



Government of Sierra Leone

COVID-19 RESPONSE INTRA-ACTION REVIEW (IAR)

REPORT

Intra Action Review Date: 22nd – 23rd September 2020
Freetown, Sierra Leone



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Report Governance and oversight

IAR dates	Completed by	Reviewed by	Endorsed by
22 nd – 23 rd Sept 2020	IAR Lead Coordinator	COVID-19 Technical Pillar Team Leads (date)	NACOVERC Date MoHS Date

1. Executive Summary

1.1 Introduction

This report details the findings of an Intra-Action Review (IAR) that was undertaken on the 22nd & 23rd September 2020, to review the COVID-19 response in Sierra Leone. Due to the protracted nature of the COVID-19 Pandemic, a decision through the **COVID-19 Technical Pillar Team Leads**, was made to undertake an IAR.

The IAR focused on the following technical areas: **Surveillance, Laboratories, Case Management, Risk Communications, Food and Nutrition and National Coordination**.

The outputs from the IAR would then be used as a means of informing any future planning or potential structural changes to the Incident Management Structure (IMS). Following international standards, as at the time of the IAR, Sierra Leone was the **5th Country globally** to undertake such a review.

Day one of the review was chaired by Professor Foday Sahr, Technical Coordinator of the National COVID-19 Emergency Response Centre (NACOVERC). The Chief of Staff, NACOVERC, provided a statement on behalf of Retired Major Kellie Conteh, who was appointed as the Incident Manager by His Excellency the President.

Day two of the review was chaired by Dr Sartie Kenneh, Strategic Member of the COVID-19 Surveillance Team. Additionally, the Minister of Health and Sanitation, Hon. Prof. Alpha Wurie, provided the key note address and expressed his appreciation of the World Health Organization (WHO) and all the other partners and pillars involved in the response.

In attendance, were representatives from across the Directorate of Health Security and Emergencies (HSE), the six technical areas that were under review, the Office of National Security (ONS), US CDC, WHO, GIZ and Implementing Partners involved in the incident response. The day attracted 90 participants, which included several District Medical Officers (DMO).

1.2 Background

COVID-19 is an infectious disease caused by a newly discovered coronavirus first detected in Wuhan, China in **December** 2019. On **January 30th**, 2020 the WHO declared the COVID-19 outbreak as a Public Health Emergency of International Concern (PHEIC).

In response to the PHEIC announcement, on the **13th February** 2020, the MoHS activated the Public Health National Emergency Operations Centre (PHNEOC) to a level 2 and established its Incident Management Structure (IMS), which was good practice. In doing so, the IMS provided a central coordination hub to mitigate against the risk of COVID-19 importation and any potential impact in country and was initially chaired by the Chief medical officer (CMO).

As a means of preventing COVID-19 entering Sierra Leone, throughout the months of February and early March, the MoHS instigated several activities, such as the orientation of Point of Entry (POE) and airport staff on IPC. There was a need for the development of periodic public health measures and travel advisories. To enhance surveillance activities, COVID-19 response Standard Operating Procedures (SOPs), guidelines and training materials were also developed, which again was considered good practice.

As the nature of the PHEIC escalated, on the **11th March** 2020, WHO declared that the outbreak could be described as a pandemic, due to its rapid spread across the globe. This was then followed by a proclamation by His Excellency the President of Sierra Leone on **24th March** 2020, of a national state of public health emergency for 12 months, which was an excellent approach.

On **31st March** 2020, Sierra Leone had its first confirmed case of COVID-19, becoming the last country in West Africa to do so. When it became inevitable that more cases were likely, the focus of the response shifted from prevention to delaying the spread. As such, on **2nd April** 2020 the MoHS escalated its incident response to level 3, formally handing over lead response coordination role to the NACOVERC.

The NACOVERC was established to provide national coordination of the response, building upon the institutional memory of the Ebola response structures. In doing so, supporting frameworks such as District COVID-19 Emergency Response Centres/DICOVERC's.

1.3 Conclusion

As can be expected from a review of this kind, several conclusions have been drawn based upon the outputs of the technical discussions. Whilst several areas of best practice were identified, some of which are listed below, more details can be found within the Findings section of this report. The conclusions have been **summarised** as follows:

What worked well

1. *Sierra Leone was among the first group of countries in Africa that had the capacity to test and confirm COVID-19. However, the testing capacity (test per capita) was suboptimal and is gradually improving.*
2. *The surveillance system was flexible enough to accommodate COVID-19. The proportion of new cases detected from the line list and known transmission chains decline significantly with time (Threshold = 80%) due to multiple issue including strikes.*
3. *The early screening and quarantine of passengers coming from countries that have reported 50 or more cases during the start of the outbreak, delayed the virus from entering Sierra Leone and provided the MoHS more time to effectively prepare for the virus.*
4. *The recruitment of Surveillance Officers at district level strengthen local ownership and made the response very effective at a district level.*
5. *The effective collaboration of the Case Management and Psychosocial with FAN pillars in supporting patients who were in denial were effectively managed and all discharge successfully.*
6. *The separation of critically ill patients and from asymptomatic patients at different treatment centers, worked well*
7. *Laboratories services were effectively carried out immediately using existing structures, that were used during the Ebola outbreak, with initially no international support.*
8. *The production and distribution of locally produced alcohol hand sanitizer and soap greatly contributed to the success of the response process.*

Challenges

1. *In the early stages of the response, there was a high rate of health care workers infection initially, which was mostly attributed to the lack of Infection Prevention and Control (IPC) materials and adherence at treatment facilities. However, there was improvement and the infections among health workers declined significantly with time.*
2. *The creation of the NACOVERC initially caused some confusion across MDA's and created duplicate systems. The transition by the MoHS to a Level 3 incident response is normally managed by the Office of National Security, which initially wasn't the case in this response.*
3. *Decentralization of COVID-19 response was faced by challenges. The national level devolved functions which were not accompanied by resources. The district structures in some districts created misunderstanding between the DHMT and the DICOVERC.*
4. *Access to essential health service were impacted upon as significant resources, both physical and material, were redirected into the COVID-19 response.*
5. *There is a need to ensure that sustainable monitoring systems and areas of best practices are maintained to mitigate against a second wave.*
6. *There were challenges in equipping CTC's and isolation units with appropriate equipment, particularly oxygen, lifesaving medicines and more widely enough Personal Protective Equipment (PPE)/IPC commodities in all health care facilities.*
7. *The incomplete contact tracing information for positive cases and data inconsistencies as a result of the various data sources and platforms that were in use.*
8. *In some instances, Laboratory results were not available for three or more days, to the end users, which created anxiety among quarantine individuals.*

1.4 Summary of Recommendations

1. *Improve the COVID-19 surveillance indicators and expand pandemic influenza sentinel surveillance to include COVID-19*
2. *Expand the testing per capital at national and subnational level to detect any unusual trend including re-surgence of COVID-19. Strengthen the system for forecasting laboratory requirements, timeliness of procurement & distribution, and monitoring supplies to avoid stock outs.*
3. *A fundamental review of the IPC management structures is required Nationally to support greater accountabilities of IPC practise at all levels. Monthly audits should be undertaken by IPC Focal Persons to ensure adherence to IPC practices are strengthened.*
4. *A functioning Public Health Emergency Management Committee (PHEMC) is required to provide strategic leadership to MoHS level 2 & 3 incident responses. This would provide a platform across MDA's, whilst ensuring that duplicate systems are avoided.*
5. *In support of recommendation 2 above, the Public Health Bill needs to be ratified as soon as possible to ensure that the MoHS has the legal mandate to manage and coordinate level 3 incidents, as part of a National Public Health agency.*
6. *The COVID-19 strategic plan needs updating to ensure that a roadmap for the implementation of the immediate, medium and long- term recommendations is in place. Monitoring and Evaluation of such activities needs to be overseen at the highest administrative level.*
7. *The rapid procurement of IPC, medical equipment and other items used in clinical settings during emergencies, needs to involve technical staff in the process*
8. *Contingency plans are required to ensure that the maintenance of essential healthcare services become an integral part of the COVID-19 response going forward.*

2. RATIONALE, OBJECTIVES AND METHODOLOGY OF THE REVIEW

- a. Due to the protracted nature of the COVID-19 Pandemic, the Government of Sierra Leone, through the **COVID-19 Technical Pillar Team Leads**, met to discuss the ongoing requirements of the in-country response.
- b. As a means of informing any future planning or potential structural changes to the Incident Management Structure (IMS). It was recommended by the COVID-19 Technical Pillar Team Leads that an Inter-Action Review be undertaken.
- c. Following the Technical Pillar Team Leads meeting, WHO were invited to give a presentation at the Emergency Preparedness Resilience and Response Group (EPRRG) Meeting, outlining the IAR process and its methodology.
- d. To support the delivery of the IAR, a COVID-19 IAR Coordination Team was formed, made up of representatives from the **National COVID-19 Emergency Response Centre (NACOVERC)** and that of the **Ministry of Health and Sanitation (MoHS)**, as well as **Partners**.
- e. Recognizing that there were several crosscutting areas unearthed during each pillar review, the District Medical Officer's participated and represented their Districts at the two day event.
- f. Following international standards, and the MoHS's Learning from Incident and Exercises Guidance, the COVID-19 IAR Coordination Team arranged several consultation meetings to discuss the scope and requirements of the IAR.
- g. The outcomes of these discussions concluded that the IAR would focus on the **Technical Side** of the Incident management System (IMS) alongside the **National Coordination Cell**.
- h. A series of training sessions were held for the IAR Facilitators and Coordinators, as a means of ensuring that all Pillar level reviews would be undertaken in the same systematic way.
- i. Recognising that that each pillar level review would be different, in terms of length of time, in the main each pillar was given between 3-4 days to complete their review. The outputs of the pillar level review then fed into the main IAR.
- j. Recognising that IAR can focus on singular or multiple components of a response, it was decided that the Operational Cell was **out of scope** and would be picked up during a future review.
- k. As outlined, the focus of the IAR was aimed at the National Coordination, as well as the following Technical Pillar Areas:

Surveillance, including Points of Enter (POE)

Case Management, including Psychosocial and Infection Prevention & Control (IPC)

Laboratories

Risk Communication, including Social Mobilisation

Food assistance and Nutrition



l. The **aim** of the IAR was to review the Technical Pillars and Coordination Structure within the National COVID-19 Response Plan.

m. The specific **objectives** of the review were to:

1. To provide an opportunity to **share experiences** and collectively analyze the ongoing in-country COVID-19 response by identifying challenges and best practices.
2. To facilitate consensus building and compiling lesson learning among the various response stakeholders to **improve** the current response by sustaining best practices that have demonstrated success and preventing recurrent errors.
3. To document and apply **lessons learned** from the response efforts to date for **health systems strengthening**.
4. To provide a basis to **validate and update** the Country COVID-19 strategic preparedness and response plan and other strategic plans accordingly.

n. The **methodology** of the IAR focused around three themed areas:

1. Objection Observation

Establishes how actions were **actually implemented** during the response, in contrast to how they are **supposed to** or usually happen, according to plans and procedures.

2. Analysis of Gaps & Best Practices and Contributing Factors

Identify the gap between **planning and practice**. Analyse what worked well and what worked less well and why.

3. Identification of areas of Improvement

Identify actions to strengthen or **improve performance** and how-to follow-up.

- o.* Using the themed areas outlined above, each pillar was then able to develop a presentation which provided an overview of the pillars response plans that were in place, whilst outlining a timeline of events.
- p.* Other areas covered in pillar presentations included **What went well? What went less well? Why?** In terms of answering the why, a root cause analysis was undertaken, as a means of drilling down to the main issues.
- q.* Each group then presented what they felt could be done better to **improve** the COVID-19 response with specific requirements.
- r.* Regarding the way forward, each pillar was the required to develop an **Activity Plan** with clear timelines for the delivery and implementation of key activities.
- s.* Day One of the event attracted **90** delegates, with opening remarks provide by MOHS, NACOVERC, WHO, CDC, and GIZ.. Day Two of the event attracted **77** delegates, who were graced with the presence of the Minister of Health and Sanitation Hon. Prof. Alpha Wurie who expressed his appreciation of WHO and all the partners and pillars involved in the response.
- t.* It is important to note that within 3.5 weeks of the request being made to undertake an IAR, all of the Technical Pillars and Coordination Cell had met and the main IAR had been successfully concluded, with a richness of ideas, which is a credit to the country.

3. FINDINGS and RECOMMENDATIONS

The findings within this report are derived from the IAR and the recommended course of actions, to strengthen the response to the ongoing COVID-19 pandemic in country.

The findings focus on the root causes that explain why best practices and challenges occurred. And more importantly, what is required to both maintain and improve activities.



Whilst a series of recommendation are made, they are presented to ensure that areas of best practice are maintained, whilst challenges are addressed.



As a means of ensuring implementation of the recommendations within this report, it is advisable that an oversight committee is established to provide the required ongoing governance.

The structure of this report template is based on the Technical Areas and National Coordination elements of the response that were under review. Whilst recognizing that issues raised are cross-

cutting, the lead responsibility for implementation of each action sits with the technical areas, aligned to the activity plan that they have developed.

Moving forward, it is hoped that the outputs from the IAR will be used to inform and strengthen future system within the response. In doing so, there is recognition that a review of other response areas, such as Operations and District level response structures, is also undertaken.



The findings listed below are specific to:

- **Surveillance**, including Points of Enter (POE)
- **Case Management**, including Psychosocial and Infection Prevention & Control (IPC)
- **Laboratories**
- **National Coordination**
- **Risk Communication**, including Social Mobilisation
- **Food assistance and Nutrition**



3.1 Surveillance (including 117 hotline, point of entry, case investigation, contact tracing, quarantine, data management)

1) Significant challenges were identified as a result of incomplete contact tracing information for positive cases and data inconsistencies as a result of the various data sources and platforms in use.

Recommendations: *There is a need for data verification and validation especially at district level. Often there are delays in updating data in DHIS2 which needs improving, as delays lead to erroneous reports.*



2) At the beginning of the outbreak, delayed laboratory results of between 3-4 days created anxiety amongst quarantined individuals.



Recommendation: *Whilst these delays in lab results have reduced significantly, there is need to establish an alert & monitoring system for COVID-19 specimen collection and dissemination of lab results.*

3) Logistical challenges both financially and materials were highlighted as a major concern and accessing funds was and is still a difficult cumbersome process. Because of the diverse makeup of the Surveillance team, there was recognition of the inconsistencies in the submission of staffing details which resulted in delays of incentive payments.

Recommendation: *Financial processes need to be thoroughly reviewed and examined against current requirements. Additionally, at a district level, there needs to be a verification event to ensure that staffing establishments are correct.*

3.1.1 Surveillance, POE Pillar Review	
Best practices	<ul style="list-style-type: none"> - Development and adaptation of Standard case definition for COVID-19 and case investigation tools. Establishment of case investigation structure and processes. - Identification of quarantine facilities that met SOP guidelines and established MOUs. Periodic structured assessment of approved quarantine facilities in WAU and WAR. - Recruitment and training of surveillance staff across sub-pillars. Regular coordination meetings within and between pillars. - Establishment of enhanced surveillance strategies (surge strategies). - Simulation exercises at major points of entry – Airport. - Creation of (a smaller) surveillance pillar strategic group. Conduct regular supportive supervision of COVID-19 surveillance activities. - Decentralization of electronic data entry at various levels. Electronic data capture (Case based). Harmonization of laboratory

	<p>and case management pillar data.</p> <ul style="list-style-type: none"> - 117 (hotline) Real time information dissemination.
<p>Challenges</p>	<ul style="list-style-type: none"> - Inadequate collaboration among pillars - Delays in COVID-19 specimen collection from persons in quarantine - Delay in communicating lab results to quarantine persons - Inadequate coordination/engagement between technical and operations component of quarantine sub-pillar - No cross border coordination meetings - Delayed decentralization of response activities to districts - No cross border coordination meetings - Irregular and inconsistent disbursement of incentives -
<p>Recommended actions</p>	
<p>a. For immediate implementation:</p> <ol style="list-style-type: none"> 1. Develop guidelines to ensure effective collaboration across all surveillance sub-pillars 2. Establish an alert & monitoring system for COVID-19 specimen collection and dissemination of lab results 3. Define roles and responsibilities between technical and operations component of quarantine sub-pillars <p>b. For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:</p> <ol style="list-style-type: none"> i. Establish cross border virtual coordination meetings ii. Create and share a harmonized schedule of and regular payment of incentive iii. Develop comprehensive MOUs that ensure inclusion of all surveillance units e.g PoE iv. Provide timely technical, financial and logistic support for the decentralised district response v. Conduct enhanced supportive supervision to districts, focusing on data quality, comprehensive contract tracing and quarantine 	

3.2 Case Management (including IPC, Mental Health and Psychosocial)

1. There was a high rate of health care workers infection initially, which was mostly attributed to the lack of IPC materials and adherence at treatment facilities.

Recommendation: *There is a need for continuous education and training of health care professionals on the appropriate use of IPC procedures and standards in healthcare settings.*



2. There were challenges in equipping CTC's and isolation units with appropriate equipment, particularly oxygen, life saving medicines and more widely sufficient PPE/IPC commodities in all health care facilities.

Recommendation: *Systems need to be developed for the rapid procurement of IPC items, medical equipment and other items used in the clinical settings, with the involvement of the technical teams.*

3. There was a lack of engagement with the psycho-social team and community leaders during the early stages of the risk communication roll out. As a result, there was limited support to individuals in quarantine and healthcare workers.

Recommendations: *There is a need to develop infrastructure for mental health and Psycho-Social Support (PSS) at district level. Additionally, there is a requirement for the harmonization of mental health and Psycho-social support training with Case management and IPC training.*

3.2.1 Case Management, Infection Prevention & Control, Mental Health & Psychosocial Pillar Review	
Observations	
Best practices	<ul style="list-style-type: none"> - Installation of oxygen plant at the 34 Military Hospital. - Establishment of a COVID death review committee. - Establishment of a treatment center within the prison complex. - Nationwide IPC sensitization on COVID-19 by displaying of posters and introduction of COVID-19 hygiene practice, washing hands, use of sanitizers etc. - Nationwide IPC training of trainers in educational institutions. - The production and distribution of locally produced alcohol hand sanitizer and soap greatly contributed to the success of the response process. - Conduction of a refresher training and deployment of personnel at established isolation centers and formal border crossing points; Lungi airport, Kambia (the border with Guinea) and Jendema (the border with Liberia.) - Harmonization of mental health and Psychosocial support training with Case management and IPC training.

	<ul style="list-style-type: none"> - Psychosocial and Risk communication support to healthcare workers.
<p>Challenges</p>	<ul style="list-style-type: none"> - High infections among health workers at the onset of the pandemic in Sierra Leone - The lack of oxygen concentrators and cylinders impacted up clinical care - Delayed payment of incentive for health workers - Limited training of frontline healthcare workers as the number of cases increased - Guidelines or policies on case management for COVID-19 were not available to all frontline workers at the initial stage of the pandemic - Shortage of needed PPE. - Poor coordination between IPC and Case management at the onset of the response - Failure by some healthcare centers to properly separate COVID waste from non-COVID waste during disposal. - Not being able to meet the expectations of COVID-19 patients in terms of comfort (entertainment, feeding, etc) at treatment centers and emolument particularly for discharged patients. - Stigmatisation of quarantined homes and Covid 19 patients - Lack of understanding of professional boundaries and competence - The belief by some members of the populace that COVID-19 is not real.
<p>Recommended actions</p>	
<p>a. For immediate implementation:</p> <ul style="list-style-type: none"> - Continuous training in Case Management (CM) , IPC and PSS - Develop a scientific and research capacity - Support the production of alcohol based sanitisers and liquid soap <p>b. For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:</p> <ul style="list-style-type: none"> - Expand district isolation capacity to about 30-50 beds. - Develop critical care capacity in regional headquarters (regional ICU) - Develop infrastructure for mental health and PSS at district level - Install Oxygen Plant at each regional hospital incl. 34 Military, Ola During, PCMH and Connaught 	

3.3 The National laboratory system

1. Turnover time for the release of result impacted upon some travelers, resulting in them missing their flight, and was a cause of great concern.

Recommendation: *There is a need to increase mobility at District Health Management Team (DHMT) to improve the movement of samples to regional testing centers. National level should expedite release of results to clients to facilitate travel and identification of cases.*



2. There was a marked discrepancy between the increased testing (Surge) and the laboratory capacity which contributed to delays and created a backlog of lab samples.

Recommendation: *Clinicians should be trained in specimen collection, which would help to fast-track the process. The practice of specimen collection should be integrated into health care system, additionally to the decentralisation of laboratories at district level.*



3. There was a disconnect between labs, surveillance and case management pillars, which resulted in poor communication regarding sample tracing.

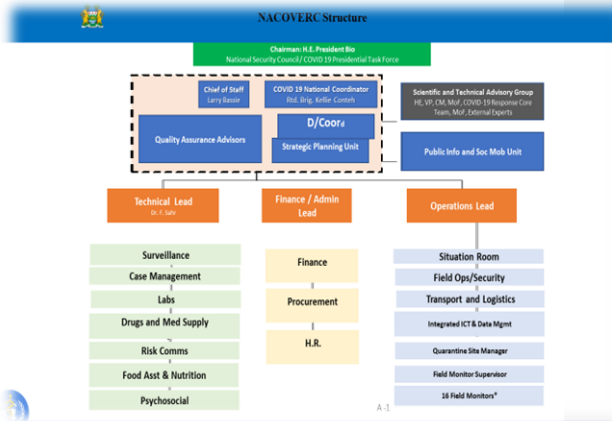
Recommendation: *The collection of samples should be done in collaboration with surveillance and case management to ensure effective line listing, contact tracing, and follow up for effective management of each case.*

3.3.1 The National laboratory system Pillar Review	
Observations	
Best practices	<ul style="list-style-type: none"> - Transitioning of the Laboratory Technical Working Group (LTWG) to Lead the Laboratory Pillar Response - Early planning and preparation on declaration of COVID-19 as an epidemic - Establishment of a central specimen management system - Extension of laboratory operational hours to 24hrs - Use of electronic platforms for dissemination of laboratory information/ results - Implementation of Quality Assurance (QA) in the response
Challenges	<ul style="list-style-type: none"> - Limited number of human resources/ staff - Prolonged turn-around-time from specimen collection to receipt in the lab in some instances

	<ul style="list-style-type: none"> - Inadequate/ incorrect supply of equipment, reagents and consumables as strategy changes eg. surge, traveller testing, proposed school testing and land border, sentinel testing; Reagents supplied with inserts in foreign language - Delayed remuneration of personnel - Compromised staff health and safety - Late notification for preparedness for new strategic interventions eg Surge - Inadequate storage capacity - Inadequate bio-safety measures in place
Recommended actions	
<p>a. For immediate implementation:</p> <ul style="list-style-type: none"> - Improve timeliness of procurement and distribution of fit-for-purpose equipment, reagents, consumables and supplies to all COVID-19 testing laboratories in-country, including automated high-throughput equipment. - Regular stock-taking for laboratory equipment, reagents, consumables, supplies. - Involve laboratory pillar in all strategic response planning and interventions (e.g surge, school testing, etc). - Review specimen storage policy and improve specimen storage infrastructure in laboratory facilities (freezers, spaces). <p>b. For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:</p> <ul style="list-style-type: none"> - Conduct regular QC and EQA for COVID-19 and other public health diseases. - Develop and implement a laboratory waste management policy. - Accreditation (ISO 15189) of COVID-19 testing laboratories. - Activate a centralised specimen storage mechanism (biobank). - Develop/ expand and fund national institutional capacity for specialized training for epidemic prone diseases. - Human resources capacity building through Continuous Medical Education – (e.g On-the-job/ refresher training for specimen collectors and transporters, lab personnel). - Conduct meetings to strengthen coordination between laboratories, partners, response personnel, communities, and other stakeholders. - Monitoring and supportive supervision for all laboratory facilities. - 	

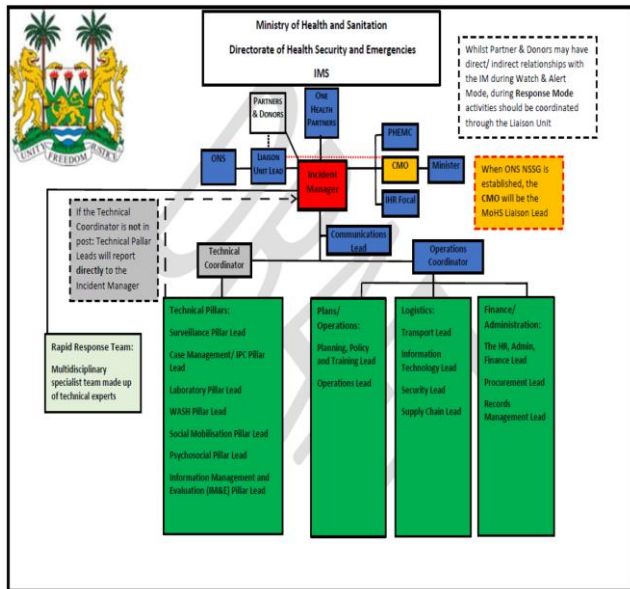
3.4 Coordination Pillar

1. A significant amount of training and exercising had been done to strengthen the relationship between the MoHS and the ONS. The creation of the NACOVERC & DiCOVERC, was new, in terms of systems and processes, so initially had little regarding the clarity of roles and responsibilities. National Disasters at a MoHS Level 3 are normally managed and coordinated by the ONS, but this wasn't initially the case in this response. This led to Parallel structures been formed and a duplication of efforts.



Recommendations: The creation of a Public Health Agency is contingent upon the passing into law the revised Public Health Act, which is in an advanced stage with the consultation with key stakeholders. Such an agency would have the legal mandate to lead and manage Level 3 responses, with the support from other MDA's. However, the MoHS should address the consistent lack of resources, at all levels, for emergency preparedness and response.

2. The Public Health Emergency Management Committee (PHEMC) failed to meet before and during the COVID-19 response, to provide the strategic leadership for the MoHS. As such, several existing documents and mechanisms were not followed through and resources were not fully utilised as planned.



Recommendation: As de-escalation is being considered, the PHEMC should be established or reactivated to provide the strategic leadership and guidance to technical teams. The PHEMC is an important part of the MoHS IMS and will be key in briefing higher authorities as well as coordination across MDA's.

3. The Incident Management Structures in place were not fully understood by all actors. This in turn led to poor transition, due to misunderstanding of the IMS. NACOVERC and DiCOVERCs meetings were held rather than Pillar meetings and Partners were not aware of some meetings, resulting in silo working.

Recommendation: *There should be proper orientation, with clear terms of reference (TOR) of all actors involved in the response. As part of de-escalation, there is need to ensure that security authorities are continually linked to the response and are appropriately briefed.*



3.4.1 Coordination Pillar Review	
Observations	
Best practices	<ul style="list-style-type: none"> - There were existing and available emergency management documents in place which were used (in part) to guide the emergency preparedness efforts and develop various plans. - Pandemic influenza Plan adapted to develop initial response plan. - Concept of Operation (ConOps) was available. - Activation of One Health Platform. - Early COVID-19 Simulation Exercises(Simex) for all DMOs and Airport SOPs Simex. - The early introduction of risk mitigation and preventive measures was also crucial. - The early establishment of NaCOVERC also played a key role in response measures, provided wider coordinated leadership, command and control. - The retention of trained emergency staff by the ministry and also absorption of some former National Ebola Response Centre (NERC) response personnel into NaCOVERC was another best practice. - Decisive political leadership. - Airport shut down and strict adherence to screening procedures implemented. - Implementation of quarantine policy at the Airport for travellers from countries with a threshold of fifty (50) cases and above.
Challenges	<ul style="list-style-type: none"> - Weak Governance Structures In Place For Resource Mobilization and Management. - Uncoordinated Communication Channel/ Pathway. - Inadequate Knowledge and Improper Use Of The IMS.

	<ul style="list-style-type: none">- Weak Partner Coordination.- Vulnerable Populations Not Considered And Protected In The Response.- Lack of Clear Mechanism To Access Emergency Funds.- Data Discrepancies.- Lack Of Proper Orientation Of Response Actors At All Levels of the IMS.- Inadequate Logistics For The Response.
Recommended actions	
<p>a. For immediate implementation:</p> <ul style="list-style-type: none">- PHEMC should meet regularly and brief higher authorities appropriately (Immediate/Short Term)- There should be proper orientation, with clear terms of reference (TOR) of all actors in the response. (Immediate/Short Term)- Escalation and De-escalation from level 2 to level 3 should be guided by the IMS process (use of ConOps - SOPs), with clear orientation of new team. (Immediate/Short Term)- Popularization of strategies to all pillars/ partners, and MDA`S (Short Term/Medium Term)	

3.5 RISK COMMUNICATION AND COMMUNITY ENGAGEMENT PILLAR

1. A lack of coordination among various government agencies with delivery messaging early in response was a major challenge. This led to mixed messaging and confusion among the public. The lack of evidence-based information to share early on in the epidemic created a void for fake news to fill.

Recommendation: *Provide Basic Risk Communication Training for Spokespersons of MDAs. Additionally, all those trained in Risk Communication(RC) should be given refresher training and be captured in a database. This will provide easy retrieval and trained individuals can be used in future responses or in the event of resurgence.*



2. There was a low level of trust in government officials, which lead to an unwillingness among certain sectors of the public to accept compliance messages. Because of the nature of the COVID-19 disease and the large percentage of asymptomatic carriers, the low risk perception led to low compliance.

Recommendation: *Intensify Community engagement through training Community Liason officers, active in every chiefdom and ward in Western Area.*

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3. The Risk Communication & Social Modilisation (RCSM) experienced several resource constraints which contributed to limited and delayed activities and interventions. There were a number of bottlenecks in accessing funds and a perceived lack of appreciation of the importance of RCSM.

Recommendation: *There is a need to develop a business continuity plan for the RCSM Pillar. The plan will clearly define the interdependencies of responding pillars*



3.5.1 Risk Communication and Community engagement Pillar Review	
Observations	
Best practices	<ul style="list-style-type: none"> - RC Strategy was in place - Partners Involvement in Developing the Strategy - Existing RC (OH) structure across the country - Regular Update to the public & Responding to Public Concerns - Appointment of Strategic Advisers - Regional meetings and supportive supervision with district RCSM leads - Building capacity of media practitioners in terms of reporting on COVID-19
Challenges	<ul style="list-style-type: none"> - Nature of the coronavirus disease - Changes in science and messaging - Resource constraints - Non-compliance with prevention measures by public officials and community leaders - Low level of trust in government officials - Lack of automated media monitoring system - Lack of coordination among various government agencies with delivering messaging early in response - Infodemic/huge surge of fake news and misleading information shared online and social media
Recommended actions	
<p>a. For immediate implementation:</p> <ul style="list-style-type: none"> - <u>To develop a business continuity plan for RCSM Pillar</u> - Intensify Community engagement through CLA - <u>Refocus RCSM activity plan to deal with emerging trend</u> - Data Base of trained RCSM personnel and other stakeholders across the country - <u>Procure and set up an automated media</u> - <u>Establish mechanism to sustain partnership with media</u> <p>b. For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:</p> <ul style="list-style-type: none"> - Institutionnalise Public Health Agency - Review OHRC Strategy - Provide Basic Risk Communication Training for Spokesperson in MDAs 	

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3.6 Food Assistance and Nutrition Pillar

1. The Food Assistance and Nutrition (Fan) Pillar was the last one to be formed during the response and identified weak coordination and poor communication between suppliers and caregivers (MoHs staff/NaCOVERC). Additionally, there was weak data management, inconsistencies in food supplies leading to wastage, duplication and inefficient use of resources.

Recommendation: *Establishment of a public health agency would provide the opportunity for emergency funds to be readily available for FAN, supported by updated and costed emergency response plan.*

2. Delays in accessing emergency funds severely affected the quality of services, resulting in some services not being delivered. With non-adherence to the SOP menu, limited manpower led to uncoordinated processes and multiple requests from partners.

Recommendation: *There is a need to ensure that food contractors are urgently paid.*

3. The Fan Pillar was able to provide food for all persons in quarantine including breakfast, lunch and dinner. However, observations were made on the timing and quality of the food provided. Food supplies to hospitals had been recently challenged, to the extent that even during the lockdown, people had to leave the hospitals for lack of food.



Recommendation: *FAN should review their standard operating procedures to ensure the timely supply of food distribution and improvements of service. In addition, nutritional related services at hospital level should be strengthening with the involvement of the FAN pillar for effective service at facility level.*

3.6.1 Food Assistance & Nutrition Pillar Review

Observations

Best practices	<ul style="list-style-type: none"> - Establishment of FAN Pillar in the COVID-19 by Government. - Development of SOP for FAN implemented and disseminated nationwide - The availability of a plan to mitigate starvation for targeted population during lock down. - Establishment of FAN Pillar in the COVID-19 by Government. - Integration of focal persons from line ministries and partners into the response. - Decentralisation of FAN at district levels to support COVID-19
Challenges	<ul style="list-style-type: none"> - Delay in accessing emergency funds - Delayed data flow and inconsistent data to address food needs across pillars - Delay in the establishment of food assistance and nutrition structures at the beginning of the pandemic - Lack of inclusion/integration of nutrition in the FSMS - Inadequate support to welfare/grant institutions and vulnerable groups eg. DPOs - Delay in payment of food service providers during emergencies

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Recommended actions

- a. For immediate implementation:
 - Establishment of public health agency
 - Establishment of public fund
 - Updated and costed emergency response plan
 - Urgent payment of food contractors
 - Capacity building for staff and service providers
- b. For mid to long-term implementation to improve the response to the ongoing COVID-19 outbreak:
 - Capacity building of staff and stakeholders in the different locations/pillars during pandemic
 - Provide social support for vulnerable groups and staff in pandemic
 - Assessment and identification of vulnerable groups
 - Improve coordination and data flow across pillars

4. THE WAY FORWARD

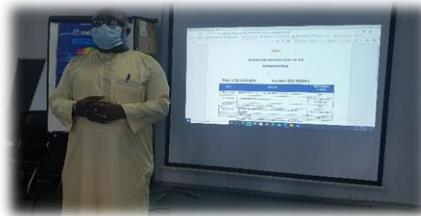
In terms of ensuring that the recommendations and supportive activities are implemented, a whole of government approach is required. It is therefore recommended that this report is presented to the Senior Leadership of the NACOVERC for consideration.



Whilst discussions are ongoing regarding de-escalation of the COVID-19 response, there is a need to ensure that core Pillars within the IMS are maintained and where required, improvements upon.

Whilst response Pillars are responsible for following through with activities that have been highlighted within this report. There is a realisation that financial and material support will be required to facilitate implementation of activities.

As such, NACOVERC and/ or the MoHS need to clearly define how the implementation of the recommendations will be supported and monitored. To support this, an IAR follow-up Team should be formed to provide the required governance and oversight of activities, including monitoring and evaluation.



Whilst activities have been divided into short, medium and longer plans, there is still a need to prioritize them. Timelines for implementation should be strictly adhered to, ensuring that actions are completed in a timely manner.

In considering the identified longer-term activities, they should be looked at in the context of other planned activities, such as the National Action Plan for Health Security (NAPHS).

As the MoHS transition into the progressive realisation of a National Public Health Agency, the scope of authority needs to be clearly defined.

5. ANNEXES

Annex 1: IAR Agenda



COVID-19 INTRA-ACTION REVIEW (IAR)

5.1.

Government of Sierra Leone

22nd- 23rd September 2020

Golden Tulip, Essential Kimbima Hotel, Freetown

Agenda Day 1

TIME	SESSION	RESPONSIBLE PERSON
09 :30-09 :55	Registration and administrative formalities and instructions	Admin
09 :55-10 :00	Call to order	Mr J. Bunting Graden
10 :00-10 :15	Chairman Welcome Address/ Opening Remarks (MoHS, NACOVERC, Partners)	Prof Foday Sahr
10 :15-10 :25	Introductions, IAR Aims & Objectives for next two days	Prof Foday Sahr
10 :25-10 :40	COVID-19 in the WHO African region	Dr Charles Njuguna
10 :40- 10 :50	COVID-19 in Sierra Leone	Dr Mohamed Vandi
10 :50-10 :55	Intra-Action Review Methodology and running order	Mr Ian Rufus
11 :00-12 :30	Review 1. Surveillance/POE	Pillar Representative
12 :30-13 :30	Lunch	Admin
13 :30-15 :00	Review 2. Case Management, Psychosocial, IPC	Pillar Representative
15 :00-15 :15	Coffee break	Admin
15 :15-16 :45	Review 3. Laboratories	Pillar Representative
16 :45-17 :00	Round up of Day one : Key observations	Prof Foday Sahr

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Agenda Day 2

TIME	SESSION	RESPONSIBLE PERSON
09 :30-09 :55	Registration and administrative formalities and instructions	Admin
09 :55-10 :00	Call to order/ Individual prayers	Mr J. Bunting Graden
10 :00-10 :05	Chairman Welcome Address	Dr Sartie Kenneh
10 :05-10 :30	Recap of Day 1, Introduction to day 2	Dr Sartie Kenneh
10 :30-11 :30	Review 4. Risk Communication	Pillar Representative
11 :30-12 :30	Review 5. Food Assistance & Nutrition (FAN)	Pillar Representative
12 :30-13 :30	Lunch	Admin
13 :30-15 :00	Review 6. NACOVERC, Coordination	Pillar Representative
15 :00-15 :15	Review 7. Success Stories	Mr Steve Ngaojia
15 :15-15 :30	Coffee break	Admin
15 :30-16 :30	Review 8. Action Planning, Way Forward and Report	Dr Claudette Amuzu/ Dr Robert Musoke
16 :30-16 :45	Round up of Intra Action Review : Key take home messages	Dr Sartie Kenneh

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Annex 2: Composition of the IAR Lead Coordinators.

Role	Name	Organization	Partners	Main responsibility
IAR LEAD COORDINATOR	Joseph Bunting Graden Steve Ngaojia	MOHS NACOVERC	WHO	IAR oversight and programme management
Lead facilitators	Prof Foday Sahr Dr Sartie Kenneh Prof Samai	NACOVERC MOHS COMMAHS	WHO/CDC	Lead the facilitation in the main IAR providing technical oversight
Lead Note takers and report writer	Mohamed Sundifu Mr. Emile Koroma	NACOVERC MOHS	Breakthrough-Action WHO CDC	Capture discussions and support the writing of the IAR report.
Admin Support			WHO	Admin, IT and finance

The table below sets out the composition of the Pillar Level IAR team.

Pillar	Focal person/convener	Organization	Pillar facilitator	Partner facilitator
Coordination	Mukeh Fahnbulleh Commodore Miller	MOHS NACOVERC	Dr Dennis Marke Dr Joan Shepherd	WHO/CDC/AFENNET
Surveillance/POE	Dr Kanu Dr Squire	MOHS MOHS	Dr Alie Wurie	WHO/CDC/AFENNET
Case Management, psychosocial, IPC	Dr Sevalie Christiana Kallon Hon Haji Kella Dr Sandi	NACOVERC MOHS NACOVERC	Dr Ramatulie Wurie	WHO/Kings College/PIH/CDC
Labs	Dr Zikan Prof Gevao	MOHS NACOVERC	Dr Yvonne Harding Dr Isata Wurie	WHO/CDC
Risk Communication	Harold Thomas Solomon Jamiru Alfred Jamiru	MOHS NACOVERC	Dr Tonya Musa	Breakthrough-Action/WHO/UNICEF
Food & Nutrition	Aminata Shमित Koroma Mrs Nenebah Jalloh	MOHS NACOVERC	Patricia Bah Dr Lynda Foray	WHO/WFP/UNICEF

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**Annex 3: List of participants at the Intra-Action Review
Day 1**

VENUE - Golden Tulip

Dates: 22-09-2020

WHO REGISTRATION FORM
WORLD HEALTH ORGANIZATION SUPPORTING THE MINISTRY OF HEALTH AND SANITATION
COVID-19 INTRA-ACTION REVIEW (IAR)



Daily Attendance Register -

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53							

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WHO REGISTRATION FORM

WORLD HEALTH ORGANIZATION SUPPORTING THE MINISTRY OF HEALTH AND SANITATION
 COVID-19 INTRA-ACTION REVIEW (IAR)



VENUE *Garden Pavilion*

Dates: *21/9/2020*

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Delegates List Day 2

WHO REGISTRATION FORM

WORLD HEALTH ORGANIZATION SUPPORTING THE MINISTRY OF HEALTH AND SANITATION
 COVID-19 INTRA-ACTION REVIEW (IAR)



VENUE - Golden Tulip

Dates: 23rd Sept to 20th Oct 2020

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