



EBOLA OUTBREAK

**UPDATED OVERVIEW OF NEEDS AND
REQUIREMENTS FOR JANUARY-JUNE 2015**



"How do I feel about setting an Ebola community centre in my chiefdom? I feel crazy good!"

Bai Bantha Nkenedie II,
Paramount Chief of Buya Romende
Chiefdom, Kamasondo, Sierra Leone

Photo: WHO/Chris Black

Cover photo: WHO/Chris Black



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INTRODUCTION



Photo: WHO/Chris Black

The Ebola outbreak is presenting the world with an extraordinary public health challenge with consequences for millions of people and far beyond the health sector. We have also seen an extraordinary response, primarily by people in communities living with the outbreak. It has been distressing to witness the individual suffering but at the same time it has been encouraging to see how local communities, governments in the affected countries, and the international community at the highest possible level have come together to stop the outbreak.

There has been significant progress in the last three months. The outbreak is coming under control in some areas: transmission remains intense in others. The only way forward is to eliminate transmission—to get to ZERO.

We have been working on the basis the Ebola outbreak could develop in several different ways. The most extreme of these scenarios that were considered possible in October have not materialized: the number of cases and deaths has not accelerated at the rate it was thought could be possible. This is a result of outstanding efforts by the people and governments of affected countries and the support of the international community through financial contributions and the hard work of many international responders.

We are all grateful for all the efforts and resources that have made our collective success in reducing the Ebola outbreak possible. Looking forward we will need additional financial and in-kind resources and human capacity to sustain this success.

The present picture is not of a single outbreak but of a number of smaller and quite diverse outbreaks each with its own epidemiological characteristics. In some areas the situation is not yet under control; in other areas the disease incidence is extremely low and elimination is feasible. Life is getting ready to return to normal. We are all being expected to work together and manage a complex and diverse situation.

We can see that the strategy we are working to (the STEPP Strategy) can stop the outbreak but the implementation of the strategy will now evolve – to be even more nimble and flexible. The approach is to adapt the response at local level to reflect local realities and local needs. Thus, where the numbers of cases are high or where a re-importation of the virus is expected, access to treatment and to safe burials are the top priorities. Where the incidence is lower, ambitious contact tracing must be implemented. The overall aim is to find all cases, stop transmission chains and get to zero.

It is also time to focus even more on re-establishing and reinforcing essential services (non-Ebola health services, education, WASH, social protection and legal services) and to plan for recovery at the right moment.

However no effort must stand in the way of Getting to Zero as that is the only way forward – 100% Ebola free countries must be our goal!

SCOPE OF THE UPDATED OVERVIEW

The initial comprehensive UN system Ebola response was founded on the STEPP Strategy and expressed in an Overall Overview of Needs and Requirements (ONR) published on 16 September 2014. The ONR provided both a description of the strategic priorities at that time as well as what financial and non-financial resources were required.

A revision of the costs was communicated after a planning workshop in Accra in October 2014. The total financial needs were increased from USD 987 million to USD 1.5 billion. The increase was mainly related to expanded activities related to the stop and treat part of the STEPP strategy as well as the enabling support functions. The costs for essential services, preparedness and recovery were not reviewed.

Based on the evolution of the outbreak since then and the fact that the implementation of the strategy has, and will need to be, adjusted over time the overall needs and requirements have now been updated.

The Overview of Needs and Requirements covers the costs of the Ebola response and preparedness activities. The needs and requirements are based on the latest information available from each of the most affected countries. The national plans and budgets comprise the framework and the Overview of Needs and Requirements defines the contributions planned by the UN system as well as the major international civil society organizations.

The financial cost estimates include both additional investments costs and running costs. The non-financial needs are also described and the human resources need more in detail.

The estimated needs and requirements covers the first six-months of 2015. And the cost of essential services, food and nutrition and preparedness has now been updated.

The link between investing in stopping the outbreak and the economic basis for recovery is obvious and needs to be kept constantly in our thinking and planning. The total cost for recovery is not included as more detailed work is needed and a complementary process has started.

This update is independent of the Ebola Recovery Assessment (ERA) effort being conducted in accordance with the Post-Disaster Needs Assessment protocols and led by UNDP. However this ONR update will be included in the ERA process and the recommendations herein will be aligned with any report from the ERA process.

STRATEGIC OBJECTIVES

- 1 STOP**
the outbreak
- 2 TREAT**
the infected
- 3 ENSURE**
essential services
- 4 PRESERVE**
stability
- 5 PREVENT**
outbreaks in countries currently unaffected

OVERVIEW OF THE PRESENT SITUATION



Survivor's wall, MSF Ebola
Treatment Centre
Photo: UNMEER/Simon Ruf

In December 2013 a 2-year-old boy in Guinea died from an unexplained infectious disease. In retrospect this was the start of the current Ebola outbreak in West Africa. This event was not identified as Ebola and did not trigger any alarms at the time as it happened in a remote part of Guinea and in a part of Africa where Ebola was not considered to be a risk.

Subsequently the virus was transmitted in social and healthcare settings and through funerals and burials and the disease spread until it was officially declared an Ebola outbreak in Guinea in March 2014 and cases were then confirmed in Liberia and, by May 2014, in Sierra Leone.

Although the outbreak broadly conformed to the known pattern of Ebola outbreaks (with high levels of spread in healthcare settings and through burials) an early unusual feature was spread into the capital cities of Monrovia, Conakry and Freetown. There were also exportations of cases into Senegal, Nigeria and Mali but fortunately none of these resulted in sustained chains of transmission in the community.

From June to September 2014, the epidemic in Guinea, Liberia and Sierra Leone grew exponentially with national doubling times of 16 – 30 days.

By mid-September 2014, the trajectory of the epidemic suggested that there could be 21 000 cases in the 3 countries by November 2.

However, the anticipated continued exponential rise in case numbers did not, in fact, materialise and the pattern of the epidemic has shifted.

By the end of 2014, the cumulative total of cases stood at 20 206 with 7 905 deaths across the affected countries. In the 4 weeks preceding December 14, the number of cases ranged from 77 – 154 cases per week in Guinea, 73 – 138 in Liberia and 327 – 537 in Sierra Leone. Sierra Leone has overtaken Liberia in terms of total numbers of cases. At the same time, some of the very active localities have shown signs of calming—Gueckedou in Guinea has reduced from an average of 11 cases per week between March and September to 2 cases per week from October to December while districts that were particularly affected in Sierra Leone (Kenema and Kailahun) and Liberia (Lofa) have gone from an average of 120 cases per week in July and August to 2 cases per week since the beginning of November. However, cases are still occurring across all 3 countries and in all 3 capitals.

Several features of the epidemiology are particularly important:

The pattern suggests continuing chains of transmission in many localities in all 3 of the most affected countries. Although the numbers of cases in each locality are smaller than expected, the number of localities with cases is increasing.

There are suggestions that, following the “seeding” of cases from rural areas into capital cities, there is now re-seeding from the capitals back to rural areas.

There are continuing chains of transmission that cross the porous border areas between the countries and into neighbouring countries such as Mali.

In effect the pattern now is not that of a large epidemic across 3 countries but rather a series of local outbreaks, perhaps as many as 60, that may be interconnected in terms of chains of transmission but which are to all intents and purposes multiple independent outbreaks.

It is not entirely clear why the epidemiology has started to shift but undoubtedly changes in behaviour by local communities alongside significant responses by national governments and unprecedented mobilisation of support across the international community have each made a contribution.

The implications of the changes in epidemiology are important. When governments and the international community were anticipating the continued exponential rise in cases from September 2014, the response was scaled up to that of a humanitarian crisis with substantial engagement of UN agencies and the establishment of a UN Mission (UNMEER). The emphasis of the response was placed on dealing with cases through the establishment of Ebola Treatment Centres, supported by international medical responders, and dealing with the dead in a safe and dignified way. This has been an effective strategy but the shift in epidemiology now requires a shift in the response to reflect the position of multiple smaller outbreaks that need a far greater emphasis on the public health component of the response.

More broadly, to address the threat that Ebola poses nationally and globally, action to prevent the spread of Ebola and to get to zero cases includes work on the response; preparedness; research and development and health systems rebuild.

THE RESPONSE STRATEGY

SHIFTING THE EMPHASIS

OPERATIONAL PRINCIPLES

1 STOP

the outbreak

- 1 Identify and Trace people with Ebola
- 2 Safe and Dignified Burials

2 TREAT

the infected

- 3 Care for Persons with Ebola and Infection Control
- 4 Medical Care for Responders

3 ENSURE

essential services

- 5 Provision of Food Security and Nutrition
- 6 Access to Basic (including non-Ebola Health) services
- 7 Cash Incentives for Workers
- 8 Recovery and Economy

Since September 2014, the global Ebola response has been delivered within the STEPP strategy. This builds on the lessons learned from previous Ebola outbreaks in Africa but also recognizes the unique nature of the current outbreak in West Africa. The strategy encompasses the key activities that are necessary to tackle an intense Ebola outbreak, to bring it under control, then to move to eliminating the outbreak and to prevent its recurrence. The STEPP strategy recognizes that people and their communities are those most affected by the outbreak and that they need to be at the centre of the response. The responders—especially those who are in direct contact with people affected by Ebola—are critically important and need special attention to reduce their risk of infection and suffering.

Communities touched by an Ebola outbreak need support – in particular they need to be able to access the services essential for life and livelihoods. An Ebola outbreak can only be controlled successfully if the people it affects are in a position to own it, to act on it and to change their ways of life so that it reduces its hold on their societies. They change their behaviour in ways that reduce the risk of transmission of Ebola within their community – including the early identification and reporting of people with Ebola, enabling them to isolate themselves and changing long-held healing and burial practices.

Country leadership, community ownership and effective coordination must be our guiding principles for the work.

Within the STEPP strategy, activities are adapted in response to changes in the outbreak epidemiology.

In the autumn of 2014, there were exponential rises in the number of cases being seen across the region. The focus was on scaling up the response to tackle intense transmission of Ebola. The high case numbers meant that some parts of the Ebola response strategy—case finding and contact tracing—were given lower priority.

The emphasis was on developing sufficient treatment capacity to ensure that people identified with Ebola had access to appropriate treatment (and isolation) and to ensuring that those who died were buried in a safe and dignified manner so that, if they had died with Ebola, the risk of onward transmission was reduced.

The international support for national responses has contributed to promising results with reduced incidence of infection. The next phase (phase 2) of the response focuses on bringing the outbreak under control.

This requires an appreciation that presently there are multiple (perhaps 60) localised outbreaks of Ebola spread across the three countries.

So in this phase 2 the **emphasis** is on **stopping transmission of the virus**. That means putting in place the systems and capacity to track down chains of Ebola transmission.

This requires a renewed emphasis on case finding and contact tracing, good epidemiology and strong public health leadership. **Effective crisis management needs to be combined with public health competences**. Once it becomes clear that all new cases are coming from lists of known contacts the disease is under control.

Once we see the outbreak coming under control, the emphasis of the response becomes elimination of the disease—getting to zero cases. At present only some of the district level outbreaks are under control. That implies a need to continue ensuring that there is enough **treatment capacity** in place to ensure those who need it can access it easily and locally.

It is likely that the need for treatment beds will change over time with greater emphasis **on smaller, but more local, facilities and Ebola centres** working in a hub and spoke system integrated with the local public health response.

It will mean that over time the skills mix of the international responders needed to support local actions will also change and move from those with clinical treatment expertise to a more public health approach – but at the moment we still also need a strong cadre of international responders for treatment centres.

This will help transition the Ebola response into a more systematic approach to recovery of the health system as well as the economies and societies at large.

It is equally true that we are not yet free from the risk of failing **essential services** and we need to maintain a focus on supporting these until we get to a more sustainable national and local system. At the same time, re-establishing safe essential health services for non-Ebola patient care will be key to the successful functioning of Ebola treatment centres. This work will increasingly link into recovery of health and other systems – but we are not ready for that full transition just yet.

OPERATIONAL PRINCIPLES

4 PRESERVE stability

9 Reliable supplies of materials and equipment

10 Transport and Fuel

11 Social Mobilization and Community Engagement

12 Messaging

5 PREVENT outbreaks in countries currently unaffected

TURNING STRATEGY INTO OPERATION

ADJUSTING THE RESPONSE



Photo: UNMEER/Simon Ruf

ONE GOAL: ENDING THE OUTBREAK

The initial strategy has worked, as evidenced by the slowing of cases. But a more rigorous approach is needed now—one which goes beyond reducing transmission to enabling societies to manage the consequences of the outbreak and to stop it completely. The goal of the response in 2015—of “phase two”—is to work with communities to end all chains of transmission, strengthen national capacities to recover stronger and maintain health security, and ensure that societies (with support from their health systems) can respond to future outbreaks, drawing on flexible and rapidly deployable resources.

TAKING STOCK OF THE PRESENT SITUATION

The success of control measures to date, with their emphasis on behaviour change, treatment units and safe burials, has been encouraging. But it is uneven given variations in capacity across the affected countries and the shifting geographic patterns of transmission. As of December 2015, the incidence of new cases is declining overall but people with Ebola are now spread over a wider geographic area. Detailed epidemiological analyses suggest that there are several outbreaks at sub-national, each with varying intensity, each at a different stage of evolution, and each with the potential

to flare up unexpectedly if not properly managed. This is a significant risk given that many deaths are still unreported, and communities in some areas are still reluctant to adopt safe burial practices. This means that intense transmission can restart even in areas which currently report decreasing numbers of cases. In addition, there is always the possibility of the disease being re-introduced into places from which it has been eliminated.

The implication of this complex and diverse situation is that as the outbreaks evolve there is a need not only to adjust the focus of the strategy but also **how** the strategy is being implemented: the response needs to be **flexible, rapid, nimble and localized**.

UNDERSTANDING THE DIFFERENT "SUB-NATIONAL OUTBREAKS"

Localized responses should reflect the stage of disease in each area. It is helpful to distinguish different stages of the Ebola outbreak that are being seen in the 60 or so districts, counties and prefectures in the affected countries. Identifying the particular pattern in any one district helps all concerned to work out the most effective ways in which to respond, the precautions that they must take, and the action needed to ensure that actions within each location are aligned for best effect. It may be useful to think in terms of four different stages of disease and response:



Photo: UNMEER/Simon Ruf

STAGE 1: Intense transmission: Numbers of new cases are increasing day-by-day, illness is widespread and those who have Ebola may be unable quickly to access effective treatment. This is the situation that was faced in many parts of the affected countries in September 2014.

STAGE 2: Slowed transmission: Numbers of new cases each day are constant or starting to reduce: this may be associated with community engagement, accessible treatment, new cases being quickly detected and contacts are being traced; the response can be adjusted at any time if there is a sudden increase in transmission.

STAGE 3: Getting to zero: Numbers of new cases each day are approaching zero; this may be associated with revival of other health services and the recovering socio-economy of societies. Those involved in the response should be confident that they know most of the chains of transmission and that any new cases are seen in known contacts of those with the disease: there are very few unexpected flare-ups.

STAGE 4: Maintaining zero: Numbers of new cases remain at zero over a period of several weeks. Transmission is stopping in an increasingly wider area and re-introduction is prevented through vigilant action by communities and surveillance-based health systems; revival of health services and recovery of economies and societies is advanced.

SYNERGIZED LOCALISED IMPLEMENTATION OF ACTIONS TO COMBAT EBOLA

Localized responses to different patterns of disease must be built around response teams with strong public health expertise: they have a broad range of tasks which involve working directly with local communities to

change behaviours, to find cases and contacts, to ensure that all cases and contacts are appropriately supported with a view to reducing transmission, and to assist communities to manage their dead in a way that does not increase risk of disease.

The massive international response is provided in support of **governments**: the governments seek to work with national and international partners (including WHO, UNMEER and other agencies of the UN system as well as CSOs) to achieve the most effective and sustained response. To this end, national coordination mechanisms are now in place in the most affected countries: the continuing challenge is to ensure that they are inclusive, effective and responsive to changes in public health information. The UN's coordination tools are increasingly being made available to encourage rapid and coordinated actions of multiple responders (and changes in these actions when the situation requires).

In all that is done, the strategy should focus on Getting to Zero Cases and restoring essential services. Financial, human and logistical resources are needed to support and enable the most effective and flexible local implementation of strategy.

PUBLIC HEALTH-FOCUSED TEAMS AT DISTRICT LEVEL

With a more tailor made, nuanced and localized approach there is a need for smaller more active units, anchored with the local authorities with integration, decentralization and teamwork rather than working as separate pillars of operation.

The strong district-level public health response teams and mobile clinics are being staffed by national personnel—mostly from the health sector—with support from partner organizations, donors and across UN and international agencies. They are needed in up to 60 locations: they require support and empowerment to identify every case and every contact and track down every chain of transmission.

A clear lesson from the response to date is that nothing can be done for people without engaging them directly. Empowering and equipping people with knowledge and resources have proven to be the most effective ways to stop the outbreak. Changing behaviour and values have been essential in reducing the spread of the virus by changing how people relate to family members who have died or someone in the community who is showing signs of the illness.

The local response teams will need good leadership, good information support, good logistical support and good coordination nationally. The teams will work with local government and communities to identify what needs to be done and how it will be done locally and they will need to be able to draw on support from international expertise as necessary to enable their work. ***The task for the global community becomes one of ensuring the expertise and support gets where it is needed.***

A key task for the local response teams will be to ***continually assess the outbreak***, and the local capacity of the health system both for public

health actions and for treatment, and adjust the response to meet local needs. They can then gradually work towards tracking down all chains of transmission as conditions allow.

Thus, in areas where transmission is still high and case numbers are not yet coming down, the emphasis of the response will still focus on treatment and burials but as numbers start to fall, local public health teams will start to switch to more aggressive case finding and contact tracing. In areas where the numbers have already fallen, we should move now to the aggressive case finding approach.

Border areas will require particular attention and specific action to ensure that new cases exported or imported across borders are identified and referred properly, and appropriate border management procedures are in place, public health responses started immediately, so that transmission can be prevented before it develops. The experiences of Senegal, Nigeria and Mali show that this is possible, but it requires a robust and well-coordinated system.

Responders must remain alert however and be ready to switch emphasis in response to changes in the local epidemiology as Ebola can easily re-ignite from just one, or a few, uncontrolled chains of transmission until we get to a true zero.

MONITORING AND ACCOUNTABILITY

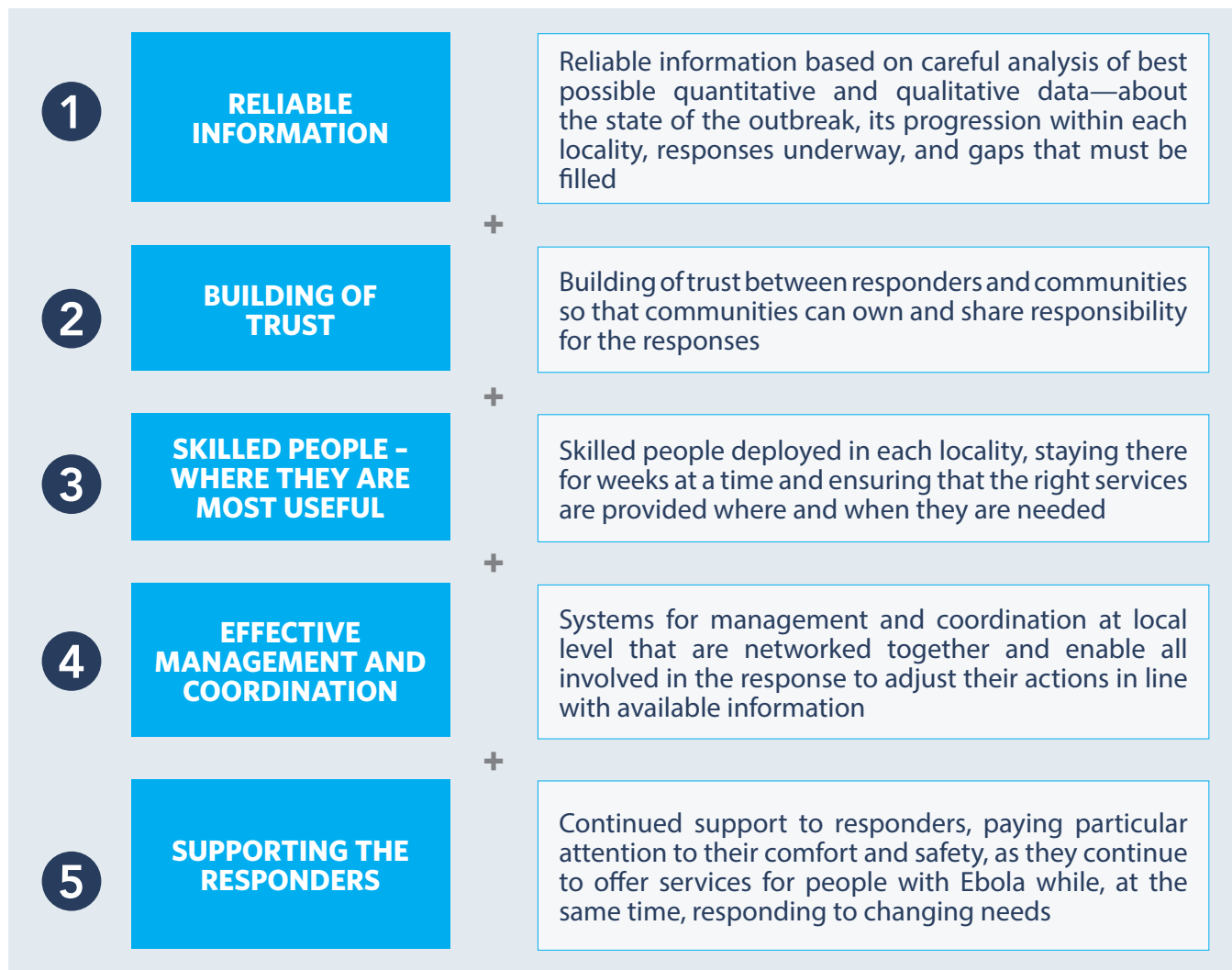
As new systems and routines are put in place, there will be an even stronger focus on systematic tracking of resources used, monitoring of results, and accountability—to communities and governments—for what is being achieved by the overall response. Coordination of this tracking, monitoring and accountability is a responsibility of the Office of the SG's Special Envoy on Ebola in close cooperation with all partners involved in the response.

On 20 October, WHO officially declared Nigeria free of Ebola virus transmission. This is a spectacular success story that shows that Ebola can be contained.

Photo: WHO/A. Esiebo — in Nigeria



REQUIREMENTS FOR SUCCESSFUL IMPLEMENTATION - 5 ESSENTIALS



REQUIREMENT 1: RELIABLE INFORMATION:

Affected communities need to be able to benefit from health services staffed by people expert in case finding, supportive treatment, contact tracing and surveillance. Getting these services to where they are needed calls for reliable up-to-date information on what is happening and resources that can easily be redeployed. If services are to be adjusted in response to communities' needs, those working in each district should be able to ensure that the right services are provided when and where they are needed.

REQUIREMENT 2: **THE BUILDING OF TRUST IS CRITICALLY IMPORTANT:**

members of the affected communities are the primary source of information about the evolution of the outbreak and the primary actors in the response. The collective experience to date is that, without full community engagement, people who are ill will not come forward for diagnosis and treatment. Contacts will refuse daily check-ups to see if they themselves become ill (indeed, they are likely to run away and hide). Unsafe funerals will take place and lead to new chains of transmission. People will be scared and resist control measures. The response works when communities—through their leaders—are in a position to “own” both the outbreak and the response, to plan for themselves and to implement their plans.

REQUIREMENT 3: **SKILLED PEOPLE – WHERE THEY ARE MOST USEFUL:**

To date, external support has been concentrated on medical teams to staff Ebola Treatment Units. These are still necessary but now they need to be supplemented by public health teams with complementary skills. These include the ability:

- to negotiate with and establish trusting relationships between communities and responders;
- to find out what is happening with regard to the outbreak,
- to undertake data analysis and epidemiology,
- to establish accepted and efficient systems to coordinate responders;
- to establish and maintain contact tracing and surveillance systems;
- to ensure that people receive the best possible care—for Ebola and other health and livelihood challenges;
- to identify gaps in essential services and make sure they are promptly filled;
- to sustain the ability to react rapidly when information about flare-ups is received.

REQUIREMENT 4: **EFFECTIVE MANAGEMENT AND COORDINATION:**

Effective management is crucial and there is a need for all responders to optimize;

- the understanding of the needs as they change over time
- the flow and matching of demands to supply of human resources, cash and equipment
- the delivery of key enablers (logistics, local management support etc)

This calls for a well-directed and networked system of coordination built around professional teams—assembled at district level—that encourage community ownership and ensure that services get to where they are needed. They are being set up now, led by national governments and supported by international experts. There is a need for a more rapid deployment of skilled personnel backed by a coordination service that is used by Government and all the responder organizations that are working in each community and location. In coming weeks more teams will be established in each local government area and the coordination network will need to cover all 60 of the districts, prefectures and counties from which the response is being managed.

REQUIREMENT 5:
SUPPORTING THE RESPONDERS:

All involved in this 2015 phase of the response need logistical, communications and human resources, material and financial support to work in an effective and decentralized manner. These “enabling factors” need to be accessible to each local public health team. Coordination must involve all actors so as to ensure that as data on the progression of the outbreak at local level become available, all actors draw on the data analysis to decide what services are needed and where, and that the best possible use is made of the capacity that is available. Where there are gaps, ways need to be found to fill them.

CONTRIBUTION OF THE UNITED NATIONS SYSTEM AND KEY CIVIL SOCIETY ORGANISATIONS

The United Nations system—working through the in country Ebola Crisis Managers (ECMs) and the office of the SRSG—has an essential role to play in supporting national governments. The UN system can assist in ensure (a) reliable analysis of real-time data on the evolution of the outbreaks and responses, (b) earning the trust of, and engaging, local communities, (c) locating skilled people to support local teams as they use a public health approach to adapt responses to needs; (d) effective management and coordination of different actors' responses at local level including across borders—networking local coordination so that it links with national mechanisms, and (e) all-round support for responders including efforts to reduce risks of infection among responder personnel. There will also be a need to factor in the possible availability of new technologies (for diagnosis, prevention, treatment, public health and the revitalization of health systems) as the response advances. There should also be a recognition that new partners are coming on board at all times—especially scientific groups and businesses—indeed there is powerful engagement of the private sector in many aspects of the response.

The UN system actors include WHO—which is playing a major role in all areas—together with key UN entities—UNICEF, WFP, UNDP, UNFPA, UNDP, OCHA and the World Bank.

The present response is a massive joint operation involving Governments, development agencies, partner organizations including IFRC, MSF and IOM, and other Civil Society Organisations as well as national organisations such as US CDC. The civil society plays a particular important role in terms of having been responding at a very early stage and today having massive experiences.

A number of governments have also provided direct bilateral support both in kind and in cash. Thousands of international responders have joint national colleagues in the fight against Ebola. And very important logistical support has been made available as well as materiel and supplies. This needs to continue and be an important part of the international response complementary to the UN system's and key civil society organisation's inputs.

The coordination challenge is massive: WHO is scaling up its presence and capacity at local level to be ready to lead and support the local efforts and UNMEER is increasing its capacities in the region to offer a robust coordination network and operations support platforms at multiple levels.

The **Global Ebola Response Coalition (GERC)** has been created in order to ensure strategic engagement and alignment of key responders

at international level. The coalition approach is increasingly reflecting the national- and district-level coordination arrangements that are being established by national and local Governments, together with their partners—be they donors, scientific groups, NGOs or entities from the UN system.

Photo: WHO/Winnie Romeril



OVERVIEW OF NEEDS AND FINANCIAL REQUIREMENTS

In 2014, the ONR appealed in September 2014 for USD 987 million and in October 2014 for an increase of USD 512 million and therefore a total of USD 1.5 billion.

In 2015, for the first half of this year from January – June, the overall costs of the international effort to get to zero is estimated to be USD 1.54 billion. USD 482 million is already available so the total appeal amounts USD 1.05 billion.

The estimations of financial needs are based on the assumption that the following key services will be needed during the next 6 months. Those are national requirements and the figures are validated with all three governments. The needs for this period is mainly for running cost and less for investments as most of the infrastructure are in place. The gaps are now smaller than previous but an issue is yet that some of those services are not available in the right geographical location.

In addition to the above-indicated key services there are other needs and priorities, which falls within the framework of the STEEP strategy; care for responders, food and nutrition, essential services, preparedness, cash incentives, transport and fuels & supplies and materials (which has now been grouped together under the heading of regional enabling support). The costs for those needs have been calculated by the lead UN agencies and do not necessarily include all national costs. Most of the cost for recovery will be estimated through the ERA process and has not been included here.

	GUINEA		SIERRA LEONE		LIBERIA	
	In place	Gap	In place	Gap	In place	Gap
Contact tracers	1,000	0	5,000	0	5,845	0
Laboratory sample capacity per day	300	50	620	0	395	0
Burial teams	69	0	125	0	69	0
Ebola treatment center beds	384	0	1,096	0	484	0
Community care center beds	54	274	371	0	103	0
Social mobilization volunteers	20,250	0	4,300	0	15,203	0
Sub-national EOC teams	17	0	13	0	4	11

OVERVIEW OF FINANCIAL REQUIREMENTS

1 STOP the outbreak

1 Identify and trace people with Ebola

\$0 MILLION COMMON SERVICES	\$12 MILLION GUINEA	\$52 MILLION LIBERIA	\$48 MILLION SIERRA LEONE	\$0 MILLION REGIONAL	\$112 MILLION TOTAL
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RESPONDING AGENCIES
WHO, IFRC, IOM, UNFPA,
UNHCR

2 Safe and dignified burials

\$0 MILLION COMMON SERVICES	\$15 MILLION GUINEA	\$9 MILLION LIBERIA	\$12 MILLION SIERRA LEONE	\$0 MILLION REGIONAL	\$37 MILLION TOTAL
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RESPONDING AGENCIES
WHO, IFRC

2 TREAT the infected

3 Care for Persons with Ebola and Infection Control

\$0 MILLION COMMON SERVICES	\$79 MILLION GUINEA	\$55 MILLION LIBERIA	\$148 MILLION SIERRA LEONE	\$0 MILLION REGIONAL	\$282 MILLION TOTAL
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RESPONDING AGENCIES
WHO, IFRC, IOM, UNFPA,
UNHCR, UNICEF

4 Medical Care for Responders

\$5 MILLION COMMON SERVICES	\$2 MILLION GUINEA	\$2 MILLION LIBERIA	\$10 MILLION SIERRA LEONE	\$0 MILLION REGIONAL	\$19 MILLION TOTAL
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RESPONDING AGENCIES
WHO, IOM

3 ENSURE essential services

5 Provision of Food Security and Nutrition

\$1 MILLION COMMON SERVICES	\$56 MILLION GUINEA	\$41 MILLION LIBERIA	\$62 MILLION SIERRA LEONE	\$0 MILLION REGIONAL	\$159 MILLION TOTAL
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RESPONDING AGENCIES
WFP, FAO, UNDP, UNHCR,
UNICEF

6 Access to Basic (including non-Ebola Health) services

\$3 MILLION COMMON SERVICES	\$44 MILLION GUINEA	\$82 MILLION LIBERIA	\$82 MILLION SIERRA LEONE	\$2 MILLION REGIONAL	\$213 MILLION TOTAL
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RESPONDING AGENCIES
UNICEF, OCHA, UNDP,
UNFPA, UNHCR

7 Cash Incentives for Workers

\$0 MILLION COMMON SERVICES	\$8 MILLION GUINEA	\$3 MILLION LIBERIA	\$3 MILLION SIERRA LEONE	\$0 MILLION REGIONAL	\$14 MILLION TOTAL
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RESPONDING AGENCIES
UNDP, UNHCR

8 Recovery and Economy

\$1 MILLION COMMON SERVICES	\$21 MILLION GUINEA	\$20 MILLION LIBERIA	\$16 MILLION SIERRA LEONE	\$0 MILLION REGIONAL	\$59 MILLION TOTAL
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RESPONDING AGENCIES
UNDP, FAO, IFRC

4 PRESERVE stability

9 Reliable supplies of materials and equipment

\$1 MILLION COMMON SERVICES	\$13 MILLION GUINEA	\$113 MILLION LIBERIA	\$10 MILLION SIERRA LEONE	\$1 MILLION REGIONAL	\$139 MILLION TOTAL
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RESPONDING AGENCIES
UNHCR, UNHCR

10 Transport and Fuel

\$0 MILLION COMMON SERVICES	\$0 MILLION GUINEA	\$0 MILLION LIBERIA	\$0 MILLION SIERRA LEONE	\$0 MILLION REGIONAL	\$0 MILLION TOTAL
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RESPONDING AGENCIES
UNHCR

11 Social Mobilization and Community Engagement

\$3 MILLION COMMON SERVICES	\$31 MILLION GUINEA	\$29 MILLION LIBERIA	\$30 MILLION SIERRA LEONE	\$1 MILLION REGIONAL	\$94 MILLION TOTAL
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RESPONDING AGENCIES
UNICEF, FAO, IFRC, IOM, UNDP,
UNHCR, UNWOMEN

12 Messaging

\$0 MILLION COMMON SERVICES	\$0 MILLION GUINEA	\$0 MILLION LIBERIA	\$0 MILLION SIERRA LEONE	\$0 MILLION REGIONAL	\$0 MILLION TOTAL
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RESPONDING AGENCIES
UNHCR

5 PREVENT outbreaks in countries currently unaffected

13 Preventing spread to other countries

\$6 MILLION COMMON SERVICES	\$2 MILLION GUINEA	\$1 MILLION LIBERIA	\$1 MILLION SIERRA LEONE	\$126 MILLION REGIONAL	\$135 MILLION TOTAL
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RESPONDING AGENCIES
WHO, FAO, IOM, UNHCR,
UNICEF

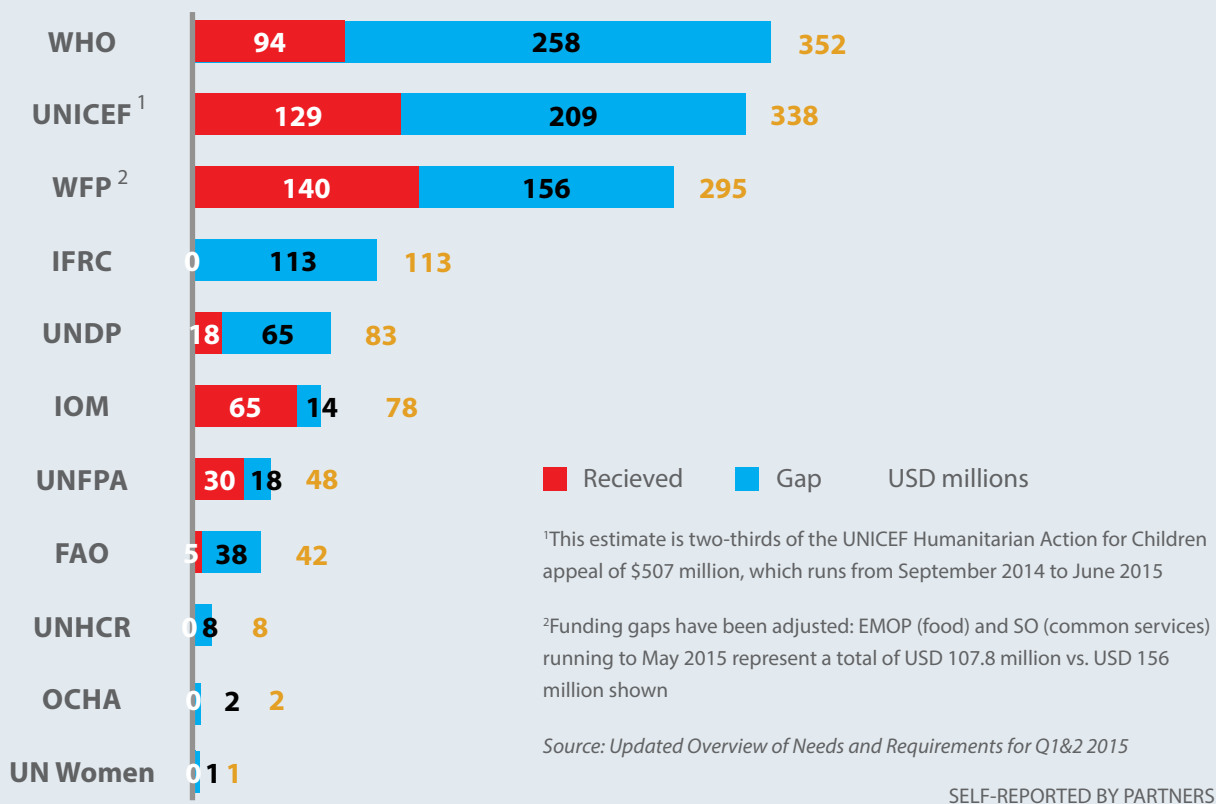
OTHER Enabling support to all objectives

\$13 MILLION COMMON SERVICES	\$63 MILLION GUINEA	\$77 MILLION LIBERIA	\$62 MILLION SIERRA LEONE	\$60 MILLION REGIONAL	\$274 MILLION TOTAL
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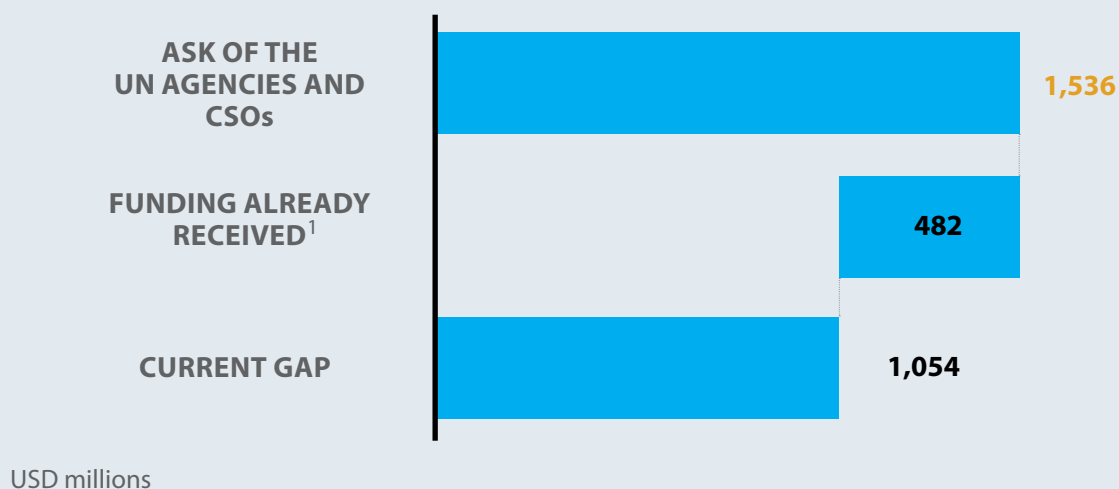


\$32 MILLION TOTAL	\$345 MILLION TOTAL	\$484 MILLION TOTAL	\$484 MILLION TOTAL	\$192 MILLION TOTAL	\$1,536 BILLION GRAND TOTAL
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ASK BY THE UN AGENCIES AND CSOs FOR JANUARY TO JUNE 2015



NEEDS, AVAILABLE RESOURCES, AND CURRENT GAP



¹Number may vary from OCHA FTS as amounts were not reported by all agencies, and because OCHA FTS also includes NGOs such as MSF

Source: Updated Overview of Needs and Requirements for Q1&2 2015

SELF-REPORTED BY PARTNERS

MISSION CRITICAL ACTIVITIES

MCA 1 IDENTIFY AND TRACE PEOPLE WITH EBOLA

- Enhance support for community-led contact tracing of Ebola-exposed patients facilitation of transportation and communication for community-based responders reaching all Ebola-affected areas.
- Establish early case detection at the community and health facility levels including across borders; reporting and referrals of cases through active surveillance; and extended outbreak investigation.
- Increase information-sharing and case detection training. Enhance response capacity for surveillance, specimen transport and accurate reporting of Ebola cases at county level.
- Strengthen coordination of contact tracing among various actors through data collection, collation, and analysis.
- Increase capacity of local national authorities to monitor response activities through the provision of transport (i.e. vehicles, motorcycles)
- Increase response capacity at key border crossings with ambulatory support for medical reference of suspected and infected persons.

MCA 2 SAFE AND DIGNIFIED BURIALS

- Support continuous training on safe and dignified handling of infected dead bodies
- Support community volunteer burial teams as well as other existing burial teams
- Provide logistic, financial and operational support for safe burials – e.g. Personal Protective Equipment (PPE), transport, body bags, etc.
- Put in place secure burial practices and cremation where appropriate

MCA 3 CARE FOR PERSONS WITH EBOLA AND INFECTION CONTROL

- Establish and continue to support adequately equipped treatment centers to ensure safe, prompt and effective case management and appropriate infection prevention and control approaches for all suspected and confirmed cases,
- Introduce early and effective case management among refugees.
- Provide special care for children in EVD treatment and care facilities, including an integrated package of health and nutrition treatment and care.
- In treatment facilities and in containment areas, support the procurement of water, sanitation and hygiene equipment and supplies, as well as appropriate training for the health and medical partners.

MCA **4** **MEDICAL CARE FOR RESPONDERS**

- Establish and continue to support medical care referral centers in affected countries for national and international responders
- Provide protective gear to health workers
- Conduct training of health workers on all aspects of the EDV response including on infection prevention and control effective hand hygiene and approaches for appropriate cleaning and disinfection purposes for ebola prevention
- Reduce exposure to ebola virus amongst health workers and service providers during delivery of maternal health services

MCA **5** **PROVISION OF FOOD SECURITY AND NUTRITION**

- Provide food assistance, including patients in ebola treatment centres, survivors of ebola discharged from treatment centres and communities with widespread and intense transmission.
- Distribute emergency food assistance to affected communities, to entail significant strengthening of existing logistics pipelines in affected countries.
- Conduct joint national comprehensive vulnerability analyses of food security situation with national authorities, UN and NGOs. Develop tools, pre-test and train data collectors, conduct data collection and analysis, and present and disseminate a final report to stakeholders.
- Assess the impact of EVD on the production and marketing of agricultural inputs and food security and on the livelihood security of affected communities, in collaboration with national authorities, UN and NGOs.
- Provide nutrition support to in-treatment and convalescent patients (RUTF)
- Re-establish SAM screening and treatment in affected areas
- Conduct nutritional assessments and ensure adequate response for severe acute malnutrition (SAM) and moderate acute malnutrition (MAM) caseloads

MCA **6** **ACCESS TO BASIC (INCLUDING NON-EBOLA HEALTH) SERVICES**

- Provide support for the safe provision of essential health services by training of health workers in infection prevention and control and the management of suspected ebola cases, ensuring the availability and appropriate use of supplies for universal precautionary measures, addressing occupational health and safety hazards, and the implementation of community health, triage and care processes that protect health workers and communities.

- Provide support to ensure the continuity of safe essential health services, including reproductive health services, the integrated management of childhood illnesses, insecticide-treated bed net distribution, immunizations, malaria treatment, emergency surgical services, and HIV prevention and treatment.
- Conduct risk assessment and analyze the impact of the EVD outbreak on health outcomes and essential services
- Provide access to Water, Hygiene and Sanitation for t service delivery points and populations living in Ebola affected areas
- Address disruptions in critical health systems functions for essential health services including supply chain systems to assure the availability of essential medicines, diagnostics, reproductive health kits and other supplies, human resources management (recruitment, deployment, salaries, incentives), laboratory services and information systems.
- Ensure continuity in access to education, through innovative approaches to learning and alternative learning channels until schools are reopened and the academic year can be recovered
- Provide psychosocial support services to children and families affected by Ebola, and support for the most vulnerable children;
- Support unaccompanied and separated children (UASC) and children abandoned or orphaned for long term care and case management to re-establish contact with their families and relatives, including alternative care, home-based or foster care, and protection; including for children with disabilities
- Procure and distribute dignity kits to widows and most vulnerable women and girls in affected communities and refugees camps.
- Provide gender sensitive hygiene kits to households with vulnerable targeted women, girls and young people.
- Recruit socio-anthropologist expert in female genital mutilation to engage in a dialogue with community leaders and traditional healers to protect girls from EVD.
- Support the global assessment of EVD impact on women and girls vulnerability.
- Monitor and report human rights/protection violations such as discrimination and stigmatization of victims and their families, and restrictions on freedom of movement and association, and conduct sensitization campaign on mainstreaming human rights into ebola response activities.
- Increase capacity for treatment and care services for survivors of sexual violence in health facilities and one-stop centres, including adherence to universal precautionary measures.

MCA 7

CASH INCENTIVES FOR WORKERS

- Salary-incentives and top-up schemes for health workers and service providers

- Support decentralized ebola surveillance teams
- Pay incentives for social workers and mental health clinicians to provide psychosocial support and case management, including to orphans and families
- Pay incentives for distribution assistants to expedite non-food items (NFI) distribution.

MCA **8** RECOVERY AND ECONOMY

- Conduct periodic rapid recovery assessment and/or socio-economic impacts of EVD at the household, district and national levels to inform early recovery and economic policies and programmes.
- Provide cash transfer/compensation/cash for work scheme for affected communities.
- Support early livelihoods and early economic recovery of local communities through emergency employment, provision of grants and start-up packages for the recovery of micro, small and medium enterprises /businesses, and rehabilitation of Ebola affected socioeconomic infrastructure at community level.
- Establish /Strengthen business support services/ platforms for entrepreneurial training, reestablishment of market linkages, support to local economic planning and recovery;
- Assess the impact of EVD on health outcomes and health systems, analyze critical health systems vulnerabilities and constraints to the ability of health systems to provide person-centered, integrated, quality health services to the population, and identify priority health sector developments, reforms and investments necessary to build resilience of the health system against future shocks
- Strengthen country-led processes, redesign and strengthen health systems to be fit for purpose in meeting the current and future health needs of its population through Universal Health Coverage.
- Develop assessments and plans at the West Africa regional level for effective cross-border disease surveillance, control and response.
- Provide resilience support to households in communities affected by EVD due to loss of production, rising prices, and food in availability.
- Develop nutritional education and hygiene awareness modules to complement entrepreneurial and compressed multi- skills training in technical trades such as welding, market-oriented training in handicraft industries, and improvement of rice value chain through introduction of mobile threshing machine.
- Provide agricultural livelihood support in terms of market flows, storage facilities and food production to households affected by the EVD outbreak and provide training in nutrition sensitive agriculture and bush-meat handling, inter alia, for households affected by the EVD outbreak.
- Provide alternative sources of animal protein (especially among communities reliant on bush meat) by supporting poultry and pork production and establishing fish farms.

- Support farmer associations involved in savings and loans initiatives with a special attention to women associations in the affected areas.
- Strengthen capacity of local and national authorities to lead and coordinate planning for recovery and economic revitalization.
- Build capacity of civil society and community based organisations to support the recovery process;

MCA 9 RELIABLE SUPPLIES OF MATERIALS AND SUPPORT

- Facilitate regular coordination meetings and provide information management services.
- Create additional storage capacity available in specific locations, as well as provide the staffing, logistics, and engineering capabilities for the humanitarian community to respond to the crisis.
- Establish and maintain inter-agency emergency telecommunications systems and communication centers in operational hubs.
- Enhance the capacity of national authorities in the procurement and delivery of the equipment required to respond. Support timely and adequate logistical support to outbreak response activities by national authorities.
- Procure and provide essential medical supplies, including protective equipment and health kits (including diarrheal disease treatment kits), vaccines and cold chain equipment, as well as non-food items/materials to support treatment and care facilities and households in affected areas.
- Provide timely logistical support to refugee camps.

MCA 10 TRANSPORT AND FUEL

- Provide general logistical coordination support to governments
- Facilitate the movement of health care professionals from organizations such as WHO and from MSF and other health sector NGOs, working the front line of the response, through provision of an UNHAS air fleet.
- Procurement of fuel, spare parts, motor cycles, pick-ups, ambulances and commercial trucks.

MCA 11 SOCIAL MOBILIZATION AND COMMUNITY ENGAGEMENT

- Support scale-up of social mobilization interventions to outside districts and border zones.
- Reinforce training of community mobilizers, including teachers, community health workers, community and religious leaders, in outreach techniques and messaging around the care and prevention of Ebola

- Increase public awareness and social mobilization initiatives through local radio/television broadcasts; door-to-door campaigns; and cellphone messaging, promoting responsible behaviors, dispel rumors, and reduce stigma.
- Support the design, printing and distribution of Ebola prevention materials targeting women and girls and young people, translated into local languages through mobile public announcement systems, including use of taxi, and traditional communication channels.
- Support intensified information, education and communication of women, girls and young people, through regular broadcasting of Ebola prevention messages via national and local radio and TV.

MCA **12** **PREVENTING OF SPREAD TO OTHER LOCATIONS**

- Undertaking adequate preparedness and response measures, particularly in communication and social mobilization border crossing management, monitoring of mobile populations flows and in critical sectors of health, and water, sanitation and hygiene. Specific activities include: preparedness and prevention measures in partnership with government and NGO actors and regional and sub-regional entities/institutions, including contingency planning, communication, establishment of standby committees, prepositioning of supplies and setting up coordination mechanisms.
- Scaling-up social mobilization activities linking C4D, WASH, Health and Emergency coordination to support containment and control efforts and scaling up efforts for hygiene promotion and non-food item (NFI) prepositioning.
- Supplying government counterparts with tents, buckets, basins, bottles of chlorine, Aquatabs and basic medical equipment including thermometers and masks, and diarrheal disease treatment kits to prepare potential suspected cases.
- Identifying and training partners in wildlife cadaver data collection and sampling, using appropriate bio-security measures
- Conducting a risk assessment of virus spillover from wildlife/ animals to humans
- Formulating risk management options focusing on the interface between human, animals and the ecosystems to mitigate the risks of virus spillover from wildlife to humans.

OVERVIEW OF HUMAN RESOURCES REQUIREMENTS

In addition to the financial requirements partners responding to the Ebola virus disease (EVD) outbreak are seeking additional operational, material and human resources support.

HUMAN RESOURCES

Successful management of the outbreak will be dependent on the ability to deploy a large number of technical and operational staff.

To date, external support has been concentrated on medical teams to staff Ebola Treatment Units. These are still necessary but now they need to be supplemented by public health teams with complementary skills. With a more tailor made, nuanced and localized approach there is a need for smaller more active units, anchored with the local authorities with integration, decentralization and teamwork rather than working as separate pillars of operation.

Among the four strategic objectives of the collective EVD response is to prevent infections as well as to treat and provide care for those who have been infected. Central to this objective is still the establishment of dedicated services in Ebola Treatment Units (ETUs) staffed by well trained, well equipped, and supervised staff.

	GUINEA	LIBERIA	SIERRA LEONE	GRAND TOTAL
INTERNATIONAL STAFF	610	700	861	2,171
Contact tracing and community surveillance	33	195	167	395
Laboratory	14	16	25	55
Safe and dignified burial	12	14	25	51
Ebola treatment center	157	155	368	680
Community care center	31	10	39	80
Social mobilization	74	56	16	146
Sub-national hub	289	255	221	765
NATIONAL STAFF	25,150	24,723	15,730	65,603
Contact tracing and community surveillance	1,067	6,235	5,333	12,635
Laboratory	63	71	112	246
Safe and dignified burial	549	621	1,125	2,295
Ebola treatment center	1,509	1,491	3,542	6,542
Community care center	595	187	761	1,542
Social mobilization	20,790	15,608	4,415	40,813
Sub-national hub	578	510	442	1,530
GRAND TOTAL	25,761	25,422	16,590	67,773

Staffing projections have been made for the next six months. Based on these projections, it is estimated that over 2 171 international staff and 65 603 national staff will be required to manage the 12 mission critical functions, including managing ETUs.

The UN system and the key international CSOs can only provide part of this and the strong support from e.g. the African Union, the US, UK, France, China, Sweden needs to continue.

Given the many ongoing emergencies globally—partners are currently responding to five Grade/Level 3 emergencies—there are competing demands for senior emergency and technical staff by many operational agencies. Secondment of staff from global technical networks, standby partners, UN agencies and other organizations has been invaluable to date. But additional support from governments and other organizations to identify and second senior technical and operational staff will be necessary to ensuring a timely and effective scale-up of operations.

Estimates of requirements for national and international staff are outlined in the following table. These are subject to review, given the rapid evolution of the outbreak.

Sadly, a total of 678 health-care workers are known to have been infected with EVD up to the end of 28 December 2014, 382 of whom have died. The reasons for these deaths are complex: some are health care workers who have been infected while conducting the professional duties and are in contact with Ebola patients; others are health care workers who are approached informally while in their community. The investigation of the deaths of health care workers and the prevention of the infection of health care workers is a top priority of those responsible for Ebola treatment and care.

SUPPORT FOR MEDICAL EVACUATIONS

To control the EVD outbreak, thousands of international responders are required. But among the major constraints to recruitment of international staff has been access to medical evacuation for those who may have been exposed to Ebola during the course of their work. As requests for a continued expansion of international operations are issued to international partners, it is essential that staff be guaranteed reliable access to timely medical evacuation to pre-identified medical facilities, regardless of their nationality or organizational affiliation.

At the request of the international community, WHO works to coordinate the medevac of any international agency personnel with suspected or confirmed EVD infection, and who been involved in the Ebola emergency response in West Africa. WHO has established a global medevac coordination team composed of trained medical officers. These WHO staff members are on duty 24/7 and, whenever a medevac is needed, work in close collaboration with several stakeholders, and coordinate the different actions to ensure that the medevac is successfully completed:

- with the agency who wishes to medevac any staff or non-staff;
- with the health facility that will receive the patient and be responsible for their care;
- with the transport company ferrying the patient;

Medevacs are highly time- and resource intensive. In the past four months, WHO has arranged the medical evacuation of 12 international workers with confirmed EVD infection: 7 worked in ETUs of which 3 had likely exposure in ETU and 4 likely outside ETU; a further 5 worked in obstetrics, family medicine, epidemiology or surveillance outside the Ebola context. WHO has also arranged a further 6 medevacs of international workers with suspected EVD infection. The countries that received patients include USA, Spain, Germany, UK, France, Norway, Switzerland. Medevac costs vary considerably depending on which airline and facilities are used to transport and then treat the individuals. WHO anticipates over the coming six months—January to September 2015—the potential need to arrange medevac for at least 24 patients both with confirmed and suspected EVD infection.

Meanwhile specific ETUs have been set up in each of the affected countries for health workers (either locally or internationally recruited) where all suspected or confirmed EVD infected health workers can receive diagnosis and primary care. Depending on the severity of the case, and if needed, the patient can be med-evacuated. The need to provide care to all national and international health workers who may be exposed to EVD is an essential part of the response effort and continues to require substantial additional resources.

MATERIAL SUPPORT

The response will also be dependent on the consistent supply of essential equipment and supplies. In-kind contributions of vehicles, personal protective equipment (PPE), body bags, and laboratory supplies would be of great assistance for the response especially where these contributions are provided flexibly so that they can quickly be deployed to the country and area of greatest need. Logistic support for the field operations is challenging, because of the poor roads and remoteness of some “hot spot” sites. It will require reliable telecommunications, four wheel drive vehicles and motorcycles. Ambulances are necessary to transport suspect cases to appropriate facilities. Supplies of PPE—seven sets per patient per day—are critical for appropriate infection prevention and control. An outline of priority material needs for the response is presented below.



SOCIAL MOBILIZATION BEING APPLIED TO CURB EBOLA IN SIERRA LEONE

As part of the Western Area Surge Operation in Sierra Leone to curb the Ebola virus disease outbreak in the country, social mobilization teams are deployed to promote health and to facilitate community acceptance of new surveillance, clinical care and burial procedures in Freetown. Community members attend a briefing by a social mobilization team in Lester Road, Freetown.

22 December 2014

UN Photo/Martine Perret

RESTORING ESSENTIAL SERVICES

While halting the transmission of virus and providing care and treatment for the sick will continue to be a main focus in this second phase of the response, it has become clear that enabling services in health, nutrition, WASH, education and protection need urgent increased support in order to maintain and eventually adjust them, as well as bolster their resilience.

Moreover, the establishment of safe essential health services to manage patients presenting with illnesses other than Ebola will be essential if the system of Ebola triage and care is to function. Although the situation differs by country in terms of the level of services that were closed, the concentration in the first phase on containing the Ebola outbreak, while justified, has created other risks (no immunisation services, no schools, reduced access/utilisation of PHC, treatment of childhood illnesses, including malnutrition, ante-natal care and safe deliveries, etc.) and has exacerbated already very weak basic social services. This trend has to be urgently reversed.

In this context, the UN and international partners, in support of national Governments and local partners, will, in the continued work, substantially increase their work on and support to:

- I. Essential health services, including catch-up campaigns for immunization, treatment of malaria and training of CHWs as well as the procurement of essential health and nutrition commodities, including essential medicines and vaccines and infection prevention and control equipment and supplies;
- II. Other key essential social services, including nutrition, HIV, clean water, hygiene and sanitation (WASH) and social protection services for affected families;
- III. Education, safe and responsible return, when the decision is made, to re-open the schools, including training of teachers and provision of hand-washing facilities, screening tools, back to school supplies, and reporting and referral mechanisms between schools and health authorities;
- IV. Social protection for children and vulnerable groups including refugees
- V. Food safety and security including special attention to nutrition
- VI. Community engagement in Ebola response, assist governments and civil society partners to improve ownership of more resilient local systems.

Core interventions and priorities in **Guinea** include support to the Government and partners to bringing health service delivery close to the affected communities; provide protection services, including child protection, and social cash transfers to vulnerable families, support to

the integration of survivors; support to nutritional interventions; blanket provision of hygiene kits to households in affected areas; and support to schools with hand washing kits and remote learning.

In **Liberia**, the UN and key international CSOs will continue to play key roles in support of the Government and partners to install water supply and sanitation in health facilities; to provide essential, and in some cases, life-saving supplies (health, hygiene, nutrition and WASH); to provide psychosocial support, family tracing, reunification, and reintegration for children and families affected by Ebola. In the nutrition sector, the international system provides programmatic guidance and inputs for nutritional care and support, feeding of affected children and adults, and identification and treatment of severely malnourished children using a modified protocol. Support to PHC services includes training on IPC, and procurement of essential commodities for service provision and universal precautions to ensure the safe reopening and functioning of all facilities. The international system will also support innovative ways to deliver education, including educational radio programmes, while at the same time working with key partners to finalize protocols for the reopening of schools.

In **Sierra Leone**, support will be provided to the government and partners in the construction/ establishment of WASH facilities, the provision of nutrition inputs (RUTF, RUIF, UHT milk, BP-100) to specific target populations in facilities, quarantined communities/households and interim care centers. Other activities include the training of health staff in all 1,200 PHC units across the country in IPC and the use of protective equipment; protection programmes to provide psychosocial support, family tracing and reunification, and distribution of relief items to Ebola affected children and households. Psychosocial support is also continuously being provided to survivors to reintegrate into communities. The UN, CSOs, the Ministry of Education and partners are working to support children's continued learning by airing daily, hour-long lessons on radio stations nationwide, including community radios, and self-directed learning modules as well as developing protocols and plans around the safe reopening of schools.

ACCELERATED PREPAREDNESS & EARLY ACTION

Prevention, response preparedness and early action are pivotal to containing an EVD outbreak within a country and preventing its further spread to other countries. All countries must urgently ensure that they are operationally ready to rapidly detect and effectively respond to suspect EVD cases. They must strengthen their core capacities under the International Health Regulations (2005) and increase the overall resilience of their health systems. In addition, a new approach that promotes health systems capacity in disease surveillance, public health functions and health systems resilience is urgently needed.

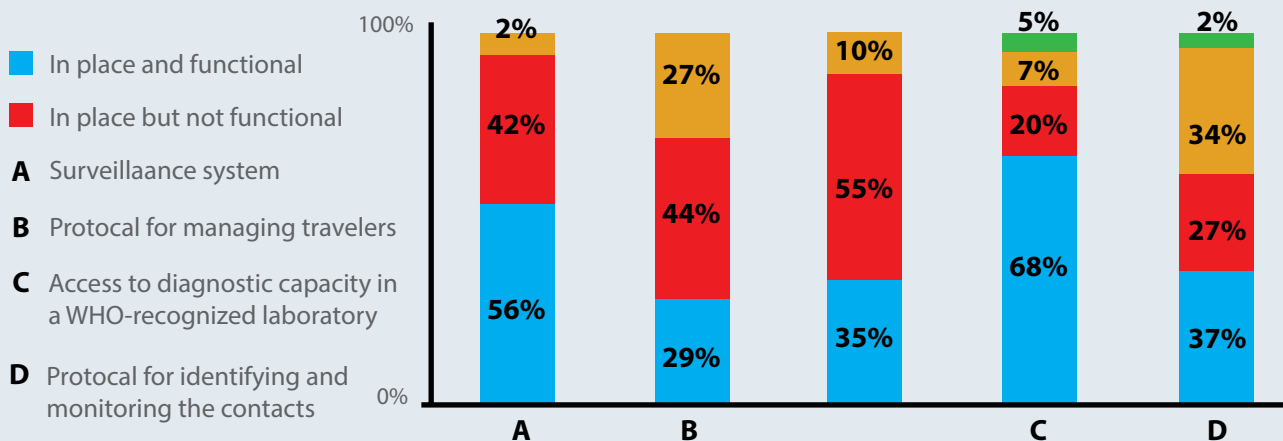
GLOBAL PREPAREDNESS FOR EBOLA VIRUS DISEASE

To mitigate the spread of the outbreak, all countries need to implement minimum requirements across the ten components of preparedness and many will require additional funding to support this effort.

All countries in the world are at some risk of introduction of Ebola but the risk of further spread, once a case is introduced to a new country, depends critically on the overall strength of the health system and the level of EVD specific preparedness. In the African region, surveys undertaken in September 2014 revealed significant preparedness gaps. Recent improvements have been seen across key indicators (see figures) but further immediate steps to become operationally ready to respond are still required.

Outside of the African region country visits, training workshops and simulation exercises have targeted over 50 countries to identify areas where technical support is required. WHO has developed minimum

RESULT OF ASSESSMENT OF NON-AFFECTED COUNTRY ON PREPAREDNESS AND RESPONSE TO EVD OUTBREAK, SEPTEMBER 2014.



requirements necessary for each country to consider and implement in order to be ready should an Ebola patient present in the country. These minimum requirements have been applied in the African Region and are being rolled-out globally with a suite of WHO guidelines, tools and preparedness training materials.

PRIORITY COUNTRIES IN AFRICA

Priority countries targeted for accelerated Ebola Preparedness include the four countries (Guinea-Bissau, Mali, Senegal, Côte d'Ivoire) bordering those with widespread and intense Ebola transmission and eleven other countries (Benin, Burkina Faso, Cameroon, Central African Republic, Democratic Republic of Congo, Gambia, Ghana, Mauritania, Nigeria, Togo, South Sudan).

INDICATOR	PRIORITY COUNTRIES IN AFRICAN REGION		OTHER COUNTRIES IN AFRICAN REGION	
	Sep 2014	Nov 2014	Sep 2014	Nov 2014
# Countries with enhanced surveillance system	54%	94%	64%	96%
# Countries with protocol for managing travellers with suspected EVD	0%	94%	48%	89%
# Countries with established isolation units	8%	56%	52%	71%

Countries bordering an EVD-affected country with widespread and intense transmission (Guinea, Liberia and Sierra Leone) are at especially high risk. Côte d'Ivoire and Guinea-Bissau, continue to require urgent preparedness measures to be implemented across all preparedness components. Countries that have received an initial case or cases, or with localized transmission (Nigeria, Senegal and Mali) require increased readiness and vigilance for further cases. Other priority countries in the African region - identified during a survey carried out in September 2014 – have been identified because of heavy population, trade or airline connections to EVD-affected countries or due to weak health systems or concurrent humanitarian crises.

URGENT SUPPORT TO IMPLEMENT OPERATIONAL PLANS

Priority countries require immediate support from the international community to implement operational plans with key deliverables at 30, 60 and 90-day marks.

WHO and its implementing partners have sent Preparedness Strengthening Teams (PST) to fourteen countries (Mali, Côte d'Ivoire, Ghana, Mauritania, Cameroon, Guinea-Bissau, Benin, Senegal, Burkina Faso, Gambia, Togo, CAR, Ethiopia, Niger) to provide urgent technical assistance, develop operational plans, and facilitate medium and longer term capacity strengthening.

Following the PST missions in these priority countries, the second phase of preparedness requires continued strong and coordinated actions at the international and national levels to achieve the following three goals:

- Provide tailored and targeted technical support to strengthen EVD capacities in human resources; operationalising plans; testing and improving procedures through field exercises and drills as well as financial and logistic support for the implementation of preparedness plans.
- Strengthen national core capacities under the International Health Regulations (2005) and the resilience of health systems in concert with broader health systems strengthening efforts;
- Increase global health security and regional networks for health surveillance.

Immediate support is required in priority countries across the following 10 components:

1. Overall coordination: High-level operational incident management structures to manage and coordinate preparedness and response activities;
2. Rapid Response Teams (RRTs): Trained and equipped RRTs to respond to alerts across the country;
3. Public awareness and community engagement: Risk Communication plans and activities implemented using technically-correct messaging and community engagement strategies;
4. Infection Prevention and Control (IPC): Standard and additional precautions for IPC to establish safe working conditions;
5. Case management: Safe clinical management strategies for all EVD patients in health facilities, and burials conducted safely and in a dignified manner;
6. Epidemiological Surveillance: A surveillance system exists to manage alerts and immediately notify cases from across the country, including from within local communities;
7. Contact tracing: Trained contact tracing teams ready to identify and follow-up any direct contacts with EVD cases;
8. Laboratory: Procedures and agreements to ensure safe sample collection, transport and analysis within an appropriate laboratory nationally and/or internationally;
9. Points of Entry: Plans and procedures available to strengthen border management detect and refer de EVD cases at major borders, land-crossings, ports and airports;
10. Overall budget: Sufficient funds and mechanisms to pay high-risk workers available to enable early action to be taken in any location in the country.
11. In addition, countries must also develop the optimal Logistics platform to ensure appropriate support across all EVD Preparedness components.

RESEARCH AND DEVELOPMENT

WHO is leading the international research and development effort in response to the Ebola outbreak. This work is in addition to the Mission Critical Actions covered by the ONR and is not included in the ONR costs presented by WHO in this report.

A series of consultations and high-level meetings has been convened with key experts and stakeholders involved in the research, development, regulation and funding of potential medical solutions for Ebola. Based on concerted expert advice, the best evidence available and ethical oversight, WHO has prioritized a number of products for further investigation through human testing. These products include two candidate vaccines, two antiviral drugs and convalescent whole blood and plasma. In addition, WHO is working on a number of emergency procedures with countries and other partners for assessment and fast-track development of adapted diagnostics, as well as joint reviews of vaccine clinical trial protocols.

For January – June 2015, WHO estimates its financial requirements for R&D will be USD\$22.6 million. In 2014 WHO secured funds totalling USD\$16 million and utilized USD\$7.5 million. Therefore the funding gap for WHO Research and Development work is USD\$14.1 million. The funds are required to support WHO activities as follows:

- Convening experts and stakeholders involved in research, development, regulation, and funding to continually review and prioritize interventions for further investigation through human testing.
- Providing technical and financial support to accelerate verification, development, testing and, if safety and efficacy are found, deployment of Ebola medical products.
- Providing technical guidance to affected countries, including advocating for patient safety and strict ethical oversight throughout the testing phases and potential deployment.
- Assessing national capacity for delivering safe blood products.
- Supporting community engagement activities in African countries where trials are already taking place.

In January, 2015 GAVI approved an estimated budget of USDF\$ 340 million for Ebola vaccine deployment. This would be an additional sum to be raised as part of the overall Ebola response effort.

NATIONAL RESPONSE PLANS

The United Nations, in close collaboration with the Governments of Guinea, Liberia, and Sierra Leone, has developed country-based response plans to tackle the epidemic and its adverse secondary effects on basic services including non-ebola medical care, food and water. Thematic areas in the Sierra Leone and Guinean plans are aligned with those of the national plans. Liberia follows a sectoral approach. All UN plans reflect the expertise of UN agencies specializing in humanitarian and early recovery activities at country level.

GUINEA Planned Response to the Ebola Virus Disease in Guinea

National Plan: the goal of the national plan is to reduce morbidity and mortality due to Ebola virus by breaking the chain of transmission at the national and regional level, and also on disease prevention.

At the end of December 2014, the CNLE (Cellule National de Lutte contre l'Ebola), launched the "Zero Ebola in 60 days" campaign. This new initiative aims to strengthen the classical intervention components (case management, IPC measures, contact tracing, safe burials and social mobilization), but puts a special emphasis on supporting planning, implementation and monitoring at Prefecture level. The CNLE held planning sessions with relevant partners for 2.5 days with the aim to finalize the strategy and action plan for the different intervention components. The presentation of the outcome of the planning sessions resulted in a decision to send multi agency planning teams under national lead to all the affected prefectures to provide direct advice and support to the DPSs through development of detailed action plans.

United Nations Plan: the UN Plan shares the two Strategic Objectives (SO) of the National Plan, adding a third SO towards building resilience and supporting recovery and livelihood activities. The UN Response Plan was finalized at the end of August and covers a period of 5 months, from August - December 2014.

LIBERIA Operational Plan for Accelerated Response to Re-Occurrence of Ebola Epidemic

National Plan: the national plan uniquely addressed the second wave of the EVD that returned in May of 2014 following the first appearance of the disease in March 2014.

United Nations Plan: In view of the rapidly escalating crisis and spreading of the health crisis to other vital parts of society, the UN national appeal for Liberia was revised in early September 2014. The plan was developed to cover a period of six months taking a multi-sectorial approach in support of the Government of Liberia's response to the Ebola crisis.

Adopting the WHO roadmap to stop the transmission in line with the STEPP strategic approach the scope of the appeal was to address the immediate

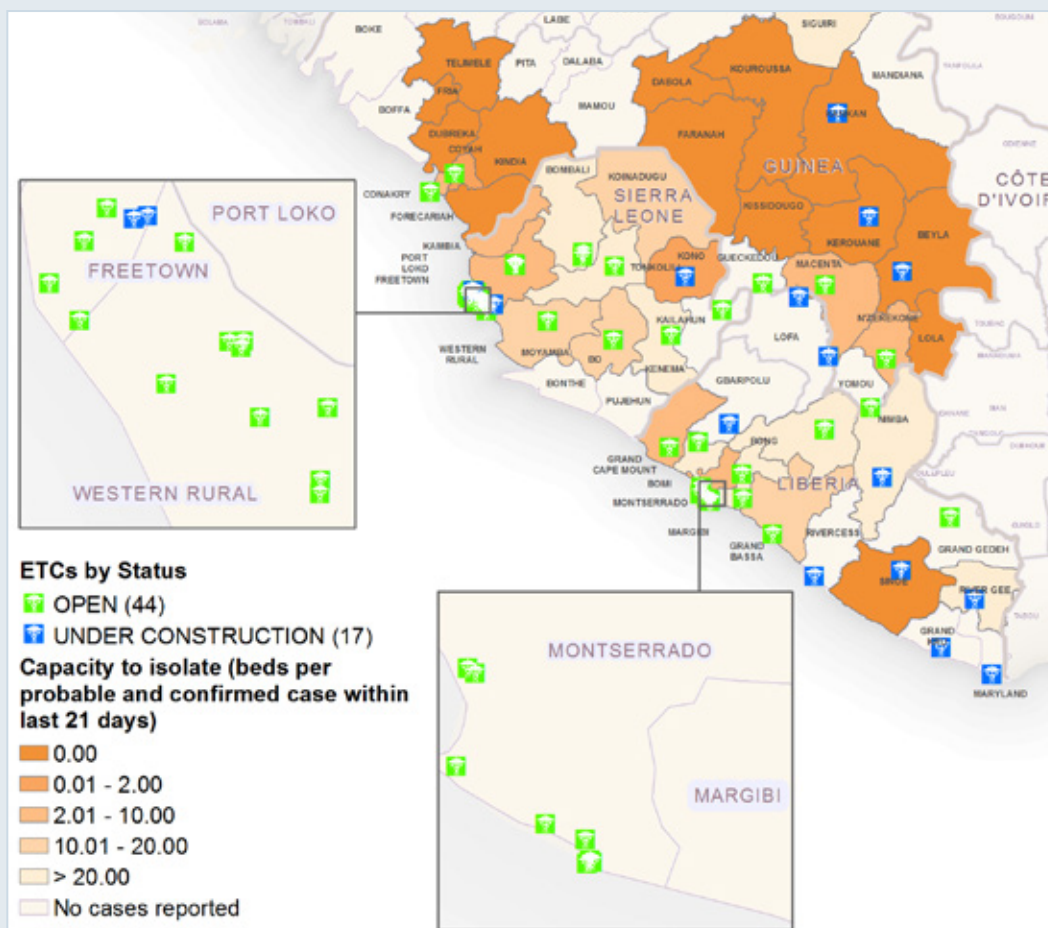
expanding response needs to the Ebola response and some of the immediate early recovery response efforts organized around the sectors of health, logistics, food security, WASH, Early Recovery, Education and Coordination. The plan and budget covered the period from September 2014 – February 2015.

SIERRA LEONE Accelerated Ebola Outbreak Response Plan

National Plan: the goal of the operational plan is to reduce morbidity and mortality due to ebola through prompt identification, notification and effective management of cases, effective social mobilization and coordination of the epidemic response activities. The plan takes includes activities to be implemented at district level to break the chains of transmission of the virus to new communities in Sierra Leone and neighboring countries.

United Nations Plan: the UN Response Plan was finalized at the end of August and covers a five-month period from August-December 2014. The Annex to the response plan, which covers food and nutrition needs, will cover a period of 15 months from September 2014 - December 2015.

Location of Ebola Treatment Centres and capacity to isolate probable and confirmed cases by district in Guinea, Liberia, and Sierra Leone



A stylized map of West Africa is shown in the background. The landmass is light gray, and the surrounding water is a solid blue. Three countries are highlighted in a vibrant red color: Liberia, Sierra Leone, and Guinea. Their borders are defined by a white outline. The title 'COUNTRY PERSPECTIVES' is centered over the map in a large, bold, dark blue font.

COUNTRY PERSPECTIVES

LIBERIA
SIERRA LEONE
GUINEA

LIBERIA



SITUATION

In March 2014, Liberia became the third country to report that EVD had spread from neighbouring Guinea, and as of the end of December 2014, had reported the most deaths . During the September-October period, there was a sharp increase mainly driven by a surge in cases in the capital, Monrovia and at the same time, evidence of substantial underreporting of cases and deaths.

However, since mid-November, Liberia has experienced a decline in new cases. In the last three weeks of December, Liberia reported 91 confirmed cases, down from (insert a good reference here). As of 31 December, Liberia reported 8018 cumulative cases and 3423 deaths.

However, an already low-capacity health care system has been unable to meet non-ebola medical needs. Restrictions on movement have hindered trade and caused price increases that cannot be matched by the average Liberian. The outbreak is disproportionately affecting women as the primary caregivers. Moreover, school closures are preventing children from pursuing their education, making the restoration of services increasingly important for families.

RESPONSE

The nature of the ongoing ebola outbreak requires an integrated response to both stop transmission and restore services. Liberia has reached its goal of isolating all patients and making nearly all EVD burials safe and dignified,

"We are one team with one goal, and that is to fight on until we win over this virus... I am just doing my job, because my Liberians were getting sick. I am not afraid because we are all being very careful!"

Moses J. Soka - Director of Ebola Treatment Unit 1, Liberia Ministry of Health staff, Monrovia, Liberia
Photo: WHO/R. Sørensen

and the Government of Liberia's Operational Plan includes a number of measures designed to strengthen the response further.

This includes improving mobility by strengthening rapid response capacities which can be deployed quickly to remote locations to contain localized outbreaks before they spread. Towards this goal, the Rapid Isolation and Treatment for Ebola (RITE) has been operationalised since November in Liberia. This requires additional air support, as well as mobile lab and ETU capacities which UNMEER and UNHAS are working together to provide. Necessary supplies such as RITE kits, tents, and life-saving medical and infection control supplies have been assembled and positioned at the WFP Main Logistics Hub, ready to be flown to outbreaks, and have also been pre-positioned in all of the five (5) Forward Logistics Bases (FLBs) which can be transported overland to outbreaks.

Contact tracing in Liberia has improved but there is still a need to ensure that a greater percentage of contacts are reflected on contact lists. Liberia has scaled-back on the number of EVD treatment beds from 790 at the end of November to 660, in response to the declining case-load. The Government estimates that this capacity could be scaled up to 1,279 beds within 48 hours.

Liberia has 99 burial teams including case investigators across 14 districts, which represents 99% of the target. Additionally, there are 26 standby teams ready to be deployed. It is estimated that 98% of all reported dead bodies are collected within 24 hours and receive safe and dignified burials. The country has reached 100% where religious and community leaders promote safe and dignified burials in all districts. Importantly, IFRC in collaboration with Global Communities, government authorities and the local community facilitated the establishment of a national cemetery in Monrovia. The new site will contribute to burial needs more generally, not just Ebola victims.

In support of Government efforts, MSF completed the construction of a new 120-bed case management centre in Monrovia, one of the largest Ebola treatment centers ever built by the organisation. MSF has also recently launched a response in Lofa county, rehabilitating the isolation centre in Foya with 40 beds in line for the management of the disease, while IOM directly provides operational management, clinical treatment and care of 3 ETUs with a collective 150 bed capacity in three counties – Bomi, Grand Bassa and Grand Cape Mount. UNICEF is scaling up the provision of essential health services (Ebola and non-Ebola), leading on communication with communities, ensuring the provision of life-saving supplies (medical and WASH) and also ensuring psychosocial support for children and families affected by Ebola. WFP aims to provide food assistance to 405,000 people, logistics and emergency telecommunications services to responders, and UNHAS flight services to the three affected countries, as well as a helicopter to reach remote destinations within Liberia.

While the bulk of the operational work is carried out by UN agencies, funds and programmes, as well as national and international NGOs and response workers, UNMEER has continued to carry out its vital function of crisis management and ensuring overall coherence in the United Nations system response.



Health care workers who have completed the Ministry of Health and Social Welfare, Republic of Liberia/WHO Ebola training course in Liberia posed with WHO Representative for Liberia, Alex Gasasira, and their 'graduation' certificates.

Health care workers who received the certificates came from the African Union and countries such as China, Cuba, Liberia and Sweden, among others.

Photo: WHO/R. Sørensen — in Liberia

KEY PERFORMANCE INDICATORS FOR THE EBOLA RESPONSE IN LIBERIA

Indicator	Source dates	Current status	% of planned/target
% of districts with laboratory services accessible within 24h	As of 04/01/15	100%	100%
% of ETC beds operational	As of 12/01/15	26% (510 beds)	1989 beds
% of CCC beds operational	As of 02/01/15	22% (93 beds)	428 beds
Capacity to Isolate	22/12/14 -11/01/15	Average: 13.9 beds per reported case (probable and confirmed) Median: 7.5 Range: 0 - 399	
Case fatality rate (%) among hospitalized patients	Cumulative (to 11/01/15)	58%	
% of burial teams trained and in place	As of 08/01/15	64% (64 teams)	100 teams
% of registered contacts to be traced who were reached daily	05/01/15 -07/01/15	99%	
# of newly infected national HCWs	05/01/15 -07/01/15	1 (1 - Grand Cape Mount)	
% of districts with a list of identified key religious leaders or community groups who promote safe and dignified burials	As of 05/01/15	Data not yet available	

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SIERRA LEONE



Kadiata Koroma and her nephew Sorie Koroma and niece Hawa Koroma, now recovered from Ebola virus disease and waiting at the Kamosondo peripheral health unit (PHU) to go home. The efforts of David Gbla and his team kept this small family alive. They will be the last to stay at the Kamosondo PHU: now everyone is being treated at the community care centre, built by the Kamosondo community with help from WHO. "I just want to go fishing" says Sorie, impatient to leave. However he has to remain until he has had blood tests confirming he is now Ebola negative
Photo: WHO/S. Gborie
—in Sierra Leone

SITUATION

As of 28 December, a cumulative 9,446 (confirmed, probable, and suspected) and 2,392 deaths have been reported in Sierra Leone. The incidence of EVD in Sierra Leone remains very high, with 337 new cases reported in the past week. There were great improvements in the response rates of all alerts made, especially in the Northern region. Western Area continues to register the highest number of cases (153), followed by Port Loko (70) Kono (41) and Bombali (30) Districts respectively. Kono still remains a concern.

With one doctor for every 33,000 people, the country's fragile health system is ill-equipped to respond to the outbreak. In Sierra Leone, the outbreak erupted at a crucial period in the agricultural season for rice and other important food crops. Many farmers were not able to complete key, time-critical agricultural activities. This may have dire consequence for individuals, households, villages, districts and, consequently, the nation as a whole. The closure of markets, roads and banks has further reduced the availability and increased the price of food.

RESPONSE

The Accelerated Ebola Outbreak Response Plan was launched by President Ernest Bai Koroma on 30 July 2014. The plan is organized around the following areas: 1) Case Management led by MoHS, WHO; 2) Surveillance - led by MoHS, UNFPA, CDC, WHO; 3) Safe and Dignified Burials - led MoHS, IFRC, 4) Social Mobilization & Communications - led by MoHS, UNICEF 5) Psycho-social support, Gender, Children – led by MoSWGCA, UNICEF; MoHS, 6) Logistics - led by UNMEER, WFP, UNDP, WHO, UNICEF. As of 29 December, there are 19 operational ETCs with approximately 896 available beds, and total bed capacity of 1,413. They are run by the MoHS, U.K. Government, Médecins Sans Frontières, Save the Children, China, IFRC, Plan International, GOAL, Partners in Health, and other partners. WHO, CDC and UNFPA are engaged in surveillance and contact tracing. UNICEF and WHO are leading on social mobilization and public awareness, and large-scale communication campaigns are underway to inform and educate the population on the risk associated with Ebola and support services available. WFP provides UNHAS flights to transport responders and supplies, and facilitate logistics and emergency telecommunications.

WHO is leading efforts to strengthen surveillance activities in the districts, in partnership with MoHS and CDC. The World Health Organization continues to coordinate the activities of Foreign Medical Teams in Sierra Leone and to support the laboratory system. As Co-Chain of the Case Management and Surveillance pillars, WHO supports the creation of guidelines and protocols and works with the Ministry of Health and Sanitation to ensure that they are implemented effectively.

UNICEF is working closely with partners to provide health, water, sanitation and hygiene services as well as essential medicines. With school closures, UNICEF is also developing alternate learning forums including radio learning to reach children in affected areas. UNICEF, and WFP have joined together to ensure the provision of food assistance to medical facilities, families and communities directly affected by the outbreak - last week, WFP assisted over 86,300 people across the country, including 168 patients, 500 survivors, more than 5,000 contact cases and over 80,600 persons in areas of widespread transmission. Based on food security assessments, FAO and WFP will help to restore robust local agricultural productivity and livelihoods to prevent affected communities from slipping into chronic food insecurity and extreme poverty. Particular attention is being paid to rehabilitation of the nutritional status of children under five years old with severe acute malnutrition, and infants and children of EVD affected mothers from age 0 to 23 months.

As endorsed by host authorities and WHO, IOM is managing a training academy building capacity of national and international personnel working in the EDV response. Additionally, IOM works in close coordination with CDC and the SL Authorities to enforce EDV health identification and referral protocols at the Lungi international airport. Finally, IOM is involved in community mobilization and distribution of essential PPE equipment for families of home based EDV cases and vulnerable affected communities.



Head of Operations at the Hastings Ebola Treatment Centre in Freetown, Sierra Leone, Dr. Major H.S. Bangura briefs Dr. Rotceh, lead physician for the Cuban medical staff working at the Centre, and his Cuban colleagues on a morning rotation schedule.

Photo: WHO/W. Romeril

KEY PERFORMANCE INDICATORS FOR THE EBOLA RESPONSE IN SIERRA LEONE

Indicator	Source dates	Current status	% of planned/target
% of districts with laboratory services accessible within 24h	As of 04/01/15	100%	100%
% of ETC beds operational	As of 12/01/15	68% (1207 beds)	1783 beds
% of CCC beds operational	As of 07/01/14	36% (437 beds)	1208 beds
Capacity to Isolate	22/12/14 -11/01/15	Average: 6.4 beds per reported case (probable and confirmed) Median: 3.3 Range: 0 - 75	
Case fatality rate (%) among hospitalized patients	Cumulative (to 11/01/15)	60%	
% of burial teams trained and in place	As of 10/01/15	86% (92 teams)	107 teams
% of registered contacts to be traced who were reached daily	05/01/15 -11/01/15	84%	
# of newly infected national HCWs	05/01/15 -11/01/15	(0)	
% of districts with a list of identified key religious leaders or community groups who promote safe and dignified burials	As of 05/01/15	100%	

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GUINEA



SITUATION

Guinea is the epicentre of the ebola virus disease outbreak in West Africa. The first cases were detected in March 2014 in the Guinea Forest region in the south east of the country. As of 19 January 2015, there have been a total of 2,873 (confirmed, probable and suspected) cases and 1,879 deaths reported.

A national health emergency was declared on 13 August. Guinea is one of the poorest countries in the world, ranking 178/187 countries on the UNDP HDI Index. Preceding the EVD outbreak, the country had a low functioning healthcare system, poverty was endemic and malnutrition high, and the road infrastructure made many communities outside of the capital inaccessible.

The national trend in Guinea has been fluctuating since September 2014. At present, there is a discernible downward trend in the country and the epidemic continues to be concentrated in two main areas: (i) Conakry and adjacent prefectures (Coyah, Kindia, Dubreka, Forécariah) and (ii) the Forest Region prefectures (Macenta, Kissidougou, Nzérékoré, Kérouané, Guéckédou).

EBOLA TREATMENT CENTRE IN NZÉRÉKORÉ, GUINEA

Alliance for International Medical Action (ALIMA) has been running a 40-bed Ebola Treatment Centre in Nzérékoré, Guinea since November 2014. Patients with confirmed Ebola infection are now being offered the new anti-viral agent, favipiravir, as part of a multi-center clinical trial run by the French National Institute for Health (INSERM) in collaboration with the Guinean Ministry of Health. The UN Mission for Ebola Emergency Response (UNMEER) has donated two vehicles for use at the treatment centre.

An Ebola survivor and now child care provider at the Child Care Centre washes a child whose mother is being treated at ALIMA's Ebola Treatment Unit (ETU).

09 January 2015

Photo: UNMEER/Martine Perret

The month of December 2014 saw a 7.4% decrease in the number of reported cases compared to November. However, the total number of confirmed cases in December (496) still exceeded the total in the month of October (445). The total number of deaths in December stood at 297 compared to 333 in November. From 1 to 19 January 2015, 82 deaths and 101 confirmed cases were reported, tending to show a comparative decrease, with one ETU reporting no new cases in the last weeks.

While efforts to date have focused largely on medical interventions to contain the EVD outbreak, it seems increasingly clear that a great deal more needs to be done to address the secondary effects of the outbreak increasing access to food and improving communication with affected communities towards preventing social unrest. A key factor undermining the response in remaining affected areas is resistance by local communities in adopting prevention measures (e.g. referring ill persons to treatment centres, accepting contact tracing and safe burials). Also of concern during the first weeks of January 2015 was the occurrence of several security incidents whereby local community members targeted EVD responders and law enforcement personnel.

RESPONSE

In support of the Government's response plan, a number of partners are currently operating in Guinea. WHO is leading the surveillance activities in close collaboration with the CDC in support of the Ministry of Health, as well as strengthening data management and laboratory capacity with the Institut Pasteur Dakar and EU mobile lab. Five ETUs are now operating in Guinea, marking an increase in bed capacities. Two new ETCs have been opened to patients in January, one in Coyah with 50 beds (mixed Guinean, Cuban and AU team) and one for Ebola Responders with 10 beds (French Army Medical Service). MSF has taken the lead in the provision of treatment for EVD patients and is running two Ebola treatment centres – one in the capital, Conakry, and one in Guéckédou. IFRC is supporting the Guinean Red Cross efforts to conduct safe burials.

UNICEF is leading social mobilization activities while WFP will provide food to 352,000 people, run UNHAS flights to transport responders and supplies, and provide logistics and emergency telecommunications services. IOM is supporting the government to strengthen their EDV response coordination at the prefectural level as well as build capacity for local civil society to take over some the EDV preparedness and response activities.



Photo: UNMEER/Simon Ruf

KEY PERFORMANCE INDICATORS FOR THE EBOLA RESPONSE IN GUINEA

Indicator	Source dates	Current status	% of planned/target
% of districts with laboratory services accessible within 24h	As of 04/01/15	100%	100%
% of ETC beds operational	As of 12/01/15	38% (250 beds)	655 beds
% of CCC beds operational	As of 08/01/15	1 operational CTCOM (Siguri - 8 beds) with 62 planned	
Capacity to Isolate	22/12/14 - 11/01/15	Average: 3.2 beds per reported case (probable and confirmed) Median: 0 Range: 0 - 24	
Case fatality rate (%) among hospitalized patients	Cumulative (to 11/01/15)	57%	
% of burial teams trained and in place	As of 02/01/15	98% (61 teams)	62 teams
% of registered contacts to be traced who were reached daily	05/01/15 - 11/01/15	92%	
# of newly infected national HCWs	05/01/15 - 11/01/15	3 - Dubreka, 1 - Forecariah	
% of districts with a list of identified key religious leaders or community groups who promote safe and dignified burials	As of 05/01/15	71%	

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HOW TO ASSIST

UN Secretary-General's Ebola Response Multi-Partner Trust Fund

The UN Secretary-General's Ebola Response Multi-Partner Trust Fund (MPTF) was established in September 2014 to finance unfunded critical priorities of the Ebola response outlined in the September 2014 Overview of Needs and Requirements. The Ebola MPTF has mobilized \$142 million from 39 donors and has programmed \$130 million for programmes of UNMEER, WHO, WFP, UNICEF, UNDP, UNOPS, UNFPA, and ICAO. The Trust Fund has addressed critical gaps by funding activities ranging from logistical operations, to district surveillance and infection prevention and control, and to community mobilization and preparedness. The Fund has played a critical role in enhancing the coherence and efficiency of the overall UN response to the Ebola crisis. Further contributions are required in 2015 to finance response, preparedness and recovery actions. To learn about the Secretary-General's UN Ebola Trust Fund, please visit: <http://mptf.undp.org/ebola>

United Nations Foundation

This fund will enable individuals, corporations and civil society organizations seeking US tax deduction to support UN entities engaged in the Ebola outbreak response in West Africa.

Donate to UN Agencies and Partners Responding to the Ebola Crisis

- [Food and Agriculture Organization of the United Nations \(FAO\)](#)
- [International Federation of Red Cross and Red Crescent Societies \(IFRC\)](#)
- [International Medical Corps \(IMC\)](#)
- [International Rescue Committee \(IRC\)](#)
- [Médecins Sans Frontières \(MSF\)](#)
- [International Organization for Migration \(IOM\)](#)
- [Plan International](#)
- [Save the Children](#)
- [United Nations Children's Fund \(UNICEF\)](#)
- [United Nations Development Programme \(UNDP\)](#)
- [United Nations High Commissioner for Refugees \(UNHCR\)](#)
- [United Nations Office for the Coordination of Humanitarian Affairs \(OCHA\)](#)
- [United Nations Office of the High Commissioner for Human Rights \(OHCHR\)](#)
- [United Nations Population Fund \(UNFPA\)](#)
- [United Nations Entity for Gender Equality and the Empowerment of Women \(UN Women\)](#)
- [World Health Organization \(WHO\)](#)
- [World Food Programme \(WFP\)](#)

In addition to the list above, the UN is working with numerous non-governmental and civil society organizations in West Africa to address the crisis. Businesses are encouraged to continue supporting these efforts through new and existing partnerships. Find NGOs operating on the Ebola response through the following:

- [Interaction](#)
(<http://www.interaction.org/crisis-list/interaction-members-respond-ebola-crisis>)

Contribute to Ebola National Responders

For donors wishing to contribute towards response to the Ebola crisis bilaterally, the Governments of Guinea, Liberia and Sierra Leone welcome cash/in kind contributions.