

Evaluation of UNICEF Work in Public Health Emergencies

Case study: Ebola in the Democratic Republic of the Congo



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For further information, please contact:

UNICEF
Evaluation Office
Three United Nations Plaza
New York, New York 10017
evalhelp@unicef.org

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Abbreviations

CAC	community action cell
CAI	Integrated Analytics Cell (Cellule d'Analyse Intégrée)
CCCs	Core Commitments for Children
CFR	case fatality rate
DRC	the Democratic Republic of the Congo
ETC	Ebola treatment centre
EVD	Ebola virus disease
FGD	focus group discussion
HZ	health zone
IOA	Integrated Outbreak Analytics
IOA/CAI	Integrated Outbreak Analytics Cell
IPC	infection prevention and control
KII	key informant interview
OPM	Oxford Policy Management
PHE	public health emergency
PPE	personal protective equipment
PSEA	prevention of sexual exploitation and abuse
PSS	psychosocial support
RCCE	risk communication and community engagement
SRP	strategic response plan
WASH	water, sanitation and hygiene
WHO	World Health Organization



Introduction

This case study examines how preparedness for, and response to, Ebola virus disease (EVD) in the Democratic Republic of the Congo (DRC) has developed over the period covered by the evaluation – from 2015 to 2021 – and how UNICEF has contributed to this development.

The research question for the case study is:

To what extent and how has UNICEF contributed to strengthening DRC's response to, and preparedness for, Ebola outbreaks over the evaluation period (2015 to the present)?

Answering this question involved:

- ▶ Making an assessment of how the effectiveness of DRC's response and preparedness has developed over the evaluation period;
- ▶ Identifying the relevant activities that UNICEF has undertaken over the evaluation period, both in response to specific outbreaks and in building national capacity;
- ▶ Assessing how effective and appropriate to the context UNICEF's activities have been in contributing to both response to outbreaks and building national preparedness;
- ▶ Assessing how UNICEF's systems, resources and management have influenced performance.

The conceptual framework for the case study uses the Core Commitments for Children (CCCs) benchmarks to provide judgement criteria for assessing response, and a framework derived from the World Health Organization (WHO) Health Emergency and Disaster Risk Management framework to provide judgement criteria on preparedness.

The outbreaks of Ebola that have taken place in DRC during the period covered by the evaluation are listed in Table 1. The case study pays particular attention to the largest outbreak (in terms of cases, fatalities and duration), the tenth, which occurred in North Kivu between 2018 and 2020 and was declared a Level 3 emergency. The challenges encountered in responding to the tenth outbreak (discussed in section 2.3) have shaped subsequent developments, including UNICEF's approach to Ebola preparedness and response. It should be noted that the tenth outbreak has been recently evaluated as part of the Evaluation of UNICEF DRC Multisectoral Approach to Public Health Emergencies (AAN Associates, 2022), the findings of which (see Appendix B) informed this evaluation.

In assessing how national preparedness and response and UNICEF's activities developed over the evaluation period and how lessons learned and initiatives taken as a result of the experience of the tenth outbreak have influenced how Ebola is addressed, the case study examined response to subsequent outbreaks, with a particular focus on the fourteenth outbreak, which occurred in Mbandaka, Equateur Province, between April and July 2022.

INTRODUCTION

The main sources of data for the case study included the following:

- ▶ UNICEF management and reporting documentation including strategy and planning documents, situation reports and internal documentation relating to specific EVD outbreaks and UNICEF initiatives.
- ▶ Other documentation on aspects of EVD preparedness and response, including from the DRC Government, other international partners and academic and research literature, particularly the substantial literature on the tenth outbreak.
- ▶ Interviews with UNICEF key informants, both in relation to the experience of the most recent outbreaks and to obtain staff perspectives over the whole of the period covered by the evaluation.
- ▶ Interviews with key informants who have been involved in preparedness and response working on behalf of partners.
- ▶ Members of communities affected by the fourteenth outbreak and UNICEF field staff interviewed during a field visit to Mbandaka (see Appendix E for further details).

This report is structured as follows. Following the introduction (section 1), section 2 describes the national context in DRC, including providing summary information on Ebola outbreaks. Section 3 reviews the main features of the tenth outbreak, including lessons identified. Section 4 describes UNICEF's role and main initiatives in addressing Ebola in DRC, focusing on how lessons from the tenth outbreak influenced UNICEF's actions, both during the outbreak and subsequently. Section 5 focuses principally on the fourteenth outbreak and includes the findings from focus group discussions (FGDs) on community perceptions of the response. Section 6 presents the findings of the case study as answers to the evaluation questions, including the assessment of preparedness and response against the frameworks used for the evaluation. Section 7 presents the conclusions from the case study.

Additional information is included in appendices. Appendix A lists the key informants interviewed. Appendix B summarizes the conclusions concerning UNICEF's response to the tenth outbreak from the 2022 multisectoral evaluation conducted by AAN Associates. Appendix C provides the consent protocols used for key informant interviews (KIIs) and FGDs. Appendix D includes the instruments used for KIIs and FGDs and contains information about the fieldwork and ethical review process. Appendix E summarizes key findings from the FGDs conducted with community and community action cell (CAC) members in relation to the fourteenth outbreak.





The national context and EVD in DRC

This chapter provides a summary of the main features of the national context and of EVD in DRC over the period covered by the evaluation.

2.1 Political and security context

DRC is characterized by its large size, significant biodiversity and natural resources, and growing population. Political instability has contributed to endemic violence, including continuous conflict in eastern DRC since the mid-1990s, fuelled by ethnic tensions, political grievances and regional geopolitics. Civilians have been not only caught in the middle of these conflicts, but also deliberately targeted. A patchwork of local and foreign rebel groups operate in Ituri, North Kivu and South Kivu that are hostile to each other, the Congolese Government and the United Nations Organization Stabilization Mission in the Democratic Republic of the Congo. Contributing to this volatility is a host of local, ethnically and politically aligned armed militias known as Mai-Mai, whose activities and interests intersect, often opaquely, with local economies and politics. The country is in the grip of a protracted humanitarian crisis. Communities in the east of the country have been left on their own, claiming to receive little support from the national government, the United Nations and other humanitarian actors (World Health Organization, 2019).

The multidimensional crisis in DRC is characterized by recurrent armed conflicts, severe food insecurity, nutritional crises, displacements and epidemics. The humanitarian situation remains of particular concern in the conflict-affected provinces of North Kivu, South Kivu, Ituri, Kasai, Kasai-Central and Kasai-Oriental (United Nations Children's Fund, 2019b).

The high prevalence of infectious diseases and multiple simultaneous epidemics have further exacerbated the complexity and gravity of the humanitarian situation in DRC, where access to basic services and infrastructure is very limited.

In 2022, the humanitarian situation in DRC continued to deteriorate due to the activities of armed groups, violent inter-community conflicts, epidemics, natural disasters, nutritional crises and food insecurity.

Population displacements have significant and disruptive consequences on the lives of affected populations as people leave behind their homes, essential household items, food stocks and livelihoods. Access to basic services such as drinking water points, latrines, health centres and schools is often limited due to insufficient infrastructure in host communities or spontaneous camps, directly impacting household hygiene and health and increasing the risk of morbidity and mortality. The loss of livelihoods also has consequences for food security and resilience (United Nations Children's Fund, 2020a).

2.2 Organization and provision of health and related services

The mission of the ministry of health is to contribute to the improvement of the state of health of the entire Congolese population by organizing quality and equitable health services for the restoration of people's health and the promotion of the best possible health status in all communities.¹

The DRC National Health Policy, adopted in 2001, emphasizes primary health care. The operational implementation unit is the health zone (HZ), which organizes the structures responsible for providing global, continuous and integrated health care.

The DRC Ministry of Public Health is structured in three levels, namely:

- ▶ the central level (currently undergoing administrative reform)
- ▶ the provincial level
- ▶ the peripheral or operational level.

The provincial level is made up of the provincial minister in charge of health, a provincial health division, a provincial health inspectorate, the provincial hospital and other provincial health structures. Decentralization gives the provinces exclusive powers to organize and manage primary health care. The provincial divisions of health are decentralized structures placed under the supervision of the provincial ministers whose duties involve health. They ensure the role of technical supervision and the follow-up and translation of directives, strategies and policies in the form of instructions to facilitate the implementation of actions at the level of the HZs.

The provincial health inspectorates are decentralized structures that exercise the functions of control and inspection at the provincial level, under the supervision of the governor of the province. They ensure the inspection and control of health care, pharmaceutical and science establishments. Other provincial services are the provincial hospitals, the provincial laboratories and the regional drug distribution centres. They provide secondary referral health care and support for HZs in their specific areas.

The operational level includes 516 HZs with 393 general reference hospitals and 8,504 planned health areas, of which 8,266 have a health centre. This level is responsible for implementing the primary health care strategy (Ministry of Public Health, 2018; Vivalya et al., 2021).

The organization of the supply of care is ensured by public structures and private structures. The public sector is organized around health centres, general references hospitals, provincial hospitals, armed forces hospitals, police and other departments organizing care for their workers.

The private sector is subdivided into two categories: private for-profit on the one hand and not-for-profit (health services of non-governmental organizations and faith-based organizations) and traditional medicine on the other. The pharmaceutical sector is essentially in private hands. The lucrative private sector is especially flourishing in urban areas and in economic centres. It is made up of medical and paramedical practices, clinics or polyclinics, and diagnostic centres (laboratories, imaging). Opening authorizations are granted by the Ministry of Public Health of DRC, while the opening request is approved by the province.

The denominational and associative private sector has been present in the country since independence in 1960 and represents approximately 40 per cent of the health care offer (Ministry of Public Health, 2010). The main actors are the Catholic, Protestant, Kimbanguist and Salvationist churches, which manage health facilities (hospitals and health centres).



2.3 Organization of response to EVD

The national response to EVD relies mainly on the leadership of the government, which is the main decision-maker and coordinator. The DRC Ministry of Public Health is the operational body for the government and provides technical and strategic coordination. This coordination is supported by eight technical commissions, which are in turn supported by the partners according to their mandates and areas of expertise. At the beginning of a response, the government (national and/or provincial) quickly sets up the coordination and the commissions. The committees are then responsible for defining the operational response.

The main response strategy to the tenth EVD outbreak was the zonal approach, which was integrated into the existing system at all levels of the health pyramid. This approach was based on three axes:

- ▶ public health response axis
- ▶ multisectoral axis
- ▶ coordination and support to operations axis.

Health system actors are directly involved in the organization, execution and evaluation of the response. These actors at the operational level receive the

support of experts from both the central and provincial levels of the ministry of health and partners, as well as the resources mobilized. The Health Zone Executive Team is strengthened in the coordination and management of activities by this expertise. This approach has enabled strategic coordination and maintained the uniqueness of the response in order to break the chain of transmission.

The health system is not sufficiently equipped to handle the additional demand for health care during and after disasters and is unable to maintain the supply of health care in crisis situations. Hospital providers are unprepared for emergency and disaster management. Specific service packages at the health facility level, such as the Minimum Package of Activities and Complementary Package of Activities, do not include specific activities and responsibilities for preparing for and responding to health and humanitarian emergencies.

Major epidemics weaken health services: the trained human resources who previously operated in other programmes are all involved in the response to the EVD epidemic, leaving other disease control programmes without quality resources. There is no contingency plan for hospitals, and capacity is lacking for mass accident management (Conseil National de la Couverture Santé Universelle, 2021).



2.4 EVD in DRC

Characteristics of EVD

The natural reservoir for EVD is believed to be fruit bats, though transmission to humans has occurred in people handling chimpanzees, gorillas and forest antelopes. EVD can be transmitted between people through direct contact with blood, organs or other bodily fluids as well as through contaminated objects such as clothing. Burial practices involving direct contact with the body and health care with insufficient infection control or barrier nursing can also lead to transmission. The onset of EVD is usually sudden, and clinical diagnosis of EVD in the early stages of disease is difficult because the early symptoms are similar to those of other infections, especially malaria. Laboratory diagnosis must be carried out under high-level biological containment conditions. Treatment of EVD requires intensive supportive therapy, while two monoclonal antibodies have been available for EVD caused by Zaire ebolavirus (which has accounted for most outbreaks in DRC). Prevention requires isolation of patients and the use of strict barrier nursing techniques, as well as the prompt and safe burial or cremation of the bodies of EVD victims. As discussed below, the vaccine rVSV-ZEBOV has been found to be effective against Zaire ebolavirus and has been used in DRC since the tenth outbreak. There are currently no licensed vaccines for the prevention of EVD caused by Sudan ebolavirus (which was responsible for the 2022 outbreak in Uganda), though candidate vaccines are being developed (UK Health Security Agency, 2023).

Controlling EVD outbreaks presents formidable social challenges in a context of widespread poverty and insecurity and a lack of confidence in the state, particularly given the need for interventions in culturally sensitive aspects of life, including burials, and the disruption to families and livelihoods that results from infection control measures. The need to maintain strict barrier nursing protocols, provide appropriate personal protective equipment (PPE) and infection prevention and control (IPC) materials, and organize vaccination and treatment are also formidable challenges for weak health systems.

Outbreaks in DRC

As Figure 1 illustrates, DRC has seen the largest number of outbreaks of EVD in Africa, and a large majority of outbreaks – apart from those in West Africa in 2014–2015 – have occurred either in DRC or close to DRC's borders in neighbouring countries.

DRC's first recorded outbreak of EVD took place in 1976 in Yambuku in the current province of Nord Ubangi. It concerned only one HZ and resulted in 318 cases and 280 deaths. A second outbreak involving a single case occurred the following year, but there was no further outbreak until 1995. This took place in three HZs of the former province of Bandundu and was focused in the city of Kikwit, with 315 cases and 250 deaths recorded. This was the largest outbreak until the tenth. Further outbreaks followed in 2007 and 2008 in the province of Kasai in Mweka. In the first, three HZs were affected, with 264 cases and a case fatality rate (CFR) of 70.8 per cent; in the second, only one HZ was affected, with 32 cases recorded and 15 deaths (46.9 per cent CFR). Then in 2012, the current province of Haut-Uélé was affected in two HZs, which recorded 36 cases and 13 deaths (36 per cent CFR). Two years later, in 2014, the province of Tshuapa was affected in two HZs, which recorded a total of 66 cases and 49 deaths (74.2 per cent CFR).



The first outbreak that occurred during the period covered by this evaluation was the eighth in 2017, which took place in the current province of Bas-Uélé in the HZ of Likati and recorded 8 cases and 4 deaths (50 per cent CFR). The next outbreak, the ninth, took

place in 2018 in three HZs of Equateur province and resulted in 54 cases and 33 deaths (61.1 per cent CFR). All of the outbreaks since the eighth have occurred either in Equateur Province or in North Kivu, in the conflict-affected East (*see Table 1*).

Table 1. Ebola outbreaks in DRC over the evaluation period

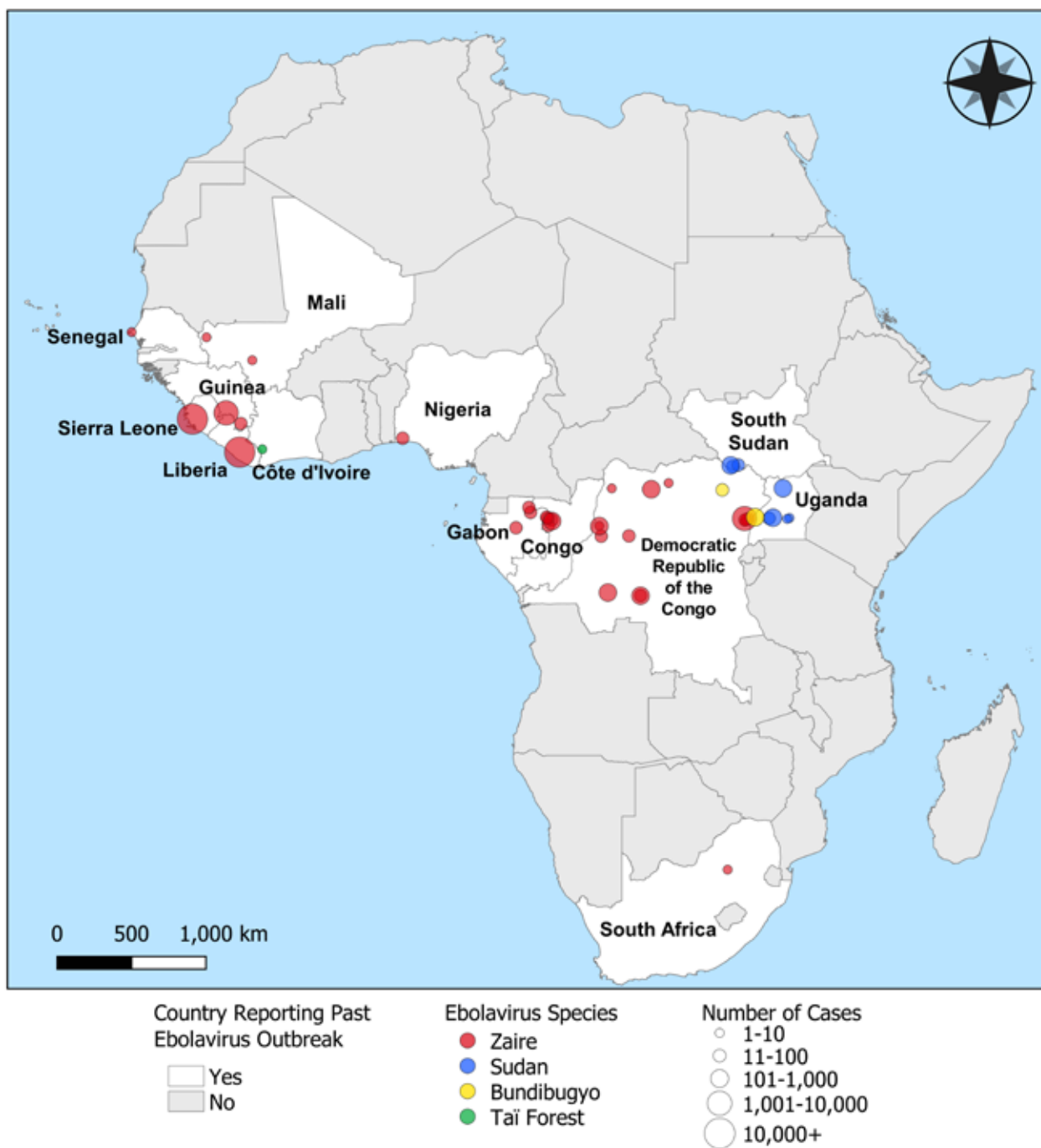
Year	Outbreak number	Start	End	Location, province	Cases	Deaths
2017	8th	11 May	2 Jul	Likoi, Bas-Uélé	8	4
2018	9th	8 May	24 Jul	Bikoro, Equateur	54	33
2018–2020	10th	1 Aug 2018	25 Jun 2020	North Kivu	3,470	2,287
2020	11th	1 Jun	18 Nov	Mbandaka, Equateur	130	55
2021	12th	7 Feb	3 May	Biena, North Kivu	12	6
2021	13th	8 Oct	16 Dec	Beni, North Kivu	11	6
2022	14th	23 Apr	3 Jul	Mbandaka, Equateur	5	5
2022	15th	22 Aug	28 Sep	Beni, North Kivu	1	1

Source: Centers for Disease Control and Prevention, 2023b.

DRC has also frequently suffered from epidemics of other diseases, which put additional strain on resources and services. In 2021, for instance, outbreaks of measles, meningitis, cholera and plague

occurred in addition to the two EVD outbreaks and two waves of COVID-19, in some cases affecting the same parts of the country (United Nations Children’s Fund, 2021a).

Figure 1. Ebola virus outbreaks by species and size since 1976



Source: Centers for Disease Control and Prevention, 2023a.



The tenth outbreak

On 1 August 2018, the Ministry of Public Health of the Government of DRC declared the country's tenth outbreak of EVD in North Kivu. By the time the outbreak was declared over on 25 June 2020, nearly 3,500 people had been infected, of whom close to 2,300 died – the largest-ever outbreak in DRC and the second largest in the world after the West African outbreak of 2014–2016 (World Health Organization, 2020). This was the first outbreak of EVD identified in eastern DRC. A key informant reflected, “I think there's never been in modern history a more challenging kind of outbreak, in the middle of an armed conflict and all kinds of specific local dynamics that went along with it.”

Overall leadership and coordination of the EVD response was in the hands of the Government of DRC, which brought significant technical and operational experience to the task, having successfully contained nine previous outbreaks in the country since Ebola was first identified there in 1976. As the disease progressed, government strategies were adjusted through a series of strategic response plans (SRPs).

One consequence of the outbreak and the nature of the response was an increase in violence against women. Stark et al. (2020) note, “The 2018–2020 Ebola outbreak in DRC saw a notable increase in the reported risk and experience of violence, especially among women and girls. Communities reported an increased incidence of sexual and physical violence and increased sexual exploitation and abuse of

women and girls. Gender norms became further entrenched, increasing tasks required of women and girls, including tending to the sick while simultaneously managing household responsibilities” (p. 2).

In addition, women and girls (including pregnant women) avoided health services due to fear of Ebola, while the availability of health services was reduced. Incidents of sexual abuse, including by WHO personnel and contractors involved in the response to the outbreak, were also reported (World Health Organization, 2021).

During the third phase (January to June 2020), the Ebola Emergency Response Team's role ended following evidence of a downward trend in new infections, with responsibilities transferred to the humanitarian coordinator. While the outbreak was officially declared over in June 2020, attention shifted to the eleventh outbreak – which occurred in Equateur Province – and the COVID-19 pandemic, with the result that less follow-up took place than had been envisaged.



UNICEF's role in addressing Ebola in DRC

4.1 Overview of UNICEF's role

UNICEF (2021b) describes its approach during the tenth outbreak as follows: "In support of the national SRP, the UNICEF Ebola response strategy focused on a cross-cutting community engagement approach, including IPC/WASH [water, sanitation and hygiene], psychosocial care, RCCE [risk communication and community engagement], education, and nutrition interventions [Pillar 1]. In addition, to improve ownership and appropriation of the Ebola response by affected communities, thus boosting community engagement and the response effectiveness, UNICEF supported a set of complementary interventions, known as Pillar 3, to address the most pressing social and humanitarian needs identified by Ebola-affected communities and minimize the negative effects of the Ebola outbreak on health systems and social services for children, mothers and communities at large" (p. 4).

Under the leadership of the government, UNICEF co-led the Risk Communication and Community Engagement (RCCE) Commission, the IPC/Water, Sanitation and Hygiene (WASH) Commission and the Psychosocial Support (PSS) Commission.

The main activities undertaken and results achieved by UNICEF included the following:

- ▶ RCCE activities focused on mobilizing more than 210,000 influential leaders and specific groups through a range of communications approaches;

- ▶ Engagement with communities through CACs;
- ▶ Obtaining and responding to community feedback through the U-Report platform;
- ▶ Strengthening IPC measures and improving access to WASH services in 3,935 health facilities, providing handwashing facilities to more than 21,000 health facilities, and providing hygiene and infection prevention kits to more than 22,000 households with confirmed EVD cases or contacts with them;
- ▶ Provision of tailored psychosocial support to more than 24,900 households with confirmed or suspected EVD cases and to more than 10,000 orphaned and separated children. Provision of nutrition assistance to EVD cases and affected children;
- ▶ Provision of educational materials to schools, teachers and pupils;
- ▶ Support for the establishment of an Integrated Analytics Cell (CAI), previously the Epi and Cellule d'Analyse en Sciences Sociales (CASS) cell, which conducted regular research and formative studies;
- ▶ Prevention of sexual exploitation and abuse (PSEA).

The following sections provide more details on the main areas of UNICEF activity during the tenth outbreak, which have also shaped responses to subsequent outbreaks.

4.2 Risk communication and community engagement

RCCE interventions aimed to enhance dialogue and partnerships between Ebola response teams and individuals or communities in affected areas, enabling community ownership of the response and real-time exchange of information. To enhance risk communication and promote community engagement and to boost the adoption of EVD prevention behaviours, UNICEF, together with implementing partners, organized interpersonal communication sessions, community dialogues, educational talks and mass communication campaigns in the affected HZs, including door-to-door visits, church meetings, small-group training sessions, briefings with leaders and journalists, community animation groups and radio broadcasts.

These activities aimed to train, brief and sensitize the local population, including community workers, religious and opinion leaders, educators, moto-taxi drivers, military, journalists, and youth and women associations, on the risks associated to Ebola, the importance of their engagement in the response and the promotion of prevention behaviours. To reduce community reluctance, the RCCE teams focused their efforts on tailoring responses to specific situations of resistance, working closely with community leaders and groups or specific professional categories. As part of this approach, for example, UNICEF promoted the organization of guided visits to the Ebola treatment centres (ETCs), during which people, accompanied by local influencers and the response team, could interact with the response team to better understand the functioning of the ETC and the importance of EVD prevention measures.

These efforts were able to neutralize tense situations and create an enabling environment for other key response pillars, such as surveillance, vaccination, safe and dignified burials, medical assistance, IPC/WASH and PSS, to better implement their activities. In several cases, community engagement efforts have empowered local leaders and influential groups to take charge of future incidents themselves.

To increase community engagement in the response, UNICEF reinforced local community structures, especially the community action cells, as a key entry point for reaching people at risk of EVD. Composed of key actors at community level, such as religious and opinion leaders, community-based organization delegates and representatives of local sectorial structures, CACs, in the context of the Ebola response, are responsible for reporting alerts, promoting EVD prevention measures, managing community refusals and resistance against the response, and promoting community dialogue to facilitate vaccinations and other key response activities.

The CACs have been considered to be a valuable actor in sensitizing local communities on EVD response intervention and facilitating their acceptance by reticent communities. As part of mass communication campaigns, UNICEF partnered with local radio stations, which produced and broadcast radio programmes, interactive and participatory radio shows, and radio spots with messages on Ebola prevention, early referral of cases, decontamination,



vaccination and the importance of the engagement of communities in the response. The involvement of Ebola survivors through their testimonies and as key local influencers during interactive radio programmes strongly contributed to reducing community reluctance to the response.

In line with the RCCE component of the EVD response, UNICEF piloted and developed the U-Report platform in all Ebola-affected provinces. U-Report is a public polling platform on Ebola and other development issues that informs strategies and approaches through providing community feedback and reports from EVD mobilizers, partners and managers. The platform includes both a Short Message Service and real-time person-to-person hotline to respond to concerns and provide life-saving information to callers. It also provides training via smartphones to mobilizers, key influencers, team members, radio stations and other local RCCE actors. The platform is linked to community radio stations and social media channels to stimulate social dialogue. Measures were also taken to facilitate the hiring of local influencers and their payment through mobile phone transfer systems.

4.3 Infection prevention and control

UNICEF worked on improving IPC and ensuring WASH essential services in health facilities, including traditional healers' premises, schools and community sites in all EVD-affected areas. Though the provision of handwashing points and clean water in health facilities, schools and public places, the installation of chlorination points and capacity building of health personnel on hygiene promotion and disinfection, UNICEF contributed to reducing nosocomial infections and promoting EVD prevention measures.

In addition, support was provided to health facilities for the improvement of medical waste management, the repair, reconstruction or installation of water sources, and the construction of latrines, showers and other hygiene facilities.

To reduce the risk of EVD transmission, UNICEF and its partners also distributed hygiene and prevention kits to households of confirmed cases and contacts and neighbours of confirmed cases with adequate messaging in WASH practices for EVD prevention. In September 2019, all decontamination activities were handed over from WHO to UNICEF, including in households, health facilities, traditional healers' premises and public places. To reduce reluctance towards decontamination by local communities, especially in households, UNICEF engaged family members in this activity, under the supervision of trained IPC specialists.

Similarly, in health facilities, UNICEF trained local hygienists already working in the facility to conduct decontaminations. To strengthen community engagement in the response, UNICEF IPC/WASH teams finalized a series of partnership agreements with local associations and enterprises for various activities such as the construction of water points, wells and latrines, with a focus on improving WASH infrastructure beyond the Ebola response.

As part of the IPC/WASH response, UNICEF worked with local partners and international non-governmental organizations. UNICEF also worked with local private companies to ensure the availability of IPC supplies such as mattresses, chlorine, boots, gloves, buckets, jerrycans, laundry soap and hand-washing gels.



Furthermore, UNICEF enhanced preparedness activities in areas at risk of EVD, especially in Tshopo and South Kivu Provinces, including the construction or rehabilitation of latrines, showers and incinerators, as well as impluviums in health centres and schools, together with the distribution of WASH and hygiene kits, the training of health providers – including traditional healers – on IPC/WASH protocols and, in collaboration with UNICEF education teams, the briefing of school authorities and students on EVD prevention measures. Community engagement and the promotion of EVD preventive behaviours were also implemented through activities in schools.

Unlike the previous EVD epidemics in the country, schools remained open, and thanks to the preventive measures promoted in schools, UNICEF allowed schools in Ebola-affected areas to maintain a safe and secure learning environment for children and their teachers. UNICEF supported the government's primary, secondary and technical education institution in the production of the Guidance Note for the Prevention and Control of Ebola Virus Disease in School Settings to provide school actors with essential information on Ebola transmission and prevention measures in schools. Distribution of the note was accompanied by training for primary, secondary and technical education inspectors, who, in turn, trained teachers, who briefed students on Ebola transmission and prevention. Investing in the sensitization of children to EVD prevention measures was a key vehicle in sensitizing their entire family.

In collaboration with IPC/WASH teams, education teams ensured that supported schools were equipped with WASH materials, and school brigades, composed by students, were set up in each school to promote hygiene prevention measures, identify possible EVD suspected cases in schools, and isolate them or refer them to the ETCs.

4.4 Psychosocial support

The psychological and social impact of EVD has been significant for affected people, especially children, with repercussions for their families and communities. The fear of EVD in communities has led to isolation and stigmatization of survivors and their families. Children are affected by EVD both as confirmed cases and as separated or orphaned children and often end up in situations of high vulnerability. Psychosocial support and child protection have therefore been integral parts of the EVD response, with the goal that each affected adult and child (confirmed, suspected, cured or contact case), as well as his/her family, is emotionally and materially accompanied throughout all EVD prevention and response actions.

Through the deployment of psychologists and locally recruited psychosocial assistants, UNICEF ensured dedicated PSS for EVD cases, affected families – especially children and adolescents – and contacts through individualized counselling, groups sessions and home visits. These activities contributed to reducing the stigmatization and isolation of EVD cases and their families, both within families and in their community. In ETCs, transit centres and nurseries, UNICEF promoted an integrated approach to case management of children, including PSS and medical and nutritional care.



On the premises of ETCs, UNICEF built or rehabilitated, equipped and ensured the functioning of five nurseries in Beni, Butembo, Katwa, Mangina and Goma for the integrated care of young separated children, particularly infants. Separated children and adolescents also benefited from PSS at the community level. Children who were orphaned for EVD-related reasons were also supported through age-appropriate PSS and/or material assistance according to their needs, both for the child and for the affected family. Material assistance included food assistance, hygiene and dignity kits, newborn kits, non-food item kits, recreational kits, and school assistance including the payment of school fees for one year and the provision of school uniforms and kits. According to the specific case, the teams searched for long-term solutions for orphans and unaccompanied children. Specialized staff and psychologists also intervened to help orphans and families with more severe psychological or social problems and needs. At community level, UNICEF provided PSS to EVD contacts, facilitating their follow-up by the surveillance teams, and to the Ebola survivors to promote their reintegration into their families and communities. UNICEF also integrated mental health and PSS in the other components of the response, especially in vaccination, decontamination procedures and the organization of safe and dignified burials, to raise awareness on the need to consider the psychological impact of the disease in affected populations.

4.5 Integrated Outbreak Analytics Cell (IOA/CAI) and Integrated Analytics Cell

The CAI – previously the Epi and CASS cell – is a UNICEF-led multi-actor umbrella initiative that includes active participation from WHO, the Centers for Disease Control and Médecins Sans Frontières Epicentre.² It supports the response to better understand community feedback and encourage community support and engagement, and conducts regular research and formative studies

The CAI was an innovation that allowed the collection and analysis of social and behavioural data in an outbreak context that could inform response in real time. Composed of local and international anthropologists and researchers, and working with implementing partners, the cell conducted several quantitative and qualitative studies to understand community beliefs and practices around health and to identify high-risk behaviours to advocate for strategic change in response actions and ensure that response is both appropriate for and accountable to affected populations. Key findings have been used to tailor response interventions since the tenth outbreak (United Nations Children's Fund, 2020b).

Key successes in terms of changes in the response prompted by the CAI analysis include support to pregnant and lactating women, who were not initially included in monitoring and reporting among vaccination and surveillance teams as they were not eligible for the vaccine. Following the CAI's recommendations, UNICEF put in place a programme to offer infant feeding support to breastfeeding mothers who wished to be vaccinated. This work also resulted in a change among both vaccination and surveillance teams to begin documenting pregnant and lactating women who were contacts and unvaccinated. This documentation improved the surveillance of and support for pregnant and lactating women and also provoked discussions on vaccination eligibility,

2 In addition to researchers from different institutions who work with the CAI in country, the Centers for Disease Control provides three full-time team members based in Atlanta to support quantitative data analysis. The CAI collaborates with those working on feedback analysis (the International Federation of Red Cross and Red Crescent Societies and Internews), with non-governmental organization partners working on independent studies (such as Translators Without Borders) and on university-funded studies (London School of Hygiene and Tropical Medicine and Oxford University). The CAI is also connected with global social sciences research partners including the Harvard Humanitarian Initiative, the Social Science in Humanitarian Action Platform and the Global Outbreak Alert and Response Network.

eventually leading to a change in vaccination protocol in June 2019 to include pregnant and lactating women. Similarly, multiple CAI studies indicated the lack of understanding of Ebola symptoms. This finding resulted in a change in all communication tools: new tools include more common Ebola symptoms and focus on reinforcing health seeking for “malaria-like symptoms”.

As described by AAN Associates (2022), “Between 2018-2020, IOA/CAI teams conducted 55 local research studies to understand outbreak dynamics, risks and prevention behaviours for communities and health workers, and potential operational challenges using customized data collection tools/formats and

methods. The findings were shared and deliberated on a regular basis with response teams and sub-commissions (RCCE/C4D [Communication for Development], PSS, IPC/WASH, vaccination, patient care and coordination) to jointly develop recommendations (actions to be taken to address identified challenges). Afterwards these recommendations were presented to the relevant commission at the HZ for adoption into action plans” (p. 18).

Table 2 summarizes some of the main findings from the IOA/CAI and related studies and how these were reflected in adjusted response plans during the tenth outbreak.

Table 2. Community needs identified by Integrated Outbreak Analytics (IOA) and response strategies, tenth outbreak

Community Needs/Realities	Alignment of Response Strategies
Distrust of response teams and misconceptions around EVD led to unnecessary delays in seeking treatment. Communities were found to be distrustful and carried certain misconceptions causing unnecessary delays in seeking treatment for suspected and confirmed cases. Most common misconceptions included: everything is Ebola; Ebola is not real; Ebola is linked with political and financial interests of the government; vaccines contain Ebola to kill people who get vaccinated. Delays in management of suspected/confirmed cases reduce the chances for survival and increase the risk of nosocomial infection as well as transmission of disease through other means.	RCCE/C4D aimed to address the prevalent misbeliefs in target communities. Despite concentrated efforts, initially the response operations were not well accepted by communities. This is attributed to the implementation modalities where armed military/police escorts were used for case identification, contact tracing and follow-up, which created fear of the disease and stigma for the patients and contacts.
The studies indicate high level of reluctance around seeking health care, driven by factors such as local beliefs, affordability, accessibility and over-reliance on traditional practitioners. Different factors contributed to poor health seeking behaviour such as socio-economic factors (lack of affordability and reliance on traditional healers). This behaviour resulted in missed vaccinations, lack of antenatal care visits, unskilled deliveries and delayed diagnosis of diseases.	RCCE/C4D aimed to improve health seeking behaviours in terms of seeking early health care in case of sickness, avoiding self-treatment and promoting visits to the health facility instead of traditional healers. Community elders, church and local leaders, a public announcement system and leaders of women's groups were involved as designated agents of change to promote health seeking behaviour.
Misunderstandings around symptoms of EVD: The initial symptoms (such as headache, throat, stomach, joint and muscle pain) of EVD overlap with other common ailments, and therefore communities often ignored them. The lack of understanding and information on the symptoms of EVD was observed at the community level, but also, to a lesser extent, among health personnel.	RCCE/C4D interventions aimed to help people understand the differential symptoms of EVD for early detection and confirmation of EVD cases, isolation, effective contact tracing and referrals to the ETCs. The overall aim was to gain community trust and remove misunderstanding around symptoms of EVD.

Unhygienic practices increase the risk of contamination. Community members lacked awareness on preventive measures and ways to minimize the risk of contamination such as adoption of hygienic practices.	IPC/WASH measures aimed to educate communities on infection prevention and control measures at individual, household, community and health facility levels.
Patients/survivors and family experienced trauma and require PSS. EVD patients and their families suffer from psychological trauma and stress. In addition, the persistent armed conflict and insecurity put children and adolescents at high risk of protection issues (abductions, forced recruitment of children into armed groups, child labour and sexual exploitation of children).	PSS and child protection services under the response aimed to fulfil the psychosocial needs of the affected individuals (and their loved ones) as well as to offer protection services for adolescents and children.
Inaccessibility of health services in target provinces. Communities faced significant challenges in accessing health services due to bad road conditions (water and air are the most common means of inter-city travel). This increased the risk of undiagnosed cases and delayed treatment.	Mobile response teams were deployed to hard-to-reach areas. Moreover, specific means such as boats and helicopters (for visits by senior officials) were used to access remote communities.

Source: AAN Associates, 2022, p. 19.
C4D: Communication for Development

4.6 Prevention of sexual exploitation and abuse

Building on the experience of sexual exploitation during the tenth outbreak, UNICEF has, in the preparation of partnership agreements, reaffirmed the importance of including specific indicators and targets related to gender and PSEA. All partners must have a code of conduct signed by all staff and have implemented activities related to gender-sensitive issues, including awareness-raising activities on the promotion of girls' education, sexual violence and HIV/AIDS prevention. Particularly, UNICEF supported new local partners who were not equipped on these topics through training and the sharing of code of conduct forms, including on PSEA requirements.

In addition to the above-mentioned steps UNICEF staff and implementing partners undertook to improve PSEA, in February 2020 UNICEF released its Procedure for Managing Risks of Sexual Exploitation and Abuse in Implementing Partnerships. This procedure established requirements for UNICEF offices implementing UNICEF's programme interventions through partnerships with civil society organizations to operationalize the screening of implementing

partners as required by the United Nations Protocol on Allegations of Sexual Exploitation and Abuse Involving Implementing Partners and to apply appropriate risk mitigation measures to minimize the risk of sexual exploitation and abuse in partnerships with civil society organizations.



According to this procedure, all such organizations partnering with UNICEF are expected to undergo a PSEA assessment, valid for five years, on risks derived from their organizational capacities to protect against and prevent sexual exploitation and abuse and address risks of harm to children and beneficiaries from sexual exploitation and abuse, as well as reputational risk to UNICEF. The organizational capacity rating converts to a SEA risk rating. Where the PSEA assessment risk rating is high, in high-risk contexts, or to verify the extent of compliance with PSEA policies, procedures and systems as declared in the PSEA assessment, UNICEF includes a component on beneficiary-level monitoring with specific questions related to sexual exploitation and abuse in its programmatic visits agenda. On completion of the PSEA assessment, the implementing partner is encouraged to develop an action plan to address gaps in its organizational capacity to prevent sexual exploitation and abuse. In this process, UNICEF provides support to the implementing partner by sharing a comprehensive PSEA toolkit that contains key PSEA resources such as examples of a code of conduct, action plans, etc., and by organizing specific trainings.

Addressing the organizational capacity gap is the basis for revising the PSEA assessment-specific criteria ratings and the overall SEA risk rating accordingly. Upon completion of the PSEA assessment, if the SEA risk rating is high, the implementing partner is informed that if adequate preventive measures sufficient to gain a lower SEA risk rating are not in place within 12 months from the date of the PSEA assessment, the partnership will be terminated. Follow-up letters are sent throughout this period if the SEA risk rating remains high. If, after 12 months, the implementing partner has not taken necessary measures to address the gaps identified in the PSEA assessment and the SEA risk rating remains high, or no PSEA assessment has been performed, then the SEA risk rating is assumed to be high and the partnership agreement is terminated to improve compliance with PSEA requirements.

In August 2020, UNICEF organized two training sessions for all its implementing partners, recalling UNICEF's zero tolerance for sexual exploitation and abuse. After reviewing partner self-assessments, UNICEF transmitted its assessed SEA risk level to partners and shared the PSEA toolkit. Partners

were encouraged to use the toolkit as a guide to develop or improve their PSEA policies, procedures and systems. UNICEF also strengthened PSEA inclusion in all steps of the programme cycle. During programme design, UNICEF and partner organizations systematically identify and address risks related to sexual exploitation and abuse by carrying out the following measures:

- ▶ Conduct thorough and inclusive risk assessments on sexual exploitation and abuse before designing projects, if possible as part of the initial needs assessment;
- ▶ Conduct consultations with beneficiaries and local communities, including women, children and other relevant stakeholders, on PSEA as part of needs assessment;
- ▶ Incorporate prevention and safety measures for sexual exploitation and abuse in standard programme design (e.g., provide assistance in public, safely accessible and well-lit areas; limit one-on-one interactions between personnel and beneficiaries whenever possible; and include female personnel in programme implementation teams when possible).

During project implementation, monitoring for high-risk partners should look for respect for PSEA measures as well as the organization of awareness raising on PSEA at the beneficiary level. Monitoring of programme implementation for SEA low- or moderate-risk partners also reviews the extent of compliance with, and effectiveness and efficiency of, the organization's PSEA policy, procedures and systems.





The fourteenth outbreak

5.1 Overview

On 23 April 2022, the Government of DRC, through the ministry of health, declared the resurgence of the EVD epidemic in the health zone of Wangata, in the provincial capital of Mbandaka. The first confirmed

case was a patient hospitalized on 19 April at the ETC of the general hospital in Mbandaka. On 25 April 2022, a second case was confirmed.

The main actions taken by UNICEF are summarized (from the situation report) in Figure 2.

Figure 2. UNICEF actions in response to the fourteenth outbreak



Infection Prevention and Control (IPC)/Water, Hygiene and Sanitation (WASH)

- ▶ In support to the IPC-WASH commission, the decontamination of the Ebola affected household of the two confirmed cases, surrounding communities and medical facilities has been completed.
- ▶ UNICEF is dispatching supplies to Mbandaka, including personal protective equipment, disinfection materials, and other items, such as mattresses for health care facilities.



Risk Communication and Community Engagement (RCCE)

- ▶ UNICEF teams are providing support to facilitate the interventions of frontline workers for the collection of swab samples, the decontamination of households, the listing and vaccination of contacts.
- ▶ UNICEF is supporting the dissemination of key Ebola sensitization and communication materials in the affected health zones in Mbandaka and Wangata. The U-Report platform has already engaged with more than 36,000 U-Reporters across the whole on key information related to Ebola prevention.



Psychosocial Support and Child Protection

- ▶ UNICEF is supporting social workers and clinical psychologists from the Ministry of Social Affairs to provide psychosocial support to the families of the two confirmed cases, listed contacts, health teams, as well as the burial team.

	Nutrition UNICEF is dispatching key nutritional supplies for the Ebola Treatment Centre (ETC), including 29 cartons of ready to use infant formula, 30 cartons of ready to use therapeutic food and anthropometric supplies (scales, mid-upper arm circumference tapes, etc.).
	Gender Based Violence/Gender/PSEA Based on lessons learned from the previous epidemics, PSEA is being integrated from the onset of the response. Through UNICEF partners, safe community-based complaint mechanisms to report sexual exploitation and abuse (SEA) put in place during and after 11th EVD epidemic are being strengthened. SEA risk mitigation through training of responders and community awareness raising using local radio stations and U-Report is also currently ongoing.
	Funding UNICEF has already allocated US\$400,000 to meet critical needs until additional funding is secured. Availability of flexible and timely funding will continue to play an important role in this response as it will enable UNICEF and partners to act rapidly to contain the outbreak.
	External media Since the announcement of the new Ebola case detected in Mbandaka in Equateur Province, UNICEF has relayed this information through its social media platforms, including communications on prevention measures and initial response activities on the ground to contain the outbreak. Multimedia material is available on Weshare.

Source: UNICEF, *UNICEF DRC Ebola Situation Report #1, 22-26 April 2022*, www.unicef.org/media/119716/file/DRC-Ebola-Situation-Report-26-April-2022.pdf.

5.2 Community perceptions of the fourteenth outbreak and response

Feelings about the outbreak

Community members (especially women) reported feelings of fear and worry at the news of an Ebola outbreak and questioned why repeat outbreaks occurred. There was initial denial before subsequent acceptance, though previously affected families were readily accepting and took appropriate action.

“It is more nurses and doctors who accept the occurrence of the outbreak. The people do not accept. Like at home, it was only my brother who is a doctor who accepted.”

“Many do not accept that the disease is rampant in the community. It is only after there are deaths that we accept that this is true.” (Wangata community)



“For me, I went to check at home where the case was detected because I had not accepted.” (Wangata community)

“Already the news makes us suffer because it is a very lethal disease. Then we have to take steps to prevent the disease.”

The experience was compared to preparing for the start of a war. Community members also considered, however, that guidance and awareness provided through the CAC provided reassurance. CAC members in Wangata noted that some sections of the community, particularly indigenous peoples, were sceptical about the reality of the disease outbreak:

“ Among the indigenous peoples (pygmies), it is more difficult, because there is total ignorance and they suspect political complicity for financial interest.”
(CAC Wangata)

Views on effectiveness of response

In both communities, participants in community FGDs considered that the response by government and partners to the outbreak was effective and generally well received and that there was good awareness of measures required to control the disease:

“ In the household of the confirmed case in my neighbourhood, we disinfected the house and burned everything that belonged to the patient. Then raising awareness of preventive measures. Afterwards, the psychosocial agents supported the family, especially the mother of the deceased child.”

The use of community members as part of the response was appreciated:

“ Another positive point, the community agents have been recruited in our community, moreover among us there are some, too. We really enjoyed that.”

Both communities, however, lacked access to reliable clean water supplies as required to meet recommended hygiene measures, while participants in the Bolenge FGD noted that they lacked access to soap and toilet and hand-washing facilities:

“ We are asked to drink clean water but we do not have a suitable source. We have to travel miles to reach a water source.”

“ The IPC inputs were not made available to the community. This stopped at the level of the health structures. This often results in rejection from the community.”

“ And then, the situation of the latrines: we demand that we also have public latrines, instead of arranging only in the health centre. Do we all have to defecate at the health centre?”

“ Telling communities to wash their hands is better. But you have to know that not all water is suitable.”



Community members also considered that the requirement to pay for access to health care meant that guidance to seek hospital care could not always be followed.

Members of the CAC FGDs considered that the response was effective and that community engagement through sensitization activities paid off. Lack of access to food immediately after vaccination was considered to have discouraged some from seeking vaccination. Delays in payment and perceived favouritism and the use of non-community members were noted as potentially undermining community support:

“The suspicion is that the Ebola business community is controlled by the government and its partners. Government friends are selected in priority. But the principle of the community: when you do something without the community, then you’re not doing it for the community. They bring us strangers or foreigners to work in the community.”

CAC members also had concerns about the move away from individual payment to community health workers (as had happened in earlier outbreaks) to payments just to support income generation activities in communities, as well as the use of mobile money for payments, which was seen as contributing to delays and nonpayment.

Role and operation of CACs

Members of both communities (and members of CACs) considered that CACs were effective in reporting community concerns to partners and other authorities, both during outbreaks and at other times, and in providing surveillance and promoting disease awareness including through home visits (which had encouraged routine child vaccination), as well as strengthening community involvement and supporting revenue generation activities:

“Indeed, the CAC is like a bridge: it brings the problems of the community to the health centre on the one hand, and on the other hand, news from the health centre to the community.”

Both communities noted that CACs had advocated addressing water access problems but that this did not always lead to results:

“For example in our village, the borehole is damaged. The villagers came to the CACs to complain. The CACs have reported the information. Now a group of UNICEF agents came recently to assess and promised to bring us the solution by then.”

“At the Mission village we have a water problem. Since when it was addressed to the CACs, nothing has been undertaken. While we solved the water problems in the health centre next door – the community fetches water from the health centre.”



More action to ensure that concerns raised by CACs were addressed was seen as important to maintain credibility:

“ It is some care providers in their health centre who are resistant and hinder our work for their personal interest. We ask UNICEF as sponsor of CAC and other partners to take measures that will accompany us to bring together health care providers and community relays. This will allow us to play our role as a bridge.”
(CAC Wangata)

In Wangata concern was also expressed, in both the community and CAC member FGDs, that not all CAC members came from the community:

“ Compared to our participation in activities during the outbreak, we were not 100 per cent beneficiaries. There were people from elsewhere, not knowing the environment and not being as well known by the community. The community refused to receive such people.” (CAC Wangata)

“ Sometimes even we from the committee are not involved in the activities. One is only surprised to see unknown people carrying out community activities.” (CAC Wangata)

“ It's when the community sees the imported people that they ask questions. They surely think there are no diseases, these service providers create their business to earn money.” (CAC Wangata)

In Wangata, there was a particular concern about the need for UNICEF and other partners to take more account of the indigenous population (pygmies) as beneficiaries of its activities. A representative of the indigenous peoples on the CAC congratulated UNICEF for its commitment to the education of pygmy children, which was highly valued in the community, but she pled for a system to be established to facilitate the medical care of pygmies in hospitals.

Both community and CAC member FGDs emphasized the importance of continued training for CAC members, particularly to take account of the turnover of membership and to ensure capacity is built ahead of future outbreaks:

“ In the CAC, we have what is called revitalization; that is to say when we work there are [members] who are traveling and others change environment. Those who join the CAC must also be trained. Then training should be continuous in relation to outbreaks to enable mastery of techniques and approaches. Or we can be equipped with new approaches learned during outbreaks in other places.” (CAC Wangata)



Gender and PSEA

Community members in Bolenge (both male and female) considered that gender issues were effectively addressed through the CAC because the majority of CAC members are women, who are also involved in revenue-generating activities. In Wangata, male community members in particular felt that women needed to take more active roles, though a female CAC member said that male support was required for women to take such roles. In both communities, greater involvement of women in providing services was seen as required for awareness raising.

In all FGDs, participants considered that there was now greater awareness of PSEA and a willingness to identify and complain about it:

“It really made us aware because we were ignorant. We didn’t think it was exploitation or abuse.”

“For us, one of the activities that we add in our minimum package of activities. Because the community is a victim of influence peddling from partners or outsiders who come during outbreaks. Sometimes they do sexual abuse to offer a job.” (CAC Wangata)

RCCE and PSS

PSS was considered useful and important by community members, and it was believed that it had helped to minimize stigma and discrimination against Ebola patients:

“In the family of the confirmed case of Bongonde, we saw the psychosocial team go to them to support and accompany him.”

“Before we were afraid of infected people and their family members. But with the sensitization of community relays and psychosocial agents, this has allowed us to live better with family members and the cured person whom we have reintegrated into the community.”

Home visits were also found to be very useful by the Wangata community because they allow exchange of information in order to prevent diseases:

“It is an activity that gives us a lot of support and assurance, although at first their presence is worrying since we do not know what news they will announce.”

CAC members in both communities considered that home visits had played a crucial role in building community trust, including overcoming concerns about vaccination and other Ebola interventions, as well as identifying patients:

“I think if you think home visits are not important, so that would mean that we all became nurses or doctors. I assure you if only we stop this practice, you will see how we will be overwhelmed by several outbreaks.” (CAC Wangata)



“ If there is an outbreak, the CACs will find out before anyone else. When this Mbandaka Ebola outbreak started, it was not the nursing staff who detected or alerted. Yet it was one of ours who noticed a child vomiting blood and defecating blood ... that’s how he alerted and then the health personnel arrived.” (CAC Wangata)

CAC members, however, were very critical of the quality of the people recruited as psychosocial agents, while also stressing the need for engagement on a continuing basis rather than just during outbreaks:

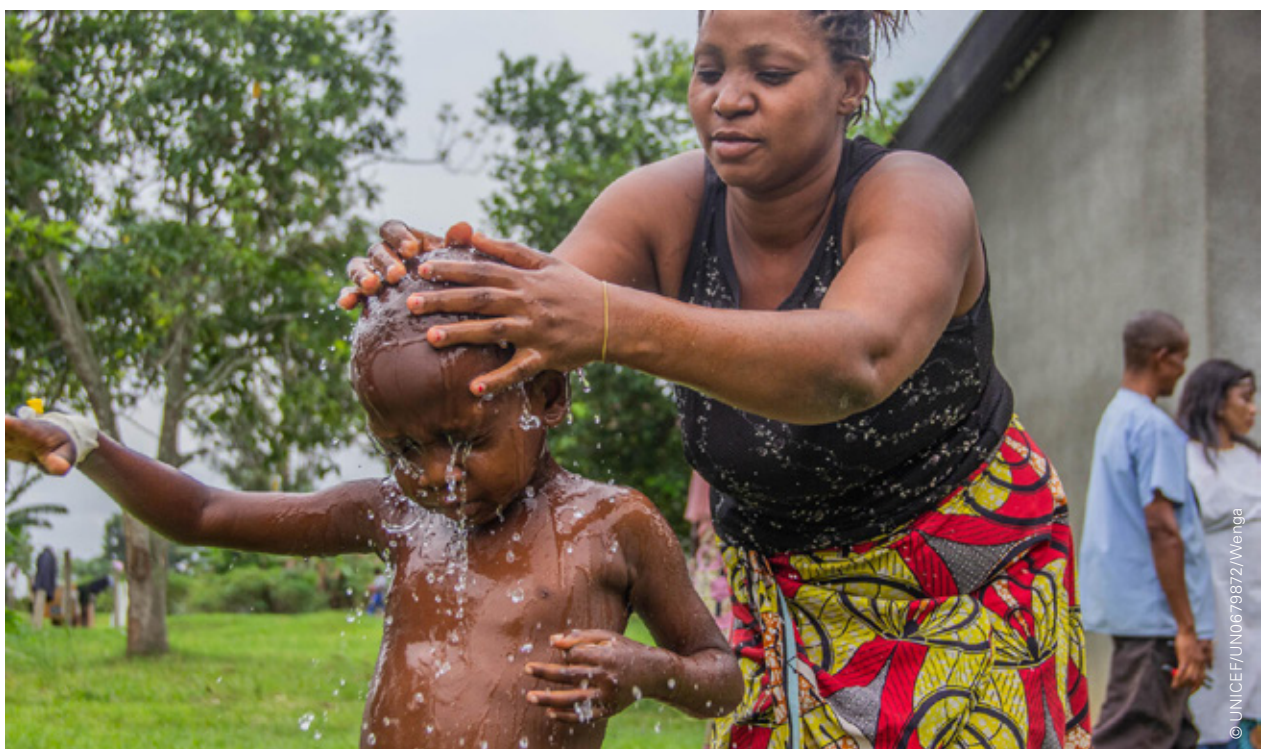
“ The recruits are not really the trained psychosocial agents; it is their way of doing things on the ground that creates a bit of tension in the community. We suggest that UNICEF train psychosocial agents in each CAC, because they will now do what is called continual social assistance. With us, these are routine activities even post-Ebola during the period of resilience.”

IPC and WASH at community level

In both communities it was noted that many hand-washing devices and water sources established (with UNICEF support) during the outbreak were no longer functioning, in part because they were set up as one-off activities carried out by outsiders and without maintenance arrangements. The CACs were seen as having a central role in sustainably addressing water supply, but their advocacy was not always effective. For instance, it was noted that indigenous people did not have a water supply point although the need for this had been raised with CAC and partners:

“ It’s about 95 or 98 per cent of developed water points that are no longer functional in our Bolenge health zone.” (CAC Bolenge)

“ Even where we have placed water supply points, this does not cover the needs of the environment according to the population and even the extent of the entity. Example in Mama Balako with an area of 6 km² and a population of about 36,000 inhabitants, there is only one pump located in the health centre. The furthest CAC is 5 km away.” (CAC Wangata)



5.3 Perspectives from UNICEF field office staff on the fourteenth outbreak

UNICEF field staff considered that the prior investment in the CAC approach had greatly contributed to the effective response to the fourteenth outbreak, including the fact that the index case was detected by the community, and the role of the CAC in raising alerts, promoting good practices and community feedback, and as a route for distributing kits to affected families. UNICEF's ongoing involvement in communities through CACs facilitated community acceptance of UNICEF staff during outbreaks:

“Because we were not working on Ebola only, we were also doing community activities such as the development of water sources, water boreholes, the construction of latrines in schools in the communities for example in Butembo, Biakato ... so where there was more resistance, we changed the approach. We went there with the community approach and for that, even when there were attacks, it was rare for UNICEF staff to be worried.”

UNICEF's actions in outbreaks have therefore been made more effective by the positive community dynamics that UNICEF's programmes have stimulated and maintained.

While CACs have been successful, UNICEF staff considered their effectiveness to be limited by the facts that not all partners are fully aligned on the CAC approach and that while the CACs are envisaged as a multisectoral structure, they are not directly involved in actions across all social and economic sectors. The importance of continuing investment in CACs as permanent structures for community engagement was emphasized, as was extending their work on social marketing and behaviour change, as well as increasing engagement from young people through digital communication.

UNICEF had also contributed to preparedness through earlier work on strengthening hospital hygiene and the training of local teams integrated into hospitals that were capable of launching a response in the event of an outbreak. An example identified of a desirable permanent investment to strengthen capacity was the construction of permanent nurseries at hospitals to avoid the need to recreate them in future outbreaks.



Field staff considered that they had received effective and understanding support from the DRC Country Office and that a change had occurred so that there was much more effective sharing of information across programmes and awareness of the links between programme activities and epidemic control:

“The fourteenth, we managed it alone internally, but regional office colleagues were organizing calls to strengthen us. So they are careful to say what are you doing there? What is your difficulty? What do you want us to do for you? Even the national office because when there is the phone call we do it with the regional office, Kinshasa. They really supported us.”

“We had the support of the emergencies unit, whose managers came here in emergencies for a week and taught us how to work in particular on the response, the selection of partners ... so that everything is ok, the disbursement of funds, the supply comes from where ... do we have sufficient teams to be able to do all that. And that, I think that at the country level, people are now trained. I am confident that Ebola can occur today, and indeed we will have the necessary support at the country level. And for Mbandaka, the staff is already trained.”

“All I have to do is call the sub-office manager and things speed up, the solution is found quickly.”

Constraints on the effectiveness of response related to political action included a delay of almost two weeks in the declaration of the outbreak by the governor and a delay of almost two months in issuing a ministerial decree on the management of burials. UNICEF and other partners advocated for the decision-making to be transferred to the HZ in order to be as close as possible to the HZ.

Other factors identified as constraining the effectiveness of response were:

- ▶ Non-acceptance and denial of the existence of the disease in some parts of the community;
- ▶ The financial interests of community leaders: “for them, outbreak equals money”;
- ▶ The parachuting of outsiders into communities, which generates tension;
- ▶ Delays in paying service providers by the ministry of health, which led to demotivation;
- ▶ Friction between medical and social perspectives: “we don’t get enough support or consideration from our health collaborators; they find that it’s not important when it’s very important because they don’t manage the social issues generated by the epidemic.”





Findings

This chapter summarizes evidence from the case study in relation to the evaluation questions. It draws on the KIIs as well as documentary sources, including the multisectoral evaluation, where appropriate.

To what extent has UNICEF's work on Ebola in DRC contributed to a common vision with national government policies and plans?

6.1 Relevance

To what extent has UNICEF's work on Ebola in DRC been aligned with the needs and priorities of those most affected and at risk (especially children and the most vulnerable groups)?

UNICEF has used IOA, the U-Report system and community engagement through CACs to understand and respond to needs, though challenges remain in responding fully to community priorities.

Key informants considered that UNICEF's initiatives in developing IOA, U-Report and the CACs have contributed (along with UNICEF's active presence in communities) to a greatly increased understanding of community needs, including those of the most vulnerable people in the most difficult contexts, compared to the situation earlier in the period covered by the evaluation. Challenges remain – as evidenced by the community FGDs carried out in Mbandaka – in ensuring community priorities are met, particularly in strengthening access to IPC/WASH and health services.

UNICEF has worked closely with the ministry of health and has influenced the development of national capacity and plans, while UNICEF's activities have been strongly aligned on SRPs.

UNICEF has worked closely with the Government of DRC, particularly the ministry of health, in developing policies and operating procedures that draw on lessons learned from experience. UNICEF's engagement has been strongly aligned on SRPs, but UNICEF also played an important role in raising concerns about the lack of progress under SRPs 1 to 3 during the tenth outbreak, which led to agreed changes in both government and partner management arrangements as well as the operational approach under SRP 4. In the case of the fourteenth outbreak, such changes occurred while activities agreed in a joint work plan with government following the earlier outbreak in Mbandaka (the eleventh outbreak) were being implemented, alignment on which facilitated the reactivation of the emergency component.

How successfully and in what ways has UNICEF adapted its work on Ebola in DRC to evolving circumstances and changing needs and priorities?

UNICEF developed and used a range of monitoring approaches to guide adaptation of its interventions during the tenth outbreak and has built on this approach in addressing subsequent outbreaks.

The multisectoral evaluation found that UNICEF used a range of monitoring information during the tenth outbreak and that limited evidence was available to indicate use of implementing partner-led monitoring data for decision-making around course correction.

Subsequently, UNICEF's work has been highly adaptive, with each of the main innovations developing in response to lessons and experience. The tenth outbreak played a key role:

“ The tenth Ebola epidemic practically changed a lot of things, bringing many strategies adapted according to the priorities and needs of communities. For example, the crib next to ETCs for children separated from their parents tested positive for the Ebola virus. This strategy was adopted and applied in the outbreaks that followed after.” – *UNICEF staff member*

“ The major challenge during the tenth was the decontamination activities. We were able to address the different challenges of epidemics. The implementation of rapid response teams during the eleventh outbreak was a strategy adapted to the circumstances.” – *UNICEF partner*

6.2 Effectiveness

To what extent and how has UNICEF contributed to improving preparedness to address Ebola in DRC? What factors have facilitated or constrained this contribution?

UNICEF has made substantial contributions to improving preparedness in DRC, including in developing national capacity, supporting community structures, improved approaches to RCCE, IPC/WASH and PSS, and developing IOA approaches and capacity. The extent to which adequate investments will be made in building and maintaining preparedness, however, remains uncertain.

There was a strong consensus from key informants (both UNICEF staff and others) that preparedness for Ebola outbreaks improved substantially across many dimensions over the period covered by the evaluation and that UNICEF contributed to this preparedness in many ways. As a result, DRC has an institutionalized response and capacity that have contributed to more effective subsequent Ebola outbreak control. Lessons learned have contributed to increasing effectiveness in addressing Ebola outbreaks. More generally the ninth and tenth outbreaks were:

“ ... a lab for conceptualizing and preparing UNICEF's approach to PHEs [public health emergencies] which was used and adapted [internationally] for COVID-19.” – *UNICEF staff member*

There was also consensus, however, that weaknesses remained both at the national and provincial level (mainly relating to management and governance arrangements and the availability of adequate finance) and at HZ and community level, where levels of preparedness varied and this preparedness remained fragile, particularly because of the underlying weakness of health systems and access to adequate IPC/WASH, as well as continuing poverty and insecurity in some parts of the country.

Important progress has been made in developing a cadre of trained and experienced national staff members who can be quickly and effectively deployed to help address outbreaks as they occur:

“ UNICEF has mainly contributed by building the capacity of human resources. On this side the DRC is already ready to face any outbreak that will come ... there is a multidisciplinary team that goes into the field and we have epidemiologists, we have logisticians, we have psychologists, we have all the experts.”
– UNICEF staff member

As an example, UNICEF has supported the training of national service providers from the social affairs division:

“ Initially [when] ... in the area we needed psychologists, we had to import but this time the Division of Social Affairs has clinical psychologists who try to support ... who in a way are pre-positioned to deal with as needed if there is an epidemic and/or crisis issues.” – UNICEF staff member



In addition, standard operating procedures have been developed (particularly based on experience from the tenth outbreak), with UNICEF contributing importantly to these, and coordination arrangements are more effective. UNICEF focuses on pre-positioning inputs and setting up a team ready to be deployed quickly. UNICEF has also produced guidance materials on how to address Ebola and a model response plan that can be adapted to specific outbreaks.

The increasing attention that has been paid to national preparedness was described by one key informant:

“ Before the ninth outbreak there was hardly any talk of preparation. But with the ninth outbreak there was implementation of preparation activities in provinces neighbouring affected Equateur. This preparation effort intensified for the tenth outbreak (for six at-risk provinces and neighbouring countries) with a systematic assessment of available capacities [based on a consolidated WHO checklist], training and equipping of rapid response teams, pre-positioning of kits and inputs, strengthening of multisectoral coordination. After the thirteenth outbreak, a working group on operational readiness was established under the leadership of the ministry of health and in parallel, a preparedness working group.”
– UNICEF staff member



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Key informants noted, however, that compared to the COVID-19 pandemic, there was still insufficient clarity during the tenth outbreak about which level of government (central, provincial, zonal) should manage the epidemic, and that while the Incident Management System that had been established should have solved this problem, its implementation remained incomplete:

“The level of preparation is mixed ... it’s not really optimal. Of course, at the HR [human resources] level, we can say that with several experiences of outbreak, in the East, in North Kivu, the human resources who are there have acquired a certain experience to manage the outbreak. We have a good level of experience at the staff level ... but it is other aspects that pose issues at the governance level, at the operational level and even at the strategic level because we realize that the countries do not put in place the resources (for example contingencies) to cope in a way quick to an outbreak appearing somewhere. So the governance level, the strategic level and even the operational level, that still poses problems in terms of preparation.”
– *UNICEF staff member*

The delays in declaring the fourteenth outbreak at province level (see above) were cited as an example of continuing governance issues. More generally, the process of declaring a public health emergency (PHE) so that specific procedures and legal arrangements are automatically triggered (on the basis of criteria that must go beyond the narrowly epidemiological) is not yet fully developed in DRC. One key informant considered UNICEF to be insufficiently involved in operational preparations.

UNICEF’s contributions to information management and preparedness (at both national and sub-national level) were highlighted as of particular value, including:

- ▶ Support with the establishment of the CAI, which has made a very significant contribution to date;
- ▶ UNICEF’s contribution to setting up information management units by supporting the ministry of health;
- ▶ Training in analysis of service providers from the ministry of health, using the R software;
- ▶ The establishment of a common database for encoding IPC pillar data during the tenth epidemic.

UNICEF’s major contribution to strengthening IPC/WASH was also noted. This included the establishment of a national IPC protocol that is being put in place by the ministry of health and partners including UNICEF with a view to establishing IPC activities as routine rather than triggered only during epidemics, as well as encouraging the establishment of hygiene committees in health facilities. UNICEF is also supporting emergency WASH diploma training at the School of Public Health in Kinshasa as well as investing in community managed, improved local water supplies.

Progress at the strategy and standard operating procedure level, however, is not consistently reflected in local practice:

“The contribution of UNICEF in the implementation of strategies, policies and standard operating procedures for IPC at the national level, in addition to the field experience during the last outbreaks, especially the tenth, has allowed many lessons to be learned and knowledge that is being formalized.”
– *UNICEF staff member*

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“Most frustrating is the fact that most health zones/provinces have benefited from operational readiness activities over the years, but the constant is bitter disappointment once on the ground.”
– *UNICEF staff member*

In North Kivu, IPC was noted to be an issue:

“In the meantime, at the level of the health areas, for example, we have seen that there are all the IPC aspects which always remain a little chaotic. Because we have noticed that [in] evaluations of health facilities the IPC score remains well below 80 per cent. So that means that in terms of preparation for outbreak, we are still very far away.”
– *UNICEF staff member*

As an example of a further operational weakness in preparation, it was noted that during the fifteenth EVD outbreak (North Kivu), no ETC was put in place.

As discussed above, UNICEF's contribution to preparedness in improving water supply and hygiene at health facilities was considered to be an important factor in the successful response to the fourteenth outbreak. However, the FGDs in Mbandaka showed community frustration in the limited progress that had been made towards improving local access to safe water and hygiene arrangements.

UNICEF staff involved in the response to the fourteenth outbreak identified the following key elements of local preparedness to which UNICEF had contributed:

- ▶ Reinforcement of hospital hygiene (water supply, waste areas, etc.);
- ▶ Training of local teams integrated into hospitals capable of independently launching a response in the event of an outbreak;
- ▶ The reinforcement of the CACs as a local hub for households and a bridge between communities and responders.

There were seen to be important opportunities to build on what had been done to strengthen preparedness further at local level:

“We would like to work this time on the basic cells that, apart from outbreaks, work on social marketing, behaviour change, support for routine activities. And when there are outbreaks, it is the same that switches with capacity building and perhaps with some additional resources for specific response activities.” – *UNICEF staff member*

Priorities identified for strengthening preparedness included:

- ▶ Engaging young people through digital communication;
- ▶ Working with the media through a partnership on addressing health challenges;
- ▶ Establishing an improved system for reporting incidents of sexual exploitation or abuse;
- ▶ The construction of permanent nurseries at health facilities to avoid needing to repeat these investments in future outbreaks.

In general, at the HZ and community level, areas that have experienced multiple outbreaks have developed local capacity both in communities (particularly through CACs) and in health facilities. This capacity, however, is regarded as uneven in coverage, potentially fragile, and requiring continued and sustained investment – for instance through ongoing training and support to the CACs. Key informants expressed concerns over the lack of government resources to support the structures and processes, as well as lack of consistency in donor priorities that may threaten sustainability of local and community preparedness. UNICEF's ongoing work with communities was regarded as critical for enabling UNICEF to work effectively during outbreaks because of the community acceptance that this brought (as discussed above in relation to Mbandaka), but again key informants had concerns about how this acceptance could be sustained and community expectations met.

Table 3. Preparedness: functions and assessment criteria

Functions	Assessment criteria	Assessment	UNICEF contribution
Policies, strategies and legislation	Structures, roles and responsibilities of governments and other actors for managing PHE risks are clearly defined and agreed; strategies for strengthening PHE risk management capacities are in place.	Structures, roles and responsibilities of different levels of government are clearly defined and agreed, including zonal approach, which has proved effective, but capacity and political will at provincial and zonal level are variable. No explicit strategies are in place for strengthening risk management capacities.	UNICEF has supported implantation of zonal approach and capacity development at different levels of government.
Planning and coordination	Effective coordination mechanisms and effective leadership are in place for planning and operations for managing PHE risks, including across sectors. Contingency plans are in place and response protocols are tested through simulation and exercises.	Coordination arrangements developed during the tenth outbreak have been maintained and have been effective in controlling subsequent outbreaks, including adoption of multisectoral approach. No evidence indicates the extent to which contingency plans are in place and response protocols tested.	UNICEF contributed to developing revised management arrangements during the tenth outbreak. UNICEF played a major role in developing and implementing a multisectoral approach.
Human resources	Plans are in place for staffing, education and training across the spectrum of PHE risk management capacities at all levels, including for the occupational health and safety of personnel.	National-level capacity has been significantly strengthened and is generally regarded as effective. Provincial and zonal capacity is strong in areas that have experienced repeated outbreaks, but there are concerns about continuing availability of resources for training and capacity development/renewal.	UNICEF has contributed to developing capacity, especially at zonal and community level.
Financial resources	Appropriate financial resources are available to support implementation of PHE risk management activities, capacity development and contingency funding for emergency response and recovery.	In general sufficient financial resources have been secured to address outbreaks, but they dependent on donor support. Funding of preparedness activities is considered insufficient and insecure given other donor interests and priorities.	UNICEF has played a critical role in resource mobilization to address outbreaks.
Information and knowledge management	Harmonized systems are in place and functioning effectively to provide information on risk assessment, surveillance, early warning, information management, technical guidance and research.	Surveillance and information management have proved effective in recent outbreaks. The IOA approach has greatly strengthened understanding of social factors and capacity to analyse these to improve quality of response.	UNICEF has led development of the CAI and the IOA approach.

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Risk communications	Effective communications mechanisms are in place to deliver appropriate, coordinated and trusted information to the general public, including vulnerable groups. Public information activities should be coordinated among stakeholders to avoid dissemination of conflicting information and should be tailored to the risks and needs of diverse at-risk populations, including those with higher levels of vulnerability.	Effective approaches for RCCE have been developed, and CACs have proved to be effective mechanisms for community engagement. Long-term resourcing of CACs (e.g., refresher training), however, is not secure, and community expectations of CACs are not fully met. Harmonized approaches to public information have generally been applied.	UNICEF has led efforts on RCCE and provision of support to CACs.
Health infrastructure and logistics	Safe, sustainable, secure and prepared health facilities, critical infrastructure, and logistics and supply systems are in place to support management of PHE risks.	There has been some improvement of health facilities in areas that have been subject to outbreaks, but in general health facilities do not meet requirements. National logistics and supply systems are weak, but UNICEF is effective in supply and logistics.	UNICEF has contributed to strengthening local health facilities, particularly in relation to WASH and IPC. UNICEF has developed effective supply and logistics arrangements to support outbreak response.
Health services	The full range of health and related services required for supporting management of PHE risks is provided, including nutrition, mental health and PSS; health services have capacity to scale up to meet increased health needs and specific risks resulting from a PHE.	Outbreak responses since the tenth outbreak have been based on provision of a full range of health and related services in affected areas. Follow-up after the end of outbreaks may not be sustained.	UNICEF has led on the provision of PSS and nutrition and on the development of PSS capacity.
WASH services	WASH services (including infrastructure, service management arrangements and behaviour) are provided to support management of PHE risks.	IPC and improved WASH services have been provided as part of outbreak response, but systemic weaknesses remain in access to safe water and sanitation.	UNICEF has led on IPC and supported community-managed WASH development.
Community capacities for health	Local health workforce capacities are sufficient to address PHE risks in conjunction with inclusive community-centred planning and action.	Local health workforces and communities (through CACs) have effective capacity to address outbreaks in areas that have experienced multiple outbreaks, but sustainability of capacity is dependent on donor support.	UNICEF has contributed to improving the capacity of the local health workforces and support to CACs.

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Monitoring and evaluation	Processes are established to monitor progress towards meeting PHE risk management objectives, including monitoring risks and capacities and evaluating the implementation of strategies, related programmes and activities.	Effective processes are in place for monitoring outbreaks and outbreak response.	UNICEF has contributed to systematic reporting on outbreaks, e.g., through situation reports.
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To what extent and how has UNICEF contributed to effective response to Ebola outbreaks in DRC through its partnerships and programmes? What factors have facilitated or constrained response?

UNICEF's response to the tenth outbreak was ultimately effective, though it had mixed results in achieving planned outcomes and requiring substantial changes to approaches to overcome constraints related to the situation of conflict and community resistance. Responses to subsequent outbreaks have been highly effective and have been based on what are now well-established response approaches, resulting in strong local UNICEF staff that have been empowered to lead response efforts with effective support, and well-established community relations based on ongoing interventions.

The multisectoral evaluation found (see Appendix B.2) that UNICEF's response strategies were "mostly effective" against planned outcomes, with 73 per cent of outcome indicators achieved. As shown in Figure 2, the achievement of planned outcomes was highest in PSS and RCCE and lowest in education and IPC/WASH. In contrast, the multisectoral evaluation assessed the RCCE pillar as only partially successful.

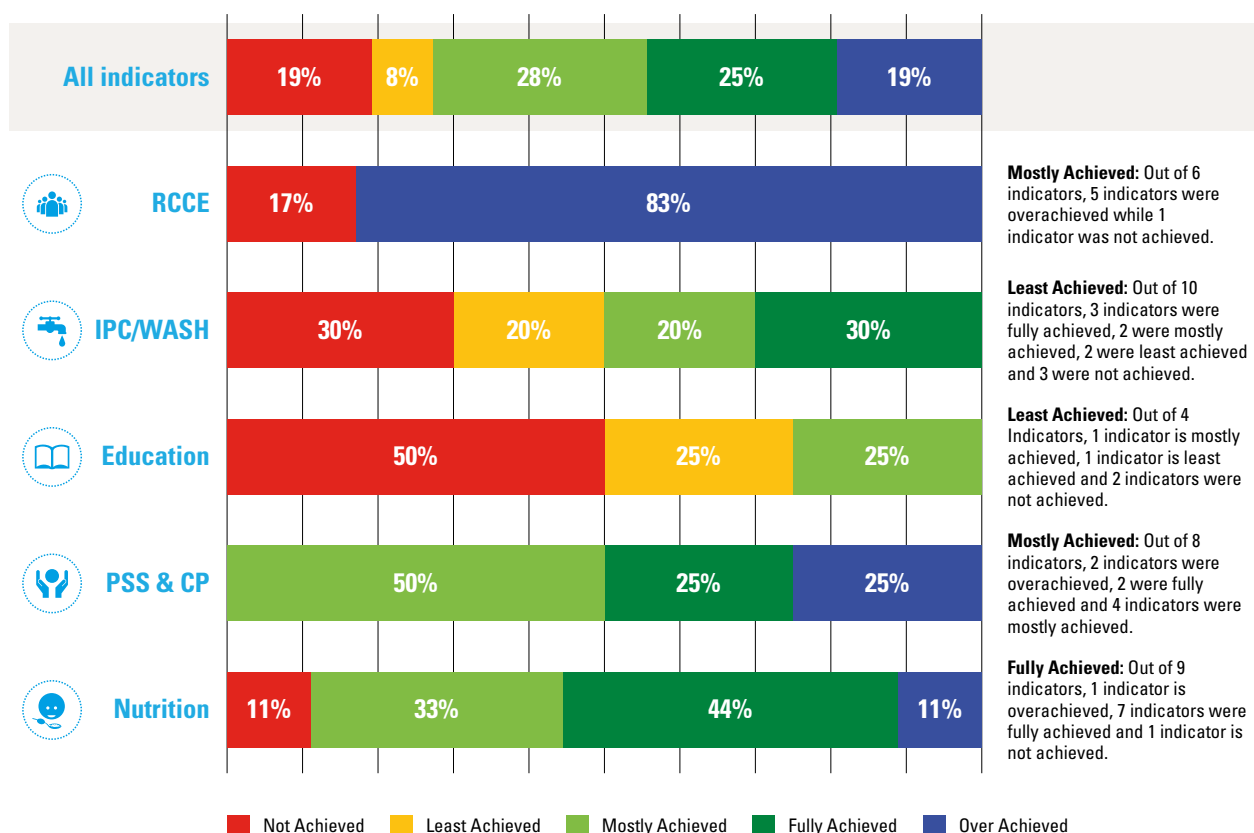
The multisectoral evaluation also found that:

- ▶ UNICEF's capacity building within the public sector was focused more on national than on provincial or HZ levels;
- ▶ UNICEF conducted multiple community capacity development activities under different pillars with mixed results;

- ▶ Approaches including "revitalising CACs; involving local and influential leaders; establishing ETC and child nurseries; conducting household visits to provide PSS and infection control (disinfection) services; [and the] 'ring approach' to selectively target people for vaccination" were judged to be "effective in identifying the confirmed cases, providing them with integrated support and controlling the epidemic";
- ▶ Key enablers of effective response by UNICEF included the use of a diversity of communication means and products, prior experience of working in the local context, availability of local implementing partners, the insights obtained from IOA and the adoption of community engagement approaches. Response was disrupted by political instability and insecurity, poor road networks, "inappropriate implementation modalities such as high visibility of the armed escorts and foreigners resulted in fear and reluctance in affected communities", limited technical capacities of ministry of health staff and COVID-19-related restrictions.



Figure 3. Achievement of UNICEF response interventions by response pillar, tenth outbreak



Source: AAN Associates, 2022, p. 21. CP: child protection.

There was a strong consensus among key informants that effectiveness of response had improved substantially as lessons from the tenth outbreak were used to inform response to subsequent outbreaks. The core lesson from the tenth outbreak was the need to move away from a health sector-led to a proper multisectoral PHE response: “this was a big breakthrough that has influenced subsequent thinking, especially for COVID-19.” One key UNICEF staff member noted, however, that many of the key lessons (for instance the need to focus on communities) had already been identified from the 2014–2015 West Africa Ebola outbreak “and it felt like we were starting from scratch” rather than being adequately informed by this prior experience.

Critical elements of effective response identified by key informants included:

- ▶ An effective multisectoral package of support to response involving the zonal approach to surveillance, RCCE, IPC, PSS, effective case management for children including establishment of creches, and the use of IOA to guide actions;

- ▶ The deployment of rapid response teams;
- ▶ Localization and having empowered capacity on the ground (including at UNICEF field offices);
- ▶ Avoiding reliance on bringing in outsiders to the community as part of the response;
- ▶ The building of strong community relations through CACs and a pre-established relationship with communities (including through support to community-led WASH).

The existence of effective vaccines was also seen as “a gamechanger” for effective response and it was noted that 22,000 people were vaccinated during the fourteenth outbreak.

The successful control of the three outbreaks in North Kivu that have occurred since the tenth outbreak was noted as indicating successful learning of lessons and building of capacity. This was based on effective detection, follow-up of contacts and improved community dynamics, especially through the CACs:

“ [Now, in response to outbreaks in North Kivu] we do not need to move a whole support battery. The detection was made very, very quickly by the health system itself and the fact that the central level has decentralized the management ... and it has put it at the level of the provinces, which quickly brings together the partners (WHO, UNICEF and others) [has been effective]. We set up a little coordination [arrangement] around the health zone – the reflexes are there at the system level, which did not exist before, and the community base that we have accompanied by putting in place CACs. [These] help us so much in the community-based surveillance and especially the follow-up. It has meant that in the resurgences that we have had, that we have a better follow-up rate of contact.”
– UNICEF staff member

The fourteenth outbreak was effectively controlled with only limited resources from the national or provincial level being required. Some key informants were cautious about to what extent success could be attributed to improved preparation and effective response:

“ It is rather a combination of factors from which unfortunately one cannot easily identify the part of preparation or good luck.”
– UNICEF staff member

Thus, while key informants were confident that approaches to response were effective in regions that had already been exposed to outbreaks with pre-existing structures and sensitized populations, there remained concern that these conditions were not replicated throughout the country, such that outbreaks in new areas could still pose significant challenges.

Table 4 provides a summary assessment of the UNICEF responses to the tenth and fourteenth outbreaks using the CCCs framework.



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Table 4. Assessment of response against Core Commitments for Children commitments and benchmarks

Commitments	Benchmarks (summary)	Assessment: tenth outbreak	Assessment: fourteenth outbreak
1. Coordination and leadership Effective coordination is established with government and partners	Interagency and intersectoral coordination	Initially not effective Effective coordination mechanism established under SRP 4	Coordination arrangements effective but delays in declaration of outbreak at province level
	UNICEF-led sectors appropriately staffed and skilled	Insufficient attention paid to gender balance within teams and leadership	Teams appropriately staffed and skilled
	UNICEF core leadership and coordination accountabilities are delivered	UNICEF provided generally effective leadership and coordination in RCCE, IPC/WASH and PSS	UNICEF provided effective leadership
	Surge deployments and emergency procedures	Surge deployment judged reasonably effective in KILs	Response addressed by field office without requiring surge deployment Emergency procedures effective
	Activation of the Inter-agency Standing Committee Protocol	Activation took place	Not required
2. RCCE Communities are reached with targeted messages on prevention and services and are engaged to adopt behaviours and practices to reduce disease transmission and its impact. They participate in the design, implementation and monitoring of the response for ongoing corrective action.	Communities are reached with appropriate and accessible messages	RCCE assessed as “partially successful due to high reluctance, refusal and non-cooperation from communities up to the last part of the response operations, prolonging the epidemic” but evidence of effectiveness of promotion of knowledge and practice (AAN Associates, 2022)	Messaging by CACs reported to have been effective in general but less so in reaching indigenous minority community
	Local actors empowered to raise awareness and promote healthy practices	CACs supported by UNICEF played important role in raising awareness and promoting healthy practices, but reliance on external actors contributed to community resistance	CACs performed effective role in raising awareness and promoting healthy practice
	Systems are in place to allow communities to guide the response and provide feedback for corrective action	U-Report platform, CACs and data collection through IOA helped to identify problems and ultimately contributed to corrective action	Feedback through CACs, but frustration that not all problems identified are adequately addressed (e.g., IPC/WASH)

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3. Strengthened public health response: prevention, care and treatment for at-risk and affected populations Populations in at-risk and affected areas safely and equitably access prevention, care and treatment, to reduce disease transmission and prevent further spread. Specific attention is given to women and children.	Risk of geographical spread of the outbreak and its potential impact monitored	Use of multilayered monitoring mechanism to inform decision-making. “Limited evidence is available to indicate use of IP-led monitoring data for decision-making” (AAN Associates, 2022).	Effective monitoring undertaken
	Specific needs and vulnerabilities of children and women considered	Specific needs and vulnerabilities of women and girls not initially addressed – high levels of sexual exploitation and abuse, failure to meet needs of pregnant women, under-vaccination of pregnant and nursing women IOA contributed to identifying and addressing needs	High awareness of gender issues reported by communities Protocols and procedures in place for PSEA
	Communities directly affected by the PHE are reached with IPC measures	IPC/WASH only partially successful (AAN Associates, 2022)	Communities considered IPC/WASH needs not fully met and concerns about sustainability of investments
	PSS services are accessible	PSS “mostly successful” (AAN Associates, 2022)	Services supplied and accessible. Welcomed by community but some concern from CACs over quality of service suppliers
	Children directly affected receive integrated package of care	UNICEF promoted nurseries at ETCs to provide care Provision of nutrition support	Use of nurseries effective
	Frontline workers trained in IPC and provided with PPE	IPC training and PPE provision generally effective	IPC training and PPE provision effective

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4. Continuity of essential services and humanitarian assistance Essential services and humanitarian assistance are maintained and scaled up as necessary, and communities can safely and equitably access them.	Needs assessments are conducted early and regularly	IOA/CAI units collected information to inform understanding of needs	
	Essential services and humanitarian assistance maintained/scaled up	Negative effects (diversion of staff and resources) on routine immunization and activities for reproductive maternal, newborn, child and adolescent health Scale-up of some aspects of humanitarian assistance (e.g., nutrition interventions)	No adverse effects on essential services reported
	Protection services accessible in a safe and equitable manner	Continuing insecurity and community distrust militated against safe and equitable access to services	No security challenges Limited community distrust except in indigenous communities
	Continued and safe access to education is maintained	Schools remained open	No disruption to education
	Social protection mechanisms are maintained/expanded	Nutrition and other support provided	Nutrition and other support provided

How well has UNICEF supported innovation, including product innovation and appropriate use of new technologies, to respond to Ebola in DRC and mitigate impacts?

UNICEF has supported effective innovations including IOA, working effectively with CACs, the establishment of nurseries at health facilities, the development of an IPC scorecard and improvements to waste management at health facilities.

UNICEF has played a key role in developing the following innovations that have contributed to improving response to Ebola:

- ▶ The establishment and active use of IOA to guide and adapt response. This has since been set up as a formal unit within the DRC Ministry of Public Health and replicated in other countries, for multiple PHEs;
- ▶ The establishment and use of CACs as a bridge to communities;

- ▶ The setting up of nurseries at ETCs to care for children separated from parents or caregivers and integration of nutritional support into care provided through ETCs;
- ▶ The U-Report platform for the management of community feedback, though concerns were noted that this was not sufficiently integrated with CACs and that it may not prove sustainable (AAN Associates, 2022);
- ▶ Development of a weekly integrated IPC/WASH assessment tool (IPC scorecard) and the application of the IPC ring strategy as part of case management, involving intensive IPC/WASH activities within a 100-meter radius of cases;
- ▶ The improvement of waste management arrangements at health facilities.

To what extent is UNICEF’s work on Ebola in DRC informed by evidence including from evaluation, research and integrated multisector outbreak analytics?

UNICEF has effectively developed and used approaches for integrating research evidence, including social and epidemiological data, and these have strongly influenced the work of both UNICEF and partners.

UNICEF’s initiative in developing IOA has, since the tenth outbreak, had a major impact in improving understanding of the social context in which outbreaks and responses occur, and in guiding actions by UNICEF and partners.

The IOA approach has been taken on as an initiative under the Global Outbreak Alerts and Response Network to ensure continuity of the multi-actor approaches, methods and coordinated analysis for outbreaks in Guinea (Ebola 2021); the Republic of the Congo (COVID-19 2022), Ghana (Marburg 2022), Haiti (all health risks 2022) and Uganda (Ebola 2022). In addition, it has become a formal unit within the ministry of health in DRC as well as within the WHO global structure. UNICEF co-leads the IOA Core Team, publishing the quarterly IOA Field Exchange to promote the approach and support response actors to ensure collaboration and improved evidence use within operations.

In DRC, the CAI under the ministry of health has supported better understanding of measles, malnutrition, cholera, gender-based violence, meningitis, the plague and polio, in addition to Ebola (Integrated Analytics Cell and Ministry of Public Health, 2023). In 2022, the CAI, using the IOA approach, was able to track 281 actions co-developed with partners across the country, of which 91 per cent had been implemented on time. The CAI and the IOA approach continue to serve as a unique mechanism to bring all actors, information and data sources together not only to better understand health dynamics but to track and monitor the use of evidence by disease, response sector and location and over time.

6.3 Efficiency

People, systems and structures³

There was consensus among key informants that UNICEF has developed appropriate staffing, systems and structures to support effective response to Ebola, though problems were encountered in addressing earlier outbreaks.

It was stressed that DRC is not typical of UNICEF country offices because there has been significant experience and capacity throughout the period covered by the evaluation. UNICEF in DRC has been able to share its staff and experience, for instance in helping to address the most recent Ebola outbreaks in Guinea and Uganda.

Addressing the challenge of the tenth outbreak’s scale and threat (including to neighbouring countries) required additional staff recruitment. The deployment of managers and teams of outsiders that resulted was, however, problematic:

“ In Goma, UNICEF had a coordination that was outside the Goma office during the tenth epidemic, with a building outside where you have a manager from Kinshasa, there are plenty of senior executives who come from everywhere and do this coordination.” – *UNICEF staff member*



3 To what extent has UNICEF had the right people, systems and structures in place to contribute to preparedness and effective response to Ebola in DRC? What factors have influenced UNICEF’s staffing, systems and structures in relation to Ebola in DRC? How have staffing issues affected UNICEF’s work on Ebola in DRC?

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Subsequently there has been a strategy of focusing management of response in the UNICEF sub-office, which was regarded as highly effective by sub-office staff:

“Today, with the decentralization of work, the office has been empowered. This made it possible to manage resources and it also has an impact on reporting, capacity building of sub-office staff ... Currently at UNICEF, we have really changed. All the programme officers had their budget when at the time they knew nothing. It was the manager who came to support who knew such a grant is there, what does it finance ... no one knew the content of this grant. It was an internal dysfunction of UNICEF perhaps to individuals but that was not the mode of operation. But currently, the programme officers who are there when it is necessary to speak about Ebola, they are able. Like they talk about any other regular programme ... That doesn't mean we don't need support, but we need targeted support.”
– *UNICEF staff member*

In the case of the fourteenth outbreak, UNICEF staff considered the response appropriately staffed. Some earlier outbreaks encountered staffing constraints, but the adoption of rapid response teams under local office management proved effective:

“The reduced number of staff during the epidemic during the eleventh was a bottleneck because it was not possible to cover the 13 health zones affected by the epidemic. But the RRTs [rapid response teams] strategy has made it possible to meet this challenge.” – *UNICEF partner*

One key informant noted that although UNICEF is well supplied with WASH specialists, there is a need to focus on recruiting consultants with IPC rather than more traditional WASH profiles:

“Because most of the colleagues we work with in the field have WASH profiles, so they are sanitary engineers. And they are not too comfortable when it comes to IPC within health care facilities. When we talk about injection safety, for example, they feel uncomfortable. But when we talk about the storage capacities in the facilities, they are more comfortable ... Of course it depends on the organization, the policy and the vision of the organization. But it would be interesting, it would be better to have people who have some IPC profiles, that could help, especially with the vision, with the understanding of what we have identified here as a problem in the interventions, the activities around cases around the ring.”
– *UNICEF staff member*

Concern was also expressed by one key informant about the arrangements for consultants hired as, for instance, local researchers when it was important to build up a cadre of experienced consultants who were not used permanently. It was noted that in the past there had been problems about timely recruitment and payment of contracted consultants but that the office had successfully taken an initiative to establish a long-term agreement with a defined budget, which has simplified the process of recruiting approved temporary staff members when they are required against work orders.

Organizational relationships⁴

Organizational relationships have worked well, with field offices considering themselves empowered to lead response and receiving effective support and guidance from other parts of UNICEF.

UNICEF's intervention approach is based around the field office (sub-office) where the case or cases were notified. A small multidisciplinary team covering UNICEF's areas of intervention is responsible for operational coordination. The national level is responsible for interactions with the ministry of health and resource mobilization and is called upon as a second resort; in the event of expansion of the epidemic, the other field offices as well as the regional and headquarters level may be called upon.

There was a general consensus among key informants that organizational relationships within UNICEF in relation to Ebola response operated well. As an epidemic requiring a multisectoral approach, Ebola is managed by the emergencies section.

Mbandaka office staff felt that they had been effectively supported in the fourteenth outbreak:

“The sitrep [situation report] actually allows us to communicate with a core of managers who can request additional information and respond to our requests.”

“We had the support of the emergencies unit, whose managers came here in emergencies for a week and taught us how to work in particular on the response, the selection of partners ... so that everything is ok, the disbursement of funds, the supply comes from where ... do we have sufficient teams to be able to do all that. And that, I think that at the country level, people are now trained. I am confident that Ebola can occur today, and indeed we will have the necessary support at the country level. And for Mbandaka, the staff is already trained.”
– UNICEF staff member

“The fourteenth, we managed it alone internally, but regional office colleagues were organizing calls to strengthen us. So they are careful to say what are you doing there? What is your difficulty? What do you want us to do for you? Even the national office because when there is the phone call we do it with the regional office, Kinshasa. They really supported us ...”
– UNICEF partner

“All I have to do is call the sub-office manager and things speed up, the solution is found quickly.” – UNICEF partner



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4 How appropriate, clear and well aligned have been the activities and approaches among different divisions and offices within UNICEF in relation to Ebola in DRC? How well have headquarters and the regional office supported the DRC Country Office? What factors have influenced organizational relationships? How have relations between different parts of UNICEF affected its work on Ebola in DRC?

“ Generally, we benefit from support, capacity building support in monitoring, setting up basic indicators to be able to report and then be able to manage them as long as we are responding. So, we benefit from the support of the national level, even of the regional level, with the colleagues who come to support us.”
– *UNICEF staff member*

It was also noted that the rapid allocation by management of strategic funds to initiate the response while waiting for the full mobilization of funds facilitated a timely response.

While generally organizational relationships have worked well, the difficulty of complying with normal procedures (particularly when operating in extremely difficult contexts such as North Kivu during the tenth outbreak) was also noted:

“ So [it has been] at the strategic level hugely positive in terms of consistent management that has supported this at multiple levels, and finding solutions and everything else. But also [there are] consistently people who are like hugely frustrated by the nonconformity [with operating procedures].” – *UNICEF staff member*

Supply⁵

UNICEF’s supply arrangements for dealing with Ebola outbreaks were regarded as now working highly effectively, reflecting learning from the experience of multiple outbreaks, including about standard requirements and anticipated logistic challenges as well as the maintenance of pre-positioned IPC stocks. From a supply perspective, DRC “is not an emergency anymore – it was an emergency ... when you know how to use UNICEF procedure you can do anything.” The establishment of long-term agreement arrangements for transport was particularly important for facilitating rapid response. The major problem has been the reliance on external supply chains because of the lack of locally manufactured supplies. This led to some delays during the most recent period of disruption to international supply chains. However, government supply systems remained extremely weak, such that there was a dependence on UNICEF as a supplier.



5 To what extent were supply operations efficient in providing timely inputs to address Ebola in DRC, including local and international procurement? What factors have influenced supply performance in responding to Ebola in DRC? How has the performance of supply operations affected UNICEF’s work on Ebola in DRC?

Financial management and resource mobilization⁶

UNICEF has mobilized the financial resources required for response, drawing on RCCE to provide bridging funds while donor support is negotiated. However, there has been less funding available to support activities aimed at building preparedness.

UNICEF has succeeded in mobilizing the financial resources required for its responses to recent outbreaks, with the Central Emergency Resource Fund providing a crucial source of funds, while donor funding is arranged along with the use of other UNICEF budget resources. In the case of the thirteenth outbreak in North Kivu in 2021, the response plan was initially partly funded using UNICEF resources and funding from the Swedish International Development Cooperation Agency, but that agency subsequently provided additional top-up resources to cover some of UNICEF's costs. For the fourteenth outbreak, UNICEF's response was fully funded, drawing on the reprogramming of around US\$2.3 million in World Bank funding for health system strengthening under the DRC Government's *Projet de Développement du Système de Santé*. Response plans and frequent reporting against these two donors have been effective in maintaining donor support:



So as soon as there's an outbreak or within the first I would say 24 to 48 hours we usually try to put out an initial situation report, providing an overview of what UNICEF is doing on the ground so that they know that UNICEF is there and present and ready to respond. And usually, it's been quite effective in terms of always getting feedback from donors saying, well, thank you very much for informing us of what is going on on the ground. So there's that constant communication. And then of course, the situation report is issued, at least I think, during the Ebola once a week, to also keep donors abreast. And also, of course, in that situation report, we also put in information on our funding requirements, and how much we've have already funded from our own resources."

– UNICEF staff member

While resources have been available to respond to Ebola outbreaks when they occur, however, securing sufficient funding for prevention and preparedness has been more problematic:



I think at least we've been able to cover those initial requirements for the rapid response on the ground, etc. Now, I think it's more in terms of the longer term. So the whole preparedness – ensuring you know that the conditions are in place, so that to prevent another outbreak, etc. – I think this is where perhaps we're struggling a bit in terms of getting that funding ... Ebola is no longer the I would say, the sexy disease. So the interest from donors [is less]."

– UNICEF staff member

The DRC Country Office is, however, discussing (through the PHE team in Geneva) accessing funding from the United States Agency for International Development to support preparedness activities in North Kivu.



6 How efficiently were funds mobilized, allocated and used to address Ebola in DRC? What factors have influenced financial management performance in relation to Ebola in DRC? How has financial management affected UNICEF's work on Ebola in DRC?

6.4 Coherence⁷

Coordination arrangements were initially not effective during the tenth outbreak and UNICEF played an important role in developing improved management and coordination between partners. Subsequently coordination arrangements have generally worked well and partner activities have been coherent.

UNICEF's work has been based on its strong comparative advantage in community engagement and technical capacity in RCCE, IPC/WASH, PSS and IOA.

UNICEF has provided effective leadership and coordination in sectors that it has led.

As discussed in section 2.3, significant problems in coordination arrangements emerged during the response to the tenth outbreak, and UNICEF played an important role in the process of developing improved arrangements. As described by one key informant:

“ I do think that the Ebola outbreak in eastern DRC was, in a sense, the laboratory at a field level for UNICEF to develop a whole new generation of understanding and capacity. And whereas there were some difficulties in terms of the coordination dynamics between agencies, you know, notably WHO was in a reputational risk moment, so they were actually pretty aggressive. And I think it's generally understood by almost everyone, perhaps except still WHO, that there were some absolutely major screw-ups made in terms of the adoption of a so-called absolute no-holds-barred, no-regrets approach. They over-monetized their response. They over-securitized their response, they closed a blind eye to all kinds of behavioural issues, both on the sexual exploitation side and also on the corruption side. But after that, I think we have gotten to a point where today, UNICEF and WHO genuinely work together, both recognize that we can't do this without one another. And I think that we've gotten into a stronger place after going through a very hard time.”
– UNICEF staff member

In relation to IPC it was also noted that collaboration with WHO was difficult during the tenth outbreak but that this had improved subsequently.



7 To what extent was UNICEF's work in relation to Ebola in DRC coherent with the activities, approaches and responses of partners? What factors affected the extent of coherence? How has the level of coherence affected UNICEF's work on Ebola in DRC?
To what extent has UNICEF's role (including its leadership role) in addressing Ebola in DRC reflected UNICEF's comparative advantage?
To what extent has UNICEF provided effective leadership and coordination in addressing Ebola in DRC?

There was consensus among key informants that coordination arrangements have subsequently worked well in general and that there has been effective coherence between development partners and an appropriate division of roles. In relation to the fourteenth outbreak, collaboration arrangements were effective and it was observed that:

“ The synergy with WHO is effective since we have a MOU [memorandum of understanding] ... The area of action and activities of each party are well defined and respected.” – *UNICEF partner*

While coordination with the partner group was generally effective, however, it was also noted that:

“ Coordination is a constant challenge between partners and political authorities.” – *UNICEF staff member*

Non-UNICEF key informants also noted effective and practical coordination in the field.

Some key informants, however, suggested that stronger coordination between development partners on resource mobilization was desirable.

UNICEF's comparative advantage and leadership role have focused on RCCE, IPC and PSS as well as the initiative to develop and implement IOA. This role was regarded as appropriate, with UNICEF providing effective leadership, though a non-UNICEF key informant who had worked for WHO considered that while UNICEF's leadership on PSS and interaction with local communities had been excellent, in RCCE and IPC it had been less effective because of delays in implementation of some critical interventions.

6.5 Gender, equity and rights⁸

Gender

During the tenth outbreak the response failed initially to understand and address issues affecting the access of women (especially pregnant women and nursing mothers) to vaccination and health services, as well as the increase in gender-based violence, while the response modality facilitated sexual exploitation and abuse. UNICEF's work through IOA played an important role in identifying and developing improved approaches to address these problems. Subsequently UNICEF has played a leading role in developing and applying protocols for PSEA and has sought to ensure that more women are involved in teams and leadership roles.

There was consensus among key informants that the high incidence of sexual exploitation and abuse during the tenth outbreak (which UNICEF played a key role in highlighting) represented a “big collective failure ... individuals worked well but there was institutional failure” to adequately protect women and to be effectively accountable to communities. Key informants emphasized that there should have been greater awareness of the gender-based violence context and risks and that an approach that started from addressing community needs in totality, rather than adopting a narrowly medicalized approach, would be more effective in ensuring both that community needs are met and that the rights of the vulnerable are respected, and in outbreak control.

During the tenth outbreak, UNICEF-led IOA helped to highlight and address gender-related problems, including the under-vaccination of pregnant and breastfeeding women (representing 12 per cent of the population), as well as improving understanding of gender roles in care for the sick and handling of the dead.

Key informants emphasized that substantial progress has subsequently been made in strengthening systems and approaches for PSEA, which have also been adopted for other outbreaks such as in Uganda.

8 To what extent and how has UNICEF's work on Ebola in DRC contributed to protecting children, women and adolescent girls and other vulnerable groups?

This has included developing a strategic partnership with WHO and other partners, including ensuring collective responsibility for PSEA, ensuring that SRPs have a focus on support and accountability to communities, and establishing much stronger staff selection and management processes (including paying explicit attention to ensuring gender balance in staffing in contexts where in the past teams and management had been almost entirely male). It was also noted that DRC experience played a critical role in the promulgation of the revised CCCs in 2020. Community and CAC FGDs in Mbandaka suggested that there is a high level of awareness of PSEA issues and a willingness to raise concerns about them.

Meeting human rights standards and commitments⁹

The response to the tenth outbreak initially fell short of meeting commitments to communities and particularly to women and girls (see Table 4). Subsequent responses (including to the fourteenth outbreak) have generally met commitments.

Accountability to affected populations¹⁰

There were significant failures of accountability to local people during the tenth outbreak, with response heavily dependent on outsiders to communities who were not effectively accountable, as shown in particular by the incidence of sexual exploitation and abuse. Subsequently there has been strong attention to accountability to affected populations by working through community mechanisms and with local people.

UNICEF's work at the community level and through IOA has played an important role in improving understanding of community perspectives and needs and providing information that can guide response. Key informants considered that "UNICEF was the driving force behind accountability" and that the experience

of sexual abuse during the tenth outbreak had been a key factor in ensuring more attention was paid to accountability. The multisectoral approach was seen as critical both to effective outbreak control and to ensuring accountability.

Capacity and resources to address gender, equity and rights¹¹

UNICEF has effectively deployed and developed the capacity required. Since the tenth outbreak, UNICEF has sought to ensure that more women are involved, especially in management and leadership roles, in Ebola response. Appropriate tools and procedures have been developed to improve PSEA and provide appropriate treatment and care for children. UNICEF has through IOA placed a strong emphasis on evidence related to gender, rights and community perspectives and ensuring disaggregation of data.



9 To what extent and how has UNICEF's work on Ebola in DRC promoted and reflected gender, disability, age and human rights standards and commitments (including the CCCs)?

10 To what extent and how has UNICEF's work on Ebola in DRC been accountable to affected populations? What factors have influenced accountability? How has the level of accountability affected UNICEF's work on Ebola in DRC?

11 To what extent has UNICEF had the required capacity and resources (human resources, tools, procedures, leadership, disaggregated data and evidence) to address gender, equity and child rights in its work on Ebola in DRC?

6.6 Sustainability

Strengthening health systems to address PHEs¹²

UNICEF has contributed to building national capacity (especially in the ministry of health) to address PHEs, and to strengthening local-level health facilities especially in relation to IPC/WASH.

Strengthening community systems and engagement¹³

UNICEF seeks to ensure sustainability through community engagement based on CACs and capacity development, but the long-term funding of such interventions remains insecure.

UNICEF's approach to sustainability in improving preparedness for outbreaks and systems strengthening is strongly focused on community engagement, with CACs playing a critical role, for instance in water supply management once UNICEF has invested in improved facilities:

“CACs' revitalization strategies with a view to strengthening community involvement are very important. By working on the involvement of CACs in the health development of their community, UNICEF ensures the sustainability and resilience of the community. To this must be added the multisectoral side of this approach.”
– *UNICEF partner*

“Community involvement and ownership of response activities are at the heart of UNICEF's action. Indeed, this is done through the CACs and the involvement of local leaders in the activities. During the epidemic, the kits are distributed to affected families. The use of local organization and involvement of the community leader are success factors, especially to mark the way before any distribution.” – *UNICEF partner*

UNICEF is also contributing to strengthening health information management systems through support to analysis and training of government officials.

Key informants expressed concerns, however, about the long-term availability of funding and donor commitment for systems strengthening.

Strengthening local ownership and capacity development¹⁴

UNICEF has supported capacity development in local health facilities and through CACs. However, FGDs suggested some frustration in CACs about the extent to which communities were able to ensure that key priorities (e.g., related to improving water supply) were met.

Ensuring linkages with long-term development objectives¹⁵

The multisectoral approach to addressing PHEs, based on strong community engagement, that UNICEF has helped to develop and implement is intended to support long-term development, particularly in relation to health and WASH. Linkages to livelihoods and economic development, however, appear to be weaker.

12 To what extent did UNICEF contribute to strengthening DRC's health system to address PHEs?

13 To what extent did UNICEF contribute to strengthening community systems and community engagement to address Ebola in DRC and improve resilience?

14 To what extent did UNICEF contribute to local ownership and capacity development in DRC?

15 To what extent has UNICEF ensured linkages, coherence and mutual reinforcement of its response to Ebola in DRC with longer-term development objectives?



Evidence summary for the PHE evaluation

This section summarizes the evidence from this case study against the evaluation questions for the PHE evaluation as a whole. This summary has informed

the development of the consolidated evaluation findings.

Evaluation criteria and research sub-questions for case study of Ebola in the Democratic Republic of the Congo (DRC)	
A. Relevance: The extent to which UNICEF's work on Ebola in DRC has been aligned with the needs and priorities of affected populations and key stakeholders and adapts as needed	
A.1 To what extent has UNICEF's work on Ebola in DRC been aligned with the needs and priorities of those most affected and at risk (especially children and the most vulnerable groups)?	UNICEF has used Integrated Outbreak Analytics (IOA), the U-Report system and community engagement through community action cells (CACs) to understand and respond to need, though challenges remain in responding fully to community priorities.
A.2 To what extent has UNICEF's work on Ebola in DRC contributed to a common vision with national government policies and plans?	UNICEF has worked closely with the ministry of health and has influenced the development of national capacity and plans, while UNICEF's activities have been strongly aligned on strategic response plans.
A.3 How successfully and in what ways has UNICEF adapted its work on Ebola in DRC to evolving circumstances and changing needs and priorities?	UNICEF developed and used a range of monitoring approaches to guide adaptation of its interventions during the tenth outbreak and has built on this approach in addressing subsequent outbreaks.
B. Effectiveness: The extent to which UNICEF's work on Ebola in DRC has achieved its intended results and contributed to key outcomes	
B.1. To what extent and how has UNICEF contributed to improving preparedness to address Ebola in DRC? B1.1 What factors have facilitated or constrained this contribution?	UNICEF has made substantial contributions to improving preparedness in DRC including in developing national capacity, supporting community structures, improved approaches to risk communication and community engagement (RCCE), infection prevention and control (IPC), water, sanitation and hygiene (WASH) and psychosocial support (PSS), and developing IOA approaches and capacity. The extent to which adequate investments in building and maintaining preparedness will be made, however, remains uncertain.

EVIDENCE SUMMARY FOR THE PHE EVALUATION

B.2. To what extent and how has UNICEF contributed to effective response to Ebola outbreaks in DRC through its partnerships and programmes? B.2.1 What factors have facilitated or constrained response?	UNICEF's response to the tenth outbreak was ultimately effective though it had mixed results in achieving planned outcomes and requiring substantial changes to approaches to overcome constraints related to the situation of conflict and community resistance. Responses to subsequent outbreaks have been highly effective and have been based on what are now well-established response approaches, resulting in strong local UNICEF staff that has been empowered to lead response efforts with effective support, and well-established community relations based on ongoing interventions.
B.3 How well has UNICEF supported innovation, including product innovation and appropriate use of new technologies, to respond to Ebola in DRC and mitigate impacts?	UNICEF has supported effective innovations including IOA, working effectively with CACs, establishment of nurseries at health facilities, the development of an IPC scorecard and improvements to waste management at health facilities.
B.4 To what extent is UNICEF's work on Ebola in DRC informed by evidence including from evaluation, research and integrated multisector outbreak analytics?	UNICEF has effectively developed and used approaches for integrating research evidence including social and epidemiological data, and these have strongly influenced the work of both UNICEF and partners.
C. Efficiency: The extent to which UNICEF has made optimal use of its human and financial resources to respond to Ebola in DRC	
C.1 To what extent has UNICEF had the right people, systems and structures in place to contribute to preparedness and effective response to Ebola in DRC? C.1.1 What factors have influenced UNICEF's staffing, systems and structures in relation to Ebola in DRC? C.1.2 How have staffing issues affected UNICEF's work on Ebola in DRC?	There was consensus among key informants that UNICEF has developed appropriate staffing, systems and structures to support effective response to Ebola, though problems were encountered in addressing earlier outbreaks.
C.2 How appropriate, clear and well aligned have been the activities and approaches among different divisions and offices within UNICEF in relation to Ebola in DRC? How well have headquarters and the regional office supported the DRC Country Office? C.2.1 What factors have influenced organizational relationships? C.2.2 How have relations between different parts of UNICEF affected its work on Ebola in DRC?	Organizational relationships have worked well, with field offices considering themselves empowered to lead response and receiving effective support and guidance from other parts of UNICEF.
C.3 To what extent were supply operations efficient in providing timely inputs to address Ebola in DRC, including local and international procurement? C.3.1 What factors have influenced supply performance in responding to Ebola in DRC? C.3.2 How has the performance of supply operations affected UNICEF's work on Ebola in DRC?	UNICEF's supply arrangements for dealing with Ebola outbreaks were regarded as now working highly effectively, reflecting learning from the experience of multiple outbreaks.

C.4 How efficiently were funds mobilized, allocated and used to address Ebola in DRC? C.4.1 What factors have influenced financial management performance in relation to Ebola in DRC? C.4.2 How has financial management affected UNICEF's work on Ebola in DRC?	UNICEF has mobilized the financial resources required for response drawing on the Central Emergency Resource Fund to provide bridging funds while donor support is negotiated. There has been less funding available, however, to support activities aimed at building preparedness.
D. Coherence: The extent to which UNICEF has designed, implemented and monitored its work on Ebola in DRC in coherence and coordination with other public health emergency (PHE) actors and utilizes its comparative advantage	
D.1 To what extent was UNICEF's work in relation to Ebola in DRC coherent with the activities, approaches and responses of partners? D.1.1 What factors affected the extent of coherence? D.1.2 How has the level of coherence affected UNICEF's work on Ebola in DRC?	Coordination arrangements were initially not effective during the tenth outbreak, and UNICEF played an important role in developing improved management and coordination between partners. Subsequently coordination arrangements have generally worked well, and partner activities have been coherent.
D.2 To what extent has UNICEF's role (including its leadership role) in addressing Ebola in DRC reflected UNICEF's comparative advantage?	UNICEF's work has been based on its strong comparative advantage in community engagement and technical capacity in RCCE, IPC/WASH, PSS and IOA.
D.3 To what extent has UNICEF provided effective leadership and coordination in addressing Ebola in DRC?	UNICEF has provided effective leadership and coordination in sectors that it has led.
E. Gender, equity and rights: The extent to which gender, equity and rights – particularly the Core Commitments for Children (CCCs) – are reflected in UNICEF's work on Ebola in DRC	
E.1 To what extent and how has UNICEF's work on Ebola in DRC contributed to protecting children, women and adolescent girls and other vulnerable groups?	During the tenth outbreak the response failed initially to understand and address issues affecting access by women (especially pregnant women and nursing mothers) to vaccination and health services, as well as the increase in gender-based violence, while the response modality facilitated sexual exploitation and abuse. UNICEF's work through IOA played an important role in identifying and developing improved approaches to address these problems. Subsequently UNICEF has played a leading role in developing and applying protocols for prevention of sexual exploitation and abuse (PSEA) and has sought to ensure that more women are involved in teams and leadership roles.
E.2 To what extent and how has UNICEF's work on Ebola in DRC been accountable to affected populations? E.2.1 What factors have influenced accountability? E.2.2 How has the level of accountability affected UNICEF's work on Ebola in DRC?	There were significant failures of accountability to local people during the tenth outbreak, with response heavily dependent on outsiders to communities who were not effectively accountable, as shown in particular by the incidence of sexual exploitation and abuse. Subsequently there has been strong attention to accountability to affected populations working through community mechanisms and with local people.
E.3 To what extent and how has UNICEF's work on Ebola in DRC promoted and reflected gender, disability, age and human rights standards and commitments (including the CCCs)?	The response to the tenth outbreak initially fell short of meeting commitments to communities and particularly to women and girls. Subsequent responses (including to the fourteenth outbreak) have generally met commitments.

E.4 To what extent has UNICEF had the required capacity and resources (human resources, tools, procedures, leadership, disaggregated data and evidence) to address gender, equity and child rights in its work on Ebola in DRC? E.4.1 What factors have influenced the level of capacity and resources for addressing gender, equity and rights in UNICEF's work on Ebola in DRC? E.4.2 How has the level of capacity and resources for gender, equity and rights affected UNICEF's work on Ebola in DRC?	UNICEF has effectively deployed and developed the capacity required. Since the tenth outbreak, UNICEF has sought to ensure that more women are involved, especially in management and leadership roles, in Ebola response. Appropriate tools and procedures have been developed to improve PSEA and provide appropriate treatment and care for children. UNICEF has, through IOA, placed a strong emphasis on evidence related to gender, rights and community perspectives and ensuring disaggregation of data.
F. Sustainability: The extent to which the benefits of UNICEF's work on Ebola in DRC, including improved preparedness and systems strengthening, are sustainable beyond the intervention period	
F.1 To what extent did UNICEF contribute to strengthening DRC's health system to address PHEs? F.1.1 What were the factors that supported or hindered this strengthening?	UNICEF has contributed to building national capacity (especially in the ministry of health) to address PHEs, and to strengthening local-level health facilities, especially in relation to IPC/WASH.
F.2 To what extent did UNICEF contribute to strengthening community systems and community engagement to address Ebola in DRC and improve resilience?	UNICEF seeks to ensure sustainability through community engagement based on CACs and capacity development, but the long-term funding of such interventions remains insecure.
F.3 To what extent did UNICEF contribute to local ownership and capacity development in DRC?	UNICEF has supported capacity development in local health facilities and through CACs. However, focus group discussions suggested some frustration in CACs about the extent to which communities were able to ensure that key priorities (e.g., related to improving water supply) were met.
F.4 To what extent has UNICEF ensured linkages, coherence and mutual reinforcement of its response to Ebola in DRC with longer-term development objectives? F4.1 What factors have influenced the extent to which this has been achieved?	The multisectoral approach to addressing PHEs, based on strong community engagement, that UNICEF has helped to develop and implement is intended to support long-term development, particularly in relation to health and WASH. However, linkages to livelihoods and economic development appear to be weaker.



Conclusions

UNICEF has made substantial contributions to strengthening DRC's response to, and preparedness for, Ebola outbreaks over the period covered by this evaluation. These contributions have built principally on lessons from the experience of the tenth outbreak and have included:

- ▶ Contributing to developing improved coordination arrangements between partners;
- ▶ Building capacity at national and local level to strengthen the ability of the health system to address PHEs;
- ▶ Leading response in the areas of RCCE, IPC/WASH and PSS;
- ▶ Establishing and building on strong community links and mechanisms through CACs with a view to ensuring communities can lead and play key roles in response, reducing the need for outside intervention;
- ▶ Developing improved approaches to address PSEA;
- ▶ Strengthening IPC/WASH services in communities and health facilities;
- ▶ Developing improved care for children affected by Ebola through nurseries at ETCs;
- ▶ The development and use of IOA to understand communities and outbreak dynamics and to guide effective response.

As a result, UNICEF has contributed to effective and rapid control of outbreaks subsequent to the tenth, including repeat outbreaks in North Kivu. Responses have shown greater accountability to local communities and have met the CCCs' standards more effectively than was the case for the tenth outbreak. Effective responses have been based on UNICEF's strong and experienced field office capacity, which has been effectively supported from the country office.

Key informants noted that effectiveness of response has been facilitated by the development of a strong cadre of staff members (both within UNICEF and with partners) who have experience working together through what are now tried and trusted systems and procedures in what remains an extremely difficult context for effective PHE control.

Some ongoing causes of concern, however, can be identified. FGDs conducted for the case study found some frustration from CACs about the extent to which community needs in relation to WASH were being met, and it was noted that IPC standards in health facilities were not sufficiently maintained.

There is a persistent concern among key informants that adequate resourcing for preparedness and system strengthening will not be available (as donor attention may switch to other priorities) and that capacity and community awareness about Ebola and acceptance of response strategies are likely to be weaker in areas that have not been subject to repeated outbreaks.



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Appendix A: Key informants interviewed

Key informants

Name	Organization	Position/role
UNICEF staff		
Abdelli, Rachida	UNICEF DRC Country Office, Kinshasa	Regional Supply Specialist
Amboko, Modestine	UNICEF DRC Country Office, Mbandaka	Communication for Development Officer
Carter, Simone	UNICEF, DRC Country Office and Global	Lead, Integrated Outbreak Analytics, Public Health Emergencies Formerly: Manager – Social Sciences Analytics Cell Ebola, North Kivu
Fall, Marie Noelle	UNICEF DRC Country Office, Kinshasa	Resource Mobilization Manager Formerly: Emergency Specialist, Office of Emergency Programmes
Fuamba, Pierre	UNICEF DRC Country Office, Kindu	WASH Officer
Gaha, Thomas Noel	UNICEF DRC Country Office, Kinshasa	Emergency Health Manager
Gendron, Typhaine	UNICEF DRC Country Office, Kinshasa	Chief, Emergency
Khomba, Paul	UNICEF DRC Country Office, Mbandaka	Health Specialist

APPENDIX A: KEY INFORMANTS INTERVIEWED

Leaity, Grant	UNICEF DRC Country Office, Kinshasa	Representative Formerly: Deputy Director, Emergency Programmes
Pfaffmann, Jerome	UNICEF Headquarters, Geneva	Senior Adviser, Public Health Emergencies
Rubuz, Richard	UNICEF DRC Country Office, Mbandaka	WASH Officer
Toure, Khalil	UNICEF DRC Country Office, Goma	Health & Nutrition Manager
Tshikangu, Felicien	UNICEF DRC Country Office, Mbandaka	Protection Officer
Other key informants		
Adubango, Franck	United Nations Office for the Coordination of Humanitarian Affairs	Associate Humanitarian Affairs Officer
Kamenga, Jean de Dieu	United Nations Office for the Coordination of Humanitarian Affairs	Management Information Systems Specialist
Mbuyi, Dr John	WHO, DRC	Formerly: IPC Officer
Mubaiyi, Clement		Psycho-clinician
Mukendi, Deby	WHO, DRC	National Infectious Hazard Management focal point
Okum, Raphael	WHO, DRC	National IPC Team Leader



Appendix B: Conclusions from the multisectoral evaluation¹⁶

Relevance

REL 1: Post-EVD10 (tenth Ebola outbreak) declaration in 2018, UNICEF-supported IOA/CAI units carried out 55 EVD-related operational studies (2018–2020) to understand outbreak dynamics (disease transmission risks and community behaviours) and co-developed recommendations to address community resistance and adapt response strategies accordingly. The evaluation concludes response strategies were appropriate to address the identified community realities and identified behaviours. These ranged from addressing health seeking behaviours and limited understanding of EVD symptoms (through RCCE/Communication for Development interventions), need for PSS and child protection services, and inaccessibility of health services (mobile response teams were deployed in hard-to-reach areas).

REL 2: The response demonstrated an adaptive approach to address COVID-19-related challenges. Key adaptations included i) integration of COVID-19 preventive messages into ongoing RCCE messaging (such as briefing of CAC teams, revival of engagement with media actors for dissemination of messages, expansion in the scope of Short

Message Service centre and use of RCCE teams to spread awareness on both EVD and COVID-19); and ii) added focus on enforcement of COVID-19-related preventive measures in the field.

Effectiveness

EFF1: The evaluation concludes response strategies were 'Mostly Effective' for level of achievements against the planned outcomes. Of the 37 outcome indicators, 27 indicators (73 per cent) were assessed to be over/fully/mostly achieved. For one-fifth of the indicators, the progress is less than 50 per cent and merits further probing by respective teams.

EFF2: UNICEF used a multilayered monitoring mechanism to generate information/evidence for decision-making, including: i) epidemiological monitoring conducted by the ministry of health and WHO and used by UNICEF for weekly situational reports; ii) implementing partner progress monitoring conducted through ActivityInfo; iii) third-party monitoring conducted by Innovative Hub for Research in Africa on the use of financial resources and the results produced by implementing partners; and iv) joint field missions and reviews conducted by

representatives from the ministry of health, UNICEF, WHO and other United Nations agencies. Limited evidence is available to indicate use of monitoring data collected by implementing partners for decision-making around course correction.

EFF 3: The capacity building of public sector stakeholders, implementing partners and communities remained the key focus of the EVD10 response interventions, but efforts were more focused at the national level, with limited focus on the provincial and HZ levels. Both formal and informal training modalities were used for capacity building at various levels. The key themes were strengthening skills on IPC/WASH, nutritional and PSS care, strengthening primary health care capabilities at HZ level and material support. Most stakeholders valued UNICEF's efforts in enhancing their technical knowledge and provision of skills that have enabled them to control the epidemic.

EFF 4: Community capacity development was supported through multiple interventions under UNICEF-supported pillars. The evaluation team has assessed the RCCE pillar as partially successful due to high reluctance, refusal and non-cooperation from communities up to the last part of the response operations (in 2020), prolonging the epidemic. Similarly, IPC/WASH was less successful in improving communities' access to water and basic hygiene facilities to enable them to implement hygienic practices. In addition, the provision of handwashing facilities reportedly required repairs and maintenance and remained unaddressed. In contrast, the PSS pillar is assessed as mostly successful, as stakeholders appreciated the support provided to the EVD survivors, family members (particularly women and children) and other contacts in coping with their disease-related stress.

EFF 5: A range of activities were employed to correctly identify and reach confirmed cases, their families and contacts, such as revitalizing CACs, involving local and influential leaders, establishing ETCs and child nurseries, conducting household visits to provide PSS and infection control (disinfection) services, and the ring approach to selectively target people for vaccination. These approaches appear to have been effective in identifying the confirmed cases, providing them with integrated support and controlling the epidemic.

EFF 6: The key enablers (for UNICEF) that facilitated effective response include: i) diversity of communication means and products, enabling wider access and influencing behaviours; ii) prior experience of working in local context and availability of local implementing partners, enabling quick response; iii) IOA/CAI-led assessments that provided valuable insights and recommendations to address local bottlenecks; and iv) adoption of community engagement approaches (in particular, community influencers) to win trust and acceptance of communities.

EFF 7: The evaluation concludes that certain disablers disrupted response. Among them: i) political instability and insecurity aggravated access to communities and heightened staff safety risks; ii) poor road networks undermined access to remote communities, thus delaying response; iii) inappropriate implementation modalities, such as high visibility of armed escorts and foreigners, resulted in fear and reluctance in affected communities; iv) limited technical capacities of ministry of health staff (knowledge and skills) undermined quality of implementation; and v) COVID-19-related public restrictions led to implementation delays.

Efficiency

ECY 1: The evaluation team faced data constraints that hindered a comprehensive efficiency analysis. From the available information, efficiency of UNICEF-led response (specific to EVD10) is assessed in terms of adequacy of financial and human resources, time and supplies. The evaluation team concludes that the response interventions were partially efficient, although funds were reportedly adequate and were completely (100 per cent) utilized between 2018 and 2020. Due to lack of specific quantitative data, the evaluation team's qualitative analysis concludes that less efficient use or overuse of some resources is noted, such as high compensation paid to response workers and inflated costs paid as per diem and/or for travel. In addition, the response took longer than envisioned (23 months as opposed to 3 months). While some delays were external (such as outbreak of COVID-19 and national elections), other delays were internal and could have been mitigated.

ECY 2: The ministry of health adopted a ‘hybrid model’ under which it played the central role in forming partnerships with development partners (in particular WHO and UNICEF) and seeking technical and financial assistance. In turn, UNICEF engaged a range of local partners to lead field-level implementation under UNICEF guidance. Where these partnerships helped to deliver response interventions, the centralized management of the implementation approach proved less efficient (more time and higher logistics costs), in comparison to the decentralized approach, which was implemented towards the end of the response (during the 90-day sustainability plan).

Impact

IMP 1: The response contributed to achieving intended impact, which is evident from reduction in mortality (reduced from an average fatality of 72 per cent during the previous nine outbreaks to 66 per cent in EVD10). Significant reduction (6 per cent) is attributed to improved management of the EVD response in comparison to previous outbreaks. The response interventions contributed to containing the spread of EVD10 both within and outside the country by active surveillance and contact tracing.

IMP 2: The response has contributed to strengthening the ministry of health’s capacities to respond effectively to future PHEs. The improved capacities are evident in terms of: i) adoption of a decentralized approach to managing PHEs, with response planning, coordination, supervision and implementation delegated to provincial health teams; ii) integration of IOA/CAI into the ministry of health structure; iii) introduction of integrated care to EVD patients comprising medical, psychosocial and nutritional support through ETCs, nurseries, follow-up home visits and survivors’ clinics; and iv) availability of trained human resources and information, education and communication material, which has proven useful in providing quick response to subsequent EVD outbreaks.

IMP 3: Concentrated focus and efforts by the Government of DRC and partners (including UNICEF) on response to the tenth outbreak led to weakening of routine immunization and reproductive maternal, newborn, child and adolescent health activities. This is evident from the reduction in routine immunization coverage, which decreased by 20 to 30 per

cent in 2019 as compared to the previous year. This decrease could be attributed to a shift in ministry of health priorities to EVD, COVID-19-driven supply disruptions and shortage of supplies, or reluctance on the part of parents/caregivers to take children to facilities due to COVID-19 risks.

IMP 4: The evaluation concludes that response interventions contributed to improved knowledge and precautionary practices. Despite not having a baseline (to compare the endline results) nor any control group numbers, the average scores of 85 per cent and more on knowledge and practice aspects – e.g., disease symptoms, risk of transmission from infected people, and prevention measures needed to manage an infected person in the family – indicate that RCCE interventions worked in raising awareness.

Sustainability

SUS 1: The evaluation concludes that there is variable sustainability of multiple response pillars, while taking note of the 90-day sustainability plan, devised in April 2020 and initiated in June 2020. The interventions/pillars that have a higher probability of sustainability include PSS (with continuation of PSS after the end of EVD10) and IOA/CAI (based on availability of data generated through research studies). In contrast, pillars such as RCCE, IPC/WASH, health and nutrition are relatively less likely to be sustainable and would require continued oversight and investments around refresher trainings and replenishment and maintenance of supplies.

SUS 2: The sustainability of multiple community feedback mechanisms varies once the support ends. The U-Report platform – a UNICEF-led initiative – may not be sustainable after the support ends. CAC members are likely to require financial and oversight support to continue their activities. Influential leaders will continue to play their role in the limited capacity they were engaged in.



Appendix C: Consent protocols

Key informant interviews

My name is Stephen Jones and my colleague is Dr. Thierry Kalonji. We are working for Oxford Policy Management (OPM), a UK-based consulting company that has been contracted by UNICEF to undertake an evaluation of UNICEF's work on public health emergencies. OPM has been commissioned to provide an independent and objective evaluation. The findings of this evaluation will be made available to UNICEF and will be used to improve the effectiveness of UNICEF's work on public health emergencies.

As part of the evaluation we are carrying out a case study of UNICEF's work on Ebola in DRC over the period of the evaluation (from 2015 to the present).

You have been selected as a key informant for this evaluation because we believe that you have experience and views that will contribute to providing evidence relevant to the objectives of the evaluation.

By participating in this interview, you will get to share your views and experiences, and may help to make UNICEF's work on public health emergencies more effective. We don't think there are any risks for you in talking to us, but if you want to follow up or make a complaint, you can contact Daniel Wate (daniel.wate@opml.co.uk) at OPM.

We would like to ask your views on a range of questions. The answers that you give us will be **completely confidential**. We would like to **record the interview** so that we can produce an **accurate transcript** of your answers. Both this recording and the transcript will remain confidential and not be shared outside the evaluation team. We will also not use your answers in the evaluation report in a way that identifies you as an individual. In the event that we may wish directly to quote you in an identifiable way, we will explicitly request your permission for this.

Before we begin, we would like to ask for your **explicit oral informed consent**. Please note that this interview is **voluntary** and you are under **no obligation to answer** any or all of our questions, although it would help us if you did. You are welcome to ask us any question during or after the interview. If you agree to this interview, you can still refuse to answer any question during the interview, or to terminate the interview at any time. If you choose not to participate, that is ok as well, and there will be no consequences to you.

Please let us know if there is anything that you want to ask us.

Focus group discussions

My name is Dr. Thierry Kalonji. I am working on behalf of Oxford Policy Management (OPM), a research organization based in the United Kingdom that has been contracted by UNICEF to study its preparedness and response to public health emergencies globally. We are conducting a case study of how effectively UNICEF helped respond to the most recent outbreak of Ebola in Mbandaka. You have been selected to participate because you are from a community in which UNICEF helped respond to the Ebola outbreak.

Your answers today in this group discussion seek to help us with our study. We would like to hear your views. We are not testing your knowledge or ability as part of this interview; there are no right or wrong answers. Your answers are completely confidential and will not be linked back to you directly in our research. We don't think there are any risks for you in talking to us, but if you want to follow up or make a complaint, you can contact our project manager at OPM, Daniel Wate (daniel.wate@opml.co.uk).

Before we begin, we would like to ask for your explicit **oral** informed consent to participate in this discussion. Your participation in this discussion is voluntary: you do not have to take part if you do not want to. You are not obliged to answer any or all of our questions, and you can ask us any questions as well. You can leave at any time without any explanation. There will be no consequences to you.

With that being said, we would like to begin now. Do you have any questions? Do you understand what I have just said? [Take the time to let people think and ask questions.]

Do you agree to take part in the discussion? If so, please raise your hand. [Note answers in table.]

With your permission, we would like to audio-record the interview using a recorder [show device] to help me and my colleagues with our notes. **If you agree, please raise your hand.** [Note answers in table below. If one person doesn't agree, you cannot use the recorder and must use written notes.]

Are we ok to begin now? Thank you.

Total should be the same per row and equal to the total number of participants.

	YES	NO
Number of respondents who agree to take part in the interview.		
Number of respondents who agree to have their answers recorded via the audio-recorder.		

Researcher name/signature

- ▶ If all the respondents have agreed, then **START** your **VOICE RECORDER** at this point. Remember to speak into the recorder in the beginning to record the interview details.
- ▶ Keep checking after intervals to ensure the recorder is on.

Date of interview



Appendix D: Instruments and protocols

Ethical review process

Instruments and protocols for KIs and FGDs were prepared in line with Oxford Policy Management's ethical review procedures. They were then submitted for review and approved through UNICEF's ethical review process. The approach, protocol and instruments for field data collection in Mbandaka were also reviewed and approved through national ethical review procedures.

Key informant interviews

This interview formed part of a case study for the PHE evaluation of how DRC's preparedness and response to Ebola have developed over the whole of the evaluation period (from 2015 up to the most recent outbreak in Equateur Province) and how UNICEF has contributed to this (including in response to the seven outbreaks that have occurred over this period). The questions below were intended to provide a checklist of issues to guide the interview. In addition to the general questions, specific questions were prepared for each interviewee based on their role and experience.

1. To what extent has DRC's preparedness for and ability to respond to Ebola outbreaks developed over the period since 2015 in each of the following areas? How has UNICEF contributed to this? What are the key outstanding challenges?

- a. Policies, strategies and legislation
- b. Planning and coordination
- c. Human resources
- d. Financial resources
- e. Information and knowledge management
- f. Risk communications
- g. Health infrastructure and logistics
- h. Health services
- i. Water, sanitation and hygiene services
- j. Community capacities for health
- k. Monitoring and evaluation

2. To what extent has response to Ebola outbreaks in DRC become more effective since 2015 in each of the following areas? How has UNICEF contributed to this? What are the key outstanding challenges?

- a. Coordination with government and partners
- b. Risk communication and community engagement
- c. Prevention, care and treatment for at-risk and affected populations
- d. Paying specific attention to women and children
- e. Ensuring continuity of essential services
- f. Ensuring provision of humanitarian assistance to the most needy

3. To what extent do you agree with each of the following statements about UNICEF's work on Ebola in DRC since 2015? What has changed over this period and why? In each area what has worked well, where have problems been encountered and what could be done better in the future?

- a. UNICEF has exercised effective leadership
- b. UNICEF has been well aligned with government on national priorities
- c. UNICEF has effectively and appropriately coordinated with WHO
- d. UNICEF has effectively and appropriately coordinated with other partners
- e. There have been clearly defined and appropriate organizational roles within UNICEF
- f. UNICEF's work has been accountable to affected people
- g. UNICEF has displayed agile and responsive management
- h. UNICEF has had appropriate numbers of skilled staff and made effective use of them
- i. UNICEF has been able access and apply

appropriate information and evidence to guide its work

- j. UNICEF has made effective use of innovative approaches
- k. UNICEF has had sufficient financial resources
- l. There has been timely and appropriate availability of required supplies
- m. UNICEF has had appropriate policies and guidance for its work on Ebola
- n. There has been effective support to the country office from regional level
- o. There has been effective support to the country office from HQ (including from the PHE Unit)

Focus group discussion guide

Process

Each FGD was organized and conducted by the lead national consultant, supported by a local note-taker and, where necessary, interpreter. UNICEF assisted in seeking the necessary permissions for the field-work and facilitating contact with local counterparts.

Two days were spent in each location. The first day was a preparatory day, during which the lead national consultant met with government representatives and community leaders to inform them of the research, and the purpose and methodology for the FGDs. During these meetings, the lead national consultant obtained their support and approval. Lists of intervention beneficiaries or staff were shared to enable the identification of FGD respondents and the organization of the FGDs the following day.

Language and translation protocols

The FGDs were conducted in Lingala, with the support of a local interpreter.

Data capture and transcription

Notes were taken throughout, and the FGDs were audio-recorded on smartphones. The audio recordings were deleted upon completion of the research and not shared beyond the case study team.

A summary of notes was prepared each day in the field, detailing the main points against each FGD question in each group discussion. These were shared with the case study lead and, if relevant, feedback was provided to improve data capture for subsequent FGDs.

Guide questions for FGDs

The FGDs were guided by the following questions:

I. Introduction

- 1 What was your experience of the Ebola outbreak earlier this year? How were you, your family and your community affected?
- 2 How effectively do you think the outbreak was addressed by government and others? What was done well, and what problems were there?

II. Revitalization of CACs

- 1 As a member of the CAC [for CAC members], do you feel integrated or engaged in community-based interventions?
- 2 Do you think that the CAC has been effective and has empowered the community?

III. RCCE and psychosocial support

- 1 Do you think that home visits for community awareness and psychosocial support were useful? Why or why not?
- 2 Has psychosocial support and community awareness helped remove the stigma around Ebola and helped reintegrate those affected?

IV. IPC/WASH at community level

- 1 Do you have access to clean drinking water in your community? What problems are there in accessing clean water?
- 2 Have you had handwashing stations placed in the community? Do you use them? If not, why not?

V. Conclusion

- 1 Is there anything that you think could be done to improve the preparedness for and response to Ebola and other disease outbreaks in your community?

National ethical approval



REPUBLIQUE DEMOCRATIQUE DU CONGO
Ministère de l'Enseignement Supérieur et Universitaire
Université de Kinshasa
ECOLE DE SANTE PUBLIQUE
COMITE D'ETHIQUE

No d'Approbation: ESP/CE/ 448./2022

Kinshasa, le 22 novembre 2022

STEPHEN JONES
Investigateur Principal
C/O Dr Robert Cissokho
Spécialiste en Evaluation
UNICEF RDC

Objet : L'approbation du protocole de recherche intitulé :
« Évaluation de la réponse de l'UNICEF aux urgences de santé publique
Étude de cas de la République Démocratique du Congo 2022 ».

Docteur,

Après examen minutieux de votre protocole dont le sujet est repris en marge, le Bureau du Comité d'Ethique de l'Ecole de Santé Publique de l'Université de Kinshasa estime que ledit protocole est bien conçu et l'étude que vous comptez entreprendre est pertinente.

Ainsi, vu que les principes éthiques relatifs au respect de la confidentialité et du consentement sont pris en compte, le Bureau du Comité d'Ethique approuve le protocole et autorise la mise en œuvre de l'étude pour la période allant du 23 novembre 2022 au 22 novembre 2023.

Cependant, tout en autorisant la mise en œuvre de l'étude, le Comité d'éthique recommande d'intégrer, dans le protocole :

- La version lingala du formulaire de consentement éclairé ;
- Les CV des différents chercheurs (STEPHEN JONES et Dr Robert CISSOKHO) ;
- Le budget détaillé de l'étude.

Toute modification apportée au présent protocole devra au préalable obtenir l'approbation du Comité d'Ethique et tout incident devra lui être notifié sans délai.

Veuillez agréer, Docteur, l'expression de notre considération distinguée.



Prof. BONGOPASI MOKE SANGOL

Vice-Président du Comité d'Ethique



For further information, please contact:

**UNICEF
Evaluation Office**

3 United Nations Plaza
New York, NY 10017
USA

 www.unicef.org/evaluation

 UNICEF-Evaluation

 evalhelp@unicef.org

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