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Emergency Plan of Action Preliminary Final Report

East Africa: Ebola Preparedness

 International Federation
of Red Cross and Red Crescent Societies

Ebola Preparedness Fund	Operation n° MDR64007
Date of Issue: 27 January 2016	Glide number:
Operation start date: 25 February 2015	Operation end date: 15 October 2015
Host National Societies: East Africa and Indian Ocean Islands (Burundi, Comoros, Madagascar, Rwanda, Somalia and Sudan)	Operation budget: CHF 181,000
Number of people affected: 200,000	Number of people assisted: 45, 413
N° of National Societies involved in the operation: French Red Cross	
N° of other partner organizations involved in the operation: None	

A. Situation analysis

Description of the disaster

An Ebola epidemic that began in March 2014 in Guinea continued to claim lives and to spread to other countries (Liberia and Sierra Leone) in West Africa. The Ebola outbreak is on record as the largest in history and the first to affect multiple countries simultaneously. It could pass for one of the biggest epidemic control and response activities ever embarked on and with multiple partners. In the context of the Red Cross and Red Crescent Movement, the outbreak provided a real time test of the preparedness and coordination capability in responding to emergencies of such scale. The declaration of Ebola-free status by the World Health Organization (WHO) in the three West African countries since January 2016 has been characterized by new findings here and there and therefore the outbreak is still far from being over, although largely contained.

However the devastation caused by the outbreak is evidently enormous as indicated in the table below:

Country	Total Cases (Suspected, Probable and confirmed)	Laboratory – Confirmed Cases	Total Deaths
Guinea	3,804	3,351	2,536
Sierra Leone	14,122	8,704	3,955
Liberia	10,675	3,160	4,809
Total	28,601	15,215	11,300

Source: WHO, 2016

In the response operation, more than 8,000 volunteers were mobilized from the 3 hardest hit West African countries while the movement deployed 459 highly trained International staff from over 30 National Societies. Their collective involvement in the response operation reached an estimated 8,000,000 people through Social Mobilization and Beneficiary Communication. Some 403,615 were provided with Psychosocial Support while 97,000 cases were traced and monitored. The operation also ensured a Safe and Dignified Burial that respects the local cultural and religious values to the dead.

Many experts believe that the official numbers substantially understated the size of the outbreak because of families' widespread reluctance to report cases. Because of the fluidity of movement of people between West Africa and several countries in the East African region, especially Kenya and Ethiopia (who in turn have extensive interaction with other countries in the region in terms of human movement), the risk of an outbreak of Ebola in East Africa was as eminent as in any of the countries bordering the affected countries in West Africa. In the face of this threat, the IFRC

Regional Office for Eastern Africa and the Indian Ocean Islands supported 6 National Societies to raise their Ebola preparedness and response capacity through training, technical support in planning and implementation of Ebola related activities, and coordination both within and outside the movement. Some of the targeted National Societies such as Burundi and Rwanda, coincidentally border the Democratic Republic of Congo (DRC) and Uganda that have had bouts of the Ebola Virus Disease (EVD).

Please note that this Preliminary Report is issued in advance of the Final Report.

Summary of response

Overview of Host National Society

Six (6) National Societies (Burundi, Comoros, Madagascar, Rwanda, Somalia and Sudan) were assisted by the IFRC Regional Office for Eastern Africa and the Indian Ocean Islands (EA/IOI) to implement the Ebola preparedness and response project. The six National Societies engaged in the following activities in the Ebola preparedness and response project supported by the IFRC Regional Office for East Africa and the Indian Ocean Islands:

- Engaged state and civil society and public actors in planning and coordinating national preparedness plans development as well as the development of national policies on Ebola.
- Organised Training of Trainers (ToT) workshops for National Society staff, volunteer leaders and other actors.
- Updated the National Society preparedness and response plans in collaboration with the national level mechanisms put in place following the Ebola alert raised by the WHO.
- Trained volunteers to conduct Social Mobilization activities.
- Developed tools and determined channels for Social Mobilization in collaboration with other actors.
- Conducted Social Mobilization activities to educate the population on the EVD and highlighting the roles and responsibilities of each and every community member and collective community responsibilities on preventive measures and response, in event of a suspected case, confirmed case or an outbreak.
- Pre-positioned Personal Protection Equipment (PPE) provided by the IFRC Regional Office for Eastern Africa and the Indian Ocean Islands.

Overview of Red Cross Red Crescent Movement in country

Activities related to coordination of Ebola preparedness and response, within and outside the RCRC movement, were part of the support pillars that the IFRC offered to National Societies that were involved in Ebola preparedness and response project. The IFRC liaised with and consulted regional and country partners on current and future Ebola initiatives that were likely to benefit National Societies in the region. Linking National Societies to available Ebola resources in their countries and in the region were an integral part of the coordination support.

At the regional level, the IFRC EA/IOI RRO was involved in:

- participation in external regional coordination meetings,
- development and update of mapping of ongoing and planned initiatives,
- sharing of relevant information with NSs and PNSs,
- PNSs mobilization for country level support

At national level, the IFRC EA/IOI RRO provided:

- Support to National Societies in key national coordination meetings to assist them define their role within the national plan and influence the strategy where needed/possible

Overview of non-RCRC actors in country

Following the Ebola alert raised by the WHO, all countries in the region activated various mechanisms to prepare and respond to any probable or prospective suspected/confirmed cases or outbreaks. In implementing this project, some actors worked in close collaboration with the respective National Societies. The principal actor was the Ministry of Health that effectively coordinated and lead the development of National Strategies on Ebola as well as the development of preparedness and response plans. The sector ministry led multi-disciplinary teams in the preparedness and response activities. The Ministry of Health equally facilitated and participated in the ToT workshops organised by the National Societies with technical support from the IFRC Regional Office for East Africa and the Indian Ocean Islands. In the particular case of the Madagascar, other partners such as the Pasteur Institute,

a medical research foundation, was actively involved in the planning and implementation of the planned activities by the National Society.

Needs analysis and scenario planning

No specific needs assessment was conducted to assist the design and implementation of the project. Much was drawn on the prevailing scenario in the three countries that were affected by the outbreak in West Africa. Based on the urgency to increase National Society capacity to respond to the unfolding outbreak, the IFRC East Africa and Indian Ocean Islands Regional Office conducted two ToT workshops for National Societies in the Region with the participation of the sector ministry from some of the countries. This was done in line with the IFRC Africa Zone Strategy to address Ebola.

The six countries that were targeted in the project were selected based on the National Society preparedness, conclusion of consultations with their governments of the preparedness plans developed at the ToT workshops and the level of risks their respective countries were exposed to. Some of the target countries in this project such as Rwanda and Burundi border countries that have ever had a bout of the EVD at one time or the other.

Risk Analysis

The risk of an Ebola occurrence in any of the countries in the EAIOL was/is in composite terms, the same as in any country in West Africa and beyond. The importation of the disease in countries as far out as America and Europe was/is a characteristic illustration of how real the risk of an Ebola spread in EAIOL was/is.

The IFRC analysed and graded the actual risk of Ebola in the region based on the following set of considerations:

1. Air traffic connection with West Africa: the region has two major airline hubs in Addis Ababa and Nairobi that serve as transit points for passengers to and from West Africa. Kenya Airways and Ethiopian Airlines together make more than 100 rotations to and from West Africa every week. This represented a potential risk of the importation of the Ebola infection from the epicentre to East Africa, until they were declared Ebola-free.
2. High fluidity of movement of people between countries in the region with most of them transiting either in Nairobi or in Addis Ababa: Passengers travelling to other countries and passing through the two exchange airports could be exposed to contamination with Ebola if a case did/does occur there.
3. Lack of adequate preparation against an Ebola outbreak: Most countries in the region were inadequately prepared to prevent or respond to an Ebola outbreak. Apart from a few countries that had established screening and quarantine facilities at some points of entry for travellers from selected origins, the majority of countries in the region had no systematic procedures to detect suspected Ebola patients at the points of entry. Some countries in the region developed contingency plans for Ebola but most had no identified or adequate funding to implement their plans.
4. Lack of knowledge and myths about Ebola: Though Ebola outbreaks had occurred before in the region there was still a considerable amount of misconception and lack of awareness about the manner in which the disease is transmitted, its natural history as well as its treatment.
5. Weak Public Health Systems: Most of the public health systems in the region were/are weak and underfunded for some and dysfunctional for others. One case of Ebola could easily spread to infect several other people before it could be contained. A case notified away from the capital city may infect many other people before it is detected and isolated. This is because of lack screening and testing facilities outside capital cities as well as lack of trained personnel.

B. Operational strategy and plan

Overall Objective

The overall objective of the project was to improve the level of preparedness against the Ebola Virus Disease in six National Societies in East Africa and Indian Ocean Islands.

Proposed strategy

The proposed strategy remained the same throughout the operation. The six National Societies were able to enhance their capacity and that of other key stakeholders such as the Ministry of Health to effectively update their knowledge of the epidemic and update their preparedness and response plans. These subsequently influenced the community mobilization activities that helped to better inform and prepare the community for any outbreaks.

The project targeted an estimated 200,000 persons but only 45,413 persons or 23% were reached due to implementation challenges encountered by the implementing National Societies.

Operational support services

Human resources (HR)

There were no human resource costs involved in the project besides the costs of the focal persons who travelled to the respective National Societies to support/facilitate the respective ToT workshops. No permanent or temporary staff was engaged for the purpose of this project.

The focal persons identified by the IFRC East Africa and Indian Ocean Islands Regional Office facilitated the ToT workshops in the respective countries and offered additional technical support to the National Societies in the dialogue with the Ministry of Health and in the implementation of the entire project.

Logistics and supply chain

The main procurement under the project was managed by the Africa Region and East Africa and Indian Ocean Islands office logistics units. The two units collaborated to facilitate the procurement and delivery of the Personal Protection Equipment (PPE) for prepositioning by the National Societies involved in the Ebola preparedness project.

Communications

With Ebola gaining global attention, each country initiated steps to activate its preparedness and response mechanisms. That received a large amount of media attention with all the activities and processes being put in place by the respective countries. The implementation of this project by the respective National Societies did not receive specific media attention to profile the National Societies but was part and parcel of the overall media reporting and commentary on the national preparedness and response initiatives.

The Ebola response in the affected West African countries however received wide global profiling of the Federation, National Societies involved as well as other actors.

Security

Besides Burundi where the run up to the Presidential elections degenerated into widespread violence, the rest of the countries implemented the project under relatively stable environments. The Burundi Red Cross had to defer the implementation of some aspects of the project until the security conditions were conducive to continue.

The National Society was eventually able to implement the planned activities following the extension requests.

Planning, Monitoring, Evaluation & Reporting (PMER)

The IFRC East Africa and Indian Ocean Islands not only assigned focal persons to support/facilitate the ToT workshops of the respective National Societies but the focal persons continued to provide other technical support to the National Societies. They equally monitored the implementation of the project in the respective countries and liaised with the Regional Health Coordinator to help address any implementation gaps and challenges identified or experienced. No field monitoring visit was however feasible by the IFRC focal persons due to financial limitations and the challenges related to timely implementation by the National Societies.

Two implementation updates were also compiled during the lifespan of the project and which were considered in the two extension requests made to the end date.

In view of the time frame of the project and challenges faced by the National Societies at one time or the other, the lessons learnt workshop, evaluation and beneficiary satisfaction surveys of the project could not be conducted.

C. DETAILED OPERATIONAL PLAN

Quality programming / Areas common to all sectors

Quality Programming/Areas common to all sectors
<p>Outcome 1: Support Coordination on Ebola Prevention, Monitoring and Evaluation and Learning. Output 1.1: Regional sector focal persons actively facilitated Ebola interaction in National Societies. Output 1.2: Conducted an end line evaluation and lessons learnt workshop.</p> <p>1.1.1: Travel and meetings in National Societies 1.1.2: Support training 1.2.1: Evaluation in 2 randomly selected National Societies 1.2.2: Lessons learnt workshop</p>
Achievements
<p>The Federation supported all six National Societies involved in the project with identified focal persons to engage and support them in the discussions with the respective sector ministries and planning for the Ebola Preparedness ToT workshops. The focal persons further provided technical support to the respective National Societies by way of facilitating the ToT workshops and assisting them to update their preparedness and response plans.</p> <p>Due to the challenges encountered by some of the National Societies in planning and implementing the activities outlined under the project, the evaluation of 2 randomly selected National Societies and the Lessons Learnt workshop could not be realized. While the Burundi Red Cross was preoccupied with responding to the election preparedness and subsequent related violence in the country, the Somali Red Crescent was equally engaged in responding to a population movement emergency arising from the Yemeni conflict. As a result of unforeseen developments, particularly in the dialogue with the state authorities, Rwanda and Madagascar Red Cross Societies on the other hand had a late start of the planning and implementation of activities under the project. The foregoing significantly contributed to the non-realization of the last two activities within the revised project end-date of 15 October 2015.</p>
Challenges
<ul style="list-style-type: none"> National Society dialogue with the Ministry of Health and other actors in some instances dragged on longer than expected and therefore affected the implementation of the project within the initial implementation period The implementation challenges encountered by the National Societies did not allow the realization of the Evaluation of 2 randomly selected National Societies, including the Beneficiary Communication survey and the Lessons Learnt Workshop.
Lessons Learned
<ul style="list-style-type: none"> Projects that will require the involvement of other actors require a reasonable time frame for implementation as discussions and consensus building could consume a lot of project time, judging from public service bureaucracy.

Health and Care

Health and Care

Outcome 2: Support the rolling out of Ebola training in National Societies and harmonization of preparedness plan.

Output 2.1: Trained staff and volunteers on Ebola transmission and prevention at branch level in National Societies.

Output 2.2: NS Ebola preparedness Plan of action is aligned to federation-wide guidelines and MoH plan.

2.1.1: Training of Trainers

2.1.2: Training of volunteers

2.2.1: Meeting between NS and MoH

2.2.2: Updating Ebola Plan of Action

Achievements

All six National Societies involved in the project significantly realized the activities outlined under this outcome. They all opened dialogue with the Ministry of Health to discuss the NS plans and participated in coordination meetings. They equally updated their respective draft preparedness and response plans that were developed at the ToT workshop organized by the IFRC Regional Office for East Africa and the Indian Ocean Islands in December 2014, following their respective in-country ToT workshops for National Society staff, volunteers and other actors.

The table below provides an overview of the numbers trained in the ToT workshops and the training of volunteers in the respective National Societies:

Country	ToT Workshop Participation			Volunteer Training Participation		
	Male	Female	Total	Male	Female	Total
Burundi	11	6	17	144	114	258
Comoros			9			50
Madagascar*	17	6	23	68	92	160
Rwanda	16	4	20	39	76	115
Somalia	8	5	13	43	34	77
Sudan	5	15	20	19	6	25
Total			102			685

*In addition, Madagascar RC trained 50 staff (15 females and 35 males)

The content of the respective trainings followed the outline used at the Regional ToT workshop in December 2014 and covered among others, the following:

Module 1: Infection control and Case management

Topics:

- Overview of the EVD,
- Infection control and universal precautions,
- Handling Ebola patients (case management),
- Contact tracing and active case finding,
- Supporting surveillance activities in the communities.

Module 2: Social Mobilisation

Topic

- Community awareness raising,
- Beneficiary Communication (Including media engagement),
- Fighting stigma and discrimination,
- Key stakeholder engagement (traditional chiefs, church leaders etc.).

Module 3: Psychosocial support

Topics

- Psychosocial Support for the caregivers (volunteers),
- Psychosocial Support for family members,
- Psychosocial Support for patients.

Module 4: Practical demonstration using Personal Protection Equipment (PPE) and disinfection equipment and solutions

Topics:

- Video demonstration (classroom),
- Practical demonstration (using PPE and other equipment).

The trainings were delivered through assorted methodologies such as power point presentations, group work and practical exercises. During the ToT workshops, participants underwent practical demonstration on the use of the PPE and other equipment used in response situations.

The Burundi Red Cross trained 17 ToTs against the planned 20. The NS also trained 258 volunteers from 15 districts, including 3 bordering neighboring countries to enhance their capacity to better prepare and respond to any suspected or confirmed case of the EVD. These capacity building activities were timely as they followed the Burundian government's endorsement of the WHO declaration of Ebola as an epidemic and the subsequent formation of a multi-disciplinary committee, the National Rapid Intervention Team (ENIR). The ENIR had the Ministry of Public Health in the lead with other actors such as WHO, UNICEF, UNFPA, Civil Protection and other Non-Governmental Organizations in the health sector as members. The Burundi Red Cross will however update its Ebola Preparedness Plan in alignment with the National Plan together with the Ministry of Public Health in 2016.

The Comoros Red Crescent on the other hand trained 9 ToTs and 50 volunteers from 3 islands to carry out advocacy work on EVD. Participants were drawn from medical and paramedical backgrounds with 4 of the ToTs coming from the Ministry of Health. In each of the islands, two participants in the volunteer training were from the Ministry of Health. The trainings were conducted in collaboration with the Ministry of Health in order to harmonize prevention activities in the country and come up with a consolidated National Ebola Preparedness Plan. In effect, the National Society's preparedness plan was updated as part of the overall national plan.

The Madagascar Red Cross conducted a ToT workshop for 23 regional coordinators (17 male and 6 female), made up of National Society staff from the regions, the Ministry of Health and organizations such as the Pasteur Institute. The National Society collaborated effectively with the Ministry of Health in implementing the project. The NS had membership of the Steering Committee on epidemic response as well as in the development of modules for the training of personnel, paramedics and mobilizers together with the WHO and the Pasteur Institute as well as in the design and adaptation of Information, Communication and Education (IEC) tools for the trainings and community mobilization. The Madagascar Red Cross also updated its draft Ebola Preparedness Plan that was fed into the National Strategic Framework on Ebola that covered different scenarios.

The Rwanda Red Cross also trained a total of 20 staff and volunteer leaders (16 male and 4 female) from 5 provinces and 15 districts of the country as ToTs. A further 115 volunteers (39 male and 76 female) were trained to support the social mobilization activities under the project. The National Society participated in Ebola Preparedness Coordination Meetings and discussions with the Ministry of Health, Local Authorities and health institutions in coming out with the preparedness plans, including social mobilization.

The Somali Red Crescent Society (SRCS) trained 13 persons (8 male and 5 female) as ToTs, made up of Health Officers from the 9 branches and National Health Officers of Somaliland and Puntland as well as the Ministry of Health and Labor in Somaliland. A further 77 volunteers together with clinic staff (43 male and 34 female) were trained from the branches in Puntland and Somaliland. Following the ToT and volunteer trainings, the National Society Ebola Plan of Action was updated for all phases. The SRCS was a member of Ministry of Health-led multi-agency Ebola Task Forces in Puntland and Somaliland respectively together with UN agencies such as UNICEF, WHO and UNOCHA.

The Sudanese Red Crescent Society trained 20 focal persons (15 males and 5 females) from the State branches and Khartoum as ToTs. The focal persons were made up of health professionals, community health focal persons and volunteers. Like the other National Societies involved in this project, the Sudanese Red Crescent society worked in close collaboration in all phases of the project with the sector ministry. The Ministry of Health was part of the discussion and planning for the activities executed while the National Society Ebola Plan of Action was updated following the activities conducted. The volunteer training focused on West Darfur where 25 were trained (6 female and 19 male).

Challenges

- The timeframe for the implementation of the project was regarded inadequate by the National Societies in view of the fact that the project had to be implemented in concert with other stakeholders, a mechanism that requires adequate time for consultation and consensus building.
- Project funding: Funding for the project was viewed as inadequate for wider coverage for such an important project. Perhaps it was envisaged that other actors would complement the project funds but not all other actors were ready or attached the same urgency to prepare for the prevention of Ebola, even if they had the intention. The funding made available for the project was therefore inadequate for the National Societies and by extension to the other actors involved in the project.
- All the National Societies worked in coordination and collaboration with other actors in order to have a national outlook to the preparedness and response plans. While a laudable idea, that approach was responsible for the delay in implementation of the project in some respects and therefore necessitating the extension of the end-date twice.

Lessons Learned

- The Ebola preparedness project provided a valuable opportunity and a major thrust for the National Societies to significantly appraise their preparedness status/capacity that was not only for the Ebola Virus Disease but had the synergic effect of being used in responding to other similar public health emergencies. The enthusiasm and motivation generated in all the trainings signified the level of consciousness of the public in the subject and making the Ebola preparedness training as one of the best in terms of active participation.
- Although the Ebola alert issued by the WHO triggered the activation of mechanisms for preparedness, the collaboration of the National Societies with the coordinating mechanisms increased the pace of preparedness by the respective countries. Not only were comprehensive plans put in place but Social Mobilization activities involving the larger community were launched. The mechanism also provided some basis for long term collaboration between the National Societies and the other actors in responding to future outbreaks and other health emergencies.
- The collaboration, though not in the case of all the National Societies involved in the project, brought out the significance or value of public-private participation with respect to responding to health emergencies and the need for all National Societies to pursue such a collaboration to tap resources from all sources.

Outcome 3: Raise awareness about Ebola transmission and prevention in the communities.
Output 3.1: Conducted radio sensitization campaigns on Ebola transmission and prevention.
Output 3.2: Printed and distributed of Information, Communication and Education (IEC) materials.

- 3.1.1: Ebola message validation
- 3.1.2: Radio campaigns
- 3.2.1: Printing of posters
- 3.2.2: Distribution of posters

Achievements

Social Mobilization and sensitization activities using different media were conducted by 5 out of the six National Societies in the project to increase community knowledge on Ebola prevention and response as well as strengthening community capacity in epidemiological surveillance in the community. The activities were also aimed at complimenting and reinforcing the efforts that the Ministry of Health had already made since the Ebola alert was issued by the WHO. Media such as the radio and other IEC materials such as leaflets and pamphlets were developed and used in the Social Mobilization activities in the respective countries.

The Burundi Red Cross was involved in the development of tools for Social Mobilization and sensitization on Ebola prevention. Some 2,000 pamphlets, 129 assorted posters on Ebola prevention were produced while 118 community sensitization trainings/sessions were conducted. In addition, 4 radio spots/messages were broadcast as part of the NS Social Mobilization activities. The Social Mobilization activities conducted by the NS reached an estimated 8,256 community members (5,160 female and 3,096 male).

Tools developed by the Comoros Red Crescent in collaboration with the Ministry of Health included 1,000 fliers and 600 posters. The trained volunteers were also provided with a set of communication tools such as boards, the Epidemic Control for Volunteers (ECV) toolkits and posters to assist them in the Social Mobilization activities and relied on plans of action they developed during their training in determining the locations and beneficiaries. The volunteers had 2 mobilization sessions per week, with an average of 16 sessions per volunteer. These were supplemented by dissemination made on radio. A total of 50 broadcasts made on the Comoros Red Crescent local radio. The Social Mobilization activities reached an estimated 24,500 persons, about 3.5-4% of the Comoros population.

The Madagascar Red Cross equally engaged in a number of Social Mobilization activities that reached approximately 5,249 community members (3,018 female and 2,231 male). The National Society participated in the design and adaptation of IEC tools in workshops organized by the Ministry of Health and the training of volunteers in dissemination. It was the only partner of the Ministry of Health that engaged in Social Mobilization activities on the Ebola Virus Disease through home visits, Focus Group Discussions and courtesy calls on local authorities. The activities of the volunteers were complimented by 13 radio and television spots/messages to disseminate information to the community on Ebola prevention.

The Rwanda Red Cross also embarked on Social Mobilization activities that reached some 1,650 community members (950 female and 700 male). Trained volunteers, organized into teams of 5-6, conducted house to house visits to disseminate Ebola prevention and control messages, particularly using mobile cinemas. There were also forums for local authorities and health center staff as part of the Ebola Social Mobilization activities

Due to the onset of the population movement emergency that arose from the Yemeni returnees/refugees, the planned sensitization activities in Somalia had to be shelved. The two locations identified for the sensitization activities, due to their risk level as key entry points into Somaliland and Puntland by sea, coincidentally were the very two port cities receiving the refugees/returnees from Yemen. Limited Social Mobilization was however conducted at the 32 clinics being managed by the National Society, mainly using materials from the IFRC that were translated into Somali. In Somaliland, the Somali Red Crescent Society (SRCS) also provided 6 tents at the two international airports and the sea port to be used in surveillance at these entry points. The SRCS however as a member of the multi-agency Ebola Task Force participated in consultative meetings that deliberated on the development of Social Mobilization tools as well as the role of the National Society in leading Social Mobilization activities associated with Ebola preparedness and response.

The Sudanese Red Crescent Society conducted 18 sensitization sessions for staff and active volunteers at the

branch level. These sessions reached a total of 425 participants (281 male and 144 female). Sixty-two per cent were staff with volunteers constituting the remaining 38% from 18 States of Sudan. At the community level, the National Society conducted 8 sensitization sessions for community leaders in 8 localities of West Darfur, attracting 151 persons comprising religious leaders, tribal leaders, head teachers, heads of community local committees, local health assistants, local authorities and women unions. The National Society also conducted 59 community awareness raising sessions including 859 door-to-door visits and 94 focus group discussions that reached a total of 5,758 persons (2,608 male and 3,150 female). Messages used were validated by all key stakeholders, including the Ministry of Health.

Challenges

- The development of tools for Social Mobilization proved a challenge for some of the National Societies. Whereas there was good coordination particularly with the Ministry of Health and United Nations agencies such as WHO and UNICEF in some countries, others were just superficial and could not come up with tools developed upon consensus.
- Time and funding limitations in the project did not allow the full potential of the Social Mobilization activities to be realized. This resulted in the realization only 23% of the target in the project reached. In the case of Somalia, an emergency that occurred did not allow the conducting of Social Mobilization activities altogether, although the NS was assigned by the task Forces to lead the Social Mobilization activities.

Lessons Learned

- Not all the sector ministries had the same capacity in leading and driving the process with effective coordination. A more careful analysis should be made in future to determine if some additional external capacity will be required in that respect. There could be a challenge with the Ministry of Health claiming and clinging to its position as the coordinating body but good dialogue could help move the project forward with good cooperation for the Ministry.
- Some Ministries of Health did not have the resources to supplement what the National Society was bringing in and this affected the pace and progress of implementing the project. Such a scenario should be envisaged in any such future project so that adequate funding is made available to ensure a successful, timely and quality project implementation.
- The Federation support to the National Societies to support country preparedness and response activities has further significantly profiled the respective National Societies in emergency preparedness and response. However with the Ebola Virus Disease still around us, the National Societies should maintain the tempo of Social Mobilization/community awareness and surveillance as continuous activities instead of being looked at as a process conducted at a point in time. This should be incorporated in on-going Social Mobilization activities.

Outcome 4: Procurement and repositioning of high contact PPE by NS.

Output 4.1: Procurement of PPE.

Output 4.2: Logistic support for repositioning of PPE in National Societies.

4.1.1: PPE requisition

4.1.2: PPE purchase

4.2.1: Delivery of PPE in the NS

Achievements

Requisition and purchase of PPE for the targeted National Societies under this project were carried out by the Africa Zone Procurement Unit. The Africa Zone Procurement Unit together with the Regional Procurement Unit facilitated procurement and delivery of 100 PPEs each to Comoros, Madagascar, Rwanda, Somalia and Sudan for repositioning. The Somalia consignment is being stored at the IFRC Somalia Country Office in Nairobi for better storage and protection.

Challenges

- The initial end date of the project proved unrealistic for the procurement and delivery of the PPEs to the respective National Societies. This is with respect to the process of determining the specifications, the procurement chain, and the different customs regulations as well as capacities of the National Societies to obtain required custom exemptions in time for the shipment and clearance of the PPE.

Lessons Learned

- Projects requiring international procurement for different countries should take the procurement and logistics chain into account in determining the project duration.
- While it is a good idea to propose the procurement of PPEs for the National Societies for repositioning, in view of the remoteness of the disease spreading to the countries involved in the project, although quite probable, it would have been ideal to procure and store the PPE centrally at the Region. In that case, it could easily be

deployed to any country that happens to have any suspected or confirmed infection or in the extreme scenario, an outbreak, in reasonable quantities. It would also be more economic and faster to deliver than to mobilize what is prepositioned in the respective countries for any initial response to any suspected case, confirmed case or an outbreak in any of the countries.

Contact information

For further information specifically related to this operation please contact:

- **IFRC Regional Representation:** Finnjarle Rode, Regional Representative for East Africa; Nairobi; phone: +254 20 283 5000; email: finnjarle.rode@ifrc.org
- **IFRC Africa Region:** Farid Abdulkadir Aiywar, Head of Disaster Management Unit, Africa region; Phone: +254 731 067 489; email: farid.aiywar@ifrc.org
- **In Geneva:** Christine South, Operations Support, Phone: +41.22.730.4529, email: christine.south@ifrc.org

For Resource Mobilization and Pledges:

- **In IFRC Africa Region:** Fidelis Kangethe, Resource Mobilization Coordinator; phone:+ 251 930 03 4013, email: fidelis.kangethe@ifrc.org

For Performance and Accountability (planning, monitoring, evaluation and reporting enquiries)

- **In IFRC Africa Region:** Robert Ondrusek, PMER/QA Delegate for Africa; Nairobi; phone: +254 731 067277; email: robert.ondrusek@ifrc.org



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1. **Revised Emergency Appeal budget (if needed) [below](#)**
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How we work

All IFRC assistance seeks to adhere to the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGO's) in Disaster Relief and the Humanitarian Charter and Minimum Standards in Disaster Response (Sphere) in delivering assistance to the most vulnerable.

The IFRC's vision is to inspire, encourage, facilitate and promote at all times all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

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The IFRC's work is guided by Strategy 2020 which puts forward three strategic aims:

1. Save lives, protect livelihoods, and strengthen recovery from disaster and crises.
2. Enable healthy and safe living.
3. Promote social inclusion and a culture of non-violence and peace.