UN EBOLA RESPONSE MPTF
FINAL PROGRAMME[1] NARRATIVE REPORT
DATE: 21 JANUARY 2019

Project Number(s) and Title(s)	**Recipient Organization(s)**
#67 - Preparedness Joint Programme 00106850 (Gateway ID)	**RUNO(s)** WHO, UNFPA, UNICEF **Project Focal Point:** Name: Matthias Percl E-mail: perclm@who.int Name: Dr. Abiodun Oyeyipo E-mail: oyeyipo@unfpa.org Name: Pa Ousman Manneh E-mail: pomanneh@unicef.org
Strategic Objective & Mission Critical Action(s)	**Implementing Partner(s)**
MCA13: Multi-faceted preparedness	UNFPA, UNICEF, WHO, Ministry of Health and Sanitation, Health Education Division, District Health Management Teams, CSOs
Location:	**Sub-National Coverage Area:**
Sierra Leone	Kambia, Moyamba, Bombali, Bonthe, Pujehun, Kailahun, Port Loko, Kono, Western Area rural, Western Area urban, Tonkolili, Koinadugu and Bombali
Programme/Project Cost (US$)	**Programme Duration**
Total approved budget as per project proposal document: MPTF[2]: • *by Agency* UNFPA: $730,275 UNICEF: $308,963 WHO: $1,456,773 Agency Contribution • *n/a* Government Contribution *(if applicable)* Other Contributions (donors) *(if applicable)* **TOTAL: $2,496,011**	Overall Duration *(months)* 15 months Project Start Date[3] *30/08/2017* Originally Projected End Date[4] *30/09/2018* Actual End date[5] *30/11/2018* Agency(ies) have operationally closed the programme in its(their) system Yes ■ No ☐ Expected Financial Closure date[6]: *30/05/2019*

[1] Refers to programmes, joint programmes and projects.
[2] The amount transferred to the Participating UN Organizations – see MPTF Office GATEWAY
[3] 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.
[4] As per approval of the original project document by the Advisory Committee.
[5] 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.
[6] Financial Closure requires the return of unspent funds and the submission of the Certified Final Financial Statement and Report.

Programme Assessment/Review/Mid-Term Eval.	Report Submitted By
Evaluation Completed ☐ Yes ■ No Date: *dd.mm.yyyy* Evaluation Report - Attached ☐ Yes ■ No Date: *dd.mm.yyyy*	○ Name: Matthias Percl ○ Title: Management Officer ○ Date of Submission: 29 January 2019 ○ Participating Organization (Lead): WHO ○ Email address: perclm@who.int *Signature:*
	Report Cleared By
	○ Name: Alexander Chimbaru ○ Date of Submission: 29 January 2019 ○ Participating Organization (Lead): WHO ○ Email address: chimbarua@who.int *Signature:*

PROJECT/PROPOSAL RESULT MATRIX

Project Proposal Title: Preparedness Joint Programme

Strategic Objective to which the project contributed: SO5 Prevent Outbreaks

MCA **[13]** [7] Multi-faceted preparedness

Output Indicators	Geographical Area	Target[8]	Budget	Final Achievements	Means of verification	Responsable Organization(s).
Number of IHR quarterly coordination meetings held	National	4		2	IHR coordination Reports	WHO
Number of meetings held to evaluate progress of implementation of NAPHS	National	1		1	JEE scorecard of 2018	WHO
Number of technical people trained in IHR	National	120		132	Training Reports	WHO
Number of PoEs assessed for implementation of IHR	National	9		9	Assessment Reports	WHO
Number of PoEs supervised	National	18		0	Supervision Reports	WHO
Number of quarterly cross-border coordination meetings held	National	24		24	Minutes and quarterly reports	WHO
Revised IDSR strategy	National	1		1	Revised strategy	WHO
Number (copies) of printed IDSR/IHR material	National	5000		6000	Invoice of printed documents Monthly Reports	WHO
Number of HWs trained in IDSR	National	455		530	Training reports,	WHO

[7] Project can choose to contribute to all MCA or only the one relevant to its purpose.
[8] Assuming a ZERO Baseline

Number of clinicians trained in clinicians role in IDSR	National	100		282	Training reports	WHO
Number of quarterly surveillance review meetings held at national level	National	4		4	Minutes and Reports from the review meetings	WHO
Number of health facilities with IDSR data quality assessed by national level	National	200		269	Assessment report,	WHO
Proportion of CBS reports verified	National	80%		63%	MoHS database of surveillance data	WHO
Number of health facilities supervised by national level in a year	National	400		456	Quarterly supervision Reports	WHO
Number of health facility focal persons trained in IDSR	National	1300		580	Training reports,	WHO
Number of local leaders sensitized	National	1750		2247	Sensitization report,	WHO
Proportion of alerts responded to	National	90%		82%	MoHS Database on suspected outbreaks	WHO
Adapted EBS guidelines	National	1		0	N/a	WHO
EBS training package developed	National	1		0	N/a	WHO
Number of EBS material printed	National	1500		1500	Weekly & Case based summary reporting tools	WHO
Number of health workers trained in EBS	National	1400		1524	Training Reports	WHO
Number of MW Investigators trained	District	14		53 midwives trained in 14 districts	Training Reports	UNFPA
Number of CHWs trained	Community	100		200	Training Reports	UNFPA
Number of M & E Officers trained	District	28		28	Training Reports	UNFPA
Number of EmONC Facilities benefiting from mentorship programme’	District	120 CHW		120	Status Report	UNFPA

Number of facilities monitored	District	14		36 facilities monitored in 14 districts	Program Reports	UNFPA
Number of district level MDSR supportive supervision visits conducted	District	14		14	Supervision Reports	UNFPA
Number of communities with enhanced maternal deaths notification	Community	70		70	Program Reports	UNFPA
IEC materials developed	National	1		1	Program Reports	UNFPA
Number of IEC materials printed and disseminated	District	5,000		5,000	Program Reports	UNFPA
Number of EmONC OJT training for HCWs	District	30		40	Training Reports	UNFPA
Number of Communities that benefited from PMTCT and HIV services	Community	30		30	PMTC and HIV Service Reports	UNFPA
Strategic Objective to which the project contributed: SO4: Preserve Stability						
MCA **[11] Social Mobilization and community engagement**						
National and district preparedness plans reviewed and updated	National	15 plans		15	District preparedness plans	UNICEF
Number of PCs and WCs oriented on preparedness plans	National	218		224	Quarterly reports from partners	UNICEF
Updated message guide for specific outbreak	National	1		1 (10,000 copies printed and distributed)	Message guide	UNICEF

Number of outbreaks supported as per IARR SOP	District	At least 2		0[9]	N/A	UNICEF
Number of community radio networks integrating positive behaviours in existing health and education radio dramas.	National	46 radio channels		59	Quarterly report from Health Education Division	UNICEF
Number of IEC materials available	National	50,000 units		52,700	IEC materials	UNICEF
Number of affected communities with intensified social mobilization	Sub-district	10 Chiefdoms		4 wards[10]		UNICEF

[9] See 'Delays and Deviation' below.
[10] See 'Delays and Deviations' below.

EXECUTIVE SUMMARY

The MPTF-supported project "Preparedness Joint Programme" was a joint initiative by UNFPA, UNICEF and WHO to consolidate the capacity gains achieved during the recovery period after the West African Ebola outbreak in 2014-15 and to address remaining national capacity gaps, particularly within the Ministry of Health and Sanitation. The main areas of support were strengthening national International Health Regulations (IHR) capacities, strengthening the indicator-based surveillance system (IDSR), improving maternal death surveillance and response (MDSR), strengthening community ownership and action for preparedness, and maintaining safe motherhood. The programme complemented other ongoing initiatives that were supported by development partners in Sierra Leone. WHO acted as the lead agency of the joint programme.

The project has achieved significant milestones. Remarkable progress was made against the majority of targets that UNFPA, UNICEF and WHO set out to achieve. A major achievement was the finalization of the National Action Plan for Health Security (NAPHS) and the first ever resource mapping globally against such a plan. The success was due to intensive stakeholder engagement and strong technical leadership by WHO. In the area of strengthening disease surveillance, innovative approaches such as rolling out electronic surveillance have helped to increase the sensitivity and timeliness of the surveillance system. The MPTF project contributed greatly to strengthening the capacity for preparedness, surveillance and response to public health emergencies at points of entry (PoE), such as airport, sea-port and border crossings. Through this project, capacity was built at PoE as Sierra Leone strives to align and comply with the requirements desired by the International Health Regulations (2005).

UNFPA provided extensive capacity building support to various levels of the health system in the area of maternal and newborn health with a focus on strengthening capacities for emergency obstetric care and maternal death surveillance. Importantly, midwives in all districts are now able to conduct maternal death investigations as an important step towards improving the quality of maternal health care. Additionally, social autopsy was piloted in selected communities thereby enhancing the prospects of more complete accountability for maternal deaths. Community Health Workers (CHWs) from districts were trained to promote family planning/contraceptive use for the provision of non-prescriptive contraceptives such as condoms and refill of oral contraceptive pills for continuing clients as well as make referrals for new clients and or dissatisfied clients. This support enabled vulnerable women/ girls who were furthest behind and most at risk with quality RH-FP services.

UNICEF focused exclusively on Strategic Objective 4 - 'Preserve Stability', Mission Critical Action 11 - 'Social Mobilization and Community Engagement'. The primary objective was to promote community ownership and participation in preparedness and response to outbreaks and other public health events. To achieve this, UNICEF worked in close collaboration with the Health Education Division of the Ministry of Health and Sanitation, Civil Society Organizations (CSO) and media at the central and district levels. This resulted in all 14 districts developing district communication and social mobilization preparedness plans; and inclusion of a communication and social mobilisation component in the national response plan for EVD. All 149 paramount chiefs and 75 newly elected ward councilors in Western Area Urban and Rural of Freetown were oriented on preparedness planning. Information, Education and Communication (IEC) materials were developed and prepositioned across the country to enhance interpersonal communication efforts in the advent of disease outbreaks. The emergency messaging guide for emergency hazards of Sierra Leone was updated and validated to ensure that critical messages are readily available for roll out in the advent of any of the identified hazards.

Background and Situational Evolution

The MPTF-supported project "Preparedness Joint Programme" was a joint initiative by UNFPA, UNICEF and WHO to consolidate the capacity gains achieved during the recovery period after the West African Ebola outbreak in 2014-15 and to address remaining national capacity gaps, particularly within the Ministry of Health and Sanitation. The main areas of support were strengthening national International Health Regulations (IHR) capacities, strengthening the indicator-based surveillance system (IDSR), improving maternal death surveillance and response, strengthening community ownership and action for preparedness, and maintaining safe motherhood. The programme complemented other ongoing initiatives that were supported by development partners in Sierra Leone. WHO acted as the lead agency of the joint programme.

Narrative section:

- **Key Achievements:**
  - Please describe the achievements as they relate to the effect indicators.
  - Please describe the achievements as they relate to the output indicators

WHO:

Promoting the implementation of IHR (2005):

With support from the WHO Regional Office for Africa (AFRO), the country conducted the prioritization of the National Action Plan for Health Security (NAPHS) 2018-2022 and resource mapping through a global health security stakeholder engagement process. The purpose of this exercise was to identify critical activities to be implemented in the short and mid-term period, to map available resources and to identify gaps in the implementation of the 5-year NAPHS. The action plan is now ready and will be launched once an appropriate date has been set by the government. In 2018, WHO led stakeholders in supporting the MoHS to prepare the annual IHR report and conduct a self-assessment (internal self-assessment on country's capacity to manage large scale health emergencies) for which a scorecard was prepared. Two IHR quarterly coordination meetings were held, instead of four. The protracted general elections and the restructuring that followed at the MoHS caused delays in implementation of activities.

Minimizing the risk of cross border spread of diseases:

WHO provided technical support in strengthening the capacity for preparedness, surveillance and response to public health emergencies at points of entry (PoE) such as airport, sea-port and border crossings. Assessment was done in ground crossing, airport and seaport to determine the operational capacity for surveillance and response. As part of recommendations from the assessment, capacity was built at PoE in compliance with the requirements desired by the international health regulations (2005). A total of 132 staff stationed at various PoE were trained on IHR and port health. The training improved the effectiveness of PoE activities to reduce the risk of cross border spread of diseases. WHO also provided technical support in the development of frameworks and standard operating procedures (SOPs) for PoEs in the country which include Lungi international airport, Queen Elizabeth Quay seaport and the seven districts that share land border with Guinea and Liberia. Once finalized, printed and disseminated, the PoEs framework and SOPs will enable cross-border personnel to carry out their duty in compliance with IHR (2005) requirements.

WHO in collaboration with CDC, IOM and West Africa Health Organization (WAHO), provided technical support in a regional cross-border coordination meeting to strengthen surveillance, joint planning and information sharing between the four Mano River Union (MRU) countries namely Sierra Leone, Guinea, Liberia and Cote d'Ivoire. The meeting brought together national experts in charge of disease surveillance, IHR (2005) and emergency response coordination in the four MRU countries, to explore ways for better collaboration and coordination so as to strengthen cross border surveillance in the

region. Quarterly cross coordination meetings were done with counterpart from Guinea and Liberia to enhance information sharing and joint collaboration in points of entry.

Strengthening real-time surveillance for priority public health diseases, conditions and events:
WHO provided technical and financial support to the MOHS to conduct Integrated Disease Surveillance supportive supervision visits in all 14 districts of the country. During each round of supervision, an average of 130 health facilities were randomly selected. The main purpose was to assess the progress of IDSR implementation at district and health facility levels, identify gaps and challenges and render support to the health facility staff through on the Job training. The findings of the supervision were always shared with MOHS and partners for corrective measures to be taken were necessary. Quarterly review meetings were also held to monitor performance of the surveillance system.

Introduction of electronic system of reporting surveillance data:
WHO led in the collaboration of partners to introduce an electronic system of reporting surveillance data. The system enables health facilities to convey the weekly surveillance data from a hand-held gadget to the central database of the Ministry of Health. Ten of the 14 districts have health facilities that are now submitting IDSR report to the next level using the electronic platform. The use of electronic reporting (eIDSR) brings significant benefits to the IDSR system, most importantly the ease of operability of the surveillance system. E-IDSR has transformed the surveillance system from a labour intensive undertaking to an efficient system with improving data quality, while sustaining the high rates of completeness and timeliness of reporting. The improved surveillance system enables early detection of and timely response to disease outbreaks and other public health emergencies should they occur.

UNFPA:

Strengthen and maintain Family Planning (FP) services at community level:
Generally, the contraceptive prevalence is low in the country therefore the project aimed to reach vulnerable women/ girls and reaching the farthest first. With funds from the Ebola response multi-partner trust fund the District Health Management Teams of Kailahun and Koinadugu Districts were engaged to increase contraceptive coverage in communities of both districts through Community Health Workers (CHWs). In Q2, 200 CHWs (100 from each district were trained to promote Family planning/ contraceptive use, provide condoms and refill of oral contraceptive pills for continuing clients as well as make referrals for new clients and or dissatisfied clients. Also, data collection tools were designed and 400 booklets (200 per district) of two types of tools were printed; 200copies of the booklet for Oral Contraceptive Pills uptake and 200 of that for referrals. Each CHW was provided with pack to enhance their work at community level and non-cash motivational pack. This activity also had supportive supervision was key activity to strengthening service delivery. The CHWs continued to provide FP services during the reporting period using the skills acquired in the training.

EmONC Training:
40 Service Providers were trained on EmONC competency-based training in Port Loko and Kailahun Districts, 20 Participants per District. The training was from the 25 to the 30 of June in Port Loko and the Kailahun training started on the 2 and finished on the 7 July.

PMTCT Training:
75 Service Providers were trained on the revised ANC package in three Regions – Northern, Southern and Eastern Regions. Bombali training was from the 18 to 25 June with 5 Participants each from Port Loko, Koinadugu, Tonkolili, Kailahun and Makeni Districts. The Bo training was from the 25 to the 27 of June with 10 Participants from Bo and 5 each from Moyamba, Bonthe and Pujehun Districts. The Kenema training was from June 28 to 30 with 5 Participant from Kailahun and 10 Participants each from Kono and Kenema. In this reporting period, the trained service providers have continued to support PMTCT activities in health facilities.

MW Investigator Training:
To improve the quality of maternal death reviews and response nationally, a total of 53 midwives investigators were trained from all the previously existing 14 districts. This consisted of 51 females and 2 males. These midwives are now supporting the maternal death investigation and their enhanced capacity is leading to improvements in the quality of maternal death investigations conducted.

M&E Training:
A total of 56 participants which included 28 M&E officers and 28 CRVS officers (45 males and 11 females) where training on the MDSR data collection tool. The training involved didactic and practical sessions on the tools to ensure a thorough understanding by the participants. The training has enhanced the quality and completeness of MDSR data collected from the districts.

CHW Training:
A total of 200 Community Health Workers were trained on basic maternal, newborn health. The training which was conducted in all 14 districts included sessions on pregnancy danger signs, reporting of maternal deaths, exclusive breastfeeding and the essence of delivering in Health Care Facilities.

Status of EmOC monitoring visit by RHFP:
Monitoring visits on EmONC were done to 36 facilities in 6 districts. The district visited included: - Koinadugu, Bombali, Port Loko, Kono, Kailahun and Kenema. The visits enabled the determination of EmONC functionality in the assessed facilities using an assessment tool. Gaps identified during the visits in terms of missing signal functions were communicated to the respective authorities. The opportunity was also utilized to provide technical support as required to the districts and facilities visited on EmONC.

Piloting Social Autopsy:
As part of strengthen MDSR, TOT done in June on social autopsy and cascade training was done in 14 communities from 2 districts. The two benefitting districts are Moyamba and Kailahun. This training has enabled the commencement of social autopsy in the 14 benefiting communities thereby enhancing the prospects of more complete accountability for maternal deaths. The community social autopsy sessions were used to get community stakeholders to participate and give their contribution towards the improvement of maternal health. The participants discussed about the maternal deaths that occurred so that the preventable deaths are not allowed to occur again. Suggestions and action points were shared at the end of each session.

Strengthening MDSR:
With support from UNFPA, MoHS continued to conduct various activities under MDSR program such as notification of maternal deaths, conduction of maternal death investigation or verbal autopsy by midwife investigators and organize district and hospital MDSR committee meetings during the period under review with the aim of strengthening MDSR process. Specifically, the objective of the investigations was to provide confidential participatory approach in investigating maternal deaths and instituting prompt response actions aimed at improving the quality of maternal health care and also advise both the PHUs staff and communities level for further action.

The Supportive Supervision was conducted in 24 health facilities in 4 districts (Pujehun, Kailahun, Kono and Koinadugu district) to ensure that the objectives of the maternal deaths reviews were being met. Observations were made on the data collection and immediate actions were addressed. Onsite coaching was done on how to complete the forms.

ANC Adaptation / Training update:
40 service providers (all female; 20 from each district) were trained in Bo and Port Loko respectively using the newly adapted ANC guideline on the provision of quality ANC care.

Support a mentoring system from C-EmONC to B-EmONC and lower facilities:
Using the Final guideline and tools for EmONC mentorship program, 40 service providers (all females)

were trained to provide competency based EmoNC services in Port Loko and Kailahun. The overall training for each district lasted six days. During the first five days the mentees were introduced to the new Emonc Protocols and Guidelines through an open discussion in the morning, followed by the revision of the patients charts to apply the new protocol approach. The mentees later presented the protocols to their colleagues and to the maternity staff followed by the clinical skills practice with anatomic models (Manual Vacuum Aspiration [MVA], Balloon Tamponade, Neonatal Resuscitation, Vaginal Examination, Partograph, Vacuum Assisted Delivery and Drugs Dilution). The last day was dedicated to the evaluation of the participants (post-test, clinical skills and partograph). In this phase one or two specialized doctors from CUAMM were working together with one experienced Midwife the District. The MOHS staff took part of the training and also to supervise the activity, in order to have a harmonized training at Country level.

IEC Materials:
200 EmOC booklet and 260 EmOC protocol printed, 200 EmoNC participant manual and 50 EmONC Facilitator guides were printed and distributed.

UNICEF:

Update National and District Community engagement and social mobilization preparedness plans
In collaboration with the Health Education Division of the Ministry of Health and Sanitation (MoHS), Office of National Security (ONS) Sierra Leone Red Cross Society, 14 district preparedness plans for community engagement and social mobilization were developed. The opportunity was maximized to ensure that district social mobilization and communication structures are revitalized. Following the breakdown of the EVD transmission, this district level coordination bodies for community engagement became dormant. The national EVD response plan, which includes a social mobilization component, was also reviewed, and a total of 149 chiefdom communication and social mobilization plans were developed. The development of the chiefdom plans ensured that community members are identified from each chiefdom to coordinate and implement emergency related communication and social mobilization interventions in the advent of emergencies. The process provided the opportunity for chiefdom and community participants to become fully aware of the possible emergency hazards specific to their chiefdoms.

Engagement of Paramount Chiefs and Ward Councilors (WA) for Chiefdom / Ward preparedness plans
In close collaboration with the Health Education Division of the MoHS at the central and district levels, as well as CSO partners, 48 personnel from all 14 districts underwent a one-day orientation for micro-level communication and social mobilization planning for emergencies. As part of developing the chiefdom level social mobilization plans for the 190 chiefdoms, these personnel engaged all the 149 paramount chiefs or their representatives. This enabled these highly influential community leaders to deepen their understanding of the emergency hazards in their chiefdoms. It also ensured that 15 community members from the Village Development Committees (VDC) which exist in the chiefdoms are identified as members of chiefdom level communication and social mobilization committees. This was expected to improve the coordination of community engagement interventions in the advent of emergencies. Similar efforts were undertaken for Western Area Urban and Rural in greater Freetown. All 75 newly elected councilors following the general elections in April 2018, were oriented on emergency preparedness. This facilitated their involvement in the development of ward communication plans for emergencies, as well as identifying ward level focal points who can quickly be mobilized to support community engagement efforts in an outbreak.

Rapid behavioural assessments and anthropological studies in case of an outbreak
No rapid behavioural assessment was conducted. However, a key indicator for this activity was updating the emergency message guide. Twenty-five technical personnel from UNICEF, MoHS, Sierra Leone Red Cross, Save the Children, WHO, OXFAM and others supported the validation of the emergency messaging guide through a one-day validation meeting conducted at the UNICEF conference hall. The guide provides readily available messages and preventive behaviours for epidemics, environmental and

social threats facing Sierra Leone. These include floods, cholera, EVD, measles, yellow fever, polio, lassa fever, monkey pox, meningitis, fire accidents and social unrest. A total of 10,000 copies of the emergency message booklet were printed and pre-positioned in all the districts. The booklets became extremely helpful following the 2017 floods, as well as in supporting the sporadic outbreaks of measles in Koinadugu and lassa fever in the eastern districts of Kenema and Kailahun.

Preposition IEC materials on key behaviours

Materials for EVD were prepositioned across in Makeni for the Northern Districts and Kenema for the South and Eastern districts. As part of the 2017 flood response, 2,000 laminated awareness cards and 300 flex banners for the prevention of cholera were printed and distributed. The materials enhanced inter-personal communication interventions, as well as served as cues to action during the mudslide/flood response. In addition, 40,000 IEC materials for meningitis, lassa fever, measles and cholera were developed, printed and strategically distributed and pre-positioned. During the measles outbreak in Koinadugu in July 2018, Kambia and Pujehun in December 2018, the pre-positioned materials enabled community mobilizers to engage families timely. This greatly contributed to the mass campaign efforts and the containment of the outbreak.

- **Delays or Deviations**

The presidential and parliamentary elections held in March 2018 posed a risk to the continuity of implementation. During the campaign period prior to the elections national counterparts at the MoHS were not fully engaged which resulted in initial delays of several activities. It was expected that following elections implementation would pick up; however, protracted restructuring of the Government and changes in the leadership of the MoHS exacerbated the situation. Project counterparts at national, district and council level were partially unavailable during this period.

Through early engagement with and sensitization of the new leadership in the MoHS, implementation continued. An extension of the project duration by three months allowed for implementation of delayed activities. As additional measure to ensure implementation, WHO re-programmed parts of the funds towards additional technical assistance to work more closely with the MoHS on project activities. That explains why for some indicators, the performance exceeds the project target. The delays caused by the elections did, however, result in the lack of implementation of EBS-related activities. The protracted general elections and the restructuring that followed at the MoHS caused delays in implementation of activities. Among the activities planned to strengthen event based surveillance, the adaptation of EBS guidelines and the development of an EBS training package were not implemented as planned in the project proposal as they are already integrated in the new 3rd edition technical guidelines for IDSR that are being rolled out. Supervision of PoEs was deferred as one had taken place just prior to commencement of the project and the requirement to build capacities at the PoEs had been identified. Therefore, emphasis was laid upon building capacities of the staff serving at PoEs. The supportive supervision for POEs has already been provided for through another stream of funding.

Alerts generated through the community Based Surveillance were verified (63%) and responded to (82%). These indicators were not fully achieved due to limitation in human resource capacity at health facility level. Health workers providing clinical services are stretched and unable visit communities regularly to verify and respond to all CBS alerts. Secondly, the logistical capacity provided (motorbikes) by WHO through another partners' support was limited, all targeted chiefdoms were not covered.

UNICEF deviated from the original plan to develop and finalise district communication and social mobilization plans for emergencies at the district level only. The opportunity was maximized to develop plans at the chiefdom level to help strengthen social mobilization platforms from the chiefdom to district level. This resulted in the development of 190 chiefdom plans.

In deviation from the plan to support at least two outbreaks per the Inter-Agency Rapid Response (IARR) Standard Operating Procedures (SOP), no major disease outbreak during the project period. As such,

during the mudslide and floods in August 2017, communication and social mobilization needs were managed under the Social Mobilization Pillar. Furthermore, while a target was set to conduct intensified social mobilization at the chiefdom level, the mudslide and floods occurred in Freetown, where there are no chiefdoms, only wards. Thus, the intensified social mobilization during the emergency response could only be reported at the ward level.

Lastly, to strengthen mitigation efforts for flooding in Freetown, MPTF funds were utilized to support the Freetown City Council to mobilize and engage all ward councilors and communities to take preventive actions to prevent flooding. Special radio and TV programmes were broadcast to support this end. While not per the original plan, this activity was deemed necessary to mobilize communities to prevent blocking of water ways and proper disposal of refuse such to ensure flooding, as occurred in August 2017, did not recur.

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

No. of Beneficiaries	
Women	145 UNFPA
Girls	
Men	1066 UNFPA
Boys	
Total	

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

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

Intersectoral collaboration played a major role in facilitating the development of chiefdom-level emergency communication plans. The exercise brought together 48 district level officials from the 12 districts at a central location for the initial orientation and planning. The four participants drawn from each of the districts comprised of the district social mobilization coordinator of the MoH, Health for All (local NGO) District Coordinator, a Sierra Leone Red Cross District Coordinator and the Community Engagement Officers of WHO. This intersectoral collaborative approach improved accountabilities ensuring that activities were implemented as planned.

Strong technical leadership proved essential in coordinating multiple actors and stakeholders in Sierra Leone towards a common goal in the medium term (e.g. health security). For example, in order to make success out of the journey from the 2018 JEE (external assessment on country capacity to manage large scale health emergencies), to the development of the National Action Plan for Health Security, major inputs by WHO were required. The commitment demonstrated by WHO's technical leadership inspired stakeholders to give their best and share roles. The outcome was Sierra Leone being among the first countries in Africa to complete the NAPHS and the first to have a costed resource mapping plan.

- **Lessons learned**

- There is still a lot of work to be done to build national capacity at all levels. In light of continuous capacity gaps, strong technical leadership is essential to support the Government in achieving their priorities.
- Elections in 2018 impacted project delivery differently and longer than anticipated. The health of women and children as well as strong disease surveillance remain priority of the new administration. However, protracted election and leadership transition period and change in operational/administrative procedures at MoHS has delayed implementation.
- The partner landscape in Sierra Leone is very diverse. Developing and maintaining strong coordination among the three UN agencies but also with other development partners has proven essential to understand entry points, identify gaps and adjust the project when required.

- The involvement of Paramount Chiefs ensured greater participation and ownership and provided these key community figures essential disaster preparedness and management knowledge, skills and experience. Some Paramount Chiefs acknowledged that they previously had little knowledge on the environmental hazards which pose a threat to their community's safety and wellbeing. Their engagement was critical and should remain so for future planning and implementation of other preparedness efforts.

- **Story on the Ground**

TBD