Evaluation of Sierra Leone Cholera Response 2012
Project Effectiveness Review

Oxfam GB
Global Humanitarian Indicator

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1 Background

1.1 The disaster and response

The 2012 cholera outbreak in Sierra Leone generated the highest number of reported cases in the country since the 1970s, when the first cholera cases were officially reported. In total 22,973 cholera cases were reported and 299 cholera deaths were recorded between January 1 and December 31 2012.

The outbreak, which was first confirmed in northern border districts in early 2012, spread across 12 out of the country’s 13 districts in the latter half of the year, greatly facilitated by heavy seasonal rains and overcrowding and poor sanitation in human settlements.

On August 17, 2012, when over 2,100 new cases were reported for the previous week and the mortality rate reached 1.8 per cent (nearly double the threshold for a state of emergency), the President of Sierra Leone tardily announced a national public health crisis.

From July 2012 Oxfam recognised the situation as a Category 2 emergency and mounted a significant scale-up to help contain and reduce the spread of cholera and its deaths in Freetown (21 city sections and three rural wards), Tonkolili (three chiefdoms) and Koinadugu (two chiefdoms). The programme, which benefited 507,949 people (108 per cent of its target), consisted of the following components:

- **Improved access to sanitation:**
  - Installation and maintenance of emergency sanitation facilities in a Freetown hospital and maintenance of 20 community latrines in Freetown city sections.

- **Improved access to water:**
  - Set up of 249 bucket chlorination points
  - Support to 10 ice/water makers/distributors in urban areas
  - Rehabilitation of 93 water point in rural areas

- **Improved hygiene practices:**
  - Set up of 177 Oral Rehydration Points
  - Training of over 1,300 volunteers on key cholera prevention hygiene messages
  - Hygiene Promotion activities with 507,949 persons

- **Advocacy and support for effective leadership and coordination by the government:**
  - Further details of the programme locations and numbers of beneficiaries are provided in Figure 1.

When the programme closed on December 31st 2012, the cholera outbreak was significantly reduced; under 20 new cases were being reported weekly, across four districts. Oxfam’s response is assumed to have been one of a number of factors leading to a decrease in cholera cases. However, the correlation between the decrease and Oxfam response has not been scientifically proven.

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1 Directorate of Disease Prevention and Control, MoHS, Sierra Leone, 2012.
2 Official statistics generated by the Ministry of Health; evidence of under-reporting suggests the number of cases and deaths may have been higher.
1.2 Evaluative methodology

This evaluation uses a methodology designed to enable Oxfam GB to estimate how many disaster-affected men and women globally have received humanitarian aid from Oxfam GB that meets established standards for excellence.

The methodology is based on a Humanitarian Indicator Tool (HIT) consisting of 12 quality standards with associated benchmarks, and a scoring system (see Appendix 2). It requires documented evidence, complemented by verbal evidence where available, to be collected and analysed against these benchmarks. A score is generated for the programme’s results against each standard, and as a cumulative total.

To evaluate the Sierra Leone response, the methodology comprised of the following steps:

- Presentation of methodology and process to Sierra Leone Country Director (CD) and nominated representatives.
- Identification and provision of relevant documentation.
- Initial analysis of documentation and identification of gaps.
- Correspondence with staff\(^3\) to obtain supplementary information.
- Assessment of all evidence against the benchmarks.
- Submission of draft report to the Sierra Leone CD, regional wash adviser and previous cholera coordinator for review.
- Analysis of input by reviewers and additional information provided.
- Final analysis and completion of evaluative report.

\(^3\) As the programme had already finished when the evaluation was conducted, the Country Director was the only staff member to participate directly in the evaluation.
1.3 Structure of report

A quantitative summary of the results of the evaluation is provided in Section 2. A fuller explanation of the rating for Oxfam’s performance against each standard is provided in Section 3.

2 Summary of results

2.1 Quantitative summary by standard

The quantitative rating given for each standard and the cumulative rating for the response are provided in Table 1.

Table 1: Quantitative ratings for the Sierra Leone Cholera Response, using the Global Humanitarian Indicator Tool.

<table>
<thead>
<tr>
<th>Standard</th>
<th>Level of achievement</th>
<th>Rating</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Rapid appraisal of facts within 24 hours of pre-defined trigger, plans in place and scale-up or start-up commenced within three days⁴</td>
<td>Almost met</td>
<td>4/6</td>
</tr>
<tr>
<td>2. Coverage uses 10% of affected population as a planned figure with clear justification for final count</td>
<td>Met</td>
<td>6/6</td>
</tr>
<tr>
<td>3. Technical aspects of programme measured against Sphere standards</td>
<td>Met</td>
<td>6/6</td>
</tr>
<tr>
<td>4. MEAL strategy and plan in place and being implemented using appropriate indicators</td>
<td>Almost met</td>
<td>2/3</td>
</tr>
<tr>
<td>5. Feedback/complaints system for affected population in place and functioning and documented evidence of information sharing, consultation and participation leading to a programme relevant to context and needs</td>
<td>Met</td>
<td>3/3</td>
</tr>
<tr>
<td>6. Partner relationships defined, capacity assessed and partners fully engaged in all stages of programme cycle</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>7. Programme is considered a safe programme: action taken to avoid harm and programme considered conflict sensitive</td>
<td>–</td>
<td>–</td>
</tr>
<tr>
<td>8. Programme (including advocacy) addresses gender equity and specific concerns and needs of women, girls, men and boys and vulnerable groups⁵</td>
<td>Partially met</td>
<td>1/3</td>
</tr>
<tr>
<td>9. Evidence that preparedness measures were in place and effectively actioned</td>
<td>Almost met</td>
<td>2/3</td>
</tr>
<tr>
<td>10. Programme has an advocacy/campaigns strategy and has incorporated advocacy into programme plans based on evidence from the field</td>
<td>Met</td>
<td>3/3</td>
</tr>
</tbody>
</table>

⁴ The timeliness standard for slow onset disasters was used because of the gradual evolution of the outbreak from January to June 2012.
⁵ Elderly, disabled, HIV positive, single women, female-headed households are examples
11. Country programme has an integrated approach including reducing and managing risk though existing longer-term development programmes and building resilience for the future | Met | 3/3

12. Evidence of appropriate staff capacity to ensure quality programming | Met | 3/3

**Final rating**

Equivalent to 85%

33/39

### 3 Detailed analysis of results

#### 3.1 Introduction

In this section of the report, the data collected from documented sources are analysed against the benchmarks for the quality standards, and justification of the rating for Oxfam’s performance against each standard is provided. The data sources are provided in footnotes, together with other explanatory information.

#### 3.2 Analysis using standards and benchmarks

##### 3.2.1 Quality Standard One: Timeliness

*Rapid appraisal of facts within 24 hours of pre-defined trigger, plans in place and scale-up or start-up commenced within three days*

*NB: Given that the cholera outbreak in Sierra Leone evolved slowly from January to June 2012, escalated rapidly from July to October, then declined rapidly in November and December, it may be considered a rapid onset disaster within a slow onset disaster. Nevertheless, the HIT benchmark for slow onset disasters was used to analyse the timeliness of Oxfam’s response as this corresponded more closely with the range of actions – including preparedness, capacity building, advocacy and response – that was required of, and undertaken by, the Oxfam team in Sierra Leone.*

Oxfam’s response to the 2012 cholera outbreak in Sierra Leone started before a pre-defined trigger or a contingency plan was established. When an unseasonal rise in cholera cases in Pujehun, Kambia and Port Loko (areas where cholera is endemic) was reported in February 2012 by WHO and the Ministry of Health and Sanitation, Oxfam staff in Sierra Leone and the West Africa Regional Centre reacted swiftly. A two-day training course on cholera was held for technical staff of the Sierra Leone team on February 2012, and on March 4 the Regional Humanitarian Coordinator granted emergency funding from Oxfam’s Catastrophe Fund to contract a consultant to develop a cholera-specific contingency plan for the country office.

The cholera contingency plan was completed by April 2012. Oxfam would respond to outbreaks in Western area, including Freetown, where its long-term programme is located, and in Kambia and Koinadugu if assessments indicated there were unmet needs. In other regions Oxfam would not respond directly but would continue its cholera preparedness/prevention activities in its traditional programme areas. The plan included triggers for scale-up, activity plans and procurement of contingency stocks.

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6 Suspected cases were reported throughout January, with the first official communication being sent out on February 27.

7 Source: *Draft Cholera Contingency Plan*, Oxfam Sierra Leone, April 2012.
Oxfam’s early reaction and start-up, however, lost some of its pace over the following trimester due to significant staff turnover in the Sierra Leone team in April and reduced oversight by regional staff of the potential crisis. Incoming staff monitored the evolution of the outbreak and participated in national preparedness/response planning, but did not activate the contingency plan despite triggers already being reached in Kambia and, by the end of June, in Freetown.

On July 20th Sierra Leone’s Ministry of Health and Sanitation reported 410 suspected cases of cholera and nine deaths in Western Area, including Freetown, and over 800 new cases nationwide in the previous seven days. Now faced with an overt crisis, Oxfam rapidly moved into response mode. Within three days Oxfam in Sierra Leone produced a situation report (sitrep) containing its first ideas for a response in Freetown, and requested $80,000 from Oxfam’s Catastrophe Fund and specialist staff from Oxfam’s Humanitarian Department. Funding was approved immediately, staff were deployed, including an expert in cholera responses who developed a comprehensive response plan, which formed the basis for programme implementation and funding proposals, and from this moment onwards Oxfam’s scale-up was very fast.

Oxfam’s first humanitarian aid – in the form of the construction of WASH facilities for the CTU at Lumley Hospital – was provided on August 2. This was followed within days by the start of community cholera prevention activities in 20 city sections in Freetown, 10 of which were city sections where Oxfam’s long-term Urban WASH team had already been operating; the other 10 were targeted based on the number of cases and the absence of other WASH actors. By the end of August Oxfam was also responding in Tonkolili, and by mid-September in Koinadugu.

Overall, it is considered that Oxfam almost met the standard for timeliness. Country- and regional-level staff reacted opportunistically to early indicators of a potential crisis, and the organisation as a whole was sufficiently flexible and responsive to be able to mount a large and rapid scale-up when the number of cholera cases started to escalate in high-risk areas. Although Oxfam did not follow its own contingency plan, and therefore missed early opportunities to respond in affected rural areas and to scale-up prevention and preparedness measures ahead of the rainy season, it did react quickly to the emergence of cholera in its programme area and to requests to intervene in other areas of unmet needs. The response in Freetown could have started a few weeks earlier if additional and expert support had been drafted in sooner, but it still managed to address the peak of the crisis, as shown in Figure 2.

### 3.2.2 Quality Standard Two: Coverage

**Coverage uses 10% of affected population as a planned figure with clear justification for final count**

In the first month of its response, Oxfam’s target number of beneficiaries more than doubled, from 217,811 in Freetown, to 450,000–500,000 in three selected areas across the country including the capital, Freetown. The latter target is equivalent to approximately 8 per cent of

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8 Source: Sitrep 1, July 17, 2012.
9 July 16, 2012.
12 Week 35 of the outbreak.
13 Week 38 of the outbreak.
the total population of Sierra Leone.\textsuperscript{14} It was calculated and agreed using public health principles, information on the likely cholera scenario and on overall needs, information on coverage of other organisations, Oxfam’s cholera response guidelines and an internal assessment of Oxfam’s scale-up capacity.\textsuperscript{15}

The programme locations were selected using the criteria stipulated in Oxfam’s cholera response guidelines, as shown in Table 2 below, and other results of the assessment in each location.

\textsuperscript{14} Population of Sierra Leone is 6 million (http://countrymeters.info/en/Sierra_Leone/).

\textsuperscript{15} Sources: Sierra Leone Cholera Response Strategy, August 2012; Real Time Evaluation, October 2012.
February

- **End of February**: Training on cholera awareness, surveillance and rapid assessment is held for the Sierra Leone WASH team.

March

- **3rd March**: Oxfam Regional Humanitarian Advisor approves funding to Sierra Leone to obtain expert support to produce a cholera contingency plan.
- **March onwards**: Oxfam steps up advocacy and coordination with MinHS and health actors to deal

April

- **End of April**: Contingency plan is finalised and approved.

July

- **16th July**: Emergency response funding is requested from Oxford and approved.
- **31st July**: Expert Coordinator arrives in Sierra Leone to analyse

August and September

- **2nd August**: Oxfam completes first WASH installations for cholera response in Freetown.
- **End of August**: Oxfam starts to implement in Tonkolili
- **Mid-September**: Oxfam starts to implement in Koinadugu

**Figure 2: Timeline of Cholera Crisis and Oxfam’s response**

- Government of Sierra Leone confirms outbreak in Kambia and other border regions
- Government of Sierra Leone confirms first case in Western Region
Table 2: Rationale for selecting programme areas based

<table>
<thead>
<tr>
<th>Criterion</th>
<th>Freetown</th>
<th>Tonkolili</th>
<th>Koinadugu</th>
</tr>
</thead>
<tbody>
<tr>
<td>Epidemiological patterns</td>
<td>✓ Rapid attack rates, highest number of cases</td>
<td>✓ High CFR</td>
<td>-</td>
</tr>
<tr>
<td>Population size and density</td>
<td>✓ Capital and most populous city (exact figures not available, but population estimates range from 500,000 to over 1 million)</td>
<td>-</td>
<td>-</td>
</tr>
<tr>
<td>Convergence zones/seasons</td>
<td>✓ Confirmed cases coincided with start of rainy season</td>
<td>✓ Located at centre of Sierra Leone and borders 7 other districts.</td>
<td>✓ Strategic location as it borders Tonkolili and has an international border with Liberia. Therefore in ‘shield strategy’.</td>
</tr>
<tr>
<td>Impaired access to treatment centres</td>
<td>-</td>
<td>✓ Rural areas have poor infrastructure</td>
<td>✓ Remote, rural areas have poor infrastructure</td>
</tr>
<tr>
<td>Available human resources</td>
<td>✓ Oxfam has long-term programme</td>
<td>✓ Concern requested Oxfam’s support on WASH.</td>
<td>✓ Oxfam has long-term programme</td>
</tr>
<tr>
<td>Limited capacity of health authorities</td>
<td>-</td>
<td>✓ Capacity greatest in urban areas, not rural ones.</td>
<td>✓ Capacity greatest in urban areas, not rural ones.</td>
</tr>
<tr>
<td>Areas with high risk practices</td>
<td>✓ Most city sections lack basic WASH infrastructure</td>
<td>✓ WASH basic infrastructure lacking</td>
<td>✓ WASH basic infrastructure lacking</td>
</tr>
</tbody>
</table>

The number of beneficiaries reported on a weekly or bi-weekly basis (in sitreps) demonstrates that Oxfam was able to reach (and eventually exceed) its target very rapidly. As shown in Table 3, the programme’s coverage was not only significant in real terms and proportionate to the number of people at risk, but it was also achieved at an appropriate speed in relation to the spread of the cholera outbreak. In light of the above, it is considered that Oxfam met the standard for coverage.
### Table 3: Beneficiaries reached by the Sierra Leone Cholera Response, July to November 2012

<table>
<thead>
<tr>
<th>Date</th>
<th>Cholera situation</th>
<th>Target number of beneficiaries</th>
<th>Actual Number of Beneficiaries</th>
</tr>
</thead>
<tbody>
<tr>
<td>17 July</td>
<td></td>
<td>Undefined</td>
<td>0</td>
</tr>
<tr>
<td>8 Aug</td>
<td>6841 reported cases</td>
<td>217,811 in Freetown</td>
<td>Undefined number of patients at Lumley hospital</td>
</tr>
<tr>
<td>29 Aug</td>
<td>14,225 reported cases</td>
<td>450,000-500,000 individuals in Freetown, 3 rural districts of Western Area, Tonkolili and Koinadugu</td>
<td>75,600 households in 14 city sections in Freetown</td>
</tr>
<tr>
<td>13 Sept</td>
<td>16,096 reported cases</td>
<td>130,277 individuals</td>
<td>124,204 in 10 city sections in Freetown; 6073 in Tonkolili</td>
</tr>
<tr>
<td>19 Sept</td>
<td>Slight decrease in confirmed cholera cases in Western Area.</td>
<td>169,668 individuals</td>
<td>160,453 Freetown; 9215 in Tonkolili</td>
</tr>
<tr>
<td>26 Sept</td>
<td>19,680 reported cases</td>
<td>229,382 individuals</td>
<td>229,382 individuals</td>
</tr>
<tr>
<td>3 Oct</td>
<td>20,736 reported cases</td>
<td>263,018 individuals in total;</td>
<td>240,680 individuals in Freetown across 20 city sections;</td>
</tr>
<tr>
<td></td>
<td></td>
<td>22,338 in Tonkolili</td>
<td>283,640 individuals</td>
</tr>
<tr>
<td>10 Oct</td>
<td>21,167 reported cases</td>
<td>283,640 individuals</td>
<td>321,161 individuals</td>
</tr>
<tr>
<td>17 Oct</td>
<td>21,659 reported cases</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### 3.2.3 Quality Standard Three: Technical aspects of programme measured against Sphere standards

Sphere standards (or their relevant indicators and guidance notes) were explicitly mentioned in the following documents produced at earliest stages of Oxfam's Cholera Response in Sierra Leone:

- ECHO proposal (August 7, 2012) and Final Report (March 13, 2013)
- Sitrep 2 (August 8)
- Oxfam Cholera Response Logical Framework (September 11, 2012)
- Oxfam Cholera Response – Summary (October 8, 2012)
- MEAL Indicators (original date unknown), specifically: “100% of the treated water at the strategic water points is no less than 0.5mg/L FRC after 30 minutes based on more than 1,000 buckets tested every week in the 3 intervention areas.”

It is important to note that the design of the response drew significantly on Oxfam's Cholera Guidelines, which 'translate' the cholera-specific information in Sphere into practical steps and data collection formats for field staff. Such formats – including jar test recording sheets, bucket chlorination and household free residual chlorine monitoring forms – were provided to staff at the outset of the Sierra Leone response and were used to measure progress towards Sphere water quantity and quality standards by all staff in all locations.

It is considered that Oxfam met this standard.

### 3.2.4 Quality Standard Four: MEAL strategy and plan in place and being implemented using appropriate indicators

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16. Published one month prior to the start up of Oxfam’s response in Sierra Leone and co-authored by the same staff member who was deployed as the first Programme Coordinator from July to August 2012.
17. In the Sphere manual this is found in Guidance Notes and Appendices for water quantity and quality for CTCs and surveillance requirements.
18. Household Free Residual Chlorine Level Monitoring Form, designed on August 13; Bi-weekly jar test recording sheet, designed on August 9, 2012; Water Point Reporting Sheet (undated).
A logical framework with predominantly SMART indicators and identified means of verification was drawn up early August. This was rapidly translated into a basic MEAL Strategy, which specified responsibilities and frequencies for data collection, thus enabling monitoring to start within three weeks of the first provision of aid in this programme and at the same time as all key activities started in Freetown.

In the first days of implementation, monitoring activities focused appropriately on water-quality testing by bucket chlorinators and at other water chlorination points, and undertaking Knowledge Attitude and Practice surveys in target areas to establish a baseline for the programme. The availability of simple tools from Oxfam’s Cholera Response guidelines was key to establishing monitoring procedures and routines simultaneously to programme delivery.

Building on early achievements, the MEAL strategy was enhanced and rolled out by specialist MEAL staff. Beneficiary feedback mechanisms were included, with the first focus group discussions being held in Freetown on September 27 and 28, and a hotline functional by late September. Training, comprising presentation of the MEAL framework, familiarisation with all indicators, application of MEAL tools, beneficiary counting methods and accountability mechanisms, was held in all programme locations in the first week of October. Although by this stage the peak of the cholera outbreak had passed in Freetown and Tonkolili, it was still highly relevant for sustaining the programme’s benefits to prevent further outbreaks.

Implementation of programme activities was systematically monitored and reported in each sitrep from August 29 onwards. Discrepancies were noted and corrected, such as the methods used to count beneficiaries and the need for accelerated data entry to allow timely analysis. A Real Time Evaluation (RTE) took place in October, the conclusions of which were rapidly fed-back to the Sierra Leone team.

The MEAL system had few weaknesses considering the high speed and considerable scale at which the programme was implemented. A notable one, however, was the limited analysis made of the data collected to potentially adapt the programme to meet the specific needs of vulnerable population groups. Software and additional staff were requested to analyse the data collected during the KAP in Freetown, but they only became available after the peak of the outbreak. They were, however, used for the final KAP.

Also, in some cases the focus on a rapid scale-up may have precluded better coordination and analysis between PHE and PHP teams, resulting in, for example, inconsistent monitoring of the cleanliness of water containers in Freetown and missed opportunities to improve the location and number of bucket chlorination points in areas of high attack rates. The initial location of the MEAL team under the general coordination function rather than by project location is considered one of the main reasons for such gaps.

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20 Source: ECHO proposal (August 7, 2012)
21 Source: Sitrep 3
22 Source: Sitrep 5 and 6; RTE
23 Source: Sitrep 5
24 Source: RTE
25 Source: Sitrep 6
As noted in Section 3.2.6, another weakness of note was the absence (with one exception) of gender-sensitive indicators, and a general lack of emphasis on the need for gender-sensitivity and disaggregation of results in the analysis of monitoring data. This was subsequently acknowledged by the team, and acted upon by commissioning a study on gender and vulnerabilities to cholera and a specific evaluation on gender mainstreaming in the response.\footnote{Sources: Noelle Rancourt et al. (2012) Gender and Vulnerability to Cholera in Sierra Leone, Helene Juillard, Review of Draft HIT report, March 2013.}

Overall it is considered that Oxfam almost met the standard for having and using an appropriate MEAL framework for the programme.

3.2.5 \textit{Quality Standard Five: Feedback/complaints system for affected population in place and functioning and documented evidence of information sharing, consultation and participation leading to a programme relevant to context and needs}

Oxfam conducted assessments in Freetown, Tonkolili and Koinadugo at the end of July, August 12 and on September 20 respectively.\footnote{Source: Sitrep 2; Assessment reports Tonkolili and Koinadugu.} The methodology for these included interviews with key informants, transect walks, gender and age segregated focus-group discussions, and review of secondary data from the Ministry of Health and Sanitation and other INGOs working in the areas.

While rapid, the assessment visits provided an opportunity to consult affected and at-risk communities about what would be of most use to them and how it could best be provided. This, coupled with effective programme delivery, generated a high level of satisfaction among beneficiaries, as reflected in comments made during the RTE such as ‘85 per cent of what we suggested has been provided’.\footnote{Items such as cooking utensils, which were requested, were not provided as they were not considered a priority in terms of cholera prevention.}

Oxfam WASH teams already had a presence in 10 city sections of Freetown and in Koinadugu prior to the Cholera Response, but the expansion to 10 further city section and the inclusion of Tonkolili in the programme gave rise to a need to explain the organisation, its purpose, sources of funding, programme and intentions. All new staff and volunteers (mainly Blue Flag and bucket chlorinators) received an explanation of Oxfam’s Code of Conduct during their induction and were trained to provide the necessary information to beneficiaries.\footnote{Source: Helene Juillard, Review of draft HIT report, March 2013.}

The programme was designed using the inputs from the assessments, particularly with respect to acceptance of chlorination and the location of ORP (Oral Rehydration Points) and CTC (Cholera Treatment Centres). Targeting of the most vulnerable groups in urban areas was conducted via chiefs and volunteers, thereby generating local participation and facilitating the inclusion of local knowledge in decision-making.

Once the first activities were up and running, Oxfam moved swiftly to establish complaints and feedback mechanisms. Focus-group discussions (FGDs) were held with beneficiaries in Freetown on September 4 and in Tonkolili in early September to define the most appropriate feedback mechanisms, including the closest translations for complaint, customs relating to making complaints, and barriers to making complaints.\footnote{Questions for FGDs with beneficiaries for development of a feedback and complaints mechanism.} A proposal/strategy for a tailored
Feedback via the hotline was always given to Krio-speaking Sierra Leonian staff, thus facilitating easy communication. The hotline received 38 calls between September 21 and November 8, half of which were queries/complaints about delays in payments to volunteers. Where possible, the call operator responded to concerns and complaints, using a script and answers to FAQ. For other cases, weekly meetings were held between programme managers and the MEAL team to address the feedback. All feedback was also recorded in the database. No major issues requiring significant changes or investigations were reported, but small changes included faster mechanisms to pay volunteers, and closer management of BFGs.

In light of the results described above, it is considered that Oxfam met the standard for accountability.

**Figure 3: Reasons for calls to Hotline**

![Reasons for calls to Hotline](chart)

### 3.2.6 Quality Standard Six: Partner relationships defined, capacity assessed and partners fully engaged in all stages of programme cycle

Oxfam’s response was entirely operational, hence this standard is not applicable. The scoring system has been adjusted accordingly.

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31 September 7, 2012
32 Source: Sitrep 10
3.2.7 Quality Standard Seven: Programme is considered a safe programme: action taken to avoid harm and programme considered conflict sensitive

Oxfam was not able to provide guidelines for safe-programming or criteria for conflict sensitivity for this evaluation. It was decided, therefore, to exclude this standard from the key questions and to adjust the scoring system accordingly.

3.2.8 Quality Standard Eight: Programme (including advocacy) addresses gender equity and specific concerns and needs of women, girls, men and boys and vulnerable groups

Oxfam’s clear priority at the start of the Sierra Leone Cholera Response was scaling up in time for its activities to be relevant before and during the peak of the outbreak. For this reason, Oxfam’s initial focus was on targeting (assessing and initiating response activities) Freetown city sections with existing cases and fatalities, as well as those with high exposure in terms of population size and proximity to other districts with high attack and fatality rates, and where other WASH actors were not present or lacked capacity to intervene effectively. In rural areas in Tonkolili and Koinadugu the criteria for targeting villages was slightly different, with distance from a health centre or ORP also being a key factor to take into account.

Once a location for intervention was identified, Oxfam defined specific aspects of its programme design based on cumulative organisational experience in similar contexts, and information gathered during the rapidly conducted assessment process. Examples of the former include:

- Awareness of HIV, disabled, under 5s, and pregnant women as being among the most vulnerable population groups.
- Awareness of effectiveness of women as hygiene promoters for reaching other women, and men for men, and encouraging/facilitating the involvement of men and women in such roles.
- Effectiveness of community-based organisations for knowing who are most economically and socially vulnerable.
- Ensuring messaging is relevant to, and reaches, men, women and children by using multiple channels: radio, house-to-house visits, and IEC.

This approach was effective and produced timely results in terms of enabling Oxfam to start up activities with great speed, with the potential to benefit women, men and children living there.

In this process, however, Oxfam missed several opportunities to better understand and address engendered needs and vulnerabilities, and to tailor its programme to reach other vulnerable groups. For example:

- Talking to more women during assessment visits, rather than relying on male chiefs and other men in authority.

33 Requested by the evaluator in correspondence with the MEAL team, Oxford, in October 2012.
34 Elderly, disabled, HIV positive, single women, female-headed households are examples.
35 Source: RTE, Gender study.
Evaluation of Sierra Leone Cholera Response – Project Effectiveness Review

- Ensuring that the KAP included key gender-relevant questions, and using results to adapt the programme design to meet engendered needs and those of highly vulnerable people.
- Disaggregating all relevant monitoring data by sex and age.
- Involving women’s organisations to reach women, as those who are exposed to multiple transmission routes.
- Distributing multiple cholera prevention kits to polygamous households.
- Encouraging a more equal representation of men and women as BFV and bucket chlorinator jobs (only 30% were women), for example.
- Identifying strategies to reach street-working children and others who spend most of their time outside the home or other institutions.

Oxfam became aware of these gaps during the RTE and an internal SWOT review conducted at the end of the response and, as a result, commissioned a specific study on Gender in Sierra Leone\textsuperscript{36} to inform future responses. It is now in a very strong position to integrate measures into preparedness planning and ongoing programming, and to ensure that future responses are engendered and sensitive to the needs and rights of vulnerable sectors of the population.

On the basis of these results, Oxfam is considered to have partially met the standard for addressing gender equity and specific concerns and needs of women, girls, men and boys and vulnerable groups.

3.2.9 Quality Standard Nine: Evidence that preparedness measures were in place and effectively actioned

Oxfam managers in Sierra Leone and the West Africa Regional Centre reacted to the first news of cholera cases\textsuperscript{37} by launching two preparedness actions:

Firstly, they organised a two-day training course on cholera prevention, surveillance and response for technical staff in Oxfam’s Sierra Leone team, which was delivered by the Regional Water, Sanitation and Hygiene Adviser.

Secondly, they contracted an external consultant in March 2012 to produce a cholera-specific contingency plan for a potential cholera response and organised a training session on cholera for the urban WASH team. The plan, which included an action plan for response, including surveillance, hygiene promotion, water treatment, excreta disposal, solid waste management, and participation in set-up of Cholera Treatment Centres (CTCs), was completed in April 2012 but remained in draft form during senior management changes in the Oxfam office and the contingency stocks recommended within it were not procured. When it was subsequently consulted the incoming staff found it to be unclear on triggers for a response and insufficiently aligned with Oxfam’s guidelines for cholera responses, which caused them to disregard it (see Section 3.2.1 for further details).

More useful, perhaps, were two other longer-term preparedness measures that were better-integrated into Oxfam’s long-term programme:

1. Oxfam’s presence as a WASH actor in 10 city sections of Freetown and Koinadugu.\textsuperscript{38}

\textsuperscript{36} Gender and Vulnerability to Cholera in Sierra Leone, Noelle Rancourt et al, 2012.
\textsuperscript{37} In the first trimester of 2012.
\textsuperscript{38} Through the WASH and Governance programme.
The ongoing WASH programme provided Oxfam with a platform from which to scale-up successful programme components, such as the district-level WASH committees and Blue Flag Volunteer initiative, in which volunteers spread hygiene promotion messages and manage Oral Rehydration Points (ORPs) and mark them with a blue flag so that they can be rapidly identified and accessed in case of need.

2. Oxfam’s participation in multi-stakeholder coordinations, including the Cholera Task Force of the WASH working group.

Oxfam and other INGOs specialising in WASH began to work with the Ministry of Health and Sanitation in October 2012 on a national contingency plan. Being part of this coordination group provided Oxfam with access to general health data, information on the evolution of the cholera outbreak, information about coverage of governmental and non-governmental actors, and a working relationship with WHO and Unicef, all of which contributed to Oxfam’s capacity to respond rapidly and appropriately.

Two institutional preparedness measures were also key to the rapid response in Sierra Leone; firstly, the Catastrophe Fund, which enabled Oxfam to respond before donor funding was confirmed; and secondly, the expertise in cholera programming and additional human resources maintained by the Humanitarian Department, which were immediately deployed when requests were made by the country and region.

Based on this analysis, it is considered that Oxfam almost met the standard for preparedness. To fully meet the standard would require continued programmatic and representational preparedness (as described above), an agreed contingency plan, a nominated cholera focal point within the long-term team, and a regional/national register of potential staff to make a scale up possible if the resources at HQ were overstretched.

3.2.10 Quality Standard Ten: Programme has an advocacy/campaigns strategy and has incorporated advocacy into programme plans based on evidence from the field

The Sierra Leone cholera programme did not have a formal advocacy strategy. Nevertheless, Oxfam was active in advocacy on cholera in Sierra Leone from prior to the outbreak and during its evolution, using the terms of reference for the humanitarian advocacy adviser as a de facto strategy.

As a major WASH actor in Sierra Leone, Oxfam was a member of the National Cholera Task Force (comprised of all UN, RC, NGOs and ministries involved in cholera preparedness/response) since its activation in November 2011. Although the Task Force was diverted by the 2012 outbreak from its original purpose of drawing up a national contingency plan and preparedness plan, it still played an important role during the response. The National Cholera Task Force (NCTF) strengthened coordination among the various partners, and District level Task Forces (DCTF) were also established to do the same at their level. The establishment of a Cholera Command and Control Centre (C4) under the NCTF provided technical support to intervening organisations and coordinated technical aspects of the response.

Through it, Oxfam was able influence and support government actors to improve surveillance and dissemination of the incidence of new cholera cases within Freetown and in

39 Sources: Gender and Vulnerability to Cholera, Rancourt, 2012; RTE, October 2012.
the provinces, which was key to making targeting decisions and monitoring the impact of measures taken.\textsuperscript{40}

Also, through its pre-outbreak role as lead agency of the Urban WASH Consortium in Sierra Leone, Oxfam was able to channel concerns shared by several INGOs during the response, such as the lack of leadership by Unicef and WHO, which was felt to be hampering coordination efforts. This may have contributed to Unicef taking on a stronger leadership role in WASH, and to the integration of UNOCHA from September 2012.

Oxfam used its local experience and global voice to call on donor governments and the humanitarian community to increase financial and humanitarian support in proportion to the escalating scale of the crisis. Its media briefs were taken up by over a dozen media outlets between August 20 and 30 and may have contributed to the activation of DfID’s Rapid Response Fund (RRF) and other subsequent donor commitments, such as Irish Aid and Isle of Man government funding.

From a more technical point of view, Oxfam has played a key role in the WASH group and advocated, for example, the recognition of well chlorination as an ineffective measure to prevent cholera.\textsuperscript{41}

Currently Oxfam continues to advocate an improved data surveillance system, including sex and age disaggregated data, as recommended in the study on Gender and Vulnerability to Cholera Study that it commissioned at the end of the response.\textsuperscript{42}

Based on the evidence noted above, it is considered that Oxfam met the standard for connecting advocacy with experience and priorities from the field.

\textbf{3.2.11 Quality Standard 11: Country programme has an integrated approach including reducing and managing risk though existing longer-term development programmes and building resilience for the future}

At the end of the war in Sierra Leone in 2002, Oxfam re-oriented its programme towards improving WASH services and standards as a means of reducing and managing significant health risks in densely populated areas, such as the slums of Freetown, and in rural areas where health services and WASH infrastructure were almost non-existent. This programme provided a robust platform for the response and may have contributed to reducing the impact of the outbreak in the districts and chiefdoms where Oxfam works.\textsuperscript{43}

During the response itself, Oxfam implanted several potential resilience-building strategies.

At the local level, the programme strengthened the Blue Flag Volunteers’ and chlorinators’ knowledge of hygiene, which will continue to have a positive effect on the communities they serve beyond the timeframe of the response programme.

Although the response team was largely managed by international staff with experience of rapid scale-ups, many Sierra Leone staff were seconded into technical and support roles through which they gained hands-on experience applicable to future emergencies. Furthermore, many have continued cholera preparedness activities since the scale-down,

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\textsuperscript{40} Source: RTE, October 2012.
\textsuperscript{41} Source: Helene Juillard, Review of draft HIT report, March 2011.
\textsuperscript{42} Source: Noelle Rancourt, (2012) Gender and Vulnerability to Cholera in Sierra Leone.
\textsuperscript{43} Source: RTE, October 2012.
thereby learning to apply new knowledge and skills.

As part of its exit strategy, Oxfam purchased contingency stock to facilitate future rapid scale-ups, developed an updated cholera contingency plan, and established a cholera focal point within the national team. It has also reinforced the cholera preparedness component of its urban WASH programme, as a vehicle to promote longer-term resilience.\textsuperscript{44}

Based on these results it is considered that Oxfam met the standard for building resilience.

\textsuperscript{44} Source: Helene Juillard, Review of draft HIT report, March 2013
3.2.12 Quality Standard 12: Evidence of appropriate staff capacity to ensure quality programming

The Sierra Leone Cholera Response was well served by rapid and clear requests for additional and expert staff capacity, and by Oxfam having such expertise available at short notice.\(^{45}\)

When the cholera team were at full capacity with the core structure, out of the 66 staff who worked on the Cholera Response; eight were filled by HSPs, four were filled by International Registers, 47 were filled by Sierra Leone nationals and seven were filled by national staff seconded from other country programmes.

In general, the staff recruited were regarded as being skilled and experienced\(^{46}\) and the support from HR in Oxford, the region and in-country was considered very good throughout the response.\(^{47}\) Sitreps alerting of insufficient capacity were only produced in the first three to four weeks; from September 2012 onwards there were no significant reports of under-capacity or recruitment issues.

All incoming staff had terms of reference and/or job descriptions (many of which were modeled on those in Oxfam’s cholera guidelines). Most HSPs and seconded staff carried out end of deployment appraisals, which were overwhelmingly positive. Inductions and training on Oxfam, the Code of Conduct, Oxfam’s cholera guidelines and other relevant issues and were provided to all of staff who were new to Oxfam within a few days of starting their employment.

Based on this analysis, it is considered that Oxfam **met** the standard for HR.

### Table 4: Recruitment and retention of key management staff in the Sierra Leone Cholera Response

<table>
<thead>
<tr>
<th>Position</th>
<th>Date requested (approx)</th>
<th>Date started (approx)</th>
<th>Time taken to fill position (estimate)</th>
<th>New Recruit/Redeployment/HSP</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cholera Coordinator 1</td>
<td>13/07/2012</td>
<td>22/07/12</td>
<td>1 week</td>
<td>HSP</td>
<td>Note: 3 individuals covered this role. Coordinator 2 was a short gap cover</td>
</tr>
<tr>
<td>Cholera Coordinator 2</td>
<td>07/08/2012</td>
<td>20/08/12</td>
<td></td>
<td>Redeployment</td>
<td></td>
</tr>
<tr>
<td>Cholera Coordinator 3</td>
<td>07/08/2012</td>
<td>20/09/12</td>
<td>2 months</td>
<td>HSP</td>
<td></td>
</tr>
</tbody>
</table>

\(^{45}\) Sources: Sitreps 1-4; RTE October 2012.

\(^{46}\) Source: SWOT

\(^{47}\) Source: RTE, October 2012
## Evaluation of Sierra Leone Cholera Response – Project Effectiveness Review

<table>
<thead>
<tr>
<th>Position</th>
<th>Date requested</th>
<th>Date started</th>
<th>Time taken to fill position (estimate)</th>
<th>New Recruit/Redeployment/HSP</th>
<th>Comments</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PH Technical Coordinator 1</strong></td>
<td>15/08/12</td>
<td>5/09/12</td>
<td>3 weeks</td>
<td>HSP</td>
<td>Initial HSP sent as interim cover while awaiting long term deployment</td>
</tr>
<tr>
<td><strong>PH Technical Coordinator 2</strong></td>
<td>15/08/12</td>
<td>Oct 12</td>
<td>&gt; 1 month</td>
<td>HSP</td>
<td></td>
</tr>
<tr>
<td>Logistics Manager</td>
<td>13/07/2012</td>
<td>23/07/12</td>
<td>2 weeks</td>
<td>Register</td>
<td>Initially requested a logistician who was promoted to Logistics Manager</td>
</tr>
<tr>
<td>PHE – Freetown</td>
<td>26/07/2012</td>
<td>9/08/12</td>
<td>1 week</td>
<td>New Recruit</td>
<td>PHE sent immediately, however took on role of Cholera Coordinator</td>
</tr>
<tr>
<td><strong>PHE – Tonkolili</strong></td>
<td>15/08/12</td>
<td>22/08/12</td>
<td>1 week</td>
<td>HSP</td>
<td></td>
</tr>
<tr>
<td>PHP – Freetown</td>
<td>13/07/2012</td>
<td>25/07/12</td>
<td>1 week</td>
<td>Register</td>
<td></td>
</tr>
<tr>
<td>PHP/Prog Mgr – Koinadugu</td>
<td>22/08/12</td>
<td>10/09/12</td>
<td>2 weeks</td>
<td>HSP</td>
<td></td>
</tr>
<tr>
<td><strong>PHP – Tonkolili</strong></td>
<td>23/08/12</td>
<td>30/08/12</td>
<td>1 week</td>
<td>Register</td>
<td></td>
</tr>
<tr>
<td>Prog Mgr – Freetown</td>
<td>15/08/12</td>
<td>8/09/12</td>
<td>1 month</td>
<td>HSP</td>
<td></td>
</tr>
<tr>
<td><strong>Prog Mgr – Tonkolili</strong></td>
<td>15/08/12</td>
<td>3/9/12</td>
<td>3 weeks</td>
<td>HSP</td>
<td></td>
</tr>
<tr>
<td>HR Coordinator</td>
<td>24/07/13</td>
<td>4/09/13</td>
<td>&gt;1 month</td>
<td>Register</td>
<td></td>
</tr>
<tr>
<td>Logistician – Tonkolili</td>
<td>23/08/12</td>
<td>3/09/13</td>
<td>2 weeks</td>
<td>HSP</td>
<td></td>
</tr>
<tr>
<td>Position</td>
<td>Date requested (approx)</td>
<td>Date started (approx)</td>
<td>Time taken to fill position (estimate)</td>
<td>New Recruit/Redeployment/HSP</td>
<td>Comments</td>
</tr>
<tr>
<td>-------------------</td>
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<td>----------------------------------------</td>
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<td>--------------------------------------------------------------------------</td>
</tr>
<tr>
<td>Finance Manager 1</td>
<td>23/08/12</td>
<td>7/09/13</td>
<td>2 weeks</td>
<td>HSP</td>
<td>Initial HSP could not complete full assignment hence replacement</td>
</tr>
<tr>
<td>Finance Manager 2</td>
<td>10/10/12</td>
<td>5/11/12</td>
<td>1 month</td>
<td>Redeployment</td>
<td></td>
</tr>
</tbody>
</table>
Appendix 1 - Sources of data

Internal reports

1. Situation reports 1–16
3. Real Time Evaluation of Oxfam’s Response to Cholera Outbreak in Sierra Leone (Richmond, Hawkings & Holland, November 2012)
4. Sierra Leone Cholera Activity Report (October 12, October 14, November 7, November 14, November 21, November 28)
5. Telecon minutes – October 4, 2012 HD – WAF – Sierra Leone
7. Email update on visits to Koinadugu and Tonkolili, (Chagali, November 28, 2012)
8. Public Health Technical Coordinator
9. Oxfam Sierra Leone

Assessments

2. KAP Survey Report Oxfam Sierra Leone Cholera Response, Freetown (n.d.)
4. Problems found with the KAP Survey
5. Freetown – Cholera Response 2012 (n.d.)
6. Freetown Cholera Response Mapping (July 18, 2012)
7. Koinadugu Assessment (September 2012)
8. Tonkolili Assessment (August 2012)
9. Pujehun Assessment (August 2012)

Programme strategy and design

1. Oxfam GB Cholera Response Summary (October 8, 2012)
2. Sierra Leone WASH Cholera Strategy (October 2012)
3. PIP Outcomes (n.d.)
5. Sierra Leone Country Analysis (October 2012)
6. Revised Logframe (September 11, 2012)

Other

2. Various tools for cholera assessments and outbreak comprehension (Joachim Peeters, October 30, 2012)
3. Brief ToR for Rapid Assessment Tools Training (n.d.)
5. Sierra Leone at a glance: World Bank Profile (March 2012)
Monitoring, accountability, evaluation and learning

1. Monitoring Framework (n.d.)
3. Sierra Leone 2012 Cholera Indicators (n.d.)
4. Volunteers Questionnaire (n.d.)
5. Lumley Hospital Questionnaire (n.d.)
6. Water Point Reporting Form (n.d.)
7. Bi-weekly Jar Test Recording Sheet (Lamond, August 9, 2012)
8. Daily Recording Sheet for the Bucket Chlorinators (Lamond, August 9, 2012)
10. Guidelines for Focus Group Discussion, Monthly Satisfaction and Feedback Sessions (n.d.)
11. FGD Report Grass Field and Quarry (October 2012)
12. Post Distribution Monitoring Report First Month, Tonkolili (September 2012)
13. MEAL Handover Notes (October 9, 2012)
14. Gender & Cholera Vulnerability Analysis Research protocol for field research (n.d.)
15. Gender & Cholera in West Africa (n.d.)

Coordination

1. Oxfam Cholera Contingency Plan (April 2012)

Advocacy

1. Cholera letter to UN (August 27, 2012)
2. UN Response (August 29, 2012)
3. Terms of Reference – Alix Nijimbere, Humanitarian Advocacy Adviser
4. Press releases:
7. Donor article mentioning Oxfam response:
9. Press article:
   12. http://www.ft.com/cms/s/0/f438273e-ef2c-11e1-9da8-00144feabdc0.html#axzz2DdRdV6Oa
   16. Other:
Donor proposals and reports

2. Single Form Proposal (August 2012) and Final Report (March 13, 2013) to ECHO: Cholera containment and reduction in Western Area District, Freetown
3. Intermediate Reports to Unicef (August, September, October 2012)
4. Unicef Proposal and Workplan FORM – 4, Programme Cooperation Agreement with Oxfam Great Britain (n.d.)
5. Unicef CERF Budget (August 2012)
6. SLE 12-01 RIC Cholera Response, January 2013
7. RIC Sierra Leone Budget, January 2013
9. IOM Grant Application for Oxfam Cholera Response
10. ECHO budget final internal
11. DFID Rapid Response Facility: final report
12. Sierra Leone Funding Grip (October 2012)

Reports from external sources

2. Sierra Leone: Cholera Situation (WHO, October 16, 2012)
3. Sierra Leone Cholera Cases, Week 41 (OCHA, October 17, 2012)
5. Unicef Sitreps (August 8, 12 and 15, 2012)
6. UNOCHA Sitreps 1 and 2 (September 2012)

Human resources

1. Staff Requisition Form for PH Coordinator Cholera response, (August 15, 2010)
2. Staff Requisition Form for Logistician, Freetown (July 17, 2012)
3. Staff Requisition Form for PHE Assessment and eventually Team Leader, Sierra Leone (August 18, 2012)
4. Staff Requisition Forms for PHE Officers for Tonkolili, Koinadugu (August/September 2012)
5. Job Profile: Sub-Office Logistics/Administration Manager, Kailahun (n.d.)
7. Job profile: Cholera Response Distribution and Monitoring Officer (Lamond, August 14, 2012)
8. TOR – Funding Coordinator for Cholera Response in Sierra Leone (n.d.)
9. Sierra Leone Cholera Outbreak 2012. Jane Beesley TOR DRAFT 1.0 (September 2012)
10. Terms of Reference to conduct a Gender and Vulnerabilities analysis and Evaluation of Oxfam Sierra Leone Cholera Response (n.d.)
11. End of Deployment Appraisals for HSPs (n.d.)
12. Cholera Response Team Staff Spreadsheets (August 1; September 10; October 9, 2012)
13. Written test for post of PHP Assistant
Interviews and correspondence

1. Email: SLEA65 Additional 300K Loan Nigel Timmons (September 11, 2012)
2. Email: SLEA65 Additional 150K Loan A. Bastable (August 10, 2012)
3. Email: SLEA65 Additional 80K Loan G. Mackay (July 17, 2012)
4. Email: SLEA65 530K Loan Return Catfund (October 23, 2012)
5. Email: SLEA65 11k CatGrant 9K Loan P. Brennan (March 5, 2012)
6. Emails: Draft HiT report Sierra Leone (Grace Omner, March and April 2012)
### Appendix 2: Global Humanitarian Indicator: Degree to which humanitarian responses meet recognised quality standards for humanitarian programming

**Slow onset – drought, slow flooding, escalating conflict**

<table>
<thead>
<tr>
<th>Number</th>
<th>Quality standard</th>
<th>Met (6/6)</th>
<th>Almost met (4/6)</th>
<th>Partially met (2/6)</th>
<th>Not met (score 0/6)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Rapid appraisal of facts within 24 hours of pre-defined trigger, plans in place and scale-up or start-up commenced within three days</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Coverage uses 10% of affected population as a planned figure with clear justification for final count</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Technical aspects of programme measured against Sphere standards</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>MEAL strategy and plan in place and being implemented using appropriate indicators</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Feedback/complaints system for affected population in place and functioning and documented evidence of information sharing, consultation and participation leading to a programme relevant to context and needs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Partner relationships defined, capacity assessed and partners fully engaged in all stages of programme cycle</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>7</td>
<td>Programme is considered a safe programme: action taken to avoid harm and programme considered conflict sensitive</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8</td>
<td>Programme (including advocacy) addresses gender equity and specific concerns and needs of women, girls, men and boys and vulnerable groups[^48]</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9</td>
<td>Evidence that preparedness measures were in place and effectively actioned</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10</td>
<td>Programme has an advocacy/campaigns strategy and has incorporated advocacy into programme plans based on evidence from the field</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>11</td>
<td>Country programme has an integrated approach including reducing and managing risk though existing longer-term development programmes and building resilience for the future</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>12</td>
<td>Evidence of appropriate staff capacity to ensure quality programming</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

[^48]: Elderly, disabled, HIV positive, single women, female-headed households are examples.