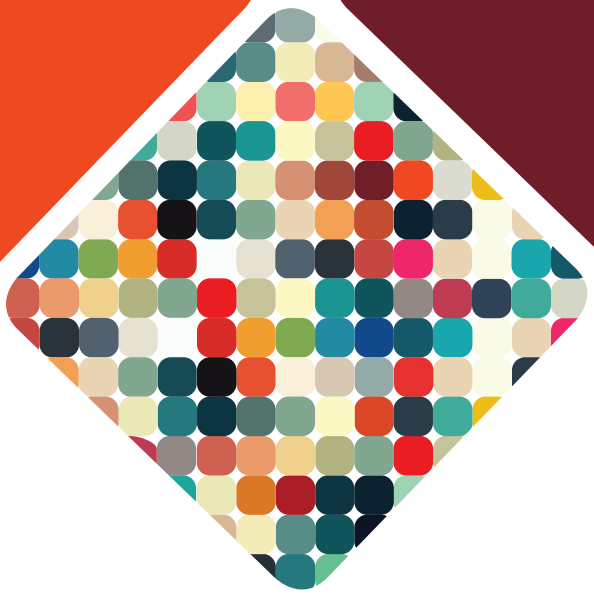

REPORT OF THE REAL TIME EVALUATION OF EBOLA CONTROL PROGRAMS IN GUINEA, SIERRA LEONE AND LIBERIA

ANNEXES

ANNEXEX 1

EVALUATION DOCUMENTS

RTE terms of reference
Inception report

BIOGRAPHICAL DATA

Alex Murray
Philimon Majwa
Tim Roberton
Gilbert Burnham

International Federation
of Red Cross and Red Crescent Societies

Terms of Reference for a Real Time Evaluation of the IFRC Response to the Ebola Virus Disease outbreak

1. Summary

1.1. The purpose of this RTE is to assess the **policy adherence, relevance and appropriateness**, **efficiency**, effectiveness**, and connectedness**[1] of the Red Cross Red Crescent response to the Ebola outbreak in West Africa. Specifically it will assess: the extent to which the response has followed the Principles and Rules for Red Cross and Red Crescent Humanitarian Assistance; the relevance of the five-pillar response strategy; if IFRC systems and structures are have been effective and efficient in achieving objectives; to what extent operations address long term interconnected problems in the three host countries.

The findings and recommendations will be used to make any corrections and improvements necessary to improve delivery and long term recovery in the operations, including identifying which strategies should be rolled out in other countries. The RTE will also inform future operations on large scale epidemics or other similar operations.

1.2. Commissioners: This RTE has been commissioned by the USG of the Programme Services Division, IFRC, Geneva.

1.3. Audience: The findings, conclusions and recommendations of this RTE will be used by the country and regional delegations supporting National Societies with a response or preparedness operation mentioned in the background section below (Nigeria, Guinea, Liberia, Sierra Leone, Mali, Cote d'Ivoire, Cameroon, Togo, Benin, Central African Republic, Senegal, Chad, Gambia, Democratic Republic of Congo). The finding and recommendations will also be used by the Africa Zone and Geneva headquarters to inform the future operation. It will also inform all operational and partner National Societies running or supporting the operations.

1.4. Duration of consultancy: approximately 30 days (with approximately 20 days in the field)

1.5. Period of advertising the consultancy: 2 week period between 14 – 28 October 2014 **(application deadline 28th October).**

1.6. Estimated dates of consultancy: During November and December 2014.

1.7. Location of consultancy: Geneva, Nairobi, Accra, Guinea, Liberia, Sierra Leone.

2. Background

The current Ebola Virus Disease (EVD) outbreak in West Africa is unprecedented in terms of the number of cases, deaths and its geographical spread. As of 29th September there have been at least 3,109 deaths and

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[1] These criteria are taken from the IFRC's Evaluation Framework. The brief definitions are as follows:

- Policy adherence: IFRC work should uphold IFRC policies and guidelines.
- Relevance focuses on the extent to which an intervention is suited to the priorities of the target group.
- Appropriateness focuses on the extent to which an intervention is tailored to local needs and context, and compliments other interventions from other actors.
- Efficiency measures the extent to which results have been delivered in the least costly manner possible. It is directly related to cost-effectiveness.
- Effectiveness measures the extent to which an intervention has or is likely to achieve its intended, immediate results.
- Connectedness refers to the need to ensure that activities of a short-term emergency are implemented in a way that takes longer-term and interconnected factors into account.

6,835 registered cases in the five countries where cases have been confirmed[2]. *(detailed figures on cases and Red Cross Red Crescent action in those countries are given in the table on the following page).*

Efforts to stop the ongoing spread and bring the epidemic to an end have gained in commitment and capacity but are not enough and the risk of further spread, both within the affected countries and more widely is also a real possibility and needs to be planned for appropriately.

Projections for the amount of confirmed and probable cases vary from 20,000 by November (WHO) to 1.4 million by January 2015 (Centers for Disease Control and Prevention). The situation is rapidly evolving and remains uncertain.

This is the first time an outbreak of this size has been experienced in West Africa. Previous outbreaks have been self-limiting, and controlled. The current outbreak however, is presenting several unique challenges:

- The recognition of EVD by the authorities in Guinea came very late when the first recorded cases were first identified as early as November and December 2013. It is only in March that the Ebola epidemic was finally officially declared by the authorities and August when WHO declared that Ebola had become an international threat.
- Affected communities and government/health services are 'new to the disease' and unfamiliar with the complexity of dealing with Ebola and do not have the appropriate equipment, facilities and procedures;
- In some rural areas, the population believe that it is the people spraying for disinfection who are bringing and spreading the disease, which has caused violent reaction and the killing of 8 people. Some communities have denied Ebola cases within their families for fear of stigmatization.
- Cultural practices, including burial practices, facilitate the spread of the disease;
- The outbreak started in an area where three countries border each other, making it a regional challenge for their respective National Societies and governments/health services, thus challenging normal control measures;
- The porous nature of the borders of the countries involved, regional trade, interconnectedness of families and fluid population movement both within and between the affected countries is key to the geographical spread. The spread has now extended to air travel, which opens up other possible and unpredictable destinations for the disease

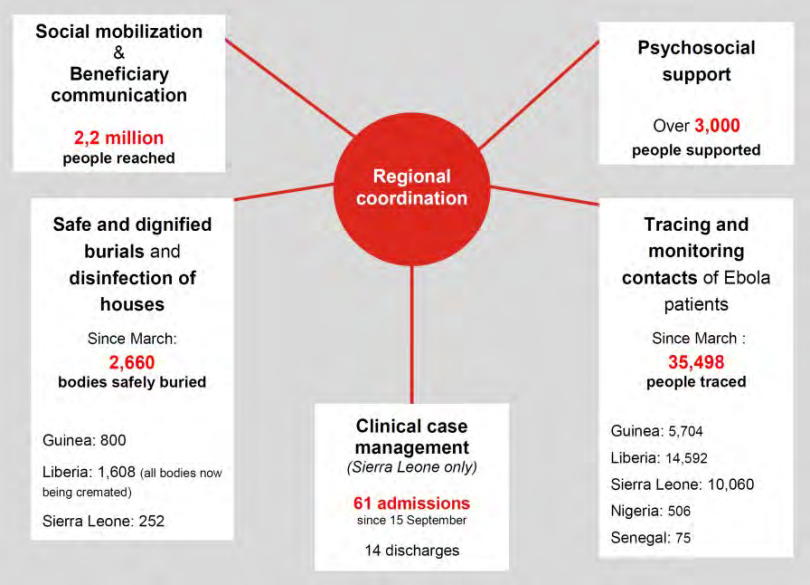
The current outbreak is no longer just a public health emergency of international concern, but a much broader humanitarian crisis – the Ebola outbreak has resulted in the suspension of other critical humanitarian services in the areas affected, including food security and nutrition programmes, water and sanitation activities, health services, and other community development programmes as well disrupting many commercial activities,.

Red Cross Red Crescent operational context

To support National Societies to combat the unprecedented Ebola outbreak affecting West Africa, IFRC has launched international Emergency Appeals in Guinea, Liberia, Sierra Leone, Nigeria and Senegal, as well as a regional coordination appeal.

[2] These figures are changing rapidly with daily increases due to new cases, as well as under-reporting and re-classification of cases.

Additionally, it is supporting smaller preparedness and response operations financed under the IFRC's Disaster Response Emergency Fund (DREF) in Mali, Cote d'Ivoire, Cameroon, Togo, Benin, Central African Republic, Chad and Gambia.



Strategies are tailored to individual countries, and are based on 5 pillars shown on the right, with regional coordination helping tie together these approaches –and the efforts of different actors. Figures shown are as available as of 09th October.

To help coordinate this effort, an Africa Ebola Management Unit has been established in Conakry. Led by a senior Operations Coordinator (Head of Operations, or HEOPs) and a technical support team to provide the necessary support to the country operations including communications and fundraising, the Ebola Management Unit enables the IFRC to consolidate its multi-country, multi-sectoral response to the outbreak under a single, unified decision-making structure.

The regional coordination appeal supports this, with an immediate focus on coordination and preparedness. It also seeks to develop guidance and support for the longer term recovery needs at country and regional level.

Operational Countries and Appeals

	GUINEA (MDRGN007)	LIBERIA (MDRLR001)	SIERRA LEONE (MDRSL005)	NIGERIA (MDRNG017)	SENEGAL (MDRSN010)	TOTAL
Cumulative Cases	1,280	3,929	2,732	21	1	**7,963**
Cumulative Health Care Worker Deaths	35	94	82	5	-	**216**
Cumulative Deaths	760	2,127	831	8	-	**3,726**
Fatality rate	60%	55%	31%	40%	0%	
Dead bodies managed by NS	800	1,608	252	0	-	**2,660**
Trained RC volunteers active in Ebola	1,299	2,000	720	184	-	**4,203**
Contacts traced by NS	5,704	14,592	14,621	506	75	**35,498**
Houses disinfected by NS	14,943	235	1,352	2		**16,532**
People reached through social mobilization[2]	710,410	433,729	763,728	314,000		**2,221,867**
People reached through Psychosocial support	342	550	1,941	184		**3,017**
People treated by NS (Kenema)	NA	NA	61	NA	NA	**61**

The operation is quite different from most of the operations that IFRC responds to for a number of reasons:

- Unlike a rapid-onset natural disaster, where the response moves toward recovery after the initial event, in this case the situation is continually worsening and becoming more complex as the operation continues.
- The need for medical precision for all equipment and procedures.

- The need for very large amounts of medical stock (e.g. PPE) to be ordered, and in place in a short period of time.
- The necessity of recruiting, training, and deploying health personnel with relevant background while ensuring a regular rotation of staff.
- Field staff and volunteer health and safety, including psycho-social support.

IFRC collaborated with John Hopkins University earlier this year on a "Real-Time Research on Ebola Communication in Guinea". This research aimed to capture experiences to date, provide technical recommendations from a public health perspective for the ongoing response and identify lessons learnt for future outbreaks. It focused one whether the actions volunteers were engaged in were appropriate and safe, by examining the experiences of volunteers and community members in Guinea.

The findings, conclusions and recommendations of this real-time research will be used to inform this RTE.

3. Evaluation Purpose & Scope

Rationale for RTEs

The IFRC secretariat is committed to ensuring quality assurance, standards and a strong culture of accountability, transparency and lesson learning in its disaster response. It is committed to carrying out RTEs during all major disasters requiring an international response and meeting certain criteria of scale, scope, complexity or risk. These RTEs aim to improve service delivery and accountability to beneficiaries, donors and other stakeholders; and to capture lessons for the improvement of IFRC's disaster response system. The response to the Ebola outbreak falls within these criteria.

Purpose

The purpose of this RTE is to assess[3] the **policy adherence[4], relevance[5] and appropriateness[6]**, **efficiency[7]**, **effectiveness[8], and connectedness[9]** of the Red Cross Red Crescent response to the Ebola outbreak in West Africa. The evaluation will be used to make any corrections and improvements necessary to improve delivery and long term recovery in the operations, as well as informing future operations on large scale epidemics or other similar operations.

Which aspects of these criteria will be assessed is defined in the key questions below. Other criteria outlined in the IFRC Evaluation Framework fall outside of the purpose and scope of this RTE – i.e. coverage; impact; sustainability.

Scope

Institutionally, the scope will be Federation-wide. This means that while the IFRC secretariat is the main focus of the assessment and analysis, the coordination, interaction and support to and from host National Societies and National Societies working internationally is a vital operational aspect and must also be considered, as well as coordination with ICRC and with external partners. The institutional analysis should provide recommendations for future operations.

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[3] The following criteria dimension are based on five of the eight criteria from the IFRC's evaluation framework.

[4] IFRC work should uphold IFRC policies and guidelines.

[5] Relevance focuses on the extent to which an intervention is suited to the priorities of the target group.

[6] Appropriateness focuses on the extent to which an intervention is tailored to local needs and context, and compliments other interventions from other actors.

[7] Efficiency measures the extent to which results have been delivered in the least costly manner possible. It is directly related to cost-effectiveness

[8] Effectiveness measures the extent to which an intervention has or is likely to achieve its intended, immediate results.

[9] Connectedness refers to the need to ensure that activities of a short-term emergency are implemented in a way that takes longer-term and interconnected factors into account.

Geographically, the focus of the RTE will be Sierra Leone, Guinea Conakry and Liberia and Nigeria where the operations are largest (however only Sierra Leone, Guinea and Liberia will be visited). The other countries where there are operations should also be considered by the evaluators, but primarily through secondary data review and possibly some phone interviews.

Operationally, the focus should be on the response operation to date, and what lessons can be learned for the future operations. The preparedness operations in countries where there is no outbreak will be a secondary focus, providing context for any conclusions and recommendations on the future of the operation.

The **time period** under review is from March 2014 to date.

4. Evaluation Key Questions

In order to consider the criteria of **upholding policy**, **efficiency**, **effectiveness**, **relevance and appropriateness** and **connectedness**, the following questions will be explored:

1) Upholding policy

a) To what extent are the Principles and Rules for Red Cross and Red Crescent Humanitarian Assistance being followed in the operation.

2) Relevance and appropriateness

a) How were the needs assessed (including analysis and predictions made), and how was criteria established for launching emergency appeals?
b) Is the IFRC response strategy (with its five pillar approach) delivering appropriately in proportion to the needs?
c) Is the regional appeal relevant/appropriate?
d) Is the response strategy balanced with realistic donor support estimates?

3) Efficiency and effectiveness

a) How well is the operation delivering on existing needs identified?
   i) ***Systems****:* Are the existing IFRC systems and structure (including response tools[10]) appropriate to deliver efficient and effective response to the outbreak?
   ii) ***Use of resources:*** How effective and efficient is the system to mobilize and utilize resources (financial, HR or others)?
   iii) ***Timeliness:*** are services being delivered within adequate time?
   iv) ***Coordination****:*
      (1) Is internal coordination within the secretariat efficient and effective?
      (2) Is the coordination mechanism effective and working for all Movement members?
      (3) Is the coordination with other humanitarian actors effective?
   v) Human resource support
      (1) Are the safety and support measures (including psycho-social) in place for staff and volunteers effective and relevant?
      (2) Are staff and volunteers sufficiently equipped and trained to perform the tasks required of them?

4) Connectedness

[10] Including DREF, Emergency Appeal & EPOA; GLS, HR, RDRT, ERU, SOPs, IFRC Delegations, DMU, etc

a) How well is the operation likely to deliver on predicted future needs?
   i) Is the structure and strategy currently in place sufficient to ensure an efficient and effective response for the probable future operation?
   ii) How can the operation scale up in an appropriate manner, considering recovery needs of the population and capacities of operating National Societies?

5. Evaluation Methodology & Process

The methodology will adhere to the IFRC Framework for Evaluations, with particular attention to the processes upholding the standards of how evaluations should be planned, managed, conducted, and utilized.

5.1 Evaluation team and management team

The **evaluation team will consist of at least three people**, one of whom will be an external evaluator (who will be the team leader), supported by a team which will include representatives from National Societies not directly involved in or providing support to the operation; team members may also include external evaluators.

Ideally the team leader and/or one of the NS representatives should have experience of the region. Ideally all candidates should have some experience of the IFRC disaster response systems and operations. All candidates should have evaluation experience or knowledge.

- The **external evaluator team leader** will provide an independent, objective perspective as well as technical experience on evaluations, and will be the primary author of the evaluation report. S/he should not have been involved or have a vested interest in the IFRC operation being evaluated, and will be hired through a transparent recruitment process, based on professional experience, competence, ethics and integrity. Detailed qualifications for the external team leader are provided in section 9.

- The **team members evaluators** will assist the external evaluator in the evaluation process, and will be able to provide perspectives on the RCRC actors and interactions in the operation. Qualifications for the team members are provided in section 9.

An **IFRC evaluation management team** will oversee the evaluation and, with the evaluators, to ensure that it upholds the IFRC Management Policy for Evaluation. The evaluation management team will consist of three people not directly involved with the operation; one from the Secretariat planning and evaluation department, one from Africa zone and one from programme services division.

The evaluation will be managed according to the IFRC Real-time Evaluation Management Guide (draft) and the report review process and development of management response will be undertaken as described in the draft guide, to be made available to the evaluation team.

5.2 Methodology

The specific evaluation methodology will be detailed in close consultation between the RTE team and IFRC, but will draw upon the following primary methods:

1. **Desktop review** of operation background documents, findings from the Ebola Communication/ Prevention Forum held in Dakar in September 2014, the John Hopkins University real-time research review, relevant organizational background and history, including prior IFRC RTE evaluation reports, and any relevant sources of secondary data, such as exit surveys from IFRC participants in the operation.

2. **Inception** workshop in Geneva to brief IFRC teams on methodology prior to field visits
3. **Field visits/observations** to selected sites and country / zonal offices.
4. **Key informant interviews and / or focus group discussions** – with Red Cross Red Crescent staff & volunteers, partner agencies and government and beneficiaries as appropriate.
5. **Review of** operations with other humanitarian organizations.
6. **Staff survey:** a short online survey for all international staff (IFRC or seconded).

The field visits will be on the three most affected countries (Guinea, Liberia, Sierra Leone); the evaluation team should ensure that this RTE does not distract from the operation.. Interviews should also be carried out remotely with stakeholders in Nigeria. It is envisaged that operations in those countries where preparedness activities are taking place will be assessed by secondary data review and key informant interviews by phone.

6. Evaluation Deliverables

Inception Report – The inception report will be a scoping exercise for the RTE and will include the proposed methodologies, data collection and reporting plans with draft data collection tools such as interview guides, the allocation of roles and responsibilities within the team, a timeframe with firm dates for deliverables, and the travel and logistical arrangements for the team.

Debriefings / feedback to management at all levels – The team will report its preliminary findings to the IFRC (in-country, zone, and Geneva) in a timely manner, before leaving the region, and will adhere to the above mentioned review process. The team leader will present the full report to Geneva management within two weeks of the return from the field.

Draft report – A draft report, identifying key findings, conclusions, recommendations and lessons for the current and future operation, will be submitted within two weeks of the consultants' return from the field.

Final report – The final report will contain a short executive summary (no more than 1,000 words) and a main body of the report (no more than 10,000 words) covering the background of the intervention evaluated, a description of the evaluation methods and limitations, findings, conclusions, lessons learned, clear recommendations. Recommendations should be specific and feasible. The report should also contain appropriate appendices, including a copy of the ToR, cited resources or bibliography, a list of those interviewed, and any other relevant materials. The final RTE report will be submitted one week after receipt of the consolidated feedback from IFRC.

All products arising from this evaluation will be owned by the Federation. The evaluators will not be allowed, without prior authorization in writing, to present any of the analytical results as his or her own work or to make use of the evaluation results for private publication purposes.

7. Evaluation Quality & Ethical Standards

The evaluators should take all reasonable steps to ensure that the evaluation is designed and conducted to respect and protect the rights and welfare of the people and communities involved and to ensure that the evaluation is technically accurate and reliable, is conducted in a transparent and impartial manner, and contributes to organizational learning and accountability. Therefore, the evaluation team should adhere to the evaluation standards and applicable practices outlined in the IFRC Management Policy for Evaluation.

The IFRC evaluation standards are:

1. **Utility**: Evaluations must be useful and used.

2. **Feasibility**: Evaluations must be realistic, diplomatic, and managed in a sensible, cost effective manner.
3. **Ethics & Legality**: Evaluations must be conducted in an ethical and legal manner, with particular regard for the welfare of those involved in and affected by the evaluation.
4. **Impartiality & Independence**; Evaluations should be impartial, providing a comprehensive and unbiased assessment that takes into account the views of all stakeholders.
5. **Transparency**: Evaluation activities should reflect an attitude of openness and transparency.
6. **Accuracy**: Evaluations should be technical accurate, providing sufficient information about the data collection, analysis, and interpretation methods so that its worth or merit can be determined.
7. **Participation**: Stakeholders should be consulted and meaningfully involved in the evaluation process when feasible and appropriate.
8. **Collaboration**: Collaboration between key operating partners in the evaluation process improves the legitimacy and utility of the evaluation.

It is also expected that the evaluation will respect the seven Fundamental Principles of the Red Cross and Red Crescent: 1) humanity, 2) impartiality, 3) neutrality, 4) independence, 5) voluntary service, 6) unity, and 7) universality. Further information can be obtained about these Principles at: www.ifrc.org/what/values/principles/index.asp

9. Qualifications

Selection of the **external evaluation consultant** will be based on the following qualifications:

1. Demonstrable experience in supervising and guiding evaluations of humanitarian or public health programs responding to major disasters, with specific experience in RTEs preferred;
2. Knowledge of strategic and operational management of humanitarian operations and proven ability to provide strategic recommendations to key stakeholders;
3. Have a post-graduate qualification and 7-10 years' experience in public health in humanitarian emergencies, including qualifications and/or experience in epidemiology. Further experience in any of the following areas would all be an additional advantage: nursing or medicine, infection control and psychosocial support .
4. Strong analytical skills and ability to clearly synthesize and present findings, draw practical conclusions, make recommendations and to prepare well-written reports in a timely manner;
5. Experience in qualitative data collection and data analysis techniques, especially in emergency operations;
6. Knowledge and experience working with the Red Cross Red Crescent Movement preferred;
7. Understanding of institutional mandates and operations of key stakeholders operationally active in the Ebola response, including MSF, WHO, UN, governments and donors
8. Demonstrated capacity to work both independently and as part of a team;
9. Excellent English writing and presentation skills in English, with relevant writing samples of evaluation reports, policy, strategic or other analytical documents/ reports.
10. Regional knowledge of West Africa required.
11. Immediate availability for the period indicated.

Selection of the **evaluation team members** will be based on the following qualifications:

1. Demonstrable experience in leading evaluations of humanitarian and/or public health programs.
2. Strong analytical skills and ability to clearly synthesize and present findings, draw practical conclusions, make recommendations.

3. Experience in qualitative data collection and data analysis techniques, especially in emergency operations;
4. Regional knowledge of West Africa strongly preferred but not required.
5. Background in one or more of the following: public health, disaster management, nursing, infection control, clinical care and psychosocial support. The combined experience of the entire team will be considered in making the selection.

10. Personal protection of evaluation team

IFRC will cover any personal protection equipment that may be needed for the RTE team members, and will also provide basic training / orientation in personal protection measures to avoid catching the virus.

11. Application Procedures

Candidates should apply using the following link: http://www.ifrc.org/en/who-we-are/working-with-us/current- vacancies/job-description/?nPostingId=734&nPostingTargetId=1317&id=QPFFK026203F3VBQB79LO793E&LG=UK before the **application deadline of 28th October.**

Application materials (for both team leader and team member applicants) should include as attached documents:

1. **Curricula Vitae**.
2. **Cover letter** clearly summarizing your experience as it pertains to this RTE, languages in which you are competent, your daily rate, and three professional references.
3. **A writing sample**, ideally of an evaluation report, otherwise a policy, strategic or other analytical document/ report.

If you have any queries with using the platform for the application process, please send an email to misgana.ghebreberhan@ifrc.org.

We thank you in advance for understanding that only short-listed candidates will be contacted for the next step in the application process.

2. Inception report

International Federation
of Red Cross and Red Crescent Societies

Inception Report

Real Time Evaluation of the IFRC Response to the Ebola Virus Disease outbreak

30 November 2014

Alexandra Murray
Philimon Majwa
Tim Roberton
Gilbert Burnham

I. Introduction

The Ebola virus causes an acute, serious illness which is often fatal if untreated. Ebola virus disease (EVD) first appeared in 1976 in 2 simultaneous outbreaks, one in Nzara, Sudan, and the other in Yambuku, Democratic Republic of Congo. The latter occurred in a village near the Ebola River, from which the disease takes its name.

The current outbreak in West Africa, (first cases notified in March 2014), is the largest and most complex Ebola outbreak since the Ebola virus was first discovered in 1976. There have been more cases and deaths in this outbreak than all others combined. It has also spread between countries starting in Guinea then spreading across land borders to Sierra Leone and Liberia, Nigeria, Senegal and Mali. The most severely affected countries, Guinea, Sierra Leone and Liberia have very weak health systems, lacking human and infrastructural resources, having only recently emerged from long periods of conflict and instability.

It is thought that fruit bats of the Pteropodidae family are natural Ebola virus hosts. Ebola is introduced into the human population through close contact with the blood, secretions, organs or other bodily fluids of infected animals such as chimpanzees, gorillas, fruit bats, monkeys, forest antelope and porcupines found ill or dead or in the rainforest. Ebola then spreads through human-to-human transmission via direct contact (through broken skin or mucous membranes) with the blood, secretions, organs or other bodily fluids of infected people, and with surfaces and materials (e.g. bedding, clothing) contaminated with these fluids. Health-care workers have frequently been infected while treating patients with suspected or confirmed EVD. This has occurred through close contact with patients when infection control precautions are not strictly practiced. Burial ceremonies in which mourners have direct contact with the body of the deceased person can also play a role in the transmission of Ebola. People remain infectious as long as their blood and body fluids, including semen and breast milk, contain the virus. Men who have recovered from the disease can still transmit the virus through their semen for up to 7 weeks after recovery from illness.

II. Current Emergency Response

IFRC is supporting Guinea Red Cross Society, Liberia Red Cross Society, Sierra Leone Red Cross Society, Nigeria Red Cross Society and Senegal Red Cross Society with international emergency appeals to combat Ebola in Guinea, Liberia, Sierra Leone, Nigeria and Senegal. The IFRC strategy is developed around 5 pillar approach which is: Beneficiary Communication and Social Mobilization; Contact Tracing and Surveillance; Psychosocial Support; Clinical Case Management; Safe, Dignified Burials and Disinfection. IFRC also continues to support smaller preparedness and response operations financed under its Disaster Response Emergency Fund (DREF) in Mali, Cote d'Ivoire, Cameroon, Togo, Benin, Central African Republic, Chad, Gambia, Kenya and Guinea Bissau and now Ethiopia, making a total of 16 countries that have emergency operations relating to this outbreak. Other response tools which the IFRC have deployed for the management of the operation include RDRT, FACT and ERUs as immediate support to the affected National Societies.
Some of the humanitarian policy guidelines which the IFRC have used to ensure that the Ebola emergency response meet the recognized emergency response standards include Principles and Rules of Disaster Relief, Disaster Preparedness Policy, Emergency Response Policy and Sphere

Standards among other standards available within the humanitarian sector. It is envisaged that the current Ebola response strategy will contribute to the achievement of the IFRC Strategy 2020 with emphasis on saving lives and rebuilding livelihoods.

The table below summarizes the achievement of IFRC and National Societies Ebola response strategy.

Catagories	Guinea	Liberia	Sierra Leone	Nigeria	Senegal
Cumulative Cases	2094	7168	6460	21	1
Cumulative Health Care worker Deaths	56	172	104	5	0
Cumulative deaths	1257	3016	1282	8	0
Safe and dignified burials by NS	1578	2666	1896	0	0
Contacts traced by NS	7516	17781	26269	891	75
Houses disinfected	16,899	340	2858	14	
People reached through Social Mobilization	1025167	910771	897895	958086	
People reached through psychosocial[support	1052	1410	13026	740	

Apart from the Red Cross Movement other aid agencies are also involved in the response activities to control the spread and management of Ebola in these countries. Medecins sans Frontieres (MSF) – has been managing the large majority of the clinical movement in all three countries (Sierra Leone, Liberia and Guinea. MSF has now announced that they are at full capacity and will not be able to scale up any further. World Health Organization (WHO) - has utilized the Global Outbreak Alert and Response Network (GOARN) heavily and deployed experts to the affected countries. Others – partners such as Institute Pasteur, Centre for Diseases Control (CDC), Canadian Public Health, academic institutions and some NGOs have been involved in the ongoing response in a variety of ways, including the provision of laboratory support, disease surveillance, social mobilization and support to the Ministries of Health (MoH). There is increasing interest in engaging by the International Committee of the Red Cross (ICRC), United Nations Children's Fund (UNICEF), United Nations Office for the Coordination of Humanitarian Affairs (OCHA), CDC and NGO's such as Save the Children, International Rescue Committee (IRC) and Concern are to become more involved in the response.

The need for an RTE was necessitated by the need of analyzing the current IFRC response in the light of saving lives while ensuring that the systems and policies are adhered to. It is envisaged that the outcome of this RTE will be used to inform the transformation of the response by taking on board new approaches while at the same time strengthening the existing structures / approaches.

III. The Real Time Evaluation

Intent of the Real Time Evaluation

This Real Time Evaluation (RTE) has been commissioned by the IFRC Secretariat to assess the response to the 2014 Ebola crisis in Guinea, Sierra Leone and Liberia from March 2014 onward. The intent of this RTE is to elucidate findings and create clear recommendations that will improve delivery of current assistance and long-term recovery to the affected regions. With a focus of improving the on-going response, the RTE will build on lessons learnt to inform future epidemics and operations of similar scale. The scope includes areas that will improve the response to above all to affected populations, but as well to stakeholders, partners and donors. These include national societies of affected countries, other national societies, and the ICRC.

The scope includes areas that will improve the response to affected populations, but as well to stakeholders, partners and donors. These include national societies of affected countries, other national societies, and the ICRC. The direction of this current epidemic is uncertain, and is likely to involve neighboring countries, and possibly become an endemic disease with periodic flare-ups within effected countries.

Audience for the report

The findings, conclusions and recommendations of this RTE will be used by the country and regional delegations supporting National Societies with a response or preparedness operation mentioned in the background section below (Nigeria, Guinea, Liberia, Sierra Leone, Mali, Cote d'Ivoire, Cameroon, Togo, Benin, Central African Republic, Senegal, Chad, Gambia, The Democratic Republic of Congo). The finding and recommendations will also be used by the Africa Zone and Geneva headquarters to inform the future operation. It will also inform all operational and partner National Societies running or supporting the operations.

Purpose

The purpose of this RTE is to assess the **policy adherence, relevance and appropriateness**, **efficiency**, **effectiveness, and connectedness** of the Red Cross Red Crescent response to the Ebola outbreak in West Africa. The evaluation will be used to make any corrections and improvements necessary to improve delivery and long term recovery in the operations, as well as informing future operations on large scale epidemics or other similar operations.

Which aspects of these criteria will be assessed is defined in the key questions below.

Other criteria outlined in the IFRC Evaluation Framework fall outside of the purpose and scope of this RTE – i.e. coverage; impact; sustainability.

Scope

Institutionally, the scope will be Federation-wide. This means that while the IFRC secretariat is the main focus of the assessment and analysis, the coordination, interaction and support to and from host National Societies and National Societies working internationally is a vital operational aspect and must also be considered, as well as coordination with ICRC and with external partners. The institutional analysis should provide recommendations for future operations.

Geographically, the focus of the RTE will be Sierra Leone, Guinea Conakry and Liberia and Nigeria where the operations are largest (however only Sierra Leone, Guinea and Liberia will be visited). The other countries where there are operations should also be considered by the evaluators, but primarily through secondary data review and possibly some phone interviews. *The team is hesitant to include Nigeria in the absence of materials and time available for a desk review.*

Operationally, the focus should be on the response operation to date, and what lessons can be learned for the future operations. The preparedness operations in countries where there is no outbreak will be a secondary focus, providing context for any conclusions and recommendations on the future of the operation.

The **time period** under review is from March 2014 to date.

In order to consider the criteria of **upholding policy**, **efficiency**, **effectiveness**, **relevance and appropriateness** and **connectedness**, the following questions will be explored:

1) Upholding policy
   a) To what extent are the Principles and Rules for Red Cross and Red Crescent Humanitarian Assistance being followed in the operation. *The evaluation team awaits instructions on which Principles and Rules should be included in this review.*

2) Relevance and appropriateness
   a) How were the needs assessed (including analysis and predictions made), and how was criteria established for launching emergency appeals?
   b) Is the IFRC response strategy (with its five pillar approach) delivering appropriately in proportion to the needs?
   c) Is the regional appeal relevant/appropriate?
   d) Is the response strategy balanced with realistic donor support estimates?

3) Efficiency and effectiveness
   a) How well is the operation delivering on existing needs identified?
      i) ***Systems****:* Are the existing IFRC systems and structure (including response tools)[1] appropriate to deliver efficient and effective response to the outbreak?
      ii) ***Use of resources:*** How effective and efficient is the system to mobilize and utilize resources (financial, HR or others)?
      iii) ***Timeliness:*** are services being delivered within adequate time?
      iv) *Coordination:*
         (1) Is internal coordination within the secretariat efficient and effective?
         (2) Is the coordination mechanism effective and working for all Movement members?
         (3) Is the coordination with other humanitarian actors effective?
      v) *Human resource support*
         (1) Are the safety and support measures (including psycho-social) in place for staff and volunteers effective and relevant?
         (2) Are staff and volunteers sufficiently equipped and trained to perform the tasks required of them?

4) Connectedness
   a) How well is the operation likely to deliver on predicted future needs?
      i) Is the structure and strategy currently in place sufficient to ensure an efficient and effective response for the probable future operation?

[1] Including DREF, Emergency Appeal & EPOA; GLS, HR, RDRT, ERU, SOPs, IFRC Delegations, DMU, etc

ii) How can the operation scale up in an appropriate manner, considering recovery needs of the population and capacities of operating National Societies?

IV. Evaluation Methodology and Process

Method of inquiry

The qualitative research methods used for the Ebola RTE will include key informant interviews, focus group discussions, and a desk review. Documents for the desk review will include internal IFRC materials (appeals, strategic plans, reports, communication materials, operational protocols, etc.) as well as external materials from other agencies and sources. Survey results from an internal online survey will also provide data for analysis. During fieldwork, the evaluation team will make structured notes from observations, and take photos and/or video when appropriate to include as part of the evaluation report.

Analysis of data will involve qualitative data analysis techniques such as comparison and coding of field notes and interview transcripts. The team will initially focus on the questions and themes listed below, but will be open and receptive to themes and avenues of inquiry that emerge during fieldwork.

Inception Phase

The RTE team met in Geneva on the 27th-29th November 2014. Preparations for the RTE were undertaken with the Evaluation Management Team (EMT) and 8 initial context relating key informant interviews were held. The inception document will be sent to the EMT on 29 November 2014.

Document review

The EMT has assisted the evaluation team with the provision of background documentation in relation to the IFRC Ebola response. Review of these documents has informed the Ebola RTE methodology and evaluation questions. A list of these documents will be included in the final report.

Key informant Interviews and focus group discussion

Key informant interviews will begin in the inception phase to gather contextual information to inform the development of the RTE. Further key informant interviews will be conducted in the evaluation. IFRC zone and regional delegation assistance is requested to identify key informants to interview in the field. IFRC assistance is also requested to identify key informants and contact details from relevant PNS's including MSF, UN and ICRC in the field. A list of Key Informants is included in the final report. Focus groups with volunteers will be conducted.

Field visits

The Ebola RTE team will visit the IFRC in Geneva before embarking upon three in-country field visits to Guinea, Sierra Leone and Liberia. The RTE team will divide into two interview teams, working in different countries simultaneously.

	27-29 Nov	30-7 Dec	8-9 Dec	9-13 Dec	14-16 Dec	17 Dec	Mid-January
Geneva	G,P,A,T						G
Guinea		A,T					
Sierra Leone		G,P	G,A,P				
Liberia				G,A,P	A,P	A	
Nairobi			T			P	

EMT assistance is requested to arrange entry visas for various countries for the duration of the RTE research phase.

The EMT and RTE team has requested Zone and regional offices to arrange interviews in Guinea, Sierra Leone and Liberia with IFRC Heads of Office, DM, Health and Support staff. Interviews will be arranged through the IFRC Regional Coordination office staff with the respective National Societies' management, ICRC management and cooperation delegates, PNS representatives, and relevant stakeholders and partners such as MSF, UN RC/HC, UNICEF (if relevant) and other UN or INGO partners.

On-line survey

A voluntary IFRC on-line evaluation survey has been created and distributed to IFRC field staff. Analysis of the e-survey response will be included in the draft and final report findings.

Feedback and Consultation

Feedback and consultation is fundamental to the RTE process. The evaluators will meet with and debrief findings with--

- the IFRC Office at the end of each country visit
- the Zone Office in Nairobi
- staff of the IFRC in Geneva

A participatory workshop is planned for mid-January in Geneva, to elucidate meaning from the findings with the IFRC staff and help form meaningful recommendations to be presented in the final report.

Draft/Final Report

As per the TOR, the main report will not exceed 10,000 words (25 pages) plus an executive summary, plus appendices. The report will be structured,

- Title, Contents, Abbreviations, Lists of Figures and Tables
- Executive Summary
- Introduction
- Background
- Methodology
- Findings: Summary of IFRC contribution by country (short with details in an Annex)
- Conclusions
- Recommendations for IFRC response to this crisis, and future crises

The report appendices will include:

- Terms of Reference
- Bibliography
- Schedule of Interviews
- Brief summary of key issues/findings from each field visit
- Summary of E-Survey results

V. Evaluation Management

Project Management

The IFRC Geneva RTE Management team, the Africa zone office and the relevant country delegations have identified contact points appointed for the evaluation. These identified persons will support the evaluation by assembling documentation, liaison with offices, branches, and other agencies to be interviewed.

The Commissioner/Client

The Commissioner for the RTE is the USG for Programme Services, Walter Cotte. Mr Cotte was interviewed at the inception stage and a meeting will be arranged for the 2nd Geneva visit. The USG has responsibility for approving the management response to the RTE, as set out in the draft IFRC RTE Management Guide.

Evaluation Management Team

The EMT have been identified and met with the RTE team at the inception phase of the Ebola RTE in Geneva. The EMT will be informed of progress regularly during the evaluation and will assist with logistical and coordination issues throughout the evaluation. Daily debriefs will be presented by telephone/skype or sent by email from the split RTE team members to the EMT.

Evaluation Team

The RTE team is:

- Gilbert Burnham (Team leader)
- Philimon Majwa (Team member)
- Alexandra Murray (Team member)
- Tim Roberton (Team member)

Limitations

The evaluation will attempt to limit the time in field to 2-3 weeks and attempt to complete the draft report within 3 weeks of the field visits being completed, inclusive of the Christmas period.

VI. Proposed respondents

	Guinea	Sierra Leone	Liberia	Regional (Accra)	Regional (Dakar)	Africa Zone (Nairobi)	Global (Geneva)
Community members	x	x	x				
NS volunteers	x	x	x				
NS leadership	x	x	x				
IFRC in-country	x	x	x				
IFRC secretariat				x	x	x	x
PNS delegates	x	x	x				
ICRC delegates	x	x	x				
External stakeholders	x	x	x	x			x

VII. Elaboration of evaluation questions and data sources

Evaluation questions listed in TORs	Questions to include in evaluation tools	Data source	
		Participants	Documents
Upholding policy			
a) To what	Are Red Cross activities and strategy consistent with internal and external policies/standards (e.g. Red	▪ IFRC secretariat	▪ Strategic docs

extent are the Principles and Rules for Red Cross and Red Crescent Humanitarian Assistance being followed in the operation?	Cross standards, Sphere standards)?	▪ IFRC in-country ▪ NS leadership	▪ Appeals ▪ Humanitarian standards
	Are existing humanitarian standards sufficient to guide humanitarian actors in the current outbreak? How could humanitarian standards be strengthened to reflect experiences in the outbreak?	▪ IFRC secretariat ▪ IFRC in-country ▪ NS leadership	▪ Humanitarian standards
Relevance and appropriateness			
b) How were the needs assessed (including analysis and predictions made), and how was criteria established for launching emergency appeals?	What assessments have contributed to IFRC strategy (since March 2014)? What mechanisms have been used for assessments? (IFRC tools? In-country research? NS assessments?)	▪ IFRC secretariat ▪ IFRC in-country ▪ NS leadership	▪ Assessment reports ▪ KAP survey reports
	Who was involved in developing IFRC and NS strategies? What community-level involvement was sought?	▪ IFRC secretariat ▪ IFRC in-country ▪ NS leadership	
	When were assessments conducted? How timely were these assessments? Are assessments up-to-date? Has current situation on-the-ground been captured in recent assessments?	▪ IFRC secretariat ▪ IFRC in-country	▪ Assessment reports ▪ KAP survey reports
	How was information from assessments shared? How were findings communicated to external stakeholders?	▪ External stakeholders	▪ Assessment reports ▪ Communication reports
	What monitoring activities exist for ongoing data collection (to inform strategy/activities)? What access and expertise does RC have to get and interpret external data (e.g. from CDC/WHO/MoH)?	▪ IFRC secretariat ▪ IFRC in-country	
	How is the IFRC and NS projecting future needs? Contingency planning? Risk planning?	▪ IFRC secretariat ▪ IFRC in-country ▪ NS leadership	▪ Strategic documents
	What was the decision-making process for initiating clinical case management activities in Sierra Leone?	▪ IFRC secretariat ▪ IFRC in-country	
c) Is the IFRC response strategy (with its five pillar approach) delivering	What are the comparative advantages of the RC (compared to other organizations/stakeholders on the ground)? Are current RC activities congruent with these strengths (comparative advantages) of the RC?	▪ IFRC in-country ▪ NS leadership	
	How appropriate are each of the five pillars given the current nature of the response? Is there a need for	▪ IFRC in-country ▪ NS leadership	

appropriately in proportion to the needs?	fewer/more pillars?	▪ External stakeholders	
	What gaps exist in the overall Ebola response? What gaps could NS and IFRC potentially fill?	▪ IFRC in-country ▪ External stakeholders	
	How have volunteer activity protocols evolved since earlier in the Ebola response? How have findings from earlier research/evaluations been reflected in revised protocols?	▪ NS volunteers ▪ NS leadership	
d) Is the regional appeal relevant/appropriate?	How appropriate/useful is the IFRC regional coordination structure that was added in August 2014?	▪ IFRC in-country ▪ IFRC secretariat	
	Is there duplication of activities/resources in country appeals and regional appeals?		▪ Appeals
e) Is the response strategy balanced with realistic donor support estimates?	Has enough money been raised to implement current strategies? Has the RC over-planned/under-planned, given available funding?		▪ Appeals ▪ Financial records
	Will currently accessible resources be sufficient for projected activities (foreseen and unforeseen)?	▪ IFRC in-country	▪ Appeals ▪ Financial records
	Are NS able to fundraise at their national level?	▪ NS leadership	
Efficiency and effectiveness			
How well is the operation delivering on existing needs identified?	Do staff/volunteers believe the IFRC/NS are responding to the Ebola crisis as best as possible?	▪ IFRC in-country ▪ NS leadership ▪ NS volunteers	
	What do staff/volunteers see as the main successes of the response to date? What aspects of the Red Cross Ebola response are having the biggest impact for the local population (in the opinion of staff/volunteers and external stakeholders)?	▪ IFRC in-country ▪ NS leadership ▪ NS volunteers	
	What do staff/volunteers see as the current challenges and obstacles to the Ebola response? What areas of the Ebola response are inefficient or represent a misuse of resources?	▪ IFRC in-country ▪ NS leadership ▪ NS volunteers	
	What actions could the IFRC and/or NS take to improve the overall Ebola response? What opportunities exist to enhance the impact of the Red Cross Ebola response?	▪ IFRC in-country ▪ NS leadership	
Systems			
Are the existing IFRC systems and structure (including response tools) appropriate to deliver efficient and effective	What systems exist for information sharing and data management? How is information communicated internally and externally? What gaps exist for information sharing and data management?	▪ IFRC in-country ▪ NS leadership ▪ NS volunteers	▪ Communication reports
	What in-country systems exist for monitoring and evaluation? Which in-country staff are responsible for M&E? What other systems exist for quality assurance? How is the information generated through these	▪ IFRC in-country ▪ NS leadership ▪ NS volunteers	▪ M&E reports

response to the outbreak?	systems being used and acted upon? [If respondents believe that M&E is weak, add: Why have effective M&E systems not been established? What are the bottlenecks/obstacles to stronger M&E?]		
	How are resource needs identified (staff, vehicles, finances)?	▪ IFRC secretariat ▪ IFRC in-country ▪ NS leadership ▪ NS volunteers	
	Volunteer systems: How are volunteers recruited? How are volunteers trained? How are volunteers supervised?		▪ Volunteer recruitment and training records
Use of resources			
How effective and efficient is the system to mobilize and utilize resources (financial, HR or others)?	Financial resources: How are financial resource needs identified? What financial controls (checks and balances) exist at in-country level (IFRC and NS)? How does IFRC support effective spending within NS?	▪ NS leadership ▪ IFRC in-country	
	Human resources: Are roles/responsibilities clearly defined? Are there overlaps in roles/responsibilities?	▪ IFRC in-country	▪ Job descriptions
	Vehicle management: Who is responsible for in-country fleet management? What procedures are in place to minimize misuse of vehicles?	▪ NS leadership ▪ IFRC in-country	
Timeliness			
Are services being delivered within adequate time?	Are strategic decisions made in a timely fashion? Are strategic plans updated with appropriate frequency?	▪ IFRC secretariat ▪ IFRC in-country	▪ Assessment reports ▪ Strategic documents
	Are needs assessments conducted and utilized in a timely fashion (data collection, data analysis, data sharing)? Are strategic plans responsive to assessments and new information?	▪ IFRC in-country	▪ Assessment reports
	Timeliness of logistical supplies? Are needs identified in adequate time to allow for procurement process? Is procurement process sufficiently streamlined to allow for timely logistics?	▪ IFRC secretariat	
	Timeliness of on-the-ground volunteer activities? Response time for burial volunteers? Response time for contact tracing? Frequency of social mobilization activities?	▪ NS leadership ▪ NS volunteers	▪ Volunteer activity protocols
Coordination			
Is internal coordination within the secretariat	Are the roles/responsibilities of IFRC actors understood by all? (Roles of offices? Roles of specific personnel?)	▪ IFRC secretariat ▪ IFRC in-country ▪ NS leadership	

efficient and effective? (i.e. IFRC Geneva, Nairobi, Regional)	Are roles/responsibilities clearly delineated? (Is there overlap, duplication of roles?)	▪ IFRC secretariat ▪ IFRC in-country ▪ NS leadership	
	What is the current decision-making structure? Are there more effective ways for decisions to be made?	▪ IFRC secretariat ▪ IFRC in-country	
Is the coordination mechanism effective and working for all Movement members? (i.e. between IFRC, National Societies, PNSs, ICRC)	How effective is the relationship between NS leadership and in-country IFRC leadership?	▪ NS leadership ▪ IFRC in-country	
	How do NS leaders feel about their relationship with IFRC, ICRC and PNS partner organizations? Do NS staff feel as though their voice is being heard? Do NS staff feel connected to the greater response structure? Do NS have a sense of ownership for local response activities?	▪ NS leadership	
	What is the relationship between IFRC, NS, ICRC and PNS? Are ICRC and PNS strategies aligned with NS strategies and overall response strategy?	▪ PNS delegates ▪ ICRC delegates	▪ PNS strategic documents
Is the coordination with other humanitarian actors effective?	What mechanisms exist for coordination with in-country external actors? Global/regional external actors?	▪ IFRC in-country ▪ External stakeholders	
	Are RC actors contributing sufficiently to coordination with other actors?	▪ External stakeholders	
Human resource support			
Are the safety and support measures (including psycho-social) in place for staff and volunteers effective and relevant?	What supervision and quality assurance mechanisms exist to oversee volunteer activities? How often is supervision and refresher training provided?	▪ NS volunteers ▪ NS leadership	▪ Volunteer activity protocols ▪ Training records ▪ Supervision records
	What challenges do volunteers face?	▪ NS volunteers	
	What PSS are staff/volunteers receiving? What is the nature and extent of this support? With what frequency is PSS being delivered? How do staff/volunteers feel about the provision of PSS?	▪ NS volunteers ▪ NS leadership	
	What are the plans for long-term support to volunteers? How will RC support volunteers beyond the outbreak?	▪ IFRC in-country ▪ IFRC secretariat ▪ NS leadership	
Are staff and volunteers sufficiently equipped and trained to perform the tasks required	How are volunteers recruited? Who is responsible for recruitment? Are there adequate numbers of volunteers to implement activities effectively?	▪ NS leadership ▪ NS volunteers	▪ Volunteer recruitment and training records
	How are volunteers trained? How do volunteers feel	▪ NS volunteers	▪ Volunteer

of them?	about the training they receive?		recruitment and training records
	How motivated are volunteers to conduct activities? What incentives are offered to volunteers?	▪ NS volunteers	
Connectedness			
Is the structure and strategy currently in place sufficient to ensure an efficient and effective response for the probable future operation?	How is the RC (IFRC, NS, ICRC, PNS) projecting the future needs of the Ebola response?	▪ IFRC secretariat ▪ IFRC in-country ▪ PNS delegates ▪ ICRC delegates	▪ Strategic documents ▪ Appeals
	To what extent do strategic documents articulate plans for future operations?		▪ Strategic documents ▪ Appeals
	Have sufficient resources been mobilized or identified to support future operations?	▪ IFRC secretariat ▪ IFRC in-country	▪ Appeals
How can the operation scale up in an appropriate manner, considering recovery needs of the population and capacities of operating National Societies?	What process is in place to determine post-outbreak recovery needs? What recovery needs have already been identified?	▪ IFRC secretariat ▪ IFRC in-country	
	What opportunities exist for recovery activities?	▪ NS leadership	
	What plans exist for long-term support to volunteers? How will IFRC/NS support volunteers beyond the outbreak?	▪ IFRC secretariat ▪ IFRC in-country	
	How will IFRC be engaged in Ebola case management in the future?	▪ IFRC secretariat ▪ IFRC in-country	
	What is the role of RC in reconstructing health services?	▪ IFRC secretariat ▪ NS leadership	

VIII. Questions on specific volunteer-based activities

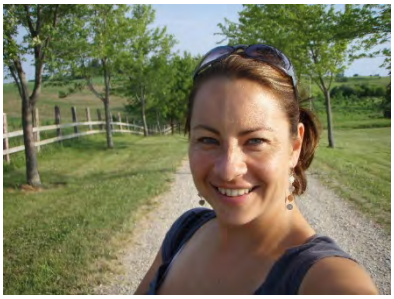
Strategy	Questions for actors involved in specific activities
Social mobilization and beneficiary communication	How are social mobilization volunteers recruited? How are volunteers trained? How are volunteers supervised? Are there adequate numbers of volunteers to implement activities effectively? How is volunteer morale? What incentives are offered to volunteers? What are the current social mobilization activities? Are these activities appropriate and relevant for the current response operation? What are the issues do volunteers face? (Challenges? Problems? Opportunities?)

	What is the relationship between volunteers and community members? Do volunteers feel supported by the communities in which they work? What messages are being communicated to communities? What communication tools/materials are being used? What channels of communication are being used? What other actors are involved in social mobilization? Are volunteers effectively engaging and utilization other community actors? Engagement of other opinion-formers: local politicians, local community leaders, local religious leaders? Coordination and integration of social mobilization activities with national strategy for social mobilization? Are RC activities harmonized with activities of other actors?
Safe and dignified burials and disinfection of houses	How are burial volunteers recruited? How are volunteers trained? How are volunteers supervised? Are there adequate numbers of volunteers to implement activities effectively? What processes are in place for quality assurance? How are burial volunteers being supervised? How often is refresher training delivered? Are volunteers being supported for quality assurance as planned? What are plans for long-term support to volunteers? How will RC respect/reward volunteers beyond the outbreak? What are current burial protocols? How have these protocols evolved since earlier in the Ebola response? How have findings from earlier research/evaluations been reflected in revised protocols? How are families being respected/involved in burial protocols? Commitment to respecting cultural traditions?
Clinical case management	What was the decision-making process for initiating clinical case management activities in Sierra Leone? What risks/challenges did decision bring? Does IFRC want to be engaged in Ebola case management in the future? Does the ETU have sufficient resources to operate effectively? Does the RC have sufficient expertise to manage the ETU? What challenges is the ETU currently facing? What risk management, safety, quality assurance measures are in place for ETU? What is the role of RC in reconstructing health services?
Psychosocial support	What is meant by psychosocial support? How is PSS defined? What are the goals for PSS activities? Who are PSS activities targeting? Staff? Volunteers? Beneficiaries? How is PSS delivered? What tools are they using to conduct PSS? Who is involved to deliver PSS?

	How are PSS needs identified? What capacity does RC have to deliver PSS?
Tracing and monitoring contacts	What are the current systems/procedures for contact tracing in the three countries? What level of coverage are contract tracing activities achieving? What are success factors and bottlenecks for effective contact tracing? What aspects of the system are working well or not working well?

I. Proposed Timelines

		Nov-14																	Dec-14				Jan-15			
	Task description	27	28	29	30	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16		1wk	2wk	3wk	4wk
1	Preliminaries																									
	Contracting																									
	Administrative arrangement and travel logistics																									
2	Inception Report																									
	Design, methodology, Data collection tools																									
3	Field Visits and Data Collection																									
	Travel from Geneva to Sierra Leone																									
	Travel from Geneva to Guinea																									
	Guinea and Sierra Leone Interviews																									
	Guinea field visit																									
	Sierra Leone field visit																									
	Interviews in Kenema																									
	Debriefing in Kenema and travel back to Freetown																									
	Debrief in Freetown and in Conakry																									
	Travel to Liberia from Sierra Leone																									
	Travel to Nairobi from Conakry																									
	Interviews in Monrovia																									
	Field Visits in Liberia																									
	Debrief in Monrovia																									
	Travel to host countries																									
	Debrief in Nairobi																									
4	Preparation of RTE Report draft 0																									
	Presentation of RTE report draft 0 to Evaluation Management team																									
	Feedback from Evaluation Management Team																									
	Incorporation of feedback from Evaluation Management and submitting Draft 1 for validation on factual issues by interviewees																									
	Incorporation of feedback on draft 1, and submitting draft 2																									
5	(if no further feedback to be incorporated) Submission of final RTE report to Evaluation Management Team																									



Curriculum Vitae

Alexandra Murray

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Employment:

2013-14 (16 months) Projects Manager Farm Practices: GRDC
2012 Catchment Coordinator- Monitoring and Evaluation: Lachlan CMA
2011 Agriculture Teacher: JSCHS
2009-10 Agricultural & Environmental consultant: AM AgriSolutions
2008 Agricultural Liaison Officer: NSW Minister of Primary Industries Office
2008 Locust Emergency State Chemical Coordination & Distribution and Reporting officer: (Nov) NSW Department of Primary Industries State Control Centre (SCC)
2007 Equine Influenza Emergency Situation and Planning Officer: NSW SCC
1999-2006 District Agronomist, Rice-based Systems: NSW DPI (Food Security)

Major International Project work:
2011 Australian Red Cross (ARC)/ ICRC Strategic Evaluation of Flood Relief in Pakistan
2005 The French Red Cross (FRC), Maldives: Community Development and Livelihoods
2005 FAO, Maldives: Technical Specialist, Agriculture
2002 UNDP, Cambodia: Participatory Methodology Specialist: Increasing government extension officers' capacity for engagement with the indigenous rural community
2000 Ausaid, Maldives: Food Security and Empowerment of Women, Agricultural project

Tertiary Education:

2012 Diploma of Education; University of New England
2005 Master of Rural Development and Management; University of Queensland, Australia/ Wageningen Research University, Netherlands, Europe
1999 Bachelor of Rural Science; University of New England, Armidale, Australia

Appropriate Certificates and Courses

2014	Capacity Development Across Cultures (CDAC) ARC scheduled Nov.
2014	International Humanitarian Protection Training (IHPT) ARC
2013	FAO Improved Global Governance for Hunger Reduction (online cont.)
2011	St John's First Aid Certificate
2009	Capacity Development (ARC) AQFIV Managing Chemical Use (original course 2002)
2009	Monitoring and Evaluation (ARC-Clear Horizon)
2008	NSW Agriculture Emergency Management Basic Training Course (BTC)
2006	Red Cross Delegate BTC: AND Women Ambassadors on Boards
2005	Certificate IV in Work place Training
2003	Australia Asia New Leaders Program: Asialink (University of Melbourne)
2002	Cultural diversity in the Workplace

Professional Development

Position	Aim	Outcome
GRDC Farm Practices Project Manager 2013 (June 2013)	Deliver research and development outcomes to benefit the Australian grains industry	Manage issue identification, procurement, implementation, progress and MERI of $10M of agricultural systems development. Organisational leadership: facilitate theme strategy, MERI planning and process refinement. Coordinate evaluation process for the Strategic Plan review.
Catchment Coordinator: Strategic Planning 2012	Create strategic relevance and direction for Lachlan CMA	Created framework for Monitoring and Adapting the 2013-2022 Lachlan Catchment Strategic Plan. Applied resilience thinking and continuous improvement to link strategic, evaluation and operational plans.
Agricultural Science Teacher 2011	To create inclusive pedagogy so students engage in student centred, constructive learning. Build curriculum to develop capacity of students in agriculture	Students engage in adapted curriculum in order to achieve learning goals. Used creative pedagogy with varied learning methodology to scaffold learning. Conducted training, extended knowledge and assessed and evaluated learning
Agricultural and Environmental Management Consultancy 2009/10	Provide Agricultural liaison and capacity development of Environmental project design, M&E and technical expertise	Efficient agricultural liaison for state gas line construction Commonwealth funded modernisation for Jemalong and Narromine Irrigation Schemes and individual farm upgrades
EMERGENCY: State Chemical Coordination & Distribution Locust Plague Emergency, Nov. **2009 (3 months)**	Coordination: Coordinate and distribute resources for the NSW Locust emergency program	Efficient and resourceful management of the coordination and distribution of pesticide for the Locust emergency program Proficient communication and provision of planning information and situation progress reports to key State and National stakeholders, emergency management staff and community.

Position	Aim	Outcome
Liaison Officer (Agriculture), for NSW Minister for Primary Industries **2008**	Liaise with key stakeholders on issues for State agricultural policy analysis and development	Successful development of key agricultural stakeholder and government relationships. Key conduit for stakeholder consultation for bio-security policy and agricultural development
EMERGENCY: Situation Report Officer Equine Influenza (EI) Emergency SDCHQ **2007 (6 months)**	Planning: Coordination of the daily Situation Report and daily Plan for the EI emergency program	To effectively communicate the EI daily outcomes to stakeholders and emergency staff involved in the program To communicate the daily EI program plans for that lead to the efficient coordination for the containment and eradication of the disease Coordination of the EI operational debriefs and evaluation workshops.
NSW DPI **District Agronomist**, NSW DPI **1999-2006**	Managed agronomy services to increase the sustainable rural livelihoods of dry-land and irrigation farmers and key stakeholders in Australia's isolated temperate rice growing region. Expanded agricultural commodity value-chains Engagement with key agricultural and environmental policy stakeholders	Lead technical advisor for district agronomy and promotion of sustainable crop intensification, crop protection (IPM) and resilience to climate change Strengthened networks and coordinated collaborative R&E work between key industry stakeholders, institutions, government, non government organisations and small holder farmers Increased the adoption of sustainable agronomy, management techniques based on Conservation Agriculture practices. Successfully coordinated and facilitated regional farmer agronomy discussion groups, meetings, national conferences and seminars dealing with plant production and livelihood security

Position	Aim	Outcome
EMERGENCY: Post Tsunami Technical Specialist Agricultural recovery, FAO, Maldives, **2005 (6 months)**	Advise the Maldives' Ministry of Agriculture strategic recovery direction Advise on agricultural constraints in the post Tsunami environment.	Collaboration to create 5 yr recovery operational plan and budget matrix for Ministry of Agriculture, post Tsunami Development of technical guidelines for FAO agricultural recovery kits Facilitated workshops on Tsunami impact and recovery of soils. Technical instruction with agriculture officers on production of technical extension materials and the use of salinity monitoring tools
EMERGENCY: Post Tsunami Community Development and Livelihood Advisor, French Red Cross, Maldives, **2005 (6 months)**	Managed implementation of Recovery for Livelihood sector for Internally Displaced Persons (IDP's) in Laamu Gan, Maldives Facilitate stakeholder participation in IDP livelihood recovery program Efficiency of recovery budget	Grassroots participatory livelihood Needs Analysis of IDP's. Evaluate and assess vulnerability of IDP's using Livelihoods Framework. Formed risk management strategies. Engaged beneficiaries with Participatory Rural Appraisal (PRA) skills such as participatory planning management tools and local knowledge and abilities to set strategic direction of Maldives recovery process Chief advisor for French Red Cross $21M recovery budget fund for Maldives
Agriculturalist-Community Development Advisor, Ausaid, Maldives, **2000 (6 months)**	Empowerment of rural women to increase Food Security and Livelihood income generation Building volunteer counterpart capacity to plan and manage nutrition projects.	Training and extension of vegetable production with women in impoverished and nutritionally poor Capacity building mentorship for the local management of four community gardens and the development of a commercial garden Workshops on soil amelioration, plant protection, nutrition, chemical and food safety.

Conferences and Presentations

- 2013 Australasian Evaluation Society International Conference, *Creating Effective Use Of Evaluation Through An Operationally Embedded Adaptive Management Framework,* Brisbane.
- 2013 APEN International Conference, *A Solution to Rigid Government Planning through Adaptive Management,* Lincoln University, New Zealand.
- 2013 Australian Soil Science Society (Riverina Branch), *Lachlan CMA Soils Program Performance*, CSU, Albury.
- 2012 LCMA. *Monitoring and Adapting the 2013-2022 Lachlan Catchment Action Plan.*
- 2008 Bridging the Gap for Climate Change The *Farmers Guide to Managing Climate Risk* , Portoroz, Slovenia (poster presentation)
- 2005 National Irrigation Conference, Round Table Presentation: *Gender; female involvement in a male dominant industry*, Mildura, Australia.
- 2005 FAO, *Post Tsunami Salinity Train the Trainer Workshops,* Ministry of Agriculture, Republic of Maldives
- 2003 GRDC Irrigation Update, Presentation of Paper: *Year to Date, Deniliquin District,* Moama, Australia
- 2002, The Inwent International *Workshop on Participatory Methods in Poverty Reduction*, Phnom Phen, Cambodia.
- 2001, Eurorice 2001, Presentation of paper: *The Australian Process and Involvement of Extension in Rice Breeding*, Krasnodar, Russia.

Referees

Strategic Planning and Evaluation

Ms Lyndal Hassellman PhD candidate
former Program Manager- Planning: Lachlan CMA
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Farming Systems Referees

Brondwen MacLean GRDC
Head Research Farming Systems,
Phone +61 (0) 2 61664500
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Dr David Herridge
School of Environmental and Rural Science- *former Principal scientist DPI*
University of New England
Phone: +61 (0)488 682037 or (0)2 49426950
Email david.herridge@dpi.nsw.gov.au

Liaison and Development Referee

Mr Kamina Ntenda Musangu, (former FAO officer)
Rural Development Advisor
UNDP-PNUD Haiti
Phone: +66890506401 or + 509 6587247
Email kamina.ntenda@undp.org

CURRICULUM VITAE

1. **Family name:** **Majwa**
2. **First name:** Philimon
3. **Residence:** Nairobi, Kenya
4. **Email:** Philimon@ventrixconsulting.co.ke philimonomondi@yahoo.com
5. **Telephone** **+254713764507**
6. **Availability** **1st November 2014**
7. **Daily Rate** **USD 500**
8. **Education:**

Institution (Date from - Date to)	Degree(s) or Diploma(s) obtained:
Kenyatta University, Nairobi, Kenya January 2013 – To date	Doctor of Philisophy (Environmental Health) Area of study: Impact of nutrition intervention on reduction of malnutrition among under-five children during drought in Turkana Central sub-county, kenya
Kenyatta University, Nairobi, Kenya July 2006 – December 2009	Master in Public Health Degree: (Environmental Health and Disaster Management)
Jomo Kenyatta University, Thika, Kenya April 1997 – December 2000	Bachelor of Science Degree

9. **Language skills:** Indicate competence on a scale of 1 to 5 (1 - excellent; 5 - basic)

Language	Reading	Speaking	Writing
English	**1**	**1**	**1**
Kiswahili	**1**	**1**	**1**

10. **Key qualifications**

Philimon Majwa has worked in the Environmental health and disaster management sector focusing mainly in Emergencies since 2003 when he joined Kenya Red Cross Society as a Programme Coordinator worked with International Federation of Red Cross Society, Oxfam GB, Actionaid International and Catholic Development Commission in Malawi. His professional experience spans over 10 years and includes Disaster Management, project management, proposal and report writing, technical assessments, workshop facilitation, water quality assessment, knowledge management, monitoring and evaluation, WASH in schools, hygiene promotion, editorial, capacity building and training, gender, coordination, supervision and advocacy. He has done assignments in Kenya, Somaliland, Southern Sudan, Rwanda, Burundi, Ethiopia, Tanzania, among other African countries focusing on emergency preparedness and response.

11. **Specific experience in the region:**

Country	Date from - Date to
South Sudan	2009
Somaliland	2010 - 2012
Kenya	2000 – 2009, 2013
Malawi	2009 - 2010
Tanzania	2007
Uganda	2007, 2011, 2013

12. Professional experience:

Date from-to	Location	Position	Description
May 2012 – May 2014	Nairobi Kenya.	Emergency Preparedness advisor	• Supported 15 Actionaid Africa Country Programmes and 3 Actionaid Americas country programmes to assess country level (including partner) capacities and gaps for emergency response. • Facilitated Disaster Preparedness training for Actionaid and Partner staff in 14 Actionaid Country Programmes in Africa and 3 Actionaid Country Programmes in Americas to inform and implement disaster preparedness plans at local, regional and national levels • Supported in reviewing and integration of disaster preparedness in 6 Country Strategic Plans, 15 Country Engagement plans and 2 Country Development plans. • Supported the development of 12 Disaster Preparedness Plans in 12 Actionaid Country Programmes in Africa and 2 Disaster Preparedness plans for Actionaid Country Programmes in Americas • Designed and developed an LRP and Country Programmes mapping tool to assist in disaster mapping and tracking of emergency response activities within the Actionaid country Programmes • Supported 16 Actionaid Country Programmes in Africa and 2 Actionaid Country Programmes in Americas to put in place Disaster preparedness guidelines, policies and partnerships to enhance effective disaster preparedness planning and disaster response • Supported 3 Actionaid Country Programmes in Africa to run, review and act on in-country simulation exercises based on preparedness plans. • Supported fundraising for disaster preparedness programmes at the country and regional level to enhance risk reduction within Africa and Americas Actionaid countries • Engaged on advocacy and lobbying on aid effectiveness within the Actionaid target countries in Africa and Americas through continuous engagement with the various political blocks mainly Africa Union, IGAD, ECOWAS and SADC.
0th January 2011 – 30th April 2012	Hargeisa, ,Somaliland	Disaster Risk Reduction Advisor	• Supported 5 local implementing partners to effectively deliver the drought risk reduction Programme and integrate Gender issues within Somaliland. • Organized and facilitated disaster preparedness and contingency planning for Oxfam implementing partners. • A team member of a task force to review Somaliland Disaster Management Policy and Pastoral Management Policy. • Coordinator emergency response on floods and drought together with the implementing partners. • Ensured that rights-based programming is well-tailored into the drought

Date from-to	Location	Position	Description
			preparedness project • Guided the implementation scheme of the project activities by drawing up detailed implementation process and monitoring it accordingly • Supported National Environmental Research and Disaster Preparedness Authority (NERAD) implement its disaster preparedness and management strategy, plans and coordinate with others whom their work related to disasters • Lead the development of national disaster preparedness plans and organizational emergency contingency plans for both Oxfam GB and its partners mainly government of Somaliland • Initiated capacity audit of Oxfam GB Somaliland and partners in DRR and emergency response • Supported capacity building programmes on DRR, contingency planning and Early Warning System for Oxfam implementing partners • Reviewed annual budgets and forecasts developed by Oxfam Implementing partners and ensure timely submission to funding partners. • Responsible for project budget management, including monitoring expenditure against budget, projections v actuals • Ensured effective and efficient management of project resources
4th January 2010 - 31st December 2010	Malawi	Disaster Risk Reduction Advisor	*Supporting Catholic development commission in Malawi to integrate Disaster risk reduction into Livelihood projects across Malawi*
13th March 2009 - 31st December 2009	Kenya	*Water, Sanitation and Hygiene Specialist*	*Consultancy Programmes on Water, Sanitation and Hygiene Sector*
26th November 2006 – 19th January 2009	Eastern African based in Kenya	*Disaster Management Manager*	• Supported Kenya, Uganda, Ethiopia, Burundi, Rwanda, Madagascar, Somalia and Tanzania National Societies to respond to a total of 15 disasters ranging from Floods, Drought, Cholera, Landslides, Population movement and Hepatitis E emergencies. • Supported 13 Red Cross National Societies in developing and updating their Preparedness and Contingency plans for various hazards within their countries • Organised and facilitated 6 disaster preparedness training for 6 Red Cross National Societies. • Reviewed the application for Disaster Emergency Relief Fund applications for localised emergencies from 12 Red Cross National Societies • Developed 4 Emergency Appeals for Ethiopia, Kenya, Uganda and Madagascar for donor support and fundraising activities.

Date from-to	Location	Position	Description
			• Supported Red Cross National Societies to develop Climate Change Adaptation Plans for the vulnerable communities living along the coastal areas. • Supported IFRC organizational five year strategy development on Disaster Risk Reduction and Community Health • Supported setting of annual targets during the annual Disaster Management planning to achievement the IFRC strategy within Eastern Africa
3rd February 2002 – 20th November 2006	Kenya	*Programme Coordinator*	*Coordinating Disaster response and preparedness activities, Community based Health project activities in Kisumu District.*
Consultancy Experience			
11th June 2014 – 30th July 2014	*Tanzania*	*International Consultant*	Assessment of Develoment Results under the Crisis Response and Recovery Cluster. The consultancy was assessing the achievement made by UNDP and its Partners in Tanzania from 2007 – 2010 UNDAF and 2011 -2015 UNDAP programming cycle.
24th March – 5th April	*Kenya and South Sudan*	*National Consultant*	Mid-term evaluation of ECHO Enhanced response capacity funding facility targeting the ECHO funded projects in Kenya and South Sudan.
June – September 2013	*Somaliland and Ethiopia*	*Consultant*	Evaluation of Oxfam GB ECHO funded Regional drought Decision in Somaliland and Ethiopia: The main objective of the project was to have credible analysis of the impact of the four phases of the Ethiopia and Somaliland cross border community based disaster risk management programme, and draw lessons to build Oxfam GBs institutional knowledge and that of stakeholders. Key features were to evaluate relevance, effectiveness, efficiency, sustainability and to document lessons learnt from Oxfam GB ECHO funded project.
14th March – 22nd April, 2009	*Southern Sudan*	*Consultant (Water, Sanitation and Hygiene Specialist)*	**1.1.** KAP survey on Water, Sanitation and Nutrition in Southern Sudan. The objective of the study was to gather, analyze and present qualitative and quantitative information that will guided the development of a Behavioral Change Communication (BCC) strategy, and served as baseline information for measuring interventional impacts. **1.2.** The study targeted caregivers and duty bearers at the household level, but also sought leverage with the community, service providers and policy makers.
April, 2009	Kenya	*Consultant (Water, Sanitation and Hygiene Specialist)*	*Training of Water Service Board on Social Mobilization for WASH programme* Developed training manual for Social mobilization for WASH programme. Trained the Water service boards in Nyeri and Isiolo on social mobilization for the WASH programme. Conducted a pre-test of social mobilization exercise at the community level with the trainees. *Developed implementation plans for the WASH social mobilization within the district.*
3rd – 21st May, 2009	Kathmandu, Nepal	Consultant (Water,	**1.3.** Developing a training curriculum for WASH in Emergency. Conducted desk review of UNICEF manuals on Emergency Response and

Date from-to	Location	Position	Description
		Sanitation and Hygiene Specialist)	Preparedness, Contingency Plans during emergency. Drafted a training manual for the WASH in emergency. Pre-tested the Manual for its effectiveness. *Conducted 2 trainings for UNICEF staff on WASH in Emergency.*
1st June – 30th October, 2009	Kenya	Deputy Team Leader (Water, Sanitation and Hygiene Specialist)	**1.4.** Conducting a Diagnostic Study on Sanitation Coverage in Lake Victoria South Water Service Board area. Reviewing and update the current state of sanitation and hygiene in the LVSWSB area; Preparing a sanitation strategy that is pro-poor, in consultation with both government and community stakeholders aimed at evolving an integrated sanitation system for the cities/towns included in the study, involving a combination of sewerage and on-site sanitation systems as appropriate; Propose institutional and managerial interventions needed in the sanitation sector to support improved planning, implementation, and management of the recommended combination of sanitation systems; Develop and standardize appropriate technological options and guidelines for sustainable sewerage and on-site sanitation systems where appropriate; and Prepare a sanitation and hygiene framework for action and a phased investment plan for the rehabilitation, development and expansion of sanitation systems in the LVSWSB area.
2007	*Southern Sudan*	*Consultant Trainer*	Basic First Aid training for 100 Sudanese Returnees. Training of 100 Sudanese returnees on basic first aid skills. *Developing post training implementation plan for the trainees.*
2009	Eldoret	Consultant (Water, Sanitation and Hygiene Specialist)	**1.5.** Training on sustainability of WASH in Schools Programmes in Eldoret Developing a training manual for sustainability of WASH in schools through community participation in operation and maintenance. Training of stakeholders mainly teachers and ministry of education staff on sustainability of WASH in schools. *Developed an implementation plan for the schools and the ministry of education staff.*

TIMOTHY JAMES ROBERTON

MPH, MIntS, BA Hons

Nationality	Australian	**Email**	timroberton@gmail.com
DOB	25 December 1979	**Post**	1 East Chase St, Apt 812 Baltimore MD 21202
Phone	+1-443-844-9749		

EMPLOYMENT

Institute for International Programs: Johns Hopkins University

January 2012 – Present
Baltimore, USA

Research Assistant

Technical assistance for a large-scale evaluation of the Burkina Faso Ministry of Health's community case management (CCM) program. Responsibilities include the collection and analysis of data related to implementation strength, quality of care, and program impact. As part of my work I have:

- designed and led a qualitative study on factors affecting the utilization of community health workers;
- trained and supervised interviewers and clinicians for a quality of care assessment of CCM services (including community-based observation and re-examination of child consultations);
- trained interviewers and coordinated data management for a large-scale survey of 18,000 households to model changes in child mortality as a result of the CCM program;
- designed and programmed multi-level survey questionnaires for electronic data collection using Pendragon survey software.

Other recent projects through Johns Hopkins University

- Review of iCCM Taskforce's Indicator Handbook as applied to the routine monitoring systems for CCM in DRC, Madagascar, Niger, Senegal, South Sudan and Zambia.
- Qualitative data analysis and manuscript preparation for a study on formal health system supports for community health workers in Tanzania.
- Quantitative data analysis for a study on community-based management of acute malnutrition (CMAM).

Grassroots Strategies

July 2008 – August 2011
Perth, Australia

Community Development Consultant

Contracted by government and non-government organizations to design, coordinate and evaluate community development projects in Australia and abroad. Work included coordination of a two-year project to increase recreational opportunities for young adults with high support needs, development of a health education program and organizational strategic plan for a local NGO in rural Malawi, and in-country rapid assessment and project support to World Vision Georgia in the aftermath of the 2008 Russia-Georgia conflict.

Australian Red Cross
January 2008 – July 2008
Banda Aceh, Indonesia

Project Officer: International Blood Projects

Responsible for monitoring and evaluation of a five-year technical project in Banda Aceh, Indonesia, to restore the local blood service following the December 2004 tsunami. Work included the revision of volunteer blood donor guidelines.

Disability Services Commission
December 2006 – January 2008
Perth, Australia

Local Area Coordinator

Employed on a permanent basis by the Western Australian state government Disability Services Commission as a Local Area Coordinator in the north-east metropolitan region of Perth. Established multiple programs to increase inclusive recreational opportunities for people with a disability or mental health illness.

World Vision: Russian Federation
July 2005 – December 2006
North Caucasus, Russia

Program Officer

Responsible for monitoring and evaluation of all World Vision projects throughout Russia, including oversight of an integrated health, psychosocial and child protection project involving mobile health teams, child friendly spaces and health promotion activities. Also responsible for staff training in Sphere standards and the development of a regional disaster preparedness plan.

World Vision: West Bank/Gaza Strip
March 2004 – July 2005
Jerusalem

Program Assistant

Responsible for monitoring and evaluation of selected health and agriculture projects, communication with the Israeli and Palestinian defense forces, and development of a disaster preparedness plan for the Israeli disengagement from the Gaza Strip in August 2005.

EDUCATION

Doctor of Public Health (IN PROGRESS)
August 2011 – Present
Baltimore, USA

Johns Hopkins University

Master of Public Health
August 2007 – July 2009
Perth, Australia

University of Western Australia

Master of International Studies
January 2002 – December 2002
Sydney, Australia

University of Sydney

Bachelor of Arts
September 1998 – July 2001
Cambridge, England

University of Cambridge

TRAINING

- **Health Emergencies in Large Populations** (Baltimore, July 2010)
- **Leadership and Service Development in Human Services** (Perth, October 2007)
- **LEAP Design, Monitoring and Evaluation International Training** (Bangkok, May 2006)
- **Sphere Humanitarian Relief Standards, Training of Trainers** (Jordan, August 2005)
- **World Vision: Security Management** (Germany, May 2005)
- **Local Capacities for Peace / Do No Harm Framework** (Jordan, October 2004)

AWARDS

- Winner of the 2012 Humanitarian Assistance Award from the Center for Refugee and Disaster Response at the Johns Hopkins Bloomberg School of Public Health
- Winner of the 2010 Postgraduate Student Award from the Public Health Association of Australia
- Awarded a Churchill Fellowship in 2010 to travel to France to study the work of *L'Association Ressource Nationale Musique et Handicap*
- Winner of the 2009 University of Western Australia School of Population Health Postgraduate Student Association Prize (for obtaining the highest aggregate mark in the MPH program)
- Winner of the 2009 University of Western Australia Konrad Jamrozik Prize (for obtaining the highest aggregate mark in the core units of the MPH program)
- Finalist for the 2009 WA Young Australian of the Year Award

ADDITIONAL SKILLS & EXPERIENCE

Languages — **French** – advanced fluency in spoken and written French, having obtained DELF A1, A2, B1 and B2 diplomas and having spent one year working in a French-speaking organization in Burkina Faso.

Software — Professional experience with Microsoft Office Suite, Adobe Creative Suite, Stata, SPSS, NVivo, Atlas.ti and Pendragon.

Volunteering — Founded Catch Music Inc, a non-profit organization that runs community music activities in Perth, Australia. Extensive volunteer experience in Australia with TEAR, the WA State Emergency Service, and Prison Fellowship.

BIOGRAPHICAL SKETCH

Provide the following information for the key personnel and other significant contributors in the order listed on Form Page 2.
Follow this format for each person.

NAME	POSITION TITLE
Gilbert M Burnham	Professor of International Health
eRA COMMONS USER NAME	

EDUCATION/TRAINING *(Begin with baccalaureate or other initial professional education, such as nursing, and include postdoctoral training.)*

INSTITUTION AND LOCATION	DEGREE *(if applicable)*	YEAR(s)	FIELD OF STUDY
Southern University, Collegedale, Tennessee	BA	1964	Biology
Loma Linda University, Loma Linda, California	MD	1968	Medicine
Fitzsimons Army Medical Center, Denver, Colorado	FACP	1974	Internal Med Residency
London School of Hygiene & Tropical Medicine	MSc	1976	Clinical Tropical Medicine
London School of Hygiene & Tropical Medicine	PhD	1988	International Health

A. Positions and Honors. List in chronological order previous positions, concluding with your present position. List any honors. Include present membership on any Federal Government public advisory committee.

1969-71 General Medical Officer/Battalion Surgeon, 7th Infantry Division (Korea); Letterman Gen Hospital (CA)
1974-75 Deputy Hospital Commander, Noble Army Hospital, Ft McClellan, Alabama
1976-77 Physician, Mwami Hospital, Private Bag 5, Chipata, Zambia
1977-91 Medical Director & Physician, Malamulo Hospital, PO Makwasa, Malawi
1980-91 Principal Investigator, Thyolo District Onchocerciasis Research Project, Malawi
1980-91 Medical Director Shire Valley Leprosy Control Project, Chikawa and Nsanje districts, Malawi
1981-91 Director, Malamulo School of Health Sciences, Makwasa, Malawi
1991-97 Assistant Professor, Johns Hopkins Bloomberg School of Public Health
1997- Associate Professor, Johns Hopkins Bloomberg School of Public Health
1997- Director, Center for Refugee and Disaster Studies, Johns Hopkins Bloomberg School of Public Health
2005- Professor, Johns Hopkins Bloomberg School of Public Health

B. Selected peer-reviewed publications since 2004 (in chronological order).

- Burnham G. Onchocerciasis in Malawi I: prevalence, intensity and geographic distribution in *Onchocerca volvulus* infection in the Thyolo
- Roberts L, Lafta R, Garfield R, Khudhairi J, Burnham G. Mortality before and after the 2003 invasion of Iraq: cluster sample survey. *Lancet*, 2004; 364:1857-64.
- Singh, K., Karunakara UK, Burnham G, and Hill KH. Forced Migration and Under-five Mortality: A Comparison of Refugees and Hosts in Northwestern Uganda and Southern Sudan. *European Journal of Population*. 2005;21:247-270.
- Ahmet A, Edward A, Burnham G. Health indicators for mothers and children in rural Herat Province, Afghanistan. *Prehospital and Disaster Medicine,* 2004;4;19:221-224.
- Nsungwa-Sabitti J, Burnham G, Pariyo G, and the Uganda IMCI documentation team. Implementing the Integrated Management of Childhood Illness (IMCI) programme in Uganda *Journal of Health and Population in Developing Countries,* 2004, 5 Nov 2004, 1-15.
- . Doocy S, Norrell D, Burnham G. Credit program outcomes: coping capacity and nutritional status in the food insecure context of Ethiopia. *Social Science and Medicine,* 2005,60:2371-82.
- Singh K, Karunakara U, Burnham G, Hill K. Using indirect methods to understand the impact of forced migration on ling-term under-five mortality. *Journal of Biosocial Science,*2005;37:741-760
- Pariyo G, Gouws E, Bryce J, Burnham G, Improving facility-based care for sick children in Uganda. *Policy and Planning, in press*
- Smith J, Burnham G. Conceiving and dying in Afghanistan. Editorial Commentary, *Lancet,* 2005 Mar 5-11;365(9462):827-8
- Doocy S, Norrell D, Teffera S, Burnham G. Outcomes of an Ethiopian Microfinance Program and Management Actions to Improve Service. *Journal of Microfinance, in press.*
- Singh, K., Karunakara UK, Burnham G, and Hill KH. Using indirect methods to understand the impact of forced migration on long-term under-five mortality. *Journal of Biosocial Sciences,* 2005;37:741-460.
- Doocy S, Burnham G. Point of use water treatment and diarrhea reduction in the emergency context: an effectiveness trial in Liberia. *Journal of Tropical Medicine and International Health,*2006;11:1542-1552.
- Burnham G. Preventing Disaster-Realizing Vulnerabilities and Looking Forward. *Harvard International Review*, 2006;23:83-84.
- Shannon Doocy, Gilbert Burnham. Assessment of socio-economic status in the context of food insecurity: implications for field research. World Health & Population. May 2006, p1-11.

• Dima Q, Doocy S, Tuschida D, Burnham G. The West Bank barrier decreases access to schools and health services. *Pre Hospital and Disaster Medicine, 2006, in press.*

• Doocy S, Vu A, Marks P, Burnham G. Malnutrition in the Conflict-Affected Beja Population of Northeastern Sudan: A Forgotten Emergency. *Journal of Emergency Management, in press*

• Burnham G, Lafta R, Doocy S, Roberts L. Mortality after the 2003 Invasion of Iraq: a cross-sectional, cluster sample survey. *Lancet,* 2006, online 12 October.

● Todd, C, Barbara Y, Doocy S, Ahmadzai A, Burnham G. Prevalence of HIV and related factors in tuberculosis patients in Afghanistan. *Sexually Transmitted Diseases,* 2007*,* 34;878-82.

● Peters D, Noor A, Singh LP, Hansen P, Gupta S, Kakar, F, Burnham G. Balanced Scorecard for Health Services in Afghanistan. *Bulletin of the World Health Organization,* 2007;85:146-151.

● Abdallah S, Heinzen R, Burnham G. Immediate and long-term assistance following the bombing of the US embassies in Kenya and Tanzania. *Disasters* 2007;31:417-434.

● Bishai D, Mirchandani G, Pariyo G, Burnham G, Black R. The cost of quality improvements due to integrated Management of Childhood Illness (IMCI) in Uganda. *Health Economics* 2008;17:5-19.

● Rowley E, Crape B, Burnham G. Violence-related mortality and morbidity of humanitarian workers. *American Journal of Disaster Medicine*, 2008;3:39-46*.*

● Nagai M, Karunakara U, Rowley E, Burnham G. Violence against refugees, non-refugees and hospt populations in southern Sudan and northern Uganda. *Global Public Health,* 2008;3:249-70

● Hansen PM, Peters DH, Edward A, Gupta S, Arur A, Niayesh H, Burnham G. Determinants of primary care service quality in Afghanistan.. *International Journal of Quality in Health Care*. 2008 Dec;20(6):375-83.

● Hansen PM, Peters DH, Viswanathan K, Rao KD, Mashkoor A, Burnham G. Client perceptions of the quality of primary care services in Afghanistan. *International Journal of Quality in Health Care,* 2008:20:384-91.

● Hansen PM, Peters DH, Niayesh H, Singh LP, Dwivedi V, Burnham G. Measuring and managing progress in the establishment of basic health services: the Afghanistan health sector balanced scorecard. *International Journal of Health Planning and Management,* 2008;23:107-17

● Morton M, Burnham G. Iraq's Internally Displaced Population. JAMA, 2008;300:727-8.

● Mayhew M, Hansen P, Peters D, Edward E, Singh L, Dwivedi D, Mashkoor A, Burnham G. Determinants of skilled birth attendant utilization in Afghanistan: A cross-sectional study. *Am Journal of Public Health,* 2008;98:1849-56.

● Doocy SC, Todd CS, Llainez YB, Ahmadzai A, Burnham G. Population-based tuberculin skin testing and prevalence of tuberculosis infection in Afghanistan. *World Health & Population,*. 2008 10:44-53

● Llainez YB, Todd CS, Doocy SC, Ahmadzai A, Burnham G. Prevalence of respiratory symptoms and cases suspicious for tuberculosis among public health clinic patients in Afghanistan, 2005-2006: Perspectives on recognition and referral of tuberculosis cases. *Tropical Medicine & International Health, in press*

● Burnham G, Lafta R, Doocy S. Departure of doctors from 12 tertiary hospitals in Iraq. *Social Science and Medicine, in press*

● Weiss W, Winch PJ, Burnham G. Factors associated with missed vaccination during mass immunization campaigns. *Health, Population and Nutrition,* 2009 *in press*

• Doocy S, Robinson C, and Burnham, G. Estimating Demographic indicators in a conflict-affected population in Eastern Sudan. *Prehospital and Disaster Medicine*, 2007;22:112-119.

• Burnham G, Lafta R, Doocy S. Departure of doctors from 12 tertiary hospitals in Iraq. *Social Science and Medicine,* 2009;69:172-7.

• Murray L, Burnham G. Understanding sexual abuse of girls in Africa (editorial commentary). *Lancet,* 2009, 373:1924-26.

• Weiss W, Winch PJ, Burnham G. Factors associated with missed vaccination during mass immunization campaigns. *Health, Population and Nutrition,* 2009;27:358-67.

• Weiss W. Burnham G, Winch P. Evaluating the Experience of GAPS—A Method for Improving Quality of Mass Immunization Campaigns in Developing Countries. *J Health Popul Nutr,*2009;27:684-95.

• Arur A, Peters D, Hansen P, Mashkoor MA, Steinhardt LC, Burnham G. Contracting for health and curative care use in Afghanistan between 2001 and 2005. *Health Policy and Planning,* 2009, Oct 22.

• Edward A, Dwivedi V, Mustafa L, Hansen P, Peters D, Burnham G. Trends in the quality of health care for children aged less than 5 years in Afghanistan 2004-2006. *Bulletin of the World Health Organization*, 2009;87:940-49.

• Chang C, Bonhoure P, Alam S, Burnham G. Use of the balanced scorecard to assess provincial hospital performance in Afghanistan. *World Medicine & Health Policy,* 2010;2:83-106.

• Doocy S, Malik S, Burnham G. Experiences of Iraqi doctors in Jordan during conflict and factors associated with migration. *Disaster Medicine*. 2010; 5:41-47.

• Opryszko MC, Majeed SW, Hansen PM, M;yers JA, Baba D, Thompson RE, Burnham G. Water and hygiene interventions to reduce diarrhea in rural Afghanistan: a randomized controlled study. *Journal of Water and Health,* 2010, 8;.687-702..

• Viswanathan K, Becker, S, Hansen PM, Kumar D, Kumar B, Niayesh H, Peters DH, Burnham G. Infant and under-five mortality in Afghanistan: current estimates and limitations. *Bulletin of the WHO,* 2010;88:576-583.

• Burnham G, Malik S, Al-Shibli, ASD, Mahjoub AR, Baqer AQ , Baqer ZQ, Faraj A, Doocy S. Understanding the impact of conflict on health services in Iraq: information from 401 Iraqi refugee doctors in Jordan. International Journal of Health Policy and Management, 2011, *Int J Health Plann* Manage. 2011 Jun 2. doi: 10.1002/hpm.1091

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- Rowley E, Burkle FN, Burns LN, Burnham G. Research review of non-governmental organizations' security policies for humanitarian programs in war, conflict, and post-conflict environments. *Disaster Medicine and Public Health Preparedness,* 2010, 4(doi:10.1001/dmp.2010.0723).
- Morton MJ, Burnham GM. Dilemmas and controversies within civilian and military organizations in the execution of humanitarian aid in Iraq: a review. *Am J Disaster Med*. 2010 Nov-Dec;5(6):385-91.
- Viswanathan K, Becker S, Hansen PM, Kumar D, Kumar B, Niayesh H, Peters DH, Burnham G. Infant and under-five mortality in Afghanistan: current estimates and limitations. *Bull World Health Organ.* 2010 Aug 1;88(8):576-83.
- Doocy S, Malik S, Burnham G. Experiences of Iraqi doctors in Jordan during conflict and factors associated with migration. *Am J Disaster Med.* 2010 Jan-Feb;5(1):41-7.
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- Malik S, Doocy S, Burnham G. Career plans for Iraqi refugee doctors in Jordan. *International* Migration, 2011, in press.
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- Doocy S, Sirois A, Anderson J, Tileva M, Biermann E, Storey JD, Burnham G. Food security and humanitarian assistance among displaced Iraqi populations in Jordan and Syria. *Soc Sci Med*. 2011 Jan;72(2):273-82.
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C. Research Support, selected examples

National Health Performance Assessment in Afghanistan (World Bank)-Co-PI
Assessing Hospital Performance in Afghanistan (World Bank) PI
Measurement of health needs among Congolese refugees in Tanzania (USAID) PI
Assessing health and fertility patterns among Sudanese refugees in Uganda (USAID) PI
Mortality Assessment, Iraq (MIT)-PI
Assessment of tuberculosis prevalence in Afghanistan (Ministry of Public Health, Afghanistan) PI

Measuring Impact of Child Health Initiatives in Uganda (USAID and WHO) PI
Strengthening Palestinian hospitals in Lebanon (US State Dept) PI
Public Health Leadership Initiative for East Africa (USAID) PI
Health Emergency Planning for district health teams, 6 countries in East Africa (USAID) PI
Measuring response to the tsunami in Aceh, Indonesia co-PI
Health Seeking Behavior among North Koreans (UNDP) PI
Health and livelihoods among Iraqi refugees in Jordan and Syria (Private funds) Investigator
Use of geospatial information in disaster preparedness (NSF) Investigator
HIV surveillance, Afghanistan, Investigator(Ministry of Public Health, Afghanistan)
National Drug Quality Assessment, Afghanistan, (Ministry of Public Health, Afghanistan) PI
Assessment of national maternal mortality reporting system, (USAID) Iraq, co-PI
Evaluation of IT-based rural health service information systems, (USAID) Iraq, co-PI
Multi country drug access study (Gates Foundation) PI

ANNEXEX 2

GUINEA ATTACHMENTS

List of persons interviewed

Guinea Emergency Appeal, Nov 1

Guinea Emergency Appeal,
Emergency Plan of Operations, Nov 1

Name	Organization	Position and Organization	Data Collection Method
In Geneva...			
Birte Hald	IFRC	Regional HEOPs for Ebola Response	Phone interview
Magna Olafsdottir	IFRC	Delegate, Ebola, Water, Sanitation and Emergency Health	Meeting
Walter Cotte	IFRC	Under Scretary Genera, Programme Services Division	Meeting
Bhupinder Tomar	IFRC	Head of Operations, Africa Zone	Phone interview
Sune Bulow & Ben Adinoyi Adeiza	IFRC	Health Department, Africa Zone	Phone interview
Panu Saaristo	IFRC	Health Department Geneva	Meeting
Isabelle Sechaud	IFRC	Logistics	Meeting
In Guinea...			
Multiple staff of GRC	GRC	GRC National Commission for Ebola	Meeting
Aliou Boly	IFRC	Head of Operations, IFRC Guinea	Interview
Ombretta Baggio	IFRC	Beneficiary Communications, IFRC Geneva	Interview
Jacques Katshitshi	IFRC	Regional Ebola Advisor	Interview
Papa Ousmane Faye	IFRC	Admin / Finance Delegate	Interview
Norbert Allale	IFRC	Deputy Regional Coordinator	Interview
Basile Zevounou	IFRC	Logistics Delegate, IFRC Guinea	Interview
Mamadi Keita	GRC	Field Coordinator Macenta, Guinea	Interview
Yvonne Kabagire	IFRC	Beneficiary Communications, Regional	Interview
Marion	UNMEER		Interview
?	MoH	National Coordination Representative	Interview
?	CDC	?	Interview

Red Cross Volunteers in Matoto	GRC	SDB volunteers	Focus Group
Gabrielle	Danish Red Cross	Country Representative	Interview
Yann	ICRC	Country Representative	Interview
Mohamed Ag Ayoya	UNICEF	Country Representative	Interview
Office debriefing	IFRC	All office	Group Meeting
MoH Representative for Coyah (name unknown)	MoH	MoH Representative for Coyah	Interview
Red Cross Volunteers in Coyah	GRC	SDB volunteers	Focus Group
Zachary Kamara	GRC	Field Coordinator, Conakry	Interview
Terry Carney	IFRC	Resource Mobilization	Interview
Louis Rol	IFRC	Logistics	Interview
Helena Humphrey	IFRC	Regional Communications	Interview

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Emergency appeal
Guinea: Ebola virus disease

International Federation of Red Cross and Red Crescent Societies

Revised Emergency Appeal **n° MDRGN007** Glide n° **EP-2014-000039-GIN**	**11.1 million people** to be assisted **CHF 250,000** DREF allocated **CHF180,000 ERU** **CHF 28.69m** budget	Appeal timeframe: 15 months End date: June 2015 Launched: April 2014; revised in July and November 2014

This revised Emergency Appeal for a total of some **CHF 28.69m** (increased from CHF 8.93m) enables the IFRC to support the **Guinea Red Cross Society** to respond to the escalating EVD outbreak by delivering assistance and support to some **11.1m people**, with a focus on **information and communication, education, awareness raising, and social mobilization, surveillance, case identification and contact management, safe and dignified burials and disinfection of houses, psychosocial support and patient transport**. With the Emergency Response Unit (ERU) component valued at some CHF 180,000, the total amount sought amounts to CHF 28.69m. The revised plan reflects an increased number of people to be reached, a scale-up of activities and the number of volunteers, and an enlarged geographic scope (see map), as well as support to national authorities in coordination of safe and dignified burials activities nation-wide. The planned response reflects the current situation and information available at this point of the evolving operation, and will be adjusted based on further developments and more detailed assessments.

Details are available in the Emergency Plan of Action (EPoA)

<click **here** for the Revised Budget and **here** for the contact details >

The disaster and the response

March 2014: Ebola outbreak occurred in Gueckedou, Guinea

March and April 2014: **CHF 250,000 DREF allocated**

April 2014: **Field Assessment and Coordination team (FACT)** deployed (rapid assessment); **ERUs** deployed (logistics and health). **Emergency Appeal** launched for total of CHF 1.2m (including ERU bilateral component of CHF 366,000) for 3m people)

28 June 2014: suspected, probable and confirmed caseload reaches 450 with 330 deaths.
30 July 2014: IFRC launched **revised emergency appeal for CHF 2.6m.**

August 2014: third wave in Guinea. Situation deteriorates with a total of 15 (out of 33) districts affected.

8 September 2014: Cumulative caseload reaches 690 with 460 deaths. **IFRC issues revised appeal for CHF 8.8m**

15 November 2014: The EVD outbreak continues to escalate resulting in a total of 1,958 cases in 25 out of 34 prefectures with 1,189 deaths. **IFRC revises emergency appeal to a total of CHF 28.69m**

The operational strategy

The overall goal is to stop the transmission of Ebola Virus Disease and bring an end to the current epidemic through the following outcomes:

- **Outcome 1:** The prevalence of Ebola Virus Disease in Guinea is reduced/eliminated through establishment of an appropriate response structure, local authorities and community engagement, beneficiary communication and social mobilisation, contact tracing and surveillance, provision of psychosocial support, safe and dignified burials, disinfection and Case management and treatment.
- **Outcome 2:** The existing capacity of the Guinea Red Cross National Society and IFRC management and technical support is enhanced and effective and sustainable action ensured
- **Outcome 3:** Support is provided to national authorities for countrywide coordination and information management of the overall safe and dignified burial and disinfection of houses response.

The operational strategy is based on latest epidemiological predictions and possible scenarios. Since the establishment of UNMEER, the IFRC and the GRC have been engaged in coordination and operational plans are being aligned with the overall humanitarian planning to ensure effective contribution to a consolidated response. The current strategy is based on responding to worst-case scenarios and is regularly being revised to reflect the situation and present the most realistic response plan.

The standard recommended public health actions implemented, using WHO standards, for stopping the Ebola outbreak, include;- the early identification of cases; isolating and treating all patients in Ebola Treatment Centres (ETCs) under the guidance of MSF; establishing rigorous contact tracing; providing safe and dignified burial practices (SDB); supported by coherent social mobilisation and sound risk communication practices. These key public health activities have been characterised as the five pillars of the IFRC Ebola response known as:

- Community engagement, beneficiary communication and social mobilisation
- Psychosocial Support
- Surveillance and contact tracing
- Safe and dignified Burials and disinfection, formerly called Dead Body Management
- Case Management and treatment.

Coordination and partnerships

The National Coordination committee, reporting directly to the Head of State, counts the following members: MSF, CDC, UNMEER, CRG/IFRC, African Union/ASEOWA, OOAS, ELU, MAE-Fr, and the Ministry of Health. This committee is composed of technical teams and support teams. The IFRC and GRC lead the SDB and sanitation teams, whereas other partners lead the following:

- Surveillance: WHO
- Case Management: MSF
- Communication and Social mobilisation: UNICEF
- Research: Dr Sekou Conde

The technical team, led by the IFRC/GRC includes transport of patients, sanitation and disinfection, as well as safe and dignified burials. In addition, IFRC/GRC is also active in other technical groups such as social mobilisation and contact tracing. The IFRC and GRC work in close cooperation and coordination with Red Cross movement partners in country, the ICRC and the Danish Red Cross are supporting the GRC community response activities while the French Red Cross have established an Ebola Treatment Unit in Macenta.

Proposed sectors of intervention

Health and care

Outcome 1: The prevalence of Ebola Virus Disease in Guinea is reduced/eliminated through establishment of an appropriate response structure, local authorities and community engagement, beneficiary communication and social mobilisation, contact tracing and surveillance, provision of psychosocial support, safe and dignified burials, disinfection and Case management and treatment

Output 1: Social mobilisation, community engagement and beneficiary communication

Community understanding, engagement, ownership and implementation of prevention and control measures is ensured through effective social mobilisation and two-way communication with beneficiaries, community leaders and religious leaders to prevent further transmission and control the outbreak

Activities planned
• Train 120 supervisors and 2,000 volunteers in EVD signs and symptoms, prevention measures and referral mechanisms as well as personal protection. (discontinued)
• Re-training of 100 supervisors and 1,000 volunteers (3 supervisors and 30 volunteers per branch) in social mobilisation, community engagement and beneficiary communication according to revised strategy and in coordination with UNICEF.
• Refresher training of 100 supervisors and 1000 volunteers every three months
• Mobilisation of 100 supervisors and 1,000 volunteers for 15 days per month
• Establish Ebola management teams (beneficiary communication, logistics and field coordination) in each of the 37 branches
• Equip all branches with vehicle for field movement
• Coordinate with and feed into national commission messaging / package development
• Reproduce and disseminate guidance and tools of community supervision cases – remove (does this mean discontinued or should the line be removed)
• Procure 2,400 “low-risk” PPE kits and train volunteers on the use of PPEs (Discontinued) • (93k equipment + 50k transport)
• Produce and disseminate 100,000 pieces of context-specific Information, Education and Communication (IEC) materials, including leaflets and posters
• Procurement of social mobilisation kits including banners, megaphones and other teaching materials for all branches.
• Procurement and distribution of 80,000 Epidemic hygiene kits (soap, chlorine, bucket)
• Procure visibility equipment and materials, including t-shirts, caps, stockers etc.
• Conduct health promotion campaigns using house-to-house, community sensitization and media campaign in affected districts
• Procure and distribute infrared thermo flash thermometers to all branch teams
• Establishment of TERA SMS broadcast system and broadcast of awareness messages.
• Establishment of one hour live interactive weekly television programme to be broadcast across Guinea with a focus on gathering and responding to communities needs for information
• Scaling up of current radio activities to two weekly one hour interactive radio broadcasts across Guinea with a focus on gathering and responding to communities needs for information
• Establishment of IVR (pre-recorded information exchange) system in cooperation with Local Telecommunication providers to provide access to pre-recorded prevention and programmatic information related to Ebola
• Train 470 volunteers in basic community engagement and beneficiary communications with a focus on the dissemination of Ebola information and feedback in all districts going (house-to-house) as well as document with mini-KAPS using RAMP/ODK
• 30 Short forums (2 per district) and engagement with “community resource oriented persons” Chiefs, traditional healers, teachers, soldiers and police, hunters, musicians, sport personalities etc. To build a team of leaders for communities to prevent Ebola and use as spokespersons on broadcast mediums

Radio and TV.
• Train Ben Comms field staff and volunteers in data collection RAMP/ODK to support SDB teams in information gathering and community engagement during SDB process.
• Establish system of data and information collection from all BC activities to disseminate for use on broadcast mediums, SMS, IVR, management and operational teams to allow a clearer understanding of current community thoughts and understandings of Ebola (identify gaps)
• Produce 5 minute radio dramas for broadcast on weekly SLRC Radio Broadcasts
• Produce 20 x 15minutes of audio recorded DRAMA series for distribution on CD or other media to communities
• Communication community field trips for TV/radio broadcast weekly gathering of audio and video programing
• Media training and workshop with national media companies to discuss Humanitarian BC activities
• Press briefings (if necessary)
• One day sessions with artists and musicians, film producers to discuss national Ebola strategy and how SLRC can work with these groups
• Short Training in community engagement and beneficiary communications to all operational staff
• Production of billboards, wall murals,
• Radio and TV production promotion materials for broadcast use
• Audio and Video training for BC field staff
• Bi weekly meeting (by phone) establish regional network of Ben Comms practitioners in the Ebola affected countries
• Two time BC regional meetings for affected country BC representatives
• Outside broadcast community engagement activities utilising radio retransmission (OB Unit)
• Upgrade and revamp the current Guinea RC hotline system to allow more efficient service delivery to communities
• Training of national headquarters staff on beneficiary communications techniques
• Distribution of solar/dynamo radio to communities to allow more access to Radio program information
Output 2: Safe and Dignified Burials and Disinfection of Houses *Risk of transmission of disease in the communities at household level and in health facilities reduced through disinfection and Safe and dignified burials.*
Activities planned
• Development of protocol and safety regulations for implementation of SDB
• Establishment of 76 SDB teams (9 people and 2 vehicles per team)
• Procurement and pre-positioning of personal protective equipment, body bags and other SDB related supplies
• Development of integrated community engagement, social mobilisation and psychosocial support tools and training packages.
• Training in SDB protocol and procedures, personal protection, safety measures and SOPs
• Refresher training of all personnel involved in SDB every three weeks
• Establishment of data collection and management systems
• Training of 76 volunteers on data collection tools
• Fitting of HF and HVF radio system in all vehicles and establishment of radio network linked to the national alert system.
• Procure and distribute infrared thermo flash thermometers to all branch teams
• Deployment of 76 SDB teams on an average of 20 days per month
Output 3: Psychosocial and economical support is provided to affected population
Activities planned
• Recruitment of PSS delegate
• Train 250 volunteers in psychosocial support techniques using the IFRC Reference Centre for psychosocial support material

• Refresher training of 250 PSS volunteers every three months
• Establish volunteer care mechanisms and systems.
• Provide psychosocial counselling to patients, affected family members, people who have been separated and volunteers.
• Accompany and support individuals discharged from isolation back to their communities to assist in re-entry and re assure community
• Conduct community visits for mitigation and reduction of stigma and fear.
• Establish selection criteria and validation systems for beneficiary selection; Transfer 1,000,000 GNF (130 CHF) to 10,000 families (with positive case/s)
• Procure and distribute infrared thermo flash thermometers to all branch teams
Output 4: community surveillance and contact tracing *In coordination with partner agencies, an effective alert investigation and contact tracing system is implemented to ensure rapid referral and care*
Activities planned
• Train 250 volunteers in contact tracing and community surveillance in accordance with national agreed procedures and guidance
• Refresher training every three months
• Deploy 250 volunteers to organize the active search for suspected cases and contacts in the community to detect suspected cases of EVD under the guidance of CDC and UNFPA
• Enumerate all the contacts and place them under daily surveillance for 21 days in order to detect the possible onset of fever.
• Procure and distribute infrared thermo flash thermometers to all branch teams
Output 5: Clinical case management support *Provision of patient transport services from communities to established ETCs*
Activities planned
• Mobilise and fit 50 makeshift pickup-truck ambulances (2 per projected response district)
• Train 200 volunteers in patient transport, protocols, personal protection, safety and SOPs
• Deploy 200 volunteers in 50 teams on an average of 20 days per month
• Procurement and pre-positioning of personal protective equipment and other patient transport related supplies
Outcome 2: The existing capacity of the Guinea Red Cross National Society and IFRC management and technical support is enhanced and effective and sustainable action ensured
Output 1: The NS has the necessary capacity to lead the operation and ensure sustainable impact
Activities planned
• Conduct a rapid assessment in the community to describe the current epidemic, in order to ensure that all actions of the chain of transmission are identified and measures to prevent future infections are implemented.
• Establish GRC task force at headquarter level maintaining close coordination with national health authorities, partner organizations and the GRC branches in the affected areas.
• Develop and maintain detailed emergency plan of action.
• Provision of office equipment and rehabilitation of 37 branch offices
• Pre-positioning of IEC and PPE at all branches.
• Provision of 10 bicycles and 2 motorbikes for each of the 37 branches
• Establishment of Ebola management teams in all 37 branches
• Provision of office equipment and establishment of operations coordination centre at headquarters level
• Establishment of central GRC warehouse and necessary personnel and procedure structure
• Train 100 community volunteers per branch in Ebola preparedness
• Establish and test contingency plans at national, regional and branch level
Output 2: Necessary IFRC resources are provided to support the operation.(A0202)
Activities planned

• Deploy FACT to support the NS in planning and implementation of the international response to the epidemic
• Conduct a rapid assessment in the community to describe the current epidemic, in order to ensure that all activities of the chain of transmission are identified and measures to prevent future infections are implemented.
• Deploy logistics ERU to support management of transport of personnel and equipment, incoming goods, procurement.
• Deploy IFRC delegates and an IFRC Regional Disaster Response Team to support GRC in implementation and management of the operation.
• Establish 5 warehouses for prepositioning of stocks to cover all affected areas
• Perform a real-time evaluation of the operation to guide further planning and implementation
• Conduct a final evaluation of the response
Outcome 3: Support is provided to national authorities for country-wide coordination and information management of the overall Safe and Dignified Burial and disinfection of Houses response
Output 1: SDB coordination and information management hub in Conakry is established
Activities planned
• Recruitment of SDB Coordinator and SDB Information Manager
• Contribute to national Coordination of the SDB work performed by all partners involved in the Ebola response
• Identification of key partners
• Assessment of SDB needs and response
• Consolidate, review and disseminate current standards.
• Collect, analyse and present key SDB response information
• Reporting of SDT indicator progress to the UNMEER response monitoring dashboard
Outcome 4: Longer-term effects of the outbreak and needs for early recovery, livelihoods and food security interventions are identified and IFRC/GRC activities planned.
Output 1: Food security and livelihoods assessment conducted
Activities planned
• Training of volunteers and National Society staff in food security and livelihoods assessment
• Conducting assessments and writing report
• Conduct discussion with key partners and share the outcome of the assessment
• Plan of action leads to revision of the Appeal and mobilisation of financial resources for food and nutrition security response and livelihoods recovery

Budget

- See attached IFRC Secretariat budget for details.

Walter Cotte
Under Secretary General
Programme Services Division

Elhajd As Sy
Secretary General

Reference documents ↘

Click here for:

- Emergency Plan of Action (EPoA)

Contact Information

For further information specifically related to this operation, please contact:

- **Guinea Red Cross Society:** Facély Diawara, Head of Health and Community Care department; phone: 224 642 265 08; Email: faceli76@yahoo.fr
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How we work

All IFRC assistance seeks to adhere to the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief and the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable. The IFRC's vision is to inspire**, encourage, facilitate and promote at all times all forms of humanitarian activities** by National Societies, with a view to **preventing and alleviating human suffering**, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

EMERGENCY APPEAL-REVISED BUDGET

18/11/2014

Budget Group	Multilateral Response	SDB Coordination	Bilateral Response	Appeal Budget CHF
Shelter - Relief	0			0
Shelter - Transitional	0			0
Construction - Housing	0			0
Construction - Facilities	0			0
Construction - Materials	0			0
Clothing & Textiles	0			0
Food	0			0
Seeds & Plants	0			0
Water, Sanitation & Hygiene	137,280			137,280
Medical & First Aid	5,941,640			5,941,640
Teaching Materials	229,980			229,980
Utensils & Tools	483,000			483,000
Other Supplies & Services	0			0
Emergency Response Units			180,000	180,000
Cash Disbursements	1,300,000			1,300,000
Total RELIEF ITEMS, CONSTRUCTI	**8,091,900**	**0**	**180,000**	**8,271,900**
Land & Buildings	0			0
Vehicles Purchase	396,000			396,000
Computer & Telecom Equipment	638,600	4,000		642,600
Office/Household Furniture & Equipn	97,133			97,133
Medical Equipment	0			0
Other Machinery & Equipment	0			0
Total LAND, VEHICLES AND EQUIP	**1,131,733**	**4,000**	**0**	**1,135,733**
Storage, Warehousing	112,000			112,000
Distribution & Monitoring	82,260			82,260
Transport & Vehicle Costs	6,355,054	24,000		6,379,054
Logistics Services	5,760			5,760
Total LOGISTICS, TRANSPORT AN	**6,555,074**	**24,000**	**0**	**6,579,074**
International Staff	2,366,500	144,000		2,510,500
National Staff	46,763			46,763
National Society Staff	817,770			817,770
Volunteers	2,963,340			2,963,340
Total PERSONNEL	**6,194,373**	**144,000**	**0**	**6,338,373**
Consultants	207,000			207,000
Professional Fees	0			0
Total CONSULTANTS & PROFESSI	**207,000**	**0**	**0**	**207,000**
Workshops & Training	2,175,000			2,175,000
Total WORKSHOP & TRAINING	**2,175,000**	**0**	**0**	**2,175,000**
Travel	74,000	20,000		94,000
Information & Public Relations	1,694,168			1,694,168
Office Costs	223,250	30,000		253,250
Communications	137,000	12,000		149,000
Financial Charges	30,000	2,000		32,000
Other General Expenses	0			0
Shared Support Services	19,552			19,552
Total GENERAL EXPENDITURES	**2,177,970**	**64,000**	**0**	**2,241,970**
Programme and Supplementary Serv	1,724,648	15,340	0	1,739,988
Total INDIRECT COSTS	**1,724,648**	**15,340**	**0**	**1,739,988**
TOTAL BUDGET	**28,257,699**	**251,340**	**180,000**	**28,689,039**
Available Resources				
Multilateral Contributions	6,978,330			6,978,330
Bilateral Contributions			180,000	180,000
TOTAL AVAILABLE RESOURCES	**6,978,330**	**0**	**180,000**	**7,158,330**
NET EMERGENCY APPEAL NEEDS	**21,279,369**	**251,340**	**0**	**21,530,709**

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Emergency Plan of Action (EPoA) Update
Guinea: Ebola Virus Disease

International Federation of Red Cross and Red Crescent Societies

Emergency Appeal n° MDRGN007	**Glide n° EP-2014-000039-GIN**
Date of launch: 4 April, 2014 **Plan of Action revised:** 30 July and 9 September 2014 **Date of issue:** 18 November, 2014	**Expected timeframe:** 15 Months (Expected end date: 30 June 2015)
DREF allocated: CHF 250,000**; Appeal budget: CHF 28.69 million** (including CHF 180,000 in bilateral support)	
Number of people affected: At-risk communities country wide (11,176,026)	**Number of people to be assisted:** At-risk communities nationwide with specific actions in already affected Prefectures (11,176,026)
Host National Society presence: 2,854 Guinea Red Cross volunteers, 150 GRC staff in 37 branch offices and national headquarters.	
Red Cross Red Crescent Movement partners actively involved in the operation: ICRC, Danish Red Cross, French red Cross	
Other partner organizations actively involved in the operation: Ministry of Health, Centre for Disease Control (CDC), Institut Pasteur Dakar, World Health Organisation (WHO), United Nations International Children's Emergency Fund (UNICEF, Médecins sans Frontières (MSF), Caritas Guinea Plan Guinea and Save the Children Guinea	

Summary of major revisions made to emergency plan of action

This revised plan of action includes the increasing Ebola caseload into consideration and on scaling up the IFRC support to the Guinea Red Cross (GRC) response operation to be able to meet needs based on the worst-case scenario of the epidemic. The main changes include:
-Implementation of a new HR structure of the GRC which includes a dedicated task force into the headquarter structure as well as three dedicated Ebola related functions in each of the 37 branch offices.
-The increase of international delegates from 12 to 28 with increased field presence
-The creation of an IFRC Head of Delegation position
-An increase from 14 to 76 Safe and Dignified Burials (SDB) teams
-An increase from 4 to 50 patient transport teams and ambulances
-An adapted strategy to cooperate and work with the UNICEF-led pillar role in social mobilisation targeted interventions and including a social mobilisation team member in each of the SDB teams.
-Increase in mass media and community engagement activities
-Creation of a country-level Safe and Dignified Burial coordination function.

A. Situation analysis

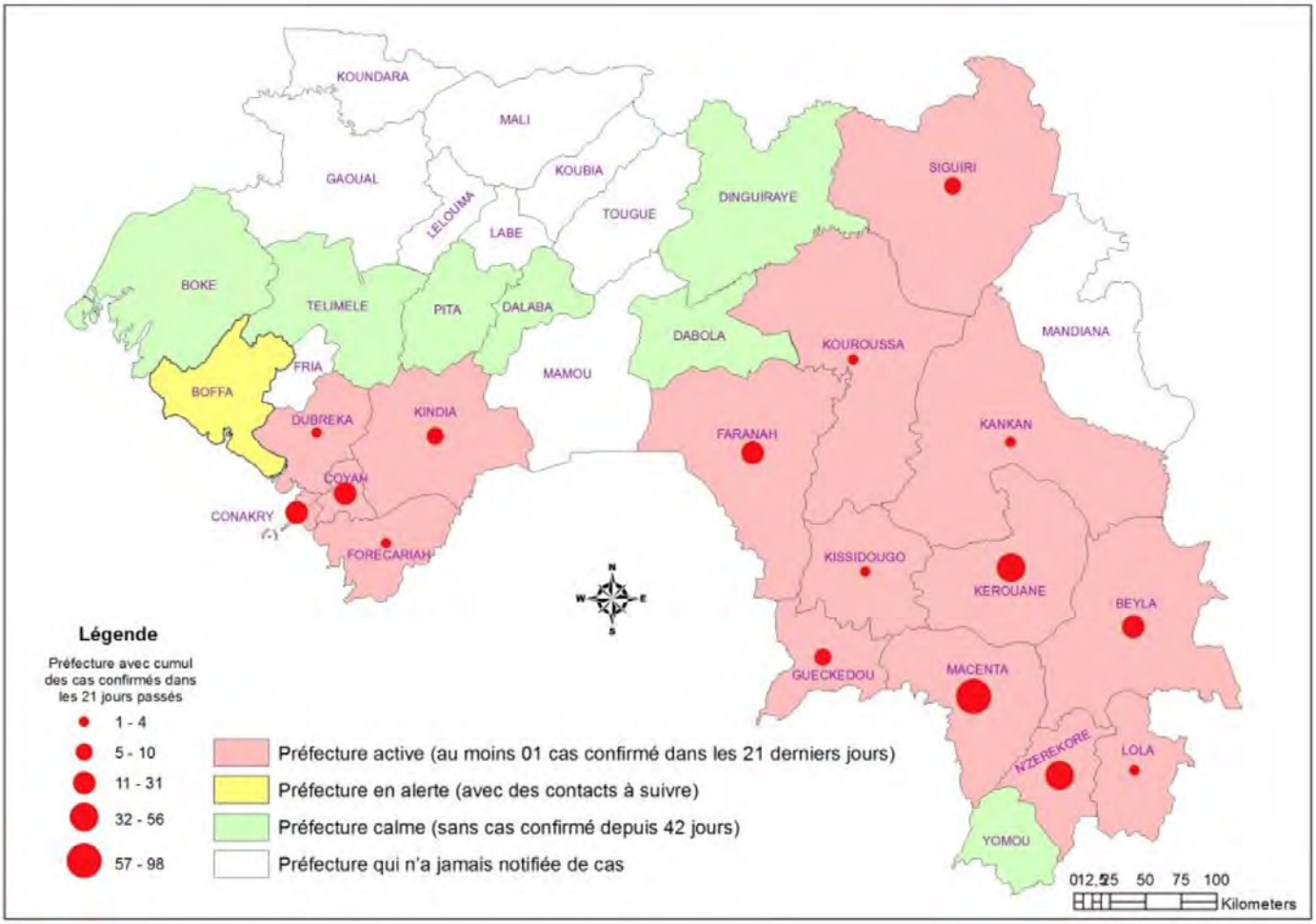
Description of the disaster

On 21 March 2014, the Government of Guinea declared the Ebola Virus Disease (EVD) epidemic. The first cases appeared in December 2013 but were not reported until March 2014. This delay increased the risks of many people being exposed and infected by EVD since there were no control measures in force.

The outbreak was initially concentrated in the southern prefectures of Macenta, Guéckédou and Kissidougou. By the end of March 2014, a total of 111 clinically suspected cases with 79 deaths (71% case fatality rate on the basis of clinical suspicion) were recorded in the prefectures of Guéckédou, Macenta, and Kissidougou. The first confirmed case is believed to have been recorded in the prefecture of Guéckédou and then spread to Macenta and Kissidougou. Soon cases started appearing in Dabola and Dinguiraye. The disease then spread to Conakry, mainly affecting health-care workers then spreading to the general population. By mid-April EVD was at its highest levels in Guéckédou and spread to the capital Conakry, with an unpredictable pattern. By the end of May, Guéckédou was the only prefecture reporting cases; then soon after other areas were reporting their first cases. In June, the outbreak seemed to have been brought under control, but then again resurgence in the number of confirmed cases was reported early August 2014. At least 82 healthcare workers have been infected and half have died of the disease as of

31 October, 2014. To date EVD has reached its peak with a current total of **1,958 cases and 1,189 deaths (1,688 confirmed cases and 979 deaths)** with a case fatality rate (CFR) of 61 percent. This increase is blamed on the cross border movements between Guinea, Liberia and Sierra Leone. The deteriorating situation in Guinea has increased both in total number of cases and in geographical spread. Currently 25 prefectures and the capital Conakry are affected which represents 83 percent of the country. On 31 October, 15 prefectures reported active cases, 8 considered calm and 2 are on high alert.

Figure 1: Map of affected districts as of 31t October 2014



The intensity of EVD transmission persists in Guinea, despite stabilizing in some districts; with fluctuating numbers that still remain consistently high. There were 145 new confirmed cases in the week to 9 November with disease transmission continually high in Macenta in the south-west close to the Liberian border with 33 new confirmed cases in that week. Transmission is persistent in the neighbouring district of Kerouane, with 30 new cases. N'Zerekore and Beyla report high levels with 22 and 12 new confirmed cases respectively. Conakry reported 18 confirmed cases in the past week (figure 1) with huge and sustained efforts required to control the disease. Coyah and Faranah also report high levels of EVD activity, with 6 and 10 new confirmed cases respectively in that week. The district of Siguiri, which borders Mali, reported three new confirmed cases; a high level of vigilance is required in this border area, particularly due to its proximity to Mali, which also recently reported more EVD cases.

New cases have been declining in the outbreak's epicentre of Guéckédou, with one confirmed case in the past week, after not reporting a single case the previous week. Out of a total of 34 districts in Guinea, 10 remain unaffected by Ebola.

Table 1: Distribution of confirmed Ebola cases and deaths in Guinea as of 15 November, 2014

Location	Cases	Deaths
Conakry	265	112
Guéckédou	371	309
Macenta	665	402
Dabola	5	5
Kissidougou	11	9

Dinguiraye	1	1
Telimele	26	10
Boffa	26	16
Kouroussa	5	5
Siguiri	20	7
Pita	8	4
N'zorekore	194	129
Yomou	11	6
Dubreka	22	8
Forécariah	22	14
Kerouane	136	70
Coyah	67	33
Dalaba	12	2
Beyla	38	20
Kindia	17	2
Lola	17	12
Boke	1	0
Mamou	0	0
Faranah	17	12
Kankan	11	12
TOTAL	**1,958**	**1,189**

Source: Report on the epidemiological situation15 November 2014, World Health Organization

Since the start of the outbreak, the International Federation of Red Cross and Red Cross Society (IFRC) has been supporting the activities of the Guinea Red Cross (GRC) and despite measures being implemented by the Red Cross and other partners, EVD has an exponential growth rate. It is estimated that each single confirmed case of EVD is responsible for infecting 1.5 to 2.0 additional individuals over a 10 to 20 day period and, therefore, the outbreak is in a phase of very rapid growth and intense transmission.

The major factors that continue to quicken the spread of the virus include: poor understanding of the disease; inadequate communication; misconceptions and fear among the affected communities; lack of adherence to strict protocols by healthcare workers in dealing with EVD; and limited responding capacities. The risk of exposure to the Ebola virus is aggravated by inappropriate household care and customary burial procedures where family members and other mourners come into contact with the corpses, which are highly infectious at this stage. An increasing numbers of people are getting infected due to contact with Ebola patients increasing the fear and anxiety spreading among the communities. The fear of contracting the virus among health-care workers has led to a general degradation of care to all patients and inappropriate prevention and control measures. Close community ties and cross-border movement between Guinea, Liberia, and Sierra Leone makes tracing and following up contacts an even greater daunting task.

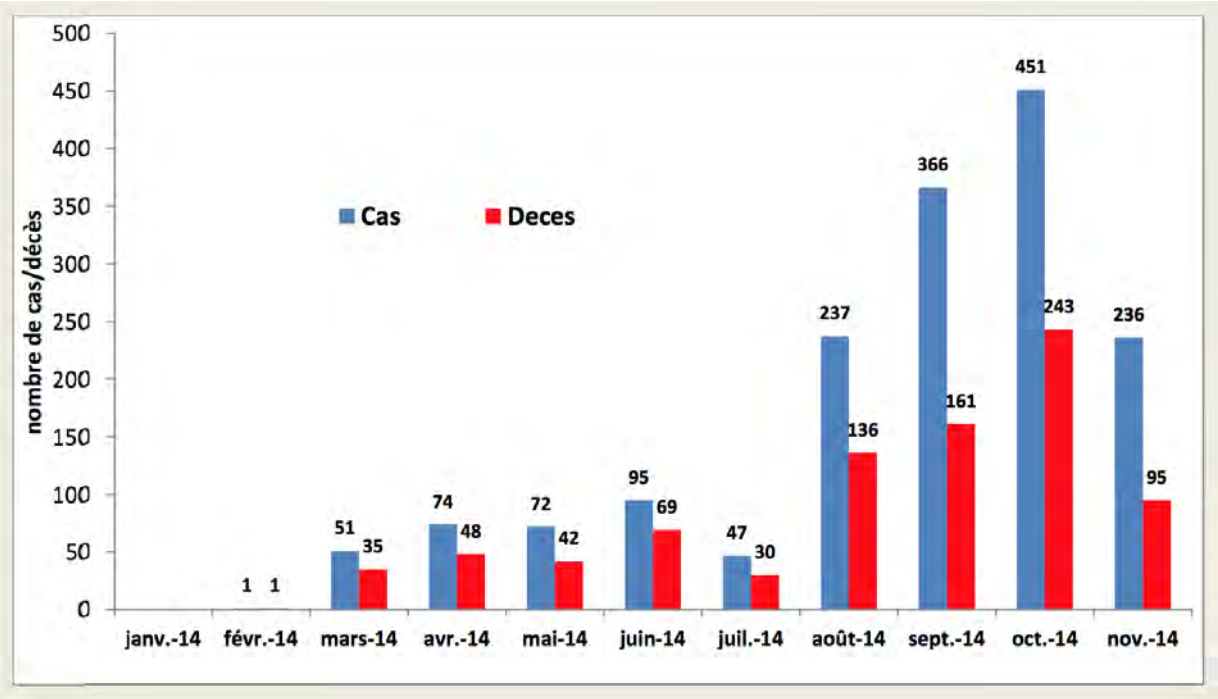
In Guinea, the magnitude and geographical extent of the EVD outbreak in this huge country requires significant and robust response capacities and structures. The outbreak poses serious challenges in terms of human, financial and operational capacities and logistics requirements and threatens national and international health.

On 20 September, United Nations Secretary General Ban Ki-Moon established the United Nations Mission for Ebola Emergency Response (UNMEER) headquartered in Accra, Ghana. This followed the declaration of the current Ebola outbreak as a threat to peace and security. The Mission will provide the operational framework and unity of purpose to ensure the rapid, effective and coherent action necessary to stop the outbreak, to treat the patients, to ensure essential services, to preserve stability and to prevent the spread to countries currently unaffected.

The IFRC also recently completed the revision of its regional operational framework to combat the EVD. This framework will serve as a 'living document' to provide a quick overview of priorities, guide operations, and help the Red Cross Societies involved in the response to stay focused and disciplined in a context of multiple competing priorities.

In the graph below, a sharp upward trend in the number of cases and deaths can been noted since the month of August 2014. This trend is forecasted to increase exponentially if resources are not available immediately to scale-up the current response. One of greatest needs is more personnel to be deployed to supplement the overstretched and almost collapsing health sector. Medical doctors, nurses, psychosocial support experts, social mobilisation experts, logisticians, data management experts are needed as a matter of urgency.

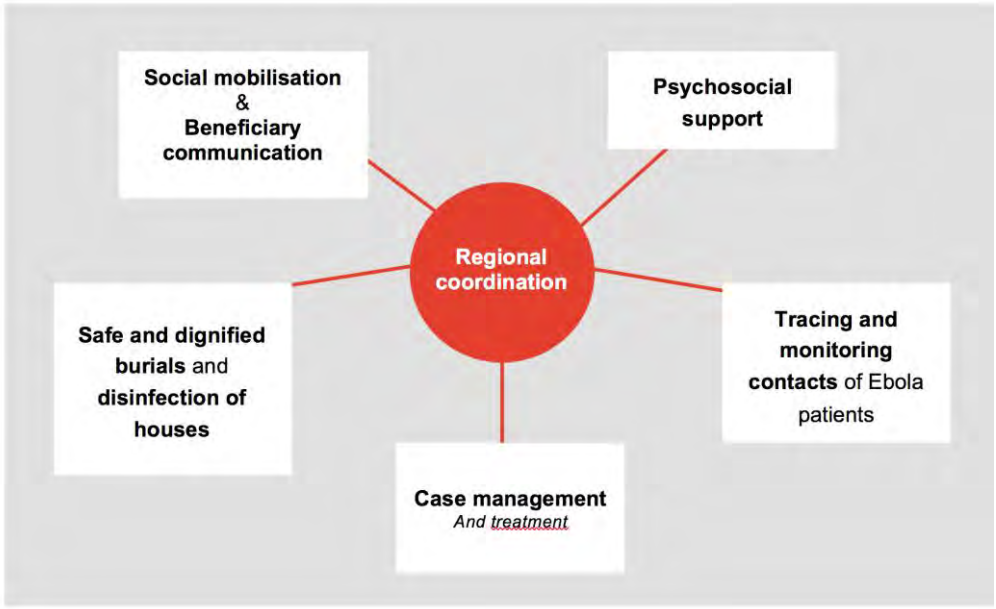
Figure 2: Graphical representation of monthly number of cases and deaths in Guinea. (Source WHO)



The standard recommended public health actions implemented, which are using WHO standard for stopping the EVD outbreak, include;- the early identification of cases; isolating and treating all patients in Ebola Treatment Centres (ETCs) under the guidance of MSF; establishing rigorous contact tracing; providing safe and dignified burial practices (SDB); supported by coherent social mobilisation and sound risk communication practices.

These key public health activities have been characterised as the five pillars of the EVD response known as:

Figure 3: IFRC five pillar interventions



Following a UNMEER meeting held in Accra in October, the IFRC has been assigned to technically lead in the safe and dignified burials (SDB) and disinfection. The Guinea Red Cross is engaged in all five pillars of response.

GRC is focused on the following four pillars:

1. **Social mobilisation (SM)-** Response activities in social mobilisation and sensitization are taking place during the removal of bodies and during safe and dignified burials. Households are being visited and reached with

messages after the retrieval of their departed loved ones. Sensitization is taking place in households and public market places. Some communities in Guinea have and continue to show resistance even to the point of becoming a threat to humanitarian activities. Sensitization is used in these communities to change their behaviour and mind-set. This has started to bear fruit as some communities are engaging with the Red Cross and the local authority. To date 935,987 people have been reached through social mobilisation. SM will increasingly take place in cooperation and partnership with UNICEF who is leading in this pillar.

2. **Safe and dignified burials (SDB) and disinfection of houses -** currently there are 42 burial teams composed of 6 members including the driver. The number of teams will be scaled up 76 and the number of team member's will be increased from 6 to 9, according to the recommendations of the Accra meeting. The National Society has reported to have conducted a total of 1,309* burials so far(this number includes all cases confirmed and unconfirmed). Disinfection continues to take place in households, clinics, and market places. A total of 16,411 houses have been disinfected by the national society. In addition, GRC provides an **ambulance services** supporting the authorities with currently 6 active ambulance teams, which have transported 2,107 patients to date.
3. **Psychosocial support (PSS)** – is an integrated part of the SDB interventions. The GRC has delivered 427 direct PSS sessions including the provision of financial aid to some of the affected families.
4. **Contact tracing** – GRC is supporting the coordinated efforts through mobilisation and training of volunteers. A total of 6,251 contacts have been traced to date. UNFPA has been assigned as leading this pillar and as such there will be increased cooperation and partnerships with the GRC.
5. **Case management and treatment** - The French Red Cross has established an Ebola Treatment Unit (ETU) in Macenta prefecture.

Overview of Red Cross Red Crescent Movement in country

While IFRC does not have a representation in Guinea, a Ebola response team has been put in place since the start of the emergency consisting of an operations manager, a field coordinator, 2 emergency health delegates, 2 water and sanitation delegates, 2 finance and administration delegates, and a logistics delegate providing country-level coordination and support. Additional human resources are needed in health, logistics and beneficiary communication and are expected soon. The plan is to have a team of 26 internationally recruited staff, and a head of delegation position included to assume responsibility for overall country level management, security management, strategic support to the GRC and representation and advocacy, while the operations manager will dedicate efforts for implementation of the Emergency Plan of Action.

IFRC and Guinea Red Cross participate in all national and other coordination meetings which include all international and local humanitarian players involved in responding to the outbreak. On a daily basis, IFRC and GRC attend the national crisis meeting where nationwide information on the outbreak is shared and where important decisions are taken. IFRC is also a, member of a restricted decision making group with MoH, WHO, WFP, UNICEF, MSF and CDC. The GRC also meets with local committees in Conakry to plan and carry out prevention activities and strategies needed to mobilize the population in the fight against the outbreak. The National Society is also working in close contact with prefectural committees in all affected areas as called upon by the Head of State.

Danish Red Cross (DRC) has a representation in Guinea sitting inside GRC premises. ICRC is present in country and the delegation is kept informed of the evolving situation as well as of IFRC's planned response to date, ensuring close coordination and support to the National Society. Both DRC and ICRC have provided support to the GRC. The ICRC supported the initial training of 100 volunteers and provides equipment, while the DRC contributed to the Emergency Appeal. DRC is also providing support to the GRC branches in Middle Guinea to strengthen their capacities in term of training of volunteers. A bi-monthly Movement coordination meeting is held to share updates and strategic analyses on the outbreak.

In terms of action, IFRC in partnership with GRC is leading in it's been support to the GRC in all their activities in disinfection, and safe and dignified burials. In Forest Guinea and Upper Guinea, the IFRC and GRC are involved in the transportation of patients from villages to the treatment centres. The IFRC are visible and active in community messaging, communication and sensitization and also distribute soap, chlorine and hygiene kits to those affected by the outbreak. Psychosocial activities including household economic support programming are active in certain regions of the country and will continue to expand as the situation permits. All of these activities are coordinated with local health authorities and other humanitarian actors to ensure adequate and proper coverage of the affected populations while remaining in close coordination with Conakry.

The French Red Cross is committed to establish an Ebola Treatment Centre (ETC) in Macenta, which is planned to be operational during the month of November 2014. French Red Cross will be managing the ETC in collaboration with the French authorities as a part of the Red Cross Red Crescent coordinated Ebola response.

The IFRC accepted a request by UNMEER and partners in the UNMEER Planning Conference in Accra held between 15 and 18 October 2014 to take up a leading role in the Safe and Dignified Burials, disinfection of households and contaminated areas, as well the transportation of sick patients in certain regions.

This plan indicates the need for 154 burial teams in the three countries of Liberia, Sierra Leone and Guinea by 1 December to perform SDB of up to 5 cases per day. The coordination role and activities have been included in this plan, and covered by a separate component of the appeal budget dedicated to the coordination role.

Coordination and partnerships and pillar roles and responsibilities
The National Coordination committee is reporting directly to the Head of State and is made up of the following members: MSF, CDC, UNMEER, WFP, CRG/IFRC, USAID/OFDA, African Union/ASEOWA, OOAS, ELU, MAE-Fr, and the Ministry of Health. This committee is composed of technical teams and support teams.

The Government of Guinea - a national coordination body CNLEB has been put in place after Ebola was declared an emergency in August 2014 by the President of the Republic. This coordination is divided into several commissions: the Commissions of Communications, Surveillance and Logistics among others.

- The **IFRC and GRC pillar leads with MoH in the SDB pillar**; and also provide transportation of patients and sanitation, working with MSF other partners in other pillar leads (Social Mobilisation, Tracing and Surveillance).
- **World Health Organisation (WHO) and the Ministry of Health (MoH) - Pillar leads in Case Management** and work with CDC - responsible for overall health strategy and advice, and coordination among the partners.
- **MSF** – even if not assigned with a pillar lead in case management they have been leading in clinical case management in Ebola treatment centres in Guéckédou and in Conakry, and in epidemiologic surveillance. They have also been training their staff and the Red Cross staff and volunteers
- **UNICEF** – **is pillar lead with MoH in social mobilisation, communication and community engagement**. This is aimed at ensuring behaviour change to avert transmission. Messaging will need to address issues around burial practices, early reporting to health centres, socio-cultural activities that may fuel transmission of the disease and rumours and misconceptions that continue to surface.
- **UNFPA** – **co-pillar leads in surveillance** with MoHs, CDC and WHO, providing support to health structures, assistance to the population affected by the epidemic, social mobilisation, coordination, logistics, and leads in contract tracing and epidemiologic surveillance.

The IFRC/GRC are active and will be increasingly partnering with other technical pillar groups mostly in social mobilisation and contact tracing.

The IFRC is also providing support to the Red Cross in capacity building, human resources, training, logistics and data management.

Needs analysis, beneficiary selection, risk assessment and scenario planning

Needs Assessment
Through regular coordination and task force meetings, secondary data and gap analysis assessments remain continual work-in-process. They evolve with the epidemiological indicators, which contribute to the prediction of the most likely situation scenarios of the outbreak. The MoH scaled up its response to the outbreak, but is hampered by a weak health system, limited disease surveillance capabilities and increasing absence of health staff in key locations.

The Red Cross Movement has identified several areas where it may provide some urgent assistance:

1. **Information, education and communication of the population;**

Due to the highly infectious nature of the disease many people are fearful and stigma remains high. Despite the major efforts deployed so far in awareness raising and education, there is still a significant need for scale up as the main obstacle to effective patient identification, contact tracing and reintegration is ignorance.

There are also specific behavioural issues that contribute to the spread of the disease and that could be specifically addressed such as transportation of dead bodies or sick which are often transported on taxi-brousse (bush taxis), with other passengers, relatives and the driver. There are also important cultural customs with families that wish to see or touch the body of a relative prior to their burial. The traditional funeral rituals in many communities involve substantial contact with washing the deceased person.

To date, the social mobilisation strategy is significantly addressing the potential stigma that individuals and families affected by EVD may experience.

Overall, there is a need to regularly review the key messages to ensure they are relevant to the current situation and meet the information and educational needs of the community. This is being address by the national commission in charge of social mobilisation supported by UNICEF.

2. **Contribution to epidemiological investigation, surveillance and epidemic control; case finding, contact tracing, disinfection, safe and dignified burials, patient transportation**

The effect of epidemiological control measures is directly linked to the result of the response to the current outbreak. While a number of partners are supporting the government in coordination of the epidemic control measures, the Red Cross has a unique role and responsibility as many of these activities are done at community level. As mentioned, a high level of community tensions still exists, and this brings on the need for taking in cultural challenges in order to perform epidemic control measures in a dignifying and culturally acceptable way, not least the SDB process. There is a need to continue all these measures until the end of the outbreak by mobilising the Red Cross volunteers who may have easier access to and understanding of the communities.

3. **National Society strengthening; volunteer training, logistics support, material support**

The significant scale-up of activities of course has an effect on the Guinea Red Cross' organisation and structure, and there is a need to ensure that the National Society has the capacity to absorb increasing resources, activities and demands. These demands and changes must be dealt with in parallel to the response, and must be supported by organisational changes, technical support and with human resources.

Risk Assessment

Due to the highly contagious nature of EVD, IFRC, in support of GRC, is doing its utmost to protect the volunteers while carrying out planned activities to mitigate the spread of the disease.

An epidemic with a high case/fatality ratio induces fear in the population and among the health care workers (HCW), leading to absenteeism. At the end of October, WHO indicates that 82 health professionals were affected by EVD, with 50% of them dying. This has increase absenteeism in health facilities with direct and indirect consequences for the population in terms of basic health provided. Besides the Ebola outbreak, the country has recently experienced measles, meningitis and cholera outbreaks in addition to high rate of malaria. As the NS has engaged in the response to all of these epidemics, their operational capacity is reaching its limits.

As a consequence of the current epidemiological situation in Guinea, the threat of wide scale fear and panic in Guinea and neighbouring countries poses a significant risk. Despite WHO not recommending any trade or travel restrictions, several countries have already tightened border control or closed their border with Guinea and others countries are reinforcing with precautions, such as infra-red scanning at airports. The high rates of fear, stigma, and general panic that the disease creates, has much wider implications beyond the affected populations and the surrounding areas, and requires urgent attention.

Finally, considering the continuous cross-border movement Sierra Leone and Liberia and given the possibility of contamination and re-contamination between the three countries, the risk of having a major and continuous outbreak in the whole West African region is a real threat.

B. Operational strategy and plan

Overall objective

This plan aims to help stop the transmission of EVD and bring an end to the current epidemic through the following 4 outcomes:

1. **Outcome 1: Contribute to elimination Ebola Virus Disease in Guinea through community engagement, beneficiary communication and social mobilisation, contact tracing and surveillance, provision of psychosocial support, safe and dignified burials and disinfection and case management and treatment.**
2. **Outcome 2: Effective and sustainable impact through strengthening the existing capacity of the National Society and the provision of necessary IFRC management, technical and support resources.**
3. **Outcome 3: Support is provided to national authorities for country-wide coordination and information management of the overall Safe and Dignified Burial and disinfection of Houses response.**

4. **Outcome 4: Longer-term effects of the outbreak and needs for early recovery, livelihoods and food security interventions are identified and IFRC/GRC activities planned.**

Proposed strategy

The operational strategy is based on latest epidemiological predictions and possible scenarios. Since the establishment of UNMEER, the IFRC and the GRC are engaged in coordination and making sure operational plans are being aligned with the overall humanitarian planning to ensure effective contribution to a consolidated response strategy. The current strategy is based on responding to the worst-case scenarios and is regularly being revised to reflect the situation and present the most realistic response plan.

This revised emergency strategy adopts a new management and personnel structure for both the GRC and the IFRC. Following the establishment of the new Ebola management structures of the national authorities, including a dedicated Ebola task force reporting directly to the Head of State, a dedicated task force or management team has been established at the Red Cross level, reporting directly to the President. The task force consists of all relevant management, technical and support functions and all are full-time and dedicated to the Ebola response. This new central structure is being complemented by a significant scale-up of committed functions at regional and branch level.

Three dedicated Ebola functions are being established in all 37 branches:
1. Logistics.
2. Beneficiary communication.
3. Field coordination.

All the necessary IT/Telecommunications and office equipment is being mobilized to make all branches operational. The IFRC support structure is being scaled-up in parallel and will include 6 to 8 health and water and sanitation internationally deployed staff working at branch level at any time.

Geographical distribution of activities:
The outbreak is currently active in 18 out of the 33 prefectures and this number is expected to increase with the further spread of the epidemic. The strategy aims to reinforce operational capacity at national headquarters level while also increasing the number of dedicated resources in each of the prefectures. Due to the unpredictable spread of the epidemic, all 37 branches in 33 prefectures are being targeted for strengthened capacity activities, while the current response is based on a prediction of 25 active response prefectures at any time.

Beneficiary selection
Given the current dynamic of the outbreak which is affecting communities in 18 districts localized both in rural and urban areas and the potential risk of the spread of the disease, the beneficiaries of this operation are the entire population of the country. Moreover, this revised version of the emergency appeal gives a special focus on women who are on the frontline as the most affected group by the disease with a rate of 53% of those affected.

In addition, the following vulnerable groups are targeted:
- Public and private health care professionals
- Traditional healers
- Urban and inter-urban transport operators: taxi/motto-taxi drivers
- Religious and traditional leaders

Operational support services

Human resources:
The operation engages a total of 2,854 GRC volunteers across the country.

Table 2: Summary of the engagement of volunteers.

Areas of engagement	Number of volunteers
Social mobilisation, community engagement and beneficiary communication	1,470
Safe and Dignified Burials	684
Psychosocial support	250
Contact tracing and community surveillance	250
Patient transport services	200
Total	2,854

To date, with the support of IFRC, GRC mobilized and trained up to 2,842 volunteers, of which 1,337 are currently active in the different areas of intervention under the supervision of 80 trained GRC senior staff (medical and national disaster response teams (NDRT)). Most of the Red Cross staff functions have now been converted into dedicated Ebola response functions as most of the other programming has been suspended.

The GRC staffing covered by this plan includes 30 full time functions of the GRC Ebola task force, which has been established on the 31st of October including a number of related headquarter support functions. As mentioned earlier, in order ensure the necessary field presence, dedicated commitment and readiness, three functions (logistics, beneficiary communication and field coordination) are being established in each of the 37 branches (5 in Conakry and 32 in remaining prefectures) for the duration of the outbreak.

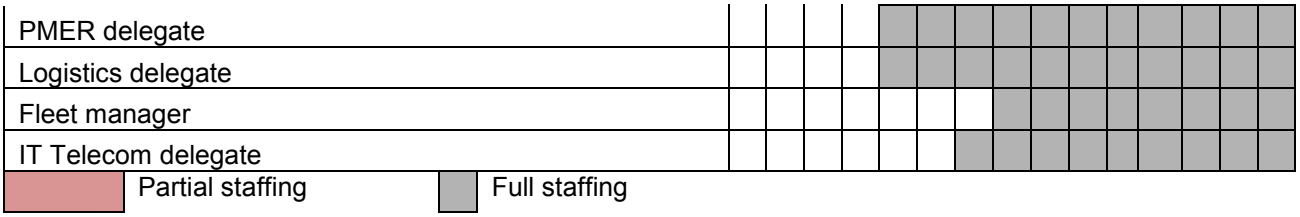
To provide planning and implementation support and project management, the IFRC deployed a FACT and an operations manager in April. To complement the team, a regional disaster response team member, a health ERU team supported by the French Red Cross and a logistics ERU supported by the Swiss Red Cross were deployed.

The IFRC country presence has been scaled up and this revision includes a new HR structure including a head of delegation managing security, strategic planning, representation and partnership building, an operations manager responsible for the implementation of the plan of action and a field coordinator providing leadership to an increasing number of field technical delegates. The management and programme personnel structure is being reinforced by a logistics team, finance, administration, IT/telecoms and finance development functions. National staff are being recruited to complement the team of internationally recruited personnel.

The recruitment and deployment of delegates is a challenge with many gaps exist in the current structure. Short-term support has been requested from partner national societies holding ERU and FACT rosters, but response is still very limited.

Table 3: Summary of the actual and planned international staffing needs for which support is required

	2014									2015					
Social mobilisation and beneficiary communication	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J
Regional disaster response team															
Health ERU team															
Beneficiary Communications															
Emergency Health delegate															
Safe and Dignified Burials (SDB) and disinfection															
Regional disaster response team															
SDB Coordinator (coordination structure)															
SDM IM (coordination structure)															
Emergency Health Delegate (3)															
WATSAN Delegate (3)															
Psychosocial support															
PSS delegate															
Community surveillance and contact tracing															
Regional disaster response team															
Health ERU team															
Emergency Health Delegate (5)															
IFRC support functions															
Field assessment and coordination team (FACT)															
Regional disaster response team (RDRT)															
Country Representative															
Operations Manager															
Finance and Administration delegate															
Finance development delegate															
Communications delegate															



Logistics and supply chain

Vehicles and transport: Vehicles are being mobilized through the IFRC vehicle rental programme (VRP) and the IFRC fleet base in Dubai and hub in Dakar. Due to the large number of vehicles and the urgent needs, some of the vehicles are being procured and a donation to the GRC has been offered by UNMEER. To meet urgent needs, vehicles are currently being rented on a daily basis locally, which is very expensive and unsustainable.

Table 4: Summary of the planned vehicle needs

Teams to be allocated	Number of vehicles
Safe and Dignified Burials (76 teams)	152
Patient transport	33
Social mobilisation, PSS and contact tracing	25
Operations management and monitoring	16
Total	226

Of these, 38 are currently in country, 3 are arriving this week, 25 are being airfreighted into Conakry and an additional 34 ordered by sea-freight.

Warehousing: To ensure proper reception, storage and dispatch of the increasing response supplies, establishment of a GRC central warehouse is planned in Conakry. The main warehouse will serve four satellite warehouses strategically placed to provide supplies for prepositioning and storage in the branch offices, based on epidemiological data related to the caseload and geographical spread of the disease. The satellite warehouses will be based in N'zerekore, Gueéckédou, Mamou and Kerouane.

Supplies and procurement: Personal protective equipment and body bags are needed in quantities not available in Guinea and a central IFRC pipeline has been established. The supplies have been secured by IFRC and are being supplied to the response countries on a regular basis. Additional supplies such as hygiene kits, sprayers, chlorine and other supplies will be procured through the IFRC global logistics services (GLS). Any smaller quantities of supplies are being sourced locally.

Personnel: A logistics ERU was deployed in April and a logistics regional disaster response team member was deployed in May. One logistics delegate is currently deployed in Guinea and an additional logistics delegate, a fleet delegate and two logistics officers are being recruited. A second ERU deployment has been requested to support the increased need for logistics management during the main scale-up exercise. Two logistics officers of the GRC are being covered by the plan and are receiving training from the IFRC team. Logistics functions in all 37 branch offices are also planned.

Information technologies (IT)
Adequate ICT systems have been established in Conakry for the operation, and a reinforcement of the current GRC IT systems and infrastructure is on-going. Laptops and internet connectivity is essential to ensure the necessary reporting and communication channels, and this is being provided to the operational teams.

For security and fleet management purposes, the current HF and VHF system of the GRC is being repaired and additional mobile units and base stations are being installed. Recruitment and training of radio operators is planned in the Plan of Action budget, and an IFRC IT telecom delegate is being recruited.

A number of ICT solutions are being supported for the massive community engagement and beneficiary communication component. This includes video and still picture editing equipment and software, video presentation solutions and a SMS broadcasting system (TERA), which has been successfully implemented in other Red Cross national societies.

Communications
The GRC, with support from IFRC Zone and Regional Communications is organizing various awareness and publicity activities, to sensitize the public, media and donors on the situation on the ground and the humanitarian response.

Activities to date include: identifying and updating qualified IFRC and Red Cross spokespeople and sharing with media; producing facts and figures, key messages, questions and answers, press release and two web stories; conducting several media interviews with print, television, radio and on-line organizations. The IFRC Sahel Communication Senior Officer provided support to produce communication materials (video, stories, photos, fact and figures, study cases and key messages) which are all posted on the IFRC web site, shared with partners and donors and picked up by many humanitarian portals. The videos are available on YouTube (http://www.youtube.com/watch?v=YLcPU0IhTrY).

Planned Activities

- Hire photographer/videographer consultant to produce additional high quality photographs with extended captions, and video B-roll and interviews of operations
- Hold press conferences, in Guinea, Dakar, Nairobi or Geneva as warranted
- Continue producing twice-weekly facts and figures, and weekly updated key messages and reactive lines, and share with relevant stakeholders, including beneficiaries and partners
- In collaboration with programmes, continue working on advocacy messages to address issues linked to the outbreak, in Guinea and the region (protection, prevention, fear, stigma etc.)
- Pursue production of news releases, fact sheets, videos, photographs and qualified spokespeople contacts and make available to media and key stakeholders
- Proactively continue engaging with international media regarding the added value of Red Cross interventions
- Organize media field trips to raise awareness among stakeholders and to raise the profile of the Red Cross Society of Guinea and IFRC
- Maintain a social media presence throughout the operation utilizing IFRC sites such as Facebook and Twitter
- Continue supporting this appeal and its major milestones throughout the operation using people-centred approach, community level diverse content, including web stories, blogs, video footage and photos with extended captions.
- Share any communications material created through this appeal with IFRC for use on various communications channels including the newly launched IFRC Africa web page, www.ifrc.org/afriqueand www.ifrc.org/africa
- Provide the NS communications team with communications training and appropriate equipment as needed (photo and video camera)

Security

Guinea has a history of ethnic tension and political and social unrest, all of which have been exacerbated by the Ebola crisis. Conakry has sporadically high rates of petty criminality as well as a heightened risk of civil unrest due to economic pressures and widespread dissatisfaction over persistent water and electricity cuts. This has led to disruptive and at times violent protests so far in 2014, which have resulted in a number of deaths. The N'Zérékoré region in southern Guinea is volatile due to inter-ethnic tensions and anti-government sentiment, as are pockets of the Kankan region. The IFRC has a security framework in place for its operations in Guinea. The Operations Manager is responsible for the security of IFRC personnel in-country. The Regional Security Delegate in Dakar provides on-going support to the Operations Manager and IFRC Personnel in Guinea.

Planning, monitoring, evaluation and reporting (PMER)

The IFRC operations manager in Conakry is responsible for the necessary planning, monitoring, evaluation and reporting of the operation. This includes regular revisions of the plan based on changes in the situation and IFRC overall response strategy. Progress indicators have been established for monitoring of the implementation and for communication of current impact. Weekly reports are being provided to the IFRC Regional Ebola Management Unit, which issues a weekly consolidated IFRC Ebola Operations Update. The data is presented in a weekly snapshot and a number of other communication materials.

The IFRC has recruited a reporting delegate who will support the reporting requirements of the operation, including the need for timely and accurate reporting to donors. The reporting delegate will work closely with the GRC to build necessary monitoring and reporting systems and capacity of the GRC.

Administration and Finance

GRC has a permanent administration and finance staff that ensures the proper use of financial resources in accordance with conditions laid down in the memorandum of understanding between the National Society and the IFRC. Financial resource management is performed according to GRC regulations and IFRC guidelines. In addition, the GRC's own procedures are being applied to the justification of expenses process and done on IFRC formats. A finance officer of the IFRC regional office in Dakar is deployed in Guinea and is providing dedicated finance management support to the operation. Given the scope of the operation and the need of being compliant with IFRC finance and administration system (CODA), this position is being changed into a delegate one.

C. DETAILED OPERATIONAL PLAN

Health and Care

The below describes in detail the context in which each of the five intervention pillars is being implemented and the rationale behind the implementation plan:

1. Community engagement, beneficiary communication and social mobilisation

The national authority coordination of community engagement and social mobilisation pillar is supported by UNICEF in Guinea in accordance with UNMEER guidance and national coordination structure. The GRC interventions in the social mobilisation area is done in partnership with UNICEF and interventions are implemented under their guidance. While door-to-door and mass sensitization was the main strategy for this component during the first six months of the operation, the strategy was changed following a knowledge, attitude and behaviour analysis and an IFRC technical cross-border meeting in August to be more targeted on directly affected areas and as an integrated part of the other pillars. As a result of recent analysis, distribution of revised hygiene kits to approximately 600,000 beneficiaries out of the 1.2m target still remaining to be reached has been planned from this revision onwards. The kits include soap, chlorine and buckets.

The social mobilisation component is complemented by a significant community engagement and dialogue component which has been heavily scaled up in this revised plan. Community engagement is a core activity and encompasses the way in which we work with communities to implement all pillars. Community engagement entails beneficiary communication and social mobilisation activities and comprises behaviour change communication and health education, utilizing a PSS approach. It ensures participation that extends beyond acceptance and knowledge and guarantees that this knowledge is turned into action and advocacy. It is targeted on risk factors and focuses on two-way communication with those most affected, be it a sick person in the family, the death of a family or community member, the admission to an ETC or the notification of being a contact.

This component focuses on establishing systems that allow communities to voice their needs to assist in reducing fear and rumours and raise awareness. Efforts are directed towards effective and sustained two-way communication and engagement with beneficiaries, as the most effective mean to tackle the disease and build collective trust, confidence and a lasting community understanding of how to prevent and control Ebola.

The strategy entails a mix of communication channels, which includes radio programming, SMS messages, distribution of posters and leaflets and door-to-door visits in communities.

Community-based solutions as to how we conquer Ebola are at the forefront of the response. As much as we try to provide solutions, it will be the communities who are the main implementers and will play a joint role as frontline responders. Establishing processes within established communication networks and communities that allow the population to clearly voice their understanding of the issues and provide feedback will build stronger trust and a more community-led solution.

Approaches that emphasize community strengthening and participation, as well as partnership building between communities and participating agencies have proven to be more effective than top-down communication interventions. These approaches go beyond educating people about health risks. They facilitate local dialogue and relationships that empower people to abandon unhealthy traditional practices and harmful norms, building more community resilience to respond to the impacts of disease outbreaks.

Embedded in the SDB teams will be a Beneficiary Communications / Community Engagement (BC/CE) volunteer tasked with the process of engaging with the community during the body removal process. The BC/CE volunteer will utilize the time during the process to talk with the community about their understanding of the SDB process, their understanding of Ebola in general and answer any questions the community members may have. There will also be an opportunity to provide IEC materials. The BC/CE volunteer will also be tasked with gathering information using a set of questions within the RAMP system, a mobile phone data-gathering tool. The information will allow the RC to gather information that will allow us to assess the current situations and perceptions in the communities, as well as gather data about the family and the affected person. The process will strengthen our accountability to the community and families by providing safe and dignified burials and through the collection of data enable us to provide information related to the affected person's status of Ebola and location of burial.

2. Safe and Dignified Burials and Disinfection of houses.

The revised plan significantly scales up the SDB activities in Guinea, aligning the scale of operation with projected figures for casualties, and aims for a total coverage of the needs in Guinea with 76 active teams consisting of 9 members each. The lead role of the Red Cross in this pillar is well recognized by the national authorities and partners.

Safe and dignified burial and disinfection is an expansion of the key activity of dead body management, reflecting what teams are delivering in practice. The terminology indicates that the Red Cross teams do more than manage

bodies. They care for families and their loved ones ensuring that the burial is conducted in a dignified and safe way, and limit further spread by making them understand the need for precautions, whilst understanding and respecting their loss.

Highly trained burial teams, in conjunction with community engagement volunteers, educate the communities about the need for safe burials and explain the process and the equipment used. They open a dialogue with the community to find contacts; they explain and sensitize on the risks of transmission; and share prevention messages encouraging the adoption of safe behaviours, participation in contact tracing and early presentation if symptoms are present.

The same approach is utilised for disinfection of houses, ensuring communities understand the need and process before commencing. The respect of the deceased and care of their families at this time is a key interaction with the community that can affect their willingness to continue to engage and change behaviour to break the cycle of transmission.

This care with dignity extends to the practicalities, including the reporting and recording of deaths, their names, age, gender and the location of burials to ensure accountability at the end of the epidemic and assist in restoring family links when needed.

Safe tools have been designed, developed and rolled-out for Safe and Dignified Burials with two types of PPE kits to support the SDB teams. These include;
1. Dead Body Management Starter kit, including all re-usable items for 3 months for a SDB team.
2. Dead Body Management Kit, which contains consumables for 20 safe burials.

3. Psychosocial support
Currently these activities consist of PSS support and the provision of a solidarity kit with key items for families that have lost material goods through disinfection or who are unable to manage their normal lives because of isolation schemes or other measures related to having an Ebola patient in the family or being a contact. The kits are offered to families with a sick person who are experiencing social exclusion and stigma, or after the safe burial and disinfection team has completed their task, or on discharge of a survivor from the ETC, with the possible stigma and further safety measures that need to be respected for cured patients during 90 days.

Red Cross volunteers, within their own communities, are conducting door-to-door visits, working with elders and community and religious leaders to engage people and families in a meaningful dialogue to address stigma, dispel rumours or cultural misperceptions about the disease. Door-to-door visits are a key community interaction that should be used to provide support, information and improve engagement with the community and individuals affected.

The psychosocial support includes establishment of a volunteer and staff care system to address the extreme psychological effects of the epidemic and the risk and fear of contamination, stigmatization and longer-term effects of involvement in the response.

4. Surveillance and contact tracing
The surveillance and contact tracing interventions are provided as community-based services under the national coordination supported by CDC and UNFPA. The GRC services rely on data management and operational guidance from the pillar lead and does not entail development or management of information management and analysis systems.

Alert and surveillance is a key activity that focuses on the follow up of potential contacts to ensure early presentation to the ETC if need be. Contact tracing is a key interaction with potential 'new' cases and is an important engagement in trying to limit the next generation of cases. Engagement with the individual and the family is extremely important to ensure adaptation of behaviours to protect the family and community. Contacts require a large amount of information but also reassurance and support. Contact tracing is conducted utilising community engagement and a PSS approach.

However, alert and surveillance goes beyond contact tracing and includes the notification of potential cases for transfer and of potential Ebola deaths. The information from alert and surveillance should be utilised by all teams to inform programming and resource allocation.

5. Case management and treatment
In Guinea, the IFRC multilateral engagement in the case management and treatment pillar is limited to transport of patients, while the French Red Cross is establishing an ETC in Macenta on a bilateral basis but under the coordination of the IFRC.

National Society Capacity Building

The capacity building activities are focused on enabling the GRC to fill the role in the response agreed with national authorities and partners and maintain a level of readiness and institutional capacity to adapt to the fluid situation and be able to address longer term consequences of the epidemic. This includes:

- Inclusion of task force functions for strategic partnerships, institutional learning and capacity building
- Provision of necessary office equipment (including IT equipment and power supply) for the GRC national headquarters
- Provision of office equipment, transport equipment and rehabilitation of the 32 provincial branches and the five branches in Conakry.
- Increased community engagement, training and preparedness planning in all branches.
- Establishment of necessary IFRC support structures to support project management and programme implementation, technical guidance and support.

Early Recovery

The impact of the epidemic will be far reaching. Steps need to be taken now to assess the impact and planning should begin in the coming weeks. Some prefectures have already seen a steep decline in cases, such as in Guéckédou, and so these districts may be ready for recovery to begin sooner, keeping in mind the unpredictable nature of this outbreak. It's important that the epidemic is taken district by district and response design based on the case loads in each area. Due to the mobility of the population in the affected areas, it is to be noted that the potential disappearance of cases in one area does not mean that a resurgence will not occur again, thus, branches need to be ready for response even if recovery efforts have started.

While the efforts to contain the disease continue, there is a need to closely follow up the food and nutrition and livelihoods situation of both those affected by Ebola and those who are indirectly affected by Ebola-driven problems. Due to the situation and safety problems, it has not been possible to undertake a proper food security assessment to determine the number of people affected by food and nutrition insecurity and provide timely and appropriate support. According to the Vulnerability Analysis and Mapping (VAM) reports from WFP, in Guinea, only Guéckédou was moderately food insecure before the crisis. Based on the scenarios developed by the experts, under the low Ebola scenario, Guéckédou and Coyah districts are expected to become food insecure as a result of the disease by the end of March 2015. The absence of detailed information about the food and nutrition situation requires a coordinated effort to come up with the number of people whose livelihoods are negatively impacted by the crisis, either directly or indirectly.

Going forward, IFRC will also focus on assessing economic and food security impact; the health care system and the trust in health care workers (HCW), as this will greatly affect health seeking behaviour; the impact on family dynamics and child care practices, which is key given the large amount of inter-household transmission that has occurred.

While the situation does not allow for detailed recovery planning yet, as all attention is directed towards responding to the immediate threats of the epidemic, the operational plan includes a recovery delegate recruitment in order to have the necessary assessment and planning capacity available as soon as the situation allows.

Outcome 1: The prevalence of Ebola Virus Disease in Guinea is reduced/eliminated through establishment of an appropriate response structure, local authorities and community engagement, beneficiary communication and social mobilisation, contact tracing and surveillance, provision of psychosocial support, safe and dignified burials, disinfection and Case management and treatment

Output 1: Social mobilisation, community engagement and beneficiary communication (A0101)

Community understanding, engagement, ownership and implementation of prevention and control measures is ensured through effective social mobilisation and two-way communication with beneficiaries, community leaders and religious leaders to prevent further transmission and control the outbreak

	2014									2015					
Activities planned Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J
• Train 120 supervisors and 2,000 volunteers in EVD signs and symptoms, prevention measures and referral mechanisms as well as personal protection. (discontinued)															
• Re-training of 100 supervisors and 1,000 volunteers (3 supervisors and 30 volunteers per branch) in social mobilisation, community engagement and beneficiary communication according to revised strategy and in coordination with UNICEF.															
• Refresher training of 100 supervisors and 1000 volunteers every three months															
• Mobilisation of 100 supervisors and 1,000 volunteers for 15 days per month															
• Establish Ebola management teams (beneficiary communication, logistics and field coordination) in each of the 37 branches															
• Equip all branches with vehicle for field movement															
• Coordinate with and feed into national commission messaging / package development															
• Reproduce and disseminate guidance and tools of community supervision cases – remove (does this mean discontinued or should the line be removed)															
• Procure 2,400 “low-risk” PPE kits and train volunteers on the use of PPEs (Discontinued) • (93k equipment + 50k transport)															
• Produce and disseminate 100,000 pieces of context-specific Information, Education and Communication (IEC) materials, including leaflets and posters															
• Procurement of social mobilisation kits including banners, megaphones and other teaching materials for all branches.															
• Procurement and distribution of 80,000 Epidemic hygiene kits (soap, chlorine, bucket)															
• Procure visibility equipment and materials, including t-shirts, caps, stockers etc.															
• Conduct health promotion campaigns using house-to-house, community sensitization and media campaign in affected districts															
• Procure and distribute infrared thermo flash thermometers to all branch teams															

• Establishment of TERA SMS broadcast system and broadcast of awareness messages.															
• Establishment of one hour live interactive weekly television programme to be broadcast across Guinea with a focus on gathering and responding to communities needs for information															
• Scaling up of current radio activities to two weekly one hour interactive radio broadcasts across Guinea with a focus on gathering and responding to communities needs for information															
• Establishment of IVR (pre-recorded information exchange) system in cooperation with Local Telecommunication providers to provide access to pre-recorded prevention and programmatic information related to Ebola															
• Train 470 volunteers in basic community engagement and beneficiary communications with a focus on the dissemination of Ebola information and feedback in all districts going (house-to-house) as well as document with mini-KAPS using RAMP/ODK															
• 30 Short forums (2 per district) and engagement with “community resource oriented persons” Chiefs, traditional healers, teachers, soldiers and police, hunters, musicians, sport personalities etc. To build a team of leaders for communities to prevent Ebola and use as spokespersons on broadcast mediums Radio and TV.															
• Train Ben Comms field staff and volunteers in data collection RAMP/ODK to support SDB teams in information gathering and community engagement during SDB process.															
• Establish system of data and information collection from all BC activities to disseminate for use on broadcast mediums, SMS, IVR, management and operational teams to allow a clearer understanding of current community thoughts and understandings of Ebola (identify gaps)															
• Produce 5 minute radio dramas for broadcast on weekly SLRC Radio Broadcasts															
• Produce 20 x 15minutes of audio recorded DRAMA series for distribution on CD or other media to communities															
• Communication community field trips for TV/radio broadcast weekly gathering of audio and video programing															
• Media training and workshop with national media companies to discuss Humanitarian BC activities															
• Press briefings (if necessary)															
• One day sessions with artists and musicians, film producers to discuss national Ebola strategy and how SLRC can work with these groups															
• Short Training in community engagement and beneficiary communications to all operational staff															
• Production of billboards, wall murals,															

• Radio and TV production promotion materials for broadcast use																
• Audio and Video training for BC field staff																
• Bi weekly meeting (by phone) establish regional network of Ben Comms practitioners in the Ebola affected countries																
• Two time BC regional meetings for affected country BC representatives																
• Outside broadcast community engagement activities utilising radio retransmission (OB Unit)																
• Upgrade and revamp the current Guinea RC hotline system to allow more efficient service delivery to communities																
• Training of national headquarters staff on beneficiary communications techniques																
• Distribution of solar/dynamo radio to communities to allow more access to Radio program information																
Output 2: Safe and Dignified Burials and Disinfection of Houses (A0102) Risk of transmission of disease in the communities at household level and in health facilities reduced through disinfection and Safe and dignified burials.																
	2014									2015						
Activities planned Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
• Development of protocol and safety regulations for implementation of SDB																
• Establishment of 76 SDB teams (9 people and 2 vehicles per team)																
• Procurement and pre-positioning of personal protective equipment, body bags and other SDB related supplies																
• Development of integrated community engagement, social mobilisation and psychosocial support tools and training packages.																
• Training in SDB protocol and procedures, personal protection, safety measures and SOPs																
• Refresher training of all personnel involved in SDB every three weeks																
• Establishment of data collection and management systems																
• Training of 76 volunteers on data collection tools																
• Fitting of HF and HVF radio system in all vehicles and establishment of radio network linked to the national alert system.																
• Procure and distribute infrared thermo flash thermometers to all branch teams																
• Deployment of 76 SDB teams on an average of 20 days per month																

Output 3: Psychosocial and economical support is provided to affected population																
	2014									2015						
Activities planned Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
• Recruitment of PSS delegate																
• Train 250 volunteers in psychosocial support techniques using the IFRC Reference Centre for psychosocial support material																
• Refresher training of 250 PSS volunteers every three months																
• Establish volunteer care mechanisms and systems.																
• Provide psychosocial counselling to patients, affected family members, people who have been separated and volunteers.																
• Accompany and support individuals discharged from isolation back to their communities to assist in re-entry and re assure community																
• Conduct community visits for mitigation and reduction of stigma and fear.																
• Establish selection criteria and validation systems for beneficiary selection; Transfer 1,000,000 GNF (130 CHF) to 10,000 families (with positive case/s)																
• Procure and distribute infrared thermo flash thermometers to all branch teams																
Output 4: community surveillance and contact tracing (A0104) *In coordination with partner agencies, an effective alert investigation and contact tracing system is implemented to ensure rapid referral and care*																
	2014									2015						
Activities planned Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
• Train 250 volunteers in contact tracing and community surveillance in accordance with national agreed procedures and guidance																
• Refresher training every three months																
• Deploy 250 volunteers to organize the active search for suspected cases and contacts in the community to detect suspected cases of EVD under the guidance of CDC and UNFPA																
• Enumerate all the contacts and place them under daily surveillance for 21 days in order to detect the possible onset of fever.																
• Procure and distribute infrared thermo flash thermometers to all branch teams																
Output 5: Clinical case management (A0105) *Provision of Ebola clinical case management services in areas reporting large amount of transmissions and lack of treatment facilities. This includes establishment of Ebola treatment centres and support to community or home based care as interim solution.*																
	2014									2015						
Activities planned Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
• Mobilise and fit 50 makeshift pickup-truck ambulances (2 per projected response district)																

• Train 200 volunteers in patient transport, protocols, personal protection, safety and SOPs															
• Deploy 200 volunteers in 50 teams on an average of 20 days per month															
• Procurement and pre-positioning of personal protective equipment and other patient transport related supplies															

Outcome 2: The existing capacity of the Guinea Red Cross National Society and IFRC management and technical support is enhanced and effective and sustainable action ensured

Output 1: The NS has the necessary capacity to lead the operation and ensure sustainable impact

	2014									2015					
Activities planned Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J
• Conduct a rapid assessment in the community to describe the current epidemic, in order to ensure that all actions of the chain of transmission are identified and measures to prevent future infections are implemented.															
• Establish GRC task force at headquarter level maintaining close coordination with national health authorities, partner organizations and the GRC branches in the affected areas.															
• Develop and maintain detailed emergency plan of action.															
• Provision of office equipment and rehabilitation of 37 branch offices															
• Pre-positioning of IEC and PPE at all branches.															
• Provision of 10 bicycles and 2 motorbikes for each of the 37 branches															
• Establishment of Ebola management teams in all 37 branches															
• Provision of office equipment and establishment of operations coordination centre at headquarters level															
• Establishment of central GRC warehouse and necessary personnel and procedure structure															
• Train 100 community volunteers per branch in Ebola preparedness															
• Establish and test contingency plans at national, regional and branch level															

Output 2: Necessary IFRC resources are provided to support the operation.(A0202)

	2014									2015					
Activities planned Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J
• Deploy FACT to support the NS in planning and implementation of the international response to the epidemic															
• Conduct a rapid assessment in the community to describe the current epidemic, in order to ensure that all activities of the chain of transmission are identified and measures to prevent															

future infections are implemented.																
• Deploy logistics ERU to support management of transport of personnel and equipment, incoming goods, procurement.																
• Deploy IFRC delegates and an IFRC Regional Disaster Response Team to support GRC in implementation and management of the operation.																
• Establish 5 warehouses for prepositioning of stocks to cover all affected areas																
• Perform a real-time evaluation of the operation to guide further planning and implementation																
• Conduct a final evaluation of the response																

Outcome 3: Support is provided to national authorities for country-wide coordination and information management of the overall Safe and Dignified Burial and disinfection of Houses response

Output 1: SDB coordination and information management hub in Conakry is established

	2014									2015					
Activities planned Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J
• Recruitment of SDB Coordinator and SDB Information Manager															
• Contribute to national Coordination of the SDB work performed by all partners involved in the Ebola response															
• Identification of key partners															
• Assessment of SDB needs and response															
• Consolidate, review and disseminate current standards.															
• Collect, analyse and present key SDB response information															
• Reporting of SDT indicator progress to the UNMEER response monitoring dashboard															

Outcome 4: Longer-term effects of the outbreak and needs for early recovery, livelihoods and food security interventions are identified and IFRC/GRC activities planned.

Output 1: Food security and livelihoods assessment conducted

	2014									2015					
Activities planned Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J
• Training of volunteers and National Society staff in food security and livelihoods assessment															
• Conducting assessments and writing report															

• Conduct discussion with key partners and share the outcome of the assessment															
• Plan of action leads to revision of the Appeal and mobilisation of financial resources for food and nutrition security response and livelihoods recovery															

Annex 1: Human and physical resources mobilised today

Prefectures / Districts	Functional GRC Branches / Sub-Offices	Number of IFRC Vehicles VRPs	Number of GRC vehicles (including those purchased or donated by the Government)	*Number of vehicles locally rented	**Number of IFRC Delegate in country (country team)	GRC HQ and Branches staff	Total number of volunteers trained	Total number of Safe and Dignified Burials (SDB) Teams	Total number of volunteers trained on Social Mobilization)	Total number of volunteers trained on contact tracing	Total number of volunteers trained on conducting of inter active broadcasts
Conakry	5	5	6	4	3	25	306	6	208	80	04
Guéckédou	10	4	1	1	3	16	382	2	369	3	04
Macenta	14	3	1	13	0	25	221	6	201	6	10
Dabola	1	0	0	0	0	3	32	1	0	0	0
Kissidougou	1	0	0	0	0	9	68	1	38	**0**	0
Dinguiray	1	0	0	0	0	3	42	1	37	0	0
Télimélé	1	0	0	0	0	3	42	2	32	0	0
Boffa	1	0	0	0	0	3	42	2	32	0	0
Kourroussa	1	0	0	0	0	3	51	1	46	0	0
Siguiri	1	0	0	0	0	3	41	2	31	0	0
Pita	1	0	0	0	0	5	32	2	22	4	0
NZérékoré	1	0	3	0	0	5	99	3	10	8	0
Yomou	1	0	0	1	0	5	20	2	10	2	0
Dubréka	1	0	0	0	0	3	41	1	40	0	0
Forékaréah	1	0	0	0	0	5	61	3	46	0	0
Kérouané	1	1	0	3	1	5	73	4	39	2	**0**
Coyah	1	0	0	0	0	6	41	1	40	0	0
Dalaba	1	0	0	0	0	3	32	1	10	4	0
Beyla	1	0	1	0	0	5	12	2	0	0	0
Kindia	1	0	0	0	0	5	32	2	22	0	0
Lola	1	0	0	0	0	3	41	2	18	0	0
Boké	1	0	0	0	0	3	42	1	0	0	0
Mamou	1	0	0	0	0	3	32	1	0	0	0
Faranah	1	0	0	0	1	5	32	1	0	0	0
Kankan	1	0	0	0	0	3	41	0	0	0	0
TOTAL	**51**	**13**	**12**	**22**	**8**	**157**	**1858**	**50**	**1251**	**109**	**18**

Budget

- See attached budget for details.

Contact Information

For further information specifically related to this operation, please contact:

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

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How we work

All IFRC assistance seeks to adhere to the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief and the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable. The IFRC's vision is to inspire**, encourage, facilitate and promote at all times all forms of humanitarian activities** by National Societies, with a view to **preventing and alleviating human suffering**, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

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

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

REVISED EMERGENCY APPEAL BUDGET

18/11/2014

Budget Group	Multilateral Response	SDB Coordination	Bilateral Response	Appeal Budget CHF
Shelter - Relief	0			0
Shelter - Transitional	0			0
Construction - Housing	0			0
Construction - Facilities	0			0
Construction - Materials	0			0
Clothing & Textiles	0			0
Food	0			0
Seeds & Plants	0			0
Water, Sanitation & Hygiene	137,280			137,280
Medical & First Aid	5,941,640			5,941,640
Teaching Materials	229,980			229,980
Utensils & Tools	483,000			483,000
Other Supplies & Services	0			0
Emergency Response Units			180,000	180,000
Cash Disbursements	1,300,000			1,300,000
Total RELIEF ITEMS, CONSTRUCTI	**8,091,900**	**0**	**180,000**	**8,271,900**
Land & Buildings	0			0
Vehicles Purchase	396,000			396,000
Computer & Telecom Equipment	638,600	4,000		642,600
Office/Household Furniture & Equipn	97,133			97,133
Medical Equipment	0			0
Other Machinery & Equipment	0			0
Total LAND, VEHICLES AND EQUIP	**1,131,733**	**4,000**	**0**	**1,135,733**
Storage, Warehousing	112,000			112,000
Distribution & Monitoring	82,260			82,260
Transport & Vehicle Costs	6,355,054	24,000		6,379,054
Logistics Services	5,760			5,760
Total LOGISTICS, TRANSPORT AN	**6,555,074**	**24,000**	**0**	**6,579,074**
International Staff	2,366,500	144,000		2,510,500
National Staff	46,763			46,763
National Society Staff	817,770			817,770
Volunteers	2,963,340			2,963,340
Total PERSONNEL	**6,194,373**	**144,000**	**0**	**6,338,373**
Consultants	207,000			207,000
Professional Fees	0			0
Total CONSULTANTS & PROFESSI	**207,000**	**0**	**0**	**207,000**
Workshops & Training	2,175,000			2,175,000
Total WORKSHOP & TRAINING	**2,175,000**	**0**	**0**	**2,175,000**
Travel	74,000	20,000		94,000
Information & Public Relations	1,694,168			1,694,168
Office Costs	223,250	30,000		253,250
Communications	137,000	12,000		149,000
Financial Charges	30,000	2,000		32,000
Other General Expenses	0			0
Shared Support Services	19,552			19,552
Total GENERAL EXPENDITURES	**2,177,970**	**64,000**	**0**	**2,241,970**
Programme and Supplementary Serv	1,724,648	15,340	0	1,739,988
Total INDIRECT COSTS	**1,724,648**	**15,340**	**0**	**1,739,988**
TOTAL BUDGET	**28,257,699**	**251,340**	**180,000**	**28,689,039**
Available Resources				
Multilateral Contributions	6,978,330			6,978,330
Bilateral Contributions			180,000	180,000
TOTAL AVAILABLE RESOURCES	**6,978,330**	**0**	**180,000**	**7,158,330**
NET EMERGENCY APPEAL NEEDS	**21,279,369**	**251,340**	**0**	**21,530,709**

Budget summary per output

Guinea: Ebola Emergency Appeal

17.11.2014

Activity based summary per budget group

Budget Group	*Social mobilisation*	DBM & Disinfection	PSS	Surveillance and tracing	Patient transport	NS Capacity	IFRC support	SDB coordination	Total
Total RELIEF ITEMS, CONSTRUCTION AND SUPPLIES	**126,000**	**6,315,940**	**1,300,000**	**0**	**0**	**499,960**	**30,000**		**8,271,900**
Total LAND, VEHICLES AND EQUIPMENT	**197,000**	**72,400**	**95,200**	**0**	**136,000**	**566,133**	**65,000**	**4,000**	**1,135,733**
								0	
Total LOGISTICS, TRANSPORT AND STORAGE	**362,436**	**4,807,660**	**463,681**	**315,058**	**537,400**	**13,500**	**55,340**	**24,000**	**6,579,074**
Total PERSONNEL	**1,478,361**	**1,684,557**	**507,922**	**380,643**	**534,875**	**336,751**	**1,271,263**	**144,000**	**6,338,373**
Total CONSULTANTS & PROFESSIONAL FEES	**150,000**	**0**	**0**	**22,000**	**0**	**0**	**35,000**	**0**	**207,000**
Total WORKSHOP & TRAINING	**292,000**	**1,251,000**	**40,000**	**100,000**	**400,000**	**92,000**	**0**		**2,175,000**
Total GENERAL EXPENDITURES	**1,722,168**	**26,000**	**20,000**	**0**	**0**	**277,500**	**132,302**	**64,000**	**2,241,970**
Programme and Supplementary Services Recovery	281,318	920,241	157,742	53,151	104,538	116,080	103,279	15,340	1,739,988
Total INDIRECT COSTS	**281,318**	**920,241**	**157,742**	**53,151**	**104,538**	**116,080**	**103,279**	**15,340**	**1,739,988**
TOTAL BUDGET	**4,609,282**	**15,077,798**	**2,584,545**	**870,852**	**1,712,813**	**1,901,924**	**1,692,184**	**251,340**	**28,689,039**

ANNEXEX 3

SIERRA LEONE ATTACHMENTS

List of persons interviewed

Sierra Leone Emergency Appeal, Sept 9, 2014

Sierra Leone Emergency Appeal,
Emergency Plan of Operations, Sept 9, 2014

Sierra Leone Standard Appeal Report,
December 2014

SIERRA LEONE: Persons interviewed by the RTE evaluation team

Name	Position	Telephone
Ansumona, Henry	SDB volunteer, Kenema Branch	
Banya, Aruna	PSS volunteer, Kenema Branch	
Bockarie, Jonathon	Branch Health Coordinator, Kenema	076 643 604
Bune Ruth	Psychosocial Support Volunteer, Western Area Branch	
Bunting-Graden, Joseph	Provincial Security Coordinator, East	078 767 767
Carew Unisa	Head of Administration, Western Area Branch	
Cozma, Vlad	IFRC information management	
Davis, Edward	Education Advisor, DfID Sierra	076 801 498
Dumbuye Simon	Social Mobilization Volunteer, Western Area Branch	
Fleming, John	IFRC Health Coordinator	079 423 686
Gamanga Mustafa	Beneficiary Communication Volunteer, Western Area Branch	
Garbar Joseph	Social Mobilization Volunteer, Western Area Branch	
Gegbai Francis	Social Mobilization Volunteer, Western Area Branch	
Ghebrat, Yohannes	WHO Field Coordinator, Kenema	079 010 886
Hamad Hawalu	Beneficiary Communication Volunteer, Western Area Branch	
Jalloh Ramata	PSS / Contact Tracing Officer, Western Area Branch	
Jambai Amara	Director Surveillance, Sierra Leone, Ministry of Health	
Jambawani, George	PSS volunteer, Kenema Branch	
Jarjou, Andrew	IFRC Operations Manager, Ebola	
Jude	Finance Delegate	
Kabo Haja	Contact Tracing Volunteer, Western Area Branch	
Kamara Mohamed	SDB Volunteer, Western Area Branch	
Karim. Haja Kultami	USG	
Kopomeh, Chrisaina	PSS volunteer, Kenema Branch	
Koroma, Ibrahim	SDB volunteer, Kenema Branch	
Koroma, Mannah	PSS volunteer, Kenema Branch	
Kpandeyenge Sylvia	Social Mobilization Volunteer, Western Area Branch	
Lonseh, Augustine	Supervisor, Kenema Branch	
Mambu, Adbul Rahman	SDB volunteer, Kenema Branch	
McAndrews, Stephen	IFRC Head of Emergency Operations	079 236 795
McClelland, Amanda	IFRC Senior Emergency Health Coordinator	076 184 424
Mve Yvet	Watsan Delegate	
Mukwabi Bernard	PMER Delegate	
Musa Tamba	Beneficiary Communication Volunteer, Western Area Branch	
Ngandi, Edward	SLRC President	076 668 566
Ngauja David	SDB Volunteer, Western Area Branch	

Noah Glen	Psychosocial Support Volunteer, Western Area Branch	
Nyukeh, Henry	SLRC National Ebola Coordinator	
Philip	Undersecretary Finance, SRCS	
Rogers Mustafa	Beneficiary Communication Volunteer, Western Area Branch	
Samba-Kelfala, Joseph	Chair, Kemena District Council	
Sisay Osman	Social Mobilization Volunteer, Western Area Branch	
Smith Victoria	Human Resource, SRCS	
Songray David	Contact Tracing Volunteer, Western Area Branch	
Stephen Patrick	Head of Logistics, SRCS	
Takano Fatuma	Contact Tracing Volunteer, Western Area Branch	
Tarawallie, Abu Bakkar	USG	
Tasawa Fatuma	SDB Volunteer, Western Area Branch	
Tinberg, Tonje	ETC Hospital Manager	079 517 516
Tommy, Emmanuel	Secretary General SLRC	
Tourray Augustine	SDB Volunteer, Western Area Branch	
Turay Idrissa	Logistics Officer, SRCS	
Vedrasco, Liviu	WHO technical officer, Ebola	
Walia, Sonia	Deputy DART Team leader	078 1115 588

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Saving lives, changing minds.

Emergency appeal
Sierra Leone: Ebola Virus Disease

International Federation of Red Cross and Red Crescent Societies

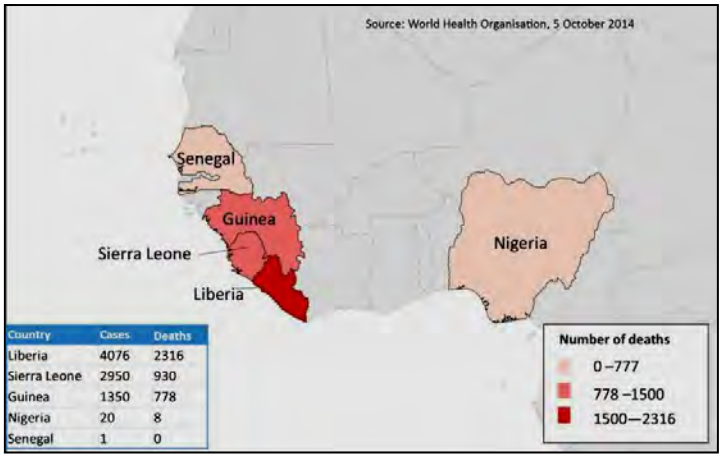
Revised Emergency Appeal No. 3 (MDRSL005) Glide n° **EP-2014-000039-SLE**	**6.3 million people** to be assisted **CHF 41.1m** Appeal budget **CHF 1.2m** DREF allocated, including **CHF 1.0 million** for pre-financing of the **ERU**	Launched: June 2014 1st revision: July, 2014 2nd revision: September,2014 Appeal timeframe: 15 months End date: June, 2015

This revised Emergency Appeal seeks a total of **CHF 41.1m** (increased from CHF 12.9m) to enable the IFRC to support the **Sierra Leone Red Cross Society (SLRCS)** to respond to the worsening Ebola Virus Disease (EVD) outbreak for **6,348,350 people.** This revised Appeal represents a significant scaling up of SLRCS activities to conduct contact tracing, safe and dignified burials, social mobilisation, communications, and psychosocial support to **11** operational areas in **10** districts. It will extend the clinical case management component through the established Ebola Treatment Centre (ETC) in Kenema; increase physical resources such as vehicles, motorbikes and protective equipment; increase human resources (28 international staff, 97 national staff, and active 2,188 volunteers). Safe and dignified burial teams will be increased from **3** to **29** teams across the country. A beneficiary communications component includes use of mobile phone technology by Red Cross volunteers in data collection and reporting. The planned response reflects the current situation and information available at this point of the rapidly evolving operation, and will be adjusted based on further developments and more detailed assessments.

Details are available in the Emergency Plan of Action (EPoA).

The disaster and the response to date

March - April: Ebola outbreak first detected in Guinea; Sierra Leone established National Ebola Task Force. IFRC 1st DREF allocation of CHF 113,217 for preparedness.



Country	Cases	Deaths
Liberia	4076	2316
Sierra Leone	2950	930
Guinea	1350	778
Nigeria	20	8
Senegal	1	0

26 May: First ebola case reported in Sierra Leone near the border with Guinea, with rapid caseload spread as a result of the movement of health care workers.

June: IFRC Field Assessment and Coordination team (FACT) deployed (rapid assessment); IFRC 2nd DREF allocation of CHF 114,119 and Emergency Appeal launched for CHF 880,000.

July: IFRC issues revised appeal for CHF 1.36m and deploys Emergency Response Units to establish the Ebola Treatment Centre in Kenema with extraordinary DREF allocation of CHF 1m.

September - October: with confirmed caseload spiralling out of control and twelve out of thirteen districts affected; IFRC issues revised appeal for CHF 12.85m. The IFRC ebola operation has achieved the following: 433 safe and dignified burials; 820 volunteers trained and active in the ebola operation; 17,470 contacts traced and followed up by the Red Cross volunteers; 1,352 houses and public facilities disinfected; 774,348 people reached through door to door social mobilization campaigns; 2,090 people received psychosocial support and re-integrated back to the community after treatment; 126 patients treated at the Red Cross treatment centre in Kenema; over 7 million SMS's on ebola prevention sent across the country; millions of people have been reached with ebola prevention and awareness through radio dramas and the weekly live one-hour radio call-in show for questions and

answers about Ebola; pre-positioning of personal protective equipment and related training on their proper use and disposal; Interagency coordination through the National Task Force.

The operational strategy

Overall objective: Contribute to the reduction of mortality and morbidity related to the Ebola virus disease in Sierra Leone through awareness messaging, safe and dignified burials, contact tracing, social mobilization provide psychosocial support and case management/treatment to those affected.

Proposed strategy: The appeal strategy follows the agreed Ebola regional framework with activities developed to ensure a harmonised approach and collaboration around the key activities based on technical recommendations. Each pillar (listed below) is of equal importance and reliant on the others to be effective. One of the objectives of social mobilization is to encourage people to identify possible symptoms early, and present themselves to case management. With no case management, the impact of social mobilisation is limited, but the same can be said for the effectiveness of case management if no one is willing to present themselves to the health centre.

1. Community Engagement: Social mobilization, two-way beneficiary communication and sensitization
2. Safe and dignified Burial and Disinfection, formerly Dead Body Management (DBM)
3. Psychosocial Support (PSS): Re-entry and Social Re-integration into Society
4. Surveillance and Contact Tracing
5. Case management and Treatment

Beneficiary selection: In addition to having a national range, and based on the assessments carried out and indications provided by the Ministry of Health and Sanitation, the plan of action particularly targets high risks groups and opinion leaders. These groups are the same as in the previous appeals:

- Women's groups and associations
- Bike riders and drivers
- Schools
- Religious and traditional healer leaders
- Health workers
- Ebola patients

Special attention is given to women and women's groups since they are particularly vulnerable. To date, MoHS reports indicate that 59% of the people affected by EVD are women. The health workers affected have been mainly women and women are the ones that take care of their sick family members and relatives. They are also the ones that care for the body of the person that has died, which is highly infectious if not dealt properly with.

Coordination and partnerships

The IFRC has established a regional Ebola response and preparedness coordination function through its Ebola Management Unit in Conakry, Guinea. The unit ensures outbreak-wide data collection and analysis, knowledge management, cross-border collaboration, resource mobilization, consistent effective preparedness and response and provides coordination at strategic level. The Sierra Leone Red Cross Society is a member the National Ebola Taskforce with the Ministry of Health, World Health Organization and NGO partners including Médecins Sans Frontières, Save the Children and Action Contre la Faim. It is also a member of the taskforces established at a district level and daily coordination meetings take place in Kailahun under joint MoHS/WHO leadership. Under the national taskforce are five pillars: laboratories and surveillance; case management, social mobilization, logistics and coordination. The same technical coordination structures have been established in Kailahun and each of these groups meet twice a week. Updates on the epidemiological situation are provided at the taskforce meetings and are also published on the Ministry of Health and Sanitation's Facebook page and the WHO Global Alert and Response website.

The overall IFRC response is coordinated from the IFRC Ebola coordination centre in Conakry where the IFRC head of emergency operation leads a programme support team in order to maintain a coordinated response in multiple countries following the same response strategy but adapted to specific contexts and National Society capacity, role and mandate.

Health and care

Outcome: Contribute to the reduction of mortality and morbidity related to the Ebola Virus Disease in Sierra Leone through community awareness and social mobilisation, contact tracing and surveillance, provision of psychosocial support, safe and dignified burials and case management to those affected.
Output 1: Community understanding, engagement, ownership and implementation of prevention and control measures is ensured through effective social mobilisation and two-way communication with beneficiaries, community leaders and religious leaders to prevent further transmission and control the outbreak.
Activities planned:
Train 550 volunteers nation-wide in EVD signs, symptoms, prevention and referral mechanisms (50 social. mob volunteers per each of the identified locations)
Training/briefing on PHAST/CHAST and CBSC communications for social change (11 training sessions)
Identify/recruit and train community-based groups/teams (at least 5 groups per chiefdom.) in 113 chiefdoms in 10 districts
Build and Install 10 Red Cross information kiosks and hand washing station in 11 operation areas.
Conduct health promotion campaigns using house-to-house and street-to-street approach.
Organize child-to-child activities in targeted areas (production of games, kids t shirts, little radios etc.) in the 11 operational areas
Organize focus group discussions with the most vulnerable people in the operational areas
Organize mass sensitization and sanitation campaigns
Organize briefing and debriefing sessions for 550 volunteers on community-based awareness-raising, social mobilization and PSS (4 sessions in each of the 11 operational areas).
Produce 3,000 flash cards – PHAST pictures on Ebola and PHAST toolkits 10 sets per operational area
Re-production of 500 community HP T-shirts
Procurement of 1,130 hand washing stations. 10 stations with buckets, taps and kiosks per each of the 113 chiefdoms in the country.
Distribute social mobilization / hygiene promotion kits (chlorine, soap, back pack, hand sanitizer, megaphones and batteries to the chiefdoms
Organize regular Knowledge Attitude and Practices (KAP) survey.
Recruitment of 11 Branch Social mobilization Officers (11)
Establishment of nation-wide monitoring and reporting system to track implementation progress and inform operational planning.

Output 2: To engage people and families in a meaningful dialogue to address stigma, dispel rumours or misperceptions of the disease, bury bodies safely and respectfully and highlight the importance of seeking early treatment and provide opportunities for communities to voice their say and ask questions using different communication mediums.
Activities planned:
Establishment of one hour live interactive weekly Television program to be broadcast across SLBC footprint with a focus on gathering and responding to communities needs for information. (4 times per month)
Scaling up of current Radio activities to two weekly one hour interactive Radio Broadcasts across SLBC with a focus on gathering and responding to communities needs for information (4 times per month)
Establishment of IVR (pre-recorded information exchange) system in cooperation with Local Telecommunication providers to provide access to pre-recorded prevention and programmatic information relating to Ebola
Scale up the use of the TERA system to a set structure of targeted messaging and community feedback
Establish TERA on second Telecommunication network Africell in Sierra Leone
Train 470 volunteers in basic community engagement and beneficiary communications with a focus on the dissemination of Ebola information and feedback in all districts going (house-to-house) as well as document with mini-KAPS using RAMP/ODK
30 Short forums (2 per district) and engagement with “community resource oriented persons” Chiefs, traditional healers, teachers, soldiers and police, hunters, musicians, sport personalities etc. To build a team of leaders for communities to prevent Ebola and use as spokespersons on broadcast mediums Radio and TV.
Train Ben Comms field staff and volunteers in data collection RAMP/ODK to support DBM teams in information gathering and community engagement during DBM process.
Establish system of data and information collection from all BC activities to disseminate for use on broadcast mediums, SMS, IVR, management and operational teams to allow a clearer understanding of current community thoughts and understandings of Ebola (identify gaps)
Produce 5 minute radio dramas for broadcast on weekly SLRC Radio Broadcasts
Produce 20 x 15 minutes of audio recorded DRAMA series for distribution on CD to communities
Communication community field trips for TV/radio broadcast weekly gathering of audio and video programming
Media training and workshop with National media companies to discuss Humanitarian BC activities
Press briefings (if necessary)
One day sessions with Artists and musicians, film producers to discuss national Ebola strategy and how SLRC can work with these groups
Short Training in community engagement and beneficiary communications to all operational staff
Production of IEC materials print, billboards, wall murals,
Radio and TV production promotion materials for broadcast use
Audio and Video training for BC field staff
Bi weekly meeting – phone - Establish Regional network of BC practitioners in the Ebola affected countries

Procure 150 smart phones for ben comms volunteers
Recruitment of Branch Ben comm Officers (11)
Recruitment of Ben Com staff for the National Society HQ

Output 3: Risk of transmission of disease in the communities at household level and in health facilities reduced through disinfection and safe and dignified burials.
Activities planned
Provide surge (specialized) vehicles for teams involved in activities related to Dead Body Management teams in the 11 operational areas (at least 1 pickup vehicle for burial, 1 for DBM volunteers and 1 community engagement activities per branch).
Specialized DMB training for 10 DBM team in Freetown
Perform safe burials of human remains in the 11 operational areas, including from the /Ebola Treatment Centre (ETC) and within communities in close collaboration with the Ministry of Health and Sanitation / District Health Management Teams.
Identify and train 11 national society DBM trainers
Establish coordination and clear referral mechanism with country health teams
Train 224 volunteers on Dead Body Management (transport of body, and disinfection /fumigation of dwellings (houses, toilets, kitchens, utensils and personal effects of affected families) the 11 operational areas.
Regular refresher training sessions (8 sessions), on the dressing and proper removal (best practices) of the PPE as well as disinfection every 6 weeks for DBM.
Procurement 900 DBM Starter kits and 1,800 replenishments kits.
Organize cross-border workshop on Dead Body Management.
Nutrition support for DBM volunteers (water and sandwich).
Medical support (multi-vitamins, and water).
Recruitment of a Dead Body Management Supervisor at headquarters.
Procure additional DBM materials (local procurement of rain boots, shovels, cutlasses, pick axes, chopping axes, duck tapes, converse ropes, hand sanitizers, jerry cans and buckets)
Conduct quality assurance check of DBM team by an external partner or supervisors.
Conduct regular DBM activity monitoring by the National Society and IFRC
Development of DBM Sop and IFRC guidelines on EVD cross border epidemics/Translation
Rented accommodation (room) for DBM Teams (11 districts). 1 room per operational area.
First aid training for all DBM volunteers
Recruitment of 11 Branch DBM Officers (11)
Recruitment of 11 DBM trainers for the National Society
Recruitment of National Society Dead Body Management Supervisor and trainer

Output 4: Psychosocial support is provided to families and individuals affected by the epidemic with a sick person in the family or a deceased, including a survival kit (essential food and non-food).
Activities planned
Train 400 volunteers in all the 11 operational areas districts that are following up contact in psychosocial first aid. Normal training cost
Provide psychosocial counselling to affected persons, family members, and volunteers.
Conduct community visits for mitigation and reduction of stigma and fear.
Prepare communities for re-integration / acceptance of suspects / probable / confirmed cases.
Accompany and support individuals discharged from isolation back to their communities to assist in re-entry and reassure communities.
Procurement and distribution of appropriate resettlement packages/survival kits for 2000 affected families. (orphans and children)
Real-Time review of post-traumatic stress disorders (PTSD) risk factors for staff and volunteers in Ebola operation.
Recruitment of 11 Branch PSS Officers

Output 5: In coordination with partner agencies, an effective alert investigation, community surveillance, and contact tracing system is implemented to ensure rapid referral and care
Activities planned:
Train 330 volunteers in all the 11 branches for Surveillance and Contact Tracing of suspected, probable and confirmed cases (11 training sessions)
Undertake contact tracing and follow-up activities by volunteers in communities
Provision of mobile phones for CT volunteers
Recruitment of Branch 11 Contact Tracing Officers
Procurement of 30 infra-red thermometers for offices of the National Society.
Regular Reporting of CT

Output 6: Provision of EVD clinical case management in areas reporting large amount of transmissions and lack of treatment facilities
Activities planned:
Assessment and scoping mission
Initial Emergency Response Unit deployment
Construction of Ebola Treatment Centre in Kenema

Recruitment of management, technical and support staff
Mobilization of establishment materials and running supplies
Build and manage 60 bed ETC
Train 200 local staff to work safely in ETC
Procure medicines and personnel protective equipment
Establish pre deployment training course in Geneva for incoming specialists teams
Open recruitment internationally support
Establish data management system HMIS using RAMP and Redat
Implement full clinical care of suspected, probably and confirmed cases of Ebola (including DBM)
Provide discharge support for all patients from ETC
Engage in community outreach activities in support of coordination and prevention activities
Decommissioning and handover

Output 7: The capacity of Sierra Leone Red Cross Society to manage Ebola virus disease outbreak response has been expanded and strengthened.
Activities planned:
Recruitment of National Society Ebola staff at headquarters and Branches in the operational areas.
Identification and recruitment of SLRCS National Ebola Coordination at headquarters.
Recruitment of NS support staff (programme staff, warehouse/fleet, finance staff, security guards etc.)
Establishment of Monitoring Rapid Response (Mobile) Team (RRT) consisting of a doctor/nurse, DBM specialist, Contact Tracing specialist, and a driver.
Provision and transportation services (mini buses) for the transportation of NS headquarters staff to avoid public transport so as to minimise body contact.
Training of newly recruited national society staff from 6 operation areas (34 staff): *Bo, Bombali, Kailahun, Kenema, Port Loko, Western Area Rural and Urban*.
Training of additional recruited national society staff on Ebola response mechanisms and reporting for 4 more operational areas (16 staff)*: Moyamba, Tonkolili, Pujehun and Kambia*
Capacity building in computer skills and reporting etc. (local training)
Provision of office equipment and materials for the operational areas (electricity supply, internet connectivity, stationery, etc.)
IT support for at least 11 operational areas plus headquarters (laptops and desk top computers, printers, photocopiers, digital cameras)
Refurbishment at national headquarters building (painting, electricity and plumber works, etc.
Upgrading branch infrastructure (refurbishment work) at branches based on needs.
Improvement of national headquarters Emergency Operations Room (EOR) with internet facility, computers, printers, telephone hotlines, information and information dissemination, and updates on Ebola
Provision of complementary insurance covering local and international staff and volunteers involved in the Ebola operations.
International Federation insurance cover against accidents and injuries for 1,850 National Society volunteers for a period of one year.
Support to SLRCS participation in international Ebola trainings programmes and workshops, conferences and meetings.(flights tickets accommodation per diem)
Restoration / repairs of national headquarters and branch radio communication base stations equipment.
Volunteer recognition - ceremony and certificate award to all volunteers and staff involved in the Ebola operation

Output 8: Mobilization and establishment of IFRC support functions and structures in Sierra Leone.
Activities planned:
Recruitment of Delegates
IFRC technical support / monitoring visits
Regional Ebola Workshop Field Level
Develop SDB SoPs and IFRC guidelines on EVD cross border epidemics and their translation
Real- Time Evaluation of the Ebola operation in Sierra Leone
IFRC Office Set Up- HQ/Office Rent
Regional office, Zone and Geneva communication costs

Programme support services

Human Resources

The National Society has extended its response capacity to the Ebola operation, and therefore is severely overstretched. The current scale-up is targeted in clinical staff and logistics, in addition to needs initially proposed through the Emergency Appeal launched in June, including expansion of volunteer mobilization in education, awareness raising and social mobilization, contact tracing and surveillance, PSS support and dead body management, supervision of burials and disinfection of houses. In Sierra Leone, an organic chart has been developed to address the needs of both: the IFRC ETC in Kenema and the expanded activities in 6 districts. The human resources needed for long term operation are in place or are currently being recruited and the global tools emergency personnel will be phased out in the coming weeks. Details on the human resources of the operation are available in

the Emergency Plan of Action (EPoA). Related to human resources for Ebola response-wide coordination, support services, institutional learning, cross-border collaboration and programme guidance will be managed by the IFRC Ebola coordination function in Guinea under the IFRC Ebola coordination and preparedness appeal (MDR60002).

Logistics and supply chain: Global markets for essential items such as PPE, Chlorine and Body Bags are being depleted, and in order to avoid being compelled to use non-standard items, there is a need for IFRC to ensure that the logistics set up is in place to ensure that the operations can run without interrupted supplies, which would put RC staff and volunteers at risk. The Ebola logistics teams will be supported by Head of Zonal Logistics Unit based in Nairobi. Sierra Leone will have one logistics coordinator who will report to the Head of Operations (HeOPs) and a technical reporting line to the Head of ZLU in Nairobi. The logistics staffing includes the current Logistics ERU team. From October onwards, a new structure will be in place, with logistics personnel based in Freetown, Kenema, and Kailahun. A detailed and up-to-date mobilization table is established and available on the Federation's Disaster Management Information System (DMIS). All contributions must be coordinated with Dubai Global Logistics Service.

Information Technologies: Access to Internet goes from limited to non-existent in the affected regions and information flow between branches and headquarter is limited, with adverse effect on timely reporting. A local internet company has been identified to provide internet in all the six identified districts. Additionally, VSATs equipment have been installed in Kenema and Freetown operation hubs. The running costs of the internet service provision currently in place in Kailahun and planned to be installed in the other 11 operational areas will be covered through the Emergency Appeal for the remaining period of the operation. The appeal will also support costs for IT delegate, radio stations, TERA and other telecommunication needs for the Ebola operation.

Communications: The Sierra Leone Red Cross Society, with support from IFRC regional and zone communications, has been coordinating various awareness and publicity activities, to sensitize the public, media and donors on the situation on the ground and the humanitarian response. A communication delegate has been recruited to support and increase the operation's profile who will ensure that key messages are updated, engage with media regarding the added value of Red Cross interventions, support the launch of this appeal and other major milestones throughout the operation using people-centred, community level diverse content, and provide the NS communication team with communication training and appropriate equipment.

Security: IFRC Africa Security Delegate and Security Unit in Geneva continue to work closely with our in country Operation Managers and support team in Geneva to monitor and support on security related matters. The Volunteer Security Booklet – "Volunteer Stay Safe" in English is being sent to the operations to ensure that all volunteers involved in the operation have access to the document to raise their security awareness. Although Security Guidelines are in place, there will need to be an in depth analysis of the different contingencies and challenges that could arise from various threats and changing context, such as disruptions in international travel, border closings and ad-hoc quarantine orders.

Planning, monitoring, evaluation, and reporting (PMER): The monitoring of the operation will be strengthened through establishment of a robust nation-wide monitoring and reporting system to track implementation progress and inform operational planning through continuous situation assessments. Sierra Leone Red Cross Society, in close cooperation with the IFRC will monitor the progress of the operation. The PMER delegate will support the NS to develop and use data collection tools including real time data collection using RAMP (mobile data collection), with two KAP surveys planned in 2015. In addition, a real time evaluation (RTE) to assess policy adherence, relevance and appropriateness, efficiency, effectiveness, and connectedness of the response to the Ebola outbreak in West Africa will be conducted from late October to early December 2014.

Administration and Finance: Financial resource management will be according to the Sierra Leone Red Cross Society regulations and IFRC guidelines. In addition, the National Society's own procedures will be applied to the justification of expenses process and will be completed on IFRC formats. Finance delegates for the operation to provide dedicated finance management support in the entire duration of the operation. The IFRC will provide overall financial support to the National Society support in a bid to build its capacity and ensure that the National Society is able to take up some financial and administration responsibilities for the operation.

€ Budget

See attached IFRC Secretariat budget (Annex 1) for details.

Walter Cotte
Under Secretary General
Programme Services Division

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How we work

All IFRC assistance seeks to adhere to the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief and the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable. The IFRC's vision is to inspire**, encourage, facilitate and promote at all times all forms of humanitarian activities** by National Societies, with a view to **preventing and alleviating human suffering**, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

Sierra Leone: Ebola Emergency Appeal

24.10.2014

Budget Group	Multilateral Response	Inter-Agency Shelter Coord.	Bilateral Response	Appeal Budget CHF
Shelter - Relief	324,819			324,819
Shelter - Transitional	0			0
Construction - Housing	0			0
Construction - Facilities	0			0
Construction - Materials	0			0
Clothing & Textiles	95,550			95,550
Food	530,712			530,712
Seeds & Plants	0			0
Water, Sanitation & Hygiene	904,117			904,117
Medical & First Aid	7,815,893			7,815,893
Teaching Materials	7,917			7,917
Utensils & Tools	457,054			457,054
Other Supplies & Services	212,720			212,720
Emergency Response Units	400,000		722,000	1,122,000
Cash Disbursements	0			0
Total RELIEF ITEMS, CONSTRUCTION AND SUPPLIES	**10,748,782**	**0**	**722,000**	**11,470,782**
Land & Buildings	0			0
Vehicles Purchase	457,140			457,140
Computer & Telecom Equipment	339,191			339,191
Office/Household Furniture & Equipment	102,997			102,997
Medical Equipment	0			0
Other Machinery & Equipment	0			0
Total LAND, VEHICLES AND EQUIPMENT	**899,328**	**0**	**0**	**899,328**
Storage, Warehousing	859,620			859,620
Distribution & Monitoring	1,576,122			1,576,122
Transport & Vehicle Costs	4,375,309			4,375,309
Logistics Services	0			0
Total LOGISTICS, TRANSPORT AND STORAGE	**6,811,051**	**0**	**0**	**6,811,051**
International Staff	7,370,482			7,370,482
National Staff	76,500			76,500
National Society Staff	3,950,826			3,950,826
Volunteers	2,567,968			2,567,968
Total PERSONNEL	**13,965,776**	**0**	**0**	**13,965,776**
Consultants	358,977			358,977
Professional Fees	12,000			12,000
Total CONSULTANTS & PROFESSIONAL FEES	**370,977**	**0**	**0**	**370,977**
Workshops & Training	1,355,218			1,355,218
Total WORKSHOP & TRAINING	**1,355,218**	**0**	**0**	**1,355,218**
Travel	578,252			578,252
Information & Public Relations	860,389			860,389
Office Costs	1,697,194			1,697,194
Communications	553,753			553,753
Financial Charges	90,000			90,000
Other General Expenses	0			0
Shared Support Services	472			472
Total GENERAL EXPENDITURES	**3,780,060**	**0**	**0**	**3,780,060**
Programme and Supplementary Services Recovery	2,465,527	0	0	2,465,527
Total INDIRECT COSTS	**2,465,527**	**0**	**0**	**2,465,527**
TOTAL BUDGET	**40,396,719**	**0**	**722,000**	**41,118,719**

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Emergency Plan of Action (EPoA)
Sierra Leone: Ebola virus disease

International Federation of Red Cross and Red Crescent Societies

Revised Emergency Appeal	**Operation n°:** MDRSL005 **Glide n°:** EP-2014-000039-SLE
Date of issue: 9 September, 2014	
Operations Manager (responsible for this EPoA): Stephen McAndrew	**Point of contact:** Constant Kargbo, Under-Secretary General, Programmes and Operations, Sierra Leone Red Cross Society
Operation start date: 7 April, 2014 **Emergency Appeal launch date:** 26 June 2014	**Expected timeframe:** 15 months **End date:** 15 June, 2015.
Overall operation budget: CHF 12,901,729	
Number of people affected: Country population at risk (6,348,350)	**Number of people to be assisted:** Nationwide, with specific actions in high risk communities (6,348,350)
Host National Society presence (n° of volunteers, staff, branches): 1,640 volunteers from Sierra Leone Red Cross Society , 52 National Society staff , 13 branches	
Red Cross Red Crescent Movement partners actively involved in the operation: None	
Other partner organizations actively involved in the operation: Ministry of Health, World Health Organization and Médecins sans Frontières, Save the Children, Action Contre la Faim	

Summary of major revisions made to emergency plan of action:

This EPoA update represents a significant scale-up of SLRCS activities in response to the Ebola outbreak supported by IFRC. The revision and related scale-up of activities has been triggered by a continuous increase in Ebola Virus Disease caseload, limited capacity of the current humanitarian response to the outbreak, and the related deterioration of the situation. Major changes are the following:

- Appeal timeframe extended from 9 to 15 months.
- Budget revised from CHF 1,366,156 to CHF 12,901,729
- Inclusion of a clinical case management component through establishment of Ebola treatment centre in Kenema.
- Inclusion of all 13 districts as response areas
- Increase in IFRC and SLRCS staffing
- Increase of physical resources such as vehicles, motorbikes and protective equipment.

A. Situation analysis

Description of the disaster

On 26 May, the Ministry of Health and Sanitation announced that the first case of EVD had been detected in Sierra Leone. Soon after, a further seven cases were identified. All of these early cases resided in the Kissi Teng Chiefdom which forms the easternmost part of Kailahun District.

The first announcement of cases in Sierra Leone were accompanied by reports that 6 of the initial 8 suspected and confirmed cases had refused to be placed in isolation and had gone into hiding. There were also reports that Ministry of Health and Sanitation officials had been subjected to aggression in the communities they visited. As a result, early attempts to control the outbreak were unsuccessful.

Since the initial detections, the epidemic has spread in a westerly direction to affect the whole of Kailahun and is rapidly deteriorating in Kenema as well. In Kenema, where the first treatment centre was set up, a senior medical doctor in the local hospital has been infected with the Ebola virus and passed away. Due to this, many of the remaining staff have

temporarily stopped going to their work, which has left many patients unattended. Critical shortages of clinical staff, nurses in particular, have left a 60 bed capacity isolation ward under-staffed, which affected the clinical case management, infection prevention and control activities. On 19 July, the Ministry of Health and the WHO requested the IFRC for clinical hospital staff support for Kenema.

Isolated cases have started to surface in other districts as well. Much of this spread has occurred as a result of movement of healthcare workers infected while caring for the first cases and from relatives having become infected as they attended the burial of someone who died of the disease.

Sierra Leone has crossed the 1000 case threshold with confirmed cases totalling 1,077 with confirmed deaths of 388 as of 1 September, 2014.This number reflects confirmed cases and the situation on the ground indicates much higher case loads.

Twelve out of thirteen districts have reported confirmed cases, with Koinadugu being the only district not affected to date. Cases are quickly spreading in several areas including Bo, Porto Loko and Western area which indicates a significant spread of the case load and will present significant challenges in the response. Rapid escalation of cases in Western Area in the last week is of particular concern and is an early indication that there may be a significant level of transmission occurring in the capital city.

As of 1 September, 2014, 248 patients survived the Ebola Virus Disease and have been subsequently discharged. The current total number of new confirmed cases are: Kenema 6, Bombali 3; Tonkolili 2; Port Loko 3; Pujehun 2; Western Area Rural 3 and Western Area Urban 1

The total number of cumulative confirmed deaths is 388 and cumulative number of confirmed cases is 1,106 with Kailahun 469, Kenema 356; Bombali 44; Port Loko 64, Bo 35; Western Area Urban 51; Western Area Rural 28.Koinadugu still remains the only district that has not registered confirmed cases of Ebola in Sierra Leone

On 24 and 25 August 2014, five new cases of Ebola infection amongst health workers were reported, in Kenema and in Kailahun.These are 2 national staff and 3 expatriate staff. On 27 August 2014, it was reported that another lab technician from Kenema Hospital had been infected.

On 11 June, the President of Sierra Leone declared that Kailahun was in a state of emergency and the House of Parliament on 21 August, 2014, unanimously ratified “The Public Health Amendment Act, 2014” which seeks to amend the Public health Act, taking into account the Ebola epidemics and its effects in the country. The quarantining of the districts of Kenema and Kailahun continues to be enforced and only essential services are permitted to commute with special passes but all persons must undergo the hand washing and temperature checks at the various checkpoints.

On 4 August, 2014 a national stay at home for family reflection, education and prayers on the Ebola outbreak was proclaimed, with an initial implementation period of 60 – 90 days. This announcement has had a number of effects:

- Schools are closed.
- Large gatherings are prohibited.
- Limits of the opening hours of places of entertainment limited.
- Burial is prohibited without approval of the District Health Medical Team.
- Vigorous social mobilisation and public sensitisation through the mass media, in religious mosque or church services.
- Quarantining and restriction of movement of people moving and non-essential services into or out of Kailahun and Kenema must be screened by volunteers taking their temperature, looking for symptoms of the disease, under supervision of the military.
- Setting up police and military check points in road between Freetown and Kailahun.
- Strict traffic regulation on motorbikes riders and commercial vehicles in main cities including Freetown.
- Provision of chlorine and disinfectant liquids at the entrances of main offices, public and commercial/business centres.
- Temperature checks by infra-red thermometers public places and offices.
- Assess travel restriction measures (suspension or cancellation of international flights) and border closures within affected countries.

Summary of the current response

Since the first alert that suspected cases could have crossed the border, SLRCS has been coordinating its activities with the Ministry of Health and Sanitation (MoHS). In preparedness for response, the IFRC provided the National Society with 200 kits of personal protective equipment (PPE) and body bags, half of which were handed over to the MoHS as they depleted their own stocks in the response.

On 1 April, the Ministry of Health and Sanitation formally requested Sierra Leone Red Cross Society to lead on awareness and social mobilization campaigns at the county level due to its large numbers of volunteers on the ground. A further meeting was held with the Ministry of Health and Sanitation in which assistance was requested for volunteers to support contact tracing and psychosocial support activities.

Since the initial confirmation of cases, the government has responded with the following activities:

- Provision of free treatment for EVD cases.
- Intensification of community sensitization activities.
- Distribution of Personal Protective Equipment to affected regions.
- Strengthening of surveillance.
- Development of a case management protocol.
- Allocation of 1.4 billion Leones (CHF 286,700) for case management.
- Training of healthcare workers to staff isolation rooms and treatment centres.

In response to the geographical spread and increasing case loads, several case management centres are planned but will take several weeks to be operational. The Set-up of the Bo MSF Treatment Centre is on target to be operational by in the near future, and the Kenema Red Cross Treatment Centre is also intended to be functional by mid September. A temporary holding centre is being established at Lakka for the Western Area, and a treatment centre is underway at Kerry Town.

The Government of Sierra Leone is supporting the construction of a treatment centre at Kerry Town and it is expected to be functional in the next couple of weeks. Up to 6 senior WHO epidemiologists have arrived in country to support contact tracing and surveillance. A temporary holding centre and a mobile laboratory from South Africa is being set up at the Lakka centre to cover Western Area, and a treatment centre is underway at Kerry Town.

Health Ministers and technical staff from 11 countries, representatives from IFRC, MSF, WHO and key international partner organizations met in an Emergency Ministerial meeting in Accra, Ghana between 2 and 3 July to address the ongoing EVD outbreak in West Africa. After updates and country and field experiences were shared, they agreed on a strategy for an accelerated operational response to control the outbreak with. Since then, WHO opened a regional control center in Conakry, Guinea, and urged governments to work with religious and community leaders to improve awareness and understanding of EVD.

Following the confirmation of cases in Guinea on March 28 2014, the IFRC allocated CHF 113,217 for its Disaster Relief Emergency Fund (DREF) for Ebola preparedness activities in Sierra Leone. Following the confirmation of cases within the border of Sierra Leone, the DREF allocation was converted into a start-up loan for the Emergency Appeal operation launched on 26 June 2014.

Until the outbreak, the IFRC did not have representation in the country and had been supporting SLRCS through its regional office for West Africa in Cote d'Ivoire. In the first DREF-funded phase of the response, a WatSan officer from the IFRC regional office was deployed to the field in support of preparedness activities. As the first case was confirmed and the National Society went into response mode, an IFRC Field Assessment and Coordination Team (FACT) was deployed and arrived in Freetown in early June, followed shortly thereafter by Health and Hygiene promotion ERU HR and an IT/Telecomm Emergency Response Unit.

Since then, the IFRC set up its field base of operations in the SLRCS Kailahun Branch office. Other Branch offices, Kenema, Port Loko, Western Area, Bo and Bombali shall be strengthened to enhance a well-coordinated and effective response. The main MoH treatment facility is in Kenema, where MSF has helped it increase its in-patient capacity. MSF also runs its own 64-bed treatment centre in Kailahun (and considering expanding it to 100 beds), and supports two pre-referral facilities in Daru and Koindu. The Ministry of Health and Sanitation and the World Health Organization have also

established an Ebola Emergency Operations Centre (EOC) - started functioning on 15 July with support from CDC Consultant) at the WHO Country Office in Freetown.

WFP will provide food for the discharged patients. UNFPA have provided the contact tracers with mobile phones in Kailahun. MSF case management centre refers vulnerable discharges and affected families to the Kailahun branch BHO for follow-up by SLRCS PSS volunteers. Save the Children serves as referral point on child protection issues.

Health and Hygiene promotion ERU HR were deployed to support the national society and the Ministry of Health and Sanitation with community based surveillance and health promotion activities. The ERU has concluded its deployment mission in the country but an IT and a Logistics specialists continue to provide the needed support services at the IFRC operational hub in Kailahun.

An IFRC Operations Manager has been mobilised and deployed through this emergency appeal to oversee the response operation and ensure that necessary support is provided to the national society for successful implementation of the operations. The supplementary technical assistance (delegates and/or RDRTs) to further build the response capacity of the national society field operations has been solicited.

IFRC in Sierra Leone will continue to maintain and further support the National Society in scaling up community outreach through streamlined social communication strategies and messages, psychological support contract tracing and safe burial of human remains.

- **Social mobilisation:** Strengthening the National Society's volunteer and coordination networks through capacity-building activities. Preparedness for response through volunteer training in communication around epidemics and behavioural change. Adaption and dissemination of information, education and communication material linked with community social mobilisation activities. Information, education and communication to the population and reduction of stigma.
- **Surveillance and contact tracing:** Contribution to epidemiological investigation and epidemic control measures through case finding and contact tracing.
- **PSS**: Psychosocial support provided to survivors, families, communities and volunteers to assist them to cope with crisis, grief and loss.
- **Dead Body Management:** Management of dead bodies and supervision of burials in the community and from case management centres. Pre-positioning of personal protective equipment and related training on their proper use and disposal.
- **Coordination:** Interagency coordination through the National Task Force and at the field level in Kailahun and Kenema.
- **Case Management:** Further to the government of Sierra Leone and WHO's requests to the IFRC for clinical hospital staff support, an ERU alert was issued on 19 July and the deployment order on 29 July. Spanish RC is deploying equipment and staff while British RC and Norwegian RC are deploying additional human resource.

Interagency Coordination
The Sierra Leone Red Cross Society is a member the Emergency Operations Centre (EOC) with the Ministry of Health, World Health Organization and NGO partners including Médecins Sans Frontières, Save the Children and Action Contra la Famme. It is also a member of the taskforces established at district level and daily coordination meetings which take place in Kailahun under joint MoHS/WHO leadership. Under the national taskforce are five pillars: laboratories and surveillance; case management, social mobilization, Psychological Support Services logistics and coordination. The same technical coordination structure will be implemented in the other operational branches.

Updates on the epidemiological situation are provided at the taskforce meetings and are also published on the Ministry of Health and Sanitation's Facebook page and the WHO Global Alert and Response website.

In Kenema, WHO Global Outbreak Alert and Response-deployed clinical physician staff are currently working with national physician and nursing colleagues in Kenema but require additional nursing and medical support until the national capacity is restored. There has been interest from the Minister of Health and the WHO country representative to support the offer of clinical assistance to the Kenema hospital by a Red Cross Red Crescent medical ERU.

Risk Assessment
Initial hopes that the outbreak could be contained within Kailahun have subsided as cases started appearing in the districts of Port Loko, Kono, Bo, Freetown, and have increased in Kenema. In addition, new chains of cases may emerge with unknown contacts or from sources outside Sierra Leone. Already, the capacity of the Ministry of Health and

Sanitation to identify and isolate cases has proved insufficient. MSF has also warned that it is facing difficulties in scaling up to needs, as it is already taking care of most of the current caseload. Until now, most of the response, including education, social awareness and dead body management has been at relatively low-risk. However, entering treatment response alone poses high safety and health risks to both volunteers and staff, especially surrounding hygiene health safety precautions. Strict procedures and an increase in supervision will be needed as clinical care is provided to at least 60 isolation ward patients, including an average of 15 critical patients.

Contact tracing and surveillance is extremely difficult in the current context due to the sheer number of potential cases, the geographical spread and difficulties in getting communities to fully cooperate. The difficulties in accessing communities to track potential contacts, along with the insufficient infrastructure to deal with the rapidly increasing caseload, make it difficult to ascertain precisely the evolution of the outbreak. The number of reported cases and deaths, contacts under medical observation and the number of laboratory results are in constant flux.

Brief moments of tension and social unrest have occurred at the Kenema health centre, mostly surrounding patient deaths and fear. It is possible that the outbreak, or the measures implemented to control the outbreak, could further lead to tensions and social unrest. While not on a scale such as what has been happening in neighbouring Guinea, isolated attacks have taken place against MoHS ambulances in the course of their Ebola-related activities, perpetrated by angry community members.

Organisational risk
EVD is a highly infectious disease. There is the risk that Red Cross staff and volunteers operating in affected communities will come into contact with cases and could contract the disease, particularly in the course of DBM activities. The IFRC's global volunteer insurance only provides coverage in case of accidents, but not from diseases like Ebola. SLRCS and IFRC are currently looking at additional coverage options in country to provide complementary insurance to its staff and volunteers.

Needs analysis
Upon its deployment, the FACT team carried out an initial needs assessment that included:

- Attendance at the National Ebola Taskforce meeting in Freetown.
- Attendance at the Kailahun District Taskforce meeting.
- Meeting the Kailahun District Medical Officer and his team.
- Discussions with Kailahun programme administrator officer and branch volunteers.
- Meeting partner organizations including WHO, Médecins Sans Frontières and Save the Children.
- Conducting focus groups in communities in the Kailahun.
- Conducting a Rapid Mobile-Phone based (RAMP) survey to determine the current knowledge, attitudes and practices relevant for the EVD outbreak.

Based on this assessment and on the evolution of the situation since, the following needs have been identified:

1. **Social mobilization**

Knowledge of Ebola virus disease and mode of transmission is limited within the population and there are rumours and misconceptions regarding the mode of transmission, as well as denial that it even exists. Due to the highly infectious nature of the disease many people are fearful and stigma remains high. Despite the major efforts deployed so far in awareness raising and education, there is still a significant need to scale these up as the main obstacle to effective patient identification, contact tracing and reintegration remains general ignorance.

The needs assessment (including preliminary results of the Rapid Mobile-Phone based survey) identified a number of information gaps that could be contributing to disease transmission. For example, people believe that Ebola is almost universally fatal and, as a result, do not see the reason for seeking healthcare when they have symptoms. There is also a lack of awareness that dead bodies are a significant source of transmission. Several people expressed that they would not believe EVD existed until they had seen it themselves.

There are also specific behavioural issues that could contribute to the spread of the disease and that could be specifically addressed. For example, dead bodies are often transported on motorcycles, held between the driver and a relative. There are also important cultural reasons why families wish to see the body of a relative prior to their burial. The traditional funeral rituals in many communities involve substantial contact with the deceased person.

To date, the social mobilization strategy has only started to address the potential stigma that individuals and families affected by EVD may experience.

Overall, there is a need to review the key messages to ensure they are relevant to the current situation and meet the information needs of the community. It will be important to specifically address perceptions about EVD that lead to stigmatisation of families affected by the disease.

There is also a need to identify new approaches to disseminate information to communities and to target those at highest risk as well as communities where the most vulnerable are to be found. For example, women are disproportionately represented in this outbreak, most likely because they tend to care for sick family members. Discharged patients, both Ebola survivors and those tested Ebola negative also face substantial risk of stigmatization and rejection and therefore targeting their families and communities is vital both before and after discharge.

Based on the results from the knowledge, attitudes and practices around EVD survey done through Rapid Mobile-Phone system, most people get their information through: friends and neighbours, radio, health centre or health workers and Red Cross volunteers or staff, which are their most trusted source of information. Radio programmes as a way of disseminating messages should specially be used since 90 percent of the people have access to them. Radio Moa and Sierra Leone Red Cross Society are the two main radio stations that people listen to in the eastern districts.

Given that the worst affected chiefdoms have strong cultural ties to people in the neighbouring districts in Guinea and Liberia, there is a need to ensure communication with this group is coordinated across all three countries and that and messages targeting this group are consistent.

2. Surveillance and contact tracing

Each district has a government surveillance team. In Kailahun, for example, there is a currently two to three team of 3 people in each. The actual need is estimated to be eight teams of 4 people. Given the rapidly increasing number of cases, these teams do not have the capacity to follow-up all alerts in a timely manner, monitor contacts and collecting accurate epidemiological data.

The current surveillance system relies mainly on sick people identifying themselves or others to the healthcare system. However, in some communities, ill people have been reluctant to seek help from healthcare workers. Hence, it is likely that cases are not being notified and managed. Early identification and isolation of cases as well as follow-up of case contact is critical to control of the outbreak, so this area continues to be a critical need.

3. Case management

The Ministry of Health and Sanitation is training healthcare workers to staff 25 isolation rooms around the country. The aim is that all suspected cases will be placed in these isolation rooms until confirmatory testing is completed. Those who test positive will be transferred to a treatment centre currently in Kalihun and Kenema. These centres are for suspected cases until lab results have been received, then negative cases are discharged and positive cases are transferred to isolation wards. The Ministry of Health and Sanitation plans to open a centre in Lakka and Kerry in Freetown, using equipment provided by Médecins Sans Frontières WHO and support from donors.

At the request of the Sierra Leone government, IFRC has mobilised a field hospital that is currently being constructed as an Ebola isolation unit 17 kms outside of Kenema town. The unit will start with a 60 bed capacity and will require approximately 200 local staff and 35 expatriate staff to function safely. The construction of the unit has met several significant challenges, especially in the supply chain with cancelation of flights and global shortages of PPE being the major constraints.

4. Dead body management and disinfection of houses

One of the main risks of transmissions comes from dead bodies. Currently, a team from the Lassa Fever Hospital in Kenema is tasked with managing bodies and the Ministry of Health and Sanitation is training an additional team to be stationed in Kailahun. The increasing number of casualties has already exceeded the MoHS capacity to manage them in a timely and dignified manner. Some families in remote communities have had to wait for up to three days for the body of their deceased relatives to be taken away and properly buried, at the time when these bodies present the most risk for contagion. As casualties increase especially in the hotspot area of Kenema, more volunteers will be needed to scale up DBM efforts.

Another high risk of contamination comes from traditional burial practices, where relatives touch and wash the body of the deceased family member then share a meal together. Proper supervision of the burial practices, accompanied with active

education and awareness activities and engagement from religious leaders, is a high priority to reduce the risk of transmission during burials.

It also appears that the homes of many confirmed cases are not being disinfected. Where this takes place, there is a need to provide support to those whose possessions have to be destroyed. Additional efforts must also be made to ensure that houses are properly disinfected to eliminate risk of further contamination of family members.

All Dead body management (disinfection) teams will undergo a quality assurance check by an external partner or supervisor from another area every six weeks or so to ensure best practice.

5. Psychosocial support

Fear of Ebola and stigmatization of those affected and others have both short- and long-term effects. In the short-term fear and stigmatization discourages a help seeking behaviour, i.e. the belief that Ebola is incurable and that sick people are dangerous, makes people helpless and fearful when faced with disease, this also stigmatizes health workers as they are seen to be potentially dangerous and contagious. In the long term the stigma on affected individuals and families is likely to linger and health care workers and volunteers working with Ebola have experienced significant, long-lasting stigmatization in their home communities.

Volunteers, many of whom will be living in affected communities, are likely to be under great stress during the epidemic therefore, close supervision, psychosocial support and organizational recognition for volunteers is a vital component of the response.

Training for SLRC volunteers in community mobilisation and PSS is essential to get the right Ebola messages and right preventive and case management methods through. The training is meant to update and refresh the knowledge on Ebola. Information about contact tracing and dead body management is essential as well to alleviate the fear and stigma.

6. Regional preparedness, coordination and response

To build on lessons learned from previous Ebola responses and to facilitate regional peer-to-peer learning, steps are being taken to deploy an experienced PSS resource

An interagency cross border meeting took place in Kailahun on 3 July, and was attended by SLRCS, Guinean Red Cross and IFRC delegates from the two countries. Best practices and lessons learned in Guinea on DBM were discussed during the day and helped lay the foundation for the program to be replicated in Sierra Leone.

In mid-August 2014, a cross-border meeting attended by representative from national societies of the three affected countries and the IFRC met in Gueckedou to review the current operations and ensure best practices in terms of technical implementation, improve collaboration and coordination between countries affected and supported by IFRC, standardisation and harmonisation of dead body management and disinfection protocols/procedures.

As many internationally deployed staff (IFRC, ERU and RDRT) have entered the operation without any training or full briefings, a central training designed for new staff entering outbreak should be established to ensure people are fully briefed before entering.

Considering complication and risks involved in dead body management (disinfection) teams will undergo a quality assurance check by an external partner or supervisor every six weeks. At least, to ensure best practice and zero or very low fatality rate amongst staff and volunteers involved in DBM.

An IFRC set of guidelines in management of an EVD epidemic that crosses borders is currently being developed and the deployment of an IFRC Ebola Response Coordinator.

B. Operational strategy and plan

Overall objective

Contribute to the reduction of mortality and morbidity related to the Ebola virus disease in Sierra Leone through awareness messaging and social mobilization, provide psychosocial support to those affected and safe burial of human remains.

Proposed Strategy

The revised plan of action will build on the activities already being conducted and the lessons learnt related to the evolution of the outbreak. The ongoing escalation in cases and the engagement of other partners in some areas of the response requires a change of strategy that allows more integration of the key pillars and a focus on areas where the National Society can contribute most effectively to breaking the chain of transmission in effort to control the outbreak. Case management will be an additional component in this appeal due to the severe shortage of appropriate facilities for care of confirmed cases. .

Since the President's declaration of the state of emergency and the implementation of a number of interventions including a 'day of stay at home reflection', quarantine, the banning of gatherings among others. There has been an amazing community compliance indicating the knowledge and awareness of at least the macro issues is well understood.

In contrast to this, we still have isolated communities that are experiencing large clusters of cases, are reporting cases late and possibly even still undertaking community burials.

This requires a change in strategy to ensure targeted interventions designed to impact the spread of the epidemic rather than general awareness raising.

The evolution of the epidemic requires a flexible strategy that is now focused on a disciplined approach to breaking the chain of transmission down to the very last case. To ensure that this is possible, every interaction with the community needs to be utilised and should enhance community cooperation and trust to ensure we can limit transmission, bury safely, and admit to isolation early. A focus on safe burial, target health education and coordinated contact tracing is required to curb the epidemic.

The SLRCS is strategically placed to help intervene at the household level through its extensive network of community-based volunteers. Because they are community based and because of the trust in the Red Cross, access and engagement with communities is available to the SLRCS that may be denied to others.

Despite efforts to contain it, the outbreak has kept spreading to areas outside of Kailahun, and Kenema has become a hotspot with a surge in cases. The resources deployed so far in the response –by the country's authorities, the RC/RC Movement, MSF and other partners- are proving insufficient.

Most recently, in regards to the ERU request for treatment response at the Kenema Hospital, the need to scale up is mostly manifested in clinical staff and logistics, in addition to needs initially proposed through the Emergency Appeal launched in June, including expansion of volunteer mobilization in education, awareness raising and social mobilization, contact tracing and surveillance, PSS support and dead body management, supervision of burials and disinfection of houses.

The revised plan of action will build on the activities already being conducted in these districts to enhance the response to EVD and focus on the needs of Kenema Hospital. In addition to clinical staff, the ERU requested needs logistical, finance and administrative support.

The SLRCS will recruit a National Ebola Coordinator based at HQ in Freetown and at branch level District Operation Managers, DBM Coordinators and Community Engagement Officers, will be recruited. Their responsibilities will be devoted exclusively to the Ebola response operation. At HQ at Mobile Team will be established, consisting of 1 doctor/nurse, DBM and Contact Tracing specialists and 1 driver.

Social Mobilisation, Contact Tracing and PSS will be carried out nationally, in all the 13 districts. 650 volunteers in all districts will be trained in EVD signs and symptoms, prevention measures and referral mechanisms including personal protection. Special training will be conducted for 325 volunteers in Surveillance and Contact Tracing in all the 13 districts.

The following SLRCS branch offices will be fully operational (well-functional offices: internet facility, generators, IT equipment, vehicles, stationary) in Kailahun, Kenema, Port Loko, Western Area, Bo and Bombali Districts. Six out of the thirteen districts in Sierra Leone will be fully operational in promoting community awareness, preventative hygiene measures and safe burials.

The Dead Body Management teams will consist of 30 volunteers per district in the fully operational offices/areas. The DBM teams will be allocated accommodation in each of the operational areas to enable them to recuperate; shower and rest as a considerable number of volunteers are exposed to rejection by their own families. A cook will be provided to help with their living arrangements.

To aim for a zero fatality rate for the volunteers and staff involved in DBM activities, their training in the use of PPE will be refreshed regularly (every six weeks) and will be subject to a quality assurance check by external specialists (MSF or WHO). All deaths in the hot-spots are considered Ebola related unless proven otherwise by laboratory tests, therefore the DBM teams conduct all burials if and when contacted by the District Health Management Team. Procurement of 5000 personnel protective kits and 5000 body bags.

The plan is to have, in each of those districts going into response, at least 120 volunteers engaged in hygiene promotion and community mobilization, contact tracing and surveillance, psychosocial support activities and dead body management. This will bring the number of volunteers involved in the operation to a total of 1640 countrywide.

The National Society will procure 20 infra-red thermometers for use in all its offices throughout the country, with special volunteers/staff to be trained on the usage of this equipment.

Education, awareness and social mobilization are the most effective means to tackle the disease as it increases reporting of sick people to seek early medical attention and facilitates access for medical personnel and contact tracers to communities. Proper contact tracing and surveillance allows for an informed response and detection of potential cases, while the timely management of dead bodies, proper and supervised burial practices and disinfection are the most effective way to prevent further propagation.

The evolution of the outbreak now requires a change of strategy for Serra Leone. Numerous other NGO's, key stakeholders, religious groups and politicians are now heavily engaged in social mobilization and spreading the word on Ebola utilizing the standard key messages.

As contact training and surveillance systems improve, the SLRC should be utilizing this information to identify affected villages for target intervention to reduce transmission. Utilizing surveillance data that records where cases and contacts are, will allow specific villages at risk of high rates of transmission to be targeted for prevention education, contact tracing and alert notification. By ensuring those that are most at risk understand how to prevent further transmission, when and why they should come to the hospital we can reduce the amount of transmission within these communities. This includes even targeting down to the household level that is experiencing heavy transmission and clusters of cases. Social mobilization and health education should be implemented using a PSS approach targeting the effected community to limit next generation transmission and ensure community compliance.

In reality this means, volunteers need to be crossed training in PSS and social mobilization and should be working as one team. The work plan for the day should be guided by the surveillance and contact tracing data that would indicate specific clusters of cases.

This will require more technical engagement and oversight as well as have implications on logistics as teams will need to move to the cases rather than just work in their specific areas.

Rapid response and Scale up capabilities. Given the limited global resources available for further scale up its imperative that we move to areas of new transmission quickly. Scale up key activities, including contact tracing, dead body management and community engagement. A rapid response to new districts will limit transmission and allow for localised cases to be contained. All SLRC districts have been trained and are implementing key prevention activities. If a confirmed case is registered in a district, and gaps in response capacity are identified, the rapid response team from Freetown will be deployed. The objective of this team is to quickly implement key activities in a safe and controlled way and undertake training, capacity building and supervision of new teams that are established in response to the new cases. This will also assist in sharing learning and best practice across districts.

Prevention and disease surveillance. All districts without cases will be continuing social mobilisation and active disease surveillance to ensure any cases are rapidly identified and communities understand the need to come forward as soon as possible. This activity is key and should be prioritised despite current constraints as it will stop further geographical spread of cases.

This revision of the strategy will require more technical engagement and oversight as well as it has implications on logistics. Teams will need to move to the cases rather than work in their specific areas. Engagement with available technical advisors on the ground both internally, and through agencies such as CDC and WHO will provide the technical analysis needed to target transmission hot spots ensuring we are having maximum impact on transmission changes and the evolution of the epidemic.

Prevention and Disease Surveillance team. Will provide support to non-infected or cleared districts to ensure disease surveillance. The Rapid Response Team (Mobile Team) at SLRCS national headquarters consisting of a doctor/nurse, DBM specialist, Contact Tracing specialist, allocated with a vehicle and a driver, to respond to spikes/alerts within 48 hours.

Definitions of Activities:

- **Community Engagement:** Social mobilization will include discussions and interactions with communities to educate them about Ebola and to ensure that they are implementing the key messages to prevent and contain Ebola. It also involves passive contact tracing, meaning, if cases are found at the community level they will be referred or notified. This is done using a PSS approach. Social mobilization should include a full communication plan and rumor management strategy.
- **Alert and contact team**: Active cases follow up with a PSS approach will involve volunteers who will be assigned specific contacts to follow up for 21 days. Social mobilization occurs as part of the follow up to educate families on prevention and control. A PSS approach ensures improved engagement and compliance.
- **Active PSS:** This includes targeted PSS activities including grief management and community re-entry.
- **Dead Body Management:** Involves collection of bodies from the communities of clinical facilities for burial with a PSS approach, ensuring cultural practices when possible and care for families when needed.
- **The epidemic 'frontline'** – a focus of all key activities in districts that have large amounts of active transmission. This includes Kenema, Kalihun, and Western district. This will include contributing to case management in Kenema.

Progress of implementation to date:

The Sierra Leone Red Cross Society has been implementing its response along the following five pillars:

1. Education, awareness raising and social mobilization

A widespread program of targeted community sensitization was undertaken during the preparation phase funded under the DREF using a set of 13 key messages approved by the Ministry of Health and Sanitation. The National Society played a major role in the sensitization program, training 15 volunteers in six districts (Freetown and the five districts that border Guinea) on EVD, including the signs and symptoms, mode of transmission and what people should do if they become sick. In Kailahun, the Programme Administrator arranged for an additional 35 volunteers to be trained to make a total of 50. Following their training, the volunteers have conducted sensitization activities in all targeted districts.

SLRCS volunteers in Kailahun and Kenema have been trained in awareness and sensitization. They have been carrying out sensitization and awareness session for women's groups, bikers union, religious congregations and disabled people (blind, amputees, polio patients and war wounded).

A Red Cross Drama Group has on several occasions performed a play where through acting; they address issues around Ebola such as stigma, myths and awareness. The Drama group is in high demand and is being used in numerous trainings in Kailahun District, as it generates a lot of questions and discussions from the audience after each performance.

Religious Leaders from the interreligious Council agree on common messaging aiming to reconcile religious rites (particularly during burials) with the measures required to protect mourners from contamination. Divine intervention in all places of workshop

A total of 401 leaders from various community networks participated in three days of awareness raising communication organized by the Red Cross, MSF and the MoHS. These included Paramount Chiefs, Section Chiefs, Speaker Mammy Queens Youth Leaders, Chiefdom Soweis, Religious leaders, Ward Councilors, Children representatives, Bike Riders, Traders and Drivers' Union. At the end of the day, these leaders and opinion-makers drafted plans of action to disseminate Ebola related messaging to their respective networks.

IEC material has been prepared and distributed to the branches in Kailahun and Kenema and the volunteers and ERU delegates have participated in local radio shows where the listeners could call in to ask questions.

Approximately 370 people have been reached through house-to-house awareness visits in Kailahun while almost 690 households have received visits from the SLRCS in Kenema.

Over 106 from Women's groups in Kailahun participated in an awareness-raising workshop. This specific group was targeted because women, as traditional caregivers, are more exposed to the virus and constitute 60 percent of the affected population. Over 20,000 people have been reached directly so far by the SLRCS, over 193 communities in six districts.

The SLRCS is using the TERA (Trilogy Emergency Relief Application) SMS system to reach hundreds of thousands of people with simple, practical advice on preventing and responding to Ebola, as well as information to counteract the myths and stigma surrounding the disease. The TERA system gives SLRCS the capacity to target SMS to specific geographical locations, meaning the information received by people can be tailored to their actual situation and needs, and therefore more relevant and likely to have an impact. Since the outbreak of the Ebola epidemic SLRCS has sent more than 289,000 SMS to people in affected areas, increasing the reach and impact of health activities beyond those who can be reached face to face. SMS is also a safe means of reaching people remotely, when face-to-face contact is a risk for volunteers. While the SMS themselves are free to send, there are technical support fees and some running costs, which are included in the appeal budget.

In early July, cases started to appear in Bo, the second largest city in Sierra Leone. In response, two of the ERU hygiene promoters redeployed there to do an awareness and sensitization training to 30 volunteers.

2. Surveillance, case identification and contact management

A total of 120 volunteers have been trained in contact tracing in Kailahun and Kenema. In August 2014, the PSS delegate conducted a national PSS training-of-trainers workshop for 31 Staff and volunteers in Freetown. These volunteers are part of the larger +200 group of volunteers managed and supervised by the MoHS.

The IFRC epidemiologist has assisted MoHS, WHO and MSF in data collection and management activities and to identify potential gaps in contact tracing and supported the SLRCS to develop a strategy for monitoring daily activities of the Red Cross volunteers engaged in tracing.

SLRCS will continue to have volunteers attend the trainings and join the surveillance networks as they are expanded to other districts. The next five districts to be prioritized are Kenema, Port Loko, Western Area, Bo and Bombali

3. Dead Body Management

A memorandum of understanding on dead body management between the national society and the Ministry of Health and Sanitation has been signed.This memorandum of understanding (MOU) defines coordination modalities and the respective roles and responsibilities of each partner.

As the caseload increased and the MoHS resources proved insufficient to respond, the SLRCS received an official request from the government on 6 July to engage in the management of dead bodies, burials and disinfection of houses. This being a new technical area of intervention for the National Society, the IFRC facilitated contact with MSF and WHO to organise training on safe practice and procedures. A total of 14 volunteers were trained in Dead Body Management (DBM) on 11 July. The training was conducted for 3 days, after which the team was ready to support the response in transport of the corpse, disinfection and burials. These trained SLRCS volunteers will be joined by a more experienced team of 6 people who have been doing DBM with the MoHS since May and who will be inducted in the National Society.

In some cases, potentially contaminated items belonging to infected patients will need to be destroyed. In these instances, the DBM teams will refer the families to the PSS volunteers accompanying the deceased person's relatives for them to provide a support package (hygiene kit, mattress)

The model will be replicated to other districts based on the evolution of the disease.

4. Case Management Treatment Support

Clinical staff, consisting of 45 nurses, 15 doctors and logistical support staff will be deployed to treat 60 isolation ward patients and critical patients at the Kenema Hospital, and will work alongside national and WHO staff to provide and demonstrate best practice in use of infection prevention and control measures, use of PPE and clinical care.

Construction of a large-scale Ebola treatment centre almost 17km from Kenema Hospital is ongoing will be finalised and operational soon. The hospital will have a capacity of 60 beds, which will require a staff of around 200 people working 24 hours a day. Recruitment process of around 110 local staff for those that will work within the hospital has already begun. Training sessions on the Ebola virus with these new recruits has commenced.

Teams of volunteers from the Sierra Leone Red Cross Society have been working hard to sensitise the population that lives close to the new treatment centre, with visual materials, namely pictures of the MSF centre in Kailahun to show to the local population. Our medical team is assisting those working in Kenema hospital to increase the capacities of local staff working at the hospital but with the recent reports of new infections forcing some national staff to refuse to get too close to Ebola patients in the hospital.

5. Psychosocial Support

A Red Cross community-based psychosocial support (PSS) intervention is being organized in Kailahun district for vulnerable groups including vulnerable hospitalized and discharged patients (Ebola survivors and Ebola negative) and families affected by Ebola (separated, bereaved). In addition, the psychosocial support team may support with community dialogue and reintegration, preparing the ground for activities of other RC teams and partners (surveillance, case management and burial) and provide targeted sensitization in hot spots. The PSS intervention is planned, coordinated and conducted in collaboration with Médecins Sans Frontières, Save the Children, Community Association for Psychosocial Support (CAPS) and the Children's Advocacy and Rehabilitation (CAR) centre of the SLRCS. The community based psychosocial intervention will be conducted by 70 volunteers (5 for each of 14 chiefdoms in Kailahun district).

The volunteers are receiving initial one-day training on sensitization and psychosocial support and will receive monthly follow-up trainings, including case management and peer support sessions. Ongoing support will be provided through weekly supervision calls by trained counsellors from the CAR centre. The team will also include trained psychosocial counsellors from CAPS. The counsellors may support the volunteers with the work in the communities, if necessary. The volunteers will also feedback any information on affected cases and developments in the community to the Branch Health Officer (BHO) at Kailahun branch. The BHO will also serve as the focal point for referrals of vulnerable beneficiaries from partners (Médecins Sans Frontières, Save the Children and others).

PSS volunteers will also be the focal points for families having had personal property items destroyed as part of the disinfection process, to replace those items with a standardized support package.

The information needs of the community will be regularly reviewed using a further survey, feedback from volunteers and community members and other media such as talkback radio. Messages will be updated to ensure these needs continue to be met. SLRCS will continue to seek new opportunities to access and influence communities and groups that have been hard to reach or are at high risk.

Beneficiary selection

In addition to having a national range, and based on the assessments carried out and indications provided by the Ministry of Health and Sanitation, the plan of action emphasises high risks groups and opinion leaders such as:

- Contacts in communities/villages
- Bike riders union and drivers
- Disabled people (blind, amputees, polio patients and war wounded).
- Families of Ebola victims
- Ebola discharged/survivors

Special attention will be given to women and women's groups since this is an especially vulnerable group. To date, MoHS reports indicate that 59 percent of the people affected by the EVD are women. The health workers affected have been mainly women and women are the ones that take care of their sick family members and relatives. They are also the ones that care for the body of the person that has died, which is highly infectious if not dealt properly with.

Operational support services

Human resources

Sierra Leone Red Cross Society plans to mobilize up to 1,640 volunteers in all districts to carry out the activities outlined in this operation. The National Society's finance, health, disaster management and logistics managers will be providing support to operation. Additional staff will also be mobilized as necessary at the district level to supervise and monitor the implementation of the operation.

The SLRCS will recruit a National Ebola Coordinator based at HQ in Freetown and at branch level District Operation Managers, DBM Coordinators and Community Engagement Officers, will be recruited. Their responsibilities will be devoted exclusively to the Ebola response operation. At HQ at Rapid Response Mobile Team will be established.

A 6-person strong community health Emergency Response Unit was deployed to support SLRCS with community based surveillance and health promotion activities. The team deployed with Hygiene Promotion kit and a team leader to give better reinforcement of the team in Kailahun. All FACT ERU have ended their missions in Sierra Leone and are now being replaced by RDRTs and long term delegates.

ERU and BHC personnel will be deployed to support treatment response at the Kenema Hospital, including up to 45 nurses (and/or paramedics), 15 doctors and logistical support staff.

To ensure longer-term oversight and management of the operation, Head of Emergency Operations and doubles as team leader for Sierra Leone, assisted by IFRC operations manager, health delegates, Finance and Admin consultant, information management intern, have been mobilized through this emergency appeal, supported by RUC logistics delegates in Kailahun and Freetown.

Human resources for Ebola response-wide coordination, support services, institutional learning, cross-border collaboration and programme guidance will be managed by the IFRC Ebola coordination function in Guinea under the IFRC Ebola coordination and preparedness appeal (MDR60002). Since the Ebola coordination function is a temporary set-up, an operations coordinator in the IFRC regional office is supported under this emergency appeal to ensure transition from the temporary set-up into regular IFRC structure and coherence with other disaster management programming in the affected countries.

In Sierra Leone, an organic chart has been developed to address the needs of both the Case Management Clinic in Kenema and the expanded activities in 6 districts. The human resources needed are currently being recruited and the global tools emergency personnel will be phased out.

Logistics and supply chain

A robust logistics system will need to be in place to manage this operation effectively, this will include personnel, vehicle assets and a constant supply of PPE kits along with consumables for disinfections activities. It is planned to have a Logistics Coordinator based in Freetown in addition to a roving Fleet Delegate and a Logistics Delegate to support the field teams and national logistics officers in Kenema and Kailahun.

A logistics Coordinator will support the operation and the National Society by providing technical support and advice, by implementing IFRC logistics procedures and contribute to the enhancement of the logistics structure, systems and capacities including warehouse management, fleet management and local procurement.

In total Dubai Global Fleet Unit will provide 9 vehicles on VRP whilst 2 vehicles have already been purchased for the Sierra Leone Red Cross. The fleet delegate will be responsible for managing this fleet and its drivers. The operation will also purchase 6 Ambulances for the National Society.

The main activities within the treatment centre, dead body management and case tracing will require a constant supply of Personal Protection Equipment that will be sourced via the Global Logistics Service in Geneva. All equipment provided meets EU standards for the required use, specifically the overall complies with high level of protection against biological hazard and resistance to penetration by infective agents due to mechanical contact with contaminated liquids (conform to standard EN 14126, EN 14605, EN 13034, ISO 13982).

Items required for disinfection activities (sprayers and chlorine) and the construction of the treatment and isolation units will be procured locally if available, otherwise brought in internationally. Any local procurement will be implemented

following IFRC procedures and in compliance with standard policies.ZLU will also provide technical validation of procurement process according to the established rules and regulations.

Personal Protection Equipment and body bags will be procured through Geneva, while other material such as sprayers and chlorine for disinfection of houses will be procured locally following IFRC procedures and in compliance with standard policies. ZLU will also provide technical validation of procurement process according to the established rules and regulations.

Information Technologies

Access to Internet goes from limited to inexistent in the affected regions. A local internet company has been identified to provide internet in all the six identified districts. In Kailahun the IFRC has move office at the Child Advocacy and Rehabilitation Centre where both the IFRC and SLRCS Kailahun Branch have access to the internet. The running costs of the internet service provision currently in place in Kailahun and planned to be installed in the other five districts/branches shall covered through the Emergency Appeal for the remaining period of the operation.

Communications

The Sierra Leone Red Cross Society, with support from IFRC regional and zone communications, has been coordinating various awareness and publicity activities, to sensitize the public, media and donors on the situation on the ground and the humanitarian response.

A number of radio and TV interviews have been given by the team in Kailahun to National and international outlets (BBC, Radio-Canada, South African Radio, CNN). On 5 July, the IFRC's Communications Manager for Africa Zone was deployed to Sierra Leone to increase the operation's profile.

Planned Activities:

- Hire photographer/videographer consultant to produce high quality photographs with extended captions, and video b-roll and interviews of operations.
- Hold press conferences, either in Sierra Leone, Dakar or Geneva as warranted.
- Produce weekly facts and figures, and weekly updated key messages and reactive lines, and share with relevant stakeholders, including beneficiaries and partners.
- Weekly operational snapshots and regular operation updates.
- In collaboration with programmes, work on advocacy messages to address issues linked to the outbreak, in Sierra Leone and the region (protection, prevention, fear, and stigma).
- News releases, fact sheets, videos, photographs and qualified spokespeople contacts are immediately developed and made available to media and key stakeholders.
- Proactively engage with international media regarding the added value of Red Cross interventions.
- Facilitate media field trips to raise awareness among stakeholders and to raise the profile of the Sierra Leone Red Cross Society and IFRC.
- Maintain a social media presence throughout the operation utilizing IFRC sites such as Facebook and Twitter.
- Support the launch of this appeal and other major milestones throughout the operation using people-centred, community level diverse content, including web stories, blogs, video footage and photos with extended captions. Share any communications material created through this appeal with IFRC for use on various communications channels including the newly launched IFRC Africa web page, *www.ifrc.org/afrique and www.ifrc.org/africa.*
- Provide the NS communication team with communication training and appropriate equipment as needed (photo and video camera).

Security

IFRC Africa Security Delegate and Security Unit in Geneva continue to work closely with our in country Operation Managers and support team in Geneva to monitor and support on security related matters.

The Volunteer Security Booklet – "Volunteer Stay Safe" in English is being sent to the operations to ensure that all volunteers involved in the operation have access to the document to raise their security awareness.

A security review will be done of the Sierra Leone operations, to identify the multiple challenges of the current situation. Although Security Guidelines are in place, there will need to be an in depth analysis of the different contingencies and challenges that could arise from various threats. The security challenges to the environment will require continual adjustment as the current Ebola outbreak is changing rapidly, causing disruptions in things such as international travel, border closings and ad-hoc quarantine orders.

Planning, monitoring, evaluation and reporting (PMER)

Sierra Leone Red Cross Society, in close cooperation with the IFRC regional office will monitor the progress of the operation and provide necessary technical expertise and updates. The monitoring and reporting of the operation will be undertaken by the Sierra Leone Red Cross Society and delegates deployed over the duration of the operation. A communication delegate shall be recruited who will temporarily take up reporting before such position in established.

Administration and Finance

The first DREF allocation of CHF 113,217 released in early April for preparedness activities has already been spent and accounted for, and the SLRCS and delegates are currently using the second DREF advance to carry out the above-mentioned activities.

The operation's budget holder is now the Head of Emergency Operation HEOPs for Sierra Leone who is on a three-month mission

Financial resource management will be according to the Sierra Leone Red Cross Society regulations and IFRC guidelines. In addition, the National Society's own procedures will be applied to the justification of expenses process and will be completed on IFRC formats. A finance and admin consultant has been recruited and will provide dedicated finance management and administrative support to the operation.

Key Challenges

- Global supply chain of PPE and body bags is a significant constraint at the moment, both in terms of supply and in transport to the country.
- Vehicles – the quality and quantity of vehicles is also extremely limited and is impacting the ability of teams to scale up and move safely.
- High level technical support required in epidemiology is limited.
- Poor healthcare delivery services in the country as considerable number of hospitals in Freetown. In addition, particular, people are scared to go to hospitals and there are few hospital staff, nurses apparently on strike, empty hospital bed.

C. DETAILED OPERATIONAL PLAN

Health and Care

Outcome 1: The immediate risks to the health of affected populations are reduced															
Output 1: The capacity of Sierra Leone Red Cross to manage Ebola virus disease outbreak response has been strengthened															
Activities planned Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
• Establish a National Society task force at headquarter level to coordinate with internal and external partners.															
• Longer term capacity is provided through the deployment of an Head of Emergency Operations (HEOPs), Operations Manager, Emergency Health Delegate and Hygiene Promotion/Sanitation Delegate, PSS Delegate, Communications Delegate, Field Coordinators, Finance/Admin Delegate, Logistics Delegate, IT Delegate and Internship for an Information Manager.															
• Provide surge capacity through the deployment of a Basic Health Care and IT and Telecommunications Emergency Response Unit and a Regional Disaster Response Team (RDRT)															
• Conduct a sequence of rapid assessments using RAMP in Kailahun, Kenema, Port Loko, Western Area, Bo and Bombali and other districts as dictated by the evolution of the outbreak and incorporate the findings into plan of action.															
• One National Ebola Coordinator assigned at SLRCS headquarters exclusively responsible for Ebola response.															
• One NS District Operations manager will be assigned to each district to ensure supervision at field level.															
• One Dead Body Management Coordinator for Kailahun, Kenema, Port Loko, Western Area, Bo and Bombali districts.															
• One Community Engagement Officer for each district to oversee targeted social mobilisation, contract tracing and PSS in all the 13 districts.															
• Establishment of Mobile Team consisting of a doctor/nurse, DBM specialist, Contact Tracing specialist, and a driver.															
• Mobilise (procure/rent) 18 surge vehicles and maintain operational capacity at field level.															
• Procured 30 motorbikes for the 13 districts.															
• Provision of office equipment and															

materials for the operational offices in Kailahun Kenema, Port Loko Western Area, Bo and Bombali (computers and accessories, generators, internet connectivity, stationery)																
• IT support for at least 6branches(laptop and desk top computers, printers, photocopiers, digital cameras)																
• volunteer recognition - ceremony and certificate award to all volunteers and staff involved in the Ebola operation																
Output 1.1 : Effective staff and volunteer safety and security system, including pre, during and post-deployment support																
Activities planned Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	
• Local insurance cover for 400 volunteers of the NS																
• International Federation insurance cover against accidents and injuries for 1,640 volunteers																
Output 1.2: Risks to volunteers are minimised																
Activities planned Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	
• Procure protective raingear, footwear and sanitizer for volunteers																
Output 2: Community-based disease prevention and health promotion is provided to targeted population																
Activities planned Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	
• Develop communication strategy for targeted areas.																
• Train 1,640 volunteers nationally in EVD signs, symptoms, and prevention and referral mechanisms.																
• Refreshers training for 650 volunteers on community-based awareness-raising, social mobilization and PSS.																
• Produce 75,000 (leaflets/brochures) and disseminate context-specific Information, Education and Communication materials.																
• Procure 5,000 Personal Protective Equipment (PPE) and distribute to branches.																
• Re-production of 1,640 T-shirts, caps and ID cards.																
• Conduct health promotion campaigns using house-to-house or street-to-street community sensitization and media campaign in all the 13 districts.																
• Continuous monitoring and evaluation.																
Output 3: Contribution to epidemiological investigation and epidemic control																
Activities planned Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**	
• Provide surge vehicles for teams involved in activities related to Dead Body Management teams in the 6 operational areas.																
• DBM: Perform safe burials from communities and clinical management centres in the 6 operational areas.																
• Train 325 volunteers in all the 13																

branches for Surveillance and Contact Tracing.															
• Establish coordination and clear referral mechanism with county health teams.															
• Train 975 volunteers (325 contact tracers + 650 Social Mob. and PSS) in all the 13 branches in the basic use Personal Protective Equipment.															
• Sensitize, recruit, prepare and train volunteers in Dead Body Management and house disinfection in the 6 operational areas.															
• Quality assurance check of DBM team by an external partner or supervisor.															
• Regular refresher training (4 sessions) on the dressing and proper removal (best practices) of the PPE as well as disinfection every 6 weeks.															
• Refreshers training sessions of DBM teams on regular bases.															
• Procure 5000 DBM and Disinfection Kit as well as DBM Starter Kit (1 kit per team, for every 3 months).															
• Provision of phone top-ups for contract tracers.															
• Organise cross-border workshop on Dead Body Management.															
• Procurement of 30 infra-red thermometers for offices if the national society.															
Output 4: Psychosocial and economical support is provided to affected population															
Output 4.1: Psychosocial support provided to affected individuals, families and communities															
Activities planned Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
• Train 650 volunteers in all the 13 districts who are following up contact in psychosocial first aid.															
• Provide psychosocial counselling to affected persons, family members, and volunteers.															
• Conduct community visits for mitigation and reduction of stigma and fear.															
• Prepare communities for re-integration / acceptance of suspects / probable / confirmed cases.															
• Accompany and support individuals discharged from isolation back to their communities to assist in re-entry and reassure communities.															
• Establish volunteer care mechanisms and systems.															
Output 4.2 :Economical support is provided to individuals or families who have lost belongings due to disinfection and epidemic control measures															
Activities planned Month	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
• Procurement and distribution of appropriate resettlement packages/survival kits for 1,000 affected families															

Output 5: Clinical case management.															
Activities planned **Month**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
• Deploy IFRC basic health unit emergency response unit															
• Establish unit for isolation and life support in Kenema.															
• Supervision and capacity building of local nursing staff.															
• Refresher course on contact tracing for volunteers in Kenema.															
Outcome 6: The management of the operation is informed by a comprehensive monitoring and evaluation system															
Output 6.1: A process of monitoring and evaluation maintained and reported on throughout the program															
Activities planned **Month**	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**	**11**	**12**	**13**	**14**	**15**
• Establish regular monitoring system to map cases and National Society field capacity.															

Budget

- See attached IFRC Secretariat budget for details.

Contact Information

For further information specifically related to this operation please contact:

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

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How we work

All IFRC assistance seeks to adhere to the Code of Conduct for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief and the Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere) in delivering assistance to the most vulnerable. The IFRC's vision is to inspire, encourage, facilitate and promote at all times all forms of humanitarian activities by National Societies, with a view to preventing and alleviating human suffering, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

International Federation of Red Cross and Red Crescent Societies

Sierra Leone: Ebola Emergency Appeal budget

Currency: CHF
Date: 09.09.2014

Activity	Account	Description	Quantity	Unit	SLL	Cost	Total
3. Health and Care							
Outcome 1	**The immediate risks to the health of affected populations are reduced**						
Output 1.1	**The capacity of Sierra Leone Red Cross to manage Ebola virus disease outbreak response has been strengthened**						
A0311	593	Surge vehicle x 1 Year	365	days	-	135	49,275
A0311	593	VRP vehicle rental (9 vehicles for 12 months)	108	months	-	830	89,640
A0311	593	Vehicle Fueling (9 Vehicles x 400L x 48 weeks)	172,800	litres	-	1	162,432
A0311	593	VRP maintenance	12	months	-	6,000	72,000
A0311	582	Laptops	20	units	-	3,600	72,000
A0311	582	Desktop Computers	6	units	-	1,000	6,000
A0311	582	Printers, Photocopiers and Scanner s	6	units	-	1,500	9,000
A0311	593	Fuel for traveling (Kailahun- Freetown 500km - 4,500 SLL per l	1	lump sum	-	2,300	2,300
A0311	584	Generator 6 Fully Operational Districts	6	units	-	12,000	72,000
A0311	730	Fuel for generator	6	districts	-	4,600	27,600
A0311	581	Motorbikes for volunteer 30 Units	30	units	-	3,000	90,000
A0311	593	Motorbikes Fuel for 30 units	36,000	litres	-	1	33,840
A0311	680	Conduct a rapid assessment in 4 Districts - fuel, accommodatic	6	sessions	-	750	4,500
Total Output 1.1							**690,587**
Output 1.2	**Increased public awareness about EVD (signs and symptoms, transmission risk factors, actions for suspected cases and anti-stigma information)**						
A0312	680	Train 650 volunteers in EVD signs and symptoms, prevention measures and referral mechanisms, personal protection	26	sessions	-	5,360	139,360
A0312	680	Training of the Ebola Response Mobile team at headquarters	2	sessions	-	1,500	3,000
A0312	680	Training of newly recruited national society staff for the operations	2	sessions	-	3,000	6,000
A0312	662	HQ Travels/Periderm- Monitoring	24	trips	-	174	4,166
A0312	550	Megaphones (5x13districts)	150	kits	-	36	5,400
A0312	550	Batteries for megaphones	150	batteries	-	5	767
A0312	710	Radio discussions (13 districts x 28 weeks)	364	weeks	-	72	26,208
A0312	710	radio spot development and airtime	1	lump sum	-	3,500	3,500
A0312	710	SMS blast system sundry fees and maintenance	1	lump sum	-	3,000	3,000
A0312	710	Visibility and communication (T-shirt/ Caps and ID Cards)	1,640	pcs	-	18	29,520
A0312	550	Production of IEC materials 100,000 Leftlets	100,000	pcs	-	1	61,000
A0312	740	TERA SMS broadcast system licensing and maintenance	1	lump sum		6,000	6,000
A0312	680	One awareness raising training on Ebola for all 13 branches x	13	Branches	-	1,300	16,900
A0312	680	Accommodation and transport NS Facilitators (10 TechnGrpx4	6	trainings	-	677	4,062
A0312	667	Volunteer mobilization (13 districts x 50 volunteers/district 3 da	33,600	days	-	4	134,400
A0312	662	Incentive for Supervisors/Comm. Outreach - for 180 days	1,800	days	-	10	18,000
A0312	680	Community mobilization (transport costs) - 90 sessions (10/dist	4,500	people	-	2	9,000
A0312	593	Vehicle hire for awareness raising (13 branches x 20 weeks - 1	260	days/vehicle	-	150	39,000
A0312	730	PA system for vehicles (13 branches x 20 weeks - 1 day a wee	260	days	-	51	13,260
A0312	593	Fuel for vehicles (9 districts x 400L x 24 weeks)	18,800	litres	-	1	17,672
Total Output 1.2							**540,214**
Output 1.3	**Epidemiological investigation and epidemic control measures carried out**						
A0313	680	Incentive for Supervisors/Comm. Outreach (3 days per week x	1,400	days	-	10	14,000
A0313	680	Special training of 325 volunteers in surveillance and contact tr	26	trainings	-	2,000	52,000
A0313	680	DBM Team Training for 30 Volunteers per Team X 6 Districts	6	districts	-	8,000	48,000
A0313	680	Per diem facilitators from 8 DHMT	26	people	-	40	1,040
A0313	530	Chlorine to support control activities and for volunteers use	750	kg	-	18	13,275
A0313	540	Personal Protective Kits (100 high risk)	5,000	units	-	150	750,000
A0313	540	Infra-Red Thermometers	30	units	-	250	7,500
A0313	540	Body bags	5,000	units	-	16	80,000
A0313	530	Spraying material (sprayers + chlorine)	1	lump sum	-	20,000	20,000
A0313	592	Air transport body bags	1	lump sum	-	18,000	18,000
A0313	592	Air transport Personal Protective Kits	1	lump sum	-	20,000	20,000
A0313	667	DBM Volunteer incentive (120 Volunteer x4 Districts X 12 mont	23,040	days	-	11	253,440
A0313	680	Refresher Training session Dressing and Removal Protocols (	10	training	-	4,000	40,000
A0313	680	Cross-border workshop on dead body management	2	training	-	5,000	10,000
A0313	581	Purchase of Vehicle 1 Units (Toyota Hilux)	1	units	-	29,300	29,300
A0313	581	Purchase of Vehicle 1 Units (Toyota Land Cruiser Pick up)	1	units	-	43,000	43,000
A0313	593	VRP pick-up trucks, 4x 12 months	48	months	-	830	39,840
A0313	593	VRP hard tops, 3x12 months	36	months	-	830	29,880
A0313	593	VRP vehicle maintenance costs	12	months	-	4,000	48,000
A0311	593	rental pick-up trucks (2 trucks x 30 days/month @ CHF100/day	360	days	-	100	36,000
A0313	593	Fuel for vehicles (9 vehicles x 400L x 10 weeks)	172,800	litres	-	1	162,432
A0313	500	Tarpaulin and cleaning materials	4	piece	-	1,000	4,000
Total Output 1.3							**1,719,707**
Output 1.4	**Psychosocial support provided to the target population**						

A0314	680	Special training of 650 volunteers in psychosocial support	26	training	-	3,000	78,000
A0312	667	Volunteer mobilization Incentives (650 volunteers 3 days/week	78,000	days	-	6	468,000
Total Output 1.4							**546,000**
Output 1.5	**Provide support to individuals or families who have lost belongings due to disinfection and epidemic control measures**						
A0315	560	Procurement and distribution of resettlement packages	2,000	family	-	200	400,000
Total Output 1.5							**400,000**
Output 1.6	**Risks to volunteers are minimised**						
A0316	510	Rain gear for volunteers in 13 districts	2,000	units	-	9	18,000
A0316	510	Rain gear for branch staff in 13 distritcs	100	units	-	9	900
A0316	540	Hand sanitizer (13 Districts x 120 volunteers)	2,000	units	-	4	8,200
A0316	510	Footwear for volunteers in 13 districts	2,000	units	-	8	16,200
A0316	667	complementary volunteer life insurance (in-country)	1	lump sum	-	16,000	16,000
A0316	667	Recognisition of Volunteers (ceremony and Certificate award)	1	lump sum	-	12,000	12,000
A0316	662	Accommodation for DBM Teams 6 Teams (6 District)	12	months	-	1,000	12,000
A0316	667	Volunteer insurance	1,640	volunteers	-	3	4,100
Total Output 1.6							**87,400**
Output 1.7	**Clinical case management in Kenema**						
A0315	540	ERU Health Procurement (PPE Kits, Drugs)	1	lump sum	-	1,419,542	1,473,770
A0315	594	IFRC Global logistics services fees	1	lump sum		70,977	70,977
A0315	592	air freight	1	Lumpsum	-	90,950	90,950
A0315	530	Water, Sanitation & Hygiene	1	lump sum	-	196,284	196,284
A0315	500	Emergency shelter and household items	1	lump sum	-	322,254	322,254
A0315	571	ETC ERU personnel (funded by IFRC)	1	lump sum	400,000	400,000	400,000
A0315	571	ETC ERU personnel (BILATERAL)	1	lump sum	458,000	458,000	458,000
A0315	600	Additional ETC personnel (see ERU detailed budget)	1	lum sum	558,000	558,000	558,000
A0315	550	Teaching Materials	1	piece	-	1,700	1,700
A0315	593	Ambulances (with modification for infectious disease)	36	months	-	930	33,480
A0315	730	Fuel for generator clinical unit	14,400	litres	-	1.10	15,840
A0315	584	6.5 KVA generator	1	units	-	8,000.00	8,000
A0315	584	1.5kva generator	1	units	-	5,000.00	5,000
A0315	730	Fuel for back up office generator	12,800	litres	-	1.10	14,080
A0315	593	Fuel for operational vehicles	76,800	litres	-	1.10	84,480
A0315	593	Mini bus transport for local staff	4	months	-	4,775.25	19,101
A0315	662	Check point at local staff bus stop	1	Lumpsum	-	1,889.00	1,889
A0315	662	complementary Kenema Staff life insurance (in-country)	1	Lumpsum	-	8,000.00	8,000
A0315	593	Mini Bus for expat staff	4	months	-	5,834.50	23,338
A0315	530	water trucking	20	trips	-	2,518.90	50,378
A0315	593	truck rental 3 tonne	1	trips	-	4,251.00	4,251
A0315	593	Land Cruisers	18	months	-	830	14,940
A0315	730	Office furniture (tables, chairs, etc.)	1	Lumpsum	-	388	388
A0315	740	IT upgrade	1	Lumpsum	-	7,557	7,557
A0315	680	lessons learnt workshop	1	Lumpsum	-	11,335	11,335
A0315	710	Visibility (T-shirts, caps, posters)	400	units	-	9	3,780
A0315	790	branch support office costs	1	Lumpsum	-	472	472
A0315	730	Office running costs	6	months	-	1,500	9,000
A0315	730	Office utilities (electricity, water, etc.)	6	months	-	400	2,400
A0315	760	Bank charges	6	months	-	5,000	30,000
A0315	593	Transport by trucks	1	Lumpsum	-	4,500	4,500
A0315	590	Warehouse rent	6	months	-	1,000	6,000
A0315	540	Isolation contingency	1	Lumpsum	-	9,445	9,445
A0315	710	Information & public Relations SLRC	1	Lumpsum	-	944	944
A0315	740	Laptop	1	units	-	472	472
A0315	740	GM360	22	units	-	567	12,469
A0315	740	Magnetic VHF antennas	20	units	-	47	945
A0315	740	GP360	15	units	-	661	9,918
A0315	740	Mast	2	units	-	945	1,889
A0315	740	VHF Antenna	2	units	-	756	1,511
A0315	730	Power supply	2	units	-	189	378
A0315	730	Cables, connectors and tools	1	Lumpsum	-	472	472
A0315	790	Miscellanea	1	Lumpsum	-	2,834	2,834
A0315	667	volunteer incentives (dead body management)	64	people	-	210	13,434
A0315	667	volunteer incentives (family liaison)	40	people	-	126	5,038
A0315	667	volunteer incentives (contact tracing)	120	people	-	126	15,113
A0315	680	induction training expats (accommodation/transport)	150	people	-	94	14,169
A0315	680	induction training local staff	250	people	-	9	2,363
A0315	662	NS Staff Salary Cost (See ERU Budget Attached)	1	lump sum	-	171,728	171,728
A0315	700	ETC personnel travel, accomodation and ETC decommisioning	1	lump sum	-	285,114	285,114
Total Output 1.5							**4,478,379**
Outcome 2	**Regional Ebola preparedness measures and coordination mechanisms are in place**						
Output 2.1	**Sierra Leone and bordering National Societies are prepared and respond in a coordinated manner**						
A0321	680	Regional Workshop Field Level (volunteers and Officers, 20 parts)/ operational meetings	1	training	-	30,000	30,000
A0321	680	Regional Workshop National Level (National Society coordinators, IFRC and PNSs, 20 participants)	1	training	-	35,000	35,000

A0321	710	Development of an IFRC guidelines on EVD cross border epidemics/Translation	1	lump sum	-	15,000	15,000
Total Output 2.1							**80,000**
Outcome 3 The management of the operation is informed by a comprehensive monitoring and evaluation system							
Output 3.1 A process of monitoring and evaluation maintained and reported on throughout the program							
A0331	700	HQ Travels/Monitor and report on activities carried out	1	lump sum	-	12,000	12,000
A0331	740	Mobile phones for the use of RAMP to do reporting and monitoring 1 x branch	18	units	-	180	3,240
A0331	740	Airtime for mobiles for expats and technical support	1	lump sum	-	12,000	12,000
Total Output 3.1							**27,240**
National Society operation support costs (where not included in sector based activities)							
A0811	593	Vehicle Maintenance	6	vehicle	-	2,000	12,000
A0811	730	Fuel generators in the branches (4h pd x 3 days pw x 13 branches x 48 weeks x 4,500 SLL per litre)	13	branches	-	2,000	26,000
A0811	730	Stationary / printing / sundry admin for all branches	1	lump sum	-	12,000	12,000
A0811	730	Generator fuel	6	districts	-	6,000	36,000
A0811	662	Community engagement officer (6)	72	months	-	400	28,800
A0811	662	Alert and contact officer (9)	108	month	-	400	43,200
A0811	662	Active PSS officer (9)	108	month	-	400	43,200
A0811	662	Dead body management Coordinators (6)	72	month	-	400	28,800
A0811	662	District Operations Managers (6)	72	month	-	1,200	86,400
A0811	662	Drivers (18)	216	month	-	250	54,000
A0811	662	complementary 6 District Staff life insurance (in-country)	1	Lumpsum	-	8,000	8,000
A0811	662	NS Finance Officer salary	12	month	-	1,200	14,400
A0811	662	National Ebola Coordinator	12	month	-	1,500	18,000
A0811	662	Establishment of Mobile Team HQ (Training, Mobilise Deploy a	30	trips	-	1,500	45,000
A0811	662	Salary Support for the DM officer	12	month	-	1,500	18,000
A0811	730	HQ/ 6 District Office Supplies (Stationaries)	1	Lumpsum	-	20,000	20,000
A0811	730	HQ/6 Districts Office Rental	12	month	-	3,500	42,000
A0811	730	Diesel - Generator For NS- HQ	57,600	litres	-	1	54,144
A0811	730	Generator Repairs and Servicing For NS	1	Lumpsum	-	12,000	12,000
A0811	730	General office maintenance For NS	1	Lumpsum	-	6,000	6,000
A0811	730	Water Rate For NS	1	Lumpsum	-	3,500	3,500
A0811	730	Furniture For NS	1	Lumpsum	-	19,000	19,000
A0811	584	7 Air Conditioners - (N1500 x 7) For NS	7	units	-	1,000	7,000
A0811	730	Electricity Bill For NS	1	Lumpsum	-	6,000	6,000
A0811	584	Photocopier Machine for HQ Office	2	units	-	2,500	5,000
A0811	593	Support for NS HQ Vehicle Fueling	1	Lumpsum	-	30,000	30,000
A0811	593	NS Vehicle Maintenance HQ/ 6 District	1	Lumpsum	-	28,000	28,000
A0811	710	NS press conference - refreshment	6	sessions	-	152	912
A0811	710	NS press conference - transport	6	sessions	-	203	1,218
A0811	790	NS Administrative Cost	12	month	-	7,555	90,660
A0811	662	NS driver - per diem and accommodation during field trips (90 days at 90,000 SLL per day)	4	person	-	1,651	6,604
A0811	740	Airtime for phones and internet	6	months	-	2,500	15,000
Total NS support costs							**820,838**
IFRC operation support costs							
A0821	700	IFRC technical support / monitoring visit	30	trips	-	3,000	90,000
A0821	571	ERU - Basic Health Care personnel (6 individuals per rotation)	3	rotation	-	72,000	216,000
A0821	571	ERU - IT/Telecom personnel (2 individuals per rotation)	2	rotation	-	24,000	48,000
A0821	582	ERU - IT/Telecom equipment	1	lump sum	-	20,000	20,000
A0821	740	Internet Connectivity (Internet Provider in 4 Branches + HQ	12	month	-	15,000	180,000
A0821	670	IFRC Ebola Finance and Admin Consultant	3	month	-	9,000	27,000
A0821	600	IFRC Geneva technical mission support FACT	3	people	-	6,000	18,000
A0821	600	IFRC Regional Surge Staff or RDRT (4x3 months)	24	month	-	6,000	144,000
A0821	600	IFRC Operations Manager x 12 months	12	month	-	12,000	144,000
A0821	600	IFRC Finance and Admin Delegate x 12 months	12	month	-	12,000	144,000
A0821	600	IFRC Head of Emergency Operations x 6 month	6	month	-	12,000	72,000
A0821	600	IFRC Regional Finance delegate x 4 months (Support)	4	month	-	12,000	48,000
A0821	600	IFRC Communications Delegate 6 Months	6	month	-	12,000	72,000
A0821	600	IFRC Reporting Delegate X 12 Months	12	month	-	12,000	144,000
A0821	600	IFRC Logistic/Fleet Delegate X 6 Months	6	month	-	12,000	72,000
A0821	600	IFRC IT delegate x 3 month	3	month	-	12,000	36,000
A0821	600	IFRC Logistic Delegate X 12 Months	12	month	-	12,000	144,000
A0821	600	IFRC Logistic Coordinator (General) 12 months	12	month	-	12,000	144,000
A0821	600	IFRC WATSAN/DBM Delegate X 12 Months	12	month	-	12,000	144,000
A0821	600	IFRC Health Delegate X 12 Months	12	month	-	12,000	144,000
A0821	600	IFRC Health Coordinator 12 Months	12	month	-	12,000	144,000
A0821	600	IFRC Health Delegate X 12 Months	12	month	-	12,000	144,000
A0821	600	IFRC Health Delegate x 12 months	12	month	-	12,000	144,000
A0821	600	Regional Operations coordinator	4	month	-	12,000	48,000
A0821	661	Water, sanitation, hygiene intern (6 months) (Accom Inclusive)	6	month	-	6,000	36,000
A0821	730	IFRC Office Set Up- HQ/Office Rent	1	lump sum	-	55,000	55,000
A0821	740	Regional office communication costs	12	month	-	500	6,000
A0821	740	Zone and Geneva communication costs	12	month	-	500	6,000

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A0821	760	Bank charges & forex	1	lump sum	-	60,000	60,000
A0821	710	Media / Communications support	2	trips	-	12,000	24,000
A0821	670	Real time evaluation	1	RTE		50,000	50,000
Total IFRC support costs							**2,768,000**

SUB TOTAL BUDGET:	**12,158,366**

Programme support:	**743,364**

TOTAL BUDGET:	**12,901,729**

Disaster Response Financial Report

MDRSL005 - Sierra Leone - Ebola Virus Disease

Timeframe: 06 Apr 14 to 15 Jun 15

Appeal Launch Date: 26 Jun 14

Annual Report

Selected Parameters			
Reporting Timeframe	2014/7-2014/11	Programme	MDRSL005
Budget Timeframe	2014/7-2015/6	Budget	BUDGET9
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

I. Funding

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
A. Budget		**40,183,182**				**40,183,182**	
B. Opening Balance		**65,950**				**65,950**	
Income							
Cash contributions							
American Red Cross		*497,548*				*497,548*	
Bill & Melinda Gates Foundation		*37,625*				*37,625*	*1,015,793*
British Red Cross		*452,707*				*452,707*	
British Red Cross (from British Government)*		*19,838,278*				*19,838,278*	
British Red Cross (from Children's Investment Fund Foundation)*		*1,634,417*				*1,634,417*	
European Commission - DG ECHO		*499,717*				*499,717*	
Finnish Red Cross		*1,446*				*1,446*	
French Red Cross (from Total)*		*200,325*				*200,325*	
Icelandic Red Cross		*94,755*				*94,755*	
Italian Government Bilateral Emergency Fund (from Italian Government)*		*1,201,951*				*1,201,951*	
Japanese Government		*97,294*				*97,294*	*911,576*
Japanese Red Cross Society		*87,854*				*87,854*	
Norwegian Red Cross		*42,728*				*42,728*	
Red Crescent Society of Islamic Republic of Iran		*10,000*				*10,000*	
Red Cross of Monaco		*18,097*				*18,097*	
Spanish Red Cross		*294,963*				*294,963*	
Swedish Red Cross		*130,823*				*130,823*	
Swiss Red Cross		*308,312*				*308,312*	
The Canadian Red Cross Society		*4,127*				*4,127*	
The Canadian Red Cross Society (from Canadian Government)*		*891,795*				*891,795*	
The Netherlands Red Cross (from Netherlands Government)*		*1,205,940*				*1,205,940*	
United States Government - USAID		*535,587*				*535,587*	*2,842,042*
C1. Cash contributions		***28,086,288***				***28,086,288***	***4,769,410***
Inkind Goods & Transport							
British Red Cross		*100*				*100*	
Finnish Red Cross		*37,380*				*37,380*	
Spanish Red Cross		*14,040*				*14,040*	
Swiss Red Cross		*127,872*				*127,872*	
C2. Inkind Goods & Transport		***179,392***				***179,392***	
Inkind Personnel							
Australian Red Cross		*2,373*				*2,373*	
C3. Inkind Personnel		***2,373***				***2,373***	
Other Income							
DREF Allocations		*772,664*				*772,664*	
C4. Other Income		***772,664***				***772,664***	
C. Total Income = SUM(C1..C4)		**29,040,717**				**29,040,717**	**4,769,410**
D. Total Funding = B +C		**29,106,667**				**29,106,667**	**4,769,410**

* Funding source data based on information provided by the donor

Disaster Response Financial Report

MDRSL005 - Sierra Leone - Ebola Virus Disease

Timeframe: 06 Apr 14 to 15 Jun 15

Appeal Launch Date: 26 Jun 14

Annual Report

Selected Parameters			
Reporting Timeframe	2014/7-2014/11	Programme	MDRSL005
Budget Timeframe	2014/7-2015/6	Budget	BUDGET9
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

II. Movement of Funds

	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/RC work	Joint working and accountability	TOTAL	Deferred Income
B. Opening Balance		65,950				**65,950**	
C. Income		29,040,717				**29,040,717**	**4,769,410**
E. Expenditure		-7,612,853				**-7,612,853**	
F. Closing Balance = (B + C + E)		21,493,814				**21,493,814**	**4,769,410**

Disaster Response Financial Report

MDRSL005 - Sierra Leone - Ebola Virus Disease

Timeframe: 06 Apr 14 to 15 Jun 15

Appeal Launch Date: 26 Jun 14

Annual Report

Selected Parameters			
Reporting Timeframe	2014/7-2014/11	Programme	MDRSL005
Budget Timeframe	2014/7-2015/6	Budget	BUDGET9
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

III. Expenditure

Account Groups	Budget	Expenditure						Variance
		Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/ RC work	Joint working and accountability	TOTAL	
	A						B	A - B
BUDGET (C)			**40,183,182**				**40,183,182**	
Relief items, Construction, Supplies								
Shelter - Relief	324,819		115,422				**115,422**	**209,397**
Shelter - Transitional			41,730				**41,730**	**-41,730**
Construction Materials			22,590				**22,590**	**-22,590**
Clothing & Textiles	95,550		67,333				**67,333**	**28,217**
Food	530,712		1,289				**1,289**	**529,423**
Water, Sanitation & Hygiene	904,117		137,403				**137,403**	**766,714**
Medical & First Aid	7,815,893		720,748				**720,748**	**7,095,145**
Teaching Materials	7,187		20,033				**20,033**	**-12,847**
Utensils & Tools	456,795		12,343				**12,343**	**444,452**
Other Supplies & Services	212,720		66,096				**66,096**	**146,624**
ERU	390,000							**390,000**
Total Relief items, Construction, Sup	10,737,793		1,204,989				**1,204,989**	**9,532,804**
Land, vehicles & equipment								
Vehicles	444,640		803,071				**803,071**	**-358,431**
Computers & Telecom	327,172		115,796				**115,796**	**211,376**
Office & Household Equipment	102,997		45,131				**45,131**	**57,866**
Total Land, vehicles & equipment	874,809		963,998				**963,998**	**-89,189**
Logistics, Transport & Storage								
Storage	858,886		150,747				**150,747**	**708,139**
Distribution & Monitoring	1,571,201		1,383,944				**1,383,944**	**187,257**
Transport & Vehicles Costs	4,351,279		1,020,009				**1,020,009**	**3,331,270**
Logistics Services			146,859				**146,859**	**-146,859**
Total Logistics, Transport & Storage	6,781,366		2,701,559				**2,701,559**	**4,079,807**
Personnel								
International Staff	7,365,321		703,859				**703,859**	**6,661,462**
National Staff	67,761		44,722				**44,722**	**23,039**
National Society Staff	3,939,105		246,178				**246,178**	**3,692,927**
Volunteers	2,537,609		149,007				**149,007**	**2,388,602**
Total Personnel	13,909,796		1,143,766				**1,143,766**	**12,766,030**
Consultants & Professional Fees								
Consultants	358,977		28,310				**28,310**	**330,667**
Professional Fees	12,000		89,346				**89,346**	**-77,346**
Total Consultants & Professional Fee	370,977		117,655				**117,655**	**253,322**
Workshops & Training								
Workshops & Training	1,330,366		224,412				**224,412**	**1,105,954**
Total Workshops & Training	1,330,366		224,412				**224,412**	**1,105,954**
General Expenditure								
Travel	578,252		221,032				**221,032**	**357,220**
Information & Public Relations	826,144		65,114				**65,114**	**761,030**
Office Costs	1,697,194		59,275				**59,275**	**1,637,919**
Communications	553,753		95,123				**95,123**	**458,630**
Financial Charges	69,843		13,511				**13,511**	**56,332**
Other General Expenses	394		12,420				**12,420**	**-12,026**
Shared Office and Services Costs			20,789				**20,789**	**-20,789**
Total General Expenditure	3,725,580		487,264				**487,264**	**3,238,316**
Operational Provisions								

Disaster Response Financial Report

MDRSL005 - Sierra Leone - Ebola Virus Disease

Timeframe: 06 Apr 14 to 15 Jun 15

Appeal Launch Date: 26 Jun 14

Annual Report

Selected Parameters			
Reporting Timeframe	2014/7-2014/11	Programme	MDRSL005
Budget Timeframe	2014/7-2015/6	Budget	BUDGET9
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

III. Expenditure

		Expenditure						
Account Groups	**Budget**	Raise humanitarian standards	Grow RC/RC services for vulnerable people	Strengthen RC/ RC contribution to development	Heighten influence and support for RC/ RC work	Joint working and accountability	**TOTAL**	**Variance**
	A						**B**	**A - B**
BUDGET (C)			**40,183,182**				**40,183,182**	
Operational Provisions			248,306				**248,306**	**-248,306**
Total Operational Provisions			248,306				**248,306**	**-248,306**
Indirect Costs								
Programme & Services Support Recove	2,452,495		459,189				**459,189**	**1,993,306**
Total Indirect Costs	2,452,495		459,189				**459,189**	**1,993,306**
Pledge Specific Costs								
Pledge Earmarking Fee			59,215				**59,215**	**-59,215**
Pledge Reporting Fees			2,500				**2,500**	**-2,500**
Total Pledge Specific Costs			61,715				**61,715**	**-61,715**
TOTAL EXPENDITURE (D)	**40,183,182**		**7,612,853**				**7,612,853**	**32,570,328**
VARIANCE (C - D)			**32,570,328**				**32,570,328**	

Disaster Response Financial Report

MDRSL005 - Sierra Leone - Ebola Virus Disease

Timeframe: 06 Apr 14 to 15 Jun 15

Appeal Launch Date: 26 Jun 14

Annual Report

Selected Parameters			
Reporting Timeframe	2014/7-2014/11	Programme	MDRSL005
Budget Timeframe	2014/7-2015/6	Budget	BUDGET9
Split by funding source	Y	Project	*
Subsector:	*		

All figures are in Swiss Francs (CHF)

IV. Breakdown by subsector

Business Line / Sub-sector	Budget	Opening Balance	Income	Funding	Expenditure	Closing Balance	Deferred Income
BL2 - Grow RC/RC services for vulnerable people							
Disaster response	40,183,182	65,950	29,040,717	29,106,667	7,612,853	21,493,814	4,769,410
Subtotal BL2	40,183,182	65,950	29,040,717	29,106,667	7,612,853	21,493,814	4,769,410
GRAND TOTAL	**40,183,182**	**65,950**	**29,040,717**	**29,106,667**	**7,612,853**	**21,493,814**	**4,769,410**

ANNEXEX 4

LIBERIA ATTACHMENTS

List of persons interviewed

Liberia Emergency Appeal, November, 2014

Liberia Emergency Appeal, Emergency Plan of Operations, November, 2014

Liberia Financial Management Report, December 2014

LIBERIA: Persons interviewed by the RTE evaluation team

Name	Position	Telephone
Abay, Mesfin	IFRC Country Representative	880 528 771
Alao, Ademola	Program Advisor	777 577 3562
Angeline Roberts	Health Officer, Montserrado Chapter	
Campbell, Penelope	UNICEF, Emergency health specialist	770 25 7 971
Candy, Neima Nora	National Ebola Coordinator	888 511 519
Casablanca, Jean-Jerome	Head of Delegation	777 566 588
Flemo, Fred	Volunteer	
Gbanya, Miatta	Deputy to the Assistant Minister	
Hald, Birte	Former Head of Operations, Ebola Regional Coordination Unit	079 708 4588
Isohanni, Heidi	Health Delegate	886 379 190
Maboundou, Jacques	Finance and Administration Delegate	
Jah, William	Field Officer, Bassa Chapter	
Jallah, Yossah	Health Officer, Margibi Chapter	
Jebboe, Susannah	PSS officer, Sinoe County	
Jeverson, Macky	PSS Volunteer	
Imanol, Jesus	ECHO representative	
Jonhere, Linette	Monitoring and Evaluation delegate	770 413 399
Keffa, Paul	Field Officer, Sinoe	
Kiawu, K. Christopher	Supervisor CERT, Margibi Chapter	
Kin, Damoh	PSS Volunteer	
Konah, Paul	Field Officer, Cape Mount Chapter	
Korto, Sanif	Health Officer, Montserrado Chapter	
Massaquoi, Moses	Clinton Foundation	886 383 487
Martha, Korpu	Heath Officer, Montserrado Chapter	
Merlin, George	Field Officer, Rivercess Chapter	
Mikkelsen, Tage	Safe and Dignified Burial delegate	770 413 457
Moetsabe, Titus	UNICEF, C4D specialist	770 25 7957
Nyenswah, Tolbert	Assistant Minister of Health	
Njoroge Benson	Fleet Delegate	
Owili, Collins	Emergency Health Officer	770 413 471
Perry, Aloysius	NS Fleet Manager	
Quaye, Zinnah	Field Officer, Bomi Chapter	
Reines, Tracy	Deputy Operations Manager	775 703 323
Ryan, Stephen	Benn Coms Delegate	777 990 377
Laurence, Sally	Emergency Coordinator, MSF	
Schliecher, Peter	Operations Manager	886 796 533
Singbee, Kollie	PSS Counsellor, Margibi Chapter	886 653 963
Singh, Guruvez	Emergency Health delegate, Africa zone	777 990 356
Tamba, Fayuah	Secretary General, LRCS	770 458 187
Tarweh, Seth	Field Officer, Gharpolie	
Tate, Gareth	Logistics Delegate	770 211 390
Freeman, Thomas	Technical / Liason Officer, Montserrado Chapter	
Wankali, Jackson	Field Officer, Montserrado Chapter	
Kwiah, Wheimar	Head of Support Services	
Zanghelini, Thomas	PSS Delegate	775 103 329

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Saving lives, changing minds.

Emergency Appeal
Liberia: EVD outbreak

International Federation of Red Cross and Red Crescent Societies

Revised Emergency Appeal **n° MDRLR001**	**4.5 million people** to be assisted	DREF allocated **CHF 101,388**
Glide n° **EP-2014-000039-LBR**	Appeal timeframe 15 months	ERU deployment **CHF 96,000**
	Launched April 2014; revised July, September and November 2014; End date June 2015	Revised Appeal budget **CHF 24.5M**

This revised Emergency Appeal for a total of CHF **24.5m** (increased from CHF 8.5m) enables the IFRC to support the **Liberian National Red Cross Society (LNRCS)** to respond to the escalating Ebola Virus Disease (EVD) outbreak by delivering assistance and support to some **4.5m people**, with a focus on **information and communication, education, awareness raising, and social mobilization, surveillance, case identification and contact management, safe and dignified burials (SDB), psychosocial support, and regional collaboration**. With the Emergency Response Unit (ERU) component valued at some CHF 96,000, the total appeal budget is CHF 24.5m. With available resources of CHF 9.6m, the net appeal amount sought is CHF 14.8m. The revised plan reflects a significant increase in all activities and the number of volunteers (including dead body management), and an enlarged geographic scope (nation-wide response) and additional response components - home-based protection and early recovery. The response reflects the current situation and information available at this point of the evolving operation, and will be adjusted based on further developments and more detailed assessments.

Click here for the detailed Emergency Plan of Action (EPoA)

The disaster and the response

March 2014: Ebola outbreak occurred in Guinea

March 2014: first cases detected in Liberia, remaining constant at 12 until May 2014

April 2014: IFRC Field Assessment and Coordination team (FACT) deployed; CHF 101,388 DREF allocated; Emergency Appeal launched for CHF 517,766

May 2014: Emergency Response Unit (ERU) deployed

June 2014: second wave of outbreak, spreading in Lofa and Montserrado counties

July 2014: 173 cumulative cases. Emergency Appeal revised to CHF 1.9m

8 September: cumulative caseload in Liberia reaches 1,923 with a total of 1,125 deaths. Revised Appeal issued for CHF 8.5m

March - November: more than 5,000 LNRCS volunteers trained, over 2,500 safe and dignified burials completed, 17,600 recorded Ebola contacts traced and monitored, and more than 650,000 people reached through direct social mobilization

November 2014: Cumulative caseload of 6,878 cases with 2,836 deaths. Revised emergency appeal for CHF 24.5m

The operational strategy

Overall objective: stop the transmission of EVD and bring an end to the current epidemic through the following outcomes:

- **Outcome 1:** The prevalence of EVD in Liberia is reduced / eliminated through establishment of an appropriate response structure, local authorities and community engagement, beneficiary communication and social mobilisation, contact tracing and surveillance, provision of psychosocial support, safe and dignified burials, disinfection and Case management and treatment.
- **Outcome 2:** The existing capacity of the Liberia Red Cross National Society and IFRC management and technical support is enhanced and effective and sustainable action ensured.
- **Outcome 3:** Support is provided to national authorities for countrywide coordination and information management of the overall safe and dignified burial and disinfection of houses response.
- **Outcome 4:** reduction of longer-term effects of the EVD outbreak through initiation of early recovery assessments and interventions, addressing increased vulnerability caused by food security and livelihood challenges and decreased capacity of health and care systems.

Proposed strategy: To ensure the success of this operation the LRCS has developed strategies and continues to improve them in order to achieve the following results:

1. Train volunteers on EVD prevention, social mobilization skills, hygiene promotion and proper utilization of personal protective equipment.
2. Promote health in the community through a communication campaign to mobilise and educate communities regarding the EVD, and reduce stigma.
3. Support community-level committees in the coordination and supervision of activities.
4. Provide training and support to volunteers in case identification, referrals and contact tracing.
5. Support the Government authorities with services including SDB, cremation and disinfection of households.
6. Support trained counsellors to provide psychosocial support and conflict/trauma resolution, monitor and evaluate the impact of response activities.
7. Strengthen capacity of the LRCS in the management and control of epidemics.
8. Pilot the community-based protection approach, ensuring proper and safe care is given to the sick pending availability of bed space in the treatment centres or community care centres while also ensuring safety of the family and community members.
9. Conduct assessments to identify the broader impacts of the disease on livelihood and economic security, and develop recovery programming aiming to mitigate these effects.

Proposed sectors of intervention

Coordination and partnerships

The National EVD Task Force, of which LRCS is a member, convenes to share information and coordinate the response. County coordination meetings continued in Margibi, Lofa, Bong, Nimba, Montserrado and now all the 15 counties where there are now 15 national officers who are technical assistants to the county health team (CHTs) including WHO staff who were deployed to Lofa, Montserrado and other counties to support coordination, surveillance and health promotion efforts of the counties.

The overall IFRC response is coordinated from the IFRC Ebola coordination unit in Conakry (moving to Accra) where the IFRC head of emergency operation leads a team of programme support functions in order to maintain a coordinated response in multiple countries following the same response strategy but adapted to specific contexts and National Society capacity, role and mandate.

Health and care
Outcome 1: Community-based diseases prevention and health promotion are timely provided to the affected population.
Output 1: Community engagement, beneficiary communication and social mobilization -- community-based disease prevention and health promotion is provided to the target population

Activities planned
• Train 3,800 volunteers in case identification (EVD signs, symptoms and referrals), prevention measures, awareness campaign methods, and data collection at community level
• Conduct regular refresher trainings for volunteers active in EVD operation
• Conduct health promotion campaigns using household visits, community sensitization, group sessions and media campaign in targeted counties
• Produce and disseminate prevention and control IEC material
• Procure and distribute visibility equipment and materials
• Disseminate key messages through drama performance and role plays at markets and other public community.
• Engaging opinion leaders such as religious leaders, traditional healers, town chiefs, clan chiefs in social mobilization and awareness campaigns
Output 2: Beneficiary communication and community engagement -- LRCS engages affected communities in meaningful dialogue, addressing stigma, dispelling rumours, etc. and provides them with a voice using different communication mediums throughout the EVD response operation
Activities planned
• Increasing capacity of LRCS to deliver BC activities nationally (systems, radio, advocacy, training teams respectively)
• Train and manage 400 volunteers in basic BC/CE strategies (dissemination of EVD information and feedback, data collection using mini-KAPS (RAMP)
• Establish system of data and information collection and management to disseminate using broadcast mediums, SMS, IVR
• Scaling-up of radio activities to include two weekly national and 45 community level one hour interactive broadcasts and outside broadcasts
• Produce radio dramas (5 min / 20 x 15 minute) including CDs to be distributed
• Distribution of solar/dynamo radio to communities to increase listenership to our radio programme
• Establish IVR (pre-recorded information exchange) system and deployment of the TERA system
• Deliver 30 community forums (2 per county) engaging with “community resource oriented persons” (Chiefs, traditional healers, teachers, soldiers and police, musicians, sport personalities
• Production of IEC materials e.g. print, billboards, wall murals
Output 3: Safe and Dignified Burials and disinfection of houses -- risk of transmission of disease in the communities at household level and in health facilities reduced through disinfection and safe and dignified burials (SDB).
Activities planned
• Establish community emergency response teams (CERT) in affected communities
• Recruitment of additional health officers for 15 chapters
• Provide transportation (vehicles and motor bikes) for CERT
• Train volunteers for contact daily surveillance for 21 days to detect possible onset of symptoms
• Establish coordination and clear referral mechanism with country health teams (CHT)
• Conduct training and refresher and deploy 20 SDB teams (safe transportation, swabs, burial and disinfection of homes and bodies)
Output 4: Psychosocial and economical support -- psychosocial support provided to affected individuals, families, community members and volunteers. Food and non-food items provided to individuals and families who lost belongings due to epidemic control measures (disinfections and burning).
Activities planned
• Establish community emergency response teams (CERT) in 15 affected counties
• Recruit and integrate 15 certified counsellors into the CERT
• Mapping of MHPSS[1] 4Ws[2] to avoid duplication of efforts and resources
• Provide psychosocial counselling to affected persons, family members and volunteers
• Train volunteers who are following up contacts in psychosocial first aid
• Provide ToTs on PSS targeting counsellors and CERT members
• Conduct ant-stigma campaign through community visits to challenge attitudes and change behaviour
• Assess community beliefs and understanding of EVD including fears

• Identify and prevent rumours and actions that may harm epidemic control efforts (use of hotline
• Prepare communities for re-integration and anti-stigmatization of suspects/ probable/ confirmed cases
• Establish volunteer care mechanism consistent with organizational policy and MoHSW
• Psychosocial support for the SSDB team and staff at all levels
• Provide contacts with food parcels and non-food items (survival kits)
• Provide unconditional cash or in-kind replacement for belongings lost due to epidemic control measures
Output 5: Community surveillance and contact tracing -- in coordination with partner agencies, an effective alert investigation and contact tracing system is implemented to ensure rapid referral and care.
Activities planned
• Recruit additional health officers for 15 chapters
• Train volunteers for contact daily surveillance for 21 days in order to detect the possible onset of symptoms
• Establish coordination and clear referral mechanism with country health teams (CHT)
• Train volunteers in the 15 counties on basic personal protective measures for contact tracing
• Initiate cross border collaboration for contact tracing and follow-up
Output 6: Community home-based protection -- communities with limited access to ebola treatment units (ETUs) or community care centres (CCCs) are provided with hygiene and protective equipment kits.
Activities planned
• Support targeted communities with provision of protection kits where necessary
• Conduct ToT for identified communities members on use of protection kits
• Distribute to survivals, orphans, and contact replacement, recovery and resettlement kits in high risk quarantine communities

National Society capacity building and support
Outcome 2: Sustainable impact achieved through strengthening of existing capacity of the LRCS and provision of necessary IFRC management, technical and support resources.
Output 1: National Society capacity development -- the National Society has the necessary capacity to lead the operation and ensure sustainable impact
Activities planned
• Construction of a disaster management center for the coordination of disasters (including 25 bed rooms, conference facilities and warehouse facilities)
• Establish a EVD task force at headquarter level to coordinate activities and partnerships (internal and external)
• Develop and maintain a detailed emergency plan of action
• Establish and roll-out regular monitoring system to track progress, National Society field capacity across all key results areas and pillars
• Institutional strengthening of LRCS HQ and chapter structures.
Output 2: IFRC support to the National Society -- necessary IFRC resources are provided to support the operation
Activities planned
• Intensified capacity is provided to the National Society through the deployment of an operations manager, emergency health, psychosocial support, beneficial communication, logistics/fleet, finance, information technology and PMER delegates
• IFRC coordination and support staff (not technical staff)
• IFRC supporting the operational running costs
• External communication
• Organize headquarters and field level review and learning workshops
• Adapt IFRC guidelines
• Extra office annexes to accommodate increasing needs for operational working spaces for the EVD Response Teams (LRCS)

Outcome 3: Safe and Dignified Burials (SDB) coordination -- National level SDB support is provided to national authorities for country-wide coordination and information management of the overall Safe and Dignified Burial and Infection of Houses response
Output 1: Establishment of SDB coordination and information management hub in Monrovia
Activities planned
• Recruitment of SDB coordinator and SDB information manager
• Contribute to national coordination of the SDB work performed by all partners involved in the Ebola response
• Identification of key partners
• Assessment of SDB needs and response
• Consolidate, review and disseminate current standards.
• Collect, analyse and present key SDB response information
• Reporting of SDB indicator progress to the UNMEER response monitoring dashboard

Early recovery
Outcome 4: Early recovery from the longer term-effects of the EVD outbreak is supported through livelihood, food security and health and sanitation activities
Output 1: The most vulnerable population affected by the direct and indirect effects of the outbreak are supported through livelihoods and food security related interventions
Activities planned
• Deployment of recovery delegate
• Rapid assessment and initial program planning
• Household economic survey and detailed assessments / plans
• Distribution of farming tools and supplies combined with necessary training
• Integration of early recovery into longer-term community resilience building
Output 2: Health risk management -- improved knowledge, attitude and practice of communities on prevention and control in health emergencies and provision of necessary water, sanitation and hygiene promotion services in six counties
Activities planned
• Conduct hazard and risk assessments and develop a community disaster risk reduction (CDRR) plan
• Train communities and volunteers in establishing community maps and identifying hazards and vulnerabilities
• Reactivate and train community-based risk reduction structures
• Community sensitization on measures to prevent and control disease outbreaks
• Train volunteers as hygiene promoters and conduct refresher training
• Conduct health and hygiene promotion activities in EVD affected communities (WASH)

Budget

See attached IFRC Secretariat budget for details. With the ERU component valued at some CHF 96,000, the total appeal budget is CHF 24.5m. With available resources of CHF 9.6m, the net appeal amount sought is CHF 14.8m.

Walter Cotte
Under Secretary General
Programme Services Division

Eljajd As Sy
Secretary General

Reference documents ↘

Click **here** for:

- Emergency Plan of Action (EPoA)

Contact Information

For further information specifically related to this operation please contact:

- **Liberia Red Cross Society:** Fayiah Tamba, Acting Secretary General. Phone +231 886 458 187; Email: tmbfayiah@yahoo.com
- **IFRC Liberia**: Mesfin Abay, Country Representative; Phone: +231 880 528 771; Email: mesfin.abay@ifrc.org
- **IFRC Ebola Coordination**: Birte Hald, Head of Emergency Operations, IFRC Ebola response, phone: +224 620100615 / +41 79 7084588, email: birte.hald@ifrc.org
- **IFRC DMU:** Daniel Bolaños, Disaster Management Coordinator for Africa; Phone: +254 731 067 489; Email: daniel.bolanos@ifrc.org
- **IFRC Geneva:** Cristina Estrada, Senior Officer, Operations Quality Assurance; Phone: +41 22 730 42 60; Email: cristina.estrada@ifrc.org
- **IFRC Zonal Logistics Unit:** Rishi Ramrakha, Nairobi; Phone +254 20 283 5142; Email: rishi.ramrakkha@ifrc.org

For Resource Mobilization and Pledges:

- **In IFRC Zone:** Martine Zoethouthmaar, Resource Mobilization Coordinator; Phone: +251 93-003 6073; email: martine.zoethoutmaar@ifrc.org

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

- **IFRC Zone:** Robert Ondrusek, PMER Coordinator; Phone: +254 731 067277; email: robert.ondrusek@ifrc.org

How we work

All IFRC assistance seeks to adhere to the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief and the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable. The IFRC's vision is to inspire**, encourage, facilitate and promote at all times all forms of humanitarian activities** by National Societies, with a view to **preventing and alleviating human suffering**, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

Liberia EVD - MDRLR001

28.11.2014

REVISED BUDGET

Budget Group	Multilateral Response	SDB Coordination	Bilateral Response	Appeal Budget CHF
Shelter - Relief	0	0		0
Shelter - Transitional	0	0		0
Construction - Housing	0	0		0
Construction - Facilities	0			0
Construction - Materials	0			0
Clothing & Textiles	19,460			19,460
Food	571,562			571,562
Seeds & Plants	100,000			100,000
Water, Sanitation & Hygiene	1,661,309			1,661,309
Medical & First Aid	3,767,465			3,767,465
Teaching Materials	28,800			28,800
Utensils & Tools	0			0
Other Supplies & Services	526,850			526,850
Emergency Response Units			96,000	96,000
Cash Disbursements	0	0		0
Total RELIEF ITEMS, CONSTRUCTION AND SUPPLIES	**6,675,446**	**0**	**96,000**	**6,771,446**
Land & Buildings	1,475,520			1,475,520
Vehicles Purchase	518,000			518,000
Computer & Telecom Equipment	234,350	4,000		238,350
Office/Household Furniture & Equipment	176,000			176,000
Medical Equipment	0			0
Other Machinery & Equipment	0			0
Total LAND, VEHICLES AND EQUIPMENT	**2,403,870**	**4,000**	**0**	**2,407,870**
Storage, Warehousing	62,500			62,500
Distribution & Monitoring	70,000			70,000
Transport & Vehicle Costs	1,315,400	18,000		1,333,400
Logistics Services	201,400			201,400
Total LOGISTICS, TRANSPORT AND STORAGE	**1,649,300**	**18,000**	**0**	**1,667,300**
International Staff	2,412,000	144,000		2,556,000
National Staff	0			0
National Society Staff	2,256,295			2,256,295
Volunteers	4,171,340			4,171,340
Total PERSONNEL	**8,839,635**	**144,000**	**0**	**8,983,635**
Consultants	181,000			181,000
Professional Fees	40,000			40,000
Total CONSULTANTS & PROFESSIONAL FEES	**221,000**	**0**	**0**	**221,000**
Workshops & Training	1,253,580			1,253,580
Total WORKSHOP & TRAINING	**1,253,580**	**0**	**0**	**1,253,580**
Travel	62,600	20,000		82,600
Information & Public Relations	710,000			710,000
Office Costs	439,400	30,000		469,400
Communications	206,635	12,000		218,635
Financial Charges	255,500	2,000		257,500
Other General Expenses	1,040			1,040
Shared Support Services	23,811			23,811
Total GENERAL EXPENDITURES	**1,698,986**	**64,000**	**0**	**1,762,986**
Programme and Supplementary Services Recovery	1,478,218	14,950		1,493,168
Total INDIRECT COSTS	**1,478,218**	**14,950**	**0**	**1,493,168**
TOTAL BUDGET	**24,220,035**	**244,950**	**96,000**	**24,560,985**
Available Resources				
Multilateral Contributions	9,604,137			9,604,137
Bilateral Contributions			96,000	96,000
TOTAL AVAILABLE RESOURCES	**9,604,137**	**0**	**96,000**	**9,700,137**
NET EMERGENCY APPEAL NEEDS	**14,615,898**	**244,950**	**0**	**14,860,848**

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Emergency Plan of Action (EPoA) Revision
Liberia: EVD Outbreak

International Federation of Red Cross and Red Crescent Societies

Emergency Appeal n° MDRLR001	**Glide n°** EP-2014-000039-LBR
Appeal launch date: 30 April 2014; Revised on 28 November 2014	
Operation manager (responsible for this EPoA): Peter Schleicher	**Point of contact:** Precious Dennis, Programme Focal point, Liberia Red Cross Society.
Operation start date: 9 April 2014	**Expected timeframe:** 15 months (End date: 30 June 2015)
Overall operation budget: CHF 24.5 million	
Number of people affected: Country population at risk	**Number of people to be assisted:** 3.8 million
Host National Society presence (n° of volunteers, staff and branches): 3,800 volunteers and 75 staff from Liberian Red Cross Society (LRCS) with present additional ongoing recruitment, all of the country's 15 Chapters/Counties are now actively involved in the Ebola intervention. This revised EPoA covers all the 15 counties.	
Red Cross Red Crescent Movement partners actively involved in the operation: ICRC, Danish Red Cross and Spanish Red Cross.	
Other partner organizations actively involved in the operation: Ministry of Health and Social Welfare (MOHSW), Ministry of Internal Affairs (MIA), World Health Organisation (WHO), UNICEF, Centre for Disease Control (CDC), Médecins Sans Frontières (MSF) and Samaritan´s Purse, Semi Darby and Global Communities.	

Summary of major revisions made to emergency plan of action:

The Ebola virus disease (EVD) Emergency Plan of Action and corresponding appeal for Liberia was initially designed for a six month implementation period, with a budget of CHF 517,766. It has since been revised twice; firstly in July to a budget of CHF 1.9 million for a period of 9 months; then in September by further extending the timeframe to 15 months until June 2015 with a budget of CHF 8.5 million. This current revised plan reflects another increase in the scope and cost of the operation to CHF 27.8 million for the same timeframe of 15 months, up to 30 June 2015 with an enlarged geographic area (from 12 to 15 counties) and additional response components - home-based protection and early recovery. This re-adjustment has been necessary to meet the increased needs created by the further spread of the disease since the last revision process.

Following the decision of the IFRC to take a lead role in Safe and Dignified burials coordination support to national authorities, the revised plan includes a SDB coordination function, separated from the operations implementation team but reporting to the IFRC country representative.

The Liberia Red Cross Society (LRCS), with support of the IFRC operations team, increased the number of volunteers active in this operation to 3,800 with 2,500 for social mobilization, 800 for contact tracing and 500 for psychosocial support, where there is a huge gap because of the grief and trauma situation in the counties. The number of Safe and Dignified Burial (SDB) and disinfection teams have also had to be increased to meet the increased needs brought by the surging death toll. The LRCS operations capacity has been enhanced by recruiting a national coordinator for EVD and three key staff members, 15 health officers (nurses, PAs), 12 psycho-social counsellors, 5 regional focal persons. LRCS field staff have been increased to manage the response - 10 supervisors for 15 chapters, 12 psychosocial support (PSS) counsellors in additional 12 chapters and 12 health officers in 15 branches and additional support staff will be recruited to cover all 15 counties. The field officers (FOs) will actively support operations in these counties along with project/programmes staff in the respective 15 counties. There is ongoing recruitment of additional staff for the EVD operations at all levels in the 15 counties, which will ensure implementation of the EPoA. The operation continues to receive support of the LRCS health and care, disaster management teams and the head of programmes, ensuring quality implementation in collaboration with the international staff deployed to the country.

To assess and address longer-term needs created by EVD, the LRCS intends to conduct a recovery assessment in six targeted high-risk quarantine counties. The assessment will inform the strategies for engaging in the **recovery phase** of the operation. This revised plan of action integrates new sectoral activities such as the provision of **community-based**

protection kits. The protection kits component is being piloted by the LRCS/IFRC in collaboration with UNICEF to contain the disease and reduce the level of infection amongst communities. In addition, the revised EPoA considers scaling-up in all sectors/components to for rapid response in the event of a likely escalation of the EVD outbreak.

As the epidemic evolves, small pockets of infection in remote communities add to those appearing in larger urban areas. A flexible approach to address cases quickly is needed. To deal with this dynamic, the LRCS and IFRC, in partnership with UNICEF, are rolling-out a three-tiered program of infection, prevention, and control (IPC) and care options by providing training on IPC supplies to help enable safer isolation and community-based home protection for persons suspected to be infected with EVD. The programme is a measure of last resort when no available isolation facilities are available and is aimed at protecting households until patients can be transferred. The community-based protection programme will be targeting 'hot spot' locations, identified through available data and where LRCS has been conducting social mobilisation and psychosocial support (PSS) activities. The community-based protection is based on a model initially developed by WHO and CDC, with support from UNICEF, and has been validated by the Ministry of Health and Social Welfare (MoHSW) to be implemented by available partners.

LRCS and IFRC are aware of the risks health involved in delivering this training; therefore skilled, registered nurses have been employed as Health Officers in every LRCS chapter in each county as the focal points for this programme. Mass distribution of the protection kits at household level is not possible; instead agreements will be made with each designated community using existing structures to train a small number of people - preferably with a relevant prior health programme background. The kits will be strategically placed in chapters and branches to be released once the community alerts of a symptomatic sick person. Additionally, in high incidence and/or remote areas, a small number of kits will be kept at the community level in the care of the chief. The revised appeal incorporates the emergency community-based response project that supports the affected communities (high risk and quarantine) EVD in three counties (namely Montserrado, Bong and Margibi) as a pilot. This emergency community-based response project has already been successfully implemented by LRCS/Danish Red Cross in three counties (Lofa, Bong and Nimba).

The revised appeal also integrates the strengthening of the National Society's institutional and operational capacity, to meet the challenges ahead including over the recovery phase of the operation.

<Click **here** to see the budget for details and **here** for the contact details>

A. Situation analysis

A.1 Description of the disaster

Since March 2014, an outbreak of Ebola Virus disease (EVD) in West Africa, affected Guinea, Sierra Leone and Liberia. The first cases of EVD were acknowledged in Liberia in March, 2014. Although a time span of double the 21-day incubation period after the cases in April was recorded, which would normally indicate the end of an outbreak, the alert in Liberia was maintained as the situation in Guinea was not yet under control and the situation in Sierra Leone was fast developing. At the beginning of June the second phase of the EVD outbreak surfaced in Liberia initially with a few cases, which spread to Lofa, Montserrado and later Margibi. The disease has since spread to all the 15 counties of Liberia. The caseload quickly increased with a cumulative total of more than 6,856 cases and more than 1,179 deaths in the country by the end of October 2014.

The outbreak in Guinea, Sierra Leone and Liberia, follows a similar pattern, and the response of the affected population is characterized by fear, stigma, denial, ignorance and low knowledge of the disease. The increasing number of deaths has already exceeded the MoHSW's capacity to manage safe burials in a timely and dignified manner: Some families have waited for up to three days for the bodies of their deceased relatives to be taken away and properly buried, at the time when these bodies present the most risk for contagion. The risk of contamination is very high at traditional burials where relatives touch and wash the body of the deceased family member and then share a meal together. Proper supervision of safe burial practices, accompanied with active education, awareness activities and engagement from community opinion leaders is high priority to reduce the risk of transmission during burials. In several cases the families and communities are still in denial and refuse any contact. Insufficient lab testing capacity still creates the additional challenge of bodies not being tested for EVD, and therefore not considered as contagious and handled accordingly. This tends to increase infections because people are not quarantined and have no information on tests done on the deceased. The LRCS signed a MoU with the MoHSW on 23 July, 2014, to coordinate the burial activities in Montserrado where deaths are highest.

The MoHSW with support from its partners has four EVD treatment units (ETUs) available for infected patients in Montserrado County in addition to one holding and community care centre. Lofa is where the first ETU centre was established and presently there is an ETU in Bomi, Nimba, Bong and holding centres in Grand Bassa and Margibi. There is need to construct additional holding centres and ETUs in the 15 counties by MoHSW and other partners. These facilities will accommodate reported cases at their various locations. In Montserrado, the current epidemic centre there is still need for additional ETU. It also appears that the homes of many confirmed cases are not being disinfected, which has to be done to eliminate risk of further contamination of other community members. It is also important to provide support to those whose possessions have to be destroyed as part of the decontamination procedure. LRCS and ICRC are piloting a project to replace items that are disinfected, disposed and burnt by the burial teams.

WHO, USAID and CDC have provided substantial amounts of protective materials to the MoHSW while additional personnel have arrived and more is expected in the country. MSF has over 50 expatriates in Lofa and in Montserrado for the time being assisting primarily case management within the treatment centres. MSF will offer LRCS/IFRC SDB trainings and refresher training. The WHO is providing a number of experts to reinforce the intervention and coordination in Guinea, Sierra Leone and Liberia.

Health ministers and technical staff from 11 countries, representatives from IFRC, MSF, WHO and key international partner organizations attended an emergency ministerial meeting held in Accra, Ghana between 2 and 3 July 2014 to address the ongoing EVD outbreak in West Africa. After updates and country and field experiences were shared, they agreed on a strategy for *an accelerated operational response to control the outbreak*. Since then, WHO has opened a regional coordination hub in Conakry, Guinea and urged governments to work with religious and community leaders to improve awareness and understanding of EVD.

A.2 Summary of current response

Overview of Host National Society
A total of CHF 150,000 from the IFRC Disaster Relief Emergency Fund (DREF) was provided to LRCS to undertake preparedness, social mobilization and contact tracing activities. This allocation was converted into an Emergency Appeal operational start-up loan on 30 April, 2014 when the initial Emergency Appeal was launched. A health Field Assessment and Coordination (FACT) team member deployed by the IFRC arrived in Liberia on 3 April, later providing surge support to start the operation. The team was composed of specialists in health, logistics and PSS. The IFRC team has since been providing support to LRCS to assess, coordinate and implement the response.

Since the alert that suspected cases may have crossed the border, LRCS coordinated its response with the MoHSW and provided more than 150 personal protective equipment (PPE) kits to the authorities. The LRCS also provided 13 PPE kits to the international airport upon request whilst the IFRC has provided the National Society with 3,000 plus PPE kits. LRCS further donated: 3,400 gloves, 2,280 masks, 4,000 aprons, 900 PPE gowns, 15 drums of chlorine, 35 megaphones, megaphone batteries, buckets, 25 spray cans and 6 cartons of hand sanitizer. LRCS with support from partners continues to make donations when necessary.

The National EVD Task Force, of which LRCS is a member, convenes to share information and coordinate the response. A joint assessment team, which included WHO, MoHSW and United Nations Mission in Liberia were deployed to Lofa County to assess the magnitude of the cases and determine existing capacities and capabilities. The authorities pledged to provide logistical support and assured the counties and partners of its commitment, which helped to alleviate health workers' fears. County coordination meetings continued in Margibi, Lofa, Bong, Nimba, Montserrado and now all the 15 counties where there are now 15 national officers who are technical assistants to the county health team (CHTs) including WHO staff who were deployed to Lofa, Montserrado and other counties to support coordination, surveillance and health promotion efforts of the counties. The authorities plan to:

- Mobilize resources to scale-up surveillance and social mobilization/health promotion activities including schools, religious gatherings, market places and work places;
- Continue training of health professionals in targeted 15 counties;
- Alert major health centres, hospitals in Montserrado and other counties bordering Guinea to identify isolation units and medical staff;
- Urgently procure and supply health facilities with PPE;
- Mobilize resources to support PSS and contact tracing and follow-up activities in counties reporting contacts.

LRCS county level chapters are part of the EVD coordination meetings organized in their respective counties with CHTs and partners. On 1 April, the MoHSW formally requested LRCS to lead on awareness and social mobilization campaigns at the county level due to its large team of volunteers on the ground. A further meeting was held with the MoHSW in which assistance was requested for volunteers to support contact tracing and PSS activities in all response counties where necessary.

The LRCS is complementing the efforts of local authorities by implementing an operation in 15 counties with holistic approach to activities that include awareness raising, social mobilisation, contact tracing, PSS, and with specific focus on SDB only in Montserrado. Recently, the NS is piloting the community-based protection in collaboration with UNICEF and plans to support children orphaned by EVD, with provision to targeted beneficiaries victims and survivors. The LRCS EVD plan covers the 15 counties of Liberia addressing the immediate priorities needs of intervention during the outbreak. Internally, the LRCS chairs regular coordination meetings attending by in-country partners: Danish, German, IFRC and ICRC.

Overview of Red Cross Red Crescent Movement in country
IFRC Country Representation continues supporting LRCS organizational development, backed by the IFRC West Coast Regional Representation office based in Abidjan, Cote d'Ivoire. The EVD operational is managed by an in-country operational team of international and national staff with technical support of the EVD regional coordination team in Conakry, Guinea.

The IFRC supports LRCS participation at coordination meetings held at the WHO, MoHSW and Ministry of Internal Affairs (MIA) offices. Internally, the LRCS chairs regular coordination meetings attending by in-country partners: Danish, German, IFRC and ICRC. Bilateral support is provided by Canadian, Danish, Japanese and Spanish Red Cross in EVD operation and other long-term developmental projects. The German Red Cross completed carrying out an assessment with a view to set up ETUs and have confirmed running and establishing an ETUs at the National Samuel K. Doe sports (SKD) complex in Monrovia, Montserrado County. A MoU has been signed between the MoHSW, LRCS, IFRC (for coordination) and the German Red Cross.

The initiatives of ICRC are highly relevant and coherent with IFRC EVD PoA, which include support to MoHSW with technical experts, logistic and administrative aspects of Safe and Dignified Burials (SDB) at jurisdiction level. ICRC is also collaborates with MSF in supplying food items at the ETUs and with LRCS in running an interactive hotline on PSS in Montserrado. WHO, USAID and CDC donated to the MoHSW and the county health teams (CHTs) substantial amount of protective materials and technical personal; more is expected. MSF has transferred staff to Liberia with more than 50 expatriates deployed in Lofa and in Montserrado primarily assisting in case management within the treatments centres. MSF will also offer LRCS/IFRC SBD trainings.

Overview of non-RCRC actors in country
The LRCS has the support of in-country partners/donors such as SIME Darby, Exxon Mobil and French Companies, UNICEF, Swiss Government, and Global Communities. Recently the sister national society – the Botswana Red Cross donated five land cruisers in support of the operation. A memorandum of understanding (MoU) has been signed with UNICEF for delivery of 10,000 community care kits, to be delivered to designated LRCS Chapters and warehouses.
As of 1 November, the IFRC SDB office took over all the previously rented cars from Global Communities and the vehicle owners have signed a two months contract. IFRC/LRCS will be responsible for managing the use of the vehicles.

The Red Cross is providing leadership on SDB in standardisation, information management and coordination as guided by the UN Mission for Ebola Emergency Response (UNMEER). This is the first-ever UN emergency health mission, set up in response to the unprecedented EVD outbreak; prioritising prevention, treatment and provision of essential services. The WHO is responsible for overall health strategy and advice within the Mission, while other UN agencies will act in their area of expertise. The Mission works closely with governments and national structures in the affected countries, regional and international actors to ensure a rapid, effective, efficient and coherent response to the crisis.

The lead agency role in SDB taken up by the IFRC during the UNMEER Accra conference October 15-18, entails a responsibility to convene agencies working on SDB, to map the response, identify gaps, agree on common protocols and good practice, provide guidance, carry out advocacy, define what constitutes appropriate response and develop a common strategy. It will ensure that information management is well-coordinated as well as response at country level and an overview of who-does-what-where-and-when. Agencies involved in SDB are not subordinate to the IFRC, as it will act merely as convener or facilitator of consensus- based processes amongst all those responding. The EPoA includes a two

person team (SDB coordinator and IM) dedicated to this function at country level, reporting to the IFRC country representative.

The National Society participates in the daily coordination meetings in response to epidemics attended by other actors' present in-country at the WHO, MOHSW and Ministry of Internal Affairs (MIA) offices. The WHO, USAID and CDC donated to the MoHSW and the county health teams (CHTs) substantial amount of protective materials and technical personal; more is expected. MSF has transferred staff to Liberia with more than 50 expatriates deployed in Lofa and in Montserrado primarily assisting in case management within the treatments centres. MSF will also offer LRCS/IFRC SBD trainings.

A.3 Needs analysis and scenario planning

Needs analysis:
Initial needs assessment identified that Red Cross could provide added value and expertise in social mobilization and awareness, contact tracing and in working with the communities affected to reduce stigma and fear through PSS intervention/approach. The LRCS/IFRC response operation aims to help increase knowledge and awareness about the disease, its mode of transmission, promote behavioural change and to strengthen the capacity of volunteers actively involved in the operation. It is necessary to scale up social mobilization and awareness-raising within the affected counties, with strategies adapted for the urban and rural areas respectively. The Government of Liberia has requested LRCS to scale up its SDB activities in Montserrado to reduce risk of Ebola transmission. There is also a need to scale-up specifically in the area of contact tracing to reduce secondary infections. The need for PSS cannot be overemphasized because of the grief and trauma experienced in affected families and communities. The operation also needs to strengthen activities related to anti-stigma and psychosocial support provided by trained volunteers and counsellors.

With the EVD situation evolving, there is a need to start transitioning into an early recovery phase to address the immediate post disaster needs of affected families. Consequently the LRCS/IFRC have increased the scope of operations to include activities meant to recover household economic security, health risk management, community cohesion as well as strengthening health systems. Initially six counties are targeted under early recovery and adjustments will be made based on further developments and findings of a more detailed assessment. The NS has also decided that all existing projects should integrate/mainstream EVD awareness and prevention activities as a cross cutting intervention. The revised appeal also integrates the institutional and operational capacity strengthening of the LRCS to address the challenges of scaling up its present operations and its post emergency sustainability.

The early recovery component will build on the existing emergency programme ensuring a phased approach on risk reduction and building resilience. The strategy to meet immediate needs of the communities will be informed by a Household Economic Security (HES) assessment, complemented by an Emergency Market and Mapping Analysis (EMMA). The LRCS has projected the needs to help families recover household economic security, community cohesion, health risk management and strengthened health system.

It can already be induced that there is significant risk that food insecurity will increase post EVD epidemic. The farming season has been severely disrupted by the outbreak due to fear, weakened labour force and death of heads of households. These severely affected communities in EVD affected counties will require agricultural inputs and materials to revamp small income generating activities and food items where necessary as advised the HES.

Risk Analysis
There is risk that Red Cross staff and volunteers operating in affected communities will come into contact with cases and could contract the disease. The IFRC's global volunteer insurance only provides coverage in case of accidents, and does not include epidemic coverage. However, IFRC has put in place a compensation policy for the LRCS' volunteers involved in the operation. Due to the highly contagious nature of the disease, a priority for Red Cross Movement partners is supporting the LRCS to protect volunteers while managing patients and during SDB activities.

Beneficiary selection
In the initial phase the LRCS focused the response in the counties affected by the epidemic including Lofa, Montserrado, Margibi, Bong and Nimba. As the second phase evolved by the beginning of June to date, additional counties were included: Cape Mount, Gbarpolu, River Cess, Grand Bassa, Sinoe, Bomi and Nimba due to their vicinity to Sierra Leone and Guinea and also the movement of people. Presently this revised appeal covers the 15 counties because of the spread of the EVD in these locations.

At present Lofa, Cape Mount, Montserrado, Margibi, Bong, River Cess, Grand Bassa, Sinoe, Nimba, River Gee, Bomi Gbarpolu, Grand Gedeh, Grand Kru and Maryland are considered all response counties. The beneficiaries have been identified as:

- At-risk population, general social mobilization and awareness raising
- Families and individuals having been in close contact with an EVD patient, likely to develop EVD
- Families and individuals directly affected by EVD, either by death, survival, orphans or suspected case proved negative for EVD and therefore discharged from treatment unit
- Families of deceased in terms of SDB and disinfection – safe burials.
- Protection kits package for quarantine, affected communities, difficult to reach ETUs/CCCs /holding centres

B. Operational strategy and plan

Overall objective: Contribute to the eradication of mortality and morbidity related to the EVD in Liberia through;
(1) Raising awareness through messaging and social mobilization,
(2) Providing PSS to those affected,
(3) Assisting the community health teams (CHTs) in contact tracing
(4) Assisting the national authorities in SDB and disinfections
(5) Providing community household protection kits and community based EVD emergency activities
(6) Addressing longer-term needs created by the disease by developing and implementing recovery programming for survivors

Proposed strategy

To ensure the success of this operation, LRCS has developed strategies and continues to improve them in order to achieve the following results:

1. Train volunteers on EVD prevention, social mobilization skills, hygiene promotion and proper utilization of personal protective equipment.
2. Promote health in the community through a communication campaign to mobilise and educate communities regarding the EVD, and reduce stigma.
3. Support community-level committees in the coordination and supervision of activities
4. Provide training and support to volunteers in case identification, referrals and contact tracing.
5. Support the MoHSW/MIA with services including SDB, cremation and disinfection of households
6. Support trained counsellors to provide psychosocial support and conflict/trauma resolution, monitor and evaluate the impact of response activities
7. Strengthen capacity of the LRCS in the management and control of epidemics
8. Pilot the community-based protection approach, ensuring proper and safe care is given to the sick pending availability of bed space in the treatment centres or community care centres while also ensuring safety of the family and community members.
9. Conduct assessments to identify the broader impacts of the disease on livelihood and economic security, and develop recovery programming aiming to mitigate these effects.

All community-based activities are coordinated with MoHSW, MIA and WHO. It is important that the clinical services provided by MoHSW are supplemented by high levels of community engagement which is important for early case identification, isolation, contact tracing and follow up. LRCS is in a good position to support community-based activities with volunteers already in place within the affected counties. It is also important that communities participate in social mobilization and organise their own taskforce groups to complement the efforts of the government and other partners in stopping the spread on EVD.

In line with the authorities' plans, the LRCS plans to provide direct financial and emergency items support to affected families. Suspected cases in isolation with limited access to markets will receive a food basket and basic non-food items. Families who have lost belongings due to disinfection activities will receive a cash grant or in-kind replenishment of the lost belongings.

Psychosocial support (PSS) strategies

The PSS plan of action builds on the activities already in place. Considerations have been given based on the mapping of MHPSS[1] 4Ws[2] to avoid duplication of efforts and resources. PSS activities implemented by IFRC/LRCS Ebola operation team are as follows:

1. Enhancing the capacity of the PSS counsellors in county level;
2. Enhancing the PSS activities in county level;
3. Psychosocial support for the SDB team
4. PSS staff support at the headquarters LRCS
5. Enhance PSS through the public mobile hotline:
6. Contribute to the coordination of the nation-wide PSS activities.
7. Enhance PSS support through TOT PSS training to increase PSS staff and volunteers

PSS has been identified as a priority, and LRCS has identified 12 trained counsellors with experience working with individuals and communities in conflict resolution and trauma deployed in Lofa, Montserrado, Bong, Margibi, Bomi and now Grand Bassa, River Cess and Cape Mount. These counsellors are based at the county-level branches to provide PSS to volunteers and their families, training volunteers and working with the communities to minimize fear, stigma denial and mitigate potential conflict. The counsellors are supervised by a trained officer, whilst the PSS contact persons at NHQ coordinates activities in all counties reporting to the National coordinator. The NS has also recruited contact persons for social mobilization and contact tracing, five regional persons for household protection also supervised by national coordinator.

EVD Recovery Phase

The impact of the epidemic will be far reaching, and while response to end the epidemic is still scaling up, steps need to be taken now to assess the impact and planning should begin in the coming weeks. Some counties have already seen a steep decline in cases, and so these counties may be ready for recovery to begin sooner, keeping in mind the unpredictable nature of this outbreak. It's important that the epidemic is taken county by county and response design based on the case loads in each area. Due to the mobility of the population in the affected areas, it is to be noted that the potential disappearance of cases in one area does not mean that resurgence will not occur again, thus, branches need to be ready for response even if recovery efforts have started.

Going forward, IFRC will also focus on assessing economic and food security impact; the health care system and the trust in health care workers (HCW), as this will greatly affect health seeking behaviour; the impact on family dynamics and child care practices, which is key given the large amount of inter-household transmission that has occurred.

While the situation has only allowed for limited recovery assessment and planning, as all attention is directed towards responding to the immediate threats of the epidemic, the operational plan includes a number of initial activities have been planned, including a recovery delegate recruitment in order to have the necessary assessment and planning capacity available as soon as the situation allows.

Livelihoods and food security: Household economic and food security support is aligned with the LRCS regular programmes with the aim to restore and build sustainable community resilience. An integrated and community-based programming approach forms the basis for the initiative with health and WASH as entry points to the community. Livelihood and food security are some of the key concerns. The recovery component will succeed the emergency phase through a phased approach to ensure continuity of actions towards building community resilience. The immediate needs of the communities will be decided from Household Economic Security (HES) assessment as it is currently difficult to measure the impact of the EVD in the counties, though some activities could be projected based on the assessments already carried out. Community cohesion and the mitigation of community tensions run throughout the programme to ensure that we do not initiate damage.

There is significant risk of a looming food insecurity situation. Some communities will need inputs for the 2015 farming season as they missed the food production season because of fear of EVD coupled with deaths from EVD. Other people

[1] Mental Health and Psychosocial support (MHPSS)
[2] 4Ws – Who is doing What, Where and When

have migrated for fear of being stigmatised. Land disputes may arise due to people claiming their deceased relatives' land. The NS will target the counties most severely affected by EVD. The focus will be to provide the inputs to farmers based on the HES assessment results.

Health and Care recovery: The severity of the EVD outbreak has led to the closure of many health facilities and a general loss of trust in health care. In most of the counties, only the capital city's health facilities are opened but in the rural areas major facilities are still closed because of fear and inadequate materials /equipment supplies (PPE etc.). While it is still early to come to a definitive conclusion on the impact of the EVD on the overall health situation in Liberia, it is already clear that the impact on an already fragile system will be significant. The LRCS/IFRC plans to conduct an assessment looking at all health-related components, including the CBHFA approach in order to inform the health strategy as well as the health risk management component under the recovery phase.

The EVD outbreak has aggravated existing health issues. Other diseases such as malaria, diarrhoea and need for under five immunisation still exist, but communities no longer trust the health authorities to seek treatment or taking children for vaccinations. As a result maternal mortality is rising because pregnant women prefer giving birth in the community with help from trained traditional midwives rather than going to available health facilities where available. In other instances pregnant women in some communities are calling for help when in labour but die while waiting for the ambulance or health assistance. These are factors that will be considered during the recovery phase; at this point the need to empower communities and re-establish trust and link with health facilities is a priority.

The LRCS promotes community-based approach in health and care programming where it has been recognized that community involvement in preventing spread of EVD is crucial. This can be achieved through effectively building communities capacity, ensuring full participation and ownership (using the CBHFA approach) in order to increase resilience and preventing future outbreaks. The need for WASH facilities should not be overlooked because the EVD situation has resulted in many organizations in the WASH sector diverting funds to response operations and left targeted communities with WASH needs largely unattended. During the recovery phase, the LRCS hopes to provide WASH facilities in six targeted counties, with high-risk and quarantined EVD affected communities.

Operational support services

Human resources

LRCS has mobilized 2,900 volunteers to date and will continue scaling up to reach 3,800 supporting supervisors, health officers and psycho-social counsellors to carry out the activities outlined in this revised Appeal. Additional staff will also be required to monitor the implementation of the operation. Two PMER officers and two communication officers have been recruited. The number of national staff has been increased to 11 health officers, 16 PSS counsellors, 10 supervisors, 1 National coordinator, 2 HR volunteers, 2 finance officers, 2 store keepers, 1 fleet supervisor, 20 drivers and ongoing recruitment for positions identified in this revised appeal to achieve specific planned indicators.

The number of international staff (IFRC delegates) has been increased to include: An Operation Manager, 4 Emergency Health Delegates, 1 ERU-Health, 1 Logistics Delegate, 1 Communications Delegate, 2 PSS Delegates, 1 Finance Delegate, 1 Coordinating SDB Delegate and 1 IT/Telecoms Delegate. A Recovery Delegate will be recruited in the next phase of the operation and has been included in the budget. Human resources for Ebola coordination, support services, institutional learning, cross-border collaboration and programme guidance will be managed by the IFRC Ebola coordination function in Guinea under the IFRC Ebola coordination and preparedness appeal (MDR60002). Since the Ebola coordination function is a temporary set-up, an operations coordinator in the IFRC regional office is supported under this emergency appeal to ensure transition from the temporary set-up into regular IFRC structure and coherence with other disaster management programming in the affected countries.

The operation will cover LRCS staffing costs of core staff with dedicating time to the EVD operational planning and implementation. This includes six to eight months support of the LRCS finance controller, head of programmes, PMER coordinator and warehouse supervisor and eight months support of 12 field officers or equivalent Chapter Ebola coordinators where relevant, four district supervisors in Lofa and two in Montserrado, four Chapter health officers and seven PSS counsellors. There is approximately 75 national staff presently working in the operation with some recruitment ongoing as needed. Drivers have been hired for the additional vehicles rented through the IFRC Vehicle Rental Programme. At LRCS headquarters a national EVD coordinator hired as well as an assisting officer to support the coordination between the field and headquarters. The NS Ebola Coordinator works in coordination with the IFRC operations manager. An HR assistant has also been assigned fully to the Ebola operation.

At branch level, the Chapter Emergency Response Teams consist of a Field Officer responsible for the Chapter or an equivalent EVD Chapter coordinator, a PSS counsellor and a health officer. In Lofa and Montserrado there are two counsellors, two health officers and the volunteers. The teams will work closely with the MoHSW county health teams and other organizations where relevant. All activities will be coordinated with the CHTs.

Logistics and supply chain

The PPE kits are being procured by IFRC to ensure they meet the necessary standards. All other necessary items will be procured locally. IEC materials are being reproduced from messages prepared by the IFRC in response to the outbreak and will be printed locally.

The fleet used for this operation will be increased as cases spread into all counties of Liberia and the increased need in the SDB of the operation. There is a combination of vehicles already available with the LRCS and the IFRC Country Representation and vehicles acquired specifically for this operation. In addition to the vehicles available, more vehicles are being hired locally for the targeted chapters and additional vehicles will be leased through the IFRC Vehicle Rental Programme (VRP) for the SDB activities.

IFRC will be supporting the National Society to specifically strengthen the warehousing process and procedures to support in the safe storage of personal protective equipment through the support of the Logistics delegate and warehouse supervisor.

A new operational base for the SDB component is being acquired for effectiveness and efficiency as the number of teams and logistics increases. With the increase in the number of personnel (international and national), the operation is expanding the EVD operational base at the LRCS headquarters, which will also contribute to the strengthening of the National Society's institutional capacity. There is a need for extension of existing structure at headquarters, which will promote a more conducive healthy working environment with adequate space; the revised appeal incorporates consideration of an extension of the structure.

Communications

Visibility of the work of the LRCS volunteers will continue to be ensured during the operation through local media and visibility material. The National Society's management team will also periodically inform the authorities and public regarding the progress of the operation. Meanwhile, IFRC has prepared a fact sheet and identified spokespersons for media interviews, with the aim of providing regular updates on the operation.

The LRCS, with support from the communications delegate, IFRC regional and zone communications teams, aims to coordinate various awareness and publicity activities, to sensitize the public, media and donors on the situation on the ground and the humanitarian response. The communications activities will be used to support the implementation of the advocacy plan with the authorities to position the LRCS as the principal humanitarian organisation in the country whilst advancing the operation to meet the needs of affected people.

Activities to date include; identifying and updating qualified IFRC and National Society spokespeople and sharing with media; producing facts and figures, key messages, questions and answers, press releases and web stories; conducting media interviews with print, television, radio and on-line organizations.

Planned Activities

- Support the LRCS in the development and maintenance of an advocacy plan, working with the MoHSW and other partners, to help advance the emergency operation in a manner that will best meet the needs of those affected and those at risk.
- Hire photographer/videographer consultant to produce high quality photographs with extended captions, and video b-roll and interviews of operations.
- Hold press conferences, either in Liberia, Abidjan, Dakar or Geneva as warranted.
- Produce weekly facts and figures, key messages and reactive lines and share with relevant stakeholders, including beneficiaries and partners.
- In collaboration with programmes, work on advocacy messages to address issues linked to the outbreak, in Liberia and the region (protection, prevention, fear and stigma).
- News releases, fact sheets, videos, photographs and qualified spokespeople contacts are immediately developed and made available to media and key stakeholders.

- Proactively engage with international media regarding the added value of Red Cross interventions.
- Facilitate media field trips to raise awareness among stakeholders and to raise the profile of the LRCS and IFRC.
- Maintain a social media presence throughout the operation utilizing IFRC sites such as Facebook and Twitter.
- Set up beneficiary communications system in the NS
- Support the launch of this appeal and other major milestones throughout the operation using people-centred, community level diverse content, including web stories, blogs, video footage and photos with extended captions. Share any communications material created through this appeal with IFRC for use on various communications channels including the newly launched IFRC Africa web page, www.ifrc.org/afrique and www.ifrc.org/africa
- Provide the National Society communication team with communication training and appropriate equipment as needed (still and video cameras).

With challenges faced in telecommunications as some of the communities lack good telephone network, IFRC is supporting LRCS in reactivating its VHF radio communication at the headquarters and in all the chapters.

Beneficiary Communication - Community Engagement

Beneficiary Communication and Community engagement is a core activity and encompasses the way in which we work with communities to implement all pillars. Community engagement entails beneficiary communication and social mobilisation activities and comprises behaviour change communication and health education, utilizing a PSS approach.

It ensures participation that extends beyond acceptance and knowledge and guaranties that this knowledge is turned into action and acceptance. It is targeted on risk factors and focuses on two-way communication with those most affected, be it through a sick person in the family, the death of a family or community member, the admission to an ETC or the notification of being a contact.

This component focuses on establishing systems that allow communities to voice their needs to assist in reducing fear and rumours and raises awareness. Efforts are directed towards effective and sustained two-way communication and engagement with beneficiaries, as the most effective mean to tackle the disease and build collective trust, confidence and a lasting community understanding of how to prevent and control Ebola.

The strategy entails a mix of communication channels, which includes radio programming, SMS messages, distribution of posters and leaflets and door-to-door visits in communities.

Community based solutions to how we conquer Ebola are at the forefront of the response. As much as we try to provide solutions, it will be the communities who are the main implementers and will play a joint role as frontline responders. Establishing processes within established communication networks and communities that allow the population to clearly voice their understanding of the issues and provide feedback will build stronger trust and a more community led solution.

Approaches that emphasize community strengthening and participation, as well as partnership building between communities and participating agencies have proven to be more effective than top-down communication interventions. These approaches go beyond educating people about health risks. They facilitate local dialogue and relationships that empower people to abandon unhealthy traditional practices and harmful norms, building more community resilience to respond to the impacts of disease outbreaks.

Embedded in the SDB Teams will be a Beneficiary Communication /Community Engagement (BC/CE) volunteer tasked with the process of engaging with the community during the body removal process. The BC/CE volunteer will utilize the time during the process to talk with the community about their understanding of the SDB process, their understanding of Ebola in general and answer any questions the community members may have. There will also be an opportunity to provide IEC materials. The BC/CE volunteer will also be tasked with gathering information using a set of questions within the RAMP system, a mobile phone data-gathering tool. The information will allow the RC to gatherer information that will allow us to assess the current situations and perceptions in the communities as well as gathering data about the family and the affected person. The process will strengthen our accountability to the community and families by providing save and dignified burials and through the collection of data enable us to provide information relating to the affected persons status of Ebola and location of burial.

Security
The EVD outbreak has exacerbated already weak economic conditions in Liberia contributing to underlying instability. A security support mission was recently completed with a view to updating and strengthening the in-country security framework. With support from the Regional Security Delegate, security risks will continue to be monitored and responded to accordingly. IFRC works closely with both the LRCS and the ICRC on issues concerning security. There is some risk that RC/RC staff or volunteers operating in affected communities may come into contact with EVD cases. Given that the IFRC's global volunteer insurance excludes coverage of diseases such as EVD, the IFRC and LRCS are currently looking at complementary local insurance cover for both staff and volunteers.

Planning, monitoring, evaluation and reporting (PMER)
The LRCS, in close cooperation with the IFRC regional representation PMER will monitor the progress of the operation and provide necessary technical expertise. The monitoring and reporting of the operation will be undertaken by the National Society and IFRC. Whenever the need arises, the IFRC regional PMER team will be requested to support the country team. The LRCS will provide brief weekly updates to the IFRC on general progress of the operation, and regular monitoring reports will provide detailed indicator tracking. The field reports will feed into IFRC reporting. Regional situation snapshot are being prepared on a regular basis and progress on the operation will be presented through Emergency Appeal Operation Updates. A PMER delegate has been recruited to support the operation, along with two PMER national staff to support accordingly.

The impact of the behavioural change process will be monitored and evaluated through Knowledge, Attitude and Practice (KAP) baseline and impact survey implemented with the use of the IFRC Rapid Assessment using Mobile Platform (RAMP) survey tool. The RAMP will also be utilised to monitor and report in real time for SDB and community based protection programmes.

An evaluation on the impact of the IFRC supported intervention and lessons learnt workshop would be conducted at the end of the operation. The outcomes of the lessons learnt workshop, which could be organized in-country or regional – as similar operation are ongoing in Guinea and Sierra Leone, will aim to guide the Red Cross Movement and its partners on any subsequent intervention in similar situation.

Administration and Finance
The LRCS has an administration and finance set up which ensures the proper use of financial resources in accordance with conditions laid down in the memorandum of understanding between the National Society and IFRC. Financial resource management of the LRCS will be strengthened during the operation through technical assistance and additional staff deployment from the regional representation. IFRC will utilise standard procedures when justifying expenses and providing working advances to the National Society. A finance and admin delegate is engaged to support the operation and contribute to increase the capacity of the LRCS finance staff.

Progress towards Outcomes

Health and Care

- A total of 1,142 volunteers trained and engaged in community mobilization activities, reaching up to 716,237 people.
- A total of 106 volunteers trained and engaging in contact tracing, and have traced 5,152 contacts to date
- Cumulative number of communities reached countrywide – 2,185.
- Cumulative number of households reached – 101,026
- Radio broadcasts (1 hour per week) are ongoing while drama groups in market places and other gatherings are also used to disseminate key messages.
- Local media shows established in seven counties (Lofa, Nimba, Bomi, Grand Bassa, Grand Gedeh and Maryland).
- A total of 12 PSS officers are working eight counties (Montserrado - 2, Lofa - 4, Margibi - 1, Bomi - 1, Grand Bassa - 1, River Cess -1, Grand Cape Mount – 1, Bong - 1). Recruitment is ongoing in all counties.
- A total of 50 volunteers were trained in community -based psychosocial support and psychological first aid in Bomi, Bong and Margibi.
- PSS counselors have been engaged locally in the counties and reintegration support has been initiated.

Capacity and Support

- LRCS/ IFRC taskforce in place and meeting weekly.
- Detailed EPoA in place.
- Operations manager, health, logistics and 2 psychosocial support delegates in place.

SDB Coordination

- There are 8 SDB teams with 10 members in each team, and 3 disinfection teams with 4 members in each one.
- SDB teams have conducted a total of 2519 burials/cremations. LRCS has been assisting in SDB in Montserrado County since July 2014, with 12 SDB teams (7 people per tem) and six disinfection teams.

Challenges:

- Contact tracing is extremely difficult due to resistance and denial. Lack of cooperation from the contacts and their families is common. County health teams' surveillance officers face challenges when looking for contacts. LRCS volunteers are assisting as they are generally accepted and respected in their communities.
- SDB teams have sometimes faced violent resistance from communities refusing to have their members bodies collected

BUDGET

Click **here** to see the attached IFRC Secretariat budget for details.

C. DETAILED OPERATIONAL PLAN

Health and Care

Outcome 1: Community-based diseases prevention and health promotion are timely provided to the affected population.																
Output 1: Community engagement, beneficiary communication and social mobilization for community-based disease prevention and health promotion is provided to the target population																
	2014									2015						
Activities planned Week / Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
Train 3,800 volunteers in case identification (EVD signs, symptoms and referrals), prevention measures, awareness campaign methods, and data collection at community level.	X	X		X		X	X	X			X			X		
Conduct regular refresher trainings for volunteers active in EVD operation.				X				X			X			X		
Conduct health promotion campaigns using household visits, community sensitization, group sessions and media campaign in targeted counties	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Produce and disseminate prevention and control IEC material	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Procure and distribute visibility equipment and materials	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Disseminate key messages through drama performance and role plays at markets and other public community.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Engaging opinion leaders such as religious leaders, traditional healers, town chiefs, clan chiefs in social mobilization and awareness campaigns	X			X			X			X			X			
Output 2:<u>Beneficiary Communication and Community Engagement</u>:LRCS engages affected communities in meaningful dialogue, addressing stigma, dispel rumors and provides them with a voice using different communication mediums throughout the EVD response operation																
	2014									2015						
Activities planned Week / Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
Increasing capacity of LRCS to deliver BC activities nationally (systems, radio, advocacy, training teams respectively)							X	X	X	X	X	X	X	X	X	
Train and manage 400 volunteers in basic BC/CE strategies (dissemination of EVD information and feedback, data collection using mini-KAPS (RAMP)									X	X	X	X	X	X	X	
Establish system of data and information collection and management to disseminate using broadcast mediums, SMS, IVR, etc.							X	X	X	X	X	X	X	X	X	
Scaling up of radio activities to include two weekly national and 45 community level one hour interactive broadcasts and outside broadcasts.							X	X	X	X	X	X	X	X	X	
Produce radio dramas (5 min / 20 x 15 minute) including CDs to be distributed.									X	X	X	X	X	X	X	
Distribution of solar/dynamo radio to communities to increase listenership to our radio programme									X	X	X	X	X	X	X	
Establish IVR (pre-recorded information exchange) system and deployment of the TERA system									X	X	X	X	X	X	X	
Deliver 30 community forums (2 per county) engaging with “community resource oriented persons” (Chiefs, traditional healers, teachers, soldiers and police, musicians, sport personalities.										X	X	X	X	X	X	

Productions of IEC materials e.g. print, billboards, wall murals.								X	X	X	X	X	X	X			

Output 3: Safe and Dignified Burials and Disinfection of Houses: Risk of transmission of disease in the communities at household level and in health facilities reduced through disinfection and safe and dignified burials (SDB).

	2014									2015						
Activities planned Week / Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
Establish community emergency response teams (CERT) in affected communities	X	X	X	X	X	X	X									
Recruitment of additional health officers for 15 chapters	X	X	X	X	X	X	X	X	X							
Provide transportation (vehicles and motor bikes) for CERT	X	X	X	X	X	X	X	X	X							
Train volunteers for contact daily surveillance for 21 days to detect possible onset of symptoms	X	X		X		X	X	X			X			X		
Establish coordination and clear referral mechanism with country health teams (CHT)	X	X	X	X	X	X	X	X	X							
Conduct training and refresher and deploy 20 SDB teams (safe transportation, swabs, burial and disinfection of homes and bodies)	X	X	X	X	X	X	X	X	X			X		X		

Output 4: Psychosocial and economical Support: Psychosocial support provided to affected individuals, families, community members and volunteers.
Food and non-food items provided to individuals and families who lost belongings due to epidemic control measures (disinfections and burning)

	2014									2015						
Activities planned Week / Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
Establish community emergency response teams (CERT) in 15 affected counties.	X	X	X	X	X	X	X	X	X	X						
Recruit and integrate 15 certified counsellors into the CERT	X	X	X	X	X	X	X	X	X							
Mapping of MHPSS[1] 4Ws[2] to avoid duplication of efforts and resources	X				X	X		X	X							
Provide psychosocial counselling to affected persons, family members and volunteers	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Train volunteers who are following up contacts in psychosocial first aid					X	X		X	X	X	X	X	X	X	X	
Provide ToTs on PSS targeting counsellors and CERT members					X				X	X	X	X	X	X	X	
Conduct ant-stigma campaign through community visits to challenge attitudes and change behaviour	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Assess community beliefs and understanding of EVD including fears	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Identify and prevent rumors and actions that may harm epidemic control efforts (use of hotline	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Prepare communities for re-integration and anti-stigmatization of suspects/ probable/ confirmed cases.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Establish volunteer care mechanism consistent with organizational policy and MoHSW						X	X	X	X	X	X	X				
Psychosocial support for the SSDB team and staff at all levels	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Provide contacts with food parcels and non-food items (survival kits)					X	X	X	X	X	X	X	X	X	X	X	

Provide unconditional cash or in-kind replacement for belongings lost due to epidemic control measures	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

Output 5: <u>Community Surveillance and contact tracing</u>: In coordination with partner agencies, an effective alert investigation and contact tracing system is implemented to ensure rapid referral and care

	2014									2015						
Activities planned Week / Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
Recruit additional health officers for 15 chapters	X	X	X	X	X	X	X	X	X							
Train volunteers for contact daily surveillance for 21 days in order to detect the possible onset of symptoms	X	X		X		X	X	X			X			X		
Establish coordination and clear referral mechanism with country health teams (CHT)	X	X	X	X	X	X	X	X	X							
Train volunteers in the 15 counties on basic personal protective measures for contact tracing	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Initiate cross boarder collaboration for contact tracing and follow-up	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

Output 5: <u>Community home-based protection:</u> Communities with limited access to Ebola treatment units (ETUs) or community care centres (CCCs) are provided with hygiene and protective equipment kits (HPE)

	2014									2015						
Activities planned Week / Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
Support targeted communities with provision of protection kits where necessary	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Conduct ToT for identified communities members on use of protection kits	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Distribute to survivals, orphans, and contact replacement, recovery and resettlement kits in high risk quarantine communities.	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	

Capacity and Support

<u>Outcome 2</u>: Sustainable impact achieved through strengthening of existing capacity of the LRCS and provision of necessary IFRC management, technical and support resources.

Output 1: <u>National Society capacity development:</u> The NS has the necessary capacity to lead the operation and ensure sustainable impact

	2014									2015						
Activities planned Week / Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
Construction of a Disaster management Center for the coordination of disasters (including 25 bed rooms, conference facilities and warehouse facilities											X	X	X	X		
Establish a EVD task force at headquarter level to coordinate activities and partnerships (internal and external)					X											
Develop and maintain a detailed emergency plan of action	X			X			X			X			X			
Establish and roll-out regular monitoring system to track progress, National Society field capacity across all key results areas and pillars			X	X	X	X	X	X	X	X	X	X	X	X	X	

Institutional strengthening of LRCS HQ and chapter structures.			X	X	X	X	X	X	X	X	X	X	X	X	X	
Output 2: IFRC support to the National Society: Necessary IFRC resources are provided to support the operation																
Activities planned Week / Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
Intensified capacity is provided to the National Society through the deployment of an operations manager, emergency health, psychosocial support, beneficial communication, logistics/fleet, finance, information technology and PMER delegates	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
IFRC coordination and support staff (not technical staff)	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
IFRC supporting the operational running costs	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
External communication	X	X	X	X	X	X	X	X	X	X	X	X	X	X	X	
Organize headquarters and field level review and learning workshops										X		X		X		
Adapt IFRC guidelines	X	X	X	X	X	X	X	X	X							
Extra office annexes to accommodate increasing needs for operational working spaces for the EVD Response Teams (LRCS)							X	X	X	X						

Safe and Dignified Burials coordination

Outcome 3: National level SDB support: Support is provided to national authorities for country-wide coordination and information management of the overall Safe and Dignified Burial and Infection of Houses response																
Output 1: Establishment of SDB coordination and information management hub in Monrovia																
Activities planned Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
Recruitment of SDB Coordinator and SDB Information Manager								X	X	X	X	X	X			
Contribute to national Coordination of the SDB work performed by all partners involved in the Ebola response								X	X	X	X	X	X			
Identification of key partners								X	X	X	X	X	X			
Assessment of SDB needs and response								X	X	X	X	X	X			
Consolidate, review and disseminate current standards.								X	X	X	X	X	X			
Collect, analyze and present key SDB response information								X	X	X	X	X	X			
Reporting of SDB indicator progress to the UNMEER response monitoring dashboard								X	X	X	X	X	X			

Early Recovery

Outcome 4: Early recovery from the longer term-effects of the EVD outbreak is supported through livelihood, food security and health and sanitation activities																
Output 1: The most vulnerable population affected by the direct and indirect effects of the outbreak are supported through livelihoods and food security related interventions																
	2014									2015						
Activities planned Week / Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
Deployment of recovery delegate																
Rapid assessment and initial program planning																
Household economic survey and detailed assessments / plans																
Distribution of farming tools and supplies combined with necessary training																
Integration of early recovery into longer-term community resilience building.																
Output 2:<u>Health risk management:</u> Improved knowledge, attitude and practice of communities on prevention and control in health emergencies and provision of necessary water, sanitation and hygiene promotion services in six counties																
	2014									2015						
Activities planned Week / Month	A	M	J	J	A	S	O	N	D	J	F	M	A	M	J	
Conduct hazard and risk assessments and develop a community disaster risk reduction (CDRR) plan												X	X	X		
Train communities and volunteers in establishing community maps and identifying hazards and vulnerabilities												X	X	X		
Reactivate and train community-based risk reduction structures												X	X	X		
Community sensitization on measures to prevent and control disease outbreaks												X	X	X	X	
Train volunteers as hygiene promoters and conduct refresher training										X	X			X		
Conduct health and hygiene promotion activities in EVD affected communities (WASH)										X	X	X	X	X	X	

Contact Information

For further information specifically related to this operation please contact:

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For Resource Mobilization and Pledges:

- **In IFRC Zone:** Martine Zoethouthmaar, Resource Mobilization Coordinator; Phone: +251 93-003 6073; email: martine.zoethoutmaar@ifrc.org

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

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How we work

All IFRC assistance seeks to adhere to the **Code of Conduct** for the International Red Cross and Red Crescent Movement and Non-Governmental Organizations (NGOs) in Disaster Relief and the **Humanitarian Charter and Minimum Standards in Humanitarian Response (Sphere**) in delivering assistance to the most vulnerable. The IFRC's vision is to inspire**, encourage, facilitate and promote at all times all forms of humanitarian activities** by National Societies, with a view to **preventing and alleviating human suffering**, and thereby contributing to the maintenance and promotion of human dignity and peace in the world.

Liberia EVD - MDRLR001

28.11.2014

REVISED BUDGET

Budget Group	Multilateral Response	SDB Coordination	Bilateral Response	Appeal Budget CHF
Shelter - Relief	0	0		0
Shelter - Transitional	0	0		0
Construction - Housing	0	0		0
Construction - Facilities	0			0
Construction - Materials	0			0
Clothing & Textiles	19,460			19,460
Food	571,562			571,562
Seeds & Plants	100,000			100,000
Water, Sanitation & Hygiene	1,661,309			1,661,309
Medical & First Aid	3,767,465			3,767,465
Teaching Materials	28,800			28,800
Utensils & Tools	0			0
Other Supplies & Services	526,850			526,850
Emergency Response Units			96,000	96,000
Cash Disbursements	0	0		0
Total RELIEF ITEMS, CONSTRUCTION AND SUPPLIES	**6,675,446**	**0**	**96,000**	**6,771,446**
Land & Buildings	1,475,520			1,475,520
Vehicles Purchase	518,000			518,000
Computer & Telecom Equipment	234,350	4,000		238,350
Office/Household Furniture & Equipment	176,000			176,000
Medical Equipment	0			0
Other Machinery & Equipment	0			0
Total LAND, VEHICLES AND EQUIPMENT	**2,403,870**	**4,000**	**0**	**2,407,870**
Storage, Warehousing	62,500			62,500
Distribution & Monitoring	70,000			70,000
Transport & Vehicle Costs	1,315,400	18,000		1,333,400
Logistics Services	201,400			201,400
Total LOGISTICS, TRANSPORT AND STORAGE	**1,649,300**	**18,000**	**0**	**1,667,300**
International Staff	2,412,000	144,000		2,556,000
National Staff	0			0
National Society Staff	2,256,295			2,256,295
Volunteers	4,171,340			4,171,340
Total PERSONNEL	**8,839,635**	**144,000**	**0**	**8,983,635**
Consultants	181,000			181,000
Professional Fees	40,000			40,000
Total CONSULTANTS & PROFESSIONAL FEES	**221,000**	**0**	**0**	**221,000**
Workshops & Training	1,253,580			1,253,580
Total WORKSHOP & TRAINING	**1,253,580**	**0**	**0**	**1,253,580**
Travel	62,600	20,000		82,600
Information & Public Relations	710,000			710,000
Office Costs	439,400	30,000		469,400
Communications	206,635	12,000		218,635
Financial Charges	255,500	2,000		257,500
Other General Expenses	1,040			1,040
Shared Support Services	23,811			23,811
Total GENERAL EXPENDITURES	**1,698,986**	**64,000**	**0**	**1,762,986**
Programme and Supplementary Services Recovery	1,478,218	14,950		1,493,168
Total INDIRECT COSTS	**1,478,218**	**14,950**	**0**	**1,493,168**
TOTAL BUDGET	**24,220,035**	**244,950**	**96,000**	**24,560,985**
Available Resources				
Multilateral Contributions	9,604,137			9,604,137
Bilateral Contributions			96,000	96,000
TOTAL AVAILABLE RESOURCES	**9,604,137**	**0**	**96,000**	**9,700,137**
NET EMERGENCY APPEAL NEEDS	**14,615,898**	**244,950**	**0**	**14,860,848**

Project Financial Management Report

Highlights, Charts

Selected Parameters	
Year/Period	2014/4-2015/7
Project	PLR017

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Project Highlights

2014/4-2015/7

Project PLR017 - EVD Outbreak

Plan (Appeal) MDRLR001 Liberia - EVD Outbreak

Project Manager Mesfin HALEFOM ABAY

Project Time Frame 09/04/2014 - 30/06/2015

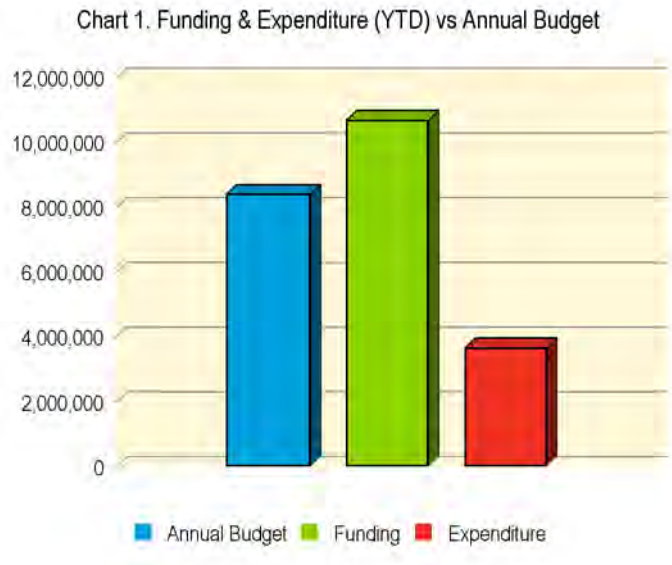
Annual Expenditure Budget (CHF)	8,387,155
Funding (YTD) incl. Opening Balance	10,677,541
Expenditure (YTD)	3,641,049
Project Closing Balance	7,036,493
Deferred Income (reserved for future periods)	0
Project Funding (%)	127%

Approved Expenditure Ceiling (PEAR)	5,032,293
Expenditure > Budget and or PEAR	0
Funding Gap vs PEAR ceiling	-
Pledge Deficit	200
Outstanding Pledges	3,973,959
Budget Implementation (YTD)	43%

Project Expenditure vs YTD and Annual Budget Analysis

Expenditure Categories	Actual Expenditure vs. Budget Analysis (2014/4-2015/7)					Annual Outlook (Indicative)	
	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance	Annual Variance	Commitments	Variance
Relief items, Construction, S	1,014,910	1,014,910	175,418	839,492	839,492	91,986	747,507
Land, vehicles & equipment	449,000	449,000	298,212	150,788	150,788	-	150,788
Logistics, Transport & Stora	1,286,900	1,286,900	387,755	899,145	899,145	3,687	895,458
Personnel	4,632,693	4,632,693	1,094,910	3,537,783	3,537,783	318,864	3,218,919
Consultants & Professional	78,000	78,000	62,996	15,004	15,004	-	15,004
Workshops & Training	83,300	83,300	27,733	55,567	55,567	-	55,567
General Expenditure	330,460	330,460	311,124	19,336	19,336	803	18,533
Operational Provisions	0	0	1,155,054	-1,155,054	-1,155,054	-	-1,155,054
Indirect Costs	511,892	511,892	114,300	397,592	397,592	-	397,592
Pledge Specific Costs	0	0	13,546	-13,546	-13,546	7,775	-21,321
Total	**8,387,155**	**8,387,155**	**3,641,049**	**4,746,106**	**4,746,106**	**423,114**	**4,322,992**

Project Performance in a Nutshell



Areas to Check, Analyse and take Potential Action

1	Budget Variances	Check
2	Expenditure > Budget and or PEAR	
3	Funding Gap vs PEAR ceiling	
4	Pledge Deficit	Check
5	Overdue Outstanding Pledges	Check
6	Overdue Pledge Reports	

Explanation for above targets and checks

1	YTD Exp is less or more than YTD budget by 30%
2	YTD Actual Expenditure is more than PEAR
3	Funding plus Deferred Income is less than PEAR ceiling
4	Closing balance on M-codes have negative values
5	There are overdue outstanding pledges
6	There are overdue pledge reports

Project Financial Management Report

Actual Expenditure, Commitments and Budget Analysis

Selected Parameters	
Year/Period	2014/4-2015/7
Project	PLR017

Refreshed on 12-Dec-2014 at 09:41

Project: PLR017 - EVD Outbreak **Project Manager:** Mesfin HALEFOM ABAY

Project Expenditure vs YTD and Annual Budget Analysis 2014/4-2015/7

Acc Category	Actual Expenditure vs. Budget Analysis (2014/4-2015/7)					Annual Outlook (Indicative)	
	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance	Annual Variance	Commitments	Variance
						24,059	-24,059
Construction - Facilities	0	0	966	-966	-966		-966
Construction Materials	0	0	0	0	0	67,926	-67,926
Clothing & Textiles	2,960	2,960	2,138	822	822		822
Food	0	0	904	-904	-904		-904
Water, Sanitation & Hygiene	43,900	43,900	78,061	-34,161	-34,161		-34,161
Medical & First Aid	657,000	657,000	75,566	581,434	581,434		581,434
Teaching Materials	28,800	28,800	15,234	13,566	13,566		13,566
Utensils & Tools	7,250	7,250	0	7,250	7,250		7,250
Other Supplies & Services	275,000	275,000	2,548	272,452	272,452		272,452
Relief items, Construction,	**1,014,910**	**1,014,910**	**175,418**	**839,492**	**839,492**	**91,986**	**747,507**
Vehicles	340,500	340,500	201,153	139,347	139,347		139,347
Computers & Telecom	96,500	96,500	76,667	19,833	19,833		19,833
Office & Household Equipm	12,000	12,000	20,392	-8,392	-8,392		-8,392
Land, vehicles & equipmer	**449,000**	**449,000**	**298,212**	**150,788**	**150,788**		**150,788**
Storage	50,000	50,000	1,439	48,561	48,561		48,561
Distribution & Monitoring	30,000	30,000	95,179	-65,179	-65,179	3,687	-68,866
Transport & Vehicles Costs	1,206,900	1,206,900	271,983	934,917	934,917		934,917
Logistics Services	0	0	19,154	-19,154	-19,154		-19,154
Logistics, Transport & Sto	**1,286,900**	**1,286,900**	**387,755**	**899,145**	**899,145**	**3,687**	**895,458**
International Staff	1,332,000	1,332,000	347,540	984,460	984,460	318,864	665,596
National Staff	0	0	274	-274	-274		-274
National Society Staff	1,062,053	1,062,053	264,404	797,649	797,649		797,649
Volunteers	2,238,640	2,238,640	468,162	1,770,478	1,770,478		1,770,478
Other Staff Benefits	0	0	14,530	-14,530	-14,530		-14,530
Personnel	**4,632,693**	**4,632,693**	**1,094,910**	**3,537,783**	**3,537,783**	**318,864**	**3,218,919**
Consultants	78,000	78,000	19,044	58,956	58,956		58,956
Professional Fees	0	0	43,952	-43,952	-43,952		-43,952
Consultants & Professiona	**78,000**	**78,000**	**62,996**	**15,004**	**15,004**		**15,004**
Workshops & Training	83,300	83,300	27,733	55,567	55,567		55,567
Workshops & Training	**83,300**	**83,300**	**27,733**	**55,567**	**55,567**		**55,567**
Travel	45,000	45,000	71,730	-26,730	-26,730		-26,730
Information & Public Relatio	74,000	74,000	21,488	52,512	52,512		52,512
Office Costs	74,500	74,500	164,035	-89,535	-89,535		-89,535
Communications	95,985	95,985	29,042	66,943	66,943		66,943
Financial Charges	7,000	7,000	23,579	-16,579	-16,579		-16,579
Other General Expenses	33,975	33,975	816	33,159	33,159		33,159
Shared Office and Services	0	0	435	-435	-435	803	-1,238
General Expenditure	**330,460**	**330,460**	**311,124**	**19,336**	**19,336**	**803**	**18,533**
Operational Provisions	0	0	1,155,054	-1,155,054	-1,155,054		-1,155,054
Operational Provisions	**0**	**0**	**1,155,054**	**-1,155,054**	**-1,155,054**		**-1,155,054**

Project Expenditure vs YTD and Annual Budget Analysis

2014/4-2015/7

Acc Category	Actual Expenditure vs. Budget Analysis (2014/4-2015/7)					Annual Outlook (Indicative)	
	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance	Annual Variance	Commitments	Variance
Programme & Services Sup	511,892	511,892	114,300	397,592	397,592		397,592
Indirect Costs	**511,892**	**511,892**	**114,300**	**397,592**	**397,592**		**397,592**
Pledge Earmarking Fee	0	0	9,083	-9,083	-9,083		-9,083
Pledge Reporting Fees	0	0	4,463	-4,463	-4,463	7,775	-12,238
Pledge Specific Costs	**0**	**0**	**13,546**	**-13,546**	**-13,546**	**7,775**	**-21,321**
Total	**8,387,155**	**8,387,155**	**3,641,049**	**4,746,106**	**4,746,106**	**423,114**	**4,322,992**

Project Financial Management Report

Actual Expenditure, Commitments and Budget Analysis

Selected Parameters	
Year/Period	2014/4-2015/7
Project	PLR017

Refreshed on 12-Dec-2014 at 09:41

Project: PLR017 - EVD Outbreak **Project Manager:** Mesfin HALEFOM ABAY

Project Expenditure vs YTD and Annual Budget Analysis 2014/4-2015/7

Acc Category	Actual Expenditure vs. Budget Analysis (2014/4-2015/7)					Annual Outlook (Indicative)	
	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance	Annual Variance	Commitments	Variance
No specific activity	0	0	85,855	-85,855	-85,855	41,272	-127,127
Social mobilisation and beneficiary communication	8,387,155	8,387,155	1,318,978	7,068,177	7,068,177	334,079	6,734,098
Disinfection and DBM	0	0	450,545	-450,545	-450,545		-450,545
Psychosocial support	0	0	952	-952	-952		-952
community surveillance and contact tracing	0	0	156,480	-156,480	-156,480		-156,480
NS Support costs	0	0	1,371,751	-1,371,751	-1,371,751		-1,371,751
IFRC Support costs	0	0	255,478	-255,478	-255,478	47,763	-303,241
Expected Result 4, Activity 4	0	0	1,010	-1,010	-1,010		-1,010
Total	**8,387,155**	**8,387,155**	**3,641,049**	**4,746,106**	**4,746,106**	**423,114**	**4,322,992**

Project Financial Management Report

Actual Expenditure, Commitments and Budget Analysis

Selected Parameters	
Year/Period	2014/4-2015/7
Project	PLR017

Refreshed on 12-Dec-2014 at 09:41

Project: PLR017 - EVD Outbreak **Project Manager:** Mesfin HALEFOM ABAY

Project Expenditure vs YTD and Annual Budget Analysis 2014/4-2015/7

Acc Category	Actual Expenditure vs. Budget Analysis (2014/4-2015/7)					Annual Outlook (Indicative)	
	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance	Annual Variance	Commitments	Variance
International Staff	0	0	29,963	-29,963	-29,963	33,497	-63,460
Consultants	0	0	1,058	-1,058	-1,058		-1,058
Professional Fees	0	0	40,000	-40,000	-40,000		-40,000
Travel	0	0	1,947	-1,947	-1,947		-1,947
Communications	0	0	126	-126	-126		-126
Programme & Services Supp	0	0	8,299	-8,299	-8,299		-8,299
Pledge Reporting Fees	0	0	4,463	-4,463	-4,463	7,775	-12,238
A000 - No specific activity	**0**	**0**	**85,855**	**-85,855**	**-85,855**	**41,272**	**-127,127**
						24,059	-24,059
Construction Materials	0	0	0	0	0	67,926	-67,926
Clothing & Textiles	2,960	2,960	2,138	822	822		822
Food	0	0	904	-904	-904		-904
Water, Sanitation & Hygiene	43,900	43,900	17,811	26,089	26,089		26,089
Medical & First Aid	657,000	657,000	75,566	581,434	581,434		581,434
Teaching Materials	28,800	28,800	15,234	13,566	13,566		13,566
Utensils & Tools	7,250	7,250	0	7,250	7,250		7,250
Other Supplies & Services	275,000	275,000	38	274,962	274,962		274,962
Vehicles	340,500	340,500	201,153	139,347	139,347		139,347
Computers & Telecom	96,500	96,500	31,567	64,933	64,933		64,933
Office & Household Equipme	12,000	12,000	0	12,000	12,000		12,000
Storage	50,000	50,000	802	49,198	49,198		49,198
Distribution & Monitoring	30,000	30,000	89,205	-59,205	-59,205	3,687	-62,892
Transport & Vehicles Costs	1,206,900	1,206,900	134,557	1,072,343	1,072,343		1,072,343
Logistics Services	0	0	19,154	-19,154	-19,154		-19,154
International Staff	1,332,000	1,332,000	182,694	1,149,306	1,149,306	237,603	911,702
National Staff	0	0	274	-274	-274		-274
National Society Staff	1,062,053	1,062,053	111,021	951,032	951,032		951,032
Volunteers	2,238,640	2,238,640	169,894	2,068,746	2,068,746		2,068,746
Other Staff Benefits	0	0	12,787	-12,787	-12,787		-12,787
Consultants	78,000	78,000	7,745	70,255	70,255		70,255
Workshops & Training	83,300	83,300	21,623	61,677	61,677		61,677
Travel	45,000	45,000	46,812	-1,812	-1,812		-1,812
Information & Public Relatior	74,000	74,000	14,899	59,101	59,101		59,101
Office Costs	74,500	74,500	19,377	55,123	55,123		55,123
Communications	95,985	95,985	16,432	79,553	79,553		79,553
Financial Charges	7,000	7,000	25,673	-18,673	-18,673		-18,673
Other General Expenses	33,975	33,975	62	33,913	33,913		33,913
Shared Office and Services (	0	0	435	-435	-435	803	-1,238
Operational Provisions	0	0	27,441	-27,441	-27,441		-27,441
Programme & Services Supp	511,892	511,892	68,904	442,988	442,988		442,988
Pledge Earmarking Fee	0	0	4,776	-4,776	-4,776		-4,776

Project Expenditure vs YTD and Annual Budget Analysis 2014/4-2015/7

Acc Category	Actual Expenditure vs. Budget Analysis (2014/4-2015/7)					Annual Outlook (Indicative)	
	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance	Annual Variance	Commitments	Variance
A0101 - Social mobilisation and beneficiary communication	**8,387,155**	**8,387,155**	**1,318,978**	**7,068,177**	**7,068,177**	**334,079**	**6,734,098**
Construction - Facilities	0	0	966	-966	-966		-966
Water, Sanitation & Hygiene	0	0	60,250	-60,250	-60,250		-60,250
Other Supplies & Services	0	0	41	-41	-41		-41
Office & Household Equipme	0	0	13,066	-13,066	-13,066		-13,066
Storage	0	0	579	-579	-579		-579
Distribution & Monitoring	0	0	265	-265	-265		-265
Transport & Vehicles Costs	0	0	86,865	-86,865	-86,865		-86,865
International Staff	0	0	17,945	-17,945	-17,945		-17,945
National Society Staff	0	0	29,656	-29,656	-29,656		-29,656
Volunteers	0	0	138,008	-138,008	-138,008		-138,008
Other Staff Benefits	0	0	450	-450	-450		-450
Workshops & Training	0	0	1,735	-1,735	-1,735		-1,735
Travel	0	0	6,032	-6,032	-6,032		-6,032
Information & Public Relatior	0	0	1,236	-1,236	-1,236		-1,236
Office Costs	0	0	59,670	-59,670	-59,670		-59,670
Communications	0	0	4,539	-4,539	-4,539		-4,539
Other General Expenses	0	0	401	-401	-401		-401
Operational Provisions	0	0	7,805	-7,805	-7,805		-7,805
Programme & Services Supp	0	0	18,729	-18,729	-18,729		-18,729
Pledge Earmarking Fee	0	0	2,305	-2,305	-2,305		-2,305
A0102 - Disinfection and DBM	**0**	**0**	**450,545**	**-450,545**	**-450,545**		**-450,545**
Other Supplies & Services	0	0	1,235	-1,235	-1,235		-1,235
Transport & Vehicles Costs	0	0	-16,676	16,676	16,676		16,676
International Staff	0	0	11,486	-11,486	-11,486		-11,486
National Society Staff	0	0	2,687	-2,687	-2,687		-2,687
Workshops & Training	0	0	1,096	-1,096	-1,096		-1,096
Information & Public Relatior	0	0	12	-12	-12		-12
Office Costs	0	0	1,690	-1,690	-1,690		-1,690
Operational Provisions	0	0	579	-579	-579		-579
Programme & Services Supp	0	0	-1,004	1,004	1,004		1,004
Pledge Earmarking Fee	0	0	-154	154	154		154
A0103 - Psychosocial support	**0**	**0**	**952**	**-952**	**-952**		**-952**
Other Supplies & Services	0	0	1,235	-1,235	-1,235		-1,235
National Society Staff	0	0	2,856	-2,856	-2,856		-2,856
Volunteers	0	0	143,986	-143,986	-143,986		-143,986
Workshops & Training	0	0	77	-77	-77		-77
Programme & Services Supp	0	0	7,234	-7,234	-7,234		-7,234
Pledge Earmarking Fee	0	0	1,092	-1,092	-1,092		-1,092
A0104 - community surveillance and contact tracing	**0**	**0**	**156,480**	**-156,480**	**-156,480**		**-156,480**
Computers & Telecom	0	0	16,835	-16,835	-16,835		-16,835

Project Expenditure vs YTD and Annual Budget Analysis 2014/4-2015/7

Acc Category	Actual Expenditure vs. Budget Analysis (2014/4-2015/7)					Annual Outlook (Indicative)	
	Annual Budget	YTD Budget	YTD Expenditure	YTD Variance	Annual Variance	Commitments	Variance
Office & Household Equipme	0	0	1,810	-1,810	-1,810		-1,810
Transport & Vehicles Costs	0	0	58,235	-58,235	-58,235		-58,235
National Society Staff	0	0	118,096	-118,096	-118,096		-118,096
Volunteers	0	0	16,255	-16,255	-16,255		-16,255
Other Staff Benefits	0	0	1,288	-1,288	-1,288		-1,288
Professional Fees	0	0	3,952	-3,952	-3,952		-3,952
Workshops & Training	0	0	2,843	-2,843	-2,843		-2,843
Travel	0	0	520	-520	-520		-520
Information & Public Relatior	0	0	4,324	-4,324	-4,324		-4,324
Office Costs	0	0	39,643	-39,643	-39,643		-39,643
Communications	0	0	4,349	-4,349	-4,349		-4,349
Operational Provisions	0	0	1,097,999	-1,097,999	-1,097,999		-1,097,999
Programme & Services Supp	0	0	5,012	-5,012	-5,012		-5,012
Pledge Earmarking Fee	0	0	590	-590	-590		-590
A0201 - NS Support costs	**0**	**0**	**1,371,751**	**-1,371,751**	**-1,371,751**		**-1,371,751**
Computers & Telecom	0	0	27,317	-27,317	-27,317		-27,317
Office & Household Equipme	0	0	5,516	-5,516	-5,516		-5,516
Storage	0	0	58	-58	-58		-58
Distribution & Monitoring	0	0	5,709	-5,709	-5,709		-5,709
Transport & Vehicles Costs	0	0	9,001	-9,001	-9,001		-9,001
International Staff	0	0	105,451	-105,451	-105,451	47,763	-153,214
National Society Staff	0	0	86	-86	-86		-86
Volunteers	0	0	19	-19	-19		-19
Other Staff Benefits	0	0	5	-5	-5		-5
Consultants	0	0	10,242	-10,242	-10,242		-10,242
Workshops & Training	0	0	360	-360	-360		-360
Travel	0	0	16,420	-16,420	-16,420		-16,420
Information & Public Relatior	0	0	1,017	-1,017	-1,017		-1,017
Office Costs	0	0	43,656	-43,656	-43,656		-43,656
Communications	0	0	3,596	-3,596	-3,596		-3,596
Financial Charges	0	0	-2,094	2,094	2,094		2,094
Other General Expenses	0	0	353	-353	-353		-353
Operational Provisions	0	0	21,230	-21,230	-21,230		-21,230
Programme & Services Supp	0	0	7,063	-7,063	-7,063		-7,063
Pledge Earmarking Fee	0	0	475	-475	-475		-475
A0202 - IFRC Support costs	**0**	**0**	**255,478**	**-255,478**	**-255,478**	**47,763**	**-303,241**
Computers & Telecom	0	0	948	-948	-948		-948
Programme & Services Supp	0	0	62	-62	-62		-62
A0404 - Expected Result 4, Activity 4	**0**	**0**	**1,010**	**-1,010**	**-1,010**		**-1,010**
Total	**8,387,155**	**8,387,155**	**3,641,049**	**4,746,106**	**4,746,106**	**423,114**	**4,322,992**

Project Financial Management Report

Project Movement of Funds with Pledge Details:Timeframe, Earmarking, Reporting Requirements

Selected Parameters	
Year/Period	2014/4-2015/7
Project	PLR017

Refreshed on 12-Dec-2014 at 09:41

Project: PLR017 - EVD Outbreak **Project Manager:** Mesfin HALEFOM ABAY

Movement of Funds by M-code (Pledge Earmarking & Reporting Details) 2014/4-2015/7

M-Code	Description	S	Opening Balance	Period Movement		Closing Balance	Deferred Income	Commitments	Outstanding Pledge	Pledge timeframe		Pledge Report	
				Income	Expenditure					Start Date	End Date	Type	Due Date
M1405040	China Red Cross, Hong Kong brar	A	0.00	13,395.25	0.00	13,395.25		-	0.00				
	USD 15,000 for Liberia Ebola virus disease,activities related to the health ERU tasks.Pledge is inclusive of PSSR.												
M1405093	American Red Cross	A	0.00	44,798.85	-41,018.65	3,780.20		-	0.00			Standard Final Financial	31.01.2015
	USD 50,000 for Liberia ebola virus disease outbreak,80% operartions(relief items and supplies, land, vehicle & equip,logs, transport&storage and workshop/trainings)20% support(staff, consultants & prof fees, general expenditures, indirect costs). Refer 062-36220-70-2799-54921-0736.											Standard Final Narrative	31.01.2015
M1406017	Finnish Red Cross	A	0.00	36,589.83	-33,920.11	2,669.72		-	0.00	30.04.2014	30.10.2014	Standard Final Financial	31.12.2014
	EUR 30,000 for Liberia Ebola virus disease, output 1.4 psychosocial support(as per the budget). Balance to be used for social mobilization activities.Please see annex for FRC comments. Refer FRC-HUM,7057,R21/15.5.2014.												
M1406042	Swedish Red Cross	A	0.00	96,989.74	-47,893.76	49,095.98		-	0.00	30.04.2014	30.10.2014	Standard Final Financial	28.02.2015
	SEK 750,000 for Liberia ebola virus disease outbreak, 50% towards health activities (community health,PAP,epidemic prevention and control) and 50% towards related operation costs.Subject earmarking including 6.5% PSSR and 1% pledge coding. No DREF replenish authorised.											Standard Final Narrative	28.02.2015
M1407025	Finnish Red Cross	A	0.00	16,085.17	-16,285.17	-200.00		-	16,108.88				
	CHF 16,108.88 for Liberia - EVD Outbreak, to be used for Heidi Isohanni's in-country costs only. Excluding SOSC (agreed between Finnish RC HR Officer Sirpa Mikkola and HR Manager Joseph Sikueye). Refer 230-9957.												
M1407072	Norwegian Red Cross	A	0.00	52,347.44	-5,006.82	47,340.62		-700.00	23,862.05			Standard Final Financial	1.03.2015
	NOK 200,000 for Liberia Ebola virus disease. Refer PAF 14125(Nodhjelpsreserve 800731).											Standard Final Narrative	1.03.2015
	e-m. T.Carney,17.11.14: additional NOK 175,000 announced payable by 05.11.14 with additional narrative reports due by 01.03.15.												
M1407118	China Red Cross, Hong Kong brar	A	0.00	10,000.00	-32.52	9,967.48		-	0.00				
	CHF 10,000 for Liberia Ebola virus disease, activities related to ERU Health and PSS tasks. Pledge is inclusive of PSSR.												
M1408048	Japanese Government	A	0.00	139,693.42	-3,121.89	136,571.53	0.00	-700.00	0.00	20.08.2014	19.02.2015	Standard Final Financial	20.05.2015
	USD 150,000 for Liberia ebola virus disease as per attached proposal.											Standard Final Narrative	20.05.2015

Project Financial Management Report

Project Movement of Funds with Pledge Details:Timeframe, Earmarking, Reporting Requirements

Selected Parameters	
Year/Period	2014/4-2015/7
Project	PLR017

Refreshed on 12-Dec-2014 at 09:41

Project: PLR017 - EVD Outbreak **Project Manager:** Mesfin HALEFOM ABAY

Movement of Funds by M-code (Pledge Earmarking & Reporting Details) 2014/4-2015/7

M-Code	Description	S	Opening Balance	Period Movement		Closing Balance	Deferred Income	Commitments	Outstanding Pledge	Pledge timeframe		Pledge Report	
				Income	Expenditure					Start Date	End Date	Type	Due Date
M1408052	American Red Cross	A	0.00	407,085.09	-164,739.82	242,345.27		-700.00	0.00			Standard Final Financial	31.03.2015
	USD 450,000 for Liberia Ebola Virus Disease Outbreak. Refer $ 450,000 USD to 062-36220-70-2587-54921-0736.											Standard Final Narrative	31.03.2015
M1408056	United States Government - USAI	A	0.00	973,501.30	-210,789.30	762,712.00	0.00	-700.00	973,501.30	13.08.2014	28.02.2015	Standard Final Financial	28.05.2015
	USD 1,000,000 Liberia ebola virus disease outbreak, as per attached program description.											Standard Final Narrative	28.05.2015
M1409038	British Red Cross	A	0.00	298,311.14	-8,555.24	289,755.90		-700.00	0.00	30.04.2014	31.12.2014	Standard Final Financial	31.03.2015
	GBP 196,027 for Liberia ebola virus disease, earmarked against the attached earmarking note. Please include numbers of people reached within the PBR. Please email the PBR to DisasterResponseTeam@redcross.org.uk.This pledge is inclusive of PSSR and all reporting fees. ReferR/54518/271/P6461/W1624.											Standard Final Narrative	31.03.2015
	e-m. M.Mudhar,11.09.14: corrected funding source to 100% from DFID/British government.												
M1409039	British Red Cross	A	0.00	16,700.00	-12,092.81	4,607.19		-	0.00	28.07.2014	28.10.2014	Standard Final Financial	30.01.2015
	CHF 16,700 for Liberia ebola virus disease outbreak,earmarked to the in-country costs for a 3 months logistician as part of the EVD response.See attached earmarking note.Contact disasterresponseteam@redcross.org.uk. This pledge is inclusive of PSSR. Refer R/54518/2741/P6461/W1624.												
M1409074	Sime Darby Berhad	A	0.00	139,552.75	-48,026.90	91,525.85		-700.00	69,945.33			Standard Final Financial	31.08.2015
	MYR 500,000 for Liberia Ebola Virus Disease Outbreak,to be utilised for expenses to carry out community based health awareness and training.											Standard Final Narrative	31.08.2015
M1410043	Japanese Government	A	0.00	988,403.76	-505,186.61	483,217.15	0.00	-700.00	0.00	15.10.2014	14.07.2015	Standard Final Financial	15.10.2015
	USD 1,040,275 for Liberia Ebola virus disease Outbreak. Financial report has to have 0 for balance and deferred income											Standard Final Narrative	15.10.2015
M1410131	Finnish Red Cross	A	0.00	288,815.25	0.00	288,815.25		-700.00	0.00	1.04.2014	1.06.2015	Standard Final Financial	1.08.2015
	EUR 120,000 for Liberia Ebola Virus Disease Outbreak. Please see annex for FRC comments. Refer FRC-HUN,7059,R35/16.10.2014.											Standard Final Narrative	1.08.2015
	e-m. T.Carney,17.11.14: additional EUR 120,000 announced payable by 27.11.14.												
M1410132	French Red Cross	A	0.00	200,360.41	-184,011.20	16,349.21		-700.00	200,360.41			Standard Interim Financial	31.12.2014
	EUR 166,667 for Liberia ebola virus disease outbreak.											Standard Interim Narrative	31.12.2014

Project Financial Management Report

Project Movement of Funds with Pledge Details:Timeframe, Earmarking, Reporting Requirements

Selected Parameters	
Year/Period	2014/4-2015/7
Project	PLR017

Refreshed on 12-Dec-2014 at 09:41

Project: PLR017 - EVD Outbreak **Project Manager:** Mesfin HALEFOM ABAY

Movement of Funds by M-code (Pledge Earmarking & Reporting Details) 2014/4-2015/7

M-Code	Description	S	Opening Balance	Period Movement		Closing Balance	Deferred Income	Commitments	Outstanding Pledge	Pledge timeframe		Pledge Report	
				Income	Expenditure					Start Date	End Date	Type	Due Date
												Standard Final Financial	31.07.2015
												Standard Final Narrative	31.07.2015
M1411007	British Red Cross	A	0.00	112,761.00	0.00	112,761.00		-200.00	0.00				
M1411060	British Red Cross	A	0.00	2,370,225.00	-361,487.06	2,008,737.94		-700.00	2,370,225.00			Standard Final Financial	31.03.2015
	GBP 1,554,979 for Liberia ebola virus disease, national society activities as earmarked against the attached earmarking note and operational budget. Please email the PBR to DisasterResponseTeam@redcross.org.uk. This pledge is inclusive of PSSR and all reporting fees. Refer R/54518/P6461/W1624.											Standard Final Narrative	31.03.2015
M1411075	Bill & Melinda Gates Foundation	A	0.00	478,826.30	0.00	478,826.30		-	0.00	13.10.2014	7.10.2015		
M1411076	Bill & Melinda Gates Foundation	A	0.00	430,943.67	0.00	430,943.67		-	0.00	13.10.2014	7.10.2015		
M1412030	China Red Cross, Hong Kong brar	A	0.00	50,231.76	0.00	50,231.76		-200.00	50,231.76	5.12.2014	15.06.2015	Standard Final Financial	15.09.2015
	HKD 400,000 for Liberia ebola virus disease outbreak, dead body management kits and body bags, specification see appendix. The amount is 7.5% PSSR inclusive.												
M1412031	Finnish Red Cross	A	0.00	3,269.47	0.00	3,269.47		-200.00	3,269.47	14.11.2014	10.01.2015	Standard Final Financial	31.03.2015
	EUR 2,719.66 for Liberia ebola virus disease outbreak, to be used for Heidi Isohanni's in-country costs only. Refer 230-9958.												
M14DM094	SCHLEICHER Peter		0.00	54,988.61	-54,988.61	0.00		0.00	-				
M14DM117	ISOHANI Heidi		0.00	26,700.00	-26,700.00	0.00		-	-				
M14DM161	TATE Gareth		0.00	24,516.13	-24,516.13	0.00		0.00	-				
M14DM242	MIKKELSEN Tage		0.00	11,767.74	-11,767.74	0.00		0.00	-				
M14DM267	GLOECKLE Michael		0.00	3,263.33	-3,263.33	0.00		0.00	-				

Project Financial Management Report

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Selected Parameters	
Year/Period	2014/4-2015/7
Project	PLR017

Refreshed on 12-Dec-2014 at 09:41

Project: PLR017 - EVD Outbreak **Project Manager:** Mesfin HALEFOM ABAY

Movement of Funds by M-code (Pledge Earmarking & Reporting Details) 2014/4-2015/7

M-Code	Description	S	Opening Balance	Period Movement		Closing Balance	Deferred Income	Commitments	Outstanding Pledge	Pledge timeframe		Pledge Report	
				Income	Expenditure					Start Date	End Date	Type	Due Date
MDRLR001	Liberia - EDV Outbreak		0.00	3,387,418.98	-1,877,645.22	1,509,773.76		-277,376.25	266,454.67				
	Total		0.00	10,677,541.39	-3,641,048.89	7,036,492.50	0.00	-312,731.35	3,973,958.87				

ANNEXEX 5

IFRC EBOLA OPERATION REAL-TIME STAFF AND DELEGATE SURVEY ANALYSIS

The following analysis is based on the IFRC Ebola operation real-time staff survey for Whole Organization as at 18th December 2014 at 13:11pm (GMT). In the following sections, common responses to various questions are summarized.

1. Please explain ONE thing that you feel worked particularly well in this operation

The most common descriptive terms provided by the Ebola RT Staff Survey to describe what worked well in the operation include;

- Team
- National staff
- Support
- Cooperation
- Pillars

The staff survey indicated the importance of 'team' work; leader/s, leadership, spirit and attitude were paramount to the current success of the Ebola operation in West Africa. In particular, team leaders including Amanda McClelland and Steve McAndrew were highlighted as enabling leaders whom endowed a strategic and scientific approach to work. They are praised for providing direction and forging effectiveness through teamwork, communication and support to all team members.

The multinational teams of delegates working in partnership with national staff under solid IFRC leadership were able to adapt and cope notably with the shortage of supplies and with top down decisions that went against team recommendations. Teams have good relationships and a common approach with excellent attitudes that inspire confidence.

The 5 Pillar approach was named as a critical approach to the Ebola operation. It was noted that a more balanced representation and implementation of the pillar approach would benefit overall outcome and goal to save lives. The pillar that Red Cross has preformed exemplarily is the SDB pillar. The success of the Safe and Dignified Burial teams are testament to the skills and attitudes that effective teamwork necessitates. Staff are in no doubt of the success of the SDB teams for the success of the operation.

There is positive praise toward the work with national RC staff, for their dedication to the operation and belief that support for the national staff is the cornerstone of the success to their operation. The cooperation with competent and experienced national staff was praised, as was working in cooperation with key persons at the National level, in the health authorities and with external partners, contributing heavily to the success of the operation.

2. Please explain ONE thing that you feel did not work well in this operation

The most common descriptive terms provided by the Ebola RT Staff Survey to describe what didn't work well in the operation include;

- IFRC
- Information
- Management
- Staff
- Coordination

The staff survey drew focus to an unclear IFRC hierarchical structure, lack of planning, inefficient coordination and lack of management of information and staff concerns.

The IFRC staff structure does not align adequately with the SLRCS, not allowing delegates to effectively work with respective units in the National Societies. Parallel structures are advised to create effective collaboration and capacity strengthening platforms. The hierarchical nature of the IFRC is confusing with the management line beyond the country level unclear. Combined with short international missions (4 weeks) there is a level of uncertainty and delay in decision making to implementation that creates inefficiency. SOPs need to be understood for the management of this type of prolonged extreme events to avoid the situation caused by IFRC's frequent changes and multi leveled, multi positioned senior management.

At the regional level, the Regional Ebola Coordination of IFRC was deemed to be 'not in touch, nor aware of country level situation' leading to frustration and decisions that were seemingly against on-ground recommendations. This chain of command needs accurate information and processes that enlighten their decision-making.

The lack of information management is also highlighted as a major problem in the emergency operation. Better coordination and information sharing between all actors on the ground will lead to a more efficient and effective response to the outbreak. There were vies that many organizations are working in silos which appear counter productive. IFRC participate in coordination meeting yet need to continue to improve upon information sharing amongst Movement partners and external partners. To facilitate this as well as information from staff, volunteers and communities, processes and a feedback mechanism needs to be established as feedback from beneficiaries is limited.

The operation would benefit from IFRC country management taking a more proactive role in planning of infection control measures in Red Cross premises, evacuation plans and exit strategies. Concerns for risk of staff and volunteers at conducting their work, is a priority that has been voiced across working units from case management, SDB teams to office staff.

Early IFRC ineffectiveness including not enough money, not enough IPC staff, no TLCOM support and WATSAN/WATHAB not being involved in the operation, continue to weigh on the operation efficiency today. Understaffing remains a concern; HR needs to scale up the operations appropriately to include logistics, financial, coordination, information management, financial management positions and decision

management processes to support the IFRC operation. Appropriate HR staffing i.e. more Infection Prevention and Control personnel and fewer medical doctors need to be addressed.

Local staff and volunteer risks and security need reviewing. It has been noted a double standard between local staff and international delegates regarding vehicles and accommodation and security is paramount for close collaboration.

3. If you could do the operation over again, what ONE thing would you do differently to make it better?

The most common descriptive terms provided by the Ebola RT Staff Survey to describe one thing to do differently to make the operation better include;

- Information
- Management
- Communication
- Coordination
- Staff

Information management and sharing of information was the most commented issue to improve the Ebola operation. The lack of information for planning and decision-making is creating operational inefficiency. Communications were of second interest in the medically concerned interests of the operation. This has led to inefficiency. There needs to be clear channels of communication between offices,

It was stated that effective and rapid mobilization of human resources was needed from the start. Deployment of additional leadership and support at country and Ebola case management level was needed and or place an experienced emergency delegate to coordinate and also a health coordinator from the outset to ensure good strategic planning. Faster decision making to manage the operation from the Federation Secretariat in Geneva would also improve efficiency.

Immediate recruitment of more national staff and delegates to sufficiently cover the affected communities needs to occur. Sufficient management to manage these staff need also be implemented. Improvement to the process/system of recruitment for staff needs to occur. Roles and responsibilities need to be set out and timing of positions needs to match the need in the field. Due to the language difficulty in Guinea, under staffing is proving to take its toll and staff are overwhelmed.

Staff believe the initial response was medically biased and that a broader view on the whole operation would have positioned the operation to transition from emergency to recovery more efficiently in the long term. The operation is believed to have entered a more consolidated phase and it would be both possible and useful to have a somewhat longer working perspective and a broader approach. Deployment for 4 weeks is not long enough for effective continuation of work by the international delegates.

Generally more focus is needed on scaling up education, beneficiary communication, social mobilization = PREVENTION and the support structures such as logistics, planning and coordination to enable the operation to significantly make a difference.

management processes to support the IFRC operation. Appropriate HR staffing i.e. more Infection Prevention and Control personnel and fewer medical doctors need to be addressed.

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Suggestions that agreements with UN at regional level are not clear; RC are auxiliary to governments and these points make UN and government believe Red Cross is subservient to UN. It is a perception that is counter to RC independence.

Incentives allocated to burial teams counter RC volunteer service. It could be argued that the principle of voluntary service is not well observed in some countries. There was a position where another national society was operational in country without the permission or knowledge of the host national society; this could be deemed to counter unity.

The ever increasing security threats to burial teams have had volunteers working with police presence, which is not really in conformity with the basic principles. This has been deemed necessary for safety and to facilitate the job to be done Local staff have been observed to carry out religious practices with patients on a regular basis, which could be deemed non-conformist with the basic principles.

6. Please provide any additional comments in relation to accountability to beneficiaries.

Many staff felt that they could not answer this question. Additional relevant comments in relation to accountability to beneficiaries as provided by the Ebola RT Staff Survey mostly included information on;

- No accountability check system
- There was no formal mechanism to respond to public enquiries

Beneficiaries have access through their community leaders to express how they feel and give feedback. Operations are also monitored by delegates and Liberian RC Field Officers who go to the communities and listen to what they have to say not just about the RC response but also how other aspects of their lives are being affected and what they need. This enables the RC volunteers and monitors to bring information back to Monrovia. Where this feedback is used, should determine iterations in the implementation of the operational plan.

- Changing focus from advocacy/information dissemination, shifting to clinical services and volunteers to neighboring Kenema is causing distress. Volunteers do great and important work and it should be recognized continuously, not leave them unacknowledged and shift only to clinical sector. Prevention is of a great importance for eradication of Ebola and protection of communities.

- Ebola beneficiaries are not the usual. The burial program is for dead people. The treatment center is for persons already infected with Ebola. The target of the operation is to stop the transition, and not directly targeted to beneficiaries.

"Word Cloud" representation of the most common words used by delegates in response to question 1. *'Please explain ONE thing that you feel worked particularly well in this operation '.*