UN EBOLA RESPONSE MPTF
PROJECT MONTHLY PROGRESS REPORT - *VERSION 1*
Period February 2016

Project Number and Title: #17- Strengthening EVD Surveillance, Community Engagement and Response for getting to and sustaining at Zero Ebola cases in Sierra Leone	**PROJECT START DATE[1]:** 10-08-2015	**AMOUNT ALLOCATED by MPTF** *(please indicate different tranches if applicable)* $ 2,073,205	**RECIPIENT ORGANIZATION** World Health Organization (WHO)
Project ID: 00096318			
Project Focal Point: Name: Elaina Davis E-mail: davise@who.int	**EXTENSION DATE:** 31-12-2015	**FINANCIAL COMMITMENTS**	
Strategic Objective (STEPP) SO1 – Stop the Outbreak	**PROJECTED END DATE:** 31-03-2015	**EXPENDITURES** 1,974,991 $	**IMPLEMENTING PARTNER(S):** Ministry of Health and Sanitation of Sierra Leone
Mission Critical Action MCA1 – Identifying and tracing of people with Ebola			
Location: Sierra Leone	**Sub-National Coverage Areas:** All 14 districts: Western Area Urban, Kambia, Port Loko and Tonkolili; without on-going transmission: Bo, Kailahun, Pujehun, Bonthe, Moyamba, Kono, Kenema, Bombali, Koinadugu, Western Area Rural		

MONTHLY PROGRESS REPORT RESULTS MATRIX

OUTPUT INDICATORS

Indicator	Geographic Area	Projected Target (as per results matrix)	Quantitative results for the (one month) reporting period	Cumulative results since project commencement (quantitative)	Delivery Rate (cumulative % of projected total) as of date
Description of the quantifiable indicator as set out in the approved project proposal					
Proportion of health facilities submitting weekly IDSR reports on time to districts	National	>80%	82%	73.4%	92%
% of districts which have functional IDSR	National	100%	100%	100%	100%

[1] The date project funds were first transferred.

systems					
% of contacts monitored on a daily basis and reported effectively	National	100%	62%	96%	96%
# of trained community health workers in implementation of community based disease surveillance (CBDS) for sustaining resilient zero	4 districts with on-going transmission	200	0	42	21%
# of border service focal points established and equipped with all necessary tools to ensure effective monitoring	National	7 in Sierra Leone	2	2	28.57%
# of information exchange sessions (in line with established standards and tools) taken within the timeframe of the project	7 border districts	5 in each district (total 35)	2 (1 Kambia, 1 Koinadugu in February)	9	26%
# of simulcast communications aired for getting to and sustaining zero	National	30	13	41	100%
# of people (audience) of simulcasts	National	500,000	>500,000	>500,000	100%
EFFECT INDICATORS (if available for the reporting period)					
# of Integrated Disease Surveillance System fully operational in Sierra	National (with primary introduction	1	1	1	100%

Leone	in 4 districts with on-going transmission)				
Proportion of new confirmed cases from known contact lists	National	90%	0%	100%	100%
Number of transmission chains which derive from cross-border contacts	National	0	0	0	100%
# of districts that fully implemented cross-border cooperation mechanisms (including regular exchange of information)	7 Cross border districts in Sierra Leone	7	2	2	28.57%
# of escapes (absences) from ETUs and CCCs	4 districts with on-going transmission	0	0	0	100%
Number of new resistance cases	National	0	0	0	100%

Explanation of above results and indicators

The '# of trained community health workers in implementation of community based disease surveillance (CBDS) for sustaining resilient ZERO' refers to the 3 levels of CBDS training: district level training of trainers; training of facility based HCWs; and training of community health workers (CHWs). Training of trainers was conducted in December 2015 in six districts. A total of 42 trainers were trained. WHO will continue with this activity; there are plans to train around 1400 CHWs in three districts by end of May 2016.

The 'proportion of new confirmed cases from known contact lists' refer only to the data from the recent flare up. As was explained in the January report, the end of the outbreak on 7 November marked the end of that event, and thus the flare up is being measured as a new event. The flare up was rapidly contained and as such there was one index case (index cases are not counted due to their nature of being the index case) and one further case. This first generation case came from a contact list, so consequently the indicator is reported at 100%.

As indicated in previous reporting, WHO does not conduct simulcasts. Therefore for this indicator the scope of communications has been broadened to include wider communications including TV and national and local radio. Additionally, with the end of the Ebola outbreak on 7 November 2015 messaging has been focused on sustaining a resilient zero, but increasingly also on other key health areas such as the polio campaign, and NIDs. The indicator therefore reflects this communications focus which has adapted with the MoHS's health priorities. WHO does not have the means to accurately record the number of people reached through its communications, however, given the variation of channels and volume of

communications it is seen as strongly likely that 500,000 or around 7% of the population have been reached through various channels. For example, WHO community mobilisers reached 3,000 people as part of their face-to-face communications in two chiefdoms of one district as part of the vaccine campaign.

NARRATIVE

Situation Update (*please describe critical changes, if any, in the situation that affect the project (1-2 paragraphs*))

The focus of activities in the month of February has been on containing EVD transmission from the index case reported in January to meet the target of containing any EVD flare up within the second generation of cases. This involved the close follow up of contacts in quarantine and accounting for the missing contacts in Kambia District.

In order to mitigate the residual risk posed by the missing contacts in Kambia a multi-pillar 21-day plan was developed and implemented to ensure that the missing contacts were accounted for and that there was no undetected transmission chain in the district. Six Epidemiologists were deployed to provide the technical support for active case finding and to boost capacity to detect and promptly respond if required. Community Engagement colleagues worked collaboratively to ensure engagement with the communities was effective and that communities understood the importance of identifying the missing contacts and of identified contacts participating in voluntary quarantine. Additionally, case management capacity was enhanced through supportive supervision at the Kambia Government hospital as well as the Rapid Deployable isolation and treatment facility (RDITF) to improve the health facilities to identify, isolate and manage any confirmed or suspect case. Through the implementation of the 21-day plan 44 of the 48 missing contacts had been accounted for by the end of February with none of these contacts displaying symptoms.

Following 21-days of close monitoring with no EVD symptom being reported, 78 contacts were discharged in Tonkolili, Kambia and Port Loko, with the last group of contacts being discharged in Tonkolili on 11th February. Therefore, no known second generation cases occurred, in fact only one additional case has been identified as occurring. Consequently, the countdown to 0+42 days remained the 5th of February with the discharged of the last confirmed case from the treatment center following a second negative test on 4th February. The country is now firmly on the countdown to 0+42 days.

WHO continued the follow up of all 212 persons that had received EBOV rSV vaccine and have found that no major adverse event has been reported.

Furthering the efforts to maintain vigilance and a resilient ZERO all districts and the national level have a functional IDSR system. A key achievement in February has been the sustained improved routine weekly health facility reporting rates above the target 80% for four consecutive weeks.

The WHO IDSR team has continued to support the Ministry of Health and Sanitation (MoHS) to develop guiding documents in preparation for the rollout of Community Based Surveillance (CBS). The rollout will be conducted- in 3 stages: the training of trainers; training of district facility based HCWs; and finally the training of around 1400 community health workers (CHWs) in three districts. CBS guidelines and training modules have been developed and validated in a national CBS stakeholders' forum. The training modules were used during a pilot training of 28 district level trainers for CBS cascade training. However, to appropriately adapt these resources to the capacity and needs of CHWs job aides have been developed to support the training material. This necessary process has delayed the– roll out of CBS training. The training material, guidelines and job aides will need to be printed before training of CHWs can commence. However, WHO commit to implementing this activity with core funding if it cannot be undertaken with MPTF funding in the timeframe of the project. To assist with the roll out of this training, WHO Community Engagement team have been preparing the ground for CBS activities by conducting 149 chiefdom level advocacy engagement to promote live and death alerts and have heightened community engagement with surveillance and reporting by utilizing IDSR data.

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During February Kambia and Koinadugu districts continued to engage counterpart prefectures in Guinea on information exchange, joint response and planning on a monthly basis, Kambia increased this to bi-monthly when active transmission was ongoing. WHO supported these districts to develop MOUs by November 2015 to guide cross-border activities with their counterparts in The Republic of Guinea. These MOUs have been essential in facilitating community engagement for contact tracing and follow-up during the recent EVD flare up. In addition to information exchange, joint response and planning, point of entry (POE) screening services in the two districts are on-going and form a key component of the cross-border surveillance. In respect to the remaining five districts which have competent authority yet lack POE screening services, WHO is providing support to MoHS to develop a regional cross-border engagement MOU and national cross-border surveillance guidelines. The process of developing these guidelines has been initiated but due to the review and validation requirements WHO project that these will be completed in May. Due to political constraints it has been difficult to initiate cross border activities without an MOU and validated guidelines in place to guide constituting and operationalizing cross-border management committees and commencement of POE screening services in the 5 cross-border districts. During the reporting period no EVD cases are reported to have initiated from cross-border transmission (discounting the fact that all transmission is ultimately linked to the initial cross border transmission in 2014), however, WHO will continues to focus on the implementation of cross border collaboration to enhance surveillance and ensure a resilient ZERO beyond the end of the project period. This has become particularly important given the continuation of flare-ups across all 3 countries.

WHO has assisted in the development of Guidelines and Standard Operating Procedures for responding to public health emergencies which will strengthen technical capacity for investigating and responding to public health emergencies and alerts in the future.

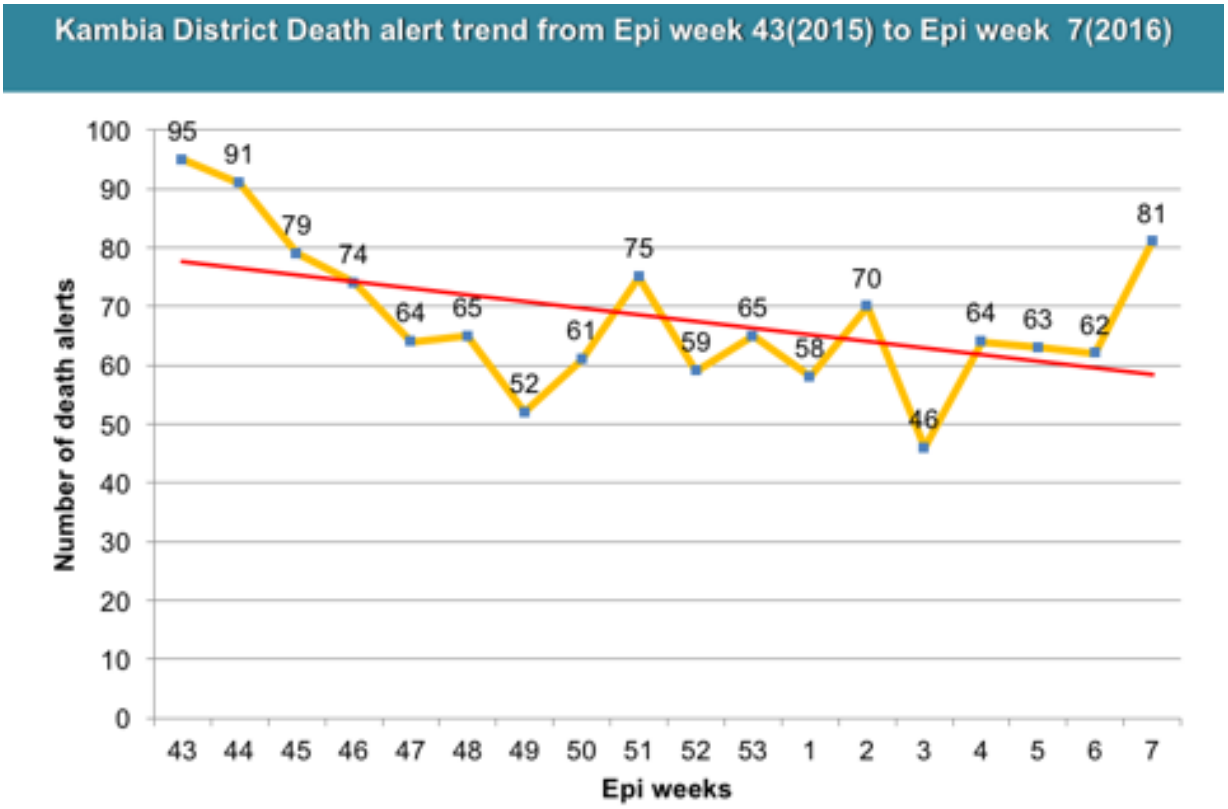
During February, WHO provided technical support to the MoHS through the technical working group to the development of an electronic surveillance reporting system (e_IDSR). The system will ease reporting, improve the quality of reports and establish an electronic database that enable realtime web access to the data and provide historic database for identifying disease trends. As a result of this collaborative support, an initial version of the platform has been developed and will be piloted during March 2016. Based on the success and findings of the pilot, further revisions may then be made to the platform before roll-out of the eIDSR system and associated training is conducted. With this in mind WHO anticipate that the roll-out of the system by the MoHS with partners support will not be completed until June 2016. WHO commit to ensuring the implementation of this activity beyond the end of the project period utilising core funding as required.

Key Achievements (*please use this section to highlight your key achievements for the month, using bullet points if preferred)*

Ebola Response Activities

- Conducted active case search in all 107 health facilities in Tonkolili and the 68 health facilities in Kambia. During these active case searches consultation records for the previous months were reviewed and patients who presented with EVD like symptoms but for whom no alert was raised were followed up with in the community to determine their status;
- Discharged and integrated one Survivor from Military 34 Hospital back into the community following here second negative test on 4th February;
- Closely monitored and later discharged 78 contacts from quarantine facilities in Tonkolili, Kambia and Port Loko;
- Conducted clinical mentorship and supportive supervision for health care workers (HCWs) at the Mateneh Treatment centre in Makeni;
- Conducted community engagement activities in Kambia utilizing community structures including the Inter-Religious Council, Village Development Committees and Chiefdom Health Committees. Alongside enhanced surveillance this resulted in the voluntary return of 91% of the missing contacts (44 out of 48) as well as a substantial increase in the

reporting of death alerts in the district from epidemiological week 4 to 6 (see graph below) to achieve a level of reported death alerts not achieved since 15 weeks. A total of 261 communities were visited during active case search.



- More broadly, activities to sustain a resilient zero have continued in the remaining 10 districts not affected by the recent flare up. These activities include investigation and swabbing of all reported deaths with a slight increase in both live and death alerts being registered nationally during the month of February.

Sustaining the gains made in establishing a robust disease surveillance systems

- The national IDSR health facility reporting rate for the month of February was above the 80% target.
- WHO conducted a pilot training of 20 clinicians from healthcare facilities (HCFs) in Freetown on surveillance with an emphasis on the clinician's role in IDSR. The purpose of the training was to create capacity for appropriate performance of surveillance functions among clinicians in HCFs, including detection and reporting of priority diseases. Based on the pilot training WHO colleagues are reviewing training materials before rolling out the clinicians training across all districts.
- Kambia and Koinadugu each held a cross-border review and planning meeting with their counterparts from Guinea. This was particularly important in Kambia in light of the recent EVD flare and the associated monitoring of contacts and follow up of missing contracts.
- WHO IDSR colleagues participated in an IDSR mop-up training of 93 HCWs from nine districts. The HCWs came

from HCFs that had not participated in the initial cascade training of HCWs on IDSR, and as such the training assisted in improving the coverage of IDSR capacity across the country.

- An initial version of the electronic IDSR reporting platform was unveiled and reviewed by the technical working group in readiness for piloting during March 2016. WHO IDSR colleagues provided technical support towards developing the e-IDSR platform and will continue to be involved in any necessary revisions based on the findings of the pilot. This assist in ensuring that the version rolled out across all districts will ease IDSR reporting activities, create an information database and provide a feedback and data access platform that is comprehensive and effective.

- An electronic integrated IDSR support supervision checklist was developed and validated with technical partners and the MoHS. This tool will make it possible to use the platform during IDSR supportive supervision and consequently will create a secure database of supportive supervision findings that may act as a reference point to inform subsequent supervision activities.

- The IDSR team continued to provide technical support to the Government in developing a draft International Health Regulations (IHR) plan of action for the period 2016 – 2017. Sierra Leone had never fully implemented IHR 2005. The process of developing the action plan was informed by an IHR core capacities assessment conducted in December 2015 generating actionable areas. The action plan will have a strong component of cross-border surveillance and surveillance at POE to inform subsequent actions towards improving cross-border surveillance.

- The provision of technical support to production of the weekly epidemiological bulletins was sustained during the month of February. This involved review of the weekly data reported by districts, creation of graphics and editorial assistance. Feedback generated from bulletins to districts is helping improve performance.

<u>Strategic communication for getting to and sustaining zero</u>

- WHO Community Engagement team conducted 149 chiefdom level advocacy engagements to promote the reporting of Live and Death Alerts. They have deployed 920 Community Event Management members (690 for Western Area and 230 for Kenema) to support DHMTs and IDSR focal persons to sustain disease surveillance and the maintenance of a resilient zero. This activity is increasing community ownership to detect and report health related issues to HCFs.

- Previously produced messaging for communities to remain vigilant in order to maintain a resilient zero, which are adapted to reflect the local context, are still available to the DHMTs/Health Education Division for use in health communications. While no new messaging was developed February regarding getting to and maintaining a resilient zero, WHO provided district level supported to drafting messaging produced for the Neglected Infectious Diseases (NIDs) campaign that took place in February.

- WHO reviewed health communication messages approved by HED for implementation in the field and submitted health communication messages to HED for revision and approval. Many district staff, including our Community Engagement Officers utilized HED messaging, adapting it to the local context.

- Some WHO Community Engagement Officers went on the local radio station with their respective DHMT counterparts (District Social Mobilization Coordinators) to raise awareness during the NID campaign:

    - Western Area- Did not go to radio station but guided the DHMT social mobilization lead to draft messages and discussion points
    - Kono-Did not go to radio station but guided the DHMT social mobilization lead to draft messages and discussion points
    - Koinadugu-Did not go to radio station but guided the DHMT social mobilization lead to draft messages and discussion points
    - Tonkolili- Provided guidance in drafting messages and did a joint radio discussion with DHMT (Radio Gbafgh-in Mile 91)

- Bombali- Provided guidance in drafting messages and did a joint radio discussion with DHMT (Radio Maria and Sierra Leone Broadcasting Channel-SLBC)
- Kambia- Did not go to radio station but guided the DHMT social mobilization lead to draft messages and discussion points
- Port Loko- DHMT did not do any radio programs
- Bo- Provided guidance in drafting messages and did a joint radio discussion with DHMT (SLBC)
- Bonthe- Did not go to radio station but guided the DHMT social mobilization lead to draft messages and discussion points
- Pujuhun- Provided guidance in drafting messages and did a joint radio discussion with DHMT (Radio Wanjei)
- Moyamba- Provided guidance in drafting messages and did a joint radio discussion with DHMT (Modcar Radio)
- Kenema-Did not go to radio station but guided the DHMT social mobilization lead to draft messages and discussion points
- Kailahun- Did not go to radio station but guided the DHMT social mobilization lead to draft messages and discussion points

- WHO community engagement team conducted advocacy engagements for health messages in 149 chiefdoms and 69 wards to promote positive health behaviors.

- A WHO representative spoke on a national level TV broadcast on NIDs. While the reach of the programme is unknown, given that it was broadcast at national level it is though that the reach of this would be fairly significant.

- Additionally, WHO posted 4 facebook posts in February relating to the discharge of contacts, the rebuilding of health systems, the countdown to 0+42 days and the Polio campaign. WHO currently has a facebook following of 1,744 followers on facebook, however, it is noted that many of these will be from countries outside of Sierra Leone.

Delays or Deviations (*if any, briefly describe the delays or changes in focus, approach or targets, and provide a short justification for the change (1-2 paragraphs*))

The number of competing high priority activities and the political nature of cross border engagement between sovereign states has led to delays in developing cross border engagement tools and establishing information exchange sessions. Sierra Leone, Liberia and Guinea have all reached the 0+42 date confirming the end of the initial outbreak with Guinea achieving this on the 29th December 2015. This dramatically reduced the emphasis placed on establishing strong cross border surveillance as compared to community based surveillance activities through the following months. Additionally, through reviewing data throughout the outbreak we see that cross-border transmission only made up the source of transmission in a relatively small number of cases, discounting the cascade impact of the initial cross-border transmission. With the rapidly contained flare-up in Sierra Leone in January 2016 and the anticipation of future flare ups across the three countries and associated potential for cross-border transmission there is still a need to take forward activities relating to cross border surveillance to ensure that strong systems are in place to monitor and react to future events. Consequently, beyond the end of the MPTF award, WHO are committed to achieving these activities, and as such will continue to fund them from core resources. Cross-border points will be established following the development and finalisation of the above mentioned SOPs and MOUs essential to taking this activity forwards.

Roll out of CBS training to all districts remains contingent on the development and printing of CBS guidelines and training modules. These were finalised as February drew to a close and have been processed for printing. In line with standard WHO procurement guidelines, it is expected that copies will be received in April. Once received, WHO will be enabled to initiate the roll-out of CBS. This has therefore caused a delay in the commencement of training of CHWs as planned. Once these guidelines and modules are printed, CBS will be rolled out in a phased manner beginning with training of trainers and training of CHWs in April and May 2016.

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Gender and Environmental Markers *(Please provide disaggregated data, if applicable)*

No. of Beneficiaries	
Women	
Girls	
Men	
Boys	
Total	

Environmental Markers
e.g. Medical and Bio Hazard Waste
e.g. Chemical Pollution

Additional Information (*Optional*)

Figure 1 Supportive visit to Magburaka Isolation facility

Figure 2 Assessment of the Kambia Government hospital isolation facility