



**INTERNATIONAL RESCUE COMMITTEE  
SIERRA LEONE PROGRAM**

---

**QUARTERLY REPORT**

**"COMMUNITY EVENT-BASED SURVEILLANCE (CEBS) IN SIERRA LEONE"**

**(AGREEMENT NO: AID-OFDA-G-15-00237)**

**1 AUGUST - 30 SEPTEMBER 2015**

**PRESENTED TO:**

**THE USAID OFFICE OF FOREIGN DISASTER ASSISTANCE**

**Collaborating Partner:**

International Rescue Committee Sierra  
Leone  
c/o Saffea Senessie, Country Director  
Telephone: +232 (0) 76 622998  
Email: [Saffea.Senessie@Rescue.org](mailto:Saffea.Senessie@Rescue.org)

**Agency Headquarters:**

International Rescue Committee  
c/o Adrian Clarke, Program Officer  
Telephone: 212.551.0954  
Email: [Adrian.Clarke@Rescue.org](mailto:Adrian.Clarke@Rescue.org)

**OCTOBER 31, 2015**

## **I. Executive Summary**

---

<b>PROGRAM TITLE:</b>	Community Event-Based Surveillance (CEBS) in Sierra Leone
<b>PROJECT NO:</b>	AID-OFDA-G-15-00237
<b>AGENCY:</b>	International Rescue Committee
<b>COUNTRY:</b>	Sierra Leone
<b>REPORTING PERIOD:</b>	1 <sup>st</sup> August - 30 <sup>th</sup> September 2015
<b>GOAL:</b>	Strengthen community-level systems for rapid disease detection and reporting across nine districts in Sierra Leone.
<b>OBJECTIVE(S):</b>	Maintain and strengthen active surveillance at the community level in nine districts in Sierra Leone through continuing support for the CEBS approach.
<b>BENEFICIARIES:</b>	Total targeted: 7,895 (including 7,742 Community Health Monitors and 153 Community Surveillance Supervisors) Direct; 3,310,776 Indirect IDP beneficiaries: N/A
<b>LOCATION:</b>	Nine out of the 14 districts of Sierra Leone (Bo, Bombali, Kailahun, Kambia, Kenema, Kono, Moyamba, Pujehun, and Tonkolili)

## **I. Introduction**

The reporting period was characterized by marked reductions in Ebola virus disease (EVD) caseload and an increasing geographic confinement of the outbreak, with the number of confirmed cases per month reducing from 27 in July (across 4 districts) to 3 in August (across 3 districts), before rising slightly to 6 in September (across 2 districts). Overall, the number of EVD cases decreased from 121 between April and June to only 36 between July and September.<sup>1</sup> Despite notable improvements in surveillance and response capacity, the cases occurring during this reporting period were illustrative of the ongoing risks that the region will continue to face over the coming months. These include the risk of imported cases, as demonstrated in July when a contact of a previous EVD case traveled from Freetown to Tonkolili and subsequently infected two others; as well as the challenge of late detection, as occurred in Kambia during August when an EVD-positive woman was detected only after her death and resulted in five secondary cases. The death of an EVD-positive adolescent female from a village in Bombali with no recent active transmission also raises the concern of sexual transmission from EVD survivors. In short, these cases highlight the need for continued vigilance in the coming months, as international support draws down and the risk of complacency increases among the general population and response personnel alike.

Since January 2015, the International Rescue Committee (IRC) has been leading the Ebola Response Consortium (ERC) to support the Ministry of Health and Sanitation (MoHS) in rolling out Community Event-Based Surveillance (CEBS) in nine districts. Funding for the initial implementation and management of CEBS was provided through the United Kingdom's Department for International Development (DFID) from January through July 2015, and the USAID Office of Foreign Disaster Assistance (OFDA) has been supporting CEBS since the beginning of August. The CEBS approach uses a network of trained Community Health Monitors (CHMs) to detect and report a list of specific "trigger events" which could indicate potential EVD transmission in their communities. Upon detecting an event, the CHM calls his or her Community Surveillance Supervisor (CSS), who works with the local MoHS Community Health Officer (CHO) to conduct a preliminary screening in order to determine if it is necessary to escalate the alert to the District Ebola Response Center (DERC). If so, the CSS or CHO calls in the alert to the DERC, which dispatches a case investigation team to follow up on the case. The objective of CEBS is to improve the timeliness with which EVD cases are detected, isolated, and provided with appropriate care.

## **II. Summary of Activities**

During this reporting period, IRC and its partners carried out the following activities:

### *National CEBS Partners Meeting*

A national CEBS partners meeting was held on September 17-18, 2015 and brought together implementing partners from all nine ERC-supported districts. The first day began with a presentation of the recent national CEBS data and a refresher training on reporting tools, while the afternoon was comprised of structured discussion focusing on key implementation areas (e.g. supportive supervision approaches, methods for engaging DHMTs) to allow for districts to learn from each other through sharing their challenges and best practices. A training-of-trainers session was held on the second day, where new training tools were introduced and revised based on partner feedback, and a common approach for the upcoming CEBS refresher trainings was agreed to between partners to ensure that these trainings would be delivered in a standardized way across all nine districts. ERC partners have now begun cascading their refresher trainings to their respective DHMTs, CHOs, CSSs, and CHMs, and an update on these trainings will be provided in the next quarterly report.

---

<sup>1</sup> World Health Organization (WHO), Weekly Ebola Situation Reports (April-September 2015)

### *Training of Additional CHMs*

A total of 344 additional CHMs were trained during this reporting period, including 60 in Kambia and 284 in Moyamba. This was done to improve CEBS coverage in both areas, as Kambia has had recent active EVD transmission and Moyamba had previously had the lowest number of CHMs of any ERC-supported district. The total number of CHMs participating in CEBS is now 7,416, up from 7,072 at the beginning of the project.<sup>2</sup>

### *Ongoing CEBS Reporting*

The CEBS system continued to function as intended over the reporting period, bringing a large number of alerts into the surveillance system. Overall, there were 4,550 CEBS alerts during August and September, bringing the total number of alerts reported through CEBS to nearly 12,000 to date. Of the CEBS alerts reported during August and September, 86% were for deaths while 13% were for sick cases and 1% was for other suspicious events. Ninety-four percent of the alerts raised through CEBS during the reporting period were escalated to the DERCs for follow-up, while six percent were screened out by the CSSs/CHOs. Notably, the index case for the only new known cluster of EVD occurring across the country during the reporting period was detected and reported through CEBS in Kambia district, thus enabling the body of the case to be buried safely and a quarantine to be initiated before the resulting secondary cases were able to spread the infection to other households.

### *Development of District CEBS Dashboards*

One of the key findings from a rapid assessment of CEBS conducted by the IRC and Centers for Disease Control and Prevention (CDC) from April to June was that there should be more regular sharing of CEBS data with the DERCs, DHMTs, and other surveillance partners in each district. Beginning in August, the ERC team in Freetown began to generate district-specific CEBS dashboards, which are produced using data from the ERC partners' weekly report submissions and sent back to partners within 48 hours for sharing with their respective DHMTs. The template for these dashboards was developed based on ERC partner feedback and shows a collection of key CEBS performance indicators, thus allowing the DHMTs and other surveillance partners to see at a glance how CEBS is performing in their district both over time and in relation to other districts.

## **III. Indicator Tracking**

<b>HEALTH</b>				
<b>Indicator</b>	<b>Target</b>	<b>Quarterly Result</b>	<b>Cumulative</b>	<b>Remark</b>
<b>Sub Sector: Community Health Education/Behavior Change</b>				
Number of CHWs trained and supported (total and per 10,000 population within project area), by sex <sup>3</sup>	7,742	7,416	7,416	344 additional CHMs were recruited and trained during this quarter. The quarterly result and cumulative totals are not disaggregated by sex as this information was not available during this quarter.

<sup>2</sup> Due to a discrepancy in partner reports, the number of CHMs trained at the beginning of August was 7,072, not 7,206 as reported in the original proposal. The final target number of CHMs to be trained by the end of the project remains at 7,742.

<sup>3</sup> For this indicator, the number of CHWs will be interpreted as the number of CHMs, as this is a more relevant measure of CEBS performance and the majority of CHMs were taken from the pre-existing pool of CHWs.

Number and percentage of targeted CHWs specifically engaged in public health surveillance	7,742 (100%)	7,416 (95.8%)	7,416 (95.8%)	
Number and percentage of trained CHMs that reported at least once during the past week (including reports of no alerts)	5,800 (75%)	6,696 (90%)	6,696 (90%)	The quarterly result is the number and percentage of CHMs that reported during the final week of September.

#### **IV. Constraints and Challenges**

##### *Growing Complacency as EVD Caseload Declines*

One of the key challenges encountered over the previous months has been a growing complacency among both the general population and response workers, which has translated into low numbers of sick cases being reported to the DERs. This trend has been driven by several factors, including the significant decline in EVD caseload, which has lowered the population’s perception of risk, community resistance to reporting sick cases, and the non-specific nature of EVD symptoms themselves, many of which mirror that of other more common communicable diseases such as malaria. In Kambia, an elderly woman who was not being contact traced contracted EVD at the end of August and died before she was reported by the community to the local CHM, and as a result five additional cases were infected. While the case could have likely resulted in several more cases had CEBS not reported the death for a safe burial, the family’s decision to delay in reporting the woman’s sickness to the CHM ultimately resulted in the infection of several other members of the household.

##### *Malfunctioning Closed User Groups (CUGs)*

The malfunctioning of the CUG phone system allowing CHMs and CSSs to communicate with each other free of charge continues to be a challenge. Despite intensive and sustained follow up on this issue with mobile providers, the CUGs continue to malfunction in several districts and many ERC partners have now resorted to distributing mobile credit individually to their CHMs and CSSs on a monthly basis, which is logistically challenging and places more strain on partners’ internal procurement systems.

##### *Poor Network Coverage*

Poor mobile network coverage continues to be a challenge in the more rural and isolated areas, with some CHMs reporting that they have to walk long distances to neighboring villages in order to call their CSSs. There is little the program can do to address this, however, and this challenge does not appear to have substantially impacted CHM reporting rates, the weekly averages for which remained above 90% throughout the reporting period.

##### *Increasingly Restrictive MoHS Oversight*

In November 2014, the president challenged the MoHS and transferred responsibility for coordination of the response from the MoHS Emergency Operations Center to the military-led National Ebola Response Center (NERC). As EVD transmission declined and the recovery preparatory work began, the government of Sierra Leone issued recovery and transition priorities in April 2015, which is a short-term recovery plan to transition from the Ebola response back to the long-term development agenda. In June 2015, the MoHS introduced Service-Level Agreements (SLAs) in an aim to reassert central-level “coordination and regulation in the public health sector and to ensure efficiency, effectiveness, and transparency”. While the aims of the SLA to ensure better coordination of health activities and more cost effective use of resources are commendable, the introduction of the SLAs has also delayed some NGO activities. However, this project has been able to continue without interruption.

## **V. Activities for the following reporting period**

During the next phase of the project, ERC partners will focus on rolling out the refresher trainings and strengthening the involvement of the DHMTs in CEBS in order to improve ownership and sustainability going forward. As with the initial CEBS trainings conducted back in January-March, the refresher trainings will be delivered using a three-level approach in each district, with the DHMTs being trained first, followed by the CHOs/CSSs and finally the CHMs. A cascade “training of trainers” approach will be used wherein each cadre will be trained by the level above it (with support from ERC partners) so as to strengthen relationships and ensure that every person trained has an understanding of how his or her roles and responsibilities fit in relation to the other levels of the CEBS system. In order to improve DHMT involvement, IRC and partners will begin holding district-level surveillance meetings on a monthly basis, which will provide a forum to review the month’s CEBS data, highlight notable surveillance trends, share implementation challenges, and discuss strategies that could be used to improve CEBS performance. Monthly supportive supervision visits of CSSs and CHMs will also continue to be conducted jointly between ERC partners and their DHMTs using standardized supervision tools in order to monitor implementation, identify and address any performance gaps, and provide encouragement.

At the national level, the ERC will continue to engage in relevant working groups to plan for the transition of CEBS to Integrated Disease Surveillance and Response (IDSR). Nationally, the IDSR trainings have now been rolled out to the DHMT and facility levels in most districts through WHO support, and the ERC is currently working with the MoHS, WHO, and other surveillance partners to determine how the network of CHMs established through CEBS could be used for community IDSR. The ERC is also liaising closely with the MoHS-led CHW Technical Working Group to advocate for the inclusion of key surveillance activities within the normal CHW scope of work going forward, with the end goal of having all future CHW programs in Sierra Leone using a standardized approach for community surveillance. There has been significant interest in this nationally and the ERC is optimistic that this suggestion will be incorporated into the group’s revisions to the National CHW Policy, which are due to be formally presented to the Minister of Health for approval at the end of 2015.