



**UN EBOLA RESPONSE MPTF
FINAL PROGRAMME NARRATIVE REPORT
DATE: 27 JUNE 2016**

<p align="center">Project Number(s) and Title(s)</p> <p>#17- Strengthening EVD Surveillance, Community Engagement and Response for getting to and sustaining at Zero Ebola cases in Sierra Leone 00096318 (Gateway ID)</p>	<p align="center">Recipient Organization(s)</p> <p>RUNO(s) Project Focal Point: Name: Elaina Davis E-mail:davise@who.int</p>								
<p align="center">Strategic Objective & Mission Critical Action(s)</p> <p>SO1 – Stop the Outbreak MCA1 – Identifying and tracing of people with Ebola</p>	<p align="center">Implementing Partner(s)</p> <p>Ministry of Health and Sanitation, Government of Sierra Leone</p>								
<p>Location:</p> <p>Sierra Leone</p>	<p>Sub-National Coverage Area:</p> <p>All fourteen districts: Western Area urban, Western Area Rural, Port Loko, Kambia, Bombali, Tonkolili, Koinadugu, Kono, Kailahun, Kenema, Bo, Pujehun, Bonthe, Moyamba</p>								
<p align="center">Programme/Project Cost (US\$)</p> <p>Total approved budget as per project proposal document: MPTF¹:</p> <ul style="list-style-type: none"> • 2,073,205USD to WHO <p>Government Contribution (iapplicable)</p>	<p align="center">Programme Duration</p> <p>Overall Duration (<i>months</i>) Project Start Date² (10.08 2015)</p> <table border="0"> <tr> <td>Originally</td> <td>Projected</td> <td>End</td> <td>Date³</td> </tr> <tr> <td>(31.12.2015)</td> <td></td> <td></td> <td></td> </tr> </table> <p>Actual End date⁴(31.03.2016)</p> <p>Agency(ies) have operationally closed the programme in its(their) system - Yes <input type="checkbox"/> No <input type="checkbox"/></p>	Originally	Projected	End	Date ³	(31.12.2015)			
Originally	Projected	End	Date ³						
(31.12.2015)									

¹ The amount transferred to the Participating UN Organizations – see [MPTF Office GATEWAY](#)

² The date of the first transfer of funds from the MPTF Office as Administrative Agent. The transfer date is available on the online [MPTF Office GATEWAY](#).

³ As per approval of the original project document by the Advisory Committee.

⁴ If there has been an extension, then the revised, approved end date should be reflected here. If there has been no extension approved, then the current end date is the same as the originally projected end date. The end date is the same as the operational closure date, which is the date when all activities for which a Participating Organization is responsible under an approved project have been completed. As per the MOU, agencies are to notify the MPTF Office when a programme completes its operational activities. Please see [MPTF Office Closure Guidelines](#).

Other Contributions (donors)
(if applicable)

TOTAL:

Programme Assessment/Review/Mid-Term Eval.

Evaluation Completed

Yes No Two monitoring visits with comprehensive assessment against evaluation criteria conducted on 23 October 2015 and 10 February 2016.

Evaluation Report - Attached

Yes No Date: *dd.mm.yyyy*

Expected Financial Closure date⁵:

Report Submitted By

- Name: Elaina Davis
- Title:
- Date of Submission: 09 June, 2016
- Participating Organization (Lead): WHO
- Email address: davise@who.int

Signature:

⁵ Financial Closure requires the return of unspent funds and the submission of the [Certified Final Financial Statement and Report](#).

Project Proposal Title:						
Strategic Objective to which the project contributed		<i>Stop the Outbreak</i>				
MCA 1 ⁶		<i>Identifying and tracing of people with Ebola</i>				
Output Indicators	Geographical Area	Target⁷	Budget	Final Achievement	Means of verification	Responsible Organization(s).
<i>Proportion of health facilities submitting weekly IDSR reports on time to districts</i>	<i>National</i>	<i>>80%</i>		<i>89%</i>	<i>Weekly reports</i>	<i>WHO</i>
<i>% of districts which have functional IDSR systems</i>	<i>National</i>	<i>100%</i>		<i>100%</i>	<i>Weekly Reports and Reporting Rates</i>	<i>WHO</i>
<i>% of contacts monitored on a daily basis and reported effectively</i>	<i>National</i>	<i>100%</i>		<i>98%</i>	<i>Reports from contact tracers</i>	<i>WHO</i>
<i># of trained community health workers in implementation of community based disease surveillance (CBDS) for sustaining resilient zero</i>	<i>4 districts with on-going transmission</i>	<i>200</i>		<i>42</i>	<i>Training Report</i>	<i>WHO</i>
<i># of border service focal points established and equipped with all necessary tools to ensure effective monitoring</i>	<i>National</i>	<i>7 in Sierra Leone</i>		<i>3(Kambia, Pujehun and Kailahun)</i>	<i>Point of Entry Reports</i>	<i>WHO</i>
<i># of information exchange sessions (in line with established standards and tools) taken within the timeframe of the project</i>	<i>7 border districts</i>	<i>5 in each district (total 35)</i>		<i>11</i>	<i>Minutes of Meetings</i>	<i>WHO</i>
<i># of simulcast communications aired for getting to and sustaining zero</i>	<i>National</i>	<i>30</i>		<i>45</i>	<i>See Table within</i>	<i>WHO</i>
<i># of people (audience) of simulcasts</i>	<i>National</i>	<i>500,000</i>		<i>>500,000</i>	<i>Approximated assessment based</i>	<i>WHO</i>

⁶ Project can choose to contribute to all MCA or only the one relevant to its purpose.

⁷ Assuming a ZERO Baseline

					<i>on census and com eng record</i>	
Effect Indicators	Geographical Area (where the project directly operated)	Baseline⁸ In the exact area of operation	Target	Final Achievement	Means of verification	Responsible Organization(s)
<i># of Integrated Disease Surveillance System fully operational in Sierra</i>	<i>National (with primary introduction in 4 districts with on-going transmission)</i>	<i>0</i>	<i>1</i>	<i>1</i>	<i>1. Weekly reports 2. National IDSR database</i>	<i>WHO</i>
<i>Proportion of new confirmed cases from known contact lists</i>	<i>National</i>	<i>90%</i>		<i>60% August to November 2015 (8 cases – coming from internal residual risks). 100% for January 2016 flare up</i>		<i>WHO</i>
<i>Number of transmission chains which derive from cross-border contacts</i>	<i>National</i>	<i>0</i>	<i>0</i>	<i>0</i>		<i>WHO</i>
<i># of districts that fully implemented cross-border cooperation mechanisms (including regular exchange of information)</i>	<i>7 Cross border districts in Sierra Leone</i>	<i>4</i>		<i>4</i>	<i>Minutes of meetings</i>	<i>WHO</i>
<i># of escapes (absences) from ETUs and CCCs</i>	<i>4 districts with on-going transmission</i>			<i>0</i>		<i>WHO</i>
<i>Number of new resistance cases</i>	<i>National</i>	<i>0</i>		<i>0</i>		<i>WHO</i>

PROJECT/PROPOSALRESULT MATRIX

⁸ If data is not available, please explain how it will be collected.

FINAL PROGRAMME REPORT FORMAT

EXECUTIVE SUMMARY

The MPTF project begun on 10 August 2015 with the aim of ‘Strengthening EVD surveillance, community engagement and response for getting to and sustaining ZERO Ebola cases in Sierra Leone’ under the WHO Phase 3 strategy and in support of Ministry of Health and Sanitation’s (MoHS) leadership of the response. To this end, WHO continued to support MoHS in leading the outbreak response by maintaining a presence across all districts and working closely with MoHS at the national level to ensure implementation of effective surveillance systems, cross-border collaboration, rapid investigation and response, and community mobilization and engagement activities.

This project supported by the Ebola Response Multi-Partner Trust Fund was one of the key interventions that allowed the implementation of the lessons learned from previous phases of the response, leading Sierra Leone to declare the end of the outbreak on 7th November 2015. However, maintaining detection and response activities was crucial for sustaining a resilient ZERO beyond the 0+42 day declaration to ensure that the country had the capacity to respond to future EVD flare ups and enhance overall emergency preparedness and response capacities relevant to possible future disease events.

In total, 144 TOTs, 1546 HWs from 1315 health facilities and 20 clinicians were trained in IDSR by February 2016. Personnel from partner organizations were also trained. This helped establish a unitary operational IDSR system in the country that uses standard case definitions for case detection. WHO, in cooperation with the MoHS and partners have developed the full set of reporting tools, response procedures and protocols.

At the commencement of the MPTF project, the weekly IDSR reporting rate was just above the target 80% but declined sharply due to the establishment of and insistence on procedures and processes for reporting. However, at the end of the project as at 31 March, the average weekly health facility reporting rate for the month of March was 89% while that for the last week of March was 92%. There has therefore been a tremendous increase in quantity and quality of the weekly health facility reporting rates over the period of the project implementation.

With the close of the MPTF award as at 31 March 2016, and in the context of further EVD flare ups being anticipated across the three countries WHO will continue to support MoHS to enhance the country’s capacity to detect and respond to future disease events in an effective and coordinated manner and strengthen cross-border collaboration to minimize risk of importation.

Background and Situational Evolution:

The EVD outbreak in West Africa heavily affected the sub-region and resulted in tremendous challenges, loss of human life and disruption of livelihoods. On 8 August 2014, WHO declared the EVD outbreak as a Public Health Emergency of International Concern, invoking legal measures on disease prevention, surveillance, control, and response by member states.

Acknowledging the outbreak as a threat to international peace and security on 18 September 2014, the United Nations Security Council urged UN member states and other organizations to provide more resources to fight the outbreak, and established structures for coordinating the resources for a rapid, effective, efficient and coherent response to the Ebola crisis.

By the first week of August 2015 after over a year of responding to the outbreak, the number of new cases in Sierra Leone had dramatically declined and was at the lowest weekly total to have been reported since March 2014. It was therefore critical to cement this progress and to enhance activities to drive case numbers to ZERO. WHO working in support of MoHS identified priority strategies and actions to contain and eliminate EVD transmission, maintain system resilience and restore essential health services.

However, at this time the response was faced with some decline in the resources and momentum needed to enable the country to reach and maintain ZERO. In response to WHO's call to collective action MPTF provided funding support to these strategies and actions through WHO with the specific goal of strengthening EVD surveillance, community engagement and response for getting to and sustaining ZERO Ebola cases in Sierra Leone. The MPTF funding provided the needed momentum to accelerated efforts to stop transmission in the four districts with on-going transmission as at August 2015 and to prevent a reverse in progress to maintain zero cases and strengthen resilience in silent districts in line with WHO's Phase 3 Strategy.

The support provided was key during "Operation Northern Push" in Kambia and Port Loko districts which focused on significantly improving the quality of case investigation of existing transmission chains, enhancing the identification and follow up of contacts as well as improving quarantine conditions to reduce the number of missing contacts and consequent spread of the disease. This operation resulted in the successful implementation of the "event based" model in Kambia (Kadalo, Kagboto, SellaKafta, Camp hope), Bombali, and Tonkolili. The model, which involved the deployment of sufficient Epidemiologist (eight per event), Contact Tracing Mentors, Contact Tracers and Surveillance Officers, eventually resulted in the successful interruption of all EVD transmissions in the country by September 2015. Sierra Leone then began the 0+42 day count down, achieving an end to the outbreak and ZERO Ebola status on 7th November 2015.

With MPTFs support, surveillance and preparedness activities continued to ensure that the ZERO achieved would be a resilient ZERO with the maintenance of capacity to promptly response to future flare ups. Indeed, a new EVD case was detected in January 2016 which was successfully contained at source with only one secondary case.

Narrative section:

EVD transmission and contacts monitoring: During the project period cross border coordination for EVD response occurred between a number of border districts and their counterparts in Guinea and Liberia. From November onwards, the districts of Kambia, Pujehun and Kailahun had implemented point of entry (PoE) screening with the capacity to detain, quarantine and transport cases to health facilities. While Koinadugu district was not fully equipped for PoE screening the district held three cross border coordination meetings with Faranah sub-prefecture in Guinea (before the MPTF project began) before signing a Memorandum of Understanding (MoU) at the fourth meeting on 14 November 2015. The aim of this MoU was to further strengthen coordination efforts building on previous coordination meetings to prevent and stop the spread of EVD and other potentially epidemic diseases. Cross border engagement was also formalized through an MoU between Kambia and Forecariah. In October 2016 several meetings were held to address the lack of exit screening on the Guinean side; the lack of joint investigations of suspects found at the border that led to unilateral transfer decisions without support from the opposite side of the border; and lapses in the primary and secondary screening procedures and suspect transfer/referral mechanisms. Of particular note, is the resultant development of a bilingual investigation form to support joint investigation and enable easy transfer of patients whose onset of symptoms is from a given side back to that place for easy contact tracing purposes. This coordination and collaboration successfully implemented with funding from the MPTF project led to no cross border EVD transmission during the project period.

Most cross border meetings and exchange visits stopped in November after the declaration of the end of the outbreak. However, collaboration and coordination cross border activities were reinitiated in the event of further flare ups with cross border implications.

A total of ten EVD cases were confirmed during the reporting period (Kambia (6), Tonkolili (1), Bombali (1), Tonkolili flare (2)) from four transmission chains. The sources of all chains were due to possible resurgence from the internal residual risks (survivor populations or missed transmissions) rather than from importation of cases. For the period from August to November 60% of the cases came from contact lists. For the EVD flare up in Bombali during January 2016 there were only 2 cases, the index case which is not

a contact, and one other case which came from the contact list. With exception of Sella Kafta in Kambia all the other chains (Tonkolili 2015 and Bombali 2016) were contained within the second generation meeting the rapid response target that WHO had set.

A total of 60 Contact Tracers, supervised by 10 Contact Tracing Mentors and eight Epidemiologists followed the 2767 contacts (see figure 1) that were line listed from the 10 cases (4 events). For each event a daily average follow up rate of 98% was maintained. During this period no deaths occurred in quarantine houses largely as a result of the early detection and treatment of symptomatic contact by the contact tracers. Furthermore, no quarantined contacts absconded during the project period. This is a testament to the work of Community Engagement staff and the efforts of local communities. Consequently, all those reported as missing contacts were those who left before investigation and quarantine.

To strengthen the resilience of communities and enhance community based surveillance village health committees were formed in silent chiefdoms in Kambia and Port Loko. A total of 934 committees were formed, supported by integrated Surveillance and Social Mobilization Teams to report community deaths, refer sick people and to monitor for presence of visitors to the chiefdom. These committees helped increase the reporting of deaths and therefore improved the surveillance and detection capacity of the response.

A total of 300 Surveillance Officers were trained across Sierra Leone with the majority in Western Area (200), Port Loko (25), Kambia (20) and Bombali (30). This created enhanced case investigation capacity broadening the scope of investigation and resulting in an increase in the average number of contacts per case from 6-8 at the beginning of May to around 14-15 by September 2015. The Surveillance Team also developed and revised Surveillance and Contact Tracing Standard Operating Procedures (SOPs) to facilitate understanding of epidemiological terminology by the different response workers, improved case investigation, and contact tracing thereby supporting outbreak response teams.

The Epidemiologists and Contact Tracers were key in the investigation, identification of contacts, and their contacts (ring definition) for the pilot administration of the Ebola vaccine - (rVSV-ZEBOV-replication-competent vesicular stomatitis virus-based vaccine expressing a surface glycoprotein of Zaire Ebolavirus) in Kambia (Sella Kafta), and subsequently in Bombali (Robuya) and Tonkolili (Matsanga, Yele and Magburaka). They also conducted the follow up of those vaccinated to monitor for adverse effect. A total of 433 contacts have been vaccinated since August 2015. The use of this novel tool contributed significantly to the interruption of onward transmission of EVD in those communities.

Functional IDSR system: WHO supported MoHS to conduct an assessment of the IDSR system present in the country in January 2015. The assessment identified the need to build the technical capacity of health workers (HWs) at all levels to conduct IDSR. WHO thereafter supported the training of trainers (TOTs) at national levels and within District Health Management Teams (DHMTs), HWs and personnel involved in the clinical management of patients in health facilities.

In total, 144 TOTs, 1546 HWs from 1315 health facilities and 20 clinicians were trained in IDSR by February 2016. Personnel from partner organizations were also trained. This helped establish a unitary operational IDSR system in the country that uses standard case definitions for case detection. WHO, in cooperation with the MoHS and partners have developed the full set of reporting tools, response procedures and protocols.

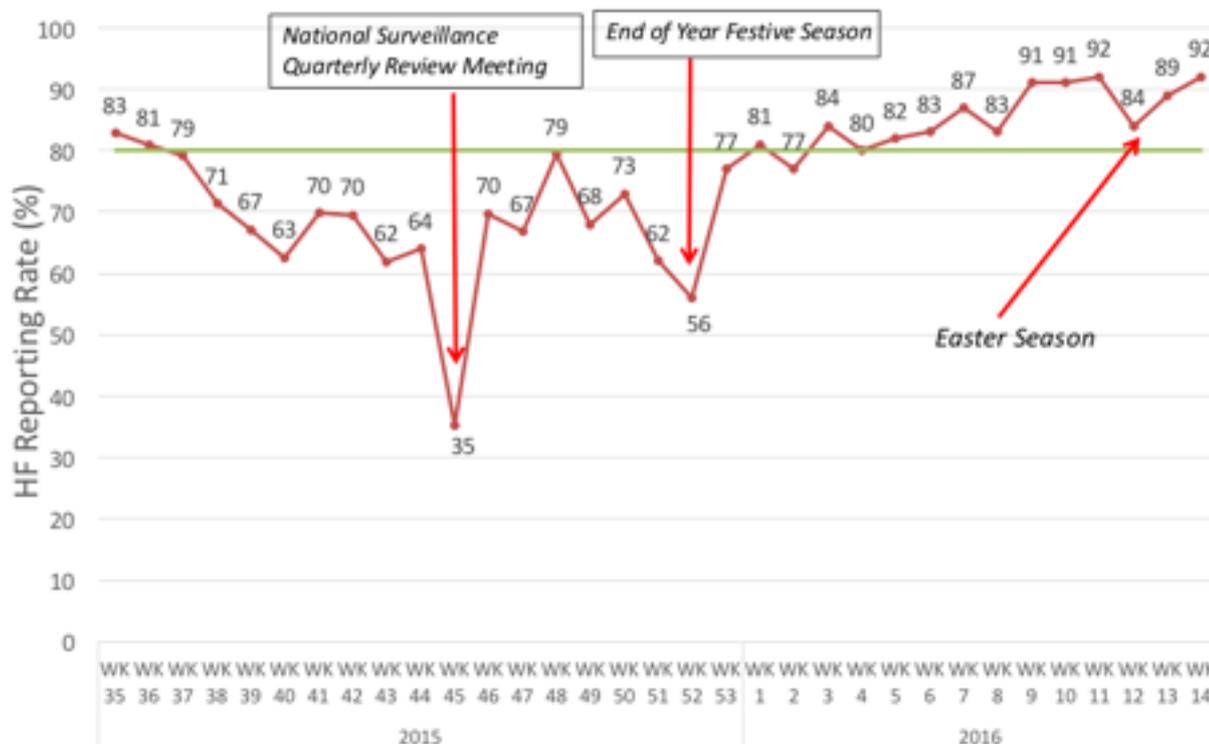
The training of all District Surveillance Officers (DSOs) and critical members of the DHMTs, and HWs from all health facilities made it possible for all districts to have functional IDSR systems with case detection, documentation, reporting and coordinated response.

IDSR Reporting Rates: Notification and reporting of the occurrence of priority diseases, conditions and events is one of the critical functions of the IDSR system. The investment in building technical capacity among HWs, together with provision of materials and tools for IDSR has led to a steady improvement in

IDSR weekly reporting rates. At the commencement of the MPTF project, the weekly IDSR reporting rate was just above the target 80% but declined sharply due to the establishment of and insistence on procedures and processes for reporting. However, at the end of the project as at 31 March, the average weekly health facility reporting rate for the month of March was 89% while that for the last week of March was 92%. There has therefore been a tremendous increase in quantity and quality of the weekly health facility reporting rates over the period of the project implementation.

However, undulations can be seen in IDSR reporting trends which coincide with major national events and seasons including national meetings, and the Christmas and Easter seasons. This calls for further efforts to cushion the system against such disruptions.

Trend of National HFs Reporting Completeness, Week 35, 2015 to Week 14, 2016



Community Based Surveillance (CBS): CBS compliments hospital-based indicator surveillance in the detection and notification of outbreaks and other events of public health concern that occur in the community. Based on experience during response to the EVD outbreak it was realised that, if fully implemented, CBS more than doubles the chances of detecting and reporting health events.

Within the MPTF project, WHO supported MoHS to train 42 CBS TOTs drawn from six districts in December 2015. This level of training (TOT level), to create capacity for CBS for sustaining resilient ZERO, is the first of the three targeted levels of CBS training: district level training of trainers; training of facility based HCWs; and training of community health workers (CHWs). WHO will escalate this activity with training of around 2700 CHWs in three districts by end of May 2016 and an additional 1800 from two districts by end of June 2016. This activity will be implemented with WHO core funding as necessary.

Cross-border surveillance: With mobility of human populations increasing, there is increasing risk of conveyance of communicable disease and other agents across international borders. On this premise, WHO has singled out cross-border surveillance as one of the key areas of investment for controlling the EVD outbreak, maintaining a resilient ZERO and detecting future disease events. Cross-border engagement activities consist of both point of entry (PoE) screening and information exchange for coordinated planning and response activities. Both were developed through the MPTF project, but in

different border districts and with different rates of implementation.

WHO provided technical support to the establishment of cross-border engagement MOUs for surveillance information exchange and coordinated response to public health events between cross-border districts in Sierra Leone and their respective prefectures in Guinea. In total, the districts held 11 officially recognised cross-border meetings with their counterparts from September 2015 to March 2016. During the meetings, information and experiences were shared, joint response coordinated and monthly plans developed. Through such meetings, information exchanged on missing contacts was used by respective teams to coordinate search for the contacts. The Guinean prefecture of Forecariah also used such opportunities to develop a better understanding about the quarantine strategy used in Kambia while the Kambia team learnt how ring vaccination was being conducted in Forecariah prefecture. The cross border engagement therefore enables lessons learned to be implemented to improve response strategies and supported coordination of activities between the countries.

Drawing from the experience during the EVD outbreak, WHO is providing technical support to the development of a national cross-border surveillance and response framework and SOP that will guide formation of cross-border structures for official cross-border engagement in the remaining cross-border districts by June 2016.

WHO will also work with the regional Inter-country Support Teams and Manu River Union to bring together the stakeholders from Guinea, Liberia and Sierra Leone to develop a regional cross-border framework of cooperation on surveillance and response that will establish an MoU that will be permissive for inter-district engagement. However, the process of establishing a regional MoU is taking longer than anticipated. Consequently, WHO Sierra Leone is now looking to unofficially build cross-border collaboration and cooperation in the remaining border districts for information exchange and coordinated response planning meetings. However, support will continue to ensure the development of the regional MoU as this will ensure longevity of engagement, which will be essential for detecting and responding to future disease events.

Out of the need to triage travelers through established PoE, screening was enhanced at Pujehun, Kailahun and Kambia district border points. Lungi International Airport and Queen Elizabeth Quay also continued screening of travelers. These five PoEs were equipped for effective monitoring of travelers and continue to conduct PoE screening.

WHO will continue providing support to the development of strategies and actions to commence effective PoE health services at the 4 remaining land crossing points as part of the IHR 2-years plan of action that is being developed following the IHR core capacities assessment conducted in December 2015. These PoE services are intended to continue infinitely.

Community engagement through communication: The MPTF project supported the WHO Crisis Communications functions, consisting of three of the 21 positions funded through the project. One of the lessons learned from earlier stages of the response was the importance of clear messaging that directly tackled the negative traditional practices that were sustaining the transmission of EVD and the misconceptions and fears around ETCs and quarantine. The focus of the WHO Crisis Communications functions was therefore to ensure that field based and national communications directly addressed these misconceptions and fears.

The WHO Crisis Communications function was a major contributor to the National Ebola Response Center's (NERCs) CEO's weekly statement to the press on getting to ZERO. This consisted of ensuring that messages broadcasted acknowledged community anxieties, responded to rumours, gave actionable information on how to get to ZERO and engaged in preventing discrimination and stigma especially against survivors. This weekly NERC media statement was shared on all of the county's written and broadcast media until 3 December 2015.

Since that date, the function has continued to be a regular guest on radio stations, engaging with listeners on their preoccupations around Ebola and its reemergence as well as pervasive issues of denial and mistrust. This direct unmediated access to listeners became an important strategy to listen to concerns and understand perceptions as well as to communicate evidence based facts maintaining WHO's technical leadership on EVD.

The WHO Crisis Communications function was heavily involved in preparations around the WHO announcement of the end of the Ebola Outbreak on 7th November 2015. This was a particularly important message in balance the achievement of the Government in ending the outbreak while also communicating the need to remain vigilant, sustain capacity and prepare for future flare ups in order to maintain a resilient ZERO. As part of this new strategy the function compiled an Inter-Agency Crisis Communications Standard Operating Procedure (SOP) and Checklists to prepare for responding to a new EVD event or flareup. This informed the Inter-Agency communication response to the EVD flare up event on 14 January 2016.

Furthermore, the WHO Crisis Communications function compiled a Communications Strategy for engaging with survivors, and developed messaging on the Virus Persistence Study for media, the general public, study participants and health workers. This was particularly important in ensuring the public received clear messaging on the ongoing risk posed while emphasizing that survivors should be celebrated and welcomed by communities instead of ostracised and discriminated against. The function also developed advocacy material on various social media platforms such as twitter and facebook (in English and Krio) of examples of the importance of community engagement, including with survivors, and the importance of heightened surveillance and reporting of live and death alerts to strengthen surveillance and maintain a resilient ZERO.

On all of the above messaging, the communications function worked closely with WHO's community engagement team to ensure that in addition to media broadcasts and interviews the messaging was being delivered directly to communities. One of the key lessons learnt during the response was that the messenger is often just as important as the message itself. Consequently WHO community engagement staff focused on engaging with trusted members of the community such as paramount chiefs, traditional healers, and religious leaders to ensure enhance the power and effectiveness of the messaging.

Delays or Deviations:

Community Based Surveillance: Structured CBS is a recent and evolving concept that shifts focus from the traditional levels of surveillance to conducting surveillance in the community. The concept has been variously implemented in varying elements and detail by partners supporting implementation of CBS in the country. The implementation of CBS depends on Community Health Workers (CHWs) who are coordinated from a separate directorate in the MoHS from the Directorate of Disease Prevention and Control. There was therefore a need to bring on board the directorate of Primary Health Care and partner organizations in an all-inclusive coordination mechanism during the essential process of developing guiding documents before the rollout of CBS. Attaining the required level of concurrence took longer than initially expected and a number of competing priorities in both directorates delayed this activity.

CBS guidelines and training modules had been developed and validated in a national CBS stakeholders' forum. The training modules were used during a pilot training of 42 district level trainers for CBS cascade training. However, to appropriately adapt these resources to the capacity and needs of CHWs it became necessary to develop job aides to support the training material. This process further delayed the roll out of CBS training. The training material, guidelines and job aides are currently undergoing printing before commencement of training of CHWs.

In spite of this delay, WHO commits to fully implement the remaining phases of CBS rollout. Health facility-based HWs and community-based CHWs from Koinadugu, Kono and Moyamba will be trained in May and those from Kambia and Bonthe in June 2016. WHO commits to using core funding to support the implementation of training as required.

Cross-border surveillance: The number of competing high priority activities and the bureaucratic nature of cross border engagement between sovereign states has led to delays in developing cross border engagement MOU, guidelines and SOPs, and establishing information exchange sessions.

EVD flare-ups in cross-border areas of Guinea and Liberia have occurred and there is a continuing risk of further flare-ups with potential for cross-border transmission. There is therefore still a need to progress implementation of activities relating to cross border surveillance and IHR at PoEs to ensure that strong

systems are in place to monitor and react to possible future events.

Consequently, beyond the end of the MPTF project, WHO is committed to achieving these activities, and as such will continue to fund them from core resources as required. Work will continue on the development of a regional member states' MOU, and in the mean-time cross-border guidelines and SOPs will be developed by end of June 2016 locally. Cross-border committees will then be established and regular cross-border meetings for information exchange and coordinated joint response and planning. WHO will also work with stakeholders to equip and operationalize service focal points for commencement of monitoring services from June 2016. This will require WHO to work with MoHS, IOM, Immigration, ONS and customs to plan to set aside space at cross border points for health screening and to determine the resources and funds to implement such activities.

Gender and Environmental Markers

No. of Beneficiaries		Environmental Markers
Women		e.g. Medical and Bio Hazard Waste
Girls		e.g. Chemical Pollution
Men		
Boys		
Total		

Best Practice and Summary Evaluation

One of the key best practices was the pairing of local surveillance officers with experienced epidemiologist. This resulted in the incorporation of the local context in the investigation while also ensuring a keen technical eye to pick out salient features that would have otherwise been missed.

The initiation of a risk based voluntary quarantine approach should also be noted as a best practice that helped reduce transmission within families as high risk contacts are separated from family members.

Additionally, the event based model of outbreak response that was piloted in Kambia and then Tonkolili and Bombali significantly improved the community cooperation as their concerns such as livelihood and welfare were addressed closely by the incident management team and the local leaders actively participated in the response. Using this model response activities included the specificity of local contexts and risks.

The use of national medical personel as mentors of contact tracers, most of whom had no medical background, greatly improved the skills and quality of the contact tracers and helped to ensure early detection of sick contacts and stopped further spread within families and communities.

The prompt response to the clusters of cases seen from August to March that was made possible by the availability of financial resources and the subsequent rapid containment with minimal spread is both a good practice and an indication of the positive impact of the funding availed by MPTF.

Regional information sharing between the three countries, and specific in person cross border collaboration in EVD response has enabled sharing of best practices that have had a significant influences on the three countries achieving ZERO. This included information sharing on approaches to quarantine, contact tracing, community engagement and rapid testing. In person best practice exchange has also occurred with colleagues in Kambia, travelling to Forecariah, Guinea in September to observe ring vaccination processes, and colleagues from Guinea then returned to understand the process of quarantining villages in Kambia.

A key best practice has been the continued focus through the three Phases of WHO's response on enhancing community engagement. In the First Phase of the response the focus was on identifying, isolating and treating cases, however, community misconceptions, fear and lack of compassionate engagement from response workers resulted in lack of community cooperation, hiding of sick contacts, secret burials and lack of follow up of contacts. Overcoming these barriers required not only stronger community engagement to explain response processes and requirements, but also deeper community engagement that utilized the established communication structures of communities and drew on the authority and respect of key community leaders. Such deepened community engagement was undoubtedly essential to driving case numbers to ZERO and continues to play an important role in enabling community based surveillance to maintain a resilient ZERO. Having seen the impact, WHO has remobilized community engagement colleagues to engage communities, through these structures, on other health issues such as vaccination and maternal health. WHO will continue to strengthen these mechanisms including mothers groups, village councils and school health clubs to continue to improve the impact of health messaging.

WHO field level engagement has enabled a more situation specific response, and initiated district level capacity building of HCFs and the DHMTs. Before the EVD outbreak, WHO's presence in Sierra Leone was based only at the Country Office in Freetown. However, following the impact of field presence in all 14 districts, WHO now plans to scale back while maintain four regional offices from 2017.

Furthermore, the compilation of field work results into a weekly bulletin, has created greater visibility of work, and the a competitive environment that has encouraged improvement to the reporting rate. The visibility of results has also enabled a platform to facilitate greater national level engagement, feedback, and support.

Lessons learned

The road to achieving ZERO Ebola status marked by the declaration of the end of the outbreak on 7th November 2015 was extremely bumpy but the lessons learned during each Phase of the response contributed to improving the subsequent response priorities and activities.

Story on the Ground

<http://www.who.int/features/2015/ebola-rapid-response-bombali/en/>

<http://www.who.int/features/2016/ebola-flare-up-tonkolili/en/>

<http://www.who.int/features/2015/ebola-then-now-gborie/en/>

Annex 1

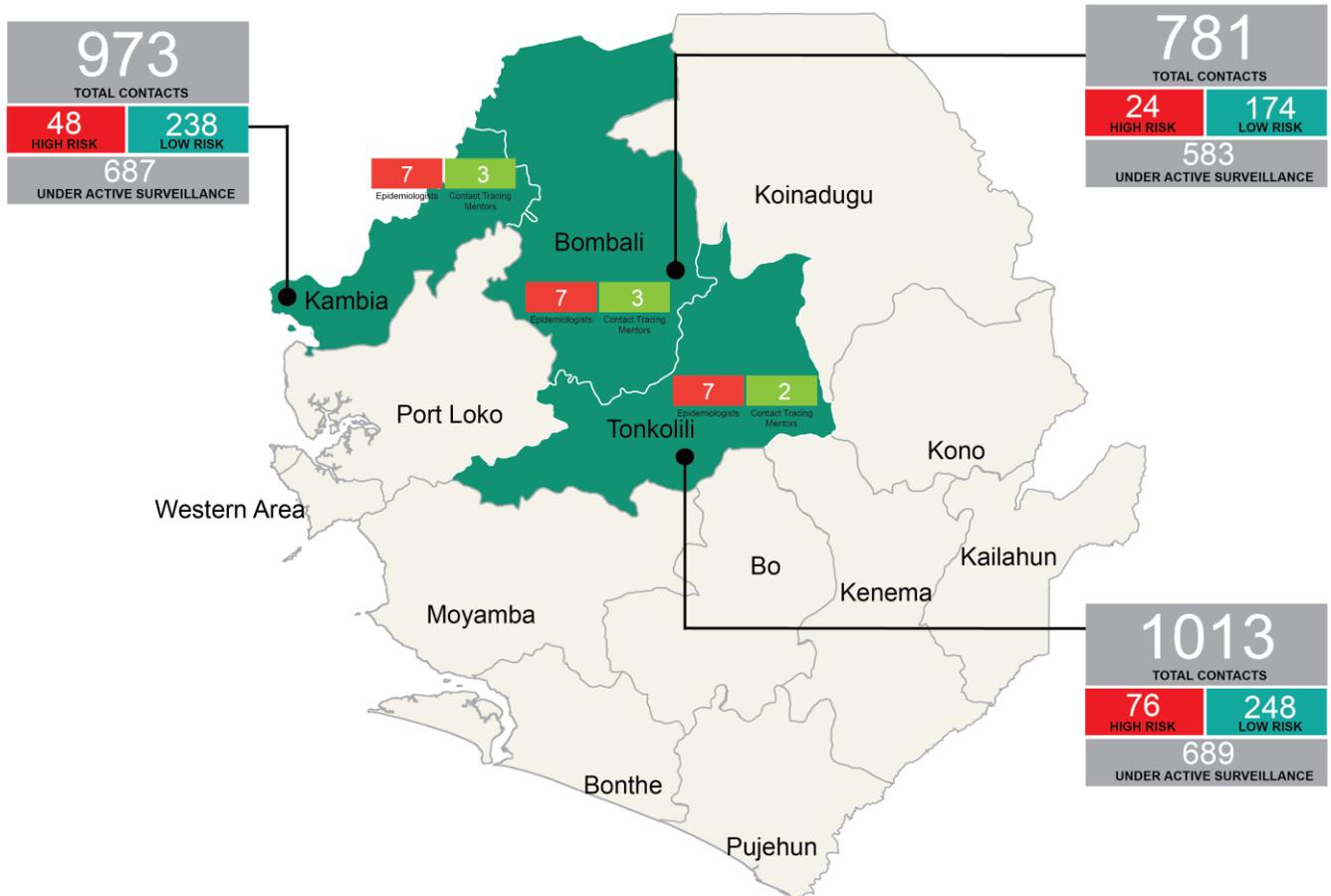


Figure 1 Map showing the Number of Epidemiologist and Contact tracing mentors Deployed and the number of Contacts followed(August 2015-March 2016)

Annex 2

Record of WHO communications from 01 August 2015 to 31 March 2016

This information is being provided as part of reporting to the MPTF regarding the award #17. The initial project proposal outlined ‘the number of simulcast communications aired for getting to and sustaining zero’ and ‘the number of people (audience) of simulcast’ as output indicators of the award. However, WHO does not, and has not conducted simulcast communications. Therefore, the below information is being provided to document the broad communications that WHO has undertaken within this period.

With the end of the outbreak on 7th November 2015 and the reactivation of activities relating to other health priorities, communications on getting to and sustaining zero have accordingly reduced. Therefore, to reflect the changing priorities of the MoHS and thus of WHO, information on recent communications around Neglected Infectious Disease has also been included.

Month	Radio Communications	TV communications
August 2015	Margaret Harris spoke to International Media following the discharge of the last positive EVD patient from Treatment centre in Bombali after second negative test.	
September 2015	At least 2 interviews on new cases in Bombali – Ebba	

	Kalondoe and MoHS.	
October 2015	<p>At least 2 interviews on NIDs – 1 was Aminata Kobie.</p> <p>WR and MoHS participated in a Press Conference or local media on on the preliminary results of the EVD Viral Persistence Pilot Study.</p> <p>WR and MoHS participated in a Virtual Press Conference for international journalists on preliminary result on EVD persistence study.</p>	<p>Aminata Kobie and MoHS featured on 1 NID broadcast by SL Broadcasting Corporation</p> <p>4 local TV stations filmed and reported on the local media Press Conference on on the preliminary results of the EVD Viral Persistence Pilot Study.</p>
November 2015	At least 3 radios broadcasted the WHO end of outbreak message delivered by WR.	Featured in all local TV stations as well international ones
December 2015	Ebba Kalondoe and MoHS spoke on Star Radio discussing the Ebola response.	
January 2016	<p>Press conference held on the confirmation of the reintroduction of a new EVD case.</p> <p>Ebba Kalondoe and MoHS discussed the Tonkolili flare up.</p>	
February 2016	<p>Community Engagement Staff spoke on district level radio regarding the NID campaign.</p> <p>Aminata Kobie and MoHS spoke on NIDs for at least 1 radio.</p>	
March 2016	<p>WR, MoHS, and ONS held Press Conference on End of flare up (0+42 days).</p> <p>Louisa Ganda participated in World TB Day Press Conference.</p>	<p>Broadcast statement delivered by WR and MoHS on end of flare up (0+42 days).</p> <p>Broadcast statement delivered by Abdoulie Jack on World TB Day.</p>

This record was created using institutional memory as no official record of such communications is kept. Therefore this record provides the minimum number of radio and TV programmes that WHO spoke on. Additionally, it does not reflect radio or TV communications done by WHO cluster members that do not

require support from the communication team.

Report reviewed by (*MPTF M&E Officer to review and sign the final programme report*)

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Comment: Not all project deliverables were achieved due to reasons provided in the report, and the explanation is detailed, although some additional efforts could have been undertaken to ensure implementation of the envisaged activities. The most notable backdrop is working with the border service.

However, in view of continuation the IDSR programme by WHO, and its commitment to finalize the programme from internal resources (I keep receiving information on IDSR operation in the country), as well as considering the exceedingly high performance over some indicators, the project is recommended for the operational closure.

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