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SUMMARY

PERFORMANCE EVALUATION OF USAID EBOLA PILLAR II ACTIVITIES (PE1)

PE1 EXECUTIVE SUMMARY: EXCERPT

Two young children are orphans after losing their parents to Ebola virus disease in Monrovia, Liberia. © 2015. K.Ochel/MI, Courtesy of Photoshare.

At the request of the United States Agency for International Development (USAID), this publication was prepared independently by International Business and Technical Consultants, Inc. (IBTCI).

EXECUTIVE SUMMARY

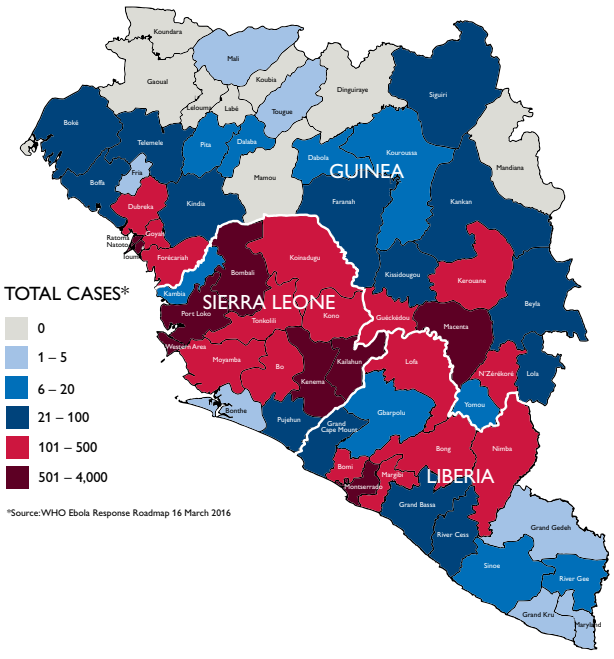
Evaluation Purpose and Questions

In October 2016, International Business & Technical Consultants, Inc. (IBTCI) received a contract from the United States Agency for International Development (USAID) to conduct an independent performance evaluation of activities funded by USAID aimed at assisting the governments of Guinea, Liberia, and Sierra Leone to recover from the 2014–2016 Ebola Virus Disease (EVD) outbreak. These activities are referred to as Pillar II, whereas Pillar I was focused on the response to control the outbreak. Based on guidance in the scope of work and discussions with USAID's Africa Bureau (USAID/AFR), the evaluation is primarily focused on USAID Ebola Pillar II activities implemented between March 2015 and December 2017.[1] The purpose of the evaluation is to document the overall performance of Pillar II activities in each of the three countries—Guinea, Liberia, and Sierra Leone—and provide information and lessons learned to inform and improve USAID's ability to respond effectively to future global health emergencies. The evaluation was guided by four questions:

1. *How are USAID's Pillar II Ebola Recovery activities in Guinea, Liberia, and Sierra Leone contributing to the achievement of the Ebola Pillar II Strategic Framework's three objectives: to halt the loss of development gains; recover and strengthen key institutions and infrastructures; and, build sustained systems through public private partnerships (PPPs), innovation, and capacity building?*
2. *What results of Pillar II activities have endured after the activities have closed, and why?*
3. *What gaps and opportunities arose in the course of Pillar II activities that influenced the achievement of Pillar II objectives?*
4. *What lessons have been learned regarding how best to use the strengths of USAID's emergency and long-term development mechanisms in a complex emergency?*

Project Background

Guinea, Liberia, and Sierra Leone were the three countries most affected by the 2014–2016 EVD outbreak (see map). This, in turn, led to the collapse of multiple government systems in each country, including health, agriculture, democracy and governance, trade and markets, and education, many of which were already fragile before the crisis. As such, the population of each country suffered significant second-order impacts on household welfare, human development, and their economy. As the U.S. Government (USG) lead for the post-EVD recovery, USAID designed, implemented, and oversaw activities with these objectives: prevent the loss of development gains; recover and strengthen existing institutions and infrastructures; and build sustainable systems through public-private partnerships, innovation, and capacity building. These activities aimed to strengthen key institutions and infrastructure (already weak before the start of the outbreak), restore citizens' trust in their governments, rebuild communities' willingness to accept social messaging on EVD, and ensure that recovery efforts increased each country's ability to respond to and recover from similar crises in the future. Pillar II activities focused on six thematic areas: Agriculture and food security; non-EVD essential health and health system strengthening; governance and economic crisis mitigation; education; water and sanitation; and innovation, technology and partnerships. Pillar II activities were programmed by numerous USAID bureaus, offices, and the three affected missions, and implemented by a diverse group of implementing partners (IPs) aligned with international and host-country government EVD recovery strategies.



Regional map of the 2014–2016 West Africa EVD outbreak

1. IBTCI collected reports and documents from the operating units (OUs) and implementing partners (IPs) before December 2017. The output and outcome figures stated in the report therefore do not reflect figures reached by December 2017.

Evaluation Design and Methods

The performance evaluation used a mix of qualitative and quantitative methods in a three-phase design to create a cross-sectional picture of Pillar II accomplishments in each country. An evaluability assessment was conducted in Phase One (January through September, 2017), when the team identified relevant data sets, reviewed background documents, and conducted key informant interviews (KIIs) within USAID and selected IPs, host-country government officials, and other stakeholders in each country to finalize the evaluation design and theory of change. During Phase Two (October 2017 through January 2018), the evaluation team focused on implementation of the evaluation, which measures the progress of and identifies challenges to the implementation of USAID-funded Pillar II activities. The data collection methods included desk reviews, KIIs, focus group discussions (FGDs), health facility surveys (IBTCI's 2017 HFS), and household surveys (IBTCI's 2017 HHS). During Phase 3 (February through March 2018), the team triangulated qualitative and quantitative data across six thematic areas and six intervention types (social protection; frontline worker support; management, coordination and partnership (MCP); information, communication and technology (ICT); social and behavior change communication (SBCC); and institutional enhancements) in all three countries to answer the evaluation questions. The evaluation questions were categorized into four analytical domains: 1) performance; 2) sustainability; 3) gaps and opportunities; and, 4) management.

Detailed information on the service delivery baseline data for outcome indicators, disaggregated by counties, prefectures, or districts is not available. It is therefore a challenge to assess and compare results of individual activities that vary greatly in duration and scale.

Findings[2]

ANALYTICAL DOMAIN: PERFORMANCE

Pillar II activities were designed to combine proven interventions in six thematic areas: agriculture and food security (AFS), non-EVD essential health services and health system strengthening, governance and economic crisis mitigation (ECM), education, water and sanitation, and innovation, technology and partnerships (ITP). The largest proportion of USAID's Pillar II activities categorized by thematic area (calculated by dividing the number of activities in a thematic area by the total number of activities), were health (60 percent; of these 78 percent were in health systems recovery, 17 percent focused on non-EVD health services, and 5 percent were survivors' programs). Fourteen percent of all Pillar II activities were implemented in the AFS sector. The governance and ECM sectors each accounted for nine percent of recovery activities. Five percent of Pillar II activities fell under ITP and one activity in Liberia was implemented in the education sector. Though many activities had ITP elements, several of these were categorized as ICT interventions in health activities. The most recent USAID obligation and disbursement table shows that as of September 2017, approximately 46 percent of the $475 million[3] obligated for Pillar II activities had been disbursed.

GUINEA

In Guinea, USAID Pillar II activities largely work in health, governance, and food security. Health activities focused primarily on frontline worker support, MCP, SBCC, and institutional enhancements. IBTCI's 2017 HFS found that in the 13 prefectures sampled, the mean number of outpatient visits to HFs increased by 74 percent between 2013 and 2017. The HHS found that the percentage of pregnant women with at least four antenatal care visits (ANC4) increased from 57 percent in the 2012 Demographic Health Survey (DHS) to 66 percent. Skilled birth attendant coverage increased from 45 percent to 80 percent and health facility deliveries increased from 40 percent to 73 percent between the two surveys.

Pillar II-funded activities achieved many successes. The Health Finance and Governance activity supported the National Assembly's Health Commission to increase the Government of Guinea (GOG) health budget by 2.4 percent over Parliament's initial proposal. Under the Fighting Ebola Grand Challenge, 3D Family Productions, working with the Ministry of Health (MOH) and *Médecins Sans Frontières* (MSF), held a national song-writing competition that increased awareness of and trust in Guinea's restored health services. The mHero interoperable mobile platform was incorporated into the MOH's HMIS strategic plan. The Consortium for Elections and Political Processes Strengthening, implemented by the National Democratic Institute (CEPPS/NDI) built the capacity of Guinea's Election

2. For the household survey data, IBTCI used previous DHSs as pre-EVD baseline. The sampling methodology and questions are similar between DHSs and 2017 IBTCI's household surveys and results are comparable. IBTCI's 2017 HHS total figures refer to priority areas only (13 prefectures in Guinea, eight counties in Liberia, and eight districts in Sierra Leone), while the DHS total figures refer to the entire country. Subnational trend comparisons are shown in Annex L tables for Liberia and Sierra Leone. Guinea 2012 DHS disaggregated data at the regional level and not at the prefecture level. Hence, prefecture-level trend comparisons are not available.
3. This report focuses on the 148 USAID-funded recovery activities funded under Ebola Pillar II (Economic Support Funds (ESF) 73%; International Disaster Assistance (IDA) 25%, Global Health Programs (GHP) 2%); see September 2017 Obligations & Expenditures spreadsheet. A total of $1.86 billion was obligated across all four pillars by September 2017.

Commission and political and civil society organizations (CSOs) and educated communities about the political process in the lead-up to the February 2018 municipal elections, which helped the electoral process move smoothly and improved women's participation. Twenty-three percent of the 30,000 candidates were women, not far from the 30 percent quota set by the electoral commission (USAID Guinea, 2016). However, IPs often cited the short duration of Pillar II activities as a challenge, compared to a longer and more traditional duration for development work. Only one AFS activity remains active, and the Health Communication and Capacity Collaborative (HC3) activity closed after two years with demonstrated success in reestablishing trust in health services and strengthening the capacity of the country's health workforce.

LIBERIA

In Liberia, Pillar II health activities focused primarily on frontline worker support, MCP, SBCC, and institutional enhancements, although ICT-based activities were also employed. Reports and indicator matrices show that Pillar II health activities achieved most of their targets, including successful testing of improved personal protective equipment (PPE) and patient management devices, and national scale-up of the mHero platform for MOH-health care worker (HCW) communication. IBTCI's 2017 HFS found positive trends as well, including a gradual increase in outpatient attendance in surveyed HFs since 2014 and growth in the use of skilled birth attendants (to 93 percent, from the Liberia 2013 DHS national estimate of 61 percent). At the time of this evaluation, both quantitative and qualitative data indicate an unmet need for care and support services for EVD survivors. However, during the data collection for this evaluation, the John Snow International Research and Training Institute Advancing Partners and Communities project (JSI R&T/APC) Ebola survivor activity was just getting started and, therefore, it was not fully operational.

UNICEF's Education Crisis Response in Liberia (ECRL) activity was the only Pillar II activity focused on basic education. ECRL improved water, sanitation, and hygiene (WASH) infrastructure in schools, distributed teaching materials, and provided limited teacher training. According to IBTCI's 2017 HHS, at least 77 percent of primary school-aged children in the eight counties covered by the survey attend school—a vast improvement from the Liberia 2013 DHS national estimate of 38 percent.

Completed AFS activities achieved or came close to achieving their targets and showed improvements in household dietary diversity and reductions in the magnitude of moderate and severe hunger. Pillar II AFS activities in Liberia implemented cash transfer (CT) programs, cash-for-work interventions, and provided agricultural inputs, vocational training, and other social protection activities. The activities were regarded by beneficiaries and implementers as having both a positive impact on the recipient HHs and success in reaching women and female-headed HHs. For example, Mercy Corps' Economic Recovery from Ebola for Liberia (EREL) provided cash to 30,077 HHs, of which 70.5 percent were female-headed. IBTCI's 2017 HHS indicates that, while 52 percent of HHs in the eight targeted counties received some form of social assistance in the past 12 months (cash, food, and educational support are the most common types of assistance), formal sources of support (e.g., GOL, NGOs, and CSOs) were mentioned by only five percent of HHs.

SIERRA LEONE

In Sierra Leone, USAID Pillar II investments primarily addressed health system recovery, restoration of non-EVD essential health services, and food security. The Advancing Partners and Communities – Post-Ebola Recovery of Health Services (PERHS) activity revitalized 305 of 365 peripheral health units (PHUs) in the five districts covered by the activity by providing basic medical equipment and furniture. Of the 305 PHUs targeted, more than 240 also received training and 110 received training and were renovated to improve infection prevention and control (IPC) standards, including installation or rehabilitation of boreholes/wells, installation or rehabilitation of toilets, waste pits, and incinerators, and installing or rehabilitating solar panels. The activity also trained more than 900 health professionals, 1,500 community health workers, and 2,500 members (predominantly women) of 214 facility management committees (FMCs). To collate morbidity and context data at the facility level, the EPIC platform and dashboard, developed under the Fighting Ebola Grand Challenge, were piloted in one district. These initiatives have improved health services for approximately two million Sierra Leoneans. KIIs with IPs and the Government of Sierra Leone (GOSL) highlighted the success of WASH services.

The AFS sector IPs supported a mix of targeted cash transfers, agricultural input vouchers, and other complementary activities. In coordination with the GOSL and with input from participating communities, the Office of Food for Peace (FFP) partnered with ACDI/VOCA, CARE, Catholic Relief Services, Save the Children, and World Vision to implement food security activities. More than 67,000 HHs (364,000 individuals) received cash transfers. Recipients used the money to purchase food and agricultural inputs. In addition, the Save the Children activity provided 400 female small-scale traders with small conditional cash grants and business training as a complementary activity.

ANALYTICAL DOMAIN: SUSTAINABILITY

Many of the activities in **Guinea** were designed to support existing policies and work with the GOG to develop new policies as needed. Health-sector activities were aligned with the GOG's Recovery and Resilience Strategy and worked

toward growing the capacity of national-level legislators to build their capacity for health financing. An FGD with USAID and KIIs with the GOG stated institutional support, such as training and capacity building of prefecture health teams and local health facility staff, will have long-lasting effects. Outcomes that GOG respondents believe are sustainable include IPC in HFs, facility rehabilitation, and health worker training.

The country's new health management information system (HMIS), built on District Health Information Software, version 2 (DHIS 2) and developed with Pillar II funds, rolled out nationally in 2018, incorporating the mHero platform for two-way communication between MOH and HCWs. The HMIS is expected to improve the quality of the data collected and increase the use of data for informed decision-making. However, infrastructure problems such as lack of electricity remain. KIIs mentioned that social mobilization on the electoral process and in conflict resolution may have long-lasting effects. AFS activities were primarily designed to provide emergency food assistance with only a few livelihood interventions.

In **Liberia**, it is not possible to map Pillar II activities along a sustainability pathway reflective of all determinants included in the sustainability framework. However, institutional enhancement interventions such as physical upgrades of HFs and WASH infrastructure strengthening in schools and communities were intended to have a longer "shelf-life" than other activities. In contrast, CT programs are not a sustainable social protection mechanism, and they generally yielded shorter-term effects (e.g., they enabled HHs to avert starvation in the midst of acute food shortages). Other forms of social protection that addressed livelihoods are linked to longer-lasting benefits (greater resilience and increased ability to meet basic household needs and send children to school). As illustrated by a case study on Maternal and Child Survival Program/Human Resources for Health (MCSP/HRH), frontline worker support activities that involve capacity building can leave a legacy if institutional support requirements are addressed. However, other sustainability determinants, such as the financing of HRH, functional accountability mechanisms, and reviews of existing policies with an eye toward health-sector readiness to rapidly mobilize and deploy HRH (in the event of another crisis) are also necessary.

In **Sierra Leone**, as in the other two countries, Pillar II interventions can be analyzed through a systems lens, which allows us to see that investments influenced many of the six WHO health system building blocks. That is, different policies were either put into place or revitalized, including the Community Health Workers Policy, the National Guidelines for WASH Services in Health Facilities, and the Integrated Disease Surveillance and Report Technical Guidelines. In addition, there were multiple interventions improving institutional performance and support, and community involvement was garnered through the FMCs and a national campaign promoted care-seeking behavior, thus addressing the human dimension. Further, reporting of service data was improved, thus alleviating health information system concerns. All of these elements contributed to health system strengthening, the effects of which will be explored further during the performance evaluation follow-up.

ANALYTICAL DOMAIN: GAPS AND OPPORTUNITIES

EVD-related death rates among health workers were high (1.45% versus 0.02% for general population). Pillar II health sector IPs designed interventions to promote frontline worker safety through IPC training and rehabilitation of HFs to include basic infrastructure and equipment. In addition, 10 of the 14 innovations funded under the Fighting Ebola Grand Challenge, from improved PPE and Ebola treatment units (ETUs) to patient monitoring devices, aimed to improve frontline worker safety. Institutional enhancements in the governance sector responded to gaps related to the country's legal and electoral procedures and institutions. The realization that inadequate community engagement was a key factor in mistrust and misconception, seen during the EVD outbreak, led IPs to include social mobilization as a key element in health and governance activities. An opportunity related to the recovery and cited by respondents was the continuation of partner coordination established during the EVD response.

EVD struck **Liberia** during the annual planting and harvesting cycle (FEWS Net, 2017a), and many HHs lost crops—frequently because people could not go to their farms or get to markets to sell or trade any surplus due to border closures, quarantines, and other restrictions on their movement. Pillar II AFS activities (social protection interventions, in particular) addressed a gap that emerged due to food insecurity and loss of income. WASH and IPC, which were addressed through institutional enhancements, frontline worker support, and SBCC in the health and basic education thematic areas, also responded to gaps related to effective hygiene practices. There were, however, missed opportunities. In some instances, seeds and other agricultural inputs were received too late for planting in the first year, and thus were saved for the next planting season. As recovery efforts evolved, some Pillar II IPs adapted to implementation challenges and seized opportunities to amplify results. The use of mobile money for CT programs capitalized on growing ICT momentum in the country. While showing great potential, this method was hampered by limited availability of cash transfer agents in rural areas and their limited liquidity, as documented in a separate review of FFP-supported responses to the EVD crises in Liberia and Sierra Leone (Radice, 2017). To mitigate these issues, IPs developed creative solutions such as increasing incentives to cash-out agents. "WASH in Schools" (WinS) activities centered on

institutional enhancements; however, the engagement of local groups such as parent-teacher associations is an example of a creative partnership approach employed to explore sustainable financing for WASH activities in schools.

In **Sierra Leone**, there were different gaps in AFS mentioned by key informants. They can be grouped in the following categories: the felt need for wider and more timely coverage and support via the CTP; the importance of involving potential beneficiaries in the planning process of recovery interventions; a desire for the expansion of support for farming and processing equipment to add value to agricultural production; and the importance of feeder-road rehabilitation activities. In the health sector, the perceived gaps centered around two major issues—expanding health provider training and assisting with retention of personnel, especially those recruited as nurse volunteers and improving the availability of pharmaceutical supplies at the facility level.

Respondents in all three countries and in Washington noted that the evaluation team's process of vetting and refining the Pillar II theory of change (conducted by the evaluation team in Phase One) was useful, as they had generally focused on work and plans within their own sector. Neither the missions nor the Washington-based operating units (OUs) used the USAID/AFR Pillar II Monitoring and Evaluation (M&E) Results Framework to create a more granular activity-specific M&E framework, as was the original intent of the Africa Ebola Unit (AEU) in USAID/AFR. The majority of support was core funded through USAID/Global Health (GH) and USAID/Bureau for Food Security (BFS) and much of the USAID/GH funding was added on to existing projects/activities. As such, from the perspective of funding OUs, it was more logical to follow existing M&E results frameworks rather than retrofit one to the AEU's Results Framework.

ANALYTICAL DOMAIN: MANAGEMENT

In **Guinea**, Pillar II activities aligned with the GOG's post-Ebola Recovery and Resilience Strategy. The supportive role of the Mission's program planning, monitoring and evaluation was highlighted. In general, respondents praised USAID for its coordination with government and other development partners. Pillar II activities have heavily targeted the health sector and GOG respondents stated that they appreciated the flexibility of USAID funding, but felt that the Pillar II activities were too short in duration. KIIs reported concern that the effects of post-EVD health sector recovery efforts will likely stop or fade away without continued support. However, some improvements, such as the use of the mHero mobile platform for MOH-HCW communication, have been incorporated into national plans, which enhances the likelihood of their continuation. GOG stakeholders responded that USAID was consultative and supportive with other non-USG development partners and government stakeholders and highlighted the supportive role of the Mission's M&E section and program planning. Respondents from a subnational level CSO stated that there was inadequate consultation with government stakeholders, especially outside Conakry. AFS and governance IP respondents reported that the Pillar II activities were too short in duration.

The pre-EVD presence of AFS activities in **Liberia** was an important strength on which to build. However, some applications for Pillar II AFS activities took several months to be approved, which delayed start-up and thus the ability to meet acute needs of individuals, HHs, and communities affected by the EVD outbreak. The Liberia Mission worked closely with the Ministry of Health to align Pillar II activities with the government's Investment Plan for Building a Resilient Health System, Liberia 2015–2021. At the time of the data collection (late 2017/early 2018), qualitative evaluation data reveal generally positive views on coordination, although stakeholders noted that coordination is not now occurring as smoothly as it did in the midst of the crisis, leading to some current duplication and cost-inefficiencies. USAID's structured reporting, M&E processes, and tools have helped to establish clear expectations and are helpful as an objective means of tracking progress. However, some GOL and CSO KII respondents noted that there is suboptimal transparency on how much funding is allocated, what impact each activity is making/has made, and at what level of quality activities have been implemented.

In **Sierra Leone**, the public sector played a crucial role in the coordination of recovery efforts. The President's Delivery Team on Transition and Recovery (PDTTR) coordinated recovery priorities outlined by the government and provided technical support in monitoring to all involved ministries, departments, and agencies, where they embedded its members. USAID's efforts and those of other donors were coordinated through this mechanism. USAID's FFP activities worked very closely with the National Commission for Social Action (NaCSA), a semi-autonomous agency in charge of coordinating and implementing all social protection interventions, to target the right beneficiaries. Cash transfer working groups were used by FFP IPs to coordinate many of their activities. In the health sector, IPs made substantial efforts to leverage synergies, technical expertise, and other resources to avoid duplication and maximize effectiveness of activities on the ground. The EPIC platform and analytics were piloted in Sierra Leone, demonstrating one approach to improving coordination and evidence-based health decision-making. district councils were the main mechanism for coordination of donor-supported efforts at the district level. These councils organized district forums to review progress of program interventions and resolve issues.

INTRA-AGENCY COORDINATION

In addition to the robust inter-agency coordination that was *in situ* from the onset of the outbreak, recovery efforts also resulted in strong intra-agency coordination (among three missions, three OUs, a regional bureau, and the AEU).

The team observed that the respective roles of the Agreement Officer Representatives (AORs) and the Mission were ill-defined. There were distinct differences noted between the management and leadership of the Secretariat; for example, daily tasks for each OU were assigned in writing to OUs in contrast to the AEU which tasks were less prescribed and not delineated in writing. Under the Secretariat, the leadership followed up daily to assess progress against the daily tasks assigned in writing and ensured execution. While the AEU was recognized across the Agency as the coordinating body for the recovery efforts, the roles and responsibilities of the AEU were not clearly set out. Further, USAID staff on the ground did not consistently comprehend the role that the Global Health Ebola Team (GHET) played *vis-à-vis* the activity managers of Ebola Pillar II-funded activities; this was despite efforts to make it clear that the Global Health Bureau was in charge of the scope and program direction of EVD activities and would provide their AORs.

The varying procurement mechanisms and differing contractual arrangements across USAID OUs made it difficult to obtain consistent information from quarterly financial reports on individual activities. However, the Bureau of Resource Management (BRM) provided IBTCI with obligation and expenditure information and the official list of Pillar-funded activities as of September 2017.

Conclusions

Pillar II activities were designed to address key recovery needs in six thematic areas: AFS; non-EVD essential health services and health system strengthening; governance; ECM; basic education; and ITP. Pillar II health activities have done more than merely prevent the loss of development gains; they have helped to elevate health behavior and inspired substantial gains in health-seeking behaviors. Various AFS and health service activities supported each other. AFS activities addressed HHs' immediate basic needs and the loss of agricultural productivity and markets. Cash transfers allowed beneficiaries to purchase food and other essentials for health, as well as to infuse money back into the markets. Assistance to market traders helped ensure that there were products to purchase. In locations where Pillar II AFS activities were implemented, standard measures of household food security improved considerably in a relatively short period of time; it is yet unknown to what extent this will translate into improved nutritional status.

Research and development initiatives under the Fighting Ebola Grand Challenge introduced improvements in ETUs, medical devices, and ICT platforms that now strengthen the countries' health systems and make them more resilient to shocks in the future.

ECM and governance activities were few in comparison to other thematic areas, funding was delayed, and achievements more difficult to link directly to ultimate outcomes of health and development at the population level. Through Pillar II investments, the government agencies, CSOs, and the media have strengthened advocacy, transparency, and accountability.

ITP activities, though a small part of each country's Pillar II funding allocation, were higher in number, implemented by multiple IPs and common to all three countries. Given local challenges (e.g., cell phone coverage, network connectivity) and the time requirements to roll out ICT interventions, the trickle-down effects of those interventions are not widely documented at this time.

Overall, Pillar II recovery activities were of relatively short duration and the actual implementation period was often further compressed by necessary start-up activities. Nonetheless, relative to activities for which there is data, IPs report achieving their outputs.

Pillar II provided a rare opportunity to observe support from and within multiple sectors directed toward achieving specific outcomes with cross-cutting relevance (e.g., accountability, citizen trust, citizen engagement). At this stage, health sector activities have bolstered key building blocks of a functional health system (e.g., health workforce, health information), strengthened health service quality, and restored trust in the health system. The AFS activities addressed poor welfare and food insecurity issues initiated by EVD and the related loss of agricultural productivity and markets. Infusions of cash, seeds, equipment, drugs, and infrastructure helped to restart and rebuild livelihoods. The questions remaining are about the sustainability of these intervention components after the AFS staff and added resources are no longer available. To bring effective innovations to the global marketplace, there is evidence of "Grand Challenge" innovations, spurring additional partnerships between innovators and private-sector entities.

Experience with mobile money in the CT programs has shown that quite a number of obstacles must be overcome before e-payment works smoothly for vulnerable HHs in rural areas.

Some of the applications for the AFS activities took several months to be approved and required some iteration on planning to align them with USAID/FFP's objectives and meet

quality standards. These delays resulted in activities starting later than initially envisioned. Although the intention was to cover food insecurity during the lean season, many of the early transfers did not reach beneficiaries until after the most challenging time had passed.

The weakness of health systems in the three countries in containing the EVD outbreak was not exclusively a health issue; it was also a function of leadership and management (governance and economy issues). Yet ECM and governance activities were sparsely funded in the recovery efforts, and thus their response was not fully mobilized for the recovery.

Recommendations

- **USAID's future emergency coordinating bodies, such as the AEU, should be based in the front office and comprise a team of leaders with senior staff experienced in development and humanitarian relief.** The team should be multi-sectoral, capable of drawing on the full range of the USAID's expertise in development, with clear rules of engagement and specific roles for the team. This central team should have the authority to solicit cooperation from OUs across the Agency. This central coordinating team should be bigger than the AEU was and should be able to exercise certain authorities for the tasks at hand without approval from each of the OUs. The team should be charged with invoking special procurement and staffing regulations and redesigned for emergencies, including explicit criteria for clearances and decision-making processes that specify the authorities of Mission and Washington OUs. OUs should identify ways to expedite access to funding while maintaining accountability and the minimum due process to protect the use of USG funds. This discussion needs to happen above the level of the individual OUs and procedures would need to be in place to avoid use of the recovery funds without constraints, misappropriation of funds, inefficiency, or mismanagement at the IP level. The agency can consider waivers for routine activity design and implementation during emergency situations. A time frame for addressing the waived actions (e.g., instituting an M&E plan) should be finalized within one to two years of implementation.
- **USAID/AFR should create standard operating procedures to be available for immediate use in future emergencies.** Protocols would include variations for applying to short-, medium-, and long-term phases of recovery.
- **USAID should judiciously consider supporting with non-emergency funds limited follow-on activities at the national and district levels in each country to prepare government agencies and communities for the sunset of Pillar II resources.** Communication and dialogue activities, using skills built during the response and recovery, can help communities to understand that the time limit was a condition of the EVD response funding from the start, the resources have been used as planned, and they have produced benefits for the people. These communication and consultation activities can invite and engage stakeholders in planning ways to sustain and extend those benefits.
- While it is understandable that M&E and reporting might get set aside during a health emergency, de-prioritizing M&E is more a result of staffing shortage than of difficulty in establishing M&E basics. **IPs must include qualified M&E staff in all staffing plans and during every phase of the activity lifecycle.** Their functions are critical to sound and rapid evidence-based decision making in all aspects of development and emergency programming.
- **It is recommended that IPs continue to invest in trust-building activities with government and civil society.** They should improve and expand the capacity and frequency of contacts between CSOs and community leaders. USAID and IPs should take every opportunity to bolster the value and mandate of government officials' willingness to listen and respond to their communities' needs.

Performance Evaluation of USAID Ebola Pillar II Activities: Final Report : Executive Summary

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