EVALUATION REPORT

LEARNING-FOCUSED EVALUATION OF UNICEF'S LEVEL 2 EBOLA PREPAREDNESS AND RESPONSE IN UGANDA

FINAL REPORT

ESARO Evaluation
September 2023

unicef | for every child

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'Learning-Focused Evaluation of UNICEF's Level 2 Ebola Preparedness and Response in Uganda', submitted by the evaluation firm hera (right to health and development) to the Evaluation Section, UNICEF Eastern and Southern Africa Regional Office (ESARO).

The evaluation was conducted by Véronique De Clerck (Team Leader), Don Johnston and Jimmy Obol. The field work was supported by Ezra Anyala.

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Final Report

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ACKNOWLEGDEMENTS

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The report has been informed by the opinions and suggestions of various stakeholders; however, the evaluation team takes full responsibility for its contents.

ACRONYMS

AAP	Accountability to affected populations
AAR	After Action Review
AGD	Age, gender, and disability
AVSI	Association of Volunteers in International Service
CCCs	Core Commitments for Children
CE	Community engagement
CEAP	Corporate Emergency Activation Procedure
CFR	Case fatality rate
CoES	Continuity of Essential Services
CPD	Country Programme Document
CRA	Community Rapid Assessment
CSO	Civil society organisation
DDMC	District Disaster Management Committee
DEO	District Education Officer
DHT	District Health Team
DLG	District Local Government
DRC	The Democratic Republic of the Congo
DTF	District Task Force
EMOPS	Emergency Operations
EMT	Emergency Management Team
EPF	Emergency Programme Funds
ERG	Evaluation Reference Group
ESARO	Eastern and Southern Africa Regional Office
ETU	Ebola Treatment Unit
FGD	Focus group discussion
GBV	Gender-based violence
GBViE	Gender-based violence in emergencies
GoU	Government of Uganda
HAC	Humanitarian Action for Children
HDP nexus	Humanitarian–development–peace nexus
HQ	Headquarters
IASC	Inter-Agency Standing Committee
IDI	Infectious Disease Institute
IEC	Information, education, and communication
IHR	International Health Regulations
IMT	Incident Management Team
IOA	Integrated outbreak analytics
IYCF	Infant and young child feeding
IPC	Infection prevention and control
KCCA	Kampala City Council Authority

KII	Key informant interview
L2	Level 2
LFE	Learning-focused evaluation
LWF	Lutheran World Foundation
MDA	Mass Drug Administration
MHPSS	Mental health and psychosocial support
MoES	Ministry of Education and Sports
MoGLSD	Ministry of Gender, Labour, and Social Development
MoH	Ministry of Health
MSF	Médecins Sans Frontières
NTF	National Task Force
OECD-DAC	Organization for Economic Cooperation and Development – Development Assistance Committee
ORE	Other resources emergency
PHE	Public health emergency
PHEIC	Public health emergency of international concern
PHEOC	Public Health Emergency Operations Centre
PPE	Personal protective equipment
PSEA	Protection from sexual exploitation and abuse
RC	Risk communication
RCCE	Risk communication and community engagement
RUIF	Ready-to-use infant formula
SDB	Safe and dignified burial
SDGs	Sustainable Development Goals
SEA	Sexual exploitation and abuse
SIRI	Strategic information research and innovation
SOPs	Standard operating procedures
SVD	Sudan Virus Disease
ToC	Theory of change
UCO	Uganda Country Office
UNDIS	United Nations Disability Inclusion Strategy
UNEG	United Nations Evaluation Group
UNHCR	United Nations High Commissioner for Refugees
UNICEF	United Nations International Children's Emergency Fund
URCS	Uganda Red Cross Society
US-CDC	US Centres for Disease Control and Prevention
VfM	Value for money
VHF	Viral haemorrhagic fever
VHT	Village Health Team
WASH	Water, sanitation, and hygiene
WFP	World Food Programme
WHO	World Health Organization

EXECUTIVE SUMMARY

This report describes the results of the Learning-Focused Evaluation (LFE) of UNICEF's Level 2 (L2) Ebola Preparedness and Response in Uganda (hereafter referred to as the 'Ebola response'). The LFE was led and implemented by the external evaluation firm hera (right to health and development). As per the United Nations Children's Fund (UNICEF) Evaluation Policy, it was managed by UNICEF's Eastern and Southern Africa Regional Office (ESARO), in close collaboration with the UNICEF Uganda Country Office (UCO) and in line with the UNICEF terms of reference (see Annex 1). The evaluation was conducted from February to August 2023.

Background and context

Ebola is a severe, often fatal, illness in humans and non-human primates that is caused by a highly virulent virus. The Government of Uganda (GoU) declared an Ebola outbreak on 22 September 2022 (Sudan virus) and called for assistance from the country's partners to strengthen its preparedness and response capacity. Four months after the first case, the World Health Organization (WHO) declared the outbreak over (on 11 January 2023). In total, the outbreak caused 164 cases, 142 of which were confirmed and 22 of which were probable; there were 55 confirmed deaths. This was the eighth Ebola outbreak declared in Uganda, marking the country's fourth outbreak within a decade and its fifth outbreak of the Sudan virus strain of Ebola.

Object of the evaluation

UNICEF activated an L2 Corporate Emergency Activation Procedure (CEAP) Scale-up from 27 October 2022 to 26 April 2023 to respond to the Ebola outbreak in Uganda. The response was led by UNICEF's UCO, with support from ESARO and Headquarters (HQ). The primary goal of the L2 activation and the implementation of the L2 emergency procedures was to scale up UNICEF's response by providing access to Emergency Programme Funds (EPF), deploying additional personnel from the regional office and HQ, assisting to establish partnership initiatives, addressing supply chain requirements, continuing advocacy efforts, and mobilising resources. The UNICEF Ebola Response Appeal budget totalled US$18.3 million.

UNICEF's Ebola response focused on supporting seven specific Ebola response pillars aligned to GoU's Ebola response: Coordination, Leadership, and Partnership; Risk Communication and Community Engagement (RCCE); Surveillance and Contact Tracing; Water, Sanitation, and Hygiene (WASH); Case Management; Addressing the Indirect Impact of the Outbreak; and Logistics and Operational Support. UNICEF added mainstreaming gender-based violence (GBV) and protection from sexual exploitation and abuse (PSEA) as priorities.

Evaluation purpose, objectives, scope, and users

The LFE serves the dual purpose of promoting learning and accountability. The evaluation objectives were, first, to assess UNICEF's response to the Ebola outbreak in Uganda vis-à-vis issues of appropriateness/relevance, effectiveness, efficiency (including value for money (VfM)), coverage, connectedness, coordination, and partnerships; and, second, to draw out key learning and recommendations to equip UCO decision makers with the information they need to formulate UCO's transition from L2 emergency to long-term strategy, ensuring humanitarian–development–peace (HDP) nexus is in place and increasing preparedness for future public health emergencies (PHEs). The intended beneficiaries include UNICEF staff, national and subnational ministries, donors, communities, civil society organisations (CSOs), and other United Nations agencies. The evaluation scope encapsulated the L2 UNICEF Ebola preparedness and response between 20 September 2022 and 26

April 2023 across the Ebola affected districts. It assessed certain institutional, programmatic, and operational elements of the Ebola preparedness and response.

Evaluation design, methodology, sampling, limitations, and ethics

The evaluation was both summative and formative, and its design was realist-based and use-focused, and allowed for robust analysis. It employed both quantitative and qualitative methods and tools. The primary data collection included 101 key informant interviews (KIIs), 27 focus group discussions (FDGs), a Community Rapid Assessment (CRA) (sample size: 524), and validation and co-creation workshops. The CRA survey was a randomised population-based survey conducted by hera in partnership with Viamo. A robot call sent a series of questions via mobile phone and gathered information on respondents' knowledge, attitudes, and practices related to Ebola. Additionally, the team reviewed a variety of internal and external documents (369) as part of a secondary data analysis. Data sources were triangulated where possible to ensure robust evidence. The evaluation encountered a few limitations, and several mitigation measures were applied. The evaluation obtained ethical clearance from Lacor Hospital Institutional Research and Ethics Committee and adhered to the ethical principles of informed consent, voluntary participation, confidentiality, data protection, and 'do no harm.'

Conclusions

The conclusions set out below are based on the LFE's findings and have been colour ranked. Red indicates that there were significant issues, delays, or problems with the intervention. Amber (Yellow) signifies there were some concerns or risks that need attention. Green indicates that progress was as planned and there were no major concerns or risks.

Conclusion 1: UCO's in-country preparedness was not sufficiently relevant to an Ebola outbreak and it did not allow for an efficient transition to the Ebola response. UNICEF's 2021 Ebola Preparedness and Response Plan was incomplete, and insufficient funding dedicated to preparedness activities hindered the establishment of relevant partnerships, contingency plans, contingency budgets, and the procurement of essential Ebola supplies. The transition from preparedness to response was therefore challenging, and this was further hampered by UCO's lack of familiarity with the L2 emergency procedures and the small number of UCO staff with Ebola expertise. As the Ebola response progressed, UNICEF demonstrated relevant adaptiveness, improving its preparedness measures. It effectively mitigated some of these shortcomings by repurposing programme funds and resources, deploying ESARO and UCO programme staff. In parallel, efforts by ESARO to invest in regional preparedness across neighbouring countries demonstrated the importance of potential cross-border spread of Ebola. However, the limited funding available raised questions about the extent to which donors are committed to funding prevention efforts.

Conclusion 2: UNICEF's leadership and coordination were mostly effective in ensuring the response was coherent. UNICEF demonstrated commendable leadership and engagement in coordinating response activities at both national and subnational levels. UNICEF's active engagement and its leadership role in co-chairing the RCCE pillars, as well as the sub-pillars of WASH and Infection Prevention and Control (IPC), Mental Health and Psychosocial Support (MHPSS) and Continuity of Essential Services (CoES), confirmed UNICEF's comparative advantage in these pillars By fostering collaboration among various local responders, such as the District Task Forces (DTFs) and District Disaster Management Committees (DDMCs), UNICEF effectively aligned preparedness and response efforts with national strategic plans. Moreover, UNICEF enhanced the relevance of the response by expanding its reach and collaboration, including working with the Ministry of Gender, Labour, and Social Development (MoGLSD) and the Ministry of Education and Sports (MoES) to promote a more multi-sectoral response. In parallel, there were notable coordination challenges, albeit mostly at onset. Such

challenges included the multiple response plans, competing roles and overlap in mandates among United Nations agencies, the absence of a clear inter-agency coordination mechanism, and also the government's unusual split of risk communication (RC) from community engagement (CE). These issues resulted in gaps or delays in critical areas, such as safe and dignified burials (SDB), IPC, CE, and Ebola case management, and raised questions about such arrangements for larger and more extensive PHEs. At the same time, internal UNICEF coordination and support mechanisms involving UCO, ESARO, and HQ were highly regarded.

Conclusion 3: UNICEF's efforts had a significant and positive impact on affected populations. The evaluation revealed many commendable efforts with high levels of appropriateness and effectiveness in addressing key issues, contributing to early case detection and reducing transmission. UNICEF's RCCE activities led to behavioural change within communities through diverse mass media channels which communicated tailored and appropriate key messages. The strategic engagement of local responders and community influencers, and the implementation of Integrated Outbreak Analytics (IOA) and anthropological studies, leveraged transdisciplinary data, helping to improve outbreak decision-making. The integration of WASH/IPC across pillars, Ebola Treatment Units (ETUs), isolation centres, community structures, and communities filled critical response gaps and showcased effective strategies for future outbreaks, including the IPC Ring approach. The evaluation also identified that UNICEF successfully facilitated access to essential nutritional supplies in ETUs, and that the response exceeded its target for reaching children and affected populations accessing MHPSS. The integration of MHPSS and child protection in the Ebola response through innovative partnerships received praise, but these interventions also exposed the dire needs experienced by children and women. UNICEF's efforts on education were a best practice and ensured every child attended school and completed their final exams. Health continuity interventions ensured primary healthcare was maintained but the lockdown measure, a lack of transport, and fear of Ebola transmission reduced healthcare utilisation.

Conclusion 4: The L2 procedures were not sufficiently applied. The effectiveness of the response faced several challenges, including significant delays. The L2 response successfully mobilised a substantial US$7,949,919, strategically allocating funds toward RCCE, case management, and WASH/IPC, showcasing efficient resource utilisation and leveraging UNICEF's comparative advantage. With support from ESARO, UNICEF demonstrated proactive measures by repurposing programme funds, redeploying UCO staff, and initiating the response even before the L2 was activated. However, the evaluation also identified areas for potential improvement, including the timing of the L2 activation, which occurred 36 days after the declaration of the Ebola outbreak. Hesitancy about declaring an L2, compounded by unfamiliarity with the L2 protocols, contributed to delays. Challenges in regard to securing funding, gaps in human resources at the field level, a lack of contingency plans, procedural delays in partnerships, and limited supplies adversely affected efficiency, leading to diminished relevance in some cases.

Conclusion 5: UNICEF's approaches were child-centred and integrated women's needs and other vulnerabilities. UNICEF successfully integrated education, child protection, GBV/PSEA, and MHPSS into the national response, demonstrating the organisation's commitment to addressing multifaceted vulnerabilities. The active inclusion of children in decision-making processes demonstrated a commitment to promoting children's voices, while partnerships with child-focused organisations increased the child-friendliness of the response. UNICEF provided gender-disaggregated targets and results, employed gender-sensitive approaches, and prioritised GBV/PSEA. UNICEF also implemented interventions for persons with disabilities, but only in certain aspects of the response. While MHPSS services benefitted 16,359 children, the response did not address the long-term needs of orphans and survivors. Important missed opportunities included a lack of advocacy for better

paediatric treatment protocols and ensuring timely paediatric medical supplies. The response also had some unintended negative consequences, potentially increasing GBV cases during lockdowns and hindering access to GBV services. While the response identified other vulnerable groups, it is not certain to what extent assistance was provided to them, particularly for Ebola survivors. As a final observation, the evaluation noted a gender imbalance at UCO, with an overrepresentation of male employees.

Conclusion 6: The Ebola response showed linkage to UNICEF's development agenda but ongoing support to affected communities was lacking. There were clear linkages to UNICEF's development programming in support of the Sustainable Development Goals (SDGs). UNICEF supported policy development, invested in sustainable WASH/IPC infrastructures, and contributed to enhanced preparedness, bolstering Uganda's resilience to future PHEs. UNICEF's support for the Uganda National Post-Ebola Response Plan underscored its dedication to fostering continuity and resilience beyond the immediate Ebola response. However, UNICEF's exit from the response was perceived as sudden and there were concerns around sustainability as some of UNICEF's investments were not adequately maintained. Cash grants, to help transition communities out of a crisis, were not implemented. Direct support to Ebola survivors and affected children fell short. Supporting some HDP nexus principles, there are indications that UNICEF strengthened certain linkages, including through, joint country analysis, collaborative programming, building local capacities, and making risk-informed decisions.

Key lessons learned

The evaluation identified several lessons for future similar disease outbreaks. The main ones include the following:

- **Lesson learned 1:** Engaging a diverse spectrum of community influencers is a critical factor in attaining impactful social and behaviour change during Ebola outbreaks. The approach employed by UNICEF, wherein Village Health Teams (VHTs), traditional leaders, healers, local politicians, musicians, and even transport drivers were effectively mobilised, can serve as a successful model.
- **Lesson learned 2:** Developing an effective Ebola exit strategy requires establishing explicit connections that can sustain results, while integrating consistent support for vulnerabilities uncovered throughout the response. Notably, the UNICEF response identified a need for continued child protection, MHPSS, and GBV services, but also sustained support to Ebola survivors.
- **Lesson learned 3:** A proactive approach to reducing ambiguities in mandates between WHO and UNICEF can improve the coherence of a response. Benefits can be obtained by pre-emptively identifying specific interventions and delineating UNICEF's precise contributions within the context of PHEs.
- **Lesson learned 4:** Applying the UNICEF emergency procedures helps ensure rapid and agile emergency responses. This lesson serves as a reminder of the need to adapt development procedures to align with the agile and adaptive requirements of emergency situations.
- **Lesson learned 5:** Extra efforts to tackle external barriers are required to ensure continuity of essential services. This lesson underscores the need to address these barriers proactively in future emergency scenarios.

Recommendations

The evaluation proposes several recommendations, which have been co-created by the evaluation team and UNICEF. The recommendations have been formulated with the Evaluation Reference Group

(ERG) to guide responses to future Ebola outbreaks and similar PHEs in Uganda and beyond. The ERG did not include external stakeholders. These recommendations are based on the LFE findings, field evidence, stakeholders' input, and document review, and insights from the evaluators. To ensure alignment to UNICEF's ambitions in regard to PHEs, the evaluation has framed the recommendations around UNICEF's White Paper[1] and UNICEF's Evaluation of the L3 Response to COVID-19. The recommendations focus on six domains:

1. **Strengthen preparedness for PHEs**. Improve and make preparedness for PHEs more relevant in Uganda, and more broadly in UNICEF. Strengthen overall preparedness plans, ensuring sufficient and relevant supplies, disease-specific annexes of the preparedness plan and partnerships are in place, and ensure epidemic preparedness is a key element in the UNICEF global Health Sector Strategic Plans. Consider attaching performance indicators to PHE preparedness and learn from UNICEF's experiences in First Action Initiatives and the Co-Funding Initiatives.

2. **Better institutionalise L2/L3 procedures**. Improve familiarity with the L2/L3 emergency procedures and consider non-refundable and easily accessible EPF funding mechanisms, including to cover unforeseen costs. Consider standardising Ebola as an automatic L2 activation.

3. **Strengthen inter-agency coherence in PHEs, in line with the Inter-Agency Standing Committee (IASC) Standard Operating Procedures (SOPs) and Protocol for the Control of Infectious Disease Events**. Conduct annual joint assessments of in-country cross-pillar preparedness, with a focus on clarifying the global-level blueprint at national level, in collaboration with WHO and the GoU. Promote joint assessments and Ebola plans, develop a United Nations advocacy strategy to promote cash-based interventions during PHEs, and promote the idea of activating a United Nations coordination mechanism under WHO for Ebola. Improve longer-term inter-agency support to Ebola survivors.

4. **Continue placing children, women, and vulnerabilities at the centre of the PHE response.** Ensure responses for women, children and vulnerable groups at early onset of a disease outbreak including quality referral for GBV/PSEA, child protection, and strengthen and advocate for gender equality in the UCO employment, and with the GoU.

5. **Prepare for better data to drive evidence-based responses**. Provide ongoing support to the GoU on implementing the IOA initiative. Develop tailored tools to collect data on children, women, and vulnerability, and develop an Ebola research agenda specifically focused on children. Continue developing community feedback mechanisms and digitalising the VHT community surveillance.

6. **Keep advancing on the HDP nexus procedures**. Build awareness around One Health and the link between climate change and emerging diseases. Ensure more systematic engagement with the International Health Regulations (IHR 2005). Continue building on risk-informed and multi-year programming through multi-agency partnerships, and build the emergency response capacity of local CSOs. Start tackling the underlying causes of child protection risks and link this to humanitarian cash transfers.

[1] UNICEF (2023) 'White Paper: Putting the Best Interest of Children, Women and their Communities at the Center of Public Health Emergency Preparedness and Response'.

1 INTRODUCTION

This report describes the results of the LFE of UNICEF's L2 Ebola response. The LFE was led and implemented by independent consultants from the evaluation firm hera (right to health and development). As per the UNICEF Evaluation Policy, it was managed by ESARO, in close collaboration with UCO.

While the LFE serves the dual purpose of promoting learning and accountability, it puts a strong focus on drawing learned lessons that can inform future actions. The lessons aim to promote learning to support long-term planning post the L2 response to the Ebola emergency in Uganda, but also to identify preparedness interventions for potential future health emergencies, and to strengthen UNICEF's accountability to affected populations, partners, and donors supporting the response at large.

UNICEF's response to the Ebola emergency aimed to contribute to Ebola-related mortality and disease transmission by facilitating timely action on a no-regrets basis through establishing multi-sectoral inter-agency partnerships, collaboration with national and local governments, and a sustained presence by partners wherever possible. The LFE was conducted from February to August 2023.

The evaluation report consists of seven sections. After this introduction, the second section provides an overview of Ebola in its broader context, as well as in Uganda. The third section presents the objectives of the evaluation. The fourth section describes the evaluation purpose, objectives, scope, and users. The fifth section provides information about the design, approach, methods, limitations, and ethics. The sixth section describes the evaluation findings and analysis, a series of innovations and missed opportunities during the response, and lessons from the Ebola response. The seventh section presents the conclusions, lessons learned, and a set of recommendations. The annexes contain supporting data, documents, and evidence.

2 BACKGROUND AND CONTEXT

This section explores the context of Ebola disease within the field of global health, UNICEF's regular programming in Uganda, and UNICEF's multi-sectoral response to the latest Ebola outbreak in Uganda. It also provides a description of expected vulnerabilities in Ebola outbreaks, with a focus on women and children. This section has been informed by a document review of grey and academic literature.

2.1 The global Ebola context

Ebola is a severe, often fatal, illness in humans and non-human primates that is caused by a highly virulent virus known as Ebola virus, which belongs to the family *Filoviridae*. The virus was first discovered during two major outbreaks in South Sudan and the Democratic Republic of Congo (DRC) in 1976[i]. Subsequent Ebola outbreaks were reported in Uganda and the DRC in 1994 and 1995, respectively. Since then, frequent large outbreaks have occurred in Gabon, DRC, Uganda, Guinea, Liberia, Sierra Leone, and Nigeria[ii], with isolated outbreaks reported in South Africa, the US, the UK, and Italy. Six species of the genus Ebolavirus have been identified, these include the following: Zaire ebolavirus, Bundibugyo ebolavirus, Sudan Virus Disease, and Côte d'Ivoire ebolavirus, which cause disease in humans; Reston, which causes disease in non-human primates and pigs; and Bombali, for which there is no evidence of disease in humans, non-human primates, or other animals as yet[iii]. The majority of outbreaks in Africa have been associated with the Zaire, Bundibugyo, and Sudan species.

The Ebola outbreak that occurred in West Africa between August 2014 and June 2016 stands as the largest and most widespread outbreak of Ebola in history. Recognising its severity, the WHO declared

it a public health emergency of international concern (PHEIC)[iv]. This devastating outbreak resulted in over 28,000 reported cases and claimed the lives of more than 11,000 individuals[v]. It served as a stark reminder of the dire consequences that weak health systems can have for global health security, and highlighted the importance of investing in the development of health infrastructure in low- and middle-income countries[vi].

The failures observed during the 2014–2016 outbreak were significant, as actions taken by both national and international entities deviated from the established strategies that the international community had designed and implemented over the course of two decades to manage global health security threats[vii]. The outbreak, which spread across international borders (including through air travel), had a profound impact on global health. It raised important questions regarding the effectiveness of the implementation of the IHR of 2005, and spurred the development of the Global Health Security Agenda. This initiative aims to prevent, detect, and respond to infectious disease threats on a global scale, shaping the way the international community approaches such challenges[viii].

Ebola is listed in the IHR as a potential PHEIC[2]. Since the adoption of the revised IHR by WHO and 196 countries in 2005, there has been a shift in how governments, non-state actors, and WHO approach infectious disease threats[ix]. The new approach integrates public health and security thinking to effectively address these threats. The IHR (2005) emphasises that addressing infectious disease threats should not be limited to the purview of health officials alone but should also be prioritised in the agendas of political, economic, and diplomatic leaders[x]. It recognises that responses to infectious diseases such as Ebola have implications for the interests of all states. By linking public health and security considerations, the revised IHR encourages a comprehensive and collaborative response to infectious disease threats. It underscores the need for coordination, cooperation, and engagement across various sectors and stakeholders to effectively manage and mitigate the impact of diseases like Ebola.

Ebola is considered a re-emerging disease. While the Ebola virus was first identified in 1976, sporadic outbreaks occurred with increasing frequency in the decades that followed. Ebola epidemics also began to spread faster and further[xi]. The Ebola crossover to humans is influenced by factors like population growth, deforestation, and direct interaction with wildlife[xii].

> *'Epidemics of infectious diseases are occurring more often, and spreading faster and further than ever, in many different regions of the world. The emergence of large-scale epidemics (such as Ebola, SARS and, more recently, COVID-19), the re-emergence of old diseases (such as haemorrhagic dengue), and the persistence of epidemics of controllable diseases (such as measles, cholera, or malaria) have led national governments and global institutions to consider epidemics to be one of the most serious major public health emergency threats for the 21st century.'*
> **Source: 'Responding to Ebola epidemics, an ALNAP Lessons Paper', 2020.**

These transmissions between human and animal highlight the need for a 'One Health' approach that addresses human, animal, and environmental health together. One Health, as defined by WHO, seeks to optimise the health of people, animals, and ecosystems through integrated efforts across sectors and disciplines[xiii]. By mobilising multiple stakeholders and aligning with the SDGs[xiv], this approach promotes wellbeing and sustainability. In response to the Ebola outbreaks in West Africa, significant

[2] The decision to declare a PHIEC is made by the WHO DG, based on advice from the constituted IHR Emergency committee for Ebola. Conditions that do not require an IHR decision in order for a PHIEC to be declared are the following: a) polio caused by wild-type poliovirus; b) smallpox; c) SARS; and d) human influenza caused by a new subtype.

progress has been made in developing medical countermeasures[xv]. However, it is crucial to combine these advancements with comprehensive public health strategies, effective communication, modelling, and ecological/environmental approaches to effectively prevent and mitigate the impact of future emerging diseases like Ebola[xvi].

The natural reservoir host of Ebola remains unknown. However, based on evidence and understanding of the nature of similar viruses, researchers believe that the virus is animal born and that bats are the most likely reservoir. Sudan virus disease (SVD), one of the six species of the Ebola genus, is highly lethal, with case fatality rates (CFRs) ranging from 53% to 100%[xvii]. Gulu district in Northern Uganda experienced the largest outbreak caused by SVD prior to the West Africa Ebola outbreak, resulting in a CFR of 53%[xviii]. SVD spreads through direct contact with the blood, tissues, and bodily fluids of infected humans or animals. The virus can persist in certain areas of the body and fluids even after recovery and can last for an extended period, up to as much as five years[xix].

2.2 The Uganda Ebola outbreak

The Republic of Uganda, located in East Africa, is a landlocked country that is divided into four regions: Central, Western, Eastern, and Northern. These regions are further divided into 146 districts, with one of those districts being the capital city Kampala. Urban areas account for approximately 12% of the country's population, with the Central region housing the majority of the urban population[xxxxi], particularly in the city of Kampala. Uganda has a total population of approximately 48 million, including 8.2 million children below five years old and 18.7 million children below 15 years old[xxii]. The country has an estimated annual population growth rate of 2.7%. In terms of human development, Uganda ranks 162nd out of 189 countries on the Human Development Index. The country's expenditure on health represents 3.94% of gross domestic product[xxiii], while education expenditure is 2.7%[xxiv].

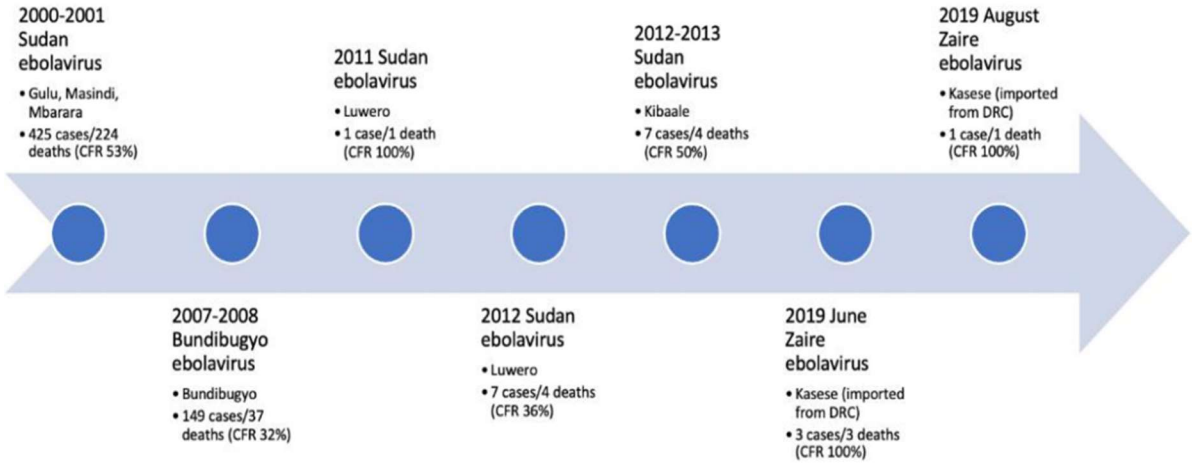
Uganda's encounter with Ebola disease has left a lasting impact on the country's public health landscape, highlighting the ongoing challenges in tackling Ebola and emphasising the need for continuous vigilance and preparedness. This is in a country context that is marked by multiple disease outbreaks and public health emergency events, such as cholera, yellow fever, meningitis, measles, rift valley, black water, malaria, and acute malnutrition during drought, which all claim more lives than Ebola because of the proportion of the population that are affected. However, with Ebola's high CFR, the impact can be devastating and so like all of the other disease outbreaks Ebola requires a dedicated response.

The first recorded Ebola outbreak in Uganda occurred in Gulu district in 2000 and resulted in 425 cases and 224 deaths (see Figure 1). Subsequently, another outbreak of the Ebola Bundibugyo virus took place in 2007 in Bundibugyo district, leading to 131 cases and 42 fatalities. Between 2011 and 2012, three smaller outbreaks of the SVD occurred. In 2018, an outbreak of the Zaire ebolavirus was reported, resulting in four cases and a 100% CFR. These incidents demonstrate the ongoing threat posed by Ebola in Uganda, emphasising the critical need to maintain preparedness measures and efficient response capabilities.

The economic ramifications associated with Ebola are well-documented and are primarily attributable to the imposition of public health and social measures, and a contraction in economic activity, ultimately leading to a loss of livelihoods, diminished productivity, and compromised economic growth[xxv]. Challenges encountered in any of these domains can present significant obstacles to the government's response efforts at both the national and district levels. The effectiveness of the GoU Ebola response hinges upon several key factors, including the attainment of economic and political stability, the capacity to govern efficiently, the robustness of healthcare infrastructure, the availability of economic resources,

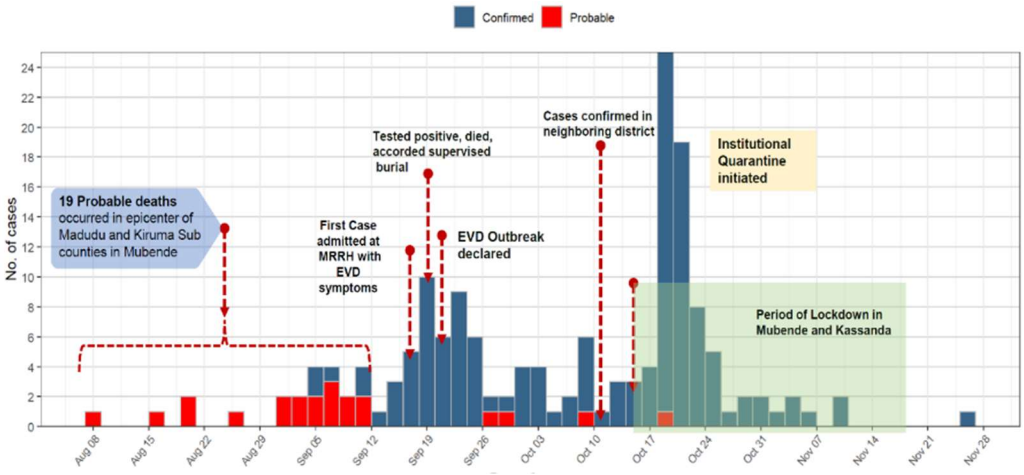
the level of public health awareness, and the active engagement of communities. Furthermore, the GoU's ability to coordinate a comprehensive and multifaceted response, while prioritising various components, remains instrumental in navigating the complex landscape of Ebola prevention, preparedness, and control.

Figure 1. Uganda Ebola outbreaks and CFR (Source: Ministry of Health (MoH) of Uganda)



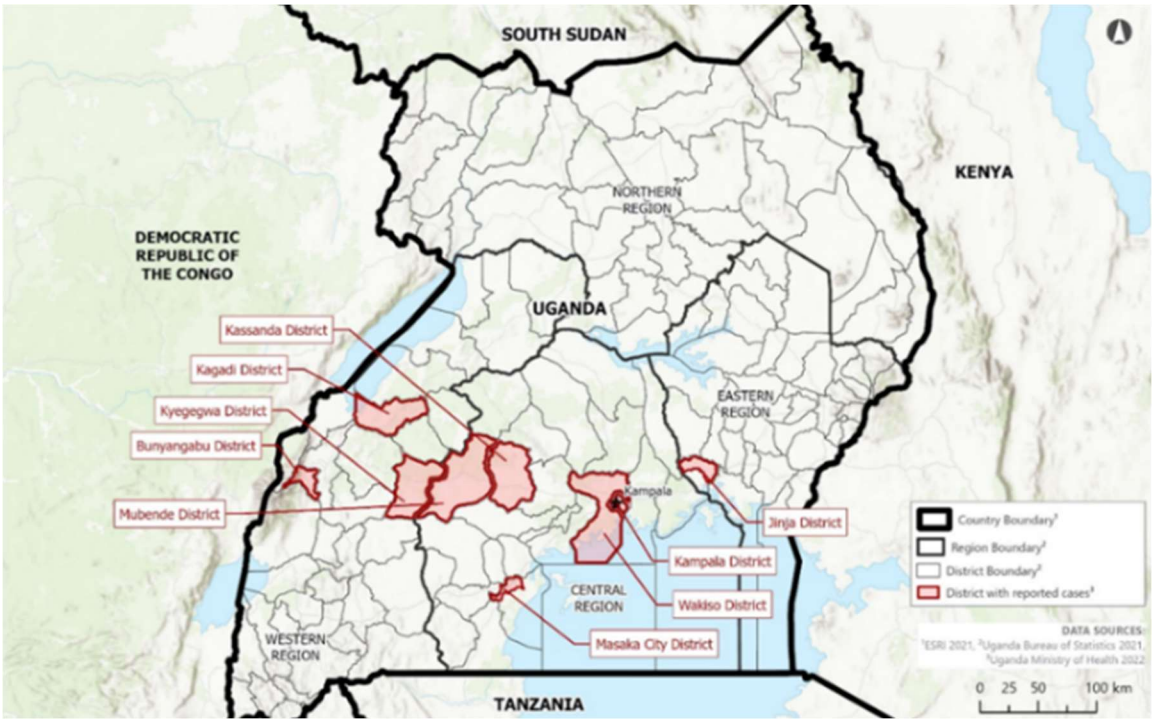
On 20 September 2022, Uganda recorded a confirmed case of the SVD in Ngabano Village in Madudu sub-county, Mubende district. Prior to this, in August, two sub-counties (Kiruma and Madudu) reported a cluster of six unexplained deaths, which were subsequently classified as probable cases of SVD (refer to Figure 2). Initial cases were subsequently identified through private clinics. The outbreak's epicentre was in Mubende district, which closely borders the neighbouring district of Kassanda, situated approximately three hours away from the capital city of Kampala and other densely populated regional towns. This proximity, and factors such as exposure during burials, family interactions, and interdistrict population movements, contributed to the transmission of the virus to neighbouring districts, including the capital city. By 8 December 2022, a total of 142 cases, including 55 deaths, were reported across nine affected districts: Mubende, Kassanda, Kyegegwa, Bunyangabu, Kagadi, Kampala, Wakiso, Masaka, and Jinja[xxvi] (see Figure 3). In addition, the lack of approved vaccines and therapeutics for SVD represented an additional challenge in curbing the outbreak.

Figure 2. Evolution of 2022 Ebola outbreak, Uganda, August–November 2022 (Source: Uganda MoH)



Subsequent to the declaration of the Ebola outbreak, MoH in Uganda formulated a comprehensive National Ebola Response Plan[xxvii]. To facilitate the coordinated implementation of activities, Uganda's National Task Force (NTF) started holding dedicated Ebola coordination meetings, applying an Incident Management Team (IMT) structure and using the Public Health Emergency Operations Centre (PHEOC) to facilitate the coordination. Before Ebola, the DTFs had last been activated for COVID-19. The DTFs also received Incident Managers from the national level to facilitate high-level coordination for the outbreak response.

Figure 3. Map of Uganda (Source: GoU)



Additionally, various structures were established to ensure effective management of the outbreak, including the IMT, response pillar leadership, DTFs, and District Health Management Teams, which were either led by local authorities or partner organisations. The response plan encompassed nine operational pillars and involved the categorisation of districts based on their level of risk. It spanned a period of three months from October to December 2022, with a primary focus on high-risk districts. However, the GoU encountered challenges in terms of funding, supplies, and capacity, necessitating the call for partners to contribute to the required budget of US$20,550,322[xxviii].

MoH took the lead in coordinating the response, receiving support from 56 partners, with WHO as co-lead. These partners included national NGOs, international NGOs, United Nations agencies such as WHO, the United Nations High Commissioner for Refugees (UNHCR), the World Food Programme (WFP), and the International Organization for Migration, as well as donors, academic institutions, and the private sector. Importantly, other crucial partners in the response included local leaders, religious leaders, traditional healers and witchcraft practitioners, transport drivers, village volunteers, and security forces. Following the COVID-19 outbreak, several important community structures were established, and these continued to be used for Ebola. These included village and parish task forces, VHTs, and village hygienists[xxix]. The VHTs are the formal community health workers in Uganda and

they provide both preventive and community curative care. They have historically been involved in outbreak response.

In response to the spread of Ebola to Kyegegwa, Kagadi, and Bunyangabu districts, and the reluctance of certain populations to comply with containment measures[3], on 15 October 2022 the GoU implemented a 42-day lockdown, movement restrictions, and a two-week curfew. While such measures are considered a public health measure to contain transmission, it is important to recognise that they may adversely affect the ability of already vulnerable populations to sustain their livelihoods[xxx]. Furthermore, the risk of intra-national and international cross-border transmission poses significant concerns in regard local and global safety, biosecurity, and trade. There were concerns regarding Ebola's potential transmission beyond Uganda's borders, facilitated by the movement of individuals, for trade and other purposes. Further, it is worth mentioning that the Ebola outbreak occurred two and a half years after the prolonged COVID-19 pandemic, which had severely strained all pillars of the health system and impacted negatively on the socio-economic situation of the country As a result, the population exhibited apathy, and healthcare workers experienced burnout.

On 11 January 2023, four months after the first case, MoH, supported by WHO, declared the outbreak over[xxxi]. In total, during the outbreak there were 164 cases (142 confirmed and 22 probable), 55 confirmed deaths, and 87 recovered patients. This includes 19 infected health workers, including seven deaths. There were a total of 1,496 suspected cases and 4,973 people were identified as contacts. The distribution by gender shows that males were disproportionally more affected in terms of both caseload (57.9%, n=164) and deaths (55%, n=55), compared to females. The overall CFR was 39%[xxxii]. This was the eighth Ebola outbreak to be declared in Uganda, marking the country's fourth outbreak within a decade and its fifth outbreak of SVD (refer to Figure 1).

2.3 Children, women, and vulnerabilities

The breakdown of 2022/23 Ebola cases by age highlights the significant impact of the disease on children under 15 years of age. Data reveals that children under 15 years old, under five years old, and under one year old constituted 20%, 7%, and 1% of the total caseload, respectively. Among the 37 children infected with Ebola, the CFR was 60%, which is significantly higher than the CFR in the general population (39%). Before the official declaration of the Ebola outbreak, there were 11 probable/suspected cases among children, all of whom died[xxxiii]. Children, especially those under five years old, are more vulnerable to severe illness and death from infectious diseases, due to their weaker immune systems. The higher proportion of the 2022/23 Ebola cases among children under 15 years old suggests that they may be more exposed to the virus, due to factors like close contact with family members and animals, and inadequate preventive measures at the household level[xxxiv] [xxxv]. Moreover, children, along with their mothers, may face a greater risk of Ebola transmission as they seek healthcare for common febrile illnesses like malaria, and nosocomial transmission can occur on paediatric and maternity wards[xxxvi]. Traditional care-giving – particularly among females – and visiting traditional healers for febrile illnesses may also contribute to nosocomial Ebola infections in children[xxxvii] [xxxviii].

Furthermore, diagnosing Ebola in small children is difficult due to their vulnerability to multiple childhood infections, non-specific clinical manifestations of the disease, and the fact that Ebola initially mimics malaria and other febrile illness. Cumulatively, these factors lead to delayed diagnosis and multiple consultations at private, public, and non-biomedical (traditional/spiritual) facilities. This results in delayed treatment and/ or potential missed cases. Besides the severe physiological impact of the

[3] There were reported incidents of hijacking dead bodies, of people moving from district to district (including travelling to Kampala City), and cultural practices such as consulting traditional healers and witchcraft.

disease, it has psychological and social impacts on children, including isolation and loss of parents, which can have lasting effects. Orphaned children are particularly vulnerable to stigmatisation, isolation, and exploitation[xxxix]. A recent WHO report has made it clear that a multifaceted approach to protect children in Ebola outbreaks is necessary, and that resources should be put in place for long-term support programmes to help affected communities[xl].

While the disaggregation of Ebola cases by gender shows that males were disproportionally affected (57.9%) (not uncommon in the initial phases of Ebola or epidemics, as a result of work-related exposure), women, in their roles as primary caregivers and clinicians (women dominate the nursing cadres), faced an increased risk of contracting the virus while assisting infected individuals. Women's role in performing traditional burial practices[xli], and inequitable power relations, both place women in vulnerable positions in terms of being exposed to the Ebola virus.[xlii]. Ebola outbreaks can further hinder access to care for pregnant women due to closed health facilities, overwhelmed healthcare staff, fear of transmission, and stigma. Ebola-infected pregnant women also experience high rates of miscarriage. Also, the survival rates for Ebola-infected newborns[xliii] is very low.

In parallel, GBV, including sexual exploitation and abuse (SEA), remains a significant challenge in Uganda in general[xliv], with approximately 22% of women aged 15–49 reporting experiencing physical violence and 14% reporting experiencing sexual violence at some point in their lives[xlv]. Furthermore, the disproportionate and exacerbating impact of crises on violence and gender has been well-documented. This highlights that Ebola interventions need to look beyond just Ebola itself, as the situation for vulnerable populations – particularly women and children – will remain challenging even after the containment of the Ebola outbreak.

Ebola's impact on persons with disabilities is not well-documented in the literature. Indeed, it is often the most marginal and vulnerable groups who are systematically ignored by, and not reached by, biomedical interventions, including those relating to Ebola[xlvi]. In alignment with the World Humanitarian Summit and the SDGs, the aid sector, including UNICEF, has pledged to 'leave no one behind' and aims to address the health needs of marginalised and highly vulnerable populations, including persons with disabilities[xlvii]. The LFE paid particular attention to the integration of persons with disabilities and people with other vulnerabilities in the response; it found that assistance to them was integrated throughout the Ebola response and recovery phase.

Multiple disease outbreaks in Uganda, including Ebola, are linked to inadequate access to clean water and sanitation. In Uganda, 48.1% of healthcare facilities have limited water services, and 57.4% have limited hand hygiene services[xlviii]. These are critical issues to address to curb future outbreaks.

Travel restrictions and lockdowns have been known to exacerbate existing vulnerabilities, in particular those of women, girls, and children. [xlix, l] For example, decreased utilisation of health services can result in plummeting immunisation rates, while faltering use of maternal and perinatal services may increase premature deaths[li]. The impacts on the mental health of children and women have also been convincingly established, with lockdowns associated with surges in depression, anxiety, and low levels of life satisfaction. Vulnerability may also be exacerbated by disrupted livelihoods, leading to increased levels of poverty[lii].

3 OBJECT OF THE EVALUATION

This section describes UNICEF, which was the object of the LFE, both through its development programming and through its emergency L2 response to the Ebola outbreak in Uganda.

3.1 UNICEF and PHEs

In its 2023 White Paper for PHE Preparedness and Response, UNICEF articulates its core commitments to children, together with nine essential recommendations in relation to PHEs in preparedness and response[liii]. Working alongside governments, communities, and partners, UNICEF seeks to safeguard the rights of children and women before, during, and after PHEs. More specifically, UNICEF seeks: 1) to ensure that the rights and needs of children are at the centre of all efforts: 2) to leverage the agency's recognised expertise in multi-sectoral preventive approaches to prevent and control outbreaks; and 3) to prevent and mitigate the humanitarian and socio-economic consequences of PHEs on communities with a whole-of-society focus. These commitments and recommendations are informed by lessons learned from the COVID-19 pandemic response and other PHEs and complement the Core Commitments to Children in Humanitarian Action[liv], the UNICEF Strategic Plan 2022–2026[lv], and UNICEF's Guiding Principles[lvi].

UNICEF WHITE PAPER FOR PHE RECOMMENDATIONS

1. Prioritise and invest in robust primary healthcare systems
2. Ensure WASH services for all
3. Invest in strong immunisation systems to reach the most marginalised
4. Strengthen the capacities of first responders
5. Ensure that no child misses out on their education
6. Foster social cohesion and build trust through social protection systems
7. Strengthen systems to care for and protect the most vulnerable children
8. Invest in informed and better decision-making through data systems
9. Make life-saving countermeasures universally accessible, relevant, and acceptable to all

3.2 UNICEF in Uganda

The UNICEF Uganda Country Programme Document (CPD)[lvii] for 2021–2025 outlines a comprehensive five-year framework that serves as a multi-sectoral roadmap for protecting and improving the situation of children and adolescents in Uganda[lviii]. The plan has been developed collaboratively (with the GoU and partners) and contributes to continued progress towards several SDGs. The CPD prioritises the following: education; child protection; social protection; health; reproductive, maternal, newborn, child, and adolescent health; HIV/AIDS; nutrition; and WASH. It also lists cross-sectoral themes, including early childhood development, adolescent development, social and behaviour change, and advocacy. The CPD further seeks to accelerate change for the most deprived children through a focus-district strategy targeting districts with the highest numbers and rates of child deprivation or with high vulnerability to external shocks, including disease outbreaks.

In addition to UCO's development work, the organisation engages in humanitarian interventions, including supporting refugees and contributing to emergency preparedness and response, such as disease outbreaks, climate-induced droughts, and floods. The humanitarian response is carried out in partnership with organisations like UNHCR, and aligns with the Uganda Comprehensive Refugee Response Framework[lix], the commitments of the Grand Bargain[4], and the current CPD, with a focus on strengthening district-level systems. UCO supports district actors in integrating humanitarian preparedness and response into their annual and midterm plans. Following the COVID-19 pandemic, UCO launched humanitarian appeals – Humanitarian Action for Children (HAC) – in 2022[lx] and 2023[lxi], with a total requirement of US$25 million and US$43 million respectively, aiming to assist 1.2 million children in 2022 and 1.9 million children in 2023. Through its humanitarian action, the organisation

[4] The Grand Bargain is a commitment made by major humanitarian donors and organisations to improve humanitarian action through enhancing collaboration, transparency, and accountability by promoting reforms in areas such as localising aid, reducing duplication, and increasing the flexibility and quality of funding.

focuses on building resilient health systems by strengthening the government's response and training health workers on innovative approaches to community-based care provision during crises. UNICEF played a significant role in the COVID-19 response by establishing a school disease surveillance system, facilitating COVID-19 vaccine deployment, and installing oxygen production plants in regional referral hospitals. During previous Ebola outbreaks, the UCO collaborated with GoU and WHO on response planning, outbreak analytics, and social and behaviour change communication.

3.3 UNICEF's Ebola response

After the declaration of the Ebola outbreak, UNICEF activated an L2 CEAP Scale-up[5] from 27 October 2022 to 26 April 2023. The primary goal of the L2 activation and the implementation of the L2 emergency procedures[lxii] was to scale up UNICEF's response by providing access to EPF, deploying additional personnel from the regional office and HQ, assisting with partnership initiatives, addressing supply chain requirements, continuing advocacy efforts, and mobilising resources. The UNICEF response plan required a total commitment of US$18.3 million.

Shortly after the GoU's declaration of the Ebola epidemic, UCO updated the Ebola Response Plan[lxiii]. The plan covered the period from October 2022 to March 2023 and was aligned with the Uganda National Response Plan, the WHO Ebola Global Strategic Response Plan[lxiv], and UNICEF's HAC. It assumed Scenario 2[6] of the Uganda National Response Plan and initially targeted 20 high-risk districts. The plan was informed by lessons learned from previous Ebola outbreaks. UNICEF's Ebola Response Plan aimed to facilitate timely action on a no-regrets basis through establishing multi-sectoral inter-agency partnerships, collaboration with national and local governments, and sustained presence by partners wherever possible.

The specific objectives of the UNICEF Ebola Response Plan were as follows:

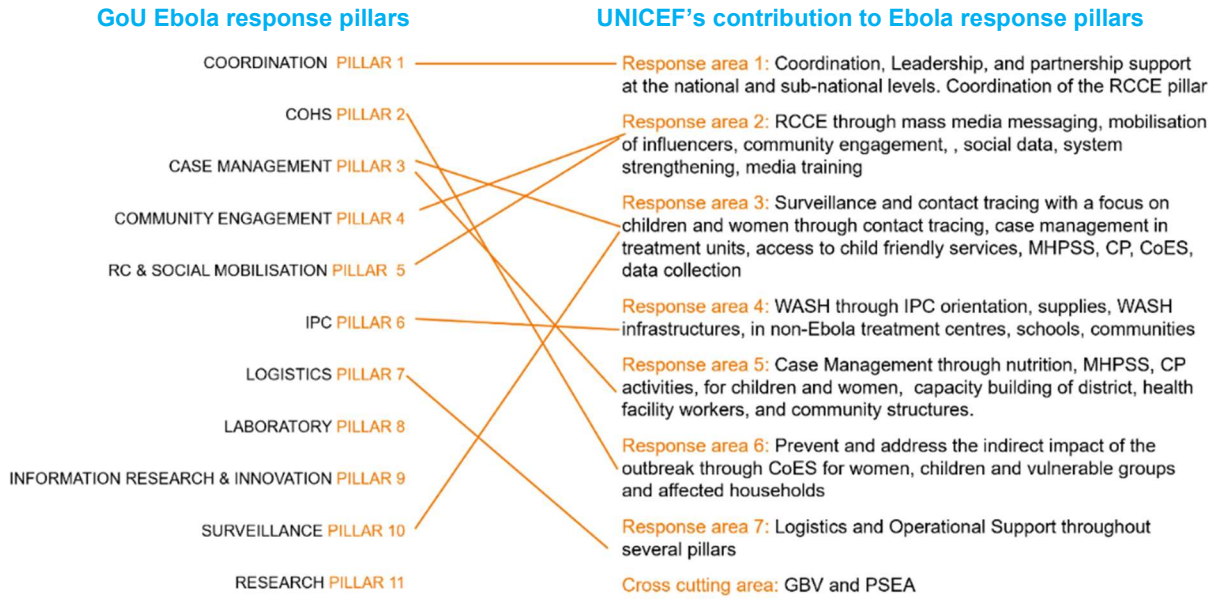
- **Strengthen multi-sectoral national and subnational coordination** by participating in the national and district taskforces, United Nations Coordination, the Steering Committee, and other forums.
- **Increase public awareness** of the threat of Ebola and galvanise community action for prevention, timely reporting, and early treatment-seeking, and to reduce the impact on children.
- **Support Ebola case management**, ensuring that there is appropriate management, including feeding for infants and young children, psychosocial support, and child protection in outbreak-affected and high-risk districts.
- **WASH**: ensure WASH in ETUs, and apply a Ring approach around cases, to prevent transmission.
- **Prevent and address the indirect impact** of the outbreak and minimise the negative human and socio-economic impacts.
- **Use IOA** to better understand outbreak dynamics and inform response adaptation to be more accountable and effective, based on evidence.
- Ensure that **GBV and PSEA** risk mitigation is mainstreamed throughout the response.

To achieve the intended objectives, UNICEF's Ebola Response Plan focused on seven response areas: Coordination, Leadership, and Partnership; RCCE; Surveillance and Contact Tracing; WASH; Case Management; Addressing the Indirect Impact of the Outbreak; and Logistics and Operational Support.

[5] The UNICEF L2 emergency response provides country offices with the capacity to scale up emergency interventions through additional support from other parts of the organisation (HQ, the regional office, and other country offices). The Regional Director provides leadership, and regional office support is enhanced.
[6] Scenario 2: Delayed detection of cases, with the outbreak spreading beyond the epicentre to other districts. The response runs for six to nine months.

UNICEF also prioritised mainstreaming GBV and PSEA. However, the delineation of response pillars, between UNICEF and the GoU, in the Ebola response, was not straightforward, as is shown in Figure 4. The GoU Response Plan was based on the WHO medical pillars, which, while valuable, do not include child-focused, public health systems priorities, as are outlined in the UNICEF White Paper.

Figure 4. UNICEF's response areas and their alignment with GoU response pillars (Source: Developed by the evaluation team based on the GoU's National Ebola Response Plan and the UNICEF Ebola preparedness and response plans)



The UNICEF Ebola Response Plan did not refer to human rights or gender equality specifically. However, in regard to the RCCE response pillar and CoES, there is explicit reference to protecting and reinforcing the capacity of vulnerable populations, including women and youth groups, health workers, refugees, children, and school-going children, as well as households directly affected by Ebola and Ebola-related stigma (Ebola cases, those in isolation, Ebola contacts).

Supporting the GoU in the Ebola response, UNICEF responded under a coordinated structure (with other United Nations agencies and partners) through direct implementation and through implementing partners such as the Association of Volunteers in International Service (AVSI), Lutheran World Federation (LWF), Save the Children, World Vision, and the Ugandan Red Cross. At national and subnational levels, UNICEF supported MoH, MoES, and MoGLSD. In parallel, it collaborated within the GoU emergency response systems, including the NTF and the IMT, including at subnational levels. Further, at the subnational level, UNICEF supported local responders, including district and village authorities, health teams, task forces, hygiene teams, burial teams, and teachers. As rights holders, the communities themselves, and in particular the local leaders (religious, cultural, and traditional healers), were central in the response, both in receiving assistance and contributing to the assistance.

In addition, UNICEF developed a Post-Ebola Response Plan covering the period from January 2023 to July 2023[lxv]. This plan was aligned with the Uganda National Post-Ebola Recovery Plan[lxvi] and covered a period of 180 days (five months) from February to June 2023. The national plan focused on the same seven response areas as the UNICEF Ebola Response Plan and called for a total budget of US$1,570,000.

3.4 Theory of change

A theory of change (ToC) was not produced as part of the Uganda Ebola L2 programme documents. This is not a requirement in emergency response (according to the UNICEF Core Commitments for Children (CCCs) for PHEs and any other standard emergency response criteria). However, the evaluation team retrospectively developed a ToC that outlines the logic underlying how and why desired changes were expected to occur as a result of UCO's Ebola response activities (see Table 1). This ToC was constructed based on UNICEF guidelines and in collaboration with UCO. The ToC includes a goal, impact statements, outcomes, output interventions, a problem statement, and cross-cutting interventions. The ToC outlines the logical framework needed to assess the effectiveness of the Ebola response. The outputs align with activity indicators in UNICEF's Ebola response monitoring system (see Annex 12). The outcomes are derived from the seven response areas outlined in UNICEF's Ebola Response Plan[lxvii].

The theory behind the UNICEF Ebola response is as follows:

- **IF** the severity of the Ebola outbreak exceeds the existing response capacities of the UCO,
- **AND** UNICEF activates a CEAP L2 emergency, triggering the establishment of the emergency cell and coordination mechanisms, the deployment of staff and supplies, and access to additional financial resources,
- **AND** UNICEF contributes to the Ebola response pillars, by proactively coordinating [THE RESPONSE PILLARS AND SUB-PILLARS], funding [GOVERNMENT AND PARTNERS], supporting [GOVERNMENT, PARTNERS, AND POPULATION] and implementing [EIGHT RESPONSE AREAS] under the National Ebola Response Programme, while upholding UNICEF CCCs and adhering to L2 MECHANISM PROCEDURES],
- **THEN** UNICEF's efforts will contribute to the national Ebola preparedness and response plan to reduce the increased needs of the affected populations in the relevant districts, save lives, and halt Ebola epidemic transmission.

The assumptions underlying the ToC are as follows:

- The required financing, supplies, and human resources are available.
- The required cooperation between the GoU and local and international partners is in place.
- An adequate number of qualified implementing partners are available.
- The affected communities collaborate and adopt social behavioural change to reduce transmission.
- The UCO receives sufficient technical, financial, and other resources from the regional office and HQ.

Table 1. ToC

GOAL	**TO CONTRIBUTE TO THE GOVERNMENT OF UGANDA'S EFFORTS TO REDUCE EBOLA-RELATED MORBIDITY AND MORTALITY, INTERRUPT TRANSMISSION AND MINIMIZE IMPACT**						
IMPACT	**COORDINATION & LEADERSHIP**	**RISK COMMUNICATION SOCIAL MOBILIZATION COMMUNITY ENGAGEMENT**	**COMMUNITY SURVEILLANCE & OUTBREAK ANALYTICS**	**WASH & IPC**	**CASE MANAGEMENT**	**PREVENT AND ADDRESS INDIRECT IMPACT OF THE OUTBREAK**	**LOGISTICS & OPERATIONAL SUPPORT**
OUTCOMES	MULTI-SECTORAL NATIONAL AND SUB-NATIONAL **COORDINATION** IS STRENGTHENED	RISK PERCEPTION AND PUBLIC **AWARENESS** OF THE THREAT OF EBOLA IS INCREASED AND COMMUNITY IS GALVANIZED INTO ACTION FOR PREVENTION, TIMELY REPORTING AND EARLY TREATMENT SEEKING	**EARLY DETECTION** OF POTENTIAL SVD CASES AND IDENTIFICATION AND REPORTING OF INDIVIDUALS WHO MAY HAVE BEEN EXPOSED TO THE VIRUS	APPROPRIATE SANITATION, HYGIENE AND INFECTION PREVENTION CONTROL MEASURES ARE **ESTABLISHED**, INTERRUPTING CHAIN OF TRANSMISSION IN HCF, SCHOOLS AND COMMUNITIES	INFANTS AND YOUNG CHILDREN RECEIVE **CHILD FRIENDLY CARE** INCLUDING CLINICAL, NUTRITIONAL, PROTECTION AND MHPSS	INDIRECT AND NEGATIVE HUMAN, HEALTH, EDUCATION, SOCIO-ECONOMIC, AND OTHER IMPACTS OF THE OUTBREAK ARE **MINIMIZED**	EBOLA RESPONSE OPERATIONS **PROCEED** SMOOTHLY AND BASIC EBOLA SUPPLIES ARE AVAILABLE
	RESPONSE AREA 1	**RESPONSE AREA 2**	**RESPONSE AREA 3**	**RESPONSE AREA 4**	**RESPONSE AREA 5**	**RESPONSE AREA 6**	**RESPONSE AREA 7**
OUTPUTS	• SUPPORTING & PARTICIPATION IN NATIONAL AND DISTRICT TASK FORCES, UN COORDINATION FORUMS, THE STEERING COMMITTEE AND OTHER FORUMS • PARTICIPATE IN PERIODIC NATIONAL RISK ASSESSMENT TO INFORM RESPONSE, READINESS AND PREPAREDNESS • SUPPORT SIRI PILLAR TO CONDUCT IOA • JOIN AND SUPPORT RAPID RESPONSE TEAMS • CONTRIBUTE TO JOINT PLANNING AND RESOURCE MOBILIZATION • PARTICIPATE AND COORDINATE INTERNALLY AS UNICEF TO BUILD CONSENCUS • ADVOCATE FOR MULTI-SECTOR & INCLUSIVE COORDINATION ACTION	• MASS MEDIA MESSAGING • ACTIVE COMMUNITY MOBILISATION/ENGAGEMENT WITH COMMUNITIES • MOBILIZATION OF KEY INFLUENCERS • INTERPERSONAL COMMUNICATION SKILLS TRAINING AND EQUIPMENT WITH COMMUNICATION TOOLS • CE WITH SOCIAL DATA/SOCIAL LISTENING • SYSTEMS STRENGTHENING COMMUNITY FEEDBACK MECHANISMS • MEDIA TRAINING • PRIVATE SECTOR & COMMUNITY HEALTH WORK FORCE ENGAGEMENT	• SUPPORT FOR ALERT MANAGEMENT SYSTEMS FOR NOTIFICATION, VERIFICATION & FOLLOW UP • ISOLATION OF PEOPLE WITH EBOLA SYMPTOMS • COMMUNITY BASED DISEASE SURVEILLANCE & NOTIFICATION OF SUSPECT CASES • STRENGTHENING FACILITY-BASED SURVEILLANCE • SUPPORT SURVEILANNCE AND DATAT ANALYTICS/ SIRI	• SUPPORT FOR IPC IN EBOLA-AFFECTED COMMUNITIES (INCLUDING INSTITUTIONS-SCHOOLS AND HEALTH FACILITIES) • STRENGTHEN HEALTH WORKER IPC CAPACITY • PROVISION OF WASH SUPPLIES AND EQUIPMENT • TRAINING TO SERVICE PROVIDERS ON IPC	• IYCF IN ETU'S, NUTRITION • CONUTRITION SERVICES • SUPPORT DEVELOPMENT OF NUTRITION RESPONSE GUIDELINES AND SOPS • NUTRITION CARE AND MANAGEMENT OF EVD PATIENTS • COUNSELING ON INFANT AND YOUNG CHILD FEEDING IN THE CONTEXT OF EVD • MHPSS & CP SUPPORT TO EVD-AFFECTED HH AND CHILDREN IN ETUS, COMMUNITIES AND SURVIVORS • ENSURE CHILD FRIENDLY APPROACH TO THE EVD RESPONSE AT LEVEL	• SUPPORT/ADVOCACY TO ENSURE CONTINUATION OF HEALTH, NUTRITION, EDUCATION, CP, MHPSS, OTHER SERVICES • SUPPORT/CONTRIBUTE TO THE DEVELOPMENT & ADAPTION OF GUIDANCE FOR THE CONTINUITY OF ESSENTIAL SERVICES, IMPLEMENTATION OF KEY PROTOCOLS AND MECHANISMS FOR ADAPTATION, TASK SHIFTING ETC • PROCURING/ DISTRIBUTING SUPPLIES, SUPPORTING ESSENTIAL SERVICES + ADVOCACY • ENSURE BOTH ROUTINE AND CRITICAL SERVICES ARE AVAILABLE AND ACCESSIBLE • PROVIDE MULTI-PURPOSE UNCONDITIONAL CASH GRANTS	• MANAGEMENT/ DISTRIBUTION OF SUPPLIES, STORAGE • ENSURING TRANSPORTATION FOR SUPPLIES & LEARNERS • OPERATIONS SUPPORT AND CUSTOMS CLEARANCE • ESTABLISHMENT & RUNNING OF TEMPORARY FIELD OFFICES/HUBS • SUPPORT COORDINATION EFFORTS OF THE LOGISTICS PILLAR AT NATIONAL AND SUBNATIONAL LEVEL • SUPPORT
CROSS-CUTTING	**AAP**	**PSEA**	**GBV**	**HDP NEXUS**	**CHILDREN**	**WOMEN**	**VULNERABILITY**
THE MECHANISM	**UNICEF ACTIVATES A CEAP L2 EMERGENCY, AIMING FOR PRINCIPLED, TIMELY, QUALITY AND CHILD-CENTERED HUMANITARIAN RESPONSE AND L2 PROCEDURES ARE IMPLEMENTED**						
PROBLEM STATEMENT	**EBOLA DISEASE OUTBREAKS ARE A SERIOUS HEALTH SECURITY RISK FOR UGANDA AND NEIGHBOURING COUNTRIES. THEY ALSO CONTRIBUTE TO DIRECT AND INDIRECT INCREASED MORTALITY, MORBIDITY AND AFFECT THE PROGRESSIVE REALISATION OF THE RIGHTS OF CHILDREN IN THE COUNTRY**						

4 PURPOSE, OBJECTIVES, SCOPE, AND USERS

This section starts by setting out the purpose and the objectives of the LFE. This is followed by a description of the evaluation's scope and its intended users.

4.1 Purpose

Overall, the LFE aims to fulfil the accountability requirement set out in UNICEF's Evaluation Policy[lxviii], by providing information to donors and community members – particularly children – about the effectiveness of UNICEF's Ebola L2 response as regards achieving its goals and addressing identified needs. The purpose of the LFE is two-pronged: to promote learning and accountability. More specifically, it is expected that the LFE's findings and recommendations will be used by UNICEF personnel to inform UCO's subsequent preparedness and response efforts vis-à-vis future PHEICs in Uganda – especially viral haemorrhagic fever (VHF) outbreaks. The evaluation aims to do the following: identify preparedness measures UNICEF (at the UCO, ESARO, and HQ levels) can take to better prepare for and respond to future PHEICs; highlight areas in which UCO was able to successfully exploit areas of comparative advantage (for the benefit of affected populations, implementing partners, and the GoU); identify areas where UCO's performance could be improved at both sectoral and institutional/ structural levels; adumbrate how UCO can enhance its accountability to affected populations (AAP), as well as partners and donors; and, lastly, pinpoint how UNICEF can intentionally and specifically incorporate PHE response activities into specific institutional HDP nexus commitments.

4.2 Objectives

The objectives of the LFE are as follows:

1. To provide an assessment of UNICEF's response to the Ebola outbreak in Uganda vis-à-vis the issues of appropriateness/relevance, effectiveness[7], efficiency (including VfM), coverage. connectedness[8], coordination, and partnerships, with a specific focus on UNICEF's level of preparedness and the adaptiveness and responsiveness of the UNICEF response and how it addressed issues for children, adolescents, and women, including those with disabilities and those facing marginalisation and deprivation.
2. To draw out key learning and recommendations to equip UNICEF Uganda decision makers with the information they need to formulate UCO's transition from L2 emergency to long-term strategy, ensuring the HDP nexus is in place and increasing preparedness for future PHEs, within the guidance of the White Paper.

The evaluation team has prioritised learning and developing actionable recommendations that align with global disease outbreak preparedness and response priorities, as well as with UNICEF's White Paper on PHEs. The recommendations have been collaboratively created with UNICEF. The evaluation has also paid particular attention to integrated responses for vulnerable and marginalised groups and communities, including women and children, persons with disabilities, and those with other vulnerabilities.

The evaluation has not assessed UNICEF's Post-Ebola Response Plan directly, but rather has reviewed that Plan to assess the alignment with longer-term objectives. It is also intended to differentiate this report from the UCO After Action Review (AAR)[lxix], to avoid duplication of findings. As a result, the present places a stronger focus on the perspectives of communities and external stakeholders.

[7] The timeliness of UNICEF's action is looked at as part of the 'effectiveness' criterion.
[8] Connectedness can be conceived as the equivalent of the 'sustainability' criterion applied to humanitarian action.

4.3 Scope

In line with the ToR, the evaluation considers the L2 UNICEF Ebola preparedness and response between 20 September 2022 and 26 April 2023, across the nine affected districts, as well as some districts that benefitted from preparedness activities. It assesses institutional, programmatic, and operational elements. A more detailed description of the evaluation scope can be found in Annex 2.

4.4 Users

Table 2 lists the different categories of stakeholders that contributed to the evaluation and describes how they can benefit from the evaluation results.

Table 2. UNICEF's response areas and their alignment with GoU response pillars (Source: Developed by the evaluation team based on the GoU's National Ebola Response Plan and the UNICEF Ebola preparedness and response plans)

Primary users	
Category I: UNICEF staff at HQ, Emergency Operations (EMOPS), ESARO, UCO, and other offices in countries at risk of Ebola	Primary users will benefit from a better understanding of the response implementation, good practices, lessons learned, innovation and gaps, and UNICEF emergency procedures and their operationalisation.
Category II: • US Centers for Disease Control and Prevention (US-CDC), Africa Centres for Disease Control and Prevention, Uganda Red Cross Society (URCS), Infectious Disease Institute (IDI), AVSI, LWF, Baylor Uganda, World Vision Uganda, Médecins Sans Frontières (MSF), Save the Children, and the management of Butabika Hospital. • United Nations agencies: WHO, WFP, International Organization for Migration, United Nations Development Programme, and UNHCR. • GoU: Office of the Prime Minister, National Taskforce, IMT, PHEOC, DDMCs, District Health Management Teams, District Health Teams (DHTs), DTFs, and District Education Officers. • Donors/development partners: United States Agency for International Development, European Civil Protection and Humanitarian Aid Operations, and development donors.	
Secondary users	
Category III: • Local NGOs and CSOs. • UNICEF-trained community volunteers, VHTs, community-based organisations, traditional leaders, traditional healers, faith-based organisations, village task forces, social workers, teachers, and transport drivers.	Secondary users may learn from best practices, lessons, and gaps, and will benefit from a greater ability to hold UNICEF to account.
Category IV: Affected populations, in particular women, adolescents, children, persons with disabilities, refugees, Ebola survivors, and students.	

5 EVALUATION DESIGN, METHODS, SAMPLING, LIMITATIONS, AND ETHICS

This section starts by describing the evaluation design used for the LFE and the evaluation questions. It then describes the evaluation's methods, sampling, limitations, and compliance with United Nations ethical standards.

5.1 Design

Following the evaluation purpose and objectives, the LFE is summative and formative, and the design is realist-based, use-focused, and allows for robust analysis. Table 3 below lists the characteristics of this type of evaluation. For detailed descriptions of the design, approaches, and methods, we encourage the reader to consult the evaluation inception report.

Table 3. Characteristics of the evaluation

A theory-based realist evaluation[lxx]	Identifies 'what works in which circumstances and for whom', rather than merely answering the question 'does it work?' Here, the evaluators aimed to identify the underlying generative mechanisms that explain how the outcomes were achieved, and the influence of context. In Ebola outbreaks, the realist question is crucial as the success of the response to the outbreak is heavily influenced by behaviour and perceptions[lxxi]:
Participatory use-focused	Creates a high-quality and useful evaluation for UNICEF, MoH, WHO, and implementing partners by involving all relevant stakeholders in the planning, data collection, analysis, and reporting phases of the evaluation. Key stakeholders were consulted during the different phases of the evaluation to determine their expectations and to identify key areas of interest.
Robust	Implies the absence of bias in the process (data validity[9] and reliability[10]), and rigour in the methodology. The evaluation team brought academic rigour to the evaluation to ensure the performance and results are benchmarked against current Ebola priorities and lessons learned. Triangulation, made possible by the use of multiple methods, data sources, and evaluators, ensured the augmentation of the robustness of the findings.

The evaluation design is presented in Figure 5, which plots the three main learning questions proposed in the ToR against the evaluation criteria of appropriateness/relevance, effectiveness, efficiency (including VfM), coverage, connectedness, coordination, and partnerships[lxxii lxxiii]. The figure partitions the L2 UNICEF response into three learning streams.

First, the L2 mechanism refers to the '**whole-of-organisation response**' processes and mechanisms needed to scale up a response. This provides data to assess whether the L2 mechanism and its processes at all levels were applied and fit for purpose to ensure timely and effective scale-up (for example, resource and partnership mobilisation, procedure application, and support functions).

Second, UNICEF's operational response refers to the '**in-country response**', and how response strategies across the seven UNICEF response pillars were aligned to relevant policy/strategy, and how they were implemented. Here, the evaluation aims to understand the extent to which UNICEF embedded its mandate

[9] Data validity relates to whether the data accurately reflects the true characteristics of the studied subject/population.
[10] Data reliability relates to whether the methods and tools produce consistent results over time, across different evaluators and settings.

and corporate commitments to children in humanitarian response (for example, alignment and coherence with the GoU response, coordination, leadership, and achieved results).

Third, the evaluation assesses the response from the angle of the **'affected population'**, and whether and how they received relevant and appropriate assistance and protection as a result of the L2 response. UNICEF's organisational commitments to gender (inclusive of GBV/PSEA), human rights, and equity (age, disability, and other vulnerabilities) are assessed as cross-cutting themes throughout the three learning streams.

Figure 5. Evaluation design (Source: The evaluation team)

5.2 Evaluation questions

The evaluation team elaborated the three key learning questions outlined in the UNICEF ToR in an evaluation matrix (see Table 4). To answer the three learning questions, 13 sub-questions were refined with UNICEF during the inception phase to provide a clear structure and to enhance clarity. The evaluation matrix specifies these sub-evaluation questions, sources of verification, and the methods used to answer the evaluation questions (refer to Annex 3). In addition, in collaboration with UNICEF, priority areas for learning were identified and integrated (refer to Annex 4).

The evaluation assesses several evaluation criteria from the Organisation for Economic Co-operation and Development's Development Assistance Committee (OECD-DAC). These include appropriateness/relevance, effectiveness, efficiency (including VfM), coverage, connectedness, coordination, and partnerships. However, the structure of the evaluation report follows the learning questions: under each learning question several OECD-DAC evaluation criteria are assessed.

Learning Question 1 is answered using the above evaluation criteria and looks at UNICEF's planning, implementation, and results through each of the above learning streams (Sub-questions 1 to 8). Learning Question 2 is answered by providing an overview of specific innovations that UNICEF applied in its partnerships, digitalisation, and operations. The evaluation also identifies pertinent missed opportunities, as well as the adoption of previously learned Ebola lessons (Sub-questions 9, 10 and 11). Learning

Question 3 is captured by Sub-questions 12 and 13. Across all sub-evaluation questions, lessons learned have been captured, and these are provided in the last section of the report, together with conclusions and recommendations.

Table 4. Evaluation learning questions (Source: UNICEF ToR)

Learning Question 1	How well prepared was UNICEF and how well has UNICEF responded to the Ebola emergency in Uganda?
Learning Question 2	What have been UNICEF's successful and/or innovative approaches and barriers in the Uganda Ebola emergency response?
Learning Question 3	What actions are required in order to: 1) strengthen the Ebola response in future outbreak scenarios; and 2) prepare for the transition to longer-term programming?

Furthermore, the evaluation seeks to avoid duplication with the AAR conducted by UNICEF, although it utilises the data obtained from that review. The LFE differs from the AAR in several key areas. The AAR was informed by UNICEF stakeholders themselves, including the UNICEF personnel who coordinated the operations. However, the LFE includes a variety of stakeholders, including an important proportion of stakeholders who are external to UNICEF. This independence diminishes the potential for conflicts of interest and bias that could not be controlled for by those conducting the AAR. The LFE therefore has access to a much broader range of qualitative data than was available to those conducting the AAR.

The evaluation also gives special consideration to the human rights of children, focusing on key principles such as non-discrimination, respect for the views of the child, addressing gender-based discrimination, and ensuring equal enjoyment of human rights for persons with disabilities.

5.3 Evaluation methodology

A mixed-methods approach was employed in the evaluation, combining qualitative and quantitative methods to gather comprehensive information (see Table 5). This approach allowed for cross-referencing, validation, and triangulation of data from different stakeholders, overcoming method-specific limitations to improve the reliability and credibility of the findings.

The evaluation team reviewed and analysed a total of 369 **programme documents**, including response planning documents, work plans, the AAR, studies, and monitoring data. For a comprehensive list of the documents that were reviewed and that are referred to in this report, please refer to Annex 5.

A total of 115 **KIIs** were conducted with stakeholders at international, national, and subnational levels. The interviewees included representatives from various stakeholder categories, such as 21% from Category I and Category II, and 89% from Category III and Category IV (refer to Annex 6 for details) [11]. Specific to Category I, there were 17% of stakeholders from HQ, 14% from ESARO, and 68% from UCO. Overall, some 42% of stakeholders were female, versus 58% male.

A total of 27 **FGDs** were held with community groups and local responders in four out of the six visited districts: Kassanda, Mubende, Kyegegwa, and Jinja (see Annex 7). There were 389 FGD participants, 42% of whom were female. The evaluation ensured the inclusion of **children's** voices through FGDs and play activities. A total of 49 children between the ages of 14 and 18 participated in FGDs conducted in the districts of Mubende, Kassanda, and Kyegegwa. This included 55% girls. Children were recruited through

[11] Category I stakeholders are UNICEF informants; Category II stakeholders are partners; Category III stakeholders are local responders; Category IV stakeholders are those from affected communities.

schools, ensuring a gender balance, and applying inclusion criteria. Children were asked to answer six learning questions according to a Likert scale from 1 to 5 (very much agreed, agreed, neutral, did not agree, did not agree at all) (see Annex 8). Children were invited to fill in a grid, and were encouraged to be transparent and to feel comfortable. There were no additional play activities. The six learning questions were as follows:

1. Did the information you received about Ebola make you feel safer coming to school?
2. Did your school have running water, soap, and a thermometer at all times?
3. Did someone come to your school to speak to you about your worries and stress?
4. Did you at any time stop attending school because of the fear of Ebola?
5. Did you feel safe at all times at home during the Ebola outbreak?
6. Did you and your family have enough food at all times during the Ebola outbreak?

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Having been informed of appropriate reporting mechanisms and sensitised as to culturally appropriate ways to enquire into these sensitive matters, the evaluation team members queried interviewees and focus group participants about potential Ebola response-related **GBV** and **SEA.** Efforts were made to include both the elderly and **persons with disabilities** in community-level focus groups, and, given the granularity of their knowledge of the makeup of the communities of which they were a part, VHT members were asked to provide information on the various **vulnerable persons** and groups within their communities. Various female-only FGDs were conducted over the course of the evaluation: these were led by female healthcare workers from the communities.

A **Community Rapid Assessment (CRA)** was conducted to collect primary data from affected populations. Through a series of 18 questions, asked via a mobile phone survey (designed by the hera evaluation team in collaboration with UCO's RCCE experts and implemented via VIAMO), the CRA gathered information on respondents' knowledge, attitudes, and practices related to Ebola. The objective of the CRA was to supply both the evaluation team and UCO members with insights into community perceptions and knowledge, which can be used to inform UCO's subsequent Ebola preparation and response programming.

Sample sizes varied by district and underwent post-stratification weighting based on age, district, and gender. The demographic breakdown for respondents was 67.5% male and 32.2% female, with 53%

between the ages of 18 and 25 years. The survey was designed to reach a diverse audience across ages, genders, locations, and educational backgrounds (see Annex 9). A robot call was sent to an audience of 25,759 people, of whom 524 completed the survey (14.7% completion rate) (see Figure 6).

Figure 6: CRA (Source: UNICEF)

The CRA was found to be a valuable data collection and analysis tool for the evaluation but was not cost efficient. The population-based phone survey findings enhanced the evaluation's depth and comprehensiveness, through providing an understanding of community perceptions on Ebola. It explored beliefs, health awareness, help-seeking, and knowledge, attitudes, and perceptions on Ebola. The results were stratified across gender, age, location (urban, rural), and education level. The CRA provided a crucial step towards achieving a comprehensive, people-centric evaluation, enriching the evaluation assessment with community insights and placing people at the centre of evaluation. Annex 9 provides a detailed analysis of the CRA data and a reflection on the value of conducting a CRA as a data collection method in programme evaluations.

The evaluation team conducted two **participatory workshops** to validate the findings and co-create recommendations. Both workshops were attended by the ERG, an advisory group that included emergency focal points and senior staff from UCO; however, the workshops did not include stakeholders beyond UNICEF.

Table 5. Methods and data sources

Methods	Number of data sources and type
Document review	369 documents reviewed
KIIs/FGDs	115 participants from Category I and Category II
FGDs	27 FGDs with 376 participants from Category III and Category IV
Children FGDs	49 children and adolescents aged 14–18 years
CRA	524 participants; completion rate 14%; F/M: 36/67; 18–25yrs: 53%
District visits	Visited Kampala, Wakiso, Kassanda, Mubende, Kyegegwa, and Jinja
Participatory workshops	Findings validation workshop – 14 August 2023 Recommendations co-creation workshop – 12 July 2023 (UNICEF staff)

5.4 Sampling

The evaluation conducted stratified purposive sampling of key stakeholders for KIIs and FGDs identified by UCO or local responders because of their knowledge of the affected communities. Snowball sampling further selected relevant stakeholders to be interviewed. The evaluation inception report includes all questionnaires, details of the inclusion and exclusion criteria, and the specific groups targeted for FGDs.

The CRA targeted individuals residing in the nine affected districts. Within those districts, a randomised sample was selected using anonymised phone numbers generated from Airtel users. The total sampling frame consisted of n=542, drawn from a population size of n=25,759. The subjects were recruited voluntarily through anonymised mobile phone databases. The sampling strategy followed a random digit dialling modality and the subjects who completed the survey received a top-up of 2,500 Ugandan shillings (US$0.90) for Airtel airtime. The CRA questionnaire is available in Annex 8. The 19-question survey was made available in three languages: Luganda, English and Rutooro. The survey was implemented at the end of May 2023, after the field visits, to allow for further tailoring of the questionnaire based on insights obtained through FGDs and other relevant sources. All data had been collected by 15 June 2023.

5.5 Limitations

The table below lists the evaluation's limitations, as well as the mitigation measures adopted to address these constraints.

Table 6. Constraints and mitigation measures

Constraints	Mitigation measures implemented
Unavailability of baseline data to measure the required change	Considerable time was spent in the field to understand the perceptions of affected populations. The consultative process, through which a revised programme ToC was formulated, helped provide a better understanding of the programme logic and components.
Delays in securing ethical clearance	A temporary oral notice was provided, which allowed data collection activities to commence.
The availability of and access to key stakeholders changed the field planning	A new field plan had to be established and the team lead spent less time in the field in order to cover interviews in Kampala.
Difficulties in attributing activities and results to UNICEF in a collective response	Regular consultative processes with UCO improved the evaluation team's understanding of what activities were carried out by UNICEF in the collective response.
UCO was in the middle of a business review process, which reduced the availability of staff	The period for conducting interviews was extended to ensure the inclusion of all relevant stakeholders.
Unavailability of regional office/HQ staff	Several emails were sent, including with support from ESARO, which increased availability.

5.6 Quality assurance

The LFE was subject to internal quality assurance processes for all deliverables. Internally, hera reviewed all documents to be submitted to UNICEF against OECD and Global Evaluation Reports Oversight System (GEROS) evaluation criteria, norms, and standards. Externally, the LFE deliverables were reviewed by UNICEF ESARO, the UNICEF Evaluation Office, and the ERG established for this evaluation process. The ERG was established and chaired by the ESARO Evaluation Section and included emergency focal points and senior staff from UCO. Its purpose was to review the evaluation milestones and deliverables, and to

provide feedback. In addition, hera facilitated ERG learning events at every stage of the evaluation, in which the LFE findings were reviewed and feedback was provided. Revisions were then made to subsequent report drafts at each round.

For quality assurance during data collection, the two evaluation leads served as the observers and notetakers for all FGDs and KIIs, and worked with local researchers who spoke the relevant local languages (Luganda, Kyegegwa, Runyoro, Runyakitara) and English. The researchers undertook a short training session to understand the FGD and KII tools, and then translated English versions of the questionnaires into relevant local languages. The training covered several topics, including an overview of the project, the methodology and data collection tools, how to prompt participants, confidentiality and consent, ensuring the comfort of participants, and the United Nations Evaluation Group (UNEG) Ethical Guidelines. A review of the instruments was conducted, involving a walk-through of the questionnaire guides, question by question, an exploration of meanings, the best ways in which to approach the topics, and the objectives behind the pattern of questioning.

5.7 Ethical issues

Ethical clearance was obtained from the Lacor Hospital Institutional Research and Ethics Committee, in regard to conducting this review in an ethical and legal manner, with regard for the welfare of those involved in and affected by the action (see Annex 10). This Committee was approved by UNICEF. The study protocol was further submitted to the Uganda National Council for Science and Technology. Throughout the evaluation, the team applied the principles of verbal informed consent, voluntary participation, assurances of anonymity and confidentiality, data protection, the best interests of the child, and do no harm. Written consent was obtained from children under 18 years of age, as well as from their parents or guardians. This also included their permission to take photos. All recordings, interview and FGD transcripts, and survey results have been de-identified. All data has been stored on a secure server. The participants were provided with a minimal amount of cash to cover transport and snacks.

The evaluation team confirms that there are no conflicts of interest involving team members and UNICEF and this evaluation (e.g. having received gifts, favours, employment, dealings with former or future UNICEF members, use of UNICEF services or facilities, etc.) that would compromise the independence, impartiality, and integrity of the team's evaluative work. Each team member was sensitised as to culturally appropriate ways to enquire into potential GBV/PSEA issues that may have occurred over the course of the response, as well as to the appropriate reporting protocols if GBV/PSEA incidents were reported to them.

Equity was not mentioned in the UNICEF Ebola response plans but some of the UNICEF results indicators included gender and disability inclusion. The evaluation included an evaluation question on gender equity, alongside other principles and standards. The report includes a specific section on women, children, people with disabilities, as well as other vulnerable groups.

Each team member was trained on and complied with the following standards:

- UNEG Norms and Standards for Evaluation in the UN System (2016)[lxxiv].
- United Nations training programme on PSEA.
- UNEG Guidance on Integrating Disability Inclusion in Evaluations and Reporting on the United Nations[lxxv].
- UNICEF Procedure on Ethical Standards in Research, Evaluation, Data Collection and Analysis[lxxvi].
- Disability Inclusion Strategy (UNDIS) Entity Accountability Framework Evaluation Indicator[lxxvii].
- UNICEF Procedure on Ethical Standards in Research, Evaluation, Data Collection and Analysis[lxxviii].

- Ethical Guidelines for United Nations Evaluations[lxxix].
- UNEG Guidance on Integrating Human Rights and Gender Equality and United Nations System-Wide Action Plan on Gender Equality[lxxx].
- UNICEF Guidance on Gender Integration in Evaluation[lxxxi].

6 FINDINGS

The findings section presents the evaluation findings and consists of 13 subsections, which correspond to each of the sub-evaluation questions in the evaluation matrix (see Annex 3). The evaluation matrix details how each of these sub-questions have been answered using specific benchmarks, indicators, and evidence from different data sources. It assesses 1) UNICEF's achieved results, 2) adaptiveness, 3) AAP and PSEA, 4) women, children, and vulnerabilities, 5) response coverage, 6) adherence to standards and commitments, 7) connectedness, 8) response efficiency, 9) innovative approaches, 10) missed opportunities, 11) previous Ebola lessons, 12) age, gender, and disability (AGD), and 13) the HDP nexus.

6.1 To what extent did the UNICEF L2 response achieve its stated objectives in terms of preparedness and response?

This section focuses on the effectiveness of UNICEF's Ebola preparedness and response. It briefly discusses results monitoring, followed by preparedness. After preparedness, each of the seven UNICEF response areas are discussed (see Table 7 below).

Table 7. UNICEF's Ebola response areas, Uganda

Response area 1: Coordination and leadership
Response area 2: RC, social mobilisation, and CE
Response area 3: Community surveillance and outbreak analytics
Response area 4: WASH and IPC
Response area 5: Case management
Response area 6: Preventing and addressing the indirect impacts of the outbreak
Response area 7: Logistics and operational support

Source: UNICEF

Monitoring results

This section on results monitoring is intentionally concise, serving as an introduction to the subsequent effectiveness sections. The evaluation acknowledges that while planned outputs and outcomes can be used to measure effectiveness, it is essential to recognise that the Ebola outbreak was a dynamic and evolving event. As a result, the evaluation has placed less emphasis on merely meeting set targets and has also assessed what worked, in which circumstances, and for whom.

UNICEF had an adequate response monitoring system in place to track planned targets across various pillars. The system provided a set of outputs with relevant indicators for result tracking and response adjustments, as is evident in UNICEF's humanitarian situation reports. However, the monitoring system lacked comprehensiveness in terms of including outcome and impact indicators, and it underrepresented UNICEF's extensive array of achievements (outputs). Additional data sets were produced by UNICEF, and these included the L2 monitoring framework, AAP results data, human resources trackers, dashboards, regular humanitarian situation reports, and sectoral results (see Annexes 11, 12, 13, and 14).Some of the data collection tools disaggregated data for sex, and age (children versus adults) but this was not implemented systematically throughout all tools. While UCO was able to provide data on disability (people reached) the data collection tools did not allow for systematic disaggregation for disability.

Preparedness

To assess preparedness, the evaluation used UNICEF's Procedures on Preparedness for Emergency Response. UNICEF is expected to ensure that preparedness is integrated across the organisation, and this includes mandatory Minimum Preparedness Actions for Country Offices[lxxxii].

UNICEF's preparedness before the 2022 Ebola outbreak was not adequate. In 2018, the UCO had an Ebola Virus Disease Contingency Plan[lxxxiii] in place, considering Uganda's proximity to the outbreak in DRC and the risk of cross-border transmission. It must be noted that UCO was not required by the ESARO to have an Ebola disease-specific preparedness plan in place, broader preparedness for PHEs was sufficient. Additionally, there was a draft 2021 Ebola Preparedness and Response Plan[lxxxiv], which was incomplete. It was only when the 2022 Ebola outbreak was declared that UCO focused on an emergency preparedness planning process, which included developing multi-hazard preparedness plans covering droughts, floods, refugees, and PHEs. It was then that Ebola planning figures were uploaded to the UNICEF emergency preparedness portal, and this was used to update the Minimum Preparedness Actions, including the standing capacity, staffing needs, and supply needs.

> *'In every army you prepare for warfare during peace times. UNICEF doesn't invest in emergency preparedness during non-Ebola times.'*
> *KII, MoH, Kampala*

UNICEF's strengths lie more in building relationships and creating platforms for CE than having adequate preparedness plans, resources, and prevention and treatment measures for at-risk populations. A 2019 survey[lxxxv] conducted by UNICEF revealed that only 13% of respondents believed that UNICEF was somewhat prepared for an Ebola outbreak in terms of the quality of its preparedness plans. Several UCO staff members confirmed that these findings had not changed regarding the preparedness status in 2022.

The UCO risk analysis conducted in July 2022 did not identify Ebola as a 'very high risk'[lxxxvi], despite the WHO AFRO assessment categorising Uganda as a Priority 1 country for Ebola from 2018 to 2020[lxxxvii]. UNICEF's CPD identified Uganda as a high-risk country, ranked 15th out of 190 countries, for humanitarian crises and disasters that could potentially overwhelm national response capacities, including the risk of Ebola outbreaks[12].

The transition from preparedness to response presented several challenges and various factors constrained UCO in its preparedness efforts. Prior to the most recent Ebola outbreak, UCO had an Ebola virus disease-specific contingency plan, contingency budgets, SOPs, etc.; however, these were based on the previous outbreak and had not been updated. Moreover, many UCO staff were not aware of them (due to staff movements, loss of Country Office institutional memory, etc.)[lxxxviii]. No partners were identified for standby programme documents[lxxxix]. The lack of PHE plans for most sections resulted in initial delays in designing the response and implementing critical interventions. The AAR highlighted that different sections within UNICEF were working in silos due to the absence of sector-specific contingency plans and budgets, leading to limited horizontal integration. Notably, the WASH/IPC sector did not benefit from sufficient preparedness efforts, resulting in a critical shortage of supplies. Though RCCE was the most organised sector during the initial phase of the response, with strategies and contingencies in place, RCCE did not benefit from any funding. Moreover, the evaluation team found no evidence of previously conducted simulation exercises that would have contributed to preparedness levels and facilitated a smooth transition to the response phase. This lack of preparedness was evident in UCO's insufficient stock of appropriate

[12] The source of this information is Inter-Agency Standing Committee/European Commission (2018) *Index for Risk Management*.

Ebola personal protective equipment (PPE) at the time of the Ebola outbreak being declared, despite being able to draw on some PHE supplies to support the response efforts.

UCO enhanced pre-existing core communication and coordination partnership arrangements with MoH. In a swift response, UNICEF repurposed 15 vehicles, donated essential supplies (including tents), and reallocated existing budgets. By 27 September, RCCE and WASH staff had been deployed to the epicentre of Mubende. While some basic WASH and health supplies helped initiate the response, UNICEF acknowledged that this was only the bare minimum. Both WASH and RCCE activities felt significantly under-resourced and fell short in terms of response capacity. While some UNICEF members stated that the organisation was well prepared, others said that they had not predicted the Ebola outbreak and were not optimally prepared for such a scenario.

'We didn't anticipate it',
KII, UNICEF UCO, Kampala

The experience and expertise gained during the COVID-19 pandemic boosted the initial response efforts. UNICEF's good reputation with the MoH and its previous Ebola partnerships contributed to there being a degree of preparedness in place. Additionally, pre-existing structures, including those from the COVID-19 response, proved valuable and were quickly reactivated. These included continuation of health services as well as expanded Emergency Management capacities, both of which were developed/enhanced during the COVID-19 response. These structures included the national and subnational coordination mechanisms, response pillars, and the EMTs. At the subnational level, across all districts, the VHTs were swiftly reactivated. The VHTs themselves stated that their knowledge and experience gained from the COVID-19 response were instrumental in understanding the principles of Ebola IPC.

During the Ebola response, UNICEF took measures to improve its overall preparedness and to strengthen its partnerships. UCO increased its overall emergency preparedness score from 88% (July 2022–January 2023) to 92% (July 2023)[13] (see Annex 15). Specific to Ebola, UCO enhanced its partner mapping to identify existing, standby, and potential partners. UNICEF identified eight partners, out of which six became actively engaged in partnerships[14]. UNICEF developed and regularly updated internal staff mobilisation plans and surge plans for Ebola. These plans were aligned with the proposed Ebola work and aimed to optimise staff deployment and resource allocation during the response. In addition to supporting several districts in developing their preparedness and response plans, UNICEF provided support to the Kampala Capital City Authority (KCCA) in developing a tailored urban preparedness and response plan, considering the unique challenges and needs of an urban environment. UNICEF's post-Ebola response plans also included investments in further preparedness efforts at district level, including 11 districts without active Ebola transmission. This is expected to strengthen readiness for future emergencies.

Allocating funding to preparedness and prevention efforts in general remains challenging. Funding is often prioritised for more immediate and urgent interventions, which can lead to suboptimal preparedness measures. Donors tend to prefer to invest in border control measures first, rather than allocating resources to preparedness and prevention initiatives. **Preparedness needs to be built into the resilience agenda and to focus externally on government, as well as on UNICEF procedures.**

'Preparedness and prevention are a luxury rather than a necessity in the current funding-restricted environment.' KII, UNICEF, Kampala

[13] Note that the Minimum Preparedness Actions consider multiple risks (e.g. refugees, PHEs, hydrometeorological hazards, etc.), as per the Uganda HAC appeal, and not just Ebola.
[14] Save the Children, AVSI, Malaria Consortium, Uganda Red Cross Society, LWF, and World Vision Uganda.

UNICEF, under the leadership of ESARO, invested in regional preparedness. By 23 November 2022, at-risk neighbouring countries, including Burundi, Rwanda, South Sudan, Kenya, and Tanzania, had developed six-month pillar-based preparedness and response plans. These plans focused on key preparedness activities, such as coordination, RCCE, human resources, WASH/IPC, supply, and resource mobilisation. ESARO supported the different country offices in developing preparedness and response plans addressing the various pillars, and coordinated with the WHO regional readiness teams. It further convened a regional WHO/AFRO and Africa Centers for Disease Control and Prevention ministerial cross-border meeting on Ebola in October 2022. However, some key preparedness pillars faced challenges and were not fully optimised. This was mainly due to delays in mobilising the necessary resources. ESARO reported that preparedness activities under Scenario 1 were only funded for 22% of the required budget of US$20,517,999. In particular, the area of WASH had a low overall preparedness status, scoring only 16%, and experienced delays in implementing preparedness activities[xc]. The cross-border regional meeting between African ministers of health was an opportunity to build on a child-focused regional response; if more time had been allotted to this, more could have been done.

Response area 1: Coordination and leadership

As mandated through the CCCs and its EMOPS benchmarks[xci], UNICEF is expected to play its part in inter-agency and intersectoral coordination mechanisms for PHEs. Furthermore, UNICEF is mandated to take on the leadership and coordination role in the GoU's pillar efforts as the primary organisation responsible for responding to a public health crisis, regardless of whether the cluster approach is activated or not[xcii].

Under response area 1 UNICEF achieved 100% of its planned target (see Annex 12). UNICEF actively engaged as an observer on the Scientific Advisory Committee and provided valuable technical assistance to the NTF. As part of its leadership role, UNICEF co-chaired the RC and CE pillars, as well as the sub-pillars of WASH/IPC, MHPSS, and CoES, in support of MoH and the Commissioner of Health Services, Health Promotion, Education, and Communication departments.

At the subnational level, the organisation supported various pillars of the Ebola response and preparedness plans of the nine Ebola-affected districts, as well as in another 11 districts for preparedness. UNICEF played a pivotal role in providing technical expertise, facilitating coordination, promoting harmonisation, and fostering collaboration among implementing partners, such as the DTFs and the DDMCs. This ensured that preparedness and response efforts were well-aligned with national strategic plans. UNICEF's strong reputation, previous extensive support to the GoU, and previous experience in coordinating the COVID-19 response greatly facilitated effective coordination and support during the Ebola response.

In addition to the pillar and management structure of the GoU, UNICEF actively engaged with other ministries and successfully advocated for the inclusion of both MoGLSD and the MoES to enhance a multi-sectoral response to the Ebola outbreak. The GoU's Ebola response efforts were initially primarily led by the MoH. However, when cases were reported in Kampala, UNICEF further extended its coordination by supporting the Kampala Metropolitan Area. All pillar leads reported positively on UNICEF's level of engagement, including as well as its inclusion of other ministries in the response.

National and subnational government officials generally expressed positive perceptions of UNICEF's support in leading and coordinating the Ebola response, which was seen as a valuable contribution. They specifically highlighted UNICEF's subnational support to DTFs and DHTs, in regard to strengthening their capacity. The initial weaknesses in government subnational coordination structures – including limited human resources, inadequate funding, coordination challenges, and lack of Ebola

experience – were addressed via UNICEF's assistance in areas such as training, funding, and coordination mechanisms. This support was seen as effectively strengthening what was previously lacking.

There were challenges in leadership and coordination at the national level. The presence of multiple response plans and the various United Nations agencies involved led to occasional confusion regarding roles and responsibilities, particularly between UNICEF and WHO. While WHO was the logical choice to lead the overall response with MoH, given its commitment to the IHR and its role as the Global Health Cluster lead under the IASC[15], there were instances where the mandates of different organisations overlapped, leading to some duplication and gaps in key areas such as SDB, IPC, case management in ETUs, and community surveillance. UCO staff acknowledged that these challenges could have been addressed if there had been stronger capacity of MoH to lead and coordinate the response, or through a more coordinated approach under the United Nations Country Team. Some UNICEF staff noted that earlier and more proactive participation by UNICEF in the process of revising the Uganda National Ebola Response Plan could have clarified roles and responsibilities more effectively. While a workable relationship was eventually established, and the outbreak remained relatively small-scale, concerns were raised about the efficiency and sustainability of this arrangement for longer and more extensive PHEs.

'United Nations agencies have realised it [PHE] is a cash cow, but we need one plan. Because money hasn't been used. It is something to be concerned about.'
KII, Category II, Kampala

UCO expanded its coordination hubs following the Ebola outbreak. Initially, efforts were focused on two hubs in high-risk areas: the Mubende hub (Mubende and Kassanda districts) and the second hub (Kyegegwa, Bunyangabu, and Kagadi districts). As Ebola cases spread to Kampala, Masaka, and Jinja, three additional hubs were established. UNICEF reactivated the EMT structure, leveraging the existing COVID-19 structures.

The support mechanisms involving UCO, ESARO, and HQ were generally perceived as valuable. ESARO's involvement before the L2 activation provided strategic and technical guidance to UCO, deployed key positions (including an emergency coordinator), and offered remote and in-person technical Ebola guidance. ESARO also supported on duty of care, the revision of existing SOPs, allowing the repurposing of programme funds for the Ebola response, and support to setting up the field hubs. Subsequently, both ESARO and HQ continued to provide support, offering funding through the EPF and the earmarked PSEA allocation, as well as surge deployment of resources. Additionally, ESARO collaborated with the five neighbouring at-risk countries to enhance their preparedness and to develop the UNICEF Regional Ebola Preparedness and Response Plan.

Response area 2: RC, social mobilisation, and CE

In accordance with the CCCs and the White Paper, UNICEF is expected to reach communities with targeted messages on prevention and services, encouraging them to adopt behaviours and practices to reduce disease transmission and its impact.

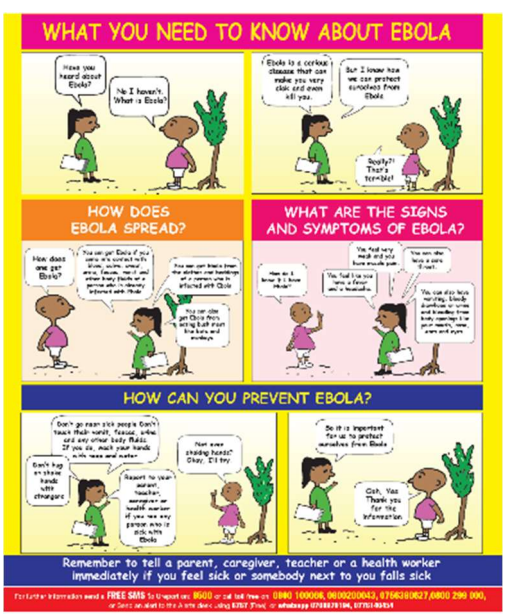
Under response area 2, the response demonstrated a high level of effectiveness in the implementation of RCCE activities. RCCE achieved 81.8% of its planned target and reached 6,215,797 people with accurate and culturally and gender-appropriate messaging on Ebola under the L2 (as shown in Annex 14). Importantly, RCCE received the highest allocation of funds, constituting 29% (equivalent to US$2,330,315) of the total funds available. It also accounted for the largest proportion of total expenditures,

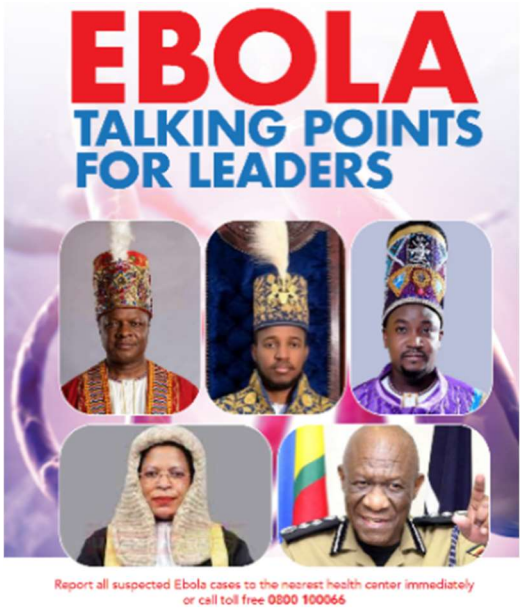
[15] Note that Uganda does not have an activated IASC clusters system.

reaching 49% (equivalent to US$2,035,935). These figures emphasise the investment made in RCCE. Further, UCO was regarded as playing a pivotal role as a co-leader, alongside the MoH, in the RC and CE pillars, working in collaboration with the Ugandan Health Promotion, Education, and Communication department of the MoH. UNICEF employed a comprehensive set of strategies, including strategies on Public Awareness and EC, Social Listening and Evidence Generation, Social Mobilisation, Stakeholder Engagement, CE, and Capacity Building. The combination of these resulted in a strong whole-of-society focus.

UNICEF invested in the most appropriate communication channels for RCCE. UNICEF invested in mass media messaging through 29 radio stations and eight TV stations. The CRA showed that radio and TV accounted for 56.9% (n=292) of preferred methods from both urban and rural populations, which was in line with the findings from UNICEF previous anthropological studies[xciii]. However, it is worth noting that Kampala residents exhibited a higher reliance on social media (29%) compared to word of mouth (10%), whereas the rural population relied less on social media (9.9%) compared to word of mouth (13.7%). Women relied nearly twice as much (16.9%) on getting information through word of mouth than men (9.4%). In contrast, tools such as banners, books, and posters proved to be less popular across all groups, accounting for only 2.9% of responses. Considering the investment of US$235,918 in printed materials, it would be prudent for UNICEF to reflect on the most appropriate and cost-efficient means of RCCE in future PHEs. Furthermore, a review of information, education, and communication (IEC) materials indicated that key messages were tailored and targeted to specific groups, including children and leaders (see Figure 7). These messages were also adapted based on previous lessons learned from RCCE Ebola efforts[xciv].

Figure 7. Tailored IEC materials





RCCE positively influenced public awareness. Broadly, most participants in both FGDs, including children, and the CRA demonstrated a good awareness of Ebola symptoms, modes of transmission, preventive measures, and the importance of seeking healthcare upon experiencing symptoms. It is noteworthy that a significant proportion of adult respondents (68.5%, n=470) demonstrated knowledge of the primary signs of Ebola, while an even higher percentage (84.4%, n=470) knew how to prevent contracting the disease. Among the 49 children consulted during FGDs, 59% (n=51) agreed or strongly agreed that the information provided made them feel safer in school, with no significant differences observed between boys and girls in their responses (refer to Annex 8 for further details). Participants in the

FGDs and KIIs revealed that, at the beginning of the Ebola outbreak, there was widespread disbelief among community members regarding the true nature of the disease. Many attributed Ebola to witchcraft or believed that its spread was politically motivated. There were also rumours that people were using the outbreak as a cover to exploit the gold mines and steal communities' resources. However, when deaths started occurring in the communities, this was the primary pivotal moment when community members began to recognise and accept the reality of Ebola.

'*UNICEF had to break down such distrust [i.e., that witchcraft was the cause of Ebola] and UNICEF did a very good job. This was UNICEF's biggest strength.'*
KII, VHT, Mubende

UNICEF's strategic inclusion of a wide variety of local responders and community influencers within the response proved highly effective in driving social and behavioural change within communities. UNICEF engaged 61,585 key influencers in Ebola prevention and 1,292,547 people participated in engagement activities (see Annex 12). The findings from the FGDs and from the CRA survey indicate that VHTs and/or village chairmen were perceived as the most trusted individuals to provide accurate information. During the Ebola outbreak, VHTs were formally financially motivated, this being a central strategy of the draft National Community Health Strategy[16]. This motivation was critical for the pivotal role that VHTs played for community surveillance, referral, and CE. Regardless of education level or residential location, village chairmen and health workers were considered the most trusted individuals in communities, with a 61% preference rate, followed by local members of parliament and/or resident district commissioners together at 14%. Conversely, religious and traditional healers were regarded as the least trustworthy across all age groups, genders, and locations, with a trust rating of only 7.3%. Further, individuals above the age of 45 relied three times more on friends and neighbours for trusted information compared to their younger counterparts. In heavily affected districts like Mubende and Kassanda, VHTs and local members of parliament and/or resident district commissioners were the most trusted sources, with trust rates of 78.2% and 12.9%, respectively, while religious leaders and healers only had a trust rating of 2%. However, it is important to note that some traditional healers expressed concerns regarding the trade-off between the advantages of being a member of the DTF and the negative impact on their business. To address this, they suggested equipping them with temperature guns to enable continued consultations with clients who do not have a fever.

'*Most valuable in terms of impact was CE by the VHTs going from household to household.'*
FGD, DTF, Jinja

Teachers played a critical role as positive influencers for children and their families, effectively transmitting key messages. From the FGDs with schoolchildren (14–18 years of age) it became clear that these children received most of their information on Ebola from school. Most children easily answered questions on Ebola signs, preventive measures, and treatment-seeking. Children also conveyed these learnings from school to their families at home. That said, while 61% of children stated that the key messages improved their understanding of the disease, 75% reported that they did not feel safe.

Although VHTs demonstrated exceptional commitment to the wellbeing of their communities and were described as the bedrock of the health system, they faced several challenges that impacted safe and timely referral. One important aspect was their contribution to early Ebola notification and non-Ebola referral. However, VHTs encountered multiple issues, including the lack of transport during lockdown. This regularly resulted in delays of several days before suspect Ebola cases reached health facilities. Also,

[16] GoU (2022) *National Community Health Strategy*.

for non-Ebola illnesses transport was reported to be insufficiently available. With the halt on local transport, VHTs could only rely on ambulances, and these were not always readily available, in particular in remote areas. There were also numerous reports of VHT members being underpaid, not paid, or paid late, by partners. VHTs reported unfulfilled promises in regard to receiving supplies, a lack of PPE for some at the beginning and others throughout the whole response, receiving incorrect materials, and experiencing social stigmatisation. However, the fact that VHTs were to be paid at all was significant for the formalisation and launch of the Community Health Strategy after the outbreak. There are also questions on long-term impact. While the engagement of these first responders has undoubtedly strengthened their capacity and indirectly enhanced the primary healthcare system[xcv], VHTs reported that they are mostly inactive as community healthcare providers. They reported that they only get activated and renumerated during emergencies. This calls into question their role as comprehensive community health providers, and is also counterproductive in regard to them becoming an integral part of a sustainable 'readiness early detection and surveillance system' for future PHEs.

'Re-awake and capacity building of parish and village task forces in Ebola for increased vigilance, early case identification, and early reporting at village and household level.'
'[We worked] every day from village to village, sub-county to sub-county.'
FGD, VHTs, Kassanda

The GoU's division of RCCE into the separate pillars of RC and CE during the COVID-19 pandemic had a notable impact on the Ebola response, but mostly at the national level. The decision of the GoU to split RCCE into two separate pillars, RC and CE – despite the fundamental principles of RCCE emphasising the importance of a two-way dialogue between authorities and communities, and recognising the significance of effective communication strategies and community involvement – led to several challenges. Informants highlighted that this split was beyond UNICEF's control, but there were suggestions that UNICEF could have been more proactive in advocating for a unified approach and participating in the development of the Uganda National Ebola Response Plan. Inter-agency coordination would likely also have had more leverage in this regard. The separation of the pillars at the national level resulted in delays in CE, as compared to RC, confusion on roles and responsibilities, duplicated efforts, the need to manage two separate teams, and the requirement for separate funding and coordination. These factors added unnecessary costs and some informants implied that this may have contributed to the maintenance of the division between RC and CE. It is worth noting that, at the subnational level, the progress of activities was not significantly affected by this division because at district level it was largely the same district staff and community cadres who led this work.

UNICEF ensured that RCCE activities were data-driven. UCO effectively utilised various feedback mechanisms, including U-Reports, helplines, the child helpline, and anthropological and social science studies, to gather insights into communities' knowledge, attitudes, and perceptions. These inputs played a crucial role in formulating targeted key messages tailored to specific groups. At the community level, UNICEF CE officers actively engaged in discussions and conducted social listening exercises to identify and address prevailing fears, misinformation, and disinformation. This community-centred approach facilitated a more informed and effective RCCE strategy, contributing to the overall success of the response efforts (see the section on AAP, p. 44). Further, this data also positively informed other sectors, including WASH and education.

Response area 3: Community surveillance and outbreak analytics

UNICEF's White Paper recommends 'to invest in informed and better decision-making through data systems that place women and children at the centre'.

In response area 3, UCO played a vital role in community surveillance. This was based on a request from the GoU and was integrated under the Strategic Information Research and Innovation (SIRI) pillar. To enhance effectiveness of the response, UNICEF provided training and support to VHTs in identifying, following up, and referring contacts and suspect cases. At the beginning of the outbreak., UNICEF deployed 15 vehicles, which greatly supported early detection. UNICEF also contributed to the strengthening of alerts management, supported training on active case search, and provided orientation to contact tracers on contact tracing guidelines, tools, and the roll-out of Go Data[17]. Additionally, UNICEF procured IPC/WASH supplies valued at US$230,000, specifically targeting VHTs involved in community surveillance. Many MoH stakeholders believed that UNICEF's surveillance support complemented the efforts of other actors and interventions under the MoH-led surveillance pillar. There is no doubt that these interventions contributed to effective and efficient contact tracing activities, contributing to timely response.

The new development of IOA was innovative and constitutes a best practice for future disease outbreaks. Following a request from the UK Foreign, Commonwealth and Development Office, UNICEF took a leading role in establishing and supporting an IOA cell, involving multiple actors and pillars[xcvi]. Applying lessons and strategies from previous DRC Ebola outbreaks, the IOA was set up under the MoH-led SIRI pillar, adopting a collaborative approach, leveraging transdisciplinary social science data, and drawing upon lessons learned from previous Ebola outbreaks and similar diseases. The IOA functions as an operational research unit that aims to conduct real-time systematic operational research collaboratively, informing operational decision-making during PHEs. UNICEF further supported the IOA cell by providing a dedicated space at IDI, donating 10 computers to MoH, and deploying two senior IOA specialists to offer support, with one co-leading the IOA working group. National MoH stakeholders stated that this system is currently being used for other disease outbreaks.

The IOA and Go Data informed disease outbreak decision-making. By mid-October 2022, efforts were made to support data management by utilising the Go Data tool for contact tracing, which proved valuable in collecting essential data to aid surveillance activities[xcvii]. Between October and December 2022, the IOA cell conducted six studies and the results were presented across pillars and DTFs (see Annex 16). Some of these studies were influential in shaping response decision-making. For instance, the health workers survey[xcviii], developed in collaboration with the WASH/IPD pillar, revealed that health workers lacked adequate understanding of Ebola symptoms and modes of transmission. Less than 50% of health workers were able to cite the first symptoms other than headache and 74% cited haemorrhagic symptoms, despite these only being present in 12% of cases[xcix]. This insight led to adapting training for health workers to address the identified gaps. Another study recommended conducting a malaria Mass Drug Administration (MDA) to reduce malaria mortality in Kassanda district[c]. There was a high incidence of malaria in the districts with active Ebola transmission. Reducing malaria incidence with MDA is beneficial not only in terms of reducing other health threats and strains on the health system but also in preventing misdiagnosis, as the symptoms of Ebola and malaria can overlap. In response to this recommendation, UNICEF actively supported the implementation of MDA in nine sub-counties across Mubende and Kassanda. Over the period from December 2022 to January 2023, a total of 181,579 individuals, including 406 persons with disabilities, received the MDA intervention[ci].

Response area 4: WASH and IPC

The UNICEF White Paper emphasises the provision of WASH services for everyone, encompassing health facilities, communities, homes, schools, and public places.

[17] Go Data is an outbreak investigation tool that is used for collecting field data during PHEs, including for case investigation, contact follow-up, visualisation of chains of transmission, and secure data exchange.

Under response area 4, UNICEF achieved important WASH and IPC outputs. As at 12 January 2023, a total of 4,233 health staff had been trained on IPC[18], 212 health facilities and 183 schools had received essential WASH supplies[19], and eight health facilities had received upgraded WASH and hygiene systems using solar-powered motorisation (see Annex 12). UNICEF further provided mobile toilets and water tanks for health centres and ETUs, and constructed two boreholes in Mubende district.

UNICEF expanded and adapted the WASH/ IPC response and covered new needs and critical gaps. When cases were confirmed in Kampala, Masaka and Jinja, UNICEF supported the health facilities in high-risk areas in Kampala, Masaka and Jinja (i.e. Mulago National Referral Hospital, Masaka Regional Referral Hospital, and Jinja Regional Referral Hospital). In 2023, priorities shifted and unused funds (200 schools had not been provided with handwashing facilities due to supply delays) were repurposed for the construction of sustainable solar-powered pumped water systems at three sites (Kalwana, Kiyuni, and Butologo).

'It was a very big achievement. We were handcuffed, and they [UNICEF] gave us support, logistics, training, support to 180 schools with water and soap, and trained teachers. They gave us thermometers for screening the children, as well as in six health facilities they put water systems.'
FDG, DTF, Kassanda

UNICEF stepped up and filled critical gaps in implementing SDB. UNICEF covered gaps in SDB capabilities by supporting URCS SDB teams with allowances, transport, and training. The socio-cultural complexities associated with SDB in the context of Ebola have been extensively documented[cii] and it was anticipated that these challenges would arise during the response. Unfortunately, the coordination of SDB – especially in regard to ensuring dignity – was a challenge, but only at the beginning of the response. Misinformation about the SDB process led to burials taking place at night, without the involvement of family members and often without the participation of cultural and religious leaders. These incidents could have been anticipated and prevented. Additionally, a shortage of fuel posed challenges for ambulance services, and SDB teams expressed dissatisfaction with their allowances, while some missed out altogether[ciii]. The absence of death certificates for individuals who died in Mubende ETUs created resentment and objections within communities[civ]. Some families exhumed their loved ones and performed additional cleansing rituals after the departure of the SDB teams, who had been responsible for their burial and choosing where it would take place[cv]. After the exhumation, UNICEF and its partners identified valuable lessons and ongoing simulation of SDB, orientation, and mentorship programmes were implemented. These lessons were derived from community feedback and collaboration with community health teams, which enabled the identification and resolution of key issues[cvi].

'We had 18 deaths, but the burials were carried out in the night. So, something didn't feel right, and the government was hiding something. Later they [the community] accepted [the night burials]. The president has signed an agreement with other countries to take our organs. Later we understood it was because they wanted to reduce the large gatherings.'
FGD, traditional healers, Kassanda

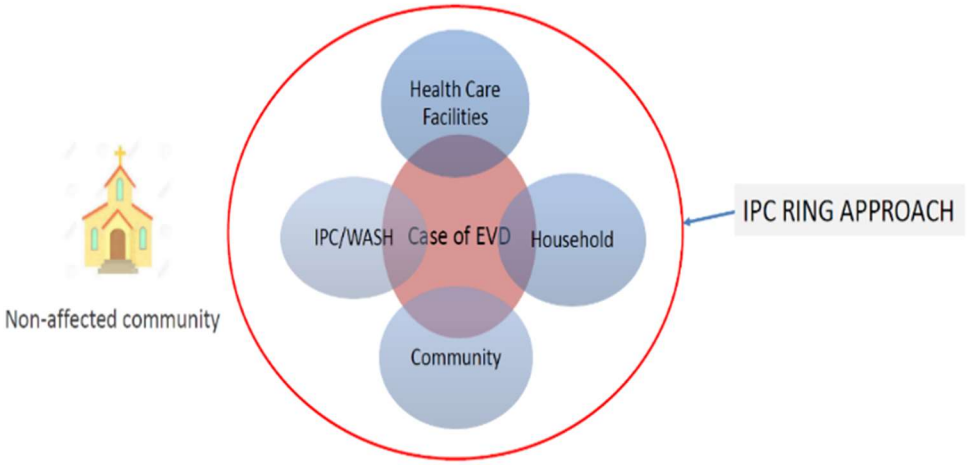
Key structural limitations within Uganda's healthcare system presented significant barriers to successful outbreak response. According to WHO, Uganda's healthcare performance ranks 186th out of a total of 191 nations[cvii]. In Madudu, the epicentre of the Ebola outbreak, as well as in several surrounding

[18] The evaluation did not have granular data on which health cadres received training and in which locations training took place.
[19] Chlorine, soap, handwashing facilities, and WASH IEC materials.

health centres, there was no running water and electricity when the outbreak started. UNICEF provided water to multiple health centres over the course of the response through temporary fixtures as well as sustainable boreholes.

UNICEF's collaboration with WHO and other partners in implementing the IPC Ring approach during this Ebola outbreak was noteworthy and should be documented for future disease outbreaks. While the evaluation team has limited primary data on the effectiveness of the IPC Ring approach (see Figure 8) in this specific context, it facilitated integrated and multi-partner responses. The IPC Ring approach bundled WASH/IPC support and training, along with key RCCE messages and engagement with VHTs and other community influencers within the Ring. It also included community surveillance and strengthened early detection and referral. UCO staff recognised the IPC Ring approach as an innovative model. It is worth noting that use of the IPC Ring approach has been previously documented in other Ebola outbreaks, further supporting its relevance and potential effectiveness in similar contexts.[cviii cix cx cxi]

Figure 8. IPC Ring approach (Source: WHO)



Response area 5: Case management

UNICEF's White Paper Recommendation 9 emphasises the importance of making life-saving countermeasures universally accessible, relevant, and acceptable to all. It also highlights the significance of protecting children and their communities.

Nutrition

Under response area 5, UNICEF performed well in regard to implementing a variety of nutrition interventions. These interventions included procuring and supplying 28,218 units of Ready-to-Use Infant Formula (RUIF) for the ETUs, as well as training 845 DHTs and health workers so as to enhance district and local health facility capacities to deliver Ebola-appropriate nutrition (see Annex 12). While national and district officials, along with health workers, provided positive feedback about UNICEF's efforts, the results fell short of the planned targets, with only 38% of the intended RUIF delivered to ETUs. This can be attributed to the overall low Ebola caseload of children. Looking at UCO's interventions through a human rights approach lens, UNICEF's nutritional interventions should be recognised as an endeavour to ensure that Ugandan children were able to enjoy their human right to adequate food and the nutritional elements necessary to lead healthy and active life.

The process of integrating nutritional protocols and adaptations for children in the ETUs was unnecessarily prolonged. While UNICEF was highly visible in the field, many NGO stakeholders reported that access to RUIF and the establishment of infant and young child feeding (IYCF) protocols took considerable, time due to cumbersome discussions and purchasing processes. The many challenges relating to children in ETUs are well-documented[cxii][cxiii] and thus partners questioned how UNICEF had institutionalised previous lessons about Ebola and IYCF. The nutrition sub-pillar under the Case Management pillar was introduced at the national level later because of the need to identify specific priorities for nutrition. It was not until 18 October 2022, one month after the declaration of the Ebola outbreak, that RUIF supplies started to be utilised[cxiv]. However, in October 2022, UNICEF took the lead in reviewing the national nutrition SOPs for nutrition and Ebola. UNICEF also reported that, by 15 December 2022, Case Management for Nutrition faced a funding gap of 91%, which potentially contributed to some of the delays.

Partner stakeholders also expressed a desire for UNICEF to advocate for improved Ebola virus disease treatment more actively for children. The CFR in children was a very high 60%, compared to 39% in the general population[cxv], and some ETU stakeholders reported that children were somewhat 'neglected' in the ETUs, in particular at the beginning of the outbreak. There was a need for age-specific critical care equipment and therapeutics for children. While there are no specific SVD treatment guidelines for children, case management stakeholders from NGOs reported their belief that more assertive treatment protocols for children should have been trialled. It was concerning that some children did not receive treatment, and it was reported that only those who received therapeutics in the ETUs survived Ebola. This was seen as a missed opportunity in managing a low-prevalence disease outbreak, but also hindered the implementation of early-onset research that could have contributed to building the evidence base for SVD in children.

MHPSS and child protection

Under response area 5, UNICEF reached 32,457 children, adolescents, and caregivers with community-based MHPSS services and trained 570 psychologists, psychiatrists, health workers, and community structures. Further, a total of 129 child protection case management interventions were carried out and child-friendly spaces were established in ETUs, including play kits and training for health workers on creating a supportive environment for children. Finally, 5,263 children and adults were able to access reporting mechanisms for SEA.

UNICEF implemented a whole-of-society-focused MHPSS and child protection response. At the national level, UNICEF collaborated with MoH and MoGLSD in developing MHPSS and child protection guidelines for PHEs. At the regional level, UNICEF established a new partnership with MoH Butabika Regional Referral Hospital, and this resulted in a referral system for MHPSS and child protection. At the community level, UNICEF took proactive measures by providing training to para-social workers at the grassroots level, enhancing their capacity to support affected communities. Simultaneously, the MHPSS and child protection teams engaged with RCCE initiatives to craft essential key messages. Moreover, UNICEF's efforts in MHPSS and child protection targeted various sectors, including ETUs, communities, schools, health workers, and government officials.

It is important to note that the implementation of MHPSS and child protection faced important delays. While MHPSS and child protection were part of the UNICEF preparedness and response in Uganda's 2018 outbreak[cxvi], these two sectors were absent from the 2022 National Response Plan and this sub-pillar was activated later on. The objections from MoH regarding the deployment of non-health workers in ETUs further hindered the timely integration of MHPSS activities, and delays were apparent in Mubende and Kassanda. Other contributors to these delays included delayed funding (November 2022), lengthy

approval for partnerships, and delays in sign-off. Some partner stakeholders noted that MHPSS and child protection trainings were conducted in late December 2022, and even in January 2023, after the Ebola outbreak had been declared over.

The integration of child protection in the PHE response shed light on the pressing needs of children in Uganda. Activating the MHPSS and child protection services highlighted the harsh reality of children's lives in Uganda, including vulnerabilities and issues of violence. This created a demand for such services. UNICEF successfully advocated within MoGLSD to integrate child protection in future emergencies and ensuring that child protection is prioritised. At the district level, child protection was integrated into emergency preparedness efforts. The approach of integrating child protection in emergency preparedness efforts aims to avoid waiting for a national-level response during emergencies, but the short nature of the Ebola response, the need for sustained resources for MHPSS and child protection long after the PHE response, and current funding gaps raise questions about how children will continue to access quality services..

> *'As a survivor I face a lot of challenges, but also the children were being discriminated against. The children never attended school. Children missed out on schools and were discriminated against – traumatising experiences for the children. The children hated school and stopped going to school.'*
>
> *FGD, Survivor, Madudu*

Response area 6: Preventing and addressing the indirect impacts of the outbreak

The UNICEF White Paper and the CCC emphasise the importance of maintaining and strengthening access to essential services, including health, education, and psychosocial support, during PHEs[cxvii].

Continuity of essential health services[20]

UNICEF enhanced the overall health service delivery capacity. At the national level, UNICEF provided technical and financial assistance to MoH, including in regard to developing Ebola guidelines. In addition to the MDA and the distribution of the long-lasting insecticidal nets, UNICEF strengthened immunisation and reached 9.7 million children with the Polio R2 nOPV vaccine. UNICEF also provided high-performance tents[21] to six ETUs, which made it possible to segregate Ebola and non-Ebola patients.

The imposed restrictions, fear, stigma, and supply shortages had a negative impact on access to essential healthcare services for many individuals. District reports noted challenges in access to healthcare, due to the movement restrictions, limited transportation, and scarcity of ambulances. FGDs revealed that fear of contracting Ebola and associated stigma were barriers to seeking healthcare for populations. IOA studies indicated that in Kassanda 57% of women reported a change in the availability of healthcare services for children, with 68% citing reduced availability due to transportation issues. Initial PPE shortages reduced health workers' safety in health facilities, and it was noted that they therefore refused to attend patients. In interviews with health workers in Kyegegwa district they noted a decrease in outpatient attendance compared to the same time in previous years, and in Kassanda they faced supply shortages as supplies were repurposed to Mubende district. Movement restrictions also affected individuals with chronic diseases. CRA respondents indicated that the main barriers to accessing essential health services were money for transport (50%), a lack of trust in healthcare service delivery (44%), and fear of being stigmatised by the community (4.2%).

[20] UNICEF's work to ensure the continuity of essential health services was an effort to ensure that even during the Ebola epidemic Ugandans continued to enjoy the right to health and their corresponding entitlement to a health system that gives them the opportunity to enjoy the highest attainable level of health.
[21] Standard UNICEF tents were adapted to be more appropriate for Ebola care.

'Nurses at the referral hospital [were] afraid of interacting with persons from this village because of fear of Ebola.'
FGD, mixed VHTs, Madudu

Continuity of learning

UNICEF contributed to ensuring continuity of education[22], thereby actualising Ugandan children's human right to education. In the aftermath of a two-year school lockdown due to COVID-19, UNICEF – in collaboration with MoES and MoH – committed to ensuring continuity of learning across different age groups. The UNICEF monitoring framework reported 3,345 schools were provided with thermometers, 283 schools had functioning Ebola task forces, 193 schools had received at least one supervision visit from MoES or the DEO, and 4,312 teachers and teaching staff were trained on Ebola prevention, early treatment-seeking, and notification. Specifically, UNICEF provided home learning materials to over 12,468 primary school children taking final examinations in Mubende and Kassanda districts, who were in home quarantine. UNICEF followed up clusters of suspected cases in children in quarantine and ensured adequate monitoring during the 21 days of follow-up.

UNICEF's transportation to support students going in and out of districts was particularly valuable. Transport was organised in and out of Kampala, Mubende, and Kassanda to ensure students could continue their education and sit their final exams in a safe manner. This reached 5,185 learners. The support was also extended to children in isolation by providing them with the necessary materials to complete their exams in Rubaga division. Perceptions from FGDs with learners, parents, and teachers, as well as from interviews with national and district authorities, were very positive on UNICEF's efforts. These results show that UNICEF was highly flexible, agile, and innovative in this regard, and demonstrate that children can continue to learn during small-scale but important PHEs like Ebola.

Some barriers and enablers identified are relevant to future similar Ebola responses. In interviews with teachers and school directors in Kassanda and Mubende districts, it was reported that school activities continued but attendance dropped. Students in FGDs reported their fear of attending school, and that those directly affected by Ebola faced discrimination. UNICEF worked with district authorities to ensure non-discrimination and the inclusion of children in schools. FGDs reported that once the outbreak was declared over, discrimination stopped. Further, movement restrictions posed challenges for teachers in reaching schools, particularly in remote locations, and especially during the rainy season. In Kyegegwa, schools were closed by the mayor. The CRA respondents highlighted that in potential future lockdown scenarios, the desired support to address barriers to essential services would have to include government subsidies (for water, electricity, and rent) (35%), cash transfers (32%), and food (13%). Ensuring continuity of education services was rated low on the priority list, with only 5.4% of respondents including it.

Continuity of services

Cash transfer interventions were not executed as part of the response. UNICEF conducted socio-economic impact surveys, but the results were released after the outbreak had already been declared over. The GoU expressed reservations about using cash transfers, fearing they could discourage people from pursuing their livelihoods. Furthermore, implementing cash transfers during a lockdown context was deemed an unsuitable strategy, although it could have benefitted the post-Ebola intervention. UNICEF cited a lack of human resources and funding as an impediment to carrying out cash interventions.

[22] UNICEF's White Paper recommends to 'ensure that no child misses out on their education and that with the exception of pathogens primarily transmitted by children, schools should be the last to close and the first to reopen'.

Response area 7: Logistics and operational support

In line with the CCCs, UNICEF should ensure the timely delivery and distribution of supplies and essential household items to affected populations, partners, and/or points of use.

UNICEF's logistical and operational support facilitated implementation of the response across several pillars and sub-pillars. UNICEF was a core member of the Logistics pillar and supported the existing government systems for procurement, distribution, and monitoring of supply by providing technical assistance and direct supply contributions. One technical officer was deployed to Mubende and Kassandra districts to work in partnership with MSF to set up the ETUs, including the provision of WASH and providing technical support to districts on supply management and monitoring. The repurposing of 15 vehicles was crucial to allow for early-onset contact tracing and case detection. Partner and MoH stakeholders were of the opinion that, alongside RCCE and WASH, UNICEF's supplies and its global procurement systems are among UNICEF's comparative advantages.

While stakeholders did not report many challenges within the logistics and supply sector, it is worth noting that PPE was critically short at the beginning of the outbreak and initially teams had to rely on COVID-19 PPE, which was not appropriate for Ebola. Supplying PPE was not solely UNICEF's responsibility. Also, supply was hampered by MoH instructions to use the COVID-19 PPE stocks first, before importing Ebola PPE. Furthermore, the GoU's centralised fuel systems were cumbersome and decentralised stock would have benefitted from more efficient distribution. Working within the existing government supply systems came with barriers. Procurement and supply systems in Uganda remain troublesome due to manual and paper-based procurement and supply processes. These result in significant stock ruptures at health facility level. Uganda's slow adoption and use of electronic logistics management information systems to support supply chain processes and functions[cxviii] was also reported to be a barrier to efficiency.

6.2 To what extent was the UNICEF L2 response adaptive and agile in the light of changing circumstances?

In line with the CCCs, adaptation is regarded as a standard for quality programming. UNICEF is expected to collect and analyse data on the situation of children and their communities to inform planning, programme design, corrective actions, and adaptation to changing needs and contexts.

UNICEF continuously adapted the response, and this maintained response relevance. UNICEF used previous Ebola lessons, data, community feedback, survey results, and IOA to monitor and adapt. Lessons included, for example the value of recruiting local influencers, and thus having access to local knowledge and a deep understanding of the context. The best results were achieved through UNICEF establishing a two-way communication modality with VHTs and other community influencers[cxix]. During the course of the outbreak, several assessments further identified specific vulnerabilities and needs of populations[cxx], including on non-Ebola health aspects. Such results instigated the implementation of the MDA[cxxi], and informed how to adapt Ebola trainings for health workers[cxxii] and how to maintain health service delivery during the outbreak[cxxiii]. UNICEF's AAR also induced reflection on how to improve L2 processes and response timeliness and effectiveness. Table 8 provides a snapshot of some of the most important adaptations captured by the evaluation.

Table 8. UNICEF Uganda's adaptations during the Ebola response, September 2022–March 2023

Adapted partnerships	• Partnering for the second time with KCCA/Kamapala Metropolitan Area (the first time was in relation to polio) to establish an Ebola urban preparedness and response plan • Partnership with URCS to cover gaps in SDB • Engagement of traditional healers and leaders as community influencers • Collaboration with Butabika Referral Hospital to ensure referral for child protection and psychosocial support services • Partnership with MoGLSD to include gender and child protection • Partnership with MoES in Ebola response to ensure continuity of education
Adaptation in kind	• Repurposing programme supplies to facilitate the initial Ebola response, including vehicles and other items • Repurposing programme funding to cover contingency funding deficits
Adapted ways of working	• Provision of ambulances to facilitate referral to and from health facilities to overcome movement restrictions • Provision of transport to ensure children could continue to be educated and take their final school exams • Establishing the Ebola U-report chatbot so users could access information on Ebola and receive real-time responses • Integrating the IOA under the SIRI pillar to ensure social science evidence could inform response decision-making • Supporting the implementation of the malaria MDA to reduce the malaria burden in the Ebola epicentre • Provision of child-friendly spaces, play kits, education items, and nurses to contribute to making ETUs child-friendly • Adaptation of training guidelines on Ebola transmission and IPC for health workers based on the IOA health workers survey[cxxiv]
Modality	• Covering implementation gaps and implementing the SDB response in collaboration with URCS • Partnership with WHO to implement the IPC Ring approach to ensure focused and timely case detection and transmission reduction
Focus	• Expanding Ebola preparedness and response to urban areas in Jinja, Kampala, and Wakiso • Identification of needs and vulnerabilities in children in the ETUs, in isolation, and who were survivors • Expansion of the National Response Plan and coordination beyond health through the inclusion of child protection, MHPSS, and GBV

6.3 To what extent were AAP and PSEA embedded in the UNICEF L2 response?

UNICEF's AAP and PSEA achievements have been benchmarked against the CCCs and UNICEF's AAP Guidance[cxxv] (see Figure 9).

Figure 9. UNICEF AAP framework (Source: UNICEF)

UNICEF was effective in putting the interests of children and affected people at the centre of decision-making[cxxvi],[cxxvii] and in establishing system-wide mechanisms for preventing, reporting, and responding to incidents of SEA.[cxxviii]

UNICEF successfully mainstreamed AAP and PSEA across all activities. Even though the concepts and practices of AAP and PSEA are external to the GoU and are seen as 'donor-driven', UNICEF's system-wide prioritisation of AAP and PSEA clearly enabled their prioritisation in the Ebola response, in line with its AAP[cxxix] and all-of-office PSEA strategic plan[cxxx].

Based on lessons learned from the DRC 'fiasco'[cxxxi], UNICEF incorporated and mainstreamed PSEA and AAP across all activities. UNICEF ensured the prioritisation of PSEA and AAP with all implementing partners and with community stakeholders. GBV and PSEA were incorporated into emergency preparedness plans and were therefore easily activated. Under UNICEF's development programme, potential UNICEF partners had been pre-evaluated according to an SEA assessment, to ensure there was no operational delay in terms of PSEA compliance in contracting implementing partner organisations during the response. Although UNICEF endeavoured to provide PSEA orientation to all temporary staff who were hired in response to the emergency, not all of them were oriented on PSEA before deploying to the frontlines. However, many frontline workers were trained in PSEA; additionally, partners were PSEA-assessed to ensure systems were in place to mitigate risks and response to allegations. Approximately 33,000 community members could access reporting channels for PSEA. PSEA was integrated into every part of the response and PSEA indicators were included in every standard emergency programme document.

The activation of the L2 emergency triggered the disbursement of US$500,000 for PSEA. However, the funds did not arrive in the country until the end of November/early December 2022. While waiting for these funds to be disbursed, UCO endeavoured to access flexible funding and worked with WHO around PSEA and GBV. However, the two-month delay caused some interviewed UNICEF members to query the cause for the delay and what that implied about the extent to which PSEA and GBV services were actually prioritised within UNICEF. There was no doubt that the L2 PSEA funding was immediately useful: it provided

for a GBV Emergency Response Team member, capacity training, IEC materials, and the procurement of dignity kits (e.g. menstrual hygiene supplies, jerry cans, soap, buckets, etc.) for SEA survivors and was key to providing services. No incidents of SEA were reported during the Ebola outbreak. The L2 monitoring framework reported that, under the coordination of the PSEA focal point, UNICEF trained 808 individuals. Among them, 61% were female. The training sessions included staff, partners (including officials, CSOs, and cultural and religious leaders), and volunteers. KIIs and FGDs with communities conducted in all visited districts did not reveal high levels of knowledge on PSEA. UNICEF partners demonstrated a good understanding of PSEA, but the majority of local authorities and implementers had limited or no knowledge regarding PSEA or AAP. This raises concerns about the effectiveness of the training conducted in these areas.

Under APP, UNICEF's engagement with communities was particularly successful (see the RCCE section). It was inclusive, participatory, and included several different methods of dialogue with communities, to understand what their needs and concerns were. UNICEF supported the GoU toll-free hotline that served as a feedback mechanism and an avenue for reporting concerns. Additionally, there was a child helpline that was designed to handle child protection cases and that also served as an avenue through which feedback was received at a national level. Feedback could also be provided via suggestion boxes, the U-Report live chats, or calling in to community radio programmes. The U-Report chat bot, developed by UNICEF, generated a cumulative figure of 33,208 users having accessed the bot between September and November 2022, with 18,705 total responses (see Annex 17). The U-Report teams responded in real time to the incoming questions and concerns through the live chats. Despite these established avenues for providing feedback, however, many complaints came through local political leaders – who were also the most trusted representatives according to the community. A significant majority of CRA respondents (68.6% for strongly agreed and somewhat agreed combined) indicated that they knew where to report complaints. Similarly, 68.9% (strongly agreed and somewhat agreed combined) were aware of where women and girls could seek support if they felt unsafe or had been violated.

Although UNICEF maintained a high level of AAP, there is one aspect of accountability UNICEF may wish to focus on for future emergency operations: greater accountability to the district governments it supports. For example, the leaders of Mubende, Kassandra, and Jinja districts indicated that they had no visibility on what assets UNICEF brought into their district during the response and, as UNICEF left Mubende district without conducting an official handover or exit interview, they also did not know what assets UNICEF had left behind. This raised issues of final accountability for them in the event of an audit. There were also challenges in collaborating with KCCA. UNICEF's funding went directly to implementing partners and was not channelled through KCCA. This led to disputes, KCCA refusing to provide access to communities, and ultimately to delays in the implementation.

6.4 To what extent were the needs and priorities of women and children, as well as those with disabilities or other vulnerabilities, embedded in the L2 response?

This section captures the findings relating to two evaluation questions from the evaluation framework (see Annex 3) and focuses on UNICEF's prioritisation of women, children, persons with disabilities, and other vulnerable groups. UNICEF is expected to ensure that vulnerable groups, including children and persons with disabilities, benefit from a full range of UNICEF interventions that embrace inclusivity and diversity[cxxxii].

Children

From the onset of the response, UNICEF prioritised children's needs and vulnerabilities. These efforts were driven by UNICEF's identity and its principles, but also by the high prevalence of Ebola cases

among children (28%) and the elevated CFR for children (60%). At the national level, UNICEF's advocacy efforts distinguished its work from that of other partners, with UNICEF successfully advocating for the integration of education, WASH, nutrition, child protection, GBV/PSEA, and MHPSS in the national Ebola response, where initially that response had primarily focused on health. This also involved including MoGLSD, MoH, and MoES in the response. Further, UNICEF supported the dissemination of the National Child Policy[cxxxiii] in KCCA in the Kampala area.

'UNICEF has always advocated for children from the start, different from what other partners have done. They excelled in providing context-specific support to children's need across case management but also across education.' KII, GoU, Kampala

The response extended its support beyond Ebola, ensuring that services remained safe and child-friendly, even in ETUs. Additionally, there are indications that the response focused on maintaining immunisation, antenatal care, safe delivery, and integrated community case management. The MDA protected children from malaria, with 16,359 children receiving MHPSS services, and 129 child survivors of violence benefitting from critical child protection case management services. Collaboration with MoH and MoES allowed schools to continue operating safely, and no school transmission was reported after the response started. Isolated children were accompanied to sit their final examinations, and UNICEF provided safe transport for them. Notably, the district of Kassanda reported that the intake of exams exceeded the intake in every previous year. UNICEF's efforts also extended to addressing the specific needs of girls by providing sanitary pads to ensure educational continuity during their menstrual periods.

UNICEF's comprehensive approach was complemented with using child-friendly materials, such as posters and comic books, to educate and empower children. Finally, through partnerships with organisations working with child-focused approaches (e.g. Save the Children, AVSI, and LWF), UNICEF further enhanced its child-friendly response. Together, these approaches contributed to expanding the coverage of specific children's needs and vulnerabilities in a PHE outbreak.

Children's voices were actively heard through various CE activities. UNICEF played a significant role in advocating for children in schools, fostering the inclusion of schoolchildren aged 5–12 and 13–18 in debates, and recognising the best performing teams and individuals. Efforts were made to identify and engage out-of-school children through dialogues held in open spaces and recreation centres. Notably, in Kyegegwa district, this inclusivity extended to refugee and migrant children as well. Children directly affected by stigma and discrimination were given opportunities to participate in discussions and received important key messages. At the national level, UNICEF provided support for the child helpline. Although it was challenging to consolidate exact numbers for children's participation in the response, the overall number of children reached during the response suggests that the participation efforts were successful.

The evaluation included the voices of children from Mubende and Kassanda districts. Overall, children in the FGDs stated that they understood the RCCE key messages they received (61% strongly agreed and agreed), the WASH/IPC support (91% strongly agreed and agreed), and the MHPSS messages (95% strongly agreed and agreed). However, most children still reported experiencing fear when going to school (57%), feeling unsafe at home (75% strongly agreed and agreed), and experiencing food insecurity during the lockdown (51% strongly agreed and agreed). UCO highlighted the lack of funding for necessary basic education and adolescent development interventions and the initial absence of allocated funds for child protection and MHPSS. The UNICEF AAR also acknowledges the need to strengthen child-centredness across UNICEF sectors.

Children directly impacted by Ebola were particularly vulnerable. They included survivors, orphans, and those who had lost a parent. Despite the gradual decline in stigma over the course of the response, FGDs with adults and children indicated that many children of survivors still faced discrimination, resulting in a strong aversion to attending school. FGDs with children revealed that families that had lost a parent no longer had the financial means to afford education. This recurring theme emerged strongly across FGDs with children, adolescents, and adults. The evaluation team did not find evidence of a comprehensive programme to support these children in the longer term.

'My father passed because of the Ebola and now I am afraid I can't go to school anymore.'
FGD, children, Kassanda

Women

The evaluation process emphasised the assessment of gender aspects in relation to the CCCs. UNICEF's commitment to integrating gender-sensitive programming in the response was evident, through several factors. Needs assessments (e.g. the study of the impact of Ebola on sexual, reproductive, maternal, and child health among women, youth, and adolescents in Kassanda and Mubende districts) revealed the specific needs of women and girls. These assessments were conducted by the IOA sub-pillar. In the response design phase, the operational plan included results and performance indicator targets that were disaggregated by gender and by district. Several sectoral responses, including child protection, MHPSS, and education, integrated gender-specific indicators. The L2 monitoring framework also disaggregated results by gender.

At the implementation level, UNICEF integrated gender aspects across RCCE, education, health, and child protection, focusing on women, adolescents, and girls. UNICEF's efforts also focused on preventing, mitigating, and responding to GBV. Strategic gender indicators and sex-disaggregated reporting were incorporated into various documents, including the L2 Benchmark Indicator Matrix and the situational analysis dashboards of cases, survivors, and health staff. Preventive actions and risk mitigation measures were implemented to address GBV, including establishing feedback mechanisms. UNICEF also mainstreamed PSEA. Partners, including CSOs, district officials, teachers, and volunteers, received training on GBV risk mitigation in the Ebola response, with an achieved target of 99% (n=695, of which 57% female). Similarly, 77% (n=808, of which 60% female) of UNICEF staff and partners (e.g. district officials, cultural and religious leaders, and volunteers) were trained on PSEA (see Annex 12). Cross-sectoral RCCE efforts included gender-sensitive messaging to address the specific needs and concerns of women and girls, and messaging on how to access the available services. Up to 11 January 2022, 594 women, girls, and boys benefitted from GBV risk mitigation, prevention, and response interventions. UNICEF also supported the development, dissemination, and implementation of clinical guidelines for the delivery of infants of Ebola-positive pregnant and breastfeeding women.

At the coordination level, UNICEF advocated for the inclusion of MoGLSD in the Ebola response; this was a notable achievement given the vertical pillar management structure of the Ebola outbreak, which initially only included MoH. GoU stakeholders acknowledged the initial lack of integration of gender, and more specifically GBV/PSEA and child protection, in their response plan, and it took UNICEF some time to advocate for the inclusion of these interventions. UNICEF developed a strategy to engage with the GoU on GBV/PSEA, but completion of the draft strategy remains pending. Additionally, UCO and ESARO staff reported that the importance of PSEA and GBV still needs greater visibility and recognition within UCO.

The outbreak of Ebola and the implementation of lockdown measures likely led to an increase in GBV cases. The lockdown posed challenges in regard to accessing services and, as a result, some cases may have gone unreported or not received sufficient attention and support. Interestingly, during FGDs

women and girls shared that they felt safe from GBV/SEA. However, the DHTs and VHTs reported an increase in cases of domestic violence due to the lockdown measures, along with knowledge gaps concerning the Ebola viral load in semen and transmission prevention measures.

'Men now were beating their wives because they now had no work with the lockdown and there was no money, so they had stress.'
FGD, affected community, Jinja

Regarding UNICEF's own Human Resources, the organisation's HR management and leadership development did not demonstrate gender equality principles. Only 23% of deployed HR were female[cxxxiv], indicating a gender imbalance that should be addressed. Interviews with UNICEF indicated that in some cadres there are fewer females than males. Also, there tend to be fewer females involved in emergency work. There was an effort to deploy females in the response, although deployment was also dependent on approval at the different levels, and on the availability of staff.

Persons with disabilities

The integration of persons with disabilities was not explicit in the UNICEF Ebola Response Plan, the Post-Ebola Response Plan, or the AAP Action Plan[cxxxv].

At the implementation level, UNICEF integrated a Disability in Early Childhood Screening Tool as part of the malaria MDA assessment in Ebola-affected districts. The programme screened children for disability and developmental delays and linked such children to appropriate services. 406 persons with disabilities were identified in nine sub-counties in Mubende and Kassanda. FGDs with VHTs and affected communities reported that individuals voluntarily took responsibility for the care of persons with disabilities. Further, through its partnerships with Save the Children and AVSI, UNICEF conducted additional deliberate efforts to both identify and target persons with disabilities and other marginalised people. Overall, there were efforts to integrate disability considerations into the MDA response. However, interviews with UCO also indicated that disability interventions were also disrupted as a result of Ebola, and that children with disability faced specific barriers like, for example, the lack of transport to get to school.

Other vulnerable groups

UNICEF's interventions aiming to reach all of society contributed to the identification of specific vulnerabilities. The organisation's CE, child protection, MHPSS, and AAP interventions further identified other vulnerable populations at ETUs and isolation facilities, and within communities. The media and IEC materials also played a role in emphasising the importance of this, and UNICEF requested all partners target vulnerable groups. UNICEF's interventions reached all layers of communities, from national to parish level, and this facilitated the identification of vulnerable people, including children with protection risks, children vulnerable to malaria, malnourished children, refugee children, and those living in urban settings. UNICEF also identified children and adolescents who were out of school, to ensure their protection, as well as child survivors and those indirectly impacted by Ebola, including orphans, children that had lost a parent, and generally vulnerable households.

While such groups were not discounted in the response, there was no quantitative data reporting on the inclusion of vulnerable people, beyond children, women, and persons with disabilities. It is also not clear what action was taken to correct this, either through UNICEF's Post-Ebola Response Plan or other longer-term planning. UNICEF interviewees stated that reaching vulnerable groups was not considered in the plan, but other interviewees indicated that this varied across districts and pillars. For example, in Bugogo subdistrict DTF members reached vulnerable groups through house-to-house visits, while in Mubende district vulnerable groups were considered for, and received, food relief distributions.

Support provided to survivors – a particularly vulnerable group – was inconsistent and varied from community to community. MoH developed a national programme to support Ebola survivors and requested support for this from partners, including UNICEF. Of the 87 Ebola survivors,16 survivors were below 19 years of age. The aim of this support to survivors was to sustain, care for, and support survivors, as well as involving knowledge management activities for 18 months after the end of the outbreak. UNICEF's post-Ebola response plan describes the support to Ebola survivors through each of its pillars, much in the same way as in the UNICEF Ebola Response Plan. According to the plan, survivors will receive ongoing case management follow-up, as well as socio-economic support to meet their basic needs. In Madudu subdistrict, survivors received food support, as well as psychosocial services and transportation to the hospital or local health centre for follow-up consultations. In FGDs in Kassanda and Mubende most survivors indicated that international organisations continued to check on survivors to monitor their health. Many survivors shared with the evaluation team that they experienced significant ongoing health problems (including in regard to their mental health), which hindered them returning to their previous occupations. Additionally, those who had lost their businesses due to lockdown, discrimination, or their employment being terminated by employers faced challenges to ensure continued livelihoods. Most survivors reported receiving no support in terms of livelihoods, and they were all concerned about how they would provide food for their families and pay for their children's school fees in the future. However, a minority mentioned receiving non-food items and food packages that assisted them in reintegrating into their lives after Ebola. The majority of national government stakeholder KIIs indicated that the exit from the Ebola response was sudden across agencies, and that support to survivors did not extend much beyond clinical follow-up.

'They burned the shop and now all the clothes were destroyed, so she lost her business.'
FGD, VHTs, Kassanda

6.5 To what extent was the L2 response adequate and proportional in its coverage?

Following the CCCs, coverage should be guided by estimates of people in need and is expected to be balanced with the quality of programme responses.

UNICEF was in the right place. UNICEF's coverage enabled the organisation to identify and respond to the severity and scale of need among affected populations. Broadly speaking, both interview and desk review data indicated that UNICEF's geographical coverage was appropriate and proportionate to the scale, urgency, complexity, and capacity of the response at the different levels (see Annex 13). UNICEF expanded its coverage by establishing five response hubs, at national and subnational levels, which were adequately staffed. UNICEF covered all nine Ebola-affected districts[cxxxvi] and another four specifically on preparedness[cxxxvii].

The organisation did not intervene in all pillars across all districts, but this approach was appropriate as regards balancing coverage with priorities, operational constraints, and the capacity of partners on the ground. For example, there were child protection and MHPSS interventions in Mubende, Kassanda, and Kyegegwa districts but these did not extend to other districts, while the urban districts of Kampala, Wakiso, and Jinja did not benefit from continuity of health and nutrition services – an appropriate approach given the low Ebola caseloads there. However, where they were needed the most, in the districts of Mubende and Kassanda, UNICEF operationalised all of its pillar and sub-pillar activities, including cross-cutting GBV and PSEA interventions. Where no population coverage was achieved this was often due to delays in response. The delays reduced the relevance of the response, and thus resources were repurposed to the post-Ebola response. Some of the monitoring results provided good evidence of population coverage. For example, 95% of the targeted people were reached with accurate, and culturally

and gender-appropriate messaging, 94% of key influencers were engaged on Ebola prevention, and 188% of targeted children and adults had access to UNICEF-supported SEA reporting channels (see Annex 14).

6.6 To what extent were relevant standards, commitments, principles, and policies adhered to throughout the response?

The CCCs describe how UNICEF's programming should adhere to relevant standards, commitments, principles, and policies to ensure a high quality of response. The CCCs, UNICEF's Emergency Procedures, and other principles have been used to inform this section.

UNICEF adhered to its core commitments and priorities in regard to emergency response. Alignment to the recent White Paper on PHEs was evident in the sense that UNICEF assumed its role as a public health player in strengthening primary healthcare through targeted health, WASH, and IPC interventions. The efforts on the continuation of education were also clearly linked to Recommendation 5 in the White Paper that no child should miss out on their education, and this was evident through the achieved education outputs. The response was guided by the CCCs, and in particular the commitments relating to PHEs, including '*Children and their communities are protected from exposure to and the impacts of PHEs*'. The UCO assumed its coordination and leadership roles in support of national and local authorities in line with the L2 emergency procedures.

However, some UNICEF staff reported that evidence and data generation should have been implemented earlier in the response. UNICEF also faced challenges in aligning with its L2 emergency procedures due to a lack of familiarity with the L2 emergency protocol (see the section on timeliness, p. 54).

While the Ebola response addressed most of the relevant operational commitments, there is no evidence in the documents reviewed that sufficient consideration was given to environmental sustainability. The CCCs highlight the importance of integrating environmental sustainability into UNICEF's humanitarian action to enhance community resilience to climate change, with support on this to be provided by ESARO and HQ. However, the clause stating 'whenever feasible and relevant' suggests that environmental considerations may not be prioritised in an Ebola scenario. Additionally, the UNICEF emergency procedures do not explicitly mention climate or environmental approaches, leaving uncertainty about the extent to which they were prioritised in the emergency response. Given the current climate agenda, its link to global health security[cxxxviii], and the anticipated increase in emerging diseases due to climate change[cxxxix], the evaluation team thought it valuable to raise this.

Humanitarian principles, as well as the principle of doing no harm, were mostly adhered to. Throughout most KIIs and FGDs participants indicated that UNICEF applied the humanitarian principles appropriately, or did not mention that adherence to the principles was a concern. KIIs with some staff indicated that UNICEF was too risk-averse, and that a 'no-regrets' approach was not sufficiently applied. However, KIIs with UNICEF indicated that this was constrained by some of the delayed funding, which pushed UCO to prioritise their efforts and resources. Some staff were unfamiliar with the idea of a 'no-regrets' approach, while others indicated that this approach was not applied before the L2 was activated. UNICEF's ability to adapt and be flexible does, however, underscore that efforts and resources were focused on the most urgent needs and vulnerabilities.

6.7 To what extent was the L2 response connected to longer-term strategy and programming?

This section describes how the emergency response aligned to UCO's existing development programming.

UNICEF connected the L2 Ebola emergency operations to longer-term strategy and programming. The Ebola Response Plan did not explicitly connect the L2 response to long-term strategy and programming[cxl], but when analysing its core activities UNICEF clearly adhered to institution-established practices for linking humanitarian and development programming.[cxli] UNICEF built on local capacity found both at the individual and community levels and strengthened established systems from the onset of the Ebola outbreak.

During the L2 there were clear linkages to UNICEF's development programming in support of the SDGs. UCO provided technical assistance to MoH in finalising the National Community Health Strategy 2022–2025[cxlii]. Here, UNICEF's advocacy for financial remuneration of VHTs has taken Uganda a step further towards formalising the role and position of community health workers within the public health system. Further, UNICEF supported the finalisation of the National IPC strategy, while also establishing mechanisms for digital community surveillance. Specific to health, UNICEF supported the development of guidelines on the management of pregnant and breastfeeding women in the context of Ebola. This was disseminated to the GoU and integrated in ETU practice. Furthermore, UCO continued to advocate for the approval of the Inclusive Education Policy[cxliii] and the Early Childhood Care and Education Policy[cxliv], both of which are currently awaiting approval from MoES[cxlv]. It also supported KCCA to adopt its Child Policy. The construction of seven permanent solar-powered boreholes and five pit latrines with permanent drainage in Kasanda and Mubende districts during the Ebola and post-Ebola interventions further showcases that the Ebola-affected areas were left with increased water and sanitation capacity. These efforts during the L2 activation demonstrated UNICEF's commitment to integrating emergency response activities with its long-term development agenda, ensuring that interventions addressed both immediate needs and contributed to the broader SDGs.

Connections between the Ebola interventions and UNICEF's longer-term strategy and programming were not always apparent to the key stakeholders consulted by the evaluation team. Most interviews with local authorities and hospital staff indicated that the physical resources that had been placed in the districts and communities during the Ebola response had either been removed or consumed. A common theme across districts and communities was that the improvements in the health system that occurred during the Ebola outbreak could not be sustained and that now they were 'left as before'. Health and education personnel – at both the village and district levels – consistently indicated to the evaluation team that they do not have adequate resources or support to respond to the next PHE. Many health and education facilities lack sustainable water supplies.

'We are not ready now because we have nothing. … We have few sanitisers, soap, even gloves. We start from nothing. We have to start but we are really badly off, and we have to take care of it. When we have an outbreak, everybody comes. When the outbreak is finished everybody leaves and we are back to zero.'

KII, Health Worker, Mubende Regional Hospital

6.8 To what extent did UNICEF scale up the L2 response efficiently?

According to the UNICEF emergency procedures, an L2 activation is expected to mobilise resources (financial, human, supplies, partnerships) to enable an efficient and effective emergency response.

Funding mobilisation

The L2 response successfully mobilised sufficient resources for the Ebola outbreak. UNICEF reported having raised US$7,949,919 under the Ebola response, which was considered adequate for the

planned interventions. Of this, UNICEF received US$6.6 million from donors and utilised other resources, including reprogrammed existing funds, totalling approximately US$1.6 million. During the active response, 81% of the received and reprogrammed funds were utilised, while the remaining 19% were allocated for the post-SVD recovery period (a total of US$1,540,000). UNICEF's contributions to the collective response during the Ebola outbreak in Uganda amounted to 10%[23].

Reprogramming regular and thematic funds enabled UCO to effectively respond to the emergency in the early phase of the response (e.g. repurposing COVID-19 funds). This reprogramming of funds was carried out before the L2 was declared and while initial discussions with donors about the availability of additional funding and the reprogramming of funds were ongoing. This is to be commended as an enabler of operational efficiency. UNICEF HQ mobilised US$925,926 from the United States Agency for International Development under an umbrella grant that was available in the first week of the outbreak. This was instrumental in accelerating the response, especially for WASH, and is a best practice that should be considered for other outbreaks. Loans from the EPF of US$2.5 million for Child Protection and US$500,000 for PSEA (as per L2 protocols) contributed to operational efficiency. However, the US$500,000 earmarked for PSEA arrived two months after the L2 activation.

Most of the funds received were spent on RCCE, followed by case management and WASH/IPC; these pillars were seen as UNICEF's comparative advantages by GoU and partner stakeholders (see Table 11). There were no reports of poor VfM specifically, but some of the delays in receiving supplies and funding resulted in diminished relevance and therefore were interpreted as wastage. Examples include the purchase of thermometers, IEC materials for schools, and WASH stations for schools, as well as the late arrival of funds for PSEA, child protection, and MHPSS. However, such funds were appropriately repurposed to relevant long-term interventions (e.g. permanent boreholes). The large proportional investment in RCCE was perceived as fair in terms of VfM in an Ebola scenario – in particular, investment in mass media over TV and radio – as well as all-of-society CE. In the education sector, the transportation of students incurred high costs per individual. However, this decision aligned with the L2 principle of 'no regrets' and UNICEF's guiding principle of 'acting in the best interests of the child' (see Annex 18).

Economic efficiency

The Ebola response programme did not have pre-set budgets linked to output and outcome targets, and this constrained the possibility of an economic efficiency assessment. However, efficiency is also affected by the series of choices made over the course of the response and is connected to both the relevance and impact of interventions.

The response made a significant contribution to improving efficiency and achieving the desired results. The pillars of the intervention, in respect to relevance, results, and effectiveness, were well designed and aligned with the context. The interventions were feasible, and the resources allocated were effectively converted into tangible outcomes. No apparent waste or misuse of funds was reported. Table 9 provides a summary of the good choices made, demonstrating how budgets were effectively translated into direct outcomes and impacts.

Table 9. UCO economic efficiency indications, September 2022–March 2023 (Source: UNICEF[cxlvi,cxlvii])

Supporting observations:
• Over 85% of the funds UCO received were spent on operations.

[23] Ebola Virus Disease Outbreak Response Accountability Forum, 10 January 2023.

- Almost 35% of the operational funds were dedicated to RCCE, which made it the most expensive component of the intervention. However, between October and December 2022, Ebola campaigns were aired on 47 radio stations, reaching 10.5 million people. During that same timeframe, 8.1 million people were reached via Ebola campaigns on TV (seven stations). Given the extensive reach of the targeted messages on prevention and services, resulting in the engagement of persons to reduce the transmission of Ebola and the proven impact of such an approach, the efficiency of the decision to dedicate 35% of operational resources to this pillar seems indisputable.
- 23% of the operational funds went to the Case Management pillar; however, nearly 50% of that expense was used to procure RUIF and nutrition commodities. There is no questioning the impact of this life-saving nutritional intervention. That said, only 38% of RUIF ended up being supplied to ETUs (although this is mostly attributed to the overall low Ebola caseload among children).
- 15% of funds went to CoES. Out of this budget, 12,468 learners were transported within and out of restricted districts, and health officials indicated that this contributed to a record level of learners sitting their national exams. The impact of this expense on the lives of the learners who benefitted from this intervention is evident.

Timeliness

The issue of earlier L2 activation, and its potential benefits for a timely response, elicited contrasting opinions. There was a notable 36-day gap between the declaration of the Ebola outbreak and the activation of the L2. This delay is particularly significant given that virus transmission was halted within 69 days and the outbreak was controlled within 113 days. It is worth mentioning that the L2 activation occurred on 27 October 2022, 16 days after the first cases in Kampala were registered and 27 days after the epidemiological peak (see Annex 19). The delay in L2 activation was partly attributed to UCO's lack of familiarity with the procedures and, according to UNICEF staff, some political resistance, despite WHO having declared an L3 emergency the day after the outbreak was declared. While some argued that an earlier activation would have been advantageous, particularly in addressing delays in HR and supplies, the impacts of these delays were primarily felt at the subnational level.

Nonetheless, UNICEF had already initiated its response prior to the L2 activation and received support from ESARO in terms of reallocation of funds, deployment of personnel, and adaptation of regular programme procedures. This enabled UNICEF to swiftly repurpose vehicles, procure necessary supplies, and commence support at the national level within seven days of the Ebola outbreak declaration (see Annex 19)

Irrespective of the timing of the L2, the response efforts were adversely affected by delays, resulting in diminished relevance. Delays to interventions were mostly due to delays in receiving funding, HR, and supplies, and these were identified in UNICEF KIIs and UNICEF's AAR report. These challenges were reported across all pillars and levels of the response, albeit to a varying degree. One delay was observed in the deployment for RCCE, which took almost a month. Internal delays in the development of, and approval process for, child protection programme documents, and also funding disbursements towards MHPSS and child protection, limited UNICEF's ability to provide timely interventions. MHPSS and PSEA staffing and funding support were only available towards the end of the response.

HR

UNICEF mobilised a total of 98 staff members, including personnel from UCO, ESARO, HQ, and locally recruited individuals. The deployment of surge personnel, combined with the timely repurposing

of eight UCO individuals within the response, contributed to initial operational efficiency, as did the deployment of an ERT Emergency Coordinator before the L2 activation. External staff started arriving in mid-October 2022 (n=17), but most arrived in November 2022 (n=23). UNICEF's HR tracking sheet showed that there were delays in deployments, and this was most apparent at subnational level, with some UNICEF staff indicating that it took one month from the Ebola outbreak declaration to have sufficient UNICEF staff in the field. There were challenges in terms of implementing the accelerated timelines for approval of emergency recruits and the timely appointment of temporary staff (despite the fact that UCO had a list of potential consultants from the COVID-19 response). The deployment of an ERT HR specialist (as per the L2 protocols) would have improved efficiency in this area and could have enabled UCO to keep pace with staffing needs. The delays in temporary appointments were caused by the need to apply an appropriate level of insurance, given the nature of Ebola (see Annex 20).

Duty of care

Regarding duty of care, UCO prioritised the safety and wellbeing of its staff. Ebola prevention protocols effectively protected all UNICEF staff from infection. Comprehensive briefings were provided by relevant personnel. UCO was fully aware of the considerable stress associated with Ebola response operations, particularly in Uganda, where no Ebola vaccine was available. Protocols were implemented to allow regular rest and recuperation for staff, preventing burnout.

Both the UCO staff interviewed and the AAR pointed to some weaknesses in this area. The duty of care was primarily focused on field staff, and Kampala staff received comparatively less attention. Additionally, living conditions for those working in the field were reported to be below acceptable standards, as highlighted by UNICEF staff at subnational levels. Some facilities lacked safe drinking water and electricity, while repairs were needed in locations where UCO personnel stayed, which led to several staff members falling ill. Although their resilience during the emergency is commendable, it is evident that more could have been done to ensure acceptable accommodation for UCO personnel working in or visiting the field.

Partnerships

Many within UCO were unfamiliar with UNICEF's Emergency Procedures[cxlviii] on partnerships. The potential implementing partners were not identified through the Minimum Preparedness Actions, and contingency programme documents were not signed. Still, UNICEF efficiently leveraged its COVID-19 partnerships in its Ebola response and established partnerships with seven partners[24], in parallel to its existing partnership with the GoU. Similarly, although PSEA assessments had been conducted for all CSO partners – a significant enabler of efficiency – UCO personnel were largely unfamiliar with/unable to action UNICEF emergency procedures that simplified and streamlined the process so as to establish and implement partnership agreements in an expedited manner. Several reports from the AAR, as well as from FGDs with local responders, confirmed that funding transfers came in late. Implementing partners also indicated that some delays in funding were caused by their own organisations.

UNICEF forged partnerships with NGOs that have experience in implementing child-friendly approaches, enabling the integration of MHPSS through collaboration with organisations like Butabika Regional Referral Hospital, as well as child protection through partnerships with AVSI and Save the Children. These organisations also had established mechanisms for AAP and PSEA, which facilitated the seamless integration of these cross-cutting approaches. Collaborating with the Red Cross facilitated swift connections with communities at the grassroots level. Some of these partnerships were pre-existing, and UNICEF's engagement with local responders and community influencers supported a whole-of-society focus.

[24] World Vision Uganda, Uganda Red Cross, Save the Children, AVSI, WLF, Living Good, and the Malaria Consortium.

Advocacy

UNICEF's advocacy efforts played an important role in promoting child-friendly policies and practices and addressed crucial programming gaps. At the country level, these efforts consistently prioritised the best interests of children, and GoU and partner stakeholders reported that UNICEF emerged as the primary 'child-focused' advocate in the response. Notable accomplishments include the IYCF practices for ETUs, the integration of child protection and MHPSS, working with survivors to support children in ETUs, sex disaggregation in ETUs and isolation units, and the inclusion of MoGLSD and MoES in the Ebola response. Furthermore, UNICEF, in collaboration with the GoU, actively participated in the development of national-level strategies (e.g. the Uganda Community Health Strategy and the Uganda IPC Strategy) that will yield long-term benefits. The research supported by UNICEF (e.g. studies conducted by the IOA and anthropological studies) provided valuable evidence to inform decision makers.

6.9 What innovative approaches were used that could be leveraged in the continued response?

To inform the section below, the evaluation applied UNICEF's definition[cxlix] of 'innovation'.

The approaches listed below were identified based on qualitative assessments and feedback gathered from various stakeholders, as well as on observations and discussions conducted with affected populations. The evaluation team believe that the innovations listed in the table yielded positive results or, at the very least, are worth documenting for future adaptation and scale-up in similar scenarios. The table provides an overview of innovative approaches, activities, and models that could be leveraged in similar and other future PHEs.

Table 10. Innovations during the Ebola outbreak, September 2022–March 2023 (Source: evaluation team)

Collaborative and partnership innovation	• The inclusion of MoGLSD and MoES in the MoH-led health response ensures a more holistic approach to Ebola beyond only health interventions. At the national level, this progresses national policy and strategy development. At the community level, this results in a positive impact on the lives of children, by identifying and addressing their non-Ebola-related needs.
Digital / data innovation	• The integration of the IOA cell under the SIRI pillar ensures the integration of social sciences in the Ebola response (knowledge, attitudes, and perceptions of affected populations), and provides real-time insights into the local context, community dynamics, and social factors influencing the disease's spread. • The digital U-report platform collects feedback and provides real-time responses, enabling timely communication and engagement with the community.
Operational innovation	• The IPC Ring approach ensures geographically focused, multi-sectoral, and integrated interventions for early detection and reduces transmission of Ebola. • Transportation arrangements for students ensure the continuation of education during lockdown. • Child-friendly approaches, including play and education, in the ETUs and isolation centres support ongoing child development. • UNICEF tents were modified to ensure their suitability for Ebola clinical care. • The inclusion of a wide variety of community influencers in the DTF ensures that key messages and actions reach all segments of society.

6.10 To what extent were there missed opportunities and gaps?

While UNICEF demonstrated many commendable efforts, the evaluation identified gaps and missed opportunities that should be leveraged in future PHEs. These include a lack of proactive advocacy for policy translation and coordination, the need to clarify roles in PHEs between United Nations agencies, the need to implement cash grants to reduce secondary impact of epidemics and their movement restrictions, the need for early onset collection of child-specific data, and the need for child-focused research to build the evidence base of emerging diseases. Incorporating these insights can enhance UNICEF's preparedness and response strategies for future Ebola outbreaks, fostering more effective, inclusive, and agile interventions. Annex 21 provides an overview of these specific missed opportunities.

6.11 To what extent were lessons learned from previous outbreaks and preparedness measures applied in this response?

In general, UNICEF applied previous and relevant Ebola lessons that are relevant to its mandate in PHEs. Annex 22 includes specific lessons from UNICEF's experience[cl], but also collective lessons[cli]. The lessons captured are those that are aligned to the UNICEF White Paper on PHEs and a red-amber-green rating is applied[clii]. Readers are encouraged to review this section with the above sections on innovations and missed opportunities (section 6.9 and 6.10)

At the time of the Ebola outbreak declaration, UCO had limited national capacity with Ebola expertise on the ground. The office was reported to have experienced rapid staff turnover and new staff did not review or learn from previous Ebola outbreaks. There were no reports of annual simulations or training to keep Ebola knowledge and information institutionalised in UCO. There was also a lack of familiarity with L2 emergency procedures, which further reduced the capacity of UCO to activate such procedures quickly and accurately. Evident lessons that should have been adopted at the beginning of the outbreak included, for example, the need to integrate child protection and MHPSS. These are UNICEF's core business but they were also highlighted in previous UNICEF Ebola lessons. However, other valuable previous Ebola lessons were indeed adopted and added significant value to the response, including the strong focus on CE, including the integration of local influencers and responders in the response. Also, the model of IOA was adopted from the previous DRC Ebola outbreak and added value to the Uganda response.

6.12 What mechanisms/systems should UCO adapt and put in place to ensure agility and to prepare for the immediate future, adjusting to the changing context and different age-, gender-, and disability-related needs of women and children?

Table 11 outlines specific age-, gender-, and disability-related (AGD-related) needs of women and children derived from the findings. The table provides action points that can strengthen the transition from the Ebola response to longer-term programming. These action points are complementary to Outcome 2.1[cliii] and 2.2[cliv] of the Uganda CPD[clv].

Table 11. UNICEF Uganda Ebola response: opportunities for adaptation to enhance AGD aspects

Proposed actions	Rationale
Systematise and expand the identification of AGD-related needs for women and children	VHTs and para-social workers can facilitate the community mapping of AGD-related needs for women and children. By maintaining this mapping at the district level, UNICEF would be able to collaborate directly with district and community officials to provide targeted support for vulnerable individuals in the future.

Strengthen effective referral pathways and services to address the AGD-related needs of women and children	The FDGs revealed that women are well aware of GBV and know where to seek help. However, they often find reporting to the police unsafe and that the police are unhelpful in providing solutions. There were also reports indicating that essential services like health and protection are either unavailable or inaccessible for them.
Establish a quality assurance mechanism as an integral part of the monitoring and evaluation process	Referral pathways currently exist, but the accessibility and quality of these services are often suboptimal. To improve this situation, insights from other agencies' practices (e.g. Marie Stopes International) need to be applied, while the implementation of systematic quality assurance processes would also be beneficial.
Ensure gender aspects are systematically integrated in all phases of the project cycle across humanitarian and development programming	While there was evidence that women were prioritised in the response, UCO's gender balance in employment does not exemplify this.
Implement unconditional cash grants to support the AGD-related needs of women and children impacted by Ebola	Cash grants were not implemented but are recommended in an Ebola response, in particular during the recovery phase.
Expand on AGD-specific data technology to monitor and evaluate results	Child and vulnerability data did not appear to be routinely and systematically collected, which limited the opportunity to inform the response effectively.
Innovate alternative ways of delivering education	UNICEF's transporting of students was commendable; however, this model is likely to only be appropriate in small-scale outbreaks. Preparation for large-scale outbreaks and lockdowns is necessary, as is investment in off-the-shelf technology to ensure continuity of education.

6.13 How can UCO integrate emergency response into the HDP nexus?

This section differs from Section 6.7 as it focuses on the emergency response in relation to the HDP nexus. UNICEF's Procedure Linking Humanitarian and Development Programming[clvi] *recommends that UNICEF's emergency interventions should be linked with development and peacebuilding actions, while strengthening collaboration, coherence, and complementarity among actors.*[clvii]

While UCO's emergency response contributed to collective Ebola outcomes and strengthened the capacities of local partners, the UNICEF Ebola Response Plan did not clearly integrate HDP nexus procedures. UNICEF's HDP nexus procedure revolves around reducing overall vulnerability and needs by addressing root causes through risk informed, multi-partnership programmes. Nexus-informed programmes typically strive to accomplish these collective outcomes via joined-up interventions between humanitarian and development programming. The evaluation also found that understanding of the HDP nexus among Category I and Category II stakeholders was nebulous. Still, there were several indicative examples of adjustments that were made during the implementation of response activities that strengthened the linkages between humanitarian and development programming. The table below lists achievements on HDP nexus linkages and provides guidance on how UNICEF can integrate emergency response into the HDP nexus.

Table 12. UNICEF Uganda Ebola response: suggestions on integrating emergency response in the HDP nexus

Indications of linking humanitarian response with development goals	**Achieved:** • Strengthening primary healthcare systems through sustainable WASH/IPC infrastructure (solar-powered boreholes) and the Continuity of Health Services pillar (e.g. malaria, immunisation, and malnutrition). • Strengthening the education system through the Continuity of Education Services pillar. • Strengthening Ebola preparedness in districts at risk and building the capacity of the VHTs, who are the local responders. • Providing training on IPC, surveillance, internet infrastructure, and CE have significantly improved preparedness in the nine affected districts, including private structures. • Collaborating with partners in the child protection system and on GBV to ensure emergency preparedness plans, including referral services, are available in the most at-risk areas. • Supporting the Uganda National Post-Ebola Response Plan in various areas.
Joint/common country analysis	**Achieved**: Along with other actors, UNICEF conducted a joint analysis of the Ebola outbreak, and gender and related risks were considered in this analysis. **Gaps to be addressed:** The analysis was disease-specific and lacked an assessment of root causes or structural vulnerabilities. While UCO included PHE preparedness in emergency plans, there is room for improvement in integrating preventive measures into the CPD and collective outcomes. To build resilience and achieve durable solutions, preventive perspectives must be incorporated into collective outcomes.
Programming and implementation	**Achieved:** UCO's Ebola response implementation demonstrated a shared vision and collaborative programming. It empowered the GoU by supporting their leadership and coordinating not only with United Nations leaders but also local and national authorities (e.g. MoH, MoES, MoGLSD, DTFs, VHTs, etc.). The UNICEF Ebola Response Plan aligned with the National Ebola Response Plan, served as a common framework, and contributed to activities that were agreed upon by all response actors. **Gaps to be addressed:** As an emergency, disease-specific response, there should be collective outcomes across the humanitarian and development responses. The response did not align incremental steps within a multi-year timeframe towards achieving specific SDGs. Preparedness measures did not prioritise prevention and did not adequately address underlying needs, structural drivers, and vulnerabilities, and nor did they aim to bring about meaningful changes in the status quo.
Funding and financing	**Achieved:** UCO demonstrated effective funding allocation by directing resources towards implementing partners.

	Gaps to be addressed: Despite UCO's admirable efforts, the repurposing of existing funds in the early response phase did not align with HDP nexus funding and financing benchmarks. The evaluation team found that the funding received for the Ebola response lacked predictability and multi-year coverage, with flexibility varying among donors. The funding for Ebola operations was not consistently flexible, unearmarked, or aligned with transition plans, leaving uncertainty regarding its coverage for the 180-day post-Ebola transition plan.
Linkages with GoU and the United Nations Country Team	**Gaps to be addressed:** PHE-specific HDP nexus organisation and planning may need to be introduced at both the country programme level and with the GoU and United Nations Regional Coordinator on an annual basis *in advance of* PHEs.

7 CONCLUSIONS, LESSONS LEARNED, AND RECOMMENDATIONS

7.1 Conclusions

The conclusions are drawn primarily from the evaluation findings. This section is structured along the key recurring themes that are relevant to UNICEF's White Paper on PHEs. Each conclusion uses a red-amber-green rating indicating the status of the conclusions. Red indicates that there were significant issues, delays, or problems with the intervention. Amber (yellow) signifies that there were some concerns or risks that needed attention, and that there were certain aspects of the intervention that would have been at risk if they were not addressed promptly. Green indicates that everything progressed as planned and there were no major concerns or risks.

Conclusion 1: UCO's in-country preparedness was not sufficiently relevant an Ebola outbreak and did not allow for an efficient transition to the Ebola response. Despite it not being a country requirement to have disease-specific preparedness plans in place, a contingency plan existed, from the previous Ebola outbreak in 2018. The draft 2021 Ebola Preparedness and Response Plan was found to be incomplete, exposing gaps in the organisation's readiness. Insufficient funding dedicated to preparedness activities compounded the challenges, hindering the establishment of partnerships, contingency plans, and contingency budgets, and the procurement of essential Ebola supplies. This also limited the horizontal integration necessary for a unified pillared response. The transition from preparedness to response was challenging due to some of the gaps in preparedness, and also due to a lack of familiarity with L2 emergency procedures and insufficient numbers of staff with Ebola expertise. Nonetheless, as the Ebola response progressed, UNICEF demonstrated adaptiveness and responsiveness, improving its preparedness measures. It effectively mitigated some of these shortcomings by repurposing programme funds and resources, and deploying UCO programme staff and staff from ESARO with Ebola expertise. In parallel, efforts by ESARO to invest in regional preparedness across neighbouring countries demonstrated the importance of potential cross-border spread of Ebola. However, the limited funding available only covered 22% of the required budget, raising questions about the extent to which donors are committed to funding prevention efforts.

Conclusion 2: UNICEF's leadership and coordination were mostly effective in ensuring the response was coherent. UNICEF demonstrated commendable leadership and engagement in coordinating response activities at both national and subnational levels. UNICEF's active engagement and its leadership role in co-chairing the RCCE pillars, as well as the sub-pillars of WASH and IPC, MHPSS, and CoES, demonstrated the value of its technical assistance. The GoU split the RCCE pillar into two separate pillars (RC and CE) and this uncommon division produced gaps and duplication among responding agencies in the early weeks of the response. By fostering collaboration among various local responders, such as the DTFs and DDMCs, UNICEF effectively aligned preparedness and response efforts with national strategic plans. Moreover, UNICEF expanded its reach and collaboration during the response by advocating for the inclusion of MoGLSD and MoES to promote a more multi-sectoral response to the outbreak. This inclusive approach enhanced the relevance of the response. However, challenges relating to the multiple response plans, competing roles among United Nations agencies, and the absence of a clear inter-agency coordination mechanism resulted in gaps in critical areas of the response, such as SDB, IPC, and Ebola case management. While a workable relationship was eventually established, concerns were raised about the long-term efficiency and sustainability of this arrangement for larger and more extensive PHEs. Internal UNICEF coordination (i.e. the support mechanisms across UCO, ESARO, and

HQ) was highly regarded. Particularly noteworthy were ESARO's proactive involvement and strategic assistance before and during the L2 activation, which enables the repurposing of funds and resources for the Ebola response, and its establishment of a Regional Ebola Preparedness and Response Plan.

Conclusion 3: UNICEF efforts had a significant and positive impact on affected populations. The evaluation revealed many commendable efforts that were appropriate and effective in addressing key issues, contributing to early case detection, and reducing transmission. UNICEF's RCCE activities led to behavioural change within communities, by reaching 6,215,797 people through diverse mass media channels with tailored and appropriate key messages, supported by a substantial allocation of funds (29%). The strategic engagement of local responders and community influencers, along with the involvement of VHTs and the implementation of IOA and anthropological studies, leveraged transdisciplinary data, contributing to outbreak decision-making. The integration of WASH/IPC across pillars, ETUs, isolation centres, community structures, and communities filled critical response gaps and showcased effective strategies for future outbreaks, including the IPC Ring approach. The evaluation also highlighted UNICEF's successful facilitation of access to essential nutritional supplies in ETUs, and the response exceeded its target for reaching children and affected populations accessing MHPSS by 130%. The integration of MHPSS and child protection in Ebola through innovative partnerships also received praise. Work around child protection, together with GBV, exposed the dire needs for children and women, but the sustainability of resources beyond the PHE response is questionable amid funding gaps. UNICEF's best practice in education ensured every child attended school and completed final exams, by providing innovative transportation approaches. Health continuity interventions ensured primary health was maintained to the extent possible.

Conclusion 4: The L2 procedures were not sufficiently applied. The response effectiveness faced several challenges, including important delays. The L2 response successfully mobilised a substantial US$7,949,919, strategically allocating funds towards RCCE, case management, and WASH/IPC, showcasing efficient resource utilisation and leveraging UNICEF's comparative advantage. With support from ESARO, UNICEF demonstrated proactive measures by repurposing programme funds, redeploying UCO staff, and initiating the response even before the L2 activation. However, the evaluation also identified areas for potential improvement. The timing of the L2 activation – which occurred 36 days after the Ebola outbreak was declared – raised questions about its impact on response efficiency and the need for timely implementation. Hesitancy about declaring an L2, compounded by a lack of familiarity with the L2 protocols and some procedures not being applied, contributed to delays. Challenges regarding securing funding, gaps in human resources at the field level, a lack of contingency programme documents, procedural delays in partnerships, and limited supplies adversely affected response efforts, leading to diminished relevance in some cases. Many of the guidance documents developed during the Ebola outbreak were expected to have been developed during non-outbreak times. Delays in MHPSS/child protection interventions, and their absence from the National Response Plan, highlighted the importance of preparedness and the inclusion of such interventions before outbreaks occur.

Conclusion 5: UNICEF's approaches were child-centred and integrated women's needs and other vulnerabilities. UNICEF's advocacy efforts at the national level distinguished its response by successfully integrating education, child protection, GBV/PSEA, and MHPSS into the national response, demonstrating the organisation's commitment to addressing multifaceted vulnerabilities in children during an outbreak that affects entire communities. The active inclusion of children in decision-making processes demonstrated a commitment to promoting children's voices, while partnerships with child-focused organisations strengthened the child-friendly response. In terms of gender, UNICEF provided gender-disaggregated targets and results, employed gender-sensitive approaches and messaging, and prioritised GBV/PSEA. UNICEF also implemented interventions for persons with disabilities in certain aspects of the response,

such as the MDA. While MHPSS services benefitted 16,359 children, the response did not address the long-term needs of all affected orphans and survivors, who will require sustained support to cope with the psychological and social impacts of the outbreak. Additionally, there was a missed opportunity for UNICEF to advocate early on for better treatment protocols and ensure the provision of specific paediatric medical supplies, which resulted in some missing out. The response also revealed unintended negative consequences, potentially increasing GBV cases during lockdowns and hindering access to GBV services. The response further identified other vulnerable groups, but there are uncertainties as to what extent assistance was provided to them, particularly for Ebola survivors. As a final observation, the evaluation noted a gender imbalance at UCO, with an overrepresentation of male employees.

Conclusion 6: The Ebola response showed linkages to UNICEF's development agenda but ongoing support to affected communities was lacking. While the Ebola response was emergency-based, and therefore short-term, there were clear linkages to UNICEF's development programming in support of the SDGs. During the Ebola response, UNICEF advanced its development agenda through policy development, investing in sustainable WASH/IPC infrastructures, and contributed to enhanced preparedness in affected districts, bolstering Uganda's resilience to future PHEs. UNICEF's support for the Uganda National Post-Ebola Response Plan underscores its dedication to fostering continuity and resilience beyond the immediate Ebola response. However, UNICEF's exit from the response was perceived as sudden by the affected populations, GoU, and local actors, and there were concerns around sustainability as some UNICEF's investments were not adequately maintained. Cash grants, to help transition communities out of a crisis, were not implemented. Direct support to Ebola survivors and affected children fell short. While the connection to the HDP nexus was not evident, and understanding of the nexus principles remained nebulous, the Ebola response showed indications of strengthening linkages, including joint country analysis, collaborative programming, building local capacities, and making risk-informed decisions. Gaps persist in effectively integrating preparedness and preventive measures, addressing root causes, formulating collective outcomes that go beyond the outbreak, and establishing multi-year predictable funding.

7.2 Lessons learned

UNICEF's Ebola response applied a series of strategies and interventions. Some of these proved successful and should be seen as good practices for possible replication and adaptation by UNICEF and other stakeholders in future PHEs. The lessons were derived from KII's.

1. **Lesson Learned 1: Engaging a diverse spectrum of community influencers is a critical factor in attaining impactful social and behaviour change during Ebola outbreaks.** The approach employed by UNICEF, wherein VHTs, traditional leaders, healers, local politicians, musicians, and even transport drivers were effectively mobilised, can serve as a successful model. Their involvement was established through comprehensive training initiatives and active participation within local task forces. The credibility these influencers held within their respective communities facilitated their roles as trustworthy sources. Their invaluable insights were integrated into the decision-making processes of the Ebola response, prominently showcased through their representation within the DTFs and Village Task Forces.

2. **Lesson learned 2: Developing an effective Ebola exit strategy necessitates establishing explicit connections to enduring practices, while integrating consistent aid for vulnerabilities uncovered throughout the response.** Notably, the response identified a need for continued child protection, MHPSS, and GBV services, but also sustained support to Ebola survivors. This underscores the need for continuous service provision beyond the immediate

emergency phase. As communities recover from crises, a crucial facet emerges: the need for comprehensive reorientation and reintegration efforts, to enable them to pursue a life of dignity and purpose.

3. **Lesson learned 3: A proactive approach to reducing ambiguities in mandates between WHO and UNICEF can improve the coherence of the response.** These circumstances resulted in both duplication in certain areas and noticeable gaps in others. Throughout the outbreak, UNICEF undertook proactive efforts to ascertain distinctive roles and duties. However, the evaluation underscores the potential benefits of pre-emptively identifying specific interventions and delineating UNICEF's precise contributions within the context of PHEs.

4. **Lesson learned 4: Applying the UNICEF emergency procedures ensures rapid and agile emergency responses.** It became evident that there was a lack of familiarity with L2 emergency procedures and this resulted in bottlenecks and subsequent delays in achieving results. These setbacks were notably experienced across multiple fronts, including deployment, supply, and partnerships. This lesson serves as a reminder of the need to adapt development procedures to align them with the agile and adaptive requirements of emergency situations.

5. **Lesson learned 5: Extra efforts to tackle external barriers are required to ensure continuity of essential services.** Lockdowns and movement restrictions impede access to health and education. Throughout the response, UNICEF commendably facilitated the uninterrupted provision of essential services. However, it became evident that several barriers hindered effective access. Notably, factors such as scarcity of transportation options, increased costs and/or loss of household income, and fear of Ebola transmission, contributed to reduced accessibility. This lesson underscores the need to address these barriers proactively in future emergency scenarios.

7.3 Recommendations

A series of recommendations have been formulated to guide responses to future PHEs in Uganda and beyond. These recommendations are based on findings from the evaluation, complemented by insights from the evaluators. The recommendations were validated, and extra nuance was added to them, in collaboration with the ERG, including UCO and ESARO, through a co-creation workshop. However, the workshop did not include external stakeholders. To ensure alignment to UNICEF's ambitions in regard to PHEs, the evaluation team has framed the recommendations around UNICEF's White Paper (see above, on page 13, but the recommendations also build on the UNICEF CCCs and the emergency procedures. Each recommendation is accompanied by suggested actions, which are designed to facilitate implementation. The reader is encouraged to read this section in tandem with the above sections on innovative approaches, missed opportunities, and lessons learned.

Recommendations and suggested actions	**Priority**	**Responsible**
Recommendation 1: Strengthen preparedness for PHEs		
Rationale: *Ebola and other emerging diseases are becoming more frequent and increasingly severe. UCO's preparedness did not sufficiently enable a timely and resource-efficient transition to the emergency response.*		
Suggested actions in line with UNICEF CCCs and emergency procedures		
• Ensure sufficient and relevant supplies, and disease specific annexes for relevant emerging disease/Ebola	Short-term	UCO, in collaboration

Recommendations and suggested actions	Priority	Responsible
• Ensure epidemic preparedness is a key part of the UNICEF global Health Sector Strategic Plans Continue strengthening relevant partnerships and the national consultancy roster with VHF experience		with GoU and partners
• Further nuance UNICEF's role and responsibilities in UNICEF's White Paper on PHEs, based on lessons learned	Medium-term	UCO, ESARO
• Attach performance indicators to preparedness measures to monitor progress and enhance accountability • Learn from UNICEF's emergency preparedness funding initiatives and assess eligibility for the First Action Initiative and the Co-Funding Initiative	Medium-term	UCO, ESARO
Recommendation 2: Better institutionalise L2/L3 procedures		
Rationale: *The L2 emergency procedures were not adequately understood by UCO, leading to insufficient application of the procedures, and causing delays in implementation.*		
Suggested actions in line with UNICEF CCCs and emergency procedures		
• Improve familiarity with L2/L3 emergency procedures across all relevant stakeholders in the region	Medium-term	ESARO
• Consider standardising Ebola (and other VHFs) as an automatic L2 emergency • At the global level, explore the establishment of a non-refundable, non-earmarked EPF that can be promptly accessed for PHEs • Establish funding mechanisms to fill gaps in PHE responses, ensuring flexibility in addressing unforeseen costs	Long-term	HQ, ESARO
Recommendation 3: Strengthen inter-agency coherence in PHEs, in line with the IASC SOPs Protocol for the Control of Infectious Disease events[25]		
Rationale: *The Ebola response was coordinated by MoH and WHO, rather than by the United Nations coordination team. There were several instances where the roles and responsibilities of implementing agencies, both in ETUs and within communities, were not clear. This lack of clarity resulted in duplication of efforts, gaps, and tensions among United Nations agencies*		
Suggested actions relevant to UNICEF as a member of the inter-agency response		
• Conduct annual joint assessments of in-country cross-pillar preparedness, in collaboration with MoH and other United Nations agencies • Implement an all-of-United Nations advocacy strategy to promote cash-based interventions during PHEs, with the aim of mitigating the secondary impact of emergencies and the associated lockdowns • Improve the implementation of the post-Ebola care for survivors, ensuring that they receive longer-term and appropriate support in their recovery process	Medium-term	UCO, with GoU and United Nations partners

[25] IASC (2019) 'Standard Operating Procedure, Humanitarian System-Wide Scaleup Activation, Protocol for the Control of Infectious Disease Events'. Available at https://interagencystandingcommittee.org/system/files/190404_iasc_infectious_disease_scale-up_activation_protocol_web.pdf

Recommendations and suggested actions	Priority	Responsible
• At the country level, establish a blueprint that clearly outlines roles and responsibilities among United Nations agencies in PHEs • Advocate on activating United Nations coordination under the WHO immediately after outbreak declaration, with a plan, division of labour, and fund-raising	Long-term	UCO with WHO, UNCT, ESARO
Recommendation 4: Continue placing children, women, and vulnerabilities at the centre of the PHE response		
Rationale: *Children, women, and vulnerable populations are disproportionately affected in crises. Although the response showed promising indications of targeting these groups, there is a need to integrate this intention from the early onset of PHEs, and to prioritise practical issues over policy/strategy development*		
Suggested actions in line with the UNICEF White Paper's recommendations 5, 6, and 7		
• Ensure GBV/PSEA risk mitigation and response at early onset in every response and prioritise quality referral services • Scale up the strengthening of child protection services across both development and emergency programming • Advocate for gender equality in employment within ministerial departments to foster a more gender-sensitive and equitable approach to addressing Ebola and other emergencies	Short- to immediate-term	HQ, ESARO, UCO
• Strive to undertake deliberate efforts to achieve gender equality on emergency response teams within the UCO office • Ensure the availability of child-specific medical supplies and equipment	Medium-term	UCO, ESARO
Recommendation 5: Prepare for better data to drive evidence-based responses		
Rationale: *UNICEF implemented several good data collection, analysis, and feedback tools/interventions. The UNICEF Ebola response collected disaggregated data, with some children's data coming in later in the response, but this was not systematic. While there are indications that the collective data informed decision-making, there is a need to have innovative, ready-to-use data management tools that promote the rights and wellbeing of all children and those with vulnerabilities at the onset of PHEs*		
Suggested actions in line with UNICEF's White Paper recommendation 8		
• Support and provide funding to the GoU to integrate IOA beyond Ebola • Develop a data collection and analysis tool that is specifically tailored to measuring the results and impact of interventions on children, women, persons with disabilities, and other vulnerable groups • Develop a research agenda that focuses on advancing the evidence base for Ebola in children • Continue to strengthen community feedback and social listening capacity (U-report) and utilisation of data • Continue to innovate and digitalise VHT community surveillance methods within the MoH community health strategy	Medium-term	UCO, in collaboration with GoU, and with support of ESARO
Recommendation 6: Keep advancing on the HDP nexus procedures		
Rationale: *Considering Uganda's limited capacity to provide adequate essential services (health, education, social services) and the growing risks of emerging diseases, UNICEF should prioritise*		

Recommendations and suggested actions	Priority	Responsible
addressing the root causes and complex challenges faced by children and communities in the Ebola-affected regions		
Suggested actions in line with UNICEF's Procedures on Linking Humanitarian and Development Programming[clviii] and the White Paper recommendations 1 to 6		
• Continue building awareness around One Health in UCO, and, in collaboration with WHO and the United Nations Food and Agriculture Organization, advocate for One Health approaches and greater awareness of the role of climate change as an underlying cause of emerging infectious disease • Ensure more systematic engagement on IHR- (2005) related processes, including joint external evaluations, state party annual reporting, simulations, and the National Action Plan for Health Security • Identify more risk informed, multi-year programming, multi-agency partnerships (including with the private sector) and with development donors that prioritise preparedness and prevention measures • Identify and build the emergency response capacity of local CSO partners for future PHE responses[26] • Start tackling the underlying causes of child protection risks and link humanitarian cash transfers with social protection	Medium-to long-term	UCO, in collaboration with WHO and the GoU

[26] https://www.ready-initiative.org/

ANNEXES
ANNEX 1: UNICEF TERMS OF REFERENCES

Learning Focused Evaluation
of the UNICEF Uganda Preparedness and Response to the L2 Ebola Emergency

TERMS OF REFERENCE

Summary

Type of Contract	Institutional Contract
Title of the Evaluation	Learning Focused Evaluation of the UNICEF Uganda Preparedness and Response to the L2 Ebola Emergency
Purpose	To promote learning and support long-term planning post-L2 response to EVD in Uganda, identify preparedness interventions for potential future health emergencies, and strengthen UNICEF's accountability to affected populations, partners, and donors supporting the response at large
Objectives	1. Provide a preliminary assessment of UNICEF's response to the Ebola crisis vis-a'-vis issues of appropriateness/relevance, effectiveness, efficiency (including value for money), coverage, connectedness, coordination, and partnerships, with a specific focus on UNICEF's level of preparedness and the adaptiveness and responsiveness of UNICEF's response and how it has addressed issues for children, adolescents, and women, including those with disabilities, marginalization and deprivation. 2. Draw out key learning and recommendations to equip UNICEF Uganda decision-makers with the information they need to make adjustments and formulate UCO's transition from L2 emergency to long-term strategy, strengthening the humanitarian-development- peace nexus and preparedness for future health emergencies.
Location	Kampala, Uganda, with travel to affected areas in Mubende, Kassanda, Kyegegwa, Kagadi, Bunyangabu, Masaka, KCCA, and Jinja.
Duration	4 months
Start Date	1st February 2023
Reporting to	UNICEF Eastern and Southern Africa Regional Office (ESARO)'s Evaluation Section

Introduction

In accordance with the coverage norms of UNICEF's Evaluation Policy 2018, short-term level two (L2) emergencies must be evaluated at least once and protracted L2 emergencies should be evaluated once every three years. Such L2 evaluations are conducted by the Evaluation Section of the respective UNICEF Regional Office.

Building on evidence from recently conducted evaluations[clix], the ESARO Evaluation Section is proposing an activity best characterized as a learning-focused evaluation (LFE) of UNICEF Uganda's response to the L2 Ebola emergency in Uganda. As UNICEF transitions its response post-L2, the evaluation can provide a

structure for reflection, learning and recommendations for post L2 response planning and how to improve preparedness for future health emergencies, while also reflecting on key opportunities of linking humanitarian-development and peace action for a strengthened and resilient public sector support to public health outbreaks. In this context, the evaluation will need to be utilization focused and forward-looking.

In line with UNICEF's Evaluation Policy, which stipulates that the regional offices are responsible for the management of evaluations of L2 emergencies, the LFE will be managed by the Evaluation Section of UNICEF's Eastern and Southern Africa Regional Office (ESARO), under the overall oversight of the ESARO Regional Director, and in close collaboration with the UNICEF Uganda Country Office (UCO). Quality assurance will be provided by UNICEF's Evaluation Office, which reports directly to UNICEF's Executive Director, and is functionally independent within the Organization. The LFE will be conducted in accordance with the provisions of UNICEF's 2018 Evaluation Policy, UNICEF's 2022 Disability inclusive evaluations in UNICEF guidance, and the norms and standards of the United Nations Development Group (UNEG).

The terms of reference present a brief description of the crisis and UNICEF's response; the scope, objectives, and key questions of the evaluation; evaluation methodology; stakeholder involvement; roles and responsibilities; evaluation process; deliverables; and evaluators' qualifications.

Background

Situation Overview & Humanitarian Needs

On 20 September 2022, Uganda declared an outbreak caused by the Sudan Ebola Virus (SVD) following a confirmed case in Mubende district. By 8 December 2022, 142 cases with 55 deaths had been reported in nine affected districts: Mubende, Kassanda, Kyegegwa, Bunyangabu, Kagadi, Kampala, Wakiso, Masaka and Jinja.

The epicentre of this outbreak continues to be in the districts of Mubende and Kassanda located approximately 3 hours away from the capital in an area of high population movement which resulted in further spread of the outbreak to Kampala and other six districts. Ebola is a serious, often fatal disease in humans and the lack of approved vaccine and therapeutics for the SVD represents an additional challenge in curbing this outbreak. There is strong leadership for the response by the MoH with support from partners, including UNICEF. A National Response Plan, comprising a total of seven pillars and covering a period of three months (October- December 2022) with focus on high-risk districts was developed by MoH and is currently under revision.

Cross pillar teams from MoH were deployed in all districts to lead response activities. There are currently nine operational Ebola Treatment Units (ETU) and/or isolation facilities across the country. In addition to testing at the national level at the Uganda Virus Research Institute (UVRI), there is on-site testing via a mobile laboratory deployed to Mubende. A multi-stakeholder National Task Force (NTF) is co-chaired by MoH and WHO coordinates the EVD response. The NTF oversees the Incident Management Team (IMT) consisting of pillar and co-pillar leads responsible for the day-to-day management of the EVD response. The IMT structure is mirrored at the district level. UNICEF provides support to and participates in coordination efforts at both national and district level, including in Task Forces, IMTs and in pillar meetings.

UNICEF Response and Funding Overview

UNICEF response in Uganda started immediately following the declaration of the outbreak on 20 September 2022 and is organized around six key pillars: a/. coordination and leadership; b/. IPC/WASH; c/. Risk Communication and Community Engagement (RCCE); d/. case management, including child friendly care and nutrition for children admitted in Ebola Treatment Units and Mental Health and Psychosocial Support (MHPSS), and e/. continuity of essential health and social services including

education, with a focus on keeping schools safe and open whilst offering remote learning where necessary and specific services for women and girls including those related to SRHR. Considering the involved risks, UNICEF activated a Level 2 (L2) Corporate Emergency Activation Procedure (CEAP)[clx] Scale-up for the Ebola outbreak in Uganda on 27 October 2022 to 26 April 2023.

Purpose and Objectives of the Evaluation

The overarching purpose of the LFE is to promote learning and long-term planning for what comes after the UNICEF Uganda L2 Ebola response, including identifying preparedness interventions for potential future public health emergencies. The secondary purpose of this evaluation is to strengthen UNICEF's accountability to children and affected populations, partners, and donors supporting the response at large. The objectives of the LFE are to:

- Provide a preliminary assessment of UNICEF's response to the Ebola outbreak in Uganda vis-a-vis issues of appropriateness/relevance, effectiveness[clxi,] efficiency (including value for money), connectedness[clxii] and coordination/partnerships, with a specific focus on UNICEF's level of preparedness and the adaptiveness/responsiveness of UNICEF response and how it has addressed issues for children, adolescents, and women, including those with disability, marginalization and deprivation.
- Draw out key learning and recommendations to equip UNICEF Uganda decision-makers with the information they need to make adjustments and formulate UCO's transition from L2 emergency to long-term strategy, ensuring humanitarian-development-peace nexus bridging and preparedness for future public health emergencies.

In line with the dual learning and accountability objectives, the evaluation is expected to generate actionable recommendations on how to strengthen the next phase of the ongoing response to the L2 emergency, how to best plan for the post-L2 phase, and how to prepare for future health emergencies, while also reflecting on key opportunities of linking humanitarian with development action for a strengthened and resilient public sector support to public health outbreaks. The evaluation will provide structure for reflection and learning and will adhere to principles of participation and utilization. The primary audience for this evaluation is UNICEF staff, management, and regional advisors who are responsible for leading the UNICEF Uganda Ebola response. The evaluation's findings will also be shared with key national and district-based counterparts, in addition to the main stakeholders involved in this evaluation at the community level.
The approach will draw on elements of a lessons learned exercise and real-time evaluation, providing real time feedback, and generating learning that can be used in the remainder of the current response and towards UNICEF's longer-term goals and preparedness planning. The LFE will be:

- Non-intrusive to response operations with a compressed timeline and a small evaluation team.
- Flexible and iterative, creating space for new questions, methods, analysis, and feedback.
- Driven by questions and issues confronting UCO's response strategy that identify priority areas, gaps, and areas of focus for the post-L2 phase.
- Designed to capture system dynamics and surface innovative strategies and ideas ('what works') and to describe which solution and response UCO has put in place to respond to the emerging and evolving needs (for instance, using real-time assessment methods - "how it works").
- Timed to strategically feed into the reflections on and development of the post-L2 strategy and preparedness planning.

Scope of the Evaluation

Institutional scope: While noting the multi-agency dimensions in the Ebola response, in particular the role played by other agencies, this LFE is limited to evaluating the work of UNICEF and its down-stream partners in responding to the crisis. However, such an evaluation needs take into account the wider framework of the response, including that of the Government counterparts (both at national and district levels), the UN

system as a whole, the donor community, the international non-governmental organizations and national civil society organizations and agencies involved in the response, in analyzing the respective role UNICEF plays in this response mix and the related expectations of stakeholders in regard to UNICEF's response. Within UNICEF, the evaluation will focus on the Ebola response implemented by UCO (and as per the UCO response plan), and will assess interactions, coordination, roles and responsibilities, support from and expectations of the UNICEF East and Southern Africa Regional Office (ESARO) and UNICEF's headquarters in New York and UNICEF's Supply Division in Copenhagen (in relation to emergency supplies and procurement services provided).

Programmatic scope: The UNICEF Uganda Ebola Preparedness and Response Plan reinforces UNICEF's 'integrated approach' to emergency response, bringing together Health, including HIV, Child Protection, Social Protection, Education, WASH, Nutrition, Social and Behavior Change (SBC), and Supply/Logistics, and implemented through the pillars of the national response to provide lifesaving interventions in the treatment and prevention of the Ebola outbreak and provision of basic services, such as health, WASH, nutrition, education, MHPSS and protection. The LFE will focus on the coverage, connectedness, timeliness, effectiveness, efficiency and relevance of the programmatic response, including UNICEF's preparedness for the response, effectiveness of mobilizing partnerships with CSO and donors, the level of internal and external coordination/partnerships contributing to success or failure factors, the adaptiveness/responsiveness of the response, the child-centred aspect of the response, and how it has addressed gender, disability and age vulnerabilities, including marginalization, deprivation, violence and abuse. Using appropriateness, effectiveness, and connectedness/coherence criteria, the LFE will also consider the humanitarian-development-peace nexus with a view to mid- to long-term planning.

Operational scope: The LFE will assess the timeliness, effectiveness and efficiency of the UNICEF response in terms of ensuring timely delivery of supplies based on needs; the timeliness and effectiveness of UNICEF scale up efforts and staffing deployments (including duty of care); the quality and inclusiveness of internal collaboration and cohesion on operational aspects of the response planning and implementation; the relevance of financial modalities, governance and assurance procedures and measures introduced; application of the L2 emergency simplified procedures and will reflect on operational opportunities, best practices, and challenges for rapid scale up in Uganda country context environment.

Geographic focus: The evaluation team will consider the districts in Uganda most affected by the crisis, and at the inception phase will establish a methodology for sampling and visiting affected localities where UNICEF provides its emergency response.

Time frame: The evaluation will consider the entire span of the UNICEF Uganda Ebola emergency response, starting from the declaration of the outbreak by the Government on 20 September 2022, going through the activation of UNICEF's Level 2 CEAP for the Uganda Ebola crisis on 27 October 2022 and covering the ongoing response. The LFE will also be forward-looking to inform the formulation of UCO's transition from L2 emergency to long-term strategy. The evaluation itself will take place from February 2023 until May 2023, timed to capture emerging results, and strategically feed into framing the post-L2 phase.

Key Learning Questions

Unlike a traditional evaluation, the focus of the LFE on utilization and learning will require a preliminary round of stakeholder engagement to help validate and vet the focus and questions as part of developing a *learning agenda*. Briefly stated, a learning agenda is a tool for articulating key challenges and opportunities, framed around key questions, that UCO is encountering and wants to learn from. The result is a living document that guides the evaluation questions, data collection, learning discussions, and feedback loops.

Creating the learning agenda will require a means to quickly vet questions for inclusion. Minimally, such process should consider criteria such as whether the question is indeed 'answerable' and if answered, whether it is actionable.

The initial set of priority Learning Agenda questions, which have been identified based on discussions during the TOR development, include:

Learning Question 1: How well prepared was UNICEF and how well has UNICEF responded to the Ebola emergency in Uganda?

1.1. To what extent does UNICEF's response meet the following criteria: a. Effectiveness (achieving stated objectives, preparedness and timeliness, adaptiveness and responsiveness, accountability to affected populations, in particular women and children including those with disabilities); b. Efficiency of UNICEF response? - How efficient was UNICEF response to date? Scaling up, deployments, use of financial resources, resource mobilization efforts, mobilizing partnerships? Duty of care? Value for Money? c. Coverage and proportionality (in scaling-up for adequate coverage, reaching all demographic populations of vulnerability and marginalisation (i.e. women, girls, boys, and youth, people with disabilities etc.) (and why); d. Quality and coherence (consistent with relevant standards and policies, i.e., CCCs, Sphere Standards and Public Health Guidance for Ebola response); e. Equity and coverage (i.e., delivered for different groups including women, girls, boys, adolescent and youth, persons with disabilities, refugee children etc. marginalization and deprivation); and f. Connectedness (sustainability from a humanitarian perspective); and f. Coordination (both internal (within UCO, with RO and with HQ) and external) and partnerships?

Learning Question 2: What have been UNICEF's successful and/or innovative approaches and barriers in the Uganda Ebola emergency response?

2.1. What are the successful and/or innovative approaches[clxiii] of the ongoing response that could be leveraged in the continued response? Were all opportunities used?

2.1. What challenges and lessons for UCO's health and emergency preparedness planning have emerged as a result of the Ebola emergency? What should we avoid doing again? Were lessons learned from previous outbreaks applied in this response? As a result of the UNICEF Ebola response, what areas have emerged as gaps – in programmatic and operational capacity, coverage etc?

Learning Question 3: What actions are required in order to strengthen the response and to prepare for the transition to longer-term programming?

3.1. Considering immediate risks and challenges: What mechanisms and systems should UCO adapt and put in place to ensure agility and prepare for the immediate future, adjusting to the changing context and different age, gender and disability related needs of women and children and the population in affected areas?
- What are the existing opportunities?
- Where are there constraints currently?
- What further adaptations would/should be made?

3.2. How can UCO integrate the emergency response into longer-term programming?
- What can be the quick wins of integrating the public health emergency response into longer-term programming, specifically in the design and operationalization of the 'humanitarian/development nexuses for outbreaks?
- How should the response be integrated into the Uganda AWP in applying a risk informed programming, preparedness, and resilience lens?

The learning questions identified above are the jumping off point for the evaluators to further elaborate during the Inception Phase of this evaluation, and then transition to the Implementation Phase.

Evaluation Approach and Methods

The approaches and methods of this LFE are largely similar to those utilized in other evaluations with important adaptations. For example, this evaluation shall combine elements of a retrospective and formative evaluation with those of a lesson learned exercise and real-time evaluation, with the intention of delivering findings and conclusions in a short timeframe. The basis of this approach is informed by some of the Organization for Economic Co-operation and Development-Development Assistance Committee criteria (i.e., relevance, connectedness, coverage, and effectiveness), and also borrows from other types of exercises and data collection tools. This type of evaluation looks at the past to understand the course of events and the history of a response. At the same time, it involves direct observation and consideration of future scenarios and planning. Even with this blended approach, the LFE is expected to adhere to UNEG Norms and Standards and Ethical Guidelines for evaluations and meet UNICEF's evaluation quality standards per the Global Evaluation Reports Oversight System (GEROS).

Since the evaluation design does not follow a classic evaluation methodology, but draws from several models and evaluation concepts, the phases of more traditional evaluations have been compressed into three main phases: 1) scoping, inception and preliminary data collection; 2) data collection, analysis and sharing of (preliminary) findings and verification, 3) report writing, recommendation development and dissemination. All three phases will have commenced within three months of contracting the evaluation firm.

For the Inception Phase, recognizing the constraints of time and being sensitive to the burden an evaluation can place on emergency response staff, it will start with desk review of existing information (including from other evaluations of UNICEF responses to Ebola crises) and analysis and be as non-intrusive as possible. In this phase, the evaluators will review existing secondary data and documentation such as SitReps; Humanitarian Appeals; UNICEF Ebola response plans, field reports, EMT updates, outbreak investigation and initial response reports; partnerships with implementing partners, monitoring indicators and reports; analysis of funding information and fundraising efforts, HR, and supply data; assessment of UCO preparedness and contingency plans reflected in the EPP, etc. Other data sources include information made available through Integrated Outbreak Analytics and its use; DHIS, geo-spatial data, Rapid Pro, Google analytics and social media and social listening analytics. This phase will also require a preliminary round of stakeholder engagement to help validate and vet the focus and questions as part of developing the learning agenda.

An evaluation matrix will be developed to demonstrate how the evaluators plan to answer each learning question, including the data sources, methods, and products that will be developed for each. A Theory of Change (ToC) approach (including reconstructing a theory of change for the response) will be used in consultation with stakeholders, as appropriate. Discussions of the ToC will focus on mapping the assumptions behind the response's desired change(s) and the causal linkages between the intervention(s) and the intended outcomes. As part of this analysis, the implementation of the response over the evaluation period will also be examined, covering UNICEF's capacity to adapt to the changing context in Uganda, and responsiveness to changing needs and priorities of the outbreak will also be looked at. At the end of the inception phase, the team will present initial findings and assumptions that will guide the implementation phase.

During the Implementation Phase, data collection will be done rapidly based on direct observation, focus group discussions, community rapid assessments (if feasible), and key informant interviews, including in

affected communities and with children and youth where possible, as per the learning agenda developed in the Inception Phase. The LFE will use a mixed methods approach to answer the learning agenda questions as outlined above. Triangulation of data sources and types, many internal, will be needed. Like the questions, the methods may change or be employed differently in order to be agile and responsive. Analytical methods are likely to include qualitative data analysis and quantitative data analysis of secondary or monitoring data. As needed, other methods could include data digest sessions, process mapping, forcefield analysis, participatory ranking and/or other approaches. Due to the ongoing Ebola outbreak, as well as the COVID-19 pandemic, the LFE should take all health and safety precautions and measures as appropriate and in adherence with national guidelines.

It is expected that the LFE apply a strong human and child rights, equity, disability inclusion, age and gender focus by: i) including human rights, equity and gender in learning agenda questions; ii) making evaluation methodology and data collection and analysis methods equity and gender-responsive; and iii) reflecting human and child rights, equity, disability, age and gender analysis in evaluation findings, conclusions and concrete recommendations and action points that can be addressed in the design of the longer-term strategy both for a better integration of human rights, equity and gender in the response, and for strengthened results for children.

With the goal to capture lessons and make conclusions that will be used to strengthen an ongoing response and an upcoming transition, the evaluation will be designed with a strong utilization focus. After collecting data, the expectation is that the evaluation team would share deliverables quickly with users and would engage with staff during two debrief sessions and two workshops to discuss, reflect, and incorporate findings into the ongoing decision-making process.

Evaluation Limitations

Key limitations of the LFE include the access and availability of data in the Uganda Ebola context and the need to balance timeliness with depth of information and well-substantiated findings. The evaluation is limited to the response in Uganda where the Level 2 CEAP has been declared. The fluid situation and COVID-19 pandemic may affect the evaluation team's ability to visit affected districts and the availability of key stakeholders to meet with the evaluators might be reduced. During the inception phase a contingency plan will be developed.

Evaluation Products and Use

To ensure the work is as useful as possible, the evaluators will employ iterative loops to feed information into decision-making process. Learning products will be focused on the needs of key decision-makers and will be designed to be useful and usable. The exact nature, format, and scope of each product will be finalised with relevant decision-makers and users during the Inception Phase. Some potential learning products to facilitate use will include:

- Options memos documenting potential pathways forward and their implications.
- Decision logs recording which decisions were made (or not made) and the rationale for why the selected action was taken (or not taken).
- Presentations during Country Management Team or Emergency Management Team meeting to facilitate development of evidence-based recommendations.
- Human interest stories that describe the response in a more personable way.
- Infographics or other data-driven references.
- Policy briefs and/or summary brief of the evaluation.
- Document Archive on SharePoint.

Workplan

The workplan below presents an illustrative timeline for evaluation activities that would span a period of approximately four months (February 2023 through May 2023). The LFE would launch on 1st February 2023 with a combined inception and initial data collection phase. During the inception mission, the evaluation team will prepare and circulate an inception report, and at the end of the mission, the evaluators will present the inception report which would include first impressions and preliminary observations for initial validation that would help inform and better refine the data collection phase. Following ethical review of the inception report, the evaluation team would undertake an intense two-week data collection mission, culminating in a debrief workshop with UCO to discuss emerging findings. Two weeks later, in online events, the evaluation team will present draft findings, conclusions and lessons learned in relation to the key questions outlined in the learning agenda. The findings and conclusions will be refined, taking into account the feedback received during the online events. A workshop will be held in Kampala in early April 2023 with staff from the regional, country and Uganda field offices to discuss and further develop the lessons and recommendations and encourage the uptake and use of the findings. In early May 2023, the first fully developed draft of the evaluation report should be ready, with a view to finalizing it by end of May 2023.

The format of and page limits for the final deliverables will be decided in the inception period. A high value will be placed on products that are concise and communicate well with different audiences. Thus, the final products should be edited and produced to include infographics and print layout in an easy-to-read format. The report structure, format and quality should adhere to the UNICEF Evaluation Report standards and the GEROS Quality Assessment System.

The workplan in this TOR is high-level and is intended to be further fleshed out during the inception phase. Key deliverables are highlighted in bold and indicated by number. The below timeline does not include presentations to the CMT and EMT but are expected to occur throughout the four-month timeline depending on when these meetings are scheduled.

Month in 2023	F	M	A	M
Inception phase				
On-board evaluation team / introduce to ESARO and UCO				
Initial desk review				
Validate key questions & **develop learning agenda and inception mission plan**	①			
Inception mission				
Draft inception report (including data collection protocols/questionnaires) for review				
Present to ERG the inception findings and assumptions	②			
Submit **inception report for ethical review**	③			
Implementation Phase				
Document review and data collection mission				
Analysis and **presentation of (preliminary) findings**		④		
Remote data collection to fill in any gaps				
Present draft findings, conclusions, and lessons (and options memos) to ERG			⑤	
Reporting, Dissemination and Use Phase				
Recommendations Workshop			⑥	
Draft Report and Learning Products submitted for review				⑦
Final Report and Learning Products submitted				⑧

Deliverables and Payment Schedule

Deliverable	Timeline	Payment Schedule

① **Draft learning agenda and inception mission plan** which includes data collection tools and inception report outline	8 Feb 23	25%
③ **Inception Report** The inception report structure, format and quality should adhere to the UNICEF Inception Report Standards and the GEROS Quality Assessment System. The evaluators will submit the evaluation protocol and tools to a national Institutional Review Board (IRB) for ethical review and approval. The evaluators will respond to all queries by the IRB and adapt protocol/instruments as deemed necessary. *(Payment also covers the ② presentation to the ERG on inception findings and assumptions)*	28 Feb 23	25%
⑦ **Draft Report** which should allow for several rounds of feedback from UNICEF and key stakeholders, to ensure understanding, agreement, and utility of the LFE outcomes. *(Payment also covers the ④ sharing of preliminary findings, ⑤ presentation of draft findings to ERG, and the ⑥ Recommendations Workshop)*	5 May 23	25%
⑧ **Final Report** with actionable and strategic recommendations validated by key stakeholders, in adherence to UNICEF Evaluation Report standards and the GEROS Quality Assessment System. All final versions of the agreed upon **Learning Products** will also be submitted.	31 May 23	25%

Management Arrangements and Quality Assurance

The evaluators will be recruited by and report to the ESARO Evaluation Section under the overall oversight of the ESARO Regional Director. For the day-to-day management of the LFE, the Evaluation Section will appoint an Evaluation Manager who will be accountable to the Regional Evaluation Adviser. Quality assurance will be provided by UNICEF's Evaluation Office.

UCO will appoint an Evaluation Focal Point who will act as the primary liaison with the Evaluation Manager and will facilitate the evaluation process at the country level.

An LFE Reference Group will be established to ensure ownership from relevant stakeholder groups of the LFE process, provide expert advice, inputs, and support to the LFE as the evaluation unfolds. The reference group will have the following responsibilities:

- Provide inputs in the inception phase to influence the approach of the evaluation, and, where necessary, provide information and institutional knowledge as key informants;
- Support the work of the evaluation team by facilitating connections with key informants and ensuring the team has relevant reference documents;
- Review selected evaluation products (implementation plan, learning products, draft, and final report) and provide written comments to the evaluation team through the evaluation manager; and,
- Contribute to the post-evaluation management response, action plan and dissemination strategy.

ESARO will assure the quality of the evaluation and guarantee its alignment with UNEG Norms and Standards and Ethical Guidelines and provide quality assurance checking that the findings and conclusions are relevant and proposed adaptations are actionable. All major deliverables will be reviewed first by ESARO (zero draft) and then by the LFE Reference Group. The inception report and draft final report will be subject to a satisfactory rating by an external quality assurance facility, using quality assurance checklists provided in Annexes 1 and 2, before payment can be made. The evaluators will be responsible

for ensuring that recommendations for quality improvement of the report(s) are fully addressed. The Final Evaluation report will be also submitted to GEROS for final quality assessment with feedback provided to ESARO/MCO on the quality of the evaluation.

Norms and Standards

The evaluators should adhere to the following UN and UNICEF norms and standards and are expected to clearly identify any potential ethical issues and approaches in their proposal. Owing to the envisaged participation of human subjects in the evaluation, particularly with vulnerable populations and using health-related data, the evaluation team should look into the requirements for ethical review board approval from a recognized Institutional Review Board in Uganda. Any ethical issues that arise during the evaluation need to be documented including how the evaluators will respond or address each. Guidance documents mentioned below are those that the evaluators are expected to comply with:

- United Nations Evaluation Group (UNEG) Norms and Standards for Evaluation in the UN System 2016;[clxiv] (including impartiality, independence, quality, transparency, consultative process);
- UNEG Guidance on Integrating Disability Inclusion in Evaluations and Reporting on the UNDIS Entity Accountability Framework Evaluation Indicator;clxv
- Ethical Guidelines for UN Evaluations;[clxvi]
- UNICEF Ethical Guidelines and standards for research and evaluation;[clxvii]
- UNEG guidance on integrating human rights and gender equality and UN System-Wide Action Plan (UN-SWAP) on gender equality; [clxviii]
- UNICEF Guidance on Gender Integration in Evaluation[clxix];
- UNICEF Guidance on Disability Inclusive Evaluationsclxx;
- UNICEF adapted evaluation report standards and GEROS;[clxxi]
- Relevant ALNAP guidance for evaluation and real-time evaluations of humanitarian action;[clxxii]
- Results Based Management principles (Theory of Change applied in the emergency should be determined by the Evaluation Team).

Location and Duration

Location: Kampala, Uganda, with travel to affected areas in Mubende and surrounding districts.
Duration: February 2023 through May 2023 (4 months).

Evaluation Team Composition, Expected Background and Experience of the Evaluators

Team Composition and responsibilities:

The evaluation will be conducted by a small evaluation team, including at least one international team leader and two national consultants with demonstrated experience in all key response areas (IPC/WASH, Risk Communication and Community Engagement (RCCE) and case management, nutrition, Mental Health, and Psychosocial Support (MHPSS), continuity of essential health and social services, coordination and operations). ***An institutional contract will be made.***

Required Qualifications:

Team Leader

- A minimum of ten years' experience evaluating humanitarian action.
- Extensive experience in similar emergency response (health emergencies), preferably with a UN agency, including experience in public health;
- Experience in leading and conducting multi-disciplinary evaluations, including evaluating rapid onset emergencies for UNICEF, other UN agencies or other international partners at the global, regional, or country levels;
- Knowledge of latest methods and approaches in humanitarian evaluation, especially participatory methods, and accountability to affected populations, and RTEs;
- Knowledge of qualitative and quantitative methods;

- Technical expertise relevant to UNICEF's emergency operations, familiarity with UNICEF's emergency response, including the Core Commitments to Children preferred;
- Experience and knowledge of child rights and participation, equity, disability inclusion, and gender equality in research and evaluation, particularly in humanitarian settings;
- Excellent oral and written communication skills (in English);
- Knowledge of qualitative and quantitative methods;
- Experience managing a team;
- Experience with the ethics of evidence generation; experience collecting data from vulnerable groups; familiarity with ethical safeguards.

Two Senior National Evaluators

- A minimum of five years' experience evaluating humanitarian action;
- Familiarity with UNICEF's emergency response, including the Core Commitments to Children;
- Experience in primary data collection in crisis-affected communities, including leading inclusive and accessible focus group discussions and participatory methods;
- Qualitative data analysis skills;
- Experience and knowledge of approaches to community care, including infection prevention and control;
- Familiarity with methods and approaches to SBC including social mobilisation and community engagement;
- Experience and knowledge of approaches to child protection in emergencies;
- Ability to undertake back-office analysis (e.g., desk review, analysis of timeline data, analysis of funding resources, etc.)
- Experience with the ethics of evidence generation; experience collecting data from vulnerable groups; familiarity with ethical safeguards;
- In-depth knowledge of the affected areas and current Ebola crisis;
- Excellent ability to communicate and write in English and local languages.

Significant advantages

- Nomination of a team leader from the 'global South'.
- Proven ability to develop attractive evidence products that present complex information via Infographics and other communication means.
- A work record in Eastern and Southern Africa and with experience in Uganda.
- In-depth knowledge of Ebola and experience in other Ebola outbreaks.
- Record of top ranked evaluation reports by GEROS.

Assessment of proposals process and methods

Interested and qualified evaluation firms are requested to submit one technical proposal and one financial proposal within the indicated deadline. After the opening, each proposal will be assessed first on its technical merits and subsequently on its price.

All bidders' proposals will be reviewed by the evaluation panel. The proposal with the best overall value, composed of technical merit and price, will be recommended for approval. The overall weighting between technical and financial evaluation will be as follows: The technical component will account for 70 per cent of the total points allocated and the financial component will account for 30 per cent of the total points allocated. The assessed technical score must be equal to or exceed 50 of the total 70 points allocated to the technical evaluation in order to be considered technically compliant and for consideration in the financial evaluation.

The financial proposal should include all eligible costs (fees, international and field travel expenses, etc.) of the evaluation team. The evaluation partner is also expected to work independently and regular overhead costs relating to office space and equipment should be included in the financial proposal. The arrangement of necessary human resources including research assistants, enumerators and data entry personnel must be well defined and costed in the proposal.

Below is allocation of points to both the technical and financial evaluation.

ITEM	TECHNICAL EVALUATION CRITERIA	MAX OBTAINABLE POINTS
1	**Overall quality of the technical proposal** *Demonstrated understanding of the assignment by the proposer and the responsiveness of the proposal submitted to the TOR.*	**15**
2	**Company experience** *Range and depth of organizational experience in the provision of the services mentioned in the TOR, samples, and references of previous work.*	**10**
3	**Proposed Methodology and Approach** *Quality and appropriateness of the overall approach and methodology proposed to design and undertake the evaluation per the evaluation criteria and key evaluation questions, including detailed work plan in line with the TOR.*	**25**
4	**Quality of the proposed team** *Relevant experience and qualifications of the proposed team for the assignment as per the TOR.*	**20**
TOTAL TECHNICAL SCORE		**70**
TOTAL FINANCIAL SCORE		**30**
SUMMARY OF TECHNICAL & FINANCIAL SCORE		**100**

ANNEX 2: SCOPE OF THE EVALUATION

Institutional scope	• Assessed performance and results of the UNICEF (with its partners) response to the Ebola outbreak. • Assessed UNICEF's leadership and coordination and its contribution to the UN coordination forum and the agreed division of roles (UN agencies, donors, government). This may include how UNICEF performed in its allocated areas of responsibility as well as in information management, and advocacy for funding. • Assessed the support and coordination mechanisms between UCO, ESARO, as well as with HQ (Emergency Operations, Health/WASH/Social Behavior Change, Public Partnership Division and UNICEF's Supply Division. This includes planning, cross-border coordination, and preparedness activities in Uganda plus neighbouring countries (South Sudan, Kenya, Tanzania, Burundi, and Rwanda).
Programmatic scope	As per the '*UNICEF Uganda Ebola Preparedness and Response Plan (Oct 22 – Feb 23)*' and The UNICEF Uganda Post-Ebola Response Plan (Jan – July 23) assess: • the emergency preparedness and response of integrated and multisectoral programming bringing together Health, including HIV, Child Protection, Social Protection, Education, WASH, Nutrition, SBC, and Supply/Logistics, and implemented through the pillars and sub-pillars of the national Ebola response planning (Health, WASH, Nutrition, Education, Mental Health, and Psychosocial Support (MHPSS) and Social Protection through cash grants). • several cross-cutting commitments and where relevant the mainstreaming of Accountability to Affected Populations (AAP)/PSEA, GBV prevention, mitigation and response, diversity, and inclusion. • the extent to which UNICEF mobilized the necessary resources (supply, human resources, funding) and partnerships as a result of the L2 activation and how these resources have been used in an effective (as per planned and timely), and value for money (VfM) manner. • duty of care, the adaptiveness/responsiveness of the response, the child-centered aspect of the response, and how it has addressed gender, disability, and age vulnerabilities, including marginalization, deprivation, violence and abuse.
Operational scope	The LFE assessed the timeliness, effectiveness, and efficiency of the UNICEF response in terms of: • timely delivery of supplies based on needs • timeliness and effectiveness of UNICEF scale up efforts and staffing deployments (including duty of care) • the quality and inclusiveness of internal collaboration and cohesion on operational aspects of the response planning and implementation • the relevance of financial modalities, governance and assurance procedures and measures introduced. • application of the L2 emergency simplified procedures and will reflect on operational opportunities, best practices, and challenges for rapid scale up in Uganda country context environment.

Geographical scope	● All nine affected districts were considered (Mubende, Kassanda, Kyegegwa, Bunyangabu, Kagadi, Wakiso, Masaka, Ninja, and Kampala) as well as some districts that benefitted from preparedness
Time scope	● Assessed the period from the GoU declaration of the Ebola outbreak on 20 September 2022 till the end of the UNICEF L2 activation, 26 April 2023. It will further assess UCO's transition from the L2 emergency to long-term strategies through its Post Ebola Response Plan.

ANNEX 3: EVALUATION MATRIX

Learning & Evaluation questions	Criteria	Indicators/ Benchmarks	Sources of verification/Methods
1.1 To what extent did the UNICEF L2 response achieve its stated objectives in terms of preparedness and timeliness	**Effectiveness**	• Evidence of preparedness and contingency and how this informed the response effectiveness and efficiency • Evidence of achieved results as per planned • Perceptions on UNICEF's comparative advantage per pillar • Perceptions from affected populations on UNICEF	**Document Review:** • UNICEF CCC's • UNICEF emergency procedures • UNICEF emergency handbook • UNICEF Ebola Response Plan • GoU Ebola response plan • UNICEF's Ebola response results and performance framework • UNICEF Uganda Ebola Updates • GoU/WHO Ebola Virus Disease in Uganda Sitreps • EMT meeting notes • Sectoral performance and results • UNICEF After Action Review **KII's with UNICEF and different stakeholders** **FGD with affected communities** **CRA**
1.2 To what extent was the UNICEF L2 response adaptive and agile to changing circumstances *(including application of the L2 procedures)*?	**Effectiveness** **Adaptability**	• Evidence of adaptation following changes in scope and severity of needs, results-based management, and risk informed management. • Evidence of the UCO to shift from regular programming to the Level 2 activation. • Perceptions from UNICEF and stakeholders on UNICEFs adaptability and agility	**Document Review:** • UNICEF CCC's • UNICEF Guidance Handbook in L1, L2 and L3 emergencies • UNICEF emergency procedures • UNICEF Disability-Inclusive Humanitarian Action Toolkit[clxxiii] • UNICEF Health and children on the move[clxxiv] • UNICFE enhancing gender in humanitarian response[clxxv]

Learning & Evaluation questions	Criteria	Indicators/ Benchmarks	Sources of verification/Methods
		● Evidence of adaptation to ensure inclusivity of vulnerable groups like children, women, youth, adolescents, refugees, and persons with disabilities	● IASC Guidelines, Inclusion of Persons with Disabilities in Humanitarian Action[clxxvi] ● UNICEF and GoU Vulnerability disaggregated results data **KII's with UNICEF and different stakeholders** **FGDs with vulnerable groups**
1.3 To what extent was accountability to affected populations (AAP and PSEA) embedded in the UNICEF L2 response?	**Relevance / appropriateness**	● Evidence of needs and vulnerability assessments that informed the response ● Evidence of CCC indicators/benchmarks/indicators for AAP: (1) participating in planning processes and in decisions, (2) informed about their rights and entitlements, (3) feedback systematically collected, (4) access to safe and confidential complaint mechanisms ● Evidence of PSEA indicators/benchmarks: (1) monitoring and mitigation measures put in place (including $500,000 Emergency Program Fund earmarked), (2) access to safe, ● child- and gender-sensitive reporting channel(s) to report SEA, (3) referral is in place, (4) safe and respectful investigation of SEA.	**Document Review:** ● UNICEF AAP, a handbook for UNICEF and partners ● UNICEF Handbook on PSEA in humanitarian action ● PSEA Office-wide Action Plan with clear roles and responsibilities ● Needs and vulnerability assessments (UNICEF or interagency) ● UNICEF Gender Action Plan **KII's with UNICEF and different stakeholders** **FGD with affected communities** **CRA**

Learning & Evaluation questions	Criteria	Indicators/ Benchmarks	Sources of verification/Methods
		● Perceptions of affected populations regarding the AAP & PSEA benchmarks	
1.4 To what extent were needs and priorities of women and children, including those with disabilities, embedded in the L2 response?	**Inclusion & Diversity**	● Evidence of CCC Benchmarks on Gender equality and empowerment of girls and women (ending GBV, Community engagement and AAP, gender responsive programming) and Disability (including inclusive needs assessments/planning/monitoring, safe access to information, participation) ● Evidence of minimum allocations for gender equality priorities (15% of funds) in line with UN standards ● Evidence of explicit gender-based violence (GBV) response in design and implementation. ● Data disaggregated per gender, age, and diversity and GBV reporting ● Perceptions regarding UNICFE's response integrating children, women, youth, adolescents, refugees, and persons with disabilities	**Document Review:** ● UNICEF CCC's ● UNICEF Gender Action plan, 2022-2025 ● GBV, a step-by-step Pocket Guide for humanitarian practitioners ● IASC Minimum Standards for Gender-Based Violence in Emergencies Programming, 2019. **KII's with UNICEF and different stakeholders** **FGD with affected communities** **CRA**
1.5 To what extent did UNICEF scale up the L2 response efficiently?	**Efficiency Value for Money**	● Evidence demonstrating timely scale up and application of the L2 procedures regarding:	**Document Review:** ● UNICEF Guidance Handbook in L1, L2 and L3 emergencies ● UNICEF emergency procedures

Learning & Evaluation questions	Criteria	Indicators/ Benchmarks	Sources of verification/Methods
		● Mobilization of human resources as per the CCC benchmarks ● Mobilization Funding across sectors/pillars, funding coverage, expenditures, VfM, partner disbursements ● Mobilization of Partners (preparedness, processes, timeliness) meeting CCC benchmarks ● Evidence of duty of care is in place, including how to reduce stigma/fear/discrimination among staff	● Timeline of key events and UNICEF actions ● UNICEF Resource Mobilization Action Plan ● Documents/data HR, partnerships, and funding scale up, allocations, and VfM ● Plans/protocols/support on duty of care **KII's with UNICEF and stakeholders**
1.6 To what extent was the L2 response adequate (severity of needs) and proportional (scale of needs) in coverage?	**Coverage**[27]	● Evidence of UNICEF geographic presence, and populations reached versus targeted ● Evidence of proportional coverage to severity and scale of needs ● Perceptions of affected populations	**Document Review:** ● UNICEF's Ebola response results and performance framework **KII's with UNICEF and stakeholders** **FGD** **CRA**
1.7 To what extent were relevant standards, commitments, principles, and policies adhered to throughout the response?	**Relevance Coherence**	● Evidence of operational adherence to UNICEF CCCs, SPHERE standards, WHO/CDC Public Health Guidance for Ebola Responses ● Evidence that human rights, humanitarian principles, do no harm, and protection have	**Document Review:** ● UNICEF CCC's ● Sphere Handbook ● WHO/CDC Public Health Guidance for Ebola Responses

[27] Reaching the greatest number of people in need, available at https://www.corecommitments.unicef.org/ccc-2-2

Learning & Evaluation questions	Criteria	Indicators/ Benchmarks	Sources of verification/Methods
		informed response design and implementation	
1.8 To what extent did the L2 response reach different groups including women, girls, boys, adolescents, and youth, persons with disabilities and refugee children?	**Equity**[28]	● Evidence of vulnerable and marginalized groups reached ● Evidence of disaggregated data that is collected, analysed, and disseminated to understand and address the diverse needs, risks and vulnerabilities of women, children, and other diversity ● Perceptions of vulnerable and marginalized groups	**Document Review:** ● UNICEF results data disaggregated across gender, age, vulnerability ● UNICEF disability inclusion policy and strategy, 2022–2030 ● UNICEF Gender Action plan, 2022-2025 **KII's with UNICEF and stakeholders** **FGD** **CRA (proxy questions)**
1.9 To what extent was the L2 response connected to longer term strategy and programming.	**Connectedness**	● List of concrete activities that benefit lasting results ● CCC commitments to linking the HDP Nexus including risk informed programming, and national/local capacities	**Document Review:** ● UNICEF's Procedure on Linking Humanitarian and Development Programming ● UNICEF Post L2 strategy **KII's with UNICEF and stakeholders**
1.10 To what extent was the L2 response well-coordinated internally and externally?	**Coordination Partnerships**	● UNICEF staff perceptions on internal coordination between the UCO, RO and with HQ ● UNICEF staff perceptions on coordination/synergies between national and subnational levels ● Stakeholder perceptions on external coordination between WHO, the Government, implementation partners?	**Document Review:** EMT meeting minutes **KII's with UNICEF and stakeholders**

[28] Reaching those in greatest need (vulnerability, marginalization), available at https://www.corecommitments.unicef.org/ccc-2-2

Learning & Evaluation questions	Criteria	Indicators/ Benchmarks	Sources of verification/Methods
2.1 What are the successful and/ or innovative approaches of the ongoing response that could be leveraged in the continued response?	**Effectiveness**	● Overview of innovative approaches/activities/models that could be leverage in future PHEOCs	**Document review:** Grey literature on Ebola lessons learned from Uganda/DRC/west Africa (WHO, NGO's, academic report) **KIIs with UNICEF and stakeholders** **FGDs**
2.2 To what extent were there missed opportunities used?	**Relevance / appropriateness** **Effectiveness** **Efficiency** **Coherence** **Coordination** **Coverage** **Connectedness**	● Overview of relevant missed opportunities that could be leveraged in the future PHEOCs	**KIIs with UNICEF and stakeholders** **FGDs**
2.3 What are positive and 'to avoid' lessons/best practices for UCO's emergency preparedness and planning?	**Relevance** **Effectiveness** **Efficiency** **Coherence** **Coordination** **Coverage** **Connectedness**	● Overview of lessons and best practices	**KIIs with UNICEF and stakeholders** **FGDs**
2.4 What extent were lessons learned from previous outbreaks and preparedness measures applied in this response?	**Relevance** **Effectiveness** **Efficiency** **Coherence** **Coordination** **Coverage** **Connectedness**	● Overview of DRC lessons adopted and their outcomes. ● Overview of previous UNICEF experiences	**Document review** Grey literature on Ebola lessons learned from Uganda/DRC/west Africa (WHO, NGO's, academic report) **KIIs with UNICEF and stakeholders** **FGDs**
2.5 What areas have emerged as gaps?	**Relevance** **Effectiveness** **Efficiency** **Coherence**	● Overview of programmatic and operational gaps,	

Learning & Evaluation questions	Criteria	Indicators/ Benchmarks	Sources of verification/Methods
	Coordination **Coverage** **Connectedness**		
3.1 What are mechanisms/systems that UCO should adapt and put in place to ensure agility and prepare for the immediate future, adjusting to the changing context and different age, gender and disability-related needs of women, children?	**Relevance** **Effectiveness** **Efficiency** **Coherence** **Coordination** **Coverage** **Connectedness**	● Overview of mechanisms/systems for UCA that can augment response agility and preparedness. ● Overview of mechanisms/systems for UCO to augment age, gender, and disability inclusions	**Document review:** ● UCO Annual Planning documents ● UNICEF Strategic Plan 2022-2025 ● UNICEF Gender Action Plan (2022–2025) ● IASC Synthesis Report - Mapping Good Practice in the Implementation of Humanitarian-Development-Peace Nexus Approaches ● DAC Recommendation on Enabling Civil Society in Development Co-operation and Humanitarian Assistance **KIIs with UNICEF and stakeholders**
3.2 How can UCO integrate the emergency response into longer-term programming?	**Connectedness** **Coordination** **Partnerships**	● Evidence of linking the HDP nexus including contribution to collective outcomes across the HDP; perceptions on UNICEF's engagement with the UN mission, development donors, government; and inclusive delivery and effective management of social services such as education, health, WASH, and child protection; strengthening capacities of communities especially for women, adolescents, and children ● Overview of 'quick wins' to augment integration of PHE	**Document review:** ● IASC Synthesis Report - Mapping Good Practice in the Implementation of Humanitarian-Development-Peace Nexus Approaches ● DAC Recommendation on Enabling Civil Society in Development Co-operation and Humanitarian Assistance **KIIs with UNICEF and stakeholders**

Learning & Evaluation questions	Criteria	Indicators/ Benchmarks	Sources of verification/Methods
		response into longer-term programming ● Overview of action for that the UCO can design and operationalize to better integrate HDP Nexus thinking ● Overview of actions for the UCO to integrate L2 PHE response into the Annual Work Plan	

ANNEX 4: EVALUATION PRIORITY AREAS

THE L2 MECHANISM

- Preparedness efforts influencing effectiveness and timeliness
- Adequacy and capacity of country teams
- Partnership processes influencing the response
- Multi-sectoral integration and engagement with partners
- VfM of ESARO/HQ funding under a no-regrets approach
- Duty of care reducing Ebola fear/stigma among UNICEF staff and implementing partners
- Coherence with internal/external global guidance for PHEs, both operational and sectoral

UNICEF OPERATIONAL PREPAREDNESS AND RESPONSE

- Influence of the emergency preparedness before and during the Ebola response
- Factors contributing to the rapid response (timeliness) and containment of the Ebola outbreak
- Integration of the UNICEF DRC Ebola lessons (and other Ebola lessons) in the Uganda Ebola response
- Examination of the UNICEF pillars that added the most value (incl. VfM) and comparative advantage
- Integration of child protection and MHPSS
- Integration of GBV, PSEA, and AAP
- Engagement with MoH and WHO
- Transition out of the Ebola responseclxxvii

AFFECTED POPULATIONS

- Populations benefitting from GBV-, PSEA- and AAP-sensitive approaches
- Education as a response mechanism
- Feedback mechanisms
- Inclusion of affected populations (including marginalised/vulnerable)
- Sustainability of results – HDP nexus thinking

OTHERS

- Effectively capturing lessons learned
- Actionable recommendations for similar future responses

ANNEX 5: DOCUMENT LIBRARY

1A Name author, name report, year.

2 UNICEF, Core Commitments for Children Humanitarian Action, 2022.

3 UNICEF, Uganda Humanitarian, SitRep No.4-July-August-2022.

4 UNICEF, Ebola Response Plan (Sudan Virus Disease) in Uganda October 2022 – March 2023

5 UNICEF, POST Ebola Response Plan (Sudan Virus Disease) in Uganda Jan-July 2023

6 Ministry of Health, Uganda National Response Plan for Ebola Virus Disease Outbreak, September – December 202

7 Ministry of Health, Press statement on confirmed Ebola outbreak in Mubende, 20th Sept, 2022

8 Presidents Press Unit, Summary Statement of President Yoweri Kaguta Museveni Address To The Nation On The Ebola Virus Disease Outbreak, 28th September, 2022

9 Presidents Press Unit, Update to The Nation on the Ebola Virus Disease Outbreak in The Country. 12th October, 2022

10 Presidents Press Unit, President of The Republic Of Uganda To The Nation Latest Updates On Ebola Virus15th October 2022 Nakasero

11 KCCA, Ebola Disease Situation Report in Kampala

12 Ministry of Health, Press statement. Update on Ebola Virus Disease Outbreak and Containment Measures. 26th October, 2022

13 Ministry of Health. Press Statement, Update on Ebola Virus Disease Outbreak and Containment Measures. 5th November, 2022

14 Presidents Press Unit. 4th Address to The Nation on The Ebola Virus Disease Outbreak By H E The President date: 15 November 2022.

15 Presidents Press Unit. H.E The President Speech on Ebola Virus Disease Outbreak Date: 26th November 2022

16 Ministry of Education and Sports. Measures to prevent and control the spread of Ebola Virus disease in schools in Uganda. 8th November, 2022

17 MINISTRY OF HEALTH. Hon Minister's Statement on Declaration of End of Ebola Outbreak in Uganda. 11th January, 2023

18 Ministry of Health. Uganda National Post Ebola Recovery Plan. January to July, 2023

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25 Ministry of Health. EBOLA VIRUS DISEASE IN UGANDA. 26th Sept 2022 as of 22 00 Hrs. Situation Report #06

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27 Ministry of Health. EBOLA VIRUS DISEASE IN UGANDA. 28th Sept 2022 as of 22 00 Hrs. Situation Report #08

28 Ministry of Health. EBOLA VIRUS DISEASE IN UGANDA. 29th Sept 2022 as of 22 00 Hrs. Situation Report #09
29 Ministry of Health. EBOLA VIRUS DISEASE IN UGANDA. 30th Sept 2022 as of 22 00 Hrs. Situation Report #10
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31 Ministry of Health. EBOLA VIRUS DISEASE IN UGANDA. 2nd Oct 2022 as of 22 00 Hrs. Situation Report #13
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83 UNICEF, Uganda Country Office Ebola Virus Disease (EVD) Humanitarian Situation Report No.5. 5 – 18 December 2022
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ANNEX 6: LIST OF PEOPLE INTERVIEWED

Name and Title	Name Organisation
Rotival Bruno	ECHO
Arnold Kabbala	FCDO
Abalo Jackeline	AVSI
Lenia Peary	AVSI
Makoga John	AVSI
Nakajjizo Patricia	AVSI
Ochoro Frank	AVSI
Okello Stephen Gerald	AVSI
Dr Akimana Benedict, MHPSS/child protection	Butabika National Referral hospital
Dr Kenneth Kalani, Senior Psychiatrist, Ministry of Health:	MoH Butabika hospital
Dr Juliet Nakku, Executive director	Butabika National Referral hospital
Ntale Jonathan, CDC/DDPHSIS/CGH/DGHT	CDC
Sande Enos, CDC/DDPHSIS/CGH/DGHT	CDC
Dr Buluma Denis, DMO KAMPALA-Rubaga	KCCA-Rubagga Division
Nazziwa Phionah, Environment Health Officer	KCCA-Rubagga Division
Abibi Brenda, Data Clerk	Local responders/community
Balindak Hassim, SEO	Local responders/community
Bbosad Ifasi, Traditional Healer	Local responders/community
Bulyerali James Dia	Local responders/community
Busulwa Abdul Whae, Shkadawa	Local responders/community
Kakaireala Manzana, Pacao	Local responders/community
Kasolo Peter, Lab Technician	Local responders/community
Kawuma Charles, DHO	Local responders/community
Kezimbira Sabastian, Probation Officer	Local responders/community
Mashate Isaac, ADHO	Local responders/community
Mayinja Rogers, Driver	Local responders/community
Mugabe Aspaphilmon, Hospital Admin	Local responders/community
Munyanga Hosea, AIMO	Local responders/community
Mutibwa Tonny, HDE	Local responders/community
Naalima Benedictyo, DIS	Local responders/community
Naalima Benedictyo, DEO	Local responders/community
Nakanjako Justine, SCDE	Local responders/community
Sekabira Abdul, DEO	Local responders/community
Ssalie Dison, DCAO	Local responders/community
Ssebulime Gonzaga, DCDO	Local responders/community
Sselyamb Afred, DIS	Local responders/community

Name and Title	Name Organisation
Ssembanyatonny Mark, Nursing Officer	Local responders/community
Tumusiime Leonard, DCAO	Local responders/community
Were Edward, SEO	Local responders/community
Monicah Rwotmon, Program Manager/Risk Communication	Lutheran World Federation
Paul Orikushaba, Programme Coordinator/Risk Communication	Lutheran World Federation
Peter M, Programme Officer	Lutheran World Federation
Dr Ronnie Bahatungire, Case Management Pillar	MoH
Augustin Westphal, MSF Country Representative	MSF
Dr Allan Muruta, Surveillance	National EVD Taskforce
Dr Charles Olaro, Continuity of essential Health Services	National EVD Taskforce
Dr Mohamed Larmode, Case Management	National EVD Taskforce
Dr Paul Mbaka, Strategic Information, Research, and Innovation (SIRI)	National EVD Taskforce
Dr Richard Kabanda, MoH Risk Communication Pillar	National EVD Taskforce
Enos Moh, Co-Chair	National EVD Taskforce
Lt. Col. Dr Henry Kyobe, Incident Commander	National EVD Taskforce
Richard Kabanda, CHS/HE&P- MoH	National EVD Taskforce
Dr Henry Kyobe, Coordination/ Incident Management	NTF Incident commander
Kevin Mubuke, Child Protection/Child Rights Advisor	Save the Children
Maurice Okoth, Child protection	Save the Children
Mystica Acheng, Child Protection Specialist	UCO Mbarara Zonal office
Susan Ngongi Namondo, UN RC	UN
Charles Nelson Kakaire, RCCE	UNICEF HQ Surge/EMOPS
Jerome Pfaffmann, HQ	UNICEF HQ Surge/EMOPS
Kevin Wyjad, Emergency specialist Risk analysis and preparedness section	UNICEF HQ Surge/EMOPS
Lola Galla, Emergency HR	UNICEF HQ Surge/EMOPS
Lucas Deroo, Case management/Surveillance (GOARN)	UNICEF HQ Surge/EMOPS
Saa Eric Dentor, GBViE/PSEA	UNICEF HQ Surge/EMOPS
Samantha Cappucci, Emergency specialist	UNICEF HQ Surge/EMOPS
Tsedeye Girma, EMOPS	UNICEF HQ Surge/EMOPS
Antony Angaluki, Coordinator	UNICEF RO Surge
Ida-Marie Ameda, Overall Response Coordinator	UNICEF RO Surge
Joan Kipwola, Emergency Coordination/ After Action Review	UNICEF RO Surge
Mandi Chikombero, Regional Adviser SBC	UNICEF RO Surge
Paul Ngwakum, Coordination/ CoHS, CM,	UNICEF RO Surge
Pierre Fourcassie, IPC/WASH	UNICEF RO Surge
Simone Carter, IOA	UNICEF RO Surge
M. Munir A. Safieldin, Representative	UNICEF UCO Staff
Abel Asiimwe, RCCE	UNICEF UCO Staff

Name and Title	Name Organisation
Alex Mokori, CM - Nutrition	UNICEF UCO Staff
Ann Robins, Coordination/CoHS	UNICEF UCO Staff
Atnafu Getachew Asfaw, Coordination/CoHS	UNICEF UCO Staff
Barbara Asire, Coordination/CoHS	UNICEF UCO Staff
Chimwemwe Msukwa, CoHS/CE	UNICEF UCO Staff
Christopher Ngwerume, Coordination	UNICEF UCO Staff
Divya Jacob, Coordination	UNICEF UCO Staff
Douglas Lubowa, RCCE (Kampala)	UNICEF UCO Staff
Esther Wamono, Case Management - Nutrition	UNICEF UCO Staff
Fred Kagwire, Coordination	UNICEF UCO Staff
George Gena, CES- Education (Kampala)	UNICEF UCO Staff
Harriet Nambassa Kajubi, Child protection/MHPSS (Kampala)	UNICEF UCO Staff
Innocent Nyasuna, Child protection/MHPSS	UNICEF UCO Staff
Irene Nabisere, Coordination	UNICEF UCO Staff
Irene Nakachwa, Case management /CES Health	UNICEF UCO Staff
Jonathan Hunter, IPC/WASH	UNICEF UCO Staff
Julius Mubangizi, Coordination	UNICEF UCO Staff
Kutloano Leshomo, Finance/ program	UNICEF UCO Staff
Lisa Zimmerman, Child protection/MHPSS	UNICEF UCO Staff
Margarita Tileva, Dep Rep	UNICEF UCO Staff
Martin Ngolobe, Health (Case management/CES)	UNICEF UCO Staff
Miriam Lwanga, RCCE/Coordination	UNICEF UCO Staff
Mystica Acheng, Child protection/MHPSS	UNICEF UCO Staff
Nikolas Swyngedouw, MHPSS/child protection	UNICEF UCO Staff
Phillips Limlim, Coordination	UNICEF UCO Staff
Sarah Achiro, PSEA/Gender	UNICEF UCO Staff
Stephen Mucungunzi, Field Coordinator	UNICEF UCO Staff
Tsige Ashagrea, Finance/ program	UNICEF UCO Staff
Vedasto Nsanzugwanko, Coordination/ CM - MHPSS	UNICEF UCO Staff
Zakaria Fusheini, CM - Nutrition	UNICEF UCO Staff
Isabella Epajja, Risk Communication	URCS
Josephine Okwera, Director Health Services/Risk Communication	URCS
Robert Kwesiga, Secretary General /Risk Communication	URCS
Abdirahman Meygag, Representative	WFP
Matthew MCILVENNA, WFP	WFP
Dr Suraj SHRESTHA, Emergency Project Coordination	WHO
Dr Elizabeth Adhiambo Mgamb, Emergency Project Coordination	WHO
Dr Solome Okware, CE	WHO
Mr. Benjamin Sensasi, WASH	WHO
Mr. Innocent Komakech, RCCE	WHO

ANNEX 7: FOCUS GROUP DISCUSSIONS

Nb	F: M	Nb of people	District	Type of FGD	SUB-COUNTY/VILLAGE
1	M	23	JINJA	PARISH TASK FORCE	BULYENGO
2	F:M	20	JINJA	AFFECTED COMMUNITY	KWYALWE. B
3	F:M	15	KASANDA	CHILDREN 12 - 17	KIKWANDA UMEA SCHOOL
4	F:M	15	KASANDA	KIKANDWA HCIII RED CROSS VOLUNTEER	KIKANDWA
5	F:M	7	KASANDA	PARISH TASK FORCE	KIKANDWA
6	F:M	12	KASANDA	DISTRICT TASK FORCE	Kassanda DLG
7	F:M	9	MUBENDE	TEACHERS	KASENYI SS
8	F:M	9	MUBENDE	PUPIL	KAWEERI PRI SCH
9	F:M	8	MUBENDE	STUDENTS	KASENYI SS
10	F:M	6	KYEGEGWA	INSPECTOR OF SCHOOLS	KDLG
11	F:M	8	KYEGEGWA	PUPIL	BUGOGO PRI SCH
12	F	9	KYEGEGWA	WOMEN AFFECTED COMMUNITY	BUGOGO
13	F:M	9	KYEGEGWA	TEACHERS PRI/SEC SCH	BUGOGO
14	F:M	16	KYEGEGWA	VHT/VILLAGE TASK FORCE	KABARUNGI/BUGOGO
15	F:M	11	MUBENDE	DISTRICT TASK FORCE	Mubende DLG
1	F:M	8	KYEGEGWA	STUDENTS	BUGOGO
16	M	9	KASANDA	BODA-BODA	KIKANDWA
17	F:M	7	KASANDA	TEACHER	UMEA PRI SCH
18	F:M	44	JINJA	HYGIENIST	MAGAMAGA
19	F	20	JINJA	WOMEN AFFECTED COMMUNITY	KAWALABYE
20	F:M	8	KASANDA	VILLAGE TASK FORCE	KIKANDWA
21	F:M	38	KYEGEGWA	LEADERS, TASK FORCE, VHT AND TRADITIONAL HEALERS	KYEGEGWA
22	F:M	7	KYEGEGWA	HEALTH CARE WORKERS	BUGOGO HCIII
23	F:M	18	KASANDA	SURVIVORS	KIKANDWA
24	F:M	8	MUBENDE	VILLAGE TASK FORCE	MADUDU
25	F:M	11	KASANDA	HEALTHCARE WORKERS	KIKANDWA HCIII
26	F:M	21	MUBENDE	TASK FORCE, LEADERS, AND TRADITIONAL HEALERS	MADUDU

ANNEX 8: CHILDREN'S FOCUS GROUP DISCUSSIONS

Reflection on the inclusion of children in FGDs in the evaluation

To elicit the perspectives of children, the evaluation team chose FGDs over individual interviews to avoid potential power imbalances between researchers and participants that might exist between an adult and a child in a one-on-one interview.

Focus groups consisting of group members familiar with each other created a safe peer environment and helped children to express their opinion. Permission from parents or legal guardians was obtained prior to conducting the FGDs. Participating children were selected using a combination of purposive (because they fulfilled the inclusion criteria of appropriate age range and gender diversity) and convenience (they were conveniently accessible and had experience with the Ebola preparedness and response) sampling. Playful group activities, concrete questions using simple language and easily recognizable symbols facilitated the participation of younger children. The FGDs were implemented in classrooms with teacher involvement to diminish shyness among the children. A combination of thematic and ethnographic analysis was used to focus on the particularities of children's experiences and practices during the Ebola epidemic. Data gathered during these FGDs opened a window into children's lived experiences during the Ebola epidemic and provided insight into how UNICEF's Ebola response activities enabled Ugandan children to survive, thrive and fulfil their potential.

While these methods did collect some rich insights from children that benefitted from UNICEF's interventions, the evaluators felt that the children's responses were heavily influenced by various factors, including a social desirability bias – the desire to please what adults want to hear – but also gratitude and reciprocity. Children who have benefited from UNICEF's programs might feel grateful for the assistance they have received. This gratitude – desire to please UNICEF but also to avoid a reduction in UNICEF's support - led to responses that mostly aligned with a positive perception of the organization's efforts and did not always result in candid and authentic responses. The evaluators had to remind the children continuously that they can express positive and less positive experiences comfortably. Other biases included peer pressure. This was particularly present among younger children wanting to conform and agree with popular opinions rather than expressing their genuine thoughts.

Still, the FGDs with children collected rich insights how children perceived UNICEF's Ebola response. As an organisation, UNICEF was known by the children and mostly through its education support. Involving children, a primary rights holder group, promoted child-centred approaches, and the right to participate and accountability.

Childrens FGDs questionnaire and results

	Questions	1		2		3		4		5		6		
	Emoji	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	Girls	Boys	**FGD Questions:**
1		14	8	18	10	17	14	1	0	2	0	0	1	1. Was the information you received about Ebola make you feel safer coming to school?
2		2	5	4	7	5	8	5	5	2	2	2	6	2. Did your school have at all times running water, soap and thermometer?
3		0	1	2	4	3	0	4	6	3	3	10	5	3. Did someone come to your school to speak to you about your worries and stress?
4		5	3	2	1	2	0	6	5	9	10	7	3	4. Did you at any time stop attending school because of the fear of Ebola?
5		6	5	1	0	0	0	10	7	11	7	8	7	5. Did you feel safe at all times at home during the Ebola outbreak?
														6. Did you and your family at all times have enough food during the Ebola outbreak?
	Total	**27**	**22**	**27**	**22**	**27**	**22**	**26**	**23**	**27**	**22**	**27**	**22**	

ANNEX 9: COMMUNITY RAPID ASSESSMENT (CRA) QUESTIONNAIRE

Reflection on use of CRA as data collection tool for evaluations

The experience of using mobile phone technology to conduct a CRA as one of this evaluation's data collection tools was mixed. In terms of VfM and quality/ quantity of data collected, when compared to traditional qualitative data collection methods, the evaluation team found the cost of the CRA to be quite high especially when considering the amount (minimal for the cost) and quality (macro, not granular) of data collected.

The purpose of the CRA was to collect rich, population-based data that would help examine behaviors and drivers in order to assess relevance and effectiveness and to better prepare UNICEF to address future Ebola outbreaks. The CRA did provide rich insight into the wider Ebola preparedness and prevention campaign to which UNICEF was a key contributor. The options of conducting a digital survey via Random Digital Dialling (RDD) or via a 1-6-1 Database survey, where a robochat is conducted via Interactive Voice Response (IVR) with randomly selected individuals located in specific set of districts (RDD), or with those who have previously opted in to participate in future digital surveys (1-6-1 Database Survey), similarly located in specific districts, did not enable the evaluation team to target individuals at the sub-district level or with UNICEF-specific knowledge. Rather, the CRA allowed for an evaluation of aspects of UNICEF's interventions only via transitive inference. An example includes for example: If the GoU-led interventions brought about the desired change in Ugandan's knowledge, attitudes, and practices vis-à-vis Ebola, and as UNICEF was a key contributor to the GoU's response, then the successes (and failures) of the GoU's interventions can be (partially) attributed to UNICEF.

An additional challenge included the low occurrence of Ebola in the population, meaning, it can be challenging to gather a large enough sample to draw meaningful conclusion which as well comes with increased costs. The survey therefor focussed primarily on assessing the effectiveness of the activities conducted at the population-level of affected districts, such as RCCE implementation. A sampling bias was mobile phone ownership and this might be influenced by socioeconomic factors. Those who can afford mobile phones and data plans might have different characteristics from those who cannot, and this potentially led to sampling bias and potential misrepresentation of the population.

Still the CRA provided some statistically significant and rich insights on knowledge, attitudes, and perceptions of Ebola in the population. The evaluation team felt like results were overall generalisable as this data reflected mostly the findings from other data collection methods like FGDs and KIIs.

CRA questionnaire

	Introduction Hello! This call is for a quick survey for adults—18-year-olds and older—to assess how effective UNICEF's response and preparedness work during the recent Ebola outbreak in Uganda was. If you are not 18 years or older, please hang up now. The data collected from you will solely be used for the purposes of improving essential services that have been delivered to you in the past year. All of your answers will be kept confidential and there will be no way to identify you. Your participation in the survey is free and voluntary (you can drop off at any

	moment). All the pre-paid mobile users that complete answering all questions in the survey will receive an incentive of 2,500 shillings as mobile top-up. This call will take about 15 minutes of your time.	
	Can you please input your age using the numbers on your keypad?	1-99. (For any responses of 17 and lower, the call will be disconnected.)
1	What is your gender/ sex	1. Male 2. Female 3. Other
2	Which district do you live in? If you do not live in one of these 9 districts, this survey is not for you, please hang up now.	1. Mubende 2. Kassanda 3. Kyegegwa 4. Bunyangabu 5. Kagadi 6. Kampala 7. Wakiso 8. Masaka 9. Jinja
3	What best describes your education level?	1. Primary school only 2. Secondary school 3. Attended university or beyond
4	Do you live in a town or city, or do you live in the countryside?	1. Countryside/ rural 2. Town or city
Awareness and risk perception		
5	Have you heard of Ebola?	1. Yes 2. No
6	Has there been Ebola in your district?	1. Yes 2. No 3. I don't know
7	Did you receive information about Ebola in the last year?	1. Yes 2. No
Knowledge on Ebola causes		
8	Which of the following messages is correct to your opinion?	1. Ebola is caused by politicians. 2. Ebola is caused by foreigners. 3. Ebola is caused by a virus. 4. Ebola is caused by God
Knowledge on Ebola transmission		
9	Which of the following messages is correct to your opinion?	1. You can get Ebola when touching an infected person. 2. You can get Ebola from drinking contaminated water. 3. You can get Ebola from mosquito bites. 4. You can get Ebola from the air
Knowledge on Ebola signs		
10	Which symptoms do you get when you have Ebola	1. Fever 2. Vomiting (with or without blood) 3. Diarrhoea (with or without blood) 4. Severe headache

		5. Abdominal pain 6. Weakness 7. All of the above
Behaviour change/ health seeking behaviour during Ebola		
11	Which of the following messages is not correct to your opinion?	1. During Ebola you should wash your hands with water and soap more than usual 2. During Ebola you should avoid attending burials or gatherings 3. During Ebola you should avoid shaking hands with other people 4. During Ebola you should wear masks
12	Which of the following messages is not correct to your opinion?	1. Health facility will take care of sick person. 2. Health facility will definitely cure sick person from Ebola. 3. Health facility won't be able to do anything for sick person. 4. Health facility will find way to kill sick person.
13	Which of the following messages is not correct to your opinion?	1. When someone has Ebola signs, they should go the clinic as soon as possible. 2. When someone has Ebola signs, they should be taken care of at home avoiding all contact and isolate them. 3. When someone has Ebola signs, they should be taken care of by the community's traditional healer
Knowledge, attitudes, and perceptions linked to UNICEF's Ebola's response pillars/sectors		
14	The Ebola health messages helped me in understanding Ebola better	1. I strongly agree. 2. I somewhat agree. 3. I don't have an opinion. 4. I somewhat disagree. 5. I strongly disagree
15	The Ebola health messages in school helped my children understand Ebola better	1. I strongly agree. 2. I somewhat agree. 3. I don't have an opinion. 4. I somewhat disagree. 5. I strongly disagree
16	During Ebola, I know where I can report complaints, so my voice and opinion are heard	1. I strongly agree. 2. I somewhat agree. 3. I don't have an opinion. 4. I somewhat disagree. 5. I strongly disagree
17	I know where women/girls that feel unsafe or are violated can go to get support	1. I strongly agree. 2. I somewhat agree. 3. I don't have an opinion. 4. I somewhat disagree. 5. I strongly disagree

18	I know where people with mental health issues can get support	1. I strongly agree. 2. I somewhat agree. 3. I don't have an opinion. 4. I somewhat disagree. 5. I strongly disagree
19	I know where people with disabilities can get support	1. I strongly agree 2. I somewhat agree 3. I don't have an opinion 4. I somewhat disagree 5. I strongly disagree
20	I have been informed about my rights and protections as a member of this community	1. I strongly agree 2. I somewhat agree 3. I don't have an opinion 4. I somewhat disagree 5. I strongly disagree

CRA survey results

[UG]-HERA-UNICEF Survey Summary Report

Viamo has been contracted by Hera / Socorro Global, an evaluation partner of UNICEF on their work towards the Ebola outbreak in the region. Viamo was to carry out a digital survey.

The survey, delivered via a random digit dial, was to assess how effective the response to the recent Ebola outbreak in Uganda was. It intended to obtain insights into the perceptions and knowledge of community members around the recent Ebola outbreak in Mubende, Kasanda, Kagadi, Kampala, Wakiso, Masaka, and Jinja.

The 19-question survey was made available in 3 languages; Luganda, English and Rutooro targeting 500 complete responses (522 were obtained).

Implementation process

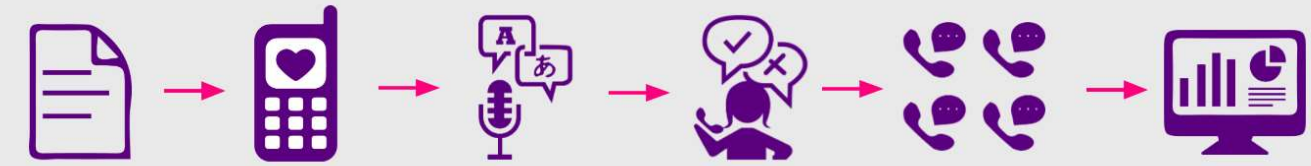
Content development
HERA drafted the script, which was reviewed and optimised for mobile phone delivery by Viamo.

Content review, approval, and deployment
- Content was reviewed and approved by HERA before translation into Luganda and Rutooro. The approved translations were then professionally recorded before uploading to the platform.
- Upon successful quality control and internal testing, the content was deployed on the 15th of June, 2023.

Project Data
- Survey raw data were exported from the Viamo cloud, cleaned and delivered to HERA.
- A live dashboard was developed for monitoring and progress. An overview is shown below.

Link to the CRA Dashboard
Link to the CRA raw data

Implementation



Hera & Viamo developed 19 survey questions.

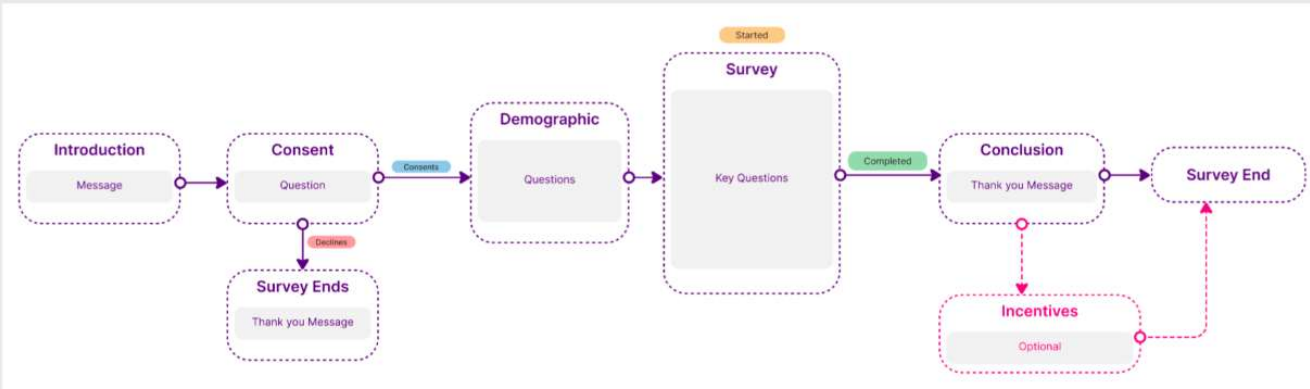
Viamo optimized questions for mobile phones

Viamo translated and recorded into Luganda and Rutooro

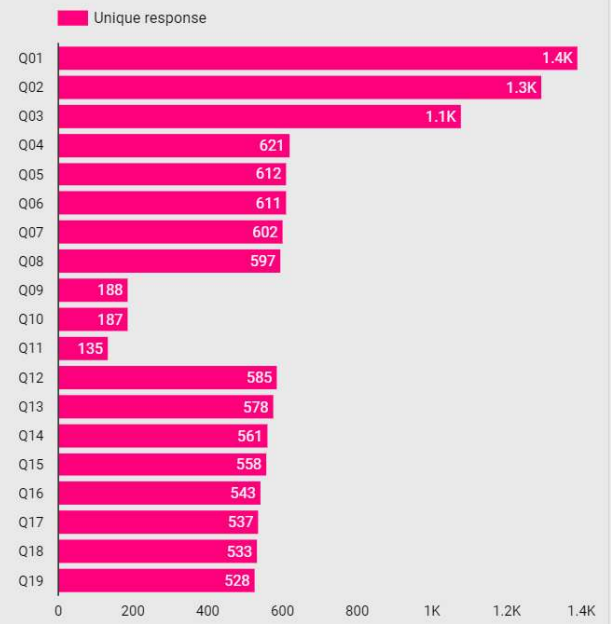
The project went live in June 2023

Dashboard developed for access to real-time data

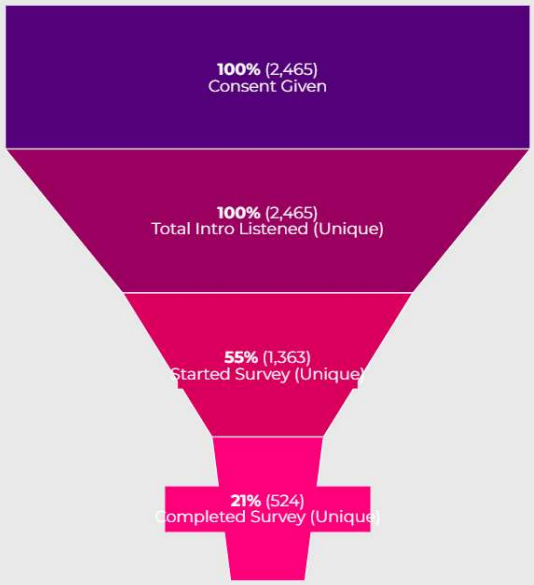
Survey Flow



Question Response

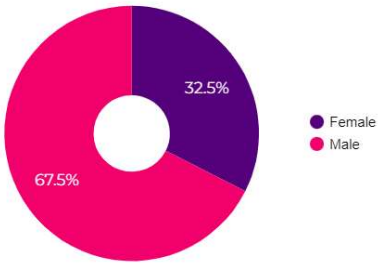


Call Funnel

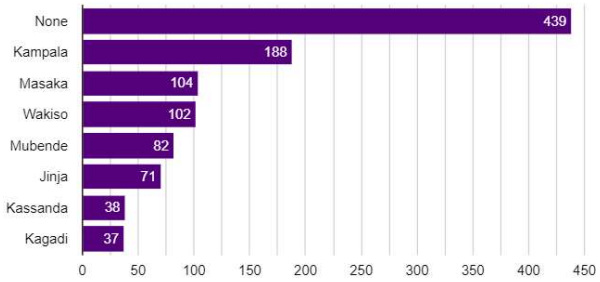


Respondent Demographics

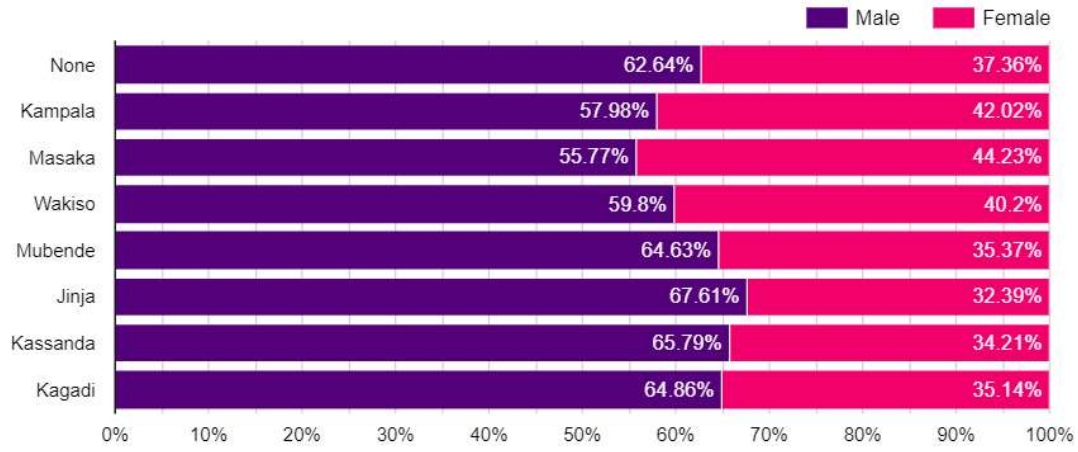
Gender

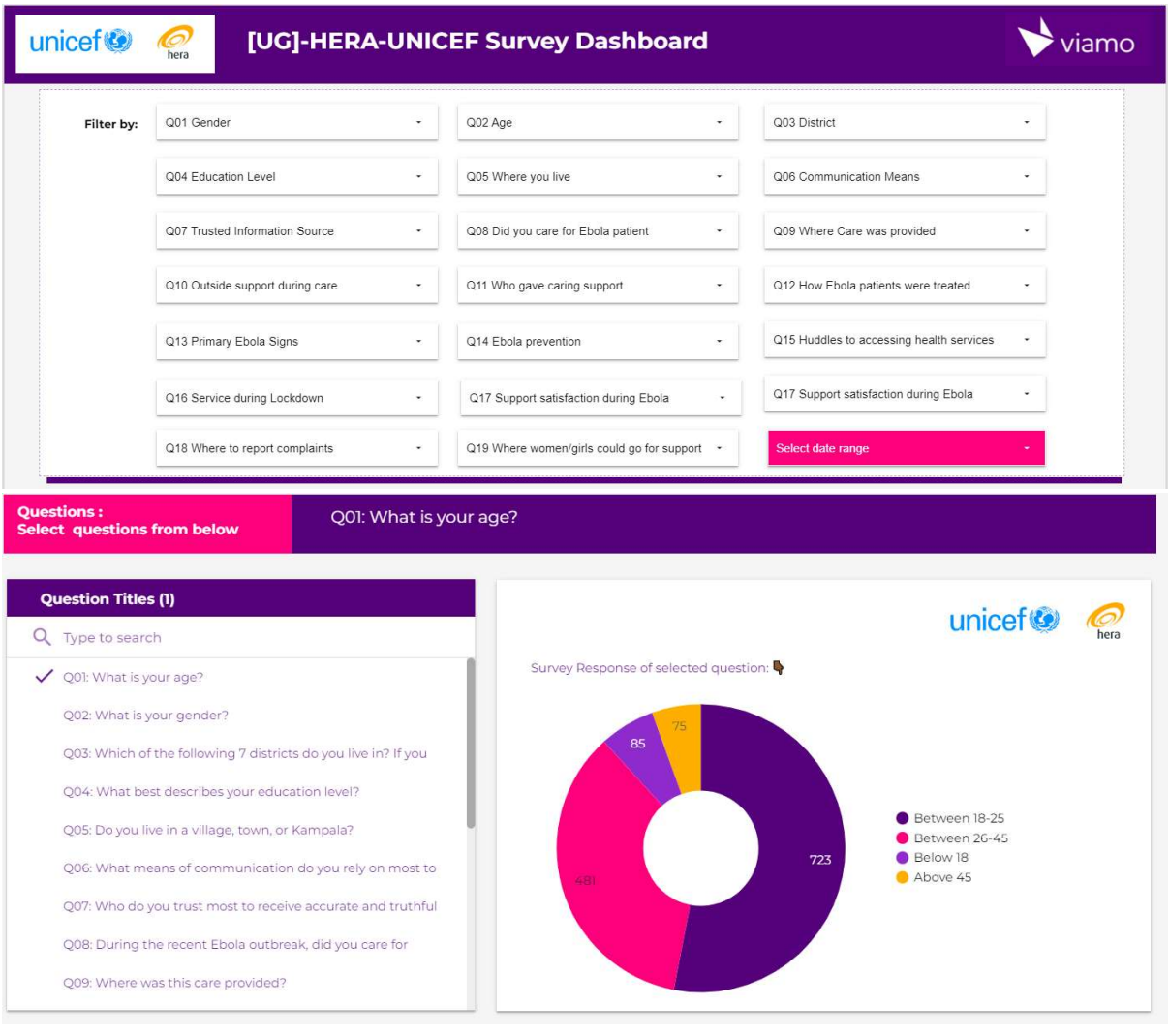


District



Respondents per district and gender





Questions :
Select questions from below

Q02: What is your gender?

Question Titles (1)

Type to search

- Q01: What is your age?
- ✓ Q02: What is your gender?
- Q03: Which of the following 7 districts do you live in? If you
- Q04: What best describes your education level?
- Q05: Do you live in a village, town, or Kampala?
- Q06: What means of communication do you rely on most to
- Q07: Who do you trust most to receive accurate and truthful
- Q08: During the recent Ebola outbreak, did you care for
- Q09: Where was this care provided?

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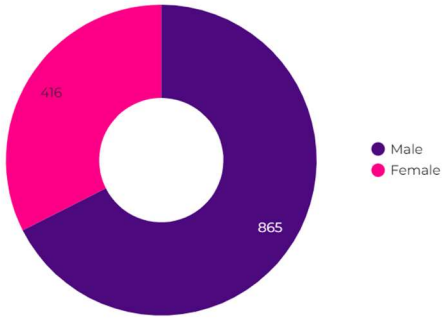
Survey Response of selected question:



Questions :
Select questions from below

Q03: Which of the following 7 districts do you live in? If you have multiple residents, choose the primary residence.

Question Titles (1)

Type to search

- Q01: What is your age?
- Q02: What is your gender?
- ✓ Q03: Which of the following 7 districts do you live in? If you
- Q04: What best describes your education level?
- Q05: Do you live in a village, town, or Kampala?
- Q06: What means of communication do you rely on most to
- Q07: Who do you trust most to receive accurate and truthful
- Q08: During the recent Ebola outbreak, did you care for
- Q09: Where was this care provided?

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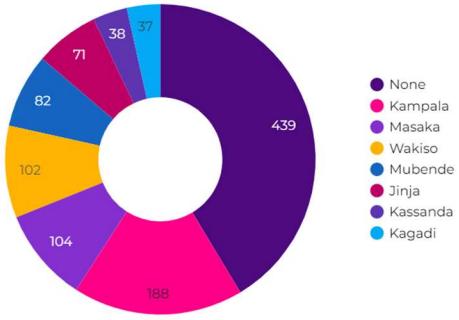
Survey Response of selected question:



Questions :
Select questions from below

Q04: What best describes your education level?

Question Titles (1)

Type to search

- Q01: What is your age?
- Q02: What is your gender?
- Q03: Which of the following 7 districts do you live in? If you
- ✓ Q04: What best describes your education level?
- Q05: Do you live in a village, town, or Kampala?
- Q06: What means of communication do you rely on most to
- Q07: Who do you trust most to receive accurate and truthful
- Q08: During the recent Ebola outbreak, did you care for
- Q09: Where was this care provided?

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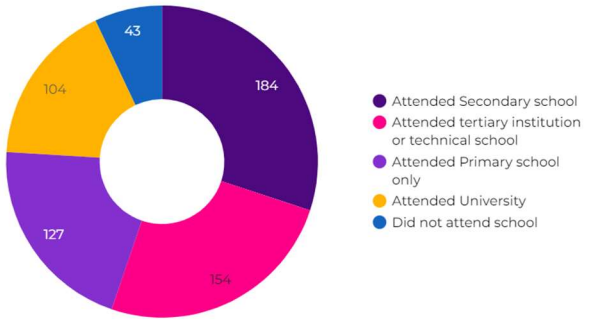
Survey Response of selected question:



Questions :
Select questions from below

Q05: Do you live in a village, town, or Kampala?

Question Titles (1)

Type to search

- Q01: What is your age?
- Q02: What is your gender?
- Q03: Which of the following 7 districts do you live in? If you
- Q04: What best describes your education level?
- ✓ Q05: Do you live in a village, town, or Kampala?
- Q06: What means of communication do you rely on most to
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- Q09: Where was this care provided?

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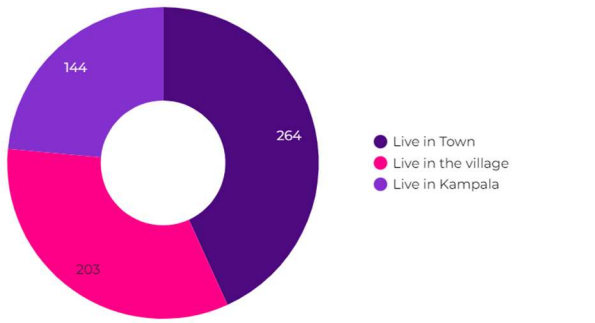
Survey Response of selected question:



Questions :
Select questions from below

Q06: What means of communication do you rely on most to receive information you can trust?

Question Titles (1)

Type to search

- Q01: What is your age?
- Q02: What is your gender?
- Q03: Which of the following 7 districts do you live in? If you
- Q04: What best describes your education level?
- Q05: Do you live in a village, town, or Kampala?
- ✓ Q06: What means of communication do you rely on most to
- Q07: Who do you trust most to receive accurate and truthful
- Q08: During the recent Ebola outbreak, did you care for
- Q09: Where was this care provided?

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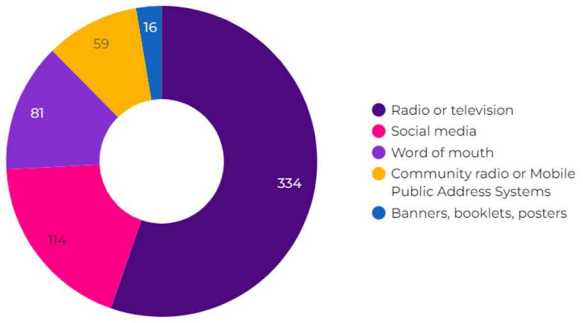
Survey Response of selected question:



Questions :
Select questions from below

Q07: Who do you trust most to receive accurate and truthful information?

Question Titles (1)

Type to search

- Q01: What is your age?
- Q02: What is your gender?
- Q03: Which of the following 7 districts do you live in? If you
- Q04: What best describes your education level?
- Q05: Do you live in a village, town, or Kampala?
- Q06: What means of communication do you rely on most to
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- Q08: During the recent Ebola outbreak, did you care for
- Q09: Where was this care provided?

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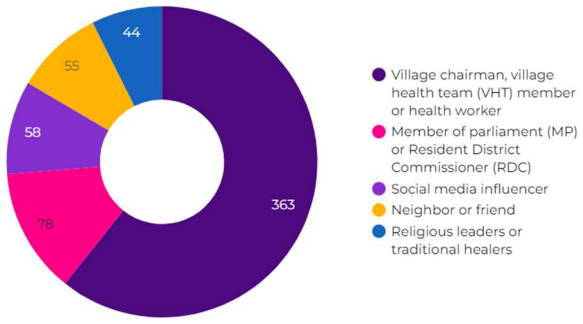
Survey Response of selected question:



Questions :
Select questions from below

Q08: During the recent Ebola outbreak, did you care for someone who had Ebola or was suspected of having Ebola?

Question Titles (1)

Type to search

- Q01: What is your age?
- Q02: What is your gender?
- Q03: Which of the following 7 districts do you live in? If you
- Q04: What best describes your education level?
- Q05: Do you live in a village, town, or Kampala?
- Q06: What means of communication do you rely on most to
- Q07: Who do you trust most to receive accurate and truthful
- ✓ Q08: During the recent Ebola outbreak, did you care for
- Q09: Where was this care provided?

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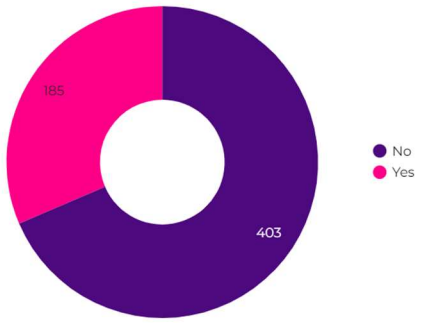
Survey Response of selected question:



Questions :
Select questions from below

Q09: Where was this care provided?

Question Titles (1)

Type to search

- Q05: Do you live in a village, town, or Kampala?
- Q06: What means of communication do you rely on most to
- Q07: Who do you trust most to receive accurate and truthful
- Q08: During the recent Ebola outbreak, did you care for
- ✓ Q09: Where was this care provided?
- Q10: While this person was being cared for, did they receive
- Q11: Who did they receive caring support from?
- Q12: In your experience, what best describes how people
- Q13: What is the primary sign and symptom of Ebola?

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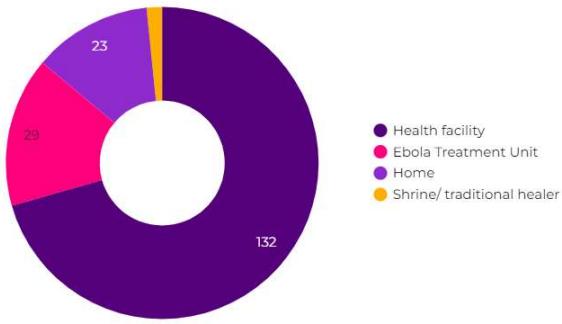
Survey Response of selected question:



Questions :
Select questions from below

Q10: While this person was being cared for, did they receive any outside support?

Question Titles (1)

Type to search

Q05: Do you live in a village, town, or Kampala?
Q06: What means of communication do you rely on most to
Q07: Who do you trust most to receive accurate and truthful
Q08: During the recent Ebola outbreak, did you care for
Q09: Where was this care provided?
✓ Q10: While this person was being cared for, did they receive
Q11: Who did they receive caring support from?
Q12: In your experience, what best describes how people
Q13: What is the primary sign and symptom of Ebola?

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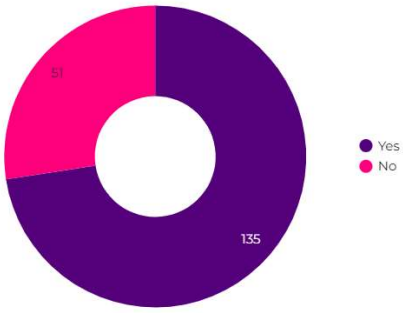
Survey Response of selected question:



Questions :
Select questions from below

Q11: Who did they receive caring support from?

Question Titles (1)

Type to search

Q05: Do you live in a village, town, or Kampala?
Q06: What means of communication do you rely on most to
Q07: Who do you trust most to receive accurate and truthful
Q08: During the recent Ebola outbreak, did you care for
Q09: Where was this care provided?
Q10: While this person was being cared for, did they receive
✓ Q11: Who did they receive caring support from?
Q12: In your experience, what best describes how people
Q13: What is the primary sign and symptom of Ebola?

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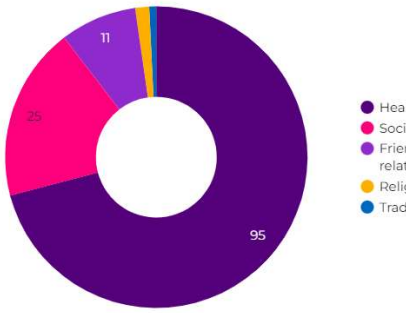
Survey Response of selected question:



Questions :
Select questions from below

Q12: In your experience, what best describes how people who were infected by Ebola or are related to someone suspected of having Ebola were treated?

Question Titles (1)

Type to search

Q06: What means of communication do you rely on most to
Q07: Who do you trust most to receive accurate and truthful
Q08: During the recent Ebola outbreak, did you care for
Q09: Where was this care provided?
Q10: While this person was being cared for, did they receive
Q11: Who did they receive caring support from?
✓ Q12: In your experience, what best describes how people
Q13: What is the primary sign and symptom of Ebola?
Q14: What would you do to prevent getting Ebola?

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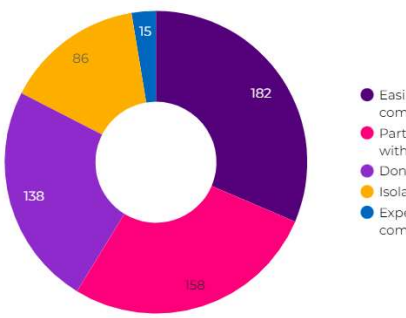
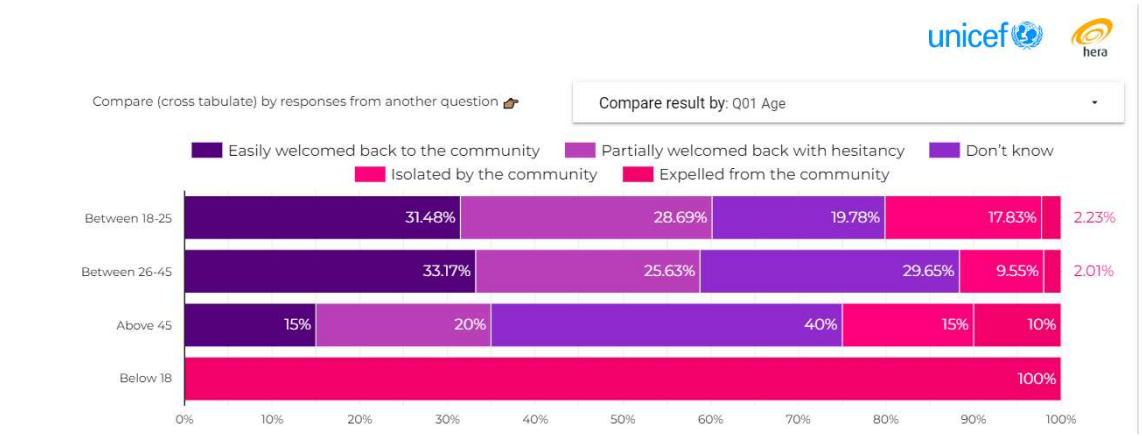
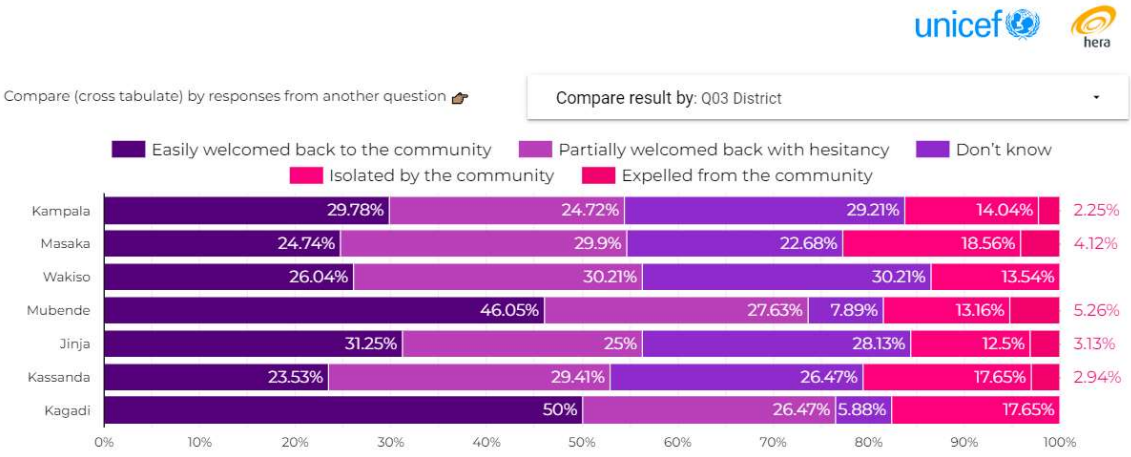
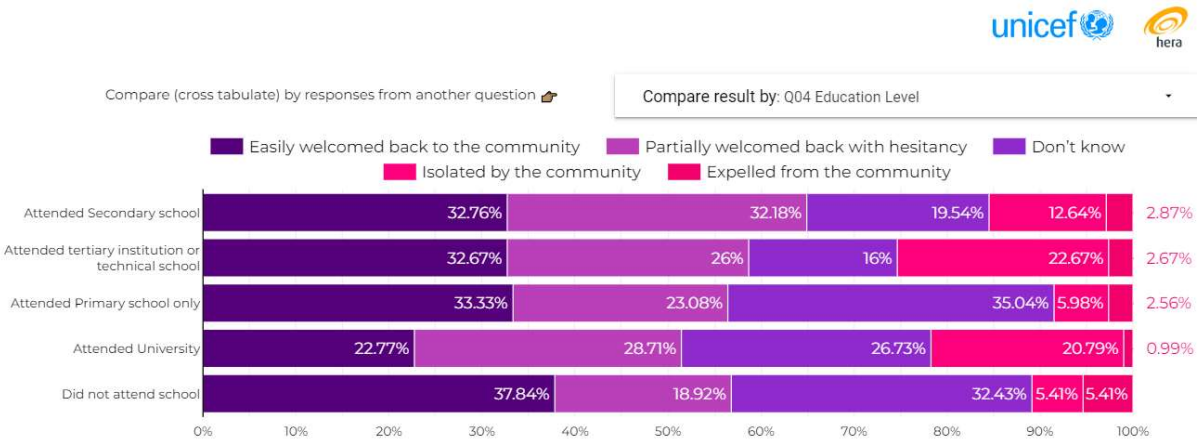
Survey Response of selected question:




Compare (cross tabulate) by responses from another question
Compare result by: Q01 Age
Easily welcomed back to the community
Partially welcomed back with hesitancy
Don't know
Isolated by the community
Expelled from the community
Between 18-25
31.48%
28.69%
19.78%
17.83%
2.23%
Between 26-45
33.17%
25.63%
29.65%
9.55%
2.01%
Above 45
15%
20%
40%
15%
10%
Below 18
100%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


Compare (cross tabulate) by responses from another question
Compare result by: Q03 District
Easily welcomed back to the community
Partially welcomed back with hesitancy
Don't know
Isolated by the community
Expelled from the community
Kampala
29.78%
24.72%
29.21%
14.04%
2.25%
Masaka
24.74%
29.9%
22.68%
18.56%
4.12%
Wakiso
26.04%
30.21%
30.21%
13.54%
Mubende
46.05%
27.63%
7.89%
13.16%
5.26%
Jinja
31.25%
25%
28.13%
12.5%
3.13%
Kassanda
23.53%
29.41%
26.47%
17.65%
2.94%
Kagadi
50%
26.47%
5.88%
17.65%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%


Compare (cross tabulate) by responses from another question
Compare result by: Q04 Education Level
Easily welcomed back to the community
Partially welcomed back with hesitancy
Don't know
Isolated by the community
Expelled from the community
Attended Secondary school
32.76%
32.18%
19.54%
12.64%
2.87%
Attended tertiary institution or technical school
32.67%
26%
16%
22.67%
2.67%
Attended Primary school only
33.33%
23.08%
35.04%
5.98%
2.56%
Attended University
22.77%
28.71%
26.73%
20.79%
0.99%
Did not attend school
37.84%
18.92%
32.43%
5.41%
5.41%
0%
10%
20%
30%
40%
50%
60%
70%
80%
90%
100%

Questions :
Select questions from below

Q13: What is the primary sign and symptom of Ebola?

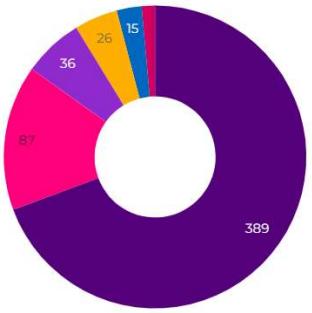
Question Titles (1)

Type to search

- Q08: During the recent Ebola outbreak, did you care for
- Q09: Where was this care provided?
- Q10: While this person was being cared for, did they receive
- Q11: Who did they receive caring support from?
- Q12: In your experience, what best describes how people
- ✓ Q13: What is the primary sign and symptom of Ebola?
- Q14: What would you do to prevent getting Ebola?
- Q15: What would prevent you or your family members from
- Q16: In case of a lockdown, what services would you think

unicef hera

Survey Response of selected question:



- High temperature, aches and pains, diarrhea and vomiting
- Cough
- Headaches
- Loss of eyesight/ Losing teeth/ tooth ache
- Deep cut or wounds that won't heal
- Swelling in feet or hands

Questions :
Select questions from below

Q14: What would you do to prevent getting Ebola?

Question Titles (1)

Type to search

- Q08: During the recent Ebola outbreak, did you care for
- Q09: Where was this care provided?
- Q10: While this person was being cared for, did they receive
- Q11: Who did they receive caring support from?
- Q12: In your experience, what best describes how people
- Q13: What is the primary sign and symptom of Ebola?
- ✓ Q14: What would you do to prevent getting Ebola?
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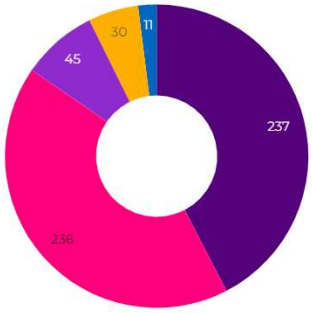
unicef hera

Survey Response of selected question:



- Washing hands, practicing social distancing, wearing a face mask
- Avoiding contact with an infected person or dead body
- Gettting vaccinated
- Avoiding eating bush meat
- Visiting a traditional healer or use herbal medicine or go for prayers

Questions :
Select questions from below

Q15: What would prevent you or your family members from accessing health services during the next Public Health Emergency?

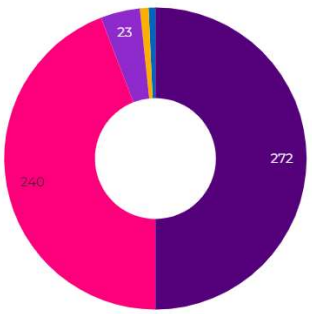
Question Titles (1)

Type to search

- Q08: During the recent Ebola outbreak, did you care for
- Q09: Where was this care provided?
- Q10: While this person was being cared for, did they receive
- Q11: Who did they receive caring support from?
- Q12: In your experience, what best describes how people
- Q13: What is the primary sign and symptom of Ebola?
- Q14: What would you do to prevent getting Ebola?
- ✓ Q15: What would prevent you or your family members from
- Q16: In case of a lockdown, what services would you think

unicef hera

Survey Response of selected question:



- No money for transport or treatment
- Health facility is not properly equipped, lack of trust in health service providers and/ or fear of becoming infected at a health facility
- Fear of Being stigmatized by my community
- Husband or wife or in-laws
- Seek treatment from traditional healer

Questions :
Select questions from below

Q16: In case of a lockdown, what services would you think the government and development partners need to provide for you and your family during the travel movement restrictions?

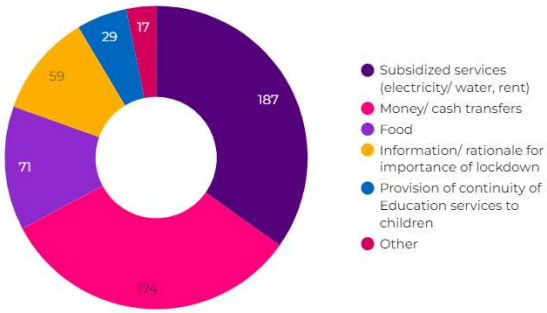
Question Titles (1)

Type to search

- Q10: While this person was being cared for, did they receive
- Q11: Who did they receive caring support from?
- Q12: In your experience, what best describes how people
- Q13: What is the primary sign and symptom of Ebola?
- Q14: What would you do to prevent getting Ebola?
- Q15: What would prevent you or your family members from
- ✓ Q16: In case of a lockdown, what services would you think
- Q17: From your perspective, to what extent were you
- Q18: If you had complaints about the agencies or

unicef hera

Survey Response of selected question:



Questions :
Select questions from below

Q17: From your perspective, to what extent were you satisfied with the support you received as part of the response to the recent Ebola outbreak?

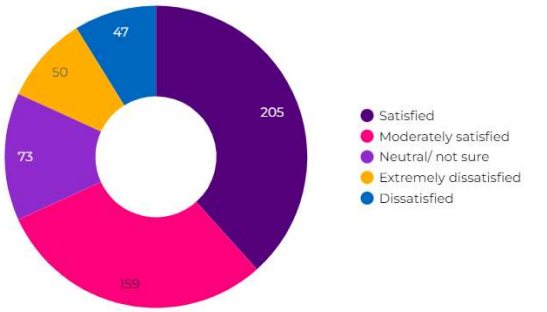
Question Titles (1)

Type to search

- Q10: While this person was being cared for, did they receive
- Q11: Who did they receive caring support from?
- Q12: In your experience, what best describes how people
- Q13: What is the primary sign and symptom of Ebola?
- Q14: What would you do to prevent getting Ebola?
- Q15: What would prevent you or your family members from
- Q16: In case of a lockdown, what services would you think
- ✓ Q17: From your perspective, to what extent were you
- Q18: If you had complaints about the agencies or

unicef hera

Survey Response of selected question:



Questions :
Select questions from below

Q18: If you had complaints about the agencies or organizations who conducted the Ebola response, did you know where you can report complaints so your voice and opinion are heard?

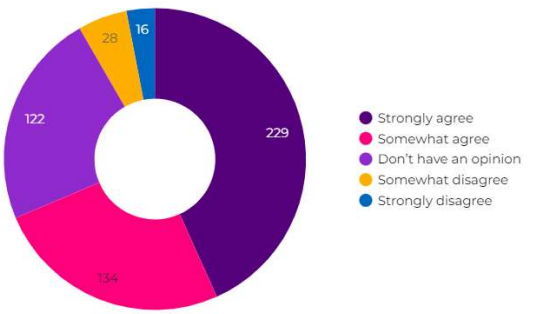
Question Titles (1)

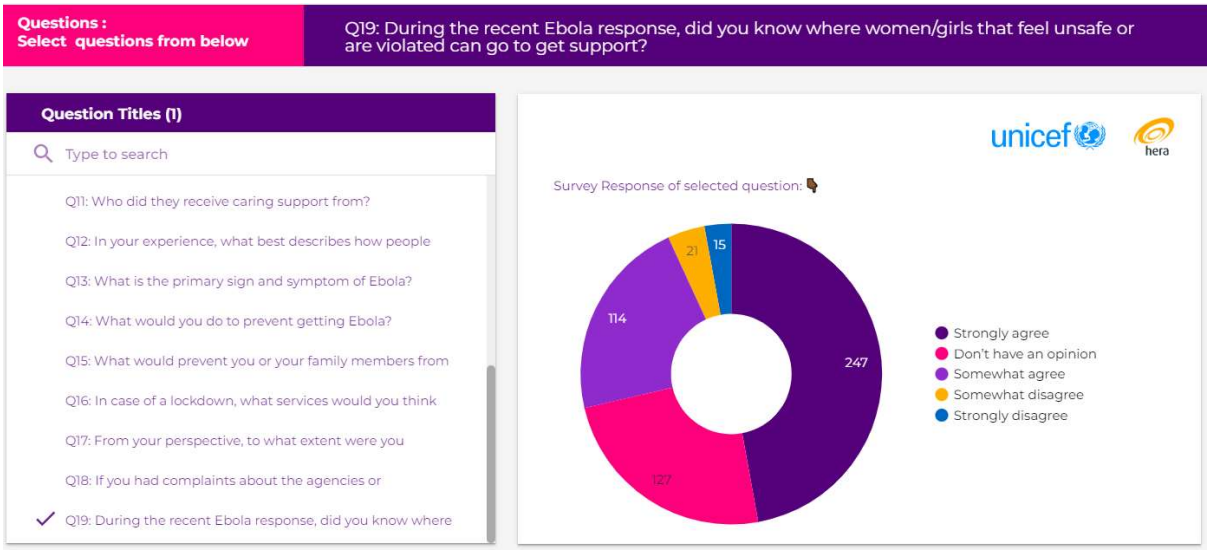
Type to search

- Q10: While this person was being cared for, did they receive
- Q11: Who did they receive caring support from?
- Q12: In your experience, what best describes how people
- Q13: What is the primary sign and symptom of Ebola?
- Q14: What would you do to prevent getting Ebola?
- Q15: What would prevent you or your family members from
- Q16: In case of a lockdown, what services would you think
- Q17: From your perspective, to what extent were you
- ✓ Q18: If you had complaints about the agencies or

unicef hera

Survey Response of selected question:




Questions :
Select questions from below
Q19: During the recent Ebola response, did you know where women/girls that feel unsafe or are violated can go to get support?
Question Titles (1)
Type to search
Q11: Who did they receive caring support from?
Q12: In your experience, what best describes how people
Q13: What is the primary sign and symptom of Ebola?
Q14: What would you do to prevent getting Ebola?
Q15: What would prevent you or your family members from
Q16: In case of a lockdown, what services would you think
Q17: From your perspective, to what extent were you
Q18: If you had complaints about the agencies or
Q19: During the recent Ebola response, did you know where
unicef
hera
Survey Response of selected question:
247
127
114
21
15
Strongly agree
Don't have an opinion
Somewhat agree
Somewhat disagree
Strongly disagree

ANNEX 10: ETHICAL APPROVAL

ST. MARY'S HOSPITAL LACOR
P.O. BOX 180, GULU-UGANDA
Tel: +256-471-432310, Fax: +256 – 471-432665
Email: info@lacorhospital.org, Website: www.lacorhospital.org

RESEARCH ETHICS COMMITTEE

19/05/2023

To: Ezra Anyala

Hera
0751481971

Type: Initial Review

Re: LACOR-2023-183: LEARNING FOCUSED EVALUATION OF THE UNICEF UGANDA PREPAREDNESS AND RESPONSE TO THE L2 EBOLA EMERGENCY

I am pleased to inform you that at the **LHIREC-002/05/2023** convened meeting on **19/05/2023**, the Lacor Hospital Institutional REC, committee meeting voted to approve the above referenced application.
Approval of the research is for the period of **19/05/2023** to **19/05/2024.**

As Principal Investigator of the research, you are responsible for fulfilling the following requirements of approval:

1. All co-investigators must be kept informed of the status of the research.
2. Changes, amendments, and addenda to the protocol or the consent form must be submitted to the REC for re-review and approval **prior** to the activation of the changes.
3. Reports of unanticipated problems involving risks to participants or any new information which could change the risk benefit: ratio must be submitted to the REC.
4. Only approved consent forms are to be used in the enrollment of participants. All consent forms signed by participants and/or witnesses should be retained on file. The REC may conduct audits of all study records, and consent documentation may be part of such audits.
5. Continuing review application must be submitted to the REC **eight weeks** prior to the expiration date of **19/05/2024** in order to continue the study beyond the approved period. Failure to submit a continuing review application in a timely fashion may result in suspension or termination of the study.
6. The REC application number assigned to the research should be cited in any correspondence with the REC of record.
7. You are required to register the research protocol with the Uganda National Council for Science and Technology (UNCST) for final clearance to undertake the study in Uganda.

The following is the list of all documents approved in this application by Lacor Hospital Institutional REC:

No.	Document Title	Language	Version Number	Version Date
1	Protocol	English	1	2023-05-12
2	Data collection tools	Lunyoro-Runyakitara	1	2023-05-12
3	Data collection tools	Luganda	1	2023-05-12
4	Data collection tools	English	1	2023-05-12

Yours Sincerely

Dr. Martin David Ogwang
For: Lacor Hospital Institutional REC

ANNEX 11: UNICEF ACTIVITY IMPLEMENTATION

On 20 September, the Government of Uganda declared an outbreak of Ebola Virus Disease (EVD) following a confirmation of a case in Mubende District. UNICEF's EVD response plan was aligned with the Government's response plan and included the following response areas:

Response area 1: Coordination, leadership, and partnerships
Response area 2: Risk communication, social mobilization, community engagement
Response area 3: Surveillance and contact tracing community
Response area 4: Water, Sanitation, and Hygiene Promotion (WASH)
Response area 5: Case Management
Response area 6: Prevent and address the indirect impact of the outbreak
Response area 7: Logistics and Operational Support

By 11 January, after 113-days, the outbreak was declared over with a cumulative 142 confirmed cases and 55 deaths in nine affected districts (Mubende, Kassanda, Kyegegwa, Bunyangabu, Kagadi, Masaka, Kampala, Wakiso and Jinja). UNICEF's support to the EVD response was substantial and all interventions are listed below.

Response area 1: Coordination, leadership, and partnerships

Internal coordination

- Establishment of four hubs in high-risk areas (Mubende (covering Kassanda), Kampala, Jinja and Masaka)
- Bi-weekly EMT and regular TET meetings chaired by the Representative including all staff involved in the response.
- Visit by the Regional Director to inform the RO on the situation
- Daily reports from the field.
- Daily updates of the dashboard and information from the Ministry of Health.

External coordination

- High level member in the Strategic management committee (SMC).
- Pivotal technical role in the National and sub-national taskforce (NTF) including coordination, harmonization, and collaboration among implementing partners.
- Participated and provided technical support to the Incident management team (IMT) including pillar and sub-pillar committees.
- Participated and provided technical support to the district task force (DTF) by technical leads in the field.
- Co-Chair of the Risk communication pillar together with the Ministry of Health, Commissioner health services health promotion, education, and communication department
- Member of the Community engagement pillar
- Member of the Water sanitation and hygiene pillar
- Member of the Infection prevention and control sub-pillar
- Member of the Surveillance pillar
- Member of the Clinical sub-pillar
- Member of the Mental health psychosocial support (MHPSS) sub-pillar
- Member of/and provided leadership in the coordination of nutrition response in the National taskforce (NTF)

- Co-chair the Continuity of essential health services sub-pillar with the Ministry of Health
- Member of the SIRI Pillar
- Observer in the Scientific advisory committee
- Member of the Logistics sub-committee
- Supported District task force and District disaster management committees (DDMC) on preparedness and response.
- Provided input to the partners 4Ws matrix.
- Raised resources based on the Ministry of Health "National Ebola virus disease plan".
- Provided technical support from GOARN to support the establishment of an IOA cell.
- Provided space for the IOA cell on behalf of the Ministry of Health at IDI.
- Provided rapid integrated analyses to the Ministry of Health to better understand outbreak dynamics and their impact on communities.

Response area 2: Risk communication, social mobilization, community engagement

Mass media messaging

- 5,9 million people reached with accurate, cultural, and gender-appropriate messaging on EVD prevention, early treatment and access to services, through mass-media messaging support to 29 radio stations and 8 TV stations.
- Social media monitoring to provide feedback to the risk communication and other pillars for action. U-Report was used to share key EVD information through polls and live conversations through the Ebola chatbot.
- UNICEF has printed information education communication materials29 for a value of US$235,918 and distributed them to all affected districts and those at high risk for risk communication.

Mobilization of key influencers

- Oriented and engaged with 56,649 key influencers30 on Ebola prevention, resulted in 1,036,547 people participated in community dialogue meetings, which were conducted to raise awareness on EVD prevention and control.

Community engagement

- 1,130 village health teams and local council member trained on risk communication and safe and dignified burials. 1,044 megaphones were distributed to affected districts to enable mobilization and communication at mass gatherings.
- UNICEF, in partnership with Ministry of Health, oriented 510 traditional healers from 9 affected districts on Ebola, aimed at promoting awareness on the early referral of their clients with Ebola-like symptoms to health facilities.
- 1,558,094 people of different age groups and profiles shared their concerns and asked questions through established feedback mechanisms through community meetings (off-line) and social listening, media monitoring, the Ministry of Health Call Center and U-Report (online).
- Supported development of a comic book targeting children and adolescents.
- 5 staff deployed in Kassanda, Kampala, Wakiso, Jinja, and Masaka to oversee implementation of community engagement activities.

[29] posters, leaflets, banners, job aides, brochures, fact sheets, question & answer booklets

[30] teachers, local leaders, traditional leaders, religious leaders, local council leaders, traditional healers, uniformed/security personnel, boda-boda cyclists

- Supported the deployment of 5 Ministry of Health staff who worked in collaboration with the districts to establish taskforces, resulting in over 3,415 village taskforces were activated, 80 parish taskforces, 4 municipal and 10 division taskforces activated.
- 5 full-time vehicles were hired to support community engagement activities in five districts with deployed staff.
- 6,500 businesses reached with EVD risk communication materials.

Systems strengthening

- 10 Social behavior change officers were recruited and deployed to provide technical support to districts to support coordination of risk communication and community engagement interventions in the district, including 10 hired and deployed vehicles to support the implementation.
- 625,570 people have been reached through engagement actions (community dialogues) conducted to raise awareness on EVD prevention and control.
- Supporting the ongoing anthropological study under risk communication and community engagement.

Vaccinations

- No vaccine was available during the response.

Media training at national and regional levels

- 21 Kampala-based editors and 337 journalists nationwide oriented on accurate, responsible, and ethical reporting to curb fake news and misinformation.

Response area 3: Surveillance and contact tracing

- 15 vehicles deployed to strengthen alerts management, active case search for EVD and support data collection.
- 1 technical officer deployed to support Ministry of Health and WHO with the Go data application31 for data collection as provided from Headquarters through Global outbreak alert and response network (GOARN).
- Procured infection prevention and control water, sanitation, and hygiene supplies (IPC/WASH) for village health teams 32 for a value of US$ 230,000 to support community surveillance for EVD suspected cases.
- Provided 10 computer tablets to the Ministry of Health to support data collection.

Response area 4: Water, Sanitation, and Hygiene Promotion (WASH)

Support for infection prevention and control in Ebola affected communities

- Supported payment of allowances to burial teams and selected Government staff in line with the level of payments to various categories of staff/responders.
- 16 vehicles were provided to the trained EVD burial teams for safe and dignified burial and control of further transmission of Ebola in Kassanda (6) and Mubende (10) Districts.
- 4,176 health care staff, including village health teams, supported with capacity building on infection prevention and control.

[31] An outbreak investigation tool for field data collection during public health emergencies including for case investigation, contact follow-up, visualization of chains of transmission and secure data exchange.

[32] including gumboots, hand sanitizers, reusable aprons, village health team referral books, heavy duty gloves and face shields

- All health facilities and schools in Mubende and Kassanda assessed in terms of water, sanitation, and hygiene services.
- Financial assistance given to Ministry of Health - Environmental health department to train health workers on infection prevention and control through water, sanitation and hygiene standards and water, sanitation, and hygiene facility improvement tool (FIT) approach to improve infection prevention and control in institutions.
- 50 directly affected households and 24 health facilities supported with critical infection prevention and control/water, sanitation, and hygiene supplies in Kassanda district through the ring approach.
- 57 affected and at-risk districts supported with infection prevention and control/water sanitation and hygiene, risk communication, and nutrition supplies worth US$757,461.

Provision of essential WASH supplies and equipment

- Upgraded the water supply systems using solar motorization in five health facilities in Kiyuni, Butologo health centre III and St. Joseph Madudu health centre III in Mubende District, Kalwana Ebola treatment unit in Kassanda District and Jinja regional referral hospital and Maga health centre III in Jinja District.
- Supported Mubende Ebola treatment unit with tanks to provide 70,000 litres of water storage. One 10,000 litre tank was connected to the National Water grid to provide a water supply to the Ebola treatment unit located within Mubende regional referral hospital.
- Provided financial assistant to Ministry of Health to conduct WASH assessments. In total, 372 health facilities, both government and private and over 200 schools with focus on Mubende and Kassanda Districts were assessed.
- Supported the safe re-opening of schools through distribution of critical WASH supplies to 330 schools and 336 health facilities and promoted infection prevention and control among health care workers.
- 40 health facilities and 38 schools in Mubende District were provided with WASH supplies.
- 24 health facilities and 50 households affected by EVD were supported with hygiene items and disinfectants in Kassanda District.
- Provided financial assistance to train health workers and teachers to adhere to infection prevention and control standards. In total 1,466 health workers benefited, and 254 teachers were trained in EVD affected districts.
- 38 non-functional handwashing facilities in Mubende District with focus on public places and high-risk areas33 were rehabilitated.
- Supported Mubende regional referral hospital with the repair/rehabilitation of the electric incinerator for proper waste management.

[33] including commercial buildings, public transport stations and markets

Response area 5: Case management

1. Nutrition

Building the capacity of the district, health facility, and community manager and service providers in IYCF and nutrition in the context of Ebola

- 863 health workers (including frontline and managers) trained on nutrition and infant and young child feeding.
- 64,901 primary caregivers counselled and educated on appropriate “infant and young child feeding”. Specifically, 75 mothers who had stopped breastfeeding due to Ebola viral disease were supported to re-lactate through continuous infant and young child feeding counselling and support by health workers and psychosocial team.
- Supported the development, printing, and dissemination of 1,490,333 standard operating procedures (SOPs) and guidelines on nutrition in response to EVD to the nine EVD affected districts.

Support access and availability of essential nutrition supplies and commodities for EVD response

- 15,312 packages of ready-to-use-infant-formula (RUIF) was procured and pre-positioned. A total of 79 infants affected by Ebola were supported with RUIF in the affected districts. Additional 57,825 packages are in the pipeline.
- 165,945 children 6-59 months received nutrition assessment using mid-upper arm circumference method (MUAC) in districts affected by Ebola as part of continuity of essential nutrition services.
- 1,491 children identified with acute malnutrition received appropriate care and management according to the national integrated management of acute malnutrition (IMAM) protocol.

2. MHPSS and child protection

Support MHPSS services for EVD-affected individuals and families, including children in ETUs and communities and survivors

- Advocated and worked closely with community-based services departments, including the probation and social welfare and community development officers in all affected districts to ensure the inclusion of protection considerations in all aspects of the EVD response.
- 492 psychologists/psychiatrists, health workers and community structures (village health teams/para social workers) were trained and deployed to Ebola treatment and isolation units and communities to provide mental health and psychosocial support to ensure adequate MHPSS services. As a result, 16,359 children and 4,671 caregivers received mental health and psychosocial support.
- 3,807 individuals reached with sensitization on child protection and mental health and psychosocial support issues to prevent violence against children by risk communication and community engagement interventions.

Support protection services, including interim care and foster care for EVD-affected children

- 129 child survivors of violence were reached with critical child protection case management services. In addition, 15 children temporarily separated from caregivers and families benefitted from alternative care services, including placement in foster families.

- A child-friendly Ebola treatment unit guidance document was developed and provided practical guidance to health workers in Ebola treatment units on ensuring the protection of children.
- 111 Play kits for children of different age groups was provided to isolation sites and Ebola treatment units and administered by mental health and psychosocial support teams in close collaboration with district community service department.
- 102 people responding to EVD from district local government, civil society organizations (CSOs), cultural and religious leaders have been trained on how to report allegations on sexual exploitation and abuse.
- 5,263 children and adults had access to a sexual exploitation and abuse reporting channel.
- 594 women, girls and boys received gender-based violence risk mitigation, prevention, or response interventions.
- Provided critical child protection case management services, including alternative care.
- Provided community-based psychosocial support.
- Raised awareness and sensitization on child protection risks in EVD contexts.
- Training and orientation of health and social welfare structures on protection of children in EVD contexts.
- Inclusion of protection from sexual exploitation and abuse (PSEA) and gender-based violence (GBV) risk mitigation measures in public health emergencies (PHEs), including allocating dedicated resources.
- Care services for survivors of gender-based violence as well as for women and children at risk.
- Ensured safe and accessible facilities and services for women and children.
- Provision and/or establishment of safe and accessible sex-segregated facilities.
- Integrating messages on protection risks, services for survivors, for women and children at risk, and how to access the available services.

Response area 6: Prevent and address the indirect impact of the outbreak

Support the safe continuity of essential health services to women, children, and vulnerable communities

- Provided financial and technical support for the development of a guideline for management of pregnancy, labor, and delivery with EVD.
- Provision of 17 high performance tents to Mubende, Kassanda, Hoima Regional Referral Hospital, Kampala region, Mukono District (Goma health centre IV and general hospital) and Mulago Referral hospital, including water system and infection prevention and control support to avoid decongestion and to maintain primary health care including integrated community case management (malaria, pneumonia, and diarrhea) and nutrition.
- Provided protective gloves for infection prevention and control/personal protective equipment supplies to ensure continuity of essential health services for Masaka regional referral hospital.
- Supported the Malaria Consortium with reaching 181,985 people with mass-drug administration for malaria.
- 9.7 million children (95 per cent coverage) reached with Polio R2 nOPV vaccine.

Support to households directly affected by EVD including survivors and chronically poor households to meet their basic needs

- Integrated study conducted to understand the dynamics between an EVD outbreak and

response on sexual, reproductive, maternal and child health service access.34
- Integrated study to understand health care workers knowledge, behavior and practices was conducted in Kampala.35
- Extending support to Makerere university to lead a study on the socioeconomic impact assessment of EVD together with the Office of the Prime Minister.

Continuity of Learning

- Supported Ministry of Health's school health team and Ministry of Education and Sports to develop and disseminate EVD standard operating procedures, job aides, guidelines for safe operation of schools, safe release of learners from districts with restrictions.
- 3,345 infra-red thermometers provided to schools to strengthen school level screening.
- Conducted training of trainers for 213 teachers on school-based management and response to EVD and related health epidemics in five districts.
- 2,170 teachers and non-teaching staff were oriented on EVD prevention, early treatment seeking and notification.
- Over 12,468 primary leaving examinations candidates within Mubende, and Kassanda Districts were provided with home learning materials for learners in home isolation.
- 5,185 learners were transported into and out of Mubende and Kassanda Districts.
- Facilitated 30 primary leaving examinations candidates in home isolation in Rubaga Division to sit for their examinations.
- Supported 140 learners in home isolation with learning materials and facilitated their reintegration back to school.
- 283 schools in high-risk sub-counties/ring received training on EVD prevention in school.
- 3,226 schools in 7 very high-risk districts were supplied with copies of Standard Operating Procedures and Guidelines for EVD prevention in schools
- 191 schools in high-risk sub-counties were supported with at least one supervisory visit from the Ministry of Education and Sports/District Education Offices.
- An assortment of learning materials and relevant textbooks were distributed to two EVD affected schools in Rubaga division, Kampala including psychosocial support for teachers and learners.

Response area 7: Logistics and Operational Support

- Contributed to the central coordination of quantification of supply needs, identification of gaps and allocation of orders to different warehouses and partners.
- 1 logistics officer was deployed to Mubende District to provide support to the Mubende and Kassanda Districts stores, including strengthening the stock management, monitoring, reporting, as well as information flow between the response pillars, the logistics team, and the district taskforce.
- Provided infrastructure for the emergency treatment units in Kassanda, Mubende and Mulago in partnership with MSF36, focusing on tents for isolation and necessary water, sanitation, and hygiene infrastructure.

[34] Presented to the Continuity of Essential Health Services pillar for action
[35] Presented to the IPC/WASH pillar for action
[36] Médecins Sans Frontiers

ANNEX 12: UNICEF RESULTS MONITORING

Indicator disaggregation by SVD pillars Case management- Infection Prevention and Control (IPC/WASH)	2022 target	2023 results as of 24 February (Last Ebola dedicated sitrep)	Results reported post Ebola period (March to date)
# of health care staff trained on infection prevention and control/ WASH in areas affected and at high risk of SVD (disaggregated by facility and community, includes VHTs)	1,406	4,233	0
# of health facilities reached with essential WASH supplies in SVD-affected and high-risk areas (including 700 health facilities, three regional referral hospitals & 20 ETUs)	350	212	303
# of health facilities/ETUs in SVD affected areas reached with upgraded WASH services (water supply & sanitation facilities)	10	8	6
# of schools in areas affected and at high risk of SVD reached with essential WASH supplies (including chlorine, soap, handwashing facilities, WASH information, education and communication materials)	350	183	306
Case management – MHPSS			
# of psychologists, psychiatrists, health workers, and community structures trained and deployed to SVD treatment and isolation units and communities to provide MHPSS	1,156	570	237
Case management- Nutrition			
# of packs of Ready-to-Use Infant Formula provided to ETUs (to cover 120 children)	73,125	28,218	0
# of health workers trained on IYCF and nutrition in SVD in affected districts	800	845	87
Case management – Health			
# of ETUs supported by UNICEF	5	5	0
Continuity of Essential services – MHPSS/Child Protection			
# of unaccompanied and separated children due to SVD (in isolation, ETUs and community) provided with alternative care and/or reunified	625	40	39
# of children, adolescents, and caregivers in affected districts accessing community-based mental health and psychosocial support.	15,000	32,457	22,963
# of girls, women and boys who have experienced violence in SVD-affected communities reached by health, social work, or justice/law enforcement services	1,875	258	19
Continuity of Essential services – Health			
# of health facilities supported with tents for decongestion and community services, including immunization	6	6	0
# of health facilities provided with targeted supplies (medical and personal protective equipment)	120	1	4
Continuity of Essential services – Education			
# of schools/learning institutions provided with infrared thermometers and accessories for screening	12,600	3,345	8,491
# of schools in high-risk sub-counties with functioning school Ebola task force	750	283	89
# of schools supported with at least one supervisory visit from Ministry of Education and Sports/ District Education Officer	375	191	120
# of teachers and non-teaching staff oriented on SVD prevention, early treatment seeking and notification	13,200	3,029	3,408
Continuity of essential services – Social Protection			
# of socioeconomic SVD impact monitoring reports produced	2	0	1
# SVD affected households reached with cash transfers	5,000	0	0

Risk communication and social mobilization/ Community Engagement			
# of people reached through accurate, cultural, and gender-appropriate messaging on SVD prevention, early treatment and access to services	6,528,690	6,215,797	7,170
# of key influencers (teachers, local leaders, traditional leaders, religious leaders, local council leaders) engaged on SVD prevention	65,287	61,585	2,698
# of people who participate in engagement actions (community dialogues) conducted to raise awareness for SVD prevention and control	1,958,607	1,292,547	1,627
# of people sharing their concerns and asking questions through established feedback mechanisms (online and offline)	2,611,476	1,876,971	2,027
Coordination and Leadership			
% of districts with UNICEF supported pillars with plans	100%	100%	0%
GBV/PSEA			
# Children and adults who have access to a UNICEF-supported SEA reporting channel	12,645	23,714	33,327
# Women, girls and boys accessing GBV risk mitigation, prevention, or response interventions	8,430	929	1,848
Additional Indicators Post EVD			
# RRHs supported for IPC strengthening (Moroto, Soroti, Mbale, Jinja, Mubende, Masaka, Hoima and Arua) # Emergency operation centres -EoC supported for establishment # IPC emergency health staff for surge			8 2 2

ANNEX 13: UNICEF SUPPORT PER DISTRICT PER PILLAR

Preparedness and Response										
Pillar	**National Level**	**Kassanda**	**Mubende**	**Kyegegwa**	**Bunyan-gabu**	**Kagadi**	**Kampala**	**Masa-ka**	**Jinja**	**Wakiso**
Coordination, Leadership, and partnership										
Res District Commissioner		X	X	X	X	X		X		
Chief admin officer		X	X	X	X	X		X		
UN RCO	**The RC:** Ms. Susan Namondo									
WHO	**The Representative:** Dr Innocent Komakech, Dr Solome Okware									
MoH	**Commander:** Dr Henry Kyobe **Emergency Operation Centre Manager:** Dr Issa Makumbi **Commissioner Surveillance**: Dr Allan Muluta									
Infection Prevention and Control / WASH										
Infection Prevention and Control / WASH		Supplies/Construction/ Capacity Building			Supplies	Supplies	Supplies		Supplies/Construction/ Capacity Building	
Assistant DH Officer Environmental Health		X	X		X	X	X			
Water Officer		X	X							
District Education Officer		X	X		X	X	X			
Case Management - Child Protection & MHPSS										

Preparedness and Response										
Pillar	**National Level**	**Kassanda**	**Mubende**	**Kyegegwa**	**Bunyan-gabu**	**Kagadi**	**Kampala**	**Masa-ka**	**Jinja**	**Wakiso**
District Comm develop officer		X	X	X	No CP/MHPSS Interventions	No CP/MHPSS Interventions				
District probation officer CP		X	X	X						
Staff at the Mental Health Unit/Psychiatric Ward - RRH		X	X							
Survivor Deployed to ETU: Mubende		X								
Butabika Hospital										
Case Management- GBViE and PSEA										
District Health Educator		X	X	X	X	X				
DCDO		X	X	X	X	X				
District Probation Officer		X	X	X	X	X				
Case Management - Nutrition										
Mubende RRH - Senior Nutritionist			X							
Mubende RRH - Nutritionist			X							
Kaweri ETU Nutritionist (Consultant) - Kassanda		X								
DHO - Kassanda		X								
Continuity of Essential Services - Health										
Assistant District Health Officer		X	X	X	X	X				

Preparedness and Response										
Pillar	**National Level**	**Kassanda**	**Mubende**	**Kyegegwa**	**Bunyan-gabu**	**Kagadi**	**Kampala**	**Masa-ka**	**Jinja**	**Wakiso**
DHO - Maternal Health										
ADHO - Environmental Health		X	X	X	X	X				
Assistant Commissioner Health Services	Dr Stavia T									
Continuity of Essential Services - Education										
District Education Officer		X	X	X	X	X	X			
District Inspector of School		X	X	X	X	X	X			
District Health Educator		X	X	X	X	X	X			
Continuity of Essential Services - Social Protection										
Risk Communication, Social Mobilization and Community Engagement (RCSM-CE)										
District Health Educator		X	X	X	X	X				
District Inspector of School		X	X	X	X	X				
Senior Education Officer		X	X	X	X	X				
District Information/ Communication Officer		X	X	X	X	X				
District Community Development Office		X	X	X	X	X				
Communication and Advocacy										

Preparedness and Response										
Pillar	**National Level**	**Kassanda**	**Mubende**	**Kyegegwa**	**Bunyan-gabu**	**Kagadi**	**Kampala**	**Masa-ka**	**Jinja**	**Wakiso**
Logistics, Operational Support, and Supplies										
Assistant Inventory Management Officer			X							
Logistics Pillar lead		X								
Technical Assistance and cross-sectoral expertise (Human Resources)										
Coordination, Leadership, and partnership										
Res District Commissioner		X	X	X	X	X		X		
Chief admin officer		X	X	X	X	X		X		
UN RCO	**The RC:** Ms. Susan Namondo									
WHO	**The Representative:** Dr Innocent Komakech, Dr Solome Okware									
MoH	**Commander:** Dr Henry Kyobe **Emergency Operation Centre Manager:** Dr Issa Makumbi **Commissioner Surveillance**: Dr Allan Muluta									

Preparedness and Response										
Pillar	**National Level**	**Kassanda**	**Mubende**	**Kyegegwa**	**Bunyan-gabu**	**Kagadi**	**Kampala**	**Masa-ka**	**Jinja**	**Wakiso**
Infection Prevention and Control / WASH		Supplies/Construction/ Capacity Building			Supplies	Supplies	Supplies		Supplies/Construction/ Capacity Building	
Assistant DH Officer Environmental Health		X	X		X	X	X			
Water Officer		X	X							
District Education Officer		X	X		X	X	X			
Case Management - Child Protection & MHPSS										
District Communication development officer		X	X	X	No CP/ MHPSS Interven-tions	No CP/ MHPSS Interven-tions				
District probation officer CP		X	X	X						
Staff at the Mental Health Unit/Psychiatric Ward - RRH		X	X							
Supervisor Deployed to ETU - Mubende		X								
Butabika Hospital										
Case Management- GBViE and PSEA										
District Health Educator		X	X	X	X	X				
DCDO		X	X	X	X	X				
District Probation Officer		X	X	X	X	X				

Preparedness and Response										
Pillar	**National Level**	**Kassanda**	**Mubende**	**Kyegegwa**	**Bunyan-gabu**	**Kagadi**	**Kampala**	**Masa-ka**	**Jinja**	**Wakiso**
Case Management - Nutrition										
Mubende RRH - Senior Nutritionist			X							
Mubende RRH - Nutritionist			X							
Kaweri ETU Nutritionist (Consultant) - Kassanda		X								
DHO - Kassanda		X								
Continuity of Essential Services - Health										
Ass District Health OffcierDHO - Maternal Health		X	X	X	X	X				
ADHO - Environmental Health		X	X	X	X	X				
Assistant Commissioner Health Services	(Dr Stavia T)									
Continuity of Essential Services - Education										
District Education Officer		X	X	X	X	X	X			
District Inspector of School		X	X	X	X	X	X			
District Health Educator		X	X	X	X	X	X			
Continuity of Essential Services - Social Protection										
Risk Communication, Social Mobilization and Community Engagement (RCSM-CE)										
District Health Educator		X	X	X	X	X				

Preparedness and Response										
Pillar	**National Level**	**Kassanda**	**Mubende**	**Kyegegwa**	**Bunyan-gabu**	**Kagadi**	**Kampala**	**Masa-ka**	**Jinja**	**Wakiso**
District Inspector of School		X	X	X	X	X				
Senior Education Officer		X	X	X	X	X				
District Information/ Communication Officer		X	X	X	X	X				
District Community Development Office		X	X	X	X	X				
Communication and Advocacy										
Logistics, Operational Support, and Supplies										
Assistant Inventory Management Officer			X							
Logistics Pillar lead		X								
Technical Assistance and cross-sectoral expertise (Human Resources)										

ANNEX 14: UNICEF L2 BENCHMARK INDICATORS

UGANDA EVD L2 Benchmarks Indicators/ Oct 2022 - March 2023, L2 Response Scale up

Benchmarks	Outputs	Indicators	Calculation method	Baseline	Target	Source	Frequency	Responsible	Status (as of March 2023)	Comments/ Remarks
Benchmark 1: Strengthened human resources capaciity	Internal staff mobilization plan and surge plan for Ebola developed and regularly updated in line with proposed Ebola work, and surge capacity for preparedness on the ground	% of surge requests by response pillar filled up	**Numerator:** Number of actual L2 key positions filled **Denominator:** Total number of planned L2 key positions requested	0	90%	STS system	Monthly	Chief HR / Dep. Rep. Operations/ Dep Rep Programmes	79%	Out of 71 staff & Surge needs identified, 78.9% have been filled. 47 completed assignments. 9 are ongoing, 15 were cancelled.
		Proportion of surge deployed to the hubs	**Denominator:** Total needs **Enumerator**: Total deployments	0	90%	Deployment Tracker	Weekly	Chief FoE/HR Manager	94%	68 staff were deployed to the field, including 56 internal staff and 12 staff on mission
Benchmark 2: Response systems in place	WASH IPC guidance developed, and package defined (staff, supplies, training, and mentoring), and approach	% of staff trained and mentored in WASH IPC	**Numerator:** Number of staff trained/mentored in WASH/IPC **Denominator:** Total number of planned staff to be trained/mentored in WASH/IPC	0	5000	WASH and Health reports ; EMT updates	Monthly	Chief CSD; WASH Manager; Health Manager	85%	Four (4) health workers from each health facilities in the hot sport areas identified and trained on IPC WASH standards,

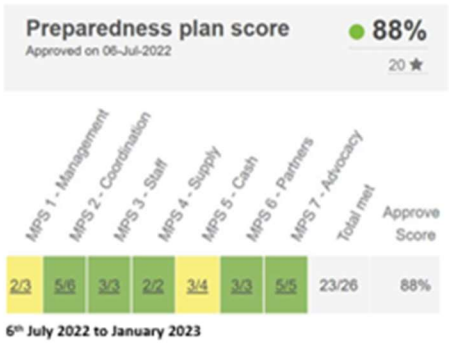
Benchmarks	Outputs	Indicators	Calculation method	Baseline	Target	Source	Frequency	Responsible	Status (as of March 2023)	Comments/ Remarks
	clearly identified									
	Nutrition guidance for Ebola included into national guidelines, and Ebola SOPs, accepted by national coordination mechanisms, and disseminated in prioritized areas.	# of health workers trained on IYCF and nutrition in Ebola-affected districts	**Numerator:** Number of health workers trained **Denominator:** Total number of health workers targeted for training	0	800	Nutrition reports; Sitreps; EMT Updates	Monthly	Chief CSD; Nutrition Manager	106%	
	Partners mapping conducted and included the identification of existing, standby, and potential PCAs for Ebola preparedness and response	% of partners engaged with Ebola preparedness and response actions	**Numerator:** Number of partners engaged for Ebola response(though PCAs, PDs and HPDs) **Denominator:** Total number of potential partners with Ebola experience	0%	100%	WASH, Health, child protection assessment reports	Monthly	Chief, CSD, Chief, Child Protection	75%	Mapping exercise results: 8 partners identified with 6/8 Partners (75%) engaged in the partnerships to respond to Ebola. IPs include Save the Children, AVSI, Malaria Consortium, Uganda Red Cross Society, Lutheran World

Benchmarks	Outputs	Indicators	Calculation method	Baseline	Target	Source	Frequency	Responsible	Status (as of March 2023)	Comments/ Remarks
										Federation and World Vision Uganda. CUAMM and FH were not engaged. No partners were identified for standby PDs
	PSEA and GBV in Public Health Emergencies guidance and training materials adapted to local context	% of staff and partners trained in PSEA	**Numerator:** Number of staff and partners trained in PSEA **Denominator:** Total number of staff and partners targeted for PSEA trainings	0	1,050	Partner and UNICEF direct implement ation reports	Monthly	PSEA Focal Point (with child protection support as needed)	77%	808 (491f,317m)-77% UNICEF staff and partners including DLG officials, CSOs, cultural, religious leaders and volunteers have so far been trained on PSEA in the EVD response.
		% of staff and partners trained in GBV	**Numerator:** Number of staff and partners trained in GBV **Denominator:** Total number of staff and partners targeted for GBV trainings	0	700	Partner and UNICEF direct implement ation reports	Monthly	PSEA Focal Point (with child protection support as needed)	99%	695 (400f,295m)-99% partners including CSOs, DLG official's, teachers and volunteers have been trained on GBV risk mitigation in the EVD response.

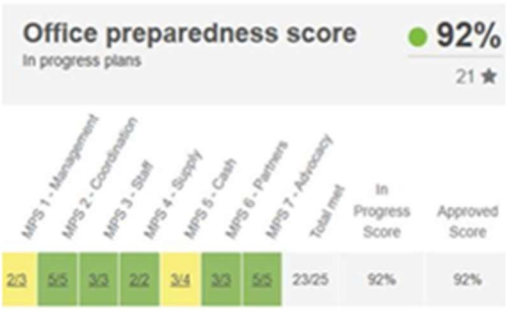
Benchmarks	Outputs	Indicators	Calculation method	Baseline	Target	Source	Frequency	Responsible	Status (as of March 2023)	Comments/ Remarks
	Risk communication and community engagement	# of people reached through accurate, cultural, and gender-appropriate messaging on Ebola prevention, early treatment and access to services	**Numerator:** Number of people reached **Denominator:** Total number of targeted people (6,528,690)	0%	100%	SBC reports	Monthly	Chief SBC	95%	Over 5,375,294 people (82%) of the target population in the 9 affected populations were reached with messages on EVD through mass media, new (social) media, and interpersonal communication .
Benchmark 3: Supply strengthened to meet the operational needs	Supply plan linked to programme requirements developed and propositioned to ensure robust response	% of essential supplies delivered in priority areas	**Numerator:** Quantity of essential supplies pre-positioned in priority areas **Denominator:** Total quantity of essential supplies planned to pre-positioned in priority areas	0%	100%	Supply reports	Monthly	Supply Manager	100%	All intended supplies for the emergency were delivered.
Benchmark 4: Coordination	UNICEF accountability in coordination is well defined and implemented, and UNICEF-related sectors have well-	% of UNICEF-supported districts with functional UNICEF-supported pillars (IPC/WASH, RCCE and MHPSS; functionality will include meetings	**Numerator:** Number of functional UNICEF-supported pillars **Denominator:** Total number of UNICEF Supported Pillars	0	100%	4Ws; Minutes of Pillar meetings, EMT updates	Monthly	Chiefs of CSD, child protection, WASH Manager, Health Manager,	100%	

Benchmarks	Outputs	Indicators	Calculation method	Baseline	Target	Source	Frequency	Responsible	Status (as of March 2023)	Comments/ Remarks
	functioning structures in place	at least twice a week with follow up action points and updated 4Ws)								
Benchmark 5: Risk Management and business continuity	BCP Contingency Plan updated to reflect Ebola risk	Completeness (%) of BCP contingency plan including Ebola risk	**Numerator**: Number of key components of BCP put in contingency plan **Denominator**: Total number of key components of BCP	0%	100%	EMT minutes	Monthly	Dep. Rep. Operations	100%	BCP updated with a component of disease including EVD
Benchmark 6: Resource Mobilization	At least 50% of funding needs for preparedness have been secured	% of preparedness and response funds secured	**Numerator:** Quantity of mobilized ORE funds by CO against 6 months L2 response plan. **Denominator**: Total quantity of existent ORE funds by CO against 6 months L2 response plan.	0%	100%	VISION system	Monthly	Chief, PME/ Dep. Rep. Programmes	45%	Gap was 55% as of March 2023

ANNEX 15: UNICEF'S MINIMUM PREPAREDNESS ACTION



6th July 2022 to January 2023

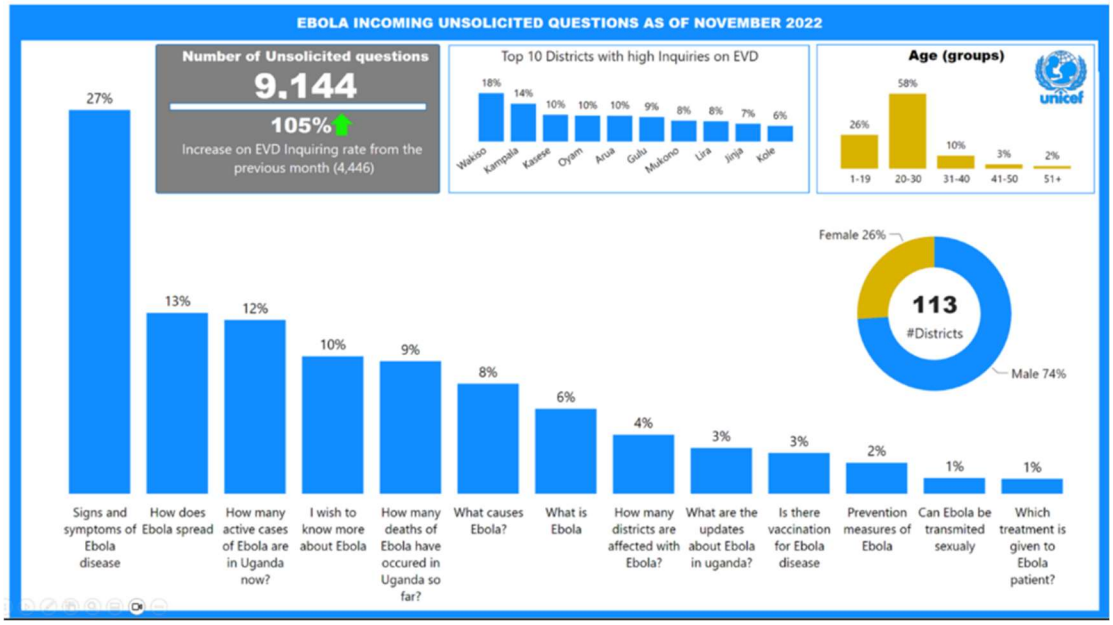


July 2023 Approved plan

ANNEX 16: IOA OPERATIONAL RESEARCH CONDUCTED

- Death burden in Kassanda and Malaria, 2022.
- Healthcare Worker Survey, 2022.
- Social economic impact of Ebola on household welfare outcomes: A case of two districts Kassanda and Mubende, 2022.
- Impact of Ebola and Utilization of Sexual, Reproductive, Maternal and Child Healthcare (SRMCH) services in the affected districts, Uganda, 2022.
- Understanding barriers and enablers to treatment seeking among persons affected by Ebola Virus Disease, Uganda, 2022.
- Understanding Ebola related healthcare facility risks through perceptions and practice among healthcare workers: Kampala, December 2022.

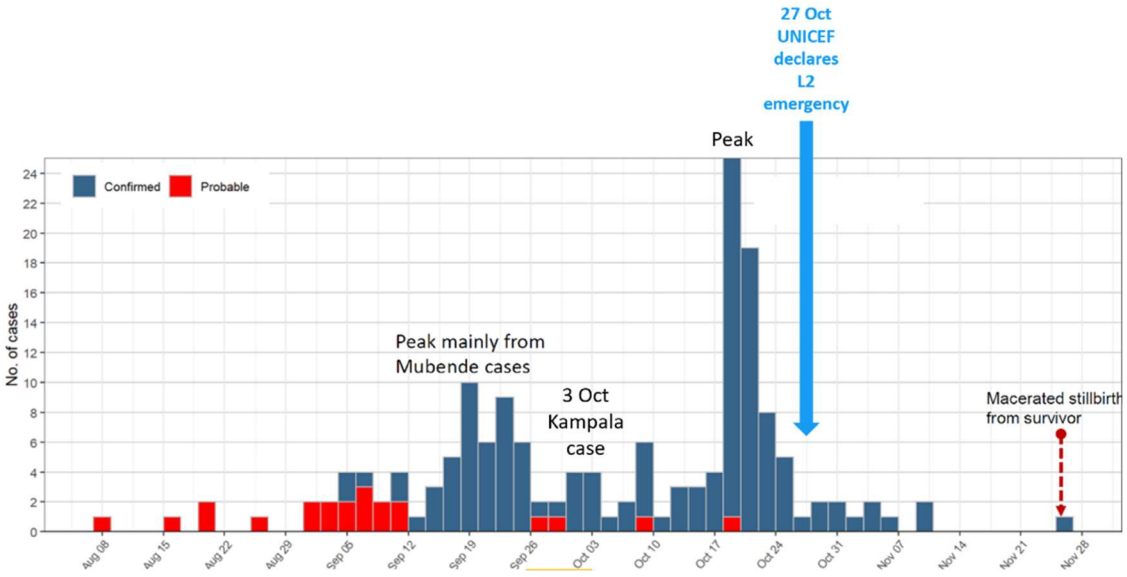
ANNEX 17: U-REPORT: EBOLA INCOMING UNSOLICITED QUESTIONS



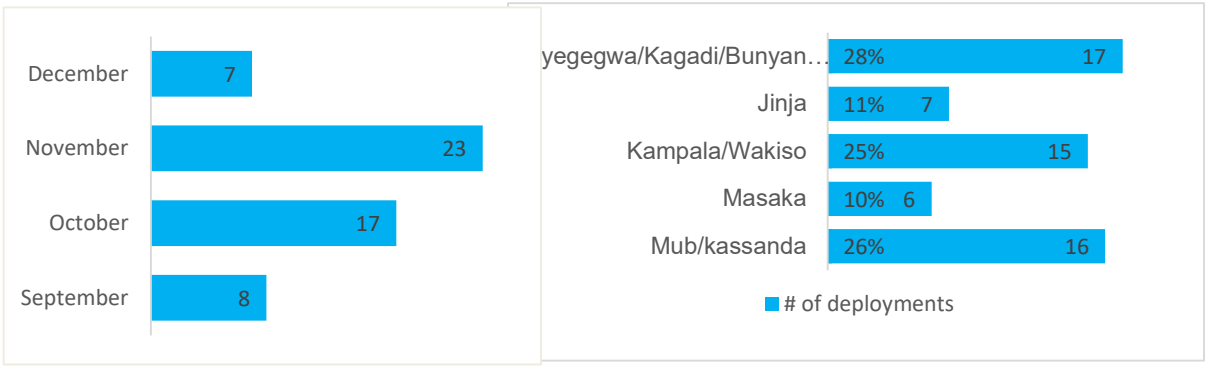
ANNEX 18: UGANDA, UNICEF FUNDING MOBILISATION

Date Received		07-Sep-22	12-Oct-22	09-Nov-22	09-Dec-22	19-Dec-22	22-Dec-22	TOTAL	%
Funds Received	**UNICEF FUNDS**	**GHTF**	**USAID**	**CERF**	**ECHO**	**SWEDEN**	**FCDO**		
Case management	$ 1,141,794	$ 500,000	$ 37,000			$ 65,790	$ -	$ 1,744,584	22%
CES	$ 479,829				$ -	$ 695,802	$ -	$ 1,175,631	15%
RCCE	$ 371,340		$ 517,484	$ 298,710	$ 350,324	$ 9,240	$ 783,217	$ 2,330,315	29%
Coordination	$ 76,007				$ -		$ 4,600	$ 80,607	1%
IPC (and WASH)	$ 14,855		$ 219,258	$ 513,135	$ 420,057		$ 260,036	$ 1,427,341	18%
Overheads			$ 152,184	$ 169,463	$ 132,062	$ 292,462	$ 445,270	$ 1,191,441	15%
Total Funds Mobilised	**$ 2,083,825**	**$ 500,000**	**$ 925,926**	**$ 981,308**	**$ 902,443**	**$ 1,063,294**	**$ 1,493,123**	$ 7,949,919	

ANNEX 19: UGANDA, EBOLA EPIDEMIC CURVE AND INTERVENTION TIMELINE



ANNEX 20: UGANDA, HUMAN RESOURCES DEPLOYED, EBOLA OUTBREAK, SEPTEMBER 2022–MARCH 2023. SOURCE: UNICEF HUMAN RESOURCE TRACKER



UNICEF Uganda early-onset activities, September 2022

IPC	IPC Supplies (various) dispatched: US$ 12,198 for: 2,567 patients x 4 months and 25 district health facilities x 3months
WASH	US$ 24,366 10 mobile toilets (capacity of 20+ people each/ total 375 people) dispatched (5 delivered to Mubende RRH; 10 to be delivered to Madudu sub county on 27 Sept) 7 Water tanks x 10,000 l for water trucking; ETA Mubende today
Contact Tracing	US$ 50,000 Rented vehicles (15),Go Data mapping (GOARN) and support to Strategic Information
RCCE	US$ 20,000 sent to Mubende and Kyegegwa district authorities for grassroot RCCE 35,400 IEC materials worth US$ 85,691 delivered
Staff deployed to Epicentre	1 WASH specialist to support IPC; 1 RCCE/SBC specialist to support risk communication for behavior change and coordination. Additional rotating staff.
Total US$	**$ 192,256 provided**

ANNEX 21: OVERVIEW OF MISSED OPPORTUNITIES OF UNICEF EBOLA RESPONSE

Advocacy	More proactive all-of-UN advocacy on coordination, and translating policy into practice, to a government that in general is open to change, would likely have resulted in better progress. It was suggested that phasing out this practice amounts to a missed opportunity for UNICEF to engage in targeted advocacy efforts. It was also suggested that such internal focused advocacy at the ministry level is more productive than continuing to engage in trainings, which amounts to a lost investment.
Preparedness and an earlier agreement on roles and responsibilities of UNICEF in PHEs	UNICEF was not a member of the GoU National Ebola Plan revision before the 2022 outbreak. When the outbreak began the UCO was therefore on the back foot vis-à-vis donors and UNICEF's role in PHEs. If the UCO had proactively put together a concept note or had previously compiled a paper that comprehensively detailed the UCO's responsibilities vis-à-vis PHEs, this could have increased donor flexibility and ended/reduced earmarking. Such a concept note could serve a dual purpose: educating donors as to UNICEF's specific needs vis-à-vis PHEs and informing the regional office and HQ on how they could best support the UCO in terms of resource mobilisation.
Cash grants	The implementation of cash grants was not carried out, which, in retrospect, was a missed opportunity to support post-Ebola needs and vulnerabilities.
Collection of child-specific data	Earlier and more comprehensive data collection on children would have likely influenced decision-making at an earlier stage. The lack of sufficient child-specific data had repercussions, particularly concerning children in isolation.
Data technology	Achieve more assertive implementation of data technology by taking the digital lead in sub-pillars that align with its mandate, such as analytics and geographic information systems.
Research and development	Collaborate/initiate clinical trials and operational research to address the specific research gap on Sudan Ebola virus in children.
Risk management	Less risk aversion, well-managed risk-taking, including no-regrets approaches, prompt decision-making, with a focus on maximizing benefits that outweigh potential costs.
Timeliness	An earlier L2 activation could have leveraged UNICEF's expertise and comparative advantage to a greater degree and with greater efficiency and effectiveness.
Climate change	In addition to solar-powered sustainable boreholes, an increased focus on bold and urgent actions on climate change would build climate-resilient communities.[clxxviii]

ANNEX 22: UNICEF UGANDA LESSONS FROM PREVIOUS EBOLA OUTBREAKS

A health epidemic requires a multi-sectoral child rights approach.	
A community-based response is optimal.	
The child protection response should be targeted and measurable.	
Mental health and psychosocial programming are an essential part of a response to a PHE but require clear definitions and expertise.	
Family and community-based emergency support should be linked to longer-term child protection systems.	
Systems in child protection programming for delivery of cash grants and supplies need re-enforcement.	
Centre-based care is a service of last resort.	
Accurate and timely data is essential.	
Coordination at the regional, national, and de-centralised levels is required for improved efficiency.	
Timely and immediate funding is key to an epidemic response.	
Recruitment and deployment of well-trained, professional staff is critical.	
Response to the epidemic should build on existing government infrastructure and capacity.	
GBV identification and referral should be integrated into the Ebola response.	
Ensure that women and girls are considered in all aspects of the planning and response, including in recruitment of staff.	
WASH is a fundamental pillar of an Ebola response, especially with regards to IPC, body management, community engagement, and promotion of health-seeking behaviours.	
Epidemic surveillance, operational research (IOA) and case detection efforts should be based on local contexts and community involvement.	
Health communication should prioritise messaging and methods that are inclusive, culturally appropriate, and trusted.	
Community engagement should not be one-size-fits-all; communities are not homogeneous, and responders should understand contextual power relations between groups to ensure a community-led response that is inclusive and relevant to all.	
Resources should not be focused solely on fighting Ebola, but ongoing healthcare provision should also be supported during an epidemic response.	
Ebola survivors should not be forgotten. Health complications due to the virus last long after the person has been cured of the infection, and survivors experience stigma, psychological trauma, and economic difficulties.	
Ebola is traumatic. People experience fear, stigmatisation, grief, and trauma. Psychosocial support should be part of the Ebola response.	

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