#67

EBOLA RESPONSE MULTI-PARTNER TRUST FUND

PROPOSAL

Proposal Title: Preparedness Joint Programme	Recipient UN Organization(s): WHO, UNICEF, UNFPA
Proposal Contact: Alex Chimbaru, a.i Address: WHO Sierra Leone Telephone: +232 79911353 E-mail: *chimbarua@who.int* Sandra Lattouf Address: UNICEF Telephone: +232 76291023 E-mail: slattouf@uniel.org Dr.Kim Dickson Address: UNFPA Telephone: +232 79 440 022 E-mail: dickson@unfpa.org	**Implementing Partner(s) – name & type (Government, CSO, etc.):** WHO, UNICEF via Government and CSO, UNFPA, Ministry of Health and Sanitation in Sierra Leone.
Proposal Location (country): ☐ Guinea ☐ Liberia ☒ Sierra Leone ☐ Common Services	**Proposal Location (provinces):** National
Project Description: Within a theory change framework (Annex 1), the joint proposal is focusing on IHR Promoting the implementation of IHR (2005) including border health components; Strengthening real-time surveillance for priority public health diseases, conditions and events; Strengthening Surveillance for public health events in the community; Establishing Events based surveillance; Promote community ownership and participation in preparedness and response to outbreaks and other public health events; Strengthening community based maternal death surveillance and response (MDSR) ; Maintaining safe motherhood	**Requested amount: $ 2,496,010** Other sources of funding of this proposal: Other Sources (indicate): DfID-SLP, DFID Resilient Zero, UNFPA Core Resources, UNICEF Core Resource, CDC, Canada, AND World Bank Government Input: Availability of District social mobilization and community engagement coordinators under Heath Education Division facilitate district and sub-district level coordination. The capacity at the MoHS Public Health Emergency Operating Center core effort wills be leveraged with this project, along with existing district capacity. Number of beneficiaries will range form 15K to 25K People

	Start Date: *1 September, 2017* End Date: 1 September, 2018 Total duration (in months): 12 Months

STRATEGIC OBJECTIVES AND MISSION CRITICAL ACTIONS to which the proposal contributes. The SO and MCAs to which each project contributes should be identified. For proposals responding to multiple Mission Critical Actions (MCAs) within one or more Strategic Objectives (SOs), [usually one only] please select the primary MCA to which the proposal contributes.	
☐SO 1 Stop Outbreak MCA1: **Identifying and tracing of people with Ebola** ☐SO 1 Stop Outbreak MCA2: **Safe and dignified burials** ☐ SO 2 Treat Infected People MCA3: **Care for persons with Ebola and infection control** ☐ SO 2 Treat Infected People MCA4: **Medical care for responders** ☐ SO 3 Ensure Essential Services MCA5: **Provision of food security and nutrition** ☐ SO 3Ensure Essential Services MCA6: Access to basic services ☐ SO 3Ensure Essential Services MCA7: **Cash incentives for workers** ☐SO 3Ensure Essential Services MCA8:Recovery and economy ☐ SO 4 Preserve Stability MCA9:**Reliable supplies of materials and equipment** ☐SO4Preserve Stability MCA10: Transport and Fuel ☐SO 4Preserve Stability MCA11:**Social mobilization and community engagement** ☐SO4Preserve Stability MCA12: Messaging ☒SO5PreventFurther Spread MCA13:Multi-faceted preparedness	
Recipient UN Organization(s) WHO Sierra Leone UNCEF Sierra Leone UNFPA Sierra Leone	***Chair of the Advisory Committee Ebola MPTF:*** Signature Date:
Name of Representative: Alex Chimbaru, a.i. Name of Agency: WHO	Signature Date:
Name of Representative: Sandra Lattouf Name of Agency: UNICEF	Signature Date:
Name of Representative: Dr.Kim Dickson Name of Agency: UNFPA	Signature Date:

Chief Medical Officer: Dr. Brima Kargbo Ministry of Health and Sanitation	Signature:
	Date:

a) **RATIONALE FOR THIS PROJECT**

The recent unprecedented Ebola Virus Disease (EVD) epidemic in West Africa that started in Guinea and later spread to neighboring Liberia and Sierra Leone confirmed the critical importance of countries strengthening health systems and in particular national disease surveillance and response capacities and inter-country as well as in-country partnerships for early outbreak detection, notification and effective response. The outbreak also demonstrated the propensity of outbreaks to rapidly spiral out of control with spill-over effects that can transcend local and national boundaries. The EVD initial cases occurred in a remote rural area of Guinea, but spread rapidly including to densely populated urban centers within the country, to neighboring nations across the porous borders (Liberia, Sierra Leone), and to other countries in the sub-region (Mali, Nigeria, Senegal) and other continents through the increasingly efficient aviation industry.

In July 2014, with (729 deaths out of 1323 cases as of 27 Jul 2014), the World Health Organization (WHO) convened an emergency meeting with health ministers from eleven countries and announced collaboration on a strategy to co-ordinate technical support to combat the epidemic.

On 8th August 2014 with the total reported cases and deaths (1779 reported cases and 961 reported deaths affecting four countries) being the highest ever recorded in any EVD outbreak and still rising, WHO declared the outbreak a Public Health Emergency of International Concern (PHEIC) and published a roadmap to guide and coordinate the international response to the outbreak. The United Nations Security Council declared the outbreak a threat to international peace and security. The Security Council unanimously adopted United Nations Security Council Resolution 2177, which among other things, urged UN member states to provide more resources to fight the outbreak and established a platform for coordinating the UN and other agencies to ensure a rapid, effective, efficient and coherent response to the EVD crisis.

In contributing to these efforts, the Ebola Response Multi-Partners Trust Fund (MPTF) accepted to avail to WHO financial support amounting to USD 2,073,205 to address the strategic objective of stopping the outbreak by identifying and tracing people with EVD. The eight months-project that started on 1st August 2015 focused on getting to and sustaining a resilient zero of EVD cases in the country through improved surveillance including community event based surveillance and response systems; enhanced rapid response and preparedness capabilities; strengthened cross border collaboration within the framework of the Mano River Union; targeted social mobilization and community engagement; and enhanced crisis communication with the general public.

These partnership efforts and commitment by national and International partners led to a steady decline in the number of EVD reported cases in the country, with the country being declared free from Ebola transmission on 27th February 2016.

Support to revitalizing capacity for health securities and emergencies:

Drawing from lessons learned during the EVD outbreak, the UN agencies started supporting the revitalization of capacities for prevention, detection, reporting and response to outbreaks and other public health events of

national and international concern from early 2015, by supporting the strengthening of implementation of the Integrated Disease Surveillance and Response (IDSR) strategy; laboratory role in clinical as well as public health; Infection Prevention and Control; and capacity for response to emergencies. This was within the national immediate and intermediate plans to stop the EVD transmission, sustain a resilient zero EVD cases, and commence national systems recovery from the effects of the outbreak. To afford the MOHS this support, the UN agencies in Sierra Leone have developed strong organizational structures and teams which are working hand in hand with international partners both at the national and sub-national level to support the government to set norms, standards and guidelines, providing technical support, catalyzing change, and building sustainable institutional capacity and ensuring coherent and effective operations.

The massive cholera outbreak of 2012-2013 and the subsequent EVD outbreak were a pointer to the prevailing weaknesses in the country's capacity for disease surveillance and response. Beginning 2015, WHO has been providing support to the revitalization of IDSR starting with adaptation of the IDSR technical guidelines, training modules and reporting tools, followed by building technical capacity among health workers at all levels through delivery of training packages. This was followed by country-wide roll-out of the IDSR strategy's Indicator Based Surveillance (IBS) to all 14 districts and more than 1375 health facilities, aiming to have at least one health worker trained in IDSR in each health facility. Subsequently, WHO plans to support the MOHS to continue building capacity of health workers to address issues of staff attrition, new staff and suboptimal IDSR performance among others.

With this foundation laid, the next phase involved improving IDSR performance parameters including completeness and timeliness of IDSR reporting. WHO field staff provided support to the District Health Management Teams (DHMTs) in receiving, transcribing, validating and reporting IDSR data. IDSR performance indicators were reviewed at national and district level and feedback provided during national diseases surveillance review meetings with district medical officers (DMOs) and district surveillance officers (DSOs) and monthly district level meetings with health facility in-charges. Feedback on IDSR performance indicators are also provided through production and dissemination of national weekly epidemiological bulletin. Districts are also supported by WHO field staff to produce the district weekly epidemiological bulletin. Mentorship of district and health facility personnel was conducted through On the Job Training (OJT), prioritizing challenged health levels and facilities. Focus was also made to critical public health challenges, including inclusion of maternal deaths surveillance in the IDSR system with the goal of establishing the trends and factors surrounding maternal deaths so as to inform public health actions.

In tandem with these support, WHO partnered with CDC and Ehealth Africa to support the use of innovations in surveillance and response. The national level was supported to conduct IDSR supportive supervision and Data Quality Assessments (DQA) with the aim to assess the functionality of the system, identify gaps and challenges and provide recommendations for improvement. The Ministry was enabled to conduct IDSR support supervision and DQA using an electronic data collecting platform that offers the benefit of real-time access to the data as it is collected, easy data retrieval and analysis, data security and establishment of a national database. The MOHS with support from WHO and other partners is working to institutionalize regular IDSR support supervision and DQA so as to monitoring the functionality of the disease surveillance and response system. An electronic web-based platform (e-IDSR) for reporting and handling routine IDSR data was developed and deployed for data entry at district level which will subsequently be rolled out in all health facilities during 3rd quarter of 2017. The system that has been integrated with the national reporting system (DHIS2) for efficiency and sustainability has eased data entry, improved data quality, ensured a national IDSR database and increase efficiency.

Drawing from the experience with Community Events Based Surveillance (CEBS) during the EVD outbreak, the country was supported to rollout for the first time Community Based Surveillance (CBS) starting in the 3rd quarter of 2016. Following the development of CBS Standard Operating Procedures, guidelines, training manual, reporting tools and job aides, CBS was first rolled out in 3 districts. The second set of 6 districts started implementing CBS in January 2017, with the final 5 districts planned to implement CBS in the 2nd quarter of 2017. Once fully implemented, CBS will increase the sensitivity of the surveillance system by further broadening the surveillance base.

Sierra Leone is a signatory to the International Health Regulations (IHR) 2005 and has also committed to joining the international collaborative effort for international health security under the Global Health Security Agenda (GHSA). The country adopted the IHR (2005) and conducted an initial assessment in 2009 but without subsequent action planning to address identified gaps and establish critical core capacities for the implementation of IHR. Beginning 2015, the country was supported to improve development of IHR core capacities, first by conducting an IHR desk review and developing a draft 2-years action plan. In 2016, Sierra Leone was the 6th country in Africa to undergo the IHR Joint External Evaluation (JEE) as a multi-sector process with the goal of determining its capacity to assure global health security under the IHR (2005)/GHSA 19 technical areas. WHO has engaged other GHSA in-country partners to support the MOHS to use the findings of this assessment to develop a 5-years National Action plan for Public Health Security (NAPHS) that will guide the implementation of IHR (2005) and contribute to the GHSA.

To strengthen border security, the country is engaged in regional efforts driven by West African Health Organization (WAHO), WHO-AFRO, WHO-IST, IOM and USAID for regional collaboration on health emergencies, malaria and Neglected Tropical Diseases (NTDs). As the administrative arrangements are still being worked on, the country is involved in bilateral initiatives with Guinea and Liberia for cross-border collaboration. To this end, all the seven border districts have been supported to form border health committees and conduct scheduled meetings with their counterparts from the two countries. At the same time, the country conducted an assessment of the functional status of its PoEs, conducted a training of personnel working at PoEs and inducted border health committees on cross-border collaboration. The ministry will shortly be supported to develop guidelines to implementation of IHR at PoEs and cross-border collaboration for health.

To address the high maternal mortality, UNFPA supported the country to adopt the institutionalization of Maternal Death Surveillance and Response (MDSR) into the national health system by developing guidelines, supporting capacity building, and establishing local and national structures, among others with the aspiration of the identification and building a response to the maternal deaths of women and girls. MDSR involves a continuous surveillance and action cycle of identification, quantification, notification and review of all maternal deaths. The interpretation of the aggregated information is used to recommend actions that will prevent future deaths. Though some progress has been made, multiple challenges persist in the realization of optimum quality of MDSR program implementation in the country. These include: few number of trained personnel on MDSR within the MDSR committees, pervasive community bylaws surrounding maternal health seeking behavior for community deaths that are linked with some punitive measures, limited institutionalization of MDSR at the grass root level, low level of community participation and ownership, limited integration of the MDSR system with Civil Registration and Vital Statistics (CRVS), poor documentation and reporting of maternal deaths on arrivals, poor documentation of notification and investigation reports, limited practices in verification of all deaths among women of child bearing age, low quality of maternal death investigation and reviews as result of poor recording of obstetric information and lack of capacity and non-adherence to standard classification of causes of maternal deaths (ICD-MM).

Following this continued support to the MOHS, the performance of the surveillance system has continued to improve. The proportion of health facilities submitting routine weekly IDSR reports to the national level through their districts has steadily increased from an average of 76% in quarter 3 of 2015 to an average of 84% in quarter 1 of 2016 and to an average of 97% in quarter 1 of 2017. During quarter one of 2017, eighty eight percent (88%) of suspected outbreaks/public health events were detected by health workers, with 13% of these having been picked up by CHWs and referred to health facilities. Eighty eight percent (88%) of the suspected outbreaks/public health events were notified on time to the district health management teams while 94 % were duly responded to on time by the district Rapid Response Teams (RRTs). These indicators are well above the IDSR standard target of 80%. The country has also realized a three-fold improvement in detection and notification of maternal deaths with.

Under the CBS strategy, all trained districts are reporting alerts to their respective health facilities weekly, with close to three quarters of the over 8,000 trained CHWs in the 9 implementing districts actively reporting weekly. Alerts reported through the CBS system are initially verified by health workers then included in the IDSR report of the verifying health facility if they meet the standard case definition. Some mechanisms are established to assess the functionality of the CBS system including the monitoring of the CBS performance indicators through the weekly epidemiological bulletin and inclusion of CBS in the IDSR support supervision.

Sustaining gains made

The UN agencies and other international partners have supported the MOHS to stop EVD transmission. In the immediate post EVD period, the next phase of partnership focused on sustaining and further developing an effective system to detect, alert and respond to new Ebola cases and other diseases of public health concern and supporting the President's Recovery Priorities of:

1. A resilient 'zero' and a sustainable health system.
2. A drastically reduction of maternal and child mortality and morbidity

The implementation of the 6-9 months post EVD plan and the 10-24 months post EVD recovery plans included strong components of disease surveillance, response, IPC, laboratory diagnostics, addressing maternal, Neonatal, childhood and adolescent health issues, and community engagement. As the last of the post EVD recovery plans (10 – 24 months post Ebola recovery plan) comes to an end in June 2017, there is need for the MOHS to be supported to transition service delivery to address routine clinical as well as public health needs building on and sustaining the gains already realized. WHO, UNICEF and UNFPA have identified specific areas whose further support is critical to establishing and maintaining the required public health security through prevention, detection and appropriate response to public health emergencies and other public health events of national and international concern.

i. IHR (2005): Following the IHR JEE and the ongoing efforts to develop the NAPHS, WHO will support quarterly IHR/GHSA/One Health meetings whose goals are: for IHR (2005) coordination around the IHR NFP and bringing in representatives from the other key implementation areas; to harmonize and synergize efforts by the GHSA partners in the country and; to improve coordination in the health sector under the One Health strategy.

Once the NAPHS is developed, resourced and implemented, there will be need for annual monitoring of the progress of implementation against the set milestones. IHR desk reviews will also be conducted for annual reporting to the World Health Assembly.

Border security is a critical component of IHR. WHO in collaboration with IOM and other partners will continue

supporting establishment of core capacities at Points of Entry (PoEs) to ensure prevention, detection and appropriate response to public health risks among travelers, conveyances, baggage, goods and cargo at PoEs. Acknowledging that a significant international movement of goods and people happens away from manned PoEs, the country will collaborate more with its immediate neighbors in the sub-region through sub-national structures (district to county in the case of Liberia or district to prefecture in the case of Guinea), bilaterally and multilaterally with administrative arrangements, meetings for information exchange, and joint planning and response to public health events

ii. IDSR: There is need to continue supporting further development and improvement of the IDSR systems three components:

- Indicator Based Surveillance (IBS) has reached a reassuring level of functioning. There is however need to revise the strategy following the ongoing revision of the 2nd edition of the IDSR strategy by WHO-AFRO. The country's strategy will be adapted to align it with the 3rd edition of the IDSR strategy. As this will affect the technical guidelines, training modules and reporting tools, these will be revised, printed and distributed to health levels and facilities.

  There will also be need to re-train health workers at all levels and health facilities in the revised strategy to bring them to speed with the changes. Technical people from other departments of the MOHS, other GOSL agencies (including Environmental Protection Agency, Ministry of Agriculture, animal health experts and customs) and partner organizations who play a role in disease prevention, detection and control will also be trained.

  In line with one of the key objectives of the IDSR strategy to increase involvement of clinicians in disease surveillance and response, clinicians too will be trained in their role in IDSR so as to maximize their role in disease detection, reporting and response which includes case management.

  In recognition of the global trends of increasing use of technology in health, and drawing from the gains made in the phase 1 rollout of e-IDSR to district level, there will be need to roll-out e-IDSR to health facilities. This will involve procurement/replacement of input gadgets, training of selected health workers in all reporting health facilities and providing Closed User Group (CUG) services linking all levels to ensure effective reporting and other communication between health facilities, districts and national. The functioning of the system will be assured through preventive maintenance and responding to technical issues.

  The MOHS will also be supported to sustain supervision, DQA and monitoring and evaluation of the IBS to sustain improvement and address evolving challenges.
- Community Based Surveillance: As roll-out of CBS will be completed in this year, the main activities will revolve around monitoring the performance of CBS and its contribution to public health surveillance. District, Chiefdom and health facility personnel will also be supported to respond to and verify CHWs reported events for management and for inclusion in the IBS data. CBS tools will also be reviewed, printed and distributed and for consideration in developing electronic platforms for CBS reporting and data management.
- Events Based Surveillance (EBS): EBS is a WHO strategy for monitoring, collecting, assessing and interpreting of mainly unstructured ad hoc information regarding health events or risks which may represent an acute risk to human health as interpreted within the country context and vulnerability. EBS relies on the different levels of the health care system scanning local and international media, tracking events on sites like promed and noting, documenting and investigating rumours of public health events

that may include animal die offs. The events may include confirmed outbreaks occurring in outside jurisdictions, media reports and rumours of illnesses in people or animals and events occurring in the environment that may affect human and/or animal life. Information from EBS is an important source of public health early warning systems that enable the country to assess risk and take appropriate measure to mitigate the potential impact on public health.

Since EBS surveillance had not been implemented in the country, the MOHS will be supported to adapt the guidelines and create technical capacity for implementing and monitoring EBS. This is critical to having a complete surveillance system as EBS complements IBS and CBS.

Infection Prevention and Control: IPC is an essential component in preventing occurrence of health care-associated infections hence promoting quality of care. The EVD outbreak provided an opportunity to establish a functional IPC system in the country. There is need to consolidate the gains and ensure IPC capacity is enhanced in line with IHR (2005). Through the MPTF support WHO plan to support the regional hospitals in providing emergency supplies of PPE and train district and hospitals IPC focal persons.

i. **Maternal Death Surveillance and Response:** UNFPA proposes to continue supporting the Ministry of Health and Sanitation in maintaining appropriate and improved maternal death surveillance and response (MDSR) system at facility and community levels in all 14 districts and 8 secondary health facilities. Understanding the challenges and lessons learnt from MDSR, UNFPA plans to lay emphasis on the need to strengthen MDSR through enhancing community mobilization and creation of awareness on the need of maternal death reporting at all levels, improving community ownership and participation and advocating for the removal of bylaws which might be an hindrance to community level maternal death reporting. In addition, UNFPA will support activities at improving quality of investigation and reviews through training and capacity building of MDSR committee members, improving documentation of clinical information, notification, investigation and reports, strengthen data quality management and use of MDSR findings as well as supporting investments on quality of care, and enhancing access to blood transfusions among others.

ii. **Community ownership and action for Preparedness:** Early on in the Ebola outbreak of 2014 the national response plan recognized 'social mobilization/ public information' as a strategic intervention 'to create public awareness about Ebola, the risk factors for its transmission, its prevention and control' (World Health Organization, 2014). The spread of the disease took a turning point once communities, specifically community leaders and village headmen, were placed at the forefront of the response and took ownership of the fight against the disease.

As an effort to sustain outbreak preparedness and response, deepened community engagement and bottom-up action for surveillance, active case finding, contact tracing, sustaining positive behaviors and preparedness & rapid response will be critical. UNICEF will lead the community engagement component in this project and build on experiences during the EVD outbreak and the subsequent recovery phase. One of the key interventions will be to consolidate and strengthen multiple community based platforms for preparedness and response with well-defined roles and responsibilities. Paramount chiefs and Ward Councillors with other identified community stakeholders will be made responsible for the functioning of the community based platforms, especially the Village Development Committees and ensure accountability at all levels. To ensure stronger co-ordination between implementing partners, administrative and traditional structures, capacities of national and district Social Mobilization Pillars will be built.

As part of the preparedness, messaging on key positive behaviours will be integrated into the ongoing radio drama series that UNICEF is supporting on health and education issues. These dramas reach very distinct audiences and will contribute to preventive behaviour adaptations thereby minimizing the impact of impending risks. In addition to these, based on risk assessments, ready to print information, education and communication (IEC) materials will be prepositioned in order to respond to any emergency in the quickest possible time.

iii. **Maintaining safe motherhood:** The Ebola outbreak resulting in the breakdown of key reproductive health services that partly accounted for the unprecedented high maternal and infant mortalities. UNFPA will support the re-building and maintenance of key reproductive health services that are vital to maternal and new-born survival. We aim to save the lives of mothers and babies through expanding ANC coverage, sustaining family planning services, maintaining PMTC services and supporting continuous on the job training of EmONC service Providers. This will enable preparing the health system capacity to continue providing such services even during outbreaks.

Finally, it is also important to note that with support from DFID, UNICEF and WFP, Canada, CDC and World Bank established an inter-agency stockpile of key supplies to respond to an EVD or any other type of diseases outbreak. These supplies have been prepositioned in the district of Port Loko.

b) PROJECT OBJECTIVES

1. Promoting the implementation of IHR (2005) including border health components
2. Strengthening real-time surveillance for priority public health diseases, conditions and events
3. Strengthening Surveillance for public health events in the community
4. Establishing Events based surveillance
5. Strengthening capacity for Infection Prevention and Control in Regional Hospitals
6. Promote community ownership and participation in preparedness and response to outbreaks and other public health events.
7. Strengthening community based maternal death surveillance and response (MDSR)
8. Maintaining safe motherhood

c) COHERENCE WITH EXISTING PROJECTS

This proposal is in continuation with the previous proposal for funding by MPTF that came to an end in March 2016, and the 6-9 months and 10 – 24 months post Ebola recovery strategies, the later which comes to an end in June 2017. It is therefore in line with on-going efforts by the MOHS, WHO, UNICEF, UNFPA and partners to rebuild the health system by establishing and maintaining routine capacities, in particular the surveillance, health information system management and response to ensure prevention, early detection, notification and appropriate response to current and future epidemics.

The proposal will allow for further strengthening and sustaining the gains made in the public health surveillance and response system at the national and district levels, in health facilities and in the community.

The proposal is also aligned to the need for the agencies to work with and alongside other health partners in the country. The implementing partners will implement the proposal in collaboration with key partners in health development and different NGOs specifically supporting surveillance and response as well as other government programs. Existing technical working groups and coordination platforms (including the IHR/GHSA/OH coordination

platform, CBS TWG, electronic reporting TWG, surveillance TWG, laboratory working group, border health working group among others) will be used for effectiveness and efficiency. These resources will be used to strengthen CBS building on the experiences of the Community-events based surveillance that's been piloted by partners.

The proposal is in consistence with the draft MOHS strategic plan and the disease surveillance program plan. It will also contribute to reducing maternal and neonatal mortality and improving health outcomes for women and children.

d) **CAPACITY OF RUNO(s) AND IMPLEMENTING PARTNERS:**

The MoHs is still faced with health system challenges, including the adequate numbers and technical capacity of health workforce. While transitioning from EVD response to establishing system resilience to provide Essential Services, the agencies will provide both technical and operational support to both MoHS and partners. The longstanding WHO and CDC collaboration on IDSR will ensure availability of additional resources and subject matter specialists especially strengthening information management and laboratory capacity for early detection of disease outbreaks. It is expected that if the capacity of the surveillance system is strengthened to detect, report, analyze data and respond, current and future outbreaks response will be more efficient and timely to save more lives.

WHO, UNICEF and UNFPA have been at the frontline in partnering with NGOs and supporting the MOHS during the EVD outbreak and in the post-EVD recovery period. The organizations have retained the requisite technical and institutional capacity to ensure this support with technical staff available at national and district levels. The agencies will continue working in complementarity with each other while focusing on agency-specific strengths.

PROPOSAL MANAGEMENT

WHO, UNICEF and UNFPA have strength in the development and adaptation of guidelines, SOPs, and operational manuals, modules and job aides. The MOHS will be supported to develop/adapt/update, print and disseminate these guiding material to provide direction in the areas that this proposal supports. UNICEF has strength in communication and community engagement.

The implementing agencies will also support the Ministry in the coordination of health sector partners' activities and in managing the resources for activities that will be directly implemented by the MOHS programs.

The agencies will provide technical and operational support for interventions at the national, district and community level, and in health facilities. Most importantly, program delivery support will be provided at the district level. To realize this, the agencies have retained personnel at the country office and in all 14 districts with the right mix of technical knowledge and skills in epidemiology, delivery of basic health care package and program management.

As a lead for the project, WHO will assume the following duties:

- Maintain a clear overview of progress against work plan activities and associated spending at all times
- Coordinate all activities related to the proposal, while ensuring activities are covering gaps, and avoiding duplication of efforts
- Maximize collaboration among partners.
- Serves as primary liaison for UNCIEF, UNFPA and MPTF
- Supports the Technical Advisor on day-to-day activities

- Assists Partners with day-to-day administration and implementation
- Provide monitoring and oversight of the project implementation

Work Plan – WHO

Objective	Activity	Indicator
1. Promoting the implementation of IHR (2005) including border health components	Hold IHR quarterly coordination meetings	Number of meetings held
	Hold a sensitization and advocacy meeting between key stakeholders involved in IHR implementation at PoEs	Number of meetings held
	Meeting to evaluate progress on implementation of the National Action Plan for Health Security	Number of meetings held
	Build capacity for implementation of IHR 2005 by training technical persons from key sectors	Number of personnel trained
	Assess Lungi International airport, one seaport and ground crossing PoEs in 7 border districts	Number of PoEs assessed
	Supervise PoEs	Number of PoEs supervised
	Support designated PoEs to develop, implement, test and update emergency operations plans	Number of designated PoEs with updated emergency operations plans
	Support quarterly cross-border surveillance coordination meetings in 7 border districts	Number of meetings held
2. Strengthening real-time surveillance for priority public health diseases, conditions and events	Revise IDSR strategy to conform to 3rd edition AFRO revision (workshop, then secretariat meeting, then validation meeting)	Availability of the revised IDSR strategy
	Print and distribute IDSR and IHR material	Number of material printed
	Train health workers and health managers on IDSR to address staff attrition, new staff and to address performance issues)	Number of health workers trained
	Train clinicians in high volume health facilities in 14 districts on clinicians role in IDSR	Number of clinicians trained
	Support Quarterly surveillance review meetings at national level and with WHO field staff	Number of meetings held
	Support national level to conduct biannual IDSR DQA at district and health facility levels	Number of districts and health facilities with IDSR data assessed by national level

Objective	Activity	Indicator
	Support districts to conduct DQA in health facilities biannually	Number of health facilities with IDSR data assessed by districts
	Support national level to conduct quarterly supportive supervision on IDSR at district and Health facility levels	Number of health facilities supervised by national level
	Support districts to conduct supportive supervision	Number of health facilities supervised by districts
	Meeting for M & E of IDSR implementation	Number of M & E meetings held
	Train Health Facility focal persons on eIDSR	Number of health facility focal persons trained on eIDSR
	e-IDSR system support and maintenance	Proportion of health facilities reporting through e-IDSR
3. Strengthening Surveillance for public health events in the community	Support sensitization of community local leaders and opinion shapers on CBS Adapt	Number of local leaders sensitized
	M & E of CBS to establish progress and contribution to public health surveillance	Number of meetings held to monitor and evaluate
	Support response to CBS alerts (1 alert per chiefdom/ward per month)	Proportion of alerts responded to
4. Establishing Events based surveillance	Event-based Surveillance (EBS) guidelines	Adapted EBS guidelines
	Develop an EBS training package	EBS training package developed CBS
	Print and disseminate the EBS guidelines and training material	Number of EBS guidelines printed
	Train health workers on event-based surveillance including early warning systems	Number of health workers trained

Work Plan – UNICEF

Objective	Activity	Indicator
1. Promote community ownership and participation in preparedness and response to outbreaks and other public health events.	Update National and District Community engagement and social mobilization preparedness plans	National and district preparedness plans reviewed and updated
	Engagement of Paramount chiefs and Ward Councilors (WA) for Chiefdom / Ward preparedness plans	Number of PCs and WCs oriented on preparedness plans
	Rapid behavioral assessments and anthropological studies in case of an outbreak	Updated message guide for specific outbreak
	Coordination and monitoring of response	Number of outbreaks supported as per IARR SOP
	Sustaining positive behavior promotion using mass media	Number of community radio networks integrating positive behaviours in existing health and education radio dramas.
	Preposition IEC materials on key behaviours	Multi-media package of IEC materials available
	Intensified social mobilization in case of response	Proportion of affected communities with intensified social mobilization

Work Plan – UNFPA

Objective	Activity	Indicator
1. Enhance the capacity of MDSR Committee Members and personnel at district, sub-district and community levels	Train Midwife investigators to efficiently investigate maternal deaths in the community (14 Districts	Number of MW Investigators trained
	Train Community Health Workers to enhance prompt maternal death notifications (14 Districts)	Number of CHWs trained
	Train Monitoring and Evaluation officers on data management and documentations (14 Districts)	Number of M & E Officers trained
2. Build health facilities capacity to respond to obstetric emergencies and track and respond maternal deaths at facility and community levels in all 14 districts and 8 secondary health facilities	Support a mentoring system from CEmONC to BEmONC and lower facilities to ensure compliance with the national EmONC guidelines	Number of EmONC Facilities benefiting from mentorship programme
	Support the monitoring of EmONC services across the EmONC facilities in all 14 Districts and 8 Secondary Hospitals	Number of facilities monitored
	Support District level to conduct quarterly supportive supervision on MDSR Personnel and Stakeholders at District and Community levels (14 Districts)	Number of MDSR Service Providers supervised
3. Maintaining improved maternal death surveillance (notification and reporting) including community based surveillance in all 14 districts	Support the establishment of community based notification for maternal deaths supported by SMS/mobile reporting system in all 14 Districts (including trainings, logistics etc.)	Number of reports received using this medium
4. Sustain accurate and timely dissemination	Develop IEC materials on Family Planning, Early Warning/Danger signs, Benefits of ANC, Hospital deliveries and Prompt reporting of Maternal deaths	IEC materials developed
	Print and disseminate IEC materials on Family Planning, Early Warning/Danger signs, Benefits of ANC, Hospital deliveries and Prompt reporting of Maternal deaths	Number of IEC materials printed and disseminated

Objective	Activity	Indicator
5. of Reproductive information and communication	Support the training and deployment of CAGs, Women groups and Civil Society groups as community advocates for positive behavioural changes around maternal/new-born health and reporting of deaths.	Number of reported deaths and reduced community maternal deaths
6. Maintaining safe motherhood	Sustain PMTC of HIV at District level	Number of Facilities that benefited
	Support OJT training of Health care Workers on EmONC competency based training	Number of HCWs trained
	Strengthen and maintain Family Planning Services at community level	Number of Communities that benefited
	Expand and sustain ANC coverage at District, sub-district and community levels.	% of ANC coverage

e) RISK MANAGEMENT:

Risks to the achievement of the set targets	Likelihood of occurrence (high, medium, low)	Severity of risk impact (high, medium, low)	Mitigating Strategy
Interruption in funding flow	Low	High	• Seeking alternative funding • Co-implementation with partners
Inadequate pool of epidemiologists with knowledge and skill in IDSR	High	Medium	• WHO to continue mentorship of local staff • FETP program to continue producing technical people • WHO personnel to offer technical back-stopping
Shifting priorities in the period leading to the national elections in early 2018.	High	High	• Continuing engagement of MOHS national and district managers • Identifying and working with engaged managers.

Risks to the achievement of the set targets	Likelihood of occurrence (high, medium, low)	Severity of risk impact (high, medium, low)	Mitigating Strategy
			• Setting right priorities
Violence associated with the electoral process	Low	High	• Right prioritization • Following security advisories • Scaling down operations • Shifting operations to safer areas • Using more local personnel
Inadequate numbers and quality of health workers	High	Medium	• Mentorship and training • Role shifting • Collaboration with partner organizations
Uncoordinated efforts amongst partners in surveillance and response leading to duplication of efforts and lack of a coherent approach.	Low	Medium	• Coordination meetings with MOHS and partners • Using TWGs for consensus setting • Establishing expectations of partner organizations.

f) MONITORING & EVALUATION

The supported UN agencies through their respective cluster and team leads will monitor activity implementation together with its outcome through monthly updates and reports from the field teams. The updates and reports that will be made by the field teams and shared with the supported UN agencies through the MOHS will include outcomes, experiences and challenges to the implementation of each activity. These will allow for tracking of progress and activity implementation planning.

The supported UN agencies will prepare quarterly and annual progress reports as well as a final project report which will be submitted to the project coordinator at WHO. The project coordinator will collate the reports and prepare summary reports that will be submitted to the MPTF office. As part of these quarterly, annual and final reports, performance measurement indicators will be computed and included as part of the monthly narrative and financial report on the status of activities.

The Final report will include a financial expenditure report which would be a reconciliation or accounts combined with a final progress report that would demonstrate the progress towards the agreed targets, outputs, deliverables and scheduled plans.

The project coordinator based at WHO will be responsible for receiving and collating reports from UNICEF and UNFPA and from the responsible WHO cluster.

Proposal Title: Preparedness Joint Programme					
Strategic Objective to which the Proposal is contributing[1]	☒ SO5PreventFurther Spread MCA13:Multi-faceted preparedness				
Effect Indicators	Geographical Area (where proposal will directly operate)	Baseline[2] In the exact area of operation	Target	Means of verification	Responsible Org.
Proportion of health facilities with updated rumor logbooks[3]	National	29%	60%	Supervision reports (quarterly)	WHO
Proportion of events detected by HWs and CHWs	National	88%	95%	Outbreak reports	WHO
MCA13:Multi-faceted preparedness					
Output Indicators[4]	Geographical Area	Target[5]	Budget (US$)	Means of verification	Responsible Org.
Number of IHR quarterly coordination meetings held	National	4	Please see budget	Quarterly reports	WHO

1. Proposal can only contribute to one Strategic Objective
2. If data are not available please explain how they will be collected.
3. This indicator measures the proportion of health facilities that are maintaining updated rumour log books as found during quarterly support supervision. The MOHS has printed and distributed rumour logbooks for use in logging and tracking events as part of EBS.
4. Project can choose to contribute to all MCA or only the one relevant to its purpose
5. Assuming a ZERO Baseline

Number of meetings held to evaluate progress of implementation of NAPHS	National	1	Please see budget	Status report	WHO
Number of technical people trained in IHR	National	120	Please see budget	Training reports	WHO
Number of PoEs assessed for implementation of IHR	National	9	Please see budget	Assessment reports	WHO
Number of PoEs supervised	National	18	Please see budget	Supervision reports	WHO
Number of quarterly cross-border coordination meetings held	National	24	Please see budget	Minutes and quarterly reports	WHO
Revised IDSR strategy	National	1	Please see budget	Revised strategy	WHO
Number of printed IDSR/IHR material	National	5000	Please see budget	Monthly reports	WHO
Number of HWs trained in IDSR	National	455	Please see budget	Monthly reports	WHO
Number of clinicians trained in clinicians role in IDSR	National	100	Please see budget	Monthly reports	WHO
Number of quarterly surveillance review meetings held at national level	National	4	Please see budget	Quarterly reports	WHO
Number of health facilities with IDSR data assessed by national level	National	200	Please see budget	Monthly reports	WHO
Proportion of CBS reports verified	National	80%	Please see budget	Monthly reports	WHO
Number of health facilities supervised by national level in a year	National	400	Please see budget	Quarterly supervision reports	WHO
Number of health facility focal persons trained in IDSR	National	1300	Please see budget	Monthly reports	WHO
Number of local leaders sensitized	National	1750	Please see budget	Monthly reports	WHO
Proportion of alerts responded to	National	90%	Please see budget	Monthly reports	WHO
Adapted EBS guidelines	National	1	Please see budget	Adapted EBS	WHO

				guidelines	
EBS training package developed	National	1	Please see budget	Developed EBS training package	WHO
Number of EBS material printed	National	1500	Please see budget	Monthly reports	WHO
Number of health workers trained in EBS	National	1400	Please see budget	Monthly reports	WHO

Number of MW Investigators trained	District	14	Please see budget	Training reports	UNFPA
Number of CHWs trained	Community	100	Please see budget	Training reports	UNFPA
Number of M & E Officers trained	District	28	Please see budget	Training reports	UNFPA
Number of EmONC Facilities benefiting from mentorship programme	District	120 HCWs	Please see budget	Status report	UNFPA
Number of facilities monitored	District	14	Please see budget	Program reports	UNFPA
Number of district level MDSR supportive supervision visits conducted	District	14	Please see budget	Supervision reports	UNFPA
Number of communities with enhanced maternal deaths notification	Community	70	Please see budget	Program reports	UNFPA
IEC materials developed	National	1	Please see budget	Program reports	UNFPA
Number of IEC materials printed and disseminated	District	5,000	Please see budget	Program reports	UNFPA
Number of EmONC OJT training for HCWs	District	30	Please see budget	Training reports	UNFPA
Number of Communities that benefited from PMTCT and HIV services	Community	30	Please see budget	PMTC and HIV Service reports	UNFPA

National and district preparedness plans reviewed and updated	National	15 plans		Compendium of preparedness and response plans.	UNICEF
Number of PCs and WCs oriented on preparedness plans	National	218	Please see budget	Orientation reports Field monitoring reports	UNICEF
Updated message guide for specific outbreak	National	1 updated messaging guide	Please see budget	Available guideline	UNICEF
Number of outbreaks supported as per IARR SOP	District	At least 2	Please see budget	Outbreak response reports	UNICEF
Number of community radio networks integrating positive behaviours in existing health and education radio dramas.	National	46 radio channels	Please see budget	Media agency report. Media Monitoring reports	UNICEF
Number of IEC materials available	National	50000 units	Please see budget	Distribution list	UNICEF
Number of affected communities with intensified social mobilization	Sub-district	10 Chiefdoms	Please see budget	Outbreak reports	UNICEF

WHO

WHO Sub-Total	1,361,470
Program Support Cost (7%)	95,303
WHO Total	**1,456,773**
UNICEF	
UNICEF Sub-Total	288,750
Program Support Cost (7%)	20,213
UNICEF Total	308,963
UNFPA	
UNFPA Subtotal	682,500
Program Support Cost : ICFUNFPA-7%;	47,775
Total Project Cost in USD	**730,275**
Grand Total	**2,496,010**

Costed Work plan – WHO

Objective	Activity	Amount (USD)
1. Promoting the implementation of IHR (2005) including border health components	Hold IHR quarterly coordination meetings	$8,400
	Hold a sensitization and advocacy meeting between key stakeholders involved in IHR implementation at PoEs	$2,800
	Meeting to evaluate progress on implementation of the National Action Plan for Health Security	$18,900
	Build capacity for implementation of IHR 2005 by training technical persons from key sectors	$37,800
	Assess Lungi International airport, one seaport and ground crossing PoEs in 7 border districts	$6,300
	Supervise PoEs	$6,300
	Support designated PoEs to develop, implement, test and update emergency operations plans	$50,000
	Support quarterly cross-border surveillance coordination meetings in 7 border districts	$58,800
2. Strengthening real-time surveillance for priority public health diseases, conditions and events	Revise IDSR strategy to conform to 3rd edition AFRO revision (workshop, then secretariat meeting, then validation meeting)	$40,000
	Print and distribute IDSR and IHR material	$47,045
	Train health workers and health managers on IDSR to address staff attrition, new staff and to address performance issues)	$80,000
	Train clinicians in high volume health facilities in 14 districts on clinicians role in IDSR	$28,500
	Support Quarterly surveillance review meetings at national level and with WHO field staff	$50,400
	Support national level to conduct biannual IDSR DQA at district and health facility levels	$16,800
	Support districts to conduct DQA in health facilities biannually	$24,500
	Support districts to conduct supportive supervision	$58,800

	Meeting for M & E of IDSR implementation	$12,600
	Train Health Facility focal persons on eIDSR	$71,500
	e-IDSR system support and maintenance	$9,800
3. Strengthening Surveillance for public health events in the community	Adapt Event-based Surveillance (EBS) guidelines	$28,875
	Develop an EBS training package	$15,750
	Print and disseminate the EBS guidelines and training material	$16,000
	Train health workers on event-based surveillance including early warning systems	$100,000
4. Establishing Events based surveillance	Support sensitization of community local leaders and opinion shapers on CBS	$61,250
	M &.E of CBS to establish progress and contribution to public health surveillance	$20,790
	Support response to CBS alerts (1 alert per chiefdom/ward per month)	$80,000
5. Strengthening capacity for infection prevention and control in regional hospitals	Procure and preposition IPC supplies for emergency response (assorted items)	$100,035
	Train districts and hospitals IPC focal persons on IPC and IDSR	$88,000
WHO Operational Cost	Wi-fi for the country office 2018	$46,688.40
	Mobile top up costs 2018	$65,853.00
	Utilities (electricity + water for WCO +Running cost)	$75,696.00
	Contribution UN Clinic Cost Sharing 2018	$33,288.30
TOTAL		$1,361,470

Costed Work plan - UNICEF

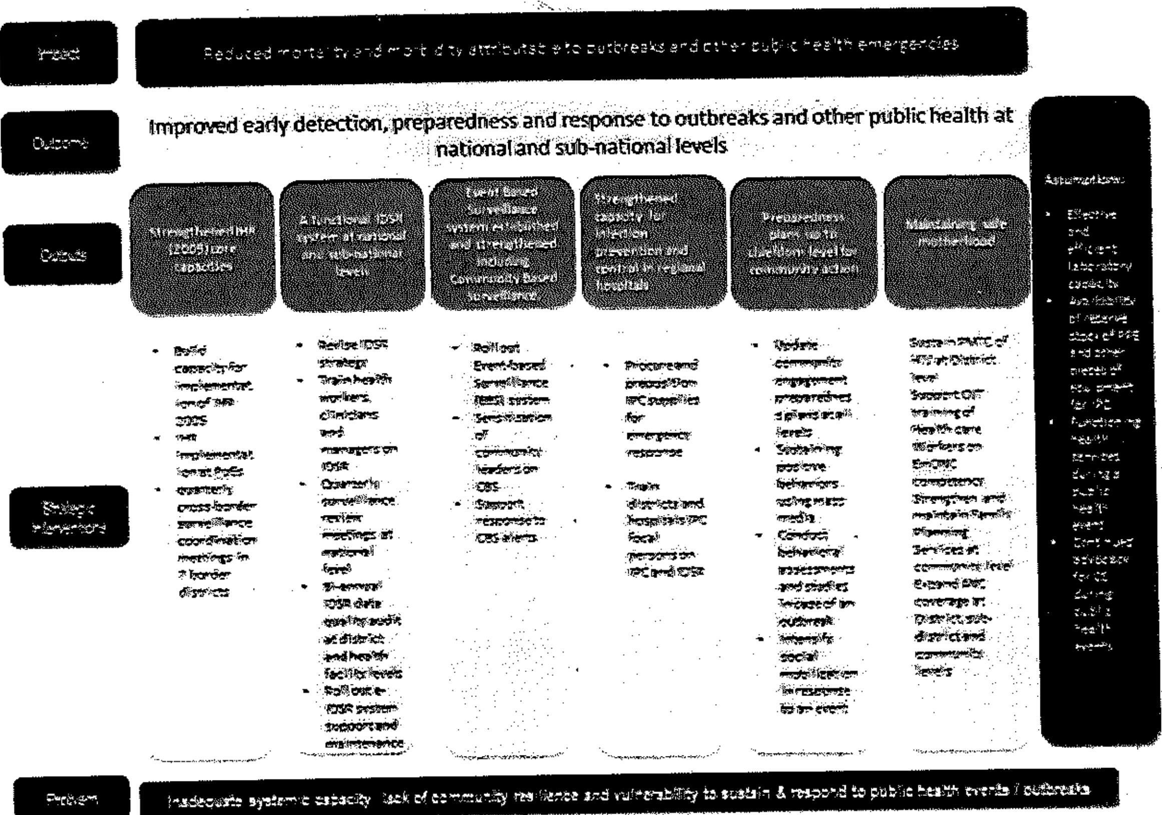
Objective	Activity	Budget (USD)
Promote community ownership and participation in preparedness and response to outbreaks and other public health events.	Update National and District Community engagement and social mobilization preparedness plans	$ 10,500
	Engagement of Paramount chiefs and Ward Councilors (WA) for Chiefdom / Ward preparedness plans	$ 52,500
	Rapid behavioral assessments and anthropological studies in case of an outbreak	$ 10,500
	Coordination and monitoring of response	$ 5,250
	Sustaining positive behavior promotion using mass media	$ 105,000
	Preposition IEC materials on key behaviors	$ 52,500
	Intensified social mobilization in case of response	$ 52,500
Sub-Total		$ 288,750

Costed Work plan – UNFPA

Objective	Activity	Budget (USD)
1. Enhance the capacity of MDSR Committee Members and personnel at district, sub-district and community levels	Train Midwife investigators to efficiently investigate maternal deaths in the community (14 Districts	15, 000
	Train Community Health Workers to enhance prompt maternal death notifications (14 Districts)	75, 000
	Train Monitoring and Evaluation officers on data management and documentations (14 Districts)	15, 000
2. Build health facilities capacity to respond to obstetric emergencies and track and respond maternal deaths at facility and community levels in all 14 districts and 8 secondary health facilities	Support a mentoring system from CEmONC to BEmONC and lower facilities to ensure compliance with the national EmONC guidelines	50, 000
	Support the monitoring of EmONC services across the EmONC facilities in all 14 Districts and 8 Secondary Hospitals	40, 000
	Support District level to conduct quarterly supportive supervision on MDSR Personnel and Stakeholders at District and Community levels (14 Districts)	30, 000

Objective	Activity	Budget (USD)
3. Maintaining improved maternal death surveillance (notification and reporting) including community based surveillance in all 14 districts	Support the establishment of community based notification for maternal deaths in all 14 Districts (including trainings, logistics etc.)	100, 000
4. Sustain accurate and timely dissemination of Reproductive information and communication	Develop IEC materials on Family Planning, Early Warning/Danger signs, Benefits of ANC, Hospital deliveries and Prompt reporting of Maternal deaths	15, 000
	Print and disseminate IEC materials on Family Planning, Early Warning/Danger signs, Benefits of ANC, Hospital deliveries and Prompt reporting of Maternal deaths	30, 000
	Support the training and deployment of CAGs, Women groups and Civil Society groups as community advocates for positive behavioural changes around maternal/new-born health and reporting of deaths	30, 000
5. Maintaining safe motherhood	Sustain PMTC of HIV at District level	50, 000
	Support OJT training of Health care Workers on EmONC competency based training	50, 000
	Strengthen and maintain Family Planning Services at community level	60, 000
	Expand and sustain ANC coverage at District, sub-district and community levels	90, 000
Coordination, Monitoring and Evaluation		32,500
Subtotal		682,500
ICFUNFPA (7%)		47,775
	Total	730,275

Change Theory



Annex 1

Project budget by UN categories

PROJECT BUDGET				
CATEGORIES	WHO	UNICEF	UNFPA	TOTAL
1. Staff and other personnel (include full details)	$ -	$ -	$ -	$ -
2. Supplies, Commodities, Materials (include full details)	$ 163,080		$ 30,000	$ 193,080
3. Equipment, Vehicles, and Furniture (including Depreciation) (include full details)				$ -
4. Contractual services (include full details)				$ -
5.Travel (include full details)	$ 182,100			$ 182,100
6. Transfers and Grants to Counterparts (include full details)	$ 794,765	$ 288,750	$ 620,000	$ 1,703,515
7. General Operating and other Direct Costs (include full details)	$ 221,525		$ 32,500	$ 254,025
Sub-Total Project Costs	$ 1,361,470	$ 288,750	$ 682,500	$ 2,332,720
8. Indirect Support Costs*	$ 95,303	$ 20,213	$ 47,775	$ 163,290
TOTAL	$ 1,456,773	$ 308,963	$ 730,275	$ 2,496,010

* *The rate shall not exceed 7% of the total of categories 1-7, as specified in the Ebola Response MOU and should follow the rules and guidelines of each recipient organization. Note that Agency-incurred direct project implementation costs should be charged to the relevant budget line, according to the Agency's regulations, rules and procedures.*