MAKING A DIFFERENCE

PROGRESS REPORT 2015

GLOBAL EBOLA RESPONSE

MAY 2015

A product of the **Global Ebola Response Information Centre**

Cover photo:
Tieni, Grand Cape Mount, Liberia. UNICEF conducted a mop-up campaign for 13 weeks in Tewor district to help communities wipe-out Ebola. It consisted of door-to-door active case searching and social mobilization. Tewor district was one of the last remaining hotspots for Ebola in Liberia, 28 January 2015. Photo: UNMEER/Martine Perret

May 2015

STATEMENT BY THE UNITED NATIONS SECRETARY-GENERAL

The Ebola outbreak in West Africa has resulted in over 25,000 people being infected with the virus and more than 11,000 deaths since the first case was identified in March 2014. Each one of these deaths is a tragedy. Beyond the tens of thousands who have been infected, hundreds of thousands more have been affected by this devastating outbreak.

Ebola has poignantly illustrated how this disease and its multidimensional impacts transcend geographic boundaries. The impact of Ebola is extensive and extends far beyond the affected countries. At the centre of the Ebola response are the communities who have struggled with, and in many cases defeated, Ebola. From youth and women's groups to traditional and religious leaders, countless individuals—mainly volunteers—have worked on the frontlines. Community members have transported patients, cared for the sick, and helped identify those exposed. I applaud their courageous, selfless and exceptional contributions.

The governments of the countries in Africa affected by Ebola deserve enormous credit for their intense efforts, supported by brave healthcare workers from the African region and the international community. This cooperation is vital in achieving progress against Ebola, and will remain fundamental for the future as countries seek to rebuild and recover. The International Ebola Recovery Conference that I will convene on 10 July 2015 will be an opportunity for the international community to demonstrate its continued shared commitment to the affected countries to get to zero and to stay there.

Together, we have made remarkable progress. As this report shows, currently thirty times fewer people are being diagnosed with Ebola each week than in September last year. *Making a Difference - Progress 2015*[1], prepared by my Special Envoy on Ebola, represents the result of work by responders, governments, the United Nations system, civil society, philanthropic organizations and the private sector. Together, we have created a powerful platform for collective action, ensuring a coordinated response.

This report provides an informative account of the impressive results achieved to date, together with a depiction of challenges along the way, to all those concerned about the Ebola outbreak and its wider implications for our world.

Ban Ki-moon
Secretary-General of the United Nations

1 The official reporting of the Secretary-General on the response to the Ebola outbreak in West Africa is published as a letter from the Secretary-General to the President of the General Assembly on a monthly basis and is publicly available. As of the date of publication of this report, the letter of the Secretary-General covering developments in the response to the Ebola outbreak at the 210-day mark since the establishment of UNMEER has been published (A/69/908).

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Guinea, February; 2015; Photo: WFP/Rein Skullerud

INTRODUCTION

On 14 January, a woman helps a young boy wash his hands in disinfecting chlorine solution at their home in Conakry, the capital of Guinea. Photo: UNMEER/Martine Perret

INTRODUCTION: At the end of 2014, the number of people being infected each week with Ebola in Guinea, Liberia and Sierra Leone was still more than 300. That number plateaued at around 100–150 for several weeks in early 2015 before decreasing. By the end of April 2015, less than 30 people were reported as infected each week—the lowest number since May last year. It is expected that—if efforts are focused, sustained, aligned and effective - the outbreak will end in 2015.

PEOPLE AT THE CENTRE OF THE RESPONSE: People in the affected countries are at the centre of efforts to contain and mitigate the outbreak. They have been supported by their social organizations, faith-based groups, local and national governments, and then by hundreds of individuals and organizations from elsewhere. Once people who were exposed to Ebola became convinced that if they behaved differently, they could mitigate the consequences of the disease, they started to make their lives safer by changing the way they live. The report explores how these changes happened and shows the importance of ensuring that all the required elements of the response are brought together in the right sequence to support communities in fighting the virus.

STRONG PROGRESS TO DATE: Progress has been remarkable and impressive results have been achieved so far—not only in terms of fewer people being infected, but also in terms of behavioural change, bed supply in treatment centres, and burial provision. Communities have engaged and the many contributors have worked together in an exemplary way.

MANY REMARKABLE CONTRIBUTORS: Behind the results is a remarkable story of individual and joint endeavour. The primary responders have come from within communities, supported by national healthcare workers. The Governments of Guinea, Liberia and Sierra Leone coordinated the response, through the strong leadership of their Presidents, and the senior officials they appointed to key positions. They have been assisted by technical experts, funds and logistical support from the international community. People have recognized the urgency of tackling Ebola, and are setting aside traditional divides so as to work together with one aim: to stop the outbreak.

PROFOUND ECONOMIC AND SOCIAL IMPACT: This Ebola outbreak has been large, complex and long-lasting. The broader effects of Ebola—beyond its impact on people's health — have been dramatic, with substantial economic and social damage that impacts more than 20 million people in the region. Continued efforts are needed to ensure that societies can combat further outbreaks and that life in the affected countries not only returns to normal but also is better than before.

RESPONSE AND RECOVERY COME TOGETHER: As the multiple efforts required for recovery become apparent, it is clear that response and recovery should reinforce each other and must be pursued in tandem. Flexible donor funding, accelerated research and development efforts will continue to be valuable as we seek to accelerate recovery. For now, achieving zero transmission and ending the outbreak, while ensuring that people have access to essential services that are safe, remains the top priority.

ANALYSIS TO BETTER PREPARE FOR THE FUTURE: The Secretary-General appointed a High-level Panel on the Global Response to Health Crises on 2 April 2015. Several other efforts are underway to analyse action and identify possible lessons that can be applied in preparation for (and response to) future crises. These analyses will ask if the response could have been quicker and better. The question will be "How to make this happen given that the nature of the next crisis cannot be predicted with any certainty?"

A REPORT TO SUSTAIN MOMENTUM AND ENCOURAGE ALIGNMENT: Here is a view of progress since the beginning of the outbreak. It is designed for those who seek to understand the progress of the response, the results and ways in which the results have been achieved. Its purpose is to galvanize the momentum needed for sustained efforts to end the outbreak. It has deliberately been kept short and is not designed to offer a comprehensive account of the response.

POTENTIAL FOR REVISION: Given that the outbreak has not yet ended and many involved in the response are still collating information about their contributions there may be a need for this report to be revised in the coming weeks: any revisions will be posted on the Global Ebola response website.

THE UN SECRETARY-GENERAL: Ban Ki-moon, the UN Secretary-General, has provided consistent leadership. The Secretary-General and Jan Eliasson, the Deputy Secretary-General, together with H.E. Sam Kutesa, the current President of the UN General Assembly, and Susana Malcorra, the Chef de Cabinet, have been deeply engaged: encouraging world leaders to become involved and contribute, establishing the first ever health UN system Mission for Emergency Ebola Response (UNMEER), and convening regular meetings where progress is debated and reviewed by UN Member States. The Secretary-General has visited the region, meeting with people affected by Ebola, Governments, responders and partners, and reviewed the work of UNMEER. His Special Representatives responsible for UNMEER—Anthony Banbury, Ismail Ould Cheikh Ahmed, and now Peter Graaff (acting)—have worked tirelessly and made exemplary contributions.

POWERFUL COMMITMENT FROM WITHIN THE UN SYSTEM AND BEYOND: Guided by the strong leadership of the UN Secretary-General, the Senior Management of the UN system has been actively engaged in and committed to the response from its outset. There have been strong responses from all parts of the UN including from the World Health Organization (WHO), World Bank Group, World Food Programme (WFP), UN Children's Fund (UNICEF), UN Development Programme (UNDP), UN Population Fund (UNFPA), Office for the Coordination of Humanitarian Affairs (OCHA), the UN Economic Commission for Africa and the UN Mission in Liberia (UNMIL). The effort has gone beyond the UN system and has been truly multi-lateral and multi-stakeholder—engaging Foreign Medical Teams from the African Union, the Red Cross Movement, many Non-Governmental Organisations, military groups, the International Organization for Migration (IOM), and contributions from national governments and regional bodies the world over. This intense collective effort is reflected in numerous meetings, appeals, documentaries, and reflections. It is also regularly showcased in the weekly information and coordination meetings of the informal Global Ebola Response Coalition.

PRODUCTION OF THIS REPORT: The core team responsible for this report, consists of Jo Nickolls, Anders Nordstrom, Trygve Ottersen, Vannina Maestracci, Hampus Holmer, Sophie Farigoul and Paddy Ilos. Many others have contributed and commented. Responsibility for the contents rests with David Nabarro who serves as the UN Secretary-General's Special Envoy on Ebola.

PART I: RESULTS ACHIEVED

The government of Liberia, WFP and WorldBank deliver rice, cereal and USAID vegetable oil to an Ebola-quarantined household in Monrovia. The 7 people living in the house had been quarantined since March 1 were medically monitored for 21 days and received psycho social counselling. Photo: World Bank/Dominic Chavez

PHASE ONE: TAKING THE HEAT OUT OF THE OUTBREAK

At the height of the outbreak between August and October 2014, hundreds of people were getting sick and dying each week. Until this time, national and international partners, including frontline non-governmental actors, particularly Médecins Sans Frontières (MSF), members of the UN country teams and the UN Mission in Liberia (UNMIL), had been active on the ground in responding to the outbreak, but the growth in transmission continued to outpace response capacity. Significantly more financial resources, trained medical personnel and clinical capacities were needed to rise to the challenge.

On 29 August 2014, the Presidents of Guinea, Liberia and Sierra Leone jointly wrote to the Secretary-General, requesting a UN resolution on a comprehensive response to the Ebola outbreak and calling for the United Nations to take the lead in coordinating the international response. In response to this letter, and with the unwavering support of the General Assembly, on 17 September, the Secretary-General informed the General Assembly of his intent to establish the United Nations Mission for Ebola Emergency Response (UNMEER), which deployed to the region ten days later with the objective of supporting the scaling up of the UN system in response to this unprecedented outbreak.

Usually, the effective response to an Ebola outbreak is to identify sick people, isolate them, offer care and treatment, then trace and follow people with whom they are in contact and ensure they are treated immediately if they show signs of infection. But at the height of this outbreak the intensity of transmission was so great that the conventional control approach had to be complemented with additional measures.

Reducing transmission meant stopping people with the disease from infecting others—when they are alive or (if they do not survive) when they died. This means that people with symptoms of Ebola have to be helped quickly to move away from their families, out of their communities and into safe places where they can receive the investigation and treatment they need with a view to achieving the best possible cure rate. If they die they must be buried in ways that minimise the likelihood that others will be infected.

Many people in the affected countries were initially confused and frightened by this new danger in their midst. They doubted that the illness was caused by an infection spread through contact with people—especially through bodily fluids. Those involved in the response had to do more than provide basic messages on how people could avoid infection. Responders had to understand how people in different communities behaved when they were sick and how they treated their dead. They had to build trusting relationships with people and encourage them to change long-held traditions around burial practices which were implemented with care by surviving relatives to ensure that the spirits within those who die were treated respectfully. So within the response there was an emphasis on the safe conduct of burials, in a dignified and respectful manner, and in ways that religious leaders and relatives could accept. In practice, most communities did change practices quite quickly, though some were—and still are—reticent about doing so.

Andrew Koroma and Mohamed Conteh (Sierra Leone)

On a bright, hot day, Andrew Koroma and Mohamed Conteh walk through Freetown's congested Rokupa community, armed with a megaphone, posters and flyers. This small team of social mobilizers is here because one particular community is currently under its second 21-day quarantine after recording an Ebola death.

"This community is one of the worst cases," says Mr. Koroma. "We have around 28 quarantined homes, 30 survivors, 20 deaths and 5 who are in treatment centres. Mr. Koroma and Mr. Conteh are among 788 'hotspot busters' in Sierra Leone. Hotspot busters deploy rapidly to communities that are considered hotspots of the epidemic, as part of an immediate response to an outbreak. Members of the community themselves, hotspot busters are trained to intensify social mobilization activities and increase engagement of communities to stop the spread of Ebola. They conduct one-on-one sensitization sessions, house-to-house visits and public awareness-raising.

To ensure that the hotspot is covered, the social mobilizers activate youth, women and volunteer networks in each community and reach approximately 9,000 households every week. They are involved in active community surveillance and are approached by community members to call the 117 Ebola hotline to refer sick loved ones to a hospital.

Since the initiative began, hotspot busters have carried out social mobilization in more than 344 hotspot communities nationwide. Some 275,103 households have been reached on their house-to-house visits.

[Adapted from: Social mobilizers empower 'hotspot' communities to fight Ebola in Sierra Leone, January 2015 http://www.unicef.org/emergencies/ebola/75941_78953.html]

THE THREE B'S

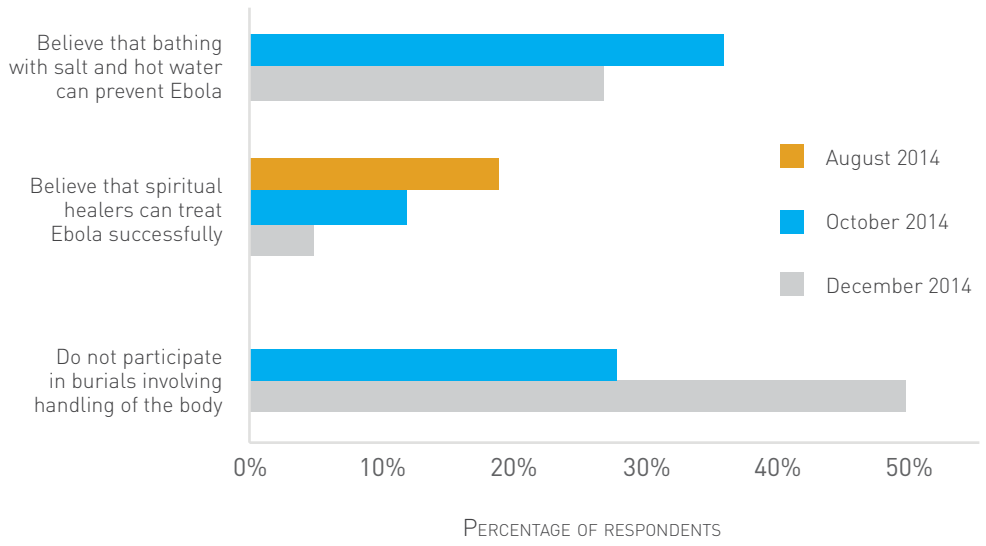
The classic approach to managing an Ebola outbreak was followed until August 2014 when the spread of disease was outstripping the response. The additional response measures focused on "the three B's": behaviour, beds and burials. **Behaviour** had to adapt and change across communities. Safe and staffed **beds** had to be provided for the sick. Given that corpses are highly infectious, **burials** of those who died from Ebola needed to be safe, acceptable within the context of local customs, and dignified.

An unprecedented range of actors—from Presidents to Non-Governmental Organisations

(NGOs)—used multiple techniques in their attempts to build trust and persuade people that Ebola was real and to encourage safer behaviours. As communities and their leaders saw sickness in their community and began to believe that Ebola was a disease that both existed and could be prevented, people were more willing to change behavior when they realized that Ebola-specific treatment facilities were more widely accessible. They were even more likely to change when they were able to get treatment—and to appreciate that early treatment greatly increased the likelihood of survival. UNMEER and WHO proposed that by 1 December 2015, 60 days after UNMEER was deployed, 70% of people with Ebola would receive treatment and 70% of those who died would be afforded safe and dignified burials.

More and more people have learnt how Ebola spread, how to avoid it and how to react at the first signs of possible infection (see Figure 1).

Figure 1. Changes in knowledge, attitudes, and practices Sierra Leone[2]



Beds were an essential complementary investment to behaviour change. For family members to agree to isolate a sick person, they needed confidence that their relative would be adequately cared for. They needed to know where the relative was and be informed of their wellbeing. Care needed to be effective—so that survival rates were high; and safe—so that Ebola would not be transmitted to health workers. And the beds needed to be in appropriate locations, rural or urban, in line with the progression of the outbreak. A network of services and infrastructure was also required. Once communities accepted the facts of Ebola, they needed to be able to quickly notify health facilities that someone was sick. Without easy access to telephones, no functioning emergency services, no diagnostic laboratories and a natural resistance to isolating sick people, none of this was easy.

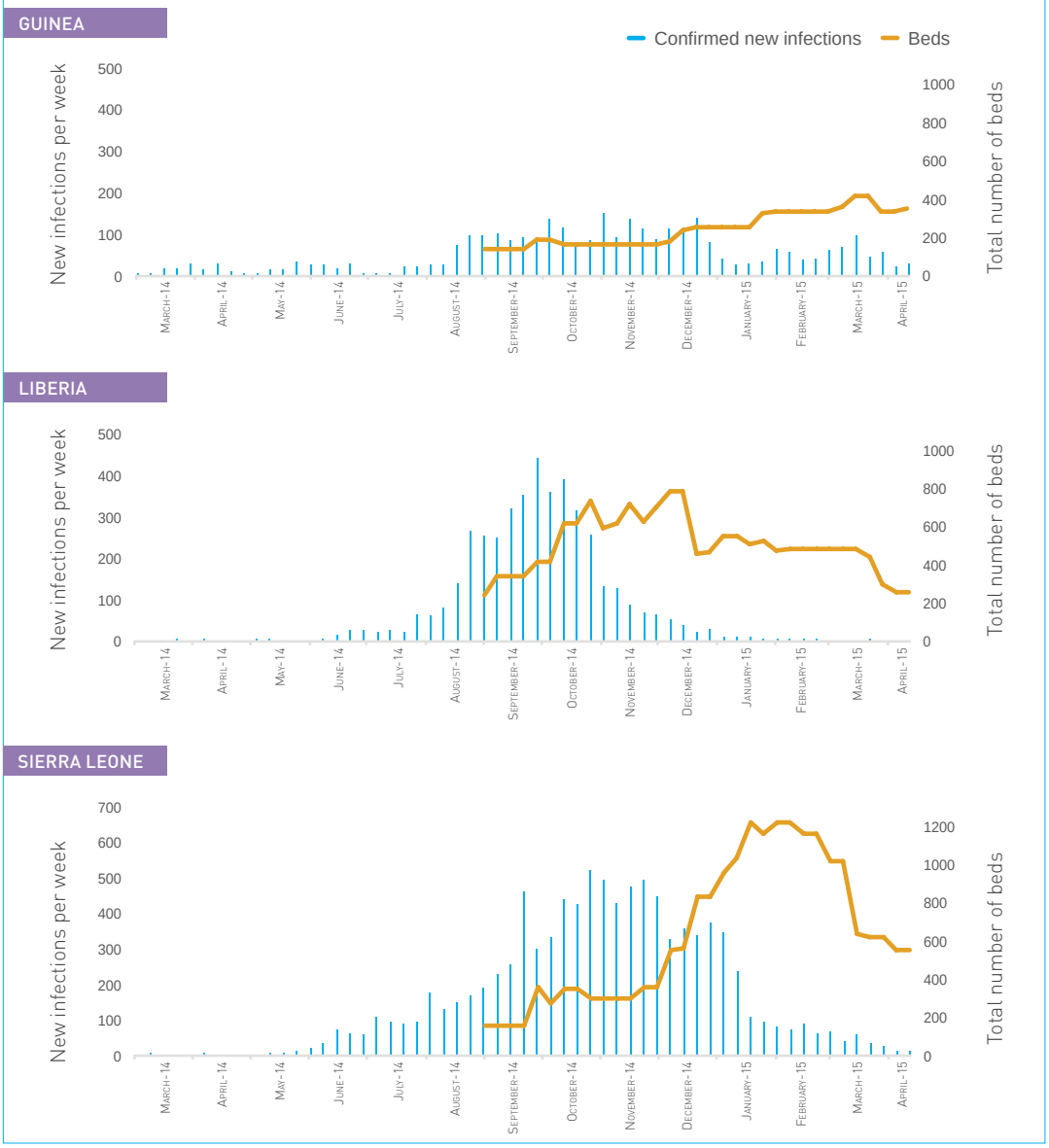
Building sufficient beds where care could be provided safely was key to encouraging people to come forward if they were sick. In Sierra Leone, *"There was a really important moment*

2 Highlights of Sierra Leone KAP Studies. Presentation by UNICEF, March 2015.

in December where for the first time really in the whole course of the outbreak, we had enough beds to get every patient … safely isolated and that didn't just mean they got good care, it meant we could protect their families at home from being exposed."[3]

In late August 2014, there were just over 500 beds available in Guinea, Liberia and Sierra Leone in eight public sector Ebola Treatment Units (ETUs)—five run by MSF and three by the Ministries of Health with WHO support, plus a private sector ETU run by Firestone Liberia, Inc.[4] The number of ETU beds rose to more than 1,500 at the beginning of December 2014 and peaked at 2,044 in the week of 8 February 2015, with 49 operational ETUs (see Figure 2).

Figure 2. Total number of beds in Ebola Treatment Units and number of new infections per week[5]



3 Dr. Oliver Johnson, Kings College, https://soundcloud.com/isurvivedebola/bbc-world-have-your-say from 27.01 minutes.
4 http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6342a6.htm.
5 Based on data from WHO.

But the scale up and staffing of beds was still unable to keep up with the rapidly increasing number of people with Ebola. Patients often had to be moved long distances to treatment centres in order to receive care. Faced with unchecked and highly mobile transmission in October 2014, communities started to construct local Community Care Centres (CCCs) where people who were sick could stay near their families. They were helped to do this by local and national Governments, NGOs and the United Nations. The total number of beds in CCCs increased from 60 in mid-November 2014 to more than 1,500 in approximately 63 CCCs in early March 2015.[6] In Liberia, home hygiene kits, containing chlorine, soap and protective gear, were distributed from September 2014, to reduce risk associated with the increasing number of people who were sick with Ebola in communities.

In addition to more beds, there was a need to accelerate the delivery of Ebola test results so that healthy people could be sent home faster, people who were sick could be treated more quickly and survivors could be discharged earlier. This involved establishing systems for handling samples (ensuring that they were safely collected and quickly transported to laboratories, labelled accurately and indelibly), as well as the establishing and managing of laboratories (reliable electricity, supply systems and staff) and efficient reporting of results (communicated promptly back to the health facility from which they came).

The International Organization for Migration (IOM) set up a mobile clinic to provide basic healthcare services to the population of about 1400 people in Gbaigbon and neighboring communities in Bomi County, Liberia, who would otherwise be unable to reach a healthcare facility. A team of one doctor, three nurses, and two ambulance drivers, who helped in screening the patients, treated close to 100 persons on the site, with some more severe cases being provided first aid and then taken to Bomi Hospital. Dr. Nisar Ul Khak, Medical Coordinator for the IOM Ebola treatment unit in Tubmanburg, said "UNMEER helps in coordinating the agencies and NGO's who are willing to support the mobile clinic." Gbaigbon, Bomi County, Liberia, on 24 March 2015. Photo: UNMEER/Simon Ruf

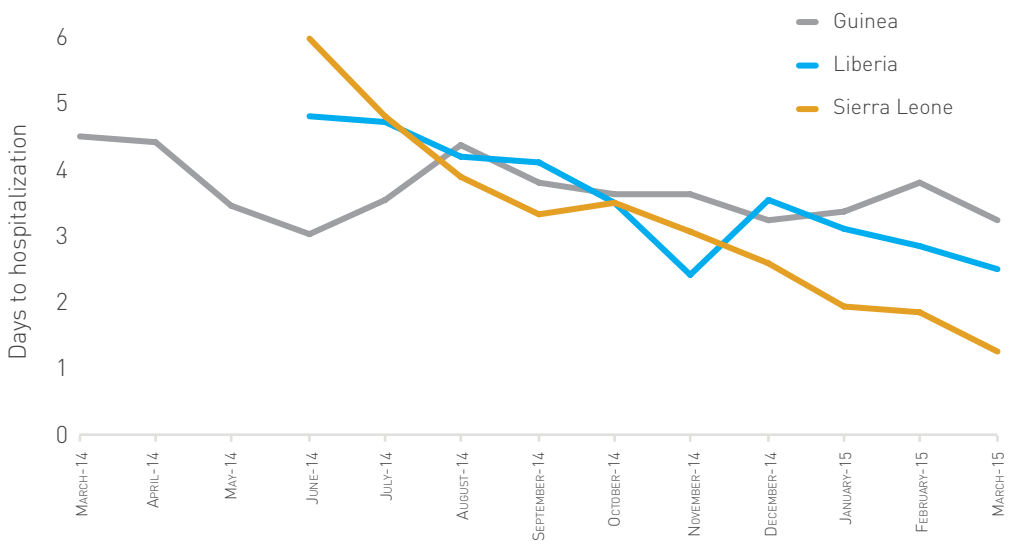
WHO reported that in October 2014 in Liberia, *"health workers had to wait 2 to 5 days to have a preliminary Ebola diagnosis confirmed by sending blood samples to another lab facility in Monrovia."* Between late August 2014 and mid-January 2015, sixteen new laboratories were constructed, taking the total in the three countries from 11 to 27. By January, it took an average of 0.7 days in Guinea, 0.5 days in Liberia, and 0.8 days in Sierra Leone from collection of a patient sample to communicating the test result to a national Ministry of Health.[7]

As the knowledge in communities about the virus grew and people could see the Ebola response system was working, people started reporting their symptoms earlier. Over the

6 WHO Ebola Situation Report, 19 November 2014, and data obtained from WHO.
7 WHO Ebola Situation Report, 28 January 2015.

course of the outbreak, the average time from the onset of symptoms to hospitalization has decreased. For the three countries taken together, that time went down from 4.4 days in June 2014 to 3 days in December 2014 and then to 2.3 days in March 2015 (see Figure 3).

Figure 3. Average time from onset of symptoms to hospitalization[8]



When the Governments of Guinea, Liberia and Sierra Leone decided to provide a safe and dignified burial for everyone who died there was a need to expand the availability of burial teams. Efforts to persuade families to report a dead body or to stop ceremonial body-washing were quickly undermined if the burial teams took too long to arrive or treated the body without the proper sensitivity and respect. Each burial team needed vehicles, fuel, personal protective equipment and disinfectants. Team members needed to coordinate with the swab collectors (who collected samples from those who died to undertake post-mortem checks for Ebola), with laboratories, contact tracers, quarantine teams, home decontaminators and people who provided food to quarantined homes. Graves must be marked and family members needed to know their locations.

In August and September 2014, the numbers of people dying as a result of the outbreak were too many given the limited capacities of burial teams. Burials could not be carried out quickly enough and bodies were left in the streets. In August 2014, the President of Liberia took the decision to introduce cremation. *"Cremation is not our culture. It was due to necessity that we had to cremate people, but it worked very well,"* said Tolbert Nyenswah, head of the Government's Ebola task force. Cremation was so far from traditional practice that, in March 2015, its impact was still being felt. In advance of "Decoration Day" when family members honour the dead, the ashes of 3,000 people who had been cremated were transferred from Monrovia's crematorium and reinterred at an Ebola safe burial site. Traditional leaders asked for forgiveness from the ancestors.[9]

8 Based on data from WHO.
9 http://www.globalcommunities.org/node/38066.

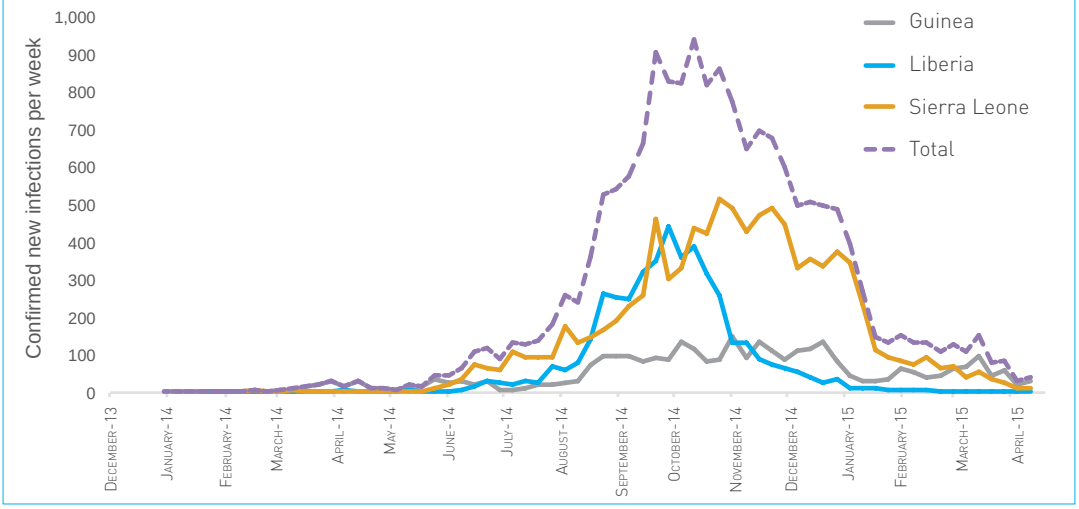
The deployment of burial teams and the active engagement of communities in ensuring that burials are safe have led to a reduction in unsafe burials. For the three most affected countries, the number of burial teams went up from 140 in October 2014 to 243 in December and to 283 in March 2015. Their work generated demonstrable results. At their peak, in the week to 8 February 2015, 84 unsafe burials were reported. By March 2015, the weekly number had fallen to around 20.

The outstanding efforts of the affected countries, communities and people, with the support of the international community, and the targeted action on behaviour, beds, and burials yielded results: the epidemic curve of "new infections per week" started to plateau and then decline in Liberia during September, and some weeks later in Sierra Leone. The projections of 1.4 million people with Ebola in Liberia and Sierra Leone by mid-January 2015[10] were avoided. By the week to 18 January, the weekly number of people newly infected had been reduced to 146 - 15% of what it had been in September. Progress was now clearly visible (see Figure 4) and the outbreak had begun to cool down.

PHASE TWO: GETTING TO ZERO

In places where Ebola incidence had declined, the response entered its second phase. Emphasis was shifted from the three B's to the three C's: **community ownership**, **case finding** and **contact tracing**. The second phase could be applied because the quality of local-level information on the outbreak and response had improved greatly by the end of 2014. A greater emphasis was placed on the district-level, and responders increasingly focused their attention and assets at local level, working closely with local officials and community leaders. As more epidemiologists and anthropologists were recruited and deployed, information systems improved, more granular data became available, and the epidemiological information was more easily interpreted. This brought a better understanding of how the virus spread and where to concentrate efforts and resources: it meant that the response could be better matched to local conditions.

Figure 4. Number of new confirmed infections per week[11]



10 "Estimating the Future Number of Cases in the Ebola Epidemic—Liberia and Sierra Leone, 2014–2015", Morbidity and Mortality Weekly Report, 26 September 2014 (Martin Meltzer, et. al.).
11 Based on data from WHO.

THE THREE C'S

The involvement of communities and their ownership of the response has been fundamental to all aspects of the effort to end the outbreak. Social mobilization teams—often working with direct support from national presidents—have engaged in dialogue directly with people as well as with their religious, traditional, and political leaders. They have involved the communities themselves in the promotion of behaviours that reduce risks of infection and help prevent the spread of the disease. Where messages have been adapted to the local context, are respectful of local customs, and are owned by the people themselves, efforts to encourage behaviour change have been more successful. Efforts to encourage community ownership are increasingly being guided by skilled anthropologists.

But even when attempts were made to engage communities some groups have not welcomed teams of responders. In late November 2014, a safe-and-dignified burial team from the Red Cross was attacked in Conakry, Guinea. *"The team was forced to retrieve a buried body, and their vehicle was destroyed".* [12] This was – unfortunately – not an isolated incident. But as demonstrated by a survey in Liberia in February 2015, burial practices can be adapted, *"Way back when someone dies, there is a culture, you bathe the body, sit down near the body, sometimes the body sleep with us... But now whenever someone dies, spray the body, carry the body, put it in bag, all that one. We are feeling bad about what is happening but we just have to adjust to the situation".* [13]

Augustine Turay and Abdul Rahman Parker

As a volunteer with the Sierra Leone Red Cross Society, Augustine Turay goes to four or five houses daily in communities around Freetown to collect the bodies of people who may have died of Ebola and to conduct safe and dignified burials. Once the teams collect the bodies, they bring them to Abdul Rahman Parker, Manager of the King Tom Cemetery in Freetown. In January 2015, numbers varied but the cemetery could bury 70 people a day. For Parker, the hardest part of the job is the stigma that comes with it: "as long as you work for the Ebola team, people stigmatize you - your friends, your family, your wife."

But despite the risks and stigma, both Parker and Turay continue to carry out the essential task of safe and dignified burials of Ebola victims. "You just have to take your inner power, your inner strength to just keep you going," says Parker, adding that burial teams "are saving our nation." "I know it's very dangerous but we do it because we want to help our country and we love our society as well," adds Turay.

[Adapted from the "It's my community. It's my country." 21 January 2015, UNMEER, https://ebolaresponse.un.org]

As confidence between people and responders improved, attitudes and practices changed. Community ownership of the response led to people with symptoms of Ebola receiving treatment more rapidly and moving out of their communities before they infected others (see figure 3). It led to greater acceptance of safe burials and contact tracing, and more widespread adoption of hand washing and other hygienic practices.

Alongside more accessible information on the state of the outbreak at district level, better understanding of local culture has been key to success in phase two. Well-planned and executed procedures for community engagement have reduced the extent of denial and built the trust necessary to ensure people's participation in the response. More than 30 anthropologists have been directly involved in the response. They have demonstrated the importance of engaging with communities on their terms, using traditional approaches when outsiders

12 IFRC Real Time Evaluation: http://reliefweb.int/sites/reliefweb.int/files/resources/Links%20to%20all%20documents%20-%20Ebola%20RTE_0.pdf.
13 National KAP Study on Ebola (Liberia), Male adult, Grand Cape Mount, Liberia.

wish to meet with them, and ensuring that explanations are both understandable and in the right language.

Private sector companies also helped to engage communities providing information directly to employees. Up to 50,000 people received information in this way through the 55-company Ebola Private Sector Mobilization Group (EPSMG). Widespread community engagement has led to reductions in the instances where communities have resisted being part of the response in all three countries. In Guinea, the proportion of locations reporting resistance went down from almost 80% during several weeks in January, to 12% for most weeks in March. The work is ongoing: in April, two four-day emergency campaigns were organized in Forécariah and Coyah. UN partners and UNICEF organized community and health workers into over 1,100 teams that made door-to-door visits to 120,000 households and 2,209 educational talks and over 13,000 awareness sessions were held in the same period. They were supported by rural radio stations that continued to broadcast messages - delivered by local leaders - about health and hygiene in the context of Ebola.[14]

The full engagement of people and their communities is a pre-requisite for successful **case finding**. Case finders start out from places where people gather, and then go house-to-house (on the basis of information received) to seek out any people with symptoms or to follow up on reports of deaths. If sick people are found, the families are encouraged to seek health assistance.

Alphonso Kanboh

"I've been a teacher for 22 years, and people around here trust me, so when I and my colleagues approach them telling them how to prevent being infected by Ebola, they are more likely to listen." Alphonso Kanboh is one of 11,000 teachers and principals from across Liberia trained by the country's Ministry of Education and UNICEF. He volunteered to undertake the training and then go from door-to-door to raise awareness on how communities can protect themselves and prevent the transmission of Ebola.

A teacher at the community school in Paynesville, Kanboh is at the heart of community outreach and his message is simple: "Ebola is still very much real here in our town. So you have to keep washing your hands before you eat. Don't touch sick people. Call the number on the poster if anyone in your family becomes sick." He also educates communities about signs and symptoms and about measures to prevent getting infected. "My whole life is about teaching the next generation," says Kanboh. But while he waits to re-enter the classroom, he is bringing education on Ebola to the community level and helping to defeat the outbreak.

[Adapted from "A teacher's turf: Community outreach in the fight against Ebola", 5 December 2014, UNICEF, www.unicef.org]

Case finding and surveillance need particular attention at national boundaries to ensure that people are not lost when they cross them: *"As we continue to fight Ebola, the focus is on proactive screening, surveillance and active case finding. To avoid infection and the possible spread from one county to another the checkpoints are an important element,"* explains Eric Peti, the Outreach Team Coordinator at an ETU managed by the International Organization for Migration (IOM) in Tubmanburg, Liberia.

To end the outbreak and "get to zero" it is critical to trace everyone who has been in direct contact with a person who has Ebola. Tracing contacts and monitoring their health ensures that those who get sick can be identified immediately. They can then be isolated and treated earlier, and each chain of transmission can be stopped. People will only come forward as a contact if they are not afraid of the consequences. They need reassurance that they can access effective treatment if they do turn out to have Ebola. They need to know that if their house

14 UNICEF Situation Report for Guinea, 15, 22 and 29 April 2015.

gets quarantined, they won't be stigmatized and that food, water and fuel will be provided. Governments and their partners seek to ensure that quarantined homes receive the food they need: much of this was provided by the UN World Food Programme.

The number of contact tracers has increased considerably over the course of the outbreak and they are now better linked to other parts of the response, including through use of information technology, global positioning systems and communications equipment such as tablet computers and smart phones. At the peak of the outbreak, UNFPA mobilized around 8,000 contact tracers in the three countries with 5,000 in Sierra Leone alone, which helps lay the ground for future regional disease surveillance systems.

A key indicator of success in contact tracing is an increase in the proportion of people newly diagnosed with Ebola who are already identified as contacts of people known to have the disease. Although that proportion has fluctuated since the start of 2015, the overall trend is positive in each affected country (see Figure 5).

Guiba Kondé

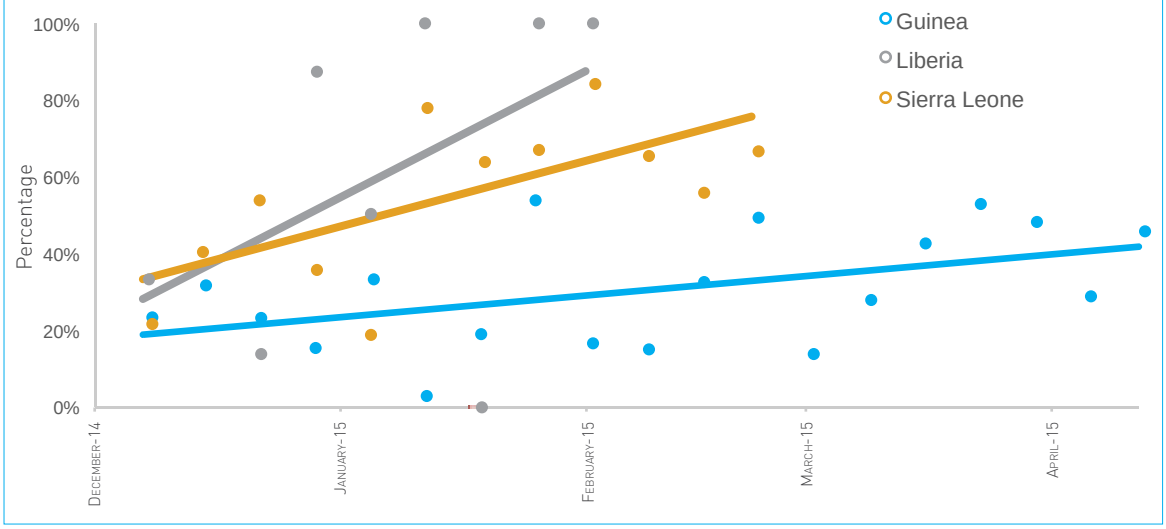
Guiba Kondé is part of the IOM border surveillance team in the isolated post of Nougani, Mali. With his colleagues, he registers the passage of all travellers from bordering Guinea, collects data such as vehicle number, nationality, age, telephone number, and origin and destination. These are validated at corresponding checkpoints on either side of the border. If any of the information does not match, the travellers are immediately turned back.

But Kondé says that one of the most important parts of his job is outreach: "We find that many of the travellers don't know about the risks of Ebola or how to stay safe. They tell us that the information we give them is really helpful." He teaches proper hand washing hygiene and explains the risks of transmission of Ebola. He also takes travellers' temperatures before allowing them to proceed.

With around 500 people transiting every day at Nougani "Flow Monitoring Point", Kondé says: "When you're here, like me, every day, and you see just how many people cross the borders every day – it never stops – you understand the risks."

[Adapted from the "Guinea-Mali Border Surveillance Stepped Up in Fight Against Ebola", 8 February 2015, UNMEER, https://ebolaresponse.un.org]

Figure 5. Proportion of new weekly infections arising from registered contacts (with trend-lines)[15]



15 Based on data from WHO.

Mohammad Bailor Jalloh

"Community engagement is the cornerstone of any public intervention. Ebola started in the community and it will end in the community." It's with that conviction, and through the NGO he founded in 2012, that Mohammad Bailor Jalloh entered the fight against Ebola in Sierra Leone.

In August 2014, the NGO, FOCUS 1000, conducted the first Knowledge, Attitudes and Practices (KAP) study on Ebola in Sierra Leone, in partnership with the United Nations Children's Fund (UNICEF) and in collaboration with Catholic Relief Services (CRS), the Centres for Disease Prevention and Control (CDC), and the Ministry of Health and Sanitation. Since then, two more studies were published and a fourth one is on its way. The aim was to capture the knowledge, perception and behaviours of the public to Ebola so that the Government and partners could offer the most adapted and targeted response.

That's also how FOCUS 1000 specifically decided to engage religious leaders in the Ebola response. "The KAP showed that apart from radio, religious leaders were the most popular and effective source of information," says Jalloh. "Religious leaders are usually trusted in their communities and people turn to them for advice especially in times of social calamities."

Among other actions, the NGO assisted religious leaders to search for scriptural evidence from both the Quran and Bible to support the public messages being promoted to prevent Ebola transmission. It also trained 50 senior religious leaders who in turn trained more than 5,000 imams, pastors, women and youth leaders in some 4,000 mosques and churches across the country.

Jalloh says that "religious leaders have contributed immensely in helping to dispel rumours and misconceptions, addressing stigma and changing traditional beliefs and practices." "Behaviour change goes beyond the message," he adds, "it calls for a trusted messenger that can deliver accurate messages in a manner the people can understand and accept. And to sustain the behaviour change, you need to create the enabling and supporting environment – which is what we have done with the engagement of religious leaders. "

Another important indicator of success in contact tracing is a reduction in the number of people who have died in their communities and who are confirmed, after death, to have suffered from Ebola. This is made possible through the analysis of samples taken at the time of death. In 2015 there was encouraging progress: across the three countries this number fell from 273 in February to 98 in March.

There have been several groups—local and national Government, faith groups, civil society and international responders—involved in community engagement, case finding and contact tracing at district, county and prefecture level in each country. Coordinators at local levels have sought to ensure the sensitive application of standard procedures and effective follow-up in case any gaps in the response are detected. The closer to the end of the outbreak, the more important it is that these systems function correctly.

People who survive Ebola need support as they seek to maintain their physical and mental health and their livelihoods. A high proportion of the survivors report that they experience emotional distress and physical health problems, and many have lost family members—and even their caregivers—to the disease. Numerous survivors report that they struggle to

regain their livelihoods: they lost possessions when they were undergoing treatment and face stigmatization from their communities. Programmes to support survivors were already initiated in the first phase of the response. For example, in December 2014, the Ministry of Social Welfare, Gender and Children's Affairs in Sierra Leone, with support from international partners, arranged special conferences for more than 400 Ebola survivors.[16] Survivors received psychosocial support and survivors' kits, which included household items and a resettlement allowance. By May 2015, several more survivor organizations had become established in all three countries and many survivors have become active in the response themselves.

ESSENTIAL SERVICES AND PREPAREDNESS

The three B's and the three C's are the public health "lines of action" that reduce the transmission of the Ebola virus. Alongside this, it has been critical (a) to sustain and restore services that are essential for ensuring the security of people's livelihoods and (b) to improve the preparedness of unaffected communities and countries to prevent the further spread of Ebola – within countries and across the region.

Governments were concerned that both the Ebola outbreak and measures taken to control it (especially restrictions on people's movements) would impair people's ability to meet their basic needs. They sought to maintain **essential public services**. Vulnerability assessments and efforts to safeguard people's access to food has been a key feature of the response. Targeted food assistance is essential when communities are quarantined and to ensure the well-being of people receiving medical treatment. Individuals and families that have survived Ebola, as well as families that have lost an income-earner (especially orphans) need continuous support to ensure they can access the nutritious food they need, and avoid the risk of malnutrition. The WFP and many partner NGOs have come together to support local and national authorities with a view to ensuring people's food and nutrition security. As of the end of February, WFP and its partners had provided food assistance to about 2.5 million beneficiaries in Guinea, Liberia and Sierra Leone.[17]

Concerted efforts have been made to mitigate the effects of school closures and the reduced use of health facilities. "School in a radio" was used across the affected countries to broadcast the key elements of the curriculum in a child-friendly way. Solar-powered radios, designed to be used without electricity or batteries, have been distributed to increase the number of listeners in Liberia.[18] Since the beginning of the year, schools have reopened safely in all three countries after intensive teacher training and provision of supplies by UNICEF and education partners, allowing for the return of 2.1 million children in Guinea from 19 January, 1.35 million in Liberia from 16 February and 1.8 million in Sierra Leone from 14 April. Fees for government schools have been waived in Sierra Leone and for certain categories of students in Liberia. And in Guinea, WFP expanded its school-feeding programme to encourage attendance: by March 2015, 88% of the 2013/2014 primary school classes were back at school.

As both schools and regular health services are re-opening, careful decontamination of facilities that were used to treat patients with Ebola is underway and enhanced measures to improve sanitation and hygiene—such as the distribution of sanitation kits and the installation of water distribution points—are being introduced.

16 http://www.unicef.org/media/media_78207.html.
17 WFP West Africa Ebola Response. Situation Report #27, 10 April 2015.
18 http://www.lr.undp.org/content/liberia/en/home/presscenter/articles/2014/12/18/bringing-information-to-new-georgia-undp-donates-solar-powered-radios/.

During the outbreak, the use of health services was significantly reduced. For example, in Guinea use of health services was reduced by over 50% from 2013 to 2014 and in November 2014, 94 health facilities (or 6%) were closed because of absence or death of healthcare personnel. Assisted deliveries were down by about 20% in Guinea and the number of DPT3 vaccinations administered fell by 30% between 2013 and 2014. As part of reopening health services, immunization campaigns have been organized in all three countries.

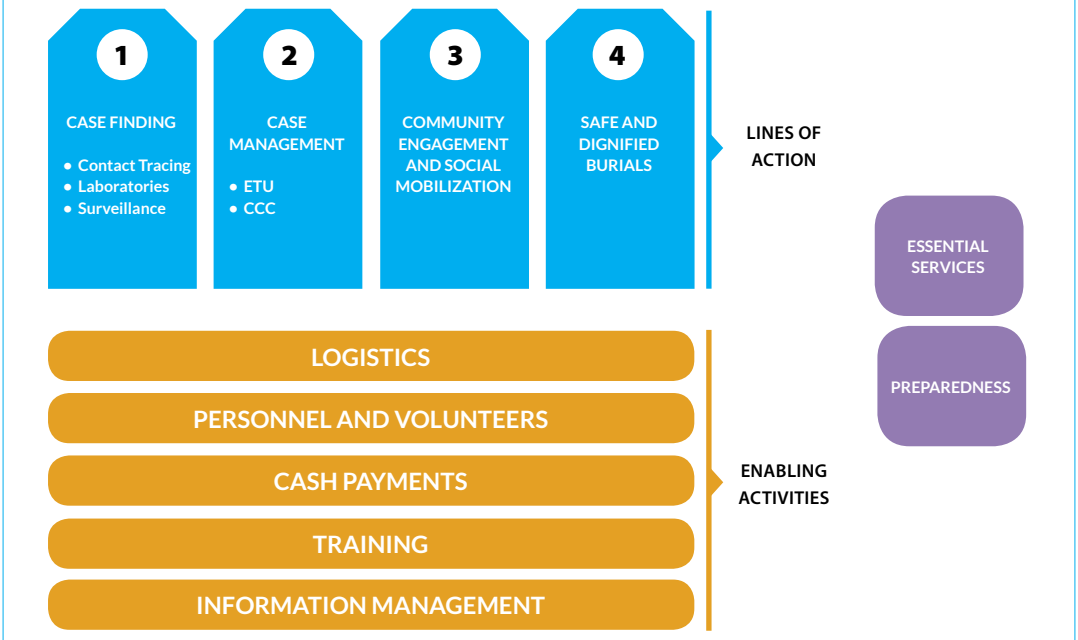
Of the 17,000 orphaned children, 8,000 have now benefited from cash transfers in Guinea and Liberia and a new initiative of cash transfers has been launched by UNICEF with the Ministry of Social Welfare, Gender and Children Affairs and the World Bank in Sierra Leone.

Efforts have been made to strengthen **preparedness** capacities both within the three most affected countries and for other countries in the region. Over the course of the current outbreak, the level of preparedness has improved in a range of areas from coordination to epidemiological surveillance and from budgetary planning to laboratory capacity. The lessons from simulation exercises have proved to be the optimal means for improving preparedness. With strengthened capacities, countries will be increasingly well prepared and better positioned to combat future outbreaks.

ENABLING ACTIVITIES

The Operational Planning Conference in Accra in mid-October 2014 played a significant role in helping the UN system and partners to maximize their contributions to a scaled-up response. At this event the priority lines of action were clarified. Essential enabling activities were identified. And the roles and responsibilities of the different actors were agreed (see Figure 6).

Figure 6. Lines of action and enabling activities



Vaccines and Therapies

There are as yet no vaccines to protect against Ebola licensed for use in humans but four vaccine candidates have been shown to be safe and efficacious in animals. They are currently at various stages of evaluation in humans.

The two most advanced are the ChAd3-ZEBOV vaccine, developed by GlaxoSmithKline in collaboration with the US National Institute of Allergy and Infectious Diseases, and the rVSV-ZEBOV vaccine, developed initially by the Public Health Agency of Canada and now licensed to NewLink Genetics (which collaborates with Merck Sharp & Dohme to register vaccines). After successful Phase 1 clinical trials conducted in various countries in North America, Europe and Africa, Phase 3 evaluation of these two advanced Ebola vaccine candidates started in the Ebola-affected countries in February 2015. The objective of these trials is to assess whether the vaccines protect against Ebola and to further document safety.

The first Phase 3 trial (PREVAIL) is a randomized controlled trial which is comparing the two vaccine candidates with an inactive placebo. It is being conducted jointly by the Liberian Government and US-NIH. While the initial stages of the trial have now been completed, successful control of Ebola virus disease in Liberia means that this trial will not be able to reach its objective of demonstrating efficacy of the vaccines, and investigators are exploring a possible extension of the PREVAIL trial to Guinea.

The Phase 3 trial (STRIVE) in Sierra Leone has a modified stepped-wedge design to test the rVSV-ZEBOV vaccine in health care workers. It is conducted in collaboration between the national Government and US-CDC and was initiated in April 2015.

The Guinean Phase 3 trial is conducted by an international collaboration including notably the Guinean Government, Norway, Canada, MSF and WHO. Started in early March 2015, the trial intends to test the efficacy of the rVSV-ZEBOV vaccine first, followed by the ChAd3-ZEBOV vaccine, through using a strategy called "ring vaccination". For this Phase 3 clinical trial, as well as for the STRIVE trial in Sierra Leone, success in demonstrating efficacy of an Ebola vaccine candidate will be largely dependent on whether there will be enough cases of Ebola in the coming weeks.

Two additional vaccines have now reached Phase 1 clinical trials in humans: a prime-boost regimen of Ad26- and MVA-EBOV developed by Johnson & Johnson and a recombinant particle made of EBOV glycoprotein produced in tobacco plants, developed by the biotech company Novavax.

Introduction of an Ebola vaccine in populations of affected countries will depend on the results of the clinical trials and review by regulatory authorities of vaccine safety and efficacy, and on the evolution of the epidemic.

Other treatments and therapies being evaluated currently in Ebola-infected patients in Sierra Leone and Guinea include transfusion of convalescent plasma donated by patients who have recovered, a cocktail of monoclonal antibodies produced in plants (ZMapp; BioLeaf TM), an siRNA produced by the company Tekmira and an antiviral drug (favipiravir; FujiFilm). Both ZMapp and siRNA have demonstrated efficacy against Ebola virus in test tubes (in vitro) as well as in monkeys infected with Ebola.

Progress was also made in the development of new diagnostic tools which allow quicker screening of suspected cases of Ebola virus disease and can be used in the field.

WHO, with World Bank funding, is working with all relevant stakeholders on each of the potential therapies, vaccines and diagnostics to continue to accelerate identification, verification, development and, if safety and efficacy are found, deployment. Final decisions on introduction are made by the Ministries of Health in the affected countries.

During this conference it was evident that multiple organizations—with a variety of professional and organisational cultures—were engaging in the response. They were involved in an extremely complex and unpredictable exercise. The Governments of each country sought to ensure that responders were enabled to be fully effective: with the support of UN entities, donor organisations, NGOs, businesses and external militaries they have been implementing *enabling actions*. Taken together, these constituted the operational support platforms that underpin the entire response: over time they have become increasingly organized and predictable. Through the support platforms, people and goods are transported; logistics and supply systems function; personnel are recruited, deployed, trained and supported (in ways that help them avoid infection); bona fide responders receive the payment to which they are entitled in remote places where there are no banks; and systems are established for managing information. Examples of these enabling actions follow:

Logistics

Many groups contributed to the transport of supplies into and within the region by air, sea and road. Through the UN's air operation for fixed wing aircraft and helicopters, WFP and UNMEER have facilitated the transport of 64,000 m^3 of cargo since September 2014.[19] This has included essential equipment such as ambulances and mortuary pick-up trucks. In addition the UN Humanitarian Air Service has transported more than 11,000 aid workers, doctors and officials, providing improved access to the region and facilitating the movement of personnel within countries to Ebola hotspots.[20] In its largest response ever in terms of supplies delivered, UNICEF has shipped almost 8,000 metric tonnes of supplies, including Personal Protective Equipment (PPE), medicines, family hygiene kits, school kits, and vehicles.[21] Several governments, including France, Germany, the Netherlands, United Kingdom, and United States, as well as non-governmental partners and businesses also contributed air, road and sea transportation capacity.

Personnel and volunteers

International technical experts, including medical, nursing, epidemiological, anthropological, logistic and management professionals, have been deployed to assist the Governments of Guinea, Liberia and Sierra Leone. They have supported local healthcare and community workers, and helped to enrich the response.

IFRC said, *"Human Resource recruitment has been one of the biggest challenges of the Ebola response".*[22] Indeed, most partners reported challenges with deploying staff. The commonly stated reason was their concern about access to medical treatment in case they became ill. But there were substantial difficulties with recruitment, ensuring medical clearance, deployment, establishing in-country healthcare and securing medical evacuations—especially from remote field locations. This meant the expansion of the international personnel presence in the region was slower than anticipated.

Many organisations including, but not limited to, the African Union (AU), MSF, the WHO and the US CDC, as well as bilateral partner governments, the Global Outbreak Alert and Response Network (GOARN), many NGOs and the Red Cross movement have provided personnel. The GOARN contribution included the establishment of a consortium of laboratories. Several organisations contributed to Incident Management and Emergency Operations Centres.

19 WFP West Africa Ebola Response, Situation Report #27, 10 April 2015.
20 http://wfpusa.org/blog/hope-looks-plane-way.
21 UNICEF. Life-saving supplies to Ebola-affected countries.
22 IFRC Real Time Evaluation: http://reliefweb.int/sites/reliefweb.int/files/resources/Links%20to%20all%20documents%20-%20Ebola%20RTE_0.pdf.

This massive input of technical advice and operational expertise was critical in shaping the response and prioritizing the necessary activities. People with experience in working in previous Ebola outbreaks have made invaluable contributions. This was particularly the case for some volunteers from African nations (as part of the AU contribution) who had worked with Ebola and for those from CDC China who had worked on Severe Acute Respiratory Syndrome (SARS).

It has not proved easy to estimate the total number of international responders who eventually participated. As one example, by 14 April 2015, around 1,000 WHO and nearly 200 UNMEER personnel were deployed throughout the three countries, including field coordinators in sub-national offices.

The broad range of international partners from all over the world that has been involved is an extraordinary feature of the response. Many have returned for second or third tours of duty. We recognise and appreciate their individual and collective contributions!

Payments

A large and ever-changing number of national Ebola response workers needed to be paid. At times, threats of strikes or loss of morale by Ebola response workers posed a very real risk to the continuity of the response. Part of the solution has been to create innovative new

In August 2014 in Sierra Leone, members of the Health For All Coalition put up a 'Kick Back Ebola' poster in Kailahun District, to raise awareness about Ebola virus disease (EVD) and best practices to help prevent its spread. Cases of Ebola have been confirmed in the district. By 20 August, a total of 2,615 EVD cases (laboratory-confirmed, probable and suspected) and 1,427 deaths had been reported in Guinea, Liberia, Nigeria and Sierra Leone. Sierra Leone has borne 392 of these deaths. Photo: UNICEF/NYHQ2014-1380/Douglas

payment mechanisms: these have been supported by UNDP and the private sector. As of early March, 95–100% of registered Ebola workers were linked to payment mechanisms and in most payment cycles, more than 90% of the workers were paid on time. In Sierra Leone, 100% of the workers have been paid digitally since December 2014.

Training

Thousands of responders have been trained to contribute effectively to the response at the local level. WHO has provided pre-deployment training in person to more than 1,900 responders—in Geneva and in Accra, as well as online training to more than 5,000. Together with MSF, International Federation of the Red Cross and Red Crescent Societies (IFRC), Spanish, French and German Red Cross provided 762 pre-deployment trainings to international responders. More than 10,000 national Red Cross volunteers were trained in various aspects of the Ebola response. IOM and partners trained more than 4,500 frontline healthcare workers at the National Ebola Training Academy in Freetown since 1 December 2014. Across all affected countries, MSF provided advice, support and guidance as well as direct training to other organisations that were stepping up their work on Ebola.

Information management

Access to accurate real-time data is essential for an effective response to any outbreak of viral haemorrhagic fever. Both responders and affected communities need information about Ebola and how it is transmitted. In practice, getting, sharing and managing information proved to be among the biggest challenges faced at local level. To begin with, lack of connectivity—for data transfer, for mobile money transfers, or even for contact with sick family members—hampered the response. Coalitions of responders worked together to improve communications and came up with innovative responses including public-private partnerships to establish wireless hotspots that provided internet connectivity to district Ebola response centres.

John Mwikaria and Jonas Tewelde

When asked why they volunteered to come to Liberia, John Mwikaria, an emergency registered nurse, and Dr. Jonas Tewelde, a general practitioner, have a similar answer. "It is our responsibility to help our brothers here in Africa," says the first man. "The biggest driving force was to give our professional assistance to our brothers and sisters in West Africa," echoes the other.

Mwikaria, from Kenya, now works at Rennie Hospital, while Tewelde, from Ethiopia, is stationed at the Redemption Hospital. Both are part of the 835 medical personnel deployed to Guinea, Liberia and Sierra Leone under the AU Support to the Ebola Outbreak in West Africa (ASEOWA). The AU's contribution makes up the largest part of the more than 1,300 foreign medical personnel who have been deployed to the three countries, which also includes a Cuban team of 230 medical personnel.

These foreign medical workers have joined local health workers to help treat and care for patients, boost local health capacity, manage ETUs, and resume essential health services for non-Ebola conditions.

"This is one of the occasions in which the governments of Africa have shown that their solidarity, their union, can tackle any problems of the continent," says Tewelde. Mwikaria says he has been encouraged by the willingness of the local medical personnel "to serve the people despite the challenges and fear that people have…. You look at their spirit -- it's encouraging," he adds.

Their story is an example of the courage and bravery shown by several hundred international personnel who joined the response.

[Adapted from "Health Workers on Ebola Frontlines Serve Countries, Risk Own Lives", 7 April 2015, World Bank, www.worldbank.org]

PART II: HOW DID THE RESPONSE COME TOGETHER?

On 21 September 2014, a social mobilizer distributes soap to a woman in Freetown, the capital. Soap, when used as part of proper handwashing techniques, helps to halt the spread of diseases, including EVD. Photo: UNICEF/NYHQ2014-1604/Bindra

Behind these impressive results is a remarkable story. The collective effort in the Ebola response has been outstanding in many ways: the sheer number of contributors; the diversity of those contributors; and the level of cooperation demonstrated. Key contributions have been led by the countries—particularly their community organizations and, most of all, the people themselves. Perhaps the most important influence has been the extraordinary leadership of the national governments of the affected countries, and their willingness to engage openly with the multiple sources of national and international assistance. This resulted in the alignment of many diverse partners behind the national responses. The governments have been supported by bilateral donor countries, multilateral organisations, NGOs, foundations, and the private sector.

It is community volunteers (including from the Red Cross societies and faith-based groups) who have been at the front lines and have driven the response. They have transported patients, cared for the sick, traced the exposed, gone door-to-door. They worked relentlessly, under exceptional circumstances and at a risk to themselves.

More than 90% of the total Ebola response workforce was national personnel, according to data from MSF and the UN. They include volunteers through national Red Cross societies and faith groups. They have been supported by an estimated cumulative total of 10,000 international personnel who have contributed over the duration of the response.

865 healthcare workers have been infected with Ebola and 504 of them paid with their lives. The overwhelming majority are citizens of West Africa. People like Augustine Turay, Abdul Rahman Parker and Alphonso Kanboh in the boxes above are the heroes of the Ebola response.

AN EVOLVING RESPONSE STRATEGY

The global Ebola response can be summed up as a focused yet flexible strategy that successfully adapted to the evolution of the outbreak and became increasingly decentralized over time. The first iteration of the strategy brought together the "Accra Response Strategy", agreed by Health Ministers from eleven West African countries on 2-3 July 2014, and the "Ebola Response Roadmap" published by WHO on 28 August 2014. The "Accra Response Strategy" was based on three pillars of action: immediate outbreak response interventions; enhanced coordination and collaboration; and scale-up of human and financial resource mobilization. The WHO Roadmap emphasized the use of complementary and controversial approaches for use in areas with intensive transmission to "take the heat out of the outbreak" with specific targets and timelines.

The contents of these two strategies were reiterated in the UN STEPP strategy, which was developed jointly with the Presidents and Governments of the affected countries in the first two weeks of September 2014. It formed the basis of the Overview of Needs and Requirements for the UN system and partners developed jointly by OCHA and the Office of the Special Envoy and launched in Geneva on 16 September 2014. The elements of STEPP are to:

- **S**top the outbreak;
- **T**reat the infected;
- **E**nsure essential services:
- **P**reserve stability; and
- **P**revent outbreaks in countries currently unaffected.

Each of the five elements in STEPP is broken down into the mission-critical public health actions and enabling activities that are required to make the response work. STEPP provided an enduring, broad and flexible framework for operations.

Over time, different elements of STEPP were prioritized. When the number of people with Ebola was increasing rapidly, the focus was on the first two elements of **S**top and **T**reat or "**ST**": this meant building safe and staffed beds, introducing safe burials and finding and training healthcare workers.

As a means to harmonize the responders, on 20 September 2014, UNMEER and WHO set a target of 70% of patients isolated and receiving care and 70% safe and dignified burials within 60 days of the Mission being rolled out (30 November 2014). In both Guinea and Liberia these were achieved on time: in Sierra Leone they were achieved before the year was out. Implementation of this **70-70-60** plan succeeded in "bending the curve" of the outbreak and reducing to less than one the number of other people infected by someone with Ebola. The next target was **100-100-90** (100% of patients isolated and receiving care and 100% of burials both safe and dignified within 90 days – by 1 January 2015).

When the intensity of the outbreak reduced and as quality care became more available and accessible, responders began to focus on the second phase—ending the outbreak through case finding and contact tracing. High quality case-finding and contact-tracing capabilities had to be scaled up throughout the region. These were needed to ensure that every chain of transmission could be mapped. However, it was only possible to focus on this at the end

of 2014, once the heat had been taken out of the outbreak and high quality disaggregated data had started to become available.

The dialogue on the establishment of the 70-70-60 and 100-100-90 targets was intense. Prioritizing certain elements over others represented a departure from the normal approach for managing a viral haemorrhagic fever outbreak. The voices of globally renowned scientists and medical experts were heard alongside the recommendations of community mobilizers and traditional leaders. In August 2014 it became clear that the exponential growth of the outbreak and widespread alarm about its potential global impact required the adoption of complementary approaches – speedily. Once agreement had been reached on the scaling up of Ebola Treatment Units and Burial Teams, a further controversy emerged. Did Community Care Centres contribute to excessive risks of infection? Would the quality of care they offered be satisfactory? The debates were resolved rapidly and providers were encouraged to establish facilities that could be adapted to national and local needs with the maintenance both of clinical standards and protocols for Infection Prevention and Control. These facilities were flexible enough to be adjusted if the scale and shape of the outbreak changed unexpectedly.

COMMUNITIES AND LOCAL ACTORS

Each community and each village that has been affected by Ebola has contributed to the overall response. In terms of official staff and volunteers, over 60,000 people[23] from Guinea, Liberia and Sierra Leone with a broad range of skills and experiences have responded. From professional health workers to local volunteers, from faith groups to traditional leaders, responders have worked collaboratively to end the transmission of Ebola.

While there was some resistance to the measures to end the outbreak in some communities, others developed their own solutions. Local and religious leaders in parts of Liberia decided to "self-quarantine", an initiative that was reported as more effective than district or individual level quarantine.[24]

On 19 September, a team of social mobilizers speaks with residents about EVD and preventing its spread, in Freetown, the capital. The mobilizers are holding illustrated posters reinforcing that information.

From 19–21 September in Sierra Leone, a public information campaign aimed to reach every household countrywide with life-saving messages on Ebola virus disease (EVD). UNICEF provided technical and financial support, including information materials, for the Government-led campaign, called the Ose to Ose Ebola Tok initiative, which means 'house-to-house talk' in the local Sierra Leonean language. During the campaign, over 28,500 trained social mobilizers, youths and volunteers went door-to-door to reach 1.5 million households and provide residents with information on protecting themselves against EVD and preventing its spread. UNICEF estimates that 8.5 million children and young people under the age of 20 live in areas affected by EVD in Guinea, Liberia and Sierra Leone, countries where disease transmission is widespread and intense. Of these, 2.5 million are under the age of 5. Nigeria and Senegal are also affected, having seen an initial case or cases, or experienced localized transmission. The current EVD outbreak in West Africa is the worst in history.
Photo: UNICEF/NYHQ2014-1558/Bindra

23 UNDP report "Payments Program for Ebola Response Worker – Results", 31 March 2015.
24 http://acaps.org/img/documents/t-acaps_thematic_note_ebola_west_africa_quarantine_sierra_leone_liberia_19_march_2015.pdf.

Continued local leadership and ownership by communities are pre-requisites for ending the outbreak. The role of local leaders in both shaping and implementing the local response has proved absolutely necessary for changes in behaviour at the community level.

Abdourahmane Balde

By profession, Abdourahmane Balde is a photo lab technician. But since the beginning of 2015, he has taken on a new job: he is now one of the 5 members of the "comité de veille des villageois" of the Gbangbaissa quartier, in Guéckédou, Guinea.

Every day of the week, Balde goes door-to-door and meets with families to raise awareness about Ebola. "Some weren't able to understand that the disease really existed," he says, adding that he is proud of the work he has done because "Ebola is going away."

These comités de veille – a community-based structure, have been established throughout the country. They are designed along the existing traditional structure of governance and bring together 5 to 7 elected members, representing the makeup of the village itself: traditional and religious leaders, representatives of women, youth and traditional brotherhoods such as traditional hunters and healers, as well as opinion leaders and representatives of different socio-professional categories. They aim to improve community engagement in the Ebola response and raise awareness about the disease. They also assist in seeking care for the sick, tracing contact of exposed family members and fighting stigma. Members of the comités act as a trusted link between the communities and external groups.

"The comités have access to places that foreigners can't go to," says Mamadou Baillo Dialo, chief of the Gbangbaissa quartier. "Foreigners know more but when they come, they give their information to the comités who then transmit it to the different communities." "Since the 'comités de veille' have been established, there's been no word of resistance in localities," he adds.

The comités have been credited with helping to stop the spread of Ebola, reducing community resistance across the country and fostering greater community engagement. Launched in December 2014, the initiative now counts 13,700 members. The comités have been established in all districts of Guinea – most of them with the support of UNICEF and through collaboration with NGOs.

As a member of a comité, Balde receives a monthly incentive of USD 56 until April 2015. He says that he would continue his work even if he isn't paid anymore because "it's important to save the population." The members of his comité in the Gbangbaissa quartier have now started raising awareness about measles.

[Based on interviews done by UNICEF - Guinea]

NATIONAL LEADERSHIP

The Presidents of Guinea, Liberia and Sierra Leone have played a critical role in the Ebola response. They provided the strategic leadership that enabled an effort of this magnitude to unfold, as well as a national vision behind which their people could align. They secured the full support of their respective governments and drove the operational response while championing behaviour change. The Presidents of the affected countries were crucial in making progress in defeating the Ebola outbreak.

At the outset of the response, the Governments faced substantial challenges. According to WHO there was virtually no experience of Ebola in Guinea, Liberia or Sierra Leone: *"No clinician had ever managed an Ebola patient. No laboratory had ever handled a diagnostic specimen. No government had the experience to understand what a disease like Ebola could do to a country's future".*[25] And none of the countries had health systems capable of mounting the full response necessary. The Liberian Minister of Foreign Affairs stated that, with Ebola the *"already weak health system has been plunged into further paralysis".*[26]

There were also concerns over the economic impact of declaring national States of Emergency. The IFRC noted that, *"poor communications and political and cultural resistance hampered timely recognition and extent of the outbreak."*[27] However, once the situation was clear, Governments took on the daunting task of defining and enabling the response to a complex and rapidly changing outbreak.

The Ministries of Health in the three countries were the first government entities to mount the response. They began to coordinate national and international actors and to provide the necessary medical and technical guidance. In Guinea, Dr. Sakoba Keita from the Ministry of Health was appointed Ebola coordinator in April 2014 a month after confirmation of the first case. On 13 August, President Condé declared a National Public Health Emergency and on 4 September, he appointed Dr. Keita as head of the newly established "Cellule nationale de la coordination contre l'Ebola". To encourage an increased effort by the people of Guinea as the weekly numbers of newly infected people started to decline, President Condé called for reinforcement of measures to cope with the ongoing health emergency, focusing particularly on the need for safe and dignified burials for all.

Liberia reactivated a pre-existing Task Force within the Ministry of Health and Social Welfare in late March 2014, when the first diagnoses of Ebola were made. President Johnson Sirleaf declared a State of Emergency on 6 August and on 10 August appointed the Assistant Minister of Health and Social Welfare, Tolbert Nyenswah, as Head of the Incident Management System. The Liberian authorities invited international experts to work directly within their government structures, and absorbed advice and support from *"MSF and WHO initially, then US CDC and later UNMEER – it worked because we created a relationship rather than a bureaucracy".*[28]

In Sierra Leone, the Ministry of Health and Sanitation established the Emergency Operations Centre (EOC) in mid-July and President Koroma declared a State of Emergency on 30 July. In mid-August the leadership was transferred to a former Cabinet Minister, Stephen Gaojia who was appointed as head of the EOC. On 17 October, the President upgraded the EOC into the National Ebola Response Centre and appointed the then Defence Minister Major (Rtd) Palo Conteh, as Chief Executive. The following day the nomination of fourteen District Coordinators represented the culmination of an ongoing process to decentralize the management of the Ebola response.

Simultaneous efforts were made to decentralize the response in Guinea to préfecture-level and Liberia to county-level as well. The establishment of functional local offices was initially challenging given logistical, funding and human resource constraints: these were mitigated through major deployments of military assets and personnel, together with rapid provision of finance. Existing infrastructure was used where possible—for example the United Nations Mission in Liberia (UNMIL) offices in the counties of Liberia. New structures were created where needed—for example British military-supported command and control centres in

25 Director General of WHO at the UN Economic and Social Council on the Ebola threat, 5 December 2014.
26 General Assembly, 3rd plenary meeting on Friday, 19 September 2014, http://www.un.org/en/ga/search/view_doc.asp?symbol=A/69/PV.3.
27 IFRC Report of the Real Time Evaluation of Ebola control programs in Guinea, Sierra Leone and Liberia, 25 January 2014.
28 From interview with Presidential Adviser Dr. Emmanuel Dolo.

certain districts of Sierra Leone. In Guinea, eight Regional Alert and Response teams were set up, with French support, to assist the Regional Health Directorates to implement their responsibilities for contact tracing and progress monitoring.

National technical working groups, pillars or clusters were established to deal with key components of the response. These covered issues which were identified as national priorities—including case management, safe and dignified burials, surveillance and laboratories. Over time they were adapted to the lines of action for the response, with additional emphasis on infection prevention and control, and on research and development. Countries developed additional structures to adapt to the national context: in Liberia, several humanitarian clusters—including health—were activated in August.

Coordination and information sharing across the technical pillars of the response proved challenging and key data from one pillar were sometimes slow to reach the technical experts working in other pillars. Early delays with establishing secretariat functions (meeting timetables, agendas, minutes etc.) in the EOCs also made it hard for district, county and prefecture-based responders to engage. This may have contributed to a sense of exclusion felt by some locally-based NGOs and local civil society organizations.

Ebola has catalysed joint work by different political parties. In Guinea, political unity against Ebola was formalized in principle in March 2015 through the Forum des Forces Vives where representatives of political parties committed to depoliticize the issue of Ebola, stating that, *"This national union against Ebola is above all existing socio-political cleavages in the country, particularly in this pre-electoral period."* [29]

REGIONAL COOPERATION

The Mano River Union (MRU) has played an important role in focusing political attention to cross-border issues and agreed on 1 August 2014 at a Special Summit, *"to take important and extraordinary actions at the inter country level to focus on cross-border regions that have more than 70 percent of the epidemic. These areas will be isolated by police and the military. The people in these areas being isolated will be provided with material support".*[30] Delivering all these commitments was challenging, in part due to insufficient operational capacity at district, county and prefecture level. On 15 February 2015, during a summit in Conakry, the leaders of the MRU approved a strategy for reaching and sustaining "Zero Ebola Infection" within 60 days, recognizing that *"to get to and stay at zero will depend on their collective political will."*[31]

The Presidents of Guinea, Liberia and Sierra Leone have also been working jointly on the preparation of the MRU sub-regional Ebola recovery plan. This was discussed during the high-level international conference on Ebola on 3 March in Brussels and the high-level roundtable in Washington DC in preparation for the establishment of a Regional Ebola Recovery Fund. Implementation by the MRU, *"requires increasing the capacity and functionality of the Secretariat urgently by setting up a special unit."*[32]

ECOWAS, in November 2014, appealed for military personnel, logistics support, medical and voluntary staff, to support awareness raising and the strengthening of national

29 Declaration from the Forum des Forces Vives de la Guinée Contre Ebola, Conakry, 12 March 2015 ("*Cette union nationale contre Ebola est au-dessus de tous les clivages socio-politiques existants dans le pays, particulièrement en cette période pré-électorale.*").
30 http://www.manoriverunion.int/JOINT%20DECLARATION%20FINAL%20VERSION.pdf.
31 http://emansion.gov.lr/2press.php?news_id=3212&related=7&pg=sp.
32 Mano River Union Post-Ebola Socio-economic Recovery Programme, April 2015.

health systems. In January 2015, ECOWAS partners, including the West Africa Health Organisation (WAHO), the private sector and development partners, stressed the need to re-establish links, mobilize investment and for debt cancellation.[33] The Chairman of ECOWAS, Ghanian President John Dramani Mahama demonstrated courageous regional leadership at a time when access restrictions and border closures were being implemented. As President of Ghana, his early decision to create an air-bridge from Ghana to the affected countries was instrumental in facilitating the work of all responders. He then agreed that the UN could establish its headquarters in Accra.

Cooperation at the regional level has also been important to the response. In September 2014, the African Union support to the Ebola Outbreak in West Africa (ASEOWA), was established to enhance the capacity of existing national and international response mechanisms through mobilization of technical expertise, resources, political and financial support. Countries welcomed, *"the solidarity of many organizations and countries, non-governmental organizations and Civil Society Organizations as well as the active mobilization of AU support..."*[34]

The #AfricaAgainstEbola campaign is coordinated by the Africa Against Ebola Solidarity Trust, a registered charity, in partnership with the African Union. The Trust was launched in November 2014.[35] In January 2015, the AU Peace and Security Council discussed Ebola and reiterated earlier calls to *"AU Member States that have not done so, to immediately lift all travel bans and restrictions and to respect the principle of free movement, as well as to take the required steps for the resumption of flights to those countries."*[36]

Nigeria's Experience with Ebola

On 20 July 2014, an acutely ill traveller arrived at Lagos airport, Nigeria, from Liberia. Three days later, he was diagnosed with Ebola. This one patient resulted in nineteen people being infected and meant 894 people in Lagos and Port Harcourt had to be regularly checked for symptoms.

The Ministry of Health, with guidance from the Nigerian Centre for Disease Control, immediately activated an Incident Management Centre and soon after opened an Emergency Operations Centre. The new Ebola incident manager brought with him technical skills and partnership experience from his previous role fighting polio in Nigeria.

A rapid, innovative and multi-disciplinary response swung into action. It pulled all the national and international experts (CDC, WHO, MSF and UNICEF) under one plan. Seeing the impact of Ebola in Guinea, Liberia and Sierra Leone, the Nigerian private sector offered support where it was most urgent and provided vehicles, protective equipment and meeting facilities. Contact tracing was ramped up. Android phones—normally used in the polio campaign—were used to map where Ebola workers went. NGOs with experience in HIV/AIDS social mobilization were called upon to help.

The Government, from the President downwards, helped with social mobilization. Traditional leaders were engaged and mosques and churches were able to include information on Ebola in their prayers. Social media was used for information sharing and community volunteers hired through Twitter and Facebook advertisements.

Nigeria was declared Ebola-free on 20 October 2014.

[From interview with Dr. Faisal Shuaib, 20 April 2015]

33 http://news.ecowas.int/presseshow.php?nb=009&lang=en&annee=2015.
34 Decision of the Executive Council Sixteenth Extraordinary Session on the Ebola Virus Disease (EVD) Outbreak, Addis Ababa, Ethiopia, 8 September 2014, http://pages.au.int/ebola/documents/decision-executive-council-sixteenth-extraordinary-session-ebola-virus-disease-evd-o.
35 http://www.africaagainstebola.org.
36 Communiqué of the 484th meeting of the PSC on the Ebola virus outbreak, http://www.peaceau.org/en/article/communique-of-the-484th-meeting-of-the-psc-on-the-ebola-virus-outbreak.

INTERNATIONAL SOLIDARITY

A high level of political commitment by heads of state and governments around the world has been a notable component of Ebola response. It has brought an unprecedented level of international attention, including commitments made by the United States in September 2014 to provide substantial financial and military contributions of 3,000 troops. On 18 September 2014, the Security Council convened an emergency session to discuss the Ebola outbreak. G7 leaders plan to review the situation when they convene in June 2015, signifying that the Ebola response remains high on the global political agenda.

The UN Secretary-General appointed a Special Envoy on Ebola on 12 August and established a comprehensive UN system-wide crisis response mechanism on 8 September. At the recommendation of the Secretary-General, the General Assembly established UNMEER to support the responses of affected nations on 19 September 2014. Every month since the establishment of UNMEER, the Secretary-General has provided an update on the operational activities carried out by the United Nations system through UNMEER and its partners as well as on the activities of his Special Envoy. At a high-level meeting on Ebola[37] on 25 September 2014, the Secretary-General led international efforts to translate the political will into concrete action noting that there was *"overwhelming international political momentum for the United Nations to play a leading role in coordinating the response".*

UNMEER has undertaken both high-level and operational advocacy throughout the crisis and has facilitated communication between the governments and across all partners. It has provided a logistics platform and provided air assets for use in the wider response. UNMEER Ebola Crisis Managers were given direct responsibility for in-country Ebola response-related activities by agencies of the UN system, reinforcing their existing coordination systems and ensuring collective accountability in response to a major multi-dimensional crisis. UNMEER's role in management and coordination has strengthened since it was established, though agencies, at all times, have operated within their own mandates and operating systems. As the country-based agencies, funds and programmes of the UN system scale up their capabilities through 2015, UNMEER will draw down. Its work will be taken on by the relevant entities and be overseen by the UN Resident Coordinators who are being supported by the Office for the Coordination of Humanitarian Affairs (OCHA).

INTERNATIONAL CONTRIBUTIONS

A unique and unprecedented coalition of multiple actors has emerged to support the efforts of people and governments in countries affected by Ebola. The UN Secretary-General created the Global Ebola Response Coalition (GERC) in September 2014, to provide strategic coordination to the Ebola response. Weekly global teleconferences have been held since, chaired by the Secretary-General's Special Envoy, with the inaugural meeting early in October 2014 initiated by the UN Deputy Secretary-General.

The GERC brings together participants from the Governments of the affected countries, as well as partner governments, NGOs, foundations, representatives of the private sector, UN agencies, funds and programmes, other international bodies and regional organizations. There are usually over fifty participants in the weekly meetings. These provide a space within which

37 http://webtv.un.org/search/ban-ki-moon-response-to-the-ebola-virus-disease-outbreak/3806807194001?term="Response to the Ebola Virus Disease Outbreak.

all involved in the response can: (i) establish a common understanding of the status of the outbreak and the response; (ii) identify challenges and develop solutions to the challenges; and (iii) align their strategies and means for implementation.

On 17 April 2015, the World Bank Group announced US$650 million in funding for recovery during the next 12 to 18 months. This took the organization's total financing for Ebola response and recovery efforts to US$1.62 billion, including US$1.17 billion from the International Development Association (IDA) and at least US$450 million from the International Finance Corporation to enable trade, investment and employment in Guinea, Liberia and Sierra Leone. The World Bank has received pledges worth US$43 million towards its Ebola Recovery and Reconstruction Multi-Donor Trust Fund. These contributions come on top of US$2.17 billion in debt relief which during 2015-17 will save the three countries about US$75 million annually in debt payments.[38]

Alongside the direct contributions to Governments and responders, a strategic and highly flexible UN Multi-Partner Trust Fund (MPTF) was established. By early April 2015, 40 contributing UN Member States, as well as businesses and foundations had enabled the distribution of more than US$130 million for priority actions being implemented through nine UN system entities. The Government of Colombia was the first contributor and the top five donors to date have been the United Kingdom, Sweden, Germany, India and Finland. The MPTF encourages adaptation of responses through a small grants programme that UNMEER administers. Grants from the MPTF have supported the construction of CCCs, set-up of logistics bases and the transportation of cargo and personnel. They have funded human resources for surveillance, contact tracing and monitoring, logistics management and social mobilization activities. They have enabled thousands of children affected by Ebola, orphans and Ebola survivors to have a better life. They have supported cross-border Confidence Building Units by the MRU.

Many donor agencies have provided imaginative and far reaching support, drawing on different capacities within their own governments, supporting civil society, professional and NGO groups, offering finance and setting up novel coordination and implementation procedures. Many countries contributed to health care for responders (including Medical Evacuation) with continuous involvement of the WHO and financial support from many – particularly the Paul Allen Family Foundation. In addition, the European Union hosted a High-level Conference on Ebola in Brussels, on 3 March, which paved the way for the recovery discussions that have followed. The Presidents of Guinea, Liberia and Sierra Leone presented their national recovery plans at the World Bank Group's high level meeting "Ebola: The Road to Recovery" on 17 April. Based on an Ebola Recovery Assessment coordinated by UNDP and supported by the broader UN family,[39] these lay out what is required to help societies get back on track and start overcoming the effects of the outbreak. These plans will be further advanced at the UN Secretary-General's International Ebola Recovery Conference, to be implemented jointly with the Presidents of the three most affected countries, on 10 July 2015 (organized by UNDP). The plans will require predictable and sustainable support from the international community.

38 http://www.worldbank.org/en/news/press-release/2015/04/17/ebola-world-bank-group-provides-new-financing-to-help-guinea-liberia-sierra-leone-recover-from-ebola-emergency.

39 http://www.undp.org/content/dam/undp/library/crisis%20prevention/Recovering%20from%20the%20Ebola%20Crisis-Full-Report-Final_Eng-web-version.pdf.

CONCLUSION

Liberian Red Cross, Monrovia, Liberia - WFP/Rein Skullerud

The Ebola response has yielded dramatic results. The number of people diagnosed with the virus has dropped markedly. Liberia was declared Ebola free on 9 May 2015. This progress is the result of remarkable contributions by numerous actors who have implemented their assistance in a flexible yet strategic manner. But, in April 2015, 30 people are still contracting Ebola every week, and we still don't know the causes of all new infections. **The outbreak is not over and the response efforts must be sustained until we get to zero cases throughout the region and are able to stay at zero for several months. At the time of writing, this outcome is not a foregone conclusion**.

The effects of Ebola go well beyond the thousands of lives lost to the disease. With increased unemployment and food insecurity, reduction of an already scarce health workforce and disruption to essential services such as primary healthcare and education, **early recovery must be pursued alongside a meticulous and vigilant response. Services must be kept safe and implemented within a context of thorough and effective surveillance**. Health systems have been stretched to their limits by the outbreak, with a negative effect on maternity wards and reproductive health services as well as other non-Ebola services. Some health facilities closed all together, others were restricted to Ebola patients or offered very limited services. Birth registration and child vaccinations declined and many more services were affected.

Many schools were closed with some being converted into ETUs, leaving approximately five million children out of school since the middle of 2014. This year, schools gradually reopened in the three most affected countries but some parents still fear sending their children to study, believing for instance that a child who survived Ebola can still infect others.

Siah Tamba

"As a survivor, I know what Ebola means." That's why Siah Tamba, a Liberian nurse aid, decided to work at the IOM Ebola Treatment Unit in Sinje, after having contracted the virus in June 2014.

Tamba was treated for two weeks in an ETU and was later pronounced free of Ebola. She then had to face the stigma of being a survivor: shopkeepers would not take her money, and she lost her house when the owner drove her out. "So still you are not free, even though you had been treated", she says.

The Liberian nurse aid now tries to educate others and reduce their fear of interacting with Ebola survivors. At the ETU where she works, she takes care of Ebola patients, "giving them courage, giving them hope." "I think it was necessary to come here and work in the fight of Ebola because I want to see Ebola getting out of Liberia," she says.

[Adapted from the "From Victim to Caregiver: An Interview with a Liberian Ebola Survivor", 4 February 2015, UNMEER, https://ebolaresponse.un.org]

On the road to recovery, overcoming stigma will be a decisive factor in rebuilding societies. Survivors face rejection from their families and neighbours. Some have lost their job or their house. Many survivors have themselves been active in combatting stigma but more work will be needed to ensure that Ebola survivors are not seen with fear.

The number of people falling below the poverty line is expected to increase by about 7.5% in Guinea, 14% in Sierra Leone and 17.5% in Liberia, compared with projections before the Ebola outbreak.[40] At the end of last year, some 520,000 people were food insecure due to Ebola, and an estimated 1,235,000 people in the three most affected countries needed immediate assistance to protect their livelihoods and prevent malnutrition at the beginning of this year.[41]

40 UNDP, Socio-Economic Impact of Ebola Virus Disease in West African Countries, 2015.
41 FAO and WFP, Special Report, FAO/WFP crop and food security assessment, 5 January 2015, and Cadre Harmonisé Technical Committee 2015.

Investment in early recovery should deliver sustainable benefits to communities across the affected countries within twelve months and should contribute to the **revival of the impressive economic growth of recent years**. To be confident that future risks of Ebola can be contained, it will be important to ensure strong prevention measures are in place and to maintain high levels of preparedness across the region. This three R's approach—Response, Recovery, Revival—should tackle the vulnerabilities that allowed the outbreak to spiral upwards and should re-establish the development trajectory that Guinea, Liberia and Sierra Leone are pursuing.

Ending an epidemic is always the hardest part. The progress that we fought so hard for could still be quickly lost if we lose focus and stop being vigilant. To get to zero and stay at zero demands programmatic perfection: a perfectly calibrated final stage of the response that is complemented by adequate investment in recovery. **This outbreak of "the terrible disease" started with one infected person: that is why this time we must not fail to eliminate Ebola from the human population**.

May 2015

Sierra Leone, March 2015; Photo: WFP/Rein Skullerud

ACRONYMS

ASEOWA	African Union Support to the Ebola Outbreak in West Africa
AU	African Union
CCC	Community Care Centre
CDC	Centers for Disease Prevention and Control
CRS	Catholic Relief Services
ECOWAS	Economic Community Of West African States
EOC	Emergency Operations Centre
EPSMG	Ebola Private Sector Mobilization Group
ETU	Ebola Treatment Unit
GERC	Global Ebola Response Coalition
GOARN	Global Outbreak Alert and Response Network
HIV/AIDS	Human Immunodeficiency Virus / Acquired Immune Deficiency Syndrome
IDA	International Development Association
IFRC	International Federation of Red Cross and Red Crescent Societies
IOM	International Organization for Migration
KAP	Knowledge, Attitudes and Practices
MPTF	Multi-Partner Trust Fund
MRU	Mano River Union
MSF	Médecins Sans Frontières
NGO	Non-Governmental Organisation
OCHA	Office for the Coordination of Humanitarian Affairs
SARS	Severe Acute Respiratory Syndrome
STEPP	**S**top the outbreak, **T**reat the infected, **E**nsure essential services, **P**reserve stability, **P**revent outbreaks in countries currently unaffected
The Three B's	Behaviour, Beds and Burials
The Three C's	Community engagement, Case finding and Contact tracing
The Three R's	Response, Recovery, Revival
UN	United Nations
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNMEER	United Nations Mission for Ebola Emergency Response
UNMIL	United Nations Mission in Liberia
WAHO	West African Health Organization
WFP	World Food Programme
WHO	World Health Organization

Help in passing: everyone should know about Ebola. UNICEF Social Mobilizers help people to better understand how to help protect themselves, Sierra Leone 2014. Photo: UNICEF/ Tanya Bindra

Back Photo:
In a project sponsored by UNMEER, volunteers work on the restoration of the NV Massaquoi School in West Point, Monrovia, Liberia, which was used as holding centre and Ebola treatment unit. It is scheduled to reopen in May 2015. Monrovia, Liberia, 11 March 2015, Photo: UNMEER/Simon Ruf


BOLA BY WASHING
S WITH SOAP
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