

EVALUATION REPORT

March, 2017

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

■■ **Evaluation Office** ■■

unicef 

for every child

EVALUATION REPORT

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

■ ■ **Evaluation Office** ■ ■

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

© United Nations Children's Fund, New York, 2016
United Nations Children's Fund
Three United Nations Plaza
New York, New York 10017
March 2017

The purpose of publishing evaluation reports produced by the UNICEF Evaluation Office is to fulfil a corporate commitment to transparency through the publication of all completed evaluations. The reports are designed to stimulate a free exchange of ideas among those interested in the topic and to assure those supporting the work of UNICEF that it rigorously examines its strategies, results, and overall effectiveness.

The contents of the report do not necessarily reflect the policies or views of UNICEF.

The text has not been edited to official publication standards and UNICEF accepts no responsibility for error.

The designations in this publication do not imply an opinion on the legal status of any country or territory, or of its authorities, or the delimitation of frontiers.

The copyright for this report is held by the United Nations Children's Fund. Permission is required to reprint/reproduce/photocopy or in any other way to cite or quote from this report in written form. UNICEF has a formal permission policy that requires a written request to be submitted. For non-commercial uses, the permission will normally be granted free of charge. Please write to the Evaluation Office at the address below to initiate a permission request.

See the full evaluation report on:
www.unicef.org/evaldatabase/index_95016.html

For further information, please contact:

Evaluation Office
United Nations Children's Fund
Three United Nations Plaza
New York, New York 10017
evalhelp@unicef.org

Photo credits

Page 21: © UNICEF/UNI172299/Bindra
Page 32: © UNICEF/UNI166991/Jallanzo
Page 46: © UNICEF/UNI176921/Nesbitt
Page 50: © UNICEF/UNI175164/Nesbitt
Page 62: © UNICEF/UNI174064/Marchador Pi
Page 66: © UNICEF/UN011612/Holt



PREFACE

Through much of 2014 and into 2015, the international community witnessed an outbreak of Ebola virus disease in parts of West Africa that was unprecedented in scale, severity and complexity. The toll in illness and death was severe: more than 28,000 people were infected and more than 11,000 died. Some 16,000 children lost parents or caregivers to Ebola.

The impact of the outbreak went far beyond those grim figures. The three most-affected countries – Guinea, Liberia and Sierra Leone – were ill-equipped to respond. As a result, the outbreak wrought serious humanitarian, economic, development and health consequences. Livelihoods were disrupted, fragile health systems were severely compromised and entire educational systems were either shut down or school openings delayed.

The outbreak revealed serious deficiencies in national and global response mechanisms aimed at controlling potential pandemics. It took the greater part of 2014 for the national and international response to help bring the outbreak under control. The outbreak was ultimately contained thanks to efforts of affected communities themselves, local leaders and the massive deployment of international resources.

This report presents results from an evaluation of UNICEF's response to the crisis. It documents and analyses UNICEF efforts, drawing out important lessons to prepare and strengthen UNICEF's approach to addressing future public health emergencies.

UNICEF country offices began responding to the Ebola outbreak in early 2014. In early September, a corporate-level emergency was declared, under which, in coordination with many partners, UNICEF mobilized an agency-wide response to the crisis. The response was sustained through 2015.

This report sets out the findings, conclusions and recommendations of an evaluation of UNICEF's response to the Ebola outbreak in West Africa. The evaluation served an accountability function and enabled stakeholders to offer feedback; it supported organizational learning by identifying key lessons for UNICEF; and it prompted strategic consideration by providing recommendations to UNICEF on preparing for future public health emergencies.

The evaluation drew on a wide range of other learning exercises and assessments. To complement these, the evaluation focused selectively on the strategic challenge of coordinating UNICEF's levels, programmes and operational functions (i.e. how these elements combined to deliver an effective response). As such, it does not provide detailed information or a technical assessment of implementation.



PREFACE (cont'd)

The evaluation found that UNICEF and partners made useful contributions to stopping Ebola transmission and that those contributions depended foremost on the organization's innovative community-based implementation model, participation in the larger international public health response with national governments, and the mobilization of corporate capacities through the Level 3 Simplified Standard Operating Procedure resource management functions.

However, the impact of these contributions was diminished by important factors. These include missed opportunities for containing the outbreak in March 2014, delays in operationalizing the community-based response, differing understandings of the rationale for intervention and weaknesses in performance management and monitoring systems. Moreover, UNICEF was challenged in its efforts to promptly and adequately address Ebola's secondary humanitarian consequences and specific effects on children.

The Ebola epidemic in West Africa was a grim reminder of the stark threat posed to humanity by communicable diseases. In the aftermath of the outbreak, there is widespread agreement that such threats will continue to arise from time to time. Drawing on the key findings from this evaluation, the recommendations presented in this report are therefore primarily focused on how UNICEF can be better prepared and capacitated to deal with future health emergencies.

The evaluation was conducted by a team headed by Andrew Lawday, and including Kerren Hedlund, Nigel Clarke, Steve Powell, Annie Lloyd, Tamba Emile Sandounou, Lynn Owen, and Alistair Hallam. It benefited from information, perspectives and feedback provided by UNICEF colleagues in the Guinea, Liberia and Sierra Leone UNICEF country offices, the UNICEF West and Central Africa Regional Office in Dakar, Senegal, as well as UNICEF Headquarters. The Evaluation Reference Group provided important contributions and guidance throughout the process. Finally, I would like to recognize Beth Plowman, who served as Evaluation Manager with support provided by Abdoulaye Seye.

We would also like to acknowledge the contributions made to this evaluation by staff in partner organizations, as well as by national officials and community members who shared their stories with the evaluation team. They gave time and attention to the evaluation during a period of enormous stress and pressure. We hope that the results of the evaluation are used to prevent or contain similar emergencies in future years, and to alleviate the concomitant loss and suffering experienced by those affected.

Colin Kirk
Director, Evaluation Office
UNICEF

CONTENTS

PREFACE	iii
ACKNOWLEDGEMENTS	vii
ACRONYMS	viii
EXECUTIVE SUMMARY	1
RÉSUMÉ ANALYTIQUE	7
RESUMEN EJECUTIVO	14
INTRODUCTION	21
Evaluation purpose, objectives and scope	22
Methodology	23
Ebola outbreak	24
UNICEF's response	29
SECTION I: EFFECTIVENESS	32
1.1 Stopping transmission	33
1.2 Contributions	41
1.3 Recovery	43
SECTION II: EFFICIENCY	46
2.1 Timeliness	47
2.2 Efficiency	49
SECTION III: INTERNAL COORDINATION	50
3.1 Procedures	51
3.2 Global coordination	51
3.3 Strategy, planning, and monitoring	53
3.4 Information management	54
3.5 Human Resources	55
3.6 Supply and logistics	57
3.7 Finance and administration	58
3.8 Implementation and innovations	59
3.9 Preparedness	60
3.10 Knowledge management	60
SECTION IV: EXTERNAL COORDINATION	62
4.1 Strategic coordination	63
4.2 Operational coordination	64
SECTION V: ACCOUNTABILITY	66
5.1 Relevance to policy	67
5.2 Relevance to epidemiology and needs	68
5.3 Appropriateness of implementation	69
5.4 Equity	70
5.5 National development	71
5.6 Accountability to the affected population	72
CONCLUSIONS	73
RECOMMENDATIONS	76
REFERENCES	79

CONTENTS (cont'd)

TABLES AND FIGURES

Figure 1:	West African Ebola cases 2014–2015	27
Figure 2:	Humanitarian Action for Children Ebola outbreak response logic model	30
Figure 3:	Knowledge, attitude and practice survey findings from Sierra Leone	36
Figure 4:	Households reached with interpersonal messages on Ebola prevention (June 2015–December 2015)	37
Figure 5:	Registered Ebola orphans provided with minimum package of care	40
Figure 6:	UNICEF stakeholder poll on the most important contributions to stopping Ebola	42
Figure 7:	How important was the contribution of internal processes to UNICEF’s overall achievements	52
Figure 8:	UNICEF supply function in response to Ebola: Supplies delivered by air and Ebola case load in the three affected countries, 2014 and 2015	57



ACKNOWLEDGEMENTS

The evaluation was conducted and the full report was written by a team contracted by Valid Evaluations Ltd.: Andrew Lawday, Team Leader; Kerren Hedlund, Research Analyst; Nigel Clarke, Senior Evaluator; Steve Powell, Senior Evaluator; Annie Lloyd, Senior Evaluator; Tamba Emile Sandounou, Senior Evaluator; Lynn Owen, Project Management Officer; and Alistair Hallam, Director, Valid Evaluations Ltd.

This evaluation was made possible by the contributions of colleagues both inside and outside of UNICEF. The evaluation team gratefully acknowledges the many people too numerous to name individually, who contributed time, information and thoughts (*see Annex 2*). The team greatly appreciates the institutional support provided by the UNICEF Evaluation Office, Programme Division, Office of Emergency Programmes (EMOPS) and others at UNICEF Headquarters (HQ) in New York, as well as the UNICEF Supply Division in Copenhagen, the UNICEF West and Central Africa Regional Office (WCARO) in Dakar and the UNICEF country offices in Guinea, Liberia and Sierra Leone.

For helping to steer the evaluation, providing expert advice and investing time and effort in reviewing the report, the evaluation team highlights the valuable contributions made by the Evaluation Reference Group and other key actors.

For their practical guidance and support, the team also thanks UNICEF colleagues Inoussa Kabore, Regional Chief, Monitoring and Evaluation (Dakar); Filippo Mazzeoli, Regional Emergency Specialist (Dakar); Cairn Verhulst, Monitoring Specialist (Dakar); Jean-Baptiste Sene, Chief, Section of Social Policy, Planning and Monitoring and Evaluation (Guinea); Seydou Dia, Chief of Emergencies (Guinea); Dr. Guy Yogo, Deputy Representative (Guinea); Zainab Al-Azzawi, Monitoring and Evaluation Specialist (Liberia); Deirdre Kiernan, Senior Emergency Coordinator (Liberia); and Maryam Abdu, Chief of Social Policy Planning and Monitoring and Evaluation (Sierra Leone).

For assisting with in-country data collection and analysis, the team thanks the national researchers Kau Belleh (Liberia), 'Fred' Fallay Kayll (Sierra Leone) and Jenneh Tooray Bunting (Sierra Leone).

The team is particularly grateful to Beth Plowman, UNICEF Senior Evaluation Specialist, as primary interlocutor and point of contact, who managed and facilitated the process, provided a wealth of technical insights and helped to raise the quality of the evaluation. The team is also grateful to Abdoulaye Seye, UNICEF Evaluation Specialist, for his essential contributions to the evaluation.



ACRONYMS

AAP	Accountability to affected populations	KEQ	Key evaluation question
C4D	Communication for Development	L3	Level 3 emergency
CCCs	Core Commitments for Children in Humanitarian Action	MSF	Médecins Sans Frontières
CC centres	Community care centres	NGO	Non-governmental organization
CDC	Centers for Disease Control and Prevention (United States)	OICC	Observational interim care centres
CO	Country office	PHEIC	Public Health Emergency of International Concern
EMOPS	Office of Emergency Programmes (UNICEF)	RITE	Rapid Isolation Treatment for Ebola
ETU	Ebola treatment unit	SOP	Standard Operating Procedures
EVD	Ebola virus disease	SQ	Sub-question
GEC	Global Emergency Coordinator	SSOP	Simplified Standard Operating Procedure
GMT	Global Management Team	STEPP	Stop the outbreak; Treat the infected, Ensure essential services; Preserve stability; Prevent outbreaks in countries currently unaffected
HAC	Humanitarian Action for Children	UNICEF	United Nations Children's Fund
HQ	Headquarters	UNMEER	United Nations Mission for Ebola Emergency Response
IASC	Inter-Agency Standing Committee	WASH	Water, sanitation and hygiene
ICC	Interim care centres	WCARO	West and Central Africa Regional Office (UNICEF)
ICT	Information and communications technology	WFP	World Food Programme
IFRC	International Federation of Red Cross and Red Crescent Societies	WHO	World Health Organization
IHR	International Health Regulations		
INGO	International non-governmental organization		



EXECUTIVE SUMMARY

The Ebola outbreak in West Africa was unprecedented in scale, severity and complexity. In the three most-affected countries – Guinea, Liberia and Sierra Leone – some of the most vulnerable communities were also among the hardest hit. Fragile health systems were severely compromised as a disproportionate number of health workers died; entire educational systems were shut down and many teachers lost their lives; and widespread fear led communities to shun Ebola sufferers, many of whom were left to die in the streets.¹ Children were disproportionately affected by the outbreak, with thousands infected, killed or orphaned. Between December 2013 and March 2016, Ebola infected 28,638 people and caused 11,316 deaths.²

This report presents the findings, conclusions and recommendations of an evaluation conducted between November 2015 and September 2016. The evaluation aims 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 evaluation objectives are to offer accountability to stakeholders through an independent assessment of the response; highlight the main lessons for UNICEF; and provide strategic recommendations for the continued response and future public health emergencies.

METHODOLOGY

The evaluation is focused on UNICEF's corporate response to the Ebola emergency in Guinea, Sierra Leone and Liberia during the period declared a Level 3 (L3) emergency (August 2014 through the end of 2015). The

assessment considers the effectiveness, efficiency, internal coordination, external coordination and accountability of the response.

The analysis is broadly focused on the strategic challenge of coordinating UNICEF's levels, programmes and operational functions (i.e. how these elements combined to deliver an effective response). As such, it does not attempt to provide detailed information on implementation. As reflected in the Terms of Reference, the evaluation prioritizes programme elements related to: 1) health/case management, including the community care centres (CC centres); 2) Communication for Development (C4D), social mobilization and community engagement; and 3) child protection, particularly family tracing and reunification and care for separated and unaccompanied children.

Data collection and analysis was conducted using mixed methods, including qualitative and quantitative data collection techniques: a lessons review; a document review; data analyses; stakeholder consultations; stakeholder polling; and case studies of affected communities. Field missions were undertaken to Guinea, Liberia, Sierra Leone and Senegal during February and March 2016. In the three most-affected countries, analysts conducted consultations and polling among implementation actors and national leaders; and in two of the most-affected communities, analysts also performed case studies. The evaluation was limited by a number of factors, including the evolving strategies for the response both within UNICEF and externally; the ongoing adaptation of performance monitoring; and the difficulties involved in using humanitarian response standards, frameworks and tools in a public health emergency.

¹ For example, see: Meredith, Catherine, 'A bottom-up approach to the Ebola response', Humanitarian Practice Network, June 2015, <<http://odihpn.org/magazine/a-bottom-up-approach-to-the-ebola-response/>>, accessed 10 November 2016.

² United Nations, Lessons learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response: Report of the Secretary-General, A/70/737, United Nations, New York, 4 March 2016.



CONTEXT AND RESPONSE

The Ebola virus disease (EVD) outbreak began in December 2013 in remote areas of Guinea and by late May 2014 had spread to Liberia and Sierra Leone. In August 2014, WHO declared a Public Health Emergency of International Concern (PHEIC). With high poverty rates, weak health systems and minimal levels of preparedness, the three most-affected countries were poorly equipped to respond. Although the outbreak's impact was most evident at the local level, with 90 per cent of cases concentrated in 20 districts across the three countries,³ it wrought serious humanitarian, economic, development and health consequences on populations across the region.⁴

The national and international responses to Ebola only brought the outbreak under control after thousands of deaths and widespread devastation had already occurred. As the outbreak spread during 2014, weak national health care systems struggled to cope and health care professionals became infected and died at alarming rates. Many of the international non-governmental organizations (INGOs) present in Guinea, Liberia and Sierra Leone were also overwhelmed by the scale of the outbreak and struggled to mobilize staff to scale up a response.

As the world became gripped by fear of Ebola, world powers strengthened their resolve to contain the outbreak. In 2014–2015, national governments, INGO partners and the United Nations system, led first by the World Health Organization (WHO) and subsequently by the United Nations Mission for Ebola Emergency Response (UNMEER), took measures to coordinate the effort to control the outbreak and prevent its further spread. These measures included the development of a regional response plan (July 2014), a response roadmap

(August 2014), UNMEER United Nations-wide operational planning (October 2014) and national Ebola recovery strategies (early 2015).

Within the larger response, UNICEF country offices in Guinea, Liberia and Sierra Leone participated in early efforts to detect and manage Ebola cases alongside their regular multisector country programmes. In September 2014, three weeks after WHO declared the PHEIC, UNICEF declared an L3 corporate emergency, developed an organizational strategy for responding to the outbreak and prepared specific country response plans. As outlined in the Humanitarian Action for Children (HAC) 2014–2015 Ebola outbreak appeal, UNICEF aimed to: 1) stop the outbreak through community-level actions; 2) prepare for outbreaks in additional countries; and 3) contribute to maintaining or building back better the primary health care and other social systems in the most-affected countries. In 2015, UNICEF accompanied these efforts with multiple learning exercises.

EFFECTIVENESS OF THE RESPONSE

Working with partners and governments, UNICEF contributed to stopping Ebola through community engagement, isolation and care; the large-scale delivery of supplies and water, sanitation and hygiene (WASH) support; and an innovative community-based response aimed at stopping transmission. Beginning in November 2014, UNICEF established 64 CC centres that facilitated community engagement, isolation and care. Although many respondents reported that the CC centres were established too late to substantially reduce transmission, the centres effectively identified hidden cases and provided basic treatment for other morbidities when few other options existed.

³ United Nations Children's Fund, 'Ebola Virus Disease Outbreak: UNICEF Regional Response Strategy', 23 October 2014.

⁴ United Nations, Lessons learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response: Report of the Secretary-General, A/70/737, United Nations, New York, 4 March 2016.



Despite capacity challenges, UNICEF also undertook community-based C4D campaigns in each country, reaching nearly 3 million households, and contributed to behaviour changes that helped to sustain or accelerate reductions in transmission. As the outbreak escalated, it became clear that informed, motivated and empowered communities were needed to stop Ebola rather than one-way communication. The C4D strategy evolved accordingly and community engagement became more consistently effective once medical anthropologists and social scientists were engaged in shaping the messaging.⁵

At the height of the epidemic in mid-2014, UNICEF provided little direct child protection services to Ebola orphans and very few children received psychosocial support. Targets for supporting Ebola orphans were only met across the three countries by September 2015, and for psychosocial support were only met across the three countries by December 2015, by which time UNICEF had reached more than 320,000 children. Overall response implementation struggled to integrate child protection services, as well as education and other services (e.g. nutrition), into the complete system at community level; and did not sufficiently involve these programmes in a sequenced second phase to address Ebola's secondary effects and humanitarian consequences.

UNICEF made broader operational contributions to the response through its largest supply operation to date, delivering more than 8,000 metric tonnes of supplies by mid-2015, and through WASH programmes implemented in CC centres, Ebola treatment units (ETUs), health structures, schools and some 2.8 million households in affected areas.

EFFICIENCY OF THE RESPONSE

UNICEF's Ebola response was well-funded, receiving US\$437.8 million, or 86 per cent of the total funding appeal, by mid-November 2015.⁶ Funding gaps were generally larger, however, during the critical period of September 2014–December 2014, when the country office responses in Guinea, Liberia and Sierra Leone were funded at 44 per cent, 37 per cent and 54 per cent, respectively. This is compared with 2015, when appeals were generally funded at over 70 per cent.

The response fell short of efficiency expectations, especially in terms of timeliness. UNICEF and partners missed key opportunities to successfully contain the outbreak (March 2014–July 2014); tackle its alarming growth (August 2014–November 2014); and deal with its secondary effects and human consequences (August 2014–early 2015). UNICEF's C4D function began to reach capacity in December 2014, and CC centres only became operational after the outbreak's peak. Targets for non-prioritized programmes such as child protection were only met several months after the L3 declaration.

The response's efficiency was primarily determined by the mobilization and utilization of supplies and human and financial resources. While the supply and logistics response demonstrated efficiency by acting with speed and competence when the L3 was declared, human resources presented a major challenge to efficiency as UNICEF struggled to mobilize sufficient numbers of emergency staff while also addressing duty of care requirements. The response was also slowed by the inconsistent application of accelerated financial and administrative procedures at the country level. At

⁵ World Health Organization, 'Report of the Ebola Interim Assessment Panel', WHO, 2015, <www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>, accessed 14 November 2016; Moon, Suerie, et al., '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, *The Lancet*, vol. 386, no. 10009, 28 November 2015.

⁶ United Nations Children's Fund, 17 November 2015.



times, key management functions, including global coordination, strategy, planning and monitoring, also undermined efficiency.

INTERNAL COORDINATION

UNICEF's Simplified Standard Operating Procedures (SSOPs) for L3 emergencies – the organization's internal coordination process for emergency response – functioned adequately and contributed to effectiveness but also showed room for improvement. The appointment in October 2014 of the dedicated Global Emergency Coordinator (GEC) with public health expertise facilitated clear direction at a time of uncertainty and brought a necessary focus to stopping transmission through a community-led approach. The GEC's public health leadership was challenged at country and regional levels, however, and decisions made through exceptional mechanisms such as the Core Directors Group instead of the Emergency Management Team were contested. The Ebola Cell struggled to mobilize an optimal emergency response without the full functional capacities of EMOPS.

In terms of strategy, planning and monitoring, although UNICEF's community-based public health strategy was essential to stopping Ebola transmission, it was also undermined by varied understandings of Ebola-related risks and the rationale for intervention. A divide was observed between those who accepted the logic of intervening primarily to stop Ebola transmission and those who felt the response should focus on addressing the impact of the outbreak on children. The UNICEF strategy also faced challenges related to programme integration and sequencing, the lack of inter-sectoral strategy development and lack of clarity about how all sectors could contribute to stopping Ebola transmission.

In regards to information management, UNICEF and partners were initially working with limited epidemiological data for guiding programmatic decisions. By 2015, however, UNICEF was making growing use of real-time monitoring,

partner reporting and innovative information and communications technology (ICT) applications to support programmes.

EXTERNAL COORDINATION

Although UNICEF's contributions to stopping Ebola involved working closely with governments, the United Nations system and other partners, external coordination sometimes constrained UNICEF's own effectiveness. At the strategic leadership level, the United Nations country teams and humanitarian country teams did not manage to contain Ebola from March to July 2014 and did not provide a well-coordinated strategic response at the L3 declaration until Ebola crisis managers were deployed. While the establishment of UNMEER in September 2014 and the appointment of Ebola crisis managers provided empowered and focused public health leadership that filled a strategic coordination gap, these mechanisms did not adequately engage United Nations operational actors.

At the operational level, the establishment of UNMEER's technical pillars partially undermined the coordination that was already underway among UNICEF and other United Nations agencies. The pillars also presented new challenges to UNICEF, as the lead of the community engagement and social mobilization coordination pillar (although this pillar was also seen to add value), and initially left gaps in the coordination of child protection, education and WASH, for which pillars were not established and other coordination mechanisms were required. Most UNICEF actors saw little added value in UNMEER, which came late in the response and detracted from early response efforts.

ACCOUNTABILITY

Accountability in the UNICEF response was satisfactory across a range of key commitments, with room for improvement at the community level. Although the response came late, its objectives and activities were well



aligned with national and international strategies for stopping Ebola and recovery, and were consistent with national development priorities related to government leadership and coordination. UNICEF's response Objective 1 (stopping Ebola) and the responses in each country were highly relevant to the epidemiological context and were delivered to affected communities without bias. At the community level, implementation strategies became increasingly appropriate through regular learning exercises, and UNICEF's community-based approach meant increasing transparency, feedback and participation – all key provisions of accountability to affected populations (AAP).

UNICEF's response fell short of wider accountabilities for humanitarian action and child protection, however. Response objectives and activities were not well aligned with UNICEF's Core Commitments for Children in Humanitarian Action (CCCs) and specific child protection responsibilities. UNICEF's response Objective 1 (stopping Ebola) and prioritized strategy were not directly relevant to meeting the secondary needs arising from the Ebola outbreak or the specific needs of affected children. The response itself did not prioritize addressing the pressing humanitarian and protection needs of children and was at times at odds with national priorities for strengthening health systems.

CONCLUSIONS

1. UNICEF's public health response made a useful contribution to stopping the transmission of Ebola, most notably through community engagement, isolation and care activities, and the large-scale delivery of supplies and WASH support.
2. UNICEF's response neither promptly nor adequately addressed Ebola's serious secondary humanitarian consequences and specific effects on children.
3. Although UNICEF worked to support, maintain and strengthen health systems in the three affected countries, the organization and partners struggled to reinforce basic services in the wider recovery effort without adequate funding and as a result, national health systems remained vulnerable to public health threats.
4. As a key health partner and actor in the WHO-led response, UNICEF shared responsibility for critical delays in preventing and responding to Ebola. In some cases, UNICEF's effectiveness was constrained by inadequate inter-agency strategic leadership and operational coordination.
5. UNICEF's contributions relied significantly on an innovative community-based response implementation model that involved targeted actions at the community level to generate community behaviour change.
6. UNICEF provided the strategic direction needed to stop Ebola transmission, but its leadership was hampered by inadequate institutional arrangements, performance management and information analysis.
7. UNICEF's mobilization of financial, human and supply capacities enabled a large-scale response and made strong material contributions to effectiveness but struggled with new Ebola-specific challenges and existing gaps in human resource competencies.
8. UNICEF's response did not sufficiently rely on knowledge management and the organization remained only partially prepared for future public health emergencies. UNICEF did, however, make significant efforts to learn by doing.
9. Although UNICEF's response was aligned with the inter-agency public health strategy and EVD epidemiological context, the lack of a suitable policy and accountability framework for public health emergencies meant that the response was disconnected from the CCCs, which were neither fully appropriate nor relevant to a public health emergency.



RECOMMENDATIONS

1. UNICEFWCARO, country offices and partners in the three most-affected countries should ensure at minimum that: 1) health systems retain a rapid response capacity to prevent Ebola outbreaks and develop International Health Regulations (IHR) core capacities; 2) community health systems are reinforced in the most-affected communities; and 3) children most affected by Ebola receive adequate protection.
2. The UNICEF Global Management Team (GMT) should develop a policy and accountability framework for responding to public health emergencies that includes: 1) specific goals; 2) programme guidance; 3) global partnership objectives; and 4) assessment of broader humanitarian risks. Whether produced as an addendum to the CCCs or a separate policy, it should complement and build on rather than duplicate UNICEF's existing emergency response policies and processes.
3. The UNICEF GMT should recognize areas for improvement and strengthen coordination, strategy and information capacities for public health emergencies. Drawing on lessons learned from the Ebola response, UNICEF should develop tools, guidance and mechanisms and strengthen capacities for: 1) global emergency coordination; 2) planning, programme support and performance monitoring; and 3) information and knowledge management functions.
4. The UNICEF GMT should continue to strengthen capacities for rapid, large-scale deployment of financial, human and material resources in emergencies by: 1) applying lessons and protocols from the Ebola response about duty of care; 2) significantly increasing emergency human resource capacities and emergency competencies in country offices; and 3) involving operational and administrative staff in strategy and programme management.
5. UNICEF EMOPS and the UNICEF Programme Division should further develop the community-based approach as an implementation modality inclusive of strong AAP and community engagement components. Recognizing the central role of communities in stopping Ebola, UNICEF should focus on strengthening local capacities and systems for health and social protection at the community level. This effort should include means of increasing capacity within UNICEF for community engagement and social mobilization and improving programme integration at the community level.



RÉSUMÉ ANALYTIQUE

L'épidémie d'Ebola qui a frappé l'Afrique de l'Ouest a été d'une ampleur, d'une sévérité et d'une complexité sans précédent. Dans les trois pays les plus sinistrés – la Guinée, le Libéria et la Sierra Leone – certaines des communautés les plus vulnérables ont aussi été les plus durement touchées. Les systèmes de santé déjà fragiles ont été gravement pénalisés par le nombre disproportionné de décès chez les professionnels de santé. Des systèmes éducatifs entiers ont été réduits à néant et de nombreux enseignants ont perdu la vie. Enfin, la peur généralisée a conduit les communautés à exclure les personnes contaminées par le virus Ebola, qui ont été nombreuses à être abandonnées à leur sort dans la rue⁷. Les enfants ont été frappés de manière disproportionnée par l'épidémie, des milliers ont été infectés, ont trouvé la mort ou se sont retrouvés orphelins. De décembre 2013 à mars 2016, le virus Ebola a contaminé 28 638 personnes et provoqué 11 316 décès⁸.

Le présent rapport expose les résultats, les conclusions et les recommandations d'une évaluation menée de novembre 2015 à septembre 2016. Cette évaluation a pour but de porter un regard objectif sur l'intervention menée par l'UNICEF pour répondre aux besoins des populations touchées et résoudre les difficultés engendrées par l'épidémie d'Ebola en Afrique de l'Ouest. Les objectifs de l'évaluation sont de rendre compte aux parties prenantes par le biais d'un examen indépendant de l'intervention, mettre en lumière les principaux enseignements pour l'UNICEF et formuler des recommandations stratégiques pour la poursuite des interventions et les urgences de santé publique ultérieures.

MÉTHODOLOGIE

L'évaluation porte sur l'intervention de l'UNICEF face à l'urgence de la crise Ebola en Guinée, en Sierra Leone et au Libéria, au cours de la période déclarée situation d'urgence de niveau 3 (d'août 2014 à fin 2015). L'évaluation porte sur l'efficacité, l'efficience, la coordination interne, la coordination externe et la redevabilité de l'intervention.

L'analyse est essentiellement axée sur la difficulté stratégique que représente la coordination des niveaux, programmes et fonctions opérationnelles de l'UNICEF (à savoir, l'intégration de ces différents éléments pour assurer l'efficacité de l'intervention). Son objectif n'est pas de fournir à elle seule des informations détaillées sur la mise en œuvre des opérations. Comme le cahier des charges le laisse paraître, l'évaluation traite en priorité les éléments du programme associés à : 1) la gestion des soins/cas, notamment les centres de soins communautaires (*community care centres*, CCC) ; 2) la Communication pour le développement (C4D), la mobilisation sociale et l'engagement des communautés ; et 3) la protection de l'enfance, en particulier la recherche et la réunification des familles et la prise en charge des enfants séparés ou non accompagnés.

La collecte et l'analyse des données ont été effectuées à l'aide de méthodes mixtes, notamment des techniques de collecte de données qualitatives et quantitatives : un examen des enseignements, une étude documentaire, des analyses de données, des consultations auprès des parties prenantes, des sondages auprès des parties prenantes et des études de cas dans les communautés touchées. Des missions sur le terrain ont été menées en Guinée, au Libéria,

⁷ Voir par exemple : Catherine Meredith, « A bottom-up approach to the Ebola response » (Une approche ascendante de l'intervention contre l'Ebola) dans *Humanitarian Practice Network*, juin 2015, disponible à l'adresse suivante : <http://odihpn.org/magazine/a-bottom-up-approach-to-the-ebola-response>, consulté le 10 novembre 2016.

⁸ Organisation des Nations Unies, Examen des enseignements tirés sur les activités de coordination menées par la Mission des Nations Unies pour l'action d'urgence contre l'Ebola (MINUAUCE) - Rapport du Secrétaire général (A/70/737), Organisation des Nations Unies, New York, 4 mars 2016.



en Sierra Leone et au Sénégal en février et mars 2016. Dans les trois pays les plus sinistrés, des analystes ont mené des consultations et des sondages auprès des acteurs chargés de la mise en œuvre des opérations et des dirigeants nationaux ; par ailleurs, dans deux des communautés les plus touchées, les analystes ont aussi effectué des études de cas. L'évaluation a été limitée par un certain nombre de facteurs, notamment l'évolution des stratégies d'intervention au sein de l'UNICEF, mais aussi en externe, l'adaptation continue du suivi des performances, et les difficultés associées au respect des normes, cadres et outils d'intervention humanitaire dans les situations d'urgence de santé publique.

CONTEXTE ET INTERVENTION

L'épidémie de la maladie à virus Ebola a débuté en décembre 2013 dans des régions reculées de Guinée ; fin mai 2014, elle s'était propagée au Libéria et en Sierra Leone. En août 2014, l'OMS a déclaré qu'il s'agissait d'une urgence de santé publique de portée internationale (USPPI). Avec des taux de pauvreté élevés, des systèmes de santé fragiles et des niveaux de préparation minimaux, les trois pays les plus touchés ont cruellement manqué de moyens pour combattre l'épidémie. Si les répercussions locales de l'épidémie étaient les plus manifestes, avec 90 % des cas concentrés dans 20 districts des trois pays⁹, celle-ci a eu de graves conséquences sur les plans humanitaire, économique, sanitaire et du développement pour les populations de toute la région¹⁰.

Lorsque les interventions nationales et internationales de lutte contre l'Ebola sont parvenues à juguler la crise, plusieurs milliers de décès et d'importants dégâts étaient déjà survenus. Avec la propagation de l'épidémie en 2014, les systèmes de santé nationaux, déjà peu performants, ont eu des difficultés à faire face, et

les taux de contamination et de décès chez les professionnels de santé ont été alarmants. Nombre d'organisations non gouvernementales internationales (ONGI) présentes en Guinée, au Libéria et en Sierra Leone ont également été dépassées par l'ampleur de la crise et ont peiné à mobiliser le personnel nécessaire pour intensifier la lutte.

Alors que le monde était saisi de crainte, les puissances mondiales se sont montrées plus déterminées que jamais à contenir l'épidémie. En 2014-2015, les gouvernements nationaux, les ONGI partenaires et le système des Nations Unies, sous la direction initiale de l'Organisation mondiale de la Santé (OMS) puis de la Mission des Nations Unies pour l'action d'urgence contre l'Ebola (MINUAUCE), ont pris des mesures pour coordonner les efforts déployés afin de contrôler l'épidémie et l'empêcher de se propager davantage. Ces mesures comprenaient l'élaboration d'un plan d'intervention régional (juillet 2014), une feuille de route pour l'intervention (août 2014), un plan opérationnel de la MINUAUCE pour l'ensemble des Nations Unies (octobre 2014) et des stratégies nationales de relèvement post-épidémie (début 2015).

Dans le cadre de l'intervention globale, les bureaux de pays de l'UNICEF en Guinée, au Libéria et en Sierra Leone ont pris part aux premières actions menées pour dépister et prendre en charge les cas d'Ebola, parallèlement à leurs programmes multisectoriels nationaux habituels. En septembre 2014, trois semaines après la déclaration d'USPPI de l'OMS, l'UNICEF a déclaré une situation d'urgence de niveau 3, mis au point une stratégie organisationnelle pour lutter contre l'épidémie et préparé des plans d'intervention nationaux spécifiques. Comme cela est précisé dans l'appel pour lutter contre l'épidémie d'Ebola et le rapport Action humanitaire de l'UNICEF pour les

⁹ Fonds des Nations Unies pour l'enfance, *Ebola Virus Disease Outbreak: UNICEF Regional Response Strategy* (Épidémie d'Ebola : la stratégie d'intervention régionale de l'UNICEF), 23 octobre 2014.

¹⁰ Organisation des Nations Unies, *Examen des enseignements tirés sur les activités de coordination menées par la Mission des Nations Unies pour l'action d'urgence contre l'Ebola (MINUAUCE) - Rapport du Secrétaire général (A/70/737)*, Organisation des Nations Unies, New York, 4 mars 2016.



enfants 2015, l'organisation s'était donné pour mission : 1) d'enrayer l'épidémie par le biais d'actions menées à l'échelle communautaire ; 2) de se préparer à des flambées épidémiques dans d'autres pays ; et 3) de contribuer à préserver ou mieux rebâtir les systèmes de santé primaire et autres systèmes sociaux dans les pays les plus sinistrés. En 2015, l'UNICEF a couplé ces efforts à de nombreux exercices de formation.

EFFICACITÉ DE L'INTERVENTION

En collaboration avec les partenaires et gouvernements, l'UNICEF a contribué à enrayer l'épidémie d'Ebola grâce à la mobilisation des communautés, aux mesures d'isolement et de prise en charge des malades, à l'approvisionnement et au soutien dans le domaine de l'eau, de l'assainissement et de l'hygiène (EAH), et à une intervention communautaire innovante visant à stopper la transmission du virus. À partir de novembre 2014, l'UNICEF a créé 64 CCC qui ont favorisé la mobilisation des communautés et facilité l'isolement et la prise en charge des malades. Nombre de personnes interrogées ont affirmé que les CCC avaient été créés trop tardivement pour réduire la transmission de façon significative, néanmoins, ces centres ont permis d'identifier de manière efficace des cas invisibles et d'administrer des traitements de base pour d'autres maladies alors que peu d'autres options existaient.

En dépit de capacités limitées, l'UNICEF a par ailleurs lancé des campagnes de C4D à l'échelle communautaire dans chaque pays, touchant ainsi près de trois millions de foyers. Il a également contribué à faire évoluer les comportements pour maintenir ou accélérer la réduction de la transmission du virus. Alors que l'épidémie se propageait, la nécessité d'informer, motiver et responsabiliser les communautés pour

enrayer Ebola, plutôt que d'assurer une communication unilatérale, est apparue évidente. La stratégie C4D a évolué en conséquence et l'engagement des communautés est devenu plus efficace une fois que des anthropologues médicaux et des sociologues ont été impliqués dans l'élaboration des messages diffusés¹¹.

Au plus fort de l'épidémie, mi-2014, l'UNICEF assurait peu de services directs de protection de l'enfance aux enfants orphelins à cause du virus Ebola, et très peu d'enfants bénéficiaient d'un soutien psychosocial. Ce n'est qu'en septembre 2015 que les objectifs fixés en matière de soutien aux enfants orphelins ont été atteints dans les trois pays. En ce qui concerne le soutien psychosocial, les objectifs n'ont été atteints qu'en décembre 2015, date à laquelle l'UNICEF avait touché plus de 320 000 enfants. Dans le cadre de la mise en œuvre générale de l'intervention, il s'est avéré difficile d'intégrer les services de protection de l'enfance, mais aussi les services éducatifs et d'autres services (par ex., la nutrition) à l'ensemble du système à l'échelle communautaire. Par ailleurs, ces programmes n'ont pas été suffisamment pris en compte dans une seconde phase visant à combattre les effets secondaires d'Ebola et ses conséquences humanitaires.

Sur le plan opérationnel, l'UNICEF a contribué plus largement à l'intervention en menant sa plus vaste opération d'approvisionnement à ce jour, avec plus de 8 000 tonnes de matériel fourni à la mi-2015, et en mettant en œuvre les programmes EAH dans les CCC, les unités de traitement d'Ebola, les structures de santé, les écoles et quelque 2,8 millions de foyers dans les zones touchées.

¹¹ Organisation mondiale de la Santé, *Rapport du Groupe d'experts chargé de l'évaluation intérimaire de la riposte à Ebola*, OMS, 2015, disponible à l'adresse suivante : www.who.int/csr/resources/publications/ebola/ebola-panel-report/fr, consulté le 14 novembre 2016 ; Moon, Suerie, *et al.*, « 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 » (L'Ebola va-t-il changer la donne ? Dix réformes essentielles à adopter avant la prochaine pandémie. Rapport du panel indépendant Harvard LSHTM sur l'intervention mondiale contre l'Ebola), dans *The Lancet*, vol. 386, n° 10009, 28 novembre 2015.



EFFICIENCE DE L'INTERVENTION

L'intervention de l'UNICEF face à l'Ebola a été bien financée avec 437,8 millions de dollars, soit 86 % de l'appel de fonds total, dès la mi-novembre 2015¹². Les déficits de financement ont en revanche été plus profonds au cours de la période critique entre septembre et décembre 2014 au cours de laquelle les interventions des bureaux de pays de Guinée, du Libéria et de Sierra Leone n'étaient financées qu'à hauteur de 44 %, 37 % et 54 %, respectivement. En comparaison, les appels ont été généralement financés à plus de 70 % en 2015.

L'efficacité de l'intervention n'est pas parvenue à satisfaire les attentes, notamment en matière de rapidité. L'UNICEF et ses partenaires n'ont pas réussi à saisir des occasions cruciales pour contenir l'épidémie (mars 2014 - juillet 2014), affronter son alarmante propagation (août 2014 - novembre 2014) et gérer ses effets secondaires et ses conséquences humaines (août 2014 - début 2015). Le potentiel maximal de la fonction C4D de l'UNICEF a été atteint en décembre 2014 et les CCC n'ont été opérationnels qu'après le pic de l'épidémie. Les objectifs des programmes non prioritaires, comme la protection de l'enfance, n'ont été atteints que plusieurs mois après la déclaration de situation d'urgence de niveau 3.

Ce sont la mobilisation et l'utilisation des fournitures et des ressources humaines et financières qui ont été les premiers facteurs de l'efficacité de l'intervention. Alors que l'efficacité de la logistique et de l'approvisionnement était démontrée par des mesures rapides et appropriées une fois le niveau 3 déclaré, les ressources humaines ont posé des problèmes majeurs, car l'UNICEF a eu des difficultés pour mobiliser suffisamment de personnels d'urgence tout en faisant face, dans le même temps, aux exigences en matière de devoir de protection. L'intervention a également été freinée par le manque de constance dans l'application des procédures financières et administratives

accélérées au niveau des pays. Parfois, l'efficacité a également pâti des fonctions de gestion essentielles, y compris la coordination générale, la stratégie, la planification et le suivi.

COORDINATION INTERNE

Les procédures opérationnelles standard simplifiées (POSS) de l'UNICEF pour les situations d'urgence de niveau 3 (le processus de coordination interne de l'organisation pour l'intervention d'urgence) ont fonctionné de façon adaptée et contribué à l'efficacité de l'intervention, mais des possibilités d'amélioration existent. La nomination, en octobre 2014, d'un coordinateur de l'intervention d'urgence à l'échelle mondiale bénéficiant d'une expertise dans la santé publique a fourni une orientation claire dans une période d'incertitude et contribué à un recentrage nécessaire afin d'enrayer la transmission grâce à une approche s'appuyant sur les communautés. L'autorité en matière de santé publique du coordinateur a cependant été mise en doute à l'échelle des pays et des régions, et des décisions prises au travers de mécanismes exceptionnels comme le Groupe des principaux directeurs plutôt que de l'Équipe de gestion des situations d'urgence ont été contestées. La Cellule Ebola a éprouvé des difficultés à mobiliser une intervention d'urgence optimale faute de disposer de toutes les capacités fonctionnelles du Bureau des programmes d'urgence.

En matière de stratégie, de planification et de suivi, même si la stratégie de santé publique de l'UNICEF fondée sur les communautés était cruciale pour arrêter la transmission de l'Ebola, elle a été ébranlée par des niveaux de compréhension variables des risques connexes et des justifications de l'intervention. Un fossé s'est creusé entre ceux qui acceptaient la logique d'une intervention destinée avant tout à enrayer la transmission de l'Ebola et ceux qui estimaient que l'intervention devait surtout s'attaquer aux répercussions de l'épidémie sur les

¹² Fonds des Nations Unies pour l'enfance, 17 novembre 2015.



enfants. La stratégie de l'UNICEF a également dû s'affranchir d'obstacles liés à l'intégration et à l'enchaînement des programmes, à l'absence d'une stratégie intersectorielle et au flou entourant la contribution de chaque secteur à l'arrêt de la transmission de l'Ebola.

En ce qui concerne la gestion des informations, l'UNICEF et ses partenaires ne disposaient initialement, pour orienter leurs décisions programmatiques, que de données épidémiologiques limitées. Toutefois, dès 2015, l'UNICEF a de plus en plus utilisé le suivi en temps réel, les rapports des partenaires et des applications innovantes dans le domaine des technologies de l'information et de la communication (TIC) pour soutenir ses programmes.

COORDINATION EXTERNE

Même si les contributions de l'UNICEF à l'éradication de l'Ebola impliquaient une étroite collaboration avec les gouvernements, le système des Nations Unies et d'autres partenaires, la coordination externe a parfois limité l'efficacité même de l'UNICEF. Au niveau de la direction stratégique, les équipes de pays des Nations Unies et les équipes humanitaires de pays ne sont pas parvenues à freiner la propagation de l'Ebola entre mars et juillet 2014 et n'ont pas proposé d'intervention stratégique correctement coordonnée après la déclaration de situation d'urgence de niveau 3 avant le déploiement des responsables de la gestion de la crise. Bien que la mise en place de la MINUAUCE en septembre 2014 et la nomination des responsables de la gestion de la crise de l'Ebola aient permis de responsabiliser et focaliser la direction de la santé publique, ce qui a permis de combler les lacunes en matière de coordination stratégique, ces mécanismes n'ont toutefois pas impliqué les acteurs opérationnels des Nations Unies de façon adéquate.

Sur le plan opérationnel, la mise en place des piliers techniques de la MINUAUCE a partiellement ébranlé la coordination déjà en cours entre l'UNICEF et les autres agences des Nations Unies. Ces piliers ont également

constitué de nouveaux obstacles pour l'UNICEF, organisation responsable du pilier relatif à la coordination de l'engagement communautaire et de la mobilisation sociale (bien que ce pilier ait été considéré comme porteur de valeur). Ils n'ont pas, à l'origine, permis une coordination parfaite de la protection de l'enfance, de l'éducation et de l'EAH, pour lesquelles les piliers n'étaient pas en place et qui nécessitaient d'autres mécanismes de coordination. La plupart des acteurs de l'UNICEF ont perçu une valeur ajoutée limitée dans la MINUAUCE, qui a rejoint l'intervention tardivement et a nui aux premiers efforts entrepris.

REDEVABILITÉ

La redevabilité de l'intervention de l'UNICEF a été satisfaisante pour plusieurs engagements clés, mais peut bénéficier d'améliorations au niveau communautaire. Malgré le déclenchement tardif de l'intervention, ses objectifs et activités correspondaient tous aux stratégies nationales et internationales d'éradication de l'Ebola et de relèvement, et étaient conformes aux priorités nationales de développement liées aux orientations et à la coordination gouvernementales. Le premier objectif de l'intervention de l'UNICEF (stopper l'Ebola) et les interventions dans chaque pays ont été très pertinents compte tenu du contexte épidémiologique et les communautés affectées en ont bénéficié en toute impartialité. Au niveau communautaire, les stratégies de mise en œuvre ont été de plus en plus adaptées grâce à des exercices d'apprentissage réguliers. L'approche communautaire de l'UNICEF signifiait par ailleurs plus de transparence, de retour d'information et de participation, des éléments essentiels de la redevabilité envers les populations affectées.

L'intervention de l'UNICEF n'a cependant pas été à la hauteur pour rendre compte plus largement de l'action humanitaire et de la protection de l'enfance. Les objectifs et les activités de l'intervention ne correspondaient pas aux Principaux engagements pour les enfants dans



l'action humanitaire (PEE) et aux responsabilités spécifiques en matière de protection de l'enfance. Le premier objectif de l'intervention de l'UNICEF (stopper l'Ebola) et la stratégie adoptée en priorité n'étaient pas directement pertinents pour faire face aux besoins secondaires causés par l'épidémie d'Ebola ou aux besoins spécifiques des enfants affectés. L'intervention elle-même n'a pas mis l'accent sur la réponse aux besoins humanitaires et de protection les plus urgents des enfants et contredisait parfois les priorités nationales pour le renforcement des systèmes de santé.

CONCLUSIONS

1. L'intervention de santé publique de l'UNICEF a apporté une contribution utile pour mettre fin à la transmission de l'Ebola, notamment grâce à l'engagement, à l'isolement et aux activités de soins des communautés, ainsi qu'à l'approvisionnement et au soutien EAH qu'elle a assurés à grande échelle.
2. L'intervention de l'UNICEF ne s'est pas attaquée de façon rapide ou adéquate aux conséquences humanitaires secondaires sérieuses et aux effets particuliers sur les enfants.
3. Même si l'UNICEF a œuvré pour soutenir, entretenir et renforcer les systèmes de santé des trois pays affectés, l'organisation et ses partenaires ont éprouvé des difficultés pour renforcer les services de base dans le cadre des efforts de relèvement plus larges, faute de financements adéquats. En conséquence, les systèmes de santé nationaux sont restés vulnérables face aux menaces de santé publique.
4. En tant que partenaire essentiel en matière de santé et acteur de l'intervention dirigée par l'OMS, l'UNICEF partage la responsabilité des retards importants dans la prévention et l'intervention face à l'Ebola. Dans certains cas, l'efficacité de l'UNICEF a été pénalisée par une direction stratégique interagence et une coordination opérationnelle inadéquates.
5. Les contributions de l'UNICEF se sont avant tout appuyées sur la mise en œuvre d'un modèle d'intervention fondé sur les communautés impliquant des actions ciblées au niveau communautaire destinées à susciter un changement de comportement des communautés.
6. L'UNICEF a fourni l'orientation stratégique nécessaire pour enrayer la transmission de l'Ebola, mais des dispositions institutionnelles, une gestion des performances et une analyse des informations inadéquates ont entravé sa direction.
7. La mobilisation des capacités financières, humaines et d'approvisionnement de l'UNICEF a permis une intervention de grande envergure et contribué de façon significative à son efficacité. Le Fonds n'est toutefois pas parvenu à s'affranchir de problèmes spécifiques à l'Ebola et des lacunes existantes dans les compétences en ressources humaines.
8. L'intervention de l'UNICEF ne s'est pas suffisamment appuyée sur la gestion des connaissances et l'organisation n'est encore que partiellement préparée à affronter de futures situations d'urgence de santé publique. L'UNICEF a cependant réalisé d'importants efforts pour apprendre par la pratique.
9. Même si l'intervention de l'UNICEF correspondait à la stratégie de santé publique interagence et au contexte épidémiologique de l'Ebola, l'absence d'un cadre de politique et de redevabilité adapté pour les situations d'urgence de santé publique a entraîné une déconnexion entre l'intervention et les PEE, qui n'étaient ni entièrement adaptés, ni pertinents pour une situation d'urgence de santé publique.



RECOMMANDATIONS

1. Le bureau régional de l'UNICEF pour l'Afrique de l'Ouest et du Centre, les bureaux de pays et les partenaires dans les trois pays les plus affectés devraient au minimum s'assurer que : 1) les systèmes de santé conservent une capacité d'intervention rapide pour prévenir les épidémies d'Ebola et améliorer les capacités essentielles établies dans le Règlement sanitaire international ; 2) les systèmes de santé communautaires sont renforcés dans les communautés les plus affectées ; et 3) les enfants les plus touchés par l'Ebola reçoivent une protection adéquate.
2. L'équipe mondiale de gestion (Global Management Team, GMT) de l'UNICEF devrait mettre au point un cadre de politique et de redevabilité pour répondre aux situations d'urgence de santé publique qui comprennent : 1) des objectifs spécifiques ; 2) une orientation en matière de programmes ; 3) des objectifs de partenariats généraux ; et 4) une évaluation des risques humanitaires élargis. Qu'il soit publié sous la forme d'un addendum aux PEE ou d'une politique séparée, il devrait compléter et s'appuyer sur les politiques et processus d'intervention d'urgence de l'UNICEF plutôt que les dupliquer.
3. La GMT de l'UNICEF devrait identifier les domaines où elle peut s'améliorer et renforcer ses capacités de coordination, de stratégie et d'information en cas de situation d'urgence de santé publique. En s'appuyant sur les leçons tirées de l'intervention contre l'Ebola, l'UNICEF devrait développer des outils, des guides et des mécanismes et renforcer les capacités pour : 1) la coordination de l'intervention d'urgence à l'échelle mondiale ; 2) la planification, le soutien aux programmes et le suivi des performances ; et 3) les fonctions de gestion des informations et des connaissances.
4. La GMT de l'UNICEF devrait poursuivre le renforcement des capacités pour un déploiement rapide et à grande échelle de ressources financières, humaines et matérielles en cas d'urgence en : 1) appliquant les leçons et les protocoles appris grâce à l'intervention contre l'Ebola en matière de devoir de protection ; 2) augmentant de façon significative les capacités de ressources humaines et les compétences en cas de situation d'urgence dans les bureaux de pays ; et 3) impliquant les personnels opérationnels et administratifs dans la gestion des stratégies et des programmes.
5. Le Bureau des programmes d'urgence et la Division des programmes de l'UNICEF devraient étendre le recours à l'approche communautaire comme modalité de mise en œuvre incluant une forte redevabilité envers les populations affectées et de solides engagements vis-à-vis des communautés. En reconnaissance du rôle central des communautés dans l'éradication de l'Ebola, l'UNICEF devrait se concentrer sur le renforcement des capacités et des systèmes locaux de protection sociale et de santé au niveau communautaire. Ces efforts devraient inclure des moyens pour augmenter les capacités au sein de l'UNICEF dans le domaine de l'engagement communautaire et de la mobilisation sociale et pour améliorer l'intégration des programmes au niveau communautaire.



RESUMEN EJECUTIVO

El brote del Ébola en África Occidental no tiene precedentes en su escala, gravedad y complejidad. En los tres países más afectados, Guinea, Liberia y Sierra Leona, algunas de las comunidades más vulnerables también se encuentran entre las más afectadas. Los debilitados sistemas de salud confrontaban graves dificultades a consecuencia de la muerte de un número desproporcionado de trabajadores de la salud; numerosos sistemas educativos tuvieron que cerrar sus puertas y muchos maestros perdieron sus vidas; y el temor generalizado llevó a que las comunidades evitaran a los enfermos del Ébola, a muchos de los cuales se les dejó morir en las calles¹³. Los niños sufrieron desproporcionadamente los efectos del brote, ya que miles de ellos resultaron infectados, murieron o quedaron huérfanos. Entre diciembre de 2013 y marzo de 2016, el Ébola infectó a 28.638 personas y causó 11.316 muertes¹⁴.

Este informe presenta las conclusiones y recomendaciones de una evaluación realizada entre noviembre de 2015 y septiembre de 2016. La evaluación tiene como objetivo proporcionar una valoración imparcial de la respuesta del UNICEF a las necesidades de las poblaciones afectadas, así como de otros desafíos derivados del brote del Ébola en África Occidental. Los objetivos de la evaluación son ofrecer una rendición de cuentas a las partes interesadas mediante una evaluación independiente de la intervención; destacar las principales lecciones para el UNICEF; y proporcionar recomendaciones estratégicas para mantener la intervención y para otras posibles futuras emergencias de salud pública.

METODOLOGÍA

La evaluación se centra en la respuesta institucional del UNICEF a la emergencia del Ébola en Guinea, Sierra Leona y Liberia durante el período declarado de emergencia de nivel 3 (L3) (agosto de 2014 hasta finales de 2015). La evaluación examina la eficacia, la eficiencia, la coordinación interna, la coordinación externa y la rendición de cuentas de la intervención.

El análisis se centra en general en el desafío estratégico que supone coordinar los niveles, los programas y las funciones operacionales del UNICEF (es decir, la manera en que estos elementos se combinan para llevar a cabo una intervención eficaz). Como tal, no intenta proporcionar información detallada sobre la ejecución. Como se refleja en los Términos de Referencia, la evaluación concede prioridad a los elementos del programa relacionados con: 1) la gestión de la salud o la gestión de casos, especialmente en los centros comunitarios de atención; 2) la Comunicación para el Desarrollo (C4D), la movilización social y el compromiso de la comunidad; y 3) la protección de la infancia, en particular la búsqueda de familias y la reunificación y el cuidado de los niños separados y no acompañados.

La recopilación y el análisis de datos se realizaron utilizando métodos mixtos, incluidas las técnicas de recopilación de datos cualitativos y cuantitativos: un examen de las lecciones; un examen de los documentos; un análisis de los datos; consultas con las partes interesadas; encuestas entre las partes interesadas; y estudios de caso de las comunidades afectadas. En febrero y marzo de 2016 se realizaron misiones sobre el terreno en Guinea, Liberia, Sierra Leona y Senegal. En los tres países más

¹³ Por ejemplo, véase: Meredith, Catherine, 'A bottom-up approach to the Ebola response', Humanitarian Practice Network, junio de 2015, <<http://odihpn.org/magazine/a-bottom-up-approach-to-the-ebola-response/>>, consultado el 10 de noviembre de 2016.

¹⁴ Naciones Unidas, Ejercicio de lecciones extraídas sobre las actividades de coordinación de la Misión de las Naciones Unidas para la Respuesta de Emergencia al Ébola: Informe del Secretario General, A/70/737, Naciones Unidas, Nueva York, 4 de marzo de 2016.



afectados, los analistas realizaron consultas y encuestas entre las personas que se encargaron de la ejecución y los dirigentes nacionales; y en dos de las comunidades más afectadas, los analistas también realizaron estudios de casos. La evaluación estuvo limitada por una serie de factores, incluyendo la evolución de las estrategias para la intervención tanto dentro del UNICEF como externamente; la adaptación en curso del monitoreo del desempeño; y las dificultades que implica el uso de normas, marcos y herramientas de respuesta humanitaria en una emergencia de salud pública.

CONTEXTO E INTERVENCIÓN

El brote de la enfermedad del virus del Ébola comenzó en diciembre de 2013 en varias zonas remotas de Guinea y hacia finales de mayo de 2014 se había extendido a Liberia y Sierra Leona. En agosto de 2014, la OMS declaró una emergencia de salud pública de interés internacional. Con altos índices de pobreza, unos sistemas de salud debilitados y niveles mínimos de preparación, los tres países más afectados estaban mal equipados para responder. Aunque el impacto del brote fue más evidente a nivel local, con el 90% de los casos concentrados en 20 distritos en los tres países¹⁵, tuvo graves consecuencias humanitarias, económicas, de desarrollo y de salud en las poblaciones de toda la región¹⁶.

Las respuestas nacionales e internacionales al Ébola sólo lograron poner bajo control el brote tras miles de muertes y una devastación generalizada. A medida que el brote se propagó durante el año 2014, los débiles sistemas nacionales de atención de la salud lucharon para hacer frente al problema y los profesionales de la salud se infectaron y murieron a una velocidad alarmante. Muchas de las organizaciones internacionales no gubernamentales (OING)

presentes en Guinea, Liberia y Sierra Leona también se vieron superadas por la magnitud del brote y lucharon por movilizar al personal para ampliar la intervención.

Cuando el mundo entero estaba atenazado por el temor al Ébola, las potencias mundiales reforzaron su determinación de contener el brote. En 2014-2015, los gobiernos nacionales, los asociados de las OING y el sistema de las Naciones Unidas, encabezados por la Organización Mundial de la Salud (OMS) y posteriormente por la Misión de las Naciones Unidas para la Respuesta de Emergencia al Ébola (UNMEER), adoptaron medidas a fin de coordinar los esfuerzos para controlar el brote y prevenir su propagación. Estas medidas incluyeron la elaboración de un plan de respuesta regional (julio de 2014), una hoja de ruta de respuesta (agosto de 2014), planificación operacional de la UNMEER a escala de las Naciones Unidas (octubre de 2014) y estrategias nacionales de recuperación del Ébola (principios de 2015).

Dentro de la respuesta más amplia, las oficinas del UNICEF en Guinea, Liberia y Sierra Leona participaron en los primeros esfuerzos para detectar y gestionar los casos del Ébola en línea con sus programas nacionales multi-sectoriales ordinarios. En septiembre de 2014, tres semanas después de que la OMS declarara la emergencia de salud pública de interés internacional, el UNICEF declaró una emergencia institucional de nivel 3 (L3), elaboró una estrategia organizacional para responder al brote y preparó planes de respuesta específicos para cada país. Como se señala en el llamado para el brote del Ébola de la Acción Humanitaria en favor de la Infancia (HAC) para 2014-2015, el UNICEF tenía como objetivo: 1) detener el brote por medio de acciones a nivel comunitario; 2) prepararse para la posible aparición de más brotes en otros países; y 3) contribuir a mantener o reconstruir mejor los

¹⁵ Fondo de las Naciones Unidas para la Infancia, 'Ebola Virus Disease Outbreak: UNICEF Regional Response Strategy', 23 de octubre de 2014.

¹⁶ Naciones Unidas, Ejercicio de lecciones extraídas sobre las actividades de coordinación de la Misión de las Naciones Unidas para la Respuesta de Emergencia al Ébola: Informe del Secretario General, A/70/737, Naciones Unidas, Nueva York, 4 de marzo de 2016.



sistemas de atención primaria de salud y otros sistemas sociales en los países más afectados. En 2015, el UNICEF acompañó estos esfuerzos con múltiples ejercicios de aprendizaje.

EFFECTIVIDAD DE LA INTERVENCIÓN

En colaboración con asociados y gobiernos, el UNICEF contribuyó a detener el Ébola por medio de la participación comunitaria, el aislamiento y la atención; la prestación a gran escala de suministros y de agua, saneamiento e higiene (WASH); y una innovadora respuesta comunitaria dirigida a detener la transmisión. A partir de noviembre de 2014, el UNICEF estableció 64 centros comunitarios de atención que facilitaron la participación, el aislamiento y la atención de la comunidad. Aunque muchos encuestados informaron que los centros comunitarios de atención se establecieron demasiado tarde para reducir sustancialmente la transmisión, los centros identificaron casos ocultos y proporcionaron tratamiento básico para otras morbilidades cuando existían pocas opciones.

A pesar de los retos en materia de capacidad, el UNICEF también realizó campañas comunitarias de C4D en cada país, llegando a casi 3 millones de hogares y contribuyendo a propiciar cambios de comportamiento que ayudaron a mantener o acelerar las reducciones en la transmisión. A medida que el brote se intensificó, quedó claro que, para detener el Ébola, era necesario que las comunidades estuvieran informadas, motivadas y capacitadas, en lugar de llevar a cabo una comunicación unidireccional. La estrategia de C4D evolucionó en consecuencia y el compromiso de la comunidad se hizo más uniformemente eficaz una vez que los antropólogos médicos y los científicos sociales se dedicaron a configurar los mensajes¹⁷.

En el punto más álgido de la epidemia, a mediados de 2014, el UNICEF proporcionó un número limitado de servicios directos de protección de la infancia a los huérfanos del Ébola y muy pocos niños recibieron apoyo psicosocial. Las metas de apoyo a los huérfanos del Ébola sólo se cumplieron en los tres países en septiembre de 2015, y las relativas al apoyo psicosocial sólo se cumplieron en los tres países en diciembre de 2015, cuando el UNICEF había llegado a más de 320.000 niños. En general, la implementación de la intervención tuvo dificultades para integrar los servicios de protección de la infancia, así como de educación y otros servicios (por ejemplo, nutrición) a nivel comunitario en todo el sistema; y no incorporó suficientemente estos programas a una segunda fase secuenciada para abordar los efectos secundarios y las consecuencias humanitarias del Ébola.

El UNICEF realizó contribuciones operacionales más amplias a la intervención mediante la mayor operación de suministro realizada hasta la fecha, mediante la cual distribuyó más de 8.000 toneladas métricas de suministros a mediados de 2015, y a través de programas de WASH implementados en centros comunitarios de atención, unidades de tratamiento del Ébola, estructuras sanitarias, escuelas y unos 2,8 millones de hogares en las zonas afectadas.

EFICIENCIA DE LA INTERVENCIÓN

La respuesta del UNICEF al Ébola estaba bien financiada, ya que a mediados de noviembre de 2015 había recibido 437,8 millones de dólares, o el 86% del llamamiento de financiación total¹⁸. Sin embargo, las brechas en la financiación fueron generalmente mayores durante el período crítico de septiembre de 2014 a diciembre de 2014, cuando las intervenciones de las oficinas del UNICEF en Guinea, Liberia y Sierra Leona sólo habían recibido un 44%, un 37% y un

¹⁷ Organización Mundial de la Salud, 'Report of the Ebola Interim Assessment Panel', OMS, 2015, <www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>, consultado el 14 de noviembre de 2016; Moon, Suerie, et al., '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, *The Lancet*, vol. 386, no. 10009, 28 de noviembre de 2015.

¹⁸ Fondo de las Naciones Unidas para la Infancia, 17 de noviembre de 2015.



54%, respectivamente, del total de la financiación. Esto se compara con el año 2015, cuando los llamamientos se financiaban en general en más del 70%.

La intervención no alcanzó las expectativas de eficiencia, especialmente en términos de puntualidad. El UNICEF y sus asociados no pudieron aprovechar una serie de oportunidades clave para contener con éxito el brote (marzo de 2014 a julio de 2014); afrontar su alarmante crecimiento (agosto de 2014-noviembre de 2014); y tratar sus efectos secundarios y consecuencias humanas (agosto 2014-principios de 2015). La función de C4D del UNICEF comenzó a alcanzar su capacidad en diciembre de 2014, y los centros comunitarios de atención sólo se pusieron en funcionamiento después de que el brote llegara a su momento más crítico. Los objetivos de los programas no prioritarios, como la protección de la infancia, sólo se cumplieron varios meses después de la declaración de la emergencia como L3.

La movilización y utilización de suministros y recursos humanos y financieros determinaron principalmente la eficiencia de la intervención. Mientras que la intervención en materia de suministro y logística demostró su eficiencia al actuar con rapidez y competencia cuando se declaró el L3, los recursos humanos presentaron un gran problema en lo que se refiere a la eficiencia, ya que el UNICEF tuvo dificultades para movilizar un número suficiente de personal de emergencia. Otra cuestión que ralentizó la intervención fue la falta de uniformidad en la aplicación de procedimientos financieros y administrativos acelerados a nivel nacional. A veces, las funciones clave de gestión, incluida la coordinación mundial, la estrategia, la planificación y la supervisión, también socavaron la eficiencia.

COORDINACIÓN INTERNA

Los Procedimientos Operativos Uniformes Simplificados del UNICEF para emergencias de nivel L3 –el proceso de coordinación interna de la organización para la respuesta

de emergencia– funcionaron adecuadamente y contribuyeron a la efectividad, pero también revelaron que existía un margen de mejora. El nombramiento, en octubre de 2014, de un Coordinador Mundial de Emergencias con experiencia en materia de salud pública facilitó que hubiera una dirección clara en un momento de incertidumbre y aportó un enfoque necesario para detener la transmisión a través de un planteamiento dirigido por la comunidad. Sin embargo, el liderazgo en materia de salud pública del Coordinador fue cuestionado a nivel nacional y regional, y se objetaron las decisiones aprobadas a través de mecanismos excepcionales como el Grupo Básico de Directores, en lugar del Equipo de Gestión de Emergencias. La Célula del Ébola trató de movilizar una respuesta de emergencia óptima sin disponer las capacidades funcionales completas de la Sección de Operaciones de Emergencia.

En términos de estrategia, planificación y seguimiento, aunque la estrategia comunitaria de salud pública del UNICEF era esencial para detener la transmisión del Ébola, también quedó socavada por las diversas interpretaciones de los riesgos relacionados con el Ébola y la justificación de la intervención. Se observó una división entre los que aceptaron la lógica de intervenir principalmente para detener la transmisión del Ébola y aquellos que consideraron que la respuesta debería centrarse en abordar las repercusiones del brote sobre los niños. La estrategia del UNICEF también tuvo que confrontar retos relacionados con la integración y secuenciación de los programas, la falta de un desarrollo de la estrategia intersectorial y la falta de claridad sobre la forma en que todos los sectores podrían contribuir a detener la transmisión del Ébola.

En lo que se refiere a la gestión de la información, el UNICEF y sus asociados trabajaron inicialmente con datos epidemiológicos limitados para orientar las decisiones programáticas. Sin embargo, hacia 2015, el UNICEF comenzó a hacer un uso cada vez mayor de la supervisión en tiempo real, la presentación de informes a



los asociados y las aplicaciones innovadoras de las tecnologías de la información y la comunicación (TIC) para apoyar los programas.

COORDINACIÓN EXTERNA

Aunque las contribuciones del UNICEF para detener el virus del Ébola implicaban trabajar estrechamente con los gobiernos, el sistema de las Naciones Unidas y otros asociados, la coordinación externa a veces limitó la propia eficacia del UNICEF. En el nivel de liderazgo estratégico, los equipos de las Naciones Unidas en los países y los equipos humanitarios no lograron contener el Ébola de marzo a julio de 2014 y no proporcionaron una respuesta estratégica bien coordinada a la declaración del nivel L3 hasta que se desplegaron sobre el terreno los gestores de crisis del Ébola. Si bien el establecimiento de la UNMEER en septiembre de 2014 y el nombramiento de los gestores de crisis del Ébola llevaron a que el liderazgo en materia de salud pública estuviera más potenciado y centrado, resolviendo de este modo una brecha en la coordinación estratégica, estos mecanismos no involucraron adecuadamente a los actores operacionales de las Naciones Unidas.

A nivel operacional, el establecimiento de los pilares técnicos de la UNMEER socavó parcialmente la coordinación que ya estaba en marcha entre el UNICEF y otros organismos de las Naciones Unidas. Los pilares también presentaron nuevos desafíos para el UNICEF como organismo encargado del pilar de la coordinación comunitaria y la movilización social (aunque también se consideró que este pilar añadía valor) e inicialmente dejó una serie de lagunas en la coordinación de la protección de la infancia, la educación y el sector WASH, para los cuales no se habían establecido pilares y se necesitaban otros mecanismos de coordinación. La mayoría de los actores del UNICEF vieron poco valor añadido en la UNMEER, que llegó tarde en la intervención y perjudicó los esfuerzos de respuesta temprana.

RENDICIÓN DE CUENTAS

La rendición de cuentas en la intervención del UNICEF fue satisfactoria con respecto a una serie de compromisos clave, con margen de mejora a nivel comunitario. Aunque la respuesta fue tardía, sus objetivos y actividades estaban bien alineados con las estrategias nacionales e internacionales para detener el Ébola y para la recuperación, y se encontraban en línea con las prioridades de desarrollo nacional relacionadas con el liderazgo y la coordinación del gobierno. La respuesta del UNICEF al Objetivo 1 (detener el Ébola) y las respuestas en cada país eran altamente pertinentes para el contexto epidemiológico, y se prestaron sin sesgo a las comunidades afectadas. A nivel comunitario, las estrategias de aplicación fueron cada vez más apropiadas mediante ejercicios de aprendizaje sistemáticos, y el enfoque comunitario del UNICEF facilitó aumentar la transparencia, la retroalimentación y la participación: todos estos elementos son disposiciones clave en la rendición de cuentas a las poblaciones afectadas.

Sin embargo, la intervención del UNICEF no alcanzó una rendición de cuentas más amplia para la acción humanitaria y la protección de la infancia. Los objetivos y actividades de respuesta no estuvieron completamente alineados con los Compromisos Básicos para los Niños en la Acción Humanitaria del UNICEF y las responsabilidades específicas de protección de la infancia. La respuesta del UNICEF al Objetivo 1 (detener el Ébola) y la estrategia priorizada no resultaron directamente pertinentes para satisfacer las necesidades secundarias derivadas del brote del Ébola o las necesidades específicas de los niños afectados. La intervención en sí no dio prioridad a la atención de las urgentes necesidades humanitarias y de protección de los niños y, en ocasiones, esta intervención estaba en desacuerdo con las prioridades nacionales para el fortalecimiento de los sistemas de salud.



CONCLUSIONES

1. La intervención del UNICEF en materia de salud pública contribuyó de manera útil a detener la transmisión del Ébola, en particular mediante actividades de participación comunitaria, actividades de aislamiento y atención, así como la distribución de suministros a gran escala y el apoyo en materia de WASH.
2. La intervención del UNICEF no abordó de forma pronta ni adecuada las graves consecuencias humanitarias secundarias del Ébola ni sus efectos específicos sobre los niños.
3. Aunque el UNICEF trabajó para apoyar, mantener y fortalecer los sistemas de salud en los tres países afectados, la organización y los asociados tuvieron dificultades para reforzar los servicios básicos en el esfuerzo más amplio de recuperación debido a una financiación inadecuada y, por consiguiente, los sistemas nacionales de salud siguieron siendo vulnerables a las amenazas de salud pública.
4. Como asociado principal y actor en la intervención dirigida por la OMS, el UNICEF comparte la responsabilidad por los retrasos esenciales en la prevención y respuesta al Ébola. En algunos casos, la eficacia del UNICEF se vio limitada por un liderazgo estratégico interinstitucional y una coordinación operativa insuficientes.
5. Las contribuciones del UNICEF se basaron, en gran medida, en un modelo innovador de aplicación de las respuestas basado en la comunidad que incluía medidas específicas a nivel comunitario para generar cambios en el comportamiento de la comunidad.
6. El UNICEF proporcionó la dirección estratégica necesaria para detener la transmisión del Ébola, pero su liderazgo se vio obstaculizado debido a que los acuerdos

institucionales, la gestión del rendimiento y el análisis de la información fueron inadecuados.

7. La movilización de las capacidades financieras, humanas y de suministro del UNICEF permitió una intervención a gran escala y contribuyó materialmente a la eficacia, pero tuvo que enfrentarse con los nuevos desafíos específicos que presentaba el Ébola y con las deficiencias existentes en las competencias de los recursos humanos.
8. La intervención del UNICEF no se basó suficientemente en la gestión de los conocimientos y la organización sigue estando solo parcialmente preparada para futuras emergencias de salud pública. No obstante, el UNICEF realizó importantes esfuerzos para aprender mientras actuaba.
9. Aunque la intervención del UNICEF estaba en consonancia con la estrategia interinstitucional de salud pública y el contexto epidemiológico de la enfermedad del virus del Ébola, la falta de un marco adecuado de políticas y de rendición de cuentas para las emergencias de salud pública significaba que la intervención no guardaba relación con los Compromisos Básicos para la Infancia, que no son ni completamente apropiados ni pertinentes para una emergencia de salud pública

RECOMENDACIONES

1. UNICEF WCARO, las oficinas en los países y los asociados en los tres países más afectados deberían garantizar, como mínimo: 1) que los sistemas de salud mantengan una capacidad de respuesta rápida para prevenir los brotes del Ébola y desarrollar las capacidades básicas del Reglamento Sanitario Internacional; 2) que se refuercen los sistemas de salud comunitarios en las comunidades más afectadas; y 3) que los niños más afectados por el Ébola reciban protección adecuada.



2. El Equipo Mundial de Gestión del UNICEF debería elaborar un marco normativo y de rendición de cuentas para responder a las emergencias de salud pública que incluya: 1) objetivos específicos; 2) orientación para los programas; 3) objetivos de la asociación mundial; y 4) evaluación de riesgos humanitarios más amplios. Tanto si se producen como un complemento de los Compromisos Básicos para la Infancia, o como una política separada, debe complementar y reforzar en lugar de duplicar las actuales políticas y procesos de intervención en situaciones de emergencia del UNICEF.
3. El Equipo Mundial de Gestión del UNICEF debe reconocer las esferas de mejora y fortalecer la coordinación, la estrategia y la capacidad de información para emergencias de salud pública. Basándose en las enseñanzas extraídas de la respuesta al Ébola, el UNICEF debería elaborar instrumentos, materiales de orientación y mecanismos, y fortalecer las capacidades para: 1) una coordinación mundial de las emergencias; 2) la planificación, el apoyo a los programas y el monitoreo del desempeño; y 3) las funciones de gestión de la información y de los conocimientos.
4. El Equipo Mundial de Gestión del UNICEF debería seguir fortaleciendo la capacidad para el despliegue rápido y a gran escala de recursos financieros, humanos y materiales en situaciones de emergencia: 1) aplicando las lecciones y protocolos de la respuesta al Ébola sobre el deber de cuidar; 2) aumentando significativamente la capacidad de los recursos humanos de emergencia y las competencias de emergencia en las oficinas en los países; y 3) incorporando al personal operativo y administrativo en la gestión de estrategias y programas.
5. La Sección de operaciones de emergencia del UNICEF y la División de Programas del UNICEF deberían seguir perfeccionando el enfoque comunitario como una modalidad de implementación que incluya componentes sólidos de rendición de cuentas a las poblaciones afectadas y de participación comunitaria. Al reconocer el papel central de las comunidades para detener el Ébola, el UNICEF debería centrarse en el fortalecimiento de las capacidades y sistemas locales de salud y protección social a nivel comunitario. Este esfuerzo debería incluir medios dirigidos a aumentar la capacidad del UNICEF en materia de participación comunitaria y de movilización social, y mejorar la integración de los programas a nivel comunitario.



INTRODUCTION

This report presents the findings, conclusions and recommendations of an evaluation conducted between November 2015 and September 2016 of UNICEF's response to the Ebola outbreak in West Africa. The report is organized into five sections covering the response effectiveness, efficiency, internal coordination, external coordination and accountability.



■ This Section describes: a) the evaluation purpose, objectives and scope; b) the evaluation methodology; c) the context of the Ebola outbreak and responses across Guinea, Liberia and Sierra Leone; and d) the UNICEF response in these countries in 2014–2015.

EVALUATION PURPOSE, OBJECTIVES AND SCOPE

The purpose of this 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”¹⁹ towards the following three specific objectives:

- 1) **Accountability:** To provide an assessment of UNICEF’s response to the Ebola outbreak in West Africa, enabling defined stakeholder groups to offer feedback and recognize overall value;
- 2) **Learning:** To highlight as conclusions the main lessons for UNICEF, to contribute to knowledge management and public health emergency preparedness; and
- 3) **Strategy:** To provide strategic recommendations a) to UNICEF HQ on preparing for future public health emergencies; and b) to UNICEF’s regional and country offices on responding to emergency, recovery and reconstruction.

The primary audiences for this report are UNICEF actors at both HQ and regional levels. The secondary audiences are country office actors in Guinea, Liberia and Sierra Leone.

Scope

The evaluation focuses on the UNICEF corporate response to the Ebola outbreak emergency, as coordinated and implemented

jointly by UNICEF country offices and partners, UNICEF WCARO and HQ-based coordination, programme and operational actors. Its primary geographic scope covers the three most-affected countries – Guinea, Sierra Leone and Liberia – and its temporal scope covers the L3 emergency period from August 2014 to the end of 2015 (*see Annex 1*).

In relation to the UNICEF HAC 2014-2015 appeal for the Ebola outbreak, the evaluation focuses on Objective 1 (stopping Ebola), for which activities were prioritized and completed, and to a lesser degree on Objective 3 (supporting early recovery), for which activities remained underway and extended beyond the evaluation period. It does not focus on Objective 2 (preparedness), which was implemented in the wider region beyond the three response countries.

The analysis is broadly focused on the strategic challenge of coordinating UNICEF’s levels, programmes and operational functions (i.e. how these elements combined to deliver an effective response). As such, it does not attempt to provide detailed information or a technical assessment of implementation. As reflected in the Terms of Reference, the evaluation prioritized HAC programmes in: 1) health/case management, including CC centres; 2) C4D, social mobilization and community engagement; and 3) child protection, particularly family tracing and reunification and care for separated and unaccompanied children. Other programmes are considered where relevant.

¹⁹ See Annex 1, Terms of Reference.



METHODOLOGY

During the inception phase, a scoping exercise and stakeholder analysis were conducted to sharpen the evaluation focus and maximize its utility. Three primary stakeholder groups were identified: 1) governance actors such as UNICEF actors at HQ and regional levels with a formal a governance or oversight stake in the organization's Ebola response; 2) implementation actors, including UNICEF country office staff and key partners responsible for delivering programmes; and 3) affected people, covering all people affected by the Ebola outbreak in West Africa, particularly in the most-affected communities.

The inception phase also saw the development of an analytical approach inclusive of an evaluation framework, evaluation questions and an evaluation matrix. The evaluation framework used the criteria of effectiveness, efficiency, coordination, relevance and coherence and evaluation questions were derived from these criteria in five key evaluation questions (KEQs) and sub-questions (SQs). The evaluation matrix defined data collection and analysis processes for each key evaluation question and sub-question and guided the team's work (*see Annex 2*).

■ KEY EVALUATION QUESTIONS

1. How effective was UNICEF's response to Ebola?
2. How efficient was UNICEF's response to Ebola?
3. How well-coordinated internally was UNICEF's response to Ebola?
4. How well-coordinated externally was UNICEF's response to Ebola?
5. How accountable was UNICEF's response to Ebola?

Data collection and analysis was conducted according to a mixed methods approach. Data collection involved both qualitative and quantitative techniques, including: 1) lessons review;

2) document review; 3) data analyses; 4) stakeholder consultations; 5) stakeholder polling (*see Annex 3*); and 6) case studies of affected communities (*see Annex 4*). Separate analyses were conducted using information gathered from each method and a synthesis analysis brought these together for each sub-question. Team-based deliberations and assessments were then conducted for each question before the report was drafted (*see Annex 5*).

Field missions were undertaken to Guinea, Liberia and Sierra Leone and to UNICEFWCARO in Dakar, Senegal, in February and March 2016. In each affected country, analysts conducted consultations and polling with implementation actors and national leaders, as well as case studies in two affected communities selected according to a defined protocol. Independent national researchers were contracted to contribute to data collection and analysis. In each mission, ongoing detailed analysis and triangulation was conducted using an evidence matrix and preliminary findings were presented to UNICEF country office leadership for the purposes of feedback and validation.

Evidence-based findings were developed by: 1) using data collected from all sources and methods to initially identify findings; 2) discussing and validating preliminary findings through sessions held in each country office, WCARO and with the Evaluation Reference Group; 3) preparing a synthesis of findings, in part through a two-day team workshop; 4) preparing draft findings in report form for review by the team and evaluation manager, which lead to the preparation of conclusions and recommendations; 5) conducting an iterative process of commenting, feedback and revision with the Evaluation Reference Group and then with a wider group of UNICEF stakeholders.

Limitations

Multiple strategies and results frameworks were expressed in a variety of documents and data, including the HAC, the Regional Response Strategy, and the Programme Guidance Note, as well as the WHO Roadmap, the STEPP strategy



(1) stop the outbreak; 2) treat the infected; 3) ensure essential services; 4) preserve stability; 5) prevent outbreaks in countries currently unaffected), three national response strategies and recovery plans. As a result of differing understandings of strategy, the performance monitoring that accompanied the response lacked a coherent framework. Performance indicators and targets were adapted to the evolving situation and at points, targets appeared misaligned, applied to some activities and not others or lacked time series data.

As a result, assessment of UNICEF's contributions to stopping the transmission of Ebola relies on stakeholder consultations, stakeholder polling and the lessons and document review. The absence of appropriate outcome monitoring made it difficult to assess the effectiveness of UNICEF's community-based approach, outcomes achieved with partners and UNICEF's impact on the Ebola outbreak.

The evaluation sought to answer whether inputs (financial, human resources and other) were broadly consistent with the results achieved. However, analysis of costs was complicated by the way spending is reported in UNICEF's Virtual Integrated System of Information, particularly the aggregate nature of financial coding. Categories such as 'health' and 'child protection' did not allow for analysis in relation to specific objectives or activities. For example, spending on CC centres was not disaggregated from wider health spending. In addition, the use of codes varied between countries and some programme areas (i.e. C4D) were captured in broad cross-sectoral categories. Due to these challenges, the available financial data are used in a descriptive manner.

Assessment of UNICEF's response process relied on the L3 SSOPs, which are designed to "simplify, streamline and clarify UNICEF procedures related to emergencies to enable a more effective response"²⁰ and are intended to "apply to all situations where the UNICEF Executive Director has declared a L3 emergency". As such, they can be translated into benchmarks of performance in humanitarian settings. However, many of the SSOPs were considered not applicable in a public health emergency and thus the evaluation could make only limited use of these standards.

Evaluating external coordination focused on the extent to which those coordination structures and mechanisms helped or hindered UNICEF's response. The evaluation did not examine how well UNICEF helped the wider, multi-actor response, which would have required an analysis beyond the scope of this evaluation.

Examination of accountability issues was limited by the lack of a suitable accountability or policy framework. UNICEF's CCCs provide an accountability framework for humanitarian responses to rapid onset natural disasters and conflicts, but were not fully applicable for a public health emergency response. Moreover, with UNICEF's focused engagement in communities, AAP commitments emerged as a particularly relevant theme but its assessment was limited by lack of clarity about UNICEF's AAP commitments and mechanisms for their implementation.

EBOLA OUTBREAK

The EVD outbreak in West Africa was unprecedented in scale, severity and complexity.²¹ From December 2013 until March 2016, Ebola infected 28,638 people and caused 11,316 deaths.²² EVD causes an acute serious illness, is often fatal

²⁰ United Nations Children's Fund, UNICEF's Corporate Emergency Activation Procedure for Level 3 Emergencies, Simplified Standard Operating Procedures, October 2015.

²¹ World Health Organization, '2015 WHO Strategic Response Plan: West Africa Ebola Outbreak', WHO, Geneva, 2015.

²² United Nations, Lessons learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response: Report of the Secretary-General, A/70/737, United Nations, New York, 4 March 2016.



(the average fatality rate is 50 per cent) and knows no cure or proven treatment.²³ The Ebola epidemic in West Africa was a reminder of the stark threat posed to humanity by communicable diseases.²⁴

Chronology

In December 2013, an outbreak of haemorrhagic fever was reported in remote areas of Guinea, and in March 2014, WHO identified the outbreak as Ebola. Cases soon emerged in the capital, Conakry, and spread into Liberia. In late May 2014, the outbreak spread to Sierra Leone, and in June 2014 it reached Monrovia, the capital of Liberia. By late August 2014, 3,685 cases were recorded overall with 500–600 new cases reported each week,²⁵ far more than all previous known cases of Ebola. On 8 August 2014, WHO declared the outbreak a PHEIC.²⁶

In September 2014, the outbreak appeared to grow exponentially.²⁷ The United States Centers for Disease Control and Prevention (CDC) estimated that without additional interventions or changes in community behaviour, up to 1.4 million cases of Ebola could occur by the end

of January 2015.²⁸ The average case fatality rate reached 71 per cent.²⁹ The United Nations Security Council designated the outbreak “a threat to peace and security.”³⁰

The outbreak reached its peak in late 2014 (see *Figure 1*). In October, case incidence began to fall in Liberia and subsequently fell in Sierra Leone. Cases in Guinea were generally lower and peaked in December 2014.³¹ In early 2015, the outbreak declined rapidly across the three countries and the number of districts with active transmission reduced substantially.³² The number of cases began to dwindle in late 2015 and by early 2016, the outbreak was limited to flare ups in hotspot communities. All three countries were eventually declared Ebola-free by January 2016.³³

Impact

The countries most affected by the Ebola outbreak were ill-equipped to respond. Ranked among the poorest and least developed countries in the world, when the crisis began, Guinea, Liberia and Sierra Leone were recovering from instability, struggling with weak

²³ World Health Organization, ‘Ebola virus disease’, WHO, January 2016, <www.who.int/mediacentre/factsheets/fs103/en/>, accessed 14 November 2016.

²⁴ United Nations, ‘Protecting Humanity from Future Health Crises: Report of the High-level Panel on the Global Response to Health Crises’, 25 January 2016.

²⁵ World Health Organization, ‘Ebola Response Roadmap Situation Report 2’, WHO, 5 September 2014, <www.who.int/csr/disease/ebola/5-september-2014-en.pdf>, accessed 14 November 2016.

²⁶ World Health Organization, ‘Statement on the 1st meeting of the IHR Emergency Committee on the 2014 Ebola outbreak in West Africa’, WHO, 8 August 2014, <www.who.int/mediacentre/news/statements/2014/ebola-20140808/en/>, accessed 14 November 2016.

²⁷ Office for the Coordination of Humanitarian Affairs, ‘Ebola Virus Disease Outbreak: Overview of needs and requirements’, OCHA, September 2014.

²⁸ Centers for Disease Control and Prevention, ‘Questions and Answers: Estimating the Future Number of Cases in the Ebola Epidemic—Liberia and Sierra Leone, 2014–2015’, CDC, September 2014, <www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/qa-mmwr-estimating-future-cases.html>, accessed 14 November 2016.

²⁹ WHO Ebola Response Team, ‘Ebola Virus Disease in West Africa — The First 9 Months of the Epidemic and Forward Projections’, *New England Journal of Medicine*, 16 October 2014.

³⁰ United Nations Children’s Fund, ‘Ebola Virus Disease Outbreak, UNICEF Regional Response Strategy’, UNICEF, 23 October 2014.

³¹ World Health Organization, ‘Ebola Situation Report –4 November 2015’, WHO, 2015, <<http://apps.who.int/ebola/current-situation/ebola-situation-report-4-november-2015>>, accessed 14 November 2016.

³² World Health Organization, ‘2015 WHO Strategic Response Plan: West Africa Ebola Outbreak’, WHO, Geneva, 2015.

³³ World Health Organization, ‘Latest Ebola outbreak over in Liberia; West Africa is at zero, but new flare-ups are likely to occur’, WHO, 14 January 2016, <www.who.int/mediacentre/news/releases/2016/ebola-zero-liberia/en/>, accessed 14 November 2016.



health systems and lacking core capacities for preparedness and rapid response.³⁴ As a result, the outbreak wrought serious humanitarian, economic, development and health consequences.³⁵ Border closures reduced trade, manufacturing slowed, small businesses closed and unemployment increased, particularly among youth. Livelihoods deteriorated for millions of people. National gross domestic product growth rates plummeted.³⁶ Fragile health systems were severely compromised as a disproportionate number of health care workers died, further reducing a low ratio of health care workers to population. Non-Ebola related deaths increased as immunization and other preventive measures were restricted. Entire educational systems were either shut down or school openings were delayed and many teachers lost their lives.³⁷

The outbreak's direct impact was most evident at the local level. UNICEF noted that 90 per cent of Ebola cases were concentrated in the 20 most-affected districts across the three countries.³⁸ Many communities were initially overcome by fear, suspicion and hostility towards external health actors. Families hid symptomatic members and continued unsafe burial practices. In some cases, EVD sufferers were shunned and left to die in the streets,³⁹ families of victims became subject to quarantine

conditions and survivors experienced stigmatization. Livelihoods suffered from temporary bans on traditional markets, local restaurants and gatherings of all kinds. Farmers were reluctant to engage in communal labour in the fields.

Children were disproportionately affected by the outbreak. More than 5,000 children were infected and children comprised one in five of all infections.⁴⁰ The mortality rate for children under 5 years was 80 per cent and for children under 1 year was as high as 95 per cent.⁴¹ Some 16,000 children lost parents or caregivers to Ebola and as a result, had to be fostered and remained vulnerable. For many of the 9 million children in Ebola-affected areas, the outbreak was terrifying. These children witnessed death and suffering and watched people in frightening protective clothes take away patients and bodies. The closure of schools in Guinea for five months, in Liberia for seven months and in Sierra Leone for nine months denied children in those countries education and normal social interaction. Ebola also overstretched crucial health, nutrition and WASH services and severely affected national activities to tackle measles, malaria and other diseases that disproportionately affect children.

³⁴ United Nations Development Programme, 2015.

³⁵ United Nations, Lessons learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response: Report of the Secretary-General, A/70/737, United Nations, New York, 4 March 2016.

³⁶ Guinea, Liberia and Sierra Leone, 'Manu River Union Post-Ebola Socio-Economic Recovery Programme', April 2015, <http://reliefweb.int/sites/reliefweb.int/files/resources/mru_sub-regional_socioeconomic_strategy_030715.pdf>, accessed 14 December 2016.

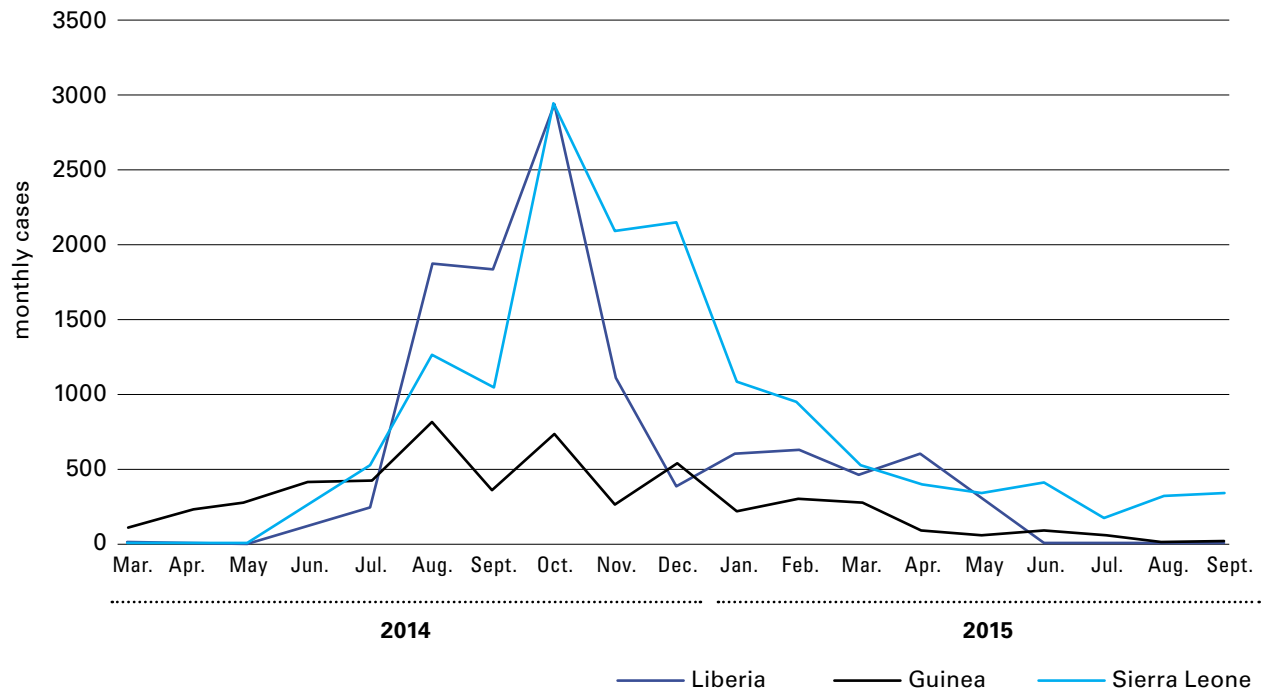
³⁷ Ibid.

³⁸ United Nations Children's Fund, 'Ebola Virus Disease Outbreak, UNICEF Regional Response Strategy', UNICEF, 23 October 2014.

³⁹ Meredith, Catherine, 'A bottom-up approach to the Ebola response', Humanitarian Practice Network, June 2015, <<http://odihpn.org/magazine/a-bottom-up-approach-to-the-ebola-response/>>, accessed 14 November 2016.

⁴⁰ United Nations Children's Fund, *Ebola: Getting to Zero—for communities, for children, for the future*, UNICEF, 2015, <www.unicef.org/publications/files/Ebola_Getting_to_zero_Mar_2015.pdf>, accessed 14 November 2016.

⁴¹ Supplement to: WHO Ebola Response Team. Ebola virus disease among children in West Africa. *N Engl J Med* 2015; 372:1274-7. DOI: 10.1056/NEJMc1415318. They also found shorter incubation periods in children, relatively high risk of death among children under 5 as compared with older children, and more rapid progression to death.

**FIGURE 1** West African Ebola cases 2014–2015

Source: World Health Organization.

National and international response

It took the national and international response the greater part of 2014 to help bring the outbreak under control.⁴² External reviews found the outbreak was aggravated by challenges related to surveillance, underestimation of scale and minimization by governments.⁴³ Deficiencies were revealed “in almost every aspect of global defences against potential pandemics”, until the outbreak was ultimately brought under control thanks to community health workers and local leaders and the massive deployment of international resources.⁴⁴

In 2014, national health care systems in particular struggled to cope with the Ebola outbreak. Health care workers became infected and died at alarming rates, further diminishing capacities and increasing fears. INGOs active in affected countries were overwhelmed by the scale of the Ebola outbreak and struggled to find adequate human resources to scale up the response or experienced personnel willing to risk exposing themselves and their families to the virus.

As the outbreak wore on, world powers strengthened their resolve to contain the outbreak. In 2014–2015, national governments, INGO partners and the United Nations system, led first by WHO and subsequently by UNMEER, took measures to coordinate response efforts

⁴² United Nations, ‘Protecting Humanity from Future Health Crises: Report of the High-level Panel on the Global Response to Health Crises’, 25 January 2016.

⁴³ Ibid.

⁴⁴ Commission on a Global Health Risk Framework for the Future, *The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises*, GHRF Commission, 2016.



to control the outbreak and prevent its further spread through the development of a regional response plan (July 2014), a response road-map (August 2014), UNMEER United Nations-wide operational planning (October 2014), national Ebola recovery strategies (early 2015) and learning exercises (2015–2016). The United States and the United Kingdom responded in Liberia and Sierra Leone, respectively, by deploying thousands of troops and logistical assets such as ships, aircraft and field hospitals. Pharmaceutical companies, governments and aid agencies also worked to develop a vaccine against Ebola, with trials beginning in September 2014.⁴⁵

As the outbreak came under control, in 2015–2016, concerted efforts were made to learn lessons from the Ebola response and strengthen global defences against public health emergencies. All exercises (listed below) offered recommendations for addressing these shortcomings moving forward.⁴⁶

- An independent assessment requested by the WHO Executive Board found organizational failings in the functioning of WHO and shortcomings in the implementation of international health regulations.⁴⁷

- A report of the United Nations Secretary General found that UNMEER brought strategic benefits but recommended that an improved and streamlined model be used for future emergencies.⁴⁸
- An independent panel from the Harvard Global Health Institute and London School of Hygiene and Tropical Medicine found that the epidemic exposed deep inadequacies in national and international institutions responsible for protecting the public from the consequences of infectious disease outbreaks.⁴⁹
- The High-Level Panel on the Global Response to Health Crises for the United Nations Secretary-General found that the outbreak was preventable and the world remains ill-prepared to address the threat posed by epidemics.⁵⁰
- The Commission on a Global Health Risk Framework for the Future found the epidemic was both a tragedy and a wakeup call that revealed deficiencies in almost every aspect of global defences against potential pandemics.⁵¹

⁴⁵ World Health Organization, 'Ebola vaccines, therapies, and diagnostics', WHO, 6 October 2015, <www.who.int/medicines/emp_ebola_q_as/en/>, accessed 14 November 2016.

⁴⁶ Commission on a Global Health Risk Framework for the Future, *The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises*, GHRF Commission, 2016.

⁴⁷ World Health Organization, 'Report of the Ebola Interim Assessment Panel', WHO, 2015, <www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>, accessed 14 November 2016.

⁴⁸ United Nations, Lessons learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response: Report of the Secretary-General, A/70/737, United Nations, New York, 4 March 2016.

⁴⁹ Moon, Suerie, et al., '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, *The Lancet*, vol. 386, no. 10009, 28 November 2015.

⁵⁰ United Nations, 'Protecting Humanity from Future Health Crises: Report of the High-level Panel on the Global Response to Health Crises', 25 January 2016.

⁵¹ Commission on a Global Health Risk Framework for the Future, *The Neglected Dimension of Global Security: A Framework to Counter Infectious Disease Crises*, CGHRF Commission, 2016.



UNICEF'S RESPONSE

UNICEF country office responses to the Ebola outbreak began in early 2014 and UNICEF eventually declared an L3 corporate emergency on 4 September 2014, three weeks after WHO declared a PHEIC.⁵² In September 2014, UNICEF country offices developed specific country response plans with support from WCARO and HQ, which contributed to the development of a first organizational strategy. UNICEF's planned response from December 2014 to June 2015 was outlined in the HAC 2014–2015 Ebola outbreak appeal,⁵³ which also provided a transparent performance framework for the response. In line with the STEPP framework, the HAC defined three goals:⁵⁴ 1) to stop the outbreak through actions at community level; 2) to prepare for outbreaks in additional countries; and 3) to contribute to maintaining or building back better of the primary health care and other social systems in the most affected countries (see *Figure 2*).

Associated with these goals, UNICEF adopted three objectives: 1) to bring the outbreak under control through contributing significantly to system-wide goals of 100 per cent early isolation and 100 per cent safe burial in each of the affected countries; 2) to prevent other high-risk countries from suffering major outbreaks

during this period;⁵⁵ and 3) to support early recovery and the initiation of building back better primary health care systems and other social services. In the HAC appeal, these objectives were underwritten by a range of key interventions and activities, which are depicted below as a logic model (see *Figure 2*). While a common approach was adopted across the three countries, each country response was also adapted to its specific context.

The HAC framework was complemented by the UNICEF Ebola Regional Response Strategy (October 2014), which defined UNICEF's contribution to the UNMEER-led STEPP objectives; a Programme Guidance Note (November 2014); and an update to the HAC to cover the period from July 2015–December 2015. The Programme Guidance Note emphasized a community approach to behaviour change for country offices, with an immediate focus on the containment of the epidemic in ways that 'do no harm'. It defined a community-based response with two objectives: 1) to reduce transmission of Ebola through isolation and care of patients at appropriately staffed and resourced CC centres located at the community level; and 2) to build trust with communities by mobilizing and empowering them as partners in the response to Ebola, including through the physical protection of affected children.

⁵² Lawry-White, S., 'Lessons Learned UNICEF's Response to the 2014-15 Ebola Outbreak in West Africa', April 2015.

⁵³ United Nations Children's Fund, 'Ebola Outbreak Response in West Africa', *Humanitarian Action for Children 2014-2015*, UNICEF, <www.unicef.org/appeals/files/Final_2015_HAC_Ebola.pdf>, accessed 14 November 2016.

⁵⁴ See UNICEF's Ebola Response commitments, available at: <www.unicef.org/appeals/ebola_response.html>, accessed 14 November 2016.

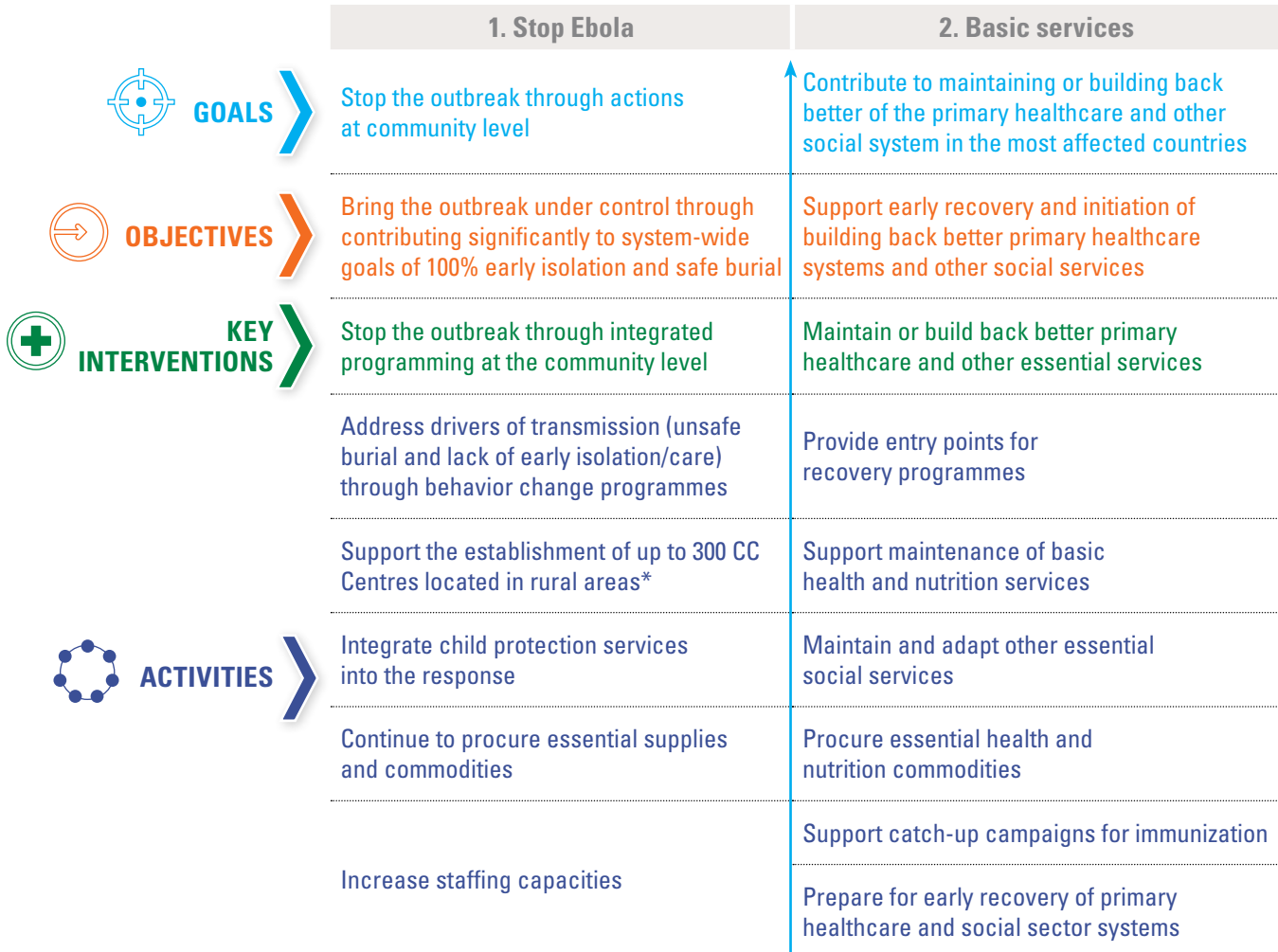
⁵⁵ Objective 2 was not assessed in this evaluation and was outside of the geographic scope of the evaluation.



FIGURE 2

Humanitarian Action for Children Ebola outbreak response logic model

HAC LOGIC MODEL



Overall UNICEF’s Ebola response was well-funded, though initially resources were slow to arrive.⁵⁶ By mid-November 2015, UNICEF had received US\$437.8 million, or 86 per cent of the total funding appeal.⁵⁷ Funding gaps were larger during the critical period of September 2014–December 2014, when the responses of Guinea, Liberia and Sierra Leone were funded at 44 per cent, 37 per cent and 54 per cent,

respectively. This is compared with 2015 when the country appeals were typically funded at over 70 per cent. The Liberia appeal was very well funded at US\$139 million, while Guinea and Sierra Leone received relatively strong funding at US\$108 million and US\$125 million, respectively, leaving gaps of 7 per cent, 23 per cent and 22 per cent, respectively by mid-November 2015. In the HAC 2015, WCARO and HQ

⁵⁶ United Nations Children’s Fund, ‘Ebola Outbreak Sub-regional Response Snapshot’, UNICEF, 22 December 2014, <www.unicef.org/appeals/files/UNICEF_Ebola_SubRegional_response_Snapshot_22_December_2014.pdf>, accessed 14 November 2016.

⁵⁷ United Nations Children’s Fund, Ebola outbreak response funding appeal status as of 17 November 2015.



(EMOPS, Supply Division, Division of Human Resources and Programme Division) costs were revised to US\$21.9 million and were 100 per cent covered.

By sector, health was the largest area of spending (35 per cent) followed by WASH (17 per cent) and C4D/cross-cutting (15 per cent).⁵⁸ The child protection and education sectors were roughly equal with 11 per cent of overall spending each. Nutrition and HIV made up much smaller amounts of total expenditures (5 per cent and 1 per cent, respectively). By cost category, the majority of expenditures were either for supplies and commodities (36 per cent) or transfer and grants to counterparts (36 per cent). General operating costs and contractual services accounted for 8 per cent and 6 per cent, respectively. By sector and cost category, health sector supplies and commodities accounted for 20 per cent of response spending across the three countries. Annex 6 provides aggregated data across the three countries by sector and cost category and a tabulation of the 10 largest expenditure items.

UNICEF made considerable efforts to learn from the response. In February 2015, UNICEF senior managers met in Dakar to consider lessons learned, take stock of the situation, identify corrective measures and inform planning for the recovery phase.⁵⁹ The resulting lesson learned document highlighted lessons and recurring challenges in key priority areas and provided more than 70 short- and long-term suggestions for action. Building on the lessons learned exercise and an accompanying management response, in November 2015, UNICEF drafted a guidance note on the agency's proposed role in future public health emergencies.⁶⁰ In January 2016 a communication by the UNICEF Executive Director launched the Health Emergency Preparedness Initiative to strengthen UNICEF's capacity to support multi-sector health emergency responses.⁶¹ In 2016, the initiative started to implement a set of key activities⁶² through a technical working group.⁶³

⁵⁸ As defined by the Virtual Integrated System of Information e-Glossary, funds utilized include open commitments and disbursements. The data presented here include Ebola-related funds utilized for the years 2014 and 2015 for the three country offices. Data were categorized by sector and expenditure type and are described above.

⁵⁹ Lawry-White, S. 'Lessons Learned UNICEF's Response to the 2014-15 Ebola Outbreak in West Africa', April 2015.

⁶⁰ United Nations Children's Fund, 'UNICEF's Role in Public Health Emergencies' (first draft), UNICEF, 16 November 2015.

⁶¹ Anthony Lake, UNICEF Executive Director, internal email communication, 28 January 2016.

⁶² United Nations Children's Fund, 'UNICEF in Global Health Emergencies Implementation Plan: UNICEF preparations for Public Health Emergencies Key activities for 2016', UNICEF, January 2016.

⁶³ United Nations Children's Fund, 'UNICEF Health Emergency Preparedness Technical Working Group Terms of Reference', UNICEF, (draft), 15 June 2016.



SECTION I

EFFECTIVENES

This section offers an assessment of the response's overall effectiveness, along with findings about 1) achievements in relations to HAC Objective 1; 2) contributions in relation to HAC Objective 1 (stopping Ebola); and 3) achievements in relation to HAC Objective 3 (recovery).



■ KEQ1. HOW EFFECTIVE WAS UNICEF'S RESPONSE TO EBOLA?

Overall, UNICEF's response to Ebola was moderately effective across the three most-affected countries. In 2015, UNICEF generally performed well in regards to the HAC Objective 1 targets and indicators. Working with inter-agency partners and governments, UNICEF contributed to stopping Ebola through community engagement, isolation and care and large-scale delivery of supplies and WASH support; and effectively implemented an innovative community-based response aimed at stopping transmission. UNICEF struggled to reinforce health care systems, however, which remained weak, and wider recovery efforts suffered from funding gaps.

1.1 STOPPING TRANSMISSION

■ SQ1.1 How well did the response achieve HAC Objective 1 and indicators?

This question is concerned with UNICEF's achievements towards HAC Objective 1, i.e. to contribute to stopping the outbreak through actions at community level and help bring the outbreak under control through early isolation and safe burial,⁶⁴ and in particular the roles of the CC centres, C4D and child protection.

Overall, UNICEF performed well against Objective 1 targets. Monitoring data shows most indicator targets and HAC targets were met by 2015, including those related to: a) establishing and operationalizing CC centres, which aimed to bring disease prevention and control capabilities to the community level; b) pre-positioning and using Rapid Isolation Treatment for Ebola (RITEs) and rapid response teams to address hotspots; c) reaching households with face-to-face Ebola messages; d) supporting Ebola orphans and providing affected children

with psychosocial support; e) supporting radio education broadcasts and providing learning kits and hygiene packages to support a return to school; f) delivering infection prevention and control supplies to health structures, training community health workers and immunizing children under 5 years against measles; g) and providing WASH services to ETUs and CC centres.

Community care centres

In line with indicator targets, UNICEF established 42 CC centres in Sierra Leone by December 2014 and a total of 64 CC centres across the three countries by late March 2015. Studies consistently suggest the CC centres were an effective community-based mechanism for screening, triaging and isolating Ebola suspects, while patients felt CC centre care was of high quality and appreciated that it was accessible and free.⁶⁵ In Sierra Leone, communities and

⁶⁴ United Nations Children's Fund, 'Ebola Outbreak Response in West Africa', *Humanitarian Action for Children 2014-2015*, UNICEF, <www.unicef.org/appeals/files/Final_2015_HAC_Ebola.pdf>, accessed 14 November 2016.

⁶⁵ Abramowitz, Sharon, et al., 'Ebola Community Care Centers: Lessons learned from UNICEF's 2014-2015 Experience in Sierra Leone', UNICEF, New York, January 2016.



national leaders saw the CC centres as a positive and important measure, and implementing partners found that they were managed well with UNICEF support and technical training. Implementers reported more difficulties in the construction of CC centres in Liberia, where the RITEs approach was preferred, and in Guinea,⁶⁶ where there was considerable resistance to CC centres from government and Guinea Country Office actors.

A number of studies and assessments found that the CC centres contributed to stopping Ebola by providing early isolation and care at the community level. In Sierra Leone, the combined introduction of thousands of additional treatment beds (through the establishment of CC centres and ETUs) is calculated to have prevented 56,600 Ebola cases,⁶⁷ while also effectively identifying new cases and reducing transmission. Lessons learned indicate that community-based care and community-level acceptance and ownership of the centres helped to turn the tide of the outbreak, especially given the distrust and fear that characterized the early epidemic.⁶⁸

Implementers in Sierra Leone noted that CC centres provided an important and trusted local 'filter' with basic treatment for other morbidities when few other options existed.⁶⁹

Communities also appreciated the CC centres for their proximity, community involvement, local staffing, free treatments for other illnesses and free meals for in-patients. UNICEF found that between November 2014 and January 2015, the 6,129 patients triaged and 719 EVD suspects identified in the 46 operational CC centres in Sierra Leone had nearly all lived nearby, were self-referred and accessed the CC centres outside of the national alert system.⁷⁰ National leaders felt the CC centres made a difference as a way of isolating suspect cases.

Many actors associated risks with the CC centres, however, including Médecins Sans Frontières (MSF), which opposed them, and stakeholders interviewed in Sierra Leone, who feared that poorly run CC centres would become "warehousing for the dying". By mid-2015,⁷¹ the CC centres were superseded by RITEs and rapid response teams better adapted to the changing epidemic and better able to tackle hotspots and resurgences in remote areas. As one WCARO expert commented, "the CC centres were right at the time and only wrong afterwards"

⁶⁶ Abramowitz, Sharon, et al., 'Evaluation of Save the Children's Community-Care Centres in Dolo Town and Worhn', 1 July 2015; Oosterhoff, Pauline, et al., 'Community-Based Ebola Care Centres: A formative evaluation', Ebola Response Anthropology Platform, 2015; Abramowitz, Sharon, et al., 'Ebola Community Care Centers: Lessons learned from UNICEF's 2014-2015 Experience in Sierra Leone', UNICEF, New York, January 2016; 'Rapid Mixed Methods Assessment of the Ebola Community Care Center Model', ICAP, New York, 2015; Abramowitz, Sharon, et al., 'Community-Centered Responses to Ebola in Urban Liberia: The View from Below', *PLOS Neglected Tropical Diseases*, vol. 9, no. 5, 9 April 2015.

⁶⁷ Kucharski, A.J., et al., 'Measuring the impact of Ebola control measures in Sierra Leone', *Proc Natl Acad Sci USA*, vol. 112, no. 46, 17 November 2016.

⁶⁸ WHO Ebola Response Team, 'Ebola Virus Disease in West Africa – The First 9 Months of the Epidemic and Forward Projections', *New England Journal of Medicine*, 16 October 2014; Government of Senegal, 'Lessons From The Response to the Ebola Virus Disease Outbreak in Sierra Leone May 2014–November 2015', summary report, 2015; Weizman, Melissa Judith, 'Analysis of the 2014 Ebola Outbreak in Guinea, Sierra Leone, and Liberia', *Peace and Conflict Monitor*, 14 August 2015; United Nations Children's Fund, 'Ebola Epidemic Child Protection Response Lessons Learned', 2016; Abramowitz, Sharon, et al., 'Community-Centered Responses to Ebola in Urban Liberia: The View from Below', *PLOS Neglected Tropical Diseases*, vol. 9, no. 5, 9 April 2015.

⁶⁹ See Weizman, Melissa Judith, 'Analysis of the 2014 Ebola Outbreak in Guinea, Sierra Leone, and Liberia', *Peace and Conflict Monitor*, 14 August 2015; Abramowitz, Sharon, et al., 'Ebola Community Care Centers: Lessons learned from UNICEF's 2014-2015 Experience in Sierra Leone', UNICEF, New York, January 2016.

⁷⁰ Pronyk, P., et al., 'The Effect of Community-Based Prevention and Care on Ebola Transmission in Sierra Leone', *Am J Public Health*, vol. 104, no. 6, April 2016.

⁷¹ Late 2014 in Liberia where the epidemic surfaced earlier. See Kateh, F. et al., 'Rapid Response to Ebola Outbreaks in Remote Areas – Liberia, July–November 2014', *Morbidity and Mortality Weekly Report*, CDC, 27 February 2015, <www.cdc.gov/mmwr/preview/mmwrhtml/mm6407a7.htm>, accessed 17 November 2016.



Despite their contributions, the CC centres became operational too late to substantially reduce transmission.⁷² By one estimate, an additional 12,500 cases might have been avoided if the CC centres had been introduced a month earlier.⁷³ HQ actors attributed critical delays to long discussions with WCARO and country office actors to reach agreement on the CC centres. Other response actors suggested it would have been much quicker and cheaper to build smaller structures using local materials or to adapt existing community structures for the same purpose. Only half of all respondents agreed that UNICEF supported the establishment of enough CC centres, facilities or sites (RITEs) in rural areas to offer early isolation and basic care for Ebola patients. Respondents in Sierra Leone were more likely to agree with this statement (77 per cent) compared with respondents in Guinea (60 per cent) and Liberia (38 per cent).

During 2015, UNICEF prepositioned RITEs in Liberia and Sierra Leone but only used them in Liberia; rapid response teams were used instead in Sierra Leone and Guinea. In Liberia, 18 RITEs were prepositioned in March 2015 – including three that were used in hotspot communities – and maintained until February 2016. In Sierra Leone, rapid response teams were used to respond to hotspots between May 2015 and December 2015. In Guinea, rapid response teams responded multiple times to hotspots between May 2015 and February 2016.

Communication for Development

Beginning in March 2014, UNICEF worked with ministries of health to implement awareness campaigns to stop Ebola. By mobilizing its more than 50,000 community volunteers, UNICEF's C4D programme conducted mass media campaigns, house-to-house sensitization campaigns, social mobilization through community-based organizations and leaders, and negotiation with affected communities about how intervention teams would work with them.

Implementers and communities reported that UNICEF effectively undertook behaviour change campaigns in each country. In Sierra Leone, UNICEF printed an estimated 90 per cent of information, education and communication materials used in the response⁷⁴ and communities acknowledged efforts to provide information by radio, posters and community mobilizers. As illustrated in Figure 3, surveys found that attitudes changed over the period of time corresponding to the expanded outreach. In Liberia, implementers report using multiple media outlets, as well as religious leaders, teachers, community meetings, radio stations, U-Report and mobile phones. Communities also praised the work of radio stations broadcasting in local languages and reaching out to communities through road shows and hosted discussions. In Guinea, implementers and communities highlighted their appreciation of door-to-door visits by mobilizers using illustrated flipcharts, as well as radio stations, theatre and community platforms.

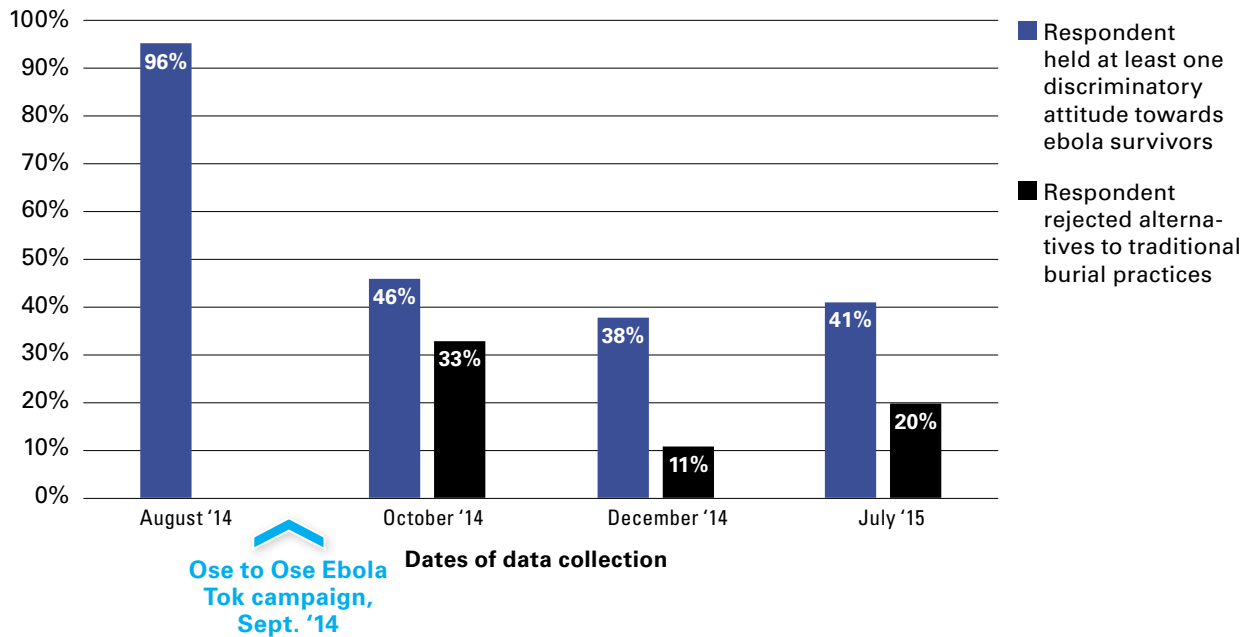
⁷² Abramowitz, Sharon, et al., 'Evaluation of Save the Children's Community-Care Centres in Dolo Town and Worhn', 1 July 2015.

⁷³ Kucharski, A.J., et al., 'Measuring the impact of Ebola control measures in Sierra Leone,' *Proc Natl Acad Sci USA*, vol. 112, no. 46, 17 November 2016.

⁷⁴ Information provided by Health Education Division, Sierra Leone Ministry of Health.



FIGURE 3 Knowledge, attitude and practice survey findings from Sierra Leone

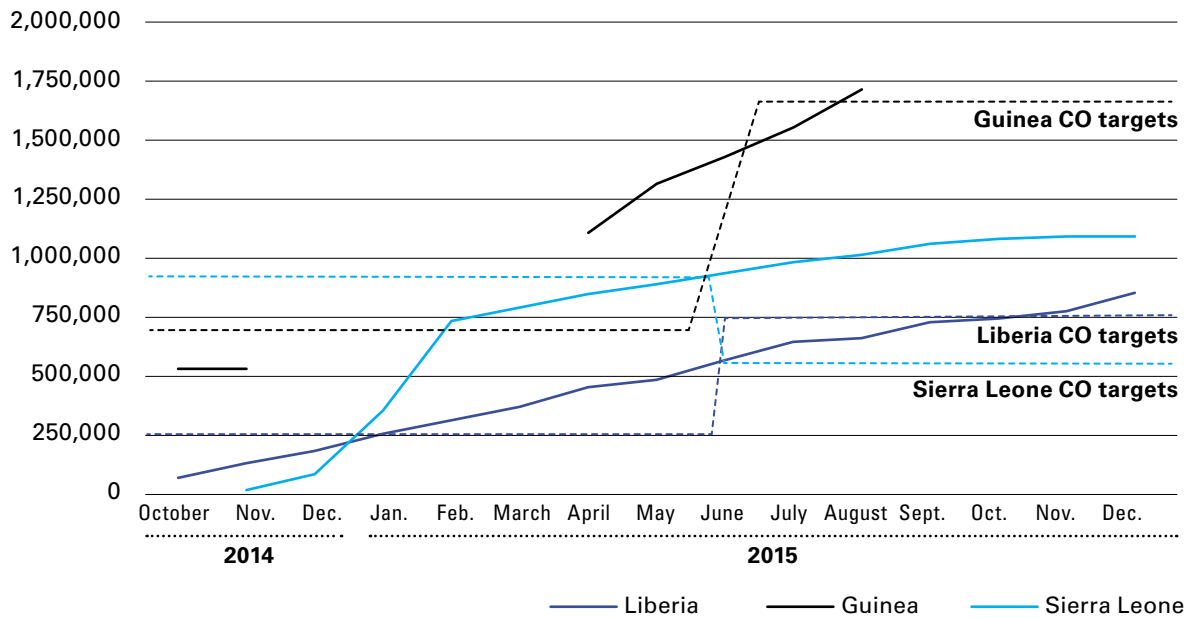


Source: Government of Sierra Leone et al., 'Follow-up Study on Public Knowledge, Attitudes, and Practices Relating to EVD Prevention and Medical Care', Government of Sierra Leone, Focus 1000, CDC and PCI Media Impact, <www.focus1000.org/index.php/downloads-resources/download/4-ebola-kap-study/32-kap-4-preliminary-findings>, accessed 17 November 2016.

UNICEF met all targets for reaching households with face-to-face Ebola messages by May 2015, reaching more than 2 million households across the three countries. In June 2015, UNICEF reached almost 3 million households, exceeding targets, and continued to reach similarly high numbers thereafter (see Figure 4).

At least until late 2014, however, external reviews and UNICEF reflections highlight that ineffective or even counter-productive communication did not effectively limit the spread of EVD.⁷⁵ As the outbreak progressed, it became clear that informed, motivated and empowered communities, rather than one-way

⁷⁵ World Health Organization, 'Report of the Ebola Interim Assessment Panel', WHO, 2015, <www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>, accessed 14 November 2016; Moon, Suerie, et al., '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, *The Lancet*, vol. 386, no. 10009, 28 November 2015; United States Agency for International Development, 'Interagency Meeting on Social Mobilization, Communication and Preparedness: Executive Summary', USAID Annex, Washington, D.C., 23-24 March 2015; United States Agency for International Development, 'Full Summary Report of Interagency Meeting on Social Mobilisation, Communication and Preparedness: Review of Ebola Social Mobilization and Communication Efforts to Date', USAID Annex, Washington, D.C., 23-24 March 2015; Oxfam, 'Interagency Meeting on Social Mobilisation', 24-25 September 2015; Fast, Shannon M., et al., 'The Role of Social Mobilization in Controlling Ebola Virus in Lofa County, Liberia', *PLOS Current Outbreaks*, 15 May 2015, <<http://currents.plos.org/outbreaks/article/the-role-of-social-mobilization-in-controlling-ebola-virus-in-lofa-county-liberia/>>, accessed 17 November 2016; Bedford, Juliet, 'Community mobilisation in the Ebola response: Case studies from Sierra Leone and Liberia', *Anthrologica*, September 2015; United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015; United Nations Children's Fund, 'UNICEF Field Support Officers workshop report', UNICEF, Kenema, 12 April 2015; United Nations Children's Fund, 'Lofa County: Communities took the matter in their own hands', Communication for Development: Responding to Ebola in Liberia, UNICEF, June 2015; United Nations Children's Fund, 'UNICEF-Liberia Ebola Virus Disease: SitRep #22', UNICEF, 2 June 2014; United Nations Children's Fund, 'UNICEF-Liberia Ebola Virus Disease: SitRep #33', UNICEF, 7 July 2014; United Nations Children's Fund, 'UNICEF-Liberia Ebola Virus Disease: SitRep #46', 8 August 2014.

**FIGURE 4** Households reached with interpersonal messages on Ebola prevention (June 2015–December 2015)

Source: United Nations Children's Fund situation reports and monitoring data, 2014-2015.

communication, were needed to stop Ebola.⁷⁶ UNICEF learning exercises recognized serious gaps in supporting community-led initiatives from July 2014,⁷⁷ while external evaluations and studies noted this approach would have been highly effective in stopping transmission.⁷⁸ In Sierra Leone, early efforts were characterized by the development of information, education and communication materials; the underfunding of a larger social mobilization package;⁷⁹ and the ineffectiveness of C4D programmes during a critical early phase (August 2014–September 2014).

Between March 2014 and August 2014, UNICEF and partners implemented many poorly-conceived public information campaigns, reflecting inadequate C4D capacities at the country office level. UNICEF initially used inappropriate stock messages (e.g. "if you get Ebola you will die), using billboards, megaphones and t-shirted groups chanting in the streets of the main towns.⁸⁰ These campaigns were highly visible and raised awareness of the EVD threat but offered few practical solutions and likely served to undermine social mobilization and behaviour change. In Guinea, women interviewed said

⁷⁶ Bedford, Juliet, 'Community mobilisation in the Ebola response: Case studies from Sierra Leone and Liberia', *Anthropologica*, September 2015; World Health Organization, 'Liberia: Working with communities is the key to stopping Ebola', WHO, October 2014, <www.who.int/features/2014/liberia-stopping-ebola/en/>, accessed 17 November 2016; Centers for Disease Control and Prevention, 'Lofa Country Lessons Learned', 2014; Abramowitz, Sharon, et al., 'Community-Centered Responses to Ebola in Urban Liberia: The View from Below', *PLOS Neglected Tropical Diseases*, vol. 9, no. 5, 9 April 2015.

⁷⁷ United Nations Children's Fund, 'Ebola Epidemic Child Protection Response Lessons Learned', 2016.

⁷⁸ See the source reference of Figure 3.

⁷⁹ United Nations Children's Fund, 'Ebola Response Plan Concept Note', UNICEF Sierra Leone, 27 July 2014.

⁸⁰ Obregon, Rafael, 'UNICEF HQ C4D Chief Support Mission to Sierra Leone CO - EVD Response', 31 March–29 April 2015; United Nations Children's Fund, 'UNICEF Communication for Development (C4D) workshop report', UNICEF, Freetown, 16 April 2015; United Nations Children's Fund, 'UNMEER/UNICEF consultation report', UNICEF, Freetown, 25-26 March 2015.



they neither understood nor believed these messages and admitted to evading and in one case hurling stones at campaigners. Learning exercises also report that between June 2014 and September 2014, uncoordinated messages among agencies created confusion.⁸¹

By late 2014, UNICEF made improvements to C4D, moving from the generation of information, education and communication materials and public awareness raising efforts towards greater dialogue with communities, widespread deployment of community-based social mobilizers and community engagement training. Reviews show that UNICEF increasingly relied on and funded local non-governmental organizations (NGOs) and consortia that were innovative, effective and community-led in their C4D approaches.⁸² Learning exercises noted that community engagement also became more consistently effective once medical anthropologists and social scientists were engaged⁸³ and communication was better informed by synchronous surveillance data and real-time behavioural and anthropological studies. Eventually, C4D managed to reflect the epidemiological and cultural idiosyncrasies and perception of the disease.⁸⁴ In Sierra Leone, implementers agreed that C4D eventually played a central role in strengthening

community engagement. In Guinea, implementers and national leaders recognized similar improvements, especially after the engagement of anthropologists.

Despite these improvements, UNICEF continued to lack the capacities needed to implement action research and incorporate learning through feedback loops, which is fundamental to C4D. Both internal and external lessons learned documents consistently found that UNICEF C4D was not prepared for EVD and underestimated the staffing capacity (in both expertise and number) necessary to support a successful C4D campaign to stop the transmission of Ebola.⁸⁵ In Liberia, UNICEF initially lacked the staff, models, horizontal and vertical networks and relationships necessary for effective C4D. The need to set up a C4D section caused delays.

UNICEF also struggled to lead and coordinate the UNMEER Community Engagement and Social Mobilization Pillar, according to external reviews and UNICEF reflection.⁸⁶ UNICEF recognized its coordination performance was inadequate, lacking the relationships, capacities and technical skills to fulfil its lead role.⁸⁷ For example, in Sierra Leone, country office actors noted

⁸¹ See the source reference of Figure 3.

⁸² United Nations Children's Fund, 'UNICEF Field Support Officers workshop report', UNICEF, Kenema, 12 April 2015; United Nations Children's Fund, 'Lofa County: Communities took the matter in their own hands', Communication for Development: Responding to Ebola in Liberia, UNICEF, June 2015; Obregon, Rafael, 'UNICEF HQ C4D Chief Support Mission to Sierra Leone CO - EVD Response', 31 March–29 April 2015; United Nations Children's Fund, 'UNICEF Communication for Development (C4D) workshop report', UNICEF, Freetown, 16 April 2015; United Nations Children's Fund, 'UNMEER/UNICEF consultation report', UNICEF, Freetown, 25-26 March 2015.

⁸³ World Health Organization, 'Report of the Ebola Interim Assessment Panel', WHO, 2015, <www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>, accessed 14 November 2016; Moon, Suerie, et al., '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, *The Lancet*, vol. 386, no. 10009, 28 November 2015.

⁸⁴ Hedlund, Kerren, 'Case Study Lofa, Liberia: Importance of SM Successes and Failures' (internal document), 2014.

⁸⁵ United Nations Children's Fund, 'UNICEF Meeting with David Nabarro on UN System Ebola Response' (meeting notes), UNICEF, August 2014; United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015.

⁸⁶ United States Agency for International Development, 'Full Summary Report of Interagency Meeting on Social Mobilisation, Communication and Preparedness: Review of Ebola Social Mobilization and Communication Efforts to Date', USAID Annex, Washington, D.C., 23-24 March 2015; Oxfam, 'Interagency Meeting on Social Mobilisation', 24-25 September 2015.

⁸⁷ United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015; Obregon, Rafael, 'UNICEF HQ C4D Chief Support Mission to Sierra Leone CO - EVD Response', 31 March–29 April 2015; United Nations Children's Fund, 'UNICEF Communication for Development (C4D) workshop report', UNICEF, Freetown, 16 April 2015; United Nations Children's Fund, 'UNMEER/UNICEF consultation report', UNICEF, Freetown, 25-26 March 2015.



weak coordination and inadequate technical leadership until additional senior-level C4D capacity was deployed.

Child protection

In line with the HAC, UNICEF worked to provide a minimum package of psychosocial support services to all children affected by EVD and a minimum package of support – including family tracing and family-based care – to Ebola orphans and survivors. Programme implementation depended on working with ministries of social welfare, national social workers and local and international child protection NGOs such as Save the Children.

UNICEF achieved its targets for supporting Ebola orphans and providing psychosocial support to children. Between late 2014 and mid-2015, the Liberia and Sierra Leone country offices provided psychosocial support to children on a steady basis, reaching 4,000 and 10,000 children, on average, respectively. Guinea began reporting on the provision of psychosocial support to Ebola-affected children in January 2015 and steadily increased the number reached through December 2015 to more than 130,000. Targets were met or exceeded from late 2014 into early 2015, with over 14,000 Ebola orphans assisted and more than 320,000 children receiving psychosocial support across the three countries by December 2015.

Yet child protection programmes struggled to address Ebola's severe secondary effects on children – such as stigmatization, increased teenage pregnancy and lack of appropriate care, family livelihoods and access to education – for much of the evaluation period.⁸⁸ An

internal review observed that UNICEF struggled to understand and address Ebola's impact on children and advocate for child protection interventions due to a lack of child-specific data.⁸⁹ Moreover, in its response to Ebola, UNICEF struggled to ensure the effectiveness of psychosocial support, the relative appropriateness of institutional care rather than family-based care, and the operational effectiveness of its cash transfer programming.⁹⁰ The review outlines specific lessons learned for the operationalization of child protection in similar circumstances and the need to institutionalize these lessons through Standard Operating Procedures (SOPs). More fundamentally, it emphasizes the need to appropriately prioritize child protection in public health emergencies and ensure adequate monitoring and data collection regarding the evolving impact of the crisis on children.

Child protection programmes began to address secondary effects more comprehensively during 2015. Eventually UNICEF strengthened child protection programmes at the community level to address psychosocial and physical protection needs, leaving more than three quarters of UNICEF stakeholders agreeing that UNICEF integrated child protection services into the response. Lessons learned also indicate that existing child protection programmes demonstrated their capacity to adequately respond with others to small outbreaks in 2015.⁹¹ Communities confirmed they set up child welfare committees and provided training in psychosocial first aid to support survivors and children otherwise affected by Ebola.

⁸⁸ Child Protection Working Group, 'Secondary Data Review: Child Protection Risks and Needs in Ebola Affected Countries', Global Protection Cluster, 19 December 2015; Menéndez, Clara, et al., 'Ebola crisis: The unequal impact on women and children's health', *The Lancet*, vol. 3, no. 3, March 2015.

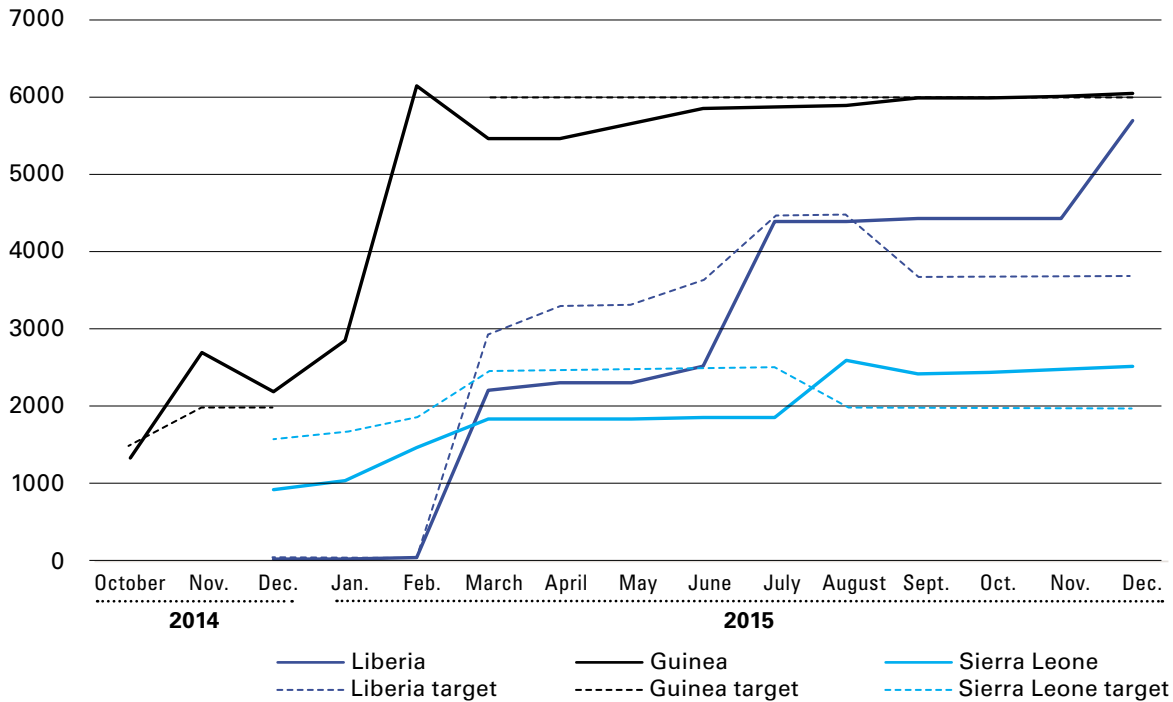
⁸⁹ United Nations Children's Fund, 'The Child Protection Response to the Ebola Virus Disease Epidemic (2014 – 2015): A Lessons Learned Assessment', UNICEF, 2016.

⁹⁰ Ibid.

⁹¹ Ibid.



FIGURE 5 Registered Ebola orphans provided with minimum package of care



Source: United Nations Children’s Fund situation reports and monitoring data, 2014-2015.
Note: this graph shows registered children who lost one or two parents/primary caregivers due to EVD provided with minimum package of support (including family tracing and reunification or placement in alternative family based care).

UNICEF supported interim care centres (ICCs) and observational interim care centres (OICCs), quarantine care facilities established to keep children who tested EVD negative but whose parents tested positive in the ETUs. ICCs and OICCs were established in Liberia in September 2014 and Sierra Leone in November 2014 to provide an immediate place of referral from the ETU for children whose families could not be located quickly and who posed a potential risk to others because they had been in contact with an infected parent or caregiver.⁹² Most of the staff at OICCs and ICCs were Ebola survivors who were at reduced risk from exposure to

EVD. UNICEF established or supported 12 ICCs and 14 OICCs in Sierra Leone⁹³ and two ICCs and two transit centres in Liberia.⁹⁴

Although child protection activities were to be conducted at the community level and the OICCs quarantined children who came into contact with Ebola, these activities were largely concerned with protecting children from Ebola’s secondary effects and not specifically designed to stop Ebola transmission by strengthening community engagement, as defined in the Programme Guidance Note. No explicit link to stopping Ebola was specified in the child protection plans outlined in the HAC 2014 or the

⁹² United Nations Children’s Fund, ‘Ebola Epidemic Child Protection Response Lessons Learned’ (internal document), 2015; Child Fund Liberia, ‘Interim Care Centers for Children Affected by Ebola in Liberia’, USAID and Child Fund Liberia, 30 April 2015.

⁹³ United Nations Children’s Fund, ‘Sierra Leone Ebola Situation Report’, 15 April 2015.

⁹⁴ United Nations Children’s Fund, ‘Liberia Ebola Situation Report no. 82’, UNICEF, 6 May 2015.



HAC 2015, and no role was specified for child protection in the STEPP or in external studies aimed at strengthening global health security and the response to public health emergencies.

Moreover, child protection programmes came too late to contribute significantly to stopping transmission. Learning exercises note early attempts made in July 2014–August 2014 to assess needs and understand the impacts of EVD on children, identify partners for family tracing and reunification and to provide training on psychosocial support; but the child protection response really only began in January 2015–February 2015 when resource mobilization and dedication of capacity allowed. Child protection initiatives were also delayed due to messaging from HQ that this was not a children's emergency, lack of clear knowledge and guidance on the child protection-related impacts of the disease, and lack of appropriate intervention strategies.⁹⁵

1.2 CONTRIBUTIONS

■ SQ1.2 How important was UNICEF's contribution to stopping Ebola?

This question is concerned with UNICEF's direct contributions to stopping the transmission of Ebola.

While there is widespread agreement that affected communities themselves made the greatest contribution to stopping Ebola,

UNICEF and partners also made useful contributions to stopping the transmission of Ebola. This was accomplished through community engagement, isolation and care, the large-scale delivery of supplies and WASH support, and the implementation of an innovative community-based response aimed at stopping transmission. The contributions of C4D and CC centres might have been greater if delivered earlier, and the community-based approach might have been more effective if child protection and education programmes had been integrated or involved in a more closely sequenced manner.

Among both external and internal analyses, there is widespread agreement that affected communities themselves made the greatest contribution to stopping Ebola.⁹⁶ More than three quarters of UNICEF stakeholders saw the "response of communities affected" as an important or most important factor contributing to stopping Ebola (*see Figure 6*).

Once scaled up, the international public health response launched in August 2014 also made an important contribution to stopping Ebola, mainly through support to communities, local and national actors. External studies highlighted deficiencies in the response and critical delays, as total numbers of cases began to flatten and then decline as international assistance programmes became fully operational (November 2014–December 2014).⁹⁷ The international response could have made a stronger contribution earlier (*see Section 2*),⁹⁸ but

⁹⁵ United Nations Children's Fund, 'The Child Protection Response to the Ebola Virus Disease Epidemic (2014 – 2015): A Lessons Learned Assessment', UNICEF, 2016.

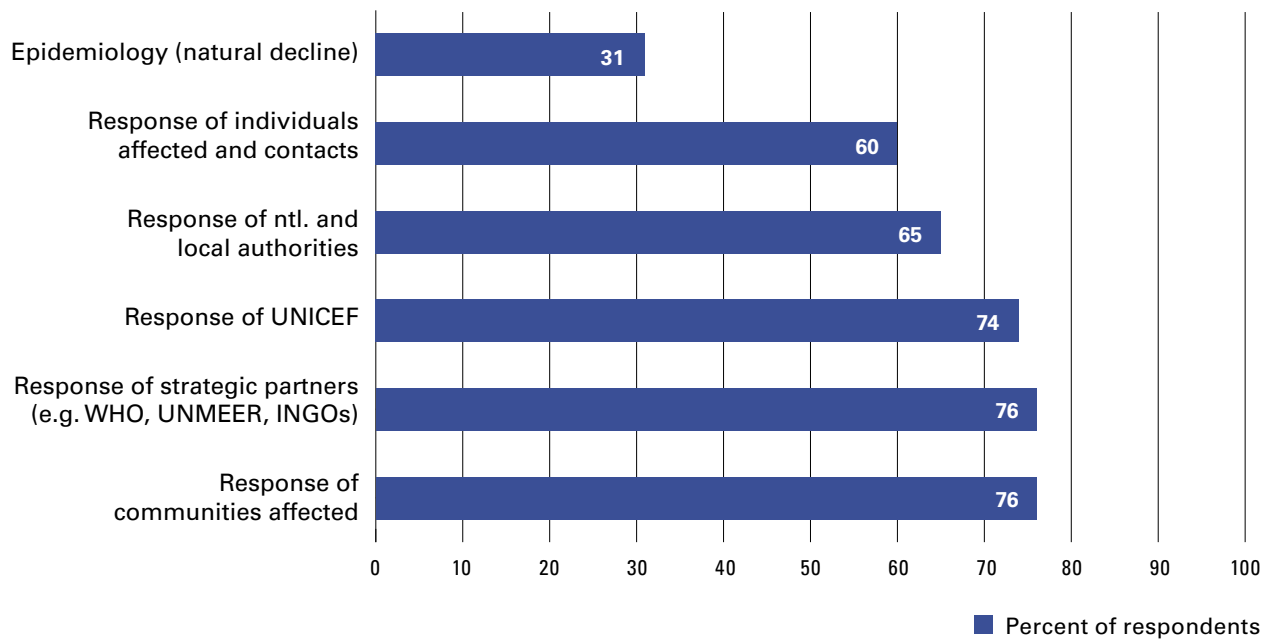
⁹⁶ United Nations, 'Protecting Humanity from Future Health Crises: Report of the High-level Panel on the Global Response to Health Crises', 25 January 2016; World Health Organization, 'Report of the Ebola Interim Assessment Panel', WHO, 2015, <www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>, accessed 14 November 2016; Human Rights Watch, 'West Africa: Respect Rights in Ebola Response', HRW, New York, 15 September 2014; United Nations Children's Fund, 'UNICEF Field Support Officers workshop report', UNICEF, Kenema, 12 April 2015; United Nations Children's Fund, 'Lofa County: Communities took the matter in their own hands', Communication for Development: Responding to Ebola in Liberia, UNICEF, June 2015; Obregon, Rafael, 'UNICEF HQ C4D Chief Support Mission to Sierra Leone CO - EVD Response', 31 March–29 April 2015; United Nations Children's Fund, 'UNICEF Communication for Development (C4D) workshop report', UNICEF, Freetown, 16 April 2015.

⁹⁷ World Health Organization, 'Ebola maps', WHO, <www.who.int/csr/disease/ebola/maps/en/>, accessed 17 November 2016.

⁹⁸ United Nations, 'Protecting Humanity from Future Health Crises: Report of the High-level Panel on the Global Response to Health Crises', 25 January 2016; World Health Organization, 'Report of the Ebola Interim Assessment Panel', WHO, 2015, <www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>, accessed 14 November 2016.



FIGURE 6 UNICEF stakeholder poll on the most important contributions to stopping Ebola



important contributions were eventually made thanks to the massive deployment of international resources.

In regards to UNICEF's contribution to stopping Ebola, the organization's impact was made primarily through community engagement, isolation and care and the large-scale delivery of supplies and WASH support (see Section 1.1). In particular, UNICEF significantly contributed to community behaviour changes (such as safe burials and handwashing), which helped to sustain or accelerate reductions in transmission and prevent new outbreaks. Early isolation was enabled by UNICEF support for community-based isolation efforts (i.e. CC centres, RITES, etc.) within the larger system (i.e. triage, ETUs, etc.). The centres also strengthened community engagement by being the locus for training a cadre of health workers and thereby supported community-led action against Ebola.⁹⁹

In terms of operational contributions, UNICEF WASH and supply efforts provided essential infection, prevention and control services and equipment to the CC centres and communities that helped to halt Ebola transmission at the community level. The organization provided WASH kits to some 2.8 million households in Ebola-affected areas; water and sanitation and waste management services to 133 Ebola treatment centres and CC centres; and handwashing stations and WASH support to nearly 1,600 health centres.¹⁰⁰ In Sierra Leone, UNICEF prioritized relevant WASH/C4D activities targeting dynamic disease transmission contexts and based on real-time monitoring, including providing support to hygiene promotion (community engagement) and handwashing stations for schools, markets and health facilities to guarantee the functionality of WASH services in non-Ebola affected locations. UNICEF also supplied safe water to ETUs, holding centres

⁹⁹ Abramowitz, Sharon, et al., 'Evaluation of Save the Children's Community-Care Centres in Dolo Town and Worhn', 1 July 2015.

¹⁰⁰ United Nations Children's Fund, *Humanitarian Action for Children 2015*, UNICEF, 2015.



and CC centres, including water collection and storage containers (jerry cans) to quarantined homes.¹⁰¹

UNICEF also made key contributions to halting Ebola transmission through its supply and logistics function. By mid-2014 UNICEF procured essential supplies and commodities for the response, including personal protective equipment, home hygiene and handwashing kits.¹⁰² By mid-2015, the organization had delivered more than 8,000 metric tonnes of supplies, the largest single supply operation in UNICEF's history.¹⁰³ The UNICEF Supply Division was able to negotiate lower prices for personal protective equipment through long-term agreements and, in most cases, to reduce the number of days needed to release sales orders.¹⁰⁴ UNICEF stakeholders polled were more confident about achievements in supply deliveries than any other activity, with 87 per cent agreeing that UNICEF procured essential supplies and commodities.

Yet the community-based response left room for considerable improvement in its operational effectiveness, integration and sequencing. First, the response was consolidated and developed as a practical innovation during the Ebola outbreak, but its operational effectiveness was undermined by delays in establishing the CC centres and implementing effective C4D activities (see *Section 1.1* and *Section 2*). Second, the approach did not adequately integrate child protection and supportive services into the complete system in a way that some actors considered necessary to change behaviour at the community level. Third, the approach struggled to involve these programmes in a sequenced second phase to address Ebola's serious secondary effects and humanitarian needs.

1.3 RECOVERY

■ SQ1.3 How well did UNICEF achieve HAC Objective 3?

This question is concerned with UNICEF's achievements in relation to HAC Objective 3, to support early recovery and the initiation of building back better primary health care systems and other social services.

Overall, UNICEF found it difficult to reinforce health care systems in Guinea, Liberia and Sierra Leone. The organization undertook some activities to support health services in Ebola-affected areas and sought to sustain community-based health care, but wider recovery efforts suffered funding gaps and health systems remained weak in the three countries. Differences of opinion also persisted in the organization about the merits of investing in CC centres versus primary health care. In the area of education, UNICEF worked to get children back to learning, reopen schools and provide guidance and support on safe and protective learning environments. The efforts contributed to preventing EVD transmission in schools, where no such cases were reported.

Health systems

As reflected in HAC indicators, UNICEF undertook activities to immunize children aged 6 to 59 months against measles, train community health workers in Ebola prevention and case management, and provide health structures in Ebola-affected areas with infection prevention and control supplies. Indicator data show that by April 2015, more than 2,000 health structures in Ebola-affected areas had received infection prevention and control supplies. Targets for training community health workers were exceeded in Sierra Leone, where 9,000 received training;

¹⁰¹ United Nations Children's Fund, 'Shifting the post for same goals: an assessment of the impact of the Ebola response on WASH interventions in Sierra Leone', UNICEF, 2015.

¹⁰² United Nations Children's Fund, *Humanitarian Action for Children 2014*, UNICEF, 2014.

¹⁰³ United Nations Children's Fund, *Humanitarian Action for Children 2015*, UNICEF, 2015.

¹⁰⁴ Ibid.



met in Liberia, where 650 received training; and not met in Guinea, where 1,600 received training against a target of 3,000. Some 2 million children were immunized in Liberia, Guinea and Sierra Leone between April 2015 and January 2016 in catch-up campaigns, achieving targets. However, these achievements, combined with the efforts of governments, other United Nations agencies, international and local NGOs and donor countries were not enough to meet the large-scale primary health care needs.

Wider recovery programmes in the three countries generated disappointing results due to significant funding gaps. From early 2015, UNICEF worked with the United Nations, the European Union, the World Bank, the African Development Bank and national governments to develop comprehensive early recovery plans, which included rebuilding health care systems, developing surveillance and building community resilience.¹⁰⁵ Poor funding from donors led to low achievement against targets, however, and national leaders in both Sierra Leone and Guinea expressed uncertainty that recovery plans were being implemented. Although a total of US\$5.2 billion was pledged for recovery at the International Ebola Recovery Conference held in July 2015,¹⁰⁶ six months later, US\$1.9 billion had not yet been committed to a specific country and little was known about how much of the remaining committed funds had been effectively delivered.¹⁰⁷

While UNICEF did work to reinforce primary health care systems during much of 2015, organizational actors expressed divergent opinions on the merits of having invested in CC centres versus primary health units. WCARO actors

argued this approach led to the establishment of parallel health structures such as CC centres and left capacity gaps in health systems, including in the areas of maternal health and child survival. Learning exercises revealed that at times, the CC centres in Sierra Leone undermined public health systems because patients used the centres to avoid the user fees charged by primary health units.¹⁰⁸ Although the CC centres were temporary structures designed for a specific use, some respondents were disappointed that only two CC centres were converted into alternate care or public health centres in Liberia, and none were converted Guinea. In Sierra Leone, however, though no CC centres were converted, CC centre supplies and capacities were transferred to the 1,185 primary health units in the country.

Community health care

During the recovery phase, UNICEF worked to sustain community-based health care to strengthen preparedness through community health services, surveillance and local engagement, despite limited funding for recovery. In Sierra Leone, UNICEF implemented a strategy focused on inter-sector community engagement and data (e.g. through village development committees instead of sectors setting up multiple committees). In Liberia, UNICEF encouraged the Ministry of Health to retain a strong focus on community-based health and supported efforts to establish a permanent community-based system to facilitate trusted access and two-way communication. WCARO actors believed that overall, UNICEF contributed to strengthening community health services through community engagement.

¹⁰⁵ United Nations, 'Recovering from Ebola', 2016; Governments of Guinea, Liberia and Sierra Leone, 'Mano River Union Post-Ebola Socio-economic Recovery Programme', April 2015.

¹⁰⁶ United Nations, 'Recovery', *Global Ebola Response*, <<http://ebolaresponse.un.org/recovery>>, accessed 17 November 2016.

¹⁰⁷ Oxfam, 'Ebola funds impossible to track', Oxfam, 31 January 2016.

¹⁰⁸ Obregon, Rafael, 'UNICEF HQ C4D Chief Support Mission to Sierra Leone CO - EVD Response', 31 March–29 April 2015; 'Rapid Mixed Methods Assessment of the Ebola Community Care Center Model', ICAP, New York, 2015; Oosterhoff, Pauline, et al., 'Community-Based Ebola Care Centres: A formative evaluation', *Ebola Response Anthropology Platform*, 2015.



Core capacities

It could not be determined what contribution UNICEF made to WHO-led efforts to build national or regional surveillance and IHR core capacities. In the recovery guidance, UNICEF and development partners recommended “developing a regional integrated disease surveillance network in West Africa”, which echoes a core capacity requirement under IHR, to maintain a “sensitive and flexible surveillance system with an early warning function.”¹⁰⁹ Strengthening core capacities (detection, assessment, reporting and response) are requirements under IHR and investment in them is essential to preventing pandemics.¹¹⁰ It is notable that after the Avian Flu crisis in 2007, donors did not provide the US\$26 million required for preparedness and response plans developed by the three countries, though this could have contributed significantly to preventing the Ebola outbreak and the need for a multi-billion dollar response.¹¹¹

Education services

With more than 5 million children out of school, the UNICEF education programme made a concerted effort to get affected children back to learning. UNICEF reached an estimated 1 million children with distance learning programmes provided through community radio¹¹² and supported governments to reopen 24,000 schools in 2015 (in January in Guinea, February in Liberia and March in Sierra Leone). UNICEF worked with the CDC and WHO to develop and implement an anti-Ebola protocols to facilitate the use of Ebola prevention measures in all affected schools and led the operationalization of Ebola-specific guidance on safe and protective learning environments. By the end of 2015, more than 6,800 schools were equipped with a minimum hygiene package for Ebola prevention.¹¹³ As a result, no cases of EVD transmission in schools were ever reported and schools helped to serve as platforms for increasing access to water and sanitation for children, promoting healthy behaviours and strengthening referrals systems between schools and health care providers.

¹⁰⁹ World Health Organization, ‘Checklist and Indicators for Monitoring Progress in the Development of IHR Core Capacities in States Parties’, WHO, April 2013.

¹¹⁰ Moon, Suerie, et al., ‘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, *The Lancet*, vol. 386, no. 10009, 28 November 2015; United Nations, ‘Protecting Humanity from Future Health Crises: Report of the High-level Panel on the Global Response to Health Crises’, 25 January 2016; Pronyk, P., et al., ‘The Effect of Community-Based Prevention and Care on Ebola Transmission in Sierra Leone’, *Am J Public Health*, vol. 104, no. 6, April 2016.

¹¹¹ Evans, Tim, ‘Solidarity and Security in Global Health What Can We Learn from the Ebola Crisis?’ World Bank Group keynote speech delivered at the opening plenary of the Prince Mahidol Award Conference, 29 January 2015.

¹¹² United Nations Children’s Fund, *Humanitarian Action for Children 2015*, UNICEF, 2015.

¹¹³ United Nations Children’s Fund, ‘Response to Ebola in West Africa’, 11 January 2016.



SECTION II

EFFICIENCY

This section offers an assessment of the response's overall efficiency¹¹⁴ based on key findings about 1) timeliness; 2) cost analysis;¹¹⁵ and 3) efficiency factors. The assessment focuses on whether the response was delivered in a timely way, whether inputs (financial, human resources and other) were broadly consistent with the results achieved and which internal process factors had the greatest impact on efficiency.

¹¹⁴ Efficiency measures the outputs – qualitative and quantitative – in relation to the inputs.

¹¹⁵ The evaluation sought to answer whether inputs (financial, human resources and other) were broadly consistent with the results achieved. However, such an analysis was not possible for reasons described in the methodology section of this report. Information on UNICEF's spending for the Ebola response is addressed in a descriptive manner on page 30 and 31.



■ KEQ2. HOW EFFICIENT WAS UNICEF'S RESPONSE TO EBOLA?

The response fell short of efficiency expectations, specifically in terms of timeliness. UNICEF missed key opportunities to contain the outbreak (March 2014–July 2014), tackle its alarming growth (August 2014–November 2014), and deal with its secondary effects and human consequences (August 2014–early 2015). At the same time, the response delivered supplies and logistics with notable speed and competence and made satisfactory use of resources appropriate for an emergency. Management, coordination and strategy were overriding efficiency challenges, however, as were mobilizing and deploying human and financial resources.

2.1 TIMELINESS

■ SQ2.1 Did UNICEF implement the response on time in affected countries?

Overall, UNICEF did not deliver a timely response. By implementing its strategy to stop Ebola just after the outbreak's peak and only meeting targets for non-prioritized programmes, especially child protection, several months after the L3 declaration, the organization missed early opportunities to contain the outbreak.

Containment delays

International actors, including UNICEF, missed an opportunity to adequately contain the Ebola outbreak in March 2014, when the virus was

first identified, allowing EVD to spread in the region for three months and necessitating an emergency response to deal with the consequences.¹¹⁶ External reviews highlighted this as a major surveillance failure. WHO's delay in declaring a PHEIC also delayed the mobilization of a coordinated response between March 2014 and September 2014,¹¹⁷ resulting in inadequate isolation and care measures and the loss of many lives. At the country level, delays were attributed to weak health systems, poor surveillance, lack of epidemiological data, denial by authorities of the magnitude of the situation for economic and political reasons, and the inability of inter-agency coordination structures to raise the alarm.¹¹⁸

¹¹⁶ World Health Organization, 'Report of the Ebola Interim Assessment Panel', WHO, 2015, <www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>, accessed 14 November 2016; Moon, Suerie, et al., '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, *The Lancet*, vol. 386, no. 10009, 28 November 2015; United Nations, 'Protecting Humanity from Future Health Crises: Report of the High-level Panel on the Global Response to Health Crises', 25 January 2016; Pronyk, P., et al., 'The Effect of Community-Based Prevention and Care on Ebola Transmission in Sierra Leone', *Am J Public Health*, vol. 104, no. 6, April 2016.

¹¹⁷ World Health Organization, 'Report of the Ebola Interim Assessment Panel', WHO, 2015, <www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>, accessed 14 November 2016.

¹¹⁸ Ibid; Moon, Suerie, et al., '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, *The Lancet*, vol. 386, no. 10009, 28 November 2015; Pronyk, P., et al., 'The Effect of Community-Based Prevention and Care on Ebola Transmission in Sierra Leone', *Am J Public Health*, vol. 104, no. 6, April 2016; Evans, Tim, 'Solidarity and Security in Global Health What Can We Learn from the Ebola Crisis?' World Bank Group keynote speech delivered at the opening plenary of the Prince Mahidol Award Conference, 29 January 2015.



Lacking a regional response strategy, UNICEF itself missed the opportunity to mount a strong enough organizational response between March 2014 and July 2014. During this time, UNICEF country offices worked with their respective governments to respond, but struggled to procure medical supplies and lacked the funds to mobilize teams for surveillance and contact tracing.¹¹⁹ With the help of an Emergency Programme Fund loan,¹²⁰ the Liberia Country Office made significant efforts to suppress initial outbreaks and continued to call for a stronger response. The UNICEF Executive Director did not declare an L3 emergency until September 2014, when the HQ-based Health Section became directly concerned and the Executive Director began a process of response coordination. Some HQ and WCARO actors felt that the organization waited too long to act in the countries where UNICEF was a major actor in the health sector and abdicated too much responsibility to WHO.

Community response delays

UNICEF's community-based response, which aimed to stop the transmission of Ebola and included the C4D function, only began to reach capacity in December 2014. By that time, new EVD cases were declining across Guinea, Liberia and Sierra Leone. The initiation of the organization's critical community engagement work was delayed because significant resource mobilization only occurred between October 2014 and December 2014 and took time to translate into adequate staffing in decentralized offices in hotspot areas.¹²¹ For example, initial efforts were made to deliver face-to-face Ebola messages to households as early as April 2014 but did not achieve scale until October 2014–November 2014.

UNICEF CC centres only became operational after the outbreak's peak due to internal delays. The CC centres were conceived of in August 2014–September 2014 in response to gaps in isolation and care at the community level. In Sierra Leone, UNICEF was contracted by the United Kingdom Department for International Development to contribute to CC centre construction in mid-October 2014, began CC centre construction in November 2014¹²² and had established 42 operational CC centres by December 2014. HQ actors felt that four to six weeks were lost in unnecessary internal debates about the validity and applicability of CC centres, which critically reduced their impact. Community members surveyed in Sierra Leone also felt that the CC centres were late and many more lives could have been saved if they had been established earlier.

Programme delays

Child protection and non-prioritized programmes did not become fully operational until 2015, more than six months after the L3 declaration. In 2014, Ebola orphans received little child protection support and only small numbers of children received psychosocial support. In early 2015, when the capacity was in place to extend services, UNICEF was able to reach more than 10,000 children in Sierra Leone and nearly 4,000 in Liberia. Eventually, large-scale psychosocial support was provided across the countries by the end of November 2015 and the child protection response reached scale by February 2015, when funding was translated into staff and programme cooperation agreements on the ground.¹²³ In Sierra Leone, implementers cited insufficient funds as a key reason why the response only became fully effective in 2015. In Guinea, communities reported the

¹¹⁹ Government of Senegal, 'Lessons From The Response to the Ebola Virus Disease Outbreak in Sierra Leone May 2014–November 2015', summary report, 2015.

¹²⁰ The Emergency Programme Fund is UNICEF's quickest and most flexible source of immediate funding for humanitarian crises.

¹²¹ United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015.

¹²² Abramowitz, Sharon, et al., 'Ebola Community Care Centers: Lessons learned from UNICEF's 2014-2015 Experience in Sierra Leone,' UNICEF, New York, January 2016.

¹²³ United Nations Children's Fund, 'Ebola Epidemic Child Protection Response Lessons Learned' (internal document), 2015.



initial response was “very medicalized” and lacked sufficient consideration of child protection needs.

2.2 EFFICIENCY

■ SQ2.2 Which factors most influenced efficiency?

The efficiency of the response was primarily determined by the strength of the mobilization and utilization of key resources – human and financial resources and supplies – as well as coordination and management. This section briefly considers how the various elements of the L3 SSOPs contributed to efficiency. Section 3 addresses how these elements helped or hindered effectiveness in more detail.

The resourcing functions, including human resources, supply and finance and administration determined efficiency in the L3 response to a greater extent than management and preparedness functions.

- Human resource management presented major challenges to an efficient response. UNICEF struggled to mobilize sufficient numbers of emergency staff to recruit and deploy and address duty of care concerns and staff fears related to the outbreak, due to inadequate human resources support at the regional and country office levels (see Section 3.5).¹²⁴ Implementers in all three countries reported delays in the deployment of emergency staff during the initial phase.
- Finance and administration presented another major challenge to efficiency. The response was slowed because country

offices did not consistently apply accelerated financial and administrative procedures due to capacity gaps, as well as weak tools, guidance and institutional arrangements (see Section 3.7).¹²⁵ Implementers in Guinea and Sierra Leone stressed an initial lack of finance capacity and inefficient UNICEF procedures.

- Supply and logistics showed operational efficiency by acting with speed and competence to support the response when the L3 was declared. Despite an initial absence of preparedness and appropriate contingency stocks, adequate supplies were delivered in a timely manner and ‘stock outs’ were largely avoided (see Section 3.6).¹²⁶

At times, the management functions, including global coordination, strategy, planning and monitoring, decreased efficiency.

- Until the appointment of a dedicated GEC in early October 2014, the response was slowed down by a lack of direction. Once appointed, the GEC’s public health leadership and decision-making were challenged at regional and country office levels, further delaying efforts to implement the strategy to stop Ebola (see Section 3.2).
- Strategy was undermined by competing understandings of Ebola-related risks and the rationale for intervention, difficulties in programme integration and sequencing, and a proliferation of different strategies (see Section 3.3).
- Monitoring was considered inefficient due to the weekly demands of producing situation reports at regional and country office levels, and of obtaining information from country offices (see Section 3.3).¹²⁷

¹²⁴ United Nations Children’s Fund, ‘UNICEF Surge In Emergency Workshop Geneva’, Workshop Report and Annexes, 18-20 August 2015; United Nations Children’s Fund, ‘Lessons Learned Review 2014-2015’, UNICEF WCARO, Dakar, April 2015.

¹²⁵ United Nations Children’s Fund, ‘Lessons Learned Review 2014-2015’, UNICEF WCARO, Dakar, April 2015.

¹²⁶ United Nations Children’s Fund, ‘Lessons Learned Review 2014-2015’, UNICEF WCARO, Dakar, April 2015; United Nations Children’s Fund, ‘Ebola Virus Disease Outbreak Response, Supplies and Lessons Learned Update’, UNICEF Supply Division, July 2015.

¹²⁷ United Nations Children’s Fund, ‘Lessons Learned Review 2014-2015’, UNICEF WCARO, Dakar, April 2015.



SECTION III

INTERNAL COORDINATION

This section offers an assessment of internal coordination, based on overall procedures and specific process elements. The assessment focuses on how each element helped or hindered effectiveness and whether it adhered to the SSOP guidance, while also making reference to the Program Guidance Note.



■ KEQ3. HOW WELL COORDINATED INTERNALLY WAS UNICEF'S RESPONSE TO EBOLA?

The L3 SSOPs, UNICEF's internal process for emergency response, functioned and contributed to effectiveness but also showed substantial room for improvement. HQ actors generally felt that the SSOPs were crucial to mobilizing an organization-wide response, that systems functioned relatively well, and that UNICEF's emergency response continually improved.

3.1 PROCEDURES

■ SQ3.1 How well did UNICEF's L3 SSOPs model enable effectiveness?

In August 2014, UNICEF activated the L3 SSOPs for the Ebola response, applying them to a PHEIC for the first time. As the response diverged from a typical humanitarian response, multiple adaptations were made to the SSOPs. Leadership became more centralized, HQ-based and top-down in nature with the extraordinary involvement of the UNICEF Executive Director and the appointment of a dedicated public health GEC. The architecture differed with the creation of an Ebola Cell in lieu of full reliance on EMOPS to facilitate the organization-wide response. Accountabilities changed with the non-application of the CCCs; strategy differed with the prioritization of a public health objective; and external coordination differed with WHO's leadership, the establishment of UNMEER and technical pillars and the Inter-Agency Standing Committee (IASC) decision not to activate the clusters. Internally, UNICEF questioned whether all of these adaptations were necessary.

Overall, considering the 13 SSOP process elements, those concerned with strategic management – global coordination, strategic guidance, performance monitoring and information management – made critical qualitative contributions to effectiveness while

leaving clear room for improvement (see Sections 3.2–3.4). UNICEF's resource management functions, particularly supply and logistics, made strong, large-scale and material contributions to effectiveness, though human resources and finance and administration struggled with the perennial and structural challenges of mobilizing additional capacities (see Sections 3.5–3.7). Preparedness and knowledge management functions did not systematically contribute to effectiveness and remained poorly defined process elements and absent from the L3 SSOPs (see Sections 3.9–3.10). Figure 7 illustrates respondent impressions of how important each internal process was to UNICEF's overall achievements in the response.

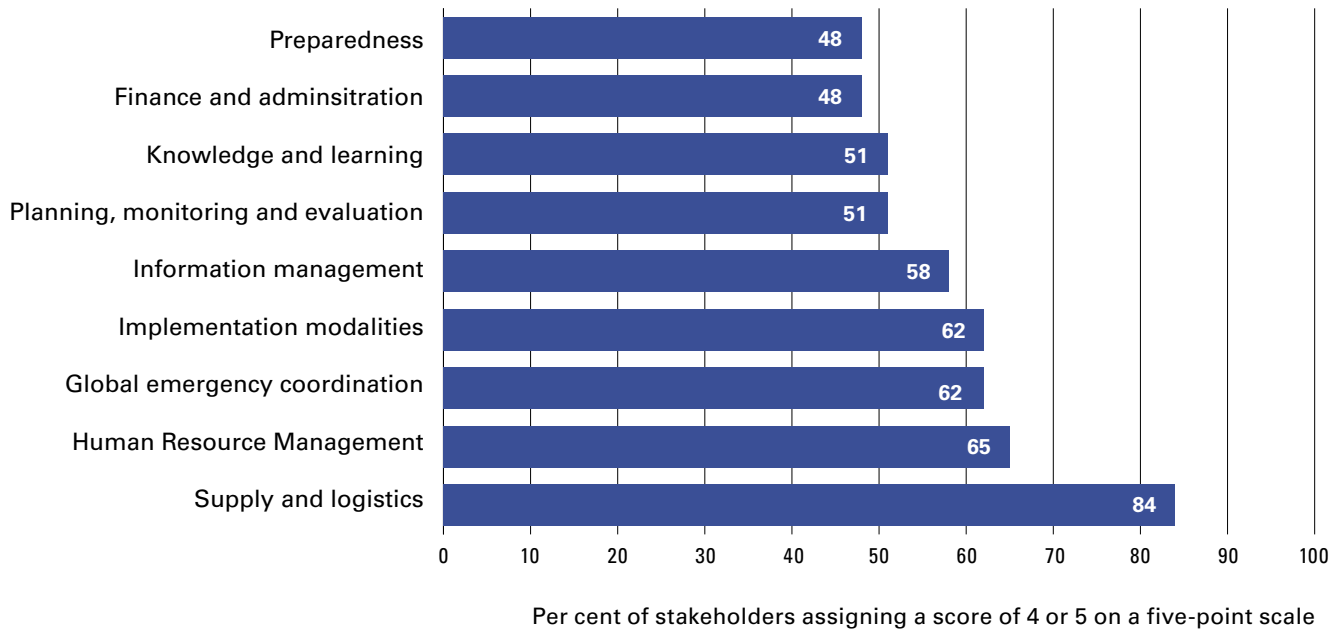
3.2 GLOBAL COORDINATION

■ SQ3.2 How did global emergency coordination, through the GEC and the Ebola Cell, enable effectiveness?

The appointment of a dedicated GEC with expertise in public health made a critical difference to strategic direction. Before this appointment, HQ actors recalled uncertainty and absence of direction at the country level. By November 2014, the GEC's Programme Guidance Note was providing clear direction to the response, with a necessary focus on stopping transmission and



FIGURE 7 How important was the contribution of internal processes to UNICEF's overall achievements



using a community-led approach. HQ actors added that the dedicated GEC brought public health and epidemiological knowledge, understanding of response requirements and credibility with external partners. WCARO actors and some country office actors recognized the exceptional value of a dedicated GEC in the response.

The GEC's public health leadership was challenged at regional and country office levels, however, where actors considered it inadequately informed by local context. WCARO actors felt the New York-based GEC was inevitably HQ-centric, excessively influenced by political and media pressures, and removed from national, local and epidemiological realities, as well as from established regional and country office relationships and coordination channels.

Decisions made through exceptional mechanisms were also contested at the regional and country levels. The use of the Core Directors Group and the Executive Director instead of the Emergency Management Team¹²⁸ for decision-making was considered ineffective and regional actors observed that this led to a proliferation of HQ-based decision-makers, micro-management and inappropriate decision-making, as well as a top-down style that reduced dialogue, technical input and implementer ownership. Country office representatives wished for more tailored directives, strategies and sequencing at the country level. In Liberia, for example, intensive negotiations took place between HQ and WCARO before the decision was made to use RITEs instead of CC centres.¹²⁹

¹²⁸ The objectives of an Emergency Management Team are primarily operational, including: to streamline HQ divisions' support to country and regional offices; monitor and reassess the level of the emergency; serve as the interface with the main inter-agency counterparts; and serve as a light and operational core team under the GEC. The fact that the Emergency Management Team did not include strategic deliberation was considered a gap in the response by some.

¹²⁹ United Nations Children's Fund, 'Liberia Lessons Learned Presentation at Lesson Learned Review', UNICEF, Dakar, February 2015.



Without the functional capacities of EMOPS, the Ebola Cell struggled to mobilize an optimal emergency response. HQ contributors noted the small Ebola Cell supported the GEC but did not offer the full support structure of EMOPS, including established working relationships with WCARO and programmes, as well as performance and knowledge management capacities. WCARO contributors found the Ebola Cell was too narrowly focused and established a multisector core group at the regional level to coordinate emergency response. Participants in internal learning exercises saw no reason to change standard ways of working through EMOPS.¹³⁰ This reflects a wider recognition in external reviews that the response established new structures that bypassed existing emergency response mechanisms, which led to delays and coordination difficulties in affected countries.¹³¹

3.3 STRATEGY, PLANNING, AND MONITORING

■ SQ3.3 How did strategic planning and monitoring of performance enable effectiveness?

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. This was the world's first large-scale EVD epidemic with outbreaks in urban areas, infection rates projected to spiral massively, a fluid and dynamic epidemiology and intense fear and political pressure.¹³² Developing a strategy was complicated by a lack of knowledge, the multi-country impact, loss of medical

staff and responders and difficulties applying UNICEF's multisector service provision model. Learning exercises have highlighted that the response was constrained by poor understanding of the disease and its epidemiology in different countries and a lack of data on the evolving situation.

In particular, UNICEF's strategy was undermined by different understandings of Ebola-related risks and the rationale for intervention. Some levels and programmes accepted the logic of intervening primarily to stop Ebola transmission on the basis of UNICEF's comparative advantage in the affected countries whereas others felt that the response must address a specific and disproportionate impact on children. Some WCARO actors felt that the response remained focused on an overstated projection of Ebola cases without considering other important risks, including the secondary effects of Ebola on children, women and basic services.

The response strategy was also undermined by difficulties related to programme integration and sequencing. Inter-sector strategy development was insufficient and the strategy development process did not sufficiently clarify to all sectors how they could contribute to stopping the transmission of Ebola. WCARO actors suggested that poor sequencing of programmes meant that recovery and preparedness work streams were deprioritized, funding to education and child protection programmes was delayed and key opportunities were missed.

The response was further undermined by a proliferation of different strategies. In September 2014, the HAC and the Regional Response Strategy presented a prioritized, multipronged

¹³⁰ United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015.

¹³¹ World Health Organization, 'Report of the Ebola Interim Assessment Panel', WHO, 2015, <www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>, accessed 14 November 2016; United Nations, 'Protecting Humanity from Future Health Crises: Report of the High-level Panel on the Global Response to Health Crises', 25 January 2016; United Nations, Lessons learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response: Report of the Secretary-General, A/70/737, United Nations, New York, 4 March 2016.

¹³² Moon, Suerie, et al., '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, *The Lancet*, vol. 386, no. 10009, 28 November 2015.



and multisector approach. In November 2014, the Programme Guidance Note emphasized a community-led response aimed exclusively at stopping transmission. Various other external strategies, programme-specific strategies and country-specific strategies remained in application. The absence of a single response plan created confusion at the country level.

UNICEF made considerable effort to monitor its performance during the response. Beginning in September 2014, HQ and WCARO actors worked with the three country offices to develop a joint humanitarian performance monitoring framework with comparable indicators. The framework allowed UNICEF to produce consolidated situation reports with regular updates on key performance indicators across the countries, which was a particular challenge in the context of multiple strategies, different understandings of strategy, and the iterative planning required to respond to the changing epidemiology. UNICEF was also able to adapt targets; for example, the HAC proposed the construction of 300 CC centres but the decline in cases required that targets be reduced accordingly.

UNICEF's performance monitoring remained poorly adapted to the requirements of the Ebola response and strategic decision-making, however. The indicators were developed in September 2014 for a multisector response and were not well suited to the prioritized community-led strategy aimed at dynamic and qualitative behaviour change (C4D). WCARO actors reported that too many indicators were imposed or changed, which reduced coherence and complicated tracking over time and country comparisons. EMOPS observed that UNICEF's humanitarian performance monitoring, which relies on standard indicators aligned

to the implementation of the CCCs, could not be easily adapted to the requirements of the Ebola response.

UNICEF lacked capacities to collect and properly analyse monitoring data at the country office level. UNICEF lessons learned indicate a need for dedicated capacity to work with and analyse the indicators across all affected countries, as well as additional capacity for information management, monitoring and reporting, down to the field office level.¹³³ HQ actors reported difficulties in data collection and analysis. In Liberia, implementers reported a lack of monitoring staff until December 2014, a lack of capacity to provide real-time monitoring information and difficulties in verifying delivery to those least accessible.

3.4 INFORMATION MANAGEMENT

■ SQ3.4 How did the collection and analysis of information (needs assessments, epidemiology, knowledge, attitude and practice surveys and studies by anthropologists) enable effectiveness?

Initially, UNICEF and partners lacked the epidemiological data needed to guide programme decisions, primarily due to capacity gaps in the affected countries. Although WHO was the lead agency for surveillance, data collection and case transmission investigation, in September 2014 and October 2014, WHO was slow to share epidemiological data¹³⁴ and the data was of poor quality and not disaggregated according to UNICEF age categories (i.e. under 1, under 5 and under 18). In 2015, UNICEF benefited from major improvements in WHO epidemiological data and, in turn, contributed its own C4D data to epidemiological mapping.¹³⁵

¹³³ United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015.

¹³⁴ United Nations Children's Fund, 'Ebola Virus Disease Outbreak Response, Supplies and Lessons Learned Update', UNICEF Supply Division, July 2015.

¹³⁵ See case studies about the use of RapidPro and U-Report at <www.unicef.org/cbsc/index_73157.html>, accessed 17 November 2016; United States Agency for International Development, 'Use of Technology in the Ebola Response in West Africa', Technical Brief, USAID, November 2014.



Throughout the response, regional and country office actors struggled to collect, clean and analyse the epidemiological data needed to target programme activities, and lacked the information and data collection systems needed to detect how EVD was affecting children.¹³⁶ External reviews highlight a lack of analysis of epidemiology and transmission dynamics, and the need for rapid knowledge production and dissemination where necessary, using ICT.¹³⁷ HQ actors noted a lack of real-time information and analysis to inform programme strategies on epidemiology, source reliability, triangulation, meaning and implications. Multiple respondents contrasted the gap in analytical capacity with the amount of effort invested in collecting monitoring data and producing situation reports.

In 2015, UNICEF made growing use of real-time monitoring, partner reporting and innovative ICT applications – such as U-Report,¹³⁸ mHero¹³⁹ and EduTrac¹⁴⁰ – to support programmes. However, UNICEF lacked a suitable information management system to collect, process, analyse and utilize the large amounts of information collected through U-Report, knowledge, attitude and practice surveys, other surveys, partners and studies conducted by anthropologists.¹⁴¹ WCARO actors reported that UNICEF's information management work relied too heavily on quantitative methods and was unable to use triangulated reporting, radio feedback and U-Report. At the community level, information management did not cover all sectors or programme intersections.

3.5 HUMAN RESOURCES

■ SQ3.5 How did human resources management (surge deployment and safety/welfare) enable effectiveness?

UNICEF experienced considerable difficulties in mobilizing the significant additional human resources needed to implement the Ebola response. Demand was high for surge capacity across West Africa in 2014 and 2015. For the Ebola response, WCARO and country offices made 662 surge capacity requests, 508 were completed and 154 were cancelled upon country/regional office request.¹⁴² Initially, the mobilization of human resources was delayed by an intense fear of Ebola, which limited the number of staff willing to deploy; thereafter, recruitment for deprioritized activities such as child protection and education was delayed and as a result, these areas did not achieve capacity until early 2015.¹⁴³ When adequate funding became available, certain categories of staff were very difficult to find, including senior management, senior operations, information management, C4D experts and francophone staff.

UNICEF faced systemic problems in the recruitment and deployment of emergency staff, with only 51 per cent of surge capacity needs met in 2014 using established surge mechanisms and the rest left to ad hoc solutions, especially staff missions from other parts of UNICEF. The Ebola response competed for surge capacity with other L3 responses (including the responses in

¹³⁶ United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015; United Nations Children's Fund, 'Ebola Epidemic Child Protection Response Lessons Learned' (internal document), 2015.

¹³⁷ World Health Organization, 'Report of the Ebola Interim Assessment Panel', WHO, 2015, <www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>, accessed 14 November 2016; Pronyk, P., et al., 'The Effect of Community-Based Prevention and Care on Ebola Transmission in Sierra Leone', *Am J Public Health*, vol. 104, no. 6, April 2016.

¹³⁸ U-Report Liberia is a free, open source text-message-based social network.

¹³⁹ mHero is a system that links into the government's existing databases of health workers and allows the Ministry of Health to ask questions, identify who is still alive and working, and ensure that necessary supplies and training are provided.

¹⁴⁰ EduTrac is a school monitoring system that uses a mobile-phone based data collection system, which was used to track school readiness to reopen and other key variables.

¹⁴¹ United Nations Children's Fund, 'UNICEF Communication for Development (C4D) workshop report', UNICEF, Freetown, 16 April 2015.

¹⁴² United Nations Children's Fund, Ebola Staffing Analysis, 29 January 2015.

¹⁴³ United Nations Children's Fund, 'Ebola Epidemic Child Protection Response Lessons Learned' (internal document), 2015.



the Central African Republic, South Sudan and the Syrian Arab Republic), and deployments left capacity gaps in the sending offices and divisions.¹⁴⁴ By October 2014, recruitment was opened to national staff and a lien procedure was introduced to safeguard posts. This was considered an important innovation.¹⁴⁵

Deployment was also slowed by the time needed to clarify international medevac procedures, questions about duty of care for all staff and inadequate human resource policy and SOPs for staff safety.¹⁴⁶ In the Liberia Country Office, for example, implementers felt that more could have been done to manage stress levels and recognize staff stress as a problem. At HQ level, UNICEF developed new policies and procedures to reinforce staff safety and duty of care, including medical care, medevac, insurance and hazard and death benefits. Under the leadership of the UNICEF Executive Director, system-wide changes were made and health protocols developed for all staff, covering the provision of kits, links with the United Nations medical centre, psychological briefings and debriefings, a 'no touch' policy in country offices, salary advances and flexible working arrangements. When one UNICEF staff member contracted Ebola in November 2014, the organization made a 'no regrets' commitment to evacuate the staff member, which increased confidence among other staff.¹⁴⁷ These procedures were developed during the crisis at considerable cost in terms of time and effort.

After medical protocols were established, country offices felt overwhelmed by surge staff of mixed quality, high levels of staff turnover, and a decreased sense of response ownership overall. Lessons exercises indicate that ownership of the response among national staff members was essential to its success and that the staffing

strategy may have undermined this.¹⁴⁸ In Guinea and Liberia, implementers reported that many staff members, including international staff between late 2014 and early 2015, had unclear roles and responsibilities. In Guinea, staff numbers increased from 90 to 200 and many of the new staff members required better induction. In Liberia, staff noted too many short-term missions of less than a month, and requested better recognition of country office contributions in the face of international deployments.

Emergency human resource managers played a lead role in mobilizing surge capacity while lacking human resources support at regional and country office levels. The human resources emergency function successfully recruited and deployed 508 surge personnel, most of which served effectively. Between September 2014 and December 2014, the number of personnel in the three countries increased more than 10-fold (from 395 to 4,616) across all deployment modalities. At UNICEF HQ, a dedicated human resources and global services unit worked well, eventually enabling new hire orientation and processing (on-boarding) to be completed in three hours instead of the usual three days, and the WCARO emergency human resource function provide coordination for country offices that lacked human resource management capacities. However, several respondents reported that UNICEF's wider human resource management function was weak and inadequately scaled up for an emergency, lacked senior capacity and the ability to quickly identify needs at the country level, and lacked training in emergency modalities (i.e. emergency human resource checklist, the right contacts, flexibility, etc.).

¹⁴⁴ United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015; United Nations Children's Fund, 'UNICEF Surge in Emergency Workshop', 2015.

¹⁴⁵ United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015.

¹⁴⁶ Ibid.

¹⁴⁷ Ibid.

¹⁴⁸ United Nations Children's Fund, 'UNICEF's Role in Global Health Emergencies and Implementation Plan' (draft), UNICEF, 2016.



3.6 SUPPLY AND LOGISTICS

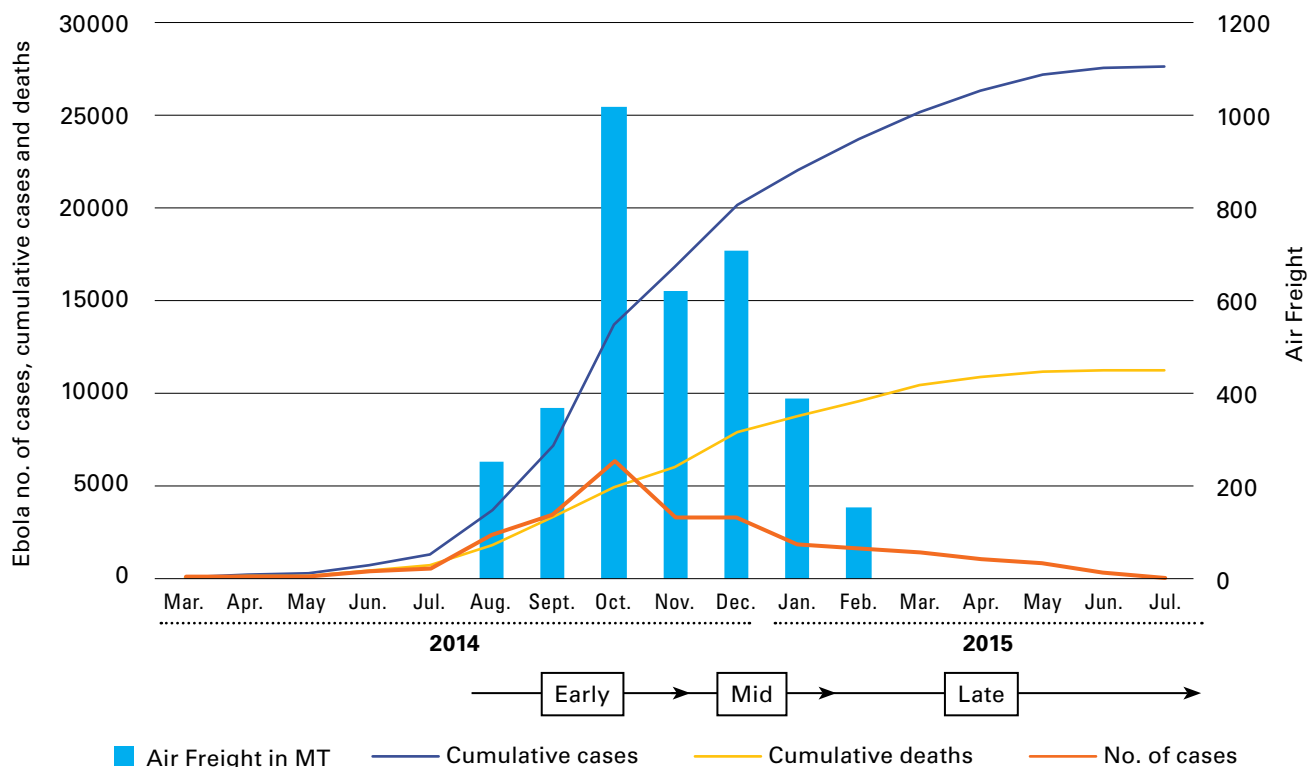
■ SQ3.6 How did supply and logistics enable effectiveness?

UNICEF’s supply and logistics activities contributed to stopping Ebola mainly through the large-scale delivery of supplies and protective equipment to the affected countries and communities. HQ and WCARO actors noted the operation was UNICEF’s largest ever in terms of the volume of supplies (8,000 metric tonnes in supplies were delivered by mid-2015). The UNICEF Supply Division’s learning exercise highlighted the successful strengthening of national systems with supplies for ETUs and

burials, and more than three quarters of all supplies were resourced in-country.¹⁴⁹ UNICEF effectively scaled up the delivery of supplies to the affected countries to coincide with the peak of the outbreak in October 2014 (see Figure 8). In October 2014, UNICEF delivered 1,019 metric tonnes of supplies – including tents, tarpaulins and electricity support – to support the first wave of CC centres.

The Supply Division acted with speed and efficiency to support the response when the L3 was declared, delivering timely and adequate supplies and largely avoiding stock outs. Learning exercises attribute success to a proactive policy of ‘no regrets’¹⁵⁰ or ‘not doing nothing’, which facilitated rapid decision-making,

FIGURE 8 UNICEF supply function in response to Ebola: Supplies delivered by air and Ebola case load in the three affected countries, 2014 and 2015



¹⁴⁹ United Nations Children’s Fund, ‘Ebola Virus Disease Outbreak Response, Supplies and Lessons Learned Update’, UNICEF Supply Division, July 2015.

¹⁵⁰ Under the ‘no regrets’ principle, the organization will prefer to err on the side of deploying more capacity and mobilizing more resources in support of the response even if this proves to have been unnecessary after the fact.



procurement and supply of essential items, improved knowledge of emergency health and WASH products, and rapid funding.¹⁵¹ HQ contributors noted that the Supply Division deployed senior staff to the region to identify supply needs in August 2014, earlier than other programmes, and facilitated real-time innovation in the development of personal protective equipment for Ebola, CC centres and family hygiene kits. In general, UNICEF actors felt that the Supply Division was highly effective,¹⁵² and all stakeholders highlighted its proactive management and competent staff.

Despite positive overall assessment, questions arose about the delivery of supplies and salaries to CC centres, with gaps noted in the provision of supplies by UNICEF and international professionals, and CC centre staff reporting that irregular supplies and payments negatively affected their motivation.¹⁵³ The United Kingdom Department for International Development felt that in Sierra Leone, UNICEF's central supply function was "world class" but distribution systems outside of Freetown were weak and potentially a risk to donor funds. In Liberia, both Country Office staff and partners noted problems with the verification of delivery to the least accessible and with the diversion of resources.

More broadly, the delivery of supplies was constrained by critical gaps in knowledge and information. The Supply Division relied on fluctuating information about the scale of supply requirements, including the September 2014 CDC projections of 1.4 million Ebola cases, which were drastically reduced one month later to 21,000 cases. Lessons indicate that the Supply Division also struggled with the inability of programmes to present an accurate

picture of needs, a lack of knowledge about Ebola-specific products, and poor information sharing among NGOs/WHO in regards to product specifications.

3.7 FINANCE AND ADMINISTRATION

■ SQ3.7 How did operations (i.e. financial and administrative procedures) enable effectiveness?

UNICEF's Ebola response was ultimately well funded, but UNICEF did not consistently apply accelerated financial and administrative procedures, which slowed the response. Reviews suggest that the commitment of funds was fast and adequate after the L3 launch, but country offices found that the arrival of funding was slow and inadequate, reflecting a systemic inability to quickly translate income into resources for action on the ground.¹⁵⁴ HQ actors pointed to a lack of finance and administration capacity for dealing with the a sudden surge of funding to country offices, including low capacities at the country level, a lack of surge capacity in this function, and a culture of risk aversion and rigidity in country office operations. Observed one respondent, "In an emergency, like Ebola, accelerated procedures kick in but country office staff, fearing the auditor, do not apply them and self-impose requirements for regular programmes. This creates bottlenecks." In Guinea, Liberia and Sierra Leone, implementers reported slow payments, cash flow problems and cumbersome procedures unsuitable for an emergency.

¹⁵¹ Data from UNICEF Sierra Leone; United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015; United Nations Children's Fund, 'Liberia Lessons Learned Presentation at Lesson Learned Review', UNICEF, Dakar, February 2015.

¹⁵² Ibid.

¹⁵³ Ibid.

¹⁵⁴ United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015.



Slow procedures were also tied to gaps in emergency-appropriate tools and guidance needed for their application. UNICEF participants at the Ebola learning exercise wondered whether SSOPs could be further lightened to speed up the response. HQ actors saw a need for more tools and training to apply accelerated procedures, including a checklist. WCARO actors felt tools such as programme cooperation agreements were too slow for emergencies. Lessons learned suggest programme cooperation agreements were inappropriate for supporting key local initiatives.¹⁵⁵

Institutional arrangements did not foster an appropriate level of involvement of finance and administration with programmes. HQ and WCARO actors observed a problematic gap separating operational functions, including finance and administration, from programmes in the Ebola response and more generally. Operations staff worked in silos, not involved in programmes as strategic programme partners. One contributor from the UNICEF Division of Finance and Administration noted that effective finance and administration staff who can use expedited procedures should be a necessary complement to all programmes. Programme experts may be highly knowledgeable in their fields but not necessarily prepared to manage budgets that suddenly grow into hundreds of millions of dollars, without the support of finance and administration experts.

3.8 IMPLEMENTATION AND INNOVATIONS

■ SQ3.8 How did implementation modalities enable effectiveness?

Although UNICEF effectively implemented the innovative community-based response aimed at stopping the transmission of Ebola (see Section 1.2), lessons remained to be learned from this innovative approach. In particular, lessons highlight the difficulty of relying on traditional INGO implementing partners, some of whom were not present in sufficient capacity or were forced to withdraw in mid-2014,¹⁵⁶ and UNICEF's consequent dependence on local partners with very limited capacity. Learning exercises recognize the central role played by civil society in stopping Ebola,¹⁵⁷ the importance of civil society organizations, local government staff¹⁵⁸ and community health volunteers.¹⁵⁹ Learning exercises also point to need for dynamic structures that keep communities at the centre of development and humanitarian programming,¹⁶⁰ as well as the lack of funding for community-led initiatives.¹⁶¹ However, lessons exercises do not examine the effectiveness of UNICEF's local capacity building¹⁶² or address the key question of how best to support communities themselves to strengthen preparedness and response in public health emergencies. This will likely require developing far more appropriate

¹⁵⁵ Oxfam, 'Interagency Meeting on Social Mobilisation', 24-25 September 2015; United Nations Children's Fund, 'Ebola Epidemic Child Protection Response Lessons Learned' (internal document), 2015; Abramowitz, Sharon, et al., 'Community-Centered Responses to Ebola in Urban Liberia: The View from Below', *PLOS Neglected Tropical Diseases*, vol. 9, no. 5, 9 April 2015.

¹⁵⁶ United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015.

¹⁵⁷ Abramowitz, Sharon, et al., 'Community-Centered Responses to Ebola in Urban Liberia: The View from Below', *PLOS Neglected Tropical Diseases*, vol. 9, no. 5, 9 April 2015.

¹⁵⁸ Oosterhoff, Pauline, et al., 'Community-Based Ebola Care Centres: A formative evaluation', *Ebola Response Anthropology Platform*, 2015; 'Rapid Mixed Methods Assessment of the Ebola Community Care Center Model', ICAP, New York, 2015.

¹⁵⁹ United Nations Children's Fund, 'Assessment of MNCH and Ebola-Related Services by Community Health Workers During the 2014-2015 Ebola Outbreak' (draft), UNICEF, January 2016.

¹⁶⁰ United Nations Children's Fund, 'Ebola Epidemic Child Protection Response Lessons Learned' (internal document), 2015.

¹⁶¹ Ibid; Abramowitz, Sharon, et al., 'Community-Centered Responses to Ebola in Urban Liberia: The View from Below', *PLOS Neglected Tropical Diseases*, vol. 9, no. 5, 9 April 2015.

¹⁶² United Nations Children's Fund, 'UNMEER/UNICEF consultation report', UNICEF, Freetown, 25-26 March 2015.



and flexible partnership mechanisms than UNICEF's existing programme cooperation agreements.¹⁶³

Additional operational questions remain about how best to use innovations to support the community-led approach, and how useful the following innovations, among others, were to the community-led model: the RITE model; the Community-Led Ebola Action approach, an adaptation of Community-Led Total Sanitation by WASH partners; social mobilization models; and U-Report and RapidPro for information sharing and reporting (see Section 3.4).

3.9 PREPAREDNESS

■ SQ3.9 How did pre-epidemic preparedness enable effectiveness?

UNICEF was unprepared to respond to Ebola in the most affected countries. Prior to March 2014, the Guinea, Liberia and Sierra Leone country offices had conducted generic preparedness activities, such as emergency and scenario planning, but these offered little specific preparation for responding to the unprecedented Ebola outbreak. Leading international health actors, including UNICEF, had not taken sufficient actions to build core IHR capacities, including in the UNICEF health programme and in community resilience-building efforts. After March 2014, lessons learned highlight a continued lack of preparedness in the affected countries, though some implementers in Sierra Leone and Liberia contested this.

In particular, UNICEF lacked community and C4D capacities needed for the response. HQ and WCARO actors agreed that UNICEF's capacity

at the community level was minimal and unprepared for a community-led approach. Lessons learned and implementers recognized that UNICEF's C4D function had acted as a limited support function for other programmes and lacked the capacity needed to deploy an emergency response, implement UNICEF's community-led strategy and provide leadership and inter-agency coordination.

During the Ebola response, UNICEF became well prepared to respond to the continued threat of Ebola in the three countries, including to three small outbreaks in Liberia during mid-2015 and flare ups in Sierra Leone in early 2016. WCARO actors observed that the response resulted in collective preparedness with all the necessary capacities, protocols, models and expertise. External reviews stress the need to maintain preparedness to respond to new cases and learning exercises emphasize that this must be sustainable.

3.10 KNOWLEDGE MANAGEMENT

■ SQ3.10 How were lessons applied and learned?

UNICEF's response was not sufficiently informed by learning from previous public health emergencies. In the inter-agency response, external evaluations noted that weak channels for ensuring lessons from previous Ebola outbreaks informed the 2014 outbreak.¹⁶⁴ Lessons learned and HQ respondents pointed to efforts to inform the Ebola response with experiences in the Democratic Republic of the Congo and Uganda, as well as with cholera and HIV. However, HQ and WCARO actors and external reviews¹⁶⁵ agreed that the response

¹⁶³ Ibid.

¹⁶⁴ Moon, Suerie et al., '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, *The Lancet*, vol. 386, no. 10009, 28 November 2015.

¹⁶⁵ Ibid; Evans, Tim, 'Solidarity and Security in Global Health What Can We Learn from the Ebola Crisis?' World Bank Group keynote speech delivered at the opening plenary of the Prince Mahidol Award Conference, 29 January 2015.



did not apply the larger lessons of Avian influenza¹⁶⁶ or specific lessons from HIV communication and community engagement, such as quickly identifying drivers of transmission, tailoring a response toward specific communities and sub-populations at risk, and relaying messages through trusted sources. HQ actors noted the response lacked support from the EMOPS policy and knowledge management function and the Ebola Cell could not leverage wider expertise and lessons learned from emergency responses.¹⁶⁷

The response did not sufficiently allow opportunities for strategic reflection and course correction. As in all humanitarian responses, the response required learning by doing and 'thinking while running', but the command and control decision-making model allowed minimal space for such critical reflection. Learning was further undermined by weaknesses in knowledge management during the response, including SharePoint, a document management system that WCARO actors considered too overloaded with detailed technical documents and lacking in organization, synthesis and analysis to inform policy and practice.

UNICEF made useful efforts to consolidate learning and prepare for future PHEICs. From early 2015, the Ebola Cell coordinated and supported learning exercises in key programme areas such as WASH, child protection and education; learning about C4D and CC centres was conducted through consortiums of research organizations

and peer reviewed publications; and other functions, namely the Supply Division and the Division of Human Resources, carried out related reviews. In February 2015, an overall lessons learned exercise was conducted and followed by a management response. A guidance note prepared in September 2015 outlined an initiative with a set of preparedness and organizational activities to enable UNICEF to better respond to future public health emergencies, in support of governments and in coordination with partners. The GMT reviewed and endorsed the initiative, and in 2016, the UNICEF Executive Director introduced the initiative to staff.

These efforts fell short of sufficiently informing future emergency responses, however. The learning exercises did not adequately cover some important aspects of the response, notably the programme strategy to stop transmission (including CC centres versus RITEs), the community-led implementation model, emergency coordination, finance and administration, preparedness and information and knowledge management. Several of the learning exercises remained unfinished, at times a disjointed set of documents of mixed quality, and not published in a format that could support improved practice.¹⁶⁸ Moreover, the lack of a distilled synthesis of these learning exercises reflects a wider problem with knowledge management in the response, that is, the general lack of organization, aggregation and translation into useful and accessible products to guide action.

¹⁶⁶ World Health Organization, *Making preparation count: Lessons from the avian influenza outbreak in Turkey*, WHO, Copenhagen, 2006.

¹⁶⁷ United Nations Children's Fund, '20 Lessons Learned to Inform C4D Responses to Ebola Outbreaks, West Africa', UNICEF, 29 August 2014.

¹⁶⁸ There is a plethora of lesson learning documents and reference materials. For example, in child protection alone, the lessons learned assessment documented 45 items and estimates well over 100 documents exist (see Annex 6 of Child Protection Lesson Learning Assessment).



SECTION IV

EXTERNAL COORDINATION

This section offers a brief assessment of the response's external coordination, based on findings on strategic coordination and operational coordination. The focus is on whether these elements helped or hindered the effectiveness of UNICEF's response, and how they matched expectations captured in the Programme Guidance Note,¹⁶⁹ which emphasized that UNICEF should actively contribute to defining and regularly adjusting the collective response strategy and tactics, and provide adequate cluster leadership and coordination, especially in the communication and community engagement pillar.¹⁷⁰

¹⁶⁹ United Nations Children's Fund, 'UNICEF's Role in Public Health Emergencies' (first draft), UNICEF, 16 November 2015.

¹⁷⁰ Note the purpose of this analysis is to contribute to learning rather than accountability for results, since the guidelines were developed on the basis of knowledge gained during the response.



■ KEQ 4. HOW WELL COORDINATED EXTERNALLY WAS UNICEF'S RESPONSE?

At times, external coordination constrained UNICEF's effectiveness. At the strategic leadership level, the United Nations country team/humanitarian country team and global IASC mechanisms did not manage to contain Ebola between March and July 2014 and did not translate into a coordinated strategic response at the L3 declaration until September 2014 when the Ebola crisis managers were deployed. At the operational level, the establishment of UNMEER's technical pillars partially undermined operational coordination that was already underway among UNICEF and United Nations agencies, presented new challenges to UNICEF as lead of the community engagement and social mobilization coordination pillar, and initially left gaps in the coordination of child protection, education and WASH, for which pillars were not established.

4.1 STRATEGIC COORDINATION

■ SQ4.1 How did strategic leadership coordination enable effectiveness?

Between March 2014 and July 2014, national governments and United Nations governance mechanisms at the global and national levels, of which UNICEF is an integral part, struggled to contain Ebola before it spread out of control. External reviews conclude that WHO did not provide sufficient strategic leadership and coordination at the global and country levels,¹⁷¹ while many UNICEF actors recognized a collective failure to respond adequately and on time,¹⁷² indicating that UNICEF waited too

long over the period May 2014–June 2014 for WHO to lead and coordinate a response. In this context, UNICEF Liberia initiated and collaborated on a range of prevention activities beginning in March 2014 but felt that its appeals to UNICEF HQ for additional support were not heeded. During that period, UNICEF country offices prioritized supporting government-led coordination and activities largely in WASH-related infection prevention and control, C4D and to some extent child protection,¹⁷³ but these efforts proved insufficient given the increasing numbers of infected over the period.

Before and immediately after the UNICEF L3 declaration in August 2014, the organization and its partners struggled to coordinate and lead an

¹⁷¹ World Health Organization, 'Report of the Ebola Interim Assessment Panel', WHO, 2015, <www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>, accessed 14 November 2016; United Nations, Lessons learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response: Report of the Secretary-General, A/70/737, United Nations, New York, 4 March 2016.

¹⁷² Lawry-White, S. 'Lessons Learned UNICEF's Response to the 2014-15 Ebola Outbreak in West Africa', April 2015; United Nations Children's Fund, 'Ebola Epidemic Child Protection Response Lessons Learned' (internal document), 2015.

¹⁷³ United Nations Children's Fund situation reports for Guinea, Liberia and Sierra Leone over the period July 2014–November 2014.



effective inter-agency response. Learning exercises cite as successes inter-agency agreement on STEPP as an overall strategy and that UNICEF took a lead role in community engagement and behaviour change.¹⁷⁴ However, other reviews highlight initial coordination gaps,¹⁷⁵ confusion in leadership roles among UNICEF and strategic partners (e.g. WHO, the International Federation of Red Cross and Red Crescent Societies (IFRC) and the World Food Programme (WFP)), and leadership weaknesses, particularly in the C4D sector.¹⁷⁶

At the national level, the establishment of UNMEER in September 2014 and the appointment of Ebola crisis managers provided empowered and focused public health leadership that filled a strategic coordination gap.¹⁷⁷ External lessons learned exercises found that at times, UNMEER stepped beyond its role as the United Nations system-wide umbrella for the Ebola response and assumed responsibility for activities that others were better positioned to undertake. External evaluations note that UNMEER lacked experience with United Nations operational approaches, including coordination systems, and collaboration remained weak during much of 2014. By early 2015, UNMEER was working with UNICEF and other strategic partners to improve coordination through the enhanced role of the Coordination Board.¹⁷⁸

In Sierra Leone, key informants noted that UNICEF was considered an effective actor in the National Ebola Response Centre, having good relations with the Government and frontline agency coordination forums. In Liberia, UNICEF was seen as a key player in the response, a good

contributor and very skilled at working with the Government. In Guinea, UNICEF was observed as having effectively asserted its leadership in coordination and community engagement and led the social mobilization pillar well despite some initial confusion. Nonetheless, some implementers in Liberia and Sierra Leone questioned whether UNICEF sufficiently pushed for the adequate inclusion of child protection and other programmes in the public health emergency strategy.

A strategic leadership challenge for UNICEF in public health emergencies remains to add value to WHO. In particular, learning exercises and UNICEF key informants highlight the need to develop a collective capacity for surveillance and epidemiological analysis, and to strengthen UNICEF capacity to study these analyses, interpret data and guide decisions at all levels. UNICEF has also raised the possibility of developing a pool of dedicated public health experts across country, regional and HQ levels to advise on preparedness and act during public health emergencies.¹⁷⁹

4.2 OPERATIONAL COORDINATION

■ SQ4.2 How did operational cluster/pillar coordination contribute to effectiveness?

UNICEF's operational coordination was initially complicated by the establishment of UNMEER and the technical pillars, which were used instead of IASC clusters. External reviews find that UNMEER struggled to coordinate operational actors and leverage existing capacities,

¹⁷⁴ Lawry-White, S. 'Lessons Learned UNICEF's Response to the 2014-15 Ebola Outbreak in West Africa', April 2015.

¹⁷⁵ United Nations Children's Fund, 'UNMEER/UNICEF consultation report', UNICEF, Freetown, 25-26 March 2015.

¹⁷⁶ United States Agency for International Development, 'Full Summary Report of Interagency Meeting on Social Mobilisation, Communication and Preparedness: Review of Ebola Social Mobilization and Communication Efforts to Date', USAID Annex, Washington, D.C., 23-24 March 2015; United Nations, Lessons learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response: Report of the Secretary-General, A/70/737, United Nations, New York, 4 March 2016.

¹⁷⁷ UNMEER lessons learned and country office interviews also credit Ebola crisis managers with a catalytic role in mobilizing resources.

¹⁷⁸ United Nations, Lessons learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response: Report of the Secretary-General, A/70/737, United Nations, New York, 4 March 2016.

¹⁷⁹ United Nations Children's Fund, 'Health Emergencies Preparedness Initiative – Key Activities Tracking Sheet', 2016.



which undermined the timeliness, sequencing, continuity and the inclusion of NGOs in the response.¹⁸⁰ The UNMEER structure was superimposed on an existing operational response and absorbed considerable capacities during the crisis. By November 2014, IASC Principals noted that “UNMEER has made a real difference, with a common operational plan across United Nations agencies and clear lines of action. But many NGOs remained unclear about in-country coordination mechanisms.”¹⁸¹ HQ actors saw little added value in UNMEER, WCARO actors considered it a costly mistake that came too late and detracted from early response efforts, and implementers in Guinea, Liberia and Sierra Leone highlighted initial delays and overlaps.

The new community engagement and social mobilization coordination pillar led by UNICEF presented significant challenges. Internally, UNICEF noted that “the capacity to play the role of coordination as being proposed needs to be deployed as soon as possible, otherwise we risk not meeting up to a mandate we have asked for.”¹⁸² To lead the sector, UNICEF's C4D function would require increased capacities for leadership, coordination and quality standards as well as purely technical skills.¹⁸³ Without it, performance in the sector was perceived by

external stakeholders as undermined by coordination difficulties.¹⁸⁴ Implementers in Sierra Leone noted the sector's coordination was weak and slow at first, as C4D staff had to learn cluster leadership and coordination skills. WCARO actors felt that the sector added value to the response despite the fact that an existing global cluster and preparedness capacities were lacking.

The effectiveness of child protection appeared to be complicated by the absence of formalized pillars or prioritized coordination structures. Although no learning exercise has been undertaken on the coordination of these functions, the lack of adequate coordination mechanisms is seen as a shortcoming in the response. UNICEF attempted to meet its other coordination responsibilities and met with varying degrees of success in the different countries.¹⁸⁵ In Liberia, the activation of the full cluster system in September 2014 facilitated sector responses. In all three countries, UNICEF worked with the relevant ministries. By November 2014, child protection sub-clusters were established in all three countries. In Sierra Leone, this included child protection desks at the District Ebola Response Committees.

¹⁸⁰ World Health Organization, ‘Report of the Ebola Interim Assessment Panel’, WHO, 2015, <www.who.int/csr/resources/publications/ebola/report-by-panel.pdf?ua=1>, accessed 14 November 2016; United Nations, ‘Protecting Humanity from Future Health Crises: Report of the High-level Panel on the Global Response to Health Crises’, 25 January 2016.

¹⁸¹ United States Agency for International Development, ‘Full Summary Report of Interagency Meeting on Social Mobilisation, Communication and Preparedness: Review of Ebola Social Mobilization and Communication Efforts to Date’, USAID Annex, Washington, D.C., 23-24 March 2015; United Nations, Lessons learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response: Report of the Secretary-General, A/70/737, United Nations, New York, 4 March 2016.

¹⁸² United Nations Children's Fund, ‘UNICEF Meeting with David Nabarro on UN System Ebola Response’ (meeting notes), UNICEF, August 2014.

¹⁸³ United Nations Children's Fund, ‘UNICEF Communication for Development (C4D) workshop report’, UNICEF, Freetown, 16 April 2015.

¹⁸⁴ Oxfam, ‘Interagency Meeting on Social Mobilisation’, 24-25 September 2015; United States Agency for International Development, ‘Full Summary Report of Interagency Meeting on Social Mobilisation, Communication and Preparedness: Review of Ebola Social Mobilization and Communication Efforts to Date’, USAID Annex, Washington, D.C., 23-24 March 2015.

¹⁸⁵ Hedlund, Kerren, ‘Background Paper on Coordination EVD’ (internal document), 2015.



SECTION V

ACCOUNTABILITY

This section offers a brief assessment of the response's accountability in terms of a number of key expectations: 1) relevance to policy frameworks; 2) relevance to epidemiology and needs; 3) appropriateness; 4) equity; 5) link to national development priorities; and 6) accountability to the affected population.



■ KEQ 5. HOW ACCOUNTABLE WAS UNICEF'S RESPONSE TO EBOLA?

UNICEF's response provided a satisfactory level of accountability for a public health emergency across a range of key commitments, with important room for improvement at the community level. Although the response came late, its objectives and activities were well aligned with national and international strategies for stopping Ebola and recovery, and consistent with national development priorities under government leadership and coordination. Objective 1 (stopping Ebola) and the responses in each country were highly relevant to the epidemiological context and delivered to affected communities without bias. At the community level, implementation strategies became increasingly appropriate through continual learning, and UNICEF's community-based approach meant increasing transparency, feedback and participation (key provisions of AAP). However, UNICEF offered little leadership in regards to AAP commitments, which were not systematically or comprehensively applied.

UNICEF's response fell short of wider accountabilities for humanitarian action and child protection. Response objectives and activities were not well aligned with the CCCs and specific child protection responsibilities. UNICEF's response Objective 1 (stopping Ebola) and its prioritized strategy were not directly relevant to meeting the secondary needs arising from the Ebola outbreak or the specific needs of affected children. The response itself did not prioritize addressing the pressing humanitarian and protection needs of children and was sometimes at odds with national priorities for strengthening health systems.

5.1 RELEVANCE TO POLICY

■ SQ5.1 Was the UNICEF response (e.g. as expressed in its objectives and activities) aligned with international and national policy frameworks?

UNICEF's response objectives were broadly aligned with the external and overarching strategies of UNMEER and WHO, as well as with government strategies. The three objectives listed in the HAC¹⁸⁶ were directly aligned with the WHO roadmap,¹⁸⁷ the STEPP framework¹⁸⁸ and government response plans.

¹⁸⁶ United Nations Children's Fund, 'Ebola Outbreak Response in West Africa', *Humanitarian Action for Children 2014-2015*, UNICEF, <www.unicef.org/appeals/files/Final_2015_HAC_Ebola.pdf>, accessed 14 November 2016.

¹⁸⁷ World Health Organization, 'Ebola Response Roadmap Situation Report 2', WHO, 5 September 2014, <www.who.int/csr/disease/ebola/5-september-2014-en.pdf>, accessed 14 November 2016.

¹⁸⁸ Office for the Coordination of Humanitarian Affairs, 'Ebola Virus Disease Outbreak: Overview of needs and requirements', OCHA, September 2014.



The HAC response objectives were not clearly aligned with the CCCs, however. Although HQ actors emphasized the need to adapt UNICEF's policy and accountability framework to stopping EVD transmission, they noted that a wholesale and mechanistic application of the CCCs initially hindered the effectiveness of the response. WCARO actors recognized that the HAC response reflected UNICEF's comparative advantage and capacities in the affected countries and shared global health security responsibilities under IHR. However, the CCCs are primarily concerned with access to services rather than behaviour change, are more applicable to 'health in emergencies' than 'health emergencies', and did not adequately cover C4D.

The HAC response objectives were also insufficiently aligned with UNICEF's wider child protection obligations.¹⁸⁹ They did not correspond to UNICEF's stated mission to prioritize and provide special protection for the most disadvantaged children.¹⁹⁰ WCARO actors felt that UNICEF's mandate for children was lost or forgotten in the stop Ebola strategy without a clear theory of change for the protection of children. This was evidenced by the fact that UNICEF was unable to describe Ebola's specific impact on children and to adequately respond to media enquiries about it.¹⁹¹

5.2 RELEVANCE TO EPIDEMIOLOGY AND NEEDS

■ SQ5.2 Were UNICEF objectives aligned with the changing epidemiology and needs?

UNICEF's response Objective 1 (stopping Ebola) was highly relevant to the spiralling epidemic in September 2014, which was projected to reach 1.4 million cases by January 2015 unless there was greater action and behaviour change.¹⁹² The community-led strategy, as defined in the Programme Guidance Note, therefore focused on the three major transmission risks at the community level: 1) unsafe care in homes; 2) unsafe burials in the community; and 3) unsafe infection prevention and control in local care centres. Learning exercises underscore the relevance of UNICEF's decentralized intervention model of working at the community level to provide rapid isolation that complements ETUs and C4D interventions to support behaviour change.¹⁹³

UNICEF responses in each country were viewed as relevant in principle to stopping Ebola. The Sierra Leone Country Office considered the response to be relevant in that it reduced transmission through early identification and community-based care in CC centres, and adaptable in that it reduced the number of centres from what was initially planned. Both communities and national leaders considered the CC centres to be useful and important in that they provided a mechanism for quick isolation at the

¹⁸⁹ United Nations Children's Fund, 'Ensuring the best interests of children in the global Ebola response', 2014.

¹⁹⁰ United Nations Children's Fund, 'UNICEF's mission statement', UNICEF, 2003, <www.unicef.org/about/who/index_mission.html>, accessed 17 November 2016.

¹⁹¹ United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF/WCARO, Dakar, April 2015; United Nations Children's Fund, 'Ebola Epidemic Child Protection Response Lessons Learned' (internal document), 2015; United Nations Children's Fund, 'Q&A on Ebola in West Africa', UNICEF, October 2014; United Nations Children's Fund, 'Q&A on Ebola in West Africa', UNICEF, November 2014.

¹⁹² Centers for Disease Control and Prevention, 'Questions and Answers: Estimating the Future Number of Cases in the Ebola Epidemic—Liberia and Sierra Leone, 2014–2015', CDC, September 2014, <www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/qa-mmwr-estimating-future-cases.html>, accessed 14 November 2016.

¹⁹³ Hussain, Misha, 'MSF says lack of public health messages on Ebola 'big mistake', *Reuters*, 4 February 2015, <www.reuters.com/article/us-health-ebola-msf-idUSKBN0L81QF20150204>, accessed 20 November 2016.



community level.¹⁹⁴ In Liberia, community case studies conducted for this evaluation indicated that communities recognized UNICEF's efforts to keep up with local developments and change messages, including via community radio and in local languages. The Guinea Country Office and national leaders reported that UNICEF's strategy was adapted to the epidemiology, that the *cerclages*¹⁹⁵ helped contain Ebola, and that efforts were made to correct and improve mistaken messages and better understand the communities.

UNICEF's response objectives were not directly germane to humanitarian needs and the specific needs of children that arose from the Ebola outbreak. HAC Objectives 1 and 3 were concerned with stopping Ebola and recovery from Ebola, but they did not directly address the severe secondary effects on the country's population. WCARO actors felt the de-prioritization of needs versus epidemiology was a major shortcoming in the response, and reflected diverging priorities between the HQ focus on isolating Ebola and the regional and country office focus on addressing the impact on children.

5.3 APPROPRIATENESS OF IMPLEMENTATION

■ SQ5.3 Were UNICEF implementation strategies appropriate to unique and evolving challenges?

In general, UNICEF's implementation strategies evolved to become increasingly appropriate. UNICEF reduced the number of CC centres

planned in Sierra Leone from more than 300 to fewer than 100, adapted the CC centre model in Liberia to the RITE model in November 2014, and adopted to the more mobile rapid response mechanism as the outbreak evolved, to tackle localized resurgences in 2015. UNICEF's community-based model became more appropriate and effective in November 2014–December 2014 when it began to draw collectively on epidemiological surveillance, anthropological studies, real-time behavioural surveys and social mobilization.¹⁹⁶

The complexities of the epidemic in Guinea, where the virus hid in 'shadow zones',¹⁹⁷ necessitated that UNICEF's implementation strategies be flexible and constantly adapt through 'learning by doing'. Implementers noted that strategies evolved more effectively with input from hired anthropologists. Community respondents in Guinea recognized the role of the 'platforms', or community coordination mechanisms, as a useful bridge between health personnel and the community at large. Guinea Country Office senior staff noted that the *Comités de Veille Villageois*, community-selected teams of social mobilizers, were highly appropriate for engaging communities once established.

In Liberia, where Ebola also had an early start, UNICEF had to learn through trial and error, including when the disease re-emerged in November 2015. Implementers noted that approaches reflected government priorities, and that the RITEs were a positive adaptation in technical and political terms, though they were ultimately needed less as the epidemic subsided. While two-way communication was initially poor, later community engagement

¹⁹⁴ Abramowitz, Sharon, et al., 'Ebola Community Care Centers: Lessons learned from UNICEF's 2014-2015 Experience in Sierra Leone', UNICEF, New York, January 2016; Oosterhoff, Pauline, et al., 'Community-Based Ebola Care Centres: A formative evaluation', Ebola Response Anthropology Platform, 2015.

¹⁹⁵ *Cerclage* incorporates movement restrictions based upon risk classifications of individual community members; ensures provision of health care services, food, and other commodities; and is supported by awareness and educational campaigns.

¹⁹⁶ Obregon, Rafael, 'UNICEF HQ C4D Chief Support Mission to Sierra Leone CO - EVD Response', 31 March–29 April 2015; United Nations Children's Fund, 'UNICEF Communication for Development (C4D) workshop report', UNICEF, Freetown, 16 April 2015; United Nations Children's Fund, 'UNMEER/UNICEF consultation report', UNICEF, Freetown, 25-26 March 2015.

¹⁹⁷ World Health Organization, 'Guinea: The Ebola virus shows it tenacity', WHO, January 2015, <www.who.int/csr/disease/ebola/one-year-report/guinea/en/>, accessed 20 November 2016.



and social mobilization efforts were recognized, as were community radio programmes in local languages. Some respondents stressed, however, that UNICEF lacked understanding of the cultural context, implementation of RITEs was standardized without adaptation to community realities, and not enough was done to address differences between communities and faiths, which posed barriers to access.¹⁹⁸

Benefitting from lessons learned in Guinea and Liberia, UNICEF's focus in Sierra Leone was on community level implementation. Communities and Sierra Leone Country Office staff believed that UNICEF's partnership approach, specifically with local partners, including religious leaders, women's organizations and youth associations, and its support for community health workers, helped to overcome fears and increased access to EVD prevention and care services.¹⁹⁹ Similar to other countries, UNICEF's C4D behaviour change efforts were slow to become relevant, but eventually progressed from inappropriate messages (too many, too complex and too hopeless) to two-way feedback allowing for trust building and dialogue that could support behaviour change.²⁰⁰

5.4 EQUITY

■ SQ5.4 Was UNICEF's response programming guided by equity considerations?

In general, UNICEF's public health response was neither biased or discriminatory. The organization's efforts to stop Ebola targeted 100 per cent of hotspot communities and messages were widely and publicly communicated through volunteers and radio programmes.²⁰¹ All stakeholders reported that UNICEF targeted affected people, did not exclude social groups and took an equitable approach to its response. Although in principle, CC centres and ETUs provided access to all suspects and cases, in practice, distance and other barriers reduced access for some. For example, in Sierra Leone, community members reported that CC centres treated people without favouritism, but in Liberia, stakeholders noted gaps in coverage and hidden biases in relation to specific minority tribal groups and remote locations.

UNICEF's community interventions did not (preferentially) target specific vulnerable groups with prevention and care activities. WCARO actors reported a lack of awareness of how specific groups were affected by EVD due to a lack of age-disaggregated epidemiological data. Some studies clearly indicated an unequal impact on women and children, including women in labour being turned away from clinics if suspected of having Ebola.²⁰² In

¹⁹⁸ See, for example, United Nations Children's Fund, 'Liberia Lessons Learned Presentation at Lesson Learned Review', UNICEF, Dakar, February 2015.

¹⁹⁹ Obregon, Rafael, 'UNICEF HQ C4D Chief Support Mission to Sierra Leone CO - EVD Response', 31 March–29 April 2015; United Nations Children's Fund, 'UNICEF Communication for Development (C4D) workshop report', UNICEF, Freetown, 16 April 2015; United Nations Children's Fund, 'UNMEER/UNICEF consultation report', UNICEF, Freetown, 25-26 March 2015.

²⁰⁰ Ibid; Oxfam, 'Interagency Meeting on Social Mobilisation', 24-25 September 2015; United States Agency for International Development, 'Full Summary Report of Interagency Meeting on Social Mobilisation, Communication and Preparedness: Review of Ebola Social Mobilization and Communication Efforts to Date', USAID Annex, Washington, D.C., 23-24 March 2015; Evaluation interviews with GOAL and the Social Mobilization Action Consortium.

²⁰¹ United Nations Children's Fund, 'UNMEER/UNICEF consultation report', UNICEF, Freetown, 25-26 March 2015.

²⁰² Menéndez, Clara, et al., 'Ebola crisis: The unequal impact on women and children's health', *The Lancet*, vol. 3, no. 3, March 2015; Médecins Sans Frontières, 'Sierra Leone: MSF opens maternity unit for pregnant women with Ebola', MSF, 29 January 2015, <www.msf.org/en/article/sierra-leone-msf-opens-maternity-unit-pregnant-women-ebola>, accessed 20 November 2016; United Nations Children's Fund, 'Ensuring the best interests of children in the global Ebola response', 2014.



addition, households in poverty or headed by women were significantly more likely to be affected by Ebola.²⁰³ An internal lessons learned review of UNICEF's child protection response found that communication was rarely modified for children until 2015.²⁰⁴ In Sierra Leone, implementers felt that messages for children were simplistic and not sufficiently prioritized.

The response did not fully anticipate or prioritize other pressing humanitarian and protection needs resulting from Ebola. HQ actors and respondents in the three affected countries recognized that the response did not adequately address the secondary effects of EVD on children and other vulnerable groups. In Sierra Leone, for example, implementers reported that the response did not do enough to assist vulnerable subgroups, such as persons with disabilities, street children and teenage girls, who became increasingly vulnerable. This resulted in a measured increase in teenage pregnancies.²⁰⁵

5.5 NATIONAL DEVELOPMENT

■ SQ5.5 Was UNICEF's response consistent with local and national development priorities?

In a formal sense, UNICEF's response was consistent with national development priorities and supported government leadership

and coordination. Learning exercises suggest STEPP and HAC plans were largely coherent with national response plans and the response supported government line ministries.²⁰⁶ HQ actors reported that the three governments led the response with support from international actors. At the country level, implementers said that UNICEF worked closely with government structures and supported national recovery plans.

In practice, UNICEF's response was sometimes inconsistent with national priorities for strengthening health systems. Internal and external learning exercises highlight the poor state of health systems in the three countries, that Ebola funds could have been better spent on public health facilities, and the risk of creating unsuitable parallel structures for the quick utilization of funds.²⁰⁷ Local stakeholders in Sierra Leone repeatedly posed the question: "Why were resources dedicated to the CC centre model not directed to strengthening local primary health care facilities?"²⁰⁸ Learning also suggests, however, that CC centres expanded the reach of the Ebola response into areas that were marginal to health services, that the CC centres did not drain primary health unit resources, and that tensions between CC centres and primary health units improved over time.²⁰⁹

²⁰³ Zafar, Ali, et al., 'Socioeconomic impact of Ebola using mobile phone survey in Guinea', The World Bank, May 2016.

²⁰⁴ United Nations Children's Fund, 'Ebola Epidemic Child Protection Response Lessons Learned' (internal document), 2015.

²⁰⁵ Ibid.

²⁰⁶ Ibid; United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015.

²⁰⁷ United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015.

²⁰⁸ Abramowitz, Sharon, et al., 'Ebola Community Care Centers: Lessons learned from UNICEF's 2014-2015 Experience in Sierra Leone', UNICEF, New York, January 2016.

²⁰⁹ Abramowitz (July 2016) finds that CC centres did not drain primary health unit resources or bifurcate the health system, and was best managed where an effective referral process existed between them. Respondents indicated that in the future, CC centre capacities should be established at primary health units in order to strengthen the primary health unit system, rather than in a separate entity. They also indicated that primary health units required a permanent capacity for isolation, testing and triage.



5.6 ACCOUNTABILITY TO THE AFFECTED POPULATION

■ SQ5.6 Was UNICEF's response implemented in a manner accountable to the affected population?

UNICEF's response did not systematically apply the IASC Commitments on Accountability to the Affected People/Populations.²¹⁰ At the lessons learned workshop, it was recognized that AAP was not fully applied and no mechanism existed for its application.²¹¹ UNICEF actors at various levels echoed this observation, pointing out that UNICEF and the involved governments lacked experience in community-focused work and accountability systems. In addition, numerous questions were raised in learning exercises and by respondents about UNICEF's specific accountabilities to women, children and the prevention of sexual exploitation and abuse; human rights and the CCCs; and for the large amounts of funding handled at national level. Stakeholders in the affected countries also reported a lack of formal mechanisms for requesting information, giving feedback or making complaints. In Sierra Leone, implementers described the initial approach as a top-down effort at mobilization that was less concerned with listening.²¹²

As the response evolved, UNICEF made significant effort to engage communities through dialogue (see Section 1.1). HQ actors noted that the establishment of a feedback loop with

communities proved essential to shaping a more effective response even as it came late and did not work well in all communities. Implementers observed that dialogue was viewed as a way to solve problems and became more central to UNICEF's approach. In Liberia, implementers reported UNICEF's community engagement approach became key to the response and facilitated dialogues with communities for each intervention. That UNICEF was perceived as dealing directly with the issues raised increased the organization's credibility. In Guinea, implementers reported community meetings where "everyone was informed about everything".

In this way, UNICEF's response became somewhat more accountable to communities after a slow start. HQ and WCARO actors perceived the response as relatively accountable to affected people by virtue of its proximity to communities and community engagement activities, though some respondents in Sierra Leone and Liberia feared this progress might not be sustained by governments and development actors. HQ and WCARO actors agreed that the response presented an important opportunity to learn lessons about AAP and to strengthen accountability at the community level, that a community-led approach requires a decentralized accountability mechanism, that AAP should be central to a community-led approach, and that mobile technology allows opportunities for rapid feedback (see Section 3.4).

²¹⁰ These may be summarized as: 1) leadership and governance (mechanisms for accountability and feedback); 2) transparency (accessible and timely information through dialogue with communities); 3) feedback and complaints (robust feedback and complaints mechanisms); 4) participation (active role for populations affected in decision-making processes); and 5) design, monitoring and evaluation (involvement in design monitoring and evaluation of the response).

²¹¹ United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015.

²¹² Obregon, Rafael, 'UNICEF HQ C4D Chief Support Mission to Sierra Leone CO - EVD Response', 31 March–29 April 2015.



CONCLUSIONS

The following conclusions outline the most important lessons emerging from the evaluation findings. They are informed by a discussion of preliminary findings presented to the Evaluation Reference Group on 23 March 2016 and by detailed feedback provided on drafts of the report.

- 1. UNICEF's public health response made a useful contribution to stopping the transmission of Ebola, most notably through community engagement, isolation and care activities, and the large-scale delivery of supplies and WASH support.** UNICEF's contributions to halting transmission depended foremost on the organization's innovative community-based implementation model, participation in the larger WHO-led international public health response with national governments, and the mobilization of corporate capacities (i.e. financial, human resources and supplies) through the L3 SSOP resource management functions. The impact of these contributions was diminished, however, by missed opportunities for containing the outbreak in March 2014 and preventing it from becoming an epidemic that cost thousands of lives; the delayed operationalization of UNICEF's community-based response; disparate understandings of Ebola-related risks and the rationale for intervention; and the absence of a performance management and monitoring system sufficiently adapted to track and contain the virus.
- 2. UNICEF's response neither promptly nor adequately addressed Ebola's secondary humanitarian consequences and specific effects on children.** Beyond the public health emergency, the Ebola outbreak led to the orphaning of more than 16,000 children, the temporary shutdown of education systems and a reported increase in mortality linked to reduced health services. Yet child protection, education and other
- 3. UNICEF and partners struggled to reinforce basic services in the wider recovery effort without adequate funding and as a result, national health systems remained vulnerable to public health threats.** During much of 2015, UNICEF worked to reinforce primary health care systems and as reflected in the indicators, undertook activities to immunize children under 5 years against measles, train community health workers on Ebola prevention and case management and provide infection prevention and control supplies to health structures in Ebola-affected areas. UNICEF and development partners also invested in developing national recovery strategies and plans aimed at economic growth, resilience and service delivery for the three countries and the Mano River Union sub-region. However, these national recovery plans did not attract the funding expected and achieved disappointing results and primary health care systems remained weak and vulnerable to public health threats.

'non-prioritized' programmes did not become fully operational until 2015, more than six months after the L3 declaration due to strategic 'de-prioritization' relative to stopping EVD transmission, different understandings of Ebola-related risks and participation in an inter-agency response that remained focused on stopping transmission, bypassed humanitarian capacities and inadequately addressed Ebola's wider consequences. Nevertheless, UNICEF ultimately implemented strengthened child protection programmes at the community level; reached more than 320,000 children affected by EVD in the three countries with psychosocial support; provided more than 14,000 Ebola orphans with a package of support; supported radio stations to broadcast learning programmes; and provided learning kits to children and supported their return to school.



- 4. As a key health partner and actor in the WHO-led response, UNICEF shared responsibility for critical delays in preventing and responding to Ebola.** UNICEF's contribution to stopping Ebola transmission was made through the inter-agency response, which, once it was scaled up, played a major overall role in stopping Ebola by supporting the efforts of communities and local and national actors, including governments. UNICEF shared responsibility, however, for collective delays in the response and for missing the opportunity to contain the Ebola outbreak in March 2014 when the virus was first identified, as well as for related shortcomings related to surveillance. UNICEF also shared responsibility for difficulties related to coordinating and leading a response to stop Ebola transmission before the epidemic peaked in late 2014. The organization also shared responsibility for challenges related to operational coordination, including the establishment of UNMEER and technical pillars, and delays in delivering a fully operational programmatic response, including in the area of child protection, until more than six months after the L3 declaration.
- 5. UNICEF's contributions relied significantly on an innovative community-based response implementation model aimed at community behaviour change.** This included reducing Ebola transmission through isolation and care of patients and building trust with communities by mobilizing and empowering them as partners in the response. As a result, UNICEF was able to encourage community behaviour changes (such as safe burials, handwashing and early isolation) and enable early isolation through the provision of community-based isolation efforts (CC centres, RITEs, etc.) within a larger system. UNICEF effectively brought together CC centre, C4D, WASH and supply activities in a complementary, mutually reinforcing and integrated manner with the common goal of stopping Ebola transmission at the community level. However, the approach also faced significant challenges. Its effectiveness

was undermined by delays in establishing the CC centres and implementing effective C4D activities; it struggled to integrate child protection, education, immunization, nutrition and HIV programmes into a holistic approach to behaviour change; and it struggled to involve these programmes in a quickly sequenced second phase to address Ebola's serious secondary effects and humanitarian needs.
- 6. UNICEF provided the strategic direction needed to stop Ebola transmission, but leadership was hampered by inadequate institutional arrangements, performance management and information analysis.** The Ebola outbreak posed unprecedented challenges and risks for which UNICEF's multi-sector emergency model was not well adapted. The appointment of a dedicated GEC with expertise in public health made a critical difference in guiding the response. However, UNICEF's strategic management approach also hindered the response due to varied understandings of Ebola-related risks and intervention logic; a proliferation of different application strategies; low acceptance of public health decisions at regional and country office levels; and unresolved challenges related to programme integration and sequencing. Strategic leadership was further undermined by institutional reliance on the Ebola Cell instead of the full capacities of EMOPS; the ineffectiveness of the Emergency Management Team as a forum for strategic deliberation; the absence of a coherent framework for performance management; and the absence of epidemiological data and a functional information management system to guide decisions.
- 7. UNICEF's mobilization of financial, human and supply capacities enabled a large-scale response and made strong material contributions to effectiveness but struggled with new Ebola-specific challenges and existing gaps in human resource competencies.** The Ebola response was well funded, receiving US\$437.8 million or 86 per cent of the



total funding appeal, by mid-November 2015. Supply and logistics delivered large-scale supplies and protective equipment with speed and efficiency. Human resources eventually deployed large numbers of emergency staff after developing new policies and procedures to reinforce staff safety and duty of care. Initially, however, the human resources response was slowed due to significant fears of Ebola within the organization, long-standing problems related to the recruitment and deployment of emergency staff, as well as the lack of international medevac procedures, questions about duty of care for all staff and inadequate human resource policy and SOPs for staff safety. Demand was also high for surge capacity across West Africa in 2014 and 2015 and the Ebola response competed for surge capacity with other L3 responses. The UNICEF Supply Division was hampered by the inability of programmes to present an accurate picture of needs, a lack of knowledge about Ebola-specific products, and poor information about product specifications. The response was also slowed by the non-acceleration of finance and administration procedures and inadequate numbers of experienced emergency staff.

- 8. UNICEF's response did not sufficiently rely on knowledge management, and the organization remained only partially prepared for future public health emergencies.** UNICEF made significant efforts to 'learn by doing', convening a learning session in February 2015 and preparing a formal management response listing planned actions. The organization also invested in numerous lessons learned exercises conducted by programmes and functions involved in the response and in November 2015, drafted a guidance note on the agency's proposed role in future public health emergencies. However, generic preparedness activities offered little specific preparation for responding to the Ebola outbreak, the response was insufficiently informed by learning from previous public health emergencies, and

UNICEF's added value, programme strategy and implementation model for the Ebola response and public health emergencies remained contested. In addition, UNICEF's capacity at the community level was minimal and unprepared and the C4D function lacked sufficient capacities, including senior experts to deploy an adequate emergency response. Looking ahead, it remains unclear whether UNICEF is sufficiently prepared to respond to public health emergencies in other countries, and at the international level, to respond to PHEICs and other public health emergencies.

- 9. Although UNICEF's response was aligned with the inter-agency public health strategy and EVD epidemiological context, the lack of a suitable policy and accountability framework for public health emergencies meant that the response was disconnected from the organization's specific obligations to children and communities in emergencies.** UNICEF's public health response was well aligned with WHO and government strategies, consistent with national development priorities and well funded by donor governments. It was highly relevant to the epidemiology in each country without preferentially targeting specific vulnerable groups with prevention and care activities and became increasingly accountable to communities through its community-based approach and community engagement activities. However, the response did not apply the CCCs, which were not fully appropriate and relevant for a public health emergency. In the absence of a suitable policy and accountability framework, the response did not adequately understand, address or prioritize the secondary effects and humanitarian needs arising from Ebola; insufficiently implemented UNICEF's child protection obligations and mission to prioritize and provide special protection for the most disadvantaged children; and did not systematically apply the Commitments on AAP.



RECOMMENDATIONS

These recommendations are derived from the evaluation's conclusions and main findings and informed by recommendations and plans from the February 2015 lessons learned exercise, the September 2015 Guidance Note, and the January 2016 Health Emergencies Implementation Plan. The recommendations have been refined based on the feedback and advice of UNICEF stakeholders.

In the absence of adequate funding to implement full recovery plans in Guinea, Liberia and Sierra Leone:

1. UNICEF WCARO, country offices and partners in the three most-affected countries should ensure at minimum that: 1) health systems retain a rapid response capacity to prevent Ebola outbreaks and develop IHR core capacities; 2) community health systems are reinforced in the most-affected communities; and 3) children most affected by Ebola receive adequate protection. In particular, it should consider:

- **Community health:** Investing in reinforcing community-based health care in most-affected communities and building on capacity provided by trained community health workers, community engagement and infection prevention and control efforts.
- **Child protection:** Ensuring with partners that children most affected by Ebola, including survivors, as well as orphans and most-affected women and families, receive adequate social protection and specific support in line with UNICEF's mission.

In preparation for a future public health emergency:

2. The UNICEF GMT should develop a policy and accountability framework for responding to public health emergencies that includes: 1) specific goals; 2) programme

guidance; 3) global partnership objectives; and 4) assessment of broader humanitarian risks. Whether produced as an addendum to the CCCs or a separate policy, it should complement and build on rather than duplicate UNICEF's existing emergency response policies and processes. In particular, it should consider:

- **Distinct goals:** Defining UNICEF's specific goals and scope in public health emergencies and means of monitoring its engagement, and aligning them clearly with public health principles, prevention and control of infectious diseases and the global health security agenda, as well as with UNICEF's core mission for children.
- **Programme guidance:** Providing guidance that enables programmes to contribute to achieving these goals in relation to public health threats, including through prioritized strategy, a focus on causes, risks and epidemiology, and implementation through an integrated community-based approach.
- **Global partnership objectives:** Defining UNICEF's role in relation to the evolving public health emergency architecture; reviewing partnership frameworks accordingly with WHO, IFRC, WFP and NGOs; and establishing an advisory mechanism to engage with international efforts to monitor, assess and manage global public health risks.
- **Assessment of humanitarian risks:** Recognizing that a public health emergency can quickly spiral into a broader humanitarian emergency, UNICEF should also be prepared to deliver humanitarian action according to the CCCs, especially in countries where public health systems and core IHR capacities are weak.



3. The UNICEF GMT should recognize areas for improvement and strengthen coordination, strategy and information capacities for public health emergencies. Drawing on lessons learned from the Ebola response, UNICEF should develop tools, guidance and mechanisms and strengthen capacities for: 1) global emergency coordination; 2) planning, programme support and performance monitoring; and 3) information and knowledge management functions.

- **Global emergency coordination:** Starting with the preparedness platform, initiate early dialogue between country, regional and HQ levels to define scenarios, risks and joint strategy; appoint a dedicated public health GEC during L3 public health emergencies but otherwise maintain senior expertise to help with a range of needs within the organization related to strengthened capacity and knowledge management; and integrate these coordination functions into existing emergency structures.
- **Planning and performance:** Developing one coherent overall strategy and articulating a common narrative; applying a suitable performance monitoring system to guide strategy; distinguishing between public health and humanitarian objectives; and establishing an appropriate forum for strategic decision-making, reflection and course correction.
- **Information and knowledge:** Developing information management systems to collect, process, analyse and synthesize large amounts of situation information needed to guide the response; developing capacities to collect and analyse epidemiological data disaggregated by age to guide programmatic decisions, especially for children; utilizing real-time monitoring and innovative ICT applications to support programmes; synthesizing learning from previous public health emergencies to guide the response;

completing all internal learning exercises about the Ebola response; and preparing a synthesis of lessons learned with a concise reference document as an entry point for users.

4. The UNICEF GMT should continue to strengthen capacities for rapid, large-scale deployment of financial, human and material resources in emergencies by: 1) applying lessons and protocols from the Ebola response about duty of care; 2) significantly increasing emergency human resource capacities and emergency competencies in country offices; and 3) involving operational and administrative staff in strategy and programme management. In particular, it should consider:

- **Duty of care:** Translating new policies and procedures for staff safety and duty of care into emergency human resource policy and L3 SSOPs, and sharing with the United Nations Department of Safety and Security and the United Nations Medical Services Department.
- **Emergency human resource capacities:** Significantly increasing emergency staff capacities to meet growing demands, including by expanding rosters with specific skills, issuing surge capacity management guidelines, training staff on emergency rosters, building public health emergency response capacity with WHO and partners, using consultants if necessary with self-insurance arrangements, and strengthening the emergency competencies of country staff in emergency-prone countries, especially for human resource management, finance and administration staff.
- **Involvement:** Exploring ways to bridge gaps between capacity mobilization functions (human resources, finance and administration and supplies) and the strategies and programmes they support, including through the involvement of



competent human resource management and operations staff in strategy and programme meetings.

5. UNICEF EMOPS and the UNICEF Programme Division should further develop the community-based approach as an implementation modality inclusive of strong AAP and community engagement components. Recognizing the central role of communities in stopping Ebola, UNICEF should focus on strengthening local capacities and systems for health and social protection at the community level. This effort should include means of increasing capacity within UNICEF for community engagement and social mobilization and improving programme integration at the community level.

- **Learning:** Reviewing and learning specific lessons about the model's practical application, including how best to support it

through partnerships and innovations (e.g. RITEs, Community-Led Ebola Action approach, social mobilization models, ICT).

- **Integration:** Advising how to build on the successful integration of key programmes (e.g. CC centres, C4D, WASH and supplies) around a focused, common goal and how other programmes (e.g. child protection, health, education, nutrition and HIV) can contribute to preventing and controlling public health threats.
- **Community engagement and social mobilization:** Invest in developing UNICEF's C4D capacities across levels to respond to emergencies and global cluster capacities for community engagement through the localization agenda of the Grand Bargain for humanitarian funding.



REFERENCES

- Abramowitz, Sharon, et al., 'Community-Centered Responses to Ebola in Urban Liberia: The View from Below', *PLOS Neglected Tropical Diseases*, vol. 9, no. 5, 9 April 2015.
- ACAPS, 'Ebola Outbreak in West Africa: Lessons learned from assessments in Sierra Leone and Liberia', 16 July 2015, <www.acaps.org/special-report/ebola-outbreak-west-africa-lessons-learned-assessments-sierra-leone-and-liberia>, accessed 20 November 2016.
- Alward, Bruce, 'Humanity vs. Ebola: The winning strategies in a terrifying war', 3 February 2015, <www.youtube.com/watch?v=m048uAa8L3k>, accessed 20 November 2016.
- Bedford, Juliet, 'Community Mobilisation in the Ebola Response: Case studies from Sierra Leone and Liberia', *Anthrologica*, September 2015.
- Bedson, Jamie, James Fofanah and Danielle Pedi, 'Community-led Ebola Action: Adapting a community-led approach to the Ebola outbreak in Sierra Leone', *Community-Led Total Sanitation*, 7 November 2015, <www.communityledtotalsanitation.org/blog/community-led-ebola-action-adapting-community-led-approach-ebola-outbreak-sierra-leone>, accessed 20 November 2016.
- Bolkan, et al., 'Ebola and Indirect Effects on Health Service Function in Sierra Leone'. *PLOS Current Outbreaks*, 19 December 2014, <<http://currents.plos.org/outbreaks/article/ebola-and-indirect-effects-on-health-service-function-in-sierra-leone/>>, accessed 20 November 2016.
- Catholic Relief Services, Focus 1000 and UNICEF, 'Study on Public Knowledge, Attitudes, and Practices Relating to Ebola Virus Disease (EVD) Prevention and Medical Care in Sierra Leone', September 2014, <<http://reliefweb.int/sites/reliefweb.int/files/resources/Ebola-Virus-Disease-National-KAP-Study-Final-Report-final.pdf>>, accessed 20 November 2016.
- Centers for Disease Control and Prevention, 'Ebola Containment Strategy Succeeding in Liberia', CDC, 20 February 2014, <www.cdc.gov/media/releases/2015/p0220-ebola-containment-strategy.html>, accessed 20 November 2016.
- Centers for Disease Control and Prevention, 'Outbreaks Chronology: Ebola Virus Disease', CDC, <www.cdc.gov/vhf/ebola/outbreaks/history/chronology.html>, accessed 20 November 2016.
- Centers for Disease Control and Prevention, 'Questions and Answers: Estimating the future number of cases in the Ebola epidemic—Liberia and Sierra Leone, 2014–2015', CDC, September 2014, <www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/qa-mmwr-estimating-future-cases.html>, accessed 14 November 2016.
- 'Ebola: A failure of international collective action', *The Lancet*, vol. 384, 23 August 2014.
- Evans, Tim, 'Solidarity and Security in Global Health What Can We Learn from the Ebola Crisis?' World Bank Group keynote speech delivered at the opening plenary of the Prince Mahidol Award Conference, 29 January 2015.
- Fast, Shannon M., et al., 'The Role of Social Mobilization in Controlling Ebola Virus in Lofa County, Liberia', *PLOS Current Outbreaks*, 15 May 2015, <<http://currents.plos.org/outbreaks/article/the-role-of-social-mobilization-in-controlling-ebola-virus-in-lofa-county-liberia/>>, accessed 17 November 2016.



- Geneva Global, *Ebola Crisis Fund Final Report*, Geneva Global, 2015.
- Government of Senegal, 'Lessons from the Response to the Ebola Virus Disease Outbreak in Sierra Leone May 2014–November 2015', summary report, 2015.
- Government of Sierra Leone, *National Ebola Recovery Strategy for Sierra Leone*, Government of Sierra Leone, March 2015.
- Human Rights Watch, 'West Africa: Respect rights in Ebola response', HRW, New York, 15 September 2014.
- Humanicontrarian, 'The Hammers and Nails of Ebola', 6 February 2015, <www.humanicontrarian.com/2015/02/06/the-hammers-and-nails-of-ebola/>, accessed 20 November 2016.
- Inter-Agency Standing Committee, 'Guidance Note on Using the Cluster Approach to Strengthen Humanitarian Response', IASC, 24 November 2006.
- Inter-Agency Standing Committee, 'IASC Principals 5 November 2014-Final Summary and Action Points' Summary of the ad-hoc meeting of the IASC Principals on Iraq, South Sudan, Central African Republic and Ebola, IASC, 5 November 2014.
- Inter-Agency Standing Committee, 'IASC Principals Ad-Hoc Meeting Ebola Response and Iraq: Final summary and action points', IASC, 12 August 2014, <https://icvanetwork.org/system/files/versions/IASCPrincipals_adhoc_meeting_summary_12Aug2014.pdf>, accessed 20 November 2016.
- International Crisis Group, *The Politics Behind the Ebola Crisis*, Africa Report no. 232, ICG, Brussels, 28 October 2015.
- International Rescue Committee, 'Risking Repetition: Are we ignoring Ebola's lessons', IRC, 2015.
- Kateh, F., et al., 'Rapid Response to Ebola Outbreaks in Remote Areas – Liberia, July–November 2014', Morbidity and Mortality Weekly Report, *Centers for Disease Control and Prevention*, 27 February 2015, <www.cdc.gov/mmwr/preview/mmwrhtml/mm6407a7.htm>, accessed 17 November 2016.
- Lawry-White, S., 'Lessons Learned UNICEF's Response to the 2014-15 Ebola Outbreak in West Africa', April 2015.
- 'Liberia's Last Two Ebola Patients Recover, Leave Hospital', *Reuters*, 2 December 2015, <www.reuters.com/article/us-health-ebola-liberia-idUSKBN0TM2KY20151203#KjFvHohoXrvFxxMK.97>, accessed 20 November 2016.
- Médecins Sans Frontières, 'Sierra Leone: MSF opens maternity unit for pregnant women with Ebola', MSF, 29 January 2015, <www.msf.org/en/article/sierra-leone-msf-opens-maternity-unit-pregnant-women-ebola>, accessed 20 November 2016.
- Menéndez, Clara, et al., 'Ebola Crisis: The unequal impact on women and children's health', *The Lancet*, vol. 3, no. 3, March 2015.
- Meredith, Catherine, 'A Bottom-up Approach to the Ebola Response', Humanitarian Practice Network, June 2015, <<http://odihpn.org/magazine/a-bottom-up-approach-to-the-ebola-response/>>, accessed 10 November 2016.
- Moon, Suerie, et al., '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, *The Lancet*, vol. 386, no. 10009, 28 November 2015.
- Office for the Coordination of Humanitarian Affairs, 'Ebola Virus Disease Outbreak: Overview of needs and requirements', OCHA, September 2014.



- Office of the United Nations Special Envoy on Ebola, 'Overview of Needs and Requirements for the Ebola Response Phase 3 Framework 1 November 2015 – 31 March 2016'.
- Oosterhoff, Pauline, et al., 'Community-Based Ebola Care Centres: A formative evaluation', Ebola Response Anthropology Platform, 2015.
- Oxfam, 'A Long Way to Go: The Ebola response in West Africa at the sixty day mark', Oxfam, <www.oxfam.org/sites/www.oxfam.org/files/file_attachments/a_long_way_to_go.pdf>, accessed 20 November 2016.
- Oxfam, 'Interagency Meeting on Social Mobilisation', 24-25 September 2015.
- Pérache, André Heller, 'To Put Out This Fire, We Must Run Into the Burning Building: A review of MSFs call for biological containment teams in West Africa', Humanitarian Practice Network, June 2015, <<http://odihpn.org/magazine/to-put-out-this-fire-we-must-run-into-the-burning-building%C2%92-a-review-of-msf%C2%92s-call-for-biological-containment-teams-in-west-africa/>>, accessed 20 November 2016.
- Pronyk, P., et al., 'The Effect of Community-Based Prevention and Care on Ebola Transmission in Sierra Leone', *Am J Public Health*, vol. 104, no. 6, April 2016.
- 'Rapid Mixed Methods Assessment of the Ebola Community Care Center Model', ICAP, New York, 2015.
- Republic of Guinea, 'Post-Ebola Socio-Economic Recovery Strategy (2015-2017)', June 2015.
- Republic of Liberia, 'The Economic Stabilization and Recovery Plan', April 2015.
- Save the Children, *A Wake-Up Call: Lessons from Ebola for the world's health systems*, Save the Children, London, 2015.
- Stillman, Sarah, 'Ebola and the Culture Makers', *The New Yorker*, 11 November 2014, <www.newyorker.com/news/daily-comment/ebola-culture-makers>, accessed 20 November 2016.
- United Nations, Lessons learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response: Report of the Secretary-General, A/70/737, United Nations, New York, 4 March 2016.
- United Nations, 'Secretary-General Appoints David Nabarro Special Envoy on Ebola, Anthony Banbury Special Representative, Head of UN Mission for Ebola Emergency Response', UN, 23 September 2014, <www.un.org/press/en/2014/sga1511.doc.htm>, accessed 20 November 2016.
- United Nations, World Bank, European Union and African Development Bank, *Recovering from the Ebola Crisis*, 2015.
- United Nations Children's Fund, '20 Lessons Learned to Inform C4D Responses to Ebola Outbreaks, West Africa', UNICEF, 29 August 2014.
- United Nations Children's Fund, 'Activation of UNICEF's Level 3 Corporate Emergency Activation Procedure for the Countries Affected by the Ebola Crisis in West Africa (Guinea, Sierra Leone, Liberia and Nigeria)', Decision Memo from Afshan Khan, Director, Office of Emergency Programmes, 27 August 2014.
- United Nations Children's Fund, 'Assessment of MNCH and Ebola-Related Services by Community Health Workers During the 2014-2015 Ebola Outbreak' (draft), UNICEF, January 2016.
- United Nations Children's Fund, 'CC centres Programme Guidance for Ebola Response November 2014 – February 2015', UNICEF, February 2015.
- United Nations Children's Fund, 'Children Hardest Hit', UNICEF, <www.unicef.org/emergencies/ebola/75941_76202.html>, accessed 20 November 2016.



- United Nations Children's Fund, 'Community Care Centers, Community Dialogue and Engagement: Key ingredients in Sierra Leone', *Communication for Development: Responding to Ebola*, UNICEF, June 2015.
- United Nations Children's Fund, 'Core Commitments for Children in Humanitarian Action', UNICEF, New York, May 2010.
- United Nations Children's Fund, 'Ebola Community Care Centers: Lessons learned from UNICEF 2014-2015 experience in Sierra Leone' (draft), Florida University and UNICEF.
- United Nations Children's Fund, 'Ebola CP Response – UASC and Alternative Care' (internal document), November 2014.
- United Nations Children's Fund, 'Ebola Emergency Response: WCARO human resources contributions March to December 2014' (internal document), 2015.
- United Nations Children's Fund, '*Ebola Epidemic Child Protection Response Lessons Learned*' (internal document), 2015.
- United Nations Children's Fund, Ebola: Getting to zero—for communities, for children, for the future, UNICEF, 2015, <www.unicef.org/publications/files/Ebola_Getting_to_zero_Mar_2015.pdf>, accessed 14 November 2016.
- United Nations Children's Fund, 'Ebola Outbreak Response in West Africa', *Humanitarian Action for Children 2014*, UNICEF, 2014, <www.unicef.org/appeals/files/20140915_HAC_Ebola_Response.pdf>, accessed 20 November 2016.
- United Nations Children's Fund, 'Ebola Outbreak Response in West Africa', *Humanitarian Action for Children 2015*, UNICEF, 2014-2015, <www.unicef.org/appeals/files/Final_2015_HAC_Ebola.pdf>, accessed 14 November 2016.
- United Nations Children's Fund, 'Ebola Outbreak Response in West Africa', *Humanitarian Action for Children 2015*, UNICEF, 1 July–31 December 2015, <www.unicef.org/appeals/files/2015_HAC_Ebola_MYR_Final.pdf>, accessed 20 November 2016.
- United Nations Children's Fund, 'Ebola Response', UNICEF, 2015, <www.unicef.org/appeals/ebola_response.html>, accessed 20 November 2016.
- United Nations Children's Fund, 'Ebola Staffing Analysis' (internal document), 29 January 2015.
- United Nations Children's Fund, 'Ebola Virus Disease Outbreak: UNICEF Regional Response Strategy', UNICEF, 23 October 2014.
- United Nations Children's Fund, 'Ebola Virus Disease Outbreak Response, Supplies and Lessons Learned Update', UNICEF Supply Division, July 2015.
- United Nations Children's Fund, 'Ending the Ebola Outbreak' (internal document), January 2015.
- United Nations Children's Fund, 'Ensuring the Best Interests of Children in the Global Ebola Response' (internal document), 2014.
- United Nations Children's Fund, 'Knowledge Management, Learning and Evaluation for Ebola L3 response' (internal document), November 2014.
- United Nations Children's Fund, 'Lessons Learned and Best Practices on Back to School from Liberia and Guinea' (internal document), 2015.
- United Nations Children's Fund, 'Lessons Learned Review 2014-2015', UNICEF WCARO, Dakar, April 2015.
- United Nations Children's Fund, 'Lessons Learning Exercise: Guinea and Liberia school reopening' (internal document), May 2015.



- United Nations Children's Fund, 'Lessons Learnt: Ebola Outbreak in West Africa 2014–2015' (internal document), 2 June 2015.
- United Nations Children's Fund, 'Liberia', *Humanitarian Action for Children 2014*, UNICEF, 2014, <www.unicef.org/appeals/files/HAC_2014_Liberia_FINAL_updated_0116.pdf>, accessed 20 November 2016.
- United Nations Children's Fund, 'Liberia Lessons Learned Presentation at Lesson Learned Review', UNICEF, Dakar, February 2015.
- United Nations Children's Fund, 'Lofa County: Communities took the matter in their own hands', *Communication for Development: Responding to Ebola in Liberia*, UNICEF, June 2015.
- United Nations Children's Fund, 'Q&A on Ebola in West Africa', UNICEF, October 2014.
- United Nations Children's Fund, 'Q&A on Ebola in West Africa', UNICEF, November 2014.
- United Nations Children's Fund, 'Sector Components of UNICEF's Ebola Response' (internal document), August 2014.
- United Nations Children's Fund, 'Shifting the Post for Same Goals: An assessment of the impact of the Ebola response on WASH interventions in Sierra Leone', UNICEF, 2015.
- United Nations Children's Fund, 'UNICEF Annual Report 2013 – Guinea', UNICEF, 2014, <www.unicef.org/about/annualreport/files/Guinea_COAR_2013.pdf>, accessed 20 November 2016.
- United Nations Children's Fund, 'UNICEF Annual Report 2013 – Liberia', UNICEF, 2014, <www.unicef.org/about/annualreport/files/Liberia_COAR_2013.pdf>, accessed 20 November 2016.
- United Nations Children's Fund, 'UNICEF Annual Report 2013 – Sierra Leone', UNICEF, 2014, <www.unicef.org/about/annualreport/files/Sierra_Leone_COAR_2013.pdf>, accessed 20 November 2016.
- United Nations Children's Fund, 'UNICEF Annual Report 2015 – Guinea', UNICEF, 2016, <www.unicef.org/about/annualreport/files/Guinea_2015_COAR.pdf>, accessed 20 November 2016.
- United Nations Children's Fund, 'UNICEF Annual Report 2015 – Liberia', UNICEF, 2016, <www.unicef.org/about/annualreport/files/Liberia_2015_COAR.pdf>, accessed 20 November 2016.
- United Nations Children's Fund, 'UNICEF Annual Report 2015 – Sierra Leone', UNICEF, 2016, <www.unicef.org/about/annualreport/files/Sierra_Leone_COAR_2013.pdf>, accessed 20 November 2016.
- United Nations Children's Fund, 'UNICEF Communication for Development (C4D) Workshop Report', UNICEF, Freetown, 16 April 2015.
- United Nations Children's Fund, 'UNICEF Ebola Response "At Pace" Lessons Learnt – Executive Summary' (internal document), 3 June 2015.
- United Nations Children's Fund, 'UNICEF Field Support Officers Workshop Report', UNICEF, Kenema, 12 April 2015.
- United Nations Children's Fund, 'UNICEF in Global Health Emergencies: Costed Implementation Plan following GMT Decision' (draft internal document), 16 November 2015.
- United Nations Children's Fund, 'UNICEF-Liberia Ebola Virus Disease: SitRep #22', UNICEF, 2 June 2014.
- United Nations Children's Fund, 'UNICEF-Liberia Ebola Virus Disease: SitRep #33', UNICEF, 7 July 2014.



- United Nations Children's Fund, 'UNICEF-Liberia Ebola Virus Disease: SitRep #46', 8 August 2014.
- United Nations Children's Fund, 'UNICEF Meeting with David Nabarro on UN System Ebola Response' (meeting notes), UNICEF, August 2014.
- United Nations Children's Fund, 'UNICEF's mission statement', UNICEF, 2003, <www.unicef.org/about/who/index_mission.html>, accessed 17 November 2016.
- United Nations Children's Fund, 'UNICEF Program Guidance Note for Immediate Ebola Response', November 2014.
- United Nations Children's Fund, 'UNICEF Response and Coordination Structures Related to the Outbreak of Ebola Virus Disease in West Africa: Overview of current status' (internal document), 2014.
- United Nations Children's Fund, 'UNICEF Response to the 2014-15 Ebola Outbreak in West Africa Terms of Reference – Revised for an RFP Extension', UNICEF Evaluation Office, 2015.
- United Nations Children's Fund, 'UNICEF's Corporate Emergency Activation Procedure for Level 3 Emergencies, Simplified Standard Operating Procedures', October 2015.
- United Nations Children's Fund, 'UNICEF's Response to the Ebola Crisis', Presentation to the UNICEF Executive Board Informal Session, 11 September 2014, <www9.unicef.org/about/execboard/files/Ebola_presentation_to_EB_11_Sept_final.pdf>, accessed 20 November 2016.
- United Nations Children's Fund, 'UNICEF's Role in Public Health Emergencies' (draft), 16 November 2015.
- United Nations Children's Fund, 'West and Central Africa including Cameroon, Guinea, Guinea Bissau, Nigeria, Senegal', *Humanitarian Action for Children 2013*, UNICEF, July 2013, <www.unicef.org/appeals/files/WCARO_HAC_Final_Revision_16_July_2013.pdf>, accessed 20 November 2016.
- United Nations Children's Fund Executive Director Anthony Lake, 'UNICEF's Corporate Emergency Activation Procedure', CF/EXD/1011-001, UNICEF, 21 March 2011.
- United Nations Children's Fund Executive Director Anthony Lake, 'UNICEF's Corporate Emergency Activation Procedure (addendum)', CF/EXD/2011-001, UNICEF, 22 December 2015.
- United Nations Children's Fund Office of Emergency Programmes, 'UNICEF HQ Ebola Crisis Timeline: A timeline of decisions and actions taken by HQ' (internal document), 2015.
- United Nations Children's Fund Programme Division, 'Guidance on Key Programme Benchmarks for UNICEF CO Ebola Response' (internal document), 14 August 2014.
- United Nations Development Programme, 'Human Development Data 2015', UNDP, 2015, <<http://hdr.undp.org/en/data>>, accessed 20 November 2016.

