UNFPA Sierra Leone

RESPONSE TO SEXUAL AND REPRODUCTIVE HEALTH IN THE CONTEXT OF EBOLA

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Country Background

The projected population of Sierra Leone was 6.4 million in 2014, with an annual growth rate of 1.8 per cent (Population and Housing Census – PHC 2004). Since the end of civil war in 2002, the country has made significant progress in peace consolidation, democratic governance, economic recovery and the fight against poverty. However, it continues to be ranked at the bottom of the Human Development Index (183 out of 187 countries in 2013) published by the UNDP. Development efforts have been constrained by the lack of adequate skilled human resources in all sectors particularly health, poor infrastructure, inadequate budgetary resources, weak governance systems, and, most recently, Ebola. At least 70 per cent of the population (mostly in the rural areas) lives in abject poverty and in extremely difficult circumstances, thereby limiting their access to basic social services and economic opportunities. This is further complicated by the limited health expenditure per capita that is currently estimated at US$ 96 per year. With inadequate health care financing strategies, Sierra Leone was ill-equipped to properly handle such health needs.

Although there has been significant investment and some improvement in service utilisation, the Maternal Mortality Ratio (MMR), estimated at 1,165 deaths per 100,000 live births (Demographic Health Survey 2013) and at 1,100 deaths per 100,000 live births (Trends in Maternal Mortality: 1990-2013), ranked the country as worst in the world. With skilled birth attendance (including Maternal and Child Health Aides) at roughly 62 per cent, and with less than 250 midwives and Obstetrician Gynaecologists in active practice, the scarcity of quality delivery assistance exists nationwide. The skilled birth attendance rate is 62 per cent inclusive of Maternal and Child Health Aides with less than 250 midwives and Obstetrician Gynaecologists in active practice (DHS 2013). Other causal factors that account for at least 36 per cent of maternal mortality include inadequate and reliable supply of safe blood products, and inability to produce and retain sufficient medical personnel (doctors, midwives and nurses) to provide Emergency Obstetric and Neonatal Care (EmONC) services. Unsafe abortion accounts for 13 per cent of all maternal deaths. Adolescents and youth constitute 55 per cent of the total population and become sexually active as early as 12 years. High teenage pregnancy (34 per cent) and adolescent birth rates (146/1,000 live births) contribute to 40 per cent of maternal deaths. At least 25 per cent of maternal deaths are due to unsafe abortion among adolescents. High maternal mortality is further worsened by the long-term health complications among women, such as obstetric fistula, uterine prolapse or infertility. It is estimated that for every woman who dies, 15-30 others are likely to face these morbidity problems (DHS 2013). There are limited facilities to address these complications, with presently only two major centres that provide services for obstetric fistula treatment and management.

Knowledge on family planning is relatively high, with 94 per cent of all women and 96 per cent of men who have heard of any modern method of contraception. Despite the Contraceptive Prevalence Rate (CPR) more than doubling from 7 per cent in 2008 to 16 per cent in 2013 (DHS reports), it is still one of the lowest in the sub-region, with a considerably high unmet need for family planning at 28 per cent.

Even though Comprehensive Emergency Obstetric and Newborn Care (CEmONC) facilities have been scaled-up with the refurbishment of 27 health facilities in five districts, there is still a vast gap in

providing adequate and quality services, with an unmet need for Maternal and Neonatal Health (MNH) services of about 76 per cent (SOWMY, 2014).

There have been improvements in Reproductive Health and Commodity Security, but challenges continue to exist for the procurement and supply chain management systems. Despite efforts to support timely clearance, distribution, storage and reporting, stock outs are still prevalent at Peripheral Health Units (PHUs). In 2013, only 53.2 per cent of Service Delivery Points (SDPs) reported "no stock outs" of contraceptives in last six months (GPRHCS Annual Survey 2013).

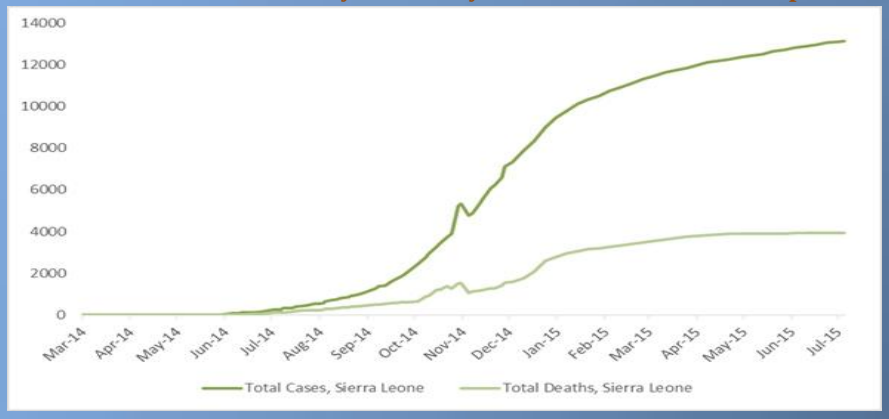
There is no legislation in place on Female Genital Mutilation or Cutting (FGM/C) with a high prevalence rate of 98 per cent among women aged 45-49 and 74 per cent for girls aged 15-19 (DHS 2013). Also, Sexual and Gender Based Violence (SGBV) is still prevalent with the records of the Family Support Unit (FSU) of the Sierra Leone Police in 2013 alone showing 7,684 reported cases of GBV, with 1,501 charged to court and 226 convictions. The FSUs are, however, ill equipped and grossly underfunded to effectively handle the overwhelming number of reported cases of SGBV.

Ebola Outbreak in Sierra Leone

The EVD outbreak in 2014 and 2015 is the largest on record and to date has affected ten countries, namely Mali, Nigeria, Senegal, Spain, Italy, the United Kingdom, United States, Guinea, Liberia and Sierra Leone. However, apart from Guinea, Liberia and Sierra Leone, the rest were able to quickly halt the disease. It is believed that the fragile economic, social and health context of Sierra Leone has significantly contributed to the severity of the outbreak.

In Sierra Leone, the first case was confirmed in the border district of Kailahun in May 2014. Since then, the country's situation progressively worsened, and cases spread rapidly. As of 8 July 2015, 8,674 cumulative confirmed cases had been recorded in Sierra Leone, including 3,574 deaths, with a Case Fatality Rate of 41 per cent (WHO Ebola Situation Report 8 July, 2015). The figure below illustrates the total suspected, probable and confirmed cases and deaths of EVD in Sierra Leone from 25 March 2014 to 5 July 2015[1].

Figure 1: Total suspected, probable, and confirmed cases and deaths of Ebola virus disease in Sierra Leone, March 25, 2014 – July 5, 2015, by date of WHO Situation Report, n=13155



[1] 2014 Ebola Outbreak in West Africa Reported Cases Graphs (CDC) http://www.cdc.gov/vhf/ebola/outbreaks/2014-west-africa/cumulative-cases-graphs.html Accessed 10 7 2015

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The outbreak has overrun and reversed gains recorded in all spheres of life of the country. Health services, education, livelihood, agriculture, food security, economic and social wellbeing have been and continue to be severely affected. It has placed an unprecedented pressure and burden on the already weak health care system and is undermining any progress toward the achievement of the Millennium Development Goals (MDGs).

Impact of Ebola on Sexual and Reproductive Health and Rights

By the time of the outbreak, Sierra Leone's capacity to deliver healthcare services was already limited. Several health-systems that are generally considered essential were either non-existent or not performing well. There were inadequate numbers of qualified health workers, particularly obstetricians and midwives. Infrastructure, logistics, health information, surveillance, governance and drug supply systems were also weak. Organisation and management of health services were also sub-optimal.

The toll Ebola has left on the health workforce has dramatically decreased the health system's capacity to provide adequate services. Medical personnel, as the frontline fighters, were among the victims. At least 306 healthcare workers were infected and 221 died (WHO Ebola Situation Report 8 July, 2015). This is especially worrisome, as these personnel were already in short supply with just 0.2 doctors and 3 nurses per 10,000 people even prior to the outbreak (WHO, Strengthening the Health Workforce to Strengthen Health Systems).

Re-allocation of resources to combating the epidemic, a general lack of logistics such as essential equipment, commodities and supplies, and health worker fears due to the risk of EVD infection decreased the level of service provision. Many health facilities were either shut down or used as Ebola holding and/or treatment centres. At the same time, communities resisted attending health facilities for fear of contracting Ebola. A general mistrust in the health system, and limited access due to movement restrictions resulted further in low service utilisation.

Furthermore, societal factors left Sierra Leone particularly susceptible to the disease. For instance, the use of and belief in traditional healers and medicines rather than the formal health care setting contributed to increased transmission in many areas. Many communities refused to believe in the existence and impact of Ebola or wrongfully attributed it to other causes, including politics and other conspiracies. Traditional burial practices left communities particularly vulnerable. Early response initiatives failed to appropriately consider this critical issue, leading to a failure to institute safe and culturally appropriate burials and the inability to prevent secret burials within the communities.

Impact of Ebola on Maternal Child Health & Family Planning Services

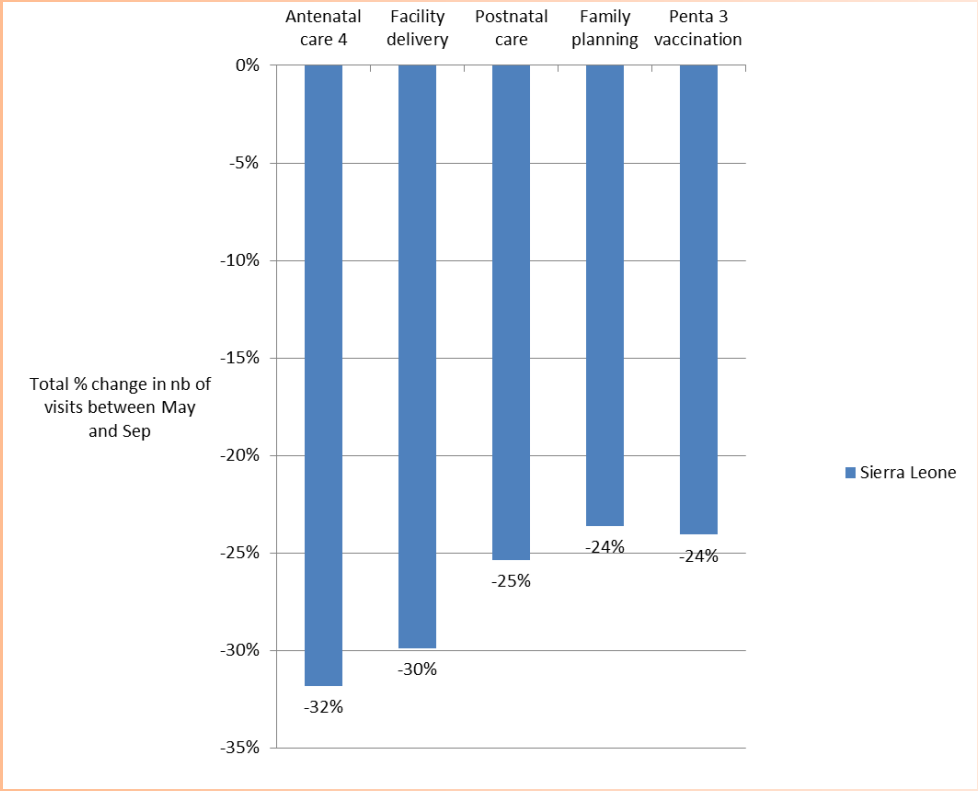
The EVD outbreak has contributed to reversing the limited gains of efforts by the Government and its partners since the introduction of the Free Health Care Initiative in 2010. As earlier indicated, health workers were overstretched, working long shifts and in fear of falling ill themselves. The combination of overwhelmed and collapsing health systems, widespread panic and quarantines left pregnant women and women seeking family planning services in dilemma. Attendance at health facilities and provision of basic reproductive health services have dropped drastically, as reflected in the graphs

reproduced below.

According to WHO, as of 8 July 2015, slightly over half of all cases of Ebola Virus Disease (EVD) were female (51.5 per cent); however, Ebola affects women disproportionately in a multitude of ways. Maternal and reproductive health services have been negatively impacted, in part due to the fear of going to the health facilities. Pregnant women have faced the double fear of dying from Ebola during their normal pregnancy and during childbirth. Pregnant women who were known "contacts", that is, those who had been exposed to Ebola cases or corpses and consequently quarantined often lack access to maternal health services. Furthermore, as traditional caregivers, women are more likely to come into contact with Ebola and also to pass it on to members within their household through the course of their duties.

According to the 2013 SL DHS, more than three-quarters (76 per cent) of women attended four or more antenatal care visits. Due to the outbreak, the proportion of pregnant women who visited Peripheral Health Units (PHUs) for their fourth antenatal care (ANC4) visit fell by 32 per cent between May and September 2014. Similarly, the proportion of pregnant women who delivered in a PHU fell by 30 per cent across the nation. The under five year old children who visited PHUs for key childhood immunisations (Penta 3, which protects against diphtheria, tetanus, pertussis, hepatitis B and poliomyelitis), also declined by 24 per cent during the period.

Figure 2: Total Percentage Change in Number of Health Care Visits Between May and Sept 2014[2]



[2] This graph displays non-statistically significant results for family planning: probably due to the poor quality of data, there is no statistical evidence that family planning utilisation decreased after May 2014. Qualitative data however does provide evidence of lower uptake of FP services after the start of the EVD outbreak.

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HMIS data-analysis shows a drop in service utilisation in 2014 compared to 2012 and 2013. The following figures show the number of short-term and long-term family planning (FP) clients from 2011 to 2014, which also shows the trend of FP service utilisation during the period.

Figure 3: Yearly Service Utilisation of Short Term FP methods from 2011 to 2014

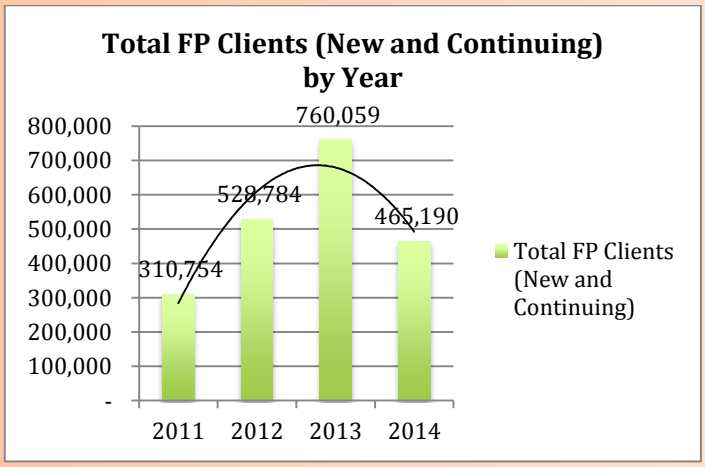
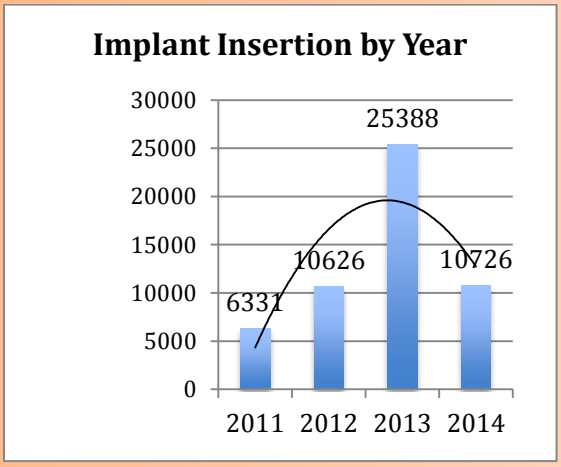
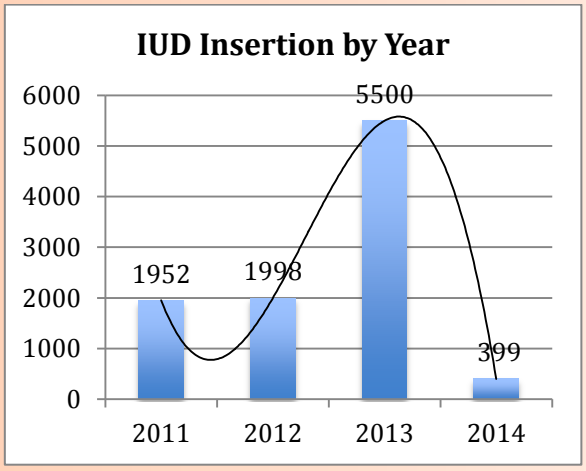


Figure 4 & 5: Yearly Service Utilisation of Long Term FP methods (Implant and IUD) from 2011 to 2014





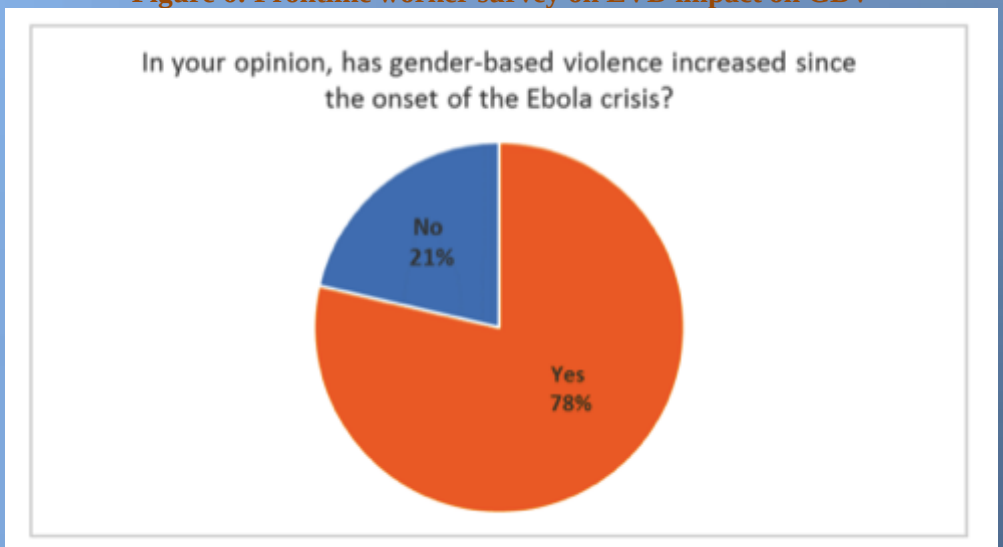
Impact of Ebola on Gender

The restrictions in movement due to response measures and mobilisation to respond to Ebola have contributed to disruption of structures that normally hold communities together. Families are facing food insecurity and unemployment. Educational institutions were only recently opened after being shut down for almost a year. There is heightened sense of insecurity and fear. The stressful time of the Ebola crisis has contributed to worsening existing gender inequalities, which is thought by the Ministry of Social Welfare Gender and Children's Affairs to have resulted in increases in gender-based violence at home and in the community. In these times, women and girls who are more vulnerable to violence are even more at risk of abuse, assault and sexual exploitation.

With the limited capacity of the security sector to address women's protection issues, including on sexual and gender based violence (SGBV), consultations[3] in Sierra Leone highlighted that the Ebola outbreak further exacerbated insecurity, social instability and gender inequities - particularly putting women and girls at risk of SGBV, compromising their health, dignity, safety and autonomy.

In light of the sensitivity of the issue, as well as of the impact of the disease on health, security and social services that are usually used to evaluate incidence of gender based violence (GBV), it is difficult to ascertain the full impact of EVD on cases of sexual and gender based violence. However, available reports[4] concur to highlight a general increase of cases, as reflected in the perception survey conducted by Keystone, Ground Truth, with frontline Ebola workers:

Figure 6: Frontline worker survey on EVD impact on GBV



Since the EVD outbreak, UNFPA has been advocating for secondary impacts of the disease to be taken into account, with particular focus on the situation of women and adolescent girls. Despite UNFPA's efforts, attention to issues related to protection, GBV and harmful traditional practices were limited in the first few months of the outbreak. The inaction by the Government to mobilise communities on other topics than Ebola, and the focus by donors on the immediate response to the disease, have hindered the work of lead agencies addressing GBV and harmful practices against women and girls. Despite these difficulties, UNFPA spared no efforts in mobilising its implementing partners, Government and other development partners.

[3] The Consultations were organised by the National Secretariat for the Reduction of Teenage Pregnancy and UNFPA in 2014, when the partners were attempting to evaluate the impact of the disease on Adolescent Girls.
[4] UNDP (Assessment of impact of Ebola on GBV, 2015), UN-Women (Assessment on the Gender Dimension of EVD, 2015) and from UNFPA's IPs (LAWYERS, WICM, Restless Development)

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UNFPA's Response

UNFPA's response to Maternal Health needs: The initial focus of government and partners to contain the EVD outbreak from June to August 2014 directly impacted the feasibility of implementing a wide range of Sexual Reproductive Maternal and Newborn Health (SR/MNH) interventions, including community mobilisation. Despite these difficulties, UNFPA continued to implement critical interventions to prevent maternal deaths and to address the SRH/MNH needs of the population.

With the support of DFID and Irish Aid, UNFPA, in partnership with MoHS, conducted a rapid assessment of EVD impact on RMNCH services and service seeking behaviour of women and girls to feed the planning of recovery and post recovery interventions and mitigation strategy.

Country Representative, Dr. Bannet Ndyanabangi, visiting pregnant women and new-borns at the Maternity Ward, Kenema Government Hospital, supported by UNFPA.

UNFPA initiated the procurement of RH kits and Infection Prevention Control (IPC) equipment and consumables, including maternity gowns/outfits disposal aprons, masks, clogs and gynaecological gloves that were supplied to maternal health care units around the country. In addition, UNFPA sustained the supply of FP commodities and essential RH drugs that were already in stock in partnership with the MoHS, Central Medical Store (CMS) and National Pharmaceutical Procurement Unit (NPPU).

A midwife wearing PPE conducted a delivery

UNFPA also conducted a detailed programme criticality assessment for all its implementing partners and identified ways in which critical RH/family planning activities could continue to be provided to women and girls. As a result, with improved infection, prevention and control (IPC) measures, Family Planning outreach teams resumed the mobile clinics during the last quarter of 2014.

Throughout the outbreak, UNFPA has continuously highlighted the impact of EVD on RH services.

In August 2014, UNFPA advocated for the other essential health services to be taken into account in the response; and continued advocacy to the MoHS, other UN Agencies and donors on the necessity to design interventions guaranteeing the provision of essential maternal health services.

In July 2014, UNFPA was the first partner agency to engage Office of the First Lady (OFL) for advocacy activities with Traditional and Religious Leaders for awareness-raising on Ebola,

community mobilisation, and support to restore MH services at health facilities throughout Sierra Leone.

On 25th March 2015, UNFPA, in partnership with OFL, organised advocacy activities with pregnant women at the Princess Christian Memorial Hospital (PCMH). The First Lady, as champion of the launch of Campaign for the Acceleration of the Reduction of Maternal Mortality in Africa (CARMMA) in Sierra Leone, assured women and girls to visit facilities for MH services.

A community volunteer leading a life-skills discussion with out-of-school youth as part of UNFPA Sierra Leone's Project implemented by Restless Development

Also, in March 2015, under the Mano River Union initiative of the OFL, UNFPA, in partnership with UN Women, rebranded the Kenema Government Hospital to regain the trust of the community in resuming health facilities visits again for MH services.

With technical assistance from UNFPA, MoHS was able to design the RH impact mitigation strategy to prevent Ebola-related maternal deaths. This document was presented to key stakeholders, including the National Ebola Response Centre (NERC), WHO, and donors. However, there were delays in kick-starting the implementation of the strategy because of budgetary constraints. UNFPA was able to secure funding for the implementation of the first phase of the RH impact mitigation strategy in December 2014, which comprised of:

- Identification of 51 frontline facilities for the provision of RMNH services (17 CEmONC and 34 BEmONC centres) in all 14 administrative districts, targeting upgrading its Human Resources for Health (HRH), equipment and infrastructure status, with the first phase focusing on five CEmONC and six BEmONC facilities
- A detailed assessment of 51 facilities conducted for rehabilitation, equipment and Human Resource
- Development of IPC protocols for Maternal Health, quality assurance systems and SOPs at national level
- Deployment of local and international health workers particularly midwives with an immediate redeployment of 99 national health workers to bring all facilities to the national HRH standards in addition to an international Senior Midwife. These included midwives, nurses, and Laboratory and Pharmacy technicians.
- Support to RMNH services, including Fistula activities were scaled up
- Strengthen outreach services to provide SRH services in communities nationwide
- Support to demand creation and community sensitisation on SRH services through Volunteer Peer Education (VPE) and CAGs programme
- The upgrade of facilities for provision of adolescent girls-focused youth-friendly services
- Engagement of civil society partner, Health for All Coalition (HFAC) to monitor the availability of essential RH drugs at Service Delivery Points

- Support to the National AIDS Secretariat to ensure counselling, availability and distribution of condoms to Ebola survivors at the treatment centres

UNFPA's response to the Women and Adolescent Girl's needs (ASRH, GBV): In September 2014, UNFPA was the first organisation to bring together key partners in the protection sector to evaluate the impact of Ebola on Adolescent Girls and to explore immediate actions to be taken and coordinate interventions. Specific issues of SGBV were discussed. A series of meetings were organised jointly with the National Secretariat for the Reduction of Teenage Pregnancy and the Ministry of Social Welfare, Gender and Children's Affairs, which contributed to the development of a Strategy to respond to the needs of Adolescent Girls in the Context of Ebola. UNFPA collaborated with DFID and UNICEF in the conceptualisation of the Protection Desks and their establishment in every district. Beyond advocacy activities, UNFPA supported activities at community level. In the third quarter of 2014, UNFPA brought together 11 Implementing Partners, which focus on gender issues and adolescent girls programmes to conduct a re-programming exercise aimed at ensuring that UNFPA supported interventions integrate the new context created by the disease.

Adolescents at the PHU-AYF Center

In particular, UNFPA's interventions were focused on maintaining the provision of Adolescent and Youth friendly SRH services at PHU level. UNFPA provided financial, technical and operational support to the Adolescent and School Health Unit of MoHS to support health workers within their facilities, ensure availability of commodities and provide supervision and mentoring to health workers.

These activities were complemented by the training and coordination of 102 Youth Community volunteers in 51 communities to inform, train and empower adolescents and young people, with a specific focus on adolescent girls. During the EVD outbreak, the activities of these volunteers included education about EVD and SRH, information/prevention of GBV, referrals to health facilities and dialogue with community leaders.

Furthermore, UNFPA:

- Mobilised the Government and Implementing Partners to respond to the prevalence of sexual and gender based violence that was reported by partners.
- Provided financial, technical and operational support to the Ministry of Social, Gender and Children's Affairs to coordinate case management of vulnerable groups during the Ebola outbreak.
- UNFPA's civil society Implementing Partners (IPs), LAWYERS and Women In Crisis Movement provided support to GBV victims, including mediations, legal advice and psycho-social services. A total of 1102 cases have been followed-up and referred to the health and justice system by UNFPA's IPs since the beginning of the outbreak.
- Established a safe space in Kono for victims/survivors. More than 140 SGBV victims/survivors were aided financially to access medical care, transportation, maintenance fee, and filing of

respective court maintenance documents and a total of 1,102 cases have been followed-up and referred to the health and justice system by UNFPA's IPs since the beginning of the outbreak.

- Finally, UNFPA mobilised existing Male Networks at community level, initiating dialogues on Ebola, awareness raising and prevention of sexual and gender-based violence as well as supporting referrals targeting three EVD hotspot districts.

UNFPA worked tirelessly to mitigate the indirect impact of the epidemic on adolescent schoolgirls who had become pregnant during the epidemic and who are not allowed to return to school, according to a policy of the Ministry of Education, Science and Technology (MEST). A survey was conducted on pregnant girls in selected chiefdoms during the outbreak, to assist MEST in establishing special provisions for school girls who have become pregnant during the outbreak. Through this survey, 1,037 were identified. UNFPA advocated for these girls not to be left behind and succeeded in working with the Government of Sierra Leone to establish a committee, bringing together MEST, MoHS and MSWGCA to identify special modalities that would allow these girls to receive education on core school subjects outside of the formal school setting, as well as SRH information and services including GBV. UNFPA has committed itself to providing operational, financial and technical support to this initiative.

UNFPA's Response to Ebola Surveillance and Contact Tracing:

UNFPA was designated by the Government of Sierra Leone, United Nations Country Team (UNCT), United Nations Mission for Ebola Emergency Response (UNMEER) and the National Ebola Response Centre (NERC) to take a leading role in contact tracing training and provision of incentives. Alongside the MoHS and WHO, UNFPA co-leads the Surveillance Pillar, responsible for ensuring effective coordination and implementation of surveillance activities at the national and district level. In January 2015, WHO came on board as the technical lead of contact tracing, with UNFPA remaining the operational lead. The MoHS and UNFPA conducted initial trainings in Kailahun district and progressed to train over 5000 contact tracers and over 600 contact-tracing supervisors nationwide. The MoHS and UNFPA trained tracers have followed up over 98,562 EVD contacts.

Contact tracer at work

Contact tracing is an essential activity in the containment of Ebola. After the identification of EVD case contacts by case investigators, persons in close contact with Ebola cases are monitored for the duration of the incubation period. Contacts with signs and symptoms of the disease must be reported immediately for evacuation to designated treatment centres or to the nearest health-care facility, which helps to prevent high-risk exposure during home-based care, customary burial procedures and other social activities. As the work of contact tracers spread all over the country, client-specific arrangements were made by each district to make services available to pregnant women in quarantined homes. Recently, the contact tracing data collection tools have been revised to record all pregnant contacts.

UNFPA has worked to better coordinate the efforts of partners involved in contact tracing through the establishment of the contact tracing sub-pillar, co-chaired with MoHS and WHO. The sub-pillar

ensured a standardised and quality approach to contact tracing in each district. Key issues on contact tracing were discussed and technical decisions made and presented to the national surveillance pillar for endorsement. UNFPA played a key role in the development of the Standard Operating Procedures (SOP) for contact tracing and supervision, the roadmap document for "Getting to Zero" and the approved training materials for contact tracing.

Furthermore, UNFPA supported:

- Ebola data entry clerks in all districts and at the national level
- Handover of 50 motorcycles, 13 desktops computers, 13 printers and 13 uninterruptable power supply (UPS) devices to the MoHS
- 149 GPS devices to assist Surveillance Officers nationwide
- TOT for surveillance officers on use of handheld GPS devices for improved case investigation
- 14 UNFPA District Contact Tracing Monitors (DCTMs), equipped with: laptops, internet connection and transport
- Hazard payment to 288 Surveillance Officers

Next steps will include continuing the roll out of interpersonal communication training with enhanced contact tracers and support to Integrated Disease Surveillance and Response. The strong relationship, which was established with the Directorate of Disease Prevention and Control at the MoHS as well as WHO in the context of jointly implemented efforts in surveillance and contact tracing, has laid the foundation for future work on maternal and child health (MCH). The robust surveillance systems set in place can be utilised for other health concerns, such as Maternal Death Surveillance and Response - MDSR). The future plan is to re-train a core group of contact tracers to conduct this work, thus building on the existing resources harnessed for the Ebola outbreak to help in health system strengthening. Currently, in line with the changing epidemiology, UNFPA supports 1245 enhanced contact tracers and 234 supervisors around the country who take part in monitoring 100 per cent of known contacts and active case search.

Resource Mobilisation and Allocation

UNFPA mobilised funding from donors including the World Bank (WB) and African Development Bank (AfDB). Additionally, after a programme criticality exercise, UNFPA reallocated its funds to better support the Ebola emergency response. The following table shows UNFPA's resource allocation to support EVD response in USD:

	WB	AfDB	ECHO	Japan	Reprogrammed funds
Sexual Reproductive Maternal and Neonatal Health	6,000,000	-	530,000	960,000	70,000
Gender Based Violence	-	-	-	-	350,000
Surveillance and Contact tracing	4,641,822	2,059,214	-	-	1,194,200

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UNFPA's Statement of Commitment

UNFPA remains committed towards complementing the efforts of the Government of Sierra Leone and other partners in the march towards zero Ebola cases. Until the country is declared free of the disease by WHO, UNFPA will continue the immediate post-Ebola recovery efforts towards building a resilient healthcare delivery system.