UN EBOLA RESPONSE MPTF
FINAL PROGRAMME NARRATIVE REPORT
DATE: 19 JANUARY 2015

Project Number(s) and Title(s)			**Recipient Organization(s)**	
#16- Strengthen District Level Case Finding, Case Management, Reporting, Logistics Management and Community Mobilization and Engagement			**RUNO(s) Project Focal Point: WHO** Name: Rick Brennan E-mail: brennanr@who.int	
Strategic Objective & Mission Critical Action(s)			**Implementing Partner(s)**	
SO1 –Stop the outbreak SO2 – Treat the infected SO4 – Preserve stability MCA01 – Identifying and tracing people with Ebola MCA03 – Care for persons with Ebola and infection control MCA09 – Reliable supplies of materials and equipment MCA11 – Social mobilization and community engagement			WHO in collaboration with MOHS Sierra Leone	
Location:			**Sub-National Coverage Area:**	
Sierra Leone			All affected districts in Sierra Leone (high and low caseload)	
Programme/Project Cost (US$)			**Programme Duration**	
Total approved budget as per project proposal document: MPTF[1]: *MCA1: $5,065,084* *MCA3: $1,302,584*	*MCA9: $2,026,848* *MCA11: $473,469*		Overall Duration *(months)* Project Start Date[2] Originally Projected End Date[3] Actual End date[4] -	 19.12.2014 28.02.2015 30.09.2015
Government Contribution	n/a		Agency(ies) have operationally closed the programme in its(their) system	**Yes** No
Other Contributions (donors)	n/a		Expected Financial Closure date[5]:	
TOTAL:				
Programme Assessment/Review/Mid-Term Eval.			**Report Submitted By**	
Evaluation Completed ☐ **Yes** ☐ No Date: 01.09.2015 Evaluation Report - Attached ☐ **Yes** ☐ No Date: 07.10.2015			○ Name: Elaina Davis ○ Title: Management Support Officer ○ Date of Submission: 19.01.2016 ○ Participating Organization (Lead): WHO ○ Email address: davise@who.int *Signature:*	

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

PROJECT/PROPOSALRESULT MATRIX

Project Proposal Title:						
Strategic Objective to which the project contributed						
MCA [1] [6]						
Output Indicators	**Geographical Area**	**Target**[7]	**Budget**	**Final Achievements**	**Means of verification**	**Responsable Organization(s).**
Proportion of suspect cases investigated within 24 hours of notification.	*14 districts in Sierra Leone*	>90%		100% (Epi investigation)	VHF/CIF forms	WHO
Weekly average of proportion of contacts monitored	*14 districts in Sierra Leone*	>95%		>95%	VHF database, MOHS database	WHO/UNFPA was a joint collaboration (WHO technical leadership, UNFPA operational leadership)
MCA [3]						
Number of new health care workers infected by district	*14 districts in Sierra Leone*	0		0		WHO
MCA [9]						
Incidence of stock out of PPEs	*14 districts in Sierra Leone*	0		0		WHO
MCA [11]						
Proportion of incidences of community resistance resolved	*14 districts in Sierra Leone*	>90%		100%		WHO
Effect Indicators	**Geographical Area (where the project directly operated)**	**Baseline**[8] In the exact area of operation	**Target**	**Final Achievements**	**Means of verification**	**Responsable Organization(s)**

[6] Project can choose to contribute to all MCA or only the one relevant to its purpose.
[7] Assuming a ZERO Baseline
[8] If data is not available, please explain how it will be collected.

FINAL PROGRAMME REPORT FORMAT

EXECUTIVE SUMMARY

- The project focused on strengthening district level case finding, case management, reporting, logistics management and social mobilization and community engagement. The resulting improvement in contact tracing, rapid isolation, and treatment have enabled Sierra Leone to go from a peak of over 500 cases a week in October 2014 to zero, achieving the first objective of Phase 3 of the response. However the project has also focused on ensuring a resilient zero and the sustainable transition of systems and trained personnel to other health areas.

Background and Situational Evolution (*please provide a brief introduction to the project and the related outcomes in relation to implementation of the project (1-2 paragraphs)*)

Narrative section:

- **Key Achievements:**

Strategic Objective MCA1- Identify and Trace People with Ebola

With persistently high numbers of new cases and cases occurring outside of contact lists, there was a clear need for case investigation and contact tracing activities to be expanded and improved. The MPTF funding enabled WHO to increase the deployment of personnel to the field and to focus on addressing the quality of contact tracing. Epidemiologists were deployed to mentor contact tracers, increasing their capacity to conduct thorough surveillance activities. By conducting after action reviews of case investigation studies, WHO epidemiologists identified gaps in case investigations and trained contact tracers to be more actively engaged with extensive investigatory practices.

Based on challenges identified, some districts went beyond the Standard Operating Procedures (SOPs) for contact tracing and brought in thermometers to assist with active engagement and complement self-reporting and observation assessment techniques. Improvements in the identification and monitoring of contacts led to a reduction in the number of deaths in quarantined homes and to rapid detection and treatment of new cases from contact lists.

The epidemiologists also worked collaboratively with social mobilisation colleagues from WHO and UNICEF to provide the technical knowledge to answer specific community questions directed at lay social mobilisers. From June most epidemiologists have double hatted as Field Coordinator with oversight for burials, contact tracing and strategic direction. District teams started using an ‘event manager model’ led by the epidemiologist with responsibility for ensuring coordination with partners and across pillars in support of the District Health Management Team (DHMT) response to specific events.

As case numbers began to fall with the improvement in contact tracing, rapid isolation, and treatment those districts reaching 42days began to focus on establishing more robust district surveillance systems including working with health facilities to review their records. Establishing a robust and sensitive data and surveillance systems is a critical component of maintaining a resilient zero and the first step in enabling rapid response and containment to any future flare ups. Additionally, this work has laid the foundations for Integrated Disease Surveillance and Response (IDSR) improving the monitoring capability for broad range of health issues.

Strategic Objective MCA3- Care for Persons with Ebola and Infection Control

MPTF has funded WHO Infection prevention and Control (IPC) experts to support the work of the District Ebola Response Centres (DERC) and DHMT in fighting Ebola and Healthcare Associated Infections in Health Care Facilities (HCF). It is important to note that this work is done under the leadership of the MoHS and in collaboration with operational partners including U.S Centre for Disease Control, and UNICEF. IPC has played an important part in the outbreak response ensuring that HCWs are protected from exposure to EVD through safe working practises. Introduction of IPC had a significant impact on reducing the number of staff infected whilst providing care to EVD patients.

An IPC expert has been deployed in each of the 14 districts in addition to the team at country office and a IPC advisor to the newly established MoHS National IPC Unit (NIPCU), supported by WHO. Th international team of experts has provided technical support and mentoring to national staff and to NIPCU During the response, WHO IPC staff focused on the Ebola treatment centres ensuring appropriate trainin safe IPC practises, and leading ring IPC responses around new cases ensuring all HCFs would be IP compliant in the event a case should present there. Through the monitoring work, 28 ECCs have improve quality; 12215 HCWs have been trained on IPC for Ebola.

In collaboration with the MoHS WHO developed an assessment tool to strengthen the screening and triage process which was then implemented by the IPC experts and national IPC counterparts in the districts to identify the gaps and challenges. The IPC teams worked closely with the DHMT in each district to address these. To date 476 facilities (PHUs and Hospitals) have been assessed, 62 more than once with a total of 558 assessments for screening and triage completed to date.

WHO also played an important role in developing the standards for decommissioning ETCs and has bee involved through external assessments using the MoHS checklist in ensuring the safe decommissioning o ETCs.

As the outbreak subsided focus shifted to sustaining a resilient zero and initiating recovery. WHO supported the MoHS in the development, review and roll out of national IPC policy and guidelines setting standards against which all health care providers must act. The team facilitated two workshops with MoHS and partners to validate the guidelines and their roll out. Printing and distribution of 300 copies of the national IPC policy and 5000 copies of the national IPC guidelines in HCFs has started and copies are being distributed across the country. To consolidate this work WHO IPC experts conducted a 2 day training of IPC technical trainers from NGOs and DHMT on the new national guideline. This training of trainers is being cascaded through the districts. Two senior managers trainings have been undertaken including DMOs, DHS and MoHS program directors covering their roles and responsibilities to support the implementation of the IPC practices and strengthen patient safety.

Having a sustained expert IPC capacity in each of the districts has yielded significant results in a short tim During transition the WHO team, in conjunction with CDC and the Ebola Response Consortium has help the NIPCU team develop a standardised assessment tool based on the core standards agreed from th guidelines to ensure IPC is maintained sustainably. This tool will now be used as standard The establishme of NIPCU, supported by WHO, demonstrates the commitment of the MoHS to strengthen IPC efforts.

Activity mapping of IPC partners provided a tool to ensure better collaboration of efforts, and a resource assist other pillars to understand our work and support cross pillar cooperation.

Strategic Objective MCA9- Reliable Supplies of Material and Equipment

With the support of MPTF funding WHO logistics and procurement team has grown in its capacity to adequately support all 14 districts. Each district was capacitated with a logistician through which WHO has continued to support the daily needs and requirements of teams across the country, ensuring the transportation of personnel and the availability of goods and equipment.

The team has supported WHO awareness raising and training events in Freetown and in the districts, including PPE trainings, IPC workshops and Campaigns for World Hand Washing Day. Additionally logistics have supported the establishment of a National IPC Unit at the MoHS through a preliminary needs assessment and supporting equipping the office.

As a pilot programme WHO and WFP collaborated in 4 districts to build WHO logistics capacity as part of a global collaborative venture. The project is ongoing until 31 Dec however the process of handover from WFP to WHO has already begun. This project has been a significant success and has capacitate WHO with the skills to provide rapid quality logistics support to future events. Based on this learning experience WHO have now deployed administrative assistants to each district to manage all petty cash and fleet management requirements.

In May the logistics and procurement team began support of a pilot study to procure and monitor usage of hand sanitizer automatic dispensaries in the main hospitals of 5 districts. The pilot will run to the end of the year to assess consumption of hand santizer. Based on results WHO logistics and IPC teams will then support MoHS with the roll out of automated dispensers across the country and the monitoring and distribution of liquid based on consumption levels.

From the beginning of August WHO aligned around a common approach to the procurement of goods and services with procurement centralised at the country office level to ensured accountability towards quality procurement in line with WHO rules. This approach responded to the requirement to meet needs rapidly and the lack of knowledge of many staff hired for short term position. With the reduced demand on emergency procurement there are plans to hand the procurement of services back to unit teams. In comparison, procurement of goods for all districts remains centralised.

In WHO country office fluctuating staffing levels created a need to assess effective use of the available space. WHO procured office equipment to unify the furniture and make more efficient use of the space. Having considered that in time staffing levels would reduce further 4 pre fabs were set up to create more flexible temporary office space increasing capacity by 12 individuals.

WHO agreed to manage the procurement process for MoHS lab units, supporting their capacity and crucial role throughout the outbreak. WHO has managed the procurement of swabs and reagents throughout the year enabling the necessary planning to ensure labs can continue to support crucial response efforts and heightened surveillance work central to maintaining a resilient zero.

WHO will continue to work closely with the MoHS, UNICEF and the National Public Procurement Unit as a key partner in the PPE procurement. WHO is focussed on monitoring goods received, facilitating custom clearance and ensuring supplies are received by the Central Medical Store for storage and

distribution. This work has helped to create better accountability records for MoHS and ensure availability of PPE supplies in country.

Strategic Objective MCA11- Social Mobilization and Community Engagement

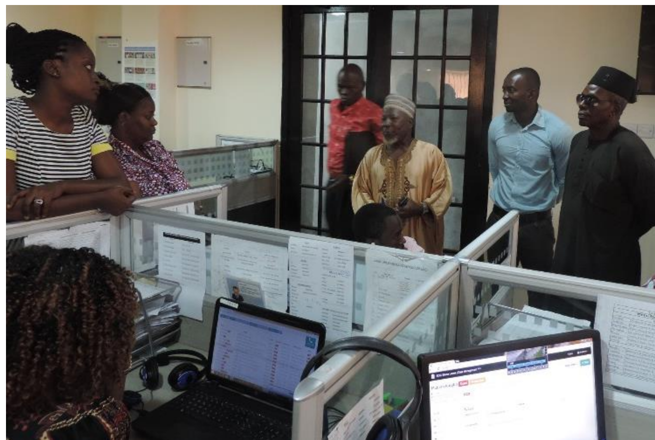
Within the EVD Response efforts WHO deployed at least 2 social mobilization experts per district – 3 of them were funded from the UN Ebola Response Multi-Partner Trust Fund. These experts were responsible for adapting strategies for social mobilization to address gaps and needs at district level, and ensured that the strategies were flexible and that the interventions addressed emerging needs and challenges. The expert was also responsible for ensuring appropriate community engagement. WHO recruited and built capacity of 32 nationals deployed across all 14 districts ensuring sustainable social mobilization capacity.

Community engagement and social mobilization approaches have changed significantly since the first responses in the early part of the outbreak. Lessons learned during the response have also led to community engagement and social mobilization being recognised as an essential element in driving the outbreak to zero and the approach has become central to WHO's response strategy.

Community engagement and social mobilization activities were initially focussed on awareness raising and the transfer of knowledge to communities. However it became apparent that negative and harmful practices and behaviours were continuing compounding the continually high case rate. In this context social mobilisation and community engagement activities adapted to focus on targeting behaviour changes, emphasizing interpersonal communication through face to face dialogue and identifying that the messenger is as important as the message.

On this premise WHO community engagement staff, in collaboration with UNICEF, DHMTs and other partners focussed on recruiting community leaders (paramount chiefs, traditional healers, religious leaders, town chiefs, and councillors) who share the same sociocultural beliefs and values as the communities and are deemed credible and trustworthy by community members. Community engagement activities were held at least twice in all 149 chiefdoms with intensified efforts during operational surges including 52 activities as part of the Tonkolili surge.

Community engagement and social mobilisation officer also worked in partnership with other pillars of the response and have been an essential element of successful case investigation, contact tracing and quarantine activities. Throughout the last year they have supported epidemiologists and contact tracers to conduct activities with the support of traditional community structures, and have also worked to dispel fear around quarantine homes and engage survivors as positive messengers on this front.



As case numbers decreased and some districts became ‘silent’ community engagement and social mobilisation officers have been focussed on activities warding against complacency and providing flexible surge capacity. As of the end of September 2015 each district has 2 social mobilisation officers. As part of sustaining a ‘resilient zero’ and the transition to recovery community engagement officers continue to work on restoring community faith in PHUs and messaging related to the recovery health priorities. For example, community engagement officers have been used during the recent Maternal and Child Health Week to sensitize communities and convey messaging on the importance of child vaccination.

This transition in the capacity of Ebola trained community engagement officers capitalises on the foundations laid engaging with communities on Ebola and creates sustainability of investment. On this work on broader health issues, Officers continue to work with UNICEF and other partners in support of the DHMT which leads and coordinates work through daily morning meetings. This effort to transition capability was supported by a workshop (26-28 October 2015) for the community engagement team to provide orientation and training on WHO/MOHS health priority areas to enable more effective programme implementation of essential health services and how best to use the lessons learned from Ebola to engage communities and encourage ownership for other health priorities.

- **Delays or Deviations** – *(Please provide short justification for any delays or deviations)*
- **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

- **Best Practice and Summary Evaluation** *(one paragraph)*

Deployed epidemiologists, IPC experts, and social mobilization experts worked closely with the framework of the District Ebola Response Centre (DERC), thereby harmonizing WHO’s work with the government and other international and domestic partners, and building local capacities. Alignment to the national strategies and high national ownership of the project results was the key best practice applied in the project.

The project was effective – the deployment of key staff to lead and mentor others proved to be an effective way to enhance capacity of a wide number of staff and the quality of essential response activities. Enhanced capacities strongly contributed to increasing the effectiveness of essential response activities thereby curbing the epidemic in communities, changing behavior of people, mobilizing community support and enabling effective IPC practices in healthcare facilities. In this way the project was also efficient by providing services throughout the whole country in a cost effective manner.

The impact of project is clear – end of Ebola outbreak in Sierra Leone on 7 November 2015 – the focus has now shifted to maintaining vigilance to ensure flare ups are identified, responded to, and contained so that a resilient ZERO is sustained.

In addition to contributing to the end of the outbreak, this project have contributed to building long term capability. While many international responder have left the country some key capacities of national staff will be retained. Through the mentoring, national contact tracers have built capacity to respond to future disease outbreaks. Lessons in IPC are applicable to ongoing health facility care and response and tools are in place to continue to build on the achievements of the Ebola response IPC work. By retraining community engagement officers in other disease areas the investment made through this project provide a platform for sustainable improvement in the health system as the country transitions from Ebola to broader health objectives. Additionally, WHO will continue to support the MOHS and embed capacity within the DHMTs to build capability and ensure that best practice in epidemic response are mainstreamed in the health system as the DMHTs take over the functions from the DERC in 2016.

- **Lessons learned**

Strategic Objective MCA1- Identify and Trace People with Ebola

- Initial focus was on case management, but it was later understood that identification of the next likely cases i.e. contacts, and determining high versus low risk was also key.
- Lack of sufficient people with sufficient skills in contact tracing. The mentoring system worked to build this local capacity efficiently.
- The rapid decline in cases in June/July resulted in an equally quick reduction in the number of employed contact tracers. Given the probability of a flare up during the period of heightened surveillance this reduction in personnel may have been premature and has resulted in some trained individuals moving out of the area. Consequently if a new cluster of cases does occur new contact tracers would need to be trained delaying response efforts. It may be advisable in future to invest in maintaining capacity in line with possible mid term re-emergence, rather than short term case numbers.

Strategic Objective MCA3- Care for Persons with Ebola and Infection Control

- Despite recommendations and standards on IPC compliance, it remains challenging for some facilities to comply. Delays in supply distribution meant it was difficult for treatment centers to fully operate according to IPC recommendations. There is a need to support MoHS in increasing their capacity in delivering a reliable supply chain and to address the parallel IPC supply chains that exist at district level.
- While the absence of a national IPC guideline and training modules has been overcome, the workshops with senior MoHS managers identified that implementation of the national guidelines will be a significant challenge due to a lack of national health and safety policy to manage the occupational health and safety needs of HCWs.
- An important aspect of improving the team's work has been through feedback from collaborating partners.
- The rotation of deployed staff has provided insight into methods of improvement and has enabled the continual adaption and improvement of the team's work and deliverables.

Strategic Objective MCA9- Reliable Supplies of Material and Equipment

- Lack of WHO office space and fluctuations in staff numbers. Additionally high rotation of the staff created high logistical demands that were not easy to plan for due to a lack of visibility on deployments and rotations.

- Staff lacked knowledge of WHO rules and procedures e.g. field coordinators being unable to approve a procurement in the system as they were unfamiliar with the system or the required processes. Additionally those on consultant contracts don't have access to the system required to approve procurement requests. While this was resolved by procurement being conducted through centrally it highlights that in addition to technical and operational knowledge coordinator need an understanding of WHO finance, HR rules, system processes.
- Preparing for the rainy season. Procured fire extinguisher, tool boxes and medical equipment for all WHO owned vehicles. All vehicles were fully equipped by May.

Strategic Objective MCA11- Social Mobilization and Community Engagement

- The practices of Traditional Healers and Secret Society Leaders are their livelihood. This has present a key challenge in messaging and trainings targeting this group. They have been deeply affected by the Ebola epidemic.
- Issues with the initial responses and the resulting association of PHUs with Ebola infection or death have deepened mistrust and reduced use of PHUs. This has impacted on other health priorities. Rebuilding trust in PHUs needs to be a core responsibility of social mobilisation officers moving forward to support effective Ebola surveillance and address other health priorities. Social mobilisation officers have received training, orientation and in depth briefing to build their capacity and ensure they understand the issues and challenges faced in the implementation of other priority health programmes in communities.
- **Story on the Ground**

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

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