PART II: HOW DID THE RESPONSE COME TOGETHER?

On 21 September 2014, a social mobilizer distributes soap to a woman in Freetown, the capital. Soap, when used as part of proper handwashing techniques, helps to halt the spread of diseases, including EVD. Photo: UNICEF/NYHQ2014-1604/Bindra

Behind these impressive results is a remarkable story. The collective effort in the Ebola response has been outstanding in many ways: the sheer number of contributors; the diversity of those contributors; and the level of cooperation demonstrated. Key contributions have been led by the countries—particularly their community organizations and, most of all, the people themselves. Perhaps the most important influence has been the extraordinary leadership of the national governments of the affected countries, and their willingness to engage openly with the multiple sources of national and international assistance. This resulted in the alignment of many diverse partners behind the national responses. The governments have been supported by bilateral donor countries, multilateral organisations, NGOs, foundations, and the private sector.

It is community volunteers (including from the Red Cross societies and faith-based groups) who have been at the front lines and have driven the response. They have transported patients, cared for the sick, traced the exposed, gone door-to-door. They worked relentlessly, under exceptional circumstances and at a risk to themselves.

More than 90% of the total Ebola response workforce was national personnel, according to data from MSF and the UN. They include volunteers through national Red Cross societies and faith groups. They have been supported by an estimated cumulative total of 10,000 international personnel who have contributed over the duration of the response.

865 healthcare workers have been infected with Ebola and 504 of them paid with their lives. The overwhelming majority are citizens of West Africa. People like Augustine Turay, Abdul Rahman Parker and Alphonso Kanboh in the boxes above are the heroes of the Ebola response.

AN EVOLVING RESPONSE STRATEGY

The global Ebola response can be summed up as a focused yet flexible strategy that successfully adapted to the evolution of the outbreak and became increasingly decentralized over time. The first iteration of the strategy brought together the "Accra Response Strategy", agreed by Health Ministers from eleven West African countries on 2-3 July 2014, and the "Ebola Response Roadmap" published by WHO on 28 August 2014. The "Accra Response Strategy" was based on three pillars of action: immediate outbreak response interventions; enhanced coordination and collaboration; and scale-up of human and financial resource mobilization. The WHO Roadmap emphasized the use of complementary and controversial approaches for use in areas with intensive transmission to "take the heat out of the outbreak" with specific targets and timelines.

The contents of these two strategies were reiterated in the UN STEPP strategy, which was developed jointly with the Presidents and Governments of the affected countries in the first two weeks of September 2014. It formed the basis of the Overview of Needs and Requirements for the UN system and partners developed jointly by OCHA and the Office of the Special Envoy and launched in Geneva on 16 September 2014. The elements of STEPP are to:

- **S**top the outbreak;
- **T**reat the infected;
- **E**nsure essential services:
- **P**reserve stability; and
- **P**revent outbreaks in countries currently unaffected.

Each of the five elements in STEPP is broken down into the mission-critical public health actions and enabling activities that are required to make the response work. STEPP provided an enduring, broad and flexible framework for operations.

Over time, different elements of STEPP were prioritized. When the number of people with Ebola was increasing rapidly, the focus was on the first two elements of **S**top and **T**reat or "**ST**": this meant building safe and staffed beds, introducing safe burials and finding and training healthcare workers.

As a means to harmonize the responders, on 20 September 2014, UNMEER and WHO set a target of 70% of patients isolated and receiving care and 70% safe and dignified burials within 60 days of the Mission being rolled out (30 November 2014). In both Guinea and Liberia these were achieved on time: in Sierra Leone they were achieved before the year was out. Implementation of this **70-70-60** plan succeeded in "bending the curve" of the outbreak and reducing to less than one the number of other people infected by someone with Ebola. The next target was **100-100-90** (100% of patients isolated and receiving care and 100% of burials both safe and dignified within 90 days – by 1 January 2015).

When the intensity of the outbreak reduced and as quality care became more available and accessible, responders began to focus on the second phase—ending the outbreak through case finding and contact tracing. High quality case-finding and contact-tracing capabilities had to be scaled up throughout the region. These were needed to ensure that every chain of transmission could be mapped. However, it was only possible to focus on this at the end

of 2014, once the heat had been taken out of the outbreak and high quality disaggregated data had started to become available.

The dialogue on the establishment of the 70-70-60 and 100-100-90 targets was intense. Prioritizing certain elements over others represented a departure from the normal approach for managing a viral haemorrhagic fever outbreak. The voices of globally renowned scientists and medical experts were heard alongside the recommendations of community mobilizers and traditional leaders. In August 2014 it became clear that the exponential growth of the outbreak and widespread alarm about its potential global impact required the adoption of complementary approaches – speedily. Once agreement had been reached on the scaling up of Ebola Treatment Units and Burial Teams, a further controversy emerged. Did Community Care Centres contribute to excessive risks of infection? Would the quality of care they offered be satisfactory? The debates were resolved rapidly and providers were encouraged to establish facilities that could be adapted to national and local needs with the maintenance both of clinical standards and protocols for Infection Prevention and Control. These facilities were flexible enough to be adjusted if the scale and shape of the outbreak changed unexpectedly.

COMMUNITIES AND LOCAL ACTORS

Each community and each village that has been affected by Ebola has contributed to the overall response. In terms of official staff and volunteers, over 60,000 people[23] from Guinea, Liberia and Sierra Leone with a broad range of skills and experiences have responded. From professional health workers to local volunteers, from faith groups to traditional leaders, responders have worked collaboratively to end the transmission of Ebola.

While there was some resistance to the measures to end the outbreak in some communities, others developed their own solutions. Local and religious leaders in parts of Liberia decided to "self-quarantine", an initiative that was reported as more effective than district or individual level quarantine.[24]

On 19 September, a team of social mobilizers speaks with residents about EVD and preventing its spread, in Freetown, the capital. The mobilizers are holding illustrated posters reinforcing that information.

From 19–21 September in Sierra Leone, a public information campaign aimed to reach every household countrywide with life-saving messages on Ebola virus disease (EVD). UNICEF provided technical and financial support, including information materials, for the Government-led campaign, called the Ose to Ose Ebola Tok initiative, which means 'house-to-house talk' in the local Sierra Leonean language. During the campaign, over 28,500 trained social mobilizers, youths and volunteers went door-to-door to reach 1.5 million households and provide residents with information on protecting themselves against EVD and preventing its spread. UNICEF estimates that 8.5 million children and young people under the age of 20 live in areas affected by EVD in Guinea, Liberia and Sierra Leone, countries where disease transmission is widespread and intense. Of these, 2.5 million are under the age of 5. Nigeria and Senegal are also affected, having seen an initial case or cases, or experienced localized transmission. The current EVD outbreak in West Africa is the worst in history.
Photo: UNICEF/NYHQ2014-1558/Bindra

23 UNDP report "Payments Program for Ebola Response Worker – Results", 31 March 2015.
24 http://acaps.org/img/documents/t-acaps_thematic_note_ebola_west_africa_quarantine_sierra_leone_liberia_19_march_2015.pdf.

Continued local leadership and ownership by communities are pre-requisites for ending the outbreak. The role of local leaders in both shaping and implementing the local response has proved absolutely necessary for changes in behaviour at the community level.

Abdourahmane Balde

By profession, Abdourahmane Balde is a photo lab technician. But since the beginning of 2015, he has taken on a new job: he is now one of the 5 members of the "comité de veille des villageois" of the Gbangbaissa quartier, in Guéckédou, Guinea.

Every day of the week, Balde goes door-to-door and meets with families to raise awareness about Ebola. "Some weren't able to understand that the disease really existed," he says, adding that he is proud of the work he has done because "Ebola is going away."

These comités de veille – a community-based structure, have been established throughout the country. They are designed along the existing traditional structure of governance and bring together 5 to 7 elected members, representing the makeup of the village itself: traditional and religious leaders, representatives of women, youth and traditional brotherhoods such as traditional hunters and healers, as well as opinion leaders and representatives of different socio-professional categories. They aim to improve community engagement in the Ebola response and raise awareness about the disease. They also assist in seeking care for the sick, tracing contact of exposed family members and fighting stigma. Members of the comités act as a trusted link between the communities and external groups.

"The comités have access to places that foreigners can't go to," says Mamadou Baillo Dialo, chief of the Gbangbaissa quartier. "Foreigners know more but when they come, they give their information to the comités who then transmit it to the different communities." "Since the 'comités de veille' have been established, there's been no word of resistance in localities," he adds.

The comités have been credited with helping to stop the spread of Ebola, reducing community resistance across the country and fostering greater community engagement. Launched in December 2014, the initiative now counts 13,700 members. The comités have been established in all districts of Guinea – most of them with the support of UNICEF and through collaboration with NGOs.

As a member of a comité, Balde receives a monthly incentive of USD 56 until April 2015. He says that he would continue his work even if he isn't paid anymore because "it's important to save the population." The members of his comité in the Gbangbaissa quartier have now started raising awareness about measles.

[Based on interviews done by UNICEF - Guinea]

NATIONAL LEADERSHIP

The Presidents of Guinea, Liberia and Sierra Leone have played a critical role in the Ebola response. They provided the strategic leadership that enabled an effort of this magnitude to unfold, as well as a national vision behind which their people could align. They secured the full support of their respective governments and drove the operational response while championing behaviour change. The Presidents of the affected countries were crucial in making progress in defeating the Ebola outbreak.

At the outset of the response, the Governments faced substantial challenges. According to WHO there was virtually no experience of Ebola in Guinea, Liberia or Sierra Leone: *"No clinician had ever managed an Ebola patient. No laboratory had ever handled a diagnostic specimen. No government had the experience to understand what a disease like Ebola could do to a country's future".*[25] And none of the countries had health systems capable of mounting the full response necessary. The Liberian Minister of Foreign Affairs stated that, with Ebola the *"already weak health system has been plunged into further paralysis".*[26]

There were also concerns over the economic impact of declaring national States of Emergency. The IFRC noted that, *"poor communications and political and cultural resistance hampered timely recognition and extent of the outbreak."*[27] However, once the situation was clear, Governments took on the daunting task of defining and enabling the response to a complex and rapidly changing outbreak.

The Ministries of Health in the three countries were the first government entities to mount the response. They began to coordinate national and international actors and to provide the necessary medical and technical guidance. In Guinea, Dr. Sakoba Keita from the Ministry of Health was appointed Ebola coordinator in April 2014 a month after confirmation of the first case. On 13 August, President Condé declared a National Public Health Emergency and on 4 September, he appointed Dr. Keita as head of the newly established "Cellule nationale de la coordination contre l'Ebola". To encourage an increased effort by the people of Guinea as the weekly numbers of newly infected people started to decline, President Condé called for reinforcement of measures to cope with the ongoing health emergency, focusing particularly on the need for safe and dignified burials for all.

Liberia reactivated a pre-existing Task Force within the Ministry of Health and Social Welfare in late March 2014, when the first diagnoses of Ebola were made. President Johnson Sirleaf declared a State of Emergency on 6 August and on 10 August appointed the Assistant Minister of Health and Social Welfare, Tolbert Nyenswah, as Head of the Incident Management System. The Liberian authorities invited international experts to work directly within their government structures, and absorbed advice and support from *"MSF and WHO initially, then US CDC and later UNMEER – it worked because we created a relationship rather than a bureaucracy".*[28]

In Sierra Leone, the Ministry of Health and Sanitation established the Emergency Operations Centre (EOC) in mid-July and President Koroma declared a State of Emergency on 30 July. In mid-August the leadership was transferred to a former Cabinet Minister, Stephen Gaojia who was appointed as head of the EOC. On 17 October, the President upgraded the EOC into the National Ebola Response Centre and appointed the then Defence Minister Major (Rtd) Palo Conteh, as Chief Executive. The following day the nomination of fourteen District Coordinators represented the culmination of an ongoing process to decentralize the management of the Ebola response.

Simultaneous efforts were made to decentralize the response in Guinea to préfecture-level and Liberia to county-level as well. The establishment of functional local offices was initially challenging given logistical, funding and human resource constraints: these were mitigated through major deployments of military assets and personnel, together with rapid provision of finance. Existing infrastructure was used where possible—for example the United Nations Mission in Liberia (UNMIL) offices in the counties of Liberia. New structures were created where needed—for example British military-supported command and control centres in

25 Director General of WHO at the UN Economic and Social Council on the Ebola threat, 5 December 2014.
26 General Assembly, 3rd plenary meeting on Friday, 19 September 2014, http://www.un.org/en/ga/search/view_doc.asp?symbol=A/69/PV.3.
27 IFRC Report of the Real Time Evaluation of Ebola control programs in Guinea, Sierra Leone and Liberia, 25 January 2014.
28 From interview with Presidential Adviser Dr. Emmanuel Dolo.

certain districts of Sierra Leone. In Guinea, eight Regional Alert and Response teams were set up, with French support, to assist the Regional Health Directorates to implement their responsibilities for contact tracing and progress monitoring.

National technical working groups, pillars or clusters were established to deal with key components of the response. These covered issues which were identified as national priorities—including case management, safe and dignified burials, surveillance and laboratories. Over time they were adapted to the lines of action for the response, with additional emphasis on infection prevention and control, and on research and development. Countries developed additional structures to adapt to the national context: in Liberia, several humanitarian clusters—including health—were activated in August.

Coordination and information sharing across the technical pillars of the response proved challenging and key data from one pillar were sometimes slow to reach the technical experts working in other pillars. Early delays with establishing secretariat functions (meeting timetables, agendas, minutes etc.) in the EOCs also made it hard for district, county and prefecture-based responders to engage. This may have contributed to a sense of exclusion felt by some locally-based NGOs and local civil society organizations.

Ebola has catalysed joint work by different political parties. In Guinea, political unity against Ebola was formalized in principle in March 2015 through the Forum des Forces Vives where representatives of political parties committed to depoliticize the issue of Ebola, stating that, *"This national union against Ebola is above all existing socio-political cleavages in the country, particularly in this pre-electoral period."* [29]

REGIONAL COOPERATION

The Mano River Union (MRU) has played an important role in focusing political attention to cross-border issues and agreed on 1 August 2014 at a Special Summit, *"to take important and extraordinary actions at the inter country level to focus on cross-border regions that have more than 70 percent of the epidemic. These areas will be isolated by police and the military. The people in these areas being isolated will be provided with material support".*[30] Delivering all these commitments was challenging, in part due to insufficient operational capacity at district, county and prefecture level. On 15 February 2015, during a summit in Conakry, the leaders of the MRU approved a strategy for reaching and sustaining "Zero Ebola Infection" within 60 days, recognizing that *"to get to and stay at zero will depend on their collective political will."*[31]

The Presidents of Guinea, Liberia and Sierra Leone have also been working jointly on the preparation of the MRU sub-regional Ebola recovery plan. This was discussed during the high-level international conference on Ebola on 3 March in Brussels and the high-level roundtable in Washington DC in preparation for the establishment of a Regional Ebola Recovery Fund. Implementation by the MRU, *"requires increasing the capacity and functionality of the Secretariat urgently by setting up a special unit."*[32]

ECOWAS, in November 2014, appealed for military personnel, logistics support, medical and voluntary staff, to support awareness raising and the strengthening of national

29 Declaration from the Forum des Forces Vives de la Guinée Contre Ebola, Conakry, 12 March 2015 ("*Cette union nationale contre Ebola est au-dessus de tous les clivages socio-politiques existants dans le pays, particulièrement en cette période pré-électorale.*").
30 http://www.manoriverunion.int/JOINT%20DECLARATION%20FINAL%20VERSION.pdf.
31 http://emansion.gov.lr/2press.php?news_id=3212&related=7&pg=sp.
32 Mano River Union Post-Ebola Socio-economic Recovery Programme, April 2015.

health systems. In January 2015, ECOWAS partners, including the West Africa Health Organisation (WAHO), the private sector and development partners, stressed the need to re-establish links, mobilize investment and for debt cancellation.[33] The Chairman of ECOWAS, Ghanian President John Dramani Mahama demonstrated courageous regional leadership at a time when access restrictions and border closures were being implemented. As President of Ghana, his early decision to create an air-bridge from Ghana to the affected countries was instrumental in facilitating the work of all responders. He then agreed that the UN could establish its headquarters in Accra.

Cooperation at the regional level has also been important to the response. In September 2014, the African Union support to the Ebola Outbreak in West Africa (ASEOWA), was established to enhance the capacity of existing national and international response mechanisms through mobilization of technical expertise, resources, political and financial support. Countries welcomed, *"the solidarity of many organizations and countries, non-governmental organizations and Civil Society Organizations as well as the active mobilization of AU support..."*[34]

The #AfricaAgainstEbola campaign is coordinated by the Africa Against Ebola Solidarity Trust, a registered charity, in partnership with the African Union. The Trust was launched in November 2014.[35] In January 2015, the AU Peace and Security Council discussed Ebola and reiterated earlier calls to *"AU Member States that have not done so, to immediately lift all travel bans and restrictions and to respect the principle of free movement, as well as to take the required steps for the resumption of flights to those countries."*[36]

Nigeria's Experience with Ebola

On 20 July 2014, an acutely ill traveller arrived at Lagos airport, Nigeria, from Liberia. Three days later, he was diagnosed with Ebola. This one patient resulted in nineteen people being infected and meant 894 people in Lagos and Port Harcourt had to be regularly checked for symptoms.

The Ministry of Health, with guidance from the Nigerian Centre for Disease Control, immediately activated an Incident Management Centre and soon after opened an Emergency Operations Centre. The new Ebola incident manager brought with him technical skills and partnership experience from his previous role fighting polio in Nigeria.

A rapid, innovative and multi-disciplinary response swung into action. It pulled all the national and international experts (CDC, WHO, MSF and UNICEF) under one plan. Seeing the impact of Ebola in Guinea, Liberia and Sierra Leone, the Nigerian private sector offered support where it was most urgent and provided vehicles, protective equipment and meeting facilities. Contact tracing was ramped up. Android phones—normally used in the polio campaign—were used to map where Ebola workers went. NGOs with experience in HIV/AIDS social mobilization were called upon to help.

The Government, from the President downwards, helped with social mobilization. Traditional leaders were engaged and mosques and churches were able to include information on Ebola in their prayers. Social media was used for information sharing and community volunteers hired through Twitter and Facebook advertisements.

Nigeria was declared Ebola-free on 20 October 2014.

[From interview with Dr. Faisal Shuaib, 20 April 2015]

33 http://news.ecowas.int/presseshow.php?nb=009&lang=en&annee=2015.
34 Decision of the Executive Council Sixteenth Extraordinary Session on the Ebola Virus Disease (EVD) Outbreak, Addis Ababa, Ethiopia, 8 September 2014, http://pages.au.int/ebola/documents/decision-executive-council-sixteenth-extraordinary-session-ebola-virus-disease-evd-o.
35 http://www.africaagainstebola.org.
36 Communiqué of the 484th meeting of the PSC on the Ebola virus outbreak, http://www.peaceau.org/en/article/communique-of-the-484th-meeting-of-the-psc-on-the-ebola-virus-outbreak.

INTERNATIONAL SOLIDARITY

A high level of political commitment by heads of state and governments around the world has been a notable component of Ebola response. It has brought an unprecedented level of international attention, including commitments made by the United States in September 2014 to provide substantial financial and military contributions of 3,000 troops. On 18 September 2014, the Security Council convened an emergency session to discuss the Ebola outbreak. G7 leaders plan to review the situation when they convene in June 2015, signifying that the Ebola response remains high on the global political agenda.

The UN Secretary-General appointed a Special Envoy on Ebola on 12 August and established a comprehensive UN system-wide crisis response mechanism on 8 September. At the recommendation of the Secretary-General, the General Assembly established UNMEER to support the responses of affected nations on 19 September 2014. Every month since the establishment of UNMEER, the Secretary-General has provided an update on the operational activities carried out by the United Nations system through UNMEER and its partners as well as on the activities of his Special Envoy. At a high-level meeting on Ebola[37] on 25 September 2014, the Secretary-General led international efforts to translate the political will into concrete action noting that there was *"overwhelming international political momentum for the United Nations to play a leading role in coordinating the response".*

UNMEER has undertaken both high-level and operational advocacy throughout the crisis and has facilitated communication between the governments and across all partners. It has provided a logistics platform and provided air assets for use in the wider response. UNMEER Ebola Crisis Managers were given direct responsibility for in-country Ebola response-related activities by agencies of the UN system, reinforcing their existing coordination systems and ensuring collective accountability in response to a major multi-dimensional crisis. UNMEER's role in management and coordination has strengthened since it was established, though agencies, at all times, have operated within their own mandates and operating systems. As the country-based agencies, funds and programmes of the UN system scale up their capabilities through 2015, UNMEER will draw down. Its work will be taken on by the relevant entities and be overseen by the UN Resident Coordinators who are being supported by the Office for the Coordination of Humanitarian Affairs (OCHA).

INTERNATIONAL CONTRIBUTIONS

A unique and unprecedented coalition of multiple actors has emerged to support the efforts of people and governments in countries affected by Ebola. The UN Secretary-General created the Global Ebola Response Coalition (GERC) in September 2014, to provide strategic coordination to the Ebola response. Weekly global teleconferences have been held since, chaired by the Secretary-General's Special Envoy, with the inaugural meeting early in October 2014 initiated by the UN Deputy Secretary-General.

The GERC brings together participants from the Governments of the affected countries, as well as partner governments, NGOs, foundations, representatives of the private sector, UN agencies, funds and programmes, other international bodies and regional organizations. There are usually over fifty participants in the weekly meetings. These provide a space within which

37 http://webtv.un.org/search/ban-ki-moon-response-to-the-ebola-virus-disease-outbreak/3806807194001?term="Response to the Ebola Virus Disease Outbreak.

all involved in the response can: (i) establish a common understanding of the status of the outbreak and the response; (ii) identify challenges and develop solutions to the challenges; and (iii) align their strategies and means for implementation.

On 17 April 2015, the World Bank Group announced US$650 million in funding for recovery during the next 12 to 18 months. This took the organization's total financing for Ebola response and recovery efforts to US$1.62 billion, including US$1.17 billion from the International Development Association (IDA) and at least US$450 million from the International Finance Corporation to enable trade, investment and employment in Guinea, Liberia and Sierra Leone. The World Bank has received pledges worth US$43 million towards its Ebola Recovery and Reconstruction Multi-Donor Trust Fund. These contributions come on top of US$2.17 billion in debt relief which during 2015-17 will save the three countries about US$75 million annually in debt payments.[38]

Alongside the direct contributions to Governments and responders, a strategic and highly flexible UN Multi-Partner Trust Fund (MPTF) was established. By early April 2015, 40 contributing UN Member States, as well as businesses and foundations had enabled the distribution of more than US$130 million for priority actions being implemented through nine UN system entities. The Government of Colombia was the first contributor and the top five donors to date have been the United Kingdom, Sweden, Germany, India and Finland. The MPTF encourages adaptation of responses through a small grants programme that UNMEER administers. Grants from the MPTF have supported the construction of CCCs, set-up of logistics bases and the transportation of cargo and personnel. They have funded human resources for surveillance, contact tracing and monitoring, logistics management and social mobilization activities. They have enabled thousands of children affected by Ebola, orphans and Ebola survivors to have a better life. They have supported cross-border Confidence Building Units by the MRU.

Many donor agencies have provided imaginative and far reaching support, drawing on different capacities within their own governments, supporting civil society, professional and NGO groups, offering finance and setting up novel coordination and implementation procedures. Many countries contributed to health care for responders (including Medical Evacuation) with continuous involvement of the WHO and financial support from many – particularly the Paul Allen Family Foundation. In addition, the European Union hosted a High-level Conference on Ebola in Brussels, on 3 March, which paved the way for the recovery discussions that have followed. The Presidents of Guinea, Liberia and Sierra Leone presented their national recovery plans at the World Bank Group's high level meeting "Ebola: The Road to Recovery" on 17 April. Based on an Ebola Recovery Assessment coordinated by UNDP and supported by the broader UN family,[39] these lay out what is required to help societies get back on track and start overcoming the effects of the outbreak. These plans will be further advanced at the UN Secretary-General's International Ebola Recovery Conference, to be implemented jointly with the Presidents of the three most affected countries, on 10 July 2015 (organized by UNDP). The plans will require predictable and sustainable support from the international community.

38 http://www.worldbank.org/en/news/press-release/2015/04/17/ebola-world-bank-group-provides-new-financing-to-help-guinea-liberia-sierra-leone-recover-from-ebola-emergency.

39 http://www.undp.org/content/dam/undp/library/crisis%20prevention/Recovering%20from%20the%20Ebola%20Crisis-Full-Report-Final_Eng-web-version.pdf.