Care for persons with Ebola and Infection Control in Guinea
MPTF OFFICE GENERIC FINALPROGRAMME NARRATIVE REPORT
REPORTING PERIOD: FROM *19 December 2014* TO 31 DECEMBER 2016

Programme Title & Project Number

- Programme Title: Care for persons with Ebola and Infection Control in Guinea
- Programme Number *(if applicable)* *# 23*
- MPTF Office Project Reference Number: *00093219*

Country, Locality(s), Priority Area(s) / Strategic Results

Country/Region: Guinea, Nzérékoré; Kankan; Kindia; Yomou; Dinguiraye; Madiana; Dalaba; Tougue; Fria

Priority area/ strategic results : 2 MCA3: Care for persons with Ebola and infection control

Participating Organization(s)

- Organizations that have received direct funding from the MPTF Office under this programme: UNICEF

Implementing Partners

National counterparts (government, private, NGOs & others) and other International Organizations: UN agencies (WHO, WFP, UNFPA) and NGOs (MSF, ALIMA); a technical steering committees comprise of WHO, MSF, ALIMA, UNMEER, Ministry of Health and the National Committee for the Ebola epidemic Response.

Programme/Project Cost (US$)

Total approved budget as per project document:
MPTF /JP Contribution:
US$9,813,619
- *by Agency (if applicable)*

Agency Contribution
- *by Agency (if applicable)*

Government Contribution *(if applicable)*

Other Contributions (donors) *(if applicable)*

TOTAL: US$9,813,619

Programme Duration

Overall Duration *(months)*
Start Date *(dd.mm.yyyy):19.12.2014*

Original End Date *(dd.mm.yyyy):* *31.12.2015*
Actual End date *(dd.mm.yyyy): 31.12.2016*

Have agency(ies) operationally closed the Programme in its(their) system? Yes ☐ No ■
Expected Financial Closure date: 31.12.2017

Programme Assessment/Review/Mid-Term Eval.

Evaluation Completed
☐ Yes ☐ No Date: *dd.mm.yyyy*
Evaluation Report - Attached
☐ Yes ☐ No Date: *dd.mm.yyyy*

Report Submitted By

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FINAL PROGRAMME REPORT FORMAT

EXECUTIVE SUMMARY

- In November 2014, UNICEF strategy emphasised a community approach to behaviour change and an immediate focus on containment of the epidemic in ways that do no harm. It defined a community-based response with two objectives: (i) to reduce transmission of Ebola through isolation and care of patients at appropriately staffed and resourced Community Care Centres (CTCOM) located at community level. (ii) To build trust with communities by mobilizing and empowering them as partners in the response to Ebola, including through the physical protection of affected children. The strategy also stressed the need to prioritize and scale up core programme areas with the clear potential to alter the course of the epidemic: (a) Social mobilization/community engagement; (b) CTCOM roll-out (with support from Health, WASH and Nutrition personnel), and (c) the associated elements of child care and protection.
- The CTComs were designed to provide 8 to 10 bed units in centres that were community-owned and run; offer the highest possible infection prevention and control measures, personal protection for family and staff; and serve as a focal point to enable safe burials and organize awareness-raising activities among communities.
- Out of the ten planned CTCom, UNICEF could deliver three functional as the other were either destroyed by the community of canceled by the government. Following to the shift in the response from CTCom to Rapid Isolation centers, UNICEF delivered six planned rapid isolation centers.
- Although the CTCom concept was welcomed and giving good results in Liberia and Sierra Leone, UNICEF faced community resistance as others partners reluctances (WHO and MSF) in implementing its CTCOM roll-out strategy.
- 449,553 women and 423,366 men benefitted from the three built and supported CTCom.

I. Purpose

- Overall, the Ebola outbreak has revealed the weaknesses of the health system, especially at the district and health facility levels. Unreliable surveillance systems, the lack of qualified personnel at the service delivery points, lack of skills and systems in place for effective triage of patients, and rapid identification and isolation of cases are among the main causes of propagation of the epidemic. At the start of the epidemic, no hospital and health centers had dedicated structures or systems in place for rapid identification and isolation of cases. This has contributed to a significant number of infections of patients and health care providers occurring within health care facilities in a short span of time. To address these deficiencies which leave the people of Guinea vulnerable to both Ebola and preventable diseases, and establish a strong and resilient health system, the National Committee for the Ebola Response had planned to place 33 twelve-bed isolation units within a number of hospitals and health centers across the country. The purpose is to strengthen the capacity of existing health structures for rapid identification and isolation of cases in case of an outbreak, quality case management and effective prevention and infection control.
- The Government requested that UNICEF take the lead in the creation of the isolation units. With the fund initially allocated, UNICEF had been able to establish six CTComs located in Kouremale, Friguiagbe, Kissidougou, Kouroussa, Bofossou and Koropara. In February 2015, the National Committee for the Ebola Response instructed UNICEF to stop the construction of the remaining four CTComs given that due to the epidemiological situation future CTComs may not be needed. Actually, in addition to the six completed, one CTCom constructed in Bossou was destroyed by the population yet after completion. In Banankoro, the construction was stopped while it was near completion following the request from the National Coordination. The remaining funds were used to the construction of requested seven isolation units within six health regions in Yomou; Dinguiraye; Madiana; Dalaba; Tougue; Fria.

II. Assessment of Programme Results

i) Narrative reporting on results:

- The Ebola outbreak has revealed the weaknesses of the health system, especially at the district and health facility levels. Unreliable surveillance systems, the lack of qualified personnel at the service delivery points, lack of skills and systems in place for effective triage of patients, and rapid identification and isolation of cases are among the main causes of propagation of the epidemic. At the start of the epidemic, no hospital and health centers had dedicated structures or systems in place for rapid identification and isolation of cases. This has contributed to a significant number of infections of patients and health care providers occurring within health care facilities in a short span of time. To address these deficiencies which leave the people of Guinea vulnerable to both Ebola and preventable diseases, and establish a strong and resilient health system, the National Committee for the Ebola Response had planned to place 33 twelve-bed isolation units within a number of hospitals and health centers across the country. The purpose is to strengthen the capacity of existing health structures for rapid identification and isolation of cases in case of an outbreak, quality case management and effective prevention and infection control.
- With the fund initially allocated, UNICEF request to seven CTComs located in Kouremale, Friguiagbe, Kissidougou, Kouroussa, Bofossou and Koropara. UNICEF delivered 3 functional CTCom. Actually, six CTCom were completed, but one CTCom constructed in Bossou was destroyed by the population yet after completion. In addition in Banankoro, the construction was stopped while it was near completion following the request from the National Coordination. Functional CTCom were technically and financially supported thanks to the provision of essential medicines and vaccines, safe drinking water and chlorine solutions, using mini water networks through boreholes with electric pump in seven prefectures. These centers have also benefited from the provision of essential supplies (NaDCC, HTH, soaps, etc.) and hardware (hand washing devices) to ensure the prevention and control of infections (IPC). In addition, hygienist teams were equipped, trained and empowered to ensure proper water treatment, preparation of chlorine solutions (at 0.5%) for the disinfection of equipment and personnel, and (0.05%) for hand washing. This team of hygienists was also trained to ensure the management of water supply systems, sanitation and management of infectious waste.
- In February 2015, the National Committee for the Ebola Response instructed UNICEF to stop the construction of the remaining four CTComs given that due to the epidemiological situation future CTComs may not be needed. The remaining funds were used to the construction of requested seven isolation units within six health regions in Yomou; Dinguiraye; Madiana; Dalaba; Tougue; Fria. They were delivered to the Ministry of Health in December 2016.
- WHO declared Guinea free of Ebola transmission on December 29, 2015, after the last Ebola patient in Guinea was discharged from an Ebola Treatment Unit on November 16, 2015. On March 17, 2016, a new case of Ebola was reported in Guinea, and related cases were subsequently identified in both Guinea and Liberia.

Qualitative assessment:

- The untested CTCom model was developed by WHO and partners in September and October 2014 as patient demand overwhelmed bed units available, and aimed to bring disease prevention and control capabilities to the community-level to complement more centralized Ebola treatment Units that provided patient care and treatment. The intentions was to establish decentralized hubs of disease information dissemination, detection, early isolation, supportive care and referral. Monitoring indicators required the CTCOMs to be established (built to specification) and functional (operated by standard operating procedures), then transformed into alternate care centers or decommissioned.
- Overall, UNICEF ‘established’ three functional CTCOMs, built three CTCOM that were not used by the government and communities and six rapid isolation centers in Guinea by December 2016

appropriately adapted to the changing epidemic which no longer required 33 CTCOMs as originally proposed. It is worthy to note that UNICEF faced in Guinea considerable resistance to CTCOMs from country actors.

- Indeed UNICEF delivered 79 'functional' CTCOMs across the three countries (Sierra Leone, Guinea and Liberia) by February 2015 as targeted, and then quickly reduced them to 15 by April 2015, when indicator targets were also removed. Consistently studies suggest the CTCOMs were an effective community-based mechanism for screening, triage and isolating Ebola suspects, while patients felt CTCOM care was of high quality and particularly appreciated that it was accessible and free. In Sierra Leone, communities and national leaders saw the CTCOMs as a positive and important measure, and implementing partners found they were managed well with support and technical training from UNICEF. In Liberia and Guinea, implementers reported difficulties in their establishment, management, and staffing; and partner coordination.

Pictures of the six completed rapid isolation centers

Works in Yomou

Works in Dinguiraye

Works in Mandiana

Works in Fria

Works in Dalaba

ii) Indicator Based Performance Assessment:

Using the **Programme Results Framework from the Project Document / AWPs** - provide details of the achievement of indicators at both the output and outcome level in the table below. Where it has not been possible to collect data on indicators, clear explanation should be given explaining why.

	Achieved Indicator Targets	**Reasons for Variance with Planned Target (if any)**	**Source of Verification**
Outcome 1[1] Persons affected with an infectious disease including Ebola that requires rapid isolation have access to Isolation Units located within the reference health structure serving their region or district **Indicator:** **Baseline:** **Planned Target:**			
Output 1.1 **Indicator 1.1.**1Number of CTCom functional **Baseline:** **Planned Target:**	3 CTCom functionnal	30% One CTCom constructed in Bossou was destroyed by the population yet after completion. In addition in 6 other planned CTCom, the construction was stopped while it was near completion following the request from the National Coordination	UNICEF reports
Indicator 1.1.2 Percentage of Isolation Units established with effective involvement of communities aligned with Global SOPs or according to norms established in the country **Baseline:** **Planned Target:**	6 Rapid isolation centers built	100%	UNICEF reports

[1] Note: Outcomes, outputs, indicators and targets should be **as outlines in the Project Document** so that you report on your **actual achievements against planned targets**. Add rows as required for Outcome 2, 3 etc.

Output 1.2 Number of Isolation Units with quality WASH services according to the national **Indicator 1.2.1** **Baseline:** **Planned Target:** **Indicator 1.2.2** **Baseline:** **Planned Target:**	6	100%	UNICEF reports

iii) Evaluation, Best Practices and Lessons Learned

- The CTCOMs were based on sound logic for addressing the growing spread of Ebola fueled by fear and mistrust. When the public health emergency of international was declared in August 2014, UNICEF actors recognized the need for community-based isolation and care, because of the risks associated with transporting suspected patients to distant Ebola treatment Units, and based on experience in the Democratic Republic of Congo of providing care closer to communities alongside prevention messages. However, many actors associated other risks with the CTCOMs, including MSF which opposed them and stakeholders who feared that poorly run CTCOMs would become death traps or 'warehousing for the dying'. By mid-2015 the CTCOMs were superseded by Rapid Isolation Treatment for Ebola better adapted to the changed epidemic and tackling hotspots and resurgences in remote areas. As one expert commented, 'the CTCOMs were right at the time and only wrong afterwards'.
- Nonetheless the CTCOMs became operational too late to substantially reduce transmission. The CTCOMs were functional in late December 2014 in Sierra Leone, in February in Guinea, and in March in Liberia, by which time the epidemic had subsided or moved to other communities. After the CTCOMs were designed and approved during August-September 2014, HQ actors attribute critical delays to long discussions to seek further approval from country response actors.

iv) A Specific Story (Optional)