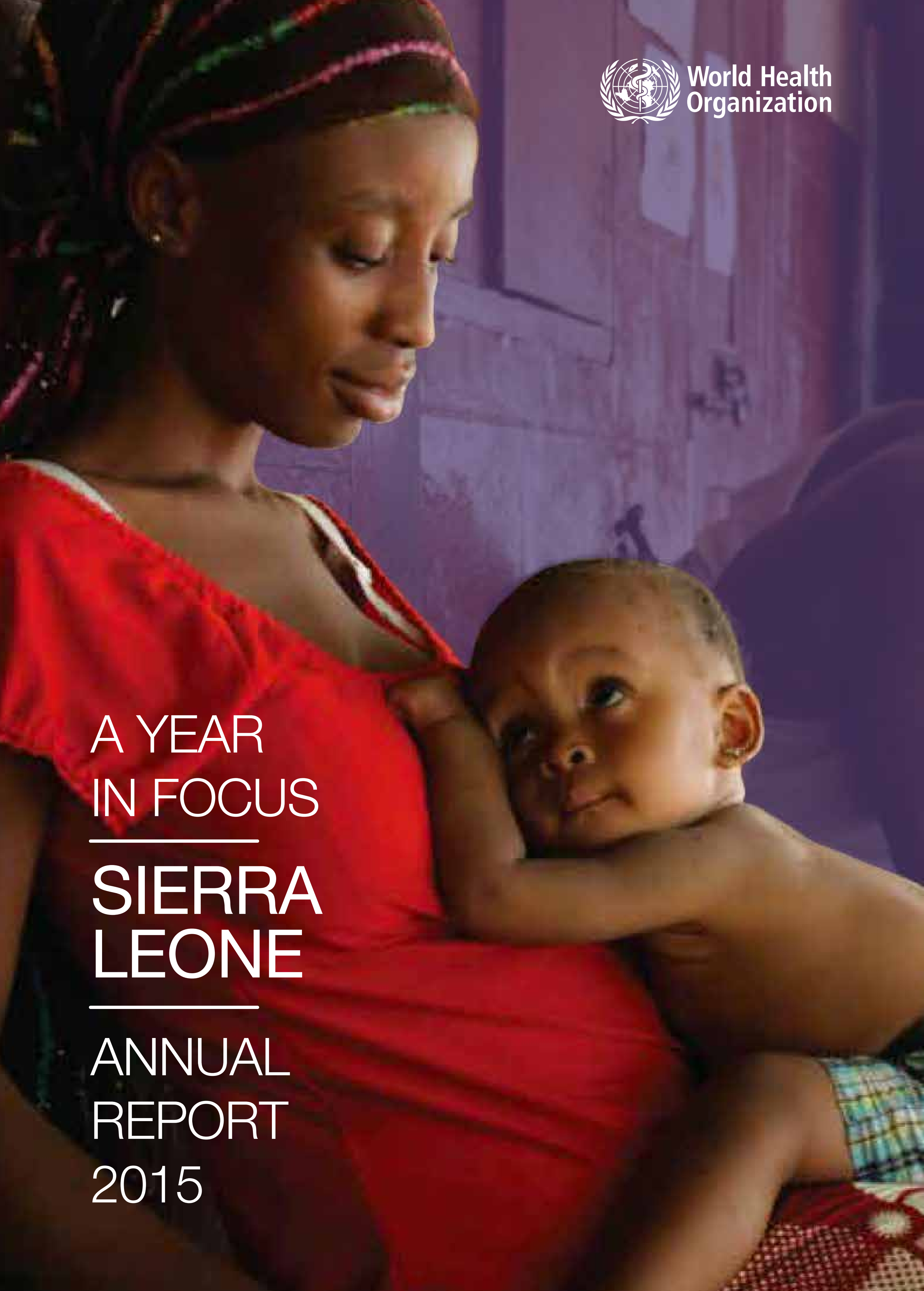
World Health Organization
A YEAR IN FOCUS
SIERRA LEONE
ANNUAL REPORT 2015

Cover photo:

A woman and her child at a government hospital in Makeni, Sierra Leone. OCHA-IRIN/N. Palus

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A YEAR IN FOCUS

SIERRA LEONE

ANNUAL REPORT 2015

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to EBOLA Outbreak in West Africa

WHO Sierra Leone

Introduction

WHO/S. Gborie

2015 was a year shaped by many lessons learned for the Organization. With these WHO now looks ahead not only to retain a vigilant focus and to evolve an improved system for the prevention and management of outbreak of diseases but also to work with the government and partners in transitioning the country from Ebola to Health and to build a strong and resilient public health system.

A major landmark achievement during 2015 was the official declaration by the World Health Organization (WHO) of the end of the Ebola Virus Disease (EVD) outbreak in Sierra Leone on 7 November 2015, 22 months after the outbreak began and 42 days after no further transmissions. A strong leadership of the government of Sierra Leone through the Ministry of Health and Sanitation and the national Ebola response structures, increased involvement and determination of the communities to report all new cases, and close collaboration among local and international partners, including the close partnership between the WHO and the Ministry of Health and Sanitation (MoHS) led to the interruption of transmissions and made possible the end of the outbreak.

Through the course of 2015 WHO provided technical and direct financial support to the government amounting to 45.5 million US$. Staffing shifted throughout the year based on response needs, however, at mid November 2015 WHO had a total of 288 staff in country of which 145 staff were working in the districts and 143 in the country office in Freetown. The financing of the work came from a range of partners including the UK, CDC, OFDA, the AfDB, the Word Bank and many others (see page 37).

Together with the MoHS much progress was made during 2015 in laying the foundations for an improved system for the prevention and management of future outbreaks with this becoming a particular focus in the second half of the year. The final months of 2015 saw the establishment of preparedness and response systems to ensure the country stands ready and better prepared than ever before to respond to future outbreaks of EVD or any other disease or public health emergency. To that end WHO contributed to the establishment of a robust inter-agency ‘Incident Management Team’ (IMT) - a shared mechanism among UN agencies, international organizations and civil society groups. The

inter-agency IMT aims to ensure a coherent and effective coordination and response mechanism, set norms and standards, promote and monitor implementation of guidelines, provide technical support, and build sustainable institutional capacity through the MoHS and the Office of National Security (ONS).

The same level of preparedness and response readiness have been instituted at the district levels, where WHO continues to maintain a presence working side by side with the District Medical Officers (DMOs) and District Health Management Teams (DHMTs) and partners. WHO is supporting the DHMTs to undertake the following: maintain a dynamic response plan with capacity to support epidemiology, case management, laboratory, and reporting mechanisms; and strengthen the capacity for multidisciplinary Rapid Response Teams (RRTs) at district level to respond to all Public Health Emergencies. Additionally, guidance was provided in capacity strengthening for multidisciplinary RRTs at the national level and technical support delivered to the MoHS regarding the prepositioning of a minimum stock of critical supplies required to respond to cholera and other endemic diseases.

The EVD outbreak was devastating in a number of ways, not least in its impact on the broader health system and services. With the end of the EVD outbreak and the transition from Ebola to Health the government has refocused its activities to prioritise a broader range of key health elements and to build a comprehensive and robust health system. In particular, focus towards the end of 2015 and for the upcoming year has been on Reproductive, Maternal, Neonatal, Child and Adolescent Health (RMNCAH).

The President of Sierra Leone has identified maternal and child mortality as one of two essential priorities for the country as it relates to the health system recovery and has set out the aim to reduce the mortality rates by 10% during the timeframe of the 10-24 month health recovery plan. To this end, the priority is to improve quality of care and accelerate progress in the reduction of preventable child, neonatal and maternal mortality, and teenage pregnancy.

Immunisation remained a strong focus and essential opportunity to improve the overall health of the country and as such guidance was provided to the MoHS, in collaboration with UNICEF, for the development of a Routine Immunisation (RI) recovery plan to accelerate RI activities. With the finalisation of the national Switch Plan in September 2015 the MoHS has developed a clear strategy with which to enable the switch from trivalent Oral Polio Vaccine (tOPV) to bivalent Oral Polio Vaccine (bOPV) by April 2016.

Work has also begun, and WHO is working with the MoHS and UNFPA, to develop Maternal Death Surveillance Response guidelines, conduct trainings, update curricula, develop standards and accreditation tools and upgrade facilities.

Disease surveillance activities are critical to enhance the detecting and controlling of disease outbreaks as well as maternal deaths. It also an essential component of detecting and combating nutritional health challenges. In this regard, technical support was provided to the Directorate of Food and Nutrition to enhance and strengthen the country's nutrition surveillance system within the framework of the Accelerating Nutrition Improvement (ANI) Project.

These activities are being conducted in line with the country's priorities as outlined in MoHS's Health Sector Recovery Plan (HSRP) 2015-2020 and the Basic Package of Essential Health Services (2015-2020) which was updated to take into account vital lessons learnt from the Ebola epidemic. These documents served as the framework for implementing activities in the 6-9 months recovery plan and are informing the development of the 10-24 months plan. Furthermore, at the request of the MoHS, WHO facilitated the review of the National Health Sector Strategic Plan (NHSSP) 2010-2015. The exercise assessed progress achieved, identified strengths and weaknesses, challenges experienced in the implementation of the Plan and proposed options for moving forward in the post-Ebola environment in 2016 and beyond.

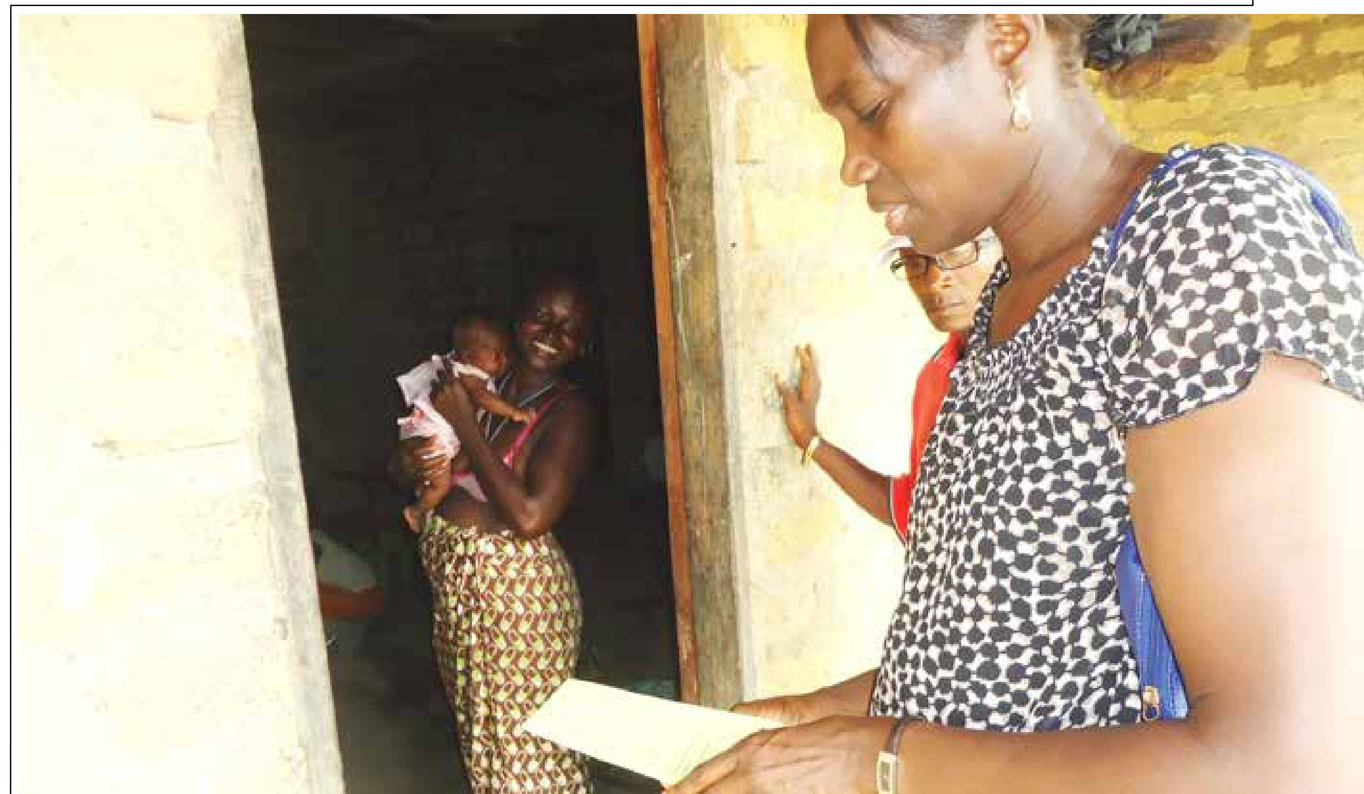
An effective and dynamic organisation is essential to be able to respond to the needs of the country. The WHO office has aligned with the vision and goals of the MoHS and has put in place the required structures, processes and people to effectively support the Ministry. Internally, increased focus has been placed on staff development and management of resources to ensure structures at national and district levels are complementary and supportive to MoHS with a focus on capacity building, that processes are compliant but also effective and fast, and finally, that people are developed and trained to work dynamically and effectively with their teams and partners.

2015 was a challenging year, but one that saw the end of the EVD outbreak in Sierra Leone. WHO now looks forward to 2016 and the continuation of its collaboration with the government of Sierra Leone and many partners to accomplishing the goals set out by the President that will enable the acceleration of health system recovery and development and the transition from Ebola to Health.

WHO Sierra Leone

OUTCOME 1

Getting to and Sustaining Zero



WHO/S. Gborie

Enhanced Surveillance, Contact Tracing and Case Investigation

The strategy during 2015 transitioned through three distinct response phases each informed by increasing knowledge and understanding of the EVD disease itself, its transmission, and of community behaviours and fears. Significant changes were made to response activities including community engagement, contact tracing, ring vaccination, burial practices, monitoring of people that may have been exposed to EVD and IPC advice. Retaining this knowledge and capacity and applying the lessons learnt from the EVD response will be essential to preventing and managing future outbreaks and as well assist the country in its transition from Ebola to Health and sustaining a strengthened health system.

The surveillance strategy employed at the peak of the outbreak was largely a reactive approach to live and death alerts. As transmission chains were interrupted in the districts, however, the support for an enhanced surveillance system was rolled out by revitalising the Integrated Disease Surveillance and Response (IDSR). IDSR prioritizes the detection and immediate reporting and prompt response to epidemic prone disease like EVD and Lassa fever as well as other diseases of public health importance like malaria. Significant progress has been made since in improving reporting from health facilities across the country which has strengthened the ability to detect EVD flare ups and the ability to respond accordingly.

In continuing to guide the response and promote evidence based interventions throughout the year, epidemiologists supported the MoHS with compiling epidemiological surveillance information on EVD incidences: average number of contacts per case and project symptom onset amongst a cohort of contacts based on the mean incubation period. Complimentary to this, the data and geographic information system (GIS) specialists supported the creation of robust data by capturing transmission and storage system for cases and contacts information. The team also provided assistance with enhanced mapping of cases, survivors, and geospatial analysis of residual risks. The information generated was then widely disseminated through the daily situational reports (Sit-Reps) and briefs.

WHO/W. Romeril

Community Engagement

Community engagement was key at the very onset of the EVD outbreak through door to door awareness raising campaigns and community dialogue as a way to transfer knowledge that aided diffusing negative and harmful practices and behaviours that were contributing to the spread of the virus.

As the number of EVD cases during 2015 continued to increase, deepened community engagement campaigns that constituted community ownership, acceptance and cooperation, and emphasis on community structures were employed. The community engagement approaches were widely practised and additional community engagement officers were trained and deployed in all of the districts. Their location of deployments were determined by their knowledge of the cultures and local practices and languages in order to foster acceptance and trust.

Community engagement officers teamed up with other EVD responders such as contact tracers in all 149 chiefdoms in the country so as to intensify efforts to diffuse hostility, resistance and behaviours that were perceived by the community as lack of empathy. Compassionate communication trainings were held for frontline staff in the various districts with the participation of key government representatives.

It was also essential to partner with influential community leaders such as paramount chiefs, traditional healers, religious leaders, town chiefs and councillors to create credible and trustworthy communication channel. The engagement resulted in a behavioural change of the affected communities all of which culminated into the interruption of transmissions and the eventual end of the outbreak.

Towards the end of 2015 when the number of cases started to decline and some districts became 'silent' with no new confirmed cases, a new need arose to drive home a new set of messages that emphasised vigilance and avoidance of complacency to sustain a 'resilient zero'. Community engagement officers at the time continued to strengthen the capacity of community structures and build trust and confidence in the health service delivery, ensuring sustainability in the area of health promotion nationally.

The EVD outbreak considerably decimated trust in the health service delivery. The increasing trends of rumours, fears and anxiety led to rapid reduction in the utilisation of health care services in health facilities across the country. However in the aftermath of the declaration of the end of the outbreak efforts have been geared toward restoring the trust that eroded with the advent of the outbreak to ensure that service utilisation is maximised.

WHO Sierra Leone

Mental Health and Psychosocial Support

Over the past year, support was provided to MoHS in its work to provide Mental Health and Psychosocial Support (MHPSS) in response to the EVD epidemic as well as for the flood victims. Guidance was also provided to the MoHS in planning for the transition to build a resilient mental health systems.

In relation to the EVD response, training of frontline responders (social mobilizers, contact tracers, epidemiologists, ambulance drivers, and burial teams) took place including communication skills, compassionate community engagement, psychological first aid and cultural understanding. A total of 134 Health Care Workers (HCWs) were trained in mental health Gap Action Programme (mhGAP) Humanitarian Intervention Guide.

In response to the impact of the flood that affected hundreds of families in the Western Area in September 2015, WHO worked in partnership with MoHS and the Ministry of Social Welfare Gender and Children's Affairs (MSWGCA) to train social workers and HCWs from the three badly affected communities of King Tom, Kru Bay and Mile 6. This enabled the establishment of Community Healing Dialogue Groups, for 15-20 people twice a week for seven weeks. These provided the flood victims with valuable support network within which to share their experiences and to support each other in their recovery. As a result of the initiate, the groups provided network of support including the contribution of financial assistance to enable a member to replace a fishing boat he lost during the floods.

With regards to the ongoing work of the MoHS to build a robust mental health system, WHO assisted with the development of a transition plan and the identification of key areas for future support. For key national level coordination and programming functions, support was provided to MoHS, including for a National Mental Health Coordination meeting held on 17 December 2015 with representation from all 14 Districts, as well as from key stakeholders from MoHS, MSWGCA and international NGOs. Technical assistance was also provided to the Ministry's review of the Mental Health Legislation, the Mental Health Policy and Strategic Plan and the process and tools for support supervision of Mental Health Services.

Case Management

During 2015, case-management activities focused on ensuring the safety of HCWs and optimizing clinical care in the EVD response. This was achieved through the provision of technical support to the National and District Ebola Response Centre(s) (NERC and DERCs) and various Ebola Treatment Centres (ETCs) across the country, as well as mentorship activities to the healthcare workforce. Additionally, this work was supported indirectly through liaising with foreign medical teams (FMTs) and other implementing partners to troubleshoot case management challenges and ensure coordination of case management activities during the response.

In an effort to promote Minimum Standards in Mainstream Health Facilities, collaborative work and mentorship ensured that all health facilities maintained effective screening, triage and quality assured case management of suspected and probable EVD cases. A total of 1024 HCWs were trained from 108 health facilities in 6 districts of the northern region. These included medical doctors, community health officers (CHOs), nurses and hygienists.

Support was provided to partners and the MoHS in delivering EVD care to patients and healthcare to quarantined individuals. Guidelines on EVD clinical management and Standard Operating Procedures (SOPs) for non EVD care in the Voluntary Quarantine Facilities (VQFs) were distributed.

Recognizing the protracted risk of EVD transmission associated with pregnancy, protocols were developed in collaboration with international partners to guide HCWs to safely optimise the care of pregnant women and neonates. Eighty midwife master trainers received training in these protocols and strategic rollout was initiated to the districts.

To meet the needs of EVD survivors and improve and harmonise their care, support was provided for the development and implementation of best-practices guidelines for managing and caring for EVD survivors. It is clear that much remains to be learned about the specific health challenges that survivors face and as such dialogues with survivors and clinicians will be essential to contribute to the development of sound healthcare guidelines moving forward.

UNMEER/M. Perret

Comprehensive Care and Support for Survivors

The largest outbreak of EVD the world has ever seen has also meant an unprecedented number of survivors. The year saw significant advances in care and management of the survivors: providing technical assistance to the Government of Sierra Leone and partners for the development and implementation of comprehensive services for EVD Survivors (EVDS), supporting collaborative work at the Survivors Steering Committee and Technical Working Group (TWG), and defining and developing the Comprehensive Programme for EVD Survivors (CPES) and its Programme Implementation Unit. CPES is a key element for the implementation of national EVD Survivor Policy in Sierra Leone, seeking support for restoration of Survivors' health and social functional capacity, their livelihood reconstruction and community reintegration through effective delivery of clinical and social services to all survivors who need them.

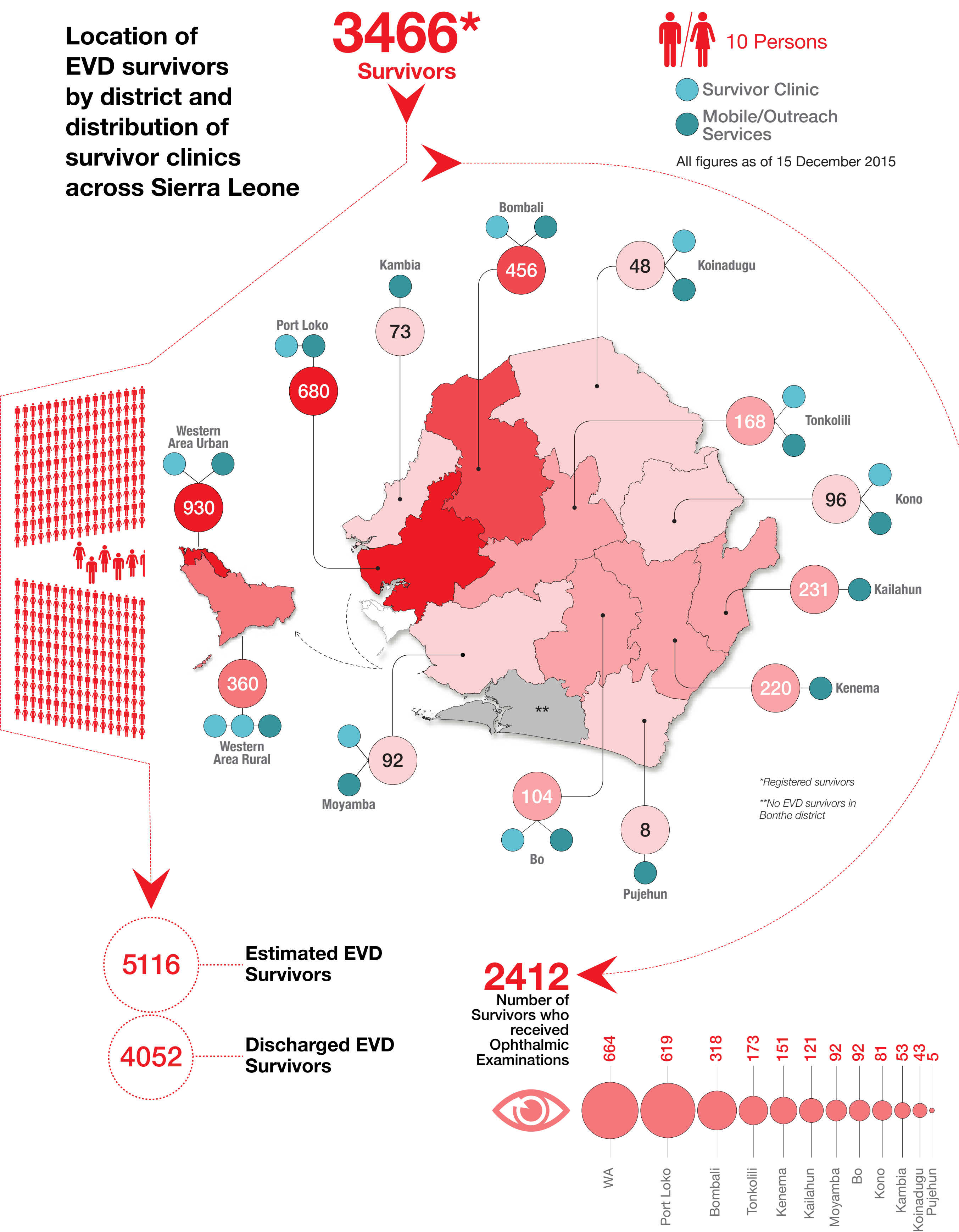
During 2015, 10 survivors clinics, mainly operated by implementing partners, were set up in nine districts with outreach services to all affected 14 districts in response to the health and psychosocial needs of survivors. However with the inception of the recovery plan the ultimate aim of the MoHS is to streamline all of these services into the existing public health facilities. This transition into the public sector has been supported. The objective is that Healthcare for EVD survivors be streamlined into the general basic services and provided in a way that strengthens MoHS facilities and staff and stewardship of survivor care by the DHMTs, not reinforcing parallel systems.

MoHS also worked with WHO and partners towards standardization of health services and development of the Sierra Leone National Guidelines on Healthcare for EVD Survivors. This was helpful for Health Workers training and operational support and implementation of a core package of basic services for survivors in the community and to target Peripheral Health Units (PHUs) at primary care level and District Hospitals with clearly defined facilitated and funded referral pathways to ensure free care and access to essential drugs and supplies.

As an example, acute inflammatory eye disease (uveitis) is common among EVD survivors, representing a risk of visual loss. The design and implementation of the National eye care program for EVDS in 2015 was a priority, through which nearly 3000 survivors in Sierra Leone received specialised diagnostic evaluation and treatment when required.

The consolidation of the Sierra Leone Association of Ebola Survivors at national and district levels is also occurring, which continues to play a key role in the validation, monitoring and evaluation of all services provided to EVDS in Sierra Leone. Due to the occasional persistence of the virus in selected body compartments of survivors, the risk of resurgence is being addressed by the Government of Sierra Leone's National SSP counselling and semen testing programme developed and implemented with support from UN agencies including WHO and UNICEF and implementing partners.

Support to the Government of Sierra Leone will continue on the road towards effective provision of quality services so that desired health and social outcomes for the survivors are attained, documented, reported and recognized.


Location of EVD survivors by district and distribution of survivor clinics across Sierra Leone
3466*
Survivors
10 Persons
Survivor Clinic
Mobile/Outreach Services
All figures as of 15 December 2015
Bombali
456
Kambia
73
48
Koinadugu
Port Loko
680
Western Area Urban
930
168
Tonkolili
96
Kono
231
Kailahun
220
Kenema
360
Western Area Rural
92
Moyamba
104
Bo
8
Pujehun
**
*Registered survivors
**No EVD survivors in Bonthe district
5116
Estimated EVD Survivors
4052
Discharged EVD Survivors
2412
Number of Survivors who received Ophthalmic Examinations
664
619
318
173
151
121
92
92
81
53
43
5
WA
Port Loko
Bombali
Tonkolili
Kenema
Kailahun
Moyamba
Bo
Kono
Kambia
Koinadugu
Pujehun

OUTCOME 2

Sustaining Zero and Safe Health Care for Patients and Health Workers

WHO Sierra Leone

Ensure Safety of Patients and Health Workers

Significant progress was made in Infection Prevention and Control (IPC) during 2015 with IPC structures established at national, DHMT, and hospital levels. Technical, financial and logistical support was provided to the Ministry of Health and Sanitation to establish the National IPC Unit (NIPCU) in March 2015 for the first time, integrating it into the existing MoHS organogram covering all 14 districts.

The National IPC Advisory Committee (NAC) was also established by MoHS with a core mandate to advocate for obtaining human and financial resources for IPC to validate IPC policies, SOPs and guidelines and to determine the monitoring and evaluation framework for IPC in the country.

In addition to the establishment of key structures to support IPC improvements, training of trainers on basic IPC was conducted from January to February 2015 for 60 MoHS HCWs. Among them, 34 were deployed to districts as IPC officers with additional support being provided at district level through mentorship, supervision, and assessment activities.

Furthermore, National IPC Guidelines and Policy were developed with the MoHS and rolled out in November 2015. To ensure the implementation of the Guidelines and Policy, 78 HCWs from the DHMTs, Hospitals and partner organizations were trained as trainers and assigned to gradually roll out the training in healthcare facilities nationwide.

In order to prevent cross transmission of EVD within Ebola Care Facilities, an IPC survey was initiated to monitor, uphold and improve IPC standards. From December 2014 to December 2015 a total of 313 assessments were conducted in 100 ECFs. This identified an IPC compliance level of 80% and above.

With the prioritisation of EVD response activities in Kambia, Port Loko and Bombali through Operation Northern Push in June and July 2015, WASH assessments were conducted and technical advice provide on safe water maintenance and health care waste management. By supporting HCFs to develop WASH improvement plans the quality of WASH standards improved accordingly in HCFs, Government Hospitals and PHUs in Kambia, Port Loko, Bombali.

Isolation bed capacity and assessment score by district

226

Assessment Score
90 - 100%
80 - 90%
70 - 80%

Koinadugu 86%
Bombali 87%
Tonkolili**
Kambia 38 94%
Kono 95%
Port Loko 18 96%
Kalihun 82%
Western Area* 101 84%
Kenema 72%
Moyamba 86%
Pujehun 86%
Bonthe***
Bo 80%

* Western Area: One health facility not operating
** Tonkolili: Assessment not conducted end of 2015
*** Bonthe: Assessments not conducted

Number of IPC assessments conducted at the district level in 2015

313

48
25
3
33
23
33
86
4
3
5
40
10
*

*Bonthe: Assessments not conducted

Strengthened Emergency Preparedness and Response Capacity

The concept of the Integrated Disease Surveillance and Response (IDSR) was adopted in Sierra Leone in 2003, but the implementation of its core components and objectives were not fully absorbed into the health sector. The Ebola outbreak was a realization of the importance to strengthen the availability and use of surveillance data for improved detection, reporting, investigation, confirmation and response to priority diseases and other public health events.

During 2015 technical and financial support has been provided to the MoHS to revitalize IDSR and International Health Regulations (IHR, 2005). IDSR technical guidelines, training modules, reporting tools and information material have since been adapted/ developed and disseminated country wide. The aim to create a critical mass of skilled health workers with knowledge of the IDSR strategy has been a priority of the government and WHO.

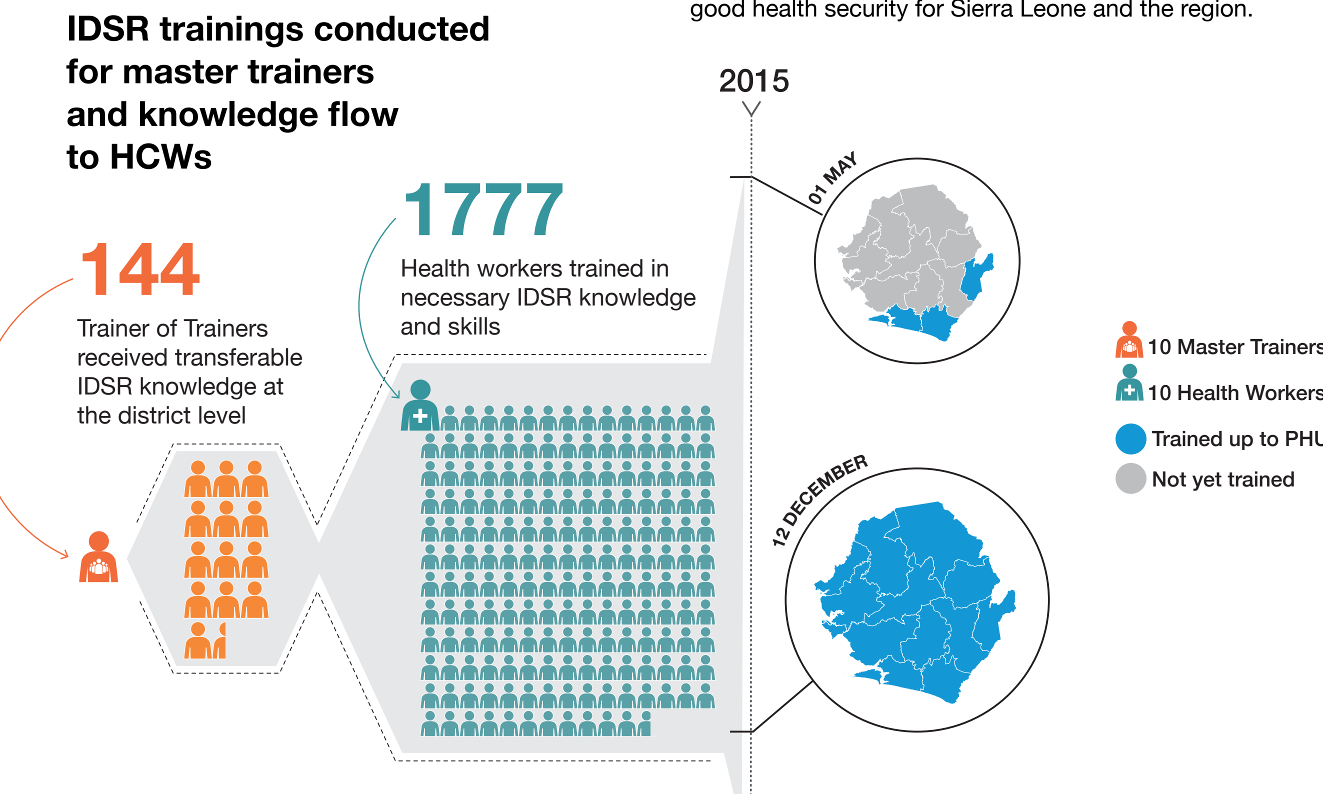
A total of 144 IDSR Trainers from MoHS national level and districts were trained in IDSR. These set of trainers cascaded trainings to all the 14 districts, a total of 1777 health workers drawn from 1303 health facilities countrywide were equipped with the necessary knowledge and skills in IDSR.

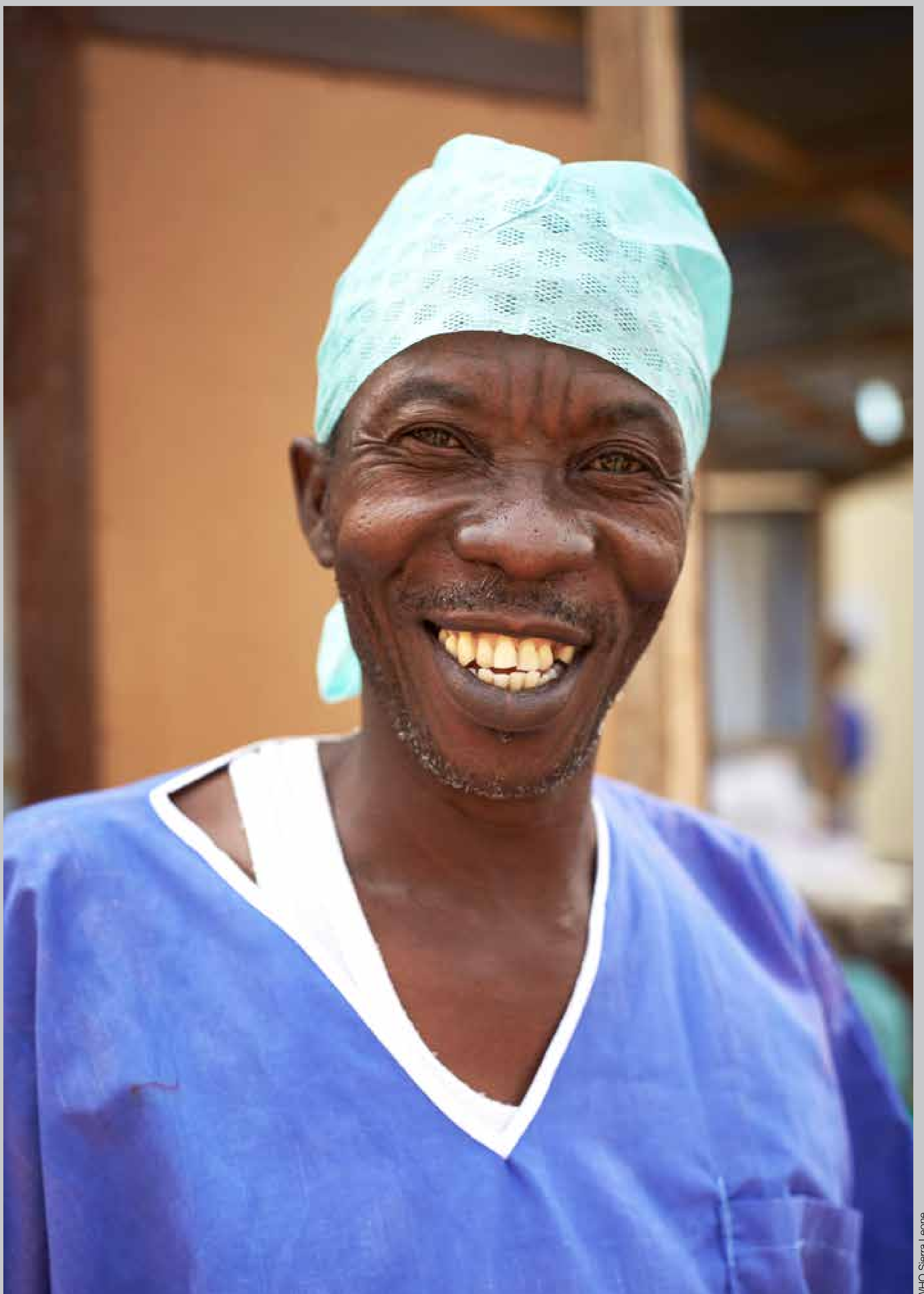
Support was also provided to the MoHS in rolling out Community-Based Surveillance (CBS). A CBS Technical Working Group (TWG) was established and Standard Operating Procedures (SOPs), training manuals, and reporting tools developed. Additional support was provided in training trainers for CBS in six districts.

Lessons learnt during the EVD response have been useful in developing capacity for response to public health emergencies. To help with overall preparedness, advice and support was provided for the establishment of rapid response capacity at all levels. Multi-disciplinary Rapid Response Teams (RRTs) were established. RRT guidelines, SOPs and training modules for RRTs were developed. These will be validated and used to train and guide the operations of the teams. A plan to strengthen the preparedness and response core capacities is in place.

The investment in IDSR is paying off. There has been a steady improvement in the quality and completeness of health facility reporting. With the recent EVD response experience and within the guidelines of the IDSR strategy, appropriate national public health responses will be mounted to respond to other suspected outbreaks of national concern that include, Inter Alia, cholera, measles, and Lassa fever. WHO is optimistic that a revitalised IDSR system and IHR (2005) will guarantee good health security for Sierra Leone and the region.

IDSR trainings conducted for master trainers and knowledge flow to HCWs





WHO Sierra Leone

OUTCOME 3

Re-establishment of Essential Health Services

WHO/S. Gborie

Immunisation

The Ebola outbreak has been devastating in a number of ways, not least in its impact on the broader health system including routine immunisation (RI). In an effort to accelerate RI activities WHO, UNICEF and other partners supported MoHS in developing an RI recovery plan for which resources were mobilised. MoHS was supported to conduct Immunisation in Practice Training for districts and service providers, to review and update the comprehensive multi-year plan, to finalise the Human Papilloma Virus costing tool and to introduce Measles Second Dose into routine Immunisation.

Guidance was also provided to MoHS in the planning and development of the national Switch Plan which was finalised in September 2015. This plan sets out the strategy to enable the replacement of all trivalent oral polio vaccine (tOPV) with bivalent oral polio vaccine (bOPV) as the current risk associated with tOPV outweighs the benefits. Work will continue with MoHS to implement the Polio End Game Strategy including the tOVP withdrawal and switch to bOPV in April 2016. Through continued collaboration with MoHS monthly monitoring of RI coverage was sustained to inform prioritising supportive supervision and providing feedback for action. WHO worked in partnership with MoHS and UNICEF to support data collection and interpretation for the completion of the WHO and UNICEF Joint Reporting Form and to contribute to the GAVI Joint Appraisal Report.

In addition to supporting the RI Acceleration Plan WHO also helped facilitate supplementary Immunisation activities (SIAs) to ensure quality campaigns are conducted. As part of accelerating the Polio Eradication Initiative and Polio End Game Strategy, MoHS was supported to conduct three Polio National immunisation Days (NIDs) and a round of measles Follow up Campaign in 2015. In addition to this two rounds of Maternal Child Health Weeks (MCHW) were conducted in April and November 2015 and African Vaccination Week was also observed in April 2015. For each campaign round, the interventions achieved administrative vaccination coverage greater than 90 percent, while the measles follow up campaign conducted in June 2015 attaining administrative coverage of an impressive 97.2 percent. For the latter campaign, a post measles coverage survey was conducted, identifying coverage of 88.1 percent. All campaign rounds were integrated with other interventions such as screening pregnant women for HIV, administration of Vitamin A and deworming, registration of births, assessing the nutrition status of children and distribution of bed nets.

This work was complemented by disease surveillance activities, which are critical for detecting and combating disease outbreaks, and are therefore essential components of work on improving healthcare. Disease surveillance activities, including acute flaccid paralysis, measles and yellow fever surveillance, were supported

through the provision of technical and financial support, facilitation of quarterly review meetings, provision of laboratory reagents and supplies, and monitoring of performance indicators. This work complements the work on adapting, training and rolling out of the IDSR system which will be essential to improving the countries capacity to rapidly detect and respond to future disease outbreaks.

In 2015, polio surveillance attained a national non-polio AFP rate of 1.2 with 76.3 percent of stool specimens collected within 14 days of paralysis onset. In line with the requirements of the Polio Eradication Certification Committee the MoHS was supported to compile and publish the Polio Annual Progress Report. Furthermore, assistance was provided to the MoHS to conduct data collection and analysis to produce the Phase One Polio Containment Report as required by the Polio End Game Strategy. Additionally, several measles outbreaks have been identified and confirmed through surveillance mechanisms with 266 suspected cases of measles reported through case-based surveillance with blood samples collected. Of these suspected cases, 125 were IgM positive for measles and nine IgM positive for rubella. Support was provided to MoHS to conduct outbreak investigations and response. A total of 26 suspected cases of yellow fever were investigated in 2015 and samples collected. However, due to the EVD outbreak only three samples were sent to the Institute Pasteur in Dakar for testing all of which were negative for yellow fever.

Coverage data for polio campaigns conducted in June, July and October 2015

Percentage Vaccinated

100% 95% 90% 85% 80% 75%

Independent Monitor's Coverage

Administrative Coverage NIDs

87.7%
98.8%

83.3%
92.4%

89%
98%

2015

A J J O N

Number of defaulters Vaccinated during the April, June, July, October and November 2015 campaigns

Number of Defaulters Vaccinated

0 5,000 10,000 15,000 20,000

0 - 11 Months

12 - 23 Months

15,803
6,254

18,553
11,197

6,196
2,769

4,504
1,075

6,457
1,773

National vaccination coverage by antigen from 2013 - 2015

ANTIGEN

Percentage (%)

20% 40% 60% 80% 100% 120%

Measles: 99% 89% 82%

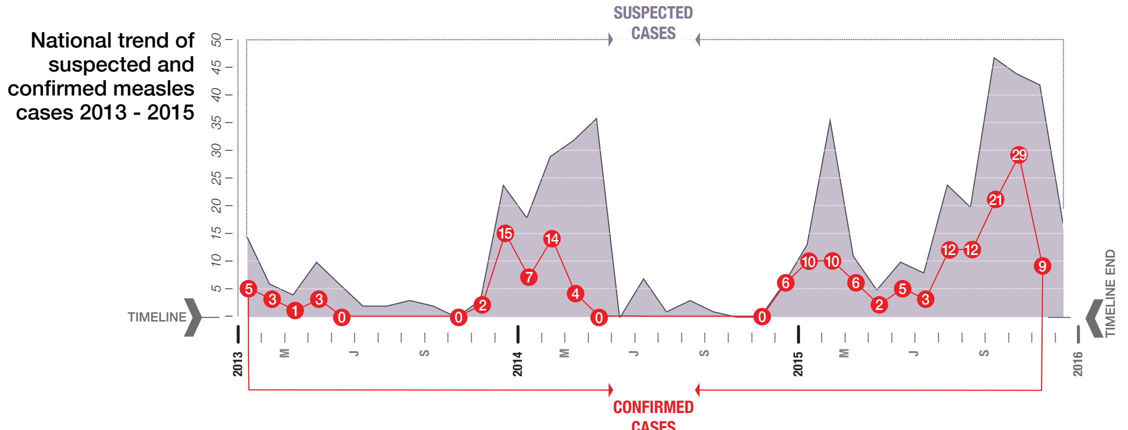
Yellow Fever: 99% 89% 83%

OPV 3: 106% 93% 85%

PCV 3: 106% 93 86%

f/Imm: 99% 88% 82%

2013 2014 2015



Reproductive, Maternal, Neonatal, Child and Adolescent Health

During 2015, assistance was provided to the Ministry of Health and Sanitation (MoHS) to scale up the availability of quality health services for reproductive, maternal, neonatal, child and adolescent health (RMNCAH). The overall aim was to improve quality of care and accelerate progress in the reduction of preventable child, neonatal and maternal mortality, and teenage pregnancy.

Support was provided to MoHS to conduct a national refresher training for facilitators in Integrated Management of Newborn and Childhood Illness (IMNCI) and subsequent training for HCWs in PHUs. Moreover, facilities have been upgraded and HCWs trained on the delivery of Adolescent Friendly Health Services, with a focus on sexual and reproductive health services and effective communication. To support this achievement adolescent peer educators and communities were sensitized on the importance of adolescent health needs and their access to care.

Technical guidance was also provided together with UNFPA to MoHS for the development of Maternal Death Surveillance Response guidelines. The training of nurse and midwifery tutors for curricula review, the updating of the two midwifery curricula, and the development of standards and accreditation tools for nursing and midwifery education conducted this year will assist in improving nursing and midwifery education in the years to come. During 2015, support was given-to three Sierra Leonean doctors undertaking specialist post-graduate training in Nigeria.

WHO led a best-practice study tour, in Malawi, for key health leaders focusing on education, regulation, accreditation and service delivery to support the MoHS formulate relevant plans to strengthen these aspects in Sierra Leone.

As Sierra Leone transitions from EVD to Health, the President of Sierra Leone has identified maternal and child mortality as a main focus for action under health system recovery. Through 2016 WHO together with other partners (UNFPA, UNICEF, UNAIDS, UNWOMEN) will continue to support MoHS with the adaptation and development of clinical guidelines, pre-service curricula, in-service training and supervision support, tools, policies and strategies in relation to RMNCAH including the 10-24 months health recovery initiatives for the accelerated reduction of child and maternal mortality.

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AIDS, Tuberculosis and Malaria activities

Due to the Ebola outbreak in 2015 HIV, TB and Malaria control interventions were stalled as a result of a low demand for services caused by the populace's fear of health service delivery points.

The National AIDS Secretariat and its partners focused on interventions aimed at mitigating the impact of EVD on HIV services and its beneficiaries. Key interventions were a defaulter tracing programme lead by the network of persons living with HIV in Sierra Leone to ensure that all known persons living with HIV could continue to access lifesaving treatment.

The similarity of symptoms between malaria and EVD meant that it was imperative to reduce incidence and prevalence of the malaria parasite in order to diminish the strain on the health system and allow true cases of EVD to be found and treated. The MoHS and its Roll Back Malaria (RBM) partners (WHO, UNICEF, MSF etc) conducted a mass distribution of the country's first line anti-malarial artesunate amodiaquine to supplement routine activities in EVD hotspots and areas where high incidence of EVD cases had been reported in December 2014. The goal of the mass drug administration (MDA) was to give everyone in the targeted location, a complete dose of effective antimalarial medicines over a very short period of time. This was to reduce the probability of developing clinical malaria disease during the therapeutic window of the treatment giving a protective effect for two to three months.

The second cycle of the MDA distribution was held during the high malaria transmission period (January 2015). Administration of this regimen was door-to-door, with Directly Observe Treatment (DOT) for the first dose. The clients were educated and encouraged to comply with the treatment regimen. Distribution was accompanied with strict adherence to the "no touch" policy.

The MoHS was supported to conduct a Rapid Impact Assessment of MDA for malaria in response to the EVD outbreak in Sierra Leone. The MDA, implemented as a temporary measure in response to the Ebola outbreak in Sierra Leone, resulted in significant reduction of morbidity of febrile cases and possibly associated mortality. The intervention also helped reduce the outpatient case load on the health system at the peak of the EVD outbreak. It must be noted that such success was attained with about 57% effective coverage of the MDA which is moderate taking into account the population coverage of 80% and 71% DOTs.

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It can concluded that MDA was an appropriate public health decision (intervention) in the context of Sierra Leone during the EVD peak.

The lifespan of the national HIV, TB and malaria strategic plans ended in 2015, WHO provided technical support for the revision of the three program national strategic plans 2016 -2020 to include: the new end TB strategy, the recommendations of the malaria programme review 2013, recognition of the impact of malaria interventions and the Health Sector Recovery 2015-2020 and a vision for Sierra Leone where HIV is no longer a public health threat.

The national HIV strategic plan 2016-2020 was launched during the World AIDS Day 2015 commemoration in Kenema by the Minister of Health and Sanitation.

Nutrition

Through the Accelerating Nutrition Improvement (ANI) Project, technical support was provided to the Directorate of Food and Nutrition, to enhance and strengthen the nutrition surveillance system. In this regard, 59 nutrition officers and their assistants were trained on data analysis, interpretation and reporting to build capacity to analyse and produce reports on the nutrition situation for their respective districts. This capacity building activity was complemented by the review and production of annual and quarterly nutrition surveillance reports.

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WHO collaborated with partners in the planning, implementation, monitoring and supervision of nutrition activities at all levels of the healthcare service. This facilitated the production and dissemination of the Sierra Leone Micronutrient Survey Report which serves as the baseline for micronutrient indicators in the National Food and Nutrition Security Implementation Plan.

Support was provided for the review of the National Training Manuals on growth monitoring and promotion (GMP). Following this, refresher training of 72 trainers on GMP, with strong IPC component, was conducted with cascade training reaching 767 HCWs in 55% of PHUs. This will facilitate the identification of children with malnutrition for timely treatment.

In October 2015, support was provided to the Directorate of Food and Nutrition to conduct a pilot study on the use of the height for age tool to monitor stunted growth in children less than five years in two communities (Goderich and Hastings) in the Western Area rural.

Furthermore, technical support was provided in the development and validation of the Infant and Young Child Feeding Strategy and the development of a Recipe Book on local complementary foods for feeding children 6 to 23 months. The Recipe Book will be rolled out for use by HCWs and caregivers.

Non Communicable Diseases and Health Promotion

Despite challenges in lack of funding for Non Communicable Diseases (NCDs) and the system wide impact of the EVD Outbreak on health services and systems, support was provided to the MoHS to produce an Annual Survey Report for Alcohol, implement the WHO Framework Convention on Tobacco Control, and develop the Associated Tobacco Control Communications Strategy. This work was conducted in addition to maintaining collaboration with the MoHS to support strategies for the prevention and control of NCDs.

During the EVD outbreak the health promotion team provided technical support to community engagement activities for prevention and control of EVD in communities that posed resisitance to response teams, especially in chiefdoms in Kambia and Port Loko districts.

In Makuma community in Kambia EVD response workers faced significant challenges engaging the community in response activities such as quarantine measures. However, through the collaboration of health promotion and community engagement, the teams were able to effectively establish mutual understanding and trust with the community that the response workers cared

about them and would listen to their fears and concerns to adapt the response where possible. As a result, people in quarantine were transferred to a more accessible community for 21 days monitoring and the community began to positively engage with responders and the recommended safety measures.

With the transition of activities from EVD response to other health priorities the focus has shifted to supporting the development and implementation of communication strategies for other health priorities. Health promotion has supported the introduction of Measles second dose, Measles Supplementary Immunization Days, and Maternal and Child Health Days and National Immunization Days for Polio Immunization campaigns and routine services. Health promotion activities have been particularly important in gaining community support for immunisation programmes in the wake of EVD activities.

Public Health and Environment

Environmental risk factors to human health such as unsafe drinking water, inadequate sanitation, and waste management pose a significant health challenge. Efforts have been focussed on tackling environmental risk factors by strengthening MoHS's capacity to assess health risks; as well as develop and implement policies, strategies and regulations for the prevention, mitigation and management of the health impacts of environmental risks.

Specifically, WHO has supported MoHS to establish a Directorate of Environmental Health and Sanitation, and to finalise the Environmental Health and Sanitation Policy and Strategic Plan. The revised Environmental Health and Sanitation Policy will be strategically important in guiding MoHS to implement, monitor and enforce environmental health and sanitation activities.

Working with MoHS , the Integrated Vector Management Strategic Plan has been developed which aims to provide guidance on the control of Malaria and neglected tropical diseases to ensure that the programmes and activities of various partners are harmonized and aligned with the goals and objectives laid out in the Strategic Plan.

Additionally, water safety in Sierra Leone has been an increasingly important issue, especially for rural and urban slum dwellers. Among households who use unimproved sources as their drinking water, only 11 per cent use some types of water treatment. In response to this issue an action plan was developed which provides step-by-step guide to advocate, promote and implement household water treatment and safe storage. Support has also been provided for the implementation of the Integrated Waste Management Strategic Plan which will be essential in minimising the transmission of water-borne diseases, such as diarrhoea and cholera, as well as malaria (through the destruction of mosquito's habitat).

Working with MoHS the Integrated Pesticides Management Policy was finalised, representing a significant achievement as there was previously no documented regulatory mechanism for pesticides with respect to wildlife and marine resources in Sierra Leone. This was despite the danger that pesticides represent if not properly applied, handles, stored or disposed of and the significant risk this poses to key economic activities including fishing.

WHO Sierra Leone

WHO Sierra Leone

OUTCOME 4

Health Sector Planning and Management at the National and District

WHO/S. Gborie

Effective Leadership and National Health Sector Coordination

The MoHS developed and costed the Health Sector Recovery Plan (HSRP) 2015-2020, ensuring all districts completed detailed operational plans to reflect the priorities in the HSRP. As part of the process, the Basic Package of Essential Health Services (2015-2020) was also updated to take into account vital lessons learnt from the Ebola epidemic. These documents served as the basis for implementing activities in the 6-9 months recovery plan and are informing the development of the 10-24 months plan.

Furthermore, at the request of the MoHS, WHO facilitated a review of the National Health Sector Strategic Plan (NHSSP) 2010-2015. The exercise assessed progress achieved, identified strengths and weaknesses, challenges experienced in implementation and proposed options for moving forward in the post-Ebola environment in 2016 and beyond.

Finally, specifically on the Health Information Management System (HMIS), support was provided to the MoHS in institutionalizing the Monitoring and Evaluation Technical Working Group (TWG), which brings together partners and key programmes within the Ministry to review and update the HMIS.

The co-chairing of the Health Development Partners forum and convening UN agencies on a regular basis around key technical and strategic issues of relevance to the health sector has and will continue to be a key role for the Organization.

Appropriately Resourced and Functioning District Health Management Teams

The District Health Management Team (DHMT) in each district, are the MoHS responsible entity for planning, organising and monitoring health provision, training personnel, engaging with communities, supplying drugs and equipment, and ensuring that quality and equitable health services reach the people of Sierra Leone. In light of the recent Ebola epidemic, more resources and responsibility are being committed to DHMTs to ensure a comprehensive and robust district health management approach.

To support the DHMTs in achieving this vision, direct side-by-side guidance and support was provided to ensure the DHMTs are properly equipped with the right set of leadership and management skills in order to deliver cost effective, high impact health service programs in their respective communities to the people of Sierra Leone. Efforts have also been underway to improve linkages between the central, district and peripheral levels.

WHO's presence in all 14 districts has been strategic in the transition from Ebola to the revival of the overall health system. The WHO district field teams provide support and advice in strengthening capacities; specifically, on the implementation of the 6-9 months recovery plan, the field offices have been actively engaging the DHMTs in reporting, monitoring and supervising activities.

Through close collaboration with the MoHS, implementing partners and experts, best practices on how to address leadership and management capacity gaps and challenges at the sub-national level in the three Ebola-affected countries were gathered and changes put in place. In 2016, some country-focused workshops will be scheduled to monitor the improvements, cross-fertilize thinking and harness critical elements of the improvement process to stimulate change at the frontline.

Human Resources for Health

As Sierra Leone recovers from Ebola and continues on the path to revitalizing health services, the country's health workers have and continue to play a critical role in these endeavours. To gain better data on health worker numbers, geographical distribution and skill levels, support was provided to MoHS to conduct a head count of all health workers in the country, using the data to populate the existing Human Resources Information System (HRIS). These findings will inform future health workforce priorities, including the development of an updated Human Resources for Health (HRH) profile, policy and strategic plan and will be finalized in early 2016.

Additionally, working with the MoHS and partners, a process was initiated to identify best practices and experiences from other countries to better shape future HRH policies in Sierra Leone. These efforts will help guide the country's work in recruiting, training, motivating and retaining skilled health workforce.

WHO Sierra Leone

WHO Sierra Leone

OUTCOME 5

Operational Support

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Effective and Efficient Human Resource and Technical Assistance

WHO continued to provide best practice, evidence based technical advice in key areas as Sierra Leone embarks on its early recovery plan towards essential health services.

As an organization it was important during 2015 that our human resources were restructured to address the growing need of the country and creating clusters of departments that would respond to the health priorities in Sierra Leone. In addressing this, a set of new organogram, new positions and revision of terms of reference were developed.

Currently, the country office is divided into five clusters including three technical clusters. The technical clusters include the Health Security and Emergencies (HSE) cluster with a priority to build the country's capacity to deal with health emergencies and disasters.

The Basic Package of Essential Health Services (BPEHS) cluster has now an expanded scope of work as we move from Ebola to Health as its work includes reproductive, maternal, neonatal and child health, Immunisation services, HIV, TB and malaria treatment, community engagement, mental health, and other areas.

The Health Systems Strengthening (HSS) cluster looks at the broader health system and supports efforts such as the National Health Sector Recovery Plan and closely links with both the HSE and BPEHS clusters on cross-functional activities.

The District Coordination (DC) cluster has been put in place to better align the support to the District Health Management Teams (DHMT) through the WHO District Offices in all 14 districts of Sierra Leone. The districts Ebola response teams are transitioning into their longer-term roles, with field coordinators taking on broader public health advisory profiles and the 'Ebola epidemiologist' taking on Integrated Disease Surveillance and Response (IDSR) profiles.

The Operations cluster continues to provide planning, coordination and enabling environment and functional support to the technical clusters for program implementation and to the senior management team to guide decision making.

Effective Financial Management and Oversight

The organization continues to use an Enterprise Resource Planning System (ERP) called Global Management System (GSM), which is a highly robust IT system to gather, collate, and produce data. The areas of programme planning, human resources, finance, travel, and procurement are all combined into one bringing together disparate work flows, procedures and systems into one common system across the Organization.

Expenditures are easily monitored and payments are managed through the WHO global service center directly to government, implementing partners or suppliers only smaller miscellaneous expenses are managed through the country imprest account, whose ceiling and transactions is monitored by the regional office and monthly returns submitted.

Throughout 2015 the office was operating under emergency SOPs which ensured a quick response in terms of core services (Planning, HR, Operational support and Logistic, Financial Management) and providing the required support in the least amount of time while ensuring that risks where mitigated by ensuring adequate controls and accountability. This is returning to a normal steady state with the end of the EVD outbreak and transition to the overall health agenda.

Administrative Assistants were deployed to each district during the year to increase the accountability of funds deployed to the district offices for operational needs and program implementation activities (i.e. trainings and workshops). The operations costs funding is an imprest account and financial field operations SOPs have also been developed and implemented to ensure correct use and accountability of funds.

Making the Organization Work

The continuous support the Organization was able to provide to the MoHS and the larger healthcare system was based on the effectiveness of the individuals, teams, and the internal organization as a whole. To be a dynamic, effective, responsive organization and to provide the required support in the role of technical advisor to the MoHS, an effort was made to first define a clear vision in alignment with the MoHS, and to ensure the necessary structure, processes, and people are in the right place to support it.

The following the building elements and focus in 2015 for “making the organization work” and will continue to be in 2016. First, a vision was developed in close cooperation with the MoHS ensuring an alignment to the government’s overall 24-months health recovery plan, which guided the work in the second half of 2015 and will continue to do so in the next two years. The key areas identified for 2016/17 are:

1. Rolling out Integrated Disease Surveillance and Response (IDSR)
2. Strengthening Infection Prevention Control (IPC)
3. Reducing child and maternal mortality
4. Enhancing Human Resources for Health (HRH)
5. Engaging the communities
6. Improving management for health and a resilient health system

For the structure of the organization, the office has retained its support both at the district and national level, with a team in each district to equally support both the DMHTs and MoHS (see above).

Second, for more effective processes, meetings involving the extended management teams and the individual technical clusters have been launched, allowing members to update, cross-fertilize, and support each other as needed. An office manual to welcome new staff members and clarify processes will be completed in early 2016. Finally, key performance indicators have been put in place to ensure monthly and quarterly progress is monitored and the goals laid out by the MoHS are achieved.

For people, the Organization has increased its emphasis on development and trainings. The members of the organization as individuals, as managers, as teams, and as a collective office committed themselves to developing and training to enable the organization to achieve the Organization’s vision. Trainings have and will include developing managers with regards to coaching and managing performance, training staff members on self-awareness, teamwork, and more.

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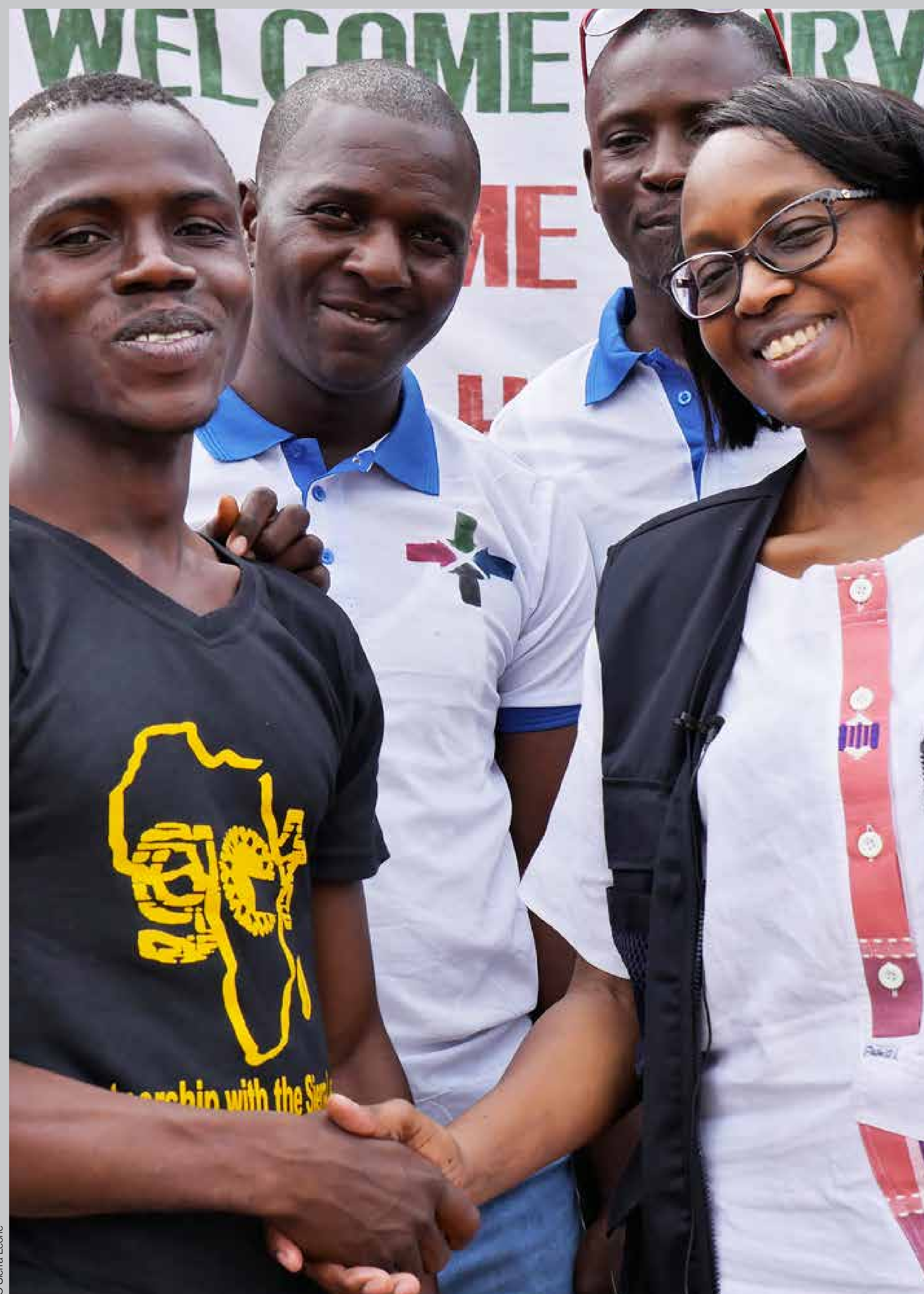
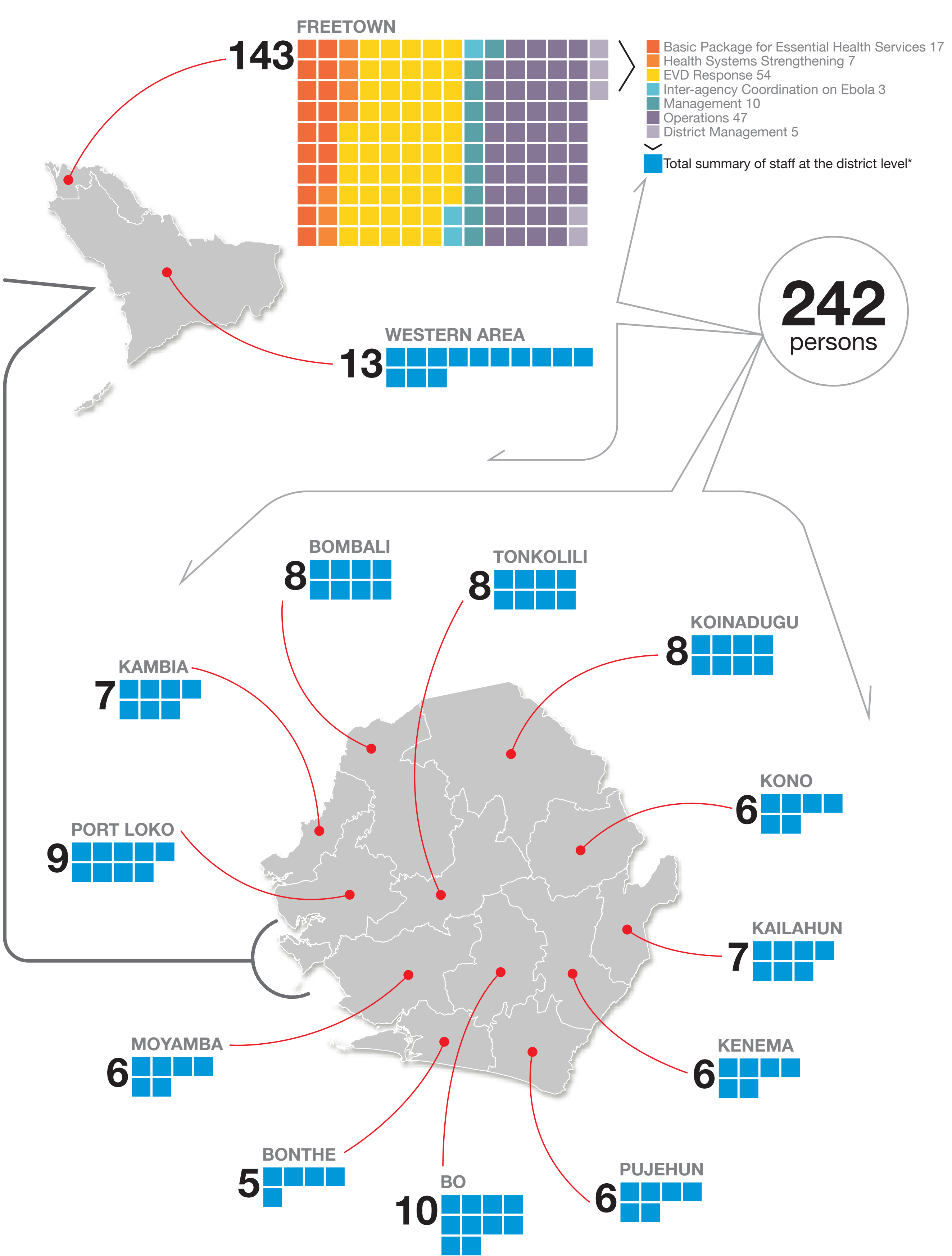


WHO Sierra Leone

WHO presence in Sierra Leone (2015)



** The default composition of district teams as of December 2015: one Field Coordinator; one Administrative Assistant; one Epidemiologist; two Community Engagement Officers; one Infection Prevention and Control expert; and two drivers.*

Achievements Against Work-plan for 2015

Outcome 1

OUTPUT	ACTIVITY	INDICATOR	BASELINE 2015	TARGET 2015	ACHIEVEMENTS (as per 12/2015)
Enhanced Surveillance, Contact Tracing and Case Investigation	1.1.1 Support ongoing active surveillance with "zero weekly reporting" of suspected Ebola cases from key facilities and community leaders	Proportion of new confirmed cases arising from known contact lists (over the past four weeks)	41% (as of 10/5/15)	100%	100%
	1.1.2 Enable integrated epidemiological case investigations to identify transmission chains and identify contacts	Proportion of contacts seen daily by contact tracers	99%	100%	100%
	1.1.3 Support the systematic monitoring of contacts for 21 days, across national and international borders where required	Proportion of the 7 border districts with functional community surveillance systems documented in a MOU	14%	100%	100%
	1.1.4 Support the management of data systems to reliably record and share epidemiological data as part of monitoring the Ebola response 1.1.5 Support and ensure high quality laboratory diagnostic capacities for Ebola	Percentage of Ebola laboratory test results released within 24 hours of receipt of sample	79%	100%	100%
Community Engagement	1.2.1 Support the development and implementation of adapted community engagement strategies and messaging to address resistance and socio-cultural barriers	Number of district community engagement workplans that specifically take into account social and cultural contexts	2	13	14
	1.2.2 Contribute and facilitate training of frontline staff for MOHS & MSWGCA in compassionate communication skills to improve service delivery communication skills.	Number of districts where training in compassionate communication skills was delivered to frontline staff	4	14	12
	1.2.3 Enable local community engagement taskforces to support Ebola response activities including engaging community leaders and traditional healers to carry out safe practices, case identification and notification	Number of chiefdoms with community engagement taskforces presence that were engaged to support Ebola response activities	74	149	149
	1.2.4 Support national and district capacity to provide psychosocial support to affected communities and Ebola survivors	Percentage of chiefdoms with community engagement taskforces in place per district	50%	100%	50%
		Number of unsafe burials reported	1 (as of 10/05/15)	0	N/A
	1.2.5 Support the development and implementation of strategies to address stigma affecting Ebola survivors at both healthcare facility and community levels	Number of psychosocial staff trained at the district level across Sierra Leone	275 (10/14 - 01/15)	150	150+ [1]
Case Management	1.3.1 Manage deployment of foreign medical teams	Number of FMTs that were successfully deployed	N/A	N/A	10
	1.3.2 Support and coordinate the decommissioning/repurposing of Ebola Treatment Centres and Community Care Centres while maintaining contingency capacity	Number of Ebola Treatment Centres present in the country	13	2	2
	1.3.3 Advise on and promote the Minimum Standards in Mainstream Health Facilities to ensure that all health facilities maintain effective screening, triage, and quality assured case management of suspected and probable Ebola cases	Proportion of health facilities implementing the Minimum Standards for effective screening, triage, and quality assured case management of suspected and probable Ebola cases	N/A	13	6
	1.3.4 Develop protocols to safely optimise the care of pregnant women and neonates recognising the protracted risk of transmission associated with pregnancy	Training programme for Midwife Master Trainers developed + training of 80 Master Trainers complete.	0	80 ToTS	80 ToTs [2]
	1.3.5 Ensure case management quality improvement by supporting the training and mentoring of healthcare workers in mainstream healthcare facilities	Number of HCWs, facilities, districts covered	0	13	6 [3]
	1.3.6 Develop and support the implementation of best practices guidelines for managing the care of Ebola survivors	Guidelines updated by clinical team in SL awaiting final input from WHO HQ	Previous guidelines	100%	100%
	1.3.7 Develop a reporting framework for lessons learnt from Ebola FMT response	Framework developed and populated	0	100%	100%
	1.3.8 Contribute to the maintenance of referral services for Ebola cases	Healthcare for and monitoring of quarantined households is provided	50%	100%	100%
Strategic Communication for getting to and Sustaining Zero	1.4.1 Recruit a crisis communication expert to manage and communicate critical outbreak response messages to the public and the international community 1.4.2 Implement interpersonal communication activities in communities and homes with ongoing EVD transmissions to combat challenges with interventions and diffuse stigma 1.4.3 Review EVD messaging in line with the current context of the outbreak response 1.4.4 Provide continuous messaging to the community using simulcast	Recruitment of international communications expert	0	100	100%
	1.4.5 Increase WHO's profile on different media platforms (website, Facebook, Twitter, and print) locally and internationally 1.4.6 Support public health advocacy and health campaigns in collaboration with MOHS 1.4.7 Improve media reportage on WHO and health events within Sierra Leone by conducting workshops with media partners	Increase visits to WHO website and social media platforms by 100%	0	100%	UNKN

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Pillar	Activity	Indicator	Baseline	Target	Result	Outcome
Enhanced Surveillance, Contact Tracing and Case Investigation	2.1.1 Support the strengthening of national IPC structures through establishment of the National IPC Committee, monthly committee meetings, and quarterly IPC Partners Coordination meetings	Number of IPC technical and coordination meeting minutes shared with stakeholders and partners	0	6	11	Outcome 2
		Assignment of international IPC advisor at MOHS	0	1	1	
	2.1.2 Support the process of finalization, validation, printing and distribution of the National IPC Guideline, training modules and educational materials	Validated, printed and distributed National IPC Guideline	0	4000	1800	
	2.1.3 Facilitate effective IPC practices at healthcare facilities through a continuous improvement program with assessments, HCWs training, and the development of supply chain management to ensure adequate IPC supplies	Number of trained health workers on validated guideline	0	5000	1642	
		Proportion of ECCS scored above 80%	74%	90%	90%	
	2.1.4 Support the monitoring of the implementation of standardized triage and isolation in all healthcare facilities including referral capacity	Percentage of the assessed secondary and tertiary governmental hospitals which have a functional triage and referral system in place	N/A	100%	89%	
	2.1.5 Support local production of alcohol-based handrubs in 5 government hospitals	Number of Hospitals with supply of ABHR at point of care	0	5	0	
	2.1.6 Support IPC with improvements to WASH and waste management at healthcare facilities	Proportion of facilities provided with WASH and waste management support	0	25%	10%	
Strengthened Emergency Preparedness and Response Capacity	2.2.1 Support the strengthening and implementation of IHR 2005 core capacities 2.2.2 Support the implementation of Integrated Disease Surveillance and Response (IDSR) guidelines at health facility, district and national levels (including CBDS)	Number of districts which have functional IDSR systems	0	13	13	
	2.2.3 Support the development of electronic tools for implementation of IDSR 2.2.4 Support the MOHS in the design, development and implementation of the Emergency Operations Centre 2.2.5 Support the coordination, development and implementation of cross border strategies for prevention and control of EVD and other priority epidemic prone diseases within the MRU framework	Number of districts which have access to and are reporting using the electronic IDSR tool	0	13	0	
	2.2.6 Establish a functional national laboratory network with adequate capacity for biosafety, quality assurance, information systems, and specimen referral 2.2.7 Support the development and implementation of capacity building activities for emergency preparedness and response through training and supervision	Percentage of laboratories scoring >80% in the national quality assurance programme	N/A	100%	100%	
Reestablishment of Essential Health Services	3.1.1 Support the planning and implementation Polio and measles supplemental immunisation activities (SIA)	Number of national immunisation campaigns held	0	0	4	Outcome 3
	3.1.2 Support the RI acceleration plan 3.1.3 Support the introduction of inactivated Polio vaccine	Inactivated Polio vaccine introduced in all districts	0	13	IPV delayed [4]	
	3.1.4 Develop and update the Sierra Leone Nutrition Strategy, and commence a quarterly Nutrition Surveillance Report	Number of PHU staff trained on Growth Monitoring and Promotion	0	676	complete	
	3.1.5 Support the strengthening of reproductive, maternal and neonatal healthcare together with UNFPA and UNICEF	Proportion of women delivering at a healthcare facility	31%	54%	N/A	
		Number of districts with 60% healthcare workers trained in IMNCI	4	8	7	
	3.2.1 Enable a skilled district/facility workforce with an emphasis on underserved areas and community based delivery	Number of facilities with healthcare workers receiving refresher training on Life Saving Skills, Immunisation In Practice, and Injection Safety training	0	125	125+[5]	
	3.3.1 Ensure key policies, strategies and guidelines on community engagement are developed to support the implementation of the BPEHS	Number of districts supported by community engagement pillar for the implementation of BPEHS programs-Key policies, guidelines and strategies	2	14	14	
	3.4.1 Strengthen and develop Health Management Information Systems including HRMIS	Develop policies, guidance and standards for Emergency Preparedness and Response and surveillance	0	complete	50%	

Optimised Heath Information and Management Systems

Community Ownership of Health Activity

Adequate, Well Trained, and Well Distributed Health Workforce

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Output	Indicator	Baseline	Target	Achieved	Status	Outcome
4.1.1 Support National Health Sector strategic planning, engage Health Development Partners, and convene other technical UN agencies working on health	Demonstrated leadership role in development partner coordination and advocacy within Sierra Leone at the national level	0	100%	100%	Fully achieved	Outcome 4
4.2.1 Support District Health Management Teams with planning, training, and service provision, reporting, and information management	Number of districts with agreed upon workplans	13	13	13	Fully achieved	Outcome 4
	Percentage of districts reporting on planned and implemented activities in a timely manner	0	100%	100%	Fully achieved	Outcome 4
4.2.2 Contribute to strengthening the operational capacity of the District Health Management Teams in rolling out the BPEHS	Monthly coordination meetings at district level with all partners, support the collation of meeting minutes and follow up actions, and assist the implementation of monthly meeting goals	0	100%	N/A	Partially achieved	Outcome 4
4.2.3 Support effective management and coordination of health service delivery activities at the district level, together with District Health Management Teams	Number of monthly coordination meetings with action points documented and achieved	0	100%	N/A	Partially achieved	Outcome 4
5.1.1 Monitor staffing by ensuring an adequate, qualified and motivated workforce in the country office	HR plan in place and updated and performance report submitted	in progress	complete	complete	Fully achieved	Outcome 5
5.2.1 Implement the finance control framework and ensure compliance with WHO's administrative policies and regulations at the country level	Manage expenditure tracking and reporting at the country level in a timely manner	on going	on going	on going	Fully achieved	Outcome 5
5.3.1 Supplies and equipment	Manage building maintenance works and establish functional amenities	complete	complete	complete	Fully achieved	Outcome 5
5.3.2 District and national office costs	Ensure rational use of staff transport vehicles	on going	on going	on going	Fully achieved	Outcome 5
5.3.3 Vehicles and fuel	Maintain zero incidents affecting the security of staff and their belongings while on duty	2	0	1	Partially achieved	Outcome 5

Provision of Operations and Logistics Suport for Health Activities (5.3.1, 5.3.2, 5.3.3)

Effective Financial Management and Oversight (5.2.1)

Effective and Efficient Human Resources Management (5.1.1)

Appropriately Resourced and Functioning District Health Management Teams (4.2.1, 4.2.2, 4.2.3)

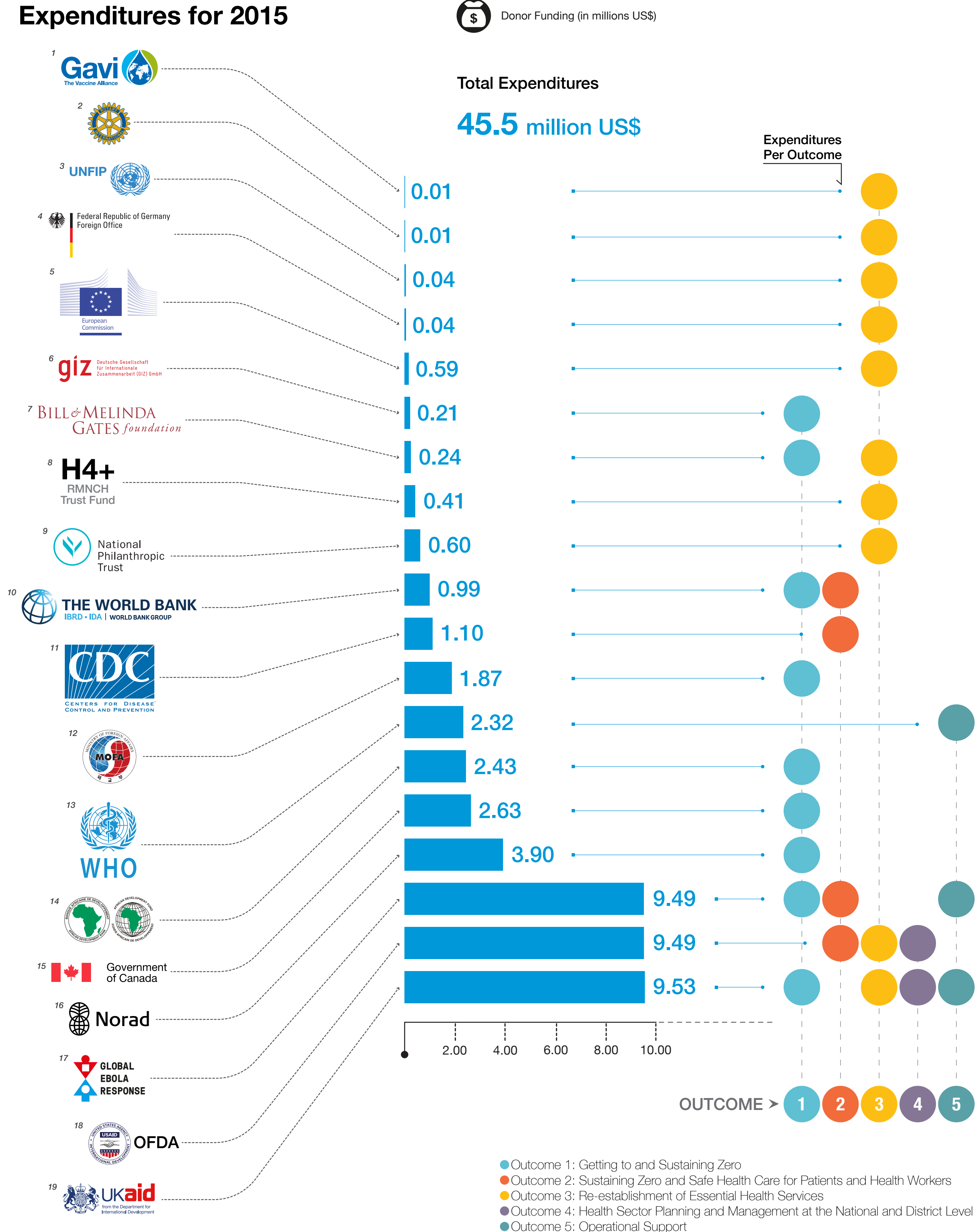
Effective Leadership and Support of National Health Sector Coordination (4.1.1)

FULLY ACHIEVED

PARTIALLY ACHIEVED

NOT ACHIEVED

[1] (1.2.5) Also12 Master trainers trained
[2] (1.3.4) 80 Master trainers trained
[3] (1.3.5) 6 Districts covered targeting 1,024 HCWs
[4] (3.1.2 -3.1.3) IPV introduction delayed to July 2016 due to global shortage of vaccine
[5] (3.2.1) 1,277 Health workers trained in immunisation practices



(1) The Global Alliance for Vaccines and Immunization (GAVI); (2) Rotary International; (3) United Nations Fund for International Partnerships (UNFIP); (4) Federal Republic of Germany; (5) European Commission (EC); (6) Gesellschaft für Internationale Zusammenarbeit (GIZ); (7) Bill and Melinda Gates Foundation; (8) RMNCH Trust Fund (H4+); (9) National Philanthropic Trust (NPT); (10) World Bank Group; (11) Centers for Disease Control and Prevention (CDC); (12) Republic of Korea; (13) World Health Organization; (14) African Development Bank Group (AfDB); (15) Government of Canada; (16) Norwegian Agency for Development Cooperation (Norad); (17) UN Multi-Donor Trust Fund (MDTF); (18) United States Agency for International Development (USAID); (19) UK Department for International Development (DfID).

Acronyms

AAFHS	Adolescent Friendly Health Services
AFP	Agencies, Funds, Programmes
ANI	Accelerating Nutrition Improvement
bOPV	bivalent Oral Polio Vaccine
BPEHS	Basic Package for Essential Health Services
CBS	Community-Based Surveillance
CDC	Centers for Disease Control and Prevention
CHOs	Community Health Officers
CPES	Comprehensive Package for EVD Survivors
DERC	District Ebola Response Centre
DFID	Department for International Development
DHMTs	District Health Management Teams
DOT	Directly Observe Treatment
DPC	Disease Prevention and Control
ERP	Enterprise Resource Planning System
ETCs	Ebola Treatment Centres
EVD	Ebola Virus Disease
EVDS	EVD Survivors
FMTs	Foreign Medical Teams
GAVI	Vaccine Alliance
GIS	Geographic Information System
GSM	Global Management System
HCWs	Health Care Workers
HRIS	Human Resource Information System
HSRP	Health Sector Recovery Plan
HSS	Health Systems Strengthening
IDSR	Integrated Disease Surveillance Response
IEC	Information Education and Communication
IHR	International Health Regulations
IMNCI	Integrated Management of Newborn and Childhood Illness
IMT	Incident Management Team
IP	Implementing Partner
IPC	Infection Prevention and Control
IPV	Inactivated Polio Vaccine
KAP	Knowledge, Attitudes, Practices
MCHW	Mental Health GAP Action Programme
MDA	Mass Drug Administration
mhGAP	Mental Health and Psychosocial Support
MHPSS	Mental Health and Psychosocial Support
MMR	Maternal Mortality Rate
MoHS	Ministry of Health and Sanitation
MSWGCA	Ministry of Social Welfare, Gender and Children Affairs
NAC	National IPC Advisory Committee
NCDs	Non Communicable Diseases
NERC	National Ebola Response Centre
NHSSP	National Health Sector Strategic Plan
NIPCU	National IPC Unit
ONS	Office of National Security
PFA	Psychological First Aid
PHUs	Peripheral Health Units
PPE	Personal Protection Equipment
RBM	Roll Back Malaria
RMNCAH	Reproductive, Maternal, Neonatal, Child and Adolescent Health
RRT	Rapid Response Teams
SHS	School Health Services
SIA	Supplemental Immunisation Activities
SLAs	Service Level Agreement
SOPs	Standard Operating Procedures
SRH	Sexual and Reproductive Health
tOPV	trivalent Oral Polio Vaccine
ToT	Training of Trainers
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
UNOCHA	UN Office for the Coordination of Humanitarian Affairs
VQF	Voluntary Quarantine Facilities
WFP	World Food Programme
WHO	World Health Organisation
3 Ws	Who does, What, Where

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