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70 YEARS FOR EVERY CHILD

Care and Protection of Children in the West African Ebola Virus Disease Epidemic

LESSONS LEARNED FOR FUTURE PUBLIC HEALTH EMERGENCIES

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The primary author of the report is Andy Brooks, Regional Child Protection Adviser for UNICEF's Office for West and Central Africa. The report is based on findings from fieldwork conducted by two consultants, Marie de la Soudiere (Guinea and Sierra Leone) and Keith Wright (Liberia) who conducted interviews and collated data across the three countries between September and October 2014. Keith Wright provided the first draft of the report.

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Contents

Kenema, Sierra Leone - Ebola survivor outside her house. (July 4th, 2016)

UNICEF/Jonathan Torgovnik/Verbarim Photo Agency

Acronyms

C4D	Communication for Development
CDC	Centers for Disease Control
CPIMS	Child Protection Information Management System
CVPE	Conseils Villageois de Protection de l'Enfance
DERC	District Ebola Response Centre, Sierra Leone
EOC	Emergency Operations Centre
ETU	Ebola Treatment Units
EVD	Ebola Virus Disease
FTR	Family Tracing and Reunification
HAC	Humanitarian Action for Children
IASC	Inter-Agency Standing Committee (Guidelines on MHPSS in Emergency Settings)
ICC	Interim Care Centre
IMO	Information Management Officer
LLA	Lessons Learned Assessment
MHPSS	Mental Health and Psychosocial Support
MoGCSP	Ministry of Gender, Children and Social Protection, Liberia
MoHSW	Ministry of Health and Social Welfare, Liberia
MSWGCA	Ministry of Social Welfare, Gender and Children's Affairs, Sierra Leone
NERC	National Ebola Response Centre, Sierra Leone
NGO	Non-Government Organisation
NYHQ	New York Headquarters
OICC	Observational Interim Care Centre
PHEIC	Public Health Emergency of International Concern
PFA	Psychological First Aid
PPE	Personal Protective Equipment
PSS	Psychosocial Support
RITE	Rapid Isolation and Treatment of Ebola
SOP	Standard Operating Procedure
TC	Transit Centres
UNMEER	United Nations Mission for Ebola Emergency Response
WASH	Water, Sanitation and Hygiene
WCARO	West and Central Africa Regional Office, UNICEF
WFP	World Food Programme
WHO	World Health Organisation

Lessons learned and recommendations

This report describes the lessons learned from those who were directly involved in the implementation of the Child Protection Programme during the Ebola Virus Disease (EVD) epidemic response in West Africa. Information is drawn from programme experience in Guinea, Liberia and Sierra Leone during the period of August 2014 through to December 2015.

The Public Health Emergency of International Concern (PHEIC) related to Ebola in West Africa was lifted on 29 March 2016. A total of 28,616 confirmed, probable and suspected cases were reported in Guinea, Liberia and Sierra Leone, with 11,310 deaths.[1] The epidemic had a dramatic effect on children. During the epidemic, 9.8 million children and youth under 20 years old were from EVD-affected areas, 2.9 million under the age of five years. Five million children were not able to go to school because of school closures. By December 2015, UNICEF reported that an estimated 22,702 children were registered as having lost one or both parents or primary caregivers to Ebola.

Ebola survivor and orphan in Freetown, Sierra Leone. (October 17th, 2015)

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In the first chaotic months of the epidemic, control measures did not take into account the impact the epidemic was having or would have on children; nor did it account for the influence children would have on how the epidemic developed. As EVD spread, the main response was a sectoral health response. Soon, however, it was clear that a health-only response was overlooking two major drivers of the epidemic: fear and mistrust. It is now agreed that a multi-sectoral response that respects social customs and works with communities should drive the strategy for a successful disease epidemic response.

Fear was a significant part of the context of the EVD epidemic in Liberia, Sierra Leone and Guinea. During the epidemic, people reacted out of fear, which sometimes led to denial and increased risk-taking behaviour. Fear can create mistrust, which can foster hostility against a humanitarian response. During the first months of the EVD epidemic, initial social mobilisation efforts were sometimes misguided in the confusion and thus contributed to fear in communities instead of alleviating it. Communication messages and methods of dissemination spread more panic than understanding. Words such as 'quarantine', 'infection' and 'isolation' were prevalent at a time when 'tolerance', 'accompaniment' and 'compassion' were what people needed to hear most.

With rumours spreading and fostering distrust and anger, people fled their villages and potentially spread the virus; EVD-affected children and families faced stigma and exclusion by their communities; communities rejected important health messages from the outside; and violence was instigated against health and humanitarian workers.

[1] http://apps.who.int/iris/bitstream/10665/205686/1/WHOsitrep_28Apr2016_eng.pdf?ua=1, page 9.

There are many reasons for why the EVD epidemic eventually began to abate and the numbers of illnesses started to decline, including that it was simply due to the natural life cycle of the virus. The reasons for it will continue to be discovered and debated for some time. But in general, there was a shift from community anger and rejection to community engagement: communities started to trust, and people started to partake in the solution.

To build trust with communities, interventions related to Child Protection increasingly worked in closer coordination with the health and social mobilization response, particularly as de-centralized coordination improved. The response took on a more holistic and indeed humane approach. What started as one-way communication on what to do and what not to do evolved into an engagement based on dialogue.

Within this evolution, social workers played a critical role by sitting down with affected communities, children and families, ready to listen, cutting through the confusion to the reality that people lived: *"I need to feed my children. I need access to health care."* Social workers could not always provide the solutions but they provided a space and time for vulnerable – often grieving – families to express their fears and basic needs. They also could coordinate with a range of service providers to facilitate appropriate responses.

The Child Protection Programme had two major roles in the EVD epidemic response: to ensure a care and support system for children directly affected by the EVD epidemic; and to provide psychosocial support (PSS) to children in their homes and communities to help them understand and come to terms with their experiences and loss. To deliver the Child Protection response, two main programme components were developed: Mental Health and Psychosocial Response (MHPSS); and care and support to EVD-affected children and their families, including centre-based care. The strength of the systems for Data Management and Programme Coordination proved critical variables in delivering an efficient and effective response, alongside the timely availability of sufficient (both in scale and quality) financial and human resources.

The degree to which the response was successful in addressing the scale and unique nature of the protection needs of children provoked by the epidemic is the subject of this report and provides the following key lessons learned and recommendations.

KEY LESSONS LEARNED

For the purposes of the Lessons Learned Assessment, a *"Lesson Learned"* included:

- An activity that was counter-productive and should be avoided in the future;
- A programme intervention that was not effective, efficient and should be avoided in the future;
- A programme intervention that was not so effective or efficient but could be improved based on our experience to date;
- A programme intervention that was effective, efficient and timely and thus should be implemented in a future public health emergency;
- An activity that was very useful and could become standard practice;
- Systems/documents that can be used in the future e.g. statistical models, SOPs, training manuals, guidelines and/or
- Aspects or factor(s) of the response that should be included in the planning and implementing process.

The following are the major lessons learned from the Child Protection response during the Ebola epidemic in West Africa.

1. A health epidemic requires a multi-sectoral child rights approach.

The Ebola Virus Disease (EVD) response in general did not sufficiently acknowledge and address children's rights: the focus on and support to children across the sectors, including the health sector, was a limited and delayed part of the overall EVD response. At times, the EVD response actually undermined children's rights by separating children from their families without parental consent, closing children's access to education and health care and failing to develop communication strategies that engaged directly with children and included them specifically in the messaging. Future epidemic or public health emergencies require a multi-sectoral response based on what is in children's best interests, in line with the most fundamental of child rights' principles.

2. A community-based response is best.

In West Africa, a community-based response should have been adopted from the outset of Ebola to tackle a dynamic, unpredictable epidemic. It is essential to work with and develop trust with communities. Community leaders must be included as part of the response. The messenger is as important – if not more important – than the message. Even during the peak of an emergency, an approach based on listening to people's concerns, rather than telling them what they should and should not do, will save resources, save time and save lives.

The evidence from the EVD response is that with an approach based on community dialogue, led by local leaders and supported in a coordinated way by social mobilization, health and social workers, then individuals, families and communities are able to adapt to difficult behaviour changes that are required to curtail an epidemic.

3. The Child Protection response should be targeted and measurable.

The Child Protection strategy for the EVD response took time to develop. The specific and priority role of Child Protection in the response was not immediately obvious and the core interventions, though familiar from other humanitarian contexts (see below), required significant adaptation in the context of Ebola.

Defining the *Minimum Package of Services* across the three affected countries in the first quarter of 2015 was an important breakthrough in both the communication and delivery of the Child Protection response. The classification of EVD-affected children (e.g. EVD survivors, EVD "orphans", children in highly-affected communities, etc.) alongside the defined package of assistance was practical and allowed for clear markers and denominators in program implementation. Although some Child Protection Officers were concerned that it was a "dumbing down" and simplification of the Child Protection Programme, the *Minimum Package of Services* was the most direct and clear way to communicate *who* the beneficiaries of the child protection programme were, *what* interventions were to support them and *how* this would be monitored.

4. Mental Health and Psychosocial (MHPSS) programming is an essential part of a response to a public health emergency, but requires clear definitions and improved expertize.

Given the nature of the epidemic, the speed with which it spread and the extent of fear and fatality it caused, psychosocial support (PSS) gained quick prominence as a priority intervention across Liberia, Sierra Leone, and Guinea. And with its prominence - based on accountabilities within UNICEF's corporate emergency response framework, the *Core Commitments for Children* - was the expectation that the Child Protection Programme would lead in defining and implementing the response. But there remained throughout the EVD response ambiguity about MHPSS: what it was exactly, and why and how to apply it in the context of a public health emergency. It was another programme area that suffered from a lack of coordination between Health and Child Protection actors.

Whilst MHPSS interventions were included in the centre-based and community-based Child Protection Programme, they were quite missing from health facilities when they were set up, such as the Ebola Treatment Units (ETUs) and the Community Care Centres (CCCs). The level of awareness on MHPSS at the outset of the emergency (e.g. familiarity with *The MHPSS IASC Guidelines*) was very limited. Many of the LLA respondents for this report commented that the ambiguity, confusion and differences in perception concerning MHPSS hampered the implementation of the Child Protection Programme.

5. Family and community-based emergency support should be linked to longer-term child protection systems.

Throughout the Child Protection response, priority was rightly given to providing care and support to children in their families, within their communities. Services under the *Minimum Package of Services* included: direct case management to the most at-risk children and families; Family Tracing and Reunification (FTR) services; community-based MHPSS activities; and establishment of and support to community-based child support structures like Child Welfare Committees (Liberia and Sierra Leone) and Village Protection Councils (Guinea). Follow-up support and monitoring of community structures over the medium to long-term will continue to be essential as the front line to children's care and protection needs. Community-based care and support is the backbone of the national child protection system, which will progressively evolve with a strengthened social welfare workforce, building on the platform set by Ebola. But this will take time and considerably more investment from the respective Governments, despite some positive signals within the Ebola Recovery Plans.

6. Systems in Child Protection programming for delivery of cash grants and supplies need re-enforcement.

In the context of the *Minimum Package of Services*, a cash grant was money provided to a family who cared for a child who had lost one or both parents or caregivers due to Ebola. Overall, cash grants, if delivered on time, were considered a viable and useful support. The grants were most effective when they were provided in periodic payments with sufficient follow-up support from a social worker as part of a strong delivery structure and monitoring system. Alongside the cash grants, kits were usually delivered for families, which again were generally appreciated.

In the future, however, each type of kit should be reviewed to identify the most appropriate contents and inform decision-making about offshore or local procurement. Some elements of the kits were thought to be culturally inappropriate; some kits had contents that fell apart quickly. Despite the benefit of cash and supplies provided to families, the related procurement, distribution, monitoring and administration processes are a significant drain on programme resources. Child Protection has relatively limited experience in these areas compared to other sectors such as Health and Education. A solid lesson learned from the EVD response was to strengthen these processes and systems in Child Protection emergency programming.

7. Centre-based care: a service of last resort.

Centres for separated and unaccompanied children were a last resort when family or community options were not possible. Initially, the major incentive to set up centres came from an alarming situation at the height of the outbreak: ambulances were bringing entire families to Ebola Treatment Units (ETUs) and infected parents were admitted to the centre with non-infected children. Children were exposed to a very dangerous environment with nowhere to go, without basic documentation of their family residence or members of extended family who might offer alternative care.

A teacher measures the temperature of a student, before entering this school in Forecariah, Guinea.

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Sierra Leone, (centre, left-right) a health worker wearing personal protective equipment, gives medicine to a baby being held by a woman, in Helemorie Village in Tonkolili District. (April 26th, 2015)

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With the benefit of hindsight, systems to register families and facilitate families' knowledge of infection control at the moment of concern about infection (again, based on stronger links between a medical and child protection response) could have reduced the number of children placed in centres or beyond family care. The length of time children spent in centres could have been reduced by systematically initiating family tracing at the child's admission to the centres (which were designed for quarantine care), not waiting for transfer to longer-term care facilities.

In Guinea, where there were the fewest children placed in centres, the mobilization of a small group of emergency foster carers in the vicinity of the ETUs was a good practice. Not only was this more socially acceptable but also cost effective.

8. Accurate and timely data is essential.

The sheer number of cases and the speed and geographic spread of the epidemic created unique data management challenges. In particular, no data on *"children affected by EVD"* were collected or shared systematically to inform the EVD response. Without accurate, daily data, there is no mechanism to guide, plan and carry out interventions. Where technical capacity for information management was strong or pre-existing for Child Protection, the programme response was more effective and better targeted. In hindsight, UNICEF should have deployed at the onset of the response a dedicated Information Manager for Child Protection: a lesson learned from this emergency, as it has been from many previous ones.

Much can be done to scale-up existing data collection tools (e.g. PRIMERO and RapidPro) during non-emergency periods to strengthen general data collection and management as well as to familiarize staff with simple approaches and technologies. If and when a country faces a large-scale humanitarian emergency, such tools are potentially agile and light enough to be adapted for an emergency context.

9. Coordination for improved efficiency: regional, national and de-centralized level.

Effective data collection is closely linked to effective coordination. When coordination works, data flows. Just as the Information Manager is an essential profile in the emergency response so too is a Coordination Officer – with or without the designation of the cluster arrangements. At the national level, coordination must be closely articulated with the de-centralized level, to ensure national response planning will target the areas of greatest need. This proved particularly challenging in the context of an epidemic that moved across the country as quickly as Ebola, shifting its epicentre at the height of the outbreak in unpredictable ways.

In Sierra Leone, when the National Emergency Response Centre (NERC) linked with the District Emergency Response Centres (DERC), coordination between national and district levels as well as between different sector interventions progressively improved. The proximity of the Protection Desks within the DERCs to other parts of the response ensured a quicker and better response to vulnerable children and families.

Across the three affected countries, the regional level (e.g. UNICEF's Regional Office for West and Central Africa) made the effort to facilitate real-time learning and coordination. But in general, there was a *"country-centric vision"* that permeated much of the EVD response. To respond to a rapidly evolving, cross-border epidemic, inter-country coordination and sharing should have been systematically managed. The EVD situation had no precedent; the staff tasked to develop strategies would have benefited from better collaboration across the countries.

Concerning the Child Protection response, the Freetown Cross-border Meeting (convened by UNICEF in November 2014) developed a joint strategic framework for the three EVD-affected countries along specific action plans for each country. However, a structured, continuous and systematic process of sharing between the three Child Protection Programmes at the technical level was limited. Standard Operating Procedures (SOPs), or technical guidelines for the strategic framework priorities, were not developed jointly by different child protection programmes. On the whole, the technical work to translate the regional framework into national SOPs and guidelines was done separately by each country, with no mechanism beyond the Regional Office missions to compare notes between them.

10. Timely and immediate funding is key to an epidemic response.

This report documents the overall funding UNICEF received for the EVD response and the percentages allocated to Child Protection (which progressively rose, reaching a peak of 10 per cent of the overall EVD contribution by August 2015). The relevance of Child Protection was not sufficiently recognized by the time of the epidemic's peak (October/November 2014) and significant funding was not received until the end of 2014. The funding gap delayed deployment of human resources required for the level of response, and delayed the signature of partnership agreements required to respond to the exponentially growing needs. As a result, the Child Protection Programme faced a backlog of cases to address by the first quarter of 2015. Its efficiency was accelerated by the definition of the *Minimum Package of Services* during this period, which coincided with the injection of increased resources and deployment of additional staff.

11. Recruitment and deployment of well-trained, professional staff is critical.

The recruitment and deployment of well-trained, professional staff for the EVD response depended on three things: assurance for staff safety (i.e. medical evacuation, treatment facilities for staff, a declared non-family duty station); sufficient funding; and the availability of people with the right expertize.

Recruiting qualified, professional personnel became more efficient and swift when health-related insurances were in place and when funding increased. But the turn-over was very high. Particularly at the beginning of the epidemic, the staff who made decisions would often be gone by the time the decisions were implemented and the repercussions played out.

The role of "surge staff" who arrived from other UNICEF Country Offices was critical, allowing for quick deployment without lengthy contractual procedures (although the Level 3 Emergency procedure supported the process). Staff who were deployed with a familiarity of UNICEF procedures helped them to hit the ground running. For National Officers who came as surge staff from other countries, the response was a stepping-stone in career development. For newly-recruited national staff in the three affected countries, the available level of both financial and human resources in the Child Protection Programme, if well managed, allowed for a concentrated learning opportunity.

The LLA highlighted specific profiles required for a Child Protection response in a public health emergency: experience with MHPSS, working with unaccompanied and separated children, information management and coordination expertize. In addition, the experience proved that, for emergencies of significant scale, the deployment of an experienced staff member (P4 level or higher) to provide management support to the Chief of Child Protection is invaluable in lifting the strain of partner relations and administrative and human resource responsibilities that come with rapidly expanding teams and budgets.

12. Response to the epidemic should build on existing government infrastructure and capacity.

Addressing the broader issue of human resources at the national level, a core and effective strategy was to support relevant government line ministries to expand the social worker workforce. Under the Child Protection response, the Governments of Liberia, Guinea and Sierra Leone were supported to increase the number of social workers with an additional 120 in Guinea, 108 in Liberia and 26 in Sierra Leone. The mid-level follow-up support system was also strengthened with experienced officers at the county/district/prefecture level, supported further by NGOs.

The experience with the social workers during the EVD response should provide caution about the tendency during a humanitarian response to concentrate limited resources on developing *new* cadres of personnel (social mobilizers, PSS workers, Family Tracing and Reunification workers, etc.). This approach is often at the expense of building an effective social work system based on *existing* structures and services, however depleted. Emergencies are often exactly the right moment to set the platform for longer-term reforms.

RECOMMENDATIONS

1. Future epidemic or public health emergencies require a multi-sectoral response that align with UNICEF's Core Commitments for Children in Humanitarian Actions (CCC) and specific Child Protection responsibilities. The response should ensure a continuum of care for the child in which medical interventions, led by the health sector, work closely in collaboration with social welfare and Child Protection actors for the overall care and protection of the child.

2. Mental Health and Psychosocial Support (MHPSS) is an essential part of Child Protection's role in a public health emergency. The staff of UNICEF and its partners, including Government frontline staff (i.e. health and social workers) must be trained in MHPSS for effective emergency preparedness, including both the Inter-Agency Standing Committee (IASC) and National Guidelines.

3. For continued support to the community-based, Child Protection mechanisms that were put in place during the EVD response, UNICEF and partners should support relevant line ministries to use case management systems to a) identify and address ongoing vulnerabilities in registered EVD-affected children, revising the overall caseload in the process; and b) expand the system, including data collection tools, to address pre-existing protection concerns and those aggravated by the epidemic.

4. Cash and supply assistance proved to be important components of the *Minimum Package of Services*. Lessons learned on how to strengthen cash and supply assistance under UNICEF Child Protection Programming will inform future emergency preparedness. Vulnerable families who were supported by short-term cash assistance during EVD should be linked with cash transfer or social protection programmes in the countries.

5. Ensuring a network of well distributed and trained foster carers is a core component of any national strategy for alternative care for separated and unaccompanied children. The pre-positioning of a network of emergency carers (ready to accept children on short notice for limited periods of time), linked to a functioning family tracing system, is a good strategy as part of future preparedness.

6. Information Management and Coordination are essential elements of success in Child Protection Programmes and during emergencies. Systems for both should be in place. Both an Information Manager and a Coordination Officer are non-negotiable profiles at the onset of an emergency.

A Ebola Survivor and Social Worker with a child orphaned by Ebola, Sierra Leone.

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7. Despite institutional procedures to group Sierra Leone, Liberia and Guinea under a Level 3 Emergency, and facing similar unprecedented risks, the global system-wide conference calls, regional coordination cells and knowledge management systems did not sufficiently cross-fertilize programmes' experience so they could learn from each other and adapt in real-time. More thought is required within the organization to define the most effective mechanism for efficient cross-border operations in a system largely defined by procedures for country-based programming.

8. Funding for Child Protection fell short of required levels and arrived late: in future public health emergencies, greater programmatic coherence across sectors at the start, particularly between health, social mobilization and child protection, would promote a more equitable distribution of funds to deliver the response in tandem, particularly at the time of the greatest needs.

9. Due to the complex nature of the EVD response, it was a struggle to attract timely deployment of staff with the right profiles and the high turnover rate was a problem. The existing emergency roster for Child Protection staff should highlight expertize for deployment in public health emergencies. In future, it is suggested that a minimum period for deployment is set (e.g. three months) with six-month deployment being ideal, whilst acknowledging that in certain cases, short-term, specific missions are useful.

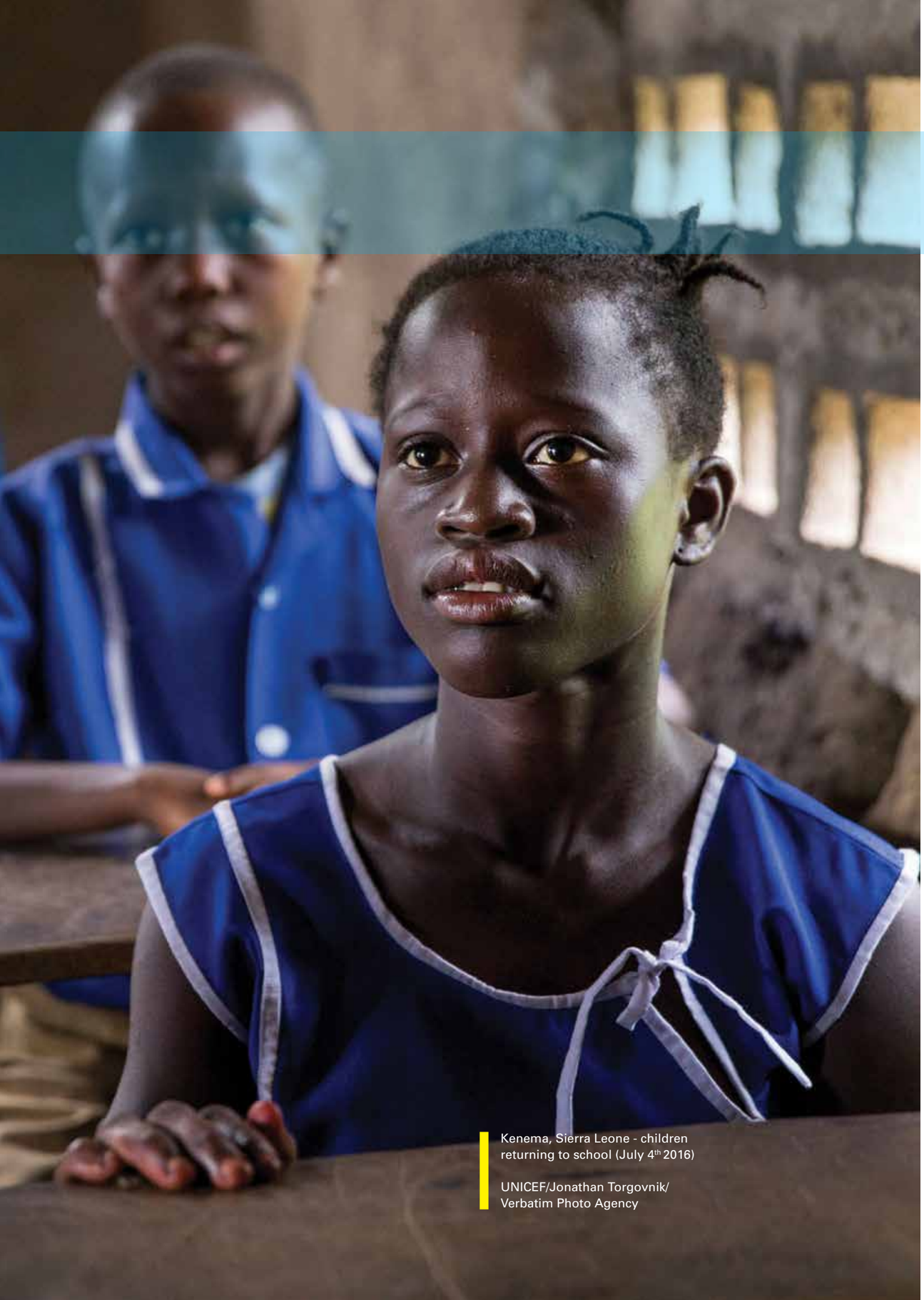
10. An emergency response should build on existing national capacities. There is a need to carefully balance a reliance on NGOs and project staff, which can complement existing personnel and accelerate the response, with well-measured and targeted support to existing social workers, building the numbers and the capacity of this limited cadre as part of the foundation for a sustainable social welfare system.

11. Annex IV presents a partial list of Standard Operating Procedures (SOPs), technical guidelines and programme strategies developed across the three EVD-affected countries. It is recommended that as a next step to the LLA, these documents are technically reviewed and verified to develop a set of common "tools" tailored to the Child Protection response in public health emergencies, including MHPSS, centre and community-based care and case management, coordination and information management. Ideally, the tools, built on best practices developed in the Ebola response, will be aligned and consolidated in a specific "kit" for future public health emergencies. The tools could also be distilled to the essential information on core interventions and included in existing normative frameworks for Child Protection response in emergencies.

12. Many of the lessons learned from the EVD response require time for reflection and verification and would benefit from an impact evaluation process. In this regard, an impact evaluation of MHPSS across the three affected countries would be particularly useful.

Children listen to a daily radio programme organized by UNICEF Rural Radio Forecariah, about Ebola, Guinea.

© UNICEF/Timothy La Rose



Kenema, Sierra Leone - children returning to school (July 4th 2016)

UNICEF/Jonathan Torgovnik/ Verbatim Photo Agency

BACKGROUND

The Lessons Learned Assessment

METHODOLOGY

This report describes the lessons learned of those who were directly involved in the implementation of the Child Protection Programme during the EVD epidemic response in West Africa. Information is drawn from the programmes in Guinea, Liberia and Sierra Leone from experience during the period of the EVD epidemic: August 2014 through December 2015.

The Lessons Learned Assessment (LLA) fieldwork was carried out in September and October 2015. It focused on the two priority programme intervention areas: Mental Health and Psychosocial Support (MHPSS) and centre-based, family-based and community-based care and support for children who lost one or both parents or caregivers and other EVD affected children. The roles of data collection and of child protection coordination - crucial to stopping any epidemic and of critical support to the two Child Protection priority programmes - were also a focus. Interviews and research were conducted in each field to determine gaps and how to address improvement.

A review of financial and human resources accessed to support the Child Protection response to the EVD epidemic was also undertaken. The information gathered is both qualitative and quantitative in nature. It was collected from interviews and field visits as well as a review of the existing information management systems related to the programme response, staffing and financial data. The LLA process had three steps: a desk review; field level information collection; and a three-country technical review meeting. Two consultants facilitated the operations of the LLA. One consultant made a field mission to Guinea and Sierra Leone and the other consultant went to Liberia.

For the desk review, UNICEF internal documents, UNICEF Country Office situation reports, guidelines and training materials, guidelines issued by the Governments of Guinea, Liberia and Sierra Leone and research/study reports were reviewed. Based on the desk review, the proposed LLA process was drafted and proposed in the "Inception Report." This included a definition of a "lesson learned"; a working description of the assessment terms (relevance, effectiveness, efficiency and timeliness); and the data collection process to be carried out by the consultants.

Before the country field missions, the consultants met with UNICEF's Regional Child Protection Adviser and other colleagues from its West and Central Africa Regional Office (WCARO) to agree on the areas on which the LLA would focus and the analytic framework for what information was to be collected. It was agreed to focus on the following areas of the EVD response:

1. The timeliness and appropriateness of the Minimum Package of Services that had been provided to EVD-affected children;
2. Coordination of the Child Protection component of the EVD Response (within country, across borders and across different levels in UNICEF);
3. The extent to which the Child Protection Response was based on adequate and timely availability of data relating to the number of EVD-affected children and their needs;
4. Interim/transit care, centre-based care, foster care and family-based care;
5. Mental Health and Psychosocial Support (MHPSS) Response;
6. The human resource strategies deployed by UNICEF for child protection;
7. Mobilization of funds and how the funds were used;
8. The degree to which the Child Protection component of the EVD Response was articulated with other sectors in UNICEF, particularly Health and Social Mobilization.

TABLE 1: CATEGORIES OF INTERVIEW RESPONDENTS FOR THE LLA

Agency or Institution	Number of Respondents	Specific Roles or Titles
NGO	78	• 16 programme managers or project managers • 62 community-level service providers
UNICEF (programme and management)	80	• Six UNHQ (two deployed to Liberia and Sierra Leone) • 10 officers from the Regional Office (WCARO) • 54 officers based in the Country Offices • 10 officers based at the sub-national level.
Governments of Liberia, Sierra Leon, and Guinea	25	• Ministers • Leaders of the EVD response • Community-level service providers
WHO	6	• Country Representative • Technical Officers

At the time of the LLA, there was EVD active transmission in Guinea and Sierra Leone and the programmes were still in an emergency-response mode. Thus, it was not entirely possible to predict whom the consultants would meet, and under what circumstances. It was decided to have semi-structured interviews. The majority of the interviews with respondents were individual interviews, some were with small groups of two to three persons and a few interviews were with specific groups i.e. international NGOs, national Child Protection NGOs, and County/District Coordinators.

A woman looks at an illustration in a flip book held by a social mobilizer, in a community in Forécariah Prefecture. UNICEF-supported social mobilizers are conducting education awareness session on EVD and providing communities in the prefecture with information on key behaviours to protect themselves against the disease. (May 7th, 2015)

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The main source of information about the lessons learned came from interviews. The LLA was not designed to collect primary-source data at the service delivery level. At the time there were no technical evaluations to draw upon.

The LLA methodology was deliberately designed to give Programme Officers the opportunity to explain their own experiences, and to offer personal assessments of what happened. The LLA was designed to be a positive learning experience for programme staff. As a consequence of the nature of the LLA described above it was agreed that there would be no individual attribution in the report.

Over 200 people were interviewed with the following breakdown of the main categories of respondents.

The UNICEF Country Offices, relevant government ministries and NGOs were requested to provide details of programme strategy and data on implementation. Information on the deployment of human resources and funding (received and expended) was requested from the UNICEF Country Offices.

The third stage of the LLA was a Technical Review Meeting. The meeting brought together Child Protection Officers from Government, UNICEF and NGOs from Guinea, Liberia and Sierra Leone. The objective of the Technical Review Meeting was to review the results of the LLA. There were 29 participants – seven from Guinea, 16 from Liberia, four from Sierra Leone and two from WCARO. Of the total participants, six were Government officers, 13 participant NGO officers and 10 UNICEF officers. All were directly involved in the provision of child protection services in the EVD Response.

LIMITATIONS OF THE LLA

The LLA process was deliberately designed to obtain lessons from the experiences and observations of programme staff. The semi-structured nature of the interviews limited the degree to which the LLA could obtain the same type of information on any one particular point from all respondents.

It was assumed that the experiences would be backed-up with specific data or examples that could be used as objective evidence. However, often the data or specific examples were not available. Data was limited in most of the programme areas. Thus it was very difficult to determine a common lesson between two or more submissions that were different or opposing. The consultants returned to contentious points, or had several interviews with the same person, to try to identify the lesson.

Many of the lessons relating to impact on the children require verification through an impact evaluation process. The fact that there was active transmission of EVD on-going in Sierra Leone and Guinea, coupled with the short period of the field visit (a week in each country in Sierra Leone and Guinea and three weeks in Liberia), limited the depth to which the interviews could go and information that could be collected. The report tries to avoid an imbalance of details and lessons from any one of the countries.

A family sit by the grave of their 2 year-old son and brother who died of measles. This family lost 29 members of their family in the EVD outbreak and were too scared to take the little boy in the picture for his final routine vaccination that included the measles vaccine. (Waterloo, Freetown, Sierra Leone, February 22th, 2016)

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CHAPTER ONE

The Ebola Virus Disease Epidemic

THE EVD EPIDEMIC IN WEST AFRICA

On December 6, 2013, in a village in Guinea, a two-year-old child fell ill and died within a few days. Later, this child became known as Patient Zero of the worst Ebola epidemic in history that swept through three West African countries with a total of 28,657 suspected cases and 11,325 deaths, the true magnitude of the outbreak generally understood to be far worse.

On 23 March 2014, Guinea's Ministry of Health notified the World Health Organization (WHO) of a rapidly evolving outbreak of Ebola Virus Disease (EVD) in forested areas in the southeast of the country. One week later, Liberia's first two cases of Ebola were confirmed in a village near the border with Guinea; by April 7, there were 21 reported, confirmed cases and a pattern was detected that would become a striking feature of the outbreak: the numbers included three cases of health care workers, all fatal. (By the end of September, Liberia would have nearly 200 infections in health care workers.) After a deceiving period of calm, in mid-June the Liberian capital, Monrovia, reported its first EVD cases. The disturbing news was indicative of another characteristic of this epidemic: the virus had spread to a city centre.

The urbanization of EVD was alarming. The epidemic's spread was swift into city centres where population density and hygiene issues are more complex, and where the illness loomed close to airports, sea ports and transportation hubs. Unlike past outbreaks in Equatorial Africa (where the Ebola virus has been confined to remote, rural areas), cities – including the capitals of all three countries – were epicenters of intense virus transmission.

In Sierra Leone, the outbreak began slowly and silently, gradually building up to an escalation of cases in late May and early June. On 11 June 2014, Sierra Leone shut its borders for trade with Guinea and Liberia but on July 20th the first case was reported in the Sierra Leonean capital Freetown. The outbreak was now un-deniable; within 10 days, the Government began to deploy troops to enforce quarantines.

> *"This was not an epidemic with three different national patterns, but likely hundreds of distinct patterns, with their own transmission dynamics, playing out within individual districts and sub-districts."* [2]

Guinea, Liberia, and Sierra Leone are among the poorest countries in the world. The region was still emerging from years of civil war and unrest that had left basic health infrastructures severely frail. West African governments were poorly prepared and overwhelmed by the social and economic upheaval that can accompany an outbreak of this disease. Populations could not understand what hit them or why. As the outbreak spread, many hospitals, short on both staff and supplies, were overwhelmed and were forced to close. Having experienced decades of civil war already in Liberia and Sierra Leone, the stress of EVD on individuals was cumulative, building on traumatic war experiences of the past. Individual stress levels were reported to be high. In some reported cases, children had reached the point of "toxic stress".[3]

The Ebola Virus Disease (EVD) is a rare and deadly viral illness spread mainly by direct contact (broken skin or mucous membranes) with blood or body fluids including, but not limited to, urine, saliva, sweat, faeces, vomit, breast milk, and semen of a person who is sick with or has died from Ebola. It can also be transmitted by objects (i.e. needles) contaminated with body fluids from an Ebola patient or from the body of a person who has died from Ebola.

Nurses wearing personal protective equipment (PPE) walk past patients at the newly opened Ebola treatment centre run by the International Federation of Red Cross and Red Crescent Societies (IFRC), in the city of Kenema in Eastern Province, Sierra Leone. (October 1st, 2014)

[2] www.who.int/csr/disease/ebola/one-year-report/liberia/en/
[3] Toxic stress is defined as "prolonged activation of stress response systems in the absence of protection Response relationship " Center of the Developing Child, Harvard University, USA. (Story reported to LLA)

A GLOBAL CRISIS

On 8 August 2014, WHO declared the outbreak a public health emergency of international concern.[4] Panic entered the international community. By September, however, with more than 1,800 confirmed EVD deaths in Guinea, Liberia and Sierra Leone, the global response was still struggling to keep up with the spread of the disease and there was genuine concern that the epidemic was beyond the control of the response being put in place. Concerned U.S. officials called for the military to be brought in.

On 26 September 2014, the WHO issued an alarming statement: *"The Ebola epidemic ravaging parts of West Africa is the most severe acute public health emergency seen in modern times"*.[5] On September 30, the US Government Centers for Disease Control (CDC) estimated that without additional interventions or changes in community behaviour, there would be approximately 550,000 Ebola cases in Liberia and Sierra Leone—or 1.4 million with corrections for underreporting—by January 20, 2015.[6] The figure spread quickly through international media channels. By October 4, President Obama had ordered 3,000 military personnel to West Africa and declared,

"This is both a biological plague and a psychological one, and fear can spread even faster than the virus."[7]

FEAR, MISTRUST AND HOSTILITY

Fear was significant in the context of the EVD epidemic in Liberia, Sierra Leone and Guinea. People reacted out of fear, which led to increased risk-taking behaviour and poor decision-making (such as hiding corpses, or running towards or away from ambulance drivers). During the first months of the EVD epidemic, initial social mobilisation efforts were sometimes misguided in the confusion and thus contributed to fear in communities instead of alleviating it. Communication messages and methods of dissemination spread more panic than understanding. Words such as 'quarantine', 'infection' and 'isolation' were prevalent at a time when 'tolerance', 'accompaniment' and 'compassion' were what people needed to hear most.

With rumours spreading and fostering suspicion, fear and anger grew in the general population. Some fled their villages in fear, increasing the potential to spread the virus. There was reported rejection of EVD-affected children and families by their communities. Communities rejected health messages from the outside as well, and there was violence committed against health workers and humanitarian workers. In the early months of the epidemic, remote communities were confused and motivated by fear; they became reluctant or outright refused to accept life-saving new behaviour advice and interventions.

The initial instinct to quarantine districts and villages was counter-productive. Without food or services provided daily to quarantined households, panic arose and distrust deepened. Villagers had more confidence in their own, traditional tribal doctors who prescribed remedies that did little to combat the pandemic.

Traditional Chiefs in Liberia and traditional leaders in Guinea later reported that the initial social mobilisation initiatives were inappropriate and insensitive. Liberian traditional leaders explained that some initial elements of the response were perceived to pose a threat to deep-rooted social values. For example, cremation, not a cultural practice, was strongly rejected; but those who died of Ebola in Montserrado County in Liberia (with 50 per cent of total reported cases) were cremated and the fear of cremation spread nation-wide.

Communities were instructed to act against their traditional rituals as well. With the "no-touch policy", a sick person was to be kept separately and no care could be given to keep him or her clean or attend to their needs. Food was to be placed outside of the room and the plate destroyed after one use; practices that went against traditional cultural habits. It was forbidden to wash a corpse or perform the wake. People died in Ebola Treatment Units (ETUs) without relatives knowing what happened or what became of the remains, and without having an opportunity to practice burial rites. Burial was done by teams of strangers, whose strangeness was accentuated by the full Personal Protective Equipment (PPE) they wore.

Those who survived EVD were accused to have brought EVD into the community. Social relations with survivors were strained and often characterized by suspicion. There was stigma and discrimination against survivors and their families.

These measures and experiences that fostered more fear, hostility and distrust towards government and outside aid created a huge challenge to controlling the outbreak. On August 16, 2014 at a facility in a Monrovian slum, several hundred people chanting 'No Ebola in West Point,' opened the gates and took patients from a centre used to temporarily isolate people suspected of carrying the virus. Many in the crowd said that the Ebola epidemic was a hoax.[8]

[4] www.who.int/mediacentre/news/statements/2014/ebola-20140808/en
[5] www.who.int/mediacentre/news/ebola/26-september-2014/en/
[6] www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/qa-mmwr-estimating-future-cases.html
[7] www.washingtonpost.com/sf/national/2014/10/04/how-ebola-sped-out-of-control/
[8] pbs.org/newshour/rundown/raid-ebola-clinic-sparks-new-fears-infection-patients-flee/

CONFUSION AND FEAR

In early August 2014 in Eastern Saniquellie, Liberia, a child was suspected of EVD infection. He was taken alone by a police vehicle on an eight hour drive. to the ETU in Monrovia. Left behind, the family was not fully informed on events and were clearly upset and scared. They demonstrated at the County Office of the Ministry of Health and physically threatened the health staff demanding to have their child returned home.

In Sierra Leone, cases were reported of children being transported between districts to an Observational Interim Care Centre (OICC) for 21-day observation, their families left at home with no means of communication. There were cases of children being taken unaccompanied to and from ETUs in ambulances and ad hoc vehicles, with neither the children nor the people they left behind confident of where they were going or when they would be back.

In a town outside of Conakry, Guinea in September 2014, two Red Cross volunteers were beaten while trying to conduct a safe burial. (In Guinea, Red Cross teams were attacked on average ten times a month in 2014.)[9] Later that month, the bodies of eight aid workers and journalists were found in the village latrine; three of them had had their throats slit. The dangers under which health workers were trying to function were worsening as frightened locals blamed doctors for perpetuating the virus. Major medical humanitarian agencies were reporting that violent attacks against their workers might force them to leave.

AN UNEXPECTED REVERSAL

Some argue that the response contributed to the situation in spreading EVD. The first communications created a top-down dynamic: the messages – *"Ebola Kills"* - and the way messages were delivered created fear. However with time, initial messaging and prescriptive approaches began to turn to dialogue with community leaders and engagement with communities.

"Communities across the region are very diverse, and a one-size-fits-all approach with one-way messaging instead of a community-centred approach is doomed to fail."[10]

Of course there are many reasons for the reversal, including that it was simply due to the natural life cycle of the virus. And how the epidemic abated will continue to be discovered and debated for some time. (For example, when facilities were set up closer to the people, trust in the system grew, and faith in the possibility of recovery from Ebola also increased.) But in general, there was a shift from community anger and rejection to community engagement: communities started to trust and started to partake in the solution.

To build trust with communities and learning from past mistakes, an increased number of Social Welfare Officers (or social workers, depending on the country) and Social Mobilization Officers worked *with* the health workers who had been leading the response. The response took an approach that was less prescriptive and distant and more engaging and humane. What started as one-way communication changed as social workers sat down beside the families and were there *to listen*, cutting through the confusion to the reality that people lived:

"I need to feed my children. I need access to health care."

Social workers could not always provide the solution but they provided a space and time for vulnerable – often grieving – families to express their fears and basic needs; and they could coordinate with a range of service providers to facilitate appropriate responses. Although the nature of the epidemic's decline varied from place to place, country to country, overall the numbers started to decrease. Communities had required unique responses tailored to each situation, and the changes had to come from within the communities, based ultimately on individual behaviour changes. In other words, the drop in cases is believed to be related to a collective community response, building on individual behaviour change.

On March 26, 2016, two and a half years after the first case of EVD was detected in the village in Guinea, WHO terminated the Public Health Emergency of International Concern (PHEIC). The end of transmission was declared in Guinea on June 1, 2016 and in Liberia on June 9, 2016. The official case count: 28,616 confirmed, probable, suspected cases were reported in Guinea, Liberia and Sierra Leone with 11,310 deaths.

[9] www.reuters.com/article/us-health-ebola-guinea-idUSKBN0LG-1GO20150212
[10] www.msf.org/en/article/ebola-crisis-update-17-july-2015

A mother holds her baby daughter in a market in the city of Nzérékoré, Guinea.

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CHAPTER TWO

Children and Child Protection in the EVD Response

I. CHILDREN AND CHILD PROTECTION

In the first chaotic months of the EVD epidemic, control measures did not take sufficiently into consideration its impact on children and, in turn, the influence that would have on how the epidemic developed. As EVD hit, the main response was a sectoral health response. This was followed by Social Mobilization (also known as Communication for Development or C4D) to attempt to address the drivers of the epidemic and change behaviour. Child Protection was brought in as it became clear that families were being separated and children's care was being seriously compromised.

Although the initial WHO and United Nations Mission for Ebola Emergency Response (UNMEER) strategies referenced the need for continuity of essential social services to ensure that children's needs and rights were covered and protected during the EVD outbreak, the LLA respondents felt that Child Protection had been given low priority by UNICEF. There was a singular UN system-wide approach in responding to EVD to which UNICEF made significant contribution. However, at least in the early months, the effort focussed predominantly on containment.

Child Protection began to gain acknowledgement as a major component of the global EVD response towards the end of 2014. In November 2014, the Child Protection component of the EVD response was reviewed, based on the experience to date, in a cross-border meeting in Freetown, Sierra Leone that brought together the Governments, UN partners and NGOs from the three affected countries with representation from international NGOs and UNICEF Headquarters and Regional Offices. In the same month, UNICEF produced a Programme Guidance Note that emphasised a community approach. The note stressed the need to prioritize and scale-up core programme areas that would alter the course of the epidemic: (a) Social mobilization/community engage-

[11] 3 November 2014 UN News Centre www.un.org/apps/news/story.asp?NewsId=49239#.Vx9TMGM4PzI

"DEATH IS ALL AROUND THEM"[11]

DISPATCH FROM THE UNITED NATIONS NEWS CENTRE, 3 NOVEMBER 2014

At UN Headquarters, Dr. Peter Salama, Global Ebola Emergency Coordinator for UNICEF, told reporters that the agency will be doubling its staff from 300 to 600 in the three most-affected countries – Guinea, Liberia and Sierra Leone – where children account for one fifth of all Ebola cases.

Dr. Salama also said an estimated 5 million children are affected and some 4,000 children have become orphaned from the current epidemic.

He described as *"terrifying"* the epidemic as seen from the eyes of the millions of children in the three most affected countries where *"death is all around them."*

"Schools are closed, children are confined to their homes and discouraged to play with other children," he said.

In addition to those orphaned, the UNICEF Global Ebola Coordinator said *"many more are sent away for their own protection"* and are confined to *"quarantine centres not knowing whether their parents are alive or dead."*

UNICEF, he said, is reaching out to Ebola survivors who are often willing to work on the frontlines of the disease response at the community level in local care centres with community health workers.

Kenema, Sierra Leone - Ebola survivor playing in the court yard of her school. (July 4th, 2016)

UNICEF/Jonathan Torgovnik/Verbatim Photo Agency

ment; (b) Community Care Centre roll-out (with support from Health, WASH and Nutrition Programmes) and (c) *the associated elements of child care and protection.* Between the time that Freetown meeting convened and March 2015, a broad regional Child Protection framework evolved into targeted and clearly-defined national strategies of support, with designated accountabilities for EVD-affected children.

By June 2015, the framework of the Humanitarian Action for Children (HAC) included Child Protection, defined as *"psychosocial support, family tracing and reunification and alternative care for separated and unaccompanied children"*, as one of the 11 UNICEF Priority Areas.[12] The other 10 priority areas were:

- Social Mobilization/Communication for Development
- Case management with a focus on community care and infection prevention and control
- Provision of Personal Protective Equipment (PPE) and other supplies for EVD response
- Access to essential medicines, health services and medical supplies
- Infant and Young Child Feeding
- Access to safe water and hand-washing
- Continuity of education through innovative approaches to learning
- Provision of non-food items
- Continuity of HIV-prevention and treatment services
- Ebola preparedness and prevention activities

Initial Child Protection Assessments

Child Protection assessments of the EVD epidemic carried out in Liberia, Sierra Leone and Guinea during the early stages of the epidemic made clear that a programmatic response for Child Protection was needed.

In July 2014, an assessment in Guinea found that at least 5,200 children, including 1,458 orphans, were directly affected by Ebola, and a total of approximately 136,900 children were living in Ebola-affected communities.[12] EVD-related vulnerabilities included family separation, stigmatization and rejection, increased child labour and neglect, school drop-out and worsening poverty. A reported 70 per cent of 10 to 14 year-old children were afraid of becoming infected, dying, being forcibly displaced and/or losing parents. They felt anxiety, withdrawal, sadness and loss of self-confidence.

In August 2014, according to the assessment carried out in Sierra Leone (Kenema and Kailahun Districts) there were signs of increased separation of children from their families.[13] Public opinion indicated that child labour was on the rise. It was reported that there was great stress on family and community relations and a growing threat to household income. Information on EVD was not reaching families and communities; service providers had limited knowledge about EVD control measures; and there was a general lack of essential commodities (e.g. bedding, clothes, and food) for children. Closure of health facilities and schools was predicted.

In August 2014, an assessment undertaken in Liberia highlighted school closure, health facilities' closure, the death of parents and caregivers (orphanhood) and EVD's far-reaching impact on children's care and protection rights.[14] The statistics at the time showed that 15 per cent of the confirmed EVD cases were children. With the health services overstretched, nearly one million children were not receiving immunisations and 26,300 malnourished children were at risk. It was feared that the slow-down of the delivery of WASH services would place about one million children at risk.

[12] MDE, UNICEF, 2014
[13] MoSWGCA, UNICEF, 2015
[14] UNICEF, 2014

II. SHAPING THE CHILD PROTECTION PROGRAMME RESPONSE

Two major steps shaped the Child Protection Programme EVD response: a cross-border meeting held in late 2014, and the subsequent development of a Minimum Package of Services.

The Freetown cross-border meeting

In November 2014, the main Child Protection agencies and actors from Liberia, Sierra Leone and Guinea met in Freetown, Sierra Leone. The cross-border meeting - a platform for a system-wide organizational response in support of the concerned Governments - was a crucial first step. The Freetown meeting brought together relevant line ministries, NGOs and UNICEF Child Protection teams from each country to compile the latest information and analysis into one framework from which the core of the Child Protection Strategy was developed. UNICEF's Associate Director for Child Protection from UNICEF Headquarters participated in the meeting with Regional Office staff and the Coordinator and Information Management Officer of the Child Protection Working Group who were based in Geneva.

Immediately after the Freetown meeting, the EVD Child Protection framework was developed, including an Action Plan for each of the three affected countries, with identified Regional Office and Headquarters' support to the Country Offices. This was the basis for targeted programmatic action for Mental Health and Psychosocial Support (MHPSS) and for the care and protection of children who had lost their parents or primary caregivers to the epidemic. The framework also profiled the additional staff required, including for MHPSS; strengthening systems for alternative and family-based care; coordination; and information management. As resources started to flow for Child Protection initiatives, additional staff were brought on board.

By the end of December 2014, following the priorities agreed upon during the Freetown meeting the month before, the Child Protection Programmes was reporting significant progress. Table 1 shows the numbers and types of care centres put in place in each EVD-affected country, and the beneficiary numbers for Psychosocial Support (PSS) and Family Tracing and Reunification (FTR).

The Minimum Package of Services

Building on the Freetown programmatic framework – and in response to increased funding that came with heightened visibility and understanding of children orphaned by Ebola – UNICEF worked across the three countries to develop a *Minimum Package of Services* for EVD-affected children. The package was finalised in January 2015 in Liberia; February 2015 in Guinea; and March 2015 in Sierra Leone. *The Minimum Package of Services* was the most direct and clear way to communicate *who* the beneficiaries of the Child Protection Programme were; *what* interventions would support them; and *how* this would be monitored. Although some Child Protection Officers were concerned that it was a "dumbing down" and simplification of the Child Protection Programme, the *Minimum Package of Services* clarified the accountabilities and deliverables of the Child Protection Programme, and became the core of the Child Protection Strategy across the three EVD-affected countries. Each country organised the support differently.

[15] The ICCs in Sierra Leone pre-existed the EVD epidemic: they were facilities providing care for separated and unaccompanied children linked to an active family-tracing network in the country.
[16] OICCs were set up in Sierra Leone to provide 21 day quarantine care for separated and unaccompanied children who had been in contact with infected persons and required the 21 day observation

TABLE 2: CARE CENTRES AND NUMBERS OF BENEFICIARIES, BY COUNTRY, AS OF DECEMBER 2014

	Guinea	Liberia	Sierra Leone
Number of Transit Centres	2	3	-
Number of Interim Care Centres (ICCs)	1	1	15[15]
Number of Observational Interim Care Centres (OICCs)[16]	-	-	13
Number of Children who received PSS	9,353	3,750	4,921
Number of Children helped with FTR	1,621	-	14,766

Source: UNICEF Situation Reports December 2014 and January 2015).

The Child Protection Strategy targeted four categories of children, recognizing a child's situation might fall under more than one category or change over time:

1. Children who lost one or two parents or a primary caregiver due to EVD
2. Children who were survivors of EVD
3. Children in quarantine situations (home, community, care centre)
4. Children who lived in communities heavily affected by EVD

The following is a general description of the Child Protection Minimum Package of Services.

1. For **children who have lost one or more parent or a primary caregiver due to EVD and children who are survivors of EVD** (i.e. categories 1. and 2. above), a case management approach included:

   - Registration and assessment;
   - Family tracing and reunification, or provision of alternative care (for children in OICCs, ICCs and TCs);
   - A cash grant;
   - Monthly follow-up and referrals (as necessary) for six months;
   - Non-food items and connection to WFP et al for food distribution;
   - Assistance to return to school and school kits;
   - Assistance to medical services and
   - Psychosocial support (by social workers on follow-ups, or referral as needed).

2. For **children in community-based quarantine**: (Children in centre-based quarantine received services in line with the minimum standards defined for centres, see "key strategies" below.)

   - Daily home visits, and support using MHPSS approaches and interventions including Psychological First Aid (PFA);
   - Coordination with other agencies to ensure provision of essential commodities and
   - FTR for children placed outside immediate family care or in OICC/ICCs with provision of six months of follow-up and with relevant referrals to other services, as needed.

3. For **EVD-affected children who live in communities heavily affected by EVD**, activities included:

   - PSS for children, including children's clubs, sports and recreation activities, and through teachers in schools trained in PFA;
   - Formation of and support to existing community Child Welfare Committees/Village Protection Councils;
   - PSS for adults in communities, including community healing events, celebration and community events and parenting education and
   - Family kits to vulnerable families.

A 10 year-old girl, whose mother and father died from ebola, attends a class in a primary school in Waterloo Freetown, Sierra Leone. (February 23th, 2016)

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TABLE 3: NUMBER OF REGISTERED ORPHANS AND SUPPORT RECEIVED, BY COUNTRY, DECEMBER 2015

	Guinea	Liberia	Sierra Leone
Registered orphans (children who lost one or both parents or primary caregivers)	6,220	7,858	8,624
Orphans reported to receive *Minimum Package of Service* support	6,001	5,401	2,496

Note that the reported figures do not specify a category for "child survivors". "Orphans" is the category that is tracked.

As the overall Child Protection Strategy took shape, consensus was built with partners on the key interventions that would be adopted to deliver results. (Specific achievements of the core programme interventions are provided in further sections of this report.)

1. Priority to **family- and community-based care and support to children** with: direct case management approaches to the most at-risk children and families; FTR services; community-based MHPSS activities; establishment and support to community-based child support structures like Child Welfare Committees (760 in Liberia) and Village Protection Councils (836 in Guinea) and community volunteers.

2. Establishment of **care centres or designated foster carers for children** who have been in contact with infected family members and do not have alternative family or community based quarantine care for a period of 21 days. Children who cannot be reunified beyond the quarantine period or who were separated from families/appropriate adult caregivers and cannot return home but were not necessarily exposed to the virus were placed in existing longer-term centers of foster families, pending family tracing and reunification or longer-term placement in alternative care;

3. **Build on existing government infrastructure and capacity:** e.g. recruitment and training of additional social workers and mental health clinicians, and establishment of a support system for the social workers at the district, county and prefecture level supported by UNICEF and partner Field Officers for the duration of the epidemic. Decentralisation of material support to social workers etc. at county and district level.

4. Support **coordination at the national and sub-national level and build/ strengthen a data system** within the social welfare system.

5. Development of **Standard Operating Procedures (SOPs), technical guidelines and programme strategies** across core interventions.

6. Provision of kits and cash grants (FTR kits, discharge kits, school kits, reintegration kits, family kits and hygiene kits) as part of the above interventions.

UNICEF met indicator targets and most HAC targets for supporting Ebola "orphans" and providing PSS to children. Table 2 shows the number of registered orphans by country who had received the *Minimum Package of Services* by end of December, 2015.

CHAPTER THREE

Core Child Protection Interventions in the EVD Response

There were two main Child Protection programme components of the EVD response: 1. Mental Health and Psychosocial Support (MHPSS) and 2. centre-based, family-based and community-based care. This chapter goes into detail on how these crucial interventions evolved, providing essential information for any future epidemic.

I. MENTAL HEALTH AND PSYCHOSOCIAL SUPPORT

The composite term "mental health and psychosocial support" (MHPSS) is used to describe any type of local or outside support that aims to protect or promote psychosocial well-being and/or prevent or treat mental disorder.[17]

Psychosocial distress experienced by people at the onset of any emergency is an issue that requires care and support, including from trained professionals. Hence, for UNICEF, MHPSS is a core area of response, especially in emergencies. UNICEF often provides leadership coordinating this issue along with other UN and international organizations.[18]

The manner in which aid is administered in emergencies has psychosocial impacts that may either support or cause harm to affected people. Humanitarian action is strengthened if at the earliest, appropriate moment, affected people are engaged in guiding and implementing the disaster response. Aid should be delivered in a compassionate manner that promotes dignity, enables self-efficacy through meaningful participation, respects the importance of religious and cultural practices and strengthens the ability of community people to support their children, families and neighbours.[19]

A woman and a child stand in a cordoned-off area for patients confirmed to have EVD, at a treatment centre run by Médecins Sans Frontières in Monrovia, Liberia. (August 29th, 2014)

In 2007, UNICEF endorsed the *IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings*, working with health, education, protection and camp management partners to develop strategies and policies, address gaps in services and help humanitarian workers better understand how to effectively serve populations living through times of crisis in a way which reinforces their well-being, dignity, and resiliency.[20]

The *IASC Guidelines on MHPSS* propose a layered response with the focus to provide basic services; establish or re-establish social and community networks and support systems; provide focussed but non-specialized services to especially vulnerable children, women and men; and provide specialized care to a significantly smaller, severely affected, percentage of the population.

UNICEF and MHPSS

Globally, UNICEF relies on four main strategies to protect and promote children's psychological and social well-being in an emergency:

1. **Support psychosocial activities for children**. This includes providing children with culturally and age-appropriate, safe and stimulating non-formal activities such as sports and activities, play and games, and activities that develop children's life skills and support resilience and coping mechanisms.

2. **Support parents and other community members to better support children**. This involves providing key messages about care of children, and engaging parents and community members (such as religious actors, youth or women's networks) in dialogue about how they can better support their children.

[17] IASC Guidelines on Mental Health and Psychosocial Support in Emergency Settings http://unicefinemergencies.com/downloads/eresource/docs/MHPSS/guidelines_iasc_mental_health_psychosocial_april_2008.pdf
[18] http://unicefinemergencies.com/downloads/eresource/mhpss.html
[19] IASC Guidelines, www.unicefinemergencies.com/downloads/eresource/docs/MHPSS/UNICEF-Advocacy-april29-Enghlish.pdf
[20] www.unicef.org/protection/57929_57998.html

3. **Ensure children and families with more severe psychological or social problems have access to professional help**. Some children and families experience problems that cannot be only managed by the existing social support network. Problems can include moderate behavioural problems in children, family disputes and/or violence, parental depression, anxiety or drug or alcohol abuse, and severe mental disorders such as Post-Traumatic Stress disorder or schizophrenia. UNICEF refers these cases to specialised service providers.

4. **Coordinate MHPSS.** UNICEF takes a leadership role in MHPSS coordination and works closely with partners working in different sectors such as health, education, protection and camp management to ensure that MHPSS and humanitarian programmes are coordinated.

MHPSS interventions and the EVD epidemic

In West Africa, fear during the EVD epidemic was a serious factor and influenced the ability to cope and make healthy decisions. For example, fear had influence over decisions such as whether to seek treatment or wait, or to report a deceased relative for appropriate burial. The nature of this epidemic especially required a holistic emergency response.

The Mental Health and Psychosocial Support (MHPSS) component of the Child Protection EVD response was arguably the largest-ever MHPSS initiative in history. MHPSS interventions got underway in September 2014 and went to scale in 2015. Well over a quarter of a million people in Guinea, Liberia and Sierra Leone were reached with PSS interventions within an unprecedented 18 months.

MHPSS is typically carried out in an environment where people can sit together or move about freely, where they can come close enough to each other to talk personally. For people in the ETUs and in the quarantine areas, however, barriers were necessary to protect the caregiver or service provider which was a less conducive way to provide MHPSS. More creativity was required to reach people affected by EVD effectively, and affected persons had to adapt as well to a different type of care. Those who in a typical emergency might be engaged to support others, such as a parent, could not be called upon to support those in ETUs or quarantine.

Under these challenges, social workers and other frontline workers (teachers, health workers, social mobilizers) used MHPSS techniques to help individuals and community groups face and grasp what was happening, understand their own reactions, and reconsider messages on prevention and social relations. This came down to a very fundamental shift in the engagement with communities: taking the time to listen rather than telling people what to do and what not to do.

UNICEF worked with other Child Protection partners to implement MHPSS through community-based group support and individual mental health interventions, keeping in sight its mandate to provide Governments with financial and technical support to develop guidelines and policies as part of its responsibility to support the development of norms and standards. Social workers were critical front line actors, and UNICEF helped the concerned Governments to increase their numbers dramatically and they were trained rapidly for field deployment.

Interventions included group and individual counselling; dialogue and one-on-one supportive listening; counselling by lay people; specialised medical care for mental health; medical care from professional service providers; some structured activities and cultural activities. People who had been through the stress of losing loved ones to Ebola (or even the fear of this) were engaged in healing ceremonies and other recreation activities. In cases when a community-based response was insufficient, there were referrals for individual children. More specifically, in Guinea simple group activities for children were conducted at village level. In centres in Sierra Leone, individual activities for children, including singing songs and playing games, were conducted.

One example of a MHPSS approach used in Liberia, Guinea and Sierra Leone was Psychological First Aid (PFA). This intervention has been used in emergencies with individuals and families immediately following a difficult event. As one approach under the umbrella of MHPSS support, PFA involves working together with the most affected populations to determine their immediate needs and linking them with appropriate support. A central component of PFA is simply communication in a supportive, non-judgemental way. This carried enormous value at a time of great fear and frustration.

During the EVD epidemic, MHPSS interventions covered a range of situations and reached different target groups. MHPSS services were provided to:

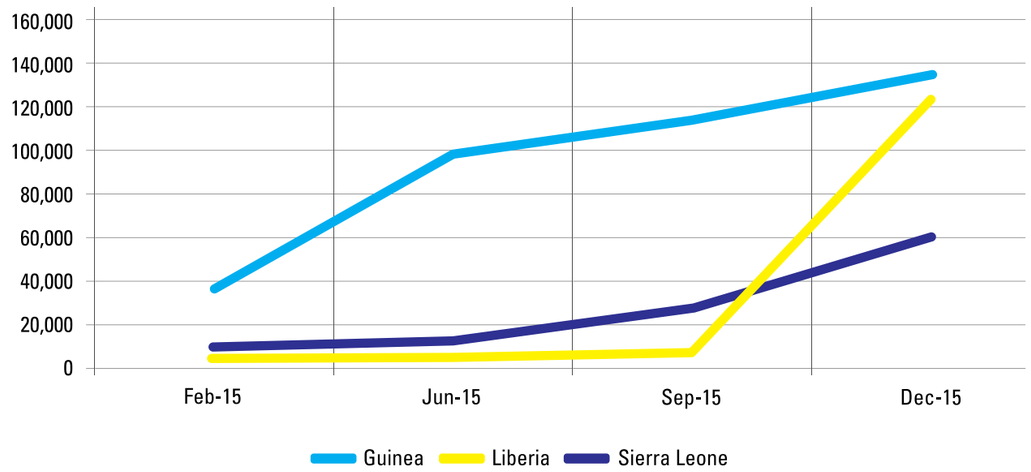
- Families in quarantined households
- Children in care centres
- Children and adults in ETUs
- Entire communities affected by EVD
- Groups of children in a community setting
- Groups of adults in a community setting
- Families of a person suspected of EVD infection
- Families considering whether a member should be referred to an ETU
- Families of a person in an ETU
- People on the contact line list

TABLE 4: NUMBERS OF CHILDREN IN LIBERIA, SIERRA LEONE AND GUINEA WHO RECEIVED PSYCHOSOCIAL SUPPORT (PSS), FEBRUARY TO DECEMBER 2015 (CUMULATIVE)

	Feb-15	Jun-15	Sep-15	Dec-15
Guinea	36,190	97,318	112,288	134,346
Liberia	3,707	4,572	7,069	122,213
Sierra Leone	9,668	11,736	27,379	58,951

Source: UNICEF Country Office Situation Reports

CHART 1: NUMBERS OF CHILDREN IN LIBERIA, SIERRA LEONE AND GUINEA WHO RECEIVED PSS, FEBRUARY TO DECEMBER 2015 (CUMULATIVE)



Source: UNICEF Situation Reports

From late 2014 to mid-2015, UNICEF Country Offices in Liberia and Sierra Leone were providing PSS to children on a steady basis. Guinea began reporting on the provision of PSS to EVD-affected children in March, 2015 and steadily increased the number of children reached to over 130,000 by late December, 2015.

UNICEF had also provided PSS to children on a large scale in the three countries, reaching more than 320,000 children by December 2015 (over a year after EVD had peaked). The increase in provision of MHPSS in the final quarter of 2015 is largely explained by the re-opening of schools in September 2015. The surge reflects teachers returning to the classroom and applying the MHPSS techniques in which they had been trained.

There was concern by some that MHPSS emphasis was on *quantity* (numbers reached), which distracted from the effort on the *quality* of services provided. Reaching large numbers in a short period with a weak service delivery structure raises questions about the quality of the outcome for the child. It raises the dilemma of reaching many quickly or reaching fewer with higher quality.

Country specific situations of MHPSS

Guinea

UNICEF Guinea focused on communities with children who were orphaned due to EVD. The work was organized by *Conseils Villageois de Protection de l'Enfance* (CVPE) that were already in place in a significant number of affected villages. By October 2015, over 3,900 community leaders from 836 CVPE were trained in child protection and Psychological First Aid (PFA); and 7,302 volunteers were trained in PFA and child-based psychosocial activities that were adapted for the EVD context. These community leaders were trained to take an active role in daily psychosocial activities for children that includ-

ed games, sports and music sessions. They were trained on referral procedures in the case of particularly vulnerable children. The trained community leaders received on-going guidance and supervision from a network of NGO partners.

In some affected villages (those with few cases of EVD-affected people), there were no orphaned children. In these cases, the establishment of CVPE was not systematic, especially toward the end of the crisis. In the context of the programme targeting the most affected areas, however, many CVPEs were put in place during the time of EVD epidemic, including in the affected prefectures.

Sierra Leone

In Sierra Leone, UNICEF staff were trained in PSS. Staff who worked in the OICCs were trained in PSS activities designed for children who resided within the boundaries of infection control. Teams of contact tracers, social mobilisation agents and food providers to quarantined households were trained in PFA. Psychosocial support to quarantined households was provided through PFA-trained personnel, including Ministry and NGO social workers and social mobility and contact tracers.

Teams operating from the Protection Desks in the newly established District Ebola Response Centres (DERC) took considerable time with each household to help address problems, provide information and assuage fears: the process was referred to as "supportive talks". The focus on survivors included discharge counselling and a counsellor escort for people returning to communities. In collaboration with religious leaders, chiefs and elders, welcome ceremonies were organised.

Liberia

In Liberia, MHPSS interventions were provided to communities in the counties where EVD was most prevalent or "heavily affected". MHPSS was provided by social workers, mental health clinicians, NGO psychosocial support workers and volunteers, including a large contingent of Liberian Red Cross volunteers and the Junior National Volunteers (members of Peace Committees) in the border counties. All volunteers were trained in PFA. UNICEF supported the training of 120 persons (social workers, mental health clinicians and NGO staff) in three weeks on "recreation for resilience" activities for children that used child-friendly approaches and active listening.

The NGOs that provided MHPSS services often had their own strategy that might include supportive listening or engagement in community dialogues. It was commendable that, for the most part, the programmes were built on existing structures and systems, and supported the relevant government ministries to carry out their leadership and management roles.

The Liberian Ministry of Health promoted a version of community healing dialogues that engaged key stakeholders over eight weeks on subjects selected by the community. Community events and celebrations were also supported, providing parent education and, if possible, support to livelihood development to encourage resiliency in affected families. Children's Clubs were designed for children comprised of recreation and sports activities and "supportive talks". PFA was part of the support package to adult survivors. Finally there was a referral mechanism to report complex cases to Ministry of Gender, Children and Social Protection (MoGCSP) social workers or the Ministry of Health mental health clinicians.

A doctor (left), part of a team from the World Health Organization, speaks with the head of a household while performing contact tracing, in Conakry, Guinea. (January 14th, 2015)

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Social workers

Social workers were essential in delivering MHPSS and directly contributed to the EVD epidemic control process, despite their limited numbers. When a family member was suspected of being infected with EVD and was taken to a treatment unit, the family became fearful. Social workers alleviated panic in a community. They took time to talk through decisions and implications with families, reducing fear and distrust in a socially and culturally acceptable manner.

Unlike a social mobiliser or a contact tracer, a social worker has a broader remit and focuses directly on the expressed needs of the people with whom he or she engages, rather than trying to promote a particular message. The social worker's roles in EVD included engaging with families and communities; liaising with health and social-mobilization workers; supporting families and children directly affected by EVD and protection of children. In the process, social workers managed and alleviated mistrust, fear and stigma.

The social worker profile varied by country during the EVD epidemic. In Guinea, there were no government social workers at the onset of the epidemic; UNICEF supported the national response by working through agreements with NGOs by case management and with cash transfers until it was able to support the Government to recruit and deploy a cadre of social workers. In Sierra Leone, a combination of government and NGO workers handled the response. In Liberia, there was an initial focus on government social workers that grew to include NGO social workers with UNICEF-supported salaries.

In the three contexts, social workers had a particular technical orientation and social approach that was invaluable. By offering support to individuals and families to make good health-seeking decisions, trained social workers were the bridge between humanitarian organizations and the people: the individuals, families and communities who had to take initiative and follow guidelines and change their behavioural habits in order for the epidemic to come to an end.

For example, in July 2015 during the outbreak in Margibi County, Liberia (with 50 per cent of the country's reported cases) a social worker on the Rapid Isolation and Treatment of Ebola (RITE) team guided families with their decision to report a family member who may have been a contact. The social worker helped them decide who went to the ETU and who stayed with and cared for the family. She guided the social relationships between the family and their community to address any potential stigma or social exclusion.

There were, however, contextual, pre-existing weaknesses in the Child Protection social welfare system and weaknesses in UNICEF's response. Before the Ebola epidemic there were very few social workers. With regard to government service-delivery, social welfare remains one of the least funded sectors and benefits from little capacity development. As a result, at the start of the Ebola epidemic in Liberia, there were only 12 social workers in the whole country and no mid-level support structure; in Sierra Leone there were 90 social workers; and in Guinea there was not a single social worker employed by the Government. The follow-up support system to the social workers was equally weak. There were few NGOs that worked in Child Protection and had the capacity to provide social work services at any scale.

UNICEF's response adopted a "build back better approach" by rebuilding, or building, the social worker workforce. As part of the Child Protection response, the Governments were supported to increase the number of social workers with an additional 120 in Guinea, 108 in Liberia and 157 in Sierra Leone. The mid-level follow-up support system was strengthened with experienced officers at the county/district/prefecture level, supported further by NGOs. Training new social workers was on an emergency basis and limited to a few days, but the intensity of their experience in the Ebola response provided them with an experience that, with the right support, will contribute to them becoming solid practitioners.

The EVD experience concerning the effective utilization of social workers should caution the tendency in humanitarian responses to concentrate limited resources on developing new cadres of personnel within project proposals (social mobilizers, PSS workers, FTR workers etc.). This can often be at the expense of building an effective social work system based on existing structures and services, however depleted. Emergencies can often be exactly the right moment to set the platform for longer-term reforms. There is a need to carefully balance a reliance on NGOs and project staff, which can complement existing personnel and accelerate the response, with well-measured and targeted support to existing social workers, building the numbers and the capacity of this limited cadre as part of the foundation for a sustainable social welfare system.

MHPSS training

In general, the MHPSS component of the programme took time to become fully operational because there was a great deal of planning and training of the MHPSS workers to carry out. All three Country Offices found it hard to recruit suitably experienced MHPSS specialists. There was limited internal capacity on MHPSS in the existing Country Programmes. In all three countries, MHPSS included training teachers in PFA (in some cases, the training is on-going). In the Guinea and Sierra Leone Country Offices, support to teacher trainings was delivered separately by the Education Programme, building on materials often developed by the Child Protection Section. In all three countries, Child Protection drafted a training manual and Child Protection Officers facilitated the start of cascade trainings down to community level. In general, few UNICEF Child Protection Officers were conversant with the MHPSS IASC Guidelines or had been trained on them. There remains ambiguity for many about the field of MHPSS and how and why it is applied in an emergency context. Many LLA respondents commented that the ambiguity, confusion and differences in perception of each activity hampered the implementation of the MHPSS programme. The terms "MHPSS", "PSS" (Psychosocial Support) and "PFA" (Psychological First Aid) are often used inter-changeably, which is not always accurate.

In June 2015, WCARO held a reportedly useful training in Dakar for Country Office staff that was facilitated by the MHPSS Specialist, which included participants from EVD-affected countries.

Training Manuals

IASC Guidelines

The Inter-Agency Standing Committee Guidelines on Mental Health and Psychosocial Support in Emergency Settings is a crucial tool in any emergency MHPSS response. The primary purpose of these guidelines is to enable humanitarian actors and communities to plan, establish and coordinate a set of minimum multi-sectoral responses to protect and improve people's mental health and psychosocial well-being in the midst of an emergency.[21]

Guinea Training Manuals

From September 2014 onwards, the WCARO Child Protection Regional Adviser recognised that there was low technical capacity in MHPSS and made an MHPSS Specialist available to support the Country Offices. The Guinea Child Protection Programme received greatest benefit from the support. Policy Guidelines were drafted in October 2014 along with the first trainings. Two MHPSS Specialists were hired in February 2015 (for six months) to support implementation. There were several visits in 2015 by the Regional MHPSS Specialist to guide drafting of the MHPSS National Strategy, the training materials and to conduct trainings. For the few NGOs with MHPSS capacity in Guinea, UNICEF's Regional Office input was welcomed. UNICEF had a leading role in the development and implementation of the strategy for MHPSS there.

Liberia Training Manuals

In Liberia under the National Ebola Response Plan, there was one Response Pillar dedicated to MHPSS that included children's needs. The MHPSS Response Pillar started with a focus on MHPSS in the ETUs, MHPSS and PFA for medical staff and establishing referral pathways. UNICEF was only able to make traction when it hired a MHPSS Specialist in January 2015.

In Liberia, the EVD epidemic actually strengthened the linkage between MPHSS and Child Protection. The social workers and mental health clinicians worked together in communities to support the children and their families. Social workers provided the frontline assessment and basic skills, referring to the mental health clinicians where additional support was required based on the assessment of vulnerability.

Sierra Leone Training Manuals

In Sierra Leone, a range of training materials was used. Originally, there was limited understanding of MHPSS among the Child Protection agencies on the ground. It was difficult to establish clear national leadership and coordination in the area of MHPSS and many NGOs used their own manuals, working independently of national frameworks. UNICEF Regional Office's role was to provide guidance on this and the regional MHPSS Specialist was regularly deployed. In Sierra Leone, the National Strategy on PSS was approved in April 2015, and MSWGCA engagement with NGOs involved in the response was through a partnership framework with UNICEF.

Unfortunately, many organisations and staff involved in MHPSS are still not clear on the concept of MHPSS and are unfamiliar with the ISAC Guidelines. There remains confusion in terms of definition and approach to MHPSS, and there was concern that certain approaches used by some organisations carried a "western bias" or were not culturally sensitive. At times, a reliance on approaches to "trauma" sometimes led to an over-medical response in a time and place where the capacity to sustain specialised interventions was limited and not appropriate- a community based response was what was required in the EVD response.

[21] www.unicefinemergencies.com/downloads/eresource/docs/MHPSS/guidelines_iasc_mental_health_psychosocial_april_2008.pdf

In Guinea, helping children find joy after a great loss

By Lianne Gutcher [22]

A boy stands together with his siblings at their home in Conakry, Guinea. (November 25th, 2014)

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For children in Guinea who have lost one or both parents to the Ebola virus, games and group activities provide a valuable way to rejoin peers and share a moment of happiness.

KANKAN, Guinea, 2 November 2015 – Excitement is running high in the Dar-es-Salaam neighbourhood of Kankan, in Upper Guinea, as children enjoy games of Simon Says, then dodge ball, then jump rope.

Four-year-old Assa Conde Bah takes her turn, and when she finishes, the other kids break into a cheer. She grins brightly.

Two weeks before, none of the other children here would play with her. As a survivor of Ebola, she was feared and stigmatized.

This stigmatization is all too common, and it affects not just Ebola survivors but also the relatives of victims. Group play and recreational activities are one way UNICEF and partner NGOs are working to help Ebola-affected children fit back into their communities.

As of mid-September, UNICEF had identified and registered 5,951 children who lost one or both parents to the Ebola virus. Among them are 58 children here in Kankan who now receive counselling and support.

Today, for example, children who have lost parents to the disease are mixing with children who have not been so directly affected. Along with supporting social reintegration, these sessions offer a way for community volunteer counsellors to provide children with the psychosocial support they may need.

"The play sessions help to eliminate any form of stigma that there might be against children who are Ebola survivors," says Mamadou Gueladjo Barry, a social worker with Enfance du Globe, an NGO that partners with UNICEF.

[22] http://www.unicef.org/emergencies/ebola/75941_86027.html

"These kids have also lost parents, and some have lost hope. We listen to them and talk to them."

Eleven-year-old Lancine Diallo lost his mother to Ebola and is now being looked after solely by his father. Lancine has been coming to the play sessions since they started at the beginning of September. He loves sports and especially likes the days when he gets to play football. Lancine says that he hasn't suffered from stigmatization himself, but he saw that when Assa arrived, she was excluded from games.

"But now it's ok," he says. *"Everyone plays with her. In the future, if I ever saw children excluding someone else, I would go and explain to them why it's wrong."*

The play sessions have nonetheless been good for Lancine, too, Mr. Barry believes, because, he explains matter-of-factly, *"They have helped him cope with the death of his mother."*

Keeping things interesting

The play sessions in Dar-es-Salaam run six days a week, and the number of children turning up is increasing daily. To keep things running smoothly, they are split into four age groups: 4 - 8, 9 - 12, 13 - 15 and 16 - 17.

The volunteer counsellors who guide the play sessions must use all their creativity to keep things interesting, inventing new games for the children to play every day. The counsellors are chosen by Village Councils for Child Protection, which UNICEF has helped establish in every village in Guinea where there are children who have lost one or both parents to Ebola.

Although there have been no registered cases of Ebola in Kankan since January, children must wash their hands and have their temperature taken as a safety precaution before they join in the games.

Family support

In addition to psychosocial support, children who have lost one or both parents to Ebola receive other types of help, as well, with funding from donors including the European Commission's Humanitarian Aid and Civil Protection department (ECHO), the US Office of Foreign Disaster Assistance (OFDA) and the governments of Germany, Sweden and the United Arab Emirates. After being registered, children's caregivers are eligible for a monthly cash transfer of $25 per child (up to $75) to buy food, clothes and other necessary items. Social workers visit their homes to make sure the family is coping and the money is being spent appropriately. The children also get a school kit containing a backpack and pens, a hygiene kit containing items such as toothpaste and soap, and a family kit with clothes and foodstuffs such as beans, rice and oil.

The volunteer counsellors are fun yet professional, and they join in all the games themselves. They are good at encouraging the children and making sure everyone gets a turn, and it's evident they have the children's trust.

In Guinea, children supervised by an adult, play outdoors in a large circle in the village of Meliandou in Guéckédou Prefecture, Nzérékoré Region. (January 10th, 2015)

© UNICEF/UNI178350/Naftalin

But when one child messes up jumping rope and is sent out by the counsellor, UNICEF's Child Development Officer in Kankan, Sarah Mouyon, has a quiet word with the counsellor. She explains that it's very important that the children are encouraged and that if they fail they must be allowed to try again, rather than being immediately side-lined.

"As well as managing the programme, my role is also to supervise the community volunteer counsellors," Ms. Mouyon says.

"The orphaned children are perhaps a little bit more shy and timid than the other kids; the death of a mother or father weighs on them. This is about helping them find joy again by playing."

II. CENTRE-BASED, FAMILY-BASED AND COMMUNITY-BASED CARE

Centre-based, family-based and community-based care was the second major component of the Child Protection EVD response.

The debate

A Child Protection Programme priority in the EVD Response was to provide care and support for children affected by the epidemic and further to the children's immediate family, extended family or community. In exceptional circumstances, a small number of affected children were cared for in especially designed centres, using existing facilities. For children who had been in contact with people who were infected by EVD (usually a family member) and could not be cared for by their family or community, centre-based facilities were opened across the three countries to provide a space for 21-day quarantine care. These children were not only vulnerable because of the loss they suffered or their separation from family care. They also represented a medical risk, as they were potentially infectious.

Family tracing was done to identify a more permanent care placement, preferably with immediate or extended family members once the quarantine period was over. If relatives were located within the 21-day quarantine and were willing to care for the children, the children would return there as soon as possible with support on how to care for the children and manage the risks. By early 2015, this included the *Minimum Package of Services* according to the National Strategy.

There was considerable debate during the Ebola response over the benefits of centre-based care systems versus children staying in family-based care (biological or non-biological family). The debate was throughout the child protection sector, between health and child protection sectors, within the influential donors, between local leaders and politicians. Opinions were divided and strongly held. In Liberia, the debate reached as far as the President.

On one side, the notion of centre-based care (within the 21-day contact period) fitted with the strategy to control the epidemic. Centre-based care provided a clear structure and pathway to manage the children of adults who were EVD cases and had themselves been exposed to the virus. It provided the best possible supervision and care to ensure children infected received fast and attentive medical care - to reduce deaths among children. It would overcome the problem of how to respond to the many situations where there was no system or structure to immediately care for the children. It was felt that children should not experience the horror of an ETU, nor see their parents in such a terrible condition or be put at risk of exposure to EVD more than what exposure had already happened. A care centre would be a place where the children could immediately go when needed. It would provide a place for proper observation and infection control and it would avoid the possibility that allowing contact children to return home would contribute to increased transmission of EVD.

On the other hand, there were many who considered that the best care, even during the epidemic (particularly the 21-day contact period), would be in a family-based setting. There was strong public support for this view. Traditional chiefs in Liberia described the fear and uncertainty concerning the epidemic which many considered a threat to some fundamental social practices, including putting children in an institution rather than keeping them with their family.[23] It was further argued that keeping the children in a centre, particularly against the wishes of the family, would increase fear. Giving up a child to a system that could lead – and contribute – to their death was unacceptable for the family. It was further argued that separation without parental permission would infringe on the rights of the child and the family. There were other concerns that even a short stay in an institution would bring an institutional mentality, as was seen in Sierra Leone

TYPES OF CARE INSTITUTIONS DURING THE EVD RESPONSE

ETU Ebola Treatment Unit, established in Guinea, Sierra Leone, Liberia.

ICC Interim Care Centre. 21 day quarantine care in Liberia and a place for post-quarantine care in Sierra Leone, which existed for separated and unaccompanied children prior to Ebola

OICC Observation Interim Care Centre, for contact children who stayed in the centre for the 21-day observation period in Sierra Leone.

Centres d'accueil temporaire de protection de l'enfant 21 day quarantine care for children in Guinea.

Transit Centre a place in Liberia for short stay for separated children (due to EVD) while family or alternative care was found (became the referral point from ICCs once they had been established and if the child's family had not been traced during the 21 day period).

[23] Ministry of Internal Affairs/The Carter Center, 2014

Women wait with their babies to see a nurse at Kondiadout, Kissidougou, Guinea. (August 1st, 2016)

© UNICEF/UN036448/Holt

and Liberia with those children who were reluctant to return home after 21 days in a centre. Both countries still carried the legacy of civil wars, during which war-affected children stayed much longer than intended in centres and orphanages, often to the personal profit of those running the institutions.

There was concern that a centre, once open, would be hard to close and would easily morph into an orphanage. Orphanages have been a continuing concern for many years. For example, there were 84 orphanages in Liberia with over 2,896 children at the time of the epidemic. For over a decade there had been a programme to improve the standards and rationalise the numbers of the orphanages but it had been hard to make significant progress. A number of "Ebola orphanages" were reported to have opened in Liberia (the LLA reported that in the height of the epidemic five orphanages opened in Lofa County where no orphanage existed before the epidemic).

Having considered all the arguments, it was decided to open care centres to ensure a care provision for a growing number of children who were being referred as completely alone and without any kind of adult care as a result of the Ebola epidemic. Each country adopted a centre-based care provision but proceeded with it at varying levels of scale and capacity.

Country specific scenarios

Guinea

In Guinea, the public attitude was overwhelmingly in favour of family-based care rather than centre-based care. As part of the Guinea Child Protection Programme two centres (Centres d'accueil temporaire de protection de l'enfant) were opened in November 2014 and February 2015. The centres received children referred by the ETU. Often they were children of parents who had been admitted as patients in the ETU. One centre had a total of eight children and the other 20 children. This was the total number of children admitted throughout the period of the epidemic. As a more socially acceptable – and cost effective - alternative, the programme created short-term foster care arrangements in communities near to an ETU for children who came with their family to an ETU. The foster homes were pre-arranged. Twenty families were on stand-by to offer short-term foster care. This system was used for 10 children by October 2015. Thus, it was a very small number of children (38) who required care outside of their immediate or extended families or communities in Guinea.

Liberia

As part of the Liberia Child Protection Programme, the first centre was opened at the beginning of September 2014. This was a Transit Centre in Monrovia: a place for short stay for separated children (due to EVD) while the family or alternative care was found. The second centre – an Interim Care Centre (ICC) - was opened one month later in October 2014 in Monrovia and closed 10 months later. The first ICC "Kerlekula" was open for all children who had been in contact with confirmed cases of Ebola.

Then an issue arose: those who had been in the centre for 15 days under observation were at risk of contracting EVD from the new arrivals, and under-five cases were more sensitive and needed special attention. The second ICC was opened for the first 15 days and the third ICC was opened for under-fives and managed by S.O.S. Children's Village, an NGO. The Transit Centre housed 67 children, of whom 98 per cent were reunited with their family. In total, the ICCs had 53 children, five of whom contracted EVD and three died. In addition, two centres (in Nimba and Bomi counties) and five Transit Centres were opened.

Sierra Leone

There were many more centres in the Sierra Leone Child Protection Programme. There were two types of centres – an Observation Interim Care Centre (OICC) and an Interim Care Centre (ICC). The OICC was for the children who were contacts and stayed in the centre for the 21-day observation period. The ICC was for those children who were already in care prior to Ebola and became the referral point for children who had been through the OICCs but whose family or an alternative care placement had not been found. The work of the centres was complemented by 22 NGOs providing FTR services, organized across the districts in the country, building on a network that had endured since the civil war that officially ended in January 2002. The children were referred by the Protection Desk (in each district). There were a total of 15 OICCs and 12 ICCs. The first OICC was opened in November 2014. As of December 2015, 610 children had received care and protection in these 15 OICCs.

Reintegration kits including a cash grant were provided upon return home or the placement of children into alternative care.

Centre-based care issues

- There was significant variation in the standard of care between the centres in Sierra Leone. A proposed process to improve and regularize standards was not approved by Ministry of Social Welfare, Gender and Children's Affairs (MoSWGCA). However, there was an SOP on management of OICCs and staff were trained on the SOP. Prior to the EVD epidemic, there were established National Guidelines and Standards plus the Alternative Care Policy concerning ICCs.

- Family tracing should have started at the moment the child entered an OICC but this was not the case at the beginning of the response. At that time, in Sierra Leone, children were transferred from the OICC to the ICC before the tracing had begun which created unnecessary delays in reunification.

- The high cost of the centres per child raised concerns for programme efficiency. For example, in Guinea a centre that cost $40,000 to establish cared for eight children before it closed after two months of operation.

- Psychological First Aid (PFA) was used by the centre staff in activities with the children; however, child protection officers raised concern about the quality of the PFA and psychosocial support that was offered.

- It was not easy to recruit appropriate staff to work in the centres. It seemed logical to employ survivors in the centres due to their immunity from the epidemic. However, the appropriateness of placing people without a social welfare background into social welfare work was questioned; it wasn't always possible to do background checks or reference checks to ensure the hired person had experience or the integrity to care for children. Hiring survivors just because of their status as survivor goes against the principle of hiring the correct fit for the position. More careful vetting and additional training would be required if survivors were to be used in another outbreak.

- Communication and information was an important issue. Coordination between service providers and the families was difficult. On occasion, families were not informed of the location of their children and the children were not informed of what was happening to them. Families had access to see the children but distance made it difficult. This issue was addressed in a number of ways, in particular through the provision of cell-phones for children and their families. Many respondents stressed the need to ensure that communication systems are established and present at the beginning of a response programme.

- The process for centre-based care and/or family-based care must begin at the same time and together with a child's case management system, referral options, and/or Treatment Unit. It will provide a continuum of service for the child, help mitigate the physical and psychological impact on children and their families, and thus contribute to reducing fear and stigma.

Family-based care

An EVD-affected child in a family or community situation benefited from a number of interventions. If they were to come via a centre they received a reintegration kit and had PFA sessions while in the centre. If the child had remained at home she or he would have PSS activities in their community and if needed PFA support from teachers (as the school-based programme rolled out). If the child was orphaned due to EVD or a survivor, he or she would receive an initial assessment followed by monthly follow-up sessions with a social worker and a cash grant.

In December 2015 UNICEF reported that some 22,702 children were registered as having lost one or both parents or their primary caregivers to EVD (Ebola orphans) in Guinea, Liberia and Sierra Leone. The majority of the children were cared for in family or community-based arrangements: in total, by December 2015, 726 children received centre-based care, representing 4.3 per cent of the total number of registered children.

The Child Protection response used the alternative care and FTR components that were part of the Child Protection Programme pre-EVD as a foundation. This was particularly the case in Sierra Leone where considerable infrastructure for children outside of family-care situations existed and where a functioning national FTR network was in place. Where appropriate, pre-existing programmes were amended to work with social mobilisation, for example with the Adolescent Girls Project in Liberia. In Liberia, the Social Protection Project continued implementation to support the most vulnerable families. However, most of the pre-existing programme components were suspended. It wasn't until mid to late 2015 that the Child Protection Programme in each country began to re-engage with regular (pre-EVD) programmes such as Violence Against Children, child marriage and teenage pregnancy, and Female Genital Mutilation (FGM/C).

As mentioned in the section on the Program Strategy, by early 2015, each of the EVD affected countries had developed a *Minimum Package* to respond to the different forms of EVD affected children. In addition to what has been said in the previous section in relation to the value of the soft part of the response through social workers and MHPSS support, it is worth looking in a little more depth at two other components of the *Minimum Package*.

Cash grants

There were two broad issues related to the provision of cash grants: the efficacy of cash grants to assist a child; and service delivery capacity to provide back-up support to the family in a timely manner once the grant is given.

The cash grant monetised the response with associated positives and negatives. The cash grant was designed to compensate for the loss of household and personal items e.g. bedding and clothing that were destroyed when a person in the household was suspected of EVD and taken to an ETU.

Each country had a different strategy for the cash grant:

TABLE 5: CASH GRANT STRATEGIES, BY COUNTRY

Guinea	US $200; to be paid in four two-monthly instalments over eight months; monetary limit of $600 per family.
Liberia	US $150; one off; per child; no financial limit to any one family.
Sierra Leone	US $80 (as part of the FTR kits) provided to designated foster families only.

Cash grants were done on a trial basis in Sierra Leone for health workers and survivors (US$35 one-off in the case of the latter). The grants were not continued or extended to other groups for fear of financial mismanagement and were replaced with the provision of kits.

Overall, cash grants, if delivered on time, were considered a viable approach. The grants were most effective when they were provided in periodic payments with sufficient follow-up support from a social worker.

There was a concern that the capacities of the delivery systems would not to be able to provide the grants in a timely manner. For example, the Town Chief of Jene Wonde (the most heavily affected community in Liberia after Monrovia) reported that of the 175 EVD orphans in town, only 23 had received cash grants by October 2015 (10 months after the last EVD case in the town). If this can happen in a high-profile community of the EVD epidemic, it raises questions about the capacity of the system to deliver.
Monetisation can, on occasion, be a disincentive or cause bias. For example, one family refused to take their nephew who had survived EVD into the family. A family nearby agreed to foster the child. However, when the biological family heard of the cash grant, they demanded that the boy come to their home, and the case was turned over to the police.

Cash grants are a short-term assistance and the main issue that families raised was the need for a regular income. The greatest unmet need was the support to develop livelihoods; it was the most common observation in the LLA. Respondents reported that many children have returned into homes with low income and poor conditions. The children in the three countries experienced extreme vulnerability even before Ebola exacerbated their situation.

A "cash grant" is money provided to a family that cares for a child who has lost one or both parents or caregivers due to Ebola.
A "cash transfer" is money provided to a vulnerable family as part of a Social Protection Programme (not part of the Ebola Response).

Cash grants were considered a viable approach, and most effective when they were provided in periodic payments with sufficient follow-up support from a social worker, Guinea. (2015)

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Kits

As part of the *Minimum Package of Services*, there were seven types of kits used by Child Protection in Liberia, Guinea and Sierra Leone:

- Reintegration kits
- Discharge kits
- School kits
- Family kits
- Family Tracing and Reunification (FTR) kits
- Hygiene kits
- MHPSS Activity kits.

On the whole, the kits were considered useful and appreciated but procurement, distribution, monitoring and administration processes were a drain on the resources of the programme.

In Guinea, the MHPSS Activity Kits had items and games that were not appropriate in the EVD context, and the kits were delayed due to offshore procurement, which also contributed to the inappropriateness of the supplies. Some games in the kits were not understood by the animators and could not be used, and the quality of sport equipment was reported to be poor. ("The balls broke after two or three days.")

But traditional musical instruments, stories, local games, dances and songs helped not only in improving children's well-being but were a means to spontaneously engage adults in participation.

In the future, each type of kit should be reviewed to identify the most appropriate. The kits could be pre-positioned and, when needed, procured quickly.

CHAPTER FOUR

Systems that Supported Child Protection Programme Delivery during the EVD Response

The previous chapter elaborated on the two main Child Protection Programme components of the EVD response: Mental Health and Psychosocial Response (MHPSS); and care and support to EVD-affected children and their families, including centre-based care. Strong Data Management and Programme Coordination were crucial to delivering these programmes, and must be prioritised as critical systems to deliver any response for future emergencies. This Chapter details the roles and experiences of Data Management and of Coordination during the EVD epidemic in West Africa.

I. DATA MANAGEMENT AND THE EVD RESPONSE

The EVD outbreak presented an enormous challenge to UNICEF Country Offices both in terms of how to respond to children in such an unprecedented emergency, as well as how to access, collect and appropriately share and manage essential data required for the response. In essence, data are meant to tell a story, provide a basis for advocacy and quick decision-making, and in this case the story was partial and blurred, with enormous blind spots, particularly in the beginning of the response. The ever-changing nature of the EVD epidemic demanded available data on a daily basis for programme planners and managers in order to make intelligent, informed decisions and focus their interventions effectively, and much of the time this was painfully difficult.

A boy laughs as he plays on a swing in the city of Kenema in Kenema District, where social mobilizers are raising community awareness about EVD and distributing soap to households during the three-day stay-at-home curfew. (March 29th, 2015)

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The broad picture of the EVD epidemic was drawn with daily figures of the number of cases (confirmed, probable and suspected); the number of deaths; the number of new contacts; and the number of survivors. Child-specific data, however, also required on a daily basis to monitor and respond to the particularly vulnerable situation of children during the epidemic, was insufficient. Data were needed on children whose parents had EVD symptoms and were therefore contacts and at-risk; children whose parents or caregivers had died and needed immediate interim care; children who themselves had symptoms and required urgent medical care, often requiring isolation and separation from one's family and caregivers; children experiencing stigma from communities as a result of being a contact or a survivor of EVD; and children who needed a wide variety of non-food items and multiple forms of psychosocial support.

As with every humanitarian response, clarity of terminology, alignment of data collection tools as well as what is measured through key indicators is vital for effective data coordination and management. As is often the case with measuring the complexity of child protection responses, however, this was challenging to fully achieve. For example, *Number of EVD-affected children provided with minimum package of PSS services*: in this context, "provided" was difficult to precisely interpret. Did a "first-case management visit" imply that the children were provided with a minimum package? Or would only completing the case management process successfully count as "provided"? What constituted a successful conclusion of the intervention for a child? Moreover, indicators that measured provision, measured *process* and the *delivery of services* but not the actual *quality of services*. The objectives of MHPSS (i.e. to support the care of children in their family/community setting and address fear, stigma and distrust) implies an outcome, but the process to measure or monitor the objectives is difficult to assess.

Owing to initial contextual differences in each country and with each country's response, there were variations and nuances in the definition of indicators used by each country. For example:

- An indicator that was defined in Sierra Leone and Guinea as "EVD-affected registered children provided with minimum package of services" was defined in Liberia as "Participants in EVD-affected areas provided with PSS package of services".

- In Sierra Leone "EVD-affected children cared for in a family-based setting" was listed in Guinea and Liberia as "Registered children who lost one or two parents or primary caregivers due to EVD who received a minimum package of support/nationally agreed package".

Data availability, access and sharing

In general and across the three EVD affected countries, data on children (i.e. age-disaggregated data) was inaccessible, incomplete and insufficient. In response to the LLA interview questions concerning data use and availability, respondents stated that they were severely constrained by the lack of consistent, high-frequency monitoring data in the planning and management of Child Protection programmes. It was difficult in each country to ensure clear systems and workflows of data collection and dissemination under the social welfare ministries, and a challenge to connect the information with the national EVD response systems.

As the epidemic evolved and coordination became better focused, however, EVD data, including age-disaggregated data on children, became more available on a higher-frequency basis. At the same time, information on UNICEF and partners' programmatic response grew.

Data available for planning varied significantly across the three countries but ultimately included:

- Numbers of EVD-infected children;
- Numbers of EVD-affected children;
- Numbers and location of children who had lost parents or caregivers;
- Numbers and locations of contact children;
- Numbers and location of child survivors.

Obtaining data in real time on the number of children infected was another challenge. The data on the incidence of EVD in children was obtained from the VHF (viral hemorrhagic fever) Linelist Patient Database (which contains detailed individual case data), but there were problems with the data's timeliness, availability, consistency and accuracy. In October 2014, UNICEF made an agreement with WHO to share the VHF Linelist and it was made available to the three UNICEF Country Offices. However, the task to clean and analyse data was great; and it was difficult with the limited staff and capacity at the Regional and Country Office level to make the most use of the data.

Data on the daily status of children who were admitted to an ETU (whether admitted or accompanied by a family member) was difficult to obtain on a regular basis. Organisations running ETUs were generally not approached by social welfare ministries or child protection agencies to collaborate with data collection. By October/November 2014 it was common practice for each ETU to have a team of MHPSS specialists on their staff, but not necessarily specialists in Child Protection nor Data Management.

Data collection

At the beginning of the response, an immediate scale-up of data collection was required from partners and government counterparts, and this was initially through paper-based forms. Each country created its own forms and methods for high-frequency data collection and reporting, which were completed by social workers and other staff working directly with children, and recorded such things as the registration of children who had lost one or both parents or caregivers, provision of a cash grant or a family-visit report. As the response evolved, the data and reporting requirements evolved as well, resulting in numerous revisions to the paper forms.

Normally the information from the paper form was transferred to a computer at the sub-national level. A government team at the national level checked the accuracy of the input and analysed the data. (This government-level data management team was hired specifically for the EVD epidemic response and was supported by UNICEF staff.)

In Guinea, data on orphans were collected by multiple Child Protection actors in the field. Most were direct implementing partners for UNICEF so information sharing was relatively straightforward, making it easier to harmonize reporting tools and maintain a functional data flow in support to the National Coordination. For other agencies and organisations, data on registered orphans was centralized and processed by the Information Manager of the Child Protection sub-cluster, and then shared with the National Coordination.

In Sierra Leone and Liberia, NGOs used their own data systems to collect data on children affected by the epidemic and on the response. Particularly during the first few months of the response and when the epidemic was spreading rapidly, the NGOs were still not in the habit of sharing data, neither between themselves nor with respective ministries. The process to develop the reporting and database system took some months and continues to be refined.

As the response scaled-up and the demand for data on children and Child Protection increased, UNICEF Country Offices shifted from a paper-based system to electronic data collection and data management systems. The scale-up to electronic data management systems was not seamless, wildly uneven at times, and yet urgently needed. As such, the three countries each explored and innovated somewhat similar approaches to mobile data collection and electronic data management systems, based on existing capacity and technical support received.

In Guinea, a mobile data collection system based on KoboToolBox was rolled out in July 2015 to monitor assistance to orphans by social workers with the Ministry of Social Affairs. The system provided up-to-date data on services received by each child registered in the orphan database. This was largely successful due to excellent child protection information management capacity that was surged for a relatively longer period to the Country Office, previous experience in the open-source KoboToolBox in other humanitarian contexts and management buy-in.

In Sierra Leone, the Chief of Child Protection had hired an innovations specialist prior to the EVD emergency response who started to support the Ebola response at UNICEF in November 2014 with existing connections in-country at the ministries and with mobile network operators. As such, with significant support from the Innovations Unit (NY/HQ) and the staff in-country, Rapid Pro was rolled out relatively quickly and used in Sierra Leone for daily data from the OICCs and the Community Care Centres. The programme issued a daily report that, by all accounts, was extremely useful. Over time, PRIMERO (the newer online platform of CPIMS+) was rolled out in Sierra Leone for a more robust case management system, and effectively replaced the basics of what had been collected via RapidPro. RapidPro, however, proved to fill an important, immediate gap in data collection. This solution was workable in Sierra Leone; in Guinea, RapidPro was tested by Child Protection but it was not fully operational due to network coverage issues in remote areas.

In Liberia, Child Protection Information Management Officers (IMOs) were led down a rockier road. While RapidPro had been rolled out for some sections, notably C4D for the use of UReport, it was not used for Child Protection. Instead, CPIMS was initially customized and used in Liberia, but it was difficult to maintain and adapt because of a lack of technical capacity in country. It required requests to New York to modify, which was largely unworkable in an emergency context. (In other words, CPIMS is widely used across the globe for Child Protection issues. RapidPro was another option that Child Protection also explored but as CPIMS was already in progress, it built on that instead.)

What emerged through each Country Office experience with data collection and data management was that where technical capacity was strong or pre-existing for Child Protection; where staff had technical savvy and familiarity with current tools used across the humanitarian sector and UNICEF for data collection and management; and where coordination mechanisms for Child Protection were functional - the response was less painful and easier to act on quickly.

KoboToolBox is a free and easy-to-use, open-source tool for mobile data collection that allows to collect data in the field using mobile devices with pre-loaded digital forms. It works offline and can be rolled out rapidly in humanitarian situations, with full professional support provided by OCHA. It has a limited built-in ability for data analysis, but allows to export data directly to Excel for further analysis as required.

Rapid Pro is an open source platform that allows to easily build and scale mobile-based applications. It is designed to send and receive data as text messages using basic mobile phones, manage complex workflows, automate analysis and present data in real-time. Its deployment relies on pre-existing mobile network coverage and prior engagement with mobile network operators.

CPIMS is an integrated, inter-agency child protection information management system that facilitates case management, family tracing and reunification and data analysis of children with specific vulnerabilities. The tool appeared to be difficult to maintain in an environment subjected to dynamic and changing information needs, as has been the case during the EVD outbreak. It has been upgraded to a new software called CPIMS+ as one of several modules within the new protection-related information management platform called PRIMERO.

Much can be done to scale up both PRIMERO and RapidPro during non-emergency periods to strengthen general data collection and management as well as to familiarize staff with simple approaches and technologies. If and when a country faces a large-scale humanitarian emergency, such tools are potentially agile and light enough to be adapted for an emergency context. This humanitarian response, however, revealed innovation and enormous courage in the face of partial data on the part of child protection actors and decision-makers, and holds promise for the future.

Data quality

Overall, there was little confidence in data quality. It was described by LLA respondents as "vague, unreliable and erratic".

The UNICEF Guinea Child Protection Programme contracted Gamal University to conduct an independent monitoring of the children who were registered as having lost their parents or caregivers. From a random sample of 10 per cent of the total number of children registered "orphans", about 10 per cent of those did not fit the definition for the registration. There was duplication of registered orphans noted in Guinea due to partners working in overlapped areas. This was resolved with a mapping of partners (3W) by the Child Protection Sub-cluster coordination and the development of a unique national database on EVD orphans.

In Sierra Leone, when a monitoring and evaluation agency was engaged to verify the number of registered children who had lost parents or caregivers, the figure was 30 per cent lower (from 18,400 to 11,000): 3,500 could not be traced because of missing addresses, another 3,900 were "not found" at the given address.

In Liberia, there were similar tracing issues due to incomplete or out-dated data sets (lack of address or unknown case status) in the incidents management lists provided by the Ministry of Gender, Children and Social Protection.

The situation was significantly improved with the recruitment of Information Management Officers (IMOs) in January 2015 in Guinea, and a month later in Sierra Leone. The UNICEF Liberia Child Protection Programme recruited an IMO for only six months, from December 2014 to May 2015; the Child Protection Sub-Cluster coordinator handled data management through the epidemic until June 2015 when the MoGCSP hired an in-house database manager and the Child Protection Emergency Manager took over the coordination.

II. COORDINATION

The role of child protection coordination in emergencies

Coordination supports programming. The Child Protection Coordinator is a powerful advocate and leader for the sector, but it is the collective commitment to coordination from everyone who responds that allows programmes to operate.

The Cluster Approach is defined by groups of humanitarian organizations (UN and non-UN) in the main sectors of humanitarian action. The Cluster Approach is used when clear humanitarian needs exist within a sector, there are numerous actors within sectors and national authorities need coordination support.

Country-specific coordination and the EVD response

Guinea

Since 2010 in Guinea, there have been Child Protection coordination structures at national, regional (CRPE), prefecture (CPPE), sous-préfecture (CLPE), district (CLPE) and village/community (CVPE) levels. The CVPE were established in 2013, but most had been somewhat dormant. They were put in place however, in particular in Upper Guinea and Guinea Forestiere, and at the onset of the EVD epidemic they were in the process of being operationalized. The Child Protection EVD response boosted the multiplication and operationalization of this community structure at village level, especially in the affected prefectures.

In August 2014, the Child Protection Sub-cluster was revitalized in Guinea with the launching of the PSS and Child Protection Needs Assessment. A ToR was developed (September 2014) and meetings were held on a monthly basis. The coordination became fully operational when UNICEF hired a Sub-cluster Coordinator dedicated to support the national coordination. The meeting agenda became every two weeks and coordination and harmonization progressively improved. Coordination difficulties, especially in Guinea Forestiere, were also progressively addressed and two additional sub-clusters were put in place in Nzérékoré and Macenta which greatly improved coordination between actors. The National Sub-cluster organized meetings at decentralized level to support coordination efforts where and when needed.

Liberia

The national leadership and coordination of the EVD response was the responsibility of the Ministry of Health (MoH) in Liberia.[24] The MoH considered child-related issues the responsibility of the Ministry of Gender, Children and Social Protection (MoGCSP).

Thus, child-related issues were not on the agenda of the daily coordination meetings unless brought up by the MoGCSP, which was rare. As a consequence, child-related issues were not high profile in the national response structure.

UNICEF Child Protection Programme had a solid relationship with both the Ministry of Health and Social Welfare (MoHSW) and the MoGCSP and supported both Ministries (mandates and responsibilities changed during the EVD response – see below) to lead the coordination of Child Protection, increasing the social welfare workforce tenfold in 2014.

The need to de-centralize the EVD response to the county level was recognised in the early stage of the epidemic. However, it took a great deal of time before it could take place. The main issues were capacity of the sub-national level teams in terms of staffing, and technical and logistical capacity of the county and district health teams to be able to lead the EVD response in their locations. The other important issues related to salary and incentives of Government staff. By mid-August 2014, some government funds were made available and the first technical teams to support the county health teams were deployed. UNICEF did not have staff on these teams, mainly because of concerns for staff safety. The first deployment of UNICEF staff to a sub-national location was in October 2014.

In the end, UNICEF had teams based in four strategic locations (Gbarnga, Voinjama, Zwedru and Harper) and child protection issues were managed by the County Social Welfare Officer or County Coordinator. There were two cadres of officers, as the Social Welfare section was transferred from the MoHSW to the MoGCSP while the epidemic was still spreading. This change in the two Ministries caused some confusion and did not help with coordination.

The Government of Liberia did not want all the structures associated with a humanitarian emergency (and did not officially declare the epidemic to be a humanitarian emergency). The cluster system was reluctantly allowed. The Child Protection Sub-Cluster, led by UNICEF Child Protection and the MoGCSP, started in October 2014 and a Sub-Cluster Coordinator was deployed. There was good attendance at the weekly Sub-cluster Coordination meetings. However, NGOs largely worked in silos. It was reported to the LLA that there was too much 4W-type coordination[25] and not enough national strategy development, building consensus, facilitating collaboration and advocating for particular interventions.

The MoGCSP insisted that data (i.e. number of orphans and children affected) should not be released unilaterally by organisations, which brought organisations

Kenema, Sierra Leone - A girl listening to the radio in her house. (July 4th, 2016)

UNICEF/Jonathan Torgovnik/Verbatim Photo Agency

together to cooperate. However, there needed to be comprehensive data available to be able to make the coordination work better for everyone. The Child Protection Programme depended on the Sub-Cluster Coordinator to manage the data. LLA respondents recommended to put in place a Coordination Officer at the beginning of an outbreak, instead of waiting for a sub-cluster to be approved.

In Liberia, the MHPSS Pillar was led by the MoH's Mental Health Unit. The first response by MHPSS was related to the situation in the ETUs. The Child Protection Sub-Cluster became aware of the children's issues in the ETUs, particularly the issue of non-infected children being taken to the ETUs with sick family members. At the early stages, actors were unsure of how to intervene as the crisis was considered a health crisis and health actions were prioritised. There were social workers working in some of the ETUs, but there was no system in place to refer children to care and protection provisions outside of the ETU. UNICEF and the MoGCSP worked together so that social workers were placed at all the government ETUs to identify and register children for ease of family placement upon discharge. Social workers monitored ETUs so that non-ill children who had no family carers available were transferred to the ICCs where they were cared for during the 21-day observation period. Social worker contacts were shared with non-government ETUs so referrals could be made for children in need.

[24] For a long period prior to the EVD epidemic there were plans to restructure social welfare. It finally took place during the time of the EVD epidemic. Social Welfare was transferred from the Ministry of Health and Social Welfare to the Ministry of Gender and Development. The former Ministry became the Ministry of Health and the latter became the Ministry of Gender, Children and Social Protection. One result of the change was that the social workers cadre became part of the Ministry of Gender, Children and Social Protection, although fixing the anomalies in the new structure has been a contracted process.

[25] 4W: who, what, where, when.

Reporting by the MHPSS Pillar to the IMS was focused on the mental health services alone. UNICEF approached the MHPSS Pillar to see how to increase the profile of children in the Pillar reporting. UNICEF Child Protection was requested to deploy an officer at the Emergency Operations Centre (EOC) with the MHPSS team, to work with the team on a daily basis. Through UNICEF's technical support, a defined plan of action was developed and costed so that child numbers were disaggregated as part of the reporting on the EVD response. The numbers came primarily from the Child Protection Sub-Cluster, which provided both the Pillar and the Protection Cluster with the figures of children affected.

UNICEF provided technical and logistical support to the MHPSS Pillar within the EOC, so that the response to children was coordinated and managed (and provided the ICC and TC services for the children that were affected). At first these centres had no services for children and didn't know what to do with them. UNICEF initiated the registration and case management support to the children and children were placed progressively in family or community-based care. The UNICEF Child Protection Programme did not have an MHPSS specialist in Liberia until January 2015; however, with ICRC and WHO, UNICEF funded and supported basic PSS trainings for the Social Workers and Mental Health Clinicians to provide them with skills to help children in the EVD epidemic.

The UNICEF Child Protection Programme played a part, but not a leading role, at the beginning in the technical direction of MHPSS strategy and interventions. From mid-2015, when three outbreaks occurred after the epidemic was thought to have abated, UNICEF led the MHPSS response and developed the Child Protection MHPSS SoP for EVD.

Sierra Leone

With advocacy from MSWGCA, a CP/PSS/Gender Pillar was established to coordinate provision of protection services for EVD affected children and families. The pillar was chaired by MSWGCA and co-chaired by UNICEF. The MSWGCA provided strong leadership in coordination of services to EVD affected children and families. A national response plan for child protection, PSS and Gender developed through the pillar provided a framework and guidance for providing services to children and their families. Protection desks established as part of the coordination structure at district level became the points of referral where EVD affected children and families were registered and referred to services. The CP/PSS/Gender Pillar met once a week at national level and in each district to plan, discuss and report on the status of EVD affected children. Additionally the MSWGCA, UNICEF and representative organizations were also part of the NERC (National Ebola Response Committee) and other coordination forums.

However, there were challenges. MSWGCA's capacity to coordinate service provision during the EVD was very limited technically and logistically. For example MSWGCA lacked adequate facilities at district and national level for hosting large meetings. At national level as well as in some districts, coordination meetings were therefore held at UNICEF offices during the Ebola crisis (chaired by the MSWGCA and co-chaired by UNICEF). Weakened capacity in the Ministry sometimes delayed timely distribution of non-food distributions to EVD affected children and families at district level.

Sometimes there were challenges in decision making as certain decisions were delayed and required protracted discussions and negotiations with the Ministry. As a result important initiatives stalled, consequently delaying provision of services to children and their families. For example, approval of the National MHPSS Strategy was delayed until July 2015. Sudden changes and unclear roles in the Ministry created confusion for NGO partners. Decisions were sometimes made without adequate consultation with NGO partners. Some of these discussions required massive strategic changes to be made by NGOs which was not always easy as NGOs had to additionally respect donor conditions. There were short-notice cancelations of major meetings by the Ministry, so meetings scheduled on a weekly basis might be held only once or twice a month.

MSWGCA wanted more involvement in decision making including for selection of NGO partners for delivery of child protection services during the Ebola. A Memorandum of Understanding was therefore developed between UNICEF and the MSWGCA on partnerships with NGOs for the delivery of child protection services during the Ebola. A list was agreed comprising NGOs recommended by UNICEF and NGOs recommended by MSWGCA but some NGOs recommended by UNICEF were left out because they were not approved by MSWGCA. Some NGOs which were not approved by MSWGCA could have contributed greatly to the EVD response.

Coordination in the EDV response: Collaboration between Liberia, Sierra Leone and Guinea

In general, there was a "country-centric vision" that permeated much of the EVD response. Ideally inter-country coordination and sharing should have been initiated at the technical level at the beginning of the epidemic. This was an issue for UNICEF as a whole and not only for Child Protection. The EVD situation had no precedent. Staff tasked to develop strategies would have benefited from collaboration across the countries. Groups could be established to link countries with the UNICEF Regional Office to foster continuous cross-fertilisation, joint initiatives and peer review and to avoid the mistakes made in one country from re-occurring in another (however much the contexts might have been different).

Social mobilizers speak with residents, including children, of a slum in Freetown, Sierra Leone, during the three-day stay-at-home curfew. (March 27th, 2015)

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There was solid coordination, however, at the planning level between the three countries, especially with the preparation of the Cross-Border Meeting in November 2014 in Freetown, Sierra Leone. Also coordination was good with the development of the Strategic Framework for Child Protection and immediate programme priorities. However, a structured, continuous and systematic process of sharing between the three Child Protection Programmes at the technical level was limited. SOPs or technical guidelines on the Strategic Framework priorities were not developed jointly by two or more of the Child Protection Programmes. In other words, the Freetown meeting developed a joint Strategic Framework for the three countries alongside specific action plans for each country, but the technical work to translate the framework into SOPs and Guidelines was done separately (and in isolation) by the countries, with no mechanism necessarily to compare notes between them.

The LLA respondents recognised the Regional Office's proactive role that included technical support with MHPSS; the deployment of Regional Office and Headquarter staff; and organising a cross-border meeting of Governments, UNICEF and NGOs.

Families assembled for the cash support program in Guinea. (May 9th, 2015)

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CHAPTER FIVE

Financial and Human Resources

The previous chapters covered how the Child Protection response was handled through two main programme components: Mental Health and Psychosocial Response (MHPSS), and care and support to EVD-affected children and their families, including centre-based care. Strong Data Management and Programme Coordination were critical systems in supporting the programme components and in delivering an efficient and effective response. Naturally, the EVD response would not have been possible without the timely availability of sufficient (both in scale and quality) financial and human resources. Well managed financial and human resources are the key element of an emergency response.

This Chapter presents the experiences with the financial and human response during the EVD epidemic in West Africa.

I. FINANCIAL RESOURCES AND THE EVD RESPONSE

Much-needed funding for UNICEF Child Protection Programmes came late to the EVD epidemic (December 2014); ultimately the funding was a relatively small percentage of the total EVD funding UNICEF received.

UNICEF Country Offices received most of the funding after the EVD epidemic had peaked, and the funding received was generally short term.[26] The respondents of the LLA indicated that funding was a significant constraint to bringing programmes to scale.

UNICEF Guinea Child Protection Programme received US$1,181,988 up until December 2014 and did not receive a significant increase until August 2015. The UNICEF Sierra Leone Child Protection Programme was progressively relatively well-funded, building on a reasonably favourable donor environment before Ebola, and secured US$10 million by December 2014. In Liberia, resource mobilization for Child Protection was more problematic, but an injection of major resources in December 2014 brought the Country Office to a total of US$8 million by the end of the year. The peak of the epidemic in Sierra Leone and Liberia was October and November 2014, highlighting the challenge of a proportionality between funding and the scale of the epidemic.

Until the resource flow for Child Protection improved, the programmes were implemented with funds reallocated from regular (pre-epidemic) programmes.

[26] Child Protection Programme activities do not generally require the type of funding that is spent immediately and up front. For example, for the EVD response relatively less funding was spent on supplies (e.g. 15 per cent in Liberia) and funds were generally allocated to: staffing OICCs, FTR, social worker salaries, cash grants, kits, and field monitoring operations.

TABLE 6: FUNDING RECEIVED BY GUINEA, LIBERIA, SIERRA LEONE COUNTRY OFFICES, AND FUNDING RECEIVED BY CHILD PROTECTION (AS A PER CENT OF TOTAL FUNDING)

	September 2014	December 2014	April 2015	August 2015
Received by Guinea, Liberia, Sierra Leone Country Offices, cumulative (US$)	35,827,632	223,032,716	335,334,938	346,476,582
Received by Child Protection (as a per cent of total funding) (US$)	1,316,370 (3.67%)	18,820,140 (8.43%)	28,986,926 (8.64%)	37,171,998 (10.72%)

Source: UNICEF Country Office Situation Reports

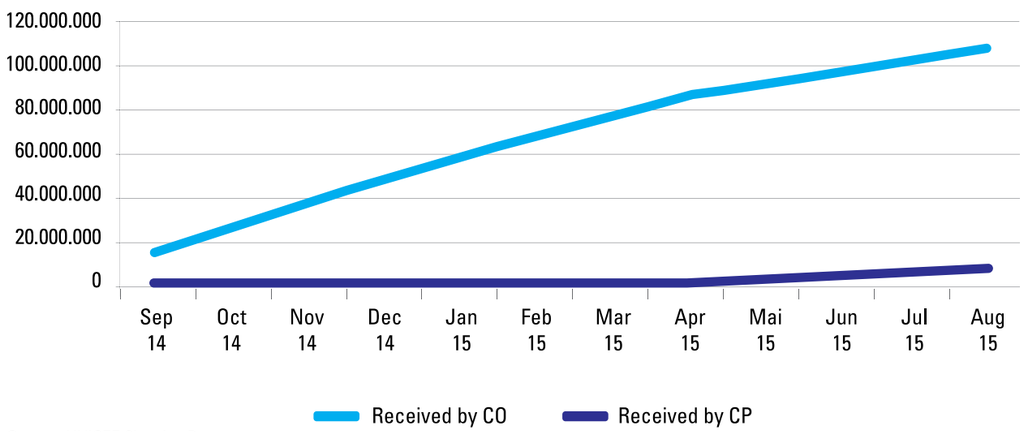
Funding Situation by Country

TABLE 7: FUNDING RECEIVED BY UNICEF GUINEA AND BY UNICEF GUINEA CHILD PROTECTION (AS A PER CENT OF TOTAL)

	September 2014	December 2014	April 2015	August 15
Funding received by UNICEF Guinea (US$)	14,609,523	48,910,882	85,077,981	106,569,053
Funding received by UNICEF Guinea Child Protection (as a per cent of total) (US$)	816,370 (5.58%)	1,181,988 (2.41%)	1,181,988 (1.38%)	7,375,403 (6.9%)

Source: HAC Appeal October 2015 & Country Office. Figures are cumulative.

CHART 2: FUNDING RECEIVED BY UNICEF GUINEA AND FUNDING RECEIVED BY UNICEF GUINEA CHILD PROTECTION (AS PERCENT OF TOTAL)



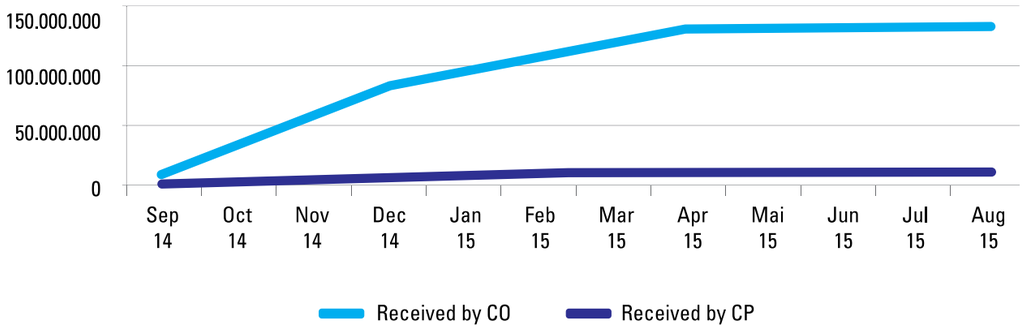
Source: UNICEF Situation Reports

TABLE 8: FUNDING RECEIVED BY UNICEF LIBERIA AND FUNDING RECEIVED BY UNICEF LIBERIA CHILD PROTECTION (AS A PER CENT OF TOTAL)

	September 2014	December 2014	April 2015	August 2015
Funding received by UNICEF Liberia (US$)	9,314,553	85,833,254	133,058,313	135,308,884
Funding received by UNICEF Liberia Child Protection (as a per cent of total) (US$)	0 (0%)	7,893,551 (9.19%)	13,265,546 (9.96%)	13,265,546 (9.98%)

Source: HAC Appeal October 2015 & Country Office

CHART 3: FUNDING RECEIVED BY UNICEF LIBERIA AND FUNDING RECEIVED BY UNICEF LIBERIA CHILD PROTECTION (AS A PERCENT OF TOTAL)



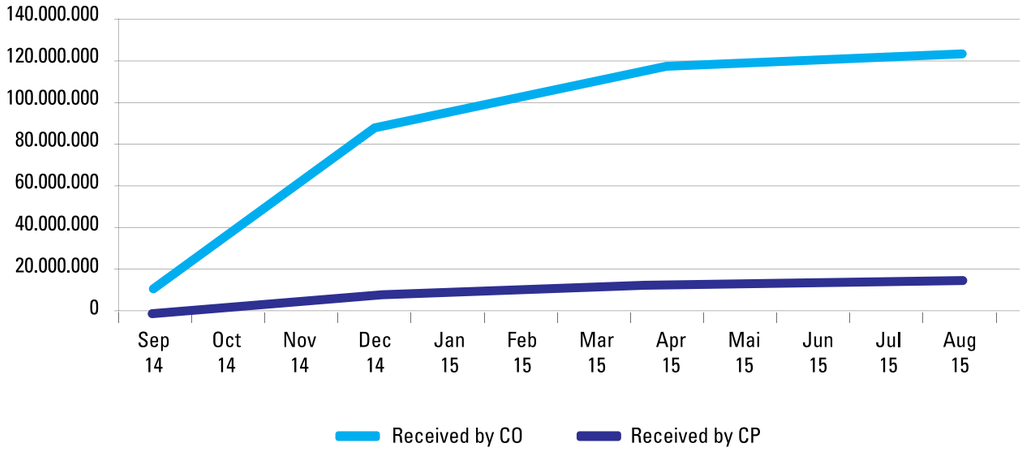
Source: UNICEF Situation Reports

TABLE 9: FUNDING RECEIVED BY UNICEF SIERRA LEONE AND BY UNICEF SIERRA LEONE CHILD PROTECTION (AS A PER CENT OF TOTAL)

	September 2014	December 2014	April 2015	August 2015
Funding Received by UNICEF Sierra Leone (US$)	11,903,556	88,288,580	117,198,644	122,598,645
Funding Received by UNICEF Sierra Leone Child Protection (As a Per Cent of Total) (US$)	500,000 (4.2%)	9,744,601 (11.03%)	14,539,392 (12.40%)	16,531,049 (13.48%)

Source: HAC Appeal October 2015 & Country Office

CHART 4: FUNDING RECEIVED BY UNICEF SIERRA LEONE AND FUNDING RECEIVED BY UNICEF SIERRA LEONE CHILD PROTECTION (AS A PERCENT OF TOTAL)



Source: UNICEF Situation Reports

II. HUMAN RESOURCES AND THE EVD RESPONSE

In general, the timing of the recruitment and deployment of staff was related to three major issues: funding, identification of sufficiently experienced experts and assurances for incoming staff on safety (i.e. medical evacuation, special treatment facilities, etc.).

Recruiting sufficient, qualified staff with proper experience was a constant challenge during the EVD epidemic, and there is also no doubt that the lack of funding limited the scale of staffing. The boost of human resource capacity came after the epidemic had peaked, when funding increased significantly by December 2014. At that point, the number of UNICEF Child Protection staff and partner staff rose quickly (national and international). Staff with crucial functions such as the Information Management Specialists in Guinea and Sierra Leone and the MHPSS Specialist in Liberia were not in-post until January or February 2015. The field offices and sub-national structures, that were part of the national Ebola responses to monitor service provision and support sub-national coordination structures (for example the Protection Desks in Sierra Leone), were not fully staffed until the first quarter of 2015.

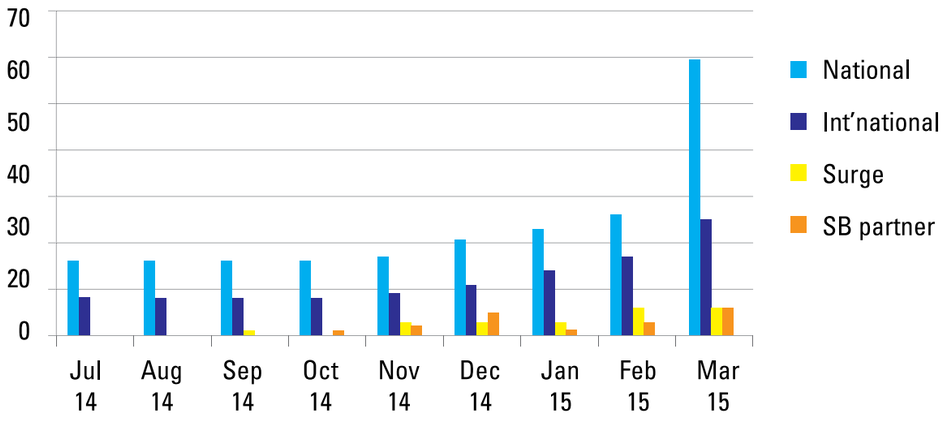
The role of national staff was essential in the response. National staff are attuned to their country's culture, beliefs and social relations, which were critical factors in how society reacted to the EVD epidemic. After the programme strategy and funding were in place in January 2015, more national staff were recruited and the majority were posted to the field offices.

Due to the economic hardship and post-conflict nature of the affected countries, there were also limits to the existing national human resource situation. In Liberia, there were only 12 social workers in the entire country and no mid-level support structure. In Sierra Leone there were 90 social workers, and in Guinea there was not one social worker employed by the Government. With UNICEF support, the Governments hired an additional 120 social workers in Guinea, 108 in Liberia (plus 65 Mental Health Clinicians under the Ministry of Health) and 157 in Sierra Leone. The mid-level support system was strengthened with experienced officers at the county/district/prefecture level. The process took time, however, and the new people in Social Worker positions (whose degrees were often in sociology and not social work) had only a few days training for the post (e.g. Guinea three days, Liberia 10 days), compared to the full three-year training programme that qualified social workers achieve.

UNICEF international deployment

During the EVD epidemic, recruiting international staff was difficult. Guinea and Sierra Leone retained a 'family duty station' status despite the fact that conditions were not ideal for families. Many existing international staff in the Country Offices had to relocate their families out of the country with limited or no support to re-locate. (Liberia was already a non-family duty station.) When the Country Offices did not change status to non-family duty station despite the situation on the ground, it was a major dis-incentive for existing staff to stay and, in some cases, for new potential staff to apply for positions.

CHART 5: UNICEF CHILD PROTECTION PROGRAMME STAFF



Source: UNICEF Situation Reports

Surge deployment

The surge system, which deploys staff from an existing UNICEF office and position to an emergency deployment, was a good way to bring in staff and was appreciated by senior staff. Staff arrived familiar with the UNICEF programming processes without the need for a recruitment process that could take time and resources when both were at a premium. In general, the surge deployments were for a maximum period of three months (with important exceptions). However, it still often required personal persuasion to encourage people to take the deployment. Most international staff came after the peak of the epidemic when emergency health arrangements had been made (e.g. guaranteed medical evacuation) and as the fear was beginning to abate.

In total, UNICEF deployed 714 people to the EVD emergency. UNICEF Liberia, Sierra Leone and Guinea requested 67 people for Child Protection and 56 were deployed. Of the 67 requested: 25 positions (37 per cent) were hired as Advisors or as Child Protection Generalists; nine positions (13 per cent) were hired as MHPSS Specialists; and eight positions (12 per cent) were hired as Coordination Officers. (These figures can be compared with other UNICEF programmes: Communication for Development (C4D) 105; WASH 83; Health Programme 82; and Emergency 74.

A woman helps a young boy wash his hands in disinfecting chlorine solution, at their home in Conakry, Guinea. (January 14th, 2015)

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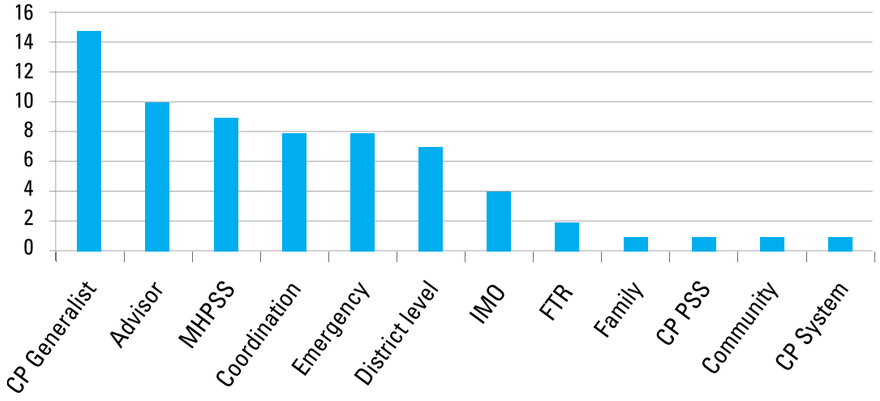
TABLE 10: DEPLOYMENT BY REQUESTED POSITION (AS OF OCT 2015)

	Total Deployment to Child Protection	Regular program staff prior to Ebola
Guinea	17	7
Liberia	9	3
Sierra Leone	30	5

CHART 6: DEPLOYMENTS BY REQUESTED POSITION



Source: UNICEF Situation Reports

Duration of deployment

There were many short-term deployments across the EVD response and with all agencies. Of the Child Protection deployments, one third of the contracts were less than a one-month duration; one quarter were over six months. The turnover rate had an impact on efficiency. Recently arrived staff and consultants were present at almost every meeting and issues often had to be repeated for the newcomers. Decisions were often made by staff who would be gone by the time the decisions were implemented. In future epidemics, it is suggested that a minimum period for deployment is set (e.g. three months) with six month deployment being ideal, whilst acknowledging that in certain cases, short-term, specific missions are best.

Several respondents in senior positions reported that not all deployments came with appropriate skills (both technical skills and emergency experience). It was suggested that a few officers at P4 level were useful but that it might have been preferable to have staff at the P3 level who would have been more willing and able to work in the field. Secondments from NGOs were useful in that regard. Most deployments were posted to the field in Sierra Leone and Guinea.

The deployment of the NYHQ-based Child Protection staff and the Regional Child Protection in Emergencies Specialist from the East Asia the Pacific Regional Office (EAPRO) was reported as a positive addition to the respective teams, even if the deployments did not take place until after the epidemic had peaked. These staff provided much needed management support to the Chiefs of Child Protection. They came in at the same level as the Chief and without undermining or take over the position, they provided a level of experience that supported representation (i.e. external meetings with donors or partners); team management (as a bridge and extra reference/advice-point between the expanding team and the Chief); and organization and follow-up on the rapidly increasing budget and management of the Programme Cooperation Agreement (PCA) process.

In future epidemics the management support role, in addition to increased technical support according to the nature of the crisis, should be given serious consideration. The development of the *Minimum Package of Services* in Liberia, the relationship management in Sierra Leone (with Government and NGOs), and moving actions through the UNICEF system in Guinea were highlighted as positive achievements by these deployments.

Respondents in senior positions reported that the Regional Child Protection Adviser was invaluable as he proactively organised technical support to the Child Protection teams, facilitated inter-country exchange, organized the Freetown Cross-border Meeting, and allowed Chiefs of Section to take R&R and medical leave by standing in for them.

Duration of Surge Deployment

Less than one month: 36 per cent
One to six months: 41 per cent
Over six months: 23 per cent

Respondents identified Information Management and MHPSS as the areas with the least technical capacity. In future, the country level MHPSS Specialist, Information Management Specialist and Coordination Officer should be deployed at the onset of an outbreak. They need to be in post for at least six months, and ideally for the full duration of the epidemic.

Children and a woman participate in a joint World Health Organization/UNICEF cash transfer distribution, in Forécariah Prefecture. (May 9th, 2015)

© UNICEF/UNI184970/La Rose

A 10th grade learner and West Point A-LIFE group member in Monrovia, Liberia. (October 10th, 2015

© UNICEF/UNI200658/Grile

The Annexes

ANNEX I

Terms of Reference for the lessons learned assessment (LLA)

Background and Context

The Ebola Virus Disease (EVD) in West Africa, first reported in December 2013, was unprecedented in its geographical spread, rates of infection and number of deaths. The affected national governments and international humanitarian organisations faced inadequate treatment facilities, insufficient human resources, limited means of coordination and community fear and mistrust.

UNICEF Child Protection (UNICEF WCARO in collaboration with the Country Offices of Guinea, Liberia and Sierra Leone) carried out a lessons learned exercise in line with the recommendation by the "Management Response to Lessons Learned from the Ebola Outbreak Response 2014 – 15".

The primary purpose of the lessons learned is to document the Child Protection response and assess critical gaps and lessons learned in order to inform UNICEF's future Child Protection Programming in emergencies that are identified as public health emergencies.

Purpose and Objectives

Key objectives of the Lessons Learned Assessment:

a) Assess the relevance, effectiveness, efficiency and timeliness of the Child Protection response to the EVD outbreak by UNICEF and its partners from the onset of the emergency to the point of recovery planning. Given the dynamic nature of the EVD outbreak, the timeliness and effectiveness of the design and roll-out of the programme response will also be assessed.

b) Identify lessons learned, best practices and mistakes in order to make recommendations on how the experience of the EVD response can be used to prepare and improve efficiency and effectiveness in future Child Protection interventions in public health emergencies. Recommendations on how systems that support programming - namely coordination and information management systems - can be improved to inform and direct the Child Protection response in future public health emergencies will be particularly important.

Scope of the Lessons Learned

The Lessons Learned will pay particular attention to priority areas of the Child Protection response that were identified in an inter-agency, cross-border Child Protection meeting held in Freetown, Sierra Leone at the peak of the epidemic (November 2014). The meeting set out the strategic framework for the Child Protection response to the EVD epidemic:

1. The timeliness and appropriateness of the Minimum Package of Services provided to EVD affected children;

2. Coordination of the Child Protection response (within country, across borders and across levels in the organization);

3. Data collection and information management;

4. Interim/transit care for children who lost their parents or caregivers, including centre-based, family-based and foster care;

5. Mental Health and Psychosocial Support (MHPSS) response;

6. Articulation of the Child Protection response with other sectors, particularly Health and Social Mobilization.

Particular attention will be given to how the Child Protection response was based on adequate and timely availability of data on the number of EVD-affected children and their needs.

In addition to these thematic areas, the Lessons Learned will examine human resource strategies deployed by UNICEF for Child Protection, the mobilization of funds and how the funds were used. The degree to which the Child Protection response was articulated with other UNICEF sectors, particularly Health and Social Mobilization, will also be assessed.

Methodology
The assignment will involve the following steps:

a) Desk study
The desk review will be conducted from the consultants' home location and will involve a systematic review of all programme documentation from Liberia, Sierra Leone and Guinea, the UNICEF Regional Office (WCARO) and UNICEF Headquarters. This will particularly include programme planning documents, internal and external; programme guidance documents developed at country, regional and global level; existing lessons learned documents; mission reports and other relevant materials. In addition to these documents, an analysis of available data from the Child Protection response will be particularly important to track the scale of protection needs and the degree to which they received a response. As part of this phase, the consultant will also carry out key informant interviews with those who can inform the assignment's objectives but are not on mission in Senegal, Liberia, Sierra Leone or Guinea.

b) Field visits
Following rules regarding the hiring of consultants for work in countries affected by EVD, the consultant will undertake field visits to Liberia and WCARO, and a Temporary Assignment (TA) will undertake field visits to Guinea and Sierra Leone in close collaboration with the consultant. On the field visits, the consultant and the TA will collect additional information/documents not gathered at the inception phase and will carry out qualitative and quantitative data collection in collaboration with partners. The field visits will also allow for key informant interviews with staff from the Country Offices, partner organizations (particularly government partners) and stakeholders at the sub-national levels including members of the affected population through observation, interaction and focus group discussions. The consultant will also participate in key informant interviews by Skype/telephone.
In Liberia, the consultant will facilitate a one-day meeting with UNICEF and partners organized around the objectives of the assignment to ensure a strong national input to the exercise and in preparation for the cross-border meeting.

c) Cross-border inter-agency meeting
Following the three country visits and a preliminary visit to the Regional Office in Dakar, the consultant will facilitate a cross-border inter-agency meeting in Monrovia to bring together key stakeholders from Liberia, Sierra Leone and Guinea with UNICEF WCARO and HQ. The consultant will facilitate the meeting with support from UNICEF Regional Office staff. The purpose of the meeting will be to present key findings from the desk review and country-based consultations to facilitate discussions and consolidate key findings from the response, define key recommendations for future practice and highlight priorities and actions moving forward in the recovery process.

Deliverables
The consultant will provide the following deliverables in line with the steps outlined above:

a) An Inception Report: based on the desk review and preliminary discussions with the Child Protection Regional Advisor in WCARO who is managing the contract, the consultant will outline the assessment questions and proposed methodologies to deliver on the objectives of the assignment, a detailed scope of work with specific plans on gathering required data, interview guides for key informants to be met on field missions (by the consultant and the TA) and a proposed timeline for the field visits and cross-border workshop.

b) Field Mission Reports: for Liberia, the consultant will provide a brief mission report, highlighting key findings in relation to the specific objectives of the assignment. The consultant will also review and validate the mission reports provided by the TA for Guinea and Sierra Leone.

c) Cross-border meeting: the consultant will propose an agenda for the meeting and work with the UNICEF Country Offices to compile a list of participants to share and for confirmation by the Regional Office. The logistics for managing the meeting will be done by the Country Office (Liberia) hosting the event. A meeting report will be the deliverable.

d) A draft Final Report: in line with the assignment objectives and particular areas of analysis and focus, the consultant will produce a first draft report for comments by key stakeholders.

e) Final Report: the final report will contain an Executive Summary not exceeding one page and ideally be no longer (not including Annexes) than 15 pages in length.

ANNEX II

Analytical framework and questionnaire

Two consultants and the Regional Adviser in Dakar, Senegal agreed on the following framework to carry out their respective field missions. One consultant worked in Liberia and the second consultant covered Sierra Leone and Guinea.

Under each subject area, questions to use as a guide and a list of documents and data to collect were provided. The consultants used the suggested questions to structure interviews with key informants. The documents and data were identified to offer the LLA basic documentation for each area.

1. Timeliness and appropriateness of the Minimum Package of Services provided to EVD-affected children
   - The main interventions
   - Identification of beneficiary children
   - Were some of the "packages" delivered by Health and/or Education?
   - Consistency in terms used and targeting
   - Strategy planning – with whom; what data used?
   - Which interventions/projects will need an impact evaluation?
   - Did the Rapid Assessment influence or guide the development of the Child Protection programme?

   Documents:
   - SOPs
   - Training Manuals
   - Skill assessments
   - Field monitoring reports

2. Psychosocial First Aid (PFA)
   - The PFA manual (multi agency including UNICEF) developed in Sept 2014: was it used?
   - Sierra Leone working on PFA strategy in February-April: completed?
   - Liberia PFA strategy/definition of terms completed?
   - When did programs start?
   - Reference materials
   - Relationship with education on training teachers? Who doing the training?
   - Monitoring and standards

3. Cash grants
   - Criteria
   - Effectiveness (impact evaluation)
   - Who was eligible; how identified; coordination to do so
   - Speed to reach all eligible children
   - Monitoring

4. Coordination of the Child Protection response (within country, across borders and across levels in the organization)
   - Collaboration on common interventions between Child Protection and Health, Social Mobilisation (C4D) and Education?
   - How effective was the sub-cluster coordination – the main outputs
   - How much time and human resources were needed to make it a success?
   - Government leadership
   - Can it be sustained?
   - What influence did the rapid assessment have on strategy for children and collaboration between the sections?

5. The extent to which the Child Protection response was based on adequate and timely availability of data relating to the number of EVD-affected children and their needs
   - Priority to sustain a data system in the regular Child Protection Programme (how much interest by NGOs to support the data system?)
   - Government ownership of the data
   - Data quality and up-to-date status
   - Need to have a specialist in each Child Protection team?
   - Terms and definitions not clear – orphans, affected, vulnerable; highly affected; highly vulnerable
   - "Affected" appears to be the most problematic term (big variation)
   - Consistency in data terminology between countries
   - IM system (what can be the common components – to have consistency?)
   - What data came from Social Mobilisation, Health and WASH that Child Protection could use?

   Indicators
   i. HPM Indicators and denominators
   ii. Was there a common understanding and definition in all countries?
   iii. Need an impact evaluation to know if the approach was effective and from there be able to know what should be the indicators in another outbreak

6. In reference to the interim/transit care, centre-based (care) and foster care
   - SOPs
   - Training materials
   - Training: who, how what, when?
   - Follow-up support
   - Monitoring and reporting standards
   - Effectiveness/impact
   - Relationship with extended family/foster family care
   - What government view of centres
   - Would centres be used in another epidemic response?

Documents:
- SOPs
- Training Manuals
- Skill assessments
- Field monitoring reports

7. In reference to the Mental Health and Psychosocial Support (MHPSS) response
   - Uniformity of approach and use of terms
   - Training: who, how what, when?
   - Follow-up support in the field
   - Monitoring process
   - How are standards assessed and maintained?
   - What evidence for effectiveness/impact?
   - What is the relationship with mental health?
   - Coordination between PSS and mental health
   - Was there PSS services as part of the CCC? Who are the service providers? How trained?

Documents:
- SOPs
- Training Manuals
- Skill assessments
- Field monitoring reports

8. Human resource strategies deployed by UNICEF for Child Protection
   - The three Country Offices had a different approach on staff deployment
   - What was the experience between the three COs?
   - Was many staff a problem or a solution?
   - What would be the best skills set profile for the CP team in an Ebola epidemic?

9. Mobilization of funds and how the funds were used
   - When were funds specifically for Child Protection received?
   - How much funding was re-allocated from the regular programme?
   - Were they long or short duration?
   - Did Child Protection have to focus on supplies so as to be able to utilize the funds in time?
   - At any time was funding a problem (too little or too much)?
   - Was it easy to report to the donors (good data; information on effectiveness or impact)?

10. The degree to which the Child Protection response was articulated with other sectors within UNICEF, particularly Health and Social Mobilization
    - Was there a common target to support children in addition to the overall strategy of "containment"?
    - Did C4D include information/messages specially targeted at children
    - Were the Child Protection people a big part in the development of messages?
    - Were children well informed about the epidemic and prevention?
    - Did Child Protection meet with C4D on targeting children?
    - Did the health interventions include services/ packages that addressed the specific needs of children? Especially, on Child Protection content to the CCC?
    - Did Health produce data on children (along with all the other data)?
    - Did Health work with Child Protection to develop protocols to address the specific needs of children who "entered' (as patient or accompanying their parent/care giver) the treatment system?
    - Did Health work with Government/WHO/MSF to establish protocols for paediatric care?
    - Did UNICEF try to get particular reference to children in the documentation of the epidemic?
    - Did external communications request information specifically about children?
    - Is there any document that describes the impact the epidemic had on the children? Is such a document being planned? Is it up to the Governments which documentation is produced?

ANNEX III

People interviewed

The following interviews were conducted in September and October 2015 in Liberia, Sierra Leone and Guinea.

	Guinea		
1	Akoye Guilavogue	Chief, Child Protection Division	Ministry of Social Affairs
2	Tamba Kourouma	Director Exécutif	Le Monde des Enfant
3	Mme Sanaba Kaba Camara	Ministre, Ministère de l'action sociale	Guinea Government
4	Sekou Konate	Directeur, Direction National de l'Enfance	Guinea Government
5	Mme. Tété Touré	Directrice Adjointe, Direction National de l'Enfance	Guinea Government
6	Akoye Guilarvogui	Officer, Direction National de l'Enfance	Guinea Government
7	Guy Yogo	Deputy Representative	UNICEF
8	Guirlene Frederic	Chief, Child Protection	UNICEF
9	Fily Diallo	Child Protection Officer	UNICEF
10	Julie Dubois	Child Protection Officer	UNICEF
11	Ildephonse Birhaheka	Child Protection Sub-Cluster Coordinator	UNICEF
12	Acha Nanette Conte	Child Protection Specialist	UNICEF
13	Eddy Bahiga	Child Protection Specialist	UNICEF
14	Fassou Isidore Lama	Child Protection Officer	UNICEF
15	Asiatou Diallo	Administrative Assistant	UNICEF
16	Mamadou Atigou Diallo	CENAFOD (seconded to UNICEF CP)	UNICEF
17	Alpha Amadou Soumare	CENAFOD (seconded to UNICEF CP)	UNICEF
18	Aye Lama Barry	CENAFOD (seconded to UNICEF CP)	UNICEF
19	N'fansou Sanoh	CENAFOD (seconded to UNICEF CP)	UNICEF
20	Mamadou Billo Sylla	CENAFOD (seconded to UNICEF CP)	UNICEF
21	Madina Bah	Chef de Bureau de Zone Ouest	UNICEF
22	Ismael Ngnie Teta	Chief, Nutrition	UNICEF
23	Gervais Havyarimana	Chief, Education	UNICEF
24	Dr. Cisse Ibrahim	Survival Specialist Health	UNICEF
25	Messou Kouassi Koffi	Child Protection Specialist, IM Sub-Cluster Protection	UNICEF
26	Dr. Sarkoba Keita	Coodinateur de la Riposte Ebola	Guinea

	Guinea		
27	Mariam Toure	Chief, C4D	UNICEF
28	Raabi Diouf	C4D Officer	UNICEF
29	Mouctar Oulare	National Coordinator, Guinea	Tostan
30	Guillaume Cailleaux	Coodinateur, programme d'urgence	SOS Village
31	Salif Keita		SOS Village
32	Alain Kolié	Case Management Coordinator	Save the Children
33	Muktar Oularé	Coordinateur National	Tostan
34	Mamadou Lamine Sonko	National Directeur	ChildFund International
35	Emmanuel Massart	Coordinator, Ebola Treatment Center Nongo	MSF (Doctors Without Borders)
36	Ousman Beladiallo	Child Protection Officer	ChildFund International
37	Aly Diallo	Child Protection Officer	ChildFund International
38	Mamadou Dian Cisse	Chargé des programmes	Aide a la Famille Africane (AFA)
39	Ousmane Diallo		Sabu Guinee
40	Youssouf Bamba	Chargé de projet	Search for Common Ground (SCG)
41	Omar Diallo	Chef de Bureau N'zerekore	SCG
42	Ismahan Ferhat	Project Officer	Save the Children
43	Daniel Millimouno	Program Implementation Manager	Plan International
44	Barry Mamadou Kaba	Project Coordinator - Ebola	Terre Des Homme
45	Modeste Deffo	Health Delegate	IFRC
46	Yvonne Kabagire	Beneficiary Communications Delegate	IFRC
47	Ibrahima Khalil Diakite	Head of Communications	Association of Guinea of Bloggers
48	Mamadou Diallo	Ebola survivor	Guinea
49	Togba Mory	Chef de la Coordination Préfectorale Ebola	Kindia, Guinea
50	Kabinet Diawara	Secrétaire Général, Collectivités décentralisées/ Président de la CPPE	Kindia, Guinea
51	Fode Moussa Camara,	Chef section enfance/Rapporteur CPPE	Kindia, Guinea
52	Six members	CPPE	Kindia, Guinea
53	Mariam Bangourna	EVD widow, left with nine children	Kindia, Guinea
54	Mariam Atileketa	Second wife, EVD widow, left with eight children	Kindia, Guinea
55	Pode Musa Kamara	EVD widow, left with five children	Kindia, Guinea
56	The Imam	Sangarea Village	Kindia, Guinea
57	14 members	CVPE	Kindia, Guinea

	Liberia		
58	Minister Duncan Cassell	Minister	MGCSP
59	Ms. L. Sherman	Deputy Minister, Child Protection	MGCSP
60	Ms. M. Dagoseh	Deputy Minister	MGCSP
61	Dr. T. Nyenswah	Deputy Minister, Chief Medical Officer Preventive Services	MOH
62	Dr. M. Massaquoi	Head of Case Management Pillar	MOH
63	Dr. M. Stone	Assistant to Chief Medical Officer Preventive Services	MOH
64	Ms. C. Worzie	Child Protection Director	MGCSP
65	County Coordinators	Montersardo, Margibi, Bong and Bomi Counties	MGCSP
66	Social Welfare Officers	Montserado, Margibi, Bong and Bomi Counties	MGCSP
67	A. Tarr Nyakoon	Acting Director, Mental Health Unit	MOH
68	Joseph Quai	Pharmacist, Mental Health Unit	MOH
69	Dr. A. Gasasira	Representative	WHO
70	Dr. A. Talisuna	Regional Advisor	WHO Regional Office for Africa
71	Dr. Patricia Omidain	Mental Heath Program Technical Advisor	WHO
72	Dr. J. Munday	County Coordinator Lofa County	WHO
73	Sr. L. Lwanga	Social Mobilisation Team Leader	WHO
74	Eric Johnson	Health Systems Advisor	WHO
75	Atty Kofi Woods	Legal Consultant	Liberia Law Society
76	Dr. Janice Cooper	Chair of MHPSS Pillar; Mental Health Program Manager	MOH/Carter Center
77	Rashid Bangurah	Child Protection Specialist	Child Fund Liberia
78	Kasele Monibah	Child Protection Technical Specialist	Save the Children
79	Shira Goldstein	Liberia Country Director	IsraAID
80	Fatimata Nabias	Regional Child Protection in Emergencies Specialist	Plan International
81	Anita Queirazza	Global Child Protection in Emergencies Specialist	Plan International
82	Nalule Lwanga Sarah	Psychosocial Activities Manager	IRC
83	Saye Tieh	PSS Officer	Helping Hands
84	Tamba Nyuma	Child Protection Adviser	Plan International
85	Rashid Bangurah	Child Protection Specialist	Child Fund Liberia
86	Ernest Smith	Executive Director	Renewed Energy Serving Humanity (RESH)
87	Chris Koroma	Project Officer	RESH

	Liberia		
88	Priciu Badu	Project Manager	RESH
89	Benedetta de Niederhausern	Emergency Response Advisor	SOS Children's Villages International
90	Caroline Grooterdorst	Program Advisor	ZOA International
91	Sue Ellen Stefomimi	Project Manager	Danish Refugee Committee
92	Barzeah Msowoya	PSS Focal Point	Liberia Red Cross
93	Jasper Mason	Project Officer	Mother Patern College
94	Grace Boiwu	Coordinator Special Projects	Mother Patern College
95	Augustus Nelson	Interim Manager	National Social Workers Association
96	Pate Chou	Executive Director	Serving Humanity with Affection Love and Open Mind (SHALOM)
97	Cavita Nelson	Focal Person	SHALOM
98	Rosana Schaach	Executive Director	Touching Humanity in Need of Kindness (THINK)
99	Tenezee Paye	Social Worker	THINK
100	Esther Williams	Project Officer	THINK
101	Siedu Awaray	Executive Director	Liberia Association of Psychosocial Services (LAPS)
102	Joseph Henah	Reginal Clinical Advisor	LAPS
103	Pewee Flomoko	Country Director	Carter Center
104	Sheldon Yett	Representative	UNICEF Liberia
105	Fazul Haque	Deputy Representative	UNICEF Liberia
106	Diedrie Kiernan	Senior Emergency Coordinator	UNICEF Liberia
107	Zinab Al-Azzavvi	M&E Specialist	UNICEF Liberia
108	Elizabeth Devlow	Chief Child Protection	UNICEF Liberia
109	Kamrul Islam	Chief Child Survival	UNICEF Liberia
110	Patrcick Signeyi	WASH Specialist	UNICEF Liberia
111	Ershad Karim	WASH Cluster Coordinator	UNICEF Liberia
112	Bernard Batidzirai	Chief Education	UNICEF Liberia
113	Rukshan Ratnam	Communications Specialist	UNICEF Liberia
114	Prabhu Prabhakaran	Resource Mobilisation	UNICEF Liberia
115	PhiipTarpeh	C4D Officer	UNICEF Liberia
116	Christopher Ngwerume	Child Protection Specialist	UNICEF Liberia
117	Miatta Abdullai Clark	Child Protection Officer	UNICEF Liberia

	Liberia		
118	Joao Mendes	Emergency Coordinator Child Protection	UNICEF Liberia
119	Hawa Page	Child Protection Officer	UNICEF Liberia
120	Dominic de Juriew	Child Protection Specialist	UNICEF Liberia
121	Tatjana Colin	Chief Child Protection	UNICEF Liberia
122	Elizabeth Okai	Project Officer, Birth Registration	UNICEF Liberia
123	John Weah	Project Officer, Youth & Adolescents	UNICEF Liberia
124	Mulvana Vatekeh	Communication Officer	UNICEF Liberia
125	Chief Sheriff	Paramount Chief, Worter District	Grand Cape Mount County
126	Chief Kamara	Town Chief, Vonzula	Grand Cape Mount County
127	Chief Sandaygar Duo	Paramount Chief, Kaba District	Margibi County
128	Issac Davis	Secretary to Chief, Kaba District	Margibi County
129	Chief Sannoh	Town Chief Jene Wonde	Grand Cape Mount County
130	Chief Musa	Paramount Chief, Quardu Gboni District	Lofa County
131	Chief Talyor	Paramount Chief, Foyah District	Lofa County
132	Mr Massaquoi	DHO Woter District, Grand Cape Mount	Ministry of Health
133	Mustapha Sombai	District Surveillance Officer, Woter District, Grand Cape Mount County	Ministry of Health
134	Saah Kortee	DHO Kabba District, Margibi County	Ministry of Health

	Sierra Leone		
135	Sandra Latouf	Deputy Representative	UNICEF
136	Matthew Dalling	Former Chief Child Protection Section	UNICEF
137	Ziharliwa Nalwage	Chief Child Protection Section	UNICEF
138	David Lamin	Child Protection Officer	UNICEF
139	Grace Harman	Child Protection Officer	UNICEF
140	Batu Shamel	C4D Officer	UNICEF
141	Brown Kanyangi	Child Protection, Information Manager	UNICEF
142	John James	External Relations Officer	UNICEF
143	Jerome kouachi	Chief Emergency	UNICEF
144	Sylvia Lee	M&E Health Specialist	UNICEF
145	Dr. Nuh Niger	Chief Child Survival	UNICEF
146	Jamshed Thomas	Child Protection Officer	UNICEF Port Loko

	Sierra Leone		
147	Joseph Sinnah	Chief Social Services Officer	MSWGCA
148	Doris Mansaray	Regional Training Advocacy Officer	MSWGCA
149	Ali Soyei	Protection Coordinator	GOAL
150	Claire Prince Bader	Director of Programme	Save the Children
151	Rosina Mahoi	Child Protection Specialist	UNICEF Port Loko
152	Nathanaiel Swaray	Child Protection Officer	UNICEF Port Loko
153	Paso Conte	Social Service Officer; IM Manager	MSWGCA
154	Fode Tarawalie	Social Service Officer	MSWGCA
155	Mohamed Jalloh		United for the Protection of Human Rights (UPHR), Port Loko
156	Mohamed Kargbo		UPHR, Port Loko
157	Alpha, S. Dumbuya		GOAL, Port Loko
158	Staff of NRD		ADPSL Port Loko
159	Sahrissa Mansray,		CONNECT SL, Port Loko
160	Ibrahim Uifana,		CONFORTI, Port Loko
161	Haroun Bangura		KIDSARISE, Port Loko
162	Henry Yarga,		PLAN SL Port Loko
163	Fodey S. Bangura,	Senior Social Welfare Officer	MoSWGCA
164	Mabinty Mansaray	OICC Manager	Port Loko
165	Resident (a boy)	Mamusa village	Port Loko
166	Amie Tholley	Child Protection Officer	UNICEF Makeni
167	Irene Parveen	Emergency Officer	UNICEF Makeni
168	Amina Sakamara	Manager OICC	Makeni
169	Kadiatu S Conteh	Livelihood Project	GOAL Makeni
170	Moada Y. Baion	Livelihood Project	GOAL Makeni
171	Sheku Koromo	Child Protection Officer	DCI Makeni
172	Foday Banugura		INACORS
173	John J. Thullah		AAD-SL

	UNICEF Regional Office		
174	Andrew Brooks	Regional Child Protection Advisor	UNICEF WACARO
175	Thi Minh Phuong Ngo	Social Policy Specialist	UNICEF WACARO
176	Lola Galla	Emergency HR & RRM Specialist	UNICEF WACARO
177	Tim Irvin	Communications Specialist Emergency Ebola	UNICEF WACARO
178	Savita Nagvi	C4D Regional Advisor	UNICEF WACARO
179	Mads Oyen	Regional Chief of Emergency	UNICEF WACARO
180	Dr. Maurice Hours	Regional Health Advisor	UNICEF WACARO
181	Cecile Marchard	Child Protection Specialist	UNICEF WACARO
182	Madeleine Decker	Information Manager - Ebola Outbreak	UNICEF WACARO
183	Umberto Caneellieri	Operations Officer - Ebola Outbreak	UNICEF WACARO

	UNICEF HQ New York		
184	Ngashi Ngongo	Health Specialist	UNICEF NY/HQ
185	Jerome Pfaffman	Health Emergency Specialist	UNICEF NY/HQ
186	Saudamini Siegrist	Child Protection Specialist	UNICEF NY/HQ
187	Ibrahim Sesay	Child Protection Specialist	UNICEF NY/HQ
188	Helen Nyangoya	Child Protection Specialist	UNICEF NY/HQ
189	Karin Heissler	Child Protection Specialist	UNICEF NY/HQ

ANNEX IV

STANDARD OPERATING PROCEDURES, GUIDELINES, TRAINING MANUALS

The following is a random and partial list of Standard Operating Procedures (SOPs), guidelines, training manuals and reference materials. The Lessons Learned Assessment estimated over one hundred documents related to EVD written or compiled by agencies and Governments in Liberia, Sierra Leone and Guinea, as well as Regional Offices and Headquarters. It is recommended that these documents are technically reviewed and verified to develop a set of common tools (i.e. MHPSS, centre and community-based care and case management, coordination and information management) that tailor a Child Protection response in public health emergencies. Ideally, the tools will build on best practices developed in the Ebola response and be aligned and consolidated in a specific "kit" for future public health emergencies. The kit could also be distilled to the essential information on core interventions, and included in existing normative frameworks for Child Protection response in emergencies.

- Alternative Care Practices; Training Notes; Liberia, July 2015.
- Child Protection, alternate care and case management in Ebola Response structures: practical aspects; Liberia Oct 2014.
- Draft Criteria for the Selection of who can access the one-off cash assistance for the Ebola Response; Liberia Oct 2014.
- Ebola Stigma Tool Kit, Liberia, MOH/USAID March 2015.
- ETU Operational Guide; Liberia May 2015.
- EVD Standard Operating Procedures; Liberia, Sept 2014.
- Feuille de route pour intervenir auprès des enfants et des familles affectés; Guinea
- Formations des Volontaires sur l'organisation et l'animation des ateliers psychosociaux (PPT); Guinea.
- Guidelines for Kinship Care, Foster Care and Supported Independent Living; Liberia Sept 2014.
- Guidelines for MHPSS Service Packages; Sierra Leone MSWGCA, March 2015.
- Guidelines for Referral & Management of Children Affected by Ebola; Liberia MoH Sept., 2014.
- Guidelines for the taking of photographs of children in an ICC/TC; Liberia 2014.
- Guidelines on communicating with families; Liberia.
- Guidelines to Ensure Children are Safe and Protected in Community Care Centers (CCC); Liberia Sept 2015.
- Infection Prevention and Control; Liberia Oct 2014.
- Infection Prevention and Control: Check list for ICCs; Liberia Nov 2014.
- La Réponse Protection de l'enfant à la FHE en lien avec les Centres de Transit Communautaires (CTC); Guinea.
- Manuel de procédures pour la Gestion du centre d'Accueil Temporaire et de Protection des enfants séparés et non accompagnés dans le contexte d'Ebola; Guinea.
- Manuel de PSP (PSA) Psychosocial First Aid (PPT); Guinea.
- Manuel pour le renforcement des capacités des membres des organisations communautaires de base et familles; Guinea.
- MHPSS an Ebola Virus Disease, a guide for Public Health Planners; Liberia Aug 2015.
- MHPSS Support in Emergencies – Do's and Don'ts; UNICEF Aug 2014.
- Module National de Soutien Psychosocial et Santé mentale en faveur des acteurs de Protection de l'Enfant Guinée; Guinea.
- Outil de gestion de cas: fiche d'identification, fiche d'évaluation des besoins, fiche de suivi, fiche de plan de prise en charge, fiche de visite domiciliaire, fiche de référence, fiche de réinsertion, fiche de clôture; Guinea.
- PFA in Schools; Liberia Oct 2015.
- PFA Training Manual; Liberia IsraAid.
- Provision of alternative care to children affected and infected with Ebola in Liberia September 2014.
- PSS considerations for Ebola Response in West Africa, UNICEF Nov 2014.
- PSS Support to Children in ETUs; Liberia MoH Jan 2015.
- Psychosocial Frist Aid during Ebola Virus Outbreaks; WHO, UNICEF, WV, CBM 2014.
- Psychosocial Social Guide for Field Workers; WHO, WV, Ware Trauma Foundation 2014.
- Psychosocial Support for Ebola-Affected Communities in Sierra Leone; Training Manual; Sierra Leone; Oct 2014.
- Psychosocial support during an outbreak of Ebola virus disease; IFRC Aug 2014.
- Recrisement des orphins et veuves d'Ebola dans le zones touches par l'epidemic; Guinea GoG, UNICEF,ICRC Oct 2014.
- Referral flowchart for abandoned children or made orphan by Ebola; Liberia Sept 2014.
- Referral Guidelines for children affected & showing symptoms; Sierra Leone MSWGCA Aug 2014.
- Referral pathway for children who are abandoned or turned orphan by Ebola Virus Disease; Liberia Sept 2014.
- Setting up Interim Care Centers; Liberia Oct 2015.
- Sierra Leone Emergency Management Programme, Standard Operating Procedure for Reintegration Ebola Survivors into communities; Sierra Leone.
- Standard Operating Procedures for Home Observation for Exposed Children; Liberia: Nov 2014.
- Stratégie nationale de Soutien Psychosocial et Santé mentale en faveur des enfants et des communautés en Guinée; Guinea.
- Strategy for the care and protection of contact children, especially those in Observation Interim Care Centres in Sierra Leone: Sierra Leone, Nov 2014.
- The Core Principles of MHPSS Service Packages; IsraAid March 2015.

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