE TAUGHT THROUGH OFDA-FUNDED TRAINING

Healthcare providers were on the front lines of the Ebola response. They needed to protect themselves not only to survive but also to keep from spreading the virus. OFDA's grantees gave training to healthcare providers in Liberia and Sierra Leone to teach them protocols to do both. Proper implementation of IPC protocols is critical to fighting and containing the Ebola virus or any infectious disease. However, our site visits showed that healthcare providers in Liberia were not consistently applying what they had learned. They were not always screening patients or visitors properly, enforcing hand hygiene, or following waste management and disposal protocols including proper use of waste incinerators.

HEALTHCARE PROVIDERS IN LIBERIA WERE NOT ALWAYS SCREENING PATIENTS OR ENSURING PROPER HAND HYGIENE

We visited 21 health facilities that received USAID-funded training: 5 in Sierra Leone and 16 in Liberia. We did not note significant issues at the clinics in Sierra Leone, but at all 16 facilities⁴ visited in Liberia, patient screening was not consistently performed. At several facilities, healthcare providers were not present in the screening areas, and the wash stations did not have water or soap for hand washing. Elsewhere, we observed

⁴ Grantees trained an estimated 313 healthcare providers across these 16 health facilities. During our visit, we interviewed 69 or 22 percent of the 313 healthcare providers.

patients passing through facilities without being screened, and the healthcare providers onsite did not intervene. Moreover, before allowing auditors into the 16 facilities, none of the healthcare providers took the auditors' body temperatures or asked about their health or where they had been recently to assess their possible exposure to infectious diseases.

We also found that healthcare providers were not always using the screening area as intended. At one clinic, healthcare providers were using the screening area as storage space and the patient isolation area as a break room.

HEALTHCARE PROVIDERS IN LIBERIA WERE NOT FOLLOWING THE WASTE MANAGEMENT PROTOCOL

Waste management was poor in all 16 facilities in Liberia. None had a three-trash-can system with clear labels in each patient or examination room. Some facilities had trash cans or a box for sharp objects but did not have separate trash cans for infectious and general waste. At a facility where we did not see any trash cans, a nurse said she took infectious waste to the emergency triage room four doors away to dispose of it; her actions went against the important instruction to contain such waste in the same room. In the same facility, the laboratory had a general can and a sharps can, both overflowing. And used gloves, valves, syringes, and general waste were scattered in the facilities' yards.

HEALTHCARE PROVIDERS IN LIBERIA WERE NOT USING INCINERATORS FOR WASTE DISPOSAL

Training emphasized disposing of infectious waste by burning it, and OFDA-funded grantees built or renovated incinerators for this purpose. During fieldwork in Liberia at 16 facilities, we observed four of five incinerators that were not operational, hindering workers' ability to adhere to waste management protocols.

- Incinerator 1, built by MENTOR Initiative to serve 10 clinics, had visible cracks and a destroyed roof. Staff at the facility where the incinerator was located said they had no place to destroy waste. Therefore, they were storing the waste from all 10 facilities around the incinerator and a waste storage shed that was already full. At the time of our visit, the facility did not have a plan for destroying the waste.
- Incinerator 2, built by MENTOR Initiative to serve 20 clinics, was partially damaged but still operational. The incinerator was overflowing with partially burnt trash, and boxes of used syringes and vaccine valves were sitting around it. The facility staff said that the incinerator could not handle the waste of 20 clinics and that the facility did not have the resources to run it. Effectively, the incinerator was not operational.
- Incinerator 3, built by Jhpiego and pictured at left on the next page, was partially destroyed but still functional. However, the officer in charge said he did not expect it to last much longer because of oxidation.
- Incinerator 4, built by Jhpiego, was not operational as shown at right on the next page. According to the officer in charge at one clinic, Jhpiego did not build a roof, so

the drum rusted faster than normal from the rain. At the time of our visit, we observed used syringes and vaccine valves, ashes, and other trash scattered in the field. The clinic started burning the trash in an open field near the entrance of the clinic.



The incinerator at left (Incinerator 3) is oxidized and was expected to cease operating by September 2016. The incinerator at right (Incinerator 4) is no longer operational, and the facility was burning waste beside it, close to the clinic entrance. Photos: OIG (January 27 and 28, 2016)

Our interviews disclosed several reasons for lack of attention to waste management protocols and improper use of incinerators. For instance, healthcare providers said they did not follow IPC protocols because these practices were new to them and would take some time to adopt. One grantee and some Liberian Government officials said when WHO declared the country Ebola free, healthcare providers relaxed their alertness and reverted to old habits. In addition, some government officials and clinic heads said the healthcare providers needed more on-the job mentoring. According to some grantee officials, after the first training, they visited the facilities to observe and reinforce healthcare providers' adherence to the IPC protocols, but the visits stopped because grantees did not have the funds to simultaneously conduct training and monitor healthcare providers' adherence to protocols. OFDA officials confirmed that they directed grantees to use remaining award funds to conduct the second training after the Ebola infection rate slowed. Moreover, OFDA officials said the incinerators were not expected to be a long-term solution. It is OFDA's mandate to restore service during a crisis.

CONCLUSION

Because Ebola has no known cure, it could resurface at any time. While Ebola is generally under control in Africa, it is critical for USAID to reflect on its experiences in funding programs to deal with the epidemic including the training of healthcare providers who were on the front lines of prevention and treatment efforts. Our work in Liberia and Sierra Leone points to opportunities to better collect and more accurately report data on the impact of its funding decisions and to design future programs in a way that ensures workers on the ground follow key protocols for patient screening, hygiene, and waste management.

We are not making recommendations in this report because we have separate wrap-up work underway assessing lessons learned from the Ebola experience. That work may identify ways that could improve USAID's response to future public health emergencies—including any new outbreaks of Ebola.

OIG RESPONSE TO AGENCY COMMENTS

We provided OFDA with our draft report on July 6, 2017, and on September 11, 2017, received its response, which is included as appendix B.

Our audit showed that, although training took place, its impact was unclear. While OFDA acknowledged that healthcare workers may not be consistently applying the training in the wake of the crisis, it disagreed with the findings in the audit report, saying they were “out of context, evaluating USAID/OFDA programs against [sustainability] objectives that those programs were never meant to achieve.”

We acknowledge that OFDA's principal goal during the crisis was to reduce the transmission of Ebola and that transmission was indeed reduced. OFDA says responsibility for ensuring that workers continue to apply the IPC techniques they were taught rests with the Government of Liberia and with implementing partners. Nevertheless, OFDA wrote that “to ensure that these skills are retained and used effectively beyond the emergency, USAID/OFDA coordinates and collaborates with the Mission and other development partners to support the [Liberian Government].” We agree that coordination between OFDA, missions, implementing partners, and governments is needed to improve the durability of emergency interventions.

Additionally, we note that OFDA did not dispute problems we highlighted with upholding data quality, screening patients, ensuring proper hand hygiene, following waste management protocols, and using incinerators for waste disposal.

On the issue of the applicability of monitoring and evaluation criteria from ADS 201, OIG agrees that OFDA enjoys certain exemptions related to monitoring, evaluation, and learning requirements, but we note that ADS 201.3.5.1, which deals with data

quality standards, states that exempted entities “should adhere to the quality standards for monitoring and evaluation noted in this subsection as feasible.”

APPENDIX A. SCOPE AND METHODOLOGY

We conducted our work from October 2015 through July 2017 in accordance with generally accepted government auditing standards. Those standards require that we plan and perform the audit to obtain sufficient, appropriate evidence to provide a reasonable basis for our findings and conclusions based on our audit objectives. We believe that the evidence obtained provides a reasonable basis for our findings and conclusions based on our audit objective.

The objective of this audit was to determine whether OFDA is achieving its goal to train and prepare healthcare providers to prevent the spread of Ebola through proper healthcare practices and to identify challenges that could hinder the goal of preventing future Ebola outbreaks at health facilities we visited. Because OFDA grants do not itemize funding by activity or objective (i.e., funding for healthcare provider training), OFDA could not provide us with a complete list of grants involving the activities we selected for this audit. Therefore, we judgmentally selected six grants (awarded to five grantees) totaling \$26 million that included activities related to our audit objective; we cannot report the amount audited.

This audit covered JSI, Jhpiego, IMC, and MENTOR Initiative activities implemented from October 1, 2014, through October 31, 2015; and IRC activities implemented from October 1, 2014, through September 30, 2015.

In planning and performing this audit, we obtained an understanding of the objectives, activities, and oversight controls at OFDA and grantees. We assessed and tested the operating effectiveness of OFDA's significant internal controls, which included reports on periodic meetings and site visits. At the grantees' locations, we assessed and tested significant controls such as oversight reporting, access and safeguarding of results, and approval of funds use. To obtain sufficient audit evidence, we conducted substantive testing such as data verification, observation of activities, and interviews with healthcare providers who received training. In addition, we consulted with an independent medical expert to assess the content of the IPC training materials.

We conducted in-country fieldwork from October 28, 2015, to November 13, 2015, and from January 25, 2016, to February 13, 2016, in Liberia and Sierra Leone. In Liberia, we visited activities in 5 of 15 counties: Montserrado, Bong, Margibi, Bomi, and Grand Bassa. In Sierra Leone, we visited activities in 3 of 14 counties: Bo District, Western Area Rural and Urban, and Port Loko. We also interviewed Ministry of Health officials in both countries, and representatives from the CDC and WHO in Sierra Leone. Furthermore, we conducted work at grantees' locations – JSI, Jhpiego, IMC and MENTOR Initiative local offices in Monrovia, Liberia, and IRC's in Freetown, Sierra Leone.

To answer the audit objective, the audit team performed the following:

- We obtained an understanding of the activities, how results are reported, systems used to store and manage data, and oversight controls in place at OFDA, and at the grantees' sites to ensure the activities were achieving their goals. We reviewed applicable laws and regulations, and USAID policies and procedures including the agreements and modifications.
- We identified and assessed the design and operating effectiveness of significant controls at OFDA and at each grantee location. We selected all performance indicators used by the five grantees related to IPC training for healthcare providers, monitoring of health facilities for adherence with IPC practices, and tracking of progress toward improved IPC practices. We also interviewed grantee employees to understand system controls in place to ensure the accuracy and completeness of performance indicator results reported to OFDA. We then assessed the system controls through observation of end users performing the controls and tracing reported data to source documents. We traced the data reported in the grantees' systems to hardcopy documents such as sign-in sheets and templates completed by grantee employees at health facilities. Because of the lack of effective controls and data errors, we determined that the grantees' computer data were not sufficiently reliable.
- We conducted site visits at 21 health facilities, clinics, and hospitals in Liberia and Sierra Leone. At the facilities, we interviewed healthcare providers, who verified trainings and other benefits provided such as triage, water stations, and waste management tools, and we observed the implementation of IPC protocols and practices. We selected a judgmental sample of health facilities based on (1) number of healthcare providers trained in the county, (2) concentration of facilities in the county, (3) diversity of activities provided to the health facilities, (4) availability of grantees' staff, and (5) accessibility to sites. As we selected the facilities based on these criteria, the results of these site visits cannot be projected to all health facilities in Liberia and Sierra Leone where workers were trained; this total was not available, as grantees did not consistently track healthcare providers by where they worked.
- We interviewed host-government officials at the central Ministry of Health and at district and county levels to understand their roles and get feedback on the activities as well as to corroborate deliverables. In addition, we solicited feedback from other donors working in the countries such as the CDC and WHO.
- The audit team assessed the evidence collectively to answer the audit objective. We verified evidence and corroborated results with beneficiaries and government officials. Therefore, we believe the results and conclusions in this report are valid.

APPENDIX B. AGENCY COMMENTS



September 5, 2017

MEMORANDUM

TO: Regional Inspector General/Pretoria, John Vernon

FROM: DCHA/OFDA Acting Director, Carol Chan /s/

SUBJECT: THE IMPACT OF OFDA'S INFECTION AND PREVENTION TRAINING TO PREVENT EBOLA'S SPREAD WAS UNCLEAR IN LIBERIA AND SIERRA LEONE (4-000-17-00X-P)

The Bureau of Democracy, Conflict, and Humanitarian Assistance, Office of U.S. Foreign Disaster Assistance (DCHA/OFDA) appreciates the opportunity to provide a formal response to OIG's findings and conclusions.

It is important to note that, as a donor, USAID/OFDA's primary goal was to reduce transmission of Ebola as outlined in the U.S. Government's three-Pillar strategic response to Ebola. USAID/OFDA's primary focus was on Pillar 1: "Control the Outbreak," which was achieved by supporting various programs through oversight and management of implementing partners rather than direct program implementation. The multi-pronged Pillar I approach contained several objectives, including Infection and Prevention Control (IPC) activities. IPC capacity building was an approach to arrive at one outcome. The collation of outcomes would eventually lead to the desired impact of transmission reduction.

OFDA/USAID implementing partners do not work in a vacuum but rather in partnership with governments where they are responding. In this instance, they contributed to the Government of Liberia (GOL) response to the outbreak by providing key components that strengthened and complemented the healthcare system during the emergency phase of the crisis. Implementing partners provided various training and capacity building opportunities to healthcare providers, both within the health facility and in the community.

The field work for this audit was carried out at the end of the Ebola response, well after the emergency phase of the outbreak concluded and when USAID/OFDA programs were closed or about to close. The findings outlined in this review are out of context,

evaluating USAID/OFDA programs against objectives that those programs were never meant to achieve. The findings cite early recovery and sustainability objectives that were not part of the Pillar I emergency effort to control the outbreak.

As emergency programs concluded, USAID/OFDA emphasized to the GOL the need to continue to monitor and supervise these healthcare providers to enhance and extend the learned behavior beyond the emergency phase. Since the field work was done after the emergency phase of the response was completed, the findings reflect on the GOL and development partners' capacity, as opposed to the success or failure of USAID/OFDA's programs.

If OIG's intention is that USAID/OFDA programs should have incorporated longer-term capacity building or sustainability objectives, the findings should focus on that strategic change and not whether the programs met longer-term objectives. However, it is important to note the limits of IDA funding and USAID/OFDA's mandate. IDA funds are legislatively designated as contingency funds for acute relief efforts only and cannot be used for programming for long-term development objectives. Alternately, a review of Pillar II objectives and the linkages/transition from Pillar I might also be more appropriate and helpful.

USAID/OFDA disagrees with the findings made in this report based on a common theme that the programs were being reviewed against objectives that they were not meant to achieve. Responses to specific findings and a further explanation of this theme are included below.

OFDA Response to OIG Findings

1. USAID did not ensure that grantees reported accurate data on whether healthcare provider training was achieving its goal.

USAID/OFDA response: USAID/OFDA acknowledges that data quality problems do exist and OFDA is working to address them through updates to our proposal guidelines and increased training and guidance on M&E for USAID/OFDA partners. However, it is important to note that USAID/OFDA is exempt from the monitoring and evaluation requirements contained in ADS 201.3.5.1, which are cited in this report despite the fact that they do not apply. Although exempted, OFDA/USAID strives to adhere to high quality standards for monitoring and evaluation for humanitarian response programs.

2. Healthcare providers in Liberia were not consistently applying protocols they were taught through OFDA funded training.

USAID/OFDA response: While USAID/OFDA acknowledges healthcare providers might not be consistently applying protocols months after training, it is important to note that USAID/OFDA's mandate is to focus on life-saving interventions during the initial emergency programming phase. Therefore,

USAID/OFDA does not have managerial oversight beyond the end dates of the emergency grants funded. However, during emergency implementation, partners put in place supervision systems that can and do serve as models for future GOL management. In order to ensure that these skills are retained and used effectively beyond the emergency, USAID/OFDA coordinates and collaborates with the Mission and other development partners to support the GOL during the transition. The GOL has the primary responsibility to provide oversight and supervision to government healthcare providers during the transition and recovery phases after the crisis. USAID/OFDA partners have provided recommendations and support to the GOL but the onus of providing proper and consistent supervision of healthcare workers is on the GOL.

3. Healthcare providers in Liberia were not always screening patients or ensuring proper hand hygiene.

USAID/OFDA response: USAID/OFDA agrees that IPC protocols are important during an epidemic emergency but also as part of a strong functional healthcare system in recovery. Maintaining this practice requires constant reinforcement and supervision. USAID/OFDA worked closely with the GOL during the emergency phase to give them the tools to continue building capacity and monitoring IPC activities throughout transition and into recovery. This audit was conducted between 12 to 18 months post peak of the epidemic and post IPC training. Observations of healthcare providers IPC actions in the health facilities, at the time of the fieldwork, primarily reflect the functionality of GOL healthcare systems in regards to human resources development, training and supervision.

4. Healthcare providers in Liberia were not following the waste management protocol.

USAID/OFDA response: USAID/OFDA agrees with the findings that improper waste management should not be acceptable to any government that wants a strong functional healthcare system. During an emergency, USAID/OFDA, through its implementing partners, strives to engage in best practices for waste management. As the disaster moves through transition and recovery, these practices need to be maintained and augmented by the GOL. USAID/OFDA recognizes that performance of an audit 12 to 18 months post emergency lends itself to only observing transition and long-term recovery practices versus short-term emergency structures put in place by USAID/OFDA.

5. Healthcare providers in Liberia were not using incinerators for waste disposal.

USAID/OFDA response: USAID/OFDA responded to the Ebola crisis with the urgent goal of saving lives. Pillar I was centered on the immediate actions needed to divert an even greater loss of life. During implementation, USAID/OFDA partners followed the guidelines and protocols for emergency medical waste

management activities including those for **emergency** incinerator construction and maintenance. These were not intended to be long-term solutions. Pillar I was short-term; Pillars II and III were designed to deliver more long term development needs and involved many other USG agencies. All waste management activities in the emergent phase are meant to be followed up with continued capacity building and supervision by the GOL. USAID/OFDA routinely stressed the importance of the GOL taking ownership as the country transitioned from disaster to recovery.