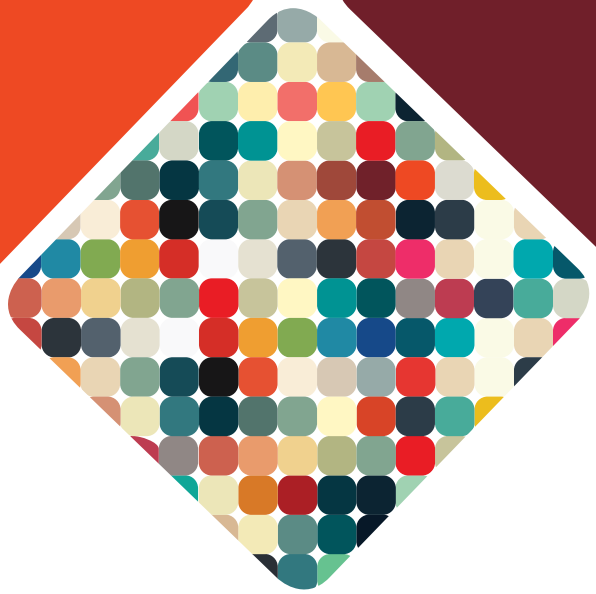


REPORT OF THE REAL TIME EVALUATION OF EBOLA CONTROL PROGRAMS IN GUINEA, SIERRA LEONE AND LIBERIA

SUMMARY

3.1 BACKGROUND

The Real Time Evaluation (RTE) was commissioned by the IFRC Secretariat to assess the Red Cross response to the 2014 Ebola crisis in Guinea, Sierra Leone and Liberia from March 2014 to date. The intent of this RTE is to specifically look at implementation issues, with a focus to improving the on-going and future response needs of affected populations.

The scope includes the assessment of activities to improve the response to affected populations, stakeholders, partners and donors, building on lessons learnt so far in this outbreak.

The RTE team set out to answer the Terms of Reference questions concerning the Red Cross Ebola programs in the three countries. Field visits were conducted at key sites including Guinea, Sierra Leone and Liberia, and Nairobi. They interviewed National Society staff, IFRC delegates, heads of operations, volunteers, representatives of key stakeholders and personnel from the respective ministries of Health. A debrief with the IFRC and National Society personnel involved with the Ebola response was conducted before leaving each country. Key Movement and humanitarian actors collaborating with the Red Cross Ebola programs were interviewed to gain further insight.

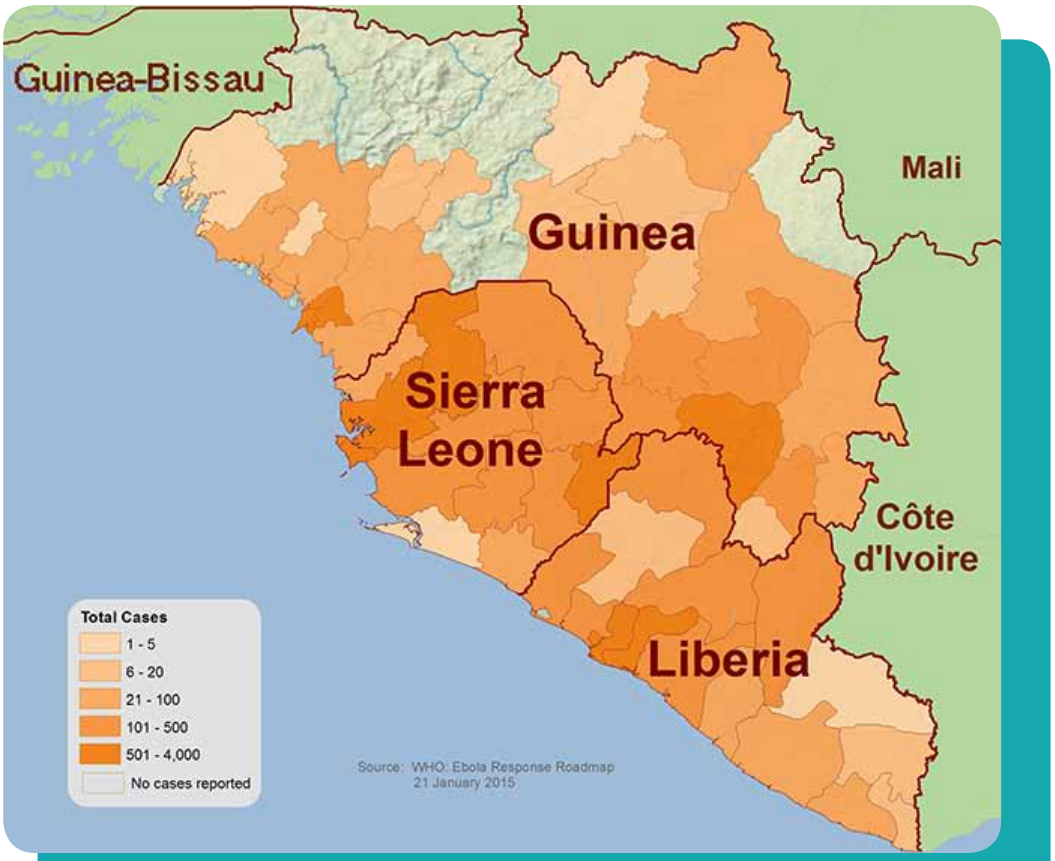
3.2 CONTEXT

The current outbreak in West Africa (first cases in December 2013, first notified in March 2014), is the largest and most complex Ebola outbreak since the Ebola virus was first discovered in 1976. There have been more cases and deaths in this outbreak than all others combined. It has spread among West African countries starting in Guinea before spreading across land borders to Sierra Leone and Liberia, Nigeria, Senegal and Mali. The most severely affected countries, Guinea, Sierra Leone and Liberia, have very weak under developed health systems, lack human and infrastructural resources, and have recently emerged from long periods of conflict and instability.

Although there have been 35 previously documented outbreaks of Ebola (23 in humans) since 1976, the cultural and geopolitical context of West Africa, coupled with fragile systems in the post-conflict region created the environment for this explosive outbreak. This is the leading public health crisis of the decade and certainly the outbreak of the decade, having infected more than 20,000 persons by December end, 2014.

Among the 23 outbreaks of Ebola in Africa, all have been rural in origin, with some previously spreading into hospitals located in small towns. This West African epidemic has demonstrated the consequences of failing to keep the epidemic contained in the rural areas, as the nature and difficulties of control are exacerbated when spread to urban areas. As a public health disaster, the course of the Ebola epidemic and the nature of response is considerably different from other disasters which move predictably from more acute to less acute needs.

The direction of this current epidemic is uncertain, and is likely to involve neighboring countries, and possibly at the same time, become an endemic disease with periodic flare-ups.



Map:Total reported Ebola cases in West Africa, 21 JAN 2015

The outbreak began in Meliandou, Guinea, with the death of a child in December 2013, thought to have been infected by a bat. The outbreak was recognized in January 2014, in the border area between Guinea, Sierra Leone and Liberia, but poor communications and political and cultural resistance hampered timely recognition and extent of the outbreak.

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

Humanitarian policy guidelines which the Federation have used to ensure that the Ebola emergency response meet recognized emergency response standards include, Principles and Rules of Disaster Relief, Disaster Preparedness Policy, Emergency Response Policy and Sphere Standards among other standards available within the humanitarian sector. It is envisaged that the current Ebola response strategy will contribute to the achievement of the Federation-wide Strategy 2020 with emphasis on saving lives and rebuilding livelihoods.

3.3 METHODS AND APPROACH

Method of Inquiry. The qualitative method of inquiry was used in the Ebola RTE. This included key informant interviews, focus group enquiry and desk review. An on-line staff survey also provided data for analysis. Analysis of these data used qualitative data interpretive techniques.

Inception phase. The RTE team met in Geneva on the 27th-29th November 2014. Preparations for the RTE were undertaken with the Evaluation Management Team (EMT) and 8 initial context related key informant interviews were held.

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

Key informant interviews and focus group discussions. Key informant interviews were held in the inception phase to gather contextual information to inform the development of the RTE. Further key informant interviews were conducted in the evaluation. IFRC assistance helped identify key informants in the field, including relevant PNS's including MSF, UN and ICRC in the field. A list of key informants is included in the final report Annex.

Field visits. The Ebola RTE team visited the IFRC in Geneva before embarking upon three in-country field visits to Guinea, Sierra Leone and Liberia and to the Nairobi Zone office. The RTE team divided into two interview teams, working in different countries simultaneously.

On-line survey. A voluntary IFRC on-line evaluation survey was analyzed and is included in the final report Annex.

Feedback and Consultation. Feedback and consultation was fundamental to the RTE process. The evaluators met with and debriefed findings with: respective Federation country offices and in many cases national society personnel, the Zone Office in Nairobi, and by telephone with the IFRC headquarters in Geneva.

3.4 GENERAL COMMENTS ON THE EBOLA RESPONSE

The Ebola Real Time Evaluation (RTE) team found very dedicated delegates, national society staff and volunteers working with great commitment in difficult circumstances. The volunteers and their work is a great credit to the Red Cross Red Crescent Movement as well as the organization and leadership of the response to this epidemic. The Red Cross activities have played a critical role in preventing progression of the epidemic and sustaining these will be a major tool for the elimination of Ebola. Volunteers have often completed these roles quietly, not receiving the attention that other organizations involved in the response have received. Particularly, this has been true for the safe and dignified burial teams. This activity by the Red Cross has played a major role in the interruption of transmission of Ebola in many parts of the three countries. The work by the Red Cross has set the standard against which the response to future outbreaks will be judged.

Excellent work has been accomplished the other four pillars as well. Some of those interviewed wished that the Red Cross had been able to establish more comprehensive activity performance in other areas. However, it is good management not to extend resources beyond means, even in the face of this emergency. Country programs with the assistance from Regional Management, extended activity into cooperative synergistic work areas with other actors involved in the response when opportunity arose.

At the same time the presence of an extensive network of volunteers across the three countries, and no major difficulty in recruiting persons to work gave the Red Cross and comparative advantage that no other organization had. The willingness of the volunteers to work in very demanding circumstances speaks very well of their commitment, as well as the leadership by the national societies and the IFRC. The RTE evaluation team found that in all places they visited the volunteers were treated with respect and concern by leadership.

The unpredictable pattern of this epidemic coupled with the weak systems in the three post-conflict countries, has made this an especially difficult challenge. The epidemic is slow to come under control in Guinea and Sierra Leone. Although Liberia has achieved considerable success, it has not reached elimination and the situation can still deteriorate. The signs point to a continuation of the epidemic well into 2015. Of particular concern is Guinea, where the response has been problematic and where the Red Cross response is the weakest of the three countries. The continued spread of the disease into remote rural areas is steadily increasing the complexity and difficulty of control as well as likely extending the amount of time required to reach zero cases.

The epidemic is of a different order than other disasters commonly dealt with by the IFRC. Instead of starting with devastation and building back services and livelihoods, the Ebola epidemic expanded and moved in uncharted ways. The effective disaster response approaches of the IFRC should be re-examined in the light of this epidemic to see how alternate management paradigms might have strengthened the Red Cross response. It could be that a modified disaster response approach, utilizing different skill sets and different approaches would be developed for future epidemics. This could build on the Red Cross/ Red Crescent experience with SARS, cholera, meningitis, MERS, H1N1 as well as measles.

The RTE team approached the evaluation with a focus on assessing how the IFRC was contributing to saving lives from Ebola. Given the directions of the epidemic and where it was currently going, what more, the team sought to find out, could be done within the Red Cross Red Crescent mandate to shorten this outbreak? The team of four evaluators visited the three countries, working in teams. For each country, the findings and recommendations are set out individually. Those that applied to all sites are noted below. Personnel from the National Societies, as well as IFRC delegates were very generous with their time and resources to assist the RTE team, for which we are most grateful.

Undoubtedly, there will be multiple retrospective examinations of this Ebola outbreak, searching for lessons learnt, and information that could shape the next response to the next outbreaks, whether they be Ebola or another emerging/reemerging disease. While the IFRC would certainly be a part of any multi-agency review and assessment, it is our suggestion that the IFRC, with the assistance of the relevant national societies undertake an in-house assessment of responses in the sectors for which it had responsibilities. This could look at multiple organizational issues as well as epidemic control issues. This would allow those who have had leadership roles in field operations as well as those in headquarters

backstopping positions to consider all phases of the response. The experience gained from managing this outbreak should be seen as a opportunity to strengthen the IFRC and national society disaster management capacities.

3.5 GENERAL CROSS-SITE RECOMMENDATIONS

The team has detailed a number of country specific recommendations, which some of these in various forms are common across countries. In the following section are listed general observations and recommendations which the RTE team applies to the three countries.

1. *Greater epidemiological and public health resources.* The response has a very strong disaster management team but is short on technical capacity in epidemiology and public health; a priority for public health disaster response. Deploying these capacities could help the Ebola response to anticipate the directions of the epidemic and utilize information already being obtained through Red Cross activities to better prepare and deploy assets and resources. Being dependent on other sources for information and directions for epidemic response puts the Red Cross efforts at a disadvantage and potentially introduces a delay in response. This limits the abilities of Red Cross to be proactive — a key element in an unpredictable epidemic. The WHO and CDC have excellent epidemiological capacities to analyze the data collected by others. The Red Cross should be in the position to analyze its own data to monitor the successes of its activities and identify unmet needs without depending entirely on other agencies which may not have the Red Cross field operation perspective. This is already a practice of some humanitarian organizations.

2. *Better use of information.* Many streams of information flow in this response. Some information is electronic and some is via paper. Getting all project data into electronic format would be an important step, as would be utlizing this data to create data "dashboards." Such dashboards could be viewed in real-time anywhere. However, connected with a process to enable decision makers to use the data would increase efficiencies in the decision-making process.

3. *Support and "duty of care" for volunteers.* This takes several forms:
    a. Safety from contracting Ebola infection. Breaches of protection standards are common. Close supervision and retraining for quality control is critical.
    b. Physical safety of volunteers is a threat in some communities such as in Guinea. Closer monitoring of at-risk areas, and collaboration with government and agencies working in these areas to share information is advised.
    c. Psychological support for volunteers; especially those in hazardous conditions, and those exposed to social discrimination for their work. Current arrangements are of an ad hoc nature and are not standardized. Psychological support is part of "duty of care".
    d. Support of morale is needed in many places. This could be achieved with non-monetary incentives, recognition, and more specific appreciation. Planning should be given to post-Ebola appreciation for the volunteers. A thorough understanding of problems with fatigue and decreasing morale is needed in order to develop appropriate support programs.
    e. Prompt payment of incentives. Delays have been present in many places, and this reduces morale. The payment process of should be reviewed to ensure timeliness.

4. *Contact Tracing.* In many areas volunteers have been undertaking contact tracing and working with local health authorities. It is now time to consider developing this into active case finding where this is possible with local authorities, as a much stronger community surveillance approach is needed to end this epidemic. The volunteers are an excellent potential resource for these activities. In some areas the majority of new cases are arising among persons not on a contact tracing list, demonstrating the limitation of simple contact tracing.

5. *Increased Communications.* Social mobilization and beneficiary communications have been carried out well in many places. More consideration for individual Behavior Change Communications (BCC) and mass-media awareness could not only reduce risks to individuals but increase the awareness of the role of the Red Cross in Ebola control. Some communications budgets are underspent.

6. *Recovery Phase.* Although typically the recovery phase is seen as separate from the disaster response phase, there are many reasons to start recovery efforts now. Many households need assistance which they are not receiving, and there are long term livelihood issues which should start promptly.

7. *Regional Ebola Management Unit.* The RTE team saw the Regional Ebola Management Unit as an excellent concept providing technical resources for the affected countries, but felt it lacked all the technical depth required to support country programs. The specific areas noted were communications, public health and information management, where the needs from the countries exceeded the resources available to them.

8. *Emergency Operations Plans.* In the Emergency Operations Plans there was a heavy emphasis on output indicators. A stronger emphasis during planning on process and outcome indicators would facilitate improving the quality of services provided.

3.6 COUNTRY SPECIFIC SUMMARIES AND RECOMMENDATIONS

3.6.1 Key findings from Guinea

Currently, broader strategic decision-making within the GRC and Guinea IFRC is informed by information collected and disseminated from external actors, such as the MoH National Ebola Coordination Committee. In negotiation with the National Coordination Committee, the GRC and IFRC decided to focus on Safe and Dignified Burials (SDB) that ultimately has been the success of slowing transmission in Guinea. Currently there is opportunity for Red Cross to scale up and implement a holistic approach in the Guinea program to facilitate community education and safety of the volunteers.

Safe and Dignified Burials. Red Cross volunteers have been engaged in Safe and Dignified Burials (SDB) from the beginning of the outbreak, but since August when the Red Cross movement agreed to be the sector lead for SDB, it has become the major component of Red Cross activities. This is appropriate and an enormous contribution to the overall Ebola response in Guinea. These SDB teams are doing excellent work, but morale is low, the volunteers are exhausted and they have not received any meaningful PSS.

Community members are reluctant to allow the Red Cross to enter and conduct dead body management per Ebola protocols, and at times this has caused tension and conflict between community members and Red Cross volunteers.

GRC has shown outstanding success in this field and should maintain its commitment to SDB, whilst scaling-up collaborative social mobilization and communication activities at village-level. The GRC should also consider options for involving Red Cross volunteers in contact tracing and for providing psychosocial support to community members.

Communications. At the start of the outbreak, social mobilization and beneficiary communication was the largest component of the Guinea Red Cross Ebola response. The recognition of the importance of Beneficiary Communication was cemented at the Dakar Communication Forum 8 and 9 September, hosted by IFRC, however, at the request of the coordination bodies, GRC focused on a single area only. The inclusion of SM volunteers as part of each SDB team is an appreciable development toward the implementation of a holistic approach to halt further Ebola Virus Disease transmission.

Volunteers. Initial volunteer training was supplemented by general PSS preparation from the PSS expert on the FACT team. However, continued updates for this aspect of social mobilization have been absent.

Few resources exist within GRC for volunteers experiencing stigmatization or anxiety about their work with Ebola. Psychosocial activities have received limited attention; volunteers have been trained, but no SDB volunteers in Guinea have received one-on-one psychosocial counseling.

The current involvement of GRC in contact tracing is minimal. Recently, "preliminary contact tracing" was integrated into SDB protocols. Now, when an SDB team retrieves a body from the community, a volunteer will sit with the family and record all of the victim's contacts.

Many Red Cross volunteers are exhausted and had negative feelings towards the GRC and IFRC management. Volunteers are most concerned with the lack of attention to their wellbeing and lack appreciation for their work. The GRC needs to understand the real possibility that without additional quality assurance and additional resources to SDB teams, more volunteers are likely to become infected with Ebola, or face further stigmatization and abuse in their communities.

Information. There is some tension between donor reporting demands, and the ability of in-country staff to provide steady information. The Guinea IFRC staff reported feeling overwhelmed by the need to provide information to regional and zone offices as frequently as they are requested to do so (i.e. directing scarce resources to donor reporting at the expense of effective implementation).

Neither the IFRC nor the GRC had an epidemiologist or health specialist to assess current and future outbreak trends for the purpose of planning activities.

There is currently no monitoring and evaluation system used to track activity efficiency and facilitate operational adaptive management. Information systems are not in place to collect and analyze data, which leaves the emergency response open to operational inefficiencies. IFRC has limited information in terms of monitoring and evaluation of internal operations.

Leadership. The GRC is hierarchically managed and does not seem able to act quickly. The GRC leadership is slow to achieve internal consensus, communicate decisions constructively or in a timely fashion. A new committee internal to the GRC leadership has been established - the GRC National Ebola Commission - which the Guinea IFRC staff hope will expedite decision-making. A reasonable staffing structure exists, but the systems and processes to accompany this staffing structure are not in place. A striking feature of the current operation is that the Guinea IFRC has no staff based in the GRC office, and vice versa. This means all communication is completed by phone, email, or during weekly meetings.

Human Resource recruitment has been one of the biggest challenges of the Ebola response in Guinea, as for other offices. Mobilizing sufficient delegates (with the necessary technical and language skills) as well as local staff are key challenges of the Guinea operation.

The IFRC and NS generally have a good working relationship, but the IFRC has limited influence to shape the actions taken by GRC leadership. The Guinea NS leadership is perceived to be protracted and ineffectual, partly due to staffing shortages and exhaustion, partly to due to culture, attitudes and personalities.

Respect. The GRC and IFRC are well known and highly respected as part of the Guinea Ebola response. Beyond coordination meetings, the RTE saw evidence of effective collaboration with other humanitarian actors, along with several missed opportunities.

3.6.2. Key recommendations for Guinea

a) Additional non-financial incentives should be considered immediately, including competency based certification that volunteers can use to gain employment after the outbreak, celebratory events, NFIs.

b) Red Cross volunteers face security threats in some parts of the country as a result of poor community-humanitarian relationships, and this is jeopardizing operations. Considerations should be given to having a security delegate in Guinea at least in the short term, if the position has not been posted already.

c) The IFRC, GRC and ICRC should develop risk thresholds whereby activities are suspended rather than putting volunteers at risk.

d) The GRC and IFRC should work with the Guinea government and others to ensure that all RC teams are supported by local government and law enforcement when needed.

e) The GRC and IFRC should develop a formal plan or protocol for responding to volunteer deaths due to Ebola and supporting the victim's family and teammates.

f) No further duties should be added to the list of tasks that SDB volunteers are currently asked to undertake.

3.6.3 Key findings from Sierra Leone

In Sierra Leone the national society (NS) works in 11 of the 13 districts with approximately 1500 of its 7500 volunteers actively involved in the Ebola program. This program consists of social mobilization (SoMob), contact tracing (CT), safe and dignified burials (SDB), and psychosocial support (PSS). In Kenema, and recently implemented in Kono district, treatment units are active; representing the five pillars of the response.
The program was slow to get started with resistance from the SLRCS, perhaps related to fear and panic that Ebola was creating in country. However the program did progress and its great success has been the SDB activities with its highly committed volunteers. An estimated 65% of deaths have occurred at home, making this an important activity. Sierra Leone had not yet (at the time of this visit) developed a national Ebola surveillance program which, along with insufficient treatment beds, heavily contributes to the epidemic's out-of-control status.

Information. There are opportunities to improve the Red Cross' information management. At present there are two parallel information systems, one using mobile phones the other paper based. Further, the data collected are not fully utilized. The Red Cross activities began in Kailahun and Kenema and districts where solid implementation of the Red Cross five pillar approach has been key to largely controlling the outbreak. A mini-KAP survey was carried out in June 2014 using non-standard methods, and has not been repeated. Contact tracing is being done, but it is not clear how information from this is being used to monitor spread of the disease.

Use of resources. The donor response to the CHF 41 Million appeal stands at 75% confirmed pledges 25% unconfirmed pledges. There seem to be a number of challenges to ensuring that the activities outlined in the emergency appeal are implemented in a timely manner.

The National Society has used its volunteer base to respond quickly to the Ebola emergency through organizing social mobilization activities in the villages and conducting the SDB activities in Kailahun and Kenema. There are some branches failing to send their monthly activity returns promptly, and this has led to delays in financial dispersals, and delays in paying incentives to the field teams. This has affected the speed at which the funds are transferred to other activities.

Communications. Though Social Mobilization and Beneficiary Communications teams run well, however the feedback voice of the community is not heard well in the current process. Mass media communications are substantially under-spent at a time when these should be at maximum rate.

Coordination. The IFRC and the NS play an active role in the coordination of activities through the National Emergency Response Centre, and work closely with the MoH. The Red Cross Ebola task force maintains a close relationship with principal donors.

Volunteers. There is a rotational assignment of volunteers mainly assigned to the Safe and Dignified Burial Teams. The National Society recognized the efforts of the volunteers through offering a risk allowance of 100,000 Leone for SDB volunteers and 50,000 Leone for 700 Social mobilization volunteers. There exists a volunteer policy which is being revised. The volunteers being assigned roles in the Ebola operation have been covered through the Federation insurance system while the NS is still organizing a local insurance company to provide insurance for the volunteers.

Capacities. The current response is built on the National Society's capacities from previous experiences during the civil war, cholera outbreaks and community based health activities. There is increased visibility of the NS society within the operation due to the support from the Federation. The multiple layers of coordination at the country, region, zone and secretariat for the Ebola response have led to some blurring of clear roles and responsibilities and may not add value to the response.

3.6.4 Key Recommendations for Sierra Leone

a) Strengthen financial management, especially in accelerating expenditures from Appeal funds.

b) Providing all volunteers with Red Cross visibility and identification, such as with T-shirts, aprons and ID badges.

c) Monitoring of outputs, outcomes and activities listed in the emergency appeal. Consider having logframes as part of the Emergency Plan of Action to help identify indicators. Currently, this is not a results based framework as there are few indicators specifically set out for outputs or outcomes. This would be more useful than just measuring financial expenditure per output.

d) Plan on long term support for the volunteers who have been engaged in the Ebola operation.

e) Strengthen information analysis and management for use in decision making starting from the branch level to the regional level.

f) Because of the large amount of funds involved and the complex and changing nature of the operation, and for the protection of the program staff, an interim internal audit should be considered.

g) Review the communications strategy for the SLRCS with support from the Ebola Regional Management unit to see how this can be made more effective now and in future disasters.

h) Improve on the paperwork and returns from the branches in time, and held up payments as a method of ensuring timely submission of returns.

3.6.5. Key findings from Liberia

This outbreak has been an opportunity for the Red Cross to demonstrate its principal of humanity in the face of great need. This has been an opportunity for the Movement to work together; the national society, IFRC, PNS and ICRC working to address a problem that affects all.

Liberia has the strongest Ebola control activities of the three countries, and the Red Cross plays an important part of this. There has been good utilization of the data from other sources at the beginning of the outbreak, though the FACT team does not seem to have collected any primary or subsequent data to determine population needs. Of the three countries, the Liberia program has the strongest information

system at the current time. Yet information collected in the course of the program is not being fully utilized.

The program was built around the five pillars with much of the early emphasis in Monserrado county and greater Monrovia where the early epidemic was concentrated. The signature program has been the Safe and Dignified Burial program. With more than 75% of the deaths occurring in the Monrovia area, the Red Cross SDB teams managed most of these deaths. There is a delegate overseeing this program which has now shifted from cremation to burials. Twenty teams are currently involved.

Communications. The communications area has been problematic. It has lacked clear goals and job descriptions which have left delegates unclear about their responsibilities, and resulted in valuable time lost in the initial stage of their short postings. New initiatives such as using local radio stations and sound trucks for the Christmas holidays were innovative. Social Mobilization works closely with Beneficiary Communications activities. With the ban on mass gatherings, basic house-to-house mobilization and small group meetings is being completed now by the volunteers. Some supervision is being provided, though we did not find the reports of these.

Clinical care. Clinical care is a pillar which applies to Red Cross activities increasingly as the country's focus is shifting to the Rapid Isolation and Treatment of Ebola (RITE) strategy. Linking several chapters together through Hubs is consistent with this. The Red Cross, with funding from UNICEF, has taken a lead in the provision of Community-protection kits. These have been dispensed to some counties such as Magibi, but there seems to be some hesitation in putting them into use.

Surveillance. Contact tracing is performed by the Red Cross and other agencies, of which the area of responsibility depends on decisions by the local County Health Teams. The elimination of Ebola in Liberia depends on active surveillance and case finding. Going forward, increased use of the volunteers should be made in the surveillance process, and analysis should be carried out on the data now being collected by the Red Cross.

Psychosocial support is an area where extensive IFRC resources have been invested. Generally this has worked well, although closer terms of reference for incoming delegates should be formulated. This is a great need as there are many widows, orphans and people without food, shelter or support as a result of Ebola. Further, as the number of survivors rise, there is increasing stigmatization against vulnerable persons, and major efforts are needed with the community to address these issues.

Implementation. At the present time the project is spending its resources at appropriate speed, though a current financial statement was not available. Among the partners there is some feeling that the Ebola activities need to be more proactive, both in the activities and the sharing of information and activities. Among some of the Movement members in Liberia, there was a feeling that a higher visibility is needed for the Red Cross activities in Liberia.

Coordination has been generally good for the Liberia program. The LNRCS could be more prominently seen at the IMS meeting where the IFRC takes a very prominent role. The incorporation of the Movement partners with regular meetings is positive, although some strengthening of these links could be made.

The Federation has a good relationship with the ECHO and UNICEF offices which provides a good opportunity for future relations with these agencies.

Conclusion. In a brief summary, this is a well-run program, but with some adjustment could be made to strengthen outcomes. In general, the program needs to be more proactive in some areas, rather than being just reactive. This is a very uncertain phase in the outbreak, so new and innovative approaches to reach zero cases is needed.

3.6.6. Key recommendations from Liberia

a) Liberia has the best data from contact tracing, yet it is un-analyzed. This should be analyzed, as this is important information to reach zero cases. Increased surveillance activities will be needed in the country before Ebola is eliminated.

b) The HUB strategy being implemented in Liberia is an excellent effort to move resources to where cases are, and should be considered by the Red Cross in the other countries.

c) Several delegates noted TORs were unclear, and clarifying tasks at the beginning of short assignments could reduce time lost developing activities.

d) Beneficiary communications have largely been top-down. Methods to assess on-going needs are needed.