UN EBOLA RESPONSE MULTI-PARTNER TRUST FUND

LESSONS LEARNED EXERCISE

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CONTENTS

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EXECUTIVE SUMMARY

The Ebola epidemic was unprecedented and unpredictable. Between March 2014 and March 2016, WHO reported 28,616 confirmed, probable and suspected cases mostly in Guinea (3,811), Liberia (10,675) and Sierra Leone (14,124). Due to state fragility and weak health and social systems, without a massive and well-organized response, the epidemic could have become a global catastrophe. In response to the growing threat, the UN General Assembly unanimously adopted resolution (69/1) and Security Council resolution 2177 (2014)[1]. Shortly after, the UN Secretary General (SG) established the UN Mission for Emergency Ebola Response (UNMEER); appointed Dr. David Nabarro as the SG's Special Envoy on Ebola; and created the UN Ebola Multi-Partner Trust Fund (TF).

The purpose of the TF was to provide a central financing mechanism to support the UN System's Ebola response including the mobilization, allocation, and targeting of resources. The TF was designed to enable donors to pool resources and provide funding or fill gaps in funding for urgent needs. Administered by UNDP Multi-Partner Trust Fund Office, the priority objective of the fund was "to offer all phases of the response a fast, collaborative and strategic financial mechanism to meet unfunded needs."[2] It included a Response Strategy with 5 Strategic Objectives (SO) and 13 related Mission Critical Actions (MCA) as well as a Recovery Strategy with 4 Strategic Objectives (See Annex 1). Considered one of the most successful Multi-Partner Trust Funds, it received over US$ 166 million from 43 UN member States, two foundations, three businesses, and many individuals, including school children. To date, nearly all the funding was allocated to twelve UN entities[3], which have financed over 70 projects covering nearly all 13 MCAs.

The overarching purpose of this Lessons Learned Exercise (LLE) is to assess the efficiency and effectiveness of the TF and identify best practices that can be applied to future pooled funding mechanisms. Based on a thorough literature review, in-country site visits, and over 100 key informant interviews and focus group discussions in Guinea, Liberia, Sierra Leone, and New York the findings of this LLE indicate that **the TF performed exceptionally well considering the unprecedented nature of the epidemic; the fragility of the three most effected countries; and the lack of preparedness of host governments and of the international community.** Critiques of the TF were limited and often beyond its control. For instance, the TF's governance structure and systems enabled rapid project approval and disbursement of funds to UN agencies. However, in certain instances, UN agencies struggled with their own bureaucracies to apply the funds resulting in delays on the ground. With few exceptions, interviewees praised the effectiveness and efficiency of the fund's governance structure, leadership and management practices, decision making processes, reporting and financial management, despite significant exogenous constraints.

Challenges and Constraints

The TF assisted UN agencies to work within and overcome the following challenges and constraints.

- Delays in the global response.
- Complex and chaotic operating environment rendering planning extremely challenging.
- Lack of precise epidemiological information.
- Unpredictable course of the epidemic.
- Limited local expertise and experience even within the UN agencies.
- Lack of preparedness and response capacity of UN agencies and governments.
- Lack of a UN culture and systems encouraging inter-agency cooperation and coordination.
- National politics and competition for resources between government institutions particularly during the recovery phase.

Despite major challenges, the TF's governance structure was remarkably effective. Overhead costs were minimal; the Secretariat staff were efficient, flexible, and responsive; and key donor / country representatives were highly engaged ensuring that project proposals were targeted and approvals were rapid and consensual. The choice to use UN agencies as the primary recipients of the TF was also optimal given the unpredictable and unprecedented nature of the outbreak, limited national institutional capacity, and the distrust of affected populations in government institutions.

Key Achievements:

1.   By aligning effective leadership, strategy, structure and resources the TF promoted a coherent, swift[4], and effective UN system response. More specifically, the TF improved UNMEER's ability to serve its mandate and encouraged inter-agency coordination, cooperation, and partnerships.

2.   Funds were allocated consistently with the STEPP framework[5] and the selection of UN recipients was based on institutional

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1   http://www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/2177(2014)
2   See 3rd Interim Report http://mptf.undp.org/document/download/16728
3   UNMEER, WHO, UNICEF, WFP, UNDP, UNFPA, UNOPS, UN WOMEN, ILO, UN-HABITAT, UNAIDS and ICAO

EXECUTIVE SUMMARY

capacities, technical competencies, field presence, and existing partnerships with national stakeholders. This results framework served as a general guide for targeting, prioritizing, coordinating and sequencing interventions. Adherence to the framework did not hinder flexibility and context specific programming.

3. A major function of the TF was to meet immediate needs required by the response that could not be funded swiftly through other financing mechanisms. By injecting rapid and non-earmarked funds, the TF was able to fill critical gaps including: logistical needs, equipment and training, construction of Ebola Treatment Facilities, payment of health workers and volunteers responsible for contact tracing and safe burials, provision of care and social services to survivors and their families, etc. This access to flexible and rapid[6] emergency funds increased the credibility to the entire UN response.

4. The TF helped to strengthen, legitimize, and coordinate national government and non-governmental institutions at the regional, national and local levels. Via Quick Impact Projects (QIPS), the TF strengthened NGOs and CBOs capacity to perform fundamental activities throughout the response and recovery phases. While the individual grants were relatively small, they supported critical activities that helped to restore confidence at community level, enabled effective social mobilization, promoted attitude and behavior change, supported key local public awareness campaigns, and provided essential equipment.

5. The Trust Fund allowed the UN System to work towards collective outcomes - stop transmission chains and getting to zero - quantifiable and measurable results that required the combined efforts of the entire UN System. The UN agencies worked in a synergistic and non-competitive manner, capitalizing on their comparative advantages and technical capabilities but also going beyond their traditional roles, competencies, and mandates. It also encouraged UN agencies to test novel approaches that could be scaled up once proven successful. For example, the use of e-banking for the payment of health workers and volunteers and the construction of special isolation units to prevent transmission among inmates in detention centers.

6. A small recovery window was created to support survivors and affected families, restore basic health services, and build resilient health systems. Although, recovery resources were limited with only 2.4% of the funds allocated by December 2015, the projects supported important gaps related to survivor health care, nutrition and social support, restoration of basic livelihoods, access to education and basic maternal and obstetric care, and some limited WASH activities. These projects were not designed to address all development and humanitarian needs that would appear in the aftermath of the crisis. Rather, the underlying rationale was to implement demonstration projects that, if successful, would be sustained and expanded with donor support and led by government institutions.

7. Despite the challenge of expediting proposal preparation, approval and implementation, reporting, and fiduciary requirements met donor expectations. Communication between the MPTF Office and donors who participated in the Advisory Board was fully satisfactory. Use of the MPTF Office Gateway monitoring and reporting system allowed easy access to a range of relevant information regarding the TF.

8. Communication with host-governments was effective at the operational level and whenever necessary it was handled personally by the UNSG Special Envoy who was actively engaged in the dialogue with high level national counterparts.

Best Practices and Lessons Learned

The Ebola Response was a learning experience for governments, civil society, and development partners including UN agencies. A major learning was that pooled financing instruments, such as UN Trust Funds supported by Member States, encourage efficiency, cooperation, and joint delivery, all of which is necessary for responding to complex health emergencies. While the context of the Ebola outbreak was unique, many of the following best practices and lessons learned from the Response can potentially be applied and adapted to other contexts.

Key actions and critical outcomes of UN Ebola Response MPTF operations, as highlighted in the 2016 Lessons Learned Exercise, draw from structural elements and operative mechanisms of the fund as well as what was learned through collaborative implementation of projects on the ground.

Structural Elements and Operative Mechanisms of the Fund – Key Actions and Outcomes

1. The UNSG Special Envoy provided **strong leadership** that capitalized on his technical and operational skills, experience handling complex emergencies, capacity for dialogue and unique aptitude for consensus building.

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4   Proposals were prepared using a simple template and discussions were inclusive of national stakeholders and other partners. After review by the Advisory Committee projects were approved by the Special Envoy with a target of 7 days to release funding. This was exceptionally swift.
5   STEPP: (1) Stop the outbreak; (2) Treat the infected; (3) Ensure essential services;(4) Preserve stability; (5) Prevent outbreaks.
6   Project selection and allocation of funds was swift: 95% of available funds were committed within three months following the creation of the TF.

EXECUTIVE SUMMARY

2. Fund operations focused the UN system's response on a simple and clearly defined **common goal** guided by a **results framework** that all stakeholders agreed upon from the onset of the operation.

3. The fund **signaled political will and commitment** from the highest level of the UN system, which helped attract support from an array of donors and brought the necessary political weight to the funding mechanism.

4. The fund **increased the credibility of UN agencies** by ensuring that they could rapidly access funds and take an active, timely and visible role in achieving results.

5. The fund infused **rapid and flexible resources** into UN agencies, enabling them to adapt to evolving contexts and unpredictable needs while also creating incentives for critical synergies.

6. By providing the UN with resources for logistics and infrastructure, such as for transport, storage facilities, safe water and the construction of Ebola Treatment Centers, the fund **strengthened the effectiveness of the UN's logistical platform.**

7. A **lean and responsive governance** structure, including an active Advisory Committee, benefited from a small, competent, committed and responsive fund Secretariat.

8. For the fund Secretariat, **Monitoring and Evaluation officers on the ground in each country** provided consistent and high-quality **Monitoring and Evaluation** as well as support for proposal preparation, field assessments and coordination.

9. The Secretariat's ability to **engage and adapt** to a broad range of donor interests and various UN agency needs, demands and modus operandi contributed to the fund's effectiveness as well as donor satisfaction with the trust fund mechanism.

10. Regular interaction with and briefings to donors by the Special Envoy and the UN MPTF Office at the technical level facilitated **transparent communication and effective operations**. This, reinforced by regular and high-quality reports on the Fund's performance, strengthened the fund's visibility.

Lessons Learned through Collaborative Implementation of Projects on the Ground

11. Engage with governments early, even if country systems for procurement or financial management are not in place. It is critical to **be inclusive, and to listen to and to recognize local leadership.** The Ebola Response MPTF successfully balanced the need for effectiveness and rapid action with respect for country leadership.

12. **Encourage Inter-agency cooperation** that accounts for technical capabilities, resources, field presence, leadership and past performance; and engage in partnerships with other donors and non-public actors such as NGOs and the private sector, whenever feasible.

13. **Recognize that communities own the response.** Once communities took leadership of the response, reticence and in some cases, violence against response workers, was replaced with action that stopped transmission. Through training, education and outreach, community members, local and traditional leaders, women and youth groups became essential partners and leaders in case detection, surveillance, referrals, education and infection control campaigns, and, critically, in safe burials, which went against most traditional beliefs and practices.

14. Infectious disease outbreaks like Ebola present country leaders with a set of politically difficult circumstances: a situation beyond their control; the need for external assistance; and devastating threats to economic development. **Recognizing the socio-cultural, economic and political implications** of a health crisis can foster effective response by helping country leaders come to terms with the need for rapid recognition and response.

15. The fund showed the importance of **building on existing structures** as much as possible, even if a unified command chain must be temporarily created under severe circumstances.

16. **Communicate frequently, clearly and transparently** about the health situation as well as on what and how resources need to be mobilized and used.

▇ EXECUTIVE SUMMARY

17. Although it may be challenging given an unprecedented and unpredictable epidemic like the Ebola outbreak, s**tart planning for recovery early**. The donor community and governments need to devise recovery projects focused on survivors, the restoration of basic health and education services and livelihoods as early as possible.

18. **Share and disseminate lessons learned.** According to the Lessons Learned Exercise, the fund needs to assure that affected countries have the support they need to exchange experiences and share best practices - mechanisms that will improve coordination as well as collaboration.

19. **Disaster preparedness and pandemic response plans need to be tested and resourced.** Most countries have developed pandemic preparedness plans or are engaged in their preparation, but preparedness goes beyond the writing of a plan, no matter how well-crafted and aligned with guidelines issued by technical agencies. Preparedness requires, among other things, the ability to quickly access emergency funding, maintenance of a critical mass of trained respondents, diagnostic/laboratory capacity, and well performing surveillance and health information systems.

Recommendations for allocation of remaining funds:

Ebola will not be the last pathogen to emerge in West Africa. Guinea, Liberia, and Sierra Leone and the region remain at risk and capabilities to detect and respond to an outbreak remain limited. The 2014-2016 Ebola epidemic tested preparedness and response capacities at the country and regional levels and within the UN system. Capacities were built, however there is a risk that these capacities and the momentum will be lost. To avoid this scenario, UN agencies could invest the remaining Ebola MPTF funding to complement ongoing efforts deployed by the countries and their partners to build more resilient health systems including the following key components of preparedness: (1) surveillance, (2) infection prevention and control, (3) health workforce readiness, and (4) community outreach.

INTRODUCTION

i. BACKGROUND

In September 2014, the UN Secretary General established the UN Ebola MPTF (TF) to provide a central financing mechanism to support the UN System's Ebola Response including the mobilization, allocation, and targeting of resources for specific activities and functions. The TF included a Response Strategy with 5 Strategic Objectives (SO) and 13 related Mission Critical Actions (MCA). It also included a Recovery Strategy with 4 SO (See Annex 1). The TF was designed to enable donors to pool their resources and provide funding or fill a gap in funding for urgent needs in Guinea, Liberia and Sierra Leone. The Ebola TF was administered by the UN Multi-Partner Trust Fund Office, the Office that administers over 100 different UN funding instruments. The priority objective of the TF was to offer a fast, collaborative and strategic financial mechanism to meet unfunded needs throughout all phases of the Ebola response and recovery process. Specific goals were to ensure a coherent UN System contribution to the overall Ebola outbreak response; speedy, coordinated, and rapid UN action; mobilization of funding; results-based management system to enable monitoring of the Fund's contribution to the Ebola response; and support for UN's efforts in establishing a global platform that facilitates the work of the other partners and stakeholders in the fulfillment of the Strategic Objectives. The TF received over US$ 166 million from 43 UN Member States, two foundations, three businesses, and many individuals, including school children. Over US$ 157 million of these funds has been allocated to twelves UN entities (UNMEER, WHO, UNICEF, WFP, UNDP, UNFPA, UNOPS, UN WOMEN, ILO, UN-HABITAT, UNAIDS and ICAO), which have financed over 70 projects in nearly all 13 MCAs.

ii. PURPOSE:

The MPTF mechanism has experienced significant growth since 2004 with over 64 operational TFs and a total cumulative value of over US$ 9.7 billion. Given the breadth of the Ebola Response and the level and diversity of contributions, this provides a unique opportunity to "identify best practices and provide greater insight on the design and operation of an effective and efficient UN pooled funding instrument that can be applied in the future."[7] Therefore, the purpose of this Lessons Learned Exercise (LLE) was to review how effective, swift and efficient the UN system was in setting up a pooled funding mechanism as an instrument to respond to an unprecedented situation than can be replicated to address other health-related emergencies and crises. More specifically, the LLE is intended to assess effectiveness and efficiency, identify best practices that can be applied to future pooled funding mechanisms, and identify constraints that have impeded effectiveness and efficiency. It also intended to examine reporting procedures, legal arrangements, the governance structure, and the process for reviewing and approving proposals and to assess how this process contributed to the TF's ability to focus on under-funded priority activities, to be flexible, and to mobilize and disburse funds rapidly.

iii. METHODOLOGY

This LLE included the following overlapping phases: (1) Desk review of relevant literature contained in the project proposals, quarterly and annual progress reports, project evaluation reports, financial reports, and relevant governance and legal documents including the MoU, Standard Administrative Arrangement, and Terms of Reference (TOR). (2) Collection of primary data including over 100 interviews with key stakeholders in Guinea, Liberia, Sierra Leone and New York, and observations through field visits to project sites in each country. The LLE also included case studies of a few specific projects in each country for deeper analysis. The field visits were preselected for the evaluation team by the MPTF field-based M&E Officers with two criteria in mind: the size of the projects and the number of projects in one district to allow the LLE team to cover more projects within a limited timeframe. Upon completion of each country visit the evaluation team debriefed representatives of the UN Country Team including head of UN agencies and Project Officers. Upon completion of the fieldwork, in-person interviews and debriefs were conducted in NYC with Dr. David Nabarro who was the UNSG Special Envoy for the Ebola Response, Ms. Jennifer Topping, MPTF Office Executive Coordinator, Ms. Olga Aleshina, Head of the Ebola Response MPTF Secretariat, and mission representatives from the affected countries as well as donors who contributed to the TF. (3) Once the primary and secondary data collection was complete, the evaluation team consolidated and analyzed data resulting in the draft report. (4) Input from the MPTF Office and the Advisory Committee was incorporated in the final report.

A few limitations to this LLE should be acknowledged. First, this LLE was an ambitious exercise given the nature of the epidemic, the size of the fund, number and diversity of projects, and multitude of stakeholders involved. Considering this, time spent in each country was limited. However, the visits were greatly facilitated by M&E Officers of the Trust Fund Secretariat posted by the MPTF Office in Guinea, Liberia, and Sierra Leone who were exceptionally helpful and managed to arrange meetings with key informants as well as to organize field visits despite time constraints and logistical challenges. Another challenge was staff turnover. By the time we reached the countries many of the key stakeholders had moved to other

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7   Stated by Dr. David Nabarro in the Foreword of the 3rd Interim Report.

INTRODUCTION

countries to take new responsibilities within the UN system. While Skype/phone interviews were conducted with some of these stakeholders, in the future, it would be preferable to conduct LLE sooner after the end of the main operations. It might have also been useful to dedicate more time for exchanges with non-UN partners who had mobilized substantial resources and staff during the response such as the US CDC, financing institutions such has the World Bank, international NGOs like Medecins Sans Frontieres (MSF), and others who played a key role in alerting public opinion and in the response, itself.

iv. CONTEXT

The Ebola epidemic was the first and largest of its kind affecting countries where the presence of the virus had never been documented or suspected. The three most affected countries: Guinea, Liberia, and Sierra Leone were low income, slowly emerging from devastating conflicts and civil unrest, and essentially fragile states with weak health and social systems. Between March 2014 and March 2016, WHO reported 28,616 confirmed, probable and suspected cases of Ebola mostly in Guinea (3,811), Liberia (10,675) and Sierra Leone (14,124). This far exceeded the number of cases reported in the 20 previous outbreaks since the 1970s, which mostly occurred in the two Congo, Uganda, and South Sudan. Other countries in the region (Nigeria, Mali and Senegal) were affected by imported Ebola cases, but these countries quickly contained the spread, which in the case of urbanized Nigeria would have taken catastrophic proportions.

The first cases of Ebola were reported in December 2013 in Guinea Forestiere, the southeastern forested mountainous region of Guinea bordering Liberia and Sierra Leone. The outbreak became an epidemic as the disease spread to other regions including urban areas and to neighboring countries. There was no functioning surveillance system in place, and the capacities for testing, isolating, and treating cases were quickly overwhelmed. Moreover, there was transmission in health care facilities resulting from poor infection control, lack of equipment and more importantly lack of previous experience in confronting the disease. Health workers were particularly vulnerable resulting in several hundred infections and mortalities from exposure.

Initial skepticism and denial were followed by panic. Neither the affected countries nor the international community were prepared. Key socio-cultural and political components of the response like community engagement were not initially recognized. How the outbreak would evolve and spread was unpredictable and planning was challenged by a lack of epidemiologists and reliable epidemiological data. Thus, the health systems collapsed, health facilities closed, vaccination campaigns stopped, and essential maternal and child health services including obstetric care were not available. Stated by CDC director, "more people probably died because of Ebola than from Ebola. The epidemic shut most health care systems and derailed programs to prevent and treat malaria, tuberculosis, vaccine-preventable diseases, and other conditions."[8]

Without a massive and well-organized global response, the Ebola epidemic could have become a global catastrophe. Per September 2014 modeling analysis the CDC "estimated that approximately 555,000 Ebola cases (1.4 million cases when corrected for underreporting) could occur in Liberia and Sierra Leone by January 20, 2015, if approximately 70% of all persons with new cases were not effectively isolated. The model also showed that the speed with which this 70% target was reached would profoundly affect the total number of cases attributable to the epidemic."[9] This prediction led to a massive scale up of resources including the "deployment of thousands of CDC employees and contracted staff over two years and approximately 3,000 U.S. Department of Defense personnel to Liberia to build ETUs and support other response activities."[10] In addition, the Africa Union Support to Ebola outbreak in West Africa (ASEOWA) was formed on August 20, 2014.

On August 8, 2014, eight months after the outbreak was reported, the WHO Director-General, declared the Ebola epidemic a Public Health Emergency of International Concern (PHEIC).[11] This decision was affected by delays related to several factors including: country situations and politics, institutional politics and culture, and the international community's failure to take notice of early warnings. On March 29, 2016, WHO declared that Ebola was no longer a Public Health Emergency of International Concern. In its wake, it resulted in 11,310 confirmed fatalities and 11,349 survivors who struggle with health issues, social stigma and integration challenges.[12] The epidemic also resulted in the loss of family and friends, widows, widowers, and orphans. Economists approximate the loss of US$ 2.8 billion in GDP across all three countries (Guinea US$ 600 million; Liberia US$ 300 million, and US$ 1.9 billion in Sierra Leone)[13].

8 See CDC's Response to the 2014–2016 Ebola Epidemic –West Africa and United States. US Department of Health and Human Services/Centers for Disease Control and Prevention - MMWR / July 8, 2016 / Vol. 65 / No. 3 (http://www.cdc.gov/mmwr/volumes/65/su/pdfs/su6503.pdf).
9 Ibid.
10 Ibid.
11 http://who.int/mediacentre/news/statements/2014/ebola-20140808/en/
12 World Health Organization (WHO) Ebola Situation Report, 19 May 2016.
13 http://www.worldbank.org/en/news/press-release/2016/05/21/world-bank-group-launches-groundbreaking-financing-facility-to-protect-poorest-countries-against-pandemics
14 Dahl BA, Kinzer MH, Raghunathan PL, et al. CDC's Response to the 2014–2016 Ebola Epidemic - Guinea, Liberia, and Sierra Leone. MMWR Suppl. 2016;65(Suppl-3):12–20. DOI: http://dx.doi.org/10.15585/mmwr.su6503a3.

■ INTRODUCTION

FIGURE 1. Ebola cases per 100,000 population - December 2013–March 31, 2016[14]

Cases per 100,000 population
- 0
- 0.1–10
- 10.1–25
- 25.1–50
- 50.1–100
- 100.1–364.2
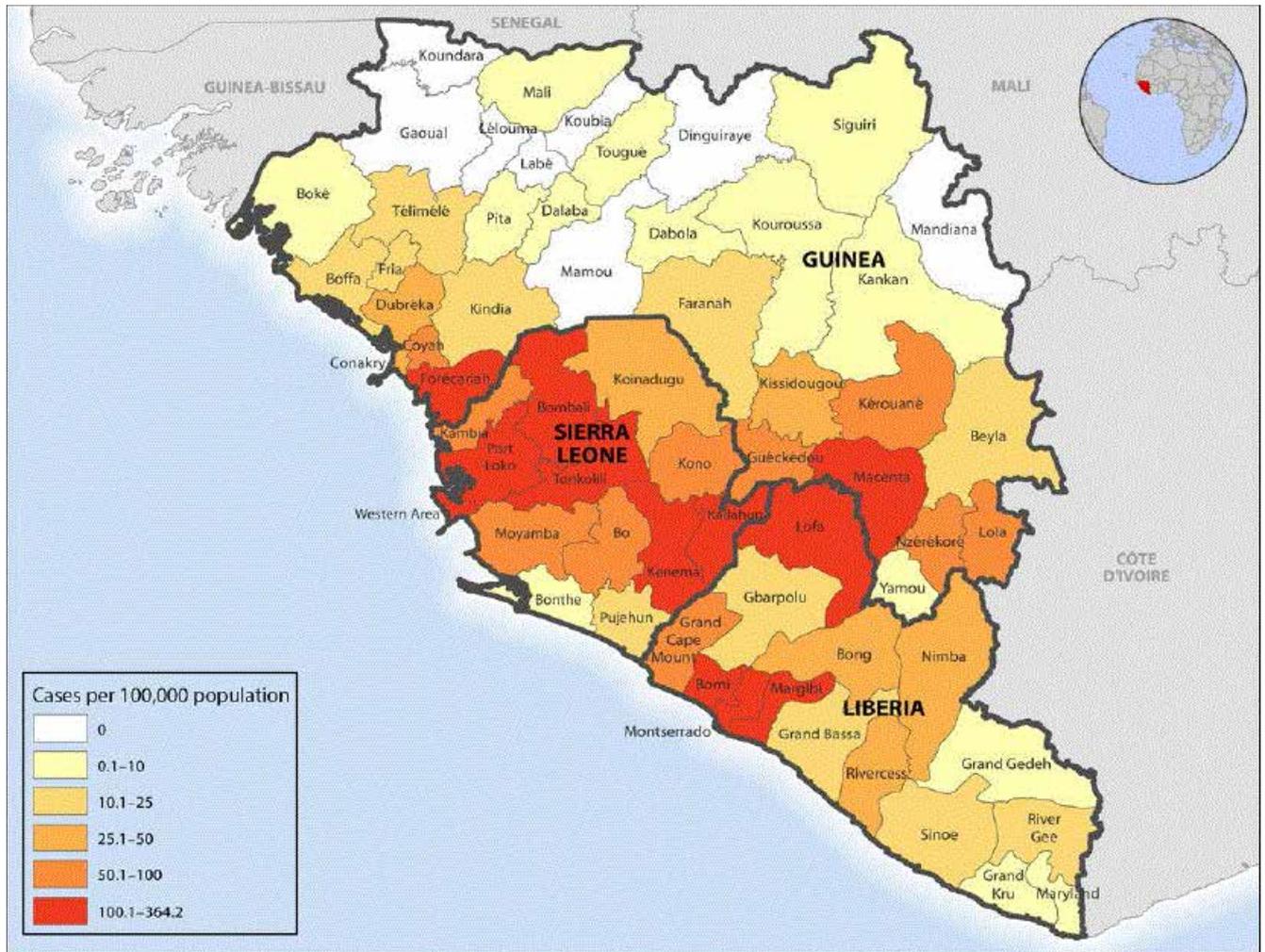
v. FORMATION OF UNMEER[15]

In response to the unanimous adoption of UN General Assembly resolution (69/1)[16] and Security Council resolution 2177 (2014)[17], the UN Mission for Emergency Ebola Response (UNMEER) was established on September 19, 2014. A few days later, Dr. David Nabarro was appointed as the UN Secretary-General's Special Envoy on Ebola "to provide strategic and policy direction for an enhanced international response, and galvanize essential support for affected communities and countries."[18] UNMEER, the first-ever UN emergency health mission, was established "to respond to immediate needs related to the fight against Ebola."[19] The mission was to "harness the capabilities and competencies of all the relevant UN actors under a unified operational structure to reinforce unity of purpose, effective ground-level leadership and operational direction, in order to ensure a rapid, effective, efficient and coherent response to the crisis."[20], The mission had a singular purpose – "to work with others to stop the Ebola outbreak."[21] More specifically, UNMEER's objectives, in line with the STEPP strategy, were to Stop the outbreak, Treat the infected, Ensure essential services, Preserve stability and Prevent further outbreaks.[22]

As a temporary mission, it was foreseen that UNMEER would bring together UN agencies to harness their combined capabilities and unite their expertise. For instance, WHO was made responsible "for overall health strategy and advice within the Mission, while other UN agencies [acted] in their area of expertise under the overall leadership and direction of a single Head of Mission."[23] In addition to leveraging the "existing presence and expertise of UN country teams", it was also

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14 Dahl BA, Kinzer MH, Raghunathan PL, et al. CDC's Response to the 2014–2016 Ebola Epidemic - Guinea, Liberia, and Sierra Leone. MMWR Suppl. 2016;65(Suppl-3):12–20. DOI: http://dx.doi.org/10.15585/mmwr.su6503a3.

15 http://www.un.org/ebolaresponse/mission.shtml

16 http://www.un.org/en/ga/search/view_doc.asp?symbol=A/RES/69/1

17 http://www.un.org/en/ga/search/view_doc.asp?symbol=S/RES/2177(2014)

18 http://ebolaresponse.un.org/special-envoy-ebola

19 Ibid.

20 Ibid.

21 Ibid.

22 Ibid.

23 Ibid.

INTRODUCTION

envisaged that UNMEER would "work closely with governments and national structures in the affected countries, regional and international actors, such as the African Union (AU) and the Economic Community of West African States (ECOWAS), and with Member States, the private sector and civil society... to minimize gaps and ensure leadership."[24] Ultimately the goal was to convene everyone around the common strategic objective of stopping the Ebola outbreak.

After achieving its objectives, UNMEER officially closed on July 31, 2015 and the leadership of the UN system's Ebola emergency response was transferred to WHO via the Inter-agency Collaboration on Ebola on August 1, 2015.[25]

vi. FORMATION OF EBOLA RESPONSE MPTF

To support UN Agencies and UNMEER, the MPTF was established in September 2014 "to offer all phases of the response a fast, collaborative and strategic financial mechanism to meet unfunded needs."[26] To following structure was devised to help guide TF priorities and sequencing based on an overarching Response Strategy and results framework that included 5 Strategic Objectives (SO) and 13 related Mission Critical Actions (MCA). It also included a Recovery Strategy with 4 Strategic Objectives (See Annex 1).

1. **Priority Category A:** *Getting to Zero*. Activities which support the strategic objective of getting to zero new cases of Ebola in the affected countries. Priority Category A included Phase 1 and Phase 2 responses. Phase 1 interventions included activities such as rapid scale-up of treatment beds, safe and dignified burial teams, and behavior change capacities, which were active from August to December 2014, and was the main strategy for allocating funds in 2014. The Phase 2 response aimed to identify all chains of transmission, ensure all new Ebola cases are from known contacts, with a result that flare-ups of Ebola cases in areas where transmission had stopped are minimized or prevented. Phase 2 interventions included:

    a. Strengthened epidemiology and contact tracing functions at district level: proposals to support adjustable, district-focused response, including people and facilities for Ebola diagnosis and treatment, for finding cases, tracing contacts and maintaining surveillance, and for assuring that people affected by Ebola can access essential services. Districts have access to the right services, provided when and where needed.

    b. Logistical capacity: proposals that directly support the UN system's ability to implement the STOP and TREAT elements of the response.

    c. Incentives for workers to actively participate in the Ebola Response: examples of proposals supporting this element would be those that fund cash and food incentives for Ebola Workers.

    d. Incentives for families/contacts and survivors and support to orphans: proposals to support Ebola survivors and families classified as contacts.

2. **Priority Category B**: *Improving Regional Preparedness*, in countries that are currently Ebola-free. Investments which mitigate the risks to those countries of getting Ebola, due to proximity to the borders of the three most affected countries. Activities include planning, institutional strengthening and knowledge sharing.

3. **Priority Category C:** *Revival and Remodeling of Essential Services*. Activities which strengthen the systems, processes and institutions which will play important roles in the process of recovery and strengthening of public systems. A special Window dealing with Recovery was activated to respond to and manage calls for proposals for Recovery.

In addition, the fund included two modalities including: (A) support to the response through UN system entities and (B) support to CSO's and NGO's primarily to support community level activities focused on raising awareness of Ebola and thereby preventing transmission.

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24 Ibid.
25 http://ebolaresponse.un.org/un-mission-ebola-emergency-response-unmeer
26 See 3rd Interim Report http://mptf.undp.org/document/download/16728

1 ACHIEVEMENT OF TRUST FUND GOALS, AND SIGNIFICANTLY CONTRIBUTING TO SOS AND MCAS

Based on a thorough literature review, structured individual interviews and focus group discussions with a broad range of over 100 stakeholders, the findings of this LLE indicate that the TF made a critical contribution to the achievement of the SOs and MCAs carried out by the recipient agencies.

The TF performed exceptionally well considering the unprecedented nature of the Ebola Epidemic and its threat of widespread contagion, the fragility of the three most effected countries, and the lack of preparedness of governments and the international community. Funds were allocated consistently with the STEPP framework and UN recipients were determined based on institutional capacities and competencies, geographic location, and key stakeholder relationships. The TF also enabled UN agencies to go beyond traditional mandates and competencies to work together to achieve SOs and MCAs. In terms of design and selection there were no inconsistencies in allocation of funds and strategic priorities. **With few exceptions, the funds were used to address well-defined and specific challenges that other instruments could not fill in a timely or appropriate manner.**

STEPP STRATEGY
Stop the outbreak
Treat the infected
Ensure essential services
Preserve stability
Prevent outbreaks

Critiques of the TF were limited and often beyond the control of the Trust Fund mechanism. The fund also demonstrated the capacity for pooled funding mechanisms to be focused on a specific goal while at the same time being situation driven and highly adaptive to evolving and unpredictable contexts. This was made possible by prioritizing funding based on three major variables including:

1. The latest assessment of the evolving epidemiology of the outbreak (from WHO and other sources);

2. Priority needs in the Ebola response, as assessed by regular interaction with all stakeholders in the response; and

3. The comparative advantage of the UN System, as assessed by the Special Envoy and his interactions with the UN Agencies, Funds and Programs.

In addition, many donors have a tendency to earmark funding making it difficult for recipients to fill gaps in a flexible and timely manner. The TF had a structured response strategy and framework that encouraged and guided un-earmarked funds so the projects remained highly relevant without being rigid so that important gaps could be filled as specific needs emerged. While the majority of contributions were un-earmarked, for those donors unable to provide un-earmarked funding, ear-marking was possible. By closely connecting the TF to UNMEER, which coordinated closely with existing government structures in each country at the national and district level, the funds were able to bolster national and community lead responses. To ensure that decisions were made based on local realities, UNMEER and governments engaged local stakeholders, UN agencies, INGOs, and NGOs to ensure that decisions were inclusive, responsive to rapidly changing needs, and field-driven. The following highlight some of the major achievements of the TF in greater detail.

1.1 PROMOTED A COHERENT AND EFFECTIVE UN SYSTEM RESPONSE

The initial alignment of the TF with UNMEER's Response Strategy (STEPP) assisted in promoting a coherent and effective UN system response. UNMEER had a regional management structure established in Ghana with UN Secretary General Special Representative and Ebola Crisis Managers appointed as leads in each of the three countries. Operations were guided by a clear strategy and results framework with guidelines for prioritizing and sequencing the response. **By aligning these four elements – leadership, strategy, structure, and resources – with the singular mission of ending Ebola, the UN could respond to the crisis as a system.** While each of these elements was fundamental to the UN's role in ending Ebola, without the TF, these elements would have been less effective because without significant additional funding, the activities of UNMEER would have remained limited. Therefore, one of the primary achievements of the TF was to enable UNMEER to implement important response initiatives. As a result, the UN system was able to operate in an unprecedented emergency situation in a complex and fluid environment. The mechanisms set by the fund improved coordination, provided access to emergency funds, and gave credibility to the UN's response.

1 ACHIEVEMENT OF TRUST FUND GOALS, AND SIGNIFICANTLY CONTRIBUTING TO SOS AND MCAS

Therefore a measure of the initial success of the TF in promoting a coherent and effective UN System response has been its **effectiveness in supporting the UN System** (UNMEER, UN Agencies, Funds, and Programmes). As stated in an UNMEER lessons learned exercise, "existing capacities required galvanizing support to scale up the level and pace of their interventions so as to be commensurate with the escalating emergency. For example, WHO advocated that it required substantial resources and robust logistics capacities to scale up to the level required."[27] Thus, there was consensus that UNMEER played a fundamental role in sending a political signal and bringing together and improving partnerships between UN agencies, which were not initially equipped or funded for a rapid response of this magnitude.

> Before UNMEER came, the UN Country Teams were operating on the ground, but the wheels were not turning quickly enough and the agencies did not have money... UNMEER came with a mandate, authority, money secured through the MPTF, and focus.

1.2 FILLING GAPS

Many UN agencies had trouble accessing funds fast enough to meet fundamental needs. The **TF generated a significant volume of unearmarked resources (including from countries that do not traditionally contribute to the UN Trust Funds), which could be programmed to address the most critical needs.** This LLE did not find that any of the projects supported by the TF were redundant or duplicative. Rather, the TF supported several key projects that were not funded through other channels. These projects filled gaps and were catalytic in enabling other important initiatives. For example, Project # 16 Epidemiology, Surveillance, and Social Mobilization and Project # 17 Integrated Disease Surveillance Reporting (IDSR) increased WHO's credibility and enabled it to scale up. This, in turn, enabled other UN agencies and the government to do their work during the Response phase. During the Recovery phase, Project # 45

Figure 1 © Peter Bauman: Ebola survivor and her family who received support from UNICEF in Liberia

Comprehensive Programme for Ebola Survivors (CPES) allowed WHO and UNICEF to work with the Ministry of Health and the Ministry of Social Welfare to shape the government's survivors program. This included creating a database of the survivors, conducting a needs assessment and screening, providing psychosocial support and support for reintegration. The following testimony from a broad range of stakeholders substantiates the TFs critical role in filling gaps.

- The TF helped us to fill gaps because it came faster than the other pledges. So we were able to fill gaps while waiting for the other pledges to become realized. The funds came rather quickly and were made available immediately... We could have operated without the TF, but the funds allowed us to go full speed... We needed to move people and things quickly – so TF supported UNHAS flights. We needed to build ETUs in Guinea and Liberia. We needed storage and forward operation bases... We needed engineers, etc.

- The governments had limited capacity to respond quickly... the TF filled the gap of payroll and stipends for health workers – no one else would have supported this.

- The World Bank had funds to also fill gaps that the TF did not fill. For example, purchasing vehicles and stipends for contact tracers. The TF also helped to divide up responsibilities between UN agencies per country. The TF was also instrumental in supplementing or assisting with the implementation of World Bank-funded activities such as the payment of health workers and volunteers.

- The TF came at the right time for Liberia. All UN agencies came together to determine the amount needed for the response. We created a road map and came up with an amount of US$ 400 million. This did not come. We tried to go bilaterally, but some donors said that their money was already in other funds or to channel their existing donations. So, the TF helped to fill this funding gap for the immediate response... For example, contact tracing would not have happened without the TF.

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27 See Report of the Secretary-General: Lessons Learned exercise on the coordination activities of the United Nations Mission for Ebola Emergency Response. Seventieth session. Agenda item 133. 4 March 2016 (A/70/737)

1 ACHIEVEMENT OF TRUST FUND GOALS, AND SIGNIFICANTLY CONTRIBUTING TO SOS AND MCAS

- The TF provided the framework for survivor care. DFID paid salaries, but not training... the TF filled this gap especially for survivor advocates who were also survivors.

- The situation was quite chaotic – the TF enabled us to put some key supplies in place in a timely manner. Even just the airlift enabled UNICEF to receive and distribute key supplies quickly (rapid distribution of Personal Protective Equipment (PPE) and nutrition and Non-Food Items (NFIs) to key priority areas). This was the largest airlift that we have ever done. 2 or 3 flights a day at the height of the response. TF was a contributing factor in stabilization. And, enabled UNICEF to largely meet the requirements.

- Detention centers filled an important gap by preventing the spread of Ebola in highly congested prisons and addressing the needs and safety of highly marginalized people.

- The Program for Payment for Ebola Response Workers filled a fundamental gap by paying allowances to all medical staff in Sierra Leone. Without this, staff would have protested, rioted, or stopped working. This became a backbone of the response by preventing major disturbances. The programmes supported by the TF in all three countries were also used to enable channeling of larger WB-funded salary payments.

- Integrated Disease Surveillance and Reporting (IDSR) provided training for people, developed curricula, and tools for IDSR to be possible. It also facilitated links between the various health units involved in the response.

1.3 RAPID AND TARGETED ALLOCATION OF RESOURCES

In accordance with the TF's priorities, during the first three months nearly all funds (95%) were used to support Category A (Getting to Zero) and were distributed via Modality A (UN Agencies). For instance, the first TF project was US$ 40 million to WFP for Special Operation Project's including: Setting up two staging areas in Guinea and Sierra Leone and five Forward Logistical Bases (FLBs); Rehabilitating two UN Clinics in Guinea and Sierra Leone; Transporting essential items by trucks and air, allowing for undisrupted functioning of ETUs and CCCs; and Providing Air Services. While WFP received significant funds for the Ebola response, the TF provided the first major infusion of resources necessary for critical operations.

Figure 2 © Peter Bauman: Ebola response facilities supported by WFP in Guinea

Figure 3 © Peter Bauman: Ebola response facilities supported by WFP in Guinea

Figure 4 © Peter Bauman: Ebola response facilities supported by WFP in Guinea

In addition to the above criteria, the TF has two primary windows: (A) The Response Window; and, (B) The Recovery Window which was created later by the decision of the Advisory Committee. Most of the funds (US$ 149 Million)[28] were allocated to the Response, which was based on 5 Strategic Objectives: Stop, Treat, Ensure essential services, Preserve stability, and Prevent. To reach these objectives 13 MCAs were defined. Among these, the three most funded MCAs were: 20.6% to MCA1 (Identify and Trace); 30% to MCA3 (Care for Persons); and, 12.7% to MCA13 (Preparedness).

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28 From the US$149 million allocated by December 2015, Guinea had received 37%, Liberia 27%, and Sierra Leone 35%.

1 ACHIEVEMENT OF TRUST FUND GOALS, AND SIGNIFICANTLY CONTRIBUTING TO SOS AND MCAS

FIGURE 5. Allocation of funds per Strategic Objective and Recipient Organization

Transfer by Strategic Objective as of 31 December 2015 (US$)[29]		Net Funded Amount by Recipient Organization, as of 31 December 2015 (US$)[30]	
Strategic Objective	Net Funded Amount	Organization	Net Funded Amount
SO1 STOP the outbreak	36,221,260	WFP	36,221,260
SO2 TREAT the infected	55,561,662	WHO	55,561,662
SO3 ENSURE essential services	15,183,185	UNDP	15,183,185
SO4 PRESERVE stability	19,663,745	UNICEF	19,663,745
SO5 PREVENT	14,955,448	UNFPA	14,955,448
RSO1 Health Nutrition WASH	1,555,336	UNOPS	1,555,336
RSO2 Socio-Economic Revitalization	748,728	UNMEER	748,728
RSO3 Basic Service & Infrastructure	1,047,396	UNWOMEN	1,047,396
RSO4 Govern Peace Building Cohesion	247,915	ICAO	247,915
TOTAL	145,184,675	TOTAL	145,184,675

The TF also supported Quick Impact Projects (QIPS). Initially these were managed by UNMEER and then transferred to UNDP. The use of QIPS varied per country, but generally included projects aimed at supporting community-based activities, social mobilization, media campaigns and logistical support. Generally small projects, QIPS were approved and implemented quickly at the local level to achieve critical outcomes. They were essentially problem-solving activities and made important contributions by directly supporting NGOs, CSOs, and communities. They also helped to gain confidence in and build trust with local partners, which enhanced the overall response.

The Recovery Window was established in April 2015 with 4 strategic objectives, in line with the Post-Ebola Recovery Framework developed by the UN, European Union, World Bank and African Development Bank: (1) Health, nutrition, revitalization, and WASH; (2) Socio economic revitalization; (3) Basic Services and Infrastructure; and (4) Governance, Peace building and Social Cohesion. The Recovery Window was small with only 2.41% of the funds being allocated by December 2015. Some recovery activities are ongoing and are expected to be supported until the closure of the MPTF in June 2017. Recovery projects were meant to amplify some elements of the response, particularly at the community level, to bridge gaps in essential health services such as obstetric care, and to support pilot projects that would serve as successful examples of reconstruction activities.[31] With a few exceptions, recovery projects largely followed these guidelines. However, some of the recovery projects could have been more focused and better designed given the limited amount of funding and truncated timeframe.

Figure 6 © Peter Bauman: UNICEF supported community radio station in Guinea

Figure 7 © Peter Bauman: UNICEF supported community radio station in Guinea.

29 See 3rd Interim Report http://mptf.undp.org/document/download/16728
30 See 3rd Interim Report http://mptf.undp.org/document/download/16728
31 Details about the projects supported by the TF can be found in the three interim MPTF reports (issued in October 2014, May 2015, and December 2015) and are accessible on the MPTF website.

1 ACHIEVEMENT OF TRUST FUND GOALS, AND SIGNIFICANTLY CONTRIBUTING TO SOS AND MCAS

1.4 FLEXIBLE AND ADAPTIVE FUNDING

The results framework, which served as a guide for targeting, prioritizing, coordinating, and sequencing interventions, did not inhibit context-specific programming. Due to contextual variations, the UN system's response had to be adaptive. TF-supported projects were context-sensitive and aligned with national responses even when they were based on slightly different approaches. For example, in Guinea the response included community outreach, active case finding, contact tracing, and rapid transport of patients to ETUs rather than the rapid construction of ETUs which was part of the approach used in Liberia and Sierra Leone. Enhanced surveillance was put in place in the most affected prefectures and later Guinea implemented the "mini-cerclage" to contain the flares. This required the provision of essential medical services, food, water and hygiene materials. Local leaders were engaged to ensure communities acceptance of restricted movements. This approach was adapted from the Rapid Isolation and Treatment (RITE) strategy in Liberia and the quarantined village approach used in Sierra Leone. Another example of adaptive approaches includes the decision to use existing facilities in some countries and establish new ETUs in others.

Representatives of UN agencies expressed appreciation for the TF's flexible and adaptive nature. Given the unique and overwhelming nature of the epidemic, the TF enabled UN agencies to test out innovative ideas that could be scaled up. For example, one representative stated, *"The TF provided resource mobilization for more creative ideas left unexplored like the payment program through e-Banking."* It also enabled UN agencies to go beyond their typical mandates to fill important gaps.

> "It was the first time UNFPA moved away from its traditional activities such as family planning, sexual and reproductive health into field-based disease control activities so it was a risk for us... the TF was willing to take the risk. The fund was flexible enough to address missing issues that other funds would not cover. For instance, due to Ebola regular maternal health and delivery services were not being provided by the medical system. Pregnant women were giving births on the street. Women would go to the hospital and get rejected... so pregnant women were very vulnerable. The TF was flexible enough to provide resources for maternal health in the most effective counties in Liberia... The midwife program gained recognition with the President and helped gain traction with the Ministry of Health for midwife program and the health system. The midwife program also helped to restore confidence in the clinics and the health system."
>
> – UNFPA representative in Liberia

1.5 RESPONSIVE TO THE NEEDS FROM THE FIELD IN A SWIFT MANNER

In all three countries, the TF made strategic early and rapid decisions to target funds on key priorities that served as catalysts for the larger Ebola response. For example, US$ 28 million (60%) of the funds allocated to Sierra Leone were invested in WFP project #1 and WHO project #16. In addition to supporting WFP and WHO with core functions, in Sierra Leone, the TF was used to support UNMEER and UNOPS (projects #11, #17, and #18) to boost the management capacity of the national government (NERC) to respond and manage the crisis by providing salaries for expert staff, rapid response capabilities, and funds to fill immediate gaps via QIPS.

The TF enabled UNMEER to respond quickly to needs on the ground, staffed and equipped NERC (National Ebola Response Center), and created systems for other financial inflows to be effective.

A relatively modest injection of funds from the TF enabled much larger funds to be effectively used.

The MPTF was set up to provide fast access to funds aimed at addressing urgent needs in the field. Response funds were released within 7 days after approval by the Advisory Committee. This was exceptionally swift. Stated by a UN Agency representative, *"The Ebola Fund moved as quick as any fund has ever moved for a TF out of NYC... Thus, UN agencies were able to identify gaps and mobilize very quickly."*

Delays in implementation were mainly caused by bottlenecks encountered at the level of the recipient agencies, but were not the result of the TF management system. It is worth noting that most projects under the response window, which was by far the largest, were approved within the first two months of the TF's life.

Figure 8 © Peter Bauman: Volunteers for Safe & Effective Burials in Sierra Leone

1   ACHIEVEMENT OF TRUST FUND GOALS, AND SIGNIFICANTLY CONTRIBUTING TO SOS AND MCAS

1.6 CATALYTIC ROLE OF TFS

While most of the UN agencies had an existing presence at the regional and country level, at the time of the Ebola outbreak, they lacked sufficient human and financial resources for the response. A few UN agencies such as WHO, WFP, UNICEF, UNDP, UNFPA, and UNOPS had a well-established capacity to function swiftly and effectively in difficult situations, but they lacked an effective mechanism that would harness their strengths towards a united response. Due to the complex nature of the epidemic and the context, multi sectoral expertise was needed. More specifically, it quickly became apparent that the response required more than health expertise. Logistical capacity, experience in rapid procurement and deployment of equipment, ability to build treatment centers or adapt existing infrastructure, and the capacity to recruit and pay respondents were all essential for a rapid and effective response. **This required UN agencies to go beyond their individual mandates and standard modus operandi because extraordinary interagency cooperation and teamwork were necessary.**

Encouraged by the Special Envoy and UNMEER, which served a convening, prioritizing, and coordinating role, UN agencies displayed flexibility in the use of their agencies respective resources and competencies. For example, while WHO remained the lead health agency, other agencies such as UNICEF presented a comparative advantage to address communication issues, mobilize communities, and help bridge the gaps that existed between the governments and communities. UNICEF's work on social mobilization enabled

> *"The TF was immensely helpful... without that source of funding we would have been unable to control and prevent the spread of Ebola as the TF supported treatment units, contact tracing, community based surveillance, etc."*
>
> - UNFPA Representative

other initiatives to work. Stated by an interviewee, "*without a high level of community engagement and buy-in none of the more technical (epidemiological) interventions would have worked.*" WFP's logistical capabilities could be mobilized from a regional platform. UNOPS had experience in construction, and UNDP provided the necessary technical assistance to use World Bank funds to pay health workers as effectively and transparently as possible. The UN recipients were also able to work together and adjust surprisingly quickly to a complex situation where no single agency could possibly respond in isolation.

> "*The overall approach to using communities for surveillance is a big lesson learned for Liberia and contributed to a major policy shift... When we started, the contact tracing we were sitting in the coordination meetings. Most of the focus was on burials, IPUs, etc. We struggled to get attention to the issue of families hiding people that were either infected or diseased... People who went to ETUs and died and families never saw them again so people stopped sending family or community members to the ETUs resulting in contagion. The contact tracers and surveillance helped to stop these transmissions.... We had youth health volunteers, but they were not incentivized... The TF allowed us to pay stipends to youth case workers, which helped turn the tide by building on existing structures... Without the TF, we would not have partnered together.*"
>
> – UNFPA representative

This substantiates the potential for TFs to have a catalytic role, which in the case of the Ebola Response allowed different members of the UN family to operate as a UN System in a synergistic manner without being hindered by traditional boundaries, agency competition, or competition for resources. Noted by a UN representative, the TF encouraged cooperation between UN agencies and limited competition between agencies on the ground. "*Without the TF, the UN Agencies all go to the same donors for money creating a fragmented approach and competition. The entire strategy will not work without a unifying mechanism for funding. The fund brings together UN agencies by providing a carrot.*"

Figure 9 © Peter Bauman: Contact Tracers in Liberia

2   GOVERNANCE STRUCTURE AND LEGAL ARRANGEMENTS

The lean and simple governance structure established for the management of the TF was very effective in managing donor expectations; promoting dialogue and transparency; expediting proposal submissions, review, and approvals; and, encouraging the UN family to work as a system.

Nearly every interview expressed great satisfaction with the governance structure and legal arrangements and suggested using this as a model for future trust funds of this nature. The structure included the following core elements.

A. The Advisory Committee consisted of The Chair, three representatives of contributing donors, a representative from each of the three most affected countries, and other members from the recipient organizations serving as resource persons to the committee. The UN MPTF Office also served as ex-officio member of the committee. The UN Secretary-General's Special Envoy on Ebola, who served as the Chair, worked in consultation with the committee to articulate funding priorities and make fund allocation decisions. The committee also served as a forum for discussing strategic issues and sharing information on funding coverage. Proposals that needed immediate support were prepared by UN agencies working together and were then prioritized and cleared by the Ebola Crisis Managers and later Resident Coordinator (RC) in each country who submitted them to the AC for approval.[32]

B. The Fund Secretariat function was housed in the MPTF Office. It supports the Chair by serving a range of functions including: providing administrative support to the Advisory Committee; supporting fund mobilization efforts led by the Chair; organizing calls for and appraisal of proposals; and monitoring and reporting on the TF's programmatic performance to the Advisory Committee. The Secretariat also oversees the TF's Operational Procedures, which were streamlined to facilitate rapid fund allocation processes. For instance, a compressed timeframe was established for the response phase with the goal of 7 days between Calls for Proposals, approvals, and fund disbursement.

C. Administrative Agent: the UN MPTF Office served as the Administrative Agent of the fund. It was responsible for TF design and set-up, legal agreements, maintenance of the TF account, receipt and administration of donor contributions, and the disbursement of funds upon instructions from the Special Envoy, and provision of periodic consolidated reports.[33] Contributions to the TF were accepted from Member States, regional legislative bodies, inter-governmental or nongovernmental organizations, businesses and individuals. To contribute to the TF, a Standard Administrative Agreement with the MPTF Office needed to be signed. Contributors were encouraged to provide un-earmarked contributions. However, if due to specific donor preferences the un-earmarked contributions were not feasible, donors could earmark contributions to a specific affected country or Strategic Objective of the Ebola Response.

UN AGENCIES AS PRIMARY RECIPIENTS

The use of national country systems was not an option for the immediate Ebola response. The government's ability to comply with basic safeguards and fiduciary requirements was not in place in public institutions. Local NGOs and CSOs also had limited management capacity. There were also governance issues and conflict of authority as ministries were not used to working under a single command structure that had been established in the three countries. In addition, political contexts were heavily charged in the three countries albeit for slightly different reasons. The affected populations were also suspicious of misuse of external assistance by their own public institutions. Therefore, the use of the UN system was practical and politically safer.

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32 The AC met 10 times, bi-weekly at the beginning of the TF operation, and the minutes of each meeting can be accessed on the MPTF website.
33 The 1% fee allocated to TF management and the 7% operational costs charged by the recipients (UN agencies) were well accepted by donors and not subject to controversy.

3 PROCESSES FOR THE REVIEW AND APPROVAL OF PROPOSALS

The TF had very specific priorities for ensuring that proposals were targeted to achieve specific goals and underfunded or unfunded necessities. For example, by using *Priority Category A* as a primary criterion during the response phase, it ensured that proposals to the TF were focused on supporting the strategic objective of *Getting to Zero*. More specifically Category A specifies that proposed activities should target: identifying all chains of transmission, ensuring all new Ebola cases are from known contacts, with a result that flare-ups of Ebola cases in areas where transmission had stopped are minimized or prevented. It goes on to provide illustrative examples of interventions including:

a.   Strengthened epidemiology and contact tracing functions at district level: proposals to support adjustable, district-focused response, including people and facilities for Ebola diagnosis and treatment, for finding cases, tracing contacts and maintaining surveillance, and for assuring that people affected by Ebola can access essential services. Districts have access to the right services, provided when and where needed.

b.   Logistical capacity: proposals that directly support the UN system's ability to implement the STOP and TREAT elements of the response.

c.   Incentives for workers to actively participate in the Ebola Response: examples of proposals supporting this element would be those that fund cash and food incentives for Ebola Workers.

d.   Incentives for families/contacts and survivors and support to orphans: proposals to support Ebola survivors and families classified as contacts.

The evaluation team found that most proposed projects targeted these categories and were in-line with the approved results framework. Given that the most immediate priority of the TF was to *Stop Ebola*, it is logical that a limited number of proposals and funds were focused on *Priority Category B - Improving Regional Preparedness; Priority Category C - Revival and Remodeling of Essential Services;* and Recovery activities.

Proposals also targeted both modalities based on capacity and context. Initiatives were channeled through the UN system entities and when appropriate and more advantageous, funds were channeled through CSO's and NGO's, via UN Agencies, to support community level activities.

Best practices, lessons learned, and recommendations emerging from interviews include:

3.1   The TF used the situation analysis performed by UNMEER and WHO, which were constantly monitoring the dynamic and fluid context. It was also able to gain input from governmental and non-governmental actors on the ground all the way down to the local level. This helped to ensure that proposals were focused on immediate priorities and not duplicative.

3.2   The above process enabled the identification of gaps, which UNMEER senior representatives in each country (Ebola Crisis Managers) channeled to the Special Envoy, David Nabarro, to inform the Advisory Committee on priorities resulting in a streamline proposal process. Once the proposals reached the board they had already been vetted and agreed to. Stated by an Advisory Committee member, *"we typically raised questions in advance of the board meetings. We discussed a lot of proposals off-line via phone and email so the minutes from the meetings only reflect the final decisions, not necessarily the actual deliberations. There was not time at the board meetings... Once we got to that stage of the board meeting, it was just to say yes to the proposals."* This somewhat informal and streamlined process ensured an efficient, effective, and targeted used of limited resources.

3.3   Initially there was occasionally some confusion on how to access the TF. However, once communicated effectively to the UN agencies the proposal and approval process was clear, simple, and efficient. Much of the relevant information was available on the MPTF's website, but verbal briefings might have been more effective during a complex emergency. Critical information was also supplemented by the deployment of the Planning, Monitoring and Evaluation Officers to each of the three affected countries.

3.4   The proposal template was simple with clear results logical framework and adapted to the context of an emergency response. It was derived from the widely approved United Nations Development Group template for Project Documents that was adapted to be simpler and more user-friendly.

3.5   Building on the previous recommendation, UN agencies appreciated the fund's flexibility and willingness to support pilot projects based on changes in context, priorities, and learning. For example, several UN agencies piloted more creative, non-medical community engagement programming that paved the way for more intrusive interventions that could not have been achieved without raising awareness and building trust first. By allowing initial proposals to simply outline a general concept that is in line with the TF's priorities it enabled UN agencies to adapt programming to the context at a very local level.

3 PROCESSES FOR THE REVIEW AND APPROVAL OF PROPOSALS

3.6   Delays between proposal approval and implementation had less to do with the TF's processes and more to do with internal UN agency bureaucracies. Thus, the MPTF Office ability to transfer funds rapidly did not always result in rapid responses on the ground as individual UN agency procurement procedures were not as streamlined as the TF itself. Although, this is not the responsibility of the TF, it did result in minor bottlenecks especially when UN agencies transferred funds to local implementing partners.

3.7   During the recovery phase the process shifted to a more passive approach whereby the UN agencies through the RC were asked to submit proposals with a broader defined goal and less defined illustrated examples of activities than were provided for Priority Category A. This level of ambiguity may have affected the focus and timeliness of projects. Maintaining the initial system for decision-making and proposal development may have helped to keep programming focused ensuring the efficient use of the remaining–and limited-funds.

3.8   Representatives of UN agencies also recommended that the Trust Fund Secretariat post someone on the ground in each country to assist with the preparation of proposals and liaise with the MPTF office. In some cases, particularly in Sierra Leone, the TF's M&E Officer delivered this service without facing major challenges and with full support from the UN country team including the RC. In Liberia and Guinea, the M&E officers had less access and struggled more to be accepted and fulfill this role. In the future, the presence and function of the M&E officers should be perhaps communicated more clearly to the UN agencies.

3.9   During the response phase, governments were included in the project selection process as much as possible without causing delays or becoming influenced by local politics. Each country had a representative on the advisory committee in NYC. However, they were admittedly not proactive in communicating with their counterparts on the ground and often had limited contextual knowledge to provide constructive feedback on proposals. The level of engagement of governments on the ground varied and was partially dependent on personalities and the institutions created by governments. Most complaints from government representatives had less to do with UN engagement with them and more to do with inter-governmental communication issues. During the recovery phase, once a unified command structure was not required, line ministries resumed their traditional responsibilities and engagement with governments in decision-making processes for proposals caused some difficulties. It is difficult to provide recommendations on how to manage a successful transition from emergency to "normal operations" as it would likely depend on the local leadership and the context. Nonetheless, it is useful to expect that government institutions will exert pressure to regain full ownership of funding allocations and operations once the emergency phase is over.

3.10   A major issue was the effect of the epidemic on basic health services. As the epidemic subsided the need to rebuild health systems became critical. The MPTF supported pilot projects through the recovery window, funded technical assistance to assist governments in preparing recovery plans, and contributed to the sectoral dialogue. However, many of the recovery projects, which were in fact influenced by MPTF donors' categorical interests could have been more carefully designed and targeted as pilot activities or demonstration projects. Stated by a UN representative, *"we want to see the recovery resources go into seed funding rather than funding complete projects. The funds should have been used to generate more resources. We did not have specific criteria for funding recovery projects. For instance, the question could be asked if the proposed recovery projects were part of a bigger program and if there are potential donors? Donors like to see proof of concept."* Other interviewees suggested that recovery funds should be used as a catalyst for more funding rather than funding complete projects, without adequate resources and time for a sustainable effort - *"US$10 million for recovery projects should have been harnessed to generate US$ 100 million."* In addition, interviewees expressed that due to staff turnover after the initial response the institutional memory was lacking and relationships between stakeholders had been weakened, which may have inhibited the focus of the recovery projects. The interviewee suggested getting commitments from donors to add additional funds to the recovery projects early on before their interest wanes or they leave. To ensure that the recovery phase is as efficient and effective as the response phase, it may be worth considering the formation of country-level sub-advisory committees who are responsible for defining priorities for the transition and reviewing proposals before they are submitted to the Special Envoy and the Advisory Committee for final approval. This would help to ensure a transfer of ownership of the recovery activities and pave the way for more sustainable funding.

4 COMMUNICATIONS

There were multiple levels of communication necessary for the effective and efficient operation of the TF. Some of these lines of communication were beyond the scope and capacity of the MPTF office and the Special Envoy, but are worth assessing for future emergency responses of this nature.

4.1 Communication between the Secretariat and Donors

Donors contributing to the TF expressed great satisfaction with the level of responsiveness and professionalism of the Fund's Secretariat. They appreciated the willingness to accommodate their specific needs and interests often with very short notice. **This positive communication encouraged several donors to contribute to the fund that typically would not support pooled funding mechanisms. This in term became a catalyst for other donor contributions.** If relevant, a recommendation for future TF's may be to inform donors that the funds may be used to support core functions. Several donor agencies expressed that they already provided funds to support UN Agencies core funding. However, it would not have been possible for UN agencies to effectively engage in the Ebola response without additional resources for operations, salaries, etc. Clearer bi-lateral communication with specific donors on why additional core funding was needed might have provided stronger justification for additional funding.

4.2 Communication between the Special Envoy, Secretariat and Trustee/Administrative Agent

Communication between the Special Envoy, the MPTF Office-based Secretariat, and the Administrative Agent was seamless, which contributed to the expeditious receipt, approval, and release of targeted funds.

4.3 Communication between the MPTF office and UN Agencies

Communication between the MPTF office and UN Agencies was also efficient and effective. Representatives of UN agencies praised the MPTF Office's responsiveness and willingness to adapt in real time to changes in context. The MPTF's website provided detailed information on all aspects of the TF including both operations and funding. However, it does not appear that everyone routinely accessed the website for information.

4.4 Communication with government representatives

In each of the three countries a national Ebola response center was established and a senior government representative was appointed to head the Ebola response. The command structure was created by the Head of State in Guinea and put under the President's direct authority. In Liberia, the Response was headed by a Deputy Minister of Health. In Sierra Leone, the Head of NERC was a prominent Cabinet member (currently Minister of Defense). In Sierra Leone, NERC served this function at the national level and was supported by district level structures (DERCs). It is worth noting that the NERC technical staff was mainly composed of expatriate Sierra Leonese mobilized for the response and that the TF covered most staff salaries. This single command structure may have generated tensions with some of the line ministries, but it helped to streamline all UN communication with the government. Stated by a NERC representative, *"David Nabarro's office was very good at engaging with the government, discussing our needs and proposing concrete solutions. Establishing this platform was a big success. It was an enabling forum to drive the response forward."* Also, through daily and weekly meetings with all stakeholders involved in the Ebola response, priorities were clearly articulated and roles and responsibilities were assigned. This helped to ensure that TF projects were not duplicative and filled important gaps. It also helped to ensure transparency of decision making and fund allocation. However, representatives of the Ministry of Health, Finance and other government bodies sometimes felt that they were not privy to decision making processes or information about how the TF resources were allocated. A UNDP representative recommended greater efforts to *"ensure that appropriate representatives of the government (i.e. President's office and Minister of Finance) are knowledgeable of the fund and how it is being used."*

4.5 Communication between MPTF office staff in NYC and M&E officers in the field

The TF also benefitted from communication between the MPTF Office and M&E officers on the ground in each country. Despite different time zones, the communication was consistent which allowed to guide M&E Officers in their day-to-day duties. In the future, these officers could be even more empowered through more active participation in the UN Country Team activities and closer integration to the operation of the UN Country Team. This would enable them to serve more effectively as communication and liaison facilitators, in addition to their project monitoring and reporting activities in the field.

4 COMMUNICATIONS

4.6 Communication across the effected countries

Cross learning was limited to a few discrete events. There were several opportunities for UN agencies to share learning across countries. The M&E officers would have also benefitted from more substantive and in-person interaction with their counterparts in each country, which could have facilitated cross-learning between UN agencies. A representative of the advisory committee reiterated this point stating: *"We did not maximize the lessons learned of what worked well. Each country was having its own crisis... Knowledge of one country could have been used to inform programming in other countries. WHO and UNDP were lead organizations in each of the three countries... they have people at every level. There should have been a system for transferring information through a central RC's office that could have been used to inform proposals."*

4.7 Communication with partners, NGOs, CSOs and the general population

Emergency operations at the scale of the Ebola response often result in rumors of misuse of funds. Lack of strategic communication plans to inform the public and non-UN agencies of the TF led to some rumors and questions of where the money was going. For instance, people questioned why so many vehicles were purchased for the government, although the TF was very cautious about the provision of equipment. Vehicles were mostly purchased by bilateral agencies. In the future, more emphasis could be placed on a public strategic communications plan to explain what the fund is and how it is being used. This should be done with prudence as it could lead to unmet expectations. This is also an important dimension of the government's communication responsibilities.

5 EFFECTIVENESS OF REPORTING PROCEDURES

The reporting procedures were more than adequate considering the unpredictable nature of the response and the diversity of recipients and projects. Also, the amount of documentation provided on the Gateway's Ebola page (http://mptf.org/ebola) was commendable considering the lean nature of the secretariat in NYC. Using the website as a repository of reports ensured transparent tracking of the use of the funding disbursed to UN agencies.

Due to the Secretariat's limited human resources in New York (Head of the Secretariat and Secretariat Support Officer) and oversight of monitoring on the ground (one M&E officer per country), a large amount of trust and responsibility had to be placed on fund recipients. Agencies were responsible for financial accountability and transparency; quality of programming and oversight; contextual understanding, local knowledge and conflict sensitivity; and an honest appraisal of their ability to execute what is offered in proposals. Noted by a senior UN representative, *"I am not worried about financial management because internal UN accounting rules and regulations apply."* However, once the funds are disbursed beyond UN agencies to secondary recipients it was relatively more difficult to account for tangible assets and their use and impact (ambulances, vehicles, buildings, phones, etc.). Despite the rapid approval and disbursement process, lean reporting requirements, and limited external M&E, robust safeguards were in place to prevent, investigate, and take corrective and legal actions against the mismanagement of funds. UN agencies have their own well-established auditing and investigation process in place. Regarding the International Federation of Red Cross/Red Crescent societies (IFRC), UNDP had assumed Managing Agent responsibilities for the money passed to the IFRC. While the purpose of this LLE exercise was not to evaluate individual projects, there were limited cases where stronger oversight could have improved accountability and encouraged higher quality program design and implementation resulting in greater impact and transference of learning within and across countries.

Since its establishment, the TF introduced monthly reporting requirements based on the request of the Mission of Sierra Leone to monitor progress in almost real time. In 2016, the reporting has been made quarterly. Representatives of UN agencies had varying responses and recommendations for reporting. The majority thought that reporting was reasonable and clear. Stated by a UNFPA representative, *"Monthly reporting was very fair... it was not heavy and the reporting template was easy... something you could do in less than an hour."* However, some interviewees thought that one month was too often and quarterly reporting would be more appropriate. Stated by a UN representative, *"Monthly reporting requirements were too much at a time when the country office had limited staff. It was difficult to even calculate the figures... this requirement was also outside of the MOU."* Many UN agencies had multiple donors with different reporting requirements, which added to the reporting burden. Stated by a WHO representative in Sierra Leone, *"the other donors expected 6-month to yearly reports. Quarterly reporting is quite unusual. But the MPTF was a rapid response mechanism and quarterly reports were justified in that context."*

Overall, the current system for reporting was more than adequate in an emergency and did not put an excessive burden on the implementing agencies while complying with accountability requirements demanded by the donors.

Recommendations for improving reporting procedures include the following:

5.1 Add more colorful reporting including film and video to capture achievements.

5.2 In addition to the interim reports, provide light regular written reports to members of the Advisory Committee to inform them of progress, setbacks, and achievements.

5.3 Provide feedback on reports so recipients of the fund feel that their efforts to provide regular and high quality reporting is needed and useful rather than just checking off a box. The provision of regular feedback on reports was one of the responsibilities of the M&E officers.

5.4 Ensure clear expectations for UN Agencies of what will be measured and reported on by defining indicators and methods of measurement in the initial proposals and as programs are adapted to the context.

5.5 One of the Secretariat's responsibilities is to clearly define the TF's role in M&E vis-à-vis existing UN agency policies and procedures. This should include defining roles and responsibilities, carefully balancing UN Agencies capacity.

5.6 UN Agencies who were the primary recipients must consider balancing the need for a rapid proposal and approval process with quality program design. When proposals are written fast they can be sloppy and indicators may be poorly defined. This inhibits effective and meaningful reporting.

5.7 Deployment of M&E officers improved the quality of proposals and therefore the effective use of resources. For example, in some instances, they helped to make sure that the programs were realistic based on the funds requested, the agencies capacity, and the context.

5.8 The performance of the M&E officers varied between countries. Factors enabling or inhibiting their ability to serve their function included: Acceptance from and access to UN agencies, clear lines of communication, and personal competencies and attributes. In the future, the roles and responsibilities of the M&E officer should be more clearly defined and discussed between the Resident Coordinator and the UN Agencies. In addition to the above, M&E officers relied on UN Agencies availability and vehicles (on a full cost recovery basis) for field visits making them dependent on UN agencies for monitoring and evaluating projects. They were not always able to return after monitoring missions to ensure that feedback was applied. Since all UN Agencies had their own evaluation officers, Joint follow-up visits could have been scheduled whenever needed.

6 BEST PRACTICES FOR OVERALL EFFECTIVE AND EFFICIENT OPERATION OF THE TF

The Ebola Response was a learning experience for governments, civil society, and development partners including UN agencies. The Ebola MPTF is considered one of the most successful pooled funding mechanisms for good reasons. While the situation is unique, many of the following best practices and lessons learned can be adapted and transferred to other contexts.

6.1 Strong leadership – The UN Special Envoy for Ebola provided the UN response, strategic advice to UNMEER and UN Agencies, and the TF management with gravitas. **His combined technical and programmatic credentials, vast experience handling complex emergencies, and unique aptitude for building consensus around a clearly defined goal and objectives was critical to the efficiency and effectiveness of the TF and the overall UN Ebola response.** Stated by a senior UN representative, *"The TF worked very well because there was very early agreement, which ensured no duplication and timely delivery. David Nabarro's relationship with WFP leadership enabled this to happen."* Other interviewees articulated specific feedback on why the leadership was so effective including:

- Create a big enough tent and bring people in.

- Encourage people to talk about their ideas and concerns and be willing to actively to everyone including individuals and organizations that the UN system does not typically engage with.

- Combine a diverse range of thoughts to create a coherent narrative.

- Provide a historical sense of direction that encourages people to jump on board.

- Provide an inclusive vision that was practical enough so there would not be too many detractors from the vision.

- Engage in quiet diplomacy early and often.

- Regularly travel to the field.

- Nurture a non-competitive environment to encourage collaboration and problem solving.

- Closely link funding to a clearly defined strategic framework and implementation plan.

6.2 Clear focus – Articulating a singular goal and objectives supported by a simple results framework assisted in defining expectations and delineating shared allocation cycle priorities, tracking results, and achieving the overall UN mission.

6.3 Political will and commitment – While the TF was not meant to address all financial needs and requirements of the Ebola Response, strategically it was an extremely important coordination and financial mechanism because it demonstrated political will and commitment to respond to an unprecedented complex emergency. This assisted in attracting donor funds and motivated a rapid and coherent UN response.

6.4 Increased credibility – Most UN agencies present at the country level were not equipped to face a complex health emergency of this magnitude. Most of the UN agencies would usually experience difficulties in accessing emergency funds, particularly unrestricted funds in a timely manner. By infusing UN agencies with quick and flexible resources the TF enabled them to act fast, which strengthened the credibility of the UN system's response at a critical time.

6.5 Enhanced cooperation to fill gaps – The TF created political and financial incentives for inter-agency cooperation. Regular dialogue resulted in effective lines of communication and enabled UN agencies to work together to identify and fill gaps based on priorities. Stated by a WFP representative, *"If we did not receive the funds it would not have been possible for UNHAS to operate. We needed additional aircrafts to get to certain locations... without the TF we could not get the supplies there on time. There would have been a bottleneck for humanitarian movement of people and cargo."* In addition, *"without constructing Ebola treatment centers in remote locations, it would have been difficult to transport people to urban centers."* The TF also supported implementation by funding technology for communications in Ebola centers including computers, Internet, telephone lines, etc. *"Many donors did not fund this side of the project."* Another example of gap-filling was the TF's support to WHO, which needed an immediate influx of funds to pay staff salaries particularly for field-based epidemiologists.

6.6 Strengthened UN platform – The TF was essential for enabling UN agencies to put systems in place by allowing them to take quick actions to build up essential internal capacities. These actions resulted in a UN platform capable of serving core logistical functions including flights, construction, and delivery of supplies. Stated by a WFP representative, *"The fund helped a lot with cooperation because it enabled WFP to serve the entire humanitarian community and the governments by providing transport, helicopters, IT, security, and treatment centers. None of the other agencies or the government had the capacity to do this rapidly. David Nabarro and WFP agreed for WFP to go all in. It is not the usual*

6 BEST PRACTICES FOR OVERALL EFFECTIVE AND EFFICIENT OPERATION OF THE TF

mandate of WFP to build treatment centers, but that is what was needed and that is what we did." The fund also enabled the UN agencies to supplement resources mobilized by other partners such as the World Bank. For instance, UNDP set up and managed a payment system for a range of Ebola response staff and volunteers. An added advantage of this set of practical actions supported by the TF-including the QIPS- was to increase public confidence and social stability especially when trust in national governments was very low.

6.7 **Rapid, flexible, and context specific response** – The TF was agile, country driven, and adaptive to changing needs and unpredictable contexts at national and local levels. Effective data collection and consultation mechanisms within the UN system and directly with field-based national response structures[34] enabled the Advisory Committee to make rapid and informed decisions.

6.8 **Lean and responsive governance structure** – The dedication, competence, flexible and receptive management style of the Advisory Committee and Secretariat enabled the TF to function efficiently and effectively while maintaining modest operating costs.

6.9 **Rapid mobilization of funds** – The TF had one of the highest levels of donor engagement ever seen in UN trust fund history. As of May 2016, the fund had received US$ 162 million of which US$ 126 million was received within the first three months. The diversity of donors was also unique. Contributions were received from 43 UN Member States, three quarters of which usually do not participate in pooled funding mechanisms, two foundations, three businesses, many individuals including school children. US$ 100 million was disbursed for approved projects during the first three months. These numbers illustrate that the Chair of the TF's Advisory Committee supported by the Secretariat effectively collected, allocated, and dispersed a large amount of resources in a rapid and transparent manner with a high level of accountability. A major attraction of the TF was its ability to leverage other donor funding, allocate funds to locally identified and prioritized needs, and help deliver response at scale while meeting transparency and accountability requirements. Due to the high-profile nature of the Ebola epidemic and the political nature of the UN's response, donor contributions often resulted in a leveraging effect. After one country contributed others felt an obligation to contribute even when they were already providing bilateral assistance to UN agencies at the central level or as technical assistance at the country level.

6.10 **Outreach and reporting** – regular interaction with and briefings to donors by the Special Envoy and the UN MPTF Office at the technical level facilitated transparent communication and effective operations. This communication was reinforced by regular and high quality reports on the Fund's performance, all of which contributed to donor satisfaction with the TF mechanism and strengthened the Fund's visibility. The Secretariat's responsiveness to different donor needs and interests was highlighted as a strength of the TF. An example includes an interest of a donor serving on the Advisory Committee in supporting maternal health, which resulted in projects including project #33 in Liberia and the posting of midwives in Guinea.

6.11 **Monitoring and Evaluation (M&E)** – Field level M&E officers in each country contributed to the TF's coherence and effectiveness. They also enabled UN agencies to draft proposals and report on projects with relative ease.

6.12 **Sustained presence** – While the TF projects contributed to the achievement of zero transmissions, they also enabled UN agencies and local governments to acquire technical capacity for surveillance and rapid response demonstrated by their ability to contain flares that re-emerged in the three countries even after WHO had announced the end of the public health emergency. The threat of resurgence of the disease in a region where the virus is still present makes this strengthening of surveillance and response systems a vital contribution.

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34 National institutions formed in each country to convene stakeholders, disseminate information, lead and coordinate the Ebola response. These included: National Ebola Response Centre (NERC) in Sierra Leone; Cellule de Coordination Nationale de Lutte Contre la Maladie à Virus Ebola (CNLE) in Guinea; and, the Ebola Response Consortium (ERC) in Liberia. The institutions provided daily updates about the rapidly evolving situation on the ground.

7   OVERCOMING CHALLENGES AND CONSTRAINTS

No funds targeting complex emergencies operate in a vacuum. Internal and external contextual factors have an impact on a funds efficiency and effectiveness. In the case of the Ebola TF, there were many constraints that could have impeded its efficiency and effectiveness. However, the TF is a flexible instrument able to pivot as the situation changed. As a result, the fund overcome many of the following obstacles:

7.1   **Delayed Global Response.** The TF could not have been launched prior to the Declaration of a PHEI by WHO and the September UN resolutions. But, a massive coordinated response by the international community (outside of NGOs already active on the ground) was overdue.

7.2   **Complex operating environment.** The situation was particularly dramatic, precise epidemiological information was scarce, evolution of the epidemic was largely unpredictable, and rapidly evolving.

7.3   **Insufficient data and inadequate expertise and experience.** Due to its unprecedented nature, there was insufficient data, inadequate expertise and experience pertaining to Ebola.

7.4   **Limited presence on the ground.** Existing UN agencies on the ground were relatively small with a few exceptions like the WFP, which was operating a large regional platform.

7.5   **Organizational culture and norms.** The development of programmatic and operational partnerships between UN Agencies was not part of their organizational culture or traditional modus operandi.

7.6   **Limited funds and absorption capacity.** Although the TF was large by UN Standards some respondents suggested that more funds would have been desirable, but even within the UN system there were limits to absorption capacity in an emergency context.

7.7   **Selection of recovery projects.** Several Recovery projects supported by the TF are still ongoing. The School Rehabilitation in West Point, a poor urban community in Monrovia, can be considered as a success story. The impact of scale of the WASH project in Liberia is not yet apparent and recovery activities are still underway. Its value as a demonstration project could be limited unless the implementing agencies disseminate the outcomes broadly to government partners and other development institutions to scale-up the interventions and ensure sustainability. WASH projects are inter-sectoral, consume large amounts of funds, take time to implement, and require long term commitments.

7.8   **Funds disbursement.** Even though the Advisory Committee, Secretariat, and Administrative Agent could review and approve proposals and transfer funds rapidly, some UN agencies struggled with their own internal bureaucracies to disburse funds either directly or through partners.

7.9   **Government endorsement of recovery projects.** Endorsement by governments of the selection of projects particularly during the recovery phase caused some delays.

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35 At some point during the outbreak West Point had been quarantined, which resulted in severe tensions between the population and law enforcement agencies. Schooling was interrupted for almost a year and some schools were used as treatment centers. It was therefore, appropriate to use the TF (US$150k) to rehabilitate a school that served a poor community, provide it with adequate water supplies and sanitation, and help put hundreds of children back in school.

8 BEST PRACTICES AND LESSONS LEARNED FOR FUTURE POOLED FUNDING MECHANISMS

8.1. Focus with Flexibility is a key to success in complex emergencies. The TF's ability to adapt to the context was paramount in its effectiveness. Stated by a government official in Liberia, *"the Ebola response was dictated by a combination of the epidemiology of the disease and unique and unforeseen socio-cultural factors."* This necessitated constant adaptation and innovation that most donor funds did not initially support. The TF filled this gap by adapting as the crisis evolved. For example, the TF supported initiatives to raise awareness, debunk myths, address cultural practices, and support community engagement by providing stipends (hazard pay) to staff and volunteers, community radio programs, and other initiatives.

8.2 Recognize that communities led and owned the response. While the international response and the TF served an important function by providing essential human and financial resources, the local communities and volunteers who were active in case detection and safe burial were the heroes of the response. Without them, none of the external resources would have reached their targets. They should be acknowledged and rewarded for their courage and efforts.

8.3 Build on existing structures. The UN agencies, national and local governments, and civil society all had existing structures many of which were already engaged in the Ebola response prior to the formation of the TF. By complementing and strengthening these structures the TF avoided duplication, the creation of parallel and uncoordinated structures, increasing inefficiencies and frustration. Instead the TF strengthened and empower existing structures.

8.4 Encourage inter-agency cooperation through joint programming funded by the TF. Further stated by a UNFPA representative, *"During the inception phase three UN agencies (UNDP, UNFPA, and WHO) partnered to work on the contact tracing and surveillance... Counties were allocated based on existing presence and capacities. Each agency used different approaches based on the context and we learned from each other and capitalized on each other's technical and geographic resources."*

8.5 Recognize socio-cultural and political aspects of complex emergency responses. The socio-cultural and political aspects of the Ebola response were just as if not more important than the technical (epidemiological) facets of the response. As one interviewee stated, *"the TF was very important for maintaining social stability."* Donors do not typically fund interventions that address these less predictable and intangible factors. The TF was strategic in testing innovative initiatives that helped to build the confidence of other donors to support similar community engagement and sensitization initiatives. The TF filled an important gap by supporting UNICEF with funds to train social workers in case management, design a child protection information management system, train mental health technicians, and provide direct funding to children who lost a parent or were orphaned.

8.6 Identify and engage with civil society and support strong local partners early – In some instances, UN agencies were not best placed to implement response and recovery initiatives. In such cases interventions were more effective when TF resources were channeled to local NGOs and CBOs. In the future, it would be prudent to identify and engage with these institutions early.

8.7 Sustain Momentum. There has been significant staff turn-over and the institutional memory from the Ebola response is waning. It is therefore important to avoid complacency, continue building capacity within and outside the UN and sustain the momentum.

8.8 Disaster Preparedness. Although Ebola was known in other parts of Africa, except for a handful of NGOs operating on the ground at the onset of the epidemic, the international community's response was delayed by several factors including politics, lack of information, and lack of local expertise costing unnecessary loss of lives. In the future, it is hoped that governments and UN agencies will be better prepared to detect and respond to complex health emergencies involving Ebola Virus as well as other pathogens. In the short term this includes the potential resurgence of Ebola in Guinea, Liberia, and Sierra Leone, perhaps where the virus is still present among survivors and in its animal reservoir. Recovery funds could be targeted to support preparedness plans supplementing other donor's involvement.

8.9 Start planning for recovery earlier in the process. While it is important not to divert funds and attention from the immediate response, specialized UN agencies could be tasked with planning for the recovery phase at an early stage, including addressing the needs of survivors. In the case of Ebola, many survivors suffered for over a year before anyone started to focus on them in a systematic manner. Beyond physical ailments, individuals and communities effected by Ebola as well as those directly involved in the response suffered from stigmatization, loss of property and livelihoods. Proposals and funding could have been allocated for this sooner although in all fairness, at an early stage it was clearly impossible to predict elements such as the survival rate, and the duration of the epidemic.

8 BEST PRACTICES AND LESSONS LEARNED FOR FUTURE POOLED FUNDING MECHANISMS

8.10 **Ensure the recovery phase is as focused as the response phase.** Clearly define what recovery means and provide more a more concrete timeframe on how long the recovery phase will last. Proposals that go beyond this time frame should include a sustainability plan. In addition, prior to the recovery phase, the TF's MoU, objectives, priorities, should be reviewed with the Board to ensure that they remain appropriate based on the changed context and priorities. This might include adapting the proposal template, reporting requirements,[36] and adjusting the TF Advisory Committee's mission. It may also include a greater balance between immediate response and broader programming from the beginning. By anticipating the programming of a recovery phase, greater planning, human and financial resources could have been allocated sooner.

8.11 **Encourage Cross-fertilization.** There was limited interaction between countries. While the context was often different there were opportunities for cross-learning that were missed. M&E officers could have been empowered and equipped to serve this cross-fertilization function by sharing best practices, lessons learned, and innovations across countries. For instance, the burial team recovery program being supported by the Federation of Red Cross in the three countries could be transferred to other potentially affected countries in the Africa region. Another example is the varied use of QIPS in each country. The richness of these experiences should be documented and shared.

8.12 **Leadership and institutional norms.** Avoid dependency on a few individuals. The success of the TF is largely attributed to the action and influence of a few individuals. It would be challenging, but useful to determine ways to turn individual initiatives and characteristics into institutional norms and systems.

8.13 **Accommodate varied donor needs and interests.** By adapting to unique demands without compromising the integrity of the TF or the response, the fund attracted a relatively large amount of funding from a very diverse range of donors.

8.14 **Equip and empower M&E officers** – this global Trust Fund piloted the country-based M&E capacity. In Liberia and Guinea, it seems that the M&E officers lacked the necessary support from UN Agencies and authority to perform their function in the most effective manner. In the future, it is recommended that M&E officers are fully equipped and empowered. It is also important that M&E Officers are a part of the Resident Coordinator's Office and are included in all meetings and briefings.

8.15 **Conduct an independent mid-term review.** While the TF employed M&E officers in each of the three countries, it would have been useful to conduct an independent mid-term review of the TF so that learning could be applied prior to the completion of the fund. This would have been especially useful for the transition from response to recovery.

8.16 **Ensure effective communication and transparency at every level.** The Fund's web-site has served as the strong communication tool, which is updated every two hours. This should include a strategic communications plan to inform non-UN agencies, CSOs, international NGOs and government institutions about activities supported by the fund.

9 MAJOR BENEFITS OF POOLED FUNDING MECHANISMS

According to the Work Bank WDR (2011), "*MDTFs have become a popular financing mechanism and are an important tool of achieving aid effectiveness. They improve the transparency of donor investments, reduce transaction costs, ensure greater coherence with national planning, and provide a platform for resource mobilization, donor coordination and dialogue with national authorities.*"

The Ebola MPTF highlighted these benefits and provided proof that pooled funding mechanisms are an effective and efficient tool for resourcing complex emergencies in fragile states with limited government capacity. Most of these strengths have been articulated throughout this report. To summarize, **the TF provided value for money by providing a rapid infusion of financial resources into the UN system with limited transaction costs and streamlined administrative procedures. It also provided a necessary level of flexibility so that UN agencies could adapt to the evolving and unpredictable reality on the ground in real time.** The response rate between proposal submission and disbursement of funds and, additionally, the provision of QIPS, enabled UN agencies to act quickly and operate across humanitarian and development divide through a blended instrument. In addition, because most the funds were not earmarked, the funds could be targeted to fill important gaps, which most donors do not support. The fund also enabled UN agencies to take calculated risks by piloting innovative approaches, which could be scaled up by UN agencies and other stakeholders. In addition to the above, the TF also exemplified the catalytic effect of pooled funding mechanisms. For example, several major donors invested in the fund to encourage other donors to invest in the Ebola response, which proved to be successful. The TF also enabled smaller nations to participate in the response.

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36 In fact, the Fund switched from monthly to quarterly requirements in 2016

10 RECOMMENDATIONS FOR BUILDING STRONGER, MORE RESILIENT HEALTH SYSTEMS

During the Ebola response and immediate recovery phases, significant efforts were made by national and internationals, public and private institutions, as well as citizens at every level. This created momentum, built human capacities, and infused resources into infrastructure and equipment. However, health systems in all three countries remain fragile and ill-equipped. Challenges related to infrastructure, human resources, HMIS and surveillance systems, quality of care and financing, as well as socio-cultural and political issues remain major obstacles to building stronger, more resilient health systems. In its current form, the MPTF is not the right mechanism to respond to the long-term recovery needs including the strengthening of the national health systems. This was never its aim. However, the momentum, human and financial resources, infrastructure, and equipment should not be squandered. The window for harnessing this opportunity is unlikely to remain open long. Therefore, the following are some recommendations for building on the current momentum and donor interest in Guinea, Liberia, and Sierra Leone.

- **Replicate the factors of a successful response** by aligning leadership, strategy, structure, and resources with a well-defined mission.

- **Identify and engage a range of stakeholders** to define a common and uniting goal with a clear strategy and results framework that national and international actors agree to. Then, set priorities to help sequence initiatives. This could begin by ensuring that recovery initiatives are clearly defined based on preventing a resurgence of Ebola and other immediate health concerns. Or, ensuring that if there is another outbreak, systems are in place to respond immediately.

- **Define roles and responsibilities** based on competencies, experience, and relationships.

- **Ensure that resources are adequate, timeframes are practical, and expectations are realistic** for building stronger, more resilience health systems.

- If seed money is allocated to support recovery projects, **planning for sustainability** is paramount and requires strong partnerships with governments other donors and financing institutions including the private sector.

- Continue and expand recovery initiatives that **build confidence in governments** at every level while also engaging with communities to gain their buy-in and support.

- Leverage support to find ways to **continue funding staff (doctors, midwives, etc.) and encouraging volunteers (surveillance, contact tracers, etc.)** to use their skills, experience, and confidence to support national, district level, and local health systems.

11 RECOMMENDATIONS FOR UTILIZING THE REMAINING BALANCE OF THE UN EBOLA MPTF

11.1 Ebola will not be the last lethal pathogen to emerge in West Africa where the risk of major diseases outbreaks or pandemics is still very real. Countries remain at great risk and with limited capabilities to detect and respond to a disease outbreak.

11.2 The 2014-2016 Ebola Virus epidemic has provided an opportunity to test the capacity for preparedness and response at country and regional levels as well as within the UN system. The epidemic highlighted numerous difficulties and in many ways the response was a painful learning experience for most actors and stakeholders.

11.3 While many useful lessons were learned, there exists a risk that the capabilities that have been built through a combination of strong national and international commitment and supported by a massive mobilization of resources will progressively - or rapidly - erode and that the momentum that has been created during the past three years will be lost.

11.4 One way for the UN agencies to capitalize on the lessons learned is to use the remaining Ebola MPTF funding to complement ongoing efforts deployed by the countries and their partners to build more resilient health systems. In the short-to-medium term the focus should be kept on preparedness and on the most effective way to support national government's capacity for response to health emergencies. While a strengthening of surveillance systems and preparedness are now included in sector investment plans developed in the three countries - and in fact, in most Sub-Saharan Africa countries - there remain gaps in the capacity and distribution of the health workforce, uncertainties about the availability of equipment for Infection Prevention and Control (IPC), the functioning of laboratory services, the effectiveness of communications and logistics. In addition, cross-border collaboration is weak, and there is a lack of coordination and alignment to address the human-animal interface.

11.5 Specialized UN agencies (WHO, UNICEF, UNFPA, UNDP, WFP) and the Red Cross are in a unique position to make an effective contribution to government-led efforts to strengthen the response capacity to known or less-known future threats.
- They have technical staff on the ground with tested expertise in disease surveillance, training, logistics, communication and the timely provision of equipment such as vehicles, IT equipment, laboratory equipment, medicines and PPE.
- Their field experience gives them the ability to link top-down response to local action.
- Their West-African experience adds to the knowledge acquired in other countries in response to different threats such as Influenza pandemics, SARS, MERS and, more recently, Zika.
- They can rely on close relationships with government institutions and have developed strong coordination mechanisms with the donor community.
- They have convincingly demonstrated their ability to act in a synergistic manner and to best use each agency's comparative advantage, as this LLE shows.
- They are in a privileged position to identify gaps in readiness.

11.6 The study recommends that the Ebola MPTF encourage concerned UN Agencies in each country to develop flagship joint programmes (one in each country) to reinforce national and subnational capacity to prevent, detect and mitigate outbreaks of priority diseases selected as the most likely causes of epidemics in each of the three countries and the region such as cholera, yellow fever and other viral hemorrhagic fevers, measles, malaria, meningitis, etc.

11.7 Within the relatively short timeframe that is left to program remaining resources, joint projects could be prepared and submitted for approval if they meet the following criteria: government-led, aligned with national priorities, community-focused, building on existing structures established for integrated diseases surveillance and response, filling gaps while avoiding duplication. It would be preferable to focus on key components of preparedness including: (1) surveillance, (2) infection prevention and control, (3) health workforce readiness, and (4) community outreach.

11.8 Several tools exist to assess preparedness, including checklists developed by WHO such as the toolkit for assessing health system capacity for crisis management, as well as several frameworks such as IHR 2005 with 2016 revisions, the Pandemic Influenza Preparedness Framework (2011-2016), the Global Health Security Agenda (2014), and the Sendai Framework for Disaster Reduction.

11.9 Each joint programme should logically be prepared after the completion of a rapid assessment to identify existing gaps in capacity, resources, and support. Programmes proposed for financing by the Ebola MPTF should aim at filling these gaps which are more likely to be found at district and community levels than at the national level.

11.10 Supporting reality checks and response testing could be included in the projects. Moreover, given the trans-boundary nature of future threats, UN agencies who operate in Guinea, Liberia and Sierra Leone should also consider engaging with UN counterparts in the neighboring countries to design and test a regional scale response exercise.

11 RECOMMENDATIONS FOR UTILIZING THE REMAINING BALANCE OF THE UN EBOLA MPTF

11.11   Projects submitted for funding to the MPTF Advisory Board should be based on joint programming but within this joint programmatic framework each agency should identify specific activities under their responsibility. For example, UNICEF would develop plans to maintain immunizations and other child health services during a crisis; UNFPA would focus on maintaining reproductive health care and newborn care; WHO would keep the lead on surveillance, hospital preparedness, infection control, laboratory support, and the sustainability of key programs such as malaria control; UNDP would be in the best strategic position to encourage and support inter sectoral actions and overall coordination; WFP would play a key role in supporting logistics and provision of air service on a cost-recovery basis. IFRC would lead the community level surveillance activities, including cross-border surveillance, and case management of facilities. All agencies could assist the central level if required but they will be encouraged to aim their support at sub-national and community levels.

11.12   Guidelines for preparation:
- To expedite preparation, the format of the joint proposals should be kept simple and straightforward as in previous projects supported by the MPTF. It should include clear and realistic goals, time-bound and measurable outcomes.
- The proposals would be based upon a rapid and candid assessment of preparedness, identifications of existing strengths and weaknesses. It should have a defined collective objective – commonly agreement quantifiable and measurable result or impact in preparedness, requiring the combined effort of different actors.
- Proposals will describe areas and functions where the UN Agencies, working together, would be in a unique position to make a significant contribution. They will show how UN agencies will work in a coordinated and synergistic way.
- To maintain the spirit of inclusiveness and transparency that prevailed during the previous TF supported operations, specific activities will be identified and discussed with governments and other stakeholders. The proposal will demonstrate alignment with government priorities and consider activities supported through other mechanisms and by other donors.
- Costing and budgeting should be realistic and directly linked to specific outcomes.
- Finally, the proposal should, as in the past, include a robust results matrix, M&E plan including intermediary results and, ideally indicators measuring improvements in the overall country preparedness.

11.13   The following section suggests, but is not limited to, some specific areas that continue to require attention. They are mentioned for illustrative purpose:
- Health workforce: continue capacity building at district or sub-district levels and institutionalize the role of community health workers.
- Hospital preparedness: how to build a surge capacity for hospitals and other health facilities to enable them to fulfill their role in national and local response and to ensure the provision of critical health services. Some hospitals may already have preparedness and response plans that could be updated and adjusted.
- Community based surveillance: training, IT and communication equipment in place for early warning and real-time reporting, logistics.
- Laboratory capacity: ensure that there is a functioning network of laboratories with reagents, guidelines and equipment for handling samples, trained technicians.
- Reserve stock of PPE and other pieces of equipment for IPC.
- Communication: this has been erratic at the onset of the Ebola epidemic and would require a more structured, planned and country/culture specific approach to provide timely and accurate information to the public and avoid repeating past mistakes.
- Planning for maintaining key services during an outbreak: immunization, safe deliveries and care of the newborn. These services had all but collapsed during the Ebola epidemic.
- Financing and conducting field tests at subnational national and regional levels. The UN agencies could support these tests while advocating for budget line items to be allocated to preparedness, including testing.

11.14   Other important issues that may be addressed with the Ebola MPTF support include: the fragmentation of regional systems and the lack of robust mechanisms for regional cooperation and rapid information sharing. The lack of attention to animal-environmental interface of disease outbreak threats could also be addressed. In addition, the UN Agencies can advocate for line item financing of IHR 2005 core capacities and support ECOWAS networking arrangements.

ANNEX 1: RESPONSE STRATEGY (STEPP) AND MISSION CRITICAL ACTIONS (MCA)

STEPP STRATEGY

Strategic Objective 1: **STOP** the outbreak
- Mission Critical Action 1: Identify and Trace People with Ebola
- Mission Critical Action 2: Safe and Dignified Burials

Strategic Objective 2: **TREAT** the infected
- Mission Critical Action 3: Care for Persons with Ebola and Infection Control
- Mission Critical Action 4: Medical Care for Responders Provision

Strategic Objective 3: **ENSURE** essential services
- Mission Critical Action 5: Provision of Food Security and Nutrition
- Mission Critical Action 6: Access to Basic (including non-Ebola Health) Services
- Mission Critical Action 7: Cash Incentives for Workers
- Mission Critical Action 8: Recovery and Economy

Strategic Objective 4: **PRESERVE** stability
- Mission Critical Action 9: Reliable Supplies of Materials and Equipment
- Mission Critical Action 10: Transport and Fuel
- Mission Critical Action 11: Social Mobilization and Community Engagement
- Mission Critical Action 12: Messaging

Strategic Objective 5: **PREVENT** outbreaks
- Mission Critical Action 13: Preventing Outbreaks
- Other: Enabling Support to all Objectives

RECOVERY STRATEGY

RECOVERY Objective 1: **RS01**
- Health, Nutrition, and Water, Sanitation and Hygiene (WASH)

RECOVERY Objective 2: **RS02**
- Socio-Economic Revitalization

RECOVERY Objective 3: **RS03**
- Basic Services and Infrastructure

RECOVERY Objective 4: **RS04**
- Governance, Peace Building and Social Cohesion

ANNEX 2: CASE STUDIES

The following illustrative examples showcase how the TF enabled flexible, adaptive, and creative programming that filled gaps and facilitated inter-agency cooperation and coordination. Many of these projects also served as catalysts enabling and enhancing other interventions. It is important to note that many of the initiatives that the TF supported had already been identified and initiated by national and local government officials, NGOs, and communities. The UN agencies should get credit for recognizing, supporting, expanding, and building on these initiatives, but major accolades should go to the nationals who had the courage to risk their lives, become infected, and severe family and communal ties to stop Ebola.

1. Quick Impact Programme (QIP) Fund - Sierra Leone

The Ebola epidemic was unprecedented and therefore unpredictable and the international and national infrastructure for such a response was inadequate and unprepared. Most donor funds were earmarked and took time to administer, which does not help when needs are immediate and difficult to plan. Even the general TF process, which was meant to be rapid, took a minimum of 7 days for approval and then there were some delays for UN agencies to liquidate and apply the funds to their proposed projects or to transfer to implementing partners. In such circumstances, it is helpful to have a bucket of un-earmarked funds that can be dispersed rapidly as needs arise. The QIPs programme in Sierra Leone served this function well. Stated by a UN representative, *"A lot of funds were big and their scopes were wide. We noticed that a lot of the work was being done by CSOs and communities. QIPs was a flexible fund that enabled UNMEER to rapidly support high impact and low cost initiatives. Our most important projects were not the 7 million or the 1.2 million, but was the 1 million dollars that was distributed across 46 projects."*

During the response phase, a total of 46 QIPS were approved (totaling US$ 700,000) and implemented in 13 of Sierra Leone's 14 districts.[37] While the resources in this fund were relatively small, many of the projects served key functions in the first and second stages of the response by filling underfunded and unfunded gaps that no other funds would have supported so rapidly (often within 24 – 48 hours). For example, during the surge phase, the QIPS supported "Ebola Treatment Centers (ETCs)... and projects focusing on Hazard pay, cross-border initiatives and Infection Prevention and Control (IPC)." During the second phase of the response QIPS supported *"social mobilization and awareness creation, especially with women; training surveillance tams on mobile-based data collection and analysis; enhancing communication through radio and TV programmes; engaging survivors and traditional healers as part of the social mobilization and awareness response; cross-border meetings to improve screening and protocols for border monitoring; supporting quarantined households; active surveillance, contact tracing, and providing Essential Services."*[38] Beyond the tangible benefits of the QIPs, they served an important function of building relationships with UN agencies and government bodies and local stakeholders who were directly involved in the response. This increased UNMEER's visibility and legitimacy at the field level, which in turn increased local trust and support for other UN agency initiatives. This assisted in creating an operational space at the local level by gaining buy-in from communities and working through them. QIPS also motivated field operations teams by assisting them to solve immediate problems. Based on the success and necessity of the QIPs in Sierra Leone, an additional US$ 500,000 was approved so that UNMEER could continue supporting flexible and rapid support to DERCs and NGOs so they could respond immediately to needs on the ground to achieve a resilient zero cases of Ebola. When UNMEER began to phase out, the management of the QIPs program was transferred to UNDP in July 2015. The following provides more concrete examples of a diverse range of QIPs projects.

- Short term operational capital injection of US$ 150,000 to enable National Ebola Response Centre's (NERC) to open rapidly particularly in areas effected by high surges of cases.

- Provided US$ 4,230 to Adnan's Supermarket to ensure the availability of freezers, cool boxes, and bungee cords that Holding Centers and Treatment Centers needed for storing blood samples and freezing cold packs for transporting the samples.

- Injected US$ 146,860.11 to support the Western Area NERC to train 3,430 community social mobilizers to conduct door-to-door visits and establish local check points and purchased fuel, vehicles, motorbikes, telecommunication and radio coverage, megaphones, batteries for thermometer /megaphones, and water. The assisted the establishment of joint surveillance and social mobilization teams, which had a significant impact on reducing contagion.

- Provided US$ 18,169 to help fuel a water treatment facility in Kambia District. This injection of funds ensured clean water to the District's Ebola Response Centre and Treatment Centers during the emergency phase. Based on the success of this project another donor took over the responsibility to fund the fuel for the treatment facility.

- Provided US$ 13,860 to the Sierra Leone Red Cross Society to mobilize, train, and deploy Ebola survivors to liaise between the Social Mobilization team and the communities in Port Loko.

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37 UNMEER Programme Narrative Report (January 2015 to May 2015)
38 Ebola Response Quick Impact Projects Under the Multi-Partner Trust Fund. Mr. Mohamed Kakay, UNMEER. UNDP Sierra Leone. 30 June 2015.

ANNEX 2: CASE STUDIES

- Provided US$ 2,362.64 to support a cross-border meeting between Gueckedou-Guinea, Lofa-Liberia, Kailahun-Sierra. Leone. This meeting helped to strengthen cross-border surveillance and responses including the formation of a cross-border monitoring mechanism for contacts and case investigation

- Provided US$ 11,200 to support the creation of an information management system to ensure an efficient and effective payment system for Ebola Response Workers.

- Provided US$ 2,945 for replacement mattresses and decontamination kits to quarantined homes.

- Provided US$ 6,642 to construct and install 20 pit latrines with shelters for quarantined homes in Kambia district.

- Provided US$ 18,376.67 to train and sensitize traditional healers to reduce the transmission of Ebola via their practices.

- Provided US$ 27,360 to renovate a Contact Accommodation Centre in Hastings to isolate high-risk contacts and keep them under surveillance.

2. Joint Disease Surveillance Project – Community Based Initiative (CBI) - Liberia

In complex health emergencies, such as the Ebola, cultural sensitivities and infrastructure constraints often pose challenges to efficient and effective responses. This is particularly true in urban slums and ethnic settlements where close-knit community structures, traditional rituals, and distrust in government and outsiders often inhibit rapid identification, isolation, and treatment. Based on the literature and interviews, lack of consideration of these constraints hindered the initial Ebola response, which was by-and-large top down. Lack of engagement with traditional, religious, and community leaders as well as women and youth, often led to distrust and ineffective external interventions focused on quarantine, body collection, and burials. Infrastructure constraints such as lack of running water and overcrowding also inhibited even the most basic protocols such as hand washing. The following excerpt articulates this reality:

The first suspected case in West Point was reported to the National Ebola Incident Management System on 6 August 2014. The slum was particularly vulnerable to intense transmission given the cramped conditions of more than 80 000 persons living in less than a half square kilometer without municipal water or a sewage system and only 1 physician. Poverty compounded the distrust of external authorities, including skepticism about whether the Ebola outbreak was real. Initially, no Ebola treatment unit facilities were available to isolate infected patients. A holding center was opened for interim isolation. When it began to receive patients from outside of West Point, unrest erupted over concern that disease was being imported into the community. On 18 August, the center was ransacked and contaminated materials were looted. To prevent the spread of Ebola, the government quarantined the entire slum on 20 August using police and military forces, leading to clashes with the community and the death of a boy shot in his legs.[39]

Members of the Ebola Incident Management System recognized this reality and the potential consequences of Ebola spreading rapidly inside and out of West Point unless a less-invasive community based approach was employed. This led to the conception of the Community Based Initiative (CBI), which was first piloted in West Point, Monrovia's largest slum and later applied in several other counties (Margibi and Montserrado) that experienced outbreaks during the resurgence of Ebola. With support from WHO, UNDP, and UNICEF, this innovative idea was first envisaged by Ms. Bernice Dahn, Minister of Health and her Deputy, Mr. Tolbert Nyenswah, and was fine-tuned through a consultative process with civil society actors including community, tribal, and religious leaders and other stakeholders who provided recommendations on how to effectively and efficiently engage communities in the public health response. Broadly, the following activities[40] ensued:

- Community led mapping of West Point to determine human resource requirements

- Identification and training of community focal points on surveillance.

- Designated community members were assigned to provide daily surveillance to approximately 25 households.

- Supervisors received and were trained to use a mobile telephone preloaded with a user-friendly application for submitting data in real time to inform rapid response action by case investigation, contact tracing, burial, and ambulance teams.

- Trained community members collected forms each day that reported on the sick, dead, visitors, and other factors that influenced Ebola transmission in their communities.

- A hierarchical reporting and coordinating structure was executed, with the community members submitting these forms to their immediate supervisors, who sent aggregate data to the district-level supervisors.

- The CBI team and local leaders developed a procedure to deliver food and offer social support to make household-based quarantine of contacts feasible.

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39 Interrupting Ebola Transmission in Liberia Through Community-Based Initiatives. Annals of Internal Medicine (Vol. 164 No. 5), March 2016. Dr. Mosoka Fallah et. al.
40 Ibid.

ANNEX 2: CASE STUDIES

These initiatives had a substantial positive impact on the community's cooperation and participation in contact-tracing and case isolation.[41] Per reports, *"Within 24 hours of launching the CBI in West Point, 42 persons with Ebola-like symptoms were identified and transported to Ebola treatment units... 34 deaths [were uncovered] from suspected Ebola and several secret burials that had not been reported because of mistrust of authorities or concern about stigma."*[42]

Based on its success, CBI was scaled up by the Ministry of Health to Montserrado County. Then, in July 2015, after Liberia was classified as Ebola-free, a new case was detected in Margibi County near the international airport. Initially, the infected boy was misdiagnosed with Malaria resulting in the potential for many contacts and contagion. The system set up by the CBI was fundamental in isolating this case and stopping contagion.[43]

This case study highlights the efficiency and effectiveness of the TF and its capacity to encourage inter-agency cooperation. In general terms, UNDP supported CBI training and employed community members and coordinators.[44] UNDP also provided vehicles and drivers for CBI staff. WHO provided technical support as well as incentives (stipends) for ACFs and coordinators and UNICEF supported social mobilization efforts at the community level as well as providing psychosocial support. WFP provided food and NFIs for isolated communities and quarantined families that were identified by the CBI teams. This initiative also worked closely with the CDC to track contacts and a consortium of INGOs headed by the International Rescue Committee (IRC) was engaged to train community members in surveillance and contact tracing.

3. Survivors Program - Sierra Leone

During complex humanitarian emergencies, emphasis is often placed on immediate needs like stopping contagion. Thus, many very vulnerable groups are often forgotten. For example, as caretakers, women were often in direct contact with Ebola cases exposing them to infection. Those that were infected and survived often lost loved ones, livelihoods, and were victims of social stigma and rejection. Also, in the process of decontamination, many survivors lost everything. To better understand the impact of the epidemic from a gender perspective, UN Women worked with the bureau of statistics, which has a presence throughout all of Sierra Leone, to disaggregate the data based on gender. Based on the findings, UN Women recognized the high impact of Ebola on women and worked with UNDP to develop the Survivors Program. The program included a solidarity package (direct unconditional cash transfer) for 650 female survivors including skill development and stipends to help them get back on their feet. Based on interviews, the program has been very successful in speeding up the de-stigmatization and re-integration process so that women survivors can go back into their communities with dignity. Stated by a UN Women staff, "because they now have financial resources, the communities see survivors as being productive and independent. It also gives them a sense of belonging... For many of the women this is the first time they have had savings in their lives... Many of the recipients are doing better than they were before they became infected... It also provided space for women to come together and learn and talk about their human rights. This was not articulated in the program design, but it was an unintended result." Not only did this program support female survivors and their families, it also increased UN Women's visibility and influence on decision making across the UN system.

4. Risk Allowance - Sierra Leone

All three countries faced extreme challenges in incentivizing health workers to continue doing their jobs and for community volunteers to serve on the front lines of the Ebola Response. Per a UN representative, the risk allowance *"was the backbone of the Ebola response... we realized there were five major parts to the response and none of them could be done without staff. People were going on strike and not going to work due to fear of Ebola. The stipend encouraged them to work and volunteer."* The TF filled this important gap that few other donors would have traditionally supported. UNDP used the funds to step out of its traditional mandate to manage the entire verification process and distribute the funds efficiently and effectively.

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41 "Door-to-door assessments in West Point were accomplished by 152 active case finders, 15 psychosocial support workers, 8 supervisors, and 2 district leaders."
42 Ibid.
43 See Responding to Resurgences of Ebola Virus Disease through the Community-based Initiative: The community leads, we follow. Mosoka Fallah et al. for a more detailed description of this case.
44 Per reports, approximately, 6500 persons were employed and equipped for 6 months at a cost of approximately US$ 65,000.

ANNEX 2: CASE STUDIES

5. Social Mobilization, Community Engagement, and Confidence Building – Guinea

Socio-cultural complexities of the Ebola response were initially underestimated. Also, during the initial response communications, especially at the local level, was not optimal, resulting in confusion and conspiracy theories. The confusion caused by often competing messages and misinformation, combined with traditional cultural norms and practices, inhibited medical responses. Recognizing the need to engage directly with communities to raise awareness and change attitudes and behaviors, the TF supported a joint program led by UNICEF and UNDP to support communities to setup a dynamic and robust communications platform including support for rural radio services, Community Watch Committees (CWCs), door-to-door sensitization and referral of suspected Ebola cased and contact cases in some of the most affected districts in Guinea. They achieved this by identifying and supporting a broad range of community influencers including traditional and religious leaders, law enforcement, women and youth groups. By providing accurate information, clear instructions, and debunking myths this program helped to inform and gain the trust of communities, which opened the door for more medical-related interventions.

Another project focused on social mobilization and community engagement particularly in Guinea's frontier regions where the threat of cross-border contamination was high. Combining their expertise, geographic reach, and national and local partners, UNFPA, UNDP, and UNICEF supported the Manu River Union (MRU) to advocate for a regional response. They also built the capacity of and supported national and local NGOs, administrative and political leaders, traditional and religious leaders and healers, youth and women's groups to increase community trust and raise awareness on ways to prevent contagion. The program also coordinated with the World Bank and the national business organization (GOHA) to better equip and construct checkpoints to monitor and secure Guinea's borders.

Additional projects led by UNICEF in Guinea also supported community engagement and built trust in the Ebola response and health services using various modalities such as the formation of CWCs, community dialogue forums, rapid response teams, engagement with transport unions for sensitization and community based surveillance, early warning and report systems using technology, sensitization through rural radios, psychosocial support to survivors and orphans, etc. This awareness raising and confidence building enabled direct community engagement. For instance, led by WHO, a project focused on Identifying and Tracing People with Ebola supported over 1,600 Contact Tracers, Supervisors, and District Monitors and 95 epidemiologists to identify and monitor over 25,000 people who had come into direct contact with the virus. This was fundamental for early treatment and containment.

6. Reinforcement of the Guinean Red Cross

Recognizing that the Guinean Red Cross (GRC) had staff, offices, existing relationships, and a large cadre of volunteers throughout Guinea, UNDP and WHO leveraged the TF to enhance the GRC's capacity in strategic areas such as **Safe and Dignified Burials** (SDB). Traditionally, family and community members come in close contact with the deceased including washing their bodies, which places them at high risk. To overcome this challenge, WHO worked with social anthropologists, community and religious leaders and organizations to adapt burial ceremonies to minimize the risks posed to mourners. This resulted in a set of guidelines for safe and dignified burials that were safe and sensitive to cultural practices and customs. Once these guidelines were developed, WHO provided experts to train volunteers (52 teams) to conduct the burials and change the community's attitudes and behaviors away from dangerous traditional practices. The TF also supported the deployment of 15 field supervisors and 6 logisticians to ensure safe burials. Thus, approximately 9,904 SDBs were performed and 7442 places were disinfected. To reward these volunteers and reinforce their sense of duty, the TF supported the Livelihoods for IFRC Safe and Dignified Burials Volunteers[45]. Many of the volunteers experienced extreme stigmatization and disenfranchisement from their families and communities due to their involvement with burials. During focus group discussions and interviews with the participants of this program, it was clear that many of the volunteers experienced trauma, stress, and many challenges during and after their involvement in the burials. This project had a major impact on their ability to overcome these challenges.

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45 IFRC also had access to its own funding sources through international appeals.

ANNEX 3: LITERATURE REVIEW AND INTERVIEW GUIDE

The following provides a general template for the literature review and interviews. Some of these questions did not apply depending on the interviewee and availability of data. The evaluation team used their discretion to determine the best methods to use for exploring these questions to the best of their ability within constraints related to time, access, and other factors.

1. Achievement of Trust Fund Goals:

1.1   A key factor determining the merits of a TF is the amount of funding it can allocate. Funding of a TF depends on country contexts and their visibility, donor budgets, and resource mobilization efforts, but also significantly on the perceived merits and performance of a TF. What are the perceived merits of this TF?

1.2   A chief attraction of the TF for the major donors is its ability to leverage other donor funding, allocate funds to locally identified and prioritized needs, and help deliver response at scale. Has the TF achieved this? What was the process of getting funds? Was this efficient and effective? How can this process be more efficient in the future? How can this be improved?

1.3   Has the Fund demonstrated its ability to be situation driven, adapt to the changing needs of country contexts, and retain flexibility?

1.4   The value of a Trust Fund lies in its ability to provide un-earmarked funding in response to emerging needs through an inclusive and field-driven decision-making process. Has the TF effectively achieved this?

1.5   The funding priorities were a function of three variables: i) the latest assessment of the evolving epidemiology of the outbreak (from WHO and other sources); ii) priority needs in the Ebola response, as assessed by regular interaction with all stakeholders in the response; and iii) the comparative advantage of the UN System, as assessed by the Special Envoy and his interactions with the UN Agencies, Funds and Programs. Have those effectively contributed to effectively achieving the goals of the Fund?

1.6   Does the TF assist in mobilizing funds from a broad range of stakeholders (Member States, regional legislative bodies, inter-governmental or nongovernmental organizations, businesses, and individuals? How can this be improved?

1.7   Does the TF provide a results-based management system to enable monitoring of the Fund's contribution to the Ebola response? How can this be improved?

1.8   What are the lessons to be included in the set-up of a future Health Emergency Trust Fund?

2. Achievement of Strategic Objectives and MCAs

2.1   Were the funds used to address well defined and specific challenges? Were these gaps that existing funds could not fill in a timely or appropriate manner.

2.2   What was the division of labor and responsibilities between the UN recipients in relation to the SOs?

2.3   Which RESPONSE Strategic Objectives and MCAs are best served by the TF and why? Which RESPONSE Strategic Objectives and MCAs are least served?

2.4   Which RECOVERY Strategic Objectives are best served by the TF and why? Which are least served by the TF and why?

2.5   What are the strengths and weaknesses of the TF mechanism?

2.6   Were the SOs (of the Response Phase) aligned with Government and other stakeholder's priorities.

2.7   Recommendations

3. Legal arrangements

3.1   Do the arrangements establishing the TF (namely the Terms of Reference, Memorandum of Understanding with UN Entities, and Standard Administrative Arrangements with donors) support or obstruct the ability to focus on under-funded priority activities?

3.2   Do they encourage or inhibit flexibility?

3.3   Do they assist in mobilizing and disbursing funds rapidly?

3.4   What works?

3.5   What does not work?

3.6   Recommendations

4. Governance Structure

4.1   Does the structure (Advisory Committee chaired by the Special Envoy on Ebola) support or obstruct the ability to focus on under-funded priority activities?

4.2   Does the structure encourage or inhibit flexibility?

4.3   Does the structure assist in mobilizing and disbursing funds rapidly? What was the process of getting funds? What this effective? Recommendations for improvement? How can this process be more efficient in the future?

4.4   Does the structure include a mechanism for risk assessment and mitigation?

ANNEX 3: LITERATURE REVIEW AND INTERVIEW GUIDE

    4.5   Does the structure incorporate an accountability mechanism?

    4.6   What works?

    4.7   What does not work?

    4.8   Recommendations

5. Processes for the review and approval of proposals

    5.1   Did the processes support or obstruct the ability to focus on under-funded priority activities?

    5.2   Were project designs kept simple and realistic?

    5.3   How effective was the TF in gap filling and how was it complementary of other funding mechanisms, resource mobilization through different channels?

    5.4   Did they encourage or inhibit flexibility?

    5.5   Did they assist in mobilizing and disbursing funds rapidly?

    5.6   Were the host governments involved in the selection of projects and allocation of funds? What was the level of consultation?

    5.7   Recommendations

6. Communications

    6.1   Communication on the TF outside the countries of operation.

    6.2   Communication on the TF in the countries of operation.

7. Effectiveness of Reporting Procedures

    7.1   Did the reporting procedures allow for transparent tracking of the use of the funding disbursed?

    7.2   Are the audit clauses covered in the MOU for financial accountability sufficient?

    7.3   Has the GATEWAY's Ebola page (http://mptf.undp.org/ebola), the one-line platform, contributed to the transparency of Fund's operations? Are there other mechanisms that promote transparency?

    7.4   Has the Fund coherently communicated its achievements?

    7.4   What are some of the challenges or obstacles to reporting?

    7.5   What works?

    7.6   What does not work?

    7.7   Recommendations

8. Summary of best practices that have contributed to the overall effective and efficient operation of the Fund.

9. Summary of constraints that have impeded the Fund's overall effectiveness.

10. Summary of Best Practices that can be applied to future pooled funding mechanisms.

11. What are the major benefits of a pooled funding mechanism? For example,

- Increase or decrease in transaction costs?
- Increase or decrease in management burdens and administrative procedures?
- Increase or decrease in flexibility and fluidity of funds?
- Increase or decrease in response rate?
- Increase or decrease in targeting of funds to underfunded gaps?
- Increase or decrease in capacity to adapt to complex contexts?
- Increase or decrease capacity to engage in low capacity and fragile environments?

12. Recommendations for building a stronger and more resilient health system

- How should existing resources in the TF be applied?

Case Studies

Pending time constraints and availability of data, the evaluation team will conduct case studies of a few specific projects in each country for deeper analysis of the efficiency and effectiveness of the TF. The UN teams have already identified field site visits in each of the three countries. Ideally, the evaluation team will utilize these field visits for these case studies. To streamline the final report, the data collected from these case studies will be included in the sections above.

ANNEX 4: PROJECTS PER COUNTRY

SIERRA LEONE

Project ID	Project description	Theme	Agency
00092527	MCA03 #1 SLE AIR SERVICES	SO2 TREAT the infected	WFP
00092528	MCA03 #1 SLE TRANSP ESS. ITEMS	SO2 TREAT the infected	WFP
00092529	MCA03 #1 GIN ESTABLSHMNT ETUs	SO2 TREAT the infected	WFP
00092530	MCA03 #1 SLE COMMUNCTN EQPMNT	SO2 TREAT the infected	WFP
00092650	MCA13 #11SLE QUICK IMPCT PRJCT	SO5 PREVENT	UNDP
00092650	MCA13 #11SLE QUICK IMPCT PRJCT	SO5 PREVENT	UNMEER
00092905	MCA07 #9 SLE PAYMNT EBOLA WORK	SO3 ENSURE essential services	UNDP
00092907	MCA13 #17 SLE RRSTs ESTABLISHM	SO5 PREVENT	UNOPS
00092907	MCA13 #17 SLE RRSTs ESTABLISHM	SO5 PREVENT	UNMEER
00092908	MCA13 #18 SLE NERC SECRETARIAT	SO5 PREVENT	UNMEER
00093086	MCA13 #5 SLE DETENTION CENTERS	SO5 PREVENT	UNDP
00093223	MCA10 #22 SLE EBOLA CHARTERS	SO4 PRESERVE stability	UNICEF
00093253	MCA01 #16 SLE EPIDEM DIST MNGM	SO1 STOP the outbreak	WHO
00093256	MCA03 #16 SLE IPC DISTRCT MNGM	SO2 TREAT the infected	WHO
00093283	MCA03 #1 SLE STORAGE CAPACITY	SO2 TREAT the infected	WFP
00093285	MCA04 #1 SLE UN CLINICS	SO2 TREAT the infected	WFP
00093528	MCA09 #16 SLE DISTRICT LOGISTI	SO4 PRESERVE stability	WHO
00093972	MCA11 #16 SLE DISTRICT SOCIAL	SO4 PRESERVE stability	WHO
00094514	MCA08 SLE #15 EBOLA SURVIVORS	SO3 ENSURE essential services	UNWOMEN
00094514	MCA08 SLE #15 EBOLA SURVIVORS	SO3 ENSURE essential services	UNDP
00095545	MCA08 #38 SLE RED CROSS VOLUNTEER	SO3 ENSURE essential services	UNDP
00096306	MCA04 #40 SLE UN MEDICAL CLINIC	SO2 TREAT the infected	UNDP
00096318	MCA01 #17 SLE STRNG EVD SURVIL	SO1 STOP the outbreak	WHO
00096723	RSO3 #45 SLE EBOLA SURVIVORS	RSO3 Basic Service & Infrastructure	UNICEF
00096723	RSO3 #45 SLE EBOLA SURVIVORS	RSO3 Basic Service & Infrastructure	WHO
00096725	MCA06 #48 SLE SOCIAL MOBILIZAT	SO3 ENSURE essential services	UNICEF
00097555	MCA13 #50 SLE SUPPORT TO THE UNRC	SO5 PREVENT	UNDP

LIBERIA

Project ID	Project description	Theme	Agency
00092448	MCA03 #1 LBR AIR SERVICES	SO2 TREAT the infected	WFP
00092643	MCA03 #1 LBR TRANSP ESS. ITEMS	SO2 TREAT the infected	WFP
00092648	MCA13 #11LBR QUICK IMPCT PRJCT	SO5 PREVENT	UNDP
00092648	MCA13 #11LBR QUICK IMPCT PRJCT	SO5 PREVENT	UNMEER
00092903	MCA07 #8 LBR PAYMNT EBOLA WORK	SO3 ENSURE essential services	UNDP
00093136	MCA06 #4 LBR CHILDREN PROTECTN	SO3 ENSURE essential services	UNICEF
00093189	MCA10 #22 LBR EBOLA CHARTERS	SO4 PRESERVE stability	UNICEF
00093218	MCA01 #10 LBR INTERRUPT TRANSM	SO1 STOP the outbreak	UNFPA
00093218	MCA01 #10 LBR INTERRUPT TRANSM	SO1 STOP the outbreak	WHO
00093218	MCA01 #10 LBR INTERRUPT TRANSM	SO1 STOP the outbreak	UNDP
00093220	MCA11 #25 LBR OUTRCH&AWARNESS	SO4 PRESERVE stability	UNICEF
00093252	MCA01 #16 LBR EPIDEM DIST MNGM	SO1 STOP the outbreak	WHO
00093255	MCA03 #16 LBR IPC DISTRCT MNGM	SO2 TREAT the infected	WHO
00093282	MCA03 #1 LBR STORAGE CAPACITY	SO2 TREAT the infected	WFP
00093527	MCA09 #16 LBR DISTRICT LOGISTI	SO4 PRESERVE stability	WHO
00093971	MCA11 #16 LBR DISTRICT SOCIAL	SO4 PRESERVE stability	WHO
00096703	RSO1 #33 LBR RESTORING MIDWIFERY	RSO1 Health Nutrition WASH	UNFPA
00097556	MCA13 #51 LBR SUPPORT TO THE UNRC	SO5 PREVENT	UNDP
00097566	RSO1 #46 LBR UPGRADING WASH	RSO1 Health Nutrition WASH	ILO
00097566	RSO1 #46 LBR UPGRADING WASH	RSO1 Health Nutrition WASH	UNHABITAT
00097566	RSO1 #46 LBR UPGRADING WASH	RSO1 Health Nutrition WASH	UNICEF

ANNEX 4: PROJECTS PER COUNTRY

LIBERIA

Project ID	Project description	Theme	Agency
00100247	MCA6 #53 LBR STRENGTH MATERN HEALTH	SO3 ENSURE essential services	UNFPA
00100247	MCA6 #53 LBR STRENGTH MATERN HEALTH	SO3 ENSURE essential services	UNICEF
00100247	MCA6 #53 LBR STRENGTH MATERN HEALTH	SO3 ENSURE essential services	WHO

GUINEA

Project ID	Project description	Theme	Agency
00092450	MCA03 #1 GIN AIR SERVICES	SO2 TREAT the infected	WFP
00092529	MCA03 #1 GIN ESTABLSHMNT ETUs	SO2 TREAT the infected	WFP
00092644	MCA03 #1 GIN TRANSP ESS. ITEMS	SO2 TREAT the infected	WFP
00092649	MCA13 #11GIN QUICK IMPCT PRJCT	SO5 PREVENT	UNDP
00092649	MCA13 #11GIN QUICK IMPCT PRJCT	SO5 PREVENT	UNMEER
00092847	MCA03 #1 GIN STORAGE CAPACITY	SO2 TREAT the infected	WFP
00092904	MCA07 #7 GIN PAYMNT EBOLA WORK	SO3 ENSURE essential services	UNDP
00093105	MCA11 #3 GIN SOCIAL MOB&COMMUN	SO4 PRESERVE stability	UNICEF
00093105	MCA11 #3 GIN SOCIAL MOB&COMMUN	SO4 PRESERVE stability	UNDP
00093219	MCA03 #23 GIN CCCs	SO2 TREAT the infected	UNICEF
00093226	MCA10 #22 GIN EBOLA CHARTERS	SO4 PRESERVE stability	UNICEF
00093251	MCA01 #16 GIN EPIDEM DIST MNGM	SO1 STOP the outbreak	WHO
00093254	MCA03 #16 GIN IPC DISTRCT MNGM	SO2 TREAT the infected	WHO
00093284	MCA04 #1 GIN UN CLINICS	SO2 TREAT the infected	WFP
00093526	MCA09 #16 GIN DISTRICT LOGISTI	SO4 PRESERVE stability	WHO
00093970	MCA11 #16 GIN DISTRICT SOCIAL	SO4 PRESERVE stability	WHO
00094442	MCA11 #29 GIN SUPPORT CBUs MRU	SO4 PRESERVE stability	UNFPA
00094442	MCA11 #29 GIN SUPPORT CBUs MRU	SO4 PRESERVE stability	UNICEF
00094442	MCA11 #29 GIN SUPPORT CBUs MRU	SO4 PRESERVE stability	UNDP
00094960	MCA01 #35 GIN SENSITIZ EARLY DETECT	SO1 STOP the outbreak	WHO
00095292	MCA11 #36 GIN SOCIAL MOBILIZAT	SO4 PRESERVE stability	UNICEF
00095447	MCA02 #30 GIN RED CROSS REINFO	SO1 STOP the outbreak	WHO
00095447	MCA02 #30 GIN RED CROSS REINFO	SO1 STOP the outbreak	UNDP
00095944	MCA02 #32 GIN SAFE BURIALS	SO1 STOP the outbreak	UNDP
00096294	MCA04 #40 GIN UN MEDICAL CLINIC	SO2 TREAT the infected	UNDP
00096648	MCA09 #42 GIN PREVENT EVD SPREAD	SO4 PRESERVE stability	UNDP
00096705	RSO2 #43 GIN STRENGTHENING RECOVERY	RSO2 Socio-Economic Revitalizn	UNFPA
00096705	RSO2 #43 GIN STRENGTHENING RECOVERY	RSO2 Socio-Economic Revitalizn	UNDP
00096708	RSO4 #44 GIN GOVERNMENT SUPPORT	RSO4 Govern PeaceBldg Cohesion	UNDP
00096724	MCA11 #47 GIN SOCIAL MOBILIZAT	SO4 PRESERVE stability	UNICEF
00097554	MCA13 #49 GIN SUPPORT TO THE UNRC	SO5 PREVENT	UNDP
00098865	MCA03 #54 GIN VACCINATION COHORT	SO2 TREAT the infected	WHO
00098865	MCA03 #54 GIN VACCINATION COHORT	SO5 PREVENT	WHO
00099263	RSO2 #52 GIN RECOVERY SUPPORT	RSO2 Socio-Economic Revitalizn	UNDP
00099916	MCA3 #57 GIN VACCINATION COHORT	SO2 TREAT the infected	WHO
00100017	RSO3 #55 GIN EMERGENCY MATERNA	RSO3 Basic Service & Infrastr	UNFPA
00101174	MCA2 #58 STRENGTHENING RESPONSE	SO1 STOP the outbreak	UNDP
00101175	MCA3 #58 STRENGTHENING RESPONSE	SO2 TREAT the infected	UNDP
00101176	MCA13 #58 STRENGTHENING RESPONSE	SO5 PREVENT	UNDP
00101177	MCA6 #59 PREVENT NEW INFECTIONS	SO3 ENSURE essential services	UNICEF
00101347	MCA10 #61 EBOLA FLARE-UP EXPENSES	SO4 PRESERVE stability	WFP

ACRONYMS

Acronym	Definition
Advisory Committee	AC
African Union	AU
Center for Disease Control	CDC
Community Watch Committee	CWC
Contre la Maladie à Virus Ebola	CMVE
Ebola Response Consortium	ERC
Economic Community of West African States	ECOWAS
International Labour Organization	ILO
International Civil Aviation Organization	ICAO
International Federation of Red Cross/Red Crescent	IFRC
Joint United Nations Programme on HIV/AIDS	UNAIDS
Infection Prevention and Control	IPC
Lessons Learned Exercise	LLE
Médecins Sans Frontières	MSF
Memorandum of Understanding	MOU
Mission Critical Action	MCA
Multi-Partner Trust Fund	MPTF
National Ebola Response Center	NERC
Non-Food Item	NFI
Personal Protective Equipment	PPE
Resident Coordinator	RC
Secretary General	SG
Standard Administration Arrangement	SAA
Strategic Objective	SO
Terms of Reference	ToR
UN Ebola Multi-Partner Trust Fund	TF
UN Mission for Emergency Ebola Response	UNMEER
United Nations Children's Fund	UNICEF
United Nations Development Program	UNDP
United Nations Entity for Gender Equality and the Empowerment of Women	UNWOMEN
United Nations Fund for Population Activities	UNFPA
United Nations Human Settlements Programme	UN-Habitat
United Nations Office for Project Services	UNOPS
World Food Program	WFP
World Health Organization	WHO

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