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

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Evaluation of UNICEF's Response to the Ebola Outbreak in West Africa, 2014-2015

Final Evaluation Report

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1 INTRODUCTION

This section describes the context and impact of the Ebola outbreak, the timeline of key phases of the outbreak and UNICEF's response within the wider global and national contexts. It gives a synopsis of the logic model which guided UNICEF's response.

■ The Ebola virus disease (EVD) 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] Between December 2013 and March 2016, Ebola infected 28,638 people and caused 11,316 deaths.[2]

This report presents a summary of the findings, conclusions and recommendations of an evaluation of UNICEF's response to the Ebola outbreak conducted between November 2015 and September 2016.

Context and impact of the Ebola outbreak

In December 2013, an outbreak of haemorrhagic fever was reported in remote areas of Guinea, and in March 2014, the World Health Organization (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 – far more than all previous known cases of Ebola – with 500–600 new cases reported each week.[3] On 8 August 2014, WHO declared the outbreak a Public Health Emergency of International Concern (PHEIC).[4]

The outbreak reached its peak in late 2014. 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.[5] In early 2015, the outbreak declined rapidly across the three countries and the number of districts with active transmission decreased substantially.[6] The number

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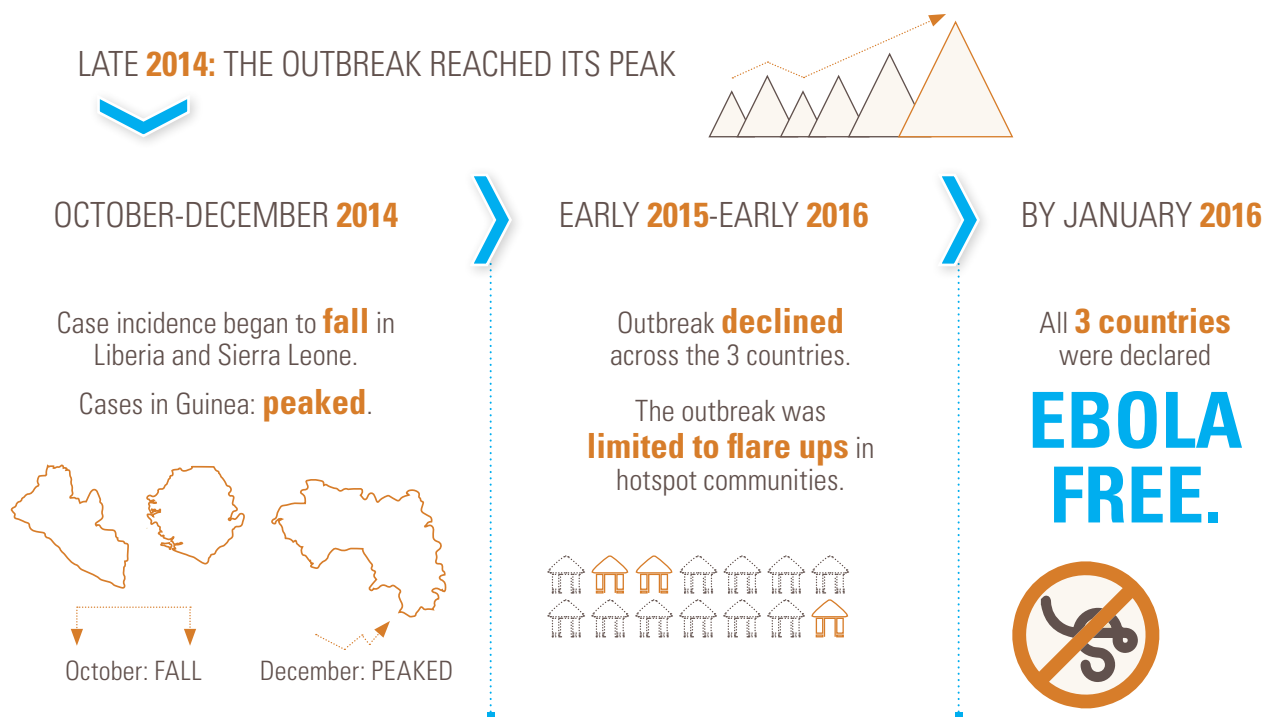
2 United Nations, Lessons learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response: Report of the Secretary-General, A/70/737, United Nations, New York, 4 March 2016.

3 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.

4 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.

5 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.

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

LATE **2014:** THE OUTBREAK REACHED ITS PEAK

OCTOBER-DECEMBER **2014**

Case incidence began to **fall** in Liberia and Sierra Leone.

Cases in Guinea: **peaked**.

October: FALL   December: PEAKED

EARLY **2015**-EARLY **2016**

Outbreak **declined** across the 3 countries.

The outbreak was **limited to flare ups** in hotspot communities.

BY JANUARY **2016**

All **3 countries** were declared

EBOLA FREE.

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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.[7]

Ranked among the poorest and least developed countries in the world, Guinea, Liberia and Sierra Leone were ill equipped to respond to the outbreak. As a result, the crisis wrought serious humanitarian, economic, development and health consequences.[8] Border closures reduced

trade, manufacturing slowed, small businesses closed and unemployment increased, particularly among youth. Livelihoods deteriorated for millions of people. The outbreak's direct impact was most evident at the local level, with 90 per cent of Ebola cases concentrated in the 20 most-affected districts across the three countries.[9]

Children were disproportionately affected by the outbreak. More than 5,000 children were infected and children comprised

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[7] 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.

[8] 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.

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

one in five of all infections.[10] 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.

National and international response

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 (NGOs) present in Guinea, Liberia and Sierra Leone were also overwhelmed by the extent of the outbreak and struggled to mobilize the staff numbers needed to scale up the response.

As the world became gripped by fear of Ebola, world powers strengthened their resolve to contain the outbreak. In 2014–2015, national governments, international NGO partners and the United Nations system, led first by WHO and subsequently by the United Nations Mission for

Ebola Emergency Response (UNMEER), took measures to coordinate the effort to control and contain the outbreak. 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).

UNICEF response

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 a Level 3 (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 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. 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

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10   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.

HUMANITARIAN ACTION FOR CHILDREN LOGIC MODEL

	1. STOP EBOLA	2. BASIC SERVICES
GOALS	Stop the outbreak through actions at community level	Contribute to maintaining or building back better of the primary healthcare and other social system in the most affected countries
OBJECTIVES	Bring the outbreak under control through contributing significantly to system-wide goals of 100% early isolation and safe burial	Support early recovery and initiation of building back better primary healthcare systems and other social services
KEY INTERVENTIONS	Stop the outbreak through integrated programming at the community level	Maintain or build back better primary healthcare and other essential services
ACTIVITIES	Address drivers of transmission (unsafe burial and lack of early isolation/care) through behavior change programmes	Provide entry points for recovery programmes
	Support the establishment of up to 300 CC Centres located in rural areas*	Support maintenance of basic health and nutrition services
	Integrate child protection services into the response	Maintain and adapt other essential social services
	Continue to procure essential supplies and commodities	Procure essential health and nutrition commodities
		Support catch-up campaigns for immunization
	Increase staffing capacities	Prepare for early recovery of primary healthcare and social sector systems

countries from suffering major outbreaks during this period;[11] and 3) to support early recovery and the initiation of building back better primary health care systems and other social services.

The Humanitarian Action for Children framework was complemented by the UNICEF Ebola Regional Response Strategy (October 2014), which defined UNICEF's contribution to the UNMEER-led strategy and objectives; a Programme Guidance Note (November 2014); and an update to the Humanitarian Action for Children 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 with two objectives: 1) to reduce transmission of Ebola through isolation and care of patients at appropriately staffed and

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[11]   Objective 2 was not a focus of the evaluation and therefore was not assessed.

resourced community care centres (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.

Overall UNICEF's Ebola response was well-funded, though initially resources were slow to arrive.[12] Funding gaps were significant 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. However, by mid-November 2015, UNICEF had received US$437.8 million, or 86 per cent of the total funding appeal.

UNICEF made considerable efforts to learn from the response. In February 2015, UNICEF senior managers met in Dakar, Senegal, to consider lessons learned, take stock of the situation, identify corrective measures, capture learning for future L3 responses and inform planning for the recovery phase.[13] In November 2015,

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based on the lessons learned exercise, UNICEF drafted a guidance note on the agency's proposed role in future public health emergencies.[14] In January 2016, the UNICEF Executive Director launched the Health Emergency Preparedness Initiative to strengthen UNICEF's capacity to support countries' multisector health emergency responses.[15]

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[12] 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.

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

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

[15] Anthony Lake, UNICEF Executive Director, internal email communication, 28 January 2016.

2 EVALUATION FEATURES

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This section outlines the evaluation's purpose and objectives as well as criteria for judgement, scope and methodology.

Evaluation methodology

The evaluation is focused on UNICEF's corporate response to the Ebola emergency in Guinea, Sierra Leone and Liberia during the period declared an L3 emergency (August 2014 through the end of 2015). It 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 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 ongoing response and future public health emergencies.

The analysis is broadly focused on the degree to which UNICEF's levels, programmes and operational functions combined to deliver an effective response.

As such, it does not provide detailed information on implementation. The evaluation prioritizes programme elements related to: 1) health/case management, particularly the CC centres; 2) social mobilization and community engagement through Communication for Development (C4D); and 3) child protection.

The evaluation **PRIORITIZES PROGRAMME ELEMENTS** related to:

1.
...community care centres (CC centres)

2.
...Communication for Development (C4D)

3.
Child protection

The evaluation examined the response across five criteria: effectiveness, efficiency, coordination, relevance and coherence. The following five key evaluation questions were derived from these criteria:

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.
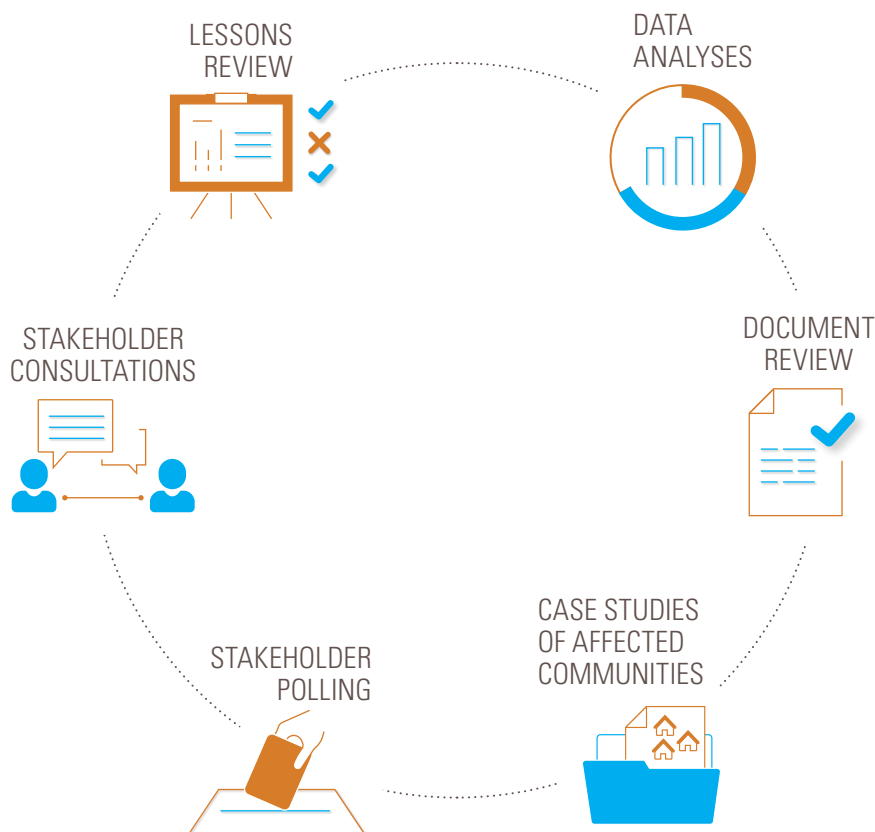How accountable was UNICEF's response to Ebola?

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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.

DATA COLLECTION

LESSONS
REVIEW

DATA
ANALYSES

STAKEHOLDER
CONSULTATIONS

DOCUMENT
REVIEW

STAKEHOLDER
POLLING

CASE STUDIES
OF AFFECTED
COMMUNITIES

3 FINDINGS AND CONCLUSIONS

This section summarizes the main evaluation findings and conclusions. It provides an assessment of UNICEF's successes and areas where the response fell short. Conclusions are drawn from the evidence generated and serve as key lessons learned.

Findings

Effectiveness of the response

Overall, UNICEF's response to Ebola was found to be moderately effective across the three most-affected countries and made useful contributions to stopping Ebola transmission. Working with inter-agency partners and governments, UNICEF contributed to stopping Ebola through community engagement, isolation and care, as well as the large-scale delivery of supplies and water, sanitation and hygiene (WASH) support. In terms of overall contribution, there is widespread agreement that affected communities themselves made the greatest contribution to stopping Ebola. More than three quarters of UNICEF stakeholders saw the "response of communities affected" as the most important factor contributing to stopping Ebola.

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Between November 2014 and March 2015, UNICEF established 64 CC centres across the three countries that facilitated community engagement, early isolation and care. Studies consistently suggest that the CC centres were an effective community-based mechanism for screening, triaging and isolating suspected Ebola cases, and patients felt CC centre care was of high quality and appreciated that it was accessible and free.[16] In Sierra Leone, the combined introduction of thousands of additional treatment beds (through the establishment of CC centres and Ebola treatment units) is calculated to have prevented 56,600 Ebola cases[17] and effectively helped identify new cases and reduce transmission. The CC centre model was not used uniformly across countries. In Liberia, the Rapid Isolation Treatment of Ebola (RITE) approach was preferred due to difficulties in the construction of CC centres. In Guinea,[18] there was considerable resistance to CC centres from government and Guinea Country Office actors.

Most stakeholders felt that the CC centres became operational too late to substantially reduce transmission.[19] By one estimate, an additional 12,500 cases might have been avoided if the CC centres had been introduced a month earlier.[20] Headquarters (HQ) actors attributed critical delays to long discussions with

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

[17] J. Kucharski et al. 'Measuring the impact of Ebola control measures in Sierra Leone,' Centre for the Mathematical Modelling of Infectious Diseases, Department of Infectious Disease Epidemiology, London School of Hygiene & Tropical Medicine, September 2015)

[18] 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.

[19] Abramowitz, Sharon, et al., 'Evaluation of Save the Children's Community-Care Centres in Dolo Town and Worhn', 1 July 2015.
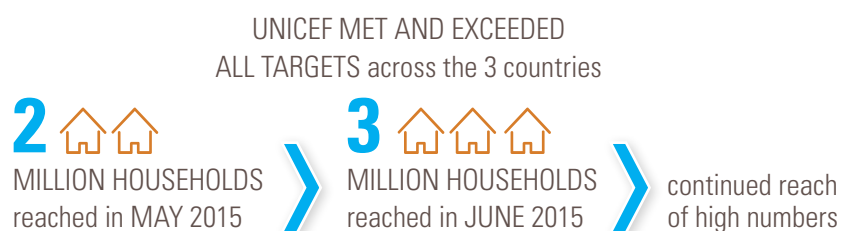
[20] Kucharski, A.J., et al., 'Measuring the impact of Ebola control measures in Sierra Leone,' *Proc Natl Acad Sci USA,* vol. 112, no. 46, 17 November 2016.

West and Central Africa Regional Office (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 or strongly agreed that UNICEF supported the establishment of enough CC centres, facilities or sites (including RITEs) in rural areas to offer early isolation and basic care for Ebola patients.

UNICEF also invested in social mobilization and community engagement through C4D campaigns. 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. By June 2015, UNICEF had reached almost 3 million households, exceeding targets, and continued to reach similarly high numbers thereafter.

However, respondents recalled that initially, public awareness campaigns were ineffective and their impact minimal.[21] As UNICEF's C4D strategy evolved, it became clear that informed, motivated and empowered communities, rather than one-way communication, were needed to stop Ebola.[22] By late 2014, UNICEF shifted from educational materials and

FACE-TO-FACE EBOLA MESSAGES

UNICEF MET AND EXCEEDED
ALL TARGETS across the 3 countries

2 MILLION HOUSEHOLDS reached in MAY 2015

3 MILLION HOUSEHOLDS reached in JUNE 2015

continued reach of high numbers

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[21] 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, 'Community mobilisation in the Ebola response Case studies from Sierra Leone and Liberia', *Anthrologica*, 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.

[22] Bedford, 'Community mobilisation in the Ebola response Case studies from Sierra Leone and Liberia', *Anthrologica*, 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.

public awareness raising towards greater dialogue with communities, widespread deployment of community-based social mobilizers and community engagement training. Reviews show that UNICEF also increasingly relied on and funded local NGOs and consortia that were innovative, effective and community-led in their C4D approaches.[23] Learning exercises noted the engagement of medical anthropologists and social scientists and the use of real-time surveys to sculpt communication strengthened community engagement significantly.[24] Eventually, C4D managed to reflect the epidemiological and cultural idiosyncrasies and perception of the disease.[25]

Child protection was another area that only achieved scale in 2015, after the outbreak had already peaked. At the height of the epidemic in mid-2014, UNICEF provided little direct child protection services and struggled to address Ebola's severe secondary effects on children, such as stigma, teenage pregnancy and lack of access to education.[26] 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. By late 2015, UNICEF had strengthened child protection programmes at the community level to address psychosocial and physical protection needs. The establishment of interim care centres and observational interim care centres –care facilities established to support children who tested EVD negative but whose parents tested positive and oftentimes staffed by Ebola survivors – was considered an important achievement.

CHILD PROTECTION SERVICES

Targets met or EXCEEDED across the three countries LATE **2014**>EARLY **2015** > and were MET by DECEMBER **2015**

>**14,000** & >**320,000**

Ebola orphans assisted

Children receiving psychosocial support

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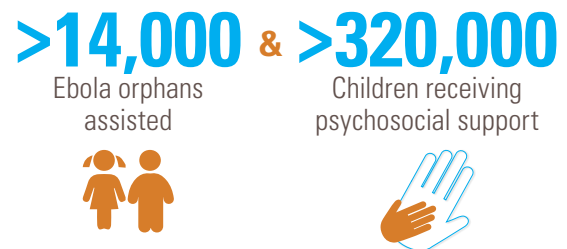
[23] United Nations Children's Fund, 'UNICEF Field Support Officers workshop report', UNICEF, Kenema, 12 April 2015; United Nations Children's Fund, 'Lofa County: Communities took the matter in their own hands', Communication for Development: Responding to Ebola in Liberia, UNICEF, June 2015; Obregon, 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.

[24] 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.

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

[26] 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.

In terms of operational contributions, UNICEF supply efforts and WASH support provided essential equipment and infection, prevention and control services that helped to halt Ebola transmission at the community level. By mid-2014 UNICEF had procured essential supplies and commodities, including personal protective equipment, home hygiene and handwashing kits[27] and by mid-2015, the organization had delivered more than 8,000 metric tonnes of supplies in the largest single supply operation in UNICEF's history.[28] 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.[29] By April

2015, more than 2,000 health structures in Ebola-affected areas were equipped with infection prevention and control supplies. The WASH response included the provision of 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.[30]

UNICEF's efforts to support early recovery by strengthening health systems and other social services met with mixed success. The organization generally struggled to effectively reinforce health care systems in Guinea, Liberia and Sierra Leone. Although UNICEF undertook

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BY MID-2014:

UNICEF had procured essential supplies and commodities, including:

✔ PERSONAL PROTECTIVE EQUIPMENT

✔ HOME HYGIENE

✔ HANDWASHING KITS
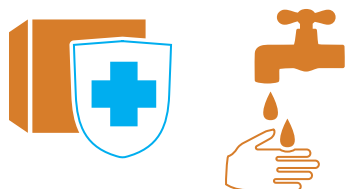
BY MID-2015:

UNICEF had delivered more than

8,000 metric tonnes of supplies

LARGEST SINGLE SUPPLY OPERATION IN UNICEF'S HISTORY

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27 United Nations Children's Fund, *Humanitarian Action for Children 2014*, UNICEF, 2014.
28 United Nations Children's Fund, *Humanitarian Action for Children 2015*, UNICEF, 2015.
29 Ibid.
30 Ibid.

activities to support health services in Ebola-affected areas and sustain community-based health care, wider recovery efforts suffered funding gaps and health systems remained weak in the three countries. Organizational actors expressed divergent opinions on the merits of having invested in CC centres versus primary health units. Regional actors argued this approach created parallel health structures and left capacity gaps in health systems and some respondents were disappointed that more CC centres weren't converted into public health centres.

The organization met with greater success in the area of education. UNICEF worked to get children back to learning, supported the reopening of schools and provided guidance and support on safe and protective learning environments. Based in part on these efforts, no cases of EVD transmission in schools were ever reported.

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Efficiency of the response

The UNICEF response fell short of efficiency expectations, particularly in terms of timeliness. International actors, including UNICEF, missed the opportunities to successfully contain the 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. UNICEF itself missed the opportunity to mount a strong enough organization response between March 2014 and July 2014; tackle its alarming growth between August 2014 and November 2014; and deal with its secondary effects and human consequences between August 2014 and early 2015. UNICEF's C4D function only began to reach capacity in December 2014, by which time new EVD cases were declining across the three countries. UNICEF CC centres only became operational after the outbreak's peak due to internal delays. 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 (see Section 4). In stakeholder polling, 75% of respondents reported that the supply and logistics function made an important contribution to UNICEF's overall achievements. 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 as UNICEF struggled to mobilize sufficient numbers of emergency staff while also addressing duty of care requirements. Country offices did not

consistently apply accelerated financial and administrative procedures due to capacity gaps, posing a major challenge to efficiency. Until the appointment of a dedicated Global Emergency Coordinator (GEC) in early October 2014, the response was slowed by a lack of direction. Strategy was undermined by competing understandings of Ebola-related risks and the rationale for intervention.

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. 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. WCARO actors found that L3 resourcing and capacity mobilization elements worked very well (human resources, finance, supplies) and allowed UNICEF to respond ever faster, but also questioned the management of the response.

The appointment in October 2014 of the dedicated GEC with public health expertise facilitated clear direction at a time of uncertainty. By November 2014, the Programme Guidance Note was providing focus for the response, particularly with

the aim of stopping transmission and the use of 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. The GEC's public health leadership was challenged at country and regional levels, however, where actors found it was too far 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 executive leadership instead of the Emergency Management Team[31] for decision-making was considered ineffective by some and regional actors observed that this led to a proliferation of HQ-based decision-makers and micro-management, as well as a top-down style that reduced dialogue, technical input and implementer ownership. Without the functional capacities of the Office of Emergency Programmes (EMOPS), the newly-introduced Ebola Cell struggled to mobilize an optimal emergency response, reflecting a wider recognition that the response established new structures that bypassed existing emergency response mechanisms, causing delays and coordination difficulties in affected countries.[32]

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[31] The objectives of an Emergency Management Team are 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 it did not include strategic deliberation was considered a gap in the response by some.

[32] 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.

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 was also undermined by a lack of programme integration and clarity about how all sectors could contribute to stopping Ebola transmission.

Initially, UNICEF and partners lacked the epidemiological data needed to guide programme decisions. Until 2015, WHO was slow to share quality epidemiological data.[33] 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.[34] By 2015, UNICEF was making increasing use

of real-time monitoring, partner reporting and innovative information and communications technology applications – such as U-Report,[35] mHero[36] and EduTrac[37] – to support programmes. However, UNICEF lacked a suitable information management system to collect, process, analyse and utilize the large amounts of information collected.[38]

UNICEF struggled to mobilize the additional human resources needed to implement the Ebola response. The emergency competed for surge capacity with other L3 responses (including in the Central African Republic, South Sudan and the Syrian Arab Republic), and deployments left capacity gaps in the sending offices and divisions.[39] Initially, the mobilization of human resources was delayed by an intense fear of Ebola, which limited the number of staff willing to deploy. Deployment was also slowed by the lack of international medevac procedures, questions about duty of care for all staff and inadequate human resource policy and SOPs for staff safety.[40] At HQ level, UNICEF developed new policies and procedures to reinforce staff safety and duty of care, including medical care,

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

[34] 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.

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

[36] 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.

[37] 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.

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

[39] 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.

[40] Ibid.

medevac, insurance and hazard and death benefits. Country offices felt overwhelmed by surge staff of mixed quality, high levels of staff turnover, and a decreased sense of response ownership overall.

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. The UNICEF Supply Division's learning exercise highlighted the successful strengthening of national systems with supplies for Ebola treatment units and burials, and more than three quarters of all supplies were resourced in-country.[41] UNICEF effectively scaled up the delivery of supplies to the affected countries to coincide with the peak of the outbreak in October and support the first wave of CC centres. The delivery of supplies was constrained by critical gaps in knowledge and information, however, including 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.

UNICEF's Ebola response was ultimately well funded, but UNICEF did not consistently apply accelerated financial and administrative procedures, which slowed the response. Country offices found that the arrival of funding was slow and inadequate until the L3 declaration, reflecting a systemic inability to quickly translate income into resources for action on the ground.[42] Slow procedures were also tied to gaps in emergency-appropriate tools and guidance needed for their application.

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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 and humanitarian country teams did not manage to contain Ebola between March 2014 and July 2014 and did not provide a well-coordinated strategic response until late 2014. 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

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

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

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.

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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 generated 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

CONCLUSION 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.

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 lack of a performance management and monitoring system sufficiently adapted to track and contain the virus.

CONCLUSION 2:
UNICEF's response neither promptly nor adequately addressed Ebola's secondary humanitarian consequences and specific effects on children.
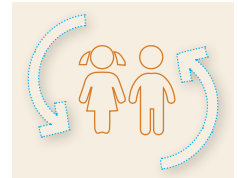
Child protection, education and other 'non-prioritized' programmes did not become fully operational until 2015, more than six months after the L3 declaration due to strategic 'de-prioritization' relative to stopping EVD transmission. Nevertheless, UNICEF ultimately implemented child protection programmes 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.

CONCLUSION 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; however, these plans did not attract the funding expected and primary health care systems remained weak and vulnerable to public health threats.

CONCLUSION 4:
As a key health partner and actor in the WHO-led (and later UNMEER-led) response, UNICEF shared responsibility for critical delays in preventing and responding to Ebola.

Once it was scaled up, the inter-agency response played a major overall role in stopping Ebola by supporting the efforts of communities and local and national actors, including governments. However, the response missed the opportunity to contain the outbreak when the virus was first identified and was stymied by shortcomings related to surveillance, operational coordination and the delivery of a fully operational programmatic response.

CONCLUSION 5:
UNICEF's contributions relied significantly on an innovative community-based response implementation model aimed at community behaviour change.

This involved empowering communities as partners in the response, encouraging behaviour change through safe burials, handwashing and early isolation and using community-based isolation efforts such as the CC centres and RITEs. UNICEF also effectively brought together health/CC centres, C4D, WASH and supply activities in a complementary, mutually reinforcing and integrated manner to stop Ebola at the community level. However, the effectiveness of these efforts was undermined by delays in establishing the CC centres and implementing effective C4D activities and lack of integration of multi-sector response elements into a holistic approach.

CONCLUSION 6:
Internally, UNICEF provided the strategic direction to guide its contribution to stopping Ebola, but leadership was hampered by inadequate institutional arrangements, performance management and information analysis.

The dedicated GEC with public health expertise played a critical role in guiding UNICEF's response but also struggled in the face of varied understandings of Ebola-related risks and intervention logic; multiple, evolving 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; non-use of the EMT as a forum for strategic deliberation; the absence of a coherent framework for performance management; and a functional information management system to guide decisions.

CONCLUSION 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 even without complete information about needs and materials. 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. The response was also slowed by the non-acceleration of finance and administration procedures and inadequate numbers of experienced emergency staff.

CONCLUSION 8:

UNICEF's response did not sufficiently rely on knowledge management, and the organization remained only partially prepared for future public health emergencies.
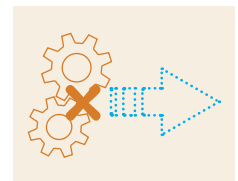
UNICEF made significant efforts to 'learn by doing', convening a learning session in February 2015 and preparing a formal management response listing planned actions. The organization also invested in numerous lessons learned exercises conducted by programmes and functions involved in the response and by 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 Ebola and the response was insufficiently informed by learning from previous public health emergencies. It remains unclear whether UNICEF is sufficiently prepared to respond to future public health emergencies in other countries and contexts.

CONCLUSION 9:
Without a suitable policy and accountability framework for public health emergencies, UNICEF's response was disconnected from its specific obligations to children and communities in emergencies.

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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 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 address the secondary effects and humanitarian needs arising from Ebola; meet UNICEF's child protection obligations; and apply the Commitments on Accountability to Affected Populations.
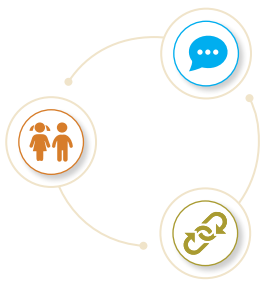
4 RECOMMENDATIONS

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This section outlines five priority recommendations aimed at preparing UNICEF for future public health emergencies.
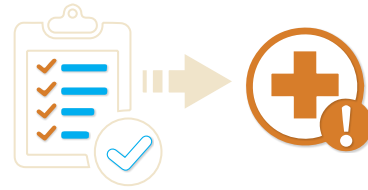
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UNICEF WCARO, country offices and partners **SHOULD ENSURE** rapid response, reinforced health systems, children protection
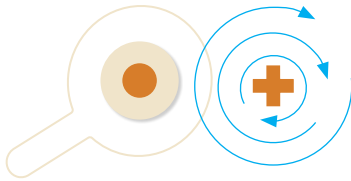
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The UNICEF Global Management Team (GMT) should **DEVELOP A POLICY AND ACCOUNTABILITY FRAMEWORK** for responding to public health emergencies

3

The UNICEF GMT should recognize **AREAS FOR IMPROVEMENT** and **STRENGTHEN** coordination, strategy and information capacities for public health emergencies.

4

The UNICEF GMT should **CONTINUE TO STRENGTHEN CAPACITIES** for rapid, large-scale deployment of financial, human and material resources in emergencies

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.

RECOMMENDATION 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 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.

RECOMMENDATION 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.
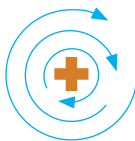
RECOMMENDATION 3:
The UNICEF GMT should recognize areas for improvement and strengthen coordination, strategy and information capacities for public health emergencies.

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.

RECOMMENDATION 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.

RECOMMENDATION 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.

The Evaluation of UNICEF's Response to the Ebola Outbreak in West Africa 2014–2015 highlights the valuable contributions made by UNICEF and partners to stopping Ebola transmission, as well as the factors that hindered or diminished those contributions. In so doing, 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.