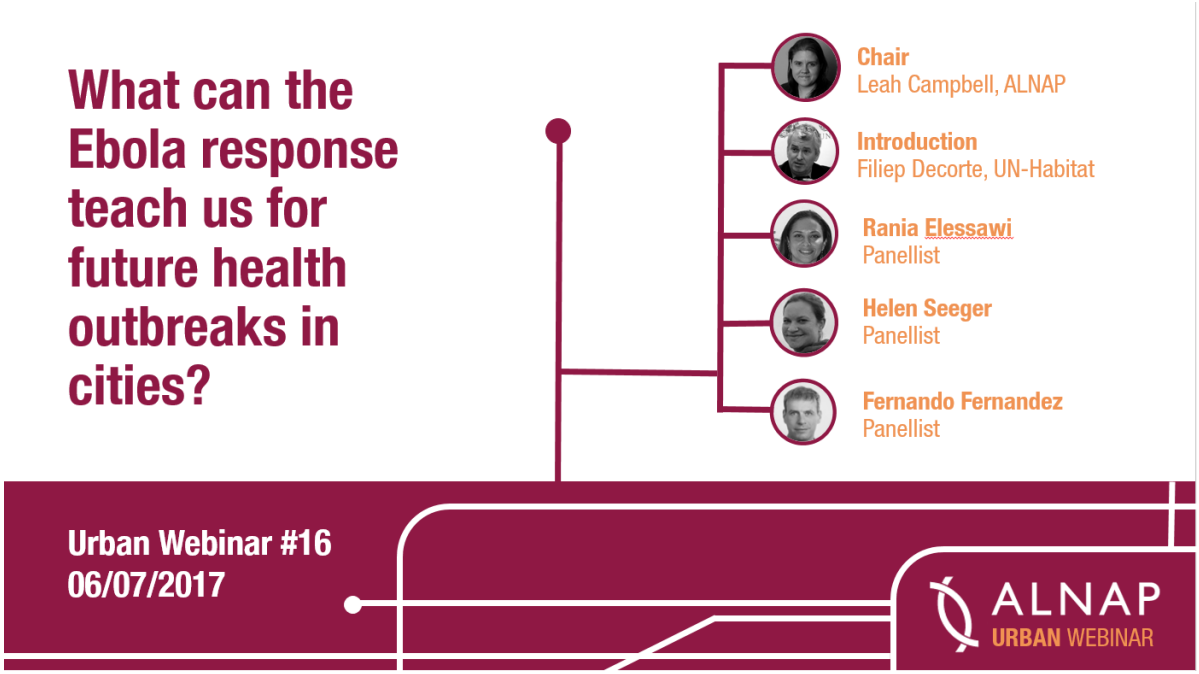
Transcript for urban webinar #16



Leah Campbell (LC): Hello everyone, and welcome to this latest instalment of ALNAP's urban webinar series. Thanks for making the time to join us today. We are going to have a great hour and a half, with some really excellent, and far more experienced colleagues than I, to share their experiences of the Ebola response in urban areas, and hopefully draw out some learning for future urban humanitarian responses. My name is Leah Campbell, and I am a senior research officer at ALNAP, and I will be both Chairing and presenting in today's webinar. In a few minutes, I'm going to tell you a bit about our panellists today, but before I do that, we wanted to start off by asking who's on the line with us today. So, we're going to launch a poll in a moment, that you can fill out while you listen to me describe who our panellists are today. There's a few different options, to tell us a bit about how much experience you, our audience, have with the Ebola response, and this will help our panellists gauge how much you know about the topic already. We're just having a technical issue with the poll, which seems to now be closed, but hopefully we can get it back up in a moment. So, I'll get started with the panellist bios, and hopefully we can get that poll back open again.

Our three panellists today are the following. We have Fernando Fernandez, who is a physician with a Masters in Public Health and a focus in healthcare management. Besides his work on healthcare systems, he's been working in different humanitarian contexts, for organisations like Merlin, WHO and ICRC. He now works for the Director General of Civil Protection and Humanitarian Aid Operations at the European Union, ECHO, and he went with ECHO to Sierra Leone during the Ebola response. We also have with us Helen Seeger, who is now a Reporting Consultant at the IOM, writing and editing reports on global migration and displacement, as part of the Displacement Tracking Matrix Team. She's been supporting humanitarian response work in various countries since 2008, including responses in Pakistan, Yemen, Nepal, Turkey and Lebanon, so all very urban crises there, and in 2015, Helen was deployed to Sierra Leone by Plan UK, and managed a large-scale project supporting quarantined homes in various areas. Our final panellist today is Rania Elessawi, who has more than 18 years' professional experience in international development, applying a human rights based approach, and results based programming, from planning to implementation, in development as well as humanitarian contexts. One of her key areas of focus and strengths has been working on building collaborative partnerships with civil society organisations, including faith based organisations, as well

as private sector organisations, media, advocating with them and leveraging or mobilising resources to support behaviour change interventions through programme implementation with UNICEF and its government partners. This was particularly instrumental for the social mobilisation and community engagement pillars of the response, during the recent West Africa Ebola outbreak, in which she worked in Liberia, throughout the first declaration of the country to be Ebola free. So, those are our three panellists.

We also have a special guest star, who I'll get to in a moment, after the poll is closed, who is Filiep Decorte, who was also involved in the Ebola response, and he's going to tell you a bit more about that. Filiep is now the Director in Charge of the New York office of UN Habitat, and has a long history that I could not possibly summarise into a paragraph, about his urban response, so, we are going to close the poll now, and I believe that'll pop up the results for us on screen. So, we have a little bit of a mishmash of you, but by and large, over half of you have read a little bit about the response, but were not involved in the response, so you're kind of like me. So, that's good to know, but we do have a few of you who were actively involved, or had some involvement, whether in rural areas or through short term deployments and HQ responses, and for those of you, I guess on both sides, if you have experiences to share, if there's something from your response that you were involved in, that you'd like to share, you can use the chat functionality, the questions function, rather, throughout the webinar, to share your own experiences, and I can certainly relay those, wherever possible, as they fit into the discussion. And for those who either responded or didn't, or have lots of questions and less answers, that is the functionality for you to use, as well. You can ask questions at any point during the webinar, and then we'll save them all up for the end session.

I'm going to turn to Filiep in just a moment. After we hear from Filiep, we're going to go through four different rounds of me sharing a little bit of the content from the papers that ALNAP has produced, capturing learning from the urban aspects of the response, and then hearing from a few of our panellists, and then at the end, we'll have about half an hour, hopefully, for questions and answers, some of which were submitted in advance, when you registered, and also any that you share with us, live in the webinar today. So, I'm going to turn now to Filiep, who is going to share some thoughts on how he got involved with UNMEER, and so we're going to turn now to Filiep.

Filiep Decorte (FD): Hi everybody. I hope you can hear me loud and clear, good morning from New York. So, I was part of UN Habitat at the time already, and had been with UN Habitat for about 15 years, and we got this request exactly for urban expertise to be seconded to the UN Ebola mission. I was the one that had made the case for it, so I was volunteered to go, and the agreement quite quickly was, when I got to Agra (ph 06.43), was to focus on Monrovia. We are talking end of September 2014, things had escalated drastically, and there was a clear sense that the fact that the virus had gotten into the urban areas was the main reason for it, but nobody really knew what it meant, and what it meant also for the response. So the question was quite simple. I had no experience in dealing with these kind of diseases. I did some quick research, and clearly, there was a lot to-, to start from. I was lucky that I ended up in Monrovia, because the representative of UNMEER there, Peter Graff, I think was very clued in, and basically said, 'Look, figure it out, and tell me how we can adapt a response to deal with the urban nature of the urban crisis.' I attended the first big coordination meetings, and one thing was very clear. Everybody was in the room, the big donors, the ministries, the key organisations, about 60, 70 people in the room, but looking at a screen of Liberia as a country, indicating the number of cases in the last weeks, and how things were moving forward.

For me, of course, as an urban expert, the thing that struck me, there was a very dark red dot on Monrovia. But the discussions were being held-, which was representing 50% of the cases at the time, but all the discussions were focusing more on the country level, and not really trying to pay attention to deal with Monrovia differently from the other counties throughout Liberia. So, the first question

was, 'What is happening within Monrovia? What is the breakdown of what is happening, and where is it happening? Which neighbourhoods, and why in those neighbourhoods?' There was no data available, so the first thing, exactly, was to try to get some data that was allowing to break it down, and understand the dynamics across the city. It took me a while to find somebody in the CDC, the American Centre for Disease Control, that basically, in his spare time, was linking some of the data he was collecting from the treatment centres to the, kind of, neighbourhood map of Monrovia. So, I worked with him to make that map. At the same time, I had received from the Bureau of Statistics, kind of a breakdown of the areas of origin in the different neighbourhoods in Monrovia, and particularly the slums, and it was very clear, there was a clear link between where cases were emerging, and people's areas of origin, and in Monrovia, at the time, more than 50% of the people were not born in Monrovia. That's a very important point, because looking into it, Monrovia, of course, has quite a high degree of slums. Slums that were created mostly after the civil war, where people from the countryside and further had arrived in Monrovia seeking safety, and then basically had never left. Were not given access to proper land, so ended up in slums, and fuelling the growth of slums with very bad conditions, sanitation-wise, very high density, but very importantly, a very high degree of mistrust with the government.

One point in case was West Point, which was the famous slum that had been quarantined by the army, shortly before, had resulted in violence and quite a number of deaths, as people tried to revolt and break out of the quarantine, and I came across an article in the New York Times, where they were interviewing Mosoka Fallah. Mosoka Fallah was a doctor, trained in the US, that basically had spent his first years in West Point in the slums, and the article was describing how he was trying to recreate some of the coping mechanisms that existed at the end of the civil war, and he was basically saying, 'Look, even West Point as a slum, it's seven different communities. Seven different backgrounds. Seven different links with different areas. Seven different sets of behaviours, based on their cultural profile, the way they were handling the death, for instance, and to care of the sick.' He basically said, 'Look, it's important to understand the diversity, and it's important, also, to build mechanisms of communication, of engaging these communities, to take into account (? 11.37). And for me, I quickly met Mosoka, and that's-, we-, I mean, for me, it was the main start of coming up with a more tailored approach to the crisis. The main point, and of course, I came across Rania, who's going to speak next, in UNICEF, how do we change communication? How do we change from the key components of the response, specifically tailor them to the urban area? Going back to the first meeting, the main absence at the meeting was the mayor. The mayor of Monrovia. None of the mayors of greater Monrovia was at the table, and I went to ask her, 'Why are you not there?' and the answer was very simple and disappointing. She was not given a role, she was not listened to, and so she decided, 'My time is better spent going out to communities, going out to markets, going out to the bus stations, going out to the different neighbourhoods, to engage community members directly,' and she was mobilising community leaders from the different neighbourhoods, into her municipality, into the city hall, and trying to, exactly, get them organised, and exchange also experiences from the different neighbourhoods.

So, we ended up, after a couple of weeks, arguing and making a proposal to decentralise the response to Monrovia, giving the same level of authority to agree on how to do things, bring the mayor to the table, but also exactly tailor communications, tailor tracing mechanisms, adapt how you deal with death, to the specific context of the city of Monrovia, and for me, that was the great breakthrough, that we managed to obtain, after a month, and I'm very much looking forward to the more detailed analysis that ALNAP and Leah led in the aftermath, and also hearing more from the other colleagues on the call, and I'll leave it at that, for the moment. Over.

LC: Great, thanks so much, Filiep, that was such a useful overview, and also a kind of visual, kind of idea and concept, for those of us who weren't there in the response, to start-, to start thinking about

things. SO, we have a slide that has the four different papers, I'll just point out at the beginning, to kind of reference as Filiep mentioned. So, where this came from is that Filiep, after being seconded to UNMEER, sent us a message, as we're in touch, he's a member of our Urban Response Community of Practice, and had this idea, so we really have Filiep to credit, for putting this idea in our heads, that there was something urban and important to capture from the response, and that there was both some urban challenges, but there was also starting to be an actual urban response to this crisis. And so that's where the idea came from, to put together a sub-group of our Urban Response Community of Practice, which eventually turned into these four learning papers, which if you haven't already seen, you certainly should. The fourth one that's on the right-hand side there, actually includes a longer version of a kind of case study story on West Point, which is the informal settlement that Filiep was mentioning there, in Monrovia. So, we'll start off in talking about the first area that we're going to talk about today, which is communication and engagement. And I'm just going to give a few brief reflections that came out of this piece of work around this topic.

The first thing is around different notions of community, and what we found when we did this research is that humanitarians really struggled to respond overall to the scale of the challenge during the Ebola response, and in particular, this was often because of the, kind of, atomised nature of community and diversity among the stakeholders that were there, so it was harder to use traditional approaches to communication and engagement. You know, in urban contexts which are full of social and economic, as well as spatial connections, this idea of, kind of, a geographically bound neighbourhood as a kind of default community just isn't everything. It doesn't give you the whole story. People might more closely identify with their cultural or faith group, with their work colleagues which are not located nearby where they live, with friends and family spread out over a wide area, even outside the city. And so these different sorts of communities require different forms of communication and engagement, in order to be effective. The second point I wanted to make around this topic is also about, kind of, the diversity of stakeholders, specifically thinking about the kind of authority and leadership which might exist in an urban environment, and Filiep there was talking about the mayor in West Point. You know, in an urban area there are so many different organisations and groups that might be representative of one another or not, and whereas perhaps in a rural setting, you might be able to more easily identify and start to work with existing community structures, it's really hard to identify and understand what those might be in an urban environment, and this was certainly the case in the cities affected by Ebola.

The learning here is around the need to work with a range of stakeholders, including religious and traditional and cultural and government actors, and while this can be a challenge in terms of decision making, and knowing who to go to about what, and also coordinating, perhaps a larger degree of relationships and different kinds of relationships, it's also an opportunity, because it implies, you know, the ability to access local knowledge, build ownership and local acceptance. And to do this, humanitarians need to try and understand better the relationships between stakeholders, and also to consider local cultural dynamics. In particular, in the EVD response, it seemed like there was, you know, quite a long history of tension between government and population, that was an important dynamic to be aware of, because it shaped many of the situations that came up in the response, including the degree to which people would accept the messages and orders that came from government, and that was important to understand.

And the last area is around messaging. We found that, particularly early on in the response, where a lot of energy was put into informing communities, despite a lot of information that was distributed, afterwards, people were saying that although they got that core message, that Ebola existed, could be transmitted, they had more-, questions of more depth that they didn't know what to do with. That messaging, kind of, was a bit too, perhaps, basic, and didn't meet the needs and realities that they were, you know, kind of confronting, such as what to do with those people who were already infected.

And because of the initial communication, being oftentimes dramatic or negative, you know, 'Ebola kills! There is no cure! Don't touch people!' these messages were scary, and so they often had the unintended effect of motivating people to stay away from healthcare because, you know, 'Well, if there's nothing we can do about it, you know, why go into a clinical environment? Why not stay home with family around?' And some of the messages also were a bit clinical, and they weren't understood by communities or made unreasonable demands, that people just, you know, completely avoid touching anybody, or using any public transport, but at the same time requiring that people take the ill to treatment units.

These approaches both created confusion and also panic, and in some cases people hid their sick relatives, which in the early stages, really disguised the true extent of the response. And while many humanitarians recognised the huge amount of misinformation, they perhaps did not effectively understand how this had been spread, or how to stop it at its source. So, those are a few points that came out from the research we did around this topic of communication and engagement, and I'm going to turn to our first panellist, Rania, to share her own experiences relating to this. So, take it away, Rania.

Rania Elessawi (RE): Great, thank you so much, Leah, and it's wonderful to hear Filiep again, on a webinar on this, and it brings back so many memories, as well. So, what I'll just start with saying, because I also don't want to reiterate so much that you've already spoken so well about, and Filiep, as well. I think one of the things that was right at the crux of this response in particular was, Ebola was not going to be tackled or stopped if people did not change their behaviours, and that put communication right at the core, and communication to whom was the biggest issue, because it had to stop among the populations. So, how did we then focus in on how do we try to understand what do we mean by 'community'? And then how does community engagement evolve, and how social mobilisation evolve? And right at the centre of that, or the heart of that, was that whatever we did, whatever we communicated, we needed to build trust, and I think that you spoke very well about this, talking about the range of stakeholders that became involved. Because one of the things is that, not only are communities just not cohesive, they also have very intense and complex power and social structures. So-, and urban communities bring even more challenges, because it's even more diverse, and even more dense.

So, what would be our entry points, therefore, within communities? Because communities were trying to take action to protect themselves. Of course, within that, there are varying degrees and capacity and knowledge amongst the different stakeholders, and people, because information, as you mentioned, fear and what was happening, and people could see their loved ones and family members and friends dying in the streets, Ebola was touching everybody. So, how did we tackle that fear of, it was so intense right in front of them, what would people be able to do for themselves? And what would be, you know, the triggers for action amongst the communities? Like, what could we do, or what kind of information could be provided to communities so that they would be motivated to be able to take their own actions? And how would that process of efficacy evolve? Because that power of everybody collectively addressing stopping Ebola, and knowing how to stop Ebola, and protecting themselves, and their families, but not only that, that if they knew someone that did get infected, how did they begin to also evolve an understanding of what they can actually do? That if someone got infected, that they can actually seek help? And of course, there were multiple, also, variables and factors that infected communities would get quarantined, and as Filiep mentioned, what happened in West Point.

So, there were so many different scenarios, especially within an urban context, that needed to be taken into account. So, as-, and as he rightly mentioned, in the beginning, it was very strictly, heavily driven by the Ministry of Health, because our traditional mechanisms of community engagement, or

the interfaces with communities, was through health workers, or extension workers, or whoever were linked to the health system that would interact with communities. And particularly in the urban settings, in Monrovia in particular, I'll focus on that, there were different divisions within the Ministry of Health that were involved in the response. So, one was the Community Health Department, which had its structure of community health workers. And then there was a Health Promotion Department, which were more programme managers that would talk about the messaging and the information. So, UNICEF particularly brought some value, in that in where we were coordinating a social mobilisation structure, and beginning too being able to organise who would we engage with? What were the relationships amongst those different stakeholders? But critically, in that, was who did communities touch the most?

And I'd like to just speak about one specific dimension, that happened during the Ebola response, as well, is the engagement of anthropologists. One that we did-, the UN did work with a lot, was Juliet, and she-, actually, Juliet Bedford was actually contributing to these papers, as well, and then the linkage with networks of anthropologists, to be able to understand community dynamics and the different dimensions within the community. Who was the most influential in decision making? If people were to trust information coming from a specific source, who would they trust? Is it their community leader? Is it their elected representative? Is it their health worker? And then among all of those different groups, how did we ensure that they all received the same information and-, so that to enhance that reassurance, that if the message is the same and the information is the same, people would understand what they would need to do, in the event that someone they knew was-, got Ebola, or how to prevent it from being transmitted. So that was a major dimension, to be able to really understand the community dynamics, so that when we planned the community engagement intervention, there was a synergy amongst the different stakeholders that were interacting with the community, and that facilitated entry into the community, because at the beginning, I think there was a lot of scrambling and, you know, 'Let's just get information out,' and if there was a new issue that came up, 'Okay, what kind of message can we provide?' But it wasn't so much the messaging, it was who was delivering the message. And I think that is very critical to keep in mind, whether it is at the rural level, but especially at the urban level, because over there, you also have multiple sources of communication media that come in. Social media, radio, access to, you know, national TV, and so the information comes from so many sources, and so do rumours. So how communities would be able to respond to that, understand it, critically process it, and be able to continue to protect themselves.

Because Filiep picked up on this, and I wanted to just elaborate a little bit more on it, because one of the critical areas, henceforth, was beyond just engaging the Ministry of Health, what were other ministries, or other administrative structures, or governance structures? So he mentioned the City Councils of Monrovia and Painesville, and we also developed a partnership with them, to engage those community leaders that Filiep talked about, and mentioned, to train them, as well, so that they could also support the health workers within the communities, because they were trusted, either elected or natural leaders, within the communities. So, having them also on board really made that push to be able to build that trust with the communities, and trust the system a bit more, and the information that was coming to them. And that's it, thank you.

LC: Great, no, thanks for that, and I'm glad you brought up the anthropologists, because certainly that was something that I found really interesting, it's the first time I've seen that, that group of specialty being brought into a response, and I think it was so critical for this one, so thanks for sharing that, and also giving some specific examples to illuminate my more general comments. We're also going to turn to Helen, next, and get her thoughts on the same topic. Helen, go ahead.

Helen Seeger (HS): Thanks very much. I wanted to talk a little bit from a programmatic perspective, about how we approached communication, to adjust and tailor our programming specifically for the

urban context. So, as Leah mentioned in the intro, I was managing a project that was distributing food packages to quarantined homes, and also, as the response went on, we started decontaminating houses that had had a sick patient or a body removed, and getting rid of people's mattresses, and any other soft furnishings, and decontaminating latrines, to make the home safe for the people who were still living there. So, we had a standard package, a food package that had been developed early on in the response, in the east of the country in (? 28.58) and Kanima (ph 28.59), in a more rural context. But as it moved to the urban area, and Free Town, we didn't have much information about how-, how appropriate it was still going to be, once we were there in a different scenario. And these were not normal food distributions as we might see in humanitarian responses all over the world. The aim was to provide people weekly packages with everything that they needed, so that they didn't leave quarantine. That was the ultimate aim. So, quite different from providing the core staples or starches or proteins that people would then top up on their own.

So, for us, the key thing was to-, how could we listen to people and gather feedback in a real-time, kind of, ongoing basis that was fast enough for us to adjust our programmatic approach and our food packages? But also the process of decontamination. How could we tell if it was working, and if not, how could we find out fast enough how to adjust? And one of the opportunities that the urban context provided was the fact that we knew, from the knowledge, attitudes and practice surveys, that cell phone usage in Free Town was much higher than in other parts of the country. We also knew, from Plan's existing work, that youth were a big resource, and we had some ongoing work with the youth who were generally very tech savvy, very enthusiastic, and relatively time rich, compared to maybe older or younger people. So, we tried to engage both technology and also these youth resources, to do a range of activities, but mostly focusing around SMS surveys, also youth reporters, but also connecting those youth-, using those youth reporters to connect to parts of the community that weren't perhaps quite so tech savvy, so to overcome some of the bias in use of technology, to include people who didn't, themselves, have mobile phones.

So, we actually got a lot of very useful information that way, that helped us to, for example, find out that people were breaking quarantine because we didn't put chilli powder in our packages, and something as small as including chilli powder made a big difference. And that the rice we were providing was not the right kind, and various other things that we used to improve the response. We were really able to gather a lot of data about the fact that the water and sanitation situation in the quarantine was abysmal, and we used that data to advocate very strongly for more attention to be put, from WASH partners onto sanitation and water efforts in the-, under quarantine. So, that was something we were able to do because of the urban context that worked quite well.

LC: Great, thanks Helen, and thanks for starting to lead us into the next topic, as well, which is quarantine. I wanted to say, at the start of this, that it sounds-, you know, this issue of quarantine might sound like quite a unique issue that probably doesn't come up in a lot of humanitarian crises, but a lot of the learning, actually, I think that comes out around working in this context of quarantine is really about issues that do come up in other urban crises, you know. So, I wanted to point out a few things about governance, about coordination, about the kind of logistics of working in, kind of, such extreme density, all of which I think you will find relevant for future urban crises. So, on governance, in the Ebola affected countries in West Africa, you know, the decisions around quarantine are made by the government, and in some cases, quarantine was enacted at a household level, and made a lot of sense, and in others it was used as a measure of social control, rather than perhaps a public health, sound medical decision. And in all three of the affected countries, with the government taking leading roles in the response, and the involvement, then there was quite a lot of involvement of different layers of government, which is, I think, what Rania and Filiep were getting at, in terms of the, lots of the different ministries involved, and different layers. And all that, and understanding, you know, how

decisions are being made, and who is the right layer, or person, to speak to, is a lot more common in an urban environment, particularly in capital cities.

And I don't know, really, how much effort was put into understanding the political context, and using this to kind of support, perhaps, advocacy around quarantine, because the research didn't end up finding much examples of this, but that doesn't necessarily mean that there wasn't action on this by humanitarians, it was just a topic we just didn't get to in the research. So that would be perhaps interesting to see if anyone has any thoughts on that. In terms of coordination, you know, in order to be effective, as a measure of reducing the risks of transmission, quarantine households needed to actually remain quarantined, you know, and be there and be willing to stay in their house all day and every day, in the required period, and this is why the interventions that Helen was just talking to you about now were so important, because without access to food and water for drinking and bathing, and assistance with decontaminating their belongings, and so on, it wouldn't be possible for quarantined households to comply with the quarantine order, and even things, like, as Helen was mentioning, you know, the spices needed, or the food that they actually wanted to eat. You know, if someone says you have to stay in your house but-, and I'll give you some food, but it's not food you like, then you know, I'm still going to leave my house, and go and get what I need.

So, the understanding of this was really important, and as was the coordination, because the-, you know, people weren't quarantined, necessarily, in a nice orderly group or row, or on the same, kind of, timescale. Each day, new households were added to quarantine lists, and these were located over a vast area, so really, the work that was done to coordinate the various organisations, providing support to quarantined households, over the area, was also important, because of the cost of gaps, and also the cost of duplication that could lead to even more transmission.

And the final area is around this context of density, kind of navigating these informal settlements, which are really, perhaps, best highlighted by this issue, because the close proximity between dwellings, shared water and sanitation facilities, really challenged whether quarantine was possible to even enforce, and it also had huge logistical considerations for those trying to respond, you know, even in other situations, where you have density, you can get close and have people come to a central distribution place. In this case, you know, people had to get these large quantities of items across a dense area, in some cases without any roads, and only pathways, to access each household, you know, for the people who could not leave that house. So, you know, that's a huge logistical challenge of density, and I know that some of our panellists were involved in doing this sort of response, so perhaps they'll have some light to shed on this. So, I'll turn first to Fernando, to hear his thoughts about how to navigate this kind of context of quarantine, and similar situations, in future urban responses.

Fernando Fernandez (FF): Okay, thank you Leah, thank you very much. First of all, good morning, or good day, to everybody. First of all, I'd like to encourage people to read the very nice documents that Leah has made, which I think summarise a lot (? 37.19)-, a lot of the issues that we encountered in this response. And particularly, the aspects of-, the implications of a response in an urban setting, versus the typical response that we would have in a rural setting. Now, quarantine is one of those examples. In previous outbreaks, typically, the authorities will put down the quarantine the whole affected area, surrounded by army, whatever, making the whole area, in that sense, already isolated. This is not something, though sometimes they try this, this is not something that could be done in West Africa, for many reasons, which may not be relevant right now, but what clearly (? 38.15) is that it is not something that you could normally do in an urban setting, as the case described from West Point described very clearly, very well explained.

The first thing I would like to say about quarantine is that it always a desperate measure. It is a measure of last resort. When we cannot control an epidemic with other tools, with other things, sometimes

authorities need to resort to the quarantine. But then the authorities have to be humble, and have to also acknowledge that in their communication. They have to explain to the people that this is not the first choice, this is because they cannot do anything else, because they are overwhelmed with the situation, and that will help to build a little bit the trust, and to buy the compliance a little bit of the population. Unfortunately, it was not always the case.

Then, as (? 39.21) recommendations of the group of experts who came after the Ebola outbreak, as we said, but the rationale for quarantine had always been made very explicit, and understandable to the population. The people, at the level, they need to understand why quarantine is important, and why is quarantine put on them? So that they can know how to comply with this quarantine. And if these explanations are not given, then it's going to be very difficult to implement it, even if you tried to enforce it with police, army or whatever. People will not respect it, and it will not be very useful, which is critical, because the quarantine has, as (? 40.13) very clearly explains, has a lot of problems. There is violation of human rights, there are plenty of issues and principles that have to be followed, but most important of all, it's going to break a lot of social consensus, it's going to create a lot of unrest amongst the population, if on top of that it's not effective, then what's the point, right? So, in order to make it effective, one of the things was that the rationale to put on the quarantine should be very clearly explained to the population. And when that rationale is gone, it's over, it no longer applies, then the quarantine should be removed, and if it has to be continued for some other rationale, then the new rationale has to be explained to them, to the population. Otherwise, people will lose confidence and will not respect it.

The other thing is that when, and this is very important, when you are putting the quarantine, for us, very clearly, coming from the humanitarian (? 41.21), you very well, you know, mentioned it, this was not suggested or imposed from the humanitarian. This was coming clearly from the health authorities, at least in the care of Sierra Leone. It was coming from the authorities very clearly. But they-, one thing that we need to remind constantly, is that if you're going to put in place quarantine measures, you still need to respect the human dignity of those people who are put under quarantine. And that means a lot of things, but it means, to start with, it means that you need to make sure that at least the basic needs are covered. This may sound like very evident, but it was not always very clearly understood. I mean, these people will still need to eat every day, but they will also need water every day, and that is-, when they started putting in these quarantine measures, it was not always well thought by the authorities around this.

And, the people who are going to be going to quarantine, as I said, they need to be informed, and they're probably going to need some sort of extra psychosocial support so that they can cope with it. Something like the food, when you put quarantine in a rural setting, well, people normally have stored food in their houses, because of the crops, because of the (? 42.53), so they are used to live at least a few days with the food they have stocked. But in an urban setting, a lot of people need to buy their food on a daily basis, and that was found in West Africa, that (? 43.08) in most cities. I mean, people don't store food for days in their houses. So, very often, you put them in quarantine, they don't have time to go and buy the food, so all of a sudden they cannot leave, and they don't have the food in the house. Very often they don't even have the cash to buy the food. So, you need to think of how to bring the daily needs of food to these people, but also the daily needs of water, and that has a lot of logistic implications and importance.

Another thing which was critical, when it comes to informing the people, our communication was critical. People need to understand the disease that we're talking about. How it can be transmitted. How-, what can they do within their house to ensure that, although they are quarantined, that other people do not get infected. How can they protect those that don't have the disease, (? 44.14) the disease from those who could have it. And these communication campaigns needed, in the case West

Africa it was critical, and very difficult, they need to fight against a lot of misconceptions, a lot of rumours, there were a lot of vested interests to spreading false rumours and false interpretations for whatever. For political reasons, for whatever reasons. But the truth is that that is affecting the campaign, because the messages do not-, the really important messages in the actual (? 44.50), this is not necessarily very clear to the people.

Then, another additional (? 44.58) between urban and rural, is that ideally, you need a certain-, certain collaboration and certain commitment from the communities that are going to go into quarantine, otherwise it will not work. The idea of quarantine will be some sort of self-isolation. You may be difficult to go to that extreme, but clearly you need some commitment, some collaboration from them. That is normally a little bit easier in rural areas, but it's very difficult in urban areas, because of the way the communities are composed, because the people don't-, they are not necessarily families among themselves, like in rural areas, they don't necessarily have the same idea that (? 45.51) community. So, making them get together into such difficult decision of isolation, in urban areas, is much more difficult. Not to mention that around the urban areas, and it has been mentioned before, when it comes to diseases, typically those more at risk are in the slums, are in what we like to call informal settlements, that are the poorest areas, the ones with least services. The areas which typically, the newcomers, first, when they settle into the city, that's the first place they go to, until they settle down in some other areas. Then, well, normally, there are worse, if any services, (? 46.46) West Africa, so we've got the slums we're talking about, they didn't have any-, almost any service, and people needed to go and fetch the water on a daily basis every time they wanted to drink. So, how can you put people in isolation if you don't bring them the water that they need to drink? So, it's a very, very tricky part that we need to be taking into account.

And to finish, I would like to make maybe two reflections on this quarantine in urban settings. One is that, because of this, the way these people live, and these slums are so densely populated, in cities, it might be necessary to think more about putting people under quarantine in some sort of facility, rather than in their own homes. First of all, because what they call home, very often, is a very limited space, with a lot of people around them in a very tiny space. Of course, this has cost implications, and this has, yes, a lot of other consequences, but when, as I said, quarantine is a desperate measure. So, if you really want to resort to this type of thing, maybe you need to think in a way that at least it's effective. Otherwise, you try to implement-, you impose the quarantine, but it's not going to be respected. The other thing is that for the people who are put under quarantine, people coming from these slums, from these areas, those people generally do not have savings or capacity, and they depend-, these people tend to depend on a daily income to ensure that they eat. So, this is one of the things that may need to be taken into account, is that it's not only providing these people with the basic needs, it's also ensuring that these people get their daily income, without having to leave the area that they're supposed to be quarantined. Otherwise, then, people will have to go and find their daily needs, they will not respect the quarantine. And I will leave it here, and pass it over to you, Leah.

LC: Great, thanks Fernando, and thanks all of our panellists so far. You know, I'm-, already I'm seeing the linkages between all of the various comments coming together, and we've certainly got a tonne of questions that have been coming in, so in the interest of time, what I'm going to do now is give the reflection from my side on the third issue, population movement, as well as the fourth issue, which is just kind of all the other things that we couldn't fit into these four papers in a huge amount of detail, and then we'll go through another round of our panellists with as brief a comments as they fit in, which I recognise is hard because they have such a wealth of experience. So, to jump right into it, on population movement, you know, I think people are constantly on the move. You know, your livelihood, as Fernando was just saying, is most likely not in your home, and if you live in an urban area you have to travel to work, you make short, regular trips to the market, to local stores, to specialty stores, located in different places. You have friends and relatives dotted around the city, and also,

particularly, as was the case in this region of West Africa, you have social connections and economic connections that go from urban to rural environments, and other urban environments, and really to be an urban dweller is to be someone on the move.

And so population movement is, without a doubt, an aspect of urban responses. And for the Ebola responses, as a comment from Filiep came and pointed out, that he'd forgotten to mention, that, you know, the implication of this movement is that the virus, you know, can spread along with you, as people move. So, a lot of the efforts were to stop this movement, which perhaps seems like a, kind of, logical thing, you know, people increase transmission when they move around, so let's stop them moving around, and a lot, actually, of the control measures which were then put in place to try and stop this, ended up having unintended consequences of increasing untraceable movements, because if people really wanted to get somewhere, you know, they'd find a way to do so. They'd find a pathway or a route, or a way to bribe someone, or whatever they needed to do, to get there.

And I think this comes down to this point, again, around kind of engagement and communication and a lot of the stuff that Rania was talking about, in her first comments, as well as question that's just come in from someone who is asking, basically, you know, considering the difficulty of getting to everyone, even with the basic needs, in an urban environment, which led to so many people breaking quarantine, how-, you know, how effective is that really, as a tool? And I think it's the same question for how effective are these kind of efforts to stop movement, and the point we tried to make in the paper is that it's, you know, there are limits, and you know, as many things as you put in place, you won't be able to stop everyone, and so that really emphasises the importance of those, kind of, communication and engagement methods. Because the few examples I read about, of a more, kind of, community-led approach to monitoring movement, where areas would be able to monitor admission of people as they arrived into the area, because they were informed of what risk they held, is I think something that I wish we could have built more on, although that does, you know, raise questions about how possible that sort of thing is in an urban environment, with all that density.

The last thing I wanted to mention about population movement is just the kind of missed opportunity of using data about movement, from other sorts of sources. If you can't stop movement, it's at least useful to know where people are going, and there's a piece in the paper on population movement about the, kind of, missed opportunity of using call detail record data, and the message there is really around the need to prepare, because ultimately, it wasn't possible to use this data in the response because there was no agreement in place, and then there were too many kinks to kind of figure out live. So the message there is around kind of putting these sorts of things in place, because in any response, population movement, you know, is going to be an issue, whether it's a health crisis like this, where the movement really spreads the transmission, or in conflict situations, or even sudden onset disasters, population movement is going to be a factor.

And so, the last thing from me is just these other urban issues that came up. So, one of them is around pre-existing vulnerabilities. You know, in all three affected countries, the healthcare infrastructure and staffing and system really had a significant impact on the outbreak and the response. The concentration of facilities in urban areas meant increased movement of infected people who had to travel to seek care, and also the lack of infrastructure and staffing was a barrier to many receiving healthcare before, during and after the response. And this low health capacity really limited the response, especially in the early stages. Another issue is rumours and misinformation, which I think we covered a bit under communication, but really, it's to point out that, you know, in a vacuum of effective communication, the knowledge gap will be filled by rumours and misinformation, and just kind of paying attention to that.

The last thing I wanted to mention, because it relates, as well, to new work that ALNAP is doing around this, is really the importance of understanding context, and this is as well what Filiep had mentioned in his opening comment, about the need to understand the context, the culture, and how that would affect the response, and I think that with some exceptions, the example of anthropologists being brought in, this was a bit of a gap, particularly efforts to understand, perhaps, the politics and governance issues, as well as the population movements, and the drivers of that movement that really related back to social and cultural and economic reasons. And I think this gap is partly a result of painting the crisis, kind of, exclusively as a public health issue, and perhaps ignoring the broader range of issues that were involved in the outbreak, and that's one of the questions that's come up from our audience, as well, is how this crisis affected a range of sectors, because this epidemic caused much more than a public health crisis, and really disrupted a range of aspects, and failure to consider each of these leaves people vulnerable.

So, I think I'm going to move now to our panellists again for one more round, before we try and fit in some final questions. So, I'll go first to Rania, and hear her thoughts about both population movement, as well as any other urban issues, either ones that I mentioned, or any others that you encountered during the response. So, over to you, Rania.

RE: Okay. Thank you so much, Leah, and I think, actually, all of the panellists, Helen and Fernando and, as well as you, we've already covered so many different dimensions. So, I will try just to kind of bridge that link around what we did with community engagement, and the linkage also again with population movement, as well as the quarantine aspect, because as I mentioned, you know, I think what was really at the core was this trust issue, and building that trust, between the health system and people within the community, where they already had people that they already trusted, and being able to manage the fear that was around-, that was around ,that was just looming around during the entire epidemic. So, I think one of the things that I'd like to highlight is also that a lot of the time, one of the fears that drove people from, also, rural areas to urban areas, was the stigmatisation that would happen in rural communities, especially for people that were infected by the virus, or related to somebody that was infected by the virus. And again, because of how dense the population is, and the urban structures, that people could disappear, basically, within those urban areas, they are so dense. So, that linkage between how community engagement and social mobilisation also worked with the contact tracing organisations, and how the ministry was able to also coordinate amongst them, and the different partners that were working for community engagement, social mobilisation, as well as contact tracing, to be able to find and identify people that were possibly infected, or infected others, or, you know, try to manage the mobility.

So, community surveillance, which you already mentioned, and self-monitoring within communities, there were lots of that that were set up, as the response went on, and there was better coordination, better information, more trust happening, because of the different types of stakeholder and influencers that were trusted, that were engaged in the community engagement and social mobilisation aspects. There was a better developed community surveillance, and that's why, when I started also speaking, I said, you know, the power of community also can't be underestimated. Although it's complex, I think as humanitarians working with governments and partners and communities, we have to challenge ourselves, and do a little bit better to really understand what were the triggers for action, and what were the drivers for communities, you know, to stay together and be able to stop the transmission of the course of the virus. So, yes, I think I'll leave it at that, and if there are any questions, that's basically what I wanted to highlight, and maybe just linking that to the last point, about what you mentioned about rumours and misinformation, that that kind of community trust, then, that was therefore built, we were able to address rumours and misinformation much better as the response went on, and there were multiple different types of technologies and tools, and as well as social networks being linked up together, to be able to address rumours and

misinformation, and as the response went on, that coordination also improved. So, I'll leave it at that, thank you so much.

LC: Great, thanks, Rania. We'll turn next to Helen, to reflect on any additional urban lessons you think there are from this response, and also this question that came in around, kind of, how this crisis affected a range of sectors. If you wanted to touch on that, at all, please, Helen, go for it.

HS: Okay, so as our programmes were implemented in both urban and rural areas, we're in a good position to compare how they were different in the two places. So one of the things we noticed was that providing water was much easier in rural areas, because often neighbours could be arranged to bring water in jerrycans, whereas in the urban environments, there was much less social cohesion, or perhaps neighbourly help, in some areas, and if the neighbours don't have water themselves, it's harder to convince them to share. One flat really sticks out in my mind, when I visited with our distribution teams, as being this multi-storey, half-finished building, with over 100 people living in it, and then the toilet for the nearby market was on the ground floor of this flat, and the police were trying to quarantine this building, and of course, any time-, if anybody else got sick in the building, that would just extend the quarantine for longer and longer, so you can kind of think of the challenges that are involved there. Another experience that sticks out in my mind is when our decontamination teams were travelling behind an ambulance going to remove a dead body from a shack that was just behind a market street, and the problems of crowd control and the security of people who were crossing the cordon, and just general much harder to keep control over the situation, and I think in humanitarian responses we like to plan, and we like in distributions to have our areas all set out, and in the very dense, urban environment, those kinds of things were just very, very challenging. Also, trying to find any locations for burying contaminated items, you might have heard that Free Town ran out of cemetery space, and they were having to bring bodies an hour, or an hour and a half out of the city, and that also caused issues with local communities over the perceived effects of the activities on nearby water supplies, whereas in the rural areas that wasn't so much of an issue.

To touch briefly on the question of the other sectors, I think protection is a very interesting part of the response that was not adequately recognised, initially, but as the response went on, people realised how important this was. We've talked already about psychosocial support to patients, also family tracing, including informing families where their loved ones were buried. I think, earlier in the response, there were cases of people being buried, or taken to hospital, and families had no idea where they'd gone, which obviously feeds into that rumour mill, and distrust and panic and fear that was quite negative and not helpful. And then ongoing work with orphans and separated children, and work to reduce stigma for both EVD survivors, but also workers, as the members of our decontamination teams, many of them told me that for the time that they worked with us, they weren't allowed to go home to their families, by their families, and would essentially sleep in their cars, and then work in this high pressure, high stress, very hot, physically challenging environment all day. So, you can imagine the difficulties there.

The last one I wanted to touch on is security, and I found that an interesting question, because I think, for me, it was the first time where I saw organisations having to respond to a very different kind of threat, or risk, to our normal kind of security issues that you might encounter in the field. I don't-, I think that organisations struggled to deal with the security threat from Ebola, and there were issues around concerns about the availability of medical evacuation, medical treatment in country, quarantine on return to country, risk to their families, that made the response quite specific, in terms of people's willingness or availability to deploy, as well.

LC: Great, thanks Helen, thanks for those really rich examples, as well. To kind of make sure that we get some questions in, I'm going to blend in, Fernando, your comments with one of the other

questions that have come in. I wanted to ask you if you have seen any-, had seen any innovative activities, anything that, you know, you think is a standout example of something that was new, and really was able to address some of the challenges that we've heard around the urban response, as well as any broader reflections you have on urban learning from the response. So, we'll go back to Fernando.

FF: Okay. Thank you, Leah. I think a good example of the innovative activity that we learned in this response, it took us some time to really build upon it, but we ended up realising it was the only way, is to build on the self-reliance of the community. It may take longer to explain that, but in the end, it's the only way to be effective, so they tended to come from the Ministry of Health institution, from the security forces, from the government, from the NGOs, UN agencies, all the humanitarian aid, the guys who know what needs to be done, doesn't necessarily ensure the type of response that you're going to need, unless you get the buy-in of the community, and that the community can somehow perceive that they can take care of their people. I think that was an interesting lesson. For me, another interesting lesson, when it comes to cities, urban settings, is that the same way that we consider the cities economic hubs, or communication hubs, when it comes to epidemics and disease, they are also hubs. So, the same way they attract people, (? 01.07.41), capital, business, artists, whatever, they will attract diseases, they will attract bacteria, viruses or whatever, because that's what people move in and out. Of course, it will depend on the type of transmission, but diseases are also-, sorry, cities are also hubs for diseases. So, whenever we see an outbreak, more and more, we have to think that the cities are high risk, and they don't need to be close, nearby, where the epidemic is taking place. It is because they are cities that they are at risk. So, that's something where we need to think carefully, the next time we are facing this type of epidemic, and don't think that it's only in a far, remote geographical area, that the outbreak will take place, but it will definitely be easy to involve cities.

Back to you.

LC: Great, thanks Fernando. Okay, to keep on going with the questions here, I'm going to go back to Helen, and ask for your thoughts on a question that's come in around communication channels in the urban context. Do you have any thoughts on what were the most effective communication channels that you were able to tap into with urban populations in this response?

HS: Sure. Yes, I mentioned in my first input about the fact that we used SMS surveys. I also found that WhatsApp was pervasive, especially in Free Town, in the urban areas, and that a lot of the rumours and the memes, and even the, kind of, gallows humour Ebola jokes that were circulating, were all being moved on WhatsApp, and we quickly realised that that was a very good way to reach people, as well, in a more positive way, and that the rumours and the stigma could also be combated in those immensely, kind of, sharable formats that would reach people well. Secondly, I think that radio was really critical, and looking back, I wish that we had realised that sooner, because I think one of the things we never quite got on top of in quarantine was how bored and scared and frustrated people were, sitting for weeks and weeks in quarantine with their whole family, and you know, never knowing if someone was going to get sick, and I think that providing radio to people in quarantine would have had a two-pronged benefit of being able to get them good quality messages, but also relieve some of that boredom. I definitely saw a lot of posters, billboards and paintings on buildings, but I would like to just echo what I think Rania and Fernando have also said, and you, as well, Leah, that I think a lot more needed to be understood about who do people trust in terms of the information, because otherwise, a lot of the, kind of, well-informed, well-intentioned traditional messaging, kind of, fell on deaf ears. There was such, especially in the early days, such a culture and feeling of conspiracy, and distrust, that there was an official Ebola message, but then something else was actually going on, and those rumours were much more-, unfortunately a lot more effective than some of our messaging, sometimes. So, I think more needed to be done, to realise, who was it that people trusted and

understood? I think some really important stuff happened, especially around engaging religious leaders, and traditional healers themselves, and not seeing the traditional healers just as vectors for disease spreading, in terms of illicit burials and things, but to actually engage with them as-, as communication channels that people would really trust.

LC: Great, thank Helen. I'm going to turn to Rania, as well, both on this one, and also just to make your life more complicated, Rania, I'm going to throw in another question, just because we're running out of time, and I want to get in as much as we can. And the question's come in from two people, so I'm going to combine it into one. One is part question, part comment, that's come in from one of our colleagues on the line, Linda Potit, who was also a really resource when we were putting together these papers. So, she'd written about, kind of, the differences between these different contexts, and that's the core of the question, and I wanted to share some of her reflections, before turning back to you, Rania. So, Linda has said that while, you know, it is hard to compare across the three countries, it's important to highlight the differences in the response, and so there were differences in terms of the approach to quarantine, of the different governments, where in Sierra Leone it was led from a more military perspective, with the Ministry of Defence in charge of security approach to the epidemic, really, you know, had an impact on how the response unfolded. And she refers to the comments I'd made about people, kind of, escaping and moving in untraceable ways. And near the end of the response in Sierra Leone, with some families being quarantined in hospitals, instead of their homes, she wondered if there'd been any research, or anyone knew anything about comparing that idea of, kind of, having people quarantined at home versus quarantined in a medical facility, which is something that Fernando has suggested as a possibility, though certainly more challenging, when you have such a scale of an urban population. So, if anyone does have any thoughts about that, you can certainly share them in.

She also pointed out the differences in each area, you know, each informal settlement, and even each, kind of, neighbourhood or sub area, in an informal area, or within an urban environment, that has its own leadership and needs to be engaged in a different kind of way. So, I guess going back to you, Rania, it's bot ha question of communication channels, and also thinking about when you have the outbreak both so different, and also the communities and people so different, across even, you know, even one city or one informal settlement, how you negotiate that. So, over to you, Rania.

RE: Okay, thank you so much, Leah. Yes, no, I'll just add a little bit to what Helen had said, because I think that this is really important, and while there was a lot of visibility of materials, I think that's really hitting it on the head, and coming back to communities and who communicates in communities, was the most critical factor throughout this response, and really trusting the people within the communities, as well. Like, because I think, exactly what Fernando was talking about, you know, humanitarians or others, or government officials, thinking that they know better how to interact within the communities, and how to build that trust, they needed to actually turn their ear to the communities and understand how to build that trust from that perspective. And I think, speaking on behalf of what happened in Liberia, that really, really evolved, quickly, because also, how the response-, how the disease transmission happened within Liberia, everybody was expecting it to be a lot worse. I mean, it was already bad enough. So, I think what wound up happening was, as soon as the pulse was put on the community, and it was like, 'How do we understand community entry a little bit more, the interactions?' and that's where we also worked with big organisations that also had networks of community radios, for example. And working with them, building their capacity, just to get the information out, you know, that standard information, or the information that we all understood that would help people to stop the transmission, what were the behavioural issues? So, working with community radios, working with religious leaders, was very big. So, we actually worked with the large inter-faith institutions that had their own networks. So, it was more about getting the

information out there, the same information to everybody, and then they went through their networks, they took it forward, because they were-, they had that trust already.

Other ones, it was mentioned, the traditional healers, Zoas, and community leaders, and working with institutions that actually worked with networks of thousands. So, during the response, in this social mobilisation arena and community engagement pillars, working with the government, I think there were mobilisers of tens of-, in the tens of thousands, and getting the information to them, and the they were taking it directly to the communities, because they were the ones already in the communities. And on this, also, sharing of information, especially to people that had family that were sick, there were rumour trackers, actually, UNICEF had worked with this, with USAID, as well as other partners, to set up rumour tracker systems, to be able to get information about what were the major rumours, and being able to respond through these different community leaders, or community leaders, and being able to address all these issues that were coming out through these rumour trackers. As well as in the Ebola treatment units, later on in the response, there was a tracker system that was set up, in which people would be able to receive at least SMS, and try to get some information, because that was a huge vacuum, and I think part of the trust building, again, was that when people would have a family member or friend, or someone they knew, going to an Ebola treatment unit, being able to get information and at least whether the person passed away, have closure that they died, or to know their progress, and if they were to be released, so to help their reintegration, and how (? 01.18.20) touch upon that area of, you know, the reintegration and stigmatisation, with people coming back after they were treated, and coming to be integrated and dealing with stigma within communities. So, that's on the communication channels part. There were vary many, I think, and as the response evolved, they were also strengthened

So, in regards to the quarantine, I'll speak specifically about Liberia, because I visited, actually, communities in urban areas, as well as rural areas, and from the context, of course, of humanitarian organisations, we are always looking from the rights angle. I think one of the things that we had to really critically balance was what was the government approach, and how could we best support, so that they had the most humane conditions? And I think that that was one of the areas that there was a lot of effort from organisations, national organisations, as well as the humanitarian organisations, to ensure that there was some type of coordination, to know the needs, and be able to support those communities. So, in Liberia, in the two communities that I had visited, and they were under quarantine, they were quarantined at home, within an urban context and at home. So, through, like, very extensive contact tracing, and being able to identify the radius, they were quarantined, and of course, again, in urban contexts, very difficult, very difficult to manage. But, it eventually worked, so, and we have that as lessons learnt. So, that's it from my side, on the quarantine situation in Liberia, but it was very different. It was not military driven, it was very much supported by Health Ministry, as well as partners, to be able to ensure that it was a bit more (? 01.20.19). Someone was always checking on a daily basis.

So, I remember one Saturday afternoon, where NGOs that had to provide food did not make their deliveries to a community, and this was immediately reported and dealt with, and even on a weekend, right, although no one was really having a weekend during that time. But, yes, so there were major issues, I'm not saying that it was-, it was perfect at all, but as it went on, there were mechanisms that were put in place to be able to respond to those issues that would come up, a bit faster. Okay, and that's it from my end, thank you.

LC: Great. Thanks, Rania. So, we are going to take two more questions, and go to Filiep and Fernando, for their final thoughts, but as we're getting to the end of the closing time of the webinar, I know that some people might have to go on to their next meeting, so I just wanted to say, in advance of those early exiters who have to leave on time, please do fill out the survey that will pop up on your screen,

and also be sent to you via email after the webinar. We really do take your feedback into consideration. And also, to let you know, we do record a video of each webinar, and also produce a transcript, and so those will be shared with you in the coming weeks, and so if you miss the last bit, you can catch up, and you can also share it with any colleagues. And finally, any questions we didn't answer, we'll be putting into the Urban Response Community of Practice, so please do follow on there. So, I'll turn to Filiep for our second to last question, because I think we have to really take advantage of having UN Habitat expertise on the line, and turn this one to you, which is, there's a question around whether the Ebola response in West Africa showed a need for improved urban planning, or what that could have perhaps brought to a crisis like this, if we were able to do that better, before and after crisis, in an environment such as these cities that were affected in West Africa. So, over to you, Filiep.

FD: No, thanks for that, Leah, and I think we underestimate the impact of informality, and people living in slums. We pointed to the issue of density, lack of sanitation, we pointed to the challenge of-, because informality means outside of formal system. So, the challenge of these people also being not part of normal discussions, not being-, not being asked for further advice, or their ideas, and so the lack of trust, the trust issues were, I think were major, in the case of Liberia, but I would say in all urban settings. Now, the challenge, of course, is that this is about managing urban growth, and maximising the amount of people who are part of the formal city, the formally planned city, the formally serviced city, and often, exactly this-, this is necessary at moments when urbanisation is accelerating, and at the end, again, of the civil war, when people were flocking to the cities, there was no capacity to plan. So, we do need to think through how we can manage urban growth, specifically when there's a big influx of population, because that's the moment when it needs to happen. The New Urban Agenda, which is the new global agenda on urbanisation, agreed in Quito last year, gives some guidance, but it's clear that it's a major challenge, but I would argue it is fundamental in ensuring better preparedness for these kind of problems going forward. And again, it's the kind of issues, unfortunately, that will come back to haunt us, and hopefully we'll take the lessons from it, and make sure we do plan our urban growth in these kind of situations. Over.

LC: Great, thanks Filiep. So, our final question, I'm going to turn to Fernando in a moment. Our final question is really reflecting on all the discussion we've had today. Fernando, do you have any thoughts on what practical things we can really do, to put these lessons from the Ebola response in West Africa, which is thankfully, now, you know, long over, but you know, crises like these are not. You know, we have the cholera outbreak in Yemen, we have other crises, certainly, affected by things like population movement across the Middle East and elsewhere, and there will be, undoubtedly, future urban responses where all of these issues comes up. So, you know, how do we-, what do we take forward, in terms of practical things we can do to make sure that this learning is taken forward? Over to you, Fernando.

FF: Okay, and we're going to see more and more of it coming, because the population is moving to the cities. We'll have more and more higher percentage of people living in cities, so yes, we're going to see more of that coming. I think, from Ebola, there were a lot of, you know, lessons learned, exercises, by a lot of organisations, (? 1.25.49). I mean, we conducted our own one with the European Union institutions, so there have been those exercises done, with this kind of, the big crisis, where a lot of people took a bit of reflection after that. And in the meantime, as a community, I think what is very relevant is that we document those lessons learnt, but (? 01.26.14) those documents. I mean, I think the documents are a very good example of what could be useful in future crisis, because people could go and look at them, and read them, and already take conclusions and examples, and see-, be able to learn faster on how to respond. It took us some time to be able to react, and to learn from this crisis. Hopefully we will be getting better and better for new crisis to come, which, they technically will also take place in cities. So, I think that documenting them is a good step. And make them available online.

LC: Great. Thank you. Well, thanks for that-, that final plug, Fernando, it's great, I didn't have to be the one to mention the papers, and also the COP, which, although the Ebola in Cities group is no longer, the Urban Response Community of Practice is still there, and I think, you know, I think also there's a responsibility for each of us to, you know, to take this learning as we go forward, into future responses, and to refer back to these examples, you know, there was certainly a wealth of them shared by the panellists today, and I know that you in the audience out there have a wealth of your own experiences, and knowledge ,and I think we are-, it's on our shoulders to take that forward, as well, and to share those examples with people, when we see these things in future. To end, I guess I really hope you've found this as useful and interesting as I have, listening to us over the last hour and a half, because I think, you know, the issues that we've covered here are really not unique to this Ebola response, you know, finding ways to engage with the municipalities, with dealing with dense and mobile populations, pre-existing vulnerabilities and informal settlements, and all the other issues we've spoken about, really do come up in all sorts of urban responses, and undoubtedly will in the future. We have so many questions come in that we weren't able to get to, questions about engaging with faith communities, you know, engaging with different types of local communities, dealing with reproductive health, all sorts of questions that have come up, and we just didn't quite make it to them, so, we'll be putting together a list of those we didn't get to, and putting those into the Urban Response Community of Practice, as well, and so please do get in touch if you're not already in the Urban Response COP, and we'll make sure that-, that you can get on that if you're not already there. So, thanks again for everyone for joining us, huge thanks to our panellists, as well as Filiep, for sharing their insights, today as well as all the 30 or so colleagues who shared their experiences with us while we were working on these papers. Thanks to my colleagues here at ALNAP, Maria and Alex, who have been behind the scenes, making sure that this webinar ran smoothly, as well as all of you, our faithful listeners, particularly those of you who've stuck it out with us, even five minutes over time. Thank you again for joining us, and we look forward to seeing you at the next urban webinar. Have a great day.

END OF TRANSCRIPT