



Ebola Crisis Appeal – Response Review

Disasters Emergency Committee (DEC)

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Great effort has gone into producing an accurate and balanced report. We apologise for any inaccuracies, should they have occurred, and would be pleased to rectify them if needed. Please contact Pauline for rectifications.

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List of abbreviations

CBO	Community-based organisation
CCC	Community Care Centre
CSO	Civil society organisation
DERC	District Ebola Response Committee
DPO	Disabled People's Organisation
MoHS	Ministry of Health and Sanitation
NERC	National Ebola Response Committee
NGO	Non-governmental organisation
WASH	Water, Sanitation and Hygiene
WHO	World Health Organisation

Executive summary

This is the review of the Ebola Crisis Appeal Response in Sierra Leone of the Disasters Emergency Committee (DEC) that unites 13 of the largest UK humanitarian charities¹ to raise funds in response to major international humanitarian crises.

The review team consisted of an external team leader, a DEC member representative and the DEC chief executive with complementary roles and expertise. Fieldwork took place from 8th to 18th February. The team visited Freetown and Western Area, Port Loko Bombali, and Tonkolili. We used semi-structured questionnaires to conduct 19 focus groups in the communities visited. Altogether we spoke with 150 female and 148 male beneficiaries, 30 male and 11 female NGO staff, 11 government staff and 12 partner staff and two members of the security forces.

Specific areas of enquiry of this review are:

- Community engagement
- Programme relevance
- Organisational learning and capacity development.

These priority areas were selected based on the terms of reference provided by DEC and discussions with DEC members at an inception meeting in London before the field visit. Visits focused mostly on DEC-funded member projects, although the review team also saw programmes that were not funded by DEC and met with some people who were not benefitting from DEC-funded projects.

Twelve DEC member agencies are responding to the Ebola crisis in Sierra Leone, Liberia and Guinea with DEC funds, with some members operating in more than one country. Nine member agencies are responding to the Ebola crisis with DEC funds in Sierra Leone, where 53% of the funding has been allocated. The Ebola Crisis Appeal is the first disease-specific emergency appeal by the DEC, raising a total of £37 million.

Situated within a broader context of a late, politicised and medically-focused international response, DEC agencies concentrated on social mobilisation to address the socio-cultural determinants of the Ebola crisis. In the early months of the overall response national coordination in Sierra Leone was weak. Traditional authorities, community-based organisations and local structures were generally underutilised. DEC members had never participated in a large Ebola response before, but they did have experience with social mobilisation in humanitarian and development contexts, including disease outbreaks, which underpinned an approach that can be characterised as a community-based public health response.

DEC members have worked through the national and district-level Ebola response coordination mechanisms. Members work on social mobilisation, as well as the provision of services such as safe and dignified medical burials, psychosocial support and the distribution of material support to quarantined households, survivors, and orphans. Those that have specific local WASH expertise, such as Oxfam and CARE, contribute specific WASH elements that enable people to act upon the information provided by the social mobilisation teams, and improve access to services such as WASH facilities in Community Care Centres.

¹ ActionAid; Age International; British Red Cross; CAFOD; CARE International UK; Christian Aid; Concern; Islamic Relief; Oxfam; Plan UK; Save the Children UK; Tearfund & World Vision

All except one of the DEC agencies had existing programmes and partners that could organise groups and individuals to respond to Ebola in Sierra Leone. Manpower for an impressive social mobilisation by DEC members also came from teachers and students as schools were closed. DEC members and their partners rely predominantly on local leadership structures, such as Paramount Chiefs, to inform lower-level traditional political authorities and community-based structures.

DEC members developed a range of relevant interventions to address the many new problems that arose during this epidemic, such as graveyard management, contact tracing, non-food item distribution to quarantined households, and social support for Ebola survivors reintegration in to communities. Agencies have adapted quickly, making great efforts to learn about and follow good practices such as safe and dignified burials. They have gone out of their comfort zones to meet the needs of people affected by the Ebola crisis, while successfully protecting their staff. NGOs had to learn to address behaviours that had not been a problem before, such as touching deceased people. There was a need to think about vulnerability differently because some of the traditionally vulnerable groups – children under five for example – were not necessarily directly more vulnerable to contracting Ebola. Yet Ebola also reinforced some well-known vulnerabilities, such as homelessness among existing target groups, including widows and orphans.

At the moment there is a risk of complacency and mobilisation fatigue in Sierra Leone. People are tired and inconvenienced by quarantine and other restrictions. Some families with Ebola infections have not only lost family members but also had all their belongings destroyed to avoid contamination. Packages for the survivors are shared among whole families. There is a need to strengthen linkages between mobilisation and allocation of existing resources and benefits, working with volunteers to provide relief items in addition to their communication and referral role. Social mobilisers also want to offer people concrete support and are already changing their mission to do so informally. The review took place when mobility restrictions had been lifted. But the number of new cases rose shortly after this and as a consequence the President reintroduced mobility restrictions on 27 February 2015.

The elderly have been disproportionately affected by Ebola² and should receive more attention in Phase 2 of the DEC response. Elderly people traditionally play important roles in care for the sick, undertaking and burials. The elderly are important because the increased infection rates that led to renewed mobility restrictions on 27 February are attributed to unsafe burial³. The needs of elderly people need to be addressed in a specific way to counter the relevant high-risk behaviours they have taken on in response to Ebola. They may also have caring duties for Ebola orphans while their ability to provide financially is limited. Elderly people who live alone may rely on food, financial remittances and other support from their children or extended family. When these support networks are disrupted – due to Ebola deaths, Ebola-related travel restrictions or food shortages – the elderly are affected.⁴ The community-wide mobilisation

² For Sierra Leone, there were an estimated 327 cases per 100,000 among those over 45 years old compared to 223 per 100,000 among those aged 15-44 and 96 per 100,000 aged 14 or under (from the World Health Organisation *Ebola Situation Report* of 28 January 2015: <http://ow.ly/MaTRR>).

³ NERC Ebola Outbreak Updates, 5 March 2015.

⁴ http://www.ebola-anthropology.net/key_messages/ebola-and-older-people-in-sierra-leone-liberia-and-guinea/

efforts during Phase 1 include the elderly, but further targeted approaches would be appropriate.

Another area that needs concerted attention in Phase 2 is sexual and reproductive health. Sierra Leone has one of the highest maternal mortality rates in the world, which is linked to high prevalence of teenage pregnancies, as well as Female Genital Mutilation (FGM), which is extremely common in Sierra Leone, and a range of other sexual and reproductive health issues. Schools have been closed for almost nine months, prolonging the school holiday when teenage pregnancies peak, and transactional sex can thrive in an economic crisis. Sexual and reproductive health needs could receive more attention in Phase 2 and perhaps be linked with emergency education efforts to help girls return to school.

The specific needs of people with disabilities with regard to Ebola are not fully known. A diverse group, disability should not be equated with vulnerability. Some people with disabilities may need additional attention while others may not, so assessments are therefore needed. As disability is a theme for DEC members, there is a need to explore requirements with agencies that are specialised in disabilities – including DPOs – if and what they can do in Phase 2.

Child Ebola survivors and members of burial teams are suffering particularly from persistent Ebola-related stigma and need continued support. Stigma is related to socio-economic fears. Relief packages can help Ebola survivors to integrate in a family but integration requires more than packages. Social protection – especially for orphans and widows – will need attention in Phase 2. Burial team members are optimistic that their family will welcome them back if they can show that they are healthy and earning a living. An unintended consequence of the stigma that burial team members face is the creation of new ‘families’ of colleagues supporting each other after being rejected by their own families. Psychosocial support for these teams by DEC members is likely to have made a positive contribution to the creation of such practical and emotional coping mechanisms. Quarantined households did not report feeling excluded because of Ebola, but they do worry about poverty, hunger and social dependence after quarantine.

Between the Ebola response and the recovery there is a ‘black box’ called transition. Ebola eradication is clearly desirable, but the risk of further micro-outbreaks will require a different surveillance and response system. Navigating this transition period will continue to be challenging. The volunteers that continue to raise awareness in communities after teachers and students return to school will need support to be able to continue to motivate and mobilise people to stay vigilant.

Recommendations

Rec 1: Reinforce and strengthen linkages between emergency mobilisation and ongoing activities

- Strengthen transparency and feedback mechanisms to ensure accountability in the allocation of resources to beneficiaries.
- As social mobilisation efforts are geared down, direct those that continue towards identifying the remaining gaps in humanitarian assistance to ensure that everyone who still needs urgent help (kits, packages and other resources) receives it.
- Take a strong stand on defending rights-based approaches. Strengthen efforts to organise and inform people as both individual beneficiaries and citizens to enhance the demand for bottom-up and transparent coordination of available resources, rights and benefits.

Rec 2: Capacity building of reduced social mobilisation volunteer workforce

- Build capacities, skills and provide psychosocial support for the remaining social mobilisation volunteers to motivate and equip them to continue working against Ebola complacency with fewer people after 31 March 2015 when the students and teachers return to school.
- Provide certificates of medical clearance to leaving volunteers.

Rec 3: Rapid and intense focus on mitigation, resilience and livelihoods

- Replenish loan and savings programmes at local village levels.
- Replace working tools.
- Consider community-based recovery and resilience-building programmes including
 - Roads
 - Water
 - Play spaces.

Rec 4: Strengthen social protection

- Family and kinship-based support for Ebola orphans, the elderly and widows.
- Engage with organisations that are focused on disability, including Disabled People's Organisations, to reach the disabled.

Rec 5: Support education

- Use DEC funds to support access to education, especially for girls, by providing:
 - Segregated WASH facilities in schools.
 - Emergency funding for uniforms and books.

Rec 6: Improve appropriate engagement with the elderly

- Develop social mobilisation activities that address the specific behaviours which put elderly people at risk of Ebola. Communicate with the elderly in culturally-appropriate ways, working with peers where possible.

- Consider peer education by mobile teams, working with respected and active elderly people to communicate with peers, as well as working with elderly members of burial teams for social mobilisation in Phase 2.
- Tailored and targeted mitigation in community action plans.

Rec 7: Support reintegration of burial teams and grave diggers

- Provide a standard package and a certificate of medical clearance for all the burial team members at the end of the project.
- Support burial team members with appropriate livelihood options building on existing skills and capacities.
- Extend and expand the psychosocial counselling for them.

Rec 8: Strengthen sexual and reproductive health

- Develop training and opportunities in livelihood activities for pregnant teenagers, teenage mothers and boys who have dropped out of school to promote economic empowerment and link this with regular, non-judgmental discussions on sexual and reproductive health and access to contraceptives, ideally through the existing primary health centres.
- Provide training, tools and other support to community-based organisations to conduct group discussions with parents and community leaders to challenge double standards for teenage girls and boys, correct misconceptions about contraceptives and support parents to talk to their children about sex and contraceptives in a time of Ebola.

Rec 9: Support civil society and community-based organisations to take back the spaces and places that these groups were intended for

- Community-based organisations can play important roles in governance issues in the transition phase and economic recovery. DEC members can support them to restart some of their old functions, while maintaining their Ebola mobilisation skills.
- Develop the capacity of civil society and CBOs/ faith-based organisations (FBOs) to continue sensitisation around Ebola.
- Recognise the wide influence that faith-based leaders have in the region and continue to involve them in Ebola prevention, tackling stigma and the provision of psychosocial support to all members of their communities.

Rec 9: Document key lessons and innovations learned during this Ebola response

- Working together as DEC agencies, ensure that specific lessons from the Ebola response are documented and communicated to the relevant authorities for enhanced preparedness for future and similar outbreaks (e.g. improved and climate-appropriate CCCs).
- Establish early warning systems that include all stakeholders, especially those who are working at the lowest administrative and village levels (i.e. faith leaders, secret society members, traditional healers and village chiefs).

- Acknowledge the important roles that community-based actors have played in the outbreak. Continue working with them in future outbreaks and build community resilience structures and monitoring activities.

1 Introduction

1.1 The Ebola Crisis Appeal: Rationale

The Ebola outbreak started in Guinea and came to light in March 2014, although it is thought the first transmission from fruit bats to humans may have taken place as early as October 2013. On 8 August 2014, WHO declared the Ebola outbreak in West Africa a Public Health Emergency of International Concern and on 19 September 2014, the UN Mission for Ebola Emergency Response was established. Last October the UN called for increased funding and reiterated the WHO's warning that the outbreak had to be brought under control within 60 days of 1 October or it would overwhelm the capacity for response.

At the time of the launch of the DEC appeal on 29 October 2014, almost 5,000 people had been killed by the disease, and infection rates were doubling every 2-3 weeks, varying from country to country. Case fatality was put between 60% and 70%⁵ and worst-case predictions stated there could be 1.2 million cases by January 2015 without rapid intervention.

There is wide consensus among UN agencies, international NGOs, media observers and academics that the overall international response to Ebola was late, and much has been written about the reasons for this delay and the politicised, medically focused and, at times, sensationalist approach to Ebola.⁶ DEC members, most of whom have long-standing programmes in the West Africa region, recognised that Ebola was more than a medical emergency.⁷ Discussions between DEC members and other key players, such as MSF, confirmed the need to address the socio-cultural determinants and structural inequities that shaped both the course of the epidemic and its impact. Local understandings of disease transmission and the risks associated with certain behaviours would be crucial for an effective response in the countries involved. Social mobilisation would be key in reducing the spread and socio-economic impact of Ebola.⁸ This informed the DEC appeal which can be categorised as an appeal for a community-based public health response with a focus on social mobilisation.

“This is not a medical emergency but a humanitarian issue.” (Oxfam representative in Sierra Leone)

⁵ There was and remains a considerable level of uncertainty over the exact numbers but as testing has improved, figures have become more reliable.

⁶ For example, see *The Guardian* 9 October 2014 (<http://ow.ly/MabIn>) and 2 December 2014 (<http://ow.ly/MabtF>), *The Washington Post* 9 January 2015 <http://ow.ly/MabTa>, BBC News 17 October 2014 (<http://ow.ly/Mac3g>) and *Tech Times* 26 February 2015 (<http://ow.ly/MacbW>).

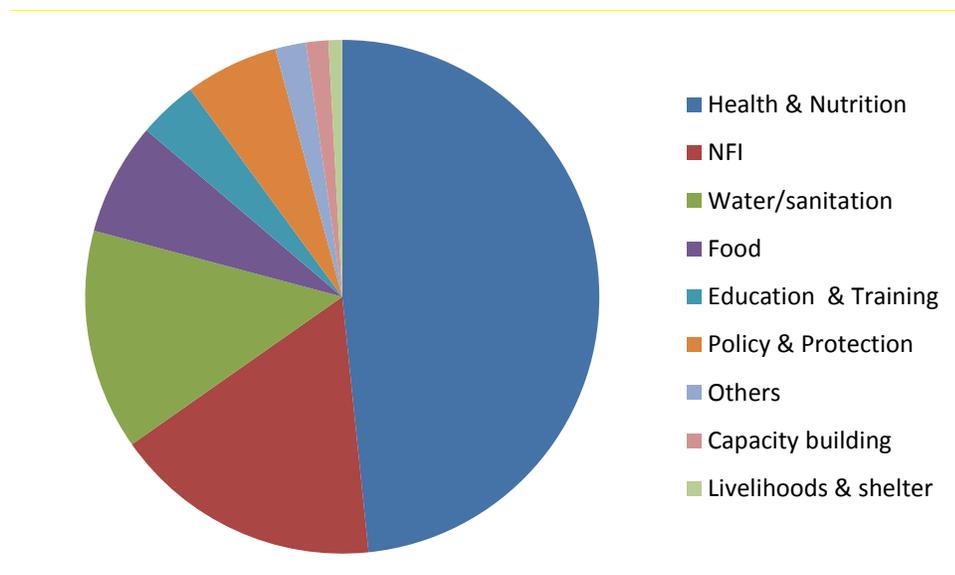
⁷ With the exception of Save the Children, the majority of DEC members did not have the capacity to mobilise medical teams to treat sick patients. They did, however, have relevant experience in community-based mobilisation and organisation as well as Water, Sanitation and Hygiene (WASH).

⁸ For example, see Devex 13 February 2015 (<http://ow.ly/MdlYD>).

The DEC appeal raised £37 million. The response is divided into two phases: Phase 1 runs for six months and Phase 2 for 18 months. The confirmed first allocation was £13,000,000 with a planned Phase 1 Budget of £9,698,187. Under DEC rules this is subject to revision at the three-month stage.

Twelve DEC Member Agencies are responding to the Ebola crisis in Sierra Leone, Liberia and Guinea with DEC funds during Phase 1, some in more than one country. Nine member agencies are responding with DEC funds in Sierra Leone, six in Liberia and two in Guinea.

Planned activities for Phase 1, Sierra Leone, by expenditure



Agencies planned to use 70% of the first allocation over the first six months; 53% is destined to be spent in Sierra Leone, which is where most organisations work. Therefore this review focuses on Sierra Leone.

1.2 Objectives of the DEC Response Review

This review aims to capture the broad picture of the NGO response to the situation. It is neither a Real Time Evaluation nor a monitoring mission on the activities of individual DEC members and their local partners.

This review of Phase 1 of the Ebola Crisis Response was conducted in February 2015 prior to the submission of plans for Phase 2 in order to gain an overview of the initial response and to learn lessons from this for the next phase. The review explores three broad areas:

1. Community engagement
2. Programme relevance
3. Organisational learning and capacity development.

Gender, age and disability-related aspects of the response are also discussed as these are cross-cutting themes in all DEC appeals. Looking closely at the coordination of the overall

response in Sierra Leone, which was led from October by the National Ebola Research Centre (NERC), was outside the remit of the review.

2. Methods

This review uses a mixed methodology and participatory approaches to explore multiple levels of the response in Sierra Leone. It has been conducted in cooperation with DEC and its members to allow for DEC and its members to learn and provide input to the review. The review questions and sub-themes can be found in Annex 1.

An external team leader from the Institute of Development Studies (IDS) worked in an international and mixed gender team with the DEC Chief Executive and a DEC representative from Oxfam. DEC members and the team jointly agreed upon the scope and focus of the review in an inception meeting in the UK based on the TOR. The team received assistance from DEC staff in the UK and was hosted in Sierra Leone by Concern.

Fieldwork took place between 8 and 18 February. The team visited Freetown and Western Area, Port Loko Bombali, and Tonkolili.

The following methods were used in the evaluation:

- A desk review of initial programme proposals, Ebola briefings, updates and research reports by UN and other international agencies and researchers.
- Group and individual interviews. We conducted 19 focus groups with men, women, burial teams and the elderly and 36 in-depth individual interviews using semi-structured questionnaires. Altogether we spoke with 150 female and 148 male beneficiaries, 30 male and 11 female NGO staff, 11 government staff (all men except one) and 12 partner staff and two members of security forces.
- Context observations and accompaniment of staff and volunteers at work during key activities such as burials, contact tracing, social mobilisation at household and village levels, inspection of water sources, and the distribution of relief packages to various beneficiaries, such as survivors and quarantined households.
- Participatory Monitoring and Evaluation exercises on the knowledge and skills learned during the programme at multiple levels.
- Feedback and validation meetings with the DEC members in the UK and Sierra Leone to validate key findings, lessons learned, and recommendations.
- Revision of the draft report based on comments and fact checking by DEC members.

2.1 Ethical considerations

The review team has in-depth and hands-on expertise working with vulnerable populations in humanitarian and health emergencies. The agenda for the field visits was designed in close collaboration with DEC members' programme staff. The interviews were voluntary, anonymous, and confidential and the report does not put names to quotes.

2.2 Limitations of the review

- Time and budget limitations. The reviewers visited projects of all member organisations but only in Freetown, Port Loko, Bombali and Tonkolili.

- Lack of reliable data. Sites were closing during the evaluation while new hotspots emerged. Data are not always gender and age segregated.
- The review only looked at DEC-funded projects while agencies were doing much more besides.
- Conducted at a specific point in time, the research can provide only a snapshot of stakeholders' views, which are liable to change during different phases of the epidemic. Moreover, the Ebola response is in the midst of a major transition and the direction is unclear. Large-scale response systems had been established with thousands of people on hazard pay to do important work for the first phase of the response, but parts of that system is being dismantled and others are being developed with the changing context.

3. Findings

3.1 Strategy and coordination

Despite the sheer variety and number of governmental and non-governmental initiatives in Sierra Leone, national coordination of the Ebola response is widely reported to have significantly improved under the third national coordinating body since the start of the outbreak, NERC (established in October 2014 to replace the National Operations Centre). NERC recognises the social determinants of health and promotes a public health approach to Ebola in a national Ebola Response Plan, with the following five pillars amongst others:

- Case management
- Safe and dignified burials
- Surveillance
- Social mobilisation
- Child protection, gender and psychosocial support.

Other pillars and elements have been added over time, such as a pillar that included water, sanitation and hygiene. DEC members work across and within these pillars, which are vertically organised but closely inter-related at the practical level. Each pillar is headed by an agency which brings the different efforts of organisations together. UNICEF, for example, heads the social mobilisation team in partnership with the Ministry of Health and Sanitation.

DEC members have expressed their appreciation of the coordination and leadership of NERC, but they have also reported facing challenges related to coordinating with the authorities and working with many different partners and staff. Each partner organisation comes with its own expectations, agendas, personalities, idiosyncrasies, strengths, and weaknesses. Some DEC member agency international staff members arriving in Sierra Leone for the emergency response reported difficulties finding out where to go and who was in charge but staff that already worked in the country found it easier to navigate their way around.

Proposals for DEC-funded activities were requested by the coordinating bodies, NERC or its District Ebola Response Centres (DERCs). Members decided whether or not to accept the assignments proposed to them after consideration of their expertise, resources, and whether others would do it better.

Senior NERC figures told the review team that the role of NGOs including DEC members has been critical in making progress in the fight against Ebola. Many NGOs were able to step up and meet the needs of communities, working in areas outside of their direct experience. On the

other hand, the officials also criticised some “well-intentioned” NGOs of sometimes “picking whatever they want” in the selection of Ebola activities, although there is no evidence that this applies to DEC agencies in particular. We found no evidence of DEC agencies working without regard for the coordination channels.

The coordination of activities closer to the ground (below the level of the DERCs and the Paramount Chiefs) was reported as very challenging. People working at the district level in the different pillars were able to interact in daily meetings. At the village level there are many more actors, many of whom are mobile and cover different villages, and their interactions are less structured.

3.2 Community engagement

Question: Did organisations have sufficient socio-cultural as well as political and historical expertise to develop appropriate socially-integrated local responses?

DEC member agencies have clearly built upon their existing relationships and socio-cultural expertise to engage communities in the Ebola response. All DEC members except one have longstanding relationships with local structures such as credit and savings groups, child sponsorship villages, kids’ clubs, mothers’ clubs, HIV-positive women’s clubs, health volunteers and Primary Health Units. Examples of these being used in the Ebola response include:

- Christian Aid and its partner, the Sierra Leone Social-Aid Volunteers, have mobilised women in credit and savings groups or children in health clubs for Ebola prevention in villages and families.
- HIV-positive women supported by ActionAid have been reaching out to members in quarantine and make sure they have access to AIDS medicines.
- World Vision has built on expertise with orphans with additional interventions for Ebola-related orphans in both old and new districts.
- Oxfam has used staff from an established gender-based violence programme as mobilisers.

DEC members have enabled and supported communities to take action with individual Ebola prevention skills, as well as community action plans and material support. Restless Development, a young peoples’ organisation and partner of DEC-member Age International, helped communities develop community action plans that include preparedness.

One of the criticisms of the early responses to the situation was a lack of engagement with grassroots organisations and traditional authorities.

“International organisations were too busy engaging with each other to engage with Sierra Leonean CBOs. Paramount Chiefs were excluded.” (NGO representative, Freetown)

DEC members and their partners have relied on traditional Paramount Chiefs and DERC to inform lower-level political authorities and community-based structures and organisations. They also work with imams and pastors. Both used respective religious scriptures to reinforce and promote messages and essential information to help prevent the spread of Ebola.

The scope of the social mobilisation efforts by DEC members has been impressive, building on community knowledge built before the DEC response.⁹ When schools closed in July 2014, teachers and students became available for social mobilisation. DEC members involved them in many of their teams, as well as recruiting others with relevant previous experience. Oxfam recruited people who had worked on cholera outbreaks and gender-based violence programmes and felt that this knowledge and experience helped shape the Ebola response. CAFOD taught school children in health clubs to become Ebola educators in their families. Many agencies have employed survivors for social mobilisation.

Social mobilisation was heavily used for making sure key education messaging reached people early on but awareness was already high when the DEC response started. The needs of families and individuals have evolved over time, with material needs becoming more urgent due to the economic down turn, the impact of quarantine, as well as the destruction of property of Ebola-infected households. In all districts we met community members who explained that they had not received enough kits to replace the possessions that had been burned. The role of social mobilisers is therefore not only focused on knowledge transfer and Ebola prevention skills, but is already changing to become broader:

“We find that our mobilisation teams are increasingly becoming social tracing and benefit surveillance teams. They try to link what they know of a situation in a household with surveillance and communicate the needs of these individual households to people who hand out the kits.” (NGO, Port Loko)

Community mobilisers in different districts find it difficult to engage people with empty hands.

“They tell us that they are hungry and need food.” (Woman from a community mobilisation team, Bombali)

Related to this, challenges are emerging with regard to sustaining community engagement. While social mobilisation for messaging and other purposes was highly relevant during the peak of the outbreak, people want to get back to normal and to address the livelihoods crisis. Further, people who joined the community groups utilised for social mobilisation joined them for a reason and are increasingly eager to get back to the work these groups were intended for.

“I joined this group to access credit and savings. Because of Ebola both my personal savings in my family and that of the group are gone. I want the group to be doing again what we wanted to do.” (Female member of a credit and savings group, Port Loko)

DEC members have to deal with the combined threat of fatigue, complacency and resistance to further restrictions and impoverishment.

3.3. Relevance

Question: To what extent has the Ebola Crisis Response been relevant?

⁹ A Knowledge, Attitudes and Practices survey conducted by UNICEF, FOCUS 1000, and Catholic Relief Services prior to DEC funding showed high levels of knowledge about Ebola (<http://ow.ly/Mn8rP>). For example, 96.9% of the respondents believed it existed, 53% knew which number to call and less than 2% of the respondents believed that it is caused by God, witchcraft, evildoing, or curse.

The DEC provides a flexible form of funding allowing members to adapt to changing contexts. This funding mechanism was extremely useful when regular programmes of DEC members were suddenly closing. All except one of the DEC members were already based and staffed in Sierra Leone and had developed Ebola response initiatives. The DEC funding was used to build upon these initiatives.

The focus on community mobilisation and decentralised engagement was appropriate for Phase 1 and was appreciated by national and district-level coordinating authorities.

DEC members also developed a range of relevant interventions to address the many new problems that arose during the epidemic, such as graveyard management, supporting burial teams, contact tracing, food and non-food distribution to quarantined households, and social support for Ebola survivors reintegration in communities. These interventions were strengthened, refined and scaled up as part of the DEC response. Three of these areas are discussed further below.

Supporting households in quarantine

In the autumn of 2014 many thousands of affected households were put under quarantine for up to three months to stop the spread of Ebola. Most had no food and no access to water at that time and householders could not get to markets. DEC member agencies and partners, such as the British Red Cross, Trócaire, Concern and CAFOD had been working to supply quarantined households with food, school packs and psychosocial support prior to the DEC response. They continued, improved and scaled up this support as part of the DEC response adding innovations and new elements along the way. Trócaire, for example, provided clean water to quarantined households and ambulances to support safe rehydration. They gave families complaint numbers, a phone with a charger and credit. Another innovation was giving quarantine kits to more than one woman in a polygamous marriage to prevent familial disputes.

Oxfam identified a problem with quarantined families not receiving enough food through the standard packages provided by the humanitarian response and are exploring giving cash instead. Cash transfers to quarantined families are complicated because they could not go out to buy things. Also, when a whole village is in quarantine, traders may avoid the village. There would need to be protocols and each family in quarantine would identify two trusted friends or neighbours who would be given the cash and would buy food for the family. They acknowledge that accountability mechanisms would have to be strong, but believe that it could be a solution to addressing the gaps in quarantine houses where not everyone is getting a good diet.

One of the surprising findings of the review was the level of social acceptance of Ebola-affected and infected households. Adults and children in households in, or just out of, quarantine received visitors. Yet members of households in quarantine are not unreasonably anxious about the end of quarantine:

“Now we are getting food. We have not been able to go out and plant. When quarantine ends we get no support.” (Woman, household in quarantine, Bombali)

“Quarantine was bad. But people came to visit. Now we are out and left to ourselves.” (Man, ex-quarantined household, Bombali).

This suggests a need to support Ebola survivors after quarantine as part of the recovery efforts.

Supporting child survivors

Many children orphaned by Ebola have had to be taken in by other households. DEC member agencies have supplied food and clothes to such children. World Vision, for example, delivered tailor-made kits to orphans, with clothes appropriate for their age and size.

Among child survivors the stigma of Ebola can still be a problem.

“Most families will reject child survivors. They fear that they are the cause of the parent’s death.” (DEC agency staff member, Tonkolili)

World Vision reported a case of Ebola-orphaned children in one household being told by their new caregivers that they should not touch anyone. The other children stayed away from them, but after they received the food packages the other children started to come and play with them. This shows that the stigma might not be related to Ebola, but be rooted in poverty and the fear of having to share scarce resources. Providing a package of resources that benefits the whole household and accommodates a child survivor can be a useful step towards their reintegration.

Supporting burial teams

DEC agencies have been supporting burial teams to provide Ebola victims with a dignified burial. Concern, for example, responded to complaints about the government burial teams by training their teams in good burial practices and paying them on time, providing them with working protective equipment and detailed training on how to interact with often distressed family members or an aggressive public. Family members were allowed to see their loved ones and be at the burial (keeping a distance); it would take place near the family home and religious leaders could be involved if the family so desired. The whole process became more humane and with more interaction between the team and the family members. Teams would arrive in regular clothes and would put on their protective gear in public view so that everyone could see them as normal human beings. They also provided psychosocial support to help burial team members cope with the work itself and the stigma they faced as consequence of the work.

It is clear, however, that members of burial teams are in need of continued support. Many people took up this role in order to make a living and to do something useful, but many have had to face Ebola-related stigma. In one of the focus groups, held with 12 burial team members, every single one had been kicked out of their house. None were allowed to be with their children.

“I have been kicked out of my house. My wife left me. Nobody wants to sell me food. I am not welcome at the water well.” (Burial team member, Freetown)

The stigma attached to the work aggravates an already weak economic position and creates fear of the future and a need for more economic support for their social reintegration.

“Will Ebola follow us around after the disease has left? Every day we ask ourselves ‘what’s next?’ That’s like our national anthem.” (Male burial team member, Freetown)

“We want that after Ebola is gone we will be given a piece of land, that some land is allocated to us or that we get some kind of package to make a living again. Just like the soldiers and the people who reintegrated after the war, the Ebola soldiers

need to be reintegrated. Our women will come back once they see that we are healthy and have something.” (Male burial team member, Freetown)

DEC-funded psychosocial support is key in the creation of these new ties, helping to create new communities of burial teams that are taking over some of the traditional roles of families.

*“Here in the burial team we speak with each other. This is my new family now.”
(Male burial team member, Freetown)*

3.4 Organisational learning and capacity development

Question: Have organisations developed the knowledge, skills and attitudes to work and learn effectively with communities to reduce the spread and socio-economic impact of Ebola in a rapidly evolving situation?

A tremendous amount of valuable learning has taken place among DEC members, their partners, communities and families. DEC member organisations appeared to adapt quickly, made efforts to follow good practices and have adopted new ways of working to meet the needs of the Ebola crisis. They have undertaken high-risk work and successfully protected their staff.

The outbreak prompted operational bottlenecks to existing programmes and development processes. Agencies could not always go out to communities because of movement restrictions, and this reinforced existing vulnerabilities. Almost all of the existing development programmes of DEC members were suspended due to Ebola.

Responding to the Ebola outbreak has taken many humanitarian agencies outside of their usual programming modality, testing their flexibility and ability to innovate. Agencies do work in epidemics, such as cholera and measles, but the nature of this disease was different. Interventions had to be developed from scratch to address some of the new problems in communities – such as delivering relief to households in quarantine, getting involved in graveyard management and contact tracing. For example, the British Red Cross supports members of the Sierra Leonean Red Cross on contact tracing and beneficiary communication.

One example of learning came from Oxfam, whose engineers learned about the building and isolation of Community Care Centres (CCCs). The ones imported were too hot for the climate. Engineers worked with medical staff to improve the CCC design: creating spaces where family members can see inside the CCC; creating thin and transparent walls to reduce heat and allow family members to see inside and providing grass roofing to plastic tents to improve isolation.

There were many reported instances of agencies adapting to address challenges. CARE trained chiefs in a burial team in case of death of a chief, addressing the fears of many chiefs that if they died they would end up being buried without the usual ceremony. Another example of creative practice came from CARE: In a community where the water from the well was erroneously believed to be poisoned, WASH staff drank the water from the well to show it was safe and to alleviate fears. The community used the well afterwards again.

One area of difficulty for all agencies involved in the response is helping people to access relief. Some people we met expressed confusion over who they needed to approach for, for example, Ebola relief packages:

“There is too much protocol and too many layers of complexity. I wished it was kept all simple.” (Village chief, Port Loko)

“We have received some [Ebola relief] packages, but I’m not sure what we should get. I would like to learn who does what.” (Elderly man, Tonkolili).

These problems apply to the general Ebola response, not DEC’s alone, but transparency, feedback and coordination mechanisms are still an issue and DEC members are and must continue to strengthen such mechanisms in a constantly changing context.

3.5 Cross-cutting DEC themes: Gender, age and disability

Question: How has the response addressed gender, age and disability related issues and inequalities?

DEC members have tried to address age and gender-related issues. Many of these issues have deeper roots and cannot realistically be fully addressed during an emergency.

Gender

Many DEC members such as ActionAid, CAFOD and Oxfam are well known for their work on gender equity, including women’s right to land, education and equal political representation. However, working mainly through paramount chiefs during the outbreak – an approach Sierra Leonean authorities and communities support – meant working through predominantly male decision-making structures. Women in all districts were vocal in their discontent about the ways decisions are traditionally taken and how they felt this has excluded them in this Ebola response.

“These are patriarchal structures, women have no representation. Men get to decide everything.” (Woman, NGO Bombali)

“We women get called in to do the dirty work for Ebola work in our community like cleaning and clearing land. When there are clean well paid jobs we don’t get them. They are given to their relatives.” (Woman, CBO Port Loko)

DEC members working with grassroots women’s organisations are aware that the Ebola crisis has limited the public space of women and their organisations. They are concerned about the long-term effects this has on gender equity and public accountability. There is a need to support women and these organisations to take back their place in the public arena as part of building local resilience and public accountability efforts.

Another area of concern is sexual and reproductive health – especially with respect to teenagers. This has clearly not been a priority at a time when stopping the outbreak took precedence, but the Ebola epidemic is likely to have ongoing implications in this important area. There has been reduced access to sexual and reproductive information, services and goods from clinics, healthcare centres and pharmacies. Confusing messages by WHO and CDC on the transmission of Ebola through sexual contact have not helped to develop consistent safe sex messages and interventions for survivors.¹⁰ Further, schools were closed from the summer

¹⁰ According to WHO, “Men who have recovered from the illness can still spread the virus to their partner through their semen for up to seven weeks after recovery” (www.who.int/csr/disease/ebola/faq-ebola/en). CDC agrees that “multiple studies have shown the Ebola virus can persist in semen for longer than in blood or other body fluids”. Yet CDC’s view is that sexual transmission of Ebola has not been definitively established (www.cdc.gov/vhf/ebola/transmission/human-transmission.html).

until April 2015, prolonging the school holiday period, when teenage pregnancies peak, to almost nine months at a time of poverty and in a context where transactional sex is a problem.

“It will take a few months until we will see consequences of quarantine on the girls bodies. But this is a problem that we are beginning to see in other countries in the region as well.” (Representative of a DEC member agency)

Sexual and reproductive health is something that should be addressed now. Gender-sensitive facilities should be provided in schools to encourage girls back into school; knowledge on WASH should be built upon; and reported moves by the government to bar pregnant girls from education¹¹ should be opposed.

Age

The cumulative number of confirmed and probable Ebola cases by sex and age group in Guinea, Liberia, and Sierra Leone collected by WHO show significantly higher rates of infection in people over 45 than in younger people.¹² Social determinants of their high infection rates may be their specific socio-cultural roles such as visiting the sick and washing the deceased.¹³ Many older people lack formal education, which makes social mobilisation through interpersonal contacts very important. NGOs had to learn to engage with these old and new groups in communities and to cope with an epidemic that was spread by contact with the sick and the deceased. Engagement with the elderly has to be tailored to meet with culturally-specific norms and roles and targeted at specific high-risk behaviour. Engagement with the elderly is likely to need particular attention in a context such as Sierra Leone, that faces inter-generational conflicts.¹⁴ It is possible that further efforts to target older people with social mobilisation efforts and deliver messages to them through, for example, older traditional chiefs, religious leaders, or older members of burial teams, could have an increased impact.

Disability

¹¹ See report on Ebola Deeply blog, 17 March 2015 (<http://ow.ly/Mkrn7>).

¹² For Sierra Leone, there were an estimated 327 cases per 100,000 among those over 45 years old compared to 223 per 100,000 among those aged 15-44 and 96 per 100,000 aged 14 or less (from the World Health Organisation *Ebola Situation Report* of 28 January 2015: <http://ow.ly/MaTRR>).

¹³ Some of the patterns and reasons for this are explored in an 11 December 2014 briefing from the Ebola Response Anthropology Platform (<http://ow.ly/Mklfe>).

¹⁴ Johanna Boersch-Supan (2012) The generational contract in flux: intergenerational tensions in post-conflict Sierra Leone, *The Journal of Modern African Studies*

Krijn Peters and Paul Richards (1998) 'Why We Fight': Voices of Youth Combatants in Sierra Africa: *Journal of the International African Institute*

Paul Richards (2005) To fight or to farm? Agrarian dimensions of the Mano River conflicts (Liberia and Sierra Leone) *African Affairs*

Catherine Bolten (2102) “We Have Been Sensitized”: Ex-Combatants, Marginalization, and Youth in Postwar Sierra Leone *American Anthropologist* Volume 114, Issue 3, pages 496–508, September 2012

Rosalind Shaw (2014) The TRC, the NGO and the child: young people and post-conflict futures in Sierra Leone. *Social Anthropology*

Disabled people are a highly diverse group: not all are especially vulnerable in an Ebola outbreak. The mobility-impaired may actually have reduced risk. People with learning difficulties and mental health problems probably have increased risk, but there is no direct evidence of this. At the NERC level, there is attention to the needs of visually and hearing impaired people. There was also a 'special needs' social mobilisation sub group led by Handicap International. Disability is a theme in all DEC responses, so it would be useful for DEC members to explore how they can work on this theme in a meaningful way in the next phase.

4. Emerging gaps and transition concerns

Question: What are the emerging gaps and issues to consider in Phase 2?

4.1 The transition period: eradicating or living with Ebola?

The focus on social mobilisation to provide information was a very important part of a community-based public health approach – it was an appropriate choice. But between Ebola Response and Ebola recovery is the black box of 'transition' and DEC agencies need to be clear on how they understand this. National and international experts, including DEC members, have diverging views on whether Ebola can be eradicated or whether we must live to learn with micro-Ebola outbreaks. There is strong agreement that Ebola eradication is desirable, but at the time of writing this review, the number of cases is increasing again, mini-Ebola outbreaks are occurring that are related to unsafe burials.¹⁵

At the same time, a major transition is going on. The Sierra Leonean government will be scaling down the response within the coming weeks. It is not clear what will happen with buildings, staff, equipment of Ebola-specific institutes including NERC and DERC. Schools are re-opening and teacher and student volunteers are returning to school, and some of the volunteers leading social mobilisation teams and WASH efforts will also not be available in the same way. It is also clear from our interviews that some of the community-based volunteers are weary of being put in charge of allocating kits and other material support, including dealing with the accusations of partiality that sometimes come with it.

The management of the transition will have major implications for the approach, the scope, the structure, or implementation of the DEC response in Phase 2. Eradicating Ebola could possibly require much of this mobilisation infrastructure to be maintained. Surveillance systems and health systems need to be improved but, as WHO has noted, 'the global surveillance and response system is only as strong as its weakest links. Shared vulnerability means shared responsibility and therefore requires sharing of resources, and sharing of information'¹⁶.

DEC members should continue to focus on the social and political determinants of health and on managing and building the resilience of communities. Mobilisation-fatigued and hungry communities still need be vigilant against Ebola complacency and protect themselves – it is not

¹⁵ A NERC press release of 5 March 2015 said: 'In recent weeks the trend of decline in new EVD cases in our country has stalled. Most new cases have been fuelled by unsafe burial practices'.

¹⁶ WHO leadership statement on the Ebola response and WHO reforms, 16 April 2015 (www.who.int/csr/disease/ebola/joint-statement-ebola/en).

about replacing one activity for another. Some important aspects of the continued response are noted below.

Addressing the livelihood crisis

A new humanitarian and economic crisis is imminent. Savings and harvests have been depleted, seeds have been eaten and many tools have been destroyed because they were abandoned in the fields when households went into quarantine. Some households lost all the property of all the members of the house when a member fell ill. Survivor packages have to be shared among a whole family.

“We had 84 people in the family. We lost 28 members and had six survivors and six packages for all of us.” (Female Ebola survivor, Tonkolili)

People are getting impatient and quarantine enforcement is getting harder.

“I don’t think I can control my people much longer. They are too hungry.” (Village chief, Port Loko)

New livelihood approaches will have to be developed in Phase 2 that help the recovery process. Community leaders feel the greatest challenge to recovery now is ensuring that people have the tools and resources for their livelihoods. Replacement of burned possessions, tools and resources for livelihoods, cash transfers, community development work (roads, houses if these have been burned down or damaged and wells) and WASH activities are feasible activities for DEC members.

Need for social protection and services plus social mobilisation (not either/or)

DEC members can continue working on social mobilisation with community structures to enable them to facilitate access to services and provide support to families, such as household kits based on DERC guidelines.

Households lost caregivers and bread earners and received orphans, taxing Sierra Leoneans’ extended and already overburdened kinship systems. Social protection for widows and orphans may need particular attention in Phase 2.

Stigma and fear can be addressed and are already changing. Stigma appears to be rooted in social concerns and economic fears – for example rejection of a child might be due to fear of not being able to provide care rather than fear of infection. Social mobilisation and psychosocial support efforts have to be cognisant of the economic dimensions of stigma and fear and the way in which material support can be helpful in countering them.

Education

Ebola has caused and reinforced educational gaps. Parents and caretakers want their children to go back to school once schools with a CCC have been decontaminated. The government has announced that school fees will be abolished for the coming two years. This is a very laudable initiative, but parents and guardians are vocal about the fact that there are still books and uniforms that need to be paid for. Many parents and caregivers think that they will not be able

afford these costs and DEC member agencies might become involved in addressing this problem.

Teenage girls need additional support to re-enter school. Unplanned pregnancies and care duties for siblings are clear obstacles to gender equity in schools. Another obstacle to girls' education is the danger that orphan girls may be kept at home to work instead of going to school. The lack of segregated WASH facilities was among the pre-Ebola obstacles for girls to enter school, and it is important that newly increased knowledge and awareness of WASH, especially among students and teachers, is built upon. The new government ruling, which excludes pregnant girls and young mothers to sit key exams, excludes girls who are already vulnerable in the education system. DEC members are in a good position to oppose this ruling and propose more constructive and inclusive policy measures.

Strategies to strengthen the health system

As part of the emergency response, separate health facilities such as CCCs, holding centres and treatment units have been set up to reduce pressure on the regular health system. The CCCs provided valuable and appreciated free services but are being dismantled. People will go back to the regular primary health facilities, but this is likely to require some efforts and these facilities had problems prior to Ebola. Triage at the Primary Health Unit might have to be strengthened and linked to triage in schools or markets. Ebola surveillance, case management and tracing will need to be moved from the DERC to the health system, probably to district health management teams. Ebola surveillance might be part of a broader surveillance system of infectious diseases such as Cholera and Lhasa fever. There are fears about blood samples in some parts of the country. These issues need to be addressed as part of rebuilding surveillance and health systems. Strengthening a health system over the longer term may have to think beyond 'rebuilding' to 'building differently' in transition and the post-Ebola period. Some of these activities could be part of the transition work of DEC member agencies – perhaps those that will be involved in managing the CCC in Phase 2.

Attention to caregiver families beyond relief packages

Families and communities find themselves in new familial and household arrangements. Getting used to new siblings is hard on any child and their family. Play is a good entry point for psychosocial support. In addition to giving relief packages to individual households, families may benefit from community-based opportunities to play. Some DEC members, notably World Vision, have an excellent track record providing toys and play spaces using local materials in other emergencies. Such activities would be useful for DEC members to consider.

Burials teams

At the time of writing (end of February 2015) the incidence of Ebola are going up again in spikes, mainly due to unsafe burials taking place outside the official system. These new infections are therefore not linked to the medical burials that are supported by DEC members. There have also been no Ebola infections among the Concern/ MOHS burial teams.

Gravediggers and burial teams – at the current level – will soon be redundant. DEC members will need to support their reintegration in to employment. But vigilance with regard to burials will continue to be required.

Cross-border work

Cross-border familial and trade connections are extensive between Sierra Leone, Liberia and Guinea. For those DEC members that already work in border areas in two or three countries, a cross-border approach might be worth considering.

Annex 1

Ebola Crisis Response Review Questions

The review explores three broad areas 1) Community engagement 2) Programme relevance and 3) Organisational learning and capacity development.

1) Community engagement

Did organisations have sufficient socio-cultural as well as political historical expertise to develop appropriate socially integrated local responses with regard to:

- Information and communication
- Surveillance, case identification and contact management
- Case management (including body management)
- Psychosocial support
- Preparedness and response.

Have different kinds of expertise – including various kinds of local expertise – been taken into account and utilised? Has the response clearly recognised how diversity and inequality within communities – such as those based on gender, age, landownership, and political affiliations – shape the response to interventions and the results? What key expertise on community engagement is still missing, and how could these gaps be filled efficiently?

2) Programme relevance

- Do programmes address the real needs and problem of the affected people and communities?
- Have agencies' programmes adjusted to the uniqueness of this situation or are they following their 'business as usual' responses?
- To the extent that agencies have gone outside their mandate and skill set, how is this experienced and perceived at different levels and how successful have they been?

3) Organisational learning and capacity development

How have organisations developed the knowledge, skills and attitudes to work and learn effectively with communities to reduce the spread and socio-economic impact of Ebola in a rapidly evolving situation?

- Have assessment of needs, capacities and gaps of local communities guided the activities? What was useful about these assessments and what was less useful?
- What are the main regrets, challenges and examples of poor Ebola response programming that we should put on the table for organisational reflection?
- What are the case studies and specific lessons or innovations that can be learned from this health emergency for future outbreaks? Can these lessons be memorised at the institutional and community level? How?
- What have been the organisational and intra-organisational level learning benefits and challenges to working on a health emergency for DEC member organisations?

