THE OXFAM EBOLA RESPONSE IN LIBERIA AND SIERRA LEONE

An evaluation report for the Disasters Emergency Committee

JOHN ADAMS

ANNE LLOYD

CAROLYN MILLER

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ACRONYMS

BRAC	Bangladesh Rural Advancement Committee
CAP	Community Action Plan
CAR	Central African Republic
CCC	Community Care Centre
CD	Country Director
CDC	U.S. Centers for Disease Control and Prevention
CEO	Chief Executive Officer
CHC	Community Health Committee
CHW	Community Health Worker
DEC	Disasters Emergency Committee
DERC	District Ebola Response Centre
DFID	UK Department for International Development
DHMT	District Health Management Team
DRR	Disaster Risk Reduction
ESVL	Emergency Food Security and Vulnerable Livelihoods
ETC	Ebola Treatment Centre
ETU	Ebola Treatment Unit
EVD	Ebola Virus Disease
gCHV	General Community Health Volunteer (Liberia)
HR	Human Resources
IHR	International Health Regulations
IRC	The International Rescue Committee
MDM	Médecins du Monde
MEAL	Monitoring, Evaluation, Accountability and Learning
MoHS	Sierra Leone Ministry of Health and Sanitation
MoHSW	Liberia Ministry of Health and Social Welfare
MSF	Médecins sans Frontières
NERC	National Ebola Response Centre
OFDA	Office of U.S. Foreign Disaster Assistance
PHE	Public Health Engineering
PHP	Public Health Promotion
PPE	Personal Protective Equipment
PHU	Peripheral Health Unit
RRT	Response and Resilience Team
RTE	Real Time Evaluation
SC	Save the Children
SLAF	Sierra Leone Armed Forces
SOPs	Standard Operating Procedures
WAHO	West African Health Organisation
WASH	Water, Sanitation and Hygiene
WHO	World Health Organization

EXECUTIVE SUMMARY

SUMMARY OF FINDINGS

Introduction

This report reviews Oxfam's response to the Ebola crisis at an organisational level and programme delivery in Liberia and Sierra Leone in 2014–2015. It is based on an evaluation commissioned by Oxfam with funding from the Disasters Emergency Committee (DEC), carried out in March and April 2015.

Oxfam has demonstrated a strong appetite for learning both from this evaluation and the Ebola response as a whole. There is a clear emphasis on how Oxfam might enhance its response to similar crises, at both an organisational level and in terms of programme effectiveness.

The context of the Ebola epidemic presented extreme challenges for Oxfam, as it did for many organisations. At the onset of the epidemic there was a general lack of understanding of the disease and how to respond to it effectively and safely. A pervasive and persistent climate of fear, coupled with changing predictions about the likely evolution of the epidemic, influenced analysis and response at all levels. There was strong pressure to treat the epidemic as a medical emergency requiring a medical response – organised through top-down processes – rather than standard humanitarian coordination.

The findings summarised below and presented in detail in the full body of this evaluation report should be read with these contextual elements in mind.

Brief summary of Oxfam's response to the Ebola epidemic

Oxfam's response to the Ebola epidemic in Liberia and Sierra Leone started in August / September 2014 at a small scale, and was scaled up considerably from October 2014 through to January 2015. In both countries the full-scale response included community mobilisation for Ebola prevention, case finding and referral, and public health engineering (PHE) interventions to support isolation and treatment of Ebola patients. The response also included water, sanitation, and hygiene promotion (WASH) improvements in schools and healthcare facilities.

Other areas of intervention, including emergency food security and vulnerable livelihoods (EFSVL), aimed at mitigating the negative impacts of the epidemic were planned but not fully underway at the time of the evaluation.

Oxfam delivered significant results though a wide-ranging response and this was recognised positively by key players. Staff on the ground played a vital role in bringing this about.

However, both Oxfam's effectiveness and its ability to influence management of the Ebola epidemic as a whole were limited by the lateness of its response and its inability to react quickly to a new and challenging situation.

Achievements

Oxfam implemented some distinctive, appropriate and effective interventions, such as evidence-based, targeted active case finding; designing and building appropriate treatment centres; and mass social mobilisation for prevention activities at community level.

It achieved this by adapting existing competencies in public health engineering and public health promotion to a new situation, and developing innovative and appropriate interventions. These contributed to prevention of Ebola transmission and treatment of people infected.

Oxfam developed innovative, effective and promising partnerships with agencies providing clinical care. The response was also built on strong local and country wide relationships that increased both speed and effectiveness.

As the epidemic declined, Oxfam's Ebola response was actively linked with long-term programmes through forward-thinking transition strategies that included food security and livelihoods as well as public health.

Oxfam contributed to coordination and leadership especially in programme and technical areas. They made notable international and local contributions to policy and advocacy on a range of aspects of the crisis.

Staff at all levels of the organisation ensured sustained engagement with the Oxfam Ebola response over time in what was a challenging environment, despite difficulty for some in seeing the results of their efforts.

As a result of the Ebola response Oxfam has gained valuable technical and other experience on how to respond to epidemics and now has a good understanding of where it fits in to future responses.

The late response

There were a number of interrelated reasons for the lateness of Oxfam's response to the Ebola epidemic. They are set out separately in this report.

The decision making process was slow and not sufficiently clear, understood or accepted. It would have benefitted from an earlier and more credible analysis of Oxfam's potential role in the response and the added value they could provide. Even when Oxfam's potential role was identified, it took several weeks to agree on an appropriate scale and focus of the response.

The emerging epidemic was treated as a threat, rather than as a crisis to respond to, which put the organisation into a defensive mode rather than a proactive intervention mode. Managing risk was heavily focused on protecting staff and the organisation. For too long this was compounded by the lack of a definitive analysis of Ebola-related risk and appropriate risk management protocols.

Once Oxfam was in a position to respond at scale the response from many other organisations was already substantial. The lateness of Oxfam's main response, coupled with the need to catch up and move quickly to scale, created a number of challenges. Funding was more difficult to secure, many good staff had already been hired by other organisations, time for building relations of trust with other local actors and people at community level was very scarce, the ability to influence other players at local and international level was weakened, coordination mechanisms were harder to influence and opportunities for participating in consortia had been lost.

The combination of these factors contributed to some weaknesses in several aspects of Oxfam's response and limited the organisation's ability to have a greater impact on the course of the epidemic.

Quality of the response

Other elements of defining and implementing the response were influential in limiting its impact. Preceding the outbreak, there was a lack of focus on preparedness and disaster risk reduction (DRR) in both countries. The cholera preparedness plan in Sierra Leone was not drawn on.

A broader public health approach, beyond Oxfam's widely recognised strengths of health promotion and public health engineering, would have enhanced effectiveness, including bringing in epidemiological skills sooner and working with other health organisations in a more integrated fashion.

An earlier programme focus on the consequences of the epidemic could have broadened Oxfam's impact. It took time, for example, to begin substantive livelihoods programmes. If started earlier, these would have enhanced international influencing activities in the relevant areas through providing an evidence base for what works.

Whilst transition from the emergency response to long-term development programmes is being carefully planned, there is a need to more strongly take in to account the fact that it will take time to build up services and that gap filling may be necessary. There would be benefit to focusing on a longer transition period, rather than moving too quickly into development thinking.

A greater emphasis or consistency on monitoring, evaluation and learning could have improved the quality of Oxfam's response and enhanced the evidence base for preparing and planning for future responses of this type and more widely.

Some of the limitations regarding programme quality were related to the rapid scale-up to large programmes that were aimed at engaging with communities and delivering results over a wide geographic area (this is particularly true for Sierra Leone). This was partly due to the challenge of getting the right resources (e.g. people and support systems) in place in a timely way. Oxfam's response had a narrower focus in Liberia than in Sierra Leone, both geographically and in terms of activities, and was able to ensure more intensive supervision and management. Both approaches achieved considerable results and there is no evidence to suggest that one strategy was better than the other. However, the experience of this crisis highlighted a longstanding tension between quality and scale in Oxfam's humanitarian response that needs to be addressed if the organisation is to respond at scale to major humanitarian crises without sacrificing quality.

In conclusion

Clearer, faster analysis and decision making and a broader and more adaptive approach to programming would have enabled a more timely and effective Oxfam response. However, despite challenges arising from the delayed response and the complex environment, Oxfam achieved a great deal and can now build on a solid base during its recovery work in Liberia and Sierra Leone, as well as applying lessons learned to future humanitarian crises.

RECOMMENDATIONS

The recommendations on the pages that follow are based on the information and discussion presented in this evaluation report. They suggest ways to improve Oxfam's response to future crises. Some are specific to Ebola and other potential disease outbreaks, some address Oxfam's humanitarian response as whole, and others relate to the challenge of responding to new and unexpected crises.

Recommendations	Supporting sections
1. Strengthen the public health component of Oxfam's work through: (i) a stronger focus on public health outcomes (ii) a more integrated approach to public health.	Section 3.2
2. Bring in additional skills and form partnerships with specialists to help develop the work and assist in a similar situation.	Sections 3.2, 3.3, 10
3. Recognise social mobilisation as an essential pillar of Oxfam's work and an intervention in its own right with clear modalities and clarity on the competencies required. Ensure that the distinctiveness, impact and added value is clearly communicated both internally and externally.	Sections 3.2, 4.1.1, 4.2.1, 5.1
4. Give a stronger voice to specialists in Oxfam's response sectors – public health promotion (PHP), PHE and EFSVL – as well as other disciplines (such as anthropology, epidemiology, gender) in strategy development. Bring them in at an early stage of decision making and ensure there is an adequate forum for specialist input.	Sections 3.2, 3.5
5. Strengthen Oxfam's humanitarian focus. Further build response capacity in terms of number of staff, skills and systems with an emphasis on supporting countries as required. Foster the ability to recognise emerging humanitarian crises and innovate.	Section 3.3
6. Define and communicate clear decision making mechanisms for a response. Ensure that staff in key management positions are (i) aware of Oxfam's humanitarian mission (ii) take the right steps to build capacity and (iii) if they do not have the experience required are aware that decisions may need to be made elsewhere with them working alongside an emergency lead.	Sections 3.5, 3.7
7. Mobilise internal and external specialist expertise early to conduct risk analysis to support rational and broadly accepted decision making led at senior level when confronted with new risks such as Ebola. Adopt a wider risk framework.	Section 3.6
8. Clarify and simplify the expectations for use of Oxfam internal funding for emergency response and the requirements for getting this money quickly.	Section 3.4
9. Undertake further work to define appropriate and relevant programming in fragile states especially the need to fill gaps, provide basic services and the length of commitment required.	Sections 3.2, 3.5

Recommendations	Supporting sections
10. Build on new partnerships formed in the Ebola response – especially with medical partners – both at country and international level, including formal agreements and joint lessons learning. Consider additional new partnerships for a future outbreak.	Section 10
11. Ensure all countries are prioritising DRR, including preparedness planning and building resilience into recovery and longer term programmes. Produce guidelines and develop partnerships. Ensure there is an agreed contingency plan where DRR is weaker than ideal.	Section 3.9
12. Begin preparedness at organisational level for potential future outbreaks of Ebola, or other diseases that could be more dangerous or complex. Further review Oxfam's current standard operating procedures (SOPs) to assess their flexibility and how they could be adapted to a different disease.	Section 3.9
13. Place greater focus on how practical evidence from programmes can contribute to country and international policy work.	Section 6
14. Strengthen the status and reinforce capacity of MEAL. Locate it more strongly as a central function of programme management and a direct responsibility of management staff, including the critical area of information management. Clarify expectations, deliverables and accountabilities relating to MEAL for managers and MEAL specialists.	Sections 3.8, 7, 9, 12
15. Consolidate and promote Oxfam's intervention role in the overall framework of Ebola response, in collaboration with other actors, for possible future outbreak responses at global level. This should include social mobilisation, including active case finding, and could also include support to quarantined communities where it is national policy and construction of isolation/treatment facilities where this can be done sufficiently early in the outbreak.	Sections 5.1, 5.2, 5.5
16. Improve assessments, baseline data and monitoring information in order to facilitate management by results.	Section 3.8, 8.1, 9
17. Strengthen accountability by developing more creative ways to give people a voice, particularly focusing on feedback from more difficult-to-reach people.	Sections 9.1, 9.2
18. Develop and use more varied and participatory methods and materials for dialogue and community action on Ebola or other epidemic diseases.	Section 4.2.1
19. Reinforce application of appropriate technical standards for WASH in healthcare facilities, particularly those relating to healthcare waste management.	Section 5.4
20. Maximise the effectiveness of community volunteers through sufficient learner-centred training and close supervision/support.	Sections 4.2.1, 5.3
21. Strengthen programming and management for WASH interventions in the recovery phase by increasing integration of PHP and PHE, investing in strategic local partnerships, working through a health system approach in the case of health facilities and ensuring local arrangements for management of infrastructure and services.	Sections 5.4, 10

1 INTRODUCTION

1.1 INTRODUCTION TO THE EVALUATION

This report presents the evaluation of the Oxfam Ebola Response in Liberia and Sierra Leone from 2014–2015. The evaluation took place in the second half of March 2015, with follow-up work in April. It focused on the programme response in Liberia and Sierra Leone and on leadership, management and decision making at and between country, regional and organisational levels. The methodology is set out in Section 2. The main headings of the terms of reference (TOR) (see Annex 1) have been used to structure this report. The section on effectiveness has been subdivided into several categories that overlap but merit individual analysis. The recommendations therefore refer to analysis from more than one section.

The evaluation coincided with related in-country studies on social mobilisation, impact and women's engagement in the Ebola response. This evaluation complements these studies, which are referred to in the report.

Oxfam has demonstrated a strong appetite for learning, both from this evaluation and the Ebola response as a whole. There is a clear emphasis in this report on how Oxfam might enhance its response to similar situations and in other crises at both an organisational level and in terms of programme effectiveness.

1.2 OUTLINE OF THE PROGRAMME EVALUATED

The Ebola crisis challenged the whole international community in terms of scale, understanding of the risks and how best to respond. Most agencies from the United Nations to non-government organisations (NGOs) were slow to react and for a long time it was considered a specialist health concern and not so much a humanitarian emergency. There was therefore not the leadership or coordination now expected in a humanitarian situation. At the time of this evaluation it remains a 'Public Health Emergency of International Concern' despite an increasing focus on early recovery. [1]

Oxfam has recognised expertise and a strong reputation for its work in emergencies on WASH promotion and food security. It has a standby team of experts at international and regional level, emergency registers and humanitarian staff based in a number of crisis countries. Before the onset of the Ebola outbreak, Oxfam's work in both Liberia and Sierra Leone focused on long-term development programmes. Sierra Leone was designated a key country for preparedness, whereas Liberia was seen as lower risk. The last Oxfam humanitarian responses in these countries were to cholera in Sierra Leone in 2012 and to the Ivorian refugee crisis in Liberia in 2011.

Oxfam responded to the Ebola epidemic with a range of related interventions that included the following:

- community mobilisation for prevention and management of infections;

- active case finding to refer suspected Ebola cases for isolation and treatment;

- construction and equipment of facilities for isolating and treating Ebola patients;

- rehabilitation of health facilities and schools;

- WASH for communities in quarantine;

- support to EFSVL;

- protection;

- advocacy on many issues, including national and international management of the epidemic, and funding for the response and for recovery.

See Section 4 for a description of the response in each country and Section 6 for a description of advocacy work.

2 METHODOLOGY

An evaluation team of three people visited Liberia, Sierra Leone and the Oxfam GB head office in Oxford, undertook interviews with staff in these locations and also spoke to staff in the region and some who had already left the programme. We also talked to key external partners and consulted Oxfam documents and other grey literature. We did not look at the work of other Oxfam affiliates in the region. Two members of the team focused primarily on the programmes – taking one country each – and the third on the organisational response and policy work, although there was some cross over and joint working. See Annex 2 for the list of people interviewed and Annex 3 for the list of documents consulted.

In Liberia and Sierra Leone, in addition to conducting key-informant interviews, the evaluators spent time with Oxfam teams and visited programme locations to carry out a range of activities, including the following:

- observation / inspection of structures, goods and services provided by Oxfam (Ebola care facilities, WASH facilities, hygiene kits etc.);

- group discussions with community members (with a cross-section of the community, including women, men and children), health workers and community mobilisers;

- participatory activities (e.g. timelines, Venn diagrams and strengths, weaknesses, opportunities, threats (SWOT) analyses) with Oxfam staff and different sections of the community to research different perspectives on Ebola and Oxfam's response.

See Annex 4 for the evaluation team itineraries.

LIMITATIONS / CONSTRAINTS

A number of important players in the earlier part of the Ebola response had since left the country programmes or regional office although we were able to interview a number of them remotely. It was not possible in the time available to visit all of the programmes or speak to as many external agencies as originally hoped, but a reasonable cross section of informants was attained.

Many organisations that responded to the epidemic were also conducting evaluations so external agencies have been bombarded with many requests and had less time to give. We coordinated with other learning activities underway in Oxfam to avoid duplication.

We found a wide range of perspectives from staff, both between and within locations, which made it difficult to draw strong conclusions but demonstrated the dilemmas that Oxfam experienced.

There were some gaps in the programme documentation covering planning, monitoring and learning, so we relied heavily on the interviews and other primary data collection methods.

3 EFFECTIVENESS

3.1 TIMELINE AND SPEED

From April 2014 onwards, as the Ebola epidemic developed, significant effort was put in at all levels of the organisation to understand the situation and define how Oxfam should respond. This involved considerable debate and discussion, which became more intense as the situation worsened around August and when country programmes had been more-or-less on hold for some weeks. Oxfam was anxious to respond and add value to international efforts, but internal discussions were drawn out. Valuable time could have been gained during this period by initiating discussions with medical or other organisations and looking for complementary roles and potential partnerships. During this time Oxfam was approached and asked to become active by a number of external agencies and donors. In the end it was slow to respond and Oxfam has been open and honest in acknowledging that fact. Once the programmes were up and running, however, there were positive responses both internally and externally. At country level, in both Sierra Leone and Liberia, Oxfam's substantial Ebola response started when the epidemic curves were at or near their tail ends. More locally, in both countries, interventions were timely enough to have some influence on the course of the epidemic in certain instances but not in others, depending on local patterns of Ebola occurrence. In both urban Western Area district in Sierra Leone and Montserrado county in Liberia, social mobilisation and active case finding were fully operational at a time when there were still substantial numbers of cases. In the rural districts in both countries, the epidemic curve was already well into its decline by the time Oxfam's intervention arrived at scale. In John Thorpe community in rural Western Area district in Sierra Leone, the Oxfam intervention arrived some weeks after the last case of Ebola. There had been 141 deaths in this village of 3,000 people.
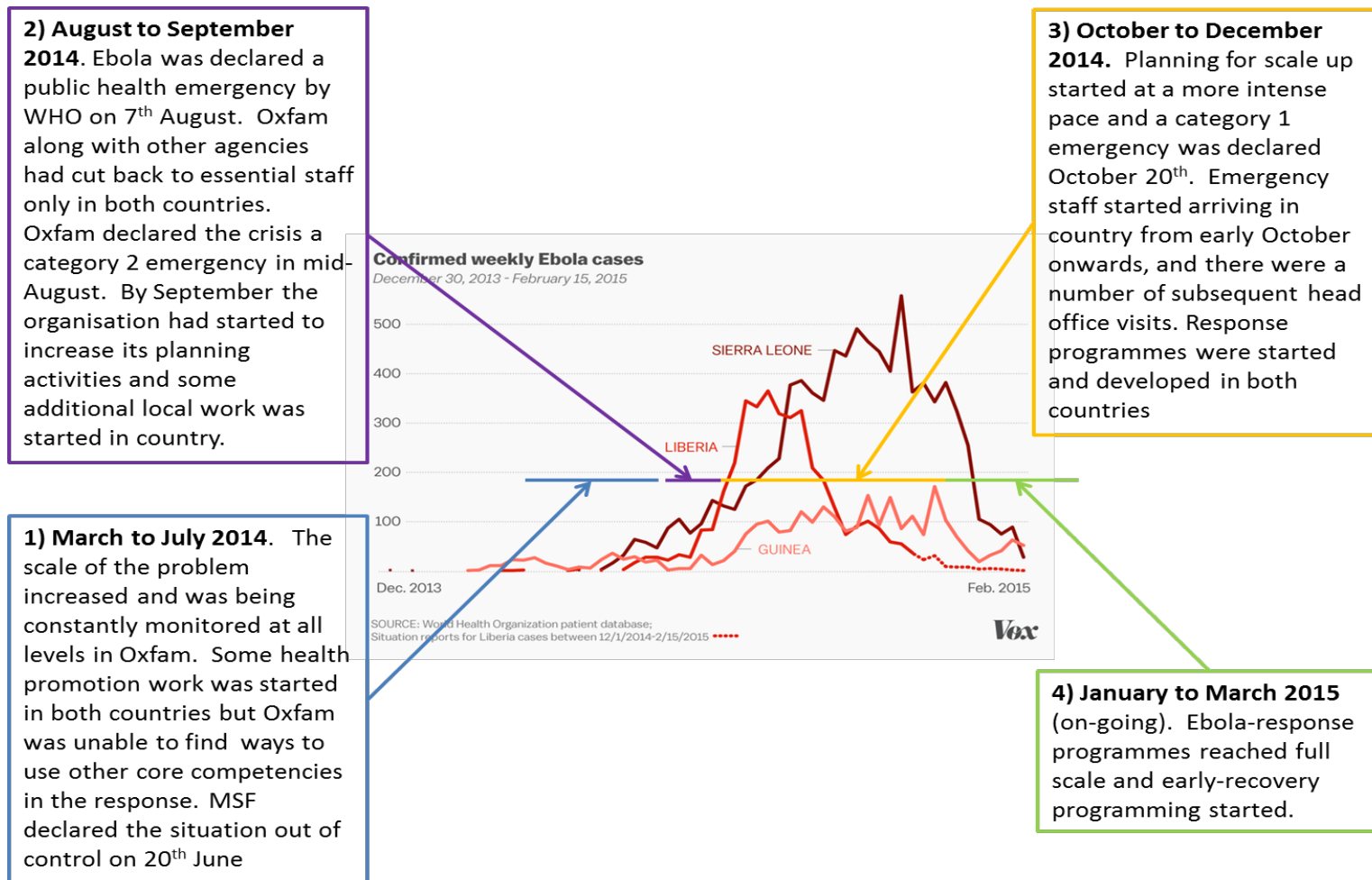
Discussion

Many other agencies were struggling with balancing the risk to staff and how to respond. However, Oxfam's declaration of category 1 and category 2 emergencies came later and scale up was slower than other agencies that were on the ground alongside Oxfam. These agencies were similarly undertaking community or public health work and also did not have skills in medical work. Oxfam had fewer key staff in-country at crucial stages, especially early September. A number of these other agencies had more emergency skills, experience or understanding within their existing staff base or they recruited those skills earlier.

Key factors that led to a slower response were (i) defining the nature of Oxfam's role, (ii) staffing capacity, (iii) securing funding and (iv) decision making which included (v) balancing staff safety with the desire to respond (risk). These are all interrelated but addressed separately below to draw out some important elements.

At the time when plans for scaling up were developed and set in motion, it was not possible to predict the likely evolution of the Ebola epidemic. As it turned out, because scale-up took a certain time and because the epidemic in both countries peaked earlier than many studies[2] predicted, Oxfam's capacity to respond in both countries reached full strength as the epidemics contracted. Nevertheless, scaling up when Oxfam did was entirely justified by what was known about the potential development of the epidemic when key decisions and commitments were made in October 2014.

Figure 1: The timeline for Oxfam's response can be broadly divided into four sections. These are presented below against the epidemic curves for the region.

2) August to September 2014. Ebola was declared a public health emergency by WHO on 7th August. Oxfam along with other agencies had cut back to essential staff only in both countries. Oxfam declared the crisis a category 2 emergency in mid-August. By September the organisation had started to increase its planning activities and some additional local work was started in country.

3) October to December 2014. Planning for scale up started at a more intense pace and a category 1 emergency was declared October 20th. Emergency staff started arriving in country from early October onwards, and there were a number of subsequent head office visits. Response programmes were started and developed in both countries

Confirmed weekly Ebola cases
December 30, 2013 - February 15, 2015

500

400

300

200

100

SIERRA LEONE

LIBERIA

GUINEA

Dec. 2013

Feb. 2015

SOURCE: World Health Organization patient database;
Situation reports for Liberia cases between 12/1/2014-2/15/2015 ••••

Vox

1) March to July 2014. The scale of the problem increased and was being constantly monitored at all levels in Oxfam. Some health promotion work was started in both countries but Oxfam was unable to find ways to use other core competencies in the response. MSF declared the situation out of control on 20th June

4) January to March 2015 (on-going). Ebola-response programmes reached full scale and early-recovery programming started.

3.2 DEFINING THE NATURE OF THE RESPONSE (SKILLS AND ADDED VALUE)

In the initial stages of the outbreak Oxfam saw this as a medical or health crisis. Both words were used interchangeably but signified that Oxfam saw the response as being outside their expertise. The first area agreed as an important contribution was the messaging component of PHP, which was adapted to ensure staff safety. The added value of PHE and the wider social mobilisation component were also discussed and gradually gained traction. The wider impact of the crisis (e.g. on livelihoods) was not considered as a programme activity until much later.

In September, in response to donor pressure from the Office of U.S. Foreign Disaster Assistance (OFDA) and the UK Department for International Development (DFID) for Oxfam to undertake a more medically-focused intervention, the value of WASH and community work was promoted but with no success until much later. In fact non-donor agency pressure on Oxfam was to come in with WASH activities. Subsequently the opportunity was not taken, or was lost, to join the DFID funded social mobilisation consortium (SMAC) in Sierra Leone. Subsequently Oxfam agreed to 'managing' isolation/treatment centres but only in partnership with a medical agency. In the end this did not happen or was not felt to be appropriate on the scale originally envisaged. In Liberia this coincided with a change in government policy. In Sierra Leone, Oxfam's role was changed to building the centres and providing WASH and training on maintenance. During this stage there was strong pressure from head office for the programmes to scale up.

Social mobilisation developed differently in each country (see Section 5.1) but became an increasingly important element in both. The active case finding in Liberia, a new initiative for Oxfam developed by the team on the ground, was widely praised. In Sierra Leone, Oxfam developed an extensive social mobilisation programme across four districts, including active case finding.

WASH support to health facilities and schools is a more traditional area of work for Oxfam. Building of medical facilities and roads and bridges was more unusual but generally carried out competently (see Sections 4.1.2, 4.2.2).

Expertise in epidemic response (e.g. epidemiology) and anthropology were mobilised once the decision had been made to scale up the response rather than help define how Oxfam might respond. The anthropologist was deployed to Liberia in early November 2014, once activities were underway.

Transition planning commenced early 2015 in Sierra Leone, sooner in Liberia, and picked up pace in March. The international community is readjusting to an early recovery stage with strong voices that the pace should not be lost. Debates in the country programmes were around how long the early recovery period would last and the difference between the nature of recovery programmes and strengthening long-term development programmes.

Discussion

The Ebola crisis had two separate elements: a health crisis and increasingly a wider humanitarian crisis. The fact that Oxfam is not a health agency was mentioned in many of the interviews. However, this was a public health crisis and public health and community health are key elements of Oxfam's emergency (and development) work and thus a key immediate strength beyond health messaging. Some of the PHP staff were arguing this at an early stage but were not clearly heard. It is worth reflecting on whether Oxfam's thinking, definition and expectations of public health needs to be broadened and reframed, or at least more clearly communicated. The epidemiological skills important to this response would be useful for other elements of public health. The promotion of disease prevention and health seeking behaviours envisaged in the community mobilisation work are a normal part of a local health worker's brief in addition to hygiene promotion. Oxfam has considerable experience responding to cholera outbreaks, including in Sierra Leone in 2012, but there was no evidence that this, or subsequent learning or preparedness was drawn on, and some staff did not see cholera preparedness as relevant to the Ebola response. The real time evaluation (RTE) for the Sierra Leone cholera response[3] made a number of recommendations to strengthen preparedness. There is now an additional opportunity for the wider public health thinking developed from this experience to in turn enhance future cholera programmes.

Applying skills early and seeking additional skills are an important factor. Sending humanitarian public health experts and an experienced epidemiologist into the countries sooner might have helped clear blockages in thinking. In addition, advice available in-country (e.g. CDC and WHO as well as other NGOs) could have been drawn on to a greater extent.

Health-systems thinking is fundamental to the effectiveness of most interventions and especially important in an outbreak. As we move towards universal health coverage, the importance of a more joined-up approach in collaboration with others is increasingly agreed to be vital. Whilst Oxfam promotes this thinking in its wider policy work, it was not highlighted in any practical sense in its public health response work. Many other agencies that responded faster were already more engaged with the health system in-country, even if only working in one specific aspect. In turn, a wider perspective on public health and its contribution to strengthening health systems on the ground could contribute more to Oxfam's policy influence.

Given that the situation was new, it demanded innovative thinking beyond looking at the traditional areas and how to adapt them. Sending in an anthropologist earlier in the analysis process, seeking other public health partnerships and looking at other complementary collaborations could have led to other solutions.

The Ebola epidemic had a very strong gender dimension in terms of the different roles of men and women in managing the disease and the ways in which the consequences and containment measures in place affected women and men differently. Oxfam's response was not particularly sensitive to this dimension and this was a lost opportunity for focusing social mobilisation work and supporting rights. It was not until February 2015 that a gender specialist was deployed to Sierra Leone.

The added value of Oxfam's work in social mobilisation was not generally understood by external partners, either before or after it started, with a few exceptions resulting from local collaboration and the communication of the active case finding in Liberia. Further work on defining this more clearly would be of great benefit.

Oxfam's response to Ebola was for the most part focused narrowly on containing the epidemic, in common with most other agencies and in line with major donor strategies and

public policy in both countries. This strategy focus was agreed at the meeting in Accra on 1–2 October 2014 and developed into a response framework.[4] There was no EFSVL advisor specialist at that meeting.

Both country strategies did include EFSVL interventions but these were not actually implemented during the major part of the epidemic, despite Oxfam's EFSVL specialists advising from August 2014 that the epidemic was creating a food security and livelihoods crisis requiring an emergency response. Oxfam did not respond in a way that reflected its broad expertise and its ambition to address humanitarian crises in a comprehensive and integrated way that promoted resilience. Opportunities were lost for mitigating the secondary impacts of the disease (e.g. on livelihoods, protection and access to basic services) and for building a substantial and timely response linked to PHE and PHP programmes, rather than coming at the end of the epidemic when other aspects of the response were scaling down.

It should be noted that both counties were fragile states before the outbreak and are now further weakened. Additional or strengthened capacity and skills within Oxfam to support the best ways of working in these more chronic situations – with a focus on the restoration of basic services, recovery and resilience – might lead to a different capacity for the spikes in the crisis that continue to occur. It may also require a rethink on Oxfam's role in service delivery.

There is significant potential for a stronger role for Oxfam in early recovery, including in coordination, and is much needed as more players come in to the country. It will involve promoting the importance of not letting up or losing pace. Recovery will take time and will require different approaches. This will need to be reflected in Oxfam's programmes. The country teams' longer-term development thinking will need further adapting.

3.3 CAPACITY

Humanitarian response is an integral part of Oxfam's mandate and has enjoyed a strong reputation from partners and donors. It is a key component of Oxfam's overall strategy which highlights improving effectiveness, increasingly through building the capacity of others. Oxfam has a standby team of response and resilience specialists (RRT) although this has recently been reduced due to funding cuts. Fundamental to the effectiveness of the core-skill areas of PHP, community mobilisation, PHE and livelihoods is that they are integrated with each other (see Section 5.9). DRR is also a key component.

At the time of the Ebola outbreak, Oxfam's overall standby and surge capacity was considered to be tested to the limits by a significant number of major responses taking place at the same time in the Middle East, Central African Republic and South Sudan. This was exacerbated by the fear that led to some staff not being prepared to go to Liberia or Sierra Leone or return there if they left the country. The West Africa Regional Office had limited capacity or willingness and some gaps in staffing. They were also more geared up for food security crises than disease outbreaks. The Liberia and Sierra Leone country programmes had a development focus and lacked humanitarian capacity and key staff with significant emergency experience.

Scaling up was a challenge and was in some cases only achieved as the epidemic declined. Skills particularly difficult to recruit for both internationally and nationally included logistics, monitoring, evaluation, accountability and learning (MEAL), PHE and PHP. Logistics capacity

and capability was a particular issue. Oxfam was also recruiting later than others, which meant that many experienced national and international staff had been employed by other agencies.

In addition, there was considerable pressure on the Oxfam emergency teams resulting from the challenges of decision making at all levels of the organisation, differing opinions, changes of plan, the lack of resources and turnover, combined with the complexity of the epidemic itself. It was therefore much harder for teams to deliver effectively.

Whilst it was a struggle to recruit the first wave of staff to lead the scale up of the Oxfam response, by October 2014 many highly experienced and effective staff were sent to the country programmes. A number of staff came forward from other Oxfam regions which led to valuable experience being utilised. From March 2015 onwards, different staff were deployed, primarily to move the emergency programmes to the transition phase.

Discussion

Other factors such as application of the staff briefings and procedures to manage risk to staff were seen to have played a significant role in the delays (see Section 3.6). The procedures became more streamlined over time and the personal risk better understood. The transition teams were hard to recruit, but this is probably related to other contributing factors.

There may be other ways to boost capacity through partnership and collaboration, both at an international level and in-country. West Africa is often considered to be a 'hard to recruit region' so alternative strategies might be even more important.

It is difficult to judge whether cuts to the RRT played a significant role, although some staff considered this to be a factor. However, it is clear that capacity at country level was an important element and ideally one that should have been addressed earlier. Decision making on managing the additional capacity deployed is discussed under country management (Section 3.7).

Overall Oxfam may wish to consider its balance of investment between humanitarian response, chronic situations, development and influencing over time. Humanitarian capacity, particularly in senior country leadership and logistics, would benefit from attention.

3.4 FUNDING – SECURING FUNDING AND USE OF OXFAM FUNDS

It was difficult to secure donor or other funding for non-medical work until around October 2014. The Oxfam and DEC appeals were not launched until October 2014 so substantial restricted or general funding was not available until November 2014. Oxfam therefore freed up some of its own money in late August 2014 and then further funding in October 2014. There was significant concern from a number of staff regarding whether this would be recouped from donor grants and how much information was required to secure this funding with some quite detailed information being sought.

Even when donor funding became more readily available, there was still pressure from donors (OFDA and DFID) for Oxfam to get involved in treatment centres and contact tracing etc. rather than areas of greater comparative advantage.

DFID funding involved a greater direct oversight of activities than is normally experienced. In addition, some of Oxfam's medical partners in Sierra Leone felt disempowered by lack of access to DFID discussions.

Discussion

Oxfam could have been stronger in negotiating with donors for funding for its proposed programmes and areas of strength at earlier stages. Putting forward clearer technical arguments and clearer advocacy on the added value of public health and community mobilisation as an essential complement to the medical focus could have achieved earlier results. There were a number of implementing agencies saying the same thing, so a more collaborative approach including beyond the NGO sector and especially with public health specialists could have resulted in a more persuasive argument.

Oxfam has acknowledged the unnecessary confusion surrounding communications at different levels regarding the use of its own funding or loans. It is worth noting that simple methods of justifying the use of emergency funds with monitoring systems that are easy to use are vital in crisis situations.

3.5 LEADERSHIP AND DECISION MAKING

An increasing number of people were involved over time in the ongoing discussions regarding a potential Ebola response from Oxfam. Normally, the main decision makers would be the region in conjunction with the country programme or programmes. In August 2014, when it became clear that decision making was not progressing, it was agreed in head office that they needed to exercise a greater degree of oversight especially as neither the regional nor the county offices were pushing to respond beyond health promotion work. It was at this stage that Oxfam declared the situation a category 2 emergency. At that time, the two countries were operating with essential staff only due to fears for staff safety – the word hibernation was used but afterwards felt to be unhelpful – and some others were on leave. A major change process was underway in Oxfam and also distracting some staff, especially in the region.

From this point on, senior managers and technical and other staff from the humanitarian department provided more key inputs. Managers involved with staff welfare and risk were also heavily involved and the importance of staff safety was paramount. This became increasingly complex. The regional office produced various frameworks at different stages with the aim of clarifying and communicating the decisions made. They played no strong leadership role.

A key point in unlocking decision making was a meeting in Accra 1–2 October 2014 with participation from all levels. This led to increased clarity, planning and recruitment and the subsequent declaration of a category 1 emergency on 20 October. Whilst at this point the lead could have been moved to head office, the region retained the lead until January 2015 although there was significant input from head office.

With the arrival of Oxfam's Ebola response teams in Liberia and Sierra Leone, October 2014, the pace picked up and much of the decision making moved to this level. This was supported by a number of high-level head office visits and the appointment of an operational lead – first based in-region and then in-country – and an organisational lead at head office.

In November 2014, after the first head office visit, the issue of risk to staff resulting from working more closely with Ebola sufferers and the lack of medical evacuation for any staff was taken to Oxfam's trustees. The trustees had played no role in decisions on timing and strategic direction of the response, but when asked to look at the risks they became closely involved and moved quickly to agree the measures required.

Strategies and proposals developed between October and December 2014 were ambitious in terms of scale and focus. This was influenced by pressure from both donors and head office. As the programmes developed and the situation on the ground and funding opportunities changed, it was possible to better assess the potential impact and the challenges of implementing at the scale envisaged in the earlier strategies. As a result, plans were scaled back and Liberia chose to implement a smaller more focused programme than in Sierra Leone.

Discussion

There was no strong call within Oxfam for an early response, but there were some strong voices for greater speed and to a lesser extent scale at an earlier point than this took place. On the other hand, there were major concerns regarding staff safety that had to be factored in. An earlier push came from public health and humanitarian staff.

The discussions also involved a considerable number of separate conversations between different groups at different levels with much going backwards and forwards. This led to a lack of focus and clarity on where leadership lay and what had been decided. There were cases where agreement was made and then withdrawn or decisions were not implemented. 'Over-management led to under-management'. The main challenge for Oxfam was how to cut through the wide array of differing views and achieve faster and more productive outcomes.

The complexity of this debate contrasted strongly with the call by many international players for a military type response. This demands swift assessment and decision making and some form of a command and control system. Whilst Oxfam was keen not to damage internal relationships, it may have ended up doing anyway due to the levels of uncertainty. Good and simple communication of the decisions was hard to achieve. The strict adherence to process, management lines and concern to get agreement of all parties contributed to delays. Staff interviewed related speed and quality of response in-country to strong teamwork and leadership.

Structural changes may need to be considered, but more important seems to be fast decision making mechanisms and clarity on management lines, expectations and where the final decision lies. Also fundamental is giving good leaders the space where merited – and identifying and dealing with poor leadership swiftly.

Whilst the Ebola crisis was a constantly changing situation, its uniqueness was overplayed. Sending in the right people earlier to help with the analysis could have helped Oxfam make decisions earlier.

There was some misunderstanding on the role of trustees who were not as risk averse as some staff believed. However, because of the timing of the shift in programme thinking, they were brought in at a relatively late stage in the process. In addition Oxfam's involvement became lower risk than originally anticipated.

3.6 RISK – BALANCING STAFF SAFETY AND HUMANITARIAN RESPONSE

Consideration of the risks around the Ebola response focused mainly on staff safety with some mention of the financial risk related to both the safety issues and more widely on funding. It was not clear how these were analysed and they were not set against a wider risk framework that included the risks of a lack of or ineffective response.

'Hibernation' of staff was one result of the anxiety for their welfare and, whilst it involved keeping essential staff working, there were very strong limitations on what these staff could do.

The development of SOPs for staff welfare went hand in hand with SOPs for different aspects of programme implementation. The latter are considered under standards (Section 8.2). Both, especially earlier versions, were considered overly restrictive and a block to effective programming by some, and by others to be vital. There were particular and understandable concerns on the inability to evacuate any staff that fell ill.

The development of SOPs for staff welfare took considerable time with a number of iterations and levels of restrictiveness. A visit by a staff welfare expert in November and December 2014 to both country programmes was instrumental in getting more usable guidance and process. Whilst it was not until January 2015 that they were finalised and rolled out, many staff felt reassured well before this date. Monitoring and adherence were stressed as key, and there were examples in both countries of swift action for non-compliance.

Oxfam was requested to recruit, train and manage hygienists to work in the red zones of Ebola facilities managed by partner agencies. After extensive discussion this was not done for a number of reasons. These included the difficulty of ensuring the safety of those staff, and of other staff and patients, given Oxfam's lack of expertise in this field, and the value of having a single and unambiguous management structure inside the facilities to ensure total control of health and safety.

Discussion

The strong focus on mitigating the risk for staff was central to decision making and has been criticised internally as narrow. However, many staff had concerns and in particular the lack of evacuation was a serious issue. It is easy to look back now we know that most of the risk was easily preventable, but this was not widely understood or communicated well at the time within the wider international community. The lack of a wider and well communicated risk framework is an important issue and an area for further development.

Oxfam didn't equip itself with the appropriate expertise to analyse the risk until too late in the response. This analysis would have required both a good understanding of the nature of the disease and staff health, and would most likely draw from different sources. Initial drafts of staff welfare guidelines were more suitable for a front line medical agency and introduced an unnecessary level of complexity. It took a long time before usable versions were rolled out into the programmes. Given the difference made once a staff welfare expert worked with the programmes in November and December 2014, a visit much earlier on in the process could have helped unblock the discussions and lengthy process. Such a visit could have helped avoid suspension of programme activities in July / August 2014 and could potentially have gained at least two months in the response.

It was widely felt that the pre-departure procedures unnecessarily delayed staff deployment, and some respondents questioned whether they needed to be in place to such a degree at the time of the evaluation.

Whilst there are now useful SOPs in place which could be very useful for a future situation a further review might be merited.

3.7 COUNTRY MANAGEMENT

Both the Liberia and Sierra Leone country directors (CDs) were aware of a potential Oxfam decision to bring in an experienced emergency CD or implement some form of separate management of the response (or step aside). It was agreed that in both cases the Ebola Response Manager in each country would report to the CD, who reported to the Operational Response Lead at regional level. Whilst both countries tried to integrate the new management structures, there was a difference in how this worked in practice, in part due to personalities and partly due to operational considerations. In Liberia, the response team operated more separately under an agreed split of some functions such as logistics and human resources (HR). Although not the original intention, the response team had to spill over into separate accommodation in January 2015. In Sierra Leone, there was co-location throughout and functions were less split with the emergency team having a clear lead in many areas.

In both countries, staff from the existing country programmes were deployed to participate on the Ebola response. Members of joint programme teams were reported to have worked together well in general, although there were distinct problems of integration for the logistics teams in Sierra Leone. The evaluators joined teams in field activities in both countries and found them to be functional and well integrated.

Discussion

The initial discussions on separate management caused some anxiety for CDs and senior staff, particularly as the question took time to resolve. The term 'step aside' is probably unhelpful because it has unnecessarily negative connotations. This may explain why although general organisational support for the integration of an emergency response team into the country management was strong, it was not universal. The faster way of working in emergencies – including less participatory decision making – was a challenge for some, but not all, existing staff. The ways of working caused frustrations for the new response team used to a different modus operandi. An Oxfam mid-term review in 2011 into the response to the influx of Ivorian Refugees in Liberia highlighted that the method of implementing an integrated structure slowed down the response.[5] Whilst a review of the 2012 cholera response in Sierra Leone[6] was more supportive of integration, there were staff who challenged this finding. Members of the emergency teams in both countries felt they were unable to act as swiftly as they needed to in this response.

In addition, the emergency lead is usually de facto the face of Oxfam in an emergency and is in the strongest position to represent the organisation externally with up to the minute and first-hand information. They therefore need the space to lead and make decisions.

The choice for Oxfam is between (i) enhancing methods of integrating teams to give sufficient decision making power to the emergency manager or (ii) giving emergency managers the freedom to lead or set up an emergency structure which takes account of existing staff skills and contributions and having the CD lead the rest of the programme or hand over completely.

In either case, especially if that decision is made on a case by case basis, clarifying expectations earlier is important.

3.8 INFORMATION MANAGEMENT

Information was required in different forms for programme management, MEAL and for communication or influencing activities. Strategies and donor proposals included aims and objectives for the intervention, but these did not lead on to monitoring frameworks used in practice for programme management. Regular situation reports (sitreps) were produced, but there was very limited reporting on achievement of results against objectives, as distinct from activities. Programme strategies and logical frameworks did not appear to have been used as project management tools.

There was little evidence of assessments being recorded and used for planning and monitoring during the emergency response to Ebola.

Three distinct streams of information management were in operation during the response: via technical coordinators and programme managers, via MEAL staff and via communications staff. These streams did not appear to be strongly linked. Limited use was made of epidemiological information, with the exception of in Montserrado, Liberia where it was used in daily briefings to orient active case finding activities and as a tool for motivating staff.

In Sierra Leone, a great deal of raw data was produced on programme activities, but little in the way of understandable and useable information. MEAL officers used excel-based data bases as repositories of data, but were not able to provide summarised information to the evaluation team. Some of the most understandable information was not produced for programme management, but for internal communications (e.g. for briefing the CEO when he visited in January 2015) and for donor reporting.

A substantial body of information was held on a dropbox, which was made available to the evaluation team. It was extremely well furnished with detailed daily and weekly reports from the active case finding in Montserrado, but information on other activities in other geographic areas of both countries was piecemeal and inconsistent. It was not possible to find consolidated reports of achievements for the country programmes, which made evaluation of results and impact problematic.

Discussion

Information management is essential to effective humanitarian response and particularly so for response to a crisis as dynamic and multi-dimensional as an epidemic disease outbreak. In this response, with the exception of the active case finding activities in Montserrado, Liberia, Oxfam's information management was often weak with the result being that programme staff worked blind to some extent focusing strongly on activities and insufficiently on context and results against objectives.

Responsibility for information management was disjointed and there were missed opportunities for using information effectively for programme performance, accountability and advocacy.

3.9 MONITORING, EVALUATION, ACCOUNTABILITY AND LEARNING

MEAL are a linked set of functions that are supported in Oxfam programmes by a dedicated team of coordinators, advisers and in-country officers, supported by the Global Humanitarian PMEAL Adviser in Oxford.

The MEAL aspect of the progamme in Liberia was largely neglected until late in the response, with the exception of intensive daily and weekly monitoring during the active case finding in Montserrado. There was a brief secondment of a MEAL adviser from Oxfam Intermon and a MEAL Officer from the Oxfam Pakistan office worked on the programme for a short while from 10 December 2014, after a lengthy recruitment process. While in Liberia, she recruited two MEAL officers who worked on assessments with the protection team and were developing a framework for MEAL at the time of the evaluation in March 2015. This was rather late in the response and had not yet been used to monitor, ensure or improve the quality of the response.

In Sierra Leone, a MEAL coordinator and nine field staff were recruited. Their work included developing MEAL frameworks and setting up databases for recording data from PHE and PHP activities and from the Ebola facilities built and supported by Oxfam. There was a strong link between the MEAL officers and the PHP teams and the officers spent much of their time with the teams in the field. Despite the work done on MEAL frameworks and recording activity data, this did not translate into results-focused monitoring or consistent and usable reporting for much of the response. There was insufficient support and direction provided to the MEAL staff in the field. In order to remedy this, an RRT MEAL adviser was deployed to Sierra Leone for two months from early March 2015.

Discussion

In both countries, the MEAL function was not effective enough to ensure that Oxfam met its internal standards on monitoring, evaluation, accountability and learning.[7] This was partly due to capacity constraints highlighted above. However, there seems to be a more fundamental problem underlying this. The capacity constraints were partly a result of inadequate priority being given to deploying the right people at the right time to ensure that MEAL was effectively implemented. Both at country level and at headquarters, the MEAL function was not sufficiently integrated into the programme response, but was to some extent an annex. Discussions with some senior programme staff suggested that they saw MEAL as something to be attended to when other more urgent humanitarian priorities had been addressed, rather than as an integral part of the management function. MEAL activities were generally carried out by relatively junior staff who may have found it difficult to ensure that it was given the necessary attention.

On the other hand, if MEAL staff cannot provide meaningful information, facilitate monitoring and reporting and help managers and others to deliver on effectiveness and ensure accountability then they are unlikely to be given the priority they need to be fully engaged in programmes.

There was a lack of clarity, or divergence of opinion, for a number of staff interviewed on the following essential points:

• what should be expected from MEAL staff and from their colleagues;

- what MEAL should actually deliver in terms of products / tools and services;
- where responsibility for the quality of this aspect of Oxfam's work sits;
- how accountability between the people responsible for delivering on quality is managed.

This lack of clarity, as well as the inconsistent and sometimes weak capacity of MEAL in Oxfam's Ebola response, contributed greatly to the shortcomings in information management and accountability described in Sections 3.8, 9 and 12.

3.10 PREPAREDNESS AND CONTINGENCY PLANNING

Oxfam places great importance on its work and strengths in emergency preparedness, DRR and resilience and they are important priorities for all countries. It has defined 20 high-risk countries, including Sierra Leone, where country preparedness – a requirement for all countries – is therefore even more important. Neither country had overall preparedness plans in place.

The Sierra Leone country team had a specific cholera contingency plan, based on experience from the 2012 epidemic, but this was not used to inform the Ebola response. During a visit from head office in July 2014 to strengthen the plan, the country rejected the suggestion to widen it to Ebola. Oxfam's Ebola contingency plan for Sierra Leone developed in May 2014 did not envisage a response to the growing epidemic, but rather contained actions to ensure staff health and wellbeing and decisions that may affect established programme implementation were made.[8]

In Liberia, the country team did not have a cholera preparedness plan. They prepared an Ebola preparedness plan in April 2014 with the aim of giving staff guidance on working safely and guidance on actions to be taken based on the possible evolution of the outbreak, the impact on staff and the plans for re-locating, keeping only 'essential staff' in case the outbreak developed further.[9] The plan did not propose to respond to Ebola beyond intensifying personal hygiene messages in areas where risks were low. The plans for hibernation and relocation were outlined. This plan was updated in July 2014.[10]

Discussion

Other agencies found their cholera preparedness plans and experience very useful but this seemed less the case for Oxfam in Sierra Leone. Overall, little thinking had been undertaken in either country or the region on how to increase response capacity and where that capacity would come from. Neither country had local emergency registers.

There was no obvious reference in discussions in either country for the need to strengthen either preparedness or resilience in the transition planning, although Liberia is setting up a national emergency register.

The lack of preparedness for anything other than cholera in Sierra Leone was surprising given its key country status for Oxfam. Liberia had experienced the 2011 refugee crisis. Both preparedness and resilience would normally be a key component of work in fragile states.

It would be useful to have stronger Oxfam guidelines in this area which include the need for pre-formed partnerships and wider country rosters.

3.11 LINKS WITH PREVIOUS ACTIVITIES

Sierra Leone

Prior to the Ebola outbreak, Oxfam was carrying out a wide range of programme activities in Freetown, and in the rural districts of Koinadugu and Kailahun, with a strong focus on WASH (both policy and practice) and promoting women's rights and livelihoods.

In June 2014 in Koinadugu district, Oxfam collaborated with other international actors in support of the district health management team (DHMT) to build the original holding centre outside Kabala.

Following this early response, the long-term programmes were suspended from August 2014. As the Ebola response started on a small scale from September 2014, the urban WASH Programme Manager and other staff were mobilised for activities such as building 108 hand washing stations in Freetown and Koinadugu, supporting the Ebola treatment centre (ETC) at the Lakka hospital with donations of personal protective equipment (PPE), training community health workers (CHWs) and commissioning radio jingles. In both Freetown and Koinadugu, long-term staff continued to be integrated into the Ebola-response teams throughout the epidemic. Although the cholera contingency plan was not used specifically, the community focus of epidemic control that was used for the cholera response was one of the two pillars of Oxfam's operational Ebola response.

Links with previous activities and relationships with local authorities, the DHMTs and other international actors was a strength in the area of PHE and PHP activities. On the other hand, in the area of programme support – logistics in particular – the decision to scale up the existing system rather than put in place a dedicated system for the Ebola response did not provide the support capacity required for such a rapidly-expanded operation.

Oxfam did not have previous activities in Port Loko and Bombali districts, which were included in the Ebola response.

Liberia

Before the outbreak, Oxfam in Liberia had a WASH development programme in the townships in Montserrado. In the early months of the outbreak (April – June) the Oxfam development team was working with the same communities, raising awareness of Ebola and its prevention through the general community health volunteer (gCHVs) doing household visits and through flyers and megaphone messages. This was a rapid response by the development programme, albeit on a small scale.

When the Ebola outbreak started, the Liberia WASH Consortium[11] made requests for funding and submitted proposals to respond to the outbreak,[12] but this was not funded. This proposal was very broad, covering many activities in Montserrado and three other districts in Liberia with little detail on how the programme would be implemented.

The WASH Consortium Coordinator went into 'hibernation' until September 2014. Following discussions with the European Union (EU) – one of the Consortium donors – the Consortium was able to use the contingency money in the EU proposal, and this 60,000 Euro was spent on hygiene kits and social mobilisation in Montserrado. The Consortium agencies then started

work on their own and the WASH cluster was activated. When the Oxfam emergency team arrived, there were coordination and collaboration problems between the Consortium Coordinator and the Oxfam Emergency Team.

Oxfam had development programmes in Grand Gee and Grand Gedeh, but it was eventually decided not to carry out an Ebola response in these areas as they did not have high incidence of Ebola. These districts were included in the EFSVL programme which started shortly before the evaluation was done.

4 PROGRAMME ACHIEVEMENTS IN LIBERIA AND SIERRA LEONE

4.1 LIBERIA

The first phase of the programme was mainly social mobilisation and the provision of hygiene items, aiming to reach 346,000 girls, women, boys and men in four townships of Montserrado, to enable them to take action to protect themselves from Ebola.

The second phase started in October 2014. The concept note 'Prevention of the Ebola Viral Disease Spread in Liberia' covering the period 1 November to 30 April 2015[13] describes the specific objective as: '*To provide targeted WASH support to women, men, girls and boys in Liberia to ensure the prevention of further Ebola virus infections'.* Programme achievements are described below against expected results from the concept note. The intended beneficiaries were 500,000 people in Montserrado and Nimba counties.

4.1.1 Public health promotion and social mobilisation

Box 1: Expected result – public health promotion
Increase in community knowledge and behaviour change on Ebola and Ebola prevention through community-led initiatives, including active referrals of suspected cases to appropriate healthcare services

All the PHP work was done in partnership with the Ministry of Health and Social Welfare (MoHSW).

Montserrado

A total of 486 gCHVs and supervisers were recruited and trained in Montserrado. In the early phase of the programme, the MoHSW recruited, trained and supervised the gCHVs, as programme staff were not able to visit the programme area due to Oxfam restrictions on travel. The initial group of 80 gCHVs trained was part of the 130 already supported through Oxfam's development programme.

During the first two months, these gCHVs did door-to-door messaging on Ebola prevention, encouraging people to follow protocols such as hand-washing, safe burials, and early referrals. Non-food items, including buckets, soaps and chlorine (at least 8,000 kits) were distributed to reinforce the messages and enable hygiene practices. Oxfam also organised radio jingles about Ebola.

The emphasis of the programme changed in November 2014. Active case finding was started, to improve early detection, rapid referral and safe transport of potential Ebola cases. Between 21 November 2014 and 7 January 2015 the team was able to saturate every section of the three areas in Montserrado, visiting and monitoring more than 46,000 households

(346,000 people). A total of 1,156 households registered with sick members; 219 cases (probable and suspected) were investigated and 55 people were referred to Ebola treatment units (ETUs).[14]

Nimba

Oxfam started work in Nimba on 24 October 2014. The social mobilisation component of the programme had similar activities to those in Montserrado, but no active case finding, as there was considered to be no need. Oxfam supported 200 gCHVs visiting households to raise awareness about Ebola and how to prevent it.

From February 2015, the focus changed from house-to-house work to more support for community structures, with training for groups such as community leaders, women's groups, religious leaders and youth groups. The aim was to empower the communities to take positive health actions and to define the roles of community leadership. Support was also given for communities to establish community action plans, giving them a voice to express their needs and plans.

4.1.2 Public health engineering

Box 2: Expected result – public health engineering

Improved public capacity to fight Ebola at both the community and government health levels.

In Montserrado, the PHE team started a programme to build or rehabilitate water and sanitation facilities in 58 peripheral health units (PHUs), 88 schools and 2 communities. This included 133 wells (both new and rehabilitated), 6 new boreholes, 218 hand-washing stations, 52 incinerators, 422 waste bins, 74 blocks of latrine cubicles (either 4 or 2 cubicles), and various other facilities such as pipes, tap stands, placenta pits and ash pits. The plan was also to do training on operation and maintenance of the WASH facilities. The locations were selected based on requests from organisations such as Médecins sans Frontières (MSF). The schools had been closed during the epidemic and many of the health units were not functioning, so provision of these services helped them to re-open and to function effectively.

Nimba County, 19 March 2015. Part of the CCC built by Oxfam. Photo: A. Lloyd/Oxfam

The Oxfam PHE team started work in Nimba in November 2014 (before the PHP team) with the construction and support of community care centres (CCC). Oxfam was initially asked to construct four out of the nine CCCs planned for Nimba, but due to the decrease in the number of Ebola cases and a change in the plans of both the government and Oxfam, only one was constructed – in Saclapea. This was finished by 19 January 2015 and handed over to Project Concern International (PCI) on 25 February.

In Nimba, the PHE team provided WASH facilities at schools and health units: 25 watsan facilities in 25 health units, with an additional 10 planned as part of the scale up; 25 watsan facilities in schools with an additional 10[15] in the scale-up plan.

Oxfam responded to requests for technical support, for example by providing latrines to some isolated families in New Community, and helping the Dollo Town community in Margibi, at the request of the government and to support MSF, as they had a high numbers Ebola cases and a poor water supply.

The PHE team also rehabilitated roads and basic bridges, to help improve access for the referral of patients, transport of samples, etc. The aim was to build, repair or rehabilitate 18 bridges with an additional 10 in the scale-up programme; and 61.5km of road with another 60km in the scale-up programme.

Nimba County, 20 March 2014. Bridge built by Oxfam. Photo: A. Lloyd,/Oxfam

4.1.3 Emergency food security and vulnerable livelihoods

At the time of the evaluation visit, assessment and planning for EFSVL interventions had been carried out and staff recruited, the households were being identified using agreed criteria according to vulnerability, and the programme interventions were due to start in April 2015.

4.1.4 Protection

The Oxfam Protection Coordinator carried out a protection assessment in December 2014 and concluded that the following areas needed attention:

• Confidentiality in active case finding;

• A referral system;

• Feedback to relatives with suspected Ebola;

• Lack of trust in the government and authorities;

• Lack of transparency on the treatment process in the ETUs;

• Stigmatisation.

Box 3: Objectives proposed for Oxfam's work on protection in Liberia

Objective:[16] To ensure the implementation of safe programming as well as to strengthen the ability of girls, women, boys and men to protect themselves in communities, schools and PHU targeted by Oxfam Ebola response.

Result 1: Safe programming approach is known and applied by all Oxfam staff

Result 2: Communities targeted by Oxfam have better access to good quality information about Ebola (prevention, containment, transmission) in order to decrease the level of fear and stigma against survivors and people affected by Ebola

Result 3: Teachers and health workers targeted are able to identify protection risks in the school environment as well as in PHUs in order to find and to apply adequate mitigation solutions

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Implementation of this component started in mid-January 2015, managed by the Protection Coordinator and four protection staff, recruited and trained.

Lack of confidentiality in active case finding was addressed, although by the time this was done, there were very few further suspected cases found.

PHE, PHP and EFSVL staff were given a one-day training on protection. One positive outcome was improved design of the privacy wall in front of school latrines. Other than this, it was not clear how staff integrated protection in their work.

The protection team started training for the women's groups, community leaders, religious leaders and youth groups trained by the PHP teams for Ebola prevention. By late March 2015, 237 women and youth had been trained in Montserrado and 192 in Nimba. In addition, 20 staff and 60 gCHVs were trained in Nimba. The protection training was carried out in small

groups, providing an orientation on protection which encouraged the communities to consider risk analysis, including on gender-based violence.

4.2 SIERRA LEONE

The results in this section are described with reference to the objectives in the two strategy documents that are most relevant to the period following Oxfam's commitment to scale up its response to the EVD epidemic in Sierra Leone.[17]

Although in the second strategy the scale of the response was far more modest than in the first, the objectives are similar. Effectiveness is described below in relation to the objectives framed in these two documents.

4.2.1 Social mobilisation[18]

Oxfam Response Strategy Ebola Virus Epidemic Emergency in Sierra Leone November 2014 to April 2015; 3 December 2014	Oxfam Response & Transition Strategy Ebola Virus Disease Emergency in Sierra Leone November 2014 to June 2015; 12 March 2015
Objective 1: To develop community action plans to reduce EVD transmission, and to increase prevention and the greater acceptance of survivors and those living in affected households.	**Objective 1:** To support the development of community-owned action plans to prevent and reduce EVD transmission; to strengthen community participation in the entire response system; to support early identification of and adequate support to EVD-affected individuals and communities.

Social mobilisation approach

Kagbasia village, Koinadugu district, 21 March 2015, CHC volunteers and supervisor with the community chief. Photo: J. Adams/Oxfam

From late September 2014, the social mobilisation approach was based on working through community health workers (CHWs) in Freetown and Koinadugu. These CHWs were trained to disseminate messages about Ebola prevention in parallel to the massive public information campaigns being pursued during that period. Oxfam's input to mass media campaigns started during the hibernation period, and included some innovative activities, such as producing CDs with Ebola songs for taxi drivers. By late October, Oxfam recognised that this approach was of limited value, as ignorance about the disease or denial of its existence were no longer the main obstacles to people adopting preventive measures and seeking treatment.

From early November 2014, starting in Port Loko district, the approach changed to the current Community Health Committee (CHC) system, aiming at community-level diagnosis and action planning to address the barriers to effective Ebola prevention and case management. A total of 4,400 CHC members were recruited and trained from November 2014 to February 2015 in 10 wards in Freetown and in Port Loko, Bombali and Koinadugu districts. They worked in groups of five in their local area to conduct household visits and hold discussions with influential local actors (chiefs, councillors, youth groups, mammy queens, religious leaders etc.). The work carried out by the CHCs was based on community action plans (CAPs) developed after carrying out "barrier analysis" to identify barriers to preventing and managing Ebola locally. The CHCs and their supervisors and coordinators received cash incentive payments.

Active case finding

This activity was started in with a pilot in John Thorpe near Freetown and Kontorloh in eastern Freetown in late January 2015 and has been used since in all areas with Ebola cases where Oxfam has been working. Overall figures for active case finding were not available during the evaluation visit. In Freetown, the CHC active case finding exercise in January identified 144 cases and referred 74 suspected cases to the CCC in Kontorloh. Of these, 15 were EVD-positive and the 59 negative patients were returned home or to a health facility, depending on their health conditions.[19]

In those places where Oxfam built or rehabilitated CCCs and holding centres, the PHP teams worked with local communities to choose acceptable sites to locate the facilities and to ensure that local people understood how they would be operated. The CHCs subsequently provided an essential link between the CCCs and community members.

Assistance to quarantined households

The state of emergency declared on 31 July 2014 empowered the Government of Sierra Leone to impose quarantine conditions on family members and other close contacts of Ebola cases. This led to thousands of people being forced to stay inside a cordon placed around their homes – sometimes around entire villages – for at least 21 days, renewable in the event of a new case within the quarantined group.

Oxfam provided assistance to several thousand people in quarantine to help meet basic needs for food, water and sanitation, based on a joint PHP/PHE assessment of the conditions and resources in each case. Assistance, coordinated with other actors, included WASH support (water supply, emergency latrines, portable toilets, latrine cleaning kits, hand washing buckets, household hygiene kits, hygiene promotion), and cash for enabling purchase of supplies to complement the basic food rations distributed by WFP.

4.2.2 Ebola treatment and isolation facilities

Oxfam Response Strategy Ebola Virus Epidemic Emergency in Sierra Leone November 2014 to April 2015; 3 December 2014	Oxfam Response & Transition Strategy Ebola Virus Disease Emergency in Sierra Leone November 2014 to June 2015; 12 March 2015
Objective 2: To provide water, sanitation, clinical care and isolation infrastructure and management services in partnership with others.	**Objective 2:** To design, build and possibly co-manage safe isolation facilities, which are accepted by and integrated into the communities served, in close collaboration with medical partners.

WASH in isolation and treatment centres

Starting with the strengthening of water supplies at the Lakka treatment centre in Freetown in early September 2014 and the installation of 108 hand-washing stations later in the month, an important part of the PHE intervention focused on traditional Oxfam strengths. From October onwards, PHE teams built community water sources and rehabilitated or improved water and sanitation facilities at peripheral health units (PHUs) in Western Area (urban and rural) and Koinadugu districts, incorporating the Freetown Urban WASH activities; albeit at a slower pace.

Building CCCs

The bulk of the Ebola-focused work in PHE from December 2014 onwards concerned the construction, rehabilitation or upgrading of CCCs, ETUs and Ebola holding centres (EHCs). CCCs were originally devised by WHO and other agencies in September and October 2014 as a way to increase access to triage and basic care for Ebola, when it was apparent that the construction and opening of ETUs could not keep pace with the increasing number of patients, particularly in more isolated regions.[20] The aim was for all chiefdoms (149) in all 12 districts of Sierra Leone to have at least one CCC to isolate and provide care to Ebola patients. In November 2014, Oxfam intended to build 14 CCCs in Sierra Leone;[21] this was later scaled down to four. Of these, one was never used and two were used as EHCs for holding patients awaiting test results, which could take up to four days before referral to an ETU or discharge/referral to an ordinary health facility. Medair ran the facility in Kontholor as a CCC. There were still two Ebola patients in the facility at the time of the evaluation visit, and one patient being discharged. In addition to the four CCCs built and handed over, Oxfam upgraded the WASH infrastructure in a number of other facilities. See Annex 5 for more details.[22]

In Kumala, Koinadugu district, as well as upgrading the CCC built by WHO and then co-managing it with Médecins du Monde (MDM), Oxfam built and managed a base camp for staff from all organisations who needed to spend time in the village to work in and around the CCC. The base camp, which provided food, lodging and office facilities, had a helipad for arrivals and departures. This facility enabled full access for Ebola-response actors to a remote hotspot. It was later handed over to the Bangladesh Rural Advancement Committee (BRAC), with continued technical support from Oxfam's PHE engineer, deployed to construct a new CCC to replace the original one so as to free up the school where it was located.

4.2.3 EFSVL, protection and gender

Oxfam Response Strategy Ebola Virus Epidemic Emergency in Sierra Leone November 2014 to April 2015; 3 December 2014	Oxfam Response & Transition Strategy Ebola Virus Disease Emergency in Sierra Leone November 2014 to June 2015; 12 March 2015
Objective 3: To mitigate the effects of the Ebola epidemic by responding to secondary issues like food security, WASH, strengthening of and access to essential services, protection and gender.	**Objective 3:** To mitigate the secondary effects of the Ebola epidemic by responding to emerging needs and vulnerability in food security, livelihoods, protection and gender equality.

Emergency food security and vulnerable livelihoods (EFSVL)

At the time of the evaluation visit, Oxfam had conducted a number of EFSVL assessments but no interventions were yet underway.

Protection

No specific information was collected on protection activities during the evaluation visit. Oxfam did not have a protection specialist in Sierra Leone. Advocacy and campaigns staff worked on advocacy on the rights of people in quarantine.

Oxfam's work to reduce stigma attached to Ebola survivors and quarantined people through its social mobilisation activities contributed to their protection.

Gender equality

Efforts were made to achieve a gender balance in the recruitment of CHCs. Despite this, there was a strong numerical bias in favour of men in most chiefdoms and city sections in Freetown. At the time of the evaluation an anthropological study was under way to explore women's and girl's roles in the Ebola response, from both male and female perspectives, and to identify key barriers and enablers for women and girls to participate in the CAPs facilitated by Oxfam. This study should provide new insights into ways to enable stronger participation of women and girls in local initiatives to deal with Ebola, but it came rather late, at the tail end of the epidemic.

A gender specialist was deployed from February 2015. Among other things, she contributed to the anthropological study, to Oxfam's *Ebola is Still Here* report[23] and helped organise a workshop in Koinadugu district on the risk of sexual transmission of Ebola.

4.2.4 Transition

Oxfam Response Strategy Ebola Virus Epidemic Emergency in Sierra Leone November 2014 to April 2015; 3 December 2014	Oxfam Response & Transition Strategy Ebola Virus Disease Emergency in Sierra Leone November 2014 to June 2015; 12 March 2015
No objective in this area	**Objective 4:** To support the eradication of EVD ('getting to zero') and the recovery and increased resilience of basic services to manage EVD risks, especially in the health sector; and to promote increased community awareness of and participation in public health risk management.

No specific activities had been completed under this objective at the time of the evaluation visit (just days after the strategy was finalised), though a number of actions had already been carried out as part of the Ebola response.

5. DISCUSSION OF PROGRAMME ACHIEVEMENTS

5.1 SOCIAL MOBILISATION

In both countries, the early focus of social mobilisation was on message dissemination to raise awareness of Ebola prevention and the importance of early treatment-seeking. The main method used in the social mobilisation was to give standardised messages to the community with a laminated flipchart of pictures or other didactic resources. This was justified at the start of the response by restrictions on movement and interaction with the population. However, the same flipchart remained the main method for communication until late in the response, and other methods, such as laminated cards for 3-pile sorting, which could have been used safely to discuss the transmission of Ebola, were not used. The social mobilisation coordination bodies in both countries encouraged involved actors to use only centrally approved material and messages, which Oxfam did; but the material could have been adapted slightly to use it for other methods. The restrictions on gathering people in groups and on close physical proximity certainly made it more difficult to use these types of methods. These constraints did become looser over time in both countries, and with some basic precautions in place, it would have been possible to adapt tools to make them more interactive.

In both countries, there were missed opportunities for social mobilisation activities with children, who were important to reach because of their roles as sharers of information, potential care-givers and participants in the chain of Ebola transmission. Although the schools were closed, some interesting awareness raising could have been done for the children, such as songs, comic books and games, e.g. snakes and ladders on Ebola that they could play in their houses. Oxfam could have tried to engage with ministries at national level to encourage promotion of these kinds of activity.

By late October, knowledge, attitudes and practices (KAP) surveys in both countries showed that there was a high degree of knowledge and awareness about Ebola, and this level of awareness and understanding was confirmed during the evaluation fieldwork. Oxfam changed focus to more dialogue and action in its social mobilisation approach, working through the gCHVs in Liberia and the CHCs in Sierra Leone to enable communities to identify barriers to more effective prevention and preparedness for Ebola, and developing CAPs to overcome those barriers.

The results of this approach were mixed. The extensive outreach network enabled Oxfam to reach approximately 1.5 million people in Sierra Leone and 0.5 million in Liberia. The approach had a number of advantages, including:

- gCHVs and CHC volunteers came from a variety of backgrounds (established community health workers, teachers, students, farmers, etc.) and were known in their locality, so were more trusted than outsiders and knew the local context and local actors;

- The system provided high coverage, which was particularly useful when carrying out active case finding. If the epidemic had developed as was anticipated in October 2014, this high coverage would have been vital for effective prevention;

- gCHVs and CHC volunteers were well placed to carry out active case finding and referral of potential Ebola cases in a supportive and appropriate way, given their knowledge of

their communities. They helped to provide a link between patients and their families during diagnosis and/or treatment;

- The process of the analysis of barriers and of developing CAPs provided a structured way to assess and address locally specific obstacles to individual and collective Ebola prevention and treatment seeking.

However, the effectiveness of the approach seems to have been somewhat limited in practice. In both Liberia and Sierra Leone the action planning process tended often to be carried out in a mechanistic way, without engaging authentic and equitable participation from ordinary community members. In Sierra Leone, examples of barrier analysis and CAPs seen during the evaluation did not address the determinants of behaviours, but the behaviours themselves. They were simply lists of behaviours ('hiding the sick', 'body contact in public gathering', etc.) that were identified as subjects to communicate about during household visits or meetings with local influencers. See Annex 6 for an example of a barrier analysis and a CAP.

Rather than addressing the legitimate and varied causes of, say 'hiding the sick' (fear of the ambulance; uncertainty of where the person might be taken; intimate conviction that the fever is due to malaria; fear of dying among strangers; concern about the possible cost of treatment and transport, etc.) the CHC volunteers tended to focus during community discussions on message-based sensitisation and awareness-raising to encourage behaviour change. This was probably more effective than mass communications messaging, but failed to deliver the full potential that such a large, expensive and time-consuming operation had. In Liberia, CAPs viewed during the evaluation visit were written in English, which many community members did not read. This gave the impression of a paper exercise that did not serve the intended purpose of facilitating collective analysis and decision making.

There are several reasons why the reality of Oxfam's social mobilisation approach did not achieve the intended effects in terms of community dialogue and action, including the following from the Sierra Leone context:

- The 2-day training for CHC volunteers, necessarily short, given the push to scale up fast, was rather too short to enable them to develop all the necessary knowledge, skills and attitudes they required for their work, particularly given the diversity of their backgrounds.
- Oxfam had little influence over the selection of the CHC volunteers, other than to agree selection criteria with their supervisors and local leaders.
- The CHC volunteers were loosely supervised and supported, particularly in the rural districts, where roads and the telephone network coverage were patchy.
- Barrier analysis is a tool to assess determinants of behaviours in order to design behaviour-change strategies (through communications, and supporting activities). The tool requires a high degree of skill and understanding to use effectively, in order to produce action plans that address behaviours through understanding and influencing their determinants.
- The incentive system and the reporting system and format, which remained in use despite attempts to change it, encouraged the CHC volunteers in 'silent' or 'inactive' areas where there were no current cases of Ebola, to focus on making their allocated number of household visits (400 per month per team of 5 in urban areas, 250 per month in rural districts) to deliver pre-determined messages, rather than working in a more collective and participatory way.

Despite the difficulty of translating the intention of community-led, action-focused social mobilisation into reality on such a large scale, the fact that so many community volunteers were recruited, trained and mobilised for the Ebola response across four districts in Sierra

Leone and two in Liberia was a huge achievement. It probably made a significant contribution to building confidence at community level, which was key to encouraging people to protect themselves from Ebola and react appropriately in case of possible infection.

5.2 ACTIVE CASE FINDING

Oxfam's extensive outreach systems for social mobilisation in Liberia and Sierra Leone really delivered benefits in the area of active case finding: seeking out community members who were sick, carrying out a rapid assessment of their health status and encouraging people with a rapid-onset fever plus any one of the associated symptoms of possible Ebola to refer for diagnosis and possible treatment.

The active case finding programme in Liberia was effective, although it would have been more so had it started earlier. There was a lot of learning as the programme was developed, and issues such as confidentially were addressed. The indicators (in the November 2014 to April 2015 proposal) are 'Number of new EVD cases per day going down over time in intervention areas' and 'Number of community referrals of person to triage unit or ETU showing EVD symptoms'. There is data available and the numbers of Ebola cases decreased, but it is difficult to attribute that to Oxfam's interventions. Oxfam's part in enabling people to get early treatment for Ebola was an essential and appropriate activity but was only one part in a chain involving multiple actors. It may have been more effective if Oxfam had also done the contact tracing; but ACF were already doing that, so Oxfam linked with them, which worked well.

In Sierra Leone, research on social mobilisation and Oxfam's contribution to the Ebola response suggests that the CHCs' work on active case finding and referral was highly appreciated. They provided essential support and encouragement to patients and their families, and this probably contributed to more early treatment and the isolation of a greater number of Ebola cases. This was both more humane and more effective than an impersonal intervention carried out by strangers to the community.

The social mobilisation strategy, which mobilised different forms and intensities of activity according to the presence or absence of Ebola cases in a particular locality (e.g. 'active', 'inactive' and 'silent' zones in Sierra Leone), was an appropriately adaptable form of epidemic response.

5.3 TRAINING

In both Sierra Leone and Liberia, training was a very important activity, both in terms of the numbers of people who needed to be trained in a short time (more than 5,000 gCHVs and CHCs as well as supervisors, staff and community leaders) and in terms of its influence on the effectiveness of the response. Training sessions observed in both countries during the evaluation were heavily based on didactic methods, rather than on an adult learning approach. For example, in a protection training for women's group members in Nimba County, Liberia, complex concepts relating to international law and rights were presented with PowerPoint slides better suited to experienced programme staff than community members. In another training observed, there were 60 learners in the group, which made participation and effective learning impossible for many. Both countries have an education system based on rote learning and a strict hierarchical relationship between learner and teacher. Moving staff

and volunteers away from this model would have required more intensive and dedicated investment in training development and support than was made.

5.4 WASH IN SCHOOLS AND HEALTH FACILITIES

WASH improvements and rehabilitation at PHUs and schools are a major part of the transition programme for Oxfam in both countries.

Visits were made in both Nimba and Montserrado in Liberia to observe the WASH facilities in the schools and peripheral health units. Generally, all the facilities looked well built, and all the health staff and teachers expressed appreciation to Oxfam for their support. During the evaluation visit a number of details were identified that would merit improvement. These are presented in Annex 7.

This programme element started later in Sierra Leone, although there were some works carried out in Western Area District, some of which were under the Urban WASH programme. There was considerable pressure on Oxfam and other NGOs to push ahead quickly with rehabilitation work, to allow schools to reopen and PHUs to function normally and safely, with a focus on quantity and not quality. The evaluation visit included time at the John Thorpe PHU where Oxfam had carried out WASH repair and improvement works as a quick fix to ensure the PHU was operational and able to function safely with the risk of Ebola patients presenting (see Box 4 below). This intervention provides important lessons for others concerning design and construction, management by PHU staff, support from the DHMT, and coordination with other actors. Interventions should take account of the health systems in and around those facilities, including staff, logistics, management and financial resources, in order to ensure they are appropriate and sustainable.

Similar concerns apply to work in schools, with the added requirement to engage with teachers, pupils and parent–teacher associations.

Sharps pit, incinerator at PHU, John Thorpe, Western Area District, 18 March 2015. Photo: J. Adams/Oxfam

The hand pump was repaired by Oxfam, then broke, was repaired again and was broken again at the time of the evaluation visit. Oxfam rehabilitated the latrines, and another NGO subsequently built two new latrines and two showers. Oxfam staff were not aware of this plan. A new incinerator was built by Oxfam out of steel sheet (firebricks were not available) to a non-standard design; it will have a relatively short lifespan and has no proper system for disposing of ash. The sharps pit already had a syringe-and-needle stuck across the bottom of the feed pipe. There was no fence around the waste-disposal zone.

5.5 CONSTRUCTION OF COMMUNITY CARE CENTRES

The construction of CCCs and, potentially, the provision of operations, maintenance and hygiene services, including clinical hygiene in the red zone was a much-debated subject in Oxfam. Such a new and specialised technical and management area, with all the associated risks to staff and patients was eschewed by some PHE advisors and managers because of Oxfam's lack of experience in this highly specialised area where mistakes could be fatal. Clinical hygiene management was not included in the response finally, but the debate, and associated uncertainty about funding and the process of working out the agreements with partners, delayed the start of construction activities. Further delays occurred in some instances because of prolonged negotiations with the medical partner and changes to plans. See Section 10 for more discussion on this. In Sierra Leone, construction of the CCCs and other Ebola facilities was mostly completed by early January 2015. At the time of the evaluation visit, work on the Kasumpe EHC outside Kabala town and the new EHC in Kumala, both in Koinadugu district, was still ongoing. The Saclapea CCC in Nimba County, Liberia, was completed and handed over to the medical partner in late February.

The CCC approach was demonstrated by CDC research and modelling to be effective in preventing Ebola infections, compared with the alternative of leaving patients at home with no safe isolation and unsafe burials, particularly at a stage where there are insufficient ETUs.[24] The effectiveness of CCCs depends essentially on them being built quickly and filling the gap in access to care in ETUs. In the case of several of the CCCs built by Oxfam in Sierra Leone, and the one in Liberia, by the time they were ready to be used, the coverage by ETUs had considerably increased, the ambulance services had vastly improved (for patient referrals and for transport of samples for diagnosis), as had laboratory services. Even more significantly, in Sierra Leone the epidemic curve countrywide and in the districts where Oxfam was operating was in steep decline (apart from in Freetown where the decline was less steep). In Nimba County, Liberia, there were no more Ebola cases when the centre was finished. The usefulness of these structures as CCCs became questionable. Again, had the epidemic continued at high intensity for longer, these facilities would have proved to have been essential. Some were to be included in a network of 30 units that the National Ebola Response Centre (NERC) planned to maintain until June 2015. See Annex 6 for more details for Sierra Leone.

The structures used as local centres for triage and diagnosis of potential Ebola cases had two main advantages: they freed up local health structures for normal health services and provided a more friendly and accessible route to diagnosis and referral for people with Ebola-

like symptoms. As such, they were appreciated by local communities and continued to play a role in supporting active case finding and broader social mobilisation activities at the final stage of the epidemic.[25]

Designs from MSF and WHO were used as the basis for the layout and operation of the CCCs. The centres visited at John Thorpe and Kontorloh were of an excellent standard of design and build, including relatively complex water-treatment and supply systems, latrines, temporary buildings and concrete floors, gravel pathways and fences. The medical staff interviewed on site were very pleased with the facilities and had found them perfectly adequate for clinical activities, infection prevention and control and for the needs of staff, patients and visitors. The construction process involved intensive consultations with the medical partners over the three to six weeks needed for building the facility and training staff.

The CCC built in Saclapea was a good combination of permanent (using the old Lassa-fever ward) and temporary structures, making it easier to convert to more permanent isolation area and infectious disease ward. PCI, the medical partner, was generally very happy with the design and the layout, although on observation, there were a few points in the layout that could be improved. These points demonstrate the need to link with people with experience of working in CCCs/ETUs to get the design appropriate to the needs.

5.6 SUPPORT TO QUARANTINED COMMUNITIES

Part of the government strategy to fight Ebola was to place immediate contacts (essentially family and neighbours) in quarantine for 21 days, to facilitate contact tracing and rapid detection of new cases, and avoid the spread of contamination out of the locality. The enforcement of quarantine was not demonstrated to be effective in controlling the spread of Ebola, giving rise to cases of abuse of basic rights to protection and assistance and contributing to a pattern of coercion, rather than enablement in the fight against Ebola. A study on the subject in Sierra Leone drew the following conclusions:[26]

• Self-imposed quarantine has proved less problematic [than imposed quarantine];

• The timely and reliable delivery of resources (e.g. food and water) and expertise (e.g. contact tracing and safe and dignified burials) is essential to ensure cooperation and deter quarantine violation;

• The communities' understanding of the benefits of quarantine and its role in stopping the outbreak is essential;

• Coercion is counter-productive.

Oxfam's support to people in quarantine in Sierra Leone reduced the hardships and made quarantine more effective by reducing people's need to leave the quarantine area to seek basic necessities. The PHP teams also worked effectively to address stigmatisation of people who had been in quarantine. At the time of the evaluation visit, 900 people were being supported in Rosanda village in Bombali district. In this particular local outbreak, the provision of latrines was an important intervention to reduce risks of cross-infection within the quarantined population by reducing the number of people having to share the same toilet.

In Liberia the quarantine policy of the government was less extensive and less draconian than in Sierra Leone. Oxfam's team in-country judged the quarantine approach was ineffective, so did not engage with it after September 2014.

5.7 DISTRIBUTION OF HYGIENE ITEMS

In Liberia, distributions of hygiene items, such as buckets for hand-washing, were popular and useful. In September 2014 these items were delivered to both quarantined households and those living in the epicentre of the Ebola outbreak. At this time, West Point township was under quarantine, so it was considered a very timely intervention. Later, the distribution of hygiene kits was shifted to focus on hand washing in communal areas. Some felt that there were enough buckets and soap at household level, so it was useful to shift to communal locations. Discussions during this evaluation (linked to a voting exercise with a group of women in Montserrado) showed that some were not clear on the distribution mechanism and didn't think it was fair. There was a need to be more transparent about decision making here (see Section 9 for more on accountability to affected people).

Oxfam's initial response in Sierra Leone involved distribution of hygiene items, such as hand washing kits in communal places. In the response from December 2014 onwards, hygiene items were used in a targeted way for specific purposes, sometimes in the form of kits (e.g. interim-care kits provided during active case finding to enable the safe care of people with Ebola-like symptoms awaiting referral; Ebola survivor kits/solidarity kits to replace personal items destroyed as part of infection prevention and control; and quarantine kits for enabling hygiene practices for people in quarantine). It was entirely appropriate to avoid mass distribution of hygiene items and to keep their use targeted and specific.

5.8 THE ROLE OF PHE

Oxfam's PHE teams were faced with an unusual situation in the Ebola response. In spite of the internal and external pressure to produce a robust WASH response, there was not an obvious substantial need to provide WASH services and facilities at community level, which is their normal speciality. There were, however, a number of technical interventions that could have helped other agencies such as MSF that lacked the necessary technical skills and equipment in the early stages of the response. Indeed, PHE teams did do some effective WASH activities, including WASH support to treatment facilities in the early stages, but on a limited scale. More substantial interventions to rehabilitate and improve healthcare facilities and schools came towards the end of the response. Oxfam also responded in a broad and flexible way by applying its strong engineering capacity to other works, such as building CCCs and other isolation and treatment facilities (with WASH as a critical core element), repairing or upgrading roads and bridges, and building a base camp for humanitarian operations. These were appropriate interventions, generally well executed on a technical level that demonstrated the organisation's capacity to adapt and be creative. If this role had been recognised and supported earlier, there could have been more activity and greater impact through PHE.

5.9 INTEGRATION OF PHP AND PHE

One of Oxfam's strengths is the integrated public health approach, through which synergistic interactions can be achieved between PHE and PHP. In the Ebola response there was mixed success in pursuing this approach, and this had an impact on the overall programme quality.

The PHE and PHP components of the Ebola programme in Liberia were generally not well integrated. The SWOT analyses done in both Nimba and Monrovia listed the lack of internal coordination and integration as a weakness. Until recently there were no joint PHP–PHE

meetings or field trips. During the evaluation visit, the team in Nimba allocated one day to PHP and one day to PHE. The PHE Montserrado sitrep of 1–15 March 2015, states, '*we have started the process of proper integration of PHE and PHP…*'. As part of this process, a meeting with the PHE and PHP team was held in Monrovia and it was clearly demonstrated that the two teams did not have a clear picture of each other's activities.

This lack of integration was in great part because the PHE activities started later than the PHP component and, in several cases, they were in different areas. In addition, much of the Ebola response focused on social mobilisation and active case finding, activities without any specific PHE component.

In Nimba, both teams worked together in January 2015 on the assessment and planning for the schools rehabilitation. However, at the time of the evaluation in March 2014, the PHE team was constructing the latrines at the schools and then 'handing over' to the PHP team; memorandum of understandings (MoUs) had not been signed with the school, or the PHE and PHP teams. The PHP team were not involved in the early stages to help get the teachers, Parent Teachers Associations and pupils engaging in increasing ownership.

In Sierra Leone, PHP and PHP teams worked closely together with local stakeholders to negotiate acceptance of CCCs where they were built. Assistance to quarantined communities was integrated, starting with the assessment of needs and resources. In some of the PHU WASH rehabilitations, attention to operation and maintenance of the facilities built or repaired was not strong (see the example of the John Thorpe PHU in Section 5.4), but this was less a question of integrating PHE and PHP than of integrating institutional and management concerns into the hardware intervention. In the bulk of the social mobilisation activities, there was no integration with PHE because there was no PHE component.

Discussion

The Ebola response was a challenge for integrating PHP and PHE, partly because the two sub-sectors were often engaged in different places, in different activities and with different actors. Whereas in a more conventional WASH programme the two sub-sectors would be working on the related 'hardware' and 'software' elements of the same intervention, in this response PHE and PHP were often engaged in divergent interventions where needs and opportunities for integration were not so great.

It was appropriate in the emergency phase that social mobilisation was a dominant element of Oxfam's Ebola response and that there was little need or possibility to integrate with PHE activities at community level. Integration is not an end in itself and is only valuable so far as the benefits outweigh the additional costs in terms of time and effort. However, WASH rehabilitation and upgrading in schools and health facilities required stronger integration than was demonstrated at the time of the evaluation.

Programme managers have a strong role to play in facilitating integration at an operational level. They need sufficient time and space to be able to do this.

The foundation of an integrated response is joined-up analysis and planning. The programme strategies for Liberia and Sierra Leone did not make explicit links between the different strands of the intervention, either in the way that objectives and activities were formulated, or in the management arrangements proposed.

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6. POLICY / ADVOCACY / COMMUNICATIONS

International influencing work began earlier in the crisis than Oxfam's scale up of activity on the ground and was therefore based on Oxfam's international knowledge and experience (e.g. of the potential economic impact). As time progressed, it was possible to use the experience from programmes to a greater degree. There were a number of key successes and the documents and events referred to below, as well as others, are referenced in Annex 8.

An important briefing produced in early November 2014[27] outlined the importance of prevention and social mobilisation. Whist it was harder to secure donor support at this stage, there was increasing success over time. The release of the report 'Ebola is still here: Voices from Liberia and Sierra Leone on response and recovery' in late February 2014 emphasised the importance of community leadership or involvement and prompted wide external endorsement including in-country but also from staff, especially at national level.

A detailed livelihoods survey undertaken by Oxfam in Liberia in December 2014 was used alongside other statistics to highlight the need for a Marshall Plan for economic recovery in February 2014. This was seized on by the President and got substantial coverage and support but raised the issue that Oxfam had no agreed programme on livelihoods recovery at that time. Subsequent discussions between Oxfam's CEO and the Liberian President led to a strong call to focus on WASH in schools in Liberia and a subsequent Oxfam led side event in Brussels took place.

Oxfam contributed comments and analysis on some health aspects of the wider response, including vaccines, medicine, research and development, epidemic governance and the need for resilient health systems. These were not based on programme experience.

A brief on the role of the private sector was used with a range of bodies and got a favourable response (e.g. from the UN Compact meeting) where it was promoted by Oxfam America. Messaging on quarantining was not possible because there was no existing policy and the two countries had different perspectives. Eventually this was part resolved with a new internal policy.

Oxfam played a strong role in lobbying work, often undertaken in collaboration with others, to get Ebola on to the agenda of key meetings (e.g. G20), secure more funding (e.g. EU) and later in pushing the message of not to let up on the response (e.g. African Union, Francophone). Joint letters with Save the Children (SC) and the International Rescue Committee (IRC) were sent to EU Ambassadors before an EU Heads of State meeting in October 2014 and used during the negotiations to push for a stronger response. Oxfam used the G20 to call on the leaders of some of the world's richest countries to ensure enough money, medics and troops were provided to Ebola-affected areas through letters, briefings, a global petition with SC, Amnesty and others, a video, a day of action and working with celebrities. Oxfam's G20 work achieved major media pickup.

As the epidemic subsided, Oxfam built up messages and influenced thinking on recovery, focused on the Brussels conference and World Bank spring meetings. This included major work at the Brussels side event on WASH in schools, the 'Ebola is Still Here' report,

influencing at the Brussels event, media work and a new report on building resilient health systems.

Initially, a Health Policy adviser led the Ebola policy work, but this was not found to be successful in providing the speed, reactivity and humanitarian focus required, so it was handed back to the Rights in Crisis team, although they continued to work jointly.

Media communications supported the advocacy work and other media work was targeted to fundraising, especially the DEC appeal where there was particularly strong coverage. In October 2014 the work on prevention presented an opportunity to highlight Oxfam's need for funding. A press release highlighting the need for military medics and money was used for the G20 lobbying. Oxfam's call for military involvement was highly unusual and received significant media pickup.

Ideally the media team would have had more local stories to use earlier but there was some reluctance in the region and countries to prioritise this.

Regional influencing work was limited to working with other agencies to promote messages on increased support and cross-border issues, targeting regional events such as a West African Health Organisation (WAHO) meeting and the Francophone Summit.

Country level policy work was slow to start due to major problems in recruitment. This also significantly hampered international level work in the early months. Advocacy work included the use of participation in coordination mechanisms at national and local levels to enhance policy and practice and also influencing through partnerships and relationships. Liberia defined a number of key areas where it wished to focus its advocacy, based on strong evidence. Their livelihoods survey was used locally to argue for the need for a short sharp cash injection across the country. Though this was unsuccessful the study provided valuable statistics that were used widely to raise the importance of the issue. Evidence from the community-mobilisation work and from the community voices publication contributed to Oxfam having a strong voice in coordination and implementation in this area and also helped shape early recovery plans including the development of a protection framework for working with communities. Involvement in achieving better national leadership of WASH has been another key area for Liberia. Influencing in Sierra Leone has included some important work on gender, quarantines, community engagement, district planning and transparency and accountability.

Discussion

Much of Oxfam's policy and influencing work has been very effective. Some powerful international messages were created and taken up and commented on positively with major pressure applied on the EU and G20. The team has undertaken very good monitoring on the take-up, even if impact is much harder to measure. Oxfam has received recognition of its work from senior leaders in the UN, World Bank and EU amongst others.

The main challenge was to ensure that the international work was connected to in-country work to give it greater credibility. Much of the evidence used for international work was from surveys or external information, rather than findings from the programmes. Some of this was due to a lack of programming activity in the policy areas highlighted. The initial and continuing attention to livelihoods did not result in any programming work in-country for a considerable period. In other cases, programme experiences could have been better used. For example, increased evidence from the social mobilisation work, including learning from the two countries, would have enhanced Oxfam's arguments in that sphere. Where international messaging was not based on local evidence could have been made clearer. Local and

regional policy and advocacy staff have an important role in helping translate programme experience to key messages to be used in-country by others and also in attending key events to influence directly.

Whilst there was increasing enhancement of national and local advocacy work in Liberia, targeted influencing at national level was found to be more difficult in Sierra Leone, mainly because of the nature of the coordination mechanisms. This might also be related to Oxfam not being in the relevant consortia.

The lack of common policy was a challenge. In addition to the different approaches on social mobilisation, this was also the case for quarantine and the approach to rebuilding livelihoods. This made overall messaging difficult. It is interesting to reflect on why it was difficult to agree Oxfam's overall position on quarantine and whether some positions should in fact be country specific. A great deal of effort was expended on quarantining and maybe an earlier discussion would have helped make this more productive.

Getting people in-region and at a senior level within both countries to prioritise the advocacy, media and communications work was a struggle at the initial stages. Admittedly, this was at a time of staff concern, skeleton staffing and other more immediate priorities. This work, however, could have helped unlock some of the thinking as well as influencing others, thus increasing impact.

7. IMPACT

The TOR for this evaluation proposed a set of proxy indicators for measuring the impact of Oxfam's Ebola response. These indicators could not be used in practice, either because they were too activity focused to be useful for measuring impact, or because they simply could not be measured in a way that would demonstrate change resulting from Oxfam's intervention.

In the response and transition strategy for Sierra Leone (12/03/15) it is suggested that: *'The impact of our work on social mobilisation and safe isolation cannot be meaningfully measured in this context.'*[28] The context certainly did create obstacles to measuring impact, including the following:

- influence on the evolution of the epidemic was multi-factorial and dependent on a combined effort in a number of inter-dependent areas (e.g. case detection, referral, safe isolation and treatment, contact tracing, safe burials, diagnostic services, health information management, social mobilisation and coordination etc.);
- multiple actors were involved in the response, often working in close interaction with Oxfam (e.g. medical partners in the CCCs, or other social mobilisation actors);
- the performance and attitudes of organisations and government agencies involved in the Ebola response changed over the course of the epidemic, as did the nature and scale of the response;
- understanding of the epidemiology of the disease changed over time, as this was the first time to see an outbreak on such a scale and for such a duration;
- the knowledge, attitudes and practices of the population with respect to Ebola also changed considerably over time as a result of a whole range of factors operating at all levels, right through to intra-household.

In addition, attributing impact would require an ability to describe data before and after an intervention. For example, measuring the impact of active case finding would require looking at data on the average duration between onset of symptoms and referral (walk-in referral or ambulance call) before and during active case-finding.[29].Oxfam's monitoring system was not sufficiently connected to public health surveillance to allow this to be done. Reporting in Sierra Leone did not track proxy indicators of impact, but focused on activity reporting. The impact of Oxfam's response on the evolution of the Ebola epidemic is probably impossible to measure at this stage given the complexity of the situation and the lack of attention to this question from an earlier stage.

Early and robust interventions are key to having an impact on epidemic disease outbreaks. Oxfam's response no doubt contributed to altering the course of the Ebola epidemic in its final phase and should help contribute to 'getting to zero', but it was too late to contribute in a major way to flattening the epidemic curve – achieving substantial reductions in Ebola morbidity and mortality – in either country.

Oxfam's response contributed to other benefits that are not directly related to changing the course of the epidemic but reflected in plans for the transition phase. These are difficult to measure, but some were being studied at the time of the evaluation in the research into social mobilisation and Oxfam's contribution to the Ebola response.

These impacts may include the following:

- restored confidence in, and use of, the health system;

- a reduction in suffering due to fear, anxiety and desperation;

- increased confidence at community level due to the presence of trained community volunteers;

- temporarily improved livelihoods through incentive payments to over 4,500 community volunteers in both countries;

- improved wellbeing and reduced stigma for people in quarantine;

- reinforcement of good hand washing practice, most likely leading to reduction in diarrhoeal disease (reported by health workers in Liberia and Sierra Leone).

Work planned and underway in the transition period is likely to produce other positive impacts connected with resumption of schooling and strengthening of local health services. If these impacts are to be measured, the baseline situation will need to be described clearly in the assessments carried out for this work.

8. STANDARDS

8.1 INTERNATIONAL HUMANITARIAN STANDARDS

The question of standards was raised with most of the Oxfam informants interviewed during the evaluation in both countries. Responses suggest that little use was made of international standards in any formal way, although this does not mean that standards were not achieved.

There were some references to Sphere technical standards for planning services – for example constructing school latrines in Liberia – and as an advocacy tool for working with quarantined households, for example to persuade the Sierra Leone Armed Forces (SLAF) to increase water deliveries to a quarantined community in Koinadugu, Sierra Leone. The Sphere standards for WASH had much less relevance to the PHE work on CCCs, although the hygiene promotion standards did have direct application to the PHP work on social mobilisation. The first Sphere WASH standard on programme design and implementation did not receive much attention in Liberia. For example, the teachers and health staff were not involved in the process of the rehabilitation of WASH facilities, and the system for management and maintenance was not yet in place at the time of the evaluation.

The Sphere Core Standards or the new Core Humanitarian Standards were not spontaneously referred to by any informant in either country, and do not appear to have been used as a programming guide. Adherence was patchy in both countries:

- Oxfam's response was **people centred**, demonstrated through the social mobilisation activities, active case finding and attention to the specific needs of people in quarantine. Local capacity was supported by building on the community groups already in place, for example the gCHVs in Liberia and the CHCs in Sierra Leone.

- Efforts were made to **coordinate** activities and collaborate, despite the unusually challenging coordination environment. Oxfam worked with the Ministries of Health at both central and district levels.

- Regarding **assessments** it is hard to judge. Very few written assessments were seen during the evaluation and although the barrier analysis was supposed to inform specific community mobilisation activities at community level, in practice it did not constitute an effective form of assessment. Major programme commitments, such as the construction of CCCs, appear to have been made without any detailed assessment being carried out by Oxfam and instead were driven by DFID's assessment of needs and appropriate response.

- The **design of the response** in Sierra Leone was heavily oriented by donor pressure and the drive to participate at large scale in the response to Ebola. This was not the case in Liberia where Oxfam developed a programme based on appeal funds and later received support for it from OFDA. The design of certain programme elements was clearly related to assessed needs, and was adapted over time. For example, the social mobilisation programme in Sierra Leone was adapted to become more focused on mobilisation and less on messaging when it became evident that knowledge about Ebola was generally good.

- On **performance, transparency and learning**, many efforts were made, including the commissioning of this evaluation. Monitoring was weak however (see Section 3.8). The

PHP team in Liberia did a mid-term learning review in January 2015, which was documented with a short report. In Sierra Leone, PHP workshops in January and February 2015 were used to review and adjust PHP and MEAL activities. A third joint workshop with PHE staff, originally planned for March 2015, had to be cancelled due to a three day 'stay-at-home'.

• On measures to ensure **aid-worker performance**, systems and procedures were in place to enable staff to work safely and effectively. In Liberia, the Ebola preparedness plan, dated April 2014, provides guidance for staff safety. There were times when the programme was severely understaffed and staff performance was hampered by challenging working conditions. There were also weaknesses in the areas of staff briefings and supervision.

The Ebola epidemic presented unique challenges and required new ways of working. However, it remained a humanitarian crisis like many others. Established humanitarian standards could have been used more effectively by Oxfam, both for promoting and monitoring the quality of its own response, and for promoting respect for humanitarian standards more generally among other actors.

8.2 TECHNICAL STANDARDS AND STANDARD OPERATING PROCEDURES

More specific standards and guidelines for the Ebola response came in the form of numerous SOPs that grew in number and scope over the period of the response. They were drafted by a range or organisations, including the respective Governments – mostly through the NERC in Sierra Leone and the MoHSW in Liberia – WHO, CDC, MSF and other NGOs. They covered such matters as active case finding, safe burial, transport of patients, construction of treatment and isolation facilities and their subsequent decontamination and decommissioning. In Liberia, the PHP staff used various guidelines, such as the MoHSW guide on active case finding, the national guidelines on hygiene promotion, and the WHO/Unicef guidelines for training gCHVs. A summary of informants' opinions on SOPs is as follows:

• there were too many SOPs (18 just for the subject of decommissioning treatment and isolation facilities);

• it was hard to know which one to follow;

• some SOPs were too complicated, some too academic;

• some came too late – not until the activity meant to be standardised had already been carried out for some time.

9. ACCOUNTABILITY TO THE AFFECTED POPULATION

Oxfam's demonstration of accountability in its Ebola response is presented below against the five accountability dimensions presented in the MEAL Minimum Standards.[30]

9.1 LIBERIA

Transparency and information sharing was difficult in the early stages of the programme due to the difficulties getting access to the population because of Oxfam's travel restrictions. Observations and discussions with key stakeholders during this evaluation showed that information about what Oxfam was doing was not clear to everyone. For example, in Nimba some school and health staff knew about the provision of toilets, but because staff were not there all of the time, there was a lack of knowledge and understanding by some key staff. The information was not written down, or posted somewhere, to enable the stakeholders to have a dialogue with Oxfam. There were no noticeboards. A very helpful information sheet 'Q&A about gCHVs' (with staff photos) was given out to communities where Oxfam was working in Montserrado, primarily to help create trust between the volunteers and community members. The language on this sheet could have been clearer and it could have also included information about other Oxfam activities, for example on PHE.

Beneficiary participation was particularly challenging in the early stages of the programme, again due to limited access to the communities. However, throughout the programme the gCHVs, who are members of the community themselves, were a key link. The main methods the gCHVs used were message based, rather than enabling the different sectors of the community, such as children, to participate in a meaningful manner.

Complaints / feedback handling was neglected in the Liberia programme. There was a satisfaction survey done in Montserrado in January 2015 using focus group discussions and key informant interviews to get the views of the beneficiaries about the Oxfam programme, but as the MEAL officer left the report was not completed. There was no effective, accessible way for the intended beneficiaries and communities, agency staff and project partners to give complaints and feedback to Oxfam. Whilst visiting key sites, such as schools and health units, it was learnt that some staff had the Oxfam engineer's phone number and this is how they would give feedback. A handpump was observed not to be working in Nimba during the evaluation and the women living nearby did not know whom to contact to report it / get it fixed. A recent Montserrado sitrep stated: *'Feedback mechanism not yet established as the team does not have enough knowledge and capacity. We are planning to arrange a detailed training for the team for better understanding and to find out the way forward.'*

Staff competencies and international standards are challenging in this type of response. Oxfam staff were inexperienced in responding to Ebola outbreaks and so needed support and guidance. A focus group discussion held as part of this evaluation with a group of gCHVs demonstrated that they are a keen group of people, happy to work with Oxfam in response to the Ebola outbreak. There were periods of staff shortages, putting more pressure on to staff.

There was no evidence of the Red Cross / NGO Code of Conduct being displayed in the Oxfam offices (see Section 8 for more on standards), however, staff and volunteers were given orientation on Oxfam's codes of conduct.

Commitment to continual improvement featured in some parts of the Oxfam programme in Liberia, such as the PHP learning review and the protection assessment which gave some background information on how people felt about Ebola and the impact on their lives.

9.2 SIERRA LEONE

Transparency and information sharing was very limited at the start of the response due to restrictions on access and the strategy of working indirectly. Later, mostly through the social mobilisation work with CHWs and then CHCs, there was a greater opportunity for dialogue. This was limited in practice by the message-focused work that was carried out by CHCs during house-to-house outreach. There was much greater dialogue involved in the active case finding where CHCs were able to inform people with suspected Ebola infection about the referral, ambulance, diagnosis and treatment system to allow them to make informed choices about seeking treatment. Social mobilisation around location and operation of the CCCs also enabled local people to understand the implications of having such facilities in their community.

Beneficiary participation was very limited throughout the response in terms of the vast majority of the 1.5 million people covered by the social mobilisation activities, again due to the one-way communication that appears to have dominated this activity so far. At a smaller scale, Oxfam's work with quarantined people and with people in isolation facilities was quite participatory. For example, feedback from patients leaving the Kumala CCC was used to improve services that Oxfam provided, such as food and clothing.

Complaints / feedback box outside John Thorpe CCC. Photo: J. Adams/Oxfam

Complaints / feedback handling started late in the response. Feedback boxes were being set up by the MEAL team at the time of the evaluation visit. In Western Area district, most of the feedback received in the boxes was from CHC members with requests for protective clothing, t-shirts and other forms of identity or complaints relating to their incentive payments being late. This information was shared with the PHP team. In Koinadugu, local people interviewed referred to the boxes as 'development boxes'. Notes found in the boxes contained requests for Oxfam to rehabilitate schools, water supplies, sanitation and roads etc. Community leaders in Alkalia village in Koinadugu village asked for Oxfam to supply a 'development box' so that they could formulate their requests. The boxes do not so far appear to have solicited feedback from community members about the quality of Oxfam's response. Many people cannot write and so may be excluded from voicing their concerns. The boxes do not seem to be an appropriate complaints and feedback mechanism for this context.

At the time of the evaluation visit, two listening groups composed of formal and informal local leaders had been set up in Kumala chiefdom and were due to meet every 15 days.

Staff competencies and international standards were a problem throughout much of the response, in the sense that it took until late January 2015 to fill all of the positions required to deliver Oxfam's Ebola response. As a result, many people were obliged to manage more than they could reasonably handle, often with inadequate resources and support. Some staff interviewed reported not having been properly briefed on their roles and on Oxfam systems before starting work. This reduced their performance and made more work for colleagues. During the evaluation visit, and through interviews, it was apparent that there were some staff attitudes that were disrespectful of CHC members and ordinary community members. For example, arranging a community meeting for nine o'clock in the morning when intending to arrive in the community at midday, or laughing at people who mistake Aquatabs for an Ebola treatment.

Commitment to continual improvement was not that evident in Sierra Leone, partly due to poor information management (see Section 3.8 for more detail on this). There is reference to accountability in various Oxfam strategies for the response, along with references to mainstreaming protection and gender and building resilience. The PHP team held workshops to capture and share experience.

10. PARTNERSHIPS AND COLLABORATION

Government relationships were actively cultivated in both countries. In Liberia, the main partnership was with the Ministry of Public Works then increasingly with the MoHSW. Government staff at district level and members of the Ebola Task Force expressed their appreciation of Oxfam support and Oxfam staff in Monrovia saw these relationships as a strength of the programme.

In Sierra Leone, Oxfam's work on social mobilisation was carried out in partnership with DHMT. While the DHMTs were a natural partner for the Ebola response, they were also heavily engaged with other external actors and in some cases under resourced and marginalised by the parallel District Ebola Response Centre (DERC) coordination system (see Section 11). Oxfam's support to DHMTs was essential in terms of supporting local capacities for sustainable access to healthcare post-Ebola, but also for promoting confidence in the health system when it had been badly shaken by the coercive nature of the state's response to the epidemic.

Formal partnerships were developed in Sierra Leone with INGOs MDM, Medair and IRC for constructing four CCCs and work on various other isolation / treatment facilities. A partnership with SC was discussed at length but not progressed. These partnerships encountered several difficulties, including: a lengthy process for developing the partnership agreements and getting them signed at headquarters levels and then shared in the field; lack of continuity and consistency in decisions due to staff turnover in partner organisations; insufficiently tight management of sub-contractors for construction work and lengthier and more complicated logistics and administration chains than if works had been carried out by the partner organisation alone. Nevertheless, the partnerships were generally felt by Oxfam managers in-country and by informants from partner NGOs to be successful overall and to provide a useful model for future collaboration of this type.

In Liberia, Oxfam had partnership agreements with:

- MSF: collaborating in discussions on rehabilitating PHUs, designing and testing incinerators and planning to do joint operation and maintenance training programmes.
- Save the Children International (SCI): Oxfam implemented a water supply system at Dolo town, Migribi county with a borehole. There have been discussions with SCI on handing over the system to them for long-term sustainable operation and maintenance.

In addition, Oxfam collaborated closely with MSF and Mentor Initiative and Catholic Relief Services in Montserrado as part of a closely coordinated comprehensive response to Ebola.

Oxfam also had a good working relationship in Liberia with local Ebola task forces, in both Nimba and Montserrado counties. In Sierra Leone, collaboration with formal and informal local leaders was an integral part of the response, as all interactions at community level inevitably involved local leadership (referred to generally as 'stakeholders'). From the early days of the Ebola outbreak, these local stakeholders had been very active in implementing local prevention and response measures, such as control of road movements, setting up hand washing stations and enforcing referral of suspected cases, often through the use of local bylaws. Local councillors, chiefs and paramount chiefs were key actors for facilitating Oxfam's

work at community level, for both social mobilisation and construction work (for example, identifying land for construction of CCCs and brokering acceptance by local people).

Oxfam was not part of the NGO Ebola Response Consortia led by IRC in both countries or the SMAC in Sierra Leone. As noted elsewhere, the Oxfam-led WASH consortia in Liberia and Sierra Leone did not contribute in the earlier stages.

As noted in Section 6, much of the advocacy work at national and regional level was undertaken in partnership with other agencies or other affiliates.

Discussion

Oxfam could undoubtedly have made better use of the WASH consortia they led in both countries, although there were varying reasons for this including their capacity at the relevant points in time and the quality of their analysis of the need and opportunities. This was then actively addressed in Sierra Leone where they were able to readjust the programme at the end of the year to include some response work. There is significant potential for them to make a valuable contribution in the early recovery phase although new WASH funding has been pledged to the Ebola Response Consortium in Sierra Leone of which Oxfam is not a member.

Two reasons cited for Oxfam not joining new consortia were that they were too late and that the consortia were not relevant. Donors are increasingly only funding consortia or significant partnerships and it was not clear that Oxfam made enough effort to join at later points. Neither was it clear that strong partnerships were seen as a way to enhance impact in either country. Oxfam might have been more open in its approach. There were new and existing agencies with additional skills in an outbreak that could have been useful.

The success or learning from the medical partnerships in Sierra Leone provides a key opportunity for the future, and the experience of the discussions in Liberia will also have been useful. Oxfam hopes to continue working with MDM in Koinadugu in Sierra Leone under a new grant and other relationships may endure. In addition, it could be useful for discussions to be held in both countries and at international level on whether there is mileage in more formal agreements as part of preparedness for future outbreaks. Joint learning activities would be useful. It is also worth reflecting on what more could have been achieved in this response regarding partnership with a medical or healthcare agency with a focus on health systems. The two agencies with the greatest potential appear to be MDM and IRC.

The relationship with health authorities at district level in both countries was positive, both for the work on Ebola response and recovery (WASH rehabilitation in healthcare facilities). It was extremely important to maintain good relationships with these long-term partners.

In Koinadugu district, Sierra Leone, the CHCs were recruited through the District Youth Council and the Chiefdom Youth Councils, and the supervisors and coordinator were from the same organisation.[31] The District Social Mobilisation Coordinator contributed to the training programme for CHCs, but otherwise the DHMT was not strongly involved with Oxfam's social mobilisation work. Engagement with the District Youth Council in Koinadugu was expedient in terms of mobilising a large number of volunteers and providing a ready-made supervision structure. In terms of strengthening health services and access to basic healthcare at district level, this was not the most appropriate strategy, particularly given the political dimension of this organisation.

Relations with local leaders in Sierra Leone were inevitably ambiguous given the history of the country over the past 25 years in which brokering aid has been a significant role for local elites. Oxfam's interventions provided many opportunities for material and symbolic benefits

for local leaders, for example through the process of recruiting and incentivising CHCs and their supervisors. Some local relations were obligatory (it is not possible to operate in rural Sierra Leone without the agreement of the local paramount chief) and some were chosen. In both cases, it was important to aware of local political dynamics when managing those relationships.

11. COORDINATION

Government and international coordination mechanisms developed differently in each country. Neither followed the usual international humanitarian systems. In both Liberia and Sierra Leone the CDs engaged with national coordination from the early stages. However it was only possible to play a more meaningful role at this level once the programme got going.

In Liberia from October 2014, the emergency team actively engaged with the coordination mechanisms, taking its experience from local level – particularly Montserrado – to national level and pushing for changes in approach in a number of areas. There was evidence of active involvement in a number of the clusters, and Oxfam's leadership or participation in a number of these was commented on positively. Perspectives on the effectiveness of coordination in Liberia were varied. A mapping of Ebola actors by Oxfam staff in Liberia showed a very complex and confusing landscape with no clear vision of overall coordination. Teams in Nimba and Monrovia also identified coordination as a weakness in the SWOT analyses (see Annex 9), and this was echoed in many interviews. However, Oxfam worked hard to strengthen coordination and made meaningful contributions.

In Sierra Leone, coordination mechanisms were unusually challenging to engage with. The NERC and the DERCs coordinated with a top-down and directive approach, rather than the collegial and facilitating approach that has been developed for other humanitarian responses through the cluster system. The response was organised through a series of pillars. There was a social mobilisation pillar that Oxfam could clearly engage with at national and district levels, but no WASH pillar. Oxfam's ability to contribute to technical coordination in WASH was therefore restricted. Oxfam's credibility in coordination was somewhat limited until its response was scaled up. Nevertheless, Oxfam did make efforts at national and district levels to coordinate and provide leadership, and this was noted by a number of external informants.

In both countries the existing WASH consortia, which could have provided a strong platform for coordination among key WASH agencies, were ineffective in the face of the epidemic and there were missed opportunities for mobilising the combined strength of WASH consortium members. On the other hand, this may have allowed Oxfam to partner with other agencies outside the WASH sector in a more focused way, for example with others in the social mobilisation pillar in Freetown and with MSF in Montserrado.

Discussion

Oxfam's ability to provide leadership for coordination was limited by the lateness of the response and the difficulty of engaging with the coordination mechanisms in place, particularly in Sierra Leone where the response was addressed primarily as a health and security issue rather than a humanitarian crisis. The organisation could have played a stronger role in coordination, despite its lateness. Although teams at local level were active in operational coordination, there could have been more impact if Oxfam had demonstrated stronger leadership and influenced at national and international levels. Possible strategies could have been pushing harder for a WASH sector coordination group or advocating more forcefully for a WASH cluster to be established. There is a great opportunity, and need, in the early recovery phase to influence coordination given the greater number of international and local actors now engaged in Sierra Leone and Liberia and the likely scale of interventions and help ensure appropriate, equitable and durable recovery.

12.   LEARNING AND NEXT STEPS

Oxfam has undertaken a range of learning activities on its Ebola response and sees this evaluation as making an important additional contribution. These include specific pieces of work commissioned to capture evidence:

• a learning review of Ebola social mobilisation interventions in Liberia and Sierra Leone;

• an anthropological study of women's engagement in the Ebola response in Sierra Leone;

• three qualitative research studies looking at the contribution of community-based social mobilisation in the Ebola response;

• a write up of the experience of active case finding and how best to achieve coordination at local / community level;

• country level meetings to capture key lessons;

• reflection meetings at head office.

There was no evidence of capturing quick feedback from departing staff and it would have been useful to better document the reflections. Whilst attempts have been made to do so, there was no strong evidence of learning between the two programmes except on specific aspects as a result of regional staff covering both programmes or staff members moving from one country to another.

Evidence of applied learning was less visible. One positive example from Liberia was plans for building staff capacity in emergency response, linked in with performance appraisals and the creation of a national emergency register.

Whilst many building blocks should now be in place for another crisis of this type, the next epidemic might be more challenging and pose new risks. Consolidation of the various strands would also be useful with better documentation and communication of this learning.

Much useful learning occurred in the area of PHE through the experience of building and supporting Ebola facilities. It is important that this is consolidated and maintained in the form of guidelines, plans and example bills of quantities etc.

Oxfam should also reflect on the learning from other recent responses and draw out anysimilarities with factors highlighted in this report to analyse if there is anything that applies more widely, such as speed of response and decision making.

Wherever possible, thoughts on applying the learning have been included in the recommendations. It will be important for Oxfam to demonstrate change as a result of the valuable learning that is taking place.

Oxfam called for an international evaluation of the response. There are a number of separate international initiatives as well as local ones, described in a coordination meeting as "an epidemic of evaluations and learning". Given Oxfam's openness and in collaboration with others, Oxfam should be in a strong position to contribute to the wider international learning that it has called for.

ANNEXES

ANNEX 1. TERMS OF REFERENCE

Terms of Reference for the evaluation of the Oxfam Ebola response In Liberia and Sierra Leone.

Background

In March 2014, a rapidly evolving epidemic of Ebola haemorrhagic fever started in Guinea. The outbreak subsequently spread massively to Sierra Leone and Liberia. Other countries such as Nigeria, Senegal, Spain, USA and recently Mali have also experienced cases of Ebola virus disease (EVD). On 8 August 8th 2014, WHO declared the Ebola outbreak in West Africa a Public Health Emergency of International Concern (PHEIC). October 17th and 20th 2014, Senegal and Mali have respectively been declared 'Ebola free' but the significant increase of cases in other affected country remains a major international concern. Governments across the world, UN agencies, INGOs and other stakeholders agree that it turned into an unprecedented global public health emergency.

The current epidemic of EVD, caused by Ebola virus, is the most severe outbreak of Ebola since the finding of Ebola viruses in 1976, and by September 2014 cases of EVD from this single outbreak exceeded the sum of all previously identified cases. The epidemic has caused significant mortality, with a case fatality rate (CFR) reported as 71%. As of January 7th, the number of cases is reported below.

Table 1: Confirmed, probable, and suspected cases in Guinea, Liberia, and Sierra Leone

Country	Case definition	Cumulative cases	Cases in past 21 days	Cumulative deaths
Guinea	Confirmed	2471	344	1499
	Probable	282	*	282
	Suspected	22	*	0
	Total	2775	344	1781
Liberia§	Confirmed	3118	70	‡
	Probable	1816	*	‡
	Suspected	3223	*	‡
	Total	8157	70	3496
Sierra Leone	Confirmed	7602	900	2577
	Probable	287	*	208
	Suspected	1891	*	158
	Total	9780	900	2943
Total		20712	1314	8220

Data are based on official information reported by ministries of health. These numbers are subject to change due to ongoing reclassification, retrospective investigation and availability of laboratory results. *Not reported due to the high proportion of probable and suspected cases that are reclassified. ‡Data not available. §Data missing for 3 and 4 January.

From April until September 2014, the Oxfam response was more around staff welfare and keeping the development programmes running. The actual response started in September 2014 as Phase1. The time from September until January 2015 has been designated Phase 2 and Phase 3 is expected to commence in February 2015.

Global objective of the evaluation

To assess the effectiveness and impact of the Oxfam response from a technical aspect and to assess whether Oxfam as an organisation was able to understand and adapt to this very different type of crisis. Learning for the future is an important aspect and recommendations for future responses will be included.

Specific objectives

These objectives have been taken from the DEC Accountability Framework[32] as required by the DEC for evaluation of an appeals response but should clearly contribute to the global objective. As this is not a Real Time Evaluation, these objectives are more appropriate than the usual Oxfam benchmarks.

• Effectiveness and impact

• Adherence to global standards

• Accountability to beneficiaries

• Partnerships

• Application and generation of learning

Methodology

A more precise evaluation methodology will be worked out during an inception meeting.

The consultant will be given a timeline prepared beforehand with key dates for both the epidemic and Oxfam's response.

A literature review will be undertaken of Oxfam key documents and possibly other grey literature.

Interviews will be carried out with Oxfam staff (including programme, media and advocacy)at headquarters, the regional office and within two of the three most affected countries (Liberia and Sierra Leone).

Where the situation permits, interviews will be held with members of the affected community as well as local officials and representatives of UN, Donors and INGOs.

Evaluation Questions

Effectiveness and impact

Effectiveness should be both from a programmatic and advocacy perspective.

• Was the response timely and did Oxfam react early enough to the impending epidemic in developing plans and implementation?

• To what extent were the country programmes/offices and regional office prepared for such an epidemic and were there contingency plans in place?

• Compared to other agencies, how quickly did Oxfam start an appropriate response programme?

• To what extent was Oxfam able to quickly understand and adapt its programmes to the evolving crisis (including an analysis of critical decision-making)?

- Were we clear on what we meant by effectiveness and did we change this definition as the situation changed? What was planned for each period of change and did we achieve this?

- Were the right timely decisions made to adjust the approach to the emerging crisis based on organisational commitments and responsibilities to for example, staff?

- How was Oxfam's risk management, both in terms of readiness and how risk approaches were developed?

- Were decision-making structures clear and were decisions made at the right level? What were the blockers?

- Did the scale-up approach provide the expected results and was it timely? Did the programme show innovation and best use of resources in terms of people, funding and relationships?

- What was Oxfam's added value in the overall response? Has the organisation responded in a way that could be expected of an agency of their size and with their expertise in WASH and EFSVL and overall commitment to humanitarian response?

- How successful was Oxfam in influencing stakeholders to support the social mobilisation approach?

- Did any overall plan exist that allowed Oxfam to put forward its competitive strength and coordinate/develop partnerships/increase its effectiveness?

In its advocacy work:

- Has Oxfam successfully raised the appropriate issues in its advocacy work in a timely manner and are there discernable results arising from this work?

For media work:

- Did Oxfam effectively profile the work of the response in its media/comms?

- Was the media work of sufficient quality and quantity? And did Oxfam get coverage in the desired target markets?

Impact

The impact of a response to an Ebola outbreak can only be measured in terms of less than expected transmission, a flattening of the epidemiological curve, a decrease in the number of cases and deaths or the number that would have died without a response. Oxfam is not a medical organisation and it would be difficult to measure impact exclusively through its activity. Impact would be best measured across all agencies as a collective impact rather than looking at individual agencies.

- In a recent publication it was stated that "Interpretation: Near-term, practical interventions to address the ongoing Ebola epidemic may have a beneficial impact on public health, but they will not result in the immediate halting, or even obvious slowing of the epidemic. A long-term commitment of resources and support will be necessary to address the outbreak.[33] This underlines the difficulty in seeing discernable positive change within a relatively short time period.

Therefore proxy indicators should be used to help judge the Oxfam response. These should include:

- The number of people who received information about the spread and prevention of Ebola but taking into account that there were several sources of information

- The number of safe burials conducted due to Oxfam kits

- The number of health staff in treatment centres who received prevention kits from Oxfam and the number of patients they were able to treat using the prevention kits

- The number of suspected cases who went earlier to the treatment centres/seek for help after hearing from a community worker. This I will be difficult to measure but some idea of the effect could be judged through qualitative data. Analysis of this should also include the "package approach" adopted by the Sierra Leone Team under the DfiD programme.

- Did we have proxy indicators before and did we measure against them? Did these change over time?

- Is there any evidence that Oxfam's advocacy work had any impact on policy and practice of other stakeholders? What were the positive outcomes of Oxfam's media work?

Adherence to global standards

There are no standards for an Ebola response but this section could be expanded to include WHO guidelines and accepted good practice from other organisations such as CDC. This will be discussed during the inception meeting.

Did Oxfam use the Oxfam accountability standards and the quality standards now included in the CHS?

Should Oxfam have used the IASC standards around protection?

Are the SOPs, including those for activities, adequate and were they timely?

Accountability to affected population

Both the governments of Sierra Leone and Liberia put in place restrictions on community gatherings and people assembly. This has had impact on the way accountability could be organised. Given these constraints the following points should be considered in the evaluation.

- Given the nature of the response, was the Oxfam feedback mechanism and information sharing appropriate?

- How did the social mobilisation evolve and how did Oxfam make decisions to change the approach? Was Oxfam timely in making changes to their approach and did they keep up with changes in the environment?

- How did Oxfam shape its relationships with both official and traditional leaders?

- How well did the advocacy and media messages reflect the concerns of Oxfam beneficiaries/affected communities?

- Did Oxfam get the balance right between protecting their staff, working within the restrictions relating to staff welfare, and meeting the needs of the beneficiaries?

Partnerships (relationships)

This benchmark has been changed slightly to include other partners at all levels and not just those with a financial partnership.

- How strategic was Oxfam in choosing its partners and working relationships?

- Did Oxfam make maximum use of the consortia already in place?

- How important were national, regional and international partnerships to the advocacy work, and what was the relative effectiveness of collaboration compared to Oxfam standalone work?

Learning

- Were the right decisions made at the right time based on available information and did Oxfam react effectively to this information?

- Was there a good balance between thinking of staff welfare and getting a programme up and running?

- How was learning done during the response and how did learning feed into the changes made to the programme?

- What has Oxfam learnt from this response and what could be done differently next time?

- What has Oxfam learnt from the new scale-up approach and did Oxfam assess organisational added value?

- Given that this type of epidemic may become more prevalent in the future, to what extent should preparedness measures be put in place both at regional and organisational levels?

- What are the longer term implications post-epidemic for Oxfam in the affected countries? How is Oxfam positioning itself for this?

- What learning is there for Oxfam humanitarian responses of this nature in the future in terms of competencies and areas of intervention?

Expected outputs

A report covering the DEC benchmarks with recommendations for country, region and HQ. The report should include a list of documents consulted and people interviewed. The report should not exceed 25 pages excluding the executive summary and annexes.

Timeframe

Five weeks for preparation, evaluation and report writing. Visits will be made to the Senegal office, Liberia and Sierra Leone

Starting date late March/early April 2015

A debriefing day will be held in each country and in Oxford

Consultant profile

A two person team will conduct this evaluation. The team needs to reflect both programmatic and advocacy experience. One consultant will have the technical skills to evaluate the actual programmatic response whilst the second team member will look at organisational decision-making and the management of the response.

Essential

- A good understanding of humanitarian programmes especially in West Africa

- A good understanding of NGO ways of working and decision-making

- Demonstrated experience of evaluation of humanitarian programmes

- An understanding of the epidemiology (of the Ebola crisis) – technical member only
- Knowledge of international standards, gender in emergencies and social accountability
- Good writing skills in English
- Experience in interpreting data both quantitative and qualitative
- Ability to lead a team of mixed expertise and to oversee interviews and qualitative data collection (team leader)
- Excellent presentational skills and ability to engage with senior management

Desirable

- Knowledge of Oxfam (including advocacy work)
- French may be an advantage for some interviews but not essential

ANNEX 2. LIST OF PEOPLE INTERVIEWED

Oxfam GB head office

Andy Bastable, Head of Water and Sanitation
Camilla Knox-Peebles, Deputy Humanitarian Director
Debbie Hillier, Policy Adviser Ebola
Foyeke Tolani, PHP Adviser
Holly Taylor, Regional Communications Officer from late August to early November 2014
Ian Gray, Humanitarian Press Officer
James Darcy, Vice Chair of the Board, Chair of the Programme Review Committee
Jane Cocking, Humanitarian Director
Jennie Richmond, Deputy International Director until April 2015
Jola Miziniak, Technical Adviser
Larissa Pelham, Head, Emergency Food Security & Vulnerable Livelihoods
Marion O' Reilly, Head of Public Health Promotion
Mark Goldring, CEO
Simone Carter, Humanitarian Desk Officer in key countries (and when in Sierra Leone)
Sophie Mack Smith, Humanitarian Communications Adviser
Sue Turrell, Ebola Response Lead (now Deputy International Director)
Suzanne Ferron, Consultant (conducted a learning review of Ebola social mobilisation intervention and was also consulted in-country)
Ulrich Wagner, Key Country Coordinator
Vivien Walden, Global Humanitarian PMEAL Adviser

Oxfam West Africa regional office

Aboubacry Tall, Regional Director (now Ebola Response Lead)
David MacDonald, Deputy Regional Director (left November 2014)
Jack Frith Powell, Regional Communications and Information Coordinator (in London and in Sierra Leone)
Nick Ward, Regional Funding Coordinator (in Liberia)
Philippe Conraud, Deputy Regional Director Humanitarian until December 15
Vincent Koch, Ebola Response Lead / Task Team Manager until March 15

Oxfam International

Carsten Voelz, Humanitarian Director Oxfam International

Liberia Oxfam

Abdullah Ampilan ("Duoi"), Public Health Promoter on the RRT (has now left Liberia)
Andy Clarke, Project Manager, was seconded to Liberia as PHE Team Leader
David Watako, Urban Sanitation Manager, Monrovia
Drake Ssenyange, WASH Consortium Coordinator
Eric Sitari, Head of Finance
Francis Kimosop, PHP Team Leader, Nimba
George Van Vulpen, PHE Coordinator (moved to Sierra Leone)
K.A. Jahan Rume, EFSVL RRT
Kenneth Kai Kombi, Human Resources and Admin Manager
Mamudu Salifu, CD

Marina di Lauro, Protection Coordinator
Mary Omondi, PHP Team Leader, Montserrado
Miriam (Mimi) Asibal, PHP Team Leader, Social Mobilisation, RRT
Mohammed Kamara, Head of Logistics and Security
Morris Kolubah, Programme Manager, Nimba
Nyan Zikeh, PHP Team Leader, West Point / Clara Town / Logan Town (previously Public Health Coordinator for Liberia)
Paul Kejira, PHP, Nimba
Peter Walker, Public Health Officer, Monrovia
Qasim Barech, PHP RRT, (now left)
Raissa Azzalini, PHP(now Adviser in Oxford)
Ranjit Topno, Accountant
Razia Laghari, MEAL Officer (works in Pakistan but was in Liberia)
Renata Rendon, Policy Adviser
Sisay Woubet, HR Coordinator
Tafirenyika Augustine Mupfanochiya, EFSVL Team Leader, Nimba
Tariq Roland Riebl, Response Manager until March 15
Teferi Goshu, Public Health Engineer, Montserrado
Yasir Khan, PHE Team Leader, Nimba
Zulfiqar Ali Haider, PHE Team Leader, RRT

Liberia external
ACF: Arnaud Phipps, CD
IBIS: Mohammed Haibe, Interim CD
IRC: Lainie, Team leader Montserrado Consortium; Liz Harmen, Project Director
MSF: Lara Jonasdatir, Liaison Officer
OCHA: Laurent Dufour, Team Leader
Plan: Koala Oumarou, CD
UNICEF: Diedre Kiernan, Emergency Coordinator

Liberia attended
Liberia Incident Management System (IMS) Coordination Meeting, 14 March 2015
WASH consortium dinner
Meeting with members of the Ebola Task Force at the District Health Office, Saclapea
Team meeting in Monrovia
Team meeting in Nimba
PHE and PHP teams meeting in Monrovia

Sierra Leone Oxfam
Abbi Luz, Programme Manager, Bombali district
Alison Hagenbuch, Risk and Compliance Manager
Anthony Lincoln, PHP Officer, Kabala, Koinadugu district
Carly Shehaan, Programme Manager, RRST
Destelia Ngwenya, MEAL Advisor
Enamul Hoque, PHE Coordinator (18 January to 15 February 2015)
Esteban Richmond, Senior Logistics Manager
Eva Niederberger, PHP Coordinator
Fatmata Dabo, HR Manager
George van Vulpen, PHE Team Leader, RRT (was previously based in Liberia)
Gwenola Grouhel, Partners and Contracts Manager
Hannah Kpange, Staff Health Adviser

Ian Jacklin, Public Health Engineer, Kumala
Jeff Juaquellie, MEAL Coordinator
Jim Nyandega, Freetown Ebola Response Manager
Lam Jordan, Humanitarian Programme Manager, Koinadugu district (Kumala chiefdom)
Luisa Dietrich, Gender Specialist
Magdelen Nandawula, Deputy Senior Programme Manager, Ebola response
Mahmoud Tunkarah, PHE Officer, Koinadugu district
Margaret Asewe, PHP Team Leader, Kabala
Melissa Ernest, Country Funding Coordinator
Melissa Minor Peters, Anthropologist
Peter Struijf, Ebola Response Manager
Rachel Wilson, Finance Manager
Safari Aime Kainamura, Programme Manager, Koinadugu district
Sajid Mohammed Sajid, Ebola Response Manager (until December 2014)
Shirley Wilson, Business Services Manager
Stephanie Tam, Programme Manager, Urban WASH, Freetown
Susanna Lardies, PHE Coordinator
Tim Forster, PHE Coordinator (5 November to 20 December 2015)
Thynn Thynn Hlaing, CD
Wairimu Munyinyi Wahome, Advocacy and Campaigns Manager (until March)

Sierra Leone external

Concern: Fiona Mclysaght, CD
MoHS: Francis Kanneh, District Social-Mobilisation Coordinator, Koinadugu
MoHS: Francis Moses, District Health Officer, Koinadugu
District Youth Council: Francis Koroma, Chair, CHC Supervisor, Koinadugu
MSFCH: Ella Watson-Stryker, Health Promotion Manager-Outreach, Freetown
IRC: Alicia Fitzpatrick and Laura Miller
IRC: Megan Coffee, Medical Manager, John Thorpe CCC
Kumala chiefdom, Koinadugu district: Paramount Chief Foday Jalloh
MDM Spain: Sara Rodriguez, Medical Coordinator, Koinadugu district
Medair: Florence Atubo, WASH Manager, Kuntorloh CCC
Medair: Trina Helderman, Medical Manager, Kuntorloh CCC
Medair: Troy Baker, Interim CD
Kumala chiefdom, Koinadugu district: Morr Jalloh, Imam
WASH Consortium: Rajesh Sivasdava
Save the Children: Rob MacGillivray, CD
UNICEF: Helen Hawkings, Hygiene Promotion Specialist
UNICEF: Karine Deniel, WASH Cluster Coordinator in Liberia (supporting GoSL on coordination of WASH response to Ebola in Sierra Leone)
WHO: Jean-Pierre Veyrenche, Ebola waste management, West Africa Region
Yagala Sengbe chiefdom, Koinadugu district: Paramount Chief Gbawru Mansaray

Sierra Leone attended

DERC meeting, Kabala, 19 March 2015

ANNEX 3. DOCUMENTS CONSULTED

Oxfam documents

Head office

Timeline of Oxfam's response to the Ebola Crisis. Created for the evaluation team

Quick Summary of Collective RiC work on the Ebola Response. Created for team

Oxfam Strategic Plan 2013 – 2019

Oxfam Ebola response in West Africa rethinking and planning visit. Jane Cocking, 27 October – 2 November 2014

Oxfam Ebola response in West Africa Humanitarian Director visit to Sierra Leone. Jane Cocking, 24th – 30th November 2014

Trip report: Liberia. Jane Cocking (Humanitarian Director) and Camilla Knox-Peebles (Deputy Humanitarian Director), 30 November to 5 December 2014

Oxfam Ebola response in West Africa visit to Sierra Leone and Liberia. Sue Turrell, Camilla Knox-Peebles, Jane Cocking, 2–12 February 2015

Ebola Response Situation Reports. Regular

Ebola Crisis Songsheets. Regular

Correspondence with and reports to trustees. November 2014

Policy documents and press releases. Various see appendix 8

Turning the tide on Ebola: Scaling up public health campaigns before it's too late, Oxfam International briefing. October 2014

Monitoring, Evaluation, Accountability and Learning (MEAL) Minimum Standards in Oxfam Humanitarian Programs, January 2012

Regional

Outcomes of the OGB Ebola Planning meeting / Final action points from Accra Ebola meeting, 1–2 October 2014

Response Framework covering the West Africa Ebola outbreak in Sierra Leone and Liberia. October 2014

Regional funding updates and funding grids. Regular

Overall strategic framework for the Ebola response (Cat 1). November 2014

Joint Oxfam Response Strategy, West Africa Ebola Crisis. D MacDonald November 2014

Liberia

Staff presentations prepared for meeting with evaluators and other visitors

Assessment and Response Update, Nimba County Liberia Ebola Response 2014. October 2014

Protection concept note February – July 2015

Protection analysis. December 2014

Protection training agenda for Ebola response in Liberia. March 2015

Protocol: Active Case Finding , data collection and monitoring. December 2014

Protection training hand-out on gender based violence.

Protection training modules 1, 2, and GBV.

Oxfam in Liberia Ebola preparedness plan. April 2014

Oxfam in Liberia Ebola preparedness plan. July 2014

Potential Programmatic responses to Ebola in Sierra Leone and Liberia. August 2014

Oxfam and Liberia WASH consortium proposed Ebola response, October 2014 – June 2015

Prevention of the Ebola Viral Disease Spread in Liberia 1.11.14 – 30.4.15

Liberia Ebola response Strategy, 1.11.14 – 30.4.15

Liberia EVD Transition Strategy February 1st to July 31st 2015

PHP midterm review, Montserrado, Liberia. January 2015

PHP Strategy, Transition from Emergency to Early recovery (6 months – February to July 2015)

PHP Strategy Ebola response in Liberia. Qasim Barech, RRT PHP, Ebola Response Liberia (November 2014 to January 2015)

Mid term review of Oxfam GB humanitarian response to the influx of Ivorian refugees in Liberia 2011

Community Mobilisation and Active Case Finding. A Learning Review 28 November 2014

Daily and weekly reports for active case finding in Montserrado, November 2014 to January 2015

Sierra Leone

Real Time Evaluation. Oxfam GB response to cholera outbreak in Sierra Leone October 2012

Ebola Response Brief Sierra Leone

Organogram March 2015

Sierra Leone Ebola Contingency Plan, May 2014

Oxfam Response Strategy Ebola Virus Epidemic Emergency in Sierra Leone November 2014 to April 2015. December 2014

Oxfam Response and Transition Strategy Ebola Virus Disease Emergency in Sierra Leone November 2014 to June 2015. March 2015

Oxfam Emergency Response Ebola Outbreak DFID Sierra Leone Mid Term Report. February 2015

Case study: John Thorpe community-based approach to CCC

Sierra Leone Ebola Standard Operating Procedures. January 2015

Sierra Leone sit rep final. Undated, referring to December 2014

Sierra Leone Sitreps 23, 24, 25, 27, 29. Covering the period mid-January to mid-March 2015

Sitrep Port Loko. 16 January 2015

Quarantines in Sierra Leone: Putting people first in the Ebola crisis

Handover notes, Tim Forster. January 2015

DFID Humanitarian Response Proposal Final. Proposed project start date 1st October 2014

Logframe Oxfam SL Ebola Response ECHO. Proposed project period August–November 2014)

Oxfam_Sierra Leone_Transitional PH strategy_v2. February 2015

Sierra Leone Ebola-response plan. August 2014

Trip report: PHP/MEAL support trip Sierra Leone. Simone Carter, 2–22 February 2015

Community based Active case finding PILOT in Freetown Western area. Presentation. January 2015

Public Health Promotion Workshop report. 2–3 January 2015

CHC Model & EVD Rapid Response. Presentation of model. Undated

Ebola Country Response Brief Sierra Leone, 26 January 2015

Port Loko Lunsar Interim Narrative Report to German Humanitarian Assistance. 26 February 2015

CCC Mid Term Report to DFID Sierra Leone. 27 February 2015 v2

DEC Phase 1 Narrative Report. December 2014

External documents

Government of Liberia, Ministry of Health and Social Welfare, National Guidelines on Hygiene Promotion, Monrovia, Liberia 2014

Liberia WASH Consortium, Ebola viral disease response project, Monrovia, Liberia. August 2014 – January 2015

UNICEF, Community training on Ebola. September 2014

Montserrado, County Health and Social Welfare Team, Accelerated integrated active case search strategic plan. November 2014

World Health Organization, Key considerations for the implementation of an Ebola Care Unit (ECU) or Community Care Centre (CCC) at community level Complementary approach – West Africa Ebola Outbreak. Second version. October 2014

Ebola health facilities spreadsheet. dev.data.sierraleone.nucivic.build/node/79/download consulted April 2015

Washington ML, Meltzer ML (2015) Effectiveness of Ebola Treatment Units and Community Care Centers - Liberia, September 23–October 31, 2014, MMWR Morb Mortal Wkly Rep 2015; 64: 67–69

ACAPS Lessons Learned from Quarantine – Sierra Leone and Liberia. March 2015

Medair, Kuntorloh ETC weekly report. 2–9 February FV

Social Mobilisation Action Consortium proposal. 29 September 2014

Table of Key Differences in KAPs (Sierra Leone). December 2014

SL WASH Cluster 4W Activity list 10-03-2015

Sierra Leone Emergency Management Programme, Standard Operating Procedures for Water, Sanitation and Hygiene facilities with reference to Ebola Community Care Units

ANNEX 4. EVALUATION TEAM ITINERARIES

Anne Lloyd

Date	Location	Activities
11.3.15	Oxford	Background reading and preparation with team. Meeting with Jola Miziniak (Skype).
12.3.15	Oxford	Briefing / inception meeting in Oxfam.
13.3.15	Oxford	Background reading. Meetings with: Raissa Azzalini (Skype), Marion O'Reilly, Abdullah Ampilan "Duoi" (Skype), Foyeke Tolani, Andy Clarkea and Suzanne Ferron (Skype).
14.3.15	Fly to Liberia	Team discussion en route to Liberia, via Casablanca
15.3.15	Arrival in Monrovia	Background reading. Meeting with Suzanne Ferron. Social evening with Mamadu Salifu and Sue Turrell.
16.3.15	Monrovia	Briefing with PHP team, including: Miriam (Mimi) Asibal, Mary Omondi, Nyan Zikeh and Suzanne Ferron. Meeting with Qasim Barech (Skype).
17.3.15	Monrovia	Meeting with Zulfiquar Ali Haider. Visit to training programme for a group of women in West Point. Meeting with K. A. Jahan Rume. Meeting with Drake Ssenyange.
18.3.15	AM: Monrovia PM: travel to Nimba	Team meeting with presentations and group activities: Venn diagrams, SWOT analysis.
19.3.15	Nimba county	Briefing meeting with Morris Kolubah. Team meeting at office. Visits with PHE team to Kpatuo Health Centre, Graie School, Zuolay Community Clinic, Mehmpa Public School, Flumpa Clinic, Saclepea CCC / Holding centre. Observed Watsan facilities, met and discussed with staff.
20.3.15	Nimba county	Visits with PHP team (Francis Kimosop and Paul Kejira) to a PHP training programme in Bahne town and a protection training programme in Lorplay. Met a gCHV, did a drawing exercise with a group of children in Lorplay and observed rehabilitated road and bridges. Had a meeting with members of the Ebola Task Force at the District Health Office in Saclapea and a meeting with a community group in Payee village. Had discussions with pair of GCHVs and a meeting with EFSVL Team Leader (Tafirenyika Augustine Mupfanochiya) and a EFSVL Field Assistant.
21.3.15	AM: Nimba PM: travel to Monrovia	Team meeting in Nimba, with activities: timelines, SWOT analysis and discussion of key findings. Travel to Monrovia.
22.3.15	Monrovia	Reviewing and writing up findings
23.3.15	Monrovia	Attended meeting with PHP and PHE teams. Visit with

Date	Location	Activities
		PHE (Teferi Goshu) to Slewion Doe School – observed handwashing and did an activity with a group of children (drawings). Attended a focus group discussion with a group of gCHWVs at the Town hall. Visit to Iron Factory PHU – observed well and incinerator. Visit to Robert H Ferguson Clinic – observed water system, toilets and incinerators, met and discussed with staff.
24.3.15	Monrovia	Debrief with team in Monrovia. Meetings with Nyan Zikeh, David Watako, Peter Walker and Tom Heath, PHE Coordinator. Debrief with Mamadu Salifu.
25.3.15	Flight home	To Oxford, UK.
27.3.15	At home	Meeting with Razia Laghari (Skype). Report writing.
30.3.15	At home	Meetings with Vivien Walden (Skype) and Andy Bastable. Report writing.
31.3.15	At home	Report writing (not full time)
1.4.15	At home	Meeting with Marina di Laura (Skype)
2–7.4.15	At home	Report writing (not full time)
22–26.4.15	At home	Report writing (not full time)

John Adams

Date	Location	Activities
11.3.15	Oxford	Background reading and preparation with team.
12.3.15	Oxford	Briefing / inception meeting in Oxfam.
13.3.15	Oxford	Background reading. Meetings with: Raissa Azzalini (Skype), Marion O'Reilly (Skype), Foyeke Tolani (Skype).
14.3.15	Fly to Sierra Leone	Team discussion en route to Liberia, via Casablanca.
15.3.15	Arrival in Freetown	Background reading. Meetings with Destelia Ngwenya and Jean-Pierre Veyrenche (WHO).
16.3.15	Freetown	Meetings with Thynn Thynn Hlaing, Jim Nyandega and other members of the Freetown Ebola-response team, George van Vulpen, Eva Niedeberger.
17.3.15	Freetown	Meeting with Melissa Ernest. Visit to Kuntorloh CCC and meeting with Medair staff. Meeting with Oxfam staff, CHCs, supervisors and local leaders. Visit to Calaba Town, meeting with CHCs and local leaders. Meeting with health staff. Meeting with Karine Deniel, UNICEF / ACF.
18.3.15	Freetown	Visit to John Thorpe rural community, meeting with CHCs, health staff and local community members. Visit to CCC and meeting with IRC staff. Meeting with Ella Watson-Stryker, MSF.
19.3.15	AM: travel to Kabala PM: Kabala	Meeting with Safari, Margaret and Mahmoud Tunkarah in Kabala. Meeting with Sara Rodriguez, MDM. Attended DERC meeting.
20.3.15	Kabala	Meeting with Francis Kanneh, MoHS. Visit to district

		hospital and Kasumpe holding centre. Visit to Bamukoro village, meeting with CHCs and local community members. Meeting with Gbawru Mansaray, Paramount Chief. Meeting with Francis Moses, MoHS in Kabala.
21.3.15	Kabala	Visit to Hermanoko village, meeting with CHCs and local community members. Visit to Kagbasia village, meeting with CHCs and local community members. Visit to Kasanikoro village, meeting with CHCs and local community members. Meeting with Francis Koroma, District Youth Council.
22.3.15	AM: Travel to Kumala PM: Kumala	Visit Kumala holding centre under construction. Meeting with Carly Sheehan. Meeting with Foday Jalloh, Paramount Chief.
23.3.15	Kumala	Individual meetings with community members in Kumala village. Visit to Alikalia village, meeting with local community members and CHCs. Meetings with Lam Jordan and Ian.
24.3.15	AM: Travel to Makeni PM: Makeni then travel to Freetown	Meeting with Abbi Luz.
25.3.15	Freetown	Preparing country debrief with Carolyn Miller. Debrief with country team. Meeting with Helen Hawkins, UNICEF. Reading. Meeting with Stephanie Tam
26.3.15	Freetown	Meetings with Melissa Minor Peters, Alison, Jack Frith Powell, Suzanne Ferron, Eva Niedeberger and Esteban Richmond.
27.3.15	Freetown (confined to the hotel)	Meeting with Simone Carter (telephone). Reviewing notes.
28.3.15	Freetown (confined to the hotel)	Meetings with Susana Lardies (telephone) and Suzanne Ferron. Reading.
29.3.15	Flight to UK	
30.3.15	Oxford	Meeting with Razia Laghari (Skype). Report writing.
31.3.15	Oxford	Meetings with Vivien Walden (Skype) and Andy Bastable. Report writing.
	AM: Oxford PM: Travel home	
30.3.15	At home	Meetings with Vivien Walden (Skype) and Andy Bastable. Report writing.
31.3.15	At home	Report writing (not full time).
1.4.15	At home	Meeting with Tim Forster (Skype).
2–4.4.15	At home	Report writing and meeting with Enamul Hoque.
23–26.4.15	At home	Report writing.

Carolyn Miller

Oxford Monday 9 March to Thursday 12 March

Interviews with key decision makers in Oxfam HO and inception meeting.

Liberia Sunday 15 March to Friday 20 March

Interviews with key decision makers in Oxfam and external partners. Attendance at the Coordination Meeting, a dinner for the WASH Consortium CDs and an afternoon visit to field activities in Montserrado.

Sierra Leone Friday 20 March to Thursday 26 March

Interviews with key decision makers in Oxfam and external partners.

April

Some follow up interviews with those who had left the programmes or not yet been interviewed.

ANNEX 5. LIST OF EBOLA FACILITIES BUILT OR IMPROVED BY OXFAM IN SIERRA LEONE

The four facilities funded by DFID in the 'build, transfer and community outreach' model are highlighted in grey.

District	Location	Oxfam contribution	Medical partner	Bed capacity	Status as of 16 February 2015
Western Area (rural and urban)	Lakka Emergency Hospital	WASH upgrade	MoHS	20	Immediate closure and decontamination of Ebola facility
	PCM Hospital	WASH upgrade	Emergency	12	Immediate closure and decontamination of Ebola facility
	John Thorpe	Construction and handover	IRC	25	Immediate closure and decontamination
	Kontorloh	Construction and handover	Medair	20	In operation
Koinadugu	Kasumpe	Construction and handover	MDM	7	Not yet used, still under construction
	Kumala	Upgrade	WHO / MDM	28	In operation awaiting the opening of a new EHC
	Yiffin	WASH installation	MDM	27	Never used, to be closed down
	Sumbaria	WASH installation	MDM	27	Never used, to be closed down
Port Loko	Lunsar	WASH installation	IMC / MoHS	50	In operation
	Kontaline	Construction and handover	IRC	25	Never used, immediate closure and decontamination
	Masiaka	Construction and handover	IRC	25	Immediate closure and decontamination

The information in this table was drawn from the following document, published by WHO and the Government of Sierra Leone: Ebola health facilities spreadsheet, dev.data.sierraleone.nucivic.build/node/79/download (consulted 2 April 2015)

ANNEX 6. EXAMPLE OF BARRIER ANALYSIS AND CAP FROM SIERRA LEONE

What are the barriers to stopping Ebola ?
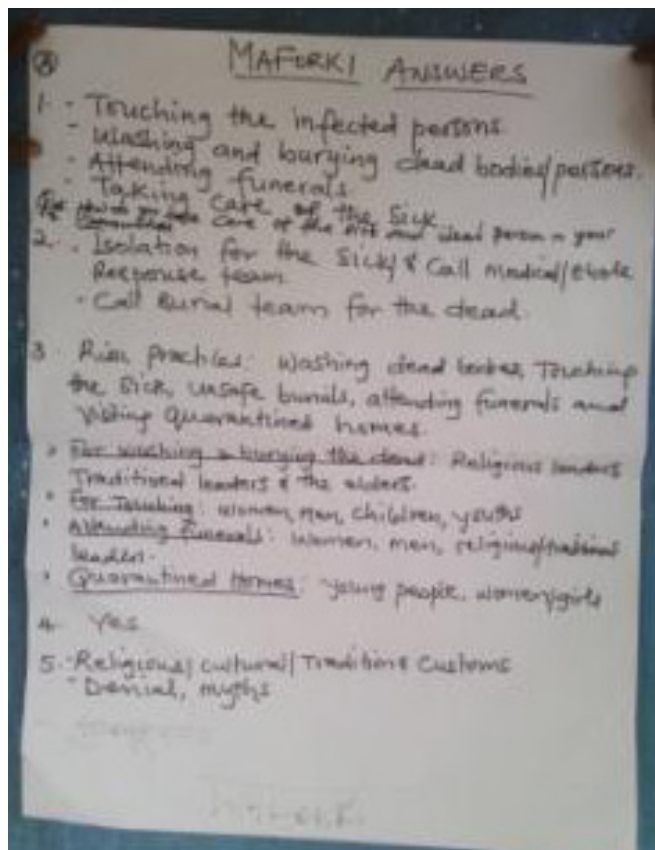
How can these barriers be broken?

Action plan

ANNEX 7. TECHNICAL APPRAISAL OF WASH FACILITIES INSPECTED DURING THE EVALUATION

WASH in schools and healthcare facilities, Liberia

- The latrines would benefit from a handrail inside the cubicle. One latrine observed in Montserrado, which was raised high as it was prone to flooding, had a set of steps but with no rail on the steps, making it risky for the young, the weak and the disabled.

- It was observed in Nimba that some health staff and teachers were not clear on how the latrines would function (they are twin-pit latrines) and when they would be complete. There was no written MoU with the staff, explaining the process.

- Some latrines in Nimba were considered complete, but they still needed hand washing facilities. The PHE team was waiting for supplies before these can be built.

- Some of the taps observed at the hand washing stations in Monterrado were not ideal as they are plastic taps with large grooves which are full of dirt.

- The numbers of latrines at the schools were calculated based on the number of pupils (which is not easy as the pupils are still not all back at school). On questioning, some teachers had the idea that they would be marking some of the latrines for the staff – so limiting the numbers of latrines for the school children.

- At a visit to a health unit in Montserrado, one set of toilets were built raised above the ground due to frequent flooding. There was no handrail on the steps, leaving it hazardous for young children, weak and disabled.

- The incinerators are an essential part of infection control and are a useful component to this programme. However, the engineers have had problems building the incinerators with the cement cracking in high heat. It is clear there is an urgent need for incinerators. Some health units observed had piles of medical waste (including needles and syringes) on the ground in the compound, and one health worker demonstrated how if he had a suspected case of Ebola, he wore protective equipment and then put it into an open bin in the clinic and the caretaker then removed it.

ANNEX 8. OXFAM'S POLICY INTERVENTIONS

Key policies, briefings etc.

Turning the Tide on Ebola: Scaling up public health campaigns before it's too late. October 2014.

A Long Way to Go: The Ebola Response in West Africa at the 60 day mark. December 2014.

Oxfam policy briefing on Ebola for the G20 Heads of State Summit Brisbane 2014. November 2014.

Ebola and the Private Sector: Bolstering the response and West African economies. December 2014.

Quarantines in Sierra Leone: Putting people first in the Ebola crisis. December 2014.

Oxfam Discussion Paper. Improving International Governance for Global Health Emergencies: Lessons from the Ebola crisis. January 2015.

Ebola is Still Here: Voices from Liberia and Sierra Leone on response and recovery. February 2015.

WASH in Schools: Liberia's first step to recovery from Ebola. February 2015.

Key events where Oxfam undertook targeted lobbying or briefing

2014

- UK Government pledging conference for Sierra Leone, 2 October 2014, London.

- EU Heads of State Meeting, 24–25 October 2014

- G20 summit November 2014

- Peace and Security Council Meeting on Ebola 28 November 2014

- Francophonie Summit 29–30 November 2014

- Anniversary 60 days

- UN Global Compact meeting, 12 December 2014

- High level ECHO meeting, 12 December 2014

- WHO High Level meeting on Ebola and Resilient Health Systems, 10–11 December 2014

2015

- Davos 21–24 January 2015

- WHO Executive Board Special Session on Ebola, 25 January 2015

- AU Summit 26–31 January 2015

- Brussels Ebola Conference 3 March, 2015

Press releases to March

More needs to be done to stop the spread of Ebola
16th Oct 2014
http://www.oxfam.org.uk/media-centre/press-releases/2014/10/more-needs-to-be-done-to-stop-the-spread-of-ebola

More military, more medics and more money needed to prevent definitive humanitarian disaster of our generation
18th Oct 2014
http://www.oxfam.org.uk/media-centre/press-releases/2014/10/more-military

Bolder EU response needed to help stop Ebola spiralling out of control
20th Oct 2014
http://www.oxfam.org.uk/media-centre/press-releases/2014/10/bolder-eu-response-needed-to-help-stop-ebola

Oxfam reaction to EU leaders' response to Ebola crisis
24th Oct 2014
http://www.oxfam.org.uk/media-centre/press-releases/2014/10/oxfam-reaction-to-eu-leaders-response-to-ebola-crisis

Mistrust and confusion are allowing Ebola to thrive in West Africa
27th Oct 2014
http://www.oxfam.org.uk/media-centre/press-releases/2014/10/mistrust-and-confusion-are-allowing-ebola-to-thrive-in-west-africa

Almost half the G20 countries have failed to deliver in the global fight against Ebola
12th Nov 2014
http://www.oxfam.org.uk/media-centre/press-releases/2014/11/almost-half-the-g20-countries-have-failed-to-deliver-in-the-global-fight-against-ebola

Oxfam calls for massive post-Ebola Marshall Plan
27th Jan 2015
http://www.oxfam.org.uk/media-centre/press-releases/2015/01/oxfam-calls-for-massive-post-ebola-marshall-plan

President Johnson Sirleaf and Oxfam call for $60m Liberia school upgrade
3rd Mar 2015
http://www.oxfam.org.uk/media-centre/press-releases/2015/03/liberian-school-upgrade

In addition to the above, there were also a range of blogs, comments and updates, etc.

ANNEX 9. SWOT ANALYSIS AND STAKEHOLDER MAPPING FROM LIBERIA

SWOT analysis, Monrovia, 18 March 2015

The SWOT analysis was carried out by approximately 30 people from the Monrovia team – managers and a selection of people from each team, including drivers and administration staff. They worked in four groups with the below result being a compilation of their work.

Although the SWOT analysis was done quite rapidly and there was only a short time for discussion, similarities, differences and main points were discussed (e.g. all four groups wrote 'active case finding' as a strength).

Strengths	Weaknesses
• Active case finding – 74 positive	• Late response
• WASH in PHUs and schools	• Internal coordination
• Field presence /awareness creation in urban slums	• Overlap with other NGOs
• Strong response, powerful decision making	• Limited support directly to the affected families
• Active community engagement	• Poor planning of activities
• Active case finding	• Later intervention, declaring Cat 2, then Cat 1, with late response
• Social /public mobilisation – radio messages	• Lack of prior experience on Ebola
• Relationships with communities	• Lack of support to households that were quarantined
• Ability to mobilise high calibre of staff both in and out of country	• New crisis – limited knowledge
• Sound SOP	• Decision making response and scale up
• Timely procurement of goods / services	• SOPs
• Active case finding	• Resource mobilisation (how to get money and HR into the country)
• Working with Ebola task force	
• Working with CHTs and partners	
• Local coordination among field workers	
• Working with gCHVs	
• gCHVs capacity development	
• Social mobilisation	
• Active case finding	
• Technical capacity: PHE, EFSVL, PHP	
• Campaign / advocacy	
• WASH capacity	
• EFSVL – CASH programme	
• Community and government acceptations / presence	
• Reputation	

Opportunities	Threats
• Learning and documentation on response – infectious diseases • Recovery / long term funding opportunities • Funding • Training (on-the-job) • Linkages to medical partners for future infectious disease response • Additional programmes (e.g. protection) • Communities confidence in Oxfam's work • Oxfam has global appeal • Capacity building (Oxfam) • Going beyond the traditional WASH response • Linking with development issues • Influence • Schools	• Sustainability of WASH facilities • Maintenance of / phase out of staff • Confidence weaning (community) • Constraining SOP (duty of care) • Limited revision of working guidelines • Backlash from communities due to unmet high expectation • Rejection of gCHVs by community dwellers • Cultural practices • Local political dynamics • Maintain quality • Exposure to Ebola

SWOT analysis, Nimba, 21 March 2015

In Nimba, at a debriefing session with a group of programme staff, three groups carried out a SWOT analysis. Below is a compilation of all three groups discussions, with notes from the plenary discussion added and clarifying issues in brackets.

Strengths	Weaknesses
• Human and capital resources – skilled personnel • Management support – capital and HQ • Coordination with other actors • Acceptance in the communities • Competent staff • Logistics / finance / HR • Reporting • Co-ordination • Good planning • WASH knowledge (being Oxfam) • Quick scale up of activities (once started scaled up quickly) • Numbers are talking for interventions (achievements)	• Integration of programmes • Control from CHT on trainings over OGB (could also be an opportunity) • Systematic impact monitoring • Limited integration (within programme) • Late start of interventions (many started late, apart from Red Cross and MSF) • Geographical spread (difficult to get programme quality to Oxfam standard • Proper feedback mechanism (to communities) • No clear coordination (between actors on the ground at the beginning) • IEC (more on video) • Support functions (sometimes problems with logistics, lack fuel, vehicles etc.)

• Geographical spread	
• Working with / through line agencies	
• Community interaction	
Opportunities	**Threats**
• Government support	• Funding
• Staff development	• Dependency on NGOs
• Learning / research	• Sustainability
• Few NGOs doing public health and livelihoods activities	• High turnover of skilled staff
• Funding (donors)	• Pulling out early may affect the impact of the programme (original plan was to leave in April, now plan to leave in July)
• Building / strengthening community structures	• Lack of link between emergency and development
• Opportunity to improve our knowledge and respond better in the future	• Lack of government support for sustainability
• Supported local economy	o Focus on number reached, then ??? (donors pushing for emphasis on numbers)
• Behaviour change communication – current and future	
• Community involvement in action planning	o Wet period and bad roads, external factor not in Oxfam control
• Coordination – WASH, social, health	
• Reach more communities in programme scope	o Further 'outbreak'
• Community support	

Stakeholder mapping done by the Oxfam team in Monrovia

NOTES

[1] http://www.who.int/entity/mediacentre/news/statements/2015/ihr-ec-ebola/en/index.html
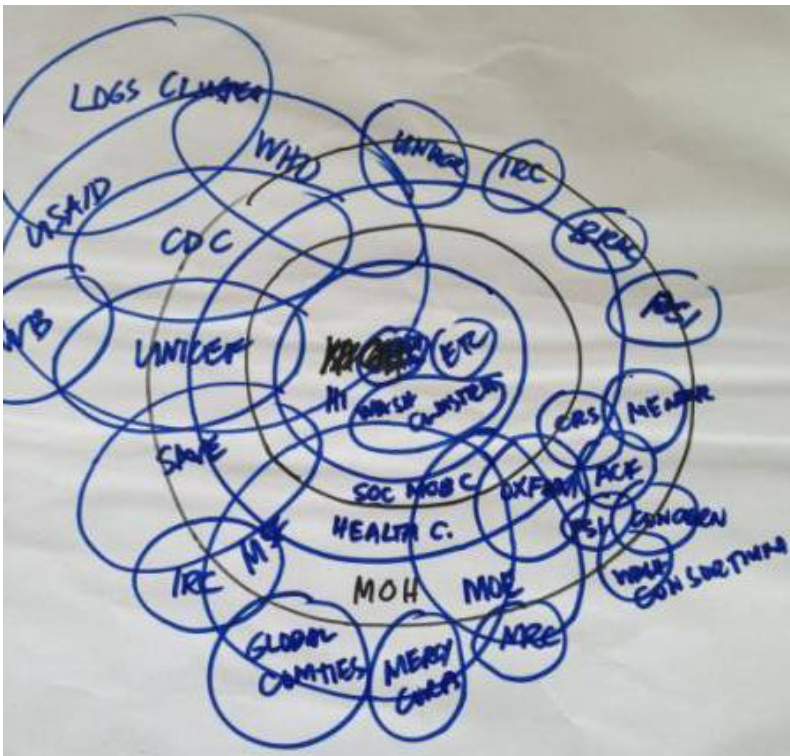
[2] For example in late September the CDC forecast that the virus could potentially infect 1.4 million people in Liberia and Sierra Leone by the end of January and extend over a far greater period than it actually did (Washington Post, 23 September 2014)

[3] Real Time Evaluation. Oxfam GB response to cholera outbreak in Sierra Leone October 2012

[4] *Response Framework covering the West Africa Ebola outbreak in Sierra Leone and Liberia.* October 2014

[5] *Mid-term review of Oxfam GB humanitarian response to the influx of Ivorian refugees in Liberia.* 2011

[6] *Real Time Evaluation. Oxfam GB response to cholera outbreak in Sierra Leone.* October 2012

[7] *Monitoring, Evaluation, Accountability and Learning (MEAL) Minimum Standards in Oxfam Humanitarian Programs,* January 2012

[8] *Sierra Leone Ebola Contingency Plan*, May 2014

[9] *Oxfam in Liberia Ebola preparedness plan,* April 2014

[10] *Oxfam in Liberia Ebola preparedness plan,* July 2014

[11] The Liberia WASH consortium was set up in 2007 as a response to the poor WASH access, lack of harmonisation and coordination in the sector. Currently 5 members (INGOs), with associate members and local partners. The focus is on advocacy, capacity development and targeted service delivery to undeserved areas. Oxfam is the lead agency.

[12] Liberia WASH Consortium, *Ebola viral disease response project, Monrovia, Liberia, August 2014 – January 2015*

[13] *Oxfam Liberia Concept Note Prevention of the Ebola Viral Disease Spread in Liberia, 1st Nov – 30th April* final version December 2014

[14] *PHP MidTerm Review*, 7.1.15

[15] Figures given are for planned results.

[16] *Oxfam Protection concept note for period Feb 2014 – July 2015*

[17] *Oxfam Response Strategy Ebola Virus Epidemic Emergency in Sierra Leone November 2014 to April 2015* 03-12-14 and *Oxfam Response & Transition Strategy Ebola Virus Disease Emergency in Sierra Leone November 2014 to June 2015* 12/03/15

[18] For more details on social mobilisation in Liberia and Sierra Leone see the report of the *Learning review of Ebola Social Mobilisation interventions in Liberia and Sierra Leone* carried out by Suzanne Ferron at the same time as this evaluation.

[19] Excerpt from *Oxfam Emergency Response Ebola Outbreak DFID Sierra Leone Mid Term Report, 17 February 2015*

[20] *Key considerations for the implementation of an Ebola Care Unit (ECU) or Community Care Centre (CCC) at community level Complementary approach - West Africa Ebola Outbreak* SECOND VERSION – OCTOBER 2014 WHO

[21] *Oxfam Response Strategy Ebola Virus Epidemic Emergency in Sierra Leone November 2014 to April 2015*

[22] *Ebola health facilities spreadsheet*, dev.data.sierraleone.nucivic.build/node/79/download consulted 02/04/15

[23] Oxfam International, *Ebola is Still Here: Voices from Liberia and Sierra Leone on response and recovery.* February 2015.

[24] Washington ML, Meltzer ML (2015) Effectiveness of Ebola Treatment Units and Community Care Centers - Liberia, September 23-October 31, 2014, *MMWR Morb Mortal Wkly Rep 2015; 64: 67-69.*

[25] For example, see the Case study, *John Thorpe community-based approach to CCC*, produced by the Social mobilisation and Oxfam's contribution to the Ebola response.

[26] ACAPS *Lessons Learned from Quarantine – Sierra Leone and Liberia,* 19 March 2015

[27] Oxfam International briefing *Turning the tide on Ebola: Scaling up public health campaigns before it's too late,* October 2014

[28] *Oxfam Response & Transition Strategy Ebola Virus Disease Emergency in Sierra Leone November 2014 to June 2015* Draft 12/03/15

[29] Medair's weekly reports from Kuntorloh ETC showed this data: for example, *Medair Kuntorloh ETC weekly report 2nd till 9th February FV*

[30] *Oxfam Minimum Standards and Accountability Dimensions,* 27/01/12

[31] The National Youth Commission was established in 2009 by the Ministry of Youth Affairs, and created a network of District and Chiefdom Youth Councils as fora for youth leaders

[32] See www.dec.org

[33] http://currents.plos.org/outbreaks/article/obk-14-0043-modeling-the-impact-of-interventions-on-an-epidemic-of-ebola-in-sierra-leone-and-liberia/

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