

EVALUATION REPORT

March, 2017

Evaluation of UNICEF's response to the Ebola outbreak in West Africa 2014–2015

■ ■ **Annexes** ■

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EVALUATION OF UNICEF'S RESPONSE TO THE EBOLA OUTBREAK IN WEST AFRICA 2014–2015

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Three United Nations Plaza
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ANNEX 1. TERMS OF REFERENCE

(TOR revised and extended till 8th September 2015)

UNICEF response to the 2014-15 Ebola outbreak in West Africa

Terms of Reference –
revised for an RFP extension

4.1. BACKGROUND

The current Ebola Virus Disease (EVD) outbreak in West Africa is unprecedented in terms of the number of cases, deaths and its geographical spread. It is the largest and most complex Ebola outbreak since the Ebola virus was first discovered in 1976. There have been more cases and deaths in this outbreak than all other Ebola outbreaks combined. The first cases occurred in December 2013 and the epidemic was first notified in March 2014. It has spread among West African countries starting in Guinea before spreading across land borders to Sierra Leone and Liberia, Nigeria, Senegal and Mali. Fear of a global pandemic escalated after the cases in Europe and the United States. The most severely affected countries, Guinea, Sierra Leone and Liberia, have recently emerged from long periods of conflict and instability and have very weak health systems and limited resources and capacity.

Once the outbreak took hold, the disease spread fast, with high fatality rates across the three affected countries, and massive disruption to all aspects of economic and social activity including the provision of basic services in health, education, nutrition, and community development. The spread of the disease was also rapid and unpredictable. By the 15 April

2015, the total number of cases stood at 25,826 (suspected, probable and confirmed), with 10,704 deaths¹.

It has also been a calamity for children in the countries affected. UNICEF estimates that 9.8 million children and young people under the age of 20 live in Guinea, Sierra Leone and Liberia; countries where disease transmission is widespread and intense. Of these, 2.9 million are under the age of five year old. UNICEF estimates that over 15,000 children have lost one or both parents or caregivers due to Ebola².

The crisis has been characterised as a twin epidemic – one of the Ebola virus and a second one of fear, which restricted economic activity, undermined trust in the authorities and disrupted services in the countries affected, and led to international concern regarding the global risks. Fear and distrust remain factors in trying to re-establish confidence in national health services and in the response measures of contact-tracing, coming forward with cases, and reporting of deaths.

In October 2014, an initial CDC estimate of a potential 1.4 million cases³ added to the sense of panic. Foreign governments took a very strong interest and UNICEF has been under unprecedented pressure from the highest political levels to perform. This meant that reputational risks were very high and UNICEF activities still remain visible and subject to scrutiny.

Ebola menaced entire populations and put everyone at risk, including children. Children face not only direct risks of exposure to the virus, but also secondary risks as a result of the loss of infected caregivers and family members. Furthermore, as basic service delivery became

¹ <http://apps.who.int/ebola/current-situation/ebola-situation-report-15-april-2015>

² http://www.unicef.org/appeals/ebola_response.html

³ Reportedly, this was never an official figure but once raised in the high level planning meeting in Accra, it went public and influenced the planning figures of other agencies.



strained as a result of the outbreak, children's access to health care, education and protection services became limited, increasing their vulnerability and risk in both the immediate and the long term. Women have been affected by the virus in their traditional role as caregivers in the home and their traditional roles as nurses, midwives and health facility cleaners, increasing their direct exposure to infected persons.

Children who have lost one or both of their parents or caregivers to Ebola, or whose caregivers were/are being quarantined or treated for extended periods in medical centers, may find themselves unaccompanied or separated and in urgent need of immediate protection and long-term support, including alternative care. Affected children also run the risk of rejection due to the stigma attached to the disease, and may be at risk of exploitation and abuse. Psychosocial support is needed to reduce stress, build trust and improve the well-being of affected communities.

In Guinea, Sierra Leone and Liberia, the collapse of health care systems challenged the provision of maternal and newborn care and the management of acute malnutrition. The disruption of health services means that many children were not receiving life-saving vaccinations, or treatment for preventable but potentially fatal common childhood illnesses such as malaria, pneumonia and diarrhea. The Ebola outbreak also shut down schools, or kept them closed for long period of time, and this may have long term effects on education.

This is the first time an Ebola outbreak of this size has been experienced in West Africa. Previous outbreaks have been relatively limited. The current outbreak however, has presented several unique challenges:

- Late recognition of the outbreak: although the first recorded cases were identified as early as November and December 2013, the recognition of EVD by the authorities in Guinea came very late. It was only in March 2014 that the Ebola epidemic was finally

officially declared by the authorities and in August 2014 when WHO declared that Ebola had become an international threat.

- Lack of familiarity: affected communities and government/health services had not experienced the disease previously, were unfamiliar with the complexities of dealing with Ebola and did not have the appropriate equipment, facilities and procedures for treatment and care.
- Fear and Stigma: fear, stigma and misperceptions about the disease hindered effective action in many areas, both urban and rural. In some locations, social mobilization teams and health workers were attacked and people were afraid to seek care in the health facilities.
- Poor hygiene and sanitation practices, unsafe burial practices and lack of early isolation and care facilitated the spread of the disease.
- Location: the outbreak started in an area where three countries border each other, giving rise to regional coordination challenges, including the application of infection, prevention and control measures.
- Mobility: the porous nature of the borders of the countries involved, regional trade, interconnectedness of families and fluid population movement both within and between the affected countries also facilitated its rapid geographical spread.

Coordination was a challenge. The Ebola response included more than 200 responding organizations, specifically (a) National Governments of the affected countries; (b) Local Government entities; (c) UNMEER; (d) Various UN organization, including WHO, UNFPA, UNDP, WFP, IOM, FAO and others; (e) Government agencies and armed forces from several OECD countries (f) Various chapters of MSF; (g) IFRC / ICRC; (h) scientific groups; and other national and international NGOs.



Coordination was informed by several frameworks. The UNMEER strategic framework envisioned that, under National Government leadership, a well-directed and networked system of coordination built around professional teams would be assembled at district level, encouraging community ownership and provision of services to locations that needed the interventions. In practice, a variety of coordination mechanisms were set up.

The UNICEF response plan was documented in the Humanitarian Action for Children, and accessible through the UNICEF internet site (please see URL in box below). Specifically, the priority areas were:

Priority areas of the UNICEF response (HAC September 2014–June 2015)

- a) Social Mobilization /Communication for Development
- b) Case management with a focus on community care and infection prevention and control
- c) Child protection including psychosocial support, family tracing and reunification and alternative care for separated and unaccompanied children
- d) Provision of Personal Protective Equipment and other supplies for Ebola response
- e) Access to essential medicines, health services and medical supplies
- f) Infant and Young Child Feeding
- g) Access to safe water and hand-washing
- h) Continuity of education through innovative approaches to learning
- i) Provision of non-food items
- j) Continuity of HIV prevention and treatment services
- k) Ebola preparedness and prevention activities

The longer-term consequences of the disease outbreak are unknown and are yet to emerge. There is a risk of a food security and nutrition crisis given the lack of agricultural activity during the peak of the crisis. UNDP has recently been leading an Early Recovery Assessment with the World Bank and the European Commission, in which UNICEF has led one of four working groups on infrastructure and basic services. The outbreak is not yet over and risks remain. Discussions about recovery are on-going.

A meeting of UNICEF senior managers was held in February 2015 to draw out lessons learned in relation to the response, highlighting many areas for improvement: some specifically related to the novel challenges raised by the crisis, others concerned recurring organisational systems issues that have been raised in reviews and evaluations of UNICEF humanitarian action.

4.2. PURPOSE AND OBJECTIVES

The purpose of the evaluation is to provide an impartial assessment of UNICEF's response to the needs of the affected populations and other challenges arising from the Ebola outbreak in West Africa. The results of the evaluation are intended to inform action by UNICEF, UNICEF's partners and other stakeholders not only in addressing the current emergency but also in responding to future large scale emergencies of a similar nature; and to prepare for recovery and reconstruction in the affected countries. The evaluation will assess how the UNICEF response has been appropriate and effective in addressing this extraordinary emergency, taking into account the unprecedented nature of the crisis. It will consider how far the response has been conducted in an efficient, timely and cost conscious way while responding to the shifting parameters of the crisis. The evaluation will not be able to address issues of impact and sustainability but will consider whether the response has established readiness to manage the risk of any resurgence of



the outbreak or possible future outbreaks and how far it has prepared the ground for recovery and reconstruction. The evaluation will review the coherence and coverage of the UNICEF response, the partnerships put in place as well as its management and internal and external coordination. The evaluation will assess how far the response took considerations of equity and gender equality as well as the UNICEF Core Commitments to Children.

The evaluation is intended to support both accountability and learning. Accountability is important, given the very substantial human and financial resources UNICEF has allocated to the emergency including the high volume of funding received by UNICEF to address the EVD outbreak. The evaluation results should help to show how far these resources have been used appropriately, efficiently and to good effect, with particular regard to the situation of children. The evaluation will also consider accountability to the affected population. The conclusions of the evaluation should clearly identify challenges and success factors to support the learning of function of the evaluation.

However, the learning aspect is particularly important, given that many elements of the current emergency were unprecedented. The evaluation results are intended to inform key aspects of UNICEF strategy, systems, procedures and actions not only with regard to the current emergency and the recovery phase already beginning, but also in addressing future large scale emergencies characterised by the technical, operational, humanitarian and ethical challenges posed by the Ebola emergency. UNICEF is already considering how best to anticipate and organise future responses to emergencies which may have similar characteristics and the evaluation is intended to support these reflections and reactions.

The evaluation will therefore include both summative and formative dimensions. The summative element will review plans and performance to date, in order to provide impartial evidence on how UNICEF has

responded to the emergency. The formative and forward-looking element is intended to contribute to improving UNICEF's response to the current emergency and recovery as well as learning lessons for application in future emergencies, where appropriate. The evaluation will also consider how far lessons learned from previous emergencies have been relevant and applied in the current response.

At the country level, the evaluation is intended to help UNICEF consider and understand which aspects of the UNICEF response have been working well, which aspects have been working less well, and why, in terms of the specific objectives of the various planning documents and in relation to established principles such as the Core Commitments to Children (CCCs) and existing guidelines and standards.⁴ Attention will also be given to assessing how far such guidelines and standards were themselves relevant and appropriate, given the unprecedented character of the emergency.

At the regional and global level, the evaluation is intended to inform, as appropriate, adjustment of UNICEF's CEAP5 and the associated Simplified Standard Operating Procedures (SSOPs) supporting the response to Level 3 corporate emergencies. The evaluation should also provide lessons on multi-country management of L3 emergencies. Throughout, UNICEF has worked closely with a range of local, national, regional and global partners. The evidence and analysis provided by this evaluation will also inform UNICEF's partners in national and local government, civil society partners and sister agencies in the UN. The evaluation will therefore have a strong utilisation focus.

The main users of the evaluation will be UNICEF country offices, the Regional Office management, and Divisions and Offices in HQ. Other users of this evaluation are expected to include national partners, other UN entities, implementation partners, donors and the UNICEF National Committees who contributed resources and support. It will also be important



to provide feedback to affected people, especially those in any way directly involved in the evaluation.

4.3. SCOPE

The outbreak was much more than a health emergency. It affected all aspects of life in the West African countries concerned and, for a period, seemed to be threatening global social and economic chaos. A wide range of interventions at all levels was launched to address the crisis. National governments responded through a multitude of interventions. A wide range of external agencies intervened in the crisis according to their mandates and the UN Secretary General established UNMEER to coordinate the response across the UN agencies involved. UNICEF was assigned specific roles within this wider set of agencies, which nonetheless influenced and constrained UNICEF's scope for action. The UNICEF response should necessarily be seen in this wider context⁴.

However, the evaluation will not attempt a comprehensive assessment. Rather than analysing these wider contextual issues in detail, this evaluation will focus closely on key roles and actions carried forward by UNICEF. It will be important that the scope of the evaluation remain limited if the key issues are to be assessed in adequate depth. Also, many other reviews and analyses have been completed or are under way at each level. This evaluation should draw on these studies, avoid duplication of effort and, importantly, must avoid taking the time of people involved at all levels, including local communities, where this is not useful or necessary.

The scope of the evaluation is therefore defined as follows:

Programmatic focus: the “priority areas” of the UNICEF response were set out in the HAC September 2014–June 2015 are presented in the Background Section of this ToR. Of these, UNICEF gave particular attention to the following and, while the multi-sectorial nature of the response needs to be acknowledged⁵, these areas will therefore be the main programme focus for the evaluation:

- Communication for Development/social mobilisation and community engagement;
- Case management with a focus on community care (including Community Care Centres (CCCs) and infection prevention and control);
- Child protection including psychosocial support, family tracing and reunification and alternative care for separated and unaccompanied children;
- Ebola prevention and control activities; and preparedness, resilience and early recovery.

In addition to the priority areas listed in the background section of this ToR, UNICEF gave close attention to internal coordination; human resource deployment and management; to public information, communications and reporting; partnerships and coordination, including working with governments in the affected countries; and resource mobilisation and management. The evaluation will consider these important operational areas in relation to the analysis of the priority results areas, with

⁴ A partial list of the evolving planning documents is as follows: UNICEF Ebola Regional Response Strategy, which was in-line with the UN Inter-agency Strategic Framework for Ebola; UNICEF Ebola Preparedness Strategy; UNICEF Humanitarian Appeal for Children 2014/Ebola Section; UNICEF Humanitarian Appeal for Children (2014-2015)/Ebola Section; UNICEF Programme Strategy documents, specifically those on Child Protection; Social Mobilization; Community Care Centres; and Communication for Development (C4D). The evolving planning documents were also influenced by the UNMEER strategic framework, Framework for Global Response to the Ebola Outbreak in West Africa and the WHO Road Map on Ebola.

⁵ UNICEF engaged and innovated strongly and successfully in the area of supply (logistics), where the response was UNICEF's biggest ever supply operation; WASH, including waste management; and nutrition, which was closely linked to other interventions. In developing the design of the evaluation, it will be important to recognize these and other UNICEF contributions, without losing the programme focus outlined above.



a view to determining how far achievements were supported or constrained by operational factors. Particular attention will be given to the following:

- Internal coordination and reporting lines, in particular the differing roles of the Global Emergency Coordinator (GEC) and the Regional Director, and the role of the Ebola Cell at HQ.
- Human resource mobilisation, deployment and management, including the special provisions made for this emergency.
- Financial resource mobilization and management, including use of CERF funds.
- Focus on the intervention strategy: As noted above, the outbreak was unusual in key respects, including the rapid and unpredictable spread of infection. This required UNICEF to adjust and re-prioritise its approach. Priority was given to case management and stopping the spread of the disease, which carried implications for the focus of effort, management of resources and the sequencing of the programmatic interventions listed above. The evaluation will therefore give close attention to the strategic decision making process, including context and consequences, and consider the implications for UNICEF's future work, including its procedures and standards.
- Geographic focus: The evaluation will focus mainly on the three countries most affected by the outbreak: Guinea, Sierra Leone and Liberia⁶.
- Institutional scope: The evaluation will focus on the UNICEF response. However, as noted, this needs to be set within the wider framework of governments and agencies involved and analysis of roles, responsibilities and expectations. Within

UNICEF, the evaluation will look not only at the work of the country offices but will look at the regional and global roles, responsibilities and actions including how far the CEAP and the SSOPs for Level 3 emergencies have worked effectively. Attention should be given to how the L3 procedures have been understood and used at HQ, regional and country level respectively.

- Resources: While the evaluation will give priority to the programmatic issues noted above, close attention will also be given to human and financial resources as factors supporting or constraining programme efficiency and effectiveness. The evaluation will consider issues of human and financial resource mobilisation, deployment and management, including the consequences of draining resources from other programmes and emergencies.

UNICEF is committed to reviewing the effectiveness, efficiency and timeliness of utilization of funds provided by the Central Emergency Response Fund (CERF). CERF funds were utilized by UNICEF in its Ebola response and attention will therefore be given to CERF funding within the wider context of fund mobilization and use.

Time frame: The evaluation will consider the entire span of the outbreak from the beginning of 2014 to the present, giving particular attention to the period from the declaration of the Level 3 emergency in August 2014.

4.4. EVALUATION QUESTIONS

As indicated above, the evaluation will be framed by the usual OECD/DAC evaluation criteria of relevance, efficiency and effectiveness as well as issues of coherence, coverage, and coordination. Issues of preparedness, risk management and connection to future requirements provide a further set of lenses as well

⁶ Although the three most affected countries will be the primary focus, the evaluation also needs to consider the considerable efforts and resources went into prevention and preparedness activities in a number of other countries.



as responsiveness to issues of equity, gender equality and children's rights. The evaluation questions below based on the criteria listed here represent a provisional list of questions to be refined by the evaluation team in the scoping and inception phase of the evaluation process.

Relevance/Appropriateness:

- How appropriate has the UNICEF response been, given the extraordinary and shifting profile of the emergency?
- Were the strategic, programmatic and partnership priorities appropriate? How far was it possible to reconcile the "stop Ebola" imperative with the UNICEF core commitments to children (CCCs)?
- Were needs assessment and analysis sufficient and were appropriate, feasible and measurable targets set out in response plans?
- How closely aligned were UNICEF's response plans with the plans of national governments and UNMEER?
- Has the UNICEF response been aligned with key sources of guidance and normative standards, including the Core Commitments to Children (CCCs), and what has been the rationale for any variance?
- Were lessons learned from previous emergencies relevant and useful? In what ways has the affected population been involved in the design, implementation and monitoring of UNICEF's response?
- How appropriate was the support provided by UNICEF HQ and the Regional Office in meeting the needs of the country offices?
- Finally, was sufficient attention given to other risks, such as resurgence of malaria or the potential for a cholera outbreak?

Efficiency:

- How well have UNICEF's resources, both human and financial, been managed to ensure the most timely, cost-effective and efficient response to the outbreak?
- How quickly was the CEAP activated, and how clearly have the SSOPs for Level 3 been communicated at various levels of the organization, and to what degree have they impacted the efficiency of the response?
- To what extent has investment prior to the outbreak resulted in emergency preparedness and a more timely, cost-effective and efficient response?
- To what extent have innovative or alternative modes of delivering on the response been explored and exploited to reduce costs and maximize effectiveness?
- What has constrained the efficiency of the response?
- With regard to CERF grants, the evaluation should assess the following: How effective, efficient and timely were allocations and expenditures against CERF grants?
- Were adequate and timely proposals established to request for CERF funds?
- To which programmatic areas were the funds allocated and how far did they support programme achievements?
- Present any evidence that CERF grants saved lives, including time frame involved. (Please refer to <http://www.unocha.org/cerf/about-us/humanitarian-financing> for objectives and additional information on CERF grants)^{7,8}

⁷ Please refer to <http://www.unocha.org/cerf/about-us/humanitarian-financing> for objectives and additional information on CERF grants. Amount of 2014 CERF funds received for the response, and allocation to UNICEF can be viewed through following links:
For Guinea: <http://www.unocha.org/cerf/cerf-worldwide/where-we-work/gin-2014>
For Liberia: <http://www.unocha.org/cerf/cerf-worldwide/where-we-work/lbr-2014>
For Sierra Leone: <http://www.unocha.org/cerf/cerf-worldwide/where-we-work/sle-2014>

**Effectiveness:**

- How successful has UNICEF been in achieving the aims set out in programmatic and operational commitments? What factors contributed to success and what factors constrained UNICEF efforts? To what extent are the results achieved attributable to UNICEF?
- Were affected communities satisfied that their needs and expectations were adequately acknowledged and addressed?
- Were the results achieved broadly equitable and were the needs of children and women adequately met?
- How far has the organization-wide mobilization under the CEAP and the SSOPs for Level 3 supported UNICEF's response and impacted its effectiveness?
- Were UNICEF systems and procedures adequate to assess and address needs?

Coverage:

- To what extent was the affected population adequately identified, targeted and reached by UNICEF and its partners across the three most affected countries, taking into account the dynamic and volatile nature of the outbreak?
- How successful has UNICEF been in reaching the most vulnerable groups, including children? Have data been disaggregated by sex, age and location?

Coordination:

- How effectively and efficiently has UNICEF fulfilled its sectoral leadership obligations?
- How effectively has UNICEF coordinated its response with other key actors in the initial phase of the response and in the transition to early recovery, taking account of the varied and shifting frameworks for coordination?

- Internally, how effective, efficient and timely has coordination between the various levels within UNICEF been, in the light of the Level 3 requirements?
- What lessons can be drawn from the establishment of the Ebola Unit at HQ?

Monitoring and reporting:

- To what extent has monitoring and reporting met UNICEF's needs at each level of the organization, and the needs of UNICEF's partners and stakeholders?
- Were the indicators set out in response plans appropriate and measurable?
- How far has monitoring and reporting been undertaken efficiently and effectively and in turn how far has it contributed to the efficiency and effectiveness of the various aspects of the response?

4.5. METHODOLOGY AND APPROACH

The evaluation will build as far as possible on existing information and analysis, including the results of the UNICEF Lessons Learned exercise. It will take a consultative approach, while being sensitive to the continuing burden on all involved in the response, including the population in the communities affected. While recognizing the constraints of time and resources, the evaluation process will aim to be systematic and evidence-based, taking care to triangulate and verify data and analysis at each step. It will employ mixed methods, using both qualitative and quantitative data. The evaluation will be focused on utilisation and will aim to engage stakeholders at key moments in the process and generate material in user-friendly formats.

Phase 1: Scoping and Inception Phase (October – November 2015) – During the first phase of the evaluation, the Evaluation Team will conduct a rapid desk review of key qualitative and quantitative data and critical information available from country offices, the Regional Office and HQ as well as documents, data and reports from



other stakeholders. Interviews with key informants will be conducted to provide orientation. These methods will establish a clear chronology and a broad overview of the response to the outbreak, as well as a framework on priority issues and questions for further examination. The main output of the scoping and inception phase will be an Inception Report, to be approved by the Evaluation Office in consultation with the in-house Reference Groups (see section on Management and Governance Arrangements below).

Phase 2: Structured Field Work (November 2015 - January 2016) – In the second phase, the evaluation team will visit Guinea, Sierra Leone and Liberia as well as the Regional Office in Dakar to collect further qualitative and quantitative data in a structured manner, undertaking key informant interviews and focus group discussions with UNICEF staff, national officials and members of the affected population, as well as staff of partner agencies and donor officials. In this phase, the team will also extend the collection of documentary evidence, to provide the basis for a formal desk review using data collection tools to code, organize and analyse the information. The evaluation team will share an aide memoire and/or powerpoint presentation of emerging findings with the UNICEF offices visited. Efforts should be made to provide feedback to members of the affected population consulted in the course of the evaluation.

Phase 3: Report Preparation (January – March) – This phase of the evaluation will include the preparation of a final report, based on systematic, impartial analysis of the information gathered in Phase 1 and 2. The expected output will be a concise assessment of the UNICEF response to the emergency, presenting conclusions and SMART recommendations. The final report shall contain an executive summary of up to 2,000 words and a main text of no more than 10,000 words (excluding annexes Annexes).

Phase 4: Dissemination (April 2016) – A series of well-facilitated participatory workshops would be conducted with the country offices,

regional office and UNICEF's key partners. The aim of these participatory workshops is to promote maximum utilization of the evaluation results. Thus, further visits to Guinea, Sierra Leone, Liberia and Regional Office will be made to communicate the findings, conclusions and recommendations of the evaluation and to facilitate strategic reflection on response and uptake of useful lessons and recommendations. Ways of providing feedback to members of the affected population should also be found. A final dissemination workshop would be held in New York and/or Geneva to share the results of the evaluation.

4.6. MANAGEMENT AND GOVERNANCE ARRANGEMENTS

In keeping with the corporate nature of the UNICEF response, the Evaluation Office will manage the evaluation, in close collaboration with the country offices, the Regional Office, the Ebola Unit and other HQ Divisions concerned. An evaluation Manager will lead the process, under the guidance of the Evaluation Office Director. The Evaluation Office will commission a team of external consultants to undertake the evaluation, and provide overall management of the evaluation process.

The Emergency Management Team will serve as a Reference Group for the evaluation to strengthen the relevance, accuracy and hence credibility and utility of the evaluation. This is an advisory role, the main responsibility being to review and comment on key evaluation outputs (i.e. this TOR, the Inception Report, reports on emerging findings and the Draft and Final Reports). Final decisions on the evaluation process and quality assurance of outputs rests with the Evaluation Office. Separately, at country level, it will be helpful to establish an evaluation working group in each country including membership from the national authorities and UNICEF's key partners to provide inputs and consider emerging findings and the final report (see Dissemination section above). A UNICEF



Team Site will be set up for the evaluation to post regular updates, promote collaboration and ensure transparency.

4.7. DELIVERABLES AND TIMEFRAME

The evaluation team will generate the following major outputs that will be reviewed by the Evaluation Office and the EMT and approved by the Evaluation Office before being disseminated more widely. These include:

- An Inception Report of maximum 8,000 words (not including annexes). The Inception Report is intended to outline the team understanding of the UNICEF response to the emergency at the country, regional and global levels. It will include a clear chronology and a broad overview of the initial response to the emergency as well as a framework presenting priority issues and questions for further examination. It will also include a data collection tool-kit (i.e., interview guides, focus group

discussion guides, direct observation forms, questionnaires for consultations with affected populations, and so on) to be used in the course of the evaluation;

- Aide memoire and/or Power-point Presentations that will be used by the evaluation Team to present the preliminary findings in participatory workshops to partners at country level;
- A draft evaluation Report that outlines clear evidence-based findings, conclusions and SMART recommendations, with a clear Executive Summary, for consideration by the EMT;
- A Final evaluation Report of no more than 10,000 words (plus Annexes), with a clear Executive Summary of no more than 2,000 words. This will address as appropriate comments on the draft report.

The evaluation will be undertaken over a period of six months from October 2015 to April 2016, as laid out in the table below.

Indicative Timeline

Step	End Date
1. Recruit evaluation Team (EO)	October
2. Commence Phase 1, including data collection and data analysis (Evaluation Team)	October - November
3. Produce Phase 1 outputs, including Inception Report for comment and data collection tool-kit (Evaluation Team)	November
4. Commence Phase 2	November
5. Produce first aide memoire / conduct validation workshops at conclusion of country visits (Evaluation Team)	Dec. 2015 – Jan. 2016
6. Produce first Draft Evaluation Report for comment by EO (Evaluation Team)	Jan. 2016
7. Produce second Draft Evaluation Report for comment by EMT (Evaluation Team)	Feb. 2016
8. Finalize Evaluation Report for management response and publication (EO/Evaluation Team)	March 2016
9. Dissemination workshops Dakar, Guinea, Sierra Leone, Liberia (EO/Evaluation Team)	April 2016
10. Dissemination workshop NYHQ/GVA (EO/Evaluation Team)	April 2016



- With respect to steps six to eight above, please note that each draft of report produced will need to be first quality checked and cleared by the Evaluation Office; after which it will be quality checked and cleared by the Reference Group before it is disseminated to relevant stakeholders for comments and feedback.

4.8. EVALUATION TEAM

UNICEF will hire a team of external consultants to conduct the evaluation, comprising:

- a) A senior team leader with extensive evaluation experience in humanitarian approaches and programmes, including experience in public health. The team leader should have at least 12 years of experience in leading evaluations and excellent writing and communication skills in French and English.
- b) Three senior consultants with the following range of competences:
 - i. familiarity with UNICEF emergency operations
 - ii. experience and knowledge of approaches to community care, including infection prevention and control
 - iii. familiarity with methods and approaches to C4D including social mobilisation and community engagement
 - iv. experience and knowledge of approaches to child protection in emergencies
 - v. ability to undertake back-office analysis (e.g., desk review, analysis of timeline data, analysis of funding resources, etc.)
 - vi. knowledge of evaluation methods
 - vii. sound knowledge of English and French
- c) A national consultant with comprehensive knowledge of at least one of the countries affected by Ebola, and familiar with participatory methods and techniques to promote consultations with affected population. The

national consultant must be from the West African region or originate from there; but preferably from an Ebola affected country.

The team leader will work on the evaluation full time from start to finish, and in a timely and high-quality manner. S/He will be responsible for managing and leading the evaluation Team, undertaking the data collection from UNICEF and available sources; analysis, conducting the participatory workshops, as well as report drafting, report finalization and dissemination. The other team members will be responsible for carrying out data collection from UNICEF and available sources, analysis, and drafting elements of the report. A gender balanced team is encouraged.

4.9. TO BE READ WITH RFPS-USA-2015-502087

- A. We estimate that the evaluation can be duly executed by a team of 4-5 evaluators/consultants with the right mix of skills and expertise. However, bidders have the right to vary the team size, with proper justification for allocation of work and cost. To that end, this contract will be offered under institutional arrangements. This section presents guidelines for submission.
- B. Background Information: Bidders are required provide to background information about their institutions as follows:
 - Date and country of incorporation
 - Summary of corporate structure and business areas
 - Corporate directions and experience
 - Location of offices or agents relevant to this proposal
 - Number and type of employees
 - Financial statements of the two most recent financial years
- C. Institutional expertise and experience: Bidders are required to provide a minimum of two (2) references from clients for whom



evaluations, or related projects of a similar scope of were carried out. Reference information should be organized as follows:

- Name and description of client company/organisation
- Names of senior individuals in the client companies who were involved in projects (referred to) who are knowledgeable
- Scope and scale of projects
- Services provided to client

UNICEF may contact referees for feedback on services provided to them by bidders.

D. The bidder should submit at least two sample reports of evaluations undertaken by the team leader (or links where the reports can be found on the internet). Preferably, these evaluations should be evaluations undertaken in a large scale emergency context.

E. Technical Proposal - General issues:

- The technical proposal should emphasize the conceptual thinking and methods proposed for the evaluation, and minimize repeating information stated in this TOR document.
- The methodology should stipulate, as clearly as possible, questions that will be explored at the different levels, global, regional and country level. The methodology should also present the mix of qualitative and quantitative analysis to be used.
- There is no minimum or maximum length for the technical proposal. However, sufficient detail and clarity are required.
- The proposal should stipulate the level of effort to be committed by the different team members in each work phase (inception, document review, field-based data collection and reporting). The same information should be featured in the financial proposal, associated cost data.

- Bidders may be asked to provide additional information at the proposal assessment stage.

F. Technical Proposal - Specific requirements: In addition to whatever other approaches and methods are proposed, the following specific items must be present in the technical proposal:

- The methodology should include a description of the key components including an approach for field-based data collection and incorporation of secondary data, an approach to incorporate data from the developmental evaluation, sampling criteria, as well as evaluation criteria for normative questions;
- CVs for team members, highlighting experiences that are relevant to the evaluation under consideration;
- Basic information about the organization submitting the bid including, the organization's evaluation profile, highlighting the organization's experience with the UN and UNICEF;
- Requirements and /or assurances (e.g. non-use of child labor) must also accompany the submission package; and,
- A declaration for intended participation of any former UNICEF staff.

G. While all contents of the technical proposal are important, special attention will be paid to the composition and strength of the proposed evaluation team, and the rigor of the proposed methodology and work plan. These two elements account for 70 percent of the points awarded for the technical proposal as indicated on page 9 of the RFPS document. The proposer's capacity and sample report will account for the remaining 30 percent.

H. Cost Proposal - General issues

- Bidders must submit a firm-fixed price bid⁹, in US Dollars.



- The quotation will not be subject to revision unless officially invited to re-submit by UNICEF.
- All prices/rates quoted must be exclusive of all taxes as UNICEF is a tax-exempt organization
- Bidders will suggest a payment schedule, linked unambiguously to contract milestones.
- Invoicing and payment will be effected by bank transfer, in US Dollars.

Budget categories and details

I. The budget should be presented in three categories: personnel costs, project costs, and overhead costs (in the case of institutional submissions). Sub-headings within the categories may be done at bidder's discretion.

- **Personnel Costs:** These should include classification (i.e. job title/function) and rates for team members; duration of work for each. This information may be contained within a table showing expected level of effort per team member, by phase. The level of effort must be visible in both the technical and the financial proposals, albeit without associated cost in the technical proposal.
- **Evaluation costs:** These should include cost of travel, including subsistence allowances, travel by air, train, road, etc., telecommunication and miscellaneous expenses. Travel to selected destinations will be on a cost-reimbursable basis. This is the sole budget component that will be charged this way; other elements will be firm-fixed price. Travel costs and subsistence rates (lodging, food, local transport, and incidentals) will be based on the lower of the rates proposed by the bidder, or the official and prevailing United Nations rates. Bidders are encouraged to submit economical travel and subsistence costs.

- **Overhead costs:** In the case of institutional contracts, general and administrative costs should include institutional overhead and fee/profit over and above overhead. Otherwise, the cost proposal must include detailed item-wise quotations, based on the terms of reference and other relevant documents.

Experience has shown that bidders often submit data using their own cost rubrics and not according to the three categories described next. This is acceptable, as long as the proposed clustering into the three headings is reflected in the cost summary.

J. **Specific requirements:** In addition to whatever other approaches and methods are proposed, the following specific items must be present in the cost proposal:

- Presentation of a work plan in four work phases (inception, document review, field-based data collection and reporting),
- The level of effort for all team members as was reflected in technical proposal, repeated in the financial proposal with costs.
- All costs will be fixed, except for travel to selected destinations, which will be on a cost-reimbursable basis.
- A payment schedule, linked unambiguously to contract milestones.

Awarding the contract and payment

K. UNICEF will award the contract after considering both technical and cost factors, on the principle of best value-for-money. Payment will be made only upon UNICEF's acceptance of the work performed in accordance with agreed schedule of payment and/or contract milestones. The terms of payment are net 30 days, after receipt of invoice and acceptance of work. Where the need arises, earlier payment may be negotiated between UNICEF and the contracted institution, on the terms indicated in the RFPS.



ANNEX 2. METHODOLOGY REPORT

This annex presents a detailed report of the methodology used for data collection and analysis.

INCEPTION

During the inception stage, a scoping exercise was conducted to sharpen the focus of the evaluation and maximize its utility. To that end, a selection of key users was consulted (see Table 3 of this Annex) at HQ and RO levels. Due to end of year demands, CO actors were not available to participate. During the exercise, informants highlighted key issues to address in the evaluation.

Given the large number of actors involved in the response, a stakeholder analysis was conducted at the inception phase. Reflecting

on the stakeholders and their ‘stakes’ in the response, three primary stakeholder groups were constructed: (i) Governance actors, the international actors at UNICEF’s headquarters and RO levels with a formal governance/oversight stake in the Ebola response; (ii) Implementation actors, UNICEF’s national and sub-national level actors, who were responsible for delivering programmes according to the HAC; and (iii) Affected population, all people affected by the Ebola outbreak in West Africa, who were concerned with prevention of Ebola, care for people infected, halting the outbreak, preparedness and prevention, and maintaining or rebuilding key services.

ANNEX 2: Table 1: Key stakeholders in UNICEF’s response

	Who are they?	What stake/s in response?
Governance actors (GA)	<ul style="list-style-type: none"> • ED, key advisers • GEC, EMT, Ebola Cell • RD, DRD, WCARO • EMOPS, PD, SD • Finance, HR, PPD, etc. 	<ul style="list-style-type: none"> • Leadership: strategic, coordination, institutional accountability • Programming: Policy, standards, guidance • Operational: support, resources, capacity • Regional-level coordination, guidance, support
Implementation actors (IA)	<ul style="list-style-type: none"> • CO Liberia • CO Sierra Leone • CO Guinea • Implementing partners • Strategic partners 	<ul style="list-style-type: none"> • National and sub-national leadership, coordination, programmes and operations • Direct implementation of UNICEF programmes • Strategic coordination with UNICEF to achieve results
Affected population (AP)	<ul style="list-style-type: none"> • Intended beneficiaries • Communities most affected by Ebola: incl. CSOs, leaders, key informants, anthropologists • National representatives, government and civil society 	<ul style="list-style-type: none"> • Prevention and care • Preparedness and prevention • Services maintained / rebuilt • Protection from secondary effects



Based on the analysis, a purposive sampling strategy⁸ was developed to ensure stakeholders were consulted in a structured manner, including the right numbers of the right people to meet evaluation objectives. The following table (Table 2) outlines the sampling strategy, with a definition of the population and

proposed sample selection criteria for each stakeholder group, followed by approaches to stratification and inclusion, and a proposed sample size. The samples are criteria-based purposive samples⁹ and not intended to be randomized or probability-based.

ANNEX 2: Table 2: Stakeholder consultation, purposive sampling strategies

Stakeholder group	Entire population	Selection criteria	Stratification	Inclusion strategy	Expected number to be consulted
Governance actors (GA)	Actors responsible for overseeing UNICEF response at HQ/RO levels	Direct involvement in oversight of response	<ul style="list-style-type: none"> • leadership • programming • operational 	Those remaining in position and those who have moved on.	20-25 HQ 20-25 RO Total: 40-60
Implementation actors (IA)	Actors responsible for implementing UNICEF response at national and sub-national levels	Direct involvement in managing response	<ul style="list-style-type: none"> • leadership • programmes • operational • implementing actors or partners • strategic partners 	Those remaining in position and those who have moved on.	20-25 S.Leone 20-25 Liberia 20-25 Guinea Total: 60-75
Affected population (AP)	Population affected and leaders, intended beneficiaries	National political and civil leaders vocal on Ebola	<ul style="list-style-type: none"> • political • religious • private sector • women and children groups • Ebola survivors 	Include: <ul style="list-style-type: none"> • men, • women, • young people 	5-10 leaders in each country Total: 15-30
		Communities most affected and most targeted by UNICEF	<ul style="list-style-type: none"> • rural/urban • time affected • other (tbd) 	Include: <ul style="list-style-type: none"> • survivors, • contacts • community groups (CBOs), • local leaders, • children and young people, • male and female • UNICEF and partner staff. 	10-15 key informants per community / case study N = 60-135
					Total: 175-300

⁸ See Better Evaluation, 'Sample,' accessed 25 June 2015 from: <http://betterevaluation.org/plan/describe/sample>

⁹ See Better Evaluation, 'Sample,' accessed 25 June 2015 from: <http://betterevaluation.org/plan/describe/sample>



FRAMEWORK

During the inception phase an evaluation framework, evaluation questions, and an evaluation matrix were developed. The evaluation framework was derived from criteria based on the OECD/DAC criteria¹⁰ and ALNAP’s guidance:¹¹ effectiveness, efficiency, coordination, relevance and coherence (see Table 3). The

evaluation questions were derived from these criteria, and translated into five key evaluation questions (KEQs) and 29 sub questions. The evaluation matrix defined how data collection and analysis would be conducted for each key evaluation question and sub-question (see Table 6), and served as a tool to guide data collection and analysis.

ANNEX 2: Table 3: Evaluation criteria

Evaluation criteria	Definitions
Effectiveness	<i>Effectiveness measures the extent to which an activity achieves its purpose, or whether this can be expected to happen on the basis of the outputs. Implicit within the criterion of effectiveness is timeliness. (...) attempt to determine why the intervention has or has not achieved its objectives. (ALNAP 2006)</i>
Efficiency	<i>Efficiency measures the outputs – qualitative and quantitative – in relation to the inputs. It is an economic term which signifies that the aid uses the least costly resources possible in order to achieve the desired results. This generally requires comparing alternative approaches to achieving the same outputs, to see whether the most efficient process has been adopted. (OECD/DAC)</i>
Coordination	<i>[C]oordination is an important consideration in the evaluation of humanitarian action (...) defined as: ‘the systematic use of policy instruments to deliver humanitarian assistance in a cohesive and effective manner. Such instruments include strategic planning, gathering data and managing information, mobilising resources and ensuring accountability, orchestrating a functional division of labour, negotiating and maintaining a serviceable framework with host political authorities and providing leadership’ (Minear et al, 1992). (ALNAP 2006)</i>
Relevance	<i>Relevance is concerned with assessing whether the project is in line with local needs and priorities (as well as donor policy). Appropriateness is the tailoring of humanitarian activities to local needs, increasing ownership, accountability and cost-effectiveness accordingly. (ALNAP 2006)</i>
Coherence	<i>The need to assess security, developmental, trade and military policies as well as humanitarian policies, to ensure that there is consistency and, in particular, that all policies take into account humanitarian and human-rights considerations. (...) why was coherence lacking or present; what were the particular political factors that led to coherence or its lack. (ALNAP 2006)</i>

¹⁰ OECD/DAC, DAC Criteria for Evaluating Development Assistance, (www.oecd.org/dac)

¹¹ ALNAP, Evaluating humanitarian action using the OECD-DAC criteria: An ALNAP guide for humanitarian agencies (Overseas Development Institute, London, March 2006); accessible at: [file:///C:/Users/User/Downloads/eha_2006%20\(2\).pdf](file:///C:/Users/User/Downloads/eha_2006%20(2).pdf)



MIXED METHODS

Data collection and analysis was conducted according to a mixed methods approach. Data collection relied on both qualitative and quantitative techniques: (i) a lessons review; (ii) a document review; (iii) data analysis; (iv) stakeholder consultations; (v) stakeholder polling; and (vi) case studies of communities affected. Detailed analyses were conducted for each document review, lessons review, data analysis, and stakeholder consultations with HQ actors, RO actors, CO actors and affected populations in Guinea, Liberia, and Sierra Leone. Before drafting the report, a synthesis analysis brought all these analyses together for each sub question, and team-based deliberations and assessments were conducted for each question.

Data analysis: Quantitative analyses of data were conducted, including financial data, monitoring data on results and timeliness, and data about resources used (VISION). Analysis of costs was limited by difficulties in using VISION to link resource inputs to results achieved, by gaps in evidence collected, and by a lack of mechanisms for monitoring cost-effectiveness.

Lessons review: A review was conducted of UNICEF internal lessons learned documents and external review documents (see Table 7). To maximize the value of learning exercises, efforts were made to integrate lessons learning into design and data collection stages of the evaluation as well as analysis. A synthesis of lessons learned was prepared and shared with the reference group and team members before data collection.

Document review: Additional document reviews were conducted. At the data collection phase, an initial assessment of hundreds of documents was conducted and 33 selected for detailed review (all listed in bibliography). During the analysis phase, a specific review was conducted of internal and external strategy documents to inform KEQ5.1. At the drafting stage, a further review of evidence was conducted to fill specific information gaps with information from documentation.

Stakeholder consultation: Structured consultation exercises were conducted with five stakeholder groups: HQ actors, RO actors, and CO actors (implementers) in Guinea, Liberia and Sierra Leone. This included drafting discussion guides, defining survey protocols, preparing a standard evidence matrix, developing sample frames, arranging and conducting interviews, transcribing and collating interviews, and triangulating data (to define areas of convergence). In addition, small consultations were conducted with national leaders in each country. Stakeholders consulted appear in Table 8.

In line with the strategy, a total of 367 stakeholders were consulted. These included 39 governance actors (HQ and RO), 80 implementation actors (3 COs), and 279 people affected (national leaders, and members of 6 highly-affected communities affected). Despite slightly fewer HQ respondents and slightly more implementation and strategic partners than expected, the approach allowed the evaluation to consult all stakeholders in a balanced, proportional, and structured manner.



ANNEX 2: Table 4: Stakeholders consulted

	Groups	Stratification	Comments	Totals
Governance actors	HQ	Leadership/Coordination: 5 Programmes: 5 Operations: 6	Enough of the right people. Slightly below target. Some not available, e.g. Child Protection; but contributed to scoping or in telecon debriefing. Included relevant directors, except ED. N.B emergency staff included as 'coordination'	16
	WCARO	Leadership/Coordination: 8 Programme: 10 Operations: 5	Targets achieved. Included relevant leaders. Three 'priority' programmes included, though CP came late. N.B emergency staff included as 'coordination'	23
Implementation actors	Guinea	Leadership/Coordination: 3 Programmes: 8 Operations: 7 Implementing partners: 9 Strategic partners: 3	NB numerous others from UNICEF and IPs were met at local level in addition to community members. These are not counted here but in case studies.	30
	Liberia	Leadership/Coordination: 3 Programme: 5 Operations: 4 IP: 8 SP: 4	Target achieved. More than expected implementation partners, who might lack understanding of overall strategy and coordination. Dep rep and health/CCCs manager not interviewed.	24
	Sierra Leone	Leadership/coordination: 3 Programme: 5 Operations: 3 IP: 8 SP: 7	Target achieved. More than expected implementation partners, who might lack understanding of overall strategy and coordination.	26
Affected population	Guinea	National leaders: 31		31
		Case 1. Farmoriah: 50		~50
		Case 2: Houndonin: 50		~50
	Liberia	National leaders: 7		7
		Case 3: Margibi: 30		~30
		Case 4: Duport Rd: 30		~30
Sierra Leone	National leaders: 5		5	
	Case 5. Hamilton: 44		44	
	Case 6: Masingbi: 34		34	
Total				367



Stakeholder polling: While consulting stakeholders, three ‘polling’ questions were asked to collect quantitative ratings on achievements, contributions, and internal coordination (see Table 5 below). This method included designing the survey, preparing and testing data collection tools (available upon request), defining a protocol, asking the polling questions to all respondents, tabulating polling data, analysing frequencies, preparing charts, and drawing narrative conclusions (see Annex 3 for results).

ANNEX 2: Table 5. Polling questions asked

<p>Q1. How much do you agree with these statements about UNICEF’s overall Ebola response? Note: 1=Strongly disagree / 5=Strongly Agree</p>
<p>Q2. How important a contribution did these make to stopping the outbreak? (Rate their importance on a scale of 1-5 where 5 is most important, and 1 is least important).</p>
<p>Q3. How important a contribution did these internal processes make to UNICEF’s overall achievements? [Do not ask to strategic partners] (Rate their importance on a scale of 1-5 where 5 is most important, and 1 is least important).</p>

Respondents included UNICEF staff at headquarters, regional and country levels as well as partners in the three countries (i.e. governance and implementation actors) but not affected populations. The polling method was not intended to produce representative data across respondent categories, but allow for inferences about the views of key stakeholder groups. Data are presented in an aggregate form as the number of responses by respondent group are not adequate for disaggregated analysis.

Overall, responses were received from 102 participants of 120 response actors with better response rates from Regional Office and

country-level. Therefore, polling results can be considered to over-represent the views of decentralized implementation actors compared to strategic coordination actors at HQ-level. Within the three countries, there was a slight over-representation of implementing partners in the polling results. While their understanding of UNICEF’s all-of-agency response may be limited, their perceptions are nonetheless included in the aggregate analysis. Throughout the report, polling data are presented as that percentage of respondents who either agreed or strongly agreed with a given statement. In order to convert scaled responses into percentages, numbers of responses for each integer (e.g. 1, 2, 3...) were summed and divided by the total number of respondents for the question.

FIELD WORK

Field missions were undertaken to the three affected countries and UNICEF’s regional office in Dakar, Senegal during February and March 2016. In each of the countries affected, analysts conduct consultations and polling among implementation actors and national leaders as well as case studies in two communities affected. Independent national researchers were contracted to contribute to data collection and analysis. In each mission, ongoing detailed analysis and triangulation was conducted using one evidence matrix, and preliminary findings were presented to UNICEF leadership to collect feedback and validation.

In Guinea, field work was conducted 8-26 February 2016. The evaluator received excellent cooperation and support from the UNICEF CO, in particular the Chef Section Politique Sociale, Planning et Suivi&Evaluation, the Chief of Emergencies and the Deputy Representative, the national researcher and team member, a Guinean medical doctor; and the EO’s specialist who participated in some of the fieldwork. In consulting key implementation actors, at total of 26 interview were conducted (19 UNICEF, 7 implementing partners), and 41 people



responded to the poll (with the unexpected inclusion of 15 local partners). In consulting the population affected, 31 national leaders were consulted and most of them at the community level. In two case studies, some 100 people were consulted including UNICEF, UNICEF partners, community members, children etc. Emerging findings were shared in a debriefing session at CO with the participation of around 14 staff, who shared constructive comments which were addressed in the next stage.

In Liberia, field work was conducted 13 February–3 March 2016. The evaluator received excellent cooperation and support from the UNICEF CO, in particular Senior Emergency Coordinator, the national researcher, and UNICEF Evaluation Office's specialist. In consulting key implementation actors, a total of 32 interviews were conducted (14 UNICEF, 12 implementing partners and 6 strategic partners); 17 of them responded to the polling questions. In consulting the population affected, 7 interviews were conducted with national leaders, and some 60 people^{3/4}including women, men, and children^{3/4}were consulted in two case studies. Emerging findings were presented in a debriefing session at CO with the participation of around 12 senior staff who shared constructive comments which were addressed in the following stages.

In Sierra Leone, field work was conducted 13 February–5 March 2016. The evaluator received cooperation and support from the UNICEF CO, in particular the Chief of Social Policy Planning Monitoring and Evaluation, UNICEF's EO Senior Evaluation Officer who was involved during the field work alongside the national researcher provided by a local consulting firm. In consulting key implementation actors, a total of 29 interviews were conducted (12 UNICEF, 9 implementing partners, and 18 people responded to the polling questions. In consulting the population affected, 5 interviews were conducted with national leaders, and some 76 people including women, men and children were consulted in two case studies. Emerging

findings were presented in a debriefing session at CO with the participation of around there was a large mixed group in attendance (50+). It included several heads of departments, as well as the Representative who shared constructive comments which were addressed in the following stages.

Case studies: To collect the views of affected communities we conducted 2 case studies of communities most affected in each country. This included identifying 3–5 among the most affected communities in each country, arranging visits, preparing a plan for each case study, speaking to a range of people affected within the community, conducting data collection using tool, preparing case study reports, compiling responses into the evidence matrix tool, and triangulating findings. The case studies are presented in Annex 4.

TRIANGULATION

Analysis: Evidence-based findings were developed using the following process of analysis. First, detailed findings were reached using data collected from: (i) analyses of financial, monitoring, and spending data; (ii) internal and external lessons reviews; (iii) document review; (iv) consultations with five sets of UNICEF actors; (v) three consultations with national leaders; (vi) six community case studies; and (vii) polling analysis of 102 respondents. Second, preliminary findings were shared, discussed and validated through five workshops held in the three COs, RO and with the Reference Group. Third, synthesis findings were prepared using all the detailed findings, informed by a 2-day team assessment session in Oxford (15–16 March 2016), with the participation of UNICEF's evaluation manager. Fourth, findings were drafted into report form and reviewed by the team and evaluation manager, leading to the preparation of conclusions and recommendations. Fifth, a process of comments, feedback and revision was conducted with the Reference Group.



JUDGMENT CRITERIA

Assessment: Judgments were made at two levels in this evaluation. First, judgments were made to address sub questions using criteria specified in the report and proposed in the evaluation matrix (annex). In the detailed findings of the report, these judgments are presented in each paragraph by a statement about whether or not the criterion was met, and then supported by evidence in the body of the paragraph. Second, assessments were made to address the five larger key evaluation questions using a notional five-point scale as follows: 1: Unsatisfactory; 2: Partly satisfactory; 3: Satisfactory; 4: Good; 5: Excellent. Qualitative adjectives are used to add specific meaning. At the beginning of each section of the report, these assessments are presented in an opening paragraph along with a balance of evidence from sub questions and criteria judgments. These tabulations appear in Annex 5.

LIMITATIONS

Performance: Assessment of performance, effectiveness and efficiency, is limited by the absence of a unified strategy and performance framework. UNICEF's public accountability framework is the HAC, but lacks details of how actions are intended to achieve objectives. UNICEF's regional response strategy and performance indicators offer a more detailed and formal strategy. UNICEF's programme guidance details how the response is intended to stop the transmission of Ebola. In addition, a range of other strategies remained in vigour: the WHO-led roadmap, the STEPP strategy, three national response strategies, multiple programme strategies in each country, and 3 national recovery plans.

Indicators and targets: To assess achievements (1.1) and timeliness (2.1), we relied on monitoring of performance data collected on key indicators and compared to targets. However, important limitations apply to the

use of monitoring data, indicators and targets. First, owing to challenges in the selection of indicators for performance monitoring (see 3.3), the evaluation relies on a set of 'Revised Indicators' selected post-hoc from a larger pool of indicators by UNICEF's monitoring and evaluation function. This approach is an appropriate means of understanding overall performance, but complicates performance accountability. Second, the associated performance targets pose further problems for evaluation. Despite efforts to rationalize targets in July 2015, targets include both HAC targets and Revised Indicator targets which are often misaligned, apply to some activities and not others, show frequent changes in levels set and language used, and sometimes lack time series monitoring data. It is unclear in many cases how the targets were set or exactly what they represent, and some are set very high in one country and low in another, making it difficult to assess performance comparatively. It is often unclear what portion targets represent of the larger population or category, and sometimes whether achievements are to be understood cumulatively or monthly. Comparing performance to these targets therefore says little about UNICEF's actual performance compared to the epidemiology.

Internal process: Assessment of the L3 process is limited by the nature of the SSOPs, which provide a long checklist of key sectors and actions that operationalize UNICEF's learning from previous emergencies. However, many of the SSOPs are not applicable in a public health emergency, lack a definition of their strategic importance (i.e. why they are necessary and how they contribute to overall effectiveness), and do not constitute an accountability framework for assessment of compliance.

External coordination: Assessment of external coordination is focused on the extent to which UNICEF's participation in external coordination structures and mechanisms helped or hindered UNICEF's response. It did not examine



how well UNICEF helped the wider, multi-actor response, which would have required a broader analysis and was beyond the scope of the evaluation.

Accountability: Assessment of accountability is limited by the lack of a suitable accountability framework. UNICEF's CCCs are designed as an accountability framework for humanitarian emergency responses to rapid onset natural disasters and conflicts, but were not appropriate or fully applicable for a public health-led response to stop the spread of Ebola. The CCCs apply to UNICEF's multi-programme commitments to provide assistance with a specific focus on meeting the specific needs of children and other predefined groups; they do not apply well to preventing virus transmission at community level through public-health led behaviour change in response to epidemiology. Given the focus of engagement in specific communities, UNICEF's AAP commitments become particularly relevant but the assessment is limited by a lack of clarity about UNICEF's AAP commitments and mechanisms for their implementation.



ANNEX 2: Table 6

Evaluation matrix - The evaluation matrix details how data collection and analysis would be conducted for each key evaluation question and sub-question. It served as a common tool to guide data collection and analysis.

KEQs / SQs	Levels of assessment	Judgment criteria	Sources for data and analysis
KEQ1. How effective was UNICEF's response to Ebola?			
1.1 Achievements: How well did the response achieve HAC objectives and indicators?	<ul style="list-style-type: none"> • 3x affected countries (Obj 1+3) • Countries at risk (Obj 2) 	<ul style="list-style-type: none"> • WCARO 'recommended' indicators • HAC objectives x3 and 'key interventions' 	<ul style="list-style-type: none"> • indicator monitoring data • stakeholder polling (GA, IA,) • stakeholder consultations (GA, IA, national leaders) • case studies in communities • document review • lessons review: Health, Child protection, C4D,
1.2 Contribution: How important was UNICEF's contribution to results (i.e. objectives)	<ul style="list-style-type: none"> • 3x affected countries 	<ul style="list-style-type: none"> • UNICEF stopped the outbreak through actions at community level (UNMEER, HAC14) • UNICEF 'contribut[ed] significantly to system-wide goals of 100 per cent early isolation and 100 per cent safe burial in each of the affected countries.' (HAC14) 	<ul style="list-style-type: none"> • stakeholder polling (GA, IA) • Consultation national leaders • case studies • lessons review: Health, Child protection, C4D, Education, Supplies, WASH
1.3 Factors: Which internal processes contributed most to UNICEF's achievement/s?	<ul style="list-style-type: none"> • 3x affected countries 	<ul style="list-style-type: none"> • Operational plans (TBD) • Country response plans (TBD) 	<ul style="list-style-type: none"> • stakeholder polling (GA, IA) • lessons review: Management lessons and response; Guidance note and implementation
KEQ2. How efficient was UNICEF's response to Ebola?			
2.1 Timeliness: Did the response deliver needed products and services on time? <ul style="list-style-type: none"> • health/case management, • C4D and • child protection? 	<ul style="list-style-type: none"> • 3x affected countries • countries at risk (TBD) 	<ul style="list-style-type: none"> • HAC targets/indicators 	<ul style="list-style-type: none"> • indicator monitoring data • lessons review • stakeholder consultations (GA, IA, national leaders) • case studies
2.2 Cost analysis: How consistent were inputs (financial, HR, and other) with results achieved? <ul style="list-style-type: none"> • health/case management, • C4D and • child protection? 	<ul style="list-style-type: none"> • 3x affected countries 	<ul style="list-style-type: none"> • Analyst perceptions • Operational plans (TBD)? • Stakeholder perceptions (TBD)? 	<ul style="list-style-type: none"> • data analysis, using UNICEF's VISION • stakeholder consultations (GA, IA) • document review



continued: ANNEX 2: Table 6

KEQs / SQs	Levels of assessment	Judgment criteria	Sources for data and analysis
2.3 Factors: Which factors most influenced efficiency? <ul style="list-style-type: none"> • HR • finance and admin • other 	<ul style="list-style-type: none"> • 3x affected countries • countries at risk (TBD) 	Comparison of factors	<ul style="list-style-type: none"> • lessons review • stakeholder consultations (GA, IA) • GEMT minutes (TBD)
KEQ3. How well-coordinated internally was UNICEF's response to Ebola?			
3.1 Procedures: How well did UNICEF's internal coordination model (as adapted for the Ebola response) enable effectiveness?	UNICEF all levels	<ul style="list-style-type: none"> • L3 SSOPS applied • ED role helped • GEC in HQ helped • Ebola Cell helped • Strategic prioritization helped 	<ul style="list-style-type: none"> • lessons review: Management lessons and response; Guidance note and implementation; Health, Child protection, C4D, Education, Supplies, WASH, HR, innovation • document review • stakeholder consultations (GA, IA)
3.2 Global coordination: How did global emergency coordination, through the GEC and Ebola Cell, enable effectiveness?		<ul style="list-style-type: none"> • Processed worked as expected (SSOPs) • process helped effectiveness • process did not hinder effectiveness 	
3.3 Planning, M+E: How did strategic planning and monitoring of performance enable effectiveness?		<ul style="list-style-type: none"> • Processed worked as expected (SSOPs) • process helped effectiveness • process did not hinder effectiveness 	
3.4 Information management: How did collection and analysis of information (needs assessments, epidemiology, KAPs and anthropology) enable effectiveness?		<ul style="list-style-type: none"> • Processed worked as expected (?) • process helped effectiveness • process did not hinder effectiveness 	
3.5 HR: How did human resources management (surge deployment and safety/welfare) enable effectiveness?		<ul style="list-style-type: none"> • Processed worked as expected (SSOPs) • process helped effectiveness • process did not hinder effectiveness 	
3.6 Supply and logistics: How did supply and logistics enable effectiveness?		<ul style="list-style-type: none"> • Processed worked as expected (SSOPs) • process helped effectiveness • process did not hinder effectiveness 	
3.7 Finance/administration: How did operations (i.e. financial and administrative procedures), enable effectiveness?		<ul style="list-style-type: none"> • Processed worked as expected (SSOPs) • process helped effectiveness • process did not hinder effectiveness 	



continued: ANNEX 2: Table 6

KEQs / SQs	Levels of assessment	Judgment criteria	Sources for data and analysis
3.8 Implementation and innovations: How did implementation modalities (incl. direct, partnerships, innovations) enable effectiveness?		<ul style="list-style-type: none"> • Processed worked as expected (SSOPs) • process helped effectiveness • process did not hinder effectiveness 	
3.9 Preparedness: How did pre-epidemic preparedness enable effectiveness?		<ul style="list-style-type: none"> • Processed worked as expected (?) • process helped effectiveness • process did not hinder effectiveness 	
3.10 Knowledge management: How were lessons applied and learned?		<ul style="list-style-type: none"> • Processed worked as expected (?) • process helped effectiveness • process did not hinder effectiveness 	
KEQ4. How well-coordinated externally was UNICEF's response to Ebola?			
4.1 Implementing partnerships: How did implementing partnerships enable effectiveness?	3x CO level	<ul style="list-style-type: none"> • Processed worked as expected (PCAs) • process helped effectiveness • process did not hinder effectiveness 	<ul style="list-style-type: none"> • stakeholder consultations (GA, IA) • stakeholder polling (GA, IA) • document review (tbd) • external lessons review
4.2 Strategy leadership: How did UNICEF's strategic leadership-level coordination enable effectiveness?	3x CO level	<ul style="list-style-type: none"> • Processed worked as expected (UNMEER/IASC) • process helped effectiveness • process did not hinder effectiveness 	<ul style="list-style-type: none"> • external lessons review: • stakeholder consultations (GA, IA) • stakeholder polling (GA, IA) • document review (tbd)
4.3 Cluster/Pillars coordination: How did UNICEF's cluster/pillar leadership contribute to effectiveness?	3x CO level	<ul style="list-style-type: none"> • Processed worked as expected (SSOPs, IASC) • process helped effectiveness • process did not hinder effectiveness 	
KEQ5. How accountable was UNICEF's response to Ebola?			
5.1 Relevance to policy frameworks: Was UNICEF response (e.g. as expressed in its objectives and indicators) aligned with international and national policy frameworks?	3x CO level mainly, regional level	<ul style="list-style-type: none"> • 3x national governments • inter-governmental: Mano River Union, ECOWAS, AU(?) • UNMEER • UNICEF CCCs 	<ul style="list-style-type: none"> • Document review (strategies) • stakeholder consultations (GA, IA, nat leaders) • Case studies (TBD)



continued: ANNEX 2: Table 6

KEOs / SQs	Levels of assessment	Judgment criteria	Sources for data and analysis
<p>5.2 Relevance to epidemiology/needs: Were UNICEF objectives aligned with changing epidemiology and needs?</p>	3x CO level mainly, regional level	<ul style="list-style-type: none"> Epidemiology by WHO, CDC needs assessments by UNMEER, UNICEF 	<ul style="list-style-type: none"> Case studies stakeholder consultations (GA, IA, nat leaders) Document review (epidemiology, needs assessments) lessons review (tbd):
<p>5.3 Appropriate: Were UNICEF implementation strategies appropriate to unique and evolving challenges?</p> <ul style="list-style-type: none"> Local/national unfamiliarity with EVD Fear, stigma, and misperceptions 	3x CO level mainly, regional level	<ul style="list-style-type: none"> perceptions of stakeholders CCCs contextual analysis Included in risk management (TBD) discussed in EMT, sitreps (TBD) 	<ul style="list-style-type: none"> lessons review (external and internal) Case studies Document review (incl. anthropologists) stakeholder consultations (GA, IA, nat leaders) data analysis (EMT meetings/) TBD
<p>5.4 Equity: Was UNICEF's response programming guided by equity considerations?</p>	regional and country levels	<ul style="list-style-type: none"> UNICEF equity approach SADD collected Priority given to the most disadvantaged children (Mission statement) 	<ul style="list-style-type: none"> Monitoring data Case studies Lessons review (TBD) stakeholder consultations (GA, IA, nat leaders) TBD
<p>5.5 National development: Was UNICEF's response consistent with local and national development priorities?</p>	regional and country levels	<ul style="list-style-type: none"> CCCs early recovery, ALNAP capacity building, and ALNAP ownership 	<ul style="list-style-type: none"> Stakeholder consultation (GA, IA, national leaders) Internal LL documentation Case studies
<p>5.6 AAP: UNICEF's response implemented in a manner accountable to the affected population?</p>	3x countries and community levels	<ul style="list-style-type: none"> transparency, information provision participation feedback/complaints monitoring, evaluation, learning staff competencies 	<ul style="list-style-type: none"> Document review (PCAs) Case studies stakeholder consultations (GA, IA, nat leaders) Internal LL documentation
<p>5.7 CERF: Did UNICEF manage CERF funds according to CERF requirements?</p>	3x affected countries	<ul style="list-style-type: none"> CERF Rapid Response criteria x4 	<ul style="list-style-type: none"> data only



ANNEX 2: Table 7

Lessons review - This annex shows a list of internal learning exercises and external reviews analysed for this evaluation.

Lessons Learned Literature
1. UNICEF (draft) Guidance note on UNICEF in Global Health Emergencies Draft 1, 16 November 2015.
2. UNICEF (2015) Lessons Learned Review 2014-2015, UNICEF April 2015, Dakar, WCARO.
3. UNICEF (draft) Health Emergencies Implementation Plan, Version 2, "UNICEF in Global Health Emergencies: Costed Implementation Plan following GMT Decision" 16 November 2015.
4. UNICEF (2015) Lessons Learned UNICEF's Response to the 2014-15 Ebola Outbreak in West Africa: Executive Summary, Internal Working Document, April 2015.
5. UNICEF (2015) UNICEF Management Response to Lessons Learned from the Ebola Outbreak Response 2014-15, 31 July 2015.
6. UNICEF (2014) Ebola Outbreak Response in West Africa, Humanitarian Action for Children (HAC), 2014-2015.
7. Harvard-LSHTM (2015) Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM: Independent Panel on the Global Response to Ebola. Health Policy, The Lancet, Published online November 22, 2015 http://dx.doi.org/10.1016/S0140-6736(15)00946-0
8. WHO (2015) Report of the Ebola Interim Assessment Panel, WHO, Geneva.
9. UNICEF (2015) Liberia Lessons learned presentation at Lesson Learned Review, Dakar, Feb 2015.
10. Government of Senegal (2015) LESSONS FROM THE RESPONSE TO THE EBOLA VIRUS DISEASE OUTBREAK IN SIERRA LEONE, MAY 2014–NOVEMBER 2015, SUMMARY REPORT, A study initiated and conducted by the National Ebola Response Centre, with support from FAO, FOCUS 1000, UNAIDS, UNDP, UNFPA, UNICEF, UNOCHA, UN Women, WFP, and WHO.
11. UNICEF (2015) Ebola Virus Disease Outbreak Response, Supplies and Lessons Learned Update, UNICEF Supply Division, July 2015.
12. UNICEF (2015) UNICEF SURGE IN EMERGENCY WORKSHOP Geneva, 18-- 20 August 2015 WORKSHOP REPORT and Annexes.
13. Michaels-Strasser and Rabkin, (2015) Rapid Mixed Methods Assessment of the Ebola Community Care Center Model in Five Districts of Sierra Leone, ICAP Columbia University, Presentation to National Ebola Response Centre (NERC) Evening Brief 04/02/2015. http://nerc.sl/sites/default/files/docs/20150204_Nerc_Eve_Brief.pdf
14. Abramowitz and UNICEF et al (draft) Ebola Community Care Centers: Lessons Learned from UNICEF 2014-2015 Experience in Sierra Leone, Maternal, Newborn, and Child Health (MNCH) Working Paper Series. Florida University and UNICEF.
15. Oosterhoff et al (2015) Community-Based Ebola Care Centres A formative evaluation, Ebola Response Anthropology Platform and Research for Health in Emergencies (R2HC). http://www.ebola-anthropology.net/wpcontent/uploads/2015/07/Community-Based-Ebola-Care-Centres_A-Formative-Evaluation.pdf
16. USAID (2015) Interagency Meeting on Social Mobilization, Communication and Preparedness: Executive Summary, March 23-24, 2015, USAID Annex, Washington
17. USAID (2015) Full Summary Report of Interagency Meeting on Social Mobilisation, Communication and Preparedness: Review of Ebola Social mobilization and Communication Efforts to Date, March 23-24, 2015, USAID Annex, Washington.



continued: ANNEX 2: Table 7

18. Oxfam (2015) Interagency Meeting on Social Mobilisation, September 24-25 2015. Facilitated by Ferron and O'Reilly.
19. Fast et al (2015) The Role of Social Mobilization in Controlling Ebola Virus in Lofa County, Liberia. PLoS Currents. 2015
20. Bedford (2015) Community mobilisation in the Ebola response Case studies from Sierra Leone and Liberia, Anthrologica. [conclusion is very well written lessons learned on community-led approaches]
21. Awylard (2014) Humanity vs. Ebola the winning strategies in a terrifying war. Ted Talk. https://www.ted.com/talks/bruce_aylward_humanity_vs_ebola_the_winning_strategies_in_a_terrifying_war/transcript?language=en
22. UNICEF (2014) UNICEF Liberia Situation Report 22 Ebola Viral Disease 2 June 2014. http://www.unicef.org/appeals/files/UNICEF_Liberia_Situation_Report_22_Ebola_Viral_Disease_2_June_2014.pdf
23. UNICEF (2014) UNICEF Liberia Situation Report Ebola Viral Disease 7 July 2014 http://www.unicef.org/appeals/files/UNICEF_Liberia_Situation_Report_Ebola_Viral_Disease_7_July_2014.pdf
24. UNICEF (2014) UNICEF Liberia Ebola Viral Disease Situation Report 8 Aug 2014 http://www.unicef.org/appeals/files/UNICEF_Liberia_Ebola_Viral_Disease_Situation_Report_8_Aug_2014.pdf
25. WHO (2014) Liberia: Working with communities is the key to stopping Ebola. October 2014, http://www.who.int/features/2014/liberia-stopping-ebola/en/
26. CDC (2014) Lofa County Lessons Learned. https://community.apan.org/cfs-file/_key/telligent-evolutioncomponents-attachments/13-10441-00-00-00-13-88-81/Lofa-County-Lessons-Learned.pdf
27. UNICEF (2015) UNICEF Field Support Officers workshop report, Kenema, Sierra Leone, 12 April 2015. [while objectives were to capture lessons learned - what worked well/did not and why it is not written this way - the why is missing]
28. UNICEF (2015) Lofa County: Communities took the matter in their own hands, UNICEF CD4 case studies.
29. UNICEF (2015) Support Mission to Sierra Leone CO - EVD Response, Rafael Obregon, Chief, C4D HQ, March 31st –April 29th, 2015
30. UNICEF (2015) UNICEF Communication for Development (C4D) workshop report, Freetown, 16 April
31. UNICEF (2015) UNMEER/UNICEF consultation report, Freetown, 25-26 March, 2015.
32. SMAC (accessed 4 February 2016) Social Mobilisation Action Consortium (SMAC) and Community-Led Ebola Action [http://www.communityledtotalsanitation.org/blog/community-led-ebola-action-adapting-community-ledapproach-ebola-outbreak-sierra-leone]
33. Stillman (2014) Ebola and the Culture Makers, The New Yorker, November 11, 2014. http://www.newyorker.com/news/daily-comment/ebola-culture-makers
34. ICG (2014) The Politics Behind the Ebola Crisis, Africa Report N°232 28 October 2015 http://www.crisisgroup.org/~media/Files/africa/west-africa/232-the-politics-behind-the-ebola-crisis.pdf
35. Van de Pas (2015) On Politics and the Ebola Pathogen Why does Community Resistance Persist in Guinea? International Health Policies, Jan 2015, http://www.internationalhealthpolicies.org/on-politics-and-the-ebolapathogen-why-does-community-resistance-persist-in-guinea/ .



<p>36. Human Rights Watch (2014) West Africa: Respect Rights in Ebola Response Protect Health Workers, Limit Quarantines, Promote Transparency, September 15, 2014. https://www.hrw.org/news/2014/09/15/west-africarespect-rights-ebola-response.</p>
<p>37. Weizman (2015) Analysis of the 2014 Ebola Outbreak in Guinea, Sierra Leone, and Liberia , Melissa Judith Weizman, University for Peace & Conflict, Monitor, August 14, 2015. http://www.monitor.upeace.org/innerpg.cfm?id_article=1089</p>
<p>38. UNICEF (draft) Assessment of MNCH and Ebola-Related Services by Community Health Workers During the 2014-2015 Ebola Outbreak, Research Protocol, January 2016, Maternal, Newborn, and Child Health (MNCH), UNICEF.</p>
<p>39. UNICEF (Draft) Ebola Epidemic Child Protection Response Lessons Learned: Consultant Report INTERNAL DOCUMENT: NOT FOR CIRCULATION, December 2015</p>
<p>40. Lancet (2014) Ebola: a failure of international collective action. Comment. Volume 384, No. 9944, p637, 23 August 2014 http://www.thelancet.com/pdfs/journals/lancet/PIIS0140-6736(14)61377-5.pdf</p>
<p>41. Abramowitz SA, McLean KE, McKune SL, Bardosh KL, Fallah M, Monger J, et al. (2015) Community-Centered Responses to Ebola in Urban Liberia: The View from Below. PLoS Negl Trop Dis 9(4): e0003706. doi:10.1371/journal.pntd.0003706</p>
<p>42. ACAPS (2015) Ebola Outbreak in West Africa: Lessons Learned from Assessments in Sierra Leone and Liberia. http://acaps.org/img/documents/t-acaps-lessons-learned-from-assessments-in-sierra-leone-and-liberia-16-jul-2015.pdf</p>
<p>43. Gratier (2015) Ebola Crisis Fund, Final Evaluation. Geneva Global, Pennsylvania, USA. www.genevaglobal.com.</p>
<p>44. CDC (2015) Ebola containment strategy succeeding in Liberia, 20 February 2015, http://www.cdc.gov/media/releases/2015/p0220-ebola-containment-strategy.html</p>
<p>45. Kateh et al (2015) Rapid Response to Ebola Outbreaks in Remote Areas Liberia, July-November 2014, Morbidity and Mortality Weekly Report (MMWR), Centres for Disease Control (CDC). http://www.cdc.gov/mmwr/pdf/wk/mm6407.pdf</p>
<p>46. Washington et al (2015) Effectiveness of Ebola Treatment Units and Community Care Centers — Liberia, September 23–October 31, 2014, Michael L. Washington, PhD1, Martin L. Meltzer, PhD MMWR, Centres for Disease Control (CDC) / January 30, 2015 / Vol. 64 / No. 3., http://www.cdc.gov/mmwr/pdf/wk/mm6403.pdf</p>
<p>47. UNICEF (2015) Community Care Centers, Community Dialogue and Engagement: Key Ingredients in Sierra Leone Communication for Development: Responding to Ebola, June 2015.</p>
<p>48. Menéndez, Clara et al. (2015) Ebola crisis: the unequal impact on women and children's health, The Lancet Global Health , Volume 3 , Issue 3. http://www.thelancet.com/pdfs/journals/langlo/PIIS2214-109X(15)70009-4.pdf.</p>
<p>49. MSF (2015) Sierra Leone: MSF opens maternity unit for pregnant women with Ebola, 29 January 2015 http://www.msf.org/article/sierra-leone-msf-opens-maternity-unit-pregnant-women-ebola</p>
<p>50. PLAN UK (2014) One in seven women could die in childbirth because of Ebola Effects. PlanUK (http://www.planuk.org/media-centre/One-in-seven-women-could-die-in-childbirth-because-of-Ebola-effects/?frommobile)</p>
<p>51. UNICEF (2015) Shifting the post for same goals: an assessment of the impact of the Ebola response on WASH interventions in Sierra Leone.</p>



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52. UNICEF (2015) Learning Exercise: UNICEF's Response to the Ebola Crisis in West Africa Education. WCARO.
53. UNICEF (2015) Lesson Learning Exercise: Guinea and Liberia School Reopening, May 2015.
54. UNICEF (2015) Lessons Learned and Best Practices on Back to School from Liberia and Guinea, 2015.
55. UNMEER (2014) Situation Report Ebola, 13 October 2014, United Nations Mission Ebola Emergency Response.
56. Humanicontrarian (2015) THE HAMMERS AND NAILS OF EBOLA, 6 February http://www.humanicontrarian.com/2015/02/06/the-hammers-and-nails-of-ebola/ . Accessed 4 February 2016.
57. UNICEF Core Commitments for Children in Humanitarian Action http://www.unicef.org/publications/files/CCC_042010.pdf
58. ILO (2015) Recovering from the Ebola Crisis Submitted by United Nations, The World Bank, European Union and African Development Bank as a contribution to the formulation of national ebola recovery strategies in Liberia, Sierra Leone and Guinea. http://www.ilo.org/wcmsp5/groups/public/---dgreports/---dcomm/--publ/documents/publication/wcms_359364.pdf
59. UNICEF (draft) The Effect of Ebola on Maternal and Child Health Services and Other-cause Mortality in Sierra Leone, 2014-2015, 6 Jan 2015.
60. MSF (2015) MSF says lack of public health messages on Ebola "big mistake" Source: Thomson Reuters Foundation Wed, 4 Feb 2015 15:06 GMT http://news.trust.org//item/20150204150344-h8zyb

External review

1. Report of the Ebola Interim Assessment Panel, World Health Organization (n.d.)
2. Will Ebola change the game? Ten essential reforms before the next pandemic. The report of the Harvard-LSHTM Independent Panel on the Global Response to Ebola, (www.thelancet.com Published online November 22, 2015)
3. Protecting Humanity from Future Health Crises, Report of the High-level Panel on the Global Response to Health Crises, 25 January 2016
4. The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises, Commission on a Global Health Risk Framework for the Future (Prepublication copy, 2016)
5. Lessons learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response, Report of the Secretary-General, 4 March 2016
6. The effect of community-based prevention and care on Ebola transmission in Sierra Leone, (Pronyk, P. et al. Manuscript Draft, n.d.)
7. Solidarity and Security in Global Health What Can We Learn from the Ebola Crisis? Tim Evans, Senior Director, Health Nutrition and Population, (World Bank Group Keynote Speech delivered at the opening plenary of the Prince Mahidol Award Conference, January 29, 2015)



ANNEX 2: Table 8.

Stakeholders consulted - This table shows all the response actors consulted according to the sampling strategy (see methodology). It does not include members of the affected population, national leaders or stakeholders consulted in the six case studies.

UNICEF Headquarters
Peter Salama, GEC from early Oct 2014 to Feb 2015
Barbara Bentein, DRC Rep until Nov 2014, Senior Adviser Ebola Cell, GEC (March-June 2015)
Annette Rolfe, Executive Manager of Ebola Cell,
Afshan Khan, ED team, GEC, Director, Director EMOPS,
Ted Chaiban, Director, Programme Division,
Mickey Chopra, Head, Health Section (World Bank now)
Heather Papowitz, Job title: Senior Advisor, Health-Emergencies (focal point)
Rafael Obregon, C4D Focal Point
Hamish Young, Chief, Humanitarian Action & Transitions Section, Programme Division
Martin Porter- Humanitarian Performance Monitoring, EMOPS/Performance
Chris Fabian, Innovation Unit
Betel Tassew, Emergency HR Focal Point
Corine Faletto, Chief Human Resources Services
Shanelle Hall, Director Supply Division
Jean-Cedric Meeus, Senior Emergency Supply Manager
Barry Wentworth, Deputy Director, Finance & Budget, Division of Financial and Administrative Management
UNICEF West and Central Africa Regional Office
Manuel Fontaine, Regional Office Director and GEC
Gianfranco Rotigliano, Regional Ebola Coordinator
Christine Muhigana, Deputy Regional Director
Grant Leaity, Regional Chief Emergencies WCARO (until end June 2014)
Claude Dunn, Ebola Support Coordination
Mads Oyen, Regional Emergency Advisor
Filippo Mazzarelli, Emergency Specialist
Herve Peries, Regional Chief of Programme and Planning
Gilles Chevallier, Regional Resilience Specialist
Maurice Hours (and health team), Regional Health Adviser
Sayo Aoki, Education in Emergencies (Ebola focus)
Francesca Bonomo, Education in Emergencies
Kelly Naylor, Regional WASH advisor
Madeleine Decker, Information Management / Knowledge Management Ebola
Lola Galla, Emergency HR Specialist
Pascale Crapouse, Regional Supply Chief
Thierry Delvigne-Jean, Regional Communications Advisor
Kamal Kamaledine, Regional ICT Advisor



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Remy Mwamba, Health Specialist (former IM)
Patrick Konan Nguessan, Regional Emergency IM Specialist
Savita Naqvi, Regional C4D Advisor
Thi Minh Ngo, Regional Social Policy Specialist
Andy Brooks, Regional Chief Child Protection
UNICEF Country Office Sierra Leone and partners
Geoff Wiffin, Representative, UNICEF
Sandra Lattouf, Dep Representative, UNICEF
Ebrima Sarr, Chief of Operations, UNICEF
Dr. Nuhu Maksha, Health Specialist, UNICEF
Kshitij Joshi, head of C4D, UNICEF
Patrick Okoth, WASH Manager
Willy Zihahirwa Nalwage, Chief of Child Protection, UNICEF
Grace Wongai Nkhoma, Chief of Education, UNICEF
Jerome Kouachi, Emergencies Coordinator, UNICEF
Amie Cholley, Child Protection Officer, UNICEF, Makeni sub-office
Seynabou Diallo, HR Manager
Philippa Thorpe, Finance Officer
Justina Conteh, Country Director, St. George's Foundation
Mohammed Magazuba, Programme Manager, St. George's Foundation
Anita Koroma, Country Director, Girl Child Network Sierra Leone
Mr. Samuel Sesay, Senior Health Education Officer, MoH Health Education Dept.
Fiona McLysaught, Country Director, Concern
Thynn Thynn Hlaing, Country Director, Oxfam
Ramatu Kargbo, Child Protection Adviser, PLAN
Bernadette Udo, Programs Manager, World Hope International
Carrie Jo Cain, Health Programs Specialist, World Hope International
Mariatu Tarrawalk, Marie Stopes
Edward Magity, Marie Stopes
Mr. Lansana Conteh, Programme Manager, Health Education Division, MoH and co-chair of SM Pillar
Dr. Miriam Nanyunja, Health Security and Emergency Coordinator and Dr. Otim Patrick, Technical Officer, Emergency Preparedness and Response, WHO
Nathalie le Roy, former Chief of Staff in UNMEER SL, now Senior Adviser to Resident Coordinator,
Lee Ferguson, Team Leader Ongoing Ebola Response, DFID Sierra Leone;
John Raine, Team Leader (District Support), DFID Sierra Leone;
Richard Carter, Social Mobilisation Adviser, DfID Sierra Leone;
Keith Thompson, led the pre-Ebola portfolio (supplemental email);
Claire Vallings, former Team Leader Ongoing Ebola Response, DFID Sierra Leone



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Sara Hersey, Country Director, Centres for Disease Control
H. E. Moijoue Kai Kai, Minister of Social Welfare, Gender and Children's Affairs
Yvonne Aki-Sawyer, Delivery Team Leader, President's Delivery Team on Transition and Recovery, Office of the Chief of Staff [and former Director of Planning for NERC]

UNICEF Liberia Country Office and partners
Zainab Al-Azzawi, UNICEF M+E specialist, 15 Feb
Sheldon Yett, Country Representative, UNICEF, 15 Feb
Bev Kauffeldt PhD., Asst. Sr. Program Manager, Samaritans Purse
Patrick Sijenyi, UNICEF Wash Specialist, 16 Feb
Elizabeth Drevlow, Chief of CP, UNICEF, 17 Feb
Maryam Hafeez, Human Resources Specialist, UNICEF, 17 Feb
Marieme Diallo, Logistics Specialist, UNICEF 17 Feb
Lydia-Mai Sherman, Deputy Minister, MINISTRY OF GENDER CHILDREN & SOCIAL PROTECTION - Child Protection and Development Division, 18 Feb
Katherine Faigao, Nutrition specialist, UNICEF, 18 Feb
Joseph Bahemuka, C4D Specialist (Field Coordination), UNICEF, 19 Feb
Ann-Dora Gbormie, Asst Min of Planning, Min of Education, 19 Feb
Mary Momolou, Head, EPI Unit, Min of Health, 19 Feb
Augustine SM Tamba
Dr. Alex Gasasira
Mayor Clara Mvogo Doe
Grace Boiwu
Teferi Goshu
YWCA
Carter Center
Dierdre Kiernan
Varney Kamara, UNICEF Head of Transport
Radio Kakata, Jerry Jenkinds Quoi director of Programmes.
Feamata M. Dunoh, Director, & Phillip S.K. Mollay, Social Worker
Dr. Adolphus T Yeiah. County health officer
Health Administrator
Valerie W Toby
Namah Moibah
Rania Elesawi C4D skype
Ngashi Ngashi Ngongo
Laurent Dufour
Tolbert Nyenswah
Hamish Young



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UNICEF Guinea Country Office and partners
Mohamed Ayoya, UNICEF Representative
Guy Yogo Deputy Representative
Timothy La Rose; UNICEF Chief of Communications External
Jean Baptiste SENE, UNICEF Chef Section Politique Sociale, Planning et Suivi & Evaluation
Seydou Dia, Emergency Specialist
Rene Ehounou Ekpini, UNICEF Guinea, Chef CSD
Guilene Frederic UNICEF Guinea Chef Protection de l'enfant.
Ismail Teta Chief Nutrition
Ada Pouye Chief C4D section
Gervais Havyarimana, Chief Education
Dr Tharcienne Ndiokubwayo UNICEF Guinea Chief of Health
Pierre- Georges Akilimali, WASH Cluster Coordinator
Ousseini Mai Maigana, Chief WASH
Michael/Head of Supplies logistic
Julienne Ngoungoung Social Anthropologist UNICEF
Amadou Bailo Bah, Administration Officer
Mirabelle de Souza. HR Specialist
Aminata Boreux, Knowledge management, Donor report specialist
Mahamat Nour Molli, Finance Specialist
Mamadou Saliou Diallo, Secrétaire Exécutif National Croix Rouge Guinée (CRG)
Yousouf Traore, Président Croix Rouge Guinée CRG
Dr Facely Diawaro, Coordinateur des opérations de Lutte contre Maladie à Virus, Croix Rouge Guinée
Association Governance pour la promotion Governance Locale (AGIL) :
Conde Mory, Directeur Exécutif ,
Pépé Koivogni,
Dr Diabite Aboubacar Nassagbe - Specialist de Santé,
Fadiga Abdoulaye - Chargé de Suivi et evaluation,
Ibrahima Khalil Diakili - responsable chargé du partenariat et mobilisation de ressources
Mamadou Barry, Coordinateur programme: Search for Comm Ground: Partner
Gakou Tata Directrice de la Santé Ville Conakry
Aljassonem Habibou Hassan, Awards & Grant manager, Save the Children Intl, Guinea
Fataoumata Diakité Directrice Adjoint aux opérations, Save the Children Intl,
Jacques Tounkara/ Plan Guinée
Dr Cyrille Dikko; Surveillance Lead, OMS
Dr Sékou Condé, Coordinateur Général Adjoint- Coordination National de Lutte Contre Ebola, Ministère de la Santé
Dr Sakoba Keita, Coordinateur National, Cellule de la Coordination national de riposte contre la fièvre Ebola, Ministère de la Santé
Dr Sékou Condé



ANNEX 3. STAKEHOLDER POLLING

This section presents an initial analysis of the polling data and graphs showing data for percentages of respondents who either ‘agreed’ or ‘strongly agreed’ with a given statement.

QUESTION 1. How much do you agree with these statements about UNICEF’s overall Ebola response?

4. A slight majority of UNICEF stakeholders believe ‘UNICEF supported early recovery and building back basic services’, with 63/99 in agreement or strong agreement.

OVERALLS

1. A majority of UNICEF stakeholders believe ‘UNICEF achieved the best possible results’ in the response, with 75/100 agreeing or strongly agreeing. The greatest doubts came from RO and HQ groups, where around half are unsure or in disagreement.
2. UNICEF stakeholders tend to doubt that ‘UNICEF brought Ebola under control through 100 early isolation and safe burial in affected countries’ with the largest number 74/99 unsure or in disagreement. This is a poor rating for UNICEF’s priority action, but appears to reflect stakeholders’ concern that UNICEF’s achievements should never be seen in isolation from the work of others, as the question and HAC objective mistakenly appeared to imply.
3. A slight majority of UNICEF stakeholders believe ‘UNICEF prevented other high risk countries suffering major outbreaks’, with 57/97 agreeing or strongly agreeing, again reflecting a caution to attribute collective achievements to UNICEF alone.
 - Countries at risk: Almost three quarters of UNICEF stakeholders agree that ‘UNICEF worked with governments in countries at risk to develop comprehensive preparedness and response plans,’ with 71/98 in agreement or in strong agreement

TOP

Supplies: More than three-quarters of UNICEF stakeholders and the largest majority across all question 1 believe that ‘UNICEF procured essential supplies and commodities including Personal Protective Equipment PPE home hygiene and hand washing kits’, with 87/101 agreed or strongly agreed.

Education: More than three-quarters of UNICEF stakeholders agree that ‘UNICEF supported emergency radio education and safe and responsible return to schools’, with 82/100 in agreement or strong agreement.

Child protection: More than three-quarters of UNICEF stakeholders agree that ‘UNICEF integrated child protection services into the response i.e psychosocial support family reunification and alternative care’, with 78/102 in agreement or in strong agreement

Health supplies: More than three-quarters of UNICEF stakeholders agree that ‘UNICEF procured essential health and nutrition commodities including essential medicines vaccines’, with 74/96 in agreement or in strong agreement

Countries at risk: Almost three quarters of UNICEF stakeholders agree that ‘UNICEF worked with governments in countries at risk to develop comprehensive preparedness and response plans,’ with 71/98 in agreement or in strong agreement



MIDDLE

Staffing capacities: Around two-thirds of UNICEF stakeholders agree that ‘UNICEF increased staffing capacities at sub national level to respond quickly to the outbreak’, with 68/101 in agreement or strong agreement.

Social mobilization: Around two-thirds of UNICEF stakeholders agree that ‘UNICEF’s social mobilization and communication activities contributed greatly to early isolation and safe burial in affected countries’, with 65/101 in agreement or strong agreement.

Health and social services: Around two thirds agree that ‘UNICEF built on community engagement to assist governments and partners to rebuilding primary health and social services’, with 64/98 in agreement or strong agreement.

Essential services: Around two thirds agree that ‘UNICEF maintained and adapted other essential social services during the EVD outbreak e.g

nutrition HIV WASH,’ with 63/99 in agreement or strong agreement.

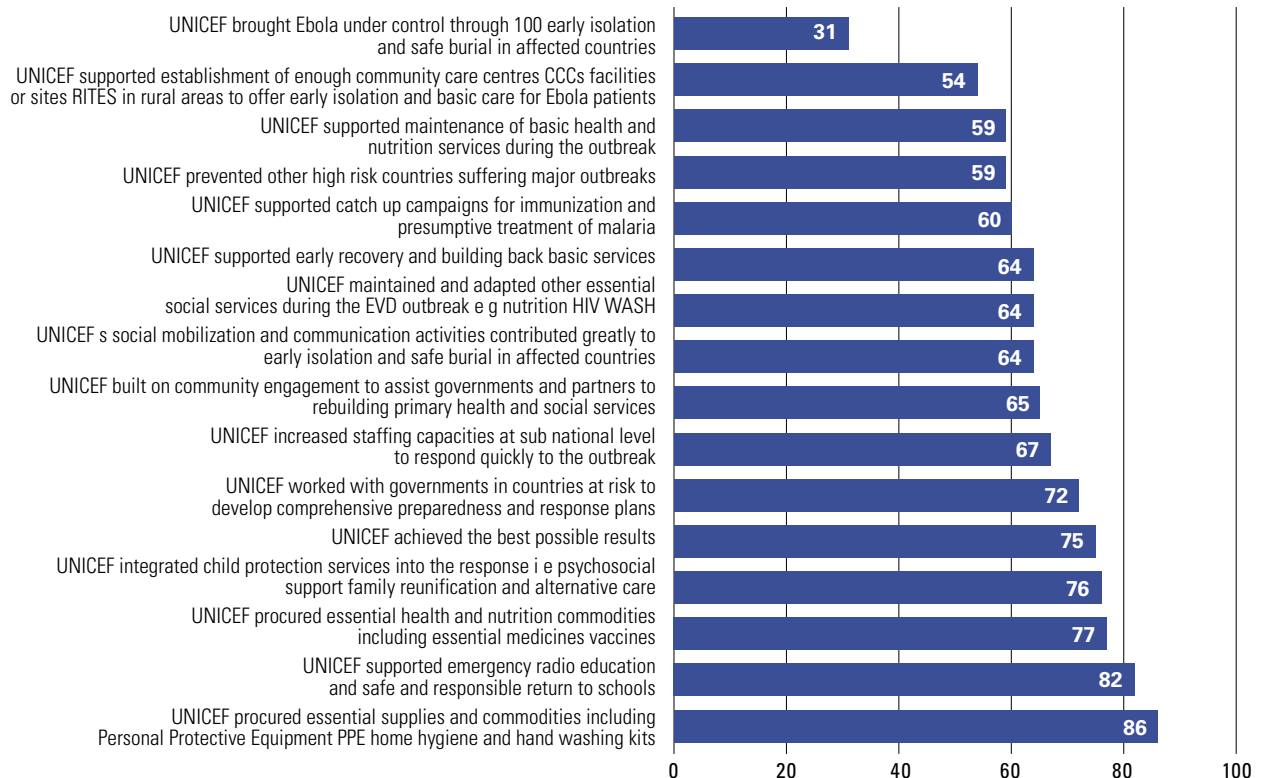
BOTTOM

Immunization: A slight majority believe that ‘UNICEF supported catch up campaigns for immunization and presumptive treatment of malaria’, with 59/99 in agreement and the rest unsure 31/99 or in disagreement 9/99.

Basic health and nutrition: A slight majority believe that ‘UNICEF supported maintenance of basic health and nutrition services during the outbreak,’ with 58/98 in agreement and the rest unsure 28/98 or in disagreement 12/98

CC Centres: The smallest majority across all of Q1 agree that ‘UNICEF supported establishment of enough CC Centres facilities or sites RITES in rural areas to offer early isolation and basic care for Ebola patients’, with 54/100 in agreement, 25/100 in disagreement, and 21/100 unsure.

Question 1: Percent of respondents who agreed/strongly agreed with statements on UNICEF’s overall response





QUESTION GROUP 2. How important a contribution did these make to stopping the outbreak?

(Rate their importance on a scale of 1-5 where 5 is most important, and 1 is least important).

- UNICEF stakeholders consider the most important contributions to stopping Ebola were made by communities themselves and the wider international response, of which UNICEF’s response was an essential part. They clearly highlight the importance of these actors, UNICEF included, above individuals, contacts, national and local authorities, and EVD itself.
- UNICEF stakeholders recognize a combination of the listed factors were important in stopping Ebola, including communities themselves (407), strategic partners (405), UNICEF (395), national and local authorities (386), and individuals infected and contacts (367).
- Most UNICEF stakeholders highlight the importance of the international intervention, but a minority across all stakeholder groups hold that Ebola declined naturally, with little impact made by the response and that another virus might have done considerably more damage.

TOP

UNICEF stakeholders tend to view the ‘response of communities affected’ as the most important contribution to stopping Ebola, with 35/100 respondents rating it as the most important, and receiving a slight majority of total importance ratings of 407.

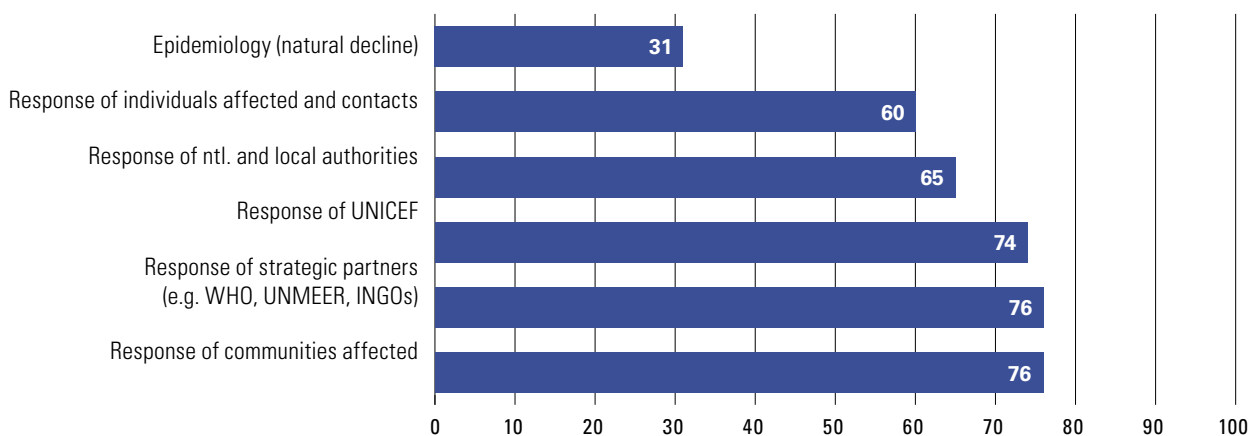
UNICEF stakeholders also view the ‘response of strategic partners WHO UNMEER INGOs etc.’ as making a highly important contribution to stopping Ebola, with 35/100 respondents rating it as most important and receiving total importance ratings of 405.

UNICEF stakeholders consider the ‘response of UNICEF’ to be almost as important, with 34/98 respondents rating it as most important and total importance ratings of 395, and suggesting that UNICEF’s response was an essential part of the response by partners.

UNICEF stakeholders highlight the importance of responses by ‘national and local authorities’ and individuals infected and contacts’, with 25/100 and 24/99 respondents rating these as most important respectively, and total importance ratings of 386 and 367 respectively.

Few UNICEF stakeholders consider the ‘epidemiology natural decline of EVD itself’ as an important factor, with a minority of 13/96

Question 2: Percent of respondents who agree/strongly agree on the important of the contribution





across all stakeholder groups rating it as most important including half of HQ respondents, and total importance ratings of 288.

QUESTION GROUP 3. How important a contribution did these internal processes make to UNICEF’s overall achievements?

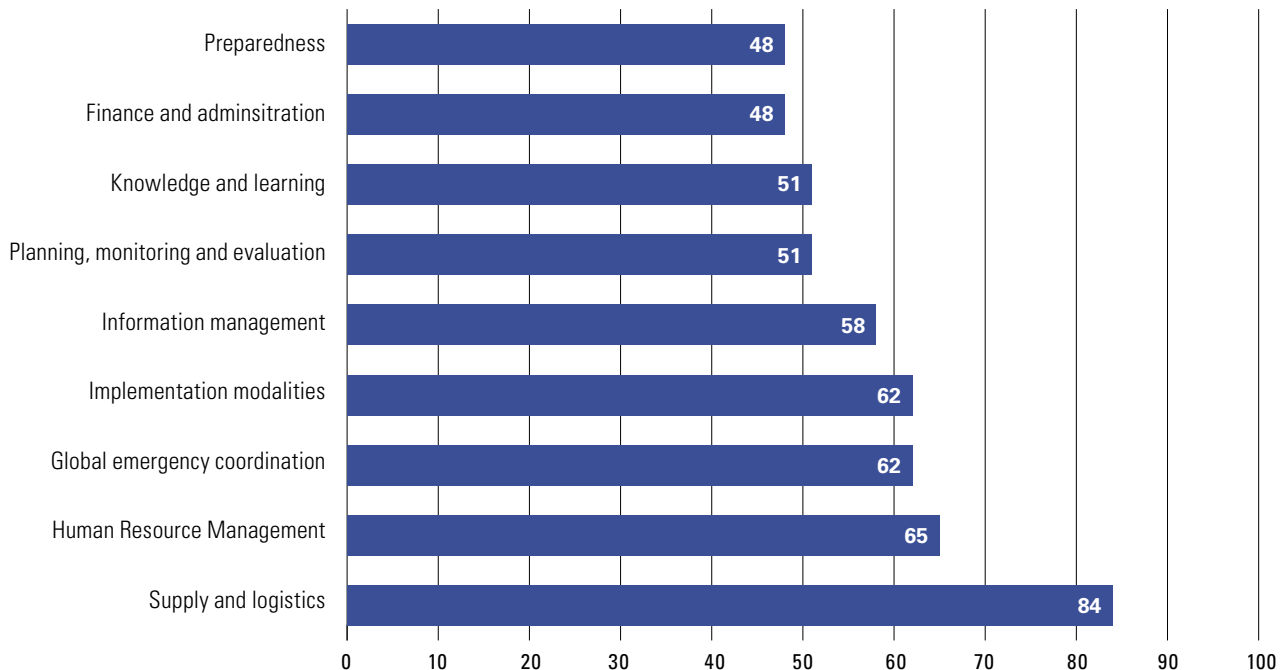
[Do not ask to strategic partners]

(Rate their importance on a scale of 1-5 where 5 is most important, and 1 is least important).

- Resourcing functions: UNICEF stakeholders highlight the greatest importance of ‘supply and logistics’ to UNICEF’s achievements (first with 40/95 respondents rating it highest) and the high importance of ‘human resource management’ (second equal with 25/94 rating it highest) ranked first and second respectively; but they also indicate the relatively less important contribution of ‘finance and administration’ (with 15/92 rating it highest) ranked 7/9 factors.

- Management functions: UNICEF stakeholders also recognize the importance ‘global emergency coordination’ and ‘information management’, ranked second and fourth with 26/95 and 23/95 giving them highest ratings respectively; this contrasts with the relatively low ratings for ‘planning monitoring and evaluation’ (with 46/94 rating it of moderate or lesser importance)
- Preparedness and learning: UNICEF stakeholders are least convinced that preparedness and knowledge management made important contributions to effectiveness, with 48/93 and 45/92 rating these of moderate or lesser importance (ranking these factors as the two least important contributions).
- Implementation function: UNICEF stakeholders appeared to recognize the importance of ‘implementation modalities’ despite the unclear meaning/difficult wording, with 56/91 rating it as important and ranking 5/9.

Question 3: Percent of respondents who agree/strongly agree on the importance of the contribution of internal processes UNICEF’s overall achievements





ANNEX 4. CASE STUDIES

CASE STUDY 1:

Farmoriah, Forécariah Préfecture,
Kindia Region, Guinea

Conducted by Annie Lloyd &
Tamba Emile Sandouno

Date: 21.3.16

1.0 OBJECTIVE

The objective of the community consultation was to gather the views of the affected population, and to produce this case study, which will be added to information gathered using other evaluation methods, to provide a mix of data and information.

2.0 PRINCIPLES

The community consultation followed the Valid International Ethical Guidelines, which includes independence and impartiality, confidentiality, rights and gender equality.

3.0 SELECTION RATIONALE

Following the evaluation protocol, the two Préfectures of Guéckédou and Forécariah in Guinea were selected for case studies, using the criteria of the areas most targeted by UNICEF and most affected by Ebola. Other factors for selecting these Préfectures included the timing of incidence of the Ebola cases: Guéckédou was the Préfecture first affected by Ebola, is on the Liberia border and is a long distance from Conakry; Forécariah is in Maritime Guinea (South West of the country) on the Sierra Leone border, nearer Conakry and was one of the Préfectures to be affected last by Ebola in Guinea

To select the area for the case study within Forécariah, in discussion with AGIL (UNICEF partner managing the Coordination Platform

in Forécariah) a list was made of all the Sous-Préfectures and the incidence of Ebola, Farmoriah Sous-Préfecture was selected, as although it was only the second highest number of cases, it was more accessible being only 30 minute drive from Forécariah town (not ideal to go to the other area which needed 3 hours to get there) and also the Sous-Préfet was available and able to help facilitate the visit.

4.0 DATA COLLECTION METHODS

The evaluator (Anne Lloyd) and Assistant (Tamba Emile Sandouno) travelled to Forécariah which is about 80 kms from Conakry (2.5 hours drive). Abdoulaye Seye from the New York Evaluation office also accompanied the Evaluation team. The Evaluator spent 1.5 days in the community with the local consultant and the Assistant evaluator spent time in Forécariah town meeting, at the 'Plateforme', meeting with UNICEF partners.

Using the tools in the protocol, such as the community discussion guide

- Meeting with the Secrétaire Général Chargé des Collectivités Décentralisées de la Préfecture de Forécariah at Forécariah Préfecture office: for introductions & background information
- Met with staff members of Association Governance pour la promotion Governance Locale (AGIL): the UNICEF partner managing the 'Plateforme' in Forécariah Préfecture
- Meeting with 4 staff from 4 different UNICEF partners who are working in Forécariah Préfecture, (Meeting held in Forécariah town)
- Reading secondary data (e.g. WHO statistics)



In Farmoriah Quartier

- Meeting with 7 community leaders at the Farmoriah Sous Préfet office
- Activities with groups of children to assess their knowledge on Ebola; including drawings of what they thought someone looked like when sick with Ebola and a question game, to demonstrate their understanding of the signs, symptoms and transmission of Ebola (varying groups of children, both boys and girls, of all ages)
- Focus group discussion/community meeting with a group of (about 10 women, most between 20 – 55 years of age), many of whom had been mobilisers/part of the CVV
- Observational walk around the area, including the town and market area.
- Discussion with a previous member of the 'Comité de Veille Villageois' (CVV) - Community Watch Committee (woman of about 30 years of age)
- Short meeting with the Chef de Centre de Santé – Doctor in charge of the Health Centre
- Discussion and visits with a member of AGIL staff based in Forécariah, who accompanied with evaluators to Farmoriah.
- Discuss with primary school teacher (male, about 30 years of age)

5.0 BACKGROUND

Forécariah has a population of 242,942 (as of 2014 census). According to the Sous-Préfet the population for Farmoriah Sous-Préfecture is 34,288 which includes 16,467 men & 17,821 women. Farmoriah borders Sierra Leone and has a health centre, schools and a large market.

UNICEF worked with many partners in Forécariah Préfecture, with funding for activities including: child protection, social mobilisation (C4D), and assistance during 'les

cerclages" (community quarantine of Ebola Contacts). UNICEF also established 'la plateforme' in Forécariah, which worked as a coordination mechanism for all stakeholders in terms of communication and social mobilisation.

6.0 FINDINGS

6.1 Context

Farmoriah town is now bustling with activities, with a thriving weekly market; many people get their incomes by trading. There is a health centre and a school.

6.1.2 Ebola in Farmoriah Sous-Préfect

The first case of Ebola in Forécariah Préfecture was notified on 26.8.14, and the last case was reported in November 2015; so the epidemic lasted 15 months in this Préfecture, with a total of 485 cases (confirmed and probable) and 335 deaths (WHO data). The epidemic lasted a long time in this Préfecture for several reasons; including being close to the Sierra Leone border with movement of people across the border, resistance by the population to accept and understand about Ebola, and unsafe burials of infected people.

6.2 Effectiveness

UNICEF supported many activities in this Préfecture, including the establishment of a 'Plateforme' to assist with coordination in terms of social mobilisation and communication. In the Sous- Préfecture of Farmoriah, we observed and collected information about activities such as the Community Watch Committee: 'Comité de Veille Villageois' (CVV).

The population consulted had difficulty separating out who had done what to give some indication of attribution for effectiveness, e.g. Association Governance pour la promotion Governance Locale (AGIL) was seen as UNICEF as they wore UNICEF logs on their T-shirts, caps etc.



The community leaders felt that the strengthening of the awareness about Ebola, involvement of Ebola survivors and the establishment of community platforms have played a key role in the effectiveness of the response

6.2.1 Health care

The Doctor in charge of the Health Centre reported that he was happy with the support he had received from UNICEF; they had helped with a lot of awareness-raising in the communities and also delivery of medicines, and hand-washing kits.

6.2.2 C4D

During the focus group discussion/group meeting with some women in Farmoriah, they described how at the beginning lots of people were coming to their communities, e.g. the Red Cross, UNICEF, PAM (WFP), the Health staff, all telling them about Ebola, with the main message they learnt was to keep clean. Then, lots of social mobilisers were recruited; e.g. ACF, AGIL, MSF, although there were many of them, the women thought the coordination worked well. All used the same 'Boîte d'images' (flipchart with pictures and messages written on the back). They felt these activities with the hand-washing kits very helpful. Other methods used included films, a sketch and messages on the radio, though the women reported the main way they had got information about Ebola was by the mobilisers going 'door-to-door'. AGIL said there had been a radio programme specifically for children, but none of the children mentioned the radio as a way they heard about Ebola.

The community members thought the CVV worked well, they had started in about January 2015, and ended in August 2015. There were 105 in Farmoriah Sous-Préfecture. A discussion was held with a woman who had worked since the beginning of the Ebola outbreak doing community mobilisation, she was recruited as part of the CVV in January 2015, as the Chef de Santé called for volunteers, although at first there was a lot of fear and reluctance to

volunteer. She was originally recruited by ACF, but then AGIL took over. There was a team of 7 people in each CVV (all from that community) and each member did the same thing: "sensibilisation" - going 'door-to-door', making people aware about keeping their houses clean and washing hands, and calling 115 if there was any sick people. Each team had a supervisor. This woman explained that she had received 4 days of training, (which according to her had included information about Ebola, how to put on gloves and how to wash hands), which was done by the Health Department staff, including the Chef de Santé. There had also been refresher training, she had received Guinea Francs: 40,000/month (equivalent to about 50 US dollars). According to the Chef de Santé, the CVV were very helpful, as it gave access to the community; 'opened the door'.

According to the community leaders the CVV and the 'door-to-door' approach had been very effective.

PHOTO: a previous member of the CVV demonstrating the 'Boîte d'images'



The Evaluator did an activity with a group of children (aged about 8 – 15 years, although some younger children joined in too) asking questions in a fun way to understand their knowledge about Ebola. In Farmoriah town, out of a group of about 30 children, most of the children said they knew the signs and symptoms of Ebola; all of them learnt about Ebola from their families, no one had learnt about it from community mobilisers. All (apart from one child) said they were given information about Ebola at school with the focus being on hand-washing.

The evaluator also asked 2 groups of children to do drawings of someone with Ebola, to demonstrate their knowledge, this was a fun activity and although the drawings were very basic it was possible to see the children could show the main signs of bleeding and body pain, as demonstrated by the photo below.

PHOTO of drawing by a small group of girls in Farmoriah to demonstrate the signs and symptoms of Ebola



6.3.3 Child protection

UNICEF had given support for orphans, assisted with the safe opening of schools and given supplies to the schools, such as equipment – all of which was appreciated.

6.3.4 Recovery

The Chef de Santé described how he was just about the start a measles campaign; he felt it very important to re-instate the vaccination programmes. He was also getting support from CDC (a visit was going on while the evaluator was there).

UNICEF and partners still have functioning mobiliser, who help with cross-border activities, they visit the border areas with Sierra Leone every 2 weeks. A couple of informants mentioned the need to strengthen the health care in the area, so that they are more prepared in the future. This area is important as it is very close to the border and has a busy weekly market.

6.4 Efficiency

6.4.1 Timeliness

A lot of the delays in the beginning was due to the resistance from the population. The CVV system started in January 2015, when there were many cases of Ebola in the area; the first case had been reported in Forécariah in August 2014.

6.5 Coordination (externally)

The Secrétaire Général Chargé des Collectivités Décentralisées de la Préfecture de Forécariah at Forécariah Préfecture Office commented that the collaboration between his office and UNICEF was very close, 'only a hair's breadth between them'.

There were reports of good coordination among the partners, the AGIL staff member said their liaison with many organisations and sometimes the WHO joined them on their mobilisation visits to investigate contacts.



AGIL (the main UNICEF partner) was responsible for coordination of the Social mobilisation, through the 'plateforme', which they felt worked well.

6.6 Accountability

The community leaders felt UNICEF had helped with the development of the area, by building water points and the local radio stations.

The children said they had not been consulted about any aspect of the Ebola programme; they said if they had any problem, they would talk with their parents who would then talk with the authorities.

The group of women said that if they had any problems, or wanted to give feedback they would complain to the Sous-Préfet; one woman said she would have rang the emergency number 115.

The group of men interviewed at the community office said there was no formal mechanism for feedback, but the local 'community plateformes' strengthened accountability, and assisted with feedback.

There were no reports of any group in the community being neglected/excluded for any reason.

CASE STUDY 2:

Houndonin Secteur, Gbangbaïssa
Quartier, Guéckédou Urban
Guéckédou Préfecture, N'Zérékoré
Region, Guinea

Conducted by Annie Lloyd &
Tamba Emile Sandouno

Date: 21.3.16

OBJECTIVE

The objective of the community consultation was to gather the views of the affected population, and to produce this case study, which will be added to information gathered using other evaluation methods, to provide a mix of data and information.

PRINCIPLES

The community consultation followed the Valid International Ethical Guidelines, which includes independence and impartiality, confidentiality, rights and gender equality.

SELECTION RATIONALE

Following the evaluation protocol, the two Préfectures of Guéckédou and Forécariah in Guinea were selected for case studies, using the criteria of the areas most targeted by UNICEF and most affected by Ebola. Other factors for selecting these Préfectures included the timing of incidence of the Ebola cases: Guéckédou was the Préfecture first affected by Ebola, is on the Liberia border and is a long distance from Conakry; Forécariah is on the Sierra Leone border, nearer Conakry and was one of the Préfectures to be affected last by Ebola.

To select the area for the case study within Guéckédou a list was made of the 9 Sous-Préfectures plus one urban area with the cumulative number of cases of Ebola, deaths



from Ebola and the population. The attack rate was calculated (per 1000 population) and a list was made with the 3 areas with the highest attack rates; one was the urban area, and two are others are Sous-Préfectures some distance from Guéckédou town, so was deemed not practical to include them as most of the day would be spent getting to and from the area, so the urban area was selected.

The population for Guéckédou Urban is 165,763 (Source of data: Direction Préfectorale de la Santé, (DPS)/District Health Directorate). In order to choose an area with a smaller population, a list was made of the populations of the Quartiers and then the Secteurs with high incidence of Ebola: Gbangbaïssa Quartier, was selected as it had a high number of cases of Ebola, and interventions by several UNICEF partners, and in order to have a more manageable population, Houndonin Secteur was selected. The population of Houndonin Secteur is 595.

DATA COLLECTION METHODS

The evaluator (Anne Lloyd) and Assistant (Tamba Emile Sandouno) travelled to Guéckédou, which is 679kms from Conakry – a full days journey. A local consultant was hired in Guéckédou, for 3 days to help with local knowledge, translation. The evaluator spent 2 days in the community with the local consultant and the Assistant evaluator spent time in Guéckédou town meeting people and did a couple of short visits to Houndonin to observe and interview people.

Using the tools in the protocol, such as the community discussion guide

- Meeting with 11 staff from 9 different UNICEF partners who are working in Guéckédou Préfectures, (Meeting held in Guéckédou town)
- Reading secondary data (e.g. WHO statistics, DPS Statistics)

In Houndonin Secteur, Gbangbaïssa Quartier

- Meeting with the Chef of the Secteur
- Focus group discussion/community meeting with a group of women (about 15 women, most between 15 – 55 years of age)
- Activities with groups of children to assess their knowledge on Ebola; including drawings of what they thought someone looked like when sick with Ebola and a question game, to demonstrate their understanding of the signs, symptoms and transmission of Ebola (varying groups of children, both boys and girls, of all ages)
- Discussion with a previous member of the Comités de Veille Villageois (CVV) / Community Watch Committee, now working for a Child Protection NGO (a 29 year old man)
- Observational walk around the community with a former member of the CVV/Social mobiliser, talking to people, visiting the water source
- Discussion with an elderly woman (62 years of age)
- Discussion with an Immam of the Secteur
- Observation of activities with children with a Child Protection NGO partner of UNICEF
- Discussion with two male Ebola survivors (a school child aged 18 years and a farmer aged 20 years)

BACKGROUND

Houndonin is a secteur of Gbangbaïssa Quartier of the urban area of Guéckédou. Although part of Guéckédou, the secteur is peri-urban, about 15 minutes drive (6 kms) from Guéckédou town centre, on the road to Macenta. It is one of the areas of Guéckédou Préfecture which had very high incidence of Ebola.



Guéckédou Préfecture, which is part of N'zérékoré region of Guinea, is the Préfecture with the first notified case of Ebola, in December 2013. Guéckédou Préfecture had a total of 270 cases of Ebola, including 204 deaths, with a case fatality rate of 75%. The last case of Ebola in Guéckédou Préfecture was reported in December 2014 (Source of data WHO: 30.12.15) The duration of the epidemic here was due to belated awareness of the disease, being on the border with Sierra Leone and Liberia – with movements of people between countries, movements of contacts, unsafe burial practices and 'reticence' (resistance/reluctance) of the population in understanding the disease and how to prevent it.

UNICEF worked with many around eleven partners in Guéckédou Préfecture, with funding for activities including: child protection, social mobilisation (C4D), CVV and assistance during 'les cerclages' (community quarantine of Ebola Contacts).

FINDINGS

Context

People in Houndonin Secteur live in simple basic houses spread alongside both sides of the road, on the edge of Guéckédou town. There is a school nearby. The nearest health facility is in Guéckédou town. The population has a variety of sources of income: working in nearby fields, masonry work and small business and trading in town. There is a protected well for water, and also an open unprotected spring, which many people also use. No one in the community has a latrine.

Ebola in Houndonin Secteur

Out of the population of 595, the Chef of the Secteur reported 32 cases of Ebola, of which 27 died and 5 were cured. Several people explained how it all started in March 2014, with a young man from the community who was a driver of a motorbike taxi, he took a sick person to the hospital, and returned to Houndonin and he got sick, and when he died several people in

the community assisted with the funeral rites such as washing the body. It was only afterwards they learnt about Ebola.

Effectiveness

Most of the members of the community, including the Chef did not know the difference between all the organisations that came to respond to the Ebola outbreak, they could list some, including UNICEF, Plan, WFP and MSF (which they know had the treatment centre in Guéckédou town), but they could not really express their feelings on the overall effectiveness of UNICEF's work when they did not know what they were doing.

The UNICEF partner organisations felt that overall the programme had been effective thanks to initiatives such as door-to-door visits and interactive radio giving information to the population.

Health care

Discussions with various community members showed that they felt access to health care was very limited during the outbreak; due to fear, people did not move around much so did not go to the health unit in Guéckédou. A couple of women mentioned there had been cases of measles in surrounding areas, though not in their community. The UNICEF partner organisations reported that the vaccination system had stopped, but started in April 2015.

C4D

During the focus group discussion, the women described how at first they did not know about Ebola, and after the motorbike taxi man died, staff from the Direction Préfectorale de la Santé (DPS)/ Préfectorale Health Department came to the community; but the women did not understand or believe the information they received about Ebola. Then, many people got sick, and lots of white cars came, with white people, everyone in the community was scared. One woman described how she would throw stones at people like us (pointing at the evaluator and



assistant), they were very reluctant to believe what was being said about Ebola. The elderly women described that it was due to ignorance that no one believed about Ebola in the beginning, they thought people were being paid to bring the illness: 'when white cars came here, we ran into the bushes', and only when 'we were ravaged by Ebola did we listen', we had no idea what happened at the treatment centre and we wanted to know.

As more people got sick, the assistance was accepted. The women reported the main method of receiving information was the 'Boîtes à images' (flipchart with pictures and messages written on the back).

PHOTO: a mobiliser using the 'Boîte à images'



There were also practical sessions with hand-washing with soap, and UNICEF had provided hand-washing buckets. There was information on the radio, but out of the group of

about 20 women, only 3 had access to a radio, although the partner organisations thought the radio transmissions were effective.

The local partner organisation working in the area reported that a couple of theatre shows had been done about Ebola, but no community member mentioned that this was how they heard/learnt about Ebola.

The Ebola survivors said they had helped with 'sensibilisation' about Ebola when they returned home, which they thought was effective as people listened to them and they could explain about what happens inside the centre, there was also a film about the centre. Although at first they had a lot of problems with stigma and being accepted back in the village, a 'white woman from MSF' came and helped the teenage boy to get back into school to sit his exams as no one wanted him in school.

The main educational/informational activities on Ebola for the children were using the 'Boîtes à images' (by a UNICEF partner organisation and the CVV members). One session done with a group of children was observed; the style was quite didactic and not participatory or targeted for children's needs.

The Evaluator did an activity with a group of children (aged about 8 – 15 years, although some younger children joined in too) asking questions in a fun way to understand their knowledge about Ebola. In Houndonin, out of a group of about 30 children, most of the children said they could not describe what someone looked like with Ebola, but about 6 of them (mostly the older children) could describe the signs and transmission of Ebola. When asked how they learnt about Ebola, they all said from the Mobilisers. The children said they learnt the importance of hand-washing before eating at school. All the children knew of people who had had Ebola, and most of them were dead. It was surprising how little the children knew about Ebola.



The evaluator also asked 4 groups of children to do drawings of someone with Ebola, to demonstrate their knowledge, this was a fun activity and although the drawings were very basic it was possible to see the children could show the main signs of bleeding and body pain, as demonstrated by the photo below.



A team of anthropologists visited the area in March 2015, which according to one staff of one of the partner organisations had the effect of 'raising the spirits' and changed the system. It is not clear who these team were, or whether they were funded by UNICEF.

The Ebola survivors said before they got Ebola they had heard about it, but did not believe it; they did not understand how people were getting sick. The women said their biggest lesson was "to listen to strangers in future"

The Community Watch Committee CVV started in this community in October 2014, during this time there were no cases of Ebola, the last case of Ebola in Guéckédou Préfecture was in December 2014. A young man described how he had been part of the CVV team, there were 5 in the team and they were all selected by the community, they had 3 days of training in a group in the town, and each team received a 'Boîte à images'. They were paid Guinea Francs 400,000 (about US \$50) a month for 4 months They were part of the first group funded by UNICEF, but they were unhappy as a second group then started (this was unclear, but possibly organised by the NGO Plan) and

they received more things such as bags and phones, the first group did not receive these or the other things they were promised such as boots and coats. The CVV member explained they wanted to strike because of this. He felt it was a problem that if they had found a case of Ebola, they would have to borrow a phone to report it.

Child protection

A UNICEF local partner organisation: Monde des Enfants (MDM) has been doing psycho-social activities in this community, which the children enjoyed and the mothers appreciated. The project had started in November 2014 (i.e. some time after the start of the outbreak) the planning for the project was done together with UNICEF staff; the objective of the project sounded unclear, but was aimed at activities for marginalised children. In April 2015, MDM received recreational kits for the children; on observation these kits had many items including colouring pencils, toys, bibs for football teams, balls etc – some of these items had not been used and were still in their bags. MDM had distributed hygiene kits (funded by UNICEF); the community said they were not asked what they wanted in these kits, but were happy with what they received. MDM also assisted with cash transfers for families of Ebola victims, which was greatly appreciated and people were asking for more assistance. MDM did recreational activities for children dividing them into different age groups with games and also as already been mentioned some education sessions on Ebola for children,

One man in the community said that if there was no means to feed the children, they were taken to the SOS Childrens village.

Children from this community did not go to school during the outbreak, the old woman described how no one could even go to the market to buy condiments, as stallholders did not want to serve us, so we came back empty handed. She described how the organisations



had provided basic food, rice etc, for a few months as they were unable to visit the market, which they appreciated.

The Director of MDM thought that at the beginning the overall response was very 'medicalised', child protection not considered at the beginning and there lacked coordination.

Recovery

The community complained a lot about not having access to toilets, they felt the need better sanitation, more soap and chlorine to be able to protect themselves. The Ebola survivors stressed their fear of being forgotten, as they feel they still need assistance.

Efficiency

Timeliness

The programme in this area was late to get started for many reasons; the UNICEF partners felt the delays had been partly due to a lack of outbreak mechanisms.

Cost analysis

Some UNICEF partners reported that they felt UNICEF funds had been misused by the local Government for coordination; however, the UNICEF Chief of the Regional Zérékoré office said there was no evidence to assert or to deny this, but felt all the money given by UNICEF to the Direction Régionale de la Santé (DRS) for example for the recruitment of the CVVs had been well used, as all the CVVs were in place and functioning.

Coordination (externally)

UNICEF did not have fixed staff in Guéckédou, 'staff came and went', the partner organisations reported that they were delegated authority by UNICEF, and there was no reported lack of coordination.

At the meeting for partners in Guéckédou, there were complaints about the UNICEF administrative and finance systems, the partners thought they were heavy and unsuitable; also they had to pre-fund themselves.

The partners felt UNICEF respected them, and had helped with capacity building, they had received a training on communication.

Preparedness

The community felt they had no preparedness for such an epidemic, and don't feel prepared for future epidemics. Although, one of the partners (Child protection) felt they were much more prepared now to deal with future epidemics

Accountability

The women described that if there was a problem, they would complain to the Chief of the Secteur, there is not other way of giving feedback or making complaints. The old woman explained that organisations like UNICEF and Plan came and asked about our problems: 'we asked for latrines and a health unit, but we got clothes and food for the children – we were happy with the food', she also said if there were problems, she would see the Chief. The children said if they had a problem, they would tell their parents.

One young man (who had been part of the CVV) described that if aid comes here 'the government takes some, then the DPS takes some and by the time it gets to us in the community there is little left'.

There were no reports of any group in the community being neglected/excluded for any reason.



CASE STUDIES 3 & 4:

Margibi and Duport Rd area (Monrovia),
Liberia

Conducted by Steve Powell

OBJECTIVE

The case studies were designed as a complement to key informant interviews. The idea was to get a more complete picture of the epidemic and the response to it, and in particular UNICEF's role in response, in the context of a specific community. In one community, we also intended to identify respondents relatively independently of UNICEF's interventions and partners. This was to try to counter the strong selection bias which is usual when identifying areas and respondents via UNICEF contacts, in other words, to see what might be visible of UNICEF's interventions in a randomly chosen highly affected area.

PRINCIPLES (INDEPENDENCE, CONFIDENTIALITY)

In both cases, the counties were identified purely on the basis of attack rate and not in consultation with UNICEF staff. The purposes of the research and the way data would be recorded and presented were explained to respondents in full before they were asked for their ascent. Respondents were assured of confidentiality. It was explained that we were working for an independent evaluation consultancy which reports to the relatively independent UNICEF evaluation office and the responses would not and could not affect any relationship between the respondents and UNICEF.

SELECTION RATIONALE

Selected the 2 counties with highest attack rate (Montserrado, Margibi)

#	County	Capital	Established	Area (km ²)	Population	Attack rate per 1000
1	Bomi	Tubmanburg	1984	1,932	84,119	1.569
2	Bong	Gbarnga	1964	8,754	333,481	0.450
3	Gbarpolu	Bopulu	2001	9,953	83,388	0.240
4	Grand Bassa	Buchanan	1847	7,814	221,693	0.262
5	Grand Cape Mount	Robertspport	1856	4,781	127,076	0.755
6	Grand Gedeh	Zwedru	1964	10,855	125,258	0.024
7	Grand Kru	Barclayville	1984	3,895	57,913	0.086
8	Lofa	Voinjama	1964	9,982	276,863	1.188
9	Margibi	Kakata	1985	2,691	209,923	1.905
10	Maryland	Harper	1857	2,297	135,938	0.029
11	Montserrado	Bensonville	1847	1,880	1,118,241	1.769
12	Nimba	Sanniquellie	1964	11,551	462,026	0.251
14	River Gee	Fish Town	2000	5,113	66,789	0.120
13	Rivercess	Rivercess	1985	5,564	71,509	0.364
15	Sinoe	Greenville	1847	9,764	102,391	0.166



Within each county, the next step was to identify 1 “community” with high attack rate.

In each case, the strategy was to first visit relevant authorities in the main town before moving to affected localities.

Margibi

Attack rate data for the districts within the county identified Kakata and Mambah-Kaba districts as the most affected. This selection was made without any influence from UNICEF. Further, the selection of the community (26 Gate) and the orphanage were made more or less at random and was not influenced by UNICEF or county staff.

Visits:

- Depart Monrovia and arrive in Margibi – Wednesday, February 24th
- Return to Monrovia – Thursday, February 25th

The original plan was to include an overnight stay but this was cancelled by UNICEF at short notice due to limited availability of drivers because of a vaccination campaign.

Interviews

- Kakata District
 - Superintendent,
 - Assistant Superintendent,
 - Head of County Health Team
 - Interview with Director of Programmes at Radio Kakata
 - Interview with hospital mental health practitioner
 - Community members in “26 Gate”; Group discussions in a “palaver hut”. About 12 women and 20 men including the Chief. This is a semirural community living mainly from petty trade especially with the rubber making facilities in nearby Firestone district and with the

county town. They had an outbreak for around five months from the end of 2014 to about April 2015.

- Mambah-Kaba District
 - (Hawa Massaquoi Institute – Transit Centre and Orphanage)
 - Director and Social Worker
 - Young people : Activity with 8-12 year olds – 4 boys & 4 girls
 - Game – about you
 - Tell us about your day
 - What do you know about Ebola
 - What messages have you heard about Ebola
 - What were you doing before Ebola
 - Discussion

Overall, with the exception of the Palaver Hut in the community we visited, it was clear that stakeholders had seen a lot of UNICEF inputs to combat the epidemic and valued them highly in terms of effectiveness, relevance and appropriateness. They felt also that UNICEF had made a contribution to building capacity such that they felt better equipped to combat future outbreaks. We were particularly impressed with the information from the radio station where UNICEF sponsored initiatives seem not only to have well implemented the program of adapting and broadcasting standard messages in local dialects and languages but also to be proactively reaching out to communities, hosting radio shows and also doing roadshows and holding community discussions. UNICEF also is giving and has already given substantial support to the orphanage in its role as a transit centre for children who are themselves survivors and / or have lost family members through Ebola. UNICEF has supplied material support, trained the staff and is still funding most of their posts. This appears to us to be vital in protecting this very vulnerable group of children at least in the short term.



However, the reception from community members in 26 Gate was much more hostile. On the face of it, they say that they have only ever received any support from one small NGO which has limited resources. This help was restricted to basic help for affected families. They say for example that they needed buckets for hand washing but never received any. They say they were never visited by any other organisations even though the community chief went more than once to the district administration to ask for help. Several of the interviewees were very angry and the position seemed to have the support of most or all of the other residents. Of course, this response has to be interpreted carefully, because especially in Liberia communities may see any international intervention as a kind of money tree and think they had a right to simply receive donations. More specifically, there may have been an element of theatrics in the sense that they hoped to either elicit donations from us directly or expected us to facilitate donations from the district offices all international organisations. Nevertheless, we are inclined to believe what they said that they only were directly supported by one small organisation, suggesting perhaps that any mechanism to ensure that the Ebola response regional communities equally may not have functioned well at least in this instance. We were accompanied the interview by an administrator from the district authorities and he did not deny or contradict the truth of what they were saying. We subsequently telephoned the County Superintendent's office and were told that they "believe the people at 26th gate and are investigating the matter."

Duport Rd area, Monrovia

- 29th February and 1st March, 2016

Duport Rd. is an urban area of Paynesville, a sister city to Monrovia, part of Montserrado county. It was the site of a one of the most recent outbreaks, in November 2015. It was selected as an urban area because the epidemic in Liberia was largely an urban one, and because it was

a very recent outbreak with a clear and significant contribution from UNICEF. In contrast with the first county, but typical for cities, the administrative districts within the County and within the twin cities are not so clearly defined, so for example, health districts and education districts do not coincide. In particular, it was not possible to get clear epidemic incidence data at levels within this county.

Interviews

- Duport Rd Health Centre
 - County health officer,
 - Community health officer,
- Focus group with a chapter of the Survivors' Network – 4 women and 4 men
- Focus group with young people (Testament School): Activity with 10th- grade students – 5 girls and 5 boys.
 - Tell us about you and your school
 - What do you know about Ebola
 - What messages have you heard about Ebola
 - what do you know about UNICEF
 - how was your community affected by Ebola
 - what kind of support did your community get during the recent hot spot
 - did your community get any support from UNICEF
 - Discussion

Situation in Duport Rd. from WHO sitrep

As of 29 November, there were two confirmed patients at the ELWA Ebola Treatment Unit.

165 contacts under follow-up in the country. 13 health care workers are high risk contacts under precautionary observation at JFK hospital and Duport Road clinic. Approximately 20 households also under precautionary observation.



A voluntary vaccination trial by PREVAIL (National Institute of Health) was carried out. Resistance to accepting the vaccination was observed among the community and health workers, indicating that social mobilization efforts have not fully succeeded.

Compliance with Infection Prevention and Control (IPC) requirements in health facilities was a major challenge.

The Ministry of Health's Incident Management System led the response, with WHO co-leading and coordinating with partners.

A temporary on-site emergency operations centre was set up at the Duport Road health facility and hosted daily operations meetings chaired by the on-site incident manager as well as response pillar briefings/debriefings. Daily incident management operations meetings also took place at the national Emergency Operations Centre.

The structure of the response included the following pillars: contact tracing and surveillance, case management, case investigation, laboratory, dead body management, infection prevention and control, WASH, logistics, social mobilisation, psychosocial support services, and food assistance.

UNICEF and WHO provided psychosocial support to the families. UNICEF and its partners have increased social mobilization activities and trained 60 community workers from affected areas. Through a UNICEF-funded network of seven Monrovia-based radio stations, and 30 community radio stations located across the country, the frequency of radio segments aired reminding communities to report EVD signs and symptoms and all deaths was increased as of 20 November.

This information according to the WHO situation report was all verified by us in the field.

Our main interest in conducting this case study was to find out how UNICEF contributed to the suppressing the recent hotspot outbreak. As the response had been just three months ago, we expected people to remember all the details, which they did. Our overall impression was of a very high degree of preparedness. The local health authorities certainly felt that they themselves were at the centre of the response but that they had full and coordinated support from international organisations and NGOs, with UNICEF being a very important member of this team. In fact their only real complaint was that sometimes it seemed that there were too many different actors who were sometimes falling over themselves to provide help; this criticism did not particularly apply to UNICEF. As in the first case study, local authorities felt confident that they would be able to respond well to future outbreaks in the short and medium term even if international agencies took more of a back seat, however we did get the impression that in practice they do rely on international organisations even for quite basic things like having the right forms to fill in. In fact, the response was very effective and transmission was soon curtailed with the only worry being lack of clarity about where the new index case came from.

We did ask whether they felt they could cope not with a new Ebola outbreak but with a different and equally unexpected hazard, for example Zika virus. Here, they were much less sure about their ability to cope. These responses coincide well with the responses from national level counterparts. While UNICEF themselves are much more sceptical about sustainability and the extent to which capacity really has been built, we should say that we were impressed with the way that local officials seemed very on top of their role and could spell out in detail different parts of their contingency plans.



The schoolchildren were excellent informants. They came from different neighbourhoods most of which were heavily affected by the main Ebola outbreak and could remember many details of interventions in their communities including specifically UNICEF interventions. We got the impression that UNICEF was a well-known and respected actor. However, we were surprised that although all the students had certainly heard of UNICEF, not one of them knew that it is a children's agency. They think of Save the Children as being the children's agency, even though it was not very active in the area.

The survivors group, in their turn, gave some quite distressing accounts of their current situation. Only one of them has a source of income and the others live from family and friends. They all have recurrence and probably increasing health problems and say they are widely stigmatised; the stigmatisation increased again during the recent outbreak because, logically enough, other residents thought perhaps Ebola can indeed be transmitted after years of remission. They did not have any direct interaction with UNICEF but were well aware of them as an important part of the Ebola response. Not surprisingly, they viewed the response partly in terms of what material or financial help they did or did not get, and complained that what little help there was, was patchy, inconsistent

and not transparent. Their main interest is in their own livelihood situation and they are very keen to do any kind of training or further education. Their network has now extended to include survivors of HIV and other illnesses and they see it as a potential direct partner for future programming. They point out that international assistance which arrives via the national government is likely to be highly diluted by the time it reaches them and they advocate for direct partnerships with organisations such as UNICEF.

Further findings from both case studies

We should also mention that the majority of respondents pointed, both spontaneously and when asked, to a potentially dire child protection situation for many children especially those who are now considered Ebola orphans. There is a common assumption that such a child who is fostered into a family will be expected to provide substantial amounts of household labour verging on domestic slavery and many respondents were also adamant that they are subject to other forms of abuse in particular street work and prostitution. We did report this information to UNICEF and they *said the problem is that there are many such accusations but it is very difficult to verify any individual cases.*



CASE STUDY 5:

Hamilton (Western Rural Area),
Sierra Leone

Conducted by Nigel Clarke

SELECTION

A purposive approach to selection was taken, whereby one case study would be conducted where a Community Care Centre was operating close to Freetown and another (see case study 2) in a more remote district. Both locations were to be in areas with high case incidence. Only two CCCs were supported by UNICEF near to Freetown, and these were in the Western Rural area. Of these, Hamilton was thought to have a more urban profile and was therefore selected.

DESCRIPTION

Hamilton is in the Western Rural area of the Freetown peninsula, about 30 minutes drive from central Freetown. The urbanisation process means there are contiguous settlements stretching back to Freetown, but Hamilton retains a relatively rural feel despite a lot of new properties being built. The community has one secondary school and three primary schools. Traditionally fishing is the most important economic activity, followed by petty trading and tourism. The fishermen usually take the boats out in the evening and land their catch in the early morning, when their female relatives take the fish to market. All these aspects of the economy are struggling and one elder complained that school drop-out rates are high in the community because of financial challenges.

There is a university (Milton Margai College) about less than ten minutes drive from Hamilton. There is one peripheral health post in the community. On the day of the case study field work the clinic was closed as the staff were

engaged in a Polio vaccination campaign elsewhere in the community. Krio is the common language spoken at the community.

During the outbreak Action Aid established a Community Care Centre with funding from UNICEF.

COMMUNITY ENTRY

The field work was scheduled for 26th February. Three days previously the local research assistant visited Hamilton to introduce the purpose of the case study and to make arrangements in advance. It was agreed that late morning would be convenient for the meeting with the elders and early afternoon (after the end of the school day). Contact was established with the Deputy Headman, Mr. Francis Turner, who agreed to gather a group of elders/community leaders (men and women) and a separate group of women (general members of the community) on the appointed day. One of the primary schools was also contacted and the headmistress agreed to assemble a voluntary group of older primary school children. The community has a meeting hall available and it was arranged to hire this venue for a modest fee.

On the 19th the Evaluator, together with two research assistants, one male and one female, arrived at around 10.00. Contact was regained with Mr. Turner who escorted us to the community hall. The elders and women arrived soon afterwards. Introductions were made through the Krio dialect and the two groups arranged sitting in circles at separate ends of the hall ready for the group discussions. There were 12 people in the 'elders' group (including 2 women) and around 12 in the women's group.

GROUP DISCUSSION WITH COMMUNITY LEADERS/ELDERS

The local research assistant led the discussion in Krio using the Questions Guide and was observed by the Evaluator, who moved



between this meeting and the women's group meeting. The group described how fearful and stressed everyone was when the outbreak started: "you didn't know who was safe or who was infected by the virus. Also, we were not permitted to bury our loved ones who died during the outbreak. We were not able to give them our last respect ". They started hearing messages about Ebola in 2014 over the radio and through the work of social mobilisation teams visiting the village: "they told us not to touch sick people and to call 1171 to bury corpses. We complied with these instructions and that was why we did not record any Ebola case at the community [i.e. no people from Hamilton itself were infected]". The CCC was a cause for concern when it was established: " people were afraid to go close to the centre or even ply the route. Some people came here to educate us not to fear the centre. The Head of Action Aid, Mr. Sillah coordinated health workers to educate community people. We were given education materials on Ebola in April, 2015".

The community itself contributed towards tackling the outbreak: " we had checkpoints where people were asked to wash their hands before entering the community and their temperature were also checked with thermometer. Visitors were not allowed to come to the community. I had to ask a relative that came to visit from the provinces to return because of the by-laws that were instituted to stop the virus from coming to Hamilton. We strongly believe that the by-laws that were instituted helped us in preventing the Ebola virus from coming to our community. We were also not burying corpses. We were calling 117".

Once people's fears about the CC Centre were allayed, they appreciated the service it provided: " People were afraid to go to the hospital when the outbreak started, but the establishment of the CC Centre helped to educate community people about the outbreak and as result they started going to the hospital. The CC Centre helped to identify cases that could have likely spread to our community. The CC Centre was

easy to access. Many people did not have money to pay transport fares to the government hospital, but with the centre here, people were motivated to seek medical help. Other illnesses like malaria, fever, typhoid and cold were also treated at the CC Centre. Treatments at the CC Centre were open to everyone and were free of cost". Interestingly, the community described a competitive process whereby both Oxfam and UNICEF wanted to run a CC Centre in the village, but the community asked both to present their case and UNICEF won [seems muddled as I don't think Oxfam ever intended to engage in CC Centres - but it might have concerned social mobilisation].

In terms of the effects on children, the group said: "schools were closed in order to prevent interaction among the children. They were also not allowed to play football or visit neighbouring houses. We also made sure that they were washing their hands frequently. You know our children were reminding us to be washing our hands regularly. Children are fast learners. The education posters helped to inform us the outbreak".

On the subject of accountability to the affected population: "a community meeting was held in order to inform us of the construction of the CC Centre. Action Aid came with a monitoring group to follow-up on what was happening at the CC Centre. Also, the people that were working at the CCC were recruited from the community. The UNICEF staff at the CC Centre were giving us feedback. The staff were well trained because no patient died at the CC Centre".

In terms of what the community learned about Ebola, they said: "to inform people about the outbreak; to report sick cases to the hospital immediately; that we should not touch sick people when they start manifesting unfamiliar symptoms or signs. Not to allow visitors from other communities when there is an outbreak. To isolate sick people who manifest unfamiliar symptoms or signs. To wash our hands regularly with soap".



Regarding the Recovery and future preparedness against similar health emergencies, people urged: "to improve our health facility. They should not take everything from the CC Centre. Let them donate some of the equipments to the health centre. Let them construct a full hospital with laboratory for peninsular communities. We should have an improved health facility at the community that addresses not just maternal and child health cases. Let them improve the skills of our health workers. To improve on disease surveillance programmes. Let them bring back health monitors in order to keep people on their toes on sanitation practices".

At the end of the meeting light refreshments were distributed by the evaluation team together with a bar of soap as a suitable token of appreciation.

GROUP DISCUSSION WITH WOMEN

The local female research assistant led the discussion in Krio using the Questions Guide and was observed by the Evaluator. The women explained that the Hamilton communities were not seriously affected by the Ebola Outbreak, because there were no Ebola cases recorded in the community. But on the whole, they were affected in some other ways. The outbreak of Ebola restricted the movement of people. As a result, people were not able to carry out their businesses. They had no source of income to sustain themselves. "Girls became pregnant because of the closure of school. Most of these girls became a dropout from school". Women did not have access to family planning programmes, so the pregnancy rate among women and teenage girls became high. "The respect for the dead was completely wiped out during the outbreak because people were not allowed to bury their loved ones. The government was responsible for the burial of the dead. The customs and traditions of the people were not respected during the scourge".

UNICEF built a caring centre [CC Centre] for people suspected to have contacted Ebola Virus Disease (EVD). Everybody was given the opportunity to visit the centre whenever he/she was ill. At the centre, patients were provided with drugs and treatment for other diseases like malaria, typhoid fever, cold etc.

The intervention of UNICEF was timely because [previously] people had to travel miles to get to the hospitals [ETCs], even the 117 response team was slow to respond to calls. With the construction of the health centre [CC Centre] by UNICEF, many lives were saved. Furthermore, the health workers at the centre were trained and accommodating. The patients at the caring centre were given three meals a day.

There was a break in communication and people in the community were afraid to go to the centre because it was rumoured that nurses were infecting people with the Ebola Virus Disease (EVD). The problem was brought under control when the health workers moved into the community to sensitize the community people that it wasn't true that they were infecting people with the virus. The people were later on encouraged by the health workers to go to the centre whenever they are unwell. After the sensitization by the health workers, the number of people visiting the centre increased gradually. The health workers were also using the public system to inform people about the availability of the centre. They were also advised to use the facility whenever they are sick. The children were also treated and taken care of at the centre – especially children who were sick and malnourished.

UNICEF health workers sensitized and educated the people in the community about how to prevent the disease. They educated them on the importance of hand washing with soap and chlorine, and buckets were placed at strategic points for people to wash their hands and also advised to avoid body contact. They were also advised not to bury the dead suspected to be Ebola victims.



UNICEF also provided jobs for the people in the community such as, cooks, cleaners, drivers etc. This employment benefitted many people in the community, especially when there was no jobs.

In terms of equity, the response of UNICEF reached the people in equitable manner. "There was no favoritism in the treating of people at the centre – people from different places like Mamboma, Ogoo Farm, Echo Centre, St. Michael were coming to the centre for treatment".

The people were confused during the outbreak as to where to go for treatment. The 117 response team was slow to respond to calls – so the construction of care centres was appropriate and timely.

The people in the community were practicing poor hygiene and sanitation practices were also poor – they were not used to washing their hands with soap and chlorine frequently. The movement of people from one place to another was restricted to avoid the spread of the Ebola Virus Disease (EVD).

The response objectives were consistent with national development. UNICEF partnered with WFP to supply the community with rice, oil, cornflour. There were also handbills to educate people on how to prevent the disease. People in the community were trained by UNICEF to work in the centres. There were frequent communications between UNICEF and the communities through meetings.

The implementation was accountable to the affected population – people were treated impartially at the centres. In terms of distribution of food items, people were informed on time about food distribution. The people appreciated the centre so much that the turn out at the centre was encouraging. The people in the community were satisfied with the services at the centres. UNICEF was monitoring the programmes to make sure people in

the community was observing the protocols in preventing the Ebola Virus Disease (EVD). Staff were well trained and people in the community were satisfied with their approach and treatment at the centres.

The community learned that they should report at the centre whenever one experiences signs and symptoms of the Ebola Virus Disease (EVD). They should wash their hands with soap. They should also avoid coming in contact with infected persons. For the Recovery phase, UNICEF and the International Community should respond quickly to the next Ebola outbreak. More health centres should be built in communities. They should train more health workers and equip the centres with drugs

At the end of the meeting light refreshments were distributed by the evaluation team together with a bar of soap as a suitable token of appreciation.

CONSULTATION WITH SCHOOL CHILDREN

A group of 20 children from a local primary school came to the community centre. The group contained equal numbers of girls and boys. The age range was 10-12. To get the children to relax, some 'ice-breaker' activities were organised. These involved introducing everyone's name through a song and dance exercise. Then a 'yes/no/don't know' exercise was conducted which involves the children making choices and moving around the room. Next the children were divided into 4 groups of mixed age a gender. They were given sheets of drawing paper and coloured pens. Two groups were asked to illustrate in pictures what they knew to be the signs and symptoms of Ebola. The other two groups were asked to illustrate means of preventing/combating Ebola. These exercises displayed that the children had a good understanding of Ebola. For signs and symptoms they were able to illustrate:



- Frequent vomiting
- Frequent stool
- Bleeding ear
- Sour throat
- Bleeding nose
- Rash
- Polio [sic]
- Bleeding mark

For preventative measures they illustrated:

- Wash hands after using toilet
- Do not touch a sick person
- Call 117 to bury corpses
- Hand washing

Next the children were asked to brainstorm the sources of information through which they heard messages about Ebola. These sources were listed on a large sheet of paper. Each child was then given 2 'votes' and asked one by one to vote which sources were the most important for them personally. The results were as follows:

1. Radio	19
2. Hospital	1
3. Television	3
4. School	17

Finally, the children were asked to brainstorm what additional means of communication could work for them in the event of a new communicable disease outbreak. Answers included telephone text messages, newspapers, newsletters, pictures/posters and social media (which they said their older relatives had access to).

The consultation session closed with refreshments being served to the children who were also given a small gift pack of a pen, exercise book and a bar of soap.

List of Participants in Meetings

ELDERS

1. Lunpkin Omotola (F) – Elder
2. Sheik A. B. Kabba (M)- Imam
3. RandolphThorpe (M)- Elder
4. Sheik Alusin F. Dumbuya (M)- Iman
5. FrancisTurner (M)- Deputy Headman
6. Solomon Koroma (M)- Elder
7. Daniel B. Koroma (M)- Elder
8. Fatu Kamara (F)- Women’s leader
9. Sorie Kamara (M)-Youth leader
10. Joseph T. Kanu (M)- Elder
11. Francis Lake (M)- Elder
12. Nathaniel Boima (M)- Chairman

[Due to an oversight the names of the persons in the women's group were not recorded. It was not deemed appropriate to record the names of the primary school-age children]



CASE STUDY 6:

Masingbi (Tonkolili District),
Sierra Leone

Conducted by Nigel Clarke

SELECTION

Several steps were taken in the selection process. It was decided to select one community close to Freetown (see case study 1) and one in a provincial district. Both case studies met the general criteria of high cumulative case incidence in terms of district-level data, although incidence in Tonkolili was perhaps more moderate than a couple of its neighbouring districts (e.g. Port Loko and Bombali). Data below district level was not obtained (not available in UNICEF). It was decided to travel to Makeni, one of only 2 UNICEF sub-offices in the country as this is the management and logistical hub for the northern districts of Kambia, Port Loko, Bombali and Tonkolili. Once in Makeni, UNICEF staff were consulted about possible locations within a 1-hour radius of the town (meaning less time would be spent on the road and allowing more time in communities). A list of around 8 locations which had CCCs was gained. This was cross-checked against data for suspected EVD cases presenting at CONCERN-run CC Centres, which were about 5 of the 8 (data not available on the others at the time). Three places with relatively high numbers of cases were selected and which were on the same road out of Makeni. The logic here was that if community entry was difficult for any reason in the selected community, there were 2 close-by 'reserves' available. Finally, random selection from these 3 was achieved by asking someone to 'draw lots' (the names being hidden from the person selecting the lot). Masingbi was selected.

DESCRIPTION

Masingbi is a small market town lying on the Makeni-Konu (metalled) road about 1 hour's driving distance eastwards from Makeni. It is close to the geographical centre of Sierra Leone. Until quite recently it was only served by a dirt road, but the new road (2014) has reduced driving distances from the west considerably. It can be reached from Freetown in 4 hours. Masingbi is also the headquarter town of the Koneka Sande chiefdom. It is large community with a population size of 2-3,000 people. The main local language is Temne. The main economic activities are subsistence farming and petty trading. There are two senior secondary schools, six junior secondary schools and eight primary schools in the community; about half of the schools are privately-run. There is no mains power and water is collected from boreholes. There is good mobile phone network coverage. The Ministry of Children and Social Welfare has a sub office in the community to facilitate work on child protection and gender-based violence in the chiefdom. There's also a Peripheral Health Unit which, unusually, seems to have managed to stay open during most of the Outbreak period. During the Ebola outbreak, Concern Worldwide was supported by UNICEF to run a Community Care Centre (CCC) and Family Homes Movement (FHM) provided child protection services.

COMMUNITY ENTRY

The town was reached at around 11.00 on 29 Feb. We were directed to where the chief was and he was presiding over a community meeting of about 50 persons (mainly male elders). We were greeted and brought to the front of the meeting and had the opportunity to introduce ourselves. The chair of the local Ebola task force (Mr. Karim) happened to be there and he translated into the local Temne language, as some of the elders do not speak Krio/English. We explained our mission and asked if we could return the following day and meet with a smaller group of elders (including women) and a small (mixed gender) groups of youths.



These things were agreed to and the whole atmosphere was very cordial. We were asked to return at 11.00 the following day. In the early afternoon two short key informant interviews were achieved (see below), before returning to Makeni to interview a UNICEF staff member.

GROUP DISCUSSION WITH COMMUNITY LEADERS/ELDERS

Having arrived in Masingbi the following day (1 March) we were directed to an open-sided community building where the leaders and elders were starting to gather. Some of them had come in from close-by villages. The group consisted of 22 adults, of whom 10 were female and the meeting got underway at 11.35 AM. A youth leader kindly translated questions from Krio to Temne, as many of the group were not fully conversant in Krio or English. This made it hard for the Evaluator to follow the meeting in any detail, but the local assistant had been briefed on the questions to ask, and they were based on the Question Guide. When needed he would consult the Evaluator for guidance. The purpose of the meeting was introduced and the group introduced themselves one by one. It was stressed we wanted to learn from their experiences and that they could be frank. After the discussion, a group timeline exercise was undertaken using a long sheet of paper stuck to a wall. The group members were invited to state times when various events (good and bad) related to Ebola occurred and these were written into the timeline for all to see. Some people found it hard to recall dates, and local events like 'rains', 'harvest' etc were also used as reference points. The whole meeting took 1.5 hours. The atmosphere was cordial throughout. Before disbanding, the group was served small refreshments and given a gift of soap as a token of appreciation.

Details from the discussion are recorded in the evidence matrix. In brief, the community did not understand about Ebola at first; there was a rumour that people were poisoning the water sources and youths were appointed to guard

these against tampering. As for Case Study 1, the nationwide adoption of Ebola-specific by-laws was seen as a significant event in starting to combat the outbreak. The anguish of not being able to care for sick relatives themselves, or to touch dead relatives was described. Although considered to be late, the erection and staffing of a Community Care Centre was widely seen as a positive thing, curtailing the need to travel long distances to seek assistance, providing a trusted service staffed by local people, and offering free treatment for non-Ebola illnesses. Several group members had been involved in child protection services sponsored by UNICEF, including having been trained in psychological first aid. In terms of the Recovery the community's 'feedback' all revolved around additional public health measures, including more water sources and latrines, better training of health workers and more availability of drugs and equipment in the centres, and continuing hand-washing practices in schools.

The community timeline (see end of this document) was useful for generating discussion about Ebola, however it also reveals that recall about dates is patchy. Timings associated with the course of Ebola (first cases, last cases etc) seems accurate compared with other data, but recall about external assistance was probably less accurate. The dates about the opening and closing of CCCs are very different (much later) than UNICEF's records and the meeting recalled schools re-opening in September 2015, whereas the nationwide 'Back to School' programme was in April 2015.

CONSULTATION WITH SCHOOL CHILDREN

As the pre-arranged meeting with youths had not been set up as planned, it was suggested we contact Mr. Tholley, Principal of The Great Maranathan Christian School, by phone to arrange a meeting with school children at the end of the school day. This was achieved and the meeting took place around 3 PM. The group



consisted of 5 girls and 5 boys and ranged in age from 14 to 17. After introductions, there followed a group discussion based on the question guide followed by an exercise to select and then rank the most important sources of information about Ebola from their perspective. The children were asked about their knowledge of Ebola, which was found to be quite advanced. They said they mainly learned about Ebola in school. Their school principal interjected to explain that during Ebola the paramount chief had asked schoolteachers to go around the community educating children about the disease. When the schools reopened more teaching sessions on Ebola were organised and Ebola was also the subject of organised debating sessions.

The children appreciated the radio education broadcasts which they thought were good, although only the 'core' subjects and economics were taught. They mentioned the written materials provided by the teachers, radios provided by Concern and books and pens provided by UNICEF. The Principal also mentioned other radios provided by the Ministry of Education with funding from UNICEF. They said during the outbreak their parents asked them to stay indoors. They had no recreational materials and regretted the year of lost school education. In the case of a future health emergency of this nature, the children said they would like recreation materials ("skipping rope; table tennis"), access to television and computer-based learning, as well as more access to textbooks and radios. School sports are still banned because of Ebola - something regretted by the children. When asked about children dropping out of school because of Ebola they mentioned children who had lost their parents, those who were poor and could not pay the fees and girls who became pregnant and felt ashamed to return to school.

An exercise was undertaken whereby the children were asked to brainstorm the means by which they learned about Ebola. The results were written on a large sheet of paper in tabular form and the children were each given 2

votes through which to assess which were the most important sources of information for them as individuals. The results are displayed below. Interestingly, the health centre, which stayed open during the crisis, was seen as one of the most important sources of information.

Rank	Source	Scores
1	Radio	7
2	Health centre	6
3	Television	3
3	School	3
5	Community elders	2
6	Newspaper	0
6	Teachers	0
6	Churches and Mosques	0

When asked what other means of communication about disease control they would like to see in future they mentioned messages via mobile phone and community awareness sessions aimed at children. At the end of the meeting the children were thanked and given some light refreshments and a small gift pack containing a pen, an exercise book and a bar of soap.

KEY INFORMANT INTERVIEWS

UNICEF in Makeni provided a contact for Mr. Andrew Koroma, a Social Worker with Family Homes Movement (FHM), a local child welfare NGO which works in Tonkolili and the Western area and has headquarters in Freetown. He has good links with the local Ministry of Social Welfare (MoSW) office (a small office in the town) and FHM is a UNICEF partner for ongoing child protection work. We were able to meet Andrew on 29 Feb and conduct an interview. He met us at the MoSW office where The SL Red Cross was distributing some NFI kits to Ebola survivors. At our request, Andrew introduced us to a couple of the female survivors and we managed to have a short interview with one of them (Mrs. Fatmata Koroma) while she waited



for her kit. On 1 March, in the afternoon following the community meeting and the exercise with the school children, we conducted a short key informant interview with Mr. James Ozen Tholley, the Principal of The Great Maranathan Christian School.

Andrew Koroma joined FHM's operations in Tonkolili in April 2015 when the situation was "much improved". His tasks were to document EVD-affected children, including survivors and orphans and to collaborate with other agencies to meet their needs. There's a caseload of 160 EVD orphans in the chiefdom and most are living with relatives in their communities, but their condition "was not good". Some are withdrawn. Some are not getting enough food (only one meal per day). Ebola has compounded previous deprivation. The primary caregivers have died and extended families (who mainly survive by subsistence agriculture and petty trading) struggle to feed their own families, let alone extra children. On the other hand, there's a good attitude towards survivors here and low incidence of stigmatisation. FHM has been involved in the reintegration of orphan/survivor children through appropriate local ceremonies; they also spot children who are out of school and conduct PSS activities, mainly recreation, which encourages children to mix freely, promotes inclusion and mitigates stress. They also conduct community engagement to combat violence against children, teenage marriage, teenage pregnancy and female genital mutilation. They support Child Welfare Committees in each ward and a network of CP focal persons which monitor abuses against children and report them. The MoSW now has an office in the chiefdom and joins in with the various activities. Sometimes it has resources from other partners to distribute (e.g. food). UNICEF is the largest 'donor' supporting CP activities. During Ebola UNICEF supported foster families, hygiene supplies, baby food, radios for the quarantined and for head teachers. FHM runs one Interim Care Centre in a nearby town. It is a referral centre and had provides interim care for child victims of sexual abuse and abandoned children.

There were more children there during Ebola. Teenage girls report that they get impregnated by motorbike taxi drivers. FHM holds awareness sessions for the parents of school-age girls. Marie Stopes provides contraceptives etc, but there's some resistance from those holding traditional beliefs. Survivors get the most support; orphans less.

Fatmata Koroma is an Ebola survivor from the neighbouring village of Mashiku. She was in Masingbi for a distribution of NFIs the Red Cross was doing for female survivors. She's a member of the local survivors' committee which was formed in 2015 and had 22 members. They aim to foster a sense of solidarity with each other. They have received some assistance [source not given] including some money, food and livelihoods support. When she got sick [probably Oct 2014] she reported to the chief who called 117 and she was taken by ambulance all the way to Kailahun, as there was no ETC near the chiefdom in those days. Her husband had died of Ebola. She now looks after her own [biological] child and she was previously looking after 2 orphans from her wider family, but she found it hard to cope and gave these 2 children to another relative to look after. However, she still sees them and they attend school. She was embraced by the community after discharge - no problems with stigmatisation. Her desire is to receive support for a small business or other income-generation activity.

The School Principal, Mr. Tholley, thought the radio programmes [sponsored by UNICEF] were excellent, but too limited in time [i.e. should have been for more hours in the day]. The teachers provided additional information to support the radio programmes by putting information on blackboards in the community (Concern supported this). Groups of around 10 children would listen to the radio together, look at the information on the blackboard and have a discussion. A no-touching rule was maintained as part of infection prevention during this activity. Felt UNICEF's radios were better (more robust) than those provided by Concern.



He is sad that sports activities are still banned in schools, as children need to keep themselves healthy. Also, such events could be used to do sensitisation messages about Ebola and other diseases. When asked whether there had been school drop-out as a result of Ebola, he said it was hard to gauge, as children move to other schools etc anyway. He is not convinced that children were effectively quarantined during Ebola. Poor children were hungry and had to go out looking for food - "you can't tell children to stay at home when there's no food".

List of Participants in Meetings

Community meeting

1. Wara Kabia (F) - Ward councilor
2. Kapr Karbgo(M) - Ceremonial chief
3. Tholley (M) - Care-taker chief
4. Kapr S. Conteh (M) - Senior section chief
5. Parok Turay (M)- Ceremonial chief
6. Haja F. Turay (F)- Elder
7. Alhaji H. Koroma (M)- Chiefdom speaker
8. Osman Koroma (M)- Headman
9. Mambu Conteh (M)- Headman
10. Hassan Conteh (M)- Town chief
11. Kapr F. Gbla (M)- Section rep.
12. Alhaji Sesay (M)- Elder
13. Kapr Sesay (M)- Ceremonial chief
14. Alhaji Sankoh (M) - Youth rep.
15. Abdul Tarawali (M) - Youth rep.
16. Imbrahim Conteh (M)- Headman
17. Mariatu Turay (F) - Youth rep.
18. Rosaline George (F) - Teachers rep.
19. Kadiatu Bangura (F) - Youth rep.
20. Mambu Sankoh (M) – Youth rep.
21. Mabinty Gbla (F) – Youth rep.
22. Fatu Sesay (F) – Elder

School children

1. Mariatu Fonah (F)- 16yrs
2. Patrick J. Bangura (M)- 16yrs
3. Foday Koroma (M) - 17yrs
4. Alpha J. Fullah (M) - 16yrs
5. Umaru Fornah (M) - 14yrs
6. Fatty M. Kanu (F) - 16yrs
7. Sultana Conteh (F) - 17yrs
8. Baindu M. Fornah (F) - 15yrs
9. Mariatu Kanu (F) - 16yrs
10. Alfred Fornah (M) - 14yrs



ANNEX 5. ASSESSMENT RATINGS

This table presents assessment ratings for each evaluation question with a corresponding rationale, and organized as strengths and challenges. The assessments are made using a notional scale (see below). Half-measures (e.g. 2-3/5) are used to signify important efforts that still fall short of ‘satisfactory’ because improvements remained necessary.

Notional scale:

- 1: unsatisfactory
- 2: partly satisfactory
- 3: satisfactory
- 4: good
- 5: excellent

Table 4: Assessment Rating – Evaluation Questions and rationale

Rating	Rationale
KEQ 1. Effectiveness: 3/5 (aggregated)	
<p>1.1 Achievements: 4/5 Qu. How well did the response achieve HAC objective 1 and indicators?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • CC Centres: Overall, UNICEF ‘established’ 42 CC Centres in Sierra Leone by December 2014 (see Figure x) and a total of 64 CC Centres across the three countries by late March 2015, exactly in line with indicator targets and appropriately adapted to the changing epidemic which no longer required 300 CC Centres as originally proposed in the HAC. UNICEF delivered 79 ‘functional’ CC Centres across the three countries by February 2015 as targeted, and then quickly reduced them to 15 by April 2015, when indicator targets were also removed. During 2015, UNICEF prepositioned RITES in Liberia and Sierra Leone but used them only in Liberia, and instead used Rapid Response Teams (RRTs) in Sierra Leone and Guinea. • C4D: Implementers and communities report that UNICEF effectively undertook behaviour change campaigns in each country. UNICEF met all targets for reaching households with face-to-face Ebola messages by May 2015, reaching over 2m households across the three countries (see Figure 6). UNICEF’s monitoring suggests reductions in resistance to Ebola interventions and continued challenges, although indicators do not measure UNICEF’s specific contribution. • Child protection: UNICEF achieved targets for supporting Ebola orphans and providing psychosocial support to children. UNICEF supported Interim Care Centres (ICCs) and Observational Interim Care Centres (OICCs), which were centre-based quarantine care facilities established as medical staff felt it inappropriate to keep children who tested EVD negative in the ETUs when their parents tested positive. <p>Challenges:</p> <ul style="list-style-type: none"> • CC Centres: While UNICEF set no targets for the decommissioning or conversion of CC Centres into health units, COs took different approaches and the future of some CC Centres remained unclear. • Child protection: Yet child protection programmes struggled to address Ebola’s severe ‘secondary’ effects on children. Child protection programmes began to address secondary effects more comprehensively by late 2015. • Perceptions: In responding to polling questions about performance on HAC 2014 activities, UNICEF stakeholders were notably more positive about achievements in supplies, education, and child protection than in immunization, basic health care, and CC Centres.



Rating	Rationale
<p>1.2 Contributions to stopping Ebola: 3/5</p> <p>How important was UNICEF's contribution to stopping Ebola?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Overall contribution: UNICEF's contribution to stopping Ebola was made through the interagency response with national governments. Among both external and internal analyses, there is widespread agreement that affected communities themselves made the greatest contribution to stopping Ebola. Once scaled up the international public health response launched in August 2014 eventually made an important contribution to stopping Ebola, mainly through support to communities, local and national actors. • Specific contributions: UNICEF contributed most to stopping Ebola through its community engagement (UNICEF's contribution was a large part of the total interagency effort in community engagement and UNICEF's most important contribution), isolation and care (It was not a central actor in the tracing and isolation activities of WHO and MSF), and large-scale delivery of supplies and WASH support (UNICEF's supply response was its largest to date, with over 8000Mt of goods supplied). • Early isolation and care: CC Centres made a notable contribution to stopping Ebola by providing early isolation and care at the community level as intended in the Programme Guidance. In Sierra Leone, UNICEF and stakeholders described how CC Centres contributed to reducing EVD transmission. The CC Centres were based on sound logic for addressing the growing spread of Ebola fuelled by fear and mistrust. • Community engagement and social mobilization: By late 2014, UNICEF made improvements to C4D, moving from IEC generation and public awareness towards greater dialogue with communities, widespread deployment of community-based social mobilizers and training in community engagement. • WASH: UNICEF's WASH activities contributed directly to stopping transmission at the community level. • Supplies: UNICEF supplies also contributed directly to stopping Ebola at the community level. • Community approach: UNICEF did quite well to implement the innovative community-based response. It managed to bring together CC Centres, C4D, WASH and supply activities at the community-level. It delivered partially integrated and prioritized activities aimed at stopping Ebola. <p>Challenges:</p> <ul style="list-style-type: none"> • Early isolation and care: Nonetheless the CC Centres became operational too late to substantially reduce transmission. Ultimately the contribution made by CC Centres to stopping Ebola was modest. • Community engagement and social mobilization: Beyond what is captured by indicators, UNICEF and partners struggled to adequately engage, mobilize and empower communities to fight Ebola as proposed in the Programme Guidance. Between March and August 2014, UNICEF implemented many poorly-conceived public information campaigns. Despite these improvements, UNICEF continued to lack adequate capacities to implement action research and incorporate learning through feedback loops, which is fundamental to C4D. UNICEF also struggled to lead and coordinate the UNMEER community engagement and social mobilization (CESM) pillar. • Child protection: Although child protection activities were to be conducted at community-level, they were not specifically designed to stop Ebola transmission as defined in the Programme Guidance. Moreover, child protection programmes came too late to contribute significantly to stopping transmission. • Education: Notwithstanding its valuable support for radio broadcast learning programmes and return to school in the three countries, UNICEF's education programme struggled to contribute directly to stopping Ebola at community level. • Other programmes: Beyond the focus of study, it is unclear how other UNICEF programmes contributed to stopping Ebola. • Community approach: Left much room for improvement in effectiveness, integration and sequencing. It struggled to integrate or involve in a sequenced manner child protection, education, and other UNICEF programmes.



continued: ANNEX 5: Table 4

Rating	Rationale
<p>1.3 Achievements towards health and social services: 2/5</p> <p>How well did UNICEF achieve HAC objective 3?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Health systems: As reflected in the indicators, UNICEF undertook activities to immunize under 5s against measles, train CHWs in Ebola prevention and case management, and provide health structures in Ebola-affected areas with IPC supplies. • Community healthcare: During the Ebola response, UNICEF recognized the importance of supporting community-based healthcare and learned lessons about how communities could be encouraged to reengage with it. • Community healthcare: UNICEF aims to sustain community-based health care in the recovery phase. <p>Challenges</p> <ul style="list-style-type: none"> • Health systems: During much of 2015, UNICEF struggled to reinforce primary healthcare systems amid critiques that it invested in parallel structures (CC Centres) and sometimes undermined public health systems. • Health systems: Wider recovery programmes in the three countries are achieving disappointing results amid significant funding gaps. • Health systems: Although UNICEF's objective was limited to supporting WHO and partners in rebuilding primary health care systems in the three countries, these systems remained weak and vulnerable to public health threats. • Core capacities: It is unclear what contribution UNICEF is making to WHO-led efforts to build national or regional surveillance and IHR core capacities.

KEQ2. Efficiency: 2/5 (aggregated)	
<p>2.1 Timeliness: 1-2/5</p> <p>Did UNICEF implement the response on time in countries affected?</p>	<p>Challenges</p> <ul style="list-style-type: none"> • Containment: International actors missed the opportunity to contain the Ebola outbreak in March 2014, when the virus was first identified. UNICEF missed the opportunity to mount a strong organizational response from March until July 2014, when it finally prepared a regional response strategy. • Community-response delays: UNICEF's community-based response aimed at stopping the transmission of Ebola became operational after the epidemic peaked. UNICEF CC Centres also became operational after the outbreak's peak due to internal delays. • Programme delays: Child protection and non-prioritized programmes did not become fully operational until 2015, more than six months after the declaration of L3.
<p>2.2 Cost analysis 3/5</p> <p>How consistent were inputs (financial, HR, and other) with results achieved?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Overall UNICEF appeared to make satisfactory use of resources as appropriate for an emergency response. UNICEF's strategy to stop Ebola was implemented according to the principle of 'no regrets', above that of pure cost-efficiency. <p>Challenges</p> <ul style="list-style-type: none"> • Questions raised about CC Centres, human resources, and supplies. • Most notably, UNICEF invested considerably in building CC Centre structures instead of alternative low-tech solutions. • HR: UNICEF also spent extensively in human resources, including international staff, national staff and partners. • Supplies: UNICEF spent large funds on supplies which required careful planning.



continued: ANNEX 5: Table 4

Rating	Rationale
<p>2.3 Efficiency factors N/A</p> <p>Which factors most influenced efficiency?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Supply and logistics showed operational efficiency by acting with speed and competence when the L3 was declared <p>Challenges</p> <ul style="list-style-type: none"> • Human resource management presented major challenges to an efficient response as UNICEF struggled to mobilize enough emergency staff, to recruit and deploy them, and to address significant fears without HR support at RO and CO levels • Finance and administration presented another major challenge to efficiency, because COs did not consistently apply accelerated financial and administrative procedures, • Until the appointment of a dedicated GEC in early October 2014, the response was slowed by a lack of direction. • Strategy was undermined by different understandings of Ebola-related risks and the rationale for intervention • Monitoring was slowed by the weekly demands of producing sitreps at RO and CO levels

KEQ 3. Internal coordination: 3/5 (aggregated)

<p>3.1 Procedures: 3-4/5</p> <p>How well did UNICEF's L3 SSOPs model enable effectiveness?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Looking at the 13 SSOP functions, those concerned with strategic management made critical qualitative contributions to effectiveness. Similarly, UNICEF's resource management functions made strong, large-scale and material contributions to effectiveness, <p>Challenges</p> <ul style="list-style-type: none"> • Strategic management functions also left clear room for improvement. HR, finance and administration struggled with perennial structural challenges. • UNICEF's knowledge management and 'learning' functions did little to contribute to effectiveness and remain poorly defined in the process.
<p>3.2 Global coordination: 2/5</p> <p>How did global emergency coordination, through the GEC and Ebola Cell, enable effectiveness?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • The appointment of a dedicated GEC with expertise in public health made a critical difference to strategic direction. <p>Challenges</p> <ul style="list-style-type: none"> • Yet the GEC's public health leadership was challenged at RO and CO levels, where it was considered inadequately informed by local context. Decisions made through exceptional mechanisms (core directors, HQ-based) were also contested at RO and CO levels. Without the capacities of EMOPS, the Ebola Cell struggled to mobilize an optimal emergency response.
<p>3.3 Strategy, planning, and monitoring: 2-3/5</p> <p>How did strategic planning and monitoring of performance enable effectiveness?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • UNICEF's prioritized community-based strategy was critical to stopping Ebola transmission, but a notable departure from the organization's standard multisector emergency response. <p>Challenges</p> <ul style="list-style-type: none"> • The Ebola emergency posed unprecedented challenges and risks for which UNICEF's multisector emergency model was not well adapted, and generated intense debates about how to respond. UNICEF's strategy was undermined by different understandings of Ebola-related risks and the rationale for intervention; by difficulties in programme integration and sequencing; and by a proliferation of different strategies. • While UNICEF made efforts to monitor its performance throughout the response, its monitoring of indicators contributed little to performance management. UNICEF lacked capacities to collect and properly analyse the monitoring data at CO level.



continued: ANNEX 5: Table 4

Rating	Rationale
<p>3.4 Information management: 2/5</p> <p>How did collection and analysis of information (needs assessments, epidemiology, KAPs and anthropology) enable effectiveness?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • During 2015, UNICEF's response made better use of epidemiological data, real time monitoring, partner reporting and innovative applications. <p>Challenges</p> <ul style="list-style-type: none"> • UNICEF lacked epidemiology data to make evidence-based programmatic decisions in 2014 and early 2015; analytical capacities to produce timely information to guide programmes; and a suitable information management function to support the emergency response.
<p>3.5 Human Resources: 2-3/5</p> <p>How did human resources management (surge deployment and safety/welfare) enable effectiveness?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • For 2014 and 2015, 662 surge capacity requests were made by WCARO and COs in the region, 508 were completed and 154 were cancelled upon CO/RO request. • At HQ level, UNICEF developed new policies and procedures to reinforce staff safety and duty of care, including medical care, medevac, insurance, hazard and death benefit. <p>Challenges</p> <ul style="list-style-type: none"> • UNICEF experienced considerable difficulties in providing the largescale additional human resources needed to implement the response. UNICEF faced systemic problems in the recruitment and deployment of emergency staff, allowing coverage of only half of surge capacity needs in 2014 and leaving the rest to 'ad hoc' solutions. • The response was delayed by significant fear of Ebola which limited the number of staff willing to deploy. After medical protocols were established, COs felt overwhelmed by surge staff of mixed quality and a decreased sense of response ownership. • Emergency HR managers played a lead role in mobilizing surge capacity without adequate HR support at RO and CO levels.
<p>3.6 Supply and logistics: 4/5</p> <p>How did supply and logistics enable effectiveness?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • UNICEF's supply and logistics activities contributed to stopping Ebola mainly through the largescale delivery of supplies and protective equipment to the countries and communities affected. UNICEF scaled up the delivery of supplies to the affected countries to coincide with the peak of the outbreak in October 2014. The SD acted with speed and efficiency to support the response when the L3 was declared, delivering timely and adequate supplies and largely avoiding 'stock outs'. <p>Challenges</p> <ul style="list-style-type: none"> • Yet the delivery of supplies was constrained by critical gaps in knowledge and information. Supply and logistic activities also made mixed contributions to UNICEF's strategy to stop transmission, and especially in the 'last mile'. Like other sections, UNICEF's supply function was not well prepared to respond to Ebola.



Rating	Rationale
<p>3.7 Finance and administration: 2/5</p> <p>How did operations (i.e. financial and administrative procedures) enable effectiveness?</p>	<p>Challenges</p> <ul style="list-style-type: none"> • Despite UNICEF's Ebola response being well-funded overall and especially by 2015, COs did not consistently apply accelerated financial and administrative procedures, which in turn slowed the response. • The persistence of slow procedures in the Ebola response is explained by gaps in emergency-competent finance capacity at CO level, and gaps in emergency-appropriate tools and guidance for their application. Institutional arrangements did not foster an appropriate integration of finance and administration with programmes.
<p>3.8 Implementation and innovations: 3/5</p> <p>How did implementation modalities enable effectiveness?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Community approach: UNICEF did quite well to implement the innovative community-based response. It managed to bring together CC Centres, C4D, WASH and supply activities at the community-level. It delivered partially integrated and prioritized activities aimed at stopping Ebola. <p>Challenges</p> <ul style="list-style-type: none"> • UNICEF is not adequately learning lessons from its innovative community-led implementation model used to break transmission. Important questions remain about how best to support this community-led approach through partnerships, and how best to use 'innovations' to support the community-led approach.
<p>3.9 Preparedness: 2/5</p> <p>How did pre-epidemic preparedness enable effectiveness?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • Following the Ebola response, UNICEF was well prepared to respond to the continuing threat of Ebola in the countries affected. <p>Challenges</p> <ul style="list-style-type: none"> • UNICEF was significantly unprepared to respond to Ebola in the countries most affected. It lacked important community and C4D capacities needed for the response. • It remains unclear how well prepared is UNICEF to respond to public health emergencies in other countries at risk worldwide, and at the international level to respond to PHEICs and other emergencies.
<p>3.10 Knowledge management: 2-3/5</p> <p>How were lessons applied and learned?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • UNICEF is making useful efforts to consolidate learning and prepare for future PHEICs. <p>Challenges</p> <ul style="list-style-type: none"> • UNICEF's response was insufficiently informed by learning from previous public health emergencies, raising questions about knowledge management mechanisms. The response allowed minimal opportunity for overall reflection and course correction. • UNICEF learning and preparedness efforts remain unready to effectively inform future emergency responses.



continued: ANNEX 5: Table 4

KEQ 4. External coordination: 2.5/5 Aggregate	
<p>4.1 Strategic coordination: 2-3/5</p> <p>How did UNICEF's strategic leadership-level coordination enable effectiveness?</p>	<p>Strengths</p> <ul style="list-style-type: none"> In Sierra Leone, key informants noted that UNICEF was considered an effective actor in the NERC, having good relations with the government, and frontline agency coordination forums. <p>Challenges</p> <ul style="list-style-type: none"> From March to July 2014, UN governance mechanisms at global and national levels, of which UNICEF is an integral part, had failed to contain Ebola before it spread out of control. Before and immediately after the internal L3 declaration, UNICEF and partners struggled to coordinate and lead a response that was proactive and adequate to the task. At national level, the establishment of UNMEER in September 2014 and the appointment of Ebola Crisis Managers provided empowered and focused public health leadership which filled a strategic coordination gap, but they struggled to engage UN operational actors adequately; not least by preferentially employing a 'command' approach over 'collaboration'. The strategic leadership challenge for UNICEF is to 'add value' to WHO. Learning exercises and UNICEF key informants highlight the need to develop a collective capacity for surveillance and epidemiology analysis, and strengthened UNICEF capacity to study these analyses, interpret data, and guide decisions at all levels.
<p>4.2 Operational coordination: 2/5</p> <p>How did UNICEF's cluster/pillar leadership contribute to effectiveness?</p>	<p>Challenges</p> <ul style="list-style-type: none"> UNICEF's operational coordination was initially complicated by the establishment of UNMEER and technical pillars. The new community engagement and social mobilization coordination pillar led by UNICEF presented significant challenges. The effectiveness of CP and WASH appeared to be complicated by the absence of pillars until clusters were established. No learning exercise has been undertaken into the coordination of these functions, but the lack of coordination mechanisms is seen as a failure.
KEQ 5. Accountability: 3-4/5 (aggregated)	
<p>5.1 Relevance to policy: 2-3/5</p> <p>Was UNICEF response (e.g. as expressed in its objectives and activities) aligned with international and national policy frameworks?</p>	<p>Strengths</p> <ul style="list-style-type: none"> UNICEF's response objectives were broadly aligned with overarching WHO and government strategies. <p>Challenges</p> <ul style="list-style-type: none"> The HAC response objectives were not clearly aligned with the CCC. Many UNICEF actors strongly contested the response's derogation of the CCC. The HAC response objectives were insufficiently aligned with UNICEF's wider child protection obligations.



continued: ANNEX 5: Table 4

Rating	Rationale
<p>5.2 Relevance to epidemiology and needs: 2-3/5</p> <p>Were UNICEF objectives aligned with changing epidemiology and needs?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • UNICEF’s response objective 1 (aimed at stopping the transmission of Ebola) was highly relevant to the epidemiology. UNICEF responses in each country affected were viewed as relevant in principle to stopping Ebola. <p>Challenges</p> <ul style="list-style-type: none"> • UNICEF’s corporate response strategy was defined too late to be relevant to the initial outbreak. UNICEF’s response objectives were not directly relevant to humanitarian needs and specific needs of children arising from the Ebola outbreak.
<p>5.3 Appropriateness of implementation: 4/5</p> <p>Were UNICEF implementation strategies appropriate to unique and evolving challenges?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • In general, UNICEF’s implementation strategies evolved to become increasingly appropriate. • The complexities of the epidemic in Guinea, with the virus hiding in 'shadow zones' forced UNICEF’s implementation strategies to be flexible and constantly adapting through 'learning by doing'. • In Liberia, where Ebola also had an 'early start', UNICEF’s had to learn the hard way with more trial and error, not least when the disease 're-emerged' in November 2015. • UNICEF’s focus on implementation at the community level, e.g. face to face communication, was appropriate – particularly given fears that health workers infected people with EVD in care centres, specific cultural beliefs and burial practices that encouraged the spread of EVD, and low literacy levels and access to information.
<p>5.4 Equity: 4/5</p> <p>Was UNICEF’s response programming guided by equity considerations?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • UNICEF’s community interventions did not preferentially target specific vulnerable groups with prevention and care activities. There were no reports of UNICEF’s response being biased or discriminatory <p>Challenges:</p> <ul style="list-style-type: none"> • The response did not fully anticipate or prioritize other pressing humanitarian and protection needs resulting from Ebola. • Some critics note that some government activities supported by UNICEF such as quarantines were implemented in a biased manner.
<p>5.5 National development: 3-4/5</p> <p>Was UNICEF’s response consistent with local and national development priorities?</p>	<p>Strengths</p> <ul style="list-style-type: none"> • In a formal sense, UNICEF’s response was consistent with national development priorities and supported government leadership and coordination. <p>Challenges</p> <ul style="list-style-type: none"> • In practice, UNICEF’s response was sometimes inconsistent with national priorities for strengthening health systems. • Questions remain about whether UNICEF sufficiently reinforced national health systems in the response.



continued: ANNEX 5: Table 4

Rating	Rationale
5.6 AAP: 3-4/5 UNICEF's response implemented in a manner accountable to the affected population?	Strengths <ul style="list-style-type: none">As the response evolved, UNICEF made significant efforts to engage communities through dialogue. Overall, after a weak start, UNICEF's response became somewhat more accountable to communities. Challenges <ul style="list-style-type: none">UNICEF's response did not systematically apply the Commitments on Accountability to Affected Populations (AAP). The initial response was often characterized by one-way communication with communities.



ANNEX 6. EXPENDITURE INFORMATION

Data on HAC spending were available through UNICEF's VISION system (Virtual Integrated System of Information). The data presented here include Ebola-related funds utilized¹² for 2014 and 2015 for the three Country Offices. Data were categorized by sector and expenditure type and are described below. The figures below depict the data aggregated across the three countries.

By sector, health was the largest area of spending (35%) followed by WASH (17%) and C4D/cross-cutting (15%). Child protection and education sectors were roughly equal with 11% of overall spending each. Nutrition and HIV made up much smaller amounts of total expenditures (5% and 1% respectively).

UNICEF Ebola response expenditure 2014-2015, by programme area, Guinea, Liberia and Sierra Leone.

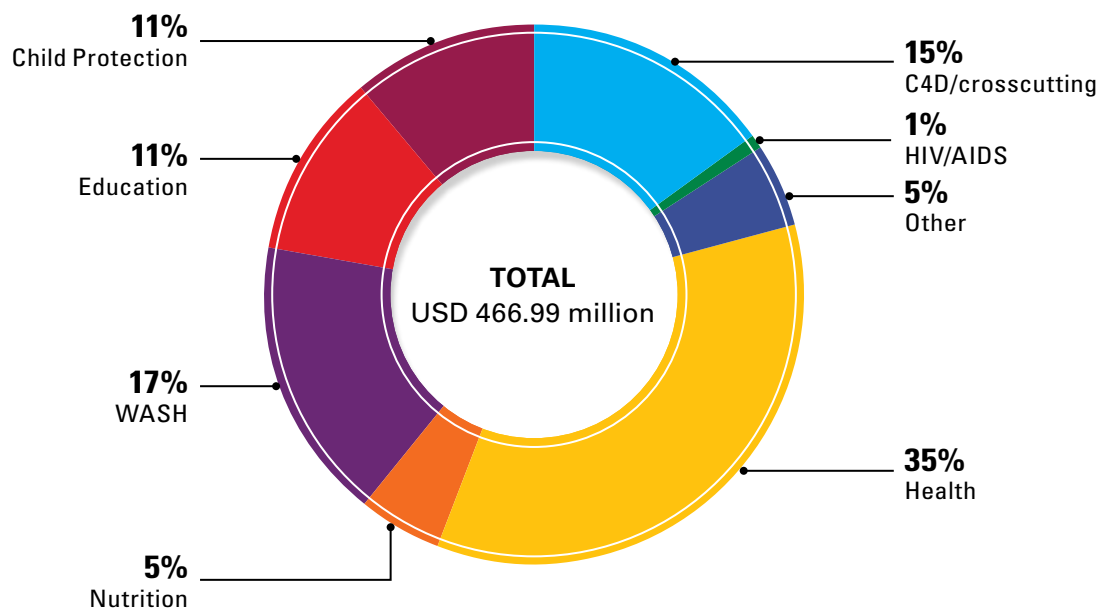


Figure 1 Expenditures by sector

By cost category, the majority of expenditures were either for supplies and commodities (36%) or transfer and grants to counterparts (36%). General operating costs and contractual services accounted for 7% and 5% respectively.

¹² As defined by the VISION e-Glossary, funds utilized include open commitments and disbursements.



UNICEF Ebola response expenditure 2014-2015, by cost category, Guinea, Liberia and Sierra Leone.

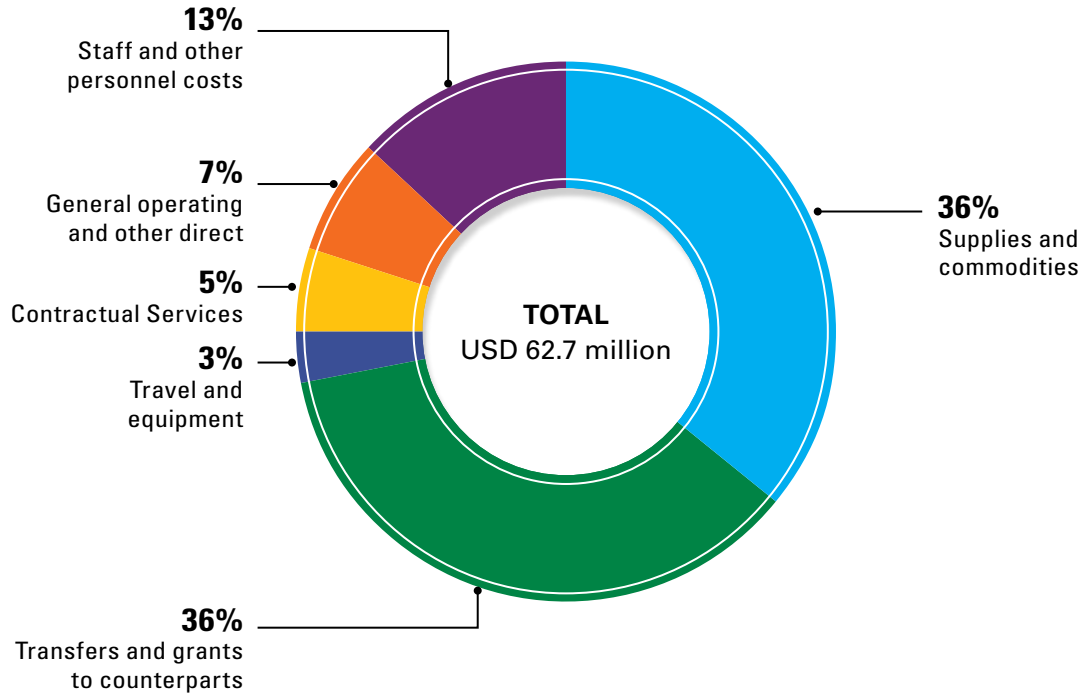


Figure 2 Expenditures by cost category

UNICEF response to Ebola, 10 largest expenditure items, 2014-2015, three affected countries

	Sector	Category	Amount	% of total
1	Health	Supplies and commodities	\$ 94.6 million	20.3%
2	Health	Transfers and grants to counterparts	\$ 40.4 million	8.7%
3	Child protection	Transfers and grants to counterparts	\$ 33.7 million	7.2%
4	WASH	Transfers and grants to counterparts	\$ 32.5 million	7.0%
5	C4D	Transfers and grants to counterparts	\$ 32.0 million	6.9%
6	WASH	Supplies and commodities	\$ 30.8 million	6.6%
7	Education	Supplies and commodities	\$ 20.1 million	4.3%
8	C4D/cross-sectoral	Staff and other personnel costs	\$ 19.1 million	4.1%
9	Education	Transfers and grants to counterparts	\$ 16.6 million	3.6%
10	Nutrition	Supplies and commodities	\$ 10.4 million	2.2%

