



REPORT OF THE REAL TIME EVALUATION OF EBOLA CONTROL PROGRAMS IN GUINEA, SIERRA LEONE AND LIBERIA

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Safe and Dignified Burial team being decontaminated in Monrovia, Liberia. *Photo Alexandra Murray*



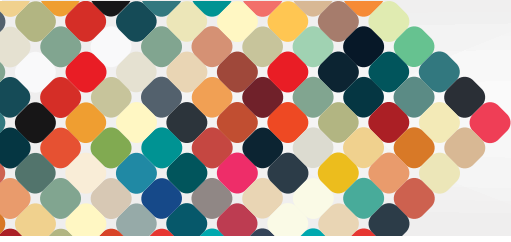


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Annexes are in Volume 2



1. ABBREVIATIONS

BCC	Behavior Change Communications
Ben Comms	Beneficiary Communications
CCP	Center for Communications Programs (CCP)
CDC	Centers for Disease Control and Prevention
CHF	Swiss Francs
CT	Contact Tracing
DFID	Department for International Development (UKAID)
DREF	Disaster Relief Emergency Funds
ECHO	European Community Humanitarian Aid and Civil Protection Department
ERU	Emergency Response Unit
ETC	Ebola Treatment Centre
EVD	Ebola Virus Disease
FACT	Field Assessment Coordination Team
GRC	Guinea Red Cross Society
HR	Human Resources
ICRC	International Committee of the Red Cross
IFRC	International Federation of Red Cross and Red Crescent Societies
IMS	Incident Management System
JHU	Johns Hopkins University
KAP	Knowledge Attitudes and Practice (surveys)
LNRCS	Liberia National Red Cross Society
MoH	Ministry of Health
MSF	Médecins Sans Frontières/Doctors without Borders
NERC	National Ebola Response Centre (Sierra Leone)
NFI	Non Food items
NS	National Red Cross Society
PMER	Program Monitoring, Evaluation and Reporting
PNS	Partner National Societies
PPE	Personal Protective Equipment
PSS	Psycho-social Support
RC	Red Cross Red Crescent
RDRT	Regional Disaster Response Team
RITE	Rapid Isolation and Treatment of Ebola
RTE	Real Time Evaluation
SDB	Safe and Dignified Burial
SLRCS	Sierra Leone Red Cross Society
SWOT	Strengths, Weaknesses, Opportunities and Threats
UNFPA	United Nations Family Planning Agency
UNICEF	United Nations Children Fund
UNMEER	United Nations Mission for Ebola Emergency Response
USAID	United States Agency for International Development
WFP	World Food Program
WHO	World Health Organization



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The RTE team would like to acknowledge the many people who have helped with this evaluation. Those who we interviewed are listed in respective country annexes. There are many others to acknowledge such as the administrators and managers who made arrangements for our travels, our interview appointments and our accommodation, both within the three countries as well as in Geneva. In particular we would like to recognize Aliou Boly, IFRC Country Representative in Guinea, Stephen McAndrew, IFRC Head of Emergency Operations, Tommy Emmanuel, Secretary General Sierra Leone Red Cross Society, Peter Schleicher, IFRC Head of Operations in Liberia and Fayiah Tamba, Secretary General Liberia Red Cross Society.

In Geneva we would like to particularly express our appreciation to Walter Cotte, Under Secretary General, Panu Saaristo (Health), the RTE management team Pierre de Rocherfort (DCM), Stephen Wainwright (PED), Robert Ondrusek (PMER Africa Zone) and Josse Gillijns (PED). We further express appreciation to Birte Hald and Amanda McClelland at the Regional Ebola Coordination office.

3.1 BACKGROUND

The Real Time Evaluation (RTE) was commissioned by the IFRC Secretariat to assess the Red Cross response to the 2014 Ebola crisis in Guinea, Sierra Leone and Liberia from March 2014 to date.

The intent of this RTE is to specifically look at implementation issues, with a focus to improving the on-going and future response needs of affected populations.

The scope includes the assessment of activities to improve the response to affected populations, stakeholders, partners and donors, building on lessons learnt so far in this outbreak.

The RTE team set out to answer the Terms of Reference questions concerning the Red Cross Ebola programs in the three countries. Field visits were conducted at key sites including Guinea, Sierra Leone and Liberia, and Nairobi. They interviewed National Society staff, IFRC delegates, heads of operations, volunteers, representatives of key stakeholders and personnel from the respective ministries of Health. A debrief with the IFRC and National Society personnel involved with the Ebola response was conducted before leaving each country. Key Movement and humanitarian actors collaborating with the Red Cross Ebola programs were interviewed to gain further insight.

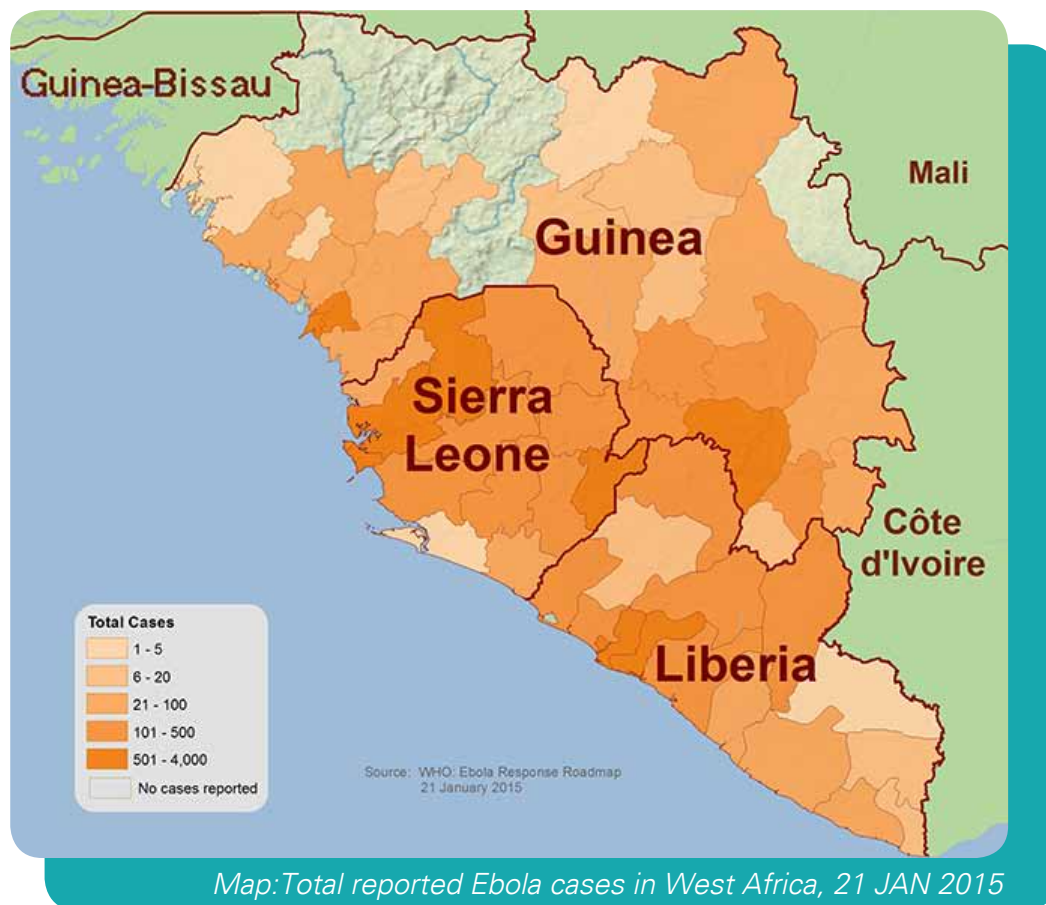
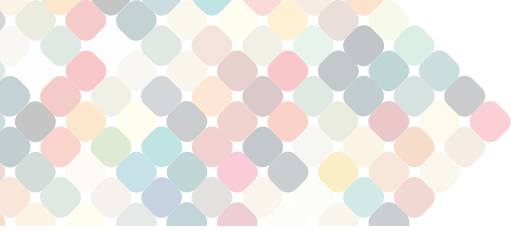
3.2 CONTEXT

The current outbreak in West Africa (first cases in December 2013, first notified in March 2014), is the largest and most complex Ebola outbreak since the Ebola virus was first discovered in 1976. There have been more cases and deaths in this outbreak than all others combined. It has spread among West African countries starting in Guinea before spreading across land borders to Sierra Leone and Liberia, Nigeria, Senegal and Mali. The most severely affected countries, Guinea, Sierra Leone and Liberia, have very weak under developed health systems, lack human and infrastructural resources, and have recently emerged from long periods of conflict and instability.

Although there have been 35 previously documented outbreaks of Ebola (23 in humans) since 1976, the cultural and geopolitical context of West Africa, coupled with fragile systems in the post-conflict region created the environment for this explosive outbreak. This is the leading public health crisis of the decade and certainly the outbreak of the decade, having infected more than 20,000 persons by December end, 2014.

Among the 23 outbreaks of Ebola in Africa, all have been rural in origin, with some previously spreading into hospitals located in small towns. This West African epidemic has demonstrated the consequences of failing to keep the epidemic contained in the rural areas, as the nature and difficulties of control are exacerbated when spread to urban areas. As a public health disaster, the course of the Ebola epidemic and the nature of response is considerably different from other disasters which move predictably from more acute to less acute needs.

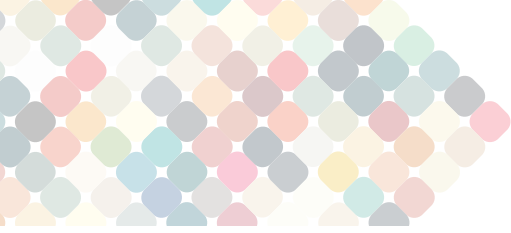
The direction of this current epidemic is uncertain, and is likely to involve neighboring countries, and possibly at the same time, become an endemic disease with periodic flare-ups.



The outbreak began in Meliandou, Guinea, with the death of a child in December 2013, thought to have been infected by a bat. The outbreak was recognized in January 2014, in the border area between Guinea, Sierra Leone and Liberia, but poor communications and political and cultural resistance hampered timely recognition and extent of the outbreak.

The IFRC is supporting international emergency appeals to combat Ebola in Guinea, Liberia, Sierra Leone, Nigeria and Senegal. The federation strategy is developed around a five pillar approach including: Beneficiary Communication and Social Mobilization; Contact Tracing and Surveillance; Psychosocial Support; Clinical Case Management; Safe, Dignified Burials and Disinfection. The IFRC also continues to support preparedness and response operations financed under its Disaster Response Emergency Fund (DREF) in Mali, Cote d'Ivoire, Cameroon, Togo, Benin, Central African Republic, Chad, Gambia, Kenya and Guinea Bissau and now Ethiopia, making a total of 16 countries that have emergency operations relating to this outbreak. Other response tools which the Federation has deployed for the management of the operation include RDRT, FACT and ERUs as immediate support to the affected National Societies.

Humanitarian policy guidelines which the Federation have used to ensure that the Ebola emergency response meet recognized emergency response standards include, Principles and Rules of Disaster Relief, Disaster Preparedness Policy, Emergency Response Policy and Sphere Standards among other standards available within the humanitarian sector. It is envisaged that the current Ebola response strategy will contribute to the achievement of the Federation-wide Strategy 2020 with emphasis on saving lives and rebuilding livelihoods.



3.3 METHODS AND APPROACH

Method of Inquiry. The qualitative method of inquiry was used in the Ebola RTE. This included key informant interviews, focus group enquiry and desk review. An on-line staff survey also provided data for analysis. Analysis of these data used qualitative data interpretive techniques.

Inception phase. The RTE team met in Geneva on the 27th-29th November 2014. Preparations for the RTE were undertaken with the Evaluation Management Team (EMT) and 8 initial context related key informant interviews were held.

Document Review. The EMT has assisted the evaluation team with the provision of background documentation in relation to the IFRC Ebola response. Review of these documents has informed the Ebola RTE methodology and evaluation questions. A list of these documents will be included in the final report Annex.

Key informant interviews and focus group discussions. Key informant interviews were held in the inception phase to gather contextual information to inform the development of the RTE. Further key informant interviews were conducted in the evaluation. IFRC assistance helped identify key informants in the field, including relevant PNS's including MSF, UN and ICRC in the field. A list of key informants is included in the final report Annex.

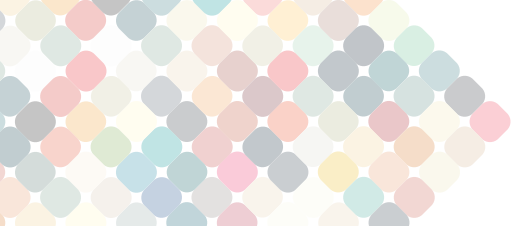
Field visits. The Ebola RTE team visited the IFRC in Geneva before embarking upon three in-country field visits to Guinea, Sierra Leone and Liberia and to the Nairobi Zone office. The RTE team divided into two interview teams, working in different countries simultaneously.

On-line survey. A voluntary IFRC on-line evaluation survey was analyzed and is included in the final report Annex.

Feedback and Consultation. Feedback and consultation was fundamental to the RTE process. The evaluators met with and debriefed findings with: respective Federation country offices and in many cases national society personnel, the Zone Office in Nairobi, and by telephone with the IFRC headquarters in Geneva.

3.4 GENERAL COMMENTS ON THE EBOLA RESPONSE

The Ebola Real Time Evaluation (RTE) team found very dedicated delegates, national society staff and volunteers working with great commitment in difficult circumstances. The volunteers and their work is a great credit to the Red Cross Red Crescent Movement as well as the organization and leadership of the response to this epidemic. The Red Cross activities have played a critical role in preventing progression of the epidemic and sustaining these will be a major tool for the elimination of Ebola. Volunteers have often completed these roles quietly, not receiving the attention that other organizations involved in the response have received. Particularly, this has been true for the safe and dignified burial teams. This activity by the Red Cross has played a major role in the interruption of transmission of Ebola in many parts of the three countries. The work by the Red Cross has set the standard against which the response to future outbreaks will be judged.



Excellent work has been accomplished the other four pillars as well. Some of those interviewed wished that the Red Cross had been able to establish more comprehensive activity performance in other areas. However, it is good management not to extend resources beyond means, even in the face of this emergency. Country programs with the assistance from Regional Management, extended activity into cooperative synergistic work areas with other actors involved in the response when opportunity arose.

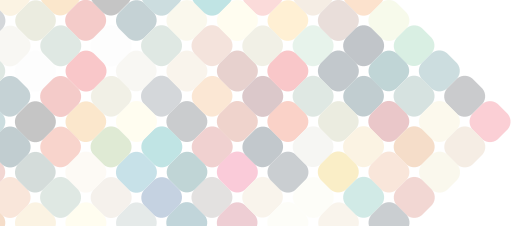
At the same time the presence of an extensive network of volunteers across the three countries, and no major difficulty in recruiting persons to work gave the Red Cross and comparative advantage that no other organization had. The willingness of the volunteers to work in very demanding circumstances speaks very well of their commitment, as well as the leadership by the national societies and the IFRC. The RTE evaluation team found that in all places they visited the volunteers were treated with respect and concern by leadership.

The unpredictable pattern of this epidemic coupled with the weak systems in the three post-conflict countries, has made this an especially difficult challenge. The epidemic is slow to come under control in Guinea and Sierra Leone. Although Liberia has achieved considerable success, it has not reached elimination and the situation can still deteriorate. The signs point to a continuation of the epidemic well into 2015. Of particular concern is Guinea, where the response has been problematic and where the Red Cross response is the weakest of the three countries. The continued spread of the disease into remote rural areas is steadily increasing the complexity and difficulty of control as well as likely extending the amount of time required to reach zero cases.

The epidemic is of a different order than other disasters commonly dealt with by the IFRC. Instead of starting with devastation and building back services and livelihoods, the Ebola epidemic expanded and moved in uncharted ways. The effective disaster response approaches of the IFRC should be re-examined in the light of this epidemic to see how alternate management paradigms might have strengthened the Red Cross response. It could be that a modified disaster response approach, utilizing different skill sets and different approaches would be developed for future epidemics. This could build on the Red Cross/ Red Crescent experience with SARS, cholera, meningitis, MERS, H1N1 as well as measles.

The RTE team approached the evaluation with a focus on assessing how the IFRC was contributing to saving lives from Ebola. Given the directions of the epidemic and where it was currently going, what more, the team sought to find out, could be done within the Red Cross Red Crescent mandate to shorten this outbreak? The team of four evaluators visited the three countries, working in teams. For each country, the findings and recommendations are set out individually. Those that applied to all sites are noted below. Personnel from the National Societies, as well as IFRC delegates were very generous with their time and resources to assist the RTE team, for which we are most grateful.

Undoubtedly, there will be multiple retrospective examinations of this Ebola outbreak, searching for lessons learnt, and information that could shape the next response to the next outbreaks, whether they be Ebola or another emerging/reemerging disease. While the IFRC would certainly be a part of any multi-agency review and assessment, it is our suggestion that the IFRC, with the assistance of the relevant national societies undertake an in-house assessment of responses in the sectors for which it had responsibilities. This could look at multiple organizational issues as well as epidemic control issues. This would allow those who have had leadership roles in field operations as well as those in headquarters

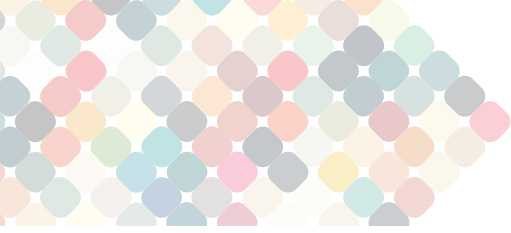


backstopping positions to consider all phases of the response. The experience gained from managing this outbreak should be seen as a opportunity to strengthen the IFRC and national society disaster management capacities.

3.5 GENERAL CROSS-SITE RECOMMENDATIONS

The team has detailed a number of country specific recommendations, which some of these in various forms are common across countries. In the following section are listed general observations and recommendations which the RTE team applies to the three countries.

1. *Greater epidemiological and public health resources.* The response has a very strong disaster management team but is short on technical capacity in epidemiology and public health; a priority for public health disaster response. Deploying these capacities could help the Ebola response to anticipate the directions of the epidemic and utilize information already being obtained through Red Cross activities to better prepare and deploy assets and resources. Being dependent on other sources for information and directions for epidemic response puts the Red Cross efforts at a disadvantage and potentially introduces a delay in response. This limits the abilities of Red Cross to be proactive — a key element in an unpredictable epidemic. The WHO and CDC have excellent epidemiological capacities to analyze the data collected by others. The Red Cross should be in the position to analyze its own data to monitor the successes of its activities and identify unmet needs without depending entirely on other agencies which may not have the Red Cross field operation perspective. This is already a practice of some humanitarian organizations.
2. *Better use of information.* Many streams of information flow in this response. Some information is electronic and some is via paper. Getting all project data into electronic format would be an important step, as would be utilizing this data to create data “dashboards.” Such dashboards could be viewed in real-time anywhere. However, connected with a process to enable decision makers to use the data would increase efficiencies in the decision-making process.
3. *Support and “duty of care” for volunteers.* This takes several forms:
 - a. Safety from contracting Ebola infection. Breaches of protection standards are common. Close supervision and retraining for quality control is critical.
 - b. Physical safety of volunteers is a threat in some communities such as in Guinea. Closer monitoring of at-risk areas, and collaboration with government and agencies working in these areas to share information is advised.
 - c. Psychological support for volunteers; especially those in hazardous conditions, and those exposed to social discrimination for their work. Current arrangements are of an ad hoc nature and are not standardized. Psychological support is part of “duty of care”.
 - d. Support of morale is needed in many places. This could be achieved with non-monetary incentives, recognition, and more specific appreciation. Planning should be given to post-Ebola appreciation for the volunteers. A thorough understanding of problems with fatigue and decreasing morale is needed in order to develop appropriate support programs.
 - e. Prompt payment of incentives. Delays have been present in many places, and this reduces morale. The payment process of should be reviewed to ensure timeliness.



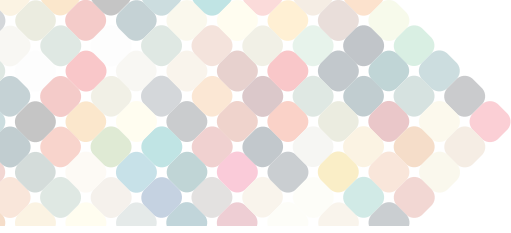
4. *Contact Tracing.* In many areas volunteers have been undertaking contact tracing and working with local health authorities. It is now time to consider developing this into active case finding where this is possible with local authorities, as a much stronger community surveillance approach is needed to end this epidemic. The volunteers are an excellent potential resource for these activities. In some areas the majority of new cases are arising among persons not on a contact tracing list, demonstrating the limitation of simple contact tracing.
5. *Increased Communications.* Social mobilization and beneficiary communications have been carried out well in many places. More consideration for individual Behavior Change Communications (BCC) and mass-media awareness could not only reduce risks to individuals but increase the awareness of the role of the Red Cross in Ebola control. Some communications budgets are underspent.
6. *Recovery Phase.* Although typically the recovery phase is seen as separate from the disaster response phase, there are many reasons to start recovery efforts now. Many households need assistance which they are not receiving, and there are long term livelihood issues which should start promptly.
7. *Regional Ebola Management Unit.* The RTE team saw the Regional Ebola Management Unit as an excellent concept providing technical resources for the affected countries, but felt it lacked all the technical depth required to support country programs. The specific areas noted were communications, public health and information management, where the needs from the countries exceeded the resources available to them.
8. *Emergency Operations Plans.* In the Emergency Operations Plans there was a heavy emphasis on output indicators. A stronger emphasis during planning on process and outcome indicators would facilitate improving the quality of services provided.

3.6 COUNTRY SPECIFIC SUMMARIES AND RECOMMENDATIONS

3.6.1 Key findings from Guinea

Currently, broader strategic decision-making within the GRC and Guinea IFRC is informed by information collected and disseminated from external actors, such as the MoH National Ebola Coordination Committee. In negotiation with the National Coordination Committee, the GRC and IFRC decided to focus on Safe and Dignified Burials (SDB) that ultimately has been the success of slowing transmission in Guinea. Currently there is opportunity for Red Cross to scale up and implement a holistic approach in the Guinea program to facilitate community education and safety of the volunteers.

Safe and Dignified Burials. Red Cross volunteers have been engaged in Safe and Dignified Burials (SDB) from the beginning of the outbreak, but since August when the Red Cross movement agreed to be the sector lead for SDB, it has become the major component of Red Cross activities. This is appropriate and an enormous contribution to the overall Ebola response in Guinea. These SDB teams are doing excellent work, but morale is low, the volunteers are exhausted and they have not received any meaningful PSS.



Community members are reluctant to allow the Red Cross to enter and conduct dead body management per Ebola protocols, and at times this has caused tension and conflict between community members and Red Cross volunteers.

GRC has shown outstanding success in this field and should maintain its commitment to SDB, whilst scaling-up collaborative social mobilization and communication activities at village-level. The GRC should also consider options for involving Red Cross volunteers in contact tracing and for providing psychosocial support to community members.

Communications. At the start of the outbreak, social mobilization and beneficiary communication was the largest component of the Guinea Red Cross Ebola response. The recognition of the importance of Beneficiary Communication was cemented at the Dakar Communication Forum 8 and 9 September, hosted by IFRC, however, at the request of the coordination bodies, GRC focused on a single area only. The inclusion of SM volunteers as part of each SDB team is an appreciable development toward the implementation of a holistic approach to halt further Ebola Virus Disease transmission.

Volunteers. Initial volunteer training was supplemented by general PSS preparation from the PSS expert on the FACT team. However, continued updates for this aspect of social mobilization have been absent.

Few resources exist within GRC for volunteers experiencing stigmatization or anxiety about their work with Ebola. Psychosocial activities have received limited attention; volunteers have been trained, but no SDB volunteers in Guinea have received one-on-one psychosocial counseling.

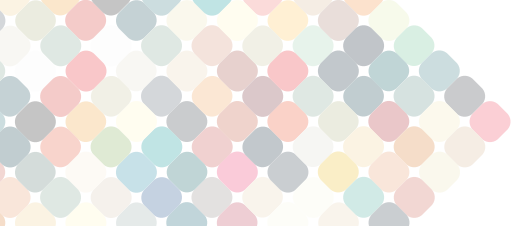
The current involvement of GRC in contact tracing is minimal. Recently, “preliminary contact tracing” was integrated into SDB protocols. Now, when an SDB team retrieves a body from the community, a volunteer will sit with the family and record all of the victim’s contacts.

Many Red Cross volunteers are exhausted and had negative feelings towards the GRC and IFRC management. Volunteers are most concerned with the lack of attention to their wellbeing and lack appreciation for their work. The GRC needs to understand the real possibility that without additional quality assurance and additional resources to SDB teams, more volunteers are likely to become infected with Ebola, or face further stigmatization and abuse in their communities.

Information. There is some tension between donor reporting demands, and the ability of in-country staff to provide steady information. The Guinea IFRC staff reported feeling overwhelmed by the need to provide information to regional and zone offices as frequently as they are requested to do so (i.e. directing scarce resources to donor reporting at the expense of effective implementation).

Neither the IFRC nor the GRC had an epidemiologist or health specialist to assess current and future outbreak trends for the purpose of planning activities.

There is currently no monitoring and evaluation system used to track activity efficiency and facilitate operational adaptive management. Information systems are not in place to collect and analyze data, which leaves the emergency response open to operational inefficiencies. IFRC has limited information in terms of monitoring and evaluation of internal operations.



Leadership. The GRC is hierarchically managed and does not seem able to act quickly. The GRC leadership is slow to achieve internal consensus, communicate decisions constructively or in a timely fashion. A new committee internal to the GRC leadership has been established - the GRC National Ebola Commission - which the Guinea IFRC staff hope will expedite decision-making. A reasonable staffing structure exists, but the systems and processes to accompany this staffing structure are not in place. A striking feature of the current operation is that the Guinea IFRC has no staff based in the GRC office, and vice versa. This means all communication is completed by phone, email, or during weekly meetings.

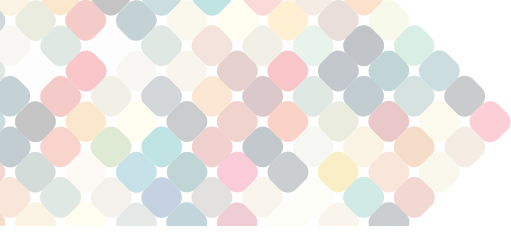
Human Resource recruitment has been one of the biggest challenges of the Ebola response in Guinea, as for other offices. Mobilizing sufficient delegates (with the necessary technical and language skills) as well as local staff are key challenges of the Guinea operation.

The IFRC and NS generally have a good working relationship, but the IFRC has limited influence to shape the actions taken by GRC leadership. The Guinea NS leadership is perceived to be protracted and ineffectual, partly due to staffing shortages and exhaustion, partly to due to culture, attitudes and personalities.

Respect. The GRC and IFRC are well known and highly respected as part of the Guinea Ebola response. Beyond coordination meetings, the RTE saw evidence of effective collaboration with other humanitarian actors, along with several missed opportunities.

3.6.2. Key recommendations for Guinea

- a) Additional non-financial incentives should be considered immediately, including competency based certification that volunteers can use to gain employment after the outbreak, celebratory events, NFIs.
- b) Red Cross volunteers face security threats in some parts of the country as a result of poor community-humanitarian relationships, and this is jeopardizing operations. Considerations should be given to having a security delegate in Guinea at least in the short term, if the position has not been posted already.
- c) The IFRC, GRC and ICRC should develop risk thresholds whereby activities are suspended rather than putting volunteers at risk.
- d) The GRC and IFRC should work with the Guinea government and others to ensure that all RC teams are supported by local government and law enforcement when needed.
- e) The GRC and IFRC should develop a formal plan or protocol for responding to volunteer deaths due to Ebola and supporting the victim's family and teammates.
- f) No further duties should be added to the list of tasks that SDB volunteers are currently asked to undertake.



3.6.3 Key findings from Sierra Leone

In Sierra Leone the national society (NS) works in 11 of the 13 districts with approximately 1500 of its 7500 volunteers actively involved in the Ebola program. This program consists of social mobilization (SoMob), contact tracing (CT), safe and dignified burials (SDB), and psychosocial support (PSS). In Kenema, and recently implemented in Kono district, treatment units are active; representing the five pillars of the response.

The program was slow to get started with resistance from the SLRCS, perhaps related to fear and panic that Ebola was creating in country. However the program did progress and its great success has been the SDB activities with its highly committed volunteers. An estimated 65% of deaths have occurred at home, making this an important activity. Sierra Leone had not yet (at the time of this visit) developed a national Ebola surveillance program which, along with insufficient treatment beds, heavily contributes to the epidemic's out-of-control status.

Information. There are opportunities to improve the Red Cross' information management. At present there are two parallel information systems, one using mobile phones the other paper based. Further, the data collected are not fully utilized. The Red Cross activities began in Kailahun and Kenema and districts where solid implementation of the Red Cross five pillar approach has been key to largely controlling the outbreak. A mini-KAP survey was carried out in June 2014 using non-standard methods, and has not been repeated. Contact tracing is being done, but it is not clear how information from this is being used to monitor spread of the disease.

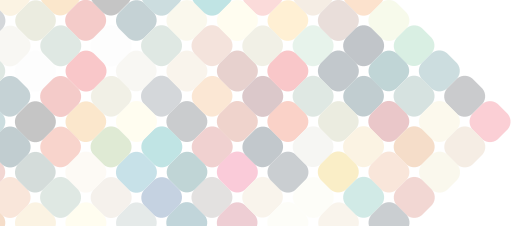
Use of resources. The donor response to the CHF 41 Million appeal stands at 75% confirmed pledges 25% unconfirmed pledges. There seem to be a number of challenges to ensuring that the activities outlined in the emergency appeal are implemented in a timely manner.

The National Society has used its volunteer base to respond quickly to the Ebola emergency through organizing social mobilization activities in the villages and conducting the SDB activities in Kailahun and Kenema. There are some branches failing to send their monthly activity returns promptly, and this has led to delays in financial dispersals, and delays in paying incentives to the field teams. This has affected the speed at which the funds are transferred to other activities.

Communications. Though Social Mobilization and Beneficiary Communications teams run well, however the feedback voice of the community is not heard well in the current process. Mass media communications are substantially under-spent at a time when these should be at maximum rate.

Coordination. The IFRC and the NS play an active role in the coordination of activities through the National Emergency Response Centre, and work closely with the MoH. The Red Cross Ebola task force maintains a close relationship with principal donors.

Volunteers. There is a rotational assignment of volunteers mainly assigned to the Safe and Dignified Burial Teams. The National Society recognized the efforts of the volunteers through offering a risk allowance of 100,000 Leone for SDB volunteers and 50,000 Leone for 700 Social mobilization volunteers. There exists a volunteer policy which is being revised. The volunteers being assigned roles in the Ebola operation have

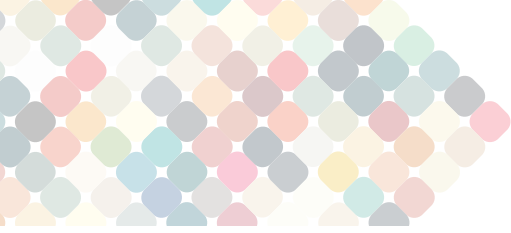


been covered through the Federation insurance system while the NS is still organizing a local insurance company to provide insurance for the volunteers.

Capacities. The current response is built on the National Society's capacities from previous experiences during the civil war, cholera outbreaks and community based health activities. There is increased visibility of the NS society within the operation due to the support from the Federation. The multiple layers of coordination at the country, region, zone and secretariat for the Ebola response have led to some blurring of clear roles and responsibilities and may not add value to the response.

3.6.4 Key Recommendations for Sierra Leone

- a) Strengthen financial management, especially in accelerating expenditures from Appeal funds.
- b) Providing all volunteers with Red Cross visibility and identification, such as with T-shirts, aprons and ID badges.
- c) Monitoring of outputs, outcomes and activities listed in the emergency appeal. Consider having logframes as part of the Emergency Plan of Action to help identify indicators. Currently, this is not a results based framework as there are few indicators specifically set out for outputs or outcomes. This would be more useful than just measuring financial expenditure per output.
- d) Plan on long term support for the volunteers who have been engaged in the Ebola operation.
- e) Strengthen information analysis and management for use in decision making starting from the branch level to the regional level.
- f) Because of the large amount of funds involved and the complex and changing nature of the operation, and for the protection of the program staff, an interim internal audit should be considered.
- g) Review the communications strategy for the SLRCS with support from the Ebola Regional Management unit to see how this can be made more effective now and in future disasters.
- h) Improve on the paperwork and returns from the branches in time, and held up payments as a method of ensuring timely submission of returns.



3.6.5. Key findings from Liberia

This outbreak has been an opportunity for the Red Cross to demonstrate its principal of humanity in the face of great need. This has been an opportunity for the Movement to work together; the national society, IFRC, PNS and ICRC working to address a problem that affects all.

Liberia has the strongest Ebola control activities of the three countries, and the Red Cross plays an important part of this. There has been good utilization of the data from other sources at the beginning of the outbreak, though the FACT team does not seem to have collected any primary or subsequent data to determine population needs. Of the three countries, the Liberia program has the strongest information system at the current time. Yet information collected in the course of the program is not being fully utilized.

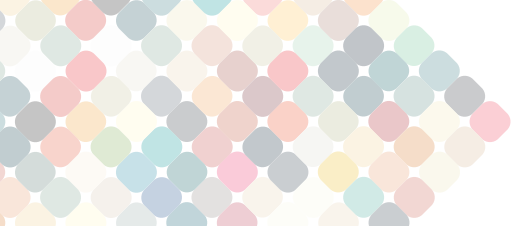
The program was built around the five pillars with much of the early emphasis in Monserrado county and greater Monrovia where the early epidemic was concentrated. The signature program has been the Safe and Dignified Burial program. With more than 75% of the deaths occurring in the Monrovia area, the Red Cross SDB teams managed most of these deaths. There is a delegate overseeing this program which has now shifted from cremation to burials. Twenty teams are currently involved.

Communications. The communications area has been problematic. It has lacked clear goals and job descriptions which have left delegates unclear about their responsibilities, and resulted in valuable time lost in the initial stage of their short postings. New initiatives such as using local radio stations and sound trucks for the Christmas holidays were innovative. Social Mobilization works closely with Beneficiary Communications activities. With the ban on mass gatherings, basic house-to-house mobilization and small group meetings is being completed now by the volunteers. Some supervision is being provided, though we did not find the reports of these.

Clinical care. Clinical care is a pillar which applies to Red Cross activities increasingly as the country's focus is shifting to the Rapid Isolation and Treatment of Ebola (RITE) strategy. Linking several chapters together through Hubs is consistent with this. The Red Cross, with funding from UNICEF, has taken a lead in the provision of Community-protection kits. These have been dispensed to some counties such as Magibi, but there seems to be some hesitation in putting them into use.

Surveillance. Contact tracing is performed by the Red Cross and other agencies, of which the area of responsibility depends on decisions by the local County Health Teams. The elimination of Ebola in Liberia depends on active surveillance and case finding. Going forward, increased use of the volunteers should be made in the surveillance process, and analysis should be carried out on the data now being collected by the Red Cross.

Psychosocial support is an area where extensive IFRC resources have been invested. Generally this has worked well, although closer terms of reference for incoming delegates should be formulated. This is a great need as there are many widows, orphans and people without food, shelter or support as a result of Ebola. Further, as the number of survivors rise, there is increasing stigmatization against vulnerable persons, and major efforts are needed with the community to address these issues.



Implementation. At the present time the project is spending its resources at appropriate speed, though a current financial statement was not available. Among the partners there is some feeling that the Ebola activities need to be more proactive, both in the activities and the sharing of information and activities. Among some of the Movement members in Liberia, there was a feeling that a higher visibility is needed for the Red Cross activities in Liberia.

Coordination has been generally good for the Liberia program. The LNRCS could be more prominently seen at the IMS meeting where the IFRC takes a very prominent role. The incorporation of the Movement partners with regular meetings is positive, although some strengthening of these links could be made. The Federation has a good relationship with the ECHO and UNICEF offices which provides a good opportunity for future relations with these agencies.

Conclusion. In a brief summary, this is a well-run program, but with some adjustment could be made to strengthen outcomes. In general, the program needs to be more proactive in some areas, rather than being just reactive. This is a very uncertain phase in the outbreak, so new and innovative approaches to reach zero cases is needed.

3.6.6. Key recommendations from Liberia

- a) Liberia has the best data from contact tracing, yet it is un-analyzed. This should be analyzed, as this is important information to reach zero cases. Increased surveillance activities will be needed in the country before Ebola is eliminated.
- b) The HUB strategy being implemented in Liberia is an excellent effort to move resources to where cases are, and should be considered by the Red Cross in the other countries.
- c) Several delegates noted TORs were unclear, and clarifying tasks at the beginning of short assignments could reduce time lost developing activities.
- d) Beneficiary communications have largely been top-down. Methods to assess on-going needs are needed.



4. METHODS

This Real Time Evaluation (RTE) set out to answer the questions concerning the Ebola programs in Guinea, Sierra Leone and Liberia. These Terms of Reference are found in Annex 1. The Evaluation team consisted of Alexandra Murray, Philimon Majwa, Tim Roberton, and Gilbert Burnham, as team leader. The biographic details of the team members are found in Annex 1 along with the evaluation schedule. The team met virtually and exchanged ideas and scheduling plans for 10 days prior to meeting in person in Geneva on 27 November, 2014.

In Geneva the team met with Pierre De Rochefort, Stephen Wainwright and Josse Gillijns, starting on Thursday afternoon the 27th of November, 2014. The initial discussions were around the structure of the RTE and the inception report. Further meetings with key staff in Geneva covered personal health issues, the nature and implementation of the Ebola program in the three countries, the management structure, the history of the appeals process for the three countries, as well as personal safety. Teleconferences were conducted with Nairobi and Conakry. On the last day the team put together the first draft of the inception report, and updated this the following day.

On 30 November, 2014, the team departed; Alex Murray and Tim Roberton to Guinea; Philimon Majwa and Gilbert Burnham to Sierra Leone. At these sites the teams interviewed National Society Staff, IFRC delegates, Heads of Operations, volunteers, representatives of key stakeholders and personnel from the respective ministries of Health. Field visits were also conducted to key sites. Time available in each site was somewhat limited. After the first week in Sierra Leone, Philimon Majwa and Gilbert Burnham moved on to Liberia, and Alexandra Murray joined the group there. Tim Roberton travelled from Guinea to Nairobi to interview staff about the Ebola program coordinated from there. From Sierra Leone the team was able to talk with Birte Hald in Conakry about the regional program.

In Sierra Leone the team spent the first part of the visit with IFRC delegates and SLRC staff and leadership. The team were then able to visit the ETC in Kenema and talk with volunteers, the WHO representative and the local Ebola control committee. In addition, a visit to the Western Area of Freetown was scheduled, but did not get beyond the branch office because of local tensions. In Liberia the team interviewed IFRC delegates, LNRCS staff and leadership and visited the Chapter offices in Margibi, Bomi County, as well as accompanying a SDB team in Montserrado County. In Guinea, the team interviewed IFRC delegates, GRC staff and leadership, spoke with ICRC and partner organizations and visited volunteers in Conakry and Coyah chapters.

After the visit to each country was completed the team members reviewed notes and recordings from the visits, and key points were set out in a report outline. This outline served as the basis for the individual country reports included in this document. A debrief with the IFRC and National Society personnel involved with the Ebola response was conducted before leaving each country. Questions arising from this verbal report were then addressed and additional information noted. Following the completion of a country activity, telephone reports were made to the IFRC Monitoring and Evaluation office in Geneva. A two page summary of findings and recommendations were sent to the Geneva office. On 29 December, a brief call was made to the Secretary General about some of the recommendations for immediate action which had been formulated by the RTE team.

In the period of time between returning to their home countries and the 31st of December, the team worked full time on the completion of the report, and have exchanged drafts and documents by email and talked on skype a number of times to finalise the Ebola RTE final report.

5. BACKGROUND OF THE CURRENT EBOLA OUTBREAK

Although there have been 35 previously documented outbreaks of Ebola previously (23 in humans) since 1976,¹ the cultural and geopolitical context of West Africa, coupled with fragile systems in the three post-conflict regions created the environment for this disastrous outbreak. This is certainly a leading public health crisis of the decade and certainly the outbreak of the decade, having infected more than 20,000 persons by December end, 2014.

The outbreak began in Meliandou, Guinea, with the death of a child probably infected from a bat in December 2013.² The outbreak was recognized in January 2014, in the border area between Guinea, Sierra Leone and Liberia, but poor communications and political and cultural resistance hampered the full recognition of the extent of the outbreak. By early May, most responders had concluded the epidemic was burning itself out. However, a failure to trace contacts and to conduct active case finding allowed the epidemic to quietly build up. The massive flare up of cases occurring from May/June onward caught many local as well as international organizations by surprise, and in many cases unprepared.

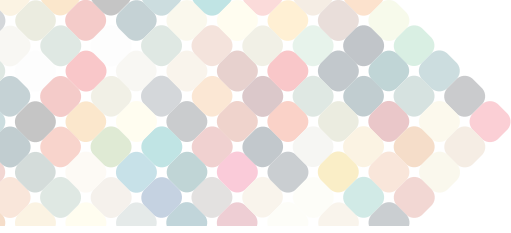


Figure 1: Location of early cases of Ebola, New York Times 31 Dec

In **Guinea** the disease had largely remained a rural disease. The disease continues to spread in rural hard-to-reach areas, while the number of new cases in early January is most in densely populated capital city Conakry. Overall the numbers of new cases remain about constant while the geographic spread increases. The geographic spread is of concern as it indicates worsening control prospects. As of 7 January there had been 344 cases reported in the previous 21 days and a cumulative number of cases of 2,775. For Guinea there are 2.1 treatment beds for each case of EVD reported. During this period of 21 days, six additional health care workers were diagnosed with Ebola. Contact tracing is being carried out generally, and these are being augmented by active case finding teams.

¹ CDC. Outbreaks Chronology: Ebola Virus Disease. <http://www.cdc.gov/vhf/ebola/outbreaks/history/chronology.html> accessed 22 Dec 2014.

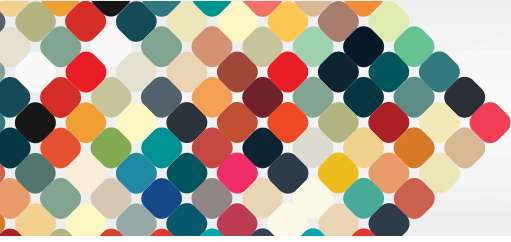
² Vogel G. Bat-filled tree may have been ground zero for the Ebola epidemic. *Science*, 2014, <http://news.sciencemag.org/africa/2014/12/bat-filled-tree-may-have-been-ground-zero-ebola-epidemic> accessed 30 Dec 2014.



In **Sierra Leone** the first impacts were seen in Kailahun May 2014 and Kemema in June. The first operational hub was set up in Kailahun in June, and the ETC opened in Kenema in August. In close cooperation with others, and with good local organization, the infection has continued here at low levels. Sierra Leone has an average of 4.6 treatment beds for each case of EVD. However the major spread was into Freetown and since has spread to most parts of Sierra Leone. As of December 2014, the epidemic is still out of control in much of Sierra Leone, with new areas of Kono and Koindugu infected as well as the Freetown area, where a third of cases are occurring now. As of 7 January 2015, there had been 900 cases in the previous 21 days with a cumulative total of 9780, making it the hardest hit of the three countries. There were no new health workers infected with Ebola during this time in Sierra Leone.

In **Liberia** the surge in cases started in July, and much of that was in Montserrado County, which includes Monrovia. A large effort to build treatment beds in Monrovia and a comprehensive Safe and Dignified Burial program by the Red Cross helped halt transmission and bring the numbers of new cases each day to single digits. Even with the small numbers of new cases, the potential for flare up still remains, as was seen with the recent outbreak in Grand Cape Mount County. Leadership from the Ministry of Health through the Incident Management System (IMS) has been particularly strong. During the 21 days leading up to 7 January there had been 70 new cases against a total of 8,157 cases to date. Most of the new cases are in Montserrado, where there is good access to beds. There is an average of 15.1 treatment beds per diagnosed case of Ebola; though the distribution does not match the location of new cases. However, the distant locations of some new cases are a warning that there is still considerable work to be done before zero new cases are reached. There were no health workers diagnosed with EVD during the most recent period of time.





6. CONTROL OF EBOLA

Among the 23 outbreaks of Ebola in Africa, all have been rural in origin, with some previously spreading into hospitals located in small towns. This West African epidemic has demonstrated the consequences of failing to keep the epidemic contained in the rural areas, as the nature and difficulties of control are exacerbated once spread to urban areas. As a public health disaster, the course of the Ebola epidemic and the nature of response is considerably different from other disasters which move predictably from more acute to less acute needs.

The control of the Ebola epidemic can be summarized as three interrelated public health principles:

1. Recognition of the Ebola infection
2. Infection prevention and control measures
3. Treatment of those suspected and confirmed as having Ebola

These three principles are captured in the five-pillar activity approach which includes, 1) social mobilization and beneficiary communications, 2) safe and dignified burial, 3) psychosocial support, 4) tracing and monitoring of contacts and 5) clinical case management.

The Red Cross has played a major role in all three elements during this epidemic. Different elements are important at different phases in the epidemic. No single organization has the capacities for all of these activities, but the Red Cross and Red Cross volunteers are well placed in communities to play a major role in all control activities, working closely with the district or county health teams. As the epidemic phase shifts, the nature of these roles needs to shift as well. The epidemic is currently at one of these inflection points.

With these efforts by the Red Cross and others around the five pillar approach, why has Ebola still not been eliminated and what will be necessary to finally eliminate Ebola? The major reasons fall into several areas.

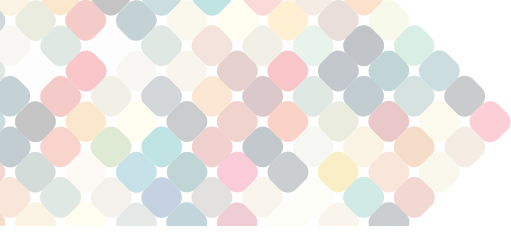
1. Cases are being missed or not quickly identified

This represents a failure of active surveillance—going to look for disease. This is a community based activity that is done working with district and county health teams. People in the community maintain regular surveillance for the sick and those coming or leaving the community. This is working with the existing local health system. National authorities take these data to understand national and local patterns. The Red Cross volunteers do contact tracing in many places, which is following contacts of known or suspected cases, so ramping up this effort toward more active case finding is possible with some additional training and coordination.

- Communities still fail to recognize Ebola virus disease through misconceptions or active re-sistance
- Increasingly, Ebola is infecting remote areas where communication is poor. It is estimated that for every known Ebola case there are 1.5 unreported cases.

2. Infection prevention and control measures are inadequate:

- At the household level when people become sick, those who care for them need protection. There have not been adequate provisions to assist in caring for the sick at home before being transported to a treatment center.
- With early recognition, others must be protected against infection until the person with Ebola can reach treatment. Community care kits can reduce risks of infection, along with safe transportation.
- Hospitals and clinics often play a role in spread of Ebola. Major deficits in infection prevention and



control measures were found in health facilities in six districts of Sierra Leone, and similar findings for Liberia were reported at the IMS meeting in December.³ Continued training and vigilance are needed for hospital workers to avoid infection.

- Safe burial practices can prevent transmission of disease. This has been a major contribution by the Red Cross to Ebola elimination. Maintaining personal protection for the teams and drivers requires continued vigilance.

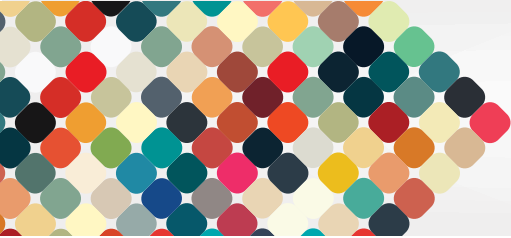
3. Treatment of those suspected or confirmed with Ebola

- Isolation and treatment must start as soon as there is suspicion or diagnosis of Ebola, but there are still not an adequate number of beds in the right places.
- As the infection is spreading into remote areas, this becomes an increasing challenge.
- Structuring ‘hubs’ for rapid response, as the Red Cross has begun in Liberia or rapid construction of ETCs, as the Red Cross has now done in Kono will facilitate more rapid treatment.
- Transportation of suspected or confirmed patients remains a huge challenge.
- Treatment includes rehabilitation and recovery. Helping people to get their lives back is both a treatment and a humanitarian task.

These three fundamental principles are useful to measure and assess the success and the deficits in the application of control measures. Understanding these will help Ebola control programs such as the Red Cross, to identify weaknesses that the virus can exploit in the communities that their volunteers serve. This will help elimination programs to get ahead of the epidemic curve, instead of just being reactive to new directions of the outbreak spread.

The critical information needed during an Ebola outbreak comes from the field sites. It is the lack of accurate field data that resulted in the resurgence of Ebola after April/May 2014. Although many organizations work with these data, it is still collected by local staff of the areas involved. The quality of the data used for epidemiological trends and estimated outbreak development is only as good as the data collected, about the epidemic. The Red Cross volunteers have been very active in the contact tracing/ monitoring in the three countries, working in collaboration with local district and county health teams, often taking on surveillance work beyond just contacts. The area of surveillance is one of the key areas that need to expand to eliminate the disease.

³ CDC. Rapid assessment of Ebola Infection prevention and control needs—six districts, Sierra Leone, October 2014. MMRW 2014; 63:1172-74.



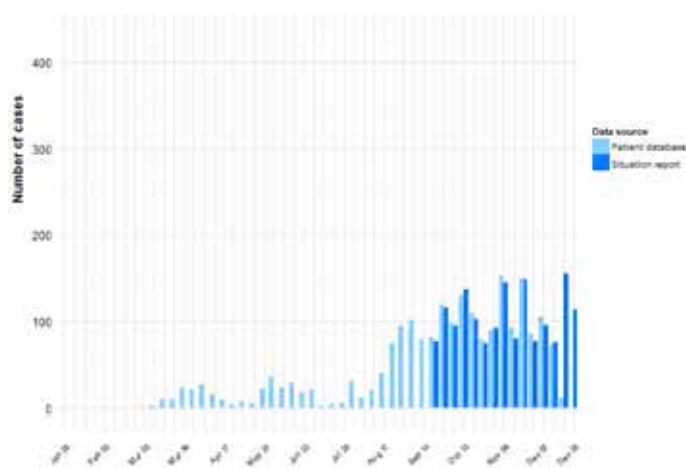
7. THE GUINEA RTE REPORT



Red Cross National Society headquarters, Conakry, Guinea
Photo Alexandra Murray

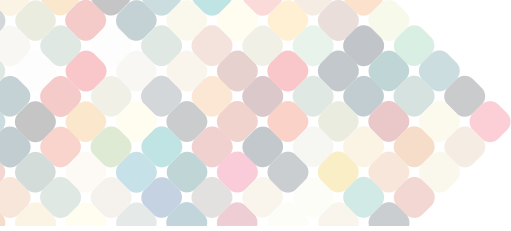
FIGURE 2. EBOLA IN GUINEA

National data



Conakry





7.1. BACKGROUND AND SUMMARY

The index case of Ebola occurred in Guinea in December 2013, and reached the capital by March 2014. In April 2014 a FACT team was deployed. Shortly after that, ERUs for logistics and health were deployed. The Appeal was launched in April 2014 for 1.2 m CHF, and revised in June and November, the last being for 28.7 million CHF. By August, 15 of the 33 districts in Guinea had confirmed cases. The Appeals and the Emergency Plan of Action are found in Annex 2.

The Ebola epidemic disease pattern in Guinea demonstrates great fluctuation. There has not been substantial change in the total number of new cases reported for the past 2 months. However, the number of new cases is increasing in districts previously only lightly affected and decreasing or persisting in others. Point epidemic transmission continues to surge in the capital Conakry. Major challenges for Guinea continue to be the geographic challenge for rapid response, mobility of the population, and the community resistance to Ebola control efforts in many areas of the country.

The information in the following sections was gained through interviews and group discussions as well as a review of relevant documents. A list of people interviewed is found in Annex 2.

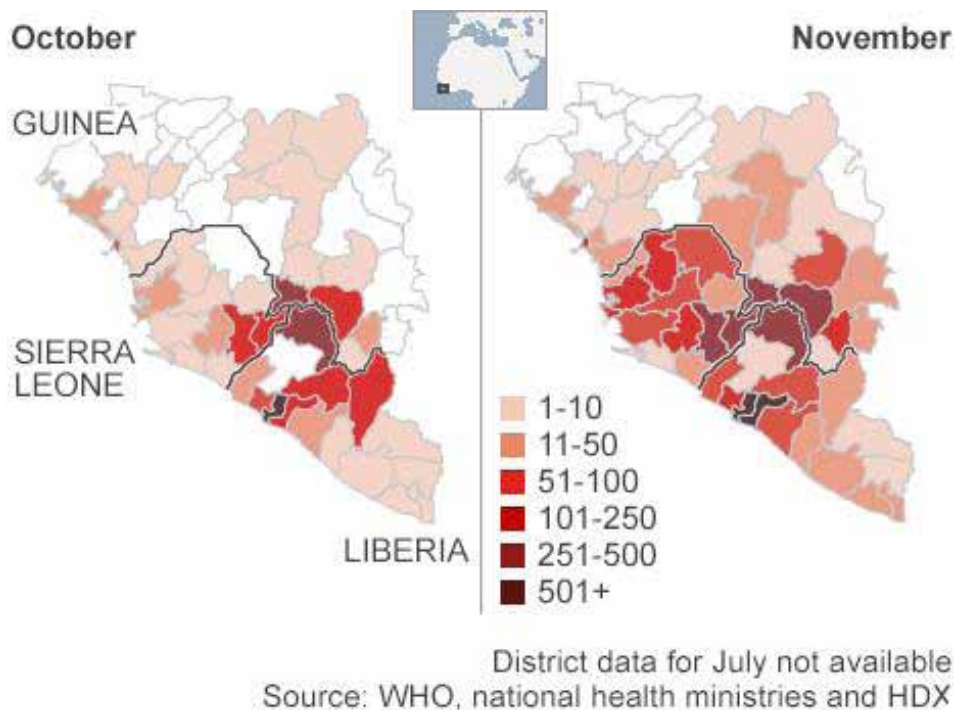
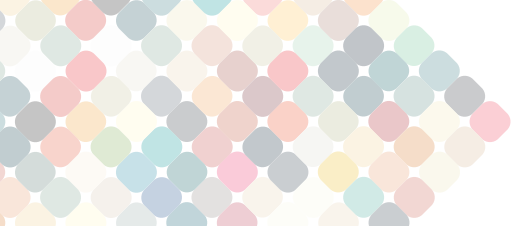


Figure 3: Ebola incidence Oct and Nov 2014



7.2. GUINEA FINDINGS

1. UPHOLDING POLICY

1A. Red Cross fundamental principles

Impartiality

The Ebola RTE found no evidence that the GRC was favoring any particular political or ethnic group. The GRC has volunteers of all ethnicities throughout the country. The Red Cross has provided assistance according to people's needs.

Independence

While working with the Ministry of Health and other government structures, the Ebola response has maintained an independence of action from the government – working as auxiliary to government and collaborating as necessary for the effective delivery of activities. There have been rumors in the community that the Red Cross is working in collusion with the government, bringing the Ebola virus to kill people for population control or to harvest body parts; these rumors are clearly false.

Voluntary service

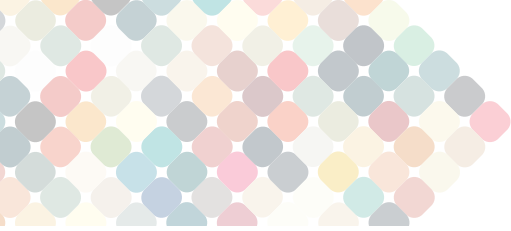
The strength of the Guinea Red Cross National Society is its network of volunteers. The GRC has a duty of care to help volunteers protect themselves from exposure to the Ebola disease and from other risks in the community arising from their work. Currently there are some volunteers dissatisfied with the lack of support, both personal and operational, being provided to them by the GRC (lack of morale support, and in some cases lack of sufficient operation supplies/equipment).

1B. Principles and rules for the Red Cross and Red Crescent Humanitarian Assistance

Red Cross volunteers in Guinea face occasional security threats in the community, particularly around Safe and Dignified Burial (SDB) activities. In some villages, community members are reluctant to allow the Red Cross to enter and conduct dead body management per Ebola protocols, and at times this has caused tension and conflict between community members and Red Cross volunteers. While the RTE evaluators were in Guinea in December, a team of SDB volunteers was attacked in Conakry. The team was forced to retrieve a buried body, and the SDB vehicle was destroyed.

To improve the security of volunteers, the GRC has begun negotiating with the Guinea government and law enforcement to resolve issues with resistant village members. For villages where community members are believed to be hostile to the Red Cross, the local police will precede to the village in advance, to facilitate access and ensure the community is receptive to the GRC entering their village to conduct SDB.

The GRC and IFRC should be mindful of how these security developments may alter the perception of the Red Cross, or change the relationship between the Red Cross and the Guinea government. This evolving relationship should be considered in light of Red Cross principles and the IFRC's duty of care toward



volunteers. At present, the relationship with the Guinea government does not seem to be jeopardizing Red Cross principles, but it is not unthinkable that this cooperation with the government may develop to undermine, or give the perception of undermining, Red Cross guiding principles.

2. RELEVANCE AND APPROPRIATENESS

General approach

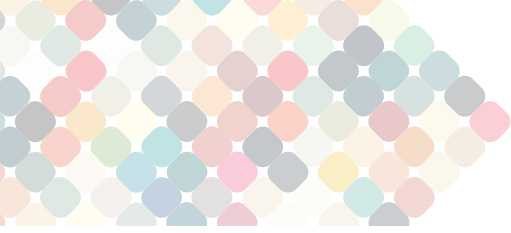
Relationship between IFRC and GRC

The IFRC exists to support and coordinate local Red Cross National Societies in an emergency response. The IFRC is a supporting partner organization to the GRC and is auxiliary to the Guinea government. The GRC is acting as an autonomous organization and is auxiliary to government in the Ebola response. The GRC receives financial support from other partner national societies (PNSs) and from external organizations (including UNICEF) although at present the IFRC is the largest financial contributor and closest operational partner.

Despite the financial support that the IFRC is providing to the GRC, the IFRC seems to have limited influence to effect necessary change within the GRC. Many interview respondents, within and outside the Red Cross movement, commented on the weak leadership capacity of the GRC, in terms of its ability to implement activities, supervise and report on operations, and manage finances (issues that are discussed in more detail below). Because of this, the IFRC is in turn struggling to implement activities - the GRC is slow to respond to suggestions, and not able to spend and acquit money or use resources as fast as necessary. The current IFRC leadership does not want to push the GRC too forcefully, because it believes that additional pressure on the GRC would have a deleterious effect on their relationship and would create more blockages. This relationship dynamic between the GRC and IFRC - with the GRC not able to deliver sufficiently, and the IFRC not wanting to be too patriarchal - is a key characteristic of the Guinea Ebola response at present. Some IFRC staff in Guinea believe the IFRC should be more heavy-handed and hold the GRC to account, while others believe that the current soft approach is crucial, given the expectations and local culture within the GRC.



Figure 4: RTE team Coyah branch GRCs



Operational approach

Another issue in terms of the general operational approach of the IFRC response is the current focus on Safe and Dignified Burials (SDB). In August, a series of multi-agency negotiations led to the establishment of different sector activities and lead organizations (for communication, case management, contact tracing, etc.) with the Red Cross taking a lead role for the SDB sector. Since that time, the GRC has focused heavily on SDB, resulting in strong capacity and delivery of SDB activities, but at the expense of other activities, particularly social mobilization, contact tracing and psychosocial support. In the first three months of the outbreak, the GRC was a key partner in social mobilization, whereas now it has only minimal activities in this sector. In the following sections of this report, the RTE argue that the GRC should maintain its commitment to SDB, whilst scaling-up collaborative social mobilization and communication activities with a short-term behavior-change campaign and ongoing village-level activities. The GRC should also consider options for involving Red Cross volunteers in contact tracing and for providing psychosocial support to community members.

2A. Needs assessment including prediction and analysis

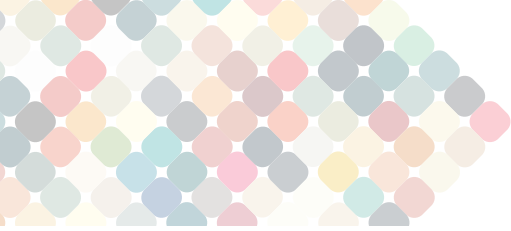
Information needs

Decision support and planning

The IFRC's Guinea Ebola response evolved throughout 2014 as a result of many formal and informal processes and decisions. The efforts of the IFRC to collect information for decision-making were stronger at the beginning of the outbreak than they are now. In the first two months of the outbreak, the IFRC used a range of needs-assessment tools for prediction and analysis. In late March, the IFRC deployed a FACT team to Guinea to assess the needs on the ground, followed by an ERU in April. The early efforts at needs assessment were a positive step and helped to inform the Ebola activities not only of the Red Cross but of other agencies as well. The WHO and other UN actors did not conduct their first fact-finding missions until several months later.

Currently, broader strategic decision-making within the GRC and Guinea IFRC is informed by information collected and disseminated from external actors, such as the MoH National Ebola Coordination Committee. The GRC's and IFRC's decision to focus on SDB was made in collaboration with the National Ebola Coordination Committee and other UN partners in mid-2014. Any large-scale changes to the GRC/IFRC Ebola response will likely occur only in response to partner-wide negotiation.

The IFRC and GRC leadership are aware of trends in case numbers and locations; for example, knowing which regions in Guinea has recently had no cases, suspected cases, newly confirmed cases, and existing cases. But it is unclear how up-to-date this information is and whether day-to-day epidemic trends are communicated to community-level management within the GRC. At the time of the RTE, neither the IFRC nor the GRC had an epidemiologist or health specialist to assess current and future outbreak trends for the purpose of planning activities. Actions have been taken since the RTE field visit to counter this insufficiency. Current program planning is often in reaction to overall outbreak developments, rather than proactively in preparation response to surveillance information.



The IFRC in Guinea is collecting limited information in terms of monitoring and evaluation of internal operations. Logistic needs are reported from the field to the Conakry office through internal mechanisms. Programmatic needs are identified informally through the GRC's chain of command. Most day-to-day decision-making is decentralized and happens at the field level in response to locally gathered information. We were told that the IFRC office in Guinea submits weekly monitoring reports to the regional and zone IFRC office. It seems this reporting is performed more for communication with the IFRC zone office and donors, rather than for operational oversight or for adaptive program management.

The Guinea IFRC has initiated a data-collection system to collect real-time information on SDBs using Magpi survey software. A questionnaire has been designed and volunteers of 3 counties have been trained with the intention of training all counties, but while the RTE were in Guinea the Magpi survey had not yet been implemented. If successful, the data collected through this survey will be a positive development and highly valuable for the Red Cross. However, it will be important for the IFRC Guinea office to ensure that data collected through the Magpi system is used as planned, and that it does not become cumbersome or distracting for volunteers.

Beneficiary Communications

The Beneficiary Communications department is planning three mini-KAP surveys in regions with different caseload profiles. This is a good initiative and will help IFRC to craft effective messages. The importance of community consultation (in the form of a KAP survey or otherwise) cannot be overstated, particularly for improving behavior change communication (BCC). Many of the IFRC's activities depend on effective BCC messaging, be it during social mobilization, SDB, or other activities.

Security

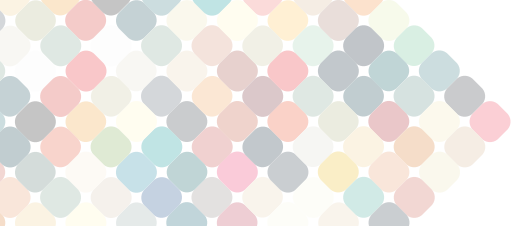
The Red Cross system for communicating security alerts seems to be working effectively. The ICRC's collaborative involvement with IFRC in the Guinea Ebola response is currently limited to security matters, and is effective. Respondents within Guinea IFRC were happy that they were receiving timely information about security alerts (which the RTE team witnessed during our week in Guinea). The rapid distribution of security information is especially important in Guinea, where volunteers in parts of the country face tension and antagonism from reticent community members.

2B. Is the IFRC 5 pillars strategy delivering appropriately?

1. Social Mobilization and Beneficiary Communication

At the start of the outbreak, social mobilization and beneficiary communication was the largest component of the Guinea Red Cross Ebola response. Volunteers were trained on key messages for Ebola prevention and control. By June, these social mobilization and beneficiary communication activities were linked with similar activities of other organizations; UNICEF became the sector lead for communications and a subset of Red Cross volunteers participated in communication activities as part of a unified multi-agency campaign.

In August, following a series of multi-agency coordination meetings across the region, the focus of the Guinea IFRC activities changed. At the request of coordination bodies, it was agreed that IFRC would scale



back its communication activities and instead become the sector lead for Safe and Dignified Burials (SDB). As a result of this coordination decision, social mobilization is now no longer the primary focus of GRC or IFRC activities. At the start of the outbreak, Red Cross volunteers were trained and equipped to do social mobilization door-to-door in their community. This is no longer occurring. It may be that volunteers are doing this of their own accord, but there is no strategy or supervision of these activities.

The SDB volunteers that the RTE spoke to were not aware of what the other Red Cross volunteers were doing in Guinea. Some SDB volunteers said that former social mobilization volunteers are still working to develop radio spots and ad hoc mass communication events to improve community understanding of Ebola. This is commendable; but the proposition value of the Red Cross in Guinea is having people based on the ground in villages throughout the country; these volunteers should continue to be used for door-to-door communication activities.

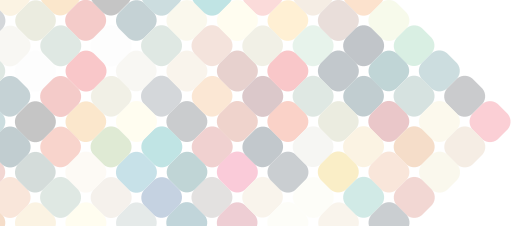
Several interview respondents talked about how the term “beneficiary communication” in the Ebola crisis differs from beneficiary communication in other crises, and that this causes some confusion. Typically, the IFRC does not view beneficiary communication as a sector activity in itself, but rather as an activity to accompany and complement other relief activities (food distribution, NFIs, shelter, etc.). For Ebola, however, beneficiary communication is a core activity.

Communicating with the population to promote disease awareness and behavior change is a cornerstone activity for halting the transmission of Ebola and arguably the only activity that will eventually stop the spread of the disease. In early 2014, some departments within the IFRC seem to have been slow to realize the importance of beneficiary communication for Ebola, and were slow to allocate sufficient resources to it. The recognition of the importance of Beneficiary Communication was cemented at the Dakar Communication Forum 8 and 9 September, hosted by IFRC. Since this forum, however, beneficiary communication does not seem to be receiving the attention it warrants in terms of HR capacity: the number of beneficiary communications staff in Guinea is limited; some of these people have a background in beneficiary communications, as traditionally understood by IFRC, but not a technical background in behavior change communication (BCC) or health promotion.

The inclusion of a social mobilization volunteer as part of each SDB team is an important development, although the addition of extra people to SDB teams may strain resources. There may also be some difficulties putting this plan into practice. The RTE spoke to some SDB teams that consisted of only 4 or 5 people. It is unclear if every SDB team is, in reality, being accompanied by a dedicated social mobilization volunteer.

2. Safe and Dignified Burial

This pillar represents the biggest component of the Guinea Red Cross and IFRC response at present. Red Cross volunteers have been engaged in SDB from the beginning of the outbreak, but since August when the Red Cross movement agreed to be the sector lead for SDB, it has become the cornerstone of the Red Cross’s activities. This is appropriate and an enormous contribution to the overall Ebola response in Guinea. It is not clear which organization in Guinea would have the capacity or willingness to take over SDB if the Red Cross were to stop its activities. The GRC and IFRC should continue to scale-up SDB activities as needed. The Red Cross recently expanded the SDB team model such that it now includes



7 volunteers, with one of these volunteers being dedicated to social mobilization activities. The mandate of the SDB teams has also been expanded to include preliminary contact tracing (discussed below). Although the current SDB strategy is robust and appropriate, there are some issues with implementation and quality assurance. These issues are discussed later in this report.



Figure 5: Dead Body Management kit.

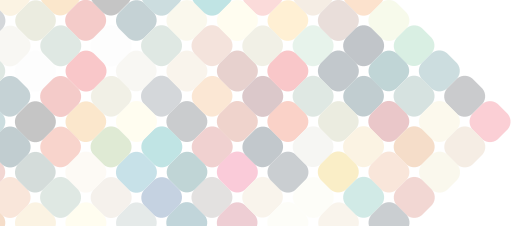
3. Clinical Case Management

The French Red Cross are managing an Ebola Treatment Unit in the south of Guinea. We were unable to talk with staff from the French Red Cross or talk to anyone who could offer meaningful comments on this activity.

4. Psychosocial support

Psychosocial support (PSS) for the community has been established as an important aspect of the Ebola outbreak response in an effort to counteract community stigma and fear. In Guinea, initial volunteer training was supplemented by general PSS preparation from the PSS expert on the IFRC FACT team. This consisted of discussions about methods of community approach, managing case-related situations, and mitigating panic and misinformation. However, continued updates for this aspect of the Ebola response have been absent. Other planned activities such as the provision of individual counseling and home-based care within the community were not implemented and assistance with community reintegration for recovered patients was minimal. Red Cross volunteers told the RTE team that the original PSS training could have benefited from additional follow-up, particularly to assist in communications with reticent villages. Further direct usage of PSS techniques was not evident, although volunteers individually tended to end up developing a sense of this approach.

Psychosocial support for the volunteers themselves remains minimal. Few resources exist within GRC for volunteers experiencing stigmatization or anxiety about their work with Ebola. Volunteers have been trained in PSS, but no SDB volunteers in Guinea have received one-on-one psychosocial counselling. A staff member within GRC has been appointed for PSS activities and sits as part of the National Ebola Commission.



5. Contact tracing and monitoring of patient contacts of Ebola

At the start of the outbreak, templates for case-based data collection were created by the coordinated efforts of MoH, WHO, and CDC, and utilized by all organizations across Guinea for contact tracing and follow-up. Any suspected clinical cases encountered in the community or at local health centers are recorded by MSF or GRC, and the relevant MSF or WHO surveillance officials are deployed to interview the patient and record possible contacts. The complete epidemiology database is managed by WHO and CDC representatives in Conakry. Resistant individuals, false community beliefs, and ease of travel within and across country borders have hampered contact follow-up.

The current involvement of GRC in contact tracing is minimal. Recently, “preliminary contact tracing” was integrated into SDB protocols. Now, when an SDB team retrieves a body from the community, a volunteer sits with the family and records all of the victim’s contacts. This contact list is sent to the MoH for follow-up and contact tracing is coordinated by UNFPA.

As with social mobilization, this is a pillar in which the Red Cross could potentially be more engaged. The Red Cross could join efforts by other organizations in select locations, with volunteers perhaps being supervised directly by UNFPA to mitigate the need for more management resources within the GRC.

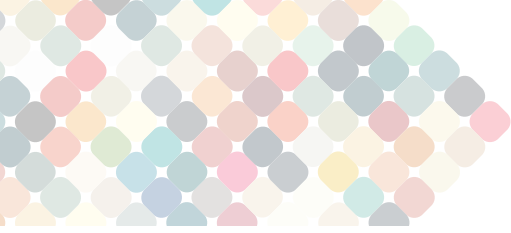
2C. Is the regional appeal relevant and appropriate?

This is discussed separately.

2D. Is the response strategy balanced with realistic donor expectations?

There is some tension between donor reporting demands, and the ability of in-country staff to provide steady information. The Guinea IFRC staff reported feeling overwhelmed by the need to provide information to regional and zone offices as frequently as they are requested to do so (i.e. directing scarce resources to donor reporting at the expense of effective implementation). Recently the three countries were requested to send updated reports to the zone office every second week, rather than weekly. The zone office approved this, but staff in Resource Mobilization are concerned that this will impact the ability of the Red Cross to meet donor expectations.

Although the RTE team did not look closely at financial reports, it appears that the GRC is not implementing activities or spending money as quickly as agreed in activity plans and donor appeal documents. It is not clear how big an issue this is for donors. For all future appeals and resource mobilization, IFRC staff should be mindful of the GRC’s ability, in reality, to implement activities.



3. EFFICIENCY AND EFFECTIVENESS

3A. How well is the operation delivering on existing needs identified?

The Red Cross achieved a positive reputation by acting quickly in the outbreak in March and April. The GRC is still one of only a handful of organizations that are contributing substantially to on-the-ground activities in Guinea. Many actors speak highly of the work conducted by the GRC and IFRC. The operation is delivering well in some areas, particularly in SDB. But as good as these activities are, the Red Cross has been slow to scale-up and is not responding well to current demands and opportunities.

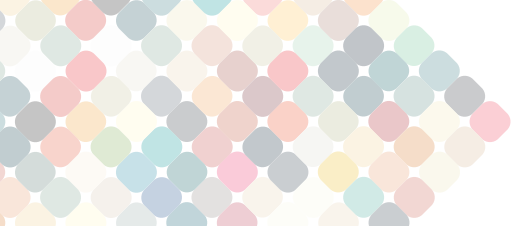
As discussed above, currently the most functional components of the Guinea Red Cross response are the Safe and Dignified Burial (SDB) teams. These SDB teams are doing excellent work, but morale is low, the volunteers are exhausted, they have not received any meaningful psychological counselling, and in their own words, “we feel abandoned”.

Guinea IFRC and GRC have sufficient funds to scale-up activities (and they desperately need to do so) but the GRC is a bottleneck, in many ways: financial processes (spending money and acquitting financial advances); implementation of new/expanded activities; recruitment of necessary personnel to implement activities; supervision and reporting on activities; and appreciation and recognition of staff and volunteers.

The GRC is hierarchically managed and does not seem able to act quickly. The GRC leadership is slow to achieve internal consensus and communicate decisions constructively and in a timely fashion. The GRC is continually slow to acquit funding advances, and often claims to the IFRC and other partners that it does not have enough money (even though a backlog of money is waiting with the IFRC to be transferred to the GRC). Some suggest that the GRC President is an impediment to functional implementation and there are rumors of internal political disputes within the GRC headquarters. The GRC is also slow to implement activities. A reasonable staffing structure exists, but the systems and processes to accompany this staffing structure are not in place. (For example: activity reporting is minimal, no lists of volunteers were attainable, no timely requests for logistics/inventory, no communication protocols.) Staff of external agencies (non-RC) also say that the GRC head office has limited capacity for financial and HR management.

A new committee internal to the GRC leadership has been established - the GRC National Ebola Commission - which the Guinea IFRC staff hope will expedite decision-making. The head of this National Ebola Commission is the Vice-President of the GRC, who has been given authority to approve Ebola management decisions directly. It has yet to be seen what impact this new structure will have on operations, although in principle it is a positive development.

The GRC supervision structure in the field is currently being reinforced, which is positive: the GRC is recruiting Zone Supervisors, and IFRC are deploying technical delegates as counterparts to these Zone Supervisors. The GRC have specifically expressed a desire for more technical support from IFRC in quality assurance. When we asked the GRC leadership what they wanted from the IFRC, they said: “We need more skills, more technical expertise to make sure that what we are doing is correct. We have been doing this for so long; we need someone to check our work.” This is a positive sign of self-awareness and capacity, and represents an opportunity for the IFRC to engage more proactively with the GRC.



3B. Systems: Are the existing IFRC systems and structure (including response tools) appropriate to deliver efficient and effective response to the outbreak?

A Field Assessment Coordination Team (FACT) team consisting of an IFRC team leader, an epidemiologist, and a psychosocial support expert was deployed to Guinea in March for three weeks following the initial outbreak declaration to evaluate the situation. By all accounts, the FACT was effective and made a great contribution not only to the Red Cross Ebola response, but to the response of other actors as well.

The experience of the ERU was also positive. A Regional Disaster Response Team (RDRT) team composed of representatives from other African countries' National Societies was sent as assistance for logistical and operational capacity support, particularly to ensure volunteer safety. Additional IFRC delegates, including an operations manager, were appointed in April to manage operational issues.

There is currently no monitoring and evaluation system used to track activity efficiency and facilitate operational adaptive management. Reporting structures are nominally used for understanding what resources are being used on the ground and there is no meaningful planning or strategy for analyzing data from the field. Information systems are not in place to collect and analyze data, which leaves the emergency response open to operational inefficiencies.

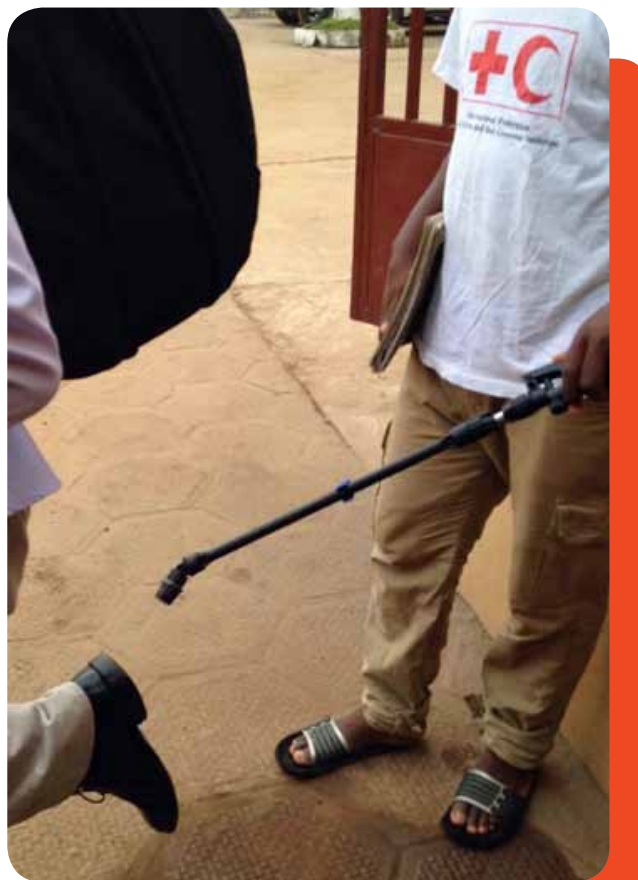
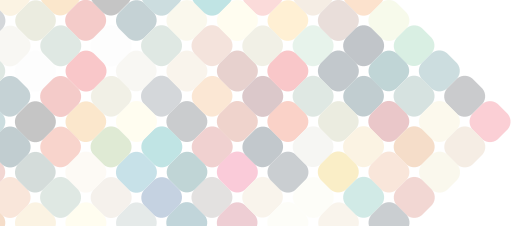


Figure 6: Sanitization of shoes with chlorine.



3C. Use of resources: How effective and efficient is the system to mobilize and utilize resources (financial, HR or others)?

Human Resource recruitment has been one of the biggest challenges of the Ebola response, for Guinea and other offices. The Country Representative in Guinea said he spends much of his time involved in staff recruitment (a sentiment echoed by the Regional HEOP). There is now a regional HR delegate, but the work required to recruit new staff is still overwhelming. The Guinea IFRC office recently submitted a new HR plan that will involve the recruitment of many more positions. Filling these positions with high-caliber francophone staff should be a priority for IFRC Nairobi/Geneva. As should the recruitment of a new sufficiently experienced Operations Manager. The HR department in Nairobi and Geneva have worked tirelessly and successfully to recruit many delegates to the Ebola response in difficult circumstances - and this should be commended - but the fact remains that mobilizing sufficient delegates (with the necessary technical and language skills) is a key challenge of the Guinea operation.

The GRC National Society faces similar HR recruitment issues. We are not clear what the bottlenecks are for recruitment at this level and whether and how IFRC can support local recruitment.

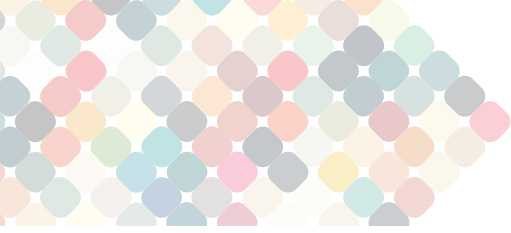
Within the GRC there are also financial system issues. The IFRC finance delegate (who has been with the Guinea Ebola response since April) said that the GRC is frequently slow to acquit funding advances. The IFRC has plenty of money in its reserves, and is happy to send this money to GRC, but the GRC is not able to process its paperwork quickly enough. The Guinea IFRC team has suggested to the GRC that an IFRC delegate support the GRC finance team to manage these financial processes, but until now the GRC has been resistant to this idea.

As noted, resource utilization and Red Cross progress against targets is not tracked. Monitoring and evaluation will enhance efficiency and facilitate adaptive management of the programs.

3D. Timeliness: Are services being delivered within adequate time?

Timing is an issue for many aspects of the Ebola response. There is a real-time need for SDB teams to respond to Ebola cases rapidly when they receive an alert of a dead body in the community. If a dead body is not attended to quickly, there is a greater chance that reticent members of the village will take matters into their own hands and, as a result, become infected. The timeliness of SDB activities depends on a number of factors, including the availability of trained volunteers and sufficient logistics and resources (including available vehicles, available Dead Body Management kits and available PPE). At the moment, there seems to be no problems in this area - volunteers and GRC staff said that on the whole, the SDB teams were doing a good job getting to dead bodies quickly.

Another broader timing issue concerns the strategic decision-making of the GRC and IFRC to scale-up activities in geographical areas with new or suspected Ebola cases. Rather than respond reactively to reports of new cases in new areas, the GRC should proactively scale-up in non-Ebola areas to “get ahead of the disease” and begin social mobilization before the disease arrives.



3E. Coordination

1. Is internal coordination within the secretariat efficient and effective?

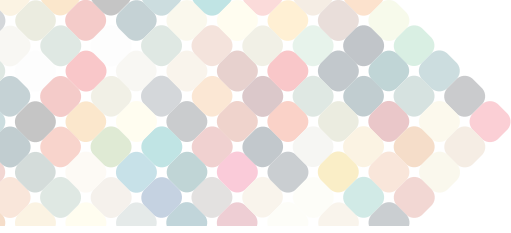
The team in the Guinea IFRC is strong with high-caliber staff at all levels, but the organization of this team and planning activities have not been a great strength of the Guinea operation. The IFRC office has the sense of being a start-up organization that hasn't yet had time to settle and develop effective routines and processes. To an extent this is understandable. From April until August there were only two to three IFRC employees on the ground in Guinea, and with such a small team these people were able to operate fluidly and independently. In the past three months however, the IFRC office has rapidly expanded, and more structure is needed for the team to work efficiently.

There are some positive signs. The office building is practical with enough office space for expansion, and support structures such as electricity, internet, security, and the kitchen are now in place. The delegates are supportive of each other, and on the RTE's last night in Conakry the whole team had a celebratory dinner where everyone seemed relaxed. Under the surface, however, there are management issues; issues that are easily solved, but could be destructive if left unchecked. Staff work hard and there is a sense of fatigue and dissatisfaction.

Management decisions are often made in the corridor, ad hoc, without due process. Office meetings are spontaneous, and when they do occur they are usually overly time-consuming, often without minutes taken or action points identified. The lines of accountability are unclear, with many GRC staff phoning the IFRC Country Representative directly (rather than their IFRC counterparts). There are no operational plans or activity plans beyond the appeal document. Mission orders take too long to approve, resulting in field trips occurring behind schedule. These issues are exhausting many staff members, especially staff who are used to working in high-performing offices. In the past month, at least two delegates decided to leave Guinea prematurely or at the end of their short-term contract, rather than extending.

Coordination with other IFRC offices (Nairobi, Geneva, and Dakar) appears to be working well. However, there have been instances of management decisions taken by the Nairobi zone office that have not been in consultation with other managers, based in Addis Ababa for example, which affect the work of regional managers and delegate's work toward deadlines for external partners and donors.

The overall IFRC Ebola command structure, from the Guinea IFRC office to the regional and zone office, is generally thought to be appropriate by staff in Guinea; although sometimes the large number of people contributing to decision-making causes frustration and confusion. One particular difficulty has been having many regional staff based in Conakry. It hasn't always been clear how these people should work with Guinea delegates; the fact that regional and country delegates sit next to each other in the Conakry office sometimes leads to informal reporting and mixed responsibilities. Regional staff are pulled in to work on Guinea country issues, and the Guinea leadership spends a disproportionate amount of time managing the needs of regional staff. In August and September there were more regional IFRC staff based in Conakry than Guinea IFRC staff. Hopefully these issues will be alleviated now that regional staff are being relocated to Accra.



A final issue is the efficiency of the regional coordination structure and the demands that reporting within the Secretariat places on in-country staff. Many Guinea IFRC staff feel burdened by the demands placed on them by working at a distance with regional/zone/HQ personnel.

IFRC support staff need information from the field in order to do their jobs, but this requires delegates on the ground to spend valuable time responding to emails and requests for information. Working remotely in this fashion creates inefficiencies. One of our findings discussed below is that there may have been an over-emphasis on recruiting regional/zone staff at the expense of in-country delegates. Rather than focusing on positions that provide remote support, IFRC should prioritize getting quality staff on the ground as part of country office structures.

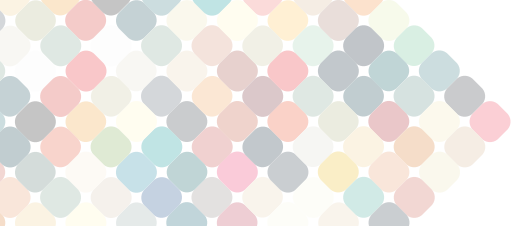
2. Is the coordination mechanism effective and working for all Movement members?

The relationship between the Guinea IFRC office and the GRC National Society has been discussed at length above. As mentioned, the Guinea NS leadership is perceived to be slow and ineffectual, partly due to staffing shortages and exhaustion, partly to due to culture, attitudes and personalities. A new committee internal to the GRC leadership has been established (National Ebola Commission) which the Guinea IFRC staff hope will expedite decision-making, but this has yet to be proved. Until now, the GRC President has been a stumbling block, hesitating on decisions and not responding as quickly as needed to enable effective activities.

Mostly, the IFRC and NS have a good working relationship, but the IFRC has limited influence to shape the actions taken by GRC leadership. IFRC staff are reluctant to deal with GRC mid-management and volunteers without first seeking the blessing of the GRC hierarchy, which is often not forthcoming. As mentioned above, some people we spoke to suggested that the IFRC should be firmer with the GRC, to hold them accountable, force them to act faster, and engage more meaningfully with volunteers. Other people we spoke to said that this would make things difficult and only lead the GRC to close up, and that continuing the current soft, diplomatic approach is best.

One striking feature of the current set-up is that the Guinea IFRC has no staff based in the GRC office, and vice versa. This means all communication is done by phone, email, or during weekly meetings. The IFRC has approached the GRC about having staff based full-time in the GRC office (e.g. a financial delegate to help the GRC with accounting processes), but the GRC were hesitant to agree to this. Working in the same building would help to build trust and respect between the two organizations. It might also increase accountability and speed up decision-making.

ICRC and IFRC are collaborating effectively on security matters. While the IFRC has its own structure for security management (the Geneva IFRC security unit supports the IFRC Security Delegate in the IFRC Sahel office, who in turn supports the IFRC Regional HEOP for Ebola), the Guinea ICRC office also supports the Guinea IFRC office on security matters by sharing information generated through its own security mechanisms. The ICRC in Guinea has no wish to take on Ebola activities itself; rather, the ICRC is happy to continue providing support on security matters and let IFRC take the lead on Ebola programs. The relationships between GRC, IFRC and ICRC seem genuinely complementary and productive. ICRC believes that Movement partners are working collaboratively, however the "IFRC has provided limited



communications as Movement coordination lead". There is also "a need for strong and clear leadership to facilitate coordination and good governance."

There is also good collaboration with other partner national societies (PNS). This is helped by the fact that only a small number of PNSs are involved in the Guinea response. The Danish Red Cross is contributing financially to the GRC Ebola operation has one expatriate staff member based in the GRC office. This delegate was working in Guinea prior to the Ebola outbreak and has an existing relationship with the GRC. The French Red Cross is involved in clinical case management, running a treatment center in the south of the country. There does not seem to be much collaboration between IFRC, GRC, and the French Red Cross because of their geographical location and because of the nature of their activities - the French Red Cross is running an ETU which is distinct from the broader Red Cross operations in Guinea. The fact that there is not more collaboration with the French Red Cross does not appear to be a concern.

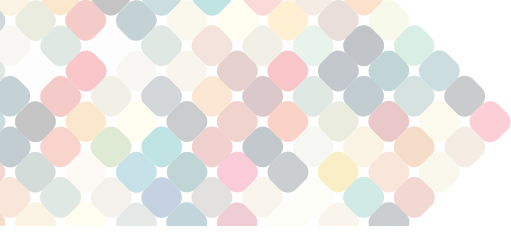
3. Is the coordination with other humanitarian actors effective?

The GRC and IFRC are well-known and highly respected as part of the Guinea Ebola response. "The Red Cross is visible, effective and doing vital work." There are fewer humanitarian actors in the Guinea Ebola response than there are in the Liberia and Sierra Leone response. Aside from MSF and UNICEF, few other organizations are as active as the Red Cross in Guinea. This smaller pool of NGOs makes coordination among partners easier than it often is in humanitarian emergencies.

Currently the National Ebola Coordination Committee meets three times per week. The Guinea IFRC Country Representative attends this meeting regularly, and if he cannot make it, another delegate attends in his place. The difficulty with these meetings is that they take place in downtown Conakry, which in traffic is a one-hour journey from the IFRC and GRC offices (which are located on the edge of the city). Attending this meeting three times a week eats into the Country Representative and Operation Manager's schedule. For this reason, the incoming acting Operations Manager has proposed the idea of delegating responsibility for attending this meeting to another 'liaison' staff member who can be based in the downtown area. This seems to be a reasonable plan, given the already well-established connections with other humanitarian actors, and the routine nature of most coordination meetings at this stage in the outbreak.

Beyond coordination meetings, the RTE saw evidence of effective collaboration with other humanitarian actors, along with several missed opportunities. The Red Cross has an excellent working relationship with MSF, going back to the first month of the outbreak. For their first activities in March and April, MSF recruited Red Cross volunteers as workers for contact tracing and dead body management. These activities were subsequently reclaimed by the Red Cross, with volunteers being employed and supervised by GRC, but with volunteers being trained by MSF. This organizational partnership continues to this day, with Red Cross volunteers who are involved in SDB activities being trained by MSF. By all accounts, the GRC-MSF collaboration is working well.

The GRC has also collaborated effectively with UNICEF, who donated a number of vehicles to GRC earlier in the year, and who lead communication activities in which Red Cross volunteers are involved. When the RTE team spoke to UNICEF, they expressed eagerness to collaborate further for communication and social



mobilization activities. UNMEER discussed potential collaboration activities including field coordination, information sharing, logistics, HR and general attention to the response effort.

There is a communication sector meeting that has recently started in Guinea, in which the IFRC Regional Communications Manager is involved; there is a great need to ensure a presence in this meeting, as communication is a key aspect of the Red Cross response.

Although the abovementioned collaborative efforts are a positive step, there may be potential for GRC to engage with more partners, and more intensively. As discussed previously, the network of Red Cross volunteers is an enormous resource for this epidemic. Red Cross volunteers that are currently inactive could be engaged to participate in activities funded and organized by other agencies (e.g. contract tracing with UNFPA, or communication activities with UNICEF).

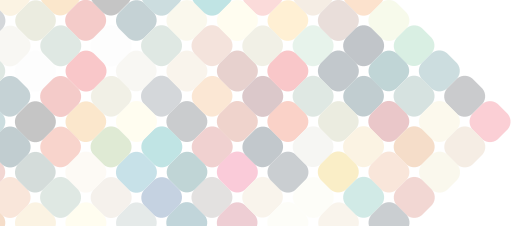
The Red Cross may also be able to identify other organizations to support their own activities and coordination of field teams; for example, humanitarian assistance from another NGO to support families of victims, which could be distributed as part of Red Cross SDB activities. At the moment, the GRC and Guinea IFRC do not appear to be actively seeking out organizational partnerships such as this. Ideally the Operations Manager or Country Representative could engage with counterparts in other humanitarian organizations and reflect on potential partnership opportunities.

3F. Human resource support:

1. Are the safety and support measures (including psycho-social) in place for staff and volunteers effective and relevant?

Many Red Cross volunteers mentioned to the RTE team that they were exhausted and had negative feelings towards the GRC and IFRC management. This was especially true of volunteers who had been working since the beginning of the operation. The most alarming aspect of these comments was the fact that volunteers said they “feel abandoned”, and that “the GRC leadership does not care about us”. One group of SDB volunteers based in Conakry (only 30 minutes’ drive from the GRC office) said the GRC President had come to see them only once throughout the whole year, and during this visit he only spoke to the volunteers’ supervisor. This sense of neglect may seem trivial, but the RTE team believes it is highly troubling in terms of the Red Cross’ ethical responsibilities to ensure volunteers are appropriately respected and rewarded for their work, and in terms of the mental well-being of volunteers. It is paramount to be aware of the potential impact that a dispirited cadre of volunteers, the Red Cross workforce, could have on the Ebola operation.

It is important to note here that the volunteers are not interested in augmenting their stipend or financial incentives (although there have been delays with the payment of per diems which the volunteers would like rectified). What the volunteers are most concerned with is the lack of attention to their wellbeing and lack appreciation for their work, especially given the dangerous work they are doing. One volunteers said, “We [the volunteers] are the Red Cross. We are the ones actually doing the work. There is no one else.” This is a warning sign that urgent steps need to be taken to lift morale within the volunteer corps. Whilst the RTE was in Guinea the first Red Cross volunteer died due to Ebola. This will clearly have an effect on volunteer morale.



The volunteers themselves listed a number of ways in which the GRC and IFRC leadership could increase morale. The first was for the GRC leadership to simply engage with the volunteers more often; for leaders to come to the field, listen to what the volunteers had to say, and appreciate their needs. “The leadership never visits us to see or hear how we are going.” The GRC - like many organizations in West Africa - has an entrenched hierarchy, with many management layers. Volunteers usually only see their direct supervisor.

Another important potential incentive for the volunteers would be the distribution of certificates (“attestations”) testifying to the work that volunteers have done. Certificates from the IFRC will help enable the volunteers get work after the Ebola crisis is over. Another possible incentive mentioned by the volunteers would be to organize celebratory occasions or meals, for example inviting the SDB volunteer teams in Conakry to come to the IFRC Guinea office to share a meal with IFRC staff. This action would be well received and contribute greatly to staff morale and the sustainability of volunteer activities.

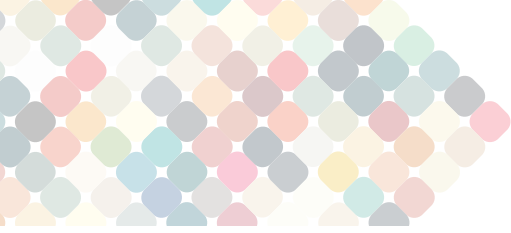
Beyond morale, the IFRC and GRC should also think carefully about the psychosocial support provided to volunteers. Most volunteers have been working for many months without psychosocial counseling. There were PSS training sessions at the start of the outbreak, and again in November, but it is not clear who or what these trainings involved. The RTE saw no evidence of current PSS activities for volunteers (or for community members). The volunteers that the RTE spoke with said they had not received any one-on-one debriefing or counselling from a professional trained to deliver PSS counselling. A Regional PSS Coordinator has been recruited who is French-speaking and will be based in Guinea.

There are still issues with volunteer safety. Over the past three months the GRC has agreed with partner organizations that SDB volunteers will undertake more tasks for each burial (e.g. initial contact tracing, disinfection), but this is draining the volunteers who have not received additional resources or incentives to handle their new responsibilities. The GRC needs to understand the real possibility that without additional quality assurance and additional resources to SDB teams, and without improved support to SDB teams from the community and government, more volunteers are likely to become infected with Ebola, or face further stigmatization and abuse in the community.

The Red Cross needs to consider its responsibilities to SDB volunteers (which may include ceasing activities temporarily while safeguards are improved, rather than putting volunteers at inappropriate risk). When the first RC volunteer died in Guinea on 5th December, neither the GRC nor IFRC had a ready plan to support his family or his SDB teammates. It is not unimaginable that more volunteers will die of Ebola.

As discussed above, Guinea RC volunteers also face security threats in some parts of the country as a result of poor community-humanitarian relationships, and this is jeopardizing operations. The GRC and IFRC should work with the Guinea government and ICRC to ensure that local government and law enforcement support all RC teams when needed (notwithstanding the need to maintain the Red Cross principle of neutrality and independence from the Guinea government).

Finally, there is growing fatigue among staff in the Guinea IFRC office. Staff have been undertaking excellent work, but many feel unappreciated. This crisis has no time limit: to prevent impending burnout and bolster morale, initiatives are needed.



2. Are staff and volunteers equipped and trained to perform the tasks required of them?

There is a need for more health expertise to guide decision-making, and to increase the ability of the Red Cross to engage with partners on technical matters. The health delegates in the Guinea IFRC office staff currently do not have a strong voice. Technical health issues seem to be second-priority to more general operational and logistical issues. One of the few health delegates with hands-on experience fighting Ebola in DR Congo (Dr. Alain) was sent to Mali to guide the operation there.

The establishment of the regional structure in September and October seems to have improved decision-making and coordination. However, there is now some hesitation about the transition to a new Regional Coordinator. During the week that we were in the Guinea IFRC office, we did not see the new Regional Coordinator interacting or supporting local IFRC staff in the way that we expected. Rather, a top-down, traditional leadership style was observed. It is essential that whoever is in this role has the capacity to lead the regional response in a way that adds value and is inclusive and supportive of in-country leadership.

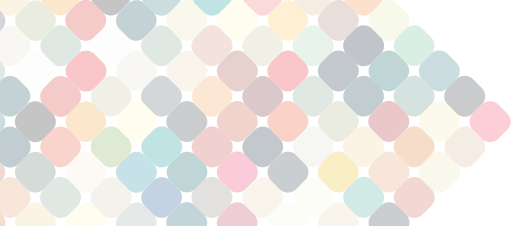
4. CONNECTEDNESS

4A. How well is the operation likely to deliver on predicted future needs?

1. Is the structure and strategy currently in place sufficient to ensure an efficient and effective response for the probable future operation?

The epidemic in Guinea has the realistic potential to worsen. Current case numbers are likely not accurate. Guinea is a big country, with cases spread over a larger geographical area than Sierra Leone and Liberia. The Guinea IFRC and GRC offices are not well positioned to scale-up activities effectively. These offices need to prioritize and establish functional office systems and processes, create more efficient working relationships, procure and recruit appropriate staff to fill gaps and technical support in information management, planning, health (epidemiology), communications, evaluation, and field supervision, to facilitate scaling up of activities.

The current focus of the RC strategy is on SDB. This is a narrow approach for the RC and the need to broaden the response is pertinent for efficiency and future effectiveness to eliminate Ebola disease. There is a need for the RC to scale up and initiate rapid response and preparedness/recovery operations simultaneously to support current and future Ebola needs.



2. How can the operation scale up in an appropriate manner, considering recovery needs of the population and capacities of operating National Societies?

The Guinea Ebola operation is already struggling to implement planned activities. However, the operation does need to be scaled-up and there are some foundational elements in place, such as the model of a SDB team, communication materials, training materials/partner relationships etc. that could be easily scaled in their current format. The existing bottleneck to scale-up is the GRC's organizational capacity to mobilize resources, manage finances, and operationalize activities.

Red Cross volunteers talked about their willingness to be involved in recovery activities. The GRC could begin to plan and integrate (communicate and consult with volunteers) potential post-outbreak opportunities. The GRC need to solicit ideas on how they can best support volunteers now so as to improve their ability to reintegrate into the workforce after the outbreak is over (e.g. linking volunteers to other organizations and/or post-Ebola humanitarian operations). The IFRC should be mindful of the Red Cross legacy post Ebola, empowering the GRC wherever possible to become self-sufficient to combat future emergency events.

7.3. CONCLUSION

The Red Cross is effective, and is doing vital work with SDB in Guinea. The extensive geographical scope, weak national society capacity, and poor organizational processes have limited operations and restricted the effectiveness of the response. Ebola continues to flare and there is a need for both a strengthened emergency response and a preparedness/recovery operational strategy to be implemented. Staff and volunteers need additional support and acknowledgement. A strong emphasis on social mobilization and psychosocial support of communities is required to ensure safety and continuation of the life-force that is the key to the response. A more balanced representation and implementation of the Red Cross 5 pillar approach would benefit the overall outcome and goal to save lives in Guinea and provide an adequate legacy of increased capacity for the Guinea Red Cross to become more self-reliant in a future emergency response.

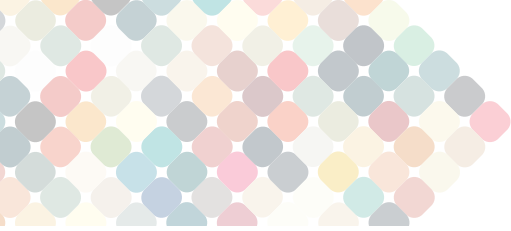
7.4. DETAILED RECOMMENDATIONS FOR GUINEA

IFRC organizational management

- A strong IFRC Operations Manager with proven leadership and organizational management capacity should be recruited to take over from the current acting Operations Manager in Guinea.
- Attention should be given not only to IFRC office processes (program planning, decision-making, reporting and information flow) but also to team-building and staff morale. Management should take the initiative to acknowledge, congratulate and encourage staff at all levels.

GRC organizational capacity

- Action is needed to increase the responsiveness of GRC leadership, which is currently slow and ineffectual, due to staffing shortages and fatigue, and also to culture, attitudes and personalities.
- The new National Ebola Commission within the GRC should be monitored and supported to deliver on its promise of improved decision-making.



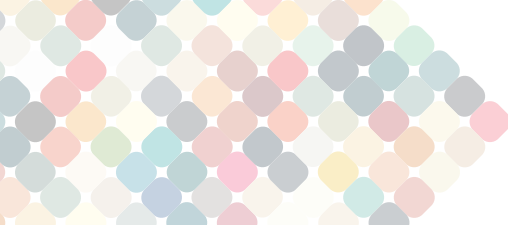

- Where possible, IFRC should provide more technical support and oversight to GRC on programmatic activities, particularly quality assurance for SDB activities.
- The IFRC should consider pushing for IFRC staff to be based in the GRC office, at least part-time (particularly a finance manager to support GRC financial processes).

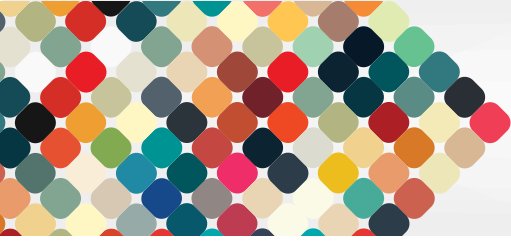
Volunteer safety and wellbeing

- More needs to be done to ensure the safety and wellbeing of volunteers, and to give the volunteers a sense of appreciation and respect. The Conakry-based GRC management, and high-level staff from the Guinea IFRC office, should bypass the field supervision structure from time to time to speak directly to volunteers to hear their frank perspectives and ensure they feel appreciated.
- Additional non-financial incentives should be considered immediately, including acknowledgement certificates, uniforms (t-shirts), celebratory events, and other non-financial incentives suggested by the volunteers themselves.
- Competency-based on-the-job certification for volunteers is highly recommended. Volunteers who perform Red Cross activities to a competent and consistent standard can be assessed through normal channels of supervision and given certification. This certification could become a regular component of Red Cross emergency in-country volunteer training, enabling meaningful volunteer training/assessment, and used to acknowledge excellent Red Cross emergency work, and to help volunteers obtain gainful employment after the outbreak.
- Financial processes need attention to ensure that volunteer per diems are not delayed.
- Red Cross volunteers face security threats in some parts of the country as a result of poor community-humanitarian relationships. The GRC and IFRC should consider options to work with the Guinea government to improve security conditions for Red Cross volunteers, without jeopardizing Red Cross principles. It may be possible for RC teams to be supported by local government and law enforcement during or prior to SDB visits; however, in doing so, the GRC and IFRC must ensure that the principle of neutrality is maintained and the RCRC Movement is not seen as too closely aligned with the Government. These decisions should be made by GRC and Guinea IFRC staff in dialogue with other IFRC secretariat staff in Nairobi and Geneva.
- Psychosocial activities need to be implemented; including one-on-one counselling for SDB volunteers.
- The GRC and IFRC should develop a formal plan or protocol for responding to volunteer deaths due to Ebola and supporting the victim's family and work teammates.
- The IFRC, GRC and ICRC should develop a risk matrix with thresholds whereby activities are suspended until measures are put in place to mitigate dangers, rather than putting volunteers in undue risk.
- No further duties should be added to the list of tasks that SDB volunteers are currently asked to undertake. Additional training and personnel should be allocated to teams that are currently under-resourced.

Program strategy and implementation

- The focus on SDB is appropriate; implementation is good but could be improved, particularly in terms of quality assurance: the IFRC currently has no way of knowing if activities on the ground are, in reality, being implemented according to protocols (for example, SDB teams are meant to have 7 people, but the RTE team were frequently told that SDB teams acted with only 5, 4 or 3 people).
- The IFRC should conduct an immediate rapid assessment to determine the current gaps/needs of volunteers working in a safe environment, in terms of facilities, supplies, and numbers of volunteers. (Some volunteer teams currently do not have a location where they can meet privately and store equipment; instead, they are meeting in a local café and storing equipment in their own homes.)

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- Supervision and quality assurance needs attention: a plan is in place for recruitment and deployment of mid-level managers/supervisors throughout the country, and this needs to be executed as a matter of priority.
 - The network of non-SDB volunteers (currently inactive) needs to be re-activated for social mobilization through intensive training and a dedicated campaign.
 - The IFRC should recruit more delegates with technical expertise in health promotion and BCC skills who can liaise and collaborate with UNICEF and other partners to successfully implement communications strategies.
 - Implementation of a two or three phase simultaneous operational approach to the Ebola emergency response needs to be discussed – emergency rapid response and a preparedness/recovery phase is suggested. Ebola survivors and families of survivors need support and direction to help their livelihoods get back on track. The etiology of the disease and its spread means that both combative measures and prevention of re-infection/recovery activities need to be implemented.
 - IFRC leadership should meet with other sector-lead organizations to determine how Red Cross volunteers could be used to fill gaps in other pillar activities in which they are not currently active (e.g. village-level communication, contact tracing, psychosocial support to community members).
 - The IFRC should urgently discuss with GRC the administrative issues of slow acquittals resulting in late payment of volunteer per diems.
 - Monitoring and evaluation of Red Cross activity will facilitate efficiency through adaptive management. This will support decision making and assist GRCs capacity to plan resource mobilization to match epidemic and community needs.
 - As with social mobilization, contract tracing is a pillar in which the Red Cross could potentially be more engaged. The Red Cross could join efforts by other organizations in select locations, with volunteers perhaps being supervised directly by UNFPA to mitigate the need for more management resources within the GRC.
 - IFRC need to increase information/M&E resources for donor information requirements at best, or negotiate for more relaxed reporting requirements to enable in-country staff to direct their time and resources appropriately (notwithstanding the operational need for timely information).
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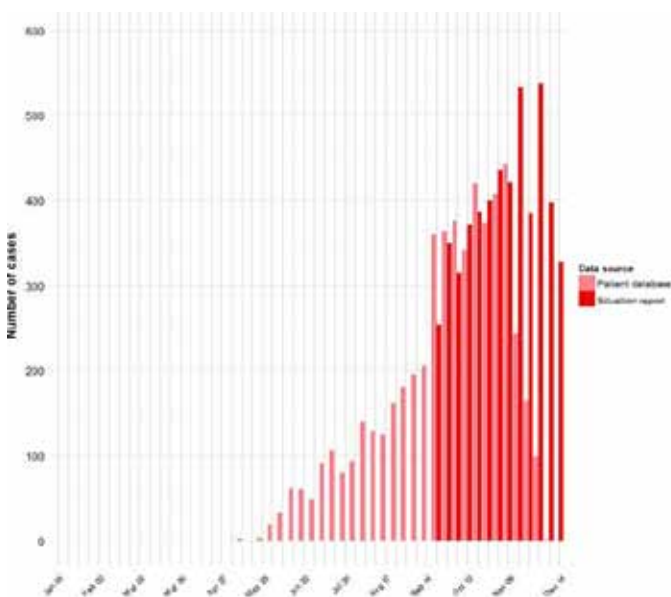
8. SIERRA LEONE RTE REPORT



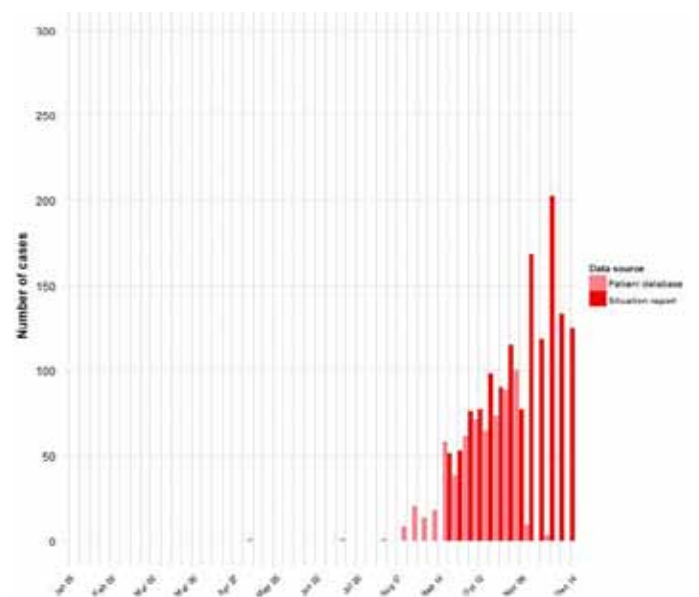
Graveyard, Kenema *Photo Daily Mail*

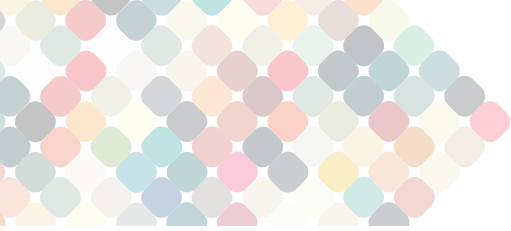
Fig 6. Ebola in Sierra Leone

National data



Freetown





8.1. BACKGROUND EBOLA IN SIERRA LEONE

As the first cases of Ebola were being reported from Gueckedou, Guinea, the Sierra Leone Red Cross Society received its first DREF funds for preparedness. On 26 March 2014 the first infections were diagnosed in Kailahun in Sierra Leone. In response, a FACT team came to Sierra Leone in June and this was followed by a 2nd allocation of DREF funds and the launch of an Emergency Appeal. The team requested the deployment of IT, Logs and Health ERU HR for Kailahun where the first operational hub was set up. In July 2014, a Revised Appeal was launched and an Emergency Response Unit (ERU) was sent to Kenema in August to begin construction of an Emergency Treatment Unit as the treatment of infectious cases in Kenema General Hospital resulted in disastrous infections of health workers and possibly other patients. This area of Sierra Leone had emerged as an area of particularly intense transmission.

The revised Appeal and the emergency plan of action are found in Annex 4, along with the list of persons interviewed for this report.

By mid-July, the Sierra Leone Red Cross Society with support of the IFRC began developing the safe and dignified burial approach to halt the transmission which was occurring from traditional burial practices. This was a steep uphill task requiring excellent communication with religious, traditional and political leaders. Training of volunteers began in the other pillars, as well: Safe and Dignified Burials, Social Mobilization, Beneficiary Communications, Psychosocial Support, as well as the clinical management in the ETC in August. Initial activities were started in Kailahun and expanded to six other districts as the epidemic unfolded. Figure 7 shows the extent of the epidemic at the end of June, 2014. Because of delays in recognizing that the outbreak was indeed not under control, and lack of public health capacity to intervene in key areas, the epidemic has now spread to increasingly-difficult areas to reach.

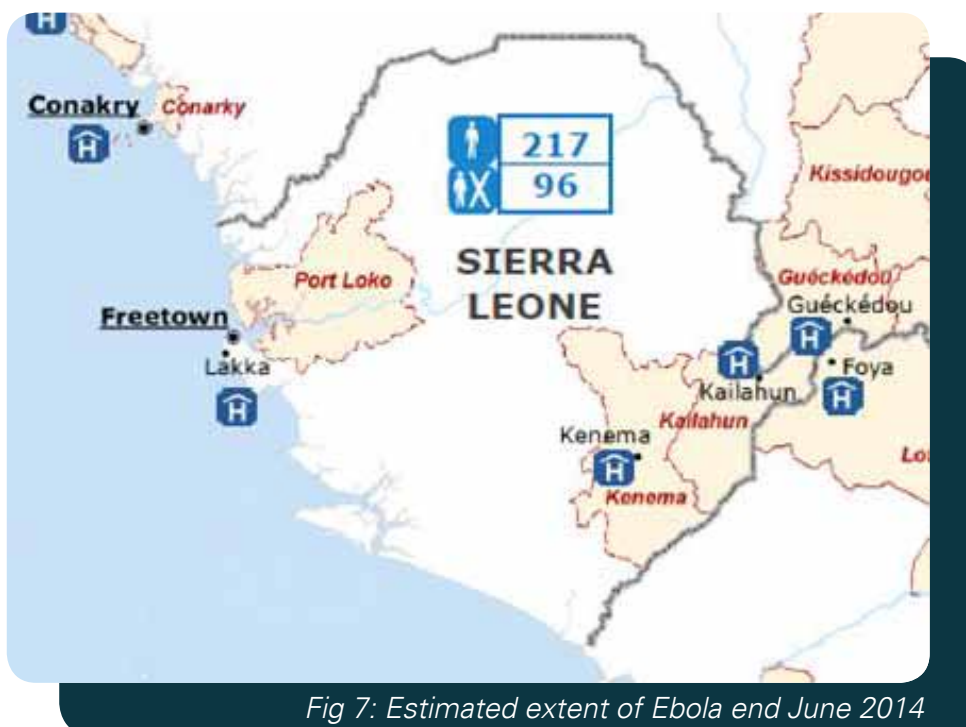


Fig 7: Estimated extent of Ebola end June 2014

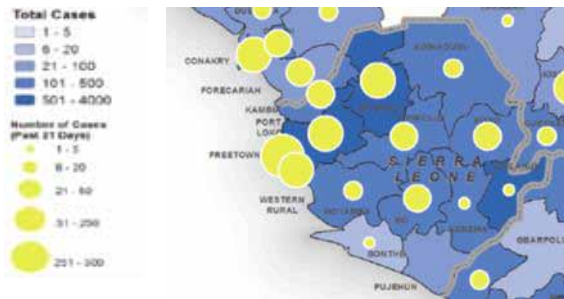
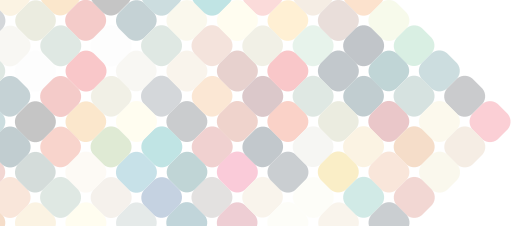


Fig 8: Distribution Ebola, December 2014



Figure 9: Treatment beds: Blue (existing), Green (planned) Freetown shows a similar ratio of number and planned to existing facilities.

The information in the following sections was gained through individual interviews and group discussions as well as the review of relevant documents. The list of those interviewed is to be found in Annex 3.

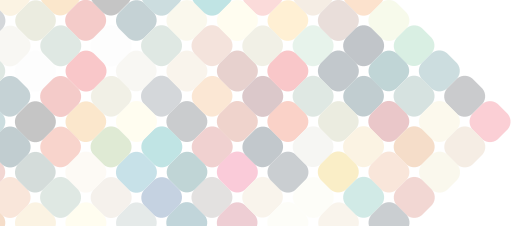
At the time of the visit by the RTE team (5 Dec 2014) the situation in Sierra Leone had deteriorated from the previous month, with new areas of infection appearing in previously unaffected locations. The disease is distributed in Sierra Leone as seen in figure 8, as of 16 December 2014. The difference between the distributions of Ebola cases in the two figures represents the extent of the on-going public health failure to contain disease in the subsequent 5 months. Figure 9 shows the mid December 2014, location of the treatment beds functioning (in blue) and planned (green). As can be seen, there is a serious mismatch between location of new cases, and existing facilities. Even where there are additional facilities planned, some of the districts are remote with poor roads and limited access to existing facilities.

The control of the Ebola epidemic can be summarized as three public health principles:

1. Recognition of the Ebola infection
2. Infection prevention and control measures
3. Treatment of those suspected and confirmed

The three public health principles are captured in a 5-pillars activity approach, which includes 1) social mobilization, and beneficiary communications, 2) safe and dignified burial, 3) psychosocial support, 4) tracing and monitoring of contacts and 5) clinical case management.

The supporting activities in Sierra Leone have progressed at different paces. The safe and dignified burial has become a great success of the Red Cross in Sierra Leone; mobilization and communications has moved more slowly. Extensive training in psychosocial support has been carried out. Contact tracing is done in many areas by the Red Cross using lists created by district health authorities for known or suspected Ebola deaths. The Kenema Ebola Treatment Center has played a major role in treating Ebola patients and reducing transmission of infection.



8.2. SUMMARY

Some of the key recommendations for Sierra Leone built around the three principles of Ebola control which are applicable to the Red Cross strategy:

1. Recognition of the Ebola infection and direction of the epidemic

- Assuming a more proactive rather than reactive response with strategic epidemiological thinking and planning; adjusting the response to changes phases of the epidemic.
- A major scale up of the active case surveillance building on work of volunteers in the community already doing contact tracing.
- Strengthening the communications activities, an under-spent activity; incorporate KAP surveys and potential for feedback from the community.
- Using data collected and available to understand the epidemic and vulnerabilities as well as monitor the outcomes of programs; develop clear pathway for use of data in program decision making.

2. Prevention and control of infection

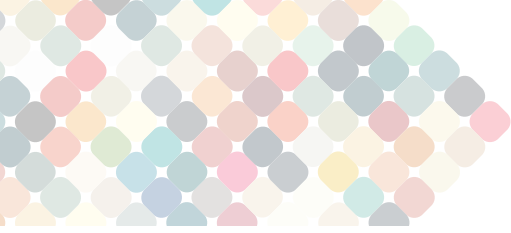
- Continue to support the SDB program
- Consider rapid response program with community infection control kits
- Rapid compensation for house contents destroyed in disinfection
- Improve the concern for health and safety of volunteers

3. Improved treatment options

- Consider satellite or regional treatment options for quick response to local outbreaks
- Stronger support to survivors and households devastated by Ebola and approaches to start individual and household recovery.
- Careful documentation of the work of the Kenema ETC, and lessons learnt

4. Support activities

- Strengthen financial management, especially in accelerating expenditures
- Provide all volunteers with Red Cross visibility and identification
- Monitoring of the outputs and outcome and the activities listed in the emergency appeal.
- Consider having log-frames as part of the Emergency Plan of Action to help identify indicators, as there are few indicators specifically set out for outputs or outcomes. This would be more useful than just measuring financial expenditure per output. Currently this is not a results based framework



8.2. DETAILS OF THE RTE FINDINGS FOR SIERRA LEONE

1. UPHOLDING POLICY

1A. Red Cross fundamental principles

Neutrality

There are no problems in the current Ebola environment which would polarize the humanitarian community and pose threats to the neutrality

Humanity

The RC has worked very hard in the community to fulfill this principle. It works for safe and dignified burials, the psychological support of survivors and families, and for the care for children as contacts at the ETC. However more can be done providing assistance for households affected by loss of family members from Ebola and household assets in the disinfection, and increasingly addressing the needs of the survivors and their households. The code of conduct needs to be signed by volunteers.

Voluntary service

This is the major comparative advantage which the Red Cross has to fight this epidemic and why it is has such an important role. More can be done to safeguard this precious resource at the branch level, including more emphasis on personal safety, refresher courses, Red Cross identification and timely payment of incentives. The Red Cross should also start planning about long term support for the volunteers who have been engaged in the Ebola operation.

Unity

This has been demonstrated very well through the support the IFRC has provided to the National Society in combating this epidemic throughout Sierra Leone. It is expected that Partner National Societies will be joining in the recovery process, and it is hoped these collegial relationships can continue. It is important to note that several of PNSs have resolved to work under the umbrella of the Federation to support the national society.

Universality

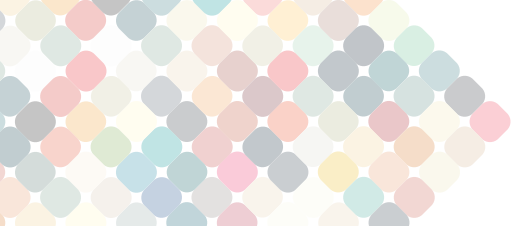
The Red Cross in Sierra Leone has been working in all areas thanks to its extensive volunteer base. However, there is a need to strengthen programs in those areas which are increasingly being affected by the epidemic. With recovery, the needs will be across Sierra Leone, but good assessments can identify those areas needing special attention.

Impartiality

The Red Cross has functioned well in providing services to different ethnic and religious groups in an equitable manner.

Independence

As the National Societies act as auxiliary to government this could pose some conflicts and overlap in responsibilities with the work of the volunteers. In general this relationship is strong, though there are sometime tensions at local levels which need to be and can be managed. The Ebola programs have maintained independence from government interference.



1B. Principles and rules for the Red Cross and Red Crescent Humanitarian Assistance

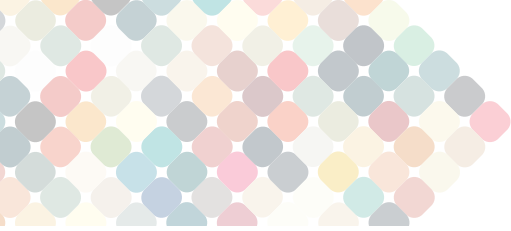
These were reviewed in relationship to the Ebola response

1. *International Assistance to the National Society.* A DREF was allocated on April 6th and a delegate from the regional office was deployed to support in its monitoring and implementation. In addition, and further to a request by the NS, a FACT team was deployed just days after the first Ebola case was confirmed in Sierra Leone
2. *IFRC Support.* IFRC supported the SLRCS in preparedness for the Ebola outbreak. In retrospect few organizations, including the IFRC were prepared with strategies for dealing with an Ebola outbreak, let alone one of this magnitude.
3. *Relief to Recovery.* As noted above, the RTE evaluation team felt this transition to be slow, as there are Ebola survivors now ready to return to their villages and facing stigma and survival difficulties. The Ebola response should be addressing needs of this group.
4. *Quality and Accountability.* 5.1 Many volunteers had not signed the Red Cross Code of Conduct. As noted above a community survey was held at the beginning of the response, however it is undetermined how and whether this data was fed back to the community. For principle 5.4, involving the community in decision making, it was not clear how this was implemented, particularly in the upward movement of community opinion to program management. 5.6 PMER, as also noted in a recommendation, information analysis and management needs to be strengthened for use in decision making. 5.11, as noted, the RTE team encourages the re-examination of safety and security risks and takes further steps to minimize these. 5.12 the team felt the Ebola operation in SL was responsible in its use of resources. 5.19 Because of the large amount of funds involved and the complex and changing nature of the operation, and for the protection of the program staff, and internal audit should be considered.
5. *Relations with Public Authority.* The relationship to public authorities is a very crucial connection in this operation, and was well respected by the SLRCS and the IFRC, but not always understood by government, often at the district level. At the national level, a close relationship exists with the Ministry of Health.
6. *Relations with External Actors.* Coordination is being done very well. The work of the Red Cross in the Ebola outbreak in Sierra Leone is very well respected.

2. RELEVANCE AND APPROPRIATENESS

General approach

The response was slow in starting. The SLRCS was hesitant in the beginning to become involved in more than mass sensitization, and by the end of June, in contact tracing. This was characteristic of many



experts who believed the outbreak was contained in March 2014, after the first few cases were reported in Guinea. Overall, the approach has tended to be more reactive than proactive, but this is true of all three countries (Guinea, Sierra Leone and Liberia). The Kenema ETC and connected Branch Ebola initiatives was an example of a very proactive initiative and the timely construction of this, most certainly blunted the outbreak in this area. The establishment of an ETC in Kono in December was evidence of the capacity for quick reaction to an evolving need. As with the other two epidemic countries, the Red Cross has taken on the management of dead bodies, and is doing this very efficiently. This is widely recognized and appreciated.

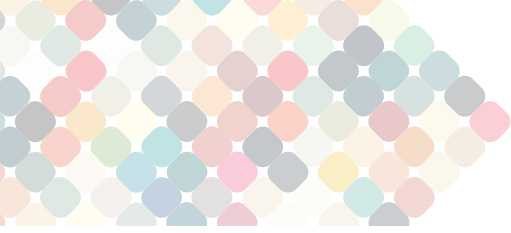
In Sierra Leone the outbreak remained very much out of control at the time of the RTE team's visit. While some of this may be due to operational and coordination issues, it is clear that at the current level and direction of response, this epidemic was going to take some time to control. The outbreak continued to spread into difficult-to-treat areas. The mismatch between location of treatment beds and location of Ebola cases still continues. The health staff of the Sierra Leone Red Cross task force are very much involved in responding to the emergency, and they do this very effectively. However, missing was the capacity to take the long view, make predictions on possible directions of the epidemic and create scenarios which could help prepare responses for the various potential scenarios which could develop. A critical missing part of the Sierra Leone response is development of active surveillance and case finding. This will be a considerable increment of effort beyond the present contact tracing by the Red Cross. Even with the contract tracing, use of the data from the contract tracing has not been fully exploited. This planning work goes beyond basic project monitoring and evaluation, and requires epidemiological skills. There is a need to develop the capacity to look ahead within the response efforts, to "think like the virus" and anticipate potential directions of the outbreak and being prepared to address this.

The five intervention pillars

These were very appropriate to the crisis in Sierra Leone, with four completed by the Red Cross across much of the country. Clinical case management was conducted in Kenema district and commenced in Kono district. Some of these activities are delivered together such as community sensitization and the beneficiary communications, and in many cases the PSS. As noted later, the communication strategy and approach was a bit unclear and patchy. Red Cross activities around these pillars have undoubtedly had a major impact on the epidemic.

2A. Needs assessment including prediction and analysis

The FACT team conducted a preliminary KAP survey in June 2014, which includes an assessment of the capacity of the national society. The KAP was just limited to knowledge about Ebola and in the early intervention areas of Kenema and Kailahun districts. The sampling methods were non-standard, and the analysis was mostly descriptive. While this provided important information on beliefs, it covered little on attitudes or practices. This was not repeated to assess how these may have changed because of health promotion measures or other activities. The findings helped shape the messages that the RC were delivering, what was used in staff and volunteer training and it also helped in preparedness activities in other countries. The findings were used for the preparedness guidelines shared with other national societies. Standard methods for surveys exist and it would be very important to have delegates familiar with these.



It is unfortunate that this KAP was not repeated on a regular basis to measure some specific indicators about how beliefs and susceptible attitudes and practices were changing, and how these were influenced by the Red Cross program activities. Particularly important would be the monitoring of the attitudes of beneficiaries.

The programme response depended on information from the MoH, CDC and WHO, and lacked its own data and the analytic capacity to shape and adapt the response. Had contact tracers been part of the SBD teams earlier and data they generated consistently supplied to Freetown for analysis, the response would have been stronger. At the same time the capacity for epidemiology should be developed at the IFRC secretariat. The two health delegates dealing with the crisis have been very involved with operational issues, and have not been in a position to develop a long-term view based on the project and other data.

The issues of information management for this and similar projects should be addressed. With multiple IFRC and local databases already on computers, pulling these together for one or more dashboards that could be seen in real time both in Freetown and Geneva, as well as giving PNSs access should be achievable. This would greatly facilitate the understanding and monitoring of program activities.

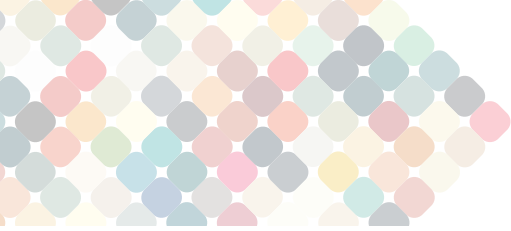
As part of the FACT an assessment of the National Society capacity would have been undertaken as specified in the FACT Guidelines.

2B. Is the IFRC 5 pillars strategy delivering appropriately?

The activities of each of the five pillars have varied with the stage of the epidemic response. With each of the pillars and those responsible for implementation, it is important to be aware of issues evolving and modifying the activities accordingly. This is important, for as the epidemic evolves in Sierra Leone, different pillars may have to respond in different ways. The absence of a feedback arm from field or beneficiary perspectives are of concern to the RTE team. The assessment of the five pillars is set out below:

1. Social Mobilization and Beneficiary Communication

Communications are critical in this outbreak, and this pillar is a vital component of the Red Cross response. In the beginning all Ebola messages had to be approved by the Ministry of Health & Social Welfare. Later after a health communications conference in Dakar, the Red Cross began developing its own messages. How much the Red Cross was involved in shaping subsequent messages was not clear to the RTE team; how they changed over time, and how their effectiveness was measured and how that information has been incorporated into new messaging. A review of the financial summary of the Appeal activities shows that these communication activities are substantially underspent. If this is indeed the case, there is the need of a clear explanation as to why at the height of the epidemic, not more funds are being spent on the crucial activities of communications. The connection between the communications resources of the IFRC and the needs for the program should be examined to see how these can be made fully operational. One of the recommendations from this RTE will be a careful review of the communications strategy at the regional level, the secretariat and the SLRCS to see how this can be made more effective now and in future disasters.



Considerable effort was put into building community or neighborhood awareness. The methods for developing these messages need to be documented. The lessons learnt from this can help inform the communications strategy. Without a ban on public gatherings, the potential scope for mass media to promote knowledge is excellent.

Effort has gone into radio and television Ebola awareness programs, using expertise from the IFRC. Measures should be employed to determine the impact of these. From the activities report, funding available for these activities is greatly underutilized.

Although a formal assessment by the RTE team was not carried out, the lack of billboards and posters for Ebola communications is striking. In most places the number of posters or billboards about HIV considerably outnumbered those for Ebola. According to the outcome records for scheduled Appeal activities, none of the ten activities in this category have been carried out to date. We would consider this a major deficiency.



Figure 10. SLRCS headquarters with waiting drivers.

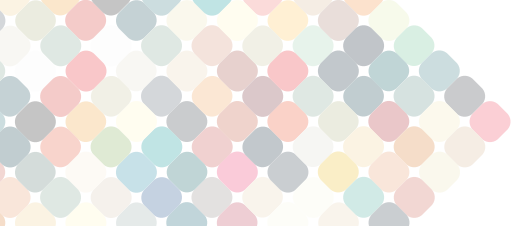
2. Safe and Dignified Burial

This pillar represents one of the major successes of the Red Cross, and for this it has received the most attention. The dignity, diligence and efficiency with which burials are conducted by the Red Cross teams is widely respected as the benchmark SDB activity. The Red Cross has been asked to train burial teams from other organizations. Without the community roots of the Red Cross and respect by government and others, this successful program could not have occurred.

Support to families and the survivors, and contact tracing has made this process an entire support package for affected households. As time has passed the protocols have been re-viewed and updated with experience. This regular updating approach should be applied to other activities as well.

A concern of the RTE team has been for the safety of volunteers, and for no group is this more important than the burial teams. Regular refresher courses and reviews, with an incident reporting system for any potential inadvertent exposure would be seen as an imperative. In other areas of Infection Prevention and Control serious breaches have been identified, and cases have been identified among drivers for SDB elsewhere, so it no stretch to think that this would be possible in all locations. The effect of an Ebola infection on the morale of the teams would weigh heavy.

Although there is insurance provided by the Federation, a county level insurance scheme is yet to be put in place. Lack of IDs and distinctive uniforms and T-shirts are a point of disappointment to volunteers. Conflicts between the MoH SDB teams and SLRC SDB has led to a go-slow by the Red Cross Volunteers and safety lapses can easily occur in such situations.



3. Clinical Case management

The clinical major activity has been the Ebola Treatment Center in Kenema which was established after it became evident that adequate management of Ebola cases in Kenema General Hospital was not possible. Using protocols from MSF, this ETC facility was established in response to the large number of cases in Kenema district as the epidemic spread from Guinea, and from requests by the MoH & SW and the WHO in Sierra Leone. In conjunction with the MSF ETC in Kailahun, this facility has brought down the number of new cases in the two districts. The ETC facility has worked with the SLRC branch office to coordinate services in the district both for Safe and Dignified Burial, but as well for case finding and referral, and this coordination has worked well. At the present time many of the patients coming to the ETC are from outside Kenema, even from Freetown. How they pass the police checkpoints where temperature is taken is not clear.

Based on the success at this ETC, discussions were underway during the RTE team's visit to Sierra Leone to create a second ETC to provide isolation facilities for the upsurge of cases in Kono, an adjacent district to Kenema and Kailahun district, and bordering on Guinea. This is currently one of the hottest spots in Sierra Leone nearby Koinadugu district with its long border along epidemic areas of Guinea. These two districts have poor roads and many difficult-to-reach-locations. While the IFRC has demonstrated the capacity to manage this facility, it is important not to stress the capacities of the IFRC too far in finding the professional staff to provide services on a recurring basis. However, if with good active case finding and control in Kenema district continues, the downsizing might be prudent, transferring the bulk of activities to neighboring districts with many new cases. At the Kenema site, the ETC has been addressing the needs of the children whose caretakers have been admitted to the ETC. This is an excellent humanitarian development. The ETC have not been regular participants in the clinical care meetings in Freetown. More of a Red Cross presence here could help build awareness of the excellent work of the Red Cross in addition to the SDB.

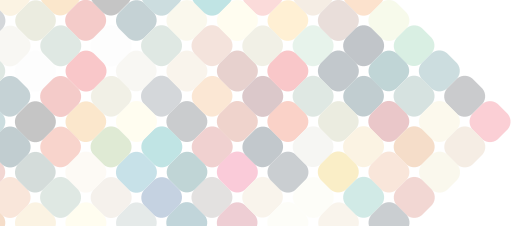
At the conclusion of this outbreak it would be appropriate to document this experience including a detailed assessment of patient characteristics and outcomes.



Figure 11: Nursing staff, Kenema

4. Psychosocial support

This activity has provided good care to the households affected by loss from Ebola, and conducted in an effective and humane manner. However there is an opportunity here to follow up with households to get a sense of how successful these interventions have been and what areas are potentially missed using the current approach. As more and more survivors return to their communities the problems of stigmatization is emerging. Specific plans to develop programs for reintegration are needed. Along with these activities



are the support to survivors in the form of shelter and food. Issues of orphans are also a concern. With many families being decimated by Ebola, work to rebuild livelihoods is needed.

The matter of how to utilize the psychosocial skills learned for the post-Ebola period was discussed with volunteers in Kenema. They pointed out the extent of mental illness and depression in the community as a whole and wondered if their training might be used to address these community needs.

The question comes up about what psychological support is available to the volunteers working in dangerous areas in discouraging circumstances. Discussions around this point have suggested that the number is small. However, it is not certain if this issue has been thoroughly explored. Volunteers suggested that holding regular branch meetings to discuss experiences and issues would be helpful.



Figure 12: PSS volunteers Kenema.

5. Contact tracing and monitoring of patients contacts of Ebola

Contact tracing is a critical part of the management of Ebola. When a case of Ebola is diagnosed or a suspected death occurs, then the contacts are listed and followed for 21 days. It appears that in some cases it was not possible for volunteers to follow contacts for the entire 21 days, and this represents a serious breach in medical case management protocol. This seemed to be a problem especially in Sierra Leone and Guinea, perhaps where there were not treatment beds close at hand.

Contact tracking is only part of the entire surveillance process that includes active surveillance and case finding. This requires on-going knowledge of community life, looking for ill persons, and in-and out-migrants. Part of the reason why the epidemic is not coming under control in Sierra Leone is the failure to institute a national Ebola surveillance process. UNFPA has been given this task, but with little institutional capacity for this type of work.

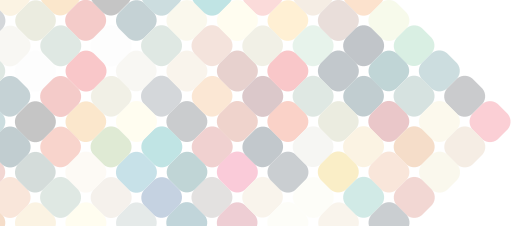
The SLRCS with its more than 7000 volunteers is the natural choice for this activity. When the RTE team was in Sierra Leone, this was being agreed. Training for surveillance personnel was to be provided by International Rescue Committee in Bo. This is an excellent step, but considerably overdue. This is an area where the Red Cross should have been leading.



Figure 13: ETC, Kenema

2C. Is the regional appeal relevant and appropriate?

This is discussed separately.



2D. Is the response strategy balanced with realistic donor expectation?

The major donor represented in Sierra Leone is DFID. A very useful meeting was held with a resident DFID advisor who has worked closely with the IFRC in the Ebola response. DFID is closely involved in the strategy and directions and activities of the program. USAID also contributes substantially.

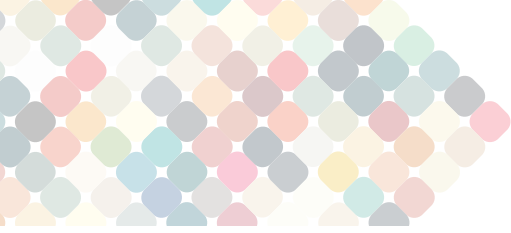
The DFID advisor expressed the concern of DFID was about failure of surveillance systems and the slow response in developing additional isolation beds where they were needed. DFID had urged the Red Cross previously to undertake the transport of patients between the community and treatment centers, but the Red Cross had declined, possibly due to logistic challenges, and not being part of the planned approach. The role of the Community Care Centers (CCC) is not entirely agreed within Sierra Leone. Many groups were concerned that transmission of Ebola was a major risk. For various reasons the Red Cross has not become involved in Community Care Centers. The views of DFID were the Red Cross was playing a very valuable role and that the SDB teams were a major achievement.

DFID was also concerned about the slow implementation of behavior change. They felt that there were adequate resources on hand, but that these were not being properly coordinated for the full benefit to be realized. Other points in their view were that the PSS was a weak link in Sierra Leone, and that protection activities were not evident. It was the view of the DFID representative that the humanitarian component of the response was not being addressed. That is, there were many humanitarian needs of households and individuals that have been eclipsed by the focus on clinical concerns.

Discussions were held with a deputy leader of the USAID DART, a major funder for the IFRC Appeal. These centered around the need for measures of effectiveness of the program activities, which she felt should be improved. USAID had a strong interest in improving the community level activities around Ebola, especially in the areas which are currently out of control. There was a particular interest in strong contact tracing and active case finding, reflecting the epidemiology strengths of the USAID team. The need for more comprehensive collection and use of community data was emphasized, with the importance of having a surveillance system in place with active case finding. There was a concern about the quality and depth of health management capacity in the rural counties.

Another USAID interest was about the survivors; the discrimination they received and the support required, and were not receiving. The representative felt that the Red Cross, with its community presence should do more in this area.

In summary, although the two principal donors are satisfied with the strategies and activities of the project, it is a concern to the reviewers that the expectations held by the donors will not be met due to the slow and patchy implementation of activities. Both principal donors were envisioning a more proactive role for the Red Cross, although the very much recognized the great contributions which the Red Cross has made to date. In some areas, such as expanded contract tracing and surveillance, the Red Cross does have the capacity to take on an expanded role, working with district health teams and other bodies with having this responsibility. This question has also been raised in the RTE recommendations.



3. EFFICIENCY AND EFFECTIVENESS

3A. How well is the operation delivering on existing needs identified?

The needs identification process was formally conducted once at the beginning of the response with a non-standard community survey. This was done in a way that no follow-up comparison would be possible. It is very concerning that a program which depends so heavily on community perceptions and response has no established way of measuring progress in a regular manner or base-line results of which can be compared to measure the outcome of programs and changing needs. There are standard ways in which this could be easily completed, and it is surprising that this has not been done.

The RTE team felt that the Regional Ebola Management Unit could have insisted that similar community measurements be carried out across the three countries and the findings used to drive design and adaptation of intervention. This is not research, but basic program management. The RTE realize that the Regional Ebola management unit was very short staffed at the beginning of operations, with the regional management unit being established only in July 2014. Adding strong epidemiology capacity to the response could help address some of these information deficits. Properly conducted, community surveys should clearly involve public health capacities, and not rest entirely with communications delegates, who may lack the experience in community surveys and basic sampling methods.

In saying this, the operation is delivering many of the services which have been identified by the Ministry of Health, the NERC, the donors and other partners set out in the Appeal. These related activities such as social mobilization, PSS and CT, are generally being done well, but have lacked and have not had the emphasis of the SDB activities. There are targets for activities set out in the Appeal, though it is not clear how these were established, if they are still relevant, and how they have been amended. Some activities, such as communications have lagged behind the Appeals targets.

A review of the output activities based on the Appeal, shows an expenditure of under 30%. Of concern with this type of reporting is that it only measures outputs, which are entirely appropriate, but does not contain obvious connections to outcome measures.

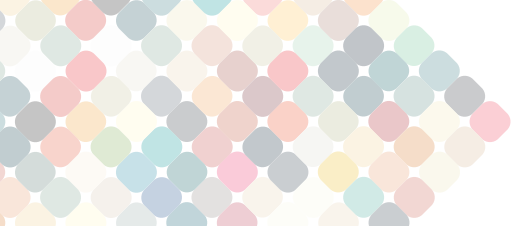
3B. Systems

National Society

The National society has a strong base of volunteers which have been used for previous seaferry disasters, floods and storms. Training prior to the Ebola disaster included psychosocial support, and community early warning measures. The Red Cross response to the 2012 cholera outbreak had helped prepare many volunteers for epidemic response. The Red Cross distinguished itself during the 1999-2002 civil war. These and other activities had created a working relationship with the IFRC, and with FACT and ERU activities.



Figure 14: Kenema Branch office



Like other organizations, the Red Cross was slow to appreciate the gravity of the Ebola outbreak. They have responded well to the outbreak despite their cramped headquarters. The district branches have responded well and added additional volunteers as the demands of the epidemic increased.

Team members interviewed at the branch level by the RTE evaluation team were enthusiastic about their work, and highly motivated. They were proud of what they had achieved. Their concerns were about timely payments of incentives, and difficulties in travelling to remote areas. From the position of the national society, they were concerned that paperwork and returns did not come from the branches in time, and held up payments as a method of ensuring timely submission of returns. Volunteers complained that they had not received any ID cards or T-shirts identifying them with the Red Cross, a lack of credibility that they felt lessened the value of their work. The RTE team understood that as of 4 December, ID cards were being printed for volunteers.

The SLRCS has the advantage of many capable staff members who have stepped in to play major roles in the Ebola response and form the strength of the Ebola Task Force.

IFRC

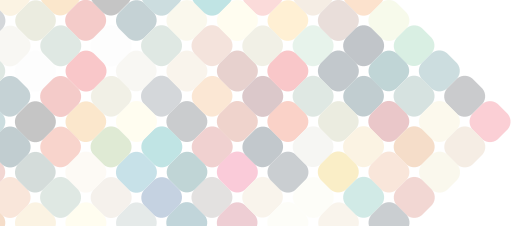
The first DREF was launched in April 2014 for CHF 113,217 for preparedness of the national society for an Ebola response. An Appeal was launched in June after Ebola had become established in Sierra Leone. A second revision in September 2014 brought the total budget to CHF 41.1m.

The IFRC FACT team was deployed in June, after the first Ebola case was reported on 24 May. It was effective and timely in helping to prepare the SLRCS. It was not certain how the capacities of the national society and its branches were assessed or appraised when drafting the Plan of Action, as specified in the FACT guidelines. The ERU set up the operational hub in Kailahun and later the ETC in Kenema which, with close cooperation of branch activities played a major role in reducing the size of the outbreak in Kailahun and Kenema districts. The systems required for sustaining the ETC involved IFRC in Freetown, Conakry and Geneva, and to some extent Nairobi. In general this has been working well with satisfaction of the managers in Kenema. Delegates to whom the team spoke were satisfied with the support they received. Cell phones using the RAMP (Rapid Mobile Phone-based survey) technology have been successfully implemented to regularly record data and made this available to control efforts. It is not clear whether it was used for collection of community data which could measure impact of programs. Yet other data continue to be collected by hand and returned on paper. The data analysis beyond output level was not conducted very extensively. There was a concern of the RTE across all three countries that information is not being handled well in this emergency.

Fleet management is now progressing using a computerized system and the recent arrival of a fleet specialist.

Are systems adequate to control the outbreak?

Rather, this should be elimination of the outbreak. The RTE team felt this was answered partially yes. The SDB was working generally well, though it is not known how many Ebola deaths were not being reported. Certainly the SDB team has done an excellent job and made a major contribution to the elimination of Ebola. The ETC, with its supporting district branch personnel has clearly played an evident role in the



reduction of Ebola in Kenema. The neighboring MSF facility in Kailahun has had a similar outcome—pointing out the importance of an integrated and consistent process.

Community mobilization and beneficiary communications have carried out many community-based activities, and raised the awareness of Ebola virus disease, dispelling much of the denial that hampered early efforts. A television program has been facilitated. Where this effort is deficient is in other areas of visual mass media such as billboards and posters. The financial statement shows serious underspending in this area, as noted above.

As noted above, the failure of Sierra Leone to develop an effective Ebola surveillance system with active case-finding is seriously limiting efforts to eliminate Ebola.

3C. Use of resources

The major resource of the Red Cross in Sierra Leone is its volunteers. It is well distributed, motivated, and has experience with community disasters, including the experience in control of cholera and many years of war. This volunteer base needs some special attention as will be noted below. The response is well organized at the national and the branch level and is active throughout the country.

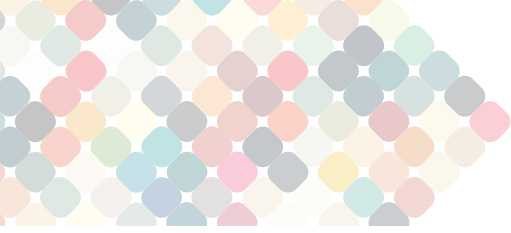
Transportation is a problem that is now coming under control with many more vehicles arriving and being deployed to branches. Fleet management systems are now coming into place to manage transport logistics. The delay experienced by Sierra Leone in confining Ebola early, has now made its elimination much more resource intensive. Volunteers and Branch staff feel that motorcycles would help with access to the difficult to reach areas.

Mobile technology is in place and widely distributed, but is not completely used for information management. As noted above, the data collected for activities around the pillars is not fully utilized for decision making.

Problems with materials including body bags and PPEs occurred earlier in the response, though this is easing now. Movement of money both from Geneva, as well as from Freetown to the districts has had problems as noted elsewhere, but does not seem to be an insurmountable problem.

Overall, the Sierra Leone activities are underspent. At this time when Ebola control has reached a crisis point in Sierra Leone, expenditures should be reviewed to determine how underspent resources could support additional initiatives to hasten elimination efforts.

The Ebola operations have really taxed the workspace of the national society, and additional temporary space could improve efficiency and effectiveness of the Ebola task force.



3D. Timeliness

As with all organizations, the Red Cross under appreciated the potential scale of Ebola in the three failed or fragile states with weak infrastructure and large and densely populated urban areas. Once the disease appeared in the region, the IFRC and the SLRCS responded appropriately. The threat of the outbreak in Kenema with the lack of capacity of the Kenema General Hospital to respond, resulted in a rapid establishment of the ETC. The development of the SDB pillar was done with great speed and commitment.

A feature of the Ebola crisis has been the way that it unfolded. Most disasters start with the situation at its worst state, and then the services and livelihoods are progressively restored. This epidemic started small, and there was not an adequate appreciation as to its direction. This allowed the overall response to get “behind the curve.” As a result the response is always trying to catch up with the new directions of the virus. The new directions are often more difficult to tackle than the previous experience. The great challenge for the Red Cross now is how to be proactive and not remain only reactive. As the Appeal is underspent, there are the resources to become involved in new directions, including strengthened surveillance, playing a part in active case finding and community watch activities, looking for unreported illness and in- and out-migration.

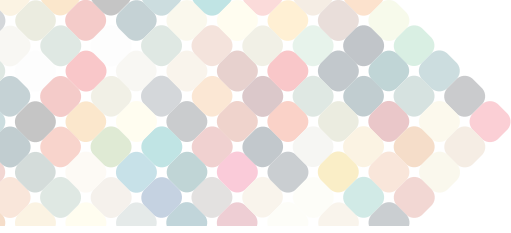
Federation timeliness

At the beginning, organizational structures in the secretariat prevented a quick response, even when the health personnel realized the gravity of the situation. Things moved quickly once the message was understood by those involved. Looking at the Ebola outbreak with the standard and established disaster management lens rather than an unpredictable prolonged epidemic lens, the response has slanted somewhat toward a more reactive approach.

The DREF was allocated in a timely manner to assist the SLRCS to prepare for an Ebola response. The FACT and ERU were established in a timely manner. Appeals were written and funding received in a timely manner, and the funds made available promptly. The movement to strengthen case finding and participate in surveillance perhaps took longer in retrospect, than if a strong epidemiological assessment had been done at the beginning. Many factors contribute to this including resistance by the WHO and the MoH as well as resistance from the national society for involvement in high risk activities. Later, the regional health delegate was very heavily committed in Kenema, establishing the ETC and dealing with the other two countries, each with their own problems, to have adequate time to address strategic issues of the epidemic as it unfolded. The role of technical support from the zonal health team was not clear. The drafting and launching of the Emergency Plan of Action was done well after the Ebola epidemic entered a new phase and some of the needs outlined in the original Appeal were no longer relevant. This has led to the revision of the Emergency plan of action with a greater increase in financial, human and logistic resources.

SLRCS timeliness

The Ebola response was a new experience for the national society, and it took some time to begin mobilizing volunteers, though in the beginning the epidemic was geographically limited. Preparation of the national society by the IFRC greatly assisted this process. However, the SLRCS has been slow in



implementing activities funded and agreed. Some of the branch staff interviewed felt that getting supplies from the Freetown office was slow. They were worried that incentives were sometimes delayed and others felt that some of the items promised to them for participation were not forthcoming.

The NS were unhappy that written forms and reports were delayed coming from the branches. The NS in-turn had their funds and incentives delayed until the reports were received in Freetown.

3E. Coordination

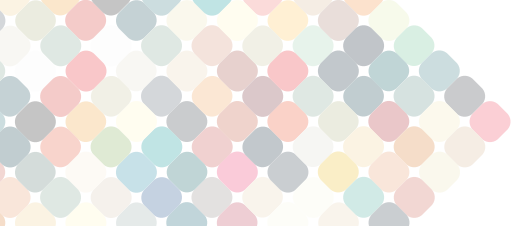
The Red Cross Ebola Task Force is active in the National Ebola Response Center (NERC) that has coordination functions. These follow the five pillars set out for the response. The IFRC health delegate is the point person for the Burial teams. The Red Cross role here is recognized, and the SLRCS carries out training in SDB for other groups in Sierra Leone undertaking this work.

The RTE team members observed the clinical management group, which was discussing many of the issues to address at the ETC in Kenema. It was unfortunate that a representative of the ETC could not participate. Afterwards a RTE team member joined the Contact Tracing “sub pillar” meeting, convened by UNFPA. There were considerable discussions on contact tracing and plans for surveillance, but there was little sense of urgency. At this meeting, the IFRC health delegate, did get an agreement that Red Cross volunteers would be considered part of the surveillance system. It seems unfortunate that the activity is treated so lightly and a non-operational agency is tasked the responsibilities. The SLRCS Ebola Task Force works closely with other response partners, as well the donors.

At the district level there are some problems with coordination. In Kenema district a District Ebola Council has been set up and this body allocates responsibilities within the district. The relationships with the Red Cross are good at the time of the visit, although there have been tensions in the past and the IFRC has been asked to pay for services that were delivered by others. There was also a strong proprietary ownership sense at the district council, and they did not always seem to appreciate the Red Cross’ role as auxiliary to government. This has happened in some other locations as well, including an instance during the RTE team visit.

The connections with the Regional Ebola Management Unit have been good, and regular visits are made by the delegates posted to the Conakry office. However, there was a sense from the SLRCS staff that they would like to have meetings with members of other national societies combating Ebola to discuss common approaches to problems.

As there are no participating national societies working with the SLRCs in its current activities, this is not an issue. Contributions and assistance from PNSs would be handled through the IFRC rather than the national society. Coordination and relationships between IFRC and the SLRCS were described by several persons interviewed as very good.



3F. Human resources

The RTE team had concerns about the health and the safety of the volunteers, both their physical safety as well as their psychological health. There were also concerns about maintaining their technical skills in communications and psycho-social support. These concerns were similar to those covered in detail elsewhere in this report. The volunteer base is critical to the mission and function of the Red Cross. Maintaining the volunteer base is a needed strength during this long and arduous campaign to eliminate Ebola, and it is a challenge.

The appropriate rewards and recognition for the conclusion of the campaign should be considered. The failure to provide volunteers with appropriate identification for their work in a timely manner seems to have been a major lapse. The participation in an insurance scheme for the volunteers is an excellent activity and this deserves full recognition.

The IFRC delegates coming to support the SLRCS have generally had the appropriate skills, and had no substantial problems with human resource management. The RTE team would have liked to have seen a greater support to communications and social mobilizations (the latter particularly in the urban areas, and for information management).

4. CONNECTEDNESS

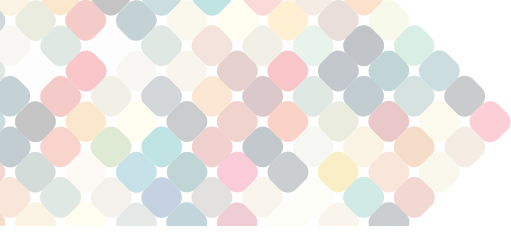
4A. How well is the operation likely to deliver on predicted future needs?

1. Strategies and structure in place

Connectedness among programs and resources within the internal structures of the Red Cross Ebola response is generally satisfactory, with some of the same issues highlighted elsewhere. The Regional Ebola Management Unit has provided the three countries with good caliber technical support. The concern here was that the field demands in some areas outstripped the resources available. For instance the services of Amanda McClelland were of such great demand setting up the ETC in Kenema, that she was not available elsewhere when needed. This also raised the need for the capacity to step back from the emergent situation and take a strategic view for longer term program direction, something that is hard to do when involved in everyday operational issues. A recommendation of the RTE addresses this issue.

A second area is connectedness among the various participants in the Ebola elimination efforts within Sierra Leone. The Red Cross is a very respected participant in the key areas of Ebola control in Sierra Leone. It maintains a strong connection with DFID and USAID major funders. These groups are major supporters of the Red Cross, but would also like to see them expanding their scope to address a changing epidemic etiology. Not all of those desires may be consistent with the capacities of the national society.

It is appropriate to start the individual recovery processes, in an area widely identified as needs for the survivors. This has been identified by other groups as well. Linking of groups into a “reintegration cell” will foster ways to stabilize the households and lives of individuals severely affected by Ebola.

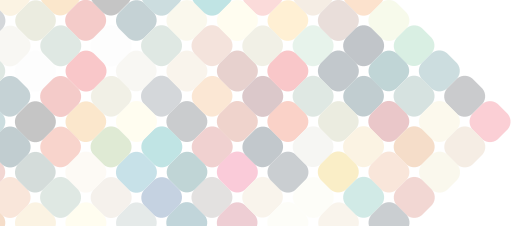


8.3. CONCLUSION

The Ebola response is an extraordinarily complex and difficult to predict disaster. It differs from other disasters in that it has been getting progressively worse instead of moving quickly to the recovery phase. Further, it holds real physical risks for the helpers and the Red Cross has mounted an excellent response in difficult circumstances. It is widely appreciated for the excellent work with the SDB teams and its ETC, as well as the availability of volunteers to participate in PSS and social mobilization. Now the epidemic is moving into a new phase, the mix and balance of activities which will be most needed will change. A great need of the Red Cross Ebola program is to focus on a strategic vision for the elimination of Ebola so it can see these needs as they are beginning to develop.

8.4. DETAILED RECOMMENDATIONS FOR SIERRA LEONE

- Invest in resources to capture and maintain a strategic epidemiological view of the epidemic to get the Red Cross efforts proactive and out ahead of the curve.
- Strengthen Red Cross capacity to take the long-term view in making predictions on possible directions of the epidemic and create scenarios which could help prepare responses for the various potential scenarios and estimate the resources required. This is especially important for the uncertain situation in Sierra Leone.
- Where arrangements can be coordinated with local response management, involve volunteers in a more comprehensive contact tracing and active case finding activity. This public health tool is being deployed late in this outbreak.
- Initiate provision for assistance to households affected by loss of family members from Ebola and household assets in the decontamination process, and increasingly addressing the needs of the survivors and their households where this is not being done.
- Improve volunteer and staff personal safety from Ebola, as safety lapses and risks are common. Refresher courses, are needed as this epidemic continues. Red Cross identification for volunteers and the timely payment of incentives should be a priority.
- Plan a long term support and recognition activity for the volunteers who have been engaged in the Ebola operation.
- Strengthen information analysis and management for use in decision making starting from the branch level to the regional level. Much of the data collected is being insufficiently utilized. How many contacts are there per verified case? What proportion develop symptoms of Ebola? What is the case-fatality rate among contacts developing disease? What proportion move away or are lost to tracing? How do families manage after and Ebola deaths? A data “dashboard” could display this in real time and is critical information for decisions on control measures.
- Due to the large amount of funds involved and the complex and changing nature of the operation, and for the protection of the program staff, an interim internal audit should be considered.
- Establish a rapid response team to manage a possible flare up in areas that are showing a decline in new cases and possibly after the end of Ebola incidence. The Ebola disease might become endemic and always present within the community, thus creating an urgent need for a rapid response strategy.
- Review the communications strategy at the regional level, the secretariat and the SLRCS to see how this can be made more effective now and in future disasters.



- Organize regular refresher courses and reviews with an incident reporting system for any potential inadvertent exposure to Ebola virus.
- Document clinical management at Kenema including a detailed assessment of patient characteristics and outcomes.
- Improve on the payments of incentives for the staff and volunteers engaged in the Ebola operation.
- Branches need to improve timely paperwork and returns to ensure payments are not held up.
- Process and distribute volunteer ID cards or T-shirts identifying them with the Red Cross.
- Review activities which are underspend to determine how resources could support additional initiatives to hasten elimination efforts.
- Initiate regular staff and volunteer counseling or at least a debrief activity for staff and volunteers, especially those in physically exhausting and stressful situations.
- The Red Cross in Freetown should look for some additional office space to accommodate functions during the duration of the Ebola response.



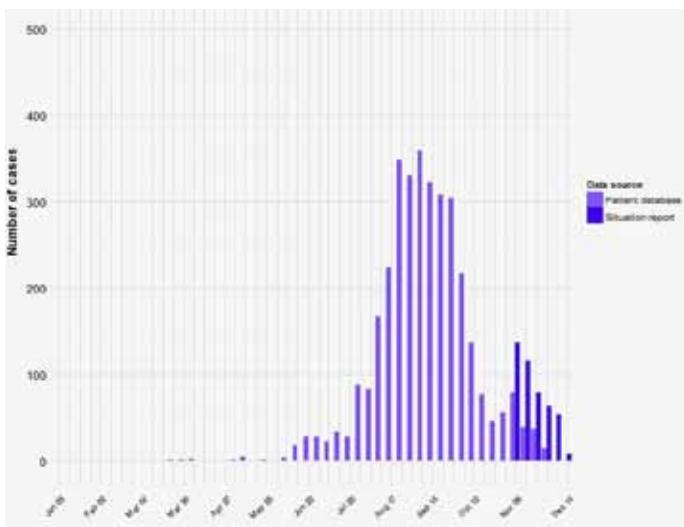
9. LIBERIA RTE REPORT



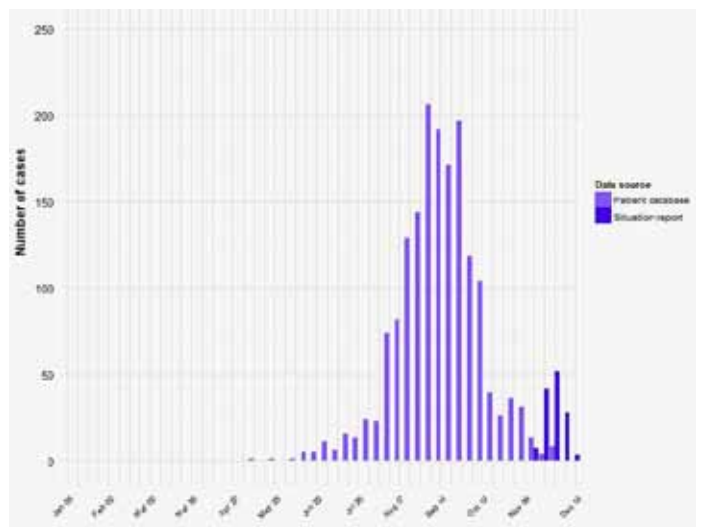
Beneficiary communications in Monrovia, Liberia.
Photo Alexandra Murray

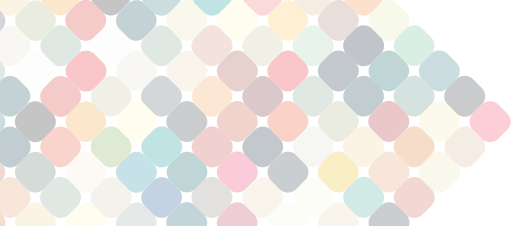
Figure 15. Ebola in Liberia

National data



Montserrado





9.1. BACKGROUND EBOLA IN LIBERIA

Ebola entered Liberia from Guinea in March 2014, showing up in the border countries of Lofa and Nimba. Ebola reached Monrovia mid-June. Health care workers were among the first affected, infected by patients who they thought had malaria or another febrile condition. Liberia accounts for about half of all health worker deaths from Ebola. By mid-July, Ebola had been reported from the counties of Lofa, Nimba, Bong, Margibi, Bomi and Montserrado (Monrovia). At that point there had been 224 cases with 127 deaths.

By July the epidemic curve was rising rapidly in Liberia. Only counties in the extreme South East were spared. By September the numbers were increasing dramatically and the epidemic was being increasingly concentrated in Montserrado county, where about a third of Liberians live. The epidemic reached its peak in late September and into October, starting to taper before dropping dramatically in late October and into November; a fall that was so rapid that many suspected cases were being missed. As can be seen from the histograms and the maps, the bulk of cases were in Montserrado and Margibi counties. The siege of the West Point area of Monrovia occurred during this time when this poor district of Monrovia was sealed off. During this time the LNRCs provided food to those quarantined.

At the same time as the numbers of infected started climbing, there was a rapid increase in the number of Ebola treatment beds available, particularly in Montserrado, Margibi and Nimba counties. In all, an estimated three-quarter of Ebola cases were in Montserrado county making it easier to construct centralized Ebola treatment units, than in other parts of the country.

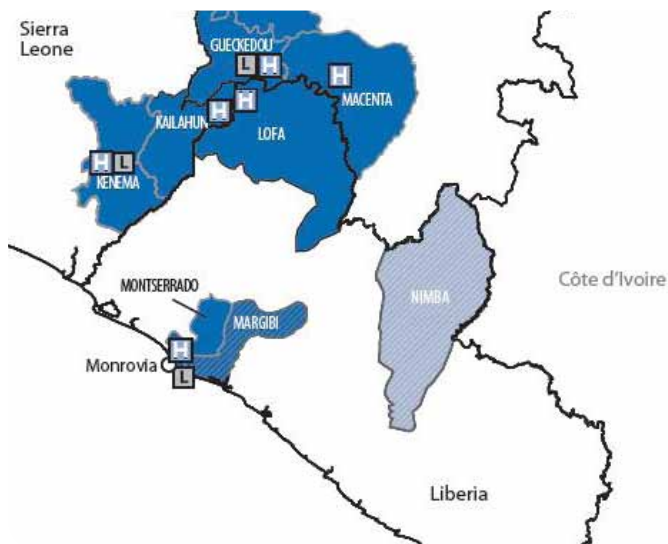


Figure 16: Ebola on 14 June 2014



Figure 17: Ebola in October 2014.

The dispersion of the Ebola treatment facilities across Liberia, constructed and planned, gives this country the best chance of the three countries of elimination of Ebola virus disease in the near future. Currently there are many unused beds in Monrovia. The robust management of the epidemic by the Ministry of Health, after some faltering steps, has contributed substantially.

A particular challenge has been the Safe and Dignified Burials. The strong resistance from the communities against burials of Ebola patients and the increasing water table due to the rainy season required an alternative solution and cremation was introduced in August. Cremation was not a popular measure with the community. The Red Cross has managed body collections in Montserrado county from an early stage, and has done this work in an exemplary fashion.



Fig 18. Ebola treatment centers, open (green) and planned (blue)

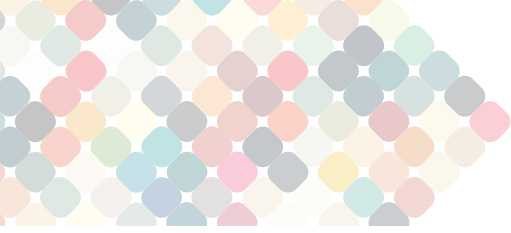
The small number of Ebola deaths currently occurring in Liberia pose a challenge to control efforts. With perceived risks decreasing, families are concealing deaths and avoiding the SDB process. A large proportion of those confirmed with Ebola are not known Ebola contacts. This is a dangerous stage in the Ebola elimination activities.

As noted elsewhere, the control of the Ebola epidemic can be summarized with three public health principles:

1. Recognition of the Ebola infection
2. Infection prevention and control measures
3. Treatment of those suspected and confirmed

9.2. SUMMARY

- The Red Cross in Liberia has contributed substantially to the first two elements through contact tracing, communications and social mobilization. These should be strengthened and reinforced, and also deserve wider appreciation.
- The hub strategy for rapid response is a sound concept and should be implemented in a timely manner.
- Further information is needed about the communities served. Survey data need to be collected and analyzed in a robust manner and these data used for decision making.
- Information systems should be strengthened so that there is a better understanding of implementation and results data being generated by the project.
- The Community Based Protection strategy is a sound strategy and should be implemented, particularly in the hot spots where there is not easy access to treatment beds.
- The “duty of care” responsibilities toward volunteers should be strengthened. There are multiple areas to this which need to be considered.



- A plan for recognition of the volunteers and the conclusion of the outbreak should be considered.
- The manner in which the TORs for IFRC delegates are developed and personnel recruited should be examined to ensure appropriateness of skills among the delegates and program continuity.

1. UPHOLDING POLICY

1A. Red Cross fundamental principles

Neutrality

Building on this value during the Liberian Civil War, the LNRCS nurtured an effective volunteer base, and was the organization that government and others thought of when the current emergency appeared.

Humanity

There has been a major emphasis on various humanitarian activities, including the psychosocial support activities and distribution of the survivor kits. This is a natural area for the Red Cross, and something other organizations are unlikely to be performing. There is a need to plan a targeted support and recovery activity cycle now and implement this on a community basis.

Voluntary service

The strength of the Red Cross movement is the volunteer basis. Many are students, and have fairly recently joined, and in some cases joined following the sensitization in schools. There is a need to promote the humanitarian values among these groups and be sure they have signed and understood the Red Cross Code of Conduct. As noted later, the LNRCS as a duty of care to help volunteers protect themselves as well as to be adequately supported in their work for the Ebola response.

Unity

Movement partners are trying to work collaboratively and are keeping others informed; PNS, ICRC, IFRC and the NS. This involved specific activities.

Universality

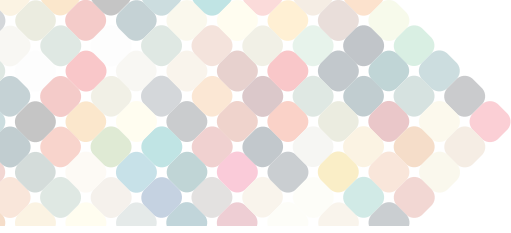
The IFRC and the LNRCS have worked closely together, with very generous support through the IFRC.

Impartiality

In the Ebola response the Red Cross efforts have provided assistance across ethnic and religious groups, according to their needs.

Independence

While working auxiliary to the Ministry of Health, the Red Cross Ebola response has maintained an independence of action from the government, and from other responders. The independence from other stakeholders was maintained.

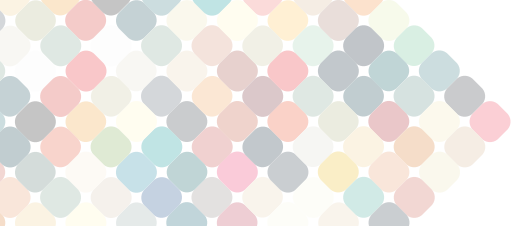


1B. Principles and rules for the Red Cross and Red Crescent Humanitarian Assistance

These following articles from the Principles and Rules (numbers given in italics) were reviewed in relationship to the Ebola response:

1. *International Assistance to the National Society*. By accounts, support to help build preparedness of the LNRCS was late, but when it eventuated it was delivered effectively. Staff were not aware of specific assessments conducted, but this could have been part of the FACT process.
2. *IFRC Support*.
 - 3.1 IFRC supported the LNRCS in preparedness for the Ebola outbreak.
 - 3.3 In retrospect few organizations including the IFRC were prepared with strategies for dealing with an Ebola outbreak, let alone one of this magnitude.
3. *Relief to Recovery*. As noted above, the RTE evaluation team felt this was lagging, as there are Ebola survivors already returning to their villages and communities facing stigma and survival difficulties. This seems less of a problem in Liberia than Sierra Leone or Guinea. However, certainly economic and livelihoods support for recovery will be required. Now is the time to think about what data are needed to inform this process.
4. *Quality and Accountability*.
 - 5.1 Volunteers whom the RTE team spoke with were more aware of the Code of Conduct than elsewhere, but many had not signed. Observed SDB teams had signed their codes of conduct papers the morning of visitation by the RTE.
 - 5.5 Beneficiary communications seemed one way, without a strong mechanism for understanding views of the community or formal mechanism for feedback. No KAP or other needs surveys had been collected. As noted above a community survey was done at the beginning, but it is not sure how this data collected were fed back to the community.
 - 5.6 PMER, as also noted in a recommendation, information analysis and management requirements needs to be strengthened for use in decision making, a similar finding as to Sierra Leone and Guinea.
 - 5.11, as noted, the RTE team encourages the re-examination of safety and security risks and takes further steps to minimize these.
 - 5.12 the RTE team felt the Ebola operation in Liberia was responsible and efficient in its use of resources.
5. *Relations with Public Authority*. The relationship to public authorities is a very crucial connection in this operation, and was well respected by the LNRCS and the IFRC. Understanding the Red Cross relief effort at the County level in the Ministry of Health programs was good.
6. *Relations with External Actors*. Coordination is being done very well. The work of the Red Cross in the Ebola outbreak in Liberia is very well respected.

Many of the current employees of the LNRCS did not come from the volunteer base but instead were former ministry of health employees or were direct hires from the community. The Red Cross principles,



humanitarian values, significance and value of the emblem and the volunteer spirit, had to be taught to volunteers as part of their hiring process. This is not always a standard Red Cross practice.

1C. Preparedness

Community based preparedness is a Red Cross practice which is consistent with the work of the Liberian Red Cross in responding to this epidemic. The IFRC DREF support was given for a quick start the social mobilization and community awareness in Lofa and Nimba counties as the threat of Ebola was impending. Work by the Danish Red Cross has been on-going for several years in community based disaster preparedness programs in Bong, Nimba and Lofa Counties. This will be a good opportunity for IFRC and the NS to collaboratively work as a Movement as the NS moves into Community Based Protection.

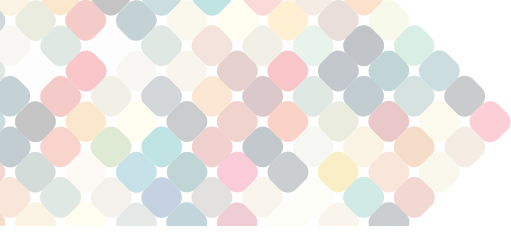
2. RELEVANCE AND APPROPRIATENESS

General approach and comments

Both the LNRCS and the IFRC recognized that the initial response was slow. The early stage of the outbreak was marked by denial among senior politicians as well as the population itself. In spite of this, the MoH moved quickly when the outbreak was recognized. In the beginning the LNRCS in particular thought that this would be a small contained outbreak and there would be little role for the LNRCS. When the seriousness of the situation was appreciated, the IFRC sent a first and then a second FACT team, followed by Emergency Response Units. Initially the areas of focus followed the spread of the epidemic from Lofa, to Nimba to Bong and then to Montserrado countries. The Red Cross worked with both the MoH as well as the individual County Health Teams who were responsible for the allocation of the responsibilities among the various organizations. In several cases, the Red Cross picked up additional responsibilities when the designated organization was not able to carry out assigned responsibilities. This included taking on dead body management in Montserrado from the MoH and expanding into initial contact tracing in various locations.

The process of working with both national and local governments was helped greatly by employment of a nurse with public health training who had previously worked with the MoH to support county health activities from the headquarters level. The operations manager has provided steady leadership to the response, and helped move the Red Cross to become major contributors to the Ebola elimination efforts. A deputy manager from the American Red Cross was perceived to have brought excellent operational organization to the emergency effort in Liberia.

In the beginning the response was chaotic, and not well coordinated. There were many logistical challenges. It was difficult to adequately supervise the activities done by the volunteers in the response counties. As many of the field officers did not have a health background, supervisors were seconded from Monrovia to the some of the response chapters to provide supervision. Health officers were added to NS chapters.



In general, the approach has been very competent. It has responded to the needs as they have developed and Red Cross was a key player during the crisis periods of the epidemic peaks particular in Montserrado. Much of the Appeal resources were spent on SDB, particularly in the beginning. As the epidemic moves forward there is a need for the Red Cross to maintain this reaction capacity, but also add a stronger proactive stance. As needs rapidly increase from affected households including those quarantined, those with widows and orphans left, and the many needs of the survivors, there is a need to step up and shift the nature of response. As the epidemic changes in characteristics, the Red Cross needs to stay ahead of these trends. The goal needs to be elimination of the disease in the three countries, not control. Control implies a few continuing cases, and these continuing cases even at a low level of transmission represent the potential seeds of further outbreaks and potential for further loss of life.

2A. Needs assessment including prediction and analysis

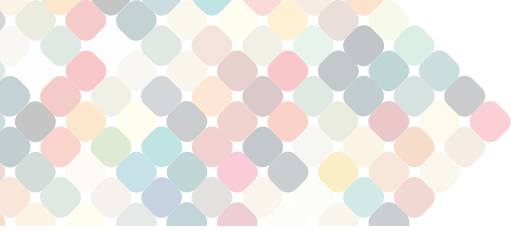
The FACT reports include a good assessment of the situation on the ground at the time, using the data that were available from multiple sources. The Red Cross has not engaged in primary data collections in this needs assessment process. However, in the course of collecting the contact tracing information as well as PSS, Ben Comms, and BDS, there is the opportunity to tabulate and analyze, at a very basic level, the service data that was routinely collected.

The Ebola response has depended on the information provided by the volunteers through their local chapters. An initial SWOT was conducted on chapter capacities. The LNRCS has seconded supervisors to some of the chapters to strengthen their work. This was an important step, and it suggests that more could be done from a quality control perspective to identify problems emerging in the community as well as problems with the quality of services being provided.

Across all three Red Cross countries, there was a deficiency in the use of information already existing, as well as the opportunity to add to this knowledge through additional data collection, to lend to response analysis and planning. In this sense the proposed mini-KAP surveys do not represent a good use of resources. As we understood the methods, they're unlikely to provide information which would contribute substantially to decision making. Instead, the response is relying on information from the UNICEF KAP survey, which will publish preliminary findings within the next few weeks. The response needs to collect and analyze its own data to be used as part of the planning and decision making process.

2B. Is the IFRC strategy with the 5 pillars—is it delivering appropriately?

The five pillars were a useful framework for activities in the various components of the response. However they have the disadvantage of discouraging an integrated thinking process. In general, the Red Cross Ebola response in Liberia has maintained connectedness between these components, though areas for improvement exist. From a program perspective, organizing several of the response areas around social mobilization makes sense, as this activity has the broadest reach. This is linked closely to communications, psychosocial support and contact tracking, where all of these activities are being carried out by the Red Cross. With a shift in the direction of the epidemic response toward more localized outbreaks and an enhanced active surveillance process, this integration of the pillars will have a greater importance.



In the following sections each of the pillars will be considered.

1. Social Mobilization and Beneficiary Communications

This is the overarching activity building awareness and developing focused communications with households directly affected by the outbreak. These activities are focused in the eight counties where the Red Cross conducts these activities. With the limitation of public gatherings, the trainers have worked with volunteers during three day sessions in a specific area. The trainers then move on, leaving the volunteers to do house-to-house visits and to meet with community leaders. In the beginning this was heavily focused on building awareness and an initial response to the outbreak. Delays occurred because messages needed to be approved first by government. An important shift now is to address the acceptance of survivors and the support for vulnerable persons. Volunteers work four or fewer hours a day for three days a week. To strengthen this connection, a community engagement coordination delegate is coming.

IFRC delegates have played the key role in developing the communication and mobilization materials, as well as the approaches to be used. At the time of the RTE team visit, plans were being made to utilize a sound truck to broadcast Ebola messages during the Christmas holiday season as mobility increases to urban areas. At the same time there is an ambitious program to get Ebola messages onto community radio, an important resource in a number of the counties. The current communications delegate is working on this, but it is uncertain if there remains enough time in his contract to complete this work. The local radio strategy was developed partway into this posting. It would seem important to continue this initiative beyond the end of his time in Liberia.

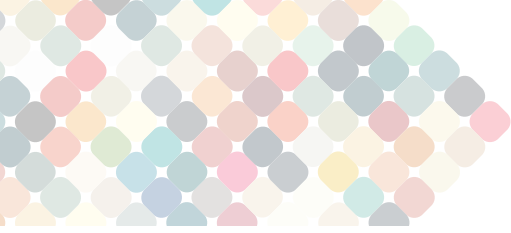
As the epidemic shifts to the next phase, which is likely to be a small number of cases continuing to come up in multiple unconnected locations, this pillar will have an increasing role. The next phase will have a greater emphasis on surveillance. This will include the existing activity of contact tracing, but will also do active surveillance for people sick in the community, people moving into the community and a “neighborhood watch” system. This is being organized by the County Health Teams. Clearly the Red Cross Volunteers could plan an important role in this.



Figure 19. SDB team, Mon-rovia

2. Safe and Dignified Burials

At the early stage of the epidemic, dead body management was in a very chaotic state, with overlap and lack of coordination, lack of capacity and lack of essential supplies. Bodies were left for days before collection. The LNRCs was requested to manage burials by the MoH based the work of the Red Cross previously performed in the Liberian civil war. In doing this work, it assumed employment of burial teams from the MoH. These have been integrated well into the project and are fully conversant with the fundamental principles and practices of the Red Cross. An agreement was made where management of dead bodies outside of Montserrado was done by the environmental NGO Global Communities, and bodies in Montserrado, where nearly three-quarter of the cumulative Ebola deaths have occurred. The SDB process is managed from the national office.



Virtually all bodies are collected within 24 hours of notification. There are currently 20 teams working in Montserrado county. At the peak of the epidemic during August-October there were up to 300 bodies a week being collected by the Red Cross throughout Montserrado county, but the bulk being collected from the densely populated Greater Monrovia.

In the beginning this was a chaotic undertaking, and occupied most of the energy of the Red Cross teams. In Montserrado there were bodies lying in the streets and in houses, often for extended periods. There was insufficient protective material available. Without a national call center, there was duplication in notification. Everyone was frightened and some of the burial teams dropped out.

Cremation was a very unpopular arrangement in Montserrado, especially when Ebola accounted for such a small number of deaths, and elsewhere bodies were being buried. On 24 December a cemetery at Disco Hill in Margibi County was opened near Monrovia.

The work of the LNRCS with extensive material and management assistance from the IFRC, is recognized widely. The Assistant Minister of Health, and director of the Ebola response activities, Tolbert Nyenswah said “The work of the Red Cross in providing safe and dignified burials is truly phenomenal.”

Linking the Beneficiary Communications and the Social Mobilization teams with the SDB teams has provided an excellent opportunity to provide Ebola messaging at the time these SDB teams are in a community.

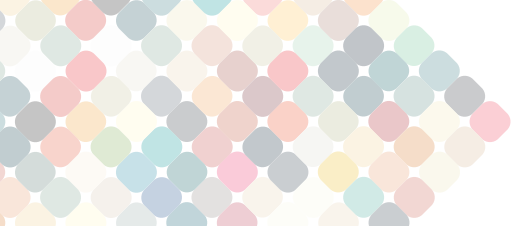
The work of the burial teams attracts certain stigma. SDB teams often do not identify themselves to the community, and often not to friends or even family members. There is some concern among the LNRCS and IFRC staff that the Red Cross is too closely identified with the dead body management alone and should receive recognition for its other successful activities. Others have felt that the Red Cross has not received the public recognition for the various activities including SDB that it should have received.



Figure 20: SDB team member.

3. Clinical Case management

In contrast to Sierra Leone and Guinea, Liberia has many treatment beds, though they are not always geographically well located. The epidemic was down to less than 10 new Ebola diagnoses per day at the time of the RTE team visit, and these are quite widely scattered through the country (see map). The Red Cross has not engaged in running direct clinical services in Liberia.



As the epidemic curve has now changed, new approaches are needed to manage the scattered appearance of and small number of outbreaks, while retaining the capacity to address major outbreaks that could still develop. This is being approached by the Rapid Isolation and Treatment of Ebola (RITE) strategy which involves rapid identification of suspect Ebola cases and their isolation. As transport may take some time to arrange and with the probability that treatment beds are distant, the rapid approach gave rise to the idea of a community-based in-dwelling safety and hygiene pack. This will help family members provide care in the home or in a Community Care Center until transport to a definitive treatment unit can be made. The kit contains rehydration powder, personal protection equipment, buckets and chlorine. This strategy was tested in two locations and now will be implemented in the next six weeks, hoping to have the Community Based Protection service in place by the end of January 2015. The response includes a team including Health, Social Mobilization, Beneficiary Communications and Psychosocial Support staff.

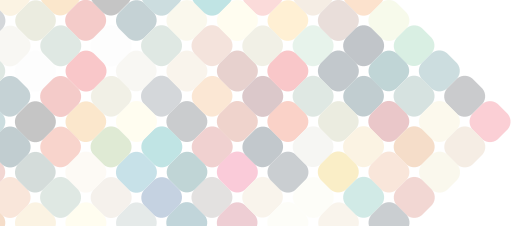
The Red Cross will have an important role to play in community-based protection. With support from UNICEF, kits have been distributed to many Chapter offices and persons have been trained in their instruction and use. In a RTE visit to Margibi chapter office, the health office indicated that she had received training and had kits on hand, but had not used them. She seemed hesitant to use them and seemed a bit unsure of their use. As Margibi is one of the more affected areas, there is concern that these may not be deployed in a timely manner when indicated.

4. Psychosocial support (PSS)

The provision of psychosocial support has become increasingly important as the damage of the epidemic continues to scale upwards. In many ways it is part of the package of Social mobilization and Beneficiary Communications. The initial training and design were done by a delegate from Hong Kong. Further work was done by a delegate at the Regional Ebola management Unit, and by the recently arrived IFRC delegate in Liberia. The curriculum includes materials on Psychological First Aid, assistance to beneficiaries in stressful situations and among the volunteers, and managing personal stress related to work. Intent for this training was to create resilient health workers and to reduce turnover among the volunteers. A training need identified by volunteers was for training in conflict management.

Training provided to the volunteers includes psychological preparation for the trauma they encounter in the community, good listening habits, empathy and providing practical assistance. Many volunteers have been trained in psychological first aid, a basic household and community supportive approach. In the approach of stigma toward Ebola survivors, the training curriculum from the WHO/UNICEF proved particularly helpful. Assistance with training has been provided through the bilateral PNS project which has been operating in the Northeast for some time. A Ugandan psychologist has worked with this team for some time and has been very helpful in the training of volunteers.

Discussions with volunteers during a psychosocial training workshop alluded to the special concern for the situation of children, both the survivors of Ebola and the increasing number of orphans. Some have no place to go as they are rejected by their families. Even the unaffected children of Ebola patients are often rejected. Adult survivors also have a very hard time, often left without food, shelter or family support. The psychosocial needs are great. An example of vulnerable persons suddenly without support is older girls with their own child. Volunteers have been supporting widows, orphans and survivors, and work with the community to promote reacceptance. Providing tangible assistance such as food and non-food items to



those persons stigmatized and also those being quarantined is an only a partially met need that the volunteers have identified. Several persons interviewed indicated that more material assistance to those affected would strengthen the humanitarian role of the Red Cross, which some saw getting less attention in the current crisis. A suggestion from the PSS-trained volunteers was to use school teachers to help identify children from households in need of PSS support. It was believed radio programs covering PSS topics for students not now in schools would be very helpful.

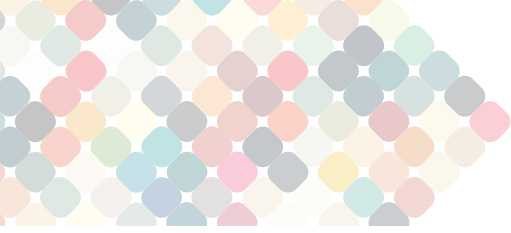
For these groups recovery starts now. It is important to start developing recovery programs for these groups now and not only in a programme “recovery phase.” Building livelihoods and developing new skills are needs that the volunteers have identified.

A question raised by members of the RTE teams concerned the psychological stress on the volunteers imposed by the epidemic. One volunteer indicated that he had lost 35 members of his extended family from Ebola. Another volunteer indicated that one of their fellow volunteers, a nurse at a local hospital had become infected and died from Ebola while worked at the hospital, unrelated to her Red Cross work. When asked about their own coping, the volunteers replied that they would get together in the Chapter offices to tell their narratives, debrief and support each other. Some volunteers indicated that their Chapter had regular seminars for support of the volunteers, but this was not reported for other Chapters. Several volunteers indicated that peer support, and their motivation for the work was the strongest support. There were concerns that reports from volunteer PSS activities were sometimes not completed. Volunteers also expressed problems with transportation, without which they could not reach more distant areas, and which they felt prevented adequate supervision of activities. A number of volunteers mentioned their interest in training that would suit them to provide mental health service in the post-Ebola period.

5. Contact tracing and monitoring of patient contacts of Ebola

One of the major public components of the public health response is contact tracing. Once a death has been identified, the county health team sends someone to carry out a death investigation which also involves a line listing of contacts. In some places the county health team has been slow in creating the line list, resulting in the Red Cross doing the line listing, with training by WHO, and in some places, even the death investigations. The county health team will then allocate the contact tracing to one of the organizations to do the follow up of contacts. In some counties the Red Cross does all contact tracing, and in others this is divided among various organizations, with the Red Cross doing part of initial stages of line listing. In some cases the Red Cross disinfects the contact dwellings. The contacts are then followed for 21 days. There are a series of variables which are recorded as part of the contact tracing. These include the percent that were followed to the 21 days, those that developed symptoms and were hospitalized, deaths and the number of lost follow up contacts. This information is relayed to the country health team and sent to the Red Cross on a weekly basis. The transfer of data has now become prompt and complete. The Red Cross has not been analyzing these data, but just storing the information and sharing this IMS program.

An enhanced approach is now being developed which will involve “neighborhood watch” persons who will be recruited from youth groups, women’s organizations and other community groups which will alert county health teams about ill persons in the community, as well as people entering or leaving the



community. This group has been referred to as “whistle blowers”. This is linked to the RITE strategy. The Red Cross is in a good position to play an important role in this activity, given its network of volunteers, but the LNRCs has not been approached for participation. As it is now, Red Cross volunteers do notify field officers about sentinel events in the community, and those messages are passed on to the country health team. During the large Ebola outbreak in West Point these whistle blowers played an important role in control of this outbreak.

2C. Is the regional appeal relevant and appropriate?

This is discussed separately.

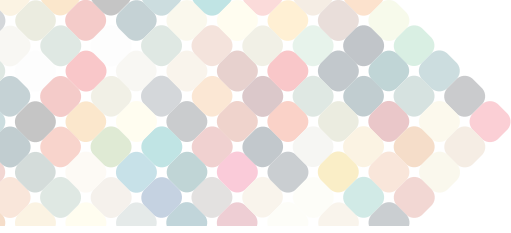
2D. Is the response strategy balanced with realistic donor expectation?

The RTE reviewers met with the ECHO Ebola representative. The viewpoint was largely positive, citing the excellent SDB work. The representative felt the current relationship with the Red Cross was a deep and committed one. He had attended training courses by the Red Cross, and was aware of activity reports. However, he felt that a better sharing of reports with the in-country donors would improve the visibility of Red Cross. He had some concerns about the rapid turnover of delegates in other agencies which he felt resulted in a loss of institutional memory and a failure to retain lessons learnt. The Red Cross Liberia Ebola project was fortunate to have a longer term operations manager who brought the leadership a consistency of style. Though one major concern raised by the ECHO representative was the perception about the influence the ministry was having in determining who is to be cremated and buried. Some officials were giving waver certificates to their relatives to avoid cremation. This may possibly cause backlash from the community in viewing Red Cross as discriminating on whom they transfer to the crematorium and whom is to be buried.

Critical analysis made by the representative on the weekly death rates showed a drastic decrease of reported deaths from 312 deaths during the peak period to 64 deaths against the mean mortality rate of Liberia of 162 deaths per week. He pointed out that this may indicate that there are secret burials being conducted at the community level due to the mistrust and the dislike of cremation by the community. This posed a risk of increasing transmission.

In an interview with a UNICEF health officer, she stressed importance of the contributions that the IFRC had made to the Ebola elimination program. She was particularly appreciative at the efforts of capacity building, and the desire to leave behind increased knowledge with the national society. At the same time she felt that the national society was feeling uncomfortable in the crowded aid community.

UNICEF has been a funder of Red Cross activities, especially the Community-protection kits that are being placed in four counties. There was concern that these were not getting out to suitable households as quickly as they should be. While the Red Cross was pushing the RITE strategy, this was not moving as quickly as the health officer felt was indicated. Concerns were expressed about the effects of the



epidemic on women and children, and that the LNRCS is not providing continuity of care for these vulnerable populations. This was important as the under five children were often the majority of contacts of Ebola cases. As with other donors, she also felt that the rapid turnover of delegates was a negative part of the IFRC response.

3. EFFICIENCY AND EFFECTIVENESS

3A. How well is the operation delivering on existing needs identified?

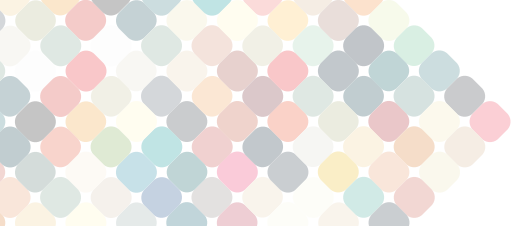
It is the opinion of the RTE team that after a slow start, the Liberian program is now delivering the services needed by the beneficiary population. The Appeals have been updated several times, most recently just before the RTE team's arrival in Liberia. Many needs have appeared or further developed as the outbreak unfolded. The team was unable to get a current financial statement for the Ebola control program. However the team was given to understand that somewhere over 72% of allocated funds for the year ending 31st December 2014 had been expended. A comparison with the activity report shows good progress on the social mobilization and SDB activities, however some activities have not yet been implemented (Annex 4)

The distinguishing part of the program has been the SDBs, and the efficient work of the Red Cross here is widely recognized and appreciated. In Liberia the Red Cross took over a chaotic and poorly functioning dead body management system from the MoH and made it function very well. The bulk of resources have been utilised here, and the delegate in charge of the SDB has been cited by several persons interviewed, for his exceptionally efficient work.

The LNRCS Ebola coordinator has contributed greatly to the effectiveness of the program, drawing on her public health training and her previous work as coordinator of central MoH activities with the county health teams.

Logistics still pose some problems with clearing items from outside the borders, although many things can be acquired in-country now. As the number of vehicles increases, there is a need for more sophisticated fleet management, and a delegate is coming to help with this in January. There is a need for a warehouse, and a national society unused care center outside of Monrovia will be converted for warehouse space.

There has been no formal needs identification process carried out, although it has been suggested that a series of mini KAP surveys be carried out, and this has been discussed elsewhere. Also as noted elsewhere, information collection and management is an area where improvements could be carried out. As the needs of the population at risk change on a regular basis, maintaining information about this would be information worth tracking and using in a regular response for social mobilization and beneficiary communications.



3B. Systems

The great strength of the LNRCS is its network of chapters, field staff and volunteers. The achievement of this is particularly remarkable considering difficulties the LNRCS had during 2013, including new leadership and staff changes. In spite of this, working with the IFRC, there was a successful response to the crisis. This system has given the Red Cross a comparative advantage, which is seen most prominently in the effective SDB program and other areas as well.

The LNRCS increased its county staff and recruited new volunteers where necessary to fulfill the new responsibilities, with some difficulties at first. Its connections with the community were an important advantage in addressing the problems of West Point, and it was able to supply food during the quarantine there.

The IFRC was able to provide a substantial amount of capacity to assist the LNRCS in the response. This was in many areas, but logistics and health areas were among the most significant. Generally the LNRCS and the IFRC have worked well together. There have been some problems with funds transfers in the beginning, but that was sorted out. The LNRCS has had an approval in the selection of delegates. The LNRCS Secretary General is happy with the quality of IFRC delegates, with minimum reservation. In general he would like to have delegates with longer postings. The LNRCS has participated closely in the writing and the revisions of the Appeals.

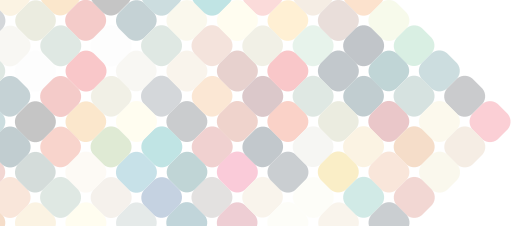
The Secretary General believes that the response and the achievements with SDB, an area which other organizations hesitated to tackle, has given the LNRCS a very strong profile. It has also brought about an opportunity to work together with the Sierra Leone Red Cross Society. A LNRCS procurement officer has now been appointed, and this promises to speed up the procurement process.

The RTE team believe that this system could be more fully utilized in the Ebola fight. The establishment of five Hubs linking the counties together in five geographic areas, are a start in this direction. This hub approach will support the MoH's RITE strategy. However, there is an emerging issue of morale in some locations which needs to be addressed by ensuring that incentive payments are prompt, and that there is generous recognition of the work done by volunteers. Staff recognition, especially for those in hardship positions is important.

The global logistics center has provided support to the operation by leasing vehicles to the IFRC, though the delivery time for the vehicles need to be shortened. The team is currently expecting 15 vehicles for the operation (7 from ICRC and 8 from Dubai). There have been some challenges in fleet management within the first 7 months of the operation with the in-country team not installing the recommended Federation fleet management system.

Are systems adequate to control the outbreak?

The LNRCS with support from the IFRC has most of the resources needed to make a major contribution to the elimination of the outbreak, a preferred term to control. However in the opinion of the RTE team, the overall national response is not yet sufficient to eliminate the disease. The remaining requirements are a strong surveillance system with solid contact tracing and active case finding coupled with a rapid response



capacity, which includes prompt hospitalization of suspected cases. The Red Cross Ebola program could benefit from at least regional epidemiological capacity within the Red Cross. Although the CDC and WHO as well as the IMS all have this capacity for a national level, the Red Cross needs this for a project planning and implementation level.

3C. Use of resources

The use of resources appears strong and the activities outlined in the Appeal satisfactorily implemented. The Project Financial Management Report, refreshed 12 December 2014, is depicted in the chart. The RTE team did not get the expenditure information by project objective. In the management report, funds are only categorized in the Social mobilization and beneficiary communication category. Of the budget listed, as of 12 December 2014, about 48.5% had been expended. The Appeal is currently being revised to CHF 24.5 million (Annex 4).

There have been some delays in movement of money, and some problems with stock management systems. As the number of vehicles has increased, steps have been taken to improve fleet management, with a delegate present and another coming in January to further build capacity. The Red Cross has not been using a recognized garage for vehicles in the Ebola program, but this has been corrected by the federation signing memorandum of understating with Toyota Liberia on 8th December 2014. Recently WFP has offered to fuel all vehicles in Ebola activities in Liberia, and this is being further investigated.

UNICEF had donated some 10,000 protection kits to the Red Cross, however the distribution of these kits is yet to be finalized. Discussion with the staff indicated that plans are underway to disburse the kits to the branches.

Salary to Chapter staff seems to be paid on time through direct bank deposits. However, incentives for volunteers are paid in cash from the Chapter offices on prescribed days. These are usually paid with not much delay. However the RTE team was concerned about the predictable movement of cash to pay points, and the security risk for armed robbery that this posed.

Project Performance in a Nutshell

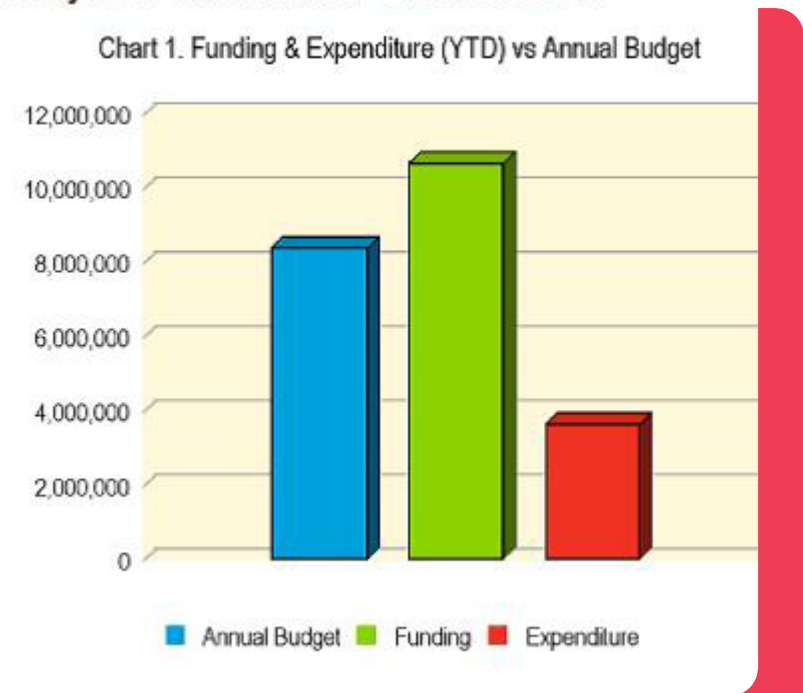
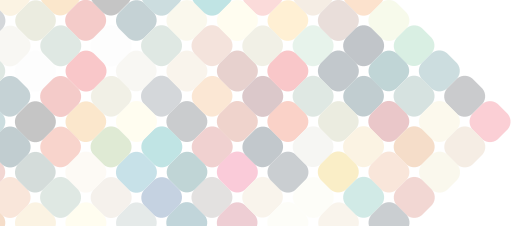


Figure 21: Financial performance.



3D. Timeliness

In the beginning of the Ebola crisis there were many delays in starting the response, including denial from communities and from political leaders. The LNRCS was reluctant in starting the response, and the IFRC also took time to increase the assistance being made available. With the great upswing of the epidemic from August – October, there were delays in collecting bodies. Much of this was a result of problems with MoH dead body management communications. Once the Red Cross assumed full responsibility for management of bodies, and the national call center was in place, bodies were being managed in a prompt and very efficient manner.

Federation timeliness

The response to changing needs of the epidemic by the IFRC in general has been very good. The decision to advance DREF to Liberia Red Cross in April for social mobilization was a sound decision based on the possible spread of Ebola from Guinea to Liberia. Additionally, the FACT support mission for assessment was also done in a timely manner, although the duration of the assessment of the Ebola emergency was considered to be short based compared to other emergencies. There have been some delegate positions which have not been filled in a timely manner and often delegate assignments are considered too short. But with only a couple of exceptions, the delegates have made important and substantial contributions to the Ebola elimination activities. Delegates are not always assigned at the right time or their skills are unsuitable for the current program activities. There were some comments that ToRs for delegates were not complete, or did not reflect activities currently needed by the project. Despite initial delays in the movement of money from the IFRC to the LNRCS, this is no longer an issue.

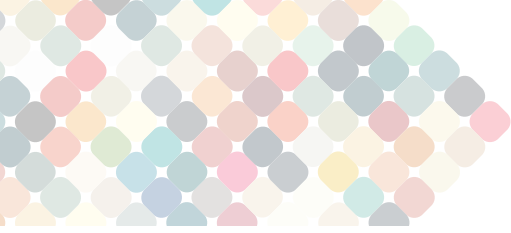
A representative of MSF observed at Federation had some challenges at the initial stages of the operations due to the dependence on the MoH logistics. There were delays in procurement of body bags through the MoH and at times the quality was inferior. These problems were not an issue with body bags procured by the Red Cross.

LNRCS timeliness

By accounts from various persons interviewed, the timeliness has improved substantially since the early days of the response. Because of the extra safeguards put into place following the reorganization of the LNRCS, some of the approval processes and response times were protracted. Actions requiring multiple signatories are a particular problem due to the availability of the signatories when required. This balance between accountability and efficiency has improved since the beginning of the response. For example, the incumbent team has delegated the bids analysis to the procurement officer who does the analysis instead of using a committee selected to do this analysis.

Chapter timeliness

The completion of the reports by the Chapters and forwarding these to Monrovia has been delayed at times. Incentive payments cannot be released until these are received by the LNRCS office, verified and approved for payment. Some information is now being sent from the Chapters to Monrovia electronically. This may speed the process and reduce delayed payment of incentives.



3E. Coordination

The Red Cross Ebola response team members are active participants in technical and coordination meetings. In the weekly IMS meetings the Red Cross has a seat at the main table and is widely consulted. The SDB team has been requested to undertake training for other organizations doing burials. The IFRC delegates have generally taken the larger role in coordination of meetings, with few staff from the LNRCS attending with the exception of the LNRCS Ebola coordinator. The Ebola team has a liaison representative with UNMEER. At the county level there is good participation from the Chapter field officers. However there is a general view that the work of the Red Cross has not received adequate recognition in the media. Much of its community work is reported through county health teams, so not all are aware of who has carried out the work. For reasons of prompt recording and analysis, the RTE team felt that the Red Cross Ebola program have its own information management capacity.

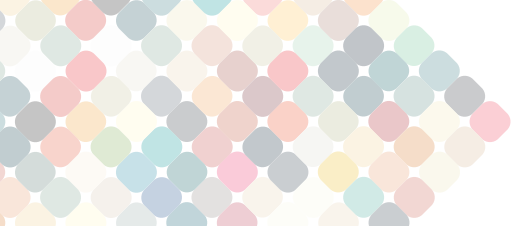
On Mondays representatives from the LNRCS, IFRC, the Danish Red Cross and the ICRC, active in the SE counties of Liberia, meet to discuss their activities. The Danish Red Cross has been doing psychosocial activities in Bong, Nimba and Lofa counties and they have done some cooperation with the PSS activities of the Ebola response. The focus of the Danish Red Cross program has been mostly around disaster preparedness. However, there is a feeling that this could be more, and that their resources are not being fully utilized. The ICRC has been working providing support to the Ebola activities, particularly in the Southeast, which so far has not been heavily affected by Ebola. They are proud of being part of this Movement activity, and are keen to remain very involved in a greater collaborative position of PSS especially.

3F. Human Resource support

At the LCRS there has been some turnover in the human resource section, and when interviewed, the current director had been in the job for only four days. She indicated that there had been delays in paper work in the past leading to delays in payments to the Chapter. Although many staff are paid through the banks, a number of staff do not have access to a bank.

The LCRS HR officer indicated that staff do have job descriptions, but these have not been updated to reflect activities in emergencies and reflect more the day-to-day functions of the office. The IFRC is providing assistance to the HR office of the LCRS with a regional delegate who visits the three countries regularly. This is helpful, but probably insufficient at the current state of the crisis. An IFRC delegate will be reportedly coming in the New Year to Liberia to provide more concentrated assistance and skills transfer.

There has been concern among volunteers about the potential loss of volunteers to Ebola (two volunteers have died so far, although unrelated to their Red Cross activities). This concern is that Ebola could be contracted in the course of the volunteer's regular work or during their volunteer time with the Red Cross. Although an insurance scheme is being implemented to provide assistance to families after a death, more needs to be done to protect the safety of the volunteers and the vulnerable families left behind. The maintenance of technical skills is particularly important in this current situation.

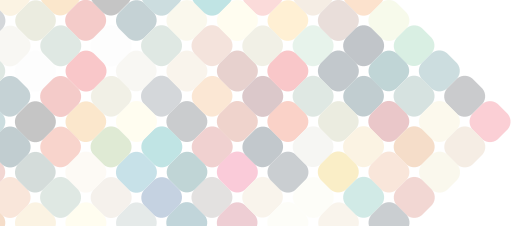


There is also major concern about the mental health needs of the volunteers and of the staff. Some volunteers, more so the ones working as SDB volunteers, will not tell their family or friends what their work is and others will not discuss its nature. There have been cases of volunteers being ostracized by their families. Some local methods have been employed such as debriefing, but this seems not to be always systematically done at the Chapter offices. This is an area which could be reexamined. In placing volunteers in these emergency situations, even with their full consent, the Red Cross has a principle "duty of care" responsibility for their health and well-being.

At the Chapter level there was a concern that more up skilling of the volunteer staff is required in some areas of the Ebola response. Although this was being done during the visit of the RTE team for PSS skills among some volunteers, it was not clear how widely this was being done for other skills used by the volunteers. This is of particular importance as the Ebola elimination program is moving into the RITE response and the hubs are being put into place. This is a major realignment of elimination efforts, and this phase may require different skills.

A topic that came up several times in conversations with volunteers is their status post Ebola crisis. This could be a time for the Red Cross to think of what recognition should be provided to volunteers in appreciation of their commitment and the risks assumed during the Ebola response. The volunteers are the major asset of the Red Cross in any emergency, yet there is a widely felt concern among volunteers that their status should receive both recognition and some form of on-going support. As about half of the volunteers are students, one idea suggested by staff and volunteers is the payment toward school fees. A rough calculation by the RTE team indicated this would be about US\$300 per volunteer pursuing courses requiring yearly fees.

At the IFRC, the recruitment and ToRs for positions are created between the regional office and Geneva. While most delegates spoken to had no specific problems, there were some that felt the ToRs were too vague, and did not match what they actually found was required. Others were unhappy that there was no handover or communications from the previous delegate conducting these prior activities. There was also a feeling from some delegates and echoed by the LNRCS that some of the missions by the delegates were too short in length. With the creation of the three and perhaps five hubs as part of the RITE strategy, health delegates would spend two weeks at these field hub sites and two weeks back in Monrovia. The team did not interview any returned delegates about the psychological support they received on return or while they were in the field, and the adequacy of the psychological support for those working in the Ebola crises needs to be explored. It was suggested for a manned but anonymous PSS call center to be established for the LNRCS staff who might be requiring the support. The current system is based on seeking support from one of the PSS delegates or staff at the LNRCS level. The issue of confidentiality in PSS could be problematic with the current arrangement.



4. CONNECTEDNESS

The RTE team reviewed the current structure and strategy, and felt this had achieved excellent success and made major contributions to the reduction of Ebola cases from the peak of the outbreak toward the end of 2014. The existing structures can probably form the basis for the changing response that will be required for the elimination of Ebola. This will require a number of changes in strategy, including closer involvement of the volunteers with national surveillance efforts and participation in the RITE strategy. Further, the RTE team has recommended additional skills and approaches to information management.

A second question is the transition from the intense Ebola elimination activities to a recovery phase. The RTE team felt that this was an artificial designation, which would be appropriate for a natural disaster. This approach is not appropriate for the Ebola outbreak, where the response cannot be neatly divided into disaster and recovery phases. There are many needs of the survivors left by the epidemic which could be considered “recovery” activities. As indicated in the recommendations, it is important to consider how the Ebola control program can institute these early rather than later.

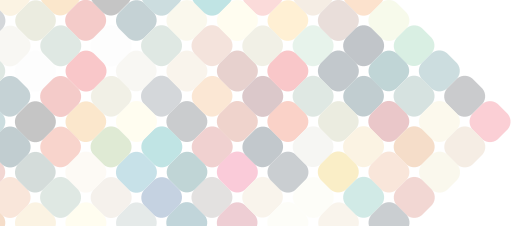
An additional question concerns the LNRCS. This current experience has certainly strengthened the national society. This has built both management and technical capacities. Their abilities to handle the recovery phase very much depends on the scope and the need for advanced technical skills required. If the recovery phase is a complex and protracted activity, then assistance will be needed for an extended time from the IFRC or PNSs, or both.

9.3. CONCLUSION

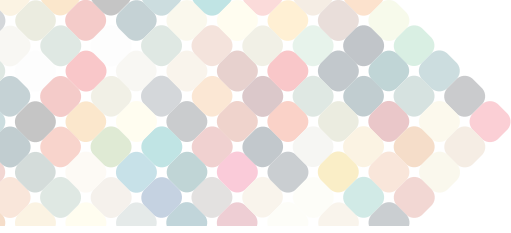
The Red Cross has contributed in a great measure to the dramatic reduction of Ebola in Liberia. The success seen so far has been greatly assisted by strong organization of the Ebola response by the MoH and the IMS. With even a few cases of Ebola continuing to occur, there is a chance for further flare-ups. Without zero total cases, these hot spots will continue. A strong emphasis on surveillance and active case finding is required, something that can build on the Red Cross community presence and current contact tracing activities. The Red Cross must be ready shortly to shift from the cremation of dead in Montserrado to burial. A further shift needs to be made to consideration of recovery, particularly as there are major needs developing now which are not being fully addressed. The safety of the volunteers remains a major concern.

9.4. DETAILED RECOMMENDATIONS FOR LIBERIA

- The SDB activities have been carried out in an exemplary manner and are a great credit to the dedication and commitment of the volunteers and the support of the LNRCS and the technical direction from the IFRC. This is transitioning to a new phase from cremation to burial. At the end of this process, the IFRC should develop a manual building on the experiences and lessons learnt from the SDB program.

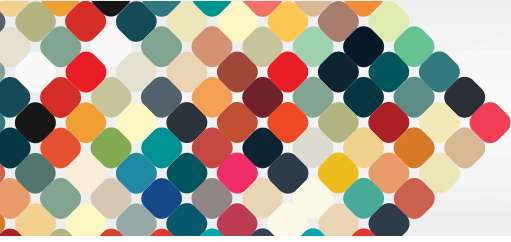


- Strengthen the project information system, and make better use of the data collected for analysis of patterns and trends. This is a weak area in all three countries. An example would be the analysis of contact tracing data to better understand the behavior of the epidemic at the community level.
- The insufficient collection and use of information further emphasizes the need for at least regional epidemiological capacities to help country programs get ahead of this evolving epidemic, rather than just being reactive. While the epidemic will most certainly be eliminated, and probably first in Liberia, enhancing systems to more effectively respond will shorten this time.
- Consider a humanitarian assistance component to help recovery of Ebola survivors and affected household members working with the various other organizations with community mandates. Now that the epidemic is ebbing in Liberia, many steps can be taken within the context of the current Appeal to relieve suffering and reduce stigmatization. This would strengthen connectedness.
- Beneficiary Communications have been very effective, but these have been largely unidirectional. There seems little up-communication (systematic feedback received) from the beneficiaries.
- Needs assessment is stressed in the IFRC approach to emergency management, and as part of this community surveys are a standard for needs assessments and understanding beliefs, knowledge, attitudes and practices. This seems to have been omitted in the Liberia Ebola response both initially and subsequently. When these are done they need to be conducted in a sound way so the results will be meaningful.
- Much of the Ebola work has focused on the SDB. As the epidemic has entered a new phase of small localized outbreaks, the Red Cross can make some shifts toward volunteers participating with the County Health Teams in community based surveillance and active case finding. This would be scaling up from current contact tracing but using the same structures and resources. Enhanced surveillance is an important need at this stage.
- A major recommendation is to reassess what support can be provided to volunteers. This falls in several categories:
 1. The safety of volunteers from infection must be strengthened. This will require refresher training for those coming into contact with contamination. Quality control elements are needed for volunteers.
 2. Physical safety of the volunteers in some places is a concern. The RTE team were not able to determine what physical safety monitoring and response capacity is in place, but this should be reassessed.
 3. Volunteers working in other areas need regular refresher training and regular supervision as well, something that is being done, but could be strengthened.
 4. Psychological support is needed for volunteers working in particularly hazardous or stressful situations through an established system. Many are feeling the effects of the stressful work, and some ad hoc arrangements exist for psychological support of volunteers, but this should be formalised.
 5. The success of the Red Cross efforts is due to its dedicated network of volunteers. A plan for formal recognition of volunteers when Ebola is eliminated should be developed. As many volunteers were students before schools closed, scholarships were frequently suggested.
- The Hub Strategy which will concentrate Red Cross response capacities in key areas is an excellent strategy moving forward. The community protection kits assisted by UNICEF, need to be pushed forward where the situation is appropriate.



- The Psychosocial Support program has been an important success. Thinking beyond the Ebola outbreak, this could be adapted to provide psychosocial support for the many other everyday events happening in the communities.
- Financial management appears sound. The Ebola response is underspent, so this provides an opportunity for the expansion of initiatives in several areas noted here. Alternatives should be sought to transferring large amounts of money in Red Cross vehicles on predictable dates to pay incentives to volunteers.
- Improvements in relevance of terms of reference and handover documents for IFRC delegates are recommended.





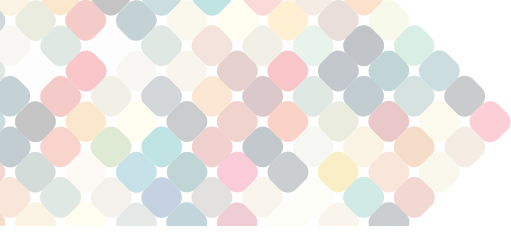
8. REGIONAL STRATEGY

The evaluators felt that the Regional Coordination and Preparedness Appeal (MDR60002) is relevant and it provides the coordination and the strong technical backup in areas such as PSS, Beneficiary Communications Health, and Human Resources that the country programs need. The selection of an experienced regional head of emergency operations facilitated development and the success of this unit. The overall objectives were clear and largely met. This was difficult and not all Red Cross offices were enthusiastic at the beginning. It was difficult to raise money from donors for a project that promoted coordination rather than direct patient care.

Once running with sufficient staff, the Regional Ebola Management Unit has been able to strengthen coordination and develop common approaches across sites to address specific deficits in technical capacity by recruiting IFRC delegates with the appropriate skill sets. In some technical areas, it was difficult to find a sufficient number of persons with the right skill sets. This has been a particular problem in Guinea, where the national society was seen to be initially slow in response. The experienced regional health delegate spent much of her time in setting up the ETC in Sierra Leone. The three countries could have benefited from additional public health resources both at the country level as well as from the regional Ebola management unit.

A strength of the Africa Ebola Management Unit has been the management of logistics, though at the beginning was slow in getting all the delegates with the necessary skills in place. The technical support to Beneficiary Communications and Social Mobilization went particularly well, and in practice these were more or less integrated, as it was the same volunteers doing these two interventions as well as the SDB. The importance of a strong communications capacity was very much emphasized from the experience of the region. Interacting with the national societies involved some tensions in the beginning. With their experience during the civil war years, some resistance was displayed at times over accepting outside assistance. Some national societies were being pulled in various ways, such as providing Ebola prevention services to mining countries, and a common direction in the three countries needed to be agreed. A regional operational framework was established to guide the collective Red Cross efforts. This needs to be updated regularly as the direction of the epidemic changes. The regional meetings organized for Sierra Leone, Liberia and Guinea have been cited as a positive learning forum in sharing lessons learnt from the three different countries.

DREF funds were made available to Sierra Leone on April 6th. Liberia, April 9th. Senegal 11th April. Cote d'Ivoire and Mali April 18th. Cameroon, Benin, Togo, CAR, DRC between August 24th and August 29th. Chad on Sept 12th, Gambia on Sept 15th, Kenya on Sept 23rd, Americas Oct 21st and Ethiopia Oct 29th. In some cases it was difficult to move the national societies to a full response, considering the pervasive fear of Ebola. Areas that lagged were in the area of information management. Although the RAMP system exists, it needs to be made more user friendly to encourage its use more widely in all phases of the response. This outbreak has pointed out the need for a new type of delegate; one with strong epidemiology and one with information management skills. This is distinguished from the traditional organizational monitoring and evaluation activities. Strengthening information management is a particular need identified in this evaluation. Building information management and epidemiological skills is particularly important in the context of weak health systems in fragile or failed states without strong institutions of governance.



The RTE team felt the need for greater and sustained on-the-ground support from technical specialists. Technical needs by the country Ebola response units was often greater than what a single regional delegate could support, even with frequent visits. This was particularly true in the area of health and human resources.

Several of the country team members felt that they could benefit from more cross border meetings, something that could be facilitated by the regional Ebola unit.





9. GENEVA EBOLA CELL

This activity is in process. Among those interviewed, there were mixed opinions. Some had a wait-and-see approach and others were concerned that it would add layers to the decision-making and the management process. The RTE team did not have any ToRs for this cell, nor was this specifically listed in the directions for the RTE, but in general the team was favorable to an activity that would concentrate Ebola expertise, and provide an institutional connection to other international bodies doing Ebola work. Further, this cell could encourage integration between the various pillars which some saw as excessively vertical. This is clearly an area for improved coordination and connectedness among the different IFRC resources now contributing to the response. It is hoped that a senior person with political support could head this so that its findings and recommendations would be taken seriously and acted on quickly.

An area of particular need sensed by the RTE team was the management of information. In an operation of this size it is not advisable to depend on other bodies such as the WHO and the CDC to interpret data for major operational planning such as what is occurring in the Ebola response. Developing the capacity to analyze and interpret program data is one important component which is needed, but a second is the understanding of how this fits together with data from other sources to guide directions for Red Cross programming.

A problem the RTE team noted was that many program indicators were weak. The majority of indicators focused on outputs. Many of the activities undertaken have processes and outcomes which can and should be measured. With stronger technical support the individual country programs could be assisted in incorporating stronger indicators which could be incorporated in subsequent Appeals.



10. NAIROBI ZONE OFFICE

The following notes represent the key points coming from interviews with Africa Zone Office staff in Nairobi. These bullet points will be expanded in the next draft of the report.

The overall IFRC Ebola command structure was articulated as follows: Country HOPs report to the Regional Head of Operations, who reports to the Zone Director, who reports to the Secretary General. Staff in Nairobi believe this to be an appropriate structure in theory, but in practice many other staff are providing input into decisions in a way that is frustrating and confusing for delegates in the field. Frequently, email conversations on important decisions spiral into long conversations with unclear decision-making. As discussed above, no ToRs have yet been distributed for the Ebola Coordination Cell in Geneva, and it is unclear how the Coordination Cell fits into the existing command structure.

HR recruitment has been one of the biggest challenges of the Ebola response. The HR department at all levels has worked successfully to deploy many new and existing staff. The successes seen in HR recruitment and deployment have come in large part to a willingness of upper-management to streamline HR processes. Recruitment appears to be easier than it was at the start of the outbreak, with more and more humanitarian workers willing to travel to West Africa now that the initial panic of the outbreak has subsided.

There may be an over-emphasis on recruiting regional/zone staff at the expense of in-country delegates. Rather than focusing on positions in Nairobi and Geneva to provide remote support, IFRC should prioritize getting staff on the ground as part of country office structures. Many in-country staff feel burdened by the demands placed on them by working at a distance with support personnel. Remote working relationships are not as productive as in-person working relationships.

The relationship between the IFRC Disaster Management Department and the IFRC Health Department has been effective and complementary. Most people agree that Disaster Management Department has by default (due to its size) taken the lead, with the Health Department providing technical expertise. This has worked well, though some speculate that the small number of technical health delegates has limited IFRC's ability to participate in technical dialogue with global partners (notwithstanding the tremendous contribution of Amanda McClelland and other Health Department staff at all levels). Red Cross is seen more as a generic NGO implementing activities than as an actor with technical depth.

There is growing fatigue among IFRC staff at all levels: country, region, zone, HQ. Staff have been carrying out excellent work, but many feel unappreciated. This crisis has no time limit. To prevent impending burnout and bolster morale, high-level management should take the initiative to congratulate and encourage staff for their efforts at all levels.