Lessons Learnt Review

The Movement Response to the 9th and 10th Ebola Outbreaks in the Democratic Republic of Congo (DRC)

Commissioned by the IFRC Africa Regional Office

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Executive Summary and Overview of Key Lessons

In May 2018, the International Federation of the Red Cross Red Crescent Societies (IFRC), launched an emergency operation in the Democratic Republic of Congo (DRC) to support the DRC Red Cross (DRCRC) in their response to the 9th outbreak of the Ebola Virus Disease (EVD) in Équateur province. While this outbreak was successfully controlled within three months, the Government of DRC and humanitarian partners, including the Red Cross Red Crescent Movement had to scale up their work in early August, to respond to the new outbreak in North Kivu province, which resulted in the declaration of the 10th outbreak of EVD in DRC. The outbreak in North Kivu happened within an active conflict environment and led to the revision of a One International Appeal for the RCRC Movement response. Despite delivery of a massive emergency response, the 10th outbreak continues to plague DRC and is widely considered one of the most complex humanitarian emergencies of recent times.

The IFRC's Africa Regional Office commissioned this internal "Lessons Learnt Review" of the category "Red" response is this complex environment to capture learning from the EVD operations in DRC and to inform the ongoing work and future epidemic responses in Africa. The review has been carried out by a small internal team and highlights lessons in six areas to support the management of similar operations in future. This has been carried out according to an analytical framework and comprised secondary data analysis and primary data collection but did not include a field visit due to time, budget and access issues. It included support from a Technical Review Group of experienced operations/health managers to advise on process.
This review did not assess the quality of technical interventions, which is covered in other research commissioned by the IFRC, such as the technical review of Safe and Dignified Burial (SDB) and Risk Communication and Community Engagement (RCCE) interventions by the London School of Hygiene and Tropical Medicine (LSHTM). This review does aim to build on lessons learnt from the West Africa EVD response operation and assess how that learning has been applied (see annex 2). This will feed into a final joint lesson learning meeting. To date, there has been no other review or evaluation of the overall operation and it will be important to have a full, final evaluation of the EVD response in DRC at the end of the Appeal. The six thematic areas of learning and the key learning in each are summarised below:

1. Delivering a category "Red" protracted public health response

The response to the EVD outbreak in DRC was rapidly declared a category "Red" response and the linked support (DREF, Emergency Appeal, surge capacity etc) were quickly scaled up and put in place. However, the challenge came in the IFRC's capacity to sustain a category "Red" for this PHE and to access the human and financial resources to respond to the changing and growing needs over a sustained period in such a complex environment. The IFRC needs to take time at the outset plan for a longer-term health response at scale and develop strategies to support sustained engagement. This could include re-deployment of personnel from the wider Secretariat and IFRC network and full-time engagement from a senior coordinator or manager, with clear authority to take decisions. It was seen as important to be able to re-assess the "Red" categorization and amend as necessary, as well as to clarify and adapt the roles and responsibilities across the different levels (Geneva, Regional and Country/Country-Cluster Offices) as the response went on. The IFRC should prioritize a formal, external evaluation of this category "Red" response, before the end of the operation, as no formal review or evaluation has yet been carried out.

2. The Emergency Response Framework (ERF) – roles, responsibilities and decision-making

The IFRC applied the steps of the ERF appropriately, in terms of the coordination of support and the enabling of the task force mechanism and these were sustained for the duration of the response. Relevant additional support was provided, through the Regional Ebola Cell, set up in the Africa RO, which was seen to have provided valuable operational and technical up stop for

the operation. It is recommended that this type of Cell be set up for any future cross-border outbreaks. However, as mentioned above, there were still issues around the clarity of management and reporting lines between office levels and a call to reinforce in-country capacity for an operation of this scale and to facilitate discussion and resolution of operational issues as they arose. The role of the Emergency Coordinator (EC) was not seen to have been able to resolve these challenges and needed work to further clarity the role's scope, decision-making authority, and relations to operational and field management. There is also a need to reinforce links between operational and health management for an epidemic response and IFRC should consider a dual management between Operations and Health across the three levels, to increase cohesion in future health emergency responses cohesion.

3. Internal and External cooperation and coordination

The EVD outbreak in North Kivu happened in a context of prolonged conflict and required an important investment in building cooperation between Movement partners. From the outset there were tensions around the priorities of each partner, particularly in relation to the ICRC's lead for security and logistics coordination for the response, although this improved over time and as trust was built. There was a clear need at the outset to build greater mutual understanding of each other's needs and priorities – this could have included recruiting delegates with experience of working with Movement partners – and there was a clear need for a Movement Coordinator and SMCC mechanisms to support systematic and effective cooperation. There was also a clearly identified need for the IFRC to strengthen its country-level support for the DRCRC's development and capacity strengthening across all levels – some capacity was strengthened at branch level due to the operation. It would have been useful to have had a liaison person between the CO and the operation to facilitate such support and an experienced NSiE delegate to manage this work in alignment with the operation and with partners in-country (as in Mozambique).

With regard to external coordination, the IFRC took on a clear role in coordinating the SDB pillar of the response and was a thought leader in its CEA feedback mechanism work. However, there was a clear need to reinforce the coordination roles for these two pillars and for wider engagement with the main partners and donors in country, particularly as this context saw new coordination approaches, through the WHO's Strategic Response Plan and with new donors in place and the IFRC needed a more experienced and reinforced coordination function at country level. The placement of a liaison person in WHO headquarters in Geneva worked well and should be replicated in future.

4. Risk management, business continuity planning and operational strategy

There is good learning in this operation around the work on scenario, business continuity and transition planning in this volatile situation. This includes learning from the Transition Plan for the exit from Equateur province, the hibernation planning for the election period at the end of 2018, and the work on "remote management" modalities and programme monitoring during the evacuation in the Spring of 2019, all of which can inform future work with and handover to national / NS teams. Based on the experience in DRC, the IFRC should strengthen its security culture and its risk management focus in such a complex context (e.g. agree its "risk threshold") and should agree clear channels to share information and local knowledge during the evolving situation. Risk management needs to be more central to all operational planning and to be regularly updated as the epidemic spreads to new areas or neighbouring countries. Risk management should include financial, security, operational and reputational risk and duty of care for staff and volunteers and should be a regular discussion point in the TF system. The IFRC should invest in adequate security training for all personnel and deploy a security coordinator to set up all necessary systems.

5. Programmatic relevance

Across the board the work in the pillars applied in the context, was relevant and of a good standard. In particular, the work of the RCRC on the CEA and SDB pillars was critical to the response. There was clear feedback on the need to further integrate the work across the pillars, particularly between CEA, SDB and PSS teams in future responses, to support inter-related community approaches. There was clear evidence from the field that the information gathered from communities had informed changes in the RCRC's work, however, it will be important to strengthen this utilization of community feedback in future and to show communities their voice is being heard. An issue that came up was the need for the IFRC to re-examine the opportunities and risks of taking on the coordination role for SDBs and, potentially, for CEA in future responses and, if agreed, to be ready to resource additional support to carry out such coordination roles. In future PHEs, IFRC should prioritise the provision of PSS support for national and international staff, as well as for volunteers, as part of if its "duty of care" and could consider wider inclusion of PSS for survivors and families, as part of its SDB pillar, if resources were available.

6. Corporate services and operational support.

Human Resources – There were real challenges in identifying appropriate human resources for this operation - people with the right technical / managerial experience, language skills and conflict / EVD aware profiles. Many delegates and partner NSs were reluctant to deploy and some key positions, such as Health, Logistics and Finance Coordinator positions proved difficult to fill over time. Surge deployments were used over and again to fill vacant long-term positions. The IFRC needs to reflect on the learning from the DRC and consider some new ideas around HR for protracted crises of this scale in complex environments. To ensure future HR capacity for "Red" responses, particularly for PHEs, IFRC will need to identify ways to recruit and maintain necessary staff levels. This could include developing surge capacity for extended 'emergency' deployments, temporarily reallocating staff from other Secretariat offices, proactively engaging with partner NSs to pre-identify and train key profiles, reinforcing the pool for the key Operations Manager (and Deputy Operations Manager) positions and supporting the early identification and fast recruitment of longer-term positions earlier in the response.

Public health profiles were especially hard to source at various points throughout the response, and indeed, a number of interviewees noted the challenges this posed for the operation especially at the beginning of the 9th Outbreak where there were significant challenges in deploying appropriate delegates with technical public health emergency profiles. At various periods across the 9th and 10th Outbreak, a number of surge deployments from various levels were required to fill these gaps, and whilst necessary at the time, this option was acknowledged as unsustainable and diverting resources from other critical functions. The need to build up technical capacity, especially at the Country, Cluster and Regional level in responding to public health emergencies, was noted as an especially important requirement and lesson from this response. It will also be critical to ensure an increase of public health profiles in the IFRC's most senior emergency leadership pools—such as the Heads of Emergency Operations (HEOps)--and indeed this is a lesson that the IFRC is already applying in the latest round of recruitment for the Developing HEOps programme.

A key innovation during the response was the piloting of a new rotation system between the field and the RO, to ensure the continuity of experienced staff in key positions, while avoiding burnout (1–2 months rotations over a 6–12 month contract). This has worked well and should be a model for future protracted crisis responses. PSS and strong security training are also key to ensure a duty of care in such a context, and it was clear in DRC that this should be provided to both volunteers and to staff / delegates. IFRC should also prioritise training, support and deployment of regional and national delegates/staff (e.g. RDRTs) with experience in epidemic responses. It would be particularly useful to develop a pool of francophone staff.

Financial management – In DRC, many actors faced serious challenges with financial management and in transferring funds to the field. The IFRC experienced particular challenges with the transfer of funds to field teams through the Working Advance system, which was not set up for the scale of a "Red" response and had to find alternative means ensure funds arrived to sustain the operation – this system and criteria would need to be reviewed to enable timely cash flow for a future response on this scale. This was a specific challenge around the payment of volunteer allowances – this was finally resolved after some time, by using Orange Mobile to pay volunteers. This system was practical and effective and can be replicated as appropriate in other contexts. It could also be pre-negotiated by NSs with local providers.

There was also a lack of experienced finance delegates or staff in the initial phase of the operation, and it was noted that the situation improved once a strong Finance Manager was identified. The IFRC needs to develop its pool of experienced financial managers / analysts at regional and global levels, so they can be deployed to set-up up financial management systems in the first phase of a response. The example of deploying members of the RFU to the Mozambique operation was positive and could be replicated. There is also an urgent need to for cross-functional solutions to improve operational managers' access to real-time financial and funding information, to enable them to make critical decisions during an emergency response of this scale. As mentioned above, there is a need for a more robust and thorough system of risk management for such operations, to manage financial risk and strategic oversight at field level throughout the response.

Logistics and Supply Chain Management – Delays in procurement and logistics were a serious challenge for this operation, especially in the initial phase. This was due to a number of reasons, including the lack of qualified and experienced logistics and procurement staff and the lack of clear understanding between the IFRC and the ICRC around logistical support. In future operations, where other Movement partners are responsible for logistics, it would be important to clarify logistics procedures in advance, to brief/train delegates on the specific procedures before deployment, and to improve engagement between logistics teams. It is also vital to have experienced logistics or procurement delegates in place from the outset, with experience or knowledge of the different approaches. IFRC should also look to optimise local procurement or pre-positioning for less specialised items where possible and investigate options to have medical procurement experience in the ROs, to minimize delays.

Partnerships and Resource Development – The mobilisation of funding for this operation started strongly, but reached a crisis in the Spring of 2019, when there was a severe shortfall in funds that risked operational continuity and impacted the staff and structure of the response. It is important that the IFRC teams across all levels develop a Resource Mobilisation Plan for an emergency of this scale, to better anticipate and manage funding over the duration and evolution of the response and that monitoring provides clearer alerts around funding levels. With changing donor presence at field level for PHEs, it will also be necessary in future for the IFRC to deploy PRD staff to support donor engagement at the country level.

There were very few PRD staff working on donor relations, particularly at the country level, and this was insufficient to deal with the new funding realities as the operation progressed. However, towards the end of 2019, it was noted that through intensive support and focus following the creation of a PRD taskforce, the funding situation improved substantially, which was also helped with renewed attention and resource allocation from donors. Nevertheless, interviewees also noted significant recent improvements in the monitoring of the funding situation of the operation, allowing for relevant staff to take early action to fill anticipated future funding gaps before they arise. Recent developments have also It is essential that the IFRC speeds up work to set up a pool of experienced PRD delegates / staff, ready to deploy in future "Red" responses. It is timely

for the IFRC to strengthen advocacy with new donors and partners to ensure mutual understanding and to seek greater donor flexibility for rapidly evolving epidemic outbreaks.

Category		Lesson or Recommendation
Delivering a category Red protracted health response	1	The IFRC's "Red" categorization of the 9th EVD Outbreak was taken with adequate speed, appropriate for the scale of the emergency and was the right level to deliver and resource such a complex response
	2	Given the unique resource requirements for a "Red" public health emergency, consideration of the time and resources required to maintain an at-scale "Red" response from the onset of the operation is required and an institutional commitment is codified and that mechanisms are established to maintain these human and financial resources over time. The IFRC will need to commit the resources required for an epidemic response of such scale and duration, including deployment of personnel from the wider Secretariat and IFRC network and take steps to manage organizational fatigue and multiple commitments
	3	The IFRC should build on learning to set up clear steps in the Emergency Response Framework (ERF) to regularly and objectively re-assess the continuation of a Category "Red" response and to amend disaster categorization (up or down).
	4	The IFRC should formally consider its business continuity plans/structure to cope with simultaneous, large-scale emergencies, including those within the same Region, to avoid losing oversight of any one major operation. This contingency planning could be an important consideration for the Disaster and Crisis Working Group (DCWG).
ERF - Roles and Responsibilities	5	Given the challenges faced by the EC during the 10th Outbreak, IFRC should re-examine the EC role to clarify the overall responsibilities of the position, including the extent of its operational "management and direction setting" responsibilities and agreeing on the mobilization level (Regional or HQ) depending on the accountability and responsibility requirements of the ERF. Special consideration should be made to the scope, timeframe, and decision-making authority of the position and whether the assignment should be standalone given the volume of work associated with the job.
	6	The Regional Ebola Cell was a positive addition to the operation, providing valuable operational and technical support and providing a vital back stop for the operation. This type of Cell should be automatic at the outset of any epidemic response, which threatens cross-border transmission
	7	Information sharing and authority lines between CO, RO and Geneva should be re-articulated and clearly defined at the start of an operation of this scale, with space for discussion and resolution of operational issues as they arise. This could include setting up a system to transparently log all key decisions. Line management of the Operations Manager role should be shifted to the CO/CCST soon after the response phase.
	8	There is a need to clarify and reinforce links between operational and health management and technical lines for an epidemic response. IFRC could consider dual management between Operations and Health across the three levels to bring in health expertise more strongly and strengthen operational cohesion.
Internal and External Cooperation and Coordination	9	In a complex context where both IFRC and ICRC are working together, inclusion of a Movement Coordination function and wider Movement cooperation mechanisms (SMCC guidance) should be prioritised to support systematic and effective cooperation between Movement partners, including negotiations around security, access and logistics and to improve integration agreements.
	10	In order to build trust amongst Movement partners and reduce the risk to staff in insecure environments, the IFRC must make a much stronger investment in adequate security management training for staff and delegates and in developing an appropriate 'security culture' for field teams.
	11	The Security Management Agreement (L3) between the IFRC and ICRC had significant implications for the operation, both positive and negative, and needed more work at the outset to understand and clarify the roles and responsibilities of the individual Movement partners, both internally and externally as well as how they were to be applied by both IFRC and ICRC leadership. The lessons garnered

		through the implementation of this agreement should inform future decision-making for both organizations and considerable effort should be made to engage experienced Heads of Delegation/Country and Operations Managers prior to the signature of future integration agreements to cross-check for potential operational challenges and coordination pitfalls.
	12	Sentiments of mistrust and misunderstanding punctuated the IFRC and ICRC relationship during the response and led to significant operational challenges. This highlights the need to continue investment in SMCC to foster better mutual respect, trust and understanding between the two organizations
	13	A key lesson of the EVD operation is the level of inter-operability the Movement has on operation and that when each component, building on their strengths and contextual comparative advantages, plays their role, the strength of the RC response is augmented exponentially.
	14	The IFRC should make specific effort to strengthen its Country Office (CO) presence in a complex context with a "Red" response. This could include short-term staff deployments to support NSD, volunteer management, Movement coordination, and resource mobilization (see Mozambique). It would be useful to have a coordination focal point to liaise between the CO and the operation.
	15	While there were clear developments in the NS's capacity, particularly at branch levels, further steps need to be taken to further strengthen the counterpart system and targeted support for the NS's priorities through the EPOA and budget. It would have been useful to deploy a NSiE delegate or NSD professional(s) early in the response, to manage capacity strengthening/NSD in alignment with the operations team and partners in-country and to strengthen engagement with the NS on all levels - governance, management and technical– and support NS financial management and accountability. This could be further supported via targeted visits from RO or Geneva financial managers, proactive risk management plans with the NS, or early audit.
	16	With regard to external coordination, the IFRC should put in place experienced staff to support coordination and representation functions within a category "Red" response, to ensure appropriate levels of engagement and information sharing with key external actors and donors. The placement of a liaison person in WHO headquarters worked well and should be replicated in future, while the IFRC should look to invest in the coordination functions for SDB and CEA in PHEs.
	17	The IFRC also needs to continue familiarizing itself with the coordination practices and funding mechanisms of WHO, World Bank, and other major actors / funders, to optimize relations and funding as well as to clarify its "position" with these actors in advance.
Risk Management, BCP, and Operational Strategy	18	For operations in complex settings, there is a need for constant focus on risk management, the elements of which—security, operations, and corporate services—are equally shared, understood, and prioritized by all Movement components who are partnered together in a response. As such, risk management should be included in all joint planning and protocols, agreements, and working modalities adapted relative to the changes in the overall situation and risk appetite.
	19	In emergency responses of this complexity, the IFRC must, at the onset, establish a comprehensive acceptable risk threshold for staff that is consistent with its organizational risk appetite and humanitarian priorities. The threshold should be developed transparently with the relevant Movement elements involved in the response but remain 'live' as to be adaptive to a changing situation.
	20	There is a need for a more robust and thorough system of risk management in operations, to ensure managers are regularly updating their risk management analysis and actions in response to the evolving situation. This should cover operational, financial, security and reputational risk and should be a critical element in planning and strategic oversight at field level throughout the response. It should also be a regular priority at JTFs and in wider discussions between CO/operations, RO and Geneva.
	21	Integration of Staff Health and MHPSS profiles from inception of the EVD operation was required but did not occur. For similar operations in the future, these profiles should form the standard and essential rapid deployment team to establish the infrastructure and mechanisms to extend the IFRC duty of care to staff.

	22	The IFRC should invest considerably in adequate security management training for staff and delegates operating in complex environments and seek to enhance its 'security culture' within field teams. Cross-learning from the ICRC would be helpful in this regard and could have long-term benefits in breaking down organizational barriers.
	23	There is good learning from work on scenario, business continuity and transition planning in this operation and in this highly volatile context. This includes detailed learning on "remote management" modalities that might be needed for the future and greater support for transition planning to support the handover to national / NS teams.
	24	At inception of an operation where IFRC and ICRC have a security integration agreement, secure channels between trusted counterparts should be established to better share information on the operation, security and the evolving context at country level with clear rules on information sharing and confidentially. This would improve risk management and operational integrity in complex contexts and could contribute to better joint analysis.
Programmatic Relevance	25	There is evidence information from communities informed changes in the pillars of our work, and it is vital in future to continue to use community feedback to improve operational delivery and to show communities their voice is being heard.
	26	It is important to further integrate the work of CEA, SDB and PSS teams in future responses, to ensure coherence and to build inter-related community approaches.
	27	There was learning shared from operational teams, that the IFRC should look to access more contextual or anthropological analysis in-country at the outset of a response to learn and inform operations from local knowledge.
	28	IFRC should examine the opportunities and risks around taking on the coordination role for SDBs and for CEA for future responses and be ready to specifically support and resource these roles if this is agreed.
	29	There are key lessons to be learned from the remote management experience and on how to exceptionally manage "distance quality assurance" for SDBs and other pillars.
	30	In future PHE, IFRC should provide PSS support for national and international staff, as well as for volunteers, as part of if its "duty of care". This could include PSS for survivors and families, as part of its SDB pillar, if expertise and resources were available.
	31	IFRC should continue to develop approaches across the pillars to learn and improve working in new areas, such as in dense urban and conflict affected areas for the future.
Corporate Services and Operational Support	32	To ensure future HR capacity for "Red" responses, particularly for PHEs, IFRC will need to identify ways to recruit and maintain the necessary staff levels. This could include temporarily reallocating staff from other Secretariat offices (Geneva/ROs) or proactively engaging with partner NSs to pre-identify and train key profiles, such as Health Coordinators, Logistics/Procurement Coordinators and Financial Managers for deployments as needed. There was also a recommendation from the field that experts from ICRC could be considered for positions in future outbreaks in complex contexts.
	33	The Deputy Operations Manager position worked well and should be an automatic consideration for future "Red" or large-scale "Orange" responses of this scale.
	34	The IFRC must increase its work to put in place more effective processes for recruiting medium to longer-term staff for protracted crises, including PHEs, to avoid reliance on surge. This could include developing surge capacity that is viable for extended 'emergency' deployments, ensuring early identification of and action on long-term recruitment needs or improving systems for the fast recruitment of long-term staff.
	35	The EVD response piloted a new rotation system between the field and the RO for key positions to ensure continuity of experienced staff in the operation, while allowing staff time out to avoid burnout (rotating every 1–2 months over a 6–12 month contract). This has worked well and should be a model for protracted epidemic outbreaks.

	36	PSS is a key priority for future PHEs - this should cover support for volunteers working in the epidemic response, including the timely provision of equipment, training, safety / security measures, and timely payment of remunerations, and the provision of PSS for delegate/staff mental health needs, as a priority duty of care, including for longer-term staff. In future EVD outbreaks, this should include access to relevant vaccinations.
	37	IFRC should prioritise the training and deployment of experienced regional and national delegates/staff with relevant experience in epidemic responses. To support this, the Africa RO should reinforce the regional capacity-building programmes to ensure regional candidates receive the support and training they need in operations management, reporting and coordination skills, to be able to take on future roles. It would be particularly useful to develop a pool of deployment-ready, francophone delegates with training in budget holder and project management responsibilities.
Financial Management	38	To support major response operations, IFRC should pay particular attention to developing its pool of experienced financial managers / analysts at regional and global levels, who can be deployed to set-up up financial management systems in the first phase. The example of deploying members of the Regional Finance Unit of the Africa Regional Office to the Mozambique operation was positive and could be replicated.
	39	It would be timely to set up a cross-functional working group or review (Finance, DCPRR and PRD) to work on solutions to improve operational managers' access to real-time financial and funding information for emergency responses on this scale. This could examine the limitations of Working Advance (WA) criteria for a level "Red" and look at options to ensure emergency operations have the fastest possible access to cash at field level in the first phase. This could include an emergency over-ride system to allow the authorised transfer of higher levels of funds than under WAs, with the necessary controls agreed with Audit and Risk Management, to avoid the use of high-risk alternatives, such as using personal cash advances.
	40	The use of Orange Mobile to pay volunteer allowances was a practical, effective, risk-averse, and easily replicable solution. It can be used in future operations, where similar mobile systems could be pre-negotiated with NSs and set up in the early phase of a response.
Logistics	41	It is important that qualified and experienced logistics and procurement staff are deployed as a priority from the outset of a major emergency. This could be from a pool of pre-trained delegates, from existing ROs or Geneva or from other trained staff who with IFRC procurement experience, ideally in a health emergency.
	42	In future, where ICRC or other Movement partners are responsible for logistics, it would be useful to have IFRC delegates who understand ICRC logistics procedures or to brief/train delegates on ICRC procedures before deployment, to improve engagement between logistics teams.
	43	IFRC could optimise local procurement opportunities for less specialised items and should commit to using local and regional procurement where possible, to minimize delays. While it is understood that some items, particularly medical items, need quality control from global-level, IFRC should investigate options to upskill existing Regional logistics staff in medical procurement and segregating responsibility to speed up procurement and delivery
PRD	44	It is urgent that PRD teams in country, region and Geneva prioritise, early on in the response, a Resource Mobilisation Plan for an emergency of this scale to better anticipate and manage funding over the long duration of the response and the changing needs, as well as systemising the monitoring process of the funding situation of the operation over time. This could be linked to a PRD task force, across all levels to coordinate approaches around the plan.
	45	With changing donor engagement at field level for PHEs over time, Operations Managers should prioritize deploying long-term PRD staff early in an operation of this scale to support RM at country level and to scale-up engagement with major donors. Similarly, grants and compliance officers should be brought on early in the response to ensure proper donor compliance and engagement over time.

	46	There were few PRD staff dealing with the complex new funding realities for this response, which posed considerable challenges to the operation in the medium-term. This report encourages regional and global PRD colleagues to continue efforts to establish a pool of experienced PRD delegates and staff ready to deploy in future.
	47	It is timely for the IFRC to strengthen its advocacy with new donors and partners to ensure they are clear of the RCRC Movement's mandate and Principles and understand the opportunities and limitations of working with it. The IFRC should engage with donors in advance and advocate for greater donor flexibility for rapidly evolving epidemic outbreaks.
	48	It is also important that IFRC improves its understanding of new donors' requirements and modalities (WHO SRP) and levels of engagement between Geneva, Region and Country Offices, to clarify communication and decision-making and avoid any reputational risk (e.g. PSSD / WB in DRC).

Introduction

In May 2018, the International Federation of the Red Cross Red Crescent Societies (IFRC), launched an emergency operation in the Democratic Republic of Congo (DRC) to support the DRC Red Cross (DRCRC) in their response to the 9th outbreak of the Ebola Virus Disease (EVD) in Bikoro and Iboko health zones in Équateur province. Within three months, the Government of DRC and humanitarian partners, including the Red Cross Red Crescent (RCRC), had successfully controlled the outbreak, which was officially declared over on 25 July 2019.

In July 2019, a cluster of positive cases from a strain of Ebola unrelated to the 9th outbreak was discovered in Mabalako health zone in North Kivu province, which resulted in the declaration of the 10th outbreak of EVD in DRC. Despite delivery of a massive emergency response, the 10th outbreak continues to plague Eastern Congo, having expanded to the surrounding provinces of South Kivu and Ituri and resulted in over 3,300 cases and 2,250 deaths (CFR 66%). This outbreak is also occurring in an active conflict area, which has suffered the effects of ongoing violence for over two decades. As a result, the 10th outbreak is the second largest in recorded history, the largest ever in the DRC, and widely considered one of the most complex humanitarian emergencies of recent times.

With a One International Appeal (OIA) launched in August 2018, currently valued at CHF 61 million, the IFRC Regional Director for Africa commissioned this Lessons Learnt Review (LLR) to deep dive into the IFRC's experience throughout these two outbreaks and to codify the lessons learnt from managing a "Red-level" response in such a complex environment. Ultimately, the results of this LLR will be used to inform the management of the ongoing response in DRC and to guide decision-makers and operational teams responding to future EVD and other outbreaks across the African continent.

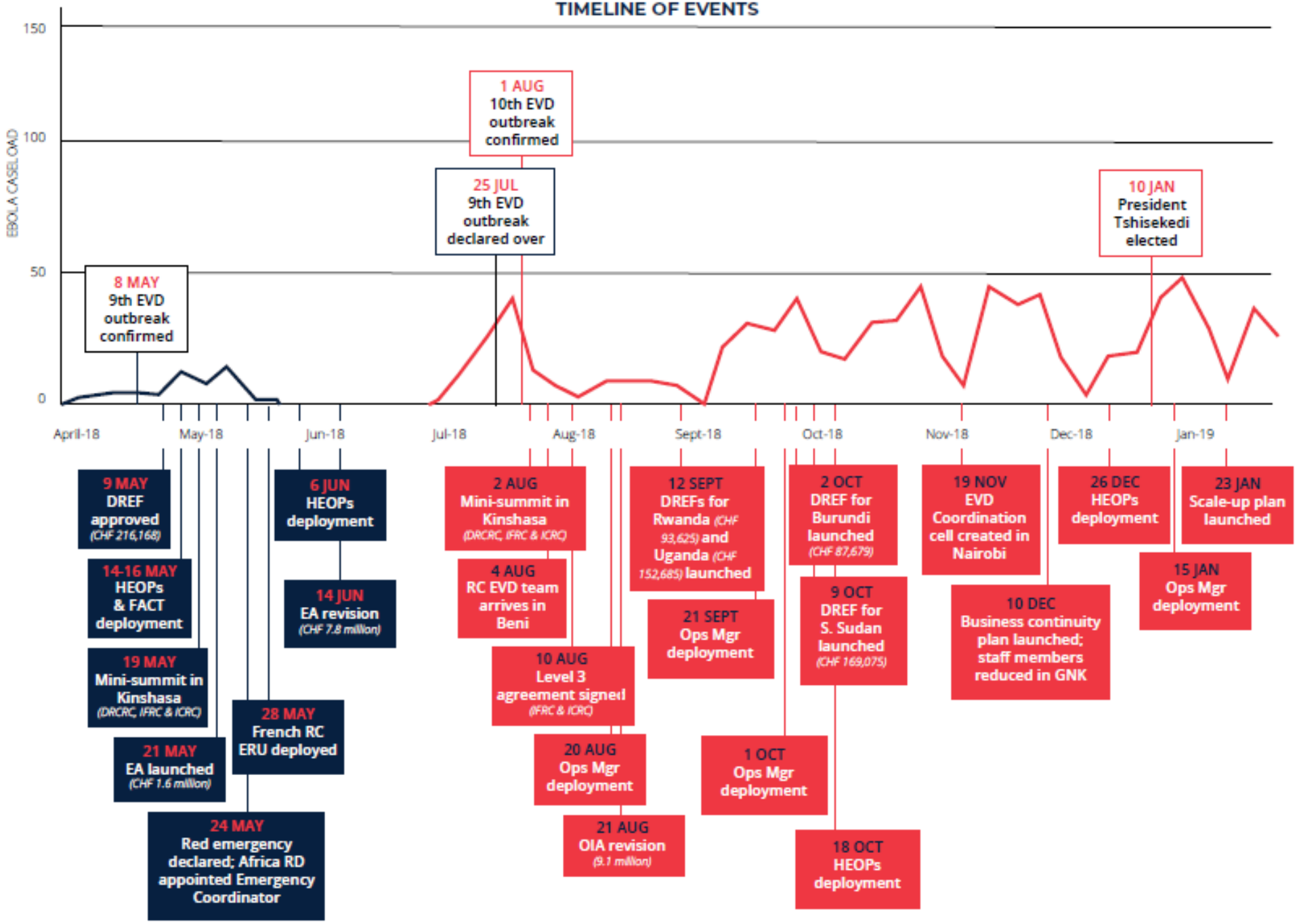
This review does not assess the relevance of the technical interventions mobilized for the EVD response, but complements other research pieces currently commissioned by the IFRC, such as the technical review of Safe and Dignified Burial (SDB) and Risk Communication and Community Engagement (RCCE) interventions by the London School of Hygiene and Tropical Medicine (LSHTM). The review also builds on existing learning from the West Africa EVD response operation to assess how that learning has been applied in the DRC (see annex 1).

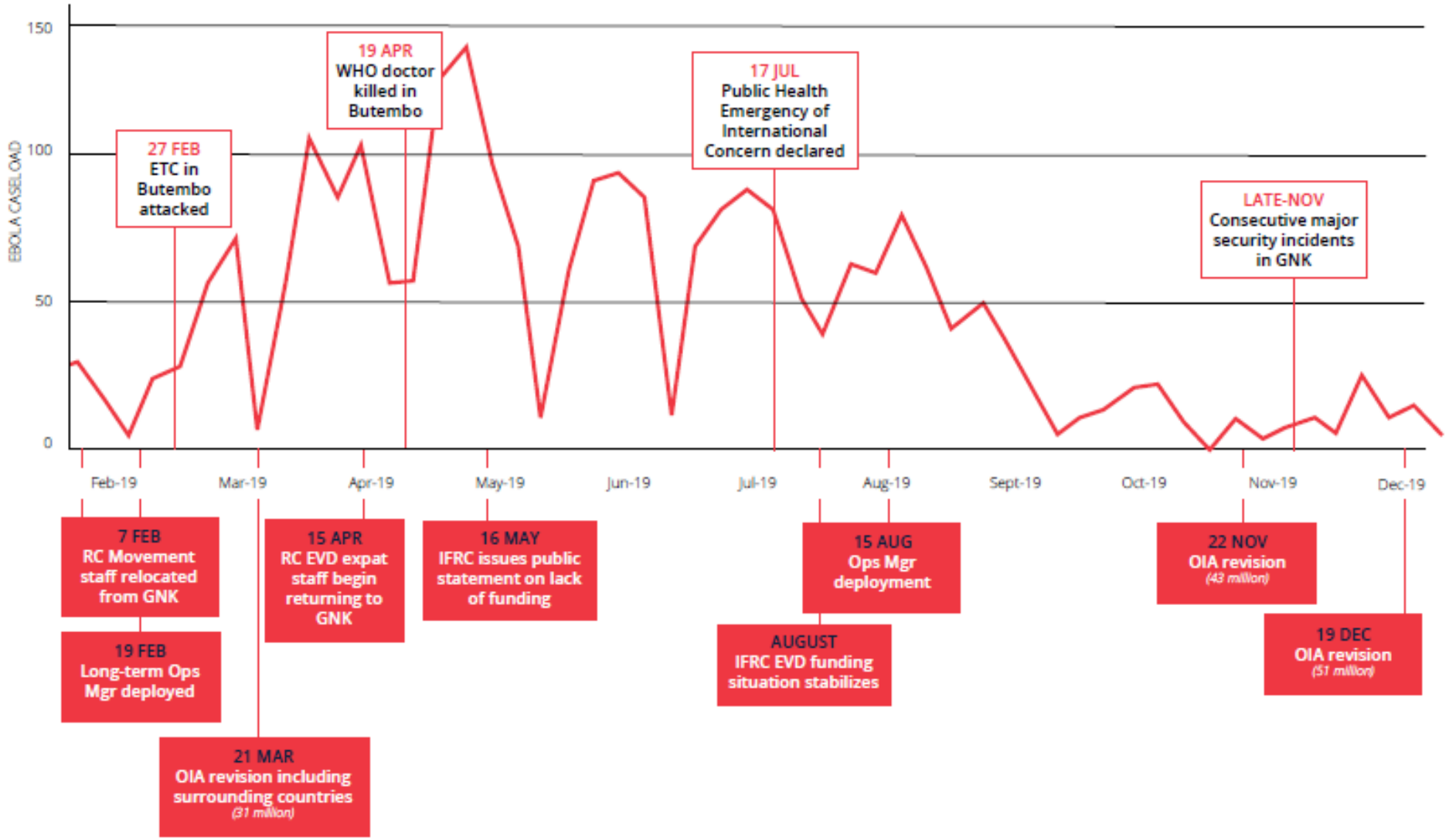
To date, there has been no RTE or other major evaluation of the operation and this is the first review or lessons learning piece for the overall operation. It is planned to have a final evaluation of the EVD response in DRC at the end of the OIA timeframe and the team recommends that a formal evaluation, with an external perspective, is carried out assessing the interventions and interoperability of all engaged components of the Red Cross Red Crescent Movement (IFRC, ICRC, and DRC RC).

This LLR report begins with an Executive Summary, then a chronology of key milestones and a list of key lessons from the review. This is followed by a description of the methodology used to guide the work. The main body of the report is six thematic sections outlining the key successes, challenges and lessons / recommendations in each area: The delivery of a level "Red" protracted health response; The Emergency Response Framework – roles and responsibilities; Movement cooperation and coordination; Risk management, business continuity planning and operational strategy, Programmatic relevance; and Corporate services and operational support. The report ends with a conclusion, which summarizes the results.

NINETH AND TENTH EBOLA OUTBREAK IN DR CONGO

TIMELINE OF EVENTS

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May-19
Jun-19
Jul-19
Aug-19
Sept-19
Oct-19
Nov-19
Dec-19
27 FEB
ETC in Butembo attacked
19 APR
WHO doctor killed in Butembo
17 JUL
Public Health Emergency of International Concern declared
LATE-NOV
Consecutive major security incidents in GNK
7 FEB
RC Movement staff relocated from GNK
19 FEB
Long-term Ops Mgr deployed
21 MAR
OIA revision including surrounding countries
(31 million)
15 APR
RC EVD expat staff begin returning to GNK
16 MAY
IFRC issues public statement on lack of funding
AUGUST
IFRC EVD funding situation stabilizes
15 AUG
Ops Mgr deployment
22 NOV
OIA revision
(43 million)
19 DEC
OIA revision
(51 million)

Purpose

As an internal IFRC management review, the purpose of this Lessons Learnt Review is to examine and highlight some of the key IFRC learnings from the response to the 9th and 10th EVD Outbreaks in DR Congo. As such, it should not be read as a formal evaluation of the emergency operation nor a detailed analysis the wider Movement response. This document is designed to support the growth and development of the IFRC as an emergency response institution by codifying the key learnings, challenges, and successes of the operation from the perspective of the IFRC.

Similarly, this Review avoids duplicating other work ongoing in the Movement including the *Lesson-Learning Review of the 'One International Appeal' Modality*, the London School of Tropical Hygiene and Medicine technical examination of the efficacy of RCRC interventions in the 10th Outbreak response, and the standard evaluation processes of the IFRC. Combining these works with the learnings and recommendations herein, this review seeks to inform policy considerations within the IFRC Secretariat to sustain successful practices in complex emergency operations as well as provide recommendations for improvements.

Scope

The Review will be done in two phases or as two components:

Component A

Component A will answer the research question by testing different elements of the emergency operation using primary and secondary research methods. To avoid bias within the Review Team, this component will be led by members of the PMER, Information Management, and Health teams who, although aligned and supporting the operation, were not directly involved in implementation of the response in DR Congo. Component A of the review will highlight lessons in six areas of the operation to inform recommendations for Operations and Health managers handling similar elements in future epidemic responses.

Component B

Will use the recommendations from Component A to outline the key strategic and operational decisions that must be taken by the IFRC in future epidemic responses in Africa to ensure operational efficiency and effectiveness. This will equally identify some preparedness / readiness measures that should be in place in advance of the onset of an epidemic in order to facilitate strategic and operational decision-making.

A final workshop with National Societies and teams from the IFRC, ICRC and PNS involved in the operations is expected in 2020 with the goal of validating the results and developing a roadmap to implement the recommendations. This was due to happen in April 2020 but had to be postponed due to the COVID-19 pandemic.

Audience

The audience for this paper is IFRC staff and senior management involved in emergency operations from the field- to headquarters-levels.

Research Question

From the perspective of the IFRC, what were the key enabling factors that supported implementation of the overall response and which elements hindered the efficient implementation of the operation? From these identified factors, what elements should be considered as standard in the conduct of future public health emergency responses and which should be improved upon to enhance the IFRC's response capacity?

Methodology

The review employs a cross-case qualitative research design aimed at temporal—synchronic—analysis of key elements within the Red Cross response to the 9th and 10th EVD outbreaks in DRC. If this study attempts to impose order on the narrative—that is to story the past in a coherent pattern—then the use of temporal examination gives the analysis an opportunity to encapsulate and perceive change by observing specific case elements as dynamic processes occurring in and over time. As such, through synchronism, the review team is able to "freeze time" to examine target events at specific moments, dynamically compare them and understand change.

At the same time, the research design is operationalized through application of the qualitative method of 'structured focused comparison'. It is 'structured' in that the research questions are posed methodically to each unit of analysis in the review and reflect the broader research objective. As such, the structural nature of the methodology allows for the standardization of the data collection, which facilitates systematic comparison. The method is also 'focused' in that it deals only with certain aspects of the historical cases examined (George and Bennett 2005).

As a reference point for the analysis, the EVD operation in West Africa will be used. Although falling outside of the formal methodological approach, the analysis will consider the lessons learned from the Liberian, Sierra Leonean, and Guinean experiences to determine to what extent they were applied to key decisions within DRC. This additional examination is critical to the review as decisions made contrary to the recommendations from the West African experience will implicitly reduce the efficacy of the response in DR Congo—strongly noting the application of context to decision-making in DRC. As such, the final recommendations made from the West Africa response will be used as a baseline from which the analysis will be examined.

Case Selection and timeframe

Given the focus of the review as an internal management exploration of the Movement's operational responses to the 9th and 10th EVD outbreaks in DR Congo, the main case selection of the analysis is pre-determined to explore the Ebola outbreaks in Equateur and North Kivu provinces. As such, the outbreaks are defined as follows to clarify the case parameters:

1. 9th Outbreak of EVD in DR Congo
    a. Geographic areas affected:
        a. **Province**: Equateur
        b. **Health zones**: Bikoro, Mbandaka, and Iboko
    b. **Date range:** 8 May[1] to 24 July 2018[2]

2. 10th Outbreak of EVD in DR Congo
    a. Geographic areas affected:
        a. **Province:** North Kivu
        b. **Health zones:** Butembo, Kalunguta, Katwa, Kayna, Komanda, Kyondo, Lubero, Mabalako, Mandima, Manguredjipa, Masareka, Musinene, Mutwanga, Nyakunde, Oicha, Rwampara, Tchomia, Vuhovi
    b. **Date range:** 1 August 2018[3] to 31 December 2019

Secondary analysis

[1] 8 May outbreak declaration after laboratory results confirm two cases of EVD in Equateur (https://reliefweb.int/report/democratic-republic-congo/new-ebola-outbreak-declared-democratic-republic-congo)
[2] 24 Jul 2018 - https://reliefweb.int/node/2711684
[3] https://reliefweb.int/node/2724779/

As a departure point for the review, a comprehensive secondary data analysis (SDA) was conducted by the IM focal point. Funded by the Canadian Red Cross, the IM team used the "Data Entry and Exploration Platform" (DEEP) to run and process the secondary data analysis. The IFRC Information Management (IM) team processed more than 236 publicly available reports, tagging over 3000 pieces of information from the following organizations: IFRC, ACAPS, OCHA, MSF, INSO, WHO, Red Cross/Red Crescent National Societies, Government of the DRC and Ministry of Health. The review also included relevant learning from the previous West Africa response, including from the RTE, the lesson learning workshop in Senegal and other evaluations and studies.

- ***Secondary data review*** of existing documents, including appeals, operations updates, minutes of Joint Task Forces, Joint Partners Calls, Situation reports (Sitreps), field assessments and reports, minutes of coordination meetings etc., using the DEEP platform and a team of taggers to identify and document findings against the Analytical Framework for the review.

In case you would like to access the IFRC EVD secondary data analysis conducted using the "Data Entry and Exploration Platform" (DEEP) please contact im@ifrc.org

Primary research

To conduct the comparative analysis under **Component A,** the following methods was applied:

- ***Analytical Framework*** to clearly and consistently outline the interview framework, themes and question areas across seven pillars of focus:- Context (political, social and epidemiological); Operations (effectiveness, relevance, adaptability with a focus on regional preparedness and RCCE); Coordination (Movement and inter-agency); Internal Processes (HR, Finance, Logistics and Resource Mobilization); National Society capacity and capacity building. This was the framework for all secondary and primary data collection and analysis.
- ***Interviews with key informants*** at country, regional and global levels to validate findings from the secondary data review, supplement knowledge gaps and broaden understanding of the successes, challenges and learning from the two response operations. These interviews will be conducted by members of the Review Team not directly involved with oversight or implementation of the emergency operation to ensure objectivity in the data collection and results production. The interviewees will include management, operational and sectoral teams responsible for all key areas of the response as well as representatives from the DRC RC, in-country National Societies, and the ICRC.

The team was not able to do a field visit or hold group discussions with the teams on the ground currently working on the EVD response in DRC or in the Regional Cell in Nairobi, due to budget, time and access issues. Contact was made with staff who had left the operation via key informant interviews by Skype or telephone.

Delivering a category "Red" protracted public health response

Key Lessons Summary:

- The IFRC's "Red" categorization of the 9th EVD Outbreak was taken **with adequate speed, appropriate for the scale of the emergency and was the right level to deliver and resource such a complex response**
- **Given the unique resource requirements for a "Red" public health emergency, consideration of the time and resources required to maintain an at-scale "Red" response from the onset of the operation is required and an institutional commitment is codified and that mechanisms are established to maintain these human and financial resources over time.** The IFRC will need to commit the resources required for an epidemic response of such scale and duration, including deployment of personnel from the wider Secretariat and IFRC network and take steps to manage organisational fatigue and multiple commitments.
- The IFRC should build on learning to set up clear steps in the Emergency Response Framework (ERF) to **regularly and objectively re-assess the continuation of a Category "Red" response** and to amend disaster categorization (up or down).
- **The IFRC should formally consider its business continuity plans/structure to cope with simultaneous, large-scale emergencies**, including those within the same Region, to avoid losing oversight of any one major operation. This contingency planning could be an important consideration for the Disaster and Crisis Working Group (DCWG).

Red Categorization

On 8 May 2018[4], the Government of DRC declared the 9th Outbreak of Ebola in Equateur province, which prompted the release of CHF 216,168 from the IFRC's Disaster Relief Emergency Fund (DREF) on 9 May 2018 (24 hours after the declaration) and the launch of an Emergency Appeal (EA) on 21 May 2018 (13 days after the declaration). Following the release of the EA, the Secretary General (SG) classified the response as category "Red" on 24 May 2018, appointing the Regional Director for Africa as the Emergency Coordinator (EC), in line with the Emergency Response Framework (ERF). This categorization also resulted in the IFRC Director of Health and Care, being appointed as the health technical focal point for the emergency response and a Head of Emergency Operations (HEOps) being deployed from the Canadian RC to lead the response. According to the Office of the Secretary General (OSG), the decision for the "Red" categorization was based on:

> *"…the evolving epidemiological situation in the DRC, the regional risk level being raised to 'high' by WHO yesterday [23 May 2018] as well as reputational risk and public attention to the crisis."*

Given these factors the "**Red" categorization decision was taken with adequate speed, appropriate for the scale of the emergency and was the right level to deliver and resource such a complex response.** As such, the IFRC system is considered to have mobilized quickly and efficiently from the outset of the response to the 9th outbreak.

Sustaining a "Red"

According to the ERF, the declaration of a "Red" implies "response to an emergency of scale, affecting a wide area and high number of beneficiaries, with levels of complexity or risk that make

[4] 8 May outbreak declaration after laboratory results confirm two cases of EVD in Equateur (https://reliefweb.int/report/democratic-republic-congo/new-ebola-outbreak-declared-democratic-republic-congo)

it an organisation-wide priority for the IFRC secretariat at all levels[5].” As such a “Red” is a system-wide activation of the Secretariat to respond to a specific crisis, in many ways similar to the “Scale-up” protocol [formerly Level 3 emergency] of the United Nations (UN) system. This has significant resource implications for the IFRC, requiring substantial, and in some cases long-term, engagement from the entire organizational structure (Country Office [CO], Regional Office [RO], and Geneva [GVA]) as well as human, financial and material resources. It also requires high levels of support from member National Societies (NS), who, on an ongoing basis, are engaged to contribute financially and materially to support the operation as well as the Host NS (HNS) who are in the lead of the operation. In the specific case of this EVD operation, it also required significant investment from the International Committee of the Red Cross, who provided logistical, security, and coordination support throughout the entirety of the 10th Outbreak operation. As of February 2020, the EVD operation in DRC has been a “Red” response for 21 months and, following the 6th Revision of the One International Appeal (OIA), is projected to continue as a “Red” until the end of December 2020, a total of two and a half years.

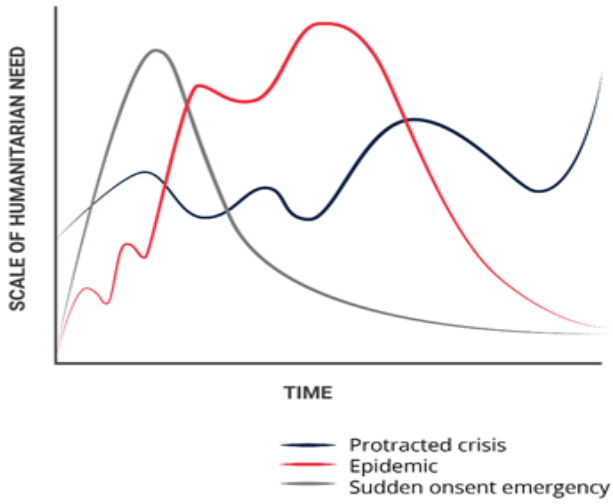
The declaration of the level “Red” started with the response to the 9th Outbreak in Equateur Province. The response here was slow to get started and was challenged by the lack of access, infrastructure, logistics and technical capacity, both for the DRC RC and for the international deployment. The IFRC was slow to mobilise teams to carry out expected SDBs and CEA work and was challenged to meet the expectations of partners and the needs of communities on the ground. On a more positive note, the 9th Outbreak did benefit from the technical experience of teams who had worked on EVD in West Africa and did provide the opportunity to scale up capacity, which could then be moved to respond to the 10th Outbreak in North Kivu. In addition, the 9th Outbreak saw strong contributions from the French RC ERU for IPC work and established a relevant Transition Plan to support the further strengthening of the DRC RC branches and infrastructure in Equateur. The IFRC was well placed therefore to move into the 10th Outbreak.

To sustain this scale of the operation, the Secretary General (SG) of the IFRC appointed, sequentially, two Emergency Coordinators (EC) to oversee coordination and management of the response—the Regional Director of Africa, followed by the global Director of Health and Care. Similarly, the IFRC, at time of writing, had held over 75 Joint Task Force (JTF) meetings, deployed three HEOps and eight surge Operations Managers, mobilized 114 rapid response personnel, and scaled-up the response in North Kivu to a contracted staffing structure of 125 IFRC staff (36 delegates and 89 local staff). It had also mobilized a global fundraising taskforce fundraise for the required CHF 61 million, maintained close and consistent coordination with Movement partners (ICRC, DRCRC and PNS) and external partners at all levels of the organization and been supported by countless hours of dedicated staff time from across the IFRC. Although impossible to quantify the investment required to maintain this scale of response, examining the JTF alone as a proxy indicator, it is estimated that over 1,875 IFRC staff hours[6] were allocated to coordination through this forum from August 2018 to December 2019.

Similarly, the ICRC established an Ebola coordination structure within their DRC delegation architecture, deploying several Supra-Coordinators to serve as counterparts to the IFRC Head of Ebola Operation and mobilizing massive numbers of staff. At the same time, the ICRC provided immense and sustained logistical support—vehicles and air capacity, communications, administrative, welcome, and housing—to the IFRC and DRC RC throughout the operation--albeit reducing this over time as the IFRC became more established in North Kivu—as well as security management for the Movement in North Kivu, South Kivu, and Ituri provinces. For the Host NS, the DRC RC mobilized and sustained their organizational structures in Equateur, North

[5] Emergency Response Framework IFRC p.1
[6] Assuming an average of 25 participants per JTF meeting at an average of one-hour per meeting

Kivu, South Kivu, and Ituri provinces as well as the Headquarters in Kinshasa to oversee implementation of the response, deployed staff and volunteers across the country to technically support the operation, and activated over 1,400 volunteers who selflessly ensured the continuation of activities, often at the risk of their own lives.



As such, the nature of this operation required sustained engagement from all components of the Movement over time, which posed unique resource requirements for the IFRC, DRCRC, and ICRC. Particularly, a 'Red' public health emergency in a non-permissive environment posed unique challenges when compared to other disaster types. Whereas a sudden onset emergency often follows a relatively standard pattern of humanitarian need--a sudden spike, which diminishes as the response transitions to longer-term recovery—the EVD outbreak faced multiple, ongoing 'peaks' of humanitarian need, which required sustained levels of intervention over time.

Going further, this response was unique even when compared to other protracted crises, such as the population movement in Cox's Bazaar or the refugee flows in Venezuela. This is because protracted emergencies in non-conflict environments are not static, often facing periods of high and low intensity, which allow humanitarian actors to scale-up or down their engagement and resources relative to this variation. This is because these crises are often more dependent on political, economic, social, and developmental factors, which require resolution at the political level. As such, while continued engagement from humanitarian actors is essential throughout a protracted crisis, the conclusion is not often directly linked to the humanitarian intervention, which provides an opportunity for organizations to vary the intensity of their engagement in line with the evolution and intensity of the crisis.

This is not the case for public health emergencies, which are unique in that the level of institutional and governmental engagement in the public health response is directly correlated to the end of the outbreak. As such, the level of commitment and resourcing over the duration of a response has a massive influence on when that outbreak will end. Using security incidents as a proxy, this reality was observed during the 10th outbreak, where deteriorations in the security environment and subsequent halt of EVD response activities, were strongly linked to increases in the caseload[7]. Therefore, maintaining at-scale operational capacity and institutional commitment across several waves of the epidemic is critical in getting to zero cases. For the IFRC, this consideration is vital when declaring a 'Red' public health response, as it requires a much higher level of institutional engagement and resources over time than for other types of emergency.

[7] Oly Ilunga Kalenga, M.D., Ph.D et al. *The Ongoing Ebola Epidemic in the Democratic Republic of Congo, 2018–2019.* New England Journal of Medicine. July 2019. P.380

However, the levels of interest, support and investment from different tiers of the IFRC varied across the 9th and 10th outbreaks. Several respondents highlighted significant challenges for the IFRC in sustaining a "Red" response of this scale and confirmed variations in the levels of attention and support. This was due in part to competing emergency operations (see case study on Cyclone Idai), organizational fatigue in the wake of a drawn out and complicated operation as well as the lack of sustainable resources at all levels. However, reduced institutional commitment over time likely led to the financial crisis faced in mid-2019, which threatened the gains made through the operation. This requires significant consideration and self-reflection within the IFRC as questions are raised on the organization's capacity to deliver a "Red" response at scale, for the duration required, and alongside other major operations (in Africa).

These findings highlight the necessity for **IFRC to consider the time and resources required to maintain an at-scale "Red" response from the onset of the operation, ensuring the institutional commitment is codified and that mechanisms are established to maintain these human and financial resources over time.** It is also necessary for **the IFRC to regularly and objectively re-assess whether the scale of the emergency warrants the continuation of the "Red" categorization** as, amongst other avenues, a potential downgrade is a useful strategy in mitigating organizational fatigue.

Case study: Simultaneous 'large-scale' response - Tropical Cyclone Idai

In March 2019, Mozambique, Malawi, and Zimbabwe were hit by Category III Tropical Cyclone Idai, considered one of the worst tropical cyclones on record to affect Africa and the Southern Hemisphere. In response, the IFRC launched an EA for CHF 32 million, deploying over 180 rapid response personnel and eight Emergency Response Units (ERU).

Given the global media attention and scale of the emergency a significant proportion of the IFRC's resources and attention were directed towards this category "Orange" response. Mozambique saw the deployment of much needed HR capacity and roles (e.g. Movement Coordination, NS in Emergencies, Volunteer Management and Resource Mobilization) that could have helped the EVD operations.

The TC Idai response, to a large extent, re-directed attention and resources away from the ongoing "Red" EVD response, which subsequently faced its most significant financial crisis in May 2019. This was also due in part to organizational fatigue (the EVD operation was in its 10th month) and weak expenditure tracking in the first six months of the 10th outbreak (see Financial Tracking). This led to major challenges on the response and ultimately required substantial interventions from the IFRC's senior management and PRD teams.

It is therefore essential **for IFRC to consider and set up its business continuity plans / structure to cope with simultaneous, large-scale emergencies, including those within the same Region, to avoid losing oversight of any one major operation.** This contingency planning could be an important consideration for the Disaster and Crisis Working Group.

As such, the LLR **supports the IFRC's ongoing review of the ERF and the inclusion of clearer steps to facilitate the possible amendment of disaster categorization (upwards or downwards) in response to an evolving crisis**. Such considerations would have been useful during the EVD operation, as they would have allowed for a better assessment of the resources required to sustain the operation and a stronger commitment to ensure them, including through collective buy-in and staff rotation to reduce organizational fatigue.

The Emergency Response Framework (ERF) – Roles, Responsibilities and Decision-making

Key Lessons Summary:

- Given the challenges faced by the EC during the 10th Outbreak**, IFRC should re-examine the EC role to clarify the overall responsibilities of the position, including the extent of its operational "management and direction setting" responsibilities and agreeing on the mobilization level (Regional or HQ) depending on the accountability and responsibility requirements of the ERF.** Special consideration should be made to the scope, timeframe, and decision-making authority of the position and whether the assignment should be standalone given the volume of work associated with the job.
- **The Regional Ebola Cell was a positive addition to the operatio**n, providing valuable operational and technical support and providing a vital back stop for the operation. This type of Cell **should be automatic at the outset of any epidemic response**, which threatens cross-border transmission
- **Information sharing and authority lines between CO, RO and Geneva should be re-articulated and clearly defined at the start of an operation of this scale, with space for discussion and resolution of operational issues as they arise**. **This could include setting up a system to transparently log all key decisions.** Line management of the Operations Manager role should be shifted to the CO/CCST soon after the response phase.
- There is a need to **clarify and reinforce links between operational and health management and technical lines for an epidemic response**. IFRC could consider dual management between Operations and Health across the three levels to bring in health expertise more strongly and strengthen operational cohesion.

Emergency Coordinator (EC)

Over the course of the operation, the SG appointed two global ECs for EVD - the Regional Director of Africa (May 2018 – June 2019) and the Director of Health and Care (June 2019 – present). As per the ERF, the EC was designated "at the level of a Regional Director or above to direct and manage the IFRC response", while the RO was still "accountable for the direction and quality of emergency response operations".

Both ECs had full-time positions closely linked to the EVD response, however, they were also still responsible for their regular portfolios. The increased workload inhibited the EC's abilities to "manage" the EVD response, particularly over the long-term. This calls into question the ability of the EC role to 'manage' the response, unless it is established as a stand-alone position or an existing senior manager is appointed with the necessary time allocated to the role.

With the appointment of the RD Africa, responsibility and accountability lines were clear, as the RO maintained its operational leadership role and its Director was both responsible and accountable for the operation. There were questions around the capacity of such a busy senior manager to take on this additional role to the level required, while continuing ongoing work.

With the appointment of the Global Director of Health and Care, the lines of responsibility and accountability became less clear, as the global level assumed 'responsibility' for the operation, while accountability remained at the regional level. This confused teams and limited the EC's decision-making authority and ability to set the direction of the operation.

Similarly, as the ERF stipulates that "technical and management support is coordinated by the RO", it was decided that the current EC would not be responsible for managing finances nor HR. Given the necessity of these sectors to effectively manage the response, the loss of authority in these areas undermined the EC's role and did not afford the authority to 'manage' the operation.

Despite this, it is critical to note the added value the EC brought to the operation from the headquarters perspective. Being at the Director-level and based at HQ afforded the EC a unique ability to drive strategic initiatives at the IFRC's highest levels, which greatly influenced the operation and, in many instances, facilitated the response. In particular, during the financial crisis for the operation in mid-2019, the EC was able to rapidly mobilize global attention for the operation and spearhead a massive fundraising initiative, which arguably avoided the collapse of the response. As such, there is substantial utility for this position and thus needs to be maintained for similar scale responses in the future.

However, considering the juxtaposition between the strategic and operational, **the IFRC needs to re-examine the EC role, to clarify the overall responsibilities of the position, including the extent of its operational "management and direction setting" responsibilities and agreeing on the mobilization level (Regional or HQ) depending on the accountability and responsibility requirements of the ERF.** There was a further recommendation around the transparency of decision-making for this level of operation and it would be useful to consider a system to log decision-making in future responses.

Inter-office roles and responsibilities

The ERF is clear in the division of roles and responsibilities between Geneva, the RO and the CO/CCST for the different response categories, including for a "Red". However, many respondents noted confusion and frustration on the application of these roles by different levels of the IFRC. This was particularly felt by participants in the various Joint Task Forces, who felt that Geneva "took control" of the operation in the JTFs and did not allow space for the regional or country levels nor to discuss or resolve the issues confronting them.

Country and Regional

In-country coordination was challenging due to the distance of the operation in eastern Congo from the CO in Kinshasa. This limited engagement and coordination and resulted in the CO feeling sidelined from the operation and from the linkages to the NS. Although a liaison officer was hired in Kinshasa in early 2019, respondents noted continued challenges with in-country coordination, as the person was largely tasked with duties other than EVD coordination. Adding to the confusion on the authority of the CO, the first and second HEOps, as per the HEOps standard operating procedures (SOP), reported to the Regional Director, which established a line management precedent for all deployed HEOps/Ops Managers and continued from May 2018 to August 2019. This further reduced the strategic and operational oversight of the CO but was rectified in August 2019 with all Operations Managers now reporting to the Country Representative (CR). **For future operations and to ensure closer linkages to the CO, line management of the Operations Manager should be re- assessed and shifted to the CO/CCST as soon as possible after the response phase (3-6 months).**

The IFRC CO has a role to support NS engagement with the operation and partners and to strengthen their capacity to operate. It was challenging for the CO to maintain the necessary level of support for the NS for such a major response and it would have been useful if the CO had received or accepted additional support for this operation. Capacity building or NSD work is being done through the liaison officer in Kinshasa, who has a limited technical focus (radio system, branch buildings and IM training). There is more evidence of capacity-building progress within the branches of the DRC RC than at HQ in Kinshasa as they have seen investment in branch infrastructure and staff development as part of this response and have "learnt from doing". **There was no evidence of a wider NSD or capacity building strategy at HQ-level to address other challenging gaps in the NS's capacity in programming or support services, or to support NS's representation to external partners, despite the inclusion of NSD as a fifth pillar in the OIA and EPoA.** Steps are now being taken to integrate the future NSD plans of

Movement partners into planning for the longer-term response and recovery under the current EA.

Geneva level

At the onset of the 9th and 10th outbreaks, some in the Africa RO and DRC CO felt they had been side-lined by the "operational machine" of Geneva and wanted to be more involved and informed in relation to the operation and issues with the NS. Many stated that "the operation was driven by Geneva", reducing the accountability of the RO and CO. This was particularly related to the experience of the many JTFs during the operation, with country and regional staff stating that these were dominated by the Geneva teams, with the field required to provide information or "answer Geneva's questions" rather than receiving support or space to find solutions or resolve issues. The JTFs were not seen as joint discussions to support operational decision-making in the field – these things happened in parallel. From the Geneva perspective, people expressed frustration with CO and RO levels and felt that they were "withholding information from the HQ".

This created **tensions between levels, with politics between Geneva, RO and CO described as "damaging to the operation and the wellbeing of teams on the ground"**. Some stated **there was a culture of "avoiding critical reflection",** with staff scared to report things that were not going well, nor asking for help. Some Field Coordinators stated their "red flags" were not addressed for months before they came up at JTFs. This led to different perceptions between teams on levels on progress and to problems going unaddressed (e.g. growing debt around volunteer and contract payments).

The Regional Ebola Cell was a positive addition to the operation, providing valuable operational and technical support, including for HR management, and giving the RO a stronger base for accountability. It proved a vital back stop for the operation. Comprised of a Regional EVD Coordinator, Regional Health Advisor and Regional Information Manager (IM), the team was greatly appreciated, given the demands of the operation and the capacities of a busy RO. It also supported all regional preparedness work with the four NSs at risk from the 10th outbreak, coordinating funding and other support for their actions and ensuring their integration within the Regional EA and strategy. **The strongest feedback was that the Cell should have been set up earlier, as it was only established in November 2018, seven months after the "Red" declaration**.

Intersection between Health and DCPRR

There was feedback from respondents that there was a lack of clarity between the management and communications lines between operations and health management. Although, at the Regional and Geneva level, respondents noted a good working relationship for the most part across technical functions at those levels. Nevertheless, recognition of the need for continued improvements was acknowledged at all levels. This is not the first time that this has occurred in a health response, but it can cause tension and a lack of clarity between the two teams. This is most clearly shown in the operational management of the initial response, the surge deployment, the development of the Emergency Appeal and the Emergency Plan of Action and the inter-action with other operational actors, where at various points, suitable health profiles were limited (see HR section for more on this point). At the same time, health's knowledge, expertise and technical coordination need to inform key priorities and decisions during the response, including advocating for and driving a clear "no regrets" policy and related actions.

It is not possible for one to lead without the other in a public health response and it is important that the team working between operational and health management is established and supported as successive teams change and as the situation evolves. This point is also applicable across the various levels of the IFRC, noting the contribution and respective roles and responsibilities of

both the region and Geneva in ‘Red’ emergencies. Part of this is ensuring the calibre of the respective operational and health managers in such a critical response, and these positions should be filled by experienced managers, with experience of co-working in an operation of this scale and severity. This should be backed up by a revised structure that outlines a co-leadership role for the operational and health teams, agreeing joint management processes and reporting lines between both operations and health at each level. It would also demand the deployment of operations and health coordinator profiles simultaneously at the outset of the response. There is a need to **clarify management and technical lines between operational management and health**, to ensure complementarity and optimise skills and capacities.

Internal and External Cooperation and Coordination

Key Lessons Summary:

- In a complex context where both IFRC and ICRC are working together**, inclusion of a Movement Coordination function and wider Movement cooperation mechanisms (SMCC guidance) should be prioritised** to support systematic and effective cooperation between Movement partners, including negotiations around security, access and logistics and to improve integration agreements.
- In order to build trust amongst Movement partners and reduce the risk to staff in insecure environments, **the IFRC must make a much stronger investment in adequate security management training for staff and delegates and in developing an appropriate 'security culture' for field teams**.
- The Security Management Agreement (L3) between the IFRC and ICRC had significant implications for the operation, both positive and negative, and **needed more work at the outset to understand and clarify the roles and responsibilities of the individual Movement partners, both internally and externally as well as how they were to be applied by both IFRC and ICRC leadership**. The lessons garnered through the implementation of this agreement should inform future decision-making for both organizations and **considerable effort should be made to engage experienced Heads of Delegation/Country and Operations Managers prior to the signature of future integration agreements to cross-check for potential operational challenges and coordination pitfalls.**
- **Sentiments of mistrust and misunderstanding punctuated the IFRC and ICRC relationship during the response and led to significant operational challenges**. This highlights the need to continue investment in SMCC to foster better mutual respect, trust and understanding between the two organizations
- A key lesson of the EVD operation is the level of inter-operability the Movement has on operation and that **when each component, building on their strengths and contextual comparative advantages, plays their role, the strength of the RC response is augmented exponentially.**
- The IFRC should **make specific effort to strengthen its Country Office (CO) presence in a complex context with a "Red" response**. This could include short-term staff deployments to support NSD, volunteer management, Movement coordination, and resource mobilization (see Mozambique). It would be useful to have a coordination focal point to liaise between the CO and the operation.
- While there were clear developments in the NS's capacity, particularly at branch levels, further steps need to be taken to further strengthen the counterpart system and targeted support for the NS's priorities through the EPOA and budget**. It would have been useful to deploy a NSiE delegate or NSD professional(s) early in the response, to manage capacity strengthening/NSD in alignment with the operations team and partners in-country and to strengthen engagement with the NS on all levels - governance, management and technical– and support NS financial management and accountability.** This could be further supported via targeted visits from RO or Geneva financial managers, proactive risk management plans with the NS, or early audit.
- With regard to external coordination, **the IFRC should put in place experienced staff to support coordination and representation functions within a category "Red" response, to ensure appropriate levels of engagement and information sharing with key external actors and donors.** The placement of a liaison person in WHO headquarters worked well and should be replicated in future, while the IFRC should look to invest in the coordination functions for SDB and CEA in PHEs.
- IFRC also needs to **continue familiarizing itself with the coordination practices and funding mechanisms of WHO, World Bank, and other major actors / funders**, to optimize relations and funding and clarify its "position" with these actors in advance.

Movement Cooperation and Coordination

As a precursor to this section, it is important to note that there is and was **a positive appreciation amongst IFRC staff of the ICRC's support in gap-filling early parts of the response through the provision of staff, funds and goods**. **It is also of note that the relationship between organizations improved considerably throughout 2019 and continues to improve to this day**. This is in part due to changes in personnel and improvements in systems which created a stronger understanding of each organization's culture and operating modalities over time and which allowed the organizations to settle into their functional mandates within the context of the EVD response in North Kivu. There was also appreciation of those who had contributed to the Movement coordination and cooperation roles, as part of their other work, at field, country, regional and Geneva levels.

Movement Security and the Level 3 Agreement

In August 2018, the RCRC Movement agreed a Level 3 (L3) security integration agreement to facilitate the EVD response in North Kivu[8] (it was not relevant in Equateur as ICRC was not present). The L3 was initiated to facilitate the operation for the IFRC, who would have faced significant difficulties conducting an operation in North Kivu, Ituri, and South Kivu without the security experience and architecture of the ICRC in eastern DR Congo. At the time there was no other agreement on the ground and the L3 was seen as a good basis for future negotiation and engagement, although there were suggestions it could have been done more quickly. The L3 only applied to the IFRC and ICRC and assigned responsibilities to both elements along technical and leadership lines. As such, the IFRC had "the operational expertise for programmatic response" and was assigned "programmatic lead" role, while "the ICRC [led] the operation, mainly in terms of security and field expertise in the area[9]" assuring the ICRC's coordination mandate was maintained in the area. It was notable that it did not cover but affected the role and perception of the DRC RC on the ground.

There was a comment that the **L3 Agreement separated accountability, with IFRC having accountability for the OIA and ICRC having overall accountability for the context of the operation in North Kivu and Ituri Provinces.** This exacerbated confusion and tensions on both sides, despite the roles agreed in the L3 Agreement. This was exacerbated by a level of naivety on what the agreement would deliver. The L3 Agreement used in DRC could provide useful learning for other operations.

However, as will be detailed below, **the L3 agreement had significant implications for the operation and needed more work at the outset to understand and clarify the roles and responsibilities of the individual Movement partners, both internally and externally as well as how they were to be applied by both IFRC and ICRC leadership.** The lessons garnered through the implementation of this agreement should inform future decision-making for both organizations and considerable effort should be made to engage experienced Heads of Delegation/Country and Operations Managers prior to the signature of future integration agreements to cross-check for potential operational challenges and coordination pitfalls. The following sections highlight some of the areas of consideration for future responses but are, by no means, exhaustive given the complexity of the context and organizational relationships.

[8] SMCC reference – Mini-summit

[9] Security Management Support Agreement (L3) between the International Federation of Red Cross and Red Crescent Societies (IFRC) and the International Committee of the Red Cross (ICRC), Introduction (p1)

Organizational cultures

Fundamentally, there were gaps in understanding and communication between the IFRC and the ICRC, which impacted the timely and effective delivery of the response. On one hand, many IFRC staff felt that the ICRC did not understand the demands of an epidemic response and were not flexible or fast enough to adapt to its requirements (e.g. on security and decision-making). This caused delays, non-delivery of critical services, and problems for field teams on the ground. As outlined in the sections below, the main areas of frustration were around security, vehicle logistics and HR limitations, which were all under ICRC's control per the L3 Agreement and which limited IFRC's access to areas where there were new cases, or which were awaiting security clearance and secure vehicle authorizations. At the same time, inconsistencies in the total number of expatriate staff allowed in the outbreak epicenter slowed operational scale-up, contributed to gaps in key positions, and limited oversight of fraud and corruption prevention (*see section on risk management*).

On the other hand, many ICRC staff, who had a long history in North Kivu, felt that IFRC staff did not understand the complexity, history or culture of the context and did not value ICRC's knowledge and experience. They saw IFRC staff as naïve and unrealistic in their expectations and felt protective of their networks and ongoing work. Some ICRC staff also noted that many in the IFRC did not understand the security implications of working in this context and did not have an adequate 'security culture' engrained in their way of working. This put all Movement elements at risk and was a source of tension between the organizations. As the IFRC will likely continue to operate in insecure environments, **the institution must make a much stronger investment in adequate security management training for staff and delegates and in developing an appropriate 'security culture' for field teams.** Cross-learning from the ICRC and exposure of key rapid response staff to ICRC's ways of working in insecure environments would be extremely valuable for the IFRC.

As such, these sentiments of mistrust and misunderstanding punctuated the IFRC and ICRC relationship during the response and led to significant operational challenges. This highlights the need to continue investment in SMCC to foster better mutual respect, trust and understanding between the two organizations. Notably, the L3 Agreement was described and needing to 'protect the image of the Red Cross in North Kivu and ensure the ICRC's humanitarian access following the end of the Ebola outbreak', which might imply that IFRC was perceived as a liability and which may have influenced how the L3 was written and applied at the outset of the response. Given historical relations in DRC, there was an inherent mistrust of the IFRC and this permeated the subsequent coordination and organizational relationships--two primary examples of this are outlined in the sections below. Part of this related, as often happens, to issues between individual personalities on all sides and levels, whereby some in IFRC felt that ICRC "watched over" their work and "recorded their irregularities", while others found the relationships "collaborative" and positive. **This highlights the lack of a systematic working set up across the operation for effective coordination and cooperation, which ultimately impacted delivery in the field**. In mid-2019, new teams were brought in to manage the ICRC response in Kinshasa and Goma and relations improved.

It was unclear why there was no Movement coordination function for this operation, as there was a clear need for this support in DRC. The ICRC had Supra-Coordinators in-country and IFRC needed a Liaison or Coordination Delegate to act as an equivalent counterpart to these ICRC teams and ensure effective cooperation and joint working around important areas, such as security analysis, epi-information, and context understanding. This function would also have been important to support Movement representation and to iron out problems.

Strategic level coordination

The development of the OIA in DRC was noted as having been well coordinated and negotiated / agreed at country and regional level, in line with OIA guidance[10]. This came out of good initial cooperation, which helped strengthen engagement and roles / responsibilities between Movement partners during the initial outbreak and show the Movements work under one plan and funding ask during the first days of the response in Equateur. It also included engagement with PNS working in country in support of the response and DRC RC capacity strengthening, although this could have been extended to more strategic level engagement. One area of concern was the not full involvement or understanding of the NS in the process. The initial good cooperation was however challenged when the context in North Kivu proved more difficult to manage. It is not clear if the OIA had any impact on increasing the levels of fundraising, though it did mean that the ICRC was not competing for funds in this context and led to some cost saving efforts. There was also learning on the management of an IFRC-led OIA, with a clause added to the Letter of Agreement (July 2018) agreeing percentage of OIA funds rather than pre-agreed amount for the ICRC. It should also be noted that strong initial cooperation around the set up of the OIA and the work to resolve subsequent challenges was also strongly supported by operational and Movement Cooperation teams in headquarters. Collective cooperation across the Movement can be seen to have been strengthened across all levels of the partner organizations over time.

One area where this was seen was in the strategic level coordination with Government and strategic partners. At the outset of the operation, the ICRC mobilized a "Supra Coordinator", who was the counterpart to the IFRC Head of Ebola Operation and mandated to oversee the "strategic coordination of the EVD response for the Movement"[11]. For the first months of the response, the ICRC represented the Movement with the DRC Government and agency principals at the daily Strategic EVD Coordination Meetings. This strategic coordination role was held by ICRC because of the relationship they had, had with the Government for many years (and needed to maintain), as well as the reported reluctance of the Government to have both organizations at strategic-level meetings. However, as the ICRC was not involved in the technical implementation of the EVD operation, it was not best placed to represent the Movement at a technical level in the meetings with the Principals of WHO, UNICEF, MSF etc. and was not seen to position DRCRC with partners. It would have been useful if a mechanism for sharing the representation role or for better sharing information had been set up early in the response. This was agreed in early 2019, when strategic representation at senior coordination meetings on the EVD operation shifted to the DRCRC and IFRC (e.g. UN EERT, SRP workshops, etc.)--coordinated with the ICRC.

This example is critical in highlighting the evolution of the strategic coordination between the IFRC, ICRC, and DRC RC throughout the implementation of the emergency operation. Many respondents noted a significant improvement in the Movement relationship throughout 2019 and which continues to this day. **This is largely due to an increased familiarity, over time, with the organizational cultures of the other but equally that each component settled into their respective roles based on the strengths and advantages they each brought. Arguably, the operation would not exist without the unique added values each Movement component brought to the response**. The ICRC, among many other things, provides unparalleled security management and logistics support, without which the IFRC would have never been able to operate safely in North Kivu, South Kivu, and Ituri. At the same time, the IFRC brings unique technical and coordination expertise as well as financial support through the One International Appeal, without which the DRC RC would have struggled to ensure the technical

[10] The DRC OIA was one of two OIAs negotiated at country / regional level and not between HQs (draft OIA Evaluation)
[11] Note explicative sur les roles et responsibilities entre CICR et la CICR [sic] dans le cadre de la riposte Ebola dans l'est de la RDC. Janvier 2019. Riposte Ebola—Termes de reference.

quality of interventions and financing for activities. Most importantly, the DRC RC is the lead of the operation, responsible for implementation of the EVD activities across the operational area. Without the commitment of the DRC RC staff and volunteers, the Movement would have been unable to implement life-saving activities in eastern Congo and contribute to the control of the epidemic.

As such, **a key lesson of the EVD operation is the level of inter-operability the Movement has and that when each component, building on their strengths and contextual comparative advantages, plays their role, the strength of the RC response is augmented exponentially.** Effort to disseminate this lesson and case study around the world is critical to more rapidly mobilize joint operations in the future but equally contribute to the ongoing Strengthening Movement Coordination and Cooperation (SMCC) efforts.

Inter-Organizational Relationships

The DRCRC's capacity and role

Engagement with the NS has been challenging for all Movement partners throughout the operation. **This was primarily due to limited engagement in or prioritization of the response and slow decision-making by the NS.** From the onset of the 9th outbreak and throughout the 10th, the DRC RC was slow to allocate resources, for both external coordination and the operation. The NS largely relied on a select few key counterparts, who did excellent work but had to cover several aspects of the engagement between the NS and the operation.

DRCRC also had internal capacity issues, with strong involvement of governance and weak management and limited capacities in many programming areas and support services functions. There was also limited coordination between HQ and the field. **This lack of capacity and engagement resulted in IFRC implementing the operation directly at the beginning of the response**, which enabled the RCRC to take direct action in many areas but did not support the localization of the response nor the longer-term capacity-building of the NS**.** To mitigate the impact of this, the IFRC included NSD within the emergency plan of action as a "fifth pillar" of the OIA to provide NSD support to DRC RC throughout the response, however the NS was slow to optimize this opportunity and continues to have large, unspent working advances NSD within the operation. An IFRC NSD delegate might have been able to better position the NSD strategy and support on implementation. Stronger consideration should be given to this position for future operations of the scale.

To support the technical capacity-building of the NS and transfer increasing responsibility to DRC RC over time, a counterpart system was established between IFRC delegates and DRCRC staff from early on in the response. However, this was met with mixed results and was not fully realized until mid-2019, when some 45 IFRC delegates were relocated out of North Kivu following a security threat and which pre-empted the planned timeframe for the transfer of responsibility to the NS, requiring the operation to quickly put in place a "remote management" system. This proved challenging, as there was limited time to prepare for, train, or handover to national counterparts and it was difficult to support and supervise them from a distance. Although there was good advance planning done, it would have been more effective if there had been time for more pre-training and preparedness. There were also questions around the skill levels of the NS staff assigned to the operation through the counterpart system. An HR commission was set up in mid-2019 at DRCRC HQ to oversee the selection but did not deliver sufficient strong profiles and did not follow a transparent selection process.

Despite this, **there was a clear strengthening of capacities at branch level in both Equateur and North Kivu** (Beni, Butembo, Goma, and Ituri) **in the key pillars** (CEA, SDB and PSS). This was mainly achieved through learning by doing, with branch leadership, key staff and volunteers learning a lot through training, hands-on experience and through improved infrastructure. In

Equateur, the CO took steps to consolidate capacities through the 'Transition Plan', including support to recruit and train new volunteers and for branch infrastructure (a new training centre). In North Kivu, particularly in Beni, Ituri, Butembo and Goma, capacity was built through the branch-level response, with branch management managing large teams of volunteers and responding to evolving needs, particularly during the periods of remote management. However, there were challenges in coordination between the NS HQ in Kinshasa and the branches in the east, which limited work to improve the finance, HR, volunteer management, IM and other systems of the NS that would have allowed for the critical operational and information management structures required to implement an emergency operation of this scale and complexity. **The NS also has a duty of care to its own staff and volunteers, to make sure they are prepared, trained, equipped, protected, and paid**. There were gaps in this support - missing PPE equipment and material support and massive delays in the payment of volunteer allowances - and it was not clear what efforts the NS made to resolve these issues with partners.

Partner National Societies

The **involvement of PNS in the EVD response was relatively limited for a category "Red"**. In Equateur, French RC ultimately took a strong lead in setting up and delivering the IPC pillar through the deployment of an IPC ERU and, as of early 2019, led this pillar under the umbrella of the IFRC in North Kivu. In Equateur, both the Spanish RC and the Belgian RC were also involved in community-level programming and capacity building in the 9th outbreak.

However, in the 10th outbreak in North Kivu, the ICRC-enforced staff ceiling meant there could only be limited use of ERUs or PNS bilateral support, which limited engagement with and support from PNS partners. PNS also described a lack of coordination with the field, often feeling disconnected from the response in the field and only being included through occasional extended participation in strategic planning meetings in Kinshasa.

With regard to overall NSD support, the Norwegian RC are also in-country trying to support the NS to improve their finance systems up to standard, alongside other initiatives by the Belgian, Swedish and Spanish RC Societies, who are all working with the DRCRC on future capacity.

External Coordination

IFRC was active in external coordination across all relevant pillars and at the strategic levels. The IFRC was Co-Lead with the Government of the SDB pillar and executed that role well. The workload involved in chairing the Sub-Commission was heavy and the expectations high, with the technical coordinators having to take on the additional workload on top of their programming role and having to deal with criticism and demands from the partners. It would have been **appropriate for IFRC to have put in place a dedicated coordinator for the Sub-Commission to manage these complex relations with the MoH and WHO. Although this was put in place later in the operation, this should be a required role from the onset of the emergency.**

The coordination role became more complex as other actors became involved in delivering SDBs—particularly Civil Protection supported by WHO--, which resulted in it being harder to maintain staff and standards for this work. This was exacerbated when CP and WHO more systematically supported the use of armed escorts in the conduct of SDB's, which had significant potential implications on the perceived neutrality of the Movement. As a result, in late 2019, a roles and responsibilities document was signed between IFRC and WHO to formalize support to the DRCRC and Civil Protection respectively, thus drawing a clear line between the RC Movement and use of armed actors in the EVD response. This highlights the necessity of strong and consistent coordination between operational partners to mitigate the effects of different, and potentially damaging, intervention approaches.

IFRC was also involved in the coordination of the CEA pillar, but did not lead it. UNICEF was responsible for the Risk Communication and Community Engagement (RCCE) Commission with the Government. **IFRC CEA staff had strong technical knowledge and expertise in CEA** and it was **important for IFRC to position itself more forcefully in the coordination.** There were even discussions of IFRC taking on the coordination function for CEA in future. However, it was clear that IFRC should only take on this role if it was prepared to put in place additional, experienced coordination staff dedicated to managing the coordination. Although this position is expected to be added to the operation in early 2020, given the significance of this pillar and the RCRC's engagement therein, a dedicated coordinator should have been brought in earlier.

During this response, the WHO took on a much stronger coordination role across all levels. The IFRC took appropriate steps to engage with the WHO, both at Geneva level, where it appointed a liaison person based at WHO headquarters to assimilate and share key information and to represent the views of the IFRC in discussions. At a country level, the IFRC engaged with the WHO in the SRP process and was seen as a key actor. However, there were some tensions at the outset, when the IFRC was not represented in the initial discussions of the SRP and missed the opportunity to put forward its priorities fully. There were also tensions around the IFRC Appeal and its perception as separate to the coordinated response under the SRP. Continued engagement is required in peacetime with the WHO and UN partners to explain the Movement's unique position and avoid similar questions in future responses. Strong relations were also maintained with UNICEF on the ground around the coordination of the CEA pillar, with the IFRC taking a strong technical lead in this area of work.

Risk Management, Business Continuity Planning, and Operational Strategy

Key Lessons Summary:

- For operations in complex settings, **there is a need for constant focus on risk management, the elements of which—security, operations, and corporate services—are equally shared, understood, and prioritized by all Movement components who are partnered together in a response.** As such, risk management should be included in all joint planning and protocols, agreements, and working modalities adapted relative to the changes in the overall situation and risk appetite.
- In emergency responses of this complexity, **the IFRC must, at the onset, establish a comprehensive acceptable risk threshold for staff that is consistent with its organizational risk appetite and humanitarian priorities.** The threshold should be developed transparently with the relevant Movement elements involved in the response but remain 'live' as to be adaptive to a changing situation.
- There is a need for **a more robust and thorough system of risk management in operations, to ensure managers are regularly updating their risk management analysis and actions in response to the evolving situation.** This should cover operational, financial, security and reputational risk and should be a critical element in planning and strategic oversight at field level throughout the response. It should also be a regular priority at JTFs and in wider discussions between CO/operations, RO and Geneva.
- **Integration of Staff Health and MHPSS profiles from inception of the EVD operation was required but did not occur.** For similar operations in the future, these profiles should form the standard and essential rapid deployment team to establish the infrastructure and mechanisms to extend the IFRC duty of care to staff.
- The IFRC should **invest considerably in adequate security management training for staff and delegates operating in complex environments** and seek to enhance its **'security culture' within field teams.** Cross-learning from the ICRC would be helpful in this regard and could have long-term benefits in breaking down organizational barriers.
- There is **good learning from work on scenario, business continuity and transition planning in this operation** and in this highly volatile context. This includes detailed learning on "remote management" modalities that might be needed for the future and greater support for transition planning to support the handover to national / NS teams.
- At inception of an operation where IFRC and ICRC have a security integration agreement, secure channels between trusted counterparts should be established to better **share information on the operation, security and the evolving context at country level with clear rules on information sharing and confidentially. This would** improve risk management and operational integrity in complex contexts and could contribute to better joint analysis.

Risk Management

Accountability and risk management were vital in this context and should have been prioritized earlier. While a risk register was set up, it was not regularly updated and was a late item in the agenda of JTFs. **More time and capacity were needed to be put into identifying and managing risk throughout the operation at all levels (Field, CO, NBO, and GVA).** Audit is a vital component of risk management in an operation of this scale and risk level and should be used earlier as standard. The audit in DRC in December was very welcome.

Operational Proximity

Lack of proximity to the operation consistently and negatively impacted risk management and operational integrity. Proximity to the emergency was essential for strong operations management - not only to ensure the relevance of the operational strategy but also to provide direct support to the NS and mitigate the risk of fraud and corruption. This tenet was central to

all of the operation's strategic plans, including the Business Continuity Plan (Dec 2018), the Scale-up Plan (Jan 2019), and the Re-Entry Plan (Sept 2019). However, due to security constraints and restrictions on access to and personnel in Nord Kivu, this was never fully achieved.

As mentioned earlier, due to the role played by the ICRC in security management, **IFRC was not able to control or predict the number of expatriates working in North Kivu** and the rational for the numbers allowed was not transparent nor consistent. The headcount for expatriates in North Kivu changed five times in the operational period[12]. The fourth of these changes in February 2019 was damaging to the operation, with the full relocation of all expatriate staff through to April 2019 and only three expatriates allowed between April and February 2020. **This severe reduction in headcount meant that IFRC was absent, at-scale, from North Kivu for a full year.** This was one of the main challenges for the IFRC response and resulted in reduced technical and programmatic oversight, lowered credibility with partners, slow procurement and supply chain, secondary security risks and an inability to support fraud and corruption prevention.

Situation analysis and security strategy

As mentioned earlier, IFRC had limited understanding of the security / risk environment and was reliant on the ICRC for all security/risk analysis and decision-making. This increased IFRC's risk exposure. **Security and access were primary determinants in the prolongation of the crisis and a stronger understanding of the evolving operating environment would have allowed for better contingency and operational planning**. IFRC did have security input from the RO and some in-country security support, however, it would have been important to enhance the IFRC's security role and engagement with ICRC, particularly around analysis. This was rectified in late 2019, when a virus risk analysis tool was created in Goma, however it was arguably added too late in the response to have supported it in a major way.

Case study:* *IFRC Direct Implementation and Security Management

Given initial capacity challenges within DRCRC, the IFRC, in agreement with the NS, took a direct implementation role for the 10th outbreak. This required a large IFRC delegate presence in GNK and, on whom, the response largely relied for coordination and implementation. However, this reliance exposed the IFRC to unforeseen challenges in operational continuity.

In January 2019, a direct threat was made against RC staff, which resulted in the relocation of all IFRC and ICRC staff from GNK and stalling of the EVD response for a period of time. Remote management was established to keep the operation running, however this proved marginally effective given the lack of time for training and preparation in advance. As such, in mid-2019, the operation shifted strategically towards 1) enhancing the capacities of DRC RC staff; and 2) relying more on IFRC national staff—both whom did not face the same security restrictions as delegates under the L3 Agreement with ICRC. This not only better realized the localization and NSD agendas but offered operational continuity in the event of a future deterioration in the security environment.

This lack of understanding likely contributed to the IFRC not defining an 'acceptable risk threshold' for eastern Congo. No red line was ever established as a trigger for IFRC to evacuate/ relocate its staff and structures. This remained under the ICRC guidance in the L3. As ICRC has a different risk threshold given its mandate, **it is critical for the IFRC to define its own organizational red lines based on its acceptable risk appetite**.

[12] The headcount was initially set at 15 expatriate personnel in Aug/Sept 2018, was then increased to 25 between the period of Oct 2018 to Jan 2019 and then authorized to increase to 35 in January 2019. However, the deterioration of the security situation in early 2019 prevented the 35 personnel being deployed. The headcount was revised to 3 between February and October 2019 where it was raised to 15.

The lack of security understanding also became a source of tension between IFRC and the ICRC, particularly around the lack of appropriate information sharing on security under the L3. This reached a crisis during the sudden relocation of IFRC staff in February 2019. Following the incident, the IFRC felt that ICRC was not sharing adequate information on the event or continuing threat, which increased its risk exposure and limited its duty of care to staff still in the field. The ICRC was however responsible for critical incident management and feared that releasing the information would risk resolving the situation. This resulted in a deterioration in relations, which required the management of both organizations to resolve. **A senior security coordinator, working with a Movement Coordinator on the ground and representing the needs of the IFRC and DRCRC could potentially have mitigated this situation**. It is important to note that relations and exchanges of security analysis improved considerably after this event. In the second half of 2019, ICRC was open in sharing security information and transparent in its decision-making, with the IFRC operations management and others given the chance to take part in security risk assessments.

At the same time, DRCRC had a strong network of volunteers and staff, on which the response relied for implementation. The NS had different security standards, however, given its capacity challenges, it relied largely on security information from the ICRC to inform its movements. **A more autonomous and capacitated NS could have facilitated an increased Movement footprint for EVD activities, as well as extended a better duty of care to its staff and volunteers.** Greater emphasis should have been put on building the security analysis capabilities of the DRCRC and IFRC to reduce the risk exposures of both organizations. This could have been done through having an experienced security coordinator and analyst profile on the ground.

Burnout Risk

There were high levels of staff burn out and, by extension, Code of Conduct issues, in this response. While some support was provided for staff for two weeks at the outset of the 10th outbreak and online, **the IFRC did not provide the needed care for staff health, particularly mental health.** Given the context in Nord Kivu (armed conflict, humanitarian targeting, and strict security) the risk of staff burnout was understood to be high. Despite this, no formal infrastructure to mitigate this risk or provide ongoing PSS, was established in either the 9th or 10th outbreaks outside the IFRC's standard practices. This was in contrast to the positive PSS support provided for DRCRC volunteers as well as the PSS support provided to both staff and volunteers in the West African outbreak. Although individual efforts were made by operations managers and team members, including the PSS pillar lead - establishment of the R&R cycles, strict work hours, mandated weekend days, social days, team-building events - this was insufficient in supporting staff.

It is worthwhile to note the "Catch 22" situation relating to delegate coverage for this operation. Delegates / staff needed to stay longer to support operational continuity, but if staff stayed too long in this extreme context, they burnt-out. Several technical and field coordinators stayed for extended deployments without rest periods (R&R) and delegates reported experiencing health problems and post-traumatic stress disorder (PTSD). In autumn 2019, a pilot rotation system was put in place, which enabled two delegates to cover key management positions (operations management, health and CEA), with one working in-country (Goma), while the other worked in the RO (Nairobi), and to rotate every one to two months. **This rotation system has worked to date, balancing the need for continuity with staff care, and is an option for future responses**

Although a staff health delegate is intended to join the operation in 2020, this was too late for the peak of the main response or to prevent burnout / provide support to those who have already left the response. **For future operations, a first-phase staff health deployment is required to establish an initial PSS architecture for staff** and funding allocations should be made from the

initial EA's operating budget for this. Given the risks the IFRC faces in losing competent personnel and being exposed to litigation, much stronger attention needs to be given to this file.

Operational Strategy

The regional containment strategy

The **regional containment strategy was an effective approach to limit or prepare for the risk of the spread of the epidemic**, both in new areas in DRC and in neighboring countries. Based on a 'ring' approach, the regional containment strategy strengthened preparedness capacities of the NS in priority at-risk countries surrounding eastern DRC - South Sudan, Rwanda, Burundi, and Uganda - as well as within the DRC provinces surrounding the epicenter of the epidemic. This was a strong operational strategy and one that was appreciated by partners and donors, but which equally capitalized on the IFRC's coordination mandate at a regional level and ensured support to the regional NSs beyond the initial, six-month DREF timeframe.

Within the **neighboring countries, preparedness activities were reasonably timely and there was evidence of good preparedness when individual cases of EVD were identified**. DREF was a useful tool to support these NS with initial preparedness measures. However, it was difficult to find funding for regional preparedness beyond DREF and most of the funds in the EA were prioritised or earmarked for work in DRC. With these limited funds for training and pre-stocking of materials, Uganda RC showed good levels of readiness when it responded to the four cases of EVD and Rwanda RC managed well, following the case in Goma and despite limited resources. South Sudan RC also used this experience to build its role as auxiliary to government for epidemic preparedness and response.

In DRC, the IFRC put energy into identifying the "ring" of areas at risk from the spread of the disease and responding to the data gathered from a range of remote areas. This may have helped limit the spread of the disease, but it is hard to prove directly. However, the scale of the area at risk was too great for the resources available and the strategy was comprised by the divergence between the scale of risk/preparedness needs and resources available for urgent response needs. Some respondents felt this approach was too time/resource heavy and that IFRC should have more clearly prioritized the response areas rather than spreading resources too thinly across the areas at risk. **There was a challenge in balancing the demands of the response in existing districts with the mitigation or preparedness measures needed in new or at-risk districts – this was a major challenge given the limited human and financial resources available.**

As such, **preparedness work in at-risk provinces in DRC was often limited by access issues and reactive**, rather than able to proactively follow risk mapping and scenario planning based on epidemiological data. This linked to wider challenges of funding flexibility and DRCRC's commitments. It was challenging to allocate limited resources to preparedness activities in at risk health zones, when these resources were needed to respond to existing caseloads. Equally, if resources were allocated to at-risk health zones, it was difficult to move them to higher risk areas as the epidemic evolved. This led to inflexibility in the preparedness strategy in the DRC that hampered its efficacy.

Business Continuity Planning

The IFRC did good timely work on transition, scenario and business continuity planning throughout the rapidly changing context and evolving epi-conditions of the two outbreaks.

- A **clear Transition Plan** was set-up at the end of the 9th outbreak in Equateur to support recovery and NS capacity building after the outbreak finished. Some work was carried out to build branch infrastructure and staff / volunteer capacity, however, focus on this work was overtaken by the 10th outbreak and resources were refocused on North Kivu.
- Good work was done in late 2018 on the **scenario/business continuity planning for the election** period, analyzing the volatile political environment and outlining adapted working modalities, hibernation plans and contingencies to support the continuity of the operation, which was used when IFRC went into hibernation for the election in December.
- Following the evacuation of 45 IFRC delegates in early 2019, the operations management team had to quickly put in place its **"remote management plan and set up",** to support national teams working in North Kivu and maintain levels of quality assurance through "remote monitoring" (see: Case study: IFRC Direct Implementation and Security Management). Although thoroughly planned, the remote management was challenging, as the hibernation continued for an extended period (two months), and it proved difficult to prepare and train existing and new national staff for the responsibilities and difficult to support and supervise from a distance. It also proved difficult for the IFRC return and regain its operational foothold and credibility.

Programmatic Relevance (CEA, SDB, PSS, IPC, IM)

Key Lessons Summary:

- There is evidence **information from communities informed changes in the pillars of our work**, and it is vital in future to continue to use community feedback to improve operational delivery and to show communities their voice is being heard.
- It is important to **further integrate the work of CEA, SDB and PSS teams in future responses**, to ensure coherence and to build inter-related community approaches.
- There was learning shared from operational teams, that **the IFRC should look to access more contextual or anthropological analysis in-country at the outset of a response to learn and inform operations from local knowledge.**
- IFRC should examine the opportunities and risks around taking on the coordination role for SDBs and for CEA for future responses and be ready to specifically support and resource these roles if this is agreed.
- There are key lessons to be learned from the remote management experience and on how to exceptionally manage "distance quality assurance" for SDBs and other pillars.
- In future PHE, IFRC should provide PSS support for national and international staff, as well as for volunteers, as part of if its "duty of care". This could include PSS for survivors and families, as part of its SDB pillar, if expertise and resources were available.
- IFRC should continue to develop approaches across the pillars to learn and improve working in new areas, such as in dense urban and conflict affected areas for the future.

The technical areas or pillars targeted in both Equateur and North Kivu were relevant and generally effective. There was evidence of the use of learning from the W.Africa Ebola response across pillars and in the use of experienced delegates but no clear learning from other outbreaks. **There was also evidence of adaptability within individual pillars** to respond to the changing needs on the ground (e.g. use of feedback to change CEA approaches and SDB modalities, such as the clear visibility body bags), changes that were appreciated by communities and others.

Community Engagement and Accountability (CEA) **was recognized as a "gold standard" for CEA for the IFRC**. It was vital given the context and the high levels of community resistance. CEA was also an integral part of the security system in DRC and played an important role in understanding and reassuring communities. The CEA pillar adapted well to changes on the ground and there is evidence it was used to inform changes in the other pillars, particularly SDB (e.g. the "clear-view" window body bag so families could see the body) and reduce community resistance. The pillar developed its data gathering and analysis capacity over the duration of the response, dealing with well over 400,000 data points and developing a comprehensive rumor-tracking mechanism that is recognized and used by other organizations. This work was noted as having put IFRC at the heart of the response. Indeed, the IFRC did a lot to raise the profile of CEA – the dashboard, data sets, and deep dives were all made available via the Community Feedback Commission - however, it was challenging to engage other actors and even the RCRC management to ensure the information was fully used to improve delivery and crucially inform operational decision making. Nevertheless, extensive work was conducted, notably through collaboration with the IFRC CEA and IM functions in the DRC along with technical support from USCDC, to build the CEA and IM capacity of volunteers at the branch level.

***Case study:** National Society capacity building in CEA and information management – focus on the branch level*

Over the course of the 10th outbreak, volunteers at the branch level were trained in data collection and the rapid analysis of feedback, allowing these processes as part of the wider community feedback system, to be decentralized to the branch level. This was an important development as it emphasized building operational capacity of National Society volunteers and staff in the field. Indeed, moving the data analysis function in this way from a centralized process managed by IFRC IM surge profiles and USCDC support staff, was seen as a critical step in ensuring branches were able to provide timely and reliable data to the various pillars and management profiles within the operation, without the need for extensive support from surge and international delegate functions. This newly developed branch capacity also proved important during periods of remote management, where security challenges reduced the presence of international technical staff at operational bases. As the IFRC continues to institutionalise CEA across the organisation, the model used in the DRC in support of the National Society offers a number of lessons which should be captured and capitalized upon moving forward.

Safe and Dignified Burials (SDBs) **were a relevant and important role for the RCRC**. There was broad agreement that the RCRC was well placed to carry out the SDB role, due to its previous experience and access to the grass-roots volunteers needed to deliver it. There was, however, some concern from respondents that it had been chosen "automatically" without consideration for the demands of a "Red" response of this complexity. It was challenging to build SDB capacities at the beginning of the 9th outbreak and to cover the scale and reach of SDBs, while maintaining quality in the 10th outbreak, particularly given the issues of access and the initial lack of materials and training for volunteers. Technical support from Geneva and experienced West African delegates meant the IFRC was able to build capacities over time. **The RCRC was able to deliver over 10,500 successful SDBs under difficult conditions, maintaining more than an 80% success rate throughout the response**, and DRC RC volunteers and branches gained skills and capacities in SDB and were able to take on more responsibility.

However, there were challenges later in the operation (spring 2019), as the number of SDBs increased and as the IFRC relocation of staff continued. The difficulties of remote management became increasingly apparent. Due to its absence and the number of burials in "red areas", the IFRC lost ground and other actors trained by the RCRC (Protection Civile, MoH/WHO etc.) took on a greater role in SDBs. There were quality assurance issues some of the work done by others – many of these other actors used armed escorts and did not fully the agreed standards for SDBs.

At the same time, the ECUMER "community harm reduction teams" were scaled-up to remotely support community burials in inaccessible or insecure areas. The approach provided training and equipment to teams of volunteers taken from remote communities, who could then return and carry out "safer community burials". This was a necessary adaptation in this context, however, over time, ECUMER became more "the norm" and was used more frequently as the duration, scale and reach of outbreak continued to grow. This increased the risks for both communities and volunteers. It is clear ECUMER should only be used as an exception.

Psycho-social support (PSS) **for volunteers was well appreciated**. This pillar was relevant in the context, given the high levels of stress and burnout among volunteers. It was also realistic in terms of the technical capacity of the RCRC and was provided to a high standard. There was a criticism that a similar level of ongoing PSS support was not provided for staff, as had been done in previous outbreaks. Professional support was initially given to delegates for a limited period at the outset and subsequently continued online. Some also suggested the RCRC could provide PSS for survivors and family members as part of SDB work—similar to others engaged in DRC.

Infection Prevention and Control (IPC) **saw less clear RCRC engagement**. While slow to get started in the 9th outbreak, this was eventually well delivered by the French RC ERU in Equateur. However, IPC was more problematic in North Kivu, where ERU presence was limited due to security and L3 limitations and work on IPC was less easy to deliver. Some good work was done in individual centres, again supported by French RC, but this was limited until later on in the response where the French RC took a much more prominent and successful role in overseeing the IPC pillar. Some felt the RCRC could have done more to extend or improve the quality of IPC, including through provision of the new vaccine.

It was appropriate that the RCRC did not get involved in case management in ETCs in this context, as the teams did not have the profile, expertise, resources or time for this in DRC. There was also no role in community surveillance and tracking in this response.

Information management (IM) **support for the operation was a success**, including the Community Feedback System (CFS) and SDB dashboard, which provided good, real-time information and visualization for the rapidly evolving disease and changing response. The development and management of these two products positioned the IFRc as a key player in the operation, helping to strengthen the perception of the Movement across humanitarian partners, the UN, the World Bank and DRC Government. The CFS is widely acknowledged by all actors in DRC and offered not only the Movement but the entire 'Riposte' the ability to modify the operational strategy based on the community fears, wants, and needs (see CEA above). These systems have to possibility to change the way the IFRC approaches emergency response in the future and efforts are being made to codify the learnings so that they can be easily applied in other settings around the world.

Corporate Services and Operational Support

Human Resources

Key Lessons Summary:

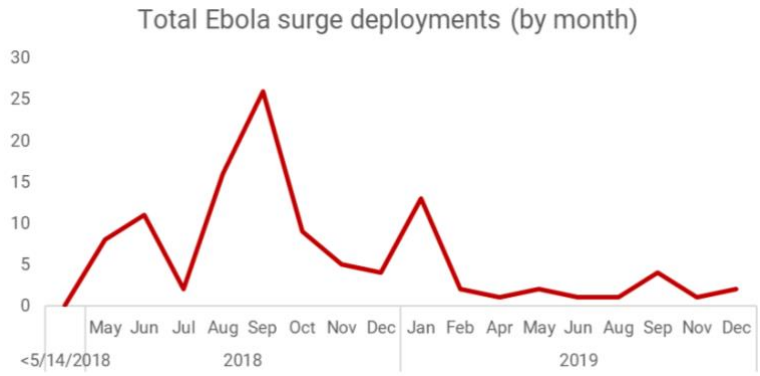
- To ensure future HR capacity for "Red" responses, particularly for PHEs, IFRC will need to identify ways to **recruit and maintain the necessary staff levels**. This could include **temporarily reallocating staff** from other Secretariat offices (Geneva/ROs) or proactively engaging with partner NSs to **pre-identify and train key profiles**, such as Health Coordinators, Logistics/Procurement Coordinators and Financial Managers for deployments as needed. There was also a recommendation from the field that experts from ICRC could be considered for positions in future outbreaks in complex contexts.
- The **Deputy Operations Manager position worked well** and should be an automatic consideration for future "Red" or large-scale "Orange" responses of this scale.
- The IFRC must increase its work to put in place **more effective processes for recruiting medium to longer-term staff for protracted crises**, including PHEs, to avoid reliance on surge. This could include developing surge capacity that is viable for extended 'emergency' deployments, ensuring early identification of and action on long-term recruitment needs or improving systems for the fast recruitment of long-term staff.
- The EVD response **piloted a new rotation system between the field and the RO for key positions** to ensure continuity of experienced staff in the operation, while allowing staff time out to avoid burnout (rotating every 1–2 months over a 6–12 month contract). **This has worked well and should be a model for protracted epidemic outbreaks**.
- **PSS is a key priority for future PHEs** - this should cover **support for volunteers** working in the epidemic response, including the timely provision of equipment, training, safety / security measures, and timely payment of remunerations, and the **provision of PSS for delegate/staff mental health needs**, as a priority duty of care, including for longer-term staff. In future EVD outbreaks, this should include access to relevant vaccinations.
- IFRC should **prioritise the training and deployment of experienced regional and national delegates/staff** with relevant experience in epidemic responses and understanding of the region. To support this, the Africa RO should **reinforce the regional capacity-building programmes** to ensure regional candidates receive the support and training they need in operations management, reporting and coordination skills, to be able to take on future roles. It would be particularly useful to **develop a pool of deployment-ready, francophone delegates with training in budget holder and project management responsibilities.**

Throughout the response, the operation faced consistent challenges with staffing. This was primarily due to the operational context, which required the intersection of four variables in order to find appropriate candidates, both surge and longer-term:

1) **Personal willingness** to deploy to an Ebola outbreak in a complex conflict environment, punctuated by sporadic targeting of EVD response workers
2) **Expertise and calibre** in the technical or managerial sector required by the operation. As a difficult operation in a complex emergency environment, the operation had a continuous need for high-calibre personnel in specific sectors.
3) **French** language skills across all profiles given the language context in DRC
4) **Availability** to deploy when surge requests were launched or position advertised.

As such, it was a challenge to identify and deploy delegates to support this operation, due to the "perfect storm" of staffing variables. Even with a "fast track" system it took time to get profiles into DRC and proved difficult to find skilled, experienced technical and management staff.

Surge / rapid response



The IFRC was able to scale up surge positions quickly in the immediate aftermath of the 9th and 10th outbreaks. In total, 114 surge personnel were deployed to the operation from 37 different countries - 48% (55) from African NS; 31% (35) from NS outside of Africa; and 21% (24) from IFRC. However, some profiles were difficult to find, particularly health and logistics/supply chain management and corporate services (Finance, HR, Admin, Logistics), which hampered initial scale-up of the response. Given the necessity for management and corporate services surge personnel experienced in internal systems, the IFRC must consider its system-wide availability and engagement for a "Red" response and consider deploying internal staff as needed.

Given challenges with sourcing long-term candidates and delays in recruitment, **IFRC did not transition quickly enough from surge to a longer-term structure** appropriate for such a public health response. The operation was "maintained [for some time] by surge deployments", which exacerbated challenges, inhibited longer-term planning, and resulted in a lack of continuity in strategy and operations. This was mentioned by Movement and non-Movement partners as a block for operational planning and negotiations.

This was particularly evident with the Head of Ebola Operation position, which was largely maintained through surge rotations, due to an inability to find appropriate candidates (five recruitment rounds were launched for this position in the 10th outbreak). To date, **twelve IFRC leadership profiles - five HEOps and seven Ops Manager - were officially deployed to the 9th and 10th outbreaks** as surge or short-term deployments and one longer-term Ops Manager left the mission. Despite repeat deployments, this continuous changeover was disruptive to the operation and did not support long-term business continuity nor consistent strategic development or engagement with partners. The ICRC faced similar challenges with a regular rotation of its Supra Coordinators. It is important to note, however, that due to the complexity of the initial operation (mid-2018 to early-2019), it was recommended that senior leadership profiles only deployed for five weeks to avoid burnout and ensure continued energy for the role. This is also partially responsible for the high turnover.

The operation benefited from the **good technical capacity of the Regional Disaster Response Teams (RDRT) from the West African Ebola response** for both outbreaks. These delegates had strong technical and practical experience in EVD response and had worked together previously, however, they required upskilling for the DRC EVD operation in other areas, such as project planning and management (this was a finding of the internal audit conducted in December 2019). Similarly, respondents felt that **national and regional staff had been underused in this operation,** which had been expatriate-led and stated that more effort could have been made by the RO to train and recruit RDRTs and other regional staff, to build and retain capacity in Africa and better support the transition to the longer-term, nationally-led response.

Staff (surge and long-term) also needed to build skills and experience in programme management, planning, reporting and coordination/representation to enhance the calibre of the operation. Poor programme planning often exposed the operation to major financial risks as exceptions to the IFRC procurement or accountability processes were regularly required to continue activities. Increase investment needs to be made across the Movement to build basic

Programme Planning Process (PPP) skills for all delegates and rapid response members and to ensure their knowledge of the IFRC's corporate services procedures - logistics, procurement, finance, admin, and HR. Operations Managers should also prioritize upskilling staff on the basics of these sectors during the emergency response, to ensure that everyone has the same understanding.

Long-term HR

Key positions, such as Operations Managers, Health Coordinators and Support/ Management Services staff, were hard to fill, with delays and gaps in coverage. All of this affected the quality and continuity of the operation, decision-making and relations across teams and with Movement and external partners. There were similar delays in identifying national staff. As such, the operation was generally under-staffed, particularly throughout the 10th outbreak.

There was a lack of stability and sustainability of positions in the response, with staff often extended for a few months at a time on continuous short-term contracts and receiving very late contract extensions. This became more problematic later in the response when there was serious shortfall in funding and the operation experienced an abnormally high turnover of staff and a lack of (de)briefings or handovers. This was noted as a major challenge by staff and led to demotivation across all teams. Although the result of wider systemic challenges within the Secretariat, short-term renewable contracts for key operational staff were ineffective in maintaining engagement and job security throughout the response.

There was a serious failure in the HR system during the funding crisis in Spring 2019, with many delegates and staff having their contracts terminated at short notice or not renewed without warning. This left staff distressed and resentful towards the IFRC. It also impacted the delivery of the operation, as most teams were left with a "skeleton staff" of one Coordinator per pillar. More could have been done to anticipate the situation, to explain it to staff and to take steps to mitigate the worst cases and ensure staff were dealt with humanely.

Due to changing requirements and the operation's scale, complex architecture, and long recruitment timeframes, **the IFRC often relied on the 'fast-track' recruitment modality to staff the operation.** This modality was critical and offered a lifeline to quickly bring in essential personnel or extend rapid response personnel beyond their surge deployments, providing time for standard recruitment to be launched while maintaining operational delivery. However, it was more often used as the norm than the exception, which highlights the challenges facing HR in emergencies and ultimately exposed the operation to audit and compliance risk.

The Deputy Operations Manager position was considered a very strong addition to the operation, balancing the Ops Manager's workload and taking on key responsibilities. The role divided the strategic and operational functions of the Head of Ebola Operation, with the Deputy coordinating the information and support services functions and overseeing the management of the Emergency Operations Centre in Goma. It was appreciated by the team in-country, as well as by IFRC structures elsewhere. The position provided much needed operational stability and gave the Head of Ebola Operation time to focus on high level engagement with Movement and external actors. Unfortunately, the role was added very late in the response (October 2019). **Given the utility of this role, it is recommended that a deputy structure is mobilized immediately for a 'Red' or large-scale 'Orange' operation in the future**. The position can be de-mobilized if deemed unnecessary, however it is critical for the immediate scale-up or for large-scale, long-term operations, it provides critical leadership stability.

Financial management

Key Lessons Summary:

- To support major response operations, **IFRC should pay particular attention to developing its pool of experienced financial managers / analysts at regional and global levels, who can be deployed to set-up up financial management systems in the first phase.** The example of deploying members of the Regional Finance Unit of the Africa Regional Office to the Mozambique operation was positive and could be replicated.
- **It would be timely to set up a cross-functional working group or review (Finance, DCPRR and PRD) to work on solutions to improve operational managers' access to real-time financial and funding information for emergency responses on this scale**. This could examine the limitations of Working Advance (WA) criteria for a level "Red" and look at options to ensure emergency operations have the fastest possible access to cash at field level in the first phase. This could include an emergency over-ride system to allow the authorised transfer of higher levels of funds than under WAs, with the necessary controls agreed with Audit and Risk Management, to avoid the use of high-risk alternatives, such as using personal cash advances.
- **The use of Orange Mobile to pay volunteer allowances was a practical, effective, risk-averse, and easily replicable solution**. It can be used in future operations, where similar mobile systems could be pre-negotiated with NSs and set up in the early phase of a response.

Financial tracking

There was **a lack of real-time financial information to inform sound operational decision-making**, including on income, expenditure and on funds available. This was a major gap in an operation with this level of budget and "burn rate" and where cash flow needed to respond to changing epidemic and security situations on the ground. Many managers felt they were unable to plan properly without such up-to-date information - one operations manager refused to act as budget holder, as he did not have the information to make responsible decisions - and some said this contributed to the financial crisis in 2019. The first consolidated budget variance analysis for the 10th Outbreak response was produced in January 2019 and, despite raising the alarm of the pending financial crisis, did not receive considerable attention until later in the year.

Working advances and cash flow

Linked to the above, **there were major problems of cash flow in this operation** and it was difficult to deal with the absence of a banking system in eastern Congo. Because of the lack of financial reports from the NS and the field, the **Working Advance (WA) system limited the amount of cash that could be transferred to the field in one transfer** (USD 1,000). This was too little to support an operation of this scale and resulted in work being delayed, left undone or paid for from other funds. Volunteers were also not paid for months and materials were not sourced. This also resulted in localized security issues for Movement personnel, which exacerbated tensions around the response and added to the complexities faced.

At the same time, the **Cash Advance (CA) system became the "go to solution", but created parallel problems**, as delegates were paying for the operation from their personal cash advances or credit cards. This was a burden on individual delegates and it is not clear if all were reimbursed. Requiring the assumption of personal financial risk from delegates to ensure the continuation of IFRC operations is questionable on several fronts, not the very least morally and ethically, and, as such, requires concerted attention within the organization.

At the same time, this modality was also a major risk for the operation and made the capturing of real-time expenditure and financial reporting very difficult. The strict financial rules and risk management potentially increased the risk of fraud in this context as the limited amount of

possible transfers pushed field staff to find alternative ways to pay contracts and volunteers – ways which were outside the financial management channels. It should be noted that all actors had problems with financial modalities for field payments (e.g. WB, UNDP) and it might be useful to work with partners to share possible solutions. It would also be useful to set up MOUs or pre-contracts with money transfer services in various countries or regions to anticipate future emergencies, and so money can move quickly.

Finance technical capacity

In the initial phase of the response in both Equateur and North Kivu, **there was limited capacity in financial management, with relatively inexperienced staff in the finance role**. The deployed delegates did not know IFRC's procedures and often blocked things rather than trying to resolve issues. In early 2019, a more experienced financial manager joined the operation and financial management improved. Even though this was a category "Red" response, there was relatively limited financial management support from Nairobi or Geneva throughout the first months of the response although this did improve over time. However, steps were taken to **deploy people from the RFU,** which is perceived to have worked well and adequately supported the later stages of the response.

There were clear issues around the NS's financial management systems and their capacity to manage and be fully accountable for all funds. This raised challenges for the IFRC's financial and operational systems and capacities, as additional work was required to compensate. It is of note that the Norwegian RC is in-country supporting DRCRC to bring their financial systems up to standard, amongst other initiatives by the Belgians, Swedish and Spanish, who are all working with the National Society to build capacity in areas of programme management.

Volunteer payments and cash preparedness

The **non-payment of volunteer allowances for many months** was a serious issue. It was due in part to blockages in the financial system but also in part to a legal issue of whether volunteers were legally classified as daily workers under national labour law and needed to be contracted after a number of days' work. This was resolved by the DRC RC who clarified internally regarding the status of these volunteers, however it highlights a wider challenge in protracted emergencies whereas volunteers work longer-term without contract and which, in some cases, contradicts local labour law. Further attention should be paid to this by NSD to ensure volunteers are protected and that their use in long-term emergency responses is in line with national legislation.

In Equateur, volunteer payments were to be provided through the DRCRC, however, for many months, volunteers were left unpaid. In North Kivu, volunteer payments were initially made via cash in envelope, however this was untenable long-term given the cash volumes and security and financial risks associated with this in eastern Congo. This also resulted in delayed payments due to internal financial processes to release the cash and transfer it to the various field bases. **This was resolved in late 2018 with the introduction of mobile money services to pay volunteers. A more accountable and simple method to pay volunteer incentives, this was seen as a positive addition to the operation**. However, the system was not fully functional and operating smoothly until the latter half of 2019, which led to delays in volunteer payments and significant reputational risk. At one point in early 2019, volunteers had not been paid for up to three consecutive months and threatened to strike. Although quickly resolved by the IFRC when raised and an SOP developed with segregated responsibility, this raised moral and ethical questions within the response team given the risk taken by volunteers in conducting EVD activities. At time of writing, volunteer payments continue uninterrupted per the SOP with volunteers paid every 2 weeks.

In terms of accountability, questions were raised over time on the legitimacy of the volunteer payment reconciliations as Finance teams had little ability to physically verify—due to security

and access constraints--whether those who had signed for a day of volunteering had, in fact, volunteered that day. Given the immense financial volumes associated with volunteer payments, this lack of monitoring oversight posed a significant financial risk to the IFRC. As such, a volunteer management system, through Red Rose, was instituted to track daily volunteering. This was seen as a significant added value to the operation

Future Operations Managers can learn from this experience, codifying as standard for Federation operations, the use of mobile money and an electronic volunteer management system. Operations Managers should consider these modalities from the earliest stages possible in a response, building on work done in cash preparedness across the Movement, and indeed it may be prudent for Country and Cluster Offices to support the development of framework agreements between the IFRC/National Societies and financial service providers.

Logistics and Supply Chain Management

Key Lessons Summary:

- It is important that **qualified and experienced logistics and procurement staff are deployed as a priority from the outset** of a major emergency. This could be from a pool of pre-trained delegates, from existing ROs or Geneva or from other trained staff who with IFRC procurement experience, ideally in a health emergency.
- In future, where ICRC or other Movement partners are responsible for logistics, it would be useful to have **IFRC delegates who understand ICRC logistics procedures** or to brief/train delegates on ICRC procedures before deployment, to improve engagement between logistics teams.
- **IFRC could optimise local procurement opportunities for less specialised items** and should commit to using local and regional procurement where possible, to minimize delays. While it is understood that some items, particularly medical items, need quality control from global-level, IFRC should investigate options to upskill existing Regional logistics staff in medical procurement and segregating responsibility to speed up procurement and delivery

IFRC experienced huge delays in the arrival of stocks in both Equateur (where vital supplies took several months to arrive at the beginning of the operation) **and North Kivu** (where volunteers were going to the field without vital PPE equipment and IFRC had to borrow stocks from other partners e.g. MSF, WHO or buy ad hoc stocks locally). Eventually, IFRC was able to access goods and equipment from existing stocks of W.African NSs or from the Africa-wide logistics stock in Las Palmas and the global pipeline started to deliver.

There was also a **lack of experienced logistics and procurement delegates and staff** in the beginning of this operation, with relatively inexperienced delegates in the field. Those interviewed noted a major change in logistics and procurement support when an experienced Logistics Coordinator arrived after the initial period and was able to improve levels of efficiency and coordination with technical programmes, including the ICRC and partners.

At the beginning of the 9th and 10th outbreaks, ICRC had responsibility for logistics, particularly for vehicles. Some people were positive about the ICRC's logistics support, stating that it proved vital in the first phase, when the IFRC had no logistics set up nor immediate access to supplies, accommodation, or vehicles. However, others found the ICRC control over stock amounts, costs and timeframes very limiting and complained about the limits on vehicles number (all vehicles needed the ICRC emblem, secure radios and panic buttons for North Kivu). This constrained the operation's speed, flexibility, access and its ability to scale up delivery. People reported getting the last-minute green light for vehicles and being late or missing operational commitments (e.g. SDBs). Renting vehicles was not allowed at first and then limited for some time. This was eventually solved as both organizations better understood each other's needs and systems and new staff brought greater knowledge of each other's logistic practices. This was also helped by the arrival of vehicles from the IFRC fleet in Dubai in mid-2019.

There was **limited utilization of planned local procurement** rather than as an ad hoc solution. Many goods could have been accessed locally and it would have been useful, in this context to have had more capacity for targeted local procurement. Unfortunately, in DRC, there were also challenges around contracting procedures and a high risk of corruption.

The **IFRC's medical procurement set up is too cumbersome**, with all medical procurement centrally managed in Geneva by one person. While it is understood that there is a need for quality control, medical procurement could be extended to include a role for regional logistics teams, who could still work according to professional standards but could multiply support for medical logistics and help speed up the medical logistics work.

Partnerships and Resource Development

Key Lessons Summary:

- It is urgent that PRD teams in country, region and Geneva **prioritise, early on in the response, a Resource Mobilisation Plan for an emergency of this scale** to better anticipate and manage funding over the long duration of the response and the changing needs. This could be linked to a PRD task force, across all levels to coordinate approaches around the plan.
- With changing donor engagement at field level for PHEs over time, Operations Managers should prioritize deploying long-term **PRD staff early in an operation of this scale to support RM at country level and to scale-up engagement with major donors.** Similarly, grants and compliance officers should be brought on early in the response to ensure proper donor compliance and engagement over time.
- There were few PRD staff dealing with the complex new funding realities for this response, which posed considerable challenges to the operation in the medium-term. This report encourages regional and global PRD colleagues to continue efforts **to establish a pool of experienced PRD delegates and staff ready to deploy in future.**
- It is timely for the IFRC to **strengthen its advocacy with new donors and partners** to ensure they are clear of the RCRC Movement's mandate and Principles and understand the opportunities and limitations of working with it. The IFRC should engage with donors in advance and advocate for greater donor flexibility for rapidly evolving epidemic outbreaks.
- It is also important that IFRC **improves its understanding of new donors' requirements and modalities** (WHO SRP) and levels of engagement between Geneva, Region and Country Offices, to clarify communication and decision-making and avoid any reputational risk (e.g. PSSD / WB in DRC).

Unpredictable and unsustainable funding

In Spring 2019, the **operation suffered a crisis in funding for the EA**. Staff said they had raised alerts around the funding situation, but were ignored, while others stated that the lack of real-time financial information precipitated the crisis. Finally, the situation became extreme, with around CHF 800,000 remaining for an operation spending about CHF 1.5m a month. The IFRC failed to anticipate this crisis and the late crisis management approach to fundraising and to managing the operation had an impact on the operation. In mid-2019, IFRC set up an emergency action plan to scale-up emergency resource mobilization and to transition activities to the NS and national teams (rather than as a planned "handover to the local RC actor"). HR contracts were terminated at short-notice and teams reduced to a "skeleton staff" across all pillars. IFRC did succeed in raising funds to continue, but at some cost to staff and reputation.

While the EA had relatively easy funding in the first phase of the response to both the 9th and 10th outbreaks, however, due to a lack of real-time financial information on available funds and a level of complacency, **there was a "sudden" lack of secure funding after Spring 2019, which had a significant effect on the operation.** This led to severe cuts in staffing and programmes. It also caused concern for the medium to long-term planning and sustainability of the operation. It was overcome by a targeted and energetic fundraising and profiling campaign to highlight the seriousness of the situation and urgent need for funds. The PRD teams worked well with operational management and communications during this campaign and were **able to scale-up fundraising and raise additional funds to ensure the continuation of the operation**.

It would **have been useful to have had a RM Plan for this response**, especially to plan for its long duration and changing needs. This would have enabled the IFRC PRD team to better explore funding opportunities, plan engagement with donors and monitor funding coverage in a more proactive way to anticipate funding needs. Some thought it would be useful to have SOPs for PRD in emergencies, covering deployments, role and responsibilities, lines of communication,

and donor monitoring / record keeping. This links to the requirement above to have clearer real-time information on the financial situation and funding exposure

PRD staffing and global taskforce

The PRD function was understaffed for the duration of the response. For extended periods, a single PRD Officer in the RO was assigned to the response but was also covering the Regional PRD role for all Africa, while a relatively inexperienced person was supporting the PRD function in Kinshasa. These people had to cover all PRD work for this major operation, including proposal and report writing, relationship management and compliance / reporting deadline management. This was insufficient to support for the extensive RM needs over the year and a half of the operation and impossible to deliver the quality or volume of PRD support required. Technical staff had to cover the PRD role around donor engagement and proposal/report writing, rather than focus on their programmes.

While there was some ad hoc support from Geneva and Nairobi PRD for specific profiles, there were no field deployments to support multilateral donor engagement in this response, as there was for Mozambique. This was much needed in both Kinshasa and Goma, to establish links with donors at coordination meetings, represent IFRC with key donors and support proposal writing. A category "Red" response requires dedicated PRD support at all levels and a willingness to send people for short missions to fill gaps. It would have been useful to have **an experienced PRD coordinator or focal point in the field even for short missions**, to help raise funds, particularly around the funding crisis.

The One International Appeal

The **OIA proved more controversial**, with some operational managers seeing it as a positive negotiation and way to present the joint operation in the early stages of the operation. The majority of respondents, however, felt that it had not added to the clarity to the operation, nor increased resource mobilization for any of the Movement partners. This included ICRC, who felt they had put a lot into the operation but received nothing of substance from the joint EA. There were also problems with the Project Agreement behind the OIA, which led to issues later on with financial management and invoicing from / financing for ICRC. In general, respondents did not see its added value to resource mobilization in the response.

There were tensions in the early phase of the response between IFRC and WHO / MOH around the launching of the OIA, as international actors were not happy to see a separate RCRC Appeal outside the appeal launched by WHO on behalf of Government. While this was understood and an appropriate strategy, steps should be taken to better communicate this with partners and donors at the global level in advance of future large-scale emergencies. Although inconclusive on this point as no partners/donors were interviewed, some IFRC staff were of the belief that the OIA was an important selling point when talking to donors. Given WHO's strong position through the SRP, presenting a solid RCRC Movement in the form of an OIA gave us leverage with partners to secure funding and position ourselves in the operation's architecture in the DRC and surrounding countries.

Non-traditional funding partners

WHO played an important, new role in this response and was quick to develop the Strategic Response Plans (SRP), which brough together the Government, UN and (I)NGOs in one Appeal. WHO took on coordination for the whole operation, supporting the Government's "Riposte Ebola", and for all funding allocations to partners working in it. This became the basis for all four SRPs, which continued to coordinate all funding for the duration of the operation and meant IFRC was sidelined in some areas of planning, coordination and funding and often had to work harder to explain its position and independence. It was vital for IFRC managers in the field

and HQ to understand WHO's role and to coordinate with them as part of the national strategic planning process and decision-making. **Work needs to be done in future to build understanding of the WHO's role in such epidemic responses and to agree the IFRC's modalities of engagement**, including around launching an EA and approaching donors. The decision to place a person in a **global coordination role in WHO headquarter in Geneva was seen to have worked well** and provided a channel for advance information and to influence discussions with WHO around strategy and funding at a higher level, but more needed to be done to strengthen coordination at a country level.

IFRC was not prepared to engage in funding relations or access funds from new development donors in this operation (WHO's SRP, World Bank funding via Government (PDSS). This was seen in the first SRP, where IFRC was not represented at country-level in strategic discussions and missed opportunities. IFRC was not decisive in its engagement with these donors, nor clear on its limitations in accepting funding from impartial sources. This had potential ramifications on relations with other partners. IFRC needs to take a stronger position on its relations with these donors and build knowledge and relations during peacetime, so that it has agreed approaches and is ready for future epidemic responses. As these funds are often development funds, new skills may be needed to access and manage this money over the longer-term.

Conclusion

This operation has had to deal with multiple challenges - a series of "perfect storms"- from working in a complex conflict environment through to the volatility and duration of the outbreak. Often the operation was interrupted by violence or security threats, access constraints, and funding issues all of which meant it lost momentum and made it harder for the IFRC to regain its position and engagement with the response. However, due to this context, it is also a rich environment from which to learn and this paper aims to capture some of the lessons that could inform future decision-making in this or other PHE responses. This is particularly important as there has been no other formal review or evaluation of this response.

The IFRC started well, with quick decision-making around the category of response, the Emergency Appeal and the deployment of global surge, but found it hard to sustain interest in and support for the EVD response in DRC, both as the context became more complex in North Kivu and for the duration and scale of the outbreak. This included sustaining both the internal engagement of IFRC management and technical teams and the external engagement of the public and of donors. This was striking, as this operation was categorized as a "Red" response, yet over its duration, the IFRC found it difficult to maintain the appropriate level of human, financial and material resources or support needed for such a high-level response through 2019 and the EVD response felt overtaken by the TC Idai response in Mozambique and other events.

The work done on the ground has been appropriate and well delivered in the target pillars – particularly in CEA, SDB and PSS. The teams of delegates and national staff / volunteers have worked hard and over time built strong experience and clear approaches in these three areas. The IFRC's work on CEA and rumour tracking is the gold standard for the response and is used by other partners, while the IFRC's role to co-coordinate and technically lead the SDB work is well appreciated, although it has become harder as new actors and approaches emerge.

The context in DRC has been a complex one for the Movement partners. There has been a strong but challenging relationship between IFRC and ICRC in North Kivu, with ICRC taking a clear lead on security and logistics, but being seen as too inflexible for the needs of an EVD response, while the IFRC has taken a strong technical lead on EVD, but has been seen as "inexperienced" in such a complex conflict setting. This led to tensions and restrictions on the scale-up of the operation in the early days, but has improved through better communication, experience of working together and personal relationships in the latter half of 2019. Engagement with the NS has been challenging throughout, as the NS has had limited capacity and has not developed counterparts in this operation, particularly at HQ level. However, branches in Equateur and North Kivu have built their experience and capacity through learning by doing.

The IFRC has had challenges with its structure – including the clarity of roles, responsibilities and capacities between Geneva, the RO and the CO in this level "Red" context. There have been serious gaps in HR/delegate deployments for this tricky context and a high turnover of short-term surge missions to maintain the response over a long period of time. This has affected continuity and has seen a high burn-out rate. In addition, there were serious challenges at the outset, with gaps in deployments of key positions including Health, Finance and Logistics Coordinators, leading to gaps in the provision of these services and heavy pressure put on technical delegates to cover multiple functions. Finally, the challenges in staffing and lack of capacity around resource mobilization, led to missed opportunities in accessing strategic new funds and led – alongside the lack of clear real-time financial information - to the financial crisis that hit the operation in Spring 2019.

All of the above make the operation in DRC a critical response that deserves the IFRC's attention for the remainder of the outbreak and provides a wealth of learning for future outbreaks in the Africa region. We recommend the IFRC carries out a formal final evaluation of the response.

Lastly, despite all the challenges and lessons learned, we must not forget the immense impact the RCRC Movement had through its considerable and joint operation in Equateur and eastern Congo. By the end of 2020, the Movement had conducted over 19,000 safe and dignified burials with an 86% overall success rate, reached over two million people with Infection, Prevention, and Control services, established a state-of-the-art community feedback mechanism, which ahd collected and analyzed over 530,000 comments from the community, and reached over two million people with risk communication messaging on Ebola. Despite the challenges, the Movement has been a key and considerable player in bringing the 9th and 10th outbreaks under control. Let us learn from the past to avoid repeating mistakes while remembering the considerable impact our organizations have had on millions of lives.

Red Cross volunteers conduct a burial in Bunia, DR Congo (IFRC/Corrie Butler)

Annex 1 – Synthesis of Key Findings from major evaluations of the Ebola Response in West Africa (2014 – 2016)

1. Duty of care for well-being of staff and volunteers It proved vital to have a clear "Duty of Care" for staff and volunteers - out of 488 deaths of health workers, only 4 RCRC workers were lost (with 10,000 volunteers active at the height of the response). No SDB team members were lost. The one area that was highlighted as needing far greater prioritisation, was Psycho-Social Support (PSS) for the staff and volunteers. • As mentioned above**, CEA** was a vital element for staff and volunteer well-being, to ensure that RCRC services were well understood and recognised by partners and communities, but also because local staff and volunteers came from those very communities, whom they wanted to "save" – this was linked to their motivation. • **Safety from EVD** was a top priority. It was important that PPE and SDB kits were secured early in the operation and that training was also provided early for staff and volunteers. Also, that there was attention given to the quality of protection standards, equipment, (re)training and supervision. There is a need for both IFRC and NSs to have plans in place for dealing with staff / volunteer deaths and for supporting their families. • **Physical safety** was also a risk in hostile communities or in areas of tension. Firstly, it is important that all volunteers and staff have appropriate identification / visibility equipment to be seen as RCRC (see link to CEA). However, it is also important to monitor the levels of risk, through monitoring systems and clear risk thresholds for suspending activities. Good cooperation with the Govt and other agencies is also key to monitoring and sharing information, and to have access to Govt or police if needed. There was a recommendation that the operation should have a security delegate. • **PSS –** It should be a priority to have a comprehensive plan for PSS for all staff and volunteers. This could include ensuring there is pre-existing capacity for PSS support (as part of normal duty of care), or if not in place, should include early mainstreaming/prioritisation, training (incl. on EVD specific issues of risk and stigma), and support for real PSS counselling not just awareness raising. There was recommendation that there should have been a PSS delegate(s) on the initial FACT deployment. • **Moral support** and recognition for staff and volunteers and the pressures they are under, was a very important aspect of the response. More could have been done to consider support programmes or non-monetary incentives (certification, NFIs), and to reinforce understanding of fatigue and pressure on staff / volunteers and to recognise their ongoing work. Prompt payment of incentives is also important • **Recruitment and retention of volunteers** was very difficult for the NSs in the EVD response, due to the risks and stigma, but also due to the NSs' weak volunteer management systems. Also, the sheer volume of volunteer support needed by the response was hard to build quickly and to sustain. By the end of the outbreak in 2016, the RCRC had trained and deployed 10,000 volunteers across the 5 pillars of intervention. NSs needed much more support to set up and manage comprehensive volunteer policies, systems and database – volunteer management support person would have been useful. There was also a need for support to plan for longer-term support, transition or exit for these active volunteers **PSS was also needed for communities, particularly given the needs of widows, orphans, and survivors, and others who had lost security, dignity, food, shelter and livelihoods, as a result of Ebola. This was a role for the SDB teams to provide a level of PSS during their work and linked to the later re-integration of EVD survivors and to longer-term recovery or livelihoods planning.**	*"It proved possible, with the right approach to conduct a large intervention in dangerous epidemic with large number of personnel (staff and volunteers), with very few lives lost* ". *"In Sierra Leone RC, they used a rotational assignment of volunteers on the SDB teams to manage the work and paid of a risk allowance for SDB and Social Mobilisation teams. Volunteers were covered by both the IFRC insurance system and a local insurance company to support wellbeing."* *"However, the psychological needs of personnel were too often an after-thought. There were many areas that needed consideration – motivation, stigmatisation, criticism, shame, stress and emotional demands, including fear, grief and denial. This was a lesson not picked up from earlier epidemic responses*
2. Value of "deep", two-way community engagement and understanding The most emphasised finding was on community engagement, and the importance of moving beyond targeted messaging and communication with communities, to ensuring real community understanding of EVD and the RCRC interventions and enabling communities to change their own behaviour in response to the different threats e.g. seeing the consequences of traditional (burial) approaches and countering unfavourable myths around SDB. This had happened in West Africa but had been slow to engage and understand community perspectives and scale up. At the outset (2014), communities learned from their own experience and from models proposed by the RCRC and others – after that success was redefined from "no additional cases" to "population adapting healthy behaviour". • A move from NS role in social mobilization to "real CEA" and adaptation of messaging to the changing context	*"The coverage of communities with key information on EVD was well planned and targeted…the strategic coverage of communities enabled most people to access key information on EVD, which assisted them to make informed choices about their safety and contributed significantly*

• Need to anticipate and counter-act reactions, rumours and myths in the early stages (e.g. to arrival of foreigners in PPE, spraying and taking away the sick and dead). The growth and impact of these myths can be anticipated and clear messages set up to counter-act them. • The importance of two-way communication, including active listening, mutual understanding, shared goals and genuine participation and empowered engagement or "deep CE". Communities starting to adapt their behaviour more quickly and at scale and agencies followed, finding new approaches closer to local values • Teams worked with trusted community leaders to provide culturally appropriate interpretations that supported safer behaviour. These people should be included in planning etc., however, there are risks in this that need to be well managed. • A need to better differentiate between diverse communities – between remote rural and over-crowded urban communities, or for specific groups, such as women or the disabled. There were few findings of specific engagement or adaptation of approaches for vulnerable groups. • Opportunity for more individual behaviour change communications and more spent on mass media awareness, which was underspent in W.Africa. • There are many opportunities in the complex levels of such an operation (between communities, volunteers, branches, HQ, and international staff), so it is important to look at communication along all the "links of the chain", to better identify and address misunderstandings. • Although coordination in the response was generally good, there was a stated need for greater inter-agency coordination around EVD messaging and CEA • CEA was also vital for staff and volunteer safety and security (see point 2). • Need to do more from the outset to convince staff and volunteers of the critical nature of CEA and to help build capacity. PSS staff were good at engaging with communities as they had no goal and could address complex, difficult emotional issues (see point 2). • There was also a need for the time and resources to prioritise the recruitment and training of large numbers of community volunteers to carry out this work. The volunteers should be inclusive of diverse groups	*to controlling EVD transmission".* *"To gain communities trust, the IFRC had to first find out how they were perceived by communities and then either fit (that) or influence it."* *"The tide started turning when communities started taking control themselves"* *"It was the engagement of communities themselves (to do the work) … and them seeing a big proportion of their neighbours dying … that modified their behaviour"* *"While the depth of CE increased substantially during the epidemic, the acceptance amongst staff and volunteers of the importance of CE trailed behind."*
3. IM was inadequate and struggled to inform learning This was a clear lesson from the EVD response around the weakness of IM to support the operation, which has clearly led to a major investment in IM in operations since. Linked to this, PMER was also limited in its role and capacity, and the operation was always chasing after data and analysis, rather than using this to inform strategic and operational decisions. There was a clear need to improve the capacity of PMER and IM to be able to provide real-time data/analysis and learning, to inform scenario planning and changes to the response • At the outset there were multiple streams of information, but it was in different paper, mobile and electronic formats. It would have made a real difference to have all project data in an electronic format and to use this to populate real-time dashboards. IM started to improve through this operation and to move towards real-time data capturing and analysis of the complexities of the response. IFRC needed to build more capacity to gather and analyse real-time data – systems like RAMP were present, but could have been better used – and to strengthen data analysis to inform decision-making at all levels (it has gone some way to do this). • For an epidemic response, it is important to have epidemic data to anticipate changes in the epidemic evolution, inform strategic decision-making and ensure the integrity of the data. Epi-data was particularly important to guide the SDB role. • NSs felt overburdened by planning and reporting for the response, including for donors, and needed IFRC support and training to guide them in PMER / IM work. • IFRC needs a much more robust M&E system to track operational efficiency and facilitate adaptive management of the epidemic response (linked to the need for stronger IM systems to collect and analyse data). The RTE noted the lack of baseline information, particularly for the later stages of the response, and the need to set up a strong Results Based Framework and output / outcome indicators, to be able to support effective planning and targeting of vulnerable groups. This is particularly critical in a volatile epidemic response of this kind. The M&E for the recovery should be more robust. There is a need for IFRC to speed up PMER scale up for emergencies and to focus beyond reporting on accountability and learning.	*"PMER seemed to have the same restricted role as in previous emergencies, trying to provide adequate data for after-the-fact reporting, rather than proactively providing models to improve real time data"*
4. The effective set up and delivery of the five-pillar epidemic response The IFRC believed strongly that all 5 pillars of the response (see below) were needed and must work well together to stop transmission – "if one pillar is weak, then no amount of curative services will end the outbreak". However, this did not mean that RCRC had	*"The five pillars of the RC interventions*

to do all 5 pillars itself, but that all needed to be in place. The RCRC "should focus on the areas where it could best add value in that context." **i)** **CEA and social mobilisation** - CEA has been covered in point 2 above, however, it is important to stress that strong CEA approaches were essential to all 5 pillars and helped turn the response around, including in remote areas. Quick recruitment and training of volunteers was vital to deliver in CEA, as well as against the work of the other 4 pillars, particularly SDB and PSS, meant that volunteers working in the different pillars were inter-dependent and needed to cooperate well together. **ii)** **Safe and Dignified Burials (SDB)** - Govt figs said 60 – 80% of deaths were linked to traditional burial practices, therefore the SDB pillar was critical and clearly avoided large numbers of secondary infections and deaths from unsafe burials. The IFRC's early interventions and major role in SDB was therefore key to saving lives and was also a good fit for the RCRC. IFRC had the acknowledged lead on SDB and was seen to deliver it well and provide good coordination (standards, info, decisions and SOPs). SDB was difficult in this context, both on a technical and human / cultural level, with challenges linked to tradition and acceptance of new practices. This took time to establish, when ideally SDBs need to be set up quickly. In future, it would be advisable to consider formal and informal traditions and attitudes to burial, as early as possible (e.g changing the appearance of body bags, need for family trust and farewells, tight deadlines for burial and the burying of those without EVD). **iii)** **Psycho-social Support** - PSS had a broad role to play in the response, covering both community PSS and PSS for staff and volunteers, but it took too long for PSS to become effective and mainstreamed across the response. PSS also became vital for survivors and survivor communities. It is important to ensure capacities in PSS are in place across the wider organisation for such a key activity in future, including PSS human resources, funding and integration with other services. There was also a recommendation to use the RCRC Reference Centres more, particularly the one for PSS. **iv)** **Surveillance and contact tracing** - The move from "surveillance" to "active contact tracing" came quite late on. However, with a clear link between active tracing and survival rate, this should have been done earlier. The slower start up on CT and PSS, had an impact on the spread of the disease and the stigma around infected persons and survivor reintegration. Again, CT is a good fit for NSs, with their wide volunteer network, though it also needs adaptation and targeted involvement with communities, and it was recommended that the RCRC volunteers could have taken on a more proactive role in community surveillance, primary CT and PSS around the SDB process, as more work in this area was vitally needed. Inter-agency coordination and IM was a weak link, limiting effective CT. v) **Case management and treatment** - IFRC increased its involvement in case management (running ETCs later on), but this is a less obvious fit and there should be a realistic assessment of the skills / resources required and the added value provided by the RCRC, to inform decisions to undertake this role in future. Under clinical care, Liberia RC used a "hub system" to group branches together to work with communities to understand the requirement for isolation in clinical care and provide Community Protection Kits and awareness of how to use them. IFRC's strongest role was in the pre-deployment training for RCRC health workers on how to work in a safe manner in ETCs and other environments. A focus on longer-term interventions and a need to move beyond the 5-pillar approach was required from quite early on (healthy behaviour, assistance for survivors and recovery). The sustainability of the 5 pillars was not clear cut, but some work in CBS, CBHP, FSL and preparedness programming continued within the NSs and contributions were also made to national level health protocols and guidance used by MOH (IDS&RS). Work on recovery and FSL was late to transition and not so well supported.	*contributed to save lives and avert deaths"* *"Barriers to (community) acceptance of SDB go beyond cultural practice and understanding. Factors include how the burial occurs, family involvement in body preparation and burial, feedback to the family on the EVD status of the deceased (the majority did not have EVD) and providing documentation to assist the families in legal matters".*
5. Need for greater technical and human resource capacity The operational side of the response was strong, but the RCRC's technical capacity in epidemiology and public health was weak, which limited its ability to analyse, adapt and anticipate the changes in the epidemic, and to therefore anticipate, prepare for and resource the necessary actions. It limited the timeliness and proactivity of the response, as the RCRC was dependant on the epidemiological data of others. This included a need for greater technical depth in the Regional Ebola Unit, particularly in public health, IM and communications. Lack of public health and health preparedness in the NSs, exacerbated	

this problem in the response and in the later recovery planning, which became disconnected from the NSs's mandates and capacities. A recurring problem was the delaying in identifying, recruiting and sustaining appropriate HR, whether that be for international delegates or for NS staff or volunteers. The delays in finding the right technical qualified and available HR with the right language skills, particularly in the health and IM sphere, impacted on a speedy scale up and on the smooth running of the operation and is still a challenge in the current outbreak in DRC. NS staff also became exhausted and more needed to be done to provide support, rotation and PSS.	
6. Scaling up of the RC response followed rather than anticipated the growing threat An EVD or other epidemic response has a very different and unpredictable pattern compared to a natural disaster. The evolution of the epidemic was unpredictable and without good real-time, epidemic data, it was hard to anticipate changes and be proactive in the response, rather than running to keep up. • There was a clear trend in RM, where resources were very limited at the outset and even through the peak of the epidemic, but much greater after the peak had past (3 to 30 time as much as at the peak or at the outset). This would be a future lesson to front load the RM approach. Much depended on how much donors were likely to support the EAs, therefore the planning started slowly, while media and donor interest built. There might be a need to be more aggressive about showcasing the situation and work of the RCRC from the outset and in trying to anticipate reputational risks. • There was a need to anticipate planning etc particularly for vulnerable groups (eg in urban areas) and for longer-term consequences, such as loss of family / orphans, loss of health care workers (EVD and wider health care), survivors needs (stigma, health care and income, land rights, missed education, economic & livelihoods loss, environmental impact, restriction of movement etc.). There were similar issue around the lack of adaptation of response in urban areas • See above for delays in HR	
7. Timeliness At the outset, most of the response activities were implemented by the NSs. However, in 2014, the IFRC managed to scale up its operation and had 94 global surge personnel in the field before the UN had declared L3. It was one of the few agencies operating in all 5 pillars from the early stages and had a strong lead on SDB and CEA. There were, however, some areas where timeliness was a problem: • Reports found that IFRC's decision-making was slow and recommended that the IFRC identify mechanisms and procedural changes to be ready for future epidemics, including setting up a global cell or Movement steering committee. As there were also timeliness issues relating to engagement with Management / Support services, it was also recommended to include these services as early and fully as possible. • There were also delays in the work of the NSs and the national agencies, who were slow to understand and act on epidemic data at the outset. Apart from messaging, most of the activities of the NSs started to reach scale when the epidemic was already in decline, including targeted CEA. The scale up of the response therefore had more impact on ensuring the epidemic did not worsen or was effectively reduced. • In turn, international agencies were also slow to respond to warnings and scale up a comprehensive, multi-sectoral response model focused around community engagement. The relatively early presence of the IFRC, with substantial activities from March / April 2014, was seen to have been successful in reducing infection risk and saving lives -an earlier substantive response would have likely limited the epidemic even earlier. Continuing and increasing activities after the end of 2014 was seen to have kept it under control. Overall, the response was seen as not proactive enough in relation to the changing situation. • The resource mobilisation (RM) was also seen as slow and behind the curve of the epidemic. Only a small percentage of the amount finally raised had come in by October 2014, when the epidemic was already slowing. At the same time, funding peaked after the epidemic slowed down, but was available for activities to bring the outbreak to a close. The continued level of support, even after the epidemic had died down, helped to avoid the potential resurgence of the disease in new or existing areas. However, there was clearly a lack of flexibility and responsiveness around RM and a need to advocate for earlier, more flexible funding, as well as to support NSs to become more active in integrating with government and agencies / donors, to receive in-country funding. There was also a recommendation to include	

PRD in surge and response planning. Improvements in IM were also seen as better supporting fundraising. • There was no evidence of any meaningful exit planning	
8. **Limited mention of planning and capacity building of the NSs**. While there was evidence of increased capacity in the NSs in the areas of health and emergency response over the period of the response, there was limited obvious support for and progress in OD[13]. There was relatively little investment in NS systems and processes to improve and speed up structures, systems and procedures in HR, volunteer management, PMER, finance, logistics etc. to respond to changes in the response. There were challenges in reaching beyond HQ to branches to further support their capacity and future preparedness. It was recommended that in future there should be more sharing of staff and offices between the NSs and IFRC, to build info sharing and capacities. Also, that an OD person with response experience, should be sent to plan OD support in emergencies, volunteer management and retention, and the transition to recovery / exit planning, to ensure alignment with NS mandates and capacities. Given future financial / audit issue, a key recommendation was around the need to reinforce the financial systems in NSs dealing with such sudden funding increases, to protect staff and the RCRC reputation. This could be maintained through using more regular and planned internal audit checks.	
9. Many lessons were not learned Many of the lessons from the EVD response, have been seen in other operations before and since. It seems as if IFRC and the wider RCRC is not willing or able to address or learn from some of these recurring issues. The Ebola RTE recommends that the IFRC investigates why the organisation is not able or ready to learn some of these key, repeating lessons from operations and to build cross learning from other epidemic responses.	
10. Coordination There was limited information on coordination in the overall findings and recommendations, but overall, it was seen to have worked well, with good coordination across the board with Government, MoH, and other actors (UN, INGOs). The RCRC was actively involved in district surveillance plans, reframing community messaging, coordination with district health management teams and community health workers (CHWs). The IFRC also established strategic partnerships with key health actors, which improved the response and set up improvements for the longer-term. There was some discussion that more could have been done on proactive humanitarian diplomacy (HD) on health and EVD issues. NSs had good relationships with their Govts and populations before the response, however, some aspects of the huge response and damaging EVD myths, created problems for NSs afterwards and needed a rebuilding of trust.	*"Throughout the response, IFRC and the NSs have been active members of the coordination set-ups in all relevant pillars, both at the central and district / county levels."* *"IFRC could have done more to ensure other actors understood and acknowledged the scale of the (NSs?) contribution … and their value to other agencies and governments."*
11. Logistics and Finance There were some references to the fact that the operation had insufficient numbers of vehicles, which delayed activities, particularly in hard to reach areas. Also, that the vehicles from the IFRC vehicle fleet in Dubai were slow to arrive. Lack of warehousing also affected procurement and distribution. There was also reference to the need for IFRC SOPs for finances in emergencies and for more to be done to help NSs prepare for and use IFRC financial procedures, including support and training	

13 Of note that there were subsequent issues with the financial capacity and integrity of these NSs. Fraud risk a real possibility in high level, unpredictable epidemic response

Annex 2 – Key Informants Interviewed

Position	Sector	Name
Deployed and CO Staff		
Ops Manager	Coordination	Antoine Belair
Ops Manager	Coordination	Nicolas Boyrie
HEOps	Coordination	Florent Delpinto
HEOps	Coordination	Chiran Livera
Ops Manager	Coordination	Balla Conde
HoCO	Coordination	Momodou Lamin Fye
Field Co	Coordination	JB Lacome
Field Co	Coordination	Thibaud St. Sebastien
Security delegate	Security	Denis Duffaut
Health Co	Health	Tiina Sarikoski
Health Co	Health	Gwen Eamer
Health Co	Health	Kate Learmonth
Health Co	Health	Marie Munoz
CEA Co	CEA	Eva Erlach
CEA Co	CEA	Ombretta Baggio
CEA Co	CEA	Sharon Reader
SDB Co	Health	Virgil Atchia
SDB Co	Health	Hubert Dedegebe
Admin Co	Admin	Laadi Perrtiangha
HR Co	HR	Khaisro Khan
PMER Co	PMER	Olta Ndoja
IM Co	IM	Henk Hoff
Nairobi Staff		
Regional EVD Co	Coordination	Nicole Fassina
Deputy Regional Director	Coordination	Robert Kaufman
Head of Logistics	Logistics	Rishi Ramrakha
Logistics delegate	Logistics	Nikola Jovanovich
Head of Finance Africa	Finance	Umadevi Selverajah
Head of PRD	PRD	Franciscah Kilel
Head of Comms Africa	Communications	Euloge Ishimwe
Regional IM	IM	Lucia Robles Dios
Geneva Staff		
Director	Coordination	Pascale Meige
Director	Health	Emanuele Capobianco
Senior Officer - PRD in Emergencies	PRD	Diana Ongiti
Senior Officer - Comms	Communications	Laura Ngo Fontaine
DRC RC Staff		
Ebola Coordinator	Coordination	Dr. Jacques Katshishi
ICRC Staff		
HoSD NK (previous)	Coordination	Luca Bigger
Supra Coord.EVD (previous)	Coordination	Olivier Jenard
Geneva Coord.EVD (previous)	Coordination	Juerg Eglin