

**EVALUATION OF IFRC WEST AFRICA EBOLA VIRAL DISEASE APPEAL RESPONSE  
SIERRA LEONE AND LIBERIA**

**FINAL DRAFT REPORT**

**16 APRIL 2018**

**BY:**

**Sophia Ayoo, Lucy Njigua and Virginie Roiron**

## LIST OF ABBREVIATIONS

CBAT	Community based action team
CBHFA	Community Based Health and First Aid
CBHP	Community Based Health Programme
CBS	Community Based Surveillance
CEA	Community engagement and accountability
CEBS	Community events based surveillance
CHAST	Children hygiene and sanitation transformation
CT	Contact Tracing
CTS	Contact Tracing and Surveillance
DERC	District Ebola Response Center
DHMT	District Health Management Team
DREF	Disaster Response Emergency Fund
DRR	Disaster Risk Reduction
EOC	Emergency Operations Centre
EVD	Ebola Virus Disease
ERT	Emergency Response Teams
ERU	Emergency Response Units
ETC	Emergency Treatment center
EWS	Early Warning System
FACT	Field assessment and coordination team
FGD	Focus Group Discussion
FSL	Food Security and Livelihood
GoSL	Government of Sierra Leone
HQ	Headquarters
HS	Health System
IDSR	Integrated disease surveillance and response
IFRC	International Federation of Red Cross and Red Crescent
IMS	Information Management System
IPC	Infection prevention and control
LRCS	Liberia Red Cross Society
M&E	Monitoring and Evaluation
MNCH	Maternal newborn and child health

MoU	Memorandum of Understanding
MSF	Médecins SansFrontières
MOA	Ministry of Agriculture
MoH	Ministry of Health
MoHS	Ministry of Health and Sanitation
NERC	National Ebola Response Center
OCA	Organisational Capacity Assessment
OD	Organisational Development
PHAST	Participatory hygiene and sanitation transformation
PPE	Personal protective equipment
PSS	Psychosocial Support
RC	Red Cross
RM	Resource Mobilization
RRA	Rapid Recovery Assessment
SDB	Safe and Dignified Burials
SDH	Social determinants of health
SGBV	Sexual and Gender Based Violence
SL	Sierra Leone
SM	Social Mobilization
SLRCS	Sierra Leone Red Cross Society
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
SSI	Semi-Structured Interview
ToR	Terms of Reference
UN	United Nations
UNDP	United Nations Development Programme
UNMEER	UN Mission for Ebola Emergency Response
WASH	Water Sanitation and Hygiene
WHO	World Health Organisation

## TABLE OF CONTENTS

<b>1. EXECUTIVE SUMMARY</b>	<b>4</b>
<b>2. BACKGROUND</b>	<b>9</b>
<b>3. SCOPE AND METHODOLOGY</b>	<b>10</b>
3.1 PURPOSE AND OBJECTIVE OF THE STUDY	10
3.2 METHODOLOGY	10
3.3 STUDY LIMITATIONS	11
<b>4. FINDINGS</b>	<b>12</b>
4.1 COHERENCE, RELEVANCE AND APPROPRIATENESS OF THE RESPONSE	12
4.1.1 EMERGENCY RESPONSE STRATEGY	12
4.2 COHERENCE, RELEVANCE AND APPROPRIATENESS OF THE RECOVERY PHASE	14
4.3 EFFICIENCY	16
4.3.1 AVAILABILITY AND UTILIZATION OF RESOURCES (FINANCIAL, HUMAN, PHYSICAL AND INFORMATIONAL)	16
4.3.2 TIMELINESS OF THE DELIVERY OF OUTPUTS IN RELATION TO THE BENEFICIARY NEEDS	21
4.4 COVERAGE	25
4.4.1 RESPONSE PHASE	25
4.4.2 RECOVERY PHASE	28
4.5 EFFECTIVENESS	28
4.5.1 COORDINATION OF THE INTERVENTION	28
4.5.2 EFFECTIVENESS OF THE RESPONSE PILLARS	29
4.5.3 EFFECTIVENESS OF THE RECOVERY PHASE	32
4.5.4 IN LIBERIA	35
4.5.5 EFFECTIVENESS IN STRENGTHENING THE NS CAPACITIES	35
4.6 IMPACT	36
4.6.1 STRATEGIES TO CONTROL AND STOP THE EPIDEMIC	37
4.6.2 SAFE AND DIGNIFIED BURIALS	37
4.6.3 COMMUNITY ENGAGEMENT AND PSS	38
4.6.4 HEALTH SYSTEM STRENGTHENING	38
4.6.5 IMPACT OF OD ACTIVITIES	38
4.6.6 IMPACT OF THE RECOVERY PROGRAMME	39
4.6.7 UNINTENDED IMPACT	39
4.7 SUSTAINABILITY	40
<b>5. CONCLUSIONS</b>	<b>42</b>
<b>6. LESSONS LEARNT AND RECOMMENDATIONS</b>	<b>44</b>
6.1 LESSONS LEARNT	44
6.2 RECOMMENDATIONS	45

## 1. EXECUTIVE SUMMARY

The Ebola virus disease (EVD) epidemic in Guinea, Liberia and Sierra Leone is the longest, largest, deadliest, most complex and challenging Ebola outbreak in history, claiming the lives of at least 11,310 people.

Following the detection of Ebola outbreak in Guinea in March 2014, the International Federation of Red Cross and Red Crescent Societies (IFRC) launched an operation that gradually expanded in scale and scope, and was followed by a recovery phase which has ended in Liberia and will continue up to June 2018 in Sierra Leone.

The IFRC EVD intervention final evaluation intended to evaluate the impact of the appeal for Ebola response in the three countries of Liberia, Guinea and Sierra Leone. It is expected that findings, key lessons learnt and recommendations from the evaluation will guide the IFRC, partner National Societies of Liberia and Sierra Leone in future programming as well as in Africa region. The evaluation was implemented in Sierra Leone and Liberia and the field work took place between 18<sup>th</sup> November and 7<sup>th</sup> December 2017.

### FINDINGS

**The IFRC response was very coherent with the existing policies and frameworks; and relevant and appropriate to the needs of the communities.** The Red Cross social mobilization activities and approaches were particularly valued by community members. The IFRC response has shown a great level of coordination within the global response and was able to effectively take the lead of the Safe and Dignified Burials (SDB) pillar for which IFRC provided good quality and widely acknowledged leadership.

**The recovery rapid assessments were participatory but they were not found sufficient to analyse needs, vulnerabilities and capacities within specific environments.** Combined with a lack of baseline information and weak Monitoring and Evaluation Systems across programmes, this resulted in the design of over-ambitious recovery plans that experienced challenges targeting the most vulnerable. **Although some components of the recovery plans are relevant to key needs such as food security and livelihoods, they lacked a strong public health focus** prioritizing community based health promotion and prevention, addressing the social determinants of health and the barriers to access to health care, epidemic preparedness, strengthening of the health systems and humanitarian diplomacy. Although particularly relevant to IFRC resilience vision, the recovery plans are not found relevant enough to the National Societies' core mandates and capacities and did not factor in the National Societies capacities. In Liberia, the recovery programme is considered insignificant as the NS was shattered by the aftermaths of the integrity issue right after the response phase and hardly implemented any recovery activities.

IFRC deployed Field Assessments and Coordination Teams, launched appeals and deployed Emergency Response Units as soon as the epidemic was declared in both countries. **IFRC quickly initiated small-scale social mobilization interventions in the affected areas and gradually expanded to the rest of the districts/branches.** IFRC personnel were brought in to provide coordination and technical support to the NS for effective implementation. **The timeliness of the operation has however been a challenge as most of the activities were slow to scale up, which can be explained by the difficulty in recruiting local and international staff combined with slow funding mobilization in the initial phase. Volunteers retention has been a challenge during the operation due to weak volunteers management policy and continues to be an issue.** The slow recruitment of staff, volunteers and deployment of delegates combined with limited NS capacities, delayed implementation of activities which resulted in a low burn rate of the funds available. The volunteers had to be recruited and trained before they could implement any activities in the community which led to some delays in the implementation. The lack of sufficient vehicles delayed the operation especially in hard to reach areas. Weak IMS and M&E meant that the operation was not able to predict the evolution of the epidemic.

The IFRC clearly identified and integrated the issue of staff and volunteers' safety which was timely and efficiently factored in the appeals and activities. Although the physical safety of staff and volunteers was properly addressed resulting in only four of them infected, their psychosocial needs were not clearly taken into consideration and systematically addressed as reported during the interviews.

**Given the scale and the complexities of the operation, the evaluation team concludes that the operation was efficiently managed.** Regardless of the inefficiency in availability and utilization of resources, a number of key activities in the response were timely and efficient: the SDB activities began immediately after the National Societies were requested to lead the pillar, social mobilization and community engagement activities were implemented immediately (although with a limited scope initially); the setting up of ETC centre was timely after the request from WHO. However, activities in contact tracing and PSS were slow to take off because they were introduced after the other activities in the operation. Introducing them earlier would have helped the operation to reduce the number of new infections and also encourage reintegration of survivors and reduce stigma of EVD infected persons. The allegation of mismanagement of funds in the two countries slowed down activities affecting efficient management of activities especially in the recovery phase. In Sierra Leone, a review in 2016 uncovered serious issues of non-compliance with regard to the awarding of a contract to build new warehouses for the Sierra Leone Red Cross. IFRC immediately requested SLRCS terminate the contract in question, and oversaw a new procurement process with additional compliance oversight. A new contract was awarded, and construction resumed in September 2017. In Liberia, a 2015 standard internal audit of expenditures uncovered irregularities which in turn triggered an internal investigation. That investigation found evidence of fraud related to inflated prices of relief items, with involvement of individuals from the National Society. As a result of that investigation, the President of Liberia dissolved the National Societies board of governors. Following this cases IFRC has put in place a strengthened 'triple defense' prevention framework to protect against fraud and corruption in high risk operations. This framework establishes new checking and enforcement measures at each line of fraud prevention defense.<sup>1</sup>

**The IFRC response coverage was strategically targeted to control EVD transmission and to address the likelihood of the quick spread of EVD to all parts of the country.** The recruitment of volunteers (both men and women) covered the local communities in all the Districts in the two countries with some representation of those living with physical disability in Sierra Leone. **The information was packaged in different modes which facilitated dissemination to all community members regardless of status, gender and age.** However, those living with disability, especially the visually handicapped were not adequately covered since there was no information in braille.

**IFRC/the National Societies community engagement and social mobilization approaches were very effective. Despite the time required to recruit and train volunteers, the National Societies eventually had access to local communities at the grassroots through the NS volunteer network in all the districts.** They recruited and trained more than 4,000 volunteers who had adequate and relevant capacity; and they effectively participated in the activities of all the five pillars of intervention. In addition, the volunteers enabled IFRC/National Societies to intervene effectively in some of the hard to reach areas and the most difficult communities to penetrate. **The evolution of the social mobilization approach eventually led to the development of the Community led Engagement Approach which was found very effective although it came at a late stage. Volunteer social mobilization activities across the five pillars contributed significantly to community positive change of attitude towards EVD intervention. The volunteers established strong links with the community and religious leaders,** an approach which was paramount in marshaling the support and active participation of communities and ensuring an effective follow up of activities.

On the ground, the five-pillars approach enabled effective community mobilization, tracing suspected cases for treatment or quarantine, providing psychosocial support to communities to cope, providing clinical services to manage and treat EVD and burying the dead in a dignified manner and disinfecting the

---

<sup>1</sup> Ebola Fraud – Communications Pack – Updated 5 January 2018

environment. **Volunteers in different pillars were interdependent and collaborated as they worked for effective results.**

**Interviews and FGD conducted during this evaluation and academic research all point to a great impact of the IFRC response in curbing and stopping the epidemic.** The role of SDB combined with CTS has been crucial and the importance of the RC social mobilization approach widely acknowledged as a major contributor to stopping the epidemic.

**Regarding sustainability, at the community level,** although knowledge and awareness on key prevention and protection measures is still there, people in both countries were found to be gradually going back to their past practices as fear has now disappeared. **The ebola response achievements in strengthening the HS are being consolidated in the CBS programmes** which are implemented nationally and to which SLRCS contributes actively. However, it is not clear at this point whether CBS will be continued by SLRCS at the end of the EVD appeal. The FSL intervention in SL has effective elements of sustainability that will require a continued monitoring and support. **In Liberia, the baseline of the current CBHP programme supported by Canadian Red Cross** indicate that ebola related knowledge is still of a reasonable level amongst communities. The NS is implementing an integrated CBHP including WASH, DRR and DM envisaged through an epidemic outbreaks angle, which led to the formulation of county-based contingency plans in Bomi County. A national LRCS preparedness program building on this experience could support to sustain the ebola response achievements.

**From a Health System Strengthening point of view, some of the Red Cross interventions are now clearly sustained within the National Health Systems of both countries.** In both countries, the successful leadership taken by IFRC in the Safe and Dignified Burials pillar led to the development of guidelines and SoP which are owned nationally. **The Integrated Disease Surveillance and Response Systems have been implemented and are being strengthened with support of CDC and WHO and are a direct legacy of the ebola lessons learnt.**

**The training of staff and volunteers in various thematic related skills have strengthened the capacity of the NS in these areas.** The National Societies have a pool of skilled staff and volunteers able to carry out social mobilization and community engagement activities, provide psychosocial support services, carry out disease surveillance and contact tracing, disaster management and early warning systems, in addition to carrying out safe and dignified burials.

**Despite these positive trends, the overall sustainability of the response lacked a focused exit strategy planning for the transition from one phase to the other from a strategic, programmatic and resources point of view.** In SL, the scope of the CBHP/WASH/DRR programme and the current level of achievements of the recovery plan remains limited, which may limit the sustainability of many EVD response achievements, both at the communities and SLRCS levels.

The capacity building of national societies improved their capacities to respond to future emergencies. However, the National Societies still struggle with lack of volunteer database and recordkeeping contributing to poor volunteer recruitment and retention. The development and implementation of policies and systems to guide the management in terms of human resources; procurement and logistics; financial management and; PMER will help the National Societies to address the challenges that they continue to face and strengthen the capacity of the National Societies. To ensure that the gains made in building the capacity of the NS are sustained, it is important that a strong capacity building programme is established to support the leadership and governance.

## **RECOMMENDATIONS**

### **FOR FUTURE RESPONSES**

- **R1: Community Led Engagement Approach**

The experience of the Community Led Engagement Approach seemed to have yielded positive results although it came late in the response. **It is therefore recommended to look into this approach more in-depth and capture lessons learnt and key best practices to mainstream those in a community engagement and accountability strategy designed for emergency responses** that would entail:

- The recruitment of a great number of community volunteers at the local community levels is an effective strategy to reach the local communities. Attempts should be made to ensure that recruitment of volunteers is inclusive of all groups of community members including those living with disability. The proactive systematic recruitment of female volunteers as part of the volunteers teams should be maintained and replicated.
- It is recommended that IFRC should systematically involve community leaders in all the stages of interventions, including planning, rather than wait and involve them before communities show signs of resentment to an intervention.
- Build on community leaders and their role in developing and implementing by-laws during the response to explore further opportunities to strengthen the sustainability of behavior changes.

- **R2: Volunteers Management**

The retention of the capacitated and motivated community based volunteers which have been a key asset to the success of the response shall be a top priority of the IFRC agenda and shall be taken into account from the onset of the operation. **It is recommended that IFRC develops strategies to enhance retention of volunteers during interventions while at the same time ensuring efficient management of their phasing out at the end of the response. Identifying relevant activities in the program areas of NS or internship programs could be a way forward. In any case, it is recommended to conduct training on volunteer development and management when the need is identified.**

Psychosocial support to volunteers needs to be better incorporated and mainstreamed in emergency response at an early stage. **It is recommended to have PSS for staff and volunteers developed during pre-disasters times as a key component of Disaster Management and OD programming.**

- **R3: Monitoring and Evaluation**

**It is recommended to IFRC to review its M&E system in emergency to be able to collect and analyse data needed to run the operation with anticipation.** In epidemic outbreak responses, a focus on epidemiological data should be emphasized in order to establish a sound data analysis function indispensable to provide strategic directions to the operation. It is also recommended to improve information management and monitoring and evaluation to ensure that there is integrity of data coming from the branches.

**Similarly, it is recommended that the M&E system in recovery is improved to allow a more efficient programme management and accountability to donors, including baseline assessments and the monitoring of realistic and workable indicators** at all levels of the program hierarchy. M&E trainings for project officers and branch managers should be conducted on a regular basis.

**R4: Transition from response to recovery**

**It is recommended to plan the transition from emergency to recovery with a clearer analysis of the National Societies mandates and capacities.** IFRC should engage in assessments of capacities and OD gaps during the response in order to plan a well-targeted transition from response to recovery. Such transition could be planned by deploying OD staff with relief experience during the response, who would be tasked to analyse OD needs and support in planning the transition in terms of availability of resources and design of programmes and OD plans. Workable and realistic exit strategies should be designed and systematically implemented to enhance the sustainability of the emergency response gains.

## **Recovery Strategic planning**

- **R5: Vulnerability Analysis**

**It is recommended that the design and implementation of recovery programming is based on systematic in-depth vulnerabilities and capacities assessments that could be conducted during a brief and focused “inception period”.** Such a phase would also allow good quality baseline assessments to be conducted. These assessments would support in refining ambitions and in designing appropriate approaches in line with existing vulnerabilities and would also form the basis of a strong participatory community development approach aiming at strengthening social cohesion and inclusion of the most vulnerable.

- **R6 : Food Security and Livelihoods**

Strategic planning for recovery needs to take into account IFRC and the operating National Societies mandate and core competencies. Food Security and Livelihood is relevant to IFRC focus on resilience but does not always translate into strategic priorities and competences at the National Societies level who traditionally do not have strong capacities in this sector. Such a discrepancy shall be addressed when planning for recovery and strategic partnerships shall be sought at the global and/or country level with key actors to overcome this challenge when it arises.

- **R7: Health**

**In the health sector which remains a core strategic priority and competence both for IFRC and the NS globally, it is recommended to conduct strong baseline data, KAP surveys and barriers analysis when planning for recovery, to ensure the design of in-depth public health programming that addresses root causes of poor health.**

Similarly to FSL, strategic partnerships with key health actors should be sought to address health issues and address social determinants of health which are not within the range of the Red Cross Red Crescent Movement priorities and competences. Humanitarian Diplomacy for health should become a systematic approach to which, combined with strategic partnerships, has the potential to substantially increase the impact of IFRC Health programming.

- **R8: Capacity Development of National Societies**

The National Societies should be supported to develop resource mobilization strategies aimed at building the NS capacities to implement programmes within their core strategic priorities and build sustainability of the programmes. Financial support services should be placed at the branch offices to support the branch managers. The National Societies headquarters should have the capacity to support the branch/county branches to have the adequate financial management skills.

Continuous capacity development programmes focusing on financial management, policy development, procurement and logistics, human resource and administration should be sustained in all the National Societies. Refresher trainings in the areas of social mobilization skills, Psychosocial support and counselling, integrated disease surveillance, contact tracing should be conducted regularly. In addition, regular monitoring of capacity building activities should be carried out.

Coaching and mentoring of NS leadership on good governance and management should be carried out on a regular basis. The national executive board should carry out annual self-assessment to evaluate their work in strengthening the NS in strategic policies and implementation of financial audits, HR, procurement, resource mobilization and sustainability. Change agents within the leadership should be identified to spearhead change and create ownership of the capacity building programme

Draft policies and procedures should be approved by the board and close monitoring of implementation carried out. During an emergency period, the board might suspend full implementation of policies and

procedures in writing. Clear timelines must be set for when this should apply and regular review of the situation should be carried out to determine if it is safe to revert back to full implementation of the policies and procedures.

#### **FOR MID TO LONG TERM PLANNING WITHIN CURRENT PROGRAMMES**

- **R9:** It is recommended that both National Societies develop a realistic and well-targeted strategic plan which will form the basis of its partnerships and resource mobilization strategies and includes a resource mobilization strategy that is based on effective programming as much as on other income generating activities.
- **R10:** CBS should remain, in this form or as ECV, part of the National Societies core programming integrated in CBHP and DRR. There is however a need to improve its sustainability by relying more on unpaid community volunteers, including possibly the Community Health Workers, and by establishing a clearer and stronger relationship between volunteers and health facilities.
- **R11:** The FSL intervention in SL has effective elements of sustainability that require a continued monitoring and support from the NS. Such support should be planned for and implemented during the remaining months of recovery appeal implementation.

## **2. BACKGROUND**

The Ebola virus disease (EVD) epidemic in Guinea, Liberia and Sierra Leone is the longest, largest, deadliest, and the most complex and challenging Ebola outbreak in history. It is unprecedented in terms of its duration, size of infections and fatality, and geographical spread. The EVD outbreak in West Africa started in Guinea on 26 December 2013 and spread across borders to both rural and urban areas, to Liberia, Sierra Leone, Nigeria, Senegal and Mali; and reached some parts of Europe and the United States of America. The first case in Liberia was recorded on 30 March 2014 in Foya District, Lofa County and in Sierra Leone (SL) on 27 May 2014 where it spread more rapidly than in the other countries. At least 11,310 people died from the disease during the outbreak.

Although the EVD outbreak was recognized in January 2014, the WHO did not declare a public health emergency of international concern until 9 August 2014, regardless of the warnings from agencies on the ground, especially Médecins Sans Frontières (MSF). Most international organizations began to respond in a significant scale only after September 2014. Delayed recognition of the extent of the epidemic was compounded further by poor communications, political and cultural resistance by communities. On 18 September 2014, the United Nations Security Council declared the EVD outbreak a threat to peace and security. This was followed by the establishment of the UN Mission for Ebola Emergency Response (UNMEER) on 19 September 2014. The EVD response continued to be destabilized by a state of panic and confusion arising from resistance by communities. The situation only began to change by the end of 2014, when the response became increasingly focused on the districts and started working closely with local officials and community leaders (DuBois, 2015).

Following the detection of Ebola outbreak in Guinea in March-April 2014, IFRC launched on 7 April a DREF of 113,217 Swiss francs (for Sierra Leone) and 101,388 Swiss francs (for Liberia) to support communication activities combined with social mobilization (SM) and community sensitization. Several hundreds of volunteers were trained on EVD awareness (use of personal protective equipment, psychosocial support, hygiene promotion and epidemic control). FACTs were deployed in May and June 2014 to Liberia and Sierra Leone (SL) respectively.

In Liberia, the first EVD Emergency Appeal was launched in April 2014 for six months with a budget of 517,766 Swiss francs and was revised four times: in July 2014 (1.9 million Swiss francs for nine months) with a focus on scaling up of dead body management; in September (8.5 million Swiss francs and timeframe extended to June 2015); in November (24.5 million Swiss francs). The fourth revision in June 2015 extended the timeframe to the end of 2017 with a revised budget of 46.3 million Swiss francs which transitions from emergency response to recovery. The first Emergency Appeal for SL was launched in June 2014 for 880,000 Swiss francs and was revised four times: in July 2014 (1.36 million Swiss francs), in September-October 2014 (12.9 million Swiss francs to include SDB and ETC), followed by revision n° 3 for 41.1 million Swiss francs, and a revision n° 4 for 56.75 million Swiss francs in March 2015.

The January 2015 IFRC Strategic framework consolidates the IFRC strategy to address EVD in the three affected countries including a focus on the post-Ebola recovery period. From February 2015 to March 2015, an IFRC Recovery Rapid Assessment (RRA) team was deployed to the three affected countries which led to the development of recovery plans.

What started as a public health crisis in Guinea on 26 December 2013 degenerated into development crises. According to UNDP, the Ebola crisis devastated fragile healthcare systems, as large numbers of healthcare workers became ill or died from the disease. Non-Ebola related morbidity and mortality, including infant and maternal mortality, also increased as resources were diverted to fighting the virus and people avoided seeking health care. The Governments response to contain the EVD led to a disruption in livelihoods and economic security due to closure of markets, roads, banks and movement restrictions. The outbreak erupted at a crucial period in the agricultural season for rice and other important food crops. Many farmers were unable to complete key time-critical agricultural activities such as harvesting and crop maintenance. Two livelihoods groups have been especially affected: the market dependent households and farmers with women being the most affected group. The outbreak had substantial effects on the countries' economies and public finances as shown by World Bank assessments. While all three countries were growing in the first half of 2014, the full-year 2014 growth dropped in Liberia to an estimated 2.2 percent from 5.9 percent expected before the crisis, and in Sierra Leone to an estimated 4.0 percent from 11.3 percent expected before the crisis. Access to basic services – such as education, water and sanitation - has been relatively limited in the Ebola-affected countries. The cohesion of affected communities was also weakened significantly as health care workers, Ebola survivors and burial teams were stigmatized and rejected by their communities (UNDG, 2016).

### **3. SCOPE AND METHODOLOGY**

#### **3.1 PURPOSE AND OBJECTIVE OF THE STUDY**

The IFRC EVD intervention final evaluation intended to evaluate the impact of the appeal for Ebola response in the three countries of Liberia, Guinea and Sierra Leone. It is expected that findings, key lessons learnt and recommendations from the evaluation will guide the IFRC, partner National Societies of Liberia and Sierra Leone in future programming as well as in Africa region. The details of the evaluation objectives and expected outputs are detailed in the ToR found in Annex 1. The evaluation was implemented in Sierra Leone and Liberia and could not be implemented in Guinea. The field work took place between 18 November and 7 December 2017.

#### **3.2 METHODOLOGY**

The final evaluation methodology is detailed in the inception report which is found in Annex 2.

The evaluation was carried out by three consultants, in Sierra Leone from 18 to 27 November and in Liberia from 28 November to 6 December 2017. The detailed itineraries are found in Annex 3.

The methodology used for data collection during the final evaluation was qualitative and included document review, observation and Focus Group Discussions (FGD) in the target communities. Semi-structured interviews (SSI) were conducted with key informants from National Societies headquarters (HQ) and branches, with district authorities, IFRC staff and other key stakeholders (see Annex 4). To the extent possible, triangulation was used to verify and validate information. FGD and SSI were conducted according to structured guides developed for the purpose of this evaluation.

### **3.3 STUDY LIMITATIONS**

- The study was conducted two years after the end of EVD Response: most of the key/lead staff involved in the response had either left the IFRC/National Societies and other organizations or were in the process of exiting. In addition, most community members are currently in the process of healing from the trauma of EVD experience and more focused on moving ahead with their lives; and were sometimes uneasy to recall events related to the response. They were understandably more focused on talking about their current daily struggle against poverty, making it challenging for the team to bring them back to painful memories.
- Accessing all key documents prior to country visits has been at times challenging given the great number of documents and the lack of centralization by IFRC.
- The timeframe for the country visits was modified a number of times, making it challenging for IFRC country teams and for the evaluation team to plan field work, at times generating time loss. Some stakeholders could not be interviewed: for instance it has not been possible to meet staff or beneficiaries knowledgeable about the Emergency Treatment Centers in Sierra Leone, which reduces the findings on this pillar.
- The short time frame allocated for a very complex multi-country study involving complex interactions limited the depth of the evaluation.
- The evaluation took place in the tense and complex context of the integrity issues affecting its operation in the three countries. In Liberia the integrity issue was unveiled early January 2016 and the National Societies was completing an in-depth and painful restructuring process during the evaluation. In Sierra Leone the issue was still emerging and being dealt with, generating tension and uncertainty. This situation meant that people were reluctant to discuss financial, logistic and procurement topics. It also meant that a great number of key staff involved in the operation was not working for the NS anymore, which limited the scope of the information gathered.
- The analysis of whether the programme activities were implemented at the right cost and maximizing the use of resources, and the total management and operational costs has not been possible based on financial documentation available. In addition, given the timing of the evaluation, it was difficult to discuss utilization of funds as it was viewed as a sensitive issue that people were reluctant to address due to the current fraud investigation. The lack of financial procurement documentation at the National Societies level also made it difficult to evaluate if the resources were used at the right cost.

## 4. FINDINGS

### 4.1 COHERENCE, RELEVANCE AND APPROPRIATENESS OF THE RESPONSE

#### 4.1.1 Emergency Response Strategy

The 'Accra Response Strategy' was agreed upon by Health Ministers from eleven West African countries in July 2014, and the 'Ebola Response Roadmap' published by WHO in August 2014. **The 'Accra Response Strategy' was based on three pillars of action:** immediate outbreak response interventions; enhanced coordination and collaboration; and scale-up of human and financial resource mobilization. The contents of these two strategies were reiterated in the **September 2014 UN STEPP strategy which is structured around five priorities:** 1. Stop the outbreak: Identify and Trace people with Ebola Safe and Dignified Burials (SDB); 2. Treat the infected: Care for Persons with Ebola and Infection Control for Responders; 3. Ensure essential services (Food Security and Nutrition, Health services, Cash Incentives); 4. Preserve stability: Reliable supplies of materials and equipment, social mobilization (SM) and Community Engagement and Messaging; 5. Prevent outbreaks in countries currently unaffected. Each of the five elements included specific targets and timelines, which called for 70percent of patients isolated and receiving care and 70percent safe and dignified burials within 60 days of the Mission being rolled out.

The classic approach to managing an Ebola outbreak was followed until August 2014 when additional response measures then focused on "the three B's": behaviour, beds and burials. Later, in places where Ebola incidence had declined, emphasis was shifted to the three C's: community ownership, case finding and contact tracing and a greater emphasis was placed on the district-level (DuBois, 2015).

**The initiation, development and scaling up of response activities by the IFRC is coherent with the response policies and approaches which guided the global response to this unprecedented EVD outbreak, and appropriate to meet the needs identified based on global policies and approaches. The IFRC appeals and the Ebola Strategic Framework results matrix captures the STEPP indicators, making IFRC strategic and operation approach completely coherent with the global response strategy.**

**IFRC was able to quickly and adequately react to the epidemic through a number of appeals and subsequent revisions. The urgency of reacting to the epidemic was quickly identified and materialized in the DREF and the FACT which adequately identified key needs and ways forward. The focus on social mobilization and related training of volunteers appeared in the initial stages of the IFRC planning for response and the same applies to contact tracing.** The issue of safety of staff and volunteers involved in a very risky response were addressed early in the response which can account for a very low number of volunteers infected (only four in both countries). The crucial Safe and Dignified Burials pillar is planned for as early as July 2014 and scaled up at the requests of both Governments

**The integration of case management through the establishment and management of 2 ETC in Sierra Leone at the request of WHO Director General is very coherent with the overall response approach and relevant to the needs of treating an increasing number of EVD patients.**

Thus, following the detection of Ebola outbreak in Guinea in March-April 2014, IFRC launched on 7 April a DREF of 113,217 Swiss francs (for SL) and 101,388 Swiss francs (for Liberia) to support communication activities combined with social mobilization (SM) and community sensitization. Several hundreds of volunteers were trained on EVD awareness (use of personal protective equipment, psychosocial support, hygiene promotion and epidemic control). FACTs were deployed in May and June 2014 to Liberia and Sierra Leone respectively.

In Liberia, the first EVD Emergency Appeal was launched in April 2014 for six months with a budget of 517,766 Swiss francs (SM, surveillance, safety through the use of PPE, PSS and support to people in quarantine). It was revised four times: in July 2014 (1.9 million Swiss francs for nine months) with a focus on scaling up of dead body management; in September (8.5 million Swiss francs and timeframe extended to June 2015); in November (24.5 million Swiss francs). **The third revision clearly spells out Beneficiary Communication –“bencomm”- as a specific outcome, capturing the crucial importance of community mobilization in the control of the epidemic. It also launched the piloting of the community based protection approach and made contact tracing and surveillance (CTS) as a separate outcome.** The fourth revision in June 2015 extended the timeframe to the end of 2017 with a revised budget of 46.3 million Swiss francs. It introduced the Community Event Based Surveillance System (CEBS) and WASH activities which are found a relevant and timely transition to recovery. The latest revised appeal transitions from emergency response to recovery.

The first Emergency Appeal for Sierra Leone was launched in June 2014 for 880,000 Swiss francs with a continued focus on social mobilization and the initiation of contact tracing and surveillance (CTS) and PSS. This appeal also included a specific output dedicated to minimizing the risks to volunteers, indicating a strategic concern for volunteers and staff security early in the response. The appeal was revised four times: in July 2014 (1.36 million Swiss francs) when Emergency Response Units (ERU) were deployed to establish the Emergency Treatment Centres (ETC) in Kenema (extraordinary DREF allocation of 1 million Swiss francs); in September-October 2014, with confirmed caseload spiraling out of control and twelve out of thirteen districts affected (12.9 million Swiss francs to include SDB and ETC), followed by revision n° 3 for 41.1 million Swiss francs, and a revision n° 4 for 56.75 million Swiss francs in March 2015.

**The January 2015 IFRC Strategic framework** consolidates the IFRC strategy to address EVD in the three affected countries including a focus on the post-Ebola recovery period. It is organized around five outcomes and their related outputs: 1. the epidemic is stopped; 2. National Societies (have better Ebola preparedness and stronger long term capacities); 3. IFRC operations are well coordinated; 4. SDB are effectively carried out by all actors; 5. Recovery of community life and livelihoods. Like other humanitarian actors, **IFRC followed the WHO standard recommended public health actions for stopping the Ebola outbreak**, which have been characterized as the five pillars of the IFRC Ebola response: 1. Community engagement – social mobilization; 2. Psychosocial support; 3. Surveillance and contact tracing; 3. Case management and treatment; 4. Safe and dignified burials and disinfection.

**IFRC response strategy is relevant to the Red Cross Red Crescent Movement core capacities and comparative advantage:** the focus on social mobilization, the deployment, training and safety of volunteers who formed the backbone of the response were appropriate and relevant to SLRCS & LNRCS mandate and capacities. Subsequent focus on CTS and SDB were particularly appropriate considering the socio-cultural dimensions of the epidemic.

**Communities interviewed highlighted the appropriateness of social mobilization activities** to effectively contain and stop the epidemic. **They particularly valued: the role of community volunteers**, their respect of cultural norms and values (which created trust and ownership in contact tracing and surveillance, use of emergency lines for calling ambulances and SDB teams), **the provision of hand washing messages and stations and the support to survivors with non-food items and psychosocial support.**

## 4.2 COHERENCE, RELEVANCE AND APPROPRIATENESS OF THE RECOVERY PHASE

**The IFRC recovery approach in both countries is found coherent with key needs and priorities identified by the National recovery programmes.**

In Sierra Leone, the **President's Recovery Priorities** (July 2015 to June 2017) prioritized immediate needs in the education, health, social protection and private sectors and identified thirteen results in seven priority sectors to transition the economy back to the Agenda for Prosperity (Health, Social protection, education, private sector development, water, energy and governance). The health sector prioritized Sexual and Reproductive Health (SRH) including Community Health strengthening; Preventing, detecting, responding to epidemics (through integrated diseases surveillance and community sanitation) while the Water sector entailed providing access to water supply to 1,300,000 people.

In Liberia, the **Economic stabilisation and Recovery plan** aimed to revitalize growth to pre-crisis levels and make it more inclusive; provide support for the poor and other at-risk groups; and rebuild and strengthen the capacity to deliver core social services with better coverage in the rural areas. The revised seven-year Health Investment Plan aimed to build a more resilient health system (HS) and prioritised epidemic preparedness and response, management capacity and enhanced service delivery. The WASH Ebola recovery plan aimed to increase access to gender friendly WASH services at the community, health centers and schools level.

From February 2015 to March 2015, an IFRC Recovery Rapid Assessment (RRA) team was deployed to the three affected countries. **The RRA applied a participatory approach consulting communities, government and non government stakeholder with full participation of both National Societies.** The RRA recovery options were derived from the analysis of the pre-EVD vulnerabilities in the country, the EVD impact and an analysis of the Governments recovery priorities, and discussed during a validation workshop.

**The RRA should have been complemented by in-depth participatory vulnerability and capacity assessments analyzing root causes and manifestations of vulnerabilities (including from a gender perspective) and proposing approaches to strengthen social cohesion.** In Sierra Leone for instance, the livelihood programme suffered from a lack of clear definition of beneficiaries, which created delays and challenges within communities: the focus on EVD survivors might seem relevant from a response continuity perspective; however stakeholders interviewed (including SLRCS, IFRC staff and communities) underlined the fact the communities as a whole had been affected by the outbreak, highlighting the need to analyse root causes of vulnerabilities including pre-EVD vulnerabilities.

The UNDP project focus on a particular category of volunteers (SDB teams) has also been questioned as lacking an overall approach of stigma and discrimination. It focused on a particular category of volunteers who were perceived to have undergone more severe psychological trauma as a result of burying many dead bodies, but its fairness was questioned by other volunteers who felt they were all engaged in a high risk intervention that put all of them at risk of EVD infection and left many of them emotionally derailed. Besides, their engagement in EVD intervention exposed all of them to very devastating stigmatization by family and community members. Interviews and FGDs with different groups of volunteers and other stakeholders confirmed that volunteers suffered serious stigmatization irrespective of the pillar activities they engaged in. As at the time of the field visit, the evaluation team met some of the volunteers who had to change houses because of eviction by their land lords; and those whose spouses had ran away and were still separated from them and; they confirmed that they were involved in other pillars (social mobilization, contact tracing) and not SDB pillar activities. **Based on the evaluation findings, most of the stakeholders including the volunteers were of the opinion that, it would have been better for the recovery intervention to focus on all the volunteers to enable them adjust to normal life after their participation in the EDV intervention; even if it would have meant conducting the intervention in different phases as more funding was being sourced to cater for the large numbers of volunteers.**

The IFRC recovery approach in Sierra Leone is captured in the appeals revision 4, 5, 6 and (March and June 2015, March 2016 and July 2017) and is structured around the following sectors and projects:

The Community Based Health Programme (CBHP) planned to expand CBHFA to 133 communities in five districts through the re-activation of community-based clubs and youth peer educators, with a focus on maternal new-born and child health (MNCH), HIV and AIDS and (Sexual and) Gender Based violence (SGBV) and support to MoHS National Immunization Days. Psychosocial Support was meant to be integrated into long-term CBHFA and Disaster Risk Reduction (DRR). WASH activities prioritized hygiene promotion through Participatory Health and Sanitation Transformation (PHAST) and Children Health and Hygiene and Sanitation Transformation (CHAST). Food security and livelihoods (FSL) activities were prioritized in 8 districts, later reduced to 4 districts due to operational challenges, with a focus on the provision of seeds, tools, livestock and training. The FSL component was implemented with earmarked funding by the Japanese Government, followed by a second phase funded from the appeal. DRR was envisaged through Community Based Surveillance System (CBS) in 5 districts. The GoSL Community events based surveillance programme (CEBS) commenced in 2015 supported by the mainstream Integrated Disease Surveillance and Response (IDSR) at the facility level. In 2016 and 2017, CEBS transitioned to CBS as an early warning system (EWS) strategy, for natural disasters and 11 communicable diseases. SLRCS operated in two of the most affected districts (Koinadugu and Bon). It was also planned to establish Disaster response teams, develop district contingency plans and conduct DRR education at the community level (including schools).

IFRC and SLRCS implemented a UNDP-funded project “Reintegration of SLRCS Volunteers Burial Teams”(hereafter referred to as the “UNDP project” - August 2015 to May 2017), which targeted 800 SLRCS SDB volunteers and 500 volunteers from the other response pillars. The goal was to re-skill and reintegrate SLRCS volunteers victims of stigma and to improve their access to livelihood opportunities.

The IFRC recovery approach in Liberia is captured in the appeals revisions 3, 4 and 5 of November 2014, June 2015 and September 2016. It was planned in the short, medium and long term and targeted 60,000 people across 5 districts (Margibi, Bomi, Montserrado, Grand Cape Mount and Gbarpolu).

In Health, it aimed to contribute to Liberia’s national HS strengthening through integrated community-based health interventions (CBHFA, CEBS, PSS and social mobilization for immunization, MNCH, common diseases). It was in the long term planned to have an overall community resilience programme entailing CBHFA, CEBS, PSS, WASH, livelihood and DRR interventions. The WASH pillar was to materialize in the rehabilitation and construction of community water points and sanitary facilities, training of community WASH committees, chlorination campaigns. The Disaster Management sector aimed to strengthen Early Warning Systems (EWS) for regular epidemics and other disasters through the reactivation of emergency response teams (ERT) and the formation of Community-Based Action Teams (CBATs) and cross-border activities. In FSL it was planned to distribute seeds and tools, provide conditional cash and vocational training. The plan also aimed to establish and maintain community engagement activities across all pillars of intervention.

**The IFRC FSL projects are relevant to the needs of communities.** They were designed to minimize the impact of EVD, enable beneficiaries to rebuild their livelihoods and enhance FS which is relevant to the needs as valued by the communities interviewed who found it appropriate to combat poverty, and coherent with Government and other key stakeholder’s policies. Similarly, the RCRC has a relevant role to play in CBS and health and hygiene promotion due to its well-trained and extended network of community-based volunteers. The importance of CBS has been valued by communities interviewed as a key tool to prevent future outbreaks. The same findings apply to the WASH sector.

**Although these approaches are found relevant to the needs, the scope of the CBHFA and WASH programmes are not found large enough to meet the health needs** The impact of communicable and water borne disease and the barriers to access to health care, especially in remote communities of both countries, generates a high burden of health problems which were pre-existing to the EVD outbreak. The weakness of the health systems (HS) has also been acknowledged as one of the key factors worsening the scope and

impact of the EVD epidemic in both countries. Communities interviewed highlighted recurrent health problems (communicable and water borne diseases, malaria, nutrition issues) and the barriers in accessing proper health care and information. In light of these factors, the evaluation finds that the recovery health strategy lacked a public health focus on health and hygiene promotion, strengthening the HS and addressing key social determinants of health (SDH) such as WASH, nutrition or gender. Due to a lack of clear prioritization and lack of capacities at SLRCS (as highlighted both by SLRCS and IFRC), the WASH intervention did not materialize in SL which is a missed opportunity.

Lastly, a long-term humanitarian diplomacy (HD) strategy targeting the barriers to access to health care (affordability, lack of performance of the national HS) would have efficiently complemented the approach, including with a focus on health care provision for ebola survivors.

**The IFRC recovery strategy, although very relevant to the needs and coherent with IFRC Strategy 2020 that prioritises community resilience, does not always match the traditional NS core competences and priorities.** FSL was not and is not a priority for SLRCS and LRCS who did not prioritise it in their strategic plans and did not have qualified staff and experience to implement such programmes. The same applies to the UNDP project in SL which materialized through a top-down modality and appears as a stand-alone project. The CBHP suffers from a lack of prioritization and focus and remains relatively modest in its ambitions, compared to other sectors. Considering the achievements of the RC Movement during the EVD response, it seems that an opportunity has been missed for the National Societies to sustain the EVD response legacy in behaviors change. This would have helped the NS to develop its resource mobilization (RM) strategy by showing good results to the donors.

**In both countries, capacity building** was envisaged as a crosscutting activity across all programme interventions with the following priorities: leadership and governance, resource mobilization, volunteer management, administration, HR, logistics and planning and PMER. In Sierra Leone there was a clear focus on financial management and accountability through a comprehensive finance management capacity assessment. In Liberia, the capacity building strategy prioritized decentralization through the establishment of 5 regional hubs.

**The OD strategy did not seem to be tailored to support the National Societies to implement the recovery programme and transition to long-term programming.** SLRCS had not been through an Organisational Capacity Assessment (OCA) prior to EVD, which made it challenging to evaluate the OD needs. The design of the recovery strategy should have assessed existing capacities and gaps both at the HQ and branches level and factored them in, as recommended by the RRA. A post EVD response volunteer demobilization and retention strategy building on the achievements of the response was also necessary to ensure the capacities built during the EVD response could be retained or tapped in when needed. The construction of a 2 million USD multi-purpose building does not seem to emerge as the outcome of a structured resources mobilization strategy.

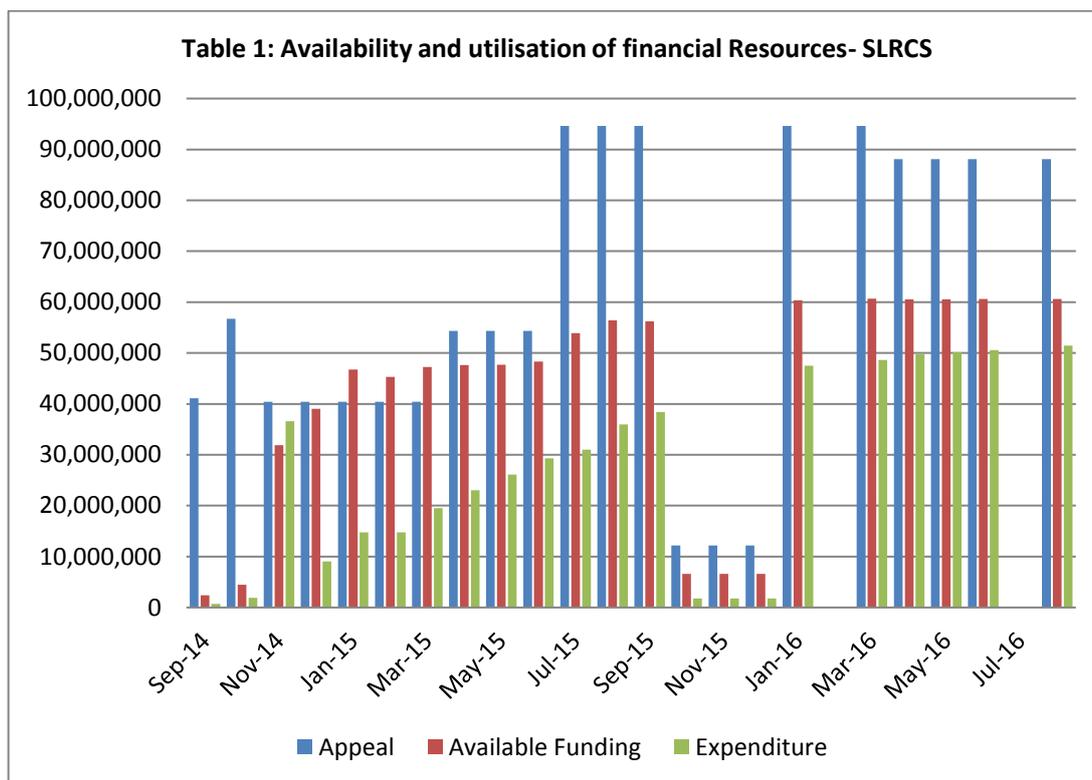
As a result, SLRCS struggled to implement, monitor and report against recovery programmes which were not owned (such as the UNDP programme which was imposed on SLRCS without prior consultation) or did not fit within its mandate and capacities (FSL). For instance, the FSL programme in SL initially targeted eight districts, which had to be reduced to 4 districts due to implementation challenges and delays.

### 4.3 EFFICIENCY

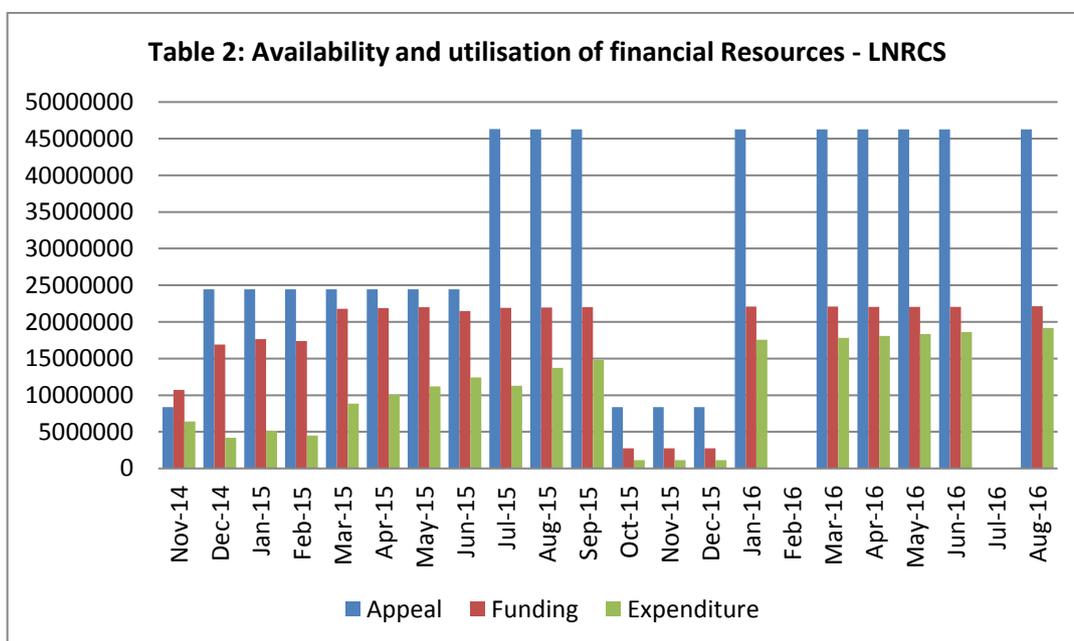
#### 4.3.1 Availability and utilization of resources (financial, human, physical and informational)

##### i. Financial Resources

## Response phase



Source: OperationUpdates



Source: Operation Updates

The trend from the graphs above shows that:

- In Sierra Leone the funding available was way below the amount of the appeals in the first months of the intervention, which was confirmed by interviews. In Liberia the funding available was mostly lower than the amount appealed for.

- From January- March 2015 in Sierra Leone, the funding exceeded the appeal amount and in Liberia this happened only once in December 2014.

The expenditure in both countries was mostly lower than the available funding throughout the EVD operation. There was a sharp increase in the appeals from July, 2015 onwards apart from October-December, 2015 where there was a significant decrease in appeal, funding and expenditure but went up again the subsequent months. The funding available was almost equal during the response and recovery period.

The first emergency appeal for Liberia was launched in April, 2014 and for Sierra Leone was carried in July 2014. These appeals were necessary to enable the IFRC to support the National Society to respond to the EVD outbreak and scale-up the surveillance and contact tracing. In Sierra Leone the funds were used to open an ETC in Kenema districts in September 2014. In June, 2015 the post-EVD recovery increased the appeal to be able to respond to the recovery phase activities, the available funding most of the times lower than the appeals but higher than the expenditure.

### **Recovery**

In Sierra Leone, resources were available to implement the UNDP project and the Food Security and Livelihoods project funded by the Japanese Government. It was reported that the 100% of the DRR funds were utilized in this project. In Liberia, most of the donors pulled out in the recovery phase but there were funds available to be utilized in both countries and it is observed that the spending remained low compared to the funding available in the recovery phase too.

Although the EVD operations in both countries struggled to kick start due to lack of funding during the first months following the appeals, the situation changed positively when the epidemics became more publicized. The funding started to exceed the amount appealed for and the operational capacities. From that moment onwards the operations had the necessary financial resources to respond. However, the challenge during the time was low burn rate; the average spending was 58% of the available funding. The low burn rates can be attributed to the delays in the recruitment of staff and volunteers therefore leading to a slow start in implementation of activities.

## **ii. Human Resources**

### **Volunteers**

In both countries the number of volunteers trained during the first months of the epidemic increased following the recruitment of new volunteers. In Sierra Leone, the number increased from 720 volunteers trained in September 2014 to 2,269 in December 2014. In Liberia, the number increased from 2000 in September 2014 to 6,170 in November, 2014. The Sierra Leone, Liberia and Guinea National Societies had an estimated base of 28,000 volunteers and approximately 7,600 volunteers specifically trained for the Ebola response (IFRC Ebola volunteering review February 2017). Both countries were able to mobilize enough volunteers on time to respond to the evolving nature of the EVD. The volunteers played an important role in support of the affected people and in response to their needs. The volunteers dedicated 2-3 hours a day to carry out EVD operation activities however, the SDB teams worked longer hours. At the beginning of the recovery period in June 2015, Sierra Leone reported an increase in the cumulative number of trained volunteers to 4,924 by December 2015. This can be attributed to the fact that activities in PSS and social mobilization had increased during this period and there was a need to increase the number of volunteers. In Liberia there was a decline in the number of trained volunteers in April 2015 to 974 trained volunteers, which can be attributed to the slowing down of activities in the response phase. However, the re-emergency of EVD in March led to an increase of volunteers to 1,124 in May, 2015 and 1369 in September, to support social mobilization and contact tracing activities. In both countries volunteers were retained in to the recovery phase to carry out psychosocial support services to the community.

Different groups of volunteers were trained on social mobilization, psychosocial, community surveillance and safe and dignified burial. This training helped the volunteers provide the necessary services in the community. The number of volunteers implementing various activities changed as EVD progressed. The SDB teams were disbanded when no deaths were reported and the psychosocial support volunteers continued to provide services throughout the operation including the recovery phase.

### **Delegates**

In both countries the deployment of delegates was efficient at the beginning with the deployment of a FACT team at the beginning of the operation. This supported the National Societies identify their needs and prepare for a full scale operation. Before the epidemic IFRC did not have representation in Sierra Leone and had been supporting SLRCS through its regional office for West Africa in Cote d'Ivoire. From April, 2014 IFRC began to support SLRCS on Ebola preparedness and response following confirmation of cases in Guinea. This triggered the start of an operation and sending of delegates to the country. Water and Sanitation (WATSAN) delegate was the first to be sent to the country. After the first case was reported, a FACT was deployed in early June 2014. Shortly after, a Health and Hygiene promotion ERU was deployed to support SLRCS and the MOHS with CBS and health promotion activities. An IT and logistics/Telecomm ERU was deployed to provide support services at the IFRC operational hub in Kailahun. Other delegates included operations manager, logistical, Health, Watsan, Beneficiary Communications, finance and administrative delegates to give support to the operation. In Liberia, IFRC had an office in Monrovia and an OD delegate before the EVD epidemic broke out. As the epidemic crisis extended the OD delegate became the operation manager for the EVD operation. A FACT team was sent to Liberia in April 2014 followed by an ERU team and RDRT team which included delegates with skills in PSS and health. Other delegates that were deployed were logisticians, finance, operations, health, administration, IT, BENCOM and Information management.

However, as the operation intensified there were delays in recruitment and deployment of delegates because of various reasons It was difficult to recruit delegates willing to travel to EVD countries and this caused delays in sending delegates with the necessary skills at the right time. IFRC collaborated with Spanish RC and MSF Switzerland to provide an EVD pre-deployment course for staff expected to be deployed. There were also delays in replacing delegates whose terms had lapsed causing delays in the implementation of activities. The delay in deployment of delegates led to inefficient response due to lack of necessary skills within the national societies that relied on the delegates to carry out activities such as training of volunteers who were vital in the implementation of activities.

The interview findings suggest that the redeployment and the exit of delegates at the end of the response phase was hurried, leaving little time for proper hand over to the National Societies. Most of the delegates left at the start of the recovery phase leaving a gap in the implementation of recovery activities. For example, in August 2015, SLRCS had to request IFRC to send a PSS delegate to support the rolling out of PSS activities after they had started implementing the recovery programme. Also, the FSL programme was implemented without a delegate, until it was realized that SLRCS did not have the capacity. In general, the delegates deployed brought in necessary skills in procurement and logistics, SBD, psychosocial, community mobilization, surveillance, Finance and administration, IT and information management, Communication all necessary to carry out the EVD operation efficiently.

### **National Staff**

In both countries the number of national staff increased drastically, especially in the category of drivers, nurses, administrative and logistics officers. The recruitment of staff had a lot of delays because of the high numbers needed and lack of administrative capacity within the NS to carry out massive recruitment within a short period. In addition, qualified people were not willing to carry out the EVD work for fear of contracting the disease and the stigma associated with it. There was also a challenge of poaching of trained staff and volunteers by the other INGOs who were paying better allowances.

In the recovery phase, the implementation of the UNDP programme in Sierra Leone faced challenges with some branch managers who did not understand their monitoring and data collection role. In addition, the

IFRC staff in charge of the project was leaving the country, handing over the project to new staff who had little understanding of the project. In Liberia, there was a shortage of volunteers to implement activities in the recovery phase such as PSS. In addition, in Sierra Leone there was a lack of capacity of a WASH expert to implement WASH activities in the recovery phase leading to postponement of these activities.

Adequate human resources were not always available when needed despite great efforts made at the IFRC Geneva and National Societies HQ levels to keep up with the needs. There were delays in recruiting and deploying and replacing delegates. At the beginning of the operation, the National Societies did not have adequate staff and volunteers and it took some time to recruit them. The deployment of FACT delegates was timely, however, there were challenges in getting qualified delegates deployed at the right time and lack of proper handover and an insufficient number of delegates in the recovery phase, which left the SLRCS struggling in managing recovery activities. Despite all the challenges, IFRC and the National Societies in both countries utilized the available human resource to achieve the objective of the operation.

### **iii. Physical Resources**

In Sierra Leone, IFRC set up two ETC, first in Kenema, then in Kono districts. This was implemented following a request from WHO. The ETC provided much needed bed space at a time when there was an increase in the number of new cases. This increased the efficiency of providing treatment and isolating sick persons in the community. The centres remained opened and were closed when fewer cases were reported and the staff were redeployed to other areas. During the EVD operation, both countries received a great number of vehicles, however, despite this increase, the evaluation found that there was still a need for more vehicles to reach the remote areas (or a better allocation of existing vehicles), especially in Liberia instance in Foya District where volunteers had to carry out their activities walking long distances in a very large area. A similar story was reported in Kenema district in Sierra Leone. The lack of enough vehicles led to a delay in the implementation of activities therefore reducing the response rate of the operation.

In June 2014, IFRC set up its field base of operations in the SLRCS Kailahun Branch office. Other Branch offices (Kenema, Port Loko, Western Area, Bo and Bombali) were strengthened to help promote a well-coordinated and effective response. Two warehouses were constructed in Kenema and Waterloo, the branches were provided with motor bikes, computers, solar panels, internet-modem, generator and printers. Other physical infrastructure activities carried out were fencing of the ETC cemetery and rehabilitation of the VHF ward in Kenema hospital. During the field visit the SLRCS was still constructing a warehouse in Waterloo as part of the recovery phase.

In Liberia, the operation initially used the three rooms at the LRCS head office as warehouse but later moved to the warehouse to the car centre. County branches such as Bomi and Bassa were used as operation field base and were equipped with computers, internet and generators to support efficient operation. The head office was also fenced during this time. There were plans to set up four regional logistical hubs to bring supplies closer to the community but this was not carried out due to a lack of a clear sustainability plan. In addition, plans to build an annex at the national head office did not take place due to lack of funds. The setting up of field bases and ensuring that they were equipped to run an operation effectively increase the efficiency of the response time. The services were brought closer to the community and therefore community were able to receive services such faster and in addition, they were able to collect information much faster and respond to community needs at a faster rate.

The operation mobilized a high number of resources but lacked some resources to run the operation efficiently. The insufficient number of vehicles throughout the operation delayed activities especially in hard to reach areas. Also, IFRC vehicles were brought from the fleet base in Dubai, which required time and created some delays in the operation. The lack of sufficient number of warehouses to store the supplies was also observed in both countries. This affected the procurement and logistics of operation as there was limited space to put up the supplies which was needed at the time. However, there was good utilization of the limited physical resources available despite the delays in ensuring that the field base offices were ready for staff to occupy and effectively coordinate operations.

#### **iv. Information**

In Sierra Leone a mobile data collection system was set up to enable GPS plotting of bodies and collection of key data on timing of responses and circumstances of death. In addition, Trilogy Emergency Response Application (TERA) and Artificial Intelligence for Disaster Response (AIDR) were used to analyse SMS broadcasts and social media content. This led to enhanced digital social mobilization by filtering and classifying social media messages related to emergencies, disasters, and humanitarian crises increasing the number of people reached. The use of mobile data collection enhanced the operation by being more efficient in collecting data for analysis and therefore increasing the efficiency of the operation. IFRC did not set up an information system capable of producing reliable and targeted epidemiological data although this had been specifically recommended by the Real time Evaluation IFRC therefore had to rely on various external sources such as WHO or CDC, which made epidemiological analysis at times challenging and led IFRC to be behind the epidemic instead of making attempts to anticipate it. Digital Divide Initiative (DDI) project enhance the information technology and communication (ICT) capacity of the National Society. The evaluation team was not able to determine utilization of information technology in Liberia.

Information Management and M&E were a challenge in such a fast spread epidemic. Accurate scenarios were discussed and planned on a monthly basis but due to the IMS and the M&E weaknesses, the response was constantly behind the outbreak in terms of resources as the information available did not allow anticipation. A better quality Information management system IMS would have allowed for instance to organize delegate surge capacity on predicted caseload rather than constantly being forced to adjust to the evolution of the epidemic. Epidemiological data was missing and it was highlighted during interviews that a staff dedicating to collect epidemiological data should have for instance been attached to SDB teams.

#### **4.3.2 Timeliness of the delivery of outputs in relation to the beneficiary needs**

##### **i. Safe and Dignified Burial**

In Liberia the SDB component was included in the fourth revised appeal and in Sierra Leone the first appeal to include SDB activities was in September and October 2014. In both countries the SDB teams were increased progressively with the increase of people dying of EVD. In Liberia, the SDB teams started with three teams and closed with fifteen teams with a total of 150 volunteers (including 15 females). The SDB teams in Liberia started their operations two months after the first case was reported in March 2014 and most deaths happened in September 2014. In Sierra Leone the team started with 36 volunteers divided into 6 teams and at the end of the response phase the team had grown to 54 burial teams which represent approximately 45% of all the teams across the country. The National Societies were responsible for at least 2,200 burials of EVD positive persons across the three countries (Tiffany et al. 2017).

The operation also increased the teams when requested by government to handle areas that they were not in charge of e.g in Liberia, where SDB activities were supposed to be in one county but the government

requested at some point LRCS to take up SDB activities in Bomi, Magibi and Capemount. LRCS then re-focused on Montserrado once the GoL had been in a position to train its own staff. In August 2014 the Sierra Leone SDB pillar scaled up its activities in six districts because the other agencies involved in SDB were beginning to pull out of the operation.

After the declaration by WHO on 7 November 2015 that declared the country free of EVD, Sierra Leone, SDBs were reduced with a small number of teams on stand-by to deal with suspicious deaths. In April 2016, after ten months of facilitating the safe and dignified collection, cremation and burial of over 3,800 bodies, LNRCS handed back the responsibility to the Ministry of Health and Social Welfare (MoHSW) but retained three SDB teams on stand-by.

After the IFRC was requested to lead the SDB pillar, both National Societies acted swiftly by recruiting and training volunteers to carry out SDB activities and they were able to adjust to the epidemic evolution and the needs on the ground. Approximately 100% of the burials had been conducted within the recommended 24 hours after receiving the alert. The SDB activities were timely and this curtailed the spread of the virus therefore reducing the number of deaths and eventually delaying the countries ebola free

## **ii. Social Mobilization and Community Engagement**

Active community mobilization activities started after the FACT team were deployed in the countries. In Sierra Leone, Red Cross Social Mobilization teams, in partnership with the MoHS carried out intensive social mobilization during the 3 day lock down by the Government in September 2014. The National Societies supported mass communication activities through radio dramas and the weekly live one-hour radio call-in show for questions and answers about Ebola aired on a national radio station. In November, 2014, SLRCS continued to scale up social mobilization in high transmission areas such as Bombali, Tonkolili, Port Loko and Western Urban and Western Rural. The radio show were increased to twice weekly for one hour interactive Radio Broadcasts In addition, Television program on national TV were introduced in January, the 2015 Construction of 140Community RC information kiosks started to be located in 14 districts. In May 2015, a new social mobilization strategy was developed to disrupt the transmission chain between Sierra Leone and Guinea which included the setting up of a technical group to coordinate cross-border activities.

In support of 'Operation Northern Push', IFRC trained and deployed an additional 697 volunteers to Port Loko through a MoU with UNICEF. Nine vehicles were deployed (including six sounds truck), 120 megaphones and batteries, 15 000 leaflets and posters, and 33 bicycles to community leaders in the hotspot areas. Exit by partners involved in SM activities led to an increasing number of requests to SLRCS to take over these activities in a number of districts.

In Liberia, Ebola awareness raising was scaled up in eleven counties by October 2014. By March 2015, volunteers continued to conduct social mobilisation across Liberia and responded to changing patterns of transmission, scaling up in hard to reach areas such as "No Way Camp" inhabited by gold miners. The number of social mobilization volunteers was being scaled down from areas with no new cases such as Grand Cape Mount. The LNRCS responded again when the Ebola outbreaks happened in May and August, 2015 and mobilized volunteers in those areas such as Margibi County.

In both countries the number of people reached by volunteers and through mass media increased steadily from September 2014 through July 2015, during which active engagement with the communities was needed to reduce the spread of EVD. In Sierra Leone, 756,987 cumulative people were reached by September, 2014 and 2,440,580 had been reached by July 2017. In Liberia, 103,470 had been reached by September, 2014 and 2,409,593 by July, 2014. In the recovery phase, Liberia social mobilization numbers did not increase but instead remained the same. However, In Sierra Leone, there was an increase in social mobilization and community engagement reaching a total of 3,561,128. Social Mobilization activities ended in November 2015 in Sierra Leone and In July 2015 in Liberia.

Social mobilization and community engagement was initiated in a timely manner but the scope of intervention was initially slow due to the limited number of volunteers available and trained at the beginning. Then a massive recruitment of volunteers took place to scale up social mobilization. The messages were also developed and constantly adapted to the changes of the context. This adaptation continued after the end of the response when messages were focused on issues of reintegration of communities. The timely use of social mobilization volunteers and use of mass media to spread correct information in the community supported the operation positively and helped reduce infections and increase community engagement and cohesion.

### **iii. Psychosocial Support Services**

In Sierra Leone, volunteers started providing PSS at Kenema ETC in September, 2014 targeting both patients and family members. They were also supporting the re-integration of treated Ebola patients back into the communities. In October 2014, 261 volunteers were trained on how to provide PSS. In January 2015, a strategy to carry out joint PSS for SDB team members was developed and a survey to determine the perception of community members towards SDB team members and their families was carried out. PSS support for staff was started in September 2015 and continued until December 2015. In April, 2015 a PSS training targeting PSS facilitators and coaches was carried; out the objective was to give skills so that they can work closely with respective Branch management to provide timely PSS to SDB volunteer and guide them in selecting course to undertake in the recovery period. In May 2016, individual and group counseling sessions were organised in 10 branches for SDB teams as well as 'de-traumatization activities in 8 district headquarters to move people to their normal lives. In June, 2016 PSS sessions were held in 22 communities from 13 districts. In Sierra Leone, the PSS Recovery Phase was intended to run from January to December 2016; but started September 2016. The late start made it difficult to complete planned project activities. A 3 months extension period was given up to march 2017; but still the activities could not be completed.

In Liberia, the initial approach was to provide PSS support to government communication Centre. However, in August 2014, the LNRCs realized that the community needed their services and therefore recruited more volunteers to provide PSS services at the community level. They recruited 70 PSS volunteers in each county. During the recovery phase PSS continued in 5 counties and they linked up survivors with the survivors' network.

PSS support was gradually seen as an important part of the program and an increasing number of volunteers were recruited to provide PSS services at the community level both in response and recovery phase. However, PSS for volunteers working in very stressful situations and being stigmatized was not integrated and systemized in the response from the onset. This gap was repeatedly highlighted during interviews and FGD. The FACT team that was deployed first did not have a PSS delegate and sometimes the operation did not have a PSS delegate (e.g Sierra Leone in August 2015 the programme did not have a PSS delegate to support the SLRCS counterpart in rolling out PSS activities). Although, PSS activities were introduced later in the operation, they have had contributed significantly in bringing community cohesion and integration. The acceptance of treated ebola patients and the support provided to help communities cope with the effect of EVD have helped the countries move beyond EVD period and focus on the normal day to day activities. PSS support provided to the SDB teams helped them select relevant courses that have helped them improve their livelihood post EVD.

### **iv. Contact Tracing and Surveillance**

During the three-day lock down September 2014, Sierra Leone Red Cross Society staff and volunteers carried out contact tracing activities that identified new cases and Ebola suspected cases in the community and among health workers. In October 2014, additional volunteers were trained to support contact tracing in both countries. The numbers of contact traced increased from 10,060 in Sierra Leone and 5,371 Liberia in September 2014, to 17,781 in Liberia and 26,269 in Sierra Leone in November 2014. The re-emergence of

new cases in Liberia September, 2015 led to an increase in contact tracing activities. After October 2015 there were no new contact reported in both countries until the end of the operation.

In May 2015, the SLRCS shared information with the Ebola Response Committee (ERC) on lessons learned in the implementation of Community Event Based Surveillance (CEBS). In addition, Community Event Based Surveillance Reporting Guidelines (booklets) were developed for volunteers and supervisors to support SMS reporting. In May, 2015, there was a delay in the registration of Closed User Groups and SIM cards and providing additional motorbikes leading to delay the implementation of activities. However, this was resolved in the month of June where mobile phones with sim cards for data collection and 77 bikes were procured.

By January, 2015 contact tracing volunteers were now reporting other diseases such as measles yellow fever, diarrhea, fever, body pain, headache, malaria, Sexually Transmitted Disease, abdominal pain, stomach pain, cough and skin rash other than EVD. They were also involved in vaccination campaign February, 2015 recorded the least number of notification received from the implementing districts as a result of volunteers refusing to report on cases from their communities due to lack of motivation and incentives, blocking of sim cards by the service provider and lack of fuel for supervisors to help them move around to assess on notifications received. In July, 2015 being part of 'Operation Northern Push' SLRCS developed an implementation plan for CEBS teams in Port Loko which is a border town affected by new Ebola cases in the community.

In Liberia, the procurement of motorbikes to improve logistics in the counties was done in December 2014. In February, 2015 due to the declining number of cases throughout the country, most of counties scaled down the number of contact tracers and in May, 2015, the Red Cross stopped conducting any contact tracing but instead focused on active case finding.

Contact tracing was slow to take off as it started in September, 2014 after the EVD had spread across the countries. Contact tracing started at a slow pace and therefore may have resulted to the rapid increase in cases in Sierra Leone and reemergence of Ebola virus in Liberia which could have been prevented if contact tracing had been carried out in a more timely manner. Contact tracers also helped in carrying out surveillance for other diseases before they became an epidemic.

#### **v. Case Management**

At the beginning of the operation IFRC/SLRCS had limited direct involvement in case management and treatment but collaborated with MoH. The Red Cross ETC in Kenema opened in mid- September 2014 and was fully operational In January 2015, while the Kono ETC opened in 10th January 2015. This increased Sierra Leone's treatment beds capacity to 1,200 and 437 community care centre beds. However, this was still not enough as WHO estimated that there was a need for 500 more treatment beds and over 750 additional community centre beds. In Kono new nurses were trained to address the shortage of nurses. In February 2015, as incidence went down, the District Health Management Teams (DHMTs) were released from Ebola facilities to accelerate recovery of the non-Ebola health system. On 30 April 2015, the Ebola Treatment Centre in Kenema was officially hibernated and the ETC in Kono was officially closed on 27 November 2015.

Case Management was timely because IFRC was able to response to the request from WHO on time and effectively. This increased the number of bed capacity therefore reducing the number of deaths. The timely response helped address the bed capacity shortage experience in Sierra Leone , this addressed this challenge and therefore provided more bed space for people infected with ebola and therefore reducing the chance of them spreading the disease and of dying.

## Timeliness of the recovery

In Sierra Leone, the UNDP project was launched in May 2015, but was postponed twice due to re-emergence of EVD in Sierra Leone and to management issues within SLRCS. In March 2016, the Project then resumed its activities, but out of its 12 months of implementation, it lost nearly ten months which necessitated extension of the project at least twice. The FSL project started in August 2016, 5 months later than planned.

In Liberia, the recovery period was faced with challenges following financial restrictions which delayed implementation of activities. The WASH, PSS, Health and Livelihood activities were only implemented for 4 months but were initially planned to run for two and a half years. Therefore many activities were not completed.

The recovery phase has faced challenges in terms of timeliness. The timing of the Recovery Response Assessment (RRA) was late as it took place in February, 2015 when most of the recovery plans nationwide were almost already in place. The start up of the recovery activities was then delayed in almost all the pillars in Sierra Leone. The UNDP project had to go through 2 non-cost extensions of about ten months, the FSL also had to be extended, and at the time of the evaluation most of the other recovery pillars were being extended to 2018 due to implementation delays. In Liberia, due to the integrity issue, the recovery programme was initiated in September 2016 and ended in December of the same year. The timeliness of the recovery phase was not adequate as it started late and was implemented for a short period, the recovery phase was not efficiently managed and this resulted to misunderstanding with the community who expected the activities to be seamlessly after the response and for a longer duration post EVD.

## 4.4 COVERAGE

### 4.4.1 Response phase

The EVD intervention was initially implemented in the Districts bordering Guinea, (Kailahun and Kenema in Sierra Leone and Foya in Liberia) where the EVD originated from, and was gradually expanded to all the Districts. The response eventually covered all the fourteen districts in Sierra Leone and fifteen districts in Liberia. The strategy was to try to control the effects of the epidemic on the communities in those areas and counter the likelihood of its fast spread to all parts of the two countries because of the high level of mobility and interactions of the people, and the panic that had gripped the entire population. At the initial stages, because of the panic, fear, denial and confusion among community members, it was difficult to reach some of the people who needed urgent support. However, as more community outreaches were conducted by volunteers, and as community members gained more understanding of EVD, the situation started to change. They became more open, accessible and receptive; and many more of them were reached by the key EVD information. As a result community members increasingly gained clearer understanding of the disease, cooperated and were able to make informed decisions about participating in the fight against controlling Ebola transmission.

Evaluation findings showed that **the IFRC EVD intervention coverage strategy aimed at reaching all those at risk of being infected by EVD in all parts of Sierra Leone and Liberia**. The first appeals and IFRC technical support targeted Kailahun, Kenema and Foya Districts where EVD started but later Appeals covered intervention expenses in the rest of the districts in the two countries. The main strategy was to ensure that both the financial resources and human technical support including volunteer activities in the five pillars gave adequate coverage to all community members who were vulnerable and at risk of being infected by EVD. Findings through interviews and FGDs with key stakeholders including community members and volunteers also confirmed that from the onset, EVD intervention targeted supporting all those who were vulnerable and at risk of being infected by EVD according to their vulnerability.

**Through FGDs and interviews, evaluation confirmed that the IFRC made attempts to ensure that EVD intervention gave support that was proportionate to the needs of different community groups to ensure their safety against EVD transmission.** For example, social mobilization outreaches were conducted to communities to enable them gain clear understanding of EVD so as to make informed choices and be safe; contact tracing was carried out among communities to locate and withdraw suspected EVD infected persons from communities and take them for treatment; PSS was provided to community members who were traumatized by EVD epidemics to enable them calm down and cope with the situation without exposing themselves to the risk of infection; SDB was carried out speedily to eliminate contact between community members with the bodies of their dead relatives to reduce chances of EVD secondary infection. SDB was followed by disinfecting environments to clear any viruses as well as putting the affected communities under quarantine for 21 days to monitor their safety against any possibilities of infection. EVD infected persons were admitted to the treatment centers for case management and treatment. Their admission for treatment reduced possibilities of EVD secondary transmission among the affected communities. It was also established that involvement of community leaders by volunteers in the outreaches to communities resulted in their active support for the intervention. Most of the community members and their leaders were able to provide feed-back and actively participate in decision making at different levels. For example community members' involvement in negotiations about SDB which resulted in accommodating some aspects of their cultural practices in SDB processes without compromising any SDB safety arrangements; communities also generated information which was later developed into by-laws by the government in Sierra Leone to guide effective implementation of EVD intervention.

**IFRC made attempts to be inclusive in all EVD prevention activities across all the five pillars by ensuring gender balance and other inclusion needs of community members such as literacy levels, disability, age and accessibility challenges due to remoteness of some locations. Through recruiting and training volunteers (both men and women) from the local communities IFRC ensured a gender balanced coverage of community outreaches for all community groups in all the Districts, with key information on EVD in their local languages facilitated by the local people of their gender whom they knew and trusted.** Interviews and FGDs with key stakeholders including women in both Sierra Leone and Liberia confirmed that they accessed key EVD information through outreaches conducted by women volunteers and they in turn shared the information with other women in the communities who were either illiterate, too busy or too old to attend the outreach meetings. They also confirmed that they shared the information with the children and they ensured that children observed the by-laws on EVD prevention for their safety.

Interviews with people living with disability (PLD) including women in both Sierra Leone and Liberia, confirmed that there were no women volunteers living with disability who could reach them. However, they confirmed that they were able to receive adequate key information from able-bodied women volunteers and through other channels of communication. The interviews also confirmed that most of the PLD were reached with key information by RC volunteers of their gender and in their local languages. It was confirmed that in Sierra Leone, one man living with physical disability was a RC volunteer and that he had reached out to many PLD with EVD messages. Interviews with the volunteer established that he did his best and reached out to many colleagues living with disability, whom he confirmed were very receptive. **It was however established by the evaluation, that people living with visual disability had no information in Braille,** so they accessed key EVD information through sources such as listening to Radio, TV broadcasts and drama. In Liberia, PLD confirmed that most of them were reached by able-bodied volunteers at their center in Monrovia since there were no RC volunteers with disability.

**The hard to reach community members like those living in Foya, Lofa District in Liberia and Kenema and Kailahun Districts in Sierra Leone were covered despite the difficulties caused by remoteness and other accessibility challenges.** It was established that the coverage in Foya District was achieved mainly through the determination and dedication of RC volunteers who walked long distances for many hours to reach communities in remote areas as IFRC had not provided adequate vehicles to Foya District chapter. **Volunteers also reached out to communities living in the crowded urban slum settlements especially in West Point and Chicken Soup Factory Community in Monrovia city, Montserrado District, which were ideal**

**settlements for EVD transmission.** Even in such places, IFRC was able to reach the community members through engaging the RC volunteers who were part of the local communities and understood them. The slum communities were usually suspicious about outsiders but trusted one of their own. In addition, the RC volunteers had worked in the slum areas before and had the skills to work among slum communities.

**The development and dissemination modes of key EVD messages were designed to ensure that accessibility of the information covered all community groups to enable them understand EVD and make informed choices to be safe.** For example key EVD messages were in form of pictorial information, drama, talk show talks, radio and TV casts, written posters and other forms of IEC materials. Interviews and FGDs with key stakeholders including women and PLD confirmed that key EVD information was disseminated in lively and very interesting ways that made most people remember the messages.

Based on available capacity, LNRCs took the lead in SDB only in Montserrado District where they buried 3,600 out of a total of 4,000 bodies. In the rest of the other Districts, they covered the other 4pillars (social mobilisation, contact tracing, psychosocial support and; case management and treatment)in collaboration with other Organizations. Interviews with the RC volunteers confirmed that their activities in the four pillars were a great support to other organizations in facilitating their successful implementation of case management and treatment of community members who were infected by EVD. In Sierra Leone, SLNRCs was the SDB lead in the whole country.

**Coverage through inclusion of community and religious leaders:** As has already been mentioned earlier, during the initial stages of the EVD intervention, key decisions and information shared with communities were made without community participation; given the overwhelming emergency nature of EVD epidemic and the need by the government and other actors to respond to the situation with speed. This made communities suspicious of the government intentions about EVD intervention and they remained fearful, indifferent and non-responsive. Community members' attitude hindered the success of EVD outreaches to them by RC volunteers and increased their vulnerability to EVD transmission. As EVD transmissions increased, (by about August 2014), IFRC realized the need to encourage active community participation in the fight against EVD transmission. Through community based RC volunteers, IFRC initiated active community participation in the EVD intervention by involving community and religious leaders. For example, community leaders were trained in key EVD information and they supported RC volunteers in conducting outreaches to their communities. They also helped RC volunteers in contact tracing and withdrawing suspected Ebola infected people who were hiding within the communities. The leaders also worked with their communities to generate information that formed the basis for EVD by-laws, which were developed by the governments of both countries to help in the fight against EVD transmission. Community leaders were also trained on SDB by RC volunteers on request by communities and they were involved in conducting burials of community members under close supervision of the RC volunteers. During interviews and FGDs it was confirmed that inclusion of community and religious leaders in the EVD intervention activities encouraged them to give further talks to their communities to support EVD intervention and also enabled them to influence community members to overcome their fears about EVD, be positive and actively participate in the fight against EVD.

IFRC/NS strategy to fight EVD through extensive and inclusive coverage of communities with key information on EVD was well planned and targeted in both Sierra Leone and Liberia, especially given the vast challenges of confronting overwhelming emergency presented by a fast spreading EVD. Although coverage for PLD was found to be inadequate, they accessed key information through other modes of communication. The strategic coverage of communities enabled most people to access key information on EVD, which assisted them make informed choices about their safety and contributed significantly to controlling EVD transmission and its end.

#### **4.4.2 Recovery phase**

Based on the findings of the RRA, and with funding by both the Swedish (UNDP Programme) and Japanese governments, recovery intervention activities were rolled out essentially in Sierra Leone as the recovery plan in Liberia hardly materialized. The evaluation confirmed that most of the activities have not been implemented as planned. Implementation has been slow, leading in some cases to the reduction of scope or target numbers. For example the Food Security and Livelihood (FSL) programme in Sierra Leone which were prioritized in eight districts, were later reduced to four districts with a focus on the provision of seeds, tools, livestock and training, due to operational challenges (for more information refer to section 4.2 of this report).

Some of the implementation challenges result from the fact that the targets identification was not adequate enough. According to staff and beneficiaries, the FSL program lacked for instance a clear definition of beneficiaries and led to reproducing existing power imbalances in communities to a certain extent. Similarly, the UNDP project focus on SDB volunteers also caused resentment among volunteers.

The Community Based Health Programme (CBHP) and Disaster Risk Reduction (DRR) activities in Sierra Leone target the overall population with specific target groups. For instance the CBHP targets women for its Maternal Newborn and Child Health (MNCH) component and DRR has a specific focus on school children which is found adequate in terms of targeting particular groups in need and with a capacity to multiply the effects of the program: children are seen as agents of change within their communities and women have a key health role in the families.

Overall, although efforts have been made in CBHP and DRR to target the neediest groups, the coverage of the recovery intervention in Sierra Leone has been limited by a weak implementation capacity such as lack of capacity within SLRCS to implement the WASH project. In addition, the lack of clear analysis of vulnerabilities which would have allowed a clearer focus on the most vulnerable (such as those without land within the FSL project).

### **4.5 EFFECTIVENESS**

#### **4.5.1 Coordination of the intervention**

The early part of the outbreak response in Sierra Leone was characterized by confusion, chaos and denial and the setting up of the response was slow to be in place. An Emergency Operations Centre (EOC) under the Ministry of Health and Sanitation (MoHS) was established in July 2014 and then transformed in the National Ebola Response Center (NERC). NERC was operated as a command and control centre, developing national strategy and overseeing the response, including the technical pillars: case management, safe burial, surveillance, social mobilization, psychosocial support and logistics. District Ebola Response Centres (DERC) were established towards the end of 2014, decentralising the response while leaving national information management and coordination under the oversight of the NERC (DuBois, 2015).

In Liberia, many stakeholders believe that the EVD impact in Monrovia (a quarter of the population live in the greater urban area) galvanised the Liberian government into action. A pre-existing Task Force (TF) within the Ministry of Health and social welfare (MoHSW) was reactivated late March 2014 and on 10 August the Incidence Management System (IMS) was established. The IMS emphasized four pillars: (1) early detection and isolation of cases; (2) safe transport of suspect patients; (3) safe burial; and (4) infection control in health care settings. County IMS teams were also established.

**Throughout the response, IFRC and the National Societies have been active members of the coordination set-ups in all relevant pillars, both at the central and district/county level.** They were very actively involved at the district/county level in the development of the District Ebola Plans, including submitting activities and geographical focus. SLRCS had a permanent representation at the Western Area Command Centre that coordinated all EVD activities in respect of alerts, ambulances and burials in Freetown. The National Societies also participated in the development of District Surveillance Plans in partnership with the District Health Management Team and WHO. LRCS nominated an Ebola response coordinator fully dedicated to coordination and was able to effectively relay feed-back from some of their volunteers active in communities, particularly within the social mobilization pillar and the framing of prevention messages. For instance, during the social mobilization daily coordination meetings in Monrovia, a “rumors box” was established where organizations could share rumors, misconceptions etc. communicated by the field volunteers, which were discussed to refine the prevention messages. LRCS played a key role thanks to its large presence of volunteers on the ground, who were able to provide valuable feed-back through LRCS branches and HQ. **It therefore appears that RC has been instrumental in contributing to adequately reframe messages in a more acceptable way for communities.**

**The implementation of the response was fully coordinated with district health management teams and community health workers (CHW) particularly in the CTS and SM pillars.**

**The design and implementation of the recovery phase was also conducted with great involvement of the government partners** (Ministry of health, agriculture, social welfare, gender, office of national security), community paramount chiefs, district health management teams and CHW which were involved in the selection of communities, training of beneficiaries. The FSL project in SL engaged with the private sector through traders and entrepreneurs associations which were involved to foster the injection of financial resources into the local economy

In both countries, the technical pillars were led by MOH and usually co-chaired by a UN agency. In SL, the IFRC co-chaired the burials pillar, which was added when coordination moved to the EOC. The pillar leads were tasked with providing technical guidance for the response, including developing evidence-based standard operating procedures, setting policies, coordinating the work of the pillars in the districts, mobilizing the assets for their pillars and providing analysis to the central level (Ross, 2017).

**IFRC has been unanimously acknowledged as a very effective SDB pillar co-lead.** IFRC provided leadership on standardization and information management, chaired weekly meetings, efficiently setting up and moving the agendas forward, providing quality inputs based on field experience, and ensuring the implementation of decisions. These meetings resulted in the development of a number of national SDB and household disinfection standard operating procedures (SoP).

#### **4.5.2 Effectiveness of the response pillars**

##### **Community engagement and social mobilization**

The effectiveness of the IFRC response was achieved through community engagement and social mobilization that involved reaching out to all communities (regardless of their status, gender and age) in their local areas with EVD messages, through RC volunteers recruited from among them.

The main purpose was to enable communities to gain a clear understanding of EVD and be able to make informed choices to be safe and actively participate in controlling EVD transmission. Initially communities had received confusing, conflicting and unclear information about EVD. They had also perceived EVD information from the government as directed at undermining their cultural norms of taking care of their sick

and participating in their burial rites. The decision to involve religious and community leaders in EVD community mobilization was strategic. RC trained religious and community leaders on key EVD messages and engaged them in community outreaches. In Liberia for instance, they were brought to the ETC to understand the usefulness and safety of treatment and convince their community members of the same. In SLRCS, task forces were established at the various levels to strengthen leaders' commitment and participation. The leaders in turn encouraged their communities to be positive about EVD intervention, which had a significant impact on community positive change of attitude leading to their active participation in the intervention. .

Community Engagement was used alongside community mobilization to enhance a practical way of reaching out to communities. The approach emphasized listening and taking the time to explain to community members/families why things needed to be done the way they were done. Initially there was no "bencomm." volunteer in the teams but this was changed when IFRC realized that there was a need for an increased engagement with families and communities. Training was organized for volunteers on community engagement and they were trained in the following key areas:

- How to approach communities in a culturally sensitive manner
- Categories of people to contact when engaging communities
- How to deliver messages in a culturally sensitive manner.

Bencomm teams were the first ones to engage with the communities/ families wherever there was a need.

Later, a Community Led Engagement Approach (CLEA) was developed by the social mobilization action consortium (SMAC) made up of NGOs and National Society in Sierra Leone. The approach targeted improving community engagement further. It involved participatory definition of problems by the communities who came up with their solutions. Examples of tools under CLEA worked this way: a person would draw a map asking where do you think Ebola attacks? What are the symptoms? Then they would ask: how can you stop this? And they would together come up with the possible answers and discuss ideas. The CLEA tools were used in Port Loko with good results. However, since it came late in the EVD Response intervention, it was not used extensively.

Volunteer outreaches enabled most communities to gain clearer understanding of EVD which was initially confusing and unclear to them. They had also perceived them as directed at undermining their cultural norms of taking care of their sick and participating in the burial rites of their loved ones. As a result, most community members developed positive attitude towards EVD intervention, supported and actively participated in its activities. For example, most communities through their local leaders participated in developing messages that were adopted by the government as by-laws to facilitate controlling the spread of EVD. The evaluation confirmed that after social mobilization awareness, most community members readily observed the by-laws on EVD transmission.

**Contact tracing and surveillance** involved active daily surveillance of suspected EVD cases by contact tracers and PSS volunteers to check their health status (based on lists provided by County health teams). Volunteers would also call health teams when they came across cases of sick people who needed to be transferred to the treatment centers. Volunteers also gave feed back to the county health teams to facilitate disinfecting the environments and putting the community under quarantine. **Effective integration of CT and provision of PSS enabled volunteers to provide counseling support as people were grounded in their houses under quarantine for 21 days with a lot of stress and anxiety.** Contact tracers were also trained in PSS to have the skills of approaching people. **Withdrawal of suspected EVD cases from communities and putting communities under quarantine contributed significantly to controlling transmission of EVD leading to its subsequent eradication.**

**PSS volunteers** conducted outreaches to various communities at the cross roads of EVD infection. Their counseling support enabled many community members to calm down and live their lives despite EVD; while

at the same time participating in controlling EVD transmission. Reducing the panic mode among communities helped to calm them down and facilitated reaching them with awareness campaigns on controlling EVD transmission among them.

**SDB volunteers** gained communities' acceptance of SDB after engaging them in dialogues which led to integrating some aspects of their cultural burial rites into SDB processes. For example allowing limited numbers of family representatives to view the body but not touch the body (wear PPE), accompany them to the burial sites and pray at the burial sites (both Muslims and Christians). This encouraged communities to open up and report death cases to SDB teams for speedy removal of bodies for burials. Efficiency in undertaking burial processes by volunteers was facilitated by the free telephone line for speedy communication between communities and SDB volunteers, availability of adequate human and material resources to conduct SDB; appropriate vehicles for transporting the bodies, volunteers and some family members to the cemeteries, availability of the cemeteries and chlorine to disinfect the environment. Efficient SDB processes contributed significantly to reducing transmission by reducing contacts with infected bodies as well as disinfecting the environment.

**Case management and treatment pillar** activities involved removing sick people suspected of EVD infection from communities to treatment centers, confirming their status and admitting them for treatment at the centres. IFRC/NS had limited direct involvement in case management and treatment initially but they collaborated with the MoH and started 2 ETCs at Kenema and Kono in Sierra Leone. IFRC provided clinical health care services at the centers in collaboration with the MoH and other medical Organizations. They gave back-up support to other ETC in SL and Liberia that were run by mainstream medical international organizations such as Médecins Sans Frontières (MSF). For example, they supported in community mobilization, SDBs, contact tracing and PSS. Their support through their volunteer network was very significant as it enabled other actors to provide treatment to many EVD infected community members contributing significantly to controlling EVD transmission and eradication of the virus.

Effective implementation of the above pillar activities significantly contributed to the achievement of set objectives by eliminating transmission of EVD and leading to the subsequent eradication of the virus through controlling contacts between EVD infected people and the rest of the community. This was achieved through:

- Tracking and withdrawing suspected EVD cases from communities and putting the rest of the people under quarantine to avoid chances of secondary transmissions
- Confining and providing treatment and care to EVD victims at designated centres away from communities
- Reducing the panic mode, fear and anxiety of EVD among communities by helping them to calm down through counseling so as to be EVD victims in a state where they could be reached with awareness campaigns on key EVD messages to enable controlling the spread of the virus.
- Controlling the spread of EVD transmission by reducing contacts with infected bodies through SDB and also by disinfecting the environment.

### **Community Based Protection**

A pilot Community Based Protection project was initiated in hard to reach areas of Liberia to ensure remote communities would be able to handle suspected cases of EVD meanwhile ambulances would be on the ground. Community health workers were trained and the kits containing basic protection equipment were pre-positioned at the health unit or community or branch level to avoid misuse by non-trained community members.

It was not possible during the evaluation to gather information on this component as staff, volunteers and community members were not in a position to elaborate on the effectiveness of the project. The evaluation team was informed that a final evaluation of this project has been conducted that concludes that the project

reduced the rate of transmission within the households. Unfortunately the team did not have access to this report.

#### **4.5.3 Effectiveness of the Recovery Phase**

##### **IN SIERRA LEONE**

The IFRC/SLRCS recovery programming in Sierra Leone materialized in the Japanese Government funded FSL project, the UNDP project, the Swedish RC supported PSS project and some activities in CBHP, DRR and OD. **Substantial challenges and delays were faced across sectors, reducing the effectiveness of the recovery programme.** As widely acknowledged both by IFRC and SLRCS staff across levels of interventions, these challenges can be related to an over-ambitious recovery plan that did not factor in the NS priorities and capacities, SLRCS weak program management capacities (including in M&E and financial management system, combined with a lack of phased IFRC exit strategy. A high staff turn-over both within the NS and IFRC towards the end of the response further complicated such transition.

Summary of recovery achievements is in Annex 5.

##### **i. WASH**

**The WASH activities have been in-effective. Activities were not been carried out** due to SLRCS lack of staff with adequate technical capacity and expertise. The WASH intervention is now planned for 2018 with British Red Cross support.

##### **ii. Food Security and Livelihood project (Japanese Government funding) - 1<sup>st</sup> March 2016 to 30 June 2017**

The project had 3 outcomes:

1. Food production increased by 20 percent among households by 2017.
2. Communities restore and enhance their quality of life with the assistance of livestock provided by 2016.
3. An effective epidemic and cross-border surveillance system is in place and contributes to maintaining zero new Ebola cases in Sierra Leone.

**At the time of the evaluation, the first yield had not taken place, the livestock had not produced off-springs and the cross-border surveillance system was not in place, making it challenging to evaluate the project effectiveness.** This was further complicated by the lack of baseline data and M&E system. However, the following positive achievements and trends were noted:

- The organizing farmers into groups enhanced collaboration among farmers and strengthened their social support systems. According to interviewed members of farmers' groups, such cooperation encouraged them to increase the size of land cultivated, which may contribute to increased agricultural production.
- The evaluation of the farmers training by the project showed that knowledge and skills have been gained and applied in the farming activities.
- The Ministry of Agriculture (MoA) experience suggests that the 1,600 goats distributed could produce 8,000 off-springs by 2019. The multiplier effect could enable households to build large goat assets.
- 1,737 students (947 males, 762 females and 28 children), and 1,352 community members (680 Males, 561 females and 111 children) were sensitized in disaster preparedness and mitigation and risk reduction mechanisms.

**The second phase of the FSL project** expands the intervention to four districts and is still underway. It is expected that most of these farmers' groups will start farming activities in the coming months.

### **iii. CBHP:**

The CBHP is focusing on reproductive, maternal and child health, HIV and AIDS and hygiene promotion, and prevention and control of communicable diseases. CBHFA and Epidemic Control for Volunteers (ECV) have been integrated into core programmes. As recovery programming continues, it is planned that SLRCS will roll-out the CBHFA approach in new communities and additional districts across the country. Historically, SLRCS has supported mothers' clubs, father's clubs and youth peer educators, as a means to promote specific health issues, such as maternal and child health, HIV and AIDS, as well as to raise awareness on GBV, through facilitating regular meetings and educational sessions at the community level. These clubs have been re-activated and supported with relevant training and the provision of tools and material.

**A number of key outputs have been achieved however it is not possible for the team to conclude on the effectiveness of this programme for which the NS does not seem to have strong capacities as widely reported during interviews.** The outcome of "immediate and medium term health needs of communities are met through enhanced capacity in CBHP and improved access to health" is found rather ambitious considering the actual scope of activities. However, the lack of detailed baseline data and key indicators measuring what "meeting health needs" and "improved access to health" entails makes it impossible to measure.

Awareness on specific diseases such as malaria, water-borne diseases or MNCH has been improved in some communities which is a positive achievement and contributes to improve health in the mid to long term. However, access to health which entails a number of key elements such as affordability, accessibility, accessibility and availability of health care services, is not part of the CBHP strategy. Most of the communities interviewed still report facing barriers to access primary health care services, particularly in remote communities, such as: distance to the nearest health facility, lack of transportation, lack of financial resources to access health services, etc.

The continuation and strengthening of the CBHP programme has the potential to further improve awareness and prevention of communicable diseases if complemented by a strategy to work towards eliminating the barriers of access to health care and improving the social determinants of health such as water and sanitation or nutrition. It would require, to be effective, to seek for strategic partnerships and strengthen collaboration and humanitarian diplomacy.

### **iv. Disaster Risk Reduction**

#### **The DRR programme has two major components:**

- **Community Based Surveillance (CBS):**

The project's outcome was "to have CEBS functional enabling effective early warning for epidemics and natural disasters".

The CBS programme has been effective in reaching its outcomes: all communities in the twenty three chiefdoms of the two districts are adequately covered by the Community Based volunteers and their activities monitored and supervised by Peripheral Health Units, volunteers supervisors and the local leadership. Between January 2016 and March 2017, a total of thirteen suspected cases of measles in the two Districts have been reported. Investigations were launched by the DHMT of the two Districts and laboratory confirmation made. This resulted in the organization of a national immunization day in response to the outbreak.

As of May 2017, 831 volunteers were regularly (i.e. at least twice monthly) participating in CEBS village committees which represents 63 percent of the target. The volunteers offer technical inputs on surveillance to the Village development committees. The role of the volunteers in surveillance in collaboration with the communities has been recognized by the local authorities as integral in prevention and control of outbreaks.

- **The target communities are sensitized on risks and involved in their prevention:**

**The effectiveness of this component has not been achieved yet** as the rolling- out is only underway in 8 schools out of 28. SLRCS challenges with project implementation seem to account for such delays. It is worth noting that the initial target should have been revised during 2017.

SLRCS hosted an early warning system workshop with key stakeholders, including the Office of National Security and other partners, both at the District level and national level in 2016. This formed part of the sensitization process, to ensure all parties were conversant with the plans SLRCS was undertaking and formed part of the District disaster risk reduction plans.

Cross-border coordination meetings with bordering district have also been fostered during response and recovery periods. Advocacy on increased collaboration in surveillance was discussed during the meetings of Mano River union that comprises of the three countries. Cross-border collaborations have also been fostered among the bordering districts in surveillance information exchange.

#### **v. PSS**

In Sierra Leone, IFRC planned to integrate PSS into long-term CBHFA and DRR through volunteers capacity development in stress management, coping skills, children’s resilience, SGBV and violence prevention, and the provision of PSS to survivors, staff, volunteers and orphans and vulnerable children. PSS volunteers training specifically prepared them to support communities hard hit by Ebola/affected communities, especially Ebola survivors and orphans to reintegrate into families and move on with life (through Basic Psychological First Aid; Community Based PSS; Crises Events and Stress management).

The PSS Recovery Phase implementation faced some of the following challenges: the one year project was intended to run from January to December 2016; but did not start until September 2016. The late start made it difficult to complete planned project activities. A 3 months extension period was given up to march 2017; but still the activities could not be completed.

The situation was compounded by the fact that the Delegate who had worked on the proposal had left and the replacement came in late, towards the end of August 2016. There were lots of funding challenges due to implementation challenges, only a little amount of funding was sent in September 2016 for limited activities. Despite the challenges that PSS Recovery faced during the Recovery Phase, the gains that were realized through the activities enabled communities to cope with the trauma faced by communities especially the situation of Ebola survivors and orphans.

#### **vi. UNDP Project (August 2015 – May 2017)**

According to the project final evaluation, **the Project has been effective in reaching its outputs, however many of the outcomes were not reached** at the time of the final evaluation as shown in Annex 6. The project is found effective in improving the volunteers’ mental health and their vocation skills, particularly the financial literacy trainings. However, **there were little results observed for the economic component, which needed further monitoring and support.** An adequate livelihood and market assessment would have made it easier to support beneficiaries to choose relevant streams. Here again, the weakness of the M&E system makes it difficult to evaluate the effectiveness.

Volunteers interviewed during the field work expressed mixed feed-back with regards to the UNDP project achievements. The initial confusing public communication by the GoSL on this project, before SLRCS was able to inform the volunteers about it, unfortunately created high expectations amongst volunteers. Many volunteers were expecting a substantial financial package which was not the purpose of the project. Their perspectives on the project effectiveness are focused on the financial aspects and still reflect this lack of proper initial understanding of the project purposes. A strong level of frustration was communicated during the focus group discussions. Despite this frustration the overall feed-back reflects a potential improvement of the livelihood of the volunteers who also highlighted the need for a continued support.

#### **4.5.4 In Liberia**

**The effectiveness of the recovery plan was greatly impacted by the integrity issues that destabilized the NS from early January 2016. It is therefore considered insignificant.** Most of the donors pulled out, the board was dissolved and most of the senior management was dismissed. Financial and procurement restrictions were placed after the 2015 IFRC audit recommendations, which slowed down the rate of implementation. Although most of the restrictions were lifted in July 2016, restriction on transfer of working advances to the National Society was maintained.

As a result, the recovery plan scope and ambitions were reduced to a minimum number of interventions which were implemented over a period of four months (September 2016 December 2016). A summary of the recovery plan outputs is provided in Annex 6.

#### **4.5.5 Effectiveness in strengthening the NS capacities**

In Sierra Leone , training manuals were developed and trainings carried out on social mobilization skills, Pyschosocial support and counselling, integrated disease surveillance, contact tracing and management of SDB, all of which enabled the staff and volunteers carry out their work effectively and support the community. These has increased the capacity of staff and volunteers NS can tap into this skilled personnel. Branch disaster response teams (BDRT) were established and trained in the seven targeted districts of Kenema, Kailahun, Bo, Pujehun, Bombali, Koinadugu, and Western Area in 2016, improving the NS capacity to be prepared and respond to emergencies. However, a number of critical core activities under this pillar have been delayed to the first quarter of 2018, which include: training of CBDMCs in health DM and setting up of EWS for disease outbreaks (integrated with CBHP);recruitment, training and equipment of NDRT and CBDMCs; updating of contingency plans ; rolling out of simulation exercises for flood prone areas.

In both countries, finance delegates trained branch managers and field officers on financial management to increase the capacity of branch and field staff in financial management especially in management of working advance and payment of volunteers. In Liberia the finance office was well functioning with qualified finance director, chief accountant and project accountants. At the time of the evaluation, finance officers involved in the EVD operation in Liberia had left the organisation and the finance office had project accountants of active grants with ICRC and Canadian RC. In Liberia, the settlement of working advance reconciliation was relaxed during the response phase leading to delays in reporting. This eventually led to audit queries and project accountants were sent to the field to collect supporting documents and inquire about advance reconciliation. However, these issues have not been resolved to date. The deployment of finance delegates, training of branch managers and field officers on financial management was inadequate in improving the skills of the national societies staff in financial management. Poor financial management continued throughout the EVD operation leading to audit queries and forensic investigation in both countries.

SLRCS underwent a MANGO assessment during the recovery phase that helped identify financial control gaps that exist in the organisation. Reorganisation and restructuring took place and recruitment of additional finance staff with skills in financial management such as an internal auditor and finance director. A draft finance and procurement policy is in place and its under review of the board for approval. The impact of the reorganisation is yet to be observed as this was carried out recently, it is hoped that this will ensure that the national society is managed more effectively.

A fleet management and warehouse management policy were developed in both countries after a training on in fleet management, security and warehouse management. In Sierra Leone the policies are still in draft waiting approval by the board. These improved the NS capacity in fleet management and new policies are in used improving the management of fleet and drivers. However, both societies are struggling with the huge numbers of vehicles that have broken down and have not been disposed.

All though there was adequate recruitment of volunteers in both countries during EVD, it was observed that both National Societies lack of a volunteer management policy and poor volunteers records management and lack of recruitment strategies at the branch level has resulted to low retention of volunteers recruited during the EVD operation. For instance the low payment for volunteers and lack of PSS support demotivated some of them who chose to join other agencies implementing EVD activities and providing better financial packages. This can be attributed to lack of training in volunteer management during the operation leading to low capacity within national societies to have volunteer management skills and policies.

SLRCS developed a HR policy after the recommendation of the MANGO assessment whereas in Liberia they had a HR policy in place. SLRCS restructured and laid off and recruited new skilled staff, a process which led to a salary increment. SLRCS HR policy is still in draft waiting approval of the board but new staff have been recruited using the guideline of the policy. The new policy has improved human resource management and recruitment.

In Sierra Leone, there were plans to develop a resource mobilization strategy but this was not carried out. In Liberia, a resource mobilization strategy was developed with strategies to increase revenue such as maximum utilisation of the Nimba Guesthouse, hiring of vehicles to other projects and provision of first aid training to other organisations. The resource mobilization remain a challenge in both NS with little resources have been mobilised by the national societies locally and internationally during and after the EVD operation. In both countries PMER teams were in place and worked with the IFRC delegates to generate data from the branches and volunteers. IFRC set up a data management system which was in use to process data. Data was collected by the volunteers and consolidated at the branches before it was shared with the HQ for consolidation. In Liberia, the society had a PMER unit prior to the emergency. Two additional staff were recruited to support with the M&E roles. The M&E system was focused on monitoring of activities when it should have included community surveillance, data from SDB, etc. used to analyse trends and be better prepared to anticipate. The setting up of PMER system and support provided by PMER delegates improved the capacity of the NS to collect data and report on time. The capacity of national society in management of data has improved in Sierra Leone with a whole department dedicated to data collection. However, in Liberia it's the opposite where the department which was previously in place has been retrenched due to lack of resources to pay them leaving the NS with inadequate PMER capacity.

The capacity building carried out during the EVD operation contributed to build the capacity of National Societies to respond to emergency programme of a complex scale. The NS staff and volunteers were trained in social mobilization, Psychosocial support and counselling, integrated disease surveillance, contact tracing and management of SDB. This enabled them to have the skills necessary to implement activities in the various pillars. However, both NS still have inadequate capacities in financial and administration, logistics and procurement, volunteer management and resource mobilization. In the recovery phase, the NS staff were trained in disaster management and early warning systems. The National Societies were supported to develop management policies and systems such as HR; finance; procurement and logistics; and PMER. However, in spite of these efforts, the national societies continued to have challenges in financial management.

#### 4.6 IMPACT

**IFRC response has been fully integrated within the overall Government and UN-led response. It is therefore difficult to directly attribute impact to the IFRC intervention, except perhaps in the SDB sector where the RC played a leading role.** The overall goal of the integrated response was to curb and stop the epidemic, an objective to which the IFRC greatly contributed thanks to the community based volunteers' network and the massive deployment of financial, logistic and technical resources.

#### 4.6.1 Strategies to control and stop the epidemic

There are debates over which of the infection prevention and control methods had the greatest impact on controlling and stopping the epidemic. **There seems to be some sort of consensus over the fact that isolation combined with treatment and SDB played a crucial role in controlling the epidemic.** Rivers et al. (2014) thus argue that of the modeled interventions applied to the epidemic, the most effective by far is a combined strategy of intensifying contact tracing to remove infected individuals from the general population and placing them in a setting that can provide both isolation and dedicated care. Research study conducted by Fang et al. (2016) in Sierra Leone revealed that the transmissibility at the chiefdom level, estimated as the average number of secondary infections caused by a patient per week, was reduced by 65% after the end of December 2014, when 100% case isolation and safe burials were essentially achieved, both compared with before October 2014.

**The evaluation team did not have access on data related to the impact of the management of 2 ETC in Sierra Leone and therefore cannot conclude on this pillar.**

Research conducted in Liberia by Kirsch et al. (2016) highlights that individual and communities' behaviour changes were critical to changing the epidemic curve, which was likely facilitated by active community engagement and communications but also occurred organically by communities and households. Local leadership was critical in organizing efforts, responding to changing conditions, and providing positive direction, but this could not have occurred without international monetary, technical and logistical support. CT has been an important part of ending the EVD transmission and was more strictly organized by the use of SoP and a unified leadership from October 2014 onwards.

#### 4.6.2 Safe and Dignified Burials

The importance of SDB as an integral part of reducing EVD transmission and stopping the outbreak has been widely documented. A recent research project conducted by Tiffany et al. (2017) focused on quantifying the impact of SDB, using data collected during epidemiological investigations. This research estimates the potential impact of the SDB programme on the 2013 to 2016 EVD epidemic as a result of activities carried out by the RC NS supported by IFRC. **The Red Cross conducted approximately 50percent of all official SDBs in Sierra Leone, 100percent in Guinea and Montserrado County, Liberia (where 40percent of the affected population in Liberia was located) during the epidemic.**

Country	Reported SDB completed	EVD positive
Sierra Leone	26,308	1,413
Liberia	3,684	538
Guinée	17,513	254
Total	47,505	2,205

Source: (Tiffany et al., 2017)

Tiffany et al. **estimate that between 1,411 (lower estimate) and 10,452 (upper estimate) secondary EVD cases may have been prevented by the SDB program across the three countries of intervention, which represents a reduction in the total size of the 2013–2016 EVD epidemic of between 4.9% (lower estimate) and 36.5percent (upper estimate).** Key actors interviewed during this final evaluation field work indicated that RC made a great difference in Montserrado County in Liberia where 40percent of the infected population was located and where the epidemic could have gone much worse and social unrest more serious if the issue of dead body management (later named SDB) hadn't been taken over by the RC.

#### **4.6.3 Community engagement and PSS**

**Community engagement was a turning point in the epidemic control. RC played a major role in supporting governments to gain trust and active participation of communities, which has been widely acknowledged by key actors and communities interviewed.** The action of RC community volunteers, their presence and their perception as “insiders” had positive effects on behavior change which in turn contributed to curve and stop the epidemic (practice of hand washing and use of sanitisers, the “don’t touch” motto, the acceptance of SDB and systematic use of emergency hotlines). The RC community based approach also led to a greater community commitment to surveillance and behaviour change.

**The RC community engagement approach (coupled with PSS support) has been reported to have contributed to “restore people’s dignity” and hope** (people used to think “we are finished”). PSS made a difference for people victims of stigma, people whose family members were infected and those in quarantine, by providing encouragement and supporting some form of “reintegration” in the communities. The follow-up of infected people in the ETC and the feeding-back to their families greatly contributed to reduce anxiety and distress amongst family members. This was also confirmed by LRCS who actively supported the reintegration of survivors by calling them “future farmers” instead of “survivors” and by encouraging communities to interact with them when going to church, farming, etc. Some women in communities of Sierra Leone reported that they are still using these skills to support each others.

#### **4.6.4 Health System Strengthening**

The presence of RC volunteers working hand in hand with CHW and district health management teams, particularly in the CTS and social mobilization activities, and later in the CEBS programme, have contributed to strengthen the HS by increasing communities knowledge and sense of responsibility for epidemic control and by better linking up communities, CHW, RC volunteers and health facilities.

The roll-out of CBS has been instrumental in early detection of disease outbreaks and has thus contributed to a strengthened surveillance system, both at the community and facility levels in the three districts. A report published by US Center for Disease Control and Prevention<sup>2</sup>, showed Sierra Leone’s Integrated Disease Surveillance and response has been strengthened, based on a review conducted between November 2015 – September 2016. It indicated that Sierra Leone’s disease reporting increased from 35percent to 96percent of health facilities reporting weekly data. This shows significant gains attributed to the role out of CBS, as an integral component of integrated diseases surveillance and response (IDSR). The result also depicts improved coordination with all stakeholders at the community, facility and district levels in surveillance and reporting. SLRCS collaborated with MoHS, Health Consortium, WHO, and Centres for Disease Control (CDC) in the development of CBS Standard Operating Procedures, technical guidelines and reporting forms which are now used across the districts. Also, the accountability to communities on project activities was strengthened through the establishment of committees both at the ward and chiefdom levels that address complaints and concerns in project implementation.

#### **4.6.5 Impact of OD activities**

The objective of the OD intervention was to build the capacity of the National Societies to be able to respond to future emergencies, which was achieved to a certain extent as detailed in the effectiveness section. The participation of volunteers in the EVD operation led to an increase of people willing to join the Red Cross volunteers. The National Societies now have a large national network of skilled volunteers, some of whom can be deployed in case of an emergency despite retention challenges. Thanks to the capacities built during the response, SLRCS was able to respond to the mud slide that recently hit the country.

---

<sup>22</sup>Sierra Leone: Integrated Disease Surveillance and Response system—using health data for public health action, 23 Dec 2016, available at: <https://www.cdc.gov/globalhealth/security/stories/sierra-leone-idsr-ghsa-in-action-story.html>

The EVD response led to a refurbishment of national societies branch offices and construction of two warehouses in Sierra Leone . However, in some instances the National Societies were left with assets that they are not able to maintain, e.g some vehicles donated have been abandoned due to lack of resources to repair and maintain them.

Prior to the EVD operation the National Societies did not have the capacity to handle a large scale operation especially in terms of financial management and despite the training in financial management for branch officers, financial management continues to be a challenge for the national societies which have little financial management capacity.

The EVD operation exposed the lack of fiduciary oversight by the governance and leadership structures of the national societies and the lack of proper management practices and policies. The LNRCs has been weakened after the EVD operation and its reputation among donors and communities was damaged. The National Society was virtually dismantled at the HQ level as a majority of senior management staff and the entire governance system were dismissed early 2016. The institutional capacity built during the EVD response was largely eroded, LRCS reputation was greatly damaged as indicated by the low level of funding of the recovery appeal. The integrity scandal also created mistrust amongst some communities where the National Society had done such a tremendous social mobilization job which had served the response as a whole. The National Society has been re-built almost from scratch at the HQ level and the new senior management is now engaged in re-structuring the NS including at the programme management level. The goal is to demonstrate good results and outcomes to gradually re-gain its reputation attract donors and grow.

#### **4.6.6 Impact of the recovery programme**

Evaluating the impact of the recovery phase in Sierra Leone is challenging considering the implementation delays and the lack of baseline data. Most of the interventions are still underway and will only be completed in June 2018. The FSL project is still awaiting the first yields to take place in 2018. The UNDP final evaluation mentions that although baselines could not be used to establish a causal relationship, there seems to be a correlation between the Project activities and the volunteers' mental stability. Also, the financial literacy training has been a success with beneficiaries reporting having a bank account, and having some basic knowledge to manage their savings. Some expressed their wish to apply for loans in the future.

In Liberia, it is not possible to discuss the impact of the recovery programme given its limited scope.

#### **4.6.7 Unintended impact**

One of the key unintended impact of the EVD response was stigma and discrimination faced by the National Societies' staff and volunteers. Volunteers involved in SDB have been particularly hit by stigma. Many have been forced to leave their house during the response and SLRCS had to provide accommodation for volunteers. Some are still struggling 2 years down the line to be re-integrated in their families and communities.

Also, the urgency of the life-saving operation required specific adjustments to the concept of volunteerism and the "payment" of volunteers was introduced to ensure availability and a certain form of compensation for the high level of risks that volunteers were exposed to. This situation created expectations amongst some volunteers who are now expecting more stipends. This situation underlines the urgency of developing a volunteer management policy that clearly outlines rights and obligations of volunteers and distinguishes between high risk emergency operations and routine long term community work.

## 4.7 SUSTAINABILITY

One of the key functions of the recovery period, apart from supporting communities and systems to get back to “normal”, is to ensure that the EVD response gains are consolidated and can be sustained. In that regard, a clear exit strategy outlining, for each of the pillars, the mid-term plans from a programmatic and resources point of view would have helped to facilitate a smoother transition from a high profile response to a mid-term recovery programme building on achievements and paving the way for long-term programming. It is unfortunate that IFRC did not implement such an exit strategy which, combined with a strong strategic recovery planning would have helped to plan: the transition from emergency to recovery in terms of presence of delegates based on the programmatic priorities identified in the recovery plan and the assessment of the NS capacities; the future needs in terms of vehicles and infrastructure with an analysis of their financial sustainability within the NS; the handover of key activities to Ministry of Health / Communities / other organizations; the volunteers needs and retention strategies and plans; the timeframe for the rolling out of exit activities; and an overall resource mobilization strategy which is essential to support the transition from emergency to recovery and then to routine long term programming.

At the community level, although knowledge and awareness on key prevention and protection measures is still there, people in both countries are found to be gradually going back to their past practices as fear has now disappeared. Hand-washing is being lost as hand washing stations have been damaged and other priorities (such as Food Security) took over. People are still aware and cautious about foreigner movements in and out of their communities but it is not clear how long it will last without the continued support of an integrated CBHP. The success of the RC community engagement approach through engagement with traditional and religious leaders made a difference in leading communities to buy in the response and to develop and respect by-laws which were crucial to curbing and stopping the epidemic. Such engagement, including the use of by-laws to sustain the gains of ebola achievements, could be supported as part of the CBHP in order to further strengthen the sustainability of behavior changes at the community level.

**The ebola response achievements in strengthening the HS are being consolidated in the CBS programmes which are implemented nationally and to which SLRCS contributes actively. However, it is not clear at this point whether CBS will be continued by SLRCS at the end of the EVD appeal.** It is doubtful that SLRCS will be in a position to sustain it without external funding as the program relies on financial incentives provided to volunteers and on substantial logistic resources. The programme is therefore quite expensive and, although its usefulness is largely acknowledged, staff and volunteers have serious concerns over its continuation in the mid to long term.

**The FSL programme in Sierra Leone has some effective elements of sustainability** as the Ministry of Agriculture now follows up farmers’ groups and is supposed to register them as Farmers Based Organisations, granting them access extension services. The farmers’ field school groups will contribute to long-term agricultural development, by promoting learning among farmers groups.

**In the DRR component, participants of the community sensitization sessions agreed to share messages with larger community groups on fire, storm, flood and epidemic mitigation activities.** The prioritization of DRR in schools is a positive step as children are agents of change and can sensitise peer groups and communities. It will however need to be strengthened and monitored to be effective.

**The UNDP project final evaluation report indicates concerns over the project sustainability:** SLRCS District branches have inconsistent capacities to follow up on beneficiaries. The vocational trainings beneficiaries need monitoring which did not happen so far.

**In Liberia, some of the current programmes implemented by LRCS with partners give room for a certain level of optimism.** For instance, the Canadian RC recovery programme baseline findings indicate that ebola related knowledge is still of a good level amongst communities. CRC and LRCS are using the ECV tool which entails prevention, management and referral of diseases such as ebola, measles, cholera or diarrhea. CRC built an integrated CBHP including WASH, DRR and DM envisaged through an epidemic outbreaks angle. The programme led to the formulation of county-based contingency plans in Bomi County and drilling exercises

were carried out with UNICEF and WHO. A national LRCS preparedness program building on this experience could support to sustain the ebola response achievements. It will be crucial for future outbreaks and will necessitate additional/refresher trainings, drilling exercises, etc.

**From a Health System Strengthening point of view, some of the Red Cross interventions are now clearly sustained within the National Health Systems of both countries.** In both countries, the successful leadership taken by IFRC in the Safe and Dignified Burials pillar led to the development of guidelines and SoP which are owned nationally and will be used when relevant. This integration undoubtedly is a very positive element of sustainability of IFRC achievements through their embedment at the national policy levels.

Similarly, the Integrated Disease Surveillance and Response Systems have been implemented and are being strengthened with support of CDC and WHO and are a direct legacy of the ebola lessons learnt. They are effective in both countries and allow a thorough disease surveillance and reporting which in turn permit swift public health interventions to control and contain potential outbreaks. Frontline Field Epidemiology Training Programs (FETPs) have been established in all 3 of the countries most affected by the Ebola epidemic. The FETP-Frontline program provides 3 months of on-the-job training and supervision for surveillance officers working within the MOH). In Liberia, the FETP-Frontline was launched in August 2015; by early 2017, more than 120 surveillance officers in Liberia had completed training, and there is now trained staff in all 15 counties and each of Liberia's 90 districts. Sierra Leone established a FETP-Frontline program in June 2016 that has now graduated >35 trainees from the national response structure, including all districts. By early 2017, FETP participants had conducted >50 case investigations for acute flaccid paralysis, rabies, maternal deaths, cholera, measles, yellow fever, meningitis, neonatal tetanus, and unexplained deaths, as well as investigations of outbreaks of Lassa fever and rubella (Marston et al., 2017).

In Liberia, as part of the implementation of the National Investment Plan to build a resilient health system, the National Public Health Institute of Liberia (NPHIL) has been established in January 2017 with a mandate to ensure prevention and control of public health threats by promoting healthy outcomes. Some of the MoH functions were transferred to NPHIL (disease prevention and control, environmental health, national referral laboratory and division of public health workforce). Based on the EVD response experience, the NPHIL has succeeded in the adaptation of the second edition of the National Technical Guidelines for Integrated Disease Surveillance and Response and the subsequent training of surveillance officers at national, county, and district levels in 2016. More specifically, there is within the NIPH a unit dedicated to DBM that is the legacy of the Red Cross intervention. Building on the lessons learnt by the RC, this unit is training actors at the country level to build capacity across the country.

### **Sustainability of the Capacity Building of National Societies**

The training of staff and volunteers in various thematic related skills have strengthened the capacity of the National Societies in these areas. The National Societies have a pool of skilled staff and volunteers able to carry out social mobilization and community engagement activities, provide psychosocial support services, carry out disease surveillance and contact tracing, disaster management and early warning systems, in addition to carrying out safe and dignified burials. LRCS has been very effective in reacting to the mudslide that hit the country in 2017 with teams of well trained volunteers that were the first ones of the ground providing well targeted assistance. This is a legacy of the ebola response achievements. However, despite this positive example of sustainability, all stakeholders interviewed reflect on the challenge to retain a sufficient number of volunteers and ensure their skills are maintained, refreshed and upgraded.

The lack of strong capacity building programme focused on the leadership and governance of the national societies during and after the operation has left the national societies vulnerable with little skills on how to manage change and crisis within their institutions. There was a lack of clear governance and management structure to support the operation at the country level that included both IFRC and the National Societies to make decisions on the operation. This resulted to little ownership of the programme intervention by the

National Societies. A governance structure made up of both IFRC and the National Societies would have ensured that there was joint decision making and ensure the capacity building activities are implemented during and after the operation.

The development of systems and policies within the NS in the areas of HR, procurement and logistics, PMER, finance and fleet management will improve the management of the National Societies and entrench good practice in the future. If these systems are fully implemented they will make the National Societies less vulnerable to unethical and corrupted practices and increase the level of integrity of management. It will also ensure that decision making is transparent and open, therefore attracting donors confidence and increasing community ownership.

Although the infrastructure and vehicle provision was efficient during the operation, the improvement of branch offices and construction of warehouses will increase the capacity of the National Societies to provide services to the communities in future emergencies. However, the increase in assets owned by the National Societies might become a challenge on how to effectively maintain and sustain these assets and ensure that they are properly utilized. The lack of a proper assets and disposal policy might lead to these assets becoming a liability to the National Societies.

A pre-audit of the National Societies should have been done at the onset of the response to evaluate financial risks and adjust the level of accountability (and the whole set up) accordingly.

The operation also lacked a clearly defined exit strategy developed at the start of the response – including from an capacity building perspective. Also, a clear and strong focus should have been put on the branches capacity building where most of the activities were taking place and financial integrity issues seem to have arose from.

Given the weak volunteer management policies and practice, the recruitment and retention of volunteers recruited during the EVD operation will be difficult to sustain by the National Societies. This may be compounded by the fact that the volunteers will expect higher allowances than what is offered by the IFRC.

## **5. CONCLUSIONS**

The IFRC EVD response has shown a great level of coordination within a global response that took time to kick start but was eventually quite well integrated. The IFRC response was very coherent with the existing policies and frameworks; and relevant and appropriate to the needs of the communities who particularly valued the RCRC social mobilization activities and approaches.

The IFRC clearly identified and integrated the issue of staff and volunteers safety which was timely and efficiently factored in the appeals and activities. Although the physical safety of staff and volunteers was properly addressed resulting in a very small number of them infected, their psychosocial needs were not clearly taken into consideration and systematically addressed.

The recovery rapid assessments were participatory but they were not found sufficient to analyse needs, vulnerabilities and capacities within specific environments. Combined with a lack of baseline information across programmes, this resulted in the design of over-ambitious recovery plans that experienced challenges targeting the most vulnerable. Although the recovery plans are relevant to key needs such as food security and livelihoods, they lacked a strong public health focus and are not found relevant enough to the National Societies core mandates and capacities. The Food Security and Livelihood programme, although relevant to the community needs and IFRC policies, is not found coherent to the National Societies mandate and capacities. CBHP and WASH, which should have formed the basis of an integrated recovery programme, suffered from a lack of prioritization and capacities within SLRCS. In Liberia, the recovery programme is considered insignificant as the NS was shattered by the integrity issue.

Overall, the IFRC is found reactive in terms of FACT and ERU deployment and preparation and revision of appeals. However, in the initial stage, most of the activities were slow to kick start compared to the needs. Such challenges are attributed to the difficulty in recruiting local and international staff combined with slow funding mobilization in the initial phase, and the need to recruit and train a high number of volunteers for such a large-scale operation. The lack of sufficient vehicle delayed the operation especially in hard to reach areas. Weak IMS and M&E meant that the operation was not able to predict the evolution of the epidemic.

Regardless of the inefficiency in availability and utilization of resources, and despite the integrity issues that affected both operations, a number of key activities in the response were timely and efficient: the SDB activities began immediately after the NS were requested to lead the pillar, social mobilization and community engagement activities were implemented immediately (although with a limited scope initially); the setting up of ETC centre was timely after the request from WHO. However, activities in contact tracing and PSS were slow to take off because they were introduced after the other activities in the operation. Conversely, the recovery phase was affected by delays in kicking off the projects and the implementation period was reduced therefore leading to inefficient delivery of activities planned in recovery phase.

The IFRC response coverage was strategically targeted to control EVD transmission and to address the likelihood of the quick spread of EVD to all parts of the country. The recruitment of volunteers (both men and women) covered the local communities in all the Districts in the two countries with some representation of those living with physical disability in Sierra Leone. The information was packaged in different modes which facilitated dissemination to all community members regardless of status, gender and age. However, those living with disability, especially the visually handicapped were not adequately covered since there was no information in braille.

The multi-faceted and integrated five pillars approach adopted in EVD Response intervention was very effective in controlling the spread of EVD and significantly contributed to eliminating the virus. IFRC community engagement approach's strength was its access to local communities at the grassroots through community based volunteers (more than 4,000 in both countries) who eventually developed adequate and relevant capacities and effectively participated in the activities of all the five pillars of intervention. Recruiting and training male and female volunteers from the local communities enabled reaching both men and women with key Ebola Information. The volunteers also established strong links with the community and religious leaders, an approach which was paramount in marshaling the support and active participation of communities and ensuring an effective follow up of activities.

It was however established that volunteers were overall dissatisfied with low payment and lack of clear terms of service on compensation for the risky EVD activities that they engaged in. Others complained of lack of PSS support to enable them cope with the risky and demanding EVD activities and the overwhelming stigmatization by families and communities. As a result, some volunteers dropped out during EVD Response and joined other organizations which offered better terms.

Interviews and FGD conducted during this evaluation and academic research all point to a great impact of the IFRC response in curbing and stopping the epidemic. The role of SDB combined with CTS has been crucial and the importance of the RC social mobilization approach widely acknowledged as a major contributor to stopping the epidemic.

Regarding sustainability, at the community level, although knowledge and awareness on key prevention and protection measures is still there, people in both countries are found to be gradually going back to their past practices as fear has now disappeared and it is not clear whether CBS Programme will be able to be continued to sustain these achievements.

In Liberia, some of the current programmes implemented by LRCS with partners give room for a certain level of optimism. For instance, the baseline findings of the LRCS recovery programme supported by the Canadian Red Cross, indicate that ebola related knowledge is still of a good level amongst communities. This integrated programme led to the formulation of county-based contingency plans in Bomi County and drilling exercises

were carried out with UNICEF and WHO. A national LRCS preparedness program building on this experience could support to sustain the ebola response achievements.

From a Health System Strengthening point of view, some of the Red Cross interventions are now clearly sustained within the National Health Systems of both countries. In both countries, the successful leadership taken by IFRC in the Safe and Dignified Burials pillar led to the development of guidelines and SoP which are owned nationally. The Integrated Disease Surveillance and Response Systems have been implemented and are being strengthened with support of CDC and WHO and are a direct legacy of the ebola lessons learnt.

The training of staff and volunteers in various thematic related skills have strengthened the capacity of the National Societies in these areas. The NS have a pool of skilled staff and volunteers able to carry out social mobilization and community engagement activities, provide psychosocial support services, carry out disease surveillance and contact tracing, disaster management and early warning systems, in addition to carrying out safe and dignified burials.

Despite these positive trends, the overall sustainability of the response lacked a focused exit strategy planning for the transition from one phase to the other from a strategic, programmatic and resources point of view. The FSL intervention in Sierra Leone has however effective elements of sustainability that will require a continued monitoring and support. The CBS programme is an interesting way to sustain the EVD response gains from a HS strengthening perspective but its sustainability is questionable.

The capacity building of National Societies improved the capacity of national societies to respond to future emergencies. The National Societies' staff and volunteers are skilled in different response strategies and provide a good network for community outreaches at the grassroots. However, the National Societies still struggle with lack of volunteer database and recordkeeping contributing to poor volunteer recruitment and retention. The development and implementation of policies and systems to guide the management in terms of human resources; procurement and logistics; financial management and; PMER will help the National Societies to address the challenges that they continue to face. It is therefore important that a strong capacity building programme is established to support the leadership and governance of the National Societies by ensuring that effective financial management curtails fraud and corruption. This will strengthen the NS head office which will lead NS providing better support to the branches to improve their capacity, especially in financial management.

## **6. LESSONS LEARNT AND RECOMMENDATIONS**

### **6.1 LESSONS LEARNT**

- The IFRC/NS coverage strategy of targeting reaching the maximum number of people across all categories of population groups is key in ensuring acceptance and effective participation of community members in emergency responses to eliminate aggressive and elusive epidemic attacks.
- The multi-faceted five pillars approach adopted by IFRC in EVD Response offered IFRC the advantage to adjust the scope of each pillar based on the needs and the epidemic evolution. The approach also ensured a combined effort against EVD through five effectively managed fronts, which contributed greatly to controlled transmission and elimination of the virus.
- Systematic incorporation of strict safety strategies for staff and volunteers in the operations by factoring in safety activities, guidelines and protocols guaranteed protection of RC staff and volunteers in a very risky environment; leading to a very limited number of casualties among them.
- Conducting a pre-audit of the NS at the onset of the response is critical to evaluate financial risks and adjust the level of accountability and identify capacity building priority areas to focus on before the start of the operations. It is difficult to build the capacity of NS during an emergency when there is little or no time to focus on Capacity building. It is also important for capacity building needs to always be

mainstreamed and factored in all the phases and pillars of the intervention and integrated in all activities implemented by the national society. In addition, Capacity building activities should be monitored and reported in the operation updates.

- Having volunteer management policies/systems in place that the NS can tap into is critical to enable timely and effective management of urgent volunteer related issues that may arise and disrupt activities during emergencies responses.

## **6.2 RECOMMENDATIONS**

### **FOR FUTURE RESPONSES**

#### **• R1:Community Led Engagement Approach**

The experience of the Community Led Engagement Approach seemed to have yielded positive results although it came late in the response. It is therefore recommended to look into this approach more in-depth and capture lessons learnt and key best practices to mainstream those in a community engagement and accountability strategy designed for emergency responses that would entail:

- The recruitment of a great number of community volunteers at the local community levels is an effective strategy to reach the local communities. Attempts should be made to ensure that recruitment of volunteers is inclusive of all groups of community members including those living with disability. The proactive systematic recruitment of female volunteers as part of the volunteers teams should be maintained and replicated.
- It is recommended that IFRC should systematically involve community leaders in all the stages of interventions, including planning, rather than wait and involve them before communities show signs of resentment to an intervention.
- Build on community leaders and their role in developing and implementing by-laws during the response to explore further opportunities to strengthen the sustainability of behavior changes.
- When developing materials for awareness raising on an epidemic, the needs of vulnerable groups including people living with disability should be taken into consideration to ensure the most vulnerable and isolated are not left out in the emergency response.

#### **• R2:Volunteers Management**

It is recommended that the retention of the capacitated and motivated community based volunteers, which have been a key asset to the success of the response, is a top priority of the IFRC agenda and is taken into account from the onset of future operations. It is recommended that IFRC develops strategies to enhance retention of volunteers during interventions while at the same time ensuring efficient management of their phasing out at the end of the response. Identifying relevant activities in the program areas of NS or internship programs could be a way forward. In any case, it is recommended to conduct training on volunteer development and management when the need is identified.

Psychosocial support to volunteers needs to be better incorporated and mainstreamed in emergency response at an early stage. It is recommended to have PSS for staff and volunteers developed during pre-disasters times as a key component of Disaster Management and OD programming.

#### **• R3: Monitoring and Evaluation**

It is recommended to IFRC to review its M&E system in emergency to be able to collect and analyse data needed to run the operation with anticipation. In epidemic outbreak responses, a focus on epidemiological data should be emphasized in order to establish a sound data analysis function indispensable to provide strategic directions to the operation. The current system focused on reporting is not found appropriate for

such purposes. It is also recommended to improve Information management and monitoring and evaluation to ensure that there is integrity of data coming from the branches.

Similarly, the M&E system in recovery shall be improved to allow a more efficient programme management and accountability to donors, including baseline assessments and the monitoring of realistic and workable indicators at all levels of the program hierarchy. M&E trainings for project officers and branch managers should be conducted on a regular basis.

#### **R4: Transition from response to recovery**

It is recommended that the transition from emergency to recovery is planned with a clearer analysis of the NS mandates and capacities. IFRC should engage in assessments of capacities and OD gaps during the response in order to plan a well-targeted transition from response to recovery. Such transition could be planned by deploying OD staff with relief experience during the response, who would be tasked to analyse OD needs and support in planning the transition in terms of availability of resources and design of programmes and OD plans. Workable and realistic exit strategies should be designed and systematically implemented to enhance the sustainability of the emergency response gains.

#### **Recovery Strategic planning**

- **R5: Vulnerability Analysis**

It is recommended that the design and implementation of recovery programming is based on systematic in-depth vulnerabilities and capacities assessments that could be conducted during a brief and focused “inception period”. Such a phase would also allow good quality baseline assessments to be conducted. These assessments would support in refining ambitions and in designing appropriate approaches in line with existing vulnerabilities and would also form the basis of a strong participatory community development approach aiming at strengthening social cohesion and inclusion of the most vulnerable.

- **R6 : Food Security and Livelihoods**

Strategic planning for recovery needs to take into account IFRC and the operating National Societies mandate and core competences. Food Security and Livelihood is relevant to IFRC focus on resilience but does not always translate into strategic priorities and competences at the NS level who traditionally do not have strong capacities in this sector. Such a discrepancy shall be addressed when planning for recovery and strategic partnerships shall be sought at the global and/or country level with key actors to overcome this challenge when it arises.

- **R7: Health**

In the health sector which remains a core strategic priority and competence both for IFRC and the NS globally, it is recommended to conduct strong baseline data, KAP surveys and barriers analysis when planning for recovery, to ensure the design of in-depth public health programming that addresses root causes of poor health.

Similarly to FSL, strategic partnerships with key health actors should be sought to address health issues and address social determinants of health which are not within the range of the Red Cross Movement priorities and competences. Humanitarian Diplomacy for health should become a systematic approach to which, combined with strategic partnerships, has the potential to substantially increase the impact of IFRC Health programming.

- **R8: Capacity Development Of National Societies**

It is recommended that the National Societies are supported to develop resource mobilization strategies aimed at building the NS capacities to implement programmes within their core strategic priorities and build sustainability of the programmes. Financial support services should be placed at the branch offices to support the branch managers. The NS HQ should have the capacity to support the branch/county branches to have the adequate financial management skills.

Continuous capacity development programmes focusing on financial management, policy development, procurement and logistics, human resource and administration should be sustained in all the NS. Refresher trainings in the areas of social mobilization skills, Psychosocial support and counselling, integrated disease surveillance, contact tracing should be conducted regularly. In addition, regular monitoring of capacity building activities should be carried out.

Coaching and mentoring of NS leadership on good governance and management should be carried out on a regular basis. The national executive board should carry out annual self-assessment to evaluate their work in steering the NS in strategic policies and implementation of financial audits, HR, procurement, resource mobilization and sustainability. Change agents within the leadership should be identified to spearhead change and create ownership of the capacity building programme.

Draft policies and procedures should be approved by the board and close monitoring of implementation carried out. During an emergency period, the board might suspend full implementation of policies and procedures in writing. Clear timelines must be set for when this should apply and regular review of the situation should be carried out to determine if it is safe to revert back to full implementation of the policies and procedures.

#### **FOR MID TO LONG TERM PLANNING WITHIN CURRENT PROGRAMMES**

- **R9:** It is recommended that both NS develop a realistic and well-targeted strategic plan which will form the basis of its partnerships and resource mobilization strategies and includes a resource mobilization strategy that is based on effective programming as much as on other income generating activities.
- **R10:** CBS should remain, in this form or as ECV, part of the NS core programming integrated in CBHP and DRR. There is however a need to improve its sustainability by relying more on unpaid community volunteers, including possibly the Community Health Workers, and by establishing a clearer and stronger relationship between volunteers and health facilities.
- **R11:** The FSL intervention in Sierra Leone has effective elements of sustainability that require a continued monitoring and support from the NS. It is recommended that such support should be planned for and implemented during the remaining months of recovery appeal implementation.