

Evaluation of UNICEF Work in Public Health Emergencies

Case study: Public health emergencies in Guinea, 2021–2022



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ABBREVIATIONS

Abbreviations

ANSS	Agence Nationale de Sécurité Sanitaire
C4D	Communication for Development
CBO	community-based organization
CSO	civil society organization
EPARE	prefectural epidemic alert response teams (équipes préfectorales d’alerte et de réponse aux épidémies)
ERARE	regional epidemic alert response teams (équipes régionales d’alerte et de réponse aux épidémies)
EVD	Ebola virus disease
FGD	focus group discussion
GBV	gender-based violence
IPC	infection prevention and control
KII	key informant interview
MVD	Marburg virus disease
NGO	non-governmental organization
OPM	Oxford Policy Management
PHE	public health emergency
PHEOC	public health emergency operations centre
PPE	personal protective equipment
PSEA	prevention of sexual exploitation and abuse
PSS	psychosocial support
RCCE	risk communication and community engagement
SitRep	situation report
UNICEF	United Nations Children’s Fund
WASH	water, sanitation and hygiene
WHO	World Health Organization



Introduction

1.1 Objective of the case study

This case study forms part of the Evaluation of UNICEF Work in Public Health Emergencies, covering the period from 2015 to the present. The overall objective of the evaluation is to assess the extent to which the United Nations Children's Fund (UNICEF) is 'fit for purpose' to prepare for and respond to public health emergencies (PHEs). Specific objectives of the evaluation are as follows:

1. Examine the appropriateness and adaptability of UNICEF work in PHEs.
2. Examine efficiency and effectiveness – in terms of human and financial resources and capabilities as well as operational policies, procedures and tools – in preparing for and responding to PHEs.
3. Assess the coherence and sustainability of UNICEF work and its synergies with the work of local, national and international actors, including for system strengthening.
4. Make actionable recommendations that help UNICEF to optimize its contribution to PHEs.
5. Identify and capture lessons learned and experiences that can be shared to improve the UNICEF contribution to PHE responses.

The case studies for the Evaluation of UNICEF Work in Public Health Emergencies are intended as a deeper dive into the actions and relationships of UNICEF and partners and their effects in relation to specific disease outbreaks. Lessons that could be applied more broadly can be extracted from each case study.

This case study examines how Guinea's preparedness for, and response to, multiple concurrent disease outbreaks developed over the period 2021–2022, and how UNICEF contributed to this preparedness and response.

The research question for the case study is:

“How effective was the UNICEF response to Ebola virus disease, Lassa fever, yellow fever and Marburg virus disease outbreaks in Guinea in 2021–2022, and to what extent was UNICEF prepared to address these outbreaks based on previous experience and guidance?”

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Answering this question has required assessments of:

- ▶ UNICEF preparations for outbreaks in 2021–2022
- ▶ the UNICEF contribution to strengthened public health responses to Ebola virus disease (EVD), Lassa fever, yellow fever and Marburg virus disease (MVD) in 2021–2022
- ▶ how UNICEF country office preparations contributed to improved PHE responses in 2021–2022 and what lessons there are for improving preparedness going forward.

The conceptual framework for the evaluation uses the Core Commitments for Children in Humanitarian Action 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.

Overall, these frameworks allowed the case study team to make assessments based on criteria that cover more than just effectiveness. It should be noted, however, that in the detailed assessments of preparedness and response provided in section 5, it was not always possible to make a judgement (that is, in instances where insufficient evidence was available).

1.2 Case study approach and data sources

Data were collected through both a document review and primary data collection in the form of key informant interviews (KIIs) and focus group discussions (FGDs).

The document review was conducted by the case study team with support from UNICEF Guinea Country Office colleagues to identify documents. Documents reviewed include UNICEF management and reporting documentation, including strategy and planning documents; situation reports (SitReps); internal documentation relating to specific outbreaks and UNICEF initiatives; and other documentation on aspects of PHE preparedness and response, including from the Government of Guinea. Where relevant, other assessments and materials have been drawn upon and cited.

Following the document review, UNICEF provided the case study team with a list of suggested key informants to interview, including UNICEF staff, government counterparts, and representatives of local organizations with which UNICEF had worked. A total of 11 UNICEF staff and 14 external, non-UNICEF counterparts were interviewed (see Appendix A). KIIs were primarily conducted through Microsoft Teams or WhatsApp from 20 to 30 October 2022, with interviews recorded where possible. Interviews were conducted by Magali Carette and Aboubacar Diakité, and Sory Condé, Leno Jean Pierre and Condé Mamadou provided support. Instruments and consent protocols were developed and reviewed in line with Oxford Policy Management's Ethical Review Committee guidelines and are included as appendices to this report.

A total of six FGDs were conducted in Faranah, Guéckédou and Nzérékoré. These sites were selected as they had each been the epicentre of an outbreak in 2021 (Faranah for Lassa fever, Guéckédou for MVD and Nzérékoré for EVD). Furthermore, while UNICEF has a suboffice in Nzérékoré covering both Guéckédou and Nzérékoré, its operations in Faranah are managed out of its Kankan office; the case study team considered that this difference could provide a useful comparison in assessing UNICEF preparedness and response for the entire country, including in areas where UNICEF had no direct presence. FGDs



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were conducted in Faranah on 3 and 4 November 2022; in Guéckédou on 5 and 6 November; and in Nzérékoré on 7 and 8 November.

In each location, the case study team conducted one interview with members of communities affected by the outbreaks in 2021–2022, and one interview with members of the One Health platform.¹ The case study team entered into contact with each local One Health team with support from UNICEF Guinea

colleagues and through local contacts. At each site, the case study team explained the purpose of the KIIs and stated the wish to interview eight members of the One Health group and, separately, eight community members – ideally an equal number of female and male participants in each case.

Despite the team's efforts to ensure gender parity, interviewing an equal number of females and males in each location proved to be a challenge.

Table 1. Composition of focus group discussions

Location	One Health members		Community members	
	Male	Female	Male	Female
Faranah	6	2	4	0
Guéckédou	7	1	7	1
Nzérékoré	6	0	5	3

All One Health FGDs were conducted in French, while the FGDs with community members were conducted in Malinké, Kissi and Guéré depending on the language spoken by participants. The One Health FGDs lasted between 55 and 75 minutes and the community FGDs between 45 and 60 minutes, depending on the participants' interactions. A translator and note-taker supported each discussion and all FGDs were recorded. The instruments, consent protocol and approach for the FGDs were reviewed and approved through the UNICEF ethical review process.

1.3 Structure of this report

The remainder of this report is structured as follows. Section 2 provides an overview of the national context and features of disease outbreaks and PHEs in Guinea. Section 3 reviews national preparedness and response to PHEs. Section 4 describes the UNICEF contribution to preparedness and response

to PHEs in Guinea.² Section 5 contains the evaluation assessment of preparedness and response to the 2021 outbreaks. Section 6 summarizes evidence against the evaluation questions for the evaluation as a whole. Section 7 presents the conclusions of the case study.

Additional information is included in the appendices. Appendix A lists the key informants interviewed. Appendix B contains the instruments used for the KIIs and Appendix C the consent protocol for the KIIs. Appendix D presents the research instruments used for the FGDs. Appendix E contains the consent protocol for the FGDs. Appendix F sets out the benchmarks from the UNICEF Guinea emergency preparedness plan.

1 The One Health forum was introduced to Guinea in 2017. It serves as a multisectoral and multidisciplinary platform that brings together community leaders and other local actors to promote and advance the interrelated health and well-being of communities, animals and the local environment. Despite its limited resources, this platform has been instrumental in supporting both preparedness and response to PHEs in Guinea since its introduction.

2 Sections 2 to 4 are largely descriptive and based on a review of documentation, with evidence from the KIIs and FGDs used to make the evaluation judgements in sections 5 and 6.



National context and disease outbreaks in Guinea

This chapter provides a summary of the national context and main PHEs in Guinea during the period covered by the evaluation and this case study.

2.1 National context

Guinea overview

Guinea is a coastal West African country, with an estimated population of 13.3 million in 2022, of which approximately 2 million live in the capital city, Conakry (Institut National de la Statistique, n.d.). Approximately 45 per cent of Guinea's population is under 14 years of age (UNICEF, 2022). Guinea's economy is dominated by the agricultural sector, which employs more than half of the total labour force; 57 per cent of all rural households receive income from agricultural practices (World Bank, 2022b). The natural resources and mining sectors are also key to Guinea's economy, despite the negative impact of both sectors on the environment and on biodiversity. Unemployment affects youth in particular and poses a significant challenge for the country. The World Bank estimates that inflation stood at 12.6 per cent in 2021 (World Bank, 2022b).

Due to its history as a French colony and its subsequent government by oppressive, socialist dictatorships, Guinea's public administration has historically been highly centralized. Since 1985, however, the Government of Guinea, with support from stakeholders, has taken steps to decentralize certain competencies and responsibilities to the local level (World Bank, 2008). Measures taken in this respect have included the pilot National Support Programme for Convergence Communities (Programme National d'Appui aux Communes de Convergence) jointly implemented by UNICEF and the government since 2018 (UNICEF, 2022c).

A military coup on 5 September 2021 removed Guinea's then President Alpha Condé, who had been regarded as the first democratically elected president of the country but subsequently moved to extend his own term limits, resulting in significant civil unrest. Following the coup, Condé was replaced by a military junta called the Comité national du rassemblement pour le développement, led by Colonel Mamadi Doumbouya as transitional president. In August 2022, the military junta named Bernard Gomou as prime minister, and negotiations were initiated between the current government and the Economic Community of West African States to determine the length of the transition period before new elections would be held (UNICEF, 2021b).

In October 2022, the Economic Community of West African States and the Guinean transitional government reached an agreement on a 24-month transition (commencing 1 January 2023), thereby averting potential economic and diplomatic sanctions. The agreement focuses on 10 points, including the (1) adoption of a new constitution; (2) review of the electoral roll; and (3) organization of general elections (UNICEF, n.d.). The coup disrupted national planning processes between the government and key partners, including the development of the Second National Economic and Social Development Plan, the United Nations Sustainable Development Cooperation Framework and the 2023–2027 UNICEF Country Programme Document.

Furthermore, the Ministry of Water and Sanitation was shut in late 2021 as part of several changes to the public administration (UNICEF, 2021b).

Social and demographic indicators

Across the country, 43 per cent of households live below the poverty line and a full 75 per cent of the population in Guinea live in precarious situations, according to the United Nations Common Country Analysis (Nations Unies Guinée, 2021). Food insecurity is an enduring issue, and UNICEF predicted that a total of 286,000 children would suffer from severe acute malnutrition in 2022 (UNICEF, 2022b).

Basic infrastructure across Guinea remains poor, with 64 per cent of schools, 69 per cent of health facilities and 21 per cent of households without access to safe drinking water (UNICEF, 2022b). Even among the households with access to safe drinking water, 43 per cent reported having no running water for at least one day in the previous two weeks, indicating the unreliability of the existing water supply. In urban areas, this figure rises to 58 per cent of households.

Although the gross education enrolment rate in Guinea is 90.8 per cent, this figure masks significant gender and urban–rural disparities. The school completion rate for girls is 45.7 per cent compared with 62.7 per cent for boys, while the completion rate for children in rural areas is just 40 per cent compared with over 75 per cent for those in urban areas. Furthermore, just 20 per cent of young children aged 3–5 years are enrolled in nursery, placing

additional pressures on their mothers or other female relatives responsible for childcare (UNICEF, 2022a).

Guinea’s public health services and system are limited. Just 42.9 per cent of women received ante-natal care in 2021. Low levels of vaccination increase children’s vulnerability to a multitude of diseases and, indeed, just 24 per cent of the country’s children under 5 years of age are fully vaccinated (UNICEF, 2022a). UNICEF reports that, in 2022, more than 2.2 million Guinean children under 5 years were due their poliomyelitis (polio) vaccination, while more than 600,000 were due their measles vaccination. While incidents of tuberculosis and polio increased slightly from 2016 to 2021, some good news exists: during that same period, reported cases of malaria decreased, and the number of people living with HIV/AIDS with access to antiretroviral therapy increased.

Gender-based violence (GBV) is also a significant threat for the country’s women: 23 per cent of women report having experienced intimate partner violence. A full 31 per cent of children under 17 years of age report having experienced physical or psychological aggression (World Health Organization, 2021).



National health system

In Guinea, the health system is organized into 8 health regions and 38 health districts administered by the Ministry of Health and Public Hygiene. Public-sector health care structures are organized into three levels, providing primary, secondary and tertiary care.

Health centres, which are at the heart of the Guinean health care system, are responsible for providing primary care. By 2021, the country's health centres included 457 public health centres, 925 health posts, 4 denominational health centres, 7 health centres affiliated with non-governmental organizations (NGOs) and 75 private health centres. At the district level, secondary care is provided by prefectoral hospitals or *centres médico-communal*; there were 38 in 2021. Regional health centres – of which there were seven in 2021 – also provide secondary care. Specialist tertiary care is provided at three university hospital centres, all of which are located in Conakry. This translates to 1 medical centre for every 7,362 inhabitants, or 1 hospital bed for every 279,103 Guineans. A total of 12,875 health professionals practise in Guinea (Ministère de la Santé et de l'Hygiène Publique, 2021).

Guinea's public-sector health facilities are marked by infrastructure of poor quality and weak capacity, resulting in low levels of use. According to the Ministry of Health and Public Hygiene, only 9 per cent of medical facilities have access to drinking water and just 3 per cent have access to electricity (Ministère de la Santé et de l'Hygiène Publique, 2020). The actual figure for the former may be slightly higher, as UNICEF Guinea's Preparedness Plan for the country states that 69 per cent of medical facilities lack access to safe water (UNICEF Guinea, 2021c). Whether the actual figure is closer to 69 per cent or 91 per cent, both estimates reveal a significant gap in sanitation capacity in medical facilities.

According to the World Bank, the Guinean government spends less on health than most other countries in the sub-Saharan Africa region, with health expenditure representing 6.5 per cent of total public spending in 2019. This figure is well below the target of 15 per cent established in the Abuja Declaration of 2001, and the shortfall results in higher health-care spending for the average Guinean (World Bank, 2022). Indeed, motivated by poor services and high costs, many Guineans resort to seeking care from traditional doctors (World Bank, 2022). According to sources, the Ministry of Health and Public Hygiene's internal Operational Action Plan for 2022 indicates that the government covers just 20 per cent of the national health financing (Ministère de la Santé et de l'Hygiène Publique, 2022). According to the World Bank, other sources of funding for Guinea's health sector include "cost recovery at health facilities, external financing from international donors, and resources made available at the local level in the communities" (World Bank, 2022).



2.2 Features of disease outbreaks in Guinea

Multiple endemic diseases

From an epidemiological perspective, Guinea's health profile is marked by the presence of numerous endemic epidemic diseases, including EVD, Lassa fever, yellow fever, measles and MVD. While Guinea has seen multiple outbreaks of all these diseases, the EVD epidemic of 2014–2016 has been the most significant to date, rocking both the country and the international public health community. First detected in Guinea in December 2013, the outbreak subsequently spread to other West African countries such as Liberia and Sierra Leone, becoming, at that time, the “longest, largest, deadliest and most complex [EVD outbreak] in history” (United Nations Development Group, 2015). It led to significant loss of life and had considerable socio-economic consequences, not only for the affected countries but also for the entire West Africa region. In Guinea alone, a total of 3,814 cases and 2,544 deaths were reported (Alliance for International Medical Action, et al., 2021).

The severity of the outbreak was due to the fact that health systems across the affected countries were unprepared and lacked the necessary human, technical and financial resources or solid health infrastructure to identify and contain the virus rapidly and efficiently. Misinformation and intense fear at the community level further led to under-reporting; mistrust in the health services offered or public health messages communicated; and aggression towards health workers sharing information or seeking to treat or isolate patients. Porous borders between Guinea, Liberia and Sierra Leone, in addition to cultural burial practices, further contributed to the spread of the disease (United Nations Development Group, 2015).

Twenty per cent of EVD cases were in children, and women were more significantly affected by the virus than men owing to their role as caregivers and, in turn, their increased risk of exposure, resulting in the feminization of EVD and the virus's disproportionate impact on women's lives and livelihoods (United Nations Development Group, 2015). The outbreak also had a devastating impact on children's

education, with the governments of the three affected countries closing approximately 24,000 schools, affecting 5 million students (UNICEF West and Central Africa, 2016).

The United Nations Sustainable Development Group report *Socio-Economic Impact of Ebola Virus Disease in West African Countries* notes the devastating impact that EVD also wrought on communities across the region, increasing poverty rates and food insecurity and slowing economic growth in both directly and indirectly affected countries. Furthermore, according to the report, the outbreak itself affected the levels of trust within communities. The report notes that rebuilding this trust, both within communities as well as between communities and the government, should be a priority (United Nations Development Group, 2015).

While this EVD outbreak has been the most devastating to date, and received the most international attention, other outbreaks of epidemic proportions have since affected Guinea. Table 2 presents the disease outbreaks that have occurred in Guinea during the evaluation period.



Table 2. Disease outbreaks and their location since 2016

Disease	Location	Cases	Deaths
Lassa fever	Guéckédou, Kissidougou, Yomou	9	8
Yellow fever	Beyla, Boké, Coyah, Dabola, Dixinn, Faranah, Fria, Gaoual, Kindia, Koundara, Kouroussa, Labé, Macenta, Mali, Mandiana, Nzérékoré, Ratoma, Siguiri, Téliélé	52	6
Measles	Guinea (all districts)	6,616	192
Marburg virus disease	Guéckédou	1	1
Ebola virus disease	Gouécké, Koropara, Nzérékoré, Macenta	23	12

Source: Data are from an interview with an Agence Nationale de Sécurité Sanitaire representative and from the websites of the Centers for Disease Control and Prevention, <www.cdc.gov>; and the World Health Organization, <www.who.int>.

Table 2 includes outbreaks of yellow fever and measles, diseases not covered by this case study. These outbreaks, however, reveal important factors relating to the use of public health services and preparedness for PHEs. For example, the measles outbreak of 2017 was driven by fear and mistrust following the 2014–2016 EVD outbreak, which led Guineans to shun health facilities. This reduced interaction with health facilities affected health outcomes such as vaccination rates. Decreased vaccination rates across the country led to the measles outbreak declared in February 2017, which affected 14 of Guinea’s 38 health districts (ReliefWeb, 2017).

Furthermore, WHO and UNICEF estimate that, between 2016 and 2019, yellow fever vaccination coverage in the country stood at 40 per cent – well below the level that ensures herd immunity. In some communities, coverage was as low as 16 per cent. This places vulnerable individuals, such as young children, at an elevated risk. Indeed, these low vaccination levels led to the 2020 outbreak that primarily affected the health district of Koundara, where 50 of the 52 cases were detected (World Health Organization, 2020).

Social factors and pressures remain a significant component of tackling PHEs in Guinea. There remains some stigma attached to suffering from diseases like EVD, which are often seen as linked to witchcraft. Actors like UNICEF have had to make concerted efforts to address the fear and mistrust

that fueled the initial ravages of the 2014 EVD outbreak. Lessons learned from that experience, however, have demonstrated the value of engaging with communities to both better understand the concerns and behaviours driving certain harmful practices, and to jointly address risks, preparedness and response.

The need for clear communication is also highlighted by the spread of misinformation, such as the rumour that when service providers arrive at a specific community or household, it must mean that an outbreak has been detected or is spreading. In fact, it may be that they are instead providing follow-up care or conducting data collection. These social factors provide important lessons for actors like UNICEF as they seek to ensure preparedness and appropriate responses to PHEs.

PHEs in Guinea have disproportionately affected women, as noted above, as sociocultural norms influence women’s access to social and medical services. Two factors in particular were identified in discussion with UNICEF respondents. The first is that women are rarely involved in or consulted on decisions regarding health or expenditure at the household level. Second, women frequently have more limited access to information than their male counterparts owing to greater levels of illiteracy and reduced internet access among women. Together, these two factors pose significant challenges for women to access information and health services.

COVID-19 pandemic in Guinea

It is against this backdrop of poor medical and public health infrastructure, a lack of trust in the national health system, and recurring outbreaks of endemic epidemic diseases that COVID-19 struck, with the first case reported in Guinea on 13 March 2020.

As elsewhere, schools in Guinea were closed as an initial prevention measure. The government reopened schools in September 2021, but Human Rights Watch notes that the 151-day closure affected 2.6 million students across Guinea (Human Rights Watch, 2022). UNICEF puts this figure at closer to 2.9 million (UNICEF Guinea, 2022). At the time, UNICEF noted that these school closures were likely to negatively affect youth and young girls in particular, with increased rates of early or forced marriage, sexual exploitation and abuse, and child labour more likely. In 2021, UNICEF estimated that the pandemic had led to a 20 per cent increase in early marriage and violence, in a context in which 29 per cent of women were already survivors of sexual violence and 55 per cent of women had experienced physical violence (UNICEF, 2021d).

Guinea began its COVID-19 vaccination drive in March 2021 by vaccinating health workers (Toure et al., 2022). By the end of December 2021, Guinea had obtained nearly 6.9 million doses of the vaccine through the COVAX facility (UNICEF, 2021c). By 2022, more than 7.6 million doses of COVID-19 vaccine had been administered in the country, despite significant logistical challenges (World Health Organization, 2022a). However, just 14 per cent of the general population had received the vaccine by December 2021 (UNICEF, 2021c).

This low coverage among the general population is partially explained by distrust of the vaccine, which remained prevalent and affected uptake, due to misinformation spread by the media, discomfort with the rapid time frame for developing the vaccine (less than 24 months compared with up to 15 years for other vaccines) and the belief that the vaccine could not be effective if people who had received it could still catch the disease (Toure et al., 2022). Vaccination rates were also affected by a disrupted vaccine supply, by distrust in government and lack of confidence in the quality of the Russian and Chinese vaccines available, and by anxiety about the potential side effects (Toure et al., 2022).

Fears about the possibility of catching COVID-19 in health facilities resulted in many families staying away from medical facilities in 2020 and 2021, negatively affecting health outcomes across the country, including vaccination rates for a range of diseases. For example, they led to a 19 per cent reduction in coverage of the pentavalent 3 vaccine. UNICEF further notes that in Guinea the pandemic led to greater food insecurity, with the number of children affected by severe acute malnutrition increasing from 210,000 to 248,000 across Guinea (UNICEF, 2021d). Furthermore, a reduction in vaccination rates led to an increase in measles and polio cases in 2021, placing additional pressures on public-sector health care and increasing the number of vulnerable, affected households (UNICEF, 2021b).



Disease outbreaks in 2021–2022

During the period covered by this case study, 2021 to 2022, Guinea experienced multiple concurrent outbreaks of epidemic diseases (see Table 3). These outbreaks came just shortly after the COVID-19 outbreak of 2020 and followed each other in rapid

succession. First, on 14 February 2021, a new case of EVD was detected in the region of Nzérékoré, with laboratory confirmation provided several days later. A few months later, in May 2021, Lassa fever broke out across several regions of the country; in August 2021, a single case of MVD was identified in Guinea.

Table 3. Disease outbreaks in Guinea during the case study period

Disease	Location	Start of outbreak	End of outbreak	Cases	Deaths
Ebola virus disease	Nzérékoré	February 2021	June 2021	23 (16 confirmed cases; 7 probable cases)	12
Lassa fever	Beyla, Faranah, Nzérékoré, Yomou	May 2021	June 2022	8	7
Marburg virus disease	Guéckédou	August 2021	September 2021	1	1

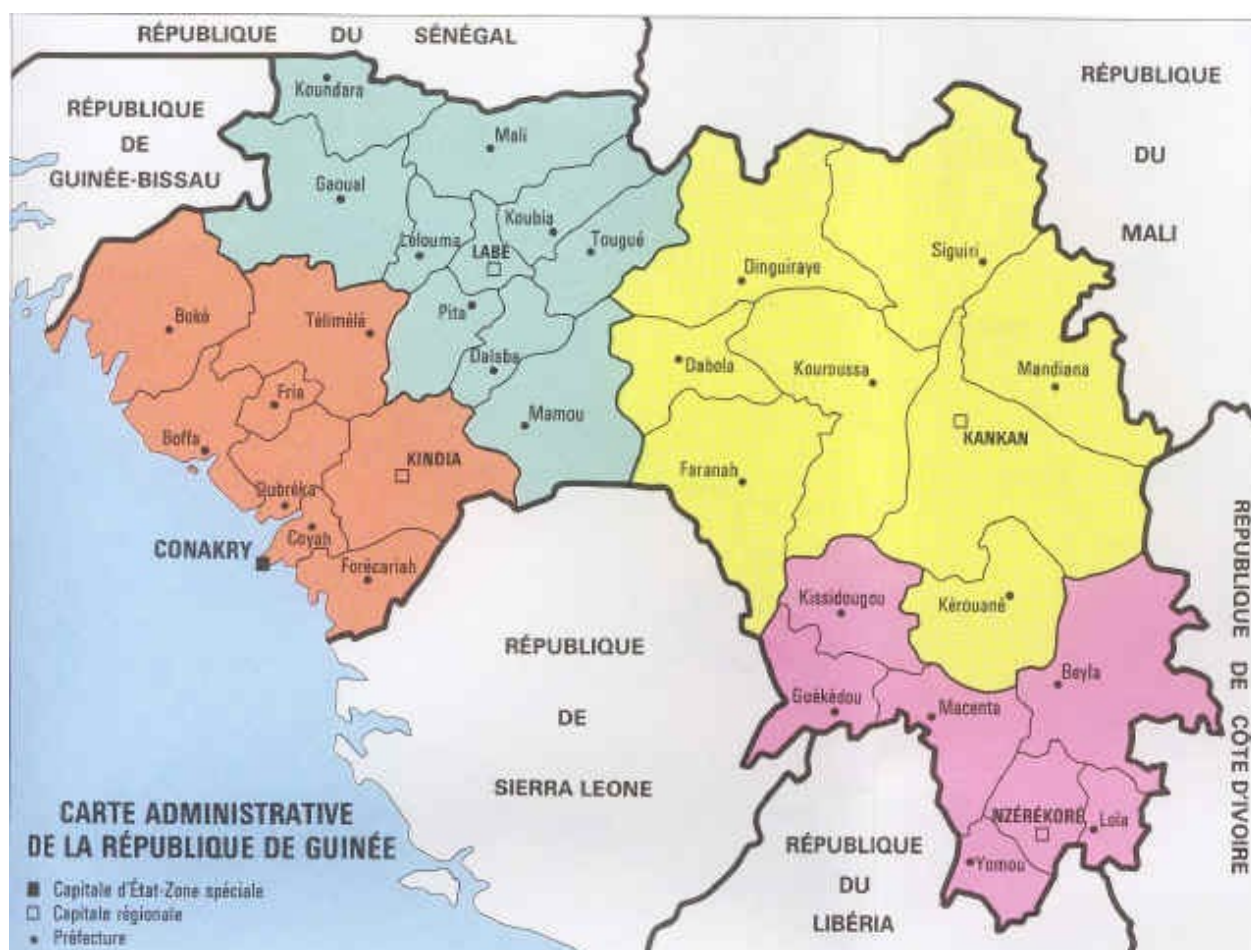
Source: Websites of the Centers for Disease Control and Prevention, <www.cdc.gov>; and the World Health Organization, <www.who.int>. Note: Despite its low caseload, the Marburg virus disease outbreak is included in this case study as it was treated as a public health emergency by the Guinean authorities, since it is a highly virulent and epidemic-prone virus and as the single case was detected in a village near Guinea's border with both Liberia and Sierra Leone.



Map 1 shows the location of each outbreak. The EVD outbreak is indicated by a red star, while the

Lassa fever outbreaks are indicated by gold stars and the MVD outbreak by a green star.

Figure 1. Map of Guinea and the locations of the 2021 outbreaks



Source: La Guinée - Présentation générale (nozay44.com)

EVD outbreak: The EVD outbreak of 2021 was announced by the Ministry of Health and Public Hygiene on 14 February 2021, after seven suspected cases were identified in Gouéké following the funeral of a nurse who died on 28 January and was buried on 1 February. Laboratory analysis confirmed EVD as the cause of death (Agence Nationale de Sécurité Sanitaire, 2021c) and the National Agency for Health Security (Agence Nationale de Sécurité Sanitaire; ANSS) reacted swiftly, immediately deploying staff to investigate the cases and deploy the tools it had developed for PHE management.

Within two days of the declaration of the outbreak, an isolation centre had been opened; within one week, available vaccines were already being administered (Keita et al., 2023). Contact tracing was activated and 184 contacts were monitored. The outbreak was declared over on 19 June 2021, with a total of 23 cases reported: 7 probable cases and 16 confirmed, of which 12 had died (Agence Nationale de Sécurité Sanitaire, 2021d). A total of 15,116 people were vaccinated in Beyla, Guéckédou, Lola, Macenta, Nzérékoré and Yomou (Agence Nationale de Sécurité Sanitaire, 2021d).

Lassa fever outbreak: Lassa fever was detected on 8 May 2021 in a patient in Yomou prefecture; by the end of the outbreak, seven additional cases had been detected – four in Nzérékoré and one each in Beyla, Faranah and Guéckédou (World Health Organization, 2021). Of these eight cases, seven died.³ Contact tracing was successfully activated, and the presence of equipped and operational laboratories in Guéckédou and Nzérékoré enabled rapid confirmation of cases and rapid activation of preventive protocols.

MVD outbreak: On 4 August 2021, a single case of MVD was detected and confirmed in Guéckédou. MVD had never before been detected in West Africa (World Health Organization, 2021). Given its profile as a potentially epidemic disease, Guinean authorities responded rapidly, setting up a PHE operations centre, conducting an epidemiological investigation, informing the necessary authorities (including in Liberia and Sierra Leone) and activating contact tracing and contingency plans. The disease was successfully contained, with no further cases detected.

3 It should be noted that the WHO and ANSS figures differ here as well. ANSS noted six cases, including five deaths.



National preparedness and response to public health emergencies in Guinea

3.1 National preparedness overview

The earthquake that struck Koumbia District in 1983 led the Government of Guinea to establish an ad hoc committee responsible for disaster preparedness. In 1992, the United Nations set up an Interagency Permanent Committee, housed within the Ministry of Territorial Administration and Decentralization, to support the management of humanitarian aid in emergencies, including PHEs. Despite legislative efforts, the committee never received sufficient funding to become fully operational (Martel et al., 2020).

Indeed, until 2000, epidemic surveillance at the national level was managed in an uncoordinated and ad hoc way, with data sharing done through very high frequency radios, and some collaboration with pilot medical treatment centres (Agence Nationale de Sécurité Sanitaire, 2020a). Some improvements to surveillance and data sharing were made following publication, by WHO, of the International Health Regulations (2005), which require countries to be able to detect, assess, report and respond to potential infectious disease threats, and the Integrated Strategy for Surveillance and Response to Diseases (Stratégie Intégrée de Surveillance et de Riposte aux Maladies). In 2007, a National Crisis Committee

responsible for the management of all PHEs was established within the Ministry of Health and Public Hygiene by presidential decree, but again, the committee failed to receive sufficient funding to become fully operational (Martel et al., 2020).

It was the 2014–2016 EVD outbreak that resulted in the most significant changes in terms of national preparedness, surveillance and response capabilities. Following the devastation wreaked by EVD across the West Africa region, the US Centers for Disease Control and Prevention invested US\$597 million into strengthening the capacity of 17 countries affected by the outbreak, including Guinea, focusing on laboratory facilities, workforce development, emergency management and epidemiology. Under this programme, the United States of America deployed 300 specialists to Guinea, setting up a Centers for Disease Control and Prevention country office and supporting country partners, including the Ministry of Health and Public Hygiene, to strengthen the country's capacities for PHE management. This work centred on the creation of a network of national- and district-level public health emergency operations centres (PHEOCs) over a period of five years, from 2014 to 2018 (Martel et al., 2020).

Through this initiative, a PHEOC network – able to provide unified command with the support of an incident management system – was established

under the guidance of the structure set up to manage the response to the EVD epidemic, the National Coordination for the Fight against Ebola (Martel et al., 2020). This network included district-level PHEOCs responsible for coordinating activities with the National Emergency Operation Centre. In 2015, PHEOCs in 28 of Guinea's 38 districts most severely affected by EVD were equipped with financial support from the United States and the International Organization for Migration (Martel et al., 2020).

This additional physical capacity was supplemented by mentoring provided by PHE management specialists under the WHO Global Outbreak Alert and Response Network. This process was neither formalized, however, nor sufficient to truly build Guinea's capacity for PHE management. At the district level, 200 health workers were trained on PHE management principles in 2016 (Martel et al., 2020).

Importantly, the 2014–2016 EVD outbreak led to the creation, by decree, of the National Agency for Sanitary Security (Agence Nationale de Sécurité Sanitaire; ANSS) in July 2016, based on the model of the National Coordination for the Fight against Ebola. ANSS sits under the health ministry and is responsible for implementing the ministry's strategies for health security, while maintaining some degree of autonomy. This new entity was to oversee the institutionalization of Guinea's PHEOC network based on the infrastructure established during the EVD epidemic. ANSS went on to establish PHEOCs in the 10 prefectures that previously had none (Martel et al., 2020).

Staff at the national level continued to receive capacity building from international partners such as the International Organization for Migration, US Department of State and WHO, including on simulation management, crisis and emergency risk communication, medical countermeasures and supply chain management (Martel et al., 2020). At the district level, district health personnel were trained on the Threat and Hazard Identification and Risk Assessment process, planning for emergencies, and Guinea's incident management system (Martel et al., 2020). Furthermore, the government recognized the need to improve its Integrated Disease Surveillance and Response capacity, and

in 2015 began an effort to strengthen its national capacity for surveillance and early warning systems and their ability to relay information from the community level up to the national level (Keita et al., 2023).

The decentralized structure under ANSS also includes epidemic treatment centres and regional and prefectural epidemic alert response teams (équipes régionales d'alerte et de réponse aux épidémies [ERARE] and équipes préfectorales d'alerte et de réponse aux épidémies [EPARE] respectively) underpinned by a training programme on field epidemiology (Agence Nationale de Sécurité Sanitaire, 2020a). ERARE and EPARE teams are based in each of Guinea's administrative regions and prefectures and hold responsibilities related to epidemic surveillance and alert management, investigations, response and awareness raising.

This structure has proven to be effective in responding to numerous PHEs between 2015 and 2019. Table 4 provides an overview of the successful activation of PHEOCs from January 2015 to March 2019.



Table 4. PHEOC activation from January 2015 to March 2019

Event	PHEOC activated	Activation period (MM/DD/YYYY)	Actions
Yellow fever outbreak in Gaoual, Boke district	National and Boke	11/2016 to 12/2016	ERARE deployed
2017 Yellow fever outbreak in Boke, Gaoual, Telimele, Siguiri	National	01/2017 to 02/2017	ERARE deployed
Measles vaccination campaign in the five districts of Conakry	DSVCO	02/07 to 02/17/2017	ERARE of Conakry deployed
Polio vaccination campaign	Forecariah, Boffa and Boke	09/07 to 09/11/2018	Logistical support and daily SitRep
Lassa fever case	National PHEOC activated; Kissidougou and Mamou in alert mode	02/02 to 02/25/2019	EPARE deployed, daily SitRep and coordination of meetings
Anthrax cases	Koubia	02/22 to 04/19/2019 (end of contact tracing)	EPARE with lead agents from the Ministries of Environment and Livestock
EPI national mass Tetanus vaccination campaign in Lélouma and Koubia	Labe	01/29 to 02/03/2019	Logistical support and communication with vaccination teams
Measles cases	Labe	02/15/2019, ongoing	EPARE deployed and daily SitRep

Source: Martel et al., 2020.

According to Martel et al. (2020), as of 2018, the national PHEOC and all of Guinea’s district-level PHEOCs had met the minimum requirements in terms of their systems, equipment and staffing levels – as ascertained by a Joint External Evaluation by WHO and the Centers for Disease Control and Prevention – thus ensuring that Guinea can “efficiently coordinate mitigation, preparedness, response and recovery activities related to epidemic-prone diseases” (Martel et al., 2020).

3.2 PHE preparedness plans and strategies

Following the 2014–2016 EVD outbreak, the government’s renewed focus on preparedness led to the development of several strategies and plans, including the Plan to Strengthen the Surveillance of Diseases with Epidemic Potential for the Period of 2015–2017 and a National Health Information System Strategic Plan. In 2018, a Risk Communication Plan was also developed (Martel et al., 2020).

Additionally, in early 2018, ANSS, with support from a range of partners including WHO and UNICEF, began to develop a Health Security Action Plan built on the recommendations of the Joint External Evaluation of national capacities on public health security conducted by WHO in 2017 (World Health

Organization, 2017). The Joint External Evaluation had identified that Guinea lacked capacity on 18 indicators and had only limited capacity on 20 indicators. Validated in 2019, the four-year plan brought together the health, environment, livestock and agriculture sectors under an approach called *Une Seule Santé* (One Health) (Keita et al., 2023). The approach sought to integrate preparedness, prevention and response activities conducted by ministries and other actors working in the health sciences, to contribute to the better health of all people, animals and plants in Guinea (Agence Nationale de Sécurité Sanitaire, 2019). Its implementation was supported by a regional strategic road map to operationalize the One Health approach, which brought together Guinea, Liberia and Sierra Leone (Keita et al., 2023).

The development of strategic national documents also led to the development of key documents for the 38 district-level PHEOCs, in part to address recommendations from the Joint External Evaluation of 2017 (Martel et al., 2020). These documents included standard operating procedures for activating and deactivating PHEOCs, and a handbook for the district-level PHEOCs based on the WHO Framework for a Public Health Emergency Operations Centre (Martel et al., 2020).

In addition, the government developed more specific documentation to support preparedness for another EVD outbreak, including the Plan to Strengthen Epidemiological Surveillance in the Framework to the EVD Response in 42 days, in the Region of Nzérékoré, 2021, as well as the National Plan to Respond to EVD in Guinea. No further disease-specific preparedness plans were developed, however, to detail the risks and needs in the event of outbreaks of other diseases.

3.3 PHE response plans

In February 2019, Guinea published its Response Plan for Public Health Emergencies. The plan was developed to complement existing documentation such as operational concepts, which provide guidance on how different subentities of ANSS should interact to manage PHEs; normalized operational procedures, describing the steps to follow to manage a PHE through the PHEOCs; and guidance on the management of priority zoonoses (Agence Nationale de Sécurité Sanitaire, 2021b).

The Response Plan for Public Health Emergencies provides a detailed overview of the steps to follow to raise an alert about a potential outbreak, as well as the steps to follow to manage an emergency with epidemic potential. It details how the PHEOCs are activated, how to evaluate response risks, and how to manage responses in collaboration with a range of partners, including the One Health platform, which will have identified a focal point.

The plan clearly indicates who has overall responsibility for managing the responses (the director-general of ANSS), as well as the chain of responsibility down to the prefectural level. It details the key steps of a response, laying out roles and responsibilities for each component of a response.

In addition, the Ministry of Health and Public Hygiene has established a process for developing response plans for specific outbreaks, such as the EVD outbreak of 2021. The corresponding National Ebola Virus Disease Response Plan in Guinea, from the Ministry of Health, was published in February 2021, the same month the outbreak was declared. It details the steps that had been taken to date to strengthen Guinea's EVD epidemic management, as well as the specific actions that would be taken to identify, contain and treat EVD patients during the new outbreak (Agence Nationale de Sécurité Sanitaire, 2021c).

The national response plan lists a series of objectives, the intended beneficiaries (though the data are not disaggregated) and the 3 strategic axes and 16 pillars that would underscore the plan's implementation (Agence Nationale de Sécurité Sanitaire, 2021c).



This plan is supplemented by the Plan to Strengthen Epidemiological Surveillance in the Framework to the EVD Response in 42 days, in the Region of Nzérékoré, 2021 (Agence Nationale de Sécurité Sanitaire, 2021a).

3.4 Responses to PHEs in 2021

While Guinea's public health capacities had been stretched by the COVID-19 response, the pandemic also meant that public health professionals were on alert and medical facilities, including regional laboratories, were operational. These factors are credited for the relatively rapid detection and containment of the subsequent disease outbreaks of 2021 (as detailed in section 2.2.3).

These outbreaks of EVD, Lassa fever and MVD all led to the activation of the PHEOCs at the national and district levels, in line with the Plan to Respond to Public Health Emergencies, published in 2019; their activation contributed to better information sharing and PHE management. Depending on the nature of the emergency, technical committees based on the relevant pillar(s) of the response were activated

as needed. In addition, interministerial commissions were set up during these emergencies, their composition again dependent on the nature of the emergency.

ANSS coordination and communication extended to the development of SitReps to provide to the domestic public health community, as well as other actors involved in the response, regular updates on progress and continued needs. During the outbreaks, ANSS produced 207 SitReps in total: 116 covering the EVD response, 56 on the Lassa fever response and 35 covering the MVD response (Agence Nationale de Sécurité Sanitaire, 2021c).

Subsequently, ANSS also took the following steps to ensure that it continued both to learn from its responses in 2021–2022 and to improve its preparedness for future outbreaks: it updated its infection prevention and control (IPC) and EVD body handling procedures, and it conducted after-action reviews of preparedness and response to EVD, MVD and yellow fever in 2021 (Agence Nationale de Sécurité Sanitaire, 2021c).





The UNICEF contribution to preparedness and response

4.1 The UNICEF contribution to preparedness and system strengthening

Summary of the role and activities of UNICEF

UNICEF has had a presence in Guinea since 1984, and its interventions in the country focus on education, child protection, health, nutrition and water, sanitation and hygiene (WASH). Operations are led by the UNICEF Guinea Country Office in Conakry, and UNICEF also has three field offices – in Kankan, Labé and Nzérékoré (UNICEF, 2022d). The Kankan office covers both the Faranah and Kankan regions, while the Nzérékoré office covers activities in the towns of Guéckédou and Nzérékoré, as both fall within the administrative zone of Nzérékoré (UNICEF, 2022d).

UNICEF activities in the country are guided by the country programme of cooperation agreed with the Government of Guinea, the current version of which originally covered the period 2018–2022 and was subsequently extended to 2023, owing to the political context. The next programme cycle (2024–2028) is under development.

The country programme of cooperation focuses on supporting the Guinean government to eliminate barriers to the realization of children's rights in the country, through the National Plans for Social and Economic Development for 2016–2020 and the United Nations Development Assistance Framework. UNICEF worked closely with the government to support the development of these plans and also provided support to the government as it developed its more PHE-focused plans (see section 3.1).

UNICEF has supported the enhancement of government capacities in health, including through vaccination programming and strengthened public health responses. For example, during the roll-out of the extended vaccination programme that started in the early 2000s, UNICEF provided particularly close technical guidance and financial support for the social mobilization and communication element of the vaccination campaign (Ministère de la Santé et de l'Hygiène Publique, 2016). For the extended vaccination programme, the national government created, by decree, an Interagency Coordination Committee, which counted UNICEF and WHO among its members. UNICEF continues to be closely involved in the delivery of routine vaccination, working with community leaders and other actors to raise awareness about the value of vaccines and to promote vaccine delivery (UNICEF, 2021b).

“ In everything we do, we support national priorities because one of our objectives is to strengthen national capacities ... UNICEF always acts in consultation with national actors to stick with these elements. In the preparedness plans, we identify the risks, scenarios and all that together ... In the national contingency plan, there is a profile of risks identified for Guinea – but the plan has not yet been validated, which poses a problem for sharing it formally.”
– UNICEF respondent

In health, UNICEF works particularly closely with the government and other national actors such as community-based organizations (CBOs), including on issues related to child and maternal health, teenage pregnancy and female genital mutilation/cutting, as well as HIV/AIDS.

UNICEF works to strengthen both the material infrastructure of public health facilities and the availability of supplies to such facilities, as well as to strengthen the knowledge and capacities of public health staff, including community health agents (UNICEF, 2022e). Although these activities are not directly implemented as part of PHE preparedness strategies or activities, stronger health systems are inevitably better prepared to respond to emerging epidemics and emergencies.

Additional activities conducted by UNICEF to strengthen preparedness and response to PHEs have included close support to the recurrent cholera outbreaks affecting the country, including in 2018. At the time, UNICEF provided support to sentinel sites for cholera and meningitis, in areas along the coast for the former and in two regions for the latter. It also supported the implementation of emergency practice drills in Boffa, Boké and Forécariah in order to strengthen Guinea’s early warning system (UNICEF, 2018). UNICEF has also introduced “active surveillance in high-risk areas, which provides quality information”, enabling UNICEF, local authorities and other actors to put in place preventive or corrective measures (UNICEF, 2018).

The role of UNICEF in preparedness has been to support system strengthening at all levels, from advocacy to inform or influence public policy and national budgeting priorities, all the way through to working with local communities. Since 2018, UNICEF has worked closely with the government to pilot the convergence municipalities approach with the support of the National Support Programme for Convergence Communities, which aims to support the decentralization process by focusing on the transfer to communes of 14 key competencies, including health (UNICEF, 2022c).

According to the ‘Country Office Annual Report 2021: Guinea’ (UNICEF, n.d., 2): “The convergence municipalities approach was critical for promoting integrated and targeted interventions across UNICEF programmes. UNICEF’s support to municipal councils led to the development of Local Development Plans (LDP) and Annual Investment Plans (AIP) which integrate key results for children.”

UNICEF support to the convergence municipalities included both capacity strengthening of community health workers, to enable them to manage illnesses more effectively (UNICEF, 2021b), and the setting up of early warning and response systems (UNICEF, 2018).



UNICEF preparedness plan

The Guinea Country Office, like all UNICEF country offices, conducts an annual exercise to develop or update its emergency preparedness plan for the year. The template for this plan includes a risk analysis; an overview of potential scenarios such as floods/landslides, epidemics/pandemics and electoral violence; response plans for each of these potential scenarios; and preparedness actions (UNICEF Guinea, 2021c).

In the Guinea Preparedness Plan, the risk analysis for epidemics and pandemics uses a scale of 1 to 5 (least to most) to indicate both the likelihood and the impact of these occurring as high (4). It describes Guinea's fragile health system, as well as the possibility of epidemic outbreaks of diseases such as cholera, measles, meningitis, yellow fever and EVD. It mentions vaccination efforts and notes that the impacts of COVID-19 are likely to be felt for the long term.

The scenario section describes the ways in which each potential scenario would affect nutrition, health, WASH, child protection, education, HIV/AIDS, social protection, Communication for Development (C4D) and gender. Under each scenario, it details the potential humanitarian impact, including a list of priority needs for women and children, and specific challenges to meeting these. It also lists potential humanitarian consequences and the possible number of affected individuals, including both confirmed cases and deaths, though no basis is provided for the calculations. Under each sectoral intervention, it lists the major humanitarian actors likely to be involved in a response, and highlights response capacity gaps, such as drinking water, psychosocial support (PSS), existing weaknesses in the supply chain and the difficulty of pre-positioning supplies (UNICEF Guinea, 2021c).

The response section, which is again broken down by sector of intervention, lists the key elements of each anticipated response, provides a target number of beneficiaries, identifies indicators to assess the response, and gives both an overview of the activities and a financial overview of the cost of the response.

Finally, the preparedness actions list the expected benchmarks for emergency management, humanitarian coordination, staff capacities, supply and logistics, cash transfers, implementing partners, and advocacy communication and resource mobilization (for more details, see Appendix F). According to the 2022 emergency preparedness plan, all of the benchmarks have been met (UNICEF Guinea, 2022).

4.2 Role and activities of UNICEF in response to PHEs

Lessons learned from the EVD outbreak of 2014–2016

The UNICEF Guinea Country Office drew extensive lessons from the evaluations and other studies undertaken following the EVD outbreak of 2014–2016. One such report, *Evaluation of UNICEF's Response to the Ebola Outbreak in West Africa, 2014–2015*, states that the UNICEF response did contribute to stop the spread of EVD and, ultimately, the epidemic, but it also details some important weaknesses (UNICEF, 2017). The report highlights one-way communication, lack of direct child protection activities and services, delays in the initial response, challenges in mobilizing staff with the necessary capacities, poor understanding of EVD-related risks, and challenges with coordination as important failings (UNICEF, 2016). It also details the way in which UNICEF improved its response over time, as the organization both gained a better understanding of the virus and community perceptions and adapted its strategies based on methods that had been demonstrated to be effective. The report notes the way in which UNICEF had improved its use of data for real-time monitoring by 2015, and states that UNICEF was generally accountable to the populations it worked with, despite there being "room for improvement at the community level" (UNICEF, 2016).

Among the points included in the management response to the evaluation, UNICEF writes that despite its initial delay in recognizing the specific needs of children, it did eventually provide child protection services to approximately 6,220 children affected by EVD in Guinea. The country office also worked closely with the Ministry of Social Welfare to train and deploy 120 social workers to work with children affected by the epidemic by providing PSS. Once the response was complete, UNICEF worked with the government to strengthen national preparedness by supporting it to draft strategies responding to gaps identified during the response – for example, the National Social Policy Strategy, which addresses actions to follow with children directly affected by EVD (UNICEF, 2016a).

A ‘lessons learned’ report, which focuses on the education response and was published by the UNICEF West and Central Africa Regional Office, notes: “The most important lesson learned from this crisis is that the education sector must be considered in the humanitarian response from the beginning. The international community was pushed by reality to accept that the EVD crisis had implications/links to health but also to food security, nutrition, economic development, education, child protection, gender issues, etc.” (UNICEF West and Central Africa, 2016).

Similar themes emerge again, as the report also emphasizes the need to rebuild trust with and within broken communities, and the value of using schools for awareness-raising and other IPC activities. It also notes the need for improvements to data collection and to ensure that data address not only outputs but also the quality of the outputs and their impact.

The UNICEF report *Care and Protection of Children in the West African Ebola Virus Disease Epidemic: Lessons learned for future public health emergencies* (UNICEF, 2016b) lists a number of lessons for the organization to take forward. It notes that the initial response did not consider the particular needs or vulnerabilities of children, but rather, “As EVD spread, the main response was a sectoral health response. Soon, however, it was clear that a health-only response was overlooking two major drivers of the epidemic: fear and mistrust” (UNICEF, 2016b). The report highlights the way in which poor communication practices led to more misunderstanding and panic, and pushed people to flee their villages, further spreading the disease.

The report concludes: “There are many reasons for why the EVD epidemic eventually began to abate and the numbers of illnesses started to decline, including that it was simply due to the natural life cycle of the virus. The reasons for it will continue to be discovered and debated for some time. But in general, there was a shift from community anger and rejection to community engagement: communities started to trust, and people started to partake in the solution” (UNICEF, 2016b). Indeed, prioritizing community engagement and communication – including through coordination and collaboration with community stakeholders, and through research-informed IPC activities to better understand community hesitations and behaviours – played a significant role in bringing the epidemic to a close and also in contributing to an enhanced response for future PHEs.



Summary of the role and activities of UNICEF in PHE responses in 2021

In 2021, UNICEF took on board extensive lessons from prior outbreaks and responses, including by investing in and supporting the development of enhanced surveillance, laboratory and treatment capacities at the national level, and by introducing its ‘no-regrets’ approach, which saw a focused mobilization of resources as soon as an outbreak was declared.

With its relevant experience and expertise, UNICEF played an important role in the response to the multiple PHEs that struck Guinea in 2021–2022, providing both leadership and coordination to responses through the IPC/WASH and risk communication and community engagement (RCCE) technical sectoral groups. UNICEF leads the United Nations pillar on Communication and Community Engagement. UNICEF also provides coordination and leadership through its existing relationships with the Government of Guinea, as well as international and national NGOs (UNICEF, 2021b). With development and public health stakeholders, UNICEF leads activities to raise awareness about prevention of sexual exploitation and abuse (PSEA). Finally, it also provides direct financing to a wide range of local NGOs and CBOs to support their preparedness and response activities.

According to its annual report and various SitReps, UNICEF also conducted the following activities in response to the multiple PHEs affecting Guinea in 2021–2022, whether directly and/or through its implementing partners:

1. Provided support to communities by ensuring the **continued provision of essential services, including health and nutrition**, during PHEs. UNICEF conducted a joint assessment mission with the minister of health and public hygiene and country representatives of UNICEF, WHO and Gavi, the Vaccine Alliance, to low-performing districts and subsequently supported the development of a road map and the creation of a monitoring committee to ensure that critical health indicators are not overlooked (UNICEF, 2021b). UNICEF continued its vaccination efforts, conducting several vaccination campaigns for polio and measles (UNICEF, 2021c). UNICEF supported a vaccine campaign that vaccinated

2,972,004 children with the bivalent oral polio-virus vaccine and 344,477 children with the measles vaccine (UNICEF, 2021c). Additionally, it provided 69 cold chain facilities and 100 coolers to support vaccination efforts. UNICEF also helped provide adequate nutrition to the most vulnerable children by treating 22,198 children with severe acute malnutrition, working in close collaboration with the United Nations Entity for Gender Equality and the Empowerment of Women, the United Nations Population Fund and the Joint United Nations Programme on HIV/AIDS (UNICEF, 2021b). UNICEF provided support to train 600 health workers and 800 women’s groups on nutrition and infant and young child feeding, and also provided nutrition inputs to enable the free treatment of children affected by acute malnutrition. A total of 152,629 caregivers and 26,230 children under 23 months of age received multi-micronutrient powders to guard against micronutrient deficiencies (UNICEF, 2021c). Furthermore, UNICEF provided equipment for delivery and newborn resuscitation to 44 health facilities and improved access to antiretroviral therapy in 176 health facilities.

“We are able to participate in the WASH thematic group meetings. Because of these experiences, we are developing an integrated community health framework.”
– Informant from local NGO



2. Enabled better IPC practices and access to safe WASH services including through the pre-positioning of supplies.

UNICEF worked with the Government of Guinea to reinforce WASH legislation and policies, advocating for expanded water and sanitation coverage in health facilities, schools and other institutions, as well as directly to communities. As a result of UNICEF efforts, 217,878 people in the Nzérékoré Region gained access to an improved water supply and 23,700 people in rural areas gained access to newly constructed water points (UNICEF, 2021c). UNICEF connected 58 schools and 40 health centres to water and sanitation facilities, benefiting 80,000 people, and built latrines in 66 schools, benefiting almost 56,800 students across 5 regions. As part of its efforts to pre-position supplies, UNICEF provided personal protective equipment (PPE) for IPC to 22 health facilities. It also trained staff from 46 health facilities on IPC and led behaviour change communication campaigns to encourage individuals to improve their sanitation and hygiene practices – crucial to disease prevention and containment. UNICEF also provided 23,712 individuals with hygiene kits to promote and encourage handwashing (UNICEF, 2021b). Finally, UNICEF, in partnership with WHO and as part of the response to the MVD outbreak, conducted refresher trainings with health agents on IPC best practices (World Health Organization, 2021). Finally, it is important to note that supplies are the most significant category of PHE-related expenditure for UNICEF.

3. Promoted the integration of measures to combat EVD in schools.

UNICEF trained 1,481 teachers, 47 headteachers, 207 school principals and 600 members of parents and friends of school associations on EVD prevention and how to support children during the epidemic. As a result of these trainings, 81,304 students were supported during the outbreak (UNICEF, 2021c).

4. Provided emergency cash transfers to 500 vulnerable households directly affected by the EVD outbreak of 2021 (UNICEF, 2021b).

5. Contributed to improved humanitarian action by supporting the expansion of local action groups

in 80 rural and vulnerable municipalities across the country, by advocating for the integration of preparedness and response into local development plans and by pre-positioning **supplies to support faster responses**. Additionally, working with local authorities and leaders, UNICEF supported the expansion of the digital community surveillance systems for EVD and other outbreaks by training 445 *relais communautaires* in surveillance. These *relais communautaires* reached 165,000 individuals during their community visits to raise awareness on EVD risks and to encourage the reporting of symptoms to local health centres (UNICEF, 2021a). The ultimate objective is for UNICEF to scale its support to local action groups to all 342 municipalities in the country (UNICEF, 2021b).



6. Prioritized community engagement and the strengthening of local capacities for surveillance, isolation, and risk communication.

Provision of financial and technical support to CBOs and civil society organizations (CSOs) and engagement with women's organizations and youth groups were intended to improve community capacities and understanding to support the rapid detection and containment of outbreaks and to deliver an integrated response. UNICEF also works with influential community members to ensure that messages on disease prevention are shared with communities by trusted individuals, for example, representatives of CBOs, religious leaders and members of the internal diaspora (migrants from rural communities who have moved to Conakry).

7. Provided mental health and psychosocial support to children and their families directly affected by PHEs. During 2021, 7,286 individuals received PSS, including 3,180 girls (43 per cent of the total beneficiaries) and 425 parents (UNICEF, 2021c). UNICEF also supported the recruitment of, and trained, 18 social workers to provide PSS for families affected by the EVD outbreak in the Nzérékoré Region (UNICEF, 2021c).

8. Led C4D activities to support the response to the multiple, concurrent epidemics affecting the country, in collaboration with ANSS. C4D activities reached 8,083,482 individuals with messaging on preventive measures and the value of vaccinations against COVID-19, and reached 776,330 individuals with essential EVD messaging. Community feedback is also sought through a number of mechanisms, including the One Health group, community sessions, and partnerships with local CBOs and CSOs. Regular community dialogues and meetings were organized, in which more than 925,000 people shared their views and concerns (UNICEF, 2021c). Finally, UNICEF continued to promote evidence-based messaging by conducting three field surveys for RCCE purposes (UNICEF, 2021c).

9. Provided PSEA training and strengthened community accountability. In 2021, UNICEF Guinea strengthened staff and partner knowledge and capacity by conducting refresher PSEA training sessions for 770 individuals who worked either at the United Nations or with service providers or partner organizations. UNICEF also conducted such training with 7,286 community members. Importantly, the UNICEF response to EVD in the Nzérékoré Region included the dissemination of information on how to reduce sexual and gender-based violence to 89,088 people, including 48,081 girls and women, through community prevention activities (UNICEF, 2021e). The terms of reference of UNICEF PSEA focal points were updated, and regional coordination committees were established. Finally, a complaint mechanism was established, and an anonymous helpline set up, through which 55,568 people were able to safely report sexual exploitation and abuse (UNICEF, 2021b).





Assessment of preparedness and response to the 2021 outbreaks

5.1 Assessment of preparedness

As set out in the inception report for the evaluation, the framework for assessing preparedness in the case studies is based on the categorization of functions in the WHO Health Emergency and Disaster Risk Management Framework, adapted to focus specifically on PHEs.⁴ This framework provides a checklist of assessment criteria to assess PHE preparedness at the national level, as well as to identify UNICEF contributions to national preparedness.

This assessment covers Guinea's level of preparedness for the outbreaks it experienced in 2021. Where relevant, some reference is made to changes over time, particularly since the 2014–2016 EVD outbreak, which resulted in some significant improvements to Guinea's state of preparedness for subsequent PHEs. The focus is Guinea's state of preparedness for the 2021 outbreaks of EVD, Lassa fever and MVD. Although other outbreaks occurred during the 2021–2022 period covered by this case study, they are beyond the scope of this work.

Table 5 provides an overview of the assessment of Guinea's performance against the Health Emergency and Disaster Risk Management Framework, while the sections that follow provide more detail on each component.



4

The Health Emergency and Disaster Risk Management Framework focuses on those functions that lead to “countries and communities [having] ... stronger capacities and systems across health and other sectors resulting in the reduction of the health risks and consequences associated with all types of emergencies and disasters.” The adaptation of the framework has involved focusing on PHEs (rather than other types of emergencies) while noting the importance of other sectors (especially WASH and Supply) that are of critical importance for PHEs.

Table 5. Summary of preparedness assessment

Functions	Assessment criteria	Assessment	UNICEF contribution
Policies, strategies and legislation	Structures, roles and responsibilities of governments and other actors in managing public health emergency (PHE) risks are clearly defined and agreed; strategies for strengthening PHE risk management capacities are in place.	Policies: Guinea has developed a number of policies related to preparedness, including the National Plan for Health Development 2015–2024, the National Contingency Plan 2015, the Health Security Action Plan and the National Health Information System Strategic Plan. While there is room for improvement, they lay out the structures, roles and responsibilities of different actors and therefore provide a foundation for Guinea’s preparedness activities and actors. Strategies: Guinea has developed strategies for preparing for new outbreaks of Ebola virus disease (EVD), as well as a more generic Response Plan for Public Health Emergencies; however, its disease-specific preparedness activities have focused almost exclusively on EVD. Legislation: Several pieces of legislation exist to guide the country’s preparedness activities, the foremost of which is the 4 July 2016 decree instating the National Agency for Health Security (Agence Nationale de Santé et Sécurité; ANSS) under the Ministry of Health and Public Hygiene, supplemented by the October 2016 decree 2016/6451/MS/CAB/SGG establishing the technical departments of ANSS.	Policies: UNICEF has worked closely with the Government of Guinea to develop and/or strengthen the policies named in the previous column. Strategies: UNICEF has supported the Government of Guinea to develop its national strategies, including its EVD strategy. Legislation: UNICEF advocacy, including on the national budget, has contributed to shape existing legislation.

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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 mechanisms and effective leadership: Coordination mechanisms are in place at multiple levels. These include coordination mechanisms through ANSS, which include its Strategic Committee, 39 public health emergency operations centres (PHEOCs), and 8 regional and prefectural epidemic alert response teams (ERARE and EPARE), as well as the One Health coordination forums. They also include interagency clusters and working groups, such as the Water, Sanitation and Hygiene (WASH) Cluster and the Risk Communication and Community Engagement (RCCE) and Prevention of Sexual Exploitation and Abuse (PSEA) pillars. During the 2021–2022 outbreaks, this coordination structure proved to be effective. Contingency plans and response protocols: At the national level, contingency plans include the National Contingency Plan 2015. Guinea’s PHEOCs conduct periodic drills to test contingency plans and response protocols, but this could be done more systematically.	Coordination mechanisms and effective leadership: UNICEF is involved in many of the coordination mechanisms in Guinea and is recognized for its leadership. UNICEF is a member of the ANSS Strategic Committee and co-leads the WASH Cluster and the RCCE and PSEA pillars with ANSS. Contingency plans and response protocols: UNICEF works closely with ANSS to support the development of national preparedness and response strategies and plans.
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.	There is insufficient evidence to assess Guinea’s plans for staffing, education and training across PHE risk management capacities.	While there is insufficient evidence on the UNICEF contribution to human resource plans, UNICEF without a doubt plays an important role in building the capacity of Guinea’s health professionals by conducting regular training of health professionals across Guinea on subjects such as infection prevention and control (IPC)/WASH and nutrition.

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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.	The adequate financing of existing preparedness plans is a significant challenge for Guinea. The majority of PHE risk management funding comes from international partners and private sources, which are considered inconsistent and vulnerable sources of funding from a sustainability perspective.	UNICEF is an important partner for Guinea for the financing of emergency response and recovery, both through its technical assistance and through the direct financial assistance it provides to a range of Guinean organizations, including community-based organizations (CBOs) and civil society organizations (CSOs).
Information and knowledge management	Harmonized systems are in place and functioning effectively to provide information on risk assessment; surveillance; early warning; information management; and technical guidance and research.	While information and knowledge management has improved since 2016, it remains a weakness that the Guinean government, including ANSS, is taking some steps to redress. Disaggregation of data by sex and age is done inconsistently, reducing the government's ability to meaningfully assess needs or responses. Significant improvements would, however, require both capacity and system building, and therefore also a significant financial investment.	UNICEF supports the government, including ANSS, with its information and knowledge management capabilities. For example, UNICEF has provided support to ANSS on data management and on the use of data to inform decision-making, including by conducting training on how to integrate gender into situation reports (SitReps).
Risk communication and community engagement	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 the dissemination of conflicting information and to tailor information to the risks and needs of diverse at-risk populations, including those with higher levels of vulnerability.	Communication mechanisms: Communication mechanisms have been introduced in Guinea, supported by coordination through the RCCE technical working group, which ensures the dissemination of accurate and consistent information. Public information activities: Public information activities are conducted by various stakeholders, including community groups such as women's groups and youth groups, as well as CSOs and CBOs and other members of the RCCE technical working group. Community-based research is conducted to ensure understanding of existing concerns and behaviours and to enable the development of targeted communication tools and activities.	Communication mechanisms: UNICEF plays a key role in the existing communication mechanisms, leading the RCCE technical working group. Public information activities: UNICEF plays an essential role in public information activities, including providing financial and technical support to a wide range of CSOs and CBOs.

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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.	Health infrastructure: Guinea's health facilities and critical infrastructure reflect those of a country that is ranked 182 out of 191 on the United Nations Development Programme's Human Development Index. The country lacks sufficient or adequate facilities to meet the existing needs of its population even outside of a PHE context. Logistics: Logistics and supply systems exist at the national level but require reinforcement. This has been recognized by the government through, for example, the development of a piece of supply management software for COVID-19 in 2021. While pre-positioning of supplies is intended to support the management of PHE risks, stores are sometimes depleted before they can be used in an emergency.	Health infrastructure: UNICEF does extensive work on health system strengthening in Guinea, through its support for the construction and supply of health facilities across the country. Logistics: UNICEF supports logistics and supply systems in various ways to better respond to PHE risks, including, significantly, through the pre-positioning of supplies.
Health services	The full range of health and related services required to support the management of PHE risks is provided, including nutrition, mental health and psychosocial support; health services have capacity to scale up to meet increased health needs and specific risks resulting from a PHE.	Provision of health services: The delivery of essential services, including health and WASH services, was devastated by the 2014–2016 EVD outbreak, but a concerted effort by both national and international actors since 2016 has yielded some improvements. The COVID-19 pandemic again affected service delivery and the public's trust in the health system, but the availability of services had resumed to normal levels by 2021. Capacity for scale-up: Guinea's health services are already stretched and failing to meet the needs of the population, limiting their ability to scale up in a PHE. The responses to the PHEs affecting the country in 2021 demonstrated, however, that resources can be effectively targeted to respond in the case of multiple, concurrent (if relatively small-scale) PHEs.	Provision of health services: UNICEF plays an invaluable role in supporting the delivery of health care and other basic services – providing either technical, financial, or infrastructural support to promote or strengthen the delivery of nutrition, mental health, and psychosocial support services among others. Capacity for scale-up: Through its financial resources, UNICEF played an important role in supporting health services to respond appropriately to the PHEs that Guinea faced in 2021.

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Water, sanitation and hygiene services	WASH services (including infrastructure, service management arrangements, and behaviour change communication) are provided to support management of PHE risks.	WASH services in Guinea are insufficient to adequately respond to the population's needs, given that 64% of schools, 69% of health facilities and 21% of households do not have access to safe drinking water. Ongoing efforts are being made, however, to strengthen the provision of WASH services through the construction of boreholes and latrines and through behaviour change communication, among other activities.	UNICEF work to strengthen WASH services across institutions has been essential in improving access to facilities and improving hygiene practices across the country. UNICEF has taken an effective multipronged approach, combining a community focus on schools and health facilities with engagement with the national government on issues related to water access.
Community capacities for health	Local health workforce capacities are sufficient to address PHE risks in conjunction with inclusive community-centred planning and action.	As noted previously, Guinea has insufficient health system capacity to meet the existing needs of its population, during or outside of a PHE. Local health workers are, however, essential in addressing risks and ensuring that communities trust, seek out and follow the medical advice they receive; efforts are conducted regularly by a range of actors to reinforce the capacities of such health workers.	Extensive efforts by UNICEF to strengthen the capacities of health workers, as well as those of CBOs and community members, have been essential in enabling these actors to recognize and address PHE risks at the community level.
Monitoring and evaluation	Established processes are in place to monitor progress towards meeting PHE risk management objectives, including the monitoring of risks and capacities and evaluation of the implementation of strategies, related programmes and activities.	Processes are in place to monitor PHE risks through ANSS and its PHEOCs and various other subentities, and an ANSS monitoring and evaluation plan uses a variety of tools to support data management for PHE risks. The extent to which these can meaningfully identify capacity gaps and assess the implementation of strategies, programmes and activities remains limited, however, owing to inadequate financial resources.	There is insufficient evidence to assess the UNICEF contribution to the development of Guinea's processes for monitoring progress towards its PHE risk management objectives.

Policies, strategies and legislation

By 2021, Guinea's legal framework for PHE preparedness and response was guided by several pieces of legislation and international agreements: the 4 July 2016 decree instating ANSS under the Ministry of Health and Public Hygiene, supplemented by the October 2016 decree 2016/6451/MS/CAB/SGG establishing the technical departments of ANSS. Additional legal obligations are prescribed by the Public Health Code of 19 June 1997, the 2011 Guide de Surveillance Intégrée de la Maladie et la Réponse, the Global Health Security Agenda, and the International Health Regulations of 2005.

In addition, these are underpinned by a number of strategic plans and policies, such as the National Plan for Health Development 2015–2024, the National Contingency Plan 2015, the Health Security Action Plan and the National Health Information System Strategic Plan, which detail the processes, roles and responsibilities of the state-level actors involved in PHE preparedness and response, under the guidance of ANSS. The government's Response Plan for Public Health Emergencies, while generic, is a comprehensive document, which provides a solid blueprint for responding to PHEs. UNICEF has played an important role, through its position on the ANSS Strategic Committee and close working relationships with the government, in helping the government to develop these preparedness plans.

It is important to note, however, that while Guinea has both generic PHE preparedness plans and plans to address the specific risk posed by EVD, the case study team could not identify any preparedness documents or plans addressing the specific risks and needs related to other potentially epidemic diseases, such as Lassa fever, yellow fever and MVD. This limits the country's preparedness for diseases with different epidemiological profiles.

UNICEF Guinea's Health Security Action Plan and its Preparedness Plan for 2021 together provide a solid foundation for preparedness planning; several changes could, however, improve the latter plan's usefulness as a PHE preparedness document. The scenario section is comprehensive but provides a somewhat disjointed narrative in discussing one response sector to the next. It could also be further improved by specifying the roles and responsibilities of the specific actors listed as key to each response. The response section is very general and could be improved by providing more details under each sector and by further disaggregating responses by potential epidemic disease. Finally, although comments on meeting the UNICEF Guinea emergency preparedness plan benchmarks are included in the document's final section, bringing greater attention to the country office's strengths and weaknesses on preparedness would strengthen the plan and contribute to a better state of preparedness. This could include detailing actions to redress certain weaknesses, such as the need for replenishment of contingency stocks.



Planning and coordination

Since 2016, coordination and response mechanisms have been introduced through ANSS, including the country's 39 PHEOCs and 8 ERARE and EPARE. The One Health coordination forums bring together both local leaders and the range of actors involved in public health preparation and response and play an essential role in both detection and response. According to UNICEF respondents and One Health FGD informants, as well as research by Martel et al. and Keita et al., these mechanisms have been particularly effective during PHEs and have played a key role in contributing to a coordinated and generally appropriate response to outbreaks (Keita et al., 2023; Martel et al., 2020). The PHEOCs conduct regular simulations at the central, prefectural and community levels to enhance their preparedness for PHEs.

Coordination mechanisms also include the inter-agency clusters and working groups that meet at the national level, such as the WASH Cluster co-led by UNICEF and the National Directorate for Public Hygiene (Direction Nationale de l'Hygiène Publique), and the Nutrition and Education clusters. UNICEF also co-leads the IPC/WASH, RCCE and PSEA pillars with ANSS.

UNICEF works closely with ANSS and is a member of its Strategic Committee, supporting the development of national preparedness and response strategies and plans, such as the National Plan to Respond to EVD in Guinea, which details steps to reinforce the epidemiological surveillance system, cross-border collaborations and IPC, as well as steps to raise awareness in communities, pre-position stocks and ensure case management. While the plan provides detailed steps, a budget and indicators to assess performance against its objectives, it does not specify who is responsible for each activity, an element that would strengthen its utility.

Financial resources

Despite significant investments following the 2014–2016 EVD outbreak, the most significant preparedness challenge for Guinea, as highlighted by several UNICEF respondents, remains the inadequate financing of existing preparedness plans. According to the Ministry of Health and Public Hygiene's internal Operational Action Plan for 2022, just 20 per cent of health financing comes from its own resources. While financing to support preparedness efforts comes from international partners including UNICEF, the World Bank and the European Union among others, the fact remains that no budget line for PHE preparedness or response exists in the national budget.

Indeed, in a country already hampered by limited financial resources, the lack of a specific budget line poses a challenge when it comes to ensuring that PHE risk management is adequately or sustainably addressed. This has led to EPARE and ERARE receiving insufficient funding. Furthermore, as a couple of One Health focus groups noted, the lack of financial resources means that the One Health forum tends to become dormant in between outbreaks, limiting the continuity of preparedness activities and surveillance efforts. Finally, relying on international partners for health financing makes Guinea vulnerable to the financial position and priorities of other countries – which is an unhealthy position to occupy from a sustainability perspective.

Despite these limitations, UNICEF is an important partner for Guinea for the financing of emergency response and recovery, both through its technical assistance and through the direct financial assistance it provides to a range of Guinean organizations, including CSOs and CBOs.

Health infrastructure and logistics

It is important to note that, in general and related to its limited financial resources, Guinea lacks adequate and quality health facilities and the critical infrastructure to support either comprehensive preparedness measures or an effective large-scale PHE response. Indeed, its health facilities and critical infrastructure reflect those of a country that is ranked 182 out of 191 on the United Nations Development Programme's Human Development Index. The country lacks sufficient or adequate facilities to meet the existing needs of its population even outside of a PHE context. For example, as several UNICEF informants noted, Guinea has insufficient secure or appropriate space for the storage of extensive quantities of supplies. Efforts by the national government and a range of actors, including UNICEF, do, however, aim to strengthen Guinea's health infrastructure. UNICEF does extensive work on health system strengthening in Guinea, through its support for the construction and supply of health facilities across the country (see section 4.1).

Furthermore, lessons from the EVD outbreak of 2014–2016 and substantial post-outbreak investments and initiatives have contributed to the establishment of mechanisms – foremost of which are the PHEOCs – that were effective at detecting and reducing the spread of outbreaks in 2021–2022. The surveillance capacities established through ANSS, the PHEOCs and other entities like ERARE and EPARE, and the One Health platform have enabled the monitoring of risks at the local level.

Furthermore, the COVID-19 pandemic led to the establishment of local laboratories with the capacity to detect diseases like EVD. These proved essential in both identifying and confirming the outbreaks of 2021. Logistics and supply systems have been developed at the national level but require strengthening. This is recognized by the government and some efforts are under way to address this weakness. For example, by the end of 2021, ANSS had developed a piece of supply management software for COVID-19. While it still lacks any comprehensive logistics management software, ANSS did manage to deliver logistical support to all PHE responses in the country (Agence Nationale de Sécurité Sanitaire, 2021).

UNICEF does extensive work on pre-positioning, including of IPC and WASH supplies. According to one UNICEF respondent, however, the necessary supplies detailed in preparedness plans and pre-positioned in government stores have, on multiple occasions, been depleted before they could be used in a PHE response. This is confirmed by UNICEF Guinea's Preparedness Plan for 2021 (UNICEF Guinea, 2021).

Long-term agreements with certain suppliers or transportation agents should, in theory, accelerate the procurement and dissemination of equipment or materials in a PHE. In reality, however, two UNICEF respondents spoke of the delays that occur in ordering and delivering supplies, particularly when international orders must be placed. UNICEF first attempts to procure items locally but resorts to international procurement when the items are unavailable locally or if local items are not of the desired quality or are too expensive. One respondent noted that the local purchase of goods and materials has led to more timely supplies; however, the necessary materials are not always available on the local market or, where available, may not be of the desired quality. Regional stockpiles could enable UNICEF to more readily mobilize resources to respond to PHEs.



Monitoring and evaluation

Surveillance and PHE risk monitoring are overseen by ANSS, with key roles played by the PHEOCs, ERARE, EPARE, One Health platform, and health centres, treatment centres and relais communautaires at the prefectural and community levels. There exists clear guidance on chains of communication and notification for these entities to follow in the event of suspected or confirmed cases of a disease with an epidemic profile.

As per the ANSS Monitoring and Evaluation Plan, Guinea uses a variety of tools to support data management for PHE risk management. These include the Guide de Surveillance Intégrée de la Maladie et la Réponse; the District Health Information System 2, which allows health centres, laboratories and other district- and central-level actors to provide alerts or track diagnostic findings; an early warning system based on Microsoft Excel; and documents such as notification and investigation forms, case definitions and protocols, lists of events or symptoms requiring immediate notification to the authorities, and lists of laboratories able to confirm diseases (Agence Nationale de Sécurité Sanitaire, 2020b). In a highly decentralized country, this framework has been effective at ensuring relatively consistent communication and information sharing between the national entities working on PHE response in 2021.

The Guinean government has established some monitoring and evaluation capabilities and invested in strengthening information and knowledge management competencies. ANSS has its own Monitoring and Evaluation Unit, guided by the detailed ANSS Monitoring and Evaluation Plan, which provides guidance on the monitoring of PHE risks (Agence Nationale de Sécurité Sanitaire, 2020b). The plan details outcome statements and indicators for each ANSS department, as well as result and impact indicators, the operational framework for activity monitoring, and a logframe for ANSS performance. The plan clearly lists the monitoring and evaluation-related responsibilities of key entities such as PHEOCs, ERARE, EPARE, the One Health platform, laboratories and ANSS itself, which is responsible for data analysis. Chains of communication are summarized in the Monitoring and Evaluation Plan (Agence Nationale de Sécurité Sanitaire, 2020b).

Information and knowledge management

While the ANSS Monitoring and Evaluation Plan provides a solid basis for monitoring and evaluation, ANSS has identified the need to strengthen its information management systems, including in relation to logistics management. It set out to strengthen its logistics management system in 2021 and by the end of the year had developed a piece of supply management software for COVID-19 (Agence Nationale de Sécurité Sanitaire, 2021c). One UNICEF respondent shared that UNICEF had also provided support to ANSS on data management and the use of data to inform decision-making, for example, conducting training on how to integrate gender into SitReps. This has led to better disaggregation of the available data and to improvements in the development of tailored RCCE materials.

Room for improvement remains, however, both at the national level, requiring a significant financial investment, and with UNICEF. At the national level, existing weaknesses in data and information management are exemplified by the fact that the case study team received different figures from different government representatives when trying to ascertain the official numbers of cases and deaths in the outbreaks of 2021–2022. Furthermore, PHE-related data available at the national level are disaggregated by neither gender nor age. Insufficient follow-up and, at times, poor documentation within UNICEF also lead to data and knowledge gaps, reducing the ability of UNICEF to appropriately monitor risks and properly evaluate implementation of programmes and strategies.



Humanitarian information management posed a problem. It was not enough to support the members of the national agency; you have to support them on how to manage databases. We were able to impact the production of SitReps, which are supposed to showcase the humanitarian action in the country, but did not integrate the gender dimension. We impacted with better data disintegration.”

– UNICEF respondent

Delivery of health and other basic services

The delivery of essential services, including health, WASH, child protection and education services, was devastated by the 2014–2016 EVD outbreak and had only just begun to recover when the COVID-19 pandemic struck, further affecting provision. According to UNICEF’s Preparedness Plan for 2021, the pandemic led to a 19 per cent reduction in pentavalent 3 vaccination levels, further weakened the WASH system and led to school closures that affected 3 million students across the country (UNICEF Guinea, 2021c). Furthermore, the school closures increased the need for child protection activities, as the closures resulted in increased rates of domestic violence, child labour, child marriage and early pregnancy.

A multitude of actors, both national and international and including UNICEF, have been involved in rebuilding or strengthening Guinea’s capacity to deliver basic services, and improvements since 2016 are evident. For example, according to the Harmonized Survey on Household Living Conditions, the rate of food insecurity decreased between the mid-2010s and 2018, and the proportion of births taking place in a health facility increased 21 percentage points to 53 per cent in 2018. The proportion of child survivors of violence with access to multisectoral services increased from 72 per cent in 2020 to 79 per cent in 2021 (UNICEF, 2021b).

UNICEF support and activities were critical to these improvements. For example, as one respondent highlighted, the organization’s support to local communities through its convergence municipalities approach was essential to the elaboration of local development and annual investment plans that incorporate results for children. The impact of this approach can be summarized with a single statistic: the treatment of pneumonia with antibiotics rose to 91 per cent of cases in communities targeted by the convergence municipalities approach, compared with 35 per cent of cases nationally. UNICEF furthermore increased its routine vaccination services and delivered essential PHE preparedness support through training to 445 community health workers and substantial EVD information campaigns (UNICEF, 2021b).

UNICEF provided essential support for education provision, by advocating for education financing and seeking to improve access to digital education nationwide, strengthening the capabilities of education leaders as well as pedagogical skills, and reaching more than 85,000 students with learning materials (UNICEF, 2021b). Despite these efforts, the impact of school closures during the COVID-19 emergency continue to be felt in students’ knowledge levels (learning loss).

Advocacy by UNICEF and other actors also resulted in the government committing to increase its resource allocation for nutrition and infant and young child feeding by 2030. UNICEF worked with women’s groups to provide an “integrated package of interventions, including IYCF [infant and young child feeding] promotion and other essential family practices (WASH, health, protection, food security), early self-screening of malnutrition by the mothers, awareness-raising on good nutritional practices, cooking demonstrations, fortification of complementary foods at home with multi-micronutrient powders, and income generating activities” (UNICEF, 2021b).



Water, sanitation and hygiene services

WASH services in Guinea are insufficient to adequately respond to the population's needs, given that 64 per cent of schools, 69 per cent of health facilities and 21 per cent of households do not have access to safe drinking water (UNICEF, 2021d). Ongoing efforts are being made, however, to strengthen the provision of WASH services through the construction of boreholes and latrines and through behaviour change communication, among other activities.

UNICEF work to strengthen WASH services across institutions in Guinea has been essential in improving access to facilities and improving hygiene practices across the country. UNICEF has taken an effective multipronged approach, combining a community focus on schools and health facilities with engagement with the national government on issues related to water access, despite delays and challenges caused by the dismantling of the Ministry of Water and Sanitation towards the end of 2021. Regardless, UNICEF leadership was recognized and valued, with one KII respondent, a representative of a local NGO working on WASH, mentioning how UNICEF coordination within the WASH sector working group had contributed to an integrated programme of community health.

According to UNICEF respondents and the UNICEF Preparedness Plan for 2021, however, factors affecting WASH and health preparedness include the technical capacity gaps of key humanitarian actors, insufficient financing at the national level for sectoral interventions, and the limited pre-positioning of contingency stocks, both in Conakry and in subregions of the country (UNICEF Guinea, 2021c).

Community capacities for health

As noted previously, Guinea has insufficient health system capacity to meet the existing needs of its population, during or outside of a PHE. Given Guinea's poor infrastructure and the country's level of decentralization, however, the ability of communities and local actors to identify and respond appropriately to PHEs is paramount to containing outbreaks and limiting severe illness and loss of life. Local health workers are essential in addressing risks and ensuring that communities trust, seek out and follow the medical advice they receive; efforts are conducted regularly by a range of actors to reinforce the capacities of such health workers.



Extensive efforts by UNICEF to strengthen the local capacities of front-line health workers, as well as those of CBOs and community members, have been essential in enabling these actors to recognize and address PHE risks at the community level. KII respondents from national NGOs and CSOs mentioned, time and time again, UNICEF activities in capacity strengthening, and felt that these had been effective. Indeed, many said that the reason why the PHEs in 2021–2022 had been so successfully contained was because of the strengthening of local health capacities.

Following a recommendation made after the 2014–2016 EVD outbreak to strengthen community surveillance, UNICEF introduced the Setting Up a Community-based Early Warning System programme. In collaboration with ANSS and the Red Cross Society of Guinea, which has strong ties with local communities and a network of 20,400 volunteers across the country, an early warning system was established to support surveillance and response (Alliance for International Medical Action, et al., 2021). Despite the acknowledged need for continued capacity strengthening for Red Cross staff and its volunteer network (Red Cross Society of Guinea, 2022), the organization's extensive presence in Guinea has given surveillance efforts a wider footprint than would otherwise have been possible.

Risk communication and community engagement

Communication mechanisms have been introduced in Guinea, supported by coordination through the RCCE technical working group, which ensures the dissemination of accurate and consistent information. Public information activities are conducted by various stakeholders, including community groups such as women's groups and youth groups, as well as CSOs and CBOs and other members of the RCCE technical working group. Community-based research is conducted to ensure understanding of existing concerns and behaviours and to enable the development of targeted communication tools and activities.

UNICEF is the RCCE lead in Guinea, and this is considered to be one of the organization's strengths nationally. Following the initially catastrophic lack of appropriate communication during the 2014–2016 EVD outbreak, UNICEF and other actors went to great lengths to better understand the concerns, misinformation and rumours that were circulating around Guinea. UNICEF established a sociological laboratory to better understand and analyse these issues and to identify means of addressing them through effective communication mechanisms. As highlighted by several UNICEF respondents, the lessons of this previous outbreak have led to the development of tailored and more appropriate communication tools, such as picture boards to communicate key messages to non-literate audiences. Improved coordination between RCCE actors also resulted in more comprehensive coverage of communities with risk messaging in 2021–2022 and, according to one UNICEF informant, greater trust among communities, which saw that different actors sought to convey the same messages.

UNICEF also collaborates regularly with trusted and reliable community actors, including CBOs and religious leaders, who are supported to disseminate behaviour change communication in trusted spaces – for example, as highlighted by one focus group of community members, after the Friday afternoon prayer in the local mosques. These efforts, which are coordinated through the One Health forum, were noted by One Health members to have been effective at raising community awareness about preventive measures and what to do in case of symptoms.

The use of evidence to inform RCCE has led to significant improvements in the relevance and quality of the materials produced. There is, however, a need for UNICEF to ensure that it continues to conduct research on a regular basis so that its messaging remains up to date and reflects changes in behaviour or attitudes.

5.2 Assessment of response

As set out in the inception report for the evaluation, the benchmarks defined in the Core Commitments for Children in Humanitarian Action are used to provide judgement criteria against which PHE

response is assessed in the case studies. Table 6 details the Core Commitments for Children, their corresponding benchmarks and the summary assessment of the extent to which each benchmark was met in the context of the multiple PHEs affecting Guinea in 2021–2022.

Table 6. Summary of assessment of the PHE response in Guinea in 2021–2022 (against the Core Commitments for Children in Humanitarian Action)

Core Commitments for Children	Benchmarks	Extent to which benchmarks have been achieved
1. Coordination and leadership Effective coordination is established with government and partners.	1a) Interagency and intersectoral coordination mechanisms, including cross-border mechanisms, are in place and allocate clear roles and responsibilities across sectors, without gaps or duplications	1a) This benchmark has largely been met. According to respondents, interagency and intersectoral coordination mechanisms are in place and operating effectively in Guinea, with roles and responsibilities clearly defined across sectors. Some efforts at cross-border coordination have been made, including through the creation of a cross-border coordination mechanism, which is supplemented by conferences such as the National Forum on the Management of Multiple and Simultaneous Epidemics, which took place from 16 to 18 November 2022 in Conakry, with delegates from neighbouring countries. There is insufficient evidence to comment on the effectiveness of the cross-border mechanism.
	1b) UNICEF-led sectors are adequately staffed and skilled at the national and subnational levels	1b) There is insufficient evidence to comment on this benchmark.
	1c) UNICEF core leadership and coordination accountabilities are delivered	1c) This benchmark has been partially met. In regions where UNICEF has a direct presence, such as Nzérékoré, its leadership and coordination abilities are well recognized and appreciated. In areas like Faranah, however, where UNICEF operates from its Kankan base, evidence indicates that there were some accountability gaps to its responses to the Lassa fever outbreak.
	1d) Surge deployments and emergency procedures are activated on a 'no-regrets' basis	1d) Surge deployments and emergency procedures were activated in 2021 on a no-regrets basis.
	1e) In case of the activation of the Inter-agency Standing Committee Protocol for the Control of Infectious Disease Events, response modalities and capacities are adapted and scaled up accordingly ⁵	1e) There is insufficient evidence to comment on this benchmark.

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2. Risk communication and community engagement (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.	2a) Communities are reached with gender- and age-sensitive and socially, culturally and linguistically appropriate and accessible messages on disease prevention and to promote the continued and appropriate use of health services	2a) This benchmark has been met. In 2021, communities were reached with tailored and appropriate messaging based on community-based research conducted by the UNICEF Communication for Development (C4D) team on risks, concerns and existing behaviours. RCCE was delivered by local actors trusted by the communities, including women's and youth groups, religious leaders and members of the internal diaspora.
	2b) Local actors are supported and empowered to raise awareness and promote healthy practices	2b) This benchmark has been met. UNICEF is recognized by a range of local community-based organizations (CBOs) and civil society organizations (CSOs) for its efforts to support them to raise awareness, through its financing and technical support for RCCE.
	2c) Systems are in place to allow communities to guide the response and provide feedback for corrective action	2c) Since the 2014–2016 Ebola virus disease (EVD) outbreak, when communities were not initially consulted, leading to fear, panic and hostility towards health workers, UNICEF and other actors have significantly improved their consultation practices with local communities, with positive results. While there remains room for improvement, this benchmark can be considered partially met.
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.	3a) The risk of geographical spread of the outbreak and its potential impact are monitored, to inform early response and preparedness in at-risk areas	3a) This benchmark has been met. Risks are now monitored through a surveillance system that extends from the public health emergency operations centres (PHEOCs) at the national and district levels, to the regional and prefectural epidemic alert response teams (ERARE and EPARE), down to community surveillance under the One Health platform and units established by UNICEF.
	3b) Specific needs and vulnerabilities of women and children are considered in prevention and treatment protocols, including in the design of patient-centred treatment programmes	3b) This benchmark has been partially met. Improvements have been made in identifying and addressing the specific needs of women and children in UNICEF activities, although continued attention to the specific needs of women and children – through the systematic integration of gender mainstreaming – would further improve PHE responses.
	3c) Communities directly affected by the public health emergency (PHE) are reached with infection prevention and control (IPC) activities, including the provision of critical medical and water, sanitation and hygiene (WASH) supplies and services at the facility, community and household levels and in public spaces	3c) This benchmark was met during the responses to the 2021 outbreaks covered by this case study. IPC activities conducted at the community level in schools and health facilities and directly with individuals are perceived as having contributed to prevent the spread of epidemic diseases.

ASSESSMENT OF PREPAREDNESS AND RESPONSE TO THE 2021 OUTBREAKS

	3d) Psychosocial support (PSS) services that contribute to reduce transmission and PHE-related morbidity are accessible to individuals and families directly or indirectly affected by the PHE	3d) This benchmark was partially met. UNICEF PSS is a valued support for affected individuals and their communities and is appropriately adapted to the Guinean cultural context. Community focus group discussion (FGD) respondents felt that the PSS services provided were well adapted to sociocultural norms, addressing specific fears or factors related to stigmatization. No PSS was provided in Faranah in response to the Lassa fever outbreak.
	3e) Children directly affected by the PHE receive an integrated package of medical, nutritional and psychosocial care	3e) This benchmark was partially met, with UNICEF supporting the delivery of an integrated package of medical, nutritional and psychosocial support in affected communities; Faranah was the exception.
	3f) Front-line workers at the facility and community levels are trained in IPC and provided with personal protective equipment (PPE) appropriate to each situation and role	3f) This benchmark has been partially met. The provision of PPE does not seem to have been an issue during the outbreaks of 2021. Although there have been improvements since 2014, there remain some challenges in ensuring the proper use of PPE by all front-line workers.
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.	4a) Needs assessments are conducted early and regularly to ascertain the impact of the outbreak on the population, humanitarian needs and underlying needs not yet addressed	4a) This benchmark has been partially met. UNICEF conducts needs assessments early on in PHEs to determine the impact of outbreaks, as well as humanitarian and underlying needs. In certain instances, as with the 2021 EVD outbreak, gender specialists are involved in the needs assessment, but this practice is not yet standardized. Furthermore, following the initial needs assessment, additional needs assessments are not always conducted consistently, which can result in an inability to address the full range of needs that may emerge following the onset of an outbreak.
	4b) Essential services and humanitarian assistance, in the areas of health, WASH, nutrition and HIV/AIDS, are maintained and scaled up as necessary, and communities can access them in a safe and equitable manner	4b) This benchmark has been largely met. In 2021, UNICEF effectively supported the continuity of essential services through its work with the government and through its financial and technical support to CSOs and CBOs providing essential services at the community level.
	4c) Protection services, including case management and PSS services, are accessible to individuals and their families in a safe and equitable manner	4c) This benchmark has been partially met. Protection services are provided to individuals and their families on an as-needed basis, with the provision of PSS targeted at children and families directly affected by outbreaks, such as the EVD outbreak in 2021. All community FGD respondents felt that the provision of PSS was done fairly. The exception to this is Faranah, where the One Health members interviewed stated that UNICEF did not provide PSS.

4d) Continued and safe access to education is maintained	4d) This benchmark was met in 2021. Following the school closures in 2020 due to the COVID-19 pandemic, UNICEF engaged in advocacy to promote the reopening of schools and to advocate for them to remain open during subsequent outbreaks and PHEs.
4e) Existing social protection mechanisms are maintained and expanded as necessary, including through establishing or scaling up humanitarian cash transfers	4e) This benchmark was largely met. Social protection mechanisms have been maintained during emergencies and expanded to meet the needs of affected households.

5.3 Coordination and leadership

According to respondents, interagency and intersectoral coordination mechanisms are in place and operating effectively in Guinea, with roles and responsibilities clearly defined across sectors. UNICEF plays a recognized and well-appreciated coordination and leadership role through its position as co-lead of the IPC/WASH, RCCE and PSEA technical sectoral groups, and as lead of the United Nations pillar on RCCE. It is recognized as both a critical counterpart to the government and an essential support to local actors such as local NGOs and CBOs, contributing to a largely effective multisectoral approach. Several UNICEF staff noted that roles and responsibilities are perceived as being clear, thanks to defined and available terms of reference.

Due to the porous borders between Guinea, Liberia and Sierra Leone, cross-border coordination and communication is essential to combat the spread of epidemic diseases. A cross-border coordination mechanism has been established and is supplemented by regular conferences such as the National Forum on the Management of Multiple and Simultaneous Epidemics, which took place from 16 to 18 November 2022 in Conakry, with delegates from neighbouring countries. The conference itself was mentioned by several UNICEF staff as an example of a cross-border coordination mechanism. Additional measures could be taken to strengthen this joint collaboration, however – for example, by jointly conducting simulations.

Surge deployments and emergency procedures were activated on a no-regrets basis to support PHE responses in Guinea in 2021–2022. Staff were deployed from the UNICEF Guinea Country Office to zonal offices to support data collection and response, and Guinea was also supported through surge deployments from the UNICEF headquarters and other country offices such as that of the Democratic Republic of the Congo. These staff, particularly when deployed early in the responses, were seen as particularly valuable in supporting an effective response. One UNICEF respondent noted, however, that the effectiveness of surge staff was, at times, limited by their inability to speak the local languages or understand the local context.



As soon as the Ebola outbreak struck, we received intensive WASH support from the regional office for two weeks. It was a critical period, and the Geneva colleagues also came to support, taking into account the specifics of the context, the scope of the emergency and the existing needs.”
– UNICEF informant

While UNICEF leadership was largely lauded during the FGDs and KIIs, respondents in the Faranah FGD were less impressed by UNICEF leadership, noting that it had been undermined by the organization's lack of follow-through after conducting an initial needs assessment at the onset of the Lassa fever outbreak and then some initial activities such as the disinfection of homes. The respondents felt that this led to a breakdown of trust between their community and the actors involved in the PHE response. This highlights the critical importance of UNICEF maintaining a presence in local communities, at a minimum by establishing a community focal point in communities that are directly affected by localized outbreaks, as was the case with the Lassa fever outbreak in 2021.

Finally, UNICEF took some important steps both to strengthen its internal accountability mechanisms and to ensure that greater attention is paid to PSEA. The creation of a complaint mechanism and hotline was overdue, but their introduction is important, particularly in a year that saw multiple outbreaks, increasing the number of vulnerable individuals. One Health members who participated in the PSEA training found it interesting, but one key informant noted that the lack of mechanisms for participants to disseminate key PSEA messages more widely limited the training's usefulness.

“ The latest responses have given a fundamental place to the generation of evidence, which has made it possible to reorient and better know the communities, to see how to better define the strategies for moving forward. Several studies with research institutions have also helped to review the best strategies ... We also supported a synergy for the SitReps, not only taking in all the UNICEF components but also showcasing the activities by all the partners.” – *UNICEF informant*

Risk communication and community engagement

RCCE is considered by respondents to be a strength of UNICEF. Since the 2014–2016 EVD epidemic, during which UNICEF and other actors initially failed to take into consideration sociocultural factors and the importance of community engagement, RCCE has been integrated meaningfully into UNICEF activities. According to several UNICEF respondents, the organization's C4D team and socioanthropologists now systematically conduct research to better understand community perspectives and behaviours, and seeks to involve community members, like religious leaders, members of the internal diaspora, and women's and youth groups, in the dissemination of key prevention messages. Risk communication is tailored to the findings of these socioanthropological studies and disseminated successfully through various means such as radio programmes, picture boards and influential community members – for example, religious leaders speaking to community members after the Friday prayers at local mosques.

“ One of UNICEF's strengths is the availability of resource persons, for example, with C4D, which provide technical support to our work.” – *Local NGO respondent*



Two respondents from local CBOs noted that the recruitment by UNICEF of significant numbers of community ambassadors and C4D staff had contributed to its ability to reach communities with gender- and age-sensitive materials.

Extensive work by UNICEF to support and empower local actors to both raise awareness and promote healthy practices has been successful and has contributed significantly to community engagement. As highlighted by a UNICEF respondent, this has included conducting advocacy with both national and local authorities to ensure that women, youth and people with disabilities are not only consulted on but also involved in the leadership of PHE responses. This approach was deemed to be effective, as the integration of issues of gender into the government's response to the Lassa fever outbreak was noticeably better than for the EVD outbreak of 2014–2016. This progress could be further ingrained, however, through continued advocacy and engagement on issues of gender.

“The regional office is very involved, but the gender issue at this level is not systematically integrated into the agenda. Technical assistance [on gender] could be strengthened from colleagues at headquarters ... Headquarters or regional office support carries additional weight.”
– *UNICEF respondent*

Since the 2014–2016 EVD outbreak, when communities were not initially consulted, leading to fear, panic and hostility towards health workers, UNICEF and other actors have significantly improved their consultation practices with local communities, with positive results.

Strengthened public health responses

Public health responses have been strengthened significantly in Guinea since the EVD outbreak of 2014–2016. From planning and prevention to care and treatment for at-risk and affected populations, PHE response has been strengthened by the extensive lessons drawn by the country from its experience of that EVD outbreak. Close collaboration between UNICEF and the national government and with a wide range of local actors contributed effectively to strengthen public health responses and contain the outbreaks in 2021.

“There has been an effort to incorporate issues specific to children and women. It's written in the protocols, and everyone sees that. But translating these protocols into action is where it remains a challenge. We see on the ground with the issues of safeguards, for orphans or unaccompanied children ... on paper the protocol can be solid, but putting it into practice ... there is a lack of training or human resources, which remains the major challenge.”
– *UNICEF respondent*

Risks are now monitored through a surveillance system that extends from the PHEOCs at the national and district levels, to the regional and prefectural epidemic alert response teams (ERARE and EPARE), down to community surveillance under the One Health platform and units established by UNICEF. Furthermore, in the response to the 2021 EVD outbreak, this system was supplemented by a 'green number', a hotline set up to allow individuals to alert health services about any health event in their community (Keita et al., 2023). Both UNICEF key informants and One Health FGD respondents credited this improved surveillance capacity for the rapid detection of the epidemic disease outbreaks of 2021–2022 and for preventing their spread beyond the region where each disease had first been found. In their article 'Guinea's Response to Syndemic Hotspots', however, Kolie et al. highlight the inadequate financing of ERARE and EPARE, noting that "at the time of notification [of the first EVD case in February 2021], ERARE and EPARE programmes had not been financially supported for almost 3 years" (Kolie et al., 2021).

Improvements have been made in identifying and addressing the specific needs of women and children in UNICEF activities, although continued attention to the specific needs of women and children – through the systematic integration of gender mainstreaming – would further improve PHE responses. FGD respondents felt that UNICEF had been important in supporting the delivery of an integrated package of medical, nutritional and psychosocial support in affected communities; Faranah was the exception.

IPC activities conducted at the community level in schools and health facilities and directly to individuals are perceived as having contributed to prevent the spread of epidemic diseases. Indeed, respondents in one community FGD noted that enhancing or building WASH facilities in schools, health facilities and other community structures, like mosques, helped to contain the epidemics. One Health respondents in one FGD also talked about how UNICEF WASH activities, combined with its advocacy efforts, helped to protect vulnerable people, including people with disabilities. Providing refresher IPC trainings to health professionals was also seen as a valuable approach, as it has contributed to strengthen not only IPC measures but also risk communication. Collaboration with community-level actors was considered effective, and UNICEF should continue to support local actors to build local capacities for IPC, as the dissemination of key safety messages through trusted community members is the most effective and sustainable way to promote safe behaviour.

It should be noted that in communities that have previously been sites of outbreaks, such as Guéckédou, the epicentre of the 2014–2016 EVD outbreak, individuals are particularly aware of the specific risks and symptoms associated with the relevant disease. UNICEF could, however, take additional steps to reinforce its IPC measures in other communities that have been unaffected to date and are less familiar with IPC practices as a result.

UNICEF PSS is a valued support for affected individuals and their communities and is appropriately adapted to the Guinean cultural context. Community FGD respondents felt that the PSS services provided were well adapted to sociocultural norms, addressing specific fears or factors related to stigmatization, such as the belief that witchcraft was behind specific cases. Respondents also appreciated that the PSS provided was respectful of religious leaders and community elders. In one community FGD, respondents also talked of how PSS house visits served to not only reassure households but also contribute to the sharing of key messages about risks and preventive measures. No PSS was provided in Faranah in response to the Lassa fever outbreak. UNICEF should ensure that it has sufficient resources to provide appropriate PSS as part of an integrated package of support for children directly affected by PHEs.



Finally, the provision of PPE does not seem to have been an issue during the outbreaks. Although there have been improvements since 2014, there remain some challenges in ensuring the proper use of PPE by all front-line workers, as highlighted by one UNICEF respondent. Additional trainings and awareness-raising activities were conducted by UNICEF in response to high infection numbers at the beginning of the epidemics, effectively leading to a subsequent reduction in infection among front-line workers.

The cash transfers provided by UNICEF to vulnerable households affected by EVD will have been a valuable resource, and one respondent noted that the collaboration between UNICEF and the World Bank on emergency cash transfers to vulnerable households in Conakry had been a success. Insufficient evidence was collected, however, to enable an assessment of the UNICEF cash transfer as part of its broader PHE response.

Continuity of essential services and humanitarian assistance

UNICEF effectively supported the continuity of essential services through its work with the government and through its financial and technical support to CSOs and CBOs providing essential services at the community level. Although one key informant from a local NGO felt that there had been some disruption to the continuity of essential services, respondents were positive overall, noting that UNICEF had done its best and had been effective at supporting national actors. One UNICEF respondent did state that UNICEF often tried to do too much and stretched itself too thin, but others felt that UNICEF collaboration with government agencies, particularly on social protection, had been invaluable. At the local level, UNICEF efforts to empower CBOs and CSOs were instrumental in ensuring that multiple actors had the capacity to react, thereby contributing to a rapid first response and to minimize gaps in service delivery.

“ There is a tendency to want to resolve everything and to do it all immediately.”
– UNICEF informant

UNICEF conducts needs assessments early on in PHEs to determine the impact of outbreaks, as well as humanitarian and underlying needs. In certain instances, as with the 2021 EVD outbreak, gender specialists are involved in the needs assessment, but this practice is not yet standardized. Furthermore, following the initial need assessment, additional needs assessments are not always conducted consistently, which can result in an inability to address the full range of needs that may emerge following the onset of an outbreak. Consistently including gender specialists in all needs assessments, and ensuring that such assessments are conducted periodically during PHEs, will further strengthen the relevance of UNICEF activities.

Protection services are provided to individuals and their families on an as-needed basis, with the provision of PSS targeted at children and families directly affected by outbreaks, such as the EVD outbreak in 2021. All community FGD respondents felt that the provision of PSS was done fairly; they understood why certain households benefited from protection services while others did not, and they did not convey any sense of inequality at having (or not having) accessed these services.



Following the school closures in 2020 due to the COVID-19 pandemic, UNICEF engaged in advocacy to promote the reopening of schools and to advocate for them to remain open during subsequent outbreaks and PHEs. Essentially, keeping schools open contributed to reduce the gender inequalities that often emerge when schools are closed and young girls are pushed into forced marriages or labour, resulting in teenage pregnancy or gender-based violence. The mapping exercise that UNICEF conducted of youth and women's organizations providing child and social protection services was useful when it came to supporting appropriate response and referral pathways for survivors of GBV. Furthermore, UNICEF successfully used schools as a forum for IPC activities, contributing to the further containment of the spread of disease.

Social protection mechanisms have been maintained during emergencies and expanded to meet the needs of affected households. Cash transfers have been provided to households in need, for example, during the EVD outbreak of 2021 in Nzérékoré. These are overseen by the Protection Department in collaboration with other departments and actors leading the PHE response. Cash transfers were also provided to vulnerable households in Conakry, and while UNICEF was not directly involved in their distribution, it did engage with the government to advocate for a more formal cash transfer mechanism.



Evidence summary for the PHE evaluation

This section summarizes evidence obtained from this case study of Guinea against the evaluation questions for the Evaluation of UNICEF Work in Public

Health Emergencies as a whole. This summary is one source of evidence that has informed the development of the consolidated evaluation findings.

6.1 Relevance

Evaluation question	Evidence summary
A. Relevance: The extent to which UNICEF work on public health emergencies (PHEs) in Guinea 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 work on PHEs in Guinea been aligned with the needs and priorities of those most at risk and affected by PHEs (especially children and other vulnerable groups)?	While respondents generally answered that UNICEF, as the United Nations agency working on child rights and protection, aligned its work closely with the needs and priorities of children and other vulnerable groups, the limited availability of gender- and age-disaggregated data at the national level and an inconsistent deployment of needs assessments inevitably affected the ability of UNICEF to systematically identify, and therefore meet the needs of, the most at risk and affected by PHEs. The introduction of a Gender Unit in Conakry and the participation of unit members in strategic meetings and during needs assessments has, however, gone some way to improve the alignment of UNICEF activities with the needs of the most vulnerable in recent years.
A.2 To what extent has UNICEF work on PHEs in Guinea contributed to a common vision among national government policies and plans?	A recurring theme in interviews was the way in which UNICEF work in Guinea was intended to support the government, and therefore aligned itself to the government's priorities, policies and plans. While some significant political developments occurred in 2021 – the coup on 5 September and the dissolution of the Ministry of Water and Sanitation – which inevitably affected planning processes and the coordination of some activities, UNICEF continued to be seen as a reliable partner for the government and continued to work closely with and support entities like the National Agency for Health Security (ANSS). UNICEF supports both the development and implementation of national plans related to development and PHE.

A.3 How successfully and in what ways has UNICEF adapted its work on PHEs in Guinea to evolving circumstances and changing needs and priorities?

UNICEF has been largely successful in adapting its work to evolving circumstances and changing needs and priorities in Guinea. The existence of terms of reference, action plans and planning documents for Ebola virus disease led to their easy adaptation for subsequent outbreaks of Lassa fever and Marburg virus disease, enabling UNICEF to adapt to emerging PHEs and their corresponding needs, work that was further informed by rapid needs assessments.

6.2 Effectiveness

Evaluation question	Evidence summary
B. Effectiveness: The extent to which UNICEF work on public health emergencies (PHEs) in Guinea 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 PHEs in Guinea?	Overall, UNICEF was mostly effective in its contributions to improving preparedness for PHEs in Guinea.
B1.1 What factors have facilitated or constrained this contribution?	This contribution was facilitated by: greater dedication to PHE preparedness at the government level, in the form of the instatement of a dedicated government agency, the National Agency for Health Security (ANSS), and its sub-entities, including the public health emergency operations centres (PHEOCs) and regional and prefectural epidemic alert response teams (ERARE and EPARE) with surveillance responsibilities; the development of strategic plans at the national level detailing roles and responsibilities; improved monitoring, evaluation and surveillance at the national level; significant improvements in community capacities for PHE risk monitoring; and the delivery of appropriate risk communication and community engagement (RCCE) through tailored communication mediums. Simultaneously, the impact of this contribution was constrained by: the lack of financial investment or ability to allocate resources to PHE preparedness at the national level; the limitations of Guinea's health systems, and its limited resources for investing in health, child protection, education and water, sanitation and hygiene (WASH); poor pre-positioning capabilities owing to limited storage space and depleted stockpiles; time delays when placing international orders of supplies; and incomplete data and weaknesses in information management.
B.2 To what extent and how has UNICEF contributed to effective response to PHEs in Guinea through its partnerships and programmes?	Overall, UNICEF was mostly effective in its contributions to PHE responses in Guinea in 2021–2022.

B.2.1 What factors have facilitated or constrained response?	This contribution to PHE response was facilitated by: the strong coordination and leadership role of UNICEF, which was well appreciated by partners; enhanced cross-border coordination; the support of headquarters, regional office and surge staff, and knowledge sharing by Democratic Republic of the Congo colleagues; the implementation of lessons learned from the responses to the 2014–2016 Ebola virus disease outbreak and the COVID-19 pandemic in 2020, which allowed Guinea to benefit from recently set up laboratories and other health structures; and close engagement with communities, women’s and youth groups and the internal diaspora. Response was also stronger in areas where UNICEF had a suboffice and therefore an existing presence on the ground. At the same time, the response was constrained by a number of factors, including incomplete data and insufficient follow-up needs assessments. Additionally, the response in Faranah was affected by the lack of a direct UNICEF presence on the ground; respondents there noted that UNICEF had conducted a needs assessment following the outbreak of Lassa fever, but that no follow-up activities were conducted.
B.3 How well has UNICEF supported innovation, including product innovation and appropriate use of new technologies, to respond to PHEs in Guinea and mitigate their impacts?	According to the UNICEF End of Year Summary for Guinea, UNICEF innovations related to health have primarily been in preparedness activities such as digitalizing social services, including by sending automated voice message reminders of vaccination appointments and introducing the use of digital data collection. They also include innovations in WASH, such as using “mixed solar water supply technology at scale” to improve the sustainable access to safe drinking water in hard-to-reach areas (UNICEF Guinea, 2021a). The UNICEF End of Year Summary for Guinea details the way in which UNICEF Guinea adapted its practices and activities to respond to the new demands of the COVID-19 pandemic. It describes the use by UNICEF of telephone surveys and virtual questionnaires to collect data on the performance of its interventions on a monthly basis, thereby demonstrating the organization’s capacity to produce quality evidence on a regular basis using technological innovations. Limited information was available, however, about innovations in light of the outbreaks of 2021–2022 covered by this case study. There is therefore insufficient evidence available to report against this evaluation question about the use of innovation in response to PHEs.
B.4 To what extent is UNICEF work on PHEs in Guinea informed by evidence, including from evaluation, research and integrated multi-sector outbreak analytics?	UNICEF work on PHEs is informed by evidence, with needs assessments conducted at the onset of outbreaks; socioanthropological research used to inform the development of RCCE materials and UNICEF activities and partnerships; and joint analysis undertaken with other actors informing response. PHE response has relied on needs assessments undertaken at the onset of outbreaks, however, whereas regularly updating such assessments through further data collection would allow UNICEF to adapt and respond to any emerging or evolving needs. Data have also not been consistently and sufficiently disaggregated to allow a full understanding of needs. While one respondent noted an improvement in the way in which data are both disaggregated and used, the individual also mentioned that further improvements could be made.

6.3 Efficiency

Evaluation question	Evidence summary
C. Efficiency: The extent to which UNICEF has made optimal use of its human and financial resources to respond to public health emergencies (PHEs) in Guinea	
C.1 To what extent has UNICEF had the right people, systems and structures in place to contribute to preparedness and effective response to PHEs in Guinea?	Respondents generally felt that the UNICEF systems and structures were clear, with the Emergencies Unit overseeing and coordinating PHE responses effectively. UNICEF staffing and skills (complemented by surge arrangements) appear to have been sufficient to contribute to effective preparedness and response.
C1.1 What factors have influenced UNICEF staffing, systems and structures in relation to PHEs in Guinea?	The Ebola virus disease outbreak of 2014–2016 led to a wide range of learning opportunities and multiple recommendations to improve UNICEF staffing, systems and structures. Many of these recommendations have been implemented, contributing to significantly better PHE preparedness and response for the outbreaks of 2021–2022.
C1.2 How have staffing issues affected UNICEF work on PHEs in Guinea?	There do not appear to have been any negative impacts on UNICEF work on PHEs in Guinea as a result of staffing issues, although a lack of local language skills constrained the effectiveness of some surge staff.
C.2 How appropriate, clear and well aligned have been the activities and approaches among different divisions and offices within UNICEF in relation to PHEs in Guinea? How well have the headquarters and regional offices supported the UNICEF Guinea Country Office?	UNICEF respondents generally felt that the division of roles and responsibilities between the country office and zonal offices is clearly established in job descriptions and contingency plans, which detail the responsibilities of each department. They noted that it is clear that the Emergencies Unit is responsible for coordinating multisectoral UNICEF responses, and that the coordination mechanisms in place in Guinea generally work well. Respondents felt that the headquarters and regional offices provide invaluable support through regular calls to discuss technical or financial matters and through support on needs assessments, risk communication and community engagement and plan development. They did note that there can be discrepancies, at different levels, between how actions and approaches are described in preparedness or contingency plans and how they are implemented in the face of a PHE, with swiftness of action a particular issue. One respondent noted that language can also prove to be a barrier between headquarters, regional and country office staff.
C.2.1 What factors have influenced organizational relationships?	There is insufficient evidence available to report against this evaluation question.
C.2.2 How have relations between different parts of UNICEF affected its work on PHEs in Guinea?	There is insufficient evidence available to report against this evaluation question.

EVIDENCE SUMMARY FOR THE PHE EVALUATION

C.3 To what extent were supply operations, including local and international procurement, efficient in providing timely inputs to address PHEs in Guinea?	Respondents felt that the existence of long-term agreements should have contributed to the rapid procurement and delivery of equipment and materials. In reality, however, procurement processes were sometimes slow and, in particular, the need to sometimes place international orders delayed the staff's ability to respond while awaiting delivery of supplies.
C.3.1 What factors have influenced supply performance in responding to PHEs in Guinea?	The poor quality of supplies available on the local market, international procurement, and diminishing supplies of pre-positioned stocks all negatively affected supply performance.
C.3.2 How has the performance of supply operations affected UNICEF work on PHEs in Guinea?	Delayed delivery of key materials and supplies had some knock-on effect on the effectiveness of UNICEF work.
C.4 How efficiently were funds mobilized, allocated and used to address PHEs in Guinea?	UNICEF has contributed to fund its own public health interventions and has done well in terms of fundraising for surveillance and response. Recent examples include fundraising for the development of the vaccination deployment plan and recent vaccination campaigns, infection prevention and control, social mobilization for behaviour change, and the implementation of the accelerated measles outbreak control plan. Several staff noted, however, that setting up a permanent emergency fund for PHEs would be beneficial. Furthermore, UNICEF remained constrained by the fundraising gap in its humanitarian appeal for 2021, having raised US\$7.9 million against its appeal target of US\$11.8 million, leaving a shortfall of US\$3.9 million – a significant amount, representing 33% of the total appeal value (UNICEF, 2021c). In general, respondents from local organizations appreciated UNICEF financial support and felt that it was sufficient and that it enabled them to deliver activities as planned. Two respondents noted that the process for obtaining funds was slow and delayed their ability to implement activities – in one case, however, the respondent noted that this delay may have been beyond the control of UNICEF.
C.4.1 What factors have influenced financial management performance in relation to PHEs in Guinea?	There is insufficient evidence available to report against this evaluation question.
C.4.2 How has financial management affected UNICEF work on PHEs in Guinea?	There is insufficient evidence available to report against this evaluation question.

6.4 Coherence

Evaluation question	Evidence summary
D. Coherence: The extent to which UNICEF has designed, implemented and monitored its work on public health emergencies (PHEs) in Guinea in coherence and coordination with other PHE actors, and uses its comparative advantage	
D.1 To what extent was UNICEF work in relation to PHEs in Guinea coherent with the activities, approaches and responses of partners?	UNICEF partners include the Government of Guinea, other international actors and local non-governmental organizations and community-based organizations (CBOs) and, overall, the partners' work is well coordinated and coherent. UNICEF collaborates closely with government departments and entities, including the National Agency for Health Security (ANSS), and its activities are aligned and coherent with government plans and priorities. UNICEF work on PHEs with international actors is coordinated through the relevant clusters and working groups, with UNICEF as lead for water, sanitation and hygiene, risk communication and community engagement, infection prevention and control and child protection. There is a sense that UNICEF sometimes attempts to do too much and should instead focus on its area of comparative advantage. One respondent noted, however, that because the World Health Organization (WHO) had struggled to raise sufficient funds in 2021–2022, UNICEF had to step in when WHO should have been the entity to take the lead in the overall PHE responses. At the regional administrative level, there also exist Public Health Emergency Operations Centres (Centres d'Opérations d'Urgences de Santé Publique), which UNICEF co-leads. Through these operations centres, UNICEF and partners offer capacity building and training to national partners, strengthening their capacity to respond. In 2022, as part of the organization of the National Forum on the Management of Multiple and Simultaneous Epidemics, the following entities technically supported the work of the 12 pillars of WHO for the response to epidemics: WHO; World Bank; Centers for Disease Control and Prevention; Food and Agriculture Organization of the United Nations; International Organization for Migration; Gavi, the Vaccine Alliance; Expertise France; Pasteur Institute; Alliance for International Medical Action; European Union; Atrial Fibrillation Network; Centre de Recherche et de Formation en Infectiologie de Guinée; National Institutes of Health (United States); Médecins Sans Frontières; United States Agency for International Development; Red Cross Society of Guinea. Local civil society organizations and CBOs played a significant part in the general response to PHEs in 2021–2022, and the support they have received from UNICEF – both financial and technical – has been instrumental to the success of their responses.
D.1.1 What factors affected the extent of coherence?	Coherence has been improved as a result of the lessons learned from the 2014–2016 Ebola virus disease outbreak. That experience highlighted the need for better coordination and communication, leading to the introduction of the One Health platform, which has played a key coordinating role since. In addition, biweekly and ad hoc emergency meetings to coordinate responses, working committees, and WhatsApp groups to support immediate communication have contributed to more coherent responses. Capacity building of national actors, delivered by UNICEF and other international partners, has contributed to improve coherence as it has enabled national partners to take the lead in community responses. One respondent also noted that the sharing of experience has helped organizations to learn from one another and therefore be more coherent in their response.
D.1.2 How has the level of coherence affected UNICEF work on PHEs in Guinea?	Coherence with national actors contributed to the generally effective response to the PHEs of 2021–2022. Community engagement and service delivery through national actors, with support from UNICEF, enabled a rapid and trusted response.

D.2 To what extent has the UNICEF role (including its leadership role) in addressing PHEs in Guinea reflected the organization's comparative advantage?	Respondents generally felt that UNICEF leadership and technical roles in addressing PHEs reflected the organization's comparative advantage. Several noted, however, that they felt UNICEF attempted to do too much and should instead focus on its strengths.
D.3 To what extent has UNICEF provided effective leadership and coordination in addressing PHEs in Guinea?	The leadership and coordination role of UNICEF in Guinea is generally recognized and appreciated. In one community in Faranah, however, respondents noted that this leadership role is undermined when UNICEF conducts needs assessments but does not subsequently deliver activities or services to meet the identified needs.

6.5 Gender, equity and rights

Evaluation question	Evidence summary
E. Gender, equity and rights: The extent to which gender, equity and rights (particularly the Core Commitments for Children in Humanitarian Action) are reflected in UNICEF work on public health emergencies (PHEs) in Guinea	
E.1 To what extent and how has UNICEF work on PHEs in Guinea contributed to protect children, women and adolescent girls and other vulnerable groups?	Respondents felt that UNICEF work on PHEs had contributed to protect children, women and adolescent girls and other vulnerable groups. They gave examples of UNICEF work to support school reopening during epidemics and to ensure a multisectoral approach to children's needs, rather than a focus on health alone. They spoke of close support to ministries working on gender, including during the COVID-19 emergency, when UNICEF conducted trainings to strengthen the government's capacity to integrate gender into its response. UNICEF successfully mobilized 300 women in Conakry, to train them to lead awareness-raising activities on COVID-19 and gender-based violence (GBV). UNICEF also led trainings on how to integrate a gender lens with a variety of public service providers active at the national level. During the Ebola virus disease outbreak of 2021, UNICEF received funds from the Central Emergency Response Fund to strengthen the ability of authorities and civil society organizations to integrate gender into and include women in their responses. According to one respondent, improvements could subsequently be detected during the Lassa fever response. UNICEF conducted a range of activities to raise awareness about GBV amid PHEs, including risk communication on the link between epidemics and gendered violence, and led a mapping exercise to identify organizations that support women and youth to address GBV. UNICEF has also delivered training on the prevention of sexual exploitation and abuse (PSEA) to its staff as well as to members of the One Health forum, but these were not provided consistently to all One Health platforms. Despite these improvements, key informants believed more could be done to systematically assess, respond to and monitor the needs of vulnerable groups by ensuring that these considerations are integrated from the outset, and therefore built into all contingency and work plans, and by improving the monitoring of activities through the consistent disaggregation of data.

EVIDENCE SUMMARY FOR THE PHE EVALUATION

E.2 To what extent and how has UNICEF work on PHEs in Guinea been accountable to affected populations?	UNICEF work on PHEs in Guinea has sought to achieve accountability to affected populations, with a number of forums provided for community members to give feedback on UNICEF activities. Communities generally reported that they considered UNICEF accountable to them, but some weaknesses remain. For example, respondents in one community affected by Lassa fever were involved in a needs assessment but did not subsequently benefit from any activities to address their needs. Although UNICEF did support the identification of Lassa fever victims and then went on to disinfect the homes of affected households, respondents felt that this work was inadequate given that additional needs had been raised during the assessment.
E.2.1 What factors have influenced accountability?	Constraints on accountability to affected populations reflect the limited presence of UNICEF in the region. For example, UNICEF activities in Faranah are covered by its Kankan office, and this distance from the affected area inhibits the ability of UNICEF to respond in a timely or comprehensive manner. Inconsistent disaggregation of data further affects the organization's ability to be truly accountable. UNICEF did, however, take action to strengthen its feedback mechanisms in 2021, setting up both a complaint mechanism and an anonymous hotline (UNICEF, 2021b).
E.2.2 How has the level of accountability affected UNICEF work on PHEs in Guinea?	There is insufficient evidence available to report against this evaluation question.
E.3 To what extent and how has UNICEF work on PHEs in Guinea promoted and reflected gender, disability, age and human rights standards and commitments (including the Core Commitments for Children)?	Significant improvements have been made in terms of attention to gender, equity and rights in UNICEF preparedness and response to PHEs in recent years. The head of UNICEF Guinea's Gender Unit now participates in the committees and task forces for PHE responses and is therefore able to advocate for the integration of gender into needs evaluations, responses and reports. Despite these efforts, however, much remains to be done to fully integrate and mainstream gender and equity consistently into UNICEF work. While collaboration between the Gender Unit and the Child Protection Section is effective, some key informants believed that gender is not always recognized as a priority by other sections/units. Furthermore, while gender, equity and rights have been incorporated into UNICEF preparedness plans and prevention protocols, it has been challenging to translate these plans and protocols into action, particularly in emergency settings. While policies may exist on safeguarding, child protection and how to deal with unaccompanied children, a lack of adequate financial and human resources (caused by insufficient awareness-raising or training) leads to poor practical application of these policies. There is insufficient evidence to report against the UNICEF disability standards.
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 PHEs in Guinea?	In recent years, significant investments have been made to increase UNICEF Guinea's capacity and resources to address gender and equity. The UNICEF Guinea Gender Unit, established in July 2018, now has three staff members and receives additional support from headquarters, including through the recent deployment of a GBV specialist who provided technical gender mainstreaming support and PSEA training. These gender resources are, however, limited compared with existing needs, and are entirely based in Conakry. While staff can be deployed to other parts of Guinea, this leads to both inconsistent capacity and the irregular application of gender and equity principles across UNICEF work throughout the country.

E.4.1 What factors have influenced the level of capacity and resources to address gender, equity and rights in UNICEF work on PHEs in Guinea?	Lessons learned from previous outbreaks, as well as increased attention to gender, equity and rights across UNICEF, have contributed to improved capacity and resources for such work in the Guinea Country Office. At the same time, limited financial resources and a management team intent on trying to balance competing priorities have meant that these themes are not always prioritized. Gender, equity and a rights-based approach should be integrated from the start of an intervention or planning process, to ensure that sufficient financial resources are set aside and that these themes are meaningfully integrated into UNICEF work on PHEs in Guinea.
E.4.2 How has the level of capacity and resources for gender, equity and rights affected UNICEF work on PHEs in Guinea?	While significant improvements have been made in recent years, the still insufficient level of capacity and resources for gender, equity and rights has meant that UNICEF cannot be certain that it is truly responding to the needs of the most vulnerable.

6.6 Sustainability

Evaluation question	Evidence summary
F. Sustainability: The extent to which the benefits of UNICEF work on public health emergencies (PHEs) in Guinea, including improved preparedness and system strengthening, are sustainable beyond the intervention period	
F.1 To what extent did UNICEF contribute to strengthening Guinea's health system to address PHEs?	UNICEF support has been important in strengthening Guinea's health system, particularly in terms of supporting the development of strategic plans; providing technical support to the National Agency for Health Security (ANSS), the Ministry of Health and Public Hygiene and other actors; its regular support to health, nutrition, child protection and other social services; and its focus on building community capacities for health.
F.1.1 What were the factors that supported or hindered this strengthening?	This system strengthening has been, and continues to be, hindered by the limited financial resources of the Government of Guinea. The lessons of the 2014–2016 Ebola virus disease outbreak have, however, provided a clear road map for how to strengthen Guinea's health system for enhanced preparedness and response to PHEs.
F.2 To what extent did UNICEF contribute to strengthen community systems and community engagement to address PHEs in Guinea and improve resilience?	UNICEF has played a significant role in strengthening community systems and community engagement to address PHEs in Guinea.
F.3 To what extent did UNICEF contribute to local ownership and capacity development in Guinea?	UNICEF has been an enabler of civil society, supporting local ownership of PHE response through capacity development on numerous elements of response, including risk communication, awareness raising, kit distribution, Communication for Development, training of community ambassadors, and infection prevention and control.

EVIDENCE SUMMARY FOR THE PHE EVALUATION

F.4 To what extent has UNICEF ensured linkages, coherence and mutual reinforcement of its response to PHEs in Guinea with longer-term development objectives?

UNICEF activities in Guinea are aligned with the National Economic and Social Development Plan, which is itself aligned with the Sustainable Development Goals.

F4.1 What factors have influenced the extent to which this has been achieved?

There is insufficient evidence to report against this evaluation question.



Conclusions

7.1 Conclusions on preparedness

Significant progress has been made in Guinea to strengthen national preparedness for PHEs through the definition of policies, strategies and coordination and planning mechanisms, particularly as a result of lessons learned from the 2014–2016 EVD outbreak and thanks to post-epidemic investments. Effective community-level communication mechanisms have also been developed, as have the capacities of the public health workforce. Surveillance systems, monitoring and evaluation, and WASH services have also been strengthened.

UNICEF has made important contributions to the improvement of national preparedness, including through support for the development of the planning framework and national response plans, pre-positioning of supplies, a community-based early warning system, and capacity development on RCCE and for local communities. The PHEOCs and One Health forum in particular are valuable resources for surveillance, preparedness and response.

Despite this progress, some important weaknesses in national preparedness remain – most notably the inadequate funding of preparation plans and related activities, as well as limited human resources for their implementation. This is reflected in the lack of a budget line for PHE preparedness and response in the national budget. The lack of consistent funding means that the One Health forum and other aspects

of local capacity (including ERARE and EPARE) tend not to function in between outbreaks, potentially limiting their effectiveness.

While preparedness plans have been developed to address EVD outbreaks, less attention has been paid to risks of and vulnerabilities to other potential epidemic diseases, and preparedness plans have not been systematically updated to reflect lessons learned from each PHE. The dismantling of the Ministry of Water and Sanitation may also threaten effective WASH service provision and the role of WASH in IPC to address outbreaks. Information systems produce inconsistent data on outbreaks and do not provide sufficiently detailed and disaggregated data to guide effective response. As yet, there is no effective system for monitoring and managing pre-positioned stocks to ensure sufficient and timely supplies when disease outbreaks occur.

UNICEF has strong relationships with the Government of Guinea and other partners and a trusted role in supporting national policies and capacities at the national and local levels. This means that the organization is well positioned to provide further support and advocacy to continue to strengthen national preparedness. Such support could include facilitating joint processes of reflection on lessons learned from each outbreak and response, as well as working with the government on the collaborative review and revision of preparedness plans and standard operating procedures. In addition, UNICEF

CONCLUSIONS

could support the government and other partners to ensure that strategies are devised to address weaknesses or gaps in existing plans and preparedness arrangements, including to overcome the currently inadequate financial provision.

7.2 Conclusions on response

UNICEF made important contributions to what are generally considered highly or mostly effective PHE responses to the 2021–2022 epidemic disease outbreaks reviewed. These contributions were based on strong leadership and coordination arrangements, with UNICEF as co-lead of the IPC/WASH, RCCE and PSEA technical sectoral groups and lead of the United Nations pillar on RCCE. UNICEF work at the community level was especially effective in supporting local response, although examples were found where community relations were damaged by a failure to follow up and deliver on initiatives taken at a local level.

Several areas were identified where performance could be strengthened. First, challenges were encountered when working in areas where UNICEF did not have a direct presence. Second, the available data were insufficiently disaggregated and needs assessments were not updated to reflect the experience of outbreaks as they occurred. Progress was made through the provision of PSEA training, but its reach could be extended; the recently established complaint mechanism has not yet been well publicized among communities. While UNICEF has contributed to greater awareness of gender issues (including GBV), more can be done to integrate gender, equity and rights into PHE preparedness and response, and to improve the available data to better inform action in this area.





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Appendix A: Key informants

Table A.1. Key informants interviewed

UNICEF key informants	
Name	Position
Henri Heikura	UNICEF Deputy Representative/Head of Operations
Adama Ouedraogo	Chief of Health Section
Hamidou Maiga	Chief of Water, Sanitation and Hygiene Section
Aliou Maiga	Chief of Child Protection Section
Théophile Bansimba	Chief of Nutrition Section
Liliana Liz Pardo Guerrero	Head of Gender Unit
Raymond Kodjovi Kouwonou	Head of Social and Behaviour Change Unit
Moise Tounkara	Head of Emergencies Unit
Abdoul Gadiy	Chief of Social Inclusion Section
Sékou Sidibe	Chief of Bureau, Kankan Office
Roger Lamah	Chief of Bureau, Zone Sud a.i.

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External key informants		
Name	Organization	Position
Thierno Hamidou Baldé	Zéro Pauvre en Afrique (non-governmental organization; NGO)	Executive Director
Lansana Diawara	Maison des Associations et Ong de Guinée (NGO)	Executive Director
Mady Blaise Sylla	Action pour le Développement et la Transparence (NGO)	Executive Director
Aboubacar Koita	Collectif des Jeunes pour la Cause de la République (NGO)	Executive Director
Sylla Salimatou	Association Nationale des Communes de Guinée (NGO)	UNICEF focal point
Dr. Abdoulaye Missidé Diallo	Ministry of Health and Public Hygiene	DGA/BSD
Dr. Facély Camara	Ministry of Health and Public Hygiene	DNASFN
Alhassane Traore	National Water Point Development Service	CDAF
Daniel Tinguiano	Ministry of Pre-University Education and Literacy	BSD
Youssouf Traoré	Red Cross Society of Guinea	President
Amadou Diallo	United Nations Resident Coordinator's Office	Humanitarian focal point
Abdoul Karim Hann	Ministry of Territorial Administration and Decentralization	Head of Department - Emergency Evaluation
Mohamed Toure	Ministry of Youth and Sports (Strategy and Development Bureau)	UNICEF focal point
Gueale Gbato Dore	Ministry of Information and Communication (Strategy and Development Bureau)	UNICEF focal point



Appendix B: Research instruments for key informant interviews

Research instrument for local non-governmental organization staff

Introductory questions

- ▶ Please state your name, your organization and your role in your organization.
- ▶ In what way do you work directly (or indirectly) with the United Nations Children's Fund (UNICEF)?

Preparedness

- ▶ How well prepared is Guinea to face multiple concurrent public health emergencies (PHEs)?
- ▶ In what way, and how effectively, did UNICEF work with national actors, including non-governmental organizations (NGOs) and community-based organizations (CBOs), to strengthen their capacity for preparedness and response?
- ▶ In what way, and how effectively, did UNICEF contribute to strengthening the national health system, to make it more resilient in times of PHE?

Response

- ▶ In your opinion, how was the overall, country-wide response to the concurrent PHEs affecting Guinea in 2021–2022?
- ▶ What is your opinion of UNICEF support to the national response to these multiple, concurrent PHEs? What could UNICEF have done better?
- ▶ Do you receive financial support directly from UNICEF? If yes, what is the process for requesting and receiving these funds during a PHE?
- ▶ In your opinion, how well did UNICEF do in terms of:
 - ▶ Risk communication and community engagement?
 - ▶ Prevention, care and treatment for at-risk and affected populations?
 - ▶ Ensuring continuity of essential services?
- ▶ Do you find UNICEF to be suitably accountable to affected populations?

Conclusion

- ▶ Is there anything that you think UNICEF should do more or less of?
- ▶ What lessons should UNICEF take from the experience to strengthen its overall response to PHEs going forward?

Research instrument for the UNICEF representative and deputy representative/head of operations

Introductory questions

- ▶ Please state your name and your role at the United Nations Children’s Fund (UNICEF).
- ▶ How long have you been working with UNICEF in Guinea?
- ▶ Have you worked with UNICEF elsewhere and, if so, in what capacity?

Preparedness

- ▶ UNICEF Guinea has a well-functioning annual emergency preparedness planning process, which seems to result in detailed and quality planning documents. How faithfully are these plans implemented throughout UNICEF preparedness and response activities? Why (or why not)?
- ▶ In your opinion, how well prepared was UNICEF to respond to concurrent public health emergencies (PHEs) in 2021–2022 in terms of:
 - ▶ Human resources?
 - ▶ Financial resources and access to/pre-positioning of relevant supplies?
 - ▶ Coordination with other actors?
- ▶ What challenges does UNICEF face in building national capacity and strengthening the national health system?
- ▶ Looking forward, what do you see as the priorities for improving UNICEF preparedness for PHEs in Guinea?

Response

- ▶ In your opinion, how effective was the overall, countrywide response to the concurrent PHEs affecting Guinea in 2021–2022?
- ▶ How successfully and in what ways has UNICEF adapted its work on PHEs to evolving circumstances and changing needs and priorities?
- ▶ To what extent and how has UNICEF work on PHEs in Guinea promoted and reflected gender, disability, age and human rights standards and commitments (including the Core Commitments for Children in Humanitarian Action)?
- ▶ Do you think UNICEF has become increasingly effective and agile in its response to PHEs in Guinea since 2015? Why (or why not)? (Please give an example.)

Conclusion

- ▶ How well has UNICEF supported innovation, including product innovation and appropriate use of new technologies, to respond to PHEs in Guinea and mitigate their impacts?
- ▶ What do you think UNICEF could do to improve its preparedness and response for PHEs going forward?

Research instrument for government representatives

Introductory questions

- ▶ Please state your name and your role in government.
- ▶ In what way do you work directly (or indirectly) with the United Nations Children’s Fund (UNICEF)?

Preparedness

- ▶ How well prepared is Guinea to face multiple, concurrent public health emergencies (PHEs)?
- ▶ In what way, and how effectively, did UNICEF work with national actors, including the government, to strengthen their capacity for preparedness and response?
- ▶ How effectively did UNICEF contribute to strengthening the national health system, to make it more resilient in times of PHE?

Response

- ▶ In your opinion, how was the overall, country-wide response to the concurrent PHEs affecting Guinea in 2021–2022?
- ▶ What is your opinion of UNICEF support to the national response to these multiple, concurrent PHEs?
- ▶ In your opinion, how well did UNICEF do in terms of:
 - ▶ Risk communication and community engagement?
 - ▶ Prevention, care and treatment for at-risk and affected populations?
 - ▶ Paying specific attention to women and children?
 - ▶ Ensuring continuity of essential services?
 - ▶ Ensuring provision of humanitarian assistance to those most in need?
- ▶ Do you find UNICEF to be suitably accountable to affected populations?

Conclusion

- ▶ Is there anything that you think UNICEF should do more or less of?
- ▶ What lessons should UNICEF take from the experience to strengthen its overall response to PHEs going forward?

Research instrument for senior management of the United Nations and the United States Agency for International Development

Introductory questions

- ▶ Please state your name, your position and the organization you work for.
- ▶ In what way do you work directly (or indirectly) with the United Nations Children's Fund (UNICEF)?

Preparedness

- ▶ In your opinion, what would strengthen Guinea's ability to prepare for and respond to multiple, concurrent public health emergencies (PHEs)?
- ▶ In what way, and how effectively, did UNICEF work with other actors, including the government, donors and the international community, to ensure preparedness for PHEs in Guinea?
- ▶ How effective are existing preparedness and response coordination mechanisms at the national and subnational levels?

Response

- ▶ In your opinion, how was the overall, country-wide response to the concurrent PHEs affecting Guinea in 2021–2022?
- ▶ How effective is the existing outbreak surveillance system in Guinea?
- ▶ What is your opinion of the role of UNICEF in the response to the multiple, concurrent PHEs affecting Guinea in 2021–2022?
- ▶ To what extent and how has UNICEF work on PHEs in Guinea contributed to protect children, women and adolescent girls, and other vulnerable groups?

APPENDIX B: RESEARCH INSTRUMENTS FOR KEY INFORMANT INTERVIEWS

- ▶ What could UNICEF do to improve its coordination with other actors, including other United Nations actors, donors and the international community?
- ▶ In your opinion, how well did UNICEF do in terms of:
 - ▶ Risk communication and community engagement?
 - ▶ Prevention, care and treatment for at-risk and affected populations?
 - ▶ Paying specific attention to women and children?
 - ▶ Ensuring continuity of essential services?

Conclusion

- ▶ What lessons should UNICEF take from the experience to strengthen its overall response to PHEs going forward?

Research instrument for heads of section/unit

Introductory questions

- ▶ Please state your name and your role at the United Nations Children's Fund (UNICEF).
- ▶ How long have you been working with UNICEF?
- ▶ Please describe your section/unit's role in UNICEF preparedness and response for public health emergencies (PHEs).

Preparedness

- ▶ How are the UNICEF Minimum Preparedness Standards and Minimum Actions for Country Offices integrated into your annual preparedness planning processes?
- ▶ In your view, what are the strengths and weaknesses of UNICEF preparedness plans for PHEs in Guinea?
- ▶ What has your section/unit done in recent years to improve its preparedness for PHEs?

- ▶ Were these changes based on lessons from previous PHEs, for example, the Ebola virus disease outbreak of 2014–2016 and the response to COVID-19?

- ▶ In your opinion, how well prepared was your section/unit to respond to concurrent PHEs in 2021–2022?
- ▶ In what way, and how effectively, did UNICEF build the capacity of national actors for preparedness and response?

Response

- ▶ In your opinion, how was the overall, country-wide response to the concurrent PHEs affecting Guinea in 2021–2022?
- ▶ What is your opinion of the UNICEF response to these multiple, concurrent PHEs?
- ▶ How well do you think UNICEF coordinated its preparedness and response activities with:
 - ▶ The national government?
 - ▶ Local partners?
 - ▶ International partners and other agencies like the World Health Organization?
- ▶ Do you feel there is clarity about the expected roles and responsibilities of different sections/units for UNICEF PHE responses?
- ▶ What is your section/unit's role in UNICEF PHE responses?
- ▶ How well do the different departments coordinate and collaborate with each other in the response to PHEs?
- ▶ Do you feel your department received sufficient financial and human resources to respond effectively and appropriately to these PHEs? Why (or why not)?
- ▶ Do you feel your department received the right support and guidance from UNICEF headquarters and regional offices to respond effectively to these PHEs? Why (or why not)?

- ▶ In your opinion, how well did UNICEF do in terms of:
 - ▶ Coordination with government and partners?
 - ▶ Risk communication and community engagement?
 - ▶ Prevention, care and treatment for at-risk and affected populations?
 - ▶ Paying specific attention to women and children?
 - ▶ Ensuring continuity of essential services?
 - ▶ Ensuring provision of humanitarian assistance to those most in need?
- ▶ What lessons should UNICEF take from the experience to strengthen its overall response to PHEs going forward?

Conclusion

- ▶ Is there anything else you would like to share with us about UNICEF Guinea's work on PHEs?



Appendix C: Consent protocol for key informant interviews

My name is Magali Carette and my colleague is Aboubacar Diakité. We work for Oxford Policy Management (OPM), a UK-based consulting company that has been contracted by the United Nations Children's Fund (UNICEF) to undertake an evaluation of its work on public health emergencies globally. OPM has been commissioned to provide an independent and objective evaluation, which includes case studies of UNICEF work on public health emergencies in specific countries, including Guinea. The findings of this evaluation will be made available to UNICEF and will be used to improve the effectiveness of UNICEF work on public health emergencies globally.

You have been selected as a key informant for this evaluation because we believe that you have experience and views that will contribute to provide 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 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. We will keep the answers that you give us **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 not use your answers in the evaluation report in a way that identifies you as an individual. In the event that we wish to quote you directly 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 questions 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 also okay, and there will be no consequences for you.

Do you have any questions?

Do you agree to participate in the interview?

Appendix D: Research instruments for focus group discussions

Table D.1. Research instrument for One Health focus group discussions

Questions
Relevance
Do you think that the United Nations Children’s Fund (UNICEF) correctly identified and responded to the needs of the local communities in its response to the Ebola virus disease/Lassa fever/Marburg virus disease outbreak?
Support to continuity of essential services
What did UNICEF do in this community to support continuity of access to basic social services including education?
Coherence and coordination
Was there a common vision and coherent plan, with clearly defined roles and responsibilities, for how One Health/ Emergency Operations Centre (Centre d’Opérations d’Urgence) would prepare for and respond to public health emergencies in this community?
How effective was UNICEF leadership and coordination related to public health emergencies?
How well did UNICEF support and empower local actors to prepare and respond to public health emergencies in 2021–2022?
Gender, equity and rights
How well did UNICEF develop gender- and age-sensitive and appropriate risk communication and community engagement message?
Were the psychosocial support services provided by UNICEF culturally appropriate?
If you or any of your colleagues were involved in prevention of sexual exploitation and abuse trainings facilitated by UNICEF, how did you find the trainings?
To what extent did UNICEF advocacy and partnerships contribute to the protection of vulnerable groups in your community during public health emergencies?

Lessons
What did UNICEF do well in its preparedness and response to public health emergencies?
What could UNICEF do to improve its preparedness and response to public health emergencies?

Table D.2. Research instrument for community member focus group discussions

Questions
Introduction
What was your experience of public health emergencies in 2021–2022? How were you affected?
What did you think of the overall response by the government, community-based organizations and non-governmental organizations to this public health emergency?
Risk communication and community engagement, and psychosocial support
Are you aware of how to prevent an outbreak or of what to do if someone in your community shows symptoms of Ebola virus disease, Lassa fever or Marburg virus disease?
What kind of activities were implemented in your community to increase awareness of these diseases?
Do you think that home visits for community awareness and psychosocial support are useful? Why (or why not)?
Health
What are the health services like in your community?
What could be done to improve the health services in your community?
Infection prevention and control, and water, sanitation and hygiene at the community level
Were handwashing stations or rehabilitated water points placed in the community, for example, in schools or health centres?
Do you think they are useful?
Have new latrine blocks been built in your community? If yes, do you use them? Why (or why not)?
What else do you think should be done to improve water, sanitation and hygiene in your community?
Conclusion
Is there anything that you think could be done to improve preparedness or response for public health emergencies in your community?



Appendix E: Consent protocol for focus group discussions

My name is Aboubacar Diakité. I am working on behalf of Oxford Policy Management (OPM), a research organization based in the United Kingdom of Great Britain and Northern Ireland, which has been contracted by the United Nations Children's Fund (UNICEF) to study its preparedness and response to public health emergencies globally. We are conducting a case study of UNICEF work in Guinea as part of this evaluation.

As part of this study, we are interviewing people like yourself in Faranah, Guéckédou and Nzérékoré. You were selected to participate because you are from a community in which UNICEF responded to an outbreak of Ebola virus disease/Lassa fever/Marburg virus disease in 2021–2022, or you are a member of the One Health or Centre d'Opérations d'Urgence group that responded to such an outbreak in 2021–2022.

Your answers today in this group discussion will help us with our study. We would like to hear your views. We are not testing your knowledge or ability as part of this discussion; there are no right or wrong answers. We will keep your answers completely confidential and will not link your answers 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 all or any of our questions, and you can ask us any questions as well. You can leave at any time without giving any explanation. There will be no consequences for you.

With that 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 discussion using a voice 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.]

Finally, we would like to ask you to keep everything that is discussed today confidential, and to not discuss it with anyone not presently in this room.

Are we okay 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/disagree to take part in the discussion.		
Number of respondents who agree/disagree to have their answers recorded via the voice 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 discussion details.

► Keep checking at intervals to ensure that the recorder remains on and is recording the discussion.

Date of discussion



Appendix F: Benchmarks from the UNICEF Guinea emergency preparedness plan

Table F.1. Emergency management benchmarks

	Benchmark	Met
B1.1	Emergency Management Team (EMT) – or an existing country office (CO) structure (e.g. CMT) – responsible for emergency preparedness and response exists in the CO	Yes
B1.2	CO staff in charge of ERM, BCP, ICT Recovery Planning, Security Risk Management and, if applicable, Programme Criticality Assessment participated in the risk analysis (EPP Step 1), and have updated and adjusted their respective plans (within the last 12 months) to enable the anticipated humanitarian response (defined in EPP Step 3)	Yes
B1.3	Standing capacity for initial response in the first 3–7 days after the onset of a crisis established based on contingency PCAs, prepositioned supplies and/or LTAs.	Yes
B1.4	Desk-top simulation exercise carried out every year (Note: applicable when a 2–3hr desktop simex is available)	Yes

Benchmarks beyond the minimum

	Benchmark	Met
B1.5	The work plan (in PER/ACHIEVE) reflect the preparedness duties of all CO's heads of programme sections/operations areas/focal points for emergency preparedness and response	Yes
B1.6	Emergency Management Team (EMT) – or an existing FO structure – responsible for emergency preparedness and response exists in all FOs	Yes
B1.7	Options for staff transportation identified in high-risk geographic areas defined in the risk analysis and scenarios (EPP Step 1 & 2) based on plans to relocate staff and surge (MPS3)	Yes
B1.8	Options for staff accommodation and office space identified in high-risk geographic areas defined in the risk analysis and scenarios (EPP Step 1 & 2) based on plans to relocate staff and surge (MPS 3)	Yes
B1.9	Potential alternative payment modalities identified (i.e, cash on hand, mobile cash, etc.)	Yes

APPENDIX F: BENCHMARKS FROM THE UNICEF GUINEA EMERGENCY PREPAREDNESS PLAN

Table F.2. Humanitarian coordination benchmarks

	Benchmark	Met
B2.1	Emergency coordination structures and potential emergency response organizations in the country mapped for UNICEF globally-led sectors/AoR	Yes
B2.2	UNICEF supported IASC Emergency Response Preparedness (ERP) if adopted by UNCT/HCT	Yes
B2.3	Leadership/co-leadership of UNICEF globally led sectors/AoR for humanitarian coordination and information management agreed with UNCT/HCT and (if feasible) with government	Yes
	Benchmark	Met
B2.4	Multi-sectoral needs assessment tool for UNICEF-led sectors/AoR agreed with UNCT/HCT and, as feasible, with government	Yes
B2.5	Roles and responsibilities for coordinated data collection agreed for UNICEF-led sectors/AoR feeding into cross-sectoral HCT/national processes	Yes
B2.6	Up-to-date inventory of sources for critical baseline data available (ref. latest IASC guidance)	Yes
Benchmarks beyond the minimum		
	Benchmark	Met
B2.7	Updated contact details for sector partners available updated	Yes
B2.8	Leadership/co-leadership of UNICEF globally led sectors/AoR agreed at sub-national level with UNCT/HCT and, as feasible, with government	Yes
B2.9	National response humanitarian standards are in place for all UNICEF-led sectors/AoR	Yes
B2.10	Emergency preparedness and response plans for UNICEF-led sectors/AoR developed and updated	Yes
B2.11	Mapping of existing operational partners conducted and gaps identified	Yes
B2.12	Capacity assessment of sectoral partners conducted recently for UNICEF-led sectors/AoR (in the last 2 years)	Yes
B2.13	Sector-specific needs assessment tools for all UNICEF-led sectors/AoR agreed with partners and, as feasible, with government	Yes
B2.14	Agreement established with UNCT/HCT for data and information sharing in emergency	Yes
B2.15	UNICEF-led sectors/AoR UNICEF-led clusters/sectors have identified Who does What and Where (3W) in emergency	Yes
B2.16	CO identified funding for conducting needs assessment	Yes

Table F.3. Staff capacities, refocusing and surge benchmarks

	Benchmark	Met
B3.1	Staff responsibilities assigned for the actions required in the first 72 hours after the onset of a crisis (in line with the SSOPs) (Who does what in the first 72 hrs)	Yes
B3.2	Staff with assigned responsibilities for the first 72 hours included in their Development Plan (in AGORA) learning activities to address their knowledge and skills gaps	Yes
B3.3	Refocusing, local recruitment and surge needs identified for key functions related to the anticipated response (defined in EPP Step 3)	Yes

Benchmarks beyond the minimum

	Benchmark	Met
B3.4	Roster of local consultants for the anticipated response (EPP Step 3) developed and updated	Yes
B3.5	Emergency Preparedness and Response training/refresher for all staff carried out in the last 24 months	Yes
B3.6	Emergency Preparedness and Response training/refresher for all key partners carried out in the last 24 months	Yes
B3.7	PSEA training/refresher for all key partners carried out in the last 24 months	Yes
B3.8	Updated list of counsellors for staff available	Yes
B3.9	PSVs identified and trained by Staff Wellbeing team (Basic PSV training course)	Yes
B3.10	Orientation package for surge staff developed	Yes

Table F.4. Supply and logistics benchmarks

	Benchmark	Met
B4.1	Supply Plan for critical emergency supplies developed with programme and operation sections, based on the anticipated response (EPP Step 3)	Yes
B4.2	Supply and Logistics Strategy developed based on the anticipated response (EPP Step 3)	Yes

Benchmarks beyond the minimum

	Benchmark	Met
B4.3	Supply and Logistics Assessment carried out and updated yearly (ideally in collaboration with the interagency/partners)	Yes
B4.4	Market assessment(s) carried out and updated yearly (ideally in collaboration with the inter-agency/partners)	Yes
B4.5	Specifications for key emergency items in the relief package agreed with the interagency partners and the governments, as applicable	Yes
B4.7	Customs procedures in emergency pre-negotiated with the government (preferably with the inter-agency)	Yes

Table F.5. Humanitarian cash transfer benchmarks

	Benchmark	Met
B5.1	HCT initiatives relevant to UNICEF mandate have been mapped	Yes
B5.2	Preliminary operational HCT feasibility assessment completed	Yes
B5.3	Sectoral (and/or multisectoral) entry points and implementation model have been identified (and reflected in EPP Step 3) if HCT is feasible	Yes
B5.4	Stand-by agreement with relevant stakeholder(s) to implement HCT signed if HCT is feasible	Yes

Benchmarks beyond the minimum

	Benchmark	Met
B5.5	CO staff responsible for cash transfers have undergone Humanitarian Cash Transfers training on AGORA	Yes

Table F.6. Implementing partner benchmarks

	Benchmark	Met
B6.1	Potential implementing partners, both CSOs and government agencies, identified for all CCC sectors as per anticipated response (EPP Step 3)	Yes
B6.2	Contingency programme documents/PCAs signed with CSOs covering CCC sectors as per anticipated response (EPP Step 3)	Yes
B6.3	All CSOs with signed contingency PD/PCAs have received training on UNICEF's HACT, FACE and CSO Procedure in the last 2 years	Yes

Benchmarks beyond the minimum

	Benchmark	Met
B6.4	All CSOs with signed contingency PD/PCAs and potential government implementing partners have received training on UNICEF's CCCs in the last 2 years	Yes
B6.5	All CSOs with signed contingency PD/PCAs and potential government implementing partners have received training on PSEA in the last 2 years	Yes

APPENDIX F: BENCHMARKS FROM THE UNICEF GUINEA EMERGENCY PREPAREDNESS PLAN

Table F.7. Advocacy, communication and resource mobilization benchmarks

	Benchmark	Met
B7.1	List of current and potential donors and private sector partners for emergency response available	Yes
B7.2	LTAs established with multimedia producers, with the ability to access high-risk geographic areas identified in the risk analysis (EPP Step 1) and scenario (EPP Step 2)	Yes
B7.3	Resource Mobilization Strategy Developed	Yes
B7.4	Advocacy Strategy developed	Yes
B7.5	CO media spokespersons, key advocacy and communication messages, factsheets and Q&As defined based on scenarios (EPP Step 2) and anticipated response (EPP Step 3)	Yes

Benchmarks beyond the minimum

	Benchmark	Met
B7.6	CO social media platforms active	Yes
B7.7	Stock of donor branding items maintained	Yes



For further information, please contact:

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